Policy Brief
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PROJECT FOR REDUCING INEFFECTIVE MEDICAID EXPENDITURES

A Framework for Identifying and Addressing Low-Value Care in Medicaid

The United States spends significantly more on health care than other highly developed countries in the world.[1] According to the National Health Expenditure Accounts, US health care spending reached $5.3 trillion dollars in 2024, accounting for 18% of gross domestic product.[2] Multiple studies have found that much of health care spending is wasteful,[3] with "low-value" care accounting for an estimated ~$100 billion in health care spending annually (Box 1).[3] Recent fiscal pressures have increased the importance of ensuring that Medicaid resources are directed toward high-value care.[4] The Center for Evidence-based Policy (Center) created the Project for Reducing Ineffective Medicaid Expenditures (PRIME) to help state decision makers identify and address low-value care in state Medicaid programs. The overall purpose of PRIME is to identify Medicaid-covered services that may warrant coverage review due to limited or no demonstrated benefit relative to harms.

Box 1. What is Low-Value Care?

Low-value care is defined as health care services for which[5,6]:

- No or little benefit for patients is provided
- The risk of harm is greater than the expected benefits
- An alternative treatment that is more effective or less harmful exists
- The expected benefits of the treatment do not justify the cost of the intervention
- The intervention is overused or used inappropriately

FRAMEWORK FOR IDENTIFYING AND ADDRESSING LOW-VALUE CARE

Center researchers reviewed published literature addressing low-value care and developed a 6-step process to assist Medicaid leaders in identifying and addressing low-value care. We applied this process to 4 use cases and prepared reports to serve as example cases (Box 2).

Box 2. PRIME Briefs

The Project for Reducing Ineffective Medicaid Expenditures (PRIME) used a practical framework to identify and analyze 4 interventions that may constitute low-value care. These 4 policy briefs are available on the Center for Evidence-based Policy's website:

- Expanded Respiratory Panel Testing and Unspecified Infection Panel Testing
- High-Complexity Genetic Testing
- Urine Drug Screening
- Residential Treatment for Opioid Use Disorder Without Follow-Up Medication

1 Identify Services That May Represent Low-Value Care

Several research articles discuss strategies state officials may use to identify potential low-value services.[7-11] Our research suggests that the following sources and activities may help states identify low-value care services:

- **Data analytics**: tracking claims data or other data sources to identify increases in utilization or spend can identify services for further investigation.
- **Evidence reviews**: health service researchers frequently publish systematic reviews of evidence for certain interventions or conditions. When reviewing such sources, however, it is important to look for potential conflicts of interest or bias in the reporting. Several states have oversight boards that review evidence for health care services for their public payers. These reports are public and may be used by other state policymaking bodies. In addition, several research groups publish evidence reviews for selected health technologies and services. See Box 3 for a list of trusted evidence sources. The Center for Evidence-based Policy also conducts workshops for state officials to help them understand how to use evidence as a foundation for health policy (Box 4).
- **Clinical practice guidelines**: Professional societies frequently publish clinical practice guidelines that review and make recommendations about evidence-based treatments and services. As with systematic reviews, it is important to look for conflicts of interest and bias in guidelines. In addition, caution is advised since some guidelines recommend treatments despite acknowledging that evidence is low quality or base their recommendations solely on expert opinion without sufficient evidence.
- **Clinician recommendations**: Trusted clinicians who serve Medicaid patients may help identify potential low-value services. Between 2012 and 2023, the American Board of Internal Medicine's (ABIM) Foundation managed the *Choosing Wisely* campaign that worked with medical specialty societies to identify tests and treatments commonly used but lacking sufficient evidence.[12] The project is no longer active, but ABIM states that "specialty societies are encouraged to publish individual lists" of low-value services.[12]
- **Federal reports and guidance**: The US Department of Health and Human Services Office of the Inspector General publishes reports on services that may be inappropriately used in federal health care programs and could be a source for identifying possible low-value services.
- **Marketing materials**: services or treatments that are heavily marketed by manufacturers may warrant attention from state policymakers. Advertising and marketing to clinicians has been shown to increase utilization and costs.[13-15]
- **Peer-to-peer sharing**: state Medicaid agencies face common challenges in addressing low-value care and may benefit from sharing experiences with colleagues in other states.

