IN THE UNITED STATES DISTRICT COURT FOR

THE NORTHERN DISTRICT OF OKLAHOMA

Katherine Fisher, Earlee Heath, and Karol Loy, on behalf of themselves and all others similarly situated,

Plaintiffs

v.

State of Oklahoma, Oklahoma Health Care Authority and Mike Fogarty, in his capacity as CEO of the Oklahoma Health Care Authority,

Defendants

Civil Action No.02cv762P(C)

Class Action

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO FOR SUMMARY JUDGMENT

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On October 9, 2002, Defendants filed a motion for summary judgment and a brief in support. For the following reasons, Defendants' motion should be denied and this Court should grant Plaintiffs' motion for a permanent injunction.

1. **Defendants Inadequate Funding Is Not Legally Sufficient to Violate the Medical Assistance Act's Home and Community-Based Waiver Requirements**

At the heart of the Defendants' Motion for Summary Judgment and their opposition to Plaintiffs' Motion for A Permanent Injunction is Defendant Mike Fogarty's testimony and the minutes of a meeting of Defendant Oklahoma Health Care Authority (Defendants' Motion for

Summary Judgment, Ex. "E"). [1] Mr. Fogarty testified the state was experiencing a "state revenue shortfall," and the Oklahoma Director of State Finance "ordered all agencies to have a general revenue cut of 4.75% for the fiscal year." (Ex. "E" at 2, emphasis added) . The specific reductions were those recommended by Medicaid agency staff, not the Director of State Finance. Thus, there is no dispute that the only reason Defendants cutback the number of prescription medications to persons in the Oklahoma Advantage Home and Community-Based Wavier was to save money.

Assuming arguendo that a "state revenue shortfall" exists and that savings had to come from all departments, nevertheless Defendants cannot escape the legal obligations they have undertaken when they decided to participate in the Medicaid program and when they accepted federal funds. Once a state has elected to participate in Medicaid, it "must comply with the requirements imposed both by the Act itself and by the Secretary of Health and Human Services." Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981).

Courts have consistently held that States must comply with Title XIX. Neither alleged inadequate funding nor other proffered administrative constraints excuse States from providing the Medical Assistance services required by Title XIX. For example, in Doe v. Chiles, 136 F.3d 709, 722 (11th Cir. 1998), the court held that the state Medicaid agency had violated the "reasonable promptness" mandate in Title XIX and, thus, had been properly enjoined from denying Medical Assistance services. In so doing, the court noted that "'inadequate state appropriations do not excuse noncompliance [with the Medicaid Act].'" Id. at 722 (quoting

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[1] Because Plaintiffs are not pursuing their due process claim, they will not address Defendants' Motion for Summary Judgment, Proposition I at 6 - 8.

Alabama Nursing Home Ass'n v. Harris, 617 F. 2d 388, 396 (5th Cir. 1980)). Many other cases and decisions stand for the same legal principle. See also, e.g., Robertson v. Jackson, 766 F. Supp. 470, 476 (E.D. Va. 1991), aff'd, 972 F.2d 529 (4th Cir. 1992) ("Lack of resources and lack of bad faith on the part of the agency officials [are] no excuse for failing to provide the plaintiffs their statutory entitlements"); Sobky v. Smoley, 855 F. Supp. 1123, 1149 (E.D. Cal. 1994) ("insufficient funding by the State and counties of methadone maintenance treatment slots has caused providers . . . to place eligible individuals on waiting lists for treatment . . . precisely the sort of state procedure the reasonable promptness provision is designed to prevent"); Madrid Home for the Aging v. Iowa Dep't of Human Services, Division of Medical Assistance, 557 N.W.2d 507, 514 (Iowa 1996) ("Budget considerations cannot excuse noncompliance with federal Medicaid law."). See generally Coalition for Basic Human Needs v. King, 654 F.2d 838, 843 (1st Cir. 1981) ("reasonable promptness" prohibited state from delaying AFDC benefits checks while the state legislature resolved a budget dispute). [2]

