



## ***I. Eleventh Amendment Immunity.***

Defendant asserts Plaintiffs' state law claims should be dismissed as they are barred by the Eleventh Amendment to the U.S. Constitution. The Eleventh Amendment states:

The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

The Amendment has been construed to prohibit suits seeking to force state officials to comply with state law. *Pennhurst State Sch. and Hosp. v. Halderman*, 465 U.S. 89 (1984). Plaintiffs argue that the state claims are properly before the Court under the doctrine of supplemental jurisdiction. The Court disagrees.<sup>2</sup> The Eleventh Amendment prohibition exists regardless of the vehicle by which state claims might otherwise find their way into state court. *Id.* at 121. Accordingly, Plaintiff's state law claims in counts six, ten and twelve must be dismissed.

## ***II. The federal claims.***

Dismissal is appropriate under Rule 12(b)(6) only “‘if it clearly appears, according to the facts alleged, that the plaintiff[s] cannot recover on any viable theory.’” *Garita Hotel Ltd. Partnership v. Ponce Fed'l Bank*, 958 F.2d 15, 17 (1st Cir.1992) (quoting *Correa-Martinez v. Arrillaga-Belendez*, 903 F.2d 49, 52 (1st Cir.1990)). As always, we review the Complaint in the light most favorable to Plaintiffs for purposes of this analysis.

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<sup>2</sup> In *Brown v. Coughlin*, 758 F. Supp. 876 (S.D.N.Y. 1991), cited by Plaintiffs, the District Court appeared to base its conclusion to the contrary on the fact that plaintiff had not sued *the state*, but rather state officials in their official capacities. In our view, this is a distinction without a difference. It is well settled that “a suit against a state official in his or her official capacity is not a suit against the official but rather is a suit against the official's office. . . . As such, it is no different from a suit against the State itself.” *Will v. Michigan Dept. of State Police*, 491 U.S. 58, 71 (1989) (citations omitted).

**A. Whether Plaintiffs have enforceable rights for purposes of 42 U.S.C. § 1983.**

Defendant argues that there is no right of private enforcement for the alleged violations of federal law contained in counts two, three, four and ten of the Amended Complaint. Section 1983 provides that:

[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

42 U.S.C. § 1983. However, there are limits on the availability of section 1983 as a remedy for alleged violations of federal statutory law. Specifically,

[a] plaintiff alleging a violation of a federal statute will be permitted to sue under § 1983 unless (1) “the statute [does] not create enforceable rights, privileges, or immunities within the meaning of § 1983,” or (2) “Congress has foreclosed such enforcement of the statute in the enactment itself.” *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).

*Wilder v. Virginia Hosp. Assn.*, 496 U.S. 498, 508 (1990). Defendant argues that it is the first of these two exceptions which preclude Plaintiffs’ claims in counts two, three, four and ten.

The question whether a particular statute creates a ‘federal right,’ enforceable under section 1983, is a three-part inquiry. First, we must determine whether Plaintiffs are the intended beneficiaries of the statute in question. *Id.* at 509 (citing *Golden State Transit v. Los Angeles*, 493 U.S. 103, 106 (1989)). If so, the statute is enforceable under section 1983 unless it expresses merely a “‘congressional preference’ for a certain kind of conduct rather than a binding obligation on the governmental unit, *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19 (1981), or unless the interest the plaintiff asserts is ‘too vague and amorphous’ such that it is ‘beyond the

competence of the judiciary to enforce.’ *Golden State, supra*, at 106.” *Id.* (internal quotations omitted).

Defendant argues that a further requirement has been added to the analysis by the Supreme Court’s decision in *Suter v. Artist M.*, 112 S. Ct. 1360 (1992). The parties agree that Congress addressed the holding in *Suter* in the Improving America’s Schools Act of 1994, by including the following provision (commonly referred to as the *Suter* Amendment):

In an action brought to enforce a provision of the Social Security Act, such provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in *Suter v. Artist M.*, 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, *this section is not intended to alter the holding in Suter v. Artist M. that section 471(a)(15) of the Act is not enforceable in a private right of action.*

42 U.S.C. § 1320a-2 (amended Oct. 20, 1994) (emphasis added). We emphasize the last sentence of the amendment because Defendant now argues that the amendment “leaves intact the holding in *Suter*, which denies a private right of action under Section 1983 unless there is adequate congressional guidance as to the implementation of the underlying federal statutory provision.” Def. Memo. at 4. We think this interpretation is somewhat strained; rather, we agree with those courts that have held the *Suter* Amendment requires us to “rewind the clock” entirely and look to the *Wilder* analysis for guidance in analyzing Plaintiffs’ claims. *Jeanine B. v. Thompson*, 877 F. Supp. 1268, 1283 (E.D. Wisc. 1995); *accord Harris v. James*, 883 F. Supp. 1511 (M.E. Ala. 1995).

