No. 20-56194

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JACKIE SALDANA, et al.,
Plaintiffs-Appellees,

v.

GLENHAVEN HEALTHCARE LLC, et al.
Defendants-Appellants,

On Appeal from the United States District Court
for the Central District of California
Case No. 2:20-cv-05631-FMO-MAA
Hon. Fernando M. Olguin

BRIEF OF *AMICUS CURIAE* JUSTICE IN AGING IN SUPPORT OF PLAINTIFFS-APPELLEES AND FOR AFFIRMANCE

Eric M. Carlson (SBN #141538)
Justice in Aging
3660 Wilshire Boulevard, Suite 718
Los Angeles, California 90010
(213) 309-9394
ecarlson@justiceinaging.org

Representing *Amicus Curiae* Justice in Aging

CORPORATE DISCLOSURE STATEMENT
REQUIRED BY F.R.A.P. 26.1

Amicus Curiae Justice in Aging is a non-profit, tax-exempt organization incorporated in the District of Columbia. The organization has no parent corporation, and no publicly held company has 10% or greater ownership.

TABLE OF CONTENTS

INTERESTS OF AMICUS CURIAE 1

SUMMARY OF ARGUMENT 3

ARGUMENT 4

I. The Federal Government for Decades Has Set Detailed Standards for Any Nursing Facility Certified for Medicare or Medicaid Reimbursement. 4

A. Detailed Federal Nursing Facility Statutes Have Governed Nursing Facility Operations Since 1990. 4

B. Detailed Federal Regulations Add to and Expand Upon Statutory Requirements. 8

C. Extensive CMS Guidance Provides Detailed Instructions Regarding Many Facility Procedures and Operations. 12

1. CMS Surveyor's Guidance Explains How Facilities Can Comply with the Federal Regulations. 12

2. CMS Issues Frequent Guidance on Nursing Facility Policy Through Memoranda. 13

II. The CDC Was Involved with Nursing Facilities Long Before COVID-19, and Has Issued COVID-Related Guidance to Many Businesses and Activities Other Than Nursing Facilities. 15

III. Contrary to Appellants' Contentions, Defendant Nursing Facility Did Not Act Under a Federal Officer. 18

CONCLUSION 21

CERTIFICATE OF COMPLIANCE 22

CERTIFICATE OF SERVICE 23

TABLE OF AUTHORITIES

Cases

Beverly Health & Rehab. Servs. v. Thompson, 223 F. Supp. 2d 73 (D. D.C. 2002) .5

Cal. Advocates for Nursing Home Reform v. Smith, 251 Cal. Rptr. 3d 636 (Cal. Ct. App. 2019) 2

Estate of Maglioli v. Andover Subacute Rehab. Ctr. I, 478 F. Supp. 3d 518 (D.N.J. 2020) 20

Jarman v. HCR ManorCare, Inc., 267 Cal. Rptr. 3d 696, 471 P.3d 1001 (Cal. 2020) 1

Northport Health Servs. of Ark. v. United States HHS, 438 F. Supp. 3d 956 (W.D. Ark. 2020) 1

Watson v. Philip Morris Companies, Inc., 551 U.S. 142 (2007) 19

Statutes

28 U.S.C. § 1442(a)(1) .... *passim*
42 U.S.C. § 1395i-3 5
42 U.S.C. § 1395i-3(a) 5
42 U.S.C. § 1395i-3(b)(2)(A) 9
42 U.S.C. § 1395i-3(b)(2)(B) 9
42 U.S.C. § 1395i-3(b)(4)(a) 6
42 U.S.C. § 1395i-3(b)(4)(C)(i) 6
42 U.S.C. § 1395i-3(b)(4)(C)(ii) 7
42 U.S.C. § 1395i-3(b)-(h) 6
42 U.S.C. § 1395i-3(d)(3)(A) 7
42 U.S.C. § 1395i-3(g)(1)(A), (2)(A)(iii)(I) 7
42 U.S.C. § 1395i-3(g)(2)(A)(ii) 7
42 U.S.C. § 1395i-3(h)(2)(B), (4) 8, 19
42 U.S.C. § 1396r 5

