

# NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES

## PAY FOR “SUCCESS” CONTRACTS POLICY AND GUIDANCE MANUAL

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# 1 INTRODUCTION

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The Success Contracts also known as Pay for Success (PFS) were launched in the United States in 2012. The federal government provided funding for programs designed to augment financial mechanisms to encourage innovation in paying for social service and health determinants. These programs continue to mandate the use of evidence-based initiatives to target the at-risk populations who are identified as low income or below the federal poverty level (FPL). The impact of the PFS has experienced varying levels of success. Even those programs that did not yield the desired expectations were able to contribute to the international and national research on best practice and support the development of tools and resources to support success in other programs across the nation. Nevada has adopted the best practices in this Policy and Guidance Manual with the overall strategy to bring government funding together with practical and private sector performance-based strategies. PFS Contracts reimburse investors only if programs reach defined outcomes. PFS Contracts provide the opportunity to limit the risk of tax dollars by not paying for programs that are not effective.

It is important to note that the “Pay for Success” or Success Contracts are sometimes used interchangeably with “Social Impact Bonds” (SIB) or “Development Impact Bonds” (DIB). PFS Contracts refers to the procurement of social services where payment is based and released only on the achievement of specific outcomes on a specific targeted population. SIBs and DIBs are financing mechanisms and may be considered as part of a future proposal, but PFS Contracts are not limited to SIBs or DIBs. DIBs have an additional provision where some, or all, of the outcomes are provided by an outside funder, typically on an international scale.

# 2 STATE AUTHORITY

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The Affordable Care Act (ACA) primary objectives were to improve health related outcomes, spur innovate policy, as well as promote cost effectiveness. In support of the ACA, Nevada modified the Nevada Revised Statute (NRS) in 2017 to allow for PFS Contracts to provide additional financial mechanisms to improve outcomes, develop innovative approaches, pay for outcomes and develop cost effectiveness or cost savings.

In 2017, Senate Bill (SB) 400 was approved and signed by the Governor which authorized the Director of the Department of Health and Human Services (DHHS) to enter into *PFS Contracts* to accomplish any purpose within the jurisdiction of the Department or any of the Divisions. The DHHS includes the Divisions of Aging and Disability Services (ADSD); Child and Family Services (DCFS); Health Care Financing and Policy (DHCFP); Public and Behavioral Health (DPBH); Welfare and Supportive Services (DWSS); the Public Defender’s Office as well as the offices and programs directly under the Director’s Office. The Grants Management Unit, under the Director’s Office, is responsible for the policy, guidance and oversight of PFS Contracts in collaboration with the respective division. This Manual has been developed to guide potential development required for a PFS contracts and to ensure compliance with NRS 232 by establishing clear requirements for the procurement and development of PFS Contracts.

### 3 HEALTH AND SOCIAL SERVICE PURPOSE

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Based on the tremendous effort required by a service provider team to apply for any proposed PFS Contract, DHHS has developed guidance 1) to ensure an open and competitive process; and 2) provide the minimum requirements that will be evaluated for a proposed future PFS Contract. This policy and guidance does not guarantee an award, nor does it guarantee the State will enter into any agreement(s) or contract(s), but rather is a plan, should the DHHS determine that a PFS Contract would be in the best interest of the State. There is no funding for the completion of any activities required for the submission of any proposal associated with PFS, by the department or any agency.

This guidance establishes the health, social purpose, and guidance for stakeholders and government agencies considering the use of PFS Contracts on social and/or health-related interventions with the requirements and capacity building mechanisms. The DHHS will ensure compliance with Chapter 333 of Nevada Revised Statutes (NRS) by developing and identifying potential contracts through a competitive procurement process. Any individual, person, or entity may provide information to the Director's Office, Chief of the Grants Management Unit (GMU), identifying services or outcomes considered for an open procurement process. **Any information provided to the Director's Office, or any Agency, will not be considered confidential and may or may not be used for a future procurement.**

The DHHS will only consider PFS Contracts for programs that are specific to legislatively defined activities for health and social service programs under the DHHS that targets vulnerable and at-risk populations. Health-related interventions and PFS Contracts must be compatible with the federal 2010 Affordable Care Act (ACA) which supports innovative medical care delivery methods designed to lower the costs of health care. The Patient Protection and ACA has increasingly emphasized cost-effectiveness, pay for performance measures, and policy innovation across all health programs and in policy. Nevada has recognized the opportunity to team on innovative strategies with PFS Contracts by linking intervention to outcomes on a targeted community.

Building service provider capacity is one of the biggest challenges facing Nevada regardless of the funding model. While interest in developing alternative payment delivery such as PFS Contracts has been considered building state capacity, more importantly the focus by DHHS will be on building service provider capacity. Service providers are essential to the success of any health or social project, as they are responsible for achieving and tracking positive outcomes for a given target population, this must be considered and addressed through any PFS procurement.

### 4 OUTCOMES BASED COMMISSIONING AKA PAY FOR SUCCESS

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Outcomes-based commissioning can support governments to achieve better results in obtaining successful outcomes for health and social service programs. DHHS has traditionally contracted third-party service providers on a 'fee for service' basis. Under this type of contract, DHHS pays for a particular service that they believe will lead to a desired social or health outcome. PFS seeks to improve the productivity of public service spending by paying only when specific outcomes are achieved by a service provider for the delivery of services. In these instances, providers are free to undertake the activities that they think will best deliver the required outcomes (as long as they comply with the law).

