BEFORE THE
MARYLAND STATE BOARD OF CONTRACT APPEALS

In the Appeal of CORRECTIONAL MEDICAL SERVICES, INC. FORMERLY KNOWN AS ARA HEALTH SERVICES, INC. d/b/a CORRECTIONAL MEDICAL SYSTEMS	)	Docket Nos. MSBCA 1822, 1867, 1868, 1869 & 1925
Under DPS&CS Contract Nos. 8804-00 and 9172-1501B, Together with the Pertinent Amendments and Modifications Thereto	)	

December 12, 1996

Equitable Adjustment - Interest - The Appeals Board has jurisdiction to hear "interest only" appeals from the payment by a unit of the principal amounts sought in claims filed with the unit. However, interest may accrue only from the time the claim is received by the Procurement Officer and ceases to accrue upon payment of the principal amount by the unit.

Equitable Adjustment - Claim Preparation Expenses - Claim preparation expenses are not allowable under a contract for the provision of medical services.

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APPEARANCE FOR RESPONDENT: Alan D. Eason
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OPINION BY CHAIRMAN HARRISON

Appellant timely appeals the denial of its claims for interest, claim preparation expenses and deductions of monies pursuant to disallowance of "aggregation" under the above captioned contracts.

Certain of the consolidated appeals focus on Appellant's assertion that it is entitled to interest on the principal amount of various claims it filed with the Respondent's Procurement Officer. Preliminarily, the Board, in response to cross motions for summary disposition regarding the claims for interest, issued an interlocutory decision and Order in relevant part as follows:

Appellant and Respondent have filed cross motions for summary disposition and presented oral argument thereon in connection with the above captioned appeals.

Appellant asserts it is entitled to interest on the principal amount of various claims it filed with Respondent's Procurement Officer from a date that precedes the date that the claims were filed with the Procurement Officer.

Respondent asserts that the MSBCA (Board) lacks jurisdiction to award interest on a claim on a contractor's appeal from the payment by a unit of only the principal amount of the claim filed with the unit. As a general matter Respondent argues that the payment of the principal amount by the unit resolves the claim and any underlying dispute and thus there is no dispute left for the Board to resolve. More specifically Respondent points out that Section 15-222 of the State Finance and Procurement Article permits the Board to award interest on money that the Board determines to be due to the contractor under a contract claim. Respondent argues that because the unit paid the claim there is thus no determination for the Board to make concerning whether money is due under the claim and thus no jurisdiction to award interest.

Appellant asserts that it is entitled to interest notwithstanding payment of the principal amount of the claim where there was no good reason for the unit's failure to pay the money sought in the claim earlier than it did. Appellant also asserts that interest may run from the date the unit knew or should have known that the amount of money involved in the claim was owed to the contractor and the reasons for non-payment were not justified rather than just from the time the Procurement Officer receives the claim.

The Board denies Respondent's motion. The Board determines that it has jurisdiction under Section 15-211 of the State Finance and Procurement Article to hear "interest only" appeals from the payment by a unit of the principal amounts sought in claims filed with the unit at least where such payment is not the result of a negotiated settlement. However, pursuant to the plain language of Section 15-222 of the State Finance and Procurement Article interest may accrue only from the time the claim is received by the Procurement Officer.[1] *The specific provisions of Section 15-222 regarding when interest may begin to accrue overrides the Langenfelder*[2] *decision cited by Appellant in support of its argument that interest may begin to run before a claim is received. In Langenfelder the Court of Special Appeals held that the Board could allow predecision interest as part of an equitable adjustment even though the General Procurement Law (Chapter 775, Acts 1980) as it then existed*

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1 While the parties are in disagreement concerning when interest may start to accrue, they agree that interest ceases to accrue upon payment of the claim by the unit.

2 Maryland Port Admin. v. C.J. Langenfelder &Sons, 50 Md. App. 525 (1982).

was silent on the matter of an award of predecision interest. See Article 21, §§7-201 through 7-203. We note that the interest limitation (that interest may not begin to run until the claim is received) presently set forth in 15-222 was first enacted in 1986 (Chapter 840, Acts 1986) a few years after the Langenfelder decision in January 1982. Thus while Langenfelder upheld the Board's power to award predecision interest, we perceive no apparent conflict in the later enactment of legislation limiting commencement of the running of predecision interest to the date the Procurement Officer receives the claim. Thus, we determine that the Board may only award interest from the date the Procurement Officer received the claim until the date the unit pays the claim.

In determining whether Appellant's motion should be granted relative to payment of interest from the date the Procurement Officer received the claim until the date paid by the unit we make the following observations.

Since its inception fifteen years ago the Board has recognized, considered and granted motions for summary disposition[3], although not specifically provided for under the Administrative Procedure Act, because of its belief that to do so is consistent with legislative direction to provide for the "informal, expeditious, and inexpensive resolution of appeals . . . ." Section 15-210, Division II, State Finance and Procurement Article; See e.g. Intercounty Construction Corporation, MDOT 1036, 1 MSBCA ¶11 (1982); Dasi Industries, Inc., MSBCA 1112, 1 MSBCA ¶49 (1983).

* * *

In all instances the legal standards the Board will apply to determine the appropriateness of summary disposition remain the same. The party moving for summary disposition is required to demonstrate the absence of a genuine issue of material fact. See Mercantile Club, Inc. v. Scheer, 102 Md. App. 757 (1995). In making its determination of the appropriate ruling on the motion, the Board must examine the record as a whole, with all conflicting evidence and all legitimate inferences raised by the evidence resolved in favor of the party (in this instance the State) against whom the motion is directed. See Honaker v. W.C. & A.N. Miller Dev. Co., 285 Md. 216 (1979); Delia v. Berkey, 41 Md. App. 47 (1978), Affd. 287 Md. 302 (1980).

The purpose of summary disposition is not to resolve factual disputes nor to determine credibility, but to decide whether there is a dispute over material facts which must be resolved by the Board as trier of fact. Coffey v. Derby Steel Co., 291 Md. 241 (1981); Russo v. Ascher, 76 Md. App. 465 (1988); King v. Bankerd, 303 Md. 98 (1985) at p. 111. Therefore, summary disposition is not appropriate if a genuine issue of material fact is in dispute. Furthermore, for purposes of a motion for

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3 The word disposition is used rather than judgment because the Board is not a court and has no equitable powers or equitable jurisdiction.

summary disposition, even where the underlying facts are undisputed, if they are susceptible of more than one permissible factual inference, the choice between those inferences should not be made, and summary disposition should not be granted. See Heat & Power Corp. v. Air Products, 320 Md. 584 (1990) at p. 591; King v. Bankerd, supra, 303 Md. at p. 111.

Applying these standards to the record developed to date it is clear that there is no agreement by the parties or sufficient evidence of record to make a determination of whether the State's refusal to pay was justified at the time the Appellant's claim was filed with the Procurement Officer and whether there was continued justification for non-payment up until the time of payment. Conflicting inferences on this question appear even from those matters which the parties at this juncture agree upon. An evidentiary hearing is necessary and the Appellant's motion is denied. Thus, both the Appellant's and Respondent's motions for summary disposition are denied. So ORDERED this 27 day of June, 1996. This ORDER is interlocutory.

The Board will now address the merits of the appeal. For ease of reading, the findings of fact and decision portions of the opinion are combined in narrative form in numbered paragraphs. The parties will recognize that much of the factual matter that follows is based on their stipulations.

