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Motivations and Conflicts in Prison Medical Contracting

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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ABSTRACT

MOTIVATIONS AND CONFLICTS IN PRISON MEDICAL CONTRACTS

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Millions of Americans experience incarceration each year. While incarcerated, local and state correctional departments are responsible for all medical care these individuals require. This puts significant stress on facilities and systems that are designed for security functions and not medical care. As a result, many correctional facilities outsource their medical program to private medical vendors. Across the literature and popular media, it is evident that many of these contracts experience significant issues that negatively impact local and state resources, including both personnel and money. The literature indicates that government contracts with private vendors may not appropriately manage the partnership risks. When conflicts arise, public administrators either placate the vendor or cancel the contract altogether and restart the process of developing a new contract with a new vendor. Both of these options waste valuable resources and can reflect negatively on the government.

This dissertation explores the relationship between public administrators' motivations and the structure, outcomes, efficiencies, and partner conflicts that arise in the contractual process. Incomplete Contract Theory and Contracts as Reference Points Theory suggest that individual motivations during contract drafting and negotiation are critical to the expectations of work to be performed during the contract term. Additionally, contract writers have to deal with tradeoffs between costs and quality of the services to be contracted. These tradeoffs are so fundamental that they are constitutive of what has been called an “essential tension” between cost and quality that drives the focus and expectations during contract drafting. This dissertation hypothesizes that the management of this essential tension will impact the likelihood of success, contract efficiencies and partnership conflicts in case of prison medical contracts.

The mixed-method study employs both quantitative and qualitative research methods, i.e. a structured survey and content analysis of contract documents. Case studies were analyzed and all findings are presented. Overall study results indicate a preliminary finding that public administrators’ motivation correlates with predictable differences in contract design and contract outcomes. Specifically,

public administrators motivated to improve quality are more likely to write contracts that allow the private vendor the space to achieve quality while restricting the way they can use the financial resources provided. When this happens, the partnerships experience more beneficial outputs with greater efficiency and less likelihood of conflict. On the other hand, states motivated to improve cost control, are more likely to allow the vendor space to manage financial resources but restrict the ability to determine efficient ways to achieve quality, which seems associated with problems in outputs, efficiencies and conflicts.

These findings have implications for contracting and the use of contracts by public administrators. The results suggest that contract completeness is more nuanced than a contract being complete or not complete on the whole. Each section of a contract may be at different levels of completeness independent from each other. Additionally, the application of completeness and incompleteness in different sections can be an intentional and strategic action on the part of the public administrator that could be used to enhance the usefulness of a complex contract. Moreover, the results support the assertion that contract partners perceive entitlements from contract negotiations which may unintentionally conflict with the strategy for contracting that the public administrator is using. From these findings, recommendations are presented.

The study contributes to the understanding of public contracting and provides insights on how to improve partnership success and expands theories regarding contract completeness. The findings can benefit public administrators, policy makers, and scholars in the field of public affairs.

CHAPTER 1: INTRODUCTION

As a result of the landmark Supreme Court case *Estelle v. Gamble* (1976), incarcerated individuals became the only group with a United States constitutional right to the provision of medical care. Specifically, and unequivocally, individuals residing in a correctional facility have the right to access medical care, receive the care ordered by a medical provider, and receive professional medical judgment for health care services. A breach of any of these three defined rights amounts to the facility staff being "deliberately indifferent" to the individual's medical needs and a violation of the incarcerated individual's 8th Amendment protection against cruel and unusual punishment (Alsan, et al., 2023).

The number of individuals these rights apply to is not insignificant. For the calendar year 2022, jails received over 7.3 million admissions with over 663 thousand individuals in the custody of a jail on the midyear point (Zeng, 2023). Of the 663 thousand individuals, only 30 percent were convicted and serving a sentence; the other 70 percent were not convicted and awaiting a court action (Zeng, 2023). Additionally, at the end of 2022, state and federal prisons housed over 1.2 million individuals (Carson, 2023). This number has been decreasing since 2009 when the number of individuals reached nearly 1.6 million in state and federal prisons (Carson, 2022). However, even with this decrease, on average across the U.S. there are 350 individuals incarcerated for every 100,000 persons (Carson, 2022).

The millions of "justice-involved" individuals each year are more likely to have higher medical and mental health needs compared to their community counterparts and higher rates of geriatric conditions when compared to like individuals within the community (Alson, et al., 2023; Puglisi & Wang, 2021). Providing medical care within a correctional setting is inherently difficult, especially as the level of medical need rises (Puglisi & Wang, 2021). Structural barriers make providing medical care difficult, such as the structure of the buildings, management of movement within the facility, management of movement outside the facility, and distance between correctional facilities and medical specialists, as facilities tend to be in more rural locations (Puglisi & Wang, 2021). Significant non-structural barriers also exist. Issues such as stigma, lack of trust, and lack of needed medical personnel make providing medical care even more difficult for these facilities.

Prison medical programs are unlike any other medical system in the United States. All state DOCs must manage a comprehensive prison medical program. A comprehensive prison medical program ensures access to all medical care, including primary care clinics, chronic disease management, urgent care, emergency room, all possible medical specialties, hospital care, assisted living resources, skilled nursing level of care, dental, vision and mental health care. The program must manage medical resource

utilization, for both on-site services and off-site care with medical specialist referrals. Diagnostics to assist providers and specialists with care must be done, including laboratory work, imaging services and other ancillary medical services (e.g. electrocardiograms, retinal screenings, etc.). Additionally, the program must manage payment for all of the medical care provided either through hiring the staff directly as state employees, contracting with providers for services and paying hourly (for either on-site or off-site work), contracting with providers for services and paying per visit rates (again, for either on-site or off-site work), and/or using an insurance type arrangement to cover the cost of all off-site medical care, including ambulance transportation, emergency room care, hospital room care, specialist visits, etc. (Pew Charitable Trust, 2017). Some states leverage Medicaid coverage for hospital care as allowed by the Centers for Medicare and Medicaid Services (CMS) and must manage the additional tasks of enrollment into the public benefits program as well as redirecting provider payments to this reimbursement source.

State departments of corrections (DOCs) struggling with the management of a prison medical program have outsourced some or all of the program to a private vendor who should have better expertise and more accountability for the production and management of medical care provided (McDonald, 1995). As of 2017, 30 states were engaged with a private vendor to outsource some or all of the state prison medical program, whereas only 16 managed the medical program themselves and four states used a state university medical center to manage inmate health care (Pew, 2017).

Contracts for prison medical programs can range from quite simple to very complex, covering only individual discrete medical services to the full comprehensive medical care program (Pew, 2017). Moreover, state DOCs report a wide range of motivations for engaging private vendors in prison medical provision. While the expected outputs of various prison medical program contracts may reflect the goal of ensuring quality medical care is provided to incarcerated individuals, the impetus behind engaging a private vendor to produce the service may be drastically different. In the Pew Charitable Trust survey (2017), state DOCs reported top motivations for using a private vendor as (1) a mechanism to control or contain cost, (2) enhanced cost predictability, (3) free prison administrator time to focus on security and not medical, (4) risk share the cost and liability of medical care, and (5) obtain access to better skills and expertise to improve quality. Additional literature corroborates these assertions and additional motivations of (6) quality improvement and (7) political pressure abatement (Lundahl, Kunz, Brownell, Harris, Van Vleet, 2009).

These large and complex outsourcing arrangements often result in conflicts between the state and private vendors. For instance, between the years 2000 and 2018, the Florida Department of Corrections (FDOC) continually struggled with outsourcing inmate medical care provision (CGL, 2019). During that

period, Florida prison administrators executed six separate contracts with four different vendors, one of which was an emergency contract to continue medical care after another vendor early terminated an agreement. In total, four of the six contracts were terminated early by either the state or the vendor. One vendor filed a lawsuit against the state for not providing the vendor with more money in order to improve quality levels. During this time, the state directly managed the medical care program for five years while litigation and disagreements over contracting played out.

FDOC is not an isolated case in experiencing contractual conflicts with a private medical vendor working in the prison industry. A quick internet search will pull dozens of articles about prisons, jails and localities having disputes with private medical vendors.

> *JSO canceled contract with jail healthcare provider Armor, hire NaphCare amid controversy*
> (Jacksonville Florida Times – Union, 2023)
>
> *County jail ends contract with medical provider Wellpath*
> (The Provincetown INDEPENDENT, 2023)
>
> *Commissioners decline to act on proposed $6.4M Lake County Jail health contract*
> (NWI Times, 2023)
>
> *Lawmakers delay $1B prison healthcare contract over cost, possible conflict of interest*
> (Montgomery Advertiser, 2023)
>
> *Charleston County sheriff opposes likely pick for jail's next health care provider*
> (The Post and Courier, 2023)
>
> *Barnstable jail stops using private health care vendor, citing staffing issues*
> (WBUR, 2023)
>
> *Governor: NM prison medical care contracts leave 'a lot to be desired'*
> (Source NM, 2023)
>
> *A prison medical company faced lawsuits from incarcerated people. Then it went 'bankrupt'.*
> (USA Today, 2023)

State DOCs who were using or have used a private vendor to manage some or all of the prison medical program reported administrative difficulty in engaging in and managing these contracts. Difficulties included lack of market options, difficulty supervising private vendor staff, lack of agreement on what services are expected of the contract, poor quality of contractual outputs, including difficulty monitoring quality of outputs, unsatisfactory payment arrangements, rent-seeking behavior after contract execution and early terminations by the private vendors. These issues all cause a significant and

unexpected increase in the time and money provided by state resources to manage the program (Aman, 2007; Lundahl et al., 2009; McDonald, 1995; Pew, 2017; Zhang & Soomro, 2015).

In the United Kingdom, the National Audit Office (NOA) performed a review (2014) of hundreds of governmental outsourcing contractual arrangements. The findings of the NOA audit reflected the same issues as state DOCs reported for their contractual arrangements for the prison medical programs. After the review, the NOA's (2014) key recommendation was to instruct administrators to refer back to the contract as the partnership guide and be more engaged with enforcing the negotiated expectations and contractual output obligations that were used to define and structure the partnership at contract start.

More recent recommendations take on an entirely different tone which suggests public parties should infuse more trust into the partnership and allow the private vendor to achieve the efficiencies expected from the competitive market (Domingues & Zlatkovic, 2015; Frydlinger, Hart, & Vitasek, 2019). This recommendation seems counter to the NOA recommendations as the NOA (2014) audit findings suggest that many issues arise because too much trust was put in the private vendor. The new recommendation does put some restraints on trust, however. The recommendation still requires a "trust but verify" mindset including diligent enforcement of the contract by the public agency in order to ensure outputs provided are appropriate based on the expectations negotiated in the contract. Therefore, public administrators tasked with managing large outsourcing contracts are left with little guidance other than to enforce the agreed upon contract.

Significance of the Research Topic

Current information accessible to prison administrators does not provide adequate guidance on how to manage contracts for prison medical programs. In the articles cited earlier, there is a presumption that state administrators are enforcing the contract as written and yet there are examples of serious disputes between the partners. There is almost no guidance or insight into how to prevent, or at least mitigate, the possibility of contractual conflicts. FDOC expects to spend close to $570 million on health care services to inmates during fiscal year 2023 which includes their large contract for a comprehensive medical program (OPPAGA, 2023). Frequently initiating, terminating, and switching a contract of that magnitude inevitably results in inefficiencies across the medical care program for the state DOC. These inefficiencies can have significant impact upon the continuity of medical care provision, risk of inmate litigation, as well as repeated duplicate expenses and sunk costs incurred by the state.

This dissertation explores the management of large prison medical contracts in relation to contractual outputs, efficiencies of resource use during the contract, and partnership conflicts. This study

evaluates these experiences by analyzing the motivations of health administrators and vendors to enter into contracts. While the prison contracting literature describes multiple motivations for correctional center administration to outsource medical care to a private vendor, a gap exists in the literature in operationalizing this motivation as a vehicle to manage the contractual partnership. It seems reasonable that conflicts with private vendors would be different for public administrators motivated to save money compared to administrators focused on improving quality. How might these differences be recognized and become part of the contract development process so as to avoid the unnecessary and expensive disputes that end up affecting both quality and budgets in prison medical care provisioning?

While contracts for comprehensive medical programs are complex, they are often similar across states and localities. If some states experience issues with outcomes, efficiencies and the partnership and others do not and all of them use the same (or very similar) contract structure, then there must be at least one other explanation for the difference. It also seems to reason that similar, or the same, contract structures or delineated outputs may not entirely be appropriate if different motivations exist behind engaging in the contract. Contract management of a medical program outsourced to ensure a more robust level of expertise may not look the same as contract management of a medical program outsourced for the purpose of containing costs.

Contract theory states that contracts serve two functions: outlining the cost of the service and outlining the quality of the service expected. Informed by the literature and relevant theories that suggest public administrators are motivated with a bias towards either the cost or quality of the contract, I asserted the following expectations[1]: (a) public administrators will be more likely to report success of cost or quality outputs that are in alignment with their motivation for contracting; (b) public administrators who are biased towards cost will be more likely to experience greater resource efficiencies compared to administrators biased towards quality; (c) public administrators who are biased towards cost will be less likely to experience partnership issues when compared to administrators biased towards quality; and (d) the language of the contract will impact reported outcomes in predictable ways.

The premise of these expectations is that the motivation of the public administrator will impact how the public administrator writes and manages the contract. No doubt, public administrators will typically care for cost and quality, but ultimately their preferences display a bias towards either cost or quality. When similar contract structures are utilized, the outputs may result in administrators struggling to fit their bias -- motivation -- into a “cookie cutter” contract and this may likely lead to more differences

[1] I am using expectations in the same sense as hypotheses and the terms are used somewhat interchangeably. This recognizes the interpretive as well as the deductive nature of the work.

in contractual efficiencies and partnership issues. This study will likely be the first to show the usefulness of considering how the motivation to contract affects contract structure and management.

Relevant Theories on Contracting

This research project was guided by Incomplete Contract Theory (ICT) and Contracts as Reference Points (CRP) theory to understand and study the possible association between motivation to contract and contract experiences.

ICT states that a complete contract is one in which the buyer is able to identify and outline all cost and quality specifications. For instance, a complete contract can be as simple as ordering a widget with certain specifications (such as color, size and material) at a specified per unit cost. This is a simple transaction and both parties can easily understand all expectations set forth prior to executing the contract. In complex contracts such as comprehensive medical programs in prisons, it is nearly impossible to identify all possible problems and all contingencies regarding cost and quality specifications. An incomplete contract, according to ICT, is one where outcomes cannot be predicted. The incompleteness implies that when the unpredicted problem arises, there is no term within the contract that dictated a resolution prior to contract execution (*ex ante*).

The 'incomplete' portions leave space for interpretation of the contractual terms. Termed "residual control rights", the party responsible for producing the contractual outputs effectively controls the interpretation of any area of the contract not written out (Hart, Shleifer, and Vishny, 1997). The public administrator controls what is written in the contract and the private vendor controls anything not written in the contract. With the residual control rights, the private company is able to independently control resource use to achieve the output defined in the "complete" portions of the contract. However, the public administrator may not approve of the route taken to achieve the contractual outputs, which are based on these independent decisions, if that route conflicts with the administrator's primary motivation for contracting (Hart & Moore, 1990).

Applying this theoretical concept, the completeness of a contract may be measured in terms of the existing or allowed residual control rights within each section. A fully complete contract, by definition, does not have any residual control rights for the other party to self-define. Therefore, a contract can have sections that are more complete, regarding the partnership, than other sections. This can be unintentional or done intentionally for a strategic purpose. In the case of a public administrator trying to use a complex contract to structure and manage a large medical program in a prison system, it naturally becomes

increasingly difficult to delineate all requirements with only a finite number of outputs and cost expectations and quality measures available. To explore this, the following example is provided.

The contract may specify the vendor ensures inmates needing specialty consults receive these consults as indicated. The private vendor may accomplish this by scheduling each specialty consult with the next available specialist and minimize the wait time for the visit. Alternatively, another way to accomplish this would be by contracting with one specific specialist at a lower per visit reimbursement rate to see all inmates. In the first scenario the wait time may be one month to see the specialist, whereas the second scenario may be two or three months to see the specialist. Because the contract did not specify a time frame, the vendor would have every right to take either path to accomplish the task. The first may be more programmatically efficient for the public administrator, where the private vendor is seeing the second as more financially efficient. Whether such an impasse would result is determined by the perspective of the public administrator and, in turn, on the initial motivation for contracting. Disregarding, for now, the preferences of the vendor, if the administrator is biased towards an increase of quality, the first scenario would look to be the desired process. The incarcerated individual is getting medical care more quickly. For the administrator biased towards containing cost, the second scenario may be the more desired process. Wanting to avoid having to provide supplemental funds to the vendor, the public administrator would want the vendor to choose the less costly option knowing the inmate is getting the care ordered.

The tug-of-war between the quality and cost functions of complex partnerships can reflect an "essential tension" (Verma, 1995) that must be managed through the contractual terms. The goal of each contract is to achieve the best cost and quality efficiencies possible. Essential tension implies that one cannot maximize both cost and quality simultaneously. Although during contracting and negotiations, each side will bias in favor of their preferred outcome, recognizing the nature of the tension means that the public administrator must simultaneously make sure not to neglect the other side (Verma, 1995). This is because a public administrator aiming to control costs must make sure to not restrict financial resources to the point that quality will be at risk of achievement at the resource level set. Likewise, a public administrator cannot set such high-quality expectations that the cost associated with those expectations exceeds the allocated budget and resources. Ignoring either prong of this essential tension, i.e., a lack of attention to either function of the contract, as a result of motivational biasing towards one function may result in the unintended incompleteness found within government contracting as described in the literature (NOA, 2014). This leads to pathological responses, such as breakdown in contract fulfilment, legal challenges, and other consequences that can negatively impact the delivery of services. The incorporation of contractual essential tension, on the other hand, can help shed light on the intended and unintended

incompleteness of contracts and help to avoid some of these consequences by better contract management.

Building upon the theory of incomplete contracts and the idea of residual control rights within noncontractible portions of the partnership, CRP identifies two types of partnership performance as it relates to the managing a contract: perfunctory performance or consummate performance by the provider (Hart & Moore, 2008). Perfunctory performance is performance by the parties in accordance with the letter of the contract, that is the complete portions of the contract. Consummate performance is performance by the parties according to the spirit or general intent of the contract, presumably based off motivations and negotiations prior to contract execution.

According to CRP, parties naturally engage in perfunctory performance after contract execution (Hart & Moore, 2008). Should a party stop their perfunctory performance, they are readily identifiable as being in breach of the contract and resolution mechanisms outlined in the contract would ensue. However, parties *choose* to engage in consummate performance. Examples of consummate performance can include the seller meeting with the buyer more often than required, providing higher level of customer service than is required or integrating the buyer's preferences into decision making when interpreting the incomplete portions of the contract. The level of consummate performance the seller engages in has the potential to shift some ownership of the residual control rights to the buyer based on how much of the buyer's interest the seller integrates into the decision-making process.

Further, CRP argues that the expression of these two types of performances can reflect both subtle and obvious disagreements between the two parties (Hart & Moore, 2008). CRP contends that the contract itself acts as a reference point for the trading relationship. And "more precisely, their feelings of entitlement" (Hart & Moore, 2008, p. 2). CRP theory is "…a model in which a party's *ex post* performance depends on whether the party gets what he is entitled to relative to the outcomes permitted in the contract" (Hart & Moore, 2008, p. 2).

For a complex contract such as one for the provision of a comprehensive prison medical program, the obvious entitlements are the outputs specified in the contract. However, feelings of additional entitlements can be a result of the nature of the business or the motivation behind engaging in the contract *ex ante*. For example, a for-profit company will always feel entitled to ensure a certain level of profit margin exists to allow for continued business and business expansion. On the other hand, a public administrator for a state DOC that is motivated to engage in the contract to ensure high level of qualified medical providers are used for medical care may feel entitled to the expectation that the company

provides enough salary for the positions to hire high quality individuals. These two entitlements may not align, as the vendor may want to restrict salaries to protect a profit margin, whereas the public administrator may prefer the salaries not be restricted. A conflict between the feelings of entitlements for the two parties is termed "entitlement disagreements". Entitlement disagreements may motivate one or both sides to engage in more negative partnership behaviors. Such behaviors include subtle shading where the vendor disengages from consummate performance, shirking where the vendor begins to disengage from some aspects of the perfunctory performance, rent seeking where the vendor requires more funds or resources to continue the service at the level originally contracted, and full hold-up of the partnership where the vendor stops all performance under the contract unless the other partner provides certain additional resources or corrects some unfairness felt by the vendor. (Frydlinger & Hart, 2019; Hart & Moore, 2008). Engagement of any of these negative behaviors by either side will cause increased partnership management burden for both sides and partnership inefficiencies.

Guided by these theories, this study asserts that motivations held by the state DOC public administrator *ex ante* can be either convergent or divergent of the vendor's motivation. The alignment of motivations may impact the likelihood of entitlements disagreements experienced through the partnership. Divergent motivations will be more likely to experience issues with the partnership and contract management.

Research Design and Methods

The results of this study can give valuable and first of its kind insight into how different motivations can create subtle but significant differences in the contractual terms and resulting partnership experiences. The primary research goal of this study was to correlate the partners' motivation to engage in an outsourcing contract with resulting contractual outcomes, experience of partnership efficiencies, and experiences of partnership issues. This study also aimed to determine if these associations are influenced by differences in contract structures and terms used. The theories of Incomplete Contract Theory and Contracts as Reference Points, along with the concept of "essential tension," were used as guiding frameworks to understand how contract negotiations and motivations to engage in a contract may impact the contract structure and terms, as well as the behavior of one or both parties after contract execution. The general hypothesis is that the private vendor and the public agency may have divergent motivation. When this occurs, the partnership will experience less of the desired contractual outputs and efficiencies and more partnership issues. These partnership outcomes are influenced by differences in contractual terms as a result of the public administrator's motivation to contract.

The literature suggests that this dissertation may be the first of its kind to explore the motivation of a public administrator and tying it with resulting contracts and experiences with contract management. This study is a mixed methods study that uses both quantitative survey data from state DOC administrators, as well as the qualitative method of deductive content analysis across pertinent contractual documents. To understand the landscape of prison medical program contracting and obtain information on the independent and dependent variables, a survey was sent to all state DOCs. For those states reporting management of a contract applicable to the study, a survey was provided that included both closed, fixed response questions along with a few open-ended questions at the end. This data collection approach gathered information on the respondent's motivation bias and reportable contract outputs, efficiencies, and partnership issues. At the end of the survey, the respondents were able to provide comments regarding their thoughts and feelings of their personal experiences with regards to the partnership and contract management.

