



7 CRUCIAL COMPLIANCE CONVERSATIONS FOR EVERY HOSPITAL CFO

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Power Up Your Collections

Introduction

A New Compliance Challenge

Most hospital CFOs will agree: The last call they want to receive is one from the board room about a disgruntled patient. Yet with alarming frequency, patient complaints are making their way up the chain through both for-profit and nonprofit hospitals – all with the support, and in some instances, encouragement, of the Federal government. Though a bit of an exaggeration, it is a statement made with a solid footing in truth. It is also the reason CFOs need to take heed: The Consumer Financial Protection Bureau (CFPB) has medical debt in its sights and it knows how to find you. Unfortunately, the silence is deafening among healthcare leaders about the impact the CFPB might have on their bottom line and the burgeoning set of new responsibilities it is placing on hospitals, EBOs and third-party medical collectors.

Hospitals and their service providers are under the mistaken assumption their operations are flying below the CFPB's radar. Unfortunately, nothing can be further from the truth.

This ebook is intended to shed light on seven major events or changes taking place in the healthcare receivables marketplace and foster conversations from the board room to the patient financial services department about the impact these changes will have on your day-to-day processes, compliance protocols, tax status (as applicable) and reputation in the community.



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A Path Over the Mountain

The Consumer Financial Protection Bureau (CFPB) is a federal agency established by Congress in 2010 that opened its doors in July of 2011. As suggested by its name, the CFPB's primary purpose is to protect consumers. It does so by enforcing consumer financial laws, promulgating regulations over banks and nonbanks, and conducting examinations of banks, credit grantors and larger market participants in nonbank markets such as credit reporting agencies, collection agencies, debt buyers and collection law firms.

The CFPB supervises depository institutions and credit unions with total assets of more than \$10 billion and their affiliates. The Bureau also has authority under the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act) to supervise nonbanks, regardless of size, in certain specific markets: mortgage companies (originators, brokers, servicers and providers of loan modification or foreclosure relief services), payday lenders and private education lenders.

The CFPB may also supervise the "larger market participants" (LMP) in other nonbank markets as the Bureau defines by rule. To date, the Bureau has issued four rules defining larger participants in the following markets: consumer reporting (effective September 2012), consumer debt collection (effective January 2013), student loan servicing (effective March 2014) and, most recently, international money transfers (effective December 2014). In September 2014, the Bureau proposed a rule defining the larger participants in the nonbank automobile finance market.

In the case of the consumer debt collection industry, the CFPB's definition of larger market participant refers only to those collection agencies, debt buyers and collection law firms that generate more than \$10 million in fees annually from the collection of bad debt, excluding healthcare debt. At the time the definition of LMP was published by the CFPB, no other mention was made to the healthcare industry, and medical debt was clearly not included in the calculation to determine whether a particular debt collector fell subject to the LMP definition. As a result, hospitals, healthcare collection agencies and EBOs have considered themselves outside the CFPB's scope of authority, unhindered by its regulation and oversight.

However, while the medical industry has been convincing itself the CFPB does not impact medical debt collection, the National Consumer Law Center, a leading consumer advocacy group, has been publishing papers and advocating the CFPB change the definition of LMP to include fees earned from medical collections in the \$10 million+ calculation. This group should be taken very seriously. It wields a lot of power in Washington, D.C. and has a very, very loud voice. To learn more about the National Consumer Law Center's efforts to convince the CFPB to amend the definition of LMP to include medical debt fees and to promulgate rules to curtail the reporting and collection of medical debt, check out the [NCLC's position paper](#).



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What does the CFPB have to do with you?

Everything.

