Technical Briefing on the Baseline Health Care Cost Growth Benchmark Submissions

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Today's Agenda

- Overview of Connecticut's Health Care Cost Growth Benchmark and Primary Care Spending Target
- Review of the Total Medical Expense Data Reporting Requirements
  - Review of Definitions and Data Collection Methodology
  - Highlight Methodological Changes
  - Walk Through of Updated Data Submission Template
- Data Reporting, Collection and Validation Process
- Preview of Forthcoming Quality Benchmark Data Request
- Questions

Overview of Connecticut's Cost Growth Benchmark and Primary Care Spend Target Programs

Connecticut's Health Care Cost Growth Benchmark

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	2.9%
2025	2.9%

- Connecticut's cost growth benchmark is an **annual rate-of-growth** benchmark for statewide healthcare spending.
- The benchmark values are based on a methodology was developed through an open public process that considered various economic indicators.

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Connecticut's Primary Care Spending Target

Calendar Year	Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

- The primary care spend target evaluates primary care spending as a percentage of total medical spending.
- Connecticut is expected to increase primary care spending as a percentage of total medical spending to 10% by 2025.

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Total Health Care Expenditures

Total Medical Expense (TME) + **Net Cost of Private Health Insurance (NCPHI)** = **Total Healthcare Expenditures (THCE)**

All incurred expenses for CT residents for all health care services, regardless of where the care was delivered and regardless of the situs of the member's plan.

The **costs to CT residents associated with the administration of private health insurance.**

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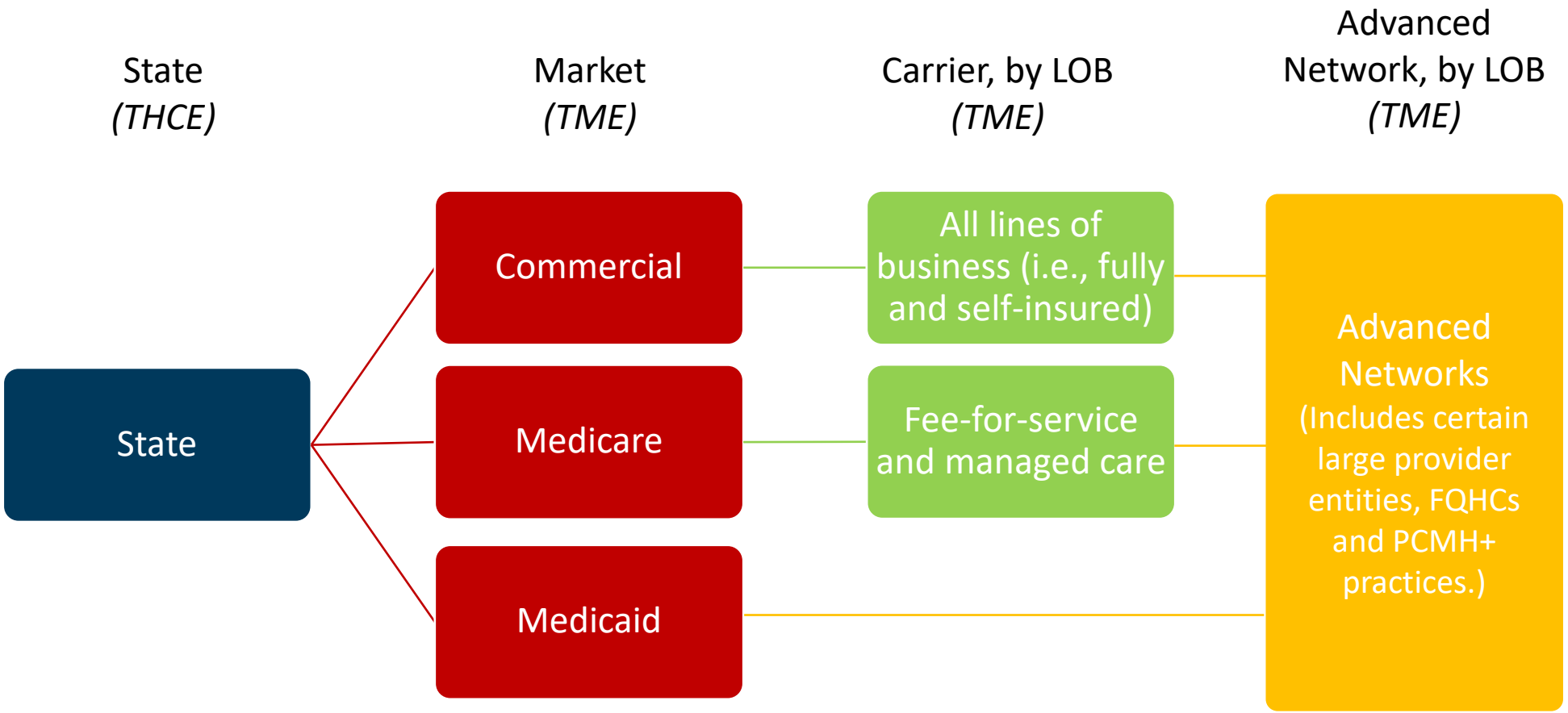
Four Levels of Public Reporting of Performance Against the Benchmark and Target



