**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| NEW LIFECARE HOSPITALS OF CHESTER COUNTY LLC, *et al.*,<br><br>*Plaintiffs,*<br><br>v.<br><br>ALEX M. AZAR II, U.S. Secretary of Health and Human Services,<br><br>*Defendant*. | Civil Action No. 19-00705 (EGS) |

**DEFENDANT'S OPPOSITION TO PLAINTIFFS' APPLICATION**
**FOR A PRELIMINARY INJUNCTION**

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## GLOSSARY

| | |
|---|---|
| **BNA** | Budget Neutrality Adjustment |
| **CMS** | Centers for Medicare & Medicaid Services |
| **HCO** | High Cost Outlier |
| **IPPS** | Inpatient Prospective Payment System |
| **LTCH** | Long Term Care Hospital |
| **PPS** | Prospective Payment System |
| **SSO** | Short Stay Outlier |

## INTRODUCTION

This case concerns a particular type of budget neutrality adjustment ("BNA") that has been utilized since October 2015 by the Secretary of Health and Human Services, through the Centers for Medicare & Medicaid Services ("CMS"), in reimbursing certain long term care hospitals ("LTCH") for the treatment of Medicare patients. Now, over three and a half years later, Plaintiffs, who are LTCHs subject to the BNA, have decided that an emergency exists warranting a preliminary injunction to enjoin CMS's longstanding use of the BNA. Plaintiffs, however, fall far short of meeting their very high burden to justify such extraordinary and drastic relief.

First and foremost, Plaintiffs utterly fail to demonstrate that they will face irreparable harm in the absence of a preliminary injunction. Such a showing is "perhaps the single most important prerequisite for the issuance of a preliminary injunction." *Sierra Club v. U.S. Army Corps of Eng'rs*, 990 F. Supp. 2d 9, 38 (D.D.C. 2013). Plaintiffs' multi-year delay in seeking relief from the Court renders implausible their assertion that they will suffer irreparable harm. Moreover, Plaintiffs' claim that the challenged BNA threatens their very existence is disproven by their own exhibits, which show that LTCHs have closed for reasons unrelated to the BNA. Indeed, during the same timeframe that the BNA has been in effect, Congress mandated significant changes to LTCH reimbursement policy, which have had a far greater impact on LTCH reimbursements than the BNA. Also undermining Plaintiffs' claim of existential crisis is the fact that Plaintiffs are owned by large, well-capitalized companies that appear more than capable of funding Plaintiffs during the course of this litigation. Given Plaintiffs' total failure to demonstrate irreparable harm, their request for emergency relief should be denied on that basis alone.

Plaintiffs also fail to demonstrate a substantial likelihood of success on the merits of their claims, all of which rest on Plaintiffs' incorrect belief that the challenged BNA, which accounts for "outlier" payments to LTCHs for certain types of cases, is duplicative of another BNA used to

account for outlier payments to acute care hospitals under a different Medicare payment system, known as the Inpatient Prospective Payment System ("IPPS"). Plaintiffs' confusion stems from the fact that the Secretary is directed by Congress to use the IPPS rates (which incorporate their own outlier budget neutrality adjustments) as inputs for calculating the LTCH reimbursement rate. But the fact that the IPPS rates are used as inputs for determining the LTCH reimbursement rate by no means suggests that the IPPS BNA would therefore account for outliers in LTCHs. To the contrary, the IPPS BNA serves only to account for outliers in IPPS hospitals; without the LTCH BNA, the Secretary would not be able to maintain budget neutrality if outlier cases that occurred in LTCHs are to be appropriately reimbursed. Thus, notwithstanding Plaintiffs' protestation to the contrary, there is no duplication or double counting.

Lastly, Plaintiffs have not demonstrated that the balance of harms or the public interest weigh in favor of an injunction. Rather than preserve the status quo pending final adjudication, Plaintiffs demand that this Court order CMS to change abruptly its reimbursement system for LTCHs that has been in effect for years. Aside from the potential significant administrative burden on the agency, such a mandatory injunction would undermine the government's policy objective in ensuring that the Medicare reimbursement system for LTCHs is budget neutral, efficient, and cost effective. Accordingly, the public interest favors continuing the government's Medicare policies without interruption. Moreover, Plaintiffs' excessive delay in seeking relief from the Court provides yet another equitable reason to deny their Motion. For all of these reasons, Plaintiffs' Motion should be denied.

# BACKGROUND

## I. Statutory and Regulatory Background

### A. Inpatient Prospective Payment System, Outlier Payments, and Budget Neutrality

Medicare "provides federally funded health insurance for the elderly and disabled." *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1226-27 (D.C. Cir. 1994). It sets out a "complex statutory and regulatory regime," *Good Samaritan Hospital v. Shalala*, 508 U.S. 402, 404 (1993), under which hospitals can obtain payment from CMS for services provided to Medicare beneficiaries.

For many years, Medicare reimbursed participating hospitals for inpatient services furnished to Medicare beneficiaries based on the "reasonable costs" the hospitals incurred. *Methodist Hospital*, 38 F.3d at 1227 (quoting 42 U.S.C. § 1395f(b) (1988)). Because this system gave hospitals inadequate incentive to reduce costs, in 1983 Congress directed HHS to implement a "prospective payment system" under which hospitals would instead generally receive fixed payments for different kinds of inpatient services, regardless of their actual costs. *Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011).

CMS pays most hospitals for inpatient services furnished to Medicare beneficiaries at fixed rates through the IPPS, or Inpatient Prospective Payment System. *See generally Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 49 (D.C. Cir. 2015); *Banner Health v. Burwell*, 126 F. Supp. 3d 28, 39 (D.D.C. 2015). The IPPS divides conditions into groups of related illnesses called "diagnosis-related groups" ("DRGs"). *Dist. Hosp. Partners*, 786 F.3d at 49. Medicare reimburses hospitals reimbursed under the IPPS ("IPPS hospitals") for a given inpatient discharge at a preset rate that depends on the patient's DRG and other factors, such as regional labor costs. *See* 42 U.S.C. §§ 1395ww(d), (g); 42 C.F.R. §§ 412.64, 412.312; *Cape Cod*, 630 F.3d at 205-06. The

payment amount for each DRG is intended to reflect the estimated average cost of treating a patient whose condition falls within that DRG. *See* 42 U.S.C. § 1395ww(d).

For each Medicare inpatient discharge that an IPPS hospital treats, Medicare generally pays the hospital the DRG prospective payment rate that corresponds to the patient's diagnosis, even though the actual cost the hospital incurs in treating that patient may be higher or lower. Recognizing that some cases are exceptionally costly, Congress provided for additional "high cost outlier" ("HCO") payments to partly offset extremely high costs that hospitals incur in particular cases. Accordingly, an IPPS hospital may request additional payments in certain statutorily defined circumstances. 42 U.S.C. § 1395ww(d)(5)(A)(ii).

Outlier payments, however, cannot increase the overall Medicare payment obligations of the federal government under the IPPS. *See id*. § 1395ww(d)(3)(B). Therefore, to account for the higher outlier payments, CMS reduces the IPPS payment rates by a certain factor calculated based on a statutory formula. *Id*. In other words, each fiscal year, CMS prospectively estimates the proportion of IPPS outlier payments and then prospectively reduces IPPS payment rates to account for those IPPS outlier payments. Moreover, Congress requires that the IPPS high cost outlier payments for a given year be projected to be between 5 and 6 percent of the total IPPS payments for that year. *Id*. § 1395ww(d)(5)(A)(iv). For Fiscal Year 2019, CMS set an outlier target of 5.1% for IPPS. 83 Fed. Reg. 41144, 41717 (AR5984). CMS then reduced the IPPS payment rates by 5.1% to adjust for the expected high cost outlier payments. *Id*. at 41723 (AR5990). This budget neutrality adjustment accounts for outlier payments under the IPPS.

### B. Long Term Care Hospitals Prospective Payment System, Outlier Payments, and Budget Neutrality

When Congress created the IPPS in 1983, it limited the application of the new payment scheme to short-term acute care hospitals. 42 U.S.C. § 1395ww(d)(1)(B); *see also Transitional*

*Hosps. Corp. of La. v. Shalala*, 222 F.3d 1019, 1021 (D.C. Cir. 2000) (the IPPS was "developed for short-term acute care general hospitals"). LTCHs and certain other types of hospitals were excluded from the IPPS and instead continued to receive reimbursement for inpatient services under the reasonable-cost system. *Id.* Long Term Care Hospitals are defined as hospitals with "an average inpatient length of stay . . . of greater than 25 days[.]" 42 U.S.C. § 1395ww(d)(1)(B)(iv).

