UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, and the States of CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA, FLORIDA, GEORGIA, HAWAII, ILLINOIS, INDIANA, IOWA, LOUISIANA, MARYLAND, COMMONWEALTH OF MASSACHUSETTS, MICHIGAN, MINNESOTA, MONTANA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, OKLAHOMA RHODE ISLAND, TENNESSEE, VERMONT, WASHINGTON, COMMONWEALTH OF VIRGINIA, and Doe States 1-21 *ex rel.* John Doe, Plaintiffs, v. CVS HEALTH CORPORATION, CVS PHARMACY INC., CONNECTICUT CVS PHARMACY, LLC, INDIANA CVS PHARMACY, LLC, and OKLAHOMA CVS PHARMACY, LLC, Defendants.	)	Civil Action No. 16-2359 (ABJ)

CONSOLIDATED COMPLAINT-IN-INTERVENTION OF THE INTERVENING STATES

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INTRODUCTION

1. This is a civil action brought by the states of Connecticut, Indiana, and Oklahoma, and the Commonwealth of Massachusetts (the "Intervening States") against CVS Health Corporation, CVS Pharmacy, Inc. and certain of their subsidiaries (collectively, "CVS") for the knowing submission of false and fraudulent claims to the Intervening States' Medicaid Programs. From at least January 1, 2016 to the present (the "relevant time period"), CVS failed to comply with regulations requiring that it submit usual and customary ("U&C") prices on prescription drug claims to Medicaid, the goal of which is to ensure that Medicaid does not pay higher prices than non-Medicaid payers.[1]

2. Because of CVS's conduct, the Intervening States' Medicaid Programs regularly paid higher prices to CVS than non-Medicaid payers for prescription drugs. That is because CVS used discount card programs, specifically a discount card program with the company Medical Security Card Company d/b/a ScriptSave, to offer cash-paying customers with a ScriptSave discount card lower prices than it reported to the Intervening States' Medicaid Programs as its U&C prices.

3. In its internal transaction data, CVS categorized discount card transactions as "cash discount" transactions. This characterization was telling. CVS's process for operationalizing cash discount transactions entailed three things. First, the CVS cash discount prices were made available to anyone who wanted to sign up for them and thus were offered to the general public. Indeed, Target pharmacies had reported these same prices as its U&C prices

[1] The purpose of U&C requirements is "to ensure that Medicaid does not pay more than the price generally available to the public." Thus, "[a]n example of usual and customary charge is a pharmacy charging $4 for commonly used generics." Medicaid and CHIP Payment and Access Commission, MEDICAID PAYMENT FOR OUTPATIENT PRESCRIPTION DRUGS ISSUE BRIEF, *available at* www.macpac.gov, p. 5 (May 2018).

before CVS acquired Target pharmacies in late 2015. After CVS took over Target pharmacy operations and Target's customer base, CVS continued to offer the same prices to cash-paying customers. CVS knew or should have known that these prices should have been reported as U&C prices, especially because CVS knew that Target had treated them as U&C.

4. Second, while CVS avoided reporting its discount prices as U&C prices under the guise that a third party, ScriptSave, offered them, ScriptSave was a CVS vendor and continued working with CVS as an administrator. CVS worked strategically with ScriptSave to set pricing, and thus CVS (and not ScriptSave) was the party offering these discounts to the general public.

5. Third, because the cash-paying customer was the relevant payer in all cash discount transactions, these transactions implicated the legal rules in the Intervening States that required that Medicaid receive the best price offered to or accepted from any payer—including the best price offered to any member of the general public via a discount program or an offered discount.

6. The Intervening States' Medicaid programs do not have access to data for cash-paying customers, like those paying with a ScriptSave discount card, and thus were unaware that CVS was offering lower prices to the cash-paying general public than it was offering to Medicaid. This material misrepresentation by CVS caused the Intervening States' Medicaid Programs to reimburse CVS at higher prices than CVS was entitled under the Intervening States' regulations.

7. Now the Intervening States, through their respective False Claims Acts and other state laws, jointly file this Complaint-in-Intervention against CVS to recover treble damages, restitution, and penalties for engaging in this fraud.

PARTIES, JURISDICTION, AND VENUE

8. Plaintiff the State of Connecticut, acting through the Connecticut Office of Attorney General ("Connecticut"), brings this action pursuant to the Attorney General's authority under the Connecticut False Claims Act. The Connecticut Department of Social Services administers the Connecticut Medicaid program using federal and state taxpayer money.

9. Plaintiff the State of Indiana was and is at all times relevant to this action a sovereign state of the United States of America represented by the Indiana Attorney General, who brings this action in the interest and on behalf of the State of Indiana, its citizens, and the Indiana Family and Social Services Administration ("FSSA"), which administers the Indiana Health Care Programs ("IHCP," a/k/a the Indiana Medicaid program) using federal and state taxpayer money.

10. Plaintiff the Commonwealth of Massachusetts is a sovereign state and body politic duly organized by law and is represented by the Massachusetts Attorney General, who brings this action in the public interest and on behalf of the Commonwealth of Massachusetts, its citizens, taxpayers, the Massachusetts Executive Office of Health and Human Services ("EOHHS") and MassHealth, which jointly administers the Massachusetts Medicaid program with the United States.

11. Plaintiff the State of Oklahoma is a sovereign state of the United States of America represented by the Oklahoma Attorney General, who brings this action in the interest and on behalf of the State of Oklahoma, its citizens, and the Oklahoma Health Care Authority ("OHCA"), which administers the Oklahoma Medicaid program, SoonerCare.

12. Defendant CVS Health Corporation is a Delaware corporation with its principal place of business in Woonsocket, Rhode Island. CVS Health Corporation owns Defendant CVS

Pharmacy, Inc., a Rhode Island corporation whose principal place of business is also located in Woonsocket, Rhode Island. Through a network of wholly owned subsidiaries, CVS conducts pharmacy business nationwide, including in the Intervening States, and is the largest retail pharmacy chain in the United States. Included among those subsidiaries are Connecticut CVS Pharmacy, LLC; CVS Indiana, LLC; Oklahoma CVS Pharmacy, LLC; and numerous other pharmacy subsidiaries throughout the United States (collectively, "Pharmacy Subsidiaries").

13. CVS Pharmacy Inc. and the Pharmacy Subsidiaries, at all times relevant to this action, operated as a single integrated entity. All financial gains and losses by the Pharmacy Subsidiaries inured to the direct benefit or detriment of CVS. From a central corporate location, CVS directed all billing and claims submission processes of the Pharmacy Subsidiaries.

14. This Court has subject matter jurisdiction under 28 U.S.C. §§ 1345, 1367(a). Additionally, the Court has supplemental jurisdiction over the state causes of action pursuant to 28 U.S.C. § 1367(a).

15. The Court may exercise personal jurisdiction over CVS, and venue is appropriate in this Court under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b), because CVS and one or more of its Pharmacy Subsidiaries can be found in and transact business in this District. The remaining Pharmacy Subsidiaries are also subject to personal jurisdiction in this District because CVS exerted centralized control over the operations of, including by directing the billing and claims submission processes of each of the Pharmacy Subsidiaries.

STATUTORY AND REGULATORY FRAMEWORK

I. The Intervening States' Medicaid Programs

16. Medicaid is a joint federal-state program that provides health care benefits, including, but not limited to, prescription drug coverage, to qualified groups such as the elderly,

impoverished, or disabled. The federal government offers funding to state Medicaid programs provided they meet certain minimum requirements set forth under the federal Medicaid statute. *See* 42 U.S.C. § 1396a. The amount of federal funding afforded to each state's Medicaid program, otherwise known as the Federal Medical Assistance Percentage ("FMAP"), is based on each state's per capita income compared to the national average. *Id*. § 1396d(b). Each state pays the remaining balance that the FMAP funds do not cover out of the state's budget ("State Share"). During the relevant time period, the State Share for the Medicaid programs of each of the Intervening States was between thirty-five (35) and fifty (50) percent.

17. Each state Medicaid program is required to implement a "State Plan" containing minimum criteria for coverage and payment of claims to qualify for federal funds for Medicaid expenditures. *See* 42 U.S.C. § 1396a.

18. During the relevant time period, CVS owned and operated numerous retail pharmacies in the Intervening States. These CVS pharmacies, either themselves or through CVS's network of wholly owned subsidiaries, enrolled as participating providers in the Intervening States' Medicaid programs.

19. When entities, including pharmacies, enroll as Medicaid providers, they must sign a provider agreement with the state that obligates them to comply with all federal and state laws, as well as all rules, regulations, and policies enacted by the state agency that administers Medicaid in each state. CVS signed these provider agreements in each of the Intervening States.

20. CVS, as a Medicaid provider, submitted or caused to be submitted claims for payment to the Medicaid programs of the Intervening States. CVS was thus obligated to ensure that it had provided services and submitted claims that conformed with the statutes, rules, regulations, and policies of each state's Medicaid program.

A. Connecticut's Medicaid Program

21. The Connecticut Department of Social Services ("DSS") is the single state agency that administers and supervises the Connecticut Medicaid program, which is encompassed within the Connecticut Medical Assistance Program ("CMAP"). Thus, the DSS sets the rules for the provision of medical services to Connecticut Medicaid beneficiaries, the circumstances in which providers can voluntarily enroll in Connecticut Medicaid, and how Connecticut Medicaid reimburses providers for these claims. Conn. Gen. Stat. § 17b-2; Regs. of Conn. State Agencies ("R.C.S.A.") § 17b-262.

22. Enrollment by providers in Connecticut Medicaid is entirely voluntary and is conditioned upon providers entering into provider agreements with the DSS. *See* 42 C.F.R. § 442.12.

23. CVS, because its pharmacies are enrolled as Connecticut Medicaid providers, must comply with Connecticut Medicaid regulations. CVS has entered into multiple provider agreements with Connecticut Medicaid throughout the relevant time period, each of which requires it to comply with all state and federal laws, regulations, and rules applicable to participation in Connecticut Medicaid.

24. Connecticut Medicaid beneficiaries receive coverage through a fee-for-service delivery system. The DSS, or its fiscal agent, pays pharmacy providers directly for items and services delivered to beneficiaries. Any improper billing or overcharging of Connecticut Medicaid by a provider causes financial injury to the State of Connecticut and its taxpayers.

25. During the relevant time period, Connecticut Medicaid was required to pay the "lowest of" various cost metrics for covered outpatient drugs dispensed by a retail community pharmacy like CVS. Connecticut Medicaid pays the lowest of: (a) the DSS's estimated

acquisition cost or its federal equivalent plus a professional dispensing fee; (b) the pharmacy provider's usual and customary charge to the general public; or (c) the amount billed by the pharmacy provider. Connecticut Department of Social Services, Connecticut Medical Assistance Program Provider Manual, Chapter 7 – Pharmacy, Medical Services Policy 174 (Drugs), *available at*: https://www.ctdssmap.com/CTPortal/Information/Publications (current since Oct. 1, 2020), § 174H.1.b. – 174H.1.d.3; *see* R.C.S.A. § 17-134d-81. The regulations further provide that "a pharmacy provider shall, when billing the Department for a good or service, bill the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program." Conn. Gen. Stat. § 17b-226a.

26. Because providers under contract with Connecticut Medicaid agree to abide by and comply with all federal and state statutes, regulations, and policies relating to Connecticut Medicaid, Provider Agreement ¶ 5, providers impliedly certify that they are complying with applicable statutes and regulations when submitting claims for payment. The provider agreements CVS entered into with Connecticut Medicaid and that were in effect during the relevant time period required CVS to bill Connecticut Medicaid only for compensation that CVS was legally entitled to receive. Provider Agreement ¶ 15.

27. When pharmacies seek reimbursement for filling a prescription for a Connecticut Medicaid beneficiary, they submit claims through a Point of Sale ("POS") online, real-time pharmacy electronic claims transmission process. R.C.S.A. § 17b-262-523(19). Using this system, pharmacy providers can submit drug reimbursement claims to Connecticut Medicaid electronically and in real time.

28. Because it is not practical for Connecticut Medicaid to process all claims manually, Connecticut Medicaid providers bill largely on the honor system. If Connecticut

Medicaid or the Connecticut Office of the Attorney General later learn that claims should not have been paid and/or should not have been paid at the rate they were—whether due to fraud, a failure by the pharmacy provider to properly report its U&C prices, or some other reason—they must use other methods to recoup these claims, which have already been paid to the provider.

29. A provider that is aware of overpayments received from the CMAP is obligated to report and return the overpayment within sixty (60) days. 42 U.S.C. § 1320a-7k(d).

30. Connecticut regulations and the Provider Agreement require that any overpayment for CMAP goods or services, defined as the excess over the allowable payment under state law and including, but not limited to, any payment obtained through fraud or abuse, shall be payable to the DSS. R.C.S.A. §§ 17b-262-533, 17b-262-523(18); Provider Agreement ¶ 23.

B. Indiana's Medicaid Program

a. <u>Indiana's Medicaid Program</u>

31. The Indiana Family and Social Services Administration ("FSSA") is responsible for administering the state's Medicaid program ("Indiana Health Coverage Programs" or "IHCP") and is empowered to adopt rules and procedures as needed to administer that program. Ind. Code §§ 12-15-1-1, 10.

32. IHCP operates a fee-for-service plan, in which providers submit claims to and are reimbursed directly by IHCP. IHCP also operates multiple managed care plans, in which a third-party insurer has contracted with IHCP and assumed responsibility for managing most types of claims and submitting payments to providers.

33. Provider enrollment is entirely voluntary, but pharmacies must enroll to be able to submit prescription drug claims to IHCP for payment. To enroll as a provider for IHCP, the provider must sign a provider agreement with FSSA. Ind. Code § 12-15-11-2.

34. The terms and conditions of that agreement require the provider to, in relevant part:

- "comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time,"
- "provide covered services and/or supplies for which federal financial participation is available for members pursuant to all applicable federal and state statutes and regulations,"
- "submit timely billing on IHCP-approved electronic or paper claims, as outlined in the policy manual, reference modules, bulletins, and banner pages, ***in an amount no greater than Provider's usual and customary charge to the general public for the same service***,"
- "certify that any and all information contained on any IHCP billings submitted on the Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete,"
- "submit claims that can be documented by Provider as being strictly for: … c. compensation that Provider is legally entitled to receive,"
- "refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt." (emphasis added)

35. The Indiana Health Coverage Programs Provider Manual is the "interpretive document or documents issued" by FSSA to inform providers "of their obligations under Medicaid to which they must conform to retain their provider status and receive payment for appropriate services, and to provide them essential information for understanding Medicaid as it relates to the services for which they are qualified to provide under the state statutes." 405 Ind. Admin. Code § 1-1-1(16).

36. By accepting payment of a claim submitted to IHCP, a provider agrees to comply with the statutes and rules governing the program. Ind. Code § 12-15-21-1.

37. A provider that is aware of overpayments received from IHCP is obligated to report and return the overpayment within 60 days. 42 U.S.C. § 1320a-7k(d).

b. IHCP Rates for Payment of Pharmacy Services

38. The terms of reimbursement for pharmacy benefits under Indiana's Medicaid program are set forth in 405 Ind. Admin. Code § 5-24-1, which states in relevant part that:

> (a) This section represents the Medicaid medical policy and covered service limitations with respect to pharmacy services provided by a pharmacy provider. Medicaid reimbursement is available for pharmacy services rendered by pharmacy providers, when such services are:
>
> > (1) provided in accordance with all applicable laws, rules of the office, and Medicaid provider manual; and
> >
> > (2) not specifically excluded from coverage by rules of the office…

39. The rate of reimbursement provided to pharmacy providers for legend drugs is governed by 405 Ind. Admin. Code § 5-24-4, which provides in relevant part that the applicable rate is the lowest of five potential price points:

> (1) The National Average Drug Acquisition Cost (NADAC) of the drug as published by the Centers for Medicare and Medicaid Services (CMS)…
>
> (2) The state maximum allowable cost (MAC) of the drug as determined by the office…
>
> (3) The federal upper limit (FUL) of the drug as determined by CMS…
>
> (4) The wholesale acquisition cost (WAC) of the drug…
>
> (5) ***The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing***. (emphasis added).