The states DOCs reporting a current contract were separated into two groups based on the self-reported motivations to engage in the contract collected in the survey. The two groups are states reporting being motivated by more financial and monetary reasons and those states reporting more quality or program improvement reasons. States with more financial and monetary reasons for engaging in the contract are expected to be more convergent with the entitlements associated with the private vendor and experience fewer issues. Alternately, those states reporting more quality or program improvement reasons will be expected to be divergent with the private vendor's interest and report more issues experienced during contract management.

To further understand the interplay between motivation and reported experiences of contract management and outcomes, a qualitative collection approach was performed after data analysis was completed from the quantitative approach. The qualitative approach used an extreme sampling design from the responses received from the quantitative approach to identify cases where very different experiences were being reported. From these cases, content analysis of contract documents used to structure and enforce the partnership was performed to ascertain connections and trends between the reports of partnership experiences and the contextual structure in which the partnerships existed. In total, three groups of case studies were created from survey data analysis and contractual content analysis. These case study groups allowed for more robust analysis of how motivation bias, contract terms and contract structure may have impacted the experiences of the partnerships reported by the state DOC public administrators.

The results of this dissertation found that states motivated for cost related reasons were less likely to achieve cost related outcomes, more likely to experience inefficiencies and more likely to experience partnership conflicts as compared to states motivated for quality related reasons. Moreover, it seems that states do strategically allow incomplete portions of the contract to exist in different areas in association with the public administrator's motivation. If the public administrator is motivated for cost reasons, the financial portion of the contract is more incomplete compared to public administrators motivated for quality reasons. Vice versa, the quality portion of a contract is more incomplete for those contracted for quality related reasons as compared to cost related reasons.

The remainder of this dissertation is organized into four chapters. Chapter 2 outlines the current and relevant literature on the topic of prison medical care, contracting for prison medical care and application of the theories to these topics. Chapter 3 outlines the research design and methods used. Chapter 4 provides the findings of the survey conducted, as well as the case studies evaluated for context purposes. The dissertation ends with Chapter 5 providing the conclusion of the study.

CHAPTER 2: LITERATURE REVIEW

In October of 1976, the Supreme Court heard arguments in the case of W.J. Estelle, the Director of the Texas Department of Corrections and J.W. Gamble (*Estelle v. Gamble*). In the case, Mr. Gamble had been performing a work-related duty while incarcerated in a Texas prison when he injured his back. Over the three months following the injury, Mr. Gamble was seen by medical personnel 17 times without any of the providers directly addressing his symptoms of a back injury. Mr. Gamble was even penalized for his inability to work due to his injury. In the court arguments, Mr. Gamble's lawyers argued that the lack of medical care for his back injury constituted a violation of Mr. Gamble's Eighth Amendment rights against cruel and unusual punishment (Estelle v. Gamble, n.d.).

While the Supreme Court ruled against Mr. Gamble's claims, the court used the landmark case to make substantial changes for prison medical care going forward. Through the *Estelle v. Gamble* (1976) majority opinion, the court acknowledged the Eighth Amendment as a legitimate vehicle for ensuring all prison inmates a constitutional right to medical care. Considering the inmate in a prison is restricted in movement and entirely reliant upon the prison staff and administration for all care, the court felt an inmate would have no redress for lack of care and would, therefore, be experiencing cruel and unusual punishment if medical treatment is withheld. Through Estelle, all incarcerated individuals were given the basic rights of access to medical care, right to care ordered by a physician, and right to a professional medical judgement (Rold, 2008). Incarcerated individuals are the only population within the United States with a constitutional right to medical care.

Estelle v. Gamble is the landmark case that defines prison medical care, but it most certainly was not the first. Court cases as early as the 1920's began to acknowledge that prison inmates must be provided medical care similar to what would be available to someone in the community and it would be up to the locality incarcerating the individual to be responsible for those medical bills (Rold, 2008). Rulings such as these were significantly impactful to both the individuals incarcerated and the individuals responsible for caring for them. Jails and prisons have been designed and managed around the premise of security since the first penitentiary. Adding the responsibility of ensuring a certain level of medical care was provided within the secured perimeter shifted the expertise required for prison administrators to have to be effective in their jobs. However, for prisons especially, medical care provision is a natural byproduct of housing inmates for a long duration of time. Around the time of Estelle, states had already began to acknowledge their inadequacy in providing and managing medical care and had begun to engage in outsourcing arrangements for medical management of incarcerated individuals in the early 1970's (McDonald, 1995).

At the time of the 1970's and 1980's, prisons were looking for assistance from private medical providers to meet the standard of level of medical care required by judicial rulings, as well as remove the liability of inmate health off the prison administrators' shoulders. The focus of using private vendors initially was to increase the quality of care provided. At this same time, President Reagan was vocal in his concern over big government and was pushing for more use of private companies in government service production for economic efficiencies as well (Weiss, 2015). The argument being private companies would naturally provide better service at less expense as a result of market competition; a government agency would only be able to leverage market competition to the extent it used private companies to leverage the market for the agency.

As of 2017, 30 states were engaged with a private vendor to outsource some or all of the state prison medical program, whereas only 16 managed the medical program themselves and four states used a state university medical center to manage inmate health care (Pew, 2017). These large and complex outsourcing arrangements often result in conflicts between the state and private vendor. For instance, between the years 2000 and 2018, the Florida Department of Corrections (FDOC) continually struggled with outsourcing inmate medical care provision (CGL, 2019). During that period, Florida prison administrators executed six separate contracts with four different vendors, one of which was an emergency contract to continue medical care after another vendor early terminated an agreement. Four of the six contracts were early terminated by either the state or the vendor and one vendor filed a lawsuit against the state for not providing the vendor more money in order to improve quality levels. During this time, the state directly managed the medical care program for five years while litigation and disagreements over contracting played out.

In a survey conducted by the Pew Charitable Trust (2017), state DOCs who were using a private vendor to manage some or all of the prison medical program reported administrative difficulty in engaging in and managing these contracts. Difficulties included lack of competitive bids to choose between, difficulty supervising private vendor staff, lack of agreement on what services are expected outputs of the contract, poor quality of contractual outputs, difficulty monitoring quality of the contractual outputs, unsatisfactory payment arrangements, rent seeking behavior after contract execution and early terminations by the private vendors, all of which required a significant and unexpected increase in the time and money from the state administrators to manage the contract (Aman, 2007; Lundahl et al., 2009; McDonald, 1995; Pew, 2017; Zhang & Soomro, 2015).

In exploring the landscape of outsourcing prison medical care, the literature review that follows describes the strategies public administrators engage in when outsourcing a government service, the use

of outsourcing prisons in the United States, governing outsourcing prisons, and outsourcing prison medical programs. Governance of outsourcing partnerships for prison medical programs are reviewed, along with common contract types. The literature review finishes with a review of the relevant contract theories and application of these theories to the literature.

Strategies for Outsourcing Public Services

Administrative Strategy. The administrative strategy is the most basic and identifies outsourcing as a bureaucratic tool that a government can engage in that provides greater flexibility and timeliness than choosing to provide the service through the government (Camp & Gaes, 2002; Feigenbaum & Henig, 1994). As another tool in the bureaucratic toolkit, a public manager would choose to buy the service from a private vendor to allow the manager more time in doing other tasks and managing the budget. For most local and state jurisdictions, public managers are required to provide detailed accounting for money requests to manage a project. That request is reviewed annually through a board or legislative process and would be subject to questions and possible budget cuts. Having to justify how each dollar would be spent on the project becomes administratively burdensome for a public manager who is already tasked with ensuring production of the service. Therefore, contracting for the provision through a separate actor both expedites the ability for the manager to begin the provision of the service as well as decrease the amount of review required regarding how the production will occur (Camp & Gaes, 2002).

Pragmatic Strategy. The pragmatic strategy rests on the general economic theory of public versus private provision of services. The pragmatic strategy states that private companies will inherently be more efficient and provide a service at a lower cost through market competition. Moreover, the private actor will also provide higher quality of goods or services than a government monopoly would (Weiss, 2015). Due to limited resources, a public manager can only focus on improving quality or decreasing cost of the service, not both at once (Hart, Schleifer & Vishny, 1997). However, a private actor trying to obtain and retain business would have a strong incentive to decrease cost while simultaneously increasing quality. Any increase in cost of production will cut into the private actor's profit margin and any decrease in quality will put the private actor at risk of losing the business contract. In this strategy, the public sector is still responsible for setting and enforcing social goals but gains the efficiencies of the private sector (Feigenbaum & Henig, 1994). Therefore, a public manager would engage in an outsourcing contract to save money and ensure quality.

Ideological Strategy. The ideological strategy argues that a government will engage in an outsourcing partnership as a result of becoming too large and no longer being able to successfully handle the responsibility (Weiss, 2015). This is the strategy that conservative governments rest on and speaks most to the Federal Government level of bureaucracy. The key components state that the government has become too large, is overloaded with what it has decided to provide and is receiving too much pressure from interest groups. All of which results in excessive spending and poor performance (Starr, 1988). Essentially, the large public sector is unable to provide the role of financing and provide the service appropriately (Torchia & Calabro, 2016). Therefore, it is best for a large government to outsource the provision of services to the furthest extent possible. This strategy has been used to support policy directives such as the U. S. Bureau of Budgets 1955 directive to rely on private actors as much as possible and the 1955 Administrative Procedure Act (APA) which made outsourced contracts exempt from the newly created rules and regulations (Aman, 2007).

Political Strategy. The political strategy focuses on understanding the motivations of actors that promote outsourcing partnerships. Feigenbaum and Henig (1994) argue that while the administrative and pragmatic strategies may accurately reflect the actions taken in a manager's office, discussion of these detract from the larger picture of "motivation", such as is highlighted in the ideological strategy. The political strategy takes a broader view of the ideological strategy and identifies how outsourced partnerships can be used by any political entity to achieve an effect of redistribution of control.

Evaluation of the political strategy identifies two types of political motivations for engaging in an outsourcing contract. The first type of motivation is that of a tactical contract. A tactical contract would be motivated by the goal to achieve a short-term political aim for a party, political or interest group. An example of a tactical contract would be sale of a government asset (Feigenbaum & Henig, 1994). The second type of motivation is that of systematic contracting. Systematic contracting is done with the intention of lowering citizens expectations for government, reducing the oversight or enforcement mechanisms on private actors, and making interest groups less supportive of governmental growth. This strategy differs from that of the ideological strategy, where the ideological strategy argues that the government is unable to do these services. The political strategy of systematic contracting argues that the government is able to do these services, but political actors are fundamentally asserting the view that the government should not be doing these services. As a result, the political strategy argues that all evaluations of outsourcing partnerships should analyze the motivation of the partnership, not just the stated goal, or actual effect, of the partnership (Feigenbaum & Henig, 1994). As an example offered by Feigenbaum and Henig (1994), providing school vouchers would have the stated goal of providing choice to parents regarding where they can obtain schooling for their children. However, the motivation of such

a program may be to create a crisis of legitimacy in public school programs and help encourage residents to use alternative schools set up by special interest groups.

Quality Sensitivity. Levin and Tadelis (2010) assert that the different strategies being employed when contracting for government services differentially impact the public administrator's value assessment of the cost and quality functions of the contract. While "the city administrator cares about the service quality and cost of provision", the public administrator may exhibit a preference for higher quality of service for services that have a higher "sensitivity" (Levin & Tadelis, 2010, p. 513). Sensitivity being defined as how aware residents will be of the quality of the service produced. The authors assert that a public administrator's evaluation of quality level expected will be modulated by the sensitivity of the service with the public and they will be more likely to pay more for a service that has higher sensitivity. Moreover, the authors assert a public administrator motivated for political reasons may over-deliver quality on some services and under-deliver on others for strategic purposes (Levin & Tadelis, 2010). Therefore, the public administrator has the ability and intentionality to focus partnership outcomes and expectations on either cost control or quality of service. After evaluating over the rates of contracting across 1,000 U.S. cities, Levin & Tadelis (2010) found that public administrators were less likely to contract for services if the service was difficult to write a complete contract for or was more sensitive to the public. For those services, public administrators requiring outside assistance to produce the service, were more likely to contract with another government agency and not a private vendor.

Use of Outsourcing for Prisons

Prison privatization is nearly as old as the use of "tax ferrets". In the early American penal system, prison wardens were known to rent out the prisoners as a labor force for local companies (Weiss, 2015). Later on, as a result of policies that resulted in drastic increases in the number of incarcerated individuals, e.g. War on Drugs, and policies that extended individual sentences, e.g. removing parole, the cost of running a prison exploded (National Research Council, 2014; Weiss, 2015). As a result, many localities and states turned to private companies. With prison systems becoming too large, states began to experience diseconomies of scale and hindrance by bureaucratic red tape. By turning prison management over to private companies, prisons would have greater flexibility and autonomy in which to control costs, all of which would result in lower taxes for the citizens (Weiss, 2015).

However, privatizing prisons is unlike privatizing other aspects of governmental functions. In the instance of a government outsourcing the building and maintenance of a road that results in a toll, citizens can opt to not utilize that road and take other routes. In the instance of a prison, an incarcerated

individual has no choice and no say in how the interaction occurs (Barak-Erez, 2011). This dynamic, specific to prison privatization, brings up ethical issues in the company's discretion and legal rights provided individuals. Considered an undermining of democratic values, or a "democracy deficit", private companies are able to perform governmental functions out of the view of the general public and with little opportunity for public input (Aman, 2007; Weiss, 2015).

Governance of Outsourcing in Prisons

Kolderie (1986) states that the government can privatize a service, such as prison management, while continuing to ensure equity through appropriate governance of the contract. The government is paying for what it wants. As such, the government should always have control over the partnership as the contractor would always be at risk of non-renewal of services (Kolderie, 1986). Further, increasing public knowledge and partnership transparency can provide the general public with the information necessary to increase democratic input in the decision to privatize a prison (Hirsch & Osborne, 2000). While the individuals in a prison may not have the ability to vote or engage in civic activities around the decision to privatize, their family and fellow community members would. Therefore, governance of the privatization partnership is of utmost importance.

Contracts as Governance. Stafford and Stapleton (2016) argue the primary basis of governance for outsourcing partnerships is the contract. The contract provides the basis of the relationship and allows for transparency in the inputs and outputs of the service. In most outsourcing partnerships, the input portion is hidden from public view (Hirsch & Osborne, 2000). For example, the maintenance of publicly owned vehicles or assets by a private company would be performed with little notice from the public. On the other hand, the outputs of the production are more visible to the public and cause greater concern for any type of democracy deficit (Hirsch & Osborne, 2000). Having the fire or entire police department work provided by a private company are examples. While the inputs are less noticeable to the public than the outputs, both are equally at risk of democracy deficit, especially in a prison setting.

In the prison setting, private, and more often than not for-profit, companies providing partial or comprehensive services make millions of dollars each year. In 2010, the top two companies that manage private prisons each made a profit of over $3 billion with each executive receiving over $3 million in salary for the year (ACLU, 2011). Private prison vendors actively engage in lobbying efforts to increase the perception that public managers need them to provide prison services, as well as craft model bills that that support their agenda (ACLU, 2011). Much of this work is out of the public view, unless a loved one happens to become incarcerated in an outsourced prison.

Therefore, a thorough contract that is publicly accessible can provide the community with details of the relationship, requirements of the vendor, quality measures the vendor must meet, and the amount for payment of services provided. Stafford and Stapleton (2016, p. 384) state that optimal contracts for outsourced partnership arrangements include the following items:

- Clear scope of service
- Identification of performance indicators
- Measurement of outputs
- Managerial reporting
- Payment mechanism
- Arrangement for contract modifications
- Benchmarking
- Best value reviews

Other literature surrounding contract governance for outsourced partnerships is broader and emphasizes aspects of the partnership instead of actionable items in a contract. Rufin and Rivera-Santos (2012) describe governance of such a partnership to include the formal mechanisms of outlining a contract, infuse equity throughout all actions and limit scope of partnership; and the informal mechanism of establishing trust between partners. Torchia and Calabro (2016) are even more broad by stating that good governance includes well-functioning institutions (both public and private), transparent and efficient processes within the partnership and accountable and competent sectors. The partners need to communicate, participate, be accountable, and transparent for a partnership to be successful (Torchia & Calabro, 2016).

Essentially, to engage in a productive outsourced partnership, the scope of the partnership needs to be clearly detailed in a contract that is transparent for all members of society, both sides need to be actively accountable for their portions of the relationship, and trust within the partnership must be established and maintained.

Governing Risk. An essential component to governing a partnership is addressing the risk associated with the partnership for both sides. For the public manager, risks associated with the partnership would include the private actor failing to provide the needed service resulting in criticism of the government, embarrassment, misuse of funds, and significant political consequences, including closure of the agency all together (Rufin & Rivera-Santos, 2012). On the other hand, the private actor may be at risk of high up-front sunk costs, high asset specificity which would preclude the vendor from

being able to use the resources in any other situation, cost overruns, bankruptcy, or closure (Rufin & Rivera-Santos, 2012; Zhang & Soomro, 2015). Therefore, the contract structure is important in outlining the risks on both sides and allocating the risk to the partner best able to manage them (Hodge, 2004; Torchia & Calabro, 2016).

With regards to prison outsourcing (either partially or comprehensively), the public sector may take on additional risk beyond what has been noted already. Infusing market forces to ensure quality services at the lowest cost is entirely reliant upon a competitive process. However, many times competition is not guaranteed in the prison sector (Aman, 2007). Private actors engaging in the prison sector may understand the lack of competition and may artificially look competitive by underbidding and overpromising on the contract (Aman, 2007). As a result, after the partnership has been established, the private company will require significant additional funds to provide the level of service expected by the public actor.

Therefore, including performance indicators, output monitoring and reporting measures in the contract can assist the public actor in ensuring the private actor is accountable for their portion of the partnership. As a result, the governance within the contract must be structured in such a way to influence behavior of both actors by changing the cost of engaging in certain behavior (Rufin & Rivera-Santos, 2012). That is, the contract must align the interest of both parties and make it more expensive for either party to engage in negative, or opportunistic, behavior that would deteriorate the partnership.

Aligning interest with behavior through a contract mechanism is achieved through the payment and incentive/penalties sections (Stafford & Stapleton, 2016). The payment section of the contract outlines the financial impact of risks being shared on either side of the partnership and attempts to ensure successful completion of the output objectives. The incentive/penalties section works to incentive good performance throughout the project which would allow a successful completion of the project. The contract may provide additional rewards for good performance along milestones of the project or allow for deducted damages to the overall payment on the project for under-performance. It is key, though, that these incentives and penalties be sufficiently large enough to properly align the behavior with desired output. As well as ensuring that oversight is maintained to hold either side accountable for partnership behavior (Stafford & Stapleton, 2016).

In order to properly apply incentives, monitoring of the partnership must be performed. Ideally, the performance measurement portions of the contract outline the desired behaviors and outputs in such a way that monitoring can be successfully performed. In a review of public-private partnership contracts by

Stafford and Stapleton (2016), the authors found that many public agencies do not perform monitoring actions themselves but, instead, allow for the private party to self-report. Moreover, even if the public party does provide the oversight function, they generally lack sufficient resources and use incorrect monitoring techniques and metrics to truly be able to monitor the key performance of the private actor. Whereas oversight of public agencies holds public managers to account (Stafford & Stapleton, 2016), the lack of oversight of private actors in outsourced partnerships leaves the public manager in significant risk, regardless of the structure or allowances in the contract.

In 2014, the National Audit Office (NAO) in the United Kingdom performed a review of all national governmental public-private partnerships contracts that existed at that time. The NAO reported that significant issues were noted to include:

- Lack of competition when picking a private actor to partner
- Governmental restraint in oversight enforcement in an effort to not disrupt the partnership
- Payment deductions allowed by contract were insufficient to incentivize performance
- Performance indicators used were weak and allowed contractor to self-report
- Contract terms allocated risk to public sector more than the public manager realized
- Not enough management level individuals involved in the contract relationship
- Contract ambiguities led to partnership disputes
- Lack of aligning contract goals and incentives with policy goals
- Not addressing risk of contract failures.

The NOA further reported that after providing feedback to contract managers with details of insufficiencies related to contract management, the NOA found no change made when following up some time later. Overall, the report concluded, there is a general lack of appreciation for the value of proper contract management, lack of enforced visibility of contract performance and the government is naturally at a disadvantage when attempting to participate in a commercial market.

Not all outsourced partnerships end in failure, though. Osei-Kyei and Chan (2015) performed a review of studies that outlined factors that made outsourced partnerships successful. The authors found that most often partnerships were successful when:

- The contract included appropriate risk allocation and sharing
- The private actor had the resources needed to be able to perform the task successfully
- Political support existed for the partnership

- The public and community expressed support for the partnership
- The procurement process was transparent
- Stable economic conditions were present throughout the partnership
- The procurement process allowed for true competition
- Both partners expressed strong commitment to the outcome
- Roles were clear for both partners.

Contract Renegotiations. If the type of contract is successfully tied to expected partnership outcomes and intended partnership effects, the cost and burden of managing the partnership should be limited to the monitoring outlined in the contract. However, there are many times when contracts must be renegotiated during the partnership, which causes increased administrative burden, monitoring and contract enforcement (Domingues & Zlatkovic, 2015). As a result, outsourced partnerships may not get the true value for the intended money. Overall factors associated with needing to renegotiate the contract after initial execution include inadequate contract at the start; incorrect contract design employed with regards to risk allocation, investment requirements, and type of financing structure used; micro-economic shocks that disrupt the ability of either party to continue with the resources originally agreed upon; and a change in the political environment that may impact approval of the terms of the contract originally agreed to by both partners (Domingues and Zlatkovic, 2015). Generally, public partners need to consider the possibility for cost overruns by the private partner, demand forecasting of usage for the private partner, and capital cost that must be incurred by the private partner to determine the appropriate level of risk sharing (Domingues and Zlatkovic, 2015) based on the motivation of the partnership.

Outsourcing Prison Medical Care

Unarguably, prison medical care has been shaped by judicial rulings and legal precedence. *Lamar v. Board of Commissioners* (1924) was the first court case that began to outline the responsibility of the local government with regards to inmate medical care. In the court decision, the county was found to be financially responsible for any medical care provided to someone in jail. Two years later in *Spicer v. Williamson* (1926), the court determined that the locality was not just financially responsible for medical care provided to jail inmates but also had a duty to arrange for the inmate to receive needed medical care. Relying on the constitutional prohibition against cruel and unusual punishment (U.S. Const. amend. IIX), the court determined that by not providing medical care, the jail inmate was at risk of a lingering death (*In re Kemmler*, 1890).

By 1972, terrible reports of prison medical care begin to surface. Florida was held liable for inadequate care for prison inmates in the class action lawsuit *Costello v. Wainwright*. In *Newman v. Alabama* (1974), it was discovered that the State of Alabama was providing inmate medical care by instructing inmates to perform medical procedures on each other. At this same time, New York City determined that public managers were unable to properly manage medical care for prisoners and was the first locality to contract out medical care to a private company (McDonald, 1955).