In fact, medical debt, and in particular the practices your hospital and its collection agencies use to collect medical debt, have moved to the top of the CFPB's agenda. Consumers are complaining about medical billing and collection practices on the CFPB's consumer complaint portal at unprecedented volumes. As mentioned already, the NCLC has demanded more regulation and supervision over hospitals with regard to their billing, medical debt collection and credit reporting practices. State attorneys general continue to advance their own consumer protection initiatives with regard to the billing and collection of medical debt. The big three credit reporting agencies, Experian, Equifax and Transunion, in collaboration with state attorneys general, just announced a landmark decision to restrict the reporting of medical debt. Our own U.S. Treasury finally released the long awaited 501(r) regulations controlling the charging, billing and collection practices of nonprofit hospitals. And last but not least, hospitals are finding their organizations named as the defendants in countless class action lawsuits alleging violations of the Telephone Consumer Protection Act.

To prepare for what will undoubtedly be a seismic change in the final stages of the revenue cycle, hospital CFOs and other executives need to have seven crucial conversations in the next several months to protect their organizations' bottom lines.

Crucial Conversation #1 - Consumer Complaints Abound

Crucial Conversation #2 - Credit Reporting and Medical Debt Collection Practices Take Center Stage at the CFPB's Field Hearing

Crucial Conversation #3 - The Big Three Bureaus Announce National Consumer Assistance Plan

Crucial Conversation #4 - New 501(r) Regulation Threatens Nonprofit Hospitals' Tax Exempt Status

Crucial Conversation #5 - Service Provider Management - The Best "E&O" Insurance Available

Crucial Conversation #6 - Hospitals - The New Target of TCPA Class Action Litigation

Crucial Conversation #7 - Revenue Cycle Software Providers - From Tool to Armor



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#1

Crucial Conversation

“Have any of our patients filed complaints against us on the CFPB’s new complaint portal? Has anyone responded?”



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#1

“Have any of our patients filed complaints against us on the CFPB’s new complaint portal? Has anyone responded?”

What defines a consumer complaint?

Anything reported to the CFPB that highlights a consumer’s dissatisfaction with your conduct, services or practices.

In July of 2011 the CFPB launched its consumer complaint portal at www.cfpb.gov. As a practical matter, consumers are encouraged to use this portal to log complaints about any organization that has left them dissatisfied with a financial product or financial service. A complaint need not identify an illegal practice. It need only highlight a consumer’s dissatisfaction. This is because the CFPB defines complaint as nothing more than written or verbal evidence of a consumer’s dissatisfaction with the conduct, services or practices of a member of the financial services industry.

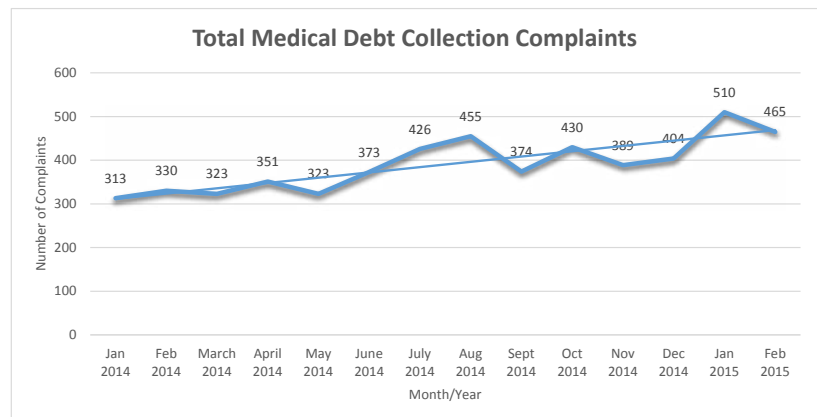
The portal is a powerful tool used by the CFPB to measure the degree to which consumers are dissatisfied with their experiences with members of the financial services industry. At first blush, it might not seem apparent to the average hospital CFO, patient account manager or even third-party medical debt collector that organization may fall subject to the oversight or supervision of the CFPB. That’s because providers don’t often consider themselves to be financial institutions. To some extent they would be right. But because the CFPB’s portal is available to all members of the public, including patients, all healthcare providers and companies that service patients directly (including EBOs and debt collectors) become a part of the financial services industry and in turn are subject to the power and authority of the CFPB at the moment a patient files a complaint.

