

Thursday, October 2, 2014

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## **MLN Connects™ National Provider Calls**

**Hospital Compare Star Ratings: Overview of HCAHPS Star Ratings — Last Chance to Register**  
*Wednesday, October 8; 1:30-3pm ET*

*To Register:* Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

CMS plans to begin publicly reporting Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Star Ratings on the [Hospital Compare](#) website in April 2015. During this MLN Connects National Provider Call, CMS will discuss the implementation of the HCAHPS Star Ratings. Participants will gain an understanding of the HCAHPS Star Ratings and how they are calculated. Hospitals interested in seeing how their facility is represented will want to participate in the call to hear details about the new HCAHP Star Ratings.

CMS is adopting star ratings across Medicare.gov Compare websites to help consumers more easily understand the information on the websites and make more informed decisions when comparing and choosing healthcare providers.

*Agenda:*

- Introduction
- Rationale for adding star ratings to the Compare websites
- Description of HCAHPS Star Ratings and methodology
- Hospital Compare Preview Report details
- Resources
- Q&A session

*Target Audience:* All Fee-For-Service providers and hospital associations, hospitals participating in the HCAHPS Survey, and HCAHPS survey vendors.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **Hospital Appeals Settlement Update — Last Chance to Register**

*Thursday, October 9; 1:30-3pm ET*

*To Register:* Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

This MLN Connects National Provider Call will provide updates about the administrative agreement for acute care hospitals and critical access hospitals (CAHs) to expediently resolve appeals of patient status denials. This is a follow-up to the [September 9 call](#), and will provide another opportunity for live Q&A before administrative agreement requests are due to CMS on October 31, 2014. For details about the providers and claims eligible for administrative agreement, as well as updated documents needed to request an agreement, visit the [Inpatient Hospital Reviews](#) web page. *Note: You do not need to wait until after this call to submit your settlement request.*

CMS encourages interested parties to submit questions in advance of the call. Submitted questions may be addressed on the call or may be used to create frequently asked questions (FAQs) that will be posted to the CMS website.

*Agenda:*

- Update on the hospital appeals settlement
- Latest FAQs
- Open Q&A

*Target Audience:* Acute care hospitals, including those paid via the prospective payment system, periodic interim payments, and the Maryland waiver; and CAHs. A full definition of each of these facility types can be found at §1886(d) or §1820(c) of the Social Security Act.

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## **Overview of the 2013 Quality and Resource Use Reports — Registration Opening Soon**

*Thursday, October 23; 2:30-4pm ET*

*To Register:* Visit [MLN Connects™ Upcoming Calls](#). Registration will be opening soon.

On September 30, CMS made 2013 Quality and Resource Use Reports (QRURs) available to group practices and physician solo practitioners nationwide. This MLN Connects National Provider Call will provide an overview of the 2013 QRUR and explain how to interpret and use the information in the report.

The 2013 QRURs contain quality and cost performance data for CY 2013, which is the performance period for the Value-Based Payment Modifier (VM) that will be applied to physician payments for items and services furnished under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals in 2015. The 2013 QRUR can be used to plan for improving the quality and efficiency of care provided to Medicare beneficiaries, and also to understand and improve performance on quality and cost measures for the 2016 VM. The 2013 QRURs include data assessing a group practice or solo practitioner's performance on cost measures, information about the services and procedures contributing most to beneficiaries' costs, as well as performance on quality measures including performance on three outcome measures.

The call will be more meaningful if you have your QRUR in front of you to follow along. We strongly encourage authorized representatives to sign up for a new Individuals Authorized Access to the CMS Computer Services (IACS) account or modify an existing account at <https://applications.cms.hhs.gov> as soon as possible in order to be able to access the QRURs prior to the call.

Quick reference guides that provide step-by-step instructions for requesting each Physician Value-Physician Quality Reporting System (PV-PQRS) system role for a new or existing IACS account are available in the "Downloads" section on the [Self Nomination/Registration](#) web page. Visit the [Medicare FFS Physician Feedback Program/Value-Based Payment Modifier](#) web page for more information on the 2013 QRURs.

### *Agenda:*

- Opening Remarks
- Overview of the 2013 QRUR
- How to understand and use the 2013 QRURs
- Question and Answer session

*Target Audience:* Physicians, practitioners, therapists, medical group practices, practice managers, medical and specialty societies, payers, insurers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

## **Transitioning to ICD-10 — Register Now**

*Wednesday, November 5; 1:30-3pm ET*

*To Register:* Visit [MLN Connects™ Upcoming Calls](#). Space may be limited, register early.

