GV 204523

THE STATE OF TEXAS	§	**IN THE DISTRICT COURT OF**
	§	
v.	§	**TRAVIS COUNTY, TEXAS**
	§	
AMCARE HEALTH PLANS OF TEXAS,	§	
INC. and AMCARE MANAGEMENT, INC.	§	**200th JUDICIAL DISTRICT**

Motion Seeking a Determination of the MedImpact Proof of Claim

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW Jean Johnson, Special Deputy Receiver ("SDR") under contract to the Permanent Receiver of AmCare Health Plans of Texas, Inc., ("AmCare Texas") and AmCare Management, Inc., who files this Motion Seeking a Determination of the MedImpact Proof of Claim and shows:

Summary of the Motion

This is a motion contemplated by Texas Insurance Code Section 443.257 to determine a proof of claim against AmCare Texas filed by MedImpact Healthcare Systems, Inc. ("MedImpact"). MedImpact asserts a claim as a general creditor under a Service Agreement. MedImpact serves as a pharmacy benefits management company. MedImpact entered into a contract with the Texas, Louisiana and Oklahoma AmCare HMOs. [Exhibit "B" to the Jean Johnson Affidavit]. This contract was terminated prior to the liquidation of the HMOs.

MedImpact filed a proof of claim seeking to establish a claim for the total sum of $1,466,504.25. The sum sought arises not only from sums allegedly due from AmCare Texas but also sums due from AmCare Oklahoma and AmCare Louisiana. MedImpact's theory is that

AmCare Texas is liable for claims against all three entities under the terms of the contract in issue.

This response will demonstrate that nothing is due on this agreement to MedImpact. The proof of claim includes billings for sums not within the contract. Further, payments by AmCare Texas have been applied to matters outside the contract. Credits due to AmCare Texas have not been correctly applied. Finally, the theory that AmCare Texas is responsible for AmCare Oklahoma and AmCare Louisiana's losses is flawed. After application of all the appropriate deductions and credits, nothing is owed by AmCare Texas to MedImpact.

Evidence Submitted in Support of the Motion

The Special Deputy Receiver submits her own affidavit as well as the Affidavit of Sharon Griffin in support of her Response.

The Quantum of the Proof of Claim

MedImpact's proof of claim seeks the total sum of $1,466,504.25. [Affidavit of Jean Johnson, paragraph 2, Exhibit "A"]. In the proof of claim, the amount alleged to arise from the Texas HMO's own matters is $265,287.33, with the remainder relating to Oklahoma and Louisiana HMO matters. [Affidavit of Jean Johnson, paragraph 2, Exhibit "A"]. In separate filings with Oklahoma and Louisiana, MedImpact has claimed the following sums:

A. Sum attributable to Oklahoma HMO matters: $750,082.30 [Affidavit of Jean Johnson, paragraph 3-4, Exhibit "A"]; and

B. Sum attributable to Louisiana HMO matters: $325,776.56 [Affidavit of Jean Johnson, paragraph 3-4, Exhibit "A"].

The sums claimed by MedImpact in its filings with Louisiana and Oklahoma were for sums less than the Oklahoma and Louisiana "portions" of the proof of claim filing with Texas, although, in theory, the balances should be directly analogous under MedImpact's theory.

The Service Agreement

The Service Agreement in issue is attached as Exhibit "B" to the Affidavit of Jean Johnson and authenticated in paragraph 3 of that Affidavit. The Service Agreement provides that MedImpact will provide various pharmaceutical benefit services to AmCare Texas. Among the duties imposed upon MedImpact under Article III is the duty to determine whether claims qualify for reimbursement. Section 3.2. Under Article VII, Section 7.3, the agreement provides in pertinent part that "Health plan appoints MedImpact as its exclusive agent for the purpose of negotiating and arranging for rebates on the purchase of prescription drugs and related services from drug manufacturers." Article XI, Section 11.1 provides that MedImpact acts as a fiduciary towards AmCare Texas with respect to the interests of AmCare Texas, and further provides that MedImpact is a "sole and exclusive agent" for the purpose of administering the pharmacy benefit program.

One issue arises in this matter because AmCare Health Plans of Texas, Inc., AmCare Health Plans of Louisiana, Inc., and AmCare Health Plans of Oklahoma, Inc. all signed the same agreement, which purports to use a single defined term for them of "Health Plan."

Section 10.4 of the Service Agreement provides that the choice of law is where the "Eligible Members" reside. Accordingly, each of the three HMOs would have a different choice of law, because each the majority of one's "Eligible Members" resided in its respective state of incorporation.

Article XII, Section 12.1 provides for the term of the Agreement. Section 12.1 provides that in pertinent part that "Termination shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of termination."