Two years later, *Estelle v. Gamble* (1976) would reshape the entire landscape of prison medical care forever. In the landmark case, the court established a standard for medical care in prisons. The case identified three basic rights for any inmate being housed in a jail. These included (1) the right to access of medical care, (2) right to care that is ordered by a medical provider, and (3) right to professional medical judgement. To determine if these rights were violated, the court established the standard of "deliberate indifference" to a serious medical need. A serious medical need was defined as a physician ordered treatment that without being provided would cause pain, discomfort, or threat to the individual's health. The court indicated that consideration should be given to the amenability of the inmate's condition to the treatment ordered, the consequence of not providing the treatment, and the likelihood of a favorable outcome if the treatment is provided (Rold, 2008). To determine if deliberate indifference occurred, the court would consider the information known about the inmate's health, treatment, and state of mind of the individual who denied access to the needed medical care.

Through further interpretations of the *Estelle* ruling, prison management were now expected to ensure access to a community level of medical care to all inmates within their charge. Localities began to struggle under the weight of becoming medical providers by default when their primary expertise was security of a jail or prison. As a result, many states began to outsource their prison medical care in an effort to obtain competent medical staff and management that the locality failed to have on staff (McDonald, 1995). In 1978, Delaware was forced to outsource its entire prison system's medical unit as a result of court order and by 1985, three states relied on entirely outsourced medical systems, five other states had hybrid systems with some outsourced care and some state managed care and one state reported using private contractors to manage individual service lines (McDonald, 1995).

Beyond obtaining medical staff that was unattainable through government hiring (due primarily to a mismatch in state pay levels and surrounding market pay), local governments also utilized private companies to take the liability of required community standard of care off of the government and onto the private company. However, in 1989, the court determined in *West v. Atkins* that private contractors providing medical care in jails and prisons were essentially "state actors" for the purposes of *Estelle v.*

Gamble and the constitutional protection against cruel and unusual punishment. Ultimately, the government who hires and oversees the contractors is still liable for the care provided by the contractors.

Reasons to Outsource Prison Medical Care. Historically, prison systems looked to private companies to provide access to medical expertise and services that could not be provided by state actors directly. This predominantly was due to restrictive state pay levels that precluded qualified and credentialled staff from applying or accepting positions. But it also was a way to combat the conflict of "dual loyalty". Dual loyalty is a conflict that occurs for a medical professional in which it becomes difficult for the individual to reconcile how they want to respond based on clinical judgement and what the prison administration is pressuring the individual to do based on administrative needs (Pont, Enggist, Stover, Williams, Greifinger, & Wolff, 2018). By separating out clinical staff from correctional leadership staff, medical personal will have greater autonomy with regards to care of the inmate. In this fashion, it may be beneficial to outsource medical care for prison inmates.

However, unlike the cost of running a prison generally, prison medical cost has increased substantially over the last few decades (Bedard & Frech, 2009). In a Government Accountability Office (GAO) report on the Bureau of Prisons (BOP) inmate health care costs, the evaluators found that medical costs had increased 37 percent between 2009 and 2016. While no change in the cost of medical staff and a decrease in overall inmate population of nine percent, the report indicated that the significant rise in medical cost was attributed to inmate entering prisons with poorer health requiring more acute care, higher proportion of new inmates coming into the system at or over the age of 55, longer sentences are leaving inmates to age in place requiring higher levels of chronic care, rising pharmacy costs due to the other reasons noted, and a 45 per cent increase in off-site medical visits to specialists that the government was not able to hire for on-site services (GAO, 2017, p. 35).

A report on prison health care published by the Pew Charitable Trust (2017) articulated that prison systems are now becoming a place where inmates are being diagnosed and treated for serious health conditions due to a lack of health care received prior to incarceration. The report states the goal for all state prison medical systems is to meet the constitutional requirement of medical care, be fiscally prudent, and ensure public safety (which has taken on more of a public health role). Essentially, all state prison medical systems have the same goals. But determining whether or not to outsource the system is a deeper evaluation. Using the prior literature's "motivation" construct from the political strategy of outsourcing allows an analysis of change desired by entering into an outsourcing partnership.

At the start of all prison medical systems, the default condition is that the prison is responsible for managing and providing access to and follow-up for needed medical care to inmates within its custody. A prison system would enter into an outsourcing partnership because it desires a change from the current state prior to the contract and the output achieved through the partnership. The literature references many benefits that may be desired, or the motivation of, an outsourcing partnership. These benefits can align with the administrative and pragmatic strategies for outsourcing. DOCs that outsource medical care for administrative reasons would do so because they feel they are not experts in medical care, looking for better flexibility with resource management, and want to outsource so they can pay more attention to their job of security. DOCs that outsource medical care for pragmatic reasons would do so to take advantage of the market competition available to private vendors and expect better efficiency and lower costs to run the system. Reported benefits include:

- Cost savings or cost containment
- Predictability in cost of medical care provision
- Free prison administration time to manage security and not medical provision
- Better economies of scale
- Risk-sharing of cost and liabilities
- Obtain access to better skills and expertise (Pew Charitable Trust, 2017).

As well as:

- Improved quality of services
- Increased comfort as a result of seeing the partnership in another sector or jurisdiction
- Political pressure abatement
- Competitive drive to decrease cost of services (Lundahl, Kunz, Brownell, Harris & Van Vleet, 2009).

Political pressure abatement as a motivation is seen throughout the prison outsourcing literature. Many states report deciding to outsource their prison medical system as a result of political requirement and mandates. For example, in 2012, Michigan's Department of Corrections was required by the state legislature to put out a Request for Proposal (RFP) to outsource their prison medical system (Zullo, 2017). As well, since 2000, the Florida Department of Corrections has had its prison medical system outsourced or self-operated as a result of legislative mandates evaluating the cost and quality of medical provision options over the years (CGL, 2019). Moreover, pressure to outsource has been linked to the majority party leanings of the impacted government. Schmitt (2016) found that outsourcing is strongly

associated with conservative, right-wing governments across developed countries. Additionally, Wang and Zhoa (2014) found that a jurisdiction is more likely to outsource if the local government has a conservative party majority.

Medical Contract Governance. Just like any other outsourcing partnership, outsourcing prison medical services requires appropriate governance and management. Any intention behind engaging in an outsourcing partnership for prison medical care must be balanced with clear and specific performance expectations, payment incentives to encourage quality and ensure rigorous oversight of performance-improvement processes (McDonald, 1995; Pew Charitable Trust, 2017).

Generally, state DOCs outsource their medical provision along three principal dimensions, which include (1) outsourcing across some or all medical service lines, (2) obtaining outsourced personnel services in addition to or replacing state employees, and (3) contracting for private services at one, many or all facilities (McDonald, 1995). In a survey conducted by the Pew Charitable Trust in 2017, 17 state departments of corrections reported directly providing medical care services by state employees; 20 departments reported providing medical care services through a contracted vendor; eight departments reported using a hybrid of both state and private vendor employees; and four departments reported using a state university system to manage inmate medical care.

Within the outsourced partnerships for prison medical care, state DOCs report common issues, including:

- Difficulty supervising staff that are not state employees under their immediate supervision
- Poor quality of partnership outputs
- Private party not providing agreed upon services
- Problems with bidding process including lack of competitive bids
- Service not being provided in a timely manner
- Hard to monitor quality of the contractor services
- Unsatisfactory payment arrangement between partners
- Private party terminating the contract early (McDonald, 1995)
- Selected unsuitable private partner
- Private partner demanding higher subsidies
- Private partner having financial problems leading to legal proceedings
- Loss of customer trust (Zhang & Soomro, 2015)
- Hidden costs to manage the partnership (Lundahl et al., 2009)

- Additional significant time and money required to manage partnership (Aman, 2007)

Yet, as identified prior, there are many different motivations that may drive a department to engage a private partner for assistance with providing inmate medical care. While the contract with the private vendor is to ensure all inmates receive appropriate medical care, motivation behind the partnership reflects the needed support the department requires in some facet of providing medical care that was disadvantaged prior to the relationship. This disadvantage was thought to require assistance and a private vendor was reached out to for this help. Such reasons are reportedly for cost containment, cost predictability, improved quality of care, improved access to qualified specialists, among others (Lundahl et al., 2009; Pew Charitable Trust, 2017). Thus, the motivation of the partnership is to ameliorate some disadvantage the state was experiencing prior to the relationship.

If a state DOC was experiencing significant increased cost of medical expenditures and wanted to engage a private partner who would use a utilization management strategy to contain cost, the contract needs to be structured in such a way as to encourage cost containment and successful use of the utilization management strategy. If, on the other hand, the state department of corrections was experiencing a lack of qualified staff to provide quality medical care and partnered with a private company to ensure better, or more, access to staff, then the contract must incentivize the private actor to engage better staff.

The contract creates the basis of the governance structure for any outsourced partnership. To have the best chance of being successful with the stated aims of the partnership, the contract must be clear of the scope expected of each partner, include specific performance indicators that keep track of the progress made towards a successful output, incentives to encourage behavior that promotes quality outputs, ensure oversight and accountability for both sides and ensure performance-improvement processes exist (McDonald, 1995; Pew Charitable Trust, 2017). Aligning the contract's financial resource provision and financial governance with the underlying motivation prior to contract execution is another important item for the partnership to be successful. The financial structure of a contract acts to direct the expected outcome of the partnership. In partnerships to outsource some or all inmate medical care in a department of corrections system, the goal of the partnership is to provide constitutionally required medical care, be fiscally prudent and ensure public safety (Pew Charitable Trust, 2017).

Common Contract Structures for Comprehensive Prison Medical Programs

Adler, Scherer, Barton and Katerberg (1998) identified three most common contract structures for prison medical programs, based on risk and payment allocation – capitated or fixed price, cost plus, and cost-sharing or incentive contracts. Similarly, the Pew Charitable Trust (2017) categorized the financial

structure of outsourced inmate medical care partnerships into three primary types when performing their survey measures – capitated or fixed price, cost plus, and other. Each of these contracts are structured based on the financial support provided to the private vendor and incentives associated with the financial support structure. According to the Pew Charitable Trust (2017) 19 states utilized a capitated contract, two states utilized a cost-plus contract and the remaining seven used a contract that was classified as "other". See Table 1 for a summary of the contract types and associated risks and benefits of each type.

With regards to outsourcing prison medical care, capitated (or fixed price) contracts outline the expected service to be provided by the private partner and pays the private partner based on a per inmate or per day fixed amount. This amount remains unchanged, regardless of the overage or underage experienced in actual cost by the private vendor. This contract type is primarily used when the specifications can be clearly delineated within the contract, the reimbursement price can be fairly and accurately calculated, and there is low contractual incompleteness (Adler et al., 1998). This contract would be beneficial to use when a state is experiencing the need to ensure cost containment or cost predictability. This sort of contract places significant financial risk on the private actor, and thereby incentivizes the private actor to meet contractual requirements using the least number of resources possible. Any funds remaining after cost are covered goes towards the private actor's profit margin (Sridharan, n.d.). When using a contract of this type, the public manager needs to be concerned with ensuring adequate levels of inputs are provided to obtain outputs at a properly level of quality, e.g. ensuring adequate level of staff are present to perform all required medical services (Aman, 2007). Managing the private partner's behavior is done through damages deducted to the fixed fee for lack of appropriate performance level.

In cost plus contracts (also known as a "cost reimbursement" contract), the public agency reimburses the private partner for all cost incurred as a result of work performed on the project plus an additional fee for managing the project. Traditionally, the additional management fee is a percentage increase applied to the cost reimbursement to cover the staff and overhead the private partner incurs as a result of the project (Adler et al., 1998). This contract places a significant amount of risk to the public partner and eliminates any incentive for the private manager to engage in cost containment or cost savings (Sridharan, n.d.). A public manager would engage in this sort of contract when the intention is to obtain assistance with managing the medical system and ensuring appropriate access to needed medical care. The private party would provide management such as on-site staffing recruitment and compliance, off-site appointment scheduling and follow ups, coordinating inmate lab and pharmacy requirements, processing off-site medical bills, etc.

The most common other contract structure outside of a capitated or cost-plus contract is a fixed price with cost sharing structure. This model follows the same provisions of a fixed price contract but identifies areas of high risk and shares this risk between partners (Adler et al., 1998; Weiss, 2015). For prison medical contracts, the highest area of financial risk is off-site medical care. With limited ability to restrict inmates from seeing medical specialists and following up as required by Estelle, the number and cost of off-site visits is unpredictable. Traditionally, the fixed fee would account for a predictable amount of off-site expenses. However, the private partner may not accept taking on this entire risk within the fixed amount. In those cases, the public manager agrees to split the cost of medical care that goes above the predicted amount included in the fixed fee (Weiss, 2015). This type of contract allows cost predictability for the public partner while addressing the private partner's concern of cost unpredictability and risk. Both partners would be at risk for cost overruns and would incentivize both sides to ensure cost containment measures are employed (Weiss, 2015).

As a note, for states that only outsource the staffing of their medical program, a staffing only contract model is driven by a lack of resources or skills available to the public manager in-house. The contract would provide reimbursement for staffing services only and would not require the private partner to take on any additional risk. This contract would be used when the public partner already manages the entire project but just needs to recruit skills and expertise to provide the services. Under this contract, the public partner keeps control of the project and costs as prior to the partnership but looks to improve the quality of the output.

It is important to note for contracts which utilize incentives to direct the private partner's behavior, the incentive is not meant to change the utility function of the private partner, but instead help them maximize the outcomes based upon already received resources (Sridharan, n.d.). That is, the partner should not need to rely on the incentive to be able to afford the improvement in quality that is desired. The private partner should be able to provide the level of quality desired using the funds already received while the incentive encourages the private partner to use more resources for improved quality. This is especially important for private prison medical vendors who are always profit driven.

Table 1. Implications of Contractual Financial Structures

Contract Type	Description	Advantage	Disadvantage
Fixed Price (Capitated)	An agreed upon price is paid to private partner based on per inmate managed or per day/month services rendered. Private partner behavior is incentivized/managed through damages (deductions from the agreed upon rate) for under performance.	Ensures cost containment and cost predictability on behalf of the public partner. Private partner takes on significant risk level.	Private partner at risk of cost overrun and early termination of contract. Public partner at risk of receiving lower quality of care as a result of restrained resources, requiring an increased level of monitoring of contract compliance. Limited transparency in the inputs and outputs of private partner.
Cost Plus (Cost Reimbursement)	The public agency reimburses the private actor at cost of staff and expenses plus an additional fee for management of the provided medical care. Normally the additional fee is a percentage applied to the cost being reimbursed. Private partner behavior is incentivized/managed through incentives (increased funds to the partner) for appropriate performance.	Eliminates any incentive for the private partner to limit staffing or medical costs. Provides incentive to ensure inmates are receiving full access to any medical care that is required. Public manager does not have to spend time managing the inmate medical system.	Eliminates incentive to engage in cost containment mechanisms. Eliminates the benefit of cost predictability for the public manager.
Fixed Price with Cost Sharing	Structured same as Fixed Price contract but identifies areas of highest risk and shares this risk between partners.	Allows cost predictability. Addresses the private partner's concern for cost unpredictability.	Requires public manager become more involved in cost containment strategies to realize full benefit of contract.
Staffing Model	Public partner procures only the skills and expertise of individuals to work on the project.	The public partner keeps absolute control over the project.	The public partner must already be willing and able to completely manage the project but just needs to procure skills and expertise.

Theoretical Framework

The literature reviewed prior indicates disputes between the public agency and the private vendor for outsourcing of government service provision could possibly be improved through better contractual

language and improved contractual management (NOA, 2014; Osei-Kyei & Chan, 2015; Stafford & Stapleton, 2016). As such, it is pertinent to review the current theoretical framework governing the understanding and management of contracts generally. Incomplete Contract Theory (ICT) broadly states that as a transactional relationship becomes more and more complex, the more difficult it will become for either party to be able to identify all possible contingencies that may arise throughout the relationship and thus impossible to determine what should be done to manage those contingencies prior to contract execution (Hart & Moore, 1990). Therefore, the contract will have greater and greater potential for incompleteness as the complexity increases. The resulting incomplete aspects of the contract can be effectuated, or effectively owned, by the private vendor providing the service. Ownership means the private vendor can define and manage any part of the relationship that is not explicitly outlined in the contract. The application of this ownership for making decisions on how to execute the contract for contingencies not foreseen are called the "residual control rights" of a contract (Hart & Moore, 1990).

During contract drafting and negotiations, both sides evaluate the implications of the complete (contractible) and incomplete (noncontractible) portions of the partnership. Both the contractible and noncontractible parts of the relationship denote risk and ownership implications for each party with regards to the cost or quality requirements. The scope of the contract is to act as the framework and structure for the relationship with specific regards to the cost and quality functions of the service outlined therein. With restraints on both sides, one cannot apply pressure to the cost or quality function of the relationship without impacting the other (Hart, Schleifer & Vishny, 1997). An increase in quality will necessitate an increase in cost resources and a decrease in cost resources will temper the level of quality that can be achieved. As first coined by Thomas Kuhn in his 1979 book of the same name, the thread that binds together the cost and quality functions can reflect an "Essential Tension" that describes and defines the service.

The tug-of-war between the quality and cost motivations of complex partnerships, as reflected as an "Essential Tension" (Verma, 1995), can only be managed through the contractual terms. The goal of each contract is to achieve the best cost and quality efficiencies possible from the partnership in the context of the existing restrictions created by the essential tension present. During contracting and negotiations, each side will bias in favor of their preferred outcome, such that they will have a preference towards an outcome related to the cost or quality function. Of course, while acknowledging that both sides wish to have both efficient cost and quality functions. However, because the essential tension acts as a restricted thread that pulls on both functions simultaneously, the public administrator must make sure not to neglect the side opposite their bias (Verma, 1995). A public administrator biasing towards cost control must make sure to not restrict financial resources to the point that desired quality will be at risk of

achievement at the resource level set. Likewise, a public administrator cannot set such high-quality expectations without making sure the cost associated with those expectations does not exceed the budget and funds they are given. A lack of attention to either function of the contract as a result of motivational biasing towards one function may result in unintended incompleteness, such as what was found within government contracting as described in the literature (NOA, 2014). Examples include insufficient payment deductions, inappropriate allocation of risk to the public sector, misalignment of contract incentives with policy goals and failure to address risk of contract failures. The incorporation of the concept of essential tension as outlined and managed in the contract, can help shed light on the intended and unintended incompleteness of contracts.

Through contract negotiation and evaluation of the risk assignment of the cost and quality functions of the partnership, Contracts as Reference Points theory asserts that each side comes to the relationship with preconceived notions of what they feel they should reasonably expect to receive throughout the partnership (Hart & Moore, 2008). Differences in the perceived expectations between parties may produce conflict between the two parties and then result in negative behaviors.

Incomplete Contract Theory

The contractual governance of a partnership is intended to outline the expectations of each party and mitigate associated partnership hazards as efficiently as possible (Klein, 2008). However, complex contracts are "unavoidably incomplete" (Williamson, 2008), including partnership contracts with explicitly "shared goals and a set of general principles that govern the relationship" (Klein, 2008, p. 436).

ICT states that a complete contract is one in which the buyer is able to identify and delineate all cost and quality specifications. In a market level transaction of purchasing a widget, a complete contract can be as simple as ordering a widget to certain specifications (such as color, size and material) at a specified per unit cost. This is a non-complex transaction and both parties can easily understand all expectations set forth prior to executing the contract. Unfortunately, in complex contracts such as comprehensive medical programs in prisons, it is very difficult to delineate all possible contingencies regarding cost and quality specifications, which unavoidably results in an incomplete contract.

The 'incomplete' parts (or non-contractible portions of the contract) leave space for interpretation of the contractual terms. Termed "residual control rights", the party responsible for producing the contractual outputs effectively "owns" the interpretation of any area of the contract not written out (Hart, Shleifer, & Vishny, 1997). With the residual control rights, the private company is able to independently determine how to use the inputted resources to achieve the output most efficiently as defined in the

contract. However, the route taken to achieve the contractual outputs, which are based on these independent decisions, may not be in alignment with the original motivation of the prison administrator when executing the contract (Hart & Moore, 1990).

Applying this theoretical concept, the completeness of a contract may be measured in terms of the existing or allowed residual control rights within each section. A fully complete contract, by definition, does not have any residual control rights for the other party to self-define. Therefore, a contract can have sections that are more complete, regarding the partnership, than other sections. This can be unintentional; or intentionally done for a strategic purpose. As Levin and Tadelis (2010) found, public administrators may choose to be more or less specific regarding quality specifications of service production based on outside quality sensitivities. Therefore, a public administrator wanting to emphasize quality may be more likely to leave less residual control rights for the private vendor regarding quality specifications (and write a more complete quality specification section of the contract) as compared to an administrator focusing less on quality.

In the case of complex contracts attempting to structure and manage a large medical program in a prison system, it is only feasible to delineate a finite number of outputs and cost expectations and quality measures. The contract may specify the vendor ensures inmates needing specialty consults receive the consults as indicated. The private vendor may accomplish this by scheduling each specialty consult with the next available specialist and minimize the wait time for the visit, whereas another vendor may accomplish this by contracting with one specific specialist at a lower per visit rate to see all inmates. In the first scenario, the wait time may be one month to see the specialist, whereas the second scenario maybe two or three months to see the specialist. Because the contract did not specify a time frame, the vendor would have every right to take either path to accomplish the task. The perspective of the public administrator would depend on the initial motivation for contracting. If the administrator is looking to increase quality, the first scenario would look to be the correct process; for the administrator looking to contain cost, the second scenario would look to be the correct process. If the administrator is motivated to control which scenario occurs, they would need to write the contract in a way that restricts the vendor's residual control rights in this aspect of the partnership. Overall, completeness is the lack of residual control rights; “more” complete contracts have “less” residual control rights.

Additionally, parties locked in a long-term transactional relationship will ultimately have diverging interests that “predictably lead to individually opportunistic behavior and joint losses” (Joskow, 2008, p. 321). The longer the relationship, especially for more complex ones with many incontractible areas, the application and use of the residual control rights may begin to diverge farther and farther apart

from the original intent or the current intent of the other party. This is especially important as the owner of these rights, though, has the power to define and bargain based on them as they are necessarily incontractible (Hart & Moore, 1990). As a result, contract incompleteness introduces hidden costs into the partnership and opportunistic behavior hazards.

