Center for Medicare & Medicaid Innovation
Strong Start for Mothers and Newborns

Strong Start: Improving Birth Outcomes

February 15, 2012 3:00 p.m. EST

OPERATOR: Good day, ladies and gentlemen, and welcome to "A Strong Start for Improving Birth Outcomes" conference call. My name is Jasmine, and I'll be your operator for today. At this time all participants are in the listen-only mode, and will remain muted for the duration of the conference. If at any time you require operator assistance, please press star followed by zero, and an operator will be happy to assist you. And now I will turn the conference over to your host for today, Mr. Ray Thorn. You may proceed, sir.

MR. RAY THORN: Thank you, Operator, and good afternoon everyone and thank you all for joining. This is Ray Thorn, and I am with the State Coordination Engagement Group here at the CMS Innovation Center. We're really thrilled that you have joined us today on this new Strong Start initiative to improve the care and health of mothers and newborns and we're very excited that this is a partnership between the CMS Innovation Center and the Center for Medicaid and CHIP Services. So thank you all again for joining.

And just a few housekeeping items just at the front. This call is being recorded and will be posted on the Innovation Center's website within a couple of days. Also the audio and the slides of today's call will be also posted within a couple of days. This is a call for State Coordinators only. This is not for the press. If you are a member of the press, please call the CMS Media Relations Group if you have a question.

This webinar today will primarily focus on the funding opportunity to deliver enhanced prenatal care for women who are covered by Medicaid and are at risk of a preterm birth. We will have future webinars that will focus on additional information on the specific approach to prenatal care and that are being tested in this funding opportunity as well as a future webinar on the first strategy in the Strong Start Initiative regarding the early elected delivery.

Let me quickly review the agenda today. First, Valinda Rutledge, Director of the Innovation Center's Patient Care Models Group will briefly discuss the Innovation Center and its mission and goals. And we will have Marsha Lillie-Blanton from the Center for Medicaid and CHIP Services give a broad overview of the Strong Start Initiative. And, lastly, Dr. Ellen Marie Whelan from the Innovation Center will provide additional specifics on the initiative.

After Ellen Marie is finished, we will have a question and answer session in which we will answer questions that have been submitted through the Strong Start email box or through the chat box on the webinar. We will not be taking questions through the phone. We will also conclude this webinar by 4 p.m. Eastern Time.

Lastly, if you do have questions and we are not able to get to them on this webinar, you can always email us. Our email address is strongstart@cms.hhs.gov. Again, if we don't answer your question or are unable to get to a question that you have submitted, the email address is strongstart@cms.hhs.gov. In addition, information on the Strong Start Initiative is on the

Innovation Center website at innovation.cms.gov under the "What's New" section on the left-hand side or under the "What We're Doing" at the top of the website. With that, I will turn it over to Valinda Rutledge.

MS. VALINDA RUTLEDGE: Thank you, Ray. First of all I want to review the mission of CMS. It is to be a constructive force and a trustworthy partner, and that partnership is between us and all of you that deliver care to America. The Innovation Center was established through the Accountable Care Act, and the purpose of the center is to test innovative payment and service delivery models. Our charge is to identify great ideas out there, test those ideas, evaluate the effectiveness of it, and potentially scale them if they're found to be effective.

We have ten billion dollars of funding that we received through the Accountable Care Act and that funding is available through 2019. The other additional resource that we have that is if we find through these pilots that they are successful in terms of the three-part aim — and I will be going through that in a second — we will be able to expand the successful models to a national level. So we were established through the Accountable Care Act.

The three-part aim and all of the projects through the Innovation Center, we focus on the achievement of the three-part aim: help for the populations that care for individuals and lower cost through improvement. And this is for all America. How we measure the success of our project at looking at those measures of success of the three-part aim: better health; are we able to improve the experience of the care of that patient looking at safety, effectiveness, patient centeredness, timeliness, efficiencies and equity.

Better health, we want to look at how can we improve the overall health of the populations that we serve and we're looking at how can we lower the total cost of care while improving quality. This will be important as each of the applicants submit their proposals for funding through this. We will want to know how you achieving three-part aim. And we will have some additional webinars on the three-part aim coming up. So with that, I will turn it over to Marsha Lillie-Blanton that will explain the overview of the program.

MS. MARSHA LILLIE-BLANTON: Today's webinar is about the launch of the Strong Start Initiative. As Ray mentioned, it is collaboration between the CMS Innovation Center and the CMS Center for Medicaid and CHIP Services. This single initiative, Strong Start, consists of two different but related components. The first effort has a goal of reducing early elected delivery before 39 weeks. It is a test of a nationwide, public-private partnership and awareness campaign to spread the adoption of best practices that can reduce the rate of early deliveries across all populations and all payer groups.

