2020 WL 1427919 (N.J.Super.L.) (Trial Order)
Superior Court of New Jersey, Law Division.
Essex County

MHA, LLC f/k/a "Meadowlands Hospital Medical Center,", Plaintiff,
v.
WELLCARE HEALTH PLANS, INC.; Wellcare Health Plans of New Jersey, Inc.; Wellcare of New Jersey Inc.; Wellcare of New York, Inc.; Wellcare of Ohio, Inc.; Wellcare of Florida, Inc.; Wellcare of Kentucky, Inc.; Wellcare of Georgia, Inc.; and ABC Corps. 1-100, Defendants.

No. ESX-L-003949-19.
March 17, 2020.

***1** Civil Action

Order

Honorable Keith E. Lynott, Judge.

This matter coming to be heard on (1) the Defendants WellCare Health Plans, Inc., WellCare Health Plans of New Jersey, Inc., WellCare of Kentucky, Inc., WellCare of New York, Inc., WellCare of Florida, Inc. and WellCare of Georgia, Inc.'s (the "Defendants"') Motion to Dismiss for Failure to State a Claim and (2) the Defendants WellCare of New York, Inc., WellCare of Florida, Inc. and WellCare of Georgia, Inc.'s Motion to Dismiss for Lack of Personal Jurisdiction; the Court having considered papers submitted by the parties and heard oral argument; for reasons stated in the accompanying Statement of Reasons; and for good cause shown,

IT IS on this 17 day of March, 2020,

ORDERED that the motion to dismiss for lack of personal jurisdiction is denied without prejudice; and it is further

ORDERED that the Plaintiff may conduct limited discovery as to the issue of in personam jurisdiction over the Defendants WellCare of New York, Inc., WellCare of Florida, Inc. and WellCare of Georgia and the Court will hold a telephonic case management conference on April 14, 2020 at 10:30AM to establish a basis for this discovery and renewal of the Defendants' motion (if desired); and it is further

ORDERED that the motion to dismiss for failure to state a claim is denied; and it is further ORDERED that a copy of this Order shall be served on all Counsel and parties within seven (7) days of the date thereof.

<<signature>>

The Honorable Keith E. Lynott

Statement of Reasons

In this action alleging underpayments of bills for medical services, the Defendants WellCare Health Plans, Inc., WellCare Health Plans of New Jersey, Inc., WellCare of Kentucky, Inc., WellCare of New York, Inc., WellCare of Florida, Inc. and WellCare of Georgia, Inc. (collectively, the "Defendants") move to dismiss the Complaint of the Plaintiff, MHA, LLC (the "Plaintiff or "MHA"), pursuant to R. 4:6-2(e). For the reasons set forth herein, the Court denies the motion to dismiss the

Complaint.

The Defendants WellCare of New York, Inc., WellCare of Florida, Inc. and WellCare of Georgia, Inc. (collectively, the "out-of-state Defendants") also move to dismiss the Complaint for lack of personal jurisdiction. The Court denies this motion without prejudice and permits limited jurisdictional discovery as set forth herein.

I

The Court first addresses whether it has in personam jurisdiction over the out-of-state Defendants. The out-of-state Defendants contend that "(1) they are not incorporated in New Jersey; (2) they do not maintain offices in New Jersey; (3) they do not have employees in New Jersey; (4) they do not contract with MHA; (5) they do not contract with any other hospitals or medical providers in New Jersey; (6) they do not solicit plan members in New Jersey; (7) they do not encourage or advise members to seek treatment from non-participating providers; (8) they only offer insurance coverage to individuals that reside outside of New Jersey; (9) they do not pay taxes in New Jersey; (10) they do not hold any New Jersey licenses; (11) they are not registered to do business in New Jersey; (12) they do not have a New Jersey registered agent; (13) they do not maintain a bank account in New Jersey; (14) they do not own property in New Jersey; (15) they do not have a New Jersey telephone number; and (16) they do not have a new Jersey post office box." The out-of-state Defendants argue that, under these circumstances, the Court does not have general or specific personal jurisdiction over them.

***2** The Plaintiff counters that there were sufficient minimum contacts to establish in personam jurisdiction. It contends that the out-of-state Defendants instructed their members to seek pre-authorized and/or emergent medical services at the nearest facility, when their members were outside of their home states. The Plaintiff asserts that there were 30 instances in which MHA rendered medical services to patients insured by WellCare of New York; 8 instances of treatment rendered to patients insured by WellCare of Florida; and 3 instances of treatment rendered to patients insured by WellCare of Georgia. The Plaintiff further alleges that the out-of-state Defendants "sent correspondence to MHA in New Jersey and transmitted (inadequate) payment to New Jersey."

The Plaintiff also contends that WellCare "holds itself out as an integrated national company" and that correspondence and interactions between MHA and the WellCare Defendants were carried out from the parent company's headquarters in Florida. It asserts that the Defendants "cannot… hide behind false divisions between the WellCare family of entities to raise a facile jurisdictional defense." It argues that "[t]here is simply no evidence whatsoever before the Court that these WellCare entities are, in fact, operated as distinct entities."

The Plaintiff further contends that, even if the Court determines on the present record that there are insufficient minimum contacts, the Court should permit the Plaintiff limited jurisdictional discovery before dismissing the Complaint. The Plaintiff argues that "discovery is necessary to determine whether WellCare of New York, Florida and Georgia are subject to jurisdiction as affiliates, agents, or alter egos of the other defendants" that have not moved to dismiss for lack of in personam jurisdiction.

The out-of-state Defendants reply that the Court need not permit limited jurisdictional discovery. They allege that "[t]here is no reason to believe that additional discovery will provide any more information" establishing the Court's jurisdiction over the out-of-state Defendants.

On a motion to dismiss for lack of in personam jurisdiction, the plaintiff is not entitled to a presumption that jurisdiction exists simply because the plaintiff asserts that to be the case. Citibank, N.A. v. Estate of Simpson, 290 N.J. Super. 519, 534 (App. Div. 1996) ("Jurisdictional allegations cannot be accepted on their face if they are disputed"). Courts are not confined by the pleadings in making a jurisdictional determination. Id. at 532. Courts can rely on the pleading together with certifications to resolve a question of in personam jurisdiction. However, "if [a question as to in personam jurisdiction] cannot be resolved on pleadings and certifications, it must be resolved by a preliminary evidential hearing after affording the parties an appropriate opportunity for discovery." Ibid.

New Jersey permits long-arm service of process on a non-resident defendant "consistent with due process of law." R.

4:4-4(b)(l). "[D]ue process requires only that in order to subject a defendant to a judgment in personam, if he be not present within the territory of the forum, he have certain minimum contacts with it such that the maintenance of the suit does not offend 'traditional notions of fair play and substantial justice.'" Lebel v. Everglades Marina. Inc., 115 N.J. 317, 322 (1989) (quoting International Shoe Co. v. Washington. 325 U.S. 310, 316 (1945) (internal quotations omitted)).

In Lebel, the Supreme Court observed that it had in the past "implicitly endorsed the [United States] Supreme Court's 'specific'/'general' jurisdiction dichotomy." Id. at 323 (citing Charles Gendler & Co. v. Telecom Equipment Corp.. 102 N.J. 460 (1986)). The court stated that "[g]eneral jurisdiction subjects the defendant to suit on virtually any claim, even if unrelated to the defendant's contacts with the forum, but is unavailable unless the defendant's activities in the forum state can be characterized as 'continuous and systematic' contacts." Ibid, (quoting Helicopteros Nacionales de Colombia. S.A. v. Hall. 466 U.S. 408,416 (1984)). "With respect to a corporation, the place of incorporation and principal place of business are 'paradig[m]… bases for general jurisdiction.'" Daimler AG v. Bauman, 571 U.S. 117, 137 (2014).

***3** The concept of "specific jurisdiction" enables the Court to exercise jurisdiction over a defendant in a given case only in circumstance in which the action arises out of or relates to the defendant's contacts with the forum State. "The 'minimum contacts' requirement is satisfied so long as the contacts resulted from the defendant's purposeful conduct and not the unilateral activities of the plaintiff." Lebel. 115 N.J. at 323 (quoting World-Wide Volkswagen Corp. v. Woodson. 444 U.S. 286, 297-98 (1980)). "This 'purposeful availment' requirement ensures that a defendant will not be haled into a jurisdiction solely as a result of 'random,' 'fortuitous,' or 'attenuated' contacts." Ibid. (quoting Burger King Corp. v. Rudzewicz. 471 U.S. 462, 475 (1985) (internal quotations omitted); World-Wide Volkswagen, 444 U.S. at 299). "The question is whether 'the defendant's conduct and connection with the forum State are such that he should reasonably anticipate being haled into court there." Id. at 324 (quoting World-Wide Volkswagen, 444 U.S. at 297). "Of course, the mere foreseeability of an event in another state is not a sufficient benchmark for exercising personal jurisdiction." Ibid. (quoting Burger King, 471 U.S. at 474 (internal quotations omitted)).

