CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Seth Edlavitch
July 11, 2012
3:00 p.m. ET

Operator: Good afternoon. My name is (Kurt) and I will be your conference operator today. At this time, I'd like to welcome everyone to the Centers for Medicare and Medicaid Service Innovation Strong Start Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you'd like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you'd like to withdraw your question, press the pound key. Thank you.

Mr. Seth Edlavitch, you may begin your conference.

Seth Edlavitch: Good afternoon, everyone and thank you all for joining the Webinar. My name is Seth Edlavitch and I am part of the Strong Start Team and I will be moderating today's session.

We are really pleased that you have joined us today in this Webinar to discuss the strong start initiatives to improve the care and health of mothers' newborn. The purpose of today's call is to discuss the key changes to the revised funding opportunity announcement or FOA that was released on July 3, 2012. Also, I'd like to note that we have posted a clarification document on our Web site at www.innovation.cms.gov.

Just a few housekeeping items, if you are a member of the press, this call is off the record. Please contact the CMS press office if you have any question.

You may also view the Webinar by going to https://Webinar.cms.hhs.gov/strongstart7_11.

Questions are being accepted via the Webinar's online question feature. Just type in the question at any time and hit "Enter". And we will monitor the questions and we will begin to answer them at the end of this Webinar.

And if you have a question or a comment that we are not able to get to today, you can always e-mail us and our address is strongstart – that's all one word – @cms.hhs.gov. If you're not able to view the Webinar today, the slides will be available on the Strong Start Web site at www.innovation.cms.gov.

This call is being recorded and the audio and transcript of today's Webinar will be posted on the Strong Start Web site.

The speakers for today are (Erin Smith), who is part of the Strong Start Program Team; (Caitlin Cross Barnet), who is part of our Rapid Evaluations Group; and (Susan Jackson), who is part of the Strong Start Program Team.

As mentioned earlier, after the presentation, there will be the opportunity for questions and answers. Please submit your questions in the online question feature. And, again, if you have questions that we're not able to get to on the call today, you can always e-mail us at strongstart@cms.hhs.gov. And, with that, I will turn it over to (Erin Smith).

(Erin Smith): Thank you, Seth. To start this off, I'll just go over (inaudible) what we'll be discussing today. First, we're going to discuss the overview of the Strong Start initiative with a little background information. And then we'll go into the key revisions of the Strong Start funding opportunity and these include the program timeline, optional letters of intent, evaluation and monitoring data, clarification and in the – the Q&A session will at the end.

So first up, we have two strategies that make up the Strong Start Initiative. The first is reducing early elective deliveries. This is a test of a nationwide public partner – public-private partnership and awareness campaign to spread the adoption of best practices intended to reduce the rate of early elective deliveries before 39 weeks and this is for all populations.

The second strategy is delivering enhanced prenatal care and this is the strategy we'll be discussing today. It's a funding opportunity for providers, states, and other applicants to test the effectiveness of enhanced prenatal care approaches and it's intended to reduce pre-term birth in women covered by Medicaid and/or CHIP.

The applicants may be providers, states, managed care organizations or conveners. Any applicant who does not directly provide prenatal care services; for instance, states, MCO's and conveners are expected to partner with providers of the OB care services.

The goal of this initiative is determine if these interventions can increase gestational age of neonates sufficiently to decrease the anticipated cost of medical care.

The three approaches that we are testing are the centering group care, birth centers, maternity care homes. The first is group care which is group prenatal care that incorporates peer-to-peer support in a facilitated setting for the three components of health assessment, education and support.

The second and birth centers, this is comprehensive prenatal care that's facilitated often by midwives, teams of health professionals which include peer counselors and doulas that is – focuses on including – the focus includes building relationships with the patient.

And then the third is maternity care homes. This is enhanced prenatal care at traditional prenatal sites. And it includes expanding access and continuity of care, coordination and content. And then all of these interventions will be delivered in addition to the standard prenatal care.

