

GAO

Report to the Chairman, Subcommittee
on Oversight and Investigations,
Committee on Energy and Commerce,
House of Representatives

September 2003

MEDICARE

Most Beneficiaries Receive Some but Not All Recommended Preventive Services





Highlights

Highlights of [GAO-03-958](#), a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicare, the federal health program insuring almost 35 million beneficiaries age 65 and older, covers certain preventive services, such as flu shots and mammograms. Most beneficiaries receive care through Medicare's fee-for-service program, under which they generally receive these services as part of visits to the doctor for specific illnesses or conditions. Other beneficiaries receive services under Medicare's managed care program, called Medicare + Choice. GAO was asked to determine (1) the extent to which beneficiaries received recommended preventive services through existing visits, (2) whether approaches used by Medicare + Choice plans provide insight for improving delivery of preventive care services for fee-for-service beneficiaries, and (3) what the Centers for Medicare & Medicaid Services (CMS) is doing to explore suggested options for delivering preventive care to fee-for-service beneficiaries.

GAO's work included analyzing data from four national health surveys and reviewing five Medicare + Choice plans considered to have innovative approaches to delivering preventive services. GAO also interviewed Department of Health and Human Services (HHS) and CMS officials and reviewed documents on CMS demonstrations related to preventive services.

www.gao.gov/cgi-bin/getrpt?GAO-03-958.

To view the full report, including the scope and methodology, click on the link above. For more information, contact Janet Heinrich on 202-512-7250.

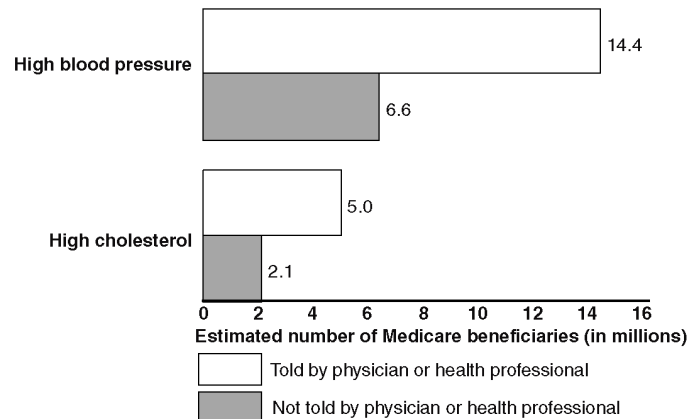
MEDICARE

Most Beneficiaries Receive Some but Not All Recommended Preventive Services

What GAO Found

Most Medicare beneficiaries receive some preventive services through their visits to physicians, but relatively few receive the full range of preventive services available. Survey data showed, for example, that in 2000 about 30 percent of beneficiaries did not receive a flu shot, and 37 percent had never been vaccinated against pneumonia. Moreover, many Medicare beneficiaries are apparently unaware that they may have conditions that preventive services are meant to detect. For example, in a 1999–2000 nationally representative survey during which people received physical examinations, nearly one-third of those age 65 and older who were found to have high cholesterol measurements said they had not previously been told by a physician or other health professional that they had high cholesterol. **Projected nationally, this percentage could represent 2.1 million people.**

Estimated Number of Medicare Beneficiaries Age 65 and Older Who Were Aware or Unaware That They Might Have High Blood Pressure or High Cholesterol, 1999–2000



Source: CDC's National Health and Nutrition Examination survey.

Note: About one-third of Medicare beneficiaries examined and found to have high cholesterol or elevated blood pressure measurements were previously unaware that they might have the condition, representing millions nationwide.

No clear "best practice" approach to delivering preventive care stands out among the innovative Medicare + Choice plans GAO studied. All five plans identify health risks, provide feedback on risks to patients or their physicians, and follow up to reduce those risks. But their follow-up programs, approaches, and priorities differ, and little is known about the effectiveness of these efforts for the Medicare-age population.

CMS has begun the development work to design a project evaluating the use of individual assessments of health risks, followed by counseling and other services, as a way to improve preventive care delivery. Another suggested approach—adding a routine physical examination benefit to Medicare's fee-for-service program—could provide more opportunities, but at increased cost and without guarantee that preventive services would actually be provided to Medicare beneficiaries.

HHS generally concurred with the findings of this report.

Contents

Letter		1
	Results in Brief	3
	Background	5
	Most Beneficiaries Receive Some Preventive Services, but Not All That Are Recommended	7
	Medicare + Choice Plans Reviewed Assess Health Risks Using Varying Approaches	11
	New Ways to Improve the Provision of Preventive Services within Medicare’s Fee-for-Service Program Are Promising but Untested	17
	Concluding Observations	24
	Agency Comments	24
Appendix I	Scope and Methodology	26
Appendix II	Preventive Services Recommended by the U.S. Preventive Services Task Force or Covered by Medicare	30
Appendix III	National Health and Nutrition Examination Survey Methodology and Results	32
Appendix IV	Comments from the Department of Health and Human Services	34
Tables		
	Table 1. Feedback Processes Described by Medicare + Choice Plans	14
	Table 2: Four National Health Surveys with Preventive Services Data, 1999–2000	26
	Table 3: Estimated Proportion of Fee-for-Service Physician Visits Made by People Age 65 and Older, by Major Reason for the Visits, 2000	27

Table 4: Estimated Proportion of Fee-for-Service Physician Visits in Which Diet Counseling Services Were Provided or Ordered, by Major Reason for the Visits, 2000	28
Table 5: Estimated Proportion of Fee-for-Service Physician Visits in Which Blood Pressure Measurements Were Provided or Ordered, by Major Reason for the Visits, 2000	28
Table 6: Medicare + Choice Plans Included in GAO’s Study	29
Table 7: NHANES Data GAO Used to Determine if Participants Had Measures of Specific Health Conditions	32
Table 8: People Age 65 and Older in the United States Found to Have Measures of Specific Health Conditions, NHANES 1999–2000	33
Table 9: People Age 65 and Older in the United States Found to Have Measures of Specific Health Conditions and Who Reported They Had Not Previously Been Told They Might Have the Condition, NHANES 1999–2000	33

Figures

Figure 1: Major Reasons for Physician Visits by Medicare Beneficiaries in the Fee-for-Service Program, 2000	8
Figure 2: Estimated Number of Medicare Beneficiaries Age 65 and Older Who Were Aware and Unaware That They Might Have High Blood Pressure or High Cholesterol, 1999–2000	11

Abbreviations

AMA	American Medical Association
ACE Inhibitor	Angiotensin-converting enzyme inhibitor
BRFSS	Behavior Risk Factor Surveillance Survey
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
NHANES	National Health and Nutrition Examination Survey
Td	Tetanus-diphtheria

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G A O

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

September 8, 2003

The Honorable Jim Greenwood
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Medicare, the federal government's health insurance program that covers almost 35 million people age 65 and older, was created largely to help pay beneficiaries' health care costs once they become ill or injured.¹ For the most part, the federal government pays physicians and other health care providers to treat Medicare beneficiaries for illnesses and health conditions. In addition, the Congress has broadened Medicare coverage to include specific preventive services, aimed at either (1) keeping an illness or condition from developing or (2) keeping it from becoming more serious through early detection and subsequent management. Immunization against influenza (a "flu shot") is an example of the first type of preventive service; a mammogram to detect breast cancer is an example of the second. Overall preventive care depends heavily on identifying health risks associated with the onset or progression of disease and taking steps to reduce or mitigate these risks.

We previously reported to you that Medicare beneficiaries' use of covered preventive services has increased over time but varies widely from service to service.² In response, you asked us to follow up on several issues. One issue is the success of providing preventive services through a Medicare service delivery system based primarily on treating existing illnesses and health conditions. Under Medicare's fee-for-service program, which enrolls about 84 percent of Medicare beneficiaries, no specific provision exists for

¹ We focused our work on the people covered by Medicare who are 65 and older—about 86 percent of the entire Medicare population. Besides this age group, Medicare also covers about 5.8 million disabled persons younger than age 65. Throughout this report, except where otherwise noted, we use the term "Medicare beneficiaries" to refer only to those beneficiaries age 65 and older.

² U.S. General Accounting Office, *Medicare: Beneficiary Use of Clinical Preventive Services*, GAO-02-422 (Washington, D.C.: April 2002).

a routine annual physical or checkup that could be a vehicle for delivering preventive services.³ Unless beneficiaries in the fee-for-service program have supplemental insurance that covers such a checkup, they may have to depend on receiving preventive services during their visits for specific illnesses or conditions, or during other visits for those specific preventive services that Medicare does cover. A second issue is what can be learned about the effectiveness of preventive service approaches put in place by plans that contract with Medicare to offer health care on a managed care basis.⁴ These plans, which enroll about 14 percent of all Medicare beneficiaries under an option known as Medicare + Choice, generally offer a benefit for periodic checkups.⁵ Some of these Medicare + Choice plans are regarded as particularly innovative in assessing risk, providing screening services, and conducting prevention programs. This report addresses the following questions:

- Do Medicare beneficiaries receive recommended preventive services through existing physician visits?
- What approaches for preventive care have been taken by selected Medicare + Choice plans, and what is known about their effectiveness for the Medicare beneficiaries they serve?
- What delivery options for identifying and reducing health risks have been suggested for Medicare fee-for-service beneficiaries, and are any of these options being explored by the Centers for Medicare & Medicaid Services (CMS), the agency administering the program?

