A Study of Hierarchical Control in a Cross-Sector Subcontracting Network

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ABSTRACT

Little attention has been paid to the nature of subcontracting relationships in a publicly-funded multi-sector contracting network. This article focuses on hierarchical control in a cross-sector sub-contracting network. Combining insights from Arthur Stinchcomb's contract-as-quasi-hierarchy treatise and transaction cost economics, it argues that although a for-profit general contractor's hierarchical control of nonprofit subcontractors (through contract-as-quasi-hierarchy) reduces the transaction costs in a nonprofit-dominated health and human services market, the hierarchically-governed subcontracting network presents new challenges for government purchasers. When such challenges are not properly handled, they may lead to bad collective outcomes. Case data is presented to illustrate the theoretical arguments.

The "wickedness" of policy issues in the 21st Century (e.g., natural-disasters, health care, poverty, homeland security) defies organizational boundaries and creates the need for concerted action across multiple organizations and multiple sectors (Kettl 2006; Salamon 2002). One way for government to organize such a collaborative network is through contracting, where government contracts with nongovernment organizations from the private and/or nonprofit sector to produce and deliver public goods and services.

To date, research on multi-sector contract networks has almost exclusively taken the government-purchasers' perspective in the government-vendor dyad (for an exception, see Johnson & Romzek, 2008). While there is increasing emphasis on public manager's role in trust-building and relationship-facilitating/brokering in the dyadic relationship (Cooper, 2003; Milward & Provan, 2006; Van Slyke, 2009), critics have called for more hierarchical control over contractors (Bloomfield, 2006; Goodsell; 2006). The collaborative-vs.-hierarchical -contract debate paid scant attention to the nature of subcontracting relationships (between a primary vendor and its subcontractors) nested in a government-vendor-subcontract network, let alone the intersection of the nature (collaborative vs. hierarchical) of the two relationships (government-vendor and vendor-subcontractor). This oversight may have non-trivial consequences in a publicly-funded mixed-sector contract network where for-profit vendors subcontract with nonprofit organizations.

I fill this research gap by focusing on hierarchical control in cross-sector subcontracting relationships. The issue of interest is when nonprofit subcontractors are subject to strong hierarchical control by for-profit general contractors, what challenges

will it pose to public managers governing the mixed-sector contract network and how will that affect the overall effectiveness of the whole contract network (comprising government purchasers, a for-profit general contractor, and nonprofit subcontractors)?

My discussion proceeds as follows. A review of two theoretical frameworks (Merging of networks and hierarchies and Hierarchical control of sub-contractual networks) will introduce the research question guiding the article. Description of the case study method and the research setting will follow. Combining insights from Arthur Stinchcomb's contract-as-quasi-hierarchy treatise and transaction cost economics, I will then explain why hierarchical control of sub-contractual networks is needed to meet the special challenges of mental health services and identify the unique governance challenges such a hierarchically controlled subcontracting network presents for government purchasers. Case data on mental health contracts with a managed care company in the Phoenix-metropolitan area will be presented to illustrate the theoretical arguments. Lastly, I will discuss the management and policy implications of cross-sector contracting.

Merging of Networks and Hierarchies

In a classic article on network forms of organization, Powell (1990) highlighted the difference between networks, market, and hierarchy. Corporate hierarchies rely on a chain of command and vertical delineation of authority to coordinate economic activities. In contrast, networks rely on trust, reciprocity, and repeated interaction as the key building blocks of economic coordination. Consistent with Powell's insights, public administration scholars emphasized the horizontal orientation of networks (Agranoff & McGuire, 2003; Kettl, 2002; 2006; Salamon, 2002). For example, there is a rapidly

growing line of research that identified collaborative management skills (e.g., contract writing and enforcement, negotiation, fostering relationships and trust, building consensus and shared meaning) for government network managers (Bingham & O'Leary, 2009; Goldsmith & Eggers, 2004; McGuire, 2002; Kettl, 2006). The surge in research interest on collaborative management is consistent with the notion that collaborative management, rather than the top-down, command and control hierarchical management (of government bureaucracies), works better in a networked context where voluntary actions, emergent structures, and social capital are needed to get things done (Milward, 1994; O'Toole, 1997).

More recently, public administration researchers offer a more positive assessment of the role of hierarchical management in network governance. In an excellent review of extant knowledge of collaborative public management, McGuire (2006) noted that a hybrid network governance approach blending hierarchical and collaborative management is clearly visible in networks led by a network administrative organization (NAO) (Provan & Kennis, 2006), in emergency management (Moynihan, 2005), and in "inchoate hierarchies" within partnerships between police departments and community development corporations (Thacher, 2004). Similarly, Herranz (2008) categorized four network management behaviors (reactive facilitation, contingent coordination, active coordination, and hierarchical-based directive administration) along a passive-to-active continuum, with hierarchical-based directive administration at the far end of the continuum. It is notable that Herranz (2008) emphasized the implications of sector-based differences in multisector network management, arguing that public, nonprofit, and commercial organizations will exhibit different network management behaviors.