Essential Tension

In 1979, Kuhn used the phrase "Essential Tension" to describe the fundamental tension that helped to define the scientific enterprise. Later, Verma (1995) adapted this same concept as a way of understanding the trade-offs that public planning professionals have to consider in decision-making and in how these decisions play out. Understanding a contract through the lens of the essential tension bias present is markedly different than understanding the contract as globally incomplete. ICT just considers a contract to be complete or incomplete wholesale or overall, with little attention to its constituent parts. Thus, it gives little attention to a contract being partially incomplete, complete across one function but incomplete across the other, or even a measure of how incomplete either function is in relation to the associated level of residual control rights left remaining from the incompleteness. A sampling of contracts may show all to be incomplete, but the implications of the incompleteness for each individual contract may vary drastically.

Understanding the essential tension of the contract will shed further light on the concept of contractual incompleteness not evaluated before. With restraints on both sides, one cannot apply pressure to the cost or quality function of the contract without impacting the other (Hart, Schleifer & Vishny, 1997). The pressure applied to one contract function as a result of the other function being pushed is the essential tension of the contract. The extent of the pressure placed on either function for any partnership is determined by the contract structure and terms outlining the partnership. Informed by the literature and relevant theories that indicate public administrators are motivated with a bias towards either the cost or quality function of the contract, it seems important that the motivational bias of the contract writer be considered when evaluating contractual partnerships.

Using ICT alone, a public administrator would likely consider that an incomplete contract is incomplete on the quality function since quality is inherently less likely to be complete by definition. However, for complex contracts that attempt to reimburse for the wide array of services provided in a comprehensive prison medical system, the cost function of the contract may be just as difficult to define completely. Both the cost and quality function of the contract do require the public administrator's attention for appropriate risk allocation to be evaluated and performed. However, a public administrator

has their own restraints, such as time, expertise, outside pressure, etc., and may only focus their attention on what they find important based on their motivational bias for contracting. A public administrator with motivation biased towards the cost function of the contract (such as controlling the increase and/or predictability of the cost of service) may bias the completeness of the contractual terms towards the cost function and may, intentionally or unintentionally, allow more incompleteness on the quality function of the contract. Alternatively, a public administrator with motivation biased towards the quality function of the contract (such as stabilizing or increasing expertise or quality levels), may bias the completeness of the contractual terms towards the quality function of the contract and may allow more incompleteness towards the cost function, again intentionally or unintentionally.

Hart, Shleifer, and Vishny (1997) provided an example of a privatized maximum-security prison hiring less qualified staff. An initial evaluation of the contract's essential tension bias would indicate that the focus of the contract is to manage the prison at a set price, and therefore the contract is biased towards cost. The identified bias would indicate that the quality specifications of running the prison would be the more incomplete aspect of the contract (as it is not the bias of the agency at the time of contract drafting). The authors note that specifying the quality of staff is difficult and may be left incomplete in the contract. Should the contract motivation have been biased towards ensuring quality staff, most likely the contractual terms would have found a way to included specifications outlining training or certification that would be required for the correctional staff to complete in order to better ensure quality of staff used.

In practice, the quality function of the contract cannot be increased without also increasing the cost associated with the project. As the public administrator lives in a finite world with limited resources, the cost function of the contract will always suppress the quality function. However, should quality improvement be the desired function, then the public administrator may find a way to garner more resources and increase the associated function allowed for the partnership. Medical units will always have some minimum level of quality required with associated cost resources, as well as a maximum available cost resource level that equates to the maximum possible quality level that can be achieved. It is in the hands of the public administrator to determine how best to manage all available resources within the program and what level of quality is acceptable.

Contracts as Reference Points Theory

The theory of Contracts as Reference Points (CRP) highlights the contract itself as an important variable in management of the partnership (Hart & Moore, 2008). As the name implies, CRP states that the contract acts as a reference point for the trading relationship. And "more precisely, their feelings of

entitlement" (Hart & Moore, 2008, p. 2). In the timeline of a contracting relationship, the parties engage in negotiations that occur prior to the contract, *ex ante*. *Ex ante* negotiations attempt to consider all possible partnership contingencies and risk and from this, outline the expected output of the relationship and financial responsibilities of each party. These discussions set up the expectations for each side on what they consider to be entitled to throughout the project, *ex post* (Hart & Moore, 2008).

Hart and Moore articulate that they "develop[ed] a model in which a party's *ex post* performance depends on whether the party gets what he is entitled to relative to the outcomes permitted in the contract" (Hart & Moore, 2008, p. 2). In alignment with ICT and residual control rights resulting from non contractible contract sections, CRP identifies two types of partnership performance as it relates to the contract: perfunctory performance and consummate performance. Perfunctory performance is performance by the parties in accordance with the letter of the contract (i.e. contractible portions). Consummate performance is performance by the parties according to the spirit or general intent of the contract (i.e. noncontractible portions).

According to CRP, parties actively engage in perfunctory performance. However, parties choose to engage in consummate performance. Should a party stop their perfunctory performance, they are quickly identifiable as in breach of the contract and resolution mechanisms outlined in the contract would ensue. On the other hand, it is difficult to ameliorate a situation where one party begins to no longer perform their consummate performance, which would be unmeasurable according to the contract. CRP argues that the contract outlines what output each party is entitled to *ex ante*. *Ex post*, either side may feel that they are not receiving what they are entitled to. In those cases, the party feeling slighted will begin to engage in negative partnership behavior, such as shading, shirking, rent seeking or actual hold-up of the partnership (Frydlinger & Hart, 2019; Hart & Moore, 2008).

Negative Partnership Behaviors. Negative partnership behaviors, often referred to as opportunistic behavior, will actively disrupt the efficiency and experiences of the partnership. When a party feels they are receiving less than the entitled best outcome they are due by the contract, the party will respond in one of five ways (Frydlinger & Hart, 2019; Hart & Moore, 2008). These responses include:

- Doing nothing and experiencing psychic costs
- Placating the other partner
- Shading the partnership
- Shirking the partnership

- Holding up the partnership.

Shading the relationship occurs when the aggrieved party continues perfunctory and consummate performance but begins to withhold favors to the other party. *Shirking* the relationship occurs when the aggrieved party begins to no longer engage in consummate performance of the contract but focuses on perfunctory performance to provide the least quality product allowable in order to recover profits that the party feels entitled to. *Holding up* the relationship occurs when the aggrieved party stops performing perfunctory performance of the contract and engages in rent seeking behavior. *Rent seeking* behavior occurs when one party looks to gain added wealth without providing any additional contribution to productivity. Essentially, the vendor is stating that they require additional resources in order to continue to provide the product at the same level of quality as being currently given.

CRP indicates that the level of negative or opportunistic behavior that one side of the party engages in will directly impact the administrative burden of monitoring and/or managing the contract for the public administrator. Therefore, as the vendor feels more and more aggrieved, they will engage in escalating negative behavior which will require the public administrator to escalate their efforts to manage the partnership. As a result, Williamson, Shleifer, and Vishny (1996) argue that the bigger the risk associated with reduction of incontractible quality levels as a result of entitlement conflicts, the better the argument is for in-house provision. At some point, the management of the contract becomes such that the public administrator may as well be managing the program in house as the benefits of contracting out become null. Thus, during *ex ante* discussions both sides must ensure that they are aware of the other's entitlement expectations and align the contractual terms and risk allocation in such a way as to avoid negative behaviors during the contract term.

Overall, these theories highlight that the discussions and expectations that occur between individuals prior to the partnership starting are important considerations and variables because it allows both sides the opportunity to understand the entitlements the other has, address the level of incompleteness of the contract and improve the efficiency of the project *ex post*. But, putting a finer point on it, the theories highlight the impact that motivations, expectations, and behaviors of individuals both before and during the partnership have on contractual outputs and efficiencies.

Applying the Theoretical Framework to Research Problem

A contract for comprehensive medical care provision within a prison or prison system is very complex as it covers the expectations of the public agency for the vendor to provide services along all medical service lines (e.g. primary care, urgent care, sick call, specialty care, pharmacy management, eye

care, etc.), in addition to providing all staff/providers, managing reimbursement and provider/facility claims, performing utilization review and management, engaging in competitive procurements, etc., all while ensuring the constitutional required level of care is available to all inmates at all times. A prison system makes a conscious decision to engage a private vendor in medical care when they contract for those services. The literature indicates prison administrators report a variety of reasons for engaging in such a contract. While all prison administrators care about the quality and cost of the medical care program, these reasons reported reflect an additional bias towards either the cost function of contracting out or the quality function. Based on data from the Pew Chariable Trusts 2017 review, some states contracted out for cost savings/cost containment, better cost predictability, better economies of scale and risk sharing of cost and liabilities. These administrators are engaging in the pragmatic strategy of outsourcing the service. All of these motivations aim to keep quality status quo, and focus attention on impacting the cost function of medical care provision. Alternatively, some public administrators reported contracting out to obtain access to individuals with better skill in managing a medical program, recruit more expertise and better providers, improve the quality of services provided, and in response to external pressure to increase quality (Lundahl, Kunz, Brownell, Harris, Van Vleet, 2009; Pew Charitable Trust, 2017). These administrators are engaging in the administrative strategy of outsourcing the service.

CRP theory states the discussions conducted before contract execution (i.e. *ex ante*) between parties to develop the framework for managing the partnership described above will assess the risks for appropriate risk allocation and sets the orientation of expectations both sides will have for outcomes during the contract term (i.e. *ex post*). As the contract is very complex, ICT indicates that the contractual framework, even after very detailed discussions, will inherently be incomplete as neither side is able to foresee all possible contingencies. Because the public administrator must manage within the bounds of the essential tension, the public administrator's bias towards which function is more important for the agency at the time of *ex ante* discussions will impact the discussions and framework developed for the partnership. Should the public administrator bias focus towards the cost function, the discussions and framework will be more likely biased towards the resources provided. Should the public administrator bias focus towards the quality function, the discussions and framework will be more likely biased towards the quality levels required for the outputs. This is all with the understanding that the goal of all contracts is to ensure the most efficient use of resources provided and the highest quality of services achievable. In no way is a bias towards the cost function of the partnership indicate a disregard for the quality function. Rather, the public administrator indicates current satisfaction with one function and a motivation to effect a change on the other. However, due to the essential tension, both functions place limits on the other.

One function must be overriding in the motivation of the public administrator in order to determine expectations along both functions for the contractual terms and framework.

In summation, theory indicates that the public administrator's bias may impact *ex ante* discussions and the framework (contractual terms) used to manage the partnership *ex post*. Because this is a complex contract, the bias of the administrator may alter the aspects of the contract that are incomplete in that the biased function may be more complete compared to a contract developed with an alternative bias. The areas that are more complete may result in less residual control rights for the private vendor which may impact the vendor's perceived entitlements *ex post*. As default, the private vendor is assumed to be motivated towards increasing profit in order to be sustainable and grow within the market, while providing the highest level of quality achievable by the limited resources.

The common issues reported by DOC's with regards to their contracts for prison medical care reflect problems with the structure of the contractual framework and *ex post* behavior issues between partners, such as issues with quality and timeliness of partnership outputs, difficulty monitoring and measuring outputs, private vendor demanding higher subsidies, hidden costs to manage the partnership and significant additional resources needed *ex post* for partnership management (Aman, 2007; Lundahl et al., 2009; McDonald, 1995; Zhang & Soomro, 2015).

As a result of incontractibility and incomplete contracts, outsourced medical partnerships used to address cost related functions (e.g. cost reduction, cost containment, cost predictability) may suit both parties better than in scenarios where quality reasons are the intention behind engaging the partnership. For cost-related partnerships, the public party is looking to keep the quality status quo while improving the efficiency of achieving the contractual outputs with less resources required. Private parties are especially good at ensuring contractual outputs are provided and this type of partnership may provide the entitlements for both parties with little disagreement and associated *ex post* issues.

However, for partnerships created with quality biased function, the public party is looking to improve quality measures. The private party is experienced at improving quality but only to the level allowable by the resources provided and how the private party choses to use these resources to produce the contractual outputs. Private vendors must achieve a profit margin in order to be successful and stay in business. Therefore, the private vendor can achieve quality only to the level of resources (i.e. funds) provided by the public party that allows the profit margin to remain. Achievable quality levels and funding allowances exist within a bounded system. Often this difference in perception is not understood between parties and the public party may have an entitlement of a higher level of quality than the private

party is intending to provide at the price point agreed upon *ex ante*. As a result, the public party has a higher chance of feeling aggrieved *ex post* and likely to put pressure on the private party to ameliorate the situation. At this point, either side may engage in negative partnership behavior, such as shading the other partner in an effort to affect change or shirking the contract. The second party feels they are being baited and are no longer receiving the partnership relationship to which they are entitled. Or they may hold up the relationship in order to obtain more funds to improve the quality of services.

These theories, used together, will provide the guiding theoretical framework for this study. The aim of this study is to understand the experiences of current public administrators of comprehensive prison medical contracts in order to discern how individual motivations and behaviors impact and are impacted by the contractual framework developed by both parties. With this information, the study will be able to develop new information for prison administrators with regards to partnership monitoring and management and prevention and mitigation of contractual disputes.

CHAPTER 3: RESEARCH DESIGN & METHODS

Research Questions and Hypotheses

Research Question 1: How does the public administrator's motivation correlate with the success of the contractual relationship?

Hypothesis 1. DOC administrators which report to have cost-related primary motivations will be more likely to report success in contractual outputs than DOC administrators which report to be quality motivated.

Contractual outputs are defined as measurable services included in the contract that exhibit compliance or non-compliance with contractual terms. Outputs can include both cost and quality items such as using a certain cost-effective sub-contractor or ensuring inmates receive follow-up from an urgent care request within a certain number of hours. According to ICT, these terms are the complete sections of the contract. CRP theory indicates that public administrators motivated for cost-related reasons will negotiate a contract with an emphasis on cost savings and outline a minimum level of quality outcomes for the private vendor. The private vendor understands the minimum quality level required and focuses on cost containment. Because the quality level is set at a minimum and the private vendor can more easily control costs as a result, the entitlements felt by both sides will be more likely met. The public administrator expects cost containment and a level of quality achievable at the resources provided; the private vendor understands the minimum quality and achieves those within the resources provided.

On the other hand, a public administrator engaging in a contract for quality related reasons will draft a contract that provides financial resources for the private vendor, but also will feel entitled to a higher level of quality and achievement of more quality outputs. Private vendors with a drive to maximize profits will be more likely to achieve a minimum level of quality based on the resources provided with the profit margin taken out, than the higher level of quality expected by the public administrator. As a result, the public administrator may be less likely to receive the higher contractual outputs expected in this case compared to the public administrator contracting for cost-related reasons.

Figure 1 depicts the natural alignment of motivations between the public administrator and private vendor in four different scenarios. For this study, I accepted the assumption that all private vendors are cost-conscious and motivated for cost-related reasons. In order to stay in business, a private company must achieve some level of profit and cannot overspend the funds provided. With this in mind, the quality column for vendor motivation is negligible in this study. Therefore, the vendor's cost

motivation can either align or misalign with the public administrator's motivation. Implications of this are within the figure.

Figure 1. Partnership Motivation Alignment

		Vendor Motivational Preference	
		Cost	***Quality***
State Motivational Preference	***Cost***	Convergent Motivations Primary Desired Outputs cost containment (both) adequate quality (both)	Divergent Motivations Primary Desired Outputs cost containment (state) increased quality (vendor)
	Quality	Divergent Motivations Primary Desired Outputs cost containment (vendor) increased quality (state)	Convergent Motivations Primary Desired Output adequate cost containment (both) improved quality (both)

Hypothesis 2. DOC administrators that report having cost-related primary motivations will be more likely to experience positive efficiencies.

Contract efficiencies for this study are defined as the ease at which the parties are able to manage the partnership throughout the term of the contract, as well as financial efficiencies of requiring renegotiation or supplemental funds added to the contract. An efficient contract after execution (*ex post*) is one in which the public administrator reports low level of monitoring burden, management burden, and no additional resources required by the vendor. Alternatively, an inefficient contract is one with high monitoring and/or management burden and rent seeking behavior by the private vendor during the contract term.

CRP theory indicates that *ex ante* discussions between the parties will create entitlements that each party will feel they have a right to receive throughout the contract term. Public administration focusing on cost containment will easily be able to outline these feelings of entitlement at that time. The private party will also easily be able to outline their feelings of entitlement to receiving the agreed upon resources. With less pressure on quality, the public administrator may be able to let the vendor manage the medical system with less monitoring and management so long as the private vendor is not asking for additional resources. Since the two parties will understand each other's feelings of entitlement at study start, the request for additional resources should be limited.

Alternatively, public administrators contracting for quality-related reasons will have less ability to articulate all levels of quality they feel entitled to when executing the contract. The private vendor will accept the contract with the level of resources provided, which will naturally restrain the level of quality that is achievable. If this achievable level, based on the private vendor's actions, is lower than the public administrator's entitlement feeling for quality level, then the public administrator may begin to monitor and manage the contract with more time and effort. Stress to improve quality as a result of the additional monitoring and management may result in the private vendor asking for additional resources in order to meet the expectations of the public administrator.

Therefore, partnerships with a public administrator motivated for cost-related reasons should be more efficient than partnerships with a public administrator motivated for quality-related reasons.

Hypothesis 3. DOC administrators with cost-related primary motivations will be less likely to report experiences of partnership issues.

In alignment with hypotheses 1 and 2, it follows that partnerships with cost-related public administrators will have better contract outcomes, more efficiencies throughout the contract term and therefore less partnership issues throughout. Partnership issues arise when either party increases the burden of the partnership for the other side. In the scenario of the cost-motivated public administrator, the public administrator is putting less pressure on the private vendor and the private vendor puts little pressure on the public administrator.

For quality-motivated public administrators, the higher likelihood of contract inefficiencies makes the chance of having a partnership issue more likely as well. The public administrator's heightened feelings of entitlement for quality outputs will place increased pressure on the private vendor who will then request more financial support. The misalignment of entitlements (the public administrator feels they have provided the necessary support for the quality being expected whereas the private vendor does not) will result in partnership issues and conflicts.

Figure 2 below depicts the likelihood of partnership conflicts based on the motivations of each party in both scenarios.

Figure 2. Partnership Conflict Risk Likelihood by Motivational Preference

		Vendor Motivational Preference	
		Cost	***Quality***
State Motivational Preference	***Cost***	The vendor limits resource use to stay within budget and achieve profit; state achieves cost predictability and cost containment. Conflict Less Likely	The vendor expends more resources than expected by the state; vendor may require more resources to continue to provide service. Conflict More Likely
	Quality	The state provides resources with intent to improve/ensure quality of service production, but vendor limits resource use to ensure profitability of company. Conflict More Likely	The state provides more resources to ensure quality level provision high with the vendor using resources for care production. Conflict Less Likely

Figure 2. Partnership Conflict Risk Likelihood by Motivational Preference

Research Question 2: In what ways does the contract impact experiences of partnership success?

Hypothesis 4. Differential focus of completeness of contractual terms by public administrator will be associated with different experiences of partnership success.[2]

Public administrators are faced with outside influences and the inherent essential tension of what can be practical to include in the contract terms. As a result, for complex contracts, they have to focus more attention on either the cost or quality function of the contract terms. If they are focusing on one aspect, it is more likely for that aspect to be complete with less residual control rights, as the administrator wishes to control the outcome of that function. Application of the theory in this manner then indicates, the other function will be left more incomplete with more residual control given to the vendor. The

[2] This research question best lends to a qualitative inquiry design. In traditional qualitative study designs, research questions are exploratory in nature and leave out hypotheses that are more traditionally included in quantitative research which is geared towards predicting behavior. Qualitative inquiry comes from a perspective of exploring an unknown phenomenon and therefore, predictive hypotheses would interrupt the qualitative study methods and could hinder the researcher's open exploration. However, some studies benefit from including both types of inquiry, such as those that use the second technique to explain initial results found from the first technique or a need exists to better test the theory being used (Mertler, 2016). Because this study is squarely situated in exploring the relationships observed in the literature through a theoretical stance, a hypothesis was used to focus the qualitative research analysis. Moreover, mixed-method studies often present more focused quantitative and qualitative research questions compared to presenting one paradigm alone, as a way to advance the data through the two research strategies (Creswell & Creswell, 2022). The second research question was posed for exploration with a hypothesized process presented based on the study theoretical foundation that could explain the phenomenon found in the analysis of the first research question.

public administrator, writing a basic expectation of the other function in the contract terms, will be more likely to accept incompleteness in the opposite function as they're less motivated to ensure that aspect. Again, this does not indicate the public administrator is disregarding or not caring about both aspects; but any increase in one function will detract from the opposite function and they must balance between the two. Importantly, all prior propositions 1-3 are based on the expectation that this assertion holds true.

Financially motivated administrators will have a more complete cost function of the contract and a less complete quality function. A vendor that is financially motivated will use the quality residual control rights to find the most efficient use of resources and achieve the entitlements expected by both sides, cost containment. Quality motivated administrators will have a basic cost function outlined with a more detailed quality function of the contract. This will provide the vendor with more residual control rights in the cost section and less residual rights in the quality. Vendors, who are profit driven, will work to find the most efficient use of resources provided to achieve a basic quality level and maximum profit. This behavior will be more likely to conflict with the public administrator's quality entitlement expectations. Therefore, how complete the two functions are within the contractual terms in relation to the motivations (and resulting expectations) of the public administrator will have a resulting impact on the outputs achieved, the partnership efficiencies obtained, and the issues experienced. My assertions have an important implication for theory application. A contract's completeness may be measured by the level of residual control rights, or flexibility, afforded to the private vendor in that section of the contract. And thus, some sections may be more complete than other sections. At present, theory indicates a contract is either complete or incomplete and does not explore partial completeness and partial incompleteness. This dissertation asserts that a contract will be more complete with regards to the contract function aligned with the public administrator's motivation to contract.

Research Design

Mixed-Method Study Design

The primary research goal of this study is to determine if a relationship exists between the public administrator's motivation for contracting and resulting experiences of the partnership. This study used a mixed-methods approach to ascertain first, if a correlation exists between the general independent and dependent variables; and second, the process that may result in these differential experiences. This study used a sequential quantitative then qualitative study design. This design sequence will allow for expansion of understanding the relationship between variables to understanding how this relationship may manifest. Data sets for both the quantitative and qualitative analyses were limited, and therefore, priority

was given equally to both paradigms in this study, denoted as QUANT → QUAL study design (Johnson & Onwuegbuzie, 2004). A quantitative approach was used to answer Research Question 1 and a qualitative approach was used to answer Research Question 2. Combining the two paradigms strengthens this study by allowing more questions to be answered and insights to be gained as an exploratory study, rather than siloing the paradigms and creating two separate projects (Johnson & Onwuegbuzie, 2004).

Quantitative Study Design

The initial part of the study uses a quasi-experimental contrasted-group design as this is most appropriate for social science studies conducting research on groups that are pre-existing along categorical variables prior to the study start (Frankfort-Nachmias, Nachmias & DeWaard, 2015). The study design allows for the natural categorization of state DOCs who engage in outsourcing agreements for financial-related motivations versus quality-related motivations. A pictorial representation of the study design is below.

