ACCOUNTABILITY IN EMERGENCY:

OIG OVERSIGHT OF FEMA'S DISASTER AWARDS

A Thesis

Presented to the faculty of the Department of Public Policy and Administration

California State University, Sacramento

Submitted in partial satisfaction of
the requirements for the degree of

MASTER OF PUBLIC POLICY AND ADMINISTRATION

by

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SUMMER

2020

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Abstract

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ACCOUNTABILITY IN EMERGENCY:

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America is living in a time of complex emergencies, and FEMA is the principal government entity tasked with managing them. To do so, it relies heavily on awarding public funds to private entities. It is unclear the extent to which FEMA and its awardees perform to expectations, and how FEMA is held accountable for its performance. While there are many different models for public accountability, there is little consensus on what is most effective, with hybrid approaches used for contractor-preferred environments. Accountability in the federal government primarily relies on the Office of Inspector General (OIG) model, which provides Legislative Branch oversight in every Executive Branch entity. For emergency management contracting specifically, the OIG model appears to have been minimally effective over the past two decades. A combination of remedies is the best policy path forward. Any major change appears likely to be delayed until after another catastrophic disaster, due to emergency management policy conforming to the *punctuated equilibrium* theory of policy change.

_____, Committee Chair
Sara McClellan, PhD

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Date

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1. INTRODUCTION

At the time of publication, COVID-19 has killed at least 150,000 Americans and infected at least another 5 million (Centers for Disease Control and Prevention [CDC] 2020). This is despite the government shutting down most of the economy for several weeks. While the full human and economic damage is still unknown, 2020 will clearly be another catastrophic disaster year. The national guard deployed in New York, California, and Washington, and FEMA issued a major disaster declaration for the entire country. Despite months of time to act, the government has still not acquired enough lifesaving intensive-care ventilators, personal protective equipment (PPE), or enough testing kits to accurately track cases. Although this year's pandemic is unique, America has recently experienced several catastrophic disasters that exposed deep flaws in our emergency management systems. In 2017, the worst hurricane season since Katrina in 2005, dozens of scandals underscored management and accountability problems that likely cost American lives.

Earlier this year in Puerto Rico, an entire warehouse of bottled water and other essential supplies was discovered, completely unused during the catastrophic 2017 hurricane season. At the end of 2019, the U.S. Attorney's office arrested a former FEMA Deputy Regional Administrator for fraud and bribery tied to a $1.8 billion contract for repairing Puerto Rico's electrical grid. Various scandals tied to Puerto Rico's disaster contracts led to the resignation of both the FEMA Administrator and Secretary of the Interior. Just last year, Americans witnessed the fourth impeachment of a President in history, and the third in only five decades. Impeachment was initiated by a confidential whistleblower complaint to the Office of Inspector General (OIG), the primary watchdog across the federal government. Since then, the President has fired at least three Inspectors General. These scandals arise at a time when numerous socio-economic and environmental crises are also coming to a head.

Increasingly severe climate change-driven disasters loom ominously in our future (Cook et. al., 2016). Broadly speaking, all climate zones are becoming warmer and all weather patterns are becoming

more severe, with catastrophic disasters becoming more frequent (UN-ISDR, 2009). According to the National Aeronautic and Space Administration (NASA) (2018) and the United Nations Intergovernmental Panel on Climate change (IPCC) (2014), climate change's costs will increase alongside temperature increases, with a 1-5 degree Celsius rise now unavoidable. Current emissions levels continue to increase and are on track to create a runaway form of warming in a potentially unstoppable positive feedback loop (IPCC, 2018; Steffen et. al., 2018, pp. 1-2). The likely outcome based on available models is that climate change will cause increasingly severe and frequent disasters, with financial damages and other costs spiraling out of control (Bouwer, 2011). These impacts will not necessarily become emergencies or disasters, unless humans fail to (a) reverse or (b) adapt to this global event. It is imperative that public policy makers proactively integrate planning for both global warming and emergency management, and the catastrophic costs they will incur (Schneider, 2011).

As climate change exacerbates and accelerates disasters, Americans are also facing a convergence of other kinds of crises. Economically, the country is at its most unequal, based on data since these metrics were first collected (Stone, Trisi, Sherman, & Taylor, 2019). The #MeToo movement highlighted deep gender inequality (Kearl, Johns, & Raj, 2019). Politically, American society appears to be at its most polarized since World War II (Pew Research Center, 2017). Racially, tensions over inequality of wealth, income, and treatment under the law are highly visible (Dimock, 2017). The country has just experienced the most widespread and destructive protests over racism and police accountability since the 1960's civil rights movements. Amidst all of this, the COVID-19 disaster may create the worst economic depression in decades, exacerbating these pre-existing fault lines.

These dramatic policy and political events provide the backdrop and inspiration for this thesis, which analyzes key concepts and mechanisms of public accountability. Holding those with power to account is an essential public policy issue for any democracy. This thesis explores accountability in the realm of public emergency management contracts, given increasing contracting out of public services

alongside increasing emergencies. It analyzes how the current "OIG model" holds accountable public contractors and the agencies using them. Specifically, it asks: Has the OIG model of oversight substantially impacted FEMA's accountability practices for federal emergency management awards?

Thesis Structure

This interdisciplinary public policy and administration thesis analyzes how concepts and mechanisms of public accountability have changed over time. More specifically, it examines the effectiveness of the OIG model of oversight, the key federal government-wide accountability mechanism. To do so as thoroughly as possible, it is comprised of five chapters. This introductory chapter explains why public contracting accountability is so relevant and explains the basics of public contracting and emergency management. The second chapter details the qualitative methodology used to answer the key question. The third chapter reviews the academic literature on accountability. The fourth chapter analyzes relevant GAO, OIG, and FEMA reports. The conclusion discusses policy implications.

The specific form of qualitative analysis used in this thesis is process-tracing, a subset of content analysis that interprets patterns in documents and policies to interpret historical and mechanical cause-and-effect relationships (Beach & Pedersen, 2019). The academic literature review is part of my content analysis. Based on the literature, I create a three-part critical framework for understanding current issues in public contracts accountability. The chapter on key findings lays out my interpretation of the policies, histories, and presumably causal processes traced over years of primary OIG and FEMA documents. The time frame in question runs from the focusing events 9/11 and Hurricane Katrina up through 2019. In the final chapter, I consider the public policy and administration implications by applying the three-part critical framework developed through the available literature. I suggest possible reforms for improving public accountability policies, based on the relative effectiveness of the OIG model thus far.

Topic Relevance

Public emergency management contracts exemplify the importance and complexity of public accountability. Much of emergency management appears to be an *inherently governmental function* (IGF): something that should rarely be contracted out (Verkuil, 2005). However, an emergency's very nature means that it requires rapid responses to unpredictable situations, so contracting will always be required to some extent. Historically, private entities have performed the majority of emergency management public services. As climate change causes disasters to occur more frequently and with greater severity, more money will be spent, more lives lost, and more property damaged. The FEMA model of emergency management favors providing federal funds to state and local partners or private entities. The main mechanism for oversight across the federal government, including contracting, is the OIG model. OIG's effectiveness is essential to saving - not wasting - money, property, and lives in a disaster. How effective OIG is impacts how well FEMA and its many awardees perform when lives are on the line.

Theorists and policy makers have highlighted issues with contractor accountability for decades, from NASA and the Challenger explosion (Romzek & Dubnick, 1987) to intelligence and the 9/11 terrorist attacks (9/11 Commission, 2004). Emergency management is one of the few public services that has substantially grown in terms of budgets, bureaus/agencies, and employees, despite a decades-long trend towards preferring private, market-based solutions over government solutions. Despite this growth, however, most of FEMA's funding each year is spent on private awardees. This contractor-preferred approach, variously referred to as New Public Management (NPM), *hollowing out* the state (Milward & Provan, 1993), or neoliberalism, has led to vast sums of money being awarded to private entities to deliver essential public services. For emergency management, and at the scale of federal government spending, this has led to numerous scandals tied to losses of money or, more seriously, American lives. As climate change causes emergencies to become increasingly frequent and severe, policy makers must

plan proactively, rather than react to scandalous failures. Unfortunately, the current paradigm of oversight appears unable to prevent serious mistakes, or even malfeasance. Below is a brief cross-section of recent scandals that illustrate systemic issues and the importance of a functional accountability system.

Scandals and Costly Mistakes

One highly visible scandal concerns the Council of Inspectors General on Integrity and Efficiency (CIGIE). That group is part of the Government Accountability Office (GAO), which is part of the Legislative Branch. CIGIE is comprised of all OIG Directors for each cabinet-level Department and independent Agency. They are currently suing the Justice Department over the OIG whistleblower complaint and retaliation that kickstarted impeachment proceedings (CIGIE, 2019). GAO has ruled that the whistleblower and OIG acted properly, while the President's actions were illegal (GAO, 2020). More recently, the President fired the intelligence community's Inspector General, who defended OIG's actions contributing to impeachment. So far, this President has also fired the Inspector Generals for the State Department, Health and Human Services, and Department of Defense (DoD). The President has also removed a Special Inspector General from overseeing the $2 trillion Coronavirus Aid, Relief, and Economic Security Act (CARES) Act spending. This highly visible political tension related to Legislative Branch oversight of Executive Branch power highlights a fundamental macro-level question of checks and balances in a democracy. OIG's daily work auditing Departments and bureaus/agencies highlights the same fundamental tensions on a more mechanical and administrative level.

One of the most widely studied examples of contracting issues is DoD, which has the largest discretionary part of the federal budget. DoD contracting is too expansive a topic for a Master's thesis, but it deserves a brief mention. DoD was recently forced by OIG to publicly disclose Department-wide fraud findings. From FY12-17, DoD had over 1,000 fraud-related criminal convictions, and over $368 million in damages recovered from 469 contracts (DoD, 2018a). Only in 2018 did DoD complete its first full audit ever in American history (DoD, 2018b). That was despite OIG classifying DoD as *High Risk*

since at least 1995, and requesting audits each year since then (DoD, 2018c). Unfortunately, while the audit uncovered substantial material issues, the audit itself was unable to adequately access and analyze required DoD information (GAO, 2019a). In short, DoD proved so convoluted that the audit could not even be completed. This inadequate oversight offers a segue into the more manageable issue of FEMA.

One of the most highly-visible recent federal emergency management scandals outside of the current pandemic was a $300 million no-bid sole-source award to a tiny Montana-based company, Whitefish Energy, owned by an individual acquainted with then-Secretary of the Interior Ryan Zinke (Wamsley, 2017). First, this scandal underscored common concerns in public contracts, such as improper awards to entities close to a person in a position of power, or awards to clearly incapable companies. Second, 2017 was the worst hurricane season since FEMA's creation in 1979, but that season appears indicative of future climate change crises. Finally, it highlighted common misunderstandings about how federal emergency management functions, as the award was not actually a FEMA contract. Instead, this contract was set up by the Puerto Rico Electric Power Authority (PREPA), which invoked FEMA's name and funding. In theory, federal disaster dollars would likely have eventually flown from Congress through FEMA to PREPA. However, public outcry and the obvious incapability of the contractor led to its cancellation. This particular contract scandal appears illustrative of a broadly ineffective federal government response to Hurricane Maria in Puerto Rico.

Mismanaging such a large sum of money for a service as essential as electricity underscores more widespread efficacy and accountability issues for the entire Puerto Rico response. OIG audits of the 2017 disaster responses found serious issues with FEMA awards that reflect public perceptions of mismanagement. For example, FEMA awarded over $30 million via two contracts to Bronze Star LLC for emergency housing supplies in Puerto Rico. The Contracting Officer (CO) did not check the company's capabilities and did not consult pre-existing emergency contractor source lists. That led to a

four-week delay of these supplies reaching Puerto Ricans, as detailed in a harsh OIG report (OIG, 2019b). As detailed later in this thesis, these mistakes were widespread and well-known before 2017.

FEMA's federal-to-state grants also have serious issues. One key FEMA program provides funds to states for buying out flooded homes from property owners, so that the property owners can relocate, and those sites can stop having residences built on them (FEMA, 2018b). Unfortunately, the average time to complete those transfers of ownership and of finances exceeds five years (Weber & Moore, 2019). During this time, the property owner must pay for wherever they currently reside, as well as pay for their past property mortgage and/or maintenance. Another example is FEMA's acquisition of mobile homes for emergency shelters in 2017, for which it paid approximately $65,000 each; after two years, they were all auctioned off at substantially lower prices (Rodriguez, 2019). Yet another example is New York City's fraudulently billing FEMA for reimbursement for millions in property damage due to Hurricane Sandy, when that property was discovered to be damaged long before (Schwartz, 2019; DoJ, 2019).

Additionally, the scandals FEMA encounters are not limited to financial waste. FEMA recently leaked over 2.5 million disaster aid recipients' personally-identifiable information, including almost 2 million recipients' bank accounts (FEMA, 2019b). In terms of abuse of power, an audit revealed that former FEMA Administrator Brock Long spent over $151,000 public dollars on his private travel, including family vacations - but then was ordered to repay less than 2% of that (Lippman & Kullgren, 2019). Yet another example of leadership, power, and accountability concerns the newest FEMA Administrator, Pete Gaynor, who does not acknowledge any connection between climate change and increasing disasters (Wallace, 2019). Many of these examples caused substantial public outcry and media attention. The previous FEMA Administrator and Secretary of the Interior both resigned amidst scandals and investigations. These cases illustrate important concerns with how public entities deliver essential public services and what happens if these entities violate public trust. It appears clear that despite established or potential oversight tools, holding public agencies accountable continues to be a significant

challenge. This challenge is made even more difficult by the complexity of federal spending, federal emergency management contracts, and the growing intensity and frequency of emergencies. The next section explains the relevance, scale, and complexity of federal government spending.

Federal Spending

At such a large scale as the federal government, public spending has profound impacts on the economy (Cogan et. al., 2010). On whom and on what the government spends money can substantially benefit both a specific awardee and a general industry. Government spending is typically broken into in-house spending on government-produced or -owned supplies, services, and employees, or on awards of dollars to contractors and grant recipients (Audet, 2003). Bovens (2014) agrees that it is fair to divide up public service delivery into that provided by a public entity and that which is contracted out, with each using both formal and informal accountability mechanisms. Governments of any kind always spend on their human capital and contract out to procure at least commercial items for daily operations. Generally speaking, contracting out public services has increased since the 1990s (Light, 2017).

It is difficult to research and analyze federal government spending for many reasons, primarily due to its sheer scale and complexity. In FY18, the federal government took in about $3.3 trillion, and spent about $4.1 trillion. This spending funded the missions of the Executive Branch's 15 Cabinet-level Departments and 54 independent agencies, the Legislative Branch's Congress and its 8 agencies, the Judicial Branch and its 11 agencies, and the White House and its 11 offices (US Government Publishing Office [GPO], 2020). Within each governmental unit are hundreds of programs and sometimes thousands of employees and contractors. In FY18, 40% of all discretionary spending was awarded to non-governmental entities (GAO, 2019b). About $550 billion of discretionary spending was private awards, an increase of 25% (~$110 billion) more than the ~$440 billion in FY15 (GAO, 2017a).

Beyond basic, top-level dollar amounts, there is very little standardized data publicly available. Spending is typically broken down by *mandatory* or *discretionary*. Mandatory spending is clearly and

indefinitely funded by specific taxes and paid to specific parties, with Social Security as the best example. Discretionary spending is directed by an appropriations bill or continuing resolution each Fiscal Year, and is funded by general taxes and other revenues, or through debt. Mandatory spending is based on clear revenues and expenditures specified by statute, so discretionary spending varies the most. Discretionary spending can be broken down in many ways, with very little standardization government-wide, other than whether it was in-house or awarded (GAO, 2017a; Department of the Treasury [USDT], 2019). Discretionary spending is typically further split into two very broad categories: defense or non-defense. This is because the overwhelming majority of discretionary spending is on defense/the military (USDT, 2019). Other than these two broad categories of (a) in-house or awarded and (b) defense or non-defense, accounting for federal government discretionary spending is an exercise in puzzle-making.

Recent initiatives to supplement GAO's and USDT's annual reports, like the publicly accessible USAspending.gov data portal, attempt to provide more accountability through transparency. Spending can be broken down by 20 different *budget function* categories, or by 7 *object class* categories, or by Cabinet-level Department and independent agency. However, many amounts on USAspending.gov do not match the GAO and USDT reports. One budget function listed is "disaster response", but it includes spending from all federal government entities, not just FEMA. Additionally, agencies/bureaus under a Cabinet-level Department–such as FEMA within Department of Homeland Security (DHS)–are not discretely listed. Outside of USAspending.gov, a Cabinet-level Department or independent agency may maintain their own data portal, with their own different categories and potentially different amounts. To look up FEMA's budgets, for example, one must find and pore over separate budget reports for each year, many of which have a different format, author, and often different terminology and financial categories.

Federal Contracting

There is little aggregated data publicly available on federal contractors beyond the above raw number of ~40% of the discretionary spending. Using public dollars to pay private contractors to fulfill

the mission of a public entity at this scale raises important questions about when an entity becomes an *instrumentality* of the government (Menteghi, 2011) and at what point the democratic sovereignty of the state begins to erode (Verkuil, 2007). Light (2017) argues that the "true size of government" (p. 3) should include contractors to understand today's *blended workforce* that uses government employees and contractors almost interchangeably. When looking at the entire blended workforce for non-defense activities with FY15 data, there are approximately 4.2 million total individuals: 2.85 million contractors plus 1.35 million government employees (Light, 2017; Office of Personnel Management [OPM], 2019). Approximately 68% of non-defense discretionary federal work is done by non-employees.

Available data indicates that federal outsourcing has steadily increased over the past three decades and is on track to continue. For FYs 11-15, defense contracting steadily decreased, while non-defense contracting stayed flat (GAO, 2017a). From FY15-18, however, contracting sharply increased across the board, while government employees stayed essentially flat (GAO, 2019b; USDT, 2019). This comes amidst renewed rhetoric from the Republican Trump Administration of "deconstructing the administrative state" (Light, 2017, pp.11-12), hiring and pay freezes, and rollbacks on contractor qualifications.

Contracting itself is a common practice for any public or private entity that needs intermediate or component supplies or services from another party with specialized knowledge. The *make-or-buy* decision is an ordinary part of any enterprise (Welch & Nayak, 1992; Prage, 1994; Brown, Potoski, & Van Slyke, 2006; Lu, 2014). Simple examples of common commercial items include leasing office space instead of building one's own structure, or procuring laptops, pens, and notebooks. However, the scale, complexity, and many unique missions of the federal government complicate apparently ordinary contracting needs. One example is stockpiling PPE that may sit for decades before a pandemic occurs. Reducing waste may conflict with maintaining constant preparedness. Making the produce-or-procure decision can become quite complex and typically requires strategic, systemic analysis beyond price alone, but organizational constraints often prevent such analysis (Welch & Nayak, 1992; Brown, Potoski, & Van

Slyke, 2006). The result is that even complex projects are often awarded to the lowest price offer since that is the simplest method of evaluation, although not necessarily the best method.