After using the sources and activities described above to generate a list of potentially low-value treatments or services, policy makers should consider the following questions:

- What is the evidence of clinical benefit?

- Is there evidence of harm?
- Is utilization highly variable?
- Is spending substantial?

The answer to these questions can help generate a list of potential low-value services. The next step is to evaluate whether items on the list should be addressed.

Box 3. Sample Trusted Evidence Sources

Three states operate public committees who commission evidence reviews of health services to guide coverage decisions in their state health care programs. These bodies publicly post their reports, and they may be accessed and used by other states in their coverage decisions.

- New York State Medicaid Evidence Based Benefit Review Advisory Committee
- Oregon Health Evidence Review Commission
- Washington Health Technology Assessment

The Center for Evidence-based Policy also manages 2 state collaboratives that produce evidence and policy reports for state Medicaid officials. The Drug Effectiveness Review Project (DERP) conducts research to help policymakers with drug coverage decisions, and the Medicaid Evidence-based Decisions Project (MED) produces reports on non-pharmacy treatments, interventions, and programs.

In addition, the following organizations review evidence for certain health technologies and treatments and make their reports publicly available for use.

- Peterson Health Technology Institute conducts independent evidence reviews of digital health technologies
- Institute for Clinical and Economic Review (ICER) produces evidence reviews for medications
- The Agency for Healthcare Research and Quality (AHRQ) conducts evidence reviews for the Centers for Medicare & Medicaid Services
- The US Preventive Services Taskforce (USPSTF) issues evidence-based reports with recommendations about coverage of clinical preventive services
- Cochrane Library is a collection of databases that compile high-quality, independent evidence reviews for health care decisionmakers

- Campbell Collaboration is a global organization that compiles evidence syntheses on social policy issues

Box 4. Evidence-Informed Health Policy Workshops

Since 2009, the Center for Evidence-based Policy (Center) has led evidence-informed health policy (EiHP) workshops to help state officials use evidence as a foundation for health policy. Center staff create customized trainings for elected and appointed state officials and their staff; trainings provide state officials with the theoretical knowledge and practical skills to:

- Understand the role of evidence in policy making
- Identify the characteristics of reliable evidence sources
- Distinguish between good and poor-quality evidence
- Use evidence to estimate the level of certainty that a program or policy will result in a desired outcome
- Discuss options for policymakers when there is a lack of evidence
- Understand how stakeholders view evidence
- Frame policy questions in a way that will facilitate the identification and application of evidence

For more information about EiHP workshops, please contact centerebp@ohsu.edu.

2 Decide Whether to Act on Identified Low-Value Services

The next step is assessing whether the potential low-value services on the list should be addressed. State officials can evaluate each service by considering 5 factors:

- **Evidence**: what is the strength of evidence supporting the treatment or intervention? To what degree is there clinical consensus on the effectiveness of the intervention?
- **Impact**: what is the magnitude of utilization and spending on the service? How many Medicaid enrollees would be affected by changes to the coverage policy? Are there equity matters to consider?
- **Stakeholders**: What stakeholder groups would be affected by the change? How might stakeholder support or opposition influence implementation?
- **Feasibility**: What Medicaid authorities are available to support action on this service? How administratively complex would the proposed policy change be? Are there legal, regulatory, or

contractual considerations that may limit available options? Are sufficient resources available to successfully implement and monitor the change?

- **Risk**: are there any potential unintended consequences from a coverage policy change, including access concerns or disruption to the provider network?

Because making coverage policy changes requires resources, states may wish to prioritize services with high utilization, high spending, or both.

