BEFORE THE
MARYLAND STATE BOARD OF CONTRACT APPEALS

In the Appeal of COPELAND & ASSOCIATES, INC.	)	
	)	
	)	Docket Nos. MSBCA
Under Contract No. IMA/CS-06/88-324	)	1408, 1431 & 1576
	)	

June 17, 1992

Equitable Adjustment - Anticipatory profit is not allowed by the General Procurement Law for work not performed. The Board noted that an exception might exist for willful breach under certain circumstances not present in the instant appeals.

Contract Interpretation - When the meaning of a contract is clear and unambiguous it is inappropriate to consider extrinsic evidence to explain a party's different interpretation of its meaning.

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OPINION BY CHAIRMAN HARRISON AND MR. MALONE

Three final decisions of the Department of Human Resources (DHR) procurement officer are under appeal in these consolidated proceedings regarding the captioned contract between Appellant (sometimes referred to herein as CAI) and DHR and the State Department of Health and Mental Hygiene (DHMH):[1] the decision to terminate Appellant for default for failing to repay a $1.2 million advance by October 31, 1988 (MSBCA 1431); the decision to deny Appellant a fee on the March 29, 1988 backclaim ($609,220)[2] (MSBCA 1408); and the decision to grant damages of $3,175,768 to the State

[1]Appellant is essentially Mr. William C. Copeland operating as Copeland and Associates, Inc. The Respondents are sometimes referred to herein as "State."

[2]Actually $609,219.51. Monetary amounts herein are sometimes rounded to the nearest dollar.

for unrealized budgeted savings for EY 1988 and FY 1989 and asserted reprocurement and project maintenance costs flowing from the alleged default (MSBCA 1576). *Inter alia*, Appellant seeks an adjustment of approximately $40,000,000.00 relating to fees it claims it earned prior to termination or would have earned had the contract not been terminated.

The contract at issue herein was, by its terms, a contract:

> [to] provide the services . . . for the purpose of enabling the maximum number of disabled and potentially disabled General Public Assistance and State Medical Assistance recipients and applicants to receive SSI/DI, Federal MA and other benefits to which they are entitled . . .. During the first 24 months of this Agreement, CONTRACTOR will research the current GPA population and all new applicants and enroll all who are presently or potentially disabled into the Program. A minimum of 6,500 recipients will be screened for eligibility for federal Medical Assistance for the disabled.

Contract, § I(1).

The provision of such services, discussed in more detail below, would reduce State general fund expenditures for medical assistance payments and general public assistance payments. Conversion of persons to Federal Medical Assistance would result in 50% of State medical payments being reimbursed by the Federal Government. Conversion of persons who were general public assistance (GPA) recipients to entitlement to Supplemental Security Income (SSI) and Supplemental Security Disability Insurance (SSDI) would eliminate the State general public assistance payments to such persons as well as automatically entitling such persons to Federal Medical Assistance upon conversion to SSI and a potential for an even greater share of federal entitlements for medical expenses for those on SSDI. The subject services are sometimes herein referred to as the "GPA-SSI Project" or "revenue project" or "DEAP project". Federal financial participation to be gained from such services is sometimes referred to herein as FFP.

Findings of Fact

A. Contract Formation

1. In early 1986, DHR began to explore ways to enhance agency

revenue to better serve its client medical assistant and general public assistance populations.

2. Subsequently, in April of 1986 DHR issued a contract to Appellant for $48,000 to generate a preliminary study concerning a number of specific revenue enhancement ideas, including the claiming of federal funds for medical assistance and general public assistance clients through conversion of the disabled and potentially disabled among such persons to entitlement to Federal Medical Assistance (FMA) and Supplemental Security Income (SSI) and Supplemental Security Disability Insurance (SSDI) ("GPA-SSI Project").

3. Pursuance to Appellant's contract, Mr. Copeland visited Maryland in the summer of 1986 and met with a number of DHR employees to explore revenue enhancement ideas. Mr. Copeland issued his final report in March of 1987 evaluating various revenue enhancement ideas and suggesting how the State might implement them.

Prior to issuing the final report, Mr. Copeland provided his conclusions regarding various revenue enhancement proposals id draft sections. The draft section which addressed GPA-SSI revenue enhancement and eventually became "Appendix A" to the contract at issue herein was completed in October 1986. At that time, October, 1986, DHR had not determined how, or whether, any of the proposed revenue enhancement projects would be implemented.

4. However, in late 1986, DHR proposed to the Department of Budget and Fiscal Planning (DBFP) and to DHMH that the GPA-SSI Project be implemented, offering several different scenarios as to its operation, including the possibility of State management or hiring a contractor at a fixed fee.

5. Also at about this time both DHMH and DHR conveyed to DBFP proposed reductions in their budgets for FY 1988 and FY 1989 based on Mr. Copeland's estimates of what a GPA-SSI revenue project could recover for the State. DBFP agreed with those reductions and DHMH and DHR made the reductions in their proposed budgets.

6. The contract at issue herein acknowledges the estimated budget reduction projections for FY 1988 by requiring that the contractor "take all reasonable actions necessary to achieve . . . savings [of $4.35 million]." Contract § I(2).

7. At the beginning of 1987, negotiations for the contract at issue on a sole source basis began between Appellant and the State (DHR, DHMH and DBFP). Initial savings projections in the DHMH and DHR FY 1988 and FY 1989 budgets envisioned a start date for the project in the early spring of 1987. However, contract negotiations took longer than anticipated due to the inability to agree on what percentage of the State savings Appellant would be entitled to as a fee for persons converted to Federal MA and/or SSI/DI, the methodology for calculating what activity the fee would apply to and the lack of State experience with the type of procurement involved. Various fee structures based on a percentage of State savings were discussed, with Mr. Copeland proposing a higher or lower percentage fee based on the degree the State was willing to fund and staff his operations.

The parties finally agreed upon a fee of 28% of the actual general fund savings resulting from the Appellant's activities for each recipient of GPA and/or State Medical Assistance converted to entitlement to SSI/DI, Federal MA and other non-State benefits for a period of 36 months after the date of eligibility.[3] Appellant had wanted a higher percentage fee. As

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[3] Appellant's right to fees is addressed in § II(2) of the contarct, pp. 11-13. Relevant subsections are quoted below.

> (A) DHR will pay CONTRACTOR 28% of the actual savings realized to DHR from General Public Assistance payments, and to DHMH from State-only Medical assistance payments for the first three years of receipt of federal payments by each recipient who is accepted for SSI and/or federal MA, as a result of the CONTRACTOR's efforts.
>
> (E) The eligible period for determining the CONTRACTOR's fee is 36 months from the date

a quid pro quo for a fee at the 28% level, the State agreed to advance Appellant up to $1,200,000.00 (sometimes referred to herein as 1.2 million) for start up costs with a provision that all funds advanced be repaid by Appellant by October 31, 1988.

The contract went into effect on July 7, 1987, the date of execution by the last signatory party, DHMH.

8. As noted above, the draft section of the 1986 exploratory contract which addressed GPA-SSI revenue enhancement was incorporated into the contract at issue herein as Appendix A and the contract, as signed, obligated Appellant to:

> ". . . execute the Program in accordance with the conceptual model in Appendix A . . . . As a minimum expectation, the hypotheses and projections contained in the CONTRACTOR's

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> each person is eligible for federal MA and/or SSI/DI or other non-State benefits.
>
> (F) ... Upon the date that a recipient is determined eligible for federal Medical Assistance for the disabled (Category 29) by the Medical Review Team, the CONTRACTOR shall have fully earned, subject to the provisions of ... § II(2)(G) ... hereof, the agreed upon percentage of the actual general fund savings ... for the entire eligible period ... unless ... the person is [finally determined ineligible, ages out, moves out of State or dies].
>
> (G) If the contract is terminated while there are any persons who have been determined eligible for federal MA for the disabled (Category 29) for whom the application process for SSI ... is underway and approval is pending, ... the parties will negotiate and calculate a net valuation of the CONTRACTOR'S right to fees for those persons determined eligible for federal MA for the disabled (Category 29) based on savings the CONTRACTOR would have derived from such proportion of those persons [who the parties agree would likely be eligible for SSI were the application process continued to completion].

> report (Appendix A) . . . shall be followed to the extent of screening all persons found to be in the highest 20% of Medical Assistance users in the current GPA population."

Contract, §I(1). The contract also required Appellant after this initial screening of the highest 20% of the MA users in the GPA population to conduct further screening to screen a minimum of 6500 recipients of State General Public Assistance and State Medical Assistance for eligibility for Federal Medical Assistance for the disabled.

Appendix A to the contract, the conceptual model which the Board finds to have been based on valid assumptions, obligated the contractor to:

> a. Put the 5,500 most handicapped GPA recipients on MA by the end of January 1988, using specially-trained (possibly non-state) Medicaid and VOC/Psych review teams.
>
> b. Put the 5,500 persons through the SSI/DI application process with the Disabillity Determination Unit (DDU) and Social Security, using the MA workup material, a new targeted case management unit for representation and follow-along in the appeals process, purchased legal services at the Administrative Law Judge (ALJ) appeal level, with the expectation of 4,250 persons moving from GPA to SSI or SSDI (or both). All 5,500 would enter the initial application process by the end of February 1988. 3,780 cases would be through the approval process by 24 months after project start. The rest would need up to three more years.

Appendix A, p. 18.

9. In more comprehensive terms the contract required Appellant to provide personnel and/or capabilities by various dates between February ~~15~~, 1987 and April 1, 1988 (which dates were subsequently extended by the mutual agreement and/or action of the parties) to accomplish the following:

"I(3)(B) On or before September 15, 1987, CONTRACTOR shall have in place:

1. Essential staff, plus the research and Medical Review Team capabilities for the first persons to enter the Program, at a minimum beginning rate of 100 persons per month, and implementation of the Program according to the program model (Appendix A).

2. Cooperative agreements executed with Disability Determination Services, Social Security Administration, and other needed cooperative arrangements.

3. A research project to validate the assumptions upon which the project model cost and savings projections are based, and thereafter, CONTRACTOR will propose necessary revisions to the Agreement. CONTRACTOR will:

(a) Document the potential eligibility of the total GPA population.

(b) Place all potential eligibles into groupings prioritized in relation to program goals, and

(c) Propose revisions to the program model, cost and revenue projections to be submitted to the DHR Project Officer.

(C) or before December 15, 1987 CONTRACTOR shall:

1. Have all staff, Medical Review Team and case management subcontracts in place; and

2. Execute an in-depth analysis of the GPA population, with revised revenue projections for FY 88 and 89, plus further model changes, with quarterly updates thereafter.

(D) On or before December 15, 1987, the CONTRACTOR agrees to lay out, test and implement a set of tasks and outcomes for an automated (batch based processing) system, and thereafter, but no later than April 1, 1988, an automated System which will be based upon the use of a Series 11 Digital Equipment Corporation mini-computer (or equivalent) and software providing for interactive operation. The CONTRACTOR will present a detailed plan for the system,including hardware and software specifications, for review and approval by DHR, DHMH and as required by law to assure its compatibility with other DHR/DHMH systems and reasonableness as to capacity and cost of the system. The system will have the capacity to:

1. Select cases from the current GPA caseload with high potential MA and SSI eligibility;

2. Provide a simple statistically tested method of screening new cases coming onto the GPA caseload for high

MA/SSI/DI potential;

3. Track all cases throughout the MA/SSI/DI (or other program) eligibility process;

4. Provide a tickler system to meet all SSI/DI/etc. appeal requirements;

5. Utilize existing State data processing capabilities in AIMS, AMF and MMIS[4] to prevent duplication and unnecessary expense.

(E) On or before December 15, 1987, CONTRACTOR shall develop forms, procedures and training to enable income maintenance workers in local departments to identify potential SSI/DI eligibles and refer them to the CONTRACTOR, along with a copy of an executed Form 340 authorizing GPA reimbursements for each candidate. Each person properly referred must be reviewed by CONTRACTOR for acceptance into the program and reasonable justification provided by CONTRACTOR to DHR for any persons denied entry.

(F) On or before February 15, 1987, CONTRACTOR shall have in place an executed legal services Agreement to cover performance of the Services specified in §I(1)(E) [representation before an ALJ, Grant Appeals Board and/or Federal District Court].

(G) CONTRACTOR shall develop and continue to refine specific indicators for probable eligibility and, using extract data (magnetic tape, diskette, hard copy) from the State's data bases, as specified in the memorandum of understanding contemplated by [in] § I (3)(A)(1), periodically screen and process all current recipients shown to be potentially eligible.

(H) CONTRACTOR shall plan for State takeover of the program upon termination of this Agreement including necessary training of DHR and DHMH staff." [The contract term was to end June 30, 1992].

10. DEAP Project cost and returns were estimated in Appendix A to the contract. It was estimated the project would cost $19 million in State general funds (assuming Federal financial participation was available) over five years and that the project would return about $95 million in State general fund savings over five years. During eighteen months in FY 1987 and FY 1988

[4] AIMS (Automated Income Maintenance System), AMF (Automated Master File), MMIS (Medicaid Management Information System).

(January 1987 through June 1988) it was estimated that the project would return about $31.7 in State general fund savings for a net return of $23.7 million during those two budget years.

11. As noted above it was estimated in Appendix A that of the 5500 most handicapped persons, 3780 would be through the SSI/DI approval process by 24 months after project start[5] and that conversion of the remainder would require up to three more years.[6]

The contract also capped fee entitlement to 28% of State savings attributable to any given person converted for a period of 36 months and consistent with the 5 year term of the contract the contract provided that the Appellant would enroll no new persons into the program after June 30, 1989.

12. The detailed efforts and procedures required to be undertaken or followed by the Appellant to earn its fee relative to any given person converted were not spelled out in the contract, but were left for resolution through a Memorandum of Understanding (MOU) to be subsequently negotiated[7] by the parties.

13. The MOU (executed on January 29, 1988) to include a detailed Operating Procedures section incorporated therein by reference describes how a case becomes eligible for FMA. As the first step the Appellant files the DHMH Title XIX application, along with

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[5] It is well to repeat here that conversion to SSI which relieves the State from making any GPA payments to such persons also automatically confers Federal Medical Assistance eligibility.

[6] It was also stated as an assumption in Appendix A that 4400 medical assistance users in the GPA population would "almost certainly" meet disability standards for Federal MA and that a significant number of these persons would be eligible for SSI/DI and ultimately Medicare.

[7] See the contract, p. 5, § I(3)(A)3, requiring Appellant to execute or effect a Memorandum of Understanding - "spelling out the methods for documenting General Fund Savings resulting from the CONTRACTOR'S efforts and the methods and procedures for calculating the CONTRACTOR'S fee."

supporting medical and financial eligibility documentation, with the DEAP Medical Assistance Unit (DMAU). Thereafter, the DMAU forwards the medical documentation to the Department of Human Resources Medical Review Team (DHR MRT) for a determination of whether the client is medically eligible; and the DMAU determines whether the client is financially eligible. MOU, Operating Procedures § II B APPROVAL FOR MA pp. 29-32.

