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Executive Summary

CSH is seeking a \$750,000 three-year Pay for Success Social Innovation Fund (SIF) award to provide Feasibility Technical Assistance (TA) to government and nonprofit organizations, building their capacity to pursue Pay for Success (PFS) pilots that improve outcomes and reduce costs for high-cost vulnerable populations, namely homeless individuals, youth and families, and disabled individuals who are inappropriately institutionalized. CSH aims to prepare a range of government and nonprofits to engage in PFS transactions by identifying evidence-based preventive interventions; conducting feasibility studies; preparing for PFS implementation; and analyzing alternate social finance strategies. Based on CSH's work in this arena for the past three years, CSH believes that PFS financing can serve as a lever for changing how government allocates resources, shifting from high cost, crisis systems of care to less expensive, community-based interventions, namely supportive housing. CSH is partnering with two sub-contractors to provide feasibility TA: the Center for Health Care Strategies (CHCS) and Third Sector Capital Partners, Inc.

Program Design

THEORY OF CHANGE. Supportive housing (SH) has received considerable attention from states and other entities considering PFS pilots. Detailed below, there is a robust body of evidence on SH's efficacy, which is affordable housing linked to support services, to improve health and housing outcomes for homeless and disabled individuals, youth and families, and to dramatically lower costs to the public systems that serve these persons. However, SH is a complex intervention. States have questions about how the model works, its core components, financing sources, and how to understand differences among providers. As well, SH serves a range of target populations, including homeless veterans, families, youth, chronically homeless individuals, and disabled individuals who had been inappropriately institutionalized. Each has different service needs and varying costs to government when homeless or unnecessarily institutionalized. Thus, states are struggling to determine which groups would be the best fit for a PFS intervention, i.e., which groups rake up the highest costs to public systems and have the potential for the greatest cost savings when housed. Absent the assistance of an expert intermediary, states may not pursue SH as part of their PFS efforts and lose out on an incredible opportunity to improve health and housing outcomes for a very vulnerable population and to stem spiraling costs for these persons. In response, CSH will provide a range of feasibility TA in order to help government and nonprofits to navigate this complexity. Due to our unparalleled knowledge of SH, CSH is uniquely positioned to help these entities to: 1) identify appropriate homeless

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and at-risk populations to target for PFS interventions, 2) determine expected cost savings and health/housing outcomes based on our review and knowledge of the SH evidence base, 3) create financial models for PFS pilots based on this analysis, and 4) prepare for full implementation, including identifying qualified community-based providers to carry out the pilots. CSH will equip more governments and nonprofits to enter the PFS arena and pursue SH.

Our feasibility TA has the potential to transform how SH is financed, shifting investment from high-cost, crisis resources to less expensive, better long-term care. Despite the substantial body of research proving that SH is cost effective and improves quality of life for vulnerable populations, government is not investing at the scale required to meet the need nationally. As well, state investments often leave gaps in funding for SH, particularly for services. PFS has the potential to be "disruptive technology" in terms of both how SH is financed and how government makes purchasing decisions. PFS: 1) Encourages government to measure impact rigorously and pay only based on results, not on activities, ensuring that incentives are aligned to achieve social impact; and 2) Leverages upfront investment from private and/or philanthropic sources to fund SH. PFS virtually removes financial risk for government. They receive valuable proof of concept and pay only if the intervention succeeds. CSH believes that the provision of Feasibility TA will result in PFS initiatives that are strongly grounded in data, with financial models that demonstrate the viability of the intervention for the target population and position Sub-Recipients to move into the deal structuring phase and implementation of successful PFS pilots. Sub-Recipients will also build their capacity to engage in future PFS initiatives. CSH's vision is that the successful execution of PFS pilots in key jurisdictions will demonstrate the efficacy of the model to such a degree that government invests public funds in SH to cover its full costs and at scale, without requiring PFS financing.

PROJECT OBJECTIVES & RELEVANCE. CSH and our partners seek to achieve the following objectives:

- *Conduct an open and transparent competition to identify Sub-Recipients seeking to explore the feasibility of a PFS initiative focused on SH that can meet the needs of a locally relevant, vulnerable target population.
- *Provide TA to the Sub-Recipients to explore the potential of a PFS initiative to provide a cost effective solution to meet the needs of the target population and clearly define its scope and scale.
- *Develop a pipeline of PFS projects that are poised to move into the deal structuring phase and toward completion.
- *Build government and non-profit capacity to evaluate PFS projects and move toward

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implementation.

*Develop frameworks and tools that can be shared to promote the creation of additional PFS initiatives.

*Establish the potential of SH, in conjunction with PFS, to foster innovative solutions to challenges faced by multiple target populations.

TARGETED SOCIAL ISSUES & PROPOSED STRATEGY. This project is focused on the intervention of SH as a cost-effective solution that results in positive outcomes for multiple target populations and pairs well with PFS, given the high cost of homelessness (e.g., use of ERs, detox, hospitalization, shelter) and institutionalization to public systems, and the savings resulting when vulnerable people are stabilized in housing and provided services to address the root causes of their homelessness and/or barriers to independent living. This approach will allow CSH to assist Sub-Recipients from a variety of geographic locations and will give communities the flexibility to analyze the feasibility of a PFS project focused on SH for a particular target population that is of interest to that jurisdiction and supports the achievement of local policy priorities and goals.

SH is a combination of affordable housing and supportive services designed to help vulnerable individuals and families use stable housing as a platform for health, recovery and personal growth. SH can take many forms, including an apartment, a duplex or a single family home. Tenants in SH have a lease, just like any other tenant, with all the rights and responsibilities of leaseholders. The services available in SH are flexible, voluntary and tenant-centered. Depending on the needs of the target population, services can include case management, mental health services, primary health services, substance abuse treatment, employment services and parenting skills.

SH has been repeatedly proven to be an effective intervention that improves housing stability, reduces the use of expensive crisis care (e.g., ERs, detox, hospitalization, nursing homes), and improves outcomes even for the most vulnerable individuals with complex needs. The cost savings resulting from SH are particularly significant when looking at the four target groups: super utilizers of health and other crisis services; disabled residents of health institutions who wish to live in the community; families with chronic child welfare system involvement; and young adults who are homeless, in foster care, and/or in juvenile justice system. These groups are described below. Since PFS deals are built on the premise that the cost of the intervention, in this case SH, will be significantly less than the cost of the status quo for a given targeted group, these four populations provide significant opportunities for successful PFS efforts.

SUPER UTILIZERS OF HEALTH OR OTHER CRISIS RESOURCES. In communities across the

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country, there is a cohort of people who cycle between emergency rooms, hospitals, jails, detox facilities and homeless shelters, at enormous expense to these systems. Through administrative data integration and analysis, the highest utilizers can be identified and targeted for SH. There is ample evidence that this strategy dramatically reduces costs to public crisis systems. In Los Angeles, 10% of the homeless population accounts for 72% of homeless healthcare costs. When comparing the year before and after entering SH: ER visits decreased 71% on average, inpatient readmissions dropped 85%; and total costs decreased 81% (Flaming, et al 2013). In Massachusetts, a statewide pilot of chronically homeless individuals showed a reduction in mean Medicaid costs from \$26,124 per person annually before entering SH to \$8,499 in the year after entering SH (MHSA 2007). Among chronically homeless persons in Seattle, overall Medicaid charges were reduced by 41% in the year after entering SH (Larimer, et al. 2009). A study of chronically homeless individuals in Denver found that SH led to a 76% reduction in the number of days spent in jail. SH resulted in total cost offsets of \$31,545 per person over a two-year period (CSH 2011). Recently, Columbia University completed a rigorous evaluation of CSH's NYC FUSE pilot which housed over 200 individuals. FUSE produced cost savings for crisis services through reduced usage of jails, health services, and shelters. Each individual generated \$15,000 annually in public savings. In a recent SH study in Oregon, there was a 39% reduction in the number of residents reporting unmet physical health needs and a 62% drop in the number of residents reporting unmet mental health needs after a year in SH (CORE, 2014).

RESIDENTS OF HEALTH CARE INSTITUTIONS. The central tenet in the Supreme Court's Olmstead decision is that people with disabilities have the right to have an alternative to an institutional setting. SH has emerged as the leading solution to allow these individuals to live independently. States are now grappling with how to fund SH at scale to meet the Olmstead mandate. The confluence of four factors creates a significant window of opportunity to use PFS to help states expand investment in SH: 1 In general, community-based care is a much cheaper alternative for the elderly and disabled as compared to institutional care. Community-based options cost about one-third of the average cost of institutional care (Houser et al 2012). Average annual expenditure per individual in state institutions was \$188,318, compared to an average of \$42,486 for Medicaid-funded home and community based services (National Council on Disability 2009). 2 Although states have been working to rebalance their Medicaid spending away from institutional-based care and toward home and community-based services, in many states, these efforts have been stymied by a lack of affordable housing and strapped State budgets. PFS can provide the upfront financing for additional units of SH. 3 States are incurring exorbitant costs for persons residing in institutional care settings,

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year after year. Long-term cost savings can be realized from moving people out of institutions and into the community. Even a gradual shift away from spending on institutional settings to services in the community can significantly reduce costs. A shift of just 2% per year can reduce spending by 15% over ten years (Kaye, 2012). 4 DOJ has stepped up its Olmstead compliance efforts, and a number of states are already under federal decrees to create SH opportunities for people with disabilities. Dozens more are now creating Olmstead implementation plans in the face of heightened scrutiny.

Research also demonstrates that community-based care promotes recovery and improves quality of life. A longitudinal study conducted in Ontario followed individuals who received community-based services after discharge from a psychiatric hospital. They demonstrated significant improvements in living situation, social skills and recreation. 86% reported that they had more independence and more privacy and overall quality of life than living in a hospital (Gerber, et al 1994). A study of quality of life of persons with severe mental illness across housing settings demonstrated that respondents in supportive community settings rated their quality of life significantly better in four life domains including work, leisure activities, living satisfaction and social relations than did persons living in institutional settings (Brunt, 2004). Research also shows housing and recovery to be closely linked, demonstrating an association between community-based housing and enhanced effectiveness of treatment and rehabilitation services (Moxham, 2000). Individuals who reported positive neighbor and landlord relations were also more likely to report higher perceptions of their own recovery from mental illness (Kloos & Shah, 2009).

