PAY FOR SUCCESS
FEASIBILITY REPORT

Volunteers of America Delaware Valley

2017
ACKNOWLEDGEMENTS
CSH wishes to acknowledge all those who participated in conversations and discussions that helped to shape this document and the feasibility technical assistance process. Most especially, CSH thanks the Volunteers of America Delaware Valley (VOADV) and the Camden Coalition of Healthcare Providers (CCHP) for their time spent in this process.

The Social Innovation Fund (SIF) was a program of the Corporation for National and Community Service that received funding from 2010 to 2016. Using public and private resources to find and grow community-based nonprofits with evidence of results, SIF intermediaries received funding to award to subrecipients that focus on overcoming challenges in economic opportunity, healthy futures, and youth development. Although CNCS made its last SIF intermediary awards in fiscal year 2016, SIF intermediaries will continue to administer their subrecipient programs until their federal funding is exhausted.

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ABOUT CSH
CSH is a national nonprofit organization and Community Development Financial Institution that transforms how communities use housing solutions to improve the lives of the most vulnerable people.

CSH offers capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends 25 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed in more than 20 locations around the country. For more information about CSH’s work related to Pay for Success, please see www.csh.org/pfs

INQUIRIES
If you are interested in learning more about ending homelessness in New Jersey, please contact Volunteers of America Delaware Valley VP of Acquisitions and Development Owen McCabe at OM McCabe@voadv.org. For information on CSH, please visit csh.org for additional online resources and materials.

If you have questions or comments regarding this document, please contact pfs@csh.org.
## Executive Summary
This report summarizes conclusions and next steps resulting from the Technical Assistance provided by CSH to the Volunteers of America Delaware Valley. The feasibility report for this initiative focuses on the following components of feasibility:

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CSH believes the local partnership has the opportunity to successfully finish designing, structuring and implementing a Pay for Success supportive housing project if there is commitment from an entity at the county or state level to making success payments for outcomes achieved. We have documented a number of options for finalizing a target population, outcomes of interest, success metric payment terms and evaluation in the event that an end payer is identified.
BACKGROUND AND OPPORTUNITIES

The Volunteers of America Delaware Valley (VOADV) were selected by CSH as a subrecipient as part of the 2014 Social Innovation Fund Pay for Success grant award from the Corporation for National and Community Service (CNCS). CSH committed to provide Technical Assistance to VOADV to determine whether its proposed Pay for Success (PFS) initiative was feasible.

The project proposed by VOADV and its partners was to explore using PFS as a tool to scale the Camden Housing First pilot launched on October 1, 2015. The scaled approach would supportive housing for 200-300 of the highest cost homeless users who cycle in and out of hospitals, jails and shelters. PFS financing would be used to fund the gaps in existing housing and service resources for this population. The initiative was expected to generate positive results in housing stability as well as reductions in health care, criminal justice and shelter costs.

This project was selected for support due to the many strengths of its community and proposal:

**A strong need for supportive housing:** At the time of the application, New Jersey’s rates of homelessness had been increasing while national and regional rates decreased. In January 2014, a total of 654 persons, in 526 households, were experiencing homelessness in Camden County, according to the Point-In-Time Count. This was an increase of 13 persons (2%) from 2013.

**Existing data collection and analysis:** The Camden Coalition, which includes VOADV as a member, has collected and compiled health data in Camden for more than 12 years. Using this data, they estimated that each year, more than $110 million is spent in hospital care for the city's residents; with 30% of these charges attributable to just 1% of super utilizers. Furthermore, the Coalition analyzed the address field in hospital claims data to reveal that 848 individuals visiting the hospital in 211 were likely to be homeless. Those individuals accounted for 2,681 emergency department visits and 330 hospitalizations, far exceeding city and national averages per person.

This detailed understanding of both super utilizers of healthcare and the health needs of the homeless population through the limited data sources available to them formed a sophisticated starting point for the data analysis to be undertaken during the feasibility process.

**Plans for data sharing**

At the time of applying for support, the Camden Coalition was in the process of integrating individual level health care claims data with homelessness data through the Homeless Management Information System (HMIS). The data sharing would enable an even deeper and more accurate assessment of healthcare utilization and needs for confirmed homeless individuals. VOADV/Camden Coalition planned to use this data to identify the target population for the PFS funded supportive housing project.

