PAY FOR SUCCESS AND SOCIAL INNOVATION
FINANCING: SERVING SANTA CLARA COUNTY’S MENTALLY ILL RESIDENTS

We are trying to signal to the community that our expectations around service provider outcomes are going to be rising. We are not just going to be giving out contracts and asking for evidence that a contractor provided a service, we need evidence that what they are doing is working.

—Gary Graves, Santa Clara County Chief Operating Officer

The idea of trying something new and innovative and engaging a broader cross section of people and organizations in effective public sector service delivery is really exciting.

—Greta Hansen, Santa Clara County Lead Deputy Counsel

There is a potential to really contribute to the mental health field through Pay For Success. It is also a chance to have measureable outcomes that can inspire more philanthropy and private investment in our field.

—Faith Richie, Senior Vice President for Development of Telecare

INTRODUCTION

On August 25, 2015, Santa Clara County Chief Operating Officer Gary Graves and Lead Deputy County Counsel Greta Hansen were at a county Board of Supervisors meeting, watching with pleasure as the high-profile mental health care project they were championing reached a major milestone. The goal of the project was to improve the health and well-being of the county’s most acute mental health care patients while lowering the costs associated with treating them—$45 million a year. The Supervisors of this Northern California county were approving a memorandum of understanding with for-profit service provider Telecare, which had expertise in transitioning patients out of expensive emergency and inpatient facilities and into less restrictive outpatient and supported residential settings. The project was unique because it was the first time a “Pay For Success” model was being used in the mental health field. Although over $200 million was being invested, Telecare would receive only a portion of the savings if the project succeeded.
million dollars² were already in play in 45 Pay for Success projects around the world, the model
was still in a proof of concept stage—with only eight projects launched in the United States,
one of which had successfully concluded.

Pay For Success (PFS) involves paying service providers for actual outcomes, such as clients’
 improved health and reduced government costs, rather than for services provided—activities and
outputs, such as the hours spent counseling clients. While providers traditionally billed for
services on a monthly, weekly, or even hourly basis, in a PFS project it might take years to
determine whether an organization achieved agreed-upon outcomes. Therefore, providers would
need working capital during this period. For this reason as well as others, PFS projects often
were paired with Social Innovation Financing (SIF), under which commercial investors,
foundations, and high net worth philanthropists fund the organization’s ongoing operations, but
lenders would only be repaid by the government to the extent the organization met those
outcomes. While there was no set formula, “capital stacks” of Pay For Success/Social
Innovation Financing projects to date generally were a combination of:

- a senior non-concessionary lender, for example, a bank, investing on commercial terms,
- foundations making below-market, or concessionary, investments through program-related
  investments (PRIs),³ and
- foundations or individual philanthropists making (non-recoverable) grants.

The repayment “waterfall” gave priority to the commercial lenders on the premise that
philanthropic institutions and individuals would assume the most risk and leverage their dollars
to attract commercial lenders.

This pairing of PFS and SIF was originally called a “Social Impact Bond,” with the term “bond”
reflecting the government’s obligation to repay the funders for successful outcomes. A more
accurate, albeit more cumbersome, name might be “investor-backed pay-for-success program.”

PFS/SIF projects required third-party evaluation experts to propose appropriate outcome metrics
and to evaluate the programs’ success. Santa Clara County’s PFS/SIF project evaluator was
Keith Humphreys, professor of psychiatry and behavioral sciences at Stanford’s School of
Medicine. In addition, Third Sector Capital Partners performed a facilitating role, using its
particular expertise and experience to put the project together, including identifying investors
and getting agreement on the terms of payment.⁴ (See Exhibit 1 for PFS/SIF overview and
Appendices A, B and C for details.)

² Emily Gustafsson-Wright et al., “The Potential and Limitations of Impact Bonds: Lessons from the First Five
Years of Experience Worldwide,” Global Economy and Development at Brookings, July 2015,
http://www.brookings.edu~/media/Research/Files/Reports/2015/07/social-impact-bonds-potential-
³ The Internal Revenue Code defines PRIs as investments whose primary purpose is to accomplish one or more
of the foundation’s exempt purposes, and treats PRIs essentially like grants for tax purposes.
⁴ Two organizations in the United States perform this facilitating role, Social Finance and Third Sector Capital
Partners. Santa Clara County chose the latter to help put together the deal.
The benefits of a well-executed PFS/SIF project included effective service delivery, accountability, efficient use of taxpayer dollars, rigorous evaluation, transparency, and, from the government’s perspective, shifting the risk of an innovative program to investors. It also provided long-term funding for service providers, which, for nonprofit organizations, reduced the need for constant fundraising. Moreover, the due diligence conducted by investors offered an additional layer of scrutiny of PFS providers and the overall PFS program design.

But there were also risks. A service provider might game the system by cherry picking clients to show high levels of success, or else provide clients with inferior services to reduce government costs (when cost savings was the metric used for success payments.) Moreover, PFS/SIF schemes had their detractors. Common arguments were that they gave too much power and influence to private funders—both over the projects chosen and over the lives of the vulnerable people being served—and that private investors should not benefit from services that it was government’s responsibility to provide. Another concern was that PFS/SIF projects were complicated and involved high transaction costs, consuming a lot of government resources and excluding small service organizations from being chosen as service providers.

Santa Clara County had nine months until the launch of the mental health PFS/SIF project, and many pieces still needed to be put in place. The county needed to figure out the best way to finance the project and line up funders who were interested in a largely untested idea—and who would align their interests with those of the county. Also, in collaboration with Humphreys, the county had to determine which metrics should be assessed—and which should be linked to payment or discontinuation of services. An added wrinkle was that it was just a month after another PFS project, aimed at reducing recidivism among young men released from New York City’s jail at Rikers Island, had made headlines when it failed to meet its targets. Graves and Hansen, as well as Telecare’s Senior Vice President for Development Faith Richie, knew that the success or failure of this project would have implications beyond this one county.

