AHEAD Model Notice of Funding Opportunity Support Office Hour Session – Transcript

March 14, 2024

>Laura Snyder: Good afternoon again and welcome to everyone who is here so far. Thank you all for joining us for the States Advancing All-payer Health Equity Approaches and Development or the AHEAD model.

This is the Notice the Funding Opportunity application office hours. My name is Laura Snyder and I'm co-lead of the head model team at CMMI along with Emily Moore.

As you know, we've scheduled these office hours to answer questions you have about the NOFO or notice the funding opportunity, the application process and requirements for the application, and participation in the AHEAD model. We are unable to answer any unrelated questions about to the AHEAD model during this time.

The NOFO application is due for cohorts one and two this coming Monday, March 18th at 3 pm eastern time.

>>Laura Synder: Now if you have joined these office hours in the past, you know that the format for these sessions is casual.

We have most of the AHEAD team on the line as well as our colleagues from the Office of Acquisition and Grants Management to answer your questions.

If you would like to ask a question, please submit it using the Q&A feature. And please know that this is a change from earlier office hours sessions in which questions were submitted via the chat feature.

However, if you would prefer to ask your question verbally, please use the hand raising feature. We will have to unmute you and when you're called on, you can go AHEAD and introduce yourself. Let us know where you're calling from, you can introduce yourself, let us know where you're calling from, and ask your questions. We'll identify the appropriate person on the team to answer from our end.

Again, we appreciate your patience. We will answer all the questions. That we can.

>Laura Synder: If there aren't any questions, later in the hour, we will still remain on the line for the duration of the office hours as scheduled in case anyone joins or other questions come up. We are recording today's office hours for anyone who is unable to attend.

If you have any objections, please exit the call at this time. The recording of today's office hours and the transcript will be posted on the AHEAD model website in the coming days as with past sessions. Thank everyone who submitted questions to the help desk in advance.

> **Laura Synder,CMS**: As a reminder, the recently released hospital global budget financial methodology is just version 1.0. The details are not set in stone and we welcome and invite your feedback. Please keep that in mind as you review the details of the methodology.

> **Laura Synder, CMS:** I will start with some of the questions that we received through the help desk and I'm actually going to invite Jamie Atwood from the Office of Acquisitions and Grant Management to answer the first few questions are for you, Jamie.

> **Laura Synder, CMS:** First question, can CMS please provide additional guidance on how applicants are to submit the application through the grants government portal? For example, what are the acceptable file types for submission, Word or PDF?

Should the project and budget narrative be combined into a single document? Any information is appreciated. Jamie, can I hit it over to you?

>Jamie Atwood, CMS: Sure, that's fine. So if you go into the notice of funding opportunity in the appendix to application and submission information (Appendix II) there's actually quite a bit of information in here including about directions to apply.

I want to make sure that everyone has taken a good close look at that. So in particular, there's some information about grants.com on page 73 as it relates to login Government credentials and then further down in that same appendix, starting on page 74, it gives you more of a deep dive about applying.

There are also links to get you directly to grants.gov. Now this is the iteration that we put in here based on the last time that we've updated our notice of funding opportunity. They have a lot of information on there, very exhaustive about how to apply and all the steps. So I would recommend that everyone go there.

We can't necessarily walk you through it, but please familiarize yourself with the website and look at the directions. In terms of uploading your documents, I think that there's also directions on grants.com, but the preferred type is a PDF. You can't upload Excel documents in there. When you go into the application kit, there's a placeholder for a project narrative, a place for our budget narrative.

You are filling out the standard forms actually in the kit. And as it says in the application checkoff list and the notice of funding opportunity, which is another appendix in here, you, it says in here, if there's not an identifying title for the document that you want to upload, you just put it under other attachments form.

There's an appendix application checkoff list direction list there as well. It basically says in there, if you don't see a title for the document that you're uploading, it will go into the other attachments form. Overall, there is a place for you to put all the documents relevant for the application when you submit to grants.com.I think that answers that question in full.