The second effort is a goal of reducing preterm births among women covered by Medicaid. It is a cooperative funding opportunity to test the effectiveness of specific enhanced prenatal care approaches to reducing preterm births among women covered by Medicaid. Can I have the next slide, please? This webinar is focused on the latter effort. But I'm going to briefly talk about our plan for the first effort: reducing early elected delivery.

For the last 20 years the American College of Obstetricians and Gynecologists (ACOG), the March of Dimes, and other had advised against early elected delivery prior to 39 weeks if there are no medical indications for an early delivery. There is now considerable evidence that critical

brain and lung develop occurs between 37 and 39 weeks, and that delivery prior to 39 weeks increases the risk of infant complications and lasting developmental impacts.

These poor outcomes drive higher costs in the healthcare systems. Our effort to safely reduce early elected delivery will include three primary activities. The first is implementing a quality improvement platform through the Partnership for Patients to share best practices and to provide technical assistance to hospitals in adopting best practices, in collecting data, and in reporting data.

The second activity is to create support for change with a broad-based campaign to engage providers, patients and the public working in partnership with organizations such as the March of Dimes and ACOG. And the third major activity is to support efforts to collect performance data, to measure success, and to promote transparency and continuous improvement.

As I mentioned earlier, this webinar is focused on the second strategy of the Strong Start Initiative: the use of several enhanced prenatal care models to reduce preterm births among women covered by Medicaid. The second effort is a cooperative agreement funding opportunity. It is an agreement for providers, for states, for managed care organizations, and for conveners to test evidence-based approaches to delivering enhanced prenatal care that improve health outcomes for mothers and infants covered by Medicaid.

Before we transition to my colleague from the Innovation Center, let me talk briefly about the challenge we're facing. The U.S. has made considerable gains in improving birth outcomes since the 1960s. But disparities in outcomes persist across those economic and racial and ethnic groups. Each year more than a half million babies are born prematurely in the U.S. And the rate of preterm infants born prematurely has been growing over the past 20 years.

About one in eight babies are born preterm, resulting in increased risk of severe health problems and lifelong disability. Medicaid currently finances about 40 percent of all births in the United States and has a role to play in addressing the challenges we are facing as a nation. Compared to women with private insurance, women covered by Medicaid are more likely to have multiple risk factors for poor outcomes and to have higher rates of poor outcomes in general, including preterm births.

We can and should do better. With that overview of the challenge we're facing, let me turn to Ellen Marie Whelan to provide you with more of the specifics about the efforts we are undertaking to address that challenge.

DR. ELLEN MARIE WHELAN: Thank you, Marsha. We're really excited to be talking about this new funding opportunity that we just announced last Wednesday. And I'm going to go through the details of what we think applicants should be better aware of if they're hoping to apply for this funding opportunity. As Marsha suggested, because of this cost to families, when a family has a child who is premature, they have a lifetime of challenges ahead of them. Some of them very expensive with children needing intervention services, special education, and a huge cost to society.

So because of that, we now have the purpose — go back to that one — because of that the purpose of this funding opportunity is to achieve better care for the individual, improve health

for the families, as well as reducing costs for both the high-risk mother who is covered by Medicaid and for their newborn. We're going to specifically be looking at women who have coverage by Medicaid, and also women who are at increased risk for having a preterm birth.

Our signs of success will be increasing the gestational age of newborns to improve their outcomes and also then decreasing the total cost of care for both the mothers as well as the infants, and we'll be measuring it for the first year of the infant's life. We'll be focusing on the impact that the non-traditional, non-medical prenatal interventions have, and we will select a series of evidence-based approaches to be able to deliver this non-medical enhanced prenatal services for women who are at-risk for preterm birth.

So what we'll talk first about is this model of enhanced prenatal care that we are interested at spending more time looking at. The enhanced prenatal care model, there are a variety of them out there. We'll talk more about the specifics in just a minute. We have focused on evidence-based enhanced prenatal care models. We found small studies, studies in many instances, studies that may have looked at just a single site, studies that may not have included women covered by Medicaid. And that is how we decided how we were going to move forward selecting these certain approaches to the delivery of enhanced prenatal care.

There are a lot of common elements in enhanced prenatal care, and the focus will generally include Medicaid population who are high-risk for preterm birth. We will look at services that are addressing psycho-social needs. This will be seen as augmenting traditional standard prenatal care, and we will be looking at improving the delivery of medical services.

