

Prescriber Letters

Letters to providers as a means to promote program integrity in Medicare Part D

Agency Objective. Reduce inappropriate prescribing of controlled substances in Medicare Part D.⁶⁸

Background. Inappropriate prescribing can threaten patient health and increase healthcare costs. A body of research shows evidence of some providers overprescribing certain pharmaceuticals, including controlled substances, benzodiazepines, and antipsychotics.⁶⁹ Through its Center for Program Integrity (CPI), the Centers for Medicare and Medicaid Services (CMS) uses a variety of approaches to combat overprescribing behavior, such as proactively identifying providers suspected of inappropriate activity and pursuing legal action through law enforcement channels.

Studies have shown that letters, especially those highlighting social comparisons, can motivate individuals to more carefully examine their own behavior. Simply stating that “9 out of 10 people pay their taxes on time,” for example, has been shown to substantially increase timely tax payments.⁷⁰ Physicians are more likely to provide vaccinations after receiving feedback on their vaccination rates relative to peers.⁷¹ CPI, in collaboration with the Office of Evaluation Sciences (OES) and academic researchers, developed and sent letters to providers incorporating this behavioral insight to promote program integrity in Medicare Part D.

Methods. Potential improper prescribers of Schedule

II drugs (e.g., opioids) were identified as those who prescribed far more than their peers in the same state and medical specialty. These providers ($n = 1,518$) were randomly assigned to be sent a letter (in September 2014) or not. The letter depicted an individual’s prescribing rates in comparison to his or her peers, and provided information about proper prescribing practices. The letter was designed to educate providers and induce them to “self-audit” to correct potentially improper payments. The effect of the letter on prescribing was tracked via Part D claims data.

Results. Using data collected over the 90 days after the letter was mailed, comparisons failed to detect an effect of the letter on Schedule II prescribing. Tests can reject that the letter reduced prescribing by more than 1.4 percent, but cannot reject effects smaller than that—though a reduction less than 1.4 percent could be medically and economically significant.

Conclusions. The letter as designed did not exert a detectable effect. Given the low cost of letter interventions, and the fact that informative letters have been shown to work in other contexts, this finding has prompted the research team to explore alternative approaches to reaching providers as well as the design, timing, and frequency of the letters. Additional letter-based testing is currently underway.

⁶⁸For a full report, see: Adam Sacarny, David Yokum, Amy Finkelstein, and Shantanu Agrawal, “Reducing Inappropriate Prescribing of Controlled Substances in Medicare Part D: Evidence from a Randomized Intervention,” (submitted, 2015).

⁶⁹Department of Health and Human Services, Office of Inspector General, “Retail Pharmacies With Questionable Part D Billing,” (OEI-02-09-00600, 2012). Mark Olfson, Marissa King, and Michael Schoenbaum, “Benzodiazepine use in the United States,” *JAMA Psychiatry* 72 (2015): 136–142. Government Accountability Office, “Antipsychotic Drug Use: HHS Has Initiatives to Reduce Use among Older Adults in Nursing Homes, but Should Expand Efforts to Other Settings,” (GAO-15-211, 2015).

⁷⁰Michael Hallsworth, John A. List, Robert D. Metcalfe, and Ivo Vlaev, “The Behavioralist as Tax Collector: Using Natural Field Experiments to Enhance Tax Compliance,” (NBER Working Paper No. 20007, 2014).

⁷¹Catarina I. Kiefe, Jeroan J. Allison, O. Dale Williams, Sharina D. Person, Michael T. Weaver, and Norman W. Weissman, “Improving Quality Improvement Using Achievable Benchmarks for Physician Feedback: A Randomized Controlled Trial,” *JAMA* 285 (2001): 2871–2879.