Center for Medicare & Medicaid Innovation

Strong Start: Preparing Your Budget for the Medicaid Funding Opportunity 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.

LACEY: Good day, ladies and gentlemen, and welcome to the CMMI Strong Start Building a Budget for the Funding Opportunity Application Webinar. My name is Lacey and I'm your coordinator for today. At this time all participants are in listen-only mode. If at any time during the call you require audio assistance, please press star followed by zero and a coordinator will be happy to assist you. I would now like to turn the presentation over to your host for today's call, Mr. Ray Thorn with the CMS Innovation Center. Please proceed.

RAY THORN: Thank you, operator, and good afternoon, everyone, and thank you all for joining. This is Ray Thorn and I'm with the Stakeholder Engagement Group here at the CMS Innovation Center. This call is being recorded and will be posted on the Innovation Center website within a couple of days next week. The audio and slides today will also be posted next week as well. The Strong Start Initiative is a partnership between the CMS Innovation Center and the Center for Medicaid and CHIP Services. It was announced in February, about a month ago actually, and so this is our third webinar of a series of webinars on the Strong Start Initiative.

Since the announcement of the Initiative, we have received lots of questions on the Strong Start Medicaid Funding Opportunity. We want to thank you for your patience and we probably will take this opportunity to address some of those questions, particularly addressing questions on eligibility and on how applicants can prepare their budget for the Strong Start Medicaid Funding Opportunity.

And we do have a news flash, an announcement that is pretty late-breaking. And what it is is that in addition to all the questions that we received, we received a lot of feedback from potential applicants and the –- and what the requests have been have been is to have more time for applicants to prepare for the non-binding Letter of Intent. So with all the feedback that we received, the new letter due date for the Letter of Intent is now May 11, 2012 at 5 p.m. So again, the Letters of Intent for the Strong Start Funding Opportunity are now due on May 11 at 5 p.m. All other dates in the FOA, including the application due date remain unchanged.

So getting back to today's webinar, the agenda for today will be solely focused on the Strong Start Medicaid Opportunity discussing the –- who is eligible, the eligibility criteria, and as well as preparing the project for the funding opportunity. We will continue to have future webinar opportunities that will focus on additional information on the Strong Start Initiative including Strategy One relating to early elective deliveries. Information on the future webinars will certainly be posted on the Innovation Center website at innovations.cms.gov.

So for the speakers for today's webinar will be Carol Backstrom, who is Senior Advisor at the Center for Medicaid and CHIP Services. She will provide a broad overview of the Strong Start Initiative and particularly the Medicaid Funding Opportunity. And Aliza Gordon from the Learning and Diffusion Group here in the Innovation Center, will discuss the eligibility criteria for the Strong Start Medicaid Funding Opportunity. Finally David Hurwitz from the Policy and Programs Group in the Innovation Center will discuss how applicants can prepare their budget for the 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 or chat function on the webinar screen. We will not be taking questions over the phone. For this question and answer session we will also be joined by Ellen Marie Whelan from the Innovation Center to help answer questions in addition to today's presentence.

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 innovations.cms.gov. There is a link to the Strong Start Initiative webpage under the "What we're doing" tether at the top of the Innovation Center homepage. And with that I will turn it over to Carol Backstrom.

CAROL BACKSTROM: Thanks, Ray. My name is Carol Backstrom and I work in the Center for Medicaid and CHIP Services and thank you, everyone, for joining us today. We are so pleased at the amount of interest that we've had in this process and in this program and in this opportunity. And so it's just really great to have you all on the line again today. Just as background we thought we would just spend a couple minutes once again providing the overview of what the project is. I know many of you have heard this before, but bear with us and this is really also for those who may be just getting up to speed at this point.

So as you know, the second slide here is really just focused on describing the two efforts within this campaign initiative. This is one Strong Start Initiative, but we have two strategies. The first strategy, of course, is reducing early elective deliveries. This 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 elective deliveries before 39 weeks for all populations.

The second strategy is this funding opportunity, which is delivering enhanced prenatal care. This funding opportunity is for providers, states, and other applicants to test the effectiveness of specific enhanced prenatal care approaches to reduce preterm birth in women covered by Medicaid.