In Baanyan Software Services. Inc. v. Kuncha, 433 N.J. Super. 466, 477 (App. Div. 2013) (internal quotations omitted), the court stated that "the burden is on [the plaintiff] to 'allege or plead sufficient facts' to warrant the court's exercise of jurisdiction, and it must do so by way of 'sworn affidavits, certifications, or testimony.'" However, "once it is established that defendant's activities relating to the action established minimum contacts with the forum state," the burden shifts to the defendant to show that the exercise of jurisdiction does not comport with the "fair play and substantial justice inquiry." The "nonresident defendant who has been found to have minimum contacts with the forum must present a compelling case that the presence of some other considerations would render jurisdiction unreasonable." McKesson Corp. v. Hackensack Med. Imaging. 197 N.J. 262, 278 (2009) (internal citations and quotations omitted).

To support their position, the Defendants cite to Innova Hosp. San Antonio, L.P. v. Blue Cross & Blue Shield of Ga.. Inc.. 995 F. Supp. 2d 587, 596 (N.D. Tex. 2014). There, the plaintiffs provided medical services to three patients enrolled in the defendant's benefit plans. The defendant was a Pennsylvania health insurer. The plaintiffs initiated the action "for the underpayment and/or non-payment of reimbursement amounts pursuant to the terms of various health benefit plans administered by [the defendant]." The plaintiffs asserted causes of action for negligent misrepresentations and promissory estoppel based on the defendant's alleged representation that it would pay the plaintiffs for the services the plaintiffs rendered.

The court held that it did not have personal jurisdiction over the defendant. It stated that "nowhere in Plaintiffs' pleadings are there allegations that [the defendant] Capital's contacts with Texas arose from a decision by Capital to direct its commercial activity at Texas rather than Capital's members' independent decisions to travel to Texas to receive medical services." Id. at 619. The court based its determination on the facts that:

> Capital… only provides insurance coverage for individuals and groups within Capital's twenty-one county service area in Pennsylvania and does not contract with hospitals or medical facilities in Texas … Capital asserts that Plaintiffs are non-participating providers without a contract with Capital, and Capital "do[es] not encourage or advise their members to seek treatment from non-participating providers." Capital also states that any coverage provided to members that seek treatment from non-participating providers "is not intended to expand sales or otherwise develop commercial activity in the forum state" where the non-participating provider is located… Capital also contends that it made the three payments because of Capital's members' respective decisions to seek care from Plaintiffs … in Texas …

***4** [Id. at 619. (citations to record omitted)]

Similarly, in Whittaker v. Medical Mut. of Ohio, 96 F. Supp. 2d 1197, 1198 (D. Kan. 2000), the plaintiff was an employee of a university for which the defendant, located in Ohio, provided health care coverage. The plaintiff moved to Kansas for medical treatment. The defendant terminated the payments because it determined that the treatment sought was not medically necessary. The plaintiff sued the defendant and its agent that processed the plaintiff's insurance claims.

The plaintiff contended that there existed sufficient minimum contacts. The plaintiff alleged that: "(1) [the defendant] agreed to pay for medical care received in Kansas, (2) Payments were made to the Menninger Institute in Kansas; (3) Plaintiff and the Menninger Institute were informed in Kansas that payments would cease; and (4) Medical Mutual used [Blue Cross Blue Shield of Kansas] as its agent to process her insurance claims." Id. at 1200.

The court held that "[the defendant] is obligated to carry out its insurance contracts no matter in which state treatment is sought. Therefore, the fact that [the defendant] acknowledged its obligation to pay under the insurance plan if plaintiff sought treatment in Kansas is not purposeful availment." Id. at 1200; see also Northshore Reg'l Med. Ctr., L.L.C. v. Dill, 94 So. 3d 155, 163 (La. App. 1 Cir. 2012) ("[i]nsurers are obligated to carry out the insurance contract no matter where treatment is sought; therefore, the fact that White Horse acknowledged (through its claims' administrator) its obligation to pay pursuant to the insurance plan if [the insured] sought treatment at NorthShore is not purposeful availment").

The Whittaker court further stated that "payment and notice of nonpayment are not sufficient to establish minimum contacts." Id. at 1200. It reasoned that "[i]t was plaintiff's unilateral decision to seek treatment in Kansas which caused defendants to have to send payments and notice into Kansas. Mail and phone communications sent to plaintiff in the forum state are insufficient to support specific jurisdiction over a nonresident defendant." Id. at 1200-21.

This Court recognizes that none of the cases cited by the Defendants is controlling. However, the Court finds the cases discussed above present facts similar to those here and thus are instructive. The Plaintiff cites to two cases in its Opposition, Lebel, 115 N.J. 317 and Blakey v. Cont'l Airlines, 164 N.J. 38 (2000). Neither case involves a dispute between a patient/provider and an insurance company.

In the case at bar, the Plaintiff did not dispute any fact stated in the Certifications submitted by the out-of-state Defendants. It is thus not disputed that none of the out-of-state Defendants is incorporated in New Jersey, and that none maintains any office or conducts business in New Jersey. See Daimler, 571 U.S. at 137. There is no showing by the Plaintiff that any of the out-of-state Defendants has "continuous and systematic" contacts with New Jersey.

The Plaintiff contends that the Court has specific personal jurisdiction over the out-of-state Defendants because the out-of-state Defendants advised - even encouraged - their members to seek pre-authorized and/or emergent medical services at the nearest facility, when outside of their home states. It argues that the Plaintiff was in direct contact with representatives of each of the out-of-state Defendants when it rendered services to patients insured by them. It asserts that the out-of-state Defendants "sent correspondence to MHA in New Jersey and transmitted (inadequate) payment to New Jersey."

***5** The Plaintiff cites statements in Medicaid manuals provided by each of the out-of-state Defendants. The cited paragraphs informed the insureds that they would be reimbursed in certain circumstances for services in out-of-state medical facilities.

The language of these manuals reflects the out-of-state Defendants' legal obligation to carry out the insurance contracts with the insureds without regard to where they seek medical treatment. The decision on the part of each patient to seek treatment from MHA in New Jersey was a unilateral one. There is no evidence presented on this record that any of the out-of-state Defendants approved in advance any insured's request to seek medical treatment at Meadowlands Hospital or in New Jersey. Absent further evidence, it appears that the Defendants communicated with and transmitted payment to the Plaintiff in New Jersey solely because of the insureds' unilateral decision to seek treatment in New Jersey.

Given these circumstances, the Court cannot conclude that it has general or specific jurisdiction over the out-of-state Defendants when the Court examines their respective activities individually. It finds the holdings in Whittker and Innova persuasive and on point. As in these cases, the unilateral decisions of the patients to seek treatment in New Jersey are an

insufficient basis on which to exercise jurisdiction over the out-of-state Defendants.

However, the Court's analysis as to in personam jurisdiction does not end here. The Plaintiff also appears to argue that the Court has in personam jurisdiction over the out-of-state Defendants because WellCare holds itself out as an integrated national company and/or the out-of-state Defendants are agents, affiliates, or alter egos of the non-moving Defendants as to which the Court does have in personam jurisdiction.

The Plaintiff cites to Charles, 102 N.J. 460. In this case, the Supreme Court reasoned that "a manufacturer that distributes its products into the stream of commerce for widespread distribution derives both legal and economic benefits from the states in which its products are sold." Id. at 147. It concluded that "the system through which the manufacturer distributes its products evidences the manufacturer's purposeful penetration of the market." Id. at 478-49. It found that "[a] foreign manufacturer that purposefully avails itself of those benefits should be subject to personal jurisdiction, even though its products are distributed by independent companies or by an independent, but wholly-owned, subsidiary." Ibid.

Moreover, the Appellate Division has held that "where appropriate, courts of New Jersey have looked beyond the corporate form to the functional reality behind it… If the disputed facts are resolved sufficiently to provide a basis for holding liable the individual defendants under alter ego theory, their presence for jurisdictional purposes cannot be said to be either unfair or unreasonable. After all, fairness is the essential due process inquiry." Star Video Entertainment, L.P. v. Video USA Associates 1 L.P., 253 N.J. Super. 216, 223-224 (App. Div. 1992). The court also noted that "[i]n the Second Circuit, jurisdiction may be predicated on alter ego theory where plaintiff demonstrates the entities' common ownership plus one's financial dependency, the other's domination/control, or either's failure to observe corporate formalities." Id. at 225 (citing Volkswagenwerk Aktiengesellschaft v. Beech Aircraft Corp., 751 F.2d 117 (2d Cir. 1984)).

***6** The Court concludes that the present record is unclear as to whether any non-moving Defendant is an affiliate, agent or alter ego of any out-of-state Defendant. Additional limited discovery is necessary to establish a record concerning the relationship and operation of the Defendants either as independent entities or as an integrated national company and the extent of the out-of-state Defendants' financial benefits from the non-moving Defendants' activities related to the claims involved in this litigation. See, e.g., Jacobs v. Walt Disney World, Co., 309 N.J. Super. 443, 457 (App. Div. 1998).