**Social Innovation Financing: Why Funders Invest**

Investing in PFS/SIF projects allowed funders to support measurable social and financial returns. Through SIF, they could fund an intervention, increase public sector accountability, build the public sector, or support an issue area, geography, or provider aligned with their mission or interests. Funders might benefit by receiving financial returns and participating in a new asset class with possible diversification benefits. PFS/SIF projects could fulfill commercial funders’ corporate responsibility mandates and provide positive public relations, given the high-profile and community-focused nature of the projects. Banks in particular might be motivated by requirements of the federal Community Reinvestment Act.\(^5\)

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\(^5\) The Community Reinvestment Act (CRA) is intended to encourage depository institutions to help meet the credit needs of the communities in which they operate, including low- and moderate-income neighborhoods, consistent with safe and sound operations. The CRA requires that each depository institution’s record in helping meet the credit needs of its entire community be evaluated by the appropriate Federal financial supervisory agency periodically.
CRITERIA FOR PFS PROJECTS

Not every project was suitable for the Pay For Success model. In choosing a project, government agencies had to determine whether there was enough data available to track outcomes. According to Alice Yu, formerly an associate at Third Sector Capital who worked closely with the county to develop and construct its PFS/SIF projects, “One of the top challenges for any Pay For Success project is whether or not governments can identify outcomes that are both meaningful and measureable and then actually put a price to them that they are able and willing to pay for.” PFS projects were meant to encourage innovation, but required enough of a track record to know if the intervention could deliver successful outcomes at certain thresholds. According to Yu:

> Among the unique aspects and benefits of SIF was that it brought an unprecedented level of private market discipline to the social services sector. Investors conducted thorough due diligence for their financial investments, including examining the organizational capacity of PFS service providers, scrutinizing and providing input to implementation plans and program design, and analyzing historical data and comparable programs to estimate the achievable range of impact and success for PFS programs. Not every provider or program is prepared to undergo this level of scrutiny.

PFS projects were most valuable in addressing the problems of high-risk populations because of their cost-benefit ratios. Social interventions such as providing housing or intensive case management often were expensive to implement. By targeting high-risk populations who used a disproportionate amount of services—resulting in high government costs—effective interventions could drive substantial impact to justify the invested resources. The target population also had to be large enough to justify the transaction costs involved in putting together the project and to enable robust evaluation of the results, whether through randomized controlled studies or other means.

The government also needed to mitigate risks by predicting the potential downsides of having the project go wrong. The government needed to be sure that the project would help the population more than hurt it. PFS programs typically had risk mitigation strategies built into the contract structure, including the right of early termination in the event of deception or other forms of misbehavior or harm to the intended beneficiaries. They also included oversight by governance and operating committees, with representation from different stakeholders who monitored the program’s ongoing activities.

From a financial and cost perspective, the government had to evaluate whether a PFS project could generate cashable savings or other benefits that outweighed its costs. The transaction costs for a PFS project were extremely high. The complicated multi-party contracts required substantial legal expenditures. Graves noted that he learned from an earlier Santa Clara County PFS/SIF project on homelessness that it took an inordinate amount of staff time. “Everyone who is working on the PFS projects has a full-time job, so everyone is contributing extra effort. I also had to buy back staff time from key officials to free them up.” In addition, governments had to think about the cost of gathering data. Some administrative data—such as jail data for recidivism prevention projects or mental health utilization data—would already be collected.
automatically by the government or another organization. But some projects might carry additional costs to collect more data or build analytical tools. The transaction costs were high for service providers as well.

**PAY FOR SUCCESS COMES TO SANTA CLARA COUNTY**

In January 2013, Santa Clara County did an analysis of the feasibility of a PFS project, focused on the county’s budget and service delivery needs. A few months later Graves recommended that the county take further steps toward PFS pilot projects. In August 2013, the Board of Supervisors vetted 11 potential initiatives, and selected two projects: chronic homelessness and acute mental illness. For both projects, Third Sector was selected as a consultant to develop the projects.

Graves explained why the county was attracted to Pay For Success:

Our goal as a staff is to focus on outcomes because we are in the business of providing services. And taxpayers have an expectation that their money is being used wisely and effectively. We have a long way to go in developing our expertise around evaluation and really focusing on outcomes. But we are trying to signal to the community that our expectations around outcomes are going to be rising. We are not just going to be giving out contracts and asking for evidence that a contractor provided a service; we need evidence that what they did is working. It doesn’t mean that there are not external forces that have an impact. But if something is not working, people have to be comfortable with the fact that we are going to switch to something else. There is always someone who says, “I can do it better.” And we are going to say, “Okay, but you will have to prove it. Or else your funding will end.”

According to Greta Hansen, this shift toward outcomes was significant: “As with many other governments, we contract with a wide variety of service providers delivering similar services. And the relative effectiveness of one provider versus another in delivering the outcomes is kind of a black box. Pay For Success provided a vehicle to get much greater insight into those questions and also provided the ability to align the incentives of the providers and the county.”

The county wanted to spark innovation, and PFS gave it a new way to do that. According to Hansen, “One of the hallmarks of PFS is for contractors to be accountable for outcomes, but be able to have a lot of flexibility in how they create their program. Overall, the idea of trying something new and innovative and engaging a broader cross section of people and organizations in effective public-sector service delivery is really exciting.”

**“Project Welcome Home”: Santa Clara County’s First Pay for Success Project**

On July 1, 2015, Santa Clara County launched the first PFS project in California. In partnership with Abode Services, a national leader in addressing homelessness, the county was targeting services to 150 to 200 chronically homeless people who were also frequent users of the county’s emergency rooms, hospitals, acute mental health facilities, and jail. Abode was providing this population access to community-based clinical services and permanent supportive housing using
evidence-based Assertive Community Treatment (ACT) and a Housing First approach. ACT was a community-based intensive intervention for individuals with serious mental illness. Dedicated clinical teams provided services on a 24-hour basis in homes and other non-clinical settings. Staff-to-patient ratios were low, and the range of treatments was comprehensive and flexible.⁶ Housing First focused on providing homeless people with housing as quickly as possible without conditions, and then providing services as needed. These services were designed to end participants’ homelessness, increase income, and provide increased access to ongoing physical and behavioral health services.

The homelessness project’s target impact was for more than 80 percent of participants to achieve 12 months of continuous stable tenancy.⁷ County success payments were based on milestones related to the number of months of continuous tenancy, as confirmed by an independent evaluator from the University of California, San Francisco (see Figure 1).