The next slide shows a pictorial image of how we hope to achieve our aim of achieving prenatal and birth outcomes. The first thing we expect every single woman who will be part of this to be getting is evidence-based prenatal care, evidence-based traditional care in the setting that occurs wherever the intervention will be taking place. This is something we will not be paying for. This is something that we expect Medicaid is providing under the traditional standard prenatal care.

The focus of this new funding opportunity is to see what role enhanced prenatal care can have on a woman's life in addition and on top of the traditional prenatal care. We will look at three general areas: addressing psycho-social needs, either alternative or additional approaches to the delivery of care, and also some non-traditional sites of care delivery, and again, improving those medical services.

Ultimately, this package we are calling 'enhanced prenatal care delivery,' and we think it will then achieve our three-part aim of better health for individuals, better care for populations, and lowering the cost of both newborns and their mothers.

What we've decided is by looking at the literature we found three different evidence-based approaches that have demonstrated that they have had the ability to decrease prematurity when delivered in particular ways. The three approaches we are moving forward in funding are, first, enhanced prenatal care through the centering or group care approach. The second approach to evidence-based prenatal care is enhanced prenatal care at a birth center. And the third is enhanced prenatal care at what we're calling maternity care homes. And we will talk about each of these in a little bit more detail next.

The first approach, enhanced prenatal care through centering or group care, is where group prenatal care is offered in an opportunity to get peer to peer support counseling in a facilitative setting. Ideally, these approaches will look at three different components to the delivery of prenatal care. That's physical health assessment, education of the moms going through the program and then taking advantage of the support that the additional women in the group's prenatal care can offer to each other.

Generally, these women will go through their pregnancy with a group of women with similar gestational age or women who are as pregnant as each other. They will share what's happening in this group approach, and receive care from their health providers in this group setting. The participants will meet with meet with their providers as a cohort that will travel through pregnancy with them, and one of the hallmarks of this is also that the series of visits will be extended, will be longer than they would have gotten in the individual setting.

The second model that we're looking at of enhanced prenatal care is that prenatal care gets delivered at birth centers. Prenatal care delivered at birth centers is extraordinarily comprehensive. It is facilitated by a broad range of both licensed and unlicensed health professionals that include teams of midwives and physicians. Some of the examples of other folks who are providing care here are peer counselors, indulas, breastfeeding experts, and a whole team of professionals are delivering the enhanced prenatal care at birth centers.

We will be looking specifically at the prenatal care, not the birth itself, although, of course, that is part of the delivery of care that happens at birth centers. And these services also sometimes include intensive case management, referral services, counseling, psycho-social support, also, though, to be highlighted in addition to the traditional or standard prenatal care at the settings.

The third evidence-based approach we're looking at is something we're calling a maternity care home. A maternity care home, again, is going to sound very similar to the others in the fact that all of these are the delivery of enhanced prenatal care, but we're going to include a specific set of approaches that this model will include.

And in this model we're going to ask the providers how they can achieve three specific categories of improved care. The first one is accessing continuity. They'll have to tell the story of how they can improve access to care in between the regularly scheduled visits, and possibly being able to get their care from the same individual throughout the prenatal period. We'll be looking to see if they can offer a package of care coordination; the ability to track the services that folks are receiving in and out of their individual practice. And the third is they'll have to demonstrate that they're content of care is enhanced, is, in fact, above and beyond what folks would be getting at a standard prenatal care practice.

Now, who is eligible to apply? We basically see four different types of applicants that will be applying for funding under this funding opportunity. The first is state Medicaid agencies will be applying. When these Medicaid agencies apply, they will be doing so in partnership with providers who are agreeing to offer one of these three approaches to enhanced prenatal care. The second, the actual providers of the care. These could be provider groups, affiliated providers or facilities that are delivering prenatal care and they select one of the three options to be able to deliver this care.

Third, managed care organizations. They can be an applicant who demonstrates how they are also working with their providers that want to offer one of these three models. They will also have to come in and partnership with their states.

And last is conveners, which we've got a few questions about what conveners are. Conveners will be an entity that pulls together providers who have agreed to offer one of these three models of care. We can talk more about that a little bit later. But these folks would then coordinate the providers of care. The money would flow through the conveners, and the conveners would then help us get the dollars to the providers. They would also help us with data collection and working with their states.

And the two bullets at the bottom are just important because all the non-provider applicants must apply in some partnership with their providers. And all of the non-state applicants must also demonstrate how they will come to us in partnership with their states. This is extraordinarily important in the data collection and the data compilation, since that's going to be the only way they're going to be able to demonstrate that there's been a successful program.