Of course this webinar today is focused on the funding opportunity, which is specifically the delivering of enhanced prenatal care. As you know, this is a cooperative agreement funding opportunity for providers, states, managed care organizations and conveners. And this is really the intent of all of this is to test those evidence-based approaches to deliver enhanced prenatal care that can improve health outcomes and reduce costs to mothers and infants in Medicaid.

We're testing three approaches in this evidence-based enhanced prenatal care. Again, we're calling all of this under one umbrella of enhanced prenatal care, but there are three approaches underneath this umbrella. There's enhanced prenatal care through centering or group care. There's enhanced prenatal care at birth centers. And there's enhanced prenatal care at maternity care homes.

ALIZA GORDON: Thank you, Carol. This is Aliza Gordon also at the Innovation Center and thank you all on the line for being here today. Before getting into the details of building a budget, I just want to take a couple of minutes to go over a few issues relating to eligibility, especially since we received so many questions through our email inbox on this topic.

First, I'd like to give a basic overview on who is eligible to apply for grants. There are four different types of applicants that can apply for funding, the first of which is state Medicaid agencies. The second type of applicant is the actual providers of care and this could be provider groups, affiliated providers or facilities that are delivering prenatal care. Third are managed care organizations. And last is conveners, which we'll talk about more in just a moment.

The last two bullets at the bottom here are a reminder that all of the non-provider applicants must apply in a partnership with providers. As awardees, they must give funding through the providers who will be actually providing the enhanced prenatal care. Additionally all of the non-state applicants must demonstrate how they will partner with states for the data collection and data compilation process, which will be necessary to show if the program is successful.

And now I'm going to talk a little bit more about conveners. The function of a convener is to bring together multiple participating health care providers to receive funds under one grant. A convener must partner with and coordinate the providers who provide enhanced prenatal care. The money will flow through the conveners to providers. And the conveners will also help us with data collection by working with their states. A convener may be any entity that is eligible to receive federal funds. And to be eligible, it must be recognized as a single legal entity by the state where it is incorporated.

Those that cannot receive federal funds, if there's anyone without a tax identification number, may not be a convener. Examples of conveners include but are not limited to national trade or professional associations, a collaborative of states or providers, and care or other health services related organizations. Another type of convener that isn't listed here could be universities and we've gotten some questions about that and that would definitely also be an eligible convener.

We have heard from many of you who would like to provide or are already providing more than one approach of enhanced prenatal care in an individual practice. It is a combination of centering or group care for centers or maternity medical homes. While as an awardee you may receive funds to administer more than one approach of enhanced prenatal care, individual practices must enroll in only one of the three approaches. However, in cases where a practice delivers more than one approach of enhanced prenatal care, we will not ask it to change how it delivers that care. Rather we are going to ask applicants to identify the approach that best describes their current practice.

We've also received many questions about the 500 minimum Medicaid beneficiaries each year or 15 hundred over the three year grant period and who is included in that figure. First I just want to go over that only pregnant women who are enrolled in Medicaid, not just Medicaid-eligible can be included in this 500 minimum. They must be enrolled in Medicaid from the start of the time that they are receiving their enhanced prenatal care. To be included these women must be receiving the intervention of enhanced prenatal care in addition to traditional prenatal care services. Control groups or comparison groups is not included in this number and you do not need to care for additional patients in a control or comparison group.

Last, if you choose to provide different approaches of enhanced prenatal care at different sites, you do not need to have 500 women receiving each approach to enhanced prenatal care. However, that

minimum of 500 total beneficiaries is required for your total application. And once again, we encourage small practices who cannot themselves provide enhanced prenatal care to 15 hundred Medicaid beneficiaries over the course of three years to partner with other practices in order to meet that minimum.

I hope that helps to clarify some issues regarding eligibility to applicants. And with that I'll turn it over to David Hurwitz at the Innovation Center, who will be speaking about building your budget.

DAVID HURWITZ: All right. Thank you, Aliza. So for the next few slides I'd like to highlight some of the key points of the Funding Opportunity Announcement and address some of the questions that we've been asked by potential applicants. So first to start with, the total funding opportunity is up to 43.2 million dollars. That is, to be clear, that is the total for all four years. So that's three years of the service delivery plus the one year of data collection, follow-up and recording. So in that one extra year we are following up on the outcomes and the babies born to mothers participating in the service program. There will not be services provided during that extra year.