**Figure 1: Success Payments as Determined by Participant Milestones**

<table>
<thead>
<tr>
<th>Success Payment per Participant</th>
<th>Participant Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,242</td>
<td>3 months of continuous tenancy</td>
</tr>
<tr>
<td>$1,863</td>
<td>6 months of continuous tenancy</td>
</tr>
<tr>
<td>$2,484</td>
<td>9 months of continuous tenancy</td>
</tr>
<tr>
<td>$6,831</td>
<td>12 months of continuous tenancy</td>
</tr>
<tr>
<td>$12,240</td>
<td>Cumulative payment through 12 months of continuous tenancy</td>
</tr>
<tr>
<td>$1,035</td>
<td>Each month after the first year of stable tenancy</td>
</tr>
</tbody>
</table>

Source: Santa Clara County.

**Social Innovation Financing for Project Welcome Home**

Through Social Innovation Financing, the county lined up $7 million in funding from Community Development Financial Institutions (CDFIs), foundations, and a corporation’s charitable arm. Abode also invested some of its own resources in the form of a deferred service fee (see Exhibit 2 for the Project Welcome Home capital stack). In addition to providing Abode with working capital to run the homelessness project, these investments shifted the risk from the county to the funders: if the project was not successful, the funders would not get repaid, and the county would not have to spend $7 million of taxpayer money.

Yu noted that the Pay For Success model attracted some investors who might not otherwise have directed their funds to a homelessness project. “For example, The California Endowment is a funder for this project, even though homelessness is not one of its focus issue areas and Santa Clara County is not one of its target geographic areas. However, the endowment is incredibly interested in the idea of Pay For Success transforming governments.”

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(accessed September 30, 2015).

⁷ Third Sector Capital Partners press release.
ACUTE MENTAL HEALTH CARE IN SANTA CLARA COUNTY: FACING THE CHALLENGE

Santa Clara County had a population of 1.8 million people, of whom 100,000 had significant mental illnesses. Treating acute mental health patients was especially challenging and expensive because many were frequent return users of the county’s emergency and inpatient mental health facilities. Of the almost 7,000 patients who used the county’s emergency and inpatient psychiatric facilities annually, over a quarter were readmitted. When patients had a serious mental health crisis episode, they could go to the county’s 24-hour Emergency Psychiatric Services (EPS) at Valley Medical Center, and would often then be admitted to an inpatient facility. They would either go to the adjacent Barbara Arons Pavilion (BAP)—a 48-bed acute inpatient psychiatric unit—or to one of several contract hospitals (see Exhibit 3).

Once patients were ready to leave acute inpatient facilities (when they no longer met the medical criteria for acute care), the county did not have enough space for them in facilities with a lower level of care, including supervised residential placements. Those patients therefore often stayed at BAP for an unnecessarily long length of time on “administrative day status” (or in “administrative beds”) while they were waiting for space to open up in an appropriate place within 60 miles. The change to administrative day status did not affect the nature of care, but social workers put in more effort to find placements for the patients as soon as possible. The result of the high number of administrative status patients was that there were fewer “acute beds” for patients who needed acute care. The county therefore had to send these patients to contract hospitals outside the county system.

This operational efficiency and capacity bottleneck was forcing the county to spend millions of dollars unnecessarily every year. Ironically, administrative beds cost the county nearly twice as much as acute beds because Medi-Cal reimbursed the county much less for them. Hansen explained why this was so: “Medi-Cal says to us, ‘Why do you have this person here who no longer needs to be hospitalized? We’re not going to reimburse you the full rate.’ So for an acute day, the county gets much more significant reimbursement from the state. We have the same cost to keep a person in a bed after they’re no longer acute and go on to this admin status, but we just get less money from the state.”

The county was spending about $16 million a year for EPS, $21.5 million for BAP and $7.6 million for contract hospitals (see Figure 2 for county costs by hour and day).

Figure 2: Mental Health Treatment Costs to Santa Clara County

<table>
<thead>
<tr>
<th></th>
<th>Cost Per Hour</th>
<th>Cost Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Psychiatric Services</td>
<td>$122</td>
<td></td>
</tr>
<tr>
<td>Contract Hospital Bed</td>
<td></td>
<td>$638</td>
</tr>
<tr>
<td>Barbara Arons Pavilion Acute Bed</td>
<td></td>
<td>$1,054</td>
</tr>
<tr>
<td>Barbara Arons Pavilion Admin Bed</td>
<td></td>
<td>$1,900</td>
</tr>
</tbody>
</table>

Source: Santa Clara County.

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8 For fiscal year 2012 – 2013.
Contract hospital beds were cheaper than county beds, partly because the county was focused on treating the sickest patients, some of whom the contract hospitals would not take. Also, the county had a fully unionized public sector workforce, while the contract hospitals had mostly non-unionized employees. But the county saw real value in having its public hospital contain an in-patient psychiatric unit. Hansen said she believed the quality of care was better, and she noted that some of the contract hospitals were not in the county, with the result that patients in crisis would not be near their families. Moreover, she remarked: “We are hemorrhaging money at our in-patient psychiatric facilities. So we have more suffering for the population and incredible cost to the county. We as a county have a really great out-patient mental health system of care, but we don’t have it for this deepest end of this population.”

Margaret Obilor, Senior Program Manager at Santa Clara Valley Behavioral Health Services, explained that the county was struggling to find the right interventions for hard-to-reach clients. The county already had Full Services Partnership programs in the form of “wrap-around” intensive services, as well as step-down programs such as crisis residential services, supplemented residential care facilities, and transitional residential programs, to meet the needs of people receiving mental health treatment:

But we tend to have some clients who we just cannot engage. Our behavioral health system is not exactly set up for preventative care, our outpatient staff members have high caseloads—a few of them are carrying up to 55 to 75 cases. So you have instances where the client requires a lot more individualized intervention and services that we are not able to provide. Our efforts to help clients who are leaving acute psychiatric care is sometimes not enough, and they end up back in the hospital. We want to avoid re-admission to psychiatric hospitals when possible and reduce the length of stay in the hospital by having alternative placements and appropriate outpatient after-care plans once the client no longer requires the inpatient level of care.

According to Hansen, “a really effective out-patient provider with appropriate resources could stabilize those people in the community and have them lead a much better quality of life.”

