This issue of the e-News will be made available in PDF format no later than 24 hours after its release, and can be found in the archive with other past issues.

CMS Medicare FFS Provider e-News

CMS Information for the Medicare Fee-For-Service Provider Community

CMS asks that you share the following important information with all of your association members and state and local chapters. Thank you!

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Colleagues—

I hope February is off to a great start for you all! Here in the CMS Provider Communications Group, February's already shaping up to be a busy month, and I have some exciting news to share with you.

In response to great feedback we've received from our partners and providers, and in our continual effort to make the Agency's educational communications more helpful and easier for you to use, we're making some changes to the Provider e-News and the Provider Communications Group's other communication mechanisms.

First, we're moving the e-News to a twice-a-week release schedule. This week, you'll begin seeing full issues of the e-News on both Tuesdays and Thursdays. Of course, as has always been the case, we'll occasionally release off-schedule standalone messages as well, when urgent CMS or HHS announcements just can't wait for the next regular e-News release.

Second, if you receive multiple communications from CMS, you may have noticed that some messages released the same day or within a few days of each other look similar but aren't always identical. We're putting into place mechanisms to fix this, so that messages reaching the provider community will contain identical wording – that way, it'll be easier for readers to identify information they've already received. Like I said, our goal is always to deliver the most reliable, accurate, and helpful Medicare Fee-For-Service information on behalf of the Agency – and this will hopefully make that information more useful for you.

We have some other developments in the works also, so be sure to keep an eye on your new bi-weekly e-News for more useful features. And as always, feel free to let us know how we're doing at FFSProviderRelations@cms.hhs.gov.

Have a great week—

Robin

The e-News for Tue Feb 7 includes…

NATIONAL PROVIDER CALLS

ANNOUNCEMENTS AND REMINDERS

CLAIMS, PRICER, AND CODE UPDATES

UPDATES FROM THE MEDICARE LEARNING NETWORK ®

National Provider Call: Medicare Spending Per Beneficiary Measure – Registration Now Open [↑]
Thu Feb 9; 1:30-3pm ET

CMS will host a National Provider Call on the Medicare Spending Per Beneficiary (MSPB) Measure, featuring CMS subject matter experts and a question & answer session.

Target Audience: Hospitals, Quality Improvement Organizations (QIOs), and Hospital Associations

Agenda:
- Opening Remarks
- Background of the MSPB measure

- Overview on how the measure is calculated, including the approach to risk adjustment and payment standardization
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day before the call at http://www.CMS.gov/NPC/Calls.

National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing – Registration Now Open [↑]
Tue Feb 21; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:
- Opening Remarks
- Program Announcements
- Overview of claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive Program
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day in advance http://www.CMS.gov/PQRS/04_CMSSponsoredCalls.asp in the "Downloads" section of the page.

Only Three Days Left to Register for the Round 2 and National Mail-Order Competitions of the DMEPOS Competitive Bidding Program [↑]

Reminder: If you are a supplier interested in participating in Round 2 and/or the national mail-order competition of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, *you must register before Thu Feb 9, 2012, at 9pm prevailing Eastern Time*. Suppliers that do not register cannot bid and are not eligible for contracts. Don't wait – go to the Competitive Bidding Implementation Contractor (CBIC) website at www.DMECompetitiveBid.com and register TODAY!

Registration is typically a quick and easy process if you follow the step-by-step instructions in the "Individuals Authorized Access to CMS Computer Services (IACS)

Reference Guide" posted on the CBIC website. To register, visit the CBIC website and click on "REGISTRATION IS OPEN" above the Registration Clock on the homepage. You will also find a registration checklist and Quick Step guides on the CBIC website. Please note that suppliers with multiple locations typically must register only one Provider Transaction Access Number (PTAN) that will submit the bid for all locations.

The target registration dates have passed for authorized officials (AOs) and backup authorized officials (BAOs). End users (EUs), as well as any AOs and BAOs who have not yet registered, should register NOW. Suppliers may wish to register multiple EUs to help enter bid data in Form B of DBidS, the online bidding system. You will need to complete a Form B for each product category/competitive bidding area (CBA) on which you are bidding. Multiple users (AO, BAOs, EUs) may be in the Form B section of DBidS at the same time as long as each user is entering information for a different product category/CBA. Only suppliers that have registered and received a user ID and password will be able to access the online bidding system and submit bids.

