



Quarterly Newsletter                      April 2010

## President's Letter to NAMSAP

Dear Members,

What an exciting year we have in store for us. Changes related to reporting, the new interest in Liability MSA issues and new member growth opportunities; make for an exciting year for all of us. NAMSAP has plans to continue to increase the value of your membership.

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1. Our Education subcommittee on Webinars has taken on the task of increasing the number and relevancy of our 2010 Webinar Schedule. You can look forward to a growing and continuing stream of learning opportunities.
2. We are scheduled in Washington, DC, for our annual education meeting. This is an election year and we hope to have interaction with Congressional interests as part of our meeting. Planning is going on as you read this, so please share any ideas you have with the Education Committee. We are already looking forward to 2011 in New Orleans, so planning is constant when it comes to education.
3. One new event this year will be NAMSAP serving as a sponsor at the Workers' Compensation Education Conference in Orlando in August of 2010. This is yet another opportunity for NAMSAP to share our mission and provide expanded opportunities for members.
4. There will be an opening on the Board of Directors this year. Term limits do not apply. We encourage all of you to consider becoming part of the leadership of our organization.
5. One of our goals this year is to provide more interaction with our members, through Webinars, involvement in WCEC, the Annual Education Meeting, and the work of various committees. We learned from the survey you participated in and will be offering relevant membership enhancements.

Your continued involvement is the key to our organization's success. Listserv continues to be a voice of our organization and many great topics are seen there. Please continue to contribute. We learn best from our peers.

Thank you for your membership, and we look forward to working together in 2010.

Sincerely,

Michael E. Westcott



Michael E. Westcott

*Hadden Case One-Pager*

On August 6, 2009, the U.S. District Court for the Western District of Kentucky issued its opinion in Hadden v. United States, No. 1:08-CV-10 (W.D. Ky., August 6, 2009), rejecting Mr. Hadden's claim for a waiver (or, more accurately, reduction) in the Government's MSP recovery on the basis of comparative fault principles. The matter presents an ideal "test case" to seek a ruling requiring CMS to consider state comparable fault principles in the MSP recovery process. The MARC Coalition has agreed to undertake Mr. Hadden's appeal to the United States Court of Appeals for the Sixth Circuit.

**The Underlying Facts and Proceedings:** On August 24, 2005, Vernon Hadden, a pedestrian in Todd Kentucky, was hit by a utility truck belonging to Pennyriple Rural Electric Cooperative that swerved to avoid a car that had run through a stop sign. While no one ever learned the identity of the driver that had caused the accident by running the stop sign, Hadden sued Pennyriple for \$1,250,000 of damages due to bodily injury and pain and suffering (we have not reviewed a copy of the complaint). As the case progressed, however, Hadden settled for \$125,000. Hadden's counsel has told us that he assessed that Pennyriple was 10% negligent, and the missing driver was 90% negligent, but that under Kentucky law he could not recover against Pennyriple any of the liability that would have been assessed against the absent driver defendant. Thus, Hadden agreed to the settlement, including an agreement to satisfy all medical expenses, liens or other claims. There is no dispute that Hadden was not at fault, and HHS never disputed below Hadden's claim that Pennyriple was 10% negligent and the missing driver 90% negligent, although there was no proof or other record evidence to support Hadden's assertion.

Medicare had expended over \$82,000 in medical expenses in treating Mr. Hadden, and promptly asserted a claim for \$62,338.07 (accounting for recovery costs) against the settlement proceeds (this amount was ultimately increased to over \$64,000, due to Mr. Hadden's payment of only \$62,000 after the date for payment set by CMS and the accrual of interest on the entire \$62,338.07 due). Hadden's counsel sought both a compromise and a waiver or reduction of the MSP recovery, asserting a variety of arguments. For purposes of this appeal, the relevant claim is that because Hadden's settlement recovery was effectively reduced by the applicable comparative fault principles, the CMS recovery should similarly be reduced. The Agency, however, rejected the request, arguing that MSP recoveries did not account for state law principles. Hadden appealed through the administrative law system, and his claim was rejected at every stop. On January 9, 2008, the final agency action was issued, allowing an appeal to federal district court, which resulted in the decision.