Because no single source contained all the information we needed to assess the extent to which Medicare beneficiaries receive preventive services through existing physician visits, we analyzed data from four

³ “Fee-for-service” is the Medicare arrangement sometimes referred to as the original Medicare plan. Under this option, Medicare pays a health care practitioner for each visit or procedure received by a patient, and a beneficiary can visit any hospital, physician, or health care provider who accepts Medicare patients. Medicare pays a set percentage of the expenses, and the beneficiary is responsible for certain deductibles and coinsurance payments—the portion of the bill that Medicare does not pay.

⁴ These are health care options (like health maintenance organizations) in some areas of the country. In most programs, the beneficiary can go only to doctors, specialists, or hospitals on the program’s list. Programs must cover all Medicare part A and part B health care but can also cover extras, like prescription drugs and periodic checkups.

⁵ Besides the 84 percent of Medicare beneficiaries in fee-for-service and the 14 percent in Medicare + Choice (2002 data), a small percentage of Medicare beneficiaries receive services through such arrangements as prepaid group practice plans or Medicare demonstrations.

nationally representative health surveys. The Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System asks a range of health questions over the telephone, including if respondents received a "routine checkup" within the past year. CMS's Medicare Current Beneficiary Survey collects self-reported data, including whether respondents have received influenza or pneumonia immunizations. CDC's National Health and Nutrition Examination Survey (NHANES) collects data on health conditions by means of both comprehensive health examinations and interviews, where patients self-report information, including whether a physician or other health professional has ever told them that they have a given health condition. Unlike the other surveys, which take a sample of the population, CDC's National Ambulatory Medical Care Survey samples physician practices, collecting detailed information about office visits, including the major reason for the visit and which preventive services were ordered or provided. In addition, this survey captured information that allowed us to assess whether visits by Medicare beneficiaries were on a fee-for-service basis. Unless otherwise noted, however, the data we report generally included beneficiaries from both systems.

To describe the approaches of selected Medicare + Choice plans in delivering preventive services, we assessed literature and interviewed national experts to identify plans that were considered innovative in preventive care. We then obtained information from five such plans: AvMed Health Plans, Group Health Cooperative, Highmark Blue Cross and Blue Shield, Kaiser Permanente, and Oxford Health Plans. Collectively, an estimated 1.2 million Medicare beneficiaries in 15 states plus the District of Columbia receive their health care under these plans. To determine suggested options for identifying and reducing health risks and what CMS is doing to assess them, we reviewed the results of past related research demonstrations and congressionally mandated studies and interviewed Department of Health and Human Services (HHS) and CMS officials and other experts. (App. I further describes our scope and methodology.) We conducted our work from October 2002 through August 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Most Medicare beneficiaries receive some but not all recommended preventive services, although they typically visit a physician several times during a year. Our analysis of year 2000 data shows that nearly 9 in 10 Medicare beneficiaries visited a physician at least once that year, with a beneficiary making an average of six visits or more within the year. Preventive services are delivered during all types of visits—whether for

illnesses, health conditions, or nonillness care. Regardless of the reason for a visit, however, many beneficiaries did not receive recommended preventive services. In 2000, for example, about 30 percent of Medicare beneficiaries did not receive an influenza vaccination and 37 percent had never had a pneumonia vaccination, as recommended under current guidelines for people age 65 and older. Moreover, many Medicare beneficiaries may have conditions of potential concern that they are unaware of. For example, among the Medicare beneficiaries who participated in a nationally representative survey and were found through physical examinations to have high cholesterol, about one-third said they had not previously been told by a physician or other health professional that they might have this condition. Projected nationally, this percentage translates into about 2.1 million people age 65 and older.

Although they differ from one another in approach and emphasis, the preventive care approaches of the Medicare + Choice plans we reviewed share common elements. In particular, their approaches screen enrollees to identify health risks and then provide a number of follow-up activities designed to reduce those risks. The plans generally use combinations of methods to ascertain needed preventive services, including periodic preventive visits, health risk questionnaires, and periodic assessments of medical claims and pharmacy data. All plans also have follow-up strategies to help beneficiaries obtain needed preventive services, although their strategies and priorities vary. Follow-up interventions include counseling programs to encourage behavioral change, cancer screening for early detection of disease, and programs to coordinate and manage chronic conditions such as diabetes and cardiovascular disease. Although some plans furnished us with data suggesting that their approaches hold promise, few had conducted a systematic evaluation of whether the approaches improved health outcomes or lowered health care costs. Those studies that do show a relationship between greater use of preventive services and improved health outcomes or cost savings are limited in terms of how their findings might be generalized to Medicare beneficiaries.

Several options have been suggested for improving the provision of preventive services under Medicare's fee-for-service program, each with its own advantages and disadvantages. Two options center on adding a new benefit for a nonillness-related examination, specifically either (1) a one-time "welcome-to-Medicare" examination for new beneficiaries or (2) a periodic examination benefit for all beneficiaries. Coverage of a one-time or periodic wellness examination could be easily administered, and the examination could provide an opportunity for beneficiaries to receive

some preventive services. Adding such a benefit, however, could increase Medicare costs and still not guarantee that beneficiaries receive the preventive services they need. The results of a past CMS demonstration indicate that offering Medicare beneficiaries packages of broad-based preventive services has not consistently improved health or lowered hospital and other costs. As a result, CMS has recently considered an alternative option that would essentially create a different structure using nonphysician providers to assess health risks and ensure the delivery of preventive services within the fee-for-service program. The agency has started the development work to design a project to examine whether assessments of individual health risks, combined with continued counseling and follow-up services provided by nonphysicians, will improve delivery of preventive services and beneficiary health. CMS also has under way several other demonstration projects related to preventive care in the fee-for-service program, such as a smoking cessation program tailored to Medicare beneficiaries. Results from these demonstration efforts are not expected for several years.

HHS reviewed a draft of this report and generally concurred with the findings.

Background

Many of the health conditions that people age 65 and older experience are preventable and linked to specific health risks. Some health risks are difficult to change, and some, such as a hereditary predisposition for a given disease, cannot be changed. For these, preventive services such as cancer screens can help identify disease in its early stages so that people can be referred to other services that can help manage or treat the disease. Other health risks, such as complications from influenza, can be successfully reduced by targeted preventive services. For example, studies show that immunizations against influenza can prevent thousands of hospitalizations and deaths each year among those age 65 and older. Health risks such as high blood pressure and high cholesterol are also considered health conditions because, if left alone, they can develop into potentially more significant conditions, such as cardiovascular disease, or lead to stroke.

The term preventive care covers a wide spectrum of actions aimed at reducing risks for deteriorating health and improving the detection and management of disease. Generally, preventive care is intended for three purposes:

-
- To prevent a health condition from occurring at all. Vaccinations and physical activity to reduce the risk of heart disease, for example, qualify as this first type of preventive care (termed primary prevention).
 - To prevent or slow a condition's progression to more significant health conditions by detecting a disease in its early stages. Mammograms to detect breast cancer and other screens to detect disease early are examples of this second type of preventive care (termed secondary prevention).
 - To prevent or slow a condition's progression to more significant health conditions by minimizing the consequences of a disease. Care coordination and self-management of an existing disease, such as diabetes or asthma, are examples of this third type of preventive care (termed tertiary prevention).

Many people associate the idea of preventive care with annual physical examinations, or “routine checkups,” by a family doctor, a practice first proposed by the American Medical Association (AMA) in the early twentieth century. In the early 1980s, however, the AMA determined that appropriate preventive care depends on an individual's age and particular health risks, not simply on the results of a standard battery of tests.⁶ To evaluate preventive care for different age and risk groups, HHS in 1984 established a panel of experts called the U.S. Preventive Services Task Force. At present, the task force recommends certain screening, immunization, and counseling services for people age 65 and older (see app. II).

Medicare covers some, but not all, of the task force-recommended preventive services (see comparison in app. II). Medicare's fee-for-service program—which comprises approximately 84 percent of Medicare beneficiaries—does not cover periodic checkups, where clinicians might assess an individual's health risk and provide needed preventive services. These Medicare beneficiaries may, however, receive some of these services during office visits for other health problems. Under Medicare + Choice, which covers about 14 percent of Medicare beneficiaries, a benefit for periodic checkups generally does exist.

⁶ The annual physical examination of healthy persons, in which a standard set of tests and procedures is performed, was first proposed by the AMA in 1922. For many years afterward, health professionals recommended routine physicals and comprehensive laboratory testing as effective preventive medicine. But in 1983, the AMA withdrew its support for a standard annual examination. Instead, the organization supported periodic visits in which patients receive preventive services depending upon the individual's unique combination of age, sex, and health risk.

Most Beneficiaries Receive Some Preventive Services, but Not All That Are Recommended

Medicare beneficiaries typically visit a physician several times during a year and most receive some preventive services, but most do not receive the full range of recommended services. Based on 2000 survey data and U.S. Bureau of the Census estimates of people age 65 and older, we estimate that beneficiaries visit a physician at least six times a year, on average, mainly for illnesses or medical conditions.⁷ About 1 in 10 visits occurred when beneficiaries were well, and most Medicare beneficiaries reported having what they considered to be a “routine checkup” in the previous year. The purposes of these routine checkups and the specific services that are delivered during these visits, however, remain unknown. Many Medicare beneficiaries did not receive recommended preventive services, such as influenza and pneumonia immunizations. Moreover, another national survey indicated that a substantial share of Medicare beneficiaries who were at risk for a condition that preventive services are meant to identify said that they had not been told by a health professional that they might have that condition.

