Center for Medicare & Medicaid Innovation

Strong Start: Partnerships Between States and Applicants Webinar

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Please note: The transcript for this activity is based on the actual webinar recording. Minimal editorial/formatting changes have been made to the transcript text.

JENADA: Good day, ladies and gentlemen, and welcome to the Strong Start: Partnerships Between States and Applicants conference call. My name is Jenada [phonetic], and I will be your operator for today.

At this time, all participants are in listen-only mode. If at any time you require operator assistance, please press star followed by zero and we will be happy to assist you. I would now like to turn the conference over to your host for today, Mr. Ray Thorn. Please proceed.

RAY THORN: Great. Thank you, operator, and good afternoon, everyone, and thank you all for joining me. We apologize for the delayed start here, but we're ready and ready to go here. Again, this is Ray Thorn. I'm with the Stakeholder Engagement Group here at the CMS Innovation Center. We're really thrilled that you have joined us today on this Strong Start Initiative webinar to improve the care and health of mothers and newborns. So, again, thank you all for joining us. Just a few housekeeping items up just at the front. This call is being recorded and will be posted on the Innovation Center's website within a couple of days. The audio and slides for today's call will also be posted within a couple of days.

The Strong Start Initiative is a partnership between the CMS Innovation Center and the Center for Medicaid and CHIP Services, so we're really thrilled to be working with our colleagues from the Center for Medicaid on this initiative.

Since the announcement of the initiative and the first webinar, we have received lots of questions. We thank you for your input and your patience, and we thought we would take this webinar opportunity to address some of those questions, particularly addressing those questions on what it means for applicants to partner and work with states.

So today's webinar will focus on the Strong Start funding opportunity, particularly the role of states in this initiative and how they can be involved. We will also discuss what it means for states to work with applicants and vice versa.

We will have future webinars that will focus on additional information on the Strong Start Initiative. Next Wednesday, we will be hosting another webinar on building a budget with respect to the funding opportunity.

The speakers for today's webinar will be Dr. Ellen Marie Whelan from the Innovation Center. She will be giving a brief overview and introduction of the Innovation Center and the partnership between the Center for Medicaid and CHIP Services.

Then we will have Eric Fennel from the Innovation Center discuss Strategy One of the Strong Start Initiative and how we're building on current efforts to reduce elective deliveries.

And Ellen Marie will briefly give an overview on Strategy Two, the Medicaid Prenatal Funding Opportunity.

And then Dr. Steve Cha, the Chief Medical Officer at the Center for Medicaid and CHIP Services, and Carol Backstrom, Senior Advisor at the Center for Medicaid and CHIP Services, will discuss the role of states in the Strong Start funding opportunity.

After the presentation, we will have a question-and-answer session in which we will answer questions that have been submitted through the Chat Box. We will not be taking questions over the phone. Again, if you'd like to submit a question, please do so through the Chat Box.

If you do have a question that we were not able to answer on this webinar, you can always email us. Our email address is strongstart@cms.hhs.gov. Again, if we don't get to your question, the email address is strongstart@cms.hhs.gov.

In addition, information on the Strong Start Initiative is on the Innovation Center website at http://www.innovation.cms.gov. There is a link to the Strong Start webpage under the What We're Doing. Enter at the top of the website.

And, with that, I will turn over to Dr. Ellen Marie Whelan.

DR. ELLEN MARIE WHELAN: Thanks so much, Ray. And I just want to reiterate our thanks to everyone that's joined us and your interest in the Strong Start Initiative.

First, just a little bit of a background on the Innovation Center. The Innovation Center here at the Centers for Medicare and Medicaid Services was created as part of the Affordable Care Act. And the purpose of the center is to test innovative payment and service-delivery models that reduce program expenditures under Medicare-Medicaid and CHIP. And reducing this cost happens only while we look to preserve or enhance the quality of care furnished.

So the charge, as per the law, asks us to identify, test, evaluate and then scale up the successful programs. We've had $10-billion funding over the next 10 years from 2011 through 2019. And this opportunity to scale up is what's so exciting about the initiatives we're doing here.

When we find a program is successful, meaning that it actually improves the quality of care while maintaining or decreasing cost, then the secretary has the authority to expand successful models to the national level in a subset or a large part of the services that CMS provides.

For every program that the Innovation Center runs, there are three measures of success, and we look to use these three measures of success across the board.

