Spring Volume 50 Issue 1

The Virginia AAHAM Insider

A Newsletter by and for the members of the Virginia Chapter of AAHAM

The President's Message

Dear Virginia AAHAM Members and Friends:

Happy Spring! I hope that you are enjoying this beautiful time of year and feeling re-energized, as I am!

On that note, this is the time of year when our chapter puts goals into action to become the best that we can be. On March 7th, our Board discussed plans to continue to improve upon our mission of bringing you quality education, certification, networking and advocacy.

Although our goals are many, if I had to pick the theme for this year, I would have to say that it is focused on networking and affordability. I am very pleased that we will be delivering on those two initiatives when we partner with the VA/DC HFMA chapter to offer a "free" conference on Thursday, May 16th. This no-cost event is made possible by the generosity of Inova Health. We cannot thank our colleagues at Inova enough! The timing is perfect, as some healthcare organizations are cutting back on travel and education, making it more difficult for our members to obtain their CEUs. And after the conference ends, we will be networking with our HFMA friends at a nearby establishment. It's wonderful to be joining forces with HFMA again. I know we will continue the collaboration long after the conference closes.

Speaking of networking, we have already been a part of two networking events this year! The first was held jointly with HFMA in Fredericksburg on January 24th. Our second event was just recently held in Charlottesville on March 7th. Both were successful undertakings, so please stay tuned for more opportunities in the future and make plans to join in on the fun! Special thanks go out to our Board of Directors. Without their originality, dedication and hard work Virginia AAHAM would not be where it is today!

Please be sure to add the following dates into your calendars:

April 15 & 16	Legislative Day – Hyatt Regency Washington on Capitol Hill, Washington, DC
May 16th	Joint HFMA Conference – Inova Health Conference Center, Fairfax, VA
September 6th	Fall Conference – Mary Washington Healthcare's Fick Center, Fredericksburg, VA
October 9th-11th	AAHAM ANI – Caesar's Palace, Las Vegas, NV
December 4th-6th	Winter Annual Conference – Kingsmill Resort, Williamsburg, VA

I look forward to seeing you at these events. The topics are timely, the CEUs are plentiful and the networking is priceless! In the words of Audrey Hepburn "To plant a garden is to believe in tomorrow".
Do you believe in yourself enough to plant AAHAM education seeds in your garden?

I wish you a great spring filled with sunshine, flowers and plentiful opportunities.

Yours in AAHAM,
Lin

Inside this Issue:

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

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The Virginia AAHAM Insider

A Newsletter by and for the members of the Virginia Chapter of AAHAM

Senate Hearing Shines Spotlight on Rural Health Care Challenges

Brett Murphy and Hsam Atari

When we examined the rural health care landscape in 2016, the overarching challenges were affordability and accessibility. Two years later, those challenges persist, as was evident in the Senate hearing on September 25 titled "Health Care in Rural America: Examining Experiences and Costs."

The hearing featured the Subcommittee on Primary Health and Retirement Security, and testimony from Tom Glause (Commissioner, Wyoming Department of Insurance), Morgan Reed (Executive Director, the Connected Health Initiative), Alan Levine (CEO, Ballad Health), and Deborah Richter, MD (Family Physician).

The hearing presented a unique perspective on what is currently preventing hospitals and doctors from delivering affordable and accessible health care in rural areas. More importantly, the hearing also provided insight on possible solutions to these issues with the goal of creating an environment where hospitals thrive in rural areas, and as a result, residents have access to affordable quality health care.

Defining Rural

The U.S. Census Bureau identifies two categories of urban areas: the first is an urbanized area of 50,000 or more people, including cities and metropolitan areas; the second is an urban cluster of at least 2,500 and less than 50,000 people, including suburbs and large towns. Rural encompasses all population, housing, and territory not included within either of the designated urban area definitions. According to 2010 census data, approximately 20% to 25% of the U.S. population lives in rural areas.

Typical demographic trends of rural areas include lower median incomes, a high proportion of seniors, higher acuity levels and lower life expectancies. There are also specific ailments that impact these communities at a higher rate than urban communities. Obesity, lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease are statistically more common in rural areas. Finally, the gap between urban and rural life expectancies is growing. According to a 2014 study published in American Journal of Preventive Medicine, consistent overall increases in U.S. life expectancy were noted during the past 40 years, from 70.8 years in 1970 to 78.7 years in 2010. However, the study reveals the rural-urban gap widening from 0.4 years in 1969 to 1971 to 2 years in 2005 to 2009, with those in urban areas living longer.