Payers Reporting Data to Assess Performance Against the Benchmark and Target

Carrier*	Commercial Fully and Self-Insured Plans	Medicare Advantage	Medicaid
Aetna Health & Life	X	X	
Anthem	X	X	
Cigna	X		
ConnectiCare	X	X	
Department of Social Services (DSS)			X
Office of the State Comptroller (OSC)**	X	X	
UnitedHealthcare	X	X	

* OHS is also collecting data from the Department of Corrections, the Veteran's Health Administration, and the Centers for Medicare & Medicaid Services.

** OSC will submit data for the purposes of measuring OSC's performance relative to the benchmark. OSC's past, current, and future TPAs should still report OSC within their data submission.

Review of the Total Medical Expense Data Reporting Requirements

Implementation Manual

- Comprehensive document that describes the:
  - Overall initiative;
  - Formulae for developing the healthcare cost growth benchmark and primary care spend target;
  - Methodology for calculating total healthcare spending against the benchmark and primary care spend against the target; and
  - Process for publicly reporting the results.
- Contains data reporting specifications for commercial and Medicare managed care carriers in Appendix A.

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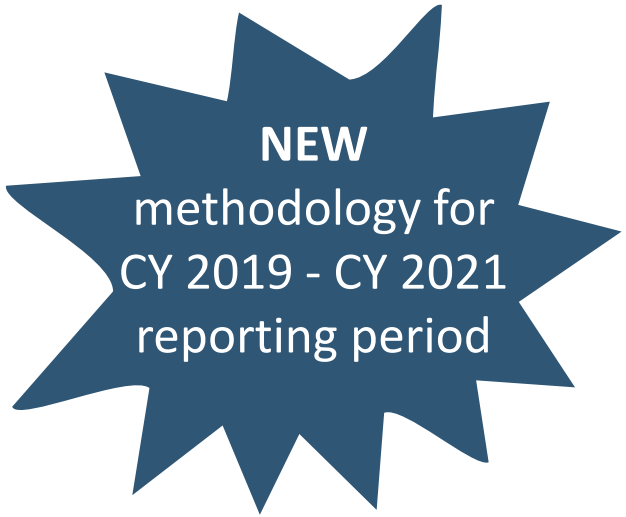
Overview of Methodological Updates

- Implementation of new methodologies for assessing benchmark performance, including:
  - Truncation of spending for high cost outliers
  - Risk-adjustment using age/sex factors
- Renamed “Large Provider Entities” as “Advanced Networks” and added additional Advanced Networks required for reporting
- Updated the primary care spending definition
- Specified that pharmacy rebates should be reported separately as medical and retail pharmacy
- Changed for collecting variance to collecting standard deviation for the purposes of developing confidence intervals

Identifying Changes in Implementation Manual

- The Implementation Manual includes call-outs to indicate important updates, major methodological changes, and items of particular interest.



Insurance Carrier Reporting Template

Header Tab	Basic carrier identifying information
Advanced Network Tabs	Total medical expense by Advanced Network and Insurer Carrier Overall, by insurance category code
Pharmacy Rebate Tabs	Pharmacy rebates by insurance category code
Line of Business Enrollment Tab	Detailed line of business enrollment and income from fees of uninsured plans
Standard Deviation Tabs	Data required for creating confidence intervals
Age/Sex Factors Tabs*	Spending by age band and by sex, for the purposes of risk adjustment
Mandatory Questions Tab	Attestation on the data accuracy, and checks on assumptions used for reporting the data
Data Validation Tabs	Series of checks to ensure data are consistent

* **Note**: The Age/Sex Factors tabs are new to 2019-2021 carrier reporting template

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No Changes to Header Tab

- Carriers should still provide the following information:
  - Reporting period start and end dates
  - Clinical risk adjustment tool, including some description of the underlying methodology
  - Listing of “d/b/a”

Header Tab

Updates to Advanced Network Tabs

- An **Advanced Network** is an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract.
  - Formerly called "Large Provider Entities"

Note: The term "Advanced Network" as used in this manual is equivalent to the term "provider entity" as used in Public Act 22-118

Advanced Network Tabs

Updates to Advanced Network Tabs (Cont'd)