FAMILIES IN CHILD WELFARE SYSTEM. On a night in January 2013, 222,197 homeless people in 70,960 families experienced homelessness, with many more experiencing homelessness throughout the year (HUD, 2013). Some of these families experiences homelessness repeatedly or long-term due to underlying addiction, mental illness, extreme poverty, and histories of trauma. These families also tend to have repeated contact with the child welfare system, often resulting in foster care placement for young children and family dissolution. The compounding challenges of behavioral health issues, extreme poverty, and domestic violence put these families at great risk for recurring child welfare involvement. The experience of foster care placement is devastating for children. One in four experience Post Traumatic Stress Disorder, as compared to 4% of all young adults. Further, homelessness, rather than substance abuse or mental illness, is the strongest predictor that children will be removed from families. Through our Keeping Families Together (KFT) initiative, CSH used data to identify 29 homeless families with repeated reports of child neglect and abuse. Together with nonprofit providers, we placed these families in SH and tracked their outcomes. KFT resulted in

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improved outcomes for these families and significant reductions in public costs. The cost offsets analysis by Metis Associates found that families placed into SH through Keeping Families Together reduced their actual and potential use of foster care services. Together, these reductions in foster care and shelter represent a total cost offset of \$1,866,592 over two years, or \$64,365 per family. 90% of families stayed housed, and child welfare involvement decreased (87% reduction of reported abuse and neglect cases). 100% of children returned from foster care, and school attendance increased. The model is now being replicated and rigorously researched by HHS's ACYF. The PFS model offers an opportunity to create SH for families, helping them gain stability, increase family functioning, and improve child and adult well-being, across a range of outcome areas and measures.

YOUNG ADULTS. Without stable housing, youth are at greater risk of physical and sexual victimization as well as mental health, and/or substance use issues. The National Alliance to End Homelessness estimates that each year, roughly 550,000 youth and young adults up to age 24 experience a homelessness episode of longer than a week. Youth homelessness is closely tied to experiences with foster care and the juvenile justice system. Each year, 28,000 youth age out of foster care (HUD, 2012). By age 26, nearly 40% of youth who aged out of foster care have experienced homelessness (Chapin Hall, 2012). According to the U.S. Interagency Council on Homelessness, 20,000-25,000 youth age out of the juvenile justice system every year. Most have limited options for housing, income, and family or other social support and experience disproportionately high rates of homelessness (e.g., at a large youth shelter in New York, 30% of the youth had prior justice system involvement) (Toro, 2007).

Young people need a stable home to achieve life goals. Stable housing can serve as a launching pad to independent living, making it easier for youth to access health care, find and sustain employment, pursue education, avoid involvement in the juvenile justice system, and become self-sufficient. CSH launched the Stable Homes, Brighter Futures Initiative in Los Angeles County to provide SH for youth aging out of the foster care system. In the first year of the pilot, participants reported improvements in their health, with 71% stating that their mental health symptoms improved, and 75% reporting that their physical health improved. Another study found that SH placement could yield an average of \$800-\$1,790 monthly savings in avoidable public costs such as emergency room, jail and shelter for young adults (18-29) with jail history in the past five years and with substance abuse and/or mental illness (Economic Roundtable, 2009).

These four target populations demonstrate the potential for cost savings under the PFS model as well as improved outcomes for the individuals and families served. The data analysis undertaken in the

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feasibility analysis stage and the data tracking and evaluation in executed deals will further demonstrate SH's efficacy as a strong match for PFS as well as a tool to improve outcomes among vulnerable populations. CSH would seek out Sub-Recipients that are looking to develop PFS pilots focused on SH for one of these four target populations.

MEASURABLE OUTCOMES AND DELIVERABLES. If awarded funds, CSH will complete the following deliverables:

- *Conduct 2-3 open and transparent competitions to select up to 12 Sub-Recipients in total.
- *For each of the 12 selected Sub-Recipients, CSH will: Complete feasibility study and report clearly demonstrating whether the target population, proposed by the Sub-Recipient, and model are appropriate for PFS; Complete preliminary financial model that demonstrates the expected expenses and savings; Develop preliminary success metrics/payment triggers in partnership with each Sub-Recipient; Develop a strategy for targeting potential investors and preliminary identification of investors; Establish criteria for selecting service providers and identify potential providers; Complete a legislative/regulatory analysis and develop strategy to execute any needed changes; Complete strategy for procurement and develop RFP(s) and strategy for assessing respondents
- *12 Sub-Recipients build knowledge of PFS and capacity to undertake this work, as evidenced by results of pre and post survey of lead agency and its partners in each site.
- *75% have viable projects and are poised to move forward into the deal structuring phase.
- *Develop case studies for projects that move forward, showcasing their capacity-building, PFS goals, and plans as they move into the deal-structuring phase.
- *Create a learning collaborative among each cohort of selected Sub-Recipients that will connect regularly via phone, email and online document sharing in order to disseminate learning and troubleshoot issues.
- *Match Sub-Recipients with peers that are further along in the PFS implementation process in order to connect efforts within the field, foster knowledge sharing, and accelerate learning curve.
- *Conduct two webinars based on lessons learned, 40 government and nonprofits attend webinar and build understanding of PFS and potential to transform SH financing for vulnerable populations. 3 Sub-Recipients serve as panelists to share their newly-gained knowledge with their peers.
- *Develop an online toolkit containing resources developed in partnership with Sub-Recipients, including project profiles and lessons learned, 100 government and nonprofits access this information.
- *Presentations at 1-2 regional and national conferences each year.

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VALUE-ADDED ACTIVITIES. CSH will provide each Sub-Recipient with a customized, robust package of technical assistance designed to facilitate the achievement of the outcomes above. Sub-Recipients will also each receive \$15,000 in cash to defray their costs to participate in the PFS pilot, help them establish or improve data tracking systems, and/or address legal and/or regulatory issues.

ACTIVITIES TO STRENGTHEN PFS FIELD. CSH will develop a cadre of 12 government agencies and/or non-profit service providers who are educated about PFS, and positioned to make educated decisions about moving forward in this arena. The planned webinars will reach a broader array of government, foundation, nonprofit, and private investor stakeholders. These individuals will help to push forward a culture in which government pays for outcomes, rather than activities, and funds interventions that are proven to provide results for vulnerable populations. Our expectation is that our feasibility TA, while specifically focused on the intervention of supportive housing for vulnerable populations, will produce case studies, tools, and lessons learned with broader applicability to the PFS field. CSH will share these resources and our findings from this project with a broad national audience through our website. We will offer a learning collaborative to allow Sub-Recipients to share experiences and trouble-shoot issues as well as tracks within the learning collaborative for Sub-Recipients focused on particular populations, such as youth. We will also match Sub-Recipients to other government or nonprofit entities that are further along in the PFS implementation process.

INCREASED AWARENESS & UNDERSTANDING OF PFS. Each time a successful PFS project moves forward into an executed deal, with all stakeholders agreeing to a common understanding of success, it supports the fundamental premise that PFS represents a powerful shift toward outcomes-based financing. This project has the potential to add up to 12 such deals to the pipeline and demonstrate successful PFS strategies that can meet the needs of super utilizers of health services, disabled persons, youth and families. Beyond directly increasing awareness and understanding among Sub-Recipients, CSH will seek to broadly disseminate lessons learned and achievement of key milestones among a wider group of government, nonprofits, and investors. CSH has collaborative relationships with trade associations (e.g., National Association of Counties (NACo), Council of Large Public Housing Authorities (CLPHA), Council of State Governments (CSG), National Association of State Budget Officers) that will help distribute resources and findings from this project to county and state government. We also participate in numerous regional and national conferences each year to share results and materials. In addition our website and newsletter are viewed by 9,000 persons.

FUNDING PRIORITIES. CSH's proposed project will address several CNCS priorities under this NOFA. First, a primary goal is to use PFS to improve healthcare access, health outcomes, and overall

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well-being among very vulnerable individuals and families in line with the Healthy Futures focus area. The project also directly targets UNDERSERVED populations, namely homeless and at-risk individuals, including homeless veterans and disabled persons who are inappropriately institutionalized. CSH is also supporting the funding priority of addressing the needs of Opportunity Youth by including them as one of the target populations. Finally, CSH's Feasibility TA will focus government and nonprofits only on PFS interventions that BOTH RESULT IN IMPROVED SOCIAL OUTCOMES AND GOVERNMENT COST SAVINGS.

DISTINCT FROM & SUPPLEMENTING OTHER FEDERALLY FUNDED PROJECTS. The proposed project builds upon and will leverage lessons from CSH's current SIF grant but is distinct as it presents the next phase in the evolution of this work, particularly with regard to how SH is financed and the sustainability of enhanced SH models. Our current SIF model is advancing enhanced supportive housing models, which combine health, housing and social services to improve health and housing outcomes for homeless frequent users of crisis and acute care. Scaling these models using PFS and expanding its use to other targeted vulnerable populations is the logical next step in CSH's efforts and those of CNCS to support communities and government in implementing solutions that work at scale. The proposed PFS project has the potential to finance many more SH pilots and to develop sustainable funding streams for these models if proven successful. While the SIF evaluation is documenting cost savings resulting from the pilot, there is no PFS mechanism included. That said, CSH expects to leverage the SIF evaluation's results in order to help Sub-Recipients develop sound financial models for PFS pilots. As well, while CSH's SIF initiative is focused only on one vulnerable population, namely, single street homeless individuals, the proposed project will reach a much broader range of underserved populations that could benefit from supportive housing. Also, we are reaching just four communities with our SIF pilot. We expect to reach many more communities through the PFS project, namely 12 Sub-Recipients and many more via webinars and other dissemination.

HOW PROPOSED ACTIVITIES WILL STRENGTHEN STATE & LOCAL GOVERNMENT CAPACITY. Detailed below, CSH has deep experience as a TA provider and has learned how to simultaneously provide TA to move a given project forward while building the capacity of the TA recipients to carry out this work independently in the future. We envision a collaborative process to achieve all proposed deliverables, involving Sub-Recipients and building their capacity along the way. For instance, we will help Sub-Recipients to understand how to analyze and use their own data to determine feasibility. This includes CSH helping Sub-Recipients to strengthen or develop data tracking systems to facilitate such analysis in the future and to capture savings to sustainably fund

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interventions that work. We will involve Sub-Recipients in each phase of the financial modeling process in an attempt to build their capacity to identify cost effective interventions. We will also work to establish a regulatory, legislative and budgetary framework that allows for the use of the PFS model for multiple deals. The Feasibility TA process will bring together multiple systems and engage them in creating integrated solutions, funding streams and planning bodies. This cross-system collaboration will provide Sub-Recipients with a strong foundation that can be used to solve not only homelessness but also other complex social issues. Finally, we will provide educational tools on PFS and quality supportive housing, which will guide future PFS efforts.

DESCRIPTION OF ACTIVITIES: PROVISION OF TA

SELECTION PLAN. CSH will design and implement an open, objective selection process to identify qualified Sub-Recipients. We estimate that we will hold competitions once a year for each of the three grant years and will select 4 Sub-Recipients in each round. Sub-Recipients in the first two years will have the opportunity to apply for additional assistance. We anticipate that the value of grants and services received by each Sub-Recipient will range from \$100,000 to \$150,000 depending upon the length of assistance. CSH will market the RFP to a broad list of state, county and city officials and nonprofits via email, and utilizing the websites and newsletters of CSH, our partners and other membership/trade organizations. CSH will hold online bidders' conferences to educate potential applicants on the Initiative, review the RFP, and answer questions. The RFP will detail the following selection criteria and application format. Applicants will describe:

*Evidence of support from the DEPARTMENT WITH BUDGETARY AUTHORITY, typically the Office of Management and Budget. The RFP will give preference to applicants that also include other relevant agencies. Non-Profits are eligible to apply as the lead but must include letters of support from relevant government partners and outline a plan to ensure active government participation.

