CENTERS FOR MEDICARE & MEDICAID SERVICES

Moderator: Raymond Thorn
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3:00 p.m. ET

Operator: Good afternoon. My name is (Jonathan) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers of Medicare and Medicaid Services, Strong Start Initiative Stakeholder Call. All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Mr. Raymond Thorn, you may begin your conference.

Raymond Thorn: Thank you, Operator and good afternoon. And thank you all for joining. This is Ray Thorn, I'm with the Innovation Center at the Centers for Medicare and Medicaid Services.

We're really thrilled that you have joined us today and we are really excited about the Strong Start Initiative to improve the care and health of mothers and newborns that the Secretary announced this morning.

So thank you, again, for joining us on this call today. We have a very packed agenda for you with some great speakers and hope that we can get to all of your questions at the end.

Just a few housekeeping items at, just at the front, this call is being recorded and will be posted on the innovation center's Web site within a couple of days. Also, this call is for stakeholders only and this is not for the press.

If you are a member of the press, this call is off the record and if you have any questions, please contact the CMS Media Relations Group.

And lastly, if you do have questions at any point and we're not able to answer them on this call, you can always e-mail us. Our e-mail address is strongstart@cms.hhs.gov and a couple of more housekeeping items before I describe the agenda.

We do have the innovation center Web site up and running for the Strong Start program. The Web site address is innovation.cms.gov and there is a link to the Strong Start program under what's new.

And then second, we will be having a Webinar next Wednesday at 3:00 pm on February 15th and that information will be forthcoming on the – the innovation center Web site. So stay tune for that.

Let me quickly review the agenda for you. First we're going to have Rick Gilfillan from the Innovation Center and Cindy Mann from the Medicaid Center to give a broad overview of the Strong Start Initiative. Then we'll have Valinda Rutledge, Eric Fennel and Ellen-Marie Whelan from the Innovation Center to provide additional specifics on the initiative.

And we'll also hear from Dennis Wagner and Paul McGann from the Partnership for Patients who will talk more about the partnership and the hospital engagement network and the opportunity that presents for us to support substantial improvements in birth outcomes.

And then we'll open it up for some questions and hopefully again, we'll get to all of your questions today. And if we didn't get to your questions, you can always e-mail us at strongstart@cms.hhs.gov.

And with that I will turn over to Rick Gilfillan, the Director of the Center for Medicare and Medicaid Innovation.

Rick Gilfillan: Thanks very much, Ray and thanks again to everyone who's out there today joining us on this call.

As Secretary Sebelius pointed out this morning, pre-term birth in early elective deliveries before 39 weeks can result in pre-term births, can lead to extended to hospital stays, chronic medical conditions, significant life-long disability and even loss of life.

As many advocates and private sector organizations have already have already demonstrated however, it is within our power to safely reduce early elective deliveries by following well established best practices.

In addition, some new care models also hold out the hope of decreasing pre-term birth in high risk expectant moms. These opportunities are very clear examples of how we can reduce health care cost by improving care.

We know that many of you with us today have been working tirelessly to improve birth outcomes in your communities. I'm pleased to share with you today that the Center for Medicaid (inaudible) Services and the CMS Innovation Center are joining your efforts by announcing the launch of the Strong Start Initiative, a public – private partnership to identify, test and spread new care models that can improve the care and health of mothers and newborns across the country.

This one Strong Start Initiative will have two different, but very related activities. The first is a test of the potential for 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 is a funding opportunity for providers, states and other applicants to test the effectiveness of enhanced prenatal care approaches to reduce pre-term births in women covered by Medicaid.

I'm very proud today to be joined by my colleague, Cindy Mann, the Director of the Center for Medicaid and CHIP Services who has spearheaded the development of this initiative over the past year.

Cindy?

Cindy Mann: Thank you. Thank you, Rick and thank you, everyone, and I would definitely say this project has been spearheaded by lots of different people, so – but I thank you for that introduction.

As Rick pointed our, pre-term birth puts children at greater risk for a life time on developmental and health problems. And as Rick also said, we can lower cost through improvement. That's of course a very important point as we're all trying to think about ways to bend the cost curve.

Pre-term births are an economic issue as well as a health issue with estimates showing that pre-term births cost our families and our nation at least $26 billion each year. Significantly, Medicaid currently finances about 40 percent of all births in the United States and Medicaid beneficiaries continue to have a high rate of pre-term births that is significantly above the rate for other women, about, close to 12 percent as compared to 8.7 percent for other women.

As you all well know there is nothing more important for a child than getting off to a healthy start. No person should have to deal with the lifetime of health problems because there mother wasn't able to access the right care.

With so much at stake, we must do all we can to help provide all caregivers with the tools they need to act on decades of research and give women the best maternal care possible.

So that's really what the Strong Start Initiative is all about. And let me turn it over to Valinda Rutledge who can tell you more particulars about the initiative.

Valinda Rutledge: Great, great. Thank you, Cindy. As a mother, this initiative is extremely close to my heart. The team and myself have been working on it for a number of months. In fact we calculated it almost at 39 weeks.

So we're very, very pleased to be able to launch this through the country. And we all know that all moms out there can relate to the importance of providing the very best start for our children.

As Cindy and Rick mentioned, the Strong Start Initiative is a collaboration between many federal partners and also with mothers, families, clinicians and providers of all kinds throughout the United States.