The CFPB’s Consumer Complaint Portal is lighting up with complaints about medical debt collection practices. Since its launch in July of 2011, consumer complaints regarding medical debt have increased from less than 8% of all consumer complaints to as high as 15.74% in January of 2015.

Medical debt collection has seen an increase of almost 50% in CFPB complaints since January 2014.

The CFPB monitors complaints against hospitals and healthcare providers and evaluates the severity and the volume of the complaints regarding medical debt collection practices. It behooves any hospital or healthcare provider to similarly monitor the complaints filed against its organization and service providers and take corrective action.

You may review the complaints filed against your organization by visiting www.cfpb.gov.



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#2

Crucial Conversation

“Do we credit report? If so, should we stop?”



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#2

“Do we credit report? If so, should we stop?”

On December 11, 2014, the CFPB conducted a field hearing in Oklahoma City on medical debt collection practices and the relationship between those practices and consumer credit reporting in general. The meeting was nothing short of a crystal ball regarding the future of medical debt collection. But somehow, it is one that has gone largely unnoticed by hospitals and the debt collection industry.

Let's review some of the hearing's most important takeaways:

CFPB Director Richard Cordray shared the Bureau's position that problems with debt collection are magnified when the debt collector reports a debt as a collection trade line to the national credit reporting companies. He characterized a collection trade line as a black mark – more like a scarlet letter – on any consumer or patient's credit report, and explained how having a reported collection item or a severe delinquency can increase that patient or consumer's interest rate and affect his or her ability to borrow money. He further highlighted some particularly startling statistics from the CFPB's recent study on credit reporting practices with regard to medical debt:

- One in five consumers with a credit report has a medical collection item on his or her credit report
- More than 1.3 billion trade lines are actively reported, and about half of the overall debt collection trade lines are from medical bills
- Fifteen million consumers have medical debt collection items as the only collection items on their credit reports, and many of them have no other seriously delinquent accounts

It should be noted first that the Director opened the hearing reiterating how debt collection practices have long been a source of frustration for many consumers, making it clear debt collection continues to be a top source of [consumer complaints](#) to the Consumer Bureau and to its sister agency, the Federal Trade Commission.

According to Cordray, those sentiments have resulted in a major new development: He explained how as part of the CFPB's ongoing effort to improve the nation's credit reporting system, the Bureau will now require the largest credit reporting companies to provide it with regular, standardized accuracy reports, specifying the number of times consumers dispute information on their credit reports during a reporting period, along with furnishers with the most disputes, industries with the most disputes and furnishers with particularly high dispute rates relative to their peers. Cordray's prepared remarks should be a wakeup call to any healthcare provider, EBO or medical debt collection agency owner. [Click here to read.](#)

WARNING: Do you credit report?

If you do, consider
it a very high
compliance risk.



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#2 *cont.*

If you, or your collection agency partners, report medical debt to consumer reporting agencies, consider the practice, by its very nature, to be very high risk. However, in order to mitigate the risk associated with the reporting of medical debt, be mindful of the following:

- If you, or your collection agency partners, report medical debt, make sure you are registered with the credit reporting agencies as a medical debt data furnisher.
- If you, or your collection agency partners report medical debt, make sure you reconcile direct payments made to the hospital with the collection agency assigned to the account daily.
- If you, or your collection agency partners have not revisited your dispute investigation work flow, please do so immediately. It is without a doubt your highest area of risk when it comes to credit reporting.
- Make sure neither your hospital staff nor your in-house or outside collectors are bartering the removal of a medical debt from a consumer's credit report in exchange for payment.
- By all means, make sure you comply with the time restrictions under both the National Consumer Assistance Plan (read on) and the 501(r) regulations (if applicable) before reporting any information about a medical debt to a consumer reporting agency.



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#3

Crucial Conversation

“How long do we wait before we report medical debt to credit reporting agencies? Is it at least 180 days?”



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#3

“How long do we wait before we report medical debt to credit reporting agencies? Is it at least 180 days?”