If the AO for your company has not already registered, CMS cannot guarantee that he or she will be able to complete the registration process before registration closes. This is especially a concern if your files with the National Supplier Clearinghouse (NSC) are not current and accurate. If your AO does not register, you cannot bid and will not be eligible for a contract. In addition, suppliers whose AOs have not registered are at risk of experiencing delays in accessing the online bidding system to get a bidder number and thereby missing the opportunity to submit financial documents by the Covered Document Review Date (CDRD).

If you have registered an AO but not a BAO, CMS strongly recommends that a BAO register NOW. The establishment of a BAO is encouraged to avoid any disruption in the bidding process. The individual in the BAO role can assume the AO role if for some reason the AO can no longer fulfill his or her bidding responsibilities. If there is no BAO for a company and the AO leaves the company, all end users associated with the company will lose access to the bidding system.

Remember, the AO and BAO must be listed on the CMS-855S enrollment form as an AO. After an AO successfully registers, the AO may designate other authorized officials on the CMS-855S to serve as BAOs; the AO and BAOs can then designate other supplier employees as EUs. BAOs and EUs must also register for a user ID and password to be able to use the online bidding system. The name, date of birth, and social security number of the AO and BAOs must match exactly with what is on file with the NSC to register successfully.

The CBIC is the official information source for bidders. All suppliers interested in bidding are urged to sign up for email updates on the homepage of the CBIC website. If you have any questions about the registration process, please contact the CBIC Customer Service Center at 877-577-5331.

- Additional material related to DMEPOS Competitive Bidding in today's e-News… [next]

Extension of Licensure Deadline for the Round 2 and National Mail-Order Competitions of the DMEPOS Competitive Bidding Program [↑]

CMS is extending the licensure deadline for the Round 2 and national mail-order competitions of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. The original licensure deadline required suppliers to have all required state licenses on file with the National Supplier Clearinghouse (NSC) and indicated in the Provider Enrollment, Chain, and Ownership System (PECOS) before submitting a bid.

NEW DEADLINE: Bidding suppliers must now ensure that copies of all applicable state licenses are RECEIVED by the NSC on or before Tue May 1, 2012.

Bids will be disqualified if a bidder does not meet all state licensure requirements for the applicable product categories and for every state in a competitive bidding area (CBA). Every supplier location is responsible for having all applicable license(s) for each state in which it provides services. For a multi-state CBA, the bidder must collectively have all applicable license(s) for every state in the CBA. Each location is not required to have licenses for every state in the CBA as long as

each state has a bidding location licensed for the product category.

Please note that the extension of the licensure deadline does NOT change any other deadlines. All bids must be submitted in DBidS, the online bidding system, by 8:59:59pm (prevailing Eastern Time) on Fri March 30, 2012. All required hardcopy documents that must be included as part of the bid package must be RECEIVED by the Competitive Bidding Implementation Contractor (CBIC) on or before Fri March 30, 2012.

A licensure directory for each state, the District of Columbia, and the territories may be found on the NSC website at www.PalmettoGBA.com/NSC. Licensure requirements vary from state to state. The NSC licensure directory provides a good starting point to assist in identifying the licenses you need. State licensure requirements change periodically and may have exceptions, so the NSC's licensure directory serves only as a guide. It remains the bidding supplier's responsibility to ensure compliance with the most current state and federal laws and regulations.

For more information on licensure requirements, you may refer to the Licensure for Bidding Suppliers Fact Sheet and the Request for Bids (RFB) Instructions. If you have any questions, please contact the CBIC customer service center at 877-577-5331 between 9am and 9pm (Eastern Time) during the registration and bidding periods.

Please note that the RFB instructions initially posted on the CBIC website contained the original licensure deadline. These instructions have now been updated to reflect the new licensure deadline shown in this announcement.

- Additional material related to DMEPOS Competitive Bidding in today's e-News… [previous]

CMS Announces Prior Authorization of Power Mobility Devices Demonstration and Recovery Audit Prepayment Review Demonstration [↑]

On Tue Nov 15, 2011, CMS announced three demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program.