Findings of Fact and Decision

A. INTEREST DOC

1. The State of Maryland, Department of Public Safety and Correctional Services (DPSCS) and its Division of Correction (the Division or DOC) issued a Request for Proposals 8804-00, DOC Health Care Services (RFP) dated September 12, 1988, which solicited bids from contractors to provide a health care program for inmates committed to the care of the Division.
2. ARA Health Services, Inc. (now known as Correctional Medical Services, Inc.) d/b/a Correctional Medical Systems, herein-after CMS or Appellant, submitted a response to the solicitation on October 14, 1988, and was awarded the Contract as executed on November 22, 1988.
3. Under the Contract the Division was obligated to pay Appellant for the health care services and products CMS provided in accordance with the Contract.
4. The Division of Audits of the Maryland General Assembly engaged in a performance audit of the Division in 1991. This audit reflected the Legislature's concern about the need to monitor the rising cost of inmate health care under the con-tracts administered by the Division.
5. In their final report, the Legislative Auditors identified deficiencies in the monitoring of the Contract and the Division's fiscal operations.
6. In early 1992, a "decision . . . was made based on the [L]egislative [A]udit that had been performed in January of 1992 . . . that the total responsibility for auditing the [Contract] in terms of billings and invoices . . . would be transferred . . . on a temporary basis . . . as part

of a corrective action of the [DPSCS] to DOAC." DOAC is the Division of Audits and Compliance, an independent unit of the DPSCS responsible for monitoring, among other things, contract compliance.

7. As part of the transfer of responsibility the two auditors from the Division who had been performing reviews of contractor invoices prior to that time were reassigned to the DOAC in March 1992.
8. The reassignment left the Division with limited ability to evaluate Appellant's request for payment.
9. The Contract required Appellant to provide the services of certain health care providers for a specific period of time each day. These services were referenced as "primary care" services. Attachment III to the Contract set forth the staffing requirements, by provider position, for CMS personnel. These requirements governed Appellant's obligations except to the extent they were modified by a monthly implementation schedule approved by the DOC.
10. Section 05.09.01.01 of the Contract permitted the Division to make a claim against Appellant "for work . . . which [CMS] did not perform in part or in whole." Under §05.01.03.03 of the Contract, if the Division questioned whether a service was provided, payment for the service could be immediately withheld in the amount stated in Attachment III of the Contract. From Contract inception through January, 1992, the Division's auditors evaluated CMS' monthly invoices and source documents. The auditors would request additional information from CMS whenever it was unclear from the source documents whether a service was provided.
11. As noted, in March 1992, invoice auditing responsibility for the Contract was transferred to the DOAC.
12. The DOAC adopted and used revised audit procedures (the Revised Audit Procedures) for recommending whether the Division should pay CMS for primary care services.
13. In the field, the DOAC auditors used an Auditing Index as a tool to implement the Revised Audit Procedures.
14. The Auditing Index listed many of the specific elements of the Revised Audit Procedures. Each such element was assigned a code.
15. The DOAC auditors reviewed the sign-in\sign-out logs, and compared them with the "Monthly Staffing Report" on which CMS set out the dates on which and the times during which Appellant's employees were to have worked at the facility. The DOAC auditors assessed the Monthly Staffing Report and the sign-in\sign-out logs under the criteria set out in the Auditing Index.
16. The sign-in\sign-out logs were the original source documents maintained at the various State prisons that the Appellant's providers would sign upon commencing or completing a shift.
17. The aforementioned Monthly Staffing Report was a summary created and forwarded by Appellant to the DOC.
18. The only original documents reviewed by the DOAC auditors were the sign-in\sign-out logs.
19. Any failure to meet an audit index standard would be identified by the applicable Auditing Index code, and a deduction would be recommended.
20. Deductions arising from a log irregularity were labeled as "B" deductions. Deductions based on the Monthly Staffing Report were labeled as "C". "A" deductions were to be based on irregularities in the institutions' timecards.
21. The Department decided that the DOAC would not review time cards because "they were in such atrocious shape" that they "lacked . . . sufficient integrity for use in the audit."

22. The extend of the recommended deduction also was set forth in the Auditing Index. For example, a DOAC auditor determining whether Appellant should be paid for hours worked by Physician's Assistant Smith (P.A. Smith) at the Roxbury Correctional Institution (RCI) on May 1, 1991 would review the RCI's sign-in\sign-out log for that date. If P.A. Smith signed in or out in pencil, the auditor would recommend a withholding as a "B-3" violation. Upon finding a B-3 violation, the Auditing Index instructed the auditor to "take all associated time not to exceed the hours required by the Contract." Accordingly, all of P.A. Smith's time for the particular shift, typically eight hours, could be recommended for deduction under the hypothetical. What was associated time varied depending upon the particular auditing index standard which was applied. In practice the majority of recommended deductions involved multiple violations of the Auditing Index standards.

23. After reviewing the services covered by a CMS invoice, the DOAC would prepare an "audit report" for the Division, recommending, among other matters, deductions from the base primary care billing.

24. Under the DOAC's procedures, it did not conduct an exit conference during which Appellant could seek to provide evidence that services covered by the Monthly Staffing Report had been provided.

25. The DOAC had an audit standard that required a signature rather than a printed name.

26. The DOAC did not use a signature key of Appellant's providers against which to check seemingly illegible signatures before recommending deductions.

27. At all times, the Division retained final authority with respect to payment decisions concerning CMS.

28. When asked how he responded to the DOAC's recommendations, the Division's Commissioner testified that:

> ". . . my assumption is what they had submitted to me was certainly correct and accurate."

29. The Commissioner also testified: "They were auditors, they presented it to me, and in the absence of having anything to the contrary, I felt it was my duty to accept what they gave me."

By October 26, 1992, however, the Commissioner was of the opinion that the DOAC audit process was seriously flawed. The Commissioner protested the DOAC's use of the strict accounting rule in a memorandum to the DOAC's Director dated October 26, 1992. The substance of the memorandum was as follows:

a. The memorandum stated that the audits based on the strict accounting rule contravened a July 28, 1992 advice of counsel from an Assistant Attorney General.

b. The Commissioner explained that the "audits continued to reflect deductions made for technical non-compliances which [the Assistant Attorney General] had indicated will not be sustained under the provisions of the Contract if appealed."

c. With the Secretary of DPSCS concurrence, the audits were returned to be "re-reviewed and re-formatted."

d. In the re-formatted audits, withholdings based upon "technical non-compliances, e.g. failure to complete the sign-in\sign-out log properly," were to be placed in a separate category from withholdings where it appeared that "the services were not provided."

e. Any "technical non-compliances" were to be discussed with CMS and [CMS] was to be provided the "opportunity to provide evidence of the service rendered in keeping with the advice of counsel."

f. "If [CMS] could provide proof of the service even though there may have been what qualifies as technical deviation from a strict interpretation of the Contract, they are, as the Com-missioner read it, entitled to payment."

g. The Commissioner believed that the "re-review" would make a "significant difference" in the recommended withholdings.

h. Without the "re-reviewed" and "re-formatted" information, the Commissioner could not "properly evaluate the situation and make an informed decision."

The DOAC never conducted a "re-review" as requested in the Commissioner's October 26, 1992 memorandum.

The Division accepted DOAC's recommendations without change.

30. After the Division began to withhold monies in reliance on the DOAC recommendations, Appellant filled a series of contract claims with the Procurement Officer for the DPSCS.

31. The Procurement Officer reviewed Appellant's claims, and the Division/ DOAC with-holdings, under what he described as the "reasonable man" standard, i.e., would a reasonable person reviewing the source materials conclude that a particular individual worked a particular shift on a particular date.

32. Focusing on "whether the services were provided, the Procurement Officer reversed the primary care withholdings at an overall rate of 97.6%, following review of the primary care claims by 6 temporary employees working under his supervision.

33. When asked whether the DOAC review and his review were conducted under the same standard, the Procurement Officer replied:

> *No. The DOAC went from the standpoint if something is wrong, then they would take an exception to it. And, therefore, if--well, let's just say something were smudged and you couldn't tell what the end time was, then you took [i.e., withheld] all of the time because you couldn't be sure just how long the person worked; whereas a reasonable man would say, what's it look like? You know does it agree with other things? And*

DOAC did not include, did not look at the timecards; whereas I did.