This one Strong Start Initiative will have two different, but related activities as Rick has said. It is, first, a test of the potential of a national wide private/public partnership and awareness campaign to spread the adoption of best practices to reduce the rate of early elective delivery before 39 weeks for all populations throughout the country.

The second part of the initiative is a funding opportunity for providers, states and other applicants to test the effectiveness of enhanced prenatal care approaches to reduce pre-term births in women covered by Medicaid.

Component one, as I said, that focuses on reducing early elective deliveries will include three primary activities. The first one will be implementing a quality improvement platform through our partnership for patients that will share best practices among hospitals to provide technical assistance to the hospitals in implementing and adopting the best practices.

The second is creating a support for change with a broad-based campaign, a national campaign that will engage providers, patients, and the public and we will be working with organizations such as March of Dimes, (inaudible) and many other national associations.

The third, we will be supporting efforts to collect performance data, measure (inaudible), promote public transparency in order to have continuous improvement of this measure. If you or your organizations are interested in

supporting these efforts related to early elective delivery, we encourage you to contact us at strongstart@cms.hhs.gov.

If you are actively participating in Partnerships for Patients, we encourage you to work directly with your selected hospital engagement network to share your interest in this.

That is component one, it is focused on reducing early elective delivery.

Component two is to test the effectiveness of approaches to enhanced prenatal care and these approaches is to reduce pre-term births. We will provide up to $43 million of funding in the form of cooperative agreements that will test and evaluate the effectiveness of three different approaches that will address behavioral and psychosocial factors that are associated with pre-term births in mothers at risk covered by Medicaid.

HRSA is currently testing the ability of a fourth care option which is home visiting, and we will work with HRSA to compare the effectiveness of this home visiting model to decrease pre-term births to the outcomes of the other three models.

And my colleague Ellen-Marie Whelan will provide more detail in a second regarding those three models.

We believe that these two initiatives, one based upon reducing early elective delivery and the second one looking at what's the most effective approach in reducing pre-term births will directly aid and support the work already being done in communities across America and it will ultimately improve care to all mothers and newborns.

At this time, I would like to turn to Eric Fennel and Ellen-Marie Whelan to describe both the components of the Strong Start Initiative in more detail and then Dr. Paul McGann and Dennis Wagner that head the Partnerships for Patients will also be explaining how Partnerships for Patients are an integral part of this initiative.

Eric?

Eric Fennel: Thanks, Valinda. Just a couple of points to underscore, the challenge and the opportunity with regards reducing early elective delivery and out strategy.

In terms of the challenge, Valinda alluded to this earlier, for more than 20 years organizations like the American College of Obstetricians and Gynecologists, March of Dimes and others have advocated for the important of reducing early elective deliveries prior to 39 weeks without medical indication, but despite these efforts, elective deliveries prior to 39 weeks still account for a fairly significant portion of all births.

Many hospitals, however, and providers are hard at work and showing great success in addressing this challenge including achieving dramatic increases in induction, (C sections) and (NECU initiative). Our aim with this initiative or this component is to build a network.

So in terms of our strategy, as (Valinda) stated, we will first try to build on the efforts and the infrastructure of the partnership for patients which (Paul) or (Dennis) will describe in more detail momentarily. We will – as part of that effort – provide technical assistance to the existing hospitals in testing and implementing strategies to reduce early elective deliveries.

We'll support their efforts to collect data, measure success, promote transparency and focus on continued quality improvement. And then we'll also partner with advocacy organizations and professional associations to develop a national public awareness campaign focused on safely reducing the rate of early elective deliveries.

We are then pleased to be able to begin this effort by supporting the work of the March of Dimes and the American College of Obstetricians and Gynecologists in an effort to both provide information education to consumers and providers.

But as (Valinda) stated earlier, this is the first step in that effort and we welcome and will continue to seek additional partnerships and look forward to your participation in that. At this time, I'd like turn it over to Dr. Paul

McGann and Dennis Wagner to provide a little background on the partnership for patients and the infrastructure available to us there.

Paul McGann: Thanks very much, Eric. Can you hear me OK?

Eric: Yes, we can hear you, Paul.

Paul McGann: OK. Great. So I'm Paul McGann and together with Dennis Wagner we co-direct the Partnership for Patients campaign. And we just can't tell you how excited we are to be a key part of the Strong Start initiative. It's really one of the most amazing things to come together in a government contracting program in many, many years.

The partnership itself is defined by and focused on our two bold aims, the first of our aims is a 40 percent reduction on preventable hospital-acquired conditions and that includes the improvement obstetrical safety for mothers and newborns.

Our second bold aim is a 20 percent reduction in 30-day readmissions for all payers across all hospitals in the United States. When we achieve these two bold aims by December 2013, it will result in more than 60,000 lives saved and preventing millions of cases of harm to patients and unnecessary readmissions and that includes mothers and their newborns.

Much of the work of our partnership is accomplished in working with – in partnership with 26 hospital engagement networks all across the country who in turn provide technical assistance and help to more than 3,900 unique hospitals who have committed to these two bold aims.

This is very exciting that we're here to report this and we're already seeing when we poll the hospital engagement networks that there's a lot of work being done already in this particular area preventing early elective deliveries across the network. Isn't that right, Dennis?