42 U.S.C. § 1396r(a) 5
42 U.S.C. § 1396r(b)(2)(A) 9
42 U.S.C. § 1396r(b)(2)(B) 9
42 U.S.C. § 1396r(b)(4)(a) 6
42 U.S.C. § 1396r(b)(4)(C)(i) 6
42 U.S.C. § 1396r(b)(4)(C)(ii) 7
42 U.S.C. § 1396r(b)-(h) 6
42 U.S.C. § 1396r(d)(3)(A) 7
42 U.S.C. § 1396r(g)(1)(A), (2)(A)(iii)(I) 7
42 U.S.C. § 1396r(g)(2)(A)(ii)(I) 7
42 U.S.C. § 1396r(h)(2)(A), (3)(C), (5) 8, 19

Other Authorities

Institute of Medicine, Improving the Quality of Care in Nursing Homes (1986) .4, 5

KFF, State Health Facts, Total Number of Certified Nursing Facilities 20

Rules

Fed. R. App. Proc. 29(a)(4)(E) 2

Treatises

Eric Carlson, Long-Term Care Advocacy (Lexis Publishing 2020) 6

Regulations

42 C.F.R. § 483.21(a)(i), (ii) 10
42 C.F.R. § 483.21(a), (b) 9
42 C.F.R. § 483.21(b)(1) 10
42 C.F.R. § 483.21(b)(2)(ii) 10
42 C.F.R. § 483.5 5
42 C.F.R. § 483.65 10
42 C.F.R. § 483.80 10
42 C.F.R. § 483.80(a) 11

42 C.F.R. § 483.80(b) 11, 16
42 C.F.R. §§ 483.5- 483.95 .... 8, 9

Legislative Materials

H.R. Rep. No. 100-391(I) 5

Federal Administrative Materials

56 Fed. Reg. 48,826 (Sept. 26, 1991) 8, 10

57 Fed. Reg. 43,924 (Sept. 23, 1992) 8

81 Fed. Reg. 68,688 (Oct. 4, 2016) 8, 10

CDC, COVID-19 Considerations for Traveling Amusement Parks and Carnivals 17

CDC, Guidance Documents for Employers, Business Owners & Community Leaders 17

CDC, Guidance for COVID-19 16

CDC, Mission, Role and Pledge 15

CMS, Compliance with Food Procurement Requirements for Nursing Homes with Gardens Producing Foods for Residents, S&C 11-38-NH (Sept. 7, 2011) 15

CMS, Infection Control Pilot: 2017 Update, S&C 17-09-ALL (Nov. 18, 2016) 16

CMS, Nursing Homes – Issuance of Revised Nutrition and Sanitary Conditions, S&C 08-28 (June 20, 2008) 13

CMS, Point of Care Devices and Infection Control in Nursing Homes, S&C 10-28-NH (Aug. 27, 2010) 14

CMS, Policy & Memos to States and Regions 13

CMS, Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Are Setting Is Now Available, QSO-19-10-NH (March 11, 2019) 11

Guidance to Surveyors for Long Term Care Facilities, Appendix PP to CMS State Operations Manual.. 12, 13

INTERESTS OF AMICUS CURIAE

Amicus Curiae notes that all parties have consented to the filing of this brief. *See* Declaration of Eric Carlson in Support of Brief of *Amicus Curiae* Justice in Aging in Support of Plaintiffs-Appellees and For Affirmance, ¶¶ 3-4.

Justice in Aging is a national non-profit legal advocacy organization that fights senior poverty through law. Justice in Aging was founded in 1972 (originally under the name "National Senior Citizens Law Center") and maintains offices in Los Angeles and Oakland, California, in addition to Washington, D.C. Justice in Aging advocates for affordable health care and economic security for older adults with limited resources, focusing especially on populations that have traditionally lacked legal protection. Justice in Aging's work includes substantial advocacy on behalf of nursing facility residents, including federal administrative and legislative advocacy. Justice in Aging has appeared on behalf of nursing facility residents in an *amicus curiae* capacity in cases including *Northport Health Servs. of Ark. v. United States HHS*, 438 F. Supp. 3d 956 (W.D. Ark. 2020) (enforceability of federal nursing facility regulation pertaining to arbitration), *Jarman v. HCR ManorCare, Inc.*, 267 Cal. Rptr. 3d 696, 471 P.3d 1001 (Cal. 2020) (interpretation of resident's rights provision of California law), and *Cal. Advocates for Nursing Home Reform v. Smith*, 251 Cal. Rptr. 3d 636 (Cal. Ct. App.