>Lauren Synder, CMS:
Great. Thank you so much, Jamie. You're perhaps not surprised that we have quite a few questions about the application so the next few are also to you. This one is about the appendices.

Laura Synder, CMS: Can the appendices include information that does not fall under the categories listed on page 37 of the NFO or are the appendices only supposed to include the information described on page 37?

>Jamie Atwood, CMS: So I would say they would have to have a larger discussion about that, but in general you should stick to what is in there. We don't want one applicant to submit a document that another applicant does not. We don't provide any unfair advantage with the application during the review process. You should stick to the documents that are requested to be part of the appendices.
I think there was also a follow-up question about the business, assessment of applicant organization. There is a 12 page limit but there's additional documents they need to attach you can also include that and that will count towards your overall appendices limit, that set in the NFO, but you should stick to what we have listed here for a tendency documents.

If there's a larger issue, we can post Q&A to the website, but we don't want individuals submitting documents that others don't. That would be unfair.

Laura Synder, CMS: Great, thank you Jamie. Next question, also to you, is regarding the business assessment of the applicant's organization.

Should they answer each question individually or in a narrative format? And if individually, should they keep the questions in the document?
There are a few applicants who have supporting documentation that will put the document over the limit.

>Jamie Atwood, CMS: Yes, so generally it should stay as a word document, and you are answering each of those questions individually in there.

You should not just be answering yes or no. You should give us some narrative response in there. Also refrain from just saying see this link or see our website. You do have to put, substantive content in the document, but it should be mostly contained within those 12 pages with the exception of something like an organizational chart.

That's an additional document that's required that would be attached to the application. Without knowing what other example documents I don't know but if there is something you want supplement, that can count towards your additional appendices.

Laura Synder, CMS: Great, thanks Jamie. We have another kind of technical system question, regarding troubleshooting.

One applicant is planning on submitting tomorrow, but an issue where their administrator needs to be changed, or one of their contacts. They need administrative rights on their account to submit the application. Do you have any suggestions on how they should go about resolving that?

>>Jamie Atwood, CMS: Please reach out to grants.gov. We don't have direct access. Grants.gov is not under CMS, so you need to reach out to them directly, to update any roles.

Laura Synder, CMS: I think this is the last one. At least for the moment for you, Jamie.

Laura Synder, CMS: If an applicant intends to use subcontractors to perform some of the work, but they have not yet procured the contractor. Should they list them as a sub-recipient and why are we why or why not?

>Jamie Atwood, CMS: So, and I think this question came up in one of the earlier office hours call. In general, we wouldn't expect you to necessarily have finalized agreements with folks because you haven't yet applied let alone been awarded an AHEAD award, so we don't want you jump the guns. We fully expect that you're going to have estimated cost and estimated agreements, contractors or self- that you're working with.

You just need to identify whether you plan to work with a contractor or sub-recipient in the application. There's an appendix in that gives you a detailed example of what a budget narrative would look like. If you look at the regulation, it gives you more details on what the differences between those are, but you're going to have to identify, okay, we plan to kind of work with this entity and answer as many of those questions that you can. The appendix kind of walks you through a list of questions you have to answer for consultants or contracts.

If you don't know who you're working with yet, you might not know the method of selection, but you can still give us an estimated budget. For that contractor or sub-recipient that you plan to work with, because that needs to be part of the overall budget that you're requesting and submitting to CMS.

But as far as difference, you guys need to identify if it's going to be a sub recipient that you're working with versus a contractor. We can't make that decision for you. And there are differences between the two. Those are in, HHS grants regulation and the own B, 2 CFR 200, but talks you through what a contract relationship is versus sub-recipient. Most of the states you guys also have those protocols set in place, but you're just identifying as much information as possible in your application.

We're not expecting to identify who you're working with necessarily right now and you and it even says in the NOFO that if you get an award you would just circle back with us once you identified who you're working with, you can answer all the rest of those other questions.

