

CSH is proposing for the State of Michigan to focus its proposed Social Impact Bond (SIB) initiative on supportive housing (SH) initiatives that target the highest-cost segments of the homeless and at-risk populations in the state. Specifically, CSH has identified three groups as the focus for the State of Michigan SIB: homeless, high utilizers of Medicaid and other public systems; mentally ill individuals in group homes; and individuals re-entering the community from prison who have histories of homelessness and are at great risk of recidivism. All three groups represent tremendous cost to the state due to their use of institutional care, shelter, prison, crisis healthcare, and/or social services. All three are ideal candidates for showing dramatic improvements in housing and social outcomes after placement in supportive housing, as well as large net cost savings for the State.

### **Technical Requirements**

All three target populations as well as the proposed intervention meet all of the State's technical requirements, as detailed in the narrative that follows.

- **A sufficient and well defined participant base.** CSH has identified three potential target populations for a SIB focused on supportive housing. Below we define the scope and size of each population.

- Mentally-ill Individuals in Group Homes. In FY2010, 67% of Michigan's Medicaid long-term services and supports (LTSS) dollars went to institutional care, with only 33% of LTSS dollars paying for community-based care. Nationally, states spend roughly half (55%) of their LTSS dollars on institutional care, suggesting that Michigan's LTSS spending is imbalanced in favor of institutional care. This reflects an over-reliance on nursing and group homes, which is costly and runs counter to the Supreme Court's *Olmstead* decision, which mandates that states offer opportunities for persons in need of long-term care (LTC) to live in the most integrated setting possible in the community. Michigan has taken several steps to comply with *Olmstead* and provide opportunities for community re-integration. For instance, under the MiChoice program, individuals who qualify for Medicaid funded nursing home care may receive long-term care services at home. The state enters into contracts with waiver agents who are responsible for screening and assessment of applicants, care planning, orchestrating the provision of services, data collection, and financial management of their programs. However, demand for the program consistently outstripped the supply of waiver slots, and in 2001, then Governor Engler restricted funding to the program, barring all new applicants. Michigan also has a Money Follows the Person (MFP) Program, funded by the federal Centers for Medicare & Medicaid Services (CMS), which allows institutionalized individuals to transition to community. The Program has completed 1,456 transitions to date, with another 435 in process. However, the program currently is only available to seniors and individuals with physical disabilities, leaving out non-elderly individuals with mental illness.

In FY2012, Michigan Community Mental Health Service Programs (CMHSPs) served 150,255 adults with mental illness for a total cost of \$842 million. While not in state psychiatric hospitals, 46,079 individuals reside in costly institutional settings: 1,016 reside in state inpatient facilities, 9,886 in Supports for Living sites, and 35,177 in community inpatient and crisis services.<sup>1</sup> Altogether, individuals across these three categories represent only 12% of the CMHSP population, yet they account for 45% of the FY2012 expenses, or \$381MM. A subset of the population in the Supports for Living program is particularly costly. For instance, 3,466 individuals resided in group homes in Wayne County in 2012 – some for the year and others for shorter stays.<sup>2</sup> They amassed a total cost of \$140MM to the State, or an average annual cost of \$40,303 per consumer. Among these individuals, costs are not spread equally; some account for a disproportionate share of group home expenses. For instance, in examining FY2012 CMHSP data for Wayne County, we can see that the top 100 most costly consumers amassed \$12.2MM in costs to

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<sup>1</sup> [http://www.michigan.gov/documents/mdch/4041\\_05\\_31\\_13\\_424022\\_7.pdf](http://www.michigan.gov/documents/mdch/4041_05_31_13_424022_7.pdf)

<sup>2</sup> Data provided by the Detroit Wayne Mental Health Authority on October 14, 2013.

CMHSP in FY2012, or an average cost of \$121,658 per consumer. The top 500 most costly consumers in the County raked up \$42MM in CMHSP costs (Medicaid plus other costs) for an average of \$84,567 in annual costs per consumer. Many of these individuals do not require AFC or group home-level care but are placed in these costly settings due to a lack of housing options. CSH is proposing to target this subset of the group home population for the supportive housing intervention. Utilizing a SIB to accelerate SH production, increase the number of available units, and provide the necessary supportive services will help the State comply with *Olmstead* and realize significant cost savings by more appropriately serving these individuals in more cost-effective settings in the community. We think an appropriate scale to consider for a SIB for this population would be a minimum of 400.

- Homeless, High Utilizers of Medicaid and Crisis Services. First documented by Hopper and colleagues in 1997, a growing body of research has identified a group of people who are caught in a revolving door of homelessness and high use of public services, such as homeless shelters and emergency rooms. These “super users” of public services typically have complex health conditions and consume a disproportionate share of Medicaid costs (e.g., the 5% of Medicaid beneficiaries who use 50% of costs). The 2012 Michigan State Point-In-Time estimate for chronically homeless individuals is 9,721. While not all chronically homeless individuals are frequent users, many cycle between shelter, ERs, detox, and the street, presenting a costly and sizable population for a SIB focused on supportive housing. For instance, the Michigan Department of Community Health (MDCH)’s March 2012 report identified 1,419 individuals with serious mental illness (SMI) who were frequent users of MDCH services. These individuals had at least 11 ER visits and inpatient admissions in just one year. An analysis of the University of Michigan and Saint Joseph Mercy health systems in Washtenaw County, MI showed that the top 100 utilizers of emergency and inpatient services amassed an average of \$178,500 in hospital charges annually with a median charge of \$99,500. A similar analysis of frequent users in Detroit/Wayne County found that the top 100 utilizers accounted for a total of \$14.5MM in health system costs in a single year, with each individual raking up \$145,480 in annual costs to this system on average. Homelessness is the root cause of excessive use of high-cost crisis care services for a large proportion of these high utilizers. An initiative targeting homeless frequent users of MDCH services could be replicated in Michigan through a SIB model. The **core components of the intervention** include: use of data and/or a triage tool to identify the highest-cost users; intensive outreach and engagement of homeless, frequent users; and strong partnerships between SH providers and community health clinics to comprehensively serve the health, housing, and social service needs of clients in a coordinated fashion. CSH would work with the State and local partners to tailor this basic model to the needs and local circumstances in Michigan.
- Vulnerable Individuals Re-entering from Prisons. In 2012, Michigan saw an increase in its prison population following five consecutive years of decline, with 43,594 inmates in the system. The increase stemmed from a decline in the number of paroled individuals, more parole revocations, and more prison commitments. What’s more, Michigan is projecting a steady increase in the prison population over the next five years, due to an expectation that these same trends will continue. Over the past several years, Michigan had succeeded in shrinking its prison population (12% drop in less than 10 years) and reducing its rate of prison recidivism (18% drop from 1999 to 2007).<sup>3</sup> Much of this success can be attributed to the Michigan Prison Reentry Initiative (MPRI), now called Prisoner Reentry. Launched in 2003, the initiative sought to equip offenders with tools to succeed in the community. MPRI began at intake; a prisoner’s risk, needs, and strengths were assessed to develop individualized programming. Michigan Department of Corrections (MDOC) data show that parolees released through MPRI returned to prison 33% less frequently than similar offenders who do not participate in the program. Yet, MPRI did not work for all types of prisons, given its light-touch approach to serving prisoners. For instance, the annual cost per