Dennis Wagner: You bet. Thank you, Dr. McGann.

This is Dennis Wagner, co-director with Dr. McGann at the Partnership for Patients. And as he noted, we are in action already with these 26-hospital engagement networks and their hospitals to generate results in this arena.

And we're pleased to note that several of the 26 hospital engagement networks have already made tremendous progress and sharply and rapidly reducing the number of early elective inductions in their hospitals, these are networks that came to this work with us a track record of performance and success already and sharply reducing these early elective inductions.

Now or even more pleased to acknowledge though that these high performers are already in action and serving as mentors, models and sources of proven best practices to the other hospital engagement networks and the hospitals that form the Partnership for Patients.

We believe that the new Strong Start initiative that was launched today would give a tremendous boost to the ongoing work of the partnership through our hospital engagement networks and to the 3,900 hospitals teamed with us to achieve the two bold aims of the Partnership for Patients.

And we pledge that the partnership in turn will do everything that we absolutely and positively can to ensure that the Strong Start initiative succeeds in it's work to improve safety and health for mothers and newborns. We're very excited about this work and so are a lot of other folks.

We want to send this out back to you Ray.

Raymond Thorn: Right. Thank you, Paul and Dennis. And with that, I will turn it over to Ellen-Marie Whelan – Dr. Ellen-Marie Whelan – who will go over the Medicaid funding opportunity of the Strong Start Initiative.

Ellen-Marie Whelan: Great. Thanks, Ray.

So the second component of the Strong Start Initiative is focusing on a funding opportunity that will pay for enhanced prenatal care delivered in a variety of different ways. And just to recap briefly, every year, more than half

a million infants in the United States are born prematurely. And this rate has grown by 36 percent over the last 20 years.

And this is at great cost to those families and to society at large. The families who have had children born prematurely bear significant cost as their children have developmental and health problems that last their lifetime.

These children could require early intervention services, special education and have conditions that impact the quality of their life into adulthood. And this is also a large cost to society. As Cindy noted, Medicaid currently finances 40 percent of all births in the United States.

On average, Medicaid pays $20,000 during the first year of life for every preterm baby and that's compared to only $2,100 for every full term birth. Overall, we estimate that preterm births account for $7 billion in first year costs for the infant alone. And the Institute of Medicine estimated that because of all the lifelong problems of these children, that's a cost to society of $26 billion every year.

And because of the potential for health improvement and the potential for enormous cost savings, CMS will invest in a variety of approaches to the delivery of enhanced prenatal care. These evidence-based approaches that we've identified have been found often in small studies to have the ability to reduce the rate of prematurity.

And the three approaches that we've identified that we will provide additional financial resources are first, enhanced prenatal care through centering or group visits, these are group prenatal care that incorporates peer to peer interactions in a facilitated setting for health assessment education and providing additional psychosocial support.

The second approach is enhanced prenatal care birth centers where comprehensive prenatal care is facilitated by an entire team of health professionals that could include peer counselors and (inaudible). The services here will include collaborative practice, intensive care management, counseling and psychosocial support.

The third approach is enhanced prenatal care at what we're calling "Maternity Care Homes." These are enhanced prenatal care which also include psychosocial support, education health promotion. And we're looking there to have sites that can identify that they are providing increased access and continuity, improved care coordination and providing enhanced content in prenatal care.

As Valinda mentioned, HRSA has embarked on an extensive national home visiting program. We also believe that home visiting may have the potential to decrease preterm birth. And because of that, we are partnering with that (HRSA) program and also the Administration on Children and Families to expand their evaluation of their home visiting program so that we can test the effect of that program on preterm births.

So we believe that this is an exciting opportunity for four different types of applicants. The four applicants we envision that will be applying will be providers of prenatal care. These could be provider groups, affiliated providers, hospitals and facilities.

The second applicant could be state Medicaid agencies. The third is Medicaid managed care organizations and the – lastly, conveners. And these conveners will be in partnership with other applicants.

And just to note here that for all non-state applicants, they'll need to provide documentation that they will be working very closely with their state and sign an agreement because we believe the states will be critical in making sure that these applications and this project can move forward.

For all the non-provider applicants, we'll also make sure that they're working in partnership with their provider partners to demonstrate their willingness and their capacity to participate in this initiative.

And I think at that point we'll close with this formal approach. I'll turn it to Ray.

Raymond Thorn: Great. Thank you, Ellen-Marie.

Just a few reminders before we head to the Q&As, I just want to tell you – I just want to reiterate that the information on the Strong Start Initiative is on the innovation center Web site at innovation.cms.gov. There is a link to the Strong Start Initiative on – under the "what's new" column in the left side of the Web site.

And you can also – in addition to finding our more information, you can access the funding opportunity announcement for the component to – with respect to the Medicaid funding opportunity. If you have – if we aren't able to get to your question today, we do have an e-mail address and you can feel free to forward – send your questions to strongstart@cms.hhs.gov.

And with that, operator, we're ready to open the floor for questions.

Operator: At this time, I would like to remind everyone in order to ask a question, please press star then the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And again, if you would like to ask a question, please press star then the number one on your telephone keypad.

Raymond Thorn: Operator, while – operator, this is Ray Thorn. While we're waiting for people to line up, if we could ask people to state their names and their affiliated organizations when they're preparing to ask their question, that will be very helpful to us.

