

Testimony of

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Good morning. My name is Scott A. Duke, Chief Executive Officer for the Glendive Medical Center (GMC) located in Glendive, Montana. I am also the current chair of the Montana Hospital Association's board of trustees. I appreciate the opportunity to testify today.

GMC is a not-for-profit, community-based health care organization that provides a full spectrum of medical services. Specifically, GMC is comprised of a 25-bed critical access hospital (CAH), 75-bed skilled nursing facility, 13-unit assisted living facility and a home care and hospice agency that serves four counties. GMC also operates the Eastern Montana Veteran's Nursing Home, an 80-bed skilled nursing facility. In addition, 22 physicians and mid-level providers practice at our facility and provide outpatient services at the Gabert Clinic, which is a federally designated rural health clinic (RHC). GMC employs more than 450 people.

Since the late 1800's, GMC has provided medical services to the citizens of Eastern Montana and Western North Dakota. Today, we serve an area with approximately 15,000 people. Three other CAH's are located within a 50-mile radius of Glendive.

The nearest large, tertiary care hospitals are a three-hour drive to the west in Billings, Montana and to the east in Bismarck, North Dakota. GMC is fortunate to have a local volunteer ground ambulance service and access to fixed wing air medical transport to transfer patients to these facilities.

GMC's mission statement is very straightforward: "We are committed to caring, healing and a healthier community."

We attempt to fulfill this mission in a variety of ways. As in all of Montana's not-for-profit hospitals, one way we do this is to provide medical treatment to anyone in need - regardless of their ability to pay.

Our facility has a clearly-spelled out policy for providing financial assistance to patients. Under this policy, persons whose income is at or below 100 percent of the federal poverty level are eligible to receive care at no charge.

Persons whose income is between 100 and 200 percent of the federal poverty level are eligible to receive financial assistance based on their income and assets. Our policy also includes assistance for catastrophic events and loans without interest if persons fail to qualify for assistance using the other criteria. I have attached a copy of these policies to my testimony.

We also take steps to ensure that patients know about and understand our policy. The "Patient Notice of Financial Aid" is given to every patient at admission, along with a patient-friendly description of the facility's financial assistance program.

Using these policies, in 2005, GMC provided nearly \$457,000 in charity care and almost \$1.5 million in uncompensated care.

GMC has a long and proud history of making investments in our community's health and well-being. In 2005, our facility provided more than \$1.3 million of community services at no charge. These services ranged from health screenings, telemedicine mental health consultations, scholarships, transportation, subsidized health services and economic development - to name just a few.

Overall, in 2005, GMC provided a total of \$3,286,057 in community benefits to the Glendive area, including charity care, community services for which we weren't paid, bad debt and the shortfall in Medicare and Medicaid payments. All of these figures are based on cost - not charges.

The total community benefit provided by GMC represents 15 percent of its operating expense and nearly four times GMC's tax obligation if it were a taxable entity.

Since 1999, GMC has voluntarily reported its community benefits, following the model established by the VHA. A summary of the 2006 report is included in my testimony.

GMC is typical of the general, acute-care community hospitals in Montana. These hospitals are the cornerstone of Montana's health care system. All of Montana's not-for-profit hospitals - no matter how big or small - are run by boards made up of community members. They tailor their services to meet the unique needs of the communities they serve.

Twelve of Montana's 57 hospitals are VHA members; another five are CHA facilities - all of whom use the VHA/CHA model as the starting point for reporting their community benefits.

Montana's hospitals have taken an additional step toward publicly demonstrating that we are fulfilling our charitable responsibilities.

The Montana Hospital Association (MHA) Board of Trustees recently adopted several policies regarding charity care, financial assistance and community benefit reporting. The board made clear that members are expected to meet these standards. These policies are attached to my testimony.

One of these policies relates to serving uninsured patients with limited means. Members are expected to provide care at no charge to uninsured patients whose income is less than 100 percent of the federal poverty level.

For uninsured patients whose income is between 100 and 200 percent of the federal poverty level, members are expected to provide financial assistance. This assistance can be on a sliding scale based on income, assets and other considerations. The MHA policy also makes clear that members are expected to work with patients to ensure that they understand the cost of their treatment, their payment options and billing and collection practices.

Another policy relates to identifying and reporting community benefits. Under this policy, members are expected to conduct a periodic community needs assessment, assign a staff person responsible for developing a community benefit plan, and identify and compile their community benefits. At a minimum, this compilation should be distributed to the full community annually.

The MHA approved policy strives to achieve consistency in reporting community benefits and, with two exceptions, follows the definitions of community benefits incorporated in the CHA and VHA model.

We differ with CHA and VHA in that we expect members to report the unpaid costs of Medicare and bad debt. We believe these costs are legitimate benefits provided to the communities we serve.

The MHA policy establishes three methods that facilities can use to compile and report community benefit information. In doing so, MHA recognized that frontier and rural hospitals in Montana - as in other states - face obstacles not faced by hospitals in urban areas. Given their many struggles, the mere fact that these facilities exist could be argued as justifying their community benefit.

Each facility is expected to select one of the three methods to identify their community benefits. Specifically facilities can:

- Using the list of community benefits as defined by CHA/VHA, list the activities in which they are engage and provide their bad debt and unpaid Medicare costs.
- Using the list of community benefits as defined by CHA/VHA, list their activities and the direct cost of engaging in those activities and provide their bad debt and unpaid Medicare costs.
- Complete the CHA/VHA Community Benefit Reporting document. In addition, members are expected to provide their bad debt and unpaid Medicare costs.

We developed this three-tiered system in recognition of the obstacles many CAHs would face if they were forced to complete the entire CHA/VHA Community Benefit Reporting document. Many CAHs staff their business office with only one or two people. It's all they can do to keep up with the routine business requirements.

Even though we don't require these facilities to complete the CHA/VHA document, we do expect them to, at a minimum, list the community services they provide, and where possible, their costs.

Montana's hospitals believe a voluntary system such as the one I've outlined is far superior to a one-size-fits-all federal mandate.

We recognize the need to demonstrate that we are fulfilling our obligation to serving community needs, and we underscore the importance of enabling communities to demonstrate their accountability in a way that fits their local circumstances.

The current Internal Revenue Service standard provides the flexibility we need to adapt our services to the specific needs of our communities. I urge the committee not to take any actions that would alter that standard and impose obligations on us that don't fit with the needs of our community. A standard designed for Manhattan in the heart of New York City, will be irrelevant to the community of Manhattan, Montana.

Montana's hospitals have a strong overall record of providing charity care and community benefits. According to an MHA survey conducted earlier this summer, virtually all of our state's hospitals have a charity care policy. Most of these policies fit within the guidelines established by the MHA Board of Trustees.

Last year, Montana's hospitals provided about \$100 million in uncompensated care, according to the MHA/AHA Annual Survey of Hospitals.

In addition, each year, Montana's hospitals also provide millions of dollars worth of community services at no charge.

We believe this evidence demonstrates our commitment to our communities and to the obligation we face as tax-exempt organizations.

Thank you for this opportunity to testify.