In summery, collaborative networks and hierarchy are not necessarily antithetical to each other. More importantly, sector-based differences may have nontrivial consequences in managing multi-sector networks. These points form the theoretical background of my study of hierarchical control of a subcontracting network in health and human services.

Hierarchical Control of Sub-Contractual Networks

The landscape of publicly-funded health and human services has changed significantly. Consistent with the New Public Management movement, public health care agencies increasingly pursue the strategy of contracting with for-profit entities (Portz, J.H., Reidy, M., Rochefort, D.A., 1999). However, for-profit contractors in health and human services generally cannot operate on their own, typically needing the expertise and legitimacy of public and nonprofit agencies to deliver the broad range of services the contracts require. This has resulted in the use of multi-sectoral contract service networks to deliver publicly-funded health services. For example, in health and human services, it is increasingly common for state Medicaid agencies to contract with managed care organizations, which then subcontract with nonprofit agencies and other business organizations to deliver Medicaid-funded health services (Essock & Goldman, 1995; Hurley & Somers, 2003; Martinez, 2006).

Such complex service delivery arrangements have received serious attention from public administration scholars. One major theoretical lens to study this complex public-private partnership is the network perspective, which emphasizes that integrated, joint delivery of services is more effective at meeting the multiple needs of vulnerable clients, such as the frail elderly, foster care children, or people with serious mental illness

(Provan and Milward, 1995; 2001). Research on public sector service delivery networks (Huang & Provan, 2007; Provan, Huang, & Milward, 2009) have found that although there are few formal contractual relationships among sub-contracted nonprofit organizations, these organizations often collaborate with each other, either formally or informally, through information sharing, joint programs, and referrals, to strive to provide a complex array of services to meet clients' multiple needs. Thus, the collection of subcontracted providers takes on the feature of a network.

On a related front, public administration scholars have studied a number of important issues in government contracting for publicly-funded services, including the decision to contract (Ni & Bretschneirder, 2007; O'Toole & Meier, 2004), contract design (Brown, Potoski & Van Slyke, 2007), contract monitoring (Brown & Potoski, 2006), and contracting performance (Brudney, Cho & Wright, 2009; Yang, Hsieh, & Li, 2009). It is notable that the government-vendor (either for-profit or non-profit organizations) dyad forms the context of most of the extant contracting research.

Thus, subcontracted provider networks and government-vendor contractual dyads have been the two main focuses of research on publicly-funded contract service networks. It is my argument that research in this area can benefit from a new focus on the issue of hierarchical control of a subcontracting network. In a multi-sector contract service network, the division of labor is such that the general contractor is the designated network administrative organization (NAO), one that is in charge of a subcontracting network. As such, the NAO plays a dominant role in the subcontracting network. Johnston and Romzek's (2008) work on a Kansas social-welfare-contract network documented hierarchical control in operation in a subcontracting network. The

researchers noted that in a child welfare network nonprofit subcontractors had little power and served "at the mercy of" the nonprofit primary contractors (p.134). Some of them tried to provide outsourced high-cost services in-house, thus posing a grave threat to subcontractors' operational and financial stability. Extending Johnston and Romzek's findings to cross-sector contracting in mental health services, it is reasonable to expect that the power and control dynamic between a for-profit managed care organization (the primary contractor) and nonprofit subcontractors will be as, if not more, visible than that noted by the researchers.

To examine hierarchical control of a cross-sector subcontracting network, I combine insights from a new theoretical framework — Arthur Stinchcomb's contract-as-quasi-hierarchy treatise — and transaction cost economics. Drawing on these two theoretical frameworks, my research enriches what Van Slyke (2009) noted as the typical single-theoretical-framework (transaction cost economics or agency theory) base in current contracting research (p.138).

Stinchcombe (1985) contends that hierarchy is not necessarily antithetical to market since hierarchical elements can be arranged in contracts, such as defense contracting and automobile manufacturer-supplier contracting. To the extent that a contract contains the same key elements as essential for the functioning of an organizational hierarchy (i.e. an incentive system, a command structure and authority system, non-market pricing, a dispute resolution system, and standard operating procedures), contracts become functional substitutes for hierarchy to coordinate complex production activities among organizations and safeguard interests of purchasers from opportunistic suppliers, hence, contracts as quasi-hierarchy.