HHS has issued a [rule](#) finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10. During this MLN Connects National Provider

Call, CMS subject matter experts will discuss ICD-10 implementation issues, opportunities for testing, and resources. A question and answer session will follow the presentations.

*Agenda:*

- Final rule and national implementation
- Medicare Fee-For-Service testing
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project
- Partial code freeze and annual code updates
- Plans for National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Home health conversions
- Claims that span the implementation date

*Target Audience:* Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) web page to learn more.

### **New MLN Connects™ National Provider Call Audio Recording and Transcript**

An audio recording and transcript are now available for the following call:

- September 17 —PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs, [audio](#) and [transcript](#). More information is available on the [call detail](#) web page.

## **CMS Events**

### **Special Open Door Forum: Star Ratings on Dialysis Facility Compare**

*Monday, October 6; 2-3:30pm ET*

CMS will host a Special Open Door Forum (SODF) call with patient advocacy groups and other interested parties to provide information and to solicit feedback on the introduction of star ratings on Dialysis Facility Compare beginning in January 2015. See the [announcement](#) for more information and participation instructions.

## **Announcements**

### **National Breast Cancer Awareness Month**

October is National Breast Cancer Awareness Month. During this national health observance, CMS reminds health professionals that breast cancer is the second most common form of cancer in women. Medicare provides coverage for screening mammography to facilitate the early detection of breast cancer for women with no signs or symptoms of disease. Medicare does not require a physician's prescription or referral for screening mammography. The screening mammography is a Medicare Part B benefit with no co-pay/co-insurance or deductible. Medicare does not cover screening mammography for men. However, Medicare does provide coverage for diagnostic mammography for men and women who meet certain coverage criteria.

A clinical breast exam is also covered under Medicare Part B as part of the screening pelvic examination for beneficiaries who meet coverage criteria. There is no co-pay/co-insurance or deductible for this screening benefit.

*For More Information:*

- [Medicare Learning Network® Screening Pelvic Examinations Booklet](#)
- [CMS General Prevention Website](#)
- [National Breast Cancer Awareness Month Website](#)
- [Quick Reference Information: Preventive Services](#)

## **CMS Makes First Wave of Drug and Device Company Payments to Teaching Hospitals and Physicians Public**

*Data promote transparency into the financial relationships between health care industry, doctors and teaching hospitals*

On September 30, CMS released the first round of Open Payments data to help consumers understand the financial relationships between the health care industry, and physicians and teaching hospitals, as part of an ongoing effort to increase transparency and accountability in health care. This release is part of the Open Payments program, created by the Affordable Care Act, and lists consulting fees, research grants, travel reimbursements, and other gifts the health care industry – such as medical device manufacturers and pharmaceutical companies – provided to physicians and teaching hospitals during the last five months of 2013. The data contains 4.4 million payments valued at nearly \$3.5 billion attributable to 546,000 individual physicians and almost 1,360 teaching hospitals. Future reports will be published annually and will include a full 12 months of payment data, beginning in June 2015.

Financial ties among medical manufacturers' payments and health care providers do not necessarily signal wrongdoing. Given the importance of discouraging inappropriate relationships without harming beneficial ones, CMS is working closely with stakeholders to better understand the current scope of the interactions among physicians, teaching hospitals, and industry manufacturers. CMS encourages patients to discuss these relationships with their health care providers.

Manufacturers submitted data to CMS this summer and CMS performed initial matching to aggregate payments to a single physician or teaching hospital. After the data were collected and displayed, registered physicians and teaching hospitals had the opportunity to review payments reported about them and dispute information they believed inaccurate.

More than 26,000 physicians and 400 teaching hospitals registered in the Open Payments system to review payments attributed to them. During the review and dispute period, CMS identified payment records that had inconsistent physician information, such as National Provider Identifier (NPI) for one doctor and a license number for another. In cases where CMS was unable to match the physician information or the record was not available for review and dispute but the company had attested that the payment had been made, the personally-identifiable information has been suppressed temporarily in the record. About 40 percent of the records published today are de-identified. This data will be fully identifiable in 2015 after the reporting entity submits corrected data, and physicians and teaching hospitals have a chance to review and dispute. In addition, data that were disputed and not resolved by the end of the September 11 review period have not been published and will be updated at a later date.