For the public sector, contracting out may generally be limited to commercial items that are not IGF. This distinction remains debated, litigated, and subject to various interpretations. Legally, IGF refers to a public function with a bona fide public interest that is for public use generally (Verkuil, 2005). More concretely, it refers to a function that will harm the general public if delegated to a private entity, such as legislation, taxation, and national defense (Verkuil, 2005). A broader interpretation considers any *essential services* to be IGF, such as clean air and water, electricity or other utilities, and emergency management (Bovens, 2014). Since at least 1999, IGF has been defined by the federal government to be only work "so intimately related to the public interest as to require performance by Federal Government employees" (OMB, 1999, p.2). In 2010, the Office of Federal Procurement Policy (OFPP) re-affirmed that definition and reiterated a goal of widespread contracting out of whatever is considered *commercial services* (Halchin et. al., 2010).

This legal gray area between what is commercial and should be contracted out, versus that which is IGF and too essential to contract out, is clarified somewhat by the government-wide Federal Acquisition Regulation (FAR). The FAR is the binding regulation for all federal contracting. Since 2015, the FAR has allowed a very broad definition of a commercial item, which now means almost any items for sale, except for those developed exclusively for government use, or real property. The FAR only explicitly includes "interpretation and execution of the laws" (FAR, 2020, Subsection 2.101, p. 2.1-11) as IGF, and explicitly excludes "functions that are primarily ministerial and internal in nature" (p. 2.1-11). Governments at all scales increasingly use contractors for essential services if they can be considered commercial. This includes: sanitation and public health; transportation; public safety; emergency medical services; and emergency management (Romzek, 2014; Romzek & Johnston, 2005; Brown, Potoski, & Van Slyke 2006). In recent years, the federal government has increasingly contracted

out even military combat and foreign intelligence (Manteghi, 2011). Overall, the trend has been to (a) narrow what counts as IGF and (b) broaden what counts as commercial, providing a broad mandate for what private contractors can do. Because of the amount of money available and the delegation of authority from a public entity to a private one, there are strict procedures in place to ensure an ethical and fair process for awarding public dollars and outsourcing public work.

Public contracting is deeply connected to ethics and politics. The first substantive part of the government-wide Federal Acquisition Regulation (FAR) addresses improper business practices and personal conflicts of interest (FAR, 2020, Part 3). Due to the scale of the finances, contracting is an area ripe for corruption. This can range from outright bribery and kickbacks to government officials helping companies gain an unfair competitive advantage (Witco, 2011; Lu, 2014). To try to prevent that, any government contract typically goes through at least three standardized phases, with the FAR prescribing very specific policies and procedures for each of these.

1. Acquisition planning/design;
2. Solicitation of competition/award;
3. Administration/modification
   (Sweatt, 2006; FAR, 2020, Parts 6, 7, and 42; Federal Acquisition Institute [FAI], 2019)

The FAR and supplemental acquisition regulations provide thousands of pages of nuanced and specific constraints about what is legal, ethical, and desirable contracting procedure. Almost all daily contracting authority is delegated to each individual CO, who can in turn delegate some authority to a Contracting Officer Representative (COR). Only a CO can make an award or impose consequences on a contractor; that authority is non-delegable. In my literature review and key findings and analysis chapters, I detail how this system is complicated and difficult to implement during a disaster. This next section summarizes the current FEMA model for federal emergency management policy, why it developed, and how it intersects with pubic contracting policy.

Federal Emergency Management Policy

American emergency management has always prioritized private sector and local responses whenever possible, although national security tends to be considered IGF. Through the 1900s, there was a slow but steady increase in the centralization of federal government authority over emergency management (Rubin, 2012). Catastrophic disaster *focusing events* (Birkland, 1998) sporadically created political opportunities to expand federal power, culminating in the creation of DHS in 2003 (Rubin, 2012). Since President Carter created FEMA in 1979 by consolidating five disconnected organizations, the FEMA model has generally remained the same, though it has grown in scope.

FEMA has always had substantial overlap and interaction with both public and private entities at state and local levels (Sylves, 2012). The FEMA model consists of waiting for states to ask for assistance, and then providing funds to local partners to use, while FEMA itself provides some very specific services to those states. Outside of the specific disaster response services FEMA provides, FEMA effectively just passes federal dollars to local entities that better understand immediate and local needs. The 1988 Stafford Act formalized and standardized how federal finances flow to state and local partners via grants and contracts. Since that Act, FEMA has increasingly provided both (a) more direct services and (b) more funds to state and local entities to handle more emergencies. FEMA funding now dwarfs state and local funds. FEMA has also gradually replaced many private sector non-profit entities, such as American Red Cross. Many private sector non-profit groups previously did most disaster response work with their own funds and with limited success.

Through the 1980s and until the collapse of the USSR, FEMA had a *dual mandate* to be prepared for *all hazards* (Sylves, 2012), with a broad categorization of (a) civil defense/national security and (b) natural disasters. Following the collapse of the USSR, from the 1990s until 9/11, FEMA experienced a "golden age" (Rubin, 2012, p. 2) where it was a fully independent agency. In that period, it had a single mandate to focus only on natural disasters, as civil defense/national security and terrorism were addressed

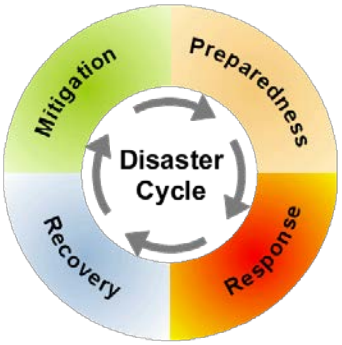
by other agencies. 9/11 and Hurricane Katrina were two focusing events that facilitated the most substantial restructuring since FDR's New Deal. 9/11 was such a major focusing event that it allowed for a substantial restructuring of the federal government, including the creation of DHS, which absorbed FEMA (Harrald, 2012). The Homeland Security Act of 2002 consolidated 22 separate agencies and offices into DHS in 2003, just before Hurricane Katrina (DHS, 2011). This was the most substantial federal restructuring in decades. It increased centralization and decreased redundancy of emergency management (Sylves, 2012). This centralization occurred as a direct result of 9/11 (Conley, 2006). It prioritized national security and counterterrorism over other disasters (O'Connell, 2006).

While FEMA became a part of DHS and once again had a dual mandate, the devastation of Hurricane Katrina soon afterward exposed systemic problems (Perrow, 2006; Gall & Cutter, 2012). Hurricane Katrina became a major focusing event by being the second-most destructive hurricane in American history. Katrina caused approximately $125 billion in damages and killed over 1,800 Americans (Farber & Chen, 2006; Gall & Cutter, 2012). It was the worst hurricane death toll in the United States since 1928. This single weather event's damage comprised 22% of all known damages since standardized measurement began (Gall & Cutter, 2012). The inadequacy of the federal government's response prompted substantial scrutiny of the mandate and capacity of both the newly reorganized FEMA and the newly created DHS (Gall & Cutter, 2012).

The human component of emergencies, and especially the racial and socio-economic determinants of victimization, also gained a new national visibility during Katrina, prompting the question of "emergency management for whom?" (Gall & Cutter, 2012, p. 204). Not only were marginalized groups more severely impacted, but the greater Louisiana region experienced massive, unprecedented depopulation as longer term residents were permanently displaced (Gall & Cutter, 2012). These highly visible and damaging events from 2001-2005, alongside substantial restructuring, redefined federal emergency management and placed it in a new public light. Natural disasters, including those

exacerbated by climate change, such as hurricanes, were thrust back into the spotlight as some of the most potentially damaging events. Since then, emergency management has formalized and standardized substantially. FEMA created a National Recovery Framework (NRF) and National Incident Management System (NIMS) to guide every state plan (FEMA, 2016). A minimum "disaster cycle" framework has been adopted nationwide, universally dividing all disasters into discrete pre- and post-event phases (Flanagan et. al., 2011; FEMA, 2016).

Figure 1: *Disaster Cycle, Simple Model (Flanagan et. al., 2011)*



The pre-disaster phases of *Mitigation* and *Preparedness* receive extensive attention because more variables are under governmental and/or social control pre-disaster (Perry & Lindell, 2003). Actions taken during a disaster constitute the Response phase, which is generally the costliest of the entire cycle (Khan, Khan, & Vasilecu, 2008; FEMA, 2016). The post-disaster phase, which can last indefinitely, constitutes *Recovery*. This standardized cycle asserts that Recovery should include better Mitigation and Preparedness for the next event (Khan, Khan, & Vasilecu, 2008; Flanagan et. al., 2011). The initial disaster Response phase always requires at least the below essential supplies/services (OIG, 2010a).

Table 1: *Initial Response Phase Essential Services and Services*

Essential Services	**Essential Supplies**
Evacuating	Vehicles, Fuel
Sheltering	Housing, Cots, Blue roof sheeting (tarps), Electricity
Feeding	Water, Meals, Ice
Medical Treatment	Medicine, Medical Expertise

Strictly in terms of financial accounting, investing in Mitigation and Preparedness potentially saves the public substantial amounts of money by improving Response and Recovery (Perry & Lindell, 2003). However, the essential activities and resources for Mitigation, Preparedness, and Recovery can vary widely and are tailored based on risks and community needs. As far as the distribution of damages from disasters, there is a wide variability in geography and demography. Some geographical regions suffer more, and broadly speaking, lower socioeconomic status groups suffer more wherever there are disasters (Bolin & Kurtz, 2018). As climate change accelerates and damages increase, those damages are likely to be more severe for lower socioeconomic status people (Cutter, 2012; IPCC, 2018).

FEMA's increased authority, budget, and workforce is the primary reason for this standardization and formalization of emergency management policy (Roberts, Ward, & Wamsley, 2012). Since 9/11, FEMA has also increased its awards to private entities (Mellitz, 2007). Despite this growing authority and power of the federal government in emergency management, there remain major policy and operational challenges to addressing both natural and human-caused emergencies (Roberts, Ward, & Wamsley, 2012a). Policy and politics are symbiotic, not mutually exclusive, and the political complexities of the USA have contributed to a consistently reactive cycle. Major disasters lead to major restructuring that fails to provide a comprehensive *all hazards* policy, thus eventually leading to another, inadequate major disaster response (Roberts, Ward, & Wamsley, 2012b).

This reactive policy-making cycle is known as *punctuated equilibrium* in which a relatively stable policy, after a period of stasis, is abruptly restructured due to a crisis, thus creating a new relatively stable equilibrium–until the next crisis (True, Jones, & Baumgartner, 1999; Roberts, Ward, & Wamsley, 2012b). Roberts, Ward, and Wamsley (2012b) believe that emergency management "appears to be among the policy arenas in which punctuated equilibrium is most evident" (p. 251), given how reactive emergency management policy has been. This is deeply unfortunate due to the severity and inequitable impact of damages, and the fact that these damages are on track to increase at an accelerating rate.

To summarize, emergency management contracting accountability is an urgent and relevant topic because we find ourselves in a time of accelerating crises, both of accountability and of emergencies. As our society struggles to manage an unprecedented pandemic and economic shutdown, our democracy is also struggling with holding those with power to account for what is happening. All of this is occurring at a time when, by some measures, almost half of the federal government's discretionary spending is awarded to private entities. While the American public relies on FEMA to manage emergencies, FEMA largely delegates work to entities to which it awards federal funds to do specific work. CO's are supposed to hold awardees accountable, and OIG is supposed to hold FEMA accountable. The effectiveness of this oversight has been called into question by scandals, wasted funds, and thousands of American deaths. The next chapter explains the methods for examining the specific case study of OIG oversight of FEMA's emergency management awards.

2. METHODOLOGY & RESEARCH DESIGN

This thesis relies on interdisciplinary analyses of public policy documents to present conceptual models and mechanisms for public emergency management contracting accountability. The methodology employed is qualitative analysis of primary and secondary texts. The secondary materials are academic/theoretical literature on the topics at hand. The primary materials are publicly available audits and reports by GAO, OIG, and FEMA. Specifically, this thesis uses a combination of content analysis and *process tracing* (Beach & Pedersen, 2019). This methodology offers the overall best approach to this thesis, despite other methods having their own advantages.

Quantitative methods would likely be a poor fit for this sort of question. While it is not impossible to do a quantitative analysis for this question, there is likely inadequate data. Additionally, there would be so many confounding variables that it would be difficult to clearly identify the impact of one independent variable (for example, number of OIG employees in a cabinet-level Department) with a dependent variable (for example, number of corrective recommendations in an audit). Having a large quantity of high-quality data like those examples may someday make such studies possible. For the purposes of this thesis, qualitative methods are a better option.

Surveys and in-depth interviews with subject matter experts would be ideal, but time and other constraints make those a poor fit for this thesis. Initial, informal discussions with my contacts in contracting and in federal emergency management revealed a deep distrust of any documentation of their responses, even those anonymized per International Review Board (IRB) guidelines. Three separate, off-the-record conversations revealed concerns about retaliation or job-related consequences, due to the today's polarized politics and the sensitive nature of the topics. Additionally, reaching out through my networks would be *snowball* or *referral* (Singleton & Strait, 2010) sampling. That fairly non-representative method would be too small-scale and biased for a study on such a broad a policy question.

Process tracing, a subset of qualitative content analysis, is the most appropriate methodology for this thesis. Content analysis is fairly straightforward: it is analysis of the contents of a text, variously defined (Neuendorf, 2016). It may be conducted quantitatively, such as by measuring the number of times a specific phrase is repeated in a text, or qualitatively, such as by analyzing the whole message of a text. The texts for this thesis are the existing academic literature, the GAO reports, OIG audits, and FEMA- or contracting-related government publications. This thesis relies on qualitative methodology partly for efficiency; it is not feasible to clean and input the content data from all of the audit reports into the appropriate software. Primarily, however, a qualitative approach using content analysis allows for a nuanced evaluation of patterns and meanings across multiple texts by focusing on a holistic understanding of each text. Specifically, this will be an *interpretive* qualitative content analysis (Fink & Gantz, 1996) in that it interprets and holistically summarizes the texts.

Process tracing is technically defined as "an analytic tool for drawing descriptive and causal inferences from diagnostic pieces of evidence - often understood as part of a temporal sequence of events" (Collier, 2011, p. 824). Specifically, it is appropriate for "detailed, within-case analysis" of "how a causal mechanism operated in real world cases" (Beach & Pedersen, 2019, p.1). Given the temporal/chronological nature of audit reports on a single topic, this method is appropriate for drawing inferences after analyzing sequential audits. There are three core components to process tracing:

1. Theorization about causal mechanisms
2. Analysis of the observable
3. Use of comparative methods to select cases and to enable generalizations
   (Beach & Pedersen, 2019, p. 3)

Components 1 and 2 typically rely on development of clear timelines to help establish cause-and-effect relationships; component 3's generalization is the interpretation of those relationships into a narrative summary (Collier, 2011). That narrative summary is the interpretive component of the analysis. In simpler terms, for this thesis, I review a detailed set of evidence in the form of content: government's analyses and recommendations. That content is found within selected texts: academic literature as

secondary sources, and audit reports as primary sources. I then draw conclusions about the cause-and-effect relationships at play in FEMA awards specifically, and generalize those out to the larger policy question of public contracting and accountability. I use this methodology because it is impractical to survey and interview the numbers of respondents required to adequately answer the question, and because this will provide a more nuanced understanding than quantitative analysis.

In order to accomplish Component 1, theorization of causal mechanisms, I spend the next chapter analyzing secondary sources by reviewing available academic literature. There is a range of literature on accountability for climate change and its related emergencies. There is an equally broad range of analysis on government contracting in general. However, literature on accountability for emergency management contractors specifically is sparse, and fragments along ideological and/or disciplinary lines. That analysis provides the basis for creating a three-part critical framework to understand public emergency management contracting issues and solutions:

- "Disaster Capitalism"/The Insourcing Frame
- The Workforce Reform Frame
- The Oversight Reform Frame

These three categories of critiques summarize current policy issues and possible solutions. The literature on the overlapping topics in this thesis varies, and *accountability* in general is relatively under-researched within public policy. There is an abundance of wide-ranging writing on privatization and contracting, particularly on the military, prisons, education, and health services. There is also some substantial work on contracting and accountability, specifically. Light (1995, 2009, 2017) and Verkuil (2007) have written extensively on the state of federal outsourcing and its implications for delivering public services efficiently and democratically. Dilulio (2014) has critiqued the downsides of widespread privatization of government work. Romzek (1998, 2014) and Laegreid (2014) have both analyzed the implication of extensive contracting out and holding private contractors accountable for public services. However, my research finds literature specifically on emergency management contracting accountability

is extremely limited. Fortunately, there is some relevant literature on emergency management, and accountability in general can be summarized as having a few core concepts and mechanisms applicable across sectors. Breaking each area down into its components allows me to synthesize them into a framework on public emergency management contracting accountability specifically.

The literature on accountability in general tends to be conceptualized to some degree as a combination of these four ideas: financial management; individual/professional responsibility; relational authority; and neoliberal or market-based incentives. Mechanically, public accountability tends to be administered using a combination of these five mechanisms: hierarchy/authority; elections/voters; evaluations; audits; and/or regulations. This thesis synthesizes disparate theories and literature on federal emergency management contracts with the above accountability theories to create the three-part framework.

In the chapter after the literature review, I analyze a selection of GAO and OIG reports from the focusing events of 9/11 and Hurricane Katrina, up through the recent 2017 hurricane season. I contextualize those within a timeline of events related to public emergency management contracting and accountability, based on findings across the primary sources. In total, I selected 32 primary source documents to analyze (see Table 4 in the appendix). I selected 27 DHS OIG documents on FEMA that focus on either systemic acquisitions issues, or on systemic issues that impact acquisitions. I included four GAO reports that focus on acquisitions and address FEMA specifically. I added one report from FEMA itself: its 2017 After Action Review.

I selected these sources through keyword searches of publicly available document titles, executive summaries, and conclusions. From 2003 to 2020, DHS OIG issued 1,009 audits, reports, memoranda, and management advisories specific to FEMA. 59 of those documents generally focused on some issue of “acquisition”, “contract”, or “procure”. 40 of the subset of 59 (68%) focused on recovering, disallowing, or de-obligating funds from individual awards, and were excluded due to their

non-systemic focus. 28 of the 59 (48%) of these documents focused exclusively on Hurricane Katrina. Some documents focused on specific disasters also addressed systemic problems; those were included in the 27 DHS OIG documents. 17 analyzed FEMA's overall acquisitions issues. 10 other DHS OIG documents in the main set of 1,009 focused on FEMA's systemic issues and reforms in a way that included, but did not solely focus on, acquisitions (see Table 3 in the appendix).

I analyzed each of the selected 32 documents' key issues, general scope, conclusions, and recommendations, and connect those to historical events, legislation, and earlier reports. I looked specifically for consistency in OIG recommendations to improve acquisitions and awardee performance across the time frame in question. The goal was to clearly understand the evolution and effectiveness of FEMA's oversight and accountability over awardees, as well as OIG's oversight and accountability over FEMA. I evaluated changes over time in these primary sources, drawing upon the three-part critical framework and the concepts and mechanisms detailed in the literature review, the next chapter.