The application of Stinchcombe's (1985) idea of hierarchical elements in a contract as inter-organizational governance mechanisms has been limited to business research. Given that a widespread practice for government agencies has been to enter into long-term contracts for complex services (e.g., in health care, national defense, and social welfare) with business organizations as general contractors, which then hire nonprofit or business subcontractors to deliver needed services (Dias & Maynard-Moody, 2006; Goldsmith & Eggers, 2004; Savas, 2000; Salamon, 2002), it seems reasonable to draw on and extend the literature on inter-firm governance mechanisms to the governance of a subcontracting network.

Specifically, I draw on Gulati and Singh's (1998) work applying Stinchcomb's idea to the study of strategic alliances maintained by business firms. The researchers found that anticipated coordination costs and expected appropriation concerns drive strategic alliances' choices of magnitude and types of hierarchical control elements in contractual relationships between alliance partners. The researchers also found that the presence of trust between alliance partners at the time of an alliance formation reduces appropriation concerns and coordination costs, thus promoting less hierarchical control in contractual relationships.

Building upon Gulati and Singh's (1998) finding of negative relationship between trust and amount of hierarchical control in contracts, I postulate that to the extent that the levels of trust between business and nonprofit organizations and between government and business organizations are low, presumably due to the considerable differences in cultures and values and lack of prior history of transaction among organizations of different ownership status (Cooper, 2003; Goldsmoth & Eggers, 2004; Herranz, 2008),

the issue of hierarchical control will be highly visible in a mixed-sector health and human service contract network (comprising a government purchaser, a for-profit general contractor, and nonprofit subcontractors). Better understanding of for-profit hierarchical control over nonprofit subcontractors in health and human services may shed light on some important health policy issues.

One such issue is the challenges facing American's health care safety net as for-profit entities become dominant players in traditionally nonprofit-dominated markets. Providing badly-needed health services to vulnerable populations (e.g., the uninsured and underinsured, Medicaid enrollees, AIDS patients, people with serious mental illness, the disabled), community-based nonprofit health and human service providers are an essential part of America's health care safety net (Brown, 2008). As such, for-profit hierarchical control over nonprofits can have substantial impact on the lives of such vulnerable populations. For one, for-profit organizations' singular focus on profit maximization gravely threatens safety net providers' ability to continue serving their uninsured patients or high-cost patients (Lewin & Baxter, 2007; Willging, Waitzkin & Nicdao, 2008). More importantly, it also affects the civil society comprising community-based nonprofits. Observers are noting that as safety net providers (nonprofit hospitals, community health centers) take different actions and strategies to adapt to the increasingly competitive and profit-driven health care market place, there is a growing disparity between the top-tier profitable large safety-net institutions and the larger group of smaller, less successful ones (Carreyrou & Martinez, 2008; Cunningham, Bazzoli & Katz, 2008; Lewin & Baxter, 2007).

Consistent with these points, this paper focuses on the issue of hierarchical control in a cross-sector subcontracting network in mental health. Contracting in mental health services provides the ideal context for the investigation of hierarchical control in cross-sector sub-contracting. First, mental health contracts between state governments and managed care companies are typically long-term ones. Four-year and five-year contracts are not uncommon between the state and for-profit contractors in mental health services. Although the contract is awarded periodically through an open competitive bidding process, the contract's long duration makes the relationship between the general contractor and a state agency a unique stable market arrangement. Given that relational stability is a prerequisite for any hierarchy, whether intra-organizational or inter-organizational, to exist, the long-duration of cross-sector contracting in mental health adequately satisfies this prerequisite.

To the extent that government's long-term mental-health contract with a for-profit managed care organization creates a cross-sector subcontracting network comprising the for-profit general contractor and nonprofit subcontractors, an interesting research question then is: How is hierarchical control realized in the subcontracting network, specifically, between a for-profit general contractor and its nonprofit subcontractors? A related research question is: Can the literature on for-profit hierarchical control of nonprofit subcontractors be extended to improve government purchasers' oversight of the nested hierarchy?

Methods

Case study method is used in this article to answer the research questions. Since very little research addressed the issue of hierarchical control in sub-contracting networks in mental health, I consider this research a first step into a new domain, one that can

certainly benefit from case-study's appropriateness to extend preexisting understandings in unexplored research areas (Eisenhardt & Graebner, 2007) and the value of richness in qualitative data (Weick, 2007).

Data collection and analysis

My research examined the publicly-funded system of treatment and care for adults with serious mental illness in Maricopa County (the Phoenix metropolitan area), Arizona. For 9 years (1999-2007) ValueOptions (VO, a subsidiary of a Virginia-based FHC Health Systems , a national for-profit managed care organization) has held the contract with the Arizona Department of Health Services (DHS) to provide services for indigent mentally ill adults in Maricopa County.

