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Executive Summary

Asthma is a chronic condition with a high burden in terms of cost and societal impact. The evidence [source: Centers for Disease Control and Prevention (CDC)] is staggering: Over 25 million Americans suffer from asthma, including 7 million children (1 in 11). Asthma costs nationwide are \$56 billion annually (\$50.1 billion in medical costs and \$5.9 billion in lost productivity). A factor critical to managing asthma included in CDC recommended guidelines for care is control of home environmental factors. According to the Robert Wood Johnson Foundation, 40% of all incidents of asthma are attributable to home-based environmental health hazards, but currently no federal healthcare programs provide resources to address them, making it an ideal opportunity for transformational impact through Pay For Success (PFS). The Green & Healthy Homes Initiative (GHHI), with a twenty year history in asthma reduction, improving home health and providing technical assistance seeks funding to conduct an open and transparent competition to educate and provide technical assistance (TA) to healthcare organizations (including integrated delivery networks, academic medical centers, and Medicaid managed care organizations) and nonprofit service providers to assess the feasibility of initiating, structuring, closing and managing five asthma-related PFS projects. One health care entity and one service provider will be selected per site, for a total of ten project sub-recipients.

The US Department of Health and Human Services Community Guide to Preventive Services finds that home-based interventions combining environmental remediation and resident education provide excellent value for the money invested, based on savings from averted costs of asthma care and improvement in productivity. Cost-benefit studies show a return of \$5.30 to \$14.0 for each dollar invested. The calculation of avoidable asthma-related costs generated from remediating home-based triggers is straightforward and generates such significant savings that it has potential to fundamentally transform asthma care in the United States. In recent evaluations, GHHI's home interventions (e.g. mold remediation, integrated pest management, air quality improvement) have been shown to reduce asthma episodes by 67%, asthma-related hospitalizations by 60%, and asthma-related emergency department visits by 25% post intervention. These outcomes led to the strategic partnering of GHHI, the Calvert Foundation (Calvert), and Johns Hopkins Hospital and Healthcare Systems (Hopkins), who together have made great progress in 2014 advancing an asthma-focused PFS project in Baltimore, Maryland. The GHHI/Calvert/Hopkins PFS provides a replicable model for the feasibility and TA work to be done under this funding. Calvert is the sole investor infusing \$10 million into the project (and will receive a return). GHHI is serving as the service provider and intends

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to deliver its proven, evidence-based housing intervention and resident education services. Hopkins, serving as the private payor, is projected to accrue \$15 million in savings through reduced emergency room visits, hospitalizations and doctor visits for patients of The Johns Hopkins Hospital and Priority Partners (Johns Hopkins; Medicaid Managed Care Organization). The PFS project is utilizing Milliman (a leading actuarial firm) projections, which anticipate GHHI interventions saving \$8359.58 per patient in three years. The PFS will target super utilizer (high cost burden) asthma patients. CDC cites that 20% of asthma patients make up 80% of the asthma medical costs.

GHHI and Calvert (The Project Team) are applying to CNCS SIF PFS to assess the feasibility of five cities or counties constructing similar asthma PFS projects. The Project Team had substantial, promising, in-person conversations with numerous stakeholders who have shown interest in this model: 1.) cities, counties and states; 2.) service providers nationally that operate the GHHI intervention model; and 3.) healthcare organizations (hospitals and insurers) that serve asthma-diagnosed, high medical utilizer patients. The business models of our target payor/medical institutions mirror Hopkins closely (by the fact that they have incentives to reduce hospital or emergency room volume, associated manage care organization costs and a vested interest in the health of local communities), which leads to reasonable assumption that that our PFS model demonstrating promise in Baltimore is replicable elsewhere. Over the past year, the Project Team has diligently worked through the feasibility activities in Baltimore, making the team uniquely qualified to provide TA to and build capacity for PFS in other jurisdictions. Savings to relevant government entities such as Medicaid programs will also be analyzed, in order to establish evidence and promote asthma PFS projects with a government payor. While our proposed PFS targets asthma-related healthcare cost reductions, our proposed housing intervention yields significant multiple-sector outcomes outside of the healthcare industry (e.g., education sector, energy sector) that we will measure as a core component of these PFS feasibility projects so that, as a result, these sectors; leaders will have the capacity to launch future, similar investment opportunities.

The GHHI/Calvert team brings deep, synergistic health, housing, and investment expertise to this project and demonstrated experience with PFS. GHHI is an evidence-based, national 501(c)3 direct service provider and technical assistance provider. GHHI combines health and energy housing interventions to improve outcomes for low-income families, and reduce public and private costs to the healthcare and energy production sectors. GHHI professionals bring substantial experience providing TA to sub-recipients on complex issues involving housing and health, and the organization has a proven track record of innovation; impact evidence; conducting open, competitive grant competitions;

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assisting sub-recipients with capacity building through training and technical assistance; financial management; project management and knowledge sharing. Calvert is a 501(c)3 impact investment firm and registered Community Development Financial Institution (CDFI) that connects individual, retail investors with organizations working to improve health, develop affordable housing, create jobs and protect the environment. Calvert plays a critical role on this project by conducting investor outreach, syndication and education within selected communities and by providing financial modeling TA services to the selected healthcare organizations and nonprofit service providers.

Program Design

GHHI and Calvert will work with five private payors (health care entities) and five service providers to assess the feasibility of and build capacity for asthma PFS projects while engaging public officials so that the PFS work yields the necessary evidence for the government to explore similar healthcare PFS projects.

Theory of Change: Our Theory of Change is two-fold. First, each PFS project, based on a strong body of current research evidence, has solid potential to: 1.) dramatically improve the health and safety of families living in low-income households; 2.) drive down public and private health care costs by shifting focus from treatment to prevention, to create savings to pay back the investors at acceptable returns; 3.) enhance the reach and impact of innovative, healthcare solutions that have evidence of improving the lives of low-income families; 4.) improve our collective understanding of ¿which fields of practice and under what conditions¿ PFS strategies can scale evidence-based practices, drive better outcomes and achieve greater cost efficiency; and 5.) engage the healthcare industry in PFS models during a time when many in this industry are transforming business and payment models towards preventative solutions.

Secondly, as it relates to the proposed housing intervention model, our Theory of Change is: 1.) measurable health (and energy, education) outcomes and cost savings are realized by combining in-home family health education with integrated housing interventions that leverage all available housing intervention resources; 2.) GHHI¿s proven model delivers positive outcomes and is scalable nationally through replication and systems change; and 3.) impact evidence will compel significant future investment nationally.

Project Objectives: The objectives are: 1.) prepare five asthma-focused PFS projects that can, once completed, quickly move to the Structure Transaction Phase and close; 2.) create the opportunity to produce thousands of new healthy, safe and energy efficient homes across five communities, improve health, economic and social outcomes for the families served and reduce preventable childhood

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asthma-related emergency room visits, hospitalizations, physicians visits and prescriptions; 3.) show the effectiveness of home-based interventions to improve health outcomes and reduce healthcare costs at scale AND show the direct connection between home-based interventions and the secondary benefits not included in the financial model (e.g., reductions in school absenteeism, missed work days and home energy bills) which will pave the way for similar PFS projects with both public and private payors; 4.) identify, assess and craft solutions to address the barriers (e.g., organizational, programmatic, budgetary/financial, legal/regulatory, and procurement) that could prevent efficient PFS projects like ours to advance; 5.) increase awareness of PFS opportunities within the healthcare sector; 6.) contribute significantly to the SIF Knowledge Initiative.

Target: The primary social issue that our PFS addresses is reducing preventable asthma-related emergency room visits, hospitalizations, doctor visits and prescriptions. Our PFS model fits squarely into the Healthy Futures Focus Area/Funding Priorities in that our intervention promotes healthy lifestyles (through family health education) and dramatically reduces the risk factors (home-based asthma triggers) that lead to serious, and costly, illness (severe asthma).

Since 40% of asthma episodes are due to preventable environmental asthma triggers in the home, unhealthy homes are the source of 2,750,000 asthma related emergency room visits annually. We are open to conducting these projects anywhere in the US where asthma incidents and costs are high and growing.

Outcomes: Our proposed asthma-focused PFS Model primarily seeks to create the following outcomes (i.e., these are in the financial model that produce the savings to the payor): 1.) reduced emergency room visits due to asthma; 2.) reduced hospitalizations due to asthma; 3.) reduced prescriptions and professional medical services due to asthma. However, our proposed housing intervention model also yields a compelling, secondary set of multi-sector outcomes that will be measured as part of each asthma-focused PFS project to add to the existing body of impact evidence in this growing Healthy Homes Industry. Some of these additional, cross-sector impact outcomes include: energy consumption reduction and reduced carbon footprints, household energy bill reduction, school absenteeism reduction (asthma is the most common reason for school absenteeism), increased worker productivity (parents miss work days taking kids for asthma care), increased local wages (our intervention model cross-trains workers across multiple trade sectors for higher-paying „green“ jobs), neighborhood stabilization, public program delivery efficiency gains (our proposed intervention model allows public agencies to produce more with flat budgets), and other health savings (e.g., childhood lead poisoning). As part of each PFS project, we propose to engage the government officials who could

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save as a result of the project (e.g., state health officials, school district officials, mayors, governors), educate them on the PFS project, secure their commitment to play a role in providing data, measure their own savings (as if they were the formal payor), and addressing policy, funding structures, legal and procurement issues that would prevent future PFS projects from moving forward.

Increasing PFS Awareness: The Team will release the RFP for sub-recipients to a broad set of healthcare organizations in order to achieve two objectives. The first objective is to expand the pool of applicants. GHHI will purchase a list of applicable healthcare organizations (there are more than 5,000 target organizations) to ensure that we reach/educate a broad set of this target audience. The second objective is to educate healthcare organizations on the fundamentals and promise of healthcare PFS projects. We will hold a series of educational webinars for applicants and for those who simply want to learn more.

Because we will design the collection of secondary outcomes evidence in partnership with state Medicaid offices, school districts, and municipal agencies (energy, housing, health), we will engage with these parties during the project in an active learning network to build capacity and understand the potential savings projected from the future transactions. Further, we will leverage GHHI's more than 20 years of experience accumulating and propagating best practices among members of our national, healthy homes network.

Because we are proposing to work on five very similar PFS projects, we hope to prove the replicability of asthma-related PFS projects. Given the scale of the asthma problem in the US, our intent is to lay the groundwork for future asthma-related PFS projects that involve an array of government payors (e.g., state Medicaid offices, school districts, municipal agencies) and create a templated process that can be readily used in locales throughout the country and which will dramatically decrease the often lengthy PFS developmental periods.

Provision of Technical Assistance Services

Sub-Recipient Selection: GHHI will design and launch an open and transparent competitive process to select five healthcare organizations (i.e., Integrated Delivery Networks, Academic Research Centers, Managed Medicaid Organizations and Hospitals) who wish to serve as a private payor in an asthma-focused PFS project in their community. GHHI will draft and release an RFP through an online procurement management system, which will enable broad marketing and efficient management of the process from design through release through selection.