Next out of this slide of kind of a visual model of these enhanced prenatal care services and our expected outcomes. So each enhanced prenatal care delivery model feeds into better health, better care and lower cost. And these include addressing psycho-social needs, uses alternative approaches to care and sites of care and uses improved delivery of medical services.

And now we begin talking about the revisions to the FOA and first up is the program timeline which has changed. We submitted the application and program timelines following the second amendment of the FOA which was released on July 3. It can be viewed on the innovation center Web site which Seth has given us a couple of times today.

The application deadline is now August 9. The anticipated award date is October 5. And the period of performance is going to be four years, as it's always been. This includes three years of the service delivery and four total years of data reporting requirements for births of the intervention infants.

The second revision following our amended funding opportunity announcement is the letters of intent. These letters of intent are no longer a requirement of application. We're going to continue to accept them through August 8, but they are – they are optional and you're not required to submit a new one if you already have one. We are keeping records of all of them. But submitting a letter will allow you to use the partnering platform online.

Also, applicants may propose multiple provider sites within their Strong Start application. However, individual provider sites can only administer one of the three approaches. Applicants must clearly identify the provider sites and the associated enhanced prenatal care packages provided under the – under each approach throughout the application.

Medicaid and/or CHIP beneficiaries should not be enrolled in two approaches of enhanced prenatal care. CMS expects that Strong Start services will be provided in addition to the current standards of care.

And, with that, I'm going to transfer over (Caitlin) to continue presenting.

(Caitlin Cross Barnet): Thank you, (Erin). This is (Caitlin Cross Barnet). I'm going to be talking about some of the evaluation strategies for the Strong Start initiative.

So we have a revised approach to the state data linkages. That's just one of the main changes in the FOA. CMS remains committed to a rigorous model evaluation. CMS will be working with states (in order to use) outside of the

solicitation to obtain linked state vital specifics and Medicaid claims and encounter data.

Applicants are not required to obtain letters of agreement for their state to provide the link data. That will be pursued by CMS. CMS will also work with states to collect data on the Medicaid maternity (corset) quality measures.

If the applicant has an internal capacity or has established relationships with their state to link by all statistics and Medicaid utilization and encounter data, they should still describe this in their application. But it may not be included in the application budget. CMS will pursue that with the states at a later time.

Health system utilization data such as in-patient length of stay for mother and baby; NICU use; the type of birth, meaning, vaginal and C-section or instrumental vaginal delivery; cost of care; health care utilization; cost of care during pregnancy and for the infant's first year of life are all going to support a broader evaluation of the Strong Start model. This linked data will supplement the comparison of gestational age and birth weight in the baseline and intervention periods.

As far as data collection for the evaluation, the applicant should state commitment and demonstrate ability to collect gestational age and birth weight for intervention infants during the intervention period. The applicant must also state commitment to and demonstrate ability to provide the same data on birth from a baseline period that spans at least two years prior to the start of the intervention. And intervention infants are those who are born to the Medicaid and/or CHIP beneficiaries who participate in one of the three enhanced prenatal care approaches.

For baseline data and the comparison population, we will be looking favorably upon applicants who state their commitment and demonstrate an ability to provide more than two years of historical baseline data. Those organizations will receive 2.5 bonus points. And to those who provide gestational age and birth weight on a comparison population during the intervention period – those will also be awarded 2.5 bonus points.

During the application review process, the applicants who can demonstrate that they can provide additional years of baseline gestational, age and birth weight data or provide the same data for a comparison group during the intervention period can be awarded up to 2.5 for each additional data measure, allowing these applicants to receive 105 total points if they have both capabilities.

There are special cases in which organizations may not have two years of their own baseline data. So organizations that do not have two years of their own baseline data may propose an alternative data source to obtain the necessary baseline data. These are startups, organizations with less than two years of service provision history, and organizations that are already providing the proposed model but to a population that is different from the population that will be served under Strong Start.