**Housing First pilot**

In October 2015, a Housing First (HF) pilot project was launched in Camden. This citywide collaborative pilot program provides scattered-site supportive housing using a high fidelity
Housing First model for medical high utilizers with a history of homelessness. It aimed to house fifty individuals over two years and ensure their access to significant wrap around support services in order to address their health issues and achieve other rehabilitation and life goals. The feasibility study anticipated building on the results of this pilot.

**Accountable Care Organization status**

At the time of application, the Camden Coalition planned to become a Medicaid Accountable Care Organization (ACO), enabling it to receive shared savings through ACO contracts with Medicaid managed care organizations (MCOs) based on improved quality and reduced costs. The mechanism for recognizing shared savings was of significant interest for the PFS work, in which entities that can realize savings from avoided service utilization are often interested in paying for outcomes that are suggestive of future savings.

**Policy environment**

PFS was seen as a particularly good fit with several of New Jersey’s Department of Human Services (DHS) initiatives around health and housing.

- DHS had made significant investments in supportive housing as part of its State Olmstead plan, and in December 2014, the Governor's interagency council on homelessness wrapped up its study, which was expected to recommend investments in low barrier supportive housing.
- In his 2014 budget address, Governor Christie charged Rutgers Center for State Health Policy with studying and making recommendations on how to improve quality and reduce costs for super utilizers within Medicaid, and it was widely expected that expansion of supportive housing to serve homeless super-utilizers would be one of the recommended strategies.
- Most significantly, in 2012, CMS approved a state plan amendment to allow for Medicaid fee-for-service billing of community support services (CSS) for supportive housing under the federal rehab option for individuals with a serious mental illness. DHS was in the process of implementing this transition to Medicaid reimbursement for supportive housing services during 2015.

**Feasibility study components and analysis**

The feasibility report documenting work undertaken with VOADV and its partners focuses on six primary areas of interest. While there are many other aspects of the feasibility process, these elements were chosen in order to highlight areas where progress has been made and others that can be further developed as the Camden partners continue their drive toward engaging an end payer for Pay for Success financing.
These elements are discussed in detail in the following sections.

**PAY FOR SUCCESS EDUCATION**

**Overview of Pay for Success**

Pay for Success refers to the concept of paying for positive social impact, rather than paying solely for services performed. Under this model, impact is measured rigorously and “success payments” are made based on agreed-upon metrics. Pay for Success typically includes performance-based contracting between an entity paying for the achievement of outcomes (the ‘end payer’), often governmental entities, and the organizations responsible for implementing a given intervention, often non-profit organizations.
Pay for Success financing varies, but most structures support Pay for Success programs by providing working capital to implement and/or scale an intervention that has been proven to produce desired outcomes, such as cost savings over time. This upfront capital investment can be provided by a variety of investors and/or philanthropic sources, which typically receive repayment via the success payments, along with a modest return on investment. In exchange for this, investors accept the repayment risk associated with the possibility that the project does not produce the required outcomes.

**Figure 2: Example of a Pay for Success Model**

1. **End Payor** partners to develop PFS effort that connects a proven intervention with a target population in need of services.
2. **Investors** provide the upfront capital to finance the intervention.
3. **Intermediary** provides the service provider(s) with the working capital to implement the intervention.
4. **Service providers** deliver the transition supports, rental assistance, and services to the target population.
5. Outcomes and costs are tracked and provided to the third-party **evaluator**.
6. The **evaluator** determines whether the agreed upon metrics have been achieved.
7. **End Payor** makes success payments to the intermediary for distribution if outcomes are met.

**Education with stakeholders in Camden**

Throughout the feasibility process, VOADV and its partners acted as local champions for PFS in the community. Their work educating Camden stakeholders about PFS included, but was not limited to: Camden County Improvement Authority Camden County, New Jersey Department of Human Services, New Jersey Division of Medical Assistance and Health Services (Medicaid), New Jersey Division of Mental Health and Addiction Services, DHS Office of Housing, New Jersey Department of Community Affairs, New Jersey Housing and Mortgage Finance Agency, United Healthcare and the Supportive Housing Association of NJ (and its Investor Council).
Stakeholder feedback
The concept of Pay for Success was well received despite being new to the majority of stakeholders engaged during the process. Common themes that appeared in conversation included:

• **PFS as a mechanism for scaling the Housing First pilot**: Stakeholders quickly grasped the value of using Pay for Success financing to scale the Housing First pilot. While they were excited by the potential to do this, there was a feeling that it was necessary to first demonstrate outcomes being achieved by the pilot before attempting to scale up. CSH believes that PFS can take a substantial amount of time to both plan and structure, and that it is best to work alongside the pilot to plan PFS prior to results being measured and released. Furthermore, it is important to note that the implementation of PFS projects brings focus to performance monitoring and management in a way that could build upon lessons learned from the pilot to deliver improved results.