The RFP will clearly define the PFS structure, this specific asthma-focused PFS opportunity and the

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proposed role and responsibilities for the healthcare organization applicant. To increase reach, we will purchase a list of procurement officers, chief financial officers and chief innovation officers at Integrated Delivery Networks, Academic Research Centers, and MCOs.

We will design a user-friendly RFP that will include one page of questions that require ratings from 1-4, and a four-page narrative response covering the scoring categories.

Proposals will be scored against the following criteria: 1.) scope of asthma challenge in terms of number of asthma diagnosed patients, prevalence of asthma in the local community, and annual asthma related costs; 2.) scale of comprehensive, community-integrated asthma prevention program and the degree to which home-based interventions can be/are a component of the framework; 3.) track record of innovation; 4.) the degree to which the applicant can show savings from both the hospital and managed care organizations; 5.) level of executive sponsorship; 6.) willingness to commit resources; and 7.) financial stability (ability to pay investors from savings). We anticipate receiving 20 strong proposals.

The Payor Selection Panel will include the Project Team staff as well as Michael Shaw, Kresge Foundation; Frank DiGiammarino, Amazon/GHHI Board; and Liz Fowler, Johnson & Johnson VP Policy.

Selected sub-recipients must comply with GHHI's standard set of Terms and Conditions for Grantees which address: 1.) grants are only for charitable purposes within the meaning of IRS code Section 170(c) (B); 2.) compliance with, for example, all anti-terrorist financing and asset control laws, regulations, rules and executive order; 3.) narrative and financial reporting requirements on the use of funds; 4.) fund management protocols (e.g., receipt and expense management, document retention, access to recordkeeping); 5.) tax-exempt status validation requirements; 6.) funding non-uses (e.g., propaganda, advocacy, political election influence, charitable giving); 7.) confidentiality and HIPAA compliance; 8.) public notification permissions; 9.) work product ownership; and 10.) control process change protocols. Out of the received proposals, 10 finalists will be selected and Project staff will visit the healthcare entities for additional evaluation. From the 10 finalists, 5 entities will be selected.

Once the payors are selected, the Team will inventory nonprofit service providers in each community that deliver home-based, asthma prevention services. We will design a second RFP that will include two pages of questions requiring ratings from 1-4 and twenty pages max of narrative responses.

Similar to applicants in the first RFP, recipients will have two months to ask questions, attend webinars, and respond. Proposals will be scored against the following criteria: 1.) scale of comprehensive, home-based direct services and production volume; 2.) protocol of intake and history

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of or ability to receive referrals from health care organizations or providers 3.) data collection, analysis, and management capacity 4.) evidence of the health and energy impacts of the organization's interventions 5.) level of executive sponsorship and capabilities of proposed team; 6.) demonstrated track record of service delivery innovation including housing interventions and resident education; 7.) ability to increase production with minimal delivery risk; 8.) willingness to commit resources to evaluate PFS; and 9.) financial stability. The selection committee will be the same as the payor competition and will select one service provider for each site. The 5 healthcare entities and 5 service providers will be the 10 sub-recipients.

Sub-Recipient Services: The Team will deliver a set of TA services to the sub-recipients as part of the feasibility assessment and capacity building project. The Team leverages strong in-house management consulting expertise (our Project Leads come from the consulting firms McKinsey, IBM and PricewaterhouseCoopers), and will contract out for additional TA and actuarial services. We will provide two types of services to the sub-recipients. First, we will provide monetary grants to support their efforts to work on the PFS Feasibility Assessment Project. Second, TA services will be provided by Green & Healthy Housing Strategies (GHHS), a wholly-owned subsidiary of Coalition to End Childhood Lead Poisoning, and Community Investment Partners (CIP), a wholly owned subsidiary of Calvert Foundation. Both services and deliverables are defined below.

Grants to Payors: The Team will award each of the five selected payors \$148,183.57 in services including an average of \$69,078.03 dollars in cash to fund efforts to complete the following sets of activities: 1.) assign executive sponsor and secure time commitment; 2.) assign and commit time of two financial operations analysts to the project (one from the hospital side, one from the managed care side & estimated at 560 hours each over 7 months); 3.) support building the financial model; 4.) define client referral process (e.g., selection criteria, process and assignments, client referral process and tools to the nonprofit service provider, post-intervention client information reporting); 5.) define the client data collection process (in-house and 3rd party), 6.) assign resources from the asthma team to refine evaluation model; 7.) define processes for payor savings acceptance/rejection; 8.) meet financial/performance reporting requirements; 9.) assign legal resource and commit time (estimated at 32 hours over two months) to serve on Launch Structure Transaction Team (legal, procurement, finance, client referrals).

Grants to Service Providers: The Team will award each of the five selected service providers \$106,855.59 in services including an average of \$34,539.00 dollars in cash support to: 1.) assign executive sponsor and secure time commitment; 2.) assign and commit time of one project manager

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with appropriate authority, knowledge and skill set (e.g., finance, service delivery, program evaluation - estimated at 280 hours over 7 months); 3.) support building the financial model by collecting and validating service delivery cost data; 4.) define client referral process with healthcare payor 5.) define client and housing intervention data collection process, 6.) work with the asthma team to adapt the Baltimore evaluation model to local environment and to develop local evaluation partners; 7.) define processes for payor savings acceptance/rejection; 8.) financial and performance reporting requirements; 9.) evaluate quality assurance / quality control protocols; 10.) assign legal resource and commit time (estimated at 32 hours over two months) to the Launch Structure Transaction Team.

TA Services: The Team will jointly lead efforts to develop and manage the feasibility work plan, customize the Baltimore PFS evaluation model, educate relevant sectors about PFS model and educate all parties on the Structure Transaction Process that lies after this feasibility project. GHHS will take the lead in quantifying the need for each of the asthma PFS projects, assess capacity and risk of each nonprofit service provider, document each nonprofit service provider's augmented intervention delivery process and increased costs that will result from the PFS project, engage public officials to secure their commitment to measure secondary outcomes, provide critical data sets and identify barriers to future PFS projects. CIP will take the lead in conducting the payor risk assessment, modeling the financial transaction, and inventorying potential investors to understand levels of interest. The Team will have monthly on-site meetings with the sub-recipients over the course of the 7 month capacity building and feasibility assessment work.

The Baltimore PFS evaluation model serves as a strong starting point for sub-recipients, as it is informed by a robust set of university data partners (e.g., Hopkins, Brown, Harvard) and non-partisan health research organizations like Hilltop Institute of the University of Maryland Baltimore County which analyzes state Medicaid data. As such, the team will have access to data that enables the measurement of the resulting savings to each selected state Medicaid budget even though they are not the formal payor, in order to build evidence and capacity for future impact investments from these government parties.

TA Service #1 - Design and Manage the PFS Feasibility Work Plan: The Team will jointly lead the effort to leverage the work plan from the Baltimore PFS project to craft this feasibility work plan collaboratively, through a series of meetings, with the selected sub-recipients. Deliverable: 10-page report that includes: 1.) narrative describing the project mission, strategy, goals/objectives, action items, roles/responsibilities, assignments and timeline; 2.) project budget (updated monthly to reflect variances); 3.) fully allocated work plan in Microsoft Project. TA Service #2 - Evaluate Need for

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Asthma PFS Project: GHHS will work with the selected sub-recipients to quantify the need for asthma-focused, home-based environmental interventions in the community. Deliverable: 10-page research report detailing: 1.) segmented asthma population in community; 2.) the components of the variable costs of an asthma patient to both the hospital side of the organization and the managed care side of the organization; 3.) an assessment of the point at which (i.e., number of clients serviced) fixed cost reductions are achieved; 4.) state Medicaid asthma costs and CMS reimbursement schedule and ratios; 5.) an inventory of asthma-reduction services available in the community served; 6.) school district absenteeism rates and lost productivity due to asthma.

TA Service #3 - Payor Risk Assessment: CIP will lead this effort to assess the payor's ability to pay the prospective investor from future, projected savings. Deliverable: Report that details the payor's financial stability, credit worthiness and ability to pay from future, projected savings.

TA Service #4 - Assess Capacity of Service Provider: GHHS will assess the strength, expertise and capacity of the service provider at each site including qualitative and quantitative assessment of their track record, operating model and protocols, data collection capabilities, strength of outcomes, compatibility with the desired PFS transaction, partnership network, and financial stability.

Deliverable: 10-page research report detailing: 1.) an assessment of each organization's management team, board alignment, interest in significantly increasing production capacity; 2.) willingness/capacity to implement new data collection and analysis capabilities; 3.) access to 3rd party data sets needed for program evaluation; and 4.) quantitative assessment using Organizational Assessment Tool, evaluating each organization across a 4-point scale that models: priorities, legal, governance/board, human resources/staffing/volunteers, strategic planning, program planning, data management, financial health and management, internal controls practices and fundraising.

TA Service #5 - Model the Financial Transaction: CIP will model the financial transaction, cash flow, payment schedule, and capital structure leveraging cost and savings data from all parties for high asthma related medical utilizers. This proposal includes additional contracting actuarial service options from Milliman in the event that the payor requires actuarial services. Deliverable: Comprehensive financial model with associated briefing to communicate the model to stakeholders.

TA Service #6 - Document Service Delivery Process/Costs: GHHS will lead the effort to refine and document the intervention delivery process and related costs of the service provider to prepare for new client intake/referral processes and increases in production volume. Deliverable: 10-page report that includes: 1.) service delivery process maps (current and future estimate) that highlight data collection nodes; 2.) an inventory and budget of additional resources required to accommodate increased unit

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production as a result of the PFS project; and 3.) inventory of new relationships/partners needed to execute.

TA Service #7 - Inventory Potential Investors: CIP will inventory potential investors and levels of interest/commitment for the upfront capital for the service provision. Deliverable: 5-page report describing potential investors including levels of interest and commitment.

TA Service #8 - Customize Baltimore Evaluation Model: The Team will assemble an advisory panel of research leaders to customize the Baltimore Evaluation Model for local use. Deliverable: 5-page report that details: 1.) an inventory of data sets/partners engaged and a list of other identified, prospective evaluation partners; 2.) a gap analysis; and 3.) an assessment of level of effort required to transfer and/or customize the Baltimore evaluation model.

TA Service #9 - Engage Public Officials: GHHS will 1.) engage leadership from the state health department's performance management division to gain access to statewide and local Medicaid, hospital and managed care data sets; 2.) engage senior leadership from the public school system to educate them on the PFS project structure and gain support in measuring the impacts of asthma-related absenteeism; 3.) engage and educate local elected officials on the PFS project structure and gain support to measure the municipal cost savings, efficiency and program synergy; 4.) engage city, county and/or state procurement and legal officials to review regulatory, statutory and programmatic barriers to implementing a public payor PFS in the selected community (this activity is designed to pave the way for future public payor PFS projects); 5.) design and execute a series of educational webinars targeting public officials. Deliverable: 15-page report that details: 1.) an inventory of engaged public officials (roles, responsibilities, commitments); 2.) a network of agreements with public officials to provide critical 3rd data sets and to measure desired, secondary set of PFS outcomes; and 3.) review and inventory of statutory, regulatory and policy barriers that could limit local efficient PFS deal flow.