In 1999, Congress directed the Secretary to "develop a per discharge prospective payment system for payment for inpatient hospital services of long term care hospitals[.]" Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA"), Pub. L. No. 106-113, § 123, 113 Stat. 1501, 1501A330 (1999) (codified at 42 U.S.C. § 1395ww, note). Congress granted the Secretary broad discretion in developing the new LTCH prospective payment system ("LTCH PPS"). *Id.* The following year, Congress further provided that the Secretary "shall examine and may provide for appropriate adjustments to the long-term hospital payment system, including . . . outliers[.]" Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, § 307(b)(1), 114 Stat. 2763, 2763A497 (2000) (codified at 42 U.S.C. § 1395ww, note). Accordingly, CMS may make outlier payments within the LTCH PPS and may do so in a budget neutral manner.[1]

CMS implemented LTCH PPS on October 1, 2002, which marked the beginning of Federal Fiscal Year 2003. 67 Fed. Reg. 55954. The Secretary modeled the LTCH PPS after IPPS. *See generally* 42 C.F.R. ch. IV, subch. B, pt. 412, subpt. O (setting forth the rules governing LTCH PPS). As in IPPS, the Secretary established a flat national rate for LTCH PPS, known as the "standard Federal rate." *Id.* § 412.523(c)(1). Also since Fiscal Year 2003, in conjunction with the

[1] Although the BBRA requires that the LTCH PPS be budget neutral, the requirement applied only to the first year of the LTCH PPS. *See* 77 Fed. Reg. 53258, 53494. Nevertheless, the Secretary is authorized to maintain budget neutrality within LTCH PPS pursuant to Section 307(b)(1) of the BIPA.

implementation of the LTCH PPS, CMS has made a budget neutrality adjustment for estimated high cost outlier payments under the standard Federal rate every year. Pursuant to the Secretary's broad authority under section 123 of Public Law 106-113, BBRA, and section 307 of Public Law 106-554, BIPA, CMS has adjusted the standard Federal rate by a reduction factor of 8 percent, which is the estimated proportion of outlier payments under the LTCH PPS. *See* 42 C.F.R. § 412.523(d)(1); 67 Fed. Reg. 55954, 56052. That BNA is not challenged in this case.

In 2013, concerned that LTCHs were admitting some patients who instead could be safely and efficiently treated in a lower-cost setting, Congress required the Secretary to create a new dual-rate payment structure whereby those patients' care would be reimbursed at a rate lower than the standard Federal rate, known as the "site neutral" rate. *See* Bipartisan Budget Act of 2013, Pub. L. No. 113-67, § 1206, 127 Stat. 1165; 80 Fed. Reg. 49326, 49601-49623 (AR1243-65). Pursuant to this congressional mandate, CMS implemented the dual-rate payment structure for the LTCH PPS in 2015, and it remains in place today. Under that structure, generally a LTCH is no longer reimbursed at the standard Federal rate if the patient did not spend at least three days in a hospital's intensive care unit immediately preceding the LTCH care or did not receive at least 96 hours of respiratory ventilation services during the LTCH stay. 42 U.S.C. § 1395ww(m)(6)(A). That is, since 2015, Medicare pays the higher LTCH rate only for patients meeting certain criteria, and other cases are paid based in part on the site-neutral payment rate.[2]

The site-neutral payment rate is defined as the lower of (1) "the IPPS comparable per diem amount determined under [42 C.F.R. § 412.529(d)(4)], including any applicable outlier payments under [42 C.F.R. § 412.525]" or (2) "100 percent of the estimated cost for the services involved."

[2] There are additional factors that affect whether payment is made at the site-neutral rate or the standard Federal rate, such as whether the patient discharge has a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation, 42 U.S.C. § 1395ww(m)(6)(A)(ii)(II), but those details are not relevant here.

42 U.S.C. § 1395ww(m)(6)(B)(ii); *see also* 42 C.F.R. § 412.522(c)(1). The "IPPS comparable per diem amount" in turn is determined based on a complex formula that uses IPPS rates as inputs for the calculation. *See* 42 C.F.R. § 412.529(d)(4). CMS makes certain adjustments to the site-neutral payment rate, including an adjustment to account for outlier payments within the LTCH PPS. *Id*. C.F.R. § 412.522(c)(2); *id*. 42 C.F.R. § 412.525(a) (providing for high-cost outlier payments to LTCHs). The adjustment is equal to "the estimated proportion of outlier payments . . . payable for discharges from a long-term care hospital . . . to total estimated payments under the long-term care hospital prospective payment system to discharges from a long-term care hospital[.]" *Id*. § 412.522(c)(2)(i).

To allow LTCHs to transition to the dual rate payment structure, Congress directed that through Fiscal Year 2019, LTCHs are paid at a blended rate for site-neutral cases, 42 U.S.C. § 1395ww(m)(6)(B)(i)(I), which is equal to one-half of the site-neutral payment rate and one-half of the LTCH PPS standard Federal payment rate. *Id*. § 1395ww(m)(6)(B)(ii). Effective Fiscal Year 2020, site-neutral cases will be paid at 100 percent of the site-neutral payment rate.

## II. Factual Background Pertaining to Rulemakings

CMS first implemented the site-neutral payment rate policy for LTCHs in Fiscal Year 2016. 80 Fed. Reg. 49326, 49601-49623 (AR1243-65). CMS adopted a 5.1% BNA for site-neutral payments "so that the estimated HCO [High Cost Outlier] payments payable to site neutral payment rate cases do not result [in] any increase in aggregate LTCH PPS payments." 80 Fed. Reg. 49326, 49622 (AR1264); *see also id*. at 49621 (AR1263) ("In accordance with the current LTCH PPS HCO policy budget neutrality requirement, we believe that the HCO policy for site neutral payment rate cases should also be budget neutral, meaning that the proposed site neutral payment rate HCO payments should not result in any change in estimated aggregate LTCH PPS payments."); *id*. at 49623 (AR1265) ("[W]e estimate that this will result in an estimated proportion

of HCO payments to total LTCH PPS payments for site neutral payment rate cases of 5.1 percent."). The 5.1% is the same percentage as the factor used to adjust payments for budget neutrality in the IPPS.

Some "[c]ommenters objected to the proposed site neutral payment rate HCO budget neutrality adjustment, claiming that it would result in savings instead of being budget neutral." *Id.* at 49622. "The commenters' primary objection was based on their belief that, because the IPPS base rates used in the IPPS comparable per diem amount calculation of the site neutral payment rate include a budget neutrality adjustment for IPPS HCO payments (for example, a 5.1 percent adjustment on the operating IPPS standardized amount), an 'additional' budget neutrality factor is not necessary and is, in fact, duplicative." *Id.* CMS responded as follows:

> We disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is unnecessary or duplicative. While the commenters are correct that the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate. The HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS, and is therefore determined based on estimated payments made under the IPPS. As such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS. Without a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments above the level of expenditure if there were no HCO payments for site neutral payment rate cases. Therefore, our proposed approach appropriately results in LTCH PPS payments to site neutral payment rate cases that are budget neutral relative to a policy with no HCO payments to site neutral payment rate cases. For these reasons, we are not adopting the commenters' recommendation to change the calculation of the IPPS comparable per diem amount to adjust the IPPS operating standardized amount used in that calculation to account for the application of the IPPS HCO budget neutrality adjustment.

*Id.*

For Fiscal Year 2017, commenters again objected to the proposed 5.1% BNA for the LTCH site-neutral payment rate on the same and similar grounds as in the prior year. Compl. ¶¶ 29-30. CMS responded, in part, as follows:

> We continue to disagree with the commenters who assert that a HCO budget neutrality adjustment for site neutral payment rate cases is inappropriate, unnecessary, or duplicative. We have made a budget neutrality adjustment for estimated HCO payments under the LTCH PPS under § 412.525 every year since its inception in FY [Federal fiscal year] 2003. Specifically, at § 412.523(d)(1), under the broad authority provided by section 123 of Public Law 106-113 and section 307 of Public Law 106-554, which includes the authority to establish adjustments, we established that the standard Federal rate (now termed the LTCH PPS standard Federal payment rate under the new dual rate system) would be adjusted by a reduction factor of 8 percent, the estimated proportion of outlier payments under the LTCH PPS (67 FR 56052). Thus, Congress was well aware of how we had implemented our HCO policy under the LTCH PPS under § 412.525 at the time of the enactment of section 1206 of Public Law 113-67.
>
> Section 1206 of Public Law 113-67 defined the site neutral payment rate as the lower of the estimated cost of the case or the IPPS comparable per diem amount determined under paragraph (d)(4) of § 412.529, including any applicable outlier payments under § 412.525. The term "IPPS comparable per diem amount" was not new at the time of enactment. That term had already previously been defined under § 412.529(d)(4), which has been in effect since July 1, 2006, and used as a component of the payment adjustment formula for LTCH PPS SSO [short stay outlier] cases. From the July 1, 2006 inception of the IPPS comparable component of the LTCH PPS' SSO payment formula, we have budget neutralized the estimated HCO payments that we expected to pay to SSO cases including those paid based on the IPPS comparable per diem amount. Congress was also well aware of how we had implemented our "IPPS comparable per diem amount" concept in the SSO context at the time of the enactment of section 1206 of Public Law 113-67. As such, we believe Congress left us with the discretion to continue to treat the "IPPS comparable per diem amount" in the site neutral payment rate context as we have historically done with respect to LTCH PPS HCO payments made to discharges paid using the "IPPS comparable per diem amount," that is, to adopt a policy in the site neutral context to budget neutralize HCO payments made to LTCH PPS discharges including those paid using the "IPPS comparable per diem amount."