Challenge One: Access to Health Care

Access remains the primary hurdle for health care in rural America: it is too difficult for residents to obtain and for hospitals to provide. There are inherent features of rural settings that contribute to this issue, such as geography and number of facilities. Hospitals are few and far between in rural areas, and reliable transportation services (e.g., buses, taxis, etc.) are not available to help overcome this. To illustrate this point, consider that only 24% of rural residents can reach a top trauma center within an hour, according to Glause's testimony at the Senate hearing.

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Aside from physical distance and lack of facilities, several other factors further constricting rural America's access to health care were discussed at the hearing. Two notable items included workforce shortage and the outdated "brick and mortar" approach to rural hospitals.

Workforce shortage – It is no secret that rural America struggles to attract and retain talented workers, and the health care industry is no exception. According to Glause, rural areas make up 57% of the primary care health professional shortage areas. There are some fundamental reasons that contribute to this shortage, including the urban-centric nature of the current health education system and the general draw of opportunities in urban areas. Workforce shortage exacerbates the access issue, as it lessens the supply of doctors, nurses, and other health professionals able to care for residents in rural areas.

Brick and Mortar – The traditional standardized hospital does not cater to the unique health problems in rural communities. For example, diabetes, heart disease, curable cancers, and drug overdoses disproportionately affect rural Americans relative to the general population, according to Levine's testimony. Thus, not only do rural residents have fewer hospital options, but those they do have are further away with less doctors and nurses. Further, the ones that do exist are not properly tailored to their needs.

Challenge Two: Affordability

Affordability continues to be a double-edged sword preventing the obtainment and delivery of quality health care in rural America. Rural residents have very limited coverage options and rural hospitals struggle to implement a cost structure that could spur more affordable services.

Rural areas have fewer insurers in the market, which increases premiums that residents are ill-equipped to afford. In fact, "nearly 30% of rural residents report delayed care or report they did not receive care in the previous year due to cost," said Glause in his testimony. It is not just the private insurance market that contributes to affordability issues. In Wyoming for example, Medicare reimbursement covers only 65% of the hospital's costs, which according to Glause shifts more costs to the non-Medicare population. This is a deliberate feature of the current system as both government and private insurer payment policies are "designed to contain or even reduce per-unit reimbursement," says Levine.

Fewer patients and tighter reimbursement directly leads to less revenue. This hinders a hospital's ability to deliver high quality health care and cover its fixed costs. According to Levine, more specifically, with less revenue to cover fixed costs such as debt service, increased compliance imposed by Medicare and Medicaid, and general overhead, cash flow takes a severe hit. This inhibits employee recruitment and retention, equipment and technology updates, and capital investments, all of which can reduce the quality of care to rural patients. Unfortunately, it does not stop there – if cash flow continues to suffer, bankruptcy and closure begin to enter the picture. Hence, 85 rural hospitals have closed down between January 2010 and July 2018.

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Solutions

The hearing was not all doom and gloom though, as many ideas and interesting solutions were discussed. These included strategies such as increasing telehealth availability and opening rural clinics to augment an existing facility. Other notable solutions include:

•One solution suggests creating a federal grant program to help both hospitals and insurers to reduce cost and increase quality of care in rural areas. For example, according to the Glause testimony, if the grants funded assistance to hospitals, new technology and transportation services, the cost would not be passed to the insurers, which would lower premiums, and in turn the rates for consumers.

•Another possible solution involves tailoring hospital services to the specific needs of communities. For example, renewable block funding based on estimable costs could enable hospitals to create new jobs and repurpose old assets. For example, according to Levine's testimony, two rural hospitals in Green County, Tennessee consolidated the inpatient acute care services at one hospital, and then repurposed the other to focus on specific outpatient services particular to that community.

•Finally, another proposed solution involved shifting from the traditional fee-for-service model to a pay-for-value that would better align doctor and hospital incentives. This could potentially attract more physicians to the area, as they "would be able to diversify their income to include the upside of the hospital's financial performance," says Levine. Additionally, such alignment would likely lead to consistency between doctor, hospital, and community as all focus on managing chronic conditions, rather than performing a reimbursable procedure.