Over time, CMS expects to make enhancements such as introducing new tools to allow for easier data searches. This improved search functionality will allow users to more easily review payments received by their personal physician, or search on criteria such as specialty, location, or types of payments received.

To view the Open Payments physician payment dataset and other background, please visit the [Open Payments](#) website.

Full text of this excerpted [CMS press release](#) (issued September 30).

## Get Ready for DMEPOS Competitive Bidding – Common Ownership and Common Control

On July 15, 2014, CMS announced plans to recompete the supplier contracts awarded in the Round 2 and national mail-order competitions of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. *If you are a supplier interested in bidding, prepare now – don't wait. Review your enrollment record.*

- *Commonly owned* suppliers are those where one or more of them has an ownership interest totaling at least five percent in the other(s). The term “ownership interest” is defined as “the possession of equity in the capital, stock, or profits of another supplier.”
- *Commonly controlled* suppliers are those where one or more of a supplier's owners is also an officer, director, or partner of another supplier.

You may not bid against yourself for the same product category in the same competitive bidding area (CBA). Therefore, if you are a commonly owned or commonly controlled supplier, when registration opens, you must register one time with one Provider Transaction Access Number (PTAN). When bidding opens, you must submit *one* bid that includes all commonly owned or commonly controlled locations that would furnish bid items in the *same* product category and the *same* CBA. *Remember*, commonly owned or commonly controlled supplier organizations that submit separate bids for the same CBA/product category combination will have their bid for the CBA/product category combination disqualified.

### *Steps to Take Now:*

- Review your current Medicare enrollment record on the Provider Enrollment, Chain and Ownership System (PECOS) for ownership interest and/or managing control information.
- Complete the appropriate sections of the CMS-855S enrollment application to update any information under your current Medicare supplier billing number.

In you need assistance or clarification on the CMS-855S enrollment application; you may visit the [National Supplier Clearinghouse \(NSC\)](#) website or call the NSC at 866-238-9652. Suppliers must maintain accurate information on its CMS-855S with the NSC and in PECOS.

For a listing of the product categories, CBAs, timeline and other bidding information, please visit the [Competitive Bidding Implementation Contractor \(CBIC\)](#) website. CMS also encourages you to register on the website to receive email updates about the program.

As a reminder, the CBIC is the official information source for bidders and bidder education. CMS cautions bidding suppliers about potential inaccurate information concerning the DMEPOS Competitive Bidding Program posted on non-government websites. Suppliers that rely on this information in the preparation or submission of their bids could be at risk of submitting a non-compliant bid.

The CBIC participates in numerous educational events to assist stakeholders in understanding the rules that govern the DMEPOS Competitive Bidding Program. Visit the CBIC website for a listing and schedule of educational events under “Educational Information” for each round.

If you have any questions or need assistance, please contact the CBIC customer service center at 877-577-5331 between 9am and 5:30pm ET, Monday through Friday.

## PQRS GPRO Registration Extended Until October 3

The Physician Value-Physician Quality Reporting System (PV-PQRS) registration system will remain open until October 3, 2014 at 11:59pm ET and can be accessed at <https://portal.cms.gov>. The PV-PQRS registration system, initially scheduled to close on September 30, 2014, allows group practices to register to participate in the PQRS Group Practice Reporting Option (GPRO) in 2014 via Qualified PQRS Registry, Electronic Health Record (EHR), or Web Interface (for groups with 25 or more eligible professionals only). In order to register,

groups must have an approved Individuals Authorized Access to the CMS Computer Services (IACS) account and indicate their reporting method for the 12-month period. The 2014 PQRS data submission window will be in the first quarter of 2015.

Please note that groups must have an approved IACS account to register for one of the GPRO options. It can take up to 24 hours for a group to receive approval for their IACS account so groups wishing to register should make sure their IACS accounts are approved as soon as possible. If you have questions about how to register or set up an IACS account please contact the QualityNet Help Desk at 866-288-8912 or via email at [Qnetsupport@hcqis.org](mailto:Qnetsupport@hcqis.org) from 7am to 7pm CT.

