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A dated, versioned report generated from public Medicare data and published behavioural literature. It is not a product brochure: no screenshots, no calls to action, no customer logos. Every figure resolves to the Source Register; reproducible concentration curves cite the deposited benchmark DOI.

Benchmark DOI: 10.5281/zenodo.22051812 <https://doi.org/10.5281/zenodo.22051812>

Web: /risk#buyer-report PDF: /api/publication/buyer-report

1. What claims show about low-value imaging concentration

Claims data show that low-value imaging spend is concentrated - among services, among orderers, and among duplicate windows - long before any vendor intervention.

The deposited inpatient imaging benchmark (10.5281/zenodo.22051812) is cited so concentration curves and rate decompositions can be reproduced from a public artefact, not retyped from a slide deck.

Figures below mix measured Medicare-shaped public samples with modeled intervals from the same modules that power the baseline self-check. Modeled figures are labelled and never substituted where a measured public one exists.

[measured] Share of low-value spend in the twenty highest-volume Schwartz services: 95.0% source: schwartz-al-landon-be-elshaug-ag-chernew-me-mcwilliams-jm-measuring-low-value-ca (Schwartz AL, Landon BE, Elshaug AG, Chernew ME, McWilliams JM. Measuring Low-Value Care in Medicare. *JAMA Intern Med.* 2014;174(7):1067-76.) Schwartz et al. Medicare concentration claim applied to the measure set.

[modeled] Non-imaging low-value pool carried by the top twenty services (Expand II method): 95.0% source: schwartz-al-landon-be-elshaug-ag-chernew-me-mcwilliams-jm-measuring-low-value-ca (Schwartz AL, Landon BE, Elshaug AG, Chernew ME, McWilliams JM. Measuring Low-Value Care in Medicare. *JAMA Intern Med.* 2014;174(7):1067-76.) Modeled onto Vol III ?9 per-attributed-life arithmetic; not a customer figure.

[modeled] Low-value share of advanced imaging (Route A anchor): 30.0% source: medpac-low-value-care-analyses-schwartz-measures-applied-to-medicare (MedPAC low-value care analyses (Schwartz measures applied to Medicare)) MedPAC / Schwartz band midpoint used in the public self-check.

[measured] Top-decile share of low-value imaging spend (reliability-adjusted): 49.7% source: cms-de-synpuf-data-entrepreneurs-synthetic-puf (CMS DE-SynPUF (Data Entrepreneurs' Synthetic PUF)) DE-SynPUF public sample; lead with reliability-adjusted curve per Part A.4.

[measured] Top-decile share of low-value imaging spend (raw, measurement-error biased upward): 53.9% source: cms-de-synpuf-data-entrepreneurs-synthetic-puf (CMS DE-SynPUF (Data Entrepreneurs' Synthetic PUF)) Shown for honesty; not the headline figure.

[modeled] Modeled low-value advanced-imaging spend at 100,000 attributed lives: \$4,000,000-\$5,000,000 source: medpac-low-value-care-analyses-schwartz-measures-applied-to-medicare (MedPAC low-value care analyses (Schwartz measures applied to Medicare)) Interval from lib/selfcheck/compute.ts; not a point estimate.

[illustrative] Duplicate share of specified advanced-imaging studies (strict window): 100.0% source: cms-de-synpuf-data-entrepreneurs-synthetic-puf (CMS DE-SynPUF (Data Entrepreneurs' Synthetic PUF)) Illustrative public sample under docs/duplicate-spec.json.

2. Variation between organisations - and by how much

Organisations differ materially in baseline low-value imaging rates before any behavioural programme is switched on. The Duke observational cohort reported a 4.2? spread between top- and bottom-decile orderers at baseline - one network, no concurrent control, but a measured starting dispersion.

Payer mix and contracted allowed amounts widen the dollar band further: the public self-check scales the same event counts by line-of-business price tilts drawn from published Medicare-commercial spreads.

Cross-organisation platform benchmarks exist only under explicit medical-director consent and differential-privacy release; this report does not show a customer-specific rate.

[measured] Baseline top-decile : bottom-decile imaging variation (Duke Primary Care network): 4.2? source: halpern-2021 (Halpern DJ, Clark-Randall A, Woodall J, Anderson J, Shah K. Reducing Imaging Utilization in Primary Care Through Implementation of a Peer Comparison Dashboard. J Gen Intern Med. 2021 Jan;36(1):108-113.) Baseline top-decile:bottom-decile variation 4.2?; year-one median imaging rate 217.3% (within-network pre-post)

[measured] Top-down imaging-and-testing LVC pool band (per 100,000 lives): \$4.0M-\$5.0M source: updating-a-claims-based-measure-of-low-value-services-applicable-to-medicare-fee (Updating a Claims Based Measure of Low-Value Services Applicable to Medicare Fee for Service Beneficiaries *1 Gen

Peer comparison in imaging has not been randomised in an ACO-attributed cohort; the Duke observational work cannot separate intervention from secular trend.

[modeled] Randomised imaging peer comparison in risk-bearing primary care: not measured in published literature source: halpern-2021 (Halpern DJ, Clark-Randall A, Woodall J, Anderson J, Shah K. Reducing Imaging Utilization in Primary Care Through Implementation of a Peer Comparison Dashboard. J Gen Intern Med. 2021 Jan;36(1):108-113.) Observational imaging work exists; RCT gap remains.

[modeled] Link from monthly peer packet to retained shared savings: not measured source: mssp-aco-shared-savings-program-pufs (MSSP / ACO Shared Savings Program PUFs) LEAD / MSSP rails exist; intervention attribution does not.

5. Implications

The concentration and variation figures above are inputs to a total-cost-of-care improvement forum, not a vendor pitch. ARKA's analysis implication is that measurement substrate and intervention layer must be kept separate: public Medicare and trial literature tell you where spend concentrates and which behavioural arms worked in analogous settings; they do not, by themselves, produce a locked pre-period, a risk-adjusted monthly peer packet, or attributed shared savings.

Source Register: /sources