• **PFS alignment with DHS initiatives**: It was recognized that Pay for Success aligns closely with the state work to expand Medicaid reimbursement for Community Support Services (CSS) using an 1115b waiver. If the target population for the PFS project were to overlap with the serious mental illness population prioritized in the CSS reimbursement, the project would be able to leverage a significant amount of Medicaid funding and minimize the amount of private capital required to pay for the services up front. However, the waiver process takes time to implement and uncertainty around what will be included or not included in the waiver has hampered the conversations around PFS alignment.

• **PFS as one initiative of many**: The strength of Camden as a dynamic community using innovative approaches to ending homelessness and improving healthcare has a corresponding drawback in the number of projects competing for funding from the state and county.
TARGET POPULATION AND ANALYSIS

Considerations for selecting a target population

**Identifying high impact populations**
1. Is this a high need population?
2. Is this population not well served by existing initiatives?
3. Does this population fit with the priorities of my local partnership?

**Implementation risk**
1. Is there an existing process for identifying this population?
2. Is there an existing process for engaging and referring this population?
3. Will the end payer commit to paying for outcomes for this population?

Data analysis is key to selecting and understanding a particular population of interest to stakeholders in the feasibility process. Camden Coalition has been aggregating and analyzing healthcare data for a number of years, and the feasibility work dovetailed with initiatives to integrate homelessness and criminal justice data into the existing healthcare information. The data analysis in this feasibility study aimed to accomplish the following:

1. Enable selection of a target population of interest to stakeholders and the end payer
2. Understand public sector costs associated with the selected population
3. Estimate the impact of housing on public sector costs pre and post tenancies

At the time of analysis, an interested end payer had not been confirmed. We were therefore unable to select criteria for the target population that we knew to be of interest to the end payer. Instead, we proceeded with the assumption that a population with high healthcare costs and frequent healthcare service utilization would be the likely target population.

In order to understand the public sector costs associated with this data, a number of data sharing agreements needed to be put in place and substantial resource was required in order to clean and match data effectively between systems. This process was delayed in Camden for a number of internal reasons, and at the time of writing the Coalition had matched healthcare data to jail data but was not yet able to match to homelessness data from the Homelessness Management Information System (HMIS).

However, Camden Coalition program staff were able to record whether clients met the HUD definition of chronic homelessness, and this tag enabled us to gain an understanding of the public sector costs of homeless individuals within Camden. The Coalition estimates that approximately 20% of its Case Management Intervention enrollees (60 individuals per year) are chronically homeless. Based on preliminary analysis of hospital, police and jail data, this medically and socially complex groups costs $37,000 per year, the vast majority of which is accrued through healthcare spending. This group comprises the target population for the existing Housing First pilot and is therefore a key focus of the feasibility study.
We were able to achieve the third aim of this analysis by estimating costs for this population pre and post supportive housing tenancy. This analysis was limited in scope, as only 25 individuals had been housed to date and the majority of those had less than six months of post-housing data. However, early evaluation efforts have shown that, compared to the two years prior to move-in, the Housing First client population experienced a 45% reduction in the number of hospital visits per patient-day.

Options for the target population
The target population could take a number of forms depending on the priorities of the final end payer. It is likely to look like one of the three options below:

1. Super utilizers of healthcare who are homeless or struggling with housing stability

This population mirrors the Housing First pilot population and focuses on medically fragile individual with an average of ten emergency room visits and just under three hospitalizations per year. These individuals are currently served through the intensive case management services tested during the pilot, and the Housing First pilot partners therefore has a track record of delivering services to this population. This makes it attractive from an external investor perspective and would help to draw private capital to the project to cover its upfront costs if a scaled up service were contracted to government on an outcomes basis.