The Court notes the alleged facts regarding the processing of the claims and mode of operations of the out-of-state Defendants and of WellCare Health Plans of New Jersey, Inc. -essentially by reliance on the central office in Florida - are sufficient to warrant limited jurisdictional discovery. A showing that the WellCare family of companies operate as an integrated national company could result in attribution of the contacts of the non-moving Defendants, including WellCare Health Plans of New Jersey, Inc., to the out-of-state Defendants.

For these reasons, the Court cannot determine at this time whether or not it has general or specific personal jurisdiction over the out-of-state Defendants on the present record. The Court thus denies the Defendants' motion to dismiss for lack of personal jurisdiction without prejudice. The Court will permit discovery into issues pertaining to in personam jurisdiction, as more fully described herein.

II

As to the Defendants' motion to dismiss the Complaint, a motion to dismiss for failure to state a claim is granted only in rare cases. In Printing Mart-Morristown v. Sharp Elec. Corp., 116 N.J. 739, 772 (1989), the Supreme Court stated that trial courts must accord such motions "meticulous and indulgent examination" and, accordingly, should grant them in only "the rarest of instances." See also Smith v. SBC Communications. Inc.. 178 N.J. 265, 282 (2004) ("The motion to dismiss should be granted only in rare instances and ordinarily without prejudice") (internal quotations omitted).

On a motion to dismiss a complaint pursuant to R. 4:6-2(e), the Court must determine whether "a cause of action is 'suggested' by the facts." Printing Mart-Morristown, 116 N.J. at 746 (quoting Velantzas v. Colgate-Palmolive Corp., 109 N.J. 189, 192 (1988)). The Court is required to examine the complaint "in depth and with liberality to ascertain whether the fundament of a cause of action may be gleaned from an obscure statement of claim." Ibid.

The Court must accept the facts alleged in the pleading as true. See Malik v. Ruttenberg. 398 N.J. Super. 489,494 (App. Div. 2008) (the court must "accept as true the facts alleged in the complaint, and credit all reasonable inferences therefrom"). The pleading party is entitled to "every reasonable inference of fact." Printing Mart-Morristown, 116 N.J. at 746. The Court is "not concerned with the ability of plaintiffs to prove the allegation contained in the complaint," but merely with "the legal sufficiency of the facts alleged on the face of the complaint." Ibid.

The examination of the complaint "should be one that is at once painstaking and undertaken with a generous and hospitable approach." Ibid; see also Piscitelli v. Classic Residence by Hyatt. 408 N.J. Super. 83, 103 (App. Div. 2009) (the court must review the complaint with "a generous and hospitable approach") (internal quotations omitted). The Court must "search the complaint in depth and with liberality" to identify the causes of action asserted. Lieberman v. Port Auth, of N.Y. & N.J.. 132 N.J. 76, 79 (1993) (internal quotations omitted). In addition, "[a] complaint should not be dismissed under this rule where a cause of action is suggested by the facts and a theory of actionability may be articulated by way of amendment." Rieder v. State Dep't of Transp., 221 N.J. Super. 547, 552 (App. Div. 1987).

***7** In examining a motion to dismiss, "the inquiry is confined to a consideration of the legal sufficiency of the alleged facts apparent on the face of the challenged claim." Ibid. (internal quotations omitted). "The court may not consider anything other than whether the complaint states a cognizable cause of action." Ibid. (internal quotations omitted). Thus, the Court may not examine materials extrinsic to the complaint itself in adjudicating a motion to dismiss. However, an exception exists for exhibits attached to the complaint, matters of public record and materials that the plaintiff relies upon in the complaint or that are integral to the plaintiff's claims. See Banco Popular N. Am. v. Gandi, 184 N.J. 161, 183 (2005) ("In evaluating motions to dismiss, courts consider allegations in the complaint, exhibits attached to the complaint, matters of public record, and documents that form the basis of a claim") (internal quotations omitted).

The Rules of Court require only that a pleading contain "a statement of facts on which the claim is based, showing that the pleader is entitled to relief, and a demand for judgment for the relief to which the pleader claims entitlement." R 4:5-2. The purpose of a pleading is not to provide a complete recitation of every possible fact or argument available, but to fairly apprise the adverse party of the claims and issues to be raised at trial. See Dewey v. R.J. Reynolds Tobacco Co., 121 N.J. 69, 75 (1980) ("Although more by way of facts regarding the design defect would have been enlightening, see Rule 4:5-2, we agree with the Appellate Division's finding that '[t]o the extent that plaintiff's complaint was deficient, the judge properly looked to the entire record, giving plaintiff every favorable inference,' 225 N.J. Super. at 382 n.5, and that the trial court had correctly concluded that the complaint was sufficient to support a claim of design defect").

III

The Court draws the pertinent facts from the Complaint. It accepts as true the averments of the Complaint solely for purpose of the pending motion to dismiss. As required by the case law, the Court examines the Complaint in depth and in its entirety and with a generous and hospitable approach.

The Complaint contains 92 separate paragraphs and seven separate counts stating causes of action for relief. The Plaintiff seeks relief for "over a thousand" Open Patient Accounts as set forth therein (the "Open Patient Accounts"). The Complaint incorporates a list of the disputed patient accounts, identifying the patient's ID number, the dates of admission and discharge, the amounts of total charges and balance. The Plaintiff alleges that "millions of dollars [] is owed by defendants to plaintiff."

MHA is "a privately held, limited liability company, organized under the laws of the State of New Jersey." It owned Meadowlands Hospital until December 2017 when its assets were sold pursuant to an Asset Purchase Agreement ("APA"). Pursuant to APA, Meadowlands "retained all receivables related to patient care prior to the date of the change of ownership including those receivables which are the subject of this litigation."

Meadowlands Hospital was a licensed general acute care hospital. It was "an out-of-network, or non-participating, healthcare provider, with respect to defendants, and provided emergency or preapproved non-emergency, medically necessary hospital and medical services to many patients who, at all relevant times, were covered under healthcare plans sponsored, funded,

operated, controlled and/or administered by defendants."

The Complaint alleges that the Defendants "sponsored, funded, operated, controlled and/or administered Medicaid and Medicare plans, and provided coverage to certain of Meadowlands' patients as identified [in the Complaint]." The Plaintiff alleges that WellCare "has issued gross underpayments or no payment for the services rendered, and has engaged in a systematic pattern of downgrading and underpaying for the services rendered by the hospital."

***8** The Court notes that this is a direct action by the provider against the respective payers. As averred in the Complaint, the Plaintiff is suing in its own capacity as a provider and not in a derivative capacity as a holder of assignments from the patients/subscribers to the Defendants' healthcare plans.

The Plaintiff asserts that it "rendered Medicaid and Medicare emergency and non-emergency pre-approved, medically necessary hospital and medical services - including inpatient, outpatient and same day surgeries" through ownership of Meadowlands Hospital. The Plaintiff alleges that "[a]fter rendering the services reflected in the Open Patient Accounts, [it] timely filed clean claims for reimbursement with WellCare." It then identifies four circumstances in which the Defendants refused to issue proper payment after the Plaintiff submitted the claims for reimbursement.

In some instances, "[p]rior to rendering several of the services reflected in the Open Patient Accounts, [the Plaintiff] had contacted [the Defendants] to request, and was provided by [the Defendants], pre-authorization and/or pre-certification to render the services. [The Plaintiff] then relied on said pre-authorization and/or pre-certification, as [the Defendants] intended, in agreeing to render the services." However, the Defendants eventually refused to issue proper payment.

In other cases, "[the Defendants] advised [the Plaintiff] prior to rendering services that pre-authorization/pre-certification was unnecessary, or the services were emergent or urgent, thereby not requiring pre-authorization/pre-certification." The Defendants then refused to issue payment.

In still other cases, "[the Defendants] indicated through word and deed that there was coverage for an initial treatment and in fact, paid for such treatment, but without notice refused to provide reimbursement for subsequent, related treatment, which should have been covered and is subject to the continuing care provision of WellCare's plans." As to other accounts, "upon receiving [the Plaintiff]'s bill, [the Defendants] agreed to reimburse [the Plaintiff] for the services rendered. However, inexplicably [the Defendants] ha[ve] since refused to honor [the] payment agreement or failed to reimburse [the Plaintiff] the proper amount."

The Plaintiff alleges that the Defendants engaged in a "systematic practice of downgrading coverage by a variety of nefarious methods including, without limitation, downcoding and bundling of claims submitted by plaintiff, as well as the issuance of coverage denials to patients. WellCare did this without the benefit of sufficient medical or clinical information or consultation with the attending physicians, and often without consultation with the attending physicians at all."