The next slide is the eligibility factor. We've had a lot of questions about these two items. I'm just going to make sure that we highlight these. The first: "Can applicants propose to implement more than one option?" Yes, an applicant can apply for more than one of these options. However, only one of the options can occur at each individual care delivery site. We are testing whether or not these three models are working to improve health outcomes and decrease prematurity. Each individual practice will have one of the identified, however, an application can say that they'll be doing more than one of these options at different care delivery sites.

The second is — although we identified that each applicant should have the capacity to serve at least 500 pregnant women with Medicaid coverage every year, we also encourage smaller providers to join with other similar practices. So the key here is that each applicant should be able to demonstrate greater than 500 pregnant women. Certainly not each practice, so the applications that will come in will show that collectively among all of the practices coming together that applicant can show that they've got 500 or more pregnant women each year that will be able to participate.

Each of our sites will need to be able to participate in our pretty extensive monitoring and evaluation. It's a big part of our investment as well since, as Valinda mentioned earlier that all of our successful models, we want to see at the end of the day if they've been able to demonstrate that they've improved care while decreasing costs. So there will be a heavy investment in evaluation that the Innovation Center does, but we expect full participation of each of the applicants and each of the providers to be able to provide us with data to help us achieve this goal.

So we'll be looking to make sure that the way that these care delivery models are offered and ultimately are they able to decrease prematurity. And, as I mentioned earlier, one of the ways that we'll be measuring the cost is not only the cost of the mom and her delivery, but also we'll be following the healthcare utilization of the infant through the infant's first year of life. One of the key things we'll be needing to do is also look at birth certificate information and make sure that that birth certificate information is being linked with the state Medicaid data.

The next is how the funding will occur in each of our Strong Start models in this cooperative agreement, so the second strategy of delivering enhanced prenatal care. We will be funding only services that are not currently funded by the state Medicaid program. So, again, we're expecting the state Medicaid programs to be funding prenatal care the way they've always been doing it, and we will be identifying additional services that the state Medicaid programs are not currently funding.

There will be some minimal funding available for selected start-up activities, and funding will also be available for states for their data collection and distribution. In the application, in the application narrative, in the funding opportunity announcement that Ray mentioned is on our webpage, we will be asking the applicants to tell us how the care delivery model will be implemented at each of the care delivery sites. And they will also have to tell us a cost effective way that they might need funding for start-up activities and how they will be getting some dollars — not a lot, but some minimal dollars — to the states for their data collection and partnering for that distribution.

The next slide is our timeline. You can get all of this information, again, as Ray pointed out, on the innovation.cms.gov webpage. Also, just to note that all of these slides will also be available on our webpage. The slides will be available in about a week, and we will also have a transcript available on the webpage, and an audio also on the webpage. We will repeat this at the end as well.

So I'll go through these dates. The dates for our letters of intent is March 21st. The letters of intent are required. No one will be able to submit an application if they've not done a letter of intent. The letter of intent is a form that you can fill out on the webpage. It is also non-binding. So, though the information is required as an applicant to be able to apply, the information on there may change, and we expect it might change, as the application is developed.

The application will be due on June 13th, 2012. We then expect the award will be made available and announced somewhere in the beginning of September, September 10th, and soon after that the performance period begins. We will also then, in this process between now and when your applications are due, we will be having a series of additional webinars. Many of them will also be able to have live questions being asked, and we ask that you go back to our webpage to see the announcement of those webinars.

Once an award will be made, CMS will award, through a cooperative agreement a set of renewable one-year agreements for up to three years to support the intervention. There's also an additional year of funds available for the evaluation in order to follow the infant's first year of life. We expect, though, the application will be a description of how the providers will be able to participate in a three-year program with the numbers over a three-year period of time. But the awards will be granted at a one-year competitive process.

The program reach: here's what we hope will be accomplished by our program. We are hoping and expecting we can test the ability of these three approaches to enhanced prenatal care to improve the outcomes in 90,000 pregnancies over the three-year period. So this means we're looking to get 30,000 women enrolled in each of our three approaches over the next three years. And by reaching these kinds of numbers we are hoping that that's what we will need to

be able to demonstrate whether or not these three approaches have an effect on decreasing preterm births.

What are the next steps? Again, these slides will be posted on our webpage in about a week. We will have both a transcript and an audio available on our webpage. We are going to start to go through some of the FAQs that have come in since our announcement and also some that have been arriving during our webinar. But, if we don't get to your question, don't fear; please submit them to our Strong Start webpage. Our email address is strongstart@cms.hhs.gov.

We have a first set of frequently asked questions already available on our webpage, and we will be updating them as we see the kinds of questions that potential applicants are asking. Again, additional webinars will be scheduled. Some of them will be based on the kinds of questions we're hearing and also just additional points that we think will be helpful for applicants to fill out of the applications.