If both determinations are positive the DMAU notifies DHMH to convert the case from GPA to FMA. MOU, Operating Procedures p. 30, a 3. However, if the DHR MRT finds the client medically ineligible, the case is sent back to Appellant. id., p. 32, ¶ b.

Appellant agreed to establish the Disability Entitlement Advocacy Program, Contract, I(1), and in the MOU, Appellant agreed to accept responsibility for all work necessary to establish FMA eligibility. Inter alia Appellant agreed to:

> Complete documentation necessary to establish medical eligibility for FMA (MOU, Operating Procedures, p. 26, 3);
>
> Organize and pay for a separate DHR Medical Review Team [DHR MRT] to establish medical assistance eligibility for FMA (MOU, p. 18, ¶10);[3]

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[3] While Appellant did this by subcontract with Immediate Care, Inc., entered into on February 1, 1988, Appellant argues that it had an in-house MRT, i.e., the Medical Documentation unit under Mrs. Patricia Caudle consisting of Copeland Associates, Inc. employees [see text below] and asserts that this unit constituted the "MRT" required to be provided by the contract. We find otherwise. The contract does not say the Medical Review Team is an in-house Medical Documentation unit. The MOU, refers to the CAI Medical Documentation staff (MOU, Operating Procedures p. 26), as an entity apart from the Appellant's MRT (id., p. 28) and the DHR MRT (id., p. 29).

The contract provides that Appellant will "[e]nter into subcontracts to obtain staff qualified to carry out disability eligibility determinations in accord with federal standards ...." CAI had no subcontract with the Medical Documentation unit, which consisted of its own employees. CAI did have a subcontract with

Reimburse DHR for costs related to establishing a separate unit to determine and redetermine technical and financial eligibility for FMA (MOU p. 18, ¶9).

14. As noted, on 29 January 1988 the Memorandum of Understanding (MOU) was executed. The contract [Agreement] of July 7, 1987 to include Appendix A and the MOU including the Operating Procedures attached thereto and made a part thereof constitute together the contract documents or contract at issue herein.

15. Thus, the contract documents, i.e. the contract, require that in order for a case to be eligible for FMA "as a result of [Appellant's] efforts," Appellant must establish both medical and financial eligibility. Appellant only earns a fee if it successfully completes both efforts. The creation of the DMAU and the DHR MRT as entities separated from Appellant's control was agreed to by the parties to lend the appearance of impartiallity to the DEAP project.

B. Contract Performance

16. On July 7, 1987, Mr. Gene Lourey, a person experienced in

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Immediate Care, Inc., the DHR MRT, which carried out disabillity eligibillity determinations in accord with federal standards for CAI cases. The MRT makes federal disability determinations "in accordance with ... federal requirements," Contract, p. 4, which by regulation required physician and social worker review. Neither Mrs. Caudle nor anyone in her unit were physicians or social workers. Mrs. Caudle did not refer to herself or her unit as the Appellant MRT, nor did Ms. Hartstein [see test below], Appellant's program supervisor. The State did not understand that the Medical Documentation unit was the contract MRT.

To get the case on FMA requires an actual medical eligibility determination by Appellant's subcontractor, Immediate Care, and an actual financial eligibility determination by the CAI funded DMAU. The State does not realize actual savings by an in-house "finding" of eligibility by Appellant.

Appellant also had a subcontract with Delmarva Foundation to provide case assessment and recommendations as the Appellant's MRT. See the MOU, pp. 10-11, ¶4, and MOU Operating Procedures, p. 28. However, Appellant does not contend that Delmarva is the MRT required by the contract. Appellant sent only five cases to Delmarva and spent only $247.50 on this consulting organization.

data processing and systems analysis, and listed in the contract as one of the "key personnel"[9] arrived in Maryland[10] to begin contract performance. Mr. Copeland and Mr. Harold Shippee[11] were also present for a period of time in July of 1987, and Bruce Copeland, Mr. Copeland's brother, arrived in August, 1987 to attend to the details of the logistics of quarters and lodging and was in Maryland from time to time through December, 1987.

17. By August, 1987 Appellant had hired Ms. Phyllis Hartstein and Mr. William Horne, individuals with experience in human services management in New York to head project implementation and operations. However, no workers to implement and operate the program were hired until October, 1987 and Mrs. Caudle who was to hire and supervise medical documentation workers was not hired until late December 1987. Appellant did not have adequate staff to implement and operate the program in place until February, 1988 and even as late as May 1988 a draft Procedures Manual required to be developed by Appellant for DEAP project operation had not been finally completed.

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[9] Key personnel identified in the contract (Appendix B), Messrs. Copeland, Iverson and Lourey, were "considered to be essential to the work being performed under this Agreement." Mr. Lourey had operated with Appellant pursuant to oral agreements on a number of projects in other States.

[10] The focus of the DEAP project was on Baltimore City (Although it was expanded to certain counties in the July to August, 1988 timeframe) and references to Maryland generally mean Baltimore City as the specific geographic location.

[11] Mr. Shippee had previously performed consultant services for the State and in 1986 had suggested to certain DHR officials that Mr. Copeland, a former colleague, might be able to assist in revenue enhancement initiatives. For the contract at issue, Mr. Shippee provided consultant services to Appellant as an individual and as an officer and stockholder of Copeland & Associates of Maryland, Inc., formed in October of 1987. While it was requested by Appellant that the contract at issue herein be transferred to Copeland & Associates of Maryland, Inc., this never occurred because the State did not believe that the Board of Public Works would approve such a transfer. Copeland & Associates of Maryland, Inc. was merged into Appellant in December of 1990.

18. Appellant as required by the MOU did establish the DHR MRT by subcontract with Immediate Care, Inc. on February 1, 1988. The DMAU, funded by Appellant and staffed with contractual employees hired by the State and supervised by DHR, was fully operational by April 25, 1988[12].

By March 24, 1988, Appellant had commenced the process of conversion to federal entitlements for only 35 persons. As of April 15, 1988 fewer than 15 of Appellant's clients had been converted from State Medical Assistance to Federal Medical Assistance and none had completed the transfer from GPA to SSI. Nevertheless, the State stipulates that by November 9, 1988 748 persons had been processed through both the DHR MRT and the DMAU for purposes of FMA eligibility. The state further stipulates that of these 748 persons 493 were eventually placed on SSI as a result of Appellant's efforts.

19. Commencing in August of 1987, the State began to pay consultant fees and expenses (through Appellant) to Mr. Copeland, Mr. Lourey and Mr. Shippee pursuant to the $1,200,000.00 advance payment provision of the contract. By the time the MOU was executed at the end of January, 1988, Messrs. Copeland, Lourey and Shippee had been paid approximately $141,000 in consultant fees and expenses out of the funds advanced by the State pursuant to the advance payment provision of the contract.[13] These consultant fee payments continued, albeit at a reduced rate ($500 a day rather than $1,000 a day) and along with other expenses, particularly payments of $68,334.02 to ERIM Corporation[14]

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[12] In the interim, financial and technical eligibility decisions were made on an ad hoc basis by borrowed staff.

[13] Mr. Bruce Copeland was paid $31,540.33 for his activities in Maryland relating to the logistics of quarters and lodging.

[14] ERIM Corporation was a Minnesota corporation retained by Mr. Lourey to provide services in support of Appellant's obligation under the contract to provide the capability to research and screen the highest 20% of State Medical Assistance users, to develop an automated system for case tracking and management and to assist in

between August 15, 1987 and December 31, 1987 and payments of $335,476.16 to ERIM Corporation between January 1, 1988 and October 6, 1988, created a serious cash flow problem for Appellant in terms of operating the DEAP project since no substantial fees were earned by it for DEAP project conversions until the summer of 1988 when it began to actually convert persons to Federal Financial Participation pursuant to its contractual obligations.

20. In order to assist Appellant with its cash flow problems, the State in the MOU agreed to permit Appellant to receive fees for certain "back claim" work. A back claim is a method of capturing State savings for items passed over for a variety of reasons in the State's previous annual Reconciliation Run.[::] The State had for many years prior to the DEAP project performed a massive transactional comparison of one set of data to another set of data at the Baltimore Data Center of the flow of medical benefits and federal participation through the Federal Health Care Financing Administration (HCFA) in those benefits. The comparison which will give a gross monetary amount of how much the State owes the Federal Government or vice versa involves a massive amount of data. Accordingly, State policy was to print a copy of only one of every 100 comparisons for individual cases. The information compared by a Reconciliation Run is dynamic and therefore reflects the status of the accounts only for the date the run is undertaken.

21. The MOU provided in relevant part in regard to back claims:

> As a potential CAI interest involving a right to contingent compensation, such "backclaims" relate:
>
> (A) to that population for which on 6/15/87 there

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the development of follow on procedures to maintain and enhance Federal Financial Participation.

[::] Run is the term used by data processing personnel at the Baltimore Data Center to describe comparing one set of data to another set of data.

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existed a right to calculate and claim for costs of services rendered during periods prior to that date and not claimed for as a "current" claim, and

(B) to that population plus others who became GPA recipients on or after 6/15/87 for services rendered to them during an eligible period from before 6/15/87 and up to 1/1/8. . . .

[I]t is expressly understood and agreed that CAI makes no claim with respect to any such "backclaim" prepared, and filed for federal payment prior to 11/1/87 by DHMH....[B]y 11/1/87, it was clearly established that CAI had participated in discussions and disclosures and shared technical information respecting "backclaims" sufficient to establish its right and interest in any claim filed thereafter with respect to the undefined population and periods.

MOU, pp. 4-5.

22. Appellant began working on back claims. Back claims were filed at various times in FY 1988 and FY 1989 and Appellant was paid its fee of 28% of back claim recoveries in accordance with the language of the MOU.

23. Appellant did not determine until the hearing of the appeal that it had actually been paid $685,331 relating to back claim fees for which it had claimed entitlement in its claims against the State. Once it discovered during the hearing that it had in fact been paid such amount for back claim work it withdrew this claim.

24. Appellant continues to assert that it is entitled to be paid a fee of $586,423 for a back claim run by the State on September 23, 1987 and filed in December 1987[16] reconciling transactions in FY 1986, a fee of $609,220 for a back claim run by the State on September 21, 1987 and filed in March of 1988 (MSBCA 1408), fees of $223,818 for back claims (including pharmacy claims) submitted after September 30, 1988 and fees of $72,394 and

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[16] Apellant's first Proof of Costs, Appendix G-1, lists $781,898.20 as the fee to which it is entitled for the State run on September 23, 1987.

$95,437 for back claims run in March and June of 1989 for FY 1987 and the first half of FY 1988 respectively.

25. Appellant argues that it is entitled to these additional fees under the language of the MOU.[17] As noted above, the State (DHMH) had routinely made reconciliation runs, i.e. back claims, on its own before Mr. Copeland first came to Maryland. These back claims often produced an unusually large refund to the State. Concern that a federal audit could result in demand for reimbursement of some of this recovery and that the large recovery was an invitation for an audit, the State decided to split up recovery of the back claims and spread it out over several future claims. The Appellant ran certain of those future claims, and the State subtracted from Appellant's fees that portion of the claim which related to the prior back claims prepared [and filed] by the State. Appellant asserts it should be paid for all back claims filed with the Federal Government by the State after November 1, 1987 even if part of the amount is included in a back claim prepared by the State prior to November 1, 1987. However, the MOU is clear. Entitlement for back claims only attaches to those claims prepared and filed with Appellant's input subsequent to November 1, 1987. The MOU does not entitle Appellant to a fee for back claims prepared by the State prior to November 1, 1987 but not filed with the Federal Government until after November 1, 1987.

26. The GPA population is a dynamic rather than a static population. During the course of the contract the actual number of persons on the State GPA rolls declined by several thousand from that estimated in Appendix A (from approximately 22,000 to 17,000). Appellant allegedly in response to such decline

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[17] Additionally, Appellant seeks a fee under various theories for projected late billings under back claims of $269,527, and anticipatory fees for pharmacy assistance back claims for the period 12/31/88-6/30/92 of $805,263, and anticipatory fees of $7,716,691 for back claims from 1/1/88 through 6/30/89.

requested that the DEAP project be expanded geographically into other counties and entitlement areas. However, such decline did not materially affect the projections and assumptions relating to the number of persons who could be converted to federal entitlements. Further, the State did not guarantee the number of persons who would be on the GPA rolls at any given time and Appellant's projections in Appendix A were estimates only. Nor was the State acting contrary to the contract or otherwise being unreasonable in its determinations not to expand the DEAP project into the counties or to other entitlement areas.

27. Mr. Copeland testified that as many as 50% of the GPA population would become converted to federal entitlement, FMA and/or SSI/SSDI, by so called "natural forces"; i.e., such converson would occur through the efforts of the GPA client himself or the efforts of the State or others even if the DEAP project had never been undertaken. Mr. Mark Friedman who was appointed the State's project manager to oversee the DEAP project in the spring of 1988 (and is also the procurement officer herein) estimated more conservatively that only 25% of the GPA population would move by "natural forces" (sometimes referred to by the parties as "base line") to federal entitlement status if the DEAP project had never been undertaken. Accordingly, Mr. Friedman reduced fee payments to Appellant by 25% to reflect this reality. We find that such "base line" reduction is appropriate in determining Appellant's fees under the contract documents. The Appellant is only entitled to a fee for 28% of the "actual savings" realized from receipt of federal payments by each recipient who is "accepted for SSI and/or federal MA, as a result of the CONTRACTOR'S efforts." The base line or natural forces reduction is consistent with the conceptual modeling approach set forth in Appendix A to the contract which acknowledges that certain persons would naturally move to federal entitlement status while others would require some level of advocacy effort. Stated another way, the contract as a whole cannot be reasonably interpreted to require the contractor to only screen, i.e.,

identify, the most likely 6500 candidates for conversion to federal entitlement and be entitled to collect a fee for any of those persons who were converted without any advocacy effort by Appellant.

C. Contract Termination

28. By the end of September, 1988, it was apparent that Appellant would not be able to repay the $1,200,000.00 advance by October 31, 1988. It was also obvious that although conversions of GPA clients to federal financial participation had increased to approximately 275 in September, 1988, the Appellant's estimates of conversions and actual State savings as contained in Appendix A of the contract which would be achieved through its efforts were and would continue to be far off the mark.[13]

29. By late October, 1988, the State had made payments to Appellant or Appellant's consultants totalling approximately $3 million. At this time estimated General Fund savings resulting from the DEAP project totalled approximately $2.2 million.

30. The parties commenced negotiations to mutually terminate the contract on or about September 29, 1988. However, by late October the parties were still several million dollars apart regarding any possible settlement.

31. The contract provided for three methods of early termination of the contract. Section IV provided:

IV. TERM OF AGREEMENT

> Performance under this Agreement shall commence on June 15, 1987, and shall continue through June 30, 1992. Enrollment of new persons into the program will end on or before June 30, 1989.