2019) (constitutionality of state law governing decision-making for facility residents lacking decision-making capacity).[1]

Amicus curiae appears in this action to describe and explain how the federal government for decades has set and enforced legal standards for nursing facilities. This brief includes the timeline and content of relevant statutes and regulations, along with related guidance issued by the Centers for Medicare & Medicaid Services (CMS). In addition, the brief describes how the Centers for Disease Control and Prevention (CDC) routinely provides expertise on infection prevention and control not only to nursing facilities, but to individuals, businesses, government agencies, and individuals across American society.

---

[1] No party's counsel authored this brief in whole or in part. Likewise, no party nor party's counsel contributed money for preparing or submitting this brief. No person or entity other than *amicus curiae* itself contributed money for preparing or submitting this brief. *See* Fed. R. App. Proc. 29(a)(4)(E).

SUMMARY OF ARGUMENT

Appellants assert that their nursing facility, and all other nursing facilities, have been essentially commandeered by the federal government during the COVID-19 pandemic. This is not true. Contrary to Appellants' arguments, the nation's 15,000-plus federally-certified nursing facilities are not "acting under" a federal officer during the COVID-19 pandemic. The basic relationship between the federal government and nursing facilities is no different than it has been for many decades:

- The government contracts with facilities that agree to serve Medicare and Medicaid beneficiaries.
- As part of the contracting process, the government sets detailed standards for nursing facility operation.

Those detailed standards include statutes, regulations, and subregulatory guidance. The subregulatory guidance in particular is extensive, and touches on virtually every facet of nursing facility operations. During the COVID-19 pandemic, the federal government issued additional guidance on COVID-19, as might be expected. This particular focus, however, did not change the essential nature of the relationship or force nursing facilities to act under federal officers; accordingly, this action should be heard in state court rather than federal court.

This brief addresses only Appellants' First Issue Presented for Review, related to interpretation and application of the federal officer removal statute, 28 U.S.C. § 1442(a)(1). *See* Appellants' Opening Br. (Dkt. #16) at 16. In short, Appellants argue that the Defendant nursing facility "acted under" a federal officer during the pandemic. Appellants' Opening Br. at 23-40. To place Appellants' claims in context, and to assist the Court's analysis, this *amicus* brief in section I describes the extensive federal regulatory structure that has governed nursing facilities for many decades. In Section II, this brief explains how the federal Centers for Disease Control and Prevention has always issued guidance to nursing facilities, and has issued guidance during the pandemic not just to nursing facilities but to a plethora of other business types and other entities. Finally, in Section III, this brief highlights how Appellants mischaracterize the current relationship between nursing facilities and the federal government.

ARGUMENT

I. The Federal Government for Decades Has Set Detailed Standards for Any Nursing Facility Certified for Medicare or Medicaid Reimbursement.

A. Detailed Federal Nursing Facility Statutes Have Governed Nursing Facility Operations Since 1990.

Since their enactment in 1965, the Medicare and Medicaid programs have each paid for nursing facility care for eligible persons. Institute of Medicine, Improving the Quality of Care in Nursing Homes, at 241-42 (Appx. A) (1986),

https://www.ncbi.nlm.nih.gov/books/NBK217552/.[2] The Medicare program immediately established standards for Medicare-certified facilities. The Medicaid program, however, did not implement federal quality regulations until 1969. *Id.* at 242 (Appx. A).