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<sup>3</sup> [http://www.michigan.gov/documents/corrections/Pew\\_Report\\_State\\_of\\_Recidivism\\_350337\\_7.pdf](http://www.michigan.gov/documents/corrections/Pew_Report_State_of_Recidivism_350337_7.pdf) p. 15.

MPRI parolee was approximately \$2,130, limiting the amount of support that could be provided with this low cost per person. As well, the program lacked the intensive engagement and case management needed among this vulnerable population.

Prisoners with special needs require more intensive resources to thrive in the community, namely intensive case management, permanent, stable housing, and links to comprehensive services. MDOC estimates that roughly 6% of the total prison population suffers from mental illness, or 2,570 individuals. However, several other sources estimate the proportion to be much higher at 20%.<sup>4</sup> This high percentage reflects the flow of mentally ill individuals into prisons following the close of state psychiatric hospitals in the state. Yet, prisons are ill-equipped to appropriately address the discharge needs of these vulnerable individuals and lack adequate resources to ensure a smooth transition into the community. This population represents a significant drain on MDOC resources. MDOC spent \$34.9MM on mental health services from October 2012 through June 2013.<sup>5</sup> In FY2013, MDOC is projected to spend a total of \$58MM on mental health services for prisoners. This population would be suitable for a SIB due to its size and high cost while incarcerated. We would propose that the State target at least one-third of those who are diagnosed with a serious mental illness who need supportive housing (at least 400 individuals), focusing on individuals with mental illness and/or other chronic illnesses, who represent the greatest cost. Once released from prison, absent a comprehensive intervention, these individuals are likely to amass enormous costs to the state's Medicaid system as they typically cycle between incarceration, emergency rooms, detox, and inpatient hospitalization at enormous expense to the state. They are also at great risk for returning to prison absent intervention. By providing stable housing linked to behavioral health and primary care services and care coordination, these individuals will stabilize in the community, with participants avoiding re-incarceration and inappropriate use of costly crisis care.

- **Availability of performance measures for assessing outcomes.** Each of the proposed populations offers the potential for the State to identify and target the group for the intervention, determine outcomes and costs before and after the intervention, and understand the counterfactual, i.e., what would have happened absent the proposed intervention.
  - **Inappropriately institutionalized individuals.** This population can be identified by examining CMHSP data and identifying the most costly utilizers among residents in adult foster care and group homes. Once this pool of individuals is developed, CSH would recommend that the State develop an assessment tool to identify the subset of these individuals who would be appropriate for supportive housing. CSH has deep experience in developing and implementing such tools in partnership with state agencies. The hypothesis to be tested for this population is that supportive housing results in: improved health outcomes, greater consumer choice and satisfaction (consistent with *Olmstead*), and reduced costs to Medicaid and Medicare. To test this hypothesis, the State and its selected evaluator would need to collect CMHSP, Medicaid, and Medicare data on participants in the year(s) prior to the intervention and in the year(s) following SH placement, examining any changes in their use of costly Medicaid and Medicare services, such as emergency room visits, hospitalizations, detox, and other costly, avoidable services. CSH recommends that the state and the evaluator also track these same outcomes and data points for a control or comparison group in order to provide a true counterfactual for the SIB pilot. To gauge impact on health outcomes, CSH would work with the State and the evaluator to identify and agree on a set of key indicators of health status that would also be tracked for the treatment and control/comparison groups. Finally, CSH would recommend the use of a survey for both groups to assess consumer satisfaction in

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<sup>4</sup> <http://ns.umich.edu/new/releases/7620>

<http://www.freep.com/article/20120916/OPINION01/309160108/Deinstitutionalizing-Michigan-s-mentally-ill-has-been-an-underfunded-disaster>

<sup>5</sup> [http://michigan.gov/documents/corrections/07-15-13\\_-\\_Section\\_802a\\_430798\\_7.pdf](http://michigan.gov/documents/corrections/07-15-13_-_Section_802a_430798_7.pdf)

supportive housing versus that experienced in adult foster care, group homes, or other institutional settings.

- **Homeless, High Utilizers of Medicaid and Crisis Services.** This population can be identified by matching data across the shelter and health systems to identify the overlapping population and narrow in on the most frequent flyers. CSH has facilitated such data matches in jurisdictions nationally. In two years alone, CSH led data matches between the homeless and health systems in six locations (Los Angeles, CA; Connecticut; San Francisco, CA; Ann Arbor, MI; Detroit, MI; Maricopa County, AZ). This work involved CSH leading the partners in developing data-sharing agreements between the public agencies, advising on how to conduct the match, and examining the data to assess the scope and size of the shared populations. We then provided intensive, onsite TA to help local partners to develop eligibility criteria (based on the results of the data match), design a SH pilot, identify funding resources, develop protocols for outreach and engagement, and create an evaluation plan. For instance, following this work, CSH is now working with SH providers, community health clinics, and local hospitals to identify and place high-utilizers in supportive housing in Los Angeles.