And this 43.2 million includes all directs and all indirect charges. And also in response to a few questions, just to be clear, this is a one-time award. It's not an annual renewal. You will not have to reapply next year for this kind of funding. They're awarding it all at the outset. We expect to fund cost of care for 90,000 women and that would be about 30,000 each of the 3 approved delivery models that were mentioned earlier in this presentation. So if you do the math, 43.2 million divided by 90,000, this equates to $480 cost per beneficiary.

A number of questions came in regarding this and again to clarify, applicants, we don't expect that everybody is going to come in with exactly $480 for their budget per beneficiary. We expect that applicants will propose costs that are lower or higher. We do not specify a maximum or a specific minimum. However, for the next few slides I will talk about how we will evaluate the budget through evaluation criteria and the concept of cost effectiveness that we'll be looking at.

So as we think about the budget, a good place to start is to think about how CMS will evaluate applications. And we've laid out in the Funding Opportunity Announcement the three key categories of criteria that we're going to use to evaluate this project. So we've stated design of project, administration, organization, and staffing and then finally the budget. So the budget is 25 points of the evaluation criteria as I'm sure you know and obviously it's very much intertwined with the design of your project and the other aspects of it. So clearly it's a very important piece.

In this slide we pulled out some of the key words from the budget and budget narrative section that are part of the Announcement and I'll talk through these a little bit further. So efficient use of funds, cost effective, clearly justified, and primarily for services. So over the next few slides I'll go a little bit more into detail about these concepts.

So one person asked and I thought this was a very good question, what does it mean to be cost effective? And I think the answer here is that it's not a perfect science. It's part science, part art. As we review these things, we understand that all applications are going to look a little bit different both in terms of their design, in terms of the location and type of application that's coming in or type of service delivery.

So I think the place I start is to think about what we've written as the ultimate purpose of this initiative, which is to achieve the three part aim of better care, improved health and reduced costs by improving outcomes for high risk pregnant Medicaid beneficiaries. So as you think about the word cost effective, I would say think about value. So achieving better care and improved health at the lowest possible cost is what gives you value. Using funds primarily for service delivery with the lowest possible administrative costs will add value.

I would note here that this is –- this really is a competitive fitting process with the understanding that everybody's application will have different elements. So to some extent we'll be comparing apples and oranges. If all else is equal and we have two applications where everything is exactly the same in terms of service design, in terms of number of beneficiaries and things like that, then clearly the lower cost application would be given an advantage in terms of the overall scoring. But I would lastly point out just to be realistic. Don't put down costs that are lower than you need to actually achieve success with your proposed program.

So we stated in the Opportunity Announcement that there are really two key budget related documents required or sections required. And the first is to fill out the SF, Standard Form 424a. And this should be pretty straightforward although there are details both in the main section as well as the appendix of the Opportunity Announcement that provide greater detail on how to fill this out. But that's absolutely critical that you fill that out clearly in a way that we can analyze well. But the budget narrative is the accompanying document with that so that we can really understand exactly the thinking that went into tying your budget numbers into your overall service design. So providing a description consistent with evaluation criteria is very important.

We've also on page 35 and 36 of the Funding Opportunity Announcement we've asked you to provide an additional table. In really taking the direct charges section, the total should match at that 424a and categorizing that into intervention costs, administrative costs, data costs, and/or startup costs. And this will help us sort of further analyze how you're thinking about the overall design of your program so that we can understand where the money is going. I think most importantly here with the budget narrative be as clear and detailed as possible on how the funds will be used.

There have been a number of specific questions as to what can or cannot be covered and in some cases we have to address that on a case-by-case basis. I would say first and foremost if your budget narrative is very clear, then that there helps us identify any issues. So generally to answer some of the questions we received, here are a few examples that are likely to be eligible for funding as long as they're directly related to the program. So employee provider salaries, training, data systems, marketing or outreach, office supplies that are directly related to the program. Leasing space as long as it is used specifically for the program may be eligible. Making minor renovations to existing physical spaces may be eligible.