- OHS has expanded the list of Advanced Networks in order to get an accurate assessment of their relative size
  - 2018-2019 data collection was for 11 Advanced Networks
  - 2019-2021 data collection is for 31 Advanced Networks
- OHS intends to reduce the number of Advanced Networks to only the largest entities in future rounds of data collection

Advanced Network Tabs

List of Advanced Networks for 2019-2021

Advanced Network/Insurer Carrier Org ID	Advanced Network/Insurance Carrier Overall	Advanced Network/Insurer Carrier Org ID	Advanced Network/Insurance Carrier Overall
100*	Insurance Carrier Overall	117	Cornell Scott Hill Health Center
101	Community Medical Group	118	Fair Haven Community Health Center
102	Connecticut Children's Medical Center	119	Family Centers
103	Connecticut State Medical Society IPA	120	First Choice Community Health Centers
104	Integrated Care Partners	121	Generations Family Health Center
105	Medical Professional Services	122	Norwalk Community Health Center
106	Northeast Medical Group	123	Optimus Health Care, Inc.
107	OptumCare Network of Connecticut	124	Southwest Community Health Center, Inc.
108	Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	125	Stamford Medical Group
109	Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	126	Starling Physicians
110	Value Care Alliance	127	UConn Medical Group
111	ProHealth	128	United Community and Family Services
112	Charter Oak Health Center	129	WestMed Medical Group
113	CIFC Greater Danbury Community Health Center	130	Wheeler Clinic
114	Community Health and Wellness Center of Greater Torrington	131	Yale Medicine
115	Community Health Center	999*	Members Not Attributed to an Advanced Network
116	Community Health Services		

Advanced Network Tabs

***Note:** IDs 100 and 999 are new to the 2019-2021 carrier reporting template

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No Change to Reporting Spending by Advanced Network

- To report spending at the Advanced Network level, members will still need to be attributed to a primary care physician (PCPs), and PCPs will need to be attributed to an Advanced Network.
  - Each carrier should use its methodology to attribute members to a primary care provider.
  - Each carrier will be asked to attribute PCPs to those Advanced Networks based on existing contractual relationships.
- All spending on members will be reported under the Advanced Network to which the members' PCP is attributed.
- Spending for members NOT attributed to an Advanced Network should be reported in aggregate in one row of the TME file (ID 999).

Advanced Network Tabs

Additional Level of TME Data Required in Advanced Network Tab

- In addition to Advanced Network level spending by Insurance Category Code, Insurance Carriers will be asked to report overall spending by Insurance Category Code
  - This additional level of reporting will be used for truncation purposes
  - Carriers should use Advanced Network/Insurance Carrier Overall ID 100 to indicate overall spending by Insurance Category Code

Advanced Network Tabs

No Change to Reporting TME by Insurance Category Code

- Mutually exclusive data categories that indicate for what market / line of business the carrier is reporting data.
- Commercial has two categories:
  - Full claims – for when the carrier holds the entire medical benefit and has all of the data.
  - Partial claims – for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers must estimate partial claims data for which it does not have access.

Insurance Category Code	Definition
1	Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

Advanced Network Tabs

No Change to General Parameters for Submitting TME

- Include spending by or on behalf of Connecticut residents regardless of where the care was delivered and the situs of the residents' plan
- Report spending on allowed claims (i.e., spending covered by payers and out-of-pocket member spending) only when carrier is the primary payer.
  - Do not include premium payments.
- Report spending based on date incurred.

Advanced Network Tabs

Additional Run-Out for Claims Spending

- Allow for a claims run-out or non-claims reconciliation period of at least **180** days after December 31 of the performance year.
  - If necessary, carriers should apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category of claims spending.
  - Carriers should apply reasonable and appropriate estimates of non-claims liability to each large provider entity that are expected to be reconciled after the 180-day review period.

No Change to Categories of Claims-based Spending to Report

- Carriers should report claims-based spending according to the following categories:
  - Hospital Inpatient
  - Hospital Outpatient
  - Professional: Primary Care (excludes OB/GYN)
  - Professional: Primary Care (for monitoring purposes) (includes OB/GYN)
  - Professional: Specialty
  - Professional: Other
  - Long-term Care
  - Pharmacy
  - Other
- The “Professional: Primary Care” categories have code level definitions in the manual which have been updated for 2019-2021.

Advanced Network Tabs

Updates to TME Claims Category Definitions

- **Hospital Inpatient** *(no change)*: The TME paid to hospitals for inpatient services, including all room and board and ancillary payments, and payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services, for physician services during an inpatient stay that have been billed directly by a physician group practice or an individual physician, and inpatient services at non-hospital facilities.
- **Hospital Outpatient** *(no change)*: The TME paid to hospitals for outpatient services, including payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance, and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, Primary Care** *(updated)*: The TME paid to primary care providers delivering care at a primary care site of care generated from claims using the code-level definition in the Implementation Manual. *This definition excludes OB/GYN.*

Summary of Updates:

- **Defines site of care**: "Primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC)"
- Expands primary care service code list to include **telehealth-related modifier codes** and **place of service (POS) codes**
- Updated **taxonomy and procedure codes**

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, Primary Care (for monitoring purposes)** *(updated)*: The TME paid to primary care providers, including OB/GYNs and midwifery, delivering care at a primary care site of care generated from claims using the code-level definition in the Implementation Manual.