The applicant must be able to demonstrate that this alternative data represents a population that is similar from a socio-demographic perspective to the population that will be served under Strong Start. Applicants who are unable to demonstrate their ability to provide at least two years of baseline data are not eligible for award.

As far as other data, in addition to gestational age and birth weight, the following variables may be reported – information collected on the 2003 version of the U.S. standard certificate of live birth; identification of cases involving elective inductions, elective cesareans and cesareans scheduled before the onset of labor; variables which address maternal and infant outcome.

Maternal outcomes may include psycho-social factors and health outcomes extending six weeks postpartum or longer, for instance, compliance with postnatal care instruction, breastfeeding practices, postpartum complications, incidents of postpartum depression and other maternal health concerns. There may also be additional variables that the applicant may want to consider based on their population and practice.

Applicants must be prepared to provide orderly reports on a variety of quality metrics for the women and infants served by Strong Start, and the detailed requirements for these quarterly reports will be further specified later.

For enrollment verification, applicants must be prepared to provide beneficiary identification numbers to CMS and/or to contractors for each woman receiving enhanced prenatal care. Applicants must also be prepared to provide beneficiary identification numbers for infants born to women participating in an enhanced prenatal care approach. Beneficiary identification numbers will be used by CMS and/or contractors for enrollment verification and evaluation purposes.

(Susan Jackson): Thank you, (Caitlin). I'm just going to provide some further clarification on some of the changes related to the budget.

So Strong Start funds should be used primarily for the provision of services rather than for overhead or administrative cost. We expected our applicants to implement their prenatal care approaches as rapidly as possible and begin service delivery within the first three months of award.

We also expect that applicants will have a minimum of 250 births within the first year and still achieve the 1,500 over the course of the three-year intervention period. We also expect that Strong Start activities that are related to startups and implementation of this program will be built into the applicant's work plan and timeline so that we can clearly specify those costs in their budget.

We will award up to 41.4 million over the four-year – over the four-year performance period, three years of service delivery and one year of data collection and reporting. This includes direct cost, intervention cost, administrative cost, cost for data collection and quarterly reporting but not cost associated with state data linkages. It does include start-up cost and indirect cost.

In order to test and draw substantial conclusions about the success of prenatal care approaches, we will need to fund the cost of Strong Start – Strong Start prenatal care intervention above the cost of usual – of the usual prenatal care

services for at least 90,000; 30,000 in each of the three approved delivery approach funded under the FOA.

This equates to about $460 per beneficiary and based on the literature and service delivery experts in the field, we believe that this is a pretty reasonable average per beneficiary amount. Applicants may propose a per-beneficiary amount that's lower or higher in the application.

Applicants may propose a per-beneficiary cost that's lower or higher than the – than the average beneficiary cost. However, we expect applicants to clearly justify these costs. And we encourage them to provide a complete justification in their budget – in their budget narrative especially if the costs are significantly higher or significantly lower than the average cost (provided). CMS – we – CMS have not specified a maximum or minimum beneficiary cost.

As far as how to apply, all of our – the revised FOA – the second amended FOA is available on grants.gov. The CDFA number is 93.611. Strong Start applicants must submit electronically through grants.gov if they would like their application to be eligible for review.

If you have issues submitting your application, then we encourage you to contact grants.gov and their support. The contact for customer service is support@grants.gov or you can call 1-800-518-4726.

The Funding Opportunity Announcement is also available on the CMMI Web site. This Web address is innovation.cms.gov.

And just to kind of summarize what we've talked about already, the applications are due August 9 at 5 p.m. Letters of intent are no longer required for application. Letters of agreement with applicant states are no longer required and CMS will work independently outside of the solicitation along the parallel track with (inaudible) to collect vital records of Medicaid and/or just claim an encounter data.

Applicants should also state their commitment and demonstrate their ability to collect gestational age and birth weight for intervention instance as well as the same data for baseline period for a minimum of two years.