Some items that are not likely to be eligible for funds, purchasing real estate is not likely to be eligible. Major construction like building a space from the ground up, probably not eligible. And things like snacks at events was a specific question and that would not be eligible. So I think you can tell there's a range –- there's a range of things that may or may not be eligible and again if you have a clear budget narrative, that's the most helpful thing. If you have specific questions as you're preparing your budget, certainly please email us and we'll do our best to answer those.

So ineligible uses of funds, there's a few broad categories that we wanted to highlight. So these are all ineligible uses. So funding for enhanced prenatal care first of all varies by state and so that's why it's

hard to some extent to just give blanket statements about what is or is not covered. But funds cannot be used to –- and I'll highlight these four different areas. One is to supplement payments for services already covered. So for example, let's say you have counseling services ongoing that currently covers you at $75 per service but the actual cost of your providing that service is $100. You cannot then apply to close the gap by asking for an additional $25 through the Innovation Center funding.

Second, supplanting funding for services already authorized. So that is ineligible use of funds. For example, if nutrition counseling is included in a state's plan under extended services to pregnant woman, an applicant would not be able to use Innovation Center dollars for nutrition counseling. Third is paying for services to women not already enrolled, not enrolled in the Strong Start Program. I think that's pretty straightforward. A nuance of that would be that if an employee is for example putting his or her time between the services that you're providing for enrollees in this program and services for women not enrolled in the program, you would want to consider that and account for that as you put together your personnel cost in your budget.

And then finally paying for enhanced prenatal services unrelated to the three approved options. Again, there's lots of things that you can do in terms of enhanced prenatal services, but we are really focusing on these specific three options that we laid out earlier. And you can refer to detailed information within the FOA.

So this is my final slide. There's been a number of questions coming in regarding data collection with states. So to be clear, applicants are expected to make arrangements with their state to access Medicaid data necessary to support evaluation. And when we talked about the 43.2 million dollar funding, the cost of that data collection should be included in the proposed budget. That said, we know there have been a lot of questions about how to make this process work, about how to estimate the cost. And so I would say my main piece of guidance here would be don't stress over this. We are working to provide you with additional guidance on the process, on requirements, and on estimated costs and we will make sure we have that prior to the application deadline.

For purposes of the Letter of Intent at this point for your budget estimate, we would just suggest that you add five percent to your intervention costs as a placeholder for obtaining this data, but again we'll provide further guidance ongoing. And that's all I have. I'll pass it back to you, Ray.

RAY THORN: Thank you, David. And before we get into the question and answer period, for those of you who may have joined late into the webinar, we did make an announcement at the beginning of my remarks due to the fact that we've received a lot of interest and a lot of number of inquiries about the Initiative and that we have received requests for additional information and time for the applicants to prepare for the non-binding Letter of Intent, the Innovation Center is modifying the Letter of Intent deadline to be now May 11 at 5 p.m. That means that we are –- the Letter of Intent is no longer due tomorrow. We are at the deadline to submit the non-binding Letter of Intent is now May 11 at 5 p.m. All of the other dates in the FOA, including the application due date of June 13th remain unchanged. So again, the Letter of Intent due date is now May 11 and that all of the other dates in the FOA, including the application due date, remain unchanged.

So the next steps here before we get into the question and answers, we are –- all of the questions that have been submitted through the Strong Start email box are being compiled into a comprehensive batch, which will be updated with the FAQ which is now posted on the Innovation Center website will be updated and posted onto the website in the near future. And in addition to this webinar and the other

two webinars, additional webinars will be scheduled in the near future. So stay tuned and the information will be posted onto the Innovation Center website and we will also email potential applicants as well as through the Innovation Center List Serve.

In addition, the previous webinars that we've done, the previous two webinars we've done, are posted on the Innovation Center website, particularly at the Strong Start webpage, which again you can access it form the Innovation Center homepage at innovations.cms.gov and go to the "What we're doing" tether at the top of the website and the Strong Start page will come –- will –- the link to the Strong Start page will come up and you can click on that link. So with that I believe we are ready for questions that have come through the chat box and I believe Aliza is going to take the first question.

ALIZA GORDON: We have a couple questions about eligibility so we'll start there. First we received a question, it's a Medicaid managed care organization can be a convener and also the public health department can be a convener. And absolutely either of these types of organizations can be a convener.

And another question that we got was does the 500 enrollees include both recipients to our straight Medicaid and managed care Medicaid? So the answer is yes. We're not differentiating between Medicaid beneficiaries who are enrolled under a managed care organization versus not.