34. The Procurement Officer utilized the timecards during his review, while the head of DOAC, maintained that the timecards were too "atrocious" to be of value.

35. The Procurement Officer testified that the difference between the two standards was "a substantive difference as opposed to a procedural difference." The Board agrees that there is a substantive difference between the two standards and that the Procurement Officer's reasonable man standard is the appropriate contract standard. The Office of the Attorney General also agrees that the reasonable man standard is the appropriate standard.

36. For the period of February 1992 through December 1992, Appellant disputed DOAC-recommended withholdings of $1,655,279 for primary care services. Seeking to "determine whether the evidence proved to a reasonable person that [CMS'] personnel were on duty as required by the Contract," the Procurement Officer recommended that Appellant was entitled to payment in the amount of $1,606,874, or approximately 97% of the claimed amount. By utilizing the appropriate contractual standard, the Procurement Officer determined that 97% of the services invoiced had been provided.

37. As noted above, the DOAC never conducted a "re-review", as requested by the Commissioner in the October 26, 1992 memorandum.

38. The Procurement Officer received the contract claims which are the subject of these consolidated appeals, including those regarding payments for primary care. There were, eventually, a total of 12 claims pending based upon Contract No. 8804-00 covering the DOC and 12 claims based on Contract #9172-1501 covering the Division of Pretrial Detention and Services (DPDS). Of these 24 claims, 9 involved withholdings of primary care payments.

39. The amounts withheld under the DOC Contract covered numerous positions staffed by Appellant at institutions of the DOC over a 19 month period. The withholdings were based on DOAC audit reports organized by month and region. That is, each DOAC audit report covered all institutions in one region for one month. Accordingly, under the model, there were a total of 76 "region-months" encompassed by the 19-month period. Of the 76 "region-months", Appellant filed claims covering 63.

40. During the period between the filing of the claims, and the partial payment of the primary care claims, the Procurement Officer undertook to review the documents bearing on all the claims. He was also responsible for significant other procurement duties, including a solicitation for a new contract covering medical care for all institutions of the DOC.

41. The Department determined to conduct a line by line review of all primary care exceptions. The Procurement Officer was unable to do this with available staff. Accordingly, the DOC retained the services of 6 temporary employees in order to conduct the review under the Procurement Officer's supervision. This process covered the period from late January, 1994 to late May, 1994, and cost in excess of $30,000.00. As discussed in more detail below, the Board finds that the State was reasonably in a position to make a determination concerning its liability to Appellant for work performed by Appellant under the reasonable man standard within 120 days (four months) of receipt of a claim to include allowance of 30 days for processing the Appellant's claim for payment. We find the State liable for interest on that portion of all claimed amounts subsequently paid commencing 120 days from the date the claim was filed until payment of the portion of such claimed amount. Pursuant to statutory

direction, as acknowledged by the parties, no interest may accrue before the Procurement Officer received a Contract claim from the contractor.

Primary Care

42. Appellant incurred costs of $128,148.30 to hire additional temporary personnel and to pay related expenses to prepare documentation addressing primary care withholdings.

43. Appellant filed DOC Contract Claim IV on April 16, 1993. That Contract Claim concerned, inter alia, the provision of primary care services during the period of January 1, 1991 through November 30, 1991. Appellant claimed $234,192 for unpaid primary care services for that period. The DOC paid $102,157.98 before Claim IV was filed. On January 21, 1994, the DOC paid an additional $215.21. On March 3, 1994, the DOC made a third payment in the amount of $67,459.78. The total of post-claim filing payments was $67,674.99, excluding interest.

44. In DOC Contract Claim IV, filed April 16, 1993, Appellant sought payment from the DOC relative to withholdings in the amount of $455,489.65, plus interest for the provision of primary care services for the period from June 1, 1991 through January 31, 1992. On January 21, 1994, the DOC paid Appellant $409,940.69. On April 18, 1994, an additional payment of $28,387 was made. A third payment of $6,000 was made on October 3, 1994. To date, the DOC has paid Appellant $444,327.69 of the principal amount claimed, but not interest.

45. In DOC Contract Claim III, filed March 12, 1993, Appellant sought payment for primary care services provided under the Contract for the period from May 1, 1992 through June 30, 1992. The amount Appellant claimed for those services was $587,868.06 plus interest. On January 21, 1994, the DOC paid Appellant $495,330.30 toward Claim III. On April 18, 1994, an additional payment of $50,604.70 was made. To date, the DOC has paid Appellant $545,935 of the principal amount claimed, but not interest.

46. In Contract Claim VII, filed April 29, 1993, Appellant sought payment for primary care services rendered under the Contract for the period from February 1, 1992 through December 31, 1992 in the amount of $1,729,511.00, plus interest. On July 27, 1993, the DOC paid Appellant $410,000. On January 21, 1994, an additional payment of $845,864.67 was made. A third payment of $171,009.33 was made on April 18, 1994. The DOC's last payment of $180,000 was made on June 21, 1994. To date, the DOC has paid Appellant $1,606,874 of the principal amount claimed, but not interest.

47. The Board finds that the four months from late January, 1994 to late May, 1994 required by the six temporary employees to conduct, pursuant to the reasonable man standard, the line by line review of all DOAC primary care exceptions under the supervision of the Procurement Officer represents reasonable and appropriate compliance with the provisions of COMAR 21.10.04.03 providing for review and investigation of a claim. Under COMAR, the Procurement Officer is required to investigate and review the facts pertinent to the claim and he may request additional information or substantiation through any appropriate procedure. We believe the Procurement Officer is permitted to allow other persons to perform aspects of the claim investigation and review function under his supervision provided that he personally makes an informed judgment on the claim. See The Driggs Corporation, MSBCA 1775, 5 MSBCA ¶397 (June 25, 1996). We find that the line by line review procedure established by the Procurement Officer and conducted under his supervision by the six temporary employees hired to assist the Procurement Officer was an

appropriate procedure that was conducted by the temporary employees in a timely manner given the massive volume of paper work and the complexity and technical nature of the issues involved in the claims.

However, we do not conclude that the result of the investigation conducted pursuant to the appropriate reasonable man standard that determined that 97% of the primary care services in dispute had been provided should not have been reached sooner. The Procurement Officer was precluded by other assigned duties from focusing on the claims to even determine whether he needed assistance with the claims for several weeks from the filing of the initial claims involving DOC primary care withholdings in March and April[4] until early May, 1993. Once the Procurement Officer determined he needed assistance, it was not until October of 1993 that the Procurement Officer received the necessary approvals and the funding commitment to hire the six temporary employees to provide the necessary assistance. The competitive procurement process required to obtain the services of the six temporary employees took three months, from October 1993 until early January 1994. Thus, the claims received no real substantive attention as to their merit for eight to nine months.

Pre-decision interest, however, is not a punitive element of the contract claims process. Pursuant to §15-222, Division II, State Finance and Procurement Article, the Board has the discretion to award pre-decision interest "from a day that the Appeals Board determines to be fair and reasonable after hearing all the facts until the day of the decision by the Appeals Board," provided that interest "may not accrue before the Procurement Officer receives a contract claim from the contractor." The Board in applying this statutory direction attempts to determine when the State knew or should have known that the claim had merit and awards interest from such time adjusted to allow a reasonable period for processing the claim for payment. See Department of General Services v. Harmons Associates Limited Partnership, 98 Md. App. 535(1993) at pp. 555-558. See also Orfanos Contractors, Inc., MSBCA 1849, 5 MSBCA ¶410 (November 19, 1996). See Williams Construction, Inc., MSBCA 1860, 5 MSBCA ¶405 (October 8, 1996) . It should be emphasized here that in the context of an award of pre-decision interest the "State" by statuary and regulatory direction means the Procurement Officer, Agency Head and Office of the Attorney General. See §15-217 and §15-218, Division II, State Finance and Procurement Article; COMAR 21.10.04. There is no liability for interest until a claim is filed with the Procurement Officer and the Board's focus must be on when the Procurement Officer knew or should have known that the claim was valid.