Additional questions can be submitted online, of course, on our Web site. Additional information is available on our Web site or can be submitted through the Strong Start inbox at cms.hhs.gov.

At this time I think we're going to open it up to some questions from the audience. We're going to start with the questions that we've received online and…

Seth Edlavitch: Great. Thank you very much. This is Seth again. I've been compiling the questions as we've been going. So – and I really appreciate that everybody's taking the time to type in the questions.

I think the first question that we will address and I think (Erin) – Susan will address this question is what's the average cost per person? Several people would like that repeated.

(Susan Jackson): The average cost per beneficiary is $460 per beneficiary. This is an average. You might go a little bit higher or a little bit lower. But we have – we really believe that this is a relatively reasonable amount that our applicants should aim for.

Seth Edlavitch: Great. Thank you. The next question that we are going to answer: Can an academic institution with a medical school and/or an affiliation with a medical center apply for this grant and, again, I'll shoot this at Susan.

(Susan Jackson): Medical schools, academic institutions are eligible to apply for Strong Start funding.

Seth Edlavitch: Great. Here's a question: Will we need to update the letters of support/agreements?

(Erin Smith): This is (Erin). You will not need a letter of support if you are a state, an MCO or a convener. And that letter will be with the provider of OB care that you'll

be partnering with. As we presented today, the letters of support are no longer necessary with your state or state entity.

Seth Edlavitch: Great. Thank you. Here's the next question: There is a reference to, and it's in quotes, two years of data and then a reference also to at least two years of data. Which is it and what would be the difference? And I will send that to (Caitlin) and Susan.

(Caitlin Cross Barnet): There is a requirement for two years of data to be able to apply. And all applicants must demonstrate that they can provide us with two years of baseline data. However, there is a preference for there to be more than two years of baseline data.

Organizations that can provide more than two years of baseline data will get a bonus of 2.5 points in their grant application. So that's where that reference comes from. There must be two years but there may also be more than two years and that will be of benefit to the applicant.

Seth Edlavitch: Thank you. There was a follow-up question to the $460 per person. The question was, is that per year or per month or how does that work?

(Susan Jackson): That is the average cost per beneficiary over the course of the program. So for one woman receiving enhanced prenatal care service, we expect that over the course of the time that she receives enhanced prenatal care services, it will be $460 just for those enhanced prenatal care services.

Seth Edlavitch: Thank you. And then just – I'm sorry, I'm jumping back and forth. A follow up to (Caitlin)'s response on the data. Is there a number of years of previous data that is more desirable – five, 10, two, one – that was the question.

(Caitlin Cross Barnet): More than two. So if you can provide us with more than two years of baseline data, there will be – you will get 2.5 bonus points in your application.

Seth Edlavitch: The next question is, do the new changes impact the budget?

(Susan Jackson): Yes, they do. They impact what you can actually budget in terms of data and evaluation. We do not expect to see any money within the Strong Start FOA applications for state data in terms of vital records linkage and Medicaid linkages.

We do expect to see many in applications that, for service providers, that is going – that will cover cost for them collecting baseline data and gestationally from birth weight for the intervention population.

Seth Edlavitch: Great. Thank you.

Female: Sure.

Seth Edlavitch: All right. So the next question is, besides birth weight and gestational age, what other data are you looking for?

(Caitlin Cross Barnet): We are looking for data that is appropriate to your organization and your intervention. We did give a list of suggestions during the Webinar of things that you might consider. You don't need to feel limited to that list.

You should provide data that you think would be useful in understanding maternal and infant health outcomes, particularly as related to pre-term birth and the health, you know, of newborns and their mothers.

So clinical standards are important, continuous quality improvement is important. (Use) the kinds of things that you would expect to be reporting quarterly to indicate that you were meeting those kinds of standards.

Again, you need to look at what kind of population your organization is serving, what kind of data that you can routinely collect and present to us, what you think would best suit your organization and strengthen your application.