The Plaintiff asserts that, under New Jersey law, statutes and regulations, "defendants are required to make payment to plaintiff within the time period set forth in the Healthcare Information Networks and Technologies Act ("HINT") and the Health Claims Authorization, Processing and Payment Act ("HCAPPA")… [and] 12% annual interest is due to plaintiff for late paid claims." It further alleges that the Plaintiff is "entitled to payment based on its usual, customary and reasonable ("UCR") fees." It also claims that it has "exhausted defendants' appeal process by filing repeated and numerous unsuccessful appeals for many of the claims."

***9** The Plaintiff contends that "[a]ll of the subject claims averred herein arise from New Jersey state common, statutory and regulatory law and not from any purported preemptive federal law or statue." It alleges that "[n]or do any of plaintiff's claims give rise to federal subject matter jurisdiction on any basis."

The First Count of the Complaint purports to state a claim for breach of an implied contract between the Plaintiff and the Defendants. It asserts that the Defendants indicated by a course of conduct, dealings and circumstances surrounding the relationship to the Plaintiff that they would pay for hospital and medical services, including emergency services, provided to the Defendants' insureds. The Plaintiff asserts that the Defendants represented that their members and beneficiaries were covered for out-of-network treatment and/or emergency care. The Plaintiff avers that the Defendants received premiums from

those patients for out-of-network emergency healthcare coverage and the services of the Plaintiff were necessary to satisfy the needs of the patients.

The First Count further avers that the Defendants indicated through a course of conduct, dealings and circumstances surrounding the relationship that they would pay the Plaintiff its UCR amounts based upon what other healthcare providers of the same specialty and the same geographic area charge for services rendered by them. It alleges that the Defendants indicated by a course of conduct, dealings and circumstances surrounding the relationship that they would honor representations to the Plaintiff that the services rendered were pre-authorized or pre-certified or that preauthorization was not required due to the need for urgent or emergent care. The Plaintiff asserts that it rendered medically necessary surgical and medical services to the patients whose open accounts are the subject of the action and reasonably expected the Defendants to "pay for them appropriately."

The Second Count of the Complaint purports to state a claim for breach of the implied covenant of good faith and fair dealing contained in the alleged implied contract. It alleges that the Defendants acted with an improper motive and "injured" the Plaintiff's rights and benefits under such contract.

The Third Count purports to state claims for unjust enrichment and quantum meruit. The Complaint alleges that the Defendants refused to pay the Plaintiff the correct amounts for the surgical and medical services provided to the patients identified in the Complaint, which patients were covered under plans sponsored, funded, insured and/or administered by the Defendants. The Plaintiff alleges such refusal was contrary to the insurance provided by the plans, and to common law, statutory and regulatory obligations of the Defendants.

The Count alleges that the Defendants needed the Plaintiff to render hospital and medical services, including emergency and urgent medical care, to such patients in order to satisfy the Defendants' legal obligations to the patients. The Plaintiff asserts that, as a result of the services the Plaintiff provided, the Defendants have received and retained a benefit because the Plaintiff rendered hospital and medical services for which the Plaintiff has been grossly underpaid. The Plaintiff alleges the Defendants were unjustly enriched by use of funds that they should have paid to the Plaintiff.

***10** The Fourth Count asserts a claim for promissory estoppel. This Count alleges that the Defendants made promises to the Plaintiff that they would afford proper coverage for hospital and medical care to members of their plans, including by pre-authorizing or pre-certifying services or paying for initial care. The Count asserts the Defendants subsequently refused to pay when the Plaintiff submitted its bills. The Plaintiff avers that the Defendants expected or reasonably should have expected MHA to rely on such assurances and MHA did so to its "definite and substantial detriment."

The Fifth Count alleges a claim for negligent misrepresentation. It asserts that the Defendants negligently represented that they would provide proper coverage to the patients at issue and pay the Plaintiff's claims for reimbursement at the UCR rates, including by way of preauthorization or precertification or by paying for initial care. The Plaintiff avers that the Defendants materially misrepresented that their plans entitled the patients to receive coverage for the hospital and medical services provided by the Plaintiff. The Plaintiff asserts that such representations were false. This Count alleges that the Plaintiff reasonably relied on such representations to the Plaintiff's "substantial detriment," as it provided hospital and medical care to the patients and the Defendants, contrary to such representations, subsequently refused payment for bills submitted by the Plaintiff.

The Sixth Count purports to state a claim for tortious interference with economic advantage. The Plaintiff alleges a reasonable expectation of economic advantage arising from the patient/provider relationship. This Count alleges that the Defendants knew or reasonably should have known of the Plaintiff's expectation of economic advantage and that the Defendants wrongfully interfered with such expected economic benefit in circumstances in which it is reasonably probable that the Plaintiff would have realized the benefit.

The Seventh Count purports to state a claim under the Healthcare Information Networks and Technologies Act, as amended by the Health Claims Authorization Processing and Payment Act. It asserts that such laws and the regulations promulgated thereunder establish a time period (30 to 40 days) within which a payor must either pay or challenge a provider's bills. The Plaintiff asserts that, under such laws and regulations, it has a private right of action to prosecute claims for the Defendants' failures to comply with the same by refusing to pay the full amount of charges submitted by the Plaintiff.

The Plaintiff alleges that the Defendants "as a matter of practice and/or policy delayed payment of properly submitted claims from plaintiff and did not pay the claims correctly, and then did not pay interest on delayed payments." It also asserts that under HCAPPA, "[a]ll overdue payments must bear simple interest at the rate of twelve (12) percent per annum, pursuant to HCAPPA."

IV

The Defendants contend that, because the Plaintiff ultimately seeks to recover for "underpayment" of Medicare reimbursement claims, the Plaintiff's cuases of action are preempted by the federal Medicare statute and implementing regulations. They also allege that the Court should dismiss the Medicare-related claims set forth in the Complaint, because the Plaintiff failed to "exhaust the exclusive federal administrative process required under the Medicare Act," citing to 42 U.S.C. § 405(g)-(h) and 42 U.S.C. §§ 1395ii, 1395w-22(g)(5).

The Defendants argue that the Medicare statute and regulations include a preemption provision, which expressly "supersedes all state laws that otherwise would apply, with the exception of licensing and plan solvency laws." In particular, the Defendants assert that the Medicare statute preempts the Plaintiff's First through Sixth Counts, as the statute prescribes the Medicare rates. They assert that the Medicare statute preempts the Seventh Count, as the statute and regulations address the timing of payments, citing to 42 C.F.R. § 422.520.[1]

***11** The Defendants further contend that both federal and state law cap the payments to the Plaintiff for emergency services rendered to the Medicaid enrollees and that the Court should dismiss the Plaintiff's Medicaid claims for emergency services seeking payment of amounts greater than the Medicaid-prescribed rate. Examining each Count of the Complaint separately, the Defendants further contend that the Plaintiff has failed in each instance to state a claim upon which relief can be granted.

The Plaintiff contends that there is a heightened presumption against preemption. It asserts that the Defendants "attempt[] to assert a fact-sensitive, affirmative defense." It states that "at this procedural posture, defendants' preemption defense is premature and must await summary judgment."

The Plaintiff argues that Medicare preemption is not a complete preemption scheme. Instead, preemption only operates to bar a state law claim if it interferes with a Medicare "standard." The Plaintiff asserts that the common law claims alleged in the Complaint do not interfere with a Medicare "standard."

The Plaintiff avers that the alleged cap on recovery does not warrant dismissal of the Plaintiff's claims. It contends that, at minimum, the Court needs to determine and compare the payment it received with the payment permitted under the Medicare statute as the Plaintiff, in at least some cases, seeks only the amount to which it was entitled under the Medicare fee schedule. Moreover, the Plaintiff argues that the Defendants "ha[ve] undertaken duties above and beyond those of the Medicare Act by its course of conduct and representations" and that Medicare preemption does not operate to bar claims grounded in such duties.

The Plaintiff also counters that failure to exhaust the established administrative process is an affirmative defense and that the Defendants must prove entitlement to this defense. MHA argues that it is premature for the Court to determine the issue at this juncture. Moreover, the Plaintiff alleges that 42 U.S.C. § 405(g) applies to enrollees, not health care providers. It contends that the Medicare Act does not provide a procedure for resolving disputes between the health care providers and Medicare plan sponsors and, in all events, does not operate to bar state law claims lodged in a state court.

The Court first addresses the issue of exhaustion of administrative remedies and related procedures. The Court concludes it cannot determine the issue at this stage of the litigation. Exhaustion of remedies is an affirmative defense as to which the Defendants bear the burden of proof. Even granting that the Plaintiff was or is required to exhaust administrative remedies and assuming the Plaintiff is required to plead exhaustion, the Plaintiffs Complaint alleges that it has done so.

Although the Defendants assert that the Plaintiff's averment as to exhaustion is limited to internal administrative appeals and

overlooks the administrative remedy and procedures prescribed by federal law, the Court is required to examine the pleading indulgently. The Plaintiff also pleads that further invocation of administrative remedies would be futile. This is a recognized exception under New Jersey law to the obligation to exhaust. Nothing more is exigible of the Plaintiff at this juncture.