CMS is pleased to announce that the Prior Authorization of Power Mobility Devices (PMDs) Demonstration and the Recovery Audit Prepayment Review Demonstration – which were delayed from their initial Sun Jan 1 start-date – are expected to move forward on or after Fri June 1, 2012. For additional information on these demonstrations, please visit http://go.CMS.gov/cert-demos.

These demonstrations will begin after receipt of a *Paperwork Reduction Act* (PRA) Office of Management and Budget control number. CMS posted a *PRA* notification for these demonstrations on Fri Feb 3 at http://www.CMS.gov/PaperworkReductionActof1995/PRAL/list.asp.

CMS significantly revised the Prior Authorization of PMDs demonstration in response to provider and supplier concerns. For more information on the adopted changes please visit http://go.CMS.gov/PAdemo.

The Part A to Part B Rebilling Demonstration began on Sun Jan 1, 2012.

To view the relevant *Federal Register* notice, visit https://s3.amazonaws.com/public-inspection.federalregister.gov/2012-02821.pdf.

CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs [↑]

Central line-associated bloodstream infections (CLABSIs) are among the most serious of all healthcare-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the US healthcare system. On Tue Feb 7, CMS announced that *Hospital Compare* will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in US hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about *Hospital Compare* is online at http://www.HospitalCompare.HHS.gov.

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing *Hospital Compare*, visit the CMS YouTube channel.

The full text of this excerpted CMS press release (issued Tue Feb 7) can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4260.

Preparing for the Version 5010 Upgrade: Questions to Ask Your Vendor [↑]

The compliance deadline to upgrade to Version 5010 from Version 4010/4010A was Sun Jan 1, 2012. CMS announced an enforcement discretion period for 90 days until Sat Mar 31, during which it would not initiate enforcement action with respect to any *HIPAA*-covered entity that is non-compliant with the ASC X12 Version 5010 (Version 5010), NCPDP Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards. However, you should continue to upgrade your systems as promptly as possible in order to meet this deadline.

In order to ensure a smooth upgrade prior to April, you will need to complete both phase I internal and phase II external testing of Version 5010 transactions. As part of your external testing, you will need to conduct tests with outside trading partners, which include vendors, clearinghouses, billing services, and payers. Your vendor is a critical partner in achieving Version 5010 compliance.

You should take the following steps to evaluate your vendor and vendor products to ensure a timely Version 5010 upgrade:

- Establish a tracking system and timeline for milestones
- Review existing and new contractual obligations with vendors
- Coordinate vendor capabilities with your practice needs and expectations
- Evaluate ease of use of vendor products

You might want to also ask your vendor some of the following questions about the Version 5010 upgrade to help assess your readiness for this upgrade:

- Have they upgraded their systems to meet Version 5010 standards?
- If they have not yet upgraded, when will they do so?
- What will be the cost for each upgrade?
- What versions of their software will be upgraded, and will these upgrades require any additional hardware upgrades?
- How often will updates occur and what is the delivery method?

- How are issues logged and how will they be addressed?
- Is there training available for new system changes and/or functionalities?

Please visit the CMS ICD-10 website for additional information and resources about the Version 5010 upgrade.

Keep Up to Date on Version 5010 and ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare, and to download and share the implementation widget today!

All Medicare Provider and Supplier Payments To Be Made By Electronic Funds Transfer [↑]

Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request, or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through electronic funds transfer (EFT). Section 1104 of the *Affordable Care Act* further expands Section 1862(a) of the *Social Security Act* by mandating federal payments to providers and suppliers only by electronic means. As part of CMS's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments *are required to submit the CMS-588 EFT form with the Provider Enrollment Revalidation application, or at the time any change is being made to the provider enrollment record by the provider or supplier, or delegated official.*

For more information about provider enrollment revalidation, review the Medicare Learning Network's Special Edition Article #SE1126, titled "Further Details on the Revalidation of Provider Enrollment Information."

Extended Deadline for CMS Technical Expert Panel Nominations: Quality Measure Development and Maintenance for Coronary Artery Bypass Grafting and Cardiac Disease Prevention and Care [↑]

CMS has contracted with Quality Insights of Pennsylvania to develop and maintain clinical quality measures for the Physician Quality Reporting System. Quality Insights is currently recruiting two Technical Expert Panels (TEPs) addressing Cardiovascular Disease, including:

- Coronary Artery Bypass Grafting (CABG)
- Cardiac Disease Prevention and Care

The purpose of this project is to develop and maintain measures used to support quality care to Medicare beneficiaries. Each of the Technical Expert Panels will advise Quality Insights on the continuing development and maintenance of existing clinical quality measures for the above-listed topics. Information and instructions about these TEPs may be at http://www.CMS.gov/MMS/15_TechnicalExpertPanels.asp.