(Erin Smith): I just wanted to add to that this is similar to other models and other innovation center. And what we're really looking for is collecting process of care information, so those are the types of measures that (Caitlin) was just describing.

Seth Edlavitch: Great. Thank you. The next question is – I'm going to summarize the question. In the budget that the applicant creates, can the funding that we submit in the budget go to the state? The wording makes it sound like if there was already a process or database, then we can include the state in the budget but if we do not already have this link, can we include it in the budget?

(Susan Jackson): I'm a bit confused by the question. We are not going to cover the cost for date linkages between vital records and Medicaid through the funding (versus) this FOA. We do – we are fully committed to still getting those linkages, but we will not fund it through this FOA.

If you already have those relationships with your states, we expect that you will describe those relationships in your application. But we do not want you to include that information within your budget.

Seth Edlavitch: Great. Thank you. The next – and I wanted to let folks on the call know that there will be a Webinar on discussing the baseline information because I know that there are lots of questions on the baseline and that Webinar, I believe, is currently scheduled for the week of the – it's not scheduled yet.

So we will send information out.

Seth Edlavitch: So we will send out more information on when that Webinar will be because I know there are lots of questions on baseline. As well as next week, on Wednesday, and we will send information out, at 3 p.m. there will be a Webinar on the grant (saga) process and how do we actually submit an application and just generally for folks who are not as familiar with grant (saga).

We will have a Webinar that discusses that whole process. So for those of you who have questions about where things should be submitted, that will be addressed then.

Seth Edlavitch: Can you please elaborate on the information needed from the baseline period that spans two years prior to the start of the intervention.

(Caitlin Cross Barnet): The only information absolutely required is the gestational age and the birth weight for the infant. If there are other variables that your organization has that it plans to pursue and can provide us a baseline, you may certainly include those. But the required variables are gestational age and birth weight.

(Susan Jackson): I do want to go into further clarification on that. And we do – those are the only required variables, but we do expect our applicants to report on continuous quality improvement, clinical standards, et cetera, that's (a kind) to any other report and you do for any grant so that we can do quarterly monitoring of the services that you provide.

In terms of the evaluation of the model, we are requiring baseline data and gestational age and birth weight for the intervention population. But you will need to report for quarterly report. And that – and the cost associated with generating those quarterly reports and that continuous quality improvement and those clinical standards should also be included in the budget

(Caitlin Cross Barnet): The other thing to remember is that the grant indicates that you must indicate that you can provide us with this baseline data and that you intend to provide us with this baseline data. You do not have to have the data all completed and ready to present at the time of application, just the information that you can and will do so.

Seth Edlavitch: Great. Thank you. The next question: Are there bonus points for comparison data collection during the three-year care period?

(Caitlin Cross Barnetto): Yes, there are. If you can provide a comparison group during the intervention period, you receive a two-and-a-half point bonus on your application.

Seth Edlavitch: Thank you. The next question – give me one moment. OK.

(Susan Jackson): There is another question that states: We had already obtained letters of agreement with our state Medicaid and the Department of Public Health. Would it be helpful and advantageous to include these letters in our application?

And I think the answer to that is, yes, you can include it as supporting. We don't show any preference to this. We can't – so you're not going to get – receive any points. It's not required and we're not paying for any of these linkages.

So any work that's done relating to these (ideal) linkages are really outside the scope of the FOA. But if you have it, and you show –you should describe these relationships within your application. So it's their gain.

Seth Edlavitch: Great. Thank you. I'm sorry. The next question sort of tails on that – will application letters from the DHEC, (they have to) be viewed more favorably than those about – I think Susan just answered that question.

(Susan Jackson): We are awarding bonus points for more than two years of baseline data and for comparison population. There are no other additional benefits that will be given bonus points within the application review criteria.

You should refer to the application –review criteria found in the FOA for a better understanding of what exactly each individual application will be evaluated on.

Seth Edlavitch: Thank you. Yes.