81 Fed. Reg. 56762, 57308 (AR2908).

For Fiscal Year 2018, CMS again proposed and later finalized a 5.1% BNA for the LTCH site-neutral payment rate and again received similar objections as in the prior years. Compl. ¶ 32. CMS responded as follows:

> We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (81 FR 57308 through 57309 and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

82 Fed. Reg. 37990, 38545-38546 (AR4612-4613).

For Fiscal Year 2019, commenters similarly objected to CMS's proposal of a 5.1% BNA for the LTCH site-neutral payment rate. Compl. ¶¶ 34-36. CMS responded as follows:

> We continue to disagree with the commenters that a budget neutrality adjustment for site neutral payment rate HCO payments is inappropriate, unnecessary, or duplicative. As we discussed in response to similar comments (82 FR 38545 through 38546, 81 FR 57308 through 57309, and 80 FR 49621 through 49622), we have the authority to adopt the site neutral payment rate HCO policy in a budget neutral manner. More importantly, we continue to believe this budget neutrality adjustment is appropriate for reasons outlined in our response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and our response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622).

83 Fed. Reg. 41144, 41738 (AR6005). CMS finalized the proposal in August 2018, and the Rule became effective on October 1, 2018. 83 Fed. Reg. 41144 (AR5411).

## STANDARD OF REVIEW

A preliminary injunction "is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (emphasis omitted) (citation omitted). The party moving for preliminary injunctive relief must demonstrate that (1) it has a substantial likelihood of success on the merits of its claims, (2) it will suffer irreparable injury unless the injunction issues, (3) the threatened injury outweighs damage to the opposing party, and (4) the injunction would not harm

the public interest. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22-23 (2008).[3] Moreover, where, as here, a plaintiff seeks a mandatory injunction to alter the status quo, the standard is even more stringent. *See Columbia Hosp. for Women Found., Inc. v. Bank of Tokyo-Mitsubishi Ltd.*, 15 F. Supp. 2d 1, 4 (D.D.C. 1997) ("[W]here an injunction . . . would alter, rather than preserve, the status quo by commanding some positive act—the moving party must meet a higher standard than in the ordinary case by showing clearly that he or she is entitled to relief or that extreme or very serious damage will result from the denial of the injunction."); *Allina Health Servs. v. Sebelius*, 756 F. Supp. 2d 61, 69 (D.D.C. 2010) (denying motion for preliminary injunction where "the Hospitals seek to disrupt the status quo by forcing the Secretary to change the [payment calculation] pending a disposition on the merits before this Court[.]").

The Administrative Procedure Act ("APA") provides for courts to "hold unlawful and set aside agency action, findings, and conclusions" if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right," *id.* § 706(2)(C). Under the APA's "arbitrary or capricious" standard, the Court "must consider whether the [agency's] decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Marsh v. Or. Nat. Res. Council*, 490 U.S. 360, 378 (1989). An agency is required to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle*

[3] In *Winter*, the Supreme Court held that a party must always demonstrate a likelihood of irreparable harm before a preliminary injunction may issue. 555 U.S. at 22. By so holding, the Court appears to have rejected the test previously used in the D.C. Circuit under which the requisite degree of likelihood of success and the degree of harm to the party seeking the injunction were balanced along a sliding scale. *See Davis v. PBGC*, 571 F.3d 1288, 1295-96 (D.C. Cir. 2009) (explaining that "this Circuit's traditional sliding-scale approach to preliminary injunctions may be difficult to square with" *Winter*) (Kavanaugh, J. concurring).

*Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *accord, e.g.*, *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 626 (1986). "[A]n agency cannot 'fail[] to consider an important aspect of the problem' or 'offer[] an explanation for its decision that runs counter to the evidence' before it," *Dist.t Hospital Partners*, 786 F.3d at 57 (quoting *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43), and it must "consider 'significant and viable and obvious alternatives,'" *id.* at 59 (quoting *Nat'l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 215 (D.C. Cir. 2013)). However, a decision that is not fully explained may be upheld "if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Ark.–Best Freight Sys., Inc.*, 419 U.S. 281, 286 (1974).

The "arbitrary or capricious" standard is "narrow . . . as courts defer to the agency's expertise." *Ctr. for Food Safety v. Salazar*, 898 F. Supp. 2d 130, 138 (D.D.C. 2012) (quoting *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43). The court "is not to substitute its judgment for that of the agency." *Id.* In Medicare cases such as this, the "'tremendous complexity of the Medicare statute . . . adds to the deference which is due to the Secretary's decision.'" *Dist. Hosp. Partners*, 786 F.3d at 60 (quoting *Methodist Hospital*, 38 F.3d at 1229); *see also Alaska Airlines, Inc. v. TSA*, 588 F.3d 1116, 1120 (D.C. Cir. 2009) (agency decisions involving "complex judgments about . . . data analysis that are within the agency's technical expertise" receive "an extreme degree of deference") (citation omitted). Finally, the court reviews the disputed rulemaking based on the administrative record that was before the agency at the time of rulemaking. *See Citizens to Pres. Overton Park v. Volpe*, 401 U.S. 402, 420 (1971).

## ARGUMENT

### I. The Court Lacks Jurisdiction Over Claims Other Than Those Concerning Fiscal Year 2019

"To obtain judicial review of claims arising under the Medicare Act, a plaintiff must first present the claims to the Secretary of Health and Human Services." *Am. Hosp. Ass'n v. Azar*, 895 F.3d 822, 823 (D.C. Cir. 2018); *see also Am. Chiropractic Ass'n, Inc. v. Leavitt*, 431 F.3d 812, 816 (D.C. Cir. 2005) ("Judicial review may be had only after the claim has been presented to the Secretary and administrative remedies have been exhausted."). Although Plaintiffs purport to challenge the BNA for fiscal years 2016 to the present, they have satisfied the presentment requirement only with respect to the 2019 BNA.

Hospitals' payments for Medicare services are calculated and processed by Medicare administrative contractors. *See* 42 U.S.C. § 1395h(a). After an administrative contractor has determined the amount of a hospital's payments, the hospital can appeal the determination to the Provider Reimbursement Review Board ("PRRB"), an administrative tribunal within HHS. *Id*. § 1395oo(a); *see also id*. § 1395oo(b) (providing for group appeals by multiple providers). If the hospital believes the PRRB lacks authority to decide a question of law, including the validity of the Secretary's regulations, the hospital can request that the PRRB authorize expedited judicial review in federal district court. *See id.* § 1395oo(f)(1) (if a provider believes the Board lacks authority to decide some "question of law or regulations relevant to the matters in controversy," it can request that the Board make a determination "that it is without authority to decide the question" and authorize expedited judicial review in federal district court). In seeking PRRB's authorization, the Medicare provider must specify each "question of law or regulations" that it intends to present to the district court. *Id*. Legal questions that the PRRB did not approve for expedited judicial review are outside the Court's subject matter jurisdiction. *See id.* As the Supreme Court has

observed, the expedited judicial review approval process gives the Board "a role in shaping the controversy that is subject to judicial review." *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 407 (1988).

Here, the PRRB granted the request for expedited judicial review on "the legal question of [whether] the Secretary incorrectly applied the outlier budget neutrality adjustment twice to the LTCH site neutral case payments for FFY [Federal fiscal year] 2019 as delineated in the August 17, 2018 Federal Register." Compl., Ex. A at 8. Accordingly, the only outlier budget neutrality adjustment at issue, and the only relief that can be granted by the Court, concerns the adjustment for Fiscal Year 2019. Nevertheless, the complaint does not limit its requested relief to the budget neutrality adjustment for Fiscal Year 2019. *See* Compl. ¶¶ 51-52 (seeking an "order directing the Secretary to remove the duplicative BNA from all LTCH PPS site neutral payments made by CMS in FFYs 2016 through 2018" and an "order directing the Secretary not to apply the BNA to LTCH PPS site neural payments in FFY 2020 and later years").[4] To the extent that Plaintiffs seek review of the Secretary's rulemakings for fiscal years other than 2019, their claims fall outside the Court's subject matter jurisdiction. *See* 42 U.S.C. § 1395oo(f)(1).

**II. Plaintiffs Fail to Establish Irreparable Harm**

Irreparable harm is "perhaps the single most important prerequisite for the issuance of a preliminary injunction[.]" *Sierra Club*, 990 F. Supp. 2d at 38 (quoting 11A Charles Alan Wright *et al.*, Federal Practice and Procedure § 2948.1 (2d ed 2013)). "A movant's failure to show any irreparable harm is grounds for refusing to issue a preliminary injunction, even if the other three factors entering the calculus merit such relief." *Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006). Where, as here, a party makes "no showing of irreparable

[4] Any challenge to the outlier BNA for Fiscal Year 2020 is not ripe because the rule has not been finalized and will not be implemented until October 2019.

injury," the court may deny the motion "without considering the other factors." *Fisheries Survival Fund v. Jewell*, 236 F. Supp. 3d 332, 336 (D.D.C. 2017).