The district court (Judge Thomas Russell) devoted most of the case to distinguishing the numerous cases cited by Hadden in his brief, and then affirmed the Appeals Board's finding that because the underlying dispute between Hadden and Pennyriple had not proceeded to trial, the allocation of fault was "purely speculative," and there was no basis on which to apply state allocation principles. While the district court did not explicitly find that comparative fault principles could not meet the "equity and good conscience" test (instead, the Court simply found that "[p]laintiff has offered no evidence demonstrating that recovery is against equity and good conscience," noting that Hadden had not supplied information regarding his financial situation), the underlying ALJ decisions make that conclusion clear. Additionally, HHS never disputed Hadden's 90% allocation assertion (even though Hadden's argument was itself unsupported). In one submission to HHS, Hadden states that the case was settled "at mediation, and no specific allocation of fault was determined" (This statement was cited by the Medicare Appeals Council in its Amended Decision - reached upon remand by the District Court - rejecting Hadden's claim). Thus, there is a basis to seek appeal on the purely legal question of whether comparative fault principles must be considered in mitigating MSP recoveries.

**Procedural Issues and Timing:** A notice of appeal was filed on September 2. Mr. Hadden's opening brief will be due on November 13, followed by the Government's response on December 7, and a reply brief due December 28. Oral argument will likely follow in early 2010 with a decision next July, or if later, September/October.

**The Merits of the Case:** This case presents an ideal "test case" for several reasons. First, Mr. Hadden is indisputably without any fault, and is truly a victim of the MSP system. Second, the case is mature, in that it has progressed through the administrative process (in this instance, as in many others, a four year process). Mr. Hadden's lawyer is eager to work with us, which is helpful. On the negative side, the record below is sparse - while Hadden's assertion of comparative fault allocation was undisputed, it is also unsupported in the record below, which gives the Sixth Circuit an easy "out" - the very same route the district court took.

**Strategy:** MARC will be asking the Sixth Circuit only to rule on the pure legal question of whether CMS must consider comparative fault principles in its MSP recovery process. We will argue that both the core MSP statute and the recovery statute's "equity and good conscience" provisions require this result. In anticipating the government's argument, we can argue that any missing "facts" to support the allocation should have been addressed through an evidentiary hearing at the ALJ level, and that if we are correct that CMS must consider comparative fault, the case should be remanded for the development of that factual record.

The Government likely will also argue that deference is due to the Agency, and can counter that advocacy by deferring to the "plain language" of the statutes, and the plain meaning of "equity." We also anticipate developing and briefing the underlying federal judicial policies favoring settlement, and the insanity of giving beneficiaries the Hobson's choice of settling and giving up most of their proceeds to CMS, or taking the case to trial and risking losing everything (not to mention considerations of judicial economy). Finally, we will also reach out to several of the beneficiary groups to solicit amicus briefs in support of our position.

**Reason for MARC Involvement:** MARC's commitment to a change in the law must be accomplished on three levels: Legislative, Regulatory and Common Law. MARC's initial focus has been on regulatory and legislative actions. The Coalition focused on how we could improve Section 111 reporting requirements by encouraging open dialogue with the Agency including education about the liability industry. This led to an extension for implementation of Section 111 and establishment of temporary reporting thresholds.

MARC then transitioned the strategy focusing on legislative reform and began to build a consensus agenda among the stakeholder groups to support the proper enhancements needed to improve the administration of the Medicare Secondary Payer Act. This has resulted in MARC moving forward with model bill language and the identification of Congressional champions to support a broader MSP reform agenda. We cannot however, correct all of the issues with the Medicare Secondary Payer Act through legislation. Congress will only support legislation where there is no cost to the federal budget. To that end, we must focus on changing how the Courts have interpreted the Medicare Secondary Payer Act.

MARC has identified the Hadden v. U.S. case as a matter that could re-shape how settlements should be approached where liability is questionable. The case will address competing policies of protecting the Medicare Trust Fund against the public policy of promoting settlements. The case presents an excellent opportunity for MARC through the judicial process to seek a ruling requiring CMS to consider state comparable fault principles in the MSP recovery process.

For additional information or to contact the Medicare Advocacy Recovery Coalition, please visit [www.marccoalition.com](http://www.marccoalition.com).