RAY THORN: Great. Thank you, Aliza. And I believe David has a question that has come through the chat room as well.

DAVID HURWITZ: Sure. So we have several questions here. One is how detailed a budget are you seeking on the Letter of Intent? We only have 750 words to work with. And I think that the answer is we are not looking for a detailed budget at all. There is a line where you're supposed to put in one flat number and that's really the key point, but we're not looking for any detailed budget breakdown for that Letter of Intent. I'll cover a few other questions as well.

Somebody did a little bit of math. So I think this is a really good example just to help clarify. This person wrote, "So if the amount per beneficiary per program that covers 500 patients per year for a total of 15 hundred patients, do I take $480 multiplied by 15 hundred? That gives me 720,000 and say will that be the amount that this will offer?" So if I understand the question correctly, just to be clear, we used, we're using the $480 average as a benchmark. So we don't anticipate that you will have to stick to that $480 number. If you can come in lower, excellent if you're able to provide those services. If you're able to provide those services at a lower price. If you need to come in higher, you can also do that. Again, we haven't specified a minimum or a maximum. But we will look at that in terms of just the general competitive process and benchmark it that way.

DR. ELLEN MARIE WHELAN: We've got a couple questions that have come in about the Letter of Intent. Somebody's asking if they can go in and change their budget estimate on the Letter of Intent or change... Somebody else asked about changing numbers. That's really not necessary. The Letter of Intent really is just an opportunity to allow you to provide an application later. It's non-binding. We're looking to see which –- who's interested, which states have an interest, and general numbers. So at this point we are not seeking any changes.

Someone else asked other than the date, have any of the other requirements for the Letter of Intent changed? And it has not. The only thing that changed we will still be accepting additional Letters of Intent to come in through 5 p.m. on May 11th.

RAY THORN: Thank you, Ellen Marie. And I believe there's another question that came through the chat room.

DR. ELLEN MARIE WHELAN: Yeah. One of the questions here is will CMS pay for providers for the new services related to the grant? And I think the answer is same as we've been saying before. If the additional set of services for the enhanced prenatal care are currently not funded by another source, then these grant funds, these additional dollars will be available to pay for the additional services. However, those additional services need to be provided. So if they need to be provided by someone that's not currently being paid by an additional source, then that would be something that's available.

Here's another one that has come in. Is there additional funding for the fourth year of data analysis? And this data analysis, the evaluation of our program will be done by CMS through another independent evaluator. So this funding opportunity is for the implementation of these programs and the funds associated with that. We have some monies available, as has been pointed out a number of times, to the states to help us get those data because we know that that can be something that's needing additional resources. But the analysis and the overall evaluation will be done by CMS through a different contractor. So not part of this funding opportunity.

RAY THORN: I believe we have an additional question from the chat room and it involves the role of who is a –- who can be a convener. And the question came up with respect to can a Medicaid MCO be a convener and can public health departments apply as conveners? So Ellen Marie, do you want to take...?

DR. ELLEN MARIE WHELAN: Yeah. We're not looking to have folks identify necessarily how they're coming in as an applicant. It was a general way of describing the folks that we see as applications. So a managed care organization is eligible to apply and they are eligible to apply however they put that grant together, be it themselves or as a convener. And I think the convener is just something that we are acknowledging that there might be a third party that helps gather practices together. They can be smaller practices. Could be convened some other way, but it's a way of getting multiple practices to come together. It would also be a single entity that's helping those practices gather the data from the states and manage that relationship that they have with the states.

RAY THORN: And we did get in those questions about the LOI due date. What is the change to the LOI due date? And again, the new due date is May 11, 2012 at 5 p.m. All the other due dates or all the other dates in the FOA, including the application due date remain unchanged. So again, the new LOI due date is May 11th at 5 p.m.

DR. ELLEN MARIE WHELAN: Someone else is asking me about the conveners. Are there any special provisions for the conveners? And there are not. We expect the conveners... One of the things the conveners will need to do is show that they have partnerships with the provider as well as showing that they've got partnerships with the states who are going to be helping to pull that data together. We also

manage managed care organizations will be extraordinarily helpful in gathering the data since they will be collecting so much of it. But no special considerations for conveners.