In terms of measuring the program's impact, the State would be able to draw on these same data sources to assess the extent to which the intervention results in reduced costs for the homeless and health systems. As well, this data would allow the State to understand how the intervention changes patterns of service use among the target population. The hypothesis to be tested is whether the intervention results in greater utilization of primary and preventive care, and, as a result, whether participants curb their use of emergency rooms, shelter, inpatient hospitalizations, detox, jail, and ambulance services. The State could work with CSH and an independent evaluator to collect information on housing status, and primary, preventive, and crisis service, detox, and jail usage among participants in the year(s) prior to supportive housing placement, and compare these rates and costs to the populations' use of each of these services in the year(s) following supportive housing placement. We would also advise the State to include a control or comparison group as part of this assessment. This approach would best position the State to definitively determine the counterfactual for the intervention and isolate the actual impact of the intervention for participating individuals.

- **Vulnerable individuals exiting prison.** In order to develop a SIB for the prison population, the state will have to commit to generating information on high-need prisoners. In addition, we recommend developing a discharge planning triage tool for prison staff to use in order to determine the needs and indicators of costly service use among the discharged population. Use of such a tool would allow prisons to identify the subset of the discharge population that is likely to incur the greatest costs to the state upon discharge, with the premise being that these costs could be contained if the intervention of supportive housing is utilized. CSH is using this approach effectively in Los Angeles and could modify this tool for use in Michigan. As well, in the past 18 months, CSH has used data to help the local homeless and criminal justice systems understand the extent to which they shared clients. We conducted such inter-agency data matches in six locations (Franklin County, OH; Richmond, VA; Bexar County, TX; Mecklenburg, NC; Denver CO; Kansas). We specifically used data matches in these jurisdictions to identify the subset of these clients who frequently cycled between homeless shelters and jail at exorbitant cost to both systems. Following these assessments, CSH has led local partners in designing and implementing SH pilots for these frequent, high-cost users. CSH would build on this proven model and our on-the-ground experience to design an appropriate model for mentally ill, returning offenders in Michigan.

In terms of measuring the program's impact, the State would be able to draw on these same data sources to assess the extent to which the intervention results in reduced recidivism and associated costs for the prison system. The hypothesis to be tested is that the intervention will result in participants stabilizing in housing and accessing services to address the root causes of their criminal justice involvement (i.e., behavioral health and substance use treatment) and, as a result, reducing the rate of return to prison. The

State could work with CSH and an independent evaluator to collect information on housing status, and utilization of needed services among participants in the year(s) prior to supportive housing placement, and compare these rates and costs to the populations' use of each of these services in the year(s) following supportive housing placement. As well, the State and evaluator should look at MDOC data before and after the intervention for participants in order to assess the pilot's impact on recidivism. We would also advise the State to include a control or comparison group as part of this assessment. This approach would best position the State to definitively determine the counterfactual for the intervention and isolate the actual impact of the intervention for participating individuals.

- **Strong evidence base indicating that the intervention model is likely to achieve the outcome targets.**

For all three potential target populations, there is strong evidence that supportive housing will yield the desired outcomes and cost savings for the State. Overall, supportive housing is a proven intervention that stabilizes vulnerable individuals, allows them to live more productive lives, reduces their inappropriate usage of costly services, and decreases costs for public systems. The evidence for each population is described below.

- **Individuals Leaving Institutions or At-risk.** For individuals with a mental illness, transitioning to community living from institutional environments is an important step in attaining recovery. Services delivered in supportive housing are designed to manage mental illnesses and addictions, coordinate needed resources, provide crisis intervention, and help tenants develop independent living skills to achieve housing stability, employment/educational goals, and community integration. There is a robust body of research that shows that supportive housing leads to improved health outcomes for a variety of high-need populations (*see below*). Much of this research is focused on improvements in healthcare access and utilization for homeless individuals who access supportive housing. While there is more limited research on SH's benefits for individuals who have been previously institutionalized, the available studies show improvements in health for this population, consistent with the broader evidence on SH's efficacy.
  - **Reduced risk of re-institutionalization.** For instance, in a 2004 study published in Health Services Research journal, Freedman et al. found that community-based living with support also reduced the risk of re-institutionalization and lowered the risk of functional decline in ADL. The study also showed that home health care (i.e., skilled nursing visits, home health aide visits, various therapy services, and use of durable medical equipment in the home) reduced overall care costs without compromising clinical outcomes.
  - **Improvements in health and social outcomes.** A Seattle study (Siu, Collin, 2009) examined the impact of housing, along with other federally-funded supportive services, on the elderly and disabled. The group of residents who received additional supportive services realized greater improvements in mental and physical health outcomes compared with those who did not. The group, who received supportive services, was less socially isolated and more likely to receive treatment for chronic health conditions. As well, in a 2009 study of 177 individuals in supportive housing (including a number who had transitioned to SH from nursing homes), the Heartland Alliance found a variety of health and quality of life improvements post-SH, including: improved ability to pay bills and save, frequent visits by family and friends, abstention from drugs, higher self-confidence, and a more positive outlook on life.
  - **Less use of emergency services.** The Seattle study found that 38% of the participants, who received additional support services, reported using ER services in the past year, compared to 51% of non-recipients.
  - **Cost savings for state systems.** An Ohio study (Health Management Associates, 2012) found that a National Church Residences SH model for low-income seniors saved the state of Ohio \$26,674 per person annually in Medicaid costs over living in a nursing facility, while also allowing seniors to live in communities more independently. The cost of the nursing home bed averaged \$54,545 per patient per year, while the average cost for individuals in SH averaged \$26,674, representing a 49% savings over

the cost of the nursing home bed. Finally, a HUD study (Haley et al., 2008) estimated the cost savings of a 340-day stay in SH ranged from \$25,000 to \$36,000. In 2004, a stay in a nursing home funded by Medicaid cost about \$49,000 on average, while Section 202 supportive housing (a less intensive services model) is estimated to cost only about \$13,000.