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[2] Inadequate funding cannot adversely affect any Title XIX services that must be provided. See, e.g., Cramer v. Chiles, 33 F. Supp. 2d 1342 (S.D. Fla. 1999) (legislature cannot deny persons with disabilities a choice between waiver and institutional care); McMillan v. McCrimon, 807 F. Supp. 475 (C.D.Ill 19982)(granting preliminary injunction on plaintiffs' claim that §1396a(a)(8) required Medicaid agency to accept applications for home and community-based waiver program); Morgan v. Cohen, 665 F. Supp. 1164, 1177 (E.D. Pa. 1987) (Medicaid-covered transportation services "must be furnished with reasonable promptness"); Linton v. Carney, 779 F. Supp. 925, 936 (M.D. Tenn. 1990) (policy of limiting the number of nursing homes beds that could be used for Medicaid patients violated the reasonable promptness provision by causing those patients "to experience extended delays and waiting lists in attempting to gain access to long term nursing home care"); Clark v. Kizer, 758 F. Supp. 572, 580 (E.D. Cal. 1990), aff'd in part and vacated in part on other grounds sub nom., Clark v. Coye, 967 F.2d 585 (9th Cir. 1992) (granting summary judgment on reasonable promptness claim where declarations of county public health officials indicated that a shortage of Medicaid-participating dentists caused "class members frequently [to] experience delays in obtaining appointments for regular and emergency dental care[.]")

Defendants' budgetary constraint argument must fail because it cuts out the heart of the Medicaid program: "If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will. The conditions which Congress has laid down for state participation in Medicaid and other programs would be utterly meaningless." Alabama Nursing Home Ass'n v. Califano, 433 F. Supp. 1325, 1330 (M.D. Ala. 1977) rev'd in part on other grounds sub nom., Alabama Nursing Home Ass'n v. Harris, 617 F.2d 388 (5th Cir. 1980).

2. Defendants Misunderstand Plaintiffs' ADA and 504 Argument

Despite Defendants assertion to the contrary, Plaintiffs recognize that "there is, in fact, a difference in pharmacy benefits for persons with disabilities and persons without disabilities. Recipients without disabilities receive only three prescriptions per month compared with five for Advantage recipients and unlimited prescriptions for nursing home residents." Defendants' Motion for Summary Judgment, Proposition II at 9. But that difference is not what Plaintiffs allege violates the ADA and Section 504.

Plaintiffs have never suggested that the ADA or Section 504 violation was because people with disabilities were treated differently than nondisabled persons. Plaintiffs' discrimination argument is not premised on the race or gender model of discrimination, namely comparing all people with disabilities against all people without disabilities, a disparate treatment model. Rather, in the ADA (and Section 504) Congress recognized that people with disabilities were often discriminated against in ways other groups of people (e.g., race or gender) were not.

Plaintiffs' discrimination argument is that persons with disabilities – those in the waiver who reside in the community and those who reside in the nursing home – are the same people,

with the same disabilities, and the same need for prescription medications. In fact, in order to be eligible for a waiver slot, the person must meet the level of care of the nursing home and the state must so certify. See Cramer v. Chiles, 33 F. Supp.2d 1342,1347-49 (S.D. Fla. 1999)("The regulations provide ... 'an array of home and community-based services that an individual needs to *avoid institutionalization*'. 42 C.F.R. § 441.300 . Under the waiver provisions... states may include as 'medical assistance' the cost of home and community-based services which, if not provided, would require care to be provided in a nursing home ... 42 C.F.R. §435.217.") (emphasis in original).

The discrimination in the instant case is that Oklahoma provides unlimited prescriptions to persons with a disability only if those Medical Assistance recipients reside in a nursing home or move from the community into a nursing home where they are eligible for and will receive unlimited prescription medications. The discrimination is that Oklahoma provides unlimited prescriptions only if the persons with disabilities accept the unnecessary segregation in that institution. That form of discrimination does not compare disabled and nondisabled. That form of discrimination is solely against people with disabilities and it violates both the ADA and Section 504.

The two leading ADA/unnecessary institutionalization cases both confronted the argument that Defendants in the instant case pose (i.e., that discrimination against people with disabilities can be based only on disparate treatment), and both cases rejected that argument and found for the disabled plaintiffs. In Olmstead v.L.C, 119 S.Ct.2176, 2185 (1999), the plaintiffs were two developmentally disabled women who wanted to live in the community, but the State of Georgia would provide them services only in an institution. This claim was not premised on

discrimination between the two disabled women and nondisabled people, because only disabled persons received services in the institution. The Supreme Court stated that "Unjustified isolation... is properly regarded as discrimination based on disability." (Emphases added). That is the claim in the present case - unlimited prescriptions for people with disabilities will be provided under the Medical Assistance program only if the persons with disabilities go into the nursing home institutions. Similarly, in Helen L v. DiDario, 46 F3d 325, 336 (3rd Cir. 1995), the Court stated that

> Congress has stated that 'discrimination against individuals with disabilities persists in such critical areas as ... institutionalization.'42 U.S.C. 12101(3). If Congress were only concerned about disparate treatment of the disabled as compared to their nondisabled counterparts, this statement would be a non sequitur as only disabled persons are institutionalized.")(Emphases added).