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[13] By October 31, 1988 only approximately 500 persons had been placed on FMA and approximately 40 had been placed on SSI. Appellant's expenses and payments of consultant fees were averaging $220,000 a month in the September/October 1988 time frame. Appellant did contact the Maryland National Bank and the Old Stone Commercial Corporation in the summer of 1988 to enquire about a loan to fund the project. However, Appellant never executed a loan application.

The parties, however, may mutually agree in writing to an earlier termination, or DHR, in its sole discretion, may, after consultation with DHMH serve upon the CONTRACTOR a written notification of an intention to terminate the Agreement as of sixty (60) days or more from the date of receipt of such notice, pursuant to either Section V(5) or (6) of this Agreement.

Section V, paragraphs (5) and (6) provided:

(5) Termination for Convenience: The performance of work under this Agreement may be terminated by DHR, after consultation with DHMH, in accordance with this clause in whole, or from time to time in part, whenever the Project Officer shall determine that such termination is in the best interest of the State. DHR will pay all reasonable costs associated with this Agreement that CONTRACTOR has incurred up to the date of termination and all reasonable costs associated with termination of the Agreement. However, the CONTRACTOR shall not be reimbursed for any anticipatory profits which have not been earned up to the date of termination.

(6) Termination for Default: If CONTRACTOR fails to fulfill its obligations under this Agreement properly and on time, or otherwise violates any provisions of the Agreement, DHR may terminate the Agreement. Prior to terminating this Agreement, DHR shall give CONTRACTOR thirty (30) days prior written notice of such default and if CONTRACTOR has not cured such default within the thirty (30) day period, DHR may, by written notice within five (5) days after expiration of this period, terminate the contract. The notice shall specify the acts or omissions relied on as cause for termination. All finished or unfinished supplies and services provided by CONTRACTR shall, at DHR's option, become the State's property. DHR shall pay CONTRACTOR fair and equitable compensation for satisfactory performance prior to receipt of notice of termination, less the amount of damages caused by CONTRACTOR's breach. If the damages are more than the compensation

payable to CONTRACTOR, CONTRACTOR will remain liable after termination and DHR can affirmatively collect damages.

Upon such termination, DHR reserves the right, at its sole option, after consultation with DHMH, to continue all subcontracts.

32. By letter dated November 1, 1988, Mr. Friedman, who had also assumed the role of procurement officer, advised Appellant that it was in default for failure to repay the 1.2 million advance by October 31, 1988 and provided the 30 day notice for cure.

33. Appellant did not repay the 1.2 million by December 1, 1988 (or thereafter). However, on or about November 9, 1988, the parties executed a document called "Preliminary Contract Termination Agreement."

34. By letter dated December 2, 1988, Mr. Friedman advised Appellant that its contract was terminated for default. The letter stated that the "effective date of termination will remain November 9, 1988, as specified in our Preliminary Contract Termination Agreement of that date."

35. However, the Preliminary Contract Termination Agreement, the Board finds to represent a mutual "earlier termination" of the contract pursuant to Section IV thereof set forth above. Accordingly, while there is no dispute that Appellant failed to repay the 1.2 million dollar advance, and was thus in default, the purported termination for default as set forth in Mr. Friedman's letter of December 2, 1988 had no legal effect, the parties having after lengthy negotiation that commenced in late September mutually agreed to an earlier termination date of November 9, 1988 by their execution of the November 9 Preliminary Contract Termination Agreement which provided that: "The State shall take over the DEAP project on November 9, 1988 which the parties agree is the actual termination date."

36. The DEAP project was turned over by the State to Chesapeake Health Plan, Inc. on or about November 9, 1988. Subsequently, the DEAP project work was turned over to Health Management

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Associates, Inc. (HMA).[19] Chesapeake last provided services to the DEAP project in January, 1989; thereafter the services were provided by HMA.

37. At varying times before the contract was terminated on November 9, 1988, Appellant complained about the elements of work it was required to perform by the terms of the contract and attempted to maximize its revenues by having the State perform certain of the tasks it was contractually obligated to perform. Appellant, as explained above, also sought to expand into other areas of revenue enhancement and to expand the DEAP project beyond the geographic area of Baltimore City.

Appellant also asserted its belief during the hearing of the appeals that the State deliberately frustrated its efforts to successfully pursue the DEAP project.[20] The reasons suggested by Appellant for the alleged deliberate frustration of the project were (1) that the State believed it had made a bad bargain by agreeing to pay Appellant a fee of 28% and believed it could retain a greater portion of federal participation if the DEAP project were to be taken over by another contractor and (2) dislike of Appellant's operation displayed by Nelson Sabatini, who, in the Spring of 1988, filled the position of Deputy Secretary of DHMH with responsibility for the State's Medical Assistance program of which the DEAP project was a part.

38. The Board finds that there was no deliberate attempt by the State to frustrate the Appellant's performance. The Board also finds that Mr. Sabatini did not take or refuse to take any action which adversely affected the Appellant's ability to perform pursuant to its obligations under the contract documents.

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[19] HMA was formed using personnel and resources of Chesapeake Health Plan, Inc. which initially provided the services for a few weeks.

[20] There is an implied duty in Maryland State contracts that neither party will do anything to frustrate the performance of the other party. Calvert General Contractors, MDOT 1004, 1 MICPEL ¶ 5 (1981) at p. 5.

39. Appellant also asserts that it was frustrated in its efforts to convert GPA and State MA persons to federal entitlement, and thus was unable to generate sufficient fees to repay the 1.2 million, by (1) alleged unanticipated lack of cooperation in the State bureaucracy and (2) alleged unanticipated lack of existing State procedures and resources to deal with conversion of the GPA population to federal entitlement, particularly in the data processing area. We shall first discuss alleged data processing deficiences.

40. The contract provided as follows concerning data processing use and responsibilities:

> "CONTRACTOR agrees to ... implement ... an automated [case tracking] system [which] will have the capacity to:
>
> > 5. Utilize existing State data processing capabilities in AIMS, AMF and MMIS[1] to prevent duplication and unnecessary expense." Contract, § I(3)(D).
>
> * * *
>
> "CONTRACTOR shall ..., using extract data (magnetic tape, diskette, hard copy) from the State's databases, as specified in the memorandum of understanding contemplated by § (3)(A)(1) ... screen and process all current recipients shown to be potentially eligible." Contract, § I(3)(G).

41. The contract does not make representations concerning the quality, consistency or reliability of data in and among the State's databases. Appellant agreed to perform the contract using State data processing systems "as is," i.e., (a) existing State data in a specified format (magnetic tape, diskette, hard copy), and (b) existing State data processing capabilities in three different data processing systems (AIMS, AMF, MMIS).

42. The exact data to be used by Appellant was to be "specified in the memorandum of understanding." Contract, § I (3)(G). The MOU, pp. 14-15, generally describes the data (DHR case records and automated tapes; DHMH tapes and hard copy of MMIS data) and

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[1] AIMS (Automated Income Maintenance System), AMF (Automated Master File), MMIS (Medicaid Management Information System).

the MOU, Operating Procedures, p. 22, specifies: DHR will provide AIMS and SDX[22] tapes; DHMH will provide MMIS data; and Appellant "will merge the DHR and DHMH data to create client profiles from which cases will be selected in accordance with criteria developed by CAI."

These provisions of the contract and MOU are unambiguous. Even if existing State data is "deficient", and, as discussed below, we do not find that it was for purposes of contract performance, in both the contract and in the MOU (signed by Appellant almost seven months after contract execution), Appellant agreed to use existing State data and data processing systems to perform the services called for in the contract.

43. Regarding the alleged data processing deficiencies, Appellant focuses on the following asserted defects.

a. Multiple MA numbers.

MA recipients are assigned an eight-digit MA number by the staff of the appropriate (i.e. the recipient's county of residence) local department of social services. The first two digits are the county of residence (e.g., 03 is Baltimore County). The original assigned number is supposed to be processed through to closure, but that is not always timely done, so that the same individual may have more than one MA number if for example he changes his county of residence and receives a new MA number before the old one is closed.

The extent of this multiple MA number phenomena is not ascertainable from the record. One study by the State of 46 recipients (.0025 of the 18,000 GPA population) found that 6 recipients had more than one MA number. We do not find this study to be a statistically valid indication of the number of persons having multiple MA numbers and, in any event, the effect of this phenomena on the DEAP project we conclude is de minimus.

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[22] SDX (State Data Exchange). The SDX is a tape provided by the Social Security Administration which shows cases that have become eligible for SSI.

MMIS pays claims by recipient number; there were no duplicate claims. Appellant selected high cost cases for processing (producing 10,000 client profiles), even though some recipient's claims occurred under another MA number. For the few cases with more than one MA number, the DMAU chose one number to use, usually the most recent.

b. Missing Social Security Numbers (SSNs).

The record reflects that less than 3% of the GPA population did not have a social security number listed in a data base. However, SSNs are not required for GPA participation and a GPA recipient without work history may have no SSN. HCFA did not require SSNs for FMA until 1985. However, we find that the absence of SSNs had no adverse effect on the DEAP project because Appellant selected cases for processing by MA number, not SSN.

c. Erroneous SSNs.

Erroneous SSNs could be caused by State data device operator error or SSA database errors. The extent of such errors is unknown. However, Appellant selected cases for processing by MA number, not SSN, so such errors would not have significantly affected the DEAP project.

d. MMIS/AIMS/AMF Differences.

Data is not always the same between the three systems because of human error in independent data entry and lag in system updates. However, Appellant selected cases using the MMIS eligibility file making AIMS/AMF differences redundent. Appellant resolved demographic differences by reviewing current AIMS demographic data supplied by DHR staff on a 24-hour turnaround basis. Appellant also received AIMS tapes, enabling it to review AIMS data itself.

e. MMIS/SDX Differences.

Some cases on the MMIS reflected as GPA were on the SDX as SSI caused by a lag in updating MMIS with SDX and data entry errors in SDX updating. The extent of this problem is unknown. However, one study showed 7% of a 1341 GPA case sample on SSI, or 94 cases. The effect of such error we thus find to be de minimus

even though it caused some wasted expenditures of effort on individuals who were already receiving SSI.

44. The Board finds that whether considered singly or in combination the above set forth alleged data deficiencies did not adversely affect Appellant's ability to convert GPA persons to federal entitlements. The Board also notes that when Appellant left Maryland in November of 1988 pursuant to the mutual termination of the contract it had not yet completed the automated case tracking system the contract required it to implement.

45. Concerning other alleged deficiencies in State procedures and resources Appellant principally[23] contends that it was at risk in performance of its contract obligations due to alleged audit trail[24] deficiencies in the State system which adversely affected verification that medical claims were made by eligible providers enrolled in the Medicaid program for services provided to eligible persons assuring that correct federally allowable amounts are paid in calculating and filing claims for FFP with the federal government. Appellant asserts that these alleged audit trail deficiencies required it to develop its own recordkeeping and documentation system to support a complete audit trail for all federal claims associated with its cases to ensure that State savings and hence Appellant's fees would not be subject to federal disallowance. Appellant asserts that those efforts it was allegedly required to undertake to address its audit trail concerns caused delay in implementation of the project because of Appellant's alleged inability to "piggyback"

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[23] Appellant also contended that the lack of a single State application form for all federal entitlements hampered its operation. The contract does not require that the State provide such a combined application form and, in any event, the record does not support a finding that Appellant's operations were materially affected by lack of a multi purpose form.

[24] An audit trail is a record that allows a federal reviewer to verify that a claimed amount was paid for services rendered by an eligible provider to an eligible FMA/SSI recipient.

on the State's existing retroactive claiming system as anticipated and caused alleged unanticipated additional expense and allocation of data processing resources to development of the audit trail. Such alleged expense and allocation of resources Appellant asserts also had a continuing affect on its ability to convert clients to FFP.

46. The contract provided as follows on audit trail responsibilities:

> "As soon as reasonably possible, but in no case later than September 15, 1987 [later changed to November 1, 1987 by agreement] CONTRACTOR shall ... effect the following:
>
> ...2(b)...[A]dopt procedures that will provide for a detailed, easily accessible audit trail of each case and major decision point, consistent with applicable federal and STATE laws and regulations. Contract, § 1(3)(A).
>
> The CONTRACTOR hereby agrees to immediately reimburse DHR and/or DHMH for any payments withheld from the State or adjustments made in funds otherwise due the State by the federal government in connection with any fees paid to the CONTRACTOR under this Agreement; provided, however, that such reimbursement shall not be required for payments withheld or adjustments made by reason of any failure by DHR, DHMH, or any local department of social services to comply with the terms of this Agreement." Contract, § V(3).

47. Appellant's responsibility under the contract was to affect and document changes from GPA or State MA to FMA eligibility.[25] Pursuant to such responsibility, Appellant was to adopt procedures that provide an audit trail "of each case and major decision point," subject to loss of its 28% fee in the event of audit disallowance should a federal reviewer determine, for example, that a case is not eligible for FMA.

Appellant had no responsibility for verifying that claims are made by eligible providers enrolled in the Medicaid program, assuring that the correct, federally allowable amounts are paid, or calculating and filing claims for FFP with the Federal Government. These remained the responsibility of DHMH. There

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[25] Conversion to SSI automatically entails FMA eligibility.

was no provision in the contract requiring DHMH to provide a unique audit trail to discharge its responsibilities. Pursuant to the contract DHMH was to regularly compute Appellant's fee, and Appellant was to suffer no loss of fee "by reason of any failure by DHR, DHMH, or any local department of social services to comply with the terms of this Agreement." Thus, any audit trail "failure" on the State's part would not affect Appellant's fee.

48. Nevertheless, Appellant made two assertions during performance of the contract regarding the audit trail. First, it asserted that it was responsible under the contract for repayment of 100% of any audit disallowance by the federal government, rather than repayment of its 28% fee notwithstanding that the State advised Appellant it read the contract as only requiring repayment of Appellant's 28% fee in the event of audit disallowance, and provided Appellant with an advice of counsel letter stating so. See also Contract, II (2)(H). The Board finds that Appellant was only required to repay its 28% fee in the event of an audit disallowance under a reasonable reading of the contract.

Second, Appellant asserted that DHMH had no audit trail. However, DHMH had successfully made claims for FFP for retroactive changes to eligibility for many years before Appellant's contract and had the following audit trails during the Copeland era.

a. Recipient Eligibility - Every change to a recipient eligibility record (over 400,000 Statewide as of the end of 1991) contains the following data: (1) HE01 (grant record) and HE02 (individual record) computer screens showing up to thirty periods, or buckets (begin and end dates) of eligibility, (2) input 8000 form showing the eligibility change requested, (3) a "before" image of the eligibility file, (4) output 8000 form showing the change made, (5) an "after" image of the file, and (6) a daily log titled "Recipient Eligibility Audit Trail" displaying the recipient record before and after the change is

made, and the change.