3 Choose a Strategy to Reduce Low-Value Care

Once a low-value service has been identified, states must determine the most appropriate policy response. Depending on the strength of the evidence, the service characteristics, and implementation considerations, 4 strategies are commonly used[16,17]:

- **Remove**: the service will no longer be a covered benefit. This strategy is appropriate for obsolete, ineffective, or harmful services.
- **Replacement**: the identified service is substituted with an effective alternative treatment or intervention. For example, replacing a brand name product with a cheaper generic.
- **Reduction**: the benefit remains allowable but coverage is limited to a defined population of patients or limit frequency. An example would be limiting the number of presumptive and definitive urine drug tests allowed per month or per year per Medicaid enrollee.
- **Restriction**: the benefit remains allowable but is managed through preauthorization or other criteria (e.g., step therapy, order placed by specialist).

The most appropriate strategy should depend on the strength of the evidence, the characteristics of the service, the anticipated impact on beneficiaries and providers, and the state's available policy levers. In some cases, discontinuing coverage may be warranted; in others, replacing, reducing, or restricting use may achieve similar goals while minimizing disruption. The outcome of this phase is the selection of a preliminary strategy that can be refined through stakeholder engagement and implementation planning.

4 Engage With Interested Parties Around Reducing Low-Value Care

Leaders may want to engage with other key stakeholders such as managed care organizations, providers of the service, clinical experts, and legislators. In addition, the literature on addressing low-value care encourages leaders to engage with patients, families, and advocates in identifying and addressing low-value services.[18-21]

Stakeholder discussions should focus on understanding how proposed changes may affect patients, providers, and delivery systems, while identifying factors that could support or hinder successful implementation. These conversations can also help policymakers anticipate concerns, refine policy design, and build support for change. Key questions could include:

- What are the concerns if the targeted low-value care is reduced?
- What barriers or facilitators are there to reducing the targeted low-value care?
- What communication is needed around reducing the targeted low-value care?
- How can stakeholders work together to reduce use of the targeted low-value care and communicate changes to relevant audiences?

Engaging affected parties can help identify potential concerns, surface implementation challenges, and build support for change before policy decisions are finalized. Input from providers, patients, families, managed care organizations, and other key partners can help policymakers better understand the potential impacts of reducing low-value care and identify strategies to minimize unintended consequences. The outcome of this phase is a refined implementation approach, informed by stakeholder perspectives and better positioned for successful adoption and communication.

5 Implement Changes to Policy to Reduce Low-Value Care

Step 5 moves the selected strategy from planning to implementation. Any policy changes, such as requiring prior authorization, limiting coverage to specific populations, settings, or frequency of use, or implementing step therapy should be clearly documented and communicated to affected stakeholders. Medicaid leaders may also want to consider whether addressing low-value care requires changes to managed care organization contracts, quality incentives, value-based payment arrangements, reimbursement policies, or other program requirements. Successfully implementing change may also require engagement with clinical leaders, development of clinical decision support tools, and other strategies that support alignment with the revised policy.[22,23]

In developing an implementation plan, Medicaid leaders may wish to consider the following questions:

- What operational or policy changes are needed to implement the selected strategy?
- Are updates needed to coverage policies, managed care contracts, payment models, or quality programs?
- Which stakeholders need to be informed of the change and what communication is required?
- What tools, resources, or supports are needed to facilitate adoption of the new policy?
- Are there clinical leaders or other implementation champions who can help support the change?
- How will implementation progress be monitored and evaluated?

The result of step 5 is an implementation plan that identifies key activities, responsible parties, communication needs, and measures of success.