RAY THORN: Great. Thank you, Ellen Marie. And I believe there is another question.

DR. ELLEN MARIE WHELAN: Sure. One question here is any of the costs related to Strategy One, which as folks heard, Carol talked about earlier. It's our strategy to reduce early elective delivery. That is not part of this funding opportunity. That's a different initiative as part of Strong Starts. We've got lots of interest out there in the field.

We encourage folks to send emails to us through the Strong Start email address. However, I will say that there will be more information forthcoming to try to capture all this enthusiasm. We are looking to put some interesting information on the webpage about that and looking to figure out other ways of engaging interested –- folks that are interested in expanding that. So at this point the money for the Strategy Two is specifically looking at three different approaches to reducing preterm birth.

We've got someone asking about a better definition of maternity care home. Maternity care home is in here as the third option. And we have it a little bit vaguer because we want to make sure that folks who are currently delivering an enhanced set of service in addition to the traditional prenatal care or folks that are offering just traditional prenatal care who want to offer some additional services could participate.

We do have three things that we're asking anyone who's applying as a maternity care home to comment on. And they're outlined both in the FOA and in the chart at the end of the FOA. The three areas that we would expect every maternity care home to be able to describe would be how they have improved access and continuity to care. Specifically what we'd be looking for here is the ability to offer care between scheduled visits because that's something that an enhanced set of services has the opportunity to do.

We'll ask maternity care homes to demonstrate how they're coordinating care both within the service delivery site as well as coordinating services happening outside the prenatal care site. That would be for example to WIC and other places that we have –- there's coordinating services.

And the third area that we'd ask all maternity care home applications to describe is how they will be operating enhanced services. What are the services that they're delivering that are over and above what we would think of as traditional clinical prenatal services?

RAY THORN: Great. Thank you, Ellen Marie. And I believe there is another question that has come through the chat room. How many proposals is CMS planning to fund?

DR. ELLEN MARIE WHELAN: We haven't decided how many proposals. What we are looking at as David mentioned earlier in the webinar, is we have three different evidence-based approaches that we're looking to fund and we're looking to fund overall programs for 90,000 women and we're looking to have 30,000 in each of the 3 sites. So ultimately our ideal funding source of applications would be the number of applicants that it took to show that we have provided care for 30,000 women in each of the 3 sites over the 3-year period. So not a defined number of totals but more looking at how many women.

And we got those numbers because as we pointed out, this is we're testing models of care. We at the end of the day want to demonstrate that whether or not these enhanced prenatal care models could decrease prematurity. And that's the number of women that we think need to be enrolled given our statistical analysis to demonstrate whether or not each of these three models has the ability to decrease prematurity over time.

RAY THORN: Thank you, Ellen Marie. I believe we have another question. Carol?

CAROL BACKSTROM: We've had a couple of questions about again about working with states on the data. One has just come up asking would cooperative agreements with Medicaid contractors be sufficient or does the agreement have to be with the state itself? And if I understand this question correctly and I'm not sure if I understand what is meant by Medicaid contractors. I'm assuming it means Medicaid managed care. But if not, let me know. The answer to that question though is that the agreement does indeed need to be with the state itself in terms of providing the data elements that we will need.

And a related question on this has come up asking about the timing, what our plans are on providing additional information as to how to work with states on the creation of a budget, et cetera for data needs. And we are looking to do this as soon as possible. We've been working with a number of our national association partners in exploring the ability to provide contacts for states in states; looking at creating some model language for example for what these agreements might look like at least for the application purposes; as well as providing some information around the data element that might be needed so that these applicants can work with states and states can work amongst themselves in terms of estimating or creating the budget for this purpose.

So in other words, we're thinking about the creation of some templates or worksheets that we think will really help facilitate the process, but it's taking us some time to work with our national partners. I should say it's taking some time on the CMS end to work with our national partners in exactly how best to create the documents and go from there. So just stay tuned on that we realize that this is an area of a lot of confusion –- not confusion but just where there's a lot of questions. And so we're really trying to streamline and a line that process.

RAY THORN: Thank you, Carol. And I believe Ellen Marie has a couple of questions from the chat room.