Capital Considerations

In terms of cost savings, a thoughtful capital structure is still an important point to consider. Therefore, rural hospitals should be examining all financing programs and options as it pertains to bolstering much needed cash flow. This would allow rural hospitals to reinvest in their facilities, open specialty clinics, upgrade equipment and technology, and ultimately increase the affordability, availability, and quality of health care for rural America. Specific programs that can assist in this manner include the USDA Community Facilities Program (USDA CF) and the Federal Housing Administration (FHA) Sec. 242 mortgage insurance program. USDA CF is reserved for rural nonprofit organizations, including hospitals and skilled nursing facilities, and provides below market fixed-rate, long-term, non-recourse financing for construction and refinance. The FHA's Sec. 242 program provides agency-insured, long-term, fixed-rate debt at relatively high leverage points.

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A holistic approach to these challenges, one that includes careful consideration of both financing and operational options, will help to ensure that hospitals are doing all they can to mitigate risk and provide quality care for their communities. As is evidenced by the hearing in Washington, this is an issue that is on the minds of not just operators, but legislators as well. As the political landscape affects organizational decisions, it is important to stay aware of both changes and potential solutions available to rural facilities that will align a facility's operations with best practices that maximize financial stability.

About the authors:

Brett T. Murphy is a vice president with Lancaster Pollard, a financial services firm based in Columbus, Ohio, that provides capital funding to the senior living and health care sectors.

In addition to underwriting tax-exempt bond offerings, Lancaster Pollard provides a complete range of funding alternatives through its HUD-FHA/GNMA/FNMA/ USDA-approved, mortgage lender subsidiary. It can also provide bridge-to-agency lending, private equity, balance sheet lending and M&A advisory services. Mr. Murphy is responsible for the Illinois market.

Prior to joining the firm in 2013, Mr. Murphy worked in the Credit Risk division of Banco Santander during its acquisition of Sovereign Bank, and held credit-focused positions at both Wells Fargo and State Street Bank & Trust.

Mr. Murphy earned his MBA from the University of Notre Dame with a dual focus in Corporate Finance and Investments. He earned his Bachelor of Science degree in Finance with a minor in Law from Bentley University. Mr. Murphy holds professional licenses as a Registered Limited Investment Banking representative (Series 79), Municipal Securities representative (Series 52), and Uniform Securities agent (Series 63).

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Can the Revenue Cycle Assist with Value-based Contracts?

By Rob Borchert, MBA, FHFMA, CRCE-I

Value-based contracts are on the rise in our industry. Anything that insurers, including government insurers, can do to hinder or reduce payment for services can be found in letting them design a value-based contract for you! This basic history of insurance coverage and insurance payments, including government payers, is that they have presented contracts to us with what they wanted to cover and exclude those things that they do not want to cover. They typically have not even considered the various types of services that a specific hospital may offer. In fact, they typically have not even recognized many 'centers of excellence' and specialty practices in many facilities because it was "out of their spectrum" to figure out how and what to pay for these advanced, lower cost services offered to their members.

Government payers like Medicare, Medicaid and Tricare, have traditionally gathered statistics on what services have been offered and provide some coverage for all of them without recognizing 'value'. Yes, they have formulated bundled payments, as an example, and it is all based on statistics and how they can best reduce payment. Look at the history of DRGs (Diagnostic Related Groups) and how the initial payment is/was based on the principal diagnosis for the patient's admission to the hospital. Then further fine tuning this ''process" to not just days of coverage but stating 'no payment' if the patient is re-admitted with the same diagnosis within a certain period of time. Also, putting global periods on providers in the case of follow-up visits which is good patient care…but no payment. As we all know, whatever the government puts forth and seems to work by reducing the outlay of payment, all third-party insurers adopt. Now, as it appears that they have squeezed every portion of patient care into some type of 'episode', they have presented us with "only paying for value".