**Payment by results is intended to:**

1. Improve service quality by offering higher payments for better performance;
2. Improve transparency around spending by specifying how much will be paid for different results; and
3. Ease pressure on public spending budgets by staggering payments over longer time periods.

## 5 PROGRAM FOCUSED STRUCTURE

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Any DHHS PFS Contract will be focused on models that align with population health goals. Nevada has adopted the following program structure to avoid the challenges with proposed investing and solutions to support PFS financial model development:

1. Nevada will avoid all-or-nothing structures; instead have different levels of payments for different levels of performance toward outcome targets.
2. Nevada will review both large and small impact projects and base the outcome payments on specific, measurable, and accomplished metrics.
3. Nevada will only target projects that utilize evidence-based interventions, to reduce the risk in financing untested interventions.
4. Any program response to the PFS Contract must secure all the partners' commitment before submitting the proposal. *This does not include DHHS or any agency under DHHS.*
5. Programs will only be considered if they provide scalable solutions.
6. Any program response must ensure that all relevant partners are defined. For example, if cost savings or benefits are spread over multiple payors (i.e. State and county), the proposed intervention must include a commitment to contract with each Payor, outside of DHHS.

## 6 MEDICAID LIMITATIONS

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Nevada Medicaid is the largest payor of health services in Nevada and the Medicaid-eligible population is considered a prime target population for PFS Contracts. Any proposals regarding Medicaid populations must ensure compliance with all rules and regulations defined in the Code of Federal Regulations (CFR) and the Centers for Medicare and Medicaid Services (CMS). Proposals will not be solicited for services not currently authorized through existing contractual, legislative, or waiver programs provided to Nevada by CMS.

Many frameworks of social determinants of health focus on improving health and decreasing expenditures through Medicaid. While interventions aimed at low-income populations could result in a request for proposal for Medicaid savings alone, CMS restricts the way in which federal matching funds can be made available. When reviewing savings, it is important to remember that Medicaid is authorized to provide federal funds to help states specifically pay for "medical assistance" to eligible beneficiaries. This does not allow for social investments that may be across other payors such as housing, childcare, or education.

Federal rules permit states to build financial incentives in their contracts with Medicaid managed care organizations. However, there are policies that limit the availability of federal Medicaid funding for services commonly associated with PFS Contracts. This means that either all or a disproportionate share of an investor payout would have to come from unmatched state Medicaid funds, even though savings would accrue to both the state and federal governments.

It is also important to note that states must seek approval from the federal government to spend federal Medicaid funds on non-clinical services. Nevada develops their Medicaid programs within federal parameters that define allowable services and must seek approval from CMS for program changes. ***For projects involving Medicaid, any proposal must not be contingent on any waivers or changes in federal policy.***

## 7 PRINCIPLE STAKEHOLDERS

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To ensure compliance with evidence and national best practices, all PFS Contracts will include not less than five (5) principal stakeholders. These are mandatory partners. This does not necessarily represent a complete list but will be the minimum number of stakeholders for a proposed PFS Contract. This is in addition to other partners and the target population identified.

1. **Payor:** *State Government Agency or Sub-Recipient Agency*, who is responsible to enter into an agreement with the service provider. If the outcome targets are met, the payor will make “outcome payments” that cover the cost of the intervention, plus a modest bonus, often from savings the payor realizes from the intervention, if developed in the transaction model. *Note that the payor, if submitted on RFP, for the DHHS is considered “tentative,” until and if a project is selected, and the contract is approved by the appropriate authorities.*
2. **Service Provider:** Under the agreement with the payor, the service provider delivers the intervention to the target population, with the goal of achieving the outcomes specified. For example, a service provider may provide housing services with the primary objective of reducing homelessness.
3. **Intermediary:** The payor will be working to contract with an intermediary who will structure and coordinate the project or the proposal for consideration by the State. The intermediary’s responsibilities may include facilitating agreements between partners, overseeing project implementation, and commissioning an independent evaluation. All partners will need to be identified for consideration for any State proposal.
4. **Independent Evaluator:** Evaluators are critical to the PFS contract and are involved in the all levels of the project to include payments for services tied to specific outcomes and interventions. Independent evaluators must be identified for consideration of any State proposal.
5. **Investors:** Investors are a mandatory partner with all state PFS contracts and proposals. These partners should be clearly defined and often provide up front capital to cover the cost of the service provider delivering the intervention or program. Generally, proposals may include repayment to investors with “outcome payments” if, and when, outcomes are achieved. Investors often accept a level of risk with the investment.

## 8 EVIDENCE-BASED PROGRAM DEVELOPMENT

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The Nevada Department of Health and Human Services (DHHS), through the Division of Health Care Financing and Policy (DHCFP) has adopted the *Triple Aim* as a fundamental component of healthcare reform. The “Triple Aim” is defined as improving individual patient experience, improving the health of populations, and reducing the per capita costs for care population. As part of this initiative, ensuring safe and appropriate health care in Nevada is critical to every program. Nevada requires all contracts, including those developed under PFS Contracts, to follow evidence-based and nationally defined best-practices when delivering services.