Medicare Beneficiaries Visit Physicians Often, and Most Report Receiving Routine Checkups

In 2000, 88 percent of Medicare beneficiaries reported that they visited a physician at least once that year.⁸ On the basis of data from CDC’s National Ambulatory Medical Care Survey, we estimate that, on average, beneficiaries visit physicians at least six times a year.⁹ Almost 9 in 10 visits made by beneficiaries in the fee-for-service program were to treat illnesses or health conditions: more than half the visits targeted preexisting (chronic) problems, more than one-fourth targeted illnesses of sudden or recent onset (acute), and about 10 percent of visits took place pre- or postsurgery or to follow up after injuries. Only about 10 percent of visits

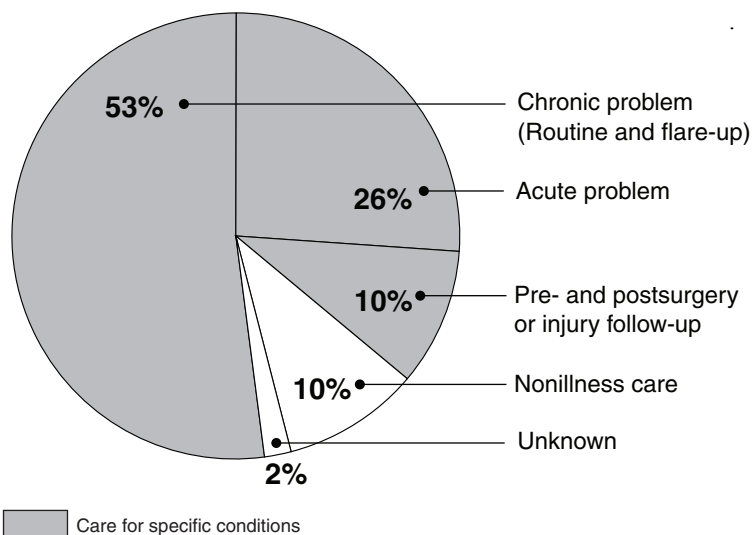
⁷ The surveys and other data sources from which we developed our information generally did not disaggregate the information into beneficiaries receiving care through fee-for-service and beneficiaries receiving care through Medicare + Choice programs. As a result, unless otherwise noted, the data reported include beneficiaries from both groups.

⁸ CMS’s Medicare Current Beneficiary Survey, 2000.

⁹ To estimate the average number of physician visits, we used data from the National Ambulatory Medical Care Survey and the U.S. Bureau of the Census. See app. I for a description of our methodology. We believe that the result is a conservative estimate of the average number of physician visits, since the segment of the survey that we analyzed excluded visits made in hospital outpatient and emergency departments or other institutional settings and also excluded physicians in the specialties of anesthesiology, pathology, and radiology.

dealt with nonillness care when the patient was considered healthy (see fig. 1).¹⁰

Figure 1: Major Reasons for Physician Visits by Medicare Beneficiaries in the Fee-for-Service Program, 2000



Source: CDC's National Ambulatory Medicare Care Survey, 2000.

Note: Numbers do not add to 100 percent due to rounding. The survey defined an "acute problem" as a condition or illness of sudden or recent onset, a "chronic problem" as a preexisting long-term or recurring condition or illness, and "nonillness care" as a general health maintenance examination or routine periodic examination of a presumably healthy person. For chronic problems, the survey reported results separately for "routine chronic problems" and for "chronic problem flare-ups." We combined these results in this figure. The separate results are found in app. I.

Even though the majority of visits to physicians are for treating illness or health conditions, most Medicare beneficiaries reported receiving routine checkups. In CDC's 2000 Behavioral Risk Factor Surveillance System Survey, for example, 93 percent of respondents age 65 and older reported that they had received a "routine checkup" within the previous 2 years.

¹⁰ Because Medicare's fee-for-service program does not cover routine physical examinations but does cover some preventive services, such as immunizations and certain cancer screening tests, it is possible that some of the nonillness visits in 2000 were to obtain such services. In addition, some fee-for-service beneficiaries may be paying for nonillness examinations through other means, such as employer-provided or other supplemental insurance. According to CMS's Medicare Current Beneficiary Survey, in the year 2000 about 41 percent of Medicare fee-for-service beneficiaries had insurance from former employers to supplement their basic Medicare benefit.

This survey did not, however, provide information on which specific services were delivered during those checkups. Indeed, as the following section shows, few beneficiaries receive all recommended services, although they receive some preventive services during visits when they are healthy as well as during visits to treat illnesses or health conditions.

Despite Frequency of Visits, Many Medicare Beneficiaries Do Not Receive the Full Range of Recommended Preventive Services

Despite how often Medicare beneficiaries visit physicians, many of them do not receive a full complement of recommended preventive services, including some recommended by the U.S. Preventive Services Task Force and currently covered by Medicare. As we reported earlier, use of specific preventive services varies widely by service.¹¹ Although each preventive service we reviewed was delivered to a majority of Medicare beneficiaries, relatively few beneficiaries received the full range of preventive services. For example, 91 percent of female Medicare beneficiaries received at least one preventive service, but only 10 percent were screened for cervical, breast, and colon cancer and also immunized against influenza and pneumonia.¹² Our analysis of additional data since our previous report shows that many Medicare beneficiaries still do not receive certain recommended preventive services. The task force recommends, for example, that all people age 65 and older receive an annual influenza vaccination and at least one pneumonia vaccination. In CMS's Medicare Current Beneficiary Survey of 2000, however, about 30 percent of Medicare beneficiaries did not receive an influenza vaccination, and 37 percent had never had a pneumonia vaccination.

Survey data showing the services provided during office visits indicate that Medicare beneficiaries do receive some preventive services during visits when they are ill or being treated for a health condition, and services are delivered at comparable rates during all types of visits, whether for nonillness care or for treating acute or chronic conditions. Beneficiaries in the fee-for-service program receive preventive services, such as cholesterol and blood tests, during visits when they are healthy and during visits to treat acute or chronic health conditions. Some tests are typically provided or ordered slightly more often during visits for nonillness care. In

¹¹ GAO-02-422.

¹² In January 2003, the U.S. Preventive Services Task Force released new recommendations for the use of pap smears to screen for cervical cancer. The task force now "recommends against screening women 65 and older who have had adequate recent screenings with normal Pap smears and are not otherwise at increased risk for cervical cancer."

2000, for example, blood tests for anemia¹³ were provided in about 16 percent of visits for nonillness care, compared with 7 percent of visits for chronic problems and 5 percent of visits for acute conditions. Other preventive services were provided at similar rates during the different types of visits. For example, we estimate that blood pressure measurement, a clinical screen for conditions such as hypertension, was done during 56 to 62 percent of visits, depending on the type of visit. Diet counseling services were provided during 13 to 20 percent of visits, depending on the type of visit.¹⁴

Many Beneficiaries May Be Unaware of Their Risk for Health Conditions That Preventive Care Is Meant to Detect

Many Medicare beneficiaries may not know that they are at risk for health conditions that preventive care could detect—strong evidence that they may not be receiving the full range of recommended preventive services.¹⁵ For example, data from CDC’s NHANES for 1999–2000 show that, of beneficiaries participating in this nationally representative survey who had a physical examination and were found to have elevated blood pressure readings at the time of the examination, 32 percent reported that no physician or other health professional had ever told them about the condition. On the basis of this survey, we estimate that, during the period when the survey was conducted, 21 million Medicare beneficiaries may have been at risk for high blood pressure, and an estimated 6.6 million of them may have been unaware of this risk. Similarly, 32 percent of those found in the 1999–2000 survey to have a high cholesterol level reported

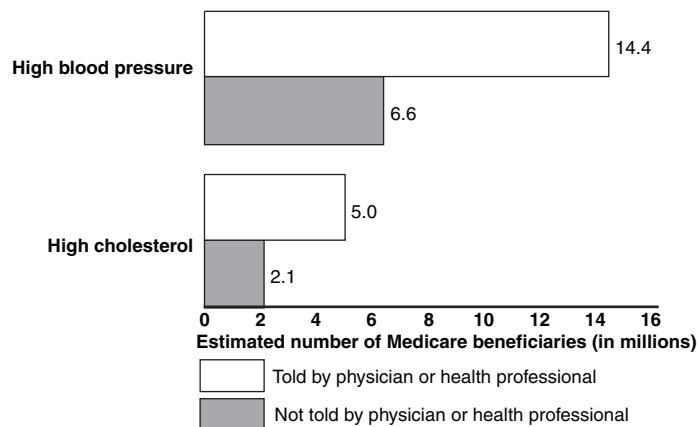
¹³ Anemia is a condition in which the blood is deficient in red blood cells, hemoglobin, or total volume. The hematocrit/hemoglobin test is used to test for anemia and to measure the concentration of packed red blood cells and hemoglobin in the blood. Hemoglobin is an iron-containing respiratory pigment in red blood cells that helps transport oxygen from the lungs to the body tissues.

¹⁴ Specifically, blood pressure measurements were provided at 56 percent of visits for acute problems, 59 percent of visits for chronic problems, and 62 percent of nonillness visits. Diet counseling services were provided at 13 percent of visits for acute problems, 20 percent of visits for chronic problems, and 18 percent of nonillness visits. For both blood pressure measurement and diet counseling service estimates, the differences in these percentages were not statistically significant at the 95 percent confidence level. See app. I for a discussion of the methodology and specific results. Source: CDC’s National Ambulatory Medical Care Survey, 2000.

¹⁵ The source of data for this statement was CDC’s National Health and Nutrition Examination Survey of 1999–2000. This survey oversampled—that is, included a larger number of persons age 60 and older in the sample, providing for a sample size that enabled us to focus our analysis specifically on the Medicare-age population for selected conditions. App. III contains a description of this survey and the specific results of our analyses.

that no one had told them that they had high cholesterol. Projected nationally, this percentage translates into 2.1 million Medicare beneficiaries (see fig. 2).