40. The term "usual and customary charge" for pharmacy services is defined in 405 Ind. Admin. Code § 5-24-2(b) as "the amount a pharmacy provider offers to charge the general public for a pharmacy service." If a discount is made available to the general public, "***the usual and customary charge shall be the amount that results from the application of the discount***" or the lowest amount if there are multiple applicable discounts. *Id.* (emphasis added).

c. Submission of Claims to IHCP

41. At all relevant times, IHCP has allowed enrolled pharmacy providers to submit claims for reimbursement online at the point of sale (a "POS Transaction") through a real-time pharmacy electronic claims transmission process. This process is administered by a third-party pharmacy claim processor, Optum Rx.

42. In submitting a claim through the POS Transaction system, the pharmacy enters the IHCP beneficiary's member ID and the prescription information and transmits the information to Optum Rx. The POS Transaction system then analyzes the information provided by the pharmacy to determine the eligibility of the claim for reimbursement, approves or denies the claim, and selects the applicable reimbursement rate for the service rendered.

43. In submitting a pharmacy claim for reimbursement through the POS Transaction system, the pharmacy is required to input its U&C charge. That amount is compared against the other potential price points and the system determines the lowest of those prices. Providing an inaccurate U&C charge amount can result in IHCP paying more than it otherwise would have, if the U&C amount would have been lower than the other potential price points.

C. Massachusetts's Medicaid Program

44. The Massachusetts Medicaid program ("MassHealth") is administered by the Executive Office of Health and Human Services ("EOHHS"). Because CVS enrolls its pharmacies as MassHealth providers, CVS must comply with MassHealth regulations. CVS has entered into multiple provider contracts with MassHealth throughout the relevant time period, each of which requires it to comply with all state and federal laws, regulations, and rules applicable to participation in MassHealth.

45. MassHealth's regulations governing pharmacy services are set forth at 130 C.M.R. §§ 406.000 *et seq.*

46. MassHealth's regulations governing the rates paid for pharmacy services are set forth at 101 C.M.R. §§ 331.000 *et seq.*

47. The administrative and billing regulations governing all providers who participate in MassHealth are set forth at 130 C.M.R. §§ 450.000 *et seq*.

a. <u>Pharmacy Services and Rate Regulations</u>

48. MassHealth pays for "pharmacy services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations." 130 C.M.R. § 406.403(A)(1). A pharmacy must be "a participant in MassHealth on the date of service in order to be eligible for payment." 130 C.M.R. § 406.404(A).

49. Under MassHealth's pharmacy rate regulations, other than for drugs obtained through the 340B Drug Pricing Program,[2] MassHealth pays the lowest of a variety of cost metrics, including "the usual and customary charge."

50. Pursuant to 101 C.M.R. § 331.04(1), for multiple source drugs, MassHealth pays ***the lowest of***: "(a) the Federal Upper Limit of the drug, if any, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or (b) the Massachusetts Maximum Allowable Cost ["MAC"] of the drug, if any, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or (c) the [Actual Acquisition Cost] of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or ***(d) the usual and customary charge***." (emphasis added).

51. Pursuant to 101 C.M.R. § 331.04(2), for blood clotting factor, MassHealth pays ***the lowest of***: "(a) the Federal Upper Limit of the drug, if any, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or (b) the [Actual Acquisition Cost] of the drug, plus the

[2] The 340B Drug Pricing Program is "a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992," 101 C.M.R. § 331.02, which enables covered entities like hospitals to procure outpatient drugs at discounted rates.

appropriate dispensing fee as listed in 101 CMR 331.06; or (c) 106% of the Average Sales Price of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or ***(d) the usual and customary charge***." (emphasis added).

52. Pursuant to 101 C.M.R. § 331.04(3), for all other drugs other than those listed above and drugs obtained through the 340B Drug Pricing Program, MassHealth pays ***the lowest of***: "(a) The Massachusetts [MAC] of the drug, if any, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or (b) The [Actual Acquisition Cost] of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or ***(c) The usual and customary charge***." (emphasis added).

53. Pursuant to 101 C.M.R. § 331.05, for over-the-counter drugs, MassHealth pays ***the lowest of***: "(1) the Massachusetts [MAC] of the drug, if any, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or (2) the [Actual Acquisition Cost] of the drug, plus the appropriate dispensing fee as listed in 101 CMR 331.06; or ***(3) the usual and customary charge***." (emphasis added).

54. MassHealth defines "usual and customary charge" to mean "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service, in Massachusetts, including but not limited to the shelf price, sale price, or advertised price for any drug including an over-the-counter drug." 101 C.M.R. § 331.02. This definition is commonly referred to as a "Most Favored Nation" requirement.

55. MassHealth's "Most Favored Nation" requirement became effective on June 11, 1995, though the definition of U&C charge has been amended since that time.

56. MassHealth has not, in any of its amendments to regulations or communications to providers, informed providers that it only requires compliance with its "Most Favored Nation" requirement with respect to certain categories of drugs, such as brand drugs.

57. In fact, Massachusetts is a "generic first" state, meaning that Massachusetts law encourages providers and pharmacies to dispense generic drugs instead of brand drugs when possible. *See* Mass. Gen. Laws ch. 112, § 12D ("The standards shall permit the practitioner to instruct the pharmacist to dispense a brand name drug product by indicating 'no substitution'. The standards shall require that the indication of 'no substitution' shall not be the default indication and further that the prescription indicate the 'Interchange is mandated unless the practitioner indicates "no substitution" in accordance with the law'. Where the practitioner has so indicated 'no substitution', the pharmacist shall dispense the exact drug product as indicated by the practitioner."); 105 C.M.R. §§ 720 Foreword (""The Massachusetts List of Interchangeable Drugs, is prepared by the Drug Formulary Commission (DFC) and the Department of Public Health. The DFC is . . . for the express purpose of developing a list of those drug products that are safely interchangeable – that is, equivalent to each other in all significant respects . . . This law was enacted with the intent of saving money for consumers of prescription drugs, since drug products that are marketed under trademark or proprietary names are often available in the generic forms from competing manufacturers at substantially lower prices. [Mass. Gen. Laws ch. 112], § 12D mandates prescription forms that allow practitioners to prescribe interchangeable drug products by simply signing the signature line. If a practitioner determines that a brand name drug product should be dispensed, he/she must sign the signature line and write the words 'no substitution' in his/her own handwriting in the space provided below the signature line.").

58. In or about August 2008, MassHealth advised pharmacy providers of a change to the U&C definition, effective September 2008, which was intended to clarify that it covered cash-paying customers. Specifically, MassHealth issued Transmittal Letter 58, noting that the change would:

> alter the definition of "usual and customary charge," by clarifying that pharmacy providers are required to include cash-paying customers along with insurers when determining the lowest payment that the provider will accept. The definition also clarifies that providers must include over-the-counter drug formulations when determining the lowest cost drug….

59. MassHealth pharmacy providers were also advised in December 2011, in a document labeled "MassHealth Pharmacy Facts," that they must report an accurate U&C charge for each drug included on all pharmacy claims.

b. <u>All Provider Regulations</u>

60. In addition to the regulations governing specific provider types, all MassHealth providers are subject to the "all provider" regulations at 130 C.M.R. §§ 450.000 *et seq.*

61. These "all provider" regulations state, in relevant part, that every provider under contract with MassHealth agrees to comply with all laws, rules, and regulations governing MassHealth. 130 C.M.R. § 450.223(C)(1).

62. The regulations also state that every provider under contract with MassHealth certifies when submitting a claim for payment that "the information submitted in, with, or in support of the claim is true, accurate, and complete." 130 C.M.R. § 450.223(C)(2)(e). Therefore, providers impliedly certify that they are complying with applicable regulations when submitting claims for payment.

63. The MassHealth regulations governing overpayments state, "[a] provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost

report, by the date any corresponding cost report is due, whichever is later." 130 C.M.R. § 450.235(B).

64. A provider is liable to the MassHealth agency for the full amount of any overpayments, or other monies owed under 130 C.M.R. §§ 450.000 *et seq.*, including but not limited to 130 C.M.R. § 450.235(B), or under any other applicable law or regulation. 130 C.M.R. § 450.260(A).

c. MassHealth Claims Submission

65. MassHealth members may receive coverage through MassHealth fee-for-service or managed care entities, third-party insurers that administer services to MassHealth members. MassHealth pays providers directly for services delivered to members on a fee-for-service plan, which is the source of payment relevant to this complaint.

66. In 1995, Massachusetts implemented a Pharmacy Online Processing System ("POPS") for processing MassHealth pharmacy claims. Using this system, pharmacy providers submit drug reimbursement claims to MassHealth electronically.

67. When a pharmacy provider submits a claim in POPS, the pharmacy is responsible for filling out various fields. MassHealth also obtains pricing data from a third party that populates various cost metrics, such as the MAC of the drug. Typically, in Massachusetts, pharmacies like CVS submit the cash price paid for the drug in the "usual and customary" field, while pharmacies submit the "usual and customary charge," as defined by MassHealth's regulatory requirements, in the "gross amount due" field.

68. When a claim is filed, claims are batched for submission and are then approved or denied by a computer program that evaluates such claims based on system edits that have been programmed into the system. A system edit may automatically deny a claim if a required field is not filled out—for example, the name of the member who received the services. Additionally,

claims or providers may be flagged for further review for high utilization of certain codes or other anomalies.

69. Once a claim is approved for payment, the POPS system algorithm reviews the fields populated by the pharmacy provider, including the "usual and customary charge" and "gross amount due" fields, as well as the third-party cost metrics, to pay the lowest of the various cost metrics reflected in MassHealth's regulations.

70. In short, because it is not practical to process all claims manually, MassHealth providers bill largely on the honor system. If MassHealth or the Massachusetts Attorney General's Office later learn that claims should not have been paid and/or should not have been paid at the rate they were—whether due to fraud, a failure by the pharmacy provider to properly report its U&C charge, or some other reason—they must use other methods to recoup these claims, which have already been paid to the provider.

D. Oklahoma's Medicaid Program

a. <u>Oklahoma's Provision of Services to Medicaid Beneficiaries</u>

71. It is the policy of the State of Oklahoma to provide comprehensive health care to those who are dependent on the state for necessary medical care. Okla. Stat. tit. 63, § 5003(A).

72. The Oklahoma Legislature established the OHCA as the single state agency responsible for administering and supervising the Oklahoma Medicaid program. Okla. Stat. tit. 63, § 5009.

73. The Oklahoma Legislature recognizes that the State of Oklahoma is a major purchaser of health care services, and the increasing costs of such health care services poses a great financial obligation on the state. Okla. Stat. tit. 63, § 5003(A).

74. Any improper billing or overcharging of Oklahoma Medicaid by a provider causes financial injury to the State of Oklahoma and its taxpayers.

75. Through the OHCA, the State of Oklahoma endeavors "to develop effective and efficient health care delivery systems and strategies for procuring health care services in order for the state to continue to purchase the most comprehensive health care possible." *Id.*

76. The OHCA sets the rules for the provision of medical services to Oklahoma Medicaid beneficiaries, the circumstances in which providers can voluntarily enroll in Oklahoma Medicaid, and how Oklahoma Medicaid reimburses providers for these claims. Okla. Stat. tit. 63, §§ 5003 *et seq.*

77. Enrollment by providers in Oklahoma Medicaid is entirely voluntary. To receive reimbursement for services provided to Oklahoma Medicaid members, "providers must have on file with OHCA, an approved Provider Agreement." *See* Okla. Admin. Code § 317:30-3-2.

78. Every provider under contract with Oklahoma Medicaid agrees "[t]o comply with all applicable statutes, regulations, policies, and properly promulgated rules of OHCA." Provider Agreement ¶ 4.1(f).

79. Through approved provider agreements, "the provider certifies that all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations." *See* Okla. Admin. Code § 317:30-3-2; *see also* Provider Agreement ¶¶ 4.1(f), 4.3(e).

80. Providers further agree that "all claims shall be submitted to OHCA in a format acceptable to OHCA and in accordance with OHCA regulations." Provider Agreement ¶ 4.3(e).

81. Therefore, providers impliedly certify that they are complying with applicable statutes, rules, and regulations when submitting claims for payment.

82. When an overpayment occurs, a provider must immediately refund the overpayment to the OHCA. *See* Okla. Admin. Code § 317:30-3-2.

b. Oklahoma's Payments for Pharmacy Services

83. Provider agreements for pharmacy services are site-specific; therefore, each individual pharmacy location in Oklahoma must separately enter into a provider agreement with the OHCA.

84. CVS has entered into multiple provider agreements with Oklahoma Medicaid throughout the relevant time period. Each provider agreement requires CVS to comply with all state and federal laws, regulations, and rules applicable to participation in Oklahoma Medicaid.

85. When pharmacies seek reimbursement for filling a prescription for an Oklahoma Medicaid beneficiary, they submit claims through a real-time pharmacy electronic claims transmission process.

86. Because it is not feasible for the OHCA to manually review every claim for payment they receive from providers, including pharmacies, and because the OHCA does not have access to all provider-specific information relevant to reimbursement under applicable rules and regulations, the OHCA relies on providers to comply with program requirements and submit truthful, accurate, and complete certifications and claims.

87. Reimbursement for pharmacy claims in Oklahoma is capped at the U&C price that a pharmacy charges to the general public. Okla. Admin. Code § 317:30-5-78(d).

88. "The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim." Okla. Admin. Code § 317:30-5-78(d)(2).

89. "General public" is defined as "the patient group accounting for the largest number of non-[Medicaid] prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers." Okla. Admin. Code § 317:30-5-78.

90. Discount prices are included in Oklahoma's U&C price analysis. Okla. Admin. Code § 317:30-5-78. If a discount price is offered only to a portion of customers based on selective criteria, such as the customer being a senior citizen, the prices are not included in the U&C analysis unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. *Id.* Otherwise, discount prices that have open eligibility, *i.e.* which anyone is eligible to obtain, are included in the analysis. *Id.*

91. Patients who purchase their prescriptions with a cash discount card program are included within the "general public" because cash discount card programs are not considered "third-party payers" for the purposes of Okla. Admin. Code § 317:30-5-78.

II. The Intervening States' False Claims Acts and State Statutes

92. Each of the Intervening States has its own state false claims act and other state statutes that impose liability for, among other things, knowingly submitting, or causing to be submitted, false or fraudulent claims to the States' Medicaid programs.

A. The Connecticut False Claims Act

93. The Connecticut False Claims Act ("CFCA") closely follows the wording of the federal FCA, 31 U.S.C. §§ 3729 *et seq.* In pertinent part, the CFCA provides:

> (a) No person shall:
>
> > (1) Knowingly present, or cause to be presented, a false or fraudulent claim for payment for approval;
> >
> > (2) Knowingly make, use or cause to be made or used, a false record or statement material to a false or fraudulent claim; … or
> >
> > (8) Knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money … to the state[.]
>
> (b) Any person who violates the provisions of subsection (a) of this section shall be liable to the state ….

Conn. Gen. Stat. § 4-275. The CFCA defines certain terms as follows:

(1) "Knowing" and "knowingly" mean that a person, with respect to information:

(A) has actual knowledge of the information;

(B) acts in deliberate ignorance of the truth or falsity of the information; or

(C) acts in reckless disregard of the truth or falsity of the information, without regard to whether the person intends to defraud. …

(5) "Obligation" means an established duty, whether fixed or not, arising from

(A) an express or implied contractual, grantor-grantee or licensor-licensee relationship,

(B) a fee-based or similar relationship,

(C) statute or regulation, or

(D) the retention of an overpayment[.]

(6) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

Conn. Gen. Stat. § 4-274.

B. The Indiana False Claims Act

94. The Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7-1, *et seq*. ("IMFCA"), closely follows the language of the federal False Claims Act, 31 U.S.C. §§ 3729 *et seq.*

95. The IMFCA provides, in relevant part, that a person who:

(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim;

…

(6) knowingly:

(A) makes, uses, or causes to be made or used, a false record or statement concerning an obligation to pay or transmit money or property to the state; or

> (B) conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state;
>
> is, except as provided in subsection (b), liable to the state for a civil penalty of at least five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000), as adjusted by the federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note, Public Law 101-410), and for up to three (3) times the amount of damages sustained by the state. In addition, a person who violates this section is liable to the state for the costs of a civil action brought to recover a penalty or damages.