The current federal nursing facility law was enacted in 1987, and has been operational since October 1, 1990. H.R. Rep. No. 100-391(I), at 452 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-1, 2313-272; *see also Beverly Health & Rehab. Servs. v. Thompson*, 223 F. Supp. 2d 73, 76-77 (D. D.C. 2002) (short history of federal nursing facility law). The statutory standards for Medicare-certified facilities are codified at 42 U.S.C. § 1395i-3, and are largely identical to the standards for Medicaid-certified facilities, which are codified at 42 U.S.C. § 1396r.[3]

A full recitation of the federal statutory standards would require pages and pages of description. *See, e.g.*, Eric Carlson, Long-Term Care Advocacy, ch. 2-4 (Services Provided by a Nursing Facility, Admission to a Nursing Facility, and Transfers, Discharges, and Readmission in Nursing Facilities) (Lexis Publishing

---

[2] The on-line version of this publication does not include the page numbers from the printed version.

[3] Federal law refers to a Medicaid-certified facility as a "nursing facility," but uses the term "skilled nursing facility" for Medicare-certified facilities. *See* 42 U.S.C. §§ 1395i-3(a), 1396r(a). The federal regulations, however, use the term "facility" for any federally-certified nursing facility. 42 C.F.R. § 483.5. This brief uses the terms "nursing facility" or "facility' to describe a federally-certified facility.

2020). The majority of the standards are set forth in subsections (b) through (h), covering Provision of Services, Residents' Rights, Administration and Other Matters, State Requirements, Responsibilities of Secretary [of Department of Health and Human Services], Survey and Certification Process, and Enforcement Process, respectively. 42 U.S.C. §§ 1395i-3(b)-(h), 1396r(b)-(h).

For example, under the statutory requirements, a nursing facility must provide all of the following services:

- "[N]ursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident";
- Medically-related social services;
- Pharmaceutical services;
- "[D]ietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident";
- "[A]n ongoing-program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident";
- Routine and emergency dental services, and
- "Treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for … by the State."

42 U.S.C. §§ 1395i-3(b)(4)(a), 1396r(b)(4)(a). In providing such services, the facility generally must employ licensed nurses around-the-clock, and also must employ a registered professional nurse at least eight hours per day, seven days per week. 42 U.S.C. §§ 1395i-3(b)(4)(C)(i), 1396r(b)(4)(C)(i). The federal government has authority to waive or reduce these nursing requirements when,

under specified circumstances, facilities struggle to employ an adequate number of nurses. 42 U.S.C. §§ 1395i-3(b)(4)(C)(ii), 1396r(b)(4)(C)(ii).

Also, in a statutory provision particularly relevant to current COVID-19 pandemic, the federal law requires a nursing facility to "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection." 42 U.S.C. §§ 1395i-3(d)(3)(A), 1396r(d)(3)(A). To ensure that facilities comply with this requirement, the standard government survey — generally conducted on an annual basis — must include infection control along with the other mandatory areas to be evaluated. 42 U.S.C. §§ 1395i-3(g)(2)(A)(ii), 1396r(g)(2)(A)(ii)(I).

Again, the provisions discussed here represent only a small subset of federal nursing facility statutes. The law sets standards across the spectrum of nursing facility operations, including but not limited to infection control.

Furthermore, to enforce these standards, the federal law establishes regular surveys and an enforcement mechanism. State survey agencies, acting as agents of the Centers for Medicare & Medicaid Services (CMS), must survey each facility annually on average, with the interval between surveys not to exceed 15 months for each individual facility. 42 U.S.C. §§ 1395i-3(g)(1)(A), (2)(A)(iii)(I), 1396r(g)(1)(A), (2)(A)(iii)(I). Violations of law are addressed by enforcement

remedies that include denial of payment under Medicaid or Medicaid, civil money penalties, appointment of temporary management, and termination of certification. 42 U.S.C. §§ 1395i-3(h)(2)(B), (4), 1396r(h)(2)(A), (3)(C), (5).

Importantly, all of these statutory requirements apply to nursing facilities because they have chosen to accept reimbursement from the Medicare and Medicaid programs. Nursing facilities have been subject to these requirements since October 1990, with no suggestion that they have been operating "under" a federal officer for the purposes of 28 U.S.C. § 1442(a)(1).