Operator: Certainly. The first question comes from the line of (Mathew Fitzgerald) with (Provider Resources). Your line is open.

(Mathew Fitzgerald): Hi. This is very exciting and I tip my hat to all the folks at CMS that put this in place – a very exciting project. I'm curious. I think you alluded to the elective birth being something of a pilot that would lay the groundwork for a larger national campaign. And I was hoping that you could elaborate on what may be a follow-on campaign.

Rick Gilfillan: Thank you. There are two parts to that effort to reduce early elective deliveries one is to work through the Partnerships of Patients directly with

providers and hospitals to support their ongoing efforts to reduce early elective delivery.

The other activity in that component is a public awareness campaign working with organizations like ACOG and the March of Dimes to really promote both to providers and consumers the importance of reducing early elective deliveries. There really is sort of two different activities within that one component.

Eric Fennel: Could I – let me just expand on that a little bit as Rick has (inaudible) up. And if the innovation center – we – our job is to test new care models, new payment models and also models of spread of best practices. We want to make sure we understand what it takes to have the best practices spread across the country.

The Partnership with Patients is an effort to test methods of scaling or spreading best practices and component one is very clearly an effort to do that – to spread a best practice. And that the intent is to have every hospital in the country begin to operate differently to find new ways of delivering care so that they do not have as many, reductions over time in the number of elective deliveries prior to 39 weeks.

So we're spreading – we're trying to kind of test the ability of that model of the participation to spread this best practice nationally. So by it's definition, a test to scaling and spread; not a pilot in that sense.

Valinda Rutledge: Right. And as Rick and Eric have said, that second part of it is to work with other professional organizations and national associations, not just March of Dimes or (inaudible) but others that have been doing this for a number of years that we're going to join their activity.

Raymond Thorn: Great. Thank you. Operator, we're ready for the next question.

Operator: Your next question comes from the line of (Devan Mohammed). Please state your organization. Your line is open.

(Devan Mohammed): Hi, this is (Devan Mohammed). I'm calling from (Urban Midwifery). And I would like clarification on the provider model – wondering if this program will support the development of birth centers or should they be birth centers that are already in operation, maybe adding to their services.

Ellen-Marie Whelan: One of the things that we're doing is making sure that we're studying successful models so we hope that we're studying places that have a long track record. But to that end, we can imagine that folks will be expanding to new delivery sites because we are encouraging the development of these models.

So I think it would be looking at – our applications will all be judged based on the track record, their organizational infrastructure and their ability to provide the delivery services. So I think that ultimately, being able to just demonstrate some kind of history in the birth center model is what we'll be looking for.

Raymond Thorn: Thank you (Devan). Operator, next question please.

Operator: Your next question comes from the line of Dennis Daley from the University of Pittsburgh. Your line is open.

Dennis Daley: Thank you. I'm the head of Addiction Medicine Services in the Department of Psychiatry. And we work closely with some hospitals and we have a prenatal addiction center. So it's clear to me that one of the significant problems contributing to early birth is substance abuse or addiction, so that could be cocaine. It could be marijuana. It could be alcohol. It could be opioid.

And so in listening to you very quickly go through these three enhanced prenatal care approaches, my question is – and I try to take notes, but I couldn't keep up with you guys. You talked about peer counselors and (inaudible) intensive case managers. Is there a possibility of including interventions related to women – pregnant women who have substance abuse issues because that has a main adverse effect on whether they get prenatal care and follow through and so forth.

It seems to me that would be a tremendous opportunity to improve care and reduce cost.

Ellen-Marie Whelan: Thank you for the question. Absolutely. What we're expecting applicants to do is define the area where they'll be providing these services. And when they define that area, they've got to tell us those regions, the risk factors that are for pre-maturity and then tell us how they're going to demonstrate that they will meet those risk factors for pre-term births.

And we absolutely concur that substance abuse is one of them and we will expect folks to tell us how we'll be doing that. So partnering with organizations that can help them do that is exactly the kind of partnership we're hoping for the applications that we receive.

Dennis Daley: Thank you.

Raymond Thorn: Thank you, Dennis. Operator?

Operator: As a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Your next question comes from the line of Amanda Skinner with New Haven Health System. Your line is open.

Amanda Skinner: Hi. Yes, this is Amanda Skinner at Yale New Haven Health System. Like everybody else, I'm very excited about this and as a nurse-midwife for 10 years in Waterbury, Connecticut where there was a lot of high risk, I think this is really fabulous.

I want to go back to the issue about studying successful existing models and the question around group (inaudible) I remember with the (CTPP) grant, there are very specific models that were proposed for people to consider implementing like (inaudible) and the transitional care model.

And I'm wondering if you guys will be proposing specific models around group care, for example the (inaudible) pregnancy model.

Ellen-Marie Whelan: We are aware that there are certain approved models and certainly the Center in Health Care instituted – provides a curriculum for one of the most well known. But to that end, what we want to make sure that we do is look at

evidence-based approaches and if applicants can show us that they've got an evidence-based approach – the delivering of the Centering Group Care Model, we'd certainly take that into consideration.

And again, as the previous question, looking for a history, looking for some success and looking that they have been able to demonstrate that this is something that they've done in the past with successful outcomes.

