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Why Estimating Low-Value Care at a State Level is Valuable

By Beth Beaudin-Seiler, PhD, and George Miller, PhD

The low-value care assessment movement has typically included national level estimates, whether they pertain to Medicare, Medicaid or commercially-insured populations. The findings usually suggest there are extensive levels of low-value care occurring among all populations.[1,2,3,4] In a research study by the Research Consortium for Health Care Value Assessment in 2018, baseline estimates of a very select set of low-value and high-value care services was completed. The data used was a large commercially insured claims data set and, like other similar research studies, results were extrapolated to the national, commercially insured population. Results suggest that we are not making much progress on curbing the use of the selected low-value care services nor increasing utilization of the selected high-value care services.[5]

Recent research that updated the estimates on the various levels of waste in the health care system suggests that, conservatively, 20-25% of total health care expenditures in the United States are wasteful.[6] In a country that spends over $3.5 trillion dollars (17.9% of the GDP), that translates to over $800 billion in low-value or no value expenditures annually.[7] While not all those wasteful dollars can be attributed to low-value care services, those findings are startling to say the least. They can also be hard to digest and contribute to difficulty for representatives of individual states to understand where to begin in order to make positive change. What if instead of the national lens, we looked at estimates of low-value care on a state level?

How do different areas of the country compare on wasteful spending? What can be learned by looking at estimates of low-value care at a state level? The concept of estimating low value care at a state level can bring the picture into better focus and provide a roadmap of sorts on where to focus attention and resources appropriately. It should not be used to give ourselves a pass and to say, “Well, at least we’re not doing as badly as that other state.” Rather, state level estimates should be used to say, “I wonder why that state has a lower waste prevalence? Are there regulations, laws, and policies that we could implement that might reduce our levels of low-value care to similar levels?”

A growing number of states have All Payer Claims Databases[8] at their disposal to help in understanding the prevalence and costs associated with the claims occurring in their state. There are sound examples of what states can do to examine the level of low-value care occurring in their population. Washington,[9] Minnesota,[10] and Virginia[11] have contributed meaningfully to the discussion of low-value care services in their states.

In a study by the Research Consortium for Health Care Value Assessment in 2019, we provided state-level estimates of twenty low-value care services. Using a large dataset for a national commercially insured population, the data were weighted by sex and age of the commercially insured population of each state to extrapolate to the state’s commercially insured population. A composite score was calculated for each state based on the occurrence of these low-value care services.

These findings suggest that there is substantial variance (9%-20%) among states in the prevalence of these low-value services, prompting questions about why this might be happening, such as:

- Are patients significantly different among states?
- Are health care cultures significantly different among the states?
- How does how we train our health care professionals impact how they practice medicine?
- Do some states have regulations helping or hindering their ability to combat low-value care?

All these questions help to focus our attention and resources and could meaningfully broaden the conversation of low-value care.

Measuring low-value care at a state level is important. It allows us to digest these estimates at a more detailed level and help visualize the variances that occur state to state. It allows us to focus our attention on understanding why things may differ from one state to the next. This, in turn, can help us better allocate our resources on the most effective initiatives to reduce low-value care.

Notes

1. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1868536
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4314495/
3. https://www.ncbi.nlm.nih.gov/pubmed/24374418
4. https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4079-0
5. https://www.hcvalueassessment.org/application/files/5915/5853/6278/Research_Consortium_Research_Brief_No._1.pdf
6. https://jamanetwork.com/journals/jama/fullarticle/2752664?guestAccessKey=bf8f9802-be69-4224-a67f-42bf2c53e027&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=100719
7. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf
8. https://www.apcdcouncil.org/
9. https://wahealthalliance.org/wp-content/uploads/2018/12/First-Do-No-Harm_December-2018_FINAL11_29.pdf
10. https://www.health.state.mn.us/data/apcd/docs/lvsissuebrief.pdf
11. https://www.ajmc.com/journals/ajac/2019/2019-vol7-n2/reducing-lowvalue-care-in-virginia

ABOUT US

The Research Consortium for Health Care Value Assessment is a partnership between Altarum and VBID Health, with funding from the PhRMA Foundation as part of its Value Assessment Initiative, established to promote the pursuit of value in health care delivery in the U.S.

Contact: Beth Beaudin-Seiler, Ph.D., 3520 Green Court, Suite 300, Ann Arbor, MI 48105

(734) 302-5691 | www.hcvalueassessment.org | @ValueConsortium

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