Summary of Updates:

- **Defines site of care**: "Primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC)"
- Expands primary care service code list to include **telehealth-related modifier codes** and **place of service (POS) codes**
- Updated **taxonomy and procedure codes**

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, Specialty** *(updated)*: The TME paid to physicians or physician group practices generated from claims, including services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition.

Summary of Updates:

- Clarified that this category **should also include the OB/GYN spending** that was included in the "Professional, Primary Care (for monitoring purposes)" category

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, Other** *(no change)*: The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician and is not identified as primary care in the first primary care definition.
- **Pharmacy** *(no change)*: The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by the insurance carrier's prescription drug benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered. Medicare Advantage carriers that offer stand-alone prescription drug plans should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Advanced Network Tabs

Updates to TME Claims Category Definitions (Cont'd)

- **Long-Term Care** *(no change)*: All TME data from claims to providers for nursing homes and skilled nursing facilities, intermediate care and assisted living facilities, and providers of home- and community-based services, including personal care, homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community.
- **Other** *(no change)*: All TME paid from claims to healthcare providers for medical services not otherwise included in other categories, including durable medical equipment, facility fees of community health services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services.

Advanced Network Tabs

No Change to Categories of Non-Claims-based Spending to Report

- Carriers should report non-claims-based spending according to the following categories:
  - Prospective Capitation, Global Budget, Case Rate or Episode-based Payments
  - Performance Incentive Payments
  - Payments to Support Population Health and Practice Infrastructure
  - Provider Salaries
  - Recovery
  - Other
  - Total Primary Care Non-Claims Based Payments (*this category is the only category not mutually exclusive from the others*)

Advanced Network Tabs

Categories of Non-Claims-Based Spending to Report

- **Prospective Capitation, Global Budget, Case Rate or Episode-Based Payments** *(no change)***:** Includes single payments to providers to provider healthcare services over a defined period of time, prospective payments for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits are carved out, payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific time period, and payments received by providers for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.
- **Performance Incentive Payments** *(no change)*: Includes rewards to providers for achieving quality or cost-saving goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target.

Advanced Network Tabs

Categories of Non-Claims-Based Spending to Report (Cont'd)

- **Payments to Support Population Health Practice and Infrastructure** *(no change)*: Includes payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs.
- **Provider Salaries** *(no change)*: All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories.
- **Recovery** *(no change)*: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigations. This field should be reported as a negative number.

Advanced Network Tabs

Categories of Non-Claims-Based Spending to Report (Cont'd)

- **Other** *(no change)*: All other payments made pursuant to the carrier's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic.
- **Total Primary Care Non-Claims-Based Payments** *(no change)*: All non-claims-based payments included in the previous six categories that are specifically made to a primary care provider or provider organization.

Advanced Network Tabs

Changes to Risk Adjustment Methodology

- Carriers should still submit TME data as a non-adjusted value.
- Starting with 2019-2021 TME data, OHS will be risk-adjusting data by age/sex, rather than by using diagnosis-based risk scores.
  - Age/sex factor data will be discussed in further detail later in this presentation.
- Carriers should still submit clinical risk scores in the Advanced Network tab so OHS can monitor the impact of the methodological change.

Advanced Network Tabs

New Methodology - Truncation of Spending of High-Cost Outliers

- Carriers will also submit truncated claims spending and the count of members with claims truncated, using truncation points set for each market.
- Truncation will be applied at the Carrier and Advanced Network levels.

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$150,000
4	Commercial: Partial Claims	$150,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

Advanced Network Tabs

New Methodology - Truncation of Spending of High-Cost Outliers (Cont'd)

- How to Apply Truncation:
  - Truncation should be applied to individuals' total spending, inclusive of all medical and pharmacy spending.
  - For Carriers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member-level truncation should be applied after estimates of carve-out spending have been made.
  - For members who are attributed to more than one Advanced Network during the year, Carriers should "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks, and for the Carrier as a whole *(see next slide for example).*

Advanced Network Tabs

New Methodology - Truncation of Spending of High-Cost Outliers (Cont'd)

- Example of **"reset the clock" approach** when members are attributed to more than one Advanced Network during the year:

Example with a $150,000 truncation point:

- A member in Insurance Category Code 1 was attributed to Advanced Network X for 8 months with $200,000 in claims.
- The member is then attributed to Advanced Network Y for 4 months with $175,000 in claims.
- Advanced Network X's spending above the truncation would be $50,000 while Advanced Network Y's spending above the truncation would be $25,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

Advanced Network Tabs

Changes to Pharmacy Rebate Tabs

- OHS will be **separately collecting medical and retail pharmacy** rebates from each carrier to recognize it as income to the carrier.
  - Data should include PBM rebate guarantee amounts or other PBM rebates transferred to carriers.
  - Insurers should apply IBNR factors to preliminary drug rebate data.
- Pharmacy rebates should be reported as a **negative number**.