*The following conditions are required for all programs.*

- *The projects rely on an evidence-based intervention,*
- *The intervention has been shown to produce savings in health care services over the long term, and*
- *Sources of financing to scale the programs are limited or not readily available in the local context where the project seeks to operate.*

## 9 PROGRAM READINESS AND ASSESSMENT

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As part of national and international best practices, Nevada has adopted the key components of service provider readiness. This provides the framework for service providers to develop internal risk assessments and evaluate if they are program ready.

- A. **Data and Evaluation:** Nevada is focused on ensuring the appropriate data and evaluation component is included in all contracts. Social service providers must foster an environment that is focused on outcomes and continuous improvement. There must be existing mechanisms to measure and track outcomes and interventions on recipients of care. Providers that utilize both internal and external sources of data will be better able to demonstrate the efficacy of programs and position themselves to be part of a PFS Contract.

*The data infrastructure includes, but is not limited to:*

- a. Organizational culture focused on capturing outcomes, over outputs. Must have a minimum of three-years of experience in collecting and reporting on data.
- b. Track record of success in achieving goals on federal and state grants. Service organizations must have a minimum of two-years of experience providing services under a federal or state grant.
- c. Electronic and robust data tracking and analytics infrastructure capacity.
- d. Demonstrated ability to track recipients of care during, and after, intervention strategies.
- e. Internal and external evaluation experience on not less than two government funded projects.

- f. Strategic priorities linked to the relevance of the target population and service intervention.
  - g. Cost-benefit analysis completed using local data specific to proposed target population.
- B. Capacity to Scale and Demonstrate a Track Record of Success:** The costs of time and support to implement a PFS Contract are complex. The organization must be able to demonstrate the capacity to produce the benefits to all partners. The ability to identify the readiness to serve and increase participants served while ensuring fidelity of the evidence-based programs are key to the scaling of projects. Nevada will review the potential for scale through past performance on projects of similar size and scope, although they need not be specific to PFS Contracts.

*Readiness factors include, but are not limited to:*

- a. Defined organizational structure with well-defined program model and program model implementation, which includes identifying strengths and weaknesses.
  - b. Proven ability to scale or replicate existing program/intervention or launch new programs.
  - c. Internal staff experience and capacity (or sufficient funds to hire) to maintain fidelity of service delivery model currently and once scaled.
  - d. Record of success delivering services in partnership with fellow member(s) of the proposed social service providers.
- C. Financial Management:** Service providers must have the ability to track spending on a continuous basis, demonstrate a strong financial planning infrastructure, and have a least three (3) years of experience with federal or state agency pass-thru funds.

*Readiness factors include, but are not limited to:*

- a. Financial infrastructure with electronic systems for monitoring activity.
  - b. Understanding of program/intervention costs (i.e. cost per person served).
  - c. Ability to manage cash flow.
  - d. Evidence that the provider will continue operating, without the PFS Contract.
  - e. Evidence that the provider has assessed alternative approaches to ensure the lowest cost allowance available.
  - f. Existing Internal controls in compliance with federal and state regulations.
  - g. Existing Data Universal Numbering System (DUNS)/Unique Entity Identifier (UEI), Entity Identification Number (EIN), grants.gov and all appropriate licenses.
  - h. Proof of compliance with Federal Funds Accountability and Transparency Act (FFATA).
- D. Leadership and Management Support:** Approval of the Board of Directors and leadership, with recognition of the risks, prior to joining any application.

*Readiness factors include, but are not limited to:*

- a. Management plan in place for intervention.

- b. Dedicated project director.
- c. Demonstrated ability to manage one or more contracts simultaneously.
- d. Leadership support for process improvement.
- e. Effective leadership structure with minimal turnover of Board and staff.

E. **Established Partnerships:** Recognizing the success of partnerships is built through common goals and collaborations. The PFS Contract is not a good place to establish relationships based on the complexity and interventions required. Clear communication, goals, and existing relationships with other providers in the community, local, and state government agencies is critical to success.

*Focus and understanding the community landscape and partners include, but are not limited to:*

- a. Established reputations in community and among funders and government actors for effective service delivery.
- b. Evidence of past partnership with other providers in the community, a minimum of three (3) years.
- c. Demonstrated ability to manage multiple relationships.
- d. Record of success and client satisfaction based on performance-based government contracts.

Specific approaches for PFS Contracts will be focused on scaling public health services that have proven to be cost-effective, but do not fit in the traditional scope of health care services. The following will be mandatory for DHHS Department or Agency as part of any procurement for PFS Contracts.

Project Name:	
ROLE	DEFINITION
<b>Lead Agency Name</b>	Government Agency
<b>Transaction Details</b>	Funding and transaction details.
<b>Intermediary</b>	The entity most often responsible for overall project management/coordination, investor recruitment, and negotiation of contracts among payors, service providers, and investors in PFS projects. Intermediaries are typically responsible for entering into direct contracts with the government funder, liaising with potential investors to secure capital commitments to the transaction, and serving as the primary liaison among key players in the PFS relationship. Other Terms Used: transaction coordinator, project coordinator.
<b>Project Status</b>	Identify any conflicts or challenges, the teaming, the project experience and all elements of the project as it is linked to the department or lead agency strategic plan.
<b>Funding</b>	Health funds being targeted and transaction details.
<b>Health Issue being addressed</b>	Define the health or social issue being addressed, which includes the difference in approach through the project.
<b>Project Objectives</b>	What are the specific program objectives (which must be measurable)? The list of outcomes and the key agencies that are expected to benefit as a result of improvement for each outcome.
<b>Interventions</b>	A model or program that offers a discrete set of products and/or services to address a specific social issue or challenge. Other Terms Used: program model.