Value – a word that has been defined in so many different ways- brings us to a new way of paying for services that were actually defined in the 'centers of excellence' experience. Value-based services, value-based contracts for value-based services, payments for value-based services found in value-based contracts. Such a tangled web we weave. Who defines value-based services? How do they identify value-based services? How do they decide how to pay for value-based services? All good questions but the other question to ask is "who" is the identity that makes these decisions? Is it all based on industry statistics? Is it based on the general data and statistics of the third-party insurer? Does the healthcare provider (hospital or physician) have any input into the analysis of this data? What can be done to allow for a more collaborative approach to the writing of a value-based contract that has real value? Do you know how these contracts come to be? Are you, as part of the revenue cycle team have any input into the design or writing of these contracts? Do you work with any members of your internal team that deals with managed care contracting? Is your managed care contracting team dependent on the internal data that comes from each of the clinical service departments and the 'charging mechanism' associated with these services without having any discussion with the revenue cycle senior staff?

Boy, there are a lot of questions associated with value! Have you considered talking with your managed care contracting team to understand the process of 'contract negotiation'? If the current process for defining a value-based contract is only based on the third-party insurer's data, then there is opportunity. If the current process is based on the third-party's data and the presentation of your facility's data gathered by the managed care team, then there is opportunity.

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The opportunity is having revenue cycle and managed care work together to enhance the data and to work together in dealing with the third-party insurer in defining the terms of the contract based on your facility's factual data and not theirs. This approach also can assist in further defining other clinical areas and services that may be added to the value-based clinical listing as well as take some services off the insurer's list. This all involves work in understanding not only the revenue generated data from the charge master but also the actual cost of the services offered so that the negotiated reimbursement exceeds the actual cost. This kind of discussion, internally, can enhance the whole reimbursement process and assist in dealing with all the third-party insurers offering a contractual relationship.

Where does the revenue cycle input start? First place is to talk with and know that variety of services that your facility offers. You may say that you know but how many services are currently being bundled but not reported. This does happen in some facilities. How many types of Radiological services are performed not only a diagnostic and outpatient but also as surgical and repetitive? When do you (revenue cycle) learn of the services to be rendered? How do you identify and track these services? Does your charge master include Level II and Level III services, if they are needed to identify cost? Does any of your clinical departments keep their own data information on services and providers? Has anyone analyzed this data in relation to data coming from the charge master and/or charge capture and billing? How many patients move from service area to service area with the same diagnosis because it is "easier" for the clinical areas rather than identifying the true diagnostic reason for each departmental service? How about within your own 'center of excellence', if you have one? How is that data captured, and it is measured against anything? Is it a center of excellence based on patient outcomes as well as the costs associated with the outcome? Are providers measured on the same criteria and collaborative discussion occurs within the specialty area?

Each clinical area such as Outpatient Surgery, Inpatient Care, Radiology, Therapies, Laboratory, etc. all have distinct data for analysis. The Revenue Cycle has its own distinct data for analysis that addresses the various revenue and reimbursement histories by payer. The managed care are gathers data from various sources and sorts this information according to the various third-party contracts. Maybe we should all sit down and show the data to each other in order to better define (revenue and costs) the services that provide the most value to patients as well as to the profitability of the facility. When dealing with value-based contracts, we, in the Revenue Cycle arena, should always remember that we can be value-added to the whole process since our data can tell the full story and/or it can identify the areas where the story may fall short or is overburdened. We can be of great assistance to the current and growing environment if we but step up and offer our service.

By Rob Borchert, MBA, FHFMA, CRCE-I
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Legislative Update

2019 State Monitoring Report

Bill Number: hr2889

Bill Title: Closing Loopholes for Orphan Drugs Act

Introduced Date: 06/13/2017

Status:

Session: 115th Congress

Sponsor: Peter Welch

Jurisdiction: US

Summary: Closing Loopholes for Orphan Drugs Act
This bill amends the Public Health Service Act to revise the 340B Drug Pricing Program, which currently requires drug manufacturers to discount orphan drugs (drugs for rare conditions) for certain entities covered by the program. The bill discounts orphan drugs that are not being used to treat rare conditions for all entities covered by the program.