Nominations for the TEPs are due by 5pm ET on Fri Feb 17.

Determining Eligibility for the Medicare Health Professional Shortage Area Physician Bonus Payment [↑]

Physicians who may be eligible for the Medicare Health Professional Shortage Area (HPSA) bonus payment should be aware of the following information and educational resources regarding determining eligibility, in order to minimize errors during the post-payment review process.

- Information on the HPSA bonus, including the list of zip codes eligible for automatic payment, can be found at on the CMS website at

http://www.CMS.gov/HPSApsaPhysicianBonuses/01_overview.asp.

- Two MLN Matters articles are available which go into further detail:
  - "2012 Annual Update for the HPSA Bonus Payments" (MM7517) is available at http://www.CMS.gov/MLNMattersArticles/downloads/MM7517.pdf, and
  - "HPSA Bonus Payment Policy Reminders" (SE1202) is available at http://www.CMS.gov/MLNMattersArticles/downloads/SE1202.pdf.
- Websites to help determine existing designations and eligibility for the Medicare HPSA physician bonus include:
  - http://HPSAfind.HRSA.gov/HPSAsearch.aspx – to identify designations within a state,
  - http://www.FFIEC.gov/geocode/default.aspx – to identify census tracts by entering an address), and
  - http://DataWarehouse.HRSA.gov/geoadvisor/ShortageDesignationAdvisor.aspx – to see if an area is listed as being in an eligible area.

Physician Self-Referral Prohibition: Additional Information on Exception Process for Physician-Owned Hospitals [↑]

As a reminder, the Outpatient Prospective Payment System (OPPS) Final Rule that was released on Wed Nov 30, 2011, stated that, in order for a physician-owned hospital to receive an exception to the prohibition on facility expansion, it must satisfy eligibility criteria to qualify as an "Applicable Hospital" or "High Medicaid Facility."

CMS has published additional guidance at http://www.CMS.gov/PhysicianSelfReferral/85_Physician_Owned_Hospitals.asp that will address the process for accessing data, as well as provide sample computations for determining whether a hospital satisfies the respective criteria. Questions regarding this issue can be emailed to POHexceptions@cms.hhs.gov.

Better Coordination Leading to Swifter Medicare Coverage and Access – Proposed National Coverage Determination for Transcatheter Aortic Valve Replacement [↑]

On Thu Feb 2, CMS proposed that Medicare patients across the county have access to a new procedure, known as "transcatheter aortic valve replacement" (TAVR).

The result of an unprecedented level of collaboration between CMS, the Food and Drug Administration, the Agency for Healthcare Research and Quality, the American College of Cardiology, the Society of Thoracic Surgeons and Edwards Lifesciences, this Proposed Coverage Decision Memorandum for TAVR continues CMS's commitment to cross-agency collaboration and ensuring patients have access to the latest and best medical technology.

We are requesting public comments on this proposed determination pursuant to section 1862(l) of the *Social Security Act*. We are specifically interested in public comments on the use of Coverage with Evidence Development (CED) in this decision. After considering the public comments, we will make a final determination and issue a final decision memorandum.

The proposed decision will be open for 30 days of public comment before CMS issues a final decision later this year. To read the full proposal, visit http://www.CMS.gov/medicare-coverage-database/details/nca-proposed-decision-memo.aspx?NCAId=257.

The full text of this excerpted blog post can be found on the CMS blog at http://blog.CMS.gov/2012/02/02.

CMS Has Updated the EHR Information Center with New Self-Service Options [↑]

Following months of review and collective input, the Electronic Health Record (EHR) Information Center Interactive Voice Response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of information and options for callers. CMS is proud to announce that providers can now obtain information through an extensive IVR Self-Service option. Included in this option is a reinforced privacy protection module that requires your individual National Provider Identifier (NPI), the last five digits of your Tax Identification Number (TIN), and your EHR registration ID. Once accepted, this newly enhanced Self-Service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing 888-734-6433, pressing 3 for Self-Service, and entering the authentication elements. These options will be available on the IVR effective Thu Feb 16.