<b>Service Provider</b>	The entity that delivers a specific intervention financed by the PFS transaction in order to achieve predefined and agreed upon outcomes and/or impacts.
<b>Target Population</b>	People being served by interventions, and demographics.
<b>Geographic Area</b>	Identify the specific geographic area of impact.
<b>Data Sources for Outcomes</b>	Electronic reporting system and how the data will be collected.
<b>Outcome Metric</b>	Define the specific metrics in terms of impact on population, services and funding.
<b>Evaluation</b>	Define type of evaluation and how the data will be submitted and collected.
<b>Independent Evaluator</b>	An independent organization that assesses performance data and conducts an evaluation of intervention outcomes and impacts.
<b>Payor</b>	The entity that is ultimately responsible for paying the agreed amount based on the level of measurable impact achieved. Other Terms Used: payer, lead organization, outcome payor.
<b>Investor</b>	Individuals or commercial, philanthropic, or community development organizations providing upfront capital that enables service providers to deliver services over the term of the PFS contract.
<b>Entities/organization benefitting from the realized savings from the project</b>	A baseline of current services and service providers. For example, if you reduced the number of inpatient hospital admissions for mental health you must define what percentage is being expected to be reduced by the program, and also account for the dollar figure and the agencies impacted (Medicaid, SAPTA, county general fund for hospital expenditures, etc.). If the programs are running currently, must be able to explain how the measurement will distinguish between interventions.
<b>Pay for success financing</b>	The provision of upfront capital to cover the cost of the intervention deployed through a project and, in some cases, to cover related costs of the PFS project (e.g., evaluation). The principal investment is only returned (and possible additional returns are only distributed) when pre-determined outcome goals are met.

**Any procurement for PFS contracts will assess the following major components:**

- *Problem definition:* How clearly defined and understood is the problem?
- *Program strength:* How strong is the proposed solution to address the problem?
- *Provider capacity:* How strong (capacity and effectiveness) is the service provider that could deliver the program?
- *Project alignment:* How well do the all the key components of the proposed project fit together in a specific jurisdiction?
- *Project evaluability:* To what extent does the proposed project have a clear, rigorous, and feasible evaluation plan?
- *Data Systems:* Does the proposed project include individual-level data that spans multiple agencies that is both point in time and longitudinal?
- Do stakeholders have a sense of what outcomes they want to change in relation to the target population and identified program?
- Have stakeholders assessed how much is already being spent on the problem?

At the center of every PFS project is a program that aims to measurably improve outcomes for a specific population using evidence-based approaches. The success of the PFS project centers on whether the program positively affects the lives of those who receive services. This section looks at the strength of the specific program considered for a PFS project. If you are considering multiple programs, each program will be scored separately for comparison.

- Does the stakeholder identify a clear and compelling theory of change linking program activities or outputs to outcomes?
- Has the intervention undergone at least one independent, rigorous impact or outcome evaluation?
- Does the type of research design outline the size of the sample, the selection of an appropriate comparison group, and the use of suitable outcome measures, etc.?
- Has a cost-benefit analysis been conducted on the program in the past, and has it been shown to be cost beneficial?
- Does the program have clear metrics to measure program delivery and model implementation fidelity?

Every PFS project includes a contract with a service provider. The provider is responsible for implementing the PFS-funded program. This includes enrollment of the target population, service delivery, and program monitoring. Providers are an important stakeholder and should be involved at key stages of PFS project design, negotiation, implementation, and evaluation. The strength of the provider (capacity, experience, capability, etc.) is a critical component of the PFS project's overall strength.

- Does the provider have the organizational capacity to successfully implement evidence-based programs, the financial management skills to responsibly handle expenses, and the capability to scale their staff and functions as needed to implement the program?
- Does the provider have the systems and capacity to collect and analyze data on the delivery of programs and services? Do they have a history of using data to resolve program issues?
- Does the provider demonstrate an interest and willingness to engage in a rigorous evaluation of its program?
- Does the provider have past experience(s) with performance-based grants or contracts?

In PFS projects, public systems are typically the “payors.” However, government funds are often limited and the success of a PFS Contract is defined by the support of the Investor and the savings or cost avoidance.

- Has the proposed program demonstrated positive outcomes for a similar target population in the past? What data do you have?
- Does the chosen provider have experience, capacity, and skill sufficient to implement the specific proposed program?
- Has the provider had experience implementing a strong engagement and enrollment plan for a population similar to the project's target population?
- Does the DHHS and project partners have the ability to get referrals into the defined program?

- Is there a clear data-sharing agreement among project partners that enables sharing of data critical for completing core project tasks (e.g., designing project, recruiting participants, tracking outcomes, etc.)?

## 10 FEASIBILITY ASSESSMENT AND PAYMENT STRUCTURING

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Organizations must commit significant financial, human, and systemic resources towards a PFS Contact. A key component is a feasibility assessment. As part of the summary, the feasibility study will be required to identify the program with the overall State's Needs Assessment and Gap Analysis. Feasibility is the first stage and will define if an approach to implementation and a finance structure is viable. A feasibility assessment must be completed as part of any submittal for a procurement.