B. Detailed Federal Regulations Add to and Expand Upon Statutory Requirements.

Federally-certified nursing facilities also must comply with extensive federal regulations. *See* 42 C.F.R. §§ 483.5- 483.95. The original regulations were released approximately 30 years ago; the current version reflects an extensive reorganization and revision completed in 2016. *See* 56 Fed. Reg. 48,826 (Sept. 26, 1991); 57 Fed. Reg. 43,924 (Sept. 23, 1992); 81 Fed. Reg. 68,688 (Oct. 4, 2016).

Like the statutes, the regulations sweep broadly across nursing facility operations. Individual regulations cover each of the following topics:

- Resident Rights;
- Freedom from Abuse, Neglect, and Exploitation;
- Admission, Transfer, and Discharge Rights;
- Resident Assessment;
- Comprehensive Person-Centered Care Planning;
- Quality of Life;

- Quality of Care;
- Physician Services;
- Nursing Services;
- Behavioral Health Services;
- Pharmacy Services;
- Laboratory, Radiology, and Other Diagnostic Services;
- Dental Services;
- Food and Nutrition Services;
- Specialized Rehabilitative Services;
- Administration;
- Emergency Preparedness;
- Quality Assurance and Performance Improvement;
- Infection Control;
- Compliance and Ethics Program;
- Physical Environment; and
- Training Requirements.

See 42 C.F.R. §§ 483.5- 483.95. These regulations restate, expand upon, and add to the statutory requirements, providing detailed standards for nursing facility operators.

In care planning, for example, the federal statutes have long required that a care plan describe "the medical, nursing and psychosocial needs of the resident and how such needs will be met." 42 U.S.C. §§ 1395i-3(b)(2)(A), 1396r(b)(2)(A). The care plan is developed by a team that includes the resident's physician and a registered nurse, with the participation of the resident or resident's representative as practicable. 42 U.S.C. §§ 1395i-3(b)(2)(B), 1396r(b)(2)(B). The regulations expand upon this requirement by mandating both an initial "baseline care plan" and a subsequent comprehensive care plan. 42 C.F.R. § 483.21(a), (b). The

baseline care plan is developed within 48 hours of a resident's admission, and must include (among other things) initial goals, physician orders, dietary orders, therapy services, and social services. 42 C.F.R. § 483.21(a)(i), (ii). The comprehensive care plan, as the name suggests, requires much more detail. It is "person-centered" and "includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment." 42 C.F.R. § 483.21(b)(1). The interdisciplinary team that develops the comprehensive care plan, in addition to a physician, nurse and resident (and/or resident's representative), must include a nurse aide with responsibility for the resident, a member of the facility's food and nutrition services staff, and other staff or professionals as determined by the resident's needs or requested by the resident. 42 C.F.R. § 483.21(b)(2)(ii).

Nursing facility infection control regulations date to 1991; the most recent revision occurred in 2016. 56 Fed. Reg. 48,826 (Sept. 26, 1991) (promulgation of infection control regulation for nursing facilities at 42 C.F.R. § 483.65); 81 Fed. Reg. 68,688, 68,807 (Oct. 4, 2016) (revision of infection control regulation, accompanied by renumbering of regulation from § 483.65 to § 483.80). Under the current infection control regulation, which became effective several years before COVID-19 appeared, a nursing facility must develop all of the following: a program to prevent, identify, report, investigate and control infections and

communicable diseases; a system to monitor antibiotic use; and a system to record adverse incidents and the facility's corresponding corrective actions. 42 C.F.R. § 483.80(a). In addition, each facility must employ an infection preventionist with primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field. An infection preventionist must complete specialized training in infection prevention and control; such a course was jointly developed by the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), and made available starting in March 2019. 42 C.F.R. § 483.80(b); CMS, Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Are Setting Is Now Available, QSO-19-10-NH (March 11, 2019), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-10-NH.pdf.