Applicants must clearly detail who will lead the project and roles and responsibilities for members of the team.

*LEADERSHIP TEAM QUALIFICATIONS AND PLANNED ROLES for the proposed PFS feasibility work, and their financial and management infrastructure, including accounting practices, budgeting processes, associated staff/qualifications, and Information Technology systems. Applicants will describe their performance and reporting with federal contracts and funders.

*TARGET POPULATION(s) that they would explore via feasibility assistance. CSH will prioritize populations with high potential to generate significant cost savings and the potential to create positive outcomes.

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*AVAILABLE DATA to determine status quo costs for the target population. If the data is in multiple systems, applicants will describe the plan for accessing these systems. CSH is anticipating that most applicants will require support in analyzing and matching data, but is seeking to ensure that this data can be obtained for purposes of the feasibility analysis.

*LOCAL RENTAL HOUSING STOCK, overall vacancy rates, and participation rates among landlords with subsidized housing programs. CSH will assess whether applicants will be able to access housing for pilot participants. Applicants will describe available resources for services, including tapping Medicaid to pay for care coordination and case management.

*PREVALENCE OF HIGH QUALITY SERVICE and HOUSING PROVIDERS that deliver services in conjunction with supportive housing. Information should also be provided on organizations that deliver quality housing-based services.

*how the PFS project CONNECTS WITH LOCAL AND/OR STATE PRIORITIES (e.g., current initiatives targeting chronically homeless persons, State Olmstead plans, or existing collaborations with the child welfare or justice systems). CSH will prioritize projects that complement the achievement of larger local and/or state goals.

*whether the state or local government has any PRIOR HISTORY OF COLLABORATING WITH THE PRIVATE SECTOR. CSH is seeking evidence that government is open to this kind of collaborative relationship.

* whether the government currently has the AUTHORITY TO ENGAGE IN A PFS TRANSACTION. If not, applicants will describe any existing history to create such authority and/or a plan to obtain it if needed. CSH anticipates that applicants will need support in this area but wants to ensure that there are no barriers to preclude moving forward with PFS.

TIMELINE. See WORKPLAN section below for the timeline.

DIRECT TA PROVIDED. CSH anticipates that each Sub-Recipient will receive a value of approximately \$85,000 in direct TA from CSH and our partners. These services will be focused on supporting the Sub-Recipients as they work through a detailed feasibility analysis of the proposed PFS project and in most cases move toward implementation. Services include but are not limited to:

*Convene multiple cross-department stakeholders to develop or strengthen a shared understanding of the potential value of PFS implementation

*Collect and analyze data to understand status quo costs for multiple target populations that could benefit from supportive housing

*Access and cross-match data from multiple departments in order to obtain a full picture of current

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costs for a particular target population

- *Outline the structure for quality supportive housing designed to meet the needs of the identified target population and assess local capacity and conditions
- *Educate, outreach to, and develop criteria for selecting housing and service providers
- *Develop a financial model and framework that illustrates expected cost savings and sustainability for the intervention
- *Define project success with all stakeholders and create preliminary payment triggers to inform conversations with potential investors
- *Analyze need for legislative and/or budgetary changes and develop strategies to accomplish them
- *Develop strategy for publicizing and issuing RFPs
- *Craft RFPs to obtain information on the capacity of respondents to provide needed support to the PFS initiative as service provider, evaluator, or intermediary
- *Create frameworks for evaluating RFP responses received

CASH AND IN-KIND ASSISTANCE. CSH anticipates providing each Sub-Recipient with a cash grant of up to \$15,000 in order to defray their costs to participate in the PFS initiative and/or for needed outside services in the areas of data systems or evaluation support.

CAPACITY FOR REVIEWING AVAILABLE EVIDENCE & IDENTIFYING MODELS. CSH has unparalleled knowledge of the available evidence base for SH and adaptations of the model for a range of homeless and at-risk sub-populations. CSH has sponsored and helped to design numerous independent evaluations to test program efficacy on client and systems level outcomes, including varying methodologies. This work is detailed below. As well, our Government Affairs & Research unit tracks and synthesizes external research on special needs housing and its impact on a range of vulnerable populations. We would tap this in-house capacity to advise government and nonprofits on expected impacts and cost reductions for PFS interventions. Our financial modeling would draw heavily on our existing knowledge and further review of the research. Using data to identify the highest cost individuals would be at the heart of any PFS initiative. CSH has pioneered this practice in the SH sector, detailed under Organizational Capacity below. CSH is uniquely positioned to leverage this experience and expertise to guide government and nonprofits in employing data-driven targeting tools for PFS interventions. Finally, solid program design that is rooted in evidence-based models is also critical to the success of any PFS endeavor. Assisting service providers and public agencies in developing programs based on evidence-based practice is a core strength of CSH. For our existing SIF grant, CSH created the basic program model based on our on-the-ground experience, and our review

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and assessment of the national literature of what interventions were most effective in stabilizing homeless high-utilizers, improving their health, and reducing costs to public systems. We then worked with the four sub-grantees to refine and customize the basic health/housing model based on the local context.

METHODOLOGY FOR BUILDING CAPACITY. CSH will build the capacity of Sub-Recipients to conduct their own feasibility analysis for future deals. Not only will we support the Sub-Recipients' efforts to analyze their data to determine feasibility, but we will also support relevant staff in setting up systems to facilitate such analysis in the future. CSH will also work with the Sub-Recipients to build a project team that includes all relevant government departments and other stakeholders for PFS. While engaging in the PFS Feasibility process, the members of this project team will develop trust and a track record of success that will facilitate the development of additional PFS deals in the future. We will develop an online toolkit of materials to support Sub-Recipients' efforts and facilitate sharing of information. Sub-Recipients will receive a complimentary membership to CSH's training center, supporting their ability to develop capacity around quality SH and access lessons learned from other initiatives.

HELPING TO IDENTIFY HIGH-PERFORMING SERVICE PROVIDERS. CSH is unmatched in our ability to help Sub-Recipients identify high-performing service providers in the SH arena. CSH routinely assesses capacity in the SH industry through a variety of vehicles, including through our extensive grant-making and lending to SH providers. (See below for details). We would leverage scoring sheets and criteria to share with Sub-Recipients. In 2008, leveraging on 20 years of experience and conversations with SH tenants, providers, and funders, CSH created the Dimensions of Quality Supportive Housing (DOQ), a framework for what constitutes quality in supportive housing services and operations. This includes tools to assess providers and resources to support providers to improve quality. CSH has provided training and TA to numerous organizations using the DOQ as a framework. In 2013, CSH revamped the Dimensions to allow for ease of use among funders, providers, and property managers, different SH models (single-building developments versus scatter-site apartments), and different populations (e.g., families, youth, veterans, Olmstead). CSH would use the DOQ framework and tools to support Sub-Recipients in identifying providers with a strong capacity and programming.

BACK-OFFICE SUPPORT, OVERSIGHT & VALUE-ADDED SERVICES. The CSH PFS Feasibility TA team would receive significant value-added services to support their delivery of sub-grants and TA. First, the Team would report to CSH's President and Chief Operating Officer on its progress and any

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challenges. The Team will have our Executives' full support in designing the initiative, disseminating the results, and helping to secure match funders. The Team would be supported by a robust administrative infrastructure. Our nine-person Finance team would track expenses for federal and match funds, ensure expenses are allowable, and create reports for CNCS and the match funders. CSH has a dedicated Finance staff person who oversees all grant-making; he would help vet potential Sub-Recipients, develop sub-grant agreements, make payments, and monitor performance. CSH's Fund Development team would assist in match fundraising for the initiative, as it has done successfully for CSH's CNCS SIF award. IT and Communications will help the Team to develop webinars and resources to post to CSH's website. CSH currently has 105 staff in 23 locations. We would leverage staff's knowledge of local conditions to select sub-recipients and provide TA.

PLAN TO ENSURE COMPLIANCE WITH ALL LEGAL AND REGULATORY REQUIREMENTS.

CSH would leverage our existing infrastructure, protocols, and approaches for fiscal oversight, which have proven successful with past federal grants and contracts, and private grants. CSH will ensure that the funds are used effectively, efficiently, and in accordance with all applicable laws and regulations. CSH currently manages an annual operating budget of \$25 million, which includes administration of multiple, simultaneous contracts with government entities. CSH currently administers five HUD TA agreements, totaling \$9.77MM, and a \$3.15MM grant award from CNCS' SIF. CSH is currently compliant under all these agreements and awards. CSH has a robust infrastructure for tracking the use of funds from public and private sources. CSH is able to track and report out on use of each of funding source separately. When we receive a new funding source, our first step is to assign a distinct account code and hold a kick-off meeting to review allowable uses, agreement terms, and reporting requirements. We then use our robust accounting software to track expenditures and check compliance with all donor-imposed restrictions. CSH would maintain organized, detailed files for the PFS award, including all expenditures, documentation, and reporting materials. Our financial management system meets all audit requirements in accordance with Government Auditing Standards, OMB Circular A-133. Joy Granado, CSH's Controller, oversees and reviews reporting to federal entities, ensures expenditures are in line with approved budgets, and develops and implements policies and procedures to ensure compliance with all federal rules and regulations. PROVIDING LEGAL SERVICES. We do not anticipate that Sub-Recipients will have significant legal needs in the Feasibility Phase. If such services are needed, Sub-Recipients would have access to our general counsel. CSH also has pro bono legal partnerships and anticipates obtaining this in-kind support as needed. Our partner, CHCS, also has a lawyer on staff who is a member of the

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project team.

PROPOSAL FOR KNOWLEDGE SHARING/SUPPORT NATIONAL PFS EVALUATION. CSH will work closely with the Sub-Recipients to collect local data to inform feasibility analyses and capacity building efforts. Information sources may include electronic as well as hard copy materials collected during site visits, interviews, conference calls, focus groups, community-wide planning meetings, surveys and other methods. CSH will share our strategies, templates and any other data collection tools to inform the national evaluation. We will also seek permission from sites to share non-confidential data or materials with the national evaluation team. CSH will also work with the Sub-Recipients to develop an approved timeline and work plan with clear deliverables to track progress towards goals. Such deliverables may include target population data, financial models, legislative language, progress reports and other relevant items.

CSH has extensive experience working with communities to conduct large-scale data matching using administrative data from homeless, corrections, health/behavioral health, child welfare and other institutional systems. CSH analyzes these data using statistical software packages, like SPSS and SAS. Data is collected and stored in compliance with state and federal regulations around protected health and other information. CSH identifies high-cost users of multiple systems and determines cost-benefit potential. CSH has helped communities develop and execute data sharing agreements, Memorandums of Understanding and Institutional Review Board applications to facilitate such data sharing. This work would enable us to share de-identified, aggregated data with the national CNCS evaluation team.