The assessment evaluates whether:

- *The desired outcome is clear and measurable (e.g. homelessness).*
- *The quality of outcomes can improve.*
- *There is a desire to increase evidence of effective programs.*
- *There is a desire to for innovative financing or support from philanthropic partners.*

**The completion, or activities related to the completion and development of the feasibility assessment, is not a reimbursable expense and is not funded by DHHS.** However, there are statewide data and assessments available on-line that can be used as part of the feasibility study. The study must review in detail whether a contract is likely to:

- Assess whether there are promising interventions that could deliver the desired outcome if investment were forthcoming;
- Analyze public sector costs and identify where savings might be generated by early interventions;
- Develop key criteria for an outcomes-based contract;
- Identify social investors;
- Assess the level of risk transfer to investors, evaluate interest from investors and potential rates of return that they may require.
- Have a project design which describes the needs of the target population as well as the intervention (including any evidence supporting the intervention's success with the target population, the problem or need the intervention would address if implemented, and any statutory or regulatory conditions that would facilitate or present barriers to implementing PFS);
- Have a cost-benefit analysis to identify whether cost savings are possible, given expected expenditures for services and outcome payments, to include calculating a projection of the potential public value, including any savings, to be achieved through possible interventions. (More information is below)
- Assess community needs, assets, and capacity, and identify the target population.
- Identify a challenge(s) or barrier(s) for serving a particular population or addressing a social issue and determine the total costs associated with the lack of intervention.

- Analyze relevant laws and regulations to determine whether conditions are challenging or favorable for implementing PFS.
- Identify proposed transaction structuring.

As part of the feasibility study, as noted before, stakeholders are required to include a **Cost-Benefit Analysis (CBA)** that compares the likely costs of implementing the intervention to the expected benefits of its outcomes translated into dollars. To the extent possible, CBAs should rely on high-quality data from the specific intervention or program when calculating its costs and benefits. If such data are not available, the CBA should use the next most relevant data available (for example, data from the local school district, neighborhood, city, county, or state) to best represent the target population.

CBAs also factor in the timing of costs and benefits by using a discount rate to convert future costs and benefits into present values, recognizing that governments, organizations, and individuals typically value future costs and benefits less than current ones. The team must recommend how to weigh the fact that costs and benefits are borne by various stakeholders. Due to these complexities, CBAs require the completers to work closely with local stakeholders to ensure correct assumptions around valuing the costs and benefits of the intervention. Recommendations, or proposals, for transaction structuring must also be included. Using information from the cost-benefit analysis, the partners develop a final financial model, which is the mechanism for determining the costs and benefits, expressed in dollars, and the timing of when those costs and benefits will occur.

## 11 DEFINING OUTCOMES MEASURES AND FINANCING METRICS

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An 'outcome' is a measurable result of an intervention project. In a PFS, the outcome needs to be set relative to a specific population over a defined period of time and against a historical benchmark, average, or trend. While many programs are designed to have specific impacts on the populations they serve, the DHHS typically measures their performance based on easily defined activities. Measures such as the number of people served provide data for program management but do little to tell us whether the program is working. Outcomes, on the other hand, are measures that tell us whether the program is working. Workforce programs, for instance, are designed to help people re-enter the workforce and obtain meaningful employment, and as such, the desired outcomes would include employment statistics, pay rates, and retention.

For purposes of measuring success, an outcome needs to be more specific than a public policy goal such as 'reduce poverty.' An outcome in a PFS targeting recidivism, for instance, might seek to reduce the rate of re-offense by at least 10 percent over five years among nonviolent offenders in a certain age group discharged from a given prison or prison system. Answering the question of what an outcome is valued at, if achieved, considers both objective and subjective metrics. Successful preventive programs will often result in future government savings, which is complex, as savings may accrue to budgets in different agencies or at different levels of government. This must be accounted for in the measures.

All outcomes must be clearly defined and measurable. The availability of high-quality data is essential to PFS independent evaluations. Key questions to ask for the appropriateness of an outcome include:

- Is there evidence that the intervention is likely to improve the outcomes for the target population?
- Is measurement of the outcome possible within the time frame of the PFS project?
- Is the outcome measurement valid (it measures what it is supposed to measure) and reliable (it produces stable and consistent results)?
- Is it possible to track and measure the outcome data over time for the treatment group (which receives the intervention) and a comparison group (which does not receive the intervention)?

When selecting appropriate outcomes, stakeholders must review relevant laws and regulations that relate to civil rights protections and must also guard against unintended incentives and consequences.

## 12 PROCESS AND IMPACT EVALUATION

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An outside evaluator is a requirement of any PFS Contract. Both a ***process and impact evaluation*** will be important for the provider to define success. By utilizing the outcome measures and performance expectations, the outside evaluator is responsible to independently review the data and determine if the program has met the objectives. Rigorous and independent evaluation is consistently discussed in the literature as a necessary component of any PFS project. An evaluation plan must clearly describe how the outcomes will be measured and should be part of the feasibility assessment. The evaluation plan must include the methodology for determining whether the intervention group met the agreed-upon outcomes while ensuring access to, and the collection of, high-quality data. An independent evaluator is one that is not involved in delivering the intervention services and does not have a stake in whether the intervention is successful.