Amanda Skinner: Great. Thank you very much.

Raymond Thorn: Thank you, Amanda. Operator, we're ready for the next question.

Operator: Your next question comes from the line of Edward George. Please state your organization. Your line is open.

Edward George: Yes, I'm Ed George – Manchester Community Health Center in Manchester, New Hampshire. I got on the call a little late and you may have touched on this, but could you describe the timeline you have in mind when resources will be made available, over what period of time will the grant extend.

And I'm assuming you will encourage collaborative approaches within communities.

Ellen-Marie Whelan: So your last question first. Absolutely – always looking to make sure that we're partnering and having folks tell us how they're going to partner with as many community-based organization to move forward.

So the timeline – we will have mandatory letter of intent due on March 21st and you'll find a standardized form on our Webpage where you'll be able to plug in the information. It's non-binding so if folks are interested in thinking about applying, we encourage them to do that by March 21st.

Our applications are then due on June 13. And then ultimately, we imagine we'll be able to then make the awards and look for the program to begin on September 10 or thereabouts in the fall.

Edward George: Thank you very much.

Female: For the (inaudible) – actually, one other, sort of follow up to – we anticipate that we will pay for the intervention during a three-year period. So there will be one year cooperative agreements with the ability to get their second and third year. And then fourth year will be data collection because we are anticipating looking at the savings that will be generated by looking at the cost of the infant's first year of life.

So three years of intervention with the fourth year looking at collecting data to identify ultimate total cost of care savings to the system.

Edward George: Thank you.

Raymond Thorn: Thank you, Edward. Operator?

Operator: Your next question comes from the line of Shafia Monroe with the International Center for Traditional Childbearing. Your line is open.

Shafia Monroe: Thank you. Good afternoon, everyone. I'm working with an international organization – the National Organization on Infant Mortality Reduction. And now, components for – I thought they line up well with being able to reduce (inaudible) outcome.

My question is, is there component around breast feeding promotion as well as a piece of going to ensure (inaudible) competencies than to know that the (inaudible).

Ellen-Marie Whelan: Oh dear.

Operator: Ms. Monroe, if you could please hit star one on your telephone keypad once again, please.

Raymond Thorn: Operator, I think we may have lost her unfortunately.

Ellen-Marie Whelan: I can still take a crack at answering.

Raymond Thorn: Yes, (inaudible) let's go ahead (inaudible) if you want to (inaudible).

Ellen-Marie Whelan: Yes. So, I apologize. I couldn't hear the end of it, but I think first of all, because we're looking at these models to reduce preterm births – we're not specifically looking at a model of care for breast feeding, but we envision that because the kinds of enhanced prenatal care we're looking at, they will include a strong component of breast feeding.

Each of these models we described has that as part of their curriculum. And I think that that's where we probably left of with, making sure that those kinds of things happen. And we'll be monitoring in addition to preterm birth, as we go through this – there is a strong evaluation component and we'll be monitoring (inaudible) like breast feeding if we go through.

Raymond Thorn: Great. Thank you, Ellen-Marie. And unfortunately, we're sorry that we lost the caller there. And hopefully, that answers your question. If you – that isn't the question – or the answer that you're looking for, please feel free to send an e-mail to strongstart@cms-hss.gov. Operator, our next question and thank you very much for that question. Operator?

Operator: Your next question comes from the line of Cynthia Smith. Please state your organization. Your line is open. Cynthia Smith, your line is open.

Your next question comes from the line of (Brenda Campbell) with (CTM/CTEC). Your line is open.

Brenda Campbell: I was (inaudible) today. I was taking notes just as fast as I could. I know that you're going to put a recording of this on the Web, will you put the narrative. Will you write the (inaudible).

Raymond Thorn: We will have the transcript and the audio recording on the innovations center Web site at the strong start Webpage.

(Brenda Campbell): Totally awesome. Thank you.

Rick Gilfillan: Well – well, thank you. But there's even more information up on the Web site right now that people can access. So it is available.

Raymond Thorn: And also, one additional point. We will be having our first Webinar next week at Wednesday, 3PM on February 15th and more information will be forthcoming on that and that will be posted on the innovation center Web site on the Strong Start page as well.

Ellen-Marie Whelan: Followed by additional Webinar–

Raymond Thorn: Followed by additional Webinars on the three specific models. So, thank you very much for the question. Operator?

Operator: Your next question comes from the line of Patricia Gabe with Ohio State University. Your line is open.

Patricia Gabe: Yes. Thank you. And I'm excited about this proposal also and opportunities. I work with pregnant women. I would do a cooking program every week and follow them through their pregnancy.

But one of their biggest issues post-partum, their inter-pregnancy care which I guess you could say it's also pre-conception care and that seems to be so important – almost as important as the prenatal care is making sure they're in good health before they get pregnant and they safely face that next pregnancy.

So I just wonder how that enters in to the model of focusing just on prenatal care.

Rick Gilfillan: Well a couple of thoughts on that, first we all agree that that's critical and very important and I would note that much of the work that's being done through the HRSA home visiting program is focusing on all aspects of high risk family (inaudible) so they're looking at both pre-pregnancy, health and just trying to ensure good nutrition and evaluating actually the importance of good nutrition, good healthcare prior to pregnancy, looking at the pre-natal period and then looking at both the mom and child after pregnancy, and so, we know that our colleagues here at HHS are working hard to study the importance of those different periods.