However, the partners would need to consider the overall scale of the Pay for Success project. The nature of contracting with multiple entities, including external investors, and the development work that goes into determining whether a project is feasible generally requires that projects are large enough in scale to justify the upfront costs. This benchmark has previously been set at 150-200 individuals housed over the course of 2-3 years. With the population identified here, the partners estimated the addition of about 60 eligible individuals per year, which is a small number of potential participants when considering that not all eligible individuals would elect to engage with the program.
The problem of scale is surmountable, particularly if the end payer is a sub-state entity such as the Department of Human Services and is able to quickly and effectively allocate funding for end payments. This would reduce the transaction costs. Assuming that there are existing sources of funding to be leveraged for services and rental assistance, the project may also require a smaller amount of private investment that could come from a single entity without requiring substantial resource to bring the investor on board. It should be considered that more complicated funding allocation mechanisms might bring into question the value of the transaction for the smaller number of people able to be served with these population parameters.

2. **Frequent utilizers of healthcare and criminal justice who are homeless**

Data analysis has identified a high need population that could benefit from supportive housing and is not currently served through its existing interventions. These 226 individuals are frequent utilizers of both hospitals and the jail system, with 16+ emergency department encounters and 7+ arrests over a five-year period. Over 40% of these individuals (~90 people) were identified as homeless, though that number is likely to be underreported.

An emphasis on the overlap between healthcare and criminal justice systems is beneficial for the end payer, which would expect to see an impact in both of those budgets. However, the same concern of scale as discussed in option 1 applies here. This can be addressed by reviewing the criteria for these individuals and perhaps lowering the barrier to entry to contact with both systems within a single year.

**Next steps**

In order to determine the criteria for the target population, while taking into consideration the size of the potential participant pool and the interests of the end payer, follow up conversations with DHS as a potential payer should focus on these three options and seek to answer questions about the funding restrictions that may be part of the GA eligible cohort.

**Public sector value case**

The value case element of the feasibility study aims to assess different approaches to funding supportive housing by highlighting the public sector systems that currently accrue costs. It uses the best available evidence of impact to estimate cost avoidance to those systems. We have not used the term ‘cost benefit analysis’ because we have included notional value for outcomes that cannot be quantified, such as improved quality of life.

**Benefits of supportive housing**

Supportive housing is an evidence-based intervention with a track record of producing positive outcomes for vulnerable people. Its evidence spans twenty years and dozens of studies measuring its effectiveness and cost-effectiveness. Supportive housing has been repeatedly proven as an effective intervention that improves housing stability, reduces the use of expensive crisis care, and improves outcomes even for the most vulnerable individuals with complex needs. Based on this body of research, the Substance Abuse and Mental Health Services Administration (SAMHSA) has long regarded supportive housing as an evidence-
based practice that is “the most potent” intervention to impact housing stability and one that consistently helps people with disabilities achieve their desired goals.

Evaluations of supportive housing suggest that its impact includes:
1. Dramatic reductions in hospitalizations, emergency department usage, and criminal justice encounters for persons with complex co-occurring disorders including chronic health conditions, mental illness, and substance abuse disorders
2. Improved health and mental health for individuals when comparing the period before and after they enter supportive housing
3. A positive impact on housing retention, even among tenants with long histories of homelessness and the most severe psychiatric, substance abuse and health challenges
4. Improved self-reported empowerment, as measured by tenants’ degree of choice in housing

Current public sector costs
The below chart lists the definable public sector costs of homeless high utilizers of healthcare and includes unit costs for each figure where applicable. Local unit costs are used where possible. Unit cost and usage statistics from other sources, including evaluations in different locations, are highlighted in the notes.

<table>
<thead>
<tr>
<th>Value case items</th>
<th>Unit cost</th>
<th>Avg usage</th>
<th>Avg cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$602</td>
<td>10.68</td>
<td>$6,432</td>
<td>Local data</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>$9,462</td>
<td>2.82</td>
<td>$26,715</td>
<td>Local data</td>
</tr>
<tr>
<td>Jail bed days</td>
<td>$150</td>
<td>12.92</td>
<td>$1,938</td>
<td>Local data</td>
</tr>
<tr>
<td>Arrests</td>
<td>$270</td>
<td>0.91</td>
<td>$245</td>
<td>Local data</td>
</tr>
<tr>
<td>Prison days</td>
<td>$150</td>
<td>10.90</td>
<td>$1,637</td>
<td>Local data</td>
</tr>
<tr>
<td>Emergency shelter days</td>
<td>$24</td>
<td>32.00</td>
<td>$768</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Ambulance trips</td>
<td>$704</td>
<td>0.40</td>
<td>$281</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Detox visits</td>
<td>$150</td>
<td>2.00</td>
<td>$300</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Visits to crisis response center</td>
<td>$585</td>
<td>1.27</td>
<td>$742</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Mental health court episodes</td>
<td>$100</td>
<td>0.53</td>
<td>$53</td>
<td>Assumption based on other evaluations</td>
</tr>
</tbody>
</table>

| Total per person               | $39,111   |

While the majority of known costs accrue to the healthcare system, it is likely that there are many more impacts of supportive housing on economic development.
Public sector benefits
The many evaluations of supportive housing across the US have provided a wealth of evidence for impacts on these public sector costs after 12 and 24 months. We estimate the following impacts, based on a variety of sources that are available on request.