3. LITERATURE REVIEW

This chapter is comprised of three sections. The first section synthesizes disparate academic literature about accountability, with a focus on public accountability models. This section examines the four main concepts of accountability, with a focus on the current dominant paradigm for public contracting: neoliberal/market accountability. The second section explains the five most common mechanisms for implementing and administering accountability. The third and final section summarizes existing critiques of emergency contracting accountability into three broad categories. That three-part critical framework provides the basis for my primary source analysis and public policy implications and recommendations.

Accountability Overview:

Definitions of accountability vary by industry, sector, and time frame (Bovens, 2005a; Dubnick, 2014). Accountability evolved from historical roots in bookkeeping and accounting—literally, confirming a count of people, money, or other resources (Harlow, 2002; Bovens, 2005a). Whether in reference to private businesses, public entities, or governance generally, *accountability* has exploded in use since the 1960's (Dubnick, 2014). Over time, public accountability has changed to include a broad set of concepts, concurrent with the growth of the state and the various services it provides. It is conceptualized differently if one believes the state should primarily support free markets, or if one believes the state should do more and provide a broad social safety net (Cendon, 2000). Mechanisms to implement accountability also vary widely, depending on whether one is at the macro, meso, or micro level, and depending on what main concept of accountability is prioritized. The next section briefly summarizes the current OIG model, which is the default across the federal government.

Federal Accountability Policy

The primary federal government accountability mechanism is the OIG model. OIG is part of the federal government-wide GAO, an independent Legislative Branch agency that reports directly to Congress. GAO's OIG represents the transformations and evolution of public entities and public services

over the past few decades. Every federal Cabinet-level Department and every independent agency has at least one Inspector General present at all times. GAO was originally created as the General Accounting Office by the 1921 Budget and Accounting Act, but now supports legal compliance, performance, and ethics, instead of only performing financial audits (Posner & Shahan, 2014). Formal government-wide standardization began with the 1978 Inspector General Act, which created an independent office in each cabinet-level Department and most independent Agencies. Each OIG office has the authority to audit all components of the Department and Agency, but reports back to the GAO and Congress, not to the Department/Agency being audited. This model was groundbreaking at the time. It provided an auditor that was financially and relationally insulated from its audit targets, but was also physically located on-site, providing an omnipresent mechanism for whistleblowing about fraud, waste, or abuse (Bromwich, 1998). OIG is especially representative of public accountability, as it remains a contested and evolving concept variously defined by academics and by practitioners.

Public Accountability

Similar to *democracy* or the *free market*, the idea of *accountability* has grown into a "cultural phenomenon [and] powerful conceptual construct" (Dubnick, 2014, p. 28) that now "plays a major role in how we perceive the operations of modern government" (p. 30). Synonymous terms like *responsibility* or *good governance* have not experienced the same simultaneous, widespread adoption. Bovens, Schillemans, and Goodin (2014) theorize that accountability has become "the buzzword of modern governance" (p. 1), but that it is also a relevant and lasting concept in public policy, despite its trendiness and "minimal conceptual consensus" (p. 4). These authors theorize that despite some overlap across disciplines, "scholars analyze concepts of accountability and practices of account-giving" in "highly fragmented and non-cumulative" ways (2014, p. 1). Bovens (2005b) asserts that “public accountability is the hallmark of modern democratic governance... the complement of public management” (p. 183), while adding that it remains difficult to define.

Public accountability is a ubiquitous idea without a clear consensus on its general meaning, other than that it is essential to a democracy. Rainey (2009) asserts that many public organizations potentially impact every single citizen, whereas only a few private organizations have this potential. Therefore, there are unique expectations for "fairness, responsiveness, honesty, [and] openness" (Rainey, 2009, p. 83) for public accountability. A simultaneous high amount of scrutiny, high number of citizens or customers, and high demands for both transparency and efficiency make public accountability concepts more complex than private, for-profit accountability concepts. Despite differences in the terminology and the historical context used in each discipline, there tend to be two broadly agreed-upon understandings of accountability: as a concept/theory, and as a mechanism/procedure (Bovens, Schillemans, & Goodin 2014). In both understandings, there are always five key attributes:

1. **who** is held to account
2. **to whom** one is held to account
3. **what** is being accounted for
4. **how** to practice accountability, or standard operating procedures
5. **why**, or for what reason, accountability is needed.

The *why* is what most distinguishes public accountability from private. Typically, private sector accountability is done because it helps the bottom line. For the public sector, the reason is generally that it somehow relates to achieving a broader purpose or mission. Despite variable definitions beyond these five common parts, below is a general taxonomy:

A. Accountability as Financial Management
B. Accountability as Personal/Professional Responsibility
C. Accountability as Relationship
D. "Neoliberal"/Market Accountability

Concept A: Accountability as Financial Management

A count of finances gradually became *accounting*, and that in turn became a foundation for *accountability* (Bovens, 2005a). In this concept, what is held accountable is primarily money, and therefore this concept is generally the least abstract. Financial accountability is related to, but different from and less clearly defined than Generally Accepted Accounting Principles (GAAP). GAAP refers to

financial and bookkeeping "methods and disclosures that are either required by authoritative pronouncements or accepted because of their prevalent use" (Raiborn & Raiborn, 1984, p.1), and that are standardized across private and public entities. Prudent financial management is foundational for all organizations, both public and private. However, public accountability overall as a concept lacks any set of cohesive, uniform standards comparable to GAAP. The closest would be the Generally Accepted Auditing Standards (GAAS), which are promulgated by the American Institute of Certified Public Accountants (AICPA). GAAS are focused on finances more than other accountability concepts. The GAO also promulgates the Generally Accepted Government Auditing Standards (GAGAS). These standards provide guidance on financial and performance audits, plus evidence and testimony collection. As such, they promote a relatively narrow financial approach to public accountability.

Public service entities are financially distinct from private business entities in important ways. Financially, public organizations' finances are at such a scale that they impact very large numbers of citizens and residents. In theory, they can impact every single person in one location. While stockholders and customers are the key stakeholders of a publicly traded company, the entire general public, voters, and taxpayers are the key stakeholders for a public entity. This dichotomy of narrower stockholder versus broader stakeholder values is a common theme in public policy/administration, and it distinguishes public services from private businesses (Walker, 2002; Laegreid, 2014).

Public organizations serve the entire public, and therefore have many more, and more diverse, stakeholders. Private business entities, on the other hand, serve only a specific base of customers/consumers, and typically answer only to those who own shares of their company, with profitability as their bottom line (Wong & Dufrene, 1996). While the daily operations of public and private entities may be quite similar, a public entity's mission, values, and/or culture include creating *public value* for everyone (Rainey, 2009), not only *private value* for the company owners. This means that to whom a public organization answers, and why it answers as it does, is much different.

This distinction means financial accountability goes beyond simple accounting and book balancing. Another widely accepted part of public financial accountability is *public value for money* (Harlow, 2002; Bovens, 2005b). For public policy, this means that taxpayer money should be spent with minimal waste and with clear rationale as it relates to the public entity's mission. Two of the most important actions that government takes are taxing specific private activity and then redistributing those funds in the form of subsidies or services to the general public (Mintrom, 2012). At a scale as large as the federal government, this public spending can have profound impacts on the entire national economy (Audet, 2003; Cogan et. al., 2010). This requires making government spending as efficient as possible, in order to reduce waste on such large scales, and to justify the value of redistribution (Mintrom, 2012).

In other words, financial accountability means that not only should the books balance without any fraud, but the overall value to the stakeholder/citizen must be justified as money well spent. A strictly accounting-focused concept of accountability is quite narrow. If all of the books balance and programs provide a good value to the public, but the agency director commits an egregious non-financial crime, that is not acceptable. A broader understanding of accountability helps us understand public agencies' need to do more than simply come in under-budget each fiscal year.

Concept B: Accountability as Individual/Professional Responsibility

The second main concept of accountability can be summarized as knowing where "the buck stops" (Romzek, 1998, p.193), or where and with whom ultimate responsibility resides for performance, good or bad, variously measured (Jones, 2011). This can be especially challenging for public entities due to several factors. Mintrom (2012) argues that "there is no direct link between performance and continued existence" (p. 193) for a public agency overall when a political agenda or highly politicized appointee leads it. Even if performance is important and bad behavior or poor performance occurs under their leadership, there may not be clear or timely consequences for leaders. Additionally, labor unions may slow down holding rank-and-file staff accountable (Fisher, 1988).

Rainey (2009) points out that there is "more frequent turnover of top leaders due to elections and political appointments" (p. 83-84), which narrows the window of time in which any one person can be seen as fully responsible for an agency that may have existed for decades prior to their leadership. The same applies to high attrition of rank-and-file staff, particularly for emergency services. Rainey (2009) also points out that statutory "oversight and rules limit their authority" (p. 247), so even exceptionally good leaders may not in fact be able to enact as much change as they or the public want. Bolman and Deal (2013) emphasize how important political frames are for viewing organizations, and they assert that even in private businesses, the CEO relies on other executives, and that CEO may be overseen by a board of directors. This means that several individuals can ultimately be given credit for success or failure, diffusing responsibility away from a single individual. This diffusion of responsibility amongst many individual, executive-level leaders has been referred to as a *thickening* of administration (Light, 1995). Depending on the metric, the top layers of federal government leadership increased between 30% and 60% from the 1960s to the 1990s (Light, 1995).

Concept C: Accountability as Relationship

The most flexible, abstract, and comprehensive conceptual definition of public accountability is that it is an "institutional arrangement [or] social relationship" (Bovens, 2005b, p. 184) wherein one entity "feels an obligation to explain and to justify his or her conduct to some significant other" (p. 184), who is a legislator, executive, voter, citizen, resident, or other stakeholder. In this concept, power relations, or who is held accountable, and to whom, is central.

This understanding of accountability as relationship or institutional arrangement is an understandable and generalizable abstraction, but it is less concrete than the above concepts about financial management and individual/professional responsibility. Accountability as relationship or arrangement includes all of the five core parts of accountability — who, to whom, what, how, and why — but it is more functional when understood in concert with the other concepts in practice. Simply put, the

what and the *how* of public accountability must be clear in order to hold one party accountable to another. After a review of the most recent, and now dominant, neoliberal/market accountability concept, this thesis examines the five standard public accountability mechanisms, including key actions and actors for each. In each mechanism, at micro, meso, and macro levels, relationships are essential.

Concept D: Neoliberal/Market Accountability under New Public Management (NPM)

By the 1990s, the Reagan Revolution had fostered a culture of government reform, with a focus on efficiency. A key part of this was privatization by contracting out public services to private entities (Rainey, 2009). A "do more with less" (Rainey, 2009, p. 386) mentality and *corporate accountability* began supplementing and at times supplanting conventional public accountability (Rainey, 2009). This *neoliberal governance* model initiated under Reagan has expanded ever since, and it is now the dominant justification for government reforms in the name of accountability (Walker, 2002). Contracting out public services to private businesses in the name of greater accountability, rather than hiring more government employees, is also known as New Public Management (NPM). NPM is largely defined by "dis-aggregation, competition, and use of incentives" (Laegreid, 2014, p. 324) within public entities (Laegreid, 2014; Dunleavy et. al., 2006). NPM emphasizes accountability shifts "from processes...to results" (Laegreid, 2014, p. 325), with a focus on "increased efficiency, competition, and cost-effectiveness" (p. 328). NPM essentially prioritizes outcomes/outputs, not processes/inputs, while conceptualizing the public, public entities, and public services as a marketplace comparable to the private sector. Citizens or residents are conceptualized as a set of consumers who deserve quality products produced by public agencies. Marketplace competition becomes the primary mechanism to hold contractors accountable to the government entities hiring them (Hansen, 2002).

In this concept, what is held accountable is clear: performance. However, who is held accountable, to whom, and why often becomes confusing. The overt logic of neoliberalism is belief that the efficiency and cost-effectiveness of a free market justifies the privatization of public government

functions whenever possible (Ranson, 2003). According to Harvey (2005), neoliberalism is "a theory of political economic practices" (p. 2) that prioritizes "private property rights, free markets, and free trade" (p. 2), where "the role of the state is to create and preserve an institutional framework" and to “guarantee, by force if necessary, the proper functioning of those markets” (p. 3). It is beyond the scope of this thesis to dive deeply into neoliberal critiques. In lay terms, neoliberalism is the idea that the free market is better than the government in almost every situation. Ronald Reagan’s inaugural address quote sums up this ideology: “Government is not the solution to our problem, government is the problem” (Reagan Foundation, 1981). Another metaphor to summarize neoliberal governance is *the hollow state*, in which many public services are filled by outsourcing to private contractors (Milward & Provan, 1993, 2000, 2003; Howlett 2000). In both examples, the goal is for the government to delegate its authority out to private entities, rather than provide services itself.

It is important to stress the extent to which neoliberal/market accountability has become the preferred model for many government services. The privatization and deregulation championed by the Reagan Administration was expanded by successive Administrations and became common sense. This preference grew and persists at a large scale, for multiple decades, and across party lines. The 1984 Grace Commission, under the Republican Reagan Administration, laid the foundation for the argument that federal government waste and lack of public accountability required rapid and substantial cost controls. This opinion soon spread government-wide amongst federal policy makers (Moulton & Wise, 2010). In the 1990s, even during substantial economic growth, the Democratic Clinton Administration, “eliminated over 324,000 jobs from the federal workforce, bringing federal employment to its lowest level since 1950” (Rainey, 2009, p. 386).

This was done through Clinton’s National Performance Review (NPR) system, which formalized performance-based evaluations on a national scale (Brown & Brudney, 1998). Under the Republican Bush Administration, the Program Assessment Rating Tool (PART) became OMB’s method for

"assigning program budgets on the basis of results" (Rainey, 2009, p. 441-442) from surveys sent to agency or bureau directors. Decades after the Grace Commission, another Democratic Administration under President Obama emphasized their reviews and terminations of programs and employees based on performance and cost-effectiveness (Rainey, 2009). Even with substantial growth of spending and programs due to the Great Recession and health insurance reform, federal government employee levels remained essentially flat (Light, 2017; Bureau of Labor Statistics [BLS], 2019; OMB, 2019). Despite that, there was an overall increase of contractors (Light, 2017).

Neoliberal/market accountability intended to increase accountability by making public employees perform "smarter, better, faster, and cheaper" (Brown & Brudney, 1998) through competition to produce X or Y outcomes, rather than follow A or B processes. Citizens/residents were expected to benefit through more responsive public entities and through lower taxes, as government costs overall were expected to decrease by outsourcing to private contractors. Private contractors, unencumbered by public entities' mandates to follow specific processes, would theoretically deliver services more efficiently and cost-effectively. The theory is that, unlike government employees, if a private contractor failed to perform as expected, they could be rapidly terminated and replaced.

Decades into extensive outsourcing, the evidence suggests that holding public agencies and private contractors accountable has become more ambiguous and complicated, not clearer or easier to do. Part of this is due to a post-NPM push back amongst policymakers and practitioners concerned by NPM's reduction of citizens into customers that are "devoid of the entitlements or rights associated with citizens" (Laegreid, 2014, pp. 332-333) and the pressure to narrowly serve individual customers, rather than serve the larger public interest. This has led to "more complex, dynamic, and layered...hybrid accountability relations" (Laegreid, 2014, pp. 334) that are less simple than either pre-NPM relations or the NPM ideal, and that "have partly competing institutional logics" (Laegreid, 2014, pp. 335). This public *hybrid accountability* system means that all, or any one, accountability concept or mechanism may be used.

Current Neoliberal Contracting Accountability

A neoliberal market accountability model assumes that marketplace competition alone will keep contractors accountable. However, the profit-seeking motive of contractors typically leads to, and is intended to lead to, cost-cutting. For essential work, cost-cutting can undermine quality to the point where government's mandate to award based on *low price* no longer provides a good public value (Hansen, 2002). At present, the majority of pre-award accountability is focused on the government ensuring fair, full, and open competition. The entire process of soliciting competition, evaluating offers, and awarding funds should be conducted with extreme confidentiality, to minimize exchange of information between competitors or between government and contractors (Federal Acquisition Institute [FAI], 2020). Vendors have rights to protests and appeal if they feel the process was unfair.

Post-award, most accountability for awardees relies on straightforward oversight by the COR or CO, such as inspections and performance evaluations (FAR, 2020, Part 46). Specific formal accountability for inspections and evaluations vary with each individual contract's terms. Most default to performance metrics and incentives for performing to a level specified in the contract. This requires clear understanding by the government of the work, good performance metrics, and oversight of each contractor—all of which takes time and energy (Rainey, 2009; Romzek, 2014). With so much of the government contracted out, there is an excessive delegation of authority that leads to a tangled web of hierarchical relations that complicates accountability. This increases the likelihood of a contractor not being held accountable for failing to deliver. A contractor's failure during an emergency at a large scale can lead to serious harm. When problems arise or a contract has to be terminated, it is not particularly fast or easy to do. Restarting a solicitation is time-consuming, and especially difficult to do during a disaster.

Without enough government capacity for formal accountability mechanisms, government may rely on informal mechanisms. Informal accountability is less clear-cut, and relies heavily on "trust and

reciprocity" (Romzek, 2014, p. 310) between government and contractor, as well the *discipline* of the market to encourage a firm to perform well to stay competitive for future contracts (Romzek, 2014). Contractors act in self-interest and seek to maximize profit, which is at odds with the government seeking the lowest price and best value (Prager, 1994). This means the government-contractor relationship is incentivized to become adversarial, rather than cooperative. Additionally, as the state has been hollowing out, there has been decentralization and devolution of finances and authority to local public entities, contractors, and subcontractors, leading to a network of actors with little clear hierarchy (Smith & Smyth, 1996). This network includes federal, state, and local public entities, plus all private entities. As layers of public service providers grow, holding actors accountable in line with government's mission(s) leads to "a tangled web of accountability that relies on a wide array of vertical and horizontal relationships" (Romzek, 2014, p. 317). This web and its components are broken down in the following part of this chapter, which explains the five main accountability mechanisms.

Accountability Mechanisms

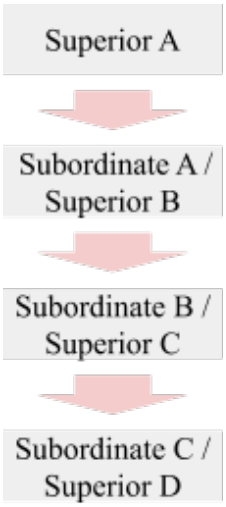
There are currently five key mechanisms for implementing public accountability: (1) Hierarchy; (2) Elections; (3) Evaluations; (4) Audits; (5) Regulations. The first two together—hierarchy and elections—demonstrate the simplest realization in a democracy of who is held accountable, and to whom they are held accountable. All of the mechanisms, to varying degrees, clarify how institutionalized power relations operationalize more abstract concepts of public accountability. The last three—evaluators, auditors, and regulators—focus on power relations, but operate more clearly in the realm of financial and individual behaviors, with a focus on market assumptions.