Since the field hearing on December 11, 2014, the three major credit bureaus, Transunion, Experian and Equifax, in collaboration with the attorney general from the State of New York and other state attorneys general, announced the National Consumer Assistance Plan. This plan includes changes to reporting consumers' medical debts and will enhance the bureaus' ability to collect complete and accurate consumer information while aiming to provide consumers more transparency and a better experience interacting with credit bureaus about their credit reports.

“During discussions over recent months, the New York attorney general and other state attorneys general allowed the credit reporting agencies to collaborate in an unprecedented manner to share industry best practices and develop a plan that will offer consistent and meaningful benefits to consumers,” according to TransUnion’s press release. Moreover, “the National Consumer Assistance Plan focuses on enhancements in two primary areas: consumer interaction with national credit reporting agencies and data accuracy and quality. In particular, medical debts won’t be reported until after a 180-day waiting period to allow insurance payments to be applied. The credit reporting agencies will also remove previously reported medical collections that have been or are being paid by insurance from consumers’ credit reports.”

Consider just a few of the new requirements presented in the National Consumer Assistance Plan. As a result of the settlement, when reporting medical accounts to a credit reporting agency hospitals and collection agencies must:

Prevent the reporting and display of medical debts identified and furnished by collection agencies when the date of the first delinquency is less than 180 days prior to the date that the account is reported to the CRAs (compliance herewith is required within three years and 90 days of the March 8, 2015, effective date).

Use the Metro 2 special comment codes of “BP” for debts identified as “paid by insurance” and “AB” for debts identified as “being paid by insurance” and remove or suppress medical accounts reported as “paid by insurance” or “being paid by insurance” if such accounts were in fact paid in full by the consumer’s insurance carrier (compliance herewith required within 18 months of the March 8, 2015, effective date).

Implement a process designed to remove or suppress known medical collections furnished by collection agencies from files within the CRAs’ databases when a medical debt is reported either as having been paid in full by insurance or as being paid by insurance (required within three years and 90 days of the March 8, 2015, effective date).



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#3 *cont.*

The question is whether all this collaboration between the credit reporting agencies and the state attorneys general will be enough. To say it differently, from the CFPB's position: Is it lipstick on a pig? The CFPB is committed to protecting consumers and their data. It recently published a report on credit reporting and the future for data furnishers does not look bright. In addition to the negotiated National Consumer Assistance Plan, the CFPB may add even more layers of protection for consumers regarding the information on their credit reports and their right to dispute the information. All of this regulation means more staff, particularly, trained staff familiar with the intricacies of the Fair Credit Reporting Act and its requirements. As a result, it is very likely the cost of being a data furnisher will soon become too high for hospitals as well as their collection agencies.



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#4

Crucial Conversation

“Who is working with our EBOs and third-party collection agencies to calculate the FAP application period and identify the approved extraordinary collection activities? Are we out of compliance as we speak?”



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#4

“Who is working with our EBOs and third-party collection agencies to calculate the FAP application period and identify the approved extraordinary collection activities? Are we out of compliance as we speak?”

“If the CFPB doesn’t get you, the IRS will.”

It is fair to say, if the CFPB won’t get you the IRS will. On February 2, 2015, the Internal Revenue Service published final regulations and guidance information regarding the requirements for charitable hospital organizations added by the Patient Protection and Affordable Care Act of 2010. The [regulations](#), first announced on December 29, 2014, will affect charitable hospital organizations in a number of ways.

As a matter of background, Section 501(r) was added to the Code by the Patient Protection and Affordable Care Act, Public Law 111–148 (124 Stat. 119 (2010)) (the Affordable Care Act), enacted March 23, 2010. This section imposes additional requirements on charitable hospital organizations that must be followed in order to maintain tax exempt status.

While most nonprofit hospitals are well aware of this regulation, many fail to see how it impacts their relationship with third-party collection agency partners. In fact, several of the regulation’s requirements pertaining to notice of extraordinary collection activities, credit reporting practices, judicial process, refunds, remediation and notice of Financial Assistance Plan eligibility may directly impact the ability of a collection agency to satisfy its duties under the Fair Debt Collection Practices Act and the Fair Credit Reporting Act.