**SANTA CLARA COUNTY’S MENTAL HEALTH PFS PROJECT**

In December 2014, Santa Clara County released the Request for Proposal (RFP) for its PFS project on mental illness. The target population would include at least 250 severely mentally ill individuals who were exhibiting acute psychiatric/behavioral issues and had been previously admitted to an inpatient facility. The project would be six years long and have the overarching goals of: (1) improving the health and well-being of acutely mentally ill individuals who were frequent users of the county’s emergency and inpatient mental health systems, (2) lowering costs through reduced and more efficient utilization of emergency and inpatient psychiatric services, and (3) conducting a rigorous evaluation of the effectiveness of an intervention. (See Exhibit 4 for project overview and Exhibit 5 for cashable savings targets.)

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9 The exact numbers were still to be determined.
Project Goals and Outcomes

The county wanted to improve the coordination of care for the target population by having them stay in acute in-patient settings for the minimum time necessary. This could be achieved by providing more effective services in a less restrictive environment. The county also wanted to improve the effectiveness of the Medi-Cal coverage for the most costly users. The county was looking to produce at least $5 million in cashable savings by reducing expenditures 1) on bed days purchased from contract psychiatric hospitals, 2) on utilization of Emergency Psychiatric Services (EPS), and 3) on “administrative” beds in the Barbara Arons Pavilion (which Medi-Cal reimbursed at a lower rate than “acute” beds).

Selecting Clients for the Project

An important component of the project’s evaluation and enrollment design would be a referral system. In the contract with the service provider, the county would clearly delineate the criteria for the target population, and the provider would then have to serve anyone the county referred who met those criteria. To maximize the county’s cost savings, the PFS project was designed to address the toughest cases. Hansen noted the potential alignment of incentives: “If the provider is looking to reduce bed days, there is an incentive for them to pick the clients who are most acute. They know that as they move into serving a less acute population, there is only so much they can reduce the utilization of services.” However, there were challenges in identifying the right people within that population. According to Humphreys, “In most health care utilization, if you pick people who have very high utilization one year—for instance, they have double what the average patient has—most of them regress to the mean the following year because you have a mix in that group of people who are having a bad year and people who are having a bad life.”

Clients would not all be chosen at the same time at the beginning of the PFS project. They would enter the program on a rolling basis as the county identified appropriate candidates, and as the contractor was able to open up space for them. As soon as a client enrolled in the program, a new control client would also be enrolled—based on a computer-generated randomization. From a metrics perspective, the rolling enrollment process would keep the measurement process more accurate, since Santa Clara County was continually creating new mental health care projects and improvements.

Measuring Success

The county’s working definition of “success” that would trigger a payment under the project was a significant reduction in visits to Emergency Psychiatric Services and admissions to Barbara Arons Pavilion and/or other contract hospitals for clients enrolled in the program. There would also be metrics related to the well-being of the target client population. The details for both types of metrics were still being worked out.

Humphreys would be designing a randomized control trial (RCT) to measure utilization reductions. “The county has data for utilization of all the mental health services—all of which can be converted to cash. So, there will be a utilization outcome around the aggregate county cost as well as the provider’s ability to keep money from leaving the county.” However, there were still some differences of opinion within the county and among other stakeholders about
how to measure cash savings. For example, many California studies showed that mental health inpatient services correlated with a decrease in incarceration. So, while the PFS project intervention might save the county money by decreasing incarceration, it did not save money in the mental health budget. The question on the table was whether reduced incarceration costs should be counted in the PFS cost savings.

Humphreys emphasized that throughout this process, “You have to protect people. There is an incentive in a utilization-lowering project to shut people off from services. So you have to have protections and look for things like a spike in suicides or people drifting into other counties for services.”

**Measuring Well-being**

The contractor would be mandated to gather information for measuring client well-being. While the success metrics for the project had not yet been decided, the bulk of the measurement data would come from mental health wellness indexes and from clients' answers to wellness questions they were asked when they enrolled in the program, and then again at regular intervals. There were several established mental health wellness indexes, such as the Brief Psychiatric Rating Scale (BPRS), which asked health care professionals to assess the patient’s condition relating to anxiety, emotional withdrawal, guilt feelings, depressive mood, hallucinatory behavior, and disorientation (see Exhibit 6 for the BPRS).

Examples of typical questions the service provider would ask clients included:

- How often do you have depression anxiety? Do you have a purpose in life?
- Do you have friends? Do you have a place to live?
- Can you take care of your food needs?
- Can you engage in daily physical activities? Can you take a walk? Can you go shopping?

In contrast to the utilization measurements, there would not be a control group for the well-being measurements. Hansen explained that PFS projects “start to quickly get out of control on the cost side if you build an evaluation that would, for example, require a neutral person to go in and evaluate the wellness and stability of both the treatment group and the control group.”

Humphreys noted that the lack of a control group made the wellness evaluation inherently weaker than the utilization evaluation:

> It is a case where you’re making the design weaker, because to make it better you would spend a third of your service budget on evaluation. So this is evaluation on the cheap. And what that means is there will be no strong test of well-being benefits because there is no way to get well-being data on the controls. You would have to track the controls in the community, which means they have to give consent and then you have to hire researchers to find them and re-interview them and say, ask them questions such as, “Do you have fewer symptoms? Is your quality of life better?” All that is difficult and expensive.

Humphreys said an alternative to having a control group would be for the service provider to compare how patients in the program did over time. “There’s no protection against regression to the mean, and there are possible reporting biases—so there are a lot of problems with that. But
that’s what you can do with a very small amount of money. And you could at least make sure people aren’t eroding. You can also measure things like deaths and incarceration—those things that suggest disaster.” There were other complications that came up with measuring client well-being. For example, how would the project evaluation handle replacements if one of the people in the study moved out of the area or died? Mortality rates were higher for the target population than for the general population.

**Challenges**

Humphreys explained that for all PFS projects, there were challenges in finding and utilizing the right metrics. For one, there were fundamental limitations to administrative data:

> It is maintained by public systems, which are there to help run a system. They are not necessarily there to evaluate the system. So, relative to something you would gather yourself, you have less control and you know less about the validity of the data. You can’t run as many checks as you would like to. I can’t assign an extra judge to double diagnose everybody and make sure that it is right. And people have other demands on them. So I am not necessarily at the front of the line.

He added that PFS programs have negotiating partners with strong interests in the evaluation design. “You have to keep the integrity of the evaluation, but at the same time not irritate people. Because if the contractor feels that this is too tough then they won’t play. And if the investors feel that there is too high a standard for them to get their money, they won’t play.”