Ind. Code § 5-11-5.7-2(a).

96. "Person" includes both natural persons and legal entities, including corporations, limited liability companies, or other business organizations. Ind. Code § 5- 11-5.7-1(b)(7).

97. "Knowing," "knowingly," or "known" means that, with respect to information, a person who: (A) has actual knowledge of the information; (B) acts in deliberate ignorance of the truth or falsity of the information; or (C) acts in reckless disregard of the truth or falsity of the information. Ind. Code § 5-11-5.7-1(b)(4).

98. "Claim" means a request or demand for money or property that is made to an officer, employer, contractor, or other entity acting on behalf of the state if the state: (i) provides or has provided any part of the money or property that is requested or demanded; or (ii) will reimburse the contractor, grantee, or other recipient for any part of the money or property that is requested or demanded. Ind. Code § 5-11-5.7-1(b)(4).

99. "Material" means having a natural tendency to influence or be capable of influencing the payment or receipt of money or property. Ind. Code § 5-11-5.7-1(b)(5).

100. "Obligation" means a fixed or temporary duty arising from:

(A) an express or implied contractual relationship;

…

(D) a fee-based or similar relationship;

(E) a statute;

(F) a rule or regulation; or

(G) the retention of an overpayment.

Ind. Code § 5-11-5.7(b)(6).

C. The Massachusetts False Claims Act and Medicaid False Claims Statute

101. The Massachusetts False Claims Act ("MFCA") establishes liability for any person who "(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to obtain payment or approval of a claim by the commonwealth or any political subdivision thereof; . . . (9) knowingly makes, uses or causes to be made or used a false record or statement material to an obligation to pay or to transmit money or property to the commonwealth or a political subdivision thereof, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the commonwealth or a political subdivision thereof; or (10) is a beneficiary of an inadvertent submission of a false claim to the commonwealth or a political subdivision thereof, or is a beneficiary of an overpayment from the commonwealth or a political subdivision thereof, and who subsequently discovers the falsity of the claim or the receipt of overpayment and fails to disclose the false claim or receipt of overpayment to the commonwealth or a political subdivision by the later of: (i) the date which is 60 days after the date on which the false claim or receipt of overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable." Mass. Gen. Laws ch. 12, § 5B(a).

102. Any person who violates these or the other provisions of the MFCA is liable for "a civil penalty of not less than $5,500 and not more than $11,000 per violation, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages, including consequential damages, that the commonwealth or a political subdivision

thereof sustains because of such violation." Mass. Gen. Laws ch. 12, § 5B(a) (internal citations omitted).

103. The MFCA defines "knowingly" as "possessing actual knowledge of relevant information, acting with deliberate ignorance of the truth or falsity of the information or acting in reckless disregard of the truth or falsity of the information; provided, however, that no proof of specific intent to defraud shall be required." Mass. Gen. Laws ch. 12, § 5A.

104. The MFCA defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." Mass. Gen. Laws ch. 12, § 5A.

105. The MFCA defines "overpayment" as "any funds that a person receives or retains, including funds received or retained under Title XVIII or XIX of the Social Security Act, to which the person, after applicable reconciliation, is not entitled." Mass. Gen. Laws ch. 12, § 5A.

106. The Massachusetts Medicaid False Claims statute, Mass. Gen. Laws. ch. 118E, § 40, is violated by any person who furnishes items or services to MassHealth for which payment may be made by MassHealth, who: (1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this chapter; or (3) having knowledge of the occurrence of any event affecting his or her initial or continued right to any such benefit or payment, or the benefit of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceals or fails to disclose such an event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized. Mass. Gen. Laws. ch. 118E, § 40.

107. If any person violates the provisions of the Massachusetts Medicaid False Claims statute, the Commonwealth is entitled to recover three times the amount of damages sustained, including the costs of investigation and litigation. *See* Mass. Gen. Laws. ch. 118E, § 44.

D. The Oklahoma False Claims Act

108. The Oklahoma False Claims Act ("OFCA") is substantially identical to the federal FCA, 31 U.S.C. §§ 3729 *et seq.* It provides, in pertinent part, that a person who:

> Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> . . . Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; . . .
>
> Knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state . . .
>
> is liable to the State of Oklahoma for a civil penalty consistent with the civil penalties provision of the Federal False Claims Act, 31 U.S.C. 3729(a), as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 101-410), and as further amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Sec. 701 of Public Law 114-74), plus three times the amount of damages which the state sustains because of the act of that person.

Okla. Stat. tit. 63, § 5053.1(B).

109. For the purposes of the OFCA, the terms "knowing" and "knowingly mean that a person: (a) has actual knowledge of the information, (b) acts in deliberate ignorance of the truth or falsity of the information, or (c) acts in reckless disregard of the truth or falsity of the information. Okla. Stat. tit. 63, § 5053.1(A)(2). Proof of specific intent to defraud is not required. *Id.*

FACTUAL ALLEGATIONS

I. Factual Allegations on Behalf of All Intervening States

A. CVS's Launch of Health Savings Pass

110. In September 2006, Walmart Inc. ("Walmart"), a retailer that also provides pharmacy services, debuted a discount savings program for cash-paying customers, where customers could pay $4 for certain generic prescription drugs. Other pharmacy providers, including Target Corporation ("Target"), soon adopted similar programs of their own.

111. State Medicaid programs, including the state Medicaid programs of some of the Intervening States, required Walmart and other pharmacies to report the discount price paid by cash-paying customers as their U&C price for drugs subject to the discount.

112. For example, on April 1, 2008, Texas's Medicaid agency issued an RxUpdate to pharmacy providers. Texas's RxUpdate, an official state publication, advised that pharmacies with prescription discount programs should "reflect the discounted prices in their Medicaid prescription claims." CVS executives received and reviewed the RxUpdate.

113. In response to growing competition from other pharmacy providers, CVS contemplated developing its own discount card program. CVS sought to balance two competing goals—ensuring that its program was attractive enough to keep its customer base from defecting but avoiding making the program too attractive such that it could reduce CVS's profits. In a May 2008 internal presentation discussing these issues, CVS noted that "[m]aking the program too attractive creates higher risk for our 3rd party pricing and profitability." CVS further expounded that "'Too much' enrollment suggests an offer that is too compelling and a larger risk of a) high cash cannibalization, b) 3rd party pricing risk, ***c) Medicaid reimbursement rates***. 'Too

little' enrollment suggests an offer that is not compelling enough to retain our higher volume customers." (emphasis added).

114. Similarly, in an August 2008 internal presentation, CVS identified the risks associated with a cash discount prescription program. CVS identified those risks as:

- Greater adoption by existing customers magnifies financial impact – would need to acquire new customers to offset cannibalization of existing business
- Retail third party volume impact
- Competitive response
- ***Medicaid reimbursements***
- Implementation of Retail program will evoke inquiries from PBM clients for access to comparable pricing. (emphasis added).

115. In that same internal presentation, CVS further cautioned that "[i]f we launch a Retail program, PBM clients are likely to request access to that level of pricing for their plan participants – need to understand financial implications" and that "[c]reation of a CVS retail cash program may put increasing pressure on 3rd party reimbursements from other payers."

116. In sum, when structuring its own discount card program to compete with Walmart, Target, and other pharmacy providers, CVS hoped to avoid reporting the discount prices paid by cash-paying customers as U&C to payers of pharmacy services, including Medicaid agencies and pharmacy benefit managers.

117. In November 2008, CVS launched its own discount card program for cash-paying customers called Health Savings Pass ("HSP"). HSP offered $9.99 pricing for 400 generic drugs, including drugs that treat diabetes, arthritis, pain, and cholesterol.

118. The catch, according to CVS, was that individuals had to pay a $10 enrollment fee to join HSP.[3] CVS viewed this enrollment fee as shielding it from having to report HSP prices as U&C prices to state Medicaid agencies. Because most states define U&C to include the price paid by the "general public," CVS reasoned, the HSP prices do not qualify, as HSP is a membership program only available to those who have paid the fee, not any member of the general public.

119. CVS's legal subterfuge did not, in fact, protect its HSP prices from having to be disclosed as U&C to state Medicaid agencies. As CVS's former Vice President of Managed Care Tom Morrison testified in other proceedings, HSP—like other discount card programs with enrollment fees that have been found by courts to be reportable as U&C—was widely available to any member of the general public. Once that person paid the nominal fee and provided the information necessary to sign up for the program, they would instantly benefit from HSP prices.

120. In the *United States ex rel. Garbe v. Kmart Corporation*, 824 F.3d 632 (7th Cir. 2016) case, the Seventh Circuit made clear that an enrollment fee alone does not shield a discount card price from being disclosed as U&C. There, the Court stated that "[e]ven if the prices were offered only to members of its 'discount programs'—and it is disputed whether this was the case—the programs themselves were offered to the general public. Kmart's programs typically offered its 'discounts' in return for nothing more than assent, demographic data the pharmacy already needed to fill a prescription, and a nominal fee." *Id.* at 643.

121. Pharmacies other than CVS have faced False Claims Act litigation because they "effectively used [their] enrollment forms as a fig leaf to disguise a [discount on] generics program without reporting those prices as U&C." *U.S. ex rel. Proctor v. Safeway, Inc.*, 30 F.4th

[3] CVS later increased this enrollment fee to $15 in 2011.

649, 660 (7th Cir. 2022), *vacated in part by U.S. ex rel. Schutte v. SuperValu Inc.*, 143 S. Ct. 1391, 1397 (2023). For example, a pharmacy's motion to dismiss was denied where the pharmacy "consistently disregarded the prescription prices afforded members of the Rx [Savings] Program when calculating its U&C for charges to government-backed insurance programs." *U.S. et al. ex rel. Rahimi v. Rite Aid Corp*., 2019 U.S. Dist. LEXIS 54854 at *21 (E.D. Mich. Mar. 30, 2019).

122. Prior litigation against pharmacies whose reported U&C prices did not reflect the pharmacies' cash discount programs has included claims brought by the Intervening States and/or by relators under the Intervening States' false claims statutes. *See U.S. et al. ex rel. Doe v. Houchens Industries, Inc*., 2015 U.S. Dist. LEXIS 2403, at *8 (S.D. Ind. Jan. 9, 2015) (denying motion to dismiss False Claims Act case where plaintiff plausibly alleged that "enrollment" process was rudimentary and open to anyone who filled prescriptions at defendant pharmacy); *U.S. ex rel. Strauser v. Stephen L. LaFrance Holdings, Inc*., 2019 U.S. Dist. LEXIS 36385 at *42-49 (N.D. Okla. Mar. 7, 2019) (denying motion to dismiss False Claims Act-based U&C case against Walgreens, its subsidiary, and individual executives); *U.S. ex rel. Baker v. Walgreens*, No. 12-cv-0300, Doc. Nos. 53 & 56 (S.D.N.Y. Jan. 24, 2019) (approving settlement agreement and voluntary dismissal by states, including Connecticut, Indiana, Massachusetts, and Oklahoma, that intervened in and settled False Claims Act U&C case against Walgreens).

B. CVS's Reconciliation Payments to Connecticut and Oregon

123. Even though it should have, CVS did not report its HSP prices to state Medicaid agencies, including the Intervening States' Medicaid agencies, as its U&C prices when it launched HSP.

124. But in May 2010, a statutory amendment by the Connecticut General Assembly became effective and required pharmacies participating in Connecticut Medicaid to bill Connecticut Medicaid the lowest price available to any member of the public participating in their savings or discount program. Pub. Act. No. 10-179, § 17 (eff. May 7, 2010).

125. CVS initially did not comply with the new requirement. In a letter dated May 18, 2010, only eleven days after the amendment went into effect, DSS notified CVS that a review of prescription drug claims submitted by CVS after May 7, 2010 revealed that CVS was continuing to charge DSS more for prescription drugs for CMAP beneficiaries than the discount drug prices paid by cash customers in the HSP program. Accordingly, DSS informed CVS that the failure to charge DSS the same discount pricing as CVS accepts from cash customers using the HSP program clearly violated the amended statute.

126. After receiving this letter from DSS, CVS internally evaluated how much money it would lose if it passed along HSP pricing to certain state Medicaid programs, including but not limited to Connecticut's Medicaid program. At least one senior CVS executive attended an internal meeting to discuss "HSP Alternative Solutions." One of the discussion items at this meeting was the "financial risk across all state Medicaid's [sic]" from CVS's implementation of HSP.

127. After having this internal meeting and after threatening to suspend the HSP program in Connecticut to avoid reporting the lower HSP prices as U&C, in November 2010, CVS ultimately began periodically refunding to Connecticut Medicaid the difference between the amount paid by Connecticut Medicaid for drugs subject to HSP pricing and the HSP drug price. A senior CVS executive acknowledged in writing to Connecticut that the recently enacted

statute would require applying CVS's discount program pricing to Connecticut Medicaid reimbursement.

128. By February 2012, CVS was delivering to DSS checks on a quarterly basis that refunded to Connecticut Medicaid the overpayments made by Connecticut Medicaid to CVS during the prior calendar quarter. These were known as quarterly reconciliation payments. A form cover letter included with most or all checks delivered by CVS to DSS explained that the check amount "reflects the aggregate difference between the amount DSS reimbursed CVS for prescription drug claims submitted to DSS for this period and the amount DSS would have reimbursed for these claims if the CVS Health Savings Pass membership pricing had been applied at the point of sale." The form letter also indicated the quarterly reconciliation payment was being provided to comply with Connecticut General Statutes Section 17b-226a.

129. Each quarterly reconciliation payment delivered by CVS to DSS was in excess of $245,000. For example, the quarterly reconciliation payment for the period October 1, 2015 to December 31, 2015 was $416,476.00.

130. For the period May 7, 2010 through January 31, 2016, CVS made over $6.6 million in reconciliation payments to DSS. The following is a chart that reflects the approximate amounts of the reconciliation payments made by CVS for the time periods indicated:

Time Period	**Reconciliation Payment Amount**
May 7, 2010 – September 30, 2011	$1,618,351
October 1, 2011 – December 31, 2011	$258,980
January 1, 2012 – March 31, 2012	$259,880
April 1, 2012 – June 30, 2012	$248,997
July 1, 2012 – September 30, 2012	$245,984
October 1, 2012 – December 31, 2012	$264,599
January 1, 2013 – March 31, 2013	$258,425
April 1, 2013 – June 30, 2013	$267,648
July 1, 2013 – September 30, 2013	$252,649
October 1, 2013 – December 31, 2013	$252,424
January 1, 2014 – March 31, 2014	$265,787

April 1, 2014 – June 30, 2014	$306,787
July 1, 2014 – September 30, 2014	$292,424
October 1, 2014 – December 31, 2014	$311,714
January 1, 2015 – March 31, 2015	$327,629
April 1, 2015 – June 30, 2015	$332,827
July 1, 2015 – September 30, 2015	$354,377
October 1, 2015 – December 31, 2015	$416,476
January 1, 2016 – January 31, 2016	$134,974

131. Similar to what happened in Connecticut, effective in September 2011, Oregon's Medicaid agency, the Oregon Health Authority, amended its regulations to provide a more comprehensive definition of U&C. The amended regulation defined "Usual and Customary Price" as "[a] pharmacy's charge to the general public that reflects all advertised savings, discounts, special promotions, or other programs including membership based discounts …." Or. Admin. Rules § 410-121-0000(ff) (2011) (currently § 410-121-0000(LL)). Oregon also amended its Medicaid pharmacy billing regulations to provide that a pharmacy "shall bill the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program[.]" Or. Admin. Rules § 410-121-0150.

132. In response to these changes, in December 2011, a senior CVS executive sent a letter to the Oregon Health Authority that acknowledged that HSP rates should apply to Oregon Medicaid reimbursements. CVS proposed using a reconciliation methodology similar to the one it was using in Connecticut to pass on its HSP pricing to Oregon Medicaid. In a letter dated December 1, 2011, CVS proposed that "[e]ach quarter, CVS will calculate and pay to [Oregon's Division of Medical Assistance ("DMAP")] the aggregate difference between the amount DMAP reimbursed CVS for prescription drug claims and the amount DMAP would have reimbursed for those claims had the HSP discount pricing been applied at point of sale." CVS wrote that it had only two retail pharmacies enrolled in the Oregon Medicaid program at this time.