In 1998 DHS awarded VO a three-year, $510 million contract that comes with a two-year renewal option based on performance. VO won the contract after the former, community-based nonprofit contractor had declared bankruptcy and the State had operated the system on its own for a year. Unlike the previous system, which was based on the fee-for-service principle (all expenditures incurred would be reimbursed), the state was in a risk-based contractual arrangement with VO. In other words, VO is paid an upfront or "prospective" capitation amount for each enrolled member. If care costs less than the contracted amount, VO makes money; if not, it loses money. In 2004 the contract was open for re-bidding. VO was selected as the winner of a $1.3 billion 3-year contract to continue providing services to Phoenix's poor and uninsured mentally ill. In 2007 VO lost the contract to another for-profit managed care company (Magellan Health Services).

I draw upon two sources of data: interview and archival materials (60 newspaper articles from The Arizona Republic, the largest newspaper in the state) on the outsourced mental health service delivery system in Phoenix, Arizona. The Arizona Republic articles covered the period of 9 years when VO was in charge of the service delivery system. All articles were captured using an online search archive (NewsLibrary), which allowed me to specify a search by region (Arizona) and a specific newspaper (The Arizona Republic). I used *ValueOptions* as the keyword to search for articles containing it in the headline or lead paragraphs. The initial search found 150 stories. On review, it was discovered that many of these initial stories had little if anything to do with hierarchical control in cross-sector sub-contracting. After excluding obvious cases where this occurred (letters from caretakers of clients, mental health advocates, and VO, the transition to Magellan, and innovative services offered by VO), the final data consists of 60 news articles.

To "triangulate" on the narratives presented from the newspaper stories and to reduce distortions from a newspaper-only focus (Yin, 1994), I interviewed executives of the for-profit general contractor and nonprofit subcontractors as a part of a larger longitudinal study (Huang & Provan, 2007; Provan & Huang, 2009; Provan, Huang, & Milward, 2009) of the evolution of the outsourced service delivery system in 2000 and 2004, respectively.

Consistent with the logic of theoretical sampling (Yin, 1994), the Phoenix case was chosen because it is unusually revelatory of the issue of hierarchical control in cross-sector sub-contracting, given the long duration of the contract and the final collapse of the cross-sector hierarchy. Therefore, it is particularly suitable for extending Stinchcomb's insights to the new context. Specifically, Stinchcomb's work provided a

theoretical search light to help me select materials that point to issues of hierarchical control in cross-sector governance. However, I also kept my eyes open for case evidence that disconfirms or modifies Stinchcomb's insight in the new setting and any patterns such evidence may present. I reiterated this procedure until no more new insights emerged from the analysis of case data.

The Need for Cross-Sector Hierarchy in Mental Health

The logic behind government contracting with business organizations can be explained by transaction costs theory (see Feiock, R. et al, 2003; Trevor, Potoski, & Van Slyke, 2006). Transaction cost theory also suggest that high transaction costs can lead to market failure when there are information asymmetries (private information), difficulty in measuring individual outputs or outcomes, acquisition of market power by a small number of participants on one or both sides of a market, and restricted entry into the market (Williamson, 1985). These problems are so accentuated in the mental health market that competitive contracting is not a good option (Smith & Lipsky, 1993;Van Slyke, 2007).

In such a thin market, like mental health, an alternative form of organization is to hire a for-profit entity to establish a hierarchy comprising a for-profit overseer and nonprofit service providers. Although hierarchy is usually used to represent the asymmetric relationship between subordinates and supervisors in organizational setting, e.g., Roman Catholic Church, business organizations, it is equally useful to describe the asymmetric relationship between two organizations with different ownership forms. The advantage of hierarchy in mental health is that hierarchy overcomes the barriers to efficient markets (e.g., teamwork, measurement difficulty, monoposony).

First, transaction costs may be less in hierarchies than in markets because there is an employment contract between nonprofit service providers and the for-profit overseer. The for-profit contractor has the authority to specify who will do what in future situations when they arise. In contrast, many contracts in the open market must specify the rights and responsibilities of various parties in a variety of contingencies. The costs of negotiating contracts with more and more contingencies are likely to increase.

The reduced transaction costs in hierarchies come from the exclusive purchasing power of the for-profit overseer, which will enable it to extract compliance and savings from its subcontractors (frontline service providers), particularly those nonprofit providers heavily dependent on contract funding. However, there is no guarantee that authority will not be used in self-benefiting transactions. To the extent that the primary goal of a for-profit organization is to make money for its shareholders or owners, it is probably unavoidable for the for-profit overseer to award lucrative sub-contracts to affiliated for-profit entities, rather than nonprofits, particularly when such non-profits may not even be available to provide the services needed.