The Medicare statute has been described as "among the most completely impenetrable texts within human experience," requiring "dense reading of the most tortuous kind." Rehab. Ass'n of Virginia. Inc. v. Kozlowski, 42 F.3d 444, 1450 (4th Cir. 1994). At its enactment, Medicare consisted of only two parts, Parts A and B. Under "traditional" Medicare, the federal government paid health care providers directly for services rendered to Medicare beneficiaries. 42U.S.C. §§ 1395c-1395i-5 (Part A), 1395j-1395w-6 (PartB). Congress authorized Part D of the Medicare Act in 2003, which provides for prescription drug coverage for Medicare enrollees. 42 U.S.C. §§ 1395w-101-154. Part E consists of "miscellaneous provisions." 42 U.S.C. §§ 1395x-lll.

***12** Part C of the Medicare Act, enacted in 1997, creates the Medicare Advantage program. 42 U.S.C. §§ 1395w-21-29. Under Part C, Medicare enrollees can receive Medicare benefits through private organizations called Medicare Advantage Organizations, or "MAOs," instead of the government. Id. The government pays MAOs monthly fees in exchange for assuming the risk of providing covered services to enrollees. 42 U.S.C. § 1395w-23. The amount that MAOs receive per enrollee is based on contracts with the Centers for Medicare and Medicaid Services ("CMS"), an agency within the United States Department of Health and Human Services. 42 U.S.C. § 1395w-27.

MAOs contract with certain health care providers to provide Medicare services in a manner akin to "in-network" arrangements of private healthcare insurers. 42 U.S.C. § 1395w-22(d)(1). However, MAOs must also provide coverage for emergency services without regard to the emergency care provider's contractual relationship with the MAO. MAOs reimburse non-contracting providers who provide these emergency services based on rates set by the Medicare Act and related regulations. See 42 C.F.R. § 422.214(a) (payments limited to what "the provider would collect if the beneficiary were originally enrolled in Medicare").

42 U.S.C. § 405(h), made applicable to the Medicare Act by 42 U.S.C. § 1395ii, provides that § 405(g) is the sole avenue for judicial review of all "claims arising under" the Medicare Act. See Heckler v. Ringer. 466 U.S. 602, 614-615 (2013). 42 USCS § 405(g) provides that:

> Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the District Court of the United States for the District of Columbia [United States District Court for the District of Columbia]…

42 USCS § 405(h), in turn, provides that:

> (h) Finality of Commissioner's decision. The findings and decisions of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28, United States Code [28 USCS § 1331 or 1346], to recover on any claim arising under this title [42 USCS §§401 et seq.].

[Emphasis added.]

Under § 405(g), a final decision of the Secretary of Health and Human Services ("Secretary") may be reviewed by a federal court. Regulations promulgated by the Secretary, see 42 U.S.C. § 1395hh, indicate that a final decision is issued only after a case has progressed through all levels of administrative review provided for each Part of the Medicare Act. See 42 C.F.R §§ 405.701-405.753 (reconsideration and appeals under Part A); 42 C.F.R. §§ 405.801-405.877 (appeals under Part B); 42 C.F.R. §§ 422.560-422.626 (grievances, organization determinations, and appeals under Part C).

***13** 42 CFR § 405.906, titled "Parties to the initial determinations, redeterminations, reconsiderations, hearings, and reviews," limits the administrative appeals process for Medicare Part A and Part B claims to "[a] provider of services who files a claim for items or services furnished to a beneficiary." A "provider" means "a hospital… that has in effect an agreement to participate in Medicare, or clinic …" 42 CFR § 405.902.

There is no dispute that the Plaintiff does not have a contract with the Defendants to participate as a provider in the Medicare program. The Plaintiff alleges in the Complaint that it is "an out-of-network, or non-participating, healthcare provider, with respect to defendants." Therefore, as to Medicare Part A and Part B claims, if any, the Plaintiff is not subject to the administrative process, as it cannot appeal through this channel.

Federal regulations provide for a separate MAO administrative review process for MAO benefits determinations (or "organization determinations") for Medicare Advantage programs (i.e. Medicare Part C). See 42 C.F.R. §§ 422.582 (first step being request for MAO reconsideration), 422.592 (second step being appeal to private independent contractor), 422.600 (third step being request for administrative law judge hearing), 422.608 (fourth step being review by Medicare Appeals Council, a division of Health and Human Services). 42 C.F.R. §422.612(b) provides that "[a]ny party, including the MA organization, may request judicial review … of the Council decision if it is the final decision of CMS and the amount in controversy meets the threshold established in paragraph (a)(2) of this section." 42 C.F.R. §422.612(c) further states that "[i]n order to request judicial review, a party must file a civil action in a district court of the United States in accordance with section 205(g) of the [Social Security] Act [i.e. 42 U.S.C. § 405(g)]."

As to step one, it appears that a provider, such as the Plaintiff, can appeal for MAO reconsideration. 42 C.F.R. § 422.582(d) provides that "[t]he parties to the reconsideration are the parties to the organization determination, as described in § 422.574, and any other provider or entity (other than the MA organization) whose rights with respect to the organization determination may be affected by the reconsideration, as determined by the entity that conducts the reconsideration." It is clear that the Plaintiff's right to reimbursement will be affected by the reconsideration. As to steps two, three and four, 42 CFR §§ 422.592(c), 422.600 (a) and 422.608 permit the same parties to MAO reconsideration to appeal under these provisions.[2]

In order to assess whether a provider such as MHA must exhaust the administrative remedies established by the Medicare Act, the Court must first determine if its claim "arises under" the Medicare Act. A claim "arises under" the Act, if "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act, Ringer, 466 U.S. at 606 (quoting Weinberger v. Salfi, 422 U.S. 749, 760-61 (1975)), or if the claim is "inextricably intertwined" with a claim for Medicare benefits, see id. at 623; see also Affiliated Prof 1 Home Health Care Agency v. Shalala, 164 F.3d 282, 286 (5th Cir. 1999) (finding that even though claims were presented as constitutional claims, they were inextricably intertwined with a claim of entitlement to Medicare benefits and thus subject to the exhaustion requirements of the Medicare Act); see also Trostle v. Ctrs. for Medicare & Medicaid Servs., 709 Fed. Appx. 736, 739 (3rd Cir. 2017).

***14** In Prime Healthcare Huntington Beach. LLC v. SCAN Health Plan. 210 F. Supp. 3d 1225 (C.D. Cal. 2016), the court noted that federal courts have reached different results as to the exhaustion issue in cases presenting facts similar to the facts here. The plaintiffs were non-contract providers seeking reimbursement by the defendant for care provided to the defendant's members "based on [the plaintiffs'] reasonable and customary rates." The plaintiffs brought claims under state contract law. The court stated that:

> Most courts forego the 'standing and substantive basis' test in favor of the 'inextricably intertwined' test where plaintiffs do not invoke Medicare in their complaints, as is the case here. See, e.g., [Do Sung Uhm v. Humana. Inc., 620 F.3d 1134, 1142 (9th Cir. 2010)] (holding that claims formulated under sources of law other than Medicare can nevertheless be "inextricably intertwined" with Medicare). Some of these courts have concluded that claims brought by providers against

> MAOs are not "inextricably intertwined" with claims for Medicare benefits. See, e.g., Ohio State Chiropractic Association v. Humana Health Plan Inc., 647 F. App'x 619 (6th Cir. 2016) (opining in dicta that a non-contracting provider did not need to exhaust administrative remedies because its state-law claims against an MAO arose from a "private billing dispute," no beneficiary was denied benefits or reimbursement, and no one contested whether Medicare covered the provided services); RenCare, Ltd. v. Humana Health Plan of Texas, 395 F.3d 555 (5th Cir. 2004) (holding that a contracting provider's claims for reimbursement from an MAO did not 'arise under' Medicare because no enrollees sought benefits, the government had no financial interest in the case, and the dispute was between the provider and MAO).
>
> [Id. at 1232.]

The Prime Healthcare court dismissed the complaint. It held that "[a]ll of [the plaintiffs'] claims aim directly at reimbursement for alleged shortfalls for Medicare benefits calculated by [the defendant] under Medicare, disguised as claims for reimbursement under state law. Plaintiffs have neither alleged that they have exhausted administrative remedies nor alleged that they meet the conditions for waiver of exhaustion." Id. at 1234. It further stated that "[t]he fact that providers, and not just enrollees, can request and appeal MAO determinations supports this interpretation of the concept aimed at by Heckler." Id. at 1232.

In contrast, in RenCare, 395 F.3d 555, the court noted that, because the providers' claims were based on state law, the standing and substantive basis for its claims is clearly not the Medicare Act. Thus, the provider must exhaust its administrative remedies and appeal the resulting administrative decision in federal court only if its claims are "inextricably intertwined" with a claim for Medicare benefits.