### **Volunteers Sought for ICD-10 End-to-End Testing in January: Forms due October 3**

During the week of January 26 through 30, 2015, a sample group of providers will have the opportunity to participate in ICD-10 end-to-end testing with Medicare Administrative Contractors (MACs) and the Common Electronic Data Interchange (CEDI) contractor. The goal of end-to-end testing is to demonstrate that:

- Providers and submitters are able to successfully submit claims containing ICD-10 codes to the Medicare Fee-For Service (FFS) claims systems
- CMS software changes made to support ICD-10 result in appropriately adjudicated claims
- Accurate Remittance Advices are produced

Approximately 850 volunteer submitters will be selected to participate in the January end-to-end testing. This nationwide sample will yield meaningful results, since CMS intends to select volunteers representing a broad cross-section of provider, claim, and submitter types, including claims clearinghouses that submit claims for large numbers of providers.

*To volunteer as a testing submitter:*

- Volunteer forms are available on your [MAC](#) website
- Completed volunteer forms are due October 3
- CMS will review applications and select the group of testing submitters
- By October 24, the MACs and CEDI will notify the volunteers selected to test and provide them with the information needed for the testing

Additional opportunities for end-to-end testing will be available in 2015. Any issues identified during testing will be addressed prior to ICD-10 implementation. Educational materials will be developed for providers and submitters based on the testing results.

*For more information:* [MLN Matters® Special Edition Article #SE1409](#), “Medicare FFS ICD-10 Testing Approach”

### **Comply with MAC Request for Fingerprints within 30 Days**

CMS implemented the fingerprint-based background requirement on August 6, 2014, as discussed in the [rule](#) published on February 2, 2011. Fingerprint-based background checks are required for all individuals with a 5 percent or greater ownership interest in a provider or supplier that falls into the high risk category and is currently enrolled in Medicare or has submitted an initial enrollment application. Medicare Administrative Contractors (MACs) have begun sending letters to these providers and suppliers, listing all owners who are required to be fingerprinted. The letters are being mailed to the provider or supplier’s *correspondence address* and the *special payments address* on file with Medicare.

Identified individuals have 30 days from the date of the letter to be fingerprinted. Failure to comply with the fingerprint requirements could result in denial of your Medicare enrollment application or revocation of your

Medicare billing privileges. Visit [Accurate Biometrics](#) for fingerprinting procedures, to find a fingerprint collection site, and to ensure the fingerprint results are accurately submitted to the Federal Bureau of Investigation (FBI) and properly returned to CMS. For more information on this requirement, see [MLN Matters® Special Edition Article #SE1427](#), “Fingerprint-based Background Check Begins August 6, 2014.” If you have any questions, contact Accurate Biometrics at 866- 361-9944, or visit their website at [www.cmsfingerprinting.com](http://www.cmsfingerprinting.com).

## CMS Announces Availability of 2013 Quality and Resource Use Reports

On September 30, CMS made 2013 Quality and Resource Use Reports (QRURs) available to group practices and physician solo practitioners nationwide. The 2013 QRURs contain quality and cost performance data for CY 2013, which is the performance period for the Value-Based Payment Modifier (VM) that will be applied to physician payments for items and services furnished under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals (EPs) in 2015. The 2013 QRURs are intended to provide clinically meaningful and actionable information that can be used to plan for improving the quality and efficiency of care provided to Medicare beneficiaries and also to understand and improve performance on quality and cost measures for the 2016 VM. The 2013 QRURs include data assessing a group practice or solo practitioner’s performance on cost measures, information about the services and procedures contributing most to beneficiaries’ costs, as well as performance on quality measures including performance on three outcome measures.

Authorized representatives of groups and solo practitioners can access the QRURs at <https://portal.cms.gov>, using a valid Individuals Authorized Access to the CMS Computer Services (IACS) User ID and password. An authorized representative of a group must obtain an IACS account with one of the following group-specific Physician Value-Physician Quality Reporting System (PV-PQRS) system roles:

- PV-PQRS Group Security Official (primary or back-up)
- PV-PQRS Group Representative

A solo practitioner or an authorized representative of a solo practitioner must obtain an IACS account with one of the following individual-specific PV-PQRS System roles:

- PV-PQRS Individual Practitioner
- PV-PQRS Individual Practitioner Representative

Quick reference guides that provide step-by-step instructions for requesting each Physician Value-Physician Quality Reporting System (PV-PQRS) system role for a new or existing IACS account are available in the "Downloads" section on the [Self Nomination/Registration](#) web page. Visit the [Medicare FFS Physician Feedback Program/Value-Based Payment Modifier](#) web page for more information on the 2013 QRURs.