CSH has a strong record of successful collaborations with local and national evaluators on a variety of large scale initiatives. This includes our current work with CNCS on our SIF initiative. CSH worked closely with the CNCS evaluation team and their consultants at JBS in order to develop, refine and approve the Sub-Grantee Evaluation Plan (SEP) for the current CSH SIF project. Our SEP is a UniSEP in which all four sub grantees are being evaluated by one national evaluator (New York University) and using a consistent and rigorous methodology. We coordinate regularly with the CNCS evaluation team in order to complete and submit progress reports and trouble shoot issues as they arise. CSH also participates regularly on the CNCS national evaluation calls, providing active input and informing the national perspective.

COLLECT & DISSEMINATE KNOWLEDGE. CSH has already begun to share and disseminate knowledge in the PFS arena. We created a web page www.csh.org/socialimpact that includes explanatory materials and will include write-ups of lessons learned, case studies, frameworks, etc. We

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will create an online social impact toolkit, including sample financial models, RFIs, RFPs, and other documents. CSH also shared information on our PFS efforts with partner organizations such as NACo and Funders Together, and would continue to participate in webinars and conferences to disseminate findings and promote the use of PFS. We will also develop two webinars based on our and the Sub-Recipients' experiences and publicize it widely. Finally, we will create peer learning communities for each round of Sub-Recipients and connect them to entities that are further along in the PFS implementation process for peer learning and information sharing.

BUILDING EVIDENCE FOR FIELD, ACQUIRING ACCESS TO DATA AND ENHANCING DATA ANALYSIS CAPACITY. CSH anticipates that a key part of our feasibility TA will be in supporting Sub-Recipients' efforts to create agreements that offer ongoing access to needed data and setting up data analysis systems, which will facilitate the evaluation of PFS projects as they move forward to deal structuring and implementation. In addition to participating in the CNCS evaluation, CSH intends to utilize data culled from the feasibility analyses to further define the average status quo costs for the target population. We will share this information on our website and in presentations to inform PFS feasibility analysis in additional locations.

PROPOSAL TO IDENTIFY INNOVATIVE, EFFECTIVE SOLUTIONS

HOW SERVICE DELIVERY STRATEGY IS INNOVATIVE OR TRANSFORMATIVE & IDENTIFIES SOCIAL CHALLENGES NOT SERVED VIA MOST PFS PROJECTS. Detailed under Goals and Objectives, PFS has the potential to transform how government invests in supportive housing, fully fund the SH service package, and bring this innovative intervention to scale nationally. Unlike most PFS deals to date, SH PFS deals would focus on highly vulnerable populations and have the power to dramatically improve their health while reducing net costs for public systems. CSH's strategy is innovative due to our focus on helping government address pressing policy issues (e.g., Olmstead, controlling healthcare costs), applying PFS to new populations, exploring Medicaid as the source of savings, blending savings from multiple systems such as criminal justice, housing and health, and producing significant cost savings.

* **SUPER UTILIZERS OF CRISIS RESOURCES** are of growing national concern, as their reliance on crisis care results in exorbitant costs to public systems. The most cutting-edge SH models have been shown to improve housing and health outcomes for frequent users while reducing public costs. Yet, these models remain at the periphery of major health systems. Via our SIF grant, CSH is collecting rich data on the cost-savings generated by these models. The proposed project would bring the SIF models to greater scale and replicate them in many more sites.

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* **DISABLED RESIDENTS OF INSTITUTIONS** Since 1999, states have been striving to comply with the Supreme Court's Olmstead decision. A major challenge is the scarcity of affordable community-based housing. PFS could expand housing availability by attracting upfront capital. This would allow states to save money and meet the Olmstead mandate.

* **HOMELESS FAMILIES.** Combining the KFT model with PFS has high potential to meet the needs of these highly vulnerable families and break their costly intergenerational cycle of poverty and systems involvement.

* While some PFS initiatives are focused on reducing recidivism among **YOUNG ADULTS**, none look at the close relationship between homelessness, foster care, and criminal justice involvement. CSH would guide government and nonprofits in designing models that take a comprehensive approach, focusing on a range of health, justice, and socio-economic outcomes for Opportunity Youth. We would use data to target the highest-need youth among this overall group, standing apart from other PFS efforts.

SUB-RECIPIENTS NEW TO PFS. CSH is excited to deepen our involvement in the PFS field and utilize our strong history of selecting and building capacity among Sub-Recipients to strengthen the field. We are also very pleased that the Center for HealthCare Strategies, a nationally recognized technical assistance provider to Medicaid agencies and their partners that has worked with nearly all 50 states, more than 160 health plans, key federal agencies, and community-based organizations, providers, and consumer groups across the country will be able to strengthen their involvement in the field. We also anticipate including Sub-Recipients who will be new to the field and welcome the opportunity to intentionally work with them to develop their capacity and increase the number of government units and non-profit organizations that are skilled at PFS projects across the country.

INNOVATIVE TOOLS AND TECHNOLOGY. CSH will leverage existing tools: 1) financial modeling template to simplify this process for sub-recipients; 2) sample data-sharing agreements to facilitate access to data for the feasibility TA and the implementation phase; and 3) sample SH provider selection criteria and assessment checklists. CSH will house these and new tools in an online toolkit for access by sub-recipients and others looking to undertake PFS work.

WORK PLAN & DELIVERABLES. See below for all deliverables and timelines, including CNCS reporting requirements. See **BUDGET ADEQUACY** section below for required staff time and positions to complete tasks. All staff are part of the existing CSH and partner team.

Oct 14: Develop RFP, conduct bidder's conference.

Nov 14: RFP responses due to CSH

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December 2014: Announce Sub-Recipients, Administer Pre-Survey regarding PFS knowledge and capacity

Jan 15: Conduct initial meetings with each Sub-Recipient, create individual work plan; Establish PFS steering committee in each site, conduct initial meeting

Feb-Mar 15: Collect and analyze data to understand status quo costs for multiple target populations, Convene steering committee to select target population, Complete legislative/regulatory analysis

Apr-Jun 15: Cross-match data from multiple departments to obtain full picture of current costs for selected target population, Complete preliminary financial model, including preliminary success metrics/payment triggers, Outline structure for quality SH to meet the needs of target population

Jul-Sept 15: Develop criteria for selecting SH providers, Develop strategy for targeting potential investors and preliminary identification of investors, Craft strategy for issuance of RFPs, present at 1-2 conferences

Oct-Dec 15: Craft RFPs for PFS initiative in each Round I site, Create frameworks for evaluating RFP responses, Complete feasibility study and report for each Round 1 sub-recipient, Administer Post-Survey regarding PFS knowledge and capacity

Oct 15: Publicize Round 2, conduct bidder's conference

Dec 15: Announce Round 2 Sub-Recipients

Dec 15-Dec 16: Provides feasibility assistance to Round 2 Sub-Recipients, see Round I above for timeline

Jul 16: Present at 1-2 conferences

Aug 16: Publicize Round 3, conduct bidder's conference

September 2016: Announce Sub-Recipients

Oct 16: Present at 1-2 conferences

Sept 16-Sept 17: Provide feasibility assistance to Round 3 Sub-Recipients, see Round I above for timeline

Jul-Sept 17: Develop case studies for projects that move forward; Conduct 2 webinars; Develop online toolkit; Present at 1-2 conferences

Organizational Capability

Established in 1991, our mission is to advance housing solutions that use services to improve the lives of the most vulnerable, maximize public resources, and build healthy communities. CSH has committed over \$353MM in loans and grants to support the creation of 75,224 new SH units nationally. For 20 years, CSH has refined the SH model, built credible evidence for its outcomes and

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cost-effectiveness, and helped establish SH as the central solution to long-term homelessness. Given its broad impact, our goal is to bring SH to the forefront of mainstream systems.

CSH provides the following core activities:

* TRAINING AND EDUCATION. CSH enriches the industry with research-backed tools, trainings and knowledge sharing. CSH has extensively researched best practices in SH development and operations, profiled projects, and conducted in-depth interviews with tenants and providers.

* LENDING. SH project sponsors must cobble together funding from disparate sources, engage in a lengthy planning process, and build community support. We provide recoverable grants, low-cost loans, and TA to overcome these challenges.

* CONSULTING AND ASSISTANCE. CSH leads the industry by developing innovative SH models with our partners and testing them through national demonstration pilots. We partner with independent evaluators to document lessons learned and assess impact. This work provides cutting-edge best practices and techniques for the industry.

* POLICY REFORM. CSH engages government leaders and public agencies through systems reform. We also increasingly partner with government agencies to effectively target frequent users.

Our sub-contractor, CHCS, founded in 1995, is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS achieves its mission by working directly with state and federal agencies, health plans, providers, and consumer groups to develop innovative and cost-effective programs, particularly for individuals with complex and high-cost health care needs.

As a national leader in the PFS field, THIRD SECTOR CAPITAL PARTNERS, Inc., our other sub-contractor, has been involved in designing, responding to, or constructing many of the current PFS undertakings across the United States, and is eager to lend its expertise in designing PFS competitions and assessing the viability of PFS proposals for CSH's proposed project.

TRACK RECORD IN SELECTING & WORKING WITH SUB-GRANTEES OR SUB-RECIPIENTS
CSH is an established grant-making entity, having provided \$11.6M in grants to 137 nonprofits in the last 5 years. We target grants to nonprofits with solid track records of developing and operating SH programs, with many grantees having performed well under third-party evaluations and/or under past CSH grants and loans. CSH combines financial support, training, TA, and coordination to guide grantees in achieving strong impact.

SELECTING SUB-GRANTEES & SUB-RECIPIENTS. CSH objectively assesses sub-grantees.

Evidence of program and organizational effectiveness plays a paramount role in CSH's selection of

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sub-grantees and sub-recipients. For each grant and loan made, we assess the viability of the particular SH project as well as the capacity of the potential grantee/borrower organization overall. Our process for several CSH initiatives is described here:

* In 2011, CSH received a CNCS SIF award to develop and test innovative SH models that promote healthy futures for homeless individuals. In early 2012, with CNCS advisement, CSH developed a RFP to sub-grant 81% of the CNCS award, created scoring criteria and a structured reviewed process, and scored and ranked 33 nonprofit applicants. We ultimately selected four nonprofit sub-grantees who scored the highest and represented the best alignment with CSH's goals for SIF.

* For FUHSI (2003-2008), a \$10MM pilot, CSH developed/tested models to serve frequent users of ERs and acute care in six counties in California. Tarzana Treatment Center and LA Family Housing were both successful grantees, per their strong evaluation results, leading CSH to make additional grants to both post-FUHSI.