We will be looking and gathering information through the first year for the infant. At this point the scope of our work will be primarily around that pre-natal and prenatal period to measure the effect of those care activities.

I would say however our evaluation will have a quantitative side where we look at the total cost of care and the quality of outcomes and we'll also have a qualitative side where we look into the pros and try and identify factors that may have made a difference. In that process we expect we will be collecting information to tell us more about the health status of moms either prior to or early in their pregnancy and to whatever extent possible given our access to the records of the providers we'll be partnering.

Cindy Mann: And this Cindy Mann, I will just add that part of the problem particularly for low-income women is that they often aren't eligible for any health coverage before they get pregnant and they don't have the financial ability often to be able to purchase health insurance if it's even made available to them at the workplace.

And so, the good news on that end is that come 2014 women actually will be eligible for coverage, and so, that will be a major step forward and there will be lots of efforts to make sure that the coverage provided is robust and meet people's needs.

Rick Gilfillan: Thank you, Cindy.

Patricia Gabe: Yes, thank you, Rick. It's just a tragedy that they come in with hypertension and diabetes out of control because they haven't had access to medical care and that's a stage for a premature birth, and so, sometime pre-natal care is really just too late to tackle the Medicaid population unfortunately.

Cindy Mann: But that will change.

Raymond Thorn: Thank you very much.

Rick Gilfillan: I would point out that this activity is, you know, obviously a direct result of the Affordable Care Act and the grace intervention that are making these resources available giving us the directive to test these kinds of model and one

of the reasons we're so keenly interested in testing a model like this is particularly important for folks who are covered by Medicaid is the reality and as Cindy points out coming up on 2014 we're going to be in a different world where people have access to that care and we'll have answered some questions and we'll have more questions answered that time and we're really looking forward to being able to help folks find the (care models) that (inaudible) that population that we know is going to grow dramatically in 2014 as a result of the Affordable Care Act.

Raymond Thorn: Thank you, Rick and Cindy and thank you caller for that question. I do want to go back to the previous caller's question regarding the information. We will also send out the information on the Webinar series through our LISTERV and you can – if you're not already signed up on our LISTERV please do so through the innovation center Web site at innovation.cms.gov.

And operator we're ready for the next question?

Operator: Your next question comes from the line of Abby Dini with the Complete Care Birthing Center, Richmond, Virginia your line is open.

Abby Dini: Hi, I wanted to know, in Richmond we have a high rate of pre-term labor and I'm actually at a private physician's office, however, we are on a campus of a large medical center that is supportive of our free (standing) birthing center.

And recently in our community there's been talk of opening a non-profit maternity education center, so in terms of applying for this funding would that be a partnership that you all would look favorably upon like a private hospital system or a private physician's office and then a non-profit considering that we all have the same goals in mind?

Cindy Mann: Absolutely we are encouraging looking at the public-private partnership looking at innovative ways to make sure that we be able to offer a traditional standard pre-term birth with the enhanced pre-term birth.

And you will see written in your funding opportunity announcement that we're encouraging partnerships of all kind to make sure that we best coordinate care and getting as many players at the table to help these pregnant women achieve

their best goals. And so, something like that I think in a partnership application would be definitely in line with what we're looking at.

Abby Dini: OK, great, because it's just – it's blowing our minds in Richmond, the amount of pre-term labor that we have and then also having just started a birthing center a year ago the lack of access to our Medicaid moms that do want to have an all natural labor because Medicaid, at least in our state, is not covering our birthing center facility fees, so, thank you.

Raymond Thorn: All right, thank you, Abby. And operator we are ready for the next question.

Operator: Your next question comes from the line of (Monica Arcy) with the Virginia Garcia Memorial Health Center, your line is open.

Monica Arcy: Hi, I am a nurse-midwife here at the Virginia Garcia Memorial Health Center and I was wondering if there was any initiative to include women that right now don't qualify for any OBY coverage.

In our state via Medicare there's only a bit covered for the delivery of a birth, some women that don't qualify and so their pre-natal care doesn't get covered at all. And I'm talking mostly about undocumented immigrants and that's the population that we work with a lot here. I'm wondering if that's going to be part of this?

Rick Gilfillan: Right now the approach that we've described for increasing early elective deliveries is we expect to be applicable for all folks who are delivering in hospitals, and so, we think that program will have impact for everyone.

The component to decreased pre-term (inaudible) is focused right now on folks who are eligible for Medicaid and receive Medicaid services. I would add it's – the funding is – funding for the enhanced care it is not a replacement or substitute for ongoing, you know, the ordinary payments for either the facility fees or professional fees for normal obstetrical care.

Raymond Thorn: Thank you, Monica, for that question.

Operator, the next question?

Operator: Your next question comes from the line of Ruth Lubic please state your organization your line is open.

Ruth Lubic: My organization is the Developing Family Center and we were just delighted that Secretary Sebelius did her launch from our site in Washington D.C. in (Ward 5) where we're serving low-income, mainly African-American people.

My question relates to the fact that we've been operating for 11 to 12 years and we have shown remarkable, on our descriptive data, a remarkable reduction in pre-term birth from the population as whole in D.C., African-America population from 15.6 percent to 5 percent through the birth center facility.

