



CASE STUDY

Proactive Compliance Readiness: How One Health System Built LD 1937 Infrastructure Before the Deadline

CLIENT PROFILE

**Regional
Integrated
Health System**



Multi-hospital
network



Significant Medicare/
Medicaid and
underinsured patient mix



Existing financial assistance
program, but largely
manual workflow

Executive Summary

When Maine's LD 1937 was signed into law, most hospitals interpreted it as a policy update. This health system viewed it differently – as a structural operational mandate.

Effective July 1, 2026, LD 1937 requires hospitals to:

- Cap income-based payment plans (up to 400% FPL; 4% of monthly income)
- Provide multilingual, plain-language billing disclosures
- Pause collections while financial assistance applications are under review
- Respond to applications within 30/45-day timelines
- Provide secure, mobile-accessible online applications
- Maintain audit-ready reporting for DHHS submission

Rather than wait until Q2 2026, leadership made a strategic decision:

***Treat compliance as
infrastructure, not as a
last-minute billing update.***

The Challenge

Initial internal assessment revealed:

- Manual income verification processes
- Limited SLA tracking for financial assistance applications
- Fragmented communication between billing, collections, and financial counseling
- Vendor contracts not yet aligned to collection-hold requirements
- No centralized reporting engine capable of audit-level documentation

Leadership identified three primary risks:

1. **Regulatory Exposure** – Inability to meet statutory response windows.
2. **Cash Disruption** – Automatic collection pauses without workflow automation.
3. **Reputational Risk** – Non-compliant patient communication.

Strategic Decision: Build Compliance Before It Is Enforced

Instead of retrofitting policy language into statements, the organization pursued a structured readiness plan.

STEP 1

Formal Compliance Mapping

A documented compliance matrix was created aligning statutory requirements to operational deliverables.

This mapped:

- Legal requirement
- Deadline
- Technology enhancement
- Internal workflow ownership
- Reporting accountability

This moved the initiative from “policy revision” to enterprise readiness planning.

STEP 4

SLA Tracking & Workflow Discipline

30-day response requirements for complete applications and 45-day windows for incomplete applications require disciplined queue management.

The system deployed:

- Automated deadline alerts
- Escalation triggers
- Centralized dashboard tracking
- Executive-level oversight reporting

Outcome: Financial assistance became a managed operational process rather than an administrative afterthought.

STEP 2

Income-Verified Payment Plan Automation

LD 1937 mandates payment plan caps tied to family income levels.

The system implemented:

- Automated income-based plan generation
- FPL verification logic
- Dynamic monthly cap calculations
- Integrated eligibility prompts within billing workflows

Result: Manual calculator workarounds were eliminated, reducing compliance variance and improving enrollment accuracy.

STEP 5

Multilingual & Digital Accessibility

LD 1937 requires multilingual notices and secure online applications, with phased digital deadlines.

Enhancements included:

- Multilingual billing disclosures
- Plain-language eligibility explanations
- Secure, mobile-friendly application portal
- Document upload capability
- Dispute tracking functionality

Strategic benefit: Improved patient engagement while simultaneously satisfying statutory requirements.

STEP 3

Collection Pause Integration

The legislation requires that collections be paused while a financial assistance application is pending.

Operational changes included:

- Automated collection hold triggers
- Real-time status visibility between billing and collections
- Vendor coordination protocols
- Dashboard-based tracking of hold status

Impact: Eliminated risk of inadvertent collections activity during protected application windows.

STEP 6

Audit-Ready Reporting Infrastructure

The law requires logging and reporting of applications, denials, plans, and outcomes.

The organization implemented:

- Centralized compliance logs
- Quarterly reporting exports
- Documentation archives
- Executive compliance dashboards

Result: Preparedness for regulatory audit before enforcement begins.



Results: Readiness 9 Months Before Deadline

By Q4 2025, the organization had:

- Completed compliance mapping
- Automated income-based plan generation
- Integrated collection hold controls
- Established SLA governance
- Launched multilingual digital access
- Implemented reporting framework

Leadership now views financial assistance not as charity policy — but as an affordability operating platform.

Key Lessons for Health Systems

- 1 Compliance cannot live in policy binders.
- 2 Manual processes will not withstand audit timelines.
- 3 Vendor contracts must be aligned before enforcement.
- 4 Affordability and revenue integrity are not mutually exclusive.
- 5 State-level regulation is accelerating — Maine is not an outlier.

STRATEGIC IMPACT



1. Reduced Regulatory Risk

Compliance obligations embedded in workflow systems, not dependent on staff memory.



2. Stabilized Cash Performance

Payment plan automation maintained structured collections without violating caps.



3. Lowered Bad Debt Exposure

Earlier engagement through compliant financial assistance pathways.



4. Strengthened Community Trust

Transparent, structured affordability standards aligned with legislative intent.

Final Perspective

- Hospitals that treat state financial assistance reform as a billing nuisance will experience disruption.
- Hospitals that treat it as affordability infrastructure will strengthen both compliance posture and financial resilience.
- Maine's LD 1937 is not the end of the regulatory trend — it is the beginning of a multi-state operating model shift.