(Susan Jackson): So we have a question here that states: Is there a minimum of how many clients we (needed to serve) as one year of the grant?

The answer to that is we want 1,500 participants over the course of the three-year intervention period. We expect to see, on average, 500 per year for a total of 1,500 over the course of the three-year intervention period. However, there is a minimum of 250 participants within the first year, so.

Seth Edlavitch: Great. Thank you very much. The next question: Did the total funding amount change? We thought it was $43.2 million, which when divided by 90,000 women, equals $480 per woman. Now it seems as if the target is $460 per woman.

(Erin Smith): Yes. This is (Erin). And good math because, yes, it has changed. We actually have changed the total funding for the cooperative agreements to $41.4 million. And that change come because we are now addressing the state data on a separate track.

So the funds that would have been used in order to get that data and that data linkages has been removed from the award. And so now the math is $41.4 million divided by the 90,000 women in the interventions which is 460.

Seth Edlavitch: Great. Thank you. The next question is: Can start-up cost be included in the budget?

(Susan Jackson): Absolutely. Start-up cost can be included in your budget. We don't want it to be – you know, we do expect that the majority of funds are going to be the provision of services, but administrative costs are allowable. And if they're doing training programs, they should be intensive and brief.

Seth Edlavitch: So the next question is: Please describe the comparison group.

(Caitlin Cross Barnet): I'm not entirely sure what – you know, what you mean by that question. But the FOA states that if you – you know, if you can provide evidence that you can produce the comparison group during the intervention period that you will be awarded bonus points.

Seth Edlavitch: Great. Thank you. The next question: The application asks that the organization described is experienced with the proposed evidence-based model. Is it required to have experienced with the proposed model and…

(Erin Smith): So, as we discussed before, one of the options is to be a start-up organization and some other types of organizations won't have a history of doing these models. So really the applicants can be any provider of OB care as state, a (MCO) or a convener. And we leave it to you to tell us how you are going to implement this enhanced prenatal care services and justify the needs for you budget.

(Susan Jackson): I just wanted to add to that and just say that you may be a new provider but we do expect you to be knowledgeable and to be able to demonstrate that you are a qualified provider of this enhanced prenatal care.

Seth Edlavitch: Great. The next question – thank you very much, Susan and (Erin). The next question: Does 1,500 participants equal 750 mothers plus 750 newborns?

Female: No.

(Erin Smith): When we're talking about participants, we mean the participants in the enhanced prenatal care intervention, so that will be the mother. That's what we're counting is the woman who is getting the prenatal care services.

Seth Edlavitch: Great. Thank you very much. The next question is an interesting question. We may not have an answer, but what if you are not a start-up organization and you still do not have experience?

(Caitlin Cross Barnet): Any provider of obstetric services who can meet this criteria of the number of people who have to be enrolled, providing the baseline data, and the other requirements of the FOA is eligible to apply to this intervention. We do expect that you will describe the experience and preparation that you have that will make you able to execute this model effectively.

Seth Edlavitch: Thank you very much. That was (Caitlin).

(Susan Jackson): I also want to encourage – and I'm not sure people – everybody is aware – but we did post the clarification document online on our Web site. And I would encourage people to read through that because that goes into a little bit more detail on some of these.

(Caitlin Cross Barnet): Some of these questions, yes.

Seth Edlavitch: Great. The next question is: Does CMS seek to award applicants that have partnered with other organizations or will smaller providers have the same chances of being funded as multi-state or multi-organizational applicant?

(Susan Jackson): Each application is judged based on the criteria laid out in the criteria section of the FOA. Each application needs to meet those criteria and will be evaluated accordingly.

Seth Edlavitch: Great. Thank you. That's a great answer. If you are a multiple provider site, would each – I'm sorry, I didn't see the whole question. If you were a multiple provider site, would each provider be required to see 1,500 mothers over the three-year period?

(Caitlin Cross Barnet): No.