Figure 2: Estimated Number of Medicare Beneficiaries Age 65 and Older Who Were Aware and Unaware That They Might Have High Blood Pressure or High Cholesterol, 1999–2000



Source: CDC's National Health and Nutrition Examination survey.

Note: CDC's NHANES measured blood pressure three or four times during its 1-day physical examination. For our analysis, we calculated the average of the blood pressure measurements and applied CDC's definition of high blood pressure: that is, a patient's having an average systolic blood pressure equal to or greater than 140, or an average diastolic blood pressure equal to or greater than 90, or a patient who reported taking hypertension medication. CDC defined high cholesterol as a total cholesterol level equal to or greater than 240.

Medicare + Choice Plans Reviewed Assess Health Risks Using Varying Approaches

The Medicare + Choice plans we reviewed vary in their specific strategies for delivering preventive services, but several common themes emerge from their efforts. First, nearly all identify members' health risks and inform them or their providers about specific services that might be needed. For example, some plans mail questionnaires to members, seeking information, such as when certain screening tests were last performed; other plans review claims and prescription data to identify at-risk members who might need a screening test or other preventive service. Second, all plans have follow-up strategies to help beneficiaries obtain needed preventive services, although their strategies and priorities vary. Third, while limited data provided by some plans suggest promising results, most plans have not evaluated the degree to which their strategies improve health outcomes or affect health care costs for Medicare beneficiaries.

Plans Use a Combination of Ways to Identify Health Risks

Although all the Medicare + Choice plans we reviewed use questionnaires to meet the requirement that they conduct health assessments for newly enrolled Medicare beneficiaries,¹⁶ they use a combination of approaches to identify health risks. The particular risks that plans seek to identify vary from plan to plan. Risks include those associated with depression or lack of physical activity; risks from not obtaining recommended immunizations or screenings, such as mammography; and more general risk of short-term hospitalization or illness.¹⁷ For example, Group Health Cooperative, Highmark Blue Cross and Blue Shield, and Kaiser Permanente use questionnaire information to calculate a risk score meant to represent each enrollee's probability of using health services heavily in the future. From its questionnaire, Kaiser Permanente also calculates the probability of 3-year survival for enrollees who have an existing advanced illness, as well as the probability that they will become dependent on others for daily care or need nursing home services during the next year (a condition Kaiser Permanente officials refer to as frailty). Oxford Health Plan, on the other hand, analyzes questionnaire data to assign enrollees a risk classification of high, moderate, or low and assigns patients to health management teams or programs appropriate for each risk level.

For existing members, plans use slightly different approaches to identify health risks, including information from claims and pharmacy data, annual risk assessment questionnaires, physician visits, and computer systems (called registries) that indicate when patients require specific preventive services. The specific approaches vary from plan to plan. For instance, Group Health Cooperative officials reported that they review the health risks, such as the immunization status, of their existing members through health maintenance visits, which they encourage Medicare beneficiaries to have every 2 years. During this visit, the provider reviews responses to a completed questionnaire that each patient is asked to bring to the visit and updates computer registry data, compiled from previous risk assessment questionnaires and physician visits. AvMed conducts a health risk

¹⁶ Medicare + Choice plans are required to make a "best effort attempt" to assess newly enrolled Medicare beneficiaries. 42 C.F.R. § 422.122(b)(4)(i) (2002).

¹⁷ The risk assessment questionnaires for some plans are as brief as a one-page form, while others are as long as eight pages. A number of questions focus on identifying functional status, such as the ability to bathe independently; immunization status; current use of prescription medications; the history of screening tests, such as mammography; past health care use, such as the number of times enrollees saw their primary care physician in the preceding 6 months; behavior risks, such as smoking; and past illnesses or existing health conditions.

assessment for each of its Medicare members and also uses claims and pharmacy data to identify members with specific diseases, so as to target preventive services. For example, using pharmacy and claims data to identify people with diabetes, AvMed invites these members to a health fair featuring services to prevent further progression of the disease. Paying a single copayment to attend the health fair, members can receive a number of services, such as a blood draw for laboratory work and vision and glaucoma screening.

Finally, some plans report that they have increased the use of specific preventive services through their participation in CMS-required national performance improvement projects.¹⁸ For example, Highmark reported that in 2002 the plan used medical claims data to identify female Medicare beneficiaries who had not received a mammogram within the past 2 years and notified the beneficiaries and their physicians. As a result, the officials reported that 60 percent of contacted beneficiaries went on to receive mammograms.

Plans Use a Variety of Follow-up Means to Reduce Identified Risks

After identifying the health risks of Medicare beneficiaries—whether new enrollees or existing members—plans we contacted reported that they also make efforts to follow up on that information by providing feedback to enrollees about risks and referring them to specific, risk-related preventive services. For example, all plans have approaches to prevent disease progression for individuals identified as having chronic health conditions. The plans sometimes differ in their types of follow-up and in their emphasis on different types of preventive services. Some plans we reviewed, for example, stress primary prevention activities, such as exercise programs for all members, to a greater degree than others.

To provide feedback, many plans contact members directly through letters or phone calls, encourage contact with primary care physicians, or combine written or oral feedback with follow-up physician examinations (see table 1).

¹⁸ CMS generally requires each Medicare + Choice plan to undertake one national quality assessment and performance improvement project per year to measure and improve its own performance in a CMS-defined national focus area. Past national focus areas include improving diabetes care and increasing vaccination rates for influenza and pneumonia.

Table 1. Feedback Processes Described by Medicare + Choice Plans

Health plan	Feedback process
Group Health Cooperative	Using data available on computer registry, health professionals can review specific health risks with members. Health professionals also monitor the computer registry to track services members use.
Kaiser Permanente	For new enrollees, physicians review a summary report and provide feedback during an initial office visit. In San Diego, existing members who visit health assessment centers receive a letter, based on a completed questionnaire and tests estimating “health age,” that discusses ways of decreasing specific health risks, and they receive a second visit for a complete exam.
Oxford Health Plans	Various departments receive health risk reports based on risk assessment questionnaires. Reports for high-risk members go to teams of registered nurses, who contact the members and their primary care physicians to coordinate care.
Highmark Blue Cross and Blue Shield	Plan sends results of health risk assessment to physicians to facilitate discussion with patients. Members with risks related to smoking, heart disease, or osteoporosis receive letters. New members identified as at risk for being frail are referred to case managers, and members identified with chronic disease are referred to a condition management program for targeted interventions.
AvMed Health Plans	Physicians receive health risk information from risk assessment questionnaires and pharmacy and claims data. Members identified as having specific risks are contacted directly by the plan if health promotion or disease management programs are available for them.

Source: Plan officials and plan documents.

In addition to educating members about their health risks, some plans also link members to specific preventive services to reduce or mitigate these risks. For example, plans may send targeted health promotion materials; offer 24-hour telephone access to a nurse to discuss health concerns; or offer access to fitness programs, nutrition courses, immunizations, exams, and disease management or care coordination programs. These care coordination programs resolve health care issues through various means, such as in-depth telephone evaluations, communication with primary care physicians, in-home visits, or connections with community resources like Meals on Wheels.

To refer Medicare members to preventive services, one plan we contacted emphasized directing them to primary prevention services, such as physical activity programs, while another plan emphasized connecting members to tertiary prevention services, such as disease management programs. For example, identifying physical activity and social isolation as two important predictors of overall health outcomes for seniors, Group Health Cooperative refers Medicare members to physical activity benefits

and other primary prevention services. In contrast, acknowledging that most individuals age 65 or older have more than one chronic health condition, AvMed focuses more on identifying members with existing conditions and referring them to preventive services that can mitigate the condition. AvMed has created eight disease management programs covering conditions such as congestive heart failure, asthma, and diabetes. The goal is to provide members having these conditions with a series of condition-specific care interventions. For example, interventions for AvMed enrollees in the congestive heart failure program include prescribing specific drugs (such as ACE¹⁹ inhibitors, diuretics, and beta-blockers), providing self-directed care plans, and monitoring weight.

Some plans described how they track the success of their efforts to provide people with specific preventive care interventions. Highmark, for example, offers financial incentives to physicians who follow specific clinical guidelines for a given condition. The plan also gives physicians quarterly report cards, generated by a computer registry, that indicate whether their patients have received all the care recommended by the management programs in which the patients are enrolled. AvMed, on the other hand, tracks the number of members identified as eligible for specific disease management programs, whether the program was offered to all eligible members, and the number who enrolled. AvMed also reported setting, monitoring, and reporting on performance goals for the percentage of members receiving specific care interventions. For example, for enrollees in the congestive heart failure management program, AvMed tracks the percentage receiving an ACE inhibitor drug.

Assessments of Health Outcomes or Cost Savings for Medicare Beneficiaries Are Limited

Few of the health plans we contacted had specifically evaluated whether their approaches to risk identification and reduction lead either to improved health outcomes for Medicare beneficiaries or to cost savings for the plan. From those plans that have such information, the available data suggest that offering disease management programs to people who have existing health conditions may hold promise, but most plans lacked evidence from controlled studies of a specific benefit to their Medicare members.

AvMed and Oxford are among the plans that have evaluated whether their approach improves health outcomes and saves money. For example,

¹⁹ Angiotensin-converting enzyme.