The D.C. Circuit "has set a high standard for irreparable injury." *In re Navy Chaplaincy*, 534 F.3d 756, 766 (D.C. Cir. 2008) (citation omitted). To be irreparable, the harm must be "certain and great, actual and not theoretical, and so imminent that there is a clear and present need for equitable relief to prevent irreparable harm." *League of Women Voters of United States v. Newby*, 838 F.3d 1, 7–8 (D.C. Cir. 2016). Thus, "'[a]n unexcused delay in seeking extraordinary injunctive relief may be grounds for denial because such delay implies a lack of urgency and irreparable harm." *Open Top Sightseeing USA v. Mr. Sightseeing, LLC*, 48 F. Supp. 3d 87, 90 (D.D.C. 2014) (internal citation omitted). Moreover, "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a [preliminary injunction] are not enough." *Chaplaincy of Full Gospel Churches*, 454 F.3d at 297. Finally, a movant seeking a preliminary injunction "must show that the alleged harm will directly result from the action which the movant seeks to enjoin." *Wis. Gas Co. v. FERC*, 758 F.2d 669, 674 (D.C. Cir. 1985) (per curiam).

**A. Plaintiffs' Delay In Seeking Emergency Relief Undermines Their Claim of Irreparable Harm**

As an initial matter, Plaintiffs' extraordinary delay in seeking emergency relief should be fatal to their claim of irreparable harm. Plaintiffs filed the instant suit on March 13, 2019—nearly three and a half years after the government first implemented the identical site-neutral outlier BNA for LTCH PPS, 80 Fed. Reg. 49326 (AR968), and over five months after its implementation of the BNA for Fiscal Year 2019, 83 Fed. Reg. 41144 (AR5411). Even then, Plaintiffs waited additional weeks, until April 5, before filing their motion for emergency relief. Plaintiffs' multi-year delay strongly implies a lack of urgency and lack of irreparable harm in this case. *See Jack's Canoes & Kayaks, LLC v. National Park Serv.*, 933 F. Supp. 2d 58, 81 (D.D.C. 2013) ("Plaintiff's delay . . .

undermine[s] any argument that its injury is of 'such imminence that there is a clear and present need for equitable relief to prevent irreparable harm.'"). Indeed, "[t]he D.C. Circuit has found that a delay of forty-four days before bringing an action for injunctive relief was 'inexcusable,' and 'bolstered' the 'conclusion that an injunction should not issue,' particularly where the party seeking an injunction had knowledge of the pending nature of the alleged irreparable harm." *Open Top Sightseeing USA*, 48 F. Supp. 3d at 90 (quoting *Fund for Animals v. Frizzell*, 530 F.2d 982, 987 (D.C. Cir. 1975)); *see also AARP v. U.S. EEOC*, 226 F. Supp. 3d 7, 22 (D.D.C. 2016); *Mylan Pharm., Inc. v. Shalala*, 81 F. Supp. 2d 30, 44 (D.D.C. 2000) (two-month delay undermined claims).

There is no doubt that Plaintiffs had knowledge of the pending nature of the alleged irreparable harm long before now. They have been analyzing the issue of the challenged BNA since at least 2015 when their parent companies submitted comments to CMS on the issue. Compl. ¶¶ 23-24. Indeed, most of the hospital closures cited by Plaintiffs occurred in 2016, 2017, and 2018. *See* Mot., Aff. of Michael Cronin ("Cronin Aff."), Exs. A-E; *id.*, Aff. of Karick Stober ("Stober Aff."), Exs. A-C; *id.*, Aff. of Clint Fegan ("Fegan Aff."), Exs. A, C; *id.*, Aff. of Richard L. Algood ("Algood Aff."), Exs. A-I. And Plaintiffs have demonstrated the ability to estimate the financial impact of the site-neutral outlier BNA early in a given fiscal year because they have already estimated such impact for Fiscal Year 2019. *See* Mot., Cronin Aff. ¶¶ 7-8; *id.*, Stober Aff. ¶¶ 7-8; *id.*, Fegan Aff. ¶¶ 7-8; *id.*, Algood Aff. ¶¶ 7-8. Plaintiffs' claim that "the totality of the harm" was not "immediately apparent" until now therefore rings hollow. Mot. at 41. Ultimately, Plaintiffs' concession that their alleged harm is based on the alleged gradual financial impact over the course of several years only shows why there is no emergency here. Their request for emergency relief therefore should be denied for this reason alone.

**B. Plaintiffs Have Not Shown Their Claimed Financial Harm is Due to the BNA At Issue in This Case**

Emergency injunctive relief is improper also because Plaintiffs have failed to show that the challenged BNA threatens their very existence. Plaintiffs acknowledge that economic loss does not, in and of itself, satisfy the high standard for irreparable injury. *See* Mot. at 37; *see also Wis. Gas Co.*, 758 F.2d at 674; *Mott Thoroughbred Stables, Inc. v. Rodriguez*, 87 F. Supp. 3d 237, 246 (D.D.C. 2015) ("The District of Columbia Circuit has resoundingly rejected the notion that economic loss constitutes irreparable harm[.]"). Nevertheless, Plaintiffs insist that the magnitude of their claimed monetary loss fits within a narrow exception to this general rule—*i.e.*, where the loss "threatens the very existence" of the plaintiff's business. *See Wis. Gas. Co.*, 758 F.2d at 674. Plaintiffs point to the closure of their affiliate hospitals as supposed proof that their own existence is threatened by the BNA. Mot. at 39. But those hospitals' and Plaintiffs' own pre-litigation statements as documented in the exhibits to the Motion indicate that those hospitals were closed for reasons unrelated to the BNA.

For example, Plaintiffs assert that various Kindred hospitals closed because of the BNA. *See* Mot., Algood Aff., ¶ 10. But Plaintiffs' own exhibits explained that several of those hospitals were closed due to a "strategic" decision by the parent company. Mot., Algood Aff., Ex. C, D, G, I. They also indicate that another Kindred hospital was closed because that specific hospital "had seen a decline in admissions," which, the exhibits also indicate, is consistent with the fact that "admissions to long term acute care facilities are down across the board." *Id.*, Algood Aff., Ex. E. Finally, two other Kindred hospitals were closed "to consolidate services into nearby Kindred hospitals." *Id.*, Algood Aff., Ex. H & J.

Similarly, Plaintiffs assert that the closure of a LifeCare hospital in Texas was due to the challenged BNA. Mot., Cronin Aff., ¶ 10. But Plaintiffs' supporting exhibit states that "*a number*

*of factors* influenced [the Texas LifeCare Hospital's] decision to make this change," without identifying the factors or indicating the challenged BNA was a factor, let alone a substantial factor. *Id*., Cronin Aff., Ex. B (emphasis added). Likewise, Plaintiff LifeCare Hospitals of Pittsburgh explained in an exhibit attached by Plaintiffs that the "decision to consolidate Monroeville operations . . . was based on a number of factors that included regulatory changes, referral patterns and other market dynamics[.]" *Id*., Cronin Aff., Ex. E. And Plaintiff Vibra Hospital of Western Massachusetts similarly explained that the decision to close a hospital was due to "current market conditions[.]" Mot., Fegan Aff., Ex. C. None of Plaintiffs' exhibits specifically blames the closure of any hospital on the BNA, much less indicates that the BNA was a substantial factor motivating the decision to close the hospitals.

It is true that some of Plaintiffs' exhibits also attribute hospital closures to regulatory changes or changes in "healthcare reimbursement." Mot. at 39. But those references are to the introduction of the site-neutral payment rate in 2015, which was vastly more significant than the challenged BNA in terms of reimbursements for LTCHs. As discussed above in the Background Section, prior to 2015, LTCHs were reimbursed at the highly profitable "standard Federal rate" based on the assumption that patient stays at LTCHs were especially costly due to the nature of the patients' illnesses or medical conditions. But that changed in 2015 when Congress mandated a new dual-rate payment structure for LTCHs based on its conclusion that LTCHs were admitting patients who could be safely and efficiently treated in a lower-cost setting. *See* Bipartisan Budget Act of 2013, Pub. L. No. 113-67, § 1206, 127 Stat. 1165; 80 Fed. Reg. 49326, 49601-49623 (AR1243-65). Pursuant to this congressional mandate, CMS generally began reimbursing LTCHs at a rate lower than the standard Federal rate if the patient did not spend at least three days in a hospital's intensive care unit immediately preceding the LTCH care or did not receive at least 96 hours of respiratory ventilation services during the LTCH stay. 42 U.S.C. § 1395ww(m)(6)(A).