Based on the record herein one could find that the Office of the Attorney General and the Commissioner of DOC were of the belief as of the date of the Commissioner's October 26, 1992 memorandum to the DOAC Director that the DOAC audit procedures were flawed and the withholding of payment would not pass the reasonable man standard called for by the General Procurement Law. However, we re-emphasize that under the General Procurement Law and its implementing regulations the Procurement Officer must make such

4 The BCDC claim had been filed the previous year and is discussed separately below.

determinations pursuant to the process set forth in COMAR 21.10.04. From the point in time that a claim herein was received by the Procurement Officer we have concluded based on the entire record and the particular facts of this appeal that the claim should have been resolved in four months consistent with the time that it took the six temporary contractual employees to review the DOAC audit findings and conclude that the contractor should be paid approximately 97% of its claim. Because we believe that such review could have been conducted much earlier we also include within this 120 day window 30 days for processing the claim for payment.

Accordingly, we award pre-decision interest for the period of time commencing four months after a primary care claim was received until payment was made. Appellant's Exhibit 26 sets forth dates of claim and dates of payment and a number of days of interest calculated from date of claim to date of payment based on 10% which we find is the appropriate rate of interest. This exhibit was computer-generated and the parties agree that the numbers and dates set forth thereon are accurate. In the interest of time, therefore, the matter is remanded to Respondent to calculate interest commencing 120 calendar days after the date of the filing of the primary care claim and continuing until the date(s) the principal portion(s) of the claim was paid. If the amount or amounts paid on the claim were paid more than 120 calendar days from the date the claim was filed the Appellant is entitled to the number of days of interest on the amount (or amounts) paid commencing with the 120th day from the date of filing of the claim until the date of payment. All interest to which Appellant is due is to be calculated at 10%. See §11-107(a) Courts and Judicial Proceedings Article; §15-222, Division II, State Finance and Procurement Article. If the amount or amounts of the principal amount of the claim were paid less than 120 calendar days from the date of the filing of the claim, Appellant is not entitled to any interest.

AIDS Medication

48. Consistent with its contractual obligations, Appellant pro-vided AZT and related medications to numerous inmates during the invoiced periods.

49. In a letter to Appellant dated March 31, 1993, the DOC Commissioner, citing various DOAC audit recommendations, rejected the invoices and documentation Appellant previously submitted for reimbursement for AIDS-related medication, and notified Appellant that the DOC would withhold from payment to Appellant the sum of $694,030.37.[5]

50. In DOC Contract Claim IV, dated April 16, 1993, CMS claimed reimbursement for the provision of AZT and related medications in the amount of $411,586.13, plus interest, for the period from July 1, 1991 through June 30, 1992, pursuant to Contract Modification 8804-00G, Sections 04.03.02.10.02 and 05.08.05. Those sections provided, in pertinent part, that the DOC will reimburse Appellant for "100% of the cost of AZT and of any similar medications developed for the treatment of AIDS patients . . . ." With respect to that portion of DOC Contract Claim IV concerning AIDS medications, the DOC paid Appellant $159,094.91 on December 28, 1993. A second payment of $247,810 was made on March 3, 1994. To date, the DOC has paid $406,904,91 of the principal amount claimed, but not

5 Contract Claim IV in the amount of $411,586.13 and Contract Claim V in the amount of $282,444.24 total the $694,030.37 withheld from Appellant as a result of the DOAC audit recommendations.

interest.

51. In DOC Contract Claim V, dated April 29, 1993, Appellant relying on Sections 04.03.02.10.02 and 05.08.05 Modification 8804-00G, claimed reimbursement in the amount of $282,444.24, plus interest, for the provision of AZT and related medication for the period from July 1, 1992 through December 31, 1992. The DOC paid CMS $75,613.51 on December 28, 1993. A second payment of $54,703.07 was made on March 3, 1994. A third payment of $151,911.00 was made on March 3, 1994. To date, the DOC has paid $282,227.58 of the principal amount claimed, but not interest. The Board finds that the DOC improperly rejected Appellant's invoices for reimbursement for AIDS related medication based on the DOAC audit recommendations. Such rejection was set forth in the DOC Commissioner's letter to Appellant dated March 31, 1993. The record reflects that by August 11, 1993, Respondent, in connection with the formal claim review function, had been provided with all necessary documentation by Appellant to complete the review of the AIDS related medication claims and was, thus, in a position to fully determined its liability to Appellant concerning payment. Allowing Respondent fifteen (15) working days to review all the necessary documentation to determine the validity of the Appellant's claim brings one to September 1, 1993.[6]

The AIDS-related medication claims were filed several months prior to September 1, 1993 on April 16 and 29, 1993. Accordingly, the Board awards interest at 10% on the AIDS-related medication claims from September 1, 1993 until such claims were paid and remands the matter to Respondent to make the necessary computer generated calculations to determine and pay such amounts of interest at 10% on the amounts paid from September 1, 1993 until payment of the principal amounts on the claims for AIDS-related medication.

Intake Physicals

52. In DOC Contract Claim IV, dated April 16, 1993, CMS claimed reimbursement for the provision of excess intake physical examinations conducted during the period from October 1, 1991 through June 30, 1992, pursuant to Contract Section 05.07. 01.05, as modified in Modification No. 8804-00C. That section stated in pertinent part, that the DOC shall pay Appellant monthly the amounts of male and female intake costs, as stated in Attachment VI of the Contract, for each intake physical examination beyond the base number of intake physical examinations stated in Attachment VI. While CMS claimed $638,884.50, plus interest, for the services, the full amount of the principal claim was ultimately determined by the Procurement Officer to be $714,625.14. On April 27, 1993, the DOC paid CMS $31,908.90. We decline to award interest on this payment made 11 calendar days after the claim was filed. A second payment of $451,000.00 was made on July 27, 1993. This payment was made within the four month window that the Board has determined was appropriate for the Procurement Officer to review and pay the Primary Care claims, which four month time frame, for the same reasons, we find to be appropriate for the intake physicals claim. Interest thereon is therefore denied. A final payment of $209,504.74 was made on March 3, 1994. Interest is awarded on such amount ($209,504.74) from 120

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6 By letter dated August 16, 1993, Appellant provided still further information supporting its claim and reduced its claim by $4,101.53 for incorrectly including non-AIDS medication on previous billings.

calendar days after the date the claim was filed on April 16, 1993 until paid on March 3, 1994. The matter is remanded to Respondent to make the necessary computer generated calculations to determine and pay such amount of interest at 10%.

State Employee Absences

53. Under Section 04.06 and Attachment IV of the Contract, the DOC was to pay CMS for work done by CMS personnel because of State employee absences.

54. Contract Claim IV regarding State employee absences was filed on April 16, 1993, seeking payment of $186,000, plus interest. The DOC paid $142,575.33 of the principal amount claimed on April 27, 1993, but not interest. The Board declines to award interest on this payment made 11 calendar days after the claim was filed.

55. Contract Claim V regarding State employee absences was filed on April 18, 1993 seeking $186,000, plus interest. The DOC paid $180,920.85 of the principal amount claimed on Claim V on April 27, 1993, but not interest. The Board declines to award interest on this payment made 9 calendar days after the claim was filed.

Home Detention Unit

56. Appellant provided health care services to Home Detention Unit (HDU) inmates at the DOC's request, beginning in July, 1991. That request was later reduced to writing in Contract Modification J.

57. In DOC Contract Claim IV, filed on April 16, 1993, Appellant claimed reimbursement in the amount of $55,742.12, plus interest, for the provision of HDU care during the period of July 1, 1991 through June 30, 1992, resulting from the monthly Average Daily Population (ADP) of HDU inmates, pursuant to Contract Section 05.06.01, as set forth in Attachments VI and VII of Modification J. On April 27, 1993, the DOC paid CMS $15,163.33 of the principal amount claimed, but not interest. The Board declines to award interest on this payment made 11 calendar days after the claim was filed.

