United States Government Accountability Office

Report to Congressional Requesters

November 2026

MEDICARE

Out-of-Pocket Costs and Other Factors Can Affect Use of Services for Cardiovascular Disease Prevention

GAO-27-108423

GAO Highlights

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Out-of-Pocket Costs and Other Factors Can Affect Use of Services for Cardiovascular Disease Prevention

GAO-27-108423 November 2026

A report to congressional requesters

Contact: Leslie V. Gordon at GordonLV@gao.gov

What GAO Found

Medicare covers two types of services for cardiovascular disease prevention: Medicare preventive services and medically necessary services. Specifically, five Medicare preventive services are covered that aim to prevent the onset of cardiovascular disease or identify it early. Two such services are cardiovascular behavioral therapy to reduce disease risk and lipid panels to screen for the disease. Medically necessary services are to diagnose or treat conditions that are cardiovascular disease risk factors and prevent disease progression. Two examples include cardiac rehabilitation, which aims to improve cardiac health through a program of supervised exercise and behavioral counseling, and lipid panels to monitor high cholesterol levels.

Examples of Services for Cardiovascular Disease Prevention

Cardiovascular behavioral therapy
A provider visit that includes blood pressure screening and counseling on topics such as diet and physical activity

Medicare preventive service:
Covered annually for all beneficiaries without cost sharing

Cardiac rehabilitation
A program of supervised exercise, counseling to reduce modifiable risk factors, and an individualized treatment plan

Medically necessary service:
Covered for beneficiaries who experienced certain events, such as a heart attack, or who have stable chronic heart failure

Lipid panel
A lab service that measures cholesterol, lipid, and triglyceride levels

Medicare preventive service:
Covered once every 5 years for all beneficiaries without cost sharing

Medically necessary service:
Covered as needed for reasons such as monitoring high cholesterol levels

Source: GAO analysis of Centers for Medicare & Medicaid Services documents. | GAO-27-108423
Note: For more details, see figures 2 and 3 in GAO-27