The first is better health care for individuals, and this improves patients' experience of care within the healthcare system. And we use the Institute of Medicine's Six Domains of Quality to measure our success in better healthcare — safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

The effective measure of success is improved health of the population, increasing the overall health of populations, addressing such things as behavioral-risk factors, while we focus on preventive care.

And the third mission is looking at how we can do all of this while we decrease cost. We believe lowering the total cost of care, while we improve quality it will result in decreased expenditures in total cost of care for all of the beneficiaries that we serve and, ultimately, for the nation at large.

As Ray mentioned, the Strong Start Initiative is a collaboration between both the Innovation Center and the Centers for Medicaid and CHIP Services. CMCS, the Centers for Medicaid and CHIP Services, provides health coverage for nearly 60-million Americans and finances about two in every five births in the country. And we're really excited about this partnership between CMCS and the Innovation Center.

The Strong Start Initiative has two strategies that we're looking at to improve birth outcomes for women who are covered by Medicaid as well as women on all different kinds of health insurance.

The first initiative is reducing early elective deliveries. This is a multi-payer nationwide, public-private partnership, an awareness campaign that we're looking to spread best practices that reduce the rate of early elective deliveries, non-medically indicated before 39 weeks for all payers and all populations.

The second strategy, and the focus of this webinar, is a project that will look to deliver enhanced prenatal care. It's a funding opportunity for providers and states and other applicants. We'll be testing the effectiveness of specific enhanced prenatal care models, which we'll talk about just in a minute, specifically looking to reduce preterm births in women who are covered by Medicaid.

I want to turn it over to my colleague, Eric Fennel, who's going to talk a little bit about Strategy One.

ERIC FENNEL: Thank you, Ellen Marie. I'll just touch on this briefly, since our focus today is on Strategy Two, but, as Ellen Marie said, part of this initiative is to focus on what we can do to effectively and safely reduce the rate of early elective deliveries.

In this regard, we have three primary activities right now. One is that we're working to leverage the infrastructure, the relationships that are already in place through the Partnership for Patients.

For those of you who aren't aware, the Partnership for Patients is a public-private initiative that we launched early in 2011 that has, to date, engaged over 3,900 hospitals who have committed, as part of that, committed to very specific goals to help improve the care and safety at hospitals nationwide.

One of the reasons we're working to leverage the Partnership for Patients is part of that commitment that these hospitals have already made is to improve various areas of obstetric care. So it's a national fit for us.

We also have in place, through that partnership, 26 what we're calling Hospital Engagement Networks. These are organizations, health systems and similar entities working in regions across the country to provide technical assistance and support to hospitals in reaching the very specific goals that they have committed to.

In addition to working through the Partnership for Patients to support hospitals in effectively and safely reducing early elective deliveries, it's also important for us to work to help inform and educate expectant mothers and providers and support them as well.

One of the things that we've identified that organizations like the American College of Obstetricians and Gynecologists have for 20 years been advocating for the need to reduce early elective deliveries. Yet, as much as 10 to 15 percent of all births are early elective deliveries, before 39 weeks and without medical indication.

So that's an opportunity for us, we believe this is an opportunity to work with organizations like ACOG, like the March of Dimes and others who have been doing great work advocating in this area to support providers and expectant mothers directly.

And then the third piece that we feel an important part of this — an important compliment to both of those efforts is to create transparency around our success collectively in reducing early elective deliveries. And we'll be working directly with hospitals and providers and other organizations to promote transparency in this area.

One last note on this. The reason that we are confident, the reason we are feeling confident we can pursue this and have success in reducing early elective deliveries is because of the work that's already going on both by states and across states today. There are a number of organizations that are not only working hard in this area, but showing real results in safely reducing early elective deliveries.

We will be speaking more about this at a future webinar. But I'm going to turn it back over to Ellen Marie right now to take us back to the main focus of today, which is our Strategy Two.

DR. ELLEN MARIE WHELAN: Thanks, Eric. And before we talk about the details of this Strategy Two and our funding opportunity, just a quick reminder of the importance of the objective that we seek here to decrease prematurity. And probably those of you on the phone don't have to be reminded, but just a quick look at the data behind the reasons that we're doing this.