CMS fully anticipated that there would be very large reductions in LTCH reimbursements as a result of the introduction of lower "site-neutral" rate, even while that rate is blended with the standard Federal rate for Fiscal Years 2016 to 2019. *See* 80 Fed. Reg. 49326, 49618 (AR1260) (discussing expectation that reimbursements for "site neutral payment rate cases would . . . in the majority of cases, [be] much lower than the payment that would have been paid if these statutory changes were not enacted."). For example, CMS predicted that the site-neutral payment rate would decrease LTCH reimbursement by about $300 million in Fiscal Year 2016. 80 Fed. Reg. 49326, 49831 (AR1473). For Fiscal Year 2017, the predicted impact was about $388 million, 81 Fed. Reg. 56762, 57334 (AR2934), and approximately $230 million for Fiscal Year 2018, 82 Fed. Reg. 37990, 38575-38576 (AR4642-43). Accordingly, the total predicted impact over Fiscal Years 2016, 2017, and 2018 for the statutorily mandated change to the payment methodology was a $918 million reduction in reimbursements to LTCHs. Here, Plaintiffs claim to constitute "more than one-quarter of the total number of LTCHs nationwide," Mot. at 1, so the impact on Plaintiffs by virtue of the change to site-neutral payment amounts can be estimated as roughly one-quarter of the $918 million figure, or $229.5 million.

In comparison, Plaintiffs' own estimated lost reimbursement due to the challenged BNA is very small. Specifically, "Plaintiffs estimate that they have lost $12,502,353 in Medicare reimbursement as a result of the . . . BNA during their FY 2016 through FY 2018 cost reporting periods." Mot. at 41. That $12.5 million loss is just 5.4% of the financial impact from the application of the new site-neutral payment rate during the same time period. And even crediting the $12.5 million estimate, each hospital individually would suffer a much smaller amount each year. Given the BNA's relatively minor impact and the fact that a major transformation to the LTCH reimbursement system was underway at the same time, Plaintiffs' claim that the challenged

BNA itself has caused LTCH hospitals to close and will soon also cause Plaintiffs to close is highly speculative and simply not credible.

Indeed, Plaintiffs' own supporting documents show that the site-neutral payment rate, not the BNA, was the cause of decreased revenues for LTCHs. For example, in Plaintiffs' Exhibit D to the Stober Affidavit, Post Acute Medical explained that a hospital closure was due to "dramatic changes designed to substantially limit the types of patients who could be treated in long-term acute care hospitals." Mot., Stober Aff., Ex. D. That is a reference to the introduction of the site-neutral payment rate, which, as discussed above, discouraged the treatment of less ill patients in the LTCH setting by reimbursing LTCHs at a rate lower than the standard Federal rate applicable to patients meeting the statutory criteria—*i.e.*, generally having spent at least three days in a hospital's intensive care unit immediately preceding the LTCH care or receiving at least 96 hours of respiratory ventilation services during the LTCH stay, 42 U.S.C. § 1395ww(m)(6)(A). Likewise, the "payment changes" leading to a hospital's closure, discussed in Plaintiffs' Exhibit A to the Cronin Affidavit, are about changes to "reduce Medicare rates paid to LT[CH]s by up to 60 percent or 70 percent for each patient unless the patient has spent at least three days in another hospitals' intensive-care unit before being transferred to an LT[CH]"; in other words, the introduction of the site-neutral payment rate. *See* Mot., Stober Aff., Ex. A.

Similarly, the Medicare Payment Advisory Commission ("MedPAC") slides Plaintiffs cite (at 39 n.33) do not even mention the BNA and instead discuss "the effect of the dual-payment rate structure."[5] The slides explain that as a result of the new payment structure, "LTCHs are admitting fewer cases that do not meet the criteria [for payment at the higher standard Federal rate]" which

[5] MedPAC, Presentation Slides, *Mandated report: Changes in post-acute and hospice care following the implementation of the long-term care hospital dual payment-rate structure* (Mar. 8, 2019), ("MedPAC Slides") at 4, available at http://www.medpac.gov/docs/default-source/default-document-library/ltch-mandated-report-march-final.pdf?sfvrsn=0.

has led to "declining occupancy rates." *Id*. at 8, 10. The slides also indicate that the hospitals that have closed are mostly "in markets with multiple LTCHs and with low occupancy, low share of cases that met the criteria, [and] higher costs than facilities that remained open." *Id*. at 17. Finally, the portion of the MedPAC public meeting transcript quoted by Plaintiffs echoes the expected market correction due to the alignment of the high LTCH reimbursement rate with patients most appropriate for LTCH care. Mot. at 39 n.34 ("the greater expectation is that you might see further adaptation of the market in terms of reduced volume overall, possible additional closures of LTCH, and *all of this resulting from the focus on those patients who are most appropriate for this level of care*") (emphasis added).[6]

In short, Plaintiffs offer nothing to suggest that the BNA has caused any hospital to close or is threatening Plaintiffs' existence. Indeed, Plaintiffs' carefully worded declarations do not actually contend that the BNA caused any hospitals to close. Rather, they assert only that "[d]ozens of LTCHs have already closed across the country since the implementation of the [alleged] duplicative BNA to the LTCH site neutral payment rate." *See, e.g.*, Cronin Aff., ¶ 10. But a temporal relationship is not a substitute for the requisite causal relationship. Absent a causal relationship between the alleged harm and the challenged action, a preliminary injunction will not redress Plaintiffs' claimed injury. *See Sierra Club v. United States DOE*, 825 F. Supp. 2d 142, 153 (D.D.C. 2011) ("A plaintiff may be irreparably harmed by all sorts of things, but the irreparable harm considered by the court must be caused by the conduct in dispute and remedied by the relief sought.") (citing cases). Accordingly, Plaintiffs' affidavits are wholly insufficient to satisfy Plaintiffs' burden to show that their claimed harm—*i.e.*, the asserted impending closure—

[6] MedPAC, Nov. 1, 2018, Public Meeting Transcript ("MedPAC Transcript"), at 48, *available at* http://www.medpac.gov/docs/default-source/default-document-library/november-2018-transcripts.pdf?sfvrsn=0.

"will directly result from" the challenged BNA. *Wis. Gas. Co.*, 758 F.2d at 674. Because what remains are Plaintiffs' own self-serving, conclusory assertions of impending doom, a preliminary injunction is not warranted.

**C. Plaintiffs Have Not Shown Any Existential Threat To Their Businesses**

Even if Plaintiffs had shown that the BNA caused them significant financial harm – and they certainly have not – that still would not support Plaintiffs' assertion that they will surely go out of business. *See Wis. Gas. Co.*, 758 F.2d at 674. Courts reject claims of irreparable harm where a movant is owned by a parent corporation capable of providing capital to offset economic losses. For example, in *Economic Research Services v. Resolution Economics, LLC*, 140 F. Supp. 3d 47, 53-54 (D.D.C. 2015), the court denied the plaintiff's preliminary injunction motion because it had "no reason to believe that [the plaintiff's] alleged losses threaten the company's very existence." *Id.* at 53. The Court reasoned that "[g]iven the size and prominence of [the plaintiff's] parent corporation," the parent could "furnish the capital necessary to help [the plaintiff] recoup its losses." *Id.*; *see also Ajilon Prof'l, Staffing, PLC v. Kubicki*, 503 F. Supp. 2d 358, 362 (D.D.C. 2007) ("Given the size and prominence of Ajilon and its parent corporation, there is no reason to believe that Ajilon's alleged loss of revenue threatens the company's ability to stay in business.").

Plaintiffs have not submitted any information about their corporate structure, financial conditions, or the finances of their parent companies that would allow the Court to conclude that they suffer an actual threat to their existence. Having failed to meet their burden, Plaintiffs' motion should be denied for that reason alone. But publicly-available evidence reveals that Plaintiffs are each owned by large, profitable businesses that likely can financially support the plaintiff hospitals during the course of this litigation.

For example, 55 of the 101 plaintiff hospitals are part of Kindred Healthcare, *see* Compl., Ex. B; *see also id.* ¶ 23 ("Kindred Healthcare, Inc. . . . [is] the parent company of many of the

Plaintiffs"), which is a multi-billion dollar organization. It boasts of "annual revenues of approximately $3.4 billion" and provides services at locations including "75 LT[CH] hospitals, 19 inpatient rehabilitation hospitals, 13 sub-acute units, [and] 98 inpatient rehabilitation units[.]"[7] Kindred Healthcare in turn is owned by TPG Capital, "a leading global alternative asset firm . . . with more than $82 billion of assets under management," and Welsh, Carson, Anderson & Stowe, a firm that since its founding has organized limited partnerships "with total capital of over $22 billion." *Id.* These figures render incredible the Kindred plaintiffs insistence that the BNA presents an existential threat to their business.[8]

Likewise, 20 of the plaintiffs are part of Vibra Healthcare, *see* Compl., Ex. B, which has projected revenues of over one billion dollars and has "10 hospitals under various stages of development."[9] The company emphasizes that it is "[c]apitalized for [g]rowth" and that with its "access to capital," it is able "to navigate today's evolving and dynamic healthcare environment." *Id*.

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[7] Press Release, *Humana, Together with TPG Capital and Welsh, Carson, Anderson & Stowe, Announce Completion of the Acquisition of Kindred Healthcare, Inc.*, (Jul. 2, 2018) available at https://www.kindredhealthcare.com/news/2018/07/02/humana-together-tpg-capital-and-welsh-carson-anderson-stowe.