The HE01 and HE02 computer screens contain a "last activity date" field. This field allows a reviewer to examine the "Recipient Eligibility Audit Trail" daily log for the date listed and determine the change made, even where later periods of eligibility overlap earlier periods. The daily log also contains a "last activity date" field, allowing a reviewer to examine the previous change by inspecting the log for the earlier date, which also contains a "last activity date." Through this process, DHMH maintains a complete audit trail record of every change to a recipient's eligibility record.

b. Claiming - DHMH's claiming mechanism for FFP resulting from retroactive changes to a recipient's eligibility is the annual reconciliation run. This run compares the category of recipient eligibility on the date a service was rendered (the category is entered on the Claims Paid History file when the claim is paid) with the category of eligibility shown, as of the date of the run on the Recipient Eligibility Master file. For example; (1) on March 1, a person eligible for GPA receives medical services from a program provided; (2) the provider's claim, when received and paid, is coded as 04 (i.e. GPA); (3) on November 1, the GPA recipient's eligibility changed to SSI (Code 06), retroactive to March 1, entitling the State to 50% FFP for the claim paid under the 04 category; and (4) in February of the next year, the reconciliation run is run. The run shows that the non-federal amount of the claim for services rendered on March 1 is now eligible for FFP, and this run is submitted as supporting documentation for retroactive adjustments claimed on line 7 of the HCFA-64 (quarterly FFP claiming report).

For over ten years before Appellant's contract, the State used the reconciliation run to adjust its claiming to the Federal Government. After the HCFA-64 was filed, federal reviewers came on site to review the supporting documentation, including the reconciliation run output. At the time of the hearing of this appeal the Federal Government had never disallowed a single claim

as a result of the form or content of the reconciliation run output.

49. As noted in Finding of Fact No. 20 above, DHMH printed only 1 change out of every 100 changes. Appellant argues this results in an inadequate data record for audit purposes. However, federal reviewers have never required more than a sample to review. For System Performance Reviews before Appellant's contract, HCFA asked DHMH to supply 80 claims from a universe of 7.5 million claims (.00001) for audit and review. While the detail of the reconciliation run has not been examined, use of samples in federal reviews of Maryland data was well-established before Appellant's contract.

Indeed, had federal reviewers desired all the detail of the reconciliation run, the State had the ability to print this detail. A change to the print mode (to capture every record, instead of every 100) can be accomplished in minutes. Should federal reviewers request every change in the onsite visit after the quarterly HCFA-64 is filed, DHMH would rerun the weekly eligibility tape used to run the reconciliation run which tape is retained for 45 days or thereafter the monthly eligibility tape retained for one year. Upon a federal request for review beyond one year, DHMH has the ability to reconstruct eligibility and claims history by comparing the two files.

Finally, notwithstanding that federal reviewers had never required such detail from documents to support claim changes, at Appellant's request, DHMH did print every change made by the reconciliation run in connection with claiming FFP for the SDX/MMIS tape matches.

50. Despite Appellant's alleged audit trail concerns, it took no records with it when it left Maryland following the mutual termination of the contract on November 9, 1988; not even a list of the names of the clients it had allegedly converted to FFP.

51. Appellant also asserts it was hampered in its efforts to achieve FFP and thus repay the $1.2 million advance by alleged unanticipated lack of cooperation in the State bureaucracy. In

this regard Appellant asserts that internal dispute within agencies and disputes between agencies over how to administer the DEAP project hampered Appellant's ability to receive prompt answers and decisions from State officials and to receive necessary data and information. The extent of such alleged disputes and lack of cooperation are set forth in a report (Rule 4 File, Tab 98) prepared by a DHR employee, Ms. Sharon Nathanson.

In summary Ms. Nathanson concluded:

This report identifies the major problems and issues in the contract between CAI, DHR and DHMH...

While six major areas have been covered, all could be subsumed under just two categories: management and clients.

Management - The project needs a much stronger management structure. A project officer needs to be officially appointed either by DHR or DHMH who can carry day to day responsibility for this contract. The designee must carry the weight of the Secretaries as well as have line authority to the people who must carry out the intricacies of this contract. A two tier management team needs to be established and should meet regularly to handle the myriad of issues arising out of this contract. Too many issues are elevated, when a decision could be made at a lower level.

The vendor needs to be held accountable to the contract, which includes the meeting of milestones, the development of timely progress reports and generally carrying out the work identified in the contract. Generally accepted management tools should be used such as a workplan, regular working meetings, minutes to record decisions, consistent statistical reports, written progress reports, etc.

The vendor also needs to clarify its management structure. Having three top management people communicate with both Departments is also confusing. One person should be designated the Project Officer for the vendor and all policy memos and issues should be resolved through that person.

Because of this lack of structure, communication is informal or between the parties which can't make a decision. There is the appearance of lack of decision making and issues never come to resolution.

The issues of contract management, contract compliance, backclaims, data processing and fee could all be resolved if a strong manager and management team(s) were in place.

Clients - Regardless of the management structure, it is still not clear if the clients are there in the numbers originally envisioned. Both Departments need an immediate detailed assessment of the number of clients which CAI anticipates processing during the term of the contract. If the clients are not there, some major restructuring of the contract will be necessary.

The Board, as noted above, does not find that the decrease in the client population adversely affected contract performance or required any restructuring of the contract. See Finding of Fact No. 26. However, the Board does find that Ms. Nathanson's report does accurately summarize the management problems encountered by both parties. These problems had been addressed and mostly remedied at the time the parties determined to mutually terminate the contract. The record does not support Appellant's contention that the State problems identified were of such severity as to materially impede or hamper Apellant's efforts to achieve FFP and repay the $1.2 million advance.

52. A certain portion (15%) of fees earned by Appellant were placed in an interest bearing escrow account on four different occasions in 1988, in the event of an audit disallowance by the Federal Government.[:]

[:] The contract provides that:

To assure that funds are available to cover any required refund of fees paid to the CONTRACTOR, 15% of all funds earned by the CONTRACTOR under this Agreement shall be retained by the State in a separate interest bearing account for a period of three years after the date of termination of the Agreement. Thereupon the parties shall review any disallowance or audit action taken or pending, and arrive at an estimate of their actual or potential cost to the State. To the extent, if any, that the value of the account hereunder exceeds such estimate, the excess shall be immediately payable to the CONTRACTOR. Not more than two years thereafter, the parties shall conduct a further review of such actions in process or pending that may result in potential charges against the account and the parties will negotiate a fair and equitable final settlement of the acount. The final contract payment will not be made until after certification is received from the comptroller of the State that all taxes have been paid. DHR is not required to, and will not withhold Federal, Maryland, FICA, FUTA, or similar taxes from payments hereunder; payment of all such

As of January 31, 1992, principal and interest on these escrowed funds totalled $372,965.84. Additionally, as of January 31, 1992 principal amounts and interest thereon of funds withheld from Appellant but not deposited into escrow totalled $82,954.05.

53. The parties have stipulated that the value of CAI inventory acquired by the State upon termination of the contract on November 9, 1988 was $59,856.80 as of November 8, 1988, and Appellant is entitled to a credit for such amount.

54. The parties have stipulated that the value of the CAI PDP-11 and ancillary computer equipment acquired by the State upon termination of the contract on November 9, 1988 and thereafter used for the State's own purposes was $47,000.00 as of November 8, 1988, and Appellant is entitled to a credit for such amount.

55. The record reflects that the State paid $30,568.95 to approximately 24 vendors[11] for services rendered to Appellant prior to contract termination on November 9, 1988. The record further reflects that such expenses were reasonable and incurred in performance of the DEAP project by Appellant in the September/October, 1988 timeframe and that payment was necessary to keep the DEAP project in operation. Accordingly, the State is entitled to a credit for its payment of $30,568.95 to various vendors.

56. The State is entitled to interest on the $1,200,000 advanced at the various rates of interest applied to the 15% of funds withheld from Appellant's fees and escrowed as discussed in Finding of Fact No. 52 above from October 31, 1988 through

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taxes are the sole responsibility of the CONTRACTOR, in accordance with §I(6). It is agreed that the percentage retained hereunder may be increased by the state beyond 15% upon written notice to the CONTRACTOR, should such increase become necessary in order to cover the cost of a disallowance of federal funds or settlement of CONTRACTOR costs below $1,500 per person screened as described in §I(5), above. Contract §II(2)(H).

[11] These vendors included among others cab companies, various medical services providers and C&P Telephone Company.

January 31, 1992 and thereafter at the rate of 10% per annum until the date of this decision. Following the date of this decision interest on the total amount ($1,200,000 plus interest) existing as of the date of this decision shall accrue interest at the rate of interest on judgments until paid.

57. The State seeks transition costs (i.e. the costs of transferring the DEAP project to HMA, the follow on contractor) in the aggregate amount of $45,514.11 paid to Chesapeake Health Plan, Inc. (Chesapeake, from which HMA was formed) and a local law firm for professional services required to affect the transition during the period November 9, 1988 to January 31, 1989. The basis for such State claim is that no transition would have been necessary and thus such costs would not have been incurred but for Appellant's default termination. However, the Board has found that the termination was for the mutual convenience of the parties and thus, while the Board finds the transition costs to be reasonable, the Appellant is not liable for such costs.

58. The State seeks to recover amounts it paid for DEAP project costs incurred during the period November 1, 1988 through November 8, 1988.

Pursuant to the Preliminary Contract Termination Agreement, the actual termination date of Appellant's contract was November 9, 1988 and upon this date the State was to take over the DEAP project. Despite the November 9 date, Appellant failed to provide funds for operating expenses from November 1 through November 8. The State claims project expenses of $65,290.26 for that period, calculated pursuant to the following methodology.

Program expenses, November 1988	$144,483.59
G & A expenses, November 1988	78,799.21
	$223,262.80
Less November 1988 Chesapeake management fees, HMA legal fees, and interest [previously claimed as	18,064.78

transition costs]	$205,198.02
Average November 1988 project costs/day ($205,198.02 divided by 22 working days)	$ 9,327.18
Project Costs, November 1-8	$ 65,290.26

We find the State's method of calculating such costs to be appropriate and to reasonably capture actual operating expenses for the period November 1, 1988 through November 8, 1988. The State is thus entitled to be reimbursed for such costs in the amount of $65,290.26.

59. Following contract termination, HMA undertook an evaluation of the computer needs of the DEAP project. HMA made a business judgment that it would be less expensive and more efficient to expand Appellant's PC-based Q and A system rather than use the PDP-11 system referenced in the contract and related SIMS[28] software. The cost (labor and equipment) of expanding the existing PC system was $98,226.62. These costs were incurred by HMA and paid by the State. The Board finds these costs to be reasonable. However, because the contract was mutually terminated by the parties, the Board need not consider whether pursuant to the termination for default clause the State is entitled to be reimbursed for the cost of the follow-on contractor's (HMA) business decision to use the expanded PC-based Q and A system and the State's claim for $98,226.62 for the cost of such expansion is denied. The State is not entitled to reimbursement for costs arising out of a business judgment by the follow on contractor under the terms of the Preliminary Contract Termination Agreement.

60. The State's claim for alleged unrealized budgeted savings for FY 1988 and FY 1989 in the amount of $3,175,768 (subsequently

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[28] Part of the expense of using the PDP-11 and SIMS software included substantial license fees payable to a third party licensor (Sedna Corporation of which Mr. Lourey was President) for use of the SIMS software.

amended upward to $3,198,360[29]) is set forth in the Procurement Officer's decision in MSBCA 1576 in relevant part as follows:

> The State reduced the budget it submitted to the General Assembly by $10,219,000 over two years, but realized only $7,043,232 in revenue. Its damages are $3,175,768, calculated as follows:
>
> Recorded savings from CAI's 747 cases through FY '89 total $3,103,810. However, this clerical record does not accurately depict actual State savings, i.e., savings the State would not have realized absent CAI's efforts. Part of the recorded savings from CAI's 747 cases are not actual savings, but, rather, are savings which duplicate savings achieved in the ordinary course of State business by a pre-existing baseline of cases converting to SSI/DI without any advocacy assistance. This baseline must be discounted in order to reflect actual State savings. A discount of 25% is applied to CAI's recorded savings from the 747 cases after two years, to adjust those savings to $2,327,858. Subtracting CAI's fee of $651,800 (28% x $2,327,858) yields a net general fund savings of $1,676,058).
>
> The State has credited CAI with $7,403,493 in gross savings achieved by various backclaims. Subtracting CAI's fees of $2,072,978 and DHMH expenses of $54,326 yields net general fund savings of $5,330,515 for backclaims.
>
> HMA's work in FY '89 produced $1,451,170 in recorded savings. Savings from HMA cases are not subject to the same 75% adjustment as CAI's cases because case selection procedures were adjusted to account for the baseline. However, because there may be some overlap in the pre-existing baseline and HMA cases, a 5% discount is applied to HMA's savings, yielding adjusted savings of $1,378,612.
>
> HMA's costs for FY '89 were $1,808,196. The State received 25.78% FFP for administrative costs, reducing HMA's costs to $1,342,043. Subtracting HMA costs from HMA savings yields a net general fund savings of $36,569.
>
> The State's claim against CAI is as follows:

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[29] Such upward amendment appears in Respondent's Response and Cross-Statement to Appellant's Statement on Proof of Costs filed with the Board in October of 1991 and in Respondent's Statement on Proof of Costs dated May 9, 1991.

Projected Revenue, FY '88 and '89 $10,219,000

Actual Revenue, FY '88 and'89

1.	CAI case revenue	1,676,058
2.	CAI backclaim revenue	5,330,515
3.	HMA revenue	36,659 [sic]
	Subtotal:	$ 7,043,232

State revenue loss: $ 3,175,768

Such claim for reasons more particularly set forth below is denied because the contract did not obligate the Appellant to specifically achieve a level of budgeted savings but only obligated Appellant to "take all reasonable actions necessary to achieve...savings [of $4.35 million in FY 1988]" because such savings had already been anticipated in the DHR and DHMH FY 1988 budgets prior to contract execution. Such language does not constitute a guarantee. Appendix A to the contract contained projections for savings which were estimates not guarantees.

61. The contract, Section II(2)(B), required Appellant to assume the costs of funding the DEAP Medical Assistance Unit ("DMAU") as part of the project costs. The MOU, p. 18, affirmed CAI's obligation to:

> Reimburse DHR for reasonable staff costs related to establishing a separate unit to determine initial technical and financial eligibility for MA and to perform redeterminations of eligibility, according to regulations, guidelines and procedures established by DHMH.

As of the date of mutual termination, November 9, 1988, DHR had incurred DMAU funding costs of $53,999.74 which CAI has not reimbursed. The State is entitled to be reimbursed such amount.

Decision

A. FMA/SSI/DI Entitlement

The parties stipulated that a 28% fee would be paid for 748

(a/k/a Group 74)[30] cases converted from GPA or State MA to SSI or FMA. The parties have stipulated that these cases were accepted as medically, financially and technically eligible by the DHR MRT and the DMAU for FMA or were converted to SSI prior to November 9, 1988 due to Appellant's efforts from which the State realized actual savings. The parties stipulated the value of the FMA savings for those 748 cases to be $7,360,363 and the GPA savings to be $3,088,464. The Board will not disturb the stipulation. However, the Board does not adopt the legal and factual stipulations of the parties as the parameters for any of the 748 cases, as being applicable to any case outside of this group. Cases outside of the 748 Group 74 stipulations must stand or fall on their own merit. Applying the requirements of the contract documents to Appellant's entitlement to a fee we find entitlement to a fee exists only for the 748 Group 74 cases. However, certain deductions or adjustment must be made to the fees for the Group 74 cases. We will initially focus principally on FMA fees and adjustments and then deal with SSI fees and adjustments.