- **Homeless, High Utilizers of Crisis Services.** Several studies have found supportive housing to be effective in decreasing public service utilization and costs among this population, while also stabilizing their health and housing. These studies, which compare utilization pre- and post- supportive housing or between supportive housing residents and a control group, document that supportive housing for people who are chronically homeless can result in the following:
  - **Significant reduction in emergency room utilization.** A study of the Chicago Housing for Health Partnership program found that an intervention group of some 200 homeless individuals who were provided housing and case management services utilized 24% fewer emergency room visits than a similar sized, randomized control group of non-housed individuals over an 18-month period. Other studies (Denver Housing First Collaborative and CSH's Frequent Users of Health Services Initiative (FUHSI) in California) place the potential for reductions at 34% (Sadowski et. al., 2009; Perlman and Parvensky, 2006; Linkins et. al., 2008). CSH is currently working with SH providers, community health clinics, and local hospitals to identify and place high-utilizers in supportive housing in Los Angeles. The Los Angeles pilot is already showing strong results in terms of decreased usage of crisis care and cost savings in the health arena. Preliminary data shows dramatic decreases in hospital emergency department visits and inpatient admissions. The pilot is showing a 34% decrease in emergency department visits by participants at California Hospital Medical Center (CMHC), with a 47% decrease in emergency department days.
  - **Sharp decrease in inpatient admissions and hospital days.** The Chicago Housing for Health Partnership study (mentioned above) saw 29% fewer hospital admissions and hospital days for the intervention group in SH as compared to the control group (Sadowski et. al., 2009). These results are similar to the reductions found in the California FUHSI, which reported a 27% percent reduction in hospital admissions and days for homeless clients connected to housing and case management, compared to a pre-intervention baseline period. Most importantly, the FUHSI evaluation showed that homeless clients who were placed in supportive housing experienced the strongest results. Clients in SH experienced a 61% decline in ER visits and a 62% decline in hospital stays over two years (Linkins et. al., 2008). As well, CSH's Los Angeles current health pilot is showing a 39% decrease in hospital admissions at CHMC. At the same time, Federally Qualified Health Center (FQHC) visits have gone up 64%. FQHCs are community-based centers that provide integrated behavioral, preventive, and primary care.
  - **Reductions in detox utilization and psychiatric inpatient admissions.** Studies of supportive housing programs report decreases of up to 87% in use of detox services (Seattle East Lake project) and decreases in psychiatric admissions (Maine) (Larimer et. al., 2009; Mondello et. al, 2007).
  - **Significant reduction in Medicaid costs.** Results from a Massachusetts statewide pilot indicate that these decreases in acute care utilization translate into real savings in Medicaid costs. Comparing actual Medicaid costs pre and one-year post housing, the study found a 67% decrease in mean Medicaid costs (\$26,124 to \$8,499) (Massachusetts Housing and Shelter Alliance, 2011). A study of the Seattle East Lake project likewise reported 41% lower Medicaid costs for residents after one year of supportive housing (Larimer et. al., 2009). For the California FUHSI project, after receiving supportive housing, the average costs saved related to emergency room visits were \$6,691 and the average costs saved related to inpatient hospitalizations were approximately \$32,000. These savings occurred during the second year of the program.
- **Vulnerable Individuals Re-entering from Prisons.** CSH has led the national supportive housing industry in pioneering models tailored to the unique needs of recently incarcerated individuals and/or

those with long histories of incarceration for non-violent offenses. For instance, in 2007, CSH partnered with the Ohio State Department of Rehabilitation and Corrections (ODRC) to design, implement, and evaluate Returning Home Ohio (RHO), a reentry supportive housing model for disabled individuals in state prisons. Through RHO, a participant group of 121 re-entering individuals were offered supportive housing. An independent evaluator, the Urban Institute, used a quasi-experimental design to assess the impact of RHO, including the use of treatment and control groups and multivariate statistical analysis. The comparison group included a contemporaneous cohort of RHO-eligible participants who were referred to the program but were not provided housing in the community. The evaluation found that the treatment group was 40% less likely to be re-arrested and 60% less likely to be re-incarcerated within a year of initial prison release as compared to the control group. In addition to the RHO data, there is a considerable body of evidence showing that supportive housing reduces recidivism and homelessness for this population. In addition to the RHO results cited above, the following studies demonstrated supportive housing's efficacy for this population and public systems, including:

- Reductions in jail and shelter use. For instance, a large-scale independent evaluation demonstrated in New York City the cost-effectiveness of supportive housing for 4,600 chronically homeless people with severe mental illness. After placement in supportive housing, they experienced fewer and shorter psychiatric hospitalizations, a 38% reduction in jail use, and a 60% drop in shelter usage. As another example, John Jay College tracked CSH's NYC Frequent Users of Systems Enhancement (FUSE) participants, who were placed in supportive housing, and a group of similar non-participants. The evaluation documented positive outcomes after a year: 91% of tenants remained stably housed; 92% experienced a drop in shelter stays; and 53% recorded a decline in jail recidivism. A Seattle study showed SH tenants' jail bookings dropped 45% (Sadowski, 2009).
- Cost reductions for homeless and criminal justice systems. In the New York City study, the evaluation showed that the costs of the housing units, mostly subsidized by the state and federal governments, were offset by savings in public spending on health services for this mentally ill, homeless population. This has important implications for a social impact bond as a model of sustainability after the initial investment. In Maine, tenants' incarceration costs and days jailed dropped 95% after SH placement (Mondello, 2007).

- **Ability to take the initiative to scale if results show that the initiative is working.** The intervention would be able to be taken to scale for all three populations. First, supportive housing has been implemented successfully in urban, suburban, and rural settings statewide in Michigan and nationally. The core elements of supportive housing are affordable housing linked to voluntary, client-driven support services. These core elements can be delivered in a variety of settings that are appropriate to the local surroundings and the specific target population. The most common SH models are: congregate site – a single building that includes all SH units and onsite services; integrated – a mixed use building that include SH units; non-SH, affordable units; and/or market-rate housing as well as onsite services; and scattered-site – housing units spread out in different locations and service staff who travel to the housing to offer services and/or provide services in an offsite location. This last option is more common in rural settings. It also works well in areas that have a large vacant housing stock, as existing housing units in the private market can be re-purposed as supportive housing with the addition of a housing subsidy and services. Second, there are nonprofits engaged in supportive housing development and operations in all counties throughout the state, enabling the intervention to be replicated and expanded if proven successful. Finally, all three populations that CSH has identified are sizeable and spread out throughout the state, providing a critical element for statewide scaling.