And with that, I'm going to go to Ray who is going to help launch us into the Q&A.

MR. RAY THORN: Thank you, Ellen Marie. And before we get into the Q&A, I do want to remind folks that, again, all of this information — the slides, the audio and the transcript — will be posted onto the Innovation Center website on the Strong Start webpage. Again, you can access that at innovation.cms.gov. And you can go to the Strong Start link under the "What's New" section on the left-hand side of the webpage or under the "What We're Doing" header at the top of the page. So click on the Strong Start link and it will take you to the Strong Start Initiative landing page, and then you can click on the funding opportunity, and all that information will be there including the FOA.

If you are having difficulty in finding the FOA, it is available on www.grants.gov. We do have the funding opportunity number, and that is CMS-1D1-12-001. If you're interested in the CDFA Number, that number is 93.611. And I do believe that we have a couple of questions that have come in already. With that, I will turn it back over to Ellen Marie.

DR. ELLEN MARIE WHELAN: Thanks, Ray. As Marsha suggested at the beginning of our presentation, the announcement we made last Wednesday was the announcement of two different approaches to improving birth outcomes. The first approach is the reducing of early elected deliveries with a bit of a campaign, a multi-paired campaign. And we've had a few questions asking just to talk a little bit more about what that initiative to look at reducing early elected deliveries is.

So with that, Eric Fennel is just going to just outline a little bit more about what that initiative is in reducing early elected deliveries.

MR. ERIC FENNEL: Thank you, Ellen Marie. I think Marsha touched on this earlier, but we're going to be undertaking a few specific tactics as part of that strategy to reduce early elected deliveries. Since the evidence is well established, as Marsha referred to, that we believe there's a great opportunity in spreading this best practices if we work in partnership with organizations who have been working so hard to advance that information and to do that research.

We have a great vehicle for doing that with the Partnership for Patients. As you know, the Partnership for Patients is a public-private partnership established in which over 3800 hospitals across the country have not only agreed to participate, but committed to very specific goals in terms of patient safety, improved outcomes and reductions in harm at hospitals around the country.

One of the areas of focus in that initiative is improving obstetrics outcomes in hospitals. To support the Partnership for Patients we have in place 26 hospital engagement networks, each of which are working with participating hospitals across the different areas of focus to help spread best practices, provide technical assistance, and other supports. So it is a perfect infrastructure for us to work on the specific topic of reducing early elected deliveries, and through the hospital engagement networks reach all of those 3800 hospitals that have an interest, a shared interest, in reducing early elected deliveries. So that is one component.

The second, as Marsha mentioned, is an effort to work with organizations like the American College of Obstetricians and Gynecologists, as well as the March of Dimes and other organizations, both professional societies and advocacy organizations, who are already in the field doing work in support of reductions in early elected deliveries. We will be, in some cases, joining existing public awareness campaigns, and then looking for and working with additional partners over the course of the year to identify other opportunities to educate both providers and support providers, as well as to educate the public in general and expectant mothers about the benefits of reductions in early elected delivery.

So those are the primary strategy or primary tactics we'll take under the first strategy here for reducing early elected deliveries. We will also focus as well on supporting data collection and measurement as a way to really support continuous quality improvement in this area.

MR. RAY THORN: Thank you, Eric. And I think, just to reiterate, if you want to ask a question, you can do it through the chat box, or you can send an email to us at strongstart@cms.hhs.gov. And I think we have some further questions, Ellen Marie, that we received through the chat box.

DR. ELLEN MARIE WHELAN: And also just to touch base, to go back to what Eric just said. There's been enough interest that we'll probably will have a webinar on the first approaches to early elected delivery that will happen in real time, not just in the future. So if that's something you're particularly interested, feel free to ask a question about it, but also know that there will be an opportunity to see more about it.

One of the other questions that is coming in is folks just wanting a little bit of clarification on what it is this funding opportunity will and will not fund. And so I'm going to turn this over to Marsha to be able to explain that a little bit further.

MS. MARSHA LILLIE-BLANTON: There's a simple answer and a little more complicated answer to that question. First, the CMMI dollars will cover funding for services not currently covered by a state Medicaid agency. Now, the key to that is what does a state Medicaid agency pay for. Fairly uniformly, state Medicaid agencies cover the cost of prenatal care, cover the cost of the delivery, cover the infant costs. So it is largely medical care that a state Medicaid agency uniformly covers.

Where there will be some variation is on the what we're calling enhanced prenatal services, and that will vary by state depending on whatever is already in a state plan of specific states. So part of what we will ask an applicant to do when they come in is to identify whatever services are currently covered by their state plan. And if those services are already covered, then it means that the funding that is available through this announcement could not be used to supplant the funding that is now available through a state Medicaid agency.