This is what happened in the Maricopa mental health contract. In 1999 the Maricopa County contractor (VO) hired three sister companies (ABS of Arizona Inc., Virginia-based RX Innovations, and AIS) to manage three crucial areas with high profit margins, i.e., case management, pharmaceutical operations, and information systems. In 2000, VO paid ABS, RX Innovations, and AIS $53.1 million, $28.9 million, and $1.5 million respectively. VO claimed that using sister companies was necessary to establish monitoring systems to prevent overmedication and over-hospitalization of mentally ill patients, notwithstanding the concern of advocates, psychiatrists, and providers that

aggressive cost control would jeopardize quality of care (Snyder & Steckner, 2001). A 2004 Arizona Republic report (Snyder & Steckner, 2004) noted that although the contract's enrollees represent only 2 percent of the number of people VO' parent (FHC Health Systems Inc.) cared for, the Maricopa County contract was expected to represent 30 percent of FHC's revenues in 2003 (Snyder & Steckner, 2004). The same report discovered a before-tax profit of $84 million for VO since it received the Maricopa contract in 1998.

Consistent with Marwell and McInerney's (2005) five-stage theoretical framework for the temporal shifts in the structure of mixed-sector social need markets (i.e., market identification, market growth, increasing cost, increasing price, cross-sector competition), VO's subcontracts with for-profit entities vividly illustrates a stratified market in which incoming for-profit entities replaced nonprofit service providers in managing those highly profitable activities. The upshot of this development is that for-profit entities have stronger incentive and better management know-how than nonprofits to achieve cost savings in such activities. However, who owns the surplus is a critical issue.

Second, unclear or nonexistent property rights (who owns the surplus of a mental health system) and distributional ambiguities (uncertainty about who will get the surplus) can greatly impede negotiation for an efficient bargain. In the mental health service market, for instance, unclear property rights and distributional ambiguities may mean that the state may take advantage of its ability to redistribute the future surplus of the mental health system generated by efficient service provision. The state may cut its mental health budget to the minimum level to sustain efficient service provision and apply the savings

to its general fund. In Gary Miller's (1992) words, "An attempt by the king to squeeze the last surplus out of the kingdom for his own use will induce his subjects to hide their gold rather than to invest and to shirk rather than work productively to produce revenue that the king will only take away" (p.155) . Unless there are credible commitments to property rights and distributional outcomes, the king's subjects lack the incentive to maximize their productivity and wealth.

The preceding scenario presumes that the king has full knowledge of the surplus of a production system. This assumption is questionable in the government-business contracting scenario. People have bounded rationality (Simon, 1957) and state procurement officers are no exception to the limits of bounded rationality. They may not be able to specify every type of surplus in a complex mental health contract. In this situation, the for-profit contractor may use shrewd business methods to appropriate those unspecified benefits. For instance, under the Maricopa mental health contract, ComCare, VO' nonprofit predecessor, had used state money to develop the ABSolute computer system to track patient care. After VO replaced ComCare as the primary contractor, ABS of Arizona Inc. (the sister company hired to manage care management) bought it from ComCare and used state money as part of its contract with VO to upgrade it. A new sister company, AIS, was then put in charge of the system and leased the system to other social service groups. The parent company (FHC Health System Inc.) planned to make the data system a cornerstone of a new corporate effort to get into database management across the country (Snyder & Steckner, Jan 15, 2001). Thus, the positive externalities of a data management system heavily funded by taxpayer dollars were captured entirely by the parent company.

From a public purchaser perspective, it is very difficult to preempt such shrewd business practices in a complex long-term contract. After all, the long-term feature of state mental health contracts, together with the risk-based capitation arrangements, represents states' credible commitments to property rights and distribution outcomes. The financial outcome of the contract, be it profits or losses, is off-limits for the state and depending on the contractor's performance, it either makes money or loses money. As the preceding example illustrates, the downside of this is that a for-profit primary contractor and its sister companies may take excessive profits out of the system, which may jeopardize the quality of care.

Third, although all the community-based service providers share the responsibility of providing a continuum of care to people with serious mental illness, clients may fall through the cracks in a situation where no organization is held accountable for the overall performance of the aggregated efforts of these organizations, i.e., meeting the multiple needs of patients with serious mental illness. There is a need for a point person and organization to be ultimately held responsible for the overall care delivered to the clients with serious mental illness. A specialized managed care organization can readily fill this role of accountability organization in the system. A byproduct of the financial ownership of the system by a managed care organization is the resulting shift from retail markets to wholesale markets for mental health services.

Dowd (2006) described the role of managed care organizations as coordinated agency, one that is acting as the clients' agent in its dealings with service providers. In heath care in general, patients have difficulty obtaining information about the price and quality of health care providers and services. Even if patients do get access to such data,

people with serious mental illness will not be able to make good purchasing decisions simply because of the debilitating nature of the illness. Also, joint production and delivery for bundled mental health services (such as psychotherapy, day treatment, legal assistance, vocational training, supportive housing) means the consumption of a service from one nonprofit provider is linked economically to consumption of services from other providers (such as a partner agency which has referral ties to the focal agency). In this situation, providers enjoy a degree of monopoly pricing power and can over-prescribe treatments and services with good intentions. However, more treatment is not necessarily associated with a better outcome in medicine.