TA Service #10 - Educate on Structure Transaction Process Ahead: GHHS and CIP, with the hired attorney, will provide example work products (e.g., term sheets, contracts, reporting templates) so that all parties understand the goals associated with the next phase and begin the process of customizing them to each site's particular deal structure. We have included time with a qualified attorney in the grants to all sub-recipients to maximize inclusion and knowledge sharing. Deliverable: The Team will deliver three working meetings with key PFS project stakeholders to present the rough project timeline and example work products and templates for the subsequent Structure Transaction Phase.

Proposal for Knowledge Sharing

The Team will open source our entire library of work assets with the PFS Competition network. Each

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of these assets will include an analysis of what worked well and what did not. The Team stands ready to support the national evaluation of PFS Competition projects. Currently, GHHI utilizes Social Solutions' Efforts to Outcomes database software to collect and analyze the data associated with the program. GHHI will work with the national evaluation team to explore data integration if disparate systems are being used.

GHHI hosts an annual Executive Leadership Institute (ELI) for health, energy and housing leaders in the national green and healthy homes industry. The 5th annual ELI will be held September 2014 in Washington, DC, for which primary learning objectives include Pay for Success and its applicability in the Healthy Homes and Energy industries. Due to popular demand and timing of the Project Team's PFS efforts to date, GHHI will offer a PFS track to highlight and detail the opportunities to leverage this approach within the participant's communities.

GHHI also hosts routine webinars with its clients, sites and stakeholders across the country, led by an experienced communications division. These are well-attended, consistently receive high evaluation marks by participants, and the Project Team intends to use this established channel to broadly share its PFS experience.

The Project Team looks forward to participating in the SIF PFS learning network that will work collaboratively to capture and share lessons learned and insights within the network to inform the work of larger philanthropic, nonprofit, and public sectors. We will meet, as requested, with our program officer, and other staff or consultants, to provide ongoing information about and access to sub-recipient and match funders. We will also encourage sub-recipients and match funders to provide information about program progress and to participate in the SIF network events and conversations. Senior leadership and SIF project staff from both GHHI and Calvert will attend the annual meeting. The Project Team will provide copies of intermediate/final findings before making them public via our Communications Department.

Identify Innovative, Effective Solutions

The PFS model that we are proposing is innovative in that it: 1.) engages the healthcare sector (a new sector to PFS); 2.) targets asthma, a growing and tremendously costly condition; 3.) targets private payors yet still reduces public costs and engages public officials; 4.) creates a body of Medicaid savings evidence to enable future policy and systems change that will encourage and enable future health PFS transactions; 5.) generates and measures multi-sector outcomes that, while not included in the financial model, will advance future investments by demonstrating the savings to other private and government payors; and 6.) leverages a social services intervention model that has received national

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acclaim for its innovation and execution.

Sector Innovation: Despite the numerous opportunities to leverage the PFS model in the healthcare industry, there are very few such initiatives underway. By funding this proposal, CNCS will be advancing one of the first sets of PFS transactions in this sector that is currently largely unaware of the PFS model.

New PFS Issue Innovation: Reducing patient exposure to known asthma triggers (e.g., moldy carpets, pests, indoor allergens) in their homes is a significant component of the solution and integral to recommended guidelines for care. For the families we serve, the emergency department and hospitalization costs PRIOR to the home intervention are known. The cost of the home intervention is known. The emergency room and hospitalization costs AFTER the home intervention are known. Through the implementation of this model cost savings is realized by Medicaid budgets at the federal and state levels; by hospitals and delivery networks that are "at risk"; by Managed Care Organizations; by private health insurers. This simplicity, and breadth of payor options, makes asthma a prime, and innovative, issue target for PFS.

Private Payor Innovation: Our PFS project represents a private payor PFS model. We selected this model for two reasons. First, the full project lifecycle should be shorter with a private medical system payor who is under pressure to implement portions of the ACA that requires them to reduce preventable and expensive hospital readmissions like asthma emergency room patients. Second, each state's Medicaid budget owner (typically housed within a state's health department) represents the most obvious government payor in an asthma-focused PFS model. However, since each State is reimbursed for Medicaid expenses at a different negotiated rate with the Center for Medicaid and Medicare Services (CMS), some states would keep more of their savings from PFS projects and some would keep significantly less. The private payors can enter into PFS transactions without additional agreements needed with CMS. State Medicaid offices may still find the savings and impact compelling enough to involve CMS later on, so we will diligently and methodically track the savings to the state Medicaid budget in partnership with state officials. Building the savings and impact evidence will increase the capacity for state Medicaid offices and CMS to advance PFS deals in the future.

Multi-Sector, Multi-Industry Outcomes Innovations: Our service delivery model yields multi-sector savings and impact beyond asthma that will be measured as a part of this project. Upon completion of this initial set of PFS projects, we anticipate future transactions that draw investment for the same intervention from non-health sector payors including school districts (to reduce absenteeism which directly impact their per pupil revenues), municipal budgets (to drive programmatic efficiencies

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through cross-program fund braiding, cross-sector field worker training, and inter-agency coordination), and utility companies (to reduce peak time energy consumption).

Service Delivery Model Innovation: Service providers will score higher in the competition for including innovations such as: 1.) Intake: obtaining clients through referrals from local community healthcare providers that are treating low-income families with a child with asthma; 2.) Home Assessment: a comprehensive assessment including health, safety, and energy; 3.) Family Case Management/Education: delivered in the home to provide health education services, legal services (e.g., tenant/landlord), and coordinated referrals to other needed services; 4.) Housing Intervention: holistic home improvements (e.g. that reduce asthma triggers, reduce lead hazards, reduce trip and fall risks, weatherize the home, etc.); 5.) Quality Assurance: Ensuring that no toxins are introduced, all intervention standards are met, and quality control inspections are conducted; and 6.) Data Collection: Collecting data at every step in the process about the clients, interventions, costs, and impact, utilizing third-party data sources to provide outcome information.

Heralded by the National Academy of Public Administration in their 2011 report on Green and Healthy Homes as a "positive force in erasing bureaucratic boundaries and addressing all of the problems of a family home at one time through a single intervention," GHHI has developed and is scaling an intervention model that is, itself, innovative. GHHI's model gained support from the White House and was presented as "a holistic solution that reduces energy and health costs" in the Vice President's 2011 Recovery Act Report to the President - "A New Way of Doing Business." As the Federal Healthy Homes Work Group notes in the February 2013 publication "Advancing Healthy Housing; A Strategy for Action:" "Rather than making smaller separate investments, GHHI creatively addresses health, energy and safety inefficiency problems in the home simultaneously."

Project Timeline:

Month 1 to 6: Draft, release healthcare payor RFP; Hold educational payor RFP webinars; Design Feasibility Assessment (e.g., framework, work products, tools). Review payor proposals, select and travel to ten finalists, select five sub-recipients. In each site, draft, release nonprofit service provider RFP; Hold educational service provider RFP webinars; Review service provider proposals, select service provider sub-recipient in each site. Select order of the 5 sites. Release monetary grants to Site #1 sub-recipients. The Project Executive Director (27 hours/month), Project Lead (51 hours/month), Project Finance Director (28 hours/month), Project Sr. Policy Analyst (51 hours/month), Investment Partner (Calvert) Vice President (17.5 hours/month), and Investment Partner Sr. Officer (40 hours/month) will carry out these activities. No new hires required. First 2 quarterly progress reports,

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expense reports, and first financial report submitted to CNCS.

Month 7 -13: Site #1 TA. (Hereafter, TA is defined by the following process steps: Quantify need; Assess service provider capacity; Assess payor risk; Model financials; Document delivery model; Inventory investors; Engage public officials; Hold educational PFS meetings with relevant sectors; Customize Baltimore evaluation model; Educate all parties on structure transaction phase). The following grantee team members will carry out support activities for site #1: Project Executive Director (74 total hours), Project Lead (90 total hours), Project Finance Director (70 total hours), Investment Partner Vice President (10 total hours), and Investment Partner Sr. Officer (15 total hours). Contractual and consultant services include Feasibility and Capacity TA, Financial Subject Matter Experts, Actuarial Consultant, Financial Legal Consultant, Healthcare entity resources, and Service Provider resources. The Feasibility project management will consist of a Project Manager (292 total hours), Healthy Homes SME (116 total hours), and a Project TA Provider (304 total hours). The Financial experts include a Financial Executive (112 total hours) and a Financial Lead (268 total hours). The Actuarial Consultant (Milliman) will be contracted as needed (projected 30 total hours). The Legal Consultant will be contracted as needed (projected 40 total hours). The selected Healthcare entity will assign 2 Healthcare Analysts (280 total hours each) and their legal counsel (32 total hours). The selected Service Provider will assign an Analyst (280 total hours) and their legal counsel (16 hours). TA staff will conduct monthly on-site visits. Complete Site #1 feasibility report. Release Site #2 monetary grants to sub-recipients. Quarterly progress reports, expense reports, and financial report submitted to CNCS. Continuation request submitted if required.

Month 13 to 19: Site #2 TA: (See TA description in Month 7-13 for detail.) Complete Site #2 feasibility report. Release Site #3 monetary grants to sub-recipients. Quarterly progress reports, expense reports, and financial report submitted to CNCS. Interim Evaluation report submitted.

Month 19 to 25: Site #3 TA: (See TA description in Month 7-13 for detail.) Complete Site #3 feasibility report. Release Site #4 monetary grants to sub-recipients. Quarterly progress reports, expense reports, and financial report submitted to CNCS.

Month 25 - 31: Site #4 TA: (See TA description in Month 7-13 for detail.) Complete Site #4 feasibility report. Release Site #5 monetary grants to sub-recipients. Quarterly progress reports, expense reports, and financial report submitted to CNCS.

Month 29 -35: Site #5 TA: (See TA description in Month 7-13 for detail.) Complete Site #5 feasibility report. Quarterly progress reports, expense reports, and financial report to CNCS.

Month 36: Submit Feasibility Report for all sites. Final financial report, progress report, and

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evaluation report submitted to CNCS. 90 days later, Final Grant Report.