133. In May 2012, Oregon Medicaid received its first reconciliation payment from CVS. As in Connecticut, the amount was mailed by check. The first payment was for $246 and related to the time period from the effective date of the regulation to March 31, 2012. The cover letter received with the check indicated that subsequent payments would be made quarterly.

134. Thereafter, reconciliation payments were made on a quarterly basis for the previous calendar quarter by check and mailed from CVS to Oregon Medicaid. These quarterly reconciliation payments ranged from $4.40 to $79.78.

C. CVS's Transition to the ScriptSave Discount Card Program

135. At some point in the early 2010s, in part due to the pressure exerted on its prices by Medicaid regulators like those in Connecticut and Oregon, CVS began considering transitioning the responsibility for administering the HSP program to a third party.

136. CVS had conversations with ScriptSave to serve as the administrator of the HSP program. Because it does not manage benefits, ScriptSave is not a pharmacy benefits manager. Rather, ScriptSave is a third-party claim processor that administers pharmacy discount programs by contracting directly with pharmacies.

137. ScriptSave does not make payments to pharmacies for prescriptions, nor does ScriptSave cover part of the cost a pharmacy charges a customer for a prescription. ScriptSave's public-facing communications all stated that what ScriptSave customers received was a "discount only" and "not insurance."[4] ScriptSave-approved marketing materials did not use the terms "plan," "benefit," "coverage," "copay," or any similar terms.

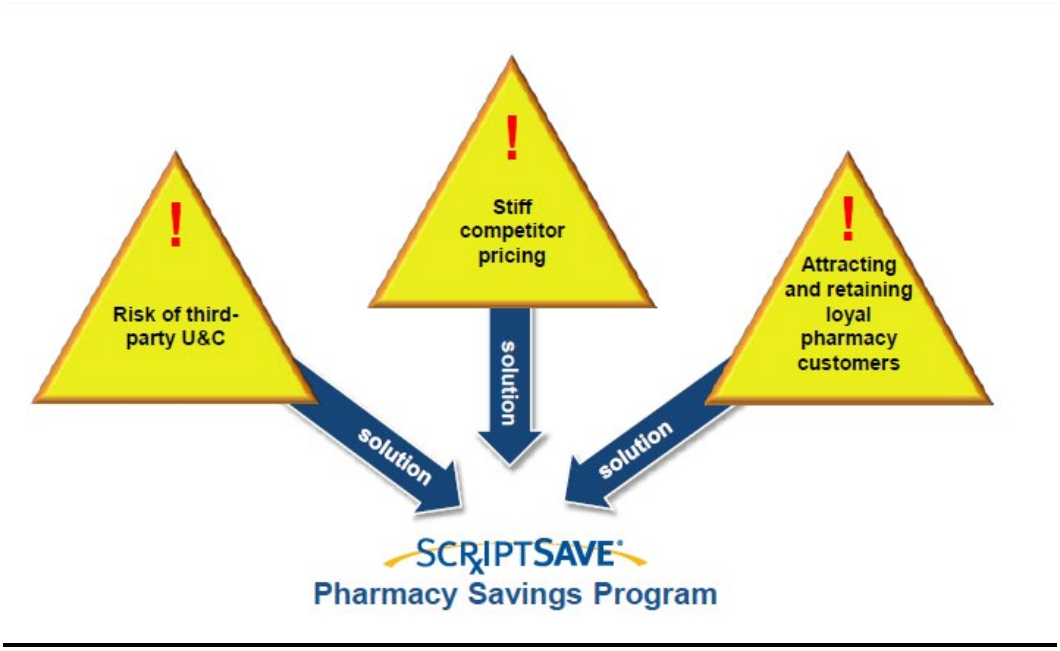
138. In its conversations with ScriptSave to discuss serving as HSP's administrator, CVS explicitly discussed concerns about the reportability of HSP prices to state Medicaid

[4] ScriptSave has since rebranded to the name WellRx.

programs. In an October 2012 slide deck concerning the possibility of ScriptSave administering the HSP program, CVS explained that "[s]tates require lowest price available; HSP was excluded from those requirements, but some states have changed their laws." CVS also described the "Goals" of the transition as to "Resolve Current Issues," including the "Pricing Issue."

139. ScriptSave understood that serving as a pharmacy's administrator of a cash-discount card program could assist pharmacies in avoiding reporting those prices as U&C to state Medicaid programs. An internal product status update at ScriptSave from August 2012 states "[b]y moving the PSP program to our paper as the administrator of the program, [ScriptSave] will now hold the regulatory responsibilities. The program is designed to help mitigate risks to U&C protection from PBMs targeting our PSP clients. This may not protect our PSP clients' U&C from government programs or even PBMs. ScriptSave to administer the program."

140. A November 2012 presentation from ScriptSave to CVS explicitly identifies the risk of third-party U&C as a basis for the transition:



141. In another presentation in November 2012, ScriptSave executives shared with CVS in a presentation their belief that: "[r]ecent changes to the laws in certain states now require that if the Health Savings Pass is the lowest price offered by CVS, CVS must pass that price to the state as well."

142. In a December 2012 presentation to CVS, ScriptSave identified its "Program Features." The first item listed was "Risk of third party U&C." ScriptSave identified that "[a] ScriptSave program can allow CVS to protect its third party reimbursement levels as ScriptSave would be the third party administrator of the program." The document further notes that ScriptSave "would be the third party administrator of the program" where claims pass through, materials indicate that ScriptSave is the administrator, and ScriptSave would be responsible for filling program materials with the states.

143. Similarly, in a March 2013 email chain, an account manager at ScriptSave described a communication with a liaison at CVS and noted, "[a]bout a year ago, Medicaid placed a target on their backs. Didn't give me more detail, but sounded like there was some litigation."

144. CVS ultimately selected ScriptSave as its vendor to administer the HSP program starting in June 2013.

145. Other than through its reconciliation payments to Connecticut and Oregon, CVS did not report its HSP prices as U&C prices to the Intervening States' Medicaid agencies after ScriptSave took over administration of the HSP program.

146. A year or two later, CVS began contemplating winding down the HSP program altogether. CVS described that "[c]ontinued regulatory and compliance pressure require[d] CVS Health to reevaluate the Health Savings Pass program." That regulatory and compliance

pressure included, in part, the cost of ongoing reconciliation payments to Connecticut and Oregon Medicaid.

147. CVS stated in an internal presentation on November 2, 2015 that "HSP Deactivation [was] Necessary Due To Regulatory and Financial Requirements." This was because CVS knew that "[s]tates [were] challenging generic membership programs and contesting that pricing should be considered and extended to State Medicaid programs." CVS knew that it had not complied with regulatory requirements for extending HSP pricing to state Medicaid programs, nor did it have any intention to comply with those requirements.

148. Ultimately, in February 2016, CVS terminated the HSP program. Rather than stop offering cash-paying customers discounts in its stores, CVS transitioned all HSP customers automatically (unless those customers affirmatively opted out) to a discount card program administered by ScriptSave, which is associated with Discount Card No. 1264. CVS referred to this in internal emails in January 2016 as a "conversion" to ScriptSave and described the HSP program as being "completely transitioned to ScriptSave."

149. CVS, via ScriptSave Discount Card No. 1264, offered cash-paying customers discounts on brand and generic drugs for no enrollment fee. In a customer letter to then-HSP customers, CVS informed them that HSP had been discontinued. In the same letter, CVS informed former HSP customers that they would be transitioned to the ScriptSave Value Prescription Savings Card, unless they affirmatively opted out.

150. A frequently asked questions document for CVS employees made clear that ScriptSave Discount Card No. 1264 was "open to anyone. There are no limits on usage, and no income or age restrictions." As such, this discount card could be used for prescriptions for "every member in a household," even "prescriptions … for the family pet." In March 2016, one

month after HSP's discontinuation, CVS stated in internal documents that "all existing customers should be offered the new ScriptSave Value Prescription Savings Card Program."

151. The pricing that CVS customers received with ScriptSave Discount Card No. 1264 was distinctive to CVS and was not necessarily available at other pharmacies. Even though Discount Card No. 1264 had an "open network" and thus could be used at other pharmacies, CVS knew that the pricing at non-CVS participating pharmacies would vary from the pricing at CVS pharmacies. CVS set pricing for ScriptSave Discount Card No. 1264 by executing an amendment of its participating pharmacy agreement with ScriptSave, which included pricing terms.

152. The pricing amendment that CVS executed for ScriptSave Discount Card No. 1264 starting in December 2015 included a 9.5% discount off AWP for branded drugs and single-source generic drugs, and a 30.0% discount off AWP for non-MAC generic drugs. As such, CVS used ScriptSave Discount Card No. 1264 to offer cash customers discounts on generic drugs and branded drugs, with the percentage discount being greater for many generic drugs.

153. ScriptSave discount cards are not an insurance program. They are not funded, directly or indirectly, by members or customers. ScriptSave's administration of discount cards makes money for ScriptSave because of the per-transaction administrative fees that CVS pays to ScriptSave.

154. For each prescription filled by a cash-paying customer using a ScriptSave discount card, CVS remitted part of the dispensing fee it collected from the customer as an administrative fee to ScriptSave. The amount of each administrative fee ScriptSave received was set by contract and/or contract amendment between CVS and ScriptSave.

155. After CVS transitioned its HSP customers to ScriptSave Discount Card No. 1264, it informed Connecticut's and Oregon's Medicaid agencies that it had "retired" the HSP program and made its final reconciliation payments. CVS thereafter ceased making reconciliation payments to Connecticut's and Oregon's Medicaid agencies. CVS never mentioned, in those communications, that it had transitioned its HSP customers to ScriptSave Discount Card No. 1264.

156. The senior CVS executive who signed two letters to Connecticut Medicaid informing Connecticut Medicaid of the "retire[ment]" of the HSP program (while making no mention of ScriptSave) was the same senior CVS executive who managed CVS's relationship with ScriptSave.

157. This same senior CVS executive, who managed CVS's relationship with ScriptSave, also signed two letters to Oregon Medicaid informing Oregon Medicaid of the "retire[ment]" of the HSP program while making no mention of ScriptSave.

D. CVS's Purchase of Target Pharmacies

158. In late 2015 and early 2016, CVS contracted with Target to acquire and operate Target-based pharmacies.

159. At the time of acquisition negotiations, Target had a loyalty program called the Prescription Savings Program that offered hundreds of drugs at low, established prices to cash-paying customers who paid an enrollment fee to join the program. Target customers could also fill certain generic drugs for $4 to $10 without paying an enrollment fee. The $4 and $10 prices of these drugs were disclosed as U&C prices by Target to payors, including state Medicaid agencies.

160. According to internal CVS communications, CVS knew that Target's Value Generic List consisted of 900 drugs at prices of $4 and $10 that were "offered via hard-coded U&C pricing." As such, CVS knew that Target, before its pharmacies' acquisition by CVS, treated the $4 and $10 discounted prices as U&C prices.

161. As part of the acquisition, CVS agreed that it would continue offering low-price drugs to Target customers once CVS began operating the Target pharmacies.

162. Unlike Target, CVS did not disclose its discount prices as U&C prices to state Medicaid agencies. Rather, to conceal the discount pricing scheme from third-party payors, CVS relied on ScriptSave to create and maintain a "discount card program" through which it would continue offering Target customers discount drugs.

163. To set up this discount card program, CVS partnered with ScriptSave to create a custom discount card for the Target pharmacies, which operated as ScriptSave Discount Card No. 1417. Plans for this discount card program took shape in July 2015, when senior CVS executives determined that CVS would "[de]velop [an] integrated discount card offering" with December 2015 as the expected completion date.

164. Target and CVS incorporated this plan into the Pharmacy Operating Agreement effective December 16, 2015, which stated as follows:

> As of the Effective Date, CVS shall accept a prescription drug discount card at all Pharmacies that will include a discount generic pharmaceutical product list with $4 and $9 prices for 30 days supply and $10 and $24 prices for 90 days supply. The initial list of pharmaceutical products covered by the prescription cash discount card program as of the Effective Date shall include the drugs on the Target generic pharmaceutical product list posted on the Target web site as of the date of signing of the Asset Purchase Agreement. CVS shall maintain the prescription cash discount card program at all Pharmacies for at least (3) years from the Effective Date. CVS shall have the right, from time to time after the Effective Date, to adapt or modify the cash discount card program in its sole discretion. CVS shall not charge any Guest a membership fee for the prescription cash discount card program.

165. Under Discount Card No. 1417, CVS chose the drugs that were subject to discount pricing, CVS selected the prices for those drugs, and CVS determined which customers were eligible for those prices with ScriptSave Discount Card No. 1417.

166. CVS automatically transitioned all Target Prescription Savings Program customers into ScriptSave Discount Card No. 1417 (unless an individual affirmatively opted out). CVS's internal claim processing instructions advised Pharmacy Team members to update each Target Prescription Savings Program customer to the ScriptSave Discount Card No. 1417 group whenever a prescription for a Target Prescription Savings Program customer was submitted after CVS acquired the Target pharmacies. CVS advised that "[t]his will automatically enroll the customer in the new ScriptSave program."

167. CVS sent a customer letter to former Target Prescription Savings Program customers informing them of their ability to use the ScriptSave Discount Card No. 1417 at CVS pharmacies. This customer letter made clear that there was no enrollment fee and that no enrollment form was required. In internal communications, CVS instructed its pharmacy employees to respond to customer questions by assuring former Target customers "that they will continue to receive the same discounted pricing" under ScriptSave Discount Card No. 1417.

168. The pricing that CVS customers received with ScriptSave Discount Card No. 1417 was distinctive to CVS and was not necessarily available at other pharmacies. CVS set pricing for ScriptSave Discount Card No. 1417 by entering into a participating pharmacy agreement and/or one or more amendments of its participating pharmacy agreement with ScriptSave, which included pricing terms.

E. CVS's Work with ScriptSave to Track Program Growth and Set Pricing

169. After CVS completed its acquisition of Target pharmacies, transitioned former Target customers into ScriptSave Discount Card No. 1417, and transitioned former HSP customers to ScriptSave Discount Card No. 1264, CVS obtained detailed data on the number of customers using those ScriptSave discount cards. This data included the number of prescriptions being processed weekly in these ScriptSave programs.

170. Thereafter, CVS closely tracked customer usage of the ScriptSave discount cards. A Statement of Work signed by CVS and ScriptSave for the transition required ScriptSave to provide monthly usage reports to CVS.

171. A senior CVS executive received and reviewed monthly reports that tracked the number of prescriptions obtained by cash customers using ScriptSave Discount Card No. 1264, ScriptSave Discount Card No. 1417, and other discount cards for which CVS contracted with ScriptSave. These reports were referred to as "group volume report[s]."

172. The group volume reports showed CVS that its program was successful and growing. The group volume report for February 2016 informed CVS that for the twelve-month period February 2016 through January 2017, over 5.21 million transactions were processed for CVS pharmacies using ScriptSave discount cards. Based on this volume of business for this time period, the bulk of which was comprised by ScriptSave Discount Cards No. 1417 and No. 1264, ScriptSave was due to receive over $6 million in administrative fees from CVS.

173. The program continued to grow thereafter. The group volume report for August 2017 informed CVS that for the twelve-month period August 2016 through July 2017, over 6.81 million transactions were processed for CVS pharmacies using ScriptSave discount cards. Based on this volume of business for this time period, the bulk of which was comprised by ScriptSave

Discount Cards No. 1417 and No. 1264, ScriptSave was due to receive over $6.3 million in administrative fees from CVS.

174. CVS and ScriptSave executives regularly discussed pricing strategy for these discount card programs. In a May 2016 conversation, according to an agenda in internal documents, CVS and ScriptSave executives discussed "cash card strategy." Another meeting document, this one with CVS and ScriptSave logos attached, referred to the then-former HSP program and the then-current ScriptSave discount card programs as CVS programs. This document contained charts showing the performance over time of, and the respective volume of CVS business under, both HSP and the ScriptSave discount cards.