Hierarchy/Authorities

Hierarchy, or an arrangement where specific actors have clearly defined power and authority over other actors, is the foundational accountability mechanism. Without some hierarchy, there is no accountability. Hierarchy is arguably the defining power relationship in all accountability mechanisms,

as the entity held to account by another entity is in some way a subordinate. In theory, clear hierarchy should exist at every level of a public accountability chain, with all parties aware of their subordinate-superior status. According to Jarvis (2014), these superior-subordinate relationships should “cascade down the chain all the way from citizens, as the ultimate superiors at the top, to 'street-level' bureaucrats” (p. 405).

Figure 2: *Hierarchical Accountability*

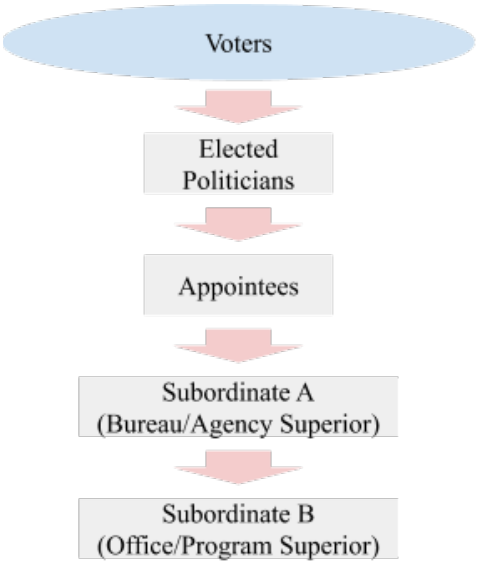


Jarvis (2014) goes on to explain that there is terminological confusion and a lack of quantitative data on how hierarchy is administered in the real world. There is also confusion between when *hierarchy* refers to macro, inter- and intra-organizational accountability systems, and when it refers to micro, individual-scale, specific supervisor-subordinate studies. Despite fractures in the theoretical literature, delegating authority is a widely agreed-upon "fundamental feature of hierarchical accountability mechanisms" (Jarvis, 2014, p. 409) that "crystallizes responsibility on a single accountable individual or actor” (p. 410). This delegation of authority appears in every power relationship between those who are being held to account, and those to whom they are giving an account.

Elections/Voters

At its most basic level, electoral accountability is macro-level democratic accountability. An election is the mechanism through which "voters can re-elect the incumbents or throw them out" (Franklin, Soroka, & Wlezien, 2014, p. 389), and it appears "in a vast body of work on empirical democratic theory" (p. 390). In practice, however, there is "an important caveat: elections are very blunt instruments" (p. 390). Without elections, there is no macro public accountability, and the system is not democratic (Lijphart, 1999). However, elections on their own do not make a democracy. Under elections, there is a theoretically clear hierarchical relationship where voters delegate authority via elections onto politicians, their appointees, each director of each public entity, and so forth (Powell, 2000). In this mechanism, street-level bureaucrats are theoretically accountable to the public by way of their superiors, who each act as agents of their superiors, all the way up the chain to voters/the public.

Figure 3: *Electoral Accountability*



Ultimately, "elections make politicians pay attention to what the public wants", but "accountability varies across institutional settings...things that politicians do...and across the times at which they do those things" (Franklin, Soroka, & Wlezien, 2014, p. 391), which makes electoral

accountability too simplistic for every situation. While elections do have consequences, there are many variables in elections themselves, and substantial time between elections. Whether or not incumbents are reelected is influenced by many factors beyond the will of the people. Assuming regular, free, and fair elections occur, the largest factor impacting electoral accountability is whether the legislature is based on single member districts, or if it is based on proportional representation (Franklin, Soroka, & Wlezien 2014). The general difference is that in our single member district system, voters hold individuals to account. With proportional representation, voters hold political parties and platforms to account. Proportional representation systems skew towards "good representation along with poor accountability," (Franklin, Soroka, & Wlezien, 2014, p. 396) while single member districts skew towards "good accountability along with poor representation" (p. 396). Ideally, a system should have both good representation and good accountability, but no democratic electoral system appears to achieve that.

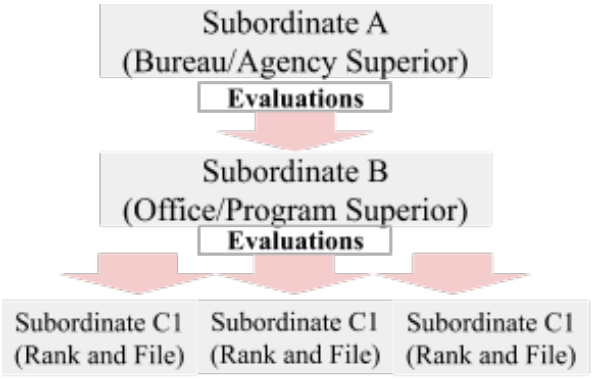
Warren (2014) argues that democracy can be largely thought of as a system of *multiple accountabilities* wherein representatives of *the people* are held accountable by elections, but wherein voting is also "a relatively weak form of democratic accountability" (p. 39). Instead, it is better to "think about accountability in terms of regimes: systems of complementary mechanisms that combine with voting to ensure greater accountability" (Warren, 2014, p. 39). In a democracy, there should be three generic elements of public accountability: (1) officials have real power over voters through delegated authority; (2) those with power must justify it; and (3) voters have the power to remove authority as well as delegate it (Warren, 2014). Hierarchical and electoral accountability are two straightforward mechanisms that should be present in any democracy. Hierarchy is essential at all levels, and elections are practical at the macro level. The three mechanisms below are more practical at the meso level.

Evaluations/Evaluators

A key mechanism within an organization is evaluation. Because voters and executive leaders cannot realistically evaluate every single street-level bureaucrat or middle manager, power to evaluate is

delegated down to those within each public entity. By default, every street-level bureaucrat's evaluator is their immediate supervisor, who should perform routine evaluations of their subordinates on a fixed schedule using impartial criteria. An evaluator's evaluation typically focuses on an individual's specific, measurable, quantified professional performance, not systemic concerns, legal compliance, or finances (Van de Walle & Cornellisen, 2014). In line with shifts to NPM, performance measurements based on expected outcomes are increasingly popular. It is important to note the flow of the diagram arrows; superiors evaluate subordinates, but subordinates rarely evaluate superiors.

Figure 4: *Evaluations/Evaluators*



How exactly performance is evaluated and who prepares and uses those metrics varies and still has an unclear relationship to performance. NPM assumed publicly available evaluation data could lead to "two pressures, from citizens and from politicians and boards" (Van de Walle & Cornellisen, 2014, p. 442) for more efficiency. In practice, though, "performance evaluation remains the domain of experts and managers, and not politicians or citizens" (Van de Walle & Cornellisen, 2014, p. 445). Since NPM reforms, it appears that performance metric-focused evaluations have supplemented or complemented existing practices, rather than displaced old practices. Part of this is because "performance accountability systems only operate in stable environments with a great deal of standardization" (Van de Walle & Cornellisen, 2014, p. 445) and where there is a "longer data use tradition" (p. 452), such as economics or

sales. When organizations or standards change substantially or frequently, the environment is not stable enough for evaluations to facilitate accountability.

It appears that performance measurement seems to only improve accountability when metrics are clear and truly reduce information asymmetry among parties that are already interested in thorough analyses. At the macro level, an unexpected and unhelpful phenomenon is "attack politics...through a selective use of data"(Van de Walle & Cornellisen, 2014, p. 452) that labels agency performance unsatisfactory, but never satisfactory or outstanding. Agency-level evaluators such as supervisors, or higher-level evaluators such as intra-government institutions, may also be susceptible to abusing the power to interpret performance data.

Audits/Auditors

Audits have become a standard best practice for private and public sector actors. They typically focus on finances, legal compliance, and/or performance (Posner & Shahan, 2014). An auditor can be an internal individual or team within an organization. An auditor can also be a higher-level or separate institutional evaluator of another public entity. Audits are more thorough than routine evaluations, and audits may be performed on a randomized basis. A key difference between auditors and evaluators is that auditors are typically never a direct subordinate or superior to their auditees. At a macro level, for public entities specifically, each country typically has some Supreme Audit Institution (SAI) that is external to organizations, separate from the legislature, has a clear mandate, and has substantial authority (Posner & Shahan, 2014). Structurally, an SAI tends to be a combination of courts or an office insulated from the national legislature. In the case of an SAI, a legal compliance audit may lead to a unilateral, legally-binding intervention. The best example is the Supreme Court.

Most audits tend to not be unilateral interventions, and most auditors are not supreme in their authority. Instead, most auditors report their findings and may include recommendations, but lack authority to implement them. Each auditor tends to be either a *police-and-patrol* or a *fire alarm* entity

(Posner & Shahan, 2014, p. 502). In the former, the entity actively engages with those they audit, and may be generally perceived as more intrusive and powerful, but less independent and neutral. In the latter, the entity "establish[es] the infrastructure of information and provide[s] open doors for others to raise alarms" (Posner & Shahan, 2014, pp. 502-503), which makes them less intrusive and powerful, but more independent and neutral. Similar to independent regulators, and unlike evaluators, independence is essential for an auditor to function properly. There must be some structural distance between an auditor and its auditees. A common practice to maintain this distance is long or lifetime appointments for leadership.

In line with other major governance and government transformations from the 1970's to the 1980's, an "audit explosion" (Posner & Shahan, 2014, p. 491) that led to a new regime of auditing focused on systemic performance issues, with the GAO's OIG serving as the critical actor across the federal government (Posner & Shahan, 2014). As noted earlier, OIG is located in every federal Cabinet-level Department and independent agency, but reports to the GAO and Congress. OIG uses both police-and-patrol and fire alarm methods, as it may choose when and where to launch an investigation or audit, but it also provides an anonymous channel for whistleblowing or other forms of reporting suspicious activity.

Regulations/Regulators

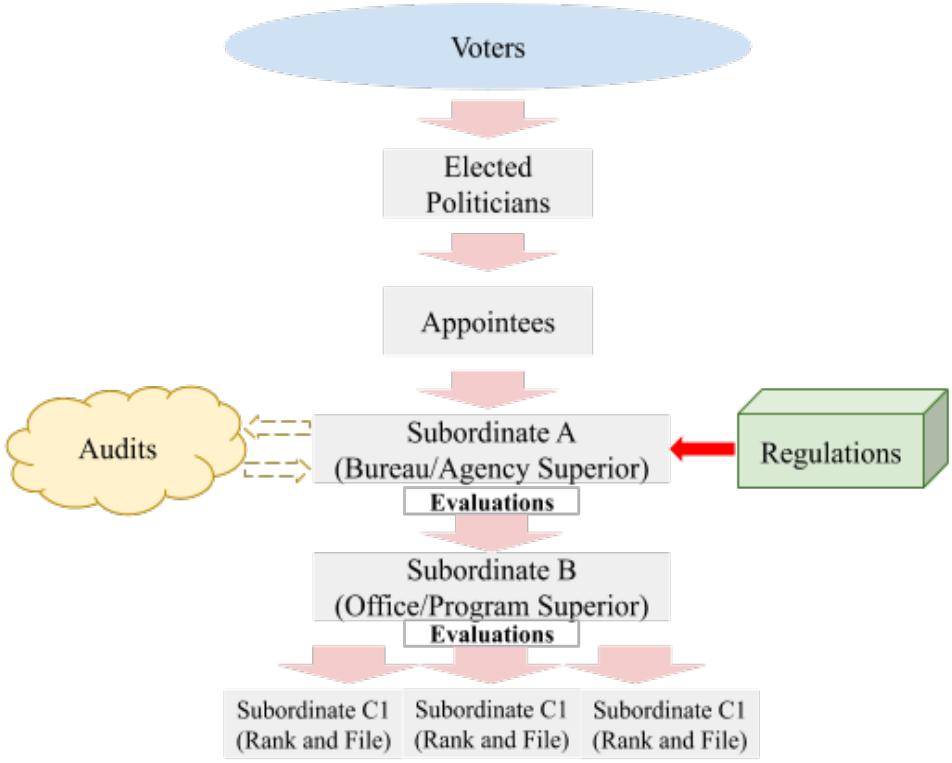
Since the 1970's, there has been a formal proliferation of independent regulators, "mechanisms established at one remove from elected politicians and government departments" (Scott, 2014, p. 472) and that are given broad power to regulate specific private sector industries and/or specific government services (Scott, 2014). In the USA, the Environmental Protection Agency (EPA) is an example of an independent regulator of private industry, whereas the Federal Election Commission (FEC) is an example of an independent regulator of public services. GAO generally, and its OIG presence at each federal department, may be considered an independent regulator for each department in which it is embedded, although GAO and OIG are closer to auditors. A regulator has a narrow scope for its regulations, and

some GAO rulings can affect government-wide practices. Additionally, OIG primarily reports data and recommendations, but does not implement changes.

A regulator has the authority to not only recommend a change, but also to implement it. However, a regulator is typically very focused on one industry or organization. In some cases, the statutes creating independent regulators grant them broad "rule-making, monitoring, and enforcement powers" (Scott, 2014, p. 476) that make them "governments in miniature" (Willis, 1958, p. 504) due to their powers independent of the highest-level legislative or executive bodies. This unilateral power to implement changes distinguishes regulators the most from auditors. Regulators should share a key feature of SAI's: that they should have long or lifetime appointments for leadership and "relative insulation from politics", which makes them "particularly important in political systems which are subject to pendulum swing politics" (Scott, 2014, p. 475) like the U.S. single member district electoral system. Regulators are "frequently described as non-majoritarian institutions" (Scott, 2014, p. 476) that are perceived to neutrally enhance public services.

Unfortunately, like most of the above accountability mechanisms, knowledge of independent regulators' impact on accountability "is limited, in part because few research projects have directly addressed their role" (Scott, 2014, p. 480). What is definitively known after almost five decades of their widespread use in the federal government of the USA is that *de facto*, not just *de jure*, independence is essential, and regulators' decisions are more impactful "where the agency was long established, [with] *de facto* independence growing over time" (Scott, 2014, p. 279). How to establish and maintain independence is less clear. Additionally, an independent regulator that is truly independent and has real regulatory power "contributes to the transparency of governmental activities" (Scott, 2014, p.472) overall—but diffusion of accountability mechanisms to regulators may erode hierarchical or electoral accountability. Long or lifetime appointments insulated from elections erodes the electoral mechanism.

Figure 5: *Audits and Regulations*



Finally, a whistleblower "accountability conspiracy" (Dowding, 1995) or paradox can sometimes emerge in fire-alarm systems. This is when "it is against the interests of key actors to blow the whistle...because failures of one are seen as failures of others" (Scott, 2014, p. 473). For example, if internal evaluations consistently documented good performance, but a whistleblower revealed widespread performance issues, it suggests systemic failure. That whistleblower may have refrained from reporting systemic failure out of fear of being held individually accountable for not reporting earlier.

Enforcing and Practicing Accountability

Romzek summarizes several essential practices for enforcing accountability in contracted public services specifically. These refer to the above five mechanisms and five key attributes of who is held accountable; to whom one is held to account; what is being accounted for; how accountability is practiced; and why—typically public interest. Those practices are:

- appropriate design;

- awareness of all stakeholders;
- clear goals;
- government management capacity;
- performance monitoring;
- a collaborative culture;
- holding accountable all parties

Appropriate design, awareness of stakeholders, and clear goals means that CO's and other government employees planning to outsource something need industry-specific technical knowledge. Government management capacity and performance monitoring both refer to adequate levels of CO's and COR's, as well as training for both of those positions. A collaborative culture refers to both public entities' operations, as well as government-contractor relationships which can become adversarial. Finally, holding accountable all parties means the actual imposition of rewards and punishments for success and failure, respectfully.

That final act is key to all of the others. Unfortunately, Romzek (2014) notes a reward or punishment is "often one of the steps omitted" (p. 220), undermining the entire process. Overall, thinning of the rank-and-file workforce, including employees who oversee awards, and a thickening of leadership layers and of public service layers, all substantially reduced the government's capacity to oversee awardees. As more and more government work has been contracted out to private businesses, the neoliberal/market accountability model has become the dominant way of thinking about enforcing accountability. However, as the chain of command has lengthened, stretching from voters all the way down to subcontractors, the web of actors has grown complicated, and a hollowed out acquisition workforce appears insufficient for the tasks in question.

I attempt to visualize these processes in two figures below. The first figure is a condensed illustration of all five mechanisms in action for a single public entity. The second figure is an expanded illustration of when public entities interact, and it highlights how complicated even a relatively small number of contractors can become. The reality of the accountability web is exponentially more

complicated, as dozens of entities may partially overlap or interact, while hiring hundreds of contractors, each of whom hire subcontractors.