**1. Counts 2 & 3 -- 42 C.F.R. § 409.33(a).**

Plaintiffs allege in counts two and three that Defendant’s criteria for long-term care eligibility violate certain federal regulations which describe those services that might be considered “skilled

nursing” services for purposes of Medicare coverage. 42 U.S.C. § 409.33(a). Plaintiffs are recipients of Medicaid, rather than Medicare. However, they argue that we should look to the Medicare regulations for a definition of “skilled nursing services.”

The federal Medicare program is an insurance program for the benefit of certain persons defined by statute. 42 U.S.C. § 1395c (“[Medicare] provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care”). Part 409 of Medicare’s implementing regulations describes the hospital insurance benefits available under the plan. The specific section upon which Plaintiffs base their claim for skilled nursing services is contained in the subpart entitled “Requirements for Coverage of Posthospital SNF [skilled nursing facility] Care.” The section purports only to list examples of those services which might fall into the definition of “skilled services” contained in the preceding section. 42 C.F.R. § 409.32.

In contrast, Medicaid is described in the implementing regulations as follows:

Title XIX of the Social Security Act, enacted in 1965, authorized Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. *Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.* Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 C.F.R. § 430.0 (emphasis added). By arguing that they are the beneficiaries of the specific descriptions of those services that may qualify as “skilled services” for purposes of Medicare, Plaintiffs are in essence arguing that those descriptions are incorporated into the “broad Federal rules” to which this section refers. The Court disagrees.

Under Medicaid, participating states are required to provide certain “medical assistance,” including “nursing facility services . . . for [qualifying] individuals 21 years of age or older.” 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A). “Nursing facility services” are defined as those “services which are or were required to be given an individual who needs or needed on a daily basis nursing care . . . or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.” 42 U.S.C. § 1396d(f). Further, the states are required to set “reasonable standards . . . for determining eligibility for and the extent of medical assistance under the [state] plan which . . . are consistent with the objectives of [the Medicaid program].” 42 U.S.C. § 1396a(a)(17).

Given the nature of these general Medicaid guidelines, the Court cannot conclude that Plaintiffs are intended beneficiaries of Medicare regulations, particularly when those regulations do no more than set forth examples of services that might be covered under Medicare. Accordingly, we find Plaintiffs have no right of private action under 42 C.F.R. § 409.33. Dismissal is appropriately entered on Counts Two and Three of Plaintiffs’ Amended Complaint.

**2. Count 10 -- 42 U.S.C. § 1396a(a)(5) & 42 C.F.R. § 431.10(c).**

Similarly, Defendant argues that Plaintiffs are not intended beneficiaries of the statutory and regulatory provisions upon which Plaintiffs base their claim in Count Ten of the Amended Complaint. Generally, the provisions require the state to designate one state agency which will be responsible for administering, or supervising the administration of, the state’s Medicaid program. Plaintiffs’ Amended Complaint alleges that Defendant has violated these provisions by delegating determinations of Medicaid *medical* eligibility.

Defendant refers the Court to the statement of the purpose of the “single state agency” provisions, which states that the purpose is to “establish[] State plan requirements for the designation, organization, and general administrative activities of a State agency responsible for operating the State Medicaid program, directly or through supervision of local administering agencies.” 42 C.F.R. § 431.1. These “purely administrative” requirements, according to Defendant, are not intended to benefit Medicaid *recipients*.

Defendant’s argument is logical, in the sense that a state agency would hardly be best suited to determine the level of medical need for a given Medicaid recipient. This position is further supported in the regulations regarding the utilization of services. Specifically, each recipient of skilled nursing care must have a physician certify, on a regular basis, that such services are necessary. 42 C.F.R. § 456.260. The stated purpose of this provision is “to safeguard against unnecessary utilization of care and services.” 42 C.F.R. § 456.1(b)(1). It is clear that the provisions invoked by Plaintiffs refer to purely administrative functions, rather than medical assessment. Accordingly, the Court agrees that Plaintiffs are not intended beneficiaries of the provisions, and dismissal is appropriate on Count Ten.