[8] Though Plaintiffs complain that Kindred Healthcare has had to close certain LTCHs, they fail to mention that the company also expanded operations in other sectors, including by announcing the construction of new inpatient rehabilitation centers in August and October 2018, *see* https://www.kindredhealthcare.com/news/2018/08/08/kindred-healthcare-and-uc-davis-announce-plans-for-inpatient-rehabilitation-hospital and https://www.kindredhealthcare.com/news/2018/10/26/kindred-healthcare-and-mercy-iowa-city-announce-plans-for-inpatient-rehabilitation-hospital. It is also notable that the BNA did not restrict the ability of Kindred Healthcare's predecessor company to pay millions of dollars in executive bonuses in 2016 and 2017. *See* SEC Form 10-K/A of Kindred Healthcare, Inc., at 28, available at https://www.sec.gov/Archives/edgar/data/1060009/000119312518139241/d522164d10ka.htm.

[9] *See* Vibra Healthcare Website, available at https://www.vibrahealthcare.com/about-us/company-history/.

Finally, twelve of the plaintiffs are part of LifeCare Health Partners. *See* Compl., Ex. B. LifeCare Health Partners describes itself as a "leading healthcare services provider" encompassing "the LifeCare family of hospitals as well as a spectrum of post-acute services including transitional care, inpatient and outpatient behavioral health treatment and home-based care."[10] It appears that LifeCare Health Partners has sufficient capital to continue to acquire new healthcare facilities.[11]

In sum, Plaintiffs are owned and operated by large, well-capitalized companies that appear more than capable of withstanding the relatively small financial impact of the BNA during the course of this litigation. The Court should reject Plaintiffs' implausible claim that a preliminary injunction is necessary to ensure the survival of these well-funded businesses. *See, e.g.*, *ConverDyn v. Moniz*, 68 F. Supp. 3d 34, 46-49 (D.D.C. 2014) (holding that projected damages of nearly $70 million in lost profits and foregone revenues over two years "failed to meet this Circuit's stringent standard for establishing irreparable harm" because they did not "threaten[] the very existence of [the plaintiff's] business"); *Coal. for Common Sense in Gov't Procurement v. United States*, 576 F. Supp. 2d 162, 169-70 (D.D.C. 2008) (holding that the plaintiff's claims of lost income did not rise to the level of irreparable harm because the losses amounted to a fraction of the plaintiff's overall business); *Leboeuf, Lamb, Greene & Macrae, LLP v. Abraham*, 180 F. Supp. 2d 65, 72 (D.D.C. 2001) ("[T]hough the plaintiff [law firm] argues that its transportation-law practice may suffer, [it] does not demonstrate whether the very existence of the entire law practice is at stake.").

[10] *See* LifeCare Health Partners Website, available at https://www.lifecarehealthpartners.com/about.

[11] *See* Home Health Care News, *Health System LifeCare Buying Up In-Home Care Agencies* (June 11, 2018), available at https://homehealthcarenews.com/2018/06/health-system-lifecare-buying-up-in-home-care-agencies.

## III. Plaintiffs Have Not Established a Likelihood of Success on the Merits

Plaintiffs likewise have not shown that they are likely to prevail on the merits of their claims under the deferential framework "set out in [*Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 845 (1984), which] applies to judicial review of claims that an agency has acted 'in excess of statutory jurisdiction, authority or limitations'" under the APA. *Cmty. Health Sys., Inc. v. Burwell*, 113 F. Supp. 3d 197, 211-12 (D.D.C. 2015). The *Chevron* framework is based on the presumption "'that Congress, when it left ambiguity in a statute' administered by an agency, 'understood that the ambiguity would be resolved, first and foremost, by the agency, and desired the agency (rather than the courts) to possess whatever degree of discretion the ambiguity allows.'" *City of Arlington v. FCC*, 569 U.S. 290, 296 (2013) (citation omitted).

Accordingly, at the first step of the inquiry, the Court must "ask whether Congress has directly addressed the precise question at issue." *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44 (2011) (internal citations omitted). If the Court concludes that the statute is silent or ambiguous with respect to the specific issue under consideration, the analysis shifts to *Chevron* step two, where "the question for the court is whether the agency's answer is based on a permissible construction of the statute." *City of Arlington*, 569 U.S. at 296 (quoting *Chevron*, 467 U.S. at 842-43). *Chevron* step two is coextensive with arbitrary or capricious review. *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011).

### A. The Challenged BNA is Not Duplicative of the IPPS BNA

Plaintiffs' claims are each premised on Plaintiffs' mistaken belief that the outlier BNA for LTCH PPS site-neutral payments is duplicative of the outlier BNA for IPPS. *See* Mot. at 18-36. Plaintiffs' claims fail because the two BNAs are not duplicative.

To begin, the two BNAs serve distinct purposes. The Secretary has "wide discretion . . . to implement the Medicare reimbursement formula, including determining how to meet Medicare's budget neutrality requirements." *Adirondack Med. Ctr. v. Burwell*, 782 F.3d 707, 710 (D.C. Cir. 2015) (addressing budget neutrality under IPPS). To ensure budget neutrality, the Secretary must offset increases in payments by reducing other payments so that the net effect is neutral within a particular payment system. One instance where budget neutrality is required relates to high cost outlier payments made to hospitals paid under IPPS. As explained above, although Medicare generally pays IPPS hospitals a set amount based on the patient's diagnosis, when cases are exceptionally costly, Medicare makes an additional outlier payment to the hospital. *See* 42 U.S.C. § 1395ww(d)(5)(A)(ii). Congress has directed the Secretary to maintain budget neutrality with respect to such outlier payments by reducing IPPS reimbursements to account for the outlier payments. *See id*. § 1395ww(d)(3)(B). This reduction, or the IPPS outlier BNA, serves to account for high cost outlier payments *within IPPS*. The statutory provision requiring budget neutrality states that the Secretary shall reduce the IPPS payment rates "by a factor equal to the proportion of payments under this subsection" estimated to be used for the "additional payments described in paragraph (5)(A) (relating to outlier payments)." 42 U.S.C. § 1395ww(d)(3)(B). The phrase "this subsection" is a reference to 42 U.S.C. § 1395ww(d), which governs payments to hospitals under the IPPS. And "paragraph (5)(A)" refers to 42 U.S.C. § 1395ww(d)(5)(A), which governs high cost outlier payments specifically within IPPS. Accordingly, the statute is clear that the IPPS outlier BNA adjusts IPPS payment rates downward to account for the high cost outlier payments within the IPPS.[12] For Fiscal Year 2019, the IPPS outlier BNA is 5.1%.

[12] For Fiscal Year 2019, CMS set an outlier target of 5.1% for IPPS. 83 Fed. Reg. 41144, 41717 (AR5984); *see also* 42 U.S.C. § 1395ww(d)(5)(A)(iv) (requiring IPPS high cost outlier payments for a given year to be between 5 and 6 percent of the total IPPS payments for that year). After selecting the 5.1% target, CMS then determined the threshold for IPPS outlier payments that would

The outlier BNA for site-neutral payments in LTCH PPS in contrast adjusts for site-neutral high cost outlier payments within the LTCH PPS, which is an altogether different payment system than IPPS. The LTCH PPS has a distinct history from the IPPS. As discussed above, Congress first directed the Secretary to develop a prospective payment system for LTCHs in 1999, which was long after the IPPS had been in place. Moreover, since the LTCH PPS was implemented in Fiscal Year 2003, CMS has made a budget neutrality adjustment for estimated high cost outlier payments every year pursuant to statutory authorities distinct from the authorities to implement the IPPS outlier BNA. *See* BIPA, § 307(b)(1), 114 Stat. 2763, 2763A497 ("The Secretary shall examine and may provide for" other "appropriate adjustments to the long-term hospital payment system, including . . . outliers[.]"). Specifically, for payments made to LTCHs under the standard Federal rate, CMS reduces the payment rate by 8%. *See* 42 C.F.R. § 412.523(d)(1). The 8% figure represents the estimated proportion of outlier payments out of the total standard Federal rate payments in LTCH PPS. *Id.* And since the introduction of the site-neutral payment rate in 2015, CMS reduces the site-neutral payment rate by a factor equal to the estimated proportion of outlier payments out of the total site-neutral payments in LTCH PPS. *See* 42 C.F.R. § 412.522(c)(2)(i). For Fiscal Year 2019, the adjustment is 5.1%. 83 Fed. Reg. 41144, 41737 (AR6004). Although CMS did set the outlier threshold based on the IPPS outlier threshold, *id.*, that was due to its projection that site-neutral payment rate cases would mirror similar IPPS cases. *Id*. at 41736-37 (AR6003-04). Indeed, the reason the site-neutral rate was developed was that certain patients at LTCHs appropriately could be treated in a lower cost IPPS setting. The outlier BNA for site-neutral payments still only accounts for outlier payments in the site-neutral payment portion of

result in outlier payments being 5.1% of the total for that year. 83 Fed. Reg. 41144, 41717 (AR5984). To do so, CMS simulated payments using historical data about patient stays and Medicare payments. *Id*.

LTCH PPS, whereas the IPPS BNA is intended to account for outlier payments made under the IPPS.