AvMed plan officials observed that, in all AvMed plans, including its Medicare + Choice plan, AvMed members with existing chronic conditions spent fewer days in the hospital during the same period when more of their members with existing conditions were enrolled in disease management programs. According to AvMed officials, between 2001 and 2002, shorter hospital stays of Medicare congestive heart failure patients led to total savings of \$1 million, and shorter hospital stays of asthma patients from all plans (not limited to Medicare beneficiaries) led to savings of \$400,000. Similarly, Oxford has estimated savings attributed to various interventions, such as a mean savings of \$219 per member per month from Medicare beneficiaries who voluntarily participated in a self-management workshop for diabetes, as compared with a random group of diabetic members who did not attend the workshop. Although these findings show potential to improve health and decrease costs, it is unclear from this information whether the decreased length of hospitalization and cost savings resulted from disease management or from other factors. It is also not clear what the long-term effects may be on Medicare beneficiaries and whether these observations would also apply to beneficiaries in a fee-for-service environment.

Some plans are evaluating specific aspects of their approaches as a first step in determining which approaches are effective. For example, Kaiser Permanente officials provided data demonstrating their ability to identify a certain type of health risk among Medicare beneficiaries, but they did not provide data demonstrating that their overall approaches to risk identification or risk reduction resulted in improved health outcomes or cost savings.²⁰ Specifically, they found that three questions on the risk assessment questionnaire, along with the patient's age, predicted with a high degree of accuracy whether a person would need daily assistance from another person during the following year. Kaiser identified these people as at risk for frailty and through additional study found that, over the next decade, frail people spent more days in nursing homes than individuals who were not frail.²¹ Kaiser Permanente officials told us that they have not identified interventions that decrease or prevent frailty from

²⁰ Specifically, over the next decade, people designated as "frail" spent 800 percent more days in nursing homes than individuals who were not frail. K.K. Brody, R.E. Johnson, and L.D. Ried, "Evaluation of a Self-Report Screening Instrument to Predict Frailty Outcomes in Aging Populations," *The Gerontologist*, 37 (1997): 182-191.

²¹ K.K. Brody et al., "A Comparison of Two Methods for Identifying Frail Medicare-Aged Persons," *Journal of American Geriatrics Society*, 50 (2002): 562-569.

developing but were instead focusing on identifying interventions to improve outcomes for those people once they were identified as frail.²²

In addition to reviewing the efforts of contacted Medicare + Choice plans, we reviewed several studies that evaluated the effectiveness of employer-sponsored approaches to providing preventive services, such as health risk assessment and feedback, to both employees and retirees. Although these studies conclude that employer-sponsored approaches hold promise in terms of increasing preventive services, improving health outcomes, and lowering cost, we found the results limited in how they might be generalized to all Medicare beneficiaries. For example, General Motors evaluated its companywide prevention program, which offered health risk assessments, individualized health profiles, a quarterly newsletter, a self-care book, and a toll-free health information line. The company reported that providing risk assessment and feedback helped participants lower their health risk status and that nearly half of this benefit was realized within the first of 5 years. Although General Motors provides a similar risk appraisal program to retirees, this study did not include them, so the study's finding cannot be generalized to the Medicare population.

New Ways to Improve the Provision of Preventive Services within Medicare's Fee-for-Service Program Are Promising but Untested

Several options have been suggested for improving the provision of preventive services within Medicare's fee-for-service program. They include adding a new benefit for a nonillness-related examination, either a one-time "welcome-to-Medicare" examination for new beneficiaries or an examination available to all beneficiaries on a periodic basis. Although covering a one-time or periodic nonillness examination could be easily administered and could increase the receipt of some preventive services, doing so could also increase Medicare costs without necessarily ensuring that beneficiaries receive the full range of preventive services. CMS has tested similar options in the past and found that they produced mixed results. It is now examining an alternative that would essentially create a different structure using nonphysician providers to assess health risks and connect individuals with preventive services. The design work will be completed at the end of 2003, and if the decision is made to conduct a demonstration, results would not be available for several years after that. Additional demonstrations also under way—such as one exploring

²² Once frail people are identified, for example, Kaiser encourages medical providers to follow guidelines intended to detect conditions such as depression and to prevent outcomes such as injuries from falls.

effective smoking cessation approaches and one giving physicians incentives to coordinate and manage the overall health care needs of beneficiaries—may provide additional insights into coordinating and delivering appropriate preventive services within the Medicare fee-for-service program.

Two Proposed Options Center on Adding a Preventive Examination to the Medicare Fee-for-Service Program

A one-time “welcome-to-Medicare” examination for new beneficiaries has been proposed as a means to better ensure that health care providers have enough time to identify individual Medicare beneficiaries’ health risks and provide preventive services appropriate for their risks.²³ Proponents assert that a one-time benefit could combine a health evaluation with screenings and immunizations, along with counseling about health promotion and disease prevention. It could also orient new beneficiaries to Medicare and encourage them to make informed choices about providers and plans. Health risk assessment and behavior counseling could be provided by a range of nonphysician professionals, including nurses, counselors, and dietitians.

A similar option would have Medicare cover an annual or periodic preventive visit available to all fee-for-service beneficiaries. In theory, many of the advantages of a one-time preventive visit would also apply to periodic examinations. For instance, dedicated preventive visits might provide greater opportunities for health care providers to assess and address health risks. Some evidence also suggests that a periodic health examination may increase use of preventive cancer screening and counseling services. For example, a National Cancer Institute-supported study surveyed general internists and family physician practices and their patients in 1992 and found that patients who had received a periodic

²³ Partnership for Prevention, *A Better Medicare for Healthier Seniors: Recommendations to Modernize Medicare’s Prevention Policies* (Washington, D.C.: Partnership for Prevention, 2003), and Gilbert S. Omenn, “Historical and Current Policy Issues in Establishing Coverage for Clinical Preventive Services under Medicare,” cited in the Partnership for Prevention’s report.

health examination within the previous year were substantially more likely to have received appropriate cancer screening and counseling.²⁴

While these options have benefits, they also have potential drawbacks. Adding a benefit for a one-time or periodic examination to the Medicare fee-for-service package could increase the program's costs without necessarily ensuring that beneficiaries receive the full range of preventive services. The Congressional Budget Office in June 2002 estimated that a one-time physical examination benefit for new enrollees could cost as much as \$1.6 billion over the 2003–2012 period.²⁵ According to a Congressional Budget Office official, the agency has not recently estimated the potential costs of a Medicare benefit for examinations provided on a periodic basis. This cost, however, would likely be substantially higher than that of a one-time visit for new beneficiaries. At the same time, establishing such a benefit would not necessarily ensure delivery of the full range of preventive services. In addition, primary care physicians typically cannot provide services such as mammography screenings for breast cancer and colonoscopies for colon cancer, because these services usually require specialists.

It also remains uncertain whether covering a one-time or periodic examination would be an effective means of improving beneficiary health outcomes. A previous CMS initiative that included preventive health care visits ended with mixed results. In the late 1980s and early 1990s, the agency conducted a congressionally mandated demonstration to test varied health promotion and disease prevention services, such as free preventive visits, health risk assessment, and behavior counseling, to see if they would increase use of preventive services, improve health outcomes,

²⁴ C.H. Sox et al., "Periodic Health Examinations and the Provision of Cancer Prevention Services," *Archives of Family Medicine*, 6 (1997): 223–230. This study reviewed a random selection of community general internists and family physician practices in New Hampshire and Vermont. Care was assessed for those who were patients of the study physicians for at least 1 year, were age 42 or older, had no life-threatening illness, and had recently visited the physician.

²⁵ See Congressional Budget Office cost estimate, H. R. Rep. 107-539, pt. 1, at 238. Beginning in 2004, the bill would have required Medicare to pay for a routine physical examination and associated services when furnished within 6 months of a beneficiary's enrollment in part B. Beneficiaries already enrolled would not have been eligible for this benefit. H.R. 4954, 107th Cong. (2d Sess. 2002).

and lower health care expenditures for Medicare beneficiaries.²⁶ The agency's final report, published in 1998, concluded that the demonstration services were marginally effective in raising the use of some simple disease prevention measures, such as immunizations and cancer screenings, but did not consistently improve beneficiary health outcomes or reduce the use of hospital and skilled nursing services.²⁷

CMS Is Exploring an Alternative for Assessing Health Risks and Delivering Preventive Services

CMS is exploring one alternative for Medicare preventive care that would provide systematic health risk assessments to fee-for-service beneficiaries through a means other than physician visits. In the late 1990s, the agency commissioned the RAND Corporation to evaluate the potential effectiveness of health risk assessment programs. Similar to the approaches taken by the Medicare + Choice plans we reviewed, such programs collect information from individuals; identify their risk factors; and refer the individuals to at least one intervention to promote health, sustain function, or prevent disease.²⁸ The study concluded that health risk assessment programs have increased beneficial behavior (particularly exercise) and improved physiological variables (particularly diastolic blood pressure and weight) and general health status. It also concluded that more research would help clarify the programs' effects on preventive services such as clinical screening.²⁹ In addition, the study stated that to be

²⁶ A 4-year demonstration was mandated in the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9314, 100 Stat. 82, 194 (1986), and extended for 1 year by the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4164, 104 Stat. 1388, 1388-100. At the time, CMS was known as the Health Care Financing Administration.

²⁷ Donna E. Shalala, *Medicare Prevention Demonstration: Final Report*, RC 87-172 (Washington, D.C.: Department of Health and Human Services, 1998). The report tempered these results by pointing out that the relatively brief period during which the services were provided (roughly 2 years) and the limited number of provider contacts and follow-ups (one to two) may have been inadequate to achieve measurable outcomes. In addition, the grouping of the health risk assessment and preventive services into a preventive package may have obscured the relative effects of individual components of the package.