Nearly one in eight babies is born prematurely in the United States and this results, of course, in an increased risk of severe health problems in the first year of life and throughout the entire life of the child into adulthood.

As I mentioned before, Medicaid finances about 40 percent of all births in the United States. This is a huge issue for CMS and Medicaid better understanding what we can do to try to decrease the problem of prematurity.

For women who are enrolled in Medicaid, they are at more risk for some negative birth outcomes compared to women who are enrolled in private insurance. For example, they're more likely to have multiple risk factors for adverse birth outcomes and they have higher rates of complications, poor outcomes and preterm births.

And in addition, besides being an expensive endeavor for every family that goes through the experience of having a preterm birth, the Institute of Medicine has estimated that preterm births cost the nation $26 billion every single year.

So, now, just a few slides to do an overview of the program before we get into the details of kind of our partnership with the states.

A quick reminder, the Strategy Two is a funding opportunity, a funding opportunity for providers and states, managed-care organizations and conveners. And we're looking to specifically test evidence-based approaches to delivering enhanced prenatal care that will improve health outcomes while reducing costs for mothers and infants who are enrolled in Medicaid.

Specifically, we're interested to looking to see how this enhanced prenatal care delivery can decrease prematurity.

We're looking at having one model of enhanced prenatal care, so there'll be a lot of overlap, but we identified three approaches to the delivery of this single model. The three approaches are enhanced prenatal care through centering of group visits, enhanced prenatal care delivered at birth centers and enhanced prenatal care at maternity-care homes.

We've gotten some questions about the ability to have an application that applies to do more than one approach, and that is fine. We'd encourage if smaller groups come together that one application may allow more than one approach. The stipulation is there can be only one approach delivered at each individual site.

So resaid [phonetic] every woman who's covered on Medicaid would only enroll in one of the three approaches, and that's because we want to study whether or not these individual approaches ultimately decrease the rate of prematurity.

Just a quick overview of who's eligible. As I mentioned, there's four different types of applicants. State Medicaid agencies are an applicant. Second, providers of obstetrical care, which could be provider groups or affiliated providers and facilities. The third applicant would be managed-care organizations. And, lastly, a convener, and conveners in partnership with other applicants.

We've also had questions about a little bit more clarity on what a convener is. We see a convener as a group that brings together multiple participating health providers. This convener would also need to partner with providers and the state Medicaid agencies and would be any entity that is eligible to receive federal funds.

And a snippet of the types of folks we see as being a convener would include national trade or professional organizations, a collaboration of states, a collaboration of providers or other health-related organizations.

Now, after a little bit of the overview of the structure, I'm going to turn this over to my colleagues at the Centers for Medicaid and CHIP Services, first to Steve Cha, the Medical Director at CMCS.

DR. STEVE CHA: Thank you, Ellen Marie. Thanks for that overview of the strategy on enhanced prenatal care.

In the strategy for enhanced prenatal care, there is a focus on the state role, and we at the Center of Medicaid are just tremendously excited about this opportunity to — great opportunity to look for ways to improve the health outcomes for women and children on Medicaid.

And, as many of you know, Medicaid is a joint federal-state partnership. Because of that partnership, the active participation of states is essential for this strategy to be successful in improving care, improving health and reducing costs.

What that also means is that non-state applicants — so, if you are a provider, an MCO or a convener, those non-state applicants must obtain an agreement with the states to support that non-state applicant.

I think it's important to know we've got a lot of these questions that the state-agreement letters are not required for the letter of intent. They are required for the final application, but not the final letter of intent.

So a couple of slides to talk about what that agreement should entail. The first group of activities are on data needs, and these data needs are critical to documenting the outcomes for enhanced prenatal care. And some of these data reside only at the state level, and that's in part why their role is absolutely critical here.

So the states have to agree to various data activities, including verifying Medicaid status for the participants, providing Medicaid program data necessary for evaluation and linking Medicaid data to vital-statistics data, such as birth-certificate data.

States are also encouraged to report state-level data on the Medicaid Maternity Core Set of Quality Measures, and that set of measures is in the FOA.

As you can see by this set of data requirements, the data sources include Medicaid and vital statistics. So while the state entities' structures may vary from place to place, those entities and agencies responsible for the Medicaid data and the vital-statistics data have to be involved in order to commit to these particular data activities.