And with the resulting total savings with pre-term birth, low birth weight and Caesarian sector of a $1.635 million in the year 2006 which we did on a 153 births. But we only got paid half our charges by Medicaid advantage care which is for profit in this town.

And so, they are the ones who realized the savings. And I have gone to the Council of the District of Columbia and suggested that we divide the savings three ways. Give a third of it to the city itself which funds the managed care organizations and give a third t the managed care organizations but let the people who are making this happen, that is the birth center and the midwives and the back-up hospital and so forth have a third of this and I have not been able to make any headway on that.

Do you see any way that this initiative can be helpful to us in order to – I mean we want to be able to be self supporting but we have not been able to do that in the past?

Rick Gilfillan: Ruth, this is Rick. And I just want to – number one, thank you and your entire organization for being such gracious and welcoming hosts today for the secretary and for the crowd of folks who showed up.

It's a wonderful place and I know it is, you know, it's representative of a whole world of great work that's being done in cities and in rural areas around the country, and so, we thank you and we thank all those folks out there and the

folks that are on the call today who are so dedicated that despite the significant business challenges they may face as you face are out there doing this work everyday.

What we hope is we can – you know we're not in a position to reach in and change the terms of, you know, contractual arrangements between local government, state governments, and health care providers.

What we can do and what we hope we will do and this initiative will do is shine the light on the outstanding work that is being done and hopefully created an environment in which people understand very clearly the positive impacts of the work that you're doing and therefore perhaps bring newfound energy to efforts to propose to kind of support you in a way that makes your organization, your business model and the many people around the country who are similarly delivering great care. Make them more viable, more sustainable going forward.

And so we certainly want to – we hope that it does have that effect and we want you to know that we are partners in trying to make everyone believe that these are sustainable and important models of care.

Ruth Lubic: Thank you, Rick.

Rick Gilfillan: Yes.

Raymond Thorn: Thank you, Ruth.

And, operator, the next question?

Operator: Your next question comes from the line of Ralph Schubert please state your organization, your line is open.

Ralph Schubert: Thank you. I'm with the Illinois Public Health Association. It's two quick questions for you.

One, is it even necessary or advisable for us to propose a randomized design for the evaluation or would a (next) case control design be enough? And two, do we need to project cost savings as a part of our proposal?

Rick Gilfillan: We will be doing an evaluation of the overall program and of the different models. So we will ask you to talk about how you think about evaluating the performance – the - your performance itself but not in the sense of randomized trials or control groups, comparison groups (better).

We're really looking to see how you manage your program to make it successful and trying – demonstrate to yourself how well you're performing, how you can do better, et cetera. So those – but that – the ability to tell us that story will be very important, however, we're not looking for you to tell us a formal evaluation story for your individual program. We will work at – and we will develop an evaluation approach across the entire initiative.

In terms of documented cost savings, as you may know from some of the other work that we've done around the innovation center, we ultimately measure success by the (three partying) with better health, Medicare, reduce cost for improvement.

We're not – there won't be a requirement necessarily that you show us exactly how you're going to save cost, but we are going to be very, very interested in folks who can tell us a strong story about – that they think in the past they have demonstrated improvements that resulted in cost savings. Or if there is a very strong story that you'd like to (tell us), we think it would ultimately make for a stronger proposal.

Ralph Schubert: OK. I was involved in the last round of innovations – applications and, of course, projecting cost savings was part of that and – but I just want to confirm that this part was a little bit different and it sounds like it is.

Rick Gilfillan: It is a little bit different, and that is, since, you know, people were coming with very much, kind of, free form, new ideas. And we wanted them to be thinking hard about how their initiatives are going to relate to the total cost of care.

We think, as (Valinda, Eric (inaudible)) and (Ellen-Marie) have mentioned that the story here about saving costs is dramatic. And it's – and we all know the opportunity to make lives better, so the real question's whether or not your

model delivers that reduction in pre-maturity and pre-term labor and that's what we'll be looking for.

Ralph Schubert: Excellent. Thank you.

Ralph Schubert: OK.

Raymond Thorn: Thank you, (Ralph).

And, operator, just to give a (heads up) we're going to take two more questions and then we'll wrap up at 4 o'clock. So we'll take two more questions.

Operator: Certainly. Your next question comes from the line of (Mary Jo Condon) with Midwest Health Initiative. Your line is open.

Mary Jo Condon: Hi. Thank you so much for offering this funding opportunity. I work with the Midwest Health Initiative. We're a regional quality improvement collaborative. And we've been working with hospitals in our region and also with employers and health plans on this issue for – just about the last year.

And I noted that you mentioned the opportunity to get some resources for measurement. That's something that we've been looking for and trying to pull together. Is there going to be a specific funding opportunity for that? Or should we just contact you offline?

Eric Fennel: The funding opportunity for measurement on component one will be something that we work or the – I should say the approach to measurement support is something that we will work on through the Partnership for Patients for component one.

The effort to get data and measurement activity, data that allows us to see results and to measure results for component two is something that there will be – we think as part of the funding opportunity for folks who are funded, there will be some funds made available for that.

Mary Jo Condon: Thank you. I was referring to component one. So thanks very much.

Eric Fennel: Yes.

Raymond Thorn: Thank you, Mary Jo. And, operator, we'll take our last question.