58. In Contract Claim V, Appellant claimed $149,784.60, plus interest, for unpaid HDU care for the period of July 1, 1992 through December 31, 1992. The DOC paid Appellant $75,490.80 on April 27, 1993. A second payment of $44,608 was made on July 27, 1993, for a total of $120,098.80 of the principal amount claimed, but not interest. The Board declines to award interest on either of these payments made respectively within 11 calendar days and within the four month window as discussed above as being a reasonable time for claim review and processing by the Procurement Officer.

HIV Testing Program

59. In Contract Claim IV, filed on April 16, 1993, Appellant claimed reimbursement in the amount of $72,618.80, plus interest, for the provision of the Voluntary HIV Testing Program for the months of April, 1991, May, 1991, and October, 1991 through June 30, 1992, pursuant to Contract Sections 05.07. 01.07 and 05.07.01.08, as modified. On April 27, 1993, the DOC paid Appellant $31,316.42 toward the principal claim. A second payment of $14,792.24 was made on July 27, 1993. Interest on these two payments is denied, having been made respectively within 11 calendar days and the four month window for claim review and processing. A third payment of $24,908.02 was made on January 21, 1994, but not interest. Interest is awarded on this payment of $24,908.02 at 10% from 120 calendar days after the date the claim was filed (April 16, 1993) until paid on January 21, 1994 and the matter is remanded to Respondent to make the necessary computer generated calculations to deter-mine such amount of interest at 10%.

60. As also set forth in Contract Claim IV, dated April 16, 1993, Appellant performed an audit of the database for the Voluntary HIV Testing Program from January 1, 1991 through December 31, 1991 and identified additional monies due Appellant in the amount of $34,518.47, plus interest. The DOC paid CMS the full principal amount claimed on July 27, 1993, but not interest. Interest on such payment is denied since payment was made with the 120 day window from the time the claim was filed on April 16, 1993.

61. In DOC Contract Claim V, filed on April 16, 1993, Appellant claimed reimbursement in the amount of $56,471.74, plus interest, for the provision of the Voluntary HIV Testing Program for the period of July 1, 1992 through December 31, 1992, pursuant to the foregoing Contract sections. On July 27, 1993, the DOC paid CMS $38,346.29. Interest is denied since payment was made with the 120 day window for review and processing of the claim by the Procurement Officer. A second payment of $18,125.45 was made on January 21, 1994, effecting payment in full of the principal amount, but not interest. Interest is awarded by the Board on such payment of $18,125.45 from 120 calendar days after the date the claim was filed until paid on January 21, 1994. The matter is remanded to Respondent to make the necessary computer generated calculations to determine such amount of interest at 10%.

Boot Camp EKGs

62. In Contract Claim Iv filed on April 16, 1993, CMS claimed reimbursement for the provision of electrocardiograms for the Jessup Region Boot Camp for June, 1992, pursuant to certain Contract Sections and Modification 8804-00E. CMS claimed $685.75, plus interest. On July 27, 1993, the DOC paid the entire balance of $685.75, but not interest. Interest is denied because the claim was paid within the 120 day window determined on the facts of this appeal to be a reasonable time frame for claim review and processing by the Procurement Officer.

63. In Contract Claim V, filed on April 16, 1993, Appellant claimed reimbursement for Boot Camp electrocardiograms for the period of July 1, 1992 through December 31, 1992, in the amount of $2,785.20, plus interest, pursuant to certain Contract Sections. On July 27, 1993 the DOC paid the entire balance of $2,785.20, but not interest. Interest is denied because payment was made within the 120 day window for claim review and processing.

B. INTEREST BALTIMORE CITY DETENTION CENTER

1. In 1991, the State awarded Appellant a contract to provide health care services at Baltimore City Detention Center (BCDC).
2. Appellant and the State of Maryland, Department of Public Safety and Correctional Services (the Department), Division of Pre-trial Detention and Services (DPDS), ultimately entered into Contract No. 9172-1501 (the Contract).
3. The Contract required CMS to provide, among other services, "primary care" services by certain health care providers for a specified period of time each day.
4. Attachment III to the Contract set forth the staffing requirements, by provider position, for CMS personnel. These requirements governed Appellant's obligations except to the extent they were modified by a monthly implementation schedule approved by the DPDS.
5. Section 05.09.01.01 of the Contract permitted the DPDS to make a claim against Appellant "for work . . . which Appellant did not perform in part or whole." Under §05.01.03.03 of the Contract, if the DPDS "question[ed] whether a service was provided," payment for the

service could be immediately withheld in the amount stated in Attachment III of the Contract.

6. At the Contract's inception, BCDC's Director of Medical Services, reviewed CMS' invoices using Division of Correction audit protocols.
7. Before the DOAC assumed auditing responsibilities for DPDS, the Director of Medical Services gave Appellant an opportunity to address and resolve discrepancies raised by her review.
8. Starting in 1992, the DOAC evaluated Appellant's payment requests under auditing rules it had developed following a late 1991 legislative audit of the Division of Correction (DOC).
9. The DOAC adopted and used revised audit procedures (the Revised Audit Procedures) for recommending whether the DPDS should pay appellant for primary care services.
10. In the field, the DOAC auditors used an Auditing Index as a tool to implement the Revised Audit Procedures.
11. The Auditing Index listed many of the specific elements of the Revised Audit Procedures. Each such element was assigned a code.
12. The DOAC auditors reviewed the sign-in/sign-out logs, and compared them with the Monthly Staffing Report on which Appellant set out the dates on which and the times during which Appellant employees were to have worked at each facility. The DOAC auditors assessed the Monthly Staffing Report and the sign-in/sign-out logs under the criteria set out in the Auditing Index.
13. The sign-in/sign-out logs were the original source documents maintained at the various State prisons that the Appellant providers would sign upon commencing or completing a shift.
14. The Monthly Staffing Report was a summary created and forwarded by Appellant to the DPDS.
15. The only original documents reviewed by the DOAC auditors were the sign-in/sign-out logs.
16. Any failure to meet an audit index standard would be identified by the applicable Auditing Index code, and a deduction would be recommended.
17. Deductions arising from a log irregularity were labeled as "B" deductions.
18. Deductions based on the Monthly Staffing Report were labeled as "C" deductions.
19. "A" deductions were to be based on irregularities in the institutions' timecards. The Department ultimately decided that the DOAC would not review time cards because "they were in such atrocious shape" that they "lacked . . . sufficient integrity for use in the audit."
20. The extent of the recommended deduction also was set forth in the Auditing Index. For example, a DOAC auditor determining whether Appellant should be paid for hours worked by Physician's Assistant Smith (P.A. Smith) at BCDC on May 1, 1992 would review BCDC's sign-in/sign-out log for that date. If P.A. Smith signed in or out in pencil, the auditor would recommend a withholding as a "B-3" violation. Upon finding a B-3 violation, the Auditing Index instructed the auditor to "take all associated time not to exceed the hours required by the contract." Accordingly, all of P.A. Smith's time for the particular shift, typically eight hours, could be recommended for deduction under the above hypothetical. What was associated time varied depending upon the particular auditing index standard which was applied. In practice, the majority of recommended deductions involved multiple violations of the auditing index standards.
21. After reviewing the services covered by an Appellant invoice, the DOAC would prepare an "audit report" for the DPDS, recommending, among other matters, deductions from the base

primary care billing.