Like the federal statutes, these federal regulations have been in effect for approximately 30 years. They have established a significant role for the federal government in ensuring nursing facility quality of care, but always with the nursing facility operating independently and not "under" a federal officer pursuant to 28 U.S.C. § 1442(a)(1).

C. Extensive CMS Guidance Provides Detailed Instructions Regarding Many Facility Procedures and Operations.

1. CMS Surveyor's Guidance Explains How Facilities Can Comply with the Federal Regulations.

In addition to the regulations, CMS also has developed Surveyor's Guidance that provides extraordinarily detailed instructions on how facilities should comply with federal regulations. The Surveyor's Guidance is a 702-page document organized around the federal regulations: each Guidance section (identified with an F-Tag number) consists of the regulatory language followed by the corresponding subregulatory guidance. *See* Guidance to Surveyors for Long Term Care Facilities, Appendix PP to CMS State Operations Manual, https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf (hereafter, "Surveyor's Guidance). As is noted on the first page, the most recent revision of the Guidance has been effective since November 22, 2017, well prior to the COVID-19 pandemic.

The level of detail is illustrated by the 39 pages of guidance on infection prevention and control. *See* Surveyor's Guidance, sections F880 (pages 634-61 of Guidance), F881 (pp. 661-666), and F882 (pages 666-673). Among other things, this guidance instructs on the proper use of personal protective equipment (PPE), including all of the following:

- Use and removal of gloves after contact with blood or bodily fluids;
- Change of gloves and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care;
- Use of gowns if resident has "uncontained secretions";
- Face protection (e.g., mask or shield) for procedures likely to generate splashes of blood or other body fluids; and
- Disposal of PPE after resident care, followed by hand hygiene procedures.

Surveyor's Guidance, section F880, p. 647. This guidance, of course, predated the appearance of COVID-19.

2. CMS Issues Frequent Guidance on Nursing Facility Policy Through Memoranda.

CMS also communicates frequently with nursing facilities by issuing memoranda on issues of importance. These memoranda, as available on the Internet, date back at least as far as June 2008, when CMS announced revised nutrition and sanitary conditions for nursing facilities. *See* CMS, Nursing Homes – Issuance of Revised Nutrition and Sanitary Conditions, S&C 08-28 (June 20, 2008), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter08-28.pdf.[4] All of these memoranda are available on the Internet at CMS, Policy & Memos to States and Regions, https://www.cms.gov/Medicare/Provider-Enrollment-and-

[4] These memorandum originally were identified as "S&C" memoranda because they were released by the Survey and Certification Group. When this group was renamed the Quality, Safety & Oversight Group, the memoranda began to be identified by the designation "QSO."

Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.

As Appellants and *amici* California Association of Health Facilities (CAHF) and American Health Care Association (AHCA) point out, many of the CMS memoranda over the past 14 months have related to COVID-19. *See* Appellants' Opening Brief (Dkt. #16), at 27-38; Appellants' Request for Judicial Notice (Dkt. #18), Exhs. ## 2, 5, 22, 24, & 27; CAHF/AHCA Brief of *Amici Curiae* (Dkt. #19-1), at 11-14, 18-19. But long before COVID-19 existed, and without any ongoing emergencies, CMS issued guidance that similarly addressed facility operations and government surveys. In 2010, for example, CMS issued infection control guidance for fingerstick devices (used to measure blood glucose levels), along with instructions to surveyors on how to assess penalties for improper facility procedures. *See* CMS, Point of Care Devices and Infection Control in Nursing Homes, S&C 10-28-NH (Aug. 27, 2010), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/SCLetter10_28.pdf. The following year, CMS instructed nursing facilities whether and how they could serve food from a garden, and advised surveyors to request facility policies in case of a food-borne illness. *See* CMS, Compliance with Food Procurement Requirements for Nursing Homes with Gardens Producing Foods for Residents,

S&C 11-38-NH (Sept. 7, 2011), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-11-38.pdf.

These are only examples of the many instances in which CMS has issued guidance related to nursing facilities well before the appearance of COVID-19. This earlier guidance does not differ significantly from the type of guidance issued during the pandemic, and none of the guidance directs any nursing facility to operate "under" a federal officer pursuant to 28 U.S.C. § 1442(a)(1).