**3. Count 4 -- 42 U.S.C. § 1396a(a)(17) & 42 C.F.R. § 440.230(b).**

Defendant argues that Plaintiffs’ claim in Count Four of the Amended should be dismissed because the standard alleged to have been violated is too “vague and amorphous” for the Court to enforce. *Golden State*, 493 U.S. at 106. The Court disagrees.

Plaintiffs allege in Count Four that “Defendant’s level of care criteria and resulting definition of medical necessity . . . violate federal law . . . because they are not based on reasonable standards

and they unlawfully restrict necessary medical services in amount, duration, and scope.” Section 1396a(a)(17) provides, in pertinent part:

A state plan for medical assistance must --

. . .

include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter . . . .

Although there is no definition of the phrase “reasonable standards” to be found in the Medicaid Act or regulations, the Court is satisfied that “reasonableness” in this context is no more vague and amorphous than the standard for negligence, with which courts are intimately familiar. *See, Wilder*, 496 U.S. at 512 (“In light of *Pennhurst* and *Wright*, we conclude that the Boren Amendment imposes a binding obligation on States participating in the Medicaid program to adopt reasonable and adequate rates and that this obligation is enforceable under § 1983 . . . .”). The Court concludes, however, that even assuming a right of private action exists with respect to Plaintiffs’ allegations in Count Four, the allegations are nevertheless insufficient to state a cause of action under the provisions cited.

In addition to the “reasonable standards” for medical eligibility requirement contained in section 1396a(17), the regulation provides that the state plan will specify the “amount, duration, and scope of each service that it provides” for Plaintiffs, and that “[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(a), (b).

These provisions set forth only the “broad Federal rules” to which the program description refers. 42 C.F.R. § 430.0. In this Circuit, however, it is not the law that the state must provide *every* medical service available under the broad categories enumerated in section 1396d. *Preterm, Inc. v.*

*Dukakis*, 591 F.2d 121, 124 (1979). Nor is it improper for the state to limit the services to those in greatest need. *Id.* at 126. Rather, the state must only be “consistent with the objectives” of the Medicaid program, which are stated in the opening section of the Act as follows:

For the purpose of enabling each State, as far as practicable under the conditions of such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. . . .

42 U.S.C. § 1396. Under the plain language of this statute, the State need only provide *medical assistance* to those unable to afford “necessary medical care.” It is *not* required to provide all “necessary medical care.” Further, it need only provide such assistance “as far as practicable under the conditions in such State.”

It is true that, once offered, a service must be “sufficient in amount, duration and scope to achieve its purpose.” 42 C.F.R. § 440.230(b). This requirement, however, does not form the basis for Plaintiffs’ claims. Plaintiffs allege that they are being improperly *denied* “skilled nursing facility care,” not that they are being provided such care, but in an amount, duration or scope that is insufficient to meet the needs such care is intended to provide. The denial of nursing facility care by virtue of allegedly unreasonable eligibility criteria is appropriately raised in Count One of Plaintiffs’ Complaint, and need not be repeated in Count Four.

Accordingly, that portion of Plaintiffs’ claim in Count Four which alleges that Plaintiffs’ “necessary medical care” is “unlawfully restricted” fails to state a claim under the Medicaid Act and should be dismissed. To the extent Plaintiffs allege that the standard for determining medical

eligibility for skilled nursing care is unreasonable, this claim is encompassed within Count One of the Amended Complaint.

**B. Whether Plaintiffs’ have stated a claim for purposes of Rule 12(b)(6).**

**1. Count 1 -- 42 U.S.C. §§ 1396a(a)(10)(A) & 1396d(a)(4)(A).**

Defendant alleges that Plaintiffs have failed to state a claim in Count One of the Amended Complaint because the statutory sections provide only that Defendant must provide skilled nursing facility services as part of its plan of care for the “categorically needy.”<sup>3</sup> Because Plaintiffs do not allege that the state plan fails to make such a provision, Defendant argues, Plaintiffs have not alleged a violation of these sections.

As noted in our discussion relative to Count Four of the Amended Complaint, Plaintiffs’ allege in Count One that Defendant’s level of care criteria unreasonably restrict Plaintiffs’ access to skilled nursing facility care. The Court reads this claim as alleging a violation of section 1396a(a)(17). As noted previously, dismissal is appropriate only “if it clearly appears, according to the facts alleged, that the plaintiff[s] cannot recover on any viable theory.” *Garita Hotel Ltd. Partnership*, 958 F.2d at 17 (citation omitted). Accordingly, Count One is not properly dismissed at this stage.