DR. ELLEN MARIE WHELAN: Yes. A couple more questions about the Letter of Intent. For those of you who have already submitted LOIs, is there any benefit to going back and further developing that summary now that there's a different date? And the answer is no. Again, it really is just –- it's the ability for us to know who's interested. At some point after the close of the Letters of Intent, we may do some targeted outreach to just those folks that have submitted an LOI. It's an opportunity for us to see if we're coming close to the 30,000 women for each of the 3 models and an opportunity for us to see which states are interested so that we can get a better understanding. Really not necessarily needing to know so much about what that is and the more important effort will be to make sure that your application is something that is competitive.

And along those lines, a question here about someone who's right now not providing centering in the OB clinic, but they would like to add it as part of this and is this acceptable? And the answer is kind of twofold. First of all, we are studying models of care. So we are looking to see if there's some kind of a

track record, but that does not mean that it's only folks that are currently doing it. So if it's competitive, we will look to see how folks that have not been currently providing these services are looking to incorporate some expertise into what they're doing.

Those centering models know there's lots of elements to that. It could be that someone has provided that service before. We're going to look to see how you are translating some expertise into a site that isn't already doing it. We also understand that some sites might be modeling off of another site that is currently doing it and expanding services that way.

RAY THORN: Great. Thank you, Ellen Marie. And Carol has a question from the chat room.

CAROL BACKSTROM: The question is should a local health department submit a Letter of Intent when we know we have to partner with the other providers and agencies that we have not yet met with? And the answer is that we would encourage you to go ahead and submit a Letter of Intent. I'm sure that the extension helps a little bit at this stage, but keep in mind that the Letter of Intent is non-binding and so it's better to get a Letter in than to not get a Letter in. So we encourage you if you're at all considering this, make sure that you get your Letters in. Thanks.

RAY THORN: Great. Thank you, Carol. And I believe we have another question. Aliza, we've got a question. So is it 500 patients per year for 3 years or 500 patients in total over a 3 year period?

ALIZA GORDON: To answer that, it's 500 patients per year for 3 years for a total of 15 hundred patients over the course of the three year grant period.

RAY THORN: Thank you, Aliza. I believe we have another question from the –- from the chat room.

DR. ELLEN MARIE WHELAN: A lot of questions about folks wanting to change their LOIs and I think at this point again that's not necessary. Another question we had and I'm still reading through some of them as they're coming in.

DAVID HURWITZ: This is David Hurwitz. There's a number of questions coming in regarding administrative costs and the indirect costs and I think we'd like to take the time to review those and provide, I think we have a frequently asked questions section on our webpage and try to answer those a little bit more broadly working with some of our colleagues here.

DR. ELLEN MARIE WHELAN: And some of these specific questions if we don't get to them today, you can certainly submit your email address. Ray's going to tell you what that email address is.

RAY THORN: It's strongstart@cms.hhs.gov. Again, it is strongstart, all one word, at cms.hhs.gov.

DR. ELLEN MARIE WHELAN: There's one here that's asking about the 43.2 million of the total amount available and this person wants to know if it's available for everyone or for each applicant. And I have to say in these times of our budget restraints, it is the total amount that we are funding for the entire

award. It's not for a single applicant. So the 43.2 million is the amount that we are now providing for all of our applicants over the period of time that you described before.

RAY THORN: Great. Thank you, Ellen Marie. We are looking through a couple of questions here. And again, just to remind everyone the Letters of Intent, the due date for the Letter of Intent has –- is now May 11 at 5 p.m. and we changed that due date because of a lot of feedback we've gotten from stakeholders and potential applicants for more time to prepare for the non-binding Letter of Intent. And since we want to continue to work in partnership with all our stakeholders, the Innovation Center and the Center for Medicaid and CHIP Services is modifying the Letter of Intent deadline to now be May 11 at 5 p.m. Again, all the other dates in the FOA, including the application due date, remain unchanged. And I believe we have another question from the chat room.

DR. ELLEN MARIE WHELAN: We're getting … and I am going to let David answer this. We're getting a couple of questions asking about how the state's cost for data collection be funded if the state's not the awardee or [audio unclear] budget proportions? And that's why we're having this now prior to the LOI because it can be limited. David's going to answer that question for you.