- **Clear and identifiable state budgetary savings.** A supportive housing intervention targeting all three of the populations would offer clear and identifiable budgetary savings for the State. All three populations represent

tremendous costs to the State currently, and supportive housing is proven to dramatically reduce costs for public systems. Expect budgetary savings for each group are detailed below.

- **Individuals Leaving Institutions and At-Risk.** As detailed above, CSH proposes that the State focus a supportive housing SIB intervention on the subset of mentally-ill adults who currently are in a CMHSP residential setting *and* consume a disproportionate amount of CMHSP and other Medicaid and Medicare dollars. Currently, the annual cost of serving these individuals under the status quo is roughly \$80,000 (based on Wayne County data). We expect the cost to Medicaid and Medicare to drop to \$30,000 annually post-SH intervention, as these individuals will continue to require primary, preventive, and behavioral healthcare. Yet, we expect healthcare costs to drop overall as these individuals will cut their usage of acute and crisis care. We estimate the annual cost of the supportive housing intervention, tailored to this population’s unique needs, to be \$25,000 (including rent), for a total cost of \$55,000 annually (SH + Medicaid/Medicare). Thus, the annual cost savings to the State would be \$10MM annually for 400 individuals.
- **Homeless, High Utilizers of Medicaid and Crisis Services.** Alternatively, should the State elect to focus a SIB intervention on homeless high utilizers of Medicaid services, there would also be clear, identifiable budgetary savings. However, it is important to note that this group touches multiple systems at the state *and* local levels. In order to fully capture their costs pre- and post- intervention, the State would need to examine their service usage and costs to jail, shelter, and Medicaid. We expect the cost to the jail and shelter systems to drop significantly post-intervention, with these costs becoming negligible post-intervention. The cost to Medicaid will drop to \$40,000 annually post-SH intervention, as these individuals will continue to require primary, preventive, and behavioral healthcare. Yet, we expect healthcare costs to drop overall as these individuals will cut their usage of acute and crisis care. We estimate the annual cost of the supportive housing intervention, tailored to this population’s unique needs, to be \$25,000 (including rent), for a total cost of \$65,000 annually (SH + Medicaid). Thus, the annual cost savings to the State would be \$6MM annually for 400 pilot participants.
- **Vulnerable Individuals Re-entering from Prisons.** The proposed intervention would reduce prison recidivism among mentally-ill adults, resulting in significant, measurable savings for the State. State prison stays typically cost \$35,000 a year per person or \$65,000 for our target population due to their need for behavioral health care, psychiatric prescriptions and other services. Thus, the marginal cost of serving these individuals in prison – and potential net savings to the state - is \$30,000 per year. The **key driver for budgetary savings for the state would be preventing returns to prison**, since our target population tends to have a high rate of recidivism absent a comprehensive intervention. We estimate the annual cost of the supportive housing intervention, tailored to this population’s unique needs, to be \$20,000 (including rent). Thus, the annual cost savings to the State would be \$10,000 per person annually or \$4MM annually for 400 participants.

Population	High-Priority	Definition	Proposed Intervention	Scale	Outcomes	Cost Savings	Time-line	Availability of Providers
<b>Individuals Leaving Institutions</b>	Per Olmstead decision, people in institutional care must be transitioned into the community	Mentally ill, physically disabled, and adults with dev. disabilities living in adult foster care and group homes	Supportive Housing Rental Subsidies  <i>Enhancements:</i> intensive support re: ADL, health care coordination & provision, Assertive Community	<b>400 for SIB pilot</b>	Reduced costs of long term care  Increased integration people with disabilities people in the community	<b>Net Impact:</b> ↓\$10MM annually  <i>Current yearly cost in group care: \$80,000</i>  <i>Estimated annual cost of SH per tenant:</i>	3-5 Years	Many SH providers in MI experienced in working with people with Mental Illness  Several providers deliver enhanced SH, including assisted living services, medication management,

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October 2013**

Population	High-Priority	Definition	Proposed Intervention	Scale	Outcomes	Cost Savings	Time-line	Availability of Providers
			Treatment, Community Support Teams			\$25,000 + Medicaid cost in SH: \$55,000		intensive case management
<b>High Utilizers of Crisis Services</b>	Affordable Care Act impetus to control costs & increase enrollment	Frequent users of ERs, inpatient care, detox, and shelter	Supportive Housing  <i>Enhancements:</i> intensive care coordination, <b>services tailored to complex health needs</b>	<b>400 for SIB pilot</b>	Reduced use of emergency health care, inpatient hospitalization, jail, nursing homes, substance use treatment	<b>Net Impact:</b> ↓\$6MM annually Public systems cost: ~\$80,000 <i>Estimated cost of SH per tenant:</i> \$25,000 + Medicaid cost in SH: \$65,000	3-5 Years	Several providers deliver enhanced SH, including assisted living services, medication management, intensive case management, health care coordination
<b>Criminal Justice (state prisons)</b>		Mentally ill individuals leaving state prisons	Enhanced SH model, includes access to behavioral care & care coordination	<b>400 for SIB pilot</b>  Point-in-Time Prison Census 43,594; 20% have Mental Illness; half ~need SH	Reduced recidivism to state prisons; less liabilities & cost of lawsuits; community integration	<b>Net Impact:</b> ↓\$4MM per year Annual marginal cost to prison: \$30,000 <i>Estimated cost of SH per tenant:</i> \$20,000	3-5 Years	Numerous SH providers focused on reentry supportive housing, mental health services, medication management

**DETAILS SURROUNDING THE INITIATIVE**

**Background on CSH**

CSH's mission is to advance solutions that use housing as a platform to deliver services, improve the lives of the most vulnerable people, and build healthy communities. CSH has 92 staff in 20 locations nationally, including three program offices and four on-the-ground staff in Michigan. CSH has unparalleled expertise in the issue of homelessness, supportive housing models, financing streams, and service delivery best practices, and deep experience in client targeting. In each community, CSH serves as a catalyst, bringing together people, skills and resources, and as a thought leader, designing new programs and policies, creating demonstration models, and educating the public, private, and nonprofit sectors to collaboratively tackle and invest in innovative solutions to some of our society's most intractable issues.