**Telecare Corporation: Lead Agency/Service Provider**

Telecare, based in nearby Alameda County, specialized in services and support for individuals with serious mental health illness and complex needs. It was founded in 1965 by a psychiatrist, a psychiatric nurse, and a businessman, a team that believed that individuals experiencing mental illness could achieve better results when they received customized services that were provided in a home-like setting. By 2015 the for-profit corporation was one of the nation’s most experienced providers of adult community behavioral health services, with 2,800 employees offering 85 programs in nine states. It had a diversified annual revenue base of more than $200 million. Family and employee owned, Telecare served over 29,000 people a year. It had collaborated with both public and private entities for service delivery, and its spectrum of services spanned early intervention to acute inpatient care. It also provided specialized services to individuals who faced challenges in addition to their mental illness, including chronic health problems, substance abuse disorders, and homelessness. Telecare was firmly rooted in the Assertive Community Treatment method (which, as described earlier, was also being used in Santa Clara County’s homelessness project’s intervention).

Calling it a conservative estimate, Telecare proposed a 34.5 percent reduction in BAP administration days and in contract hospital days, and a 51 percent reduction in EPS hours. These reductions would come from a combination of reducing the length of stay and averting admissions. Telecare Senior Vice President for Development Faith Riche said her organization responded to many RFPs every year, but Santa Clara County’s Pay For Success project was by far the most exciting:
There is a potential to really contribute to our field through Pay For Success. Mental health doesn’t have the same type of crisp outcomes as other fields. It still has a lot of stigma. Many people don’t believe that it is a brain disease; they think it is due to bad decision-making, bad morals, or a bad upbringing, etc. So we want to do anything we can to show that when people are treated, they get better. Pay For Success is also a chance to have measurable outcomes that might inspire more philanthropy and more private investment in our field. So, we were attracted to the financing of Pay For Success, the formal evaluation, and the potential to do more communication about the field and what the service interventions are.

The county viewed Telecare as a strong partner that fit its criteria. Telecare had a track record of creating strong programs and had vast experience with successfully scaling new programs in new geographies. It had an established infrastructure for tracking outcomes and had a director of program evaluation on staff, demonstrating the organization’s commitment to results. Telecare had a pragmatic approach to negotiations for a “blank slate” contract (as opposed to the standard boiler-plate contract) and had the organizational dexterity to respond to due diligence and fundraising requirements from private institutions and foundations. Hansen said Telecare’s clinical model for this project was a cut above other providers: a strong clinical design and the ability to dedicate on-site support and experienced staff, along with wrap-around 24/7 services for patients.

There were three bidders for the county’s PFS project. Telecare had not operated in any significant way in the county, and it was the only for-profit bidder. County executives were mindful of the optics and potential objections about passing over nonprofit organizations. But Graves, Hansen, and the county’s Mental Health Department leadership were convinced that Telecare’s capabilities were far above those of the other bidders. Telecare’s Richie said that the corporation always disclosed its profits, which were typically around four percent. Through the PFS process, Richie said she discovered that potential investors in the PFS project were seeing Telecare’s for-profit status as a plus.

From a cost standpoint, Hansen pointed out that “Telecare is a big corporation that is running leanly, but it’s a big machine to support. The concept was that because they are so clinically strong and have so much experience, they would be able to have enough impact to offset the comparatively high cost of their program. So balancing those two is really how we were analyzing how fiscally sound they would be for our Pay For Success Project.”

**Telecare’s Intervention Design For Santa Clara County**

To serve the target population, Telecare’s wrap-around care would consist of four multi-disciplinary field-based teams (including psychiatrists and social workers), each serving 60 to 65 clients. The teams would be available 24/7, and would address pre-crisis and crisis situations that might otherwise lead to ER and hospital usage. Richie said with Telecare’s model, her staff huddled together every morning to figure out the best way to get patients services in their community. “Our staff have very low caseloads, so the people [we are helping] get a lot of contact and support. These are folks that need a lot of contact. Maybe in the middle of the night
they are really afraid and in crisis. We don’t want them going to the ER. We want them calling us, and we will immediately go out and be with them.”

Telecare would also provide staff-supported crisis apartments for clients, addressing the needs of patients diverted from the ER and hospitals when possible, and providing a hospital step-down program to safely reduce the length of stay for clients in in-patient facilities. In addition, Telecare would provide or facilitate access to housing or alternative living situations, community and peer support programs, and staff psychiatrists to provide care in coordination with county doctors. Richie described the intervention as “Assertive Community Treatment +” or “Assertive Community Treatment on steroids.”

She explained that for much of the mental health system, patients in crisis had to make an appointment with a doctor, get a referral, and locate and get transportation to a different health provider—essentially doing their own navigating of the system while they were in crisis.

With wrap-around services we help people with that navigation. And we provide most of our services in the community. So if they are homeless, we will go find them under the bridge. If they don’t feel safe going to a doctor’s office, we will go with them and help them advocate for themselves and help them articulate their questions and concerns. We will make sure they have housing, help them reconnect with their family, and help them get a job or potentially go back to school. So we are really supporting them in all aspects of their lives. But obviously you have to be respectful, because they are still adults and can make their own decisions, but we support them.

Obilor said much of what Telecare presented in their RFP proposal was what the country was really looking for. “We have other outpatient providers in the system, but Telecare presented a lot of strategies, interventions, and housing options that I felt were innovative and different from what we currently have in the system. We can use their expertise, and we would like to use this model to see if we can develop some more preventive housing options for our clients rather than placing them in shelters.”

County COO Graves noted that for Telecare, as with any PFS service provider, it was the organization’s responsibility to figure out how to be successful:

The goal is to say to the provider, “We are not going to tell you what to do. It is up to you to be successful and meet the metrics that we set.” So their sole focus is to meet those metrics because that is what will allow them to get paid. And in designing this program for mental health, we need to make sure it is an appropriate service, but we are confident because Telecare has a good reputation and has done good things. But it is really about “is this treatment going to be that much more effective?” Because we are going to try to set the bar higher.

While Telecare was excited about being part of the PFS project, Richie said there was still a lot of work to do. Telecare had to review and vet its large amount of existing outcome data to determine how much was third-party validated. She said that in the mental health field there were very few randomized control trials (RCTs). “We have participated in one, but now we are
raising the bar on our outcome data, and it is making us think about what data to collect and how to ensure its validity so that it will withstand the scrutiny of an investor.”