²⁸ A typical health risk assessment obtains information on demographic characteristics (e.g., sex, age), lifestyle (e.g., smoking, exercise, alcohol consumption, diet), personal health history, and family health history. In some cases, physiological data (e.g., height, weight, blood pressure, cholesterol levels) are also obtained, as well as a patient's status regarding cancer screens and immunizations.

²⁹ Southern California Evidence-Based Practice Center/RAND, *Health Risk Appraisals and Medicare* (Baltimore: Centers for Medicare & Medicaid Services, 2001). RAND identified 267 articles, unpublished reports, and conference presentations, of which 27 contained data that project staff deemed necessary to be included as evidence of the effectiveness of health risk assessments.

effective, risk assessment questionnaires must be coupled with follow-up interventions such as referrals to appropriate services. The study found limited but encouraging evidence on the effectiveness of health risk assessment programs but concluded that the evidence was insufficient to accurately estimate the programs' cost-effectiveness. The study recommended that CMS conduct a demonstration to test cost-effectiveness and other aspects of the health risk assessment approach for Medicare beneficiaries.

Following up on the study's findings, CMS has begun designing a fee-for-service-focused demonstration project, called the Medicare Senior Risk Reduction Program, to identify health risks and follow up with preventive services provided by means other than physician visits. The program will use a beneficiary-focused health risk assessment questionnaire to assess health risks, such as lifestyle behaviors, and use of clinical preventive and screening services. Because the demonstration is still in its design phase, the particular set of risk factors to be included is not yet final. Risk factors that might be addressed include preventable accidents such as falls, lack of exercise, high blood pressure, obesity, and use of preventive services. The Medicare Senior Risk Reduction Program will test different approaches to administering health risk assessments, creating feedback reports, and providing follow-up services, such as referring beneficiaries to health-promoting community services including physical activity and social support groups. According to project researchers, the program will tailor preventive interventions to individual risks; track patient risks and health over time; and provide beneficiaries with self-management tools and information, health behavior advice, and end-of-life counseling where appropriate. The design phase is scheduled for completion in late 2003, when CMS will decide whether to conduct a full demonstration.³⁰ According to CMS officials, the potential demonstration's final cost was uncertain at the time our report was completed. CMS is spending approximately \$1 million on the developmental work.

Unlike some health risk assessment programs, CMS's program will be limited to questionnaires and follow-up contacts; it will not directly provide clinical screening such as blood pressure or cholesterol measurements. Instead, the program will concentrate on identifying, through information provided by the beneficiary, any modifiable lifestyle

³⁰ According to CMS, the demonstration would also require approval from the Office of Management and Budget.

and behavioral risk factors and on referring beneficiaries to services for reducing those risks. CMS officials and researchers did indicate, however, that the program's risk assessment tools will collect information on needed immunizations and cancer screenings and alert beneficiaries and their physicians to any needed services.

CMS Is Also Exploring Ways to Improve Care for Those with Identified Health Risks and Conditions

CMS has other initiatives under way that may help improve the delivery of preventive services within the fee-for-service program. The first is the Medicare Stop Smoking Program, a smoking cessation demonstration project for fee-for-service beneficiaries. Recognizing that smoking is the single most preventable cause of disease and death in the United States, posing a significant health risk to the aged, CMS launched the demonstration to identify the most effective service to help beneficiaries stop smoking. The demonstration will evaluate the effectiveness of different smoking cessation services. The four services being tested are: (1) reimbursement for provider counseling, (2) reimbursement for provider counseling and for smoking cessation drugs or nicotine replacement therapy, (3) access to a telephone counseling quit-line plus reimbursement for nicotine replacement therapy, and (4) provision of written information on smoking cessation. Seven states are participating in the demonstration: Alabama, Florida, Missouri, Ohio, Oklahoma, Nebraska, and Wyoming. The study will be completed in 2004, with the results published in 2005. CMS has budgeted approximately \$14 million for this project.

CMS is also developing a physician group-practice demonstration that was required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.³¹ The aim of this demonstration is to provide incentives for physicians to coordinate and manage the overall health care needs of Medicare fee-for-service beneficiaries, especially those with chronic health conditions. Under the 3-year demonstration, physician groups will be paid on a fee-for-service basis and may, in some circumstances, earn a bonus from savings achieved if the average Medicare expenditure for beneficiaries in their group of patients is below an established target.³² Up to six physician group practices will be selected

³¹ Pub. L. No. 106-554, app. F, § 412, 114 Stat. 2763, 2763a-509.

³² Annual performance targets will be established for each participating physician group, equal to the average Medicare expenditures of beneficiaries assigned to that group during the base period and adjusted for health status and expenditure growth.

to participate in the demonstration, which is expected to start during 2003. Under the mandate, the aggregate expenditures for this demonstration must be budget neutral. Any bonus payments made to physician groups must therefore be taken from savings produced by the participating organizations.

Finally, a 4-year coordinated-care demonstration is currently under way at 16 sites. Authorized by the Balanced Budget Act of 1997, this demonstration examines private-sector best practices for coordinating the care of patients with complex chronic conditions.³³ These conditions include congestive heart failure, other heart and lung diseases, liver diseases, diabetes, psychiatric disorders, Alzheimer's disease or other dementia, and cancer. CMS is testing whether care coordination programs—such as those that develop a plan of care after a complete assessment of patient needs and offer patient education, health care service arrangements, and coordination with providers—can, without increasing program costs, improve the quality of care and reduce avoidable hospital admissions among Medicare beneficiaries with chronic diseases. The selected sites mix case management and disease management models in their practices;³⁴ operate in urban and rural settings around the country; and include hospitals, retirement communities, and academic medical centers. CMS is required to formally evaluate the projects every 2 years after implementation and report to the Congress on its findings. HHS officially announced the selected sites in January 2001, and as of May 2003, the 16 sites had enrolled approximately 10,000 Medicare beneficiaries in the demonstration. CMS officials stated that the demonstration could eventually enroll more than 36,000 beneficiaries, although half of these will serve as a control group who will not receive coordinated care. CMS officials told us that they expect this demonstration to also be budget neutral. That is, they anticipate that overall costs to Medicare for providing the services will be offset by savings achieved from providing the care coordination services.

³³ Pub. L. No. 105-33, § 4016, 111 Stat. 343, 345.

³⁴ Case management services would be provided to help manage general health, and disease management services would be provided to help manage a specific disease.

Concluding Observations

Most Medicare beneficiaries receive some preventive services, but many do not receive services that can help prevent and manage their health risks and conditions early, before significant health problems occur. Services recommended for all people in this age group are not delivered consistently. Perhaps of most concern, nearly one-third of beneficiaries who were screened and identified as having elevated blood pressure or high cholesterol measures in a nationally representative survey had not previously been told by their physicians or other health providers that they had these conditions. Projected nationally, the survey results translate into millions of people who could be unaware that they have a health condition whose treatment could prevent or delay much more significant health concerns.

The solutions to ensure that beneficiaries receive needed services are not obvious. The experience of selected Medicare + Choice plans shows that no single approach stands out. All plans we contacted had a means to identify health risks, to provide feedback on risks to patients or their physicians, and to follow up with interventions to reduce those risks. But the follow-up programs, approaches, and priorities differed among the plans we contacted, and few had evaluated their approaches in a manner that would indicate whether these programs could, without significantly increasing costs, improve health outcomes for Medicare beneficiaries. Nevertheless, some current research shows promise for improving the delivery of preventive services—particularly when there are follow-up interventions, such as referrals to appropriate services.

Agency Comments

We obtained comments on our draft from HHS as well as from the health plans we contacted. HHS generally concurred with our findings and provided examples of CMS's successes in promoting existing preventive services and in identifying strategies that might be used in future health promotion efforts. HHS also clarified the status of its program evaluating the use of individual health risk assessments, which is in development, and clarified its Medicare Stop Smoking Program, which will assess options for a new benefit for smoking cessation but not necessarily lead to CMS coverage for these benefits. HHS emphasized that only the Congress can decide which preventive services or benefits Medicare covers. HHS also updated its estimate of this program's budget. We incorporated these clarifications in the draft.

HHS also commented that without sufficient evidence, the report links beneficiaries' lack of knowledge that they may have certain conditions, such as high blood pressure, with evidence that they are not receiving the

full range of preventive services. We did not intend to link these statements, but we have independent evidence for each of them and have added information to our summary of results to help clarify this evidence. HHS's comments are reproduced in appendix IV.

HHS and the health plans also provided technical comments that we considered and incorporated where appropriate.

As arranged with your office, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We are sending copies of this report to the Secretary of HHS, the Administrator of CMS, the Director of CDC, and others who are interested. We will make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions, please contact me at (202) 512-7119 or Katherine Iritani, Assistant Director, at (206) 287-4820. Other individuals who made contributions to this report include Matthew Byer, Sophia Ku, and Tina Schwien.

Sincerely yours,

A handwritten signature in black ink that reads "Janet Heinrich". The signature is written in a cursive style with a large initial "J".