Laura Synder, CMS: Thanks, Jamie. I think you are out of the hot seat for now. Thanks so much again. There is another question that came in through the helpdesk that will be responded by Eli from the AHEAD team. We had a question asking for clarification of, what is meant by hospital level scores are developed by computing a weighted score based on the defined geographic area proportion of hospital payments multiplied by the defined geographic area score? The follow-up question is, is it based on payment to hospitals in the geographic area or payments for beneficiaries in the geographic location? Is the geographic location always going to be the zip code for the social risk adjustments? Eli, over to you.

>Eli Boone, CMS: Thanks, Laura. I know that's a mouthful. So, I want to take a step back and just point folks towards version 1.0 of the CMS design Medicare fee for service hospital, global budget financial specifications. Those are available on our website. I'm working with our moderator right now to send a message towards, all attendees so you can find that in a link, but this question is for the social risk adjustment as part of that methodology.

Under that methodology, that social proportion of A hospital's payments received by the participating hospital in a defined geographic area. If a hospital serves 30% of, a geographic area that. Payment

proportion is then applied to that hospital at 30% if that makes sense. Then, that score is multiplied by the score either the meet or median. We're still doing some thinking there of the beneficiary risk scores at the beneficiary defined geographic area.

For the hospital level risk adjustment score for that participating hospital, that's step 6 of that social risk adjustment piece. Then that score is then compared to the entire HEAD states mean or median score. Again, some more things are underway there to calculate the social risk adjustment for the participating hospital. So hopefully that makes sense.
I do want to call out that that geographic area for the social risk adjustment may represent a zip code, a combination of zip codes or a county itself. That depends on the data available for that participating hospital.

> **Laura Synder, CMS**: Great, thanks so much, Eli. And, before you go, I think this next one is also for you, but feel free to redirect it as needed. The question about the unplanned volume change adjustment in the hospital global budget financial specifications section 3.2.2.3, step 2 it's about determining the percent of volume funded through the demographic adjustment as outlined. So will CMS be using the hospital's actual HCC adjusted growth as calculated in step 2 of the demographic adjustment methodology.

> **Eli Boone, CMS:** Thanks Laura. And I appreciate whoever sent that question in. So yes, CMS will be using a participating hospitals actual HCC adjusted growth for, as calculated during the demographic adjustment process for that unplanned volume change adjustment as well.

> **Laura Synder, CMS**: Great, thank you, Eli. Alright, looking through some of the submissions. And this next one, I hope Emily can answer this one for us. It's about commercial payers. Must commercial payers participating through state head model initiatives contract into a global budget arrangement with every participating hospital or does commercial payer participation mean that hospitals would contract specifically with that participating commercial payer in a global budget arrangement?

In other words, is it possible that only a subset of participating hospitals would be contracted with the participating commercial payer versus all participating hospitals?

> **Emily Moore:** Thanks, Laura. I appreciate that question and I certainly know. Given the importance of multi pair alignment how important this question is I'll read off a sort of what we are thinking here and where policy is landing, but the AHEAD model just to be clear does not place any specific requirements on commercial payers. Rather the model pulled states accountable for working with commercial payers to offer an aligned hospital global budget payment eligible hospital and holds the state accountable for ensuring that at least one commercial payer offers hospital budgets to eligible hospitals by performance here too. Possible participation in commercial global budgets is voluntary and hospitals would contract specifically with the participating commercial payer in the global budget arrangement. In other words, it is possible that only a subset of participating hospitals would be contract with the commercial payer versus all participating hospitals. I hope that helps to clarify.

> **Laura Synder, CMS**: Thanks, Emily. And I think it's also related to commercial pair methodology. Does CMS plan to include IME payments made by Medicare on behalf of Medicare Advantage plans? In other words, shadow bills in the global budgets for any MA cents participating in the AHEAD model.