Billing under the Service Agreement

Jean Johnson explains in paragraphs 7 and 8 of her Affidavit that MedImpact issued its billings for the business done with a break-down on a state-by-state basis. Paragraph 7 of Ms. Johnson's affidavit sets forth a number of ways in which MedImpact recognized the separation of the three HMOs for billing purposes. Exhibit "E" to Sharon Griffin's affidavit shows that AmCare Management, on behalf of AmCare Texas, made separate payments for AmCare Texas billings. Paragraph 7 of Ms. Griffin's affidavit further explains how the HMO plans had separate termination dates. MedImpact reported the pharmaceutical rebates broken down by HMO, and each HMO was terminated separately.

Argument and Authorities

Standard of Review

Texas Insurance Code Section 443.257 provides that a determination of a proof of claim denial shall be handled by the filing of a motion under Section 443.007 of the Texas Insurance Code. Section 443.007 provides in pertinent part that:

> (e) Any party in interest objecting to the application must file an objection specifying the grounds for the objection not later than the 20th day after the date of the notice of the filing of the application or within another period as the receivership court may set, and must serve copies on the receiver and any other persons served with the application within the same period. An objecting party has the burden of showing why the receivership court should not authorize the proposed action.

In this matter, the Special Deputy Receiver moves for disallowance of MedImpact's claim, and MedImpact bears the burden to show an abuse of the Special Deputy Receiver's discretion.

I. The Texas HMO is Not Responsible for Losses of the Oklahoma and Louisiana HMOs

A threshold issue is whether the Louisiana and Oklahoma sums due may be claimed against the Texas SDR. The contract does not recite that each HMO is responsible for the losses of the other HMOs. Absent such a contractual recital, the portion of the proof of claim MedImpact attributes to the Texas HMO is only $265,287.33. The SDR asserts that the liability of the Texas HMO should be limited to the sums, if any, due from the Texas HMO, which will result in a substantial reduction of the proof of claim.

MedImpact asserts in its proof of claim that the Texas HMO is liable not only for its own contractual payments to MedImpact, but also for the payments due from Louisiana and Oklahoma. MedImpact bases this assertion upon the Service Agreement [See Exhibit "A" to the Jean Johnson Affidavit, the MedImpact proof of claim]. The Service Agreement, dated May 30, 2000, uses the global definition "Health Plan" to refer to all three HMOs. MedImpact's theory is that all three HMOs are therefore jointly and severally liable for the liabilities of any of the HMOs to MedImpact.

MedImpact's position runs aground on the shoals of insurance regulatory law. The regulations applicable to HMOs require Insurance Commissioner approval before an agreement of the type that MedImpact contends for here can be effective. Under 28 TAC 11.301, the HMO must file for approval any matter which is required by 28 TAC 11.204. True and correct copies of 28 TAC §11.301 and its amendments from adoption through the year 2000 are attached hereto

and incorporated herein by reference for all purposes as Exhibits "B" and "B1" through "B10." True and correct copies of 28 TAC §11.204 and its amendments from adoption through the year 2000 are attached hereto and incorporated herein by reference for all purposes as Exhibits "C" and "C1" through "C9." The regulations thus attached show that the key language was in effect when the contract was entered into in 2000.

Under 28 TAC 11.204, the HMO must file with the Insurance Commissioner: "(13) the form of any contract or monitoring plan between the applicant and C) any exclusive agent or agency." This requirement is now codified in the Texas Insurance Code as Section 843.105, but even in 2000 the regulations contained this requirement to be effective.

The Service Agreement in this matter contains the following language in Article VII, Section 7.3: that "Health Plan appoints MedImpact as its exclusive agent for the purpose of negotiating and arranging for rebates on the purchase of prescription drugs and related services from drug manufacturers." Thus, in order for the Service Agreement's terms to be binding pre-approval of the Insurance Commissioner was required. In this instance, MedImpact wishes to bind the Texas HMO to pay debts of the Louisiana and the Oklahoma HMO. Absent pre-approval of this arrangement, the purported agreement cannot be enforced. Accordingly, MedImpact's contract claim arguably fails altogether, but certainly fails as to attempts to impute to the Texas HMO liabilities of the other HMOs. Section 10.12 of the Agreement provides that the agreement must be in compliance with all state and federal regulations, and is subject to amendment by Health Plan unilaterally if the agreement does not comply with appropriate regulations.