Figure 6: *Condensed Public Service and Private Contractor Accountability "Web"*

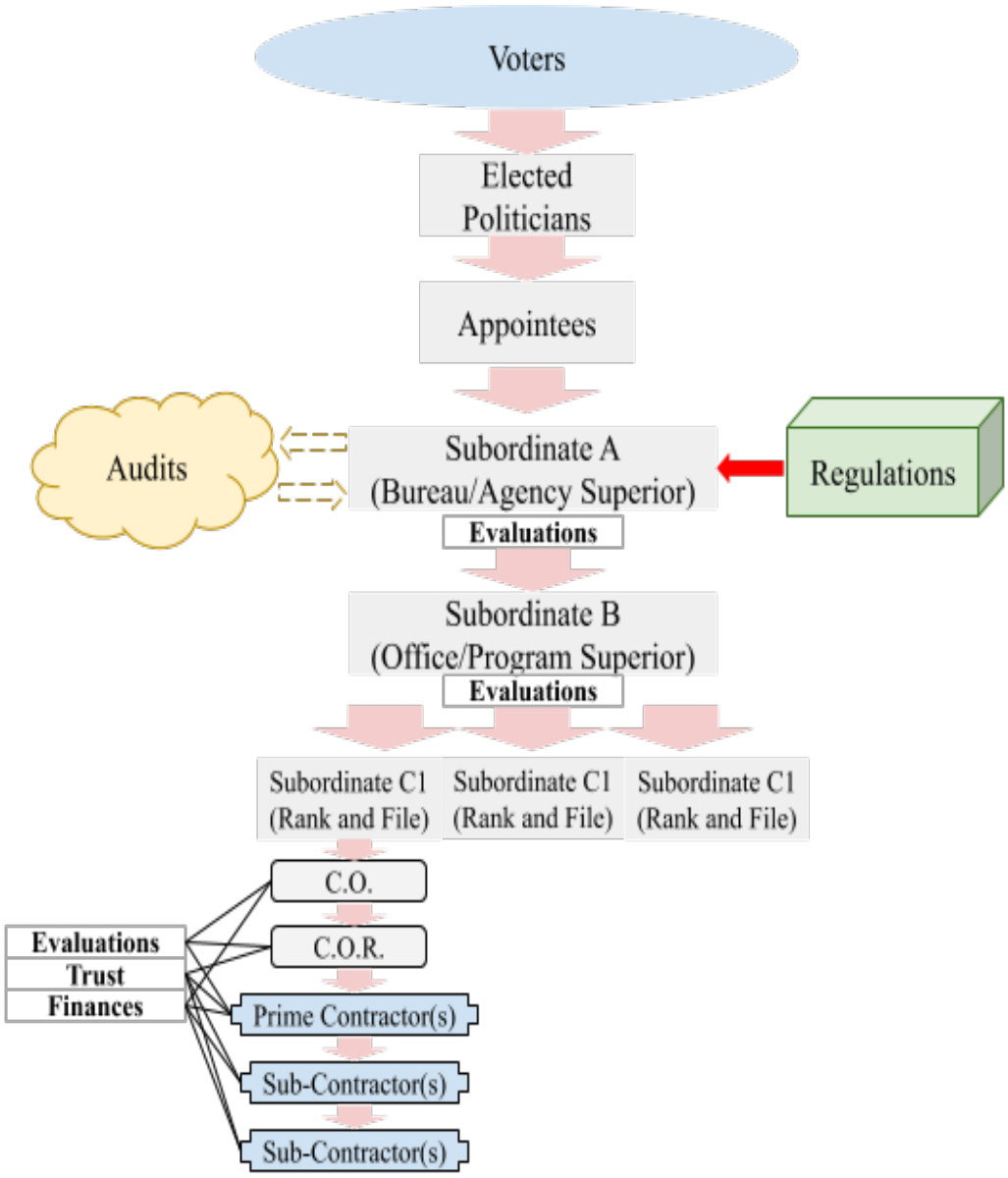
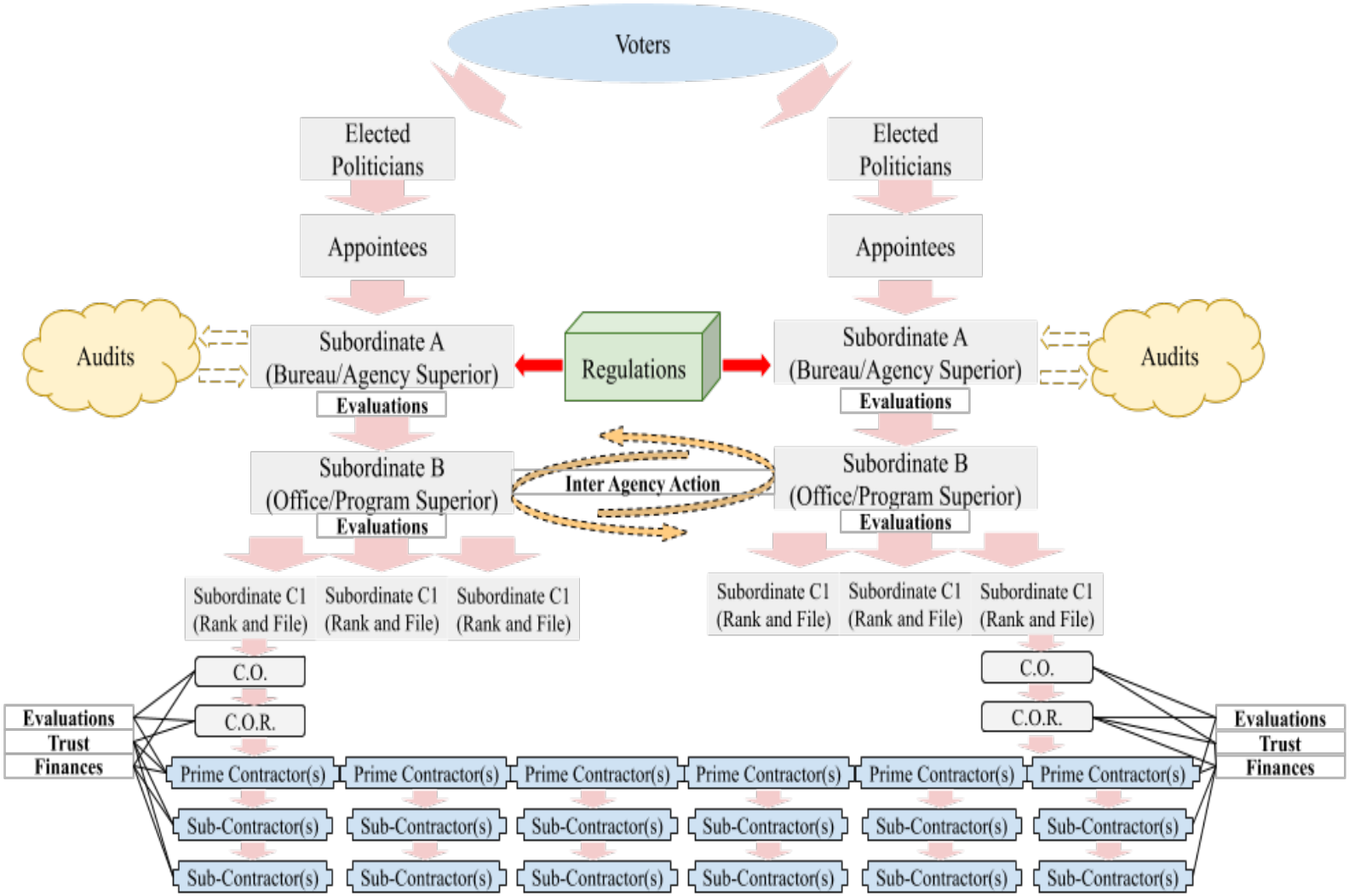


Figure 7: *Expanded Public Service and Private Contractor Accountability "Web"*



This sprawling web is meant to illustrate the excessive length and limits of hierarchical delegations of authority in a democratic contractor-preferred public accountability model. In it, external audits and regulations interact with organizations conducting their own evaluations, and an acquisitions workforce overseeing prime contractors and subcontractors—all of whom interact with each other. In practice, this web of interactions is even more complicated than this theoretical diagram illustrates, as informal incentives play out all the way up, down, and across the chain.

The consistent theme across the academic and practitioner literature is that reforms of some sort are needed. Those proposed reforms range from demands for systemic overhauls to address rampant corruption and no accountability, to more modest reforms that maintain existing systems that theoretically should facilitate adequate accountability. With this academic taxonomy and messy structure in mind, below are three practitioners' critiques of current public emergency management contracting accountability. These critiques, discretely categorized, comprise a three-part critical framework for approaching public emergency management accountability policy.

"Disaster Capitalism"/The Insourcing Frame

There are growing critiques focused on *disaster capitalism* (Klein, 2007a, 2007b). This frame is essentially a new critique of profiteering, focused on capitalism and climate change that sometimes strays into polemical territory. However, anthropogenic climate change appears to pose a real threat to human existence on a global scale. Characterizations about the scale of the problem in this frame seem to accurately describe the urgency of many problems, even if some prescribed solutions seem overly broad or lack nuance. Disaster capitalism as a frame for critiquing emergency public contracts was recently popularized by Klein (2007a, 2007b), but it is not a new idea. It builds on existing critiques of crony capitalism and war profiteering, with a focus on how *disaster profiteering* (Cray, 2005) increases as disasters increase in severity and frequency. In lay terms, disaster capitalism refers to contractors making exceptionally large

profits by price gouging the government for essential supplies/services (Loewenstein, 2015), as private contractors make abnormally high profits during disasters. The general argument is that perverse incentives exist for for-profit companies as emergency management as an industry expands, and some of those companies lobby the government to delay addressing anthropogenic climate change-related disasters (Schuller & Maldonado, 2016).

This critique is neither new nor limited to investigative journalists and anti-capitalist theorists. Critiques of exploiting the government in times of need date back to the Revolutionary War, when George Washington critiqued Continental Army contractors (FAI, 2020). In fact, complaints of profiteering persist throughout history, especially during times of crisis, emergency, and war (FAI, 2020). Locating these critiques in the domestic policy realm of American emergency management yields only a few academically peer-reviewed texts. One more academic term for this frame is *chronic disaster syndrome* (Adams, Hattum, & English, 2009). This refers to two levels of processes. On the micro level, it refers to an individual in poverty who is exposed to higher risk in a disaster, followed by disaster victimization, followed by more poverty, more reliance on assistance, and likely future victimization. The other macro level refers to the process of perpetuation of social arrangements and systemic causes of disasters, which allow for crises to become perpetual. Both levels arguably facilitate companies' reliance on perpetual crises for ongoing profitability.

Many analyses of inequitable but profitable emergency contracts focus on Hurricane Katrina (Cutter, 2012). Many others, especially in the vein of capitalist-critical research, focus on the 2010 Haiti earthquake and ongoing Pacific Islander communities as case studies for companies profiting from climate change-related crises (Bolin & Kurtz, 2018). The broad thrust of these critiques is that (a) neoliberal accountability is insufficient, and (b) powerful contractors want the government to continue to fail to address climate and to outsource its emergency management. The most uniform solution proposed based on this distrust of contractors is large-

scale insourcing, and a general end to outsourcing entirely for emergency management. This frame considers all emergency management to be IGF.

The Workforce Reform Frame

This frame tends to be the most straightforward and recommends the simplest, least complex remedies. Generally speaking, this frame argues for better training and more hiring of personnel with experience in emergency management and emergency contracts. This frame focuses on the existing acquisition workforce and largely avoids considering whether or not emergency management counts as IGF. This frame broadly maintains that most emergency management should be outsourced, and it reinforces the current neoliberal/market accountability paradigm as effective approach.

Kirsch et. al. (2012) argue that because of the growth of humanitarianism as an industry, nonprofits and government acquisitions workforce are in need of substantial professionalization and standardization. Sweatt (2006) describes how all phases of public contracting require substantial time even under optimal conditions. In the wake of Hurricane Katrina, understaffing and the scale of the damage led to contracting officers working 90-100 hours a week, with poor inter-agency support. Mellitz (2007) reiterates the problems of contracting out more work with fewer acquisition workforce to properly do it, noting that there is "an ever-increasing number of complex contractual actions with an ever shrinking workforce" (p. 45), with the impacts on emergency contracts being the most profound due to greater urgency and complexity.

Mellitz (2007) overall suggests that a basic approach of (a) better training of the acquisitions workforce for emergency contracts and (b) hiring more acquisitions full-time equivalent employees (FTEs) can solve most issues. Mellitz (2007) also argues that, given the nature of emergencies, the vast majority of disaster response contractors actually perform adequately despite suboptimal conditions, with egregious problems only arising sporadically. Roberts, Ward, and Wamsley (2012) argue that federal emergency procurement staff continues to lack numbers and training, and that all government entities that engage in emergency

procurement during a disaster still need substantial cross-training with state, local, or inter-agency functional equivalents.

The Oversight Reform Frame

This frame considers problems as neither systemic nor rooted in outsourcing itself, but rather in lack of enforcement within existing but overly-complicated oversight systems. Romzek (2014) falls under this category through their general analysis that rewards and punishments, even if in place in a contract, are rarely enforced. Atkinson and Sapat (2012) argue that disaster procurement remains seriously under-researched, with little substantive progress made since Hurricane Katrina. They believe that as much attention and reform needs to be focused on state and local partners as on federal actors. Warren (2006) and Cannon (2007) both focus on a general lack of oversight during the recovery phase of a disaster, when many projects begin to overlap with longer-term general city planning, community development projects, and permanent relocation of displaced residents. Cannon (2007) argues that improved oversight is best done through more federal conditions that state and local Recovery awards focus specifically on social programs and inclusion, as well as more investment in Mitigation. All of the above theorists agree that existing Stafford Act conditions on federal grants to state and local entities inadequately consider existing demographic and economic fractures in communities.

Literature on oversight during response operations specifically is extremely limited. Koliba, Mills, and Zia (2011) believe that emergency management during Hurricane Katrina highlighted a unique, high-visible, and complete "breakdown in democratic, market, and administrative accountability" (p. 211) across the diverse networks that tried to respond effectively, but still failed. Sweatt (2006) worked as a contractor for U.S. Army Corps of Engineers on post-Katrina recovery contracts and outlines practical challenges of contract oversight in an emergency response scenario. Sweatt defends large business contracts awarded before a disaster, as pre-placement of supplies/services expedites the government's response. Sweatt also explains that it is difficult for the acquisitions workforce to comply with FAR- and

Stafford Act-mandated socio-economic, local business, and small business requirements for federal contracts, even under ideal conditions.

Colesanti (2014) explains how the FAR and Department supplements provide broad latitude for official Stafford Act-declared emergency operations, but the amount of latitude plus the sheer volume of regulations can over-complicate the process for both government and contractors. Kirsch et. al. (2012) suggest that the quality of emergency response and recovery should be defined by those impacted by a disaster, and this definition will naturally vary with each disaster. They argue that community groups and local nonprofits are uniquely positioned to provide independent surveys and other quality control feedback mechanisms. This would provide an assessment of service delivery independent from the government or the contractors. However, these local entities may, somewhat ironically, only be able to do this work on a large scale if they are financed by the federal government. On the other hand, Madianou et. al. (2016) note that some oversight mechanisms are misused to benefit humanitarian actors by overstating the quality of services delivered to those impacted. Therefore, awardees have an incentive to say that they are performing well, even if they are not.

Morrison (2008) focuses on tradeoffs associated with larger corporate entities winning disaster contracts compared to local small businesses winning those contracts. Morrison compares how federal acquisitions regulations on locality, business size, and subcontractor practices all have spillover economic effects for long-term community revitalization. Primarily, they argue that there is less scrutiny on recovery operations after the initial response phase ends. Their general conclusions are that advance agreements with large, non-local businesses can expedite disaster response, although it goes against Stafford Act guidelines to use local and small businesses. They argue that it is more important for local and small businesses to take over work as Response fades into longer-term Recovery and Mitigation. However, that is difficult if price remains the main factor for contract award, and tends not to occur without government facilitation (Morrison, 2008). The general thrust of this frame is that reforms are needed to

improve accountability of awardees—and therefore quality of supplies/services—during an emergency. Optimal mechanisms for that oversight are vaguely defined. This frame considers some emergency management as so essential that it is IGF. This frame sees no systemic issue with substantial outsourcing during much of the disaster cycle if oversight and accountability is enforced. In this way, it generally does not confront the current neoliberal accountability paradigm.

Taken together, all the frames agree that the current FEMA and OIG models do not adequately hold public emergency management contractors accountable. Each frame, however, emphasizes different root causes and, subsequently, recommends different solutions. In the next chapter, I analyze primary sources, building upon these three categories of critiques found in the secondary sources, and on the general accountability concepts and mechanisms detailed earlier. After I present those key findings and analysis, this thesis concludes by recommending potential policy changes, arranged by these three frames.

4. KEY FINDINGS & ANALYSIS

This chapter analyzes and summarizes the 32 selected governmental sources (Table A2 in Appendix) focused on federal emergency management acquisitions from 2004 to 2019. All selected audits in some way analyze FEMA's Acquisition Management Division (AMD) and its role in disaster response. I begin with a brief summary of findings, followed by a historical timeline of events and policies for context. I then explain key findings of each report, followed by my interpretation of likely causal processes over time. I focused on consistency in audit findings and recommendations across the years, keeping in mind proximity to major focusing events and significant disasters in understanding causes of accountability changes. I applied the information from the literature review to consider the hierarchy and relationship between auditor auditee—OIG and FEMA—and to consider hierarchy, relationships, and imposition of consequences within each document. I considered the impact of each audit's recommendations, which OIG could not unilaterally force FEMA/AMD to implement.

In summary, government reports from 2004-2019 reveal systemic issues with FEMA acquisition. General systemic issues include: lack of effective tracking of audit recommendations; lack of authority over non-integrated, *stove-piped* organizational units; lack of integrating acquisitions plans into overall agency plans; and lack of leadership substantially committed to integrating acquisitions with other organizational units. I identified three major issue areas that appeared consistently across all fifteen years of documents: (1) Information Technology (IT) and supply chain management; (2) FEMA's acquisitions workforce itself; and (3) post-award oversight of awardees. IT issues were identified in 13 of 32 (40%) audits. Acquisitions workforce issues were identified in 22 of 32 (69%) of audits. Post-award issues were identified in 19 of 032 (59%) of audits. All of these issues identified above persisted across years of audits, despite repeated and specific recommendations made by OIG to address the issues. These issues' persistence despite OIG's audits reflect a broader history of attempts at improving federal government accountability mechanisms. The table below provides a broad

overview of the history and evolution of the OIG model and federal accountability generally, as well as of contractors during emergencies specifically.

Table 2: *Timeline of Major Accountability Events*

Year	**Major Accountability Events**
1921	Budget and Accounting Act; establishment of GAO: General Accounting Office
1950	Federal Disaster Relief Act; establishment of formal federal support to local authorities
1973	Watergate scandal, Nixon impeachment, and resignation; War Powers Act; growth of Legislative oversight over Executive Branch
1974	Congressional Budget and Impoundment Control Act; Office of Federal Procurement Policy Act; establishment of formal, government-wide Federal Acquisition Regulations (FAR)
1978	Inspector General Act; establishment of OIG: Offices of Inspector General governmentwide; Civil Service Reform Act
1979	Carter Reorganization Plans 1, 2, and 3; establishment of FEMA: Federal Emergency Management Agency
1980	Reagan Administration expands "neoliberal" deregulation and New Public Management-/market-based reforms
1984	Competition in Contracting Act (CICA); contract competition regulations formalized government-wide
1988	Stafford Act; establishment of statutory authority and procedures for obligating FEMA funds, with a focus on preferring local, small business contractors during disasters
1998	Clinton impeachment
1999	OMB Circular A-76: Performance of Commercial Activities; broader interpretation of what counts as "commercial" provided, plus definition of "inherently governmental" functions
2001	9/11
2003	Homeland Security Act; establishment of DHS: Department of Homeland Security, which absorbs FEMA and several other agencies and bureaus
2004	9/11 Commission Report released; FEMA again given "all hazards" responsibility; GAO issues Framework for Assessing the Acquisition Function at Federal Agencies; GAO Human Capital Act renames it "Government Accountability Office"
2005	Hurricane Katrina: "catastrophic" disaster, costing at least $125 billion; death estimates exceed 1,800
2006	Post-Katrina Emergency Management Reform Act (PKEMRA); FEMA creates AMD: Office of Acquisition Management, later renamed Acquisition Management Division
2008	Inspector General Reform Act; establishment of CIGIE: Council of Inspector Generals on Integrity and Efficiency
2010	FEMA creates Disaster Assistance Response Team (DART)

2012	Hurricane Sandy: a "catastrophic" disaster costing at least $68 billion
2014	Digital Accountability and Transparency Act (DATA); standardization of government-wide financial data reports
2016	Inspector General Empowerment Act; more investigatory powers granted to all OIGs
2017	Hurricanes Harvey, Irma, and Maria: "catastrophic" disasters costing at least $295 billion collectively; Puerto Rico death estimates exceed 2,900
2018	Disaster Recovery Reform Act (DRRA); stable, increased funding for mitigation/planning and preparedness; streamlined state/local partners for emergency housing; U.N. Intergovernmental Panel on Climate Change (IPCC) Fifth Assessment Report
2019	Trump impeachment
2020	COVID-19 pandemic; Coronavirus Aid, Relief, and Economic Security (CARES) Act; three inspectors general fired; widespread police accountability protests

Over time, it is clear that federal emergency management was consolidated into FEMA, and there were increasing reforms to contracting regulations. Since the 1970s, the pace of catastrophic disasters began increasing, as did attempts to improve federal government accountability mechanisms. This is evidenced by macro-level events, such as impeachment, and meso-level events, such as Acts of Congress that created and refined OIG as a government-wide mechanism. Several accountability reforms passed in the early 2000's after the focusing events of 9/11 and Hurricane Katrina, with OIG and transparency a major focus. Across the same period of time, from the 1970s through the present, NPM and neoliberal accountability has become established government-wide, and the pace of contracting out has increased.