CSH has invested over \$10.4MM in loans and grants to nonprofit SH project sponsors in Michigan. CSH has fostered the creation of over 3,000 SH units in Michigan through loans, grants, and technical assistance to SH providers and developers. At the state level, we have collaborated with public agencies to design supportive housing funding programs and statewide initiatives. We have worked with the local SH industry to build its capacity and to develop new SH models, including pilots to target high utilizers of emergency services in Detroit and Washtenaw County, MI.

Several aspects of our experience and capacity **uniquely position CSH to serve as the lead intermediary for a SIB/PFS initiative in Michigan focused on supportive housing**, as follows:

- Pay for Success/SIB expertise. In the past two years, CSH has led and/or advised on the development of several Pay for Success pilots. Most notably, CSH helped to craft a successful application to the Commonwealth of Massachusetts, with Third Sector and Massachusetts Housing and Shelter Alliance

(MHSA), to launch a PFS initiative focused on homeless, frequent users of health services. CSH is now working with MHSA to further refine the program model, implementation plan, and financial model as well as secure private sector investment. In Los Angeles, CSH has led local philanthropy and public agencies in discussions around scaling, Just in Reach (JIR), our local reentry supportive housing pilot, using a performance-based contracting structure. CSH has cultivated strong buy-in on the part of the County and Sheriff, a lead partner for JIR. We have also responded to RFIs for SIBs in three additional jurisdictions (IL, NY, MN), and SIB RFPs in two locations (NY and MN). Thus, CSH is quickly developing expertise in this area that could be leveraged for the Michigan pilot.

We see good potential to fundraise for grant dollars to seed the SIB pilot in Michigan. Several national foundations are eagerly watching the proliferation of SIB/PFS pilots nationally and are primed to invest in these initiatives at the grant and PRI levels. In terms of national foundations, CSH has outreached to the following funders: Robert Wood Johnson (RWJF), Rockefeller, and Arnold Foundations. RWJF is a long-standing funder of CSH and is monitoring SIB/PFS developments very closely. Rockefeller is currently funding some of CSH's planning and assessment work tied to SIB/PFS nationally. Arnold Foundation is not a current funder but CSH has met with this Foundation, and they are very intrigued by the SIB/PFS model. As well, in June 2013, CSH, in partnership with RWJF, convened 10 national funders and Obama Administration representatives in New York City to discuss the role of philanthropy in SIB/PFS models.

- Raise private sector capital. As a Community Development Financial Institution (CDFI), CSH has an excellent record of raising public and private sector resources to invest in the supportive housing industry nationally. CSH has a strong track record of raising funds for our lending and programmatic work, having secured 502 investments for \$108 MM in the last five years. Of this amount, CSH raised \$61MM in below-market rate loans, including a mix of private bank, corporation, government, faith-based, and foundation investors. In 2012, CSH raised over \$7.3MM in new signed contracts and \$7.4MM in grants, exceeding our fundraising targets. We have strong relationships with several national foundations, including the Robert Wood Johnson, Conrad N. Hilton, and Open Society Foundations. RWJF alone has invested \$40MM in grants to CSH to develop multi-site demonstration initiatives. In Michigan, CSH has partnerships with several local funders, including the Kresge and Blue Cross Blue Shield Foundations and the McGregor Fund.
- Assemble and manage teams of service providers. CSH has deep experience in assembling and coordinating teams of service providers to achieve set goals and targets for service delivery and outcome achievement. Nationally, we have made 215 grants and 353 loans to the supportive housing industry in the last five years alone. We target our grant resources to nonprofits with solid track records of developing and operating SH programs, with many grantees having performed well under third-party evaluations and under past CSH grants and loans. For each grant and loan made, we assessed the viability of the particular supportive housing project as well as the capacity of the potential grantee/borrower organization overall. A recent example of CSH's ability to manage a complicated project with multiple organizations is the three-year SIF grant from CNCS mentioned above. Following a structured RFP process, CSH made \$1.4MM in sub-grant commitments to four groups in order to implement these innovative models.
- Assist with the development of appropriate programming, utilizing evidence-based models. CSH has extensively researched best practices in supportive housing development and operations. CSH has translated that learning into 16 toolkits, including over 400 distinct tools and model documents, focused on supportive housing best practices. In Michigan, we have trained providers in harm reduction, housing first, critical time intervention, and tenant leadership along with ongoing training on how to developed mixed tenancy, scattered site, and single site supportive housing. We deploy and train property owners and service providers on Harm Reduction housing, an evidenced-based model that allows people to change behaviors with substance use and clinical services while remaining permanently housed. CSH has deep experience in designing supportive housing initiatives that target high-cost/need homeless individuals. For instance, in 2003, CSH matched 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 small but costly cohort of people who cycled between jail, shelter, and other systems for a collective cost of \$11.8MM annually. In response, CSH piloted FUSE in New York City in 2005. The model features data matching across government 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: housing stability and dramatic drops in shelter usage and jail stays. Based on the success of the NYC pilot, CSH has or is actively engaged in replicating FUSE in 11 additional sites (ranging from large urban areas such as Chicago and Denver, to lower density areas such as Fort Lauderdale and Mecklenberg County, NC), enabling communities to systematically target the highest-need/cost users of crisis systems for supportive housing. In Michigan, we have pioneered innovation and replicated promising models in close collaboration with local partners. For instance, we replicated the FUSE model in Detroit. We also selected Ann Arbor as one of only four sites for our SIF pilot. We are now working with Catholic Social Services to offer supportive housing to high cost utilizers of crisis health services in Washtenaw County.