## EHR Incentive Program: CMS Attestation System Open

The [CMS Attestation System](#) is open and fully operational. Medicare eligible hospitals can attest any time to 2014 data until 11:59 p.m. ET on November 30, 2014. Hospitals participating in the Medicaid EHR Incentive Program need to refer to their [state deadlines](#) for attestation. *Note:* Hospitals seeking to use one of the new flexibility options will be able to attest in mid-October. More information will be sent soon. Medicare eligible hospitals must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment.

### *Payment Adjustments*

The 2016 payment adjustment will be applied at the beginning of FY 2016 (October 1, 2015) for Medicare eligible hospitals that did not successfully demonstrate meaningful use in 2014 and did not receive a hardship exception. Read the eligible hospital [payment adjustment tipsheet](#) to learn more. *Note:* Critical Access Hospitals

(CAHs) have a different payment adjustment schedule. Review the [CAH Payment Adjustment and Hardship Exception Tipsheet](#).

#### *Attestation Resources*

- [Stage 1 Eligible Hospital and CAH Meaningful Use Table of Contents \(2014 definition\)](#)
- [Stage 2 Eligible Hospital and CAH Meaningful Use Table of Contents](#)
- [Stage 1 Attestation User Guide for Eligible Hospitals](#)
- [Stage 2 Attestation User Guide for Eligible Hospitals](#)

#### *More information*

To learn more, visit the [Eligible Hospital Information](#) web page.

### **ICD-10 Compliance Date Is October 1, 2015**

Reminder: HHS issued a [rule](#) finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10. This deadline allows providers, insurance companies, and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready to go on October 1, 2015. The rule requires the use of ICD-10 beginning October 1, 2015. The rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

#### *Keep Up to Date on ICD-10*

Visit the [ICD-10](#) website for the latest news and resources to help you prepare.

## **Claims, Pricers, and Codes**

### **ICD-10-CM Official Guidelines for Coding and Reporting Available**

The 2015 [ICD-10-CM Official Guidelines for Coding and Reporting](#) is now available on the [2015 ICD-10-CM and GEMs](#) web page and also on the [Centers for Disease Control and Prevention](#) website.

- Narrative changes appear in bold text
- Items underlined have been moved within the guidelines since the FY 2014 version
- Italics are used to indicate revisions to heading changes

## **Medicare Learning Network<sup>®</sup> Educational Products**

### **“Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision” Fact Sheet — Revised**

The [“Hospital-Acquired Conditions and Present on Admission Indicator Reporting Provision”](#) Fact Sheet (ICN 901046), previously titled “Present on Admission Indicator Reporting by Acute Inpatient Prospective Payment System (IPPS) Hospitals,” was revised and is now available in downloadable format. This fact sheet is designed to provide education on the Hospital-Acquired Conditions (HACs) and Present on Admission (POA) Indicator Reporting provision in IPPS hospitals. It includes the following information: background, HACs, POA indicator, exempt hospitals, and resources.

### **"Medicare Appeals Process" Fact Sheet — Revised**

The “[Medicare Appeals Process](#)” Fact Sheet (ICN 006562) was revised and is now available in a downloadable format. This fact sheet is designed to provide education on the five levels of claim appeals in Original Medicare (Medicare Part A and Part B). It includes details explaining how the Medicare appeals process applies to providers, participating physicians, and participating suppliers, in addition to including more information on available appeals-related resources.

### **Medicare Learning Network® Products Available In Electronic Publication Format**

The following products are now available as electronic publications (EPUBs) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at “[How To Download a Medicare Learning Network® Electronic Publication.](#)”

- The “[How to Use the Searchable Medicare Physician Fee Schedule](#)” Booklet (ICN 901344) is designed to provide education on how to use the Medicare Physician Fee Schedule (MPFS). It includes steps to search for payment information, pricing, Relative Value Units (RVUs), and payment policies.
- The “[How to Use The Medicare Coverage Database](#)” Booklet (ICN 901347) is designed to provide education on using the Medicare Coverage Database (MCD). It includes an explanation of the database and how to use the search, indexes and reports, and downloads features.

### **New Medicare Learning Network® Provider Compliance Fast Fact**

A new fast fact is now available on the [Medicare Learning Network® Provider Compliance](#) web page. This web page provides the latest [Medicare Learning Network Educational Products](#) and [MLN Matters® Articles](#) designed to help Medicare health care professionals understand common billing errors and avoid improper payments. Please bookmark this page and check back often as a new fast fact is added each month.

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