The court determined that a review of relevant case law and Medicare regulations revealed that the provider's claims fell outside of the category of cases that arise under the Medicare Act. It reasoned that that there were no enrollees seeking Medicare benefits. Id. at 558. Furthermore, "the government ha[d] no financial interest in the … case because it [had paid the MAO] a flat rate each month for [its] services to … enrollees, regardless of the services it renderf[ed] to … beneficiaries." Ibid. It noted that "[i]rrespective of who ultimately prevails, the government will not receive or pay out funds." Ibid. Instead, it found that "the dispute [wa]s solely between [the MAO] and [the provider] and [was] based on the parties' privately-agreed-to payment plan." Ibid.

***15** The court further determined that the administrative appeals mechanism for Part C of the Medicare Act excluded claims such as those of the provider. It held that "it appears that the administrative review process attendant to Part C does not extend to claims in which an enrollee has absolutely no interest." Id. at 559. It further noted that "there is a complete absence of [enrollees's] beneficiary interest in this dispute. The only interest at issue is [the provider's] interest in receiving payment under its contract with [the MAO]." Ibid.

When the Court examines the statutory and regulatory scheme in relation to the circumstances here, it concludes it cannot and should not determine at this time whether the Plaintiff's claims are subject to the requirement of exhaustion of administrative remedies. As an initial matter, it is not clear from the Complaint which of the Open Patient Accounts are Part A or Part B claims and which are Part C-related claims. Although it is logical to suppose that most or all of the claims are Part C, there is no administrative process available to MHA for Part A or Part B claims comprising the Open Patient Accounts.

The Court further finds there should be a more complete record on which to determine if the Plaintiff's claims "arise under" the Medicare Act, requiring exhaustion as to the Part C claims - that is, whether MHA's claims are "inextricably intertwined" with the Medicare statute. The Court notes that the Plaintiff is suing in a direct capacity. In connection with the Part C claims, here as in RenCare there is no enrollee that claims benefits and the government has no interest in the outcome.

Moreover, the Plaintiff asserts a right to reimbursement under various legal theories that, so it contends, arise from independent legal obligations under state law to pay the Plaintiff's UCR charges for services provided to the Defendants' enrollees. It alleges such obligations arise from an independent, implied-in-fact contract, or from quasi-contract, based on an independent promise or obligation to pay for a benefit conferred. It also avers that its legal rights arise from negligent misrepresentations of the Defendants as to the coverage afforded to the plan enrollees. Thus, even though there is no express contract right, as was present in RenCare, there is an alleged implied contract right of reimbursement that allegedly governs

the amount to be paid.[3]

In the circumstances, the Court concludes it is necessary to have a more complete record before determining whether any or all of the Plaintiff's claims are eligible for the administrative appeals process, "aris[e] under" the Medicare statute, and are ultimately subject to the requirement of exhaustion of administrative remedies. Before the Court were to determine these claims must proceed through the federal administrative process and ultimately to a federal court, it must first be in a position to examine the specific nature, terms and content of the parties' course of dealings and the representations and promises made to MHA. If, as alleged, promises of payment were made without regard to the Medicare Act and its regulatory scheme, then the Plaintiff's action would not be "inextricably intertwined" with the Act. The Court thus denies this aspect of the motion without prejudice to the Defendants' right to raise the issue at a later stage of the litigation.

***16** The Court renders a similar conclusion as to the Medicare preemption claim. As the Plaintiff's claims are grounded in state law causes of action sounding in contract and tort and assert obligations or promises of payment independent of the Medicare Act and its regulatory scheme, the Plaintiff's claims may not interfere with a Medicare "standard."

The Court notes that in In re Reglan Litigation, 226 N.J. 315, 329 (2016), the New Jersey Supreme Court stated that, when Congress legislates in a field where states have traditionally exercised their historic police powers, "the preemption inquiry begins with the assumption that Congress did not intend to supersede a State statute unless that was Congress's clear and manifest purpose." This presumption against preemption is especially pertinent here, given the traditional role of States in regulating healthcare. See Freedman v. Redstone, 753 F. 3d 416, 429-430 (3d Cir. 2014).

42 U.S. Code § 1395w-26 provides as follows:

> The **standards** established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.
>
> [Emphasis added.]

In New York City Health & Hosps. Corp. v. WellCare of N.Y., 801 F. Supp. 2d 126, 132 (S.D.N.Y. 2011), the court held that "'the preemption inquiry turns on the specific allegations forming the basis of [the] claims …' [and] focuses on whether the resolution of a common law claim would interfere with federal standards governing MA plans." Ibid. (quoting Do Sung Uhm v. Humana. Inc., 620 F.3d 1134, 1148 (9th Cir. 2010)). It stated that "[f]or purposes of the preemption provision, a standard is a statutory provision or a regulation promulgated under the MMA and published in the Code of Federal Regulations." Ibid. (quoting Med. Card Sys. v. Equipo Pro Convalecencia, 587 F. Supp. 2d 384, 387 (D.P.R. 2008)).

The Defendants rely principally upon provisions of the Medicare Act and implementing rules that cap the payments an out-of-network provider can obtain. The Medicare statute and regulations explicitly list the services for which an MA organization must reimburse a provider, cap the rates for non-participating providers, and include standards for the timing of review and payment of claims. 42 C.F.R. §§ 422.100(b), 422.214(b). The Defendants assert these are "standards" that preempt the Plaintiff's claims.

The preemption provision of the Medicare Act does not bar the Court from applying the Medicare-established rates in connection with the Plaintiff's claims. The Court observes that save for the provisions that cap the payment or govern the timing of payments, the Defendants do not rely upon any specific "standard" that preempts the Plaintiff's various causes of action. Putting aside the exhaustion issue already discussed, it thus appears the Plaintiff's causes of action, insofar as they seek an amount of reimbursement not in excess of the cap, would not be subject to preemption. In this regard, the Court notes that the Plaintiff alleges that, at least as to some of its Medicare-related claims, it is not seeking amounts in excess of the cap, but nonetheless claims it was underpaid. It asserts that, in relation to such claims, the Court needs to determine and compare the payment it seeks with the payment permitted under the Medicare statute. The Court's examination and disposition of such claims in accordance with the Medicare Act and regulations would not interfere with a Medicare "standard."

***17** As to the claims in respect of which the Plaintiff asserts a right to payment of its UCR rates and the same are in excess of the prescribed cap, the Court notes that the Plaintiff seeks such reimbursement on the basis of allegations, accepted as true for purposes of this motion, that the Defendants undertook independent obligations to pay such rates or represented they would

do so. Although it would appear to the Court, given the broad scope and text of the rate capping provision, that it operates to cap the amount of the Plaintiff's payment that the Plaintiff may realize for its services to the Defendants' enrollees, the Court again defers any such determination until it has an adequate record concerning the nature and intent of the alleged undertakings or course of dealings on which the Plaintiff relies.

V

The Defendants contend that, as to all emergency services provided to WellCare's Medicaid members, under both the federal Medicaid statute, 42 U.S.C. § 1396u-2(b)(2)(D), and New Jersey law, N.J.S.A. § 30:4D-6i and N.J.A.C. 10:74-9.1, the Plaintiff is only entitled to the Medicaid rate prescribed in the applicable implementing regulations. The Defendants contend that the Court should dismiss the Plaintiff's causes of action seeking the UCR for emergency services and related hospitalization for Medicaid claims.

The Plaintiff counters that New Jersey permits an insurer and provider to enter into an implied agreement to pay a rate greater than the statutory rate. The Plaintiff further contends that "in any event, WellCare paid less than the statutory rate for emergency services rendered by MHA." The Plaintiff also pointed out at oral argument that further discovery is needed as to which Medicaid claims among the Open Patient Accounts alleged in the Complaint actually involve "emergency services" as defined in § 10:74-9.1(a).

The Court determines that, even granting the federal and state statutes cap the reimbursement the Plaintiff can seek from the Defendants for Medicaid claims, such cap does not warrant dismissal of the Plaintiff's claims. As in the case of the Medicare claims, insofar as the Plaintiff's claim is for underpayment of the prescribed amount of reimbursement, the Court's role will be to compare the Medicaid rate with the amount the Plaintiff seeks. In addition, as New Jersey law also regulates Medicaid claims, this Court is more than competent to apply and interpret the state law.

The Court notes that the parties dispute as to which claims alleged in the Complaint are Medicaid claims involving "emergency services" and whether the Plaintiff is seeking more than what applicable law permits in respect of such services. It will, at minimum, be necessary to determine, on the basis of a more complete record, which claims are potentially subject to the Medicaid cap on "emergency services" and which are not.

Finally, as noted, the Plaintiff is asserting that the Defendants undertook independent obligations to bear the Plaintiff's UCR rates. As previously discussed, the Court concludes that it is more appropriate to address the issue of whether the Medicaid rates apply in such circumstances on a more complete factual record concerning the existence, and specific nature and character of such obligations. The Court thus denies this aspect of the motion without prejudice to the Defendants' right to raise such defense at a later stage of the litigation.