Now, we understand that there will be a lot of variability in that process. And in some cases, it is the packaging that might vary, but we will work with the applicant to make sure that we are clearly understanding what it now covers and pays for and what is being proposed by the applicant that might be different than what a state now covers or pays for.

MR. RAY THORN: Great. Thank you, Marsha. We do have another question, but I do also want to give Ellen Marie the answer. What about the different approaches? Can you elaborate a little bit more on that?

MS. MARSHA LILLIE-BLANTON: Thanks, Ray. Yes, we're seeming to get a lot of questions talking about the different approaches. And I think that it makes sense that folks are a little bit confused about this, because this really is something that's new that CMS and the Innovation Center and CMCS are looking at doing.

And as Marsha just described, this is not something that is a single-service. It is not a single fee for service. It is something that we are anticipating providers will be doing to be able to enhance the kind of prenatal services they are currently providing. So there are a traditional set of services that most women are expecting to get. They're evidence-based. We know that there are clinical services that are pretty standard across the country, but what the evidence is indicating is that when an enhanced set of services — a package, if you will, of services — gets delivered to a pregnant woman during the course of her pregnancy, that that different collection of services can be enough to help reduce the rate of prematurity.

So the commonalities among the different approaches — because we're looking at one model of enhanced prenatal care — are pretty significant. All of these are focusing on psycho-social. They're all focusing on a broader and more enhanced health assessment. All will be looking at educating women on a different set of services and possibly educating women in a different way than had bee occurring before.

We're looking at improved continuity, improved counseling. Looking at identify behavioral risk factors and making sure that those risk factors — as Marsha just indicated, if some of those services are being provided or paid for by Medicaid, we will not fund them. We will ask folks to tell us how this enhanced set of prenatal services is different from what other prenatal service providers are doing, but they will also have to indicate which of these things are already being paid for. What this funding opportunity will do is help provide an amount of money to the providers to be able to cover the enhanced set of services.

Where the models are different. I'll go through each of the three models to talk a little bit about how we see they are different. And they are different in just their approach to delivering this package. In the centering group practice approach, we are expecting that providers will have a track record of being able to provide this centering or group care. They certainly may be

approved by the Centering Healthcare Institute or approved by some other evidence-based curriculum.

They will be delivering a curriculum that they've been able to identify, has an evidence-base, and has been able to demonstrate that it ultimately did in other instances reduce the rate of prematurity. We expect, for example, providers in this model will be trained in group counseling, since that is something that is important. They will need to have a space where they can actually deliver this group counseling. So that is some of the things that may be unique to the centering or group care model.

For birth centers, we will be expecting the birth centers to be certified by the Commission for the Accreditation of Birth Centers. We selected this because we think the certification ensures that birth centers meet national standards set out by the American Association of Birth Centers. This certification maintains a strong continuous quality improvement program, and it also ensures that the center is compliant with applicable federal, state and local laws and regulations. This is certainly important. We're not looking to provide any new model of care delivery; this is the kind of a care delivery in a birth centers that is consistent with current federal, state and local laws and regulations.

The third approach in maternity care home is a little less defined. We are approaching this care delivery model in the way that we've done in other Innovation Center models. In this we are looking for applicants to tell us how they will achieve the goal of enhanced prenatal care in three different ways. Again, this information is included in the FOA and will be available on the slides as we move forward.

The three different areas of enhanced prenatal care at the maternity care home will be the ability to describe how they improve access and continuity. Again, access will be important for not just access to care at the scheduled visits, but also between the visits. We will expect providers of the maternity care home to be able to demonstrate how they're providing care coordination within their model, but also outside. For example, are they referring to WIC sites, are they being able to monitor if these women did take advantage of going to WIC. And the third is they have to identify how their content is enhanced and over and above the kind of care that was delivered before. Here's where we will see that individuals will be addressing the behavioral factors and other things that women come to need in their prenatal care.

So, again, many similarities in each of these approaches. But, more importantly, there's a little bit of difference in how we're seeing each of the three service delivery models.

MR. RAY THORN: Thank you, Ellen Marie. Another common question that we've been receiving is: "Can an applicant implement more than one maternity care service option?"

DR. ELLEN MARIE WHELAN: Yes, that's important, Ray. I think because we're also at a point where not only we're funding a new model of care delivery, but as I mentioned, what's really important here is that we are studying to see if these care delivery models work to improve and reduce prenatal care. So the applicant can apply to do more than one model, but what we are expecting is that only one model will occur at each of the individual care delivery sites. So we will be looking for 30,000 women enrolled in centering or group care models around the

country; 30,000 women receiving care at birth centers and 30,000 women who are receiving care from what we are calling maternity care homes.