# Company and Individual Support Needed to Advocate for the MSPEA, HR 4796

Call to Action from Katie A. Fox, MSCC, Co-Chair, Medicare Advocacy Recovery Coalition

The Medicare Advocacy Recovery Coalition (MARC) needs your individual and corporate support to aggressively advocate for H.R. 4796 by taking action today on two simple requests:

## Request #1: Company Endorsement Letter to Representatives

Patrick Murphy and Representative Tim Murphy

Endorsement Letters in support of the MSPEA are urgently needed from companies and organizations across the country. The letters will be hand delivered to our House Champions, Rep. Patrick Murphy (D-PA/8th District) and Rep. Tim Murphy (D-PA/18th ) to be used to encourage their House colleagues to co-sponsor H.R. 4796. Please complete, sign and return the endorsement letter on your organization's letterhead and don't forget to forward your letter to Susan Murdock at [mspea@marccoalition.com](mailto:mspea@marccoalition.com). A sample endorsement letter is included below in case you need it. Our goal is to collect endorsement letters from the community by May 1st and to have these letters in the hands of Rep. Patrick Murphy and Rep. Tim Murphy to show strong support for H.R. 4796.

## Request #2: Individual Support Letters to your Congressional Leaders

We also need your help in urging your own Congressman to support the MSPEA by agreeing to co-sponsor the Bill. A template letter is attached for you to print and start the process - we urge you to personalize the letter to address your particular concerns and issues. To identify your Congressional representative, go to <https://writerep.house.gov/writerep/welcome.shtml> to enter your state and zip + 4 code, and then click "Contact My Representative". You will be taken to your Congressional representative's web page where you can identify your Congressman. Please complete your individual advocacy letters to your House representatives, sign and return to MARC at [mspea@marccoalition.com](mailto:mspea@marccoalition.com). MARC will be hand delivering individual letters of support to Congressional offices in our efforts to increase House co-sponsors of H.R. 4796.

For information on MSPEA/HR 4796, go to the MARC website at [www.marccoalition.com](http://www.marccoalition.com). The MSPEA/HR4796 bill language and supplemental materials are available for your review and information.

*"Endorsement letters in support of the MSPEA are urgently needed from companies and organizations across the country."*

## MSPEA HR 4763 Advocacy Letter Sample

[TYPE YOUR NAME]  
[TYPE YOUR STREET ADDRESS]  
[TYPE YOUR CITY, STATE AND ZIP]

[Insert Date Here]

The Honorable [Type Congressional Representative Name]  
[Type House Office Building Address]  
Washington, DC 20515

Re: My Request for Support of HR #4796

Dear [Type Congressman/Congresswoman Name]:

I am writing to ask for your support of HR #4796, the Medicare Secondary Payer Enhancement Act of 2010 recently introduced by Representatives Patrick Murphy and Tim Murphy. The MSPEA's principle feature is a streamlined Medicare Secondary Payer process and allowing beneficiaries, insurers and other companies to timely reimburse the Medicare Trust Fund and settle their claims. The legislation's significant improvements to the present law will help all parties navigate through this complex issue, ensuring that the Medicare Trust Fund is timely and appropriately reimbursed, and further protect all parties from the uncertainty currently surrounding the process that has added to the delays we see today. In addition, the legislation will help clarify several other confusing aspects of the MSP law, including establishing a clear statute of limitations and removing social security numbers from the reporting process. Importantly, the legislation has bi-partisan support in Congress, is designed to have no impact on the deficit (zero cost) and enjoys broad-based support of everyone from national retailers to the trial lawyers and defense bar, and many others.

Again, I urge you to please co-sponsor HR 4796, The Medicare Secondary Payer Enhancement Act of 2010 (MSPEA). I thank you for your leadership on this important issue.

Regards,

[Type Your Name]



In *Stricker* (filed in December of 2009), the United States government filed a case in U.S. District Court to recover conditional payments and double damages plus interest under the Medicare Secondary Payer Act (42 USC §1395(b)(2)) (“MSP Act”). Though the U.S. has brought previous actions against claimants and their attorneys to recover conditional payments (see, for example, *U.S. v. Harris*, 2009 WL 891931 (N.D. W.Va.)), this appears to be the first case in which the government seeks recovery from an insurance carrier of funds paid as settlement proceeds in a mass tort liability settlement. The parties named in the suit include claimants’ counsel, insurers and corporate defendants.



Synopsis of U.S. v. Stricker, et al.