Appellant's right to fees is addressed in § II(2) of the contract; to wit:

> (A) DHR WILL pay CONTRACTOR 28% of the actual savings realized to DHR from General Public Assistance payments, and to DHMH from State-only Medical Assistance payments for the first three years of receipt of federal benefits by each recipient who is accepted for SSI and/or federal MA, as a result of the CONTRACTOR'S efforts.
>
> (E) The eligible period for determining the CONTRACTOR's fee is 36 months from the date each person is eligible for federal MA and/or

[30] The parties referred to this group during the hearing as generally encompassing persons relative to whom the State agreed Appellant was entitled to a fee. The list of names for Group 74 changed during the hearing as Appellant reorganized its groups. Appellant's various groupings of cases are discussed in detail below.

SSI/DI or other non-State benefits.

(F) ... Upon the date that a recipient is determined eligible for federal Medical Assistance for the disabled (Category 29) by the Medical Review Team, the CONTRACTOR shall have fully earned, subject to the provisions of § II(2)(G) ... hereof, the agreed upon percentage of the actual general fund savings ....

(G) If the Contract is terminated while there are any persons who have been determined eligible for federal MA for the disabled (Category 29) for whom the application process for SSI ... is underway and approval is pending, ... (2) the parties will negotiate and calculate a net valuation of the CONTRACTOR'S right to fees for those persons determined eligible for federal MA for the disabled (Category 29) based on savings the CONTRACTOR would have derived from such proportion of those persons [who would probably be eligible for SSI].

Section II(2) of the contract, thus in several separate places (subsections (A)(E)(F) & (G)), states that CAI is entitled to a 28% fee only in the event of recipient acceptance or eligibility for FMA or SSI. This is the first criteria for CAI fee entitlement: actual eligibility for FMA or SSI.

Section II(2) of the contract provides as a second criteria for fee payment to Appellant that cases be "accepted for SSI and/or federal MA as a result of the CONTRACTOR'S efforts." See also Contract p. 2, line five ("CONTRACTOR will be paid a fee equal to 28% of the actual general fund savings resulting from the CONTRACTOR'S activities...") and Contract p. 12, (2) (F) ("CONTRACTOR payment for an individual client will be calculated only for those periods in which the client receives non-State benefits as a result of CONTRACTOR activities ...."). Emphasis added.

The detailed efforts necessary for Appellant to place a case on FMA and/or SSI were not spelled out in the contract, but were left for resolution in the MOU. See Contract, p. 5, § I (3)(A)3, requiring CAI to execute or effect a "Memorandum of Understanding

... spelling out the methods for documenting General Fund savings resulting from the CONTRACTOR'S efforts and the methods and procedures for calculating the CONTRACTOR's FEE." Emphasis added.

The MOU, Operating Procedures, p. 29, § II A&B, describes how a case becomes eligible for FMA. Appellant files the DHMH Title XIX application, along with supporting medical and financial eligibility documentation, with the DMAU. Thereafter:

(1) The DMAU forwards material to the DHR MRT, which finds the client medically eligible; and

(2) The DMAU finds the client financially eligible.

If both findings are positive the DMAU notifies DHMH to convert the case from GPA to FMA. If, instead, the DHR MRT finds the client medically ineligible, the case is returned to Appellant. If the DMAU finds the case financially ineligible, the DMAU notifies Appellant of the client's ineligibility.

In the contract, CAI agreed to establish DEAP. In the MOU, CAI agreed to accept responsibility for all work necessary to establish FMA eligibility. In the aggregate, Appellant agreed to:

* Complete documentation necessary to establish medical eligibility for FMA;
* Organize and pay for a separate DHR Medical Review Team to establish medical assistance eligibility for FMA. CAI did this by subcontract with Immediate Care, Inc.;
* Complete documentation necessary to establish technical and financial eligibility for FMA; and
* Pay DHR to establish a separate DEAP Medical Assistance Unit ("DMAU") to determine technical and financial eligibility for FMA.

Thus, the contract documents (contract and MOU) provide that

in order for a case to be eligible for FMA "as a result of CAI's efforts," Appellant must establish both medicai and financial eligibility. Appellant earns a fee only if it successfully completes both efforts.

Further, Appellant is entitled to a fee only when the State receives "actual savings." The Contract, § II(2)(A) provides "DHR WILL pay CONTRACTOR 28% of the actual savings realized ...." Emphasis added. The State receives no savings until a recipient is actually converted to FMA; a medical eligibility determination alone does not result in an FMA conversion, and the State realizes no savings. Thus, the "actual savings" requirement of the contract means that a case must be eligible for and converted to FMA before CAI is entitled to a fee.

Accordingly, under the contract documents, Appellant is entitled to a fee on State MA savings if, before termination, three criteria are met:

1. A case is accepted as eligible for FMA,
2. As a result of CAI efforts, and
3. The State realizes actual savings.[31]

Pursuant to the above requirements, Appellant would have to find the client and obtain authorization for representation. it would have to evaluate the claim, file all claim forms, gather medical and financial information and provide this to the DMAU.

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[31] The contract requirement that Appellant be paid only on the basis of "actual savings" is significant in another respect. "Actual savings" must logically mean savings over and above the savings the State was already achieving from FMA/SSI conversions before contract execution. The parties shared this interpretation, but assumed that only a few SSI case conversions were occurring. The fact of a baseline (baseline cases and natural forces cases are two terms used interchangeably throughout the record) of 150-180 cases per month converting to SSI without advocacy assistance actually occurring after the contract was executed, means that all recorded savings achieved during contract performance from cases converting to FMA/SSI are not "actual" savings. Mr. Copeland testified that these "natural forces" cases could comprise as many as 50% of the converted population. Mr. Friedman used a more conservative 25% estimate.

If a file is properly before the DMAU, it would subsequently go to the DHR MRT for medical evaluation. If medically satisfactory the case would still have to meet the financial eligibility test of the DMAU. If both medical and financial criteria are met the DMAU would then notify DHMH to convert the case to FMA from State MA. All of these requirements must be met for Appellant to be entitled to a fee and they must have occurred prior to November 9, 1988. By virtue of the State stipulation as to the Group 74 748 cases that all these contractually required acts occurred prior to November 9,1988 we find entitlement. In all other respects for all other Groups or cases (i.e. Groups 73-10 as discussed in further detail below) entitlement is denied. Appellant's argument that all it need do to earn its fee was screen a person for probable eligibillity or at most screen and have an authorized representative form executed by a person ultimately found entitled to federal benefits is untenable, since it assumes someone other than CAI will complete the process. Appellant bases this argument upon a section of the contract which described valuation of fees for SSI eligibility through negotiation by the parties, if cases are not complete prior to termination.[32] However, the parties failed to negotiate and calculate a fee for these cases beyond the stipulated Group 74. The Board cannot speculate on which cases would or would not be placed on federal benefits. CAI made no attempt to directly link its efforts to any specific case beyond the 748 cases in Group 74. With very limited exception for a few GPA persons there was no showing of actual hands on advocacy by Appellant, only indicia in the record of the ultimate result.[33]

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[32] See Contract § II(2)(G).

[33] The record in this appeal concerning entitlement and quantum largely consists of Appellant's evaluation of records and applications of statistical models thereto several years after contract termination. This process of evaluation ultimately resulted in numerous revisions to the Appellant's Proof of Costs. CAI's Proof of Costs, updated and refined several times during and

Years after the termination of the contract CAI consultants attempted to reconstruct a value for the fees to which it asserts entitlement. CAI did not have a list of it's clients names. The attempted reconstruction followed the following method. Appellant requested that the State provide a complete list of names of persons listed with the DEAP project, before, during and after the CAI era or "Copeland era" which Appellant defined as July 1987 through December 1988. They used this list and requested TPQYs (a federal form reflecting SSI eligibility) from the Federal Government to find which of the cases were successful in securing federal benefits. CAI then made a detailed examination of all available records through the fall of 1991, for any indication of a date which encompassed the CAI era. If any note, TPQY, DHR-DHMH list or any other source gave indicia that something was done on an SSI/FMA claim, during the CAI era, CAI then selected that case as a CAI fee entitled case. Very little evidence was offered at the hearing or otherwise as to any link between actual work or advocacy by CAI and the ultimate success of any claimed case. In fact, the evidence presented by Appellant demonstrated that in certain instances efforts by

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once after the hearing of the appeal, relies upon the accuracy of the records of others. The Federal, State and follow on contractor's records were what Appellant used to construct and reconstruct its efforts. This was required since Appellant kept no separate records despite the contract requirements for recordkeeping as well as ordinary business care. The record keeping efforts of others resulted in enhancing Appellant's ability to present a case as to entitlement and quantum. Without the records of others and stipulations of the parties, Appellant would have been ~~un~~able to present a prima facie case. Appellant's method of refining the claims through ongoing review of the records of others also resulted in numerous reiterations of its position on various claims (some of which were abandoned) resulting in many descriptive codes and groupings. This requires one to carefully follow the evolution of various theories in Appellant's presentation. The Board has done so and has rejected Appellant's claims on the merits rather than, as it would be justified in doing, on the basis of a failure of Appellant's Proof of Costs.

others to include efforts by the client[34] himself was the causation of FMA/SSI conversion, not efforts by CAI. The parameters for FMA/SSI entitlement are set forth in the contract documents. These parameters may not be relaxed or expanded by this Board.

The purpose of the DEAP project was advocacy. Appellant was to seek GPA and Maryland MA recipients and represent them to achieve conversion to federal entitlements. The contract documents cannot reasonably be interpreted to mean that CAI could simply screen State GPA and State MA clients and wait to see if any eventually become eligible for FMA/SSI.[35] A number of this population group could be expected to become converted and had a history of conversions from GPA/MA to SSI/FMA without advocacy. This group was called the natural forces or base line group. This conversion by natural forces (i.e. conversion through client effort, 3rd party effort other than the Appellant, legal presumptions of eligibility) was estimated by CAI at 50% and at 25% by the State. The group of cases which would naturally convert to SSI/FMA was not foreseen as creating a right to a fee. Actual savings necessarily requires some savings over that which would occur if CAI had never been retained. CAI was a sole source for the expert ability to generate revenue by moving GPA and MA State cost dollars to FMA/SSI Federal cost dollars and thereby allow State general fund expenditures to reflect a reduced cost for GPA and State MA payments. The contract documents were structured to allow a fee for conversions due to CAI efforts. This Board concludes the State reduction of

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[34] Appellant in presentation for illustrative purposes of a case to demonstrate fee entitlement clearly showed that the client in that case without CAI advocacy had filed a claim prior to the CAI era and that from that client act CAI in hindsight claimed a fee.

[35] Mr. Copeland testified the only contract requirement was that CAI screen 6500 recipients of State GPA and State Medical Assistance for eligibility for federal benefits and nothing else was required for entitlement to a fee.

Appellant's fees to account for natural forces cases was appropriate and will similarly reduce the fees for the Group 74 cases by 25%.

CAI in developing its proof of costs methodology experimented with several statistical models to portray its alleged entitlement to fees. A number of these models were abandoned during the hearing and new models were developed which Appellant believed would more clearly reflect entitlement. An examination of these models reveals the expansive extent to which Appellant interpreted its rights to fee entitlement under the contract documents. First, we will review some of the abandoned models.

The parties discussed the concept of "dangling eligibility". A review of the record shows that there were at least four separate articulations of what constituted a dangling eligibility case.[36] In effect, cases which fell into this group were cases in progress which, for one of several reasons, were not completed. In one sub-group, cases which were eligible, but not reconsidered within the six month rule,[37] were allowed eligibility since the person making the judgment concluded they would ultimately be determined eligible. The contract was for processing cases from State GPA and MA rolls to federal entitlements and the parties knew from the commencement of the contract that cases would be in various stages of the process. Appellant wanted to include all cases close to or approaching eligibility where State personnel allowed a fee without meeting all requirements on some, but maintained in general full eligibility requirements to be met for the majority. However, this part of the dispute was abandoned by CAI during the hearing.

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[36] There were many varieties of "dangling eligibility." It became clear early on in the hearing of the appeal that witnesses referring to cases as "dangling" did not consistently have in mind the same type of "dangling" cases.

[37] The six month rule was a State policy that required that redetermination of eligibility be performed every six months.

Appellant also argued for entitlement for "retro-cases." These cases were those where the person was already converted to Federal entitlement and was not a CAI case. However, CAI would file a retro-claim for three months eligibility for the period prior to the conversion as allowed by Federal law. The parties argued over the number of cases that were retro-only (a/k/a ninety day cases). CAI argued that the retro-cases numbered approximately sixteen in the hope the remainder of the retro-cases would be in a full CAI category of entitlement in another one of its case groups. The State posits approximately forty were retro-cases since retro-case fee calculation is based on ninety day and not thirty-six months. However, the retro-cases argument was also abandoned by CAI during the hearing.

The record clearly reflects the opposing forces at work in performances of this contract. Appellant used statistical models which included all possible cases for the longest period of time to capture the greatest amount of State medical assistance and GPA savings, and increase the amount of the fees. The State resisted Appellant's approach and attempted to stay within contract parameters and policy decisions consistent with the provisions of the contract documents in determining the fee calculations. The parties, however, have stipulated throughout the appeal that statistical models are acceptable. The conflict then arises over which ones to use.

It is this struggle over how many cases are to be included in the correct category and what modifiers of valuation are statistically acceptable which has led to this protracted litigation. Even as to the amount of the fees to the undisputed 748 cases in Group 74 to which the State concedes some fee entitlement, there still remains for the Board statistical factors to be or not to be applied which will affect the outcome. We now address those factors which apply to the 74 Group, for which the Board as a result of the stipulation of the parties finds some entitlement. The factors are the natural forces factor, the SSDI adjustment factor and the late billings factor.

The Board, as discussed above, will apply a 25% natural forces factor to reduce CAI fees for any case.[38]

Appellant presented a statistical model to increase the amount of FMA savings in the Group 74 cases (and thus its fees) which was labeled the SSDI factor. Appellant seeks an "SSDI adjustment" intended to reflect the fact that the State may save more than 50 percent of State MA costs for beneficiaries who become eligible for SSDI and, later, Medicare. See Footnote 44, below. While the basic premise of the potential for such additional savings is stipulated to by the parties the method of analysis to most accurately reflect such actual savings is disputed.