22. Under the DOAC's procedures, it did not conduct an exit conference during which Appellant could seek to provide evidence that services covered by the Monthly Staffing Report had been provided.
23. The DPDS had no capability to evaluate or reconsider the DOAC's recommendations.
24. At all times, the DPDS retained final authority with respect to payment decisions concerning CMS.
25. The DPDS adopted the DOAC's recommendations without change.
26. After the DPDS began to withhold monies in reliance on the DOAC recommendations, Appellant filed a series of contract claims, which a DPDS employee later evaluated under the guidance of the Department's Procurement Officer.
27. For the period from August, 1991 through March, 1993, Appellant filed contract claims which disputed DOAC-recommended withholdings of $1,615,716.71 for primary care services. The DPDS eventually paid CMS the sum of $1,585,926.59 on those claims which amounted to approximately 98% of the principal amount sought.
28. At the Procurement Officer's direction, the assigned DPDS employee reviewed Appellant's claims, and the DPDS/DOAC withholdings, under the reasonable man standard; i.e., would a reasonable person reviewing the source material conclude that a particular individual worked a particular shift on a particular date. The Board finds that this reasonable man standard was the correct standard of review to apply to Appellant's claims.
29. Although the assigned DPDS employee reviewed Appellant's claims, the Procurement Officer, in his capacity as Director of Procurement, authored the final written decisions on the claims.
30. When asked whether the DOAC review and his review were conducted under the same standard, the Procurement Officer testified:

> *No. the DOAC went from the standpoint if something is wrong, then they would take an exception to it. And, therefore, if--well, let's just say something were smudged and you couldn't tell what the end time was, then you took [i.e., withheld] all of the time because you couldn't be sure just how long the person worked; whereas a reasonable man would say, what's it look like? You know, does it agree with other things? And DOAC did not include, did not look at the timecards, whereas I did.*

31. The Procurement Officer utilized the timecards during his review, while the Director of DOAC maintained that the timecards were too "atrocious" to be of value.
32. The Procurement Officer testified that the difference between the two standards was "a substantive difference as opposed to a procedural difference."
33. The DPDS Commissioner testified that the DOAC based its withholding recommendations upon strict compliance with the auditing methodology. The amounts withheld under the DPDS contract covered numerous positions staffed by CMS at the BCDC over the 20-month period from August, 1991 through March, 1993. The withholding were based on DOAC audit report exceptions organized by calendar month. Each month involved exceptions to between approximately 8 and 50 of the positions staffed by CMS, and in the majority of instances the exceptions covered the whole or portions of more than one shift for each position during the month.
34. The DOC had an audit standard that required a signature rather than a printed name.

35. The DOAC did not use a signature key of CMS' providers against which to check seemingly illegible signatures before recommending deductions.
36. The DPDS Deputy Commissioner testified that the DPDS "didn't have the staff" to review the DOAC's withholding recommendations.
37. The DPDS Commissioner testified that in the latter part of 1994, he approved payment to Appellant of previously-withheld monies based upon a "re-review of CMS claims", using different methodology than did DOAC, to confirm that primary care service had been provided.
38. Appellant's Contract Claim I was filed with the Procurement Officer on May 22, 1992.
39. The DPDS did not receive Appellant's Claim I from the Procurement Officer for review until the winter of 1993.
40. After receiving Appellant's Contract Claim I in the winter of 1993, the DPDS determined that it "didn't have the resources" to review the claim and related documents and returned them to the Procurement Officer with a request that he review the claim and resolve it.
41. In either late 1993 or early 1994, the same Claim I materials that the DPDS had returned to the Procurement Officer in early 1993 were sent back to the DPDS for review.
42. The DPDS employee who ultimately reviewed the Appellant's claim documents, did not speak with the Procurement Officer about the appropriate standard for reviewing the DPDS claims until late spring or early summer of 1993.

    The DPDS employee who did the review was to review all the exceptions to determine, in each instance, whether the health care provider for the position was present in the institution during the shift in question. Due to her other duties, the number of exceptions, and the documentation which had to be reviewed for each, she was unable to accomplish this without assistance.

    The reviews were completed on or about February 1, 1994. For all three claims, the time expended by all personnel, including non-state employees hired on a temporary basis, exceeded 561 hours, and represented state and contractual employee personnel costs exceeding $6,524.00.

    For each exception, a reviewer reviewed sign-in logs maintained by the BCDC, Appellant's materials submitted with its timecards, and in some instances other documents.
43. The DOAC used the same Revised Audit Procedures to review Appellant's BCDC primary care invoices as it did to review Appellant's DOC primary care invoices.
44. Appellant, as noted, filed DPDS Contract Claim I on May 22, 1992. That Contract Claim covered the period of service from August, 1991 through December, 1991. In Claim I, Appellant disputed DOAC-recommended withholdings in the amount of $289,427.71 and claimed that amount, plus interest. On January 21, 1994, DPDS paid Appellant $273,450.65 on that claim, but not interest. The Board awards interest on the amount paid of $273,450.65 from a point in time 120 calendar days after the claim was filed on May 22, 1992 until payment was made on January 21, 1994. The Board finds that the Procurement Officer should reasonably have reviewed and processed Appellant's claim in the same 120 calendar day period from the date the claim was filed that the Board has found to be appropriate for the DOC claims. This finding that 120 calendar days is an appropriate period for review and processing of a claim for payment herein is strictly based on the facts presented by this appeal and is not intended to suggest 120 calendar days would be appropriate in other factual contexts. The Board remands the matter to Respondent to make the necessary computer

generated calculations and pay Appellant interest at 10% from 120 calendar days from the date the claim was filed until payment of the amount of $273,450.65 thereon.

45. Appellant filed DPDS Contract Claim III on March 3, 1993. That Contract Claim covered the period of service from January, 1992 through June, 1992. In Claim III, Appellant disputed the DOAC-recommended withholdings in the amount of $571,755.00 and claimed that amount, plus interest. The Procurement Officer determined that the amount of the claim was $546,623.00. On January 21, 1994, DPDS paid Appellant $540,806.00 on that claim, but not interest. The Board for the reasons set forth in Finding of Fact No. 44 awards interest on the amount of $540,806.00 from a point in time 120 calendar days from the date the claim was filed, March 3, 1993, until payment of such amount on January 21, 1994. The matter is remanded to Respondent for appropriate calculation and payment.

46. Appellant filed DPDS Contract Claim VIII on August 20, 1993. That Contract Claim covered the period of service from July, 1992 through March, 1993. In Claim VIII, Appellant disputed DOAC-recommended withholdings in the amount of $787,088.00 and claimed that amount, plus interest. The Procurement Officer determined that the amount of the claim was $779,666.00. On January 21, 1994, DPDS paid Appellant $759,264.00 (but not interest) on that claim, and another $12,405.94 (but not interest) on April 13, 1994, for a total of $771,669.94. The Board awards interest at 10% on $759,264.00 from 120 calendar days from the filing of the claim on August 20, 1993 until such amount was paid on January 21, 1994. The Board also awards interest at 10% on the amount of $12,405.94 from a point in time 120 calendar days from the date the claim was filed, August 20, 1993, until the $12,405.94 was paid on April 13, 1994. The Board remands the matter to Respondent for calculation and payment.

C. CLAIMS EXPENSES

1. Appellant incurred costs of $14,238.70 to hire additional temporary personnel and to pay related expenses to prepare documentation addressing primary care withholdings.

2. Appellant filed a claim in the amount of $128,148.30 for reimbursement for fees, costs and expenses allegedly incurred by Appellant in order to comply with the DOAC audit procedures including the incurred costs of $14,238.70 to hire additional temporary personnel and to pay related expenses to prepare documentation addressing primary care withholdings. The issue for the Board to determine is whether expenses incurred by Appellant are properly labeled contract performance expenses resulting from the DOAC audit procedures or properly described as expenses incurred in preparing and supporting its claims filed with the Procurement Officer, i.e., properly labeled litigation expenses.