* LOAN DUE DILIGENCE AND BORROWER APPROVAL. As a certified Community Development Financial Institution (CDFI), CSH regularly makes loans to housing developers and must assess the fit of their proposed project with our mission as well as the strength of the potential borrower's project plans and organizational capacity. Over the past five years, CSH made 287 loans, valued at \$168.3M, to 165 housing developers. We have formal, Board-approved policies and procedures to assess loan applicants and manage risk. Borrowers must complete a comprehensive application for funding.

* RETURNING HOME OHIO (RHO) is a statewide reentry SH pilot. Beginning in 2007, the Ohio Department of Rehabilitation and Correction (ODRC) has committed \$4.8 million for RHO, which provides SH to people with disabling conditions who are exiting state prison. CSH provides sub-grants to nine SH providers in five Ohio cities. CSH recruited seasoned SH providers to participate and conducted interviews to make our final selection. We began with eight providers, and only five of this initial group remain in the program-CSH cut two underperforming groups (based on our review of the data and site visits) and a third left because of lack of mission alignment. With ODRC, we expanded the program in 2014, bringing on new providers using a formal RFP process.

* In 2005, CSH developed the FREQUENT USERS OF SYSTEMS ENGAGEMENT (FUSE) pilot in New York City. Working with nonprofit sub-grantees and local City agencies, we used an inter-agency data match to identify the highest cost, homeless individuals and placed them into SH. The model features in-reach into jails and shelters. CSH selected a group of nonprofits with strong track records and long tenures in the SH field. We began with nine FUSE sub-grantees for Round I of the pilot. Based on the initial, strong results, CSH expanded the program to 100 more participants.

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However, after evaluating Round I performance, we only selected the 4 highest performers to continue into Round II.

* STABLE HOMES, BRIGHTER FUTURES. In 2012, CSH released a RFP to select SH providers for our Stable Homes, Brighter Futures initiative. The goal was to develop and test new SH model for serving homeless youth in Los Angeles. A committee of CSH staff with assessed 10 proposals based on set criteria. CSH awarded \$600,000 in sub-grants to six SH providers.

* Offered SH TRAINING INSTITUTES to prepare teams to develop new SH projects. The Institute is a structured training series that features monthly trainings and 1:1 TA in between the sessions to move projects forward in the development process. Teams (SH provider + housing developer + property manager) submit a joint apply to participate. CSH evaluates their joint capacity and assesses the viability of their proposed SH project. CSH offered this Institute seven times in the past two years, reviewing 80+ applications from nonprofit applicants.

WORKING WITH SUB-GRANTEES & SUB-RECIPIENTS. Our grant-making is directly tied to clear, measurable outcomes for our grantees. CSH regularly monitors grantee progress against set targets for service/housing provision and client-level outcomes. We also provide a range of training, advisement, and support to our sub-grantees and other partners in order to overcome challenges and ultimately ensure success.

* SIF INITIATIVE. CSH is working closely with the four SIF sub-grantees and their implementation partners to ensure the success of the pilot. We are offering a robust package of support, including a mix of in-person and virtual, cross-site gatherings and trainings, as well as one-on-one assistance to each grantee and its partners. CSH meets with each sub-grantee at least monthly and often more frequently to check progress, provide advisement, and trouble-shoot issues. We also require written, formal quarterly reports from the sub-grantees. We have built the capacity of our four sub-grantees and their partners to work together effectively to comprehensively serve and house homeless, frequent users. As a result, sub-grantees have successfully identified eligible individuals and housed 357 participants to date.

* For RETURNING HOME OHIO, CSH monitors each sub-grantee's performance against set targets on a quarterly basis and provides intensive TA to address any performance issues. We use quarterly meetings with sub-grantees to review data, collectively troubleshoot issues, and develop course corrections. This approach enabled grantees to learn from the data in real-time and from their peers, and to adjust their approaches accordingly.

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* For FUSE, CSH also monitored each sub-grantee's performance against set targets on a quarterly basis and provided intensive TA to address performance issues. Our quarterly data monitoring uncovered sub-grantee performance issues and led CSH to reduce grant amounts for several grantees and reallocate these funds to other more successful sub-grantees. Detailed below, FUSE yielded strong results: housing stability and dramatic drops in shelter usage and jail stays. Based on the success of the NYC pilot, CSH has replicated FUSE in 15 additional sites, enabling communities to systematically target the highest-need/cost users of crisis systems for supportive housing.

* SUPPORT FOR BORROWERS. CSH provides extensive support to our loan borrowers. CSH requires that applicants' projects are presented in a professional format that mirrors the loan application process with traditional lenders. This approach builds the capacity of our less experienced borrowers, developing the skills necessary to later approach other lenders and public agencies for funding, which lessens our risk in lending to these borrowers.

* STABLES HOMES, BRIGHTER FUTURES. CSH holds monthly TAY Learning Community convenings. We also have provided a range of training on topics including: harm reduction, motivational interviewing, critical time intervention, and youth/adolescent development. Sub-grantees provide regular reports to CSH and the evaluator that detail progress. To date, providers have surpassed their goal of housing 55 TAY, having housed 59 youth.

* CHCS has provided TA and training to Medicaid nearly all 50 states, more than 160 health plans, key federal agencies, and community based-organizations, and consumer groups. Major CHCS initiatives include: 1) Innovations in Complex Care program, a national initiative to develop integrated care models for Medicaid's highest-need beneficiaries; 2) providing TA to states pursuing health homes programs; and 3) New York Health Home Learning Collaborative that promotes the spread of best practices in the state's health home program.

To successfully manage these multi-site initiatives, one national staff person serves as the overall lead. Local staff offers training and TA, coordinates project partners, and manages sub-grantee monitoring. Local staff and the national lead work together to support sub-grantee planning, implementation, and evaluation efforts. The national lead centrally monitors the initiative's overall progress and ensures that lessons learned are shared across sites.

PROJECT EXPERIENCE WITH PFS. In the past two years, CSH has been very active on the PFS/Social Financing front and is quickly developing expertise in this area. Several states have issued Requests for Information (RFIs) or RFPs for SIBs, many of which have specifically called out supportive housing as a potential intervention under consideration, due in part to CSH's education

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efforts. CSH has responded to several of these requests, both as the lead and as an implementing partner. Specifically, we responded to RFIs in New York, Illinois, Minnesota, Michigan, and Colorado to inform these States' thinking about how to structure the SIB and to urge them to prioritize SH in any subsequent RFP. Our responses included detail descriptions for homeless sub-populations to be targeted, including the size of each sub-population in the state, their current costs to public systems, evidence-based practices (EBPs) for serving each group, and cost study analysis on expected cost savings under a supportive housing PFS pilot. We subsequently responded to full RFPs to be a PFS intermediary in Minnesota and New York, and to be a subcontractor to the lead agency in Massachusetts. In Massachusetts, CSH was part of a successful application to the state to implement a supportive housing SIB/PFS pilot. In the past 18 months, CSH has worked intensively to advise the lead partner, the Massachusetts Housing and Shelter Alliance (MHSA), in order to refine the program model, targeting approach, and financial model. In Minnesota, CSH was selected as the lead intermediary for a SIB pilot in Minnesota focused on supportive housing for disabled individuals who are currently residing in state institutions. CSH has spent the last year negotiating the terms of the pilot with the State, including developing financial models and numerous scenarios for eligibility criteria for pilot participants. Also, in the past year in Los Angeles, CSH retooled the Just in Reach (JIR) reentry SH model, enhancing the targeting of clients for SH placement and bolstering the service package and data collection processes. In 2013, CSH received a \$1.5MM grant from the Hilton Foundation to support this work. The goal is to position the model for eventual performance under a PFS construct. We also received a contract from the United Way in Maricopa County, AZ, to conduct a ROI analysis for a SH PFS for homeless frequent users of the County jail. CSH was named as a partner in Denver's initiative to connect homeless super utilizers with SH in one of the first city-led PFS programs.

Additionally, we have created tools and resources for these groups. CSH created and is continuously refining a "plug and play" PFS financial model based on our work for Minnesota and has used it to review numbers in other states. CSH has also developed a broad framework and sample term sheet. The financial model enables us and our partners to use a broad set of parameters and indicators, and test out an array of scenarios for return on investment scenarios. The sample term sheet provides an overview and is a useful tool for state and local partners to understand what would be required of various partners and what the various roles and responsibilities of stakeholders might be in a SIB/PFS deal. We released a six-page discussion paper, co-authored with CHCS, RWJF, and the Rockefeller Foundation that outlines the benefit social impact investment offers to states implementing the

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Olmstead mandate. We also released a two-page overview of social impact investing and how it can be a tool to create SH, and a concept paper that provides a more detailed look at using social impact investing to create supportive housing for vulnerable populations. Finally, we launched CSH's social impact investing webpage housing our publications and other resources.

Third Sector has responded to over 10 procurements at the local, state, and federal levels as an intermediary organization and PFS deal construction project manager. Third Sector has been selected through competitive procurements to lead PFS deal construction efforts by the Commonwealth of Massachusetts, New York State, Illinois, and Salt Lake County. As an advisor to government clients, Third Sector has worked extensively to prepare, refine, and support various procurement processes. In Cuyahoga County, Ohio, Third Sector prepared the County's RFP to solicit PFS projects from a variety of community stakeholders. This process resulted in the identification of a PFS opportunity to serve homeless families with children placed in foster care. In Santa Clara County, Third Sector directed an RFP drafting process for the first County-level PFS project to address chronic homelessness. Third Sector also helped Santa Clara County to develop a rubric to assess RFP responses.

Strong EVALUATION CAPACITY is at the heart of any PFS initiative. CSH has sponsored, designed, and managed numerous independent evaluations nationwide to test program efficacy on client and systems level outcomes, including varying methodologies. Our work has yielded impressive client and system level outcomes, detailed above. For instance, Columbia University tracked CSH's NYC FUSE pilot's impact on housing stability, jail and shelter usage, and impact on health outcomes and health system costs. The final results are positive on all these measures, see GOALS AND OBJECTIVES section. For FUHSI, the Lewin Group's evaluation showed that homeless clients experienced a 61% decline in ER visits and a 62% drop in inpatient hospital stays. CSH worked again with Columbia on a study of service utilization for supportive housing for active substance users, released in Jan. 2014. Significant reductions in shelter, jail, and Medicaid usage were found.