(Susan Jackson): No. So if you are – if you are a multiple provider site, we expect that each application will be 1,500 mothers over the three-year intervention period.

Seth Edlavitch: Are you only interested in projects averaging 500 per year? What about a convener that has several providers so that there are over that many total mothers in the project, does there need to be 500 minimum per provider?

(Susan Jackson): No. The minimum is 1,500 over the course of the three years, 500 on average and 250 minimum in the first year. If you are a multi-site provider your application needs to serve a minimum of 1,500.

Seth Edlavitch: Thank you very much.

All right. The next question. Sorry about the delay. If a program was intending to track it's gestational age and birth weight or other measures identified for continuous quality improvement and study and comparison practices using linked vital stats with Medicaid data rather than having providers separately collect, can this be included in the budget?

(Caitlin Cross Barnet): You many not use any funds in this FOA to link data. If you have data that's already linked that you are going to use in some way, of course, you may use that. But there may be no funds used to actually make data linkages.

(Susan Jackson): And we also want to encourage you to describe those relationships within your application because we will be pursuing those linkages outside of the FOA.

(Caitlin Cross Barnet): So if you already have the capacity to do the linkages you should let us know in your application. But there won't be money – it can't be money in your application allocation to making those linkages.

Seth Edlavitch: Thank you very much for those answers. The next question: If we don't have the data at the time of the application, don't we lose the possibility of the bonus points for the longer look back?

(Caitlin Cross Barnet): The requirement is that you show us that you can provide us with that data, not that you actually have it at the time of the application. It's – and it's an ability to and a willingness to actually provide that data to us.

(Susan Jackson): We have a question that says: I'm unable to locate the partnering platform on the Web site.

(So) to be – to use the partnering platform you must submit a letter of intent. And once you submit your letter of intent and indicate your consent to share your contact information– such as e-mail, phone number, address, state, location and I think, model of care, then we will grant you access – we'll send the link and the password to get to the platform.

Seth Edlavitch: Right. So – and this is just to clarify as well. I'm sure Susan said it, but the letters of intent are not required to apply but they are required for access to the platform.

The next question – I'm sorry – is can you specify the total number of awards available?

(Erin Smith): We don't have (the exact) number of awards that we will be awarding. We – what we do have is the total number of dollars that we are able to spend on awards which is the $41.4 million that I discussed before.

So, I mean, it depends on how many babies or mothers each intervention is proposing – each application is proposing to treat. If some groups are treating more than the 1,500 minimum, then the – then we'll have less awards.

But what we need to do is make sure that we are able to treat 90,000 mothers in the enhanced prenatal care model. And that is 30,000 in each of the three models.

Seth Edlavitch: Great. The next question: Just generally speaking, where can you find the PowerPoint for this presentation?

The PowerPoint is on our Web site. The Web site is www.innovation.cms.gov. The transcript will also be up there within a week. I cannot tell you the exact day. There is also a clarification document on the Web site that discusses other things we've talked about today.

The next question: If we collected provider letters of agreement earlier to meet the first deadline, can we use those letters or do we need to collect new ones?

(Erin Smith): If those letters are still accurate and they're still the providers that you intend to partner with and still have the information needed, then those would still be fine. That requirement has not changed in this amended FOA.

Seth Edlavitch: And just to comment, somebody mentioned that they're not able to open up the clarification document posted. Just individually, if you have an issue with that, you can send an e-mail to the Strong Start inbox, strongstart@cms.hhs.gov.

(Susan Jackson): And we'll double check with our IT people to make sure that the link is running. I did access it earlier in the day today and it was working fine. But we will definitely double check it.

Seth Edlavitch: Great. Thank you very much. If an existing date linkage exists, can budget funds be used to cover cost of downloading or transferring this data?

(Caitlin Cross Barnetto): No, they can't. There is no funding in this FOA for data, for producing data linkages. We are pursuing that separately.

Seth Edlavitch: Will awards be based on current states and regional rates of pre-term births?