In its complaint, the DOJ alleges that the named parties were responsible under the MSP Act and applicable federal regulations (42 CFR §411.24, etc.) to reimburse Medicare for conditional payments made on behalf of settlement claimants for medical items and services rendered for injury-related care. The complaint alleges that the named parties failed to reimburse Medicare for conditional payments made. Within the complaint, the DOJ seeks reimbursement against the named parties for conditional payments made as well as **double damages** for any conditional payments owed.

The facts demonstrate that the defendants paid out settlement proceeds to the plaintiffs, and the insurance carriers paid the defendants. According to the complaint, it does not matter that the defendants paid out the settlement proceeds to the plaintiffs, because the DOJ claims 42 CFR §411.24(i) allows Medicare to seek payment from the liability insurance carrier regardless of whether payment has already been made to the Medicare beneficiary.

This action is an example of what may happen when settling parties fail to adequately address Medicare’s reimbursement interests from date of injury to date of settlement.

The complaint is limited only to the parties’ failure to address Medicare reimbursement claim for injury related care from date of injury to date of settlement. To the extent that “future payments” are referenced in the complaint, they relate to additional payments (to claimants and their attorneys) to be made as part of the settlement program.

This was recently appealed and further updates to this action are anticipated and being closely watched.

## MSPRC Conditional Payment Demand FAQ’s

- A Conditional Payment Letter will be generated automatically within 65 days of the issuance of the “Rights and Responsibilities Letter”;
- Conditional Payment Letters will go to all authorized parties;
- Requests for an updated CPL can only be processed every 90 days after the last CPL was issued. Rush updated letters can be requested but are not guaranteed;
- All parties should update the CPL thoroughly to make sure that only case related items are included;
- Up-to-date CPL amounts can be accessed on the MyMedicare.gov website (attorneys will need to gain access through the claimant);
- If authorization is not on record, the beneficiary will receive the letter and their attorney and/or representative must obtain a copy through the beneficiary;
- Once the case has settled, the settlement documentation must be sent to the MSPRC;
- The MSPRC will generate the final demand letter after receiving the settlement documentation;
- Payment is due within 60 days of the date of the demand letter;
- If payment is not received within 60 days of the date of the demand letter, interest will be charged from the date of the demand letter.

For additional information, please visit [www.msprc.info](http://www.msprc.info).



### Ethics and Standards Committee:

The Ethics/Standards Committee is currently inactive, having accomplished their task of establishing a document on Ethics which was accepted by the Board of Directors. They have also completed a proposed document on Standards which has been submitted to the current Board for review.

### Membership Committee:

The NAMSAP Membership Committee has submitted the 2010 goals. The approved goals are as follows:

1. Develop new and innovative ways to increase NAMSAP membership by 20%.
2. Increase the transparency of the value of becoming a NAMSAP member.
3. Expand the scope of potential membership population by beginning to communicate/advertise the organization as a resource for the entire scope of the Medicare Secondary Payer Statute compliance, instead of just the Medicare Set-Aside professional.

### Education Committee:

The Education Committee is currently working on the 2010 NAMSAP Annual Meeting and Educational Conference, which will be September 29th and 30th, in Washington, DC.

### Webinar Sub-committee:

“CMS Counters and the MSP Code” will be held on Wednesday, March 24, 2010, at 4:00 PM EST. This webinar will be presented by Matt Larkin, MSCC – V.P. Of Sales with Experea Pharmacy Services, Inc. / Experea Healthcare. This webinar presentation will focus on recent events that have led to a nationwide increase in counters as well as provide insight as to how the Medicare Secondary Payer (MSP) code is being utilized at CMS.

For more information on this webinar and to register, please click [here](#).

Additional upcoming webinars will include information on liability MSAs and drug utilization reviews.

The NAMSAP Webinar sub-committee is looking for speakers to prepare and present a webinar on Medicare related issues. Each program should be no longer than one hour in length and provide attendees with substantive information on a Medicare related topic that would be of use to NAMSAP members and other Medicare professionals. We are primarily looking for persons interested in speaking on the following topic areas:

1. Settlement of conditional payments with a primary focus on the Non-Group Health Plan Process;
2. Mandatory Insurer Reporting / Section 111 topics with a focus on its impact on liability, no-fault and workers' compensation cases;
3. Self-administration of MSAs with a focus on the difference between pre-settlement vs. post-settlement coverage (e.g., WC vs. non-WC claims, requirements to manage MSA, etc.);
4. Medicare in Crisis Analysis - a focus on industry figures, total allocations across CMS desks, average settlement amounts, right to recovery, etc.;
5. Liability MSAs - are they “required”, and industry trends on non-WC cases.