Over the post-9/11 years in question, FEMA acquisitions deficiencies identified in OIG audits are remarkably consistent. FEMA's acquisition workforce as an overall major issue appeared the most frequently, with recurring mentions of inadequate training and retention, and ongoing lack of holding CO's accountable for repeated errors. FEMA implemented some of OIG's recommended improvements to address major issues, but its persistent acquisitions deficiencies appear to contribute to problems during disaster response, and consequently higher rates of death, property damage, and financial losses. Deaths and property damage are harder to

quantify and track due to inadequate data. However, finances are the focus, and a clear metric, in many of the OIG reports issued. Over the period of reports studied, at least $12.165 billion was found to be erroneously awarded to grantees or contractors.

Beyond those hard numbers, the procedural and compliance findings of OIG were consistently critical. Pre-Katrina problems persisted through the post-Katrina era all the way up until the most recent catastrophes in 2017. To thoroughly understand the scope of issues, the next sections summarize the themes identified in the primary sources, moving chronologically from past to present, structured around the focusing event of Hurricane Katrina, Hurricane Sandy, and then the 2017 Hurricane Season.

Pre-Katrina Issues

Just before Katrina, GAO developed a framework to "enable high-level, qualitative assessments" of acquisitions at federal agencies" (GAO, 2005, pp. ii), based on four cornerstones: (1) organizational alignment and leadership, (2) policies and processes, (3) human capital, and (4) knowledge and information management (GAO, 2005). Each cornerstone is broken into two or more elements, each of which has several critical success factors. This offered a consistent method for OIG to audit an agency's acquisitions function. That year, an OIG audit of FEMA AMD found "numerous deficiencies in FEMA's record-keeping prevented...a thorough analysis of FEMA's acquisition workforce" and that "it was impossible to determine whether the acquisition personnel met training, education, and experience requirements" (OIG, 2004, p.1). That systemic disorganization extended beyond its acquisition workforce to its IT workforce and how FEMA managed their disaster supply chain.

Another audit (OIG, 2005) specifically targeting FEMA's IT systems found that they were only updated ad hoc, without long term planning, without integration into a larger strategy, and without leadership's involvement. This resulted in a patchwork of complex, customized systems that did not efficiently integrate with one another. At the time, FEMA lacked the budget to comprehensively overhaul all IT systems with 21st century technology. The audit determined

that "[IT] management issues limit the directorate's effectiveness" (OIG, 2005, pp. 5-6) and that this caused a disconnect between acquiring supplies/services and then tracking them to ensure delivery. Systemically, the audit determined that FEMA had a "tendency to rush systems acquisition to meet immediate needs… [that] contributed to many systems integration and performance problems" (OIG, 2005, p 32) during disaster responses. These deficiencies directly contributed to the catastrophic losses of the 2005, 2012, and 2017 hurricane seasons. Unfortunately, according to later current OIG reports, these deficiencies still exist in 2020. This persistent deficiency, much like the major workforce issue, underscore a limitation of the OIG model, in which its recommendations are only reported to, not imposed upon, the agency. Throughout the next sections, I detail OIG's repeatedly-identified issues and repeatedly-made recommendations on contractor accountability.

Katrina-Related Findings

20 of the 32 selected audits took place between Hurricane Katrina and Hurricane Sandy, as catastrophic losses prompted an intense set of reviews. Many reports unflinchingly identified blatant and obvious financial mismanagement and poor contractor performance, where there were inadequate consequences for mistakes made by both CO's and awardees. One of the most serious systemic issues was FEMA's inability to analyze its own systemic issues. As of 2007, FEMA lacked any OIG recommendation-tracking system, lacked the staff to implement one, and lacked a plan to develop one. A majority of 162 OIG recommendations from 2005 to 2007 were open and unresolved, and most related to contracting, especially for housing and debris removal. Of those, FEMA had not responded at all to 64 (OIG, 2007c). By 2008, there was still no effective process improvement tracking system within FEMA. In simple terms, FEMA's internal evaluations and audits were either non-existent or inadequate.

OIG instead tried to evaluate FEMA's general progress towards preparation overall for a catastrophic disaster. OIG concluded FEMA made "moderate" progress in five of nine key issue areas, modest progress in three, and limited progress in one. FEMA officials said that budget

shortfalls, reorganizations, inadequate IT systems, and limited authority for each functional area all constrained its ability to quickly improve (OIG, 2008b). At the time, Acquisition Management was one category in which OIG said FEMA had achieved "moderate" progress. Post-award oversight remained the least improved and the most problematic issue area. OIG noted FEMA had attempted to address workforce problems by hiring many more FTE's. However, FEMA's acquisitions workforce lacked guidance and understanding on Stafford Act requirements for contracting out to local/small businesses, as well as the knowledge to better analyze the prices of disaster-related offers (OIG, 2007a).

When Katrina occurred, FEMA had "approximately 55 contracting personnel" (OIG, 2008d, p.17), each of whom "was responsible for an average of $163 million" (p.17) in awards that year, far beyond the average. An additional audit in 2008 concluded that: "FEMA does not have the necessary plans and policies, or the well-prepared acquisition workforce, that it needs to respond to disasters that result in extraordinary levels of casualties, damage, or disruptions" (OIG, 2008a, p.1). Drawing on GAO's framework, OIG concluded that FEMA's human capital was still one of its worst areas. OIG reached these conclusions and recommendations despite FEMA tripling its acquisition workforce from around 50 FTE's in 2004 to around 150 in 2008. FEMA continued to lack an acquisitions-specific human capital plan. One particularly harsh finding was that "of 4,000 standby reservists, only 16 were acquisition workforce" personnel (OIG, 2008a, p. 3). Additionally, by 2008, FEMA had scaled up to around 2,600 FTE's total, but only 150, or 5.8%, were acquisitions personnel (OIG, 2008a). This was despite over 50% of FEMA's funds being awarded to private entities during a disaster response. On paper, FEMA concurred with all of OIG's recommendations on human capital basics.

Some high-cost, high-impact disaster response awards that repeatedly appeared in post-Katrina audits were "multi-tier" contracts with extensive subcontracting, energy/electrical grid contracts, housing contracts, and all three types of "assistance" awards - Individual, Technical, and Public. Each assistance award is effectively a block grant, but at a different scale. Individual

Assistance is for homeowners to rebuild or repair, and occurs during recovery. Public Assistance is a flexible award for state, tribal, or local governments to perform general disaster response work. Technical Assistance is for state, tribal, or local governments and private partners to perform preparedness and mitigation work, or are typically for unique engineering or advanced scientific recovery projects.

An audit of multi-tier subcontracting found that "it was impossible to determine the extent of subcontracting tiers" (OIG, 2008c, pp. 1) as only the first tier beneath the prime had to provide standardized reports - and CO's often failed to have oversight of even that tier. As such, there was no mechanism to ensure second or third tier subcontractors were local businesses, small businesses, competing for those awards, and so on. This prompted a major acquisitions reform in the 2006 Post-Katrina Emergency Management Reform Act (PKEMRA). That act mandates that for emergency awards over the Simplified Acquisition Threshold (SAT), any sole source award was limited to 150 days, and all subcontracts were limited to at most 65% of the award value.

One of the priority resources needed in a disaster response is energy and an operational electrical grid. Nine independent audit reports all concluded that more than half of the electric cooperatives/utilities that received FEMA funds, and then contracted out response and recovery work, failed to do so competitively or in compliance with other basic federal acquisitions regulations (OIG, 2006) The audit found that "neither the states, as grantees, nor FEMA, as the responsible federal funding source, enforced the standards when the electric cooperatives submitted their claims for reimbursement" (OIG, 2006, p. 3) of disaster costs. The result was at best a waste of taxpayer funds on overpriced contracts, and at worst poor performance of contractors that led to longer periods without electricity. Each audit on this topic found that CO's or their representatives did not impose consequences on awardees and sub-awardees, and there were unclear consequences for CO's when their awards were done improperly.

Persistent Post-Katrina Deficiencies

Like energy, housing is uniquely important for disaster response, but also uniquely expensive and difficult to acquire. A review covering 2005 to 2008 found that FEMA records were so inadequate that housing contracts and grants to states were unable to be fully evaluated. What was determined was that of the thousands of awards over the SAT for Katrina, over half were sole-sourced (OIG, 2008d). Most of those dollars awarded were for housing, most of which was temporary shelters that rapidly depreciated. Despite housing being such a major part of all response/recovery spending, there was no strategic plan and there were few advance housing agreements in place.

Multiple audits repeatedly found deficiencies with award and post-award oversight of assistance grants. The assistance process remained “hindered by untimely funding determinations, deficiencies in program management, and poorly designed performance measures" (OIG, 2009a, p. 1). There was no system for tracking award appeals, post-award modifications, or measuring performance. OIG concluded that the "root causes” of deficiencies were "employee turnover, inexperience, and lack of training" (p. 12). It also concluded that "FEMA’s workforce generally lacks sufficient experience and training to perform” (p. 13) in compliance with the FAR and Stafford Act. A separate, independent audit a year later drew the same conclusions (OIG, 2010d).

A year later, a follow-up audit by OIG found that several pre-disaster agreements for various services were in place, but were set up in a way that FEMA may be grossly over-spending in slower disaster years (OIG, 2011b). OIG again concluded that FEMA “needs to improve its acquisition function...there is still a need for substantial improvement in contract file documentation and better management oversight, including the prompt implementation of corrective actions” (OIG, 2011b, p. 2) OIG concluded that it was clear FEMA was over-spending on poorly-monitored grants, and there was a “lack of prioritizing essential response actions such as sheltering and feeding” (OIG, 2011b, p. 2). OIG also concluded that CO’s, COR’s, and other

parts of the acquisitions workforce rarely had their errors corrected. Unfortunately, that 2011 audit simply reaffirmed what multiple Post-Katrina audits published in 2008 and 2009 had already identified about the acquisitions workforce and its contract management.

In 2008, an independent audit found fundamental flaws in FEMA's contract management (OIG, 2009b). That audit sampled 32 disaster contracts at random from FY 2007. Many files were missing, misplaced, or never created. Excessive post-award price modifications were common and often lacked required justifications. Individual CO's often maintained contract files and knowledge, with high turnover leading to loss of that knowledge. In 2009, another independent audit highlighted the lack of a strategy to incorporate GAO's best practices (OIG, 2009c). While FEMA had begun using GAO's 2005 framework for federal acquisitions, and had gone from around 150 to 237 acquisitions FTE's just from 2008 to 2009, acquisitions remained under-resourced and disorganized. Acquisitions was treated as an afterthought for disaster response, and was not considered integral to other functional areas. Additionally, FEMA was authorized for many more acquisitions FTE's, but those positions remained vacant as turnover remained high. I.T. logistics deficiencies persisted, and "FEMA's method of tracking what partners have in their inventories is manual and recorded on computer spreadsheets" (OIG, 2009c, p. 11) that were only updated "periodically" (p. 12) and manually, without automation.

These audit findings repeat year after year, with OIG consistently recommending the same or similar corrections over and over. Another audit in 2010 found that most of these issues persisted and that recommendations remained open and unresolved. More than half of audited contract files still had serious issues, and, overall, "FEMA did not always provide the most cost-effective solution through contract support for disaster relief" (OIG, 2010c, p. 1). Furthermore, some major acquisitions were based on "pressure from internal and external officials" that led to CO's "making decisions that were not necessarily based on actual need" (OIG, 2010c, p. 9). Internal disorganization led to leadership not prioritizing acquisitions or strategically integrating it, leading to rushed and costly errors during a disaster (OIG, 2010c).

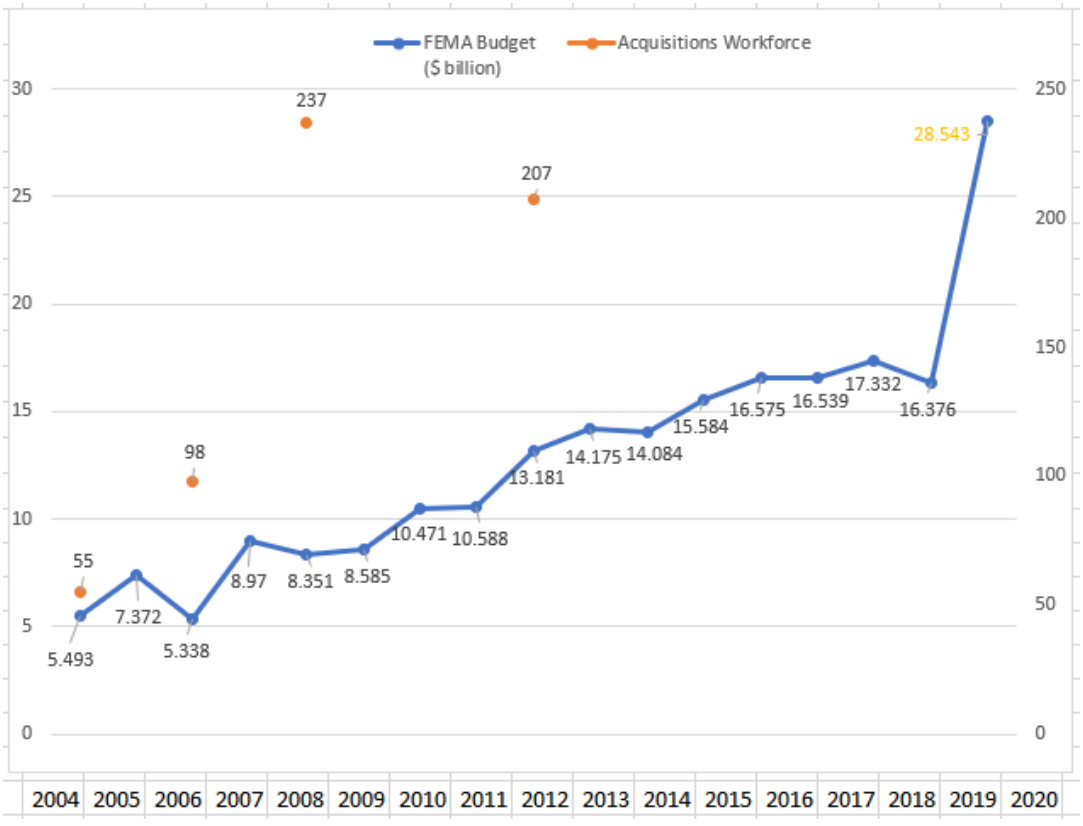
Overall, based on OIG's tracking of recommendations, FEMA had improved at least modestly in every key issue area from 2005 to 2010 (OIG, 2010b). One major improvement was creating the Disaster Acquisition Response Team (DART) in 2010, a mobile, rapid response group dispatched to each major disaster. FEMA had "substantially" improved pre-disaster contracts, and "moderately" improved acquisitions staffing. Turnover, lack of incentives to keep experienced CO's, and lack of experienced applicants all perpetuated high vacancy rates. Despite the COTR program, post-award oversight remained only "modestly" improved. Persistent IT concerns remained with tracking supplies, however, as did an overall lack of qualified FTEs. FEMA continued to fail to track OIG recommendations. From 2005-2010, only 40% of recommendations were fully closed and resolved (OIG, 2012). One major issue, post-award oversight, was only reformed by the 2006 Post-Katrina Act. That mandated FEMA's 2008 creation of a Contracting Officer's Technical Representative (COTR) training program. The program is intended to develop a larger, more effective workforce for post-award oversight that does not overly burden acquisitions FTEs. However, "inadequate training, inadequate staffing, and conflicting supervisory/management hierarchies" all complicated COTR performance (OIG, 2011a).

Post-Sandy Findings

Unlike the multitude of audits, investigations, reports, and recommendations that stemmed from the catastrophe of Hurricane Katrina, the post-Hurricane Sandy documents tend to be more general in scope, larger, and less frequently published. This is largely due to changes by the restructuring of OIG under a single entity at GAO, when the 2008 OIG Reform Act created CIGIE by consolidating the two parallel executive branch and legislative branch bodies that coordinated OIG reports. This also helped standardize the types of reports issued by OIG. The most frequent and common OIG reports are now shorter and more focused on specific awards. It is also possible that, following the large number of reports focused on FEMA's systemic deficiencies and acquisitions issues, OIG felt it had already identified the most pressing issues.

By 2014, OIG concluded that FEMA's acquisition workforce had somewhat professionalized, and had improved substantially since the pre-Katrina era, but still routinely made major errors. As one example, FEMA widely distributed inaccurate information to potential and successful awardees about federal acquisitions, if they distributed information at all (OIG, 2014). Although FEMA had "more than tripled the number of contracting officers" (GAO, 2015, p. 2) since Katrina, it still was unable "to prioritize disaster workload" (GAO, 2015, p. 3) during a response. As the chart indicates, FEMA increased acquisitions staff since Katrina, but did so erratically and not as steadily as its overall budget—much of which is spent by the acquisitions staff.

Figure 8: *FEMA Budget and Acquisitions Workforce Growth, Publicly-Available Data*



The chart and findings above highlight ongoing, systemic problems that OIG identified for years, but FEMA failed to remedy. A fraction of FEMA's workforce still spends vast sums of agency money every year, but with systemic problems remaining unresolved. Two reports just

before the catastrophic 2017 hurricane season highlighted how unprepared FEMA was to rapidly acquire and manage disaster supplies and services. The same issues of FEMA failing to analyze and act on its own improvements persisted. OIG concluded that its recommendations had not led to "permanent changes to improve its [FEMA's] oversight" because FEMA "does not have policies and procedures for conducting substantive trend analysis of audit recommendations" (OIG, 2016a, p. 3). Many awards were inadequately competed, with undue risks taken on questionable awardees, and with negligible enforcement of post-award compliance (OIG, 2016b). These deficiencies contributed at least in part to deaths and property destruction exacerbated by a lack of electricity, housing, water, food, medicine, and debris removal.

The 2017 Hurricane Season

While other storms hit nations around the Atlantic in 2017, these three Hurricanes together inflicted the bulk of the damage to the United States. Cumulative damages were at least $295 billion, and hurricane-related deaths topped 3,000 - the majority of which were Puerto Ricans. It was by far the most destructive hurricane season since Katrina in 2005. Harvey, the first hurricane of the season and one of the most powerful Category 5 storms on record, caused catastrophic flooding and property damage across Texas and the rest of The South. A few weeks later, Hurricane Irma, another Category 5 storm, severely damaged Puerto Rico and continued on to Florida. After those two events strained FEMA and state resources, Hurricane Maria dealt Puerto Rico a knockout blow.