Pharmacy Rebate Tabs

Changes to Line of Business Enrollment by Market Tab

Line of Business Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare managed care
908	Medicare/Medicaid duals

- Formerly called the "Market Enrollment" Tab
- 2019-2021 data all collected in one tab
- The Market Enrollment Tab is the source of some information to compute NCPHI:
  - Member months by line of business; and
  - Income from fees of uninsured plans (applies to self-insured only)
- Only members who are Connecticut residents should be reported in these data

Line of Business Enrollment Tab

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Changes to Standard Deviation Tabs

- Changed from collecting variance to collecting standard deviation for the purposes of statistical testing
- Insurers should still calculate and submit standard deviation data:
  - For each Advanced Network, by market
  - For the Carrier Overall, by market
- Added market codes for reporting standard deviation data

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

Changes to Standard Deviation Tabs (Cont'd)

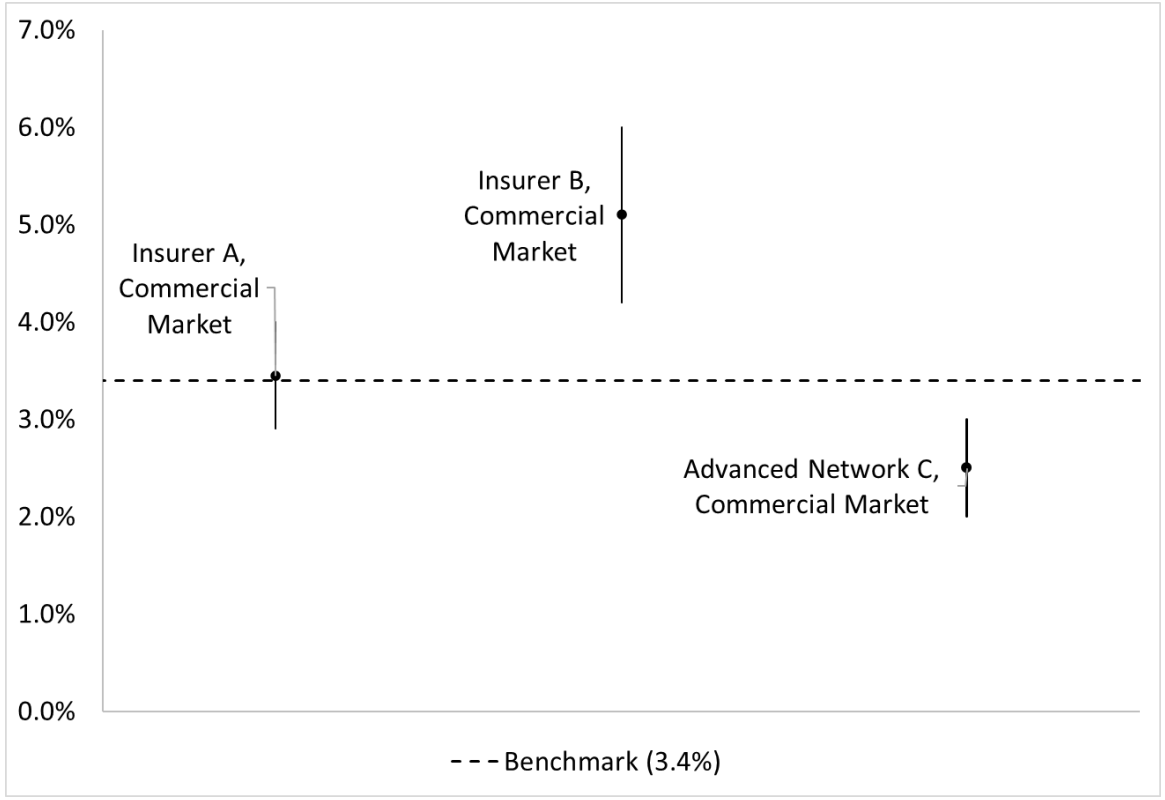
- Reminders about calculating standard deviation data:
  - Carriers should include all members attributed to an Advanced Network, including members with no utilization.
  - Standard deviation should be based on per-member-per-month (PMPM) spending.
  - Carriers should calculate the standard deviation PMPM after partial claims adjustments.
  - Non-claims expenditures should be excluded from the calculation.