DATA-DRIVEN TARGETING & PROGRAM DESIGN. Using data to identify the highest cost individuals would be at the heart of any PFS initiative that seeks to both improve outcomes and drive down costs. Thus, it is critical that any TA provider in this arena would have strong expertise in data-driven targeting. CSH has pioneered this practice in the SH sector. For instance, in 2003, CSH proposed a simple yet novel idea: match NYC Departments of Corrections (DOC) and Homeless Services (DHS) data to understand the size of the overlap between the shelter and jail populations. The data analysis revealed a pattern of cycling between jail, shelter, and other systems, and showed that a small cohort was responsible for most of this cycling. 1,100 individuals had four or more stays in both

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systems over five years, for a collective cost of \$11.8MM annually. CSH's FUSE represented a rare opportunity to cut costs for both agencies. CSH piloted FUSE in New York City in 2005 with 100 participants and has since expanded to 200 clients. The model features data matching across agencies to identify and target frequent users, in-reach into jails and shelters, and housing linked to intensive services. Detailed above, FUSE yielded strong results. For CSH's SIF initiative, we borrowed the data-driven targeting approach from FUSE. We guided each of four sub-grantees in each site in getting access to administrative data and conducting data matches in order to identify the highest cost users of shelters, ERs, and inpatient hospitalizations. We then guided the sub-grantees in outreaching to these individuals and placing them into SH. We are now continuing this work with additional systems such as child welfare agencies, hospitals and other health settings.

Solid program design that is rooted in EBPs is also critical to the success of any PFS endeavor. This helps to ensure that the pilot will achieve the targeted outcomes and cost savings for public systems. Assisting service providers and public agencies in developing programs based on EBPs is a core strength for CSH. For SIF, CSH created the basic program model based on our on-the-ground experience, and our review and assessment of the national literature of what interventions were most effective. We then worked with the four grantees to refine and customize the basic health/housing model based on the local context. CSH has extensively researched best practices in SH development and operations, profiled projects, and conducted in-depth interviews with tenants and providers. We routinely draw on this expertise to design new programs.

PROJECT MANAGEMENT. CSH excels at outcome-driven project management. We set ambitious, yet achievable goals for all of our initiatives. CSH has a long and successful track record of designing and implementing complex, multi-site demonstration initiatives that include sub-granting, managing to outcomes, and rigorous evaluation. CSH has significant experience in engaging multiple partners in a collaborative process for program design, goal-setting, implementation, outcomes management, and evaluation.

ACCOMPLISHMENTS & OUTCOMES. Outlined below is a sample of outputs and outcomes for similar CSH initiatives:

- * FUHSI. 1,180 frequent users served. 61% decline in ER visits, 62% drop in inpatient stays over 2 years; subset in SH experienced stronger outcomes than those only offered health services.
- * FUSE. 200 frequent users placed into SH. After a year: 91% of tenants remained stably housed; 92% drop in shelter stays; 53% decline in jail recidivism.
- * RHO. Placed 170 individuals into reentry SH in Ohio. Only 27% were re-arrested. RHO participants

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significantly less likely to be re-arrested or re-incarcerated than control group.

* SIF. Data-sharing agreements and evaluation plan developed. Set goal is to place 529 individuals into SH; 357 placed to date. Evaluation is seeks to test whether enhanced SH models result in improved health, reduced use of costly crisis care, and improved uptake of primary and preventive care.

SETTING & IMPLEMENTING GOALS. In 2002, CSH set an ambitious goal of creating 150,000 SH units over 10 years through direct TA and lending, and advocacy work. In 2011, six months ahead of schedule, CSH realized this goal. As well, detailed above, CSH has a solid track record of setting and achieving ambitious goals for our initiatives. We also have deep experience in using performance data to manage sub-recipients.

MANAGING FEDERAL GRANTS. CSH has a strong track record as a federal grantee, ensuring compliance with federal guidelines at the Grantee and Sub-recipient levels, detailed below.

* CNCS SIF. Detailed above, CSH currently has a \$3.45MM SIF award for which we are compliant, as evidenced by CSH's receipt of renewal funding from CNCS in 2013, given that performance and compliance are key factors in CNCS' decision-making. We require quarterly reports from the sub-grantees in order to monitor progress. We also conduct site visits to review files and ensure that the sub-grantees are meeting the terms of their awards, which incorporate federal guidelines.

* HUD TA: CSH has received and successfully managed multiple U.S. Department of Housing and Urban Development (HUD) TA awards. CSH has four awards totaling \$9.775MM, which are still active. Given that performance on past TA awards is a major factor in the awards process, our numerous awards attest to the quality and timeliness of our TA provision, and compliance with federal guidelines.

* CDFI AWARDS: CSH has received 11 awards (\$10.85MM total) from the U.S. Department of Treasury CDFI Fund. We have deployed these awards per assistance agreements with the CDFI Fund, as evidenced by our repeated awards, given the Fund's policy to only fund fully-compliant prior awardees with successful track records. The Fund requires a 1:1 match for awards, which CSH has fulfilled for each award.

ORGANIZATIONAL COMMITMENT TO PFS. CSH is fully committed to pursuing PFS for the SH field. CSH's 2013 Strategic Plan calls out five strategic priorities for realizing our mission over the next five years. One of these priorities is Deploying and Leveraging Capital, specifically calling out PFS as a key opportunity to bring additional resources to the SH sector. Paying for services is a long-standing challenge in the SH industry. Historically, funding to develop new housing and for housing vouchers

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have been in more ample supply than funds for service provision. Limited service funding has presented a seemingly insurmountable barrier to bringing SH to the scale required to meet the nationwide need. Typically, providers seek private resources to cover gaps in service funding, but this approach is not scalable. Via PFS, the SH industry could make the business case for government to pay the full cost of SH, namely addressing gaps in service funding. Thus, early on, CSH has seen the potential for PFS to remedy this long-standing issue. Since 2011, CSH has been exploring the use of SIBs and PFS models as a sustainable mechanism for funding services.

Leadership and Team

TEAM DEMONSTRATES CAPACITY EXPERIENCE FOR SUCCESS

Below is a description of the proposed team. The team possesses direct expertise in PFS, SH best practices, research, and financial modeling, all prerequisites for the proposed work.

As President and CEO, DEBORAH DE SANTIS is responsible for the overall leadership of CSH. Ms. De Santis led CSH in realizing a 10-year goal of creating 150,000 SH units nationally.

ANDY MCMAHON, Managing Director for CSH's Government Affairs and Innovation team. He oversees CSH's CNCS SIF initiative. Mr. McMahon led CSH's foray into the PFS/SIF arena.

STEPHANIE MERCIER, Senior Program Manager for Innovation, works on PFS, having developed the PFS resources described above and financial model template, and is now advising numerous jurisdictions on PFS. Stephanie would serve as the DAY-TO-DAY LEAD FOR FEASIBILITY TA PROVISION AND SUB-RECIPIENT SELECTION. Previously on the CSH Consulting team, Stephanie provided training and TA to address homelessness. She revamped CSH's Dimensions of Quality Supportive Housing. Stephanie also worked for CSH in the Illinois, Michigan, and Washington DC offices.

JANETTE KAWACHI, Director of Innovation, is responsible for providing daily leadership and management of CSH's Innovations and Research Team. Prior to CSH, Ms. Kawachi was a senior director at Catholic Social Services of Washtenaw County where she oversaw several programs in the areas of SH and healthcare for the homeless.

KIM KEATON, Senior Program Manager for Innovation, leads projects for homeless veterans, re-entry and high-cost utilizers of Medicaid and other public services. Prior to CSH, Ms. Keaton was Director of Project Management at the NYC Department of Homeless Services.

KEVIN IRWIN, Senior Program Manager for Research, oversees CSH's research and evaluation efforts. He serves as the primary liaison with the independent evaluator for SIF and provides support to the sub-grantees on data collection. He served as Senior Program Manager for CSH's Connecticut

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Program. He was the primary TA provider for the Connecticut SIF sub-grantee.

SARAH GALLAGHER, Director of CSH's Connecticut Program, manages a FUSE pilot in Connecticut, and serves as the national lead for CSH's SIF pilot.

JOSEPHINE PUFPAFF, Senior Program Manager for CSH Minnesota, is responsible for the implementation of a PFS pilot. Prior to CSH, Ms. Pufpaff was Director of Strategic Design and Evaluation for YouthLink, Inc.

TEAM LEADER. Andy McMahon will serve as the team leader for the proposed PFS TA initiative. Detailed above, Andy has been with CSH for 12 years, assuming greater levels of responsibility and leadership positions. In the past three years, he has developed expertise in the PFS arena, advising federal, state and local government, and foundations on the development of PFS models that center on SH for vulnerable populations. He is directly involved in the program and financial modeling work on the Minnesota PFS pilot, for which CSH is the lead intermediary. Mr. McMahon has presented on PFS to CSH senior leadership and the Board multiple times. Our leadership is highly supportive, evidenced by the PFS call out in our strategic plan. Prior to this, Andy led CSH's Returning Home Initiative, which includes the proliferation of reentry SH and frequent user (FUSE) models in jurisdictions nationally. Andy oversaw \$14.3MM in foundation grants, which included substantial sub-granting to SH providers and evaluation consultants. Andy brokered a partnership with NACo to more cost-effectively replicate the FUSE model nationally. 15 communities are now operating FUSE programs.

Budget Adequacy & Cost Effectiveness

BUDGET ADEQUACY FOR PROGRAM DESIGN. The staffing pattern leverages the collective and complementary expertise of our national and local staff, which has been successfully utilized for other initiatives. CSH will leverage the expertise of a range of staff while concentrating the bulk of the activities among a few key staff. Andy McMahon (at 24% FTE) will oversee the Initiative's design and implementation and provide feasibility TA. Stephanie Mercier will serve as the day-to-day lead and is budgeted at 71%. She will be supported by Kevin Irwin at 25% (tapping research expertise to inform financial modeling), Kim Keaton (at 30% advise on EBPs and data-driven client targeting), Janette Kawachi (15%) and Sarah Gallagher (5%) (providing TA drawing on SIF and research experience), and Ms. Pufpaff (advise based on MN PFS pilot) at 5%. The budget also includes fringe benefits at 30.5% of personnel costs. Supplies (rent, utilities, telephone/internet, supplies, postage, copying/printing) are also included and calculated at set percentages applied to the total personnel costs. The budget includes \$11,277 annually for overnight travel to conduct site visits and provide TA.

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We included \$66,000 annually for CHCS and \$60,000 annually for Third Sector Capital Advisors. We budgeted \$60,000 annually for sub-grants. The budget includes 16.4% in indirect costs, using CSH's federally-approved indirect rate.

DIVERSITY OF FUNDING. Our proposed budget draws on a mix of unrestricted earned income and in-hand private foundation grant funds to support the initiative's implementation. In terms of sustainability, we will direct sub-grantees to use PFS/SIF funds for one-time investments in organizational infrastructure and due diligence.

DESCRIPTION BY PHASE. The proposed annual budget breaks out as follows: \$42,171 (8%) (for pre-award planning); \$399,875 (80%) for feasibility TA, sub-grants, and TA-related travel; and \$57,951 (12%) for post-award evaluation and dissemination. The \$250,000 annual CNCS portion would follow a similar breakout: 11% for pre-award planning, 82% for feasibility TA/support, and 7%.

ANNUAL BUDGET. The annual budget is \$500,000, with \$250,000 coming from CNCS and \$250,000 coming from match sources. CSH is requesting \$750,000 over three years from CNCS.