FEMA's own after-action review revealed that, much like Katrina 12 years before, the agency was overwhelmed by the scale of response required. By the time the country had been hit by three of the strongest storms in history, FEMA proved unable to address the unique needs of an island of three and a half million residents that lost most of its infrastructure overnight. For the first half of the hurricane season, California had also endured unprecedented wildfires. In 2017, more disaster survivors registered for assistance than the previous 10 years combined. In a three-month period, FEMA "issued more contract actions than in an entire previous fiscal year to

meet disaster requirements" (FEMA, 2018a, p. viii). FEMA's acquisitions workforce was simply not large enough or robust enough.

Longstanding issues with hiring, training, and retaining acquisition staff became worse on exceptionally long and stressful deployments across the Caribbean (FEMA, 2018a, p. 21). The DART and COTR programs did not scale up adequately, and the overall workforce was too small to acquire and deliver required supplies and services in so many locations at once (FEMA, 2018a, p. 30). Existing interagency agreements were insufficient for the supplies needed. FEMA admitted that its weak logistics and supply chain management systems led to widespread shortages (FEMA, 2018a, p. 25). Most local and small businesses on Puerto Rico had been devastated, undermining a major principle of the Stafford Act and frustrating the economic needs of response and recovery contracts (FEMA, 2018a, p. 29).

In an audit immediately afterward, OIG concluded "our previous reports clearly point to FEMA's ongoing failures to oversee" awardees (OIG, 2017, p. 1). That report was "a meta-analysis of past reports on acquisitions issues, spurred in part by the catastrophic nature of the 2017 hurricane season" (OIG, 2017, p. 2). Beyond the failures FEMA itself admitted, OIG (2017) reiterated that "lack of compliance with Federal [acquisition] regulations increases the risk of favoritism, collusion, fraud, waste, and abuse" (p. 5). The final available OIG audit on FEMA's acquisitions systems blasted its "longstanding IT deficiencies" (OIG, 2019, p. 1). OIG found that, "although mandated for all federal agencies more than 20 years ago" (OIG, 2019, p. 6), in 2019 FEMA still did not have a strategic IT plan, an organizational structure that let its Chief Information Officer expedite updates, or the ability to effectively track supplies during disasters.

The 2017 catastrophes also prompted GAO to do higher-level reviews, which were equally critical. Across the entire government, almost all disaster awards-related recommendations made were for FEMA, which struggled to respond (GAO, 2019c). GAO's government-wide assessments of high risk areas for fraud, waste, and error found that disaster aid

remained one of the most serious challenges, in part because of climate change increasing all damages (GAO, 2019d). Taken as a whole, the entire selection of primary sources focused on FEMA acquisitions paints a bleak picture. Issues are not limited to poor oversight and performance of awardees and FEMA itself, but of OIG's oversight of FEMA. The same recommendations were made over and over with little impact. Changes that were implemented took years to occur, and were often implemented only after they were mandated by statute.

For the time period in question, only two leaders of FEMA ever resigned due to performance in handling a disaster: Michael Brown in 2005, after Hurricane Katrina, and Brock Long in 2019, following ongoing criticism after Hurricane Maria. No DHS Secretary resigned due to disaster response performance. There was almost no available data on FEMA's internal organizational unit leadership for the time period in question, but there appeared to be minimal consequences imposed on the acquisitions workforce for poor performance. Based on available data, it seems fair to extrapolate that as FEMA and OAM largely ignored many OIG recommendations, CO's continued to have negligible consequences imposed for their own performance failures. The lack of performance-based, evaluation-related consequences suggest that FEMA's internal accountability mechanisms do not work as intended, at the same time that external mechanisms do not work, given OIG's structural inability to impose consequences. These formal mechanistic failures appear to compound the informal market-based mechanistic failures that occurred when contractors failed to deliver supplies/services, contract costs were inflated, or when inadequate competition led to questionable awards. The next chapter reiterates and these findings and connects them back to the identified conceptual and mechanistic accountability issues back to the three-part critical framework to formulate a policy path forward.

5. PUBLIC POLICY IMPLICATIONS AND CONCLUSIONS

To return to the main focus of this thesis, accountability is about power relations, authority, and hierarchy, in which one entity holds another entity to account for their behavior (Jarvis, 2014). In a democracy, voters are the top of the hierarchy and elect officials, who appoint leaders of public entities, in which managers/supervisors oversee rank-and-file employees (Warren 2014). This thesis's case study is the very bottom of that hierarchy: private awardees who receive billions in public dollars through a relatively small group of FEMA rank-and-file acquisitions staff. During disaster response, a majority of FEMA's public dollars can be awarded to private entities. Substantial amounts of public funds are spent on such awards, which are supposed to cost-effectively protect property and save lives. The dominant thinking of this system is that private firms will compete for the award, the best vendor will earn the award, and then perform well in the hope of future awards (Hansen, 2002; Romzek, 2014).

This very long hierarchy of voters at the very top and awardees at the very bottom is a messy, hybrid accountability web, not a simple chain of command. In the current contractor-preferred system of emergency management, market incentives and acquisitions staff are supposed to be the primary mechanism that hold awardees accountable. As an additional mechanism, GAO and OIG also serve as external auditors who are supposed to have the authority to hold FEMA and its employees accountable. GAO/OIG recommendations—often systemic in nature—are supposed to change FEMA's acquisitions policies and procedures. At a higher level, Congress should be proactively and regularly drawing upon GAO/OIG data to mandate systemic changes.

The data available indicates that the current OIG model is not effective at holding FEMA accountable for pervasive, systemic acquisitions issues. The issues identified here have, at the least, exacerbated the losses of the three most catastrophic hurricane seasons in 2005, 2012, and 2017. While it is not fair to blame FEMA entirely for all damages, disasters in those years alone resulted in thousands of dead Americans and almost a trillion dollars in lost property. Parts of the

catastrophic damage in Puerto Rico may be attributed to its remoteness as an island, and its quasi-colonial political status. The OIG model appears to have substantially investigated and documented issues in need of improvement, and it has helped facilitate several incremental changes over time within FEMA. However, documentation on its own is clearly ineffective. At least three systemic issues have persisted for almost two decades without substantial improvement, despite OIG repeatedly investigating and recommending the following specific improvements:

- IT systems that effectively tracked disaster supplies and services that FEMA acquire
- An adequately staffed, trained, retained, and accountable acquisitions workforce
- A post-award oversight system that monitorsed and holds awardees accountable

It appears that informal market accountability does not adequately hold contractors accountable, at the same time that formal hierarchical accountability within FEMA does not hold CO's accountable. It also appears clear that the OIG model of holding agencies accountable through audits is ineffective. Even a GAO ruling on a specific contracting change, which can function like an industry-wide regulation, can be slow to be implemented. Procedural changes may never implemented, if that change relies on CO behavior being corrected by supervisors who do not hold CO's accountable, or if agency or functional unit leadership does not hold supervisors accountable.

Acts of Congress implemented most of the substantial reforms of the last decade by mandating in statute serious changes that would result in civil or criminal charges for CO's or awardees who do not comply. The 2006 Post Katrina Act limited subcontracting and sole source awards. The 2008 OIG Reform Act consolidated and streamlined the authority of all the OIG's government-wide. The 2016 OIG Reform act broadened investigatory powers. The 2018 Disaster Recovery Reform Act greatly streamlined some aspects of grant funding, especially for recovery, mitigation, and preparedness. These Acts did draw upon GAO/OIG documentation, proving that, in a longer-term view, this mechanism has some ability to affect change. However, this pace of change, relative to the increasing frequency and severity of disasters, will lead to

more deaths and property destruction, when needed changes have been clearly documented for decades. The next and final section of this thesis explains the implications for public policy on emergency management contracting accountability. Its structure mirrors the three-part critical framework, which substantially overlaps with the major issues identified in GAO/OIG documents.

Public Policy Implications

An Act of Congress after another catastrophe is not a proactive approach. It is not sound public policy making to wait for more deaths and destruction to punctuate the current administrative equilibrium (Roberts, Ward, & Wamsley, 2012b). Below are several specific recommendations that chould be proactively implemented to varying degrees. These are based upon and refer back to the three-part critical framework in the literature review.

Insourcing Policies

This major theoretical criticism focused on the profiteering tendency of private entities competing for public dollars during a crisis (Loewenstein, 2015). In simple terms, one solution to preventing profiteering is to insource much of the work back into the government, rather than continue to outsource to private entities and hollow out the state (Milward & Provan, 1993, 2000, 2003). This rests on the assumption that much of emergency management is IGF and too sensitive to be performed by private vendors. This frame also assumes that hierarchical accountability and a shorter hierarchical chain is better. The inherently life-or-death nature of disaster response provides a valid argument for at least some aspects of disaster response to be entirely performed by the government, not awardees. This model would be a major departure from the current one, and require constant additional standby capacity, particularly for disaster response. It could also substantially simplify some of the hybrid accountability web, by reducing the number of actors reliant on neoliberal/market accountability.

However, the entirety of all disaster response and emergency management cannot be inherently governmental functions. Even if all disaster response was inherently governmental

and should be insourced, what happens in an emergency will, by definition, exceed existing capacity and necessitate at least short-term help from elsewhere. Even if the government alone should always produce X type of supplies or services, someday there will be a disaster so catastrophic that the government cannot provide enough, and they would have to be acquired. It is simply impractical for the government to always maintain all the employees, supplies, and services necessary to manage every possible emergency. Additionally, disaster capitalism complaints about powerful corporations profiting by perpetuating disasters could not realistically be addressed just by ending the outsourcing of emergency management work to private firms. The variety of the work performed and the awardees hired for disaster response is extremely diverse compared to the relatively few industries perpetuating climate change (Bolin & Kurtz, 2018). It must also be noted that FEMA's leadership, supervisors, CO's, and COTR's did not appear particularly successful at holding themselves accountable for their own performance. Although informal market accountability does not seem to effective, there is no guarantee that bringing more workers into a formal accountability hierarchy within government will by itself improve performance.

At the least, however, it does make sense for the government to maintain some minimum capacity beyond what has become standard practice under NPM. For example, as outlined in Table 2A, there are some essential supplies/services that are needed every single year, to varying degrees. Essential supplies should be warehoused in larger numbers in more strategic locations and sold or otherwise recycled when or if they expire. FEMA and OIG have admitted that housing tends to be the costliest, and electrical grid repair tends to have the worst oversight. Those two services should have unique priority and additional staffing. Similarly, some advance contracts for known essential services could, to an extent, be replaced by inter-agency agreements to borrow existing government personnel. Some of these already exist, for example, between FEMA and Army Corps of Engineers (ACE) for levy and dam work, or between FEMA and DoD for fuel.

These agreements could be deeply expanded to establish a government-wide corps of auxiliary personnel who can be activated during the most severe disasters. Perhaps the simplest, most helpful, and most urgently-needed sort of insourcing to expand FEMA's capacity would be inter-agency agreements for borrowing personnel from other government agencies. The personnel re-assigned from other agencies could be technical, emergency management, or even acquisitions specialists. FEMA's DART and COTR programs were clearly insufficient for the 2017 Hurricane Season. An ability to rapidly draw on hundreds of other CO's elsewhere in the government would at least provide a temporary workforce boost to FEMA beyond their inadequate current FTE's.

Having additional standby capacity that goes unused may be considered a waste by some measures. However, this tradeoff must be calculated based on the value of lives saved and property preserved versus the value of always running incredibly lean. For example, during the current COVID-19 pandemic, the actual cost of storing a few million extra surgical masks seems trivial compared to saving even a dozen more lives. In 2017, storing additional blue roof sheeting or generators may have saved property and lives. This same tradeoff analysis applies to costs for training CO's in other agencies on the Stafford Act and disaster awards.

Workforce Reform Policies

These policies represent lower hanging fruit in terms of achievable policy goals. Rather than overhauling the contractor-preferred model entirely, more and better personnel could be added to FEMA. One of the most significant repeated OIG recommendation was that FEMA needed to fully staff acquisitions FTEs for which it was authorized, and to properly train and retain them. Additionally, FEMA consistently failed to prepare staff to serve as a COTR performing post-award oversight. An obvious contributor to this is funding for FTEs and low compensation in general for government employees (Mellitz 2007). FEMA's human capital issues are also partly due to the uniquely stressful nature of emergency management, which increases turnover (Sweatt 2006). Higher hazard pay or performance-based bonuses may

improve rank-and-file acquisitions FTE quality. It is logical to increase pay for COTR's taking on additional duties, or at least increase their training and include COTR duties in evaluations (Roberts, Ward, & Wamsley, 2012).

It should be noted that hiring more acquisitions FTEs has not solved systemic issues in FEMA AMD. FEMA quintupled its acquisitions FTEs from 2004 to 2018, going from around 50 to over 250. While it is possible that FEMA remains far below the number of acquisitions FTE's needed, other workforce issues appears in audits. Managers/supervisors consistently failed to hold rank-and-file employees accountable for acquisitions errors that OIG repeatedly flagged. Additionally, unclear intra-organizational authority, changing leadership, and lack of integration within FEMA allowed repeat errors for IT modernization and integrating acquisitions into strategic plans. Only hiring more FTE's will not sufficiently remedy systemic problems of poor leadership and poor organizational structure.

There should be clear policies implemented to improve the performance of CO's who repeat mistakes. There should also be clear policies to hold accountable supervisors who allow acquisitions FTE's to repeat mistakes. The Acquisition Management Division needs to be an integral part of strategic planning. That Division manager, and management above them, need to be relieved of their duties if they cannot integrate acquisitions into strategic plans. Rapidly modernizing the IT tools used by acquisitions and other functions to manage the complicated disaster supply chain must be prioritized. The division manager or other leadership that fails to do so should also be held accountable. The financial costs to modernize and implement a culture of accountability up and down the chain of command may be high. However, more deaths and property damage are the costs of the workforce continuing to stagnate.

The next two sections consider oversight reform at two levels. At the meso level, there is the issue of reforming how FEMA oversees its awardees. At the macro level, there is the issue of reforming how OIG oversees FEMA. Both have challenges, but FEMA improving its own oversight is easier to achieve.

Awardee Oversight Reform Policies

Reforming oversight of awardees consists of two possibilities. On the one hand, it may be efficient to require less oversight overall of awardees, or at least require awardees to comply with less complex regulations. On the other hand, greater capacity for FEMA staff to perform oversight duties is needed. Either of these reforms would improve the current situation in which too few staff without adequate training fail to oversee thousands of awardees, all of whom must comply with extremely complex regulations.

Not all regulations are red tape that should be cut away. There are good intentions behind regulations on how grant funds must be spent, what costs are allowable, subcontract limits, and small/local businesses (Warren, 2006; Cannon, 2007). However, similar to IT, acquisitions regulations have been patched together in a piecemeal fashion for decades, with few comprehensive overhauls. In order to ease the burden on CO's, COTR's, and awardees, some regulations should at least become easier to waive, if not relaxed permanently. To an extent, DRRA accomplished some of this by streamlining allowable costs for grantees and giving more power to state/local governments for housing. However, DRRA largely focused on Recovery, Mitigation, and Preparedness, not Response.

For disaster response, similar to how FEMA should be able to borrow employees from other agencies, FEMA should be able to tap into other agencies' existing contracts for essential supplies, if an existing vehicle is exhausted or if there is not enough time to compete a new award. On a larger level, while it is controversial, requirements for hiring small/local businesses should be able to be waived for the initial phase of response to a disaster of a certain severity. In the case of Puerto Rico, where almost all local/small businesses were destroyed during Hurricane Maria, this severely impeded the response. The intentions for hiring small/local businesses are good, and it makes sense for this to be done as often as possible, especially during the longer recovery phase. However, it is simply impractical to do so during the initial part of a catastrophic disaster.

Additionally, certain percentage regulations for hiring woman-, minority-, or veteran-owned small businesses can become burdensome during a disaster response. If a firm is minority-owned, but not veteran- or woman-owned, and the agency has only met X% of its woman-owned requirements for that year, more paperwork must be processed, or that firm cannot be hired. The various permutations of each small business regulation are excessive (Colesanti, 2014). They should be able to be waived or simplified for essential, early parts of disaster response, similar to recommended small/local business waivers.

Finally, at present, only a government employee may serve as a COTR for specific awards. However, there is a possible workaround to this in terms of more general evaluation and oversight of a disaster response. Contracts or grants for community surveys that provide data to FEMA on their performance overall should be set up in order to add an additional dimension to FEMA's situational awareness (Kirsch et. al., 2012). This could provide increased understanding of the needs of the small/local business communities, in addition to disaster response and recovery needs.

Executive Branch/FEMA Oversight Reform Policies

Even if FEMA maintained vastly larger standby reserves of employees, supplies/services, and better advance agreements, it would likely not stop gaffs like losing an entire warehouse of water bottles in Puerto Rico, or delays in restoring electricity due to alleged nepotism. Both of those incidents reflect more than longstanding IT and acquisitions deficiencies. They reflect either neglect or abuse of power by those who assume they will not be held accountable for their actions. OIG should have increased authority to implement systemic recommendations, instead of simply reporting those recommendations. The key to this is the ability to impose consequences if recommendations are not implemented, plus actual follow through on imposing those consequences. As Romzek (2014) and other theorists noted, the final step of following through with rewards or punishments is the most important part of practicing accountability, but it is unfortunately often absent.

These reforms are much more complicated and structural than the others I suggest. There is an inherent tension between the legislative branch's GAO/OIG recommendations compared to the executive branch's DHS/FEMA interpretations of policies. GAO/OIG is already seen by some as invasive and violating democratic checks and balances, despite recommendations being non-binding and poorly tracked. Expanding the power of OIG to include an ability to impose negative consequences or personnel actions would likely require an Act of Congress, and face legal and constitutional challenges. However, it is difficult to imagine what else could make FEMA change its behavior after so many years of effectively ignoring audit recommendations. There needs to either be a way for FEMA to make itself comply with audits, or make the auditor able to enforce compliance by upgrading it to a sort of regulator.

This level of oversight reform is politically difficult. Some recent legislation attempted to address parts of these problems government-wide. The Inspector General Recommendation Transparency Act (S. 2178) would have established a public database of OIG recommendations, plus identify those that had not been completed within one year. That bill passed in the Senate, but died in the House Committee on Oversight and Government Reform (Congress.gov, 2018a). The Post-Disaster Assistance Online Accountability Act (H.R. 1307) would have instructed OMB to post quarterly updates online about disaster assistance provided by each agency. It passed in the House, but died in the Senate Committee on Homeland Security and Governmental Affairs (Congress.gov, 2019a). The Disclosing Aid Spent to Ensure Relief Act (H.R. 1984), or DISASTER Act, would have reported to Congress all disaster response and recovery spending by each agency, not just that from FEMA or DHS. It also passed in the House and died in the same Senate Committee (Congress.gov, 2019b). All three bills similarly made it easier to track the status of recommendations or funds. All three were fairly modest, and all three died.