DAVID HURWITZ: Yes. So as I pointed out during the presentation, we understand that there's some questions and lack of clarity around this. So I think for the purpose of the Letter of Intent, just assume five percent to the cost of your overall intervention. And that's really just meant as a space holder, not a specific guidance. We're going to be working to provide more specific guidance in the coming days and weeks so that you have more clarity around that question and that issue.

DR. ELLEN MARIE WHELAN: Okay. A question about all of the beneficiaries being high-risk patients. And we described this a little bit more in detail in the last webinar. We are asking the applicants to describe the area that they will be serving patients and use some publicly available data to be able to describe the service area that the clinic or the site is providing care for. Once that area is described, we're looking for ways to describe areas that are at increased risk for prematurity. And there's lots of different variables that folks can use to describe who would be at increased risk. We have a table in the back of the FOA where we identify how the Institute of Medicine has defined who is at increased risk. And some of those aggregate data are available and we're asking folks to decide –- to describe their region like that.

Then once that region is described, we expect anyone who is in that region would be eligible to participate as long as they are Medicaid enrolled beneficiaries. We know that when someone has a premature birth, it's only 50 percent of them were able to be predicted with some of our current tools. So we're hoping that by allowing everyone that's living in a certain area that has been defined by the applicant as high risk would be able to have then everyone there so long as they're Medicaid eligible –- Medicaid enrolled, then they'd be able to participate.

RAY THORN: Great. Thank you, Ellen Marie. I believe Aliza or Ellen Marie now has another question from the chat room.

DR. ELLEN MARIE WHELAN: The question is if two approaches are going to be included in the same application, do we need two separate budgets? And no, you don't. Every application can have one budget. You would just have to describe in the narrative how many women you would want

participating in each of the different approaches. We also want to make sure and we said this before, that at each practice delivery site there is only one of the three approaches being delivered.

Now, that's also to say that we know that there's going to be an awful lot of overlap. When we say enhanced prenatal care, it's one model of enhanced prenatal care with three different approaches. So what we will ask of you is to describe how best your practice fits into one of these three categories. Whether or not you are using some services that might be part of one of the other care delivery sites, I think is something that we would accept because there is going to be a lot of overlap and you've got to choose which one of our three approaches that fits your site and then have that one site identified at each of the three care –- at each individual care delivery site.

ALIZA GORDON: We've got a couple questions about if you can provide services to more than 500 Medicaid beneficiaries per year. And yes, definitely. Five hundred is the minimum. So we would hope actually that you would have more than 500.

DR. ELLEN MARIE WHELAN: There's some questions about do we provide individual state Medicaid contacts that can assist with questions related to the enhanced prenatal care services. And as Carol mentioned earlier, we are continuing to work on some technical assistance that we will provide during the next upcoming months. We know that there is –- it's sometimes more difficult to figure out who it is and how to traverse this partnership with the states. We wanted to make sure that we got a little bit of this information out prior to the Letter of Intent due, but we expect to be able to provide some more detailed information. Generally at first and then we'll target it to the folks who submitted the Letter of Intent. So make sure that you're on our website. Ray can tell you how to make sure that you're signed up for our List Serve from the innovations.cms.gov.

RAY THORN: Great. Thank you, Ellen Marie. And unfortunately we are at the end of our time here. We did get a lot of questions today and unfortunately we're not able to get to all of them, but we will compile everything into a comprehensive frequently asked questions, but I think I do want to reiterate that the big news today is that the Letter, the due date for the Letter of Intent has changed to May 11 at 5 p.m. And again, all the other dates in the FOA, including the application due date remain the same.

So in closing I do want to remind folks that we will be having future webinars on additional topics relating to the Strong Start Initiative. We will announce them through our website or through the Innovation Center List Serve. And you can sign up for the Innovation Center List Serve at innovations.cms.gov. In addition, the Strong Start, the archives of the Strong Start webinars will be on the Innovation Center website and you can go to the "What we're doing" header at the top of the homepage of the Innovation Center website and link on it and select that, then select the Strong Start webpage and that will have all of the information for the Strong Start Initiative.

We again thank you for your interest in the Strong Start Program. We also thank your patience in working with us on us getting the information to you. And with that, I will thank everyone for joining us today and have a great day and we will have additional webinars in the future. Thank you.

LACEY: Thank you for your participation in today's conference. This concludes your presentation. You may now disconnect. Good day everyone.

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