II. The CDC Was Involved with Nursing Facilities Long Before COVID-19, and Has Issued COVID-Related Guidance to Many Businesses and Activities Other Than Nursing Facilities.

Pursuant to its mission statement, the Centers for Disease Control and Prevention (CDC) "conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these arise." CDC, Mission, Role and Pledge, https://www.cdc.gov/about/organization/mission.htm (accessed May 3, 2021). Although the CDC is not responsible for certifying nursing facilities, its expertise is often relevant in nursing facility operations; sometimes the CDC and CMS collaborate on nursing facility issues. As discussed above, for example, the CDC in 2019 released a training curriculum for nursing facility infection preventionists, in support of the CMS infection preventionist regulatory requirement. *See supra* at

11; 42 C.F.R. § 483.80(b) (requiring infection preventionist). Similarly, several years earlier, the CDC also cooperated with CMS on a three-year pilot program to improve assessment of infection control and prevention regulations in nursing facilities and hospitals. As part of this project, the CDC and CMS developed Infection Control Worksheets to guide facility surveys. *See* CMS, Infection Control Pilot: 2017 Update, S&C 17-09-ALL (Nov. 18, 2016), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-09.pdf.

Also, the CDC issues guidance regarding infection control and prevention to a plethora of businesses and activities other than nursing facilities, as illustrated by the CDC's work during the COVID-19 pandemic. The CDC "Guidance for COVID-19" webpage (accessed on May 1, 2021) lists multiple "audiences" for its guidance, including Employers, Business Owners & Community Leaders; Educators & School Administrators; Individuals & Consumers; and Healthcare Professionals. The "Employers, Business Owners & Community Leaders" category includes 50 items, including all of the following:

- Manufacturing Workers and Employers;
- Considerations for Communities of Faith;
- Guidance for Operating Youth and Summer Camps During COVID-19;
- Considerations for Retirement Communities and Independent Living Facilities;

- Guidance for Adult Day Services Centers;
- Guidance for Group Homes for Individuals with Disabilities;
- Interim Guidance on Unsheltered Homelessness and Coronavirus Disease 2019 (COVID-19) for Homeless Service Providers and Local Officials;
- Considerations for Non-Emergency Vehicle Transportation for Tribal Communities During COVID-19;
- Meat and Poultry Processing Workers and Employers;
- Protecting Seafood Processing Workers from COVID-19;
- COVID-19 Recommendations for Pet Stores, Pet Distributors, and Pet Breeding Facilities; and
- Considerations for Animal Activities at Fairs, Shows, and Other Events.

CDC, Guidance Documents for Employers, Business Owners & Community Leaders, https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html?Sort=Date%3A%3Adesc&Audience=General%20Public%20%3E%20Employers%2C%20Business%20Owners%20%26%20Community%20Leaders (accessed on May 1, 2021). Furthermore, the guidance generally provides significant detail. In guidance directed to amusement parks, for example, the CDC addresses such issues as using masks, temperature screening, redirecting pedestrian traffic flow, installing plexiglass barriers, reducing "touch points," and using particular types of disinfectants. CDC, COVID-19 Considerations for Traveling Amusement Parks and Carnivals, https://www.cdc.gov/coronavirus/2019-ncov/community/parks-rec/amusement-park-carnival.html.

Thus, the CDC issued guidance to nursing facilities prior to the COVID-19 pandemic, and has issued COVID-related guidance for a plethora of different businesses and activities. The CDC's current guidance to nursing facilities is

consistent with CDC's longstanding advisory role, and does not indicate that nursing facilities are operating "under" a federal officer.