- Monitor and track outcome measures. CSH is an outcome-driven organization. We set ambitious, yet achievable goals for all of our initiatives and invest in tracking the impact of our work on the supportive housing industry. CSH has a long and successful track record of designing and implementing complex, multi-site demonstration initiatives that include granting, managing to outcomes, and rigorous evaluation. We tie all financial support to very clear expectations for performance and closely monitor our grantees and loan borrowers. We couple this monitoring with training and intensive 1:1 TA to grantees and borrowers. CSH has sponsored, designed, and managed numerous independent evaluations to test program efficacy on client and systems level outcomes, including varying methodologies. As well, our work has yielded impressive client and system level outcomes. For instance, John Jay College tracked NYC FUSE participants and a group of similar non-participants, and documented positive outcomes after a year: 91% of tenants remained stably housed; 92% experienced a drop in shelter stays; and 53% recorded a decline in jail recidivism. For the Frequent Users of Health Services Initiative (FUHSI), a \$10 million pilot, CSH tested models to serve frequent users of emergency rooms and acute care in six California counties. The Lewin Group's evaluation of FUHSI showed that homeless clients experienced a 61% decline in ER visits and a 62% drop in inpatient hospital stays, and that the subset placed in SH experienced even stronger outcomes than those only offered health services. Both evaluations also examined costs savings and **showed net reductions in costs to public systems.**
- Collect and share data with Government, grantees and independent evaluator. CSH has a strong track record of partnering with public agencies to access data for client identification and evaluation purposes. For instance, through FUHSI, CSH facilitated the development of a systematic, long-term data collection strategy with hospitals and other partners. The program tracked crisis service use/entry, support service utilization, and costs. For our FUSE efforts in 11 jurisdictions nationally, CSH has brokered data-sharing agreements between multiple public systems in order to identify frequent users, target them for SH intervention, and evaluate the impact. For instance, for New York City FUSE, CSH brokered a data-sharing agreement and developed an MOU between the homeless system and the Jail to identify frequent users of both systems for jail in-reach and program enrollment. These agreements also allowed the evaluators to access administrative data from both agencies on the pilot's participants and the control group in order to monitor the pilot's impact on subsequent shelter use and jail recidivism as well as usage pre and post pilot for the control group. As well, many of the CSH-sponsored evaluations have involved Institutional Review Board (IRB) approval for the treatment of human subjects. CSH has advised the involved public agencies and evaluators to secure IRB approvals for numerous projects. Most recently, for the frequent users of health services pilot in Detroit, MI, CSH worked with the evaluator, Wayne State University, to develop the evaluation plan and to ensure that it would meet the University's requirements for IRB approval.

## **GOVERNANCE STRUCTURE**

**CSH Response to the Michigan SIB Request for Information, Project Number: #0071141113B0000535  
October 2013**

Based on our experience with SIBs and PFS efforts to date, CSH is pleased to offer the State of Michigan the following recommendations and ideas for the governance structure for a potential SIB pilot in the State.

Functions to be the responsibility of Intermediary Entity versus the State, an Independent Outcome Validator or other entity. In Michigan, CSH would create a SIB/PFS structure with several key elements. Outlined below are the potential mechanics and roles and responsibilities for all parties:

1. The State of Michigan, in conjunction with the selected intermediary, a to-be-selected 3<sup>rd</sup> party evaluator and supportive housing providers, will identify the scale and scope of the target population, and agree to outcomes and metrics to be tracked and evaluated.
2. State of Michigan enters into a pay for performance contract with the intermediary to implement the supportive housing model intervention with the target population. The State makes payments based on performance.
3. The selected intermediary acts as program intermediary and orchestrates the delivery of the supportive housing intervention through sub-contracts with supportive housing providers located throughout the state. The intermediary would not directly provide supportive housing. The intermediary develops the program model, informed by evidenced-based practice and selects a team of SH provider sub-contractors.
4. The intermediary raises private sector capital in the form of grant, loan, and equity investments to capitalize the SIB/PFS initiative.
5. The intermediary monitors and tracks self-reported data on the program from providers to: determine whether the providers are meeting the minimum standards of quality supportive housing; achieving interim benchmarks; make mid-course corrections if necessary based on our data analysis; and assure fidelity to the program model. The intermediary manages and is responsible for performance for overall PFS contract for multi-year period. The intermediary has full latitude to manage performance of individual sub-contractors over this same period, including implementing course corrections and making changes to the team of providers.
6. A wide array of state, county, city agencies will be engaged to support the initiative including: Michigan Departments of Corrections, Community Health, Human Services, State Housing Development Authority, County Community Mental Health Authorities, MI Coalition Against Homelessness, local Continua of Care (CoCs), nonprofit service providers, and housing developers.
7. An independent evaluator, with the State of Michigan's and the intermediary's assistance, monitors the performance, and measures and reports on outcomes. Given our experience in working with evaluators, CSH could assist the State in selecting an evaluator. To give additional confidence to private investors, Michigan may also want to select a validator to sign off on the evaluator's work.
8. The government-contracted intermediary is reimbursed by the government only as targeted social outcomes are achieved.

Intermediary functions to achieve desired social and financial outcomes. The intermediary should be responsible for the five following Performance Management functions:

1. Program Design. The intermediary should lead the adaptation of the evidence-based model for social innovation financing. In doing so, the intermediary will (a) maintain a holistic perspective on Michigan's goals for the SIB and the target population(s)' needs, (b) scan for and evaluate a full range of potential programmatic solutions, and then (c) select among programmatic components to develop an optimal model for the target population(s) for the SIB.
2. Procurement. The intermediary would: (a) Solicit and evaluate bids from providers of the selected program design, (b) negotiate payment contracts with selected vendors, (c) use frequent face-to-face contact and quarterly reporting techniques to monitor contract compliance/performance, and (d) take any vendor-related actions as dictated by performance results.

3. Implementation Support. The intermediary should possess extensive experience in providing various forms of support to Service Providers in order to deepen their social impact. Examples of possible support include (a) financial modeling, (b) strategic planning, (c) capacity planning, (d) interactions with a network of government and community contacts, and (e) organizational design and leadership advice.
4. Evaluation and Innovation. The intermediary should conduct annual assessments of interim progress and identify opportunities for continued innovation. Subcontracted agencies will provide the intermediary the opportunity to review case files and meet with program staff on site, upon request, so the State of Michigan can ensure program compliance. Subcontracted agencies will collect data from participants, including demographic information, whether participants have previously received government services and length of time housed. The State will collate this data from all agencies and submit reports with the following information: Narrative report detailing the implementation of the overall program; Number of homeless persons served and demographics; Average length of successfully sustained tenancy; and Average cost per participant.
5. Safeguards. The intermediary should take steps to safeguard program participants through (1) careful oversight of programs, (2) a well-defined tenant grievance procedure, (3) regular housing and program site visits, and (4) regular tenant housing and health satisfaction surveys conducted as part of data collection. Safeguards could be enhanced through consumer engagement on an oversight committee.