> Emily Moore, CMS: Sure, thanks Laura. That's a great question. I think generally, you know, payments that go through and made plans, whether it is for IME or other things like that, you know, is something that would need to be considered as part of the commercial pay or global budget methodology. That is not something that CMS is requiring, that's the flexibility for the state to. We really want Medicare Advantage plans did to participate in this model as we are encouraging states to pursue robust
multiplayer.

> Laura Synder, CMS: Thanks, Emily, I have another question for Jamie. If you are ready. This is a question about if there's a way to update an application once it's submitted. For example, if a late letter of support comes in early Monday, but the applicant would like to submit ahead of time do they have a way that they can go in and update that application in case there's any late breaking documentation?

> Jamie Atwood, CMS: No, they cannot so they would have to resubmit the application and we would take the latest submission in the system. So, if there are two applications from a state, we would take the latest one, but they would have to resubmit the whole application again.

> Laura Synder, CMS: Very good to know. Great question. Thanks, Jamie.

> Laura Synder, CMS: I think the next one is for Emily as well. How will the standard analytical file reflect the AHEAD payment starting in 2028?

> Emily Moore, CMS: So I believe that this data analytical file just to make sure that we're talking about Medicare claims is you know generally hospitals who are participating in the hospital global budgets continue to submit Medicare Fee-for-Service claims as normal. This is important for us to be able to do some of the prospective hospital global budget calculations and adjustments as well as for quality measurement. However, into the hospital being paid on a Medicare fee for service basis individual claim by claim, the portion of the claim that is covered by the global budgets will not be paid. It will be set as a no pay claim.

> Laura Synder, CMS: Instead, the hospital will be receiving the bi-weekly lump sum payment for the portion of the global budget, right?

> Emily Moore, CMS: So hospitals global budgets are projected for that year, divide into 26 lumps and payments and then sort of issued directly to the hospital using the innovation payment contractor. That is of course for the CMS design hospital global budget methodology. If there are any more questions to that end, happy to answer them, but I hope that was clarifying.

> Laura Synder, CMS: Emily, another question for you about safety net definition. So safety net hospitals are defined as those exceeding the 70 fifth percentile threshold for all congruent facilities that bill Medicare. As those exceeding the 70 fifth percentile threshold for all congruent facilties that bill Medicare, can CMS explain what congruent means for this purpose? For example, all acute care hospitals nationwide, all acute care hospitals in a participating state or something else?

> Emily Moore, CMS: Thanks, as Laura mentioned, our global budget methodology, the CMS design version 1.0 is still in draft form at the present. This definition is aligned with CMI strategy refresh metrics in which we use be the comparison is national hospitals nationally that bill Medicare certainly we can you know would welcome state feedback about that defintion.

> Laura Synder, CMS: Hey, thanks again. This next one is for Eli.
How does CMS specifically define an academic medical center for attribution purposes?

> Eli Boone, CMS: Thanks Laura. This question was covered in a previous, office hour session, so I encourage folks to go visit our head model website page where you can see a recording and a transcript from previous office hours. Academic medical centers, also known as AMCs are affiliated with medical schools and confer medical degrees. Most AMCs are also teaching hospitals, but not all teaching hospitals are AMCs.

> Laura Synder, CMS: Thank you, Eli. We have a question about the effectiveness adjustment. When comparing a hospitals' potentially avoidable utilization percentile performance to statewide average PAU percentile. Can you confirm statewide means all state hospitals? Emily, do you mind speaking to this one?

> Emily Moore, CMS: Sorry, Laura, can you repeat that question for me?

> Laura Synder, CMS: Yeah, no problem. This is on the effectiveness adjustment. When comparing a hospitals' potentially avoidable utilization percentile performance to statewide average PAU percentile, can you confirm that statewide means all state hospitals?

> Emily Moore, CMS: Sure and thanks, Laura. If a state is operating statewide, that is our interpretation. They'd be compared to all State hospitals participating vs non-participating. Of course, if a state chooses to participate in a sub state region, it would be for hospitals within that geographic sub region. We welcome feedback. I'll the effect on this adjustment. You know, again, reiterating the point about open the feedback for a version.