Organizational Capability

Track Record and Unique Qualifications

GHHI brings a demonstrated track record of success that makes the Team uniquely qualified to provide technical assistance for grant sub-recipients, evidenced by its leadership in creating funding resources and cross-sector, cross-industry, cross-agency initiatives for healthy, safe and energy efficient homes for low income families. The organization began in 1986 as a volunteer effort. In 1993, under the banner of the Coalition to End Childhood Lead Poisoning, Ruth Ann Norton was recruited to serve as President and CEO. As the organization expanded services to include a direct service program in Baltimore and TA capabilities nationally, it has served over 35,000 families and provided technical assistance and program management to 45 cities and states. Its work in response to the interrelated tragedies of deteriorating housing conditions and childhood lead poisoning launched one of the most successful public health and housing campaigns in the United States; resulting in a 98% decrease in the incidence of childhood lead poisoning between 1993 and 2012 (from 14,546 to 364) in Maryland.

In 2008, the organization proposed a dynamic shift in how federal, state and local governments and their partners deliver much needed low-income housing interventions. With support from the Council on Foundations, the Green & Healthy Homes Initiative was launched in partnership with federal agencies (HUD, CDC and DOE), national, regional and community foundations and 14 local jurisdictions throughout the United States. The organization formally changed its name to the Green & Healthy Homes Initiative in 2013. GHHI today employs 45 professionals, operates in four regional offices, and supports 18 GHHI designated sites.

Track Record in Selecting and Working with Sub-Grantees:

GHHI has proven and extensive experience operating competitive bidding processes and managing millions of dollars in sub-grantee contracts. From 2011-2013, GHHI successfully oversaw \$2.9 million in Open Society Foundation funding that GHHI competitively bid and awarded to 14 sub-recipients for housing intervention sub-grants. GHHI developed the bidding process, created a RFP, oversaw grantee performance and reporting, provided TA, disbursed funding, and managed finances and deliverables.

GHHI oversaw \$100,000 in a competitively bid process for data support grants from 2012-2014 that were awarded to 10 cities nationally. These cash and technical assistance grants were intended to improve data collection capacity within sub-recipient organizations.

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As part of a separate \$200,000 Open Society Foundation Neighborhood Stabilization Initiative Grant, GHHI oversaw an open and competitively bid RFP process for Foreclosure Prevention Impact Pilot Projects. GHHI managed the RFP, proposal review and award processes as well as the sub-grant management of the foreclosure prevention grants in 2012-2013.

GHHI has also managed \$7.8 million in HUD Lead and Healthy Homes grants that have included successful awarding and contracting with nonprofit organizations and private sector sub-grantees. GHHI has managed sub-grantees for over \$5 million in Maryland contracts since 2000. In addition, GHHI has served as senior advisor since 2005 for the US Conference of Mayors Lead Safe for Kids' Sake grant program developing criteria for awards for over \$3.8 million.

Experience with PFS, Social Financing and Related Activities

PFS Experience and Leadership: In 2011, GHHI began exploratory work and learning to build its internal capacity to construct successful Social Impact financing instruments. GHHI met with and explored innovative financing mechanisms and PFS models with representatives of Goldman Sachs, Morgan Stanley, Third Sector Capital Partners, Social Finance, Nonprofit Finance Fund, Collective Health, State Medicaid Offices, CMS, and numerous MCOs, hospitals and private foundations. GHHI is partnering with the Calvert Foundation, a proven agency that has the expertise, financial acumen, financing vehicles, and experience in securing necessary capital for social financing projects. GHHI and Calvert are currently working with Johns Hopkins Hospital and Priority Partners (Johns Hopkins Medical System MCO) in the development of a \$10 million private-payor PFS project that would finance in-home resident education and housing interventions to reduce asthma triggers in the homes of high medical utilizers. This financing model will utilize capital from Calvert that will produce a \$15 million return on investment through cost savings from reductions in asthma related hospitalizations, emergency room visits, and doctor visits for patients at Johns Hopkins Hospital and in the Priority Partners network.

Over the past year, the Project Team has diligently worked through the feasibility activities in Baltimore. Building direct experience for this proposal, the Project Team has completed the following steps for the Baltimore PFS: 1.) measured the need for asthma-focused, home-based environmental interventions; 2.) refined GHHI's service delivery process in Baltimore to be able to increase current production volume by 150% as a result of the PFS project; 3.) modelled the transaction, delivery costs, process, program evaluation and financial data by leveraging actuarial work completed by Milliman (a leading, national actuarial consulting firm) on the GHHI Baltimore asthma model to provide savings estimates; and 4.) secured access to the 3rd party medical cost control group data sets needed

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for the evaluation model.

GHHI has conducted considerable ground work in the development of similar PFS projects in Cleveland, Philadelphia, Providence, Salt Lake and the States of Michigan and Mississippi.

In addition, GHHI's leadership team has proven experience in developing and implementing Energy Services Contracts (ESCO). (ESCOs are a comparable financing mechanism to PFS and social financing projects.) In 2006, GHHI's EVP Eric Letsinger served as COO for the Baltimore Public Schools and was responsible for securing financing partners, overseeing contracting with multiple contractors and managing project execution that resulted in \$120 million in innovative, net-new capital for facilities improvements that were paid for entirely from projected energy savings. The project is now complete; all benchmarks, including energy savings, capital investment targets and MBE requirements were met.

GHHI joined with Calvert and Third Sector Capital Partners in presenting on PFS and SIB opportunities at the 2014 National Healthy Homes Conference. GHHI conducted trainings on PFS projects and innovative financing for preventive asthma intervention models at these conferences: The Funders Network for Smart Growth and Livable Communities, Affordable Comfort Institute, Grantmakers Forum of New York, Council on Foundations, HUD/EPA Regional Summit on Pediatric Home Asthma Interventions, American Public Health Association, Clinton Climate Initiative HEAL Replication Summit, National Association of State Community Service Programs, Improving Kids Health Conference, Association of Maternal and Child Health Programs, Delaware Healthy Homes Conference, and Mississippi Affordable Housing Conference. GHHI participated in a series of PFS and SIB conferences/seminars that offered training on social financing including The Aspen Institute, Clinton Global Initiative, Social Impact Exchange, Emerging Practitioners in Philanthropy, and Third Sector Capital Partners.

GHHI has secured both Lines of Credit and Working Capital loans from financial institutions, foundations and private high net worth investors to fund its strategic growth. GHHI has met all repayment obligations for these financial instruments, building on its strong history of leveraging and managing growth in a disciplined and strategic manner.

GHHI's business model is centered around, and our experience is deep in, providing technical assistance and training to sub-grantees and raising capital for sub-grantees.

Experience Implementing Innovative Models: Utilizing a \$1.4 million technical assistance contract with the CDC and HUD from 2010 to 2013, GHHI served as technical advisor to 12 cities and two American Indian Tribes nationally to develop model programs that integrate healthy homes

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interventions with energy efficiency efforts for improved health, economic and social outcomes. A key component of this work was training sites cultivation of private and public sector funding partners to contribute leverage funding. GHHI has worked with sites to generate \$69M in philanthropic, private, and corporate support and \$70M in public support. GHHI works with local site leaders to create collaborative delivery systems including a shared data platform, comprehensive home assessment tool, and integrated interventions.

Since 1999, GHHI has developed and implemented an innovative asthma intervention and education program model that includes partnerships to serve clients directly referred by: Johns Hopkins Kennedy Krieger Institute, University of Maryland Medical Center, and MCOs AMERIGroup, Priority Partners, and others. Because of the high return on investment from these relatively low cost environmental remediation and education activities, GHHI is a model that is attractive to an array of payors.

Implementing Evidence Based Models and Research: The National Institutes of Health's National Asthma Education and Prevention Program Clinical Practice Guidelines recommend incorporating environmental control practices to limit home-based exposures. In partnership with the University of Maryland Baltimore County's Hilltop Institute, GHHI is conducting a HUD Healthy Homes Technical Study funded cost benefit study of the reduction in asthma and associated Medicaid costs resulting from the implementation of the comprehensive GHHI model in low income homes in Baltimore. GHHI has also participated in other research projects that measured health and housing interventions including two HUD funded Lead Technical Studies, HUD Healthy Home Demonstration Grants, and multiple Johns Hopkins projects.

Project Management Experience: GHHI has extensive project management experience having managed \$57 million in federal and state grants directly and helped raise over \$250 million in funds for GHHI sites and technical assistance clients. The organization has managed significant federal contracts to provide technical assistance, including a DOE Weatherization Innovation Pilot Program (\$1.3 million) and eight HUD Program Grants totaling \$9.4 million in aggregate. Each HUD grant has received a green (top) rating and met or exceeded all grant benchmarks. GHHI operates a \$10 million federally funded Housing Choice Voucher program for Baltimore Housing. GHHI has managed significant philanthropic investment including more than \$1.8 million in investment from the Annie E. Casey Foundation over 16 years, \$3.2 million in investment from the Open Society Foundation, and a current, \$3 million grant from the JPB Foundation. GHHI managed \$1.4 million in national technical assistance contracts with CDC and HUD in 2010-2013, training and advising 14 sites. GHHI brings 20 years of federal grants management (HUD, EPA, CDC) to the Project.

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A 501 (c)3 nonprofit organization, GHHI has a long history of strong financial management. Publicly audited under federal A-133 standards since 1994, the organization has consistently been deemed a low-risk auditee with no management notations in any audit. GHHI was twice awarded the prestigious Maryland Association of Nonprofits Standards for Excellence certification for extensive financial controls, management policies/practice, and oversight protocols.

Commitment to PFS: GHHI's 2014-2017 Strategic Plan details our scaling program which includes expanding to 43 new sites by 2017. Sustainable financing is a key component to the national scaling plan and GHHI has developed a sustainable funding plan to include: securing health care related investments; Pay for Success programs; fee for service contracts for technical assistance and asthma intervention programs; and philanthropic funding among others. GHHI has conducted considerable ground work and stakeholder relationship building in the development of PFS transactions. As mentioned, the Project Team has had multiple, encouraging conversations with numerous healthcare organizations, governments and service providers related to this initiative. The TA and analysis to be provided by our Team to sub-recipients will not only evaluate feasibility, but will nurture those projects to a point where they are ready to enter into the transaction phase, including providing legal consultation on term sheets and other documentation needed to complete the PFS transactions. The outreach and education provided to the local political leaders, healthcare, education, and energy sectors, and investors will build capacity and momentum for PFS beyond the grant period.

Leadership and Team

Leadership: The Team is comprised of individuals from two longstanding and high-performing organizations. GHHI's 28 years and Calvert's 18 years of operation represent a significant term of consistent delivery excellence and pushing the frontiers of their respective industries.

Governance: There are 10 members of GHHI's Board of Directors who determine the mission of the organization, shoulder fiduciary responsibility for the organization, evaluate the performance of the CEO and ensure the organization has adequate resources to execute the mission. Calvert Foundation has 14 members on its Board, with decades of combined experience in risk management, socially responsible investing, community development, and innovative financing.