Both Olmstead and Helen L construed the same ADA regulation at issue in the instant case. The regulation, 42 C.F.R. § 35.130(d), included as prohibited discrimination the unnecessary and unjustified isolation of persons with disabilities. The federal regulation and discrimination in the instant case focus on the "setting" where the services are provided, not a disparate treatment analysis (which other ADA regulations focus on and include as discrimination). That nondisabled people are not in nursing homes and receive a maximum of three prescriptions per month is irrelevant to the discrimination under the "integrated mandate" regulation in the ADA and Section 504. The discrimination is because the unlimited number of prescriptions are available to persons with disabilities only in the segregated setting of a nursing home and not "in the most integrated setting appropriate" to the persons with disabilities, i.e., their communities and homes.

3. Oklahoma's Waiver Does Not Waive Comparability of Prescriptions As Defendants Argue

Defendants attach to their Motion for Summary Judgement one part of their Waiver Renewal Document, 2002-2006 as their Exhibit D from which they argue (Defendants' Motion for Summary Judgment, Proposition III, at 10) from which they argue that they "Received a Waiver of 'Comparability' Requirements for Prescription Drug Benefits." There is nothing in their Waiver application that in anyway refers to setting a limit of prescription drug benefits to no more than five month for persons in the Advantage waiver, let alone requesting or receiving from HCFA an approval of a waiver.

The federal statute provides that a waiver "may include a waiver of the requirements of Section 1396a(a)(10)(B) of this title (relating to comparability)...." 42 U.S.C. § 1396n(c)(3). [3] Plaintiffs assume that this is the comparability requirement that Defendants refer to in their Proposition III, because it is the one listed in the Oklahoma waiver document : "A waiver of the amount, duration and scope of services requirements contained in 1902(a)(10)B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver." (Def. Ex. "D" at 4, Statement 10)(Emphases added). Oklahoma checked those services for which it sought a waiver, including

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[3] By its terms, 42 U.S.C. § 1396a(a)(10)(B) requires states to assure that categorically needy Medicaid recipients receive Medicaid assistance that is not less than in amount, duration or scope than that received by other categorically needy recipients. See, White v. Beal, 555 F. 2d 1146, 1149 (3d Cir. 1977) ("[A]ll persons within a given category [of eligibility] must be treated equally.") For example, a state cannot deny "the same service to the categorically needy members of the plaintiff class that is received by other categorically needy person..., the State violates § 1396a(a)(10)(B)," Sobky v. Smoley, 855 F. Supp. 1123, 1140 (E.D. Cal. 1994) (§ 1396a(a)(10)(B) violated when some Medicaid beneficiaries are placed on waiting lists for the same treatment others receive immediately.)

for example respite care, adult day health, environmental accessibility adaptations and, with regards to prescribed drugs, it was an 'Extended State plan service." Def. Ex. "D" at 1, Statement 11.

The entire purpose of waiving 42 U.S.C. §1396a(a)(10)(B) was to provide persons in the waiver with services that people not eligible for the waiver would not have a right to receive, i.e.,services "not otherwise available ... may be provided to individuals served on the waiver." That is, the waiver of the "amount, duration and scope" provision in 1396a(a)(10)(B) means the state can legally provide fewer prescriptions to persons not in the waiver than they do for persons in the waiver. The waiver permits the state to provide "services not otherwise available under the approved Medicaid State plan ." For example, nondisabled persons who are Medical Assistance recipients (and even persons with disabilities who are Medical Assistance recipients but who have not been accepted into or do not qualify for the waiver) do not have a right to "respite care," "environmental accessibility adaptations," or "specialized medical equipment and supplies." Oklahoma's Advantage waiver checked off those services for waiver of comparability. Thus, while persons in the waiver have a right to those services, other Medical Assistance recipients do not.

Defendants have flipped the waiver of comparability on its head. A state obtains a waiver so it can affirmatively provide services to participants in the waiver that Oklahoma does not then have to provide to persons not in the waiver. That is, while persons not in the waiver are limited to three prescriptions per month, the state sought and obtained a waiver to provide more than three to persons in the waiver. By this process, persons not in the waiver have no right to sue for more than three prescriptions under the "amount, duration and scope" comparability

requirements.