175. In July 2016, CVS and ScriptSave executives again discussed pricing strategy for the ScriptSave discount cards. A slide deck created for the July 2016 discussion stated as an "Action Item" that there could be "[a]llowance for CVS to adjust pricing strategy at any time based on outcomes."

176. In October 2016, in a pricing-related communication with CVS, ScriptSave referred to its valued "relationship and strategic partnership with CVS."

177. In November 2017, CVS executives and ScriptSave executives met to discuss several reports including the group volume report, a Current Pricing Report, and a Cash Marketplace Overview.

178. CVS did not advertise or make public disclosures regarding the drug pricing available for Discount Card Nos. 1264 and 1417.

179. ScriptSave did not advertise or make public disclosures regarding the drug pricing available for Discount Card Nos. 1264 and 1417.

180. The Medicaid programs of the Intervening States had no knowledge of any contemporaneous pricing available through Discount Card Nos. 1264 and 1417 for a drug at the time that Medicaid claims were billed and paid for that drug. As such, the Intervening States had no knowledge of what the ScriptSave program prices were at the time they paid CVS's claims or even when conducting post-payment audits.

181. By 2019, Discount Card Nos. 1264 and 1417's growth resulted in the numbers of CVS prescriptions processed in ScriptSave exceeding the numbers in the HSP program before its discontinuation. HSP, during the months of September through November 2015, had a "Net Rx" count of approximately 60,000 prescriptions per month—or less than 1 million prescriptions per twelve-month period.

182. By contrast, by 2019, the ScriptSave program grew to be over ten times larger than HSP was in 2015 in terms of prescription count. The ScriptSave group volume report dated October 1, 2019 informed CVS that during the preceding twelve-month period, over 13.8 million prescriptions at CVS pharmacies were processed for customers using a ScriptSave discount card, of which over 8.2 million prescriptions were Group No. 1417 (including sub-groups) and over 1.8 million prescriptions were Group No. 1264 (including sub-groups).

II. Factual Allegations on Behalf of Specific Intervening States

A. Connecticut

183. Connecticut General Statutes section 17b-226a states that a pharmacy provider enrolled in any medical assistance program administered by the DSS, "when billing the [D]epartment for a good or service, shall bill the [D]epartment the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount program." Conn. Gen. Stat. § 17b-226a. "For purposes of this section, 'savings or

discount program' means any program, club or buying group offered by a pharmacy provider to any member of the general public for the purpose of obtaining a lower charge for any good or service than the charge made to any member of the general public who does not participate in such program." *Id.*

184. CVS offered discounts to its cash-paying customers, who were members of the general public, by actively promoting ScriptSave and making ScriptSave discount cards available to those customers. CVS did not advertise or allow in-store marketing of other companies' discount cards in its stores.

185. As CVS set pricing for ScriptSave Discount Cards No. 1417 and No. 1264 and actively promoted those discount cards to its retail pharmacy customers, ScriptSave Discount Cards No. 1417 and No. 1264 operated as CVS's discount program from at least January 1, 2016 and continuing thereafter.

186. CVS then accepted the ScriptSave discount card prices as full payment for prescription drugs dispensed at its retail pharmacies. But CVS did not offer the same discounted prices to Connecticut's Medicaid program.

187. The foregoing conduct violated Connecticut General Statutes section 17b-226a, which required CVS to bill Medicaid at the lowest price charged to or accepted from members of the general public who participated in the pharmacy's savings or discount program—here, ScriptSave. By billing Connecticut Medicaid at higher prices instead and not disclosing to Connecticut Medicaid that customers with ScriptSave discount cards were receiving lower prices, CVS knowingly presented false or fraudulent claims to Connecticut Medicaid.

188. From February 1, 2016 and thereafter, Connecticut Medicaid has never notified CVS that it approves of CVS's methodology for calculating U&C charges for prescription drugs

and has never notified CVS that it believes CVS's billing and claims submission process to be compliant with Connecticut General Statutes § 17b-226a. Connecticut Medicaid did not and does not have access to data showing the prices CVS charges to or accepts from other payers, including cash-paying customers who use ScriptSave discount cards. As such, Connecticut Medicaid could not and cannot readily determine whether the prices CVS accepted and/or accepts from ScriptSave customers for certain prescription drugs were or are lower than the prices CVS has reported as its U&C charges for those drugs.

189. If, however, Connecticut Medicaid learned that CVS accepted lower prices from ScriptSave customers for certain prescription drugs than what it reported as its U&C charges for those drugs, Connecticut Medicaid would not have paid those claims or would have taken other appropriate action to ensure that CVS did not receive payments to which it was not entitled, including by recouping payments through administrative processes, making adjustments in the claims data, or seeking return of overpayments.

190. Connecticut Medicaid has required that pharmacy providers audit themselves for compliance with Connecticut General Statutes section 17b-226a and has taken other administrative actions upon learning that a pharmacy's claims submission process to Medicaid did not account for lower prices available to cash customers through a pharmacy's discount program.

191. In particular, the DSS took action against CVS's competitor, Walgreen Co. ("Walgreens"), to recover the difference between amounts the CMAP paid to Walgreens and the lower amounts Walgreens charged to its Prescription Savings Club customers for the same drugs. On December 28, 2010, the DSS Commissioner formally ruled that Walgreens was obligated to "bill the [DSS] the discounted Prescription Savings Club price as [Walgreens'] usual and

customary charge to the general public for all qualifying prescriptions." (Dec. 28, 2010 Declaratory Ruling, hereinafter, "Declaratory Ruling"). Then, in 2013, Walgreens and Connecticut entered into a settlement agreement that required Walgreens to make monthly reconciliation payments. Pursuant to that agreement, Walgreens refunded the difference between CMAP prescription reimbursements and the lower prices available to Walgreens' cash customers through its Prescription Savings Club.

192. The DSS did not take similar action against other pharmacies, including Target pharmacies (which CVS later acquired) and Walmart pharmacies, because the DSS, at the time of its Declaratory Ruling, believed that "Wal-Mart, Target, [and other chain pharmacies] all were billing the [DSS] for prescription drugs for Medicaid beneficiaries … at the discount rate offered through their respective discount pharmacy programs available to members of the general public."

193. Set forth below and summarized in **Exhibit 1** are representative examples of transactions where Connecticut Medicaid paid more than cash customers in the ScriptSave program for purchases of the same drug and quantity. For example, the following transactions involving the same drug and quantity took place in September 2016:

- On September 28, 2016, the CVS Pharmacy at 21 Broad Street, Stamford, Connecticut, Store No. 16872, sold a thirty-day supply of Spiriva Handihaler, NDC No. 00597007541, which was thirty units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $323.99, which included a dispensing fee of $1.20.

- On September 16, 2016, the same CVS Pharmacy, Store No. 16872, dispensed a thirty-day supply of Spiriva Handihaler, NDC No. 00597007541, which was thirty units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $343.02 to CVS for this prescription, which included a dispensing fee of $1.40.

- The difference between the per-unit price of the ScriptSave prescription ($10.76) and the per-unit paid amount on the Connecticut Medicaid prescription ($11.39) multiplied by the number of units (30) equals damages of $18.83 to Connecticut Medicaid, which CVS has not repaid.

194. The following transactions involving the same drug and quantity took place at CVS in Connecticut in February 2017:

- On February 28, 2017, the CVS Pharmacy at 1099 New Britain Avenue, West Hartford, Connecticut, Store No. 00671, sold a ninety-day supply of levothyroxine sodium, NDC No. 00378180310, which was ninety units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a discount price of $15.60, which included a dispensing fee of $1.20.

- On February 17, 2017, the same CVS Pharmacy, Store No. 00671, dispensed a ninety-day supply of levothyroxine sodium, NDC No. 00378180310, which was ninety units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $35.39 to CVS for this prescription with no dispensing fee.

- The difference between the per-unit price of the ScriptSave prescription ($0.16) and the per-unit paid amount on the Connecticut Medicaid prescription ($0.39) multiplied by the number of units (90) equals damages of $20.99 to Connecticut Medicaid, which CVS has not repaid.

195. The following transactions involving the same drug and quantity took place at CVS in Connecticut on the same day in October 2017:

- On October 10, 2017, the CVS Pharmacy at 300 Chase Avenue, Waterbury, Connecticut, Store No. 17238, sold a thirty-day supply of Januvia, NDC No. 00006027731, which was thirty units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $344.90, which included a dispensing fee of $1.20.

- Also on October 10, 2017, the same CVS Pharmacy, Store No. 17238, dispensed a thirty-day supply of Januvia, NDC No. 00006027731, which was thirty units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $392.64 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($11.46) and the per-unit paid amount on the Connecticut Medicaid

prescription ($12.73) multiplied by the number of units (30) equals damages of $38.19 to Connecticut Medicaid, which CVS has not repaid.

196. The following transactions involving the same drug and quantity took place at CVS in Connecticut in December 2017:

- On December 17, 2017, the CVS Pharmacy at 875 Enfield Street, Enfield, Connecticut, Store No. 00750, sold a thirty-day supply of Advair Diskus, NDC No. 00173069500, which was sixty units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $223.80, which included a dispensing fee of $1.20.

- On December 7, 2017, the same CVS Pharmacy, Store No. 00750, dispensed a thirty-day supply of Advair Diskus, NDC No. 00173069500, which was sixty units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $289.54 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($3.71) and the per-unit paid amount on the Connecticut Medicaid prescription ($4.65) multiplied by the number of units (60) equals damages of $56.19 to Connecticut Medicaid, which CVS has not repaid.

197. The following transactions involving the same drug and quantity took place at CVS in Connecticut in August 2018:

- On August 10, 2018, the CVS Pharmacy at 24 Pershing Drive #36, Ansonia, Connecticut, Store No. 00718, sold a thirty-day supply of Diclofenac Sodium, NDC No. 16571020106, which was sixty units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $6.99, which included a dispensing fee of $1.20.

- On August 27, 2018, the same CVS Pharmacy, Store No. 00718, dispensed a thirty-day supply of Diclofenac Sodium, NDC No. 16571020106, which was sixty units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $18.95 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($0.10) and the per-unit paid amount on the Connecticut Medicaid

prescription ($0.14) multiplied by the number of units (60) equals damages of $2.41 to Connecticut Medicaid, which CVS has not repaid.

198. The following transactions involving the same drug and quantity took place at CVS in Connecticut in December 2018:

- On December 27, 2018, the CVS Pharmacy at 142 Talcottville Road, Vernon, Connecticut, Store No. 00231, sold a sixteen-day supply of Ventolin HFA, NDC No. 00173068220, which was eighteen units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $41.70, which included a dispensing fee of $3.00.

- On December 7, 2018, the same CVS Pharmacy, Store No. 00231, dispensed a sixteen-day supply of Ventolin HFA, NDC No. 00173068220, which was eighteen units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $62.37 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($2.15) and the per-unit paid amount on the Connecticut Medicaid prescription ($2.87) multiplied by the number of units (18) equals damages of $12.92 to Connecticut Medicaid, which CVS has not repaid.

199. The following transactions involving the same drug and quantity took place at CVS in Connecticut in April 2019:

- On April 2, 2019, the CVS Pharmacy at 989 Boston Post Road, Milford, Connecticut, Store No. 00071, sold a ninety-day supply of levothyroxine sodium, NDC No. 00378180910, which was ninety units, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1264, made use of the pricing descriptor "CVS VALUE – MOD PRICING" and resulted in CVS charging a price of $25.00, which included a dispensing fee of $7.00.

- On April 4, 2019, the same CVS Pharmacy, Store No. 00071, dispensed a ninety-day supply of levothyroxine sodium, NDC No. 00378180310, which was ninety units, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $42.38 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($0.20) and the per-unit paid amount on the Connecticut Medicaid

prescription ($0.35) multiplied by the number of units (90) equals damages of $13.63 to Connecticut Medicaid, which CVS has not repaid.

200. The following transactions involving the same drug and quantity took place at CVS in Connecticut in January 2020:

- On January 2, 2020, the CVS Pharmacy at 3710 Main Street, Bridgeport, Connecticut, Store No. 02143, sold a ninety-day supply of Medroxyprogesterone Acetate, NDC No. 59762453802, which was one unit, to a customer using a ScriptSave discount card. This particular ScriptSave discount card, under Group No. 1417, made use of the pricing descriptor "CVS/TARGET STORES PRICING" and resulted in CVS charging a price of $36.35, which included a dispensing fee of $4.50.[5]

- On January 13, 2020, the same CVS Pharmacy, Store No. 02143, dispensed a ninety-day supply of Medroxyprogesterone Acetate, NDC No. 59762453802, which was one unit, to a Connecticut Medicaid beneficiary. Connecticut Medicaid paid $63.36 to CVS for this prescription, which included a dispensing fee of $10.75.

- The difference between the per-unit price of the ScriptSave prescription ($31.85) and the per-unit paid amount on the Connecticut Medicaid prescription ($52.61) multiplied by the number of units (1) equals damages of $20.76 to Connecticut Medicaid, which CVS has not repaid.

B. Indiana

201. Since January 2016, CVS has owned and operated pharmacies enrolled in IHCP under multiple provider agreements. Each of these pharmacies is enrolled in IHCP using a separate IHCP provider identifier number. During this time period, CVS pharmacies operated under at least 1,159 IHCP provider identification numbers.

202. During the relevant time period, CVS has submitted more than 9.5 million fee-for-service claims to IHCP, for which it was reimbursed more than $846 million.

203. Throughout the relevant time period, CVS made its ScriptSave program available to the general public with no substantial barriers to entering the program and no meaningfully

[5] This particular store was a standalone CVS pharmacy and was not part of or related to any Target store location.

selective criteria to differentiate members of the program from the general public. By artificially dividing its customer base, CVS sought to avoid the requirement to truthfully report the price it offered to the general public.

204. Throughout the relevant time period, CVS used its ScriptSave program to offer discounts to the general public and accepted these discounted prices as full payment for the prescription drugs it dispensed. At the same time, CVS was submitting claims for dispensing the same drugs to IHCP members and reporting a U&C charge that was substantially higher than the discounted price afforded to its ScriptSave customers.

205. At no point has IHCP had access to claims data regarding CVS's sales to non-Medicaid beneficiaries, including those members of the general public using ScriptSave discount cards, and at no point did CVS notify IHCP that it was offering lower prices to the general public through its ScriptSave program. Therefore, IHCP could not have readily determined that CVS was not reporting a discounted price made available to the general public as it U&C charge.

206. At no point was CVS advised that IHCP sanctioned its determination that it did not need to report its ScriptSave program prices as its U&C charges or that it claims submission process was otherwise compliant with the statutes, rules, and regulations of IHCP.

207. CVS was aware of the price that it was offering to its cash-paying ScriptSave customers but still reported an entirely different price for the same prescription drugs to IHCP, resulting in overpayments being made by IHCP for those services.

208. If IHCP had been aware that CVS was not reporting a discounted price made available to the general public as it usual and customary price, IHCP would have taken appropriate steps to ensure that CVS did not receive payments to which it was not entitled, such as denying any claims that misrepresented the U&C charge, seeking recovery of overpayments

through administrative processes, or demanding return of overpayments directly from CVS.

209. At no time did CVS notify IHCP of such overpayments or otherwise make an effort to return any such overpayments. Instead, CVS has knowingly retained these overpayments.

210. Set forth below and summarized in **Exhibit 2** are examples of CVS's false and fraudulent claims to IHCP. For example, on June 23, 2016, CVS Store No. 6474 in Plymouth, Indiana dispensed ninety units of loratadine to an IHCP beneficiary and to two separate cash-paying members of the general public with ScriptSave Discount Card No. 1264. CVS was reimbursed $35.99 by IHCP for this service but had charged each of the cash-paying customers only $10.24 for the same amounts of the same drug, resulting in CVS receiving an overpayment of $25.75. CVS has not repaid IHCP for the difference.

211. On or about September 6, 2016, CVS Store No. 2665 in Crown Point, Indiana dispensed 6.7 grams of Proventil HFA to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $75.63 by IHCP for this service but had charged the cash-paying customer only $70.19, resulting in CVS receiving an overpayment of $5.44. CVS has not repaid IHCP for the difference.