> Laura Synder, CMS: Okay, thank you again for all the great questions that everyone has been sending in. The team's continuing to work through some of them. In the interim, we do have one question about baseline global budget calculations and annual trends. Where will CMS pull the most recent Disproportionate Share Hospital, IME and outlier factors and will these be adjusted for actual experience?

> Laura Synder, CMS: Emily, correct me if I'm wrong, but I believe this is to be determined because these are from the most recent IPPS and OPPS and packed files. But do you have anything to add?

> Emily Moore, CMS: Correct. We would be using the most recent IPPS and OPPS files that come out generally with payment regulations in late summer. So those would be used in an advance a performance year for some of those adjustments.

> Laura Synder, CMS: Thank you. Continuing to sort through some questions. So just give us a few minutes.

> Emily Moore, CMS: Laura, I can answer one of John's questions about the data source CMS will use identify AMC. John, I think you're talking about academic medical centers, but let me know if that's the case. Okay, great. In terms of academic medical centers, we are certainly aware that they serve a great purpose in a healthcare system providing specialty care and also many of them are obviously teaching hospitals. We have you given consideration to multiple different types of hospitals in our global budget methodology. Right now, there are no specific definitions for academic medical centers in our

methodology nor any specific adjustments. If they're specific or unique features of AMCs that you think might merit, updates the methodology, we welcome that feedback.

> **Laura Synder, CMS**: I think we're just about ready to respond to one other question just. Give us a few minutes. Thanks for your patience, everybody. Okay, we have a question about the social risk adjustment methodology. Is the social, risk adjustment methodology based only on Medicare fee for service payments and beneficiaries? The short answer for this one is yes. Our SRA methodology is based on Medicare fee for service payment and beneficiaries only. There are some second and possibly third parts to that question. We are just confirming the details before we respond live.

> **Emily Moore, CMS:** Thanks, Laura. I think we can take John's question, around Missouri.
> **Laura Synder, CMS**: I can go ahead and read it. How many states do you anticipate applying? Missouri is not planning to apply as of now and could a state participate in AHEAD without receiving any grant award from CMS. In other words, if the state doesn't win the cooperative agreement award could it participate if it wanted to do so?

> **Emily Moore, CMS:** Thanks, Laura and thanks, John for this question. We are certainly really excited about the number of states who have expressed interest and you know to all of you on this call would join the office hours. Generally, yes, to participatein the model, the state needs to be selected to participate either Cohort 1, 2, or 3. This application cycle is not the last chance as we, as you may know, there is another application period this summer.

Cohort 3 was intended to allow states who might need a bit more time to think through an application and whether this is the right fit for them. If you are considering participation. We'd welcome you to think about cohort 3 if Monday's deadline is not going to work for, you. Youdo need to be able to select states through this cooperative agreement application, but cohort 3 is always a possibility for those who do not apply this cycle.

>**Laura Synder, CMS**: Thank you, Emily. We did receive a couple of questions about interactions for how hospitals that participate in AHEAD and the Medicare shared savings program. there are two questions.

First, would the bonus payments under AHEAD, for example the transformation incentive adjustment or TIA and the health equity improvement bonus or ATIB, would those be considered expenses in ACO accounting? For the first question, I wanted to hand that over to Adam. If you wouldn't mind coming off mute you to speak to that one.

> **Adam Kellerman, CMS:** Thank you, Laura and thanks for the question. The overlaps discuss this in a bit more detail regarding the bonus payments, but the short answer is that the bonus payments that are the AHEAD hospital global budget adjustments, such as the transformation incentive adjustments and the health equity bonus as you as you point out here, would not count towards for the purpose of calculating financial settlement and shared savings in the SSP model.

> **Laura Synder, CMS**: Thanks, Adam. And I think there's also a follow-up question about where do ACL aligned beneficiary count and not count in the various hospital global budget financial measurements. For example, the total cost of care performance adjustment and historical revenue calculations.