The Appellant's analysis assumes that Medicare pays 91 percent of Part A costs and 80 percent of Part B costs. We find such percentages are too high. For purposes of illustration, the relevant figures for 1991 can be examined. The Part A deductible is $628 for beneficiaries with one hospitalization subject to such payment in 1991. The cost to the government of the Part A program is known to average $177 per month (the Part A voluntary premium rate), or $2,124 for the year. This suggests that Medicare pays about 77 percent of Part A costs for the typical beneficiary with a single hospitalization, and many of the beneficiaries for which Appellant claims entitlement were in fact hospitalized. However, without knowing what percentage of Medicare beneficiaries were hospitalized, and what percentage of Medicare Part A costs were attributable to them, the true percentage of savings cannot be determined.[39]

With respect to Part B, for almost a decade Congress has set the monthly premium so that it covers 25 percent of Part B

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[38] CAI accepts the validity of the natural forces adjustment but maintains it is not provided for in the contract. The fact is none of the statistical models used in this dispute are expressed in the contract documents.

[39] This information may be obtained from the Health Care Financing Administration but was not made part of the record.

program costs for the aged (exclusive of the annual deductible and coinsurance amounts). It also was Appellant's assumption tht the medical costs for the disabled are similar.[40] The deductible and coinsurance are additional costs to beneficiaries with claims (or to whoever pays these amounts on behalf of such beneficiaries). Thus Medicare might pay closer to 70 percent than to 80 percent for Part B. Based on the record we find that the overall average Medicare FFP value is approximately 75 percent and not 87 percent as claimed by Appellant.

The Appellant's analysis relies on the reported 34.3 month average duration of Appellant cases in the 74 Group with 3 months assumed for FMA status, 24 months for SSDI and 7.3 months for Medicare. This figure is derived from combining the total fee months with the "remaining" months for the "undisputed" Group 74 and dividing by the 748 members of the group. However, while membership in the undisputed group is stipulated, the number of fee months and certainly the number of remaining months are not ascertainable. The average duration is, the Board finds, approximately 32.4 months.[41] Using that figure, the average FFP for the SSDI subgroup within Group 74 declines, because the number of Medicare months is reduced.

The distribution of the Appellant's assumed 34.3 months among FMA, SSDI-only, and Medicare months is also questionable. The SSDI program has a 5-month statutory waiting period that, in practice, results in at least 7 months of FMA eligibility. The month of disability onset is not ordinarily counted toward the waiting period, and SSDI benefits are not paid until the third

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[40] ~~This~~ assumption by Appellant that medical costs for a person on SSI are as high as medical costs for a person on SSDI is without any scientifically supportable study.

[41] The State originally used 31 months as the average duration. However the State's expert's representation of the correct number of months to use to capture the SSDI adjustments was 32.4 months. The Board, while questioning certain assumptions made by the State's expert, will accept 32.4 months as the appropriate timeframe.

day after the end of the sixth full calendar month. That would be the 8th month after disability onset. Because the onset month could be the first month of FMA eligibility, 7 months of eligibility would normally have passed before SSDI benefits commenced. This assumes that adjudication of the case is timely, which is often not so. In any event, the number of low-FFP MA months is understated, again inflating the average FFP figure.

Medicare itself does not begin until the 25th month after SSDI entitlement. This is ordinarily the 31st month after disability onset. Thus, for the first 30 months of potential FMA eligibillity, Medicare eligibility ordinarily is unattainable. This also indicates that the number of high-FFP Medicare months is overstated in the Copeland analysis. Using an average duration of 31 months and eliminating the first 30 as not Medicare-eligible, the average number of high-FFP Medicare months is reduced to 1.

Additionally, the FFP value used by Appellant of 100 percent, is the maximum possible value and implies that beneficiaries with SSDI only receive no State MA benefits from the State. This would be correct only if the SSDI benefit amounts were so large as to result in State MA disqualification. In fact, slightly more than half of the SSDI-only beneficiaries receive very small SSDI benefits allowing them to remain on the State MA rolls. In such cases, the FFP value is 50 percent. Overall, we find that the correct SSDI-only FFP value is approximately 75 percent, not 100 percent as asserted by Appellant.

The distribution of FMA and SSDI months for the dually entitled subgroup is not supported by any evidence. Even if the 26 total on-Medicare months assumed in Appellant's model is correct the allocation is certainly incorrect. Beneficiaries who are dually entitled retain SSI and, thus, FMA eligibility; they have no high-FFP SSDI-only months.

Some cases went onto SSDI. When a case goes onto SSDI the medical bills are paid by others, presumbly the client. However,

those actual medical costs are not tracked by State or Federal authorities because they do not pay them. Appellant argues that since the State is not paying these medical bills, CAI has saved the State payment of these medical expenses and is entitled to a fee. Normally FMA is calculated at 50% (Standard Federal Participation) for all actual medical bills, and Appellant's fee would be 28% of such 50% saving. CAI avers in SSDI cases the State saves 100% since "others" pay the bill so the fee would be 28% of 100% of the medical bill.[42] However, there are no official records of these medical bills. Only the client (or others paying) and the providers would have knowledge of what the actual medical bills would be. CAI posits that to collect the actual medical bills would be impossible,[43] so they developed an average medical cost per month based upon the actual medical expense records for their SSI group. This model was then subjected to statistical evaluation by State and CAI experts.

Finally, the application of the SSDI adjustment factor to the entire "undisputed" 748 person population is inappropriate. The adjustment should only be applied to the SSDI subgroup within Group 74. The factor should be computed so it produces the correct adjustment when applied to the smaller group.

The SSDI adjustment can be recomputed using modified assumptions as to the FFP values of SSDI-only and Medicare months, a more appropriate distribution of the three types of months (FMA, SSDI, Medicare) and a shorter average duration. Using the modified assumptions described above applied to the distribution of the three classes of beneficiaries, the average FFP value is 60.5 percent, rather than 83.4 percent. To achieve the final multiplier for the SSDI adjustment the 60.5 percent is

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[42] The Appellant's assumption requires a belief that a client will use more than all of the SSDI benefit to pay its average medical expenses and makes no allowance for the cost of living of the client.

[43] Appellant would have to meet with the clients and obtain the actual bills.

doubled and then reduced by 100% yielding a factor of 0.21.

At the hearing Appellant concluded .664 was the appropriate factor to use as a multiplier to capture the SSDI adjustment and the State expert allowed an 0.21 factor. Assuming the Board finds entitlement the State has stipulated that Appellant could be entitled to an additional fee of $79,730 for the Group 74 SSDI adjustment of $284,748 derived from the 0.21 factor and the Board will not disturb that stipulation. However the Board finds that no SSDI modifier was contemplated by the contract documents. The contract documents are void of any provision for valuation of CAI efforts beyond actual savings. CAI was the client advocate and was obligated to provide records of actual savings to earn a fee. While there are contract provisions which envision statistical models for fee evaluation, this reconstruction-remedy existed as a negotiating tool between the parties and the Board denies Appellant's claim for an SSDI adjustment as being too speculative, since there is no evidence of actual savings but only conflicting testimony concerning theoretical savings.[44]

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[44] Appellant in reviewing cases in the MMIS for medical bills discovered a group of cases with zeros for a large number of months. In evaluation of the possible reasons for these zeros the theory of an SSDI adjustment factor was born. Since there are no actual medical bills to find in the records, Appellant created a statistical model for the medical bills you might expect to find if you went to the client and asked: did you in fact incur medical bills in these "zero" months, which bills were paid by you or by others such as; Medicare, SSDI, SSI/DI? The State MMIS showed "zero" since they did not pay any of the "expected" bills. To create the expected medical bills Appellant looked at similar groups receiving benefits from the State under different State programs. Appellant then assumed these persons must have the same medical bill history of actual bills as those persons with "zero" months, since in Appellant's view they are all essentially the same group of people.

"Zero" months occur on the State MMIS system where either: there are no actual medical bills, the client pays the medical bills, private insurers pay the medical bills, the bills are not paid by the State nor anyone else, Medicare pays the bill, SSDI pays the bill or SSI/DI pays the bill. Nevertheless, Appellant assumes that these bills exist and that Medicare, SSDI, or SSI/DI

Appellant also argues it should be entitled to a fee for "late billings". Late billings result from the ongoing process of handling claims. Providers are not required to immediately forward their bills. Some providers wait a year or more to submit bills. However, if a person is FMA entitled and one calculates the amount of that person's medical bills on a date certain one will only find the medical bills submitted as of that date. Consequently, the State savings and proportionate fee amount will be lower, since some of the bills while due and owing have not been submitted on the date of calculation and would thus not be reflected in the savings as of that date. Appellant argues it is entitled to calculate an amount for late billings using a statistical model. The State denies this claim, and maintains only those bills actually there to be counted up to the date of termination should be considered in calculating

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pays 100% of the bill or an amount equivalent to 100%. Therefore, pursuant to Appellant's theory the State saves 100% with some adjustments. Appellant believes 100% should be .834 or 83.4% in the real world since if these bills exist and are paid by Medicare, SSDI or SSI/DI the theoretical 100% is never actually attained. In order to reflect the true incremental cost in Appellant's analysis you must take (.834 x 2) - 1 to reach an .668 SSDI factor (which is amended to .664 due to a typographical error).

The State expert accepts Appellant's basic approach, without explanation in the record, with certain adjustments.

According to the State's expert (whose findings we have in part adopted) .605 or 60.5% is a better average of expected Medicare, SSDI and SSI/DI payments for these expected "zero" months. Applying the Appellant's formula [(.605x2) -1] yields an 0.21 SSDI factor. No reason is given for the formula (factor x 2)-1; it is simply accepted by all to reflect the "incremental" cost. This formula has an interesting affect on the fee, however. Appellant says 83.4% of these theoretical medical bills were paid by Medicare, SSDI and SSI/DI and the State says 60.5%; a 23% difference. Apply the formula and the difference is .664 to .210 or approximately 300% more. While the theory of an SSDI adjustment and the difference in arithmetic used by the parties is explained, proof of the basic assumption needed to support this methodolology is absent and thus Appellant fails to meet its burden of proof that "actual savings" were achieved.

Appellant's fees. We agree. Appellant's fees attributable to late billings include late billings for provider services performed prior to the CAI era. To also allow CAI a late billings adjustment for provider services performed during the CAI era but not submitted until after contraction termination is an unreasonable interpretation of the contract. The parties knew from the commencement of the contract there would be a number of medical bills for provider services that predated the contract for which CAI would be paid a fee to which they would not otherwise be entitled and that the process of tracing late billings was not cost effective. Appellant took advantage of that segment of the late billings equation. However, CAI will not be allowed to also benefit at the end of the contract. It is the responsibility of the follow-on contractor to gather and to process these late billings. The Board will not allow any late billings adjustment, beyond the stipulation of the parties.[45] If Appellant had remained on the project it would have benefited from the late billings, but nowhere in the contract is it required or contemplated that providers must have all bills submited by a date certain, i.e., the date Appellant processed its various claims. The volume of paperwork in the billing process makes this obvious.

The parties have further stipulated as to the undisputed 748 persons in Group 74 that 493 were converted to SSI by CAI efforts resulting in GPA savings of $3,088,464 for which they should receive a 28% fee in the amount of $864,769.92. Again, the Board will not disturb the parties stipulation. However, the Board will not adopt the legal or factual parameters of any of these cases as a standard for SSI entitlement beyond the stipulated group.

The Board finds that for SSI/SSDI entitlement Appellant was

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[45] A late billings adjustment is included in the $7,860,363 actual savings for FMA conversions stipulated to by the State for the 748 persons in Group 74.

required to locate the client and obtain authorization to represent the person. Appellant was then required to assemble all financial and technical information, file all necessary forms, reapply if necessary, and advocate through the ALJ level until a final determination.

Once a favorable determination is achieved, evidence of such conversion must be reflected on a Federally recognized role or indicee such as a TPQY or SDX. When the aforementioned is accomplished prior to November 9, 1988 a fee attaches. If a case does not meet all of these parameters (except stipulated cases) no fee is accruable.[46] The contract does provide for negotiation between the parties for SSI conversions not completed at termination. However, the Board will not negotiate for the parties. If the tasks are not finished, in the absence of stipulation, there is no entitlement.

The parties have not agreed as to the affect of natural forces on the stipulated 493 SSI conversions in the Group 74 cases. The Board applies the natural forces reduction[47] of 25% consistent with the rationale in the FMA section above. CAI was not to be paid for conversions that would have occurred without advocacy. Appellant's position that they merely had to show some indication of CAI involvement in the case during the CAI era to be entitled to a fee is inconsistent with any reasonable reading of the contract.

Further the Board will reduce the fee for the undisputed 748

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[46] The preliminary Contract Termination Agreement clearly states work is to stop. If Appellant wanted to preserve rights to pending type cases they should have put it in the termination agreement.

[47] As noted in footnote 38 above, Appellant accepts the validity of the natural forces adjustment, but argues that the Board should ignore the State's statistical 25% assumption for natural forces, because it is not in the contract documents. Such argument, however, is inconsistent with the entire presentation of Appellant's proof of costs most of which relies on statistical assumptions and models none of which are recited in the contract documents.

cases by $128,221.58 which represents the parties stipulation as to the costs to maintain Appellant's cases on FMA and pursue SSI appeals in Appellant's absence. Appellant asserts that it is not liable for such costs. The Board finds otherwise. Those cases were worked on by HMA after Appellant departed Maryland. If CAI was still on the project it would have incurred this expense.

However, the stipulated amount of overhead will not be adopted by the Board as to cases outside of the 748 Group 74. The record reflects a per case cost of $1,500.00 for the total cost of processing and maintaining a case pursuant to the requirements of the contract documents. Before contract work began the Appellant estimated a cost per case of $1,500.00. In subsequent correspondence between the parties, this estimate was referred to as a reasonable cost per case. The Appellant was paid advanced payments (out of the 1.2 million) based upon a projection of monthly costs of approximately $270,000.00. This figure was computed based upon consultant fees, home and field office expense, medical fees, report fees, rent, equipment program license fees, salary and other expenses.[48]

At a minimum $1,500.00 was the cost per case in light of the financial records of Appellant and testimony as to its expenses. This cost per case should be deducted from any fee entitlement beyond the 748 Group 74 cases, in addition to the "natural forces" reduction. The ultimate value of Appellant's fee must reflect the ordinary and necessary cost to produce that fee.

The Board having reviewed the undisputed 748 Group 74 cases as to FMA and SSI/SSDI fee entitlement and applied the reductions for natural forces, stipulated overhead cost,[49] fees previously

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[48] The details of these expenses are given in the Twardowicz report and supporting checks contained in App. Ex 834.

[49] As noted above the parties stipulated that administrative costs for the Group 74 cases would be $128,221.58. FMA redetermination costs were $24,477.60. ALJ costs for SSI cases were $103,743.98; $103,743.98 + $24,477.60 = $128,221.58.

paid and escrow double payment[30] finds Appellant's entitlement for those cases results in a fee of $1,889,001.

The Board now addresses cases beyond the undisputed 748 cases in Group 74 for which Appellant claims a fee. Preliminarily, as indicated above, the Board finds no entitlement to any group beyond Group 74. However, if the Board had found entitlement to cases beyond the Group 74 cases it would apply both the 25% natural forces reduction and the $1,500.00 cost per case reduction to any such case. An adjustment for SSDI would only have been allowed (had the Board found entitlement) based on a multiplier of 0.21 or a State stipulation as to entitlement. A late billings adjustment likewise would only have been allowable if the State stipulated thereto and then only for conversions up through June 30, 1989 when by the terms of the contract enrollment of new persons into the program was to end.