Janet Heinrich
Director, Health Care—Public Health Issues

Appendix I: Scope and Methodology

Because no single source contained all the information we needed to assess the extent to which Medicare beneficiaries receive preventive services through existing physician visits, we used data from four national health surveys: three conducted by the Centers for Disease Control and Prevention (CDC) and one conducted by the Centers for Medicare & Medicaid Services (CMS) (see table 2). For example, CMS’s Medicare Current Beneficiary Survey samples Medicare beneficiaries, asking them for detailed information on their demographic characteristics, insurance coverage, and health status but asking only a few questions about specific preventive services received during physician visits. In contrast, CDC’s National Ambulatory Medical Care Survey samples physicians about office visits, rather than the people who made those visits. The survey contains information about reasons for office visits and about diagnostic and preventive services provided during visits, but it cannot be used to determine the extent to which Medicare beneficiaries received these services.¹

Table 2: Four National Health Surveys with Preventive Services Data, 1999–2000

Survey	Data year	Sample size	Description
Behavioral Risk Factor Surveillance System, CDC	2000	Annual target of 189,450 adults	A state-based random telephone survey of U.S. adults covering a wide range of behaviors affecting health. The largest continuing telephone survey in the United States, it provides national as well as state-specific estimates.
National Ambulatory Medical Care Survey, CDC	2000	27,369 office visits, of which 7,381 were made by people age 65 and older	A national sample survey of visits to office-based physicians in the United States. Detailed information about each visit, such as major reason for the visit and diagnostic and preventive services ordered or provided, is collected through a patient record form completed by the physicians’ offices.
National Health and Nutrition Examination Survey, CDC	1999–2000	9,965 people, of which 1,392 were age 65 and older	This survey gathers nationally representative data on the health and nutrition of the U.S. population through direct physical examinations and interviews.
Medicare Current Beneficiary Survey, CMS	2000	About 16,000 Medicare beneficiaries	A continuous survey of a representative national sample of the Medicare population that collects detailed data on beneficiaries’ insurance coverage, health status and functioning, and health care use and expenditures.

Source: CDC and CMS.

For our analyses of these surveys, we extracted data for people age 65 and older to represent Medicare beneficiaries, because almost 95 percent of

¹ The National Ambulatory Medical Care Survey is conducted by CDC’s National Center for Health Statistics. See the Web site <http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm> for details on the survey design.

the population in this age group was enrolled in Medicare in 2000.² Also, because the National Ambulatory Medical Care Survey samples office visits to physicians, not the people who made the visits, to estimate the average number of physician visits made by Medicare beneficiaries, we first estimated the number of visits made by patients age 65 and older using this database, and then divided this number by the U.S. Bureau of the Census estimates of the civilian noninstitutionalized population age 65 and older. To determine the major reasons for physician visits and the specific types of preventive services provided to Medicare beneficiaries in the fee-for-service program, we used visit data in this survey for patients age 65 and older who did not belong to a health maintenance organization and whose visits were not paid on a capitated basis.³ Tables 3 to 5 show the estimates and standard errors in data from the National Ambulatory Medical Care Survey 2000 on major reasons for physician visits and on the preventive diet counseling services provided during those visits. We also tested at the 95 percent confidence level the statistical significance of differences we observed between nonillness and other types of visits in the proportion of visits where preventive screening tests (e.g., cholesterol and blood tests) were provided.

Table 3: Estimated Proportion of Fee-for-Service Physician Visits Made by People Age 65 and Older, by Major Reason for the Visits, 2000

Major reason	Sample size	Estimated number (in thousands)	Estimated percentage	Standard error of percentage
Acute problem	1,155	32,843	25.8	1.7
Chronic problem, routine	2,081	53,701	42.2	1.7
Chronic problem, flare-up	532	13,254	10.4	0.8
Pre- or postsurgery, injury follow-up	577	12,533	9.8	1.1
Nonillness care	395	12,479	9.8	1.1
Blank or unknown	84	2495	2.0	0.4

Source: GAO analysis of the National Ambulatory Medical Care Survey, CDC.

² According to data from CDC’s Behavioral Risk Factor Surveillance System, in 2000, almost 95 percent of adults age 65 and older reported having Medicare coverage.

³ “Capitated” refers to a method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time.

Table 4: Estimated Proportion of Fee-for-Service Physician Visits in Which Diet Counseling Services Were Provided or Ordered, by Major Reason for the Visits, 2000

Major reason	Sample size	Estimated number (in thousands)	Estimated percentage ^a	Standard error of percentage
Acute problem	1,155	4,138	12.6	3.0
Chronic problem, routine	2,081	11,785	22.0	3.0
Chronic problem, flare-up	532	1,673	12.6	2.5
Nonillness care	395	2,295	18.4	3.6

Source: GAO analysis of the National Ambulatory Medical Care Survey, CDC.

^aThe differences in rates of services provided among the different types of visits were not statistically significant. According to CDC, diet counseling services could be underreported because the survey captured this information only if it was contained in the medical record. If the physician provided counseling but did not write it in the chart, counseling would not have been captured in the survey.

Table 5: Estimated Proportion of Fee-for-Service Physician Visits in Which Blood Pressure Measurements Were Provided or Ordered, by Major Reason for the Visits, 2000

Major reason	Sample size	Estimated number (in thousands)	Estimated percentage ^a	Standard error of percentage
Acute problem	1,155	18,491	56.3	3.2
Chronic problem, routine	2,081	31,706	59.0	2.9
Chronic problem, flare-up	532	7,870	59.4	4.8
Nonillness care	395	7,762	62.2	4.8

Source: GAO analysis of the National Ambulatory Medical Care Survey, CDC.

^aThe differences in rates of services provided among the different types of visits were not statistically significant.

To estimate the proportion of Medicare beneficiaries who had health conditions that they were not previously aware of—specifically, high blood pressure or high cholesterol—we used data from both the interview and the physical examination portions of CDC’s National Health and Nutrition Examination Survey (see app. III for methodology and results from this analysis).

To describe the preventive care approaches of Medicare + Choice plans, we consulted with national experts and officials from the American

Association of Health Plans and chose five plans considered to have innovative preventive care programs. Together, these five plans serve more than 1.2 million Medicare beneficiaries in 15 states and the District of Columbia (see table 6). We interviewed officials from each plan and reviewed documents, including plan-provided studies or evaluations of their preventive services programs. We reviewed the scope and methodology of the studies done by some of the plans, but we did not independently verify the accuracy of the data.

Table 6: Medicare + Choice Plans Included in GAO’s Study

Medicare + Choice plans	Geographic areas served	Beneficiaries served
AvMed Health Plans	Florida	24,400
Group Health Cooperative	Washington	59,300
Highmark Blue Cross & Blue Shield	Pennsylvania	182,000
Kaiser Permanente	California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Ohio, Oregon, Virginia, Washington	880,000
Oxford Health Plans	Connecticut, New Jersey, New York	72,000

Source: Plan officials and plan Web sites.

To examine the alternatives for identifying and reducing health risks and CMS’s efforts in exploring them, we reviewed available literature, including results of past demonstrations and congressionally mandated studies, and interviewed experts in the field, including those conducting studies and developing position papers for the Partnership for Prevention, a nonprofit organization funded by the Robert Wood Johnson Foundation. We also interviewed Department of Health and Human Services and CMS officials and reviewed documents on planned and present CMS demonstrations related to preventive services.

Appendix II: Preventive Services Recommended by the U.S. Preventive Services Task Force or Covered by Medicare

Service	Task force recommendation for age 65+	Year first covered by Medicare as preventive service	Medicare cost-sharing requirements ^a
Immunization			
Pneumococcal	Recommends	1981	None
Hepatitis B	No recommendation	1984	Copayment after deductible
Influenza	Recommends	1993	None
Tetanus-diphtheria (Td) boosters	Recommends	Not covered ^b	N/A
Varicella	Recommends	Not covered ^b	N/A
Screening			
Cervical cancer: pap smear	Recommends against ^c	1990	Copayment with no deductible ^d
Breast cancer: mammography	Recommends ^e	1991	Copayment with no deductible
Vaginal cancer: pelvic exam	Not evaluated	1998	Copayment with no deductible ^d
Colorectal cancer: fecal-occult blood test ^f	Strongly recommends	1998	No copayment or deductible
Colorectal cancer: flexible sigmoidoscopy or colonoscopy ^f	Strongly recommends	1998	Copayment after deductible ^g
Osteoporosis: bone mass measurement	Recommends (women only)	1998	Copayment after deductible
Prostate cancer: prostate-specific antigen test and/or digital rectal examination	Insufficient evidence to recommend for or against	2000	Copayment after deductible ^d
Glaucoma	Insufficient evidence to recommend for or against	2002	Copayment after deductible
Vision impairment	Recommends	Not covered	N/A
Hearing impairment	Recommends	Not covered	N/A
Height, weight, and blood pressure	Recommends	Not covered	N/A
Cholesterol measurement	Strongly recommends	Not covered	N/A
Problem drinking	Recommends	Not covered	N/A
Depression	Recommends	Not covered	N/A
Counseling			
Smoking cessation, injury prevention, dental health	Recommends	Not covered	N/A
Aspirin for primary prevention of cardiovascular events	Strongly recommends	Not covered	N/A

Source: U.S. General Accounting Office, *Medicare: Use of Preventive Services Is Growing but Varies Widely*, GAO-02-777T (Washington, D.C.: April 12, 2002), and U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2nd ed. (Washington, D.C.: 1996) and related updates.

**Appendix II: Preventive Services
Recommended by the U.S. Preventive Services
Task Force or Covered by Medicare**

^aApplicable Medicare cost-sharing requirements generally include a 20 percent copayment after a \$100 per year deductible. Specifically, each year, beneficiaries are responsible for 100 percent of the payment amount until those payments equal a specified deductible amount, \$100 in 2003. Thereafter, beneficiaries are responsible for a copayment that is usually 20 percent of the Medicare-approved amount. For certain tests, the copayment may be higher. 42 U.S.C. § 1395(a)(1) (2000).

