

Statement of the Greater New York Hospital Association on Resolution No. 1724, Access to Mammography at a Public Hearing Held by the New York City Council's Committee on Health June 20, 2001
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Good morning. I am Susan S. Stuard, Director of Regulatory Affairs for Greater New York Hospital Association (GNYHA), which represents the interests of 175 hospitals and continuing care facilities in New York City and surrounding areas. With me today is Doris R. Varlese, Esq., Associate General Counsel for GNYHA. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions that provide state-of-the-art, acute tertiary care while, at the same time, often serving as the principal source of primary care in their service areas. GNYHA members and their related medical schools also provide extensive medical education and training and undertake cutting-edge medical research that will benefit generations to come. Finally, GNYHA members often act as the anchor for their communities by providing health care as well as other needed social services, employment, and community and urban development.

I thank you for the opportunity to appear before you today to discuss access to mammography in the City of New York. Mammography is a critical tool in the early diagnosis of breast cancer and a procedure that positively contributes to women's health. In the last decade, health care providers, the American Cancer Society, and other breast cancer advocacy organizations have made great steps in promoting mammography as the best tool available to diagnose breast cancer in its earliest stages. But providers are facing serious hurdles in their efforts to offer mammography services on a timely basis. Poor reimbursement rates, program closings, and restrictive regulatory requirements are putting mammography programs at risk. GNYHA appreciates that the New York City Council Committee on Health is turning its attention to this important issue and GNYHA urges the Committee to continue its effort to secure more appropriate reimbursement for mammography. In particular, we would like to commend the Committee for Resolution No. 1813 calling on the United States Congress to pass Senate Bill (S548) entitled Assure Access to Mammography Act 2001. This bill seeks to increase Medicare reimbursement for mammography and provide additional support for training of radiologists. Before speaking more on factors specific to mammography, I think it is essential that I present an overview of the context in which this care is delivered.

I. CIRCUMSTANCES FACING GNYHA MEMBERS

Virtually every hospital in the Greater New York area is a member of GNYHA. The vast majority of our hospital members are teaching hospitals, which means that in addition to providing patient care, they also train a considerable number of medical residents. They provide a significant amount of uncompensated care to the large numbers of uninsured and underserved individuals who rely on our member hospitals for health care. Together, these two "public goods," medical training and charity care, for which New York City hospitals are known nationwide, have taken their toll. The following describes the resulting circumstances facing our hospitals.

The Worst Margins in the Country. Notwithstanding the high esteem in which GNYHA member hospitals are held, they are, as a group, the most financially fragile hospitals in the country. For years, New York City's hospitals, both voluntary and public, have had the worst margins, ratios, and other financial indicators of hospitals anywhere in the United States. For example, in 1999, New York hospitals ranked 42nd (out of 45 states reporting) for operating margins and cash flow to total debt ratio. This situation stems in part from the historic tight rate reimbursement system imposed by New York State. However, more recently, the Federal

Balanced Budget Act's Medicare cuts, the overnight deregulation of the state's hospital reimbursement system, and managed care abuses have also contributed to the poor financial circumstances facing area hospitals.

Continued Financial Deterioration. Given the foregoing factors, the financial condition of New York City's hospitals continues to deteriorate. For example, in 1999, New York City hospitals had an operating margin of -1.00%. To the extent that data are available for 2000, the collective operating margin has fallen to -2.04%. In fact, 73% of New York City hospitals (31 hospitals out of 48 sampled) tracked by GNYHA had a negative operating margin for the first three quarters of 2000. This financial deterioration has been widespread, and if it continues New York City hospitals will have to make further cuts in service.

Caring for the Area's Uninsured. Perhaps one of the biggest problems contributing to the poor financial performance by New York City hospitals is the large number of uninsured and underinsured individuals cared for by our hospitals as well as the nature of the problems that those patients present. The proportion of New York's population that is uninsured has grown faster than the national average, such that 28% of the under-65 population in New York City is uninsured. Most of these uninsured individuals have incomes that are too low to pay directly for their medical care, and therefore hospitals provide a significant amount of uncompensated care. Although the State provides a funding mechanism for covering some of these costs, hospitals receive less than half of what they spend on care for the uninsured.

Providing Services to Special Needs Populations. GNYHA's members also serve large numbers of special needs populations, including a large proportion of Medicaid and indigent patients and individuals suffering from AIDS, substance abuse problems, and mental health problems. Given the lack of primary care in many areas of the City, GNYHA members also often act as the sole source of health care for the patients in their service areas and have created extensive outreach and community health services. Their patient populations are of course reflective of the diverse populations that live in New York City, and GNYHA's members have developed and continue to develop new programs and services to meet the health care needs of this culturally and linguistically diverse area.

II. ACCESS TO MAMMOGRAPHY

In this difficult financial environment, New York City hospitals seek to supply a full array of health care services and are struggling to provide these services in a high quality and timely fashion. In the case of mammography, however, there are several extenuating circumstances that make this service a complex and resource-intensive undertaking for our providers. First, there has been an increase in demand for mammography as breast cancer screening has been incorporated into primary care guidelines. Second, mammography is one of the most highly regulated areas of health care, creating a significant administrative burden that does not exist in other areas of health care. Third, while mammography is the best tool available for diagnosing breast cancer, it is a subjective study and known to miss 10-15% of breast cancers, no matter how careful the provider may be. As a result, mammography has some of the highest rates of malpractice lawsuits, making it an expensive service to operate. And fourth, but most important, reimbursement rates for mammography are so low that many mammography centers lose money on every patient seen.