In addition, there's — as part of the applicant's proposal, the state will need to attest to its description of Medicaid-covered services in the state plan. Now, that description can be generated in a number of ways, but, ultimately, the state does need to sign off and attest to the accuracy of that description of covered services.

The state also agrees to ensure that there's no double payment for overlapping services delivered by separate programs. And these are what simply we'll call crossover services provided by Medicaid Title 5 or other state programs.

And it's important to note that providers are also responsible for insuring that there's no federal double payment for overlapping services. So this is a shared responsibility, but the state does need to agree that it will do its part to ensure that there's no double payment for services.

And, finally, the states may not supplant existing supports, so you may not cover — use the funds under this FOA to cover currently covered Medicaid services.

So that's a quick overview of what those state agreements have to include. I'm going to turn it over to my colleague, Carol, Senior Advisor at the Center on Medicaid and CHIP Services, to talk a little bit about additional ways for states to be involved.

CAROL BACKSTROM: Thanks, Steve. Just want to talk more about sort of a couple of other ways that states can be involved in the initiative. And one, of course, is that the states themselves can be an applicant for the funding opportunity. And states can also facilitate the collaboration amongst stakeholders in a state to put together an application.

So the state, as an applicant, it's much the same as sort of a role that they need to play in supporting others' applications. But that is just to say that, you know, generally, we just need to be mindful of the agreement letter that is needed to demonstrate that the state is aware that there's a lot of data that needs to be pulled for the purposes of evaluation of the project, and we just want to see that as, again, a part of the application from a state as well, just acknowledging that that's a role to play.

And, again, states, as an applicant also, once again, just needs to make sure that there's no double payment for services. We're only paying for the enhanced services that are not included in the state plan and we can't — we just need to make sure from the state perspective that there's no supplanting of existing support.

If a state is an applicant, we will look for the relationship that the state has with providers. You know, I'm envisioning a way that a state comes together with providers, you know, willing providers who are interested in pursuing this with the state. And so I'm thinking that, you know, a state will be coming in with that provider group or an MCO or the convener really trying to demonstrate that there are linkages with all the interested parties as well as a linkage to the enhanced prenatal services, obviously, that are being delivered.

Of course, the state will need to just attest in the application that they are also responsible for the other aspects of the details in the FOA.

In terms of a state playing a role as — facilitating collaboration, they can certainly help gather the interested parties as a convener without themselves being the applicant.

In the case of multistate collaboration, the non-state applicants can also compile an application across state lines, so long as every participating state is willing to provide the data-activities letter. We just really need to emphasize that.

States can also partner with other payers, including perhaps even the state employees in a state. So we're talking about the state-employee group or other types of payers that the state might want to bring together and put together a joint application.

In terms of how CMS will support states in the strategy to — the funding opportunity, we, of course, are willing and happy to pay for the data needs that states are going to have to be pulling, and, as such, we are thinking of ourselves as a funder of states as part of the Strong Start Initiative.

And we do plan to do some more outreach and communications with states in terms of what more detail we need. And we want to really try to promote alignment of effort.

And, with that, I also just want to say that, you know, the application may feel like it has a lot of detail in it. We have plenty of time to get there between now and the time that applications are due. So if it hasn't been said already, I just want to reemphasize that I think we're looking for as

much as we can opportunities to streamline and align our efforts to make this as easy on both the states and applicants as possible. And we'll be revisiting that in pretty short order in providing more information on how we can facilitate that process to ease the burden on both provider applicants as well as state applicants.

RAY THORN: Great, thank you, Carol. And before we take questions from the Chat Box, I just want to reiterate a few things. You can always submit your question to the Strong Start email box at strongstart@cms.hhs. And we are — in addition to the webinars that we are conducting, we are also going to be taking questions that have been submitted and update our FA2 [phonetic], which will be posted onto the Innovation Center website in — hopefully, in the next week or so.

And also, in addition, additional webinars will be scheduled, and, as I mentioned at the top, you know, we will be holding another webinar next Wednesday on building the budget and the Medicaid funding opportunities.

So, with that, I would like to start taking some questions from the Chat Box, and, Steve, I believe we have our first question.