VI

The Defendants also challenge each pleaded cause of action on the basis that the pleading is insufficient to state a cause of action upon which relief can be granted. The Court now surveys each of the pleaded Counts in order to ascertain whether or not the Plaintiff has pleaded facts sufficient to sustain a viable cause of action.

The First Count claims a breach of an alleged implied contract. The Plaintiff alleges that as to each underlying reimbursement claim the Defendants engaged in a course of conduct giving rise to an implied-in-fact contractual obligation to pay the amounts subsequently billed by the Plaintiff based in at least some cases upon the Plaintiff's UCR charges.

***18** The Defendants contend that "MHA does not allege that WellCare ever agreed to pay the alleged UCR such that an implied contract formed. There are no alleged writings or oral statements evidencing such an agreement." The Defendants also assert that "there are no allegations describing the actual amount of any alleged UCR such that WellCare could even

agree to such an amount."

As noted above, the Court must examine the factual contentions of the Complaint in their entirety and with a generous and hospitable approach to the same, as required by Printing Mart-Morristown, 116 N.J. 739. The Court finds that the Complaint alleges that, as to some of the disputed patient accounts, the Plaintiff contacted the Defendants and sought and obtained preauthorization to render the services provided to the subject patients. The Plaintiff alleges an implied-in-fact agreement by which it agreed to perform services in return for the pre-authorized payment of the UCR charges for such services.

The Court concludes the factual allegations of the Complaint, read liberally and in their entirety, are sufficient to state claims for breach of an implied contract as to the underlying disputed accounts. The allegations, if proved, establish a course of dealing between the putative contracting parties, the existence of an implied contract to perform surgical or medical services in return for payment, a flow of consideration, breach of the terms of the implied contract arising from the Defendants' failure to pay the amounts billed and resulting damages.

The mutual assent discernible from the Complaint arises from the factual allegations of the parties' conduct. The Complaint alleges direct communications seeking preauthorization for hospital services to be rendered by the Plaintiff, followed by authorization by the Defendants or a notification that such authorization was not necessary in light of the emergent nature of the services and the legal requirements imposed on both parties. The Complaint alleges a course of dealing by which the Defendants agreed to coverage for the services to be provided. The Complaint alleges performance of the services and demand for payment. The terms of the implied contract alleged involve performance of services in return for payment in many cases of the UCR applicable to the services.

The Court finds the Complaint alleges consideration flowing to the Defendants in connection with the implied contracts as the disputed patient accounts. The Complaint avers that the Defendants accepted premiums on behalf of patients for plans affording such subscribers the right to secure out-of-network services in certain circumstances and that the Defendants were legally obligated under federal and state laws to cover subscribers for emergency services and acknowledged such obligations. The Complaint alleges that, by providing out-of-network emergency and/or pre-authorized services to the Defendants' Medicare/Medicaid enrollees, the Plaintiff enabled the Defendants to satisfy contractual or legal obligations to those individuals and to the Medicare/Medicaid programs. The Court finds that the Complaint contains sufficient factual allegations as to consideration to state a claim as to an implied contract.

Where a complaint alleges sufficient facts to establish the existence of a meeting of the minds as to the rendering of service in return for payment, it is not a quantum leap to conclude that a benefit of this nature is sufficient to establish consideration to support an express or as here an implied-in-fact contract. It is a hornbook principle of contract law that a court will not inquire into the amount or adequacy of consideration to support a determination that a contract exists.

***19** The Court concludes that the Plaintiff has alleged sufficient facts to determine the terms of the alleged implied-in-fact contract, namely a promise to provide out-of-network services, either emergency or pre-authorized non-emergency services, as the case may be, in return for a promise to pay the Plaintiff's charges, including UCR charges. The Complaint also alleges sufficient facts as to each underlying disputed account by detailing the patient's ID number, the dates of admission and discharge, and the amounts of total charges and balance due. The Court thus finds that the Plaintiff's pleading alleges facts from which may be derived the elements of an implied contract, including consideration, and a claim for breach thereof.

The Court finds only that the allegations of the Complaint, viewed liberally, establish the "fundament" of a cause of action for breach of an implied contract, and do so with sufficient clarity and precision to fairly apprise the Defendants of what they allegedly did wrong to permit them to answer and defend. Printing Mart-Morristown, 116 N.J. at 746. Whether on a full factual record the facts will establish a triable claim for the existence of an implied contract and a breach thereof remains a different matter. However, the Court is not concerned at this juncture with the Plaintiff's ability to prove its allegations as to existence vel non of an implied contract through a course of dealing or otherwise.

The Second Count purports to state a claim for a breach of the implied covenant of good faith and fair dealing. Having found that the pleading alleges an implied contract, that contract under New Jersey law perforce contains as one of its implied terms a covenant of good faith and fair dealing. The Plaintiff alleges that the Defendants, imbued with improper motive, breached this covenant of the contract. It alleges sufficient facts beyond the mere breach of the terms of the contract that could support

a finding of breach of the covenant of good faith and fair dealing.

The Defendants contend that the Court should dismiss this Count, because the Second Count is "based on the same alleged breach of contract that MHA asserts in the First Count." The Complaint alleges that the Defendants were engaged in "systematic practice of downgrading coverage by a variety of nefarious methods including, without limitation, downcoding and bundling of claims submitted by plaintiff, as well as the issuance of coverage denials to patients." This conduct is distinguished from the alleged breach of the implied contract by refusing to pay the UCR charges for the pre-authorized/pre-certified services rendered by the Plaintiff.

The Complaint alleges a course of conduct that could support a finding of improper efforts to deprive the Plaintiff of the benefits of the implied contract. Once again, under the Printing Mart-Morristown standard, the Court finds it is possible, on a liberal reading of the Complaint, to glean the fundament of a cause of action for breach of the covenant of good faith and fair dealing from the facts alleged.

The Third Count of the Complaint also purports to state causes of action for unjust enrichment and quantum meruit. The elements of a claim for unjust enrichment are that "[the] defendant received a benefit and that retention of the benefit would be unjust." Castro v. NYT Television, 370 N.J. Super. 282, 299 (App. Div. 2004) (internal quotations omitted). Likewise, to recover under a theory of quantum meruit, a plaintiff must establish "(1) the performance of services in good faith, (2) the acceptance of the services by the person [or the entity] to whom they are rendered, (3) an expectation of compensation therefor, and (4) the reasonable value of the services." Starkey v. Estate of Nicolaysen, 172 N.J. 60, 68 (2002).

***20** The Court concludes that the Complaint states causes of action for unjust enrichment and quantum meruit after examining the Complaint in its entirety under the Printing Mart-Morristown standard. The Defendants dispute the existence of a benefit conferred by the Plaintiff on the Defendants. The causes of action for unjust enrichment or quantum meruit require the Plaintiff to allege that it conferred a benefit upon the Defendants and as to which it would be unjust to permit the Defendants to retain the benefit without remuneration or circumstances in which it reasonably expected compensation for the same. The Defendants assert that any benefit arising from the services provided by the Plaintiff accrued to the patients and not the Defendants.

However, the Court finds that the pleading alleges sufficient facts concerning a benefit conferred on the Defendants. The Complaint alleges the Defendants "were paid premiums by the members for out-of-network and/or emergency services coverage." The Complaint avers that the performance by the Plaintiff of out-of-network emergency or pre-authorized services for the Defendants' enrollees enabled the Defendants to discharge their contractual and/or legal obligations to the Medicare/Medicaid programs and to those enrollees by permitting them to obtain such services. In light of these allegations, the Court finds that, under the Printing Mart-Morristown test, the facts pleaded are sufficient from which to glean the fundament of a cause of action for quasi-contractual relief.

The Defendants cite cases from the United States District Court for the District of New Jersey, none of which are controlling on this Court, in which courts determined that an insurer/payor received no benefit when a provider merely provides a service to an insured. But other courts, typically in cases involving claims grounded in quasi-contract arising from the performance of emergency services, have determined that the payor did receive a benefit from the provider's services - namely, the services enabled the payor to discharge a legal obligation owed to the patient/insured.

One such case is El Paso Healthcare Services v. Molina Healthcare of New Mexico, Inc., 683 F. Supp. 2d 454 (W. D. Tex. 2010). This case is particularly instructive to this Court, as it also involved a managed care organization providing coverage to Medicaid-eligible patients.[4]

***21** In El Paso Healthcare Services, 683 F. Supp. 2d at 461, the court reasoned that "[w]hile it is true that the immediate beneficiaries of the medical services were the patients, and not Molina [the payor], that company *did* receive a benefit of having its obligations to plan members and to the state in the interests of plan members, discharged" (emphasis in original). The court noted that "Molina describes this discharging of obligations benefit as 'incidental,' but the Court finds this benefit material, due to the aforementioned obligations." Ibid. It further observed that "[i]ndeed, Molina's very reason for existence is to ensure that such services are provided to plan members; seeing this core obligation fulfilled is hardly incidental." Ibid.