And, Ray, one of the things I think I also was seeing a fair amount of questions: folks have identified that there's another approach to the delivery enhanced care. People are identifying that home visiting is something that has been evidence-based and has been shown to be able to deliver enhanced prenatal care while reducing preterm births. And we agree. We think that this is important. However, one of the good news about home visiting is that in the Affordable Care Act there was the creation of a new program called the Maternal and Instant Early Childhood Home Visiting Program. It has the acronym MIECHV, which we refer to as "mick-v".

And this program, looking specifically at evidence-based home visiting was funded at $1.5 billion over five years, and is a program that is funded at the state and territory level, and is providing a lot of home visiting services across the country. Because we think that this approach is also something that might ultimately reduce preterm births, we're working closely with HRSA and the Administration on Children and Families to augment their evaluation.

Right now they're evaluating these home visiting models for a variety of outcomes, but they hadn't been looking at whether or not this home visiting services reduced preterm births. So we're working closely with them to augment their evaluation to see if, in fact, the delivery of home visiting during the prenatal phase can reduce preterm births, but we are not funding the implementation of this program because of the MIECHV program funded by the Affordable Care Act at $1.5 billion over the next five years. So we acknowledge that is really important, but we're not going to be funding that approach now.

MR. RAY THORN: Thank you, Ellen Marie. Another common question that we've been getting is, "What is the range of funding that can be requested?"

DR. ELLEN MARIE WHELAN: They range of funding is going to be determined based on the applications that are coming in. One of the things that is going to be important is part of a competitive edge will be offering a cost effective approach. It is an era that we're looking for improvement of care, but also cost saving ultimately. So the range will be based on the application. The application will tell us how they will achieve their goals. We imagine they will tell us the amount of money based on the women they're seeing. So I think that they would be able to describe the amount of money per pregnant woman that they see, and help us understand how that intervention gets delivered over the period of time during pregnancy. So there is no cap, but we expect cost-effective applications coming in.

One other question, Ray, that I see has popped up is whether federally qualified health centers are able to apply for funding. And, in fact, we do believe that that would be federally qualified health centers — or the FQHC look-alikes — are available to apply. They would probably apply as a provider of care. We imagine that the different sites in the FQHC may provide one or more of the services depending on the site that we have, but certainly we do expect that FQHCs will be able to apply for funding here.

MR. RAY THORN: Great. Thank you, Ellen Marie.

DR. ELLEN MARIE WHELAN: Here's another one, Ray. Someone else is saying that they saw that we have 500 pregnant women being a requirement, 500 pregnant women covered by Medicaid for every year. And folks are worried that that means that we may not be wanting to have small practices apply. That is in fact not the case. We encourage small practices to apply. What we would just ask is small practices gather together, probably similar practices.

It would also be important — it might be really convenient for folks in the same state to apply since there will be such a strong state partnership that smaller practices — even larger practices — coming together in a state would come together. They could work together with their state to be able to put this application together, and we would then make sure that there would be a good relationship there, and then ultimately have a bunch of different practices come together, they would easily be able to reach, we think, this 500 pregnant women per year.

MR. RAY THORN: Thank you, Ellen Marie. Another question that we've been receiving is regarding the letter of intent: "For the provider and managed care organization and convener proposals, does letter of from a state Medicaid agency need to be included in the letter of intent?"

MS. MARSHA LILLIE-BLANTON: No, it does need to be included the letter of intent, but we would expect when the application comes in that the state has co-signed an agreement between whatever is that entity. If the state is not the applicant, if it is a provider organization or a convener, we would expect that an agreement be signed that details the relationship. And one of the things we're looking for in that letter is the agreement to share data, to collect data, to help with the analysis of the data. We actually are looking at for a strong partnership between the provider group and the Medicaid agency, if the Medicaid agency is not the applicant.

DR. ELLEN MARIE WHELAN: And that would be for the conveners as well?

MS. MARSHA LILLIE-BLANTON: For the conveners as well.

DR. ELLEN MARIE WHELAN: And then also both the managed care organization and the convener must also show that they've already identified the providers, and the providers are willing to come to the table providing whichever approaches they have chosen.

RAY THORN: And I know we've covered this, but when is the letter of intent due?

DR. ELLEN MARIE WHELAN: Well, let's go through that timeline again. The letter of intent — although we say it is a letter, we've actually created a form on her webpage. And on that form you can just go through and click off and answer the questions. We're mostly looking to see who is interested. We want to try and get a bit of a sense of which models folks are interested in applying for and the kinds of numbers. We also want to get a sense of which states are interested in applying.