The parties themselves did not view the contract as a joint and several liability. MedImpact segregated the billings by HMO, and the termination dates for the HMOs varied

due to AmCare Texas is $142,243.44. If the post-termination improper billings were included, this figure would rise to $247,945. The result is displayed on Exhibit "A" to Ms. Griffin's Affidavit. As Ms. Griffin describes in paragraph 2 and 3 of her affidavit, the result is that MedImpact obtained or seeks reimbursement for numerous payments to persons who had already been terminated from the program. As Ms. Griffin describes in Paragraph 3 and Exhibit "B" of her affidavit, MedImpact had the information that these persons were terminated, but paid their claims anyway.

B. Credit for Dispensing Overcharge—$47,241.75

The Administrative Fee Schedule recites that the retail dispensing fee for pharmacy reimbursement is $2.25. However, for a number of claims, the dispensing fee charged by MedImpact exceeds this sum. The resulting excess dispensing fees are an overcharge of $47,241.75. [See Affidavit of Sharon Griffin, paragraph 4 and Exhibit "C-1" through "C-3"].

C. Credit (Deduction) for Post-9/26 Texas Claim—

A Range from $1,083,328.73 to $1,092,448.47

MedImpact has insisted that it terminated the agreement effective on September 26, 2002, but includes in its proof of claim sums which, according to MedImpact's own claims presentation, date from post-termination. MedImpact's claim should be disallowed as to Texas insureds as to post-termination services. Sharon Griffin's Affidavit points out at paragraphs 5-7 that MedImpact collected $818,478.58 in sums for services rendered post-termination. These assets should be credited to AmCare Texas. MedImpact submitted a substantial number of claims for Texas periods of service after MedImpact's own termination date. These claims must be disallowed, and MedImpact's claims reduced accordingly.

D. Credit (Deduction) for Post-9/26—Louisiana—$90,484.86

The same rationale that results in a disallowance as to post-termination events should apply to all three states. MedImpact has insisted that it terminated the agreement effective on September 26, 2002, but includes in its proof of claim sums which date from post-termination. AS these sums are for post-termination services, and not for run-off of pre-termination, then this gives rise to a further claims reduction. This amount is shown in the Exhibit "E" to the Affidavit of Jean Johnson. Exhibit "E" is a spreadsheet provided by MedImpact which shows sums due by invoice. The last page of Exhibit "E" is the break-down of sums due by state by invoice. Invoices 50553, 50559 and 50560 all relate to post-termination services. Louisiana's portion of these invoices sums to $90, 484.86.

E. Credit for Payments Applied to Post-Termination Services—$818,000

When MedImpact terminated Texas as of September 26, 2002, the conservator protested the termination shortly thereafter. AmCare Texas, in conservation, made payments of $418,000 and $400,000 to MedImpact. MedImpact now claims that the termination applied as of September 26, and yet credited these payments to claims for services after September 26. These payments must be reallocated, because MedImpact had no right to allocate them to time periods after termination, when no payments were due. These payments are authenticated by the Affidavit of Sharon Griffin, paragraph 5.

F. Application of the Deductions and Credits Exceeds MedImpact's Claim Amount

The sum of the foregoing credits and deductions exceeds MedImpact's claims amount, even if MedImpact is entitled to file a claim with Texas for Louisiana and Texas amounts.

After adjustment of the proof of claims for the appropriate deductions, MedImpact's proof of claim must be disallowed.

G. If MedImpact Were Entitled to Bill for Services Provided After Termination, the Texas HMO Would Be Entitled to Credits for Pharmaceutical Rebates Collected

MedImpact contends that it should be able to bill for monies it paid for services rendered after the contract was terminated. As set forth above, the SDR contests this contention, and asserts that MedImpact's claim must be reduced by the amount of any such charges. However, even if MedImpact's claims could be allowed post-termination, MedImpact would be subject to a credit for the pharmaceutical rebates it collected on those claims. The Affidavit of Sharon Griffin sets forth that amount as approximately $122,771 as to Texas claims, with additional sums due in credit as to the other states' claims.

H. The Texas HMO would be entitled to a credit for any sums paid by the other HMO receiverships, and for any offsets and credits established by those receiverships

Apparently, MedImpact is pursuing its claims in all three receiverships. Even if AmCare Texas were required to pay sums due from AmCare Oklahoma and AmCare Louisiana, AmCare Texas would be entitled to credit for any payments made by those HMOs or for any offsets in favor of those HMOs.

Request for Relief

Wherefore, premises considered, Jean Johnson, Special Deputy Receiver under contract to the Permanent Receiver of AmCare Health Plans of Texas, Inc., and AmCare Management, Inc., requests that this Court grant this Motion Seeking a Determination of the MedImpact Proof of Claim, and rule that:

A. the disallowance of MedImpact's claim is affirmed in full; and

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing document has been served on all interested parties in accordance with the Texas Rules of Civil Procedure and TEX. INS. CODE ANN. § 443.007(d) this the 8th day of October, 2008.

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