The following sections present unique compliance challenges for both the nonprofit hospital and its third-party collection agency partners.

- Section 501(r)(3) requires a hospital organization to conduct a community health needs assessment (CHNA) at least once every three years and to adopt an implementation strategy to meet the community health needs identified through the CHNA.
- Section 501(r)(4) requires a hospital organization to establish a written financial assistance policy (FAP) and a written policy relating to emergency medical care.
- Section 501(r)(5) requires a hospital organization to not use gross charges and to limit amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the organization’s FAP (FAP-eligible individuals) to not more than the amounts generally billed to individuals who have insurance covering such care (AGB).



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#4 *cont.*

- Section 501(r)(6) requires a hospital organization to make reasonable efforts to determine whether an individual is FAP-eligible before engaging in extraordinary collection actions.
- Section 501(r)(2)(B) requires a hospital organization to meet each of these requirements separately with respect to each hospital facility it operates.

These final regulations provide guidance on the requirements described in section 501(r), the entities that must meet these requirements and the reporting obligations relating to these requirements under section 6033. Hospitals and their collection agency partners should establish a written compliance plan to meet the requirements of 501(r). See final rules at: <https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#h-72>



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#5

Crucial Conversation

“Who are our service providers and who is managing their compliance with consumer financial laws?”



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#5

“Who are our service providers and who is managing their compliance with consumer financial laws?”

Hospitals and healthcare organizations are generally familiar with requirements they must impose on their service providers and associates in order to comply with HIPAA. Large or small, they must be even more diligent today given the advent of 501(r) regulations, the CFPB’s newfound focus on medical debt collection practices, and consumer attorneys’ compulsion to sue healthcare organizations for their business associates’ noncompliance. Though time consuming, a well-managed service provider management program can improve both parties’ compliance with the law, improve patient satisfaction and, perhaps most importantly, prevent legal battles.

From the standpoint of the regulators, you can’t manage what you don’t know. So the very first step toward establishing a robust service provider management program begins with a team. Identify the members of your staff who will be held accountable for the program. Ask the team to take inventory and prepare a list of every service provider that supports your revenue cycle in any way. This document, your Service Provider Inventory, should include any business that touches, transmits, houses or has access to patients, responsible parties, PHI or patient financial information.

Next, conduct a risk assessment of each service provider. This assessment should help you determine which service providers pose the greatest risk of harm to your patients either in terms of direct service or PHI data. Include a background check of the principals and key employees for each and do not forget to review all litigation and consumer complaints filed against them on the CFPB’s complaint portal. Finally, ensure contracts are in place with each service provider and review them to ensure each one includes:

- CFPB compliance provisions
- Requirements for on-site visits and dates to carry them out
- Compliance training requirements and dates to carry them out
- Policies and procedures regarding consumer financial laws
- Complaint and litigation review

Maintain this document in your document management system and include a date indicating when it was last updated and by whom. Continue to exercise due diligence over your service providers throughout the term of your relationship. And remember: This is only a primer on the very basic elements of service provider oversight. Your specific approach to billing, collections, scoring and auditing will likely make the process even more complex.

You can’t manage what you don’t know:

1. Establish your team
2. Take inventory of your partners
3. Conduct a risk assessment
4. Ensure contracts are in place



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#6

Crucial Conversation

“Do we use an automatic telephone dialing system (ATDS) and how are we capturing consent to call our patients on their cell phones or communicate via text?”



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#6

“Do we use an automatic telephone dialing system (ATDS) and how are we capturing consent to call our patients on their cell phones or communicate via text?”

Proper consent?
Don't know?

Dial manually!