**2. Count 5 -- 42 U.S.C. § 1393a(a)(10)(B) & 42 C.F.R. § 440.230(c).**

Defendant claims that Plaintiffs have failed to state a claim in Count Five of the Amended Complaint because the statutory provision to which Plaintiffs refer provides only that all groups of eligible Medicaid recipients must receive the same level of care. Plaintiffs, by contrast, allege in

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<sup>3</sup> The “categorically needy” are persons, like the Plaintiffs, for whom the state *must* provide services if it chooses to participate in the Medicaid program. 42 U.S.C. § 1396a(a)(10)(A)(i).

Count Five that Defendant's eligibility criteria "restrict necessary medical services in amount, duration, and scope, solely because of plaintiffs' diagnosis, type of illness, and conditions."

Defendant ignores the requirement of 42 C.F.R. § 440.230(c), which provides that the state may not "arbitrarily deny or reduce the amount, duration, or scope of a required service . . . solely because of the diagnosis, type of illness, or condition." One court faced with analyzing the meaning of these requirements stated:

The rationale adopted by the courts that have considered the meaning of the applicable regulations permits the state to place at least one type of limitation on its provision of required services: it may limit those services in a manner based upon a judgment of degree of medical necessity so long as it does not discriminate on the basis of the kind of medical condition that occasions the need.

*Curtis v. Taylor*, 625 F.2d 645, 652 (1980). Plaintiffs' Amended Complaint sufficiently alleges that Defendant's level of care criteria impermissibly discriminates according to the "kind of medical condition that occasions the need." Dismissal is inappropriate as to Count Five of the Amended Complaint.

**3. Count 7 -- 42 C.F.R. § 435.930.**

Defendant argues that Plaintiffs have failed to state a claim in Count Seven of the Amended Complaint for a violation of a regulatory provision which requires the state to continue Medicaid services until such time as a determination is made that the recipient is no longer eligible. 42 C.F.R. § 435.930(b). Plaintiffs' allegation in Count Seven states that "defendant is terminating plaintiffs' Medicaid benefits without regard to whether plaintiffs' conditions have medically improved." Defendant notes that the cited regulation makes no mention of "medical improvement."

Under section 435.930(b), Plaintiffs could have alleged Defendant terminated their benefits in the absence of a finding that they are ineligible. However, that is not the factual scenario

presented in the Amended Complaint. What Plaintiffs do allege is that the criteria under which they are now “ineligible” is unreasonable, and thus violative of 42 U.S.C. § 1396a(a)(17). As previously discussed, this claim appears in Count One of the Amended Complaint. The Court finds no authority for the proposition that section 435.930(b) imposes upon the state a requirement that Medicaid benefits continue until the recipient’s medical condition improves. To the extent Plaintiffs’ claim in Count Seven rests upon section 435.930(b), the claim is properly dismissed.

**4. Counts 7, 8, & 9 -- Due Process Clause.**

Defendant’s sole argument with respect to Plaintiffs’ claims under the due process clause (Counts Seven, Eight, and Nine of the Amended Complaint) is that the level of care criteria is rationally related to a legitimate state interest. Def. Memo. at 14-15 (citing *Pennell v. City of San Jose*, 485 U.S. 1, 14 (1988)). Defendant refers the Court to the Maine Medical Assistance Manual, which Defendant asserts “reveals the State of Maine’s detailed and rational basis for its nursing facility services care criteria.” Def. Memo. at 15. The Court declines to convert this Motion to one for summary judgment pursuant to Federal Rule 12(b). Dismissal on this ground is inappropriate.

***Conclusion***

For the foregoing reasons, Defendant’s Motion to Dismiss Plaintiffs’ Amended Complaint is hereby:

1. GRANTED as to Counts Two, Three, Four, Six, Ten, and Twelve; and
2. GRANTED as to Count Seven to the extent the claim is based upon 42 C.F.R. § 435.930(b);  
and
3. DENIED as to Counts One, Five, Eight, and Nine; and
4. DENIED as to Count Seven to the extent the claim is based upon the Due Process Clause.

***SO ORDERED.***

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Eugene W. Beaulieu  
U.S. Magistrate Judge

Dated at Bangor, Maine on February 14, 1996.