212. On or about March 13, 2017, CVS Store No. 6652 in Connersville, Indiana dispensed ninety units of loratadine to an IHCP beneficiary and to three separate cash-paying members of the general public with ScriptSave Discount Card No. 1264. CVS was reimbursed $32.99 by IHCP for this service but had charged the cash-paying customers only $10.24 each, resulting in CVS receiving an overpayment of $22.75. CVS has not repaid IHCP for the difference.

213. On or about October 4, 2017, CVS Store No. 6780 in Scottsburg, Indiana

dispensed 200 units of amoxicillin to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $15.27 by IHCP for this service but had charged the cash-paying customer only $7.00, resulting in CVS receiving an overpayment of $8.27. CVS has not repaid IHCP for the difference.

214. On or about January 23, 2018, CVS Store No. 6621 in Marion, Indiana dispensed thirty units of loratadine to an IHCP beneficiary and to two separate cash-paying members of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $12.00 by IHCP for this service but had charged each of the cash-paying customers only $4.00 for the same amounts of the same drug, resulting in CVS receiving an overpayment of $8.00. CVS has not repaid IHCP for the difference.

215. On or about September 14, 2018, CVS Store No. 6998 in Indianapolis, Indiana dispensed thirty units of loratadine to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $12.46 by IHCP for this service but had charged the cash-paying customer only $5.00, resulting in CVS receiving an overpayment of $7.46. CVS has not repaid IHCP for the difference.

216. On or about January 2, 2019, CVS Store No. 8904 in Noblesville, Indiana dispensed 200 units of amoxicillin to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $14.67 by IHCP for this service but had charged the cash-paying customer only $10.79, resulting in CVS receiving an overpayment of $3.88. CVS has not repaid IHCP for the difference.

217. On or about March 1, 2019, CVS Store No. 6621 in Marion, Indiana dispensed thirty units of cetirizine HCL to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $11.99 by IHCP for this

service but had charged the cash-paying customer only $9.99, resulting in CVS receiving an overpayment of $2.00. CVS has not repaid IHCP for the difference.

218. On or about January 22, 2020, CVS Store No. 6536 in Kokomo, Indiana dispensed 200 units of amoxicillin to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1417. CVS was reimbursed $14.79 by IHCP for this service but had charged the cash-paying customer only $10.02, resulting in CVS receiving an overpayment of $4.77. CVS has not repaid IHCP for the difference.

219. On or about September 6, 2020, CVS Store No. 6484 in Michigan City, Indiana dispensed ninety units of loratadine to an IHCP beneficiary and a cash-paying member of the general public with ScriptSave Discount Card No. 1264. CVS was reimbursed $16.66 by IHCP for this service but had charged the cash-paying customer only $14.40, resulting in CVS receiving an overpayment of $2.26. CVS has not repaid IHCP for the difference.

C. Massachusetts

a. CVS's Operations and Pharmacy Claims in Massachusetts

220. From January 2016 through December 2024, CVS has owned and operated more than 475 pharmacies throughout the Commonwealth of Massachusetts that are, or have been, credentialed and enrolled as MassHealth providers.

221. Throughout the relevant time period, CVS has entered into multiple provider contracts with MassHealth and has been assigned multiple MassHealth provider identification numbers associated with various pharmacies.

222. Individual CVS pharmacy locations are then assigned a letter code at the end of one of these provider identification numbers. Those pharmacies submit claims to MassHealth using those provider identification numbers.

223. The Massachusetts Attorney General's Office has access to claims data submitted by CVS through the Medicaid Management Information System ("MMIS"). This database allows investigators to export and review reports of claims information.

224. From January 1, 2016 through December 31, 2024, CVS has been paid more than $3.1 billion by MassHealth for more than forty-three million fee-for-service claims.

225. Below is a table identifying the prescription drugs for which CVS has received the largest amounts from MassHealth:

Drug Name	Number of Paid Claims	Paid Amount
SUBOXONE 8 MG-2 MG SL FILM	557,362	$133,663,961.83
BIKTARVY 50-200-25 MG TABLET	19,270	$64,467,576.61
HUMIRA(CF) PEN 40 MG/0.4 ML	9,291	$60,413,698.21
TRULICITY 1.5 MG/0.5 ML PEN	54,069	$39,464,627.01
PROAIR HFA 90 MCG INHALER	591,732	$38,364,036.15
TRULICITY 0.75 MG/0.5 ML PEN	53,851	$38,228,249.59
STELARA 90 MG/ML SYRINGE	1,968	$37,939,320.95
FLOVENT HFA 110 MCG INHALER	153,066	$32,345,287.45
HUMIRA PEN 40 MG/0.8 ML	6,260	$31,500,844.02
LANTUS SOLOSTAR 100 UNIT/ML	101,614	$30,200,989.04
GENVOYA TABLET	9,613	$28,433,381.12
FREESTYLE LITE TEST STRIP	335,434	$27,903,849.48
ENBREL 50 MG/ML SURECLICK	5,033	$26,390,127.78
SYMBICORT 160-4.5 MCG INHALER	100,129	$25,032,657.01
ELIQUIS 5 MG TABLET	70,980	$24,308,656.18

b. CVS's Knowing Noncompliance with Massachusetts U&C Regulations

226. CVS's methodology for determining the U&C price for a prescription drug to submit to MassHealth does not comply with MassHealth's pharmacy and rate regulations. Specifically, CVS's methodology does not ensure that MassHealth receives "***[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug*** on the same date of service." 101 C.M.R. § 331.02 (emphasis added).

227. When determining the U&C prices for prescription drugs to submit to MassHealth, CVS reviews its contracts with various payers, as well as third-party operators that negotiate the prices its cash-paying members will pay, such as ScriptSave. Those contracts typically include a formula for calculating the price CVS will be paid for certain categories of drugs. That formula often identifies a percentage discount applied to the average wholesale price ("AWP") of certain categories of drugs.

228. These formulas are reflected in contracts between CVS and ScriptSave. For example, in a December 2018 contract between CVS and ScriptSave, CVS shall be paid "AWP – 12.00%" for brand drugs and "MAC or AWP – 74.00%" for generic drugs by members using a ScriptSave discount card.

229. Contrary to the plain text of MassHealth's regulations, CVS ***only*** reviews its contracts and applicable formulas with respect to brand drugs, as opposed to other categories of drugs, such as generic drugs. CVS then selects the contract that has the steepest discount for brand drugs and submits all prices associated with that contract for all categories of drugs as its U&C prices in the "gross amount due" field.

230. CVS's methodology is outlined in its "Most Favored Nation Calculation – Massachusetts" policy. According to this policy, CVS conducts its evaluation to identify the contract with the steepest discount from AWP for brand drugs quarterly.

231. The ScriptSave contract with CVS from December 2018 illustrates why CVS's methodology results in false claims for certain categories of drugs. If CVS had a contract with a payer or third-party operator that had a steeper discount for brand drugs than ScriptSave, i.e., an "AWP – 15.00%" (as opposed to ScriptSave's "AWP – 12.00%"), the ScriptSave contract would not be selected and its prices would not be reported as CVS's U&C charges. But if that other

contract with a payer or third-party operator did not have as steep a discount for generic drugs, i.e., a "AWP – 65.00%" (as opposed to ScriptSave's "AWP – 74.00% for generic drugs), CVS would still report that other contract's generic drug pricing as its U&C charges, even though it is not "***[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug*** on the same date of service." 101 C.M.R. § 331.02 (emphasis added). That is because CVS uses ***all*** prices in the contract that has the steepest discount for brand drugs as its U&C charges, even if those prices are not the lowest price CVS accepts for other categories of drugs.

232. Furthermore, CVS's contracts with various payers, as well as third-party operators that negotiate the prices its cash-paying members will pay, often include separate provisions that establish MAC pricing for certain generic drugs. The formulas associated with generic drugs for which MAC pricing has been established may end up being the lowest price CVS accepts for that drug on a given day, but CVS does not consider those prices in submitting its U&C charges to MassHealth.

233. CVS's methodology did not even ensure that MassHealth paid the "lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," as required by 101 C.M.R. § 331.02, for brand drugs throughout the entire relevant time period. The Attorney General's Office has identified that, from January 1, 2016 through December 31, 2018, there were numerous transactions in which CVS gave customers who had ScriptSave Discount Card No. 1417 better prices than it submitted as U&C prices to MassHealth for brand drugs during that time period.

c. <u>Materiality of CVS's Noncompliance to Payment</u>

234. MassHealth has never notified CVS that it approves of CVS's methodologies for calculating U&C charges for prescription drugs under MassHealth's regulations. Furthermore, MassHealth does not have access to claims data showing the prices CVS charges or accepts from

many other payers, including cash-paying customers who use ScriptSave discount cards. As such, MassHealth cannot readily determine whether the prices CVS accepts from ScriptSave customers for certain prescription drugs are lower than the prices CVS reports as its "usual and customary charges" for those drugs.

235. If, however, MassHealth learned that CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs, MassHealth would not have paid those claims or would have taken other appropriate action to ensure that CVS did not receive payments to which it was not entitled, including by recouping payments through administrative processes, making adjustments in the claims data, or seeking return of overpayments.

236. MassHealth has conducted audits for compliance with its U&C regulations in the past and sought recoupment of payment for claims that did not comply with these regulations.

237. For example, on February 18, 2020, MassHealth issued an Initial Notice of Overpayment to CVS associated with claims submitted from January 1, 2015 through December 31, 2018. MassHealth informed CVS that "MassHealth reviewed paid claims for prescriptions [and] has identified claims where the provider charged a third party less than what was billed to MassHealth . . . MassHealth has identified overpayments totaling $2,428.61 resulting from payments made in excess of the maximum amount properly payable for the service provided, based on the agency's direct knowledge of lower amounts accepted on claims for the same quantity of the same product on the same date of service."

d. Representative Examples of CVS's False and Fraudulent Claims

238. The Commonwealth has identified numerous instances in which MassHealth paid CVS a higher price than a ScriptSave cash-paying customer paid for the same drug on the same date of service, which are set forth below and summarized in **Exhibit 3**.

239. For example, on May 14, 2017, a prescription for thirty units of "Lisinporil 20 Mg Tablet" was filled at a CVS pharmacy in Brockton, Massachusetts for MassHealth member C.W.. MassHealth paid CVS $10.95 for that prescription and C.W. paid a $1.00 copayment. Also on May 14, 2017, a cash-paying customer with ScriptSave Discount Card No. 1264 paid $7.75 for a prescription for thirty units of "Lisinporil 20 Mg Tablet" at the same CVS pharmacy. CVS has not repaid MassHealth for the difference.

240. The next day, on May 15, 2017, a prescription for twelve units of "Flovent HFA 110 MCG Inhaler" was filled at a CVS pharmacy in Clinton, Massachusetts for MassHealth member J.E. MassHealth paid CVS $230.71 for that prescription. Also on May 15, 2017, a cash-paying customer with ScriptSave Discount Card No. 1417 paid $204.80 for a prescription for twelve units of "Flovent HFA 110 MCG Inhaler" at the same CVS pharmacy. CVS has not repaid MassHealth for the difference.

241. On January 22, 2018, a prescription for twelve units of "Flovent HFA 110 mcg Inhaler" was filled at a CVS pharmacy in Dorchester, Massachusetts for MassHealth member A.V. MassHealth paid CVS $237.46 for that prescription and A.V. paid a $3.65 copayment. Also in January 2018, a cash-paying customer with ScriptSave Discount Card No. 1417 paid $204.80 for a prescription for twelve "Flovent HFA 110 mcg Inhaler" at a CVS pharmacy in Woburn, Massachusetts. CVS has not repaid MassHealth for the difference.

242. On March 10, 2018, a prescription for thirty units of "Loratadine 10 Mg Tablet" was filled at a CVS pharmacy in Revere, Massachusetts for MassHealth member W.M.-P. MassHealth paid CVS $8.35 for that prescription and W.M.-P. paid a $3.65 copayment. Also on March 10, 2018, a cash-paying customer with ScriptSave Discount Card No. 1417 paid $4.00 for

a prescription for thirty units of "Loratadine 10 Mg Tablet" at the same CVS pharmacy. CVS has not repaid MassHealth for the difference.

243. On October 12, 2018, a prescription for ten units of "Humalog 100 Unit/ML Vial" was filled at a CVS pharmacy in Worcester, Massachusetts for MassHealth member M.S. MassHealth paid CVS $267.68 and M.S. paid a $3.65 copayment. Also on October 12, 2018, a cash-paying customer with ScriptSave Discount Card No. 1417 paid $174.90 for a prescription for ten units of "Humalog 100 Unit/ML Vial" at the same CVS pharmacy. CVS has not repaid MassHealth for the difference.

244. On February 9, 2020, a prescription for sixty units of "Loratadine 10 mg Tablet" was filled at a CVS pharmacy in Worcester, Massachusetts for MassHealth member P.T. MassHealth paid CVS $9.79 for that prescription and P.T. paid a $3.65 copayment. Also in February 2020, a cash-paying customer with ScriptSave Discount Card No. 1264 paid $11.60 for a prescription for sixty units of "Loratadine 10 mg Tablet" at a CVS pharmacy in South Easton, Massachusetts. CVS has not repaid MassHealth for the difference.

245. On February 27, 2020, a prescription for thirty units of "Ibuprofen 600 Mg Tablet" was filled at a CVS pharmacy in Hudson, Massachusetts for MassHealth member S.C. MassHealth paid CVS $11.99 for that prescription. Also on February 27, 2020, a cash-paying customer with ScriptSave Discount Card No. 1264 paid $7.17 for a prescription for thirty units of "Ibuprofen 600 Mg Tablet" at the same CVS pharmacy. CVS has not repaid MassHealth for the difference.

D. Oklahoma

246. CVS separates and identifies patient groups by Condor Plan Numbers.

247. In Oklahoma, Condor Plan Number 1 (the "Cash U&C Plan") represents customers who purchase or receive their prescriptions without insurance or an established discount. At all times relevant to this action, the drug prices assigned under the Cash U&C Plan were the prices that CVS reported to Oklahoma as its usual and customary price.

248. Condor Plan Number 18220 represents customers who purchase or receive their prescriptions with a ScriptSave discount card. Condor Plan Number 18220 is further separated into group numbers that correspond to discount card numbers, including Group Nos. 1264 and 1417.

249. Upon implementation of the ScriptSave Discount Card No. 1417 discount pricing scheme and automatic transitioning of Target Prescription Savings Program customers into the program, ScriptSave Discount Card No. 1417 card users quickly became the predominant patient group at CVS pharmacies within Target stores in Oklahoma.

250. For example, at the CVS pharmacy within the Target with an NPI number ending in 4487 (the "4487 Store"), there were 1,834 ScriptSave Discount Card No. 1417 discount card 1417 transactions in 2017. There were ScriptSave Discount Card No. 1417 transactions on three hundred and forty-five (345) days in 2017 at the 4487 Store.

251. That same year, there were only forty (40) days that the 4487 Store had a Cash U&C Plan transaction—for a total of only forty-seven (47) transactions under the Cash U&C Plan in 2017. In other words, there were thirty-nine (39) ScriptSave Discount Card No. 1417 transactions for every one (1) Cash U&C Plan transaction at the 4487 Store in 2017.

252. Excluding patients who purchased or received prescriptions through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the largest patient group at the 4487 Store for at least each of the years from 2017-2022.

253. The 4487 Store was not an outlier. Collectively across all CVS locations, and excluding third-party payer transactions, ScriptSave Discount Card No. 1417 transactions were predominant in Oklahoma for at least each of the years 2018-2022.

254. Internal CVS communications demonstrate that CVS knew in 2017 that it would "create U&C risk" if it aggressively pursued a cash discount strategy to achieve its goal of increasing script volume. Nevertheless, CVS promoted the ScriptSave Discount Card No. 1417 in Oklahoma to the point that ScriptSave Discount Card No. 1417 transactions across Oklahoma stores outnumbered Cash U&C Plan transactions at least 2:1 in 2018 and 2019.