An area of concern and risk for Telecare was the unusually long project build; it was nine months as opposed to the 90 days Telecare was used to. Richie called the nine-month time frame “unbelievable”:

> It was kind of a shock to us. We just are not accustomed to that level of process. I think that it is fine because it is the first one of its kind in the country, but for this work to be sustainable, we are all going to have to learn and teach each other how to become more efficient with that. You can’t spend that kind of time bringing up programs. That is not our normal way at all. We are doing a fair amount of pro-bono investment during this process, but we think it is worth it.

The long build out time was also a risk for Telecare because the county was introducing other innovative programs in the mental health field. If the county improved its system, then the control group would get new services. That meant the delta between the target group being served in the PFS project and the control group would narrow. Because of that, Richie wondered whether a RCT would really work. There were reputation risks as well. If Telecare did not perform well in this high profile, high stakes effort, it could damage its reputation and make it harder to secure future contracts. She also noted that since this was the first PFS in mental health, it was yet to be seen if investors would be interested. “I think the cashable savings are pretty clear. So I think it will work, but it is untested.”

**PAY FOR SUCCESS / SOCIAL INNOVATION FINANCING RISKS**

PFS/SIF projects arguably had greater execution risks than traditional projects because of the complexity of the contracts and collaboration requirements. There might be unclear lines of authority, poor communication among multiple participants, lack of follow-through by one or more partners, or failure to capture timely and reliable data on progress. There were also reputational risks for the service provider, the government, the intermediary, and the PFS/SIF movement itself if the project did not achieve its goals, pay back funders, or worse, if it adversely affected the target population. As mentioned earlier, there was a particular danger that if PFS payments were based exclusively on government cost savings, service providers could save costs at the expense of clients—for example, by providing inadequate services or directing clients away from using their services.

Another danger was that a service provider could game the system by cherry picking, or “creaming,” its clients to show higher levels of success. If the government did not tightly control the randomization of the target population and the control group, the service provider could, for example, tell somebody who is extremely difficult to treat that there was no space in the program and then try to place that person into the control group. Humphreys explained how this could work:

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If you have any influence over the consent process, you can subtly guide people by saying, “You don’t really want to be in this study, do you?” or “You really want to be in this study.” And some contractors try to build some creaming into the design. You could imagine a contractor saying, “We do not serve people who have drug addiction.” But that is a population that is going to cycle a lot through mental health. And it would be my job, as the project evaluator, to stop the contractor from doing that.

There were also risks of contamination of data—which was most likely to come from the staff of the service provider. Humphreys said sometimes they do it out of compassion. “And so you get the reverse creaming, where they say ‘Boy, this person is really badly off. Let’s make sure they get into the experimental condition because this is an exciting new service.’” Other PFS studies showed that if staff had negative feelings toward people they perceived as outsiders running the project, they might make choices that undermined it.”

Social scientist Donald Campbell warned about the potential risks of relying too much on quantitative indicators in 1976 when he coined Campbell’s Law: “The more any quantitative social indicator is used for social decision making, the more subject it will be to corruption pressures and the more apt is will be to distort and corrupt the social processes it is intended to monitor.” Humphreys quoted W.C. Fields’ adage that “If a thing’s worth winning, it’s worth cheating for.”

**Pay For Success / Social Innovation Financing Detractors**

A common argument against PFS/SIF projects was that Social Innovation Financing gave too much power and influence to private funders—both over the projects chosen and over the lives of the vulnerable people being served. Detractors believed that the state should be paying for all these services, and that they should be guaranteed as a right. The fear was that unelected and unappointed people with financial resources would choose projects based on their whims and interests—rather than projects that best aligned with residents’ needs. Thus, private capital might have undue influence over how governments decide which programs to pursue. Another concern about Social Innovation Financing was that it could be used politically as an excuse to privatize public services—granted that the intention for most SIF projects was to complement government spending, not replace or reallocate it.

Reimbursement of commercial investors usually included interest payments, so it could be argued that these investors were making a profit from helping vulnerable people. Detractors questioned how much of a return on investment PFS/SIF lenders should get. While it was true that they took on greater risks, the five percent return demanded by some lenders exceeded the return from tax-exempt bonds used to finance some government projects. The capital stack structure was also the focus of criticism, since investments by commercial lenders, who had the greatest upside potential, were undergirded by philanthropic foundations, which took on the riskier positions to attract the commercial lenders.

One of the struggles governments were having with some commercial institutions was that they were quite risk averse, but still expected a five percent base return. For example, during
negotiations with Santa Clara County, one potential commercial funder for a PFS project pressed for a lower threshold of success in order to lower its financial risk. Hansen explained the reasons she saw for this, “For commercial investors, these are not philanthropic dollars, where they might have more leeway; this is their investment dollars and they want to minimize risk and maximize return. But it does raise a question for us. When you have a fiscally strong county like ours, with a $4 billion annual budget, does it makes sense to pay investors five percent if they are not actually absorbing much risk?”

Another concern was that smaller service providers would have a harder time being accepted as a PFS provider because they did not have the necessary upfront working capital for the preparation, contracts, legal requirements, etc., involved in a PFS project. Hansen said that to the extent the county moved to a PFS model:

There will be a concentration of service providers who can actually be a partner in constructing these big complicated projects. We have certain service providers who specialize in serving particular ethnic communities, for example, and if we wanted to go to performance-based contracting we probably would not have as many small one-off contracts because we could not do an evaluation for a cohort of 50 patients who received a specialized service.

Yet another concern about PFS/SIF was that “many social interventions simply defy the kind of impact measurement and linkage to financial savings that the PFS structure demands.” Some argued that focusing PFS projects on established providers meant directing funds toward projects that were known to work rather than risking capital to explore potential new ideas and new nonprofit entrants.

**POST PAY FOR SUCCESS**

A question on the minds of many people involved in Pay For Success projects was what would happen after the project ended. Graves said about the mental health project, “Once we evaluate it, if it is successful, then how do we scale it? How do we treat 750 people and not 250?” Graves added that looking down the road, the county had to be prepared to say that if the mental health project worked, it would become just a regular county program:

At the end of six years, we then say, “Hey, this is a great way to go. This becomes part of how we do business.” The goal is to say, “We’ve tested it. The investors took on the risk. Now we have all this data, and we can confidently move forward and expand to the point where we feel like we are capturing the people who are demanding the service, and no one gets turned away.”