^bAlthough the tetanus-diphtheria (Td) and varicella (chickenpox) booster vaccinations are not now covered under Medicare as a “preventive” service, these treatments might be covered under Medicare if necessary to a beneficiary’s medical treatment. Medicare provides coverage for medical treatment and services that are “reasonable and necessary for the diagnosis or treatment of an illness or injury,” provided that the services or products used are “safe and effective” and not merely “experimental.” 42 U.S.C. § 1395(a)(1)(A) (2000).

^cThe task force recommends against routinely screening women older than 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

^dThe costs of the laboratory test portion of these services are not subject to copayment or deductible. The beneficiary is subject to a deductible, copayment, or both for physician services only.

^eThe task force recommends screening mammography, with or without a clinical breast examination, every 1–2 years for women age 40 and older.

^fData are insufficient to determine which strategy is best to balance benefits against potential harms or cost-effectiveness. Barium enemas are covered as an alternative if a physician determines that their screening value is equal to or greater than sigmoidoscopy or colonoscopy.

^gThe copayment has increased from 20 to 25 percent for services rendered in an ambulatory surgical center.

Appendix III: National Health and Nutrition Examination Survey Methodology and Results

Background

Conducted by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics, the National Health and Nutrition Examination Survey (NHANES) is a nationwide population-based survey designed to estimate the health and nutrition of the noninstitutionalized U.S. civilian population. Our analysis was based on data gathered during NHANES 1999–2000, which represent the most recent information available. This survey comprises two parts: an in-home interview and a health examination. During the in-home interview, participants are asked about their health status, disease history, and diet; during the health examination, participants receive a number of tests, including blood pressure readings and a blood test to determine total serum cholesterol.¹ Details of the survey design, questionnaires, and examination components are available at <http://www.cdc.gov/nchs/nhanes.htm>.

Scope, Methodology, and Results

For our analysis, we used the NHANES data described in table 7 to determine if participants age 65 and older² had high blood pressure or high total serum cholesterol. We used the same criteria for these conditions as CDC and the National Heart Blood and Lung Institute use to estimate the conditions' prevalence.

Table 7: NHANES Data GAO Used to Determine if Participants Had Measures of Specific Health Conditions

Health condition	NHANES data
High blood pressure ^a	Average ^b systolic blood pressure \geq 140 during NHANES exam or Average ^b diastolic blood pressure \geq 90 during NHANES exam or Participant reported during NHANES interview that he or she took hypertension medication
High total cholesterol ^a	Total cholesterol level \geq 240 at NHANES examination

Source: CDC criteria and GAO methodology.

^aCDC's definitions of high blood pressure and high total cholesterol.

¹ Which examinations and blood tests a participant had depended on that participant's age and sex.

² Of the 9,282 individuals participating in both the NHANES interview and examination components, 1,196 were age 65 and older.

**Appendix III: National Health
and Nutrition Examination
Survey Methodology and
Results**

^bParticipants' blood pressure was measured three or four times during the 1-day physical examination. For our analysis, we determined the average of these blood pressure measurements and applied CDC's definition of high blood pressure.

To determine whether the participants age 65 and older found by examination to have elevated measures of these health conditions were previously unaware of having them, we used patients' responses from the NHANES interview. During the interview, participants were asked if they had ever been told by a physician or health professional that they had certain conditions, including high blood pressure and high cholesterol.

Tables 8 and 9 show the estimates and standard errors from 1999–2000 NHANES data for specific health conditions and level of awareness among participants age 65 and older.

Table 8: People Age 65 and Older in the United States Found to Have Measures of Specific Health Conditions, NHANES 1999–2000

Health condition	Sample size	Estimated number in the U.S. population	Estimated proportion	Standard error of proportion
High blood pressure	835	21,000,000	71.6%	2.07
High total cholesterol	250	7,100,000	25.6%	1.76

Source: GAO analysis of NHANES.

Table 9: People Age 65 and Older in the United States Found to Have Measures of Specific Health Conditions and Who Reported They Had Not Previously Been Told They Might Have the Condition, NHANES 1999–2000

Not previously told of the health condition	Sample size	Estimated number in the U.S. population	Estimated proportion	Standard error of proportion
High blood pressure	254	6,600,000	31.6%	2.02
High total serum cholesterol	87	2,100,000	32.1%	4.65

Source: GAO analysis of NHANES.

Estimated numbers, proportions, and standard errors were obtained using SUDAAN, a computer program for analyzing data from complex sample surveys, as suggested in the NHANES Analytic Guidelines.

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

AUG 20 2003

Ms. Janet Heinrich
Director, Health Care – Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Heinrich:

Enclosed are the Department's comments on your draft report entitled, "Medicare: Most Beneficiaries Receive Some But Not All Recommended Preventive Services." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department also provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

A handwritten signature in cursive script, appearing to read "Dara Corrigan".

Dara Corrigan
Acting Principal Deputy
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services on the General Accounting Office's Draft Report, "Medicare: Most Beneficiaries Receive Some But Not All Recommended Preventive Services" (GAO-03-958)

The Department of Health and Human Services (Department) appreciates the opportunity to review and comment on the above-referenced draft report. The General Accounting Office (GAO) report focuses on the preventive services Medicare beneficiaries receive through fee-for-service or the managed care program.

Generally, we concur with the findings of the draft report and would note that prevention is a key goal for the Secretary. To support the Secretary's goal, the Centers for Medicare & Medicaid Services (CMS) have taken a number of steps to improve the delivery of preventive services for Medicare beneficiaries. The following are examples of CMS successes in promoting existing preventive services and in identifying strategies that might be used in future health promotion efforts:

- The Healthy Aging Project produced evidence reports on how to better promote existing Medicare preventive benefits, and explore other strategies for healthy aging. These include smoking cessation, health risk appraisal programs, falls prevention, chronic disease self-management, and physical activity. These reports have allowed CMS to think prospectively about strategies to help older adults stay healthy.
- The requirement was removed from the providers' Conditions of Participation that a physician must write an individual order for each influenza and pneumococcal vaccination given in hospital and long term care settings and by home health agencies. Where allowed by State law, appropriate non-physician personnel can now provide these vaccinations under a facility-approved standing order protocol. This change to the Conditions of Participation was based on evidence generated by the Healthy Aging Project indicating that standing orders are effective for increasing immunization rates, and a CMS-Centers for Disease Control and Prevention pilot study, which implemented standing orders in nursing homes in 14 States.
- CMS also increased Medicare payment rates for influenza / pneumococcal / hepatitis B vaccine administration. Medicare's 2003 vaccine administration rate allowances average \$7.72 for 2003, a 94% increase over 2002. The rates range from \$5.34 to \$10.98 depending on geographic location.
- Recognizing that smoking is the single most preventable cause of disease and death in the United States, posing a significant health risk to the aged, CMS launched the Medicare Stop Smoking Program, a demonstration to identify the most effective strategy for helping older smokers help themselves to quit smoking. The evidence suggests that counseling by clinicians and by telephone, with and without smoking cessation medications have been effective in helping adults quit smoking. This demonstration tests these

strategies in older adults to identify which strategies are most effective for helping older smokers help themselves to quit smoking. To date, this demonstration has enrolled 3,328 seniors, and according to experts, could possibly be the largest smoking cessation study to address the needs of older smokers.

- CMS is designing the Benefits Improvement and Protection Act (BIPA) mandated “Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities.” The purpose of this demonstration is to evaluate best practices; and design, implement and evaluate projects involving new and innovative intervention models that improve health, clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services; and reduce disparities in cancer prevention and treatment for African American, Latino, Asian American/Pacific Islander, and American Indian/Alaskan Native beneficiary populations living in both urban and rural communities. The information gathered from this demonstration will inform efforts to reduce healthcare disparities.
- Colon cancer screening rates are low, with less than 50 percent of people age 50 and older receiving any screening test for colon cancer. CMS has funded Medical Review of North Carolina (MRNC), a Quality Improvement Organization, to analyze colon cancer screening rates. MRNC has an interactive website which displays State and county rates for the various Medicare-covered colon cancer screening tests, allowing organizations to target their efforts to increase rates. These data are currently being updated to include 2000-2002 data, and are the only comprehensive resource for both State and county data.
- There is collaboration between CMS and other agencies in the Department on public awareness campaigns to promote Medicare preventive and screening services, specifically colon cancer screening, mammography, and adult immunization.

CMS has initiated developmental work to design a study to evaluate the use of individual health risk assessments and tailored follow-up interventions to reduce health risks and promote the appropriate use of preventive services.

In the report, the linkage is drawn between the lack of knowledge of risk for health conditions with evidence that beneficiaries are not receiving the full range of preventive services. This linkage is presented specifically relating to high blood pressure. While we can see the correlation between the “lack of knowledge of health risk for that condition, additional evidence should be presented before extending this conclusion to the full range of preventive services.”

Two CMS initiatives are mischaracterized—the Medicare Stop Smoking Program and the design of a study to evaluate the use of health risk assessments and tailored follow-up interventions.

Several references are made to a study using health risk assessment and follow-up interventions to improve the delivery of preventive services. CMS has not yet decided whether it will conduct this study. If CMS decides to conduct this study, it will need to be approved by the Office of Management and Budget. The references to this study in this report imply that this study is underway when in fact no decision has been made about its conduct.

The description of the Medicare Stop Smoking Program implies that CMS will identify and cover a new benefit for smoking cessation. Congress, not CMS, makes coverage decisions regarding preventive services. In addition, the estimate of the project's budget is inaccurate.

We look forward to working with GAO on this and future issues.

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