EHR Information Center Hours of Operation: 7:30am-6:30pm CT, Monday through Friday, except federal holidays. (Note that General Information and Self-Service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the FAQs section of the EHR Incentive Programs website, where users can search for any questions they have about the Medicare or Medicaid EHR Incentive Programs.

Want more information about the EHR Incentive Programs? Make sure to visit the EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

➢ Additional material related to EHR in today's e-News… [next]

Updated and New FAQs Added to the CMS EHR Website [↑]

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer.
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer.
- For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations? Read the answer.
- In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official

letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? Read the answer.

- For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. Read the answer.

Want more information about the EHR Incentive Programs? Make sure to visit the CMS EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs.

➢ Additional material related to EHR in today's e-News… [next / previous]

Stay Informed via the CMS EHR Incentive Programs Listserv [↑]

CMS wants to invite you to join a free email service to receive the latest news on the EHR Incentive Programs. The CMS EHR Incentive Program listserv provides timely information on program requirements and changes in the EHR Incentive Programs.

By subscribing to this listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new Frequently Asked Questions that are published on the CMS EHR Incentive Programs website. Join the listserv and visit the listserv section of the EHR Incentive Programs website to take a review some of the recent messages we have sent. We encourage you to let others know about the CMS EHR Incentive Program listserv, and to share its messages.

Want more information about the EHR Incentive Programs? Make sure to visit the EHR Incentive Programs website for complete information about the CMS Medicare and Medicaid EHR Incentive Programs.

➢ Additional material related to EHR in today's e-News… [previous]

It's Not Too Late to Give and Get the Flu Vaccine [↑]

Take advantage of each office visit and protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention also recommends that patients, healthcare workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu.

Remember – The flu vaccine plus its administration are covered Part B benefits. CMS has posted the 2011-2012 seasonal flu vaccine payment limits at http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp. Note that the flu vaccine is NOT a Part D-covered drug.

For more information on coverage and billing of the flu vaccine and its administration, as well as related educational provider resources, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp and http://www.CMS.gov/immunizations.

Home Health Prospective Payment System CY2012 Pricer File Update [↑]

The Home Health Prospective Payment System (HH PPS) Pricer is now available for download. The updated files are ready for download from the Home Health PPS Pricer webpage at http://www.CMS.gov/PCPricer/05_HH.asp, in the "Downloads" section of the page.

From the MLN: MLN Provider Exhibit Program Schedule [↑]

Just a reminder to mark your calendars! The Medicare Learning Network will be exhibiting at the following healthcare provider conferences in the coming weeks:

- *American College of Preventive Medicine*
  Wed Feb 22 through Sat Feb 25
  Buena Vista Palace Hotel and Spa; Lake Buena Vista, Florida
  Booth #11
- *American Medical Group Association: 2012 Annual Conference*
  Thu Mar 8 through Sat Mar 10
  Manchester Grand Hyatt; San Diego, California
  Booth #802
- *2012 American Medical Student Association Annual Convention & Expo*
  Thu Mar 8 through Sun Mar 11
  Hyatt Regency Houston; Houston, Texas
  Booth #36
- *National Association of Rural Health Clinics*
  Mon Mar 19 through Tue Mar 20
  Hyatt Regency; San Antonio, Texas
- *The American College of Cardiology's 61st Annual Scientific Session & Expo*
  Sat Mar 24 through Mon Mar 26
  McCormick Place Convention Center; Chicago, Illinois
  Booth #19076
- *National Hospice & Palliative Care: 27th Management and Leadership Conference and 8th National Hospice Foundation Gala*
  Thu Mar 29 through Sat Mar 31
  Gaylord National Resort and Convention Center; National Harbor, MD

Please make a note of these dates and locations and add them to your calendar! If you are interested in having a CMS Medicare Learning Network Exhibit at your event, contact us at MLNexhibits@cms.hhs.gov.

More Helpful Links…

Check out CMS on

Twitter, LinkedIn, YouTube, and Flickr!

The Medicare Learning Network
www.CMS.gov/MLNGenInfo
Archive of Provider e-News Messages
www.CMS.gov/FFSProvPartProg/EmailArchive