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**NEXT STEPS FOR SANTA CLARA COUNTY: ATTRACT INVESTORS**

One major next step involved attracting commercial and foundation investors. The county had to decide which type of investors to court and how it wanted to structure the deal. For example, what balance did it want to strike between commercial investors and foundations, and what return on investment did it want to offer commercial investors?

One possible barrier to attracting commercial investors was the recent experience with a PFS/SIF program at Rikers Island in New York. In July 2015, the first PFS/SIF in the United States, a project aimed at reducing recidivism, shut down after three years because it failed to meet its targets. Goldman Sachs was the senior lender, providing $7.2 million in working capital—backed by a $6 million guarantee by Bloomberg Philanthropies. When the independent evaluator determined the program had failed, the city ended the project, and did not have to pay for the amount the project had cost up to that point. (See Appendix C for details on the PFS project.) While the project had failed, it also was an example of how a city could shift its risk from taxpayers to non-governmental funders. At the time, Andrea Phillips, vice president in the Goldman Sachs Urban Investment Group, said, “We continue to be enthusiastic about using capital this way.” However, the very public failure of the country’s first PFS project raised the question of whether commercial institutions would continue to participate in Social Innovation Financing, or if foundations and other philanthropic organizations would end up being the main funders.

**CONCLUSION**

Santa Clara County’s mental health PFS project was set to launch in September 2016, following a six-month ramp-up period that would be under a traditional fee for service contract with Telecare. With so many unknowns, all the players had their work cut out for them to get the program ready for the ramp-up period. The county had learned from its homelessness PFS project, as well as from the other PFS projects around the world that had come before it. “One of the things we are committed to,” said Graves, “is understanding how things evolve. And we are not going to be afraid to make changes.”

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Exhibit 1
Pay For Success (PFS) and Social Innovation Financing (SIF) Overview:
Flow of Funds and Services

Source: Third Sector Capital Partners.
Exhibit 2
Figure 1: Capital Stack for Santa Clara County’s “Project Welcome Home” Pay For Success (PFS) and Social Innovation Financing (SIF)

$6.9 mm SIF Financing (to be repaid with up to $8.0 mm success payments):

- **$1.0 million in 5% “impact loans”**
  - $0.5 mm: The Reinvestment Fund (TRF)
  - $0.5 mm: Corporation for Supportive Housing (CSH)

- **$2.5 million in 2% PRI-type loans**
  - $1.5 mm: The Sobrato Family Foundation
  - $1.0 mm: The California Endowment

- **$1.3 million in 0% interest PRI-type loans**
  - $1.0 mm: The Health Trust
  - $0.3 mm: The James Irvine Foundation

- **$1.6 million in recyclable grant investments**
  - $1.1 mm: The Laura and John Arnold Foundation
  - $0.5 mm: Google.org

- **$0.5 million in Deferred Service Fees:**
  - $0.5 mm: Abode Services

100% of principal at risk: no backstop or credit enhancement

Diverse funding base designed for future replicability

Opportunity for grants to be recycled for use in other projects

Service provider has “skin in the game”

Source: Third Sector Capital Partners.
Exhibit 3
Acute Mental Health in Santa Clara County: Continuum of Care

IMD = Institutions for Mental Disease
SNF = Skilled Nursing Facilities

Source: Third Sector Capital Partners.
## Exhibit 4
### Acute Mental Health Project Overview

<table>
<thead>
<tr>
<th>Project Overview</th>
<th>Project Success Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Population</strong></td>
<td><strong>Project Budget</strong></td>
</tr>
<tr>
<td>• 250+ severely mentally ill adults who have been treated in the County’s emergency and inpatient Mental Health facilities</td>
<td>Based on cost savings achieved by reducing County expenditures on/by:</td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td>• Reducing the need to purchase beds from non-County inpatient psychiatric hospitals</td>
</tr>
<tr>
<td>• Improve health and wellbeing of acutely mentally ill individuals while reducing costs</td>
<td>• Reducing utilization of the County’s psychiatric emergency room</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td>• Ensuring clients can be discharged from the County’s inpatient mental health facility as soon as possible</td>
</tr>
<tr>
<td>• Evidence-based interventions and best practices for treating the acute mental health population</td>
<td><strong>Success Payments</strong></td>
</tr>
<tr>
<td><strong>Timing</strong></td>
<td>• Avoided utilization of emergency and inpatient mental health services for clients in the program</td>
</tr>
<tr>
<td>• 6 year project</td>
<td><strong>Evaluation</strong></td>
</tr>
<tr>
<td><strong>Unique Characteristics</strong></td>
<td><strong>Evaluator:</strong> Stanford School of Medicine Dept. of Psychiatry (K. Humphreys)</td>
</tr>
<tr>
<td>• First Mental Health PFS project</td>
<td><strong>Evaluation Design:</strong> Randomized controlled trial to assess efficacy of project in reducing costs and improving well-being target population</td>
</tr>
</tbody>
</table>

Source: Third Sector Capital Partners.
Exhibit 5
Targets for Cashable Savings

System of Savings

1. Reduce BAP Utilization
   Acute: ($1,054/day)
   Admin: ($1,900/day)

2. Fill Unused Admin Beds with Acute Bed Use
   Admin-Acute: ($846/day)

3. Fill Unused BAP beds Instead of Purchasing Contract Hospitals Beds

1. Reduce EPS Utilization ($122/hr)

1. Reduce CH Utilization ($638/day)

Reduce Overall System Utilization
Increase Revenue Efficiency within BAP
Avoid Diversion of Clients to Contract Hospitals

Source: Third Sector Capital Partners.
Exhibit 6

Brief Psychiatric Rating Scale (BPRS)