Claim preparation fees are not ordinarily a cost incurred in the performance of contract work. See Fruin-Colnon Corp. and Horn Construction Co.,Inc., MDOT 1025, 1 MSBCA ¶165(1987) at pp. 111-112 (where the Board noted, however, that claim preparation fees may be allowable as overhead costs in a construction contract context). Effective October 1, 1996, the provisions of §15-221.2, Division II, State Finance and Procurement Article which apply only to construction contracts provide that the Board may award the reasonable cost of filing and pursuing a claim under certain circumstances.

Even if the Board were to determine that this statutory authority was intended to operate retroactively, the instant contract is not a construction contract. It is a contract involving the provision of medical services.

This appeal involves litigation in an administrative context between the State and a corporation. The claims on which the appeals are based were a necessary part of the process Appellant was required to undertake to secure the jurisdiction of this Board pursuant to §§15-217 through 15-220, State Finance and Procurement Article. In this appeal the evidence reflects that Appellant incurred the costs it seeks when it acquired temporary staff and other resources to prepare its claims filed with the Procurement Officer. The Board finds that such costs are properly described as costs incurred in engaging in litigation with the State at the agency level; i.e., are claim preparation expenses. This Board has previously considered whether such costs are recoverable (in the context of a construction contract) and determined that claim preparation expenses may not be recovered by an Appellant. Hensel Phelps Construction Co., MSBCA 1101, etc., 4 MSBCA ¶304, pp. 185-186(1992). Indeed, COMAR 21.09.01.19E (regarding permissible contract costs) provides in part that "costs incurred in litigation by or against the State are unallowable."

The expenses Appellant seeks to recover were not incurred by Appellant in performing its contractual obligations. Appellant could have pressed its claims again Respondent with whatever documentation it chose. Although the Board recognizes that the implementation of the restrictive DOAC auditing standards necessitated the filing of claims by Appellant to be paid for work actually performed and that the claims process cost Appellant money, the preparation of the claims documentation, although necessary to secure payment for services rendered, does not represent the performance of express or implied obligations under the contract. Accordingly, Appellant may not be compensated for the expenses it occurred for preparation of the claim documentation.

The conclusion is consistent with the decision of this Board in Fruin-Colnon Corp. and Horn Construction Co., Inc., supra, where the Board noted that claim preparation fees are not a cost incurred in the performance of contract work and that such costs were only recoverable to the extent that overhead costs could be recovered.

Appellant seeks to contrast its claim for costs from the filing fees, lawyer's fees, and expert witness fees specifically excluded from permissible contract costs by COMAR 21.09.01.19E.[7]. While that regulation excludes all costs involved in litigating claims in court or before this Board or the Board of Public Works, it also provides that "costs incurred in litigation by or against the State are unallowable," which we believe includes the cost of

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7 This COMAR provision provides in its entirety:
"E. Litigation Costs. Litigation costs include all filing fees, legal fees, expert witness fees, and all other costs involved in litigating claims in court or before the Appeals Board or the Board. Litigation costs incident to the contract are allowable as indirect costs in accordance with these cost principles regulations except that costs incurred in litigation by or against the State are unallowable."

preparing and documenting claims at the agency level, notwithstanding that such documentation may ultimately lead to payment of the claim in whole or in part.

Appellant urges that the claim preparation costs it seeks were actually incidental to its performance of the contract, and thus may be recovered as damages in this case. However, the Board has found that the costs did not represent expenses of contract performance. In this regard we note the observation of the U.S. Claims Court in Singer v. United States, 215 Ct. Cl. 281, 568 F.2d 695(1977) regarding the allowability of such costs:

> *Here the claims for equitable adjustment were not presented to the contracting officer until all work had been completed, they addressed no situation in which Government liability was clear or apparent and, in content, they offered nothing that could reasonably be considered as benefiting the contract purpose. Judged both from the standpoint of the time of their submission and the purpose of their submission, [the contractor's] requests for equitable adjustment were not performance-related; they bore no beneficial nexus either to contract production or contract administration. Accordingly the attorney's fees are not recoverable. As to the other claim preparation costs which the plaintiff also seeks, these too are not allowable and for the same reason -- they bear no relation to contract performance.*

215 Ct. Cl. at 328, 568 F.2d at 721.

Appellant also cites Bill Strong Enterprises, Inc. v. Shannon, 49 F.3d 1531 (Fed. Cir. 1995), in support of its arguments. However, the facts of that case are distinguishable from those in the instant appeal. The court there determined costs incurred for consulting work conducted after the work was completed were costs associated with the administration of a contract, more specifically the negotiation of issues involving alleged delay that arose during the performance of the contract and prior to the filing of a claim. While determining that such costs were allowable, the court noted that under United States procurement law and regulations, a legal, accounting, or consulting cost incurred in connection with the prosecution of a CDA claim or an appeal against the Government is unallowable. Bill Strong, 49 F.3d at p. 1549. The court noted further that an allowable cost is one which provides a benefit to the contract purpose, either in contract administration (to include costs to provide information that may promote settlement through negotiation) or contract performance. Bill Strong, 49 F.3d at p. 1549. However, the Court opined that a cost should be denied if the underlying purpose is to promote the prosecution of the claim against the government. Bill Strong, 49 F.3d at p. 1550.[8]

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8 The parties are cautioned that the Board's discussion of the Bill Strong case herein is not intended to signify an endorsement of its rationale that costs incurred to assist a contractor in negotiations prior to a claim being filed are re-coverable.

In the instant case, the costs were incurred in preparing the claims that were filed with the Respondent's Procurement Officer. The documentation, the cost for preparation of which Appellant seeks reimbursement was presented to the State for the first time at the time the claims were filed or thereafter. Such does not, therefore, constitute documentation which aided the administration or performance of the contract; they were claims documents. As such, they may not be the subject of damages awarded in this appeal. Accordingly, the appeal of this claim for preparation costs is denied.

D. AGGREGATION (MSBCA 1925)

1. In 1991, Appellant and DPDS entered into Contract No. 9172-1501B (the Contract), which provided that Appellant would deliver medical care services at DPDS.
2. BCDC houses mostly pretrial detainees, and there is a constant turnover in its inmate population.
3. At BCDC, fluctuations occur in the size of the inmate daily population, particularly after weekends and holidays.
4. Under Article 05.01.02 the Contract, DPDS was obligated to compensate Appellant for those services it delivers, so long as the services were provided in conformity with the Contract.
5. Under the Contract, Appellant was required to provide the services of certain health care providers for a specific period of time each day. For example, Attachment III to the Contract provided that a licensed practical nurse must be on duty in the general dispensary of the Women's Detention Center for eight hours per day on each of three shifts.
6. The Contract, at section 05.07.01.01, provided that the DPDS would pay to Appellant monthly a lump sum for primary care services provided under Attachment III or in accordance with a Monthly Facility Services Schedule (Schedule) approved under section 04.02.01.02.01 of the Contract. This monthly payment was to be adjusted by the hourly rates for service providers set out in Attachment III for services not provided in accordance with Attachment III or a Schedule.
7. The Contract permitted, and Appellant utilized, a practice which came to be known as "aggregation" to meet the staffing requirements of Attachment III. The term aggregation was not used anywhere in the Contract.
8. "Aggregation" is a process wherein time worked beyond the specific required hours for certain positions in a given shift is included in the total amount of hours worked for such providers for the month. For example, assume a Medical Assistant (M.A.) position is listed in Attachment III as being required eight hours per day on weekdays (Monday through Friday). The contractor provides an M.A. who in the first week in the month works 10 hours a day on four of these five days and does not work on the fifth day.

Utilizing "aggregation", the contractor would be given credit against its obligation under Attachment III for the eight hours required on these four days the M.A. worked (32 hours). The contractor would also be permitted to credit the eight "extra" hours (i.e., an additional 2 hours per day beyond the required eight hours a day) against the total number of M.A. hours required for that calendar month. Accordingly, assuming the M.A. worked eight hour days for all the week days remaining in the month, Appellant would have met its monthly

staffing hours for the M.A. position and no deduction would be taken, even though the hours were not delivered at all the times specified by Attachment III.