It is critical to understand the basic purpose of the home and community-based waiver is to avoid institutionalization (as long as the waiver services are cost-effective). Waiver of comparability is intended to provide persons, who would otherwise be institutionalized in expensive nursing homes, with services that other persons in the community (but who do not meet the level of care of the institution and/or who are not in the waiver) do not have a right to receive under the State's Medical Assistance plan. By providing those extra waiver services in the waiver, those persons in the waiver can avoid the need for institutionalization (and the state saves money).

4. **Defendants' "Scheduling" of Prescriptions Argument Violates Title XIX**

Defendants claim, based on the testimony of Nancy Nesser, that she believes that some of the Plaintiffs' prescriptions could be unnecessary, duplicative, purchased for more than one month), thereby reducing the Plaintiffs' out-of-pocket expenses. (Defendants' Motion for Summary Judgment, Proposition IV, at 11. This argument flies in the face of well-established case law that defines the "medical necessity" standards.

The Tenth Circuit in Hern v. Beye, 57 F.3d 906, 910 (10th Cir. 1995) held that Colorado's abortion restrictions violated Title XIX because Colorado's restriction of abortion funding was "essentially a limit based on the patient's degree of medical necessity pursuant to 42 C.F.R. § 440.230(d): It restricts Medicaid funding for abortions to those instances when the expectant mother's life is at stake." Id. (Emphasis added).

In the instant case, the five prescriptions is similarly a limitation based on the extent of disability, with those persons with the most severe disabilities who require more than five

prescriptions per month being denied the benefit of medically necessary prescriptions. The Hern Circuit held that Colorado's "abortion funding restriction impermissibly discriminates in its coverage of abortions on the basis of a patients' diagnosis and condition." 57 F3d at 910. The Circuit emphasized that "a state may not single out a particular, medically necessary service and restrict coverage to those instances where the patient's life is at risk." Id (emphasis added).

Thus, a state may not restrict coverage to people whose disabilities are more severe -- those are prohibited conditions. In the present case, the uncontroverted evidence is that the challenged limitation is based on the Plaintiffs' condition -- they are more severely disabled than persons who require less than five prescriptions per month. That violates Title XIX's "medical necessity" prohibition because it is based on the condition of the members of the class; Oklahoma's limitation of prescriptions is based on the degree of severity.

As in Hern, 57 F. 3 at 910-11, limiting the prescriptions to five per month is also "inconsistent with the basic objective of Title XIX - - to provide qualified individuals with medically necessary care. The purpose of Medicaid as stated in the Act is to enable states to provide medical treatment to needy persons 'whose income and resources are insufficient to meet the costs of necessary medical services'." (Emphasis added by Court).

A. Defendants' Testimony and Affidavit of Nancy Nesser Cannot Substitute for Plaintiffs' Treating Doctors' Determination that the Number, Frequency and Type of Prescriptions Were "Medically Necessary"

Defendants' Motion for Summary Judgment, Proposition IV at 11-12, assumes that a non-medical person, who testified at the hearing, regarding the named Plaintiffs whom she had

never met and who has no medical training, can trump the medical judgments of the Plaintiffs' treating doctors. That is, Nancy Nesser opined at the hearing that some of the Plaintiffs' prescriptions might be unnecessary, duplicate, some prescriptions might conflict with other medications, and some could be prescribed for larger amounts than the treating doctors had prescribed. [4]

The Eighth Circuit in Weaver v. Reagen, 886 F.2d 194 (8th Cir. 1989), noted that while all prescription drugs were an "optional medical service" under Title XIX, "[o]nce a state chooses to offer such optional services it is bound to act in compliance with the Act..., including the requirement that "[e]ach service must be sufficient in amount, duration and scope to reasonably achieve its purpose." (Quoting 42 C.F.R. § 440.230(b)).

Citing the Supreme Court's decision in Beal v. Doe, 97 S.Ct. 2355, 2371 (1977), the Eight Circuit pointed out that "a State Medicaid plan [must] provide treatment that is deemed 'medically necessary' in order to comport with the objectives of the Act." 886 F. 2d at 198. Most relevant to the instant case and the opinions of Nancy Nesser, a state employed pharmacist, the Weaver court noted

> the importance of professional medical judgment in the determination of medical necessity. 'The decision of whether or not certain treatment [or certain prescriptions, either the amount of the prescriptions, whether medications are compatible, or a particular prescription] is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials.' (Quoting Pinncke v. Preisser and citing to a Senate Report that 'the physician is to be the key figure in determining utilization of health services.').