<table>
<thead>
<tr>
<th>Value case items</th>
<th>Avg cost</th>
<th>Avg impact</th>
<th>Avg cost avoidance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room visits</td>
<td>$6,432</td>
<td>-52%</td>
<td>-$3,345</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>$26,715</td>
<td>-57%</td>
<td>-$15,227</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Jail bed days</td>
<td>$1,938</td>
<td>-71%</td>
<td>-$1,376</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Arrests</td>
<td>$245</td>
<td>-83%</td>
<td>-$203</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Prison days</td>
<td>$1,637</td>
<td>-71%</td>
<td>-$1,162</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Emergency shelter days</td>
<td>$768</td>
<td>-91%</td>
<td>-$699</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Ambulance trips</td>
<td>$281</td>
<td>-50%</td>
<td>-$141</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Detox visits</td>
<td>$300</td>
<td>0%</td>
<td>-$0</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Visits to crisis response center</td>
<td>$742</td>
<td>-71%</td>
<td>-$527</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td>Mental health court episodes</td>
<td>$53</td>
<td>-11%</td>
<td>-$6</td>
<td>Assumption based on other evaluations</td>
</tr>
<tr>
<td><strong>Total per person cost avoidance</strong></td>
<td><strong>$22,686</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Additionally, an entire range of benefits of supportive housing have not been evaluated and are therefore not included in this analysis. These include, but are not limited, to:

- Increased likelihood of employment / decreased dependence on benefits
- Improved lifestyle leading to reduced probability of the onset of health conditions such as diabetes and COPD
- Reduced police time spent ‘moving people on’
- Improved aesthetics of local areas, leading to further business development

Furthermore, supportive housing impacts a number of quality of life metrics that are not quantified in current studies:

- Increased empowerment through choice of housing
- Improved relationships with family and friends
- Improved self-rated health

We consider that these benefits, if quantified, could add an additional $15,000 per person to the savings estimate for a total public sector benefit of $37,686.
Costs of supportive housing

In Camden’s Housing First project, participating tenants have access to flexible and comprehensive supportive services delivered through an intensive case management model by South Jersey Behavioral Health Resources, Inc. It is anticipated that the scaling that would take place through PFS would utilize a similar model with a small staff to client ratio (approximately 1 to 10). The models impose no arbitrary time limits on the receipt of services, and services may be delivered onsite at a supportive housing property, or through mobile service teams that proactively work to engage tenants scattered throughout the community.

A detailed budget is in development, but it is likely that scaled up operations will cost $20,000-30,000 per person. These costs may be offset by leveraging existing sources of funding, such as rental assistance and service contracts. The cost avoidance is therefore likely to be higher than the cost of the project, resulting in a cost effective service offering.

Next steps

A conversation with the potential end payer will highlight additional areas of interest to explore for public sector costs and benefits. Access to the relevant data systems could help to quantify additional benefits resulting from supportive housing. Additionally, the final program budget should be agreed by all parties in order to finalize this value case for the end payer.

SERVICE DESIGN

Supportive housing is affordable housing where supportive service providers actively engage tenants in flexible, voluntary and comprehensive services to support tenant stability. Housing services may include tenant support services, life skills coaching, peer support, mentoring, and employment support, among others. Case management forms a key component of service coordination.

![Costs and benefits of supportive housing scale up](image)
For more information on delivering quality supportive housing, please refer to the CSH Dimensions of Quality Toolkit, available here: [http://www.csh.org/qualitytoolkit](http://www.csh.org/qualitytoolkit)

**Project philosophy**
The project will follow a high fidelity housing first model. This includes:

- Low barriers to entry – individuals will not be screened out on the basis of sobriety, compliance with medication, participation in program, criminal history (very limited exceptions), or credit history.
- Intensive engagement – the program will engage participants through consumer-centered, acceptance-driven approach (e.g. motivational interviewing, consumer driven goals, etc.). Many of the participants will already have been engaged by CCHP through its intensive care coordination program.
- Separate housing and services – participants will be supported with wrap around services, but they will not be required to participate in any particular services or program in order to remain in housing, so long as they comply with basic rules of lease and housing tenancy.