Proposed Team

The Partnership: GHHI and Calvert are partners on this project. Our partnership began when Calvert proposed to invest \$10M in a Baltimore Asthma-Focused PFS with GHHI as the service provider and Johns Hopkins (hospital and MCO) as the private payor. While GHHI brings deep direct social service delivery, technical assistance, and organizational management experience to the partnership, Calvert

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brings deep social impact financing experience. The GHHI /Calvert Team will jointly lead the efforts to develop and manage the feasibility work plan, customize the Baltimore PFS evaluation model, and educate sub-recipients on the Structure Transaction Process that lies after this feasibility project. GHHI will take the lead in quantifying the service need for each PFS project, assess capacity and risk of each of nonprofit service provider, document the service provider's intervention delivery process and costs, engage public officials to secure their commitment to measure secondary outcomes, provide critical data sets and identify barriers to future PFS projects. Calvert will take the lead in conducting the payor risk assessment, modeling the financial transaction, and inventorying and syndicating potential investors.

Team Roster, Roles and Responsibilities:

Project Executive Lead: Ruth Ann Norton, GHHI. Ms. Norton will be responsible for the success of the project, providing leadership, governing risk, ensures stable organizational continuity and keeping the project aligned with the organizations' and funders' strategy. Ms. Norton will play a key role overseeing the feasibility work plan, assembling a first-rate set of research and direct service professionals for the program evaluation advisory panels, educating and engaging public officials and assessing the capabilities of the service providers.

Ms. Norton, GHHI President & CEO, founded the organization on a framework of cross-sector collaboration to efficiently deliver green, healthy and safe homes. A founding member of the Maryland Lead Poisoning Prevention Commission, she led efforts in Maryland to reduce childhood lead poisoning by 98% and has helped develop 27 pieces of state and local legislation to create healthier homes. She has served as a consultant to 35 state and local governments to design effective programs to combat unhealthy housing. She helped raised more than \$250 million from the public and private sector for green and healthy homes programs nationally. Ms. Norton serves as a federally appointed liaison to the CDC's Advisory Committee on Childhood Lead Poisoning Prevention, as an expert panel member for HUD's Healthy Homes Guidance Manual, former member of the Maryland Medicaid Advisory Board and State Lead Commission, she is currently on the Executive Committee of the Maryland State Asthma Council and the Baltimore Sustainability Commission.

Calvert Investment Partner Vice President: Margot Kane, Calvert Foundation. Ms. Kane will be responsible for the successful delivery of her organization's work deliverables. She will work in concert with Ms. Norton to govern risk. Ms. Kane will play a strong role in overseeing the work plan, conducting the payor risk assessment, modeling the financial transaction, and seeking investors. Ms. Kane is the Vice President for Strategic Initiatives and manages strategy development, fundraising,

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and implementation of new investment initiatives, such as women's empowerment and the revitalization of iconic cities. Ms. Kane managed a \$75 million loan portfolio, originated and underwrote transactions, and developed investment strategies for Calvert's loan portfolio.

Project Lead: Eric Letsinger, GHHI. Mr. Letsinger, executive vice president, will be responsible for planning, executing and closing the project. Collaboratively with the Project Executives, he will provide timely decisions, clarify decision making frameworks, articulate priorities, engage stakeholders, govern stakeholder communications and direct sub-recipient and sub-grantee relationships. He will manage the feasibility work plan, customize evaluation models, assess capacity/risk of each service providers and prepare them for implementation. He brings more than 20 years of multi-sector, multi-industry executive management experience and a proven track record of operationalizing private sector solutions in the public/nonprofit sectors. (See following section, Proposed Project Lead.)

Calvert Investment Partner Sr. Officer: Beth Bafford, Calvert. As the project lead for Calvert, Ms. Bafford will play a pivotal role in designing/managing the work plan, designing evaluation models, conducting payor risk assessments, modeling financial transactions and seeking investors. Ms. Bafford is a Senior Officer at Calvert and works on strategy, partnership development and capital deployment. Her main areas of focus are on place-based economic development initiatives and healthcare. Prior to Calvert, she was a consultant at McKinsey & Company where she advised large health organizations on strategy and operations in the context of the changes from the Affordable Care Act. She served as a Special Assistant to the Director at the White House Office of Management and Budget during the drafting and passage of the Affordable Care Act, and as a Senior Associate at UBS Financial Services. Ms. Bafford received her MBA in Social Entrepreneurship from Duke's Fuqua School of Business where she helped launch the CASE Initiative on Impact Investing (CASE i3) and published two pieces on Social Impact Bonds, "The Feasibility and Future of Social Impact Bonds," and a Harvard Business School case study entitled "Tracy Pallandjian at Social Finance US."

Project Finance Director: Tom Bellew, GHHI. Mr. Bellew will manage all the financial, operational, administrative and procurement aspects of the project including RFP administration, sub-recipient invoicing/payment, compliance and progress reporting.

As GHHI's CFO, Mr. Bellew manages a complex array of government contracts and philanthropic grants. Prior to GHHI, he served as a Senior Financial Consultant in IBM's Healthcare Consulting Group and as the Deputy Chief of Staff for the Campaign to Fix the Debt.

Senior Policy Analyst: Michael McKnight, GHHI. Mr. McKnight will quantify the need for each

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asthma PFS project, design the evaluation model and assess the capacity of selected service providers. He will coordinate required data sets, develop the data management process/tools and provide quality assurance and control on data metrics, collections, analysis and reporting. Mr. McKnight has served as GHHI's Policy Director since 2010 and provides policy analyses, project management, program evaluation, technical trainings to sub-recipients and technical assistance to GHHI sites. He oversaw evaluation teams from Harvard School of Public Health and the CDC in their work to develop a comprehensive evaluation framework for GHHI sites.

The Baltimore Asthma PFS Program Evaluation Design Team: This advisory panel's role is to design and finalize the PFS evaluation model for the Baltimore PFS project (that will be leveraged in the TA work in this proposal). Members will include staff from Johns Hopkins, Maryland Department of Health and Mental Hygiene, Hilltop Institute, Baltimore Neighborhood Indicators Alliance, Brown University, and Harvard School of Public Health.

Proposed Project Lead: Mr. Letsinger will serve as the Project Lead. Examples of his innovative financing, executive leadership, project management and stakeholder management experience: As CFO/COO of the bi-partisan Campaign to Fix the Debt in 2012, raised \$42 million in 3 months; established 501(c)3/(c)4 entities, boards, contracts and financial processes; hired 45 staff, 17 consultants and 9 firms in 3 months; managed \$14M paid advertising campaign - won 5 Pollie Ad Awards (3 gold); managed lobbying program - won 2012 Top Ten Lobbyist Award, The Hill; Built and engaged network of champions/stakeholders including 205 CEOs, 29 coalition partners, 110 Former Members of Congress, 625 state leaders, 23 state chapters, 2,700 Small Business Owners, and 350,000+ grass roots activists (petition signers).

As COO of Baltimore City Public Schools in 2006, where he managed 1,400 employees, a \$200M operating budget and a \$150M capital budget across six divisions, he implemented the nation's first district-wide energy savings performance contracts (ESPCs), which allowed the school system to complete \$120M in capital projects without up-front capital costs that were paid for out of resulting energy savings. This innovative financing represented a partnership between the school district and energy service companies (ESCOs); in this case Johnson Controls, Pepco, NORESO and ESG. The ESCOs conducted a comprehensive energy audit of each school and identified needed capital improvements that also save energy. The ESCOs designed and constructed projects and arranged the necessary funding. The ESCOs guaranteed, through a secured bond, that the improvements would generate energy cost savings to pay for the project over the term of the contract. All energy savings have been met or exceeded.

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As COO of Baltimore Public Schools, he led the school system, city leaders and parents through a needed school closing process; 16 schools were closed, which saved \$23M in annual operating costs. As Deputy Commissioner at the Baltimore Housing Department, where he managed 400 employees and an operating budget of \$32M across seven divisions, he eliminated long-standing work order backlogs (>8,000 work orders) associated with maintaining 16,000 vacant properties through improved deployment; implemented call center technologies to improve permit processing, thus reducing processing time by 50%; implemented case management software across 200 inspectors to improve processing and management of housing violations.

As a Business Development Executive at IBM, Mr. Letsinger designed, sold and implemented the first large-scale implementation in the country of an open source financial system at Michigan State University. He grew the Education Industry practice by 30% annually by managing a broad/complex array of stakeholders that comprise the open source community.

Budget Adequacy & Cost Effectiveness

GHHI has proposed a detailed budget request for \$1,011,298 based on thorough market research, geographic cost adjustments and programmatic experience to support building capacity, providing technical assistance (TA), studying the feasibility of five (5) Pay for Success projects through a well-thought out national competition based on clear metrics and outcomes. A certified "low risk auditee" through twenty (20) A-133 annual audits, GHHI has successfully managed over \$55 million in federal, state and local government grants and supported these programs with a robust mix of private and philanthropic funding. GHHI has in hand all non-federal matching funds, in cash, needed to complete this proposed work over the next three years. While the project team will encourage match from each site to spur commitment and investment, full match funding has been committed by the JPB Foundation, GHHI and Calvert Foundation.

Project Start to Feasibility Report for All Sites (Months 1 - 36) - Utilizing its deep knowledge in health care and social impact finance, health-based housing intervention programming, evidenced-based practices and data collection, the project team, GHHI and Calvert, (led by the Project Executive Director and supported by its consultancy partners Community Investment Partners, Green and Healthy Housing Strategies, and key consultants) will oversee the entire Project including site selection (Months 1-6), feasibility studies and technical assistance (Months 7-35) and coordination of the final evaluation and dissemination (Months 13,19,25,31,35,36). Budget Description: Please note: All line item costs are matched on a dollar for dollar basis with CNCS. Project Personnel: Project Executive Lead Ruth Ann Norton (8.49% FTE), Total Cost \$58,172 (CNCS/GHHI Share: \$29,086 each); Project