NR O1
NR O2

The NR denotes non-random assignment as each state is already a member of a categoric group prior to the study being conducted. The two-line observations indicate the two separate groups to be compared. Both groups will be compared at a single time point only through a cross-sectional survey method of state DOCs.

This study was approved as an exempt study by the VCU IRB under IRB number HM20021903 on December 16, 2021.

Quantitative Research Methods

The study population includes those state DOCs that have engaged in outsourced partnerships for prison medical systems. Inmate medical care is unique in that the motivations to engage in a contract can be separated into the desire to improve quality or the desire to improve resource management (cost containment or cost savings). It should be noted that this study should not be interpreted to indicate that a state DOC only cares about cost or quality. Certainly, all state DOCs care about both the cost and quality of the medical programs within their systems. However, the literature indicates that states are motivated by one or the other as a deciding factor to engage in a contract for outsourcing the medical program.

Study Participants. As approved by the VCU IRB, the study survey was sent out to all state DOCs who have an active contract for the comprehensive medical care program within the state prisons. Publicly accessible information was used to determine the contract administrator, or health services administrator if a contract administrator is not easily ascertained, for each state. A total of 27 states currently have a contract with a private vendor for comprehensive medical care at one, some or all facilities within the state DOC system. An introductory email was sent with an attachment to the study consent form and the survey. Because the consent form would be the only item linking the survey data with the respondent and because the assurance of confidentiality to the respondents was important for obtaining responses, the IRB approved for the survey respondents to review the consent, but not required to provide a signed copy back. At the beginning of the survey, each respondent was asked to acknowledge they had read the consent and agreed to proceed with the survey questions.

The survey had a return rate of 48% of participants that received the survey link. Follow up emails and correspondences with non-responders were conducted to achieve a higher sample size. However, response to the survey was discouraged by correctional associations who would not endorse the study and states were instructed to not respond. Additionally, because topics of private medical care can become very political in nature, other respondents reported not feeling comfortable enough to respond. The survey was designed with the understanding that respondents might feel it risky to respond and this was conveyed to those that expressed this issue. The respondent had the ability to not answer any question on the survey they wished to decline to answer. All responses are anonymous and all responses will be reported in aggregate only. For questions with non-responses from a participant, the denominator used to calculate response rates by prompt response option for such a question did not include this individual in the total count. This was done to avoid counting a non-response as a response of "no" for the prompt provided. Lastly, a power analysis was not performed in this study. The goal was to obtain the highest response rate possible for the most complete information to be included in the study analysis.

Study Methods. This study will use a survey to solicit information from state DOCs regarding the study variables defined and operationalized below. This information will be married to data from the 2017 survey conducted by the Pew Research Institute regarding the cost and quality measures of state prison medical programs, such as contract type, if outsourced model, information on medical staffing numbers, medical quality metrics, annual per inmate spend on medical care, etc. Because nearly all states responded to at least some of the Pew survey in 2017, the wording used in the survey designed for this study mirrored the wording used in the Pew survey sent out. In the design of the Pew study, Pew staff collaborated with state departments of corrections to understand the sector's routinely used verbiage and contracting formats to ensure the interpretation of the survey was accurate. The wording in this survey

reflects the same. Additionally, the survey information will be complemented by publicly available information regarding state spend, state DOC spend, state political leanings, and other control variables.

Lastly, a power analysis was not performed in this study. The goal was to obtain the highest response rate possible for the most complete information to be included in the study analysis. Each state was provided the introductory email at least three times unless they submitted a response to the survey or declined completing the survey after an earlier email. Approximately six months were provided for the states to respond to the survey.

Study Variables

Motivation to Contract. The public agency's (i.e., state DOC's) motivation to contract is the concept of most interest. This variable defines the motivation that leads the state agency to engage in an outsourced partnership. The motivation to contract can be seen as a gap identified by the state agency that entering into the outsourced partnership is supposed to address or ameliorate. The survey will outline a list of reasons that the literature indicated state agencies have previously cited as reasons they engaged in outsourced partnerships for medical care provision. These reasons will be coded as quality or cost focused based on the predominant outcome expected to be achieved for each reason. With the understanding that oftentimes there are multiple reasons for engaging in an action and each state ideally wants to improve both cost and quality, the respondents will be asked to pick their top three reasons if they have that many. Each of the three reasons identified will be coded as Cost or Quality focused and the reason with the most emphasis (i.e. best out of three) will be the predominant motivation for contracting. The predominant motivation will then be used to separate respondents into the categorical groups of the independent variable. Based on the literature review, however, some states have reported engaging in outsourced partnerships based on political directive and not as a result of internal motivations. With this in mind, a third option of "political" motivation is possible. Those that report political focused motivation will be analyzed separately in the results.

Table 2. Study Primary Variable

Independent Variable	Variable Attributes	Prompts provided in survey for response
Motivation	Dichotomous motivation of change desired between D_0 and D_1 with options of minimizing resources (cost) or maximizing quality with alternative option of political requirement.	Identify the top 3 reasons for engaging in a contract for a comprehensive medical program in your prisons. i. Contain rising medical costs (COST) ii. Make medical cost more predictable (COST) iii. Obtain medical expertise and/or medical management that the agency does not have (QUALITY) iv. Obtain flexibility to recruit and retain medical staff restricted by state reimbursement limits (QUALITY) v. Obtain general flexibility that otherwise would be restricted through a bureaucratic process (QUALITY) vi. Decrease the legal liability of the state (QUALITY) vii. Political pressure put on agency to control costs (COST) viii. Political pressure put on agency to improve quality (QUALITY) ix. Political pressure for other reasons (POLIITICAL) x. In response to previous or current lawsuits or settlement agreements (QUALITY) xi. Other:_____

Success of Contractual Outcomes. Contracts for comprehensive medical programs in state prisons have common contractual outcomes expected to be provided by the private vendor. This generally holds true regardless of the financial or payment structure arranged in the contract. The below outlines the constructs associated with contractual outcomes as measured in the survey.

Table 3. Study Variables for Contractual Outcomes

Dependent Variables	Variable Attributes	Prompts provided in survey for response
Cost of Medical Expenditures	Three-point Likert scale of Improved, No Change, Worsened.	Please rate your experience with the cost of medical expenditures based on your current partnership for inmate medical care provision.
Cost Predictability	Three-point Likert scale of Improved, No Change, Worsened.	Please rate your experience with the cost predictability of medical expenditures based on your current partnership for inmate medical care provision.
Medical Quality Measures	Three-point Likert scale of Improved, No Change, Worsened.	Please rate your experience with medical quality measures based on your current partnership for inmate medical care provision.

Quality of Medical Staff	Three-point Likert scale of Improved, No Change, Worsened.	Please rate your experience with the quality of medical staff to manage/deliver care (either in quantity or expertise) based on your current partnership for inmate medical care provision.
Staffing Shortages	Three-point Likert scale of None, Minimum, Significant.	Please rate your experience with staffing shortages at outsourced institutions based on your current partnership for inmate medical care provision.

Contractual Efficiencies. All outsourced partnerships will have transactional efficiencies after the start of the contract. Efficiency is reflected in such items as the level of burden felt by the public agency to monitor the contract, manage the contractual relationship, the bureaucratic difficulty in achieving the contractual outputs listed prior, and the additional funds provided to the private vendor within the *ex post* relationship. A contractual relationship will be more efficient with lower levels of contractual burden to monitor and manage the contract, less bureaucratic difficulty in obtaining contractual outputs and less additional funds being provided to the vendor after contract execution. Additionally, more frequent changes in contract vendors will introduce further inefficiencies with regards to reviewing new proposals, negotiating a new contract, setting up a new vendor across the system, and managing new relationships *ex post*. Therefore, a partnership that is longer lasting will inherently experience increased efficiency compared to partnerships that routinely turn-over.

Table 4. Study Variables of Contractual Efficiencies

Dependent Variables	**Variable Attributes**	**Prompts provided in survey for response**
Administrative Burden of Contract Monitoring	Three-point Likert scale of None, Minimum, Significant.	Please rate your experience with the administrative burden of contract monitoring based on your current partnership for inmate medical care provision.
Administrative Burden of Contract Management	Three-point Likert scale of None, Minimum, Significant.	Please rate your experience with the administrative burden of contract management based on your current partnership for inmate medical care provision.
Level of Bureaucratic "Red Tape"	Three-point Likert scale of Improved, No Change, Worsened.	Please rate your experience with level of bureaucratic "red tape" in managing or delivery care based on your current partnership for inmate medical care provision.
Funds after Contract Execution	Three-point Likert scale of None, Minimum, Significant.	Please rate your experience providing additional funds after contract execution based on your current partnership for inmate medical care provision.

Length of Time System	Categorical variable of time length.	How long has your agency had this type of medical delivery system? • Up to 2 years • Between 2 and 10 years • Over 10 years
Length of Time Contract	Categorical variable of time length.	How long has your agency used your current contract vendor for inmate health care services? • Up to 2 years • Between 2-7 years • Greater than 7 years

Experiences of Partnership Issues. CRP theory indicates that one or both sides of a partnership may engage in negative partnership behaviors as a result of feeling slighted on perceived entitlements to be received. This study solicited information from each respondent on experiences of conflict over the contract.

Table 5. Study Variables of Partnership Issues

Dependent Variables	Variable Attributes	Prompts provided in survey for response
Conflict over Contract Terms	Three-point Likert scale of None, Minimum, Significant.	Please rate your experience conflicts with the medical vendor over contractual terms based on your current partnership for inmate medical care provision.
Recommend to Others	Dichotomous Yes/No response	Would you recommend privatizing prison medical care to surrounding or similar states?
Current Satisfaction	Four-point Likert scale of Strongly Agree, Agree, Disagree and Strongly Disagree.	Please rate your agreement with the following statement: I am very satisfied with my current inmate medical delivery system.

Possible Contextual Influences. There are many contextual influences that may impact the environment in which the state DOCs are operating when making the decision to contract out medical care services or working through partnership management. These factors will be measured for each state analyzed and integrated into data analysis and result reporting to attempt the most accurate picture of the environmental picture is presented.

DOC Expenditure Per Inmate. As reported in McDonald (1995) state DOCs report issues with unsatisfactory payment arrangement between partners and private partners demanding higher subsidies. Understanding DOC expenditure per inmate can give insight into some risk management behaviors that could influence the responses of partnership experiences as collected in this study. DOCs that are able

and willing to spend more resources per inmate may be more able to be quality biased compared to a DOC that receives less financial support from state budgets. In addition, a state that has more resources for inmate care may be more likely to provide additional funds for a private vendor at times of entitlement disagreements and less likely to report a contractual conflict. They also may be more likely to take on more of the partnership risk than would otherwise be appropriate. Likewise, a DOC that has financial restrictions or low resources for inmate care may be more sensitive to negative partnership behaviors and may report higher rates of partnership conflict. Understanding how much each group on average is able to spend on inmate care generally will provide insight into stressors that may or may not exist differentially by group.

Rate of Growth of State Revenue to State DOC Expenditure. Osei-Kyei and Chan (2015) reported that an important success factor in a partnership between a government entity and a private actor is if there is political support for the partnership. The factor of state revenue growth rate as a ratio to state DOC expenditure is taken as a proxy for general political support for the state DOC. This concept evaluates whether state DOC expenditures, and by extension state DOC budgets, grow in tandem with state revenue. States with political climates that support DOCs may be more likely to provide additional resources to the departments when funds are available versus states that may chose to put the extra revenue into another agency instead. States that invest more in the DOC system may be more likely to support DOCs with regards to their independence to make decisions and motivations that are best suited for the DOC's situation and not other motivations.

State Political Landscape. Schmitt (2016) found that outsourcing of governmental services is strongly associated with conservative, right-wing governments. As well, Wang and Zhoa (2014) found that a jurisdiction is more likely to outsource if the local government has a strong conservative party majority. Understanding the political leanings of the state will help shed light on possible tendencies the agency may have to contract out that may be irrespective of the motivation for contracting or may influence the way in which the agency engages in a contract.

Sufficient Competition. The NOA 2014 report indicated that a primary issue with the governmental contracts reviewed was a lack of competition when picking a vendor. Additionally, Osei-Kyei and Chan (2015) identified that an important factor in successful partnerships was the ability of the procurement process to allow for true competition. Understanding the perception of the competition that exists within the marketplace for the state DOCs is an important factor in understanding a possible level of self-efficacy in being able to appropriately negotiate with a vendor. Should the state agency feel that competition is limited, the public administrators may feel they do not have the ability to negotiate state

favorable terms if there are limited other options available or if the other options would have the same issues. Assessing state perceptions of the competition that exists will help provide further insight into *ex ante* behavior during contract writing and negotiations.

Political Activity of Vendor. As reported in Lundahl, et al. (2009), DOCs report being forced into contracting out for private medical services as a result of political pressure. This could be in response to a lawsuit indicating quality must be improved or political pressure to decrease the cost of inmate care. Either way, political pressure abatement takes away the ability of the public administrator to be directly motivated on a bias with regards to the contracting of medical services. Often times, vendors for private medical companies will engage in lobbying efforts in order to persuade political actors into applying pressure for the state DOC to engage in a contract. Understanding how politically active vendors are within the field that the states are contracting with will help provide further context into the field of behavior surrounding contracting and contract management.

Table 6. Possible Contextual Influences

Contextual Influences	***Reason to Include***	***Measured as:***
DOC expenditure per Inmate	Spend per inmate for all care provided by the system as a proxy measure for medical spend per inmate. An increased spend per inmate globally may indicate an increased spend per inmate for medical as well.	State DOC expenditure level divided by the average daily population to get an average per capita spend.
Ratio of Growth of State Revenue to Growth of state DOC expenditures	Evaluate the growth of state DOC expenditure budgets in relation to ability of state budget to support increased expenditures. Proxy measure to indicate the capacity of the state to support increases in DOC expenditures. Identification of an increased capacity to support DOC expenditures without an associated growth in DOC expenditures may indicate a focus on cost constraint.	Ratio calculated by 20-year slope of state revenue growth divided by 20-year slope of state DOC total expenditure for each respective state.
State Political Landscape	Literature indicates that republican politicians may be more supportive of using private vendors for government service provision compared to democratic politicians. This may influence the use of a private partner for prison medical services regardless of the state's intention to actually use a private partner.	Review of the governor and legislative party control for each state. Categorical Options: Republican, Democratic, Mixed denoting both at least one aspect of the state government is controlled by both parties.

Sufficient Competition	A lack of competition has been noted in the literature as introducing issues with *ex ante* negotiations and *ex post* efficiency that may be independent of motivation of public agency.	Self-report by a Likert scale variable question on survey regarding level of competition.
Political Activity of Vendor	Increased lobbying activity by a vendor may impact the political directive for a state to utilize a private partner for prison medical services regardless of the state's intention to actually use a private partner.	Self-report by a Likert scale variable question on survey regarding vendor political activity.

Survey Reliability and Validity. The survey used in this study is lacking validation through other testing being performed. However, the survey prompts are asking for information that is routinely discussed in the topic of prison medical programs and contract management for outsourced prison medical programs. The survey was designed to intentionally reflect the same wording used in past surveys with the same population, specifically the Pew Charitable Trust survey performed in 2017 that received responses from nearly all states regarding the cost and quality of prison medical systems. This was considered especially when defining and soliciting information on the independent variable of the survey. The language and options presented directly reflected that language and prompts/responses from the 2017 Pew survey. Additionally, the respondents targeted by the survey routinely complete similar surveys as a part of their participation in national correctional groups. It can be noted that a few months after submitting this survey, a very similar survey was circulated with the same information prompts by another group that also wished to obtain the information being solicited.

The largest threat to validity in this study design is the possibility of low response rate with such a limited population to survey. Low response rate in combination with heterogeneity of units makes statistical comparison between groups impractical. While the study variables attempt to create clear lines between responses and categories, there are inherent grey zones and mixes of intentions and responses that make exacting between groups difficult. Therefore, the study findings will not be statistically evaluated but instead presented as rates across categories or Likert scores.

Moreover, the information requested in this survey can be considered volatile information between the state DOC and the private vendor. It is expected that state respondents may introduce apprehension bias in the results and not wish to complete all or some of the questions and that anonymity will be of utmost importance. To overcome this limitation, all individuals will be assured of their anonymity with even the consent form being unsigned as to not tie the respondent back to the survey answers.

Lastly, the survey is asking for information regarding motivations from individuals that may not have been present at the time of the decision to engage a private vendor was made. As a result, recall bias may be introduced and the individual may respond based on what they have heard, assumed, or think now and not necessarily what was true at the time of contract engagement. While this bias may occur, the implication of the bias may not be detrimental to the survey results. The individual completing the form currently is also completing the form for the outcome variables. These variables and experiences of them are direct results of current partnership behaviors. The public administrator may be engaging the vendor with a motivation different from *ex ante* discussions. If that is indeed the case, the difference in motivation and outcome variables would still hold true. As the contract term progresses, it would be expected that the understanding and recall of both sides for *ex ante* discussions may change in perception and both actors begin to behave based on current expectations and understandings.

Survey Data Analysis Plan. The known respondent population at study start is only a portion of the state DOCs. With each state being divided into up to three different groups of motivations for engaging in an outsourcing contract, it was expected that the sample of each group would be quite small. However, descriptive statistics are reported within the results section for all variables listed above. Additionally, because my variables lie on an ordinal scale, I analyzed the distribution using a Somer's D test. Somer's D provides an index of association between two variables that are measured on ordinal scales (Oxford Reference, 2023). The Somer's D index provides information on the number of concordant and number of discordant pairs along the ordinal scale divided by the total number of pairs (Oxford Reference, 2023). For this test, the independent variable was coded 0 = cost-motivated and 1 = quality-motivated. Somer's D values of >0 to +1 indicates an association with the quality-motivated group and values of -1 to <0 indicates an association with the cost-related group. A value of 0 indicates no association detected. The value of the decimal reflects the strength of the association with values closer to 1 or -1 being stronger than values closer to 0. Survey responses were coded ordinally as follows for each group of possible responses: Worsened = 1, No Change = 2, and Improved = 3; None =1, Minimal =2, and Significant = 3; 1-5 years = 1, 5-10 years = 2, and >10 years = 3; and <2 years = 1, 2-7 years = 2, and >7 years = 3, as appropriate. The responses for satisfaction with system used and recommend to others were coded as dichotomous variables. For satisfaction with the system being used, responses were condensed. Strongly disagree and disagree were combined as a not satisfied indicator and coded as 1. Strongly agree and agree were combined as a yes satisfied indicator and coded as 2. For recommend to others, no was coded as 1 and yes was coded as 2. Somer's D tests were performed to analyze variable associations for Research Question 1. For each variable, Somer's D coefficient and p-values are reported.

Qualitative Study Design

A qualitative study design was used to answer Research Question 2: In what ways does the contract impact experiences of partnership success? This section of the study took a deductive, interpretivist approach which was grounded in the theories that frame the entire study. A qualitative case study design was chosen as the best option to understand the context in which the relationships existed for the respondent states. Both sides of the contract are represented by individuals that perceive and react in human ways. Therefore, a qualitative case study design will allow the most robust method of understanding this phenomenon.

A multiple case study design is the most appropriate vehicle for understanding the interaction between the two parties. According to Yin and Campbell (2018), a case study design is most applicable for a study in which it is nearly impossible to understand the phenomenon separate for the context surrounding it. Case studies incorporate multiple sources to evaluate bounded systems in order to provide a richer integration of the surrounding contexts and variables (Merriam & Tisdell, 2015). Findings from the recurring themes and patterns that manifest from the data will inform the research questions and propositions asserted (Merriam & Tisdell, 2015).

Qualitative Methods

Sampling. From the survey information results, it became evident that there was a difference in the perceptions of the burden of contract monitoring and management and reported incidences of conflict within the partnership between groups. Because of this difference, extreme sampling was the most appropriate method for aggregating into case groupings. Extreme sampling would provide the best way of detecting differences between groups during content analysis. For the case studies, the first group was chosen to be states with reported quality bias that also reported low management burden and low partnership conflicts. The second group for case study were those that were cost biased and also reported significant monitoring and management burden, along with significant conflict within the partnership. The third case study included cost biased with significant monitoring and management burden, significant partnership conflicts and high turnover of new contracts for comprehensive medical care. The selection of these cases allowed for more robust thematic understanding across the document analysis.

Content Analysis. Current and past contracts were requested and reviewed for each state. For each case grouping developed, state-level contextual factors were evaluated. Some states were able to provide up to three of the past comprehensive medical program contracts, whereas some states were able to provide only one. All contracts were analyzed for analysis. Additional documents were included in

the content analysis, such as Request for Proposal (RFP) solicitations, evaluation notes from RFP evaluation committees, and reports provided to state legislative bodies about the contract extension or new contract execution. All documents were analyzed for the same themes identified and discussed below. In total, nine contracts, three requests for proposal (RFP) documents and one set of evaluations for responses received for a request for proposals were analyzed. Since contract documents reflect partnership agreements after negotiations, RFPs were evaluated (if available) to ascertain state initial desires for the partnership. After each document was coded with themes identified, a database of all document terms coded was created. Each case study was evaluated by the themes presented to provide greater understanding of the results found in the quantitative section and provide a better understanding of the overall situations occurring within these states. Primary analysis across case studies focused a greater degree on contract language and less on the evaluation and RFP documents. However, the evaluation and RFP documents were used to provide more nuanced insight into the contract documents. For instance, ascertaining the extent to which the state changed contractual obligations as a result of negotiations based upon pre-negotiation RFP desires and post-negotiation executed contract. For the states in which more than one contract was available, all contracts were reviewed for the data set. This allowed for more robust analysis of historical changes that occurred in the case studies and associations of these changes with survey results.

Thematic Analysis. In order to appropriately evaluate the contract terms, I identified four themes a priori to analyze the contracts used. These themes included Cost, Quality, Monitoring and Enforcement. The themes of Cost and Quality were included in order to ascertain how the different groups included and characterized these values within the contract terms. References of cost and quality expectations, outcomes and measures may be more or less complete based on what detail is included in the contract terms. Analysis of these two themes allows more in-depth understanding of what function each state allowed to be more or less complete. This is important as it speaks to the public administrator's perception of risk associated with the contract terms with regards to cost and quality. The themes of Monitoring and Enforcement were included to better understand the administrative monitoring and management burden placed on both parties by virtue of the contract framework. The monitoring aspects of the contract outline the burden placed on both sides to comply and measure compliance. Enforcement terms give insight into the perception of collaboration expected during the contract term. Contracts with hard enforcement terms indicate less interest in collaborating for incomplete areas or non-compliance with the complete areas of the contract. However, contracts with softer enforcement terms may indicate more of a collaborative relationship to address issues. Both the monitoring and enforcement aspects of the contract can triangulate the quantitative analysis done for hypothesis 2 and can give further insight

into hypothesis 3. During and after the content analysis, I did not find the need to create any additional themes.