DESCRIPTION OF MATCH SOURCES AND CAPACITY. Between cash-in hand and committed grant funds, CSH currently has \$162,485 in match funds for our PFS initiative, or 22% of the required match in hand.

IN-KIND. CSH is committing \$12,485 annually for in-kind staff support.

COMMITTED FOUNDATION RESOURCES. In 2013, CSH secured a grant of \$245,190 from the Robert Wood Johnson Foundation and \$50,000 from the Rockefeller Foundation to provide PFS assistance to government and nonprofits nationally. CSH has \$150,000 remaining between both grants to commit as match.

RAISING ADDITIONAL FUNDS. CSH has longstanding ties with several foundations that have indicated a strong interest in the initiative.

Clarification Summary

CLARIFICATION QUESTIONS

PROGRAM-RELATED CLARIFICATIONS

* Please expand on the profile of the sub-recipients who will be receiving the TA. Will the sub-recipients mainly be local governments? Or partnerships with non-profits? Will the type of sub-recipient be specified or limited in the competition?

CSH will design and implement an open, objective, and transparent selection process to identify

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qualified Sub-Recipients. Units of government and non-profit organizations will be eligible to apply as lead applicants for the competition. If a non-profit organization is applying as the lead applicant, they must include letters of support from relevant government partners and outline a plan to ensure active government participation. For-profit organizations are not eligible to be the lead applicant, but may be members of the project team. For example, a team might include a for-profit housing developer who is providing the project with access to units of housing.

We anticipate that the selected Sub-Recipients will primarily be units of state and local government. However, non-profit organizations often play an important role in communities as catalysts for government involvement in innovative initiatives like Pay for Success (PFS). For this reason, we are open to non-profits as lead applicants as long as they can demonstrate evidence of government partnership and support. The anticipated Sub-Recipients will also vary depending on the target population(s) selected as outlined below:

SUPER UTILIZERS OF HEALTH OR OTHER CRISIS RESOURCES. In communities across the country, there is a cohort of people who cycle between emergency rooms, hospitals, jails, detox facilities and homeless shelters, at enormous expense to these systems. Through administrative data integration and analysis, the highest utilizers can be identified and targeted for supportive housing. We anticipate that the Sub-Recipients for a PFS initiative focused on this target population would be primarily COUNTY OR CITY GOVERNMENT since the costs and corresponding potential savings are largely realized at those levels of government. Sub-Recipients may also be STATE GOVERNMENTS looking to implement an inter-departmental effort (anticipated to be largely through connection to Medicaid expenditures) to meet the needs of the target population. As previously noted, non-profits working in partnership with county, city or state governments could also be the Sub-Recipient for this target population.

RESIDENTS OF HEALTH CARE INSTITUTIONS WHO PREFER TO LIVE IN THE COMMUNITY. The central tenet in the Supreme Court's Olmstead decision is that the Americans with Disabilities Act (ADA) gives people with disabilities the right to have an alternative to an institutional setting when they need long-term services and supports, in order to be fully integrated into their communities. Supportive housing has emerged as the leading solution to allow these individuals to live independently integrated into the community. States are now grappling with how to fund supportive

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housing at scale to meet the Olmstead mandate. We anticipate that selected Sub-Recipients interested in this target population will be STATE GOVERNMENTS. Since the primary costs and corresponding savings occur within the Medicaid system at the state level, state governments are the most likely applicant for this group. Non-profits working in partnership with state government could also be Sub-Recipients for this target population.

FAMILIES WITH HIGH UTILIZATION OF CHILD WELFARE SYSTEMS. A subset of homeless families experiences homelessness repeatedly or long-term due to underlying addiction, mental illness, extreme poverty, and histories of trauma. These families also tend to have repeated contact with the child welfare system, often resulting in foster care placement for young children and family dissolution. The PFS model offers an opportunity to create supportive housing for families, helping them gain stability, increase family functioning, and improve child and adult well-being, across a range of outcome areas and measures. Sub-Recipients interested in targeting this group are likely to be either STATE OR COUNTY GOVERNMENT as costs for this group and related savings are incurred at both levels of government. Non-profits working in partnership with state or county government could also be the Sub-Recipient for this target population.

YOUNG ADULTS WHO ARE HOMELESS, IN FOSTER CARE, AND/OR IN JUVENILE JUSTICE SYSTEM. Without stable housing, youth are at greater risk of physical and sexual victimization as well as mental health, and/or substance use issues. Youth homelessness is closely tied to experiences with foster care and the juvenile justice system. Young people need a stable home to achieve life goals. Stable housing can serve as a launching pad to independent living, making it easier for youth to access health care, find and sustain employment, pursue education, avoid involvement in the juvenile justice system, and become self-sufficient. We anticipate that Sub-Recipients interested in targeting this group will be STATE OR COUNTY GOVERNMENT as costs for this group and related savings are incurred at these levels of government. Non-profits working in partnership with state or county government could also be the Sub-Recipient for this target population.

* Can you provide more information on the role of the partners and their budget line items? In particular, can you explain how and when CHCS and Third Sector will be used and what their budget line items cover?

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CENTER FOR HEALTHCARE STRATEGIES

The Center for Health Care Strategies (CHCS), founded in 1995, is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS achieves its mission by working directly with state and federal agencies, health plans, providers, and consumer groups to develop innovative and cost-effective programs, particularly for individuals with complex and high-cost health care needs. Its work focuses on: (1) enhancing coverage and access; (2) advancing quality and efficiency through delivery system reform; (3) integrating care for people with complex needs; and (4) building Medicaid leadership and capacity.

Improving outcomes for vulnerable populations with complex needs is a cross-cutting purpose of CHCS' work. The organization has staff with policy expertise around the following key population subsets: (1) "super utilizers" - individuals with high rates of inpatient and emergency department utilization and co-occurring physical and behavioral health needs; (2) high risk children and youth - especially those with serious behavioral health needs and foster care involvement; and (3) "Dual Eligibles" - Medicare-Medicaid Enrollees and individuals receiving long-term services and supports.

Nationally recognized among Medicaid agencies and their partners for providing actionable technical assistance and training to improve the quality of publicly financed care, CHCS has worked with nearly all 50 states, more than 160 health plans, key federal agencies, and community based-organizations, providers, and consumer groups across the country. Throughout its initiatives, CHCS plays a neutral convening role, linking federal agencies and state programs to help build Medicaid leadership, policy, and operational expertise. The organization provides strategic policy advice and operational guidance; expertise working with local, state and community based organizations in managing grant procurement processes; identifying, tracking, and disseminating best practices across state programs; strengthening quality improvement capacity; forging local, state, and national partnerships and innovative financing strategies to improve quality and encourage value-based purchasing; and, ultimately, drive system-level improvements in care.

Underlying all CHCS' work is the goal of identifying and spreading best practices to a broad national audience. CHCS has forged a reputation for its practical, timely, and high-quality resources to help stakeholders advance effective health care policy and improve care at the ground level. The

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organization produces a flow of operationally relevant environmental scans, resource papers, toolkits, policy briefs, and fact sheets for stakeholders.

For the initiative, CHCS will use this strong background and expertise to support the Sub-Recipients by performing the following activities:

1. CHCS will provide technical assistance to CSH in DESIGNING THE COMPETITION for Sub-Recipients with a particular focus on leveraging its knowledge of the relevant systems of care like Medicaid and Child Welfare to ensure that complete information is obtained from applicants. This could include support in including target population specific context such as an array of tangible and intangible factors relevant to residents of healthcare institutions who prefer to live in the community such as existence of Olmstead decrees, percentage of long-term services and supports (LTSS) provided in institutional settings, and ability to identify a potential state Medicaid champion to support the effort.
2. CHCS will provide technical assistance to CSH in REVIEWING APPLICATIONS received through the competition.
3. CHCS has extensive experience in obtaining and analyzing data, particularly Medicaid data, to support states and other stakeholders in identifying opportunities to enhance efficiency, improve service delivery and implement innovative best practices. CHCS will work with Sub-Recipients to OBTAIN AND ANALYZE RELEVANT DATA to determine status quo costs.
4. As detailed above, CHCS has extensive contacts and relationships at the state and local level. They will assist Sub-Recipients in BROKERING MEETINGS WITH KEY STATE AND LOCAL OFFICIALS particularly as it relates to Medicaid, health plans and the child welfare system.
5. CHCS will partner with CSH and the Sub-Recipients to help identify the most appropriate target population for inclusion in the project, as well as ESTIMATE POTENTIAL SAVINGS AND DEVELOP THE FINANCIAL MODEL.
6. CHCS will support the Sub-Recipients in ANALYZING THE LEGISLATIVE AND REGULATORY ENVIRONMENT to determine if changes are needed and if so develop a strategy to accomplish them.
7. CHCS will also partner with CSH and the Sub-Recipients to DEFINE THE MOST RELEVANT METRICS to which success payments will be tied. CHCS will leverage its Medicaid quality measurement expertise to promote the inclusion of consensus-based, standardized measures for purposes of ensuring replicability.
8. CHCS will collaborate with CSH to EXPLORE THE POTENTIAL FOR REALIZING FEDERAL

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SAVINGS, largely Medicaid, through PFS by working in partnership with the Centers for Medicare & Medicaid Services and other relevant federal departments.

CHCS STAFF BIOGRAPHIES

ALLISON HAMBLIN, MSPH, is the vice president for strategic planning at CHCS. In this role, she helps guide CHCS' program development and organizational planning activities. Ms. Hamblin also leads CHCS' program activities related to integrating care for Medicaid beneficiaries with complex needs. Major initiatives in this area include: (1) the Innovations in Complex Care program, a national initiative supported by Kaiser Permanente Community Benefit to develop integrated care models for Medicaid's highest-need beneficiaries; (2) a contract with the Centers for Medicare & Medicaid Services to provide direct technical assistance to states pursuing health homes programs; and, (3) the New York Health Home Learning Collaborative, a New York State Health Foundation supported-effort designed to promote the spread of best practices within New York's new statewide health home program. Additional areas of focus include the use of social impact investment to support state Olmstead efforts, and opportunities for increased collaboration with the corrections system given the expansion of Medicaid under the Affordable Care Act.

Ms. Hamblin has previously led CHCS' efforts in developing return on investment tools and assessing the business case for quality initiatives. She has specific expertise in the areas of physical and behavioral health integration and complex chronic care management. Prior to joining CHCS, Ms. Hamblin worked at Apax Partners, Inc. and Goldman, Sachs & Co., where she provided venture capital and investment banking services to companies in the health care and technology industries.