**Building on the successes and challenges of the Housing First pilot**
The Housing First pilot has an in-built problem solving apparatus called the Learning Collaborative. The Collaborative is a monthly forum focused on implementation of the HF pilot. Front-line staff from each provider organization and from key government and other partners gather, identify and solve problems to ensure the most efficient and effective project implementation. CSH, which has experience leading learning collaboratives across the country, facilitates this group.

**Next steps**
Narrowing the target population to a group sharing particular characteristics will enable the service to be tailored to best support its population’s needs. For example, if the majority of the
identified population has drug and alcohol support concerns, the above intervention design could partner with relevant services as part of its offer. A review of evidence-based services should also be carried out for the identified population so that the most appropriate and effective services can be offered.

END PAYER IDENTIFICATION
Considerations for selecting an end payer

1. Which organizations benefit most from the identified outcomes for this population?
2. Which organizations are committed to expanding supportive housing or service offerings?
3. Which organizations have identified budgets that could be used to expand supportive housing or service offerings?
4. What process is needed to secure a commitment from each potential end payer organization?
5. Which potential end payer has the most expedient timeline for providing commitment?

Most critical at this stage is confirming which partner entity or entities will enter into more concrete discussions with the intention of establishing a program design, success metrics, and investment structure that could induce them to serve as an ‘end payer’ as part of the described PFS transaction.

End payers in existing Pay for Success projects are typically state or local governments. The cost avoidance and value creation from improved outcomes associated with scaling supportive housing can be attractive to state and county governments, because they should be able to see a large scale program impact in their criminal justice, homelessness and certain healthcare efforts. However, there is no reason that other organizations cannot be end payers, and in Camden County we considered a full range of potential end paying entities.

<table>
<thead>
<tr>
<th>Entity</th>
<th>Primary incentive</th>
<th>Conclusion / next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of New Jersey</td>
<td>Potential cost avoidance for prisons and potential shared Medicaid savings</td>
<td>Assess interest with new administration</td>
</tr>
<tr>
<td>NJ Department of Human Services</td>
<td>Committed to supportive housing service expansion, evidenced through current Medicaid waiver</td>
<td>Met with DHS to discuss interest and possible next steps</td>
</tr>
<tr>
<td>Camden County</td>
<td>Potential cost avoidance for local jails and homeless services</td>
<td>Interest in allocating rental subsidies but not in end payer role</td>
</tr>
<tr>
<td>CCHP</td>
<td>Committed to improving health of clients through supportive housing</td>
<td>Not able to see shared savings through ACO structure</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>Potential cost avoidance for clients’ healthcare expenditure</td>
<td>Interest in being an investor rather than end payer</td>
</tr>
</tbody>
</table>
**State of New Jersey**

The state government stands to gain demonstrated cost avoidance for a vulnerable, high cost population. However, the political climate in New Jersey is not amenable to piloting or setting aside state funds for success payments in an innovative pilot. In November 2015, Governor Chris Christie vetoed an Act known as the ‘Social Impact Bond Act’ or A-2771/S-452, sponsored by Angel Fuentes, Albert Coutinho, Angelia Jimenez and John Burichelli. The Act would have created a five-year pilot program by establishing a social innovation loan program within the New Jersey Economic Development Authority (NJEDA). The Act had passed the NJEDA prior to its veto.

A discussion with Commissioner Connolly’s office suggested that the political climate in New Jersey continues to be less than favorable toward a legislative approach to establishing the state as an end payer.

New Jersey is transitioning how it funds supportive housing services. Historically, supportive housing has been funded through contracts with the NJ Division of Mental Health and Addiction Services (DMHAS) or the Division of Developmental Disabilities (DDD) using state funds. In 2012, CMS approved a state plan amendment to allow for Medicaid fee-for-service billing of community support services (CSS) for supportive housing under the federal rehab option for individuals with a serious mental illness. New Jersey Medicaid anticipates the introduction of CSS billing this spring with state-funded contracts to make providers whole while they refine the rates and regulations for the program. A number of state departments were therefore considered as potential end payers:

Partners in the PFS project development, including VOA, CCHP, CHCS and CSH, met with Commissioner Connolly and Valerie Harr of the Department of Human Services. The initial conversation and follow up discussions demonstrated strong support from DHS in scaling supportive housing to improve outcomes for the homeless. It was suggested that DHS funds that could be used for end payments have particular criteria attached to them and that we could examine the impact of using non-disbursed General Assistance / Emergency Assistance funding as success payments. Engagement with this department continues at the time this report was written.