The evaluator must include a collection of qualitative and quantitative data from different stakeholders. *Impact evaluation* attempts to provide a definitive answer to the question of the extent an intervention was effective in meeting program objective(s). Impact can include any of the outcomes affected by an intervention, but is likely to focus on the outcome to which payment is tied. Service delivery can be described in terms of output quantities such as the numbers and characteristics of individuals that were recruited, how many training seminars were provided and how many individuals were in gainful employment after the training program completed. This means that *process evaluations* often need to be designed with the objectives and data needs of impact evaluation in mind and vice versa. Specific questions that must be considered if an evaluation design is appropriate include:

- Does the evaluation cover the entire intervention, or specific aspects?
- Will intervention recipients, control groups, or extended populations be included?
- When will the evaluation start and will it include an evaluation plan that is both process and outcome oriented?
- What is the timetable for data collection and reporting?
- Are there suitable control groups?
- Does the evaluation include the mandatory utilization of longitudinal data for long term results?
- Does the evaluation include governance and implementation policy?
- What is the measurement period for both short and long-term payment?
- What is the measurement period for both short and long-range goals?

- What difference did the services make?
- How were the services delivered?
- What was the effect of using a payment by results and more specifically the PFS?
- Are there strong data systems to support measurement of project outcomes as applicable?

## 13 PROCUREMENT GUIDANCE

PFS models offer many potential benefits. PFS is one way for governments or other entities to test the effectiveness of promising innovations or adaptations to existing service models that research indicates benefit certain contexts or populations (“evidence-based” innovations). Second, PFS provides increased access to resources needed to implement evidence-based interventions. Third, it enables the government or other payor to only pay for successful outcomes.

The DHHS, Director’s Office Grants Management Unit (GMU) will accept letters of interest describing a proposed area of focus on or before March 30<sup>th</sup> of each calendar year. Any Nevada entity may submit a letter of interest to the DHHS, GMU. The DHHS, GMU will only consider moving towards a Request for Information (RFI) upon a clear and concise proposed project and focus area that clearly demonstrates the potential for measurable change beyond a traditional funded project. Information shall be provided in Times New Roman, 12 pt. Font, 1-inch margins, and not exceed ten (10) pages.

The following template should be followed and must include all areas for consideration:

PAY FOR SUCCESS – LETTER OF INTEREST
<b>1. Name and Organization Proposing Project (include contact information).</b>
<b>2. Priority area as defined by a department, division, state or county level strategic plan or Nevada Revised Statute.</b>
<b>3. Proposed health funding to be utilized for services.</b>
<b>4. What is the critical social or health issue with historically poor outcomes being addressed?</b>
<b>6. What or who is the Target Population (including demographics)? Proposed cohort size.</b>
<b>7. What evidence is there to support a PFS project? (Identify data that demonstrates a trend of poor outcomes by traditional funding).</b>
<b>8. Geographic Area includes census tracts if any of the target areas are in opportunity zones, for the proposed project (state level, county level, city level, neighborhood level).</b>
<b>9. What performance or outcome metrics are proposed to validate the data for a PFS project which also identifies the unmet need?</b>
<b>10. Who are the key service providers?</b>

11. Is the data on services readily available?
12. How will the PFS project yield different results than a traditionally funded project? Specifically, the program must demonstrate how lives will improve, and not for results that would happen under traditional funding.
13. Does the project require a change in statutes or regulations? If yes, define.
14. Are there examples of a PFS project design that has been successful in another community with the proposed target issues?
15. Please identify evidence-based innovations that will be implemented.
16. Provide at least one letter of 'commitment to engage' in a PFS project in the proposed issue area from each of the following: 1) A non-profit service provider in Nevada, registered as a 501(c)(3) and a state vendor; 2) A private funder willing to consider providing not less than \$100,000 in subordinate funding; and 3) a Transaction Coordinator with not less than three (3) years of working on PFS projects. This letter demonstrates interest in the PFS project; however, it does not bind the organization to the PFS project.

The DHHS recognizes the potential of PFS Contracts and potential benefits to the community. The DHHS GMU will submit a Request for Information (RFI) upon the identification of a proposed area of focus. Based on the results of the RFI, the DHHS will review the interest and the program activities to determine if it will be in the best interest of the state to open a competitive process for a formal submittal using a Request for Proposal (RFP). Based on the commitment required by the partners, the RFP will be open for not less than six (6) months for completion by the service provider partnership. As with any RFI or RFP prepared by the State, there is no guarantee of contract, procurement, or project. Any information provided during an RFI process is not considered confidential and may be used in building the RFP.

## 14 GLOSSARY OF TERMS

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**Accountable Care Organizations (ACOs).** ACOs, like Managed Care Organizations (MCOs), are collectives of health care providers who are both collectively responsible for the provision of care to a given population and collectively entitled to any cost savings if they are able to identify and obtain them. They are distinguished from MCOs in that ACO patients are generally able to move out of network for care, and in that providers are generally responsible for only a portion of the total cost of care, rather than any amount not provided on a per capita basis.

**Affordable Care Act (ACA).** The "Affordable Care Act," also known as the "Patient Protection and Affordable Care Act" (PPACA) is a 2010 law which dramatically reformed the U.S. health care system. The law contained a wide range of provisions, but most fundamentally it (a) expanded access to health insurance through tax subsidies to individuals to purchase insurance, an expansion of Medicaid, and the

creation of state- or federally-run insurance exchanges, and (b) introduced a range of programs and policies intended to reform the way the federal government reimburses health care providers for their services.