The most compelling way to underscore the need for hospitals, EBOs and first- and third-party collectors to take note of the risks presented by the Telephone Consumer Protection Act (TCPA) is to summarize the four most significant cases of the past year. Each of these cases involve members of the health care industry and their collection agency partners or technology. Thousands of other cases with defendants such as Walmart, Citi Bank and the like have been filed, adjudicated or settled for dollar amounts that hit as high as \$75m.

- **Mais v. Gulf Coast Collection Bureau**

Overturning the district court decision, the 11th Circuit held the District Court lacked authority to consider or challenge the validity of the 2008 FCC ruling pursuant to the Hobbs Act, 28 U.S.C. 2342; FCC's 2008 consent ruling applies to all creditors and collectors when calling wireless telephone numbers to recover goods and services received by consumers. Debt collection is primarily regulated by the FDCPA, which includes medical bills within its broad definition of debt. The collection of medical debt falls within the purview of the FCC's 2008 consent ruling and the hospital's consent was deemed valid for its own use as well as the use of its collection agency partner.

Consent does not have to be provided to a creditor only via direct delivery; prior express consent exists when the subscriber makes the number “available” to the creditor (in this instance the hospital) regarding the debt.

- **Hudson v. Sharp Healthcare**

Court was asked to find that the act of providing a mobile contact number to a creditor does not constitute prior express consent to be called at that number using an autodialer, notwithstanding the FCC's express finding that such an act does constitute prior express consent. Refusing to adopt the lower court's decision in Mais, U.S. District Court Judge Michael M. Anello in the Southern District of California said the actions taken by the health care provider fell under the consumer's prior express consent to contact her via cell phone. He granted the health care provider's motion for summary judgment. [No. 13-CV-1807 (S.D.Cal June 25, 2014)]



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#6 *cont.*

- **Lardner v. Diversified Consultants, Inc.**

On motion for summary judgment, plaintiff argued LiveVox system fits the definition of an ATDS because it stores preprogrammed telephone numbers and then dials these numbers automatically in a sequential order from the preprogrammed list. Defendant argued “LiveVox system is not an ATDS because it does not have the present capacity to store or produce numbers to be called using a random or sequential number generator.” This U.S. District Court held in favor of plaintiff explaining, “The statute has no requirement on how long a telephone number is stored. If the equipment “has the capacity to store or produce telephone numbers,” then it meets the statutory definition of an ATDS.” Judgment for Plaintiff: \$63,000. [Case No.: 1:13-cv-22751-UU (S.D.FL April 30, 2014)]

- **Nunes v. Twitter**

If your hospital has any inclination to begin text messaging its patients, consider the plight of Twitter, the leading social media company in the world. Even a company with all the legal resources available could not overcome the plaintiff’s charge that Twitter sent her unsolicited text messages of a promotional nature in violation of the TCPA even though she had never opened a Twitter account. She claimed Twitter continued to send promotional texts to “recycled numbers,” cell phone numbers that previously belonged to people who had provided consent but that had since been transferred to other consumers.

The court rejected Twitter’s motion to dismiss citing a 7th Circuit decision that explained that “only the consent of the subscriber assigned to that cell number at the time of the call (or perhaps the person who answers the phone) justifies an automated or recorded call.”

Together these decisions make clear that hospitals as well as their EBO and first- and third-party collection agency partners must adhere to the requirements of the TCPA when communicating with patients using an autodialer. In short, if you have the appropriate consent of the patient assigned to the cell number at the precise time you are placing the call or text message you may use an autodialer to launch the communications. But without the proper consent, stop your dialers and place the call manually.

Please consult with your legal counsel and your software provider to determine whether you need a specialized contact management system to place manual calls to your patients.



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#7

Crucial Conversation

“Does our software provider understand our compliance needs and how does it address them?”