Last Action Date: 12/12/2018

Last Action: Added cosponsor: Peter J. Visclosky - (12/12/2018)

Bill Number: hr6071

Bill Title: SERV Communities Act

Introduced Date: 06/12/2018

Status:

Session: 115th Congress

Sponsor: Doris O. Matsui

Jurisdiction: US

Excerpt: regulation titled ``*340B Drug Pricing* Program *Ceiling Price* and Manufacturer Civil Monetary Penalties

Last Action Date: 12/11/2018

Last Action: Added cosponsor: Eleanor Holmes Norton - (12/11/2018)

Bill Number: hr5498

Bill Title: Rural Hospital Frontier Fairness Act

Introduced Date: 04/12/2018

Status:

Session: 115th Congress

Sponsor: Collin C. Peterson

Jurisdiction: US

Summary: Rural Hospital Frontier Faimess Act
This bill alters the Medicare prospective payment system for inpatient hospital services furnished at sole community hospitals (i.e., rural hospitals or hospitals that are the sole source of inpatient care in a certain geographic area). Specifically, the bill applies a minimum area wage adjustment to payments to sole community hospitals that are located up to 75 miles from the closest frontier (i.e., predominantly rural) state. Currently, the minimum area wage adjustment applies only to hospitals in frontier states.
The bill also amends the Public Health Service Act to allow such sole community hospitals to participate in the 340B drug pricing program (i.e., a program that allows entities to receive covered outpatient drugs at reduced prices from manufacturers).

Excerpt: eligibility for certain sole community hospitals to discounted *drug* prices under the *340B drug pricing* program

Last Action Date: 04/18/2018

Last Action: Referred to the Subcommittee on Health. - (04/18/2018)

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Highlights from the Spring Meeting

David Nicholas, Opening Remarks

Mercy Health-A Revenue Cycle Turnaround Story

Shannon White,

President/CEO of Ensemble Health

Anthony Seminaro,

Region CFO of Mercy Health

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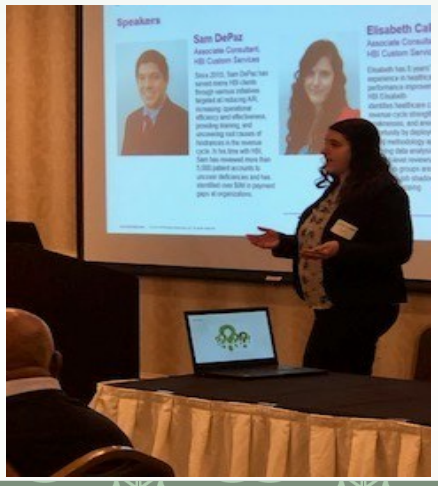
Highlights from the Spring Meeting

Utilizing Denials Intelligence Strategically

Sam DePaz, CRCL, CPAS, CPFSS, Associate Consultant HBInsights & Elizabeth Callahan, CRCL, CPAS, CPFSS, Associate Consultant HBInsights



Using Systems to Assist Revenue Integrity

Catherine (Kate) H. Clark, CPC, CRCE-I, CRIP, President, Mosaic Healthcare

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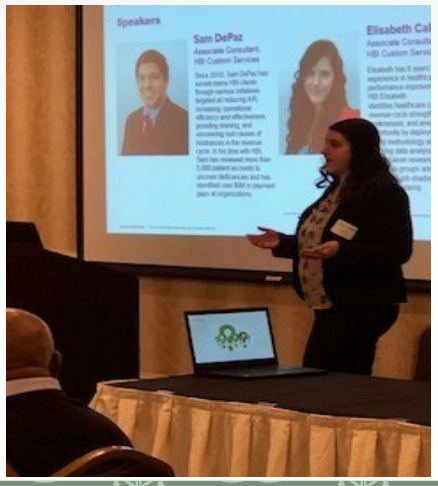
Highlights from the Spring Meeting

Utilizing Denials Intelligence Strategically

Sam DePaz, CRCL, CPAS, CPFSS, Associate Consultant HBInsights & Elizabeth Callahan, CRCL, CPAS, CPFSS, Associate Consultant HBInsights



Using Systems to Assist Revenue Integrity

Catherine (Kate) H. Clark, CPC, CRCE-I, CRIP, President, Mosaic Healthcare

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Highlights from the Spring Meeting

Sponsors, Raffle, and Education Fun!

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Highlights from the Spring Meeting

Roaring Fires, Flickering Flames, Dying Embers or Cold Ashes?

Dr. Charles Petty, President, Family Success Unlimited

Revenue Cycle IT Governance

Brett McMillan, Administrator, University of Virginia Medical Center Revenue Cycle Systems

Brent McGhee JD, Administrator, University Of Virginia Medical Center Revenue Cycle

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Legislative Updates

Jay Andrews, Vice President of Financial Policy, Virginia Hospital & Healthcare Association

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NETWORKING EVENT!