Operator: Your last question comes from the line of Max Winkler with Rockpointe Corporation. Your line is open.

Max Winkler: Yes. Just wanted to see if you guys could repeat the question e-mail address (inaudible)?

Raymond Thorn: Yes. For any questions or ideas that you want to submit, please submit them to strongstart@cms.hhs.gov.

Max Winkler: Great. Thank you.

Raymond Thorn: Well, yes.

Operator? We could take one more question.

Operator: Your next question comes from the line of Clark Tibbs with VHO. Your line is open.

Clark Tibbs: Hello. Thank you very much. I'm (Clark Tibbs) with VHO. We're a defense contractor and I specialize in bio-security and cyber-security. What say ye regarding bacterial infectious diseases? And when you talk about evidence-based, has there been any clinical trials – have there been any clinical trials in the United States using phages or bacteriophages against (strep B), for example?

Some reports recently saying, when the mother gives birth, she colonizes the baby with the feces and it contains E. Coli, for example, when I've approached (Fauci) at NIH, never hear back.

When you talk about continuous improvement and BPR – Business Process Reengineering, how can we move bacteriophages into our health system in the United States of America?

Raymond Thorn: All right. Well, that is a wonderful question to walk, you know, wind up our call and I – so, thank you for that challenge. I think that what I'm going to ask you to do is I think you could stay on the line afterwards. I think – or give the operator name (the ea) (inaudible) operator, actually, if you can e-mail us at strongstart@cms.hhs.gov, we'll be certain to follow up with you (Clark) on that question and on that issue.

(Clark Tibbs): (All right).

Female: Right.

Rick Gilfillan: I think …

Rick Gilfillan: The one thing (we'd) say is that – in terms of model two, which is, kind of – I think where this question fits, I mean, obviously, there's a whole world of knowledge and work and research that's been done around the relationship between virus and (bacteriophages) and pre-maturity.

It's out there. It's, you know, and dealing with that particular issue is something that we see as an important part of excellent prenatal care. And one of the things that while we're talking about enhanced prenatal care models today, we will expect that applicants will tell a strong story of how they're going to be sure that those patients – their patients are also receiving optimal prenatal medical care.

And we hope that these kinds of issues would be appropriately addressed along with things like prenatal steroids, antenatal steroids, the use of 17-hydroxyprogesterone, et cetera in appropriate populations.

That would be an important part of the application of folks who are coming in proposing an enhanced prenatal care model.

Ellen Marie Whelan: So these enhanced prenatal care models, as Rick mentioned before are not in place of traditional standard prenatal care. And we are expecting to be monitoring and making sure that all of the women, in addition to this enhanced prenatal care that we're looking to fund will be getting evidence-based ACOG guidelines of clinical prenatal care that would include things

like Group B Step. So thank you for bringing that up. It's a great way to end our call.

Raymond Thorn: Thank you, (Clark) for that – for that question.

And again, if we didn't fully address it, please feel free to send an e-mail to strongstart@cms.hhs.gov. At this time, we would like to wrap up the call and Rick Gilfillan want to make any closing comments I remind the folks of a few things.

Rick Gilfillan: Well, I just want to – I want to recognize our team of people that work so hard to do this number one. So you've heard from several today (Eric, Valinda, Ellen-Marie, Ray) thank you. (Inaudible) and (inaudible), thank you. (Carol) (inaudible), thank you. (Inaudible), thank you.

We've been – we have been – and (Cindy) (inaudible) and the rest of the core team in CMS has been very much involved in this also. So, I just want people out there to know that this is about building on the activities that we think many of you are doing already.

We recognize that this is work that people have been engaged in oftentimes for a career, for a lifetime. And this is about us finding a way to help you be even more successful.

And we hope that you see that as we pursue this initiative, we're pursuing it in that spirit of a partnership based out there in the wide world of community caregivers that are committed to making life better for folks who are having babies.

So we recognize that. We look forward to working with you all and we really appreciate you all calling in today. And we look forward to lots of engagement over the next several months as we plan on and figure out how to do this together.

Raymond Thorn: Great. Thank you, Rick. And just a few reminders before we end this call. First, the information is available on the innovation center Web site. You can go to innovation.cms.gov and go to the left side there is a Strong Start link.

And that will take you through the all information for the Strong Start initiative.

Second, we will be having the Webinar next Wednesday, February 15th at 3 PM an overview over the Medicaid funding opportunity and fourth information will be on – available on the Web site and also through the list serve that will be forthcoming in the coming days.

And then if there are any portions of this call that you missed, we do have a call recording that is available. You should dial 1-855-859-2056, again, 1-855-859-2056 and the conference ID is 5-033-1144 and this recording will be available until February 10th this Friday.

And we'll again have the transcript and the audio recording of the Webinar, posted on the innovation center Web site. And this time, just a …

Rick Gilfillan: One last one. I didn't mention Andy Shin who's been working tirelessly for the last 24 hours to make this work as well as (inaudible) any of his family listening out there.

We want to recognize Andy as well for doing a fabulous job and thank you, Ray as well. Great job.

Raymond Thorn: Thank you.

Rick Gilfillan: Thank you, everybody.

Raymond Thorn: Thank you, Rick. And, operator, that concludes our call.

Operator: Ladies and gentlemen, this concludes today's conference call, you may now disconnect.

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