The court stated that "[i]f these obligations are not deemed material and central to the Medicaid managed care scheme, how is such a system supposed to function?" Id. at 462. It found that "[i]n sum, these discharges were furnished for the benefit of Molina, which enjoyed and accepted them, and Molina even acknowledged as much when it tendered payment for them at a rate it deemed to be proper." Ibid. Referring to the elements of a claim in quasi-contract, the court held that "prongs two and three [requiring a benefit to be conferred upon and accepted by the defendant] have been fulfilled as well as one and four, even though Molina disputes this characterization of the facts." Ibid.

In the Fourth Count, the Complaint purports to state a cause of action for promissory estoppel. The claim for promissory estoppel requires a showing of a clear and definite promise made with the expectation of reliance, reasonable reliance, and substantial detriment. See Lobiondo v. O'Callaghan. 357 N.J. Super. 488, 499 (App. Div. 2003). Here again, the facts set forth in the Complaint considered as a whole - accepted as true under the Printing Mart-Morristown standard - establish a cause of action for promissory estoppel.

The Plaintiff alleges a promise to pay for out-of-network or emergency services delivered as to each disputed patient account. The Complaint alleges the Defendants either gave prior authorization for the services or advised that such authorization was unnecessary. In either event, the Complaint alleges the result of such communication was a promise to pay for the services on which the Plaintiff relied to their detriment.

The Complaint lodges in the Fifth Count a claim for negligent misrepresentation. Karu v. Feldman, 119 N.J. 135, 146-147 (1990), sets forth the elements of a claim for negligent misrepresentation. A plaintiff pursuing such a claim must establish that the defendant committed a negligence misrepresentation of facts or information, that the plaintiff was a reasonably foreseeable recipient of such information, that the plaintiff reasonably relied on the false representations, and that the false statements caused damages.

The Plaintiff's Complaint alleges that, as to the disputed patient accounts, the Defendants falsely advised the Plaintiff of the precertification and/or preauthorization of the treatment and/or the lack of need for the same, and of an agreement or intention to pay for services to be provided to the enrollees, including at the UCR rates. These factual averments sufficiently establish a negligent misrepresentation. The Complaint also sets forth that the Plaintiff reasonably relied on the allegedly false assurances by providing the services on the basis of the same.

The Court finds, contrary to the Defendants' contention, that the Plaintiff has pleaded the circumstances of such misrepresentations as to the disputed patient accounts with the requisite particularity. The Complaint, read as a whole, sets forth the specific nature of the misrepresentation and the approximate time - the dates of admission and discharge - when it was given. The Complaint specifically alleges facts going to reliance on the alleged misrepresentation via allegations of performance of services for each patient/insured. The Plaintiff may, of course, be required in discovery to supply additional pertinent information as to each individual disputed patient account.

***22** The Complaint purports to state a claim in the Sixth Count for interference with prospective economic advantage. To state a claim for tortious interference with prospective economic advantage, a plaintiff must allege a protected interest, including a prospective economic relationship or contract, malice - defined as an intentional interference without justification, a reasonable likelihood that the interference caused the loss of the prospective gain and damages. See Printing Mart-Morristown, 116 N.J. at 751.

The prospective economic advantage alleged here is the economic benefit to be derived from the provider/patient relationship allegedly existing between MHA and the enrollees of the Defendants who sought treatment with MHA. The Complaint alleges facts from which one may glean a claim for interference with such relationship arising from the Defendants' alleged precertification of the services to be rendered or its acknowledgment that precertification was not required for emergency services, followed by their failure or refusal to pay the full amount charged by MHA. The Complaint also sets forth facts supporting a claim that the Defendants acted intentionally, without justification and without proper purpose, at least to some Open Patient Accounts. As noted earlier, the Complaint alleges a "systematic pattern of downgrading and underpaying for the services rendered by the hospital."

The Court concludes that the facts alleged in the Complaint are sufficient to state a claim for tortious interference with prospective economic advantage. It notes that the Defendants assert there can be no claim for an interference with an

economic relationship to which it is an integral party. Although that is so as a matter of law, the Complaint, liberally construed, alleges an independent relationship between the Plaintiff and the patients with which the Defendants tortiously interfered. Whether that proves to be the case upon examination of an appropriate record concerning the nature and character of the relationship among these parties remains to be seen, but this is not a basis for dismissal now.

The Seventh Count alleges an implied private cause of action under the Prompt Pay laws and regulations adopted in New Jersey. Specifically, the Plaintiff alleges that, pursuant to the Health Information Networks and Technologies Act, N.J.S.A. 17B:30-23, 17:48-8.4, 17:48A-7.12, 17:48E-10.1, 17B:26-9.1, 17B:27-44.2 and 26:2J-8.1 and implementing rules at N.J.A.C. 11:22-1 et seq., the Defendants were obligated to pay or contest the Plaintiff's statements within a specified time period. It further alleges that overdue payments bear simple interest under such statutes and regulations of 12 percent per annum. Indeed, N.J.S.A. 17B:27-44.2(d)(9) specifically provides that an overdue payment shall bear simple interest at a 12 percent per annum rate. It further provides that "interest shall be paid to the healthcare provider at the time the overdue payment is made" and that any such amount actually paid shall be credited to any civil penalty assessed for a violation.

Neither the cited regulations nor authorizing statutes provide an express private right of action. Accordingly, the Court must consider whether the Plaintiff is among the intended beneficiaries of the statute or rule, whether there is indicia of legislative intent to establish a private right of action, and whether an implied private right of action advances the statutory regulatory objectives. See R.J. Gaydos Ins. Agency. Inc. v. Nat'l Consumer Ins. Co., 168 N.J. 255, 272 (2001).

***23** The statutory text appears to contemplate a payment of interest directly to the provider and thus the right of the provider to charge and recover the same. The provider, the Plaintiff here, is certainly among the parties whom the statute is intended to protect or benefit, in addition to the protection of the general public interest. It appears the manifest purpose of the statute - prompt payment of uncontested statements and/or prompt notice of billing disputes - would be advanced by finding an implied right of action.

The Court again finds that the Plaintiff has stated a claim for relief under the cited statutory and regulatory framework, and that the statute appears to evince an intention to permit a private right of action for interest at the established statutory and regulatory rate. For the reasons noted above, it denies the Motion to Dismiss in the Seventh Count without prejudice to the right of the Defendants to seek dismissal or summary judgment on the basis of a full record and/or more focused briefing.

Footnotes

1 The Court notes that the Plaintiff does not dispute that Medicare's prompt payment standards preempt a state's own prompt payment laws. The Plaintiff states that it will dismiss Count VII of the Complaint as to those claims involving patients covered by Medicare Part C plans once discovery relating to this issue is completed. The Court thus does not address this issue.

2 MA organizations do not have a right to hearing under 42 CFR § 422.600, but they can appeal under 42 CFR § 422.608.

3 The Plaintiff also argues the administrative remedy effected by federal law operates as a condition precedent to seeking judicial review in a federal court, the jurisdiction of which limited by federal law. It contends this regulatory scheme has no application in a state court, which exercises general jurisdiction. The parties have not extensively briefed this aspect of yhe issue and the Court concludes it is not appropriate to rule on the point without more focused briefing.

4 See also Temple University Hospital. Inc. v. Healthcare Management Alternatives. Inc., 832 A.2d 501, 507-508 (Pa. Super. 2003)("Healthcare retained a benefit in this instance because it did not pay reasonable value for the services rendered. Accordingly, we find that all of the elements of unjust enrichment were established, and that Healthcare's payment of two million dollars did not render the doctrine inapplicable. If we adopted Healthcare's position, entities like Healthcare could pay a fraction of the value of the benefit supplied by health care providers who treat Medicaid recipients and successfully argue that the doctrine of unjust enrichment was not applicable. The very thought of permitting such a result is absurd; payment of less than actual costs in [sic] unreasonable and[,] thus, inequitable"); River Park Hospital. Inc. v. BlueCross Blue Shield of Tennessee. Inc.. 173 S.W. 3d 43, 60 (Tenn. Ct. App. 2002)(In a case involving a emergency services provided by a hospital to a managed care organizations enrollees, the court stated that "we must find a contract implied in law, without the assent of either party, on the basis that it is dictated by reason and justice"); New York City Health and Hospitals Corp. v. WellCare of New York. Inc.. 35 Misc. 3d 250, 257 (N.Y. Sup. 2011)(Citing with approval to El Paso. Temple University and River Park, the court observed that "the three decisions from our sister states are variations on a basic theme—namely, that where, as here, a hospital is required by law to treat patients in an emergency room, an insurance company is unjustly enriched if it fails to pay the hospital in full for the costs incurred in rendering

the necessary treatment to the insurer's enrollees").

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