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Lead, Eric Letsinger, (12.08% FTE), Total Cost: \$103,552 (CNCS/ GHHI Share: \$51,776 each); Project Finance Director, Thomas Bellew (7.5% FTE), Total Cost: \$26,133 (CNCS/GHHI Share: \$13,066 each); Sr. Policy Analyst, Michael McKnight, (5.51% FTE), Total Cost: \$15,938 (CNCS/GHHI Share \$7,969 each); Calvert Partner Vice President (2.48% FTE), Total Cost: \$8,747 (CNCS/GHHI : \$4,374 each), Calvert Partner Sr. Officer (5.05% FTE), Total Cost: \$14,298 (CNCS/GHHI : \$7,149 each). Personnel Fringe Benefits: FICA (7.62%/base salary costs), Total Cost: \$9,394 (CNCS/GHHI : \$4,697 each); SUI (1.2%/base salary costs), Total Cost \$1,480 (CNCS/GHHI : \$740 each); Workers Comp (.35%/base salary costs), Total Cost \$432 (CNCS/GHHI : \$216 each); Health Insurance (13.4%/base salary costs), Total Cost: \$16,520, (CNCS/GHHI : \$8,260 each); Retirement, (3%/base salary costs), Total Cost: \$3,698, (CNCS/GHHI : \$1,849 each); Life Insurance, Total Cost: \$0. Travel: Airfare- for 10 sub-recipient selection trips, each 3 people, (Rate: \$750), Total Cost: \$22,500 (CNCS/GHHI : \$11,250 each); Lodging- for 10 trips for 3 people over 1 night, (Rate: \$250), Total Cost: \$7,500 (CNCS/GHHI : \$3,750 each); Mileage- for 10 trips for 3 people traveling 50 miles per trip, (Rate: \$0.565), Total Cost: \$848 (CNCS/GHHI : \$424 each); Rental Car - for 10 trips for 3 people over 2 days, (Rate: \$50), Total Cost: \$3,000 (CNCS/GHHI : \$1,500 each). Other Costs: Rent (\$346.66/month per FTE), Total Cost: \$5,132, Total Cost: \$5,132, (CNCS/GHHI : \$2,566 each); Telecommunications (\$125/month per FTE), Total Cost: \$1,850 (CNCS/GHHI : \$925 each); Background check service (\$43.47/month), Total Cost: \$1,564 (CNCS/GHHI : \$782 each). RFP Management Services to provide online Procurement Management System and services, (Rate: \$1,000), Total Cost: \$1,000 (CNCS/GHHI : \$500 each); Healthcare Research Service will provide RFP Target List, (Rate: \$2,500), Total Cost: \$2,500 (CNCS/GHHI : \$1,250 each). Post Sub-Grantee Selection (months 7-35) - Sub-Recipient/Sub-Grantee costs are broken into two categories: technical support for selected sites (a healthcare sub-recipient and a service provider sub-recipient) during the feasibility study and cash resources for the sub-grantees to support project completion. Technical Support Costs: GHHS Consultants for Healthy Homes Subject Matter Expert to provide technical assistance on Healthy Homes service delivery (Rate/Hrs (Year): \$200/100 (1), \$208/232 (2), \$216.32/248 (3)), Total Cost: \$121,904, (CNCS/GHHI : \$60,952 each); GHHS Feasibility Project Manager to assess and manage individual site and awardee progress, (Rate/Hrs (Year): \$200/268 (1), \$208/584 (2), \$216.32/608 (3)), Total Cost: \$252,942, (CNCS/GHHI : \$126,471 each); GHHS Feasibility TA Provider will provide technical assistance for program design, service delivery, assessment and evaluation Project (Rate/Hrs (Year): \$200/280 (1), \$208/608 (2), \$216.32/632 (3)), Total Cost: \$159,590 (CNCS/GHHI : \$79,795 each); Community Investment

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Partners Financial Executive will oversee site financial modeling, (Rate/Hrs (Year): \$200/96 (1), \$208/224 (2), \$216.32/240 (3)), Total Cost: \$ \$117,708 (CNCS/GHHI : \$58,854 each); Financial Lead will provide financial modeling assistance, (Rate/Hrs (Year): \$200/244 (1), \$208/536 (2), \$216.32/560 (3)), Total Cost: \$225,142 (CNCS/GHHI : \$112,571 each). Actuarial Consultant will provide financial TA, (Rate/Hrs (Year): \$200/30 (1), \$208/60 (2), \$216.32/60 (3)), Total Cost: \$52,432 (CNCS/GHHI : \$26,216 each); Financial Legal Consultant will provide legal technical assistance on documentation structure (Rate/Hrs (Year): N/A/0 (1), \$312/80 (2), \$324.48/120 (3)), Total Cost: \$63,898 (CNCS/GHHI : \$31,949 each); (5) Site Healthcare Legal will provide legal TA to Healthcare organizations and work with the Financial Legal Consultant and Service Provider Legal (Legal team) to ensure proper structure, compliance and documentation, (Rate/Hrs (Year): N/A/0 (1), \$312/64 (2), \$324.48/96 (3)), Total Cost: \$51,120 (CNCS/GHHI : \$25,560 each); (5) Site Service Provider Legal will provide legal services for selected services providers and the Legal Team to ensure proper structure, compliance and documentation (Rate/Hrs (Year): N/A/0 (1), \$312/32 (2), \$324.48/48 (3)), Total Cost: \$25,560 (CNCS/GHHI : \$12,780 each). Travel: (5) Site Airfare for 7 trips each for 4 people, (Rate: \$750/roundtrip airfare), Total Cost: \$21,000 (CNCS/GHHI : \$10,500 each); (5) Site Lodging for 7 trips for 4 people, (Rate: \$250/trip), Total Cost: \$7,000 (CNCS/GHHI : \$3,500 each); (5) Site Mileage for 7 trips for 4 people traveling 50.05 miles per trip, (Rate: \$0.565/mile), Total Cost: \$792 (CNCS/GHHI : \$396 each); (5) Site Rental Car for 7 trips for 4 people, (Rate: \$100/trip), Total Cost: \$2,800 (CNCS/GHHI : \$1,400 each).

Cash Support for (5) selected sites: (5) Site Health Care Analysts #1 assigned by grantees will provide risk assessments for the hospital, (Rate/Hrs (Year): \$100/240 (1), \$104/560 (2), \$108.16/600 (3)), Total Cost: \$147,134 (CNCS/GHHI : \$73,567 each); (5) Site Health Care Analysts #2 are assigned by grantees and will provide risk assessments for the MCOs, (Rate/Hrs (Year): \$100/240 (1), \$104/560 (2), \$108.16/600 (3)), Total Cost: \$147,134, (CNCS/GHHI : \$73,567 each); (5) Site Services Analysts will assess the capacity of the service provider and work with site Healthcare Analysts to prepare a model financial structure, (Rate/Hrs (Year): \$100/240 (1), \$104/560 (2), \$108.16/600 (3)), Total Cost: \$147,134, (CNCS/GHHI : \$73,567 each).

Indirect Cost is calculated at GHHI's federally approved rate of 16% applied to the following categories: Project Personnel \$36,296 (CNCS/GHHI : \$18,148 each); Fringe \$5,043 (CNCS/GHHI : \$2,521.50 each); Travel \$5,415 (CNCS/GHHI : \$2,707.50 each); and Other \$1,926 (CNCS/GHHI : \$963 each) for a Total Indirect Rate Cost of \$48,680 (CNCS/GHHI : \$24,340 each).

The proposed Total Project Cost is \$2,022,596 (CNCS/GHHI sharing 50% at \$1,011,298 each). In

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Year 1 criteria will be set, partners for technical assistance (TA) support will be engaged, site competition for Healthcare entities and Service providers will occur, final selections will be made, and TA for site 1 will begin. Year 1 Total: \$431,049. In Year 2 TA and feasibility study for sites 2 and 3 will occur. Year 2 Total: \$727,874. In Year 3 TA and feasibility study for sites 4 and 5 will occur, as well as the Feasibility Report for all sites and grant closing activities. Year 3 Total: \$863,678.

Match Resources

GHHI and its funding partners (JPB Foundation/Calvert) have committed \$1,011,298 in matching funds (100% match). GHHI has secured \$1,000,000 in cash matching funds from the JPB Foundation (JPB) for use on this work, well above the 10% required. GHHI intends to use a minimum of \$487,532 of JPB funds and \$118,209 of Calvert Foundation match for this proposal. GHHI will provide the balance of \$335,557 (verification letters submitted). JPB funds will provide a 100% match for personnel salaries and fringe (Project Executive Director, Project Lead, Sr. Policy Analyst, Project Finance Director), travel expenses (Airfare, Hotel, Mileage, Rental Car), contract services (the Healthy Home SME, Feasibility Project Manager, Feasibility Project TA Provider), and other costs (rent, telecommunication, and required background checks). Calvert will provide a 100% match for personnel salaries and fringe (Calvert Partner Vice President, Calvert Partner Sr. Officer), and Contract Services (Financial Executive, Financial Lead). GHHI may have competitive site applicants to provide match funding for certain Contract Services (i.e. Health Care Analysts, Health Care Legal Consultants, Service Provider Analysts, and Service Provider Legal consultants). GHHI will fully cover match costs for RFP Management Service, Health Care Research; Actuarial and Finance Legal Consultant).

Clarification Summary

Can you elaborate on GHHI's grants management experience? Response #1: Experience Operating Competitive Bidding Processes: GHHI brings proven and extensive experience successfully managing competitive and transparent bidding processes for over \$12.5 million in direct sub-grants. Examples of this work includes the management of \$3.1 million in competitive grants to 14 sub-recipients from 2011-2014, supported by funding from the Open Society Foundations for data collection, cost benefit analysis, workforce development and housing intervention programs. For all of its sub-grant programs, GHHI developed the bidding processes, created and managed RFP and selection processes, and oversaw grantee performance and reporting. For these grants, GHHI staff provided technical assistance and the GHHI finance office disbursed funding and managed grant auditing in accordance with all audit standards. GHHI has also managed \$7,767,000 million in HUD Lead and Healthy

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Homes grants that have included successful awarding and contracting with nonprofit organizations and private sector sub-grantees. Since 1997, GHHI has managed sub-grantees for over \$5 million in contracts from the State of Maryland. GHHI's President has served as senior advisor for the US Conference of Mayors "Lead Safe for Kids' Sake" grant program developing criteria and selection for \$3.8 million in awards since 2002. GHHI also awarded \$100,000 through competitive bids for data support grants to 10 cities nationally in 2012. These grants supported capacity building for data collection. Also in 2012, GHHI awarded \$100,000 in Neighborhood Stabilization Initiative Grants to 3 sub-grantees, and oversaw an open and competitively bid RFP process for "Foreclosure Prevention Impact Pilot Projects." For the latter effort, GHHI successfully managed the RFP, proposal review and award processes, as well as the sub-grant management of the foreclosure prevention grants in 2012-2013.

Grants Management Experience: GHHI has extensive grants management experience and possesses a highly competent, experienced, and professional management team to deliver quality execution and management of the proposed project and objectives. . GHHI employs 38 professionals, working in Baltimore and four regional offices that are overseen by a senior management team. Since 1993, GHHI has directly t has managed over \$65 million in federal, state, local and philanthropic grants/contracts. GHHI has an exemplary record of federal grants management including project performance, reporting, data collection and evaluation, sub-grantee oversight, and financial management. GHHI has successfully managed grant programs under federal awards from HUD, CDC, DOE, and EPA since 1998. All grants have met or exceeded all grant-related benchmarks and requirements and all have been audited under A-133 Audit standards with no findings. GHHI has also helped manage \$70 million of philanthropic support for GHHI sites nationally through its technical assistance program. managing federal grants.