Some OIG reforms did pass prior to today's highly polarized and, some would say, decreasingly democratic national environment. The 2008 Inspector General Reform Act streamlined the overall structure of OIG, and the 2016 Inspector General Empower Act expanded

its investigatory powers. However, neither gave OIG recommendations more teeth. It is also important to consider how oversight laws have often provided data for later analysis, but not authority changes. For example, the 2014 Digital Accountability and Transparency Act (DATA, S. 994) helps GAO and OIG to track assessments of agencies' spending and compliance. As of 2018, only 15 of 53 audited agencies were in compliance (GAO, 2018). Despite this documented noncompliance, there is no clear action being taken to bring all agencies into compliance with that law. At present, it appears that OIG is a watchdog with keen eyesight for identifying problems and that provides some oversight, but is almost all bark and no bite.

Conclusions

Accountability is a complex concept that is widely invoked and essential to our democracy, but still vaguely defined both in theory and in practice. Compared to the abundance of research on economic, trade, education, political science, or other policy disciplines, accountability remains relatively under-researched in public policy and administration. This remains true despite growing numbers of scandals highlighting issues with holding powerful officials to account and accounting for government performance and finances. Relative to the scale and extent to which the federal government is now outsourced to contractors and grantees, this specific issue is grossly under-researched. Lack of quantitative and qualitative data means that analyses like this thesis, and much of the academic literature in which it is grounded, relies on substantial interpretation. What is clear from the available research and primary source data is that accountability is fundamentally about hierarchical power relations and one party being able to be held accountable by another. Typically this is accomplished through the imposition or threat of negative consequences. What also appears clear is that the further removed from an oversight body, or the longer the chain of command, the more complicated accountability becomes. For emergency management awardees working in the middle of a chaotic disaster, the chain of command is long and the level of remove from ideals of accountability is quite large.

As evidenced by FEMA's acquisition rank-and-file staff and their managers/supervisors, having the authority to impose consequences on its own appears to be insufficient. If consequences are never imposed, behavior may never change, or may change so slowly as to perpetuate systemic issues. While some hierarchies appear clear, even the ideal model of voters democratically electing leaders has issues. These models further break down at the level of remove of a subcontractor operating amidst a disaster response, these theories further break down. Market accountability seems to have also failed to ensure awardees' performance. Better accountability mechanisms are needed, and my recommendations are only modest steps. It is unacceptable to wait for the equilibrium to puncture again, thousands to die, and billions of dollars to be lost before we reform GAO/OIG or DHS/FEMA.

APPENDIX A: Acronyms

ACE Army Corps of Engineers
AMD Acquisition Management Division (formerly: Office of Acquisition Management)
BLS Bureau of Labor Statistics
CARES 2020 Coronavirus Aid, Relief, and Economic Security Act
CDC Centers for Disease Control and Prevention
CICA 1984 Competition in Contracting Act
CIGIE Council of Inspector Generals on Integrity and Efficiency
COTR Contracting Officer's Technical Representative
DART Disaster Assistance Response Team
DATA 2014 Digital Accountability and Transparency Act
DHS Department of Homeland Security
DoD Department of Defense
DOI United States Department of the Interior
DoJ Department of Justice
DRRA 2018 Disaster Recovery Reform Act
EPA Environmental Protection Agency
FAI Federal Acquisition Institute
FAR Federal Acquisition Regulations
FEC Federal Election Commission
FTE Full Time-equivalent Employee
FEMA Federal Emergency Management Agency
GAAP Generally Accepted Accounting Procedures
GAAS Generally Accepted Auditing Standards
GAGAS Generally Accepted Government Auditing Standards
GAO Government Accountability Office (formerly: General Accounting Office)
GPO Government Publishing Office
IPCC Intergovernmental Panel on Climate Change
NRF National Recovery Framework (NRF)
NIMS National Incident Management System (NIMS)
NPM New Public Management
NPR National Performance Review
OFPP Office of Federal Procurement Policy
OIG Office of the Inspector General
OMB Office of Management and Budget
OPM Office of Personnel Management
PART Program Assessment Rating Tool
PKEMRA 2006 Post-Katrina Emergency Management Reform Act
PPE Personal Protective Equipment
PREPA Puerto Rico Electric Power Authority
RPM Responsible Party Model
SAI Supreme Audit Institution
USDT United States Department of the Treasury

APPENDIX B: Tables

Table 3: *59 Selected DHS OIG Acquisitions Sources*

Number	Title	Publication Date	Fiscal Year	General Scope
DS-09-04	Audit of California Department of Water Resources, Sacramento, CA, Public Assistance ID No. 000-92004, FEMA Disaster No. 1155-DR-CA	02/05/2004	2004	Specific: Other Disaster
OIG-04-12	An Audit of FEMA's Acquisition Workforce, March 2004 (PDF, 22 pages - 1.9MB)	03/01/2004	2004	Systemic: Acquisitions Overall
DD-06-04	Clearbrook, LLC Billing Errors Under Contract	11/10/2005	2006	Specific: Hurricane Katrina
DD-06-05	Washington Parish Contracting Problems	11/14/2005	2006	Specific: Hurricane Katrina
DD-11-06	Recap of Procurement of Problems Identified in Audits of Electric Cooperatives, Audit	09/08/2006	2006	Systemic: Acquisitions Overall
GC-AL-06-16	Review of Hurricane Katrina Contracts Baldwin County, Alabama	02/22/2006	2006	Specific: Hurricane Katrina
GC-AL-06-20	Review of Hurricane Katrina Contract City of Bayou La Batre, Alabama	03/15/2006	2006	Specific: Hurricane Katrina
GC-AL-06-21	Review of Hurricane Katrina Contracts City of Fairhope, Alabama	03/14/2006	2006	Specific: Hurricane Katrina
GC-AL-06-22	Review of Hurricane Katrina Contracts City of Daphne, Alabama	03/14/2006	2006	Specific: Hurricane Katrina
GC-AL-06-24	Review of FEMA Contracts Awarded by Contracting Officers Montgomery, Alabama, Joint Field Office	03/17/2006	2006	Specific: Hurricane Katrina
GC-AL-06-27	Review of Hurricane Katrina Contracts City of Orange Beach, Alabama	03/22/2006	2006	Specific: Hurricane Katrina
GC-AL-06-38	Review of Hurricane Katrina Debris Removal Contract City of Tuscaloosa, Alabama	04/28/2006	2006	Specific: Hurricane Katrina
GC-FL-06-46	Review of FEMA Contracts Awarded by Contracting Officers at the Orlando, Florida, Long Term Recovery Office	07/17/2006	2006	Specific: Hurricane Katrina

GC-HQ-06-11	Management Advisory Report on the Acquisition of Cruise Ships for Hurricane Katrina Evacuees	02/16/2006	2006	Specific: Hurricane Katrina
GC-HQ-06-41	Management Advisory Report on Contract HSFEHQ-06-C-0024 to Provide Assistance to Eligible Evacuees in Need of Housing and Pharmaceuticals	06/08/2006	2006	Specific: Hurricane Katrina
GC-MS-06-15	Review of FEMA Contracts Awarded by Contracting Officers At the Biloxi, MS Area Field Office	02/22/2006	2006	Specific: Hurricane Katrina
GC-MS-06-29	Review of FEMA Contracts Awarded by Contracting Officers At the Jackson, Mississippi Joint Field Office	03/28/2006	2006	Specific: Hurricane Katrina
GS-LA-06-57	Review of Hurricane Katrina Activities Congressional Inquiry, Contingency Payment of Contractors in St. Tammany Parish, Louisiana	09/29/2006	2006	Specific: Hurricane Katrina
DA-07-07	Review of Hurricane Katrina Activities, Alabama Department of Conservation and Natural Resources, FEMA Disaster No. 1605-DR-AL,	01/07/2011	2007	Specific: Hurricane Katrina
DA-07-13	Review of Contract Costs - Emergency Disaster Services, Contract No. HSFE04-05-7233, FEMA Disaster No. 1604-DR-MS,	08/21/2007	2007	Specific: Hurricane Katrina
DD-07-06	Interim Review of Contract Costs, Clearbrook, LLC FEMA Disaster No. DR-1603-LA, Report No.	02/06/2007	2007	Specific: Hurricane Katrina
OIG-07-36	FEMA's Award of 36 Trailer Maintenance and Deactivation Contracts,	03/30/2007	2007	Specific: Hurricane Katrina
OIG-07-65	Exchanging Contract Information with the United States Army Corps of Engineers,	08/16/2007	2007	Systemic: Acquisitions Overall
OIG-08-81	Hurricane Katrina Multitier Contracts	07/15/2008	2008	Specific: Hurricane Katrina
DA-09-09	Contract Award and Administration - Federal Emergency Management Agency, Transitional Recovery Office, Biloxi, MS	02/09/2009	2009	Specific: Hurricane Katrina
DS-09-13	California Department of Water Resources	09/25/2009	2009	Specific: Other Disaster
OIG-09-11	Challenges Facing FEMA’s Acquisition Workforce	11/20/2008	2009	Systemic: Acquisitions Overall
OIG-09-31	FEMA's Implementations of Best Practices in the Acquisition Process	02/19/2009	2009	Systemic: Acquisitions Overall

OIG-09-32	Internal Controls in the FEMA Disaster Acquisition Process	02/19/2009	2009	Systemic: Acquisitions Overall
OIG-09-70	Challenges Facing FEMA's Disaster Contract Management	05/27/2009	2009	Systemic: Acquisitions Overall
OIG-09-77	FEMA's Acquisition of Two Warehouses to Support Hurricane Katrina Response Operations	06/05/2009	2009	Specific: Hurricane Katrina
OIG-09-96	FEMA's Sourcing for Disaster Response Goods & Services	08/13/2009	2009	Systemic: Acquisitions Overall
DD-10-19	Xavier University of Louisiana, Contracting	09/24/2010	2010	Specific: Hurricane Katrina
OIG-10-53	Improvements Needed in FEMA's Disaster Contract Management	02/03/2010	2010	Systemic: Acquisitions Overall
OIG-11-02	Improvements Needed in FEMA's Management of Public Assistance-Technical Assistance Contracts	10/19/2010	2011	Systemic: Acquisitions Overall
OIG-11-106	FEMA's Contracting Officer's Technical Representative Program	09/02/2011	2011	Systemic: Acquisitions Overall
OIG-11-114	Improving FEMA's Individual Assistance, Technical Assistance Contracts	09/27/2011	2011	Systemic: Acquisitions Overall
DA-13-15	Contract Dispute Delaying Hurricane Shelters at George County, Mississippi: Interim Report on FEMA Hazard Mitigation Grant Program Funds Awarded to George County, Mississippi	05/21/2013	2013	Specific: Hurricane Katrina
DA-13-25	Pennsylvania Department of Conservation and Natural Resources Appropriately Expended $33.6 Million of FEMA Public Assistance Funds	09/05/2013	2013	Specific: Other Disaster
DD-13-11	FEMA Should Recover $46.2 Million of Improper Contracting Costs from Federal Funds Awarded to the Administrators of the Tulane Educational Fund, New Orleans, Louisiana	08/15/2013	2013	Specific: Hurricane Katrina
DS-13-04	FEMA Should Disallow $21,113 of the $654,716 in Public Assistance Grant Funds Awarded to the Alaska Department of Natural Resources, Wasilla, Alaska	03/12/2013	2013	Specific: Other Disaster
DS-13-06	FEMA Improperly Applied the 50 Percent Rule in Its Decision To Pay the Alaska Department of Natural Resources To Replace a Damaged Bridge	04/05/2013	2013	Specific: Other Disaster
OIG-14-12-D	FEMA Should Recover $10.9 Million of Improper Contracting Costs from Grant Funds Awarded to Columbus Regional Hospital, Columbus, Indiana	12/05/2013	2014	Specific: Other Disaster

OIG-14-45-D	New Jersey Complied with Applicable Federal and State Procurement Standards when Awarding Emergency Contracts for Hurricane Sandy Debris Removal Activities	02/27/2014	2014	Specific: Hurricane Sandy
OIG-14-46-D	FEMA's Dissemination of Procurement Advice Early in Disaster Response Periods	02/28/2014	2014	Systemic: Acquisitions Overall
OIG-15-113-D	FEMA Should Disallow over $4 Million Awarded to Mountain View Electric Association, Colorado, for Improper Procurement Practices	07/16/2015	2015	Specific: Other Disaster
OIG-15-48-D	FEMA Should Recover $395,032 of Improper Contracting Costs from $14.3 Million Grant Funds Awarded to East Jefferson General Hospital, Metairie, Louisiana	03/18/2015	2015	Specific: Hurricane Katrina
OIG-15-65-D	FEMA Should Disallow $82.4 Million of Improper Contracting Costs Awarded to Holy Cross School, New Orleans, Louisiana	04/14/2015	2015	Specific: Hurricane Katrina
OIG-16-103-D	Lake County, California, Should Continue to Improve Procurement Policies, Procedures, and Practices	06/09/2016	2016	Specific: Acquisitions Issue
OIG-16-104-D	The Office of Community Development Paid Most Contractors in a Timely Manner for Hazard Mitigation Work on Louisiana Homes	06/10/2016	2016	Specific: Hurricane Katrina
OIG-16-126-D	FEMA Can Do More to Improve Public Assistance Grantees' and Subgrantees' Compliance with Federal Procurement Rules	09/02/2016	2016	Systemic: Acquisitions Overall
OIG-16-94-D	FEMA Held Augusta-Richmond County, Georgia, Accountable for Not Complying with Federal Contracting Requirements when Managing a 2014 Public Assistance Disaster Grant	05/27/2016	2016	Specific: Other Disaster
OIG-17-27-MA	Management Advisory Report: Review of FEMA Region IV Strategic Source IDIQ Contract for Office Supplies (OIG-17-27-MA)	01/23/2017	2017	Specific: Acquisitions Issue
OIG-17-46-D	Minneapolis Park and Recreation Board Did Not Follow All Federal Procurement Standards for $5.1 Million in Contracts	03/16/2017	2017	Specific: Other Disaster
OIG-18-29	Lessons Learned from Prior Reports on Disaster-related Procurement and Contracting	12/05/2017	2018	Specific: Acquisitions Issue

OIG-19-38	FEMA Should Not Have Awarded Two Contracts to Bronze Star LLC	05/07/2019	2019	Specific: Hurricane Maria
OIG-19-52	FEMA's Eligibility Determination of Puerto Rico Electric Power Authority's Contract with Cobra Acquisitions LLC	07/03/2019	2019	Specific: Hurricane Maria
OIG-20-01	Review of Box Elder County, Utah's Procurement Policies and Procedures for Disaster No. 4311-DR-UT, Grant No. 003-99003-00	11/08/2019	2020	Specific: Other Disaster
OIG-20-08	Refugio County, Texas, Has Implemented Adequate Procurement Policies, Procedures, and Business Practices to Manage Its FEMA Grant	12/16/2019	2020	Specific: Other Disaster

Table 4: *32 Selected DHS, GAO/OIG, and FEMA Acquisitions Sources*

Agency	Number	Title	Publication Date	Fiscal Year	I.T.	Work-force	Post-award
DHS OIG	OIG-04-12	An Audit of FEMA's Acquisition Workforce	03/01/2004	2004	x	x	
DHS OIG	OIG-05-36	Emergency Preparedness and Response Could Better Integrate Information Technology	09/01/2005	2005	x		
DHS OIG	DD-11-06	Recap of Procurement Problems Identified in Audits of Electric Cooperatives	09/08/2006	2006			x
DHS OIG	OIG-07-65	Exchanging Contract Information with the United States Army Corps of Engineers,	08/16/2007	2007	x	x	x
DHS OIG	OIG-07-36	FEMA's Award of 36 Trailer Maintenance and Deactivation Contracts,	03/30/2007	2007			x
DHS OIG	OIG-07-66	Review of FEMA 's Recommendation Tracking Process	08/14/2007	2007			
DHS OIG	OIG-09-11	Challenges Facing FEMA's Acquisition Workforce	11/20/2008	2009	x	x	x
DHS OIG	OIG-08-34	FEMA's Preparedness for the Next Catastrophic Disaster	03/28/2008	2008	x	x	x
DHS OIG	OIG-08-81	Hurricane Katrina Multitier Contracts	07/15/2008	2008			x
DHS	OIG-08-	FEMA’s Sheltering and Transitional Housing Activities After Hurricane	09/12/2008	2008		x	x

OIG	93	Katrina					
DHS OIG	OIG-10-26	Assessment of FEMA's Public Assistance Program Policies and Procedures	12/08/2009	2010		x	x
DHS OIG	OIG-09-70	Challenges Facing FEMA's Disaster Contract Management	05/27/2009	2009	x	x	
DHS OIG	OIG-09-31	FEMA's Implementations of Best Practices in the Acquisition Process	02/19/2009	2009	x	x	
DHS OIG	OIG-09-32	Internal Controls in the FEMA Disaster Acquisition Process	02/19/2009	2009		x	
DHS OIG	OIG-09-96	FEMA's Sourcing for Disaster Response Goods & Services	08/13/2009	2009	x	x	
DHS OIG	OIG-10-101	FEMA's Logistics Management Process for Responding to Catastrophic Disasters	07/07/2010	2010	x	x	
DHS OIG	OIG-10-123	FEMA's Preparedness for the Next Catastrophic Disaster - An Update	09/27/2010	2010	x	x	x
DHS OIG	OIG-10-53	Improvements Needed in FEMA's Disaster Contract Management	02/03/2010	2010		x	x
DHS OIG	OIG-11-02	Improvements Needed in FEMA's Management of Public Assistance-Technical Assistance Contracts	10/19/2010	2011			x
DHS OIG	OIG-11-106	FEMA’s Contracting Officer’s Technical Representative Program	09/02/2011	2011		x	x
DHS	OIG-11-	Improving FEMA’s Individual Assistance, Technical Assistance Contracts	09/27/2011	2011		x	x

OIG	114						
DHS OIG	OIG-12-118	FEMA’s Management of Corrective Actions and Lessons Learned From National Level Exercises	09/11/2012	2012			
DHS OIG	OIG-14-46-D	FEMA’s Dissemination of Procurement Advice Early in Disaster Response Periods	02/28/2014	2014		x	x
DHS OIG	OIG-16-49	Analysis of Recurring Audit Recommendations Could Improve FEMA's Oversight of HSGP	03/15/2016	2016			x
DHS OIG	OIG-16-126-D	FEMA Can Do More to Improve Public Assistance Grantees’ and Subgrantees’ Compliance	09/02/2016	2016		x	x
DHS OIG	OIG-18-29	Lessons Learned from Prior Reports on Disaster-related Procurement and Contracting	12/05/2017	2018		x	x
DHS OIG	OIG-19-58	FEMA's Longstanding IT Deficiencies Hindered 2017 Response and Recovery Operations	08/30/2019	2019	x		
GAO	GAO-05-218G	Framework for Assessing the Acquisition Function at Federal Agencies	09/01/2005	2005		x	
GAO	GAO-15-783	FEMA Needs to Cohesively Manage Its Workforce and Fully Address Post-Katrina Reforms	09/01/2015	2015		x	x
GAO	GAO-19-157SP	Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas	03/01/2019	2019	x		
GAO	GAO-19-518T	FEMA Continues to Face Challenges with its Use of Contracts to Support Response and Recovery	05/09/2019	2019		x	
FEMA	n/a	2017 Hurricane Season FEMA After-Action Report	07/12/2018	2018	x	x	x

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