Appellant has categorized its cases according to an events chronology line of logic generally using November 8, 1988 and December 31, 1988 for operative events. In all groups, save Group 10, an ARF (Authorized Representative Form) or equivalent as defined by Appellant and discussed below exists. These groups are as follows:

Group 74	The 748 Group 74 undisputed cases, DHR MRT and DMAU approval was stipulated to.
Group 73	Cases claimed by Appellant where only DHR MRT approval was given by 11/8/88.
Group 72	Cases claimed by Appellant where DHR MRT had reviewed and denied the case by 11/8/88.
Group 71	Cases claimed by Appellant and received by DHR MRT without any decision by 11/8/88.

[30] The escrow double payment reduction of $39,245 represents a reduction necessary to avoid paying Appellant twice. Pursuant to the contract escrow provision § II(2)(H) the $242,887 paid to Appellant was 85% of the amount earned. The amount earned is $285,749. The difference is $39,245 which will be paid, if at all, pursuant to the provisions of § II(2)(H) at the appropriate time after remand.

Group 63	Cases claimed by Appellant and approved by DHR MRT between 11/9/88 - 12/31/88.
Group 62	Cases claimed by Appellant and returned for more work by DHR MRT between 11/9/88 - 12/31/88.
Group 61	Cases claimed by Appellant and only received by DHR MRT between 11/9/88 - 12/31/88. (Some of these cases were alleged approved by DEAP-MRT[31]).
Group 50	Cases claimed by Appellant and approved by DEAP-MRT after 12/31/88.
Group 40[32]	Cases claimed by Appellant with ARF dates between 11/9/88 - 12/31/88 only.
Group 10	Cases claimed by Appellant with no information to support the claim but Appellant believes it may find information, i.e. if an ARF exists it has not yet been located.

See Appendix A to Appellant's revised Proof of Costs.

Excepting Group 74, these groups range from Group 73 where the DHR MRT had made a finding of medical eligibility but no final decision had been made by the DMAU on technical and financial eligibility prior to 11/9/88 to Group 10 where there is no information to support a claim and only a hope that information will become available. The Board has denied entitlement to all of these groups (save Group 74) for the following reasons.

Appellant left Maryland on November 8, 1988 or shortly thereafter without a list of its clients' names. Appellant has provided no adequate explanation for this failure. In fact, the only list in the record of client names prepared by Appellant during the pendency of the contract, i.e. during the CAI era, was

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[31] The DEAP-MRT consisted of the personnel who once formed the Appellant's Medical Documentation unit under Mrs. Caudle who were retained after the Appellant departed.

[32] There was another group Group 30 which was abandoned in Appellant's revised Proof of Costs. Former Group 30 cases are resolved under the discussion of entitlement to anticipatory profits.

a list containing only several hundred names.[53] In preparation for the hearing of the appeals, Mr. William Copeland and Messrs Lourey and Iverson[54] attempted to reconstruct Appellant's efforts.

With very limited exception for illustrative purposes there were no actual advocacy files introduced in the record. Virtually the entire presentation of Appellant's claim is a review of the records of the State, Federal Government and the follow on contractor years after termination.

In view of the information vacuum[55], Appellant's consultant Mr. Iver Iversen, many months after the mutual termination of the contract, created a model to demonstrate enrollment[56] of a case for SSI entitlement. Taking a complete list of all DEAP names supplied by the State he scanned through all documents and files to find a date rooted in the Copeland era. If a date could be found, that case was listed somewhere in Group 74 through Group 10 and claimed as an "enrolled" case.[57] The word "enrolled"

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[53] See Phyllis Hartstein testimony.

[54] Mr. Iverson was listed in the contract as one of the key personnel. However, due to illness he played a small role during the CAI era. Mr. Iverson was also Chairman of the Board of Sedna Corporation during the CAI era. See Footnote 28, supra.

[55] The information vacuum was perhaps exacerbated by the relationship of the parties during contract performance. The parties to this contract were at odds from the inception. A letter writing campaign of blame and finger pointing by both sides commenced in the fall of 1987 and commencing in late March of 1988 threats of abandoning the contract by Appellant and termination by the State are found in the record. Mr. Gerald Martin, while State contract manager, had generated some 30,000 notes and written records to demonstrate the interaction of the parties. Only a few were introduced into the record. Certain records that Appellant left in Maryland after contract termination were not retained. What they consisted of cannot be determined from the record.

[56] Enrollment ["enroll"] is a contract term. Contract, I(1).

[57] Based on Mr. Iverson's information and methodology, Mr. Lourey developed Appellant's claims for FMA entitlement.

comes from the contract. Appellant has interpreted "enrolled" to mean any case which has a date in the Copeland era. Appellant does not suggest that any actual enrollment (signing of a document by a client authorizing representation) was necessary for fee entitlement. Some of these cases do have signed Authorized Representative Forms (ARF) for Appellant, but the majority rely upon other indicia of Appellant's representation. Appellant describes indicia of representation as ARF's or equivalent. This means for example that if a TPQY (a Federal Government document reflecting SSI entitlement status) has a date of Federal action on conversion during the time Appellant was working (or after they left for some groups, i.e. Groups 63 through 10 or portions thereof) then Appellant claimed a fee for such case. Appellant only reviewed cases which were successfully on Federal benefits rolls in reconstruction of its efforts. Nowhere in this litigation did Appellant claim work for cases without proof of conversion.[58] However, any case which became federally entitled at some time before, during or after Appellant's involvement in Maryland was claimed as an Appellant's case if actual or theoretical GPA or MA savings could be traced to the Copeland era and thirty six months thereafter.[59]

The word "enrolled", however, is not ambiguous. Appellant was to go out and find clients, obtain their authority to act and develop an advocacy file. If such files exist they were not produced, excepting excerpts for illustrative purposes for a handful of persons. Appellant's interpretation of enrollment is not a reasonable reading of the contract documents. The contract documents do not envision that a client, third party or other

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[58] The record does not reflect the number of cases worked on by Appellant for which no FFP was achieved. The record also does not reflect the total number of cases screened by Appellant.

[59] This approach is evident in Appellant's Proof of Costs which attempts to capture the overall successful impact of FFP for the DEAP clients and does not attempt to recreate records of Appellant's advocacy work.

force, whose actions converted a GPA or State MA person to federal benefits would entitle Appellant to a fee. This contract only awards a fee for advocacy by Appellant resulting in conversion. There can be no entitlement without an Authorized Representative Form signed by a client, after which Appellant through advocacy, even if such advocacy merely consists of Appellant filing the proper forms and applications in the proper places, converts the client to federal benefits prior to November 9, 1988, the date the parties mutually terminated this contract for their convenience.

Appellant argues that as to Group 73, the State had all elements required and wrongfully denied the cases due to an erroneous application of Federal law. This group was at least in part denied eligibility because they did not meet the financial requirements of the DMAU. The record reflects that 60 persons in Group 73 failed the financial-technical requirements because the DMAU included in their financial resources the GPA/State only funded monthly payment.[50] Appellant asserts that a correct reading of the applicable Federal Regulations do not require a State DMAU to include GPA/State funded payments in calculation of a persons financial resources. State policy during the Appellant's tenure was to include these amounts. It was suggested at the hearing that State policy makers used this more stringent application as an accounting safeguard. However, after Appellant left, the State changed its policy and did not require

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[50] Appellant asserts that this reason for denial was the sole reason for denial applied to all 940 cases claimed by it to constitute its Group 73. However, there may have been numerous other reasons applicable to each specific case for denial. There was no case by case explanation for denial. The Board does not know if any other reasons would or did result in denial for any Group 73 case. To find entitlement, if the State income determination policy was in error, would require a case by case analysis to determine if there were any other reasons for DMAU denial. No such evidence was offered at the hearing. In fact, where individual cases were discussed the parties could not agree on the specific reason for denial.

inclusion of GPA payments in the calculation of the financial status of applicants for federal benefits. As a result of this policy change, Appellant asserts that hundreds of cases which were allegedly initially denied on financial eligibility grounds and for which Appellant claimed enrollment were later converted to federal benefits.[6] Appellant argues the State should follow the less inclusive (or more liberal) application of the Federal Regulations. We disagree. The State, for policy reasons, consistently required inclusion of GPA payments in financial eligibility determinations. A State may not do less than required by Federal law, but nothing prohibits a State policy from being more restrictive as that policy relates to State contracts.[7] The State also benefits with Appellant from FFP conversions. The State was not arbitrary in its determination to deny FFP claims on financial ineligibility grounds. It is the State not Appellant that is responsible for repayment of Federal Participation if a case was challenged on audit for financial ineligibility.

The State made many policy decisions which affected the DEAP program, all of which were within its rights under the contract documents. In one group of cases, the State had a policy of requiring redeterminations every 6 months. However, this was waived for some cases and Appellant was paid a fee without strict adherence to that policy. Appellant has not complained about such waiver nor does such waiver mean that the State was required to waive the GPA payment inclusion in determination of financial eligibility. Appellant cannot dictate to the State what its

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[6] The State change in policy affected only 42 of the 60 cases previously denied under the old policy out of a total asserted Group 73 of 940 persons.

[7] Caution must be exercised in not confusing the federal rules pertaining to GPA and medical assistance under Social Security. GPA payments are not dependent on a finding of age, blindness or disability as set forth in the Social Security Act under SSI. Compare 42 CFR § 416.1124 with 42 USCA § 1396a (a)(10)(C)(i)(III).

policy should be, but must necessarily work within the confines of both State and Federal guidelines.

Finally we note that as to some cases in Group 73, work was obviously done by others after Appellant left Maryland and such work by State employees and the follow on contractor was not addressed by Appellant as to what degree the advocacy of others may have resulted in conversion for any specific person.[63] The fact someone is converted and Appellant has an ARF or equivalent is not enough for entitlement. Even if Appellant had an ARF for every case in Group 73,[64] the contract requirements including DMAU approval were not completed prior to contract termination on November 9, 1988.

Group 72 takes one more step further away than Group 73 from the fee eligibility requirements of the contract documents since there had been no determination by the DHR MRT that the person was medically eligible for FFP. The contract requires approval by a Medical Review Team (MRT) for medical eligibility. In Maryland, the decision making authority was delegated to the State by the Federal Government. Prior to the Copeland era, the State had a contract with a single physician and a social worker, which comprised the State MRT. The State used a physician and social worker because it was required by Federal law in the definition of MRT. However, the DEAP project was contracted on a grander scale and medical review of the records of many more persons than could be handled by the existing MRT was anticipated. The parties disagreed for months over what would be the MRT and who would pay the costs. Finally, it was agreed Appellant would establish and pay for the DHR MRT and it would not be supervised by Appellant. In this way, there would be no conflict of interest between Appellant and the State delegated MRT decision maker the DHR MRT. However, as discussed in

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[63] This issue was not addressed by Appellant for any group.

[64] Appellant could not locate an ARF for some persons in Group 73.

Footnote 8, Finding of Fact 13, the Appellant argues that its in-house medical records group constituted the MRT called for by the contract. Appellant hired Mrs. Patricia Caudle, a nurse familiar with medical evaluation with a background in SSA claims administration, to handle its in-house medical records group. However, Mrs. Caudle was not a physician nor a licensed social worker.[‡‡] This in-house unit reviewed, requested medical records and set up examinations and prepared the file for DHR MRT submission. Mrs. Caudle testified she never considered herself as the MRT. Appellant's assertion that final approval of medical eligibility was achieved by its in-house group finds no support in the record. The definition of MRT, as found in the contract, is not ambiguous and must conform to minimum federal standards. Appellant's argument that the medical records collection and evaluation staff (Medical Documentation unit) headed by Mrs. Caudle was the MRT for purposes of determining medical eligibility is not supported by Appellant's own witnesses, and controverts any reasonable reading of the applicable contract provisions and Federal and State requirements. Appellant is a sole source contractor who obtained this contract based upon its asserted expertise and should have been aware that it could not obtain medical eligibility without evaluation by an MRT comprised of a physician and social worker.

Also the clients listed in Group 72 takes one a step further away from the likelihood Appellant would have engaged in any significant advocacy on behalf of the client other than collection and forwarding of medical records and forms to the DHR MRT. In any event, these cases were denied by the DHR MRT prior to contract termination on November 9, 1988 and one of the requirements for fee entitlement under the contract was thus not met.

Group 71 cases claimed involve cases received by the DHR MRT

[‡‡] In Maryland a "social worker" must be licensed to use that designation.

without any decision by the DHR MRT by November 8, 1988. Appellant could not have possibly known if these cases had eligibility, since this group by definition includes persons for whom the work was not finished.

The next group of cases (collectively Groups 63, 62, 61, 50 and 40) extend the termination date of the contract from November 9, 1988 to December 31, 1988 and apply various levels of preparation to each group. The Board has found that November 9, 1988 is the termination date and that no work would be done by Appellant after November 8, 1988. The parties mutually agreed to terminate the contract by agreement dated November 9, 1988. To extend the date of termination to December 31, 1988 contradicts the action of the parties. The Appellant's argument for extension for entitlement for work in progress being conducted by others after it left Maryland is rejected.

For Group 10, Appellant has no information, not even a date ascertainable in the Copeland era. Consequently, there is no predicate for a finding of entitlement for the record is void.

Appellant also claims fee entitlement for FMA and SSI conversions for another group of cases classified by Appelant as Anticipatory Profit cases.[ii] Appellant avers if they had been on site until the date originally planned in the contract for them to transfer the project to the State in 1992 (i.e. had the agreement not been terminated), they would have processed an additional number of cases with consequent GPA and MA savings. Appellant has estimated such savings at $48,346,780 attributable to cases it claims would have been enrolled by June 30, 1989, the date set forth in the contract after which there would be no new enrollments. Consequently, Appellant claims a fee of $13,537,198 for lost anticipatory profits on such alleged savings. This calculation is based purely upon statistical projections. No work was actually done by Appellant. The Board has previously

[ii] They were also called Group 30 cases in the early stages of the hearing and in parts of the record.

suggested to the parties to this dispute that COMAR does not allow anticipatory profits that have not been earned up to the date of termination.[67] The Board concludes that neither the Maryland General Procurement Law nor COMAR provide for anticipatory profit for work not performed,[68] and Appellant's claim is denied.

The State has not directly challenged the estimates of savings for groups beyond Group 71 because it believes there is no entitlement. The Board agrees that there is no entitlement for those groups nor for Groups 73, 72 and 71. However, if the Board had found entitlement, it would have reduced all estimated fee calculations for such groups by a 25% reduction for natural forces cases and by a $1,500.00 cost per case. Absent stipulations the Board would not have allowed any SSDI adjustment or late billings adjustment.

The Board, having reviewed entitlement and quantum for the Group 74 through Group 10 and Anticipatory Profit cases, turns now to the Appellant's other claims.