Adam Kellerman, CMS: So I don't have a answer for this one at this time, but we're certainly thinking through this and we'll be sure to address these questions in subsequent updates to the financial specifications.

Webinar attendee: Thanks again.

Laura Snyder, CMS: Thanks again for all the good questions this afternoon. Please keep them coming. And we're continuing to sort through the ones that we've received. I'm looking through our questions and team's discussion. I think that we are just about through all of the questions that we have received and can answer at this time. However, members of the team, please let me know if I'm overlooking anything here.
Okay, I believe we have a question about limitations placed in the third step of geographic attribution. There was some concern that this would lead to hospitals being responsible for beneficiaries too far outside of the hospital service area. Eli, can I turn it to you to speak to that a little bit?

Eli Boone, CMS: Yeah, thanks Laura. And I want to take a quick step back and clarify. I believe this question is specific to the total cost of care performance adjustments, attribution approach, but please, sound off in, the chat if we have that I'm incorrect. To get to this question under that assumption, we did not limit step 3 of the total cost of care performance adjustment attribution approach. However, the thinking here is that the majority of beneficiaries should be attributed to hospitals through the first 2 steps in this approach. That's using the defined service area and then the plurality of services. So, that said if there are specific concerns here, you know, certainly encourage folks to write in and let their concerns be known. We're available@AHEADatcms.hhs.gov. You can write in there.

Webinar attendee: Thanks.

Laura Snyder, CMS: Thanks so much, Eli. Alright everyone, you have us for another 18 min so just keep the questions coming if you have them. You won't be getting any stand-up comedy from me, unfortunately. That's a role I'm not prepared to take over from Julia.

Emily Moore, CMS: Laura, we have another question or comment from John, which I can read and answer for us. John says: Thank you for this office hours session. I'm curious if other states could share their experience in discussing AHEAD with their hospitals, who have been lukewarm at best and in Missouri.

Certainly, other colleagues feel free to connect with John offline or share some experiences. But you know, I want to just share that we recognize that the global budgets are a place where there is a very complicated payment policy with a lot of different opportunities and each hospital will need to think through the value proposition as part of the decision on participation. Hospital recruitment as you many of you know is really important for the AHEAD overall goals and in terms of improving quality, advancing health equity, and increasing efficiency in our care. But we do want to sort of note in the NFO we've described how CMS will be working with states as part of its participation recruitment, and the like, and we'll be working to better describe our global budget methodology in subsequent versions and be a partner on this journey. So we do recognize that this is a critical part of the model in a place where, states and CMS will need to work closely together. We did want to just share that in response to your comment.
>>Laura Snyder, CMS: Jack Zelen raised his hand, so I'm moving over to unmute you.

> **Webinar attendee:** Okay, thank you very much. Hello, hi everybody. Yeah, we I just want to say we have a similar reaction. I think the hospital association itself here has lots of reservations and that's been our answer to them is look, we have time to negotiate something that works as a state strategy. So, and noting as in Maryland, the model has gone through so many, you know, incarnations and it's a very complicated one. So we're trying to work through that too, but I think probably all states are facing some of that because of the conservative nature of hospital associations in general.

> **Emily Moore, CMS:** Thanks so much Dr. Len, it's really great to hear your, perspective on this. Thanks again for speaking up.

> **Laura Snyder, CMS: I** believe I have granted you the ability to speak so please let us know if it works.

> **Webinar attendee**: Thank you. Appreciate you taking my question. I was wondering if you could provide some information about hospitals that are participating if they get selected as part of the AHEAD model. Obviously, I'm quite aware that we would be, we a hospital, if selected in a participating state would be required to follow any global payment methodology and budgeting for the Medicare and for the Medicaid program.
Of course, the other part of the AHEAD model is going to be commercial payers. So are hospitals that take part in this also required to participate in the global budget that a specific commercial payer comes up with? And I'm not sure if the way this is intended to work is that is every commercial payer has to have the global budgeting methodology or do they have some flexibility to develop their own specific global budgeting methodology, and if it's different, are hospitals required to basically take what they get from each of the commercial pairs or 2 hospitals have the right to say that they would take part in some, but not all?