VA AAHAM/VA-DC HFMA Joint Educational Session 5/16/19

Inova Health System

Merrifield, VA

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CHANGE HEALTHCARE

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AAHAM
American Association of Healthcare Administrative Management
CELEBRATING 50 YEARS
1968 - 2018

Congratulations on achieving certification!

Ebonie Griffin-Riverside Health Systems, CRCE-I

Karen Thomas-Mary Washington Healthcare, CRCE-I

Be on the lookout for upcoming webinars and join us at the events listed below

- **VA AAHAM/VA-DC HFMA Joint Educational Session 5/16/19**

⇒ **Inova Health System Merrifield, VA**

- **VA AAHAM Fall Conference 9/6/19**

⇒ **Mary Washington Healthcare-Fick Center**

- **VA AAHAM Winter Annual Conference 12/4-12/6/19**

⇒ **Kingsmill Resort Williamsburg VA**

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Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you! Certification is an investment in your personal growth and your professional future.

Benefits of obtaining AAHAM certification:

- Professional development
- Individual enrichment
- Employer awareness
- Recognition by industry and build a network of connections in the elite group that shares your designation
- Personal challenge and satisfaction
- National recognition
- Recognition and access to the positions and promotions you seek and deserve

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

Expertise—you possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination.

Professionalism—your pursuit of excellence supports the quality of service in your career and in the healthcare industry.

CRCE-I & CRCE-P exams are considered to be the best indication of knowledge in our field. Set a goal or make a promise to yourself to pass the exam. It will be gratifying to prove to yourself that you can pass this difficult exam, and that your years of experience and hard work will be evident to all by the CRCE-I/CRCE-P designation after your name.

The webinars that were held on credit & collection; Patient access and Billing are out on the web site.. Also a practice test is out there and the power points from the three webinars are on the web site. You have to be a Va AAHAM member to access this information. If

Study guides are loaned out to members. You do not have to purchase your own study guide.

If you are interested in testing your knowledge and gaining the recognition that comes with certification, contact Leanna Marshall for additional information.

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Virginia AAHAM offers a certification payment reward for passing the professional exam. AAHAM will reimburse the member for the cost of the exam.

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Woodrow Samuel Scholarship

Congratulations to our 2019 recipient, Cecilie Elliott!

Woodrow Samuel Annual Scholarship Application

Purpose:
The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987. The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter, and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization. A maximum of $1,000 scholarship award will be given.

Eligibility:
Eligible nominees must:
- ☐ Be a Virginia AAHAM member or a child of a Virginia AAHAM member as of January 1 of the current year.
- ☐ Eligible nominees can apply for the scholarship award on an annual basis.
- ☐ Members must be employed full time in a healthcare related field and dependents must be enrolled in an accredited college or school.
- ☐ Chapter dues of the member must be paid prior to the acceptance of requested scholarship applications.
- ☐ Classes taken must be taken during the current school year.

Nomination Procedure:
Nominees must:
- ☐ Complete the application form
- ☐ Include at least one letter of reference.
- ☐ Include or attach any documentation you would like to have considered.
- ☐ Include an essay on why winning the scholarship is important.

Submission:

The form will be completed and returned to the address listed at the end of the application. This application will be postmarked no later than January 30th of the year the application is submitted to the Virginia State AAHAM Scholarship Chairman. All application materials and supporting documentation will be reviewed by the Virginia State Scholarship Committee. After all applications are reviewed, the applicant will be notified if they have been selected as a Scholarship recipient by the Chair of the Scholarship Committee.

Please submit all applications to Pam Cornell by email at pam.cornell@mwhc.com or mail the application to Pam Cornell 2300 Fall Hill Ave Suite 313 Fredericksburg, VA 22401 no later than January 31st. Awards will be presented at the March AAHAM meeting to be held in March 2020 in Charlottesville.

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Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2018. Submit articles to Pam Cornell at pam.cornell@mwhc.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

This publication is brought to you through the collective efforts of the **Publications Committee**

Pam Cornell, CRCE-I

Secretary

What is AAHAM?

AAHAM is a premier professional organization for healthcare administrative management. Our goal is to provide quality member services and leadership in the areas of education, communication, representation, professional standards and certification. Virginia AAHAM was founded in 1982 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a based constituency of healthcare professionals.

I ❤ Virginia