(Caitlin Cross Barnet): We're not entirely clear on what your question is. But awards are based on the quality of application.

(Aliza Gordon): I also want you to show that you're serving a high-risk population.

(Caitlin Cross Barnet): Right. But they're not based on your particular state's rate of pre-term birth.

(Erin Smith): That's correct. I just wanted to follow up on what (Caitlin) was saying. And we are also looking for diversity across the country and diversity of locality. But we're not targeting certain regions for the awards.

Seth Edlavitch: Thank you. The next question is back to the baseline. Will an applicant's baseline data have to demonstrate that 500 participants per year have been served?

(Susan Jackson): We're going to be hosting another Webinar on baseline data in the future. And I think we should probably wait until we have that Webinar to answer that question.

(Susan Jackson): Will the comparison population be comprised of other Medicaid patients or privately-insured patients not involved in the intervention?

(Caitlin Cross Barnet): It should be comprised of a sample that's socio-demographically similar to the population that will be served under Strong Start. If you are already serving Medicaid and/or CHIP patients in your organization, then you should be using your own organization's patients in your baseline.

Seth Edlavitch: Great. Thank you very much. And I see that the individual who is having trouble finding the PowerPoint sounded online, so I'm happy to see that.

Susan's going to address a question regarding risk factors.

(Susan Jackson): So Strong Start is particularly interested in reducing the (efforts) pregnancy outcomes of low birth weight and pre-term birth for women at high risk of these outcomes. And we expect that applicants will propose target areas for

deploying these approaches and present available data to demonstrate that that proposed target areas are those in which there is a greater concentration of risk for pre-term birth.

Applicants should identify the risk factors for pre-term birth present in the area where they propose to deliver services. Applicants should also present available data to assess and describe the risk factors presented.

Appendix A of the Funding Opportunity Announcement provides a list of risk factors for pre-term birth. Applicants should also clearly demonstrate that the women who live in the proposed target area are at high risk for pre-term birth.

Official reporting sources, collecting data on indicators of pre-term birth; such as prematurity, low birth weight, infant mortality and other indicators or poor infant outcomes should be used as evidence of high risk in a geographic area. Official reporting sources may include entities like the Centers for Disease Control and Prevention, state and county health departments and the Indian Health Service.

Seth Edlavitch: Great. Thank you very much. I see there is approximately five minutes left in the Webinar. We're going to look for two more questions and then we will take all the questions that have been submitted but have not been responded to and we will work through them and we'll host them or address them. I don't know where we're going to put them, but – when will you – hold on one second.

Are providers considered co-applicants or sub-recipients or sub-contractors?

(Susan Jackson): It depends on how they apply. Providers can be a direct applicant and they can receive the award money directly. They may also be a partner who works with a convener, for instance. So they can either be an awardee or they can be somebody who has decided to partner with another awardee.

Seth Edlavitch: Thank you very much. The – one question related to the baseline data – we will – we will be having a baseline presentation scheduled soon to discuss all the baseline issues.

Seth Edlavitch: The question is: Will you be contacting the state for – I'm sorry, what was the question?

(Erin Smith): Yes. So there was a question about how we are going to be working with the states for the parallel or for the vital records and the linkages with the state and Medicaid data.

We will be working on parallels (tracks) with the state. CMS will be responsible for working with the state and we will be contacting them directly. We – for those applicants who already have partnerships with the states, we can also work with the applicant and have them involved in that process.

We understand that each applicant's situation will be different. But we intend to contact the states directly for that data and the data linkages.

Seth Edlavitch: Great. Well, thank you all very much. I'm sorry we weren't able to address everyone's question. But we really do appreciate your interest and the time that you had taken to participate on this call.

If you would like information about the Webinar and the clarification document, please go to our Web site at www.innovation.cms.gov. Also, you are welcome to submit questions to our inbox, strongstart@cms.hhs.gov. Again, thank you all very much for your time.

Operator: This concludes today's conference call. You may now disconnect.

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