> **Laura Snyder, CMS:** These are great questions and thank you so much for raising them. Emily, I'll hand it to you.

> **Emily Moore, CMS:** I'm so glad you raised that question. I'm happy to answer it. One point is that hospital participation in a head is not required. So I hope that relieves some of your concerns about mandatory participation. We certainly are encouraging of it in part given the promise that we believe global budgets have. So I think that sort of covers the Medicare fee for service portion of your questions. With regards to commercial payers, I think that this can look in 2 different ways. One is a where a commercial payer develops its own methodology. And the other is probably more efficient; it's where the state collaborates with payers on the commercial payer methodology. Certainly, the state could pursue customization in this case. But generally hospitals will not be required to take a commercial global budget. Again, that is the hospital's decision to both participate in the Medicare fee for service methodology. And if it chooses commercial, great, but again, it's voluntary. So Todd, I hope that answers some of your questions and I'm to continue the conversation.

> **Webinar attendee:** Alright, thanks for that. Thanks.

> **Laura Snyder, CMS:** Mark, your line is unmuted.

> **Webinar attendee:** Thank you. I, my question was actually Todd's question. So I'm all set.

>Emily Moore, CMS: Thanks Mark. Appreciate that. I did neglect one thing in my response which is that the hospital participation is voluntary states do have expectations in terms of hospital recruitment and participation levels. You'll see our 10% of hospital net patient revenue to proceed into the first performance year following participation is voluntary. So I hope that helps to provide additional context.

Thanks again everyone for joining us this afternoon and for submitting your very thoughtful questions in advance and also live today.

> Laura Snyder, CMS: We have 10 min left on the last office hours before the deadline for cohorts one and 2, so please speak now if you still have questions. And as we wait for any last minute questions coming in, let's go AHEAD and move to the last slide. Emily, do you have any remarks now or do you want to hold?

> Emily Moore, CMS: Sure, thanks Laura. You know we're really excited to see the applications that come in on Monday and again for those that are considering applications in the future, certainly cohort 3 is still an option so don't feel pressure. We will select up to 5 states for cohorts 1 and 2 and will reserve some spots for cohort 3, although we certainly are encouraging states to apply now. We are working our best to respond very quickly to your email responses in the AHEAD mailbox. Those that we're going to prioritize are related to the NOFO application given the upcoming deadline but as you've heard throughout the office hours, we are welcoming of feedback about the model concepts and clarifying questions whether it's around the overall construction of the model and or global budgets specifically. We have done our best to provide as much information about the model as possible on our model website, of course, for the application on Monday, but the NOFO is your best source of truth here. We recommend close study of that. As Jamie noted, some of these processes through Grants.Gov are handled by Grants.Gov so let us know if anyone runs into issues, but again, some of those must be solved through those channels. So thank you again for your interest and your participation. We're really excited to see what we receive.

> Laura Snyder, CMS: And just want to acknowledge the question in chat from, Melvin Sakharai around, persuading hospitals. I think we will get back to you on that. Appreciate the question. And then in terms of the question around the hospital aggregate area deprivation index, I will point you to the financial specifications. It is a blend of both the state and national ADI. We're winding down here just a couple more minutes. Thanks again everybody for your participation and great questions. Just a couple more minutes left if you want to get any last minute questions in and then we will wish you all a good afternoon.
All right, well, we are at the top of the hour. Thank you all again for joining. We welcome your questions and appreciate your robust engagement on this session as well as with this model and its application. Best of luck to those who are in the final push of submission and we welcome additional engagement with states as they're considering Cohort 3 as well. Thank you all and we'll be in touch. Have a great day everyone.