Based on the literature review, contract theories, and findings from the contract reviews, I developed a framework to analyze the contractual terms along these variables and dimensions in such a way that conclusions could be made from the analysis. A sketch of the analytical framework (Figure 2) presented is below ("Contract Risk Profiling Framework"). To complete the framework, each attribute considered to be a defining aspect of the desired contractual output would be identified. These identified attributes would be the areas of the partnership that are risks associated with contractual non-compliance. Once identified, the contractual terms that provide protections, allowances, monitoring and enforcement for that attribute are outlined to understand the full profile of that risk across the entire contract. Conclusions from these profiles can then be made.

This framework was used to evaluate risk profiles for state contracting of comprehensive medical services across three case studies. The first case study was that of states that reported contracting with quality-related motivations and lower burden of contract management and partnership issues; the second case study was that of states that reported contracting with financial-related motivations and high levels of contract management and partnership issues; the third case study was that of a state that also reported contracting for financial-related motivations but with very frequent vendor turn-over and very high management and partnership issues. Through these three case studies, the propositions asserted for the second research question were analyzed. For each case study, the primary risk was listed in-kind with the motivation for contracting held by the state prison system and analyzed with this assumption made.

The completed framework for each case study, in addition to the contextual factors of each case group and the quantitative results found in the first part of the study, was used to create scenarios for each case group that depicts the interplay of themes and the resulting impact for the public administrators.

Table 7. Themes Used for Content Analysis of Contractual Documents

Themes	COST	QUALITY	MONITORING	ENFORCEMENT
Description	Items that discuss money exchange or fiscal responsibility of an item	Items that discuss specific mechanisms to dictate quality levels of services being performed/provided.	Items that identify ways that the state reviews the work being performed by the vendor.	Items that identify ways the state will respond if the vendor fails to perform to the expected service levels identified in the contract.
Reason Chosen	Primary Variable of interest. Need to understand the extent of cost control, description that is included in the contract terms.	Primary Variable of interest. Need to understand the extent of quality specifications, description that is included in the contract terms.	Literature reflects that one critical aspect of contract management that is often missed is ensuring the partnership is appropriately monitored during the life of the project. Additionally, this is the areas of the contract that are most likely to trigger an issue between partners. Additionally, monitoring inherently increases the administrative burden felt by either partner that may result in entitlement disagreements.	Literature reflects that a secondary criticla aspect of contract management and partnership relations is enforcement of the contract terms. Enforcement terms can be used to understand the level of importance the state places on such items based on the level of response that will be taken if an item is not satisfied and can outline the rights afforded to the vendor for disputes.
Example Contract Terms	"Prices shall remain firm for the entire contract period and subsequent renewals. Prices shall be net delivered, including all trade, quantity and cash discounts. Any price reductions available during the contract period shall be offered to the [state]."	"Demonstrate the ability to provide a system of technical and medical support, as well as professional staff development."	"The Director of [unit] shall receive a summary of all CQI activity each month, to include compliance thresholds, problem tracking reports, and corrective action plans. Joint quarterly meetings will be held between the [unit] and the Contractor to evalute the quality of the health care being provided as documented by the CQI program data."	"If performance falls below 90%, the Contractor shall, pay to [state] as fixed, agreed, and performance guarantees $100.00 times the number of noncompliant occurrences identified during the review period."

Figure 3. Contract Risk Profiling Framework for Case Study Analysis

Column 1	Col 2	Col 3	Col 4	Col 5	Col 6
Administrator's Situation	***Risks***	***Protections***	***Allowances***	***Monitoring***	***Enforcement***
Motivation to Contract	Attributes considered important values of the outputs to be provided during or at end of contract period that place the public administrator at risk if not achieved. (listed as 1º, 2º, 3º, etc.)	Terms designed to lower the risk level for each attribute identified.	Terms designed to manage the other party's residual control rights for the protections placed. (can expand or restrict)	Passive terms designed to ensure routine review of compliance with the protections and allowances as written in the contract.	Action terms designed to provide responsiveness to the monitoring performed and dispute resolution.
	1º Attribute (i.e. biased function)				
	2º Attribute (i.e. unbiased function)				

CHAPTER 4: FINDINGS

Study analysis was performed sequentially and in order of research hypotheses presented. Findings from the quantitative portion of the study are presented first. These results were then used to create groupings of respondents for case study analysis of contextual factors and content analysis. Findings from the case study evaluation and contract content analysis are presented next.

Quantitative Study Findings

The survey was sent out to prison medical system administrators in 48 states as identified through public records. All states with a known contract for prison medical services was solicited with the survey. Of the respondents, thirteen states with a contract for comprehensive prison medical services responded to the survey. An additional six states that provided direct provision through state employees also responded to the survey. The data presented below is only reflective of the thirteen states that responded that currently managed a prison medical contract.

Survey Descriptive Statistics

Table 8. Descriptive Statistics of Survey Respondents by Provision Type

Medical System Type	2017 Pew Provision Type	2021 Provision Type	Number Responded to Survey	Percent of 2021 Type Responded
Contracted Provision	22	22	10	45%
Direct Provision	20	23	6	29%
Hybrid of Both Provisions	8	5	3	60%
Total	**50**	**50**	**19**	**38%**

Since the time of the Pew Study, the number of states with contracted medical care provision has stayed steady, although not entirely the same states. Some states did move between categories, but overall, the number using a private vendor for medical care did not change. Three states began directly providing medical care to inmates and three states moved away from hybrid models in which a private vendor managed comprehensive medical care in some fashion alongside state employees for the prison medical care system. A total of 13 states responded to the survey to make up the initial sampling pool for contextual analysis and case study evaluation.

Of the 13 states that responded, eight reported motivation that was more cost biased and five reported motivations that were more quality biased. Comparing the contextual factors that make up the landscape of these two groups, it seems that states with quality biased motivations have smaller systems with an average of 9 versus 16.75 prisons per state prison system and an average of 9,430 versus 18,758 inmates per state prison system. DOCs with quality bias seem to exist in states that have higher state revenue compared to DOC expenditures indicating that these states may not be investing as much in DOCs when the state revenues are high, but they do tend to spend more per inmate on average. State political affiliation seems to be more Republican in nature for those DOCs that are more cost biased with reports that the vendors are more likely to be politically active in those states as well. With regards to quality biased DOCs, all reported insufficient competition available within the market for proper procurement of services. See table 8 for comparative figures. It is to be noted, that the sampling on both sides is quite small and findings are not generalizable beyond this sampling as a result.

Table 9. Descriptive Statistics by Comparison Group

Descriptive Values		
	COST	**QUALITY**
Number Respondents	8	5
Number Prisons per State (avg)	16.75	9
Number Inmates per State (avg)	18,758	9,430
2020 State Spend / ADP (avg)	$50,007	$59,162
State Revenue to DOC Expend.	2.2	3
State Political Affiliation		
Divided	13%	40%
Democratic	25%	20%
Republican	63%	40%
Sufficient Competition		
Yes	50%	0%
No	50%	100%
Vendor Political Activity		
None	38%	60%
Minimal	38%	20%
Significant	13%	20%

Research Question 1 Results

Research Question 1: How does the public administrator's motivation correlate with the success of the contractual relationship?

Hypothesis 1. DOC administrators which report to have cost-related primary motivations will be more likely to report success in contractual outputs than DOC administrators which report to be quality motivated.

Survey results indicate that partnerships where the public administrator had a quality-related motivation, were more likely to be associated with both quality and cost related contractual outputs. The quality-motivated group reported experiencing better outcomes regarding medical expenditures and quality of medical staff within the facilities. Both these variables had Somer's D coefficient greater than 0.5 and p-values less than 0.05. The group reporting cost-related motivation reported higher rates of worsening medical expenditures and worsening quality of staff during the contract term. Additionally, cost-related motivated public administrators also reported greater experiences of staffing shortages during the contract with a Somer's D coefficient of -0.6 (p-value <0.05).

However, statistical analysis indicated insufficient data to make a determination on association of motivation with cost predictability or quality measures. The cost predictability variable ranged greatly for the cost group which averaged equal association with the quality group. The distribution of the quality measures variable between groups was very similar. Therefore, these two variables cannot be determined as being statistically different between groups from this sample. See table 10 for results.

Overall, for the first hypothesis, the data results indicate that quality-related motivated public administrators experience better contractual outputs across both the cost and quality functions of the contract compared with cost-related motivated public administrators. This is contrary to the initial hypothesis posed.

Table 10. Results for Contractual Outputs

Variables for Contractual Outputs								
	COST			**QUALITY**			**Somer's D**	
	Worsened	**No Change**	**Improved**	**Worsened**	**No Change**	**Improved**	**Coeff.**	**P-Value**
Medical Expenditures	43%	57%	0%	0%	100%	0%	0.571	<0.05
Cost Predictability	14%	43%	43%	0%	100%	0%	0.143	0.62
Quaity Measures	0%	29%	71%	0%	33%	67%	0.086	0.765
Quality of Medical Staff	29%	43%	29%	0%	33%	67%	0.629	<0.05
	None	**Minimal**	**Significant**	**None**	**Minimal**	**Significant**	**Coeff.**	**P-Value**
Staffing Shortage	0%	0%	100%	33%	33%	33%	-0.6	<0.05

Hypothesis 2. DOC administrators that report having cost-related primary motivations will be more likely to experience positive efficiencies.

With regards to contract efficiencies after contract execution, survey results indicate a stronger movement towards improvement with experiences of red tape for respondents that were quality-related motivated. The remainder of the efficiencies strongly indicate higher levels of burden experienced by the public administrators regarding monitoring and contract management for those that were cost-related motivated. See table 11 for results.

Public administrators that reported engaging in a contract for cost biased reasons indicated that they were much more likely to experience a worsening of bureaucratic difficulty during the partnership, as well as significant burdens of monitoring and managing the contract. All cost biased states indicated they had used a private vendor to manage their comprehensive medical care for more than the last ten years but indicated that the current contract was less than two years in at the time of the survey. Somer's D test indicates a moderate correlation that cost-related public administrators experience quicker turnover of vendors compared to quality-motivated public administrators, albeit with a p-value over 0.05. On the other hand, quality biased states were more likely to report an improvement in bureaucratic red tape with regards to providing medical care within the system, with the vast majority reporting minimal contract monitoring and management. Like cost biased states, these states reported using a private vendor for comprehensive medical care management for over the last ten years, but unlike the other group, indicated that the length of the partnership was much greater with most referencing over seven years of partnership over the last ten years.

Overall, for the second hypothesis, results indicate that public administrators that are quality motivated experience greater contract efficiencies after contract execution as compared to those that are cost motivated. Quality motivated public administrators experience less red tape, less burden on monitoring the contract and less burden on managing the contract. Additionally, these public administrators usually continue contracts with the same vendor longer than cost motivated public administrators, which results in less burden of soliciting for a new vendor, evaluating proposals, and experiencing all the transaction costs associated with switching management for all aspects of the medical system.

Table 11. Results for Contractual Efficiencies

Variables for Contractual Efficiencies	COST			QUALITY			Somer's D	
	Worsened	No Change	Improved	Worsened	No Change	Improved	Coeff.	P-Value
Experience with Bureaucratic Red Tape	14%	57%	14%	0%	67%	33%	0.657	<0.05
	None	Minimal	Significant	None	Minimal	Significant	Coeff.	P-Value
Funds Requested Ex Post	25%	38%	38%	33%	67%	0%	-0.257	0.393
Burden of Contract Monitoring	0%	13%	88%	0%	100%	0%	-1.00	<0.05
Burden of Contract Management	0%	25%	75%	33%	33%	33%	-0.686	<0.05
	1-5	5-10	> 10	1-5	5-10	> 10	Coeff.	P-Value
Length of System Type (years)	0%	0%	100%	0%	0%	100%	0	---
	< 2	2-7	> 7	< 2	2-7	> 7	Coeff.	P-Value
Length of Current Vendor Use (years)	67%	22%	11%	25%	0%	75%	0.425	0.128

Hypothesis 3. DOC administrators with cost-related primary motivations will be less likely to report experiences of partnership issues.

Lastly, the survey data results strongly indicate that public administrators with cost-related motivations experience significantly more contractual disputes as compared to their quality motivated counterparts. One-third of these individuals reported having significant conflict over the contract. On the other hand, the quality biased group indicated at most a minimal conflict with 40% indicating no conflict over the contractual terms and outcomes. With regards to satisfaction with the system, the quality motivated counterparts indicate stronger satisfaction with their current contract and system (100% satisfied compared to 17%). Surprisingly though, both sides are ambivalent with regards to recommending their arrangement to others and neither side is associated with recommending or not on a systematic level. See Table 12 for results.

Table 12. Results for Experiences of Partnership Issues

Variables for Experiences of Partnership Issues	COST			QUALITY			Somer's D	
	None	Minimal	Significant	None	Minimal	Significant	Coeff.	P-value
Conflict over Contract	0%	75%	25%	67%	33%	0%	-0.714	<0.05
	Yes	No		Yes	No		Coeff.	P-value
Satisfied with System Being Used	17%	83%		100%	0%		0.829	<0.05
Recommend to Others	57%	43%		50%	50%		0.171	0.552

Qualitative Study Findings

Case Studies Results

Based on the survey results, four groups of respondents were identified. These included quality-motivated states with low management burden and low partnership issues; cost-motivated states with high management burden and low partnership issues; cost-motivated states with high management burden and high partnership issues; and cost-motivated states with high management burden, high partnership issues, and frequent contract turnover. From these groups, three case studies were evaluated. The first included states that reported quality-related motivations with low management burden and low partnership issue. The second included states that reported cost-related motivations with high management burden and high partnership issues. The third group included states that reported cost-related motivations with high management burden, high partnership issues and high turnover of contracted vendors over time. These were chosen through extreme sampling strategy in order to have the best chance of identifying differing characteristics between groups. Descriptions of the case studies are below with completed case study frameworks following that section.

Case Study 1: Quality-Related Motivations, Low Management Burden, Low Partnership Issues

The first case study grouping was comprised of states that reported having quality-related motivations such as the intention of gaining better expertise to run the medical system, flexibility in hiring more qualified staff and/or decreasing the liability as a result of better medical system quality. These systems resided in the bottom 40th percentile with regards to inmate population size across all state DOCs and 30th percentile with regards to number of facilities within the system. Generally, these states are smaller in size compared to average with fewer number of inmates to medically manage. These states reported being in the top 50th percentile with regards to medical spend per inmate in the 2017 Pew study with one spending within the top 80th percentile.

All states within this grouping reported performing internal reports to monitor quality metrics for the medical system on a set schedule, no change in cost during the contract but improvements in quality, improvements in litigation and all states reported being satisfied with their medical system arrangement and would recommend the arrangement to others. Additionally, all states reported having a limited vendor pool for competition, no legislative required oversight and no change in legislative oversight of the department due to having a private medical vendor. With regards to the political environment of the state, all states reflected a divided government that included both republican and democrat majority representation within the state gubernatorial and legislative bodies. With regards to state spending and

departmental investment, these states varied widely by increase of revenue trends over the last twenty years and investment into the state's DOC budget base during that same time. The top growing state doubled the state DOC budget during the last twenty years whereas the lowest state increased only by 19 percent during that time. However, with these states already reflecting high spend to inmate ratio, an increase in DOC expenditures may not be as expected if the department was funded well twenty years ago.

For partnership experiences, these states reported a low burden to monitor and manage the partnership and low to no partnership issues during the time of the contract. All states indicated long term contract lengths of seven or more years per partnership. Documents analyzed for this grouping included Request for Proposal (RFP) solicitations, evaluations of proposal submitted, and current contractual documents. All documents were coded according to the themes identified and defined a priori with a framework completed to ascertain contractual trends based on these themes. Due to the long term nature of the partnerships in this group, only one contract (the current contract) for each state was analyzed as prior contracts were not available.

Contractual terms structuring the partnership for states within this group reflect a very similar pattern across all contracts evaluated. Analysis indicated a pattern of focusing attention on financial risk management and less so on quality specifications terms. All contracts within this group are financially structured as full risk with the vendor assuming all financial responsibility of the cost to provide comprehensive medical care to the inmates for the term of the agreement. The full-risk model is protected with a minimum number of inmates to be paid for, even if the population of inmates present in the facilities during the month drops below this amount. However, within the funds provided, the states segregated out funds into buckets to only be used for special purposes. Such purposes included staff training costs, special pharmacy costs, equipment purchases and Hepatitis C treatments. These items are often high-cost areas that for profit companies may avoid putting money into in order to manage the funds received for the entire program. Additionally, the funding for the partnership allocated funds specifically for administrative overhead and profit margin of the contract. Any funds remaining at the end of the contract period that remain unspent after all medical care is paid for and the administrative overhead and profit margin are provided are returned to the state. This encourages the private vendor to spend the funds provided on medical care, especially for the areas directed with special funds, and not reduce the use of medical services in order to maximize profit. At the end of the term, the vendor is fully aware of what profit margin will be received and will not feel entitled to additional profit.

On the other hand, the contract terms regarding quality related expectations provided the private vendor significant allowances and room to create programmatic plans and procedures independently. Documents indicated an actively collaborative relationship to identify and define important quality metrics and monitoring measures that would meet the goals and expectations of each side. The RFP solicitation did not attempt to create specific requirements prior to contract negotiation and all specifications included in the contracts indicated some level of negotiation and discussion prior to agreement and inclusion in the contract. The monitoring indicated in the contracts is greatly focused on quality metrics with very limited monitoring of cost related items. The monitoring that is outlined is limited to select measures and has a predetermined cap of the number of measures that can be expected to be provided each month. The collaboration and limitation of monitoring measures balances the burden of reporting out medical services with the need to monitor the services being provided. The lack of requirements presented during RFP solicitation with negotiation of these items at contract negotiation time may help both parties verbalize entitlements felt *ex ante*, which then may be more intentionally outlined in the contract.

Overall, these contracts seem to focus on financial risk management with secondary focus on basic quality requirements. In other words, the financial contract terms are more complete while quality requirements are more incomplete. The quality requirements are collaboratively developed with potentially more intentional discussion of entitlement expectations prior to contract start. These states have low vendor turnover as they experience long-term partnerships with the same vendor for over 7 years as reported in the survey. The contracts may be more general and less specific because the relationship between the two partners has already set the expectations and contractual language for requirements, monitoring and enforcement may be less necessary.

Case Study 2: Financial-Related Motivations, High Management Burden, High Partnership Issues

The second case study group comprised states that reported having financially related motivations of cost containment and/or cost predictability. For the states evaluated in this grouping, none indicated a tertiary motivation related to quality. This does not indicate that these states are not concerned with quality, but rather emphasizes their motivation to impact the cost function of the program quite specifically. These systems vary widely contextually. The range between states includes very small inmate and facility numbers to very large inmate and facility numbers. These states reported being in the top 50th percentile with regards to medical spend per inmate in the 2017 Pew study with one spending within the top 90th percentile.

All states within this grouping reported the vendors providing cost reports to monitor cost metrics for the medical system with some indicating the cost monitoring happening on a set schedule and others reporting ad hoc evaluation. All indicated performing internal reporting for cost, quality and utilization of medical service trends. All indicated no change or worsening in cost-related factors, as well as no change or worsening of most quality related factors. All states indicated they were not satisfied with the current system arrangement and would not recommend this system and arrangement to other states. With regards to the pool for competition, the states in this group were variable with some reporting very limited and some reported a significant pool to pick a vendor from.

All states indicated some level of legislative required oversight with required reporting on cost and quality measures of the DOC's medical system. With regards to the political environment of these state, most states reflected a divided government that included both republican and democrat majority representation within the state gubernatorial and legislative bodies with one reflecting a democrat majority across all governmental bodies.

With regards to state spending and departmental investment, these states reflected an average of doubling of revenue trends over the last twenty years and similarly investments into the state's DOC budget base during that same time. The top growing state doubled the state DOC budget during the last twenty years whereas the lowest state increased only by over 77 percent during that time. It seems that with a trending increase in state revenue, those states invested further funds into the DOCs to allow for growth and accommodation of inflation factors.

For partnership experiences, these states reported a high burden to monitor and manage the partnership and high levels of partnership issues during the time of the contract. All states indicated short term contract lengths with recent turnover of vendors during the study period. Documents analyzed for this grouping included the most recent three successive contracts for each state and RFP solicitations for the most recent contracts. Due to the more frequent turnover of these partnerships, successive contracts were available for evaluation. All documents were coded according to the themes identified and defined a priori with a framework completed to ascertain contractual trends based on these themes.

The contractual language for partnerships that are written by these states puts a much greater emphasis on both the quality of services to be provided and the financial management of the contract and the private vendor. These states provide more explicit quality requirements and metrics for the vendor to achieve, often relying on expecting and enforcing ACA and NCCHC requirements. These states include sections of the state law and full suites of medical policies and procedures for the vendor to use at

contract start. These states employ medical chiefs across the major disciplines, including medical, nursing, pharmacy, dental and administration, all of which oversee the medical program and provide feedback, requirements and increased monitoring from the vendor. The quality monitoring of these contracts is greater than those in case study one, whereby up to 38 quality metrics are required, facility audits are routinely performed, and the vendor is required to self-report with the state following up and providing corrective actions if reported incorrectly. Collaborative language that may have existed in these state contracts a decade ago are now gone with the state reserving the final authority over all decisions and actions made on the contract.

The contracts are full-risk contracts through a capitated model, where reimbursement modulates based on the actual number of inmates present in the facilities each month. Rates are frozen for the first few years of the contractual agreement with increases only considered after this period. Alternative forms of payment structures are experimented with across these states including cost share over/under caps and additional payments for achieving additional quality related measures, however, these either go away quickly in the partnership or are newer to the partnership and have little time to see effect. These states place greater effort towards monitoring the vendor's financial management of the contract, including monthly, quarterly and financial review. Some states evaluate the vendor's pricing proposal with the approved budget and the funds actually expended during that time to determine appropriateness of money spent on medical care during the contract term. This goes so far as evaluating the cost of each individual medical service provided to each discrete inmate with cost of service included and requiring the vendor to use certain vendors.

As stated, the states included in this case study all had multiple vendor turnover over the last decade. Contractual language showed a successive shift away from initially collaborative language in the third farthest contract to more restricted language with specific requirements and enforcement mechanisms included in the most current contract. Additionally, the monitoring of the contracts equally increased with each successive contract with a new vendor.