Speakers interested in these topics should complete the speaker information form located [here](#).



## New Life Tables for Use in Medicare Set-Aside Arrangements

CMS posted the following to the overview section of the WCMSA web page:

### **March 12, 2010**

“The Centers for Disease Control (CDC) has recently published its 2005 United States Life Tables. Effective April 12, 2010, the Centers for Medicare & Medicaid Services (CMS) will begin referencing the CDC’s Table 1: Life table for the total population: United States, 2005,

for WCMSA life expectancy calculations. This means that any newly submitted WCMSA proposal received by CMS’ Coordination of Benefits Contractor (COBC), or where any WCMSA case is reopened on or after April 12, 2010, CMS will apply the CDC’s 2005 Table 1 for life expectancy calculations. You may access the CDC’s United States Life Tables in the related links section of this page.”

To access the new life tables, please click [here](#).



## Sponsorship and Partner Information

### Platinum Sponsors

**Crowe Paradis Services Corporation (CPSC)** is a national Medicare compliance company founded by a group of entrepreneurial attorneys with extensive experience in the group disability, liability, workers' compensation and health insurance markets. By combining a best practices legal and medical approach to the Medicare Secondary Payer compliance challenge, CPSC has become a trusted consultant and provider to many of the leading insurance carriers, TPA's, self-insured's and attorneys nationwide.

**Medivest** professionally administers medical custodial accounts, provides premier MSA Allocations and other innovative solutions to preserve, protect and stretch settlement dollars in workers' compensation and liability disputes.  
[www.medivest.com](http://www.medivest.com)

**Protocols, LLC** is a multidisciplinary consulting firm that specializes in medical settlement planning for all parties involved in workers' compensation and personal injury liability cases – from the simple to the complex. The Protocols team of experts - medical, benefits and legal - works together with clients to create a comprehensive plan for the projected medical care of an injured person. We also advise on the best and most cost-effective way to finance this care. Among Protocols specialty services are medical cost projections, life care planning and Medicare set-aside analysis, allocation and administration.

### Gold Sponsors:

Experea Healthcare  
MedAllocators, Inc.

### Silver Sponsors:

The Center for Lien Resolution  
The Center for Medicare Set-Aside Administration  
The Center for Special Needs Trust  
NuQuest/Bridge Pointe  
PMSI/MSA  
Procura Management Inc. (A Healthcare Solutions Company)  
Rising Medical Solutions



## TIPS

### 1. Medicare Parts A & B do not cover:

- Acupuncture
- Attendant/Custodial Care
- Dental Services
- Diabetic Syringes/Insulin
- Eye Exams/Glasses (exception made for frames and lenses after cataract surgery)
- Nursing Home Care
- Transportation
- Routine Care (meaning that there is no underlying disease or symptom for which service was provided)

- Routine Yearly Physical Exams (exception made for coverage starting after 01/01/05. A one time physical examination within the first six (6) months will be provided if the person has Part B)

2. **Disability** is determined according to the criteria in 1382c(a)(3) of the Social Security Act. To be considered "disabled", an individual must have a diagnosed medical condition (including mental illness) that is expected to last at least 12 months or to result in death. Further, the individual must be unable to engage in substantially gainful activity due to his or her medical condition.



## MARC Coalition Update

### MARC Coalition Applauds Agency's Alert Regarding Delay in Data Exchange Deadline

February 17, 2010 (Washington, DC) *The Medicare Advocacy Recovery Coalition*

(MARC) today applauds the Centers for Medicare and Medicaid Services (CMS), for their decision to defer the reporting deadline for Section 111 MMSEA Mandatory Insurer Reporting.

"The industry has been working diligently to build in infrastructure to supply data to CMS, investing millions of dollars to ensure compliance with the data share regulation," said Roy Franco, co-chairperson of MARC and director of risk management services for Safeway Inc. "Unfortunately, there have been unforeseen difficulties and unanswered questions regarding the reporting process, and everyone's ability to get the job done by April 1."