III. Contrary to Appellants' Contentions, Defendant Nursing Facility Did Not Act Under a Federal Officer.

Amicus has submitted this friend of the court brief to place Appellants' arguments in context. Appellants (along with *Amici* CAHF and AHCA) rely heavily on the fact that CMS and the CDC have issued extensive COVID-19 guidance to nursing facilities. *See* Appellants' Opening Brief (Dkt. #16), at 27-38; CAHF/AHCA Brief of Amici Curiae (Dkt. #19-1), at 10-21. But, as this brief demonstrates, the federal guidance falls far short of demonstrating that the Defendant nursing facility was "acting under" a federal officer. *See* 28 U.S.C. § 1442(a)(1). CMS regularly issues guidance to nursing facilities — not because the facilities are working "under" CMS, but because federal law requires that level of oversight for Medicare and Medicaid certification. *See supra* at 12-15. Likewise, the CDC issues guidance both to nursing facilities and to a plethora of other entities — again, not because the nursing facilities and other entities are acting "under" the CDC, but because the CDC's role is to share its specialized expertise in infection control and prevention. *See supra* at 15-18.

Thus, Appellants err when they claim a "significant shift in the relationship between these federal agencies and skilled nursing facilities," and that the "very detailed clinical directives and operational instructions represented a marked

departure from the regulatory structure which existed before the pandemic." Appellants' Opening Br. at 28, 38. Although nursing facilities, CMS and state survey agencies understandably shifted their focus to COVID-related issues during the pandemic, the overall relationship between those entities is the same: the federal government sets and enforces standards for those facilities that have chosen to seek certification for Medicare and/or Medicaid reimbursement.

Appellants similarly err when they emphasize that a "nursing facility like DEFENDANTS *would be subject to citation, and fines for failure to implement the directives from CMS*." Appellants' Opening Br. at 34-35 (emphasis in original). Again, the basic relationships have not changed — nursing facilities always are subject to money penalties and other remedies for violating federal standards. *See, e.g.*, 42 U.S.C. §§ 1395i-3(h)(2)(B), (4), 1396r(h)(2)(A), (3)(C), (5); 42 C.F.R. § 488.406(a) (available remedies).

Despite Appellants' protestations, this case falls squarely within the Supreme Court's ruling in *Watson v. Philip Morris Companies, Inc.* As the Court held, a "private firm's compliance (or noncompliance) with federal laws, rules, and regulations does not by itself fall within the scope of the statutory phrase 'acting under' a federal 'official.'" 551 U.S. 142, 153 (2007). Furthermore, this principle holds "even if the regulation is highly detailed and even if the private firm's activities are highly supervised and monitored." *Id.*

The wrongness of Appellants' arguments is illustrated by the consequences that would ensue if they were adopted. Nothing in the federal guidance is specific to the Defendant nursing facility, so the same arguments made by Appellants could be made by any one of the over 15,000 federally-certified facilities in the United States. *See Estate of Maglioli v. Andover Subacute Rehab. Ctr. I,* 478 F. Supp. 3d 518, 535 (D.N.J. 2020) ("impermissible" to adopt broad reading of "acting under" language that would include the many entities that accepted federal COVID-19 relief funding and complied with CDC guidance); KFF, State Health Facts, Total Number of Certified Nursing Facilities, https://www.kff.org/other/state-indicator/number-of-nursing-facilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (15,061 nursing facilities in 2019). In reality, none of these facilities has been operating "under" a federal official during the pandemic. Rather, they have been operating independently under their own management, while following the regulations and guidance that come with being federally certified.

CONCLUSION

As described above, the COVID-19 pandemic has not changed the basic relationship between nursing facilities and the federal government. This tort case against Defendant nursing facility is appropriate for remand to the Los Angeles County Superior Court.

Dated: May 4, 2021

Respectfully Submitted,

JUSTICE IN AGING

By: /s/ Eric M. Carlson
Attorneys for *Amicus Curiae*
Justice in Aging

CERTIFICATE OF COMPLIANCE

On this 4th day of May 2021, the undersigned certifies that:

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because this brief contains 3,909 words, as determined by the word-count function of Microsoft Word, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and (6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

/s/ Eric M. Carlson
Eric M. Carlson

CERTIFICATE OF SERVICE

The undersigned certifies that on May 4, 2021, he caused the Brief of *Amicus Curiae* Justice in Aging in Support of Plaintiffs-Appellees and For Affirmance to be filed electronically with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

/s/ Eric M. Carlson
Eric M. Carlson