Overall, these state contracts placed more importance on ensuring increased contractual completeness with regards to quality measures. The resulting completeness may act to restrict the vendor's residual control rights greater than case study one, with more emphasis on monitoring both the quality and cost of the vendor's performance. These higher requirements increase the administrative burden of the vendor, increase the monitoring risks of the state and a combination of self-report and auditing behind can easily create conflict between the two parties. With the high vendor turnover, new vendors often times have to accept agreements based off contractual conflicts that arose in prior

relationships, but being addressed with the new vendor who has not yet had these conflict experiences. It is logical to think that these states may have started with contracts more closely resembling case study one examples, but over time and conflicts, have evolved to become more restrictive. Vendor issues with traditional contracts may have initiated more complete contracts with less residual control rights, leading to higher burden of monitoring and management and even more issues between partners. This may reflect a vicious cycle type of activity between state and vendors. This case study provides an example of a situation progressing towards the state benefiting more from producing the services internally instead of buying them.

Case Study 3: Financial-Related Motivation, High Turnover over Long Period of Time, High Management Burden, High Partnership Issues

The third case study group was comprised of states that reported having financially related motivations of cost containment and/or cost predictability with very high turnover of partnerships over many decades. For the states evaluated in this grouping, again, none indicated a tertiary motivation related to quality. Again, this does not indicate that these states are not concerned with quality, but rather emphasizes their motivation to impact the cost function of the program quite specifically. These systems do not vary. This group reflects a very high inmate population and facility numbers, but quite low spend to inmate ratio.

Like case study group two, all states within this grouping reported the vendors providing cost reports to monitor cost metrics for the medical system with some indicating the cost monitoring happening on a set schedule and others reporting ad hoc evaluation. All indicated performing internal reporting for cost, quality and utilization of medical service trends. All indicated no change or worsening in cost-related factors, as well as no change or worsening in most quality related factors.

Importantly, for case group three, the level of legislative oversight employed by the state to monitor and manage the medical system contract is quite high. All changes to the contract and increases in reimbursement must be reviewed and approved by the legislature. The state DOCs seem to not have the ability to choose to provide the medical services internally and are required by the state to contract out for these services. The political climate of the state is republican.

With regards to state spending and departmental investment, these states reflected a much slower increase in state DOC budget expenditure levels compared to state revenue increases over the last twenty years with the state revenue growing nearly four times faster than state DOC expenditure growth.

For contract experiences, these states reported a very high burden of partnership monitoring and management and high rates of partnership issues throughout each partnership term. For this case study, only contract documents were available with up to two successive contracts available for analysis.

As indicated, the states included in this case study all had significant vendor turnover over the last several decades. Contractual language shows very strict and prescribed practices that the new vendors must accept with very high levels of service level expectations and monitoring. Background information included in the contract outlines the historical judicial cases that have shaped and impacted the medical care system currently employed within the state prisons.

The pattern noted of this case study is the increase, even over case study two, of the program measures and reports required to be provided by the vendor. These cases purported rely significantly on the vendor's experience and expertise as described in the contract, however, provides the vendor with significant details, procures and requirements to ensure compliance with throughout the contract term. A total of 45 reports are required by the vendor in addition to 66 performance measures that are self-reported on by the vendor. The state employs a significant number of clinical chiefs and assistant chiefs that seem to provide program management as outlined by the staffing diagrams required for the vendor to fill whereby, they report to the state chief for their associated discipline.

The financial structure of the contract is a cost-plus structure with the option to request additional funds from the state legislature if needed. The state does provide separate funding for high-cost medications that can be purchased through the federal 340(b) program. Very limited financial review is performed compared to the significantly high-quality review being done daily, weekly, monthly, quarterly and annually. The vendor is responsible for monitoring the financial management of the funds provided and alerting the state to the need for additional funds prior to the deadline for new fund requests to be submitted to the state legislative body. Enforcement of the contract is limited to termination for cause with as little as 31 days' notice.

This seems to be an example of a position where the state may be better off producing the service internally with state employees instead of constantly managing new solicitations and new contracts repeatedly. The burden of monitoring and management, with no benefit that purchasing a service should provide, it seems detrimental for the state to continue in this path. The state seems to already have the backbone specialists (chiefs and assistant chiefs) that manage the day-to-day operations of the medical system and pays by a cost-plus financial structure, which reflects the same financial structure that would exist should the state produce the services itself.

Case Study Developed Risk Profiling Frameworks

Case Study 1: Quality-Related Motivation, Low Management Burden, Low Partnership Issues					
Administrator's Situation	***Risks***	***Protections***	***Allowances***	***Monitoring***	***Enforcement***
Motivated to sustain or improve the **quality** aspects of comprehensive medical care in the prison system.	**Quality** of services provided (1º) Vendor's expected behavior is to provide lowest quality needed to meet the expectations of the contract.	Requires the DOC to review all clinical guidelines or procedures that the vendor wishes to use for clinical care. Medical charting and notes are to be done using SOAP formatting. Staffing plans to be created by vendor and reviewed for approval. Staff to be qualified as determined by licensing or certification boards.	Provided more general statements that the contractor is responsible for all decisions regarding the type, timing and level of medical care needed by state inmates. Put general timelines in the contract of maximum days for services to be achieved (e.g. 75 days for utilization review). Staff are restricted to working 40 hours or less each week if working directly with state inmates.	Monitoring limited to basic measures of off-site appointment use, pharmacy use, staffing, claims paid. Vendor is able to collaborate on the programmatic metrics to be captured and reported out, with a cap of reported measures instituted at 13. Updates are provided during the routine weekly meeting with each prison warden as already scheduled and not an additional meeting. Overall, focuses more on quality monitoring of the contract but in a more global manner with select measures pre-determined with the vendor.	States explicitly reserve the right to override any clinical decision made by the vendor. Withhold a percentage of the annual funding to be paid at the end of the agreement period if all services are completed at the satisfaction level of the state. If non-compliance is found, the state contract monitor will meet with the vendor to determine the next course of action.
	Cost of services provided (2º) Vendor expected decisions made will be to maximize profit.	Full-risk contracts that identify specific fundings amounts within the total amount to only be used for certain items (e.g. staff training, equipment, Hepatitis C treatment, off-site, etc.) Unspent funds at the end of the year are returned to the state.	Funding source solely provided for overhead and profit margin. State to pay vendor staffing and administrative expenses twice monthly.	Monitoring is limited to claims paid off-site providers. Does not require vendor to provide routine financial reports.	State to enforce liquidated damages for staffing levels, and non-compliance of certain important items of the contractual terms. State contract monitor able to reduce or waive liquidated damages at any time.

Case Study 2: Financial-Related Motivations, High Management Burden, High Partnership Issues					
Administrator's Situation	***Risks***	***Protections***	***Allowances***	***Monitoring***	***Enforcement***
Motivated to sustain or improve the **financial** aspects of comprehensive medical care in the prison system.	**Cost** of services provided (1º) Vendor expected decisions made will be to maximize profit.	Capitated, full-risk contracts with one state attempting a shared risk model that was removed after one contract term. Price fixed for the first few years of each contract with negotiations to increase only allowed after the first several years.	Allowance for additional reimbursement as catastrophic coverage for individual inmates with very high-cost medical care. Allowance for additional reimbursement for special quality metrics met during the term of the contract. Additional funds provided for high-cost medications or carved out of the contract all together.	Evaluation of the vendor's annual financial statement, with quarterly review of the vendor's approved annual budgeted amount, payments provided under the contract and price proposal from initial negotiations *ex ante*. Significant monitoring of monthly itemized statements of services rendered by type (off-site, laboratory, imaging, etc.) for each facility under contract.	States reserve the right to require the vendor to use certain sub-contractors or secondary vendors for medical or pharmacy services. State has the right to apply liquidated damages. Some damages are at cost while others are at higher rates with statements that the higher rates are to discourage behaviors that lead to damages.
	Quality of services provided (2º) Vendor's expected behavior is to provide lowest quality needed to meet the expectations of the contract.	Requires ACA or NCCHC compliance. Requires vendor to use the policies and procedures already created and used for medical services. Stipulates that medical judgements should be "predicated on sound scientific principles, evidence-based practices and methods of care optimally tailored for" the prison setting.	Very limited allowances. Provides codified requirements and policies for programs to be implemented. Vendor stepping into state with program already set by state and prior vendor management with little room for new vendor customization of the program.	Outlines up to 38 quality metrics to be reported each month. Requires Continuous Quality Improvement (CQI) programs as the monitoring and compliance program. State employs contract monitors to do routine audits at contracted facilities with dozens of metrics measured each month. Vendor to self-report deficiencies with state auditing behind the reports.	Apply a small hold back if non-compliance of a quality item is found, but provided back once the item is rectified. States are given final decision-making authority and will cancel the contract with cause or without with small amount of notice. Language of collaborative dispute resolution disappears as new contracts are written (for the same state) and replaced with more final contract termination language.

Case Study 3: Financial-Related Motivation, High Turnover over Long Period of Time, High Management Burden, High Partnership Issues					
Administrator's Situation	***Risks***	***Protections***	***Allowances***	***Monitoring***	***Enforcement***
Motivated to sustain or improve the **financial** aspects of comprehensive medical care in the prison system.	**Cost** of services provided (1º) Vendor expected decisions made will be to maximize profit.	Cost plus model to cover actual incurred costs plus administrative effort to manage those costs with a fixed cap that the reimbursement amount cannot go over as appropriated by the state legislature.	State to pay for medications that are procured through the federal 340(b) program. Separate funding is provided for inmates with certain diagnoses being released into the community. Expects nearly all specialty providers to provide care onsite, including MRI/CT and nuclear scans to decrease the cost of care.	Requires vendor to have a risk management program to ensure financial management. Total of 66 Program measures that have associated liquidated damages ranging from $1,000 to $9,000 per occurrence or facility based on a scale of performance level.	Increase in the cap is reliant on further funding approved by the state legislature. State cannot provide additional funds over the cap directly without the state legislature giving more funds.
	Quality of services provided (2º) Vendor's expected behavior is to provide lowest quality needed to meet the expectations of the contract.	Transfers the full risk of quality compliance in association with the judicial history of the cases to the vendor. Vendor is responsible for the oversight and management of all aspects of the contract, including compliance, deliverables, analysis, and all oversight functions.	Almost none. Contract is very prescriptive with itemized policies for each section of the contract for the vendor to follow. Seems to be hiring staffing and not management but emphasizes procuring quality management experience throughout the contract. Continue relationships with educational centers close by that provide interns to fill medical positions at lower costs.	State employs chiefs and assistant chiefs for all medical disciplines that oversee the vendor's work. Requires medical staff hired by the contractor to demonstrate competencies, including demonstrated drills conducted by the state chiefs. Requires 45 reports to be provided daily, weekly, monthly, quarterly or annually.	Termination for cause can be done with 30-day notice of cure and if not cured, 24-hour notice that the state wishes to cancel the contract.

Research Question 2 Results

Research Question 2: In what ways does the contract impact experiences of partnership success?

Hypothesis 4. Differential focus of completeness of contractual terms by public administrator will be associated with different experiences of partnership success.

Findings from the case studies indicate that states may in fact bias contractual terms opposite the contract function that motivated them to engage in the partnership.

Quality Motivated Contracts. For states that reported quality-related motivations at contract start, contractual documents demonstrated greater flexibility and more residual control rights regarding the quality portion of the contract and more completeness and less flexibility with regards to the cost portion of the contract.

Quality related terms reflect a significant degree of residual control rights. Throughout the contracts, vendors are given the ability to create their own plans for medical management and quality oversight. The DOC is intentionally allowing the private vendor the space to management the quality provision of the medical program.

> *"Contractor shall identify conditions that set the frequency of period health assessments."*
>
> *"Contractor shall identify a plan that meets NCCHC and/or ACA standards."*
>
> *"The Contractor shall provide a process by which an internal review of mental health services are developed and implemented. This review is to be completed at both a statewide level and at the specific program/facility level."*
>
> *"The contractor is responsible for making all decisions with respect to the type, timing and level of services needed by Offenders, including, the determination of whether an Offender is in need of clinical care, hospitalization, referral to an outside specialist or otherwise in need of specialized care."*

Often, the contract terms for quality restrictions provide only basic measures of quality expectations. All state DOCs are responsible for minimum quality expectations, and all contracts include minimum expectations. These contracts intentionally leave more specific requirements up to the vendor to determine and execute.

> *"Urgent and priority appointments, those that are specified by the practitioner to be time specific, must occur no later than the date specified by the practitioner's order. If the practitioner specifies a range of dates i.e. two to three weeks, the relevant date shall be the*

latest day within the range specified. All other appointments, herein after referred to as routine appointments, must occur within 75 calendar days of the practitioner's orders."

"Barring other barriers to the provision of treatment, psychiatric providers are generally expected to meet productivity standards: New assessments 40-45 minutes/ 60 minutes at intake facilities; Follow up assessments 15-20 minutes; chart reviews 5 minutes."

"Providers are expected to dictate or write clinical notes and orders on the same day services are provided. Providers are expected to use SOAP note format for all follow-up assessment notes."

However, within these same contracts, the terms outlining the cost function reflect much greater specificity and greater restrictions. This demonstrates an intentionality with respect to the DOC ensuring the process for using financial resources is controlled at higher specifications.

"Per capita payments by [state] to the Contractor are considered comprehensive and shall include all costs to provide health care needs to the population, including, but not limited to: supplies, pharmaceutical costs, administrative overhead costs, treatment and related services, onsite specialty services, offsite specialty services, any hospitalizations covered under this contract."

"Prices shall remain firm for the entire contract period and subsequent renewals. Prices shall be net delivered, including all trade, quantity and cash discounts. Any price reductions available during the contract period shall be offered to the State of [xxx]."

"The Contractor, through the risk share, shall be responsible for practitioner ordered medical prosthetics and medical equipment intended for an individual's personal use. Non-durable medical supplies such as accessories and attachments for durable medical equipment such as but not limited to roho cushions, and masks and tubing for c-pap, bi-pap machines and physical therapy braces and splints will be the responsibility of the Contractor. The contractor shall be responsible for the cost of all other practitioner ordered medical equipment and supplies not herein defined, with same to be funded from the risk share."

"A sum of $XXX payable to the Contractor on or about July 1 annually, shall be set aside for the sole purpose of for the acquisition of equipment."

"The Contractor shall set aside $XXX dedicated specifically to training facility health care staff."

"No monies shall be paid from the Staffing Fund for the purpose of recruiting or retention of Contractor's staffing positions without the prior approval of the State."

"Annual increases, bonuses, moving expenses and/or any incentives provided to the contractor's personnel must be approved by the DOC."

"The State is allotting $25,000 per contract year for these items [pharmacy and eyeglasses at select facilities] which is added to the total obligation. If the cost exceeds $25,000 per contract year, an additional amendment will be completed to address the variance."

Overall, the contracts developed by public administrator's motivated for quality related reasons seem to bias restriction of the vendor on the cost function of the contract and allow flexibility on the quality function of the contract. Therefore, these contracts seem to be more complete in the cost terms and less complete on the quality terms and are associated with greater efficiencies and less partnership disputes.

Cost Motivated Contracts. For states that reported financial-related motivations at contract start, contractual documents demonstrated greater flexibility and more residual control rights regarding the cost portion of the contract and more completeness and less flexibility with regards to the quality portion of the contract.

Cost-related terms of these contracts reflect a high degree of flexibility with limited specifications on how resources provided are to be used. Often, the terms of these contracts outline basic financial resources to be provided with little to no direction on how money is to be spent. Additionally, the terms are more lenient with regards to future provision of additional financial resources to the private vendor in the event the vendor requires additional support. The ability of the DOC to understand how financial resources are used by the vendor is limited within these terms, while allowing the private vendor the space to expect further financial resources as needed.

> *"Operating the health care program in an efficient cost-effective, fiscally responsible manner which demonstrates the philosophy and spirit of transparency through the provision of full reporting and accountability to the state."*
>
> *"[Any change that] materially affects the cost to Contractor in providing the comprehensive health care services or other items or services to be provided hereunder, or impacts the scope of services or staffing hereunder, the contractor and state agree to negotiate in good faith to address any adjustment to compensation or service."*
>
> *"The contractor shall submit the next year's annual per inmate per month rate, including case load and service volume assumptions, annual cash plan to the state for review and approval for the following contract year."*
>
> *"To the extent possible, provide medications through the 340B Drug Pricing Program in a manner consistent with HRSA."*

Moreover, in these contracts, the state may ultimately take some responsibility of the financial risk associated with the production of services. Examples of the state taking on the financial risk include risk sharing and creating capping on what the vendor will be responsible for in certain expense categories. As a result, vendors are not restricted on how to utilize the resources provided and are given even further allowances to overspend in certain cases.

> *"A capitated pay for performance risk based model - [vendor] has offered to share in the risk in two of our most challenging areas Pharmacy and offsite services. Management and overhead fees are fixed."*

> *"Base Compensation: Comprehensive health services and pharmacy will be paid at the PIPM. Offsite services, regional office and corporate overhead and profit will be paid at flat rates. Contractor's responsibility for the cost of provision of catastrophic loss cases, pharmaceutical services, and off-site services will be subject to an annual limit as described further herein."*

> *"The state shall be responsible for all off-site expenses for any particular individual which exceed $85,000 in any contract year."*

On the other hand, these contracts include more restrictions and higher expectations on the quality function of the partnership. In some cases, the state has already created and provided quality requirements (such as policies, procedures, guidelines, and forms) that the vendor is required to use. Again, this demonstrates intentionality on the part of the state DOC with regards to quality specification levels and vendor compliance.

> *"The contractor shall utilize policies and procedures to be furnished that are currently in use. These shall serve as a minimal standard by which the contractor will carry out the services provided to state inmates."*

> *"The contractor shall provide [state] with site-specific policies, procedures, clinical guidelines, pathways and forms which upon [state] approval will replace the policies, procedures, clinical guidelines, pathways and forms as presented by [state]."*

> *"To the extent possible, with or without third party reimbursement, the contractor shall attempt to coordinate with community providers who treated the inmate prior to incarceration."*

> *"Currently the state contracts with an independent contractor to provide external source quality assurance functions with regards to the contract for inmate health services. The state may use an independent entity to perform a medical records review as a component of the quality oversight/auditing process."*

> *"The contractor shall institute a clinical and administrative quality assurance program. The contractor shall include the following in its quality assurance program: provide in-service health care education programs for DOC and contract staff; maintain personnel files on site; hold meetings periodically with DOC officials, facility staff and appropriate contractor staff to review issues and changes and to provide feedback relative to the contractor's quality assurance program."*

> *"The contractor shall maintain 100% ACA accreditation for mandatory and non-mandatory general standards applicable to health care."*

For the states in case study grouping three, the quality expectations are so specific that the state has invested in an internal clinical team so robust that the individual clinical chiefs direct the majority of the

day-to-day operations of the medical vendor. As part of one of those contracts, a listing of each clinical chief and their management of the private vendor is afforded. It is at this point in which the private vendor acts as a staffing company only and a business management focus for medical expenditures.

Overall, the contracts developed by public administrator's motivated for cost related reasons seem to bias restriction of the vendor on the quality function of the contract and allow flexibility on the cost function of the contract. Therefore, these contracts seem to be more complete in quality terms and less complete in cost terms and are associated with greater inefficiencies and more partnership disputes.

Overall Study Findings

Integrating the quantitative survey analysis together with the qualitative case study analysis using contract documents, this study found that public administrators reporting to have quality-related motivation to contract for private medical services experience better contractual outputs, better *ex post* efficiencies and less conflict with longer contract terms. Case study analysis indicates that the contractual terms used for quality motivated public administrators allow greater flexibility for the private vendor to achieve the expected quality levels with more structure placed on how the vendor should use the financial resources provided. Alternatively, cost motivated public administrators reported experiences worse contractual outputs, efficiencies and conflicts during the term of the contract, inclusive of experiencing frequent vendor turnover. The contract documents used by these public administrators indicate a much greater flexibility afforded to the private vendor with regards to use of the financial resources provide (with some even indicating a cost share is available by the state if efficient management of resources is not achievable by the vendor) with an increasingly restrictive quality requirement. Contracts used by cost motivated public administrators seem to include more monitoring and management actions to be completed by both the administrator and vendor. See table 13 below as a summary of the study findings.

Table 13. Summary of Study Findings

Group	Quality Motivated	Cost Motivated
Goal of Public Administrator (PA)	Administrative Strategy to improve quality and obtain expertise in managing the medical program	Pragmatic Strategy to gain financial and managerial efficiencies by having a private vendor leverage business and market competition
Quantitative Findings	➢ Better contract outcomes ➢ Better contract efficiencies ➢ Less contract conflicts ➢ Better satisfaction	➢ Worse contract outcomes ➢ Worse contract efficiencies ➢ Higher contract conflicts ➢ Less satisfaction
Qualitative Findings	➢ Quality function of contract less complete allowing vendor more space to choose how to best achieve the quality expectations ➢ Cost function of contract more complete with control of resources provided dictated by the PA ➢ Limited monitoring requirements for the PA ➢ Collaborative wording for conflict resolution and definitions of contract requirements	➢ Quality function of contract is more complete which restricts the vendor's ability to choose how to most efficiently achieve quality expectations ➢ Cost function of contract is less complete with control of resources provided dictated entirely by the vendor ➢ Greater monitoring and reporting requirements for both the PA and the vendor ➢ Non-collaborative wording for conflict resolution

CHAPTER 5: DISCUSSION OF FINDINGS

Based on the relevant contracting theories, this study hypothesized the following scenario. A prison administrator who decides to outsource the management and production of their prison medical system will do so as either an administrative strategy or pragmatic strategy for program management. Those that outsource as an administrative strategy will look for a vendor that can successfully provide quality of services that the prison administrator cannot provide. For instance, a prison administrator looking for better expertise, services, and quality (understanding that they cannot provide this expertise themselves) would administratively outsource. On the other hand, the prison administrators that outsource for pragmatic reasons do so in order to better control costs. These individuals are looking to leverage the market competition to control costs or improve cost predictability. Therefore, administrators are motivated to either obtain/improve quality or manage program costs.

Both administrators operate in an environment bound by an essential tension created by the reality of finite resources. An administrator looking to (or motivated to) obtain/improve quality will be required to provide more resources than an administrator looking for minimum quality and cost containment. The administrator will construct the contract in the context of the tension existing for the administrator. As a result, the administrator's motivation will have an impact on the structure of the contract. Administrators motivated for quality reasons will be more likely to want to control the quality aspects of the contract outcomes (that is, make the quality aspect more complete with less residual rights). Administrators motivated for cost reasons will be more likely to want to control the cost aspects of the contract instead.

Since the private vendor is profit motivated, a contract that puts more requirements on quality and thus requiring more resources may be more likely to create conflicts and inefficiencies as compared to a contract that does not. Therefore, the study predicted that partnerships with cost-motivated prison administrator will have less conflict (since quality will be less emphasized in the contract) as compared to a partnership with a quality-motivated prison administrator (and a contract with more quality focus).