886 F. 2 at 199 (emphases added). See Visser v.Taylor, 756 F. Supp. 501, 507 (D. Kan.1990)

[4] Plaintiffs have no objection to reasonable "utilization control procedures" for determining appropriate and "medically necessary" prescriptions. See 42 CFR 440.230(d). However, the ad hoc process used by the witness in the instant case is not what HCFA intended.

(Kansas enjoined from denying a specific medication used to treat schizophrenia. "The determination of whether treatment is medically necessary, for purposes of Medicaid, is a professional judgment which must be decided and certified by the treating physician.")

Under the Medicaid program, a State's prescription drug program must be "designed to make medically necessary drugs available to eligible recipients in a speedy and efficient manner" or the program violates the provisions that require that the "amount, duration and scope" must be "sufficient... to reasonably achieve its purpose." Visser, 756 F. Supp. at 506-07 (citing numerous circuit and district decisions in support).

The Medicaid Act requires states to cover certain mandatory services, and States may choose to cover additional services, including home and community-based waiver services for individuals with disabilities, see 42 U.S.C. § 1396n. Once a state chooses to provide an optional Medicaid service, it must comply with all federal Medicaid requirements, as the waiver and its services become part of the state's "medical assistance" plan. 42 U.S.C. § 1396n(c)(1). See, e.g., Weaver v. Reagan, 886 F.2d 194, 197 (8th Cir. 1989) ("Once a state chooses to offer . . . optional services it is bound to act in compliance with the [Medicaid] Act and the applicable regulations in the implementation of those services[.]").

The "medical necessary" requirements apply to all services included in the state's Medicaid plan, whether mandatory (for example, EPSDT) or optional (for example, intermediate care level services, prescription medications or home and community-based waiver services). See McMillan v. McCrimon, 807 F. Supp. 475, 481-82 (C.D. Ill. 1992) ("The fact that the HSP [home services program] waiver is an optional service does not exempt it from the requirements of section 1396a(a)(8)").

Thus, Oklahoma is not exempt from providing both "optional" and "mandatory" services that must be sufficient to meet Plaintiffs' treating doctors' "medically necessary" standards. Those doctors prescribed Plaintiffs' medications and review them on a monthly basis. Those doctors have determined that the Plaintiffs' prescription medications are "medically necessary" and Defendants cannot undercut their professional judgments. Oklahoma cannot lower either a mandatory or an optional service, like prescription drugs, to below medical necessity. Medical services capped at levels below medical necessity endanger the health, safety, welfare, and the lives of people with severe disabilities.

B. Waiver Services Cannot Limit the Number of Medically Necessary Prescriptions

Defendants' limitation on number of prescriptions for persons in the waiver program misunderstands what Congress and HCFA intended, and what the Supreme Court recognized in Olmstead. Namely, persons who meet the State's "level of care" criteria for admission into a nursing home have the right to choose to receive appropriate and cost effective (i.e., less than the cost in the nursing home) community-based services in the waiver.

In Plaintiffs' Supplemental Memorandum of Law In Support of Their Motion for Injunctive and Declaratory Relief (at 22)(filed on October 9,2002), they argued that the Medical Assistance Act's waiver provisions mandate that persons with disabilities had to be given the "choice" of whether to receive services in the community or in the nursing home. That is directly related to the ADA's "integration mandate." Namely, while many people with disabilities may prefer to reside in nursing homes, others who wish to reside in the community must be give that "choice." In Cramer v. Chiles, 33 F. Supp. 2d1342 (S.D.Fla.1999), the Court pointed out that

"[t]he freedom of choice provision creates binding obligations on any state that elects to provide supports and services in homes pursuant to the Home and Community-Based Waiver." Id at 1351. Cramer recognized that a choice had to be a "real choice." The Court pointed out that to provide for a real choice required that a State's waiver must provide "supports and services [that] will meet individuals needs." Id at 1352. This decision correctly understood how "[u]nderfunding of the Home and Community-Based Waiver program compels institutionalization, thus negating a meaningful choice," id at 1353 (emphasis added), and violated both the ADA and the Medical Assistance Act. [5] Oklahoma's limitation eviscerates a meaningful or real choice for those persons with disabilities who require more than five prescriptions a month to live.