Determining Payer and Provider Entity Performance Against the Benchmark

- OHS will use the standard deviation data to conduct statistical testing to assess carriers' and provider entities' performance against the cost growth benchmark.
- This will be done through the development of a "confidence interval" – an upper and lower bound – around each entity's cost growth.
  - A confidence interval is a type of estimate in statistics that shows a possible range of values in which we are fairly sure our true value lies.
  - In practice, it allows OHS to say, "We are 95% confident that the interval between A [lower bound] and B [upper bound] contains the true cost growth for entity C."

Standard Deviation Tabs

How OHS Will Use Confidence Intervals to Determine Performance Against the Benchmark



- Performance against the benchmark will be determined as follows:
  - Unable to determine performance when upper or lower bound intersects the benchmark (e.g., Insurer A)
  - Benchmark has not been achieved when lower bound is fully over the benchmark (e.g., Insurer B)
  - Benchmark has been achieved when the upper bound is fully below the benchmark (e.g., Advanced Network C)

Standard Deviation Tabs

New Methodology – Age/Sex Factor Data

- The measurement of Carrier and Advanced Network performance against the Benchmark will be risk-adjusted by age and sex, rather than by using diagnosis-based risk scores.
- Carriers will need to provide truncated TME data by age/sex bands in the new Age/Sex Factors tabs.

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Sex Code	Description
1	Female
2	Male

Age/Sex Factors Tabs

Changes to Data Attestation and Mandatory Questions

- Carriers will still attest to the accuracy of the data reported and answer a series of questions designed to ensure that the data reported are consistent with the requirements in the Implementation Manual.
- Several new questions were added to the 2019-2021 data submission template, related to:
  - Truncation
  - Age/sex factor data

Pre-Submission Data Validation

- Be sure to review the Data Validation Tabs before submitting data
- The Data Validation Tab includes:
  - A series of checks for inconsistencies in the data.
  - Tables that allow payers to look at per member per month (PMPM) spending on service categories by market, and by Advanced Network by market.