255. Throughout the relevant time period, CVS never attempted to identify the patient group accounting for the largest number of non-SoonerCare prescriptions from each individual pharmacy. Instead, CVS consistently reported to the OHCA that its U&C price for prescriptions at each individual pharmacy in Oklahoma was the Cash U&C Plan price, despite knowing that ScriptSave Discount Card No. 1417 customers were the predominant patient group across Oklahoma stores.

256. Pursuant to OAC 317:30-5-78(d)(2), only patients who purchase or receive their prescriptions through other third-party payers can be categorically excluded when determining a pharmacy's usual and customary price to the general public.

257. ScriptSave patients could not be excluded by CVS when it determined its U&C price to the general public because ScriptSave is not a third-party payer. Rather, ScriptSave is a third-party claims processor that does not make any payment in connection with a ScriptSave transaction. Moreover, ScriptSave discount card programs could not be combined with insurance. Consequently, ScriptSave transactions never involve a third-party payer.

258. CVS knew that ScriptSave was a third-party claims processor, not a third-party payer. CVS distributed FAQ to consumers that identified ScriptSave as a "third party claims processor." The FAQ further acknowledged and represented that ScriptSave "does not make payments to pharmacies. Members are required to pay for all health care services." Thus, CVS knew that ScriptSave patients could not be excluded by CVS when it determined its U&C price to the general public.

259. CVS further knew that ScriptSave transactions were not subject to exclusion based on the threshold volume limit in OAC 317:30-5-78(d)(2). The threshold volume limit applies to discount prices offered only to a portion of customers based on selective criteria, such as the customer being a senior citizen. *See United States ex rel. Strauser v. Stephen L. LaFrance Holdings, Inc.*, No. 18-CV-673-GKF-FHM, 2019 WL 1086363, at *10 (N.D. Okla. Mar. 7, 2019). CVS promoted ScriptSave as "open to everyone" with "no limits on usage, and no income or age restrictions." Because ScriptSave programs had open eligibility and constituted discount prices offered to everyone, the threshold volume limit in OAC 317:30-5-78(d)(2) did not apply to ScriptSave transactions. *See id.*

260. CVS knowingly concealed the low prices offered to the general public through its ScriptSave Discount Card No. 1417 program from the OHCA.

261. The OHCA did not know that, excluding customers who purchase or receive their prescriptions through other third-party payers, ScriptSave Discount Card No. 1417 customers represented the largest number of non-SoonerCare prescriptions collectively and across certain individual pharmacies.

262. CVS knowingly submitted claims to the OHCA that misrepresented CVS's U&C price to the general public in Oklahoma to maintain higher reimbursement levels from Oklahoma's Medicaid program.

263. For each of the years 2018-2022, CVS reported to the OHCA that its U&C price for prescriptions was the price paid by cash-only customers not using ScriptSave Discount Card No. 1417, despite the fact that ScriptSave Discount Card No. 1417 customers were the predominant patient group during this period of time. As a result, CVS knowingly concealed the low prices offered to the general public through its ScriptSave Discount Card No. 1417 program.

264. From at least 2018-2022, numerous CVS locations in Oklahoma failed to disclose true U&C prices for drugs on claims for reimbursement for the drugs.

265. Had CVS reported the ScriptSave Discount Card No. 1417 prices for prescriptions as U&C prices, the OHCA would not have paid CVS more for prescriptions than the ScriptSave Discount Card No. 1417 price for the same drug.

266. The State of Oklahoma has identified instances in which the OHCA paid CVS a higher price than a ScriptSave customer paid for the same drug on the same date of service, which are set forth below and summarized in **Exhibit 4**.

267. For example, on January 14, 2019, at the CVS store with an NPI ending in 1840, ScriptSave Discount Card No. 1417 customers represented the predominant patient group that did not purchase or receive their prescription through a third-party payer. On this date, there were seventeen ScriptSave Discount Card No. 1417 transactions and no Cash U&C Plan transactions. There were two ScriptSave Discount Card No. 1417 transactions for the drug Amoxicillin, NDC No. 65862001705, with a quantity of twenty. CVS represented to the OHCA that the U&C price for that drug and quantity on January 14, 2019 was $12.39. The ScriptSave

Discount Card No. 1417 customers paid $6.80. Oklahoma Medicaid paid $12.09 for a prescription for member F.M.E. for the same drug in the same quantity on the same day, resulting in an overpayment of $5.29. CVS has not repaid the OHCA for the difference. Of patients who did not purchase or receive their prescription through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the predominant purchaser of Amoxicillin, NDC No. 65862001705, at the 1840 store in 2019; Cash U&C Plan customers represented only 4.81%.

268. Similarly, on May 8, 2019, at the CVS store with an NPI ending in 5936, ScriptSave Discount Card No. 1417 customers represented the predominant patient group that did not purchase or receive their prescription through a third-party payer. On this date, there were thirteen ScriptSave Discount Card No. 1417 transactions and only one Cash U&C Plan transaction. There was one ScriptSave Discount Card No. 1417 transaction for the drug Prednisone, NDC No. 00054001725, with a quantity of thirty-two. CVS represented to the OHCA that the U&C price for that drug and quantity on May 8, 2019 was $14.29. The ScriptSave Discount Card No. 1417 customer paid $8.48. Oklahoma Medicaid paid $13.64 for a prescription for member M.A.H. for the same drug in the same quantity on the same day, resulting in an overpayment of $5.16. CVS has not repaid the OHCA for the difference. Of patients who did not purchase or receive their prescription through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the predominant purchaser of Prednisone, NDC No. 00054001725, at the 5936 store in 2019; Cash U&C Plan customers represented only 6.25%.

269. On January 24, 2020, at the CVS store with an NPI ending in 9121, ScriptSave Discount Card No. 1417 customers represented the predominant patient group that did not

purchase or receive their prescription through a third-party payer. On this date, there were fourteen ScriptSave Discount Card No. 1417 transactions and one Cash U&C Plan transaction. There was one ScriptSave Discount Card No. 1417 transaction for the drug Oseltamivir Phosphate, NDC No. 47781038426, with a quantity of 120. CVS represented to the OHCA that the U&C price for that drug and quantity on January 24, 2020 was $209.99. The ScriptSave customer paid $98.44. Oklahoma Medicaid paid $103.36 for a prescription for member I.L.H. for the same drug in the same quantity on the same day, resulting in an overpayment of $4.92. CVS has not repaid the OHCA for the difference. Of patients who did not purchase or receive their prescription through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the predominant purchaser of Oseltamivir Phosphate, NDC No. 47781038426, at the 9121 store in 2020; there were no Cash U&C Plan customers.

270. On April 13, 2020, at the CVS store with an NPI ending in 2159, ScriptSave Discount Card No. 1417 customers represented the predominant patient group that did not purchase or receive their prescription through a third-party payer. On this date, there were thirty-three ScriptSave Discount Card No. 1417 transactions and two Cash U&C Plan transactions. There was one ScriptSave Group No. 1417 transaction for the drug Metoclopramide HCL, NDC No. 00093220305, with a quantity of ninety. CVS represented to the OHCA that the U&C price for that drug and quantity on April 13, 2020 was $22.49. The ScriptSave customer paid $7.00. Oklahoma Medicaid paid $15.14 for a prescription for member K.W. for the same drug in the same quantity on the same day, resulting in an overpayment of $8.14. CVS has not repaid the OHCA for the difference. Of patients who did not purchase or receive their prescription through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the predominant

purchaser of Metoclopramide HCL, NDC No. 00093220305, at the 2159 store in 2020; Cash U&C Plan customers represented only 7.14%.

271. On April 23, 2021, at the CVS store with an NPI ending in 6492, ScriptSave Discount Card No. 1417 customers represented the predominant patient group that did not purchase or receive their prescription through a third-party payer. On this date, there were seven ScriptSave Discount Card No. 1417 transactions and two Cash U&C Plan transactions. There was one ScriptSave Discount Card No. 1417 transaction for the drug Chlorhexidine Glucoate, NDC No. 00116200116, with a quantity of 473. CVS represented to the OHCA that the U&C price for that drug and quantity on April 23, 2021 was $11.99. The ScriptSave customer paid $8.00. Oklahoma Medicaid paid $11.99 for a prescription for member R.J.B. for the same drug in the same quantity on the same day, resulting in an overpayment of $3.99. CVS has not repaid the OHCA for the difference. Of patients who did not purchase or receive their prescription through a third-party payer, ScriptSave Discount Card No. 1417 customers represented the predominant purchaser of Chlorhexidine Glucoate, NDC No. 00116200116, at the 6492 store in 2021; Cash U&C Plan customers represented only 12.8% of customers.

CAUSES OF ACTION

A. Connecticut

COUNT I – False and Fraudulent Claims
(Conn. Gen. Stat. § 4-275(a)(1))

272. Connecticut incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

273. CVS knowingly presented or caused to be presented false or fraudulent claims for payment.

274. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or acted with reckless disregard of the truth or falsity of the information.

275. By virtue of the false or fraudulent claims, Connecticut suffered damages and therefore is entitled to statutory damages under the CFCA, to be determined at trial, plus a civil penalty for each violation and the costs of the civil action.

COUNT II – False Records or Statements
(Conn. Gen. Stat. § 4-275(a)(2))

276. Connecticut incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

277. CVS knowingly made, used or caused to be made or used, false records or statements to induce the payment of false and fraudulent claims in violation of Conn. Gen. Stat. § 4-275(a)(2).

278. The false records or statements made, used or caused to be made or used, by CVS were material in that they had a natural tendency to influence or were capable of influencing Connecticut in its decision to pay the false or fraudulent claims.

279. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or acted with reckless disregard of the truth or falsity of the information.

280. By virtue of CVS's conduct, CVS suffered damages and therefore is entitled to statutory damages under the CFCA, to be determined at trial, plus a civil penalty for each violation and the costs of this civil action.

COUNT III – Concealment and Improper Avoidance of Obligation to Return Overpayments
(Conn. Gen. Stat. § 4-275(a)(8))

281. Connecticut incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

282. CVS knowingly concealed or knowingly and improperly avoided an obligation to pay money, that is, to return overpayments, to Connecticut. CVS knowingly failed to return overpayments or make reconciliation payments to the DSS for prescription drug claims with U&C charges that were higher than the prices which CVS knowingly accepted as payment in full from cash customers using discount cards administered by ScriptSave based on prices contracted with CVS.

283. CVS knowingly failed to provide information about the ScriptSave discount card programs to DSS when making statements about the end of the HSP program and related overpayments.

284. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or acted with reckless disregard of the truth or falsity of the information.

285. By virtue of CVS's conduct, Connecticut suffered damages and therefore is entitled to statutory damages under the CFCA, to be determined at trial, plus a civil penalty for each violation and the costs of this civil action.

COUNT IV – Common Law Breach of Contract

286. Connecticut incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

287. CVS's provider agreements with Connecticut Medicaid established a duty for CVS to comply with all federal and state statutes, regulations, and policies pertaining to Connecticut Medicaid. The Provider Agreements also required CVS to repay the DSS any

payment or amount thereof for goods or services which represented an excess over the appropriate payment, or any payment owed to the DSS because of a violation due to abuse or fraud. Provider Agreement ¶ 23.

288. CVS received substantial overpayments that were not due from the DSS as reimbursement for prescription drugs, when the amounts charged by CVS and received by CVS as reimbursement for those drugs exceeded the prices for which CVS charged a cash customer using a ScriptSave discount card to obtain a CVS-contracted cash discount card price for those drugs.

289. The DSS has complied with all material obligations required of it under the terms and conditions of the Provider Agreements.

290. Because CVS's provider agreements with Connecticut Medicaid required CVS to comply with all laws governing Connecticut Medicaid, CVS's violations of Connecticut General Statutes § 17b-226a caused CVS to breach its provider agreements with Connecticut Medicaid.

291. Connecticut has suffered damages from CVS's breach of the provider agreements.

292. The Provider Agreements authorize the DSS to recover all overpayments it made to CVS. Connecticut is entitled to recover the full overpayment amount, in addition to pre-judgment and post-judgment interest.

COUNT V – Common Law Unjust Enrichment

293. Connecticut incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

294. CVS benefited from the DSS's payment to CVS of Medicaid monies that were not due.

295. CVS did not provide consideration for these Medicaid payments.

296. CVS's failure to provide consideration for these Medicaid payments operated to the detriment of Connecticut and, in particular, the detriment of the DSS and the CMAP.

297. CVS has been unjustly enriched. Connecticut is entitled to recover all amounts by which CVS was unjustly enriched, in addition to pre-judgment and post-judgment interest.

B. Indiana

COUNT VI – Presentment of a False Claim
(Ind. Code § 5-11-5.7-2(a)(1))

298. Indiana incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

299. This is a claim for treble damages, statutory per claim penalties, and costs pursuant to the Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7-1, *et seq.*

300. In submitting claims for reimbursement from or causing such claims to be submitted to Indiana Medicaid for drugs in amounts greater than its usual and customary charge to the general public, CVS knowingly presented or caused to be presented false or fraudulent claims for payment, in violation of Ind. Code § 5-11-5.7-2(a)(1).

301. Indiana sustained damages as a result of these false and fraudulent claims, in an amount to be determined at trial, and is entitled to receive: (1) a civil penalty for each false or fraudulent claim presented, (2) up to three times the amount of damages, and (3) the costs of a civil action brought to recover the penalties or damages. Ind. Code § 5-11-5.7-2(a).

COUNT VII – False Record or Statement
(Ind. Code § 5-11-5.7-2(a)(2))

302. Indiana incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

303. This is a claim for treble damages, statutory per claim penalties, and costs pursuant to the Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7-1, *et seq.*

304. In the process of submitting claims for reimbursement from Indiana Medicaid for amounts greater than its usual and customary charge to the general public, CVS knowingly made, used, or caused to be made or used false statements or records material to false or fraudulent claims for reimbursement from Indiana Medicaid. Ind. Code § 5-11-5.7-2(a)(2).

305. Indiana sustained damages as a result of these false and fraudulent claims, in an amount to be determined at trial, and is entitled to receive: (1) a civil penalty for each false or fraudulent claim presented, (2) up to three times the amount of damages, and (3) the costs of a civil action brought to recover the penalties or damages. Ind. Code § 5-11-5.7-2(a).

COUNT VIII – Concealing or Avoiding an Obligation to Pay
(Ind. Code § 5-11-5.7-2(6)(B))

306. Indiana incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

307. This is a claim for treble damages, statutory per claim penalties, and costs pursuant to the Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7-1, *et seq.*

308. In retaining moneys and overpayments from Indiana Medicaid to which it was not entitled, CVS knowingly concealed or knowingly and improperly avoided an obligation to pay or transmit money or property to the state. Ind. Code § 5-11-5.7-2(a)(6)(A).

309. Indiana sustained damages as a result of these false and fraudulent claims, in an amount to be determined at trial, and is entitled to receive: (1) a civil penalty for each false or

fraudulent claim presented, (2) up to three times the amount of damages, and (3) the costs of a civil action brought to recover the penalties or damages. Ind. Code § 5-11-5.7-2(a).

COUNT IX – Breach of Contract

310. Indiana incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

311. This is a claim for the recovery of monies by which CVS has been unjustly enriched.

312. Indiana entered into a valid contract or contracts with CVS for which adequate consideration was exchanged. The terms of these agreements required CVS to abide by the agreement and all applicable statutes, rules, and regulations of Indiana Medicaid.

313. Each time it submitted a claim to Indiana Medicaid for more than its usual and customary charge to the general public, CVS knowingly committed a material breach of those agreements.

314. Indiana sustained damages as a result of these breaches, and CVS is liable to the State of Indiana for all such amounts be determined at trial in addition to any costs, expenses, and the maximum amount of interest available under law.

COUNT X – Unjust Enrichment

315. Indiana incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

316. This is a claim for the recovery of monies by which CVS has been unjustly enriched.

317. CVS received a benefit by soliciting funds from Indiana Medicaid to which it was not entitled and allowing CVS to retain any such funds would be unjust. CVS is therefore liable

to the Indiana for all such amounts, or the proceeds therefrom, the amount of which is to be determined at trial in addition to any costs, expenses, and the maximum amount of interest available under law.