Managed care can curb such wasteful tendencies by collecting and analyzing data on price, quality and outcome from not only the local market but also other markets in which it operates, and studying the effectiveness of different treatments. This knowledge can be used to extract price discounts in contract negotiations with service providers. In addition, managed care organizations, particularly those that hire their own medical personnel and sister companies, can substitute one type of health care professional or service for another, thus breaking monopoly over local professional norms or the reimbursement practices.

Contracts as Quasi-Hierarchy in a Subcontracting Network

Since a for-profit entity (a managed care organization) controls the contracts with agencies in the mental health system, the contractual relationships between the managed care organization and service providers embody a more political and hierarchical relationship to the extent that one party (service providers) in the contract has no low-cost alternatives to the relationship and must accept a contract that grants broad discretionary

authority to the other (Miller, 1992). In the aforementioned cross-sector contracting scenario, the state outsources the contracting of services to a managed care organization, which becomes the only buyer of services and nonprofit agencies have little choice but to accept the contract on the terms of managed care. In other words, service providers are under direct hierarchical control of the managed care organization through contracts. Stinchcombe's (1986) argument regarding hierarchical control elements in a contract sheds new light on the contractual relationship between the managed care organization and nonprofit service providers.

Extending Stinchcombe's insight to the context of mental health services contracts, I will attempt to identify key hierarchical elements in the cross-sector subcontracting relationships in mental health to illustrate the hierarchical control in these contracts. Specifically, the incentive system in the contract between states and a managed care organization is the capitated at-risk arrangement. Given the profit motive, the for-profit entity will have a strong incentive to provide the specified services within the limits provided in a capitated at–risk contract. The financial risk in the system is analogous to the reward and punishment tied to performance in an employment contract.

Similarly, the incentive system in the contracts between the managed care organization and service providers can also be risk-based contracting, although the more common form of incentives are discounted rates, which gives nonprofit service providers a strong incentive to cut costs and reduce unnecessary over-utilization. The authority system is obvious in the contracted out mental health system in that a managed care organization is carrying out its business of running the mental health system under the auspices of the state government, which delegates decisive authority of contracting to the

managed care organization through the master contract. This decisive authority enables a managed care organization to negotiate discounted rates from nonprofit service providers, which is tantamount to non-market pricing. On the other hand, a managed care organization can also employ its subsidiaries to run the more lucrative businesses for the mental health system (e.g., pharmacy, case management, information system). In such a scenario, the rates for these services may be higher than that in an open market. This is another form of non-market pricing.

A good example of that is the publicly-funded Maricopa mental health system. As stated in preceding sections, VO was in a risk-based contractual arrangement with the state of Arizona. In the capacity of Regional Behavior Health Authority (RBHA), VO served as the sole purchaser of mental health services for the Maricopa County region. Specifically, VO pays public and nonprofit providers overwhelmingly in the form of block payment, which is a combination of block grant and risk-based contract (phone interview with the Vice President of Network Operations for VO, May 11, 2005). For example, VO might pay a service provider $1 million, in 12 installments over the period of 12 months, to care for a designated number of patients. If the provider delivered services to more Medicaid-eligible clients than it agreed to in the contract, it could negotiate with VO to obtain more funding for next year's service contract. However, the provider cannot get reimbursement for the extra costs over and above the block payment for that year. This arrangement provides strong incentive for service providers to reduce over-utilization.

In addition to purchasing services from other agencies, VO has the ability to purchase services from its sister companies, as noted in preceding sections. Although

there is a 4 percent profit cap on VO' contract with the state and a limit on VO' administrative expenses, contracting with sister companies creates the potential for the owner of VO, FHC Health Systems Inc. of Virginia, to exceed the 4 percent profit cap on VO' contract with the state. The sister companies do not operate under the profit caps, nor are they required by Arizona regulators to release financial information. This makes it impossible to measure their profits and creates ample opportunity for the managed care company to pay its sister companies at rates higher than those in an open market.