DR. STEVE CHA: Sure. So the first question is what does the state Medicaid agency have to commit to? So, you know, I just want to be clear about this. I think it's a critical point, and I'm assuming the question comes in the context of a non-state applicant. And, again, the non-state applicant has to obtain that letter of agreement from the appropriate state agencies. In some places, the state Medicaid agency and the Vital Statistics agency are going to be the same agency or department. In some places, they will be separate, but the state Medicaid agency certainly has to commit to verifying the Medicaid status of the participants in that particular demonstration and providing the Medicaid program data necessary for evaluation. And so this is going to be a range of various types of data from the Medicaid database in terms of actual claims data that are for the participants in that particular evaluation.

And, in addition, this is outside the state Medicaid agency, but just to reinforce, there is going to be — the Medicaid data are going to need to be linked to the vital-statistics data at that beneficiary level in order for the kind of evaluation that we think needs to happen here.

And, aside from that, the other requirements for the letter is an attestation of the description of the Medicaid-covered services in the state plan.

So those are the key pieces of that letter, and this is in addition to the anti-fraud components like the no double payments and no supplanting existing support.

The second question that we wanted to address is one from — that says, Doesn't FQHC need a letter from the Medicaid agency? And we got similar questions about other also state entities that are not the Medicaid agency, do those state entities need to obtain a letter.

And the answer is yes. Again, I think the letter from the state needs to ensure that those data components and that attestation and that insurance against no double payments. The agencies that are responsible for those need to be the ones that are signing off on that letter. So there does need to be a letter from those appropriate agencies that are involved in there. And that goes for whether it's a university, a state university, an FQHC or whatever.

RAY THORN: Thank you, Steve. And I think Carol has another question from the Chat Box.

CAROL BACKSTROM: A question just came in asking whether or not the state can partner with more than one applicant. And the answer to that is yes. We actually encourage this. We're really looking for some partnership and innovation. And so, yes, we encourage the state to go ahead and partner with more than one applicant if the opportunity presents itself.

DR. STEVE CHA: One more question that's come in is about — from an FQHC about whether the funding can be used to fund the difference between the bundled rate for the FQHC and the actual rate.

I think it's important to go back and talk about the services that we're talking about here. The model for enhanced prenatal care is trying to look at and test whether enhanced prenatal care can improve health outcomes or reduce costs. And those — the approaches for enhanced prenatal care is enhanced prenatal care to — essentially in group care, enhanced prenatal care birth centers and enhanced prenatal care maternity-care homes.

And, again, the idea is that these would go actually beyond the current scope of Medicaid-covered services. So the direct answer to that question is that you wouldn't be able to fund your currently-covered services. This would have to be showing that you are, in fact — these funds would be used to fund enhanced services that go beyond the scope of the current services. And that's why the attestation for the description of Medicaid-covered services is so important in order to document that this goes beyond that.

RAY THORN: Great. Thank you, Steve. And I believe we have our next question from the Chat Box. Ellen Marie.

DR. ELLEN MARIE WHELAN: Yeah, I've got a couple of questions here that aren't specifically about state partnerships, but we thought we'd answer them because they're coming in.

One of the questions, which is a good one, is we state in a few places that we are looking to target women who are at high risk for preterm birth. And they're wondering how they're going to know if there is high risk.

And what we've asked folks to do in the application is identify the neighborhood, the region, the area where the women who will be served are residing. And there's also some data that's available publicly that will help grantees describe the areas that they are providing care, and we'd like to see that those areas are areas that have some risk factors that would make the women that reside there more at risk for having a preterm birth.

And as a bit of a guide, there is a table in the back of the FOA where we identify how the Institute of Medicine lists different types of risk factors. And, certainly, any of those elements in the table would be something that we would consider if you describe your neighborhood as having high rates of any one of those.

There is another question about we have a requirement in there that there'll be 500 births per year, and I think 500 births per year over the three-year life of the program.

And the question is whether or not you need that 500 per year. And although we are certainly looking to have small partners, small providers partner, so that there is a larger number coming in, as you just heard, there's a fair amount of requirements we have for states with data. So the bigger the application, sometimes, it might be easier.

However, we are more looking to see that over the three-year period that there are 1,500 births over that entire three-year period, understanding that there might be a little bit of a ramp up to get up to that 1,500.

RAY THORN: I just want to remind everyone that the funding opportunity announcement is on the Innovation Center website. It's on the Strong Start webpage, and you can access the Strong Start webpage at http://www.innovation.cms.gov. Go up to the What We're Doing header at the top of the page, click on Strong Start, and that's where the funding opportunity announcement will be.