Findings contradicted the predicted scenario. Based on the case studies, results indicate that prison administrators motivated for cost reasons will in fact focus their contracts on being more complete with regards to the quality items of the contract. For instance, these contracts are more likely to outline medical policies, procedures and requirements than contracts written by prison administrators motivated for quality reasons. Quality motivated administrators, on the other hand, will leave the medical quality sections more incomplete while focusing attention on the resource use, cost management, section of the

contract. Study analysis found an association between being more complete with regards to the quality aspects of the contract and higher rates of inefficiencies and partnership conflicts. While the study scenario linked higher quality specifications and higher rates of inefficiencies and partnership conflicts, the case studies indicate that this is associated with cost-motivated public administrators instead of quality-motivated ones. Overall, the study findings have significant implications for the application of the Incomplete Contract Theory and Contracts as Reference Points Theory.

Theoretical Implications

Incomplete Contract Theory

Incomplete Contract Theory states that the more complex a program becomes, the more incomplete the contract to manage that program will be. This is an unavoidable consequence of the complexity, making identification of all possible contingencies difficult. The assumption that a complete contract is always the goal and only complete contracts will avoid disputes. The theory falls short of exploring levels of incompleteness and relies on dichotomous, and absolute, complete or incomplete value. However, this study suggests that contracts can have levels of completeness and that completeness may not always be a benefit to the partnership.

The case studies evaluated contract completeness along the dimensions of cost and quality and found that prison administrators intentionally focused completeness on sections of the contract where they felt particular risk. This seems natural. The prison administrator contracting for cost containment, most likely felt that the biggest risk posed was the vendor containing costs to the point of risking quality. Therefore, these contracts spent more time making the quality section complete versus the cost section. The opposite held true for the quality motivated administrators. Those motivated for quality purposes, spent more time ensuring that the resource management sections were more complete to ensure financial resources were spent on areas at highest risk of being cut (such as training and equipment). Therefore, these contracts, while all being incomplete, are incomplete in very different ways.

The differences in the distribution of incompleteness within the contracts had very important impacts on the experiences of the partnership. A contract being more complete effectively reduces or eliminates flexibility from the private vendor in making determinations on how to best achieve the expected outputs. For the comprehensive prison medical contracts, the contracts that were more incomplete on the quality sections provided significant flexibility to the private vendor with regards to how to manage and produce the service. On the other hand, the contracts with more complete quality sections really restricted the private vendor in significant ways. The quality restriction on the vendor

correlates to more conflicts and lower efficiencies. These findings suggest that a complete contract may not in fact be the desired goal for complex partnerships.

Moreover, incompleteness in a contract may be a strategic move that can enhance or enable the vendor's strengths. If the contracted vendor's strength is to ensure utilization management, or develop appropriate policies, procedures and guidelines, then allowing the vendor the flexibility to develop these items without complete contract terms may best allow the vendor to reach their full potential. This is in comparison to a contract that will require use of already existing policies, procedures and guidelines. A company that develops the policies and procedures themselves will have an easier time following, enforcing and management resources for those guidelines as compared to adopting foreign policies and procedures they have to learn on day one.

Contracts as Reference Points Theory

Contracts as Reference Points Theory states that the terms and conditions agreed to at time of contract negotiation and execution create perceived entitlements for both parties. Both parties evaluate achievement of these entitlements throughout the contract and either party may feel aggrieved if they perceive an entitlement not being met as expected. The findings from this study suggests that public administrators reflect their perceived entitlements via the more complete sections of the contract, which findings suggest is the opposite function of their motivation to contract.

As noted, administrators with cost-related motivations put more complete terms into the contract outlining their perceived entitlements to certain quality levels. Whereas administrators with quality-related motivations put more complete terms into the contract outlining their entitlements to resource management uses. The completeness of these sections reflects what the administrator perceives as the biggest risk of the partnership and their work to ensure their entitlements are clearly communicated to the other party. This exemplifies the balancing act the prison administrator is trying to achieve with regards to the existing essential tension of resource provision and quality assurance.

The differences in risk perception (either decrease in quality or decrease in resource spending) further emphasize the underlying administrative or pragmatic strategy being leveraged by the public administrator. The difference in strategies and difference in risk management results in the administrators effectively purchasing different commodities even if the contract is for the same service with the same vendor.

Commodity Implications

For states motivated for quality-related reasons, the commodity being procured aligns more with expertise in prison medical care services. For states motivated for cost-related reasons, the commodity being procured aligns more with expertise in controlling medical care spend. In the realm of medical care management, these two commodity types are fundamentally different. Take a hospital as an example. Physicians and clinical personnel manage ensuring the services being provided meet a certain level of quality, whereas the business and financial personnel manage ensuring appropriate resource utilization is achieved. The experience, education and skill set are markedly different between these two groups.

Based on these different interpretations, the structural set up of the contractual terms and the residual control rights deemed important by the public administrator to be allowed for vendor flexibility vary drastically. Each state seemingly provides to the vendor the residual control rights felt appropriate for sufficient flexibility in which the state will receive the most optimal use of the vendor's expertise. For public administrators reporting cost-related motivations, these contracts provide more residual control rights to the vendor with regards to resource management and use. Whereas, public administrators reporting quality-related motivations, the contracts provide more residual control rights to the vendor with regards to quality management and clinical service production. Each public administrator is expecting the private vendor to maximize the use of the procured skill set; either quality management or business efficiencies. The public administrator provides the flexibility to use these skills while wanting to control the outcome on the function where the perceived skill set is lacking.

An administrator looking for a business skill set to control and manage costs, expects those skill sets to not also be able to effectively manage the quality aspect and therefore places more specifications on that function of the contract. Alternatively, a public administrator looking for a quality improvement skill set may expect that skill set to be lacking in the ability to appropriately manage the business aspect of the partnership and may place more specifications on this side. Each administrator writes the contract to maximize the commodity skill set being procured and guide and control the commodity skill set not directly being procured. Therefore, it is indeed the portion of the contract opposite the motivation (e.g. the quality function of the contract for cost-motivated agencies) which seems to be more restrictive complete with residual control rights restricted for the vendor. This is contrary to the hypothetical expectation at the start of the study that the public agency will make the portion of the contract reflective of their motivation more complete.

The difference in commodity interpretation and more completeness of the contract opposite the motivation has significant implications for the way in which states address the management of the primary risk. For states motivated for quality-related reasons, these states seem to address management of the primary risk by protecting resource use and encouraging maximum spend on quality. That is, the cost portion of the contract is more explicitly outlined to protect and encourage resource utilization. Examples include terms requiring use of certain funds for specific purposes (e.g., training and equipment) where the private vendor may have the lowest motivation to use the resources for those purposes; terms that protect a certain level of profit with no expectation that the vendor can achieve any higher profit than that given; and return of any unused funds back to the state at the end of the contract year and project. All of these examples emphasize ensuring resources provided by the state are used to the maximum capacity by the vendor, even for items that the vendor is not motivated to pursue and eliminate any motivation by the vendor to restrict resources.

However, quality-motivated states provide contractual allowances to the private vendor that gives flexibility and freedom on how to achieve the required quality levels, which would seem to maximize the intended benefits of procuring a private vendor for the services for these states. As mentioned previously, these states interpret the commodity as being experts in quality medical care production. By providing allowances and flexibility in medical care production, these states will receive the most optimal value from the vendor for the state's purchase. Examples of this include allowing the vendor to develop and use their own medical management guidelines and policies; allowing the vendor to assist in quality metric development and reporting strategies; and minimizing the prescribed oversight of the vendor *ex ante*. With the focus of these states on addressing the risk of resource restriction while still allowing the private vendor the residual control rights to bring their expertise and experience to the partnership seems to achieve an optimal balance for both partners, alleviate the burden of monitoring and management for both partners and significantly decrease the likelihood of experience issues and negative partnership behaviors within the contract term.

On the other hand, states that are motivated for cost-related reasons seem to focus their contracts on ensuring a certain level of quality and thereby indirectly controlling resource use and management. These contracts provide the same fixed-price contracts with little in the way of resource management, except for requiring increased levels of monitoring and reporting. Even with the monitoring and reporting, the state has little in the way of enforcing any directive with regards to money management of the private vendor. However, these contracts spend a great deal of time outlining specifications for quality measures and reporting metrics. It seems that these states understand that a decrease in quality is the greatest risk associated with the contract and focuses on ensuring that risk is addressed. Yet, by

placing a greater burden and prescription on requirements for quality measures, monitoring and enforcement, the public administrator essentially restricts the private vendor's use of resources provided. The essential tension of the partnership dictates that an increase in quality will necessitate an increase in resource use. These states procure a skill set to be efficient but are indirectly restricted in being able to achieve maximum efficiency as a result of the detailed quality requirements provided.

Essentially, the terms of the financially motivated contracts place a unique pressure to increase quality while being motivated to contain cost that may drive inefficiencies and partnership disputes. The prescribed quality measures work contrary to encouraging efficient resource management. The private vendor continues to be motivated towards cost savings and a profit drive with added stress of specified quality levels. With the stress of saving money and the added stress of improving quality, the vendor and public administrator are more likely to experience entitlement disagreements and negative partnership behaviors. Even though the motivations converge for the two partners, the method in which the partnership is structured seems to undermine the convergence and actually manifests a divergence of understanding. The state is motivated to save or control costs yet focuses the contract on quality levels.

In review of the contract documents, it was discovered that all states that are financially motivated engaged in some form of risk sharing with the private vendor. This is evidence of the significant stress placed on the essential tension of these partnerships. The public administrator places significant prescription of the quality measures which limits the private vendor's business management abilities and the state then compensates for this restriction by providing more funds.

Study Recommendations and Conclusions

This study provides evidence that the motivation held by an individual writing a contract may differentially impact the terms and completeness of the resulting contract. Moreover, the motivation of that individual may also impact the perception of the commodity being procured. This difference in perception results in different terms of the contract and may result in drastically different experiences of the partnership. These experiences may be tied to different levels of stressors placed on the quality-cost essential tension of the partnership as a result of the public administrator's placement of afforded residual control rights.

Based on the study results, public administrators should draft contracts that ensure appropriate and sufficient flexibility for the private vendor to be able to achieve the highest outcome of the skillset being procured by the administrator. This means that the administrator must reflect well on what services are ultimately being contracted for and allow for designed incompleteness in the contract terms that

reflect this skill set. When writing contracts, the public administrator should focus their energy on creating more completeness for the portion of the contract that compliments the skill sets being purchased. For instance, if the administrator is contracting for a service, the vendor should be given flexibility on how to perform the service (more incomplete section) with the financial management of the contract to be more complete. The understanding being, the public administrator is purchasing an expert in providing the service, but that expert is most likely not also an expert in financial management. On the other hand, if a public administrator is purchasing a service to manage the cost of a service, the contract should be more complete with regards to the definition of the actual service. The expertise being purchased is cost management, but not directly production of the service. Essentially, the public administrator should let the vendor have the rights to manage the services their skill sets provide but ensure the risks associated with non-skill set work that the public administrator wants to control is appropriately communicated to the vendor and managed by the public administrator.

The findings also suggest that the public administrator achieves the best partnership outcomes when outsourcing as part of an administrative purpose. For those situations where the administrator is self-aware that an outside vendor would be better at managing and producing the entire service and focuses the partnership on those services (managing and producing) at the level of quality the administrator would provide, the partnership seems to naturally be better structured. These contracts allow the flexibility the vendor needs and the protections the administrator requires with the best outcomes achieved.

On the other hand, the partnerships created as part of a more pragmatic strategy seem to encourage market efficiencies by providing flexibility with resource use to the vendor, but ultimately restricts the vendor's flexibility in production decisions which negated the ability to leverage market efficiency. The contract structure for those used in a pragmatic strategy made the strategy ineffective. The only way for the vendor to have the ability to engage in market efficiency is by allowing the flexibility and control to make production decisions, not just resource use decisions. At the end of the day, a contract with a private vendor done as part of an administrative strategy will most likely achieve pragmatic benefits if the contract allows the vendor to do so.

In the case studies, contracts that progressively became more restrictive and complete with regards to the quality decisions reflected increasingly more control by the prison administrator. This increased control indicated an investment by the department in internal expertise and management staff. For these situations, the conflicts with the private vendors were the highest experienced by the prison administrators as the private vendor was under significant oversight and control by the internal staff. A

consideration for these states may be to continue investment in internal skill set development (e.g. the business management expertise) that the contracts are ultimately attempting to procure. Contracts with extensive quality control mechanisms are truly purchasing management skills instead of medical production skills. Therefore, these states may most efficiently manage their medical system through self-operation, as the state has already developed and is using medical policies, procedures and guidelines. Additionally, these states are already managing the system by the medical expertise on staff. As such, self-operation may be more efficient due to the elimination of the burden on monitoring, managing and addressing vendor conflicts throughout the contract term. Even if the cost of self-operation was equivalent to the cost of having the vendor manage the program, the overall transaction costs of the program will be less for the state staff than continuing with these contracts.

Future Research

This study is limited by the small sample size and exploratory analysis but is possibly the first study to evaluate the public administrator's motivation in relation to contract structure and partnership conflicts experienced. Previous research has separately evaluated partnership contracting and partnership conflicts and not the public administrator's motivation. As an active participant in the contract structure and negotiations it makes sense that the administrator's thoughts and feelings, including motivations and entitlements, be taken into consideration on this topic. The field would further benefit from research in this area. In particular, further research evaluating the connection between an administrator's motivation, applicable strategy (administrative, pragmatic or political) and contract completeness would be useful in making more clear connections on the impact of motivation and contract design for future predictability models. Additionally, further research performed in this field would benefit from acknowledging and including the inherent essential tension that all public administrators must balance for new contracts created. While this concept is included more fluently in other disciplines, it will help to incorporate it further into public policy and administration. Lastly, evaluating contract design and the connection to partnership conflicts in greater detail and larger sample size would further develop the understanding of the nuances of contract completeness and associated impacts.

APPENDIX A: SURVEY INSTRUMENT

SURVEY INSTRUMENT

What state are you responding for?

What is your name?

What is your title?

ALL RESPONDENTS

a. Please indicate which type of inmate medical delivery system you currently use throughout your facilities:
   - ☐ Direct Provision - All inmate medical care is managed/delivered by state employees (but not a state university system)
   - ☐ Private Outsourced Provision - All inmate medical care is managed/delivered by one or more private companies
   - ☐ Hybrid Provision - System with some medical care managed/delivered by state employees and some managed/delivered by one or more private companies (Includes answers for both outsourced comprehensive set of medical services and outsourced individual discrete services such as dialysis, mental health, pharmacy, etc.)
   - ☐ University Provision - All inmate medical care is managed/delivered by a state university system
   - ☐ Other: _____.

a2. How long have you had this type of medical delivery system?
   - ☐ Up to 2 years
   - ☐ Between 2 and 10 years
   - ☐ Over 10 years

DIRECT PROVISION → GO TO QUESTION **n**
OUTSOURCED PROVISION → GO TO QUESTION **b**
UNIVERSITY PROVISION → GO TO QUESTION **b**

OUTSOURCED PROVISION

b. How long has your agency used your current contract vendor for inmate health care services?
   - ☐ Up to 2 years
   - ☐ Between 2-7 years
   - ☐ Greater than 7 years

c. (For respondents answering "Up to 2 years" in Question b) If your agency has switched vendors in the last two years, please answer the following questions for the most recent previous vendor.

d. Which part(s) of your inmate medical delivery system do you outsource?
   - ☐ A comprehensive set of medical care is managed/delivered by the university or private company
   - ☐ The agency uses the university system or private companies to manage/deliver discrete services (e.g. mental health, dialysis, pharmacy, etc.)
   - ☐ Our agency used many university systems or private companies to manage/deliver the combination of a Comprehensive Set and Discrete Services

e. Please indicate **up to three** primary *motivations of your agency* for outsourcing some or all of your inmate medical care system.
   - ☐ Contain rising medical costs
   - ☐ Make medical cost more predictable
   - ☐ Obtain medical expertise and/or medical management that the agency does not have
   - ☐ Obtain flexibility to recruit and retain medical staff restricted by state reimbursement limits
   - ☐ Obtain general flexibility that otherwise would be restricted through a bureaucratic process
   - ☐ Decrease the legal liability of the state
   - ☐ Political pressure put on agency to control costs
   - ☐ Political pressure put on agency to improve quality
   - ☐ Political pressure for other reasons
   - ☐ In response to previous or current lawsuits or settlement agreements
   - ☐ Other:_____

f. Does your state legislature, or other governmental body, require you to provide reports on the cost and/or quality of the inmate medical delivery system?
   - ☐ Yes
   - ☐ No

g. Does your agency complete any internal reports on the cost and/or quality of the inmate medical delivery system?
   - ☐ Yes
   - ☐ No

h. What is the focus of any report or analysis? (Choose all that apply)
   - ☐ Cost of inmate medical care
   - ☐ Utilization of inmate medical care (including changes in utilization rates over time)
   - ☐ Quality metrics of inmate medical care
   - ☐ Comparison of outsourced medical services versus medical services managed/delivered by state employees
   - ☐ Other (Open box)

i. Does your agency perform ad hoc (one time, as needed) or routine unofficial analysis of cost or quality metrics for outsourced medical care?
   - ☐ No
   - ☐ Yes, we review metrics sometimes but infrequently
   - ☐ Yes, we frequently review metrics but not as a set routine
   - ☐ Yes, we have a set schedule to review metrics for outsourced medical care

j. Do you have the ability to easily obtain cost or quality information from your university or private vendor?
   - ☐ Yes
   - ☐ No
   - ☐ N/A, the university system or private vendor provides reports and direct data is not needed by the agency

k. If you are able to obtain information from the university system or private vendor, do you request and/or use this information for analysis?
   - ☐ Yes
   - ☐ No

l. If using private medical vendor for inmate medical care management/delivery, do you feel that the market for inmate medical care vendors is sufficiently competitive? [choose one answer]
   - ☐ Yes, we are able to select among many qualified vendors
   - ☐ Yes, for small vendors for discrete services but not large vendors providing the comprehensive set of inmate medical care
   - ☐ Yes, for large vendors providing the comprehensive set of inmate medical care but not smaller vendors for discrete services
   - ☐ No, our ability to choose a vendor is limited by few to choose from
   - ☐ N/A, we use a university system
   - ☐ N/A, we were required to use a specific vendor

m. Please rate your experience with the below based on your current partnership for inmate medical care provision.

	Improved	***No Change***	***Worsened***
Cost of Medical Expenditures			
Cost Predictability of Medical Expenditures			
Medical Quality Measures			
Quality of Medical Staff to Manage/Deliver Care (either in quantity or expertise)			
Level of Competition for Services			
Level of Bureaucratic Red Tape in Managing/Delivery Care			
Inmate Litigation about Medical Care Provision			
Inmate Medical Care Scrutiny from Legislative Body			
	None	***Minimal***	***Significant***
Administrative Burden of Contract Monitoring			
Administrative Burden to Manage Contract			
Vendor being Politically Active			
Number of Submissions to Evaluate from RFPs			
Staffing Shortages at Outsourced Institutions			
Request for Additional Funds After Contract Execution			
Conflict with Medical Vendor over Contractual Terms			

DIRECT PROVISION SECTION

n. Has your agency outsourced the medical delivery system in the past?
   - ☐ Yes
   - ☐ No

o. Please indicate **up to three** primary areas that would *motivate your agency* to outsource some or all of your inmate medical care system.
   - ☐ Contain rising medical cost
   - ☐ Make medical cost more predictable
   - ☐ Obtain medical expertise and/or medical management that the agency does not have
   - ☐ Obtain flexibility to recruit and retain medical staff restricted by state reimbursement limits
   - ☐ Obtain general flexibility that otherwise would be restricted through a bureaucratic process
   - ☐ Decrease the legal liability of the state
   - ☐ Political pressure put on agency to control costs
   - ☐ Political pressure put on agency to improve quality
   - ☐ Political pressure for other reasons
   - ☐ In response to previous or current lawsuits or settlement agreements

p. If your agency outsourced inmate medical care management/delivery in the past, please indicate which type of system was used.
   - ☐ Direct Provision - All inmate medical care is managed/delivered by state employees (but not a state university system)
   - ☐ Private Outsourced Provision - All inmate medical care is managed/delivered by one or more private companies
   - ☐ Hybrid Provision - System with some medical care managed/delivered by state employees and some managed/delivered by one or more private companies (Includes answers for both outsourced comprehensive set of medical services and outsourced individual discrete services such as dialysis, mental health, pharmacy, etc.)
   - ☐ University Provision - All inmate medical care is managed/delivered by a state university system
   - ☐ Other: _____

q. If your agency outsourced inmate medical care management/deliver in the past, please indicate the **primary** reason your agency is no longer using private vendors for inmate medical care service delivery.
   - ☐ Medical vendor entered into an agreement and quickly indicated they could not perform in accordance with the initial contract agreement.
   - ☐ Medical vendor unable to provide service needed and ended contract
   - ☐ Quality provided by medical vendor was sub-standard and agency ended contract
   - ☐ Medical vendor had financial problems and could not continue contract
   - ☐ Medical vendor required more funds than agency could provide, and agency took over management/delivery
   - ☐ State political body instructed to manage/deliver inmate medical care in an alternate fashion (e.g., state employees or university provision)
   - ☐ Legal case that led to new medical delivery setup
   - ☐ Other (comment box)
   - ☐ N/A, did not outsource in the past or unknown

r. If your agency outsourced inmate medical care management/deliver in the past, how long ago did your agency switch from using private vendors to state employees for inmate medical care management/delivery?
   - ☐ Up to 1 year
   - ☐ Between 1 and 5 years
   - ☐ Between 5 and 10 years
   - ☐ Greater than 10 years

FOR ALL RESPONDENTS

s. Have experiences with private medical vendors in other states impacted your thoughts or behaviors of using a private medical vendor?
   - ☐ Yes
   - ☐ No

t. Have judicial rulings in other states impacted your thoughts or behaviors of using a private vendor for inmate medical care management/deliver?
   - ☐ Yes
   - ☐ No

u. Have judicial rulings in your own state impacted your thoughts or behaviors of using a private vendor for inmate medical care management/delivery?
   - ☐ Yes
   - ☐ No

v. Would you recommend privatizing prison medical care to surrounding or similar states?
   - ☐ Yes
   - ☐ No

w. Please rate your agreement with the following statement: I am very satisfied with my current inmate medical delivery system.
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Disagree
   - ☐ Strongly Disagree

x. Please share any additional comments you feel are important regarding this topic (open box)

Please indicate if you wish to receive a copy of the analyzed results of this survey:

☐ Yes, please enter email address for analysis to be sent _____ ☐ No

Please indicate if you wish to receive a copy of the consent form for this study:

☐ Yes, please enter email address for consent to be sent _____ ☐ No

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