Nevertheless, Plaintiffs insist that the two BNAs are duplicative because "the IPPS comparable per diem amount," required by Congress to be one of two possible values of the site-neutral rate, "has already been reduced by the same percentage by the IPPS outlier BNA." Mot. at 14. But it is not accurate to say that "the IPPS comparable per diem amount" has already been reduced by 5.1%. Rather, merely certain *inputs* to the IPPS comparable per diem amount calculation incorporate the IPPS outlier BNA. More specifically, Congress defined the site-neutral payment rate so that it includes the adjusted IPPS base rates as inputs to the calculation of the site-neutral payment. The site-neutral payment rate is statutorily defined as the lower of:

> (I) the IPPS comparable per diem amount determined under paragraph (d)(4) of section 412.529 of title 42, Code of Federal Regulations, including any applicable outlier payments under section 412.525 of such title; or
>
> (II) 100 percent of the estimated cost for the services involved.

42 U.S.C. § 1395ww(m)(6)(B)(ii).

Accordingly, Congress directed the Secretary to compute the "IPPS comparable per diem amount" using the calculation described at 42 C.F.R. § 412.529(d)(4). That regulation describes a complex process for calculating the "IPPS comparable per diem amount," which includes determining the applicable IPPS "standardized amount" and IPPS "Federal rate." *Id*. The IPPS regulations for "[c]omputing the standardized amount" require the standardized amount to be adjusted to account for outlier payments. *See id*. §§ 412.64(c), (f). Likewise, the IPPS regulations for determining the Federal rate require that rate to be adjusted to account for outlier payments. *See id*. § 412.308(c)(2). Therefore, when Congress instructed the Secretary to compute the "IPPS comparable per diem amount" in accordance with 42 C.F.R. § 412.529(d)(4), it understood that certain inputs to the calculation would reflect the application of the IPPS outlier BNA.

Importantly, the adjusted IPPS "standardized amount" and the adjusted IPPS "Federal rate" are not the site-neutral payment paid to LTCHs but are merely inputs used to determine that payment. *See* 42 C.F.R. § 412.529(d)(4) (describing payment computation). As CMS has explained, while "the IPPS base rates that are used in site neutral payment rate calculation include a budget neutrality adjustment for IPPS HCO [high cost outlier] payments, that adjustment is merely a part of the calculation of one of the inputs (that is, the IPPS base rates) that are used in the LTCH PPS computation of site neutral payment rate." 80 Fed. Reg. 49622 (AR1264). Again, "[t]he HCO budget neutrality factor that is applied in determining the IPPS base rates is intended to fund estimated HCO payment made under the IPPS," and "[a]s such, the HCO budget neutrality factor that is applied to the IPPS base rates does not account for the additional HCO payments that would be made to site neutral payment rate cases under the LTCH PPS." *Id.* To maintain budget neutrality within LTCH PPS, the Secretary reasonably determined that it is not sufficient to merely rely on adjustments incorporated into certain of the inputs for the calculation of the site-neutral payment rate because those adjustments account only for outliers in IPPS hospitals. To properly adjust for outlier payments in LTCH PPS, the Secretary determined that CMS must adjust the site-neutral payment rate amount itself. 42 C.F.R. § 522(c)(2). As CMS further explained, "[w]ithout a budget neutrality adjustment when determining payment for a case under the LTCH PPS, any HCO payment payable to site neutral payment rate cases would increase aggregate LTCH PPS payments" to a level that upsets budget neutrality. *Id.* At the very least, the agency's determination is reasonable and entitled to *Chevron* deference, *Chevron*, 467 U.S. at 845, particularly given the Secretary's "wide discretion" in "determining how to meet Medicare's budget neutrality requirements." *Adirondack Med. Ctr.*, 782 F.3d at 710 (addressing budget neutrality under IPPS).

Plaintiffs essentially maintain that that there should not be a distinct LTCH outlier BNA for site neutral cases because the IPPS comparable per diem amount already encompasses an

outlier BNA, albeit the IPPS outlier BNA. *See* Mot. at 34; *see also id* at 21 (arguing it is "not reasonable for CMS to apply a 5.1% BNA to the LTCH site neutral payment rate to offset the cost of high cost outlier payments *after* CMS already applied the same 5.1% BNA to the IPPS payment rate") (emphasis in original). But Congress clearly did not perceive any duplication of budget neutral adjustments in CMS's methodology. As CMS has explained, the term "IPPS comparable per diem amount" was not new when Congress required that CMS establish a dual payment structure and when it defined what constitutes a site neutral rate. 81 Fed. Reg. 56762, 57308 (AR2908). The term has been defined in 42 C.F.R. § 412.529(d)(4) since 2006. *Id.* Moreover, CMS had used it as a component of the payment adjustment formula for LTCH PPS short stay outlier cases and has budget neutralized the estimated high cost outlier payments that it expected to pay to short stay outlier cases. *Id.* Congress was well aware of how CMS had implemented the "IPPS comparable per diem amount" concept in the short stay outlier context. *Id.* Thus, in using that term to describe the site neutral payment rate and in providing that the IPPS comparable per diem amount is to include "any applicable outlier payments" under 42 C.F.R. § 412.525, Congress understood that the Secretary's determination of the IPPS comparable per diem amount would include IPPS outlier BNA.

In sum, the outlier BNA for site-neutral payments under the LTCH PPS serves a purpose that is distinct from the purpose of the IPPS outlier BNA and it is therefore not duplicative. Moreover, the IPPS outlier BNA is not an adjustment "to the LTCH site neutral payment rate," as Plaintiffs claim. Mot. at 34. Rather, the IPPS outlier BNA is one part of the calculation of certain inputs to the IPPS comparable per diem amount. The Secretary appropriately accounts for high cost outlier payments within LTCH PPS by reducing the LTCH payment rates per the challenged BNA, thus maintaining budget neutrality within LTCH PPS.

### B. Plaintiffs' Claims Alleging Substantive APA Violations Are Unlikely to Succeed on the Merits

Because the challenged BNA is not duplicative, Plaintiffs cannot show that CMS's decision to apply the BNA to site-neutral payment cases is arbitrary, capricious, an abuse of discretion, not in accordance with law, or otherwise in violation of the APA.

First, the challenged BNA is not contrary to law. The Secretary clearly has the authority to make the challenged budget neutrality adjustment; Congress specifies that the Secretary "may provide for appropriate adjustments to the long-term hospital payment system, including . . . outliers[.]" BIPA, § 307(b)(1), 114 Stat. 2763, 2763A497. Plaintiffs argue that the challenged BNA is not an "appropriate adjustment" because it allegedly duplicates the impact of the IPPS BNA. Mot. at 33-35. The argument is again premised on the ill-conceived duplication theory, and accordingly, fails for the same reasons as discussed previously. The same is true with Plaintiffs' theory that the challenged BNA shifts Medicare costs to non-beneficiaries. Mot. at 35-36. Not only is the LTCH BNA not duplicative of the IPPS BNA, but as already discussed above, the statutory scheme grants the Secretary broad discretion to set the LTCH PPS reimbursement formula and to make outlier adjustments. *See* 42 U.S.C. § 1395ww, note. Particularly in light of the Secretary's broad discretion, his determinations easily pass muster under the deferential APA and *Chevron* standards. *See Chevron*, 467 U.S. at 845.

Next, Plaintiffs argue that the challenged BNA violates the dual-rate structure for LTCH PPS. Mot. at 35. But that argument too hinges on a mistaken view—that LTCH PPS site neutral payment must be identical to the IPPS payment for similar cases, and thus, when CMS reimburses LTCHs at the site neutral payment rate, reduced to adjust for outliers in LTCH PPS, it purportedly creates an improper differential with the IPPS rate. But the statute does not require identical payments under these two distinct payment systems; rather, it calls for calculation of a

"comparable" amount. 42 U.S.C. § 1395ww(m)(6)(B)(ii). As CMS has explained, "differing statutory requirements between the two payment systems result in comparable LTCH PPS site neutral payment rate cases and IPPS cases not being paid exactly the same amount[.]" 80 Fed. Reg. 49326, 49619 (AR1261). Indeed, the statutory requirement in 42 U.S.C. § 1395ww(m)(6)(B)(ii) that CMS pays the estimated cost for the services involved for a site neutral case if that cost is lower than the comparable IPPS per diem amount already creates a differential. *See* 80 Fed. Reg. 49326, 49619 (AR1261). In addition, the statute specifies that the IPPS comparable amount is calculated as a per diem capped at the full amount as set forth under 42 U.S.C. § 412.529(d)(4), which also creates a differential. *Id.* Thus, the statute does not require exact payment equality between IPPS and LTCH PPS, and CMS's application of the LTCH BNA is proper under the statutory scheme. In any event, LTCHs are currently being paid a blended rate equal to one-half of the site-neutral payment rate and one-half of the LTCH PPS standard Federal payment rate, 42 U.S.C. § 1395ww(m)(6)(B)(ii), which is likely higher than what the hospitals would be paid for a similar stay under IPPS.