**BRIEF PSYCHIATRIC RATING SCALE (BPRS)**

<table>
<thead>
<tr>
<th>Score</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Somatic Concern</td>
</tr>
<tr>
<td>2.</td>
<td>Anxiety</td>
</tr>
<tr>
<td>3.</td>
<td>Emotional Withdrawal</td>
</tr>
<tr>
<td>5.</td>
<td>Guilt Feelings</td>
</tr>
<tr>
<td>6.</td>
<td>Tension</td>
</tr>
<tr>
<td>7.</td>
<td>Mannerisms and Posturing</td>
</tr>
<tr>
<td>8.</td>
<td>Grandiosity</td>
</tr>
<tr>
<td>10.</td>
<td>Hostility</td>
</tr>
<tr>
<td>11.</td>
<td>Suspiciousness</td>
</tr>
<tr>
<td>13.</td>
<td>Motor Retardation</td>
</tr>
<tr>
<td>15.</td>
<td>Unusual Thought Content</td>
</tr>
<tr>
<td>16.</td>
<td>Blunted Affect</td>
</tr>
<tr>
<td>17.</td>
<td>Excitement</td>
</tr>
<tr>
<td>18.</td>
<td>Disorientation</td>
</tr>
</tbody>
</table>
Appendix A
Pay For Success and Social Innovation Financing:
Key Players, Process and Capital Stacks

Key Players

1. Government
A government entity initiates the Pay For Success (PFS) contract, manages the project (usually with the assistance of a third-party consultant) and is the end payer for successful outcomes. (Santa Clara County is the government entity in the Mental Health PFS Project)

2. Lead Agency/ Service Provider
The Lead Agency delivers the services and receives modest profits plus potentially additional financial rewards based on the success of the project. (Telecare)

3. Funders
The funders provide working capital to the lead agency/service providers. Funders are re-paid by the government if the project meets agreed-upon targets, or they may lose capital if the project is unsuccessful. Examples of funders are retail banks, investment banks, community foundations, family foundations, and high-net worth individuals. (Funders had not yet been determined for the Santa Clara County Mental Health PFS Project)

4. Evaluator
The evaluator supports rigorous evaluation design and measures progress towards outcomes based on contract requirements. (Keith Humphreys, professor of psychiatry and behavioral sciences at Stanford School of Medicine)

5. Consultant/Technical Advisor to the County
A third-party consultant/technical advisor to the government entity plays a variety of roles, including conducting an overall landscape analysis of possible PFS projects, assisting the County with drafting the RFP, selecting the provider, collaborating with the parties on intervention design, developing a financial model for the project, leading efforts to raise funding for SIF, leading negotiations among PFS stakeholders, and generally managing the project. (Third Sector Capital Partners)
Process

There are five main steps of the PFS/SIF Process:

1. Construct the PFS: The government entity constructs the PFS contract with all project stakeholders; the Lead Agency/Service Provider designs the intervention; the Evaluator creates an evaluation plan for the project; and the Funders and Government negotiate funding terms.

2. Through loans or grants from commercial investors, foundations, or high net-worth individuals, Funders provide upfront financing to provide payment for services to the Lead Agency.

3. The Lead Agency delivers services to the target population.

4. The Evaluator measures success outcomes and determines total success payments due.

5. The Funders are repaid by the Lead Agency or Government based on the successful outcomes of the program.

Social Innovation Financing Capital Stacks

Each PFS/SIF project had its own, bespoke capital stack for Social Innovation Financing. Typical capital stacks include:

- **A market-rate senior loan**
  - Commercial investor
  - Five percent interest rate (paid quarterly after proof of success)
  - 100 percent of principal at risk
  - Re-paid first from government Success Payments

- **Junior below-interest loans**
  - Two percent interest rate (paid quarterly after proof of success)
  - Repaid after senior loan

- **Grants or zero percent loans**
  - Foundations or individual donors
  - Not repaid, but success returns may be repurposed for other PFS projects

- **Deferred Service Fees for Service Provider and Consultants**
  - Puts these parties’ “skin in the game”
Appendix B

PFS Case Study: Recidivism Reduction in Massachusetts

The fourth and largest PFS in the country, launched in Massachusetts in early 2014, was a $27 million, seven-year initiative designed to improve the lives of at-risk young people, reduce crime, promote safer and stronger communities, and save taxpayer dollars. Massachusetts chose the non-profit organization Roca, based in Chelsea, as the service provider. Roca was providing high-impact intervention to 929 at-risk young men aged 17 to 23 who were in the probation system or were exiting the juvenile justice system. Roca’s programming aimed to reduce recidivism and increase employment through intensive street outreach and targeted life skills, education and employment training. The Roca intervention was being delivered over an intensive two-year period followed by two years of follow-up engagement. Massachusetts would make up to $27 million in success payments based on decreases in incarceration, increases in job readiness, and increases in employment. The target impact was a 40 percent decrease in days of incarceration, with Massachusetts capturing all savings after a 40 percent reduction in recidivism. Success was measured through an independently conducted randomized control trial confirmed by a validator.

Social Innovation Financing brought in $18 million in upfront financing. The rest of the financing for success payments came from grants from the federal and state governments.

Capital Stack for Massachusetts Juvenile Justice Initiative

Source: Third Sector Capital Partners.
Massachusetts Juvenile Justice PFS Initiative Deal Structure

Source: Third Sector Capital Partners.
Appendix C
PFS Case Study
“Adolescent Behavioral Learning Experience Project for Incarcerated Youth”

In July 2015, the first PFS/SIF projects in the United States, aimed at reducing recidivism, shut down because it failed to meet its targets. Launched in 2012, the New York City “Adolescent Behavioral Learning Experience (ABLE) Project for Incarcerated Youth” was a large-scale initiative serving 16- to 18-year old youth detained at Rikers Island, a New York City jail. Service provider Osborne Association carried out the intervention, in which 1,500 teenagers in that age range participated in a course of cognitive behavioral therapy. Although 750 of these youths reached positive outcomes as defined by the terms of the program, the intervention failed to have a statistically significant impact on recidivism numbers compared to the status quo. Goldman Sachs was the senior lender, providing $7.2 million in working capital—backed by a $6 million guarantee by Bloomberg Philanthropies. The outcome that would have triggered success payments from New York City was a 10 percent reduction in recidivism, which would have allowed the city to save money by closing down a section of the jail. Goldman’s returns would have risen if outcomes exceeded 10 percent, and the city would have kept a share of the savings.

Factors that had a negative impact on the efficacy of the program included: the loss of a clear control group when teenagers from the control group took part in the therapy sessions; and the exit of the city’s Education Department, which was supposed to support the program by having teachers participate in the intervention. Osborne Association’s budget was also cut when Rikers’ teenage population unexpectedly fell below the numbers laid out in the PFS contract, hampering Osborne’s efforts. When the independent evaluator determined the program had failed, the city ended the project, and did not pay for the amount the project had cost up to that point.

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