So that information is available on our webpage in a form, and that will be due on March 21st. Again, that is required, but non-binding. So individuals who have gotten their application in on the letters of intent by March 21st will then have until June 13th to get their application in. The application process through www.grants.gov is not as user-friendly as some would like, and so

we strongly encourage individuals not to wait until the last minute to apply, to get their applications in. It makes sense to go earlier, establish the kinds of numbers, really get a better sense of what www.grants.gov is all about. People who don't have experience with applications on www.grants.gov, especially, we're encouraging to go early, take a look at that, get a sense of the kinds of numbers, the kinds of requirements that you may need. Most of this is outlined, we hope, pretty clearly in our FOA, our Funding Opportunity Announcement. And as Ray said, is available both on our webpage as well as at www.grants.gov.

So the two key deadlines: March 21st, fill out the form on our webpage that we're calling a letter of intent that is required, but not binding. And the application is due on June 13th. Time for both of them is 5:00 p.m., but would make sense to pretend it's a couple of days ahead of time so if it doesn't work you've gotten some extra time to be able to get those things in.

RAY THORN: Okay. Thank you, Ellen Marie. And just a reminder, if you would like to ask a question, you can send an email to the Strong Start email box at strongstart@cms.hhs.gov. Or you can ask a question from the chat box. Ellen Marie, I think we've received another question?

DR. ELLEN MARIE WHELAN: Yes, here's another one, Ray. This is someone asking if you're already providing one of these care delivery models, are you eligible to apply. And, in fact, yes. Because we are wondering if each of these three approaches can demonstrate that it decreases preterm births, we're actually very much encouraging individuals who have experience in each of these three models to apply.

If they are already providing these, we imagine that a subset of these services are not being covered currently by Medicaid, so we will look to have you tell us what is already being provided by Medicaid and tell us how you are providing the enhanced set of services that is not being covered. And if you spell that out for us and put it in the application, that is the kind of thing we're looking to serve.

Since we're testing models, this track record will actually be important. This is the kind of thing we're looking for when we judge our applications. This can be for not only where you are currently, but we're also encouraging practices to look to say maybe we would like to augment and have our model now go to another practice that is not currently providing this kind of enhanced prenatal care using the experience you've gleaned at one practice to expand to a new practice that is not currently offering them.

MR. RAY THORN: Great. Thank you, Ellen Marie. I think we have time for one more question. Do you want to take it away, Ellen Marie?

DR. ELLEN MARIE WHELAN: Yes, I think so. So our time is winding down. Again, this is the first of what we see as a series of webinars. We hope to cover more details in other webinars, and we will continue to welcome the questions that we're trying to as quickly as possible answer on our webpage.

One of the questions that just came in here is about high-risk, how we're saying what's a high-risk, someone who is at high risk. They wanted to know if it is just medical risk or if it is social factors as well. Of course, we acknowledge that there are many social factors that are responsible for having women be at a bit of an increase risk for preterm births. We have a table

in our funding opportunity announcement. It is Appendix A on page 47 that we summarize what the Institute of Medicine identified in their landmark document on how to reduce preterm birth.

And in there not only do we indicate what some of the medical risk factors are, but we also show what the demographic risk factors of preterm birth is and the social risk factors. So, of course, when we are asking individuals to describe where they would like to provide these additional services, what kinds of risk factors that they think they will be able to begin to take into account and then offer appropriate services; that the kind of risk factors that we see listed here are the kinds of things we think would be important to take into account.

Of course, there are things like substance abuse. We would then imagine if that's the neighborhood that you're looking at, it may have increased risk of some of the substance abuses, we would expect then those providers to tell us the kinds of services they'll be offering that will address those kinds of things. So look for that information on page 47 of our funding opportunity announcement, and we will expect the applicant to tell us why they think certain areas and where they're going are in fact areas that where the women live would put them at increased risk for a preterm birth.

MR. RAY THORN: Thank you, Ellen Marie. Unfortunately, we have run out of time to answer your remaining questions. So if we didn't get to your question, please send an email to strongstart@cms.hhs.gov. And we'll also take a look at the remaining questions and compile a frequently asked questions document that will be posted onto Innovation Center website as soon as possible. Again, all of this information in today's conference call webinar will be posted onto the Innovation Center website at innovation.cms.gov. And that includes the audio, the transcript, and the slides from today's webinar. For more information on the Strong Start Initiative, please visit innovation.cms.gov.

At this time, that concludes our call and we hope everyone has a great day. Thank you very much.

OPERATOR: Ladies and gentlemen, this concludes today's conference. Thank you for your participation. You may now disconnect. Have a wonderful day.

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