

Reducing Low-Value Care Is a Feasible Approach to Enhancing Access to and Affordability of High-Value Care for Older Americans

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The 60 million Americans who are 65 years or older are frequently confronted with financial and structural barriers to receiving high-value clinical services.¹ Older adults report delaying or forgoing necessary medical care due to financial costs,² and in 2022, 3.5 million older adults with Medicare Part D had difficulty paying for their prescription medications.²⁻⁵ A population that is increasing in medical complexity, older adults face ongoing health system navigation and care coordination challenges.¹ The 2023 *National Healthcare Quality and Disparities Report* highlights the critical need to promote the health of the aging population through improved delivery of clinical preventive services and earlier and better care for older patients with chronic health conditions.⁶

In this issue of *The American Journal of Managed Care*, Barthold et al linked data from the Health and Retirement Study to traditional Medicare claims data to quantify the use of selected high- and low-value health services delivered to older adults with and without cognitive impairment.⁷ Overall, 20% to 50% of individuals in the study sample did not receive the specified high-value medications, and 60% to 97% of individuals did not receive selected high-value vaccines throughout the study period (1996-2018). Delivery of 3 high-value services (antihypertensives, glucose-lowering drugs, and antiresorptive therapy) was significantly less likely in older adults with cognitive impairment or dementia compared with those with normal cognitive status. These disappointing results reflect a missed opportunity to improve chronic disease management, mitigate adverse events, improve quality of life, and potentially reduce medical expenditures for older adults.

Although not directly addressed in this study, well-established factors such as decreased mobility, lack of transportation, limited access to technology, challenges with completing required paperwork, and the rising shortage of gerontology-trained clinicians are likely contributors to these discouraging findings. Multipronged implementation strategies and innovative funding mechanisms that do not increase costs are needed to enhance access to and affordability of high-value care for all older Americans. Moreover, such efforts should prioritize individuals with known social and structural barriers to high-value health care, including members





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of racial/ethnic minority groups, individuals living in underserved communities, and those with certain medical conditions such as dementia.

In the study by Barthold et al, selected low-value services—defined as health services that offer no net clinical benefit in certain scenarios—were delivered to 4% to 13% of older adults during the 23-year study period.⁷ Although the reported rate may seem modest, only 5 low-value services were studied. Taking additional frequently used low-value services and the size of the population into account would better ascertain the true magnitude of low-value care use among older adults.

Lessening the substantial clinical and emotional harm, eliminating the associated unnecessary medical service cascades, and avoiding contributions to health care disparities⁸⁻¹³ are reasons enough to prioritize the deimplementation of low-value care. In addition, the allocation of savings resulting from a reduction in low-value care utilization is a feasible strategy to fund increased spending on high-value services. The potential pool of funds is considerable, as estimates of Medicare spending annually on unnecessary services are in the billions of dollars.¹⁴ Further, it is important to note that out-of-pocket spending on low-value care is not trivial.¹⁵ Of the \$630 million paid for 48 low-value services by commercial payers in 4 states, nearly \$100 million was paid directly by patients.¹⁶

The mechanisms by which reducing low-value care can increase capacity for high-value care delivery are numerous, most notably including:

- Reduce patient burden.** Older adults spend an average of 21 days per year interacting with the health care system.¹⁷ For many older patients, using health services requires transportation assistance, support from families or caregivers, exposure to illness, and missing out on other opportunities. It can also be stressful and exhausting.¹⁸ Those with cognitive impairment or multiple medical conditions may be particularly impacted. Obtaining low-value health services contributes to the burden associated with seeking health care. 
- Improve clinician productivity.** The COVID-19 pandemic exacerbated the high demands, administrative burden, resource shortages, and rate of burnout faced by clinicians.¹⁹ Low-value care creates unnecessary workload. Decreasing the provision of unnecessary care is one mechanism for reducing clinician workload, thereby creating time and capacity to provide high-value care.²⁰ 
- Enhance resource stewardship.** Delivery of low-value health services to patients who are unlikely to benefit limits access by patients likely to benefit. For example, up to 1 in 5 screening colonoscopies are delivered to patients who exceed the recommended screening age,^{21,22} a trend that continued throughout the COVID-19 pandemic despite dramatic reductions in screening capacity.²³ Delays in screening are associated with delayed diagnoses and poorer patient outcomes. Limiting delivery of low-value colorectal cancer screenings can reduce the screening backlog for the more than 55 million Americans who are eligible but not up to date on colorectal screening.²⁴ 
- Increase spending efficiency.** Reallocating spending for unnecessary low-value care to enhance the delivery of high-value services is a potential approach to improve patient satisfaction, reduce disparities, and improve quality *without increasing costs*. For example, our team demonstrated that the potential savings incurred from reducing unnecessary cervical cancer screening (not concordant with current guidelines) would be nearly enough to fully eliminate patient cost sharing for clinically necessary follow-up care after an abnormal initial cervical cancer screening test.²⁵ 

Although sobering, the finding by Barthold et al of large gaps in quality of care provided to older Americans—disproportionally greater among more vulnerable older adults with cognitive impairment—is not surprising, and it is consistent with prior research.^{26–28} Given the troubling persistence of these undesirable outcomes,

coupled with the dearth of affordable, implementable solutions, we should more seriously consider a strategy that reallocates the substantial workforce effort and financial resources currently devoted to low-value care to enhance access to and affordability of high-value services. This approach requires aligned incentives for patients (eg, lower cost sharing), providers (eg, no prior authorization, adequate reimbursement), and payers (eg, cost neutral) that could produce a rare win-win-win scenario of better patient-centered outcomes, enhanced safety and equity, and increased value of health expenditures. ■

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