Also, we do are only accepting the letters of intent through the web form, and that web form is also accessible on the Innovation Center webpage through the Strong Start webpage. So there'll be two links, one for the funding opportunity announcement and one for the — to submit a non-binding letter of intent.

And I believe we do have our next question from the Chat Box with — Carol Backstrom will take.

CAROL BACKSTROM: The next question we have is whether or not groups need to partner with more than one organization if the applicant is a provider or do we need to partner with anyone else to apply for the grant?

And the answer to that is no. You don't need to partner with more than one organization, but you do need to partner with the state.

RAY THORN: Okay. Great. Thank you, Carol. And I think we have another question, Ellen Marie.

DR. ELLEN MARIE WHELAN: Yeah. Here's another non-state question is what are the criteria that will be used to determine if someone is eligible for the award?

And you'll notice there's two real specific areas in the FOA that folks should pay attention to as they are writing the application. One is the application narrative. And we go through and identify the kinds of questions that we think everyone should be able to answer, and that's what we hope is included in the document that you provide for us.

And then, as you look further down, there is an area that says exactly what the criteria are. There's three areas. There's points assigned to each of the three areas, and we're looking for things, for example — I'll let you read it yourself, but the kinds of things we're looking for there are is there some kind of a track record. Do you have some kind of a history of doing something like this before?

That means people that are providing these kinds of services now are certainly someone that we are looking to make sure. Remember, one of the things that's really important about this project is we want to test if these approaches work. So we're looking to have folks that have some kind of a history in being able to do it.

If it's a new organization, are you partnering, are you talking with, working with an organization that has done this before, to demonstrate that there is a real understanding of each of the three different approaches?

Along those lines, the third approach, maternity-care homes, is a little less defined than the others. And we did that on purpose to encourage lots of different folks to be able to apply.

But there's three key areas that we think our applicants would have to demonstrate if you're applying to be a maternity-care home. And you have to demonstrate there that you've improved access to care, and that would look to however that increased access should be, but, in particular, making sure that these moms — future moms have access to care between their scheduled visits.

The second, can you demonstrate that you're coordinating the care that's being delivered in coordination with things like WIC, since we know working with WIC is something that would — we know that that helps decrease prematurity.

And the last of the three, if you're defining what it is to have to be able to be a maternity-care home, the last of the three is are you delivering the enhanced services? What are you doing over and above traditional prenatal care that you think would decrease prematurity?

Because, of course, in all three models, we're expecting high-quality, evidence-based, traditional clinical care, and we're then looking to pay additional for the enhanced set of services.

I think I'll turn it over to my colleague, Carol, now.

CAROL BACKSTROM: We had a question come in asking whether or not a public-private partnership at the state level that includes the Medicaid agency would they be eligible to apply as a convener to support testing of models with multiple providers in the state?

And I think this is similar to the last question that I just had, which is, yes, we really do encourage multiple types of partnerships. So a public-private partnership at the state level that includes the MA agency, they can apply as the convener to support the testing of models in multiple locations, in multiple provider groups in the state. So, yes, the answer to that is yes.

RAY THORN: And I believe Steve Cha has another question coming from the Chat Box.

DR. STEVE CHA: Yeah, and this is a quickie, but I think — got a couple of ones like this. Is there any preference for managed-care organizations, particularly in states with a high penetration of managed-care organizations?

And the answer there is no. There's no preference for managed-care organizations, but, certainly, these partnerships may need to be thought of in creative fashions where MCOs have a lot of the women coming in. These data need to come in — are a critical piece of this whole effort, and so I think if the states — I think the — data can be handled at the state and vital-statistics level. So there's no preference for the MCO. I think it's just simply the data requirements and the 500-per-year cutoff.

RAY THORN: Thank you, Steve. Ellen Marie.

DR. ELLEN MARIE WHELAN: Yeah, we've got — some folks have been asking about a little bit of a clarification of the high — women that are at high risk for preterm birth. And one of the questions was, Once we identify that region where the women who live there are at increased risk for preterm birth would all of the women who live in that region be eligible?

And, of course, the requirement is they're covered by Medicaid, but, in fact, yes. If anyone that's covered by Medicaid, lives in that region, they would be eligible. And we did that for a couple of reasons. First of all, it's hard for providers to be able to say, You get the service. You don't.