Next, Plaintiffs' assertion that CMS "refus[ed] to seriously consider whether the adjustment is duplicative" is belied by the record. Mot. at 23. For years, CMS has carefully considered comments that the outlier BNA for the LTCH site-neutral payment rate was duplicative of the IPPS outlier BNA and has explained why those concerns are incorrect. *See* Background Section. Given that CMS's responses on this issue are discussed and quoted in Plaintiffs' own complaint, Compl. ¶¶ 27, 31, 32, 37, it is perplexing for Plaintiffs' to claim that CMS has "entirely failed to consider an important aspect of the problem." Mot. at 23.

Also, there is nothing "internally inconsistent" about CMS's reasoning, as Plaintiffs contend. Mot. at 24. The fact that CMS uses the same threshold and targets for outliers in IPPS as in LTCH PPS does not require CMS to forgo applying a BNA for outliers in the LTCH PPS.

As discussed, CMS set the outlier threshold based on the IPPS outlier threshold because of its projection that site-neutral payment rate cases would mirror similar IPPS cases. 83 Fed. Reg. at 41736-37. That is no surprise because the reason the site-neutral rate was developed was that certain patients at LTCHs otherwise could be treated appropriately in a lower cost IPPS setting. But to maintain budget neutrality within LTCH PPS, CMS must account for outlier payments within LTCH PPS. The LTCH outlier BNA is necessary to maintain budget neutrality within LTCH PPS.

Next, Plaintiffs have not shown any "clear error of judgment" on the part of CMS. Mot. at 27-29. The agency plainly did not "ignore[] evidence," *id*. at 28, but rather carefully considered comments that the LTCH PPS BNA was duplicative and reasonably determined that it was not. Likewise, there were no "computational errors" in CMS's determination of payment rates for LTCHs. *Id*. at 29. The LTCH reimbursements are based on CMS's reasoned analysis and its proper application of Medicare payment policy pursuant to statutory requirements and broad authority conferred by Congress. Once again, the Secretary properly determined that the BNA for site-neutral payments is necessary to maintain budget neutrality within LTCH PPS. Accordingly, Plaintiffs are not likely to prevail on their claims that CMS's decision was arbitrary, capricious, or otherwise in violation of the APA.

**C. Plaintiffs' Procedural APA Claim Is Unlikely to Succeed on the Merits**

Plaintiffs also contend that the Secretary failed to respond adequately to comments on the outlier BNA for site-neutral payments. Mot. at 31-32. The Secretary's response to those comments, however, easily met his obligation to respond to comments.

The D.C. Circuit has recognized that an agency's obligation to respond to comments on a proposed rulemaking is "not 'particularly demanding.'" *Ass'n of Private Sector Colls. & Univs. v. Duncan*, 681 F.3d 427, 441–42 (D.C. Cir. 2012) (quoting *Pub. Citizen, Inc. v. FAA*, 988 F.2d

186, 197 (D.C. Cir. 1993)). "[T]he agency's response to public comments need only 'enable [courts] to see what major issues of policy were ventilated . . . and why the agency reacted to them as it did.'" *Pub. Citizen, Inc.*, 988 F.2d at 197 (quoting *Auto. Parts & Accessories Ass'n v. Boyd*, 407 F.2d 330, 338 (D.C. Cir. 1968)); *cf. Simpson v. Young*, 854 F.2d 1429, 1435 (D.C. Cir. 1988) ("The agency need only state the main reasons for its decision and indicate that it has considered the most important objections.").

As discussed above, for the past several years, CMS has repeatedly considered comments that the outlier BNA for the LTCH site-neutral payment rate was duplicative of the IPPS outlier BNA and has explained why those concerns are incorrect. *See* Background Section. Plaintiffs' own complaint acknowledges the responses. Compl. ¶¶ 27, 31, 32, 37. Nevertheless, Plaintiffs argue that CMS's response in the Fiscal Year 2019 rulemaking was inadequate because it allegedly did not offer "a substantive response" and did not "explain why the BNA is *not* duplicative" of the IPPS BNA. Mot. at 31-32. Plaintiffs' argument is meritless because CMS's 2019 rulemaking expressly referenced CMS's earlier substantive responses and incorporated the "reasons outlined in [CMS's] response to the nearly identical comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 57308 through 57309) and [CMS's] response to similar comments in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49621 through 49622)." 83 Fed. Reg. 41144, 41738 (AR6005). The APA does not require CMS to reiterate word-for-word the responses given in prior years to nearly identical comments instead of referencing them as it did.

The Secretary's response thus reflects his consideration of the concerns raised by the comments and gives his reasons for disagreeing. It accordingly satisfied his obligation to respond. *See Pub. Citizen, Inc.*, 988 F.2d at 197.

## IV. The Balance of the Equities and the Public Interest Weigh Against Granting a Preliminary Injunction

A party seeking a preliminary injunction must demonstrate "that the balance of equities tips in [its] favor, and that an injunction is in the public interest." *Winter*, 555 U.S. at 20. "These factors merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). Here, they weigh against a preliminary injunction.

Rather than preserve the status quo pending final adjudication, Plaintiffs request a mandatory injunction, demanding that this Court order CMS to change its Medicare reimbursement policy for LTCHs. As discussed before, motions for a mandatory injunction are subject to a higher standard, and the moving party must show "clearly that he or she is entitled to relief or that extreme or very serious damage will result from the denial of the injunction." *Columbia Hosp. for Women Found., Inc.*, 15 F. Supp. 2d at 4; *see also Allina Health Servs.*, 756 F. Supp. 2d at 69. Plaintiffs seek to justify this micromanagement by assuming that they will succeed on the merits of their claims, *see* Mot. at 42-45, but as explained above, they are unlikely to do so.

Plaintiffs also repeat their specious claim that their lost reimbursement purportedly resulting from the BNA "threatens the very existence" of their businesses, Mot. at 42, but that argument fails for the several reasons discussed previously. *See* Section II. Similarly, Plaintiffs assert that "there is a public interest in ensuring that Plaintiffs' LTCHs will remain open and continue to treat Medicare beneficiaries who are critically ill and/or medically complex[.]" Mot. at 44. But Plaintiffs have not established that any hospitals were closed because of the challenged BNA as opposed to the introduction of the site-neutral payment rate or the myriad other factors that Plaintiffs themselves attributed the closures to. In any event, Plaintiffs' own cited documents state that the impacts of LTCH reimbursement policy on LTCHs "are consistent with [Congress's]

policy objectives"[13] in avoiding excessive Medicare reimbursement for LTCH patients who otherwise could be treated safely and efficiently in a lower cost setting, and that the impacts indicate that "the policy does seem to be working as intended."[14] Thus, even if the requested mandatory injunction concerning the challenge BNA could reverse these trends, which it cannot as explained above, the injunction would be inconsistent with public policy. *See Pursuing Am.'s Greatness v. FEC*, 831 F.3d 500, 511 (D.C. Cir. 2016) (stating that an agency's "harm and the public interest are one and the same, because the government's interest *is* the public interest.").

Although Plaintiffs contend that a mandatory injunction would not place any significant burden on Defendant, Mot. at 42, Plaintiffs fail to appreciate the substantial administrative burdens associated with effectuating an abrupt revision of Medicare payment policy. *See Allina*, 756 F. Supp. 2d at 69 (denying motion for preliminary injunction where the "burden of this injunction on the Secretary and the interruption it could cause to [Medicare] payments would be great" because "[t]his is not a dispute over a specific reimbursement or payment, but the method of calculating [part of the Medicare reimbursement that applies broadly]"). Furthermore, if the Court ultimately ruled in the government's favor on the merits, the process of recouping overpayments to LTCHs resulting from a mandatory injunction would similarly impose significant burden on CMS.

Lastly, it is well-established that "a party requesting a preliminary injunction must generally show reasonable diligence." *Benisek v. Lamone*, 138 S. Ct. 1942, 1944 (2018) (denying preliminary injunction in part because "plaintiffs' unnecessary . . . delay in asking for preliminary injunctive relief weighed against their request"). Plaintiffs' excessive delay in seeking relief from the Court not only undermines their claims of irreparable harm, for the reasons discussed above,

[13] MedPAC Slides, *supra* n.5, at 18.

[14] MedPAC Transcript, *supra* n.6, at 47-48.

but it also shifts the balance of equities in favor of Defendant. Plaintiffs should not be granted extraordinary relief in the form of a mandatory injunction after waiting years to seek relief from this Court.

## CONCLUSION

For the foregoing reasons, the Court should deny Plaintiffs' Motion for Preliminary Injunction.

Respectfully submitted,

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**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| NEW LIFECARE HOSPITALS OF CHESTER COUNTY LLC, *et al.*,<br><br>*Plaintiffs,*<br><br>v.<br><br>ALEX M. AZAR II, U.S. Secretary of Health and Human Services,<br><br>*Defendant*. | Civil Action No. 19-00705 (EGS) |

**ORDER**

Upon consideration of Plaintiffs' Application for a Preliminary Injunction, Defendant's response thereto, and the entire record herein, it is hereby **ORDERED** that Plaintiffs' Application is **DENIED**.

It is **SO ORDERED** this ____day of _____, 2019.

_____
United States District Judge