Contracts can also provide a system for resolving disputes between the managed care organization and the contracted service providers. The mental health system may be organized under a federalist regime, in which the core agency may consist of members from the contracted service providers and serve as the forum for resolving disputes between parties to the contracts. A case in point is the publicly-funded system of treatment and care for adults with serious mental illness in Pima County (the Tucson metropolitan area). The state awarded the contract for Pima County to a nonprofit entity called the Community Partnership of Southern Arizona (CPSA) in 1995. Under the managed care arrangement, CPSA was fully at risk financially to the state. CPSA then contracted directly with three large and one smaller nonprofit provider agencies, which were directly responsible for service provision and case management and were fully at risk to CPSA. A critical organizational component of the new system was that three of the four key providers contributed financially to the performance bond required by the state to create CPSA, and the executive directors of these three providers served on the CPSA board (Provan, Isett, & Milward, 2004). This arrangement promoted the balancing

of strategic tension between the financial and cost-containment demands of the state and the service-oriented focus and resource needs of providers.

Alternatively, the mental health system may be organized under a nested hierarchy model. A local mental health authority (a managed care organization) is the overseer, which acquires this status through its master contract with the state, and the nonprofit front-line service providers become the subcontractors of the mental health authority. Collectively, the state purchasing agency, the for-profit overseer, and its subcontractors constitute a nested hierarchy, one in which the state purchaser's hierarchical control over the for-profit overseer is typically weaker than for-profit hierarchical control over nonprofit subcontractors. Under such a configuration, the for-profit overseer's (the managed care organization) view usually prevails in its disputes with its subcontractors. This is tantamount to the winner-take-all approach.

The standard procedures in the mental health contracts between a managed care organization and the service providers involve managed care techniques (centralized case management, prior authorization and reauthorization, clinical practice guidelines, utilization review, and formulary). Such standard procedures are deemed as infringing on the autonomy of service providers but are necessary for cost containment and increased accountability. Researchers have lamented the increased standardization and bureaucratization of mental health service delivery system under Medicaid managed care (Willging, Waitzkin, & Wagner, 2005). Thus, the contracts between a managed care organization and service providers can be designed in such a way that the contracts constitute the functional substitutes of a hierarchy.

This leads to the tentative answer to the original research question: How is hierarchical control realized in cross-sector contracting in mental health, specifically, between a for-profit general contractor and its nonprofit subcontractors? As the preceding case analysis clearly shows, the for-profit general contractor created an effective inter-organizational hierarchy over the nonprofit sub-contractors by implementing hierarchical elements of control in its contractual relationship with those nonprofits and rendering contracts the functional substitutes of a hierarchy.

The relationship between the managed care organization and the state purchasing agency (the State Department of Health, DHS) was marked by escalation of government oversight and hierarchical control of the for-profit contractor over time. The initial trust the purchasing agency placed in VO resulted in little government oversight of the contractor, as the annual audits from 2001 to 2004 were waived to give VO the time to get a good start. More tellingly, the state relied on internal reviews from the contractor for quality assurance. This good-partner relationship was rocked by a court-appointed monitor's audit of Maricopa County's mental health system for adults in 2004, which found poor patient care, problems with case management and a lack of system oversight by state health officials. Two highly-publicized suicides of clients soon after their visits to VO's clinics in 2004, coupled with the audit's unflattering finding, created the momentum for all three branches of state government to intervene.

On the executive side, the Office of then-Governor Janet Napolitano sent VO a strong letter, vowing to fire VO if care does not improve and demanding more information about the suicides (Synder & Steckner, 2005). On the judicial side, a Maricopa County Superior Court Judge called DHS and VO to a series of status hearings

to correct problems and give regular progress reports as part of a long-standing lawsuit against the state to improve care for people with serious mental illness (Steckner, 2005b). On the legislative side, state lawmakers passed legislation requiring a review of DHS' oversight of its contract with VO by the state auditor general (Steckner, 2005a). Then-Governor Janet Napolitano signed the legislation in May 2005. These pressures created the perfect storm for DHS. In response, DHS escalated its oversight and hierarchical control of the for-profit contractor by opening a new compliance division to closely monitor its mental-health contractors. In 2005 DHS issued precedent-setting fines ($275,000) against VO and ordered the firm to make internal changes after finding that it failed two clients who committed suicide. DHS also established a phone line to take complaints and comments from VO staffers and met regularly with advocates. DHS required VO to do the same (Steckner, 2005c).

In summery, the state might have realized some initial cost-savings from its early hands-off approach to the outsourced service delivery system. However, as critical reports about the poor performance of VO mounted, the state was under increasing legal and political pressure to hold VO accountable by taking drastic enforcement actions. Unfortunately, such coercive actions were costly for government in terms of damaged reputation, ruined careers of top executives (chief of DHS's Division of Behavioral Health Services resigned after months of criticism over patient care and Director of DHS announced early retirement) (Steckner & Snyder, 2005), and poor relations with the state legislature. Such costs may well exceed the initial cost-savings.