We also know that for most women who deliver a preterm birth we are only able to accurately predict that in about 50 percent of cases. So we think that women who are living in regions where the rest of the women who also live in that region are at increased risk for preterm birth are among the women that we would like to provide the services for.

RAY THORN: And, great. Thank you, Ellen Marie. And I think Carol has the next question from the Chat Box.

CAROL BACKSTROM: We had a question coming from a group that describes themselves as a high-risk pregnancy provider. They're asking, Would we work with the state to participate or can we apply on our own?

And I think the answer is if you have a willing partner at the state, that's great, you know, to put together a joint application. On the other hand, there's nothing that stops a provider group from applying on their own, so long as we have sort of the letter of agreement from the state and the attestation of the state plan services, et cetera, et cetera, that the services that we are — or the parts of the application that we have covered earlier.

RAY THORN: Great. Thank you, Carol. And, again, if you want to submit a question, please do so through the Chat Box. And if we aren't able to get to your question today, you can always email us at strongstart@cms.hhs.gov.

And then, also, the funding opportunity announcement is on line on our website at http://www.innovation.cms.gov, and that is under the Strong Start web page, and, again, you can access that under the What We're Doing header on the front page of our website.

And, Ellen Marie, I think you have the next question from the Chat Box.

DR. ELLEN MARIE WHELAN: Yes. Someone else is asking about a little bit more clarification of the maternity-care home. You'll also find a table that we had at the end in Appendix B that starts to do a little bit of a differentiation.

One reminder, since we're looking at one model of enhanced prenatal care. There's going to be a lot of overlap here, and we imagine that these enhanced prenatal care services are going to be similar regardless of the site. But there's some pretty clear distinctions, at least between the first two.

Women that are receiving centering or group care is a very distinct model where women are getting — are in classes with approximately 10 other women who are all about the same area of pregnancy. They're as pregnant as the other women in their class, and they go through their

pregnancy together. The visits are much longer, 90 to 120 minutes, but the services they're delivering are probably pretty similar.

Second, of course, a birth center, is a different way to deliver the babies. The infants do not need to be delivered in the birth center. We're specifically looking at the prenatal care delivered in a birth center. Again, the services will probably be similar to other places, but the difference there is that the care is being delivered in a birth center.

And, again, the last one is a little bit more vague because we really wanted to encourage folks who are doing a great job providing enhanced prenatal services in a setting that we didn't already define.

What we did instead here is we looked to where the evidence said what kinds of things are responsible for improved, enhanced care that also ultimately decreased prematurity. And the three areas that we will be asking the applicant to describe to us is how you have demonstrated improved access and continuity, showing timely prenatal care and access to care between those scheduled visits.

The second is demonstrating how the enhanced services are coordinated well between the services delivered within the site as well as services they're referred to.

And, lastly, demonstrating the content is, in fact, enhanced and over and above the traditional standard prenatal care.

Just to reiterate, in each of the three models, we are expecting evidence-based, high-quality prenatal care. Things that we will probably be monitoring throughout the prenatal care days and — are described a little bit in the monitoring section of the FLA.

RAY THORN: Great. Thank you, Ellen Marie. I think Carol has another question from the Chat Box.

CAROL BACKSTROM: I think this is probably a question that a lot of folks have on their minds, and this gets back to this issue that I alluded to a little bit earlier. And that is do you know who we can go to at the state-government level, and pointing out that there will be need from both the Medicaid agency as well as the public-health agency in terms of vital statistics.

And I just want to acknowledge that this is definitely an emerging issue that we're realizing, and we acknowledge that this is going to be a challenge. We really do want to help on this front and streamline and align that effort as much as we can.

Our plan, at this point, is to work with our stakeholder partners, such as the National Association of Medical Directors and the Medicaid medical directors themselves across the states, as well as through the Association of State and Territorial Health Officials.

I think that we can try to figure out a way where we can really try to ease the application process as well as streamline contacts at states for how to best get this information, and just more news to come on that front. We just acknowledge that this is going to be a challenge and it's something that we're working very hard to address as soon as we can.

RAY THORN: Thank you, Carol. And I think Ellen Marie has another question from the Chat Box.

DR. ELLEN MARIE WHELAN: We've had a few questions asking about, first of all, covering preconception care. And while we think that preconception care is critical to having healthy births, we are — this is a reminder. We're looking to evaluate whether or not three models of care are successful in introducing preterm birth.