Increasing Demand For Mammography Services. There is reason to believe that patient demand for mammography is increasing. The American Cancer Society and other breast cancer advocacy organizations have, in the last decade, successfully promoted regular screening mammography for women ages 40 and over as the best practice in breast cancer detection.

When forced to confront scarce resources, however, many providers are choosing to prioritize diagnostic as opposed to screening mammography.

By way of explanation, there is an important distinction between the screening and diagnostic mammography. Screening mammography is a procedure undertaken for the early detection of breast cancer. The patient should not be symptomatic and a physician's order is not required for the procedure to be covered by health insurance. Diagnostic mammography is performed when there is reason to believe that the patient is symptomatic, either because a finding was noted upon physical examination or the patient has a prior history of breast cancer or other suspicious findings. Diagnostic mammography is covered by health insurance when ordered by a physician.

So when hospitals place the priority on diagnostic mammography, they are attempting to treat symptomatic women as quickly as possible. Caring for symptomatic women, however, can leave routine screening programs without the needed resources to meet growing patient demand.

Intensely Regulated Industry. Mammography is one of the most intensely regulated areas of health care. Hospitals offering mammography services not only maintain an operating license with New York State and accreditation with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), but must also meet the requirements of both the Mammography Quality Standards Act (MQSA) and the American College of Radiology (ACR). MQSA operates under the auspices of the Food and Drug Administration and has been conducting annual accreditations of mammography programs since 1992. ACR accredits mammography programs at three-year intervals with annual updates during that interval. These regulatory bodies are endowed with significant authority over the operations of mammography facilities. For example, MQSA has the authority to order the immediate shut down of a mammography facility if the program does not meet its strict requirements for equipment, quality assurance, record keeping, staff training and education, film quality, and patient notification.

Meeting the requirements of multiple regulatory bodies creates administrative and program demands that threaten to overwhelm some mammography programs. For example, by October 2002, MQSA requires all mammography machines to include additional safety features such as hands-free compression control and reduced radiation output. These requirements render obsolete most mammography units bought prior to 1995 and means that programs wishing to continue operations must purchase new machines at a cost of \$80,000 to \$90,000 per unit. Hospital mammography programs already operating at a loss may be unable to meet this additional capital expenditure and, as a result, be forced to stop mammography because their equipment does not meet MQSA requirements. This looming regulatory requirement threatens to decrease an already shrinking mammography capacity in New York City and across the country.

Mammography Is A Subjective Test. Despite the fact that some breast cancers are unobservable via mammography, it is the best tool currently available for the early diagnosis of this cancer. As indicated, mammography is a subjective test known to miss 10-15% of breast cancers, no matter how careful the provider may be. Since the test is not foolproof and relies on subjective interpretation, mammography precipitates an extraordinarily high rate of malpractice lawsuits making it expensive to initiate and maintain a program. In fact, an alleged error in diagnosing breast cancer is the reason most cited in malpractice lawsuits (American Journal of Radiology, November 1999, Vol 173, pp. 1161-1162). The effort to manage lawsuits and procure appropriate malpractice insurance consumes significant resources, thus adding to the overall

costs of operating a mammography program.

Mammography Programs Cannot Cover Costs Because Reimbursement Rates Are Too Low. At the current rate of reimbursement under Medicare, \$69.23 for screening mammography, providers cannot cover their operating costs. GNYHA's members estimate that the actual cost to provide a mammogram in New York City is between \$100 and \$120. As a result, hospitals lose money on mammography - up to \$50 on every procedure. This poor reimbursement also creates a disincentive to add mammography capacity because a bigger program will simply mean losing more money. And since Medicare sets the standard for reimbursement in health care, most private health insurance companies base their reimbursement upon the rate set by Medicare.

Given the low reimbursement for mammograms, private practice providers are eliminating this service. A private practice seeing 20,000 mammography patients annually, East River Medical Imaging Associates, has been very public about its elimination of this service due to low reimbursement and high administrative burden. In fact, since September 1999, 247 mammography clinics nationwide have shut their doors. These closings clearly indicate that reimbursement is too low. If private practices cannot cover their costs for mammography, they can choose to stop providing the service. But because hospitals have a mission to provide care, they often continue to provide mammography even if the program operates at a loss. But as more patients are forced into hospital programs for mammography, waiting times increase and a hospital may not have the financial resources to add capacity to a program whose deficit will only increase as patient volume increases.

III. Conclusion

GNYHA would like to thank the City Council for the opportunity to appear before you and discuss access to mammography in New York City. We would also like to commend the Committee for Resolution No. 1813 calling on the United States Congress to pass Senate Bill (S548) entitled Assure Access to Mammography Act 2001. This bill seeks to increase the rate of Medicare reimbursement for screening mammography from \$69.23 to \$90.00 and provide support for training of radiologists. The Council's support of this bill will be of material assistance as GNYHA advocates for an increased mammography reimbursement. We also stand ready to work with the New York City Council Committee on Health as you consider additional mechanisms to address access to mammography.