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[67] COMAR 21.07.01.12 Termination for Convenience prohibits reimbursement for anticipatory profits that have not been earned up to the date of termination. The General Procurement Law does not provide for anticipatory profits that have not been earned up to the date of termination. It does mandate Termination for Convenience and Default clauses in all State procurement contracts. The clauses as set forth in COMAR define the remedies and damages allowed. See M&M Hunting Preserve, MSBCA 1279, 2 MSBCA ¶ 145 (1987). The same result obtains, i.e., the same legal principles apply, whether the parties use the long form termination for default or convenience clause as set forth in COMAR or a short form version.

[68] The Board has never allowed anticipatory profit in a contract dispute for work not performed. However, in Dewey Jordan, Inc., MSBCA 1569 (1991), the Board suggested that if an Appellant could show evidence of "willful breach", as where the contractor was terminated without good faith to specifically deny profits and require the contractor to only perform that work where the profit was minimal thus denying the contractor the benefit of its bargain, there may be a predicate for considering the appropriateness of an award of anticipatory profit. The record does not reflect any such willful breach by the State in the instant appeal.

B. Back Claims

Appellant claims fees for "back claim" work. A back claim as previously indicated is a method of capturing State savings for items passed over for a variety of reasons by the State's annual Reconciliation Run.[69] Once a year the State performed a massive transactional comparison of the flow of benefits and Federal Financial Participation in those benefits known as a Reconciliation Run. It is a true audit of these transactions and after sorting through tens of thousands of transactions will give a gross monetary amount of how much the State owes the Federal Government or vice versa. This comparison involves a massive amount of data. Thus State policy was only to print a copy of one of every 100 comparisons for individual cases, otherwise massive printout would result.

The contract as executed on July 7, 1987 did not specifically provide for Appellant to claim a fee for back claims. However, the DEAP project was in financial difficulty and Appellant realized that by making some data processing changes to the back claim parameters,[70] additional large sums of Federal Participation could be reasonably claimed. The contract did provide for expansion of Appellant's effort for revenue enhancement with the consent of the State. The State agreed to assist the financially troubled Appellant and the parties provided for back claim endeavors in the MOU. The operative language provided:

> "CAI's financial interest in such backclaiming shall be limited for cases for which current claims are made for the first time on or after 1/1/88, to:

(A) those individual cases who have been identified and

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[69] The information compared by a Reconciliation Run is dynamic, and therefore reflects the status of the accounts only for the date the run is completed.

[70] An example would be the assumption that entitlement should be found at an earlier date in a client's claim.

accepted as "Copeland Cases" as hereinafter identified, for any part of which cases periods of backclaims shall be counted as part of the total 36 months of maximum CAI participation in a case; or

(B) to any future net addition to a "backclaim" which CAI during its active participation in this project may discover and bring to attention after such "backclaim" has been prepared and filed by the State, totalling no more than 36 months of CAI participation in a case.

Notwithstanding the generality and inclusiveness of interest in populations and time periods here specified to involve a CAI interest in backclaiming, it is expressly understood and agreed that CAI makes no claim with respect to any such "backclaim" prepared and filed for federal payment prior to 11/1/87 by DHMH. This is an express recognition by all parties that there was a need for continuity of process after 6/15/87 as responsibility was being relayed to and assumed by CAI. It also recognizes that by 11/1/87, it was clearly established that CAI had participated in discussions and disclosures and shared technical information respecting "backclaims" sufficient to establish its right and interest in any claim filed thereafter with respect to the defined population and periods."

MOU pp. 5-6.

Appellant began working on backclaims and was paid $1,713,802 in fees prior to termination. However, Appellant claims it is entitled to additional fees on various back claims as set forth in Finding of Fact No. 24 under its interpretion of the MOU. The State routinely made reconciliation runs (a/k/a back claims) before the contract at issue herein was entered into. These back claims produced an unusually large refund to the State and from an audit point of view "stuck out like a sore thumb". This concerned State officials as an invitation for Federal audit and to avoid this the State decided to split up recovery of FFP that would be generated by any given back claim and spread it over several future claims. The Appellant ran those future claims, and the State subtracted from Appellant's fees that portion of the claim which related to the prior back claims prepared and filed in part by the State. Appellant argues

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it should be paid on all of the back claims, even if the amount included prior State work. We disagree. The contract is clear and admits of but one construction.[10] Entitlement for back claims attaches to those claims prepared and filed with Appellant's input subsequent to November 1, 1987.

The Appellant additionally wants the inclusion of $269,527 in late billings in its back claim fees under the same theory of late billings adjustment described earlier that providers should submit their bills immediately. We find no entitlement for a late billing adjustment for back claims. This adjustment is not reasonable in light of the ongoing process of billings by providers and is not provided for in the contract. Appellant is only entitled to back claims which they prepared and filed resulting in actual savings to the State. The State paid Appellant $1,713,802 for back claims. The Board finds that is the correct amount to be paid under the contract. Appellant is not entitled to any compensation for amounts pending from previous back claims or any back claims filed in the future.[11]

C. Miscellaneous Claims and Adjustments

The Board next addresses the remaining miscellaneous modifiers or adjustments and classes of claims which have not

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[10] When the meaning of a contract is clear and unambiguous it is inappropriate to consider extrinsic evidence to explain a party's different interpretation of its meaning. Dominion Contractors, Inc., MSBCA 1040, 1 MICPEL ¶18 (1982) at p. 8; Intercounty Construction Corporation, MDOT 1036, 2 MICPEL ¶164 (1987). The written language embodying the terms of an agreement will govern the rights and liabilities of the parties, irrespective of the intent of the parties at the time that they entered the contract, unless the written language is not susceptible of a clear and definite understanding. Cam Construction Company, MSBCA 1088, 1 MICPEL ¶62 (1983) at p. 8.

[11] Appellant originally made claim for additional fees in the amount of $685,331.00. During the hearing it discovered it had already been paid such amount so that portion of the claim for backclaims was withdrawn. The parties have stipulated that Appellant is entitled to an additional $3,000 in fees for the runs set forth in Appendices G-2 and G-3 up to and including the run on 9/10/88.

been abandoned,[73] reorganized or merged,[74] redefined or otherwise disposed of by the numerous revisions to Appellant's Proof of Costs.

Appellant seeks an adjustment (i.e. fees) for "pharmacy assistance claims" in the amount of $805,263 for pharmacy backclaims from 12/31/88 to 6/30/89. We find no entitlement. These claims were not recited in the contract documents and despite Appellant's request to expand into such area, FFP therefrom was not actually claimed by the State until late in the CAI era. Further, the prohibition on anticipatory profit will not support inclusion of these alleged anticipated amounts captured by others after termination for which the Appellant performed no work.

Appellant agrees that an adjustment for mortality should be applied. However, the record does not contain a factual predicate for a finding of an actual mortality rate other than the fact some of the GPA/MA population died during the litigation period. A mortality factor is included in the parties stipulation of GPA and FMA savings in the Group 74 cases.

As discussed above, Appellant also makes several statistical-averaged projections for its anticipatory profits cases including backclaims. None of these projections are supported by the record. Any finding of entitlement must be based upon actual savings not, by way of example, an assertion by Appellant that the State should expect average annual increases in FFP of 12.0325%. There was no factual presentation as to the basis of these anticipatory profit claims during the hearing and

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[73] Examples of abandoned theories of recovery are Excess Zero Claim Months Adjustment, Remaining Months Adjustment (abandoned as to the Group 74 cases at that point when 36 months from November 8, 1988 had run), Case Group 30, Retro Cases and Dangling Eligibility cases.

[74] Zero and Remaining Months were merged into the SSDI Adjustment.

they are denied.[13]

State Claims

The State asserts a claim for alleged revenue loss in the DHR and DHMH FY 1988 and FY 1989 budgets in the amount of $3,175,768.

Respondents characterize their contract with Appellant as a contract to save the State a sum certain by a date certain.

By its terms, this was an Agreement

> "[to] organize and carry out a program . . . [to] provide the services described . . . for the purpose of enabling the maximum number of disabled and potentially disabled General Public Assistance and State Medical Assistance recipients and applicants to receive . . . [federal benefits] . . ."
>
> "[A]s a minimum expectation, the hypotheses and projections contained in the CONTRACTOR'S report [Appendix A] . . . shall be followed to the extent of screening all persons found to be in the highest 20% of Medical Assistance users in the current GPA population."

Contract, I(1).

Appellant did not assume a contractual obligation to save the State a particular sum of money. Appellant contracted to "take all reasonable actions necessary to achieve . . . savings [of $4.35 million in FY 1988]." Contract, § I(2). In Appendix A, Appellant projected estimated State savings for FY 1988 of $28.65 million and even greater savings for FY 1989. DHR and DHMH budgeted certain of these projected (anticipated) savings from the DEAP project before the contract was executed and before the Board of Public Works had approved the contract.

The State's claim for revenue loss, although styled as a claim for unrealized savings, is the equivalent of a claim for lost profits - i.e., it seeks to hold CAI accountable for estimated revenue the State believes CAI should have generated

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[13] As noted above, Appellant's anticipatory profits claims are denied on other grounds as well.

had the contract been performed.

Maryland applies the objective law of contract interpretation. See General Motors Acceptance Corp. v. Daniels, 303 Md. 254, 261-262 (1985); State Highway Admin. v. Greiner, 83 Md. App. 621, 638-639 (1990). Applying such a standard, and in the absence of any suggestion of ambiguity advanced by the parties, we find no language in the contract pursuant to which the Appellant agreed to achieve a minimum amount of savings in FY 1988 and FY 1989. If the parties had intended that Appellant would achieve through its advocacy efforts a minimum level of savings (or increase in revenue through conversion of GPA and State MA recipients to federal entitlements) they should have so stated in the contract. Language obligating the contractor to take "all reasonable actions necessary to achieve . . . savings," and language estimating levels of savings (i.e. "the hypotheses and projections contained in the CONTRACTOR'S report" [Appendix A]) do not rise to the level of a contractually mandated minimum savings guarantee. We also note that the mutual termination of the contract in November of 1988, less than 4-1/2 months into FY 1989, would vitiate any claim for unrealize savings for FY 1989. Accordingly, the State's claim for $3,175,768 in alleged revenue loss is denied.

Credits

The parties have stipulated that the value of CAI inventory acquired by the State upon termination of the contract on November 9, 1988 was $59,656.80, and Appellant is entitled to a credit for such amount.

The parties have stipulated that the value of the PDP-11 and ancillary computer equipment acquired by the State on November 9, 1988 and thereafter used for the State's own purposes was $47,000.00 as of November 8, 1988 and Appellant is entitled to a credit for such amount

The record also reflects that the State paid $30,568.95 to approximately 24 vendors for services rendered to Appellant prior to mutual contract termination on November 9, 1988. The Board

has found that such expenses were reasonable and incurred in performance of the DEAP project by Appellant in the September/October, 1988 timeframe and that payment was necessary to keep the DEAP project in operation. Accordingly, the State is entitled to a credit for its payment of $30,568.95 to various vendors.

Finally, the State is entitled to a credit of $65,290.26 for its payment of DEAP project operating expenses for the period November 1, 1988 through November 8, 1988 as discussed in Finding of Fact No. 58 and a credit for $53,999.74 for DMAU costs as discussed in Finding of Fact No. 61.

Predecision Interest

The Board determines in its discretion that it is not appropriate to award predecision interest on any award of monies or equitable adjustment to either party herein except as specifically set forth below. See § 15-222, State Finance and Procurement Article.

The Board determines in summary that each party is entitled to the following monetary awards and/or credits with interest as noted.

A. State

1. The 1.2 million advance represents a known amount with a contractual promise to repay. Accordingly, the State is entitled to be paid its $1,200,000 advance with interest in this case. See § 15-211, State Finance and Procurement Article; Affiliated Distil. v. R.W.L. Co., 213 Md. 509, 516-517 (1957). Interest shall accrue at the various rates of interest applied to the 15% of fees escrowed and withheld from Appellant's fees from October 31, 1988 through January 31, 1992 and thereafter at the rate of 10% per annum until the date of this decision. Following the date of this decision the rate of interest on the total amount owed (including interest) as of the date of this decision shall be at the rate of interest on judgments.

2. The State is entitled to be reimbursed for the DEAP project costs incurred during the period November 1, 1988 through

November 8, 1988 in the amount of $65,290.26. The State is likewise entitled to be reimbursed for the DMAU costs in the amount of $53,999.74. Interest on such amounts shall only accrue from the date of this decision until paid at the rate of interest on judgments.

3. The State is entitled to be reimbursed for its payment of DEAP project invoices from various vendors in September and October 1988 for expenses incurred by Appellant necessary to DEAP project operations in the amount of $30,568.95. Interest on such amount shall only accrue from the date of this decision until paid at the rate of interest on judgments.

B. Appellant

1. Appellant is entitled to be paid, after deduction of fee amounts already paid[16] and escrow amount and application of the various adjustments[17] discussed above, a fee of $1,889.001[18]

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[16] Appellant was paid $242,887 in fees.

[17] i.e., adjustments as discussed above for natural forces, late billings, mortality and overhead.

[18]

1. Total State Savings (including mortality and late billings adjustments)

GPA Savings	$ 3,088,464
FMA Savings	7,860,363
Total	$10,948,827
Fee Percentage	X .28
Fee	$ 3,065,672

2. Adjustments

Less:

Natural Forces (.25)	$ 766,418
State Costs for 748 Cases	128,121
Fee Payments	242,887
Escrow Double Payment	39,245
Subtotal	$ 1,176,671

relating to the 748 Group 74 cases. Interest on such amount shall only accrue from the date of this decision at the rate of interest on judgments.

We have been advised of the escrowed funds and non-escrowed funds withheld from CAI's fee payments (see Finding of Fact No. 52) and Appellant at the hearing and in post hearing briefs has asserted entitlement to these funds. As of January 31, 1992, principal and interest on the escrowed funds totalled $372,965.84 and principal amounts and interest thereon of funds withheld from Appellant but not deposited into escrow totalled $82,954.05. This matter is remanded for action by the parties consistent with the provisions of § II(2)(H) of the contract.

2. As noted in Findings of Fact Nos. 53 and 54, Appellant is entitled to a credit against amounts otherwise owed to the State of $59,856.80 for inventory and $47,000.00 for computer equipment. Interest on such credits shall only accrue from the date of this decision at the rate of interest on judgments.

3. The parties have stipulated that Appellant is entitled to an additional fee of $3,000 for back claims. Interest thereon shall only accrue from the date of this decision at the rate of interest on judgments.

In all other respects the claims of the parties are denied and the appeals are remanded to the State for action consistent with this opinion.

3.	Recap	$ 3,065,672
		1,176,671
	Total	$ 1,889,001

Dated: June 17, 1992

Robert B. Harrison III
Chairman

Neal E. Malone
Board Member

I concur:

Sheldon H. Press
Board Member

* * *

I certify that the foregoing is a true copy of the Maryland State Board of Contract Appeals decision in MSBCA 1408, 1431 and 1576, appeals of COPELAND & ASSOCIATES, INC., under DGS Contract No. IMA/CS-06/88-324.

Dated: June 17, 1992

Mary E. Priscilla
Recorder

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