And we have looked, you'll see in the FOA that we've looked to see if we can get 30,000 women enrolled in each of our three approaches. And because we're looking at enrolling 30,000 women in each of the approaches, we have to wait until the women are pregnant to be able to enroll them.

So we're not certainly discounting the importance of preconception care, and it would be something that's great for all of the practices that could talk about those kinds of things, but we are only able to identify folks that can show us that they're providing prenatal care to women who are covered by Medicare.

These women need to be covered by Medicare throughout their preterm, the whole preterm phase, prenatal phase, because, of course, all of these enhanced care models need to occur throughout the entire prenatal period.

And, of course, with the Medicaid, we think, of course, that it's important to have women who are not — have any insurance. We certainly acknowledge that they need to have healthcare, but this is beyond the scope of what our current charge from the Affordable Care Act was. We have to look to programs — As CMS, we have to look to programs that are covering folks on Medicare, Medicaid and CHIP.

RAY THORN: Thank you, Ellen Marie. And I believe Carol has another question from the Chat Box.

CAROL BACKSTROM: Question is if the states see applicants, can they ask other applicants to partner with the state instead of submitting an individual application? And the answer to that question is yes. It can go both ways as well in terms of a provider as an applicant and putting together — you know, working with the state and trying to get an application put together as a partner.

So just wanted to say yes, this is the state's applicant, they can ask other applicants to partner with the state instead and put together one big application.

RAY THORN: Great. Thank you, Carol. And, again, you can access the funding opportunity announcement on our website at http://www.innovation.cms.gov. Just go up to the top to the header, What We're Doing, select the Strong Start webpage, and that funding opportunity agreement will be on the webpage — on that webpage.

So — and then also the letter of intent, which is a web form which you must submit by March 21st, Wednesday, March 21st, and that is the only way we're accepting the letter of intent is through the web page on the Innovation Center website.

I think Ellen Marie has a question from the Chat Box.

DR. ELLEN MARIE WHELAN: And just following what you just mentioned, there's a question about what are the specific questions that must be answered in the LOI?

And although we call it a letter of intent, if you go to our webpage, we've actually created a form where we'll just ask you the specific questions. You can just enter it right into the form, click Submit and you're done.

These are non-binding, although we are trying to get a sense of who and from which states. Although they're non-binding, they are required. So unless you have submitted a letter of intent, you cannot submit an application. So, because of that, we encourage anybody who's even remotely thinking of applying for this to please go to our web page, http://www.innovations.cms.gov. Go to the Strong Start webpage, and you can click then to our letter of intent form, where you'll see the questions there.

One of the — The follow-up question to that was, Does the LOI have to state which of the approaches that they are using?

Yes, you've got to tell us which ones you're thinking. And, again, you can, in a single application, have more than one approach. The stipulation is that only one approach per healthcare-delivery site, and you can just — if you're not sure, tell us the numbers at this point that you're thinking, and then they can be further developed by the time you get to the full application.

And, again, we will have an increased number of frequently-asked questions on our website. There's some there now, but as we get more and more questions, we'll be putting more and more of them up there. And as the questions come in, we'll determine future webinars.

So as we're seeing, for example, it's been mentioned a couple of times, next week, we're going to be doing one on budgeting, how to build a budget. There's been lots of questions about the data that will be needed. Certainly, we'll be spending a lot more time with that, possibly only after the letters of intent are in we will do targeted outreach to everyone who has submitted a letter of intent and invite those folks to be able to come in and get more information on the data as well.

RAY THORN: Great. Thank you, Ellen Marie. And, unfortunately, we do have a lot more questions here that were submitted, but we have run out of time today for this webinar.

We do hope that you find it informative, and if you did submit a question that we were not able to answer, you can always email us at strongstart@cms.hhs.

And, again, we will have another webinar next week. The information on — the details on that webinar will be posted on the Innovation Center website. So stay tuned for that. It will most likely be Wednesday afternoon around three o'clock. Again, stay tuned for further details on the Innovation Center website.

And at that point — at this point, that concludes our webinar and we thank you all for joining. Operator.

JENADA: Ladies and gentlemen, that concludes today's conference. Thank you for your participation. You may now disconnect. Have a great day.

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