HUD: GHHI has received \$7,677,000 in direct HUD funding for lead hazard reduction, safety, and Healthy Homes assessments, interventions and outreach: 1.) HUD Healthy Homes Production Grant (MDHHP0004-11), \$930,000, grant period 11/1/11-10/31/14, status - in progress, 153 of 160 Healthy Homes units completed to date; 2.) HUD Healthy Homes Demonstration Grant (MDLHH0206-09), \$875,000, grant period 5/1/10-4/30/13, status -- Completed with Green rating, met or exceeded all program benchmarks including completing 200 of 200 Healthy Homes units intervention benchmark; 3.) HUD Healthy Homes Demonstration Grant (MDLHH0160-07), \$1,000,000, grant

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period 11/1/07-10/31/10, status -- Completed with Green rating, met or exceeded all program benchmarks including completing 250 of 250 Healthy Homes unit intervention benchmark; 4.) HUD Operation Lead Elimination Action Program (LEAP) (MDLHO0029-07), \$2,000,000, grant period 11/01/08 - 10/31/11, status -- Completed with Green rating, met or exceeded all performance benchmarks including completing 320 units -exceeding the 300 unit benchmark; 5.) HUD Operation LEAP (MDLHO0021-05), \$2,000,000, grant period 10/1/05 - 9/30/09, status - Completed with Green rating, met or exceeded all performance benchmarks by performing lead hazard reduction interventions in 383 units exceeding the benchmark of 380 units; 6.) HUD Healthy Homes Demonstration Grant (MDLHH0103-02), \$872,000, grant period 2/15/03- 9/30/05, status -- Completed with a Green rating, met or exceeded all of its benchmarks including completing 530 units exceeding the benchmark of 300 units. Organization performance score of 100 out of 100.

DOE: GHHI was awarded and successfully managed the Weatherization Innovation Pilot Program, \$1,287,000, grant period 10/1/10 - 3/31/14, status: Completed. The program completed 218 units in exceeding the benchmark of 210 units as part of a DOE Innovation Pilot Program that was designed to support the GHHI comprehensive intervention model to leverage other private resources in producing comprehensive Green & Healthy Homes Initiative interventions.

EPA: GHHI has been awarded four EPA grants that it has managed successfully including one outreach and education grant (2007 - \$243,000) and three environmental justice grants (1998 - \$25,000; 2006 - \$25,000; 2013 - \$30,000).

CDC: Green & Healthy Homes Initiative (GHHI) Federal Grants and Technical Assistance Contracts (CDC/HUD), \$1,400,000, contract Period 7/1/2010 -- 9/30/13, status - GHHI provided ongoing national technical assistance for policy development, training, and implementation of the GHHI model in 16 GHHI sites. Match funded support included \$27 million in philanthropic funding for the GHHI sites that was developed with technical support from GHHI.

State of Maryland: Since 1997, GHHI has successfully executed contracts in the aggregate of \$12.015 million for services including: technical assistance, outreach, training, compliance assistance, legal services, family advocacy, lead hazard reduction, Healthy Homes, weatherization/energy efficiency, and policy analysis. GHHI's proven grants management capabilities and high performance have

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resulted in GHHI consistently receiving grants and contracts annually from various state agencies including: 1.) Maryland Department of the Environment (1997-2014: \$4,300,000) -- for statewide outreach and education, training, legal services, family advocacy services, and rental property owner compliance assistance, 2.) Maryland Department of Health and Mental Hygiene (1999 - 2014: \$4,000,000) -- to conduct statewide outreach and education, training, and lead poisoning and asthma prevention capacity building, 3.) Maryland Department of Housing and Community Development (2014-2016: \$3,300,000) -- to provide combined lead hazard reduction, safety, and energy efficiency interventions in homes in Maryland, 4.) Maryland Energy Administration (2008-2014: \$415,000) -- to conduct energy audits and energy efficiency interventions in low income homes in Baltimore. Baltimore City: GHHI has received grants and conducted contract work for the City of Baltimore Departments of Housing and Health in the aggregate amount of \$11.5 million since 1994. These grants include: 1) \$1 million from the Department of Health for outreach, education, case management and community capacity building; 2) \$8 million from the Department of Housing and Community Development for lead hazard reduction and weatherization services and 3) \$2.5 million from Baltimore's CDBG program to support hazard intervention services. In addition, GHHI manages a Housing Choice Voucher Program and a program to perform Foster Care inspection services for the City that have an aggregate value of over \$10 million.

Financial Grants Management: GHHI maintains sound financial practices in accordance with the organization's By-Laws, Internal Controls, Accounting and Audit Policies guided by OMB A-122 standards. GHHI is annually audited under OMB A-133 standards by an independent auditor. GHHI's Finance Office oversees all Program disbursements and billings under its Internal Controls and Accounting Policies. GHHI will use its established grants management accounting systems to administer funds, allocate all Program specific expenses, and monitor all billing and sub-grantees payments. GHHI has an impeccable history of excellent A-133 audits. Throughout its history GHHI has remained a "low-risk" auditee without any audit findings. GHHI maintains strict financial internal controls under the auspices of an external Finance Committee of the Board of Directors, outside accountants and auditors as well as excellent finance staff. The Board Finance Committee meets monthly and is chaired by experienced finance professionals from the fields of banking and investment banking.

GHHI was awarded the Maryland Association of Nonprofits Standards for Excellence Certification for its management practices, fiscal controls, and service delivery. This requires that extensive financial

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controls and oversight protocols are in place for all program operations. Any sub-recipient awarded by the project will enter into a written contract or Memorandum of Agreement that includes a detailed Scope of Services to be delivered and which will include strong accounting and reporting procedures. All expenditures and payments under this project will be coded separately and tracked accordingly. GHHI has a formal purchase order process that requires the written approval of senior management personnel for any purchase or expenditure by the project. For all Program vendors, payments will be made within 30 days after presentation of valid Invoices for services rendered.

Can you elaborate on the division of labor and budget between GHHI and Calvert Foundation? The budget narrative was unclear with respect to the roles of each organization. Response #2: GHHI and Calvert Foundation are applying as partners, with GHHI serving as the lead grantee. GHHI and Calvert Foundation, through their work on a similar, joint PFS project in Baltimore, have developed a productive working relationship with complementary competencies. GHHI brings to the partnership strong competencies in asthma-related service delivery design and program evaluation, project management, competitive grants management, and cross-sector/cross-industry engagement. Calvert Foundation brings to the partnership deep expertise in healthcare finance, PFS financial modeling, risk assessment, evaluation design, and impact investor recruitment. Our total request of \$1,011,298 allocates 17.5% (\$176,469) to Sub-Recipient Evaluation/Selection and 82.5% (\$834,829) on Sub-Recipients and Sub-Grantees Services delivered to the 10 selected sub-recipients.

Sub-Recipient Evaluation/Selection: Project team members from GHHI and Calvert Foundation will conduct all of the tasks and responsibilities associated with sub-recipient selection and evaluation. With support from Calvert Foundation team members, GHHI will lead the following activities described in our proposal: 1.) draft and manage two RFP processes including finalist site visits, 2.) manage grant reporting (progress, expenses, financial), 3.) coordinate legal support services at each site, 4.) coordinate actuarial services, and 5.) manage knowledge sharing efforts including Communities of Practices (CoPs) and webinars. 90.5% (\$159,685) of the sub-recipient evaluation/selection costs (i.e., personnel, fringe, travel, other and indirect) are allocated to GHHI, and 9.5% (\$16,784) are allocated to Calvert Foundation, which reflects GHHI's role as leading this aspect of the work with Calvert in support.

Sub-Recipients and Sub-Grantees Services: Both GHHI and Calvert Foundation will be delivering TA

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services to the 10 selected sub-recipients from each of their respective wholly-owned consulting services subsidiaries, Green & Healthy Housing Strategies (GHHS) for GHHI and Community Investment Partners (CIP) for Calvert. With support from Calvert's CIP team members, GHHS will lead the delivery of the following TA services (each service scope and deliverable is described in our proposal) at each of the 5 sites: 1.) TA Service #1 - Design and Manage the PFS Feasibility Work Plan, 2.) TA Service #2 - Evaluate Need for Asthma PFS Project, 3.) TA Service #4 - Assess Capacity of Service Provider, 4.) TA Service #9 - Engage Public Officials, 5.) TA Service #6 - Document Service Delivery Process/Costs, 6.) TA Service #8 - Customize Baltimore Evaluation Model, 7.) TA Service #10 - Educate on Structure Transaction Process Ahead. With support from GHHS team members, Calvert's CIP team members will lead the delivery of the following TA services to each of the 10 sub-recipients: 1.) TA Service #3 - Payor Risk Assessment, 2.) TA Service #5 - Model the Financial Transaction, 3.) TA Service #7 - Inventory Potential Investors.

Of the total budget of programmatic services provided to sub-recipients, 34% (\$267,218) are allocated to GHHI's GHHS for sub-recipient TA services, 20.5% (\$171,425) are allocated to Calvert's CIP for sub-recipient TA services. Additionally, 31% (\$259,041) are allocated to sub-recipient monetary grants, 3.8% (\$31,949) are allocated to legal services, 3.2% (\$26,126) are allocated to actuarial services, and 7.5% (\$78,980) are allocated to travel.

In terms of selecting nonprofit organizations: If the community does not have quality service providers, how will the project address this in selecting nonprofit organizations? Response #3: The GHHI/Calvert team will execute two RFPs to: first select five healthcare organizations; second, to select 5 service providers. As part of their proposals in the first RFP process, each healthcare organization applicant will be required to list and evaluate (strengths, weakness, capacity, etc.) the nonprofit service providers that operate asthma-focused home-based interventions to low-income households within their communities. As stated in the project plan, the team will conduct webinars to provide additional education and assist with any questions as potential applicants work on responding to the RFP. We anticipate receiving twenty strong responses to the healthcare entity RFP, and will select ten healthcare organizations for further evaluation that includes a site visit. During each of these site visits, the team will meet with service providers to both inform them of the pending RFP and assess their capacity to and interest in participating in the RFP and subsequent PFS project. If a service provider does not exist within the community (we expect this to be rare), then the healthcare organization's proposal will not be able to score high enough to be one of the five selected entities. We

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will make the proposal scoring methodology clear and transparent in each RFP. We strongly believe that this will dramatically reduce, if not eliminate, the chances of our selecting a healthcare organization that operates in a community that does not have quality service providers. Once the health care entities are finalized, the team will release the service provider RFP. Based on the responses, the team will evaluate and select the service provider in each community that scores the highest based on the RFP methodology, ensuring that the final selected service provider is in the best position to work with the project team and the healthcare entity on the PFS project.

TA Service #4: Will capacity assessment of service providers happen before provider is selected?