Additionally, the intermediary should be responsible for several PFS/SIB Platform Functions as follows:

1. Governance and Reporting. The intermediary should be responsible for the formation of a new corporate entity to house the PFS/SIB partnership. This entity would be governed as dictated by its by-laws and in accordance with a formal partnership agreement held among CSH, the state and several leading investors.
2. PFS/SIB Formation. Senior management of the intermediary should be intimately involved in the negotiations, construction, and implementation of the SIB arrangement. This will include the overlay of capital modeling and the integration of appropriate evaluation methodology and mechanics.
3. Fiscal Agency. The intermediary would perform many of the functions classically performed by an independent fiscal agent in project finance. These include: (a) collection of information as needed from all parties to drive the execution of contracted terms, (b) maintenance of records, (c) issuing of capital calls and payments as dictated by contracts, (d) monitoring and reporting of contract covenant compliance, and (e) bank account maintenance and cash management. An independent auditor would inspect and confirm all actions performed by the fiscal agency function.
4. Capital Raising and Investor Relations. The intermediary would be responsible for raising the full amount required to finance this project. In addition, the intermediary will reach out to major investors on a quarterly basis to: (a) provide progress updates and (b) solicit investor input. The intermediary should:
  - a. Develop the required financial modeling to establish the programmatic costs and funding requirements.
  - b. Integrate business and financial models with outcome metrics.
  - c. Structure the capital requirements and appropriate capital "layers".
  - d. Design repayment profile and performance return constructs.
  - e. Develop Investment Memorandum and supporting investor materials.
  - f. Market/road show the investment opportunity with prospective investors.
  - g. Structure and negotiate investor agreements.
5. Government Relations. Through the intermediary, partners would maintain regular contact, at least on a quarterly basis, with government counterparts to: (a) provide progress updates, (b) report upon safeguards for individuals served, and (c) mutually address any issues that may come up. In addition, the intermediary would reach out to a broader collection of government officials to maintain high levels of communication and support.

**OTHER ISSUES OR CONSIDERATIONS**

In addition to issues of governance, CSH would like to provide additional considerations and input in terms of how a potential RFP and SIB intervention would be structured and managed by the State.

Establish realistic, measurable targets for program success. One of the most critical components of a SIB/PFS initiative is the ability to establish ambitious, yet realistic targets for program success and to accurately measure the results. Creating a comprehensive plan for establishing and measuring these metrics will involve **significant discussion and negotiation between the intermediary and the State to determine what administrative data sources and data collection strategies are available** to measure key outcomes, negotiate and establish targets for outcomes, and facilitate access to necessary data. Examples of administrative data sources include Medicaid data (emergency room, ambulance, detox, and inpatient hospitalization utilization and costs), HMIS data (number and length of shelter stays), and corrections data (number and length of incarcerations).

CSH believes the following steps would be crucial in this process: (1) A comprehensive literature review of existing evaluations to consider metrics to be tracked, methods for data collection and analysis, and benchmarks for expected impact; (2) Determine the range of administrative data sources and data collection strategies are available to measure key outcomes and the process for accessing this data on an ongoing basis; (3) Define and articulate a shared vision of what a successful program would accomplish for the target population, and (4) based on information collected and documented, negotiate and establish ambitious but realistic outcome measures with clearly defined thresholds for success. CSH has deep experience in leading public and private partners and funders in completing all of these steps in order to lay a foundation for the successful implementation and evaluation of demonstration programs. We have facilitated the development of MOUs and data-sharing agreements between and among state and local agencies nationally, as well as having conducted numerous literature reviews and developed many evaluation plans.

Need for independent evaluator. Given the structure of a SIB/PFS initiative, we recommend using a third party to conduct the evaluation to reduce the real or perceived conflict of interest based on the risk and rewards of the program. Without rigorous, independent evaluation, there could be significant concern regarding the validity of the project's impact and cost-savings. The evaluator partner would need to have considerable expertise in conducting large scale, rigorous evaluations and ideally have a team composed of experts in the fields pertinent to the project intervention. They would need to have team members with extensive experience with the statistical methods and data analysis skills necessary to evaluate impact with a rigorous experimental or quasi-experimental methodology. CSH has worked with a wide variety of evaluation partners with the expertise to conduct rigorous evaluation. We could leverage this expertise to assist the State on the development of criteria for selecting the evaluator, assessing firm's qualifications, and/or developing its scope of work. The state will also need to be actively involved in the evaluation on an ongoing basis to ensure that the evaluator has access to data.

Process and outcome evaluation needed. We propose to collect both quantitative and qualitative data as part of a process evaluation that will allow CSH, as the SIB/PFS intermediary, to monitor progress, remedy any operational issues, and ensure the initiative remains on track. Specifically, CSH would collect and review program data to: determine whether the providers are meeting the minimum standards of quality supportive housing; achieving interim benchmarks for housing placement, support service utilization, housing stability, and use of primary and preventive health services; make mid-course corrections if necessary based on our data analysis; assure a minimum level of fidelity to the program model; understand differences between provider results; and document the program model and best practices in implementation for the purposes of further expansion and replication. Our approach for assessing grantee progress would be based on CSH's Seven Dimensions of Quality for Supportive Housing framework and assessment tools. The Dimensions provide a framework for a common understanding of what constitutes quality in SH operations and services, and allows providers to identify specific areas in need of improvement and action items for each Dimension of quality and

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performance. CSH would leverage this framework and tools to monitor and improve the capacity of PFS grantees/sub-contractors.

Need for investor incentives and ensure risk-sharing among all parties. Another potential hurdle will be in recruiting philanthropic partners and private investors for the initiative, given that SIB/PFS is a relatively new construct or investment vehicle. Yet, there is tremendous interest in this model among foundations and banks, which can be leveraged to secure investments in the proposed initiative in Michigan. While CSH has a successful track record of generating philanthropic and private sector investment in innovative initiatives, it would be helpful for the State to provide a guarantee in order to entice private investors. As well, the state could make the bond or other SIB investments free from state taxes in order to increase the effective rate of return for SIB investors. CSH believes that these incentives could prove critical in enticing early investors for SIB models.

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