The Alert posted by the Centers for Medicare and Medicaid Services allows testing to continue through December 31, 2010, and only begins live reporting on January 1, 2011. "This expansion of an additional nine months will allow time for both the Agency and the industry to navigate system roadblocks and clarify open policy issues," states Katie Fox, co-chairperson of MARC and MSP Compliance & Resolution Manager for MedInsights, Inc. "MARC is committed to working with the Agency to ensure the reporting process is effective and to minimize the delay of benefit to the Medicare beneficiaries."

"The claims community will continue to exchange data with Medicare in a collaborative effort to improve the data reporting systems," says Marcia Nigro, Assistant Vice President and Complex Claim Consultant for Sedgwick CMS. "The certification and testing for the claim detail data exchange will continue through 2010, which will benefit everyone involved." The MARC Coalition had written to CMS in January seeking changes to the April 1, 2010, reporting deadline, and had been working with CMS and a wide variety of stakeholders to ensure that reporting was not required until the appropriate systems were functional and in place, and until important policy guidance, including a new User Guide, was issued. MARC applauded the CMS announcement that CMS will issue this important new guidance the week of February 22.

*The Medicare Advocacy Recovery Coalition (MARC) advocates for the improvement of the Medicare Secondary Payer program. The coalition has been collaborating and developing strategic alliances with Congressional leaders and government agencies to focus on broader Medicare Secondary Payer (MSP) reform. MARC member organizations are comprised of entities representing virtually every sector of interested stakeholders, including attorneys, brokers, insureds, insurers, insurance and trade associations, self-insureds and third-party administrators. For more information, please visit [www.marccoalition.com](http://www.marccoalition.com).*



NAMSAP holds a spot on the Steering Committee of MARC, the Medicare Advocacy Recovery Coalition.

## Medicare's Wheelchair and Scooter Benefit

For Medicare to cover any of the wheelchairs and scooters listed below, the claimant's physician must state that the claimant needs this equipment because of their medical condition or injury. Medicare will pay 80% of the Medicare-approved amount, after the claimant meets the Part B deductible. The claimant will be responsible for 20% of the Medicare approved amount.

For a claimant to be eligible for any device referred to as "mobility assistive equipment" or "MAE" (cane, crutches, walkers, manual wheelchair, power wheelchair, scooter), the equipment must be needed in the claimant's home.

To get mobility assistive equipment, the claimant must meet the following requirements:

- Have a health condition where they need

help with activities of daily living like bathing, dressing, getting in or out of bed or chair, moving around, or using the bathroom.

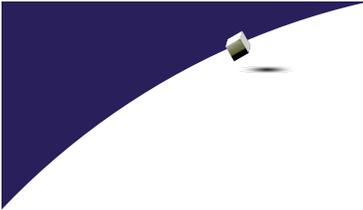
- Be able to safely operate and get on and off the wheelchair or scooter.
- Have good vision.
- Be mentally able to safely use a scooter, or have someone with them who can make sure the device is used correctly and safely.

The equipment also must be useful within the physical layout of the claimant's home (i.e., not too large for home).

Additional provisions may apply based on case specifics.

For more information, please call Medicare at (800) Medicare.





# National Alliance of Medicare Set-Aside Professionals

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**The mission of NAMSAP is to foster the highest standards of integrity and competence among Medicare Set-Aside Professionals and those they serve.**



NAMSAP is the only non-profit association exclusively addressing the issues and challenges of the Medicare Secondary Payer Statute and its impact on workers' compensation and liability settlements. Through the voluntary efforts of our members, NAMSAP is a forum for the exchange of ideas and is a leading resource for information and news in this constantly evolving area of practice. The collective knowledge of our members and NAMSAP's resources will provide you with the ingredients essential to your success!

## Announcements

### Call for Articles:

The Communications Committee would like to extend an offering to all interested authors. We are currently receiving articles for the first quarter 2010 newsletter to be published in March. We currently have three categories for articles: Legal, Legislative, and Medical. If you are interested in contributing to one of these categories, or have an idea for a new category, please contact April Pettengill, Chairperson for the Communications Committee. You can contact April by email at [april@alpmedicalconsultants.com](mailto:april@alpmedicalconsultants.com), or call her at (802) 849-2956.

### "Letters to the Editor":

In addition to contributing authors, every interested member is invited to send their "Letters to the Editor", or provide comments on articles that are published in the newsletter.

### CMS Updates:

One of the primary goals of the Communications Committee is to provide updates on each CMS regional office. If you have an experience with a particular regional office of CMS, please submit those to April so we can share those with other members of NAMSAP.