Response #4: Our capacity assessment of service providers will happen both before and after each service provider is selected. The capacity assessment that we will conduct before selection includes a detailed evaluation of their program capabilities, management/leadership strength, organizational and financial stability, data collection history and board commitment the project. This assessment will come from the response to the service provider RFP as well as additional project staff research when onsite visiting the ten finalists. The key questions we will be attempting to answer are: 1.) Could this service provider, with technical assistance, be ready to take on this project? 2.) Does leadership understand what will be required of the organization as we conduct our feasibility and capacity building work? 3.) Can the provider effectively work with the selected healthcare entity and is the current quality of services high enough? The capacity assessment that we will conduct after selection is designed to define and scope the specific gaps that exist between where the organization is today and where it needs to be on Day #1 of the PFS Project. Because of our expertise and experience on not only PFS feasibility but also delivering services for asthma patients, the project team is uniquely qualified to provide this level of assessment. The key questions we will be attempting to answer are: 1.) Is it feasible for this organization to launch a PFS project immediately after the technical assistance and capacity building work from a service delivery, management, staffing, data system, internal operations processing and leadership perspective? 2.) If not, then for each element, what are the gaps, what actions are needed to close the gaps, what resources are needed, what is the timeframe to carry out those necessary steps, and who should be responsible for each action? 3.) Given all the identified and analyzed gaps, how feasible is it to move to the transaction stage in the very near future?

How will GHHI prioritize geographies in the sub-recipient selection process? Response #6: We are committed to building capacity for PFS projects in diverse geographic contexts, areas and populations

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that have not typically been the focus of PFS projects to date. This is consistent with our organizations' past history of grant-making/investment and technical assistance, which has included jurisdictions in states throughout the country. Under-served populations, which are a focus of SIF and CNCS, are also a focus of the GHHI/Calvert team. We will include in both RFPs that we reserve the right to weigh geographic diversity in our selection process and we seek a broad portfolio spread of projects across the country. Applications from rural and economically depressed communities and tribal communities will be favored in the scoring matrix.

With regards to TA Service #10 (Educate on Structure Transaction Process Ahead), what will you do to ensure this moves to action or results in ancillary benefit? Where is the team based? How often will they be on the ground working with stakeholders? Response #7: The core TA team members from GHHS (GHHI) and CIP (Calvert) are based in Washington, DC and Baltimore, MD. The team will have available example work products (e.g. term sheets, contracts, reporting templates) based on the team's prior PFS work. They will deliver TA Service #10 in the field at each site. The legal attorney that will also be assisting the sub-recipients will be hired locally, thus minimizing travel expenses and increasing local knowledge of the regulatory, legislative and government procurement policy environments (e.g., challenges, obstacles and opportunities for future government-payor PFS projects). The local legal team will work with the core TA team members on customizing the work products for the local PFS structure. Assuming it will be difficult to get everyone in the room at one time, the core TA team will design, schedule and deliver three workshops at each site for all senior stakeholders involved in the project to clearly articulate the transaction stage path ahead. This will include a detailed work plan with actions, proposed assignments, risks, and timelines.

Can you provide more information on knowledge sharing plans? Response #8: In addition to the knowledge sharing plans in our proposal, the GHHI/Calvert team will develop three knowledge sharing Communities of Practice (CoPs), people who share a passion or interest, for members of the broader PFS learning network to come together in a "community" to solve problems, learn from one another, and create new knowledge. The three CoPs represent each of the three core parties in a Pay for Success Project: 1.) Service Providers, 2.) Impact Investors, and 3.) healthcare organizations. We use the term "knowledge sharing" instead of the traditional "knowledge management" because we want to emphasize that we will not only collect knowledge but will actively share it to gain the full advantage of the community's knowledge resources.

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For each CoP, we will first define the community goals (i.e., what members value) and audience needs (e.g., discussion forums, one-way dissemination, many-to-many interactions, and opportunities to engage with the project work). Based on these findings, appropriate technologies will be selected and deployed for targeted engagement types. Led by GHHI's Vice President of Marketing and Communication, the organization's Communication team has expertise and capacity in a variety of knowledge sharing strategies. Content tools to consider include blogs, status updates, wikis, collaborative documents, and social bookmarking/tagging. Member interaction tools to be considered include profiles and social networking, member commenting, discussions, and webinar services. Member feedback and research tools to consider include user-generated ratings, polls and surveys. Social media and community site tools to consider include general social networking sites and topic-specific community sites. Our plan is to leverage existing and free technologies (these are plentiful) and start small and build technical capacity if needed as each CoP matures through the life of the project.

We will also leverage GHHI's existing communication channels including: 1.) GHHI Website (www.greenandhealthyhomes.org) and online quarterly magazine called "Heathy Homes: Healthy People," 2.) monthly eNewsletter to our health, energy, housing and education network (approximately 7,000 registrants), 3.) active online social network, including Twitter Town Halls and a thought leadership blog series with partners involved in PFS projects, 4.) Annual national GHHI conference and Healthy Homes conference, 5.) knowledge sharing opportunities through industry partnerships (e.g. GHHI is speaking on PFS to national asthma stakeholders at the end of September for the Childhood Asthma Leadership Coalition), and 6.) through the speaking engagements of the CEO and senior staff nationally. Calvert maintains active communication with its stakeholders about new social investments in its portfolio. Calvert will push communications out through its array of community channels to thousands of investors, the media, and other key stakeholders in their field of community development.

Can you provide more information on your proposal for sub-recipients to provide matching funds?

Response #9: The GHHI/Calvert team intends to include a match funding requirement in the RFP to all sub-recipients and sub grantees, similar to the one in the SIF PFS RFP. In our experience determining the feasibility of a PFS deal requires real, demonstrated commitment from all parties involved. Matching funds is a big indicator of how invested the RFP respondents are to this project. We feel that it is a critical requirement, and will treat it as such in the ratings of the responses to our

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RFPs.

Please confirm the total requested amount from CNCS. Response #10: The amount we are requesting is 1,011,298 or 50% of the total budget of \$2,022,596. The eGrants application does not allow calculations at the decimal level. Our original budget was developed in a spreadsheet using rates that included decimals. The variance was caused because our narrative was written based on the original budget spreadsheet we developed.

The budget needs to be entered in eGrants by line item. Subsidiary budget function needs to be utilized. There were discrepancies in the total requested amount and submitted budget in eGrants, please ensure information is entered in eGrants. Response #11: Our budget has been entered into eGrants by line item. We utilized the subsidiary budget function and created three budgets. One is the overall budget (Subsidiary Budget #3) including both the grantee and the sub-recipients and sub-grantees, the second is a budget only for the grantees (Subsidiary Budget #2) and the third is a budget only for the sub-recipients and sub-grantees (Subsidiary Budget #3). We have updated the "Cost Effectiveness and Budget Adequacy" section in eGrants so that it matches the budget request.

PFS applicants must demonstrate that a minimum of 80% of federal funds requested are used for sub-grants or services provided to sub-recipients. Please designate the line items that include these costs with the header: "sub-recipient services/sub-grants". Response #12: In addition to Response #2, please find the break out of applicant funding vs. sub-grant/sub-recipient funding: Applicant Funding Total = \$176,469 (17.5% of total request): 1.) Project Personnel Expenses (\$113,420) GHHI : (\$101,897) Calvert: (\$11,523); 2.) Personnel Fringe Benefits (\$15,762) GHHI : (12,816) Calvert: (\$2,940); 3.) Travel (\$16,924) GHHI : (16,924) 4.) Equipment (\$0); 5.) Supplies (\$0); 6.) Contractual and Consultant Services (\$0); 7. Training (\$0); 8.) Evaluation (\$0); 9.) Other Costs (\$6,023) GHHI : (6,023) Calvert: (\$0); 10.) Indirect (\$24,340) GHHI : (22,025) Calvert: (\$2,315). Sub-Recipient Services or Sub-Grants \$834,829 Total = (82.5% of total request): 1.) Project Personnel Expenses (\$0); 2.) Personnel Fringe Benefits (\$0); 3.) Travel (\$78,980); 4.) Equipment (\$0); 5.) Supplies (\$0); 6.) Contractual and Consultant Services (\$755,849); 7.) Training (\$0); 8.) Evaluation (\$0); 9.) Other Costs (\$0); 10.) Indirect (\$0).

Personnel Fringe: Please provide a rate for each item included in the fringe benefits. Response #13:

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Rates to calculate Fringe are as follows: FICA = 7.62%, SUI = 1.2%, Workers Comp = 0.35%, Health Insurance = 13.4%, Retirement = 2%. Calculations were updated in the budget section for further clarity.

Indirect Cost Rate: Provide a copy of the most recent approved Federal Indirect Cost Rate agreement.

Response #14: Please see attached documentation for our federally approved indirect rate.

Source of Funds: Include all matching funds under Source of Funds including all in-kind contributions. For in-kind contributions, please list service, good or function. Please provide your most recent audit.

Response #15: The JPB Foundation, Calvert Foundation, and GHHI have committed a total of \$1,011,298 in matching funds for this Project. GHHI has over \$487,000 cash on hand in matching funds to begin the Project (representing 487% of the minimum requirement for proposal submission). The submitted Letters of Commitment equal 100% match for the grant term proposed.

Salaries: The personnel salary costs for the GHHI Project Executive Sponsor, GHHI Project Lead, GHHI Policy Analyst, and GHHI Project Finance Director total \$203,795 over three years. GHHI is leveraging match funds from The JPB Foundation in the amount of \$101,897 for these costs. The Calvert Partner Executive Sponsor and the Calvert Partner Project Lead salaries total \$23,045. Calvert Foundation is providing matching funds in the amount of \$11,523 for these costs. As a result, 90% of the total match needed for salaries is already in hand.

Fringe: The JPB Foundation is providing \$12,816 in matching funds which is being combined with Calvert Foundation's match of \$2,946 for a total match of \$15,762. As a result, 81% of the total match needed for fringe is already in hand.

Travel: The JPB Foundation is providing \$95,904 in matching funds for travel expenses. As a result, 100% of the total match needed for travel is already in hand.

Technical Assistance Services: The JPB Foundation, Calvert Foundation and GHHI are providing matching funds for the Consultant totaling \$755,849. The JPB Foundation is providing \$267,218 in

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matching funds (100% of the total) for the Healthy Home Subject Matter Expert, Feasibility Project Manager, and Feasibility Project TA Provider. Calvert Foundation is providing matching funds totaling \$171,525 (100% of the total) for the Financial Executive and the Financial Lead. GHHI is providing a match of \$317,206 (100% of the total) for the Actuarial Consultant and the Financial Lead Consultant. GHHI proposes to attain matching funds for the Site Health Care Analyst #1, Site Health Care Analyst #2, Site Health Care Legal, Site Services Analyst, and Site Services Legal from the sub-recipients but has guaranteed funds to cover any potential gaps.

Other Costs: GHHI is providing a match of \$1,750 (100% of the total) for the RFP Management Service and the Health Care Research Service. The JPB Foundation is providing a match of \$4,273.65 (100% of the total) for the other project costs including rent, telecommunication and background checks.

In summary, The JPB Foundation has allowed use of \$1 million in matching funds on account at GHHI. GHHI intends to draw \$487,532 (48% of the total) of these funds for this purpose, Calvert Foundation has committed a match of \$188,209 (19% of the total) and GHHI has committed a match of \$337,557 (33% of the total). In total, the Project has 48% of the total required match already in place for the Project and 480% of the minimum match requirement for this proposal. We have uploaded GHHI's 2012 audit. Our 2013 audit is currently in progress.