**Capitation.** A payment arrangement for health care service providers in which providers are paid a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

**Centers for Medicare and Medicaid Services (CMS).** CMS is the agency within Health and Human Services (HHS) that is responsible, among other things, for the federal administration of Medicaid (including the approval of Section 1115 waivers), and also houses the Center for Medicare and Medicaid Innovation. This latter group, created under the terms of the Affordable Care Act, is responsible for testing new and innovative payment and delivery system models that show potential for improving the quality of care in Medicaid and other programs, whilst simultaneously slowing the rate of growth in program costs.

**Cost Avoidance:** Resources one does not have to dedicate in the future (i.e. future savings) as a result of improved outcomes.

**Cost-Benefit Analysis (CBA):** An analysis that compares the costs of an intervention with the benefits that will result from achieving the outcome measures, including a method and description of the process used for estimating benefits that would result from implementation of the intervention. For example, a cost-benefit analysis of a preschool program may include the costs of implementing the initial program, and costs and benefits associated with later education, earnings, criminal behavior, tax payments, participation in public welfare, and health outcomes.

**Cost-Effectiveness:** A measure of the value of a particular outcome. Increased cost-effectiveness means higher value, which could reflect the same outcome for a lower cost, a greater outcome for the same cost, or a greater outcome for a lower cost.

**Cost Savings:** Cost savings are reductions in current costs that the government has already planned on incurring. Discount Rate: The interest rate used to determine the present value of future cash flows.

**Debt.** Money borrowed by one party from another. Debt is used by many corporations and individuals as a method of making large purchases that they could not afford under normal circumstances.

**Equity.** A security representing an ownership interest.

**Evaluator:** An entity with research and evaluation experience that conducts an evaluation to determine whether the intervention achieved the outcome(s) sought. It is important that the evaluator be independent to ensure that the results of the evaluation are accurate and unbiased.

**Feasibility Study:** A written report assessing the suitability of PFS to help improve outcomes for particular target population in a particular community over a particular set of years. A feasibility study includes, at a minimum, (a) a description of the intervention or program model to be implemented through PFS; (b) one or more clearly specified and measurable outcome measures; (c) a cost-benefit analysis; (d) identification of any statutory or regulatory barriers to implementing PFS; and (e) potential sources of outcomes payments from a government entity or other sources.

**Financial Model.** A quantitative model that shows public sector value (or value to other non-governmental outcomes payors), including increased tax revenue, cost savings, cost avoidance, cost-effectiveness, and societal benefit and links the costs of implementing the services that are covered, in whole or in part, by the investors to the amount and timing of outcomes payments that are made by a government entity.

**HIPAA.** HIPAA, or the “Health Insurance Portability and Accountability Act” is a 1996 law that, broadly speaking, both (a) provides individuals the ability to transfer health insurance after job loss, and (b) sets standards for the protection and confidentiality of health and health billing information.

**Impact Investing.** A general term used to describe socially conscious investment of capital to generate both social and financial returns. Social Impact Bonds and the PFS model are both forms of impact investing. Other Terms Used: social innovation financing, social impact investing, socially responsible investing, social financing, or social enterprise.

**Independent Evaluator.** An independent organization that assesses performance data and conducts an evaluation of intervention outcomes and impacts, as compared to a counterfactual.

**Independent Investor.** An individual, entity, or group that provides upfront capital to cover the operating costs and other associated costs, in part or whole, of the intervention delivered by the service provider.

**Intermediary.** The entity most often responsible for overall project management/coordination, investor recruitment, and negotiation of contracts among payors, service providers, and investors in PFS projects. Intermediaries are typically responsible for entering into direct contracts with the government funder, liaising with potential investors to secure capital commitments to the transaction, and serving as the primary liaison among key players in the PFS relationship. Other Terms Used: transaction coordinator, project coordinator, government advisor, or placement agent.

**Intervention.** A model or program that offers a discrete set of products and/or services to address a specific social issue or challenge. Other Terms Used: program model.

**Investment Guarantee.** Protection against the risk of loss in connection with an investment.

**Investor.** Commercial, philanthropic, or community development organizations providing upfront capital that enables service providers to deliver services over the term of the PFS contract.

**Offering Documents.** Documents which disclose and describe a securities offering to either public or private investors, containing information required under federal and state securities laws.

**Mission Related Investments (MRIs).** Foundation investments that are aligned with its mission and that are investments expected to generate a financial return.

**Outcomes Payments.** Payments, as agreed to in PFS legal agreements, to cover repayment of the principal investment and a return in the case that (a) an investor has covered part or all of the costs of service delivery and other associated costs, and (b) outcome measures have been achieved according to an independent evaluator.

**Managed Care Organizations (MCOs).** Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

**Medicaid.** The Medicaid program was enacted as part of the Social Security Amendments of 1965 (P.L. 89-97). Medicaid is a joint federal-state health insurance program for low-income U.S. citizens or permanent residents, their children, and certain citizens or permanent residents with disabilities. Although the federal government contributes a minimum of 50 percent of Medicaid funding for health services and program administration (the figure varies from state to state), states retain broad freedom to establish their own eligibility standards, their own provider certification structures, and their own administrative systems.