Data Reporting, Collection and Validation Process

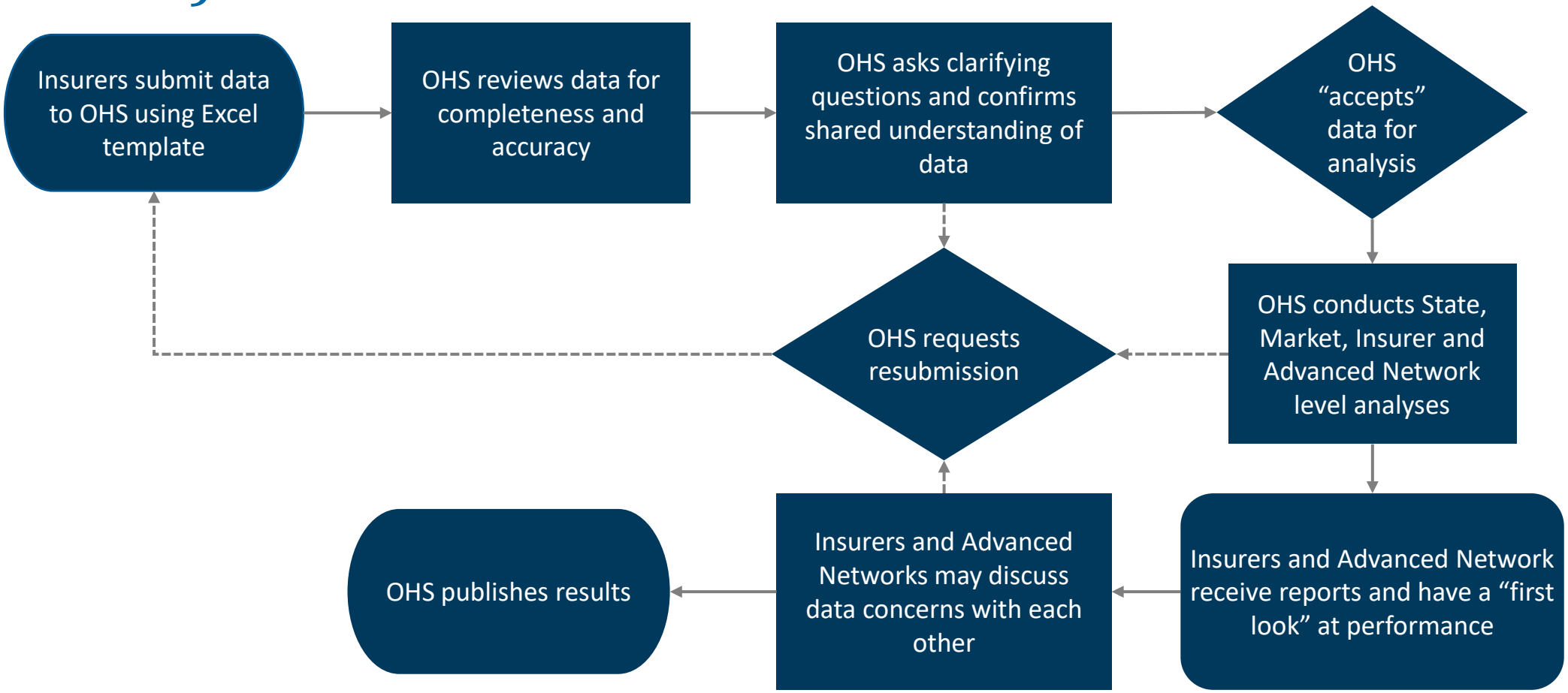
Due Date for Pre-Benchmark Data

- For this round, OHS is collecting 2019, 2020 and 2021 data.
- Data are due to OHS by August 15, 2022
- Electronic files must be submitted through the State's secure file transfer server at https://sft.ct.gov

Data Reporting, Validation and Collection Process

- Similar to the 2018-2019 data collection process, OHS will work with payers to validate TME and primary care spend data. Payers can expect to hear from OHS:
  1. After the initial data submission to ensure data were submitted using specifications outlined in the Implementation Manual and to review initial PMPM spending and trend by service category; and
  2. Once OHS aggregates payer and Advanced Network data to review payer data prior to publication.

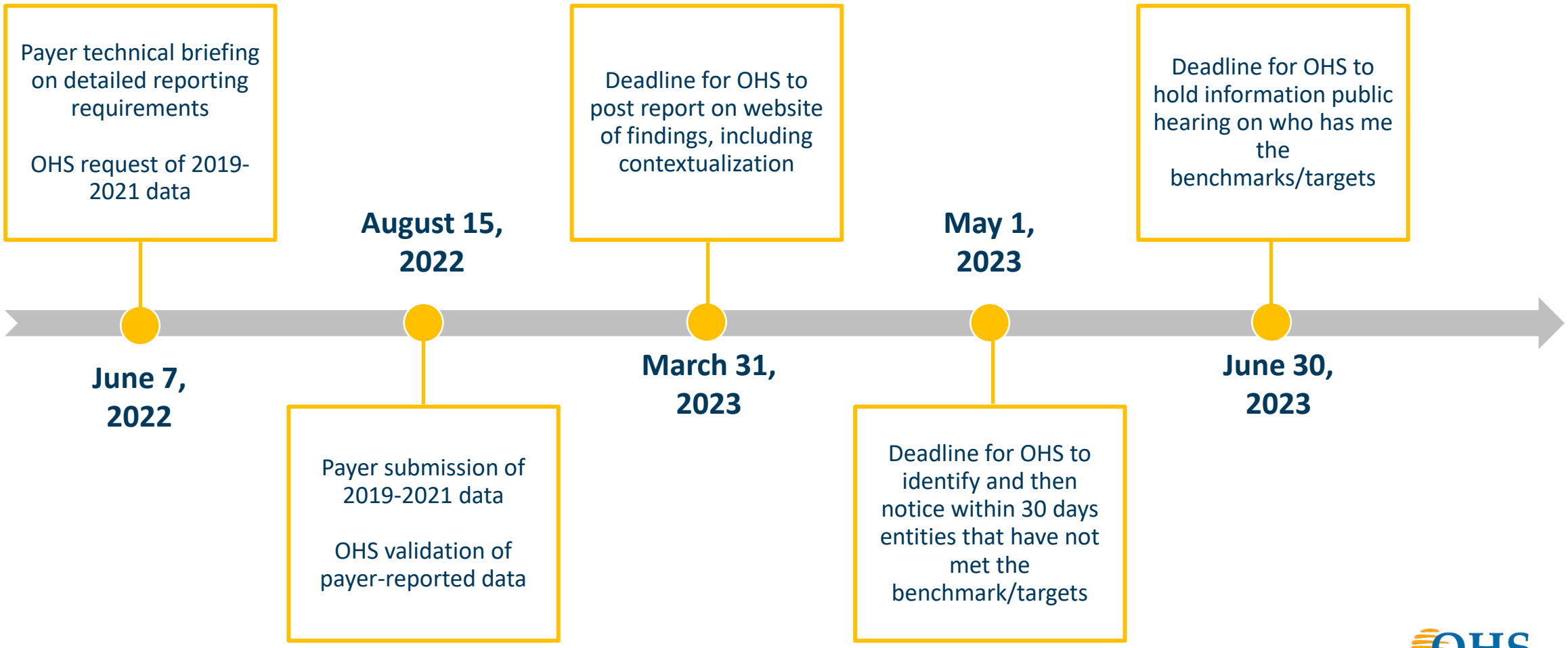
Data Reporting, Validation and Collection Process (Cont'd)