**Camden County**

VOADV works closely with Camden County and engaged them regarding this project on multiple occasions. Although a role as a potential end payer was not determined to be feasible at the time of this effort, county staff were interested in identifying ways to partner with the initiative such as through identifying housing vouchers. Further, we discussed ways in which an initiative targeting super utilizers could help contribute to the county’s goals of fostering economic development and opportunity throughout the county.

**United Healthcare (UHC)**

United Healthcare held existing relationships with CSH, VOA and CCHP prior to the PFS project development. As a large provider of healthcare insurance, UHC supports a number of
pilot and evaluation projects aimed at improving outcomes for vulnerable and medically complex populations. Through a conversation and site visit, UHC established its interest in the Housing First pilot and in supporting the PFS project development. However, its interest lies more in being an investor that offers the funding up front rather than an end payer making success payments. It continues to be kept apprised of the PFS project work.

Next steps
When one or more end payers has committed to engaging in a further exploration of this PFS model, more focused conversations should occur to determine project scale, target population, and success metrics.

PAYMENT TERMS
Payment terms for PFS projects describe how and when the end payer will make financial contributions to the project in recognition of the outcomes it has achieved.

Success metrics
Pay for Success transactions are generally contracted to a government entity entirely on the basis of achieving outcomes identified as 'success metrics'. These metrics are pre-agreed outcomes of interest that trigger payments to the service provider or the investors, depending on the structure of the project. A common metric used in four existing supportive housing PFS transactions is housing stability meaning that clients obtain and sustain permanent housing. Two transactions, Denver and Los Angeles, also have an additional payment trigger focused on reducing recidivism.

Considerations for selecting success metrics

1. Does this represent a positive outcome for the target population?
2. Is this metric of value to end payers? Can it or should it be tied to cost avoidance?
3. Are there existing methods of collecting and verifying the metric?
4. Is this metric simple to understand and explain to all stakeholders?
5. Is there an evidence base / track record of achieving this metric through supportive housing?

Success metrics must ultimately represent value for the end payer agreeing to make payments on the basis of it, but it is equally important that supportive housing has an evidence base for achieving this metric. The service providers, and any private investors funding those providers up front, must be comfortable that they are able to achieve the metric if they use best practice in service delivery.

It is for this reason that we recommend paying on the basis of stable accommodation, an outcome which should be achieved if the provider delivers high quality supportive housing. Other payment triggers, including reductions in jail days, reductions in avoidable use of crisis health care such as emergency room visits or ambulance calls or improvements in particular health outcomes, could be considered once the target population has been identified if there is evidence for this group achieving those additional outcomes of interest.
Payment thresholds
Once the success metric is selected, end payers, investors and service providers must agree when payments are made. Three examples of different payment methods for the metric ‘stable accommodation’ are below:

<table>
<thead>
<tr>
<th>Denver PFS</th>
<th>Los Angeles PFS</th>
<th>Massachusetts PFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• An agreed amount is paid after clients have maintained stable accommodation for one year</td>
<td>• Payments made for 6 and 12 months of continuous stable tenancy</td>
<td>• An agreed amount is paid after clients have maintained stable accommodation for one year</td>
</tr>
<tr>
<td>• Payments after one year are made quarterly for each day spent in stable accommodation</td>
<td></td>
<td>• Payments after one year are made for each day spent in stable accommodation</td>
</tr>
</tbody>
</table>

We recommend using one of these three models of paying for stable accommodation as a payment trigger. The values paid for time spent in stable accommodation should be valued based on a discussion between the end payer and service providers in order to agree a figure that both creates value for the public sector and enables the upfront investment in the services to be repaid, dependent on the success of the project.

Evaluation methodology
Pay for Success projects focus on data and evaluation to a larger degree than fee for service contracts, but there is variation among the current projects in the level of evaluation applied to the success metric. Options for evaluation include:

- **Tariffs**: Payments are made for each day/month/year of stable accommodation achieved. This is the most straightforward option and simplifies the calculations required to agree payments. However, it does not account for the counterfactual, or what would have happened to individuals without the intervention. It is possible that the end payer is paying for some outcomes that could have been achieved without support, though this can be included through an adjustment of the rate paid for stable accommodation.