**Outcome Payor.** An entity that makes outcome payments for specified outcomes.

**Present Value.** The current worth of a future sum of money or stream of cash flows (i.e., the cost today of increased earnings in 10 years associated with graduating from high school) given a specified rate of return.

**Payor.** The entity that is ultimately responsible for paying investors proportional to the agreed amount based on the level of measurable impact achieved. In the majority of cases, the PFS payor is a government agency. Other Terms Used: payer, lead organization, outcome payor, back-end payor, government payor.

**Pay for Success (PFS) Financing.** The provision of upfront capital to cover the cost of the intervention deployed through a PFS project and, in some cases, to cover related costs of the PFS project (e.g., evaluation). The principal investment is only returned (and possible additional returns are only distributed) when pre-determined outcome goals are met

**Program.** Also known as an intervention, a program encompasses a specific set of activities and other inputs that are delivered in a specified way and intended to yield specific improved outcomes in a target population. Different types of programs might be funded through PFS: “proven” programs to be scaled or replicated (programs that have demonstrated success through prior evaluation) and “promising” programs (ideas with a compelling theory of change but minimal existing rigorous research demonstrating their effectiveness). Example: Nurse-Family Partnership (NFP) is a program that provides home visits by registered nurses to low-income first-time mothers.

**Program-Related Investments (PRIs).** Foundation investments that are charitable in purpose and not primarily intended to produce financial returns.

**Project.** The PFS project is the umbrella for the entire endeavor, including the program, contract, outcome payments, and other constituent parts. For example, South Carolina launched a \$30 million PFS project that aims to scale NFP programs to serve 3,200 first-time, low-income mothers to improve child health outcomes over the course of five years.

**Project Manager.** An entity that may serve as the project facilitator between or among the parties in a PFS project. Responsibilities may include but are not limited to coordinating the development and

execution of legal agreements, building a financial model to guide the terms of the legal agreements, and raising capital from investors.

**Rigorous Evaluation.** An evaluation that will, if well-implemented, produce evidence about the project's effectiveness that discerns the outcomes that were produced as a direct result of an intervention and not other factors.

**Sensitivity Analysis.** An analysis that examines the risk inherent in projecting outcomes and benefits by varying the assumptions included in the cost-benefit analysis to determine costs and benefits. The sensitivity analysis shows the change in the cost-benefit ratio as a result of varying these assumptions

**Service provider.** The service provider implements the program within the context of the project. Providers are typically independent nonprofits or coalitions, but they can also be government entities or university-affiliated entities. For example, the South Carolina Department of Health and Human Services is the lead service provider in that NFP project.

**Output.** What is directly produced or funded by the program, including activities. For example, in the South Carolina project, the output is the number of nurse home visits.

**Outcomes.** Observable changes (e.g., improved academic achievement) measured through a clear metric (e.g., a standardized test). In South Carolina's NFP project, for example, the outcomes include reduction in preterm births and reduction in child hospitalization and emergency department usage.

**Impact.** The degree to which these observed outcomes can, through rigorous evaluation, be attributed to the program. South Carolina's NFP project, for example, includes a randomized controlled trial to discern the impact of the program.

**Section 1115 Medicaid Waiver.** A Section 1115 waiver, also known as a "Medicaid Demonstration" waiver, is a waiver granted by Centers for Medicare and Medicaid Services (CMS) to a state Medicaid agency, in order to allow the state to experiment with finance and delivery initiatives that are not otherwise allowed by federal statute. Section 1115 waivers are required to be budget-neutral for the federal government. Under these terms, 30 states (plus the District of Columbia) currently operate one or more Section 1115 Medicaid waivers.

**Section 1915(b) Medicaid Waiver.** A 1915(b) Medicaid waiver is a waiver granted by CMS to a state Medicaid agency in order to waive the Medicaid requirement that enrollees have "freedom of choice" of health care providers. Historically, states have used 1915(b) waivers to allow the use of MCOs and their limited provider networks in a state Medicaid program.

**Senior lender.** A bank or similar financial institution whose loan to a company or individual holds legal claim to the borrower's assets above all other debt obligations.

**Service provider.** The entity that delivers a specific intervention financed by the PFS transaction in order to achieve predefined and agreed upon outcomes and/or impacts. Other Terms Used: social service provider.

**Social Impact Funds.** Investments made into companies, organizations, and funds with the intention to generate social and environmental impact alongside a financial return. Other Terms Used: social investment funds.

**Subordinate Debt.** A loan or security that ranks below other loans and securities with regard to claims on a company's assets or earnings. Subordinate debt is also known as a junior security or subordinate loan. In the case of borrower default, creditors who own subordinate debt won't be paid until senior debtholders are paid in full.

**Subordinate Lender.** "Subordinate" financing implies that the debt ranks behind the senior lender and means that the senior lenders will be paid back before subordinate debt holders.

**Target population.** People being served by PFS interventions.

**Triple Aim.** The "triple aim" is the generally agreed-upon aim of health policymakers to (a) improve patient experience of care while simultaneously (b) improving the overall health of the target population and (c) reducing the per capita cost of health care provision. Many of the Affordable Care Act's reforms—and therefore of the Innovation Center's pilot programs—aim to unify responsibility for all three aims under a single programmatic or policy roof, instead of keeping the three goals separate.

**References and material for policy included information from:**

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