Discussion and Conclusion

Applying Stinchcomb's argument about hierarchical elements in a contract to a cross-sector subcontracting network, this study reveals that a combination of hierarchical elements were used to achieve quasi-integration between a for-profit general contractor and its nonprofit subcontractors. Consistent with Makadok and Coff's (2009) taxonomy of hybrid governance forms, which may be market-like in one or two out of three key dimensions (strong vs. weak authority, strong vs. weak ownership, and strong vs. weak incentives) while simultaneously hierarchy-like in others, VO initially operated like an autonomous profit center (hierarchy with strong incentives and autonomy) in its relationship with the state. Although the state owns the key assets used for work (clients, funding, etc.), VO had strong incentive (based on the at-risk contract) to cut costs and a high degree of autonomy to make profit. One way for VO to do that is through quasi-integration (contracts as quasi-hierarchy) of its nonprofit subcontractors. They were paid a flat salary and subject to VO's hierarchical control (managed care techniques). Thus, the combination of quasi-integration and absence of oversight associated with an autonomous profit center enabled VO to maximize profits at the expense of quality of care.

In this situation, it is reasonable to question the real value of adding a for-profit middleman between government and the nonprofit frontline providers. While strong-profit hierarchical control over nonprofits may reduce transaction costs in managing the nonprofit service delivery arm, there is a possibility that all the original transaction costs with the end providers are simply moved to the for-profit middleman in the form of corporate profit, whose contract with government adds transaction costs to the overall scheme.

Under such circumstances, it is important for governments to use their contractual power to regulate the behavior of the for-profit entities and utilize nonprofits as stewards of public interest (Van Slyke, 2007), rather than merely as agents of the for-profit entities, to reduce the possible negative externalities of service delivery systems controlled by for-profit entities. If a for-profit overseer can exert effective control over nonprofit service providers by setting up hierarchical control elements in contracts, then governments can also control for-profit entities through different types and amounts of involvement of nonprofits in those control elements (i.e., through non-market pricing, incentive systems, conflict resolution systems, standard procedures, and authority systems) in government contracts with for-profit overseers. To the extent that governments have limited contract management resources (Kelman, 2002; Van Slyke, 2003), it is important to bring other stakeholders, such as service providers, families of clients, and advocates, into the governance process. By empowering those stakeholders who have a strong public-service mission, the potential for inappropriate use of the monopoly power of the for-profit overseer can be reduced.

It is probably inevitable that the amount and type of hierarchical control in the two dyadic contractual relationships (government-vendor and vendor-subcontractor) differ greatly. However, there seems to be an interesting dynamic relationship between the two. In this case, strong for-profit hierarchical control over nonprofits, coupled with state's weak hierarchical control over the for-profit general contractor, ultimately doomed the hybrid form of governance over time by producing disastrous collective outcomes (client deaths, gaming of the system for profits, stratification of service markets). A compelling question then becomes: What combination of governance arrangements (the

amount and type of hierarchical control relative to collaborative management) in the two dyadic relationships will produce better collective outcomes? More research is clearly needed to address this question.

Another theme emerging out of the case evidence is the evolution of contract management in a multi-sector contracting network. Contrary to Van Slyke's (2009) observation that trust and collaboration between government and nonprofit vendors leads to a shift from transactional/hierarchical contracting to relational/collaborative contracting, my research showed the opposite evolutionary path, one that shifted from initial trust and collaborative contract management between the state and the for-profit vendor to hierarchical contract management. It is notable that this shift was accelerated by interventions from external sources of control (the Governor, the state legislature, and the legal system). Such development is consistent with Johnston and Romzek's (1999) idea that public agencies typically work within several different accountability relationships (e.g., legal, political, hierarchical) simultaneously, some of which are dormant and may be invoked by extraordinary events or crises. When such forces intervene in a crisis situation, they create an imperative for public managers to return to hierarchical management of the relationship.

Thus, there seems to be a cyclical relationship between collaborative management and hierarchical management until a proper balance between the two in the government-vendor dyadic relationship is achieved over time. How will such cyclical relationships unfold in the vendor-subcontractor relationships? What factors drive the evolution? Is there a relationship between the evolution of contract management style in the government-vendor dyad and that in the vendor-subcontractor dyad? If so, what is the

impact of this relationship on the collective outcomes of the whole network? Those are important questions that only future empirical work, particularly longitudinal network study, can answer.

A major limitation of this article is that it is largely conceptual, based on limited empirical data from interviews and secondary sources. One way to verify the theory-based arguments in the article is to conduct surveys of all those involved in the implementation of multi-sect contracting within a single service delivery network, such as public and nonprofit service providers, business organizations, and government procurement officers. The purpose of the research would be to ascertain the type and amount of hierarchical control relative to collaboration in the contracting relationships and probe actors' experiences and reactions to such control. Such perceptual measures can be checked against hard data such as utilization data and financial data across several points in time (before and after) to measure the effectiveness of the governance arrangement. This will be the next step.

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