6 Monitor and Track the Impact of Reducing Low-Value Care

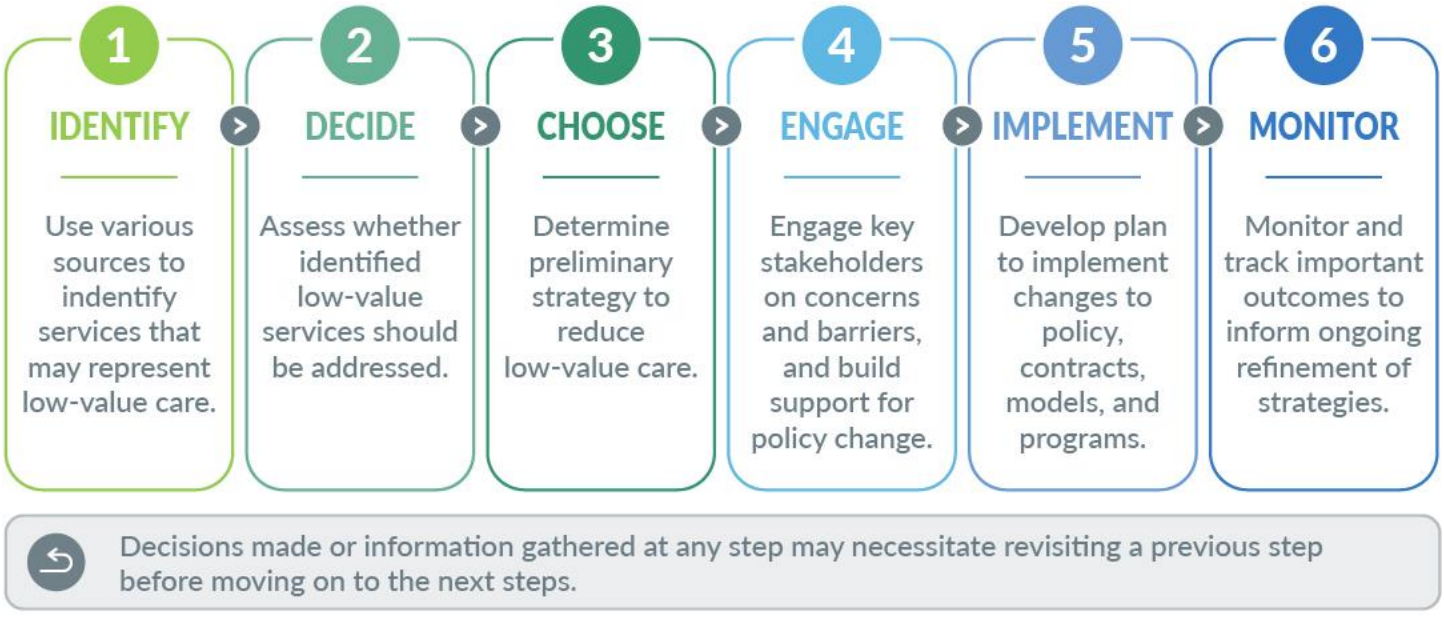
Addressing low-value care is an ongoing process. Monitoring outcomes can help states understand whether a policy change achieved its intended goals and identify any unintended consequences. Findings can also inform future stewardship efforts and help refine implementation strategies over time. At this stage, Medicaid leaders may wish to ask the following questions:

- Has utilization of the targeted service or intervention changed following implementation?
- Have beneficiary health outcomes changed? Were any populations disproportionately affected by the policy change?
- Did the policy change result in savings or other financial impacts?
- Were alternative treatments or services used in place of the targeted low-value intervention?
- Were there any unintended consequences for beneficiaries, providers, or the Medicaid program overall?
- What additional adjustments may be needed to improve outcomes or implementation?

States may wish to develop a performance dashboard or other mechanism to track measures for targeted interventions for services. Monitoring over time can help determine whether changes are producing desired results and whether additional action is warranted.

The result of step 6 is an evaluation and monitoring plan that tracks important measures such as utilization, outcomes, equity, financial impacts, and substitution effects, and informs ongoing refinement of the selected strategies.

Figure 1: Framework for Identifying and Addressing Low-value Care



CONCLUSION

While low-value care has long been a concern for state Medicaid program policymakers, increasing fiscal pressures and changes in the federal funding environment have heightened the importance of ensuring that Medicaid resources are directed toward services that provide the most meaningful value to beneficiaries. The PRIME project is designed to support those efforts by providing a practical framework that state leaders can use to identify, evaluate, and address health care services that are ineffective, provide little clinical benefit, or may cause harm. In addition, PRIME includes 4 case studies that illustrate how states can apply the framework in practice, helping Medicaid administrators identify potential low-value services within their own programs and consider policy options for improving the value and sustainability of Medicaid spending.

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The Center for Evidence-based Policy (Center) is recognized as a national leader in evidence-based decision making and policy design. The Center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The Center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The Center is based at Oregon Health & Science University in Portland, Oregon.

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