Lewis v. New Mexico Dept. of Health confronted that state's limitation on the number of persons for whom waiver services were provided, where the state argued there was "right to [waiver] services." 94 F. Supp.2d 1217,1233 (D.N.M.2000). That Court pointed out that

> Defendants also reason that because waiver services must cost less than institutional services, 42 U.S.C. § 1396n(c)(2)(D), the State can only provide such services to a limited number of persons. This does not stand to reason. If the State were able to provide home-and community-based services for less than institutional services to all recipients this provision [capping the number of recipients of waiver services] would not stand as a barrier to the former services.

Id at 1233, fn 3 (emphases added). The Lewis court pointed out, despite Defendants' argument that "the State applies for a waiver for a certain number of individuals does not prevent

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[5] In 1981 when Congress enacted the waiver provisions of the Medical Assistance Act, the focus was on the individual's needs. See OMNIBUS BUDGET RECONCILIATION ACT OF 1981, P.L. 97-35, P.965, 97th Cong., 1st Sess., reprinted in 1982 U.S.C.C.A.N. 362, 1327-8 ("The determination of which long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by evaluation, and not short-term cost savings.") Cf. Martinex v. Ibarra, 759 F. Supp. 664 (D.Colo.1991).

the State from applying for a waiver to serve enough persons that it can provided services to all eligible applications with 'reasonable promptness'." Id at 1234. The Lewis court quoted the Supreme Court's decision in Wilder v. Virginia Hospital Ass'n, with regards to setting of "reasonable" reimbursement rates, noting that "some rates [were] outside the range that no State could ever find to be reasonable and adequate under the Act." 94 F. Supp. 2 at 1234 (emphasis in original).

By analogy to both Lewis and Wilder, while Oklahoma's waiver program could achieve *some* savings in its waiver program as it computes cost-effectiveness in comparison to the costs in nursing homes, it is not reasonable or adequate to denude the waiver program by limiting the number of prescriptions to five, while at the same time doing nothing to limit either the overall reimbursements to nursing homes nor even the number of prescriptions in nursing homes. That undercuts the purpose of the community-based waiver.

After the Olmstead decision, if a State opted to participate in the Medical Assistance program, and therefore provided nursing home services, it must offer persons with disabilities the real choice of receiving appropriate services in the community via a waiver program. To not offer a meaningful choice, or as in the instant case, to offer a "choice" but without appropriate medically necessary services that are within the cost-effectiveness parameters, violates the ADA, Section 504, and Title XIX.

5. No Conflict Exists Among the Class Members

Defendants confuse Plaintiffs' counsels cross examination at the October 4, 2002 injunction hearing with the requirements of a class action. (See Defendants' Motion for

Summary Judgment, Proposition V, at 12-13). [6] At the hearing, Mr. Fogarty testified regarding what the state had considered to save funds. On his direct examination, he testified regarding eligibility for nursing home and waiver services, explaining that in Oklahoma persons whose income was 300% of Supplemental Security Income ("SSI") were eligible for both nursing home and waiver services. On cross examination, counsel for Plaintiffs asked if Mr. Fogarty had considered the fiscal savings from reducing the eligibility for both nursing homes and waiver services to less than 300% of SSI. That cross examination does not in anyway undercut the ability of counsel to represent everyone on the waiver whose prescriptions have been limited to five per month. Cross examination does not, as Defendants suggest, undercut the existence of a class of recipients of waiver services who, effective October 1, 2002, have had their prescriptions limited to five per month.

CONCLUSION

This Court should deny Defendants' Motion for Summary Judgment and grant Plaintiffs a permanent injunction, declaring that the Defendants limitation of five prescriptions per month violates the ADA, Section 504 and the Medical Assistance Act.

Respectfully submitted,

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[6] In referencing the class , the Complaint at ¶20 did refer to the Tulsa metropolitan area. However, from a res judicata perspective, it makes sense to apply a decision statewide. Otherwise, if the Court issues an injunction forPlaintiffs in the instant action, defendants are collaterally estopped in a second action on the same legal claims.

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Filed October 15, 2002 by Fax and overnight mail.

Certificate of Service

I declare and affirm that on October 15, 2002 the attached Memorandum of Law in Opposition to Defendants' Motion for Summary Judgment was faxed and overnight mailed to:

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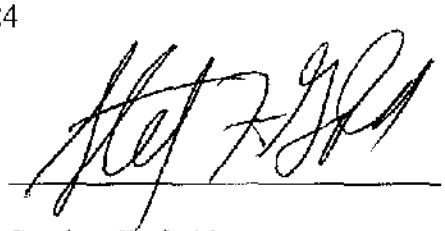

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