Without utilizing "aggregation", the contractor would be credited only for the required hours worked each day (eight hours per day for four days equal 32 hours) in accordance with the schedule set out in Attachment III, and a deduction would be taken for the entire weekday not worked in accordance with the schedule set out in Attachment III. No credit would be given (nor payment made) for the two hours per day worked beyond the eight hours set forth in Attachment III during the other four days of that week.

9. Article ll of Attachment III provided: "As provided in Article 04.02.01.02, the Contract generally is to adhere to the specified Monthly Facility Services Schedule worked out between the Division and the Contractor, however, except for those positions marked as "(I)", the Contractor may, from time to time without prior approval from the Division, temporarily adjust the Schedule when any Provider's service is to be rendered for a particular calendar month as long as the Provider renders the total amount of time required by the Monthly Facility Services Schedules during that calendar month. The Contractor is to advise the Division in writing of any schedule changes when the Contractor submits its Staffing Report for the month. If the Division believes that the Contractor is abusing its discretion, the Division can require that the Contractor obtain the Division's prior approval before making a temporary Schedule Change."
10. The Contract designated critical positions as "(I)" positions. The Contract limited Appellant's discretion to use "aggregation" to certain positions that were considered non-critical and were referred to as "non-(I)" positions.
11. When calculating its monthly invoices, Appellant was required to deduct from the monthly primary care payment for provider time specifically required under Attachment III or a Schedule, but not actually provided. Accordingly, on a monthly basis, Appellant would file with DPDS a "staffing report" listing the names of the providers and the hours they worked, as well as Appellant's deductions.
12. As contemplated by the Contract, "aggregation" allowed Appellant to maximize the use of its non-(I) providers while limiting the number of deductions, so long as the DPDS was satisfied with the staffing that resulted.
13. DPDS did not deduct for services provided on an aggregation basis until August, 1994.
14. On June 23, 1993, the Director of Health Services for DPDS, forwarded a letter to Appellant. The Director of Health Services was the Division Representative under Article 08 of the Contract. The Director was authorized to make any determinations reserved to the Division under the Contract, excepting those reserved to the Procurement Officer under COMAR, Title 21. The Board finds that the June 23, 1993 letter revoked Appellant's right to aggregate without prior approval.
15. Following the Director's June 23 letter, Appellant continued to submit invoices which did not take deductions from the monthly primary care payment for services which were not delivered in accordance with Attachment III or a Schedule. The basis for Appellant's failure to take a deduction was that it had met the total staffing hour requirements for the month, and Attachment III allowed "aggregation."
16. Appellant received a letter from the DPDS Commissioner dated August 12, 1994 challenging Appellant's continued use of "aggregation" to meet its primary care obligations for non-(I)

time.

17. The Commissioner's letter stated that DPDS had, by the Director's letter of June 23, 1993 revoked Appellant's discretion to utilize "aggregation."
18. Citing the Director's June 23 letter as justification, the Commissioner informed Appellant in his August 12 letter that DPDS was "deducting," i.e., refusing to pay for, $212,924.42 in health care services provided on an aggregation basis. DPDS calculated this deduction by subtracting all aggregated time from the staffing reports submitted by Appellant during the period of July, 1993 through May, 1994.
19. In response to the Commissioner's letter, Appellant followed the Contract's dispute resolution procedure, and ultimately, filed a claim with the Procurement Officer on October 7, 1994.
20. In its contract claim, Appellant sought reimbursement for the $212,924.42 it claimed was wrongfully withheld, and specifically "reserved the right to submit supplemental information and documentation in support of its claims . . . ."
21. Appellant's claim arising from its June, 1994 invoice was listed as "to be determined."
22. After the filing of the initial contract claim on October 7, 1994, DPDS deducted $21,977.30 from Appellant's June, 1994 invoice on the ground that certain of the services billed for in June, 1994 were provided and billed on an aggregated basis. Accordingly, the total value of Appellant's claim relating to "aggregated" was $234,921.72 ($212,924.42 + $21,997.30), plus interest.
23. The Procurement Officer released his decision concerning Appellant's claim on October 5, 1995.
24. There is no dispute that Appellant's personnel provided the required total number of non-"(I)" position hours for the months in questions.
25. The sole basis for the DPDS withholding has been its contention that the Director's June 23 letter revoked Appellant's discretion to use "aggregated."
26. On October 31, 1995, Appellant timely filed a Notice of Appeal.
27. For the period of July, 1993 through June, 1994 Appellant provided $234,921.72 in services on an aggregated basis.

The Director of Health Services letter of June 23, 1993 to Appellant provided in relevant part:

> *I am writing to inform you that I believe that Correctional Medical Systems (CMS) is "abusing its discretion" (Attachment III, Article 11) in making temporary adjustments to the monthly Facility Services Schedule. Therefore, effective July 1, 1993, as permitted by the Contract, I am requesting "that the Contractor obtain the Divisions prior approval before making a temporary schedule change." This means no change can be made in services required under the Contract, Attachment III and approved Schedules without prior approval by me or my designee.*

Appellant responded to the June 23, 1993 letter by letter dated July 21, 1993 asserting it was not abusing its discretion and suggesting that it had no alternative but to continue aggregation due to lack of administrative resources and practical reality. Appellant continued to aggregate without prior approval notwithstanding the clear direction in the June 23, 1993 letter from the Director of Health Services that prior approval be obtained. Paragraph (Article) 11 of Attachment III provides

in relevant part that: "If the Division believes that the contractor is abusing its discretion, the Division can require that the contractor obtain the Division's prior approval before making a temporary change."

The record reflects that the Director had a good faith belief that the Appellant was abusing its discretion in its staffing. We find further that the Director exercised appropriate authority under the Contract to require prior approval for aggregation. Since prior approval was not obtained, Appellant's aggregated claim is denied. We are aware that the State continued to pay Appellant pursuant to aggregation for a protracted period following the June 23, 1993 letter until August, 1994. However, we do not find, that the record reflects that such payments amount to waiver by the State of the Contract rights it asserted in the June 23 letter. See Macke Building Services, Inc., MSBCA 1128, 1 MSBCA ¶95(1995) at pp. 13-14.

Wherefore, it is ORDERED this 13th day of December, 1996 that Appellant's consolidated appeals are sustained and denied as set forth above and the matter is remanded to Respondent for determination and payment of interest pursuant to the guidance set forth above.

Dated: December 13, 1996

Robert B. Harrison III
Chairman

I concur:

Candida S. Steel
Board Member

Randolph B. Rosencrantz
Board Member

Certification

COMAR 21.10.01.02 **Judicial Review.**

A decision of the Appeals Board is subject to judicial review in accordance with the provisions of the Administrative Procedure Act governing cases.

Annotated Code of MD Rule 7-203 **Time for Filing Action.**

(a) Generally. - Except as otherwise provided in this Rule or by statute, a petition for judicial review shall be filed within 30 days after the latest of:

(1) the date of the order or action of which review is sought;
(2) the date the administrative agency sent notice of the order or action to the petitioner, if notice was required by law to be sent to the petitioner; or
(3) the date the petitioner received notice of the agency's order or action, if notice was required by law to be received by the petitioner.

(b) Petition by Other Party. - If one party files a timely petition, any other person may file a petition within 10 days after the date the agency mailed notice of the filing of the first petition, or within the period set forth in section (a), whichever is later.

* * *

I certify that the foregoing is a true copy of the Maryland State Board of Contract Appeals decision in MSBCA 1822, 1867, 1868, 1869 & 1925 appeals of correctional Medical Services, Inc. Formerly Known as ARA Health Services, Inc. d/b/a Correctional Medical Systems under DPS&CS Contract Nos. 8804-00 and 9172-1501B, Together with the Pertinent Amendments and Modifications Thereto.

Dated: December 13, 1996

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Mary F. Priscilla
Recorder