C. Massachusetts

COUNT XI – False Claims in Violation of Massachusetts False Claims Act
(MASS. GEN. LAWS ch. 12, § 5B(a)(1))

318. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

319. During the relevant time period, CVS violated G.L. c. 12, § 5B(a)(1) by knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval to MassHealth, resulting in CVS receiving payments from MassHealth to which it was not entitled.

320. Specifically, CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its "usual and customary charges" for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, MassHealth paid CVS higher rates than CVS was entitled under MassHealth regulations.

321. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

322. MassHealth was unaware of CVS's noncompliance. If, however, MassHealth learned that CVS accepted lower prices from ScriptSave customers for certain prescription drugs

than it reported as its U&C charges for those drugs, MassHealth would not have paid those claims or would have taken other appropriate action to ensure that CVS did not receive payments to which it was not entitled, including by recouping payments through administrative processes, making adjustments in the claims data, or seeking return of overpayments.

323. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT XII – False Records or Statements in Violation of Massachusetts False Claims Act (MASS. GEN. LAWS ch. 12, § 5B(a)(2))

324. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

325. During the relevant time period, CVS violated G.L. c. 12, § 5B(a)(2) by knowingly making, using, or causing to be made or used, a false record or statement to obtain payment or approval of a claim by MassHealth, resulting in CVS receiving payments from MassHealth to which it was not entitled.

326. Specifically, CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its "usual and customary charges" for those drugs when submitting claims to MassHealth. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, MassHealth paid CVS higher rates than CVS was entitled under MassHealth regulations.

327. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

328. MassHealth was unaware of CVS's noncompliance. If, however, MassHealth learned that CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs, MassHealth would not have paid those claims or would have taken other appropriate action to ensure that CVS did not receive payments to which it was not entitled, including by recouping payments through administrative processes, making adjustments in the claims data, or seeking return of overpayments.

329. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT XIII – Reverse False Claims in Violation of Massachusetts False Claims Act
(MASS. GEN. LAWS ch. 12, § 5B(a)(9))

330. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

331. During the relevant time period, CVS knowingly made, used, or caused to be made or used a false record or statement material to an obligation to pay or transmit money to the Commonwealth and/or knowingly concealed or knowingly and improperly avoided or decreased its obligation to pay or transmit money to the Commonwealth, resulting in CVS retaining higher payments for prescription drugs from MassHealth to which it was not entitled.

332. Specifically, CVS failed to return overpayments or make reconciliation payments to MassHealth for prescription drug claims that were based on CVS's knowing acceptance of lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim

submissions to MassHealth. As a result, CVS kept the payments MassHealth made to CVS at higher rates than CVS was entitled under MassHealth regulations.

333. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

334. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT XIV – Beneficiary of Overpayments in Violation of Massachusetts False Claims Act
(MASS. GEN. LAWS ch. 12, § 5B(a)(10))

335. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

336. During the relevant time period, CVS was the beneficiary of overpayments from the Commonwealth, subsequently discovered the falsity of its receipt of overpayments, and failed to disclose the receipt of the overpayments from the Commonwealth.

337. Specifically, CVS failed to return overpayments or make reconciliation payments to MassHealth for prescription drug claims that were based on CVS's knowing acceptance of lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, CVS kept the payments MassHealth made to CVS at higher rates than CVS was entitled under MassHealth regulations.

338. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

339. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus civil monetary penalties.

COUNT XV – Medicaid False Statements
(MASS. GEN. LAWS ch. 118E, § 40(1))

340. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

341. During the relevant time period, CVS knowingly, willfully, and/or with willful blindness, made or caused to be made false statements or representations of facts in its submissions of claims to MassHealth.

342. Specifically, CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, MassHealth paid CVS higher rates than CVS was entitled under MassHealth regulations.

343. These misrepresentations were material as that term is interpreted by the courts.

344. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with Mass. Gen. Laws ch. 118E, § 44.

COUNT XVI – Reverse Medicaid False Statements
(MASS. GEN. LAWS ch. 118E, § 40(3))

345. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

346. During the relevant time period, CVS knowingly, willfully, and/or with willful blindness, having knowledge of the occurrence of any event affecting its initial or continued right to any such benefit or payment, concealed or failed to disclose such an event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

347. Specifically, CVS failed to return overpayments or make reconciliation payments to MassHealth for prescription drug claims that were based on CVS's knowing acceptance of lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, CVS kept the payments MassHealth made to CVS at higher rates than CVS was entitled under MassHealth regulations.

348. By virtue of CVS's conduct, the Commonwealth has suffered damages and is entitled to recover treble damages plus the costs of investigation and litigation, in accordance with Mass. Gen. Laws ch. 118E, § 44.

COUNT XVII – Recovery of Overpayments
(MASS. GEN. LAWS ch. 118E, § 36(5), 130 C.M.R. §§ 450.260(A), (I))

349. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

350. CVS knew or should have known it had failed to comply with MassHealth regulations concerning pharmacy services, in violation of 130 C.M.R. §§ 406 *et seq.* and 101

C.M.R. §§ 331.00, *et seq*. CVS submitted claims for services that did not comply with these regulations. MassHealth paid those claims.

351. By virtue of CVS's submission of claims to MassHealth while in violation in violation of 130 C.M.R. §§ 406 *et seq.* and 101 C.M.R. §§ 331.00, *et seq.*, MassHealth made overpayments to CVS.

352. CVS is liable to repay the Commonwealth for the amount received from these overpayments because it accepted responsibility for all overpayments as a condition of its participation as a MassHealth provider. *See* Mass. Gen. Laws ch. 118E, § 36(5); 130 C.M.R. §§ 450.260(A), (I).

COUNT XVIII – Unjust Enrichment

353. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

354. During the relevant time period, CVS accepted lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, MassHealth paid CVS higher rates than CVS was entitled under MassHealth regulations.

355. Based on this unlawful submission, CVS received overpayments from MassHealth.

356. If CVS had not impliedly misrepresented compliance with applicable state laws and regulations, MassHealth would not have paid these payments. By retaining payments

improperly received from MassHealth, CVS has retained funds that are the property of the Commonwealth and to which CVS is not entitled.

357. It is unfair and inequitable for CVS to retain revenue from MassHealth for payments that it obtained in violation of MassHealth regulations and its MassHealth contracts.

358. By virtue of CVS's conduct, CVS has been unjustly enriched and is liable to account and pay such amounts to the Commonwealth.

COUNT XIX – Breach of Contract

359. The Commonwealth incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

360. CVS entered into valid contracts with MassHealth for which adequate consideration was exchanged. CVS breached its MassHealth contracts during the relevant time period by accepting lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated MassHealth regulations requiring CVS to report "[t]he lowest price that a provider charges or accepts from any payer for the same quantity of a drug on the same date of service," 101 C.M.R. § 331.02, as its U&C charges on its claim submissions to MassHealth. As a result, MassHealth paid CVS higher rates than CVS was entitled under MassHealth regulations.

361. Each false claim that CVS submitted to MassHealth constitutes a breach of CVS's MassHealth contracts.

362. As a result of CVS's breach of its MassHealth contracts, the Commonwealth has been damaged.

D. Oklahoma

COUNT XX – False and Fraudulent Claims
Violations of the Oklahoma Medicaid False Claims Act
(63 Okla. Stat. § 5053.1(B)(1))

363. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

364. Oklahoma seeks relief against CVS under Section 5053.1(B)(1) of the Oklahoma Medicaid False Claims Act.

365. CVS knowingly presented, or caused to be presented, materially false and fraudulent claims for payment or approval to Oklahoma, including claims for reimbursement by OHCA.

366. OHCA would not have paid these claims had they known that they were false and fraudulent.

367. CVS presented or caused to be presented these claims knowingly because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

368. Oklahoma, unaware of the falsity of the claims submitted for payment or caused to be submitted for payment by CVS, approved, paid, and participated in payments made by OHCA for false or fraudulent claims that would otherwise not have been approved and paid.

369. By reason of the false and/or fraudulent claims, Oklahoma has sustained damages in a substantial amount to be determined at trial and is entitled to treble damages plus a civil penalty for each false or fraudulent claim.

COUNT XXI – Use of False Statements
Violations of the Oklahoma Medicaid False Claims Act
(63 Okla. Stat. § 5053.1(B)(2))

370. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

371. Oklahoma seeks relief against CVS under Section 5053.1(B)(2) of the Oklahoma Medicaid False Claims Act.

372. As detailed above, CVS knowingly made, used, or caused to be made or used, false records or statements, which included the false statements, express and implied certifications, and representations on claim forms to obtain approval for and payment by Oklahoma for false or fraudulent claims as detailed above.

373. The false statements, express and implied certifications, and representations made, used, or caused to be made or used by CVS were material to the payment of the false or fraudulent claims by Oklahoma.

374. The false statements, express and implied certifications, and representations were made, used, or caused to be made or used with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

375. Oklahoma, unaware of the falsity of the records and statements made, used, or caused to be made or used by CVS, approved, paid, and participated in payments made by OHCA for false or fraudulent claims that would otherwise not have been approved and paid.

376. By reason of these false records or statements, Oklahoma has sustained damages in a substantial amount to be determined at trial and is entitled to treble damages plus a civil penalty for each false or fraudulent claim.

COUNT XXII – Reverse False Claims
Violations of the Oklahoma Medicaid False Claims Act
(63 Okla. Stat. § 5053.1(B)(7))

377. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

378. During the relevant time period, CVS knowingly made, used, or caused to be made or used a false record or statement material to an obligation to pay or transmit money to the State of Oklahoma and/or knowingly concealed or knowingly and improperly avoided or decreased its obligation to pay or transmit money to Oklahoma, resulting in CVS retaining higher payments for prescription drugs from the OHCA to which it was not entitled.

379. Specifically, CVS failed to return overpayments or make reconciliation payments to the OHCA for prescription drug claims that were based on CVS's knowing acceptance of lower prices from ScriptSave customers for certain prescription drugs than it reported as its U&C charges for those drugs. This conduct violated the OHCA's rules and regulations requiring CVS to report "its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim." Okla. Admin. Code 317:30-5-78(d)(2). As a result, CVS kept the payments the OHCA made to CVS at higher rates than CVS was entitled under the OHCA's rules and regulations.

380. CVS's conduct was knowing because it possessed actual knowledge of relevant information, acted with deliberate ignorance of the truth or falsity of information, and/or with reckless disregard of the truth or falsity of the information.

381. By virtue of CVS's knowing conduct, Oklahoma has sustained damages in a substantial amount to be determined at trial and is entitled to treble damages plus civil monetary penalties.

COUNT XXIII – Breach of Contract
Oklahoma Common Law

382. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

383. CVS's provider agreements with Oklahoma Medicaid established a duty for CVS to comply with all federal and state statutes, regulations, and policies pertaining to Oklahoma Medicaid.

384. Oklahoma law requires CVS to repay the OHCA any payment or amount thereof for goods or services which represented an excess over the appropriate payment.

385. CVS received substantial overpayments which were not due from the OHCA as reimbursement for covered prescription medications, when the reimbursement for those medications exceeded the prices for which CVS offered the same medications to a cash customer using a ScriptSave discount card.

386. The OHCA has complied with all material obligations required of it under the terms and conditions of the Provider Agreements.

387. Because CVS's provider agreements with Oklahoma Medicaid required CVS to comply with all rules governing Oklahoma Medicaid, CVS's violations of Okla. Admin. Code 317:30-5-78(d)(2) caused CVS to breach its provider agreements with Oklahoma Medicaid.

388. Oklahoma has suffered damages from CVS's breach of the provider agreements.

389. Oklahoma law authorizes Oklahoma to recover all overpayments it made to CVS.

COUNT XXIV – Unjust Enrichment
Oklahoma Common Law

390. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

391. Oklahoma paid claims submitted to Medicaid by CVS based on false claims and statements submitted to Oklahoma.

392. By retaining monies received from the OHCA in excess of reimbursable amounts, CVS retained money that was the property of Oklahoma to which it was not entitled.

393. Oklahoma seeks the recovery of all funds paid by Oklahoma by which CVS has been unjustly enriched at the expense of Oklahoma.

394. As a consequence of the acts set forth above, CVS was unjustly enriched at the expense of Oklahoma in an amount to be determined and which, under the circumstances, in equity and good conscience, should be returned to Oklahoma.

COUNT XXV – Payment by Mistake
Oklahoma Common Law

395. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

396. Oklahoma paid CVS for claims submitted by CVS that misrepresented CVS's U&C price for the applicable drugs, without knowledge of material facts, and under the mistaken belief that CVS was entitled to receive the amounts paid for such claims.

397. The mistaken belief of Oklahoma was material to its decision to pay CVS on such claims.

398. CVS intended that Oklahoma would rely on its false statements, representations, and material omissions of fact.

399. Oklahoma reasonably relied on CVS's false statements, representations, and material omissions of fact and, as a result, paid CVS money that it otherwise would not have been paid.

400. Oklahoma has been damaged as a result of these mistaken payments and is entitled to recover the amount of the payments in an amount to be determined at trial.

COUNT XXVI – Fraud
Oklahoma Common Law

401. Oklahoma incorporates each of the preceding paragraphs, restating and realleging each as though stated here.

402. CVS made materially false statements and representations, including material omissions of fact, to Oklahoma to obtain money from Oklahoma to which it was not entitled.

403. CVS made such statements and representations with knowledge of their materiality and falsity.

404. CVS also failed to provide information to Oklahoma about the ScriptSave program, which was a material omission.

405. CVS made such materially false statements, representations, and omissions with the intent that Oklahoma would rely on them in making determinations to pay claims submitted to Oklahoma.

406. Oklahoma reasonably relied on CVS's material misrepresentations and omissions.

407. Oklahoma was injured as a result of CVS's unlawful conduct in an amount to be determined at trial.

JURY DEMAND

The Intervening States demand a trial by jury in this action of all issues so triable.

PRAYERS FOR RELIEF

WHEREFORE, the Intervening States demand and pray that after trial on the merits, judgment be entered in their favor as follows:

a. Counts One, Two, and Three – for assessment of damages and civil

penalties as described above and to the full extent provided by law under the CFCA, the costs of this civil action, and all other just and proper relief;

b. Counts Four and Five – for the full amount of damages sustained by the State of Connecticut, to be proven at trial, pre-judgment interest, post-judgment interest, and all other just and proper relief;

c. Counts Six, Seven, and Eight – for assessment of damages and civil penalties as described above and to the full extent provided by the IMFCA, the costs of this civil action, and all other just and equitable relief in the premises;

d. Counts Nine and Ten – for the full amount of damages, or the proceeds therefrom, which are to be determined at trial, plus the costs of this civil action, expenses, the maximum amount of interest available under law, and all other just and equitable relief in the premises;

e. Counts Eleven, Twelve, Thirteen, and Fourteen – for the amount of the Commonwealth's damages, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, and civil penalties as required by G.L. c. 12, § 5B, together with such other relief as may be just and proper;

f. Counts Fifteen and Sixteen – for the amount of the Commonwealth's damages, as is proved at trial, trebled as required by law, plus the costs of investigation and litigation, including the costs of experts, together with such other relief as may be just and proper;

g. Counts Seventeen and Eighteen – for the amount of the Commonwealth's damages, as is proved at trial, together with such other relief as may be just and proper;

h. Count Nineteen – for the amount of the Commonwealth's damages, as is proved at trial, and interest at the statutory rate of 12% pursuant to Mass. Gen. Laws c. 231, § 6C, from the date of each breach of contract, together with such other relief as may be just and proper;

i. Counts Twenty, Twenty-One, and Twenty-Two – for assessment of damages and civil penalties as described above and to the full extent provided by law under the OFCA, the costs of this civil action, and all other just and proper relief;

j. Count Twenty-Three – for the full amount of damages sustained by the State of Oklahoma, to be proven at trial, pre-judgment interest, post-judgment interest, the costs of this civil action, and all other just and proper relief; and

k. Counts Twenty-Four, Twenty-Five, and Twenty-Six – for the full amount

of damages sustained by the State of Oklahoma, to be proven at trial, the costs of this civil action, and all other just and proper relief.

Dated: April 14, 2025

Respectfully submitted,

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