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#7

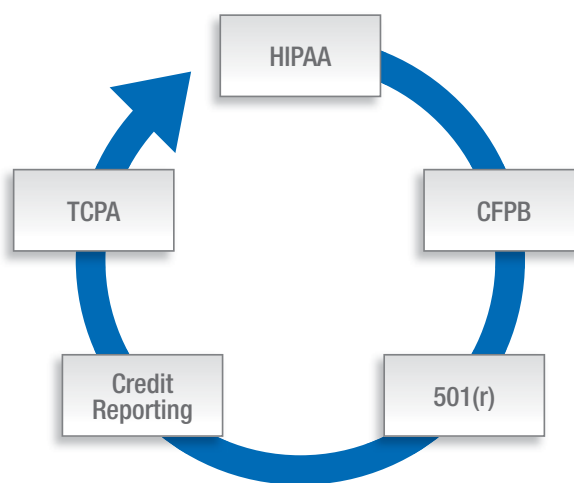
“Does our software provider understand our compliance needs and how does it address them?”

Your software applications are central to your daily operations as well as your compliance plan – so it is critical to choose a vendor with a hand on the pulse of compliance and regulation. Your chosen application’s compliance features should be trusted, automated, easy to manage, comprehensive and auditable.

No matter your stance in the accounts receivable industry - hospital, EBO or third-party healthcare collector – you should partner with a technology provider that ‘gets’ the importance of compliance. Seek a vendor that invests intentionally in compliance and regulation monitoring, lobbying and proactive product response. Check that the vendor also provide assessment services.

Your software applications should meet key design values (trusted, automated, etc.) when responding to each of the opportunities listed below.

- HIPAA Privacy and Security**
 Ensure that Protected Healthcare Information (PHI) is secure at rest and in transit. Utilize role-based security and login/password controls to protect this important patient data.
- Consumer Complaints via CFPB**
 Empower your organization to systematically enter, investigate, remediate and resolve consumer complaints. Leverage reports that highlight important consumer complaint trends.
- PPACA, the IRS and 501(r)**
 Control your Financial Assistance Program to ensure that it is fairly and equitably offered to your patients. Document FAP offers and activities to support your audit needs and IRS 990 filings.



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#7 *cont.*

- **Credit Reporting**

Ensure your technology platforms support the reconciliation of payments daily in light of credit reporting activity. Deploy a dispute resolution workflow that has been validated by internal and external experts. Leverage speech analytics that monitors account representative talk-offs and identifies policy and compliance concerns such as bartering the removal of a medical debt from a consumer's credit report in exchange for payment.

- **TCPA & Consented Contacts**

Capture patient consent for communication via their mobile device and ensure that it conveys to your business partners. With consent, you can pursue automated contact strategies (ATDS). Without consent, you cannot apply automation and instead need to dial these phone numbers manually. Seek a technology partner that will help you navigate these waters with minimal impact to operations and administration while maximizing your successful connections with your patients.



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Conclusion

Many healthcare executives remain with their heads in the sand when it comes to CFPB compliance issues – given the policies, regulations and language set forth by the Bureau, it's been a risky, but not impossible situation. But it's not long for this world. Start the conversations you need to have today before they become significant and material. You will make the same investment to meet your compliance requirements – take care of it before you are hit with a lawsuit or an audit.

For more information on the technology solutions available to help you prepare for the changes taking place in the healthcare receivables marketplace, please click the learn more button below.

[LEARN MORE >](#)

About Rozanne Andersen - Author

Over 15 years of experience as General Counsel, Chief Lobbyist, Executive Vice President and CEO of ACA International –The Association of Credit and Collection Professionals – and 14 years as a practicing attorney specializing in banking and financial services have made Rozanne one of the most respected experts in the industry. Her advocacy before both state and federal regulatory bodies and her influence over compliance enhancements integrated in the Ontario Systems product suite help our clients solve their most challenging legal issues, mitigate risk and navigate an increasing complex regulatory and legislative environment. Rozanne earned her J.D. from the William Mitchell College of Law.

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Steve is a 20+-year healthcare technology veteran, having served roles in software development, product management, customer service and business planning. Strategy, development and competitive analysis are Steve's bread and butter at Ontario Systems, where he brings channel partnership and strategic product management disciplines together to help healthcare clients achieve their most ambitious growth plans.



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