SARAH BARTH, JD, is the director of long-term services at the Center for Health Care Strategies (CHCS). In this role, she primarily works on CHCS' initiatives to help state, federal, and health plan partners advance integrated models of care for managed long-term service and supports systems and individuals who are dually eligible for Medicaid and Medicare. Ms. Barth serves as the project director for Promoting Integrated Care for Dual Eligibles (PRIDE), a consortium of high-performing health care organizations identifying and testing innovative strategies to enhance and integrate care for high-cost, high-need populations. She lends her expertise to other CHCS focus areas including social impact financing, payment and delivery reform, and Medicaid leadership development. Prior to joining CHCS, Ms. Barth served in a consulting role to several state Medicaid programs; nonprofit foundations, including the Massachusetts Medicaid Policy Institute at the Blue Cross/Blue Shield Foundation of

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Massachusetts and the Center for Health Law and Economics at the University of Massachusetts Medical School; and managed health care organizations. She has more than 18 years of experience in Medicaid administration, working for both New Mexico and Massachusetts

KAMALA ALLEN, MHS, is the vice president for program operations and director of child health quality at the Center for Health Care Strategies (CHCS). In these roles, Ms. Allen is responsible for ensuring the quality and efficiency of overall organizational programming, and providing direct oversight of all CHCS' child-focused initiatives. She has extensive experience in the application of quality improvement methodologies and the use of managed care in public child-serving systems, and is also responsible for the direction and financial management of the Children in Managed Care initiative, which has been funded since 1995 by the Annie E. Casey Foundation. Prior to assuming her current responsibilities, Ms. Allen was associate director for special projects for the Robert Wood Johnson Foundation's Medicaid Managed Care Program, where she oversaw the development and execution of state agency training programs in health care quality, and served as associate director for program analysis and communications. She also worked as a program analyst in the U.S. Department of Health and Human Services' Maternal and Child Health Bureau's Office of Program Development, where she was a contributing author to the 1994 Bureau White Paper; and as project coordinator for the states' responses to the Title V Block Grant Guidance.

CAITLIN THOMAS-HENKEL, MSW, is a senior program officer at the Center for Health Care Strategies (CHCS). In this role, she primarily works on CHCS' initiatives to integrate care for Medicaid beneficiaries with complex needs and assists with technical assistance efforts related to the Center for Medicaid and Medicare Innovation's State Innovation Model program. Ms. Thomas-Henkel also provides targeted technical assistance focusing on integrated care to states under the Robert Wood Johnson Foundation Aligning Forces for Quality Initiative. Before joining CHCS, Ms. Thomas-Henkel served as the deputy director of policy for the Rhode Island Senate President, staffing the Health and Human Services Committee and all legislative matters. In this position, she drafted several key pieces legislation including; the Senate's 2013 Healthcare Reform Legislation, designed to control costs for families and businesses while increasing the quality of care and transparency and addressing market power; and authored enabling legislation that created a pilot emergency department diversion program designed to provide more cost-effective and appropriate wrap-around services and supports for individuals with complex behavioral health disorders. She also co-authored Rhode

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Island's Temporary Caregiver Insurance legislation which expanded the state's temporary disability insurance program to provide paid, job-protected family leave.

THIRD SECTOR CAPITAL PARTNERS

As a national leader in the fields of Pay for Success and Social Innovation Financing, Third Sector Capital Partners, Inc. has developed the necessary skills to support the Corporation for Supportive Housing in advancing and evaluating interventions that align payment for services delivered as part of proven interventions with verified social outcomes through Pay for Success Contracting. Third Sector Capital Partners has been involved in designing, responding to, and/or constructing many of the current PFS undertakings across the United States, and will lend its expertise in designing PFS competitions and assessing the viability of PFS proposals for CSH's proposed project. Third Sector has gained extensive experience in both developing and responding to procurements at multiple levels of government. Third Sector has responded to more than 10 procurements at the local, state, and federal levels as an intermediary organization and PFS deal construction project manager. To date, Third Sector has been selected through competitive procurements to lead Pay for Success deal construction efforts by the Commonwealth of Massachusetts, New York State, Illinois, and Salt Lake County.

As an advisor to government clients, Third Sector has worked extensively to prepare, refine, and support various procurement processes. In Cuyahoga County, Ohio, Third Sector prepared the County's Request for Responses to solicit Pay for Success proposals and initiatives from a variety of community stakeholders, including nonprofit social service providers, evaluation experts, and potential SIF funders. This process resulted in the identification of a PFS opportunity to serve mothers who have experienced homelessness and have at least one child placed in foster care. In Santa Clara County, Third Sector directed an RFP drafting process for the first County-level Pay for Success project in the United States designed to address the challenges of chronic homelessness. TSCP drafted content and solicited input from representatives from multiple County agencies and departments. Third Sector also collaborated with Santa Clara County to develop a rubric to assess RFP responses, and was invited to participate on the County's RFP Selection Committee.  

As a partner to this effort, Third Sector's role is primarily to provide the following three services and related technical assistance activities outlined below with the bulk of Third Sector's role in the partnership focused on item 3:

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1. Third Sector will provide technical assistance to CSH in DESIGNING THE COMPETITION to identify Sub-Recipients.
 - a. Providing CSH with procurement and competition precedents.
 - b. Summarizing competition design options, along with an assessment of benefits and shortcomings of various approaches.
 - c. Drafting and revising competition documents, in close partnership with CSH staff.
2. Third Sector will provide technical assistance to CSH in REVIEWING APPLICATIONS received through the competition.
 - a. Collaborating with CSH and CHCS to design a rubric to assess responses to competition.
 - b. Collaborating with CSH and CHCS to review and assess individual competition responses.
3. Third Sector will provide direct technical assistance to Sub-Recipients in DESIGNING AND STRUCTURING PROCUREMENT PROCESSES.
 - a. Work with Sub-Recipients to ensure PFS viability in the following areas: Definition of target population, Feasibility of robust evaluation plan, Assessment of data availability, Identification of target outcomes, Level of success payments to be made, and Ability of Sub-Recipient to enter into multi-year contingent contract.
 - b. Using findings from the above, writing and revising a distinct, brief "PFS Value Proposition" for each Sub-Recipient.
 - c. Compiling and sharing precedents of all previously released PFS procurements.
 - d. Providing a written summary of key decision points regarding procurement design.
 - e. Creating and providing explanation and background on of PFS/SIF for inclusion in procurement.
 - f. Reviewing and revising procurement materials.

THIRD SECTOR CAPITAL PARTNERS STAFF BIOGRAPHIES

Third Sector anticipates that the following individuals, each of whom has experience with procurement processes and expertise in addressing the challenges of homelessness, will contribute to this project:

CALEB JONAS, Associate, will serve as the lead for Third Sector in this partnership. Caleb has led Third Sector's development of a Pay for Success effort with Santa Clara County to improve outcomes for the needy chronically homeless individuals. In this capacity, he coordinated the development of the County's RFP and assessment tool. Caleb also worked with Cuyahoga County to develop its

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groundbreaking PFS RFR, the first such county-level procurement in the United States. Caleb is a graduate of Macalester College, the Stanford Graduate School of Business, and the Harvard Kennedy School, and previously directed the City of St. Paul's AmeriCorps*VISTA Program.

LIYA SHUSTER, Associate, leads Third Sector's partnership with Cuyahoga County (OH). Liya also developed Third Sector's successful PFS procurement response for Salt Lake City, Utah. Liya previously worked at Goldman Sachs & Company in New York, after graduating from Dartmouth University.

CAROLINE WHISTLER, Co-Founder and Partner for Advisory Services, leads client and government advisory engagements for Third Sector, overseeing feasibility assessments and developing customized PFS arrangements and will serve as an advisor for this partnership. Caroline led Third Sector's successful response to the first PFS RFP in the United States, leading to a groundbreaking project undertaken by the Commonwealth of Massachusetts, in partnership with Roca, Inc., and a diverse cohort of SIF funders. Caroline oversees Third Sector's engagements in Santa Clara County (CA) and Cuyahoga County (OH), each of which has led to the development and release of a procurement.

* Is there a programmatic argument for keeping the RFP open only for 30 days? Is it possible to extend this deadline to give applicants more time to complete the application?

CSH originally proposed a timeline of 30 days for applicant responses to the RFP based on a desire to move forward quickly with the provision of TA to the selected Sub-Recipients. After further consideration, CSH is now proposing increasing this timeframe to 60 days in order to provide applicants with sufficient time to complete the application. CSH welcomes guidance from CNCS in determining the timeline for applications.

BUDGET-RELATED CLARIFICATIONS

* CONFIRM TOTAL REQUESTED AMOUNT FROM CNCS: \$750,000 over three years, \$250,000 per year.

* BUDGET TO BE ENTERED IN EGRANTS BY LINE ITEM: CSH entered the line item budget in e-grants by the original RFP deadline. This included a subsidiary budget for each of the three years for

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which CSH requested CNCS support.

* SUB-RECIPIENT SERVICES OR SUB-GRANTS. Overall, CSH has budgeted for 80% of the total project budget (CNCS + match) to support sub-recipient services and sub-grants. On an annual basis, this includes \$399,875 for sub-recipient services and sub-grants. This is comprised of \$60,000 annually for sub-grants, \$113,400 for our sub-contractors (CHCS and Third Sector) to provide feasibility TA to the sub-recipients, and \$226,475 for CSH's own provision of training and TA to the sub-recipients. The CSH portion includes \$116,979 for CSH staff salaries for direct provision of feasibility TA to the sub-grantees plus associated fringe benefits (\$35,679), OTPS (\$15,476), WebEx for trainings (\$1,000), and \$47,886 for indirect costs calculated at our federally approved rate of 16.4%.

Further, we project that 82% of the CNCS portion of the budget will directly support sub-recipient services and sub-grants. On an annual basis, this amounts to \$204,679 of the \$250,000 requested from CNCS annually. This includes: salaries for staff to provide TA (\$55,225), associated fringe benefits (\$16,844), OTPS (\$7,306), WebEx for trainings (\$480), \$54,376 for our subcontractors, \$43,156 for sub-grants, and \$22,757 for indirect costs calculated at our federally approved rate of 16.4%.

* SOURCE OF FUNDS: CSH listed all sources of match funds in the e-grants system at the time of initial application. CSH is projecting \$12,485 annually in in-kind contributions, which will come in the form of CSH staff time for our Chief Operating Officer and Communications Manager to work on the project. CSH will use general resources to support their work on the project. In-kind breaks out as follows: \$7,462 for salaries, \$2,276 for associated fringe benefits, \$987 for OTPS, and \$1,759 for indirect costs.

* The \$66,000 annual sub-contract for CHCS will include 678 hours of staff time at an average hourly rate of \$101.52 for a total of \$62,555, 72 hours of administrative support to staff providing technical assistance at an average hourly rate of \$48.46 for a total of \$3,108, and \$225 for the cost of conference calls with Sub-Recipients.

* The \$60,000 sub-contract for Third Sector is to provide feasibility TA to the sub-recipients, and includes: \$47,083 for staff salaries for direct provision of feasibility TA to the sub-grantees plus associated fringe benefits (\$5650), \$3500 for travel and \$3767 for supplies.

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GENERAL NOTE

* CSH received the request to provide the required pre-award documents and on-line financial certifications and is prepared to do so promptly once notified of a grant award.