Office Hours

- Bailit Health and OHS are offering office hours for insurance carriers to ask questions about the data specifications.
  - **Wednesday, June 15th**: 10:00am-12:00pm
  - **Tuesday, June 28th**: 1:00-3:00pm
  - **Monday, July 18th**: 2:00-4:00pm
  - **Thursday, July 28th**: 10:00am-12:00pm
  - **Friday, August 5th**: 12:00-2:00pm
- To reserve time to meet within one of the above timeslots, please email Grace Flaherty (gflaherty@bailit-health.com)

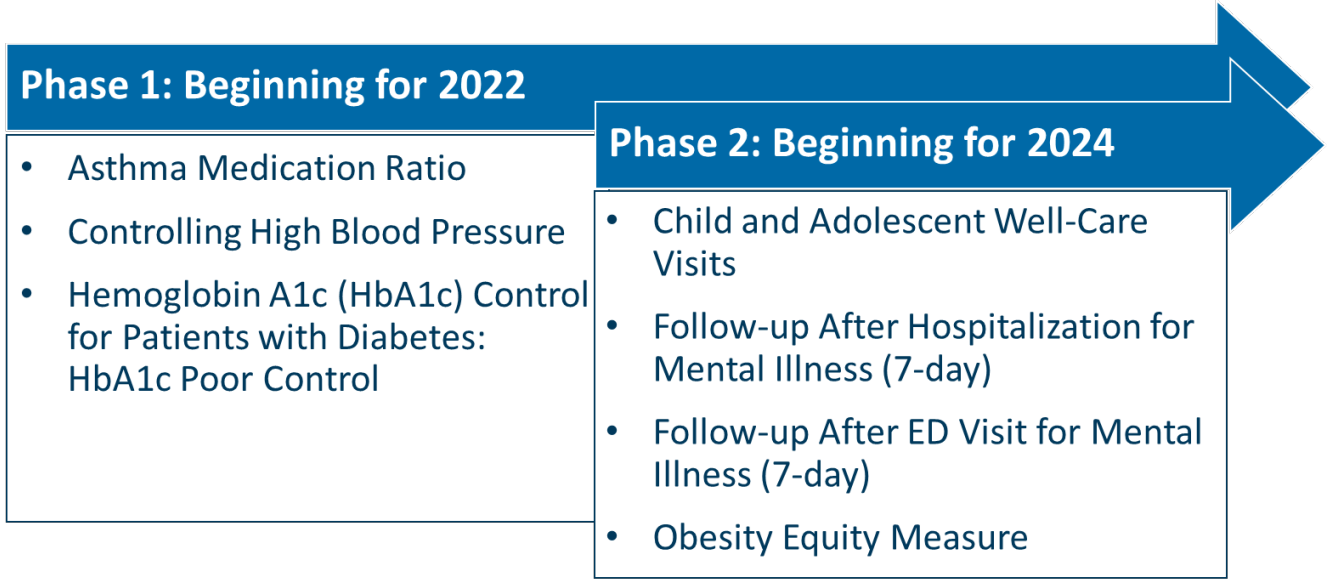
Data Collection and Reporting Timeline



Preview of Forthcoming Quality Benchmark Data Request

Overview of Connecticut's Quality Benchmarks

- The **Quality Benchmarks** are annual measures and target values that all public and private payers, providers and the State must work to achieve to improve healthcare quality in Connecticut.
- The OHS Quality Council selected three measures for 2022-2025 and seven measures for 2024-2025:



Quality Benchmark Data Request

- This year, OHS will be collecting CY 2021 baseline performance data on the Phase 1 Quality Benchmark Measures:

Quality Benchmark Measure	Steward	Levels of Measurement
Asthma Medication Ratio	NCQA	State, Market, Payer, Advanced Network
Controlling High Blood Pressure	NCQA	State, Market, Payer, Advanced Network
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	NCQA	State, Market, Payer, Advanced Network

Anticipated Timeline

- OHS' expected timeline for the Quality Benchmark data request is as follows:
  - **July 2022** – OHS to issue formal Quality Benchmark data request for CY 2021 baseline data and host technical implementation webinar
  - **September 2022** – CY 2021 Quality Benchmark data due from insurance carriers
  - **March 2023** – OHS to report on CY 2021 baseline Quality Benchmark performance

For Questions, Please Contact:

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- Grace Flaherty: gflaherty@bailit-health.com