- **Baseline threshold**: Payments are made for achievements above a defined threshold, e.g. 50% of the population achieving stable accommodation for a year. This threshold could be set with reference to a historical baseline previously achieved by the identified target population or measuring outcomes for a similar group to the target population. While this method in theory takes account of the counterfactual, it is not robust and is open to criticism on how the threshold is set.

- **Propensity score matched control group**: Payments are made for outcomes that exceed the outcomes achieved by a control group. Propensity score matching is a robust way of defining that control group and enables each program participant to be matched to one or multiple individuals with similar characteristics. If that individual achieves outcomes beyond those achieved by his/her matches, it is considered the result of the
intervention and payments are made. While this methodology takes account of the counterfactual, it also requires access to a broad set of data for many individuals not participating in the program and can therefore be lengthy to deliver. It may also be more complex to explain to stakeholders.

- **Randomized control trial (RCT):** RCT is the gold standard evaluation methodology in which all individuals referred to and eligible for the program are randomly allocated to either a group that received the intervention or a group that does not. While this is a methodologically sound approach, it also raises ethical considerations about not offering the intervention to individuals who could benefit from it. A mitigating approach may be to use a waiting list of individuals who are not yet enrolled in the program to measure control group outcomes. However, RCT evaluation also relies on having enough potential program participants to meaningfully separate into two groups.

**Conclusions and Recommendations**

Volunteers of America Delaware Valley and its partners have developed the outline of a Pay for Success project that, if taken forward, could prove successful for a number of reasons:

- The program delivery infrastructure and partnerships put in place by the Housing First pilot;
- The partnership’s experience working with a high cost, medically complex population; and
- A familiarity with data aggregation and analysis that will enable performance management and enhancement during a scale up of services and housing.

The successes of this feasibility work have included the data work undertaken by CCHP to determine public sector costs of a potential target population, the ongoing involvement of United Healthcare and its interest in investing in the program, and the promising engagement with New Jersey’s Department of Human Services.

In order to move forward with this project, a committed end payer must be identified and brought on board. Once that has been achieved, the end payer should work in collaboration with project partners to establish:

- Eligibility and enrolment criteria for the target population;
- Outcomes of interest for this population and an understanding of current outcomes achieved;
- Estimation of the outcomes that would be achieved through supportive housing;
- The payment terms of an agreed success metric; and
- The structure of a Pay for Success transaction, including the involvement of private investors.
While all of the above aspects should be discussed with the end payer, CSH recommends at the point of writing this proposal that the following elements should be included. These recommendations may change following further conversations with the identified end payer.

<table>
<thead>
<tr>
<th>Project element</th>
<th>Viable options</th>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td>End payer entity</td>
<td>• NJ Dept. of Human Services</td>
<td>NJ Dept. of Human Services has expressed interest to date and would be an appropriate source of success payments.</td>
</tr>
</tbody>
</table>
| Eligibility and enrollment criteria | • Population of chronic homeless  
• Population of healthcare superutilizers | Serving a population of chronic homeless expands the potential participant pool. This broader population is also more likely to meet any criteria attached to end payer funding. |
| Outcomes of interest | • Stable accommodation  
• Healthcare service usage  
• Medicaid spending  
• Criminal justice service usage | Stable accommodation is most tightly linked to supportive housing interventions and has good evidence to suggest it leads to cost avoidance across the public sector. |
| Estimation of outcomes achieved | • Evidence for a range of housing stability outcomes from 50-95% of cohort maintaining housing over one year | The Housing First pilot population should be used to estimate rates of stable accommodation, and evaluations of other sites should be used for longer term outcomes. |
| Payment terms of agreed success metric | • Per diem  
• Quarterly  
• Annually + per diem | Quarterly payments made on the basis of a tariff per quarter x the number of participants meeting that threshold |
| Transaction structure | • Outcomes contract with end payer held by service provider vs investors  
• Intermediary role vs no intermediary role | Outcomes contract held by a service provider might be preferable for the NJ state government in the current political climate. A contract between investors and the service provider could stipulate that success payments are passed through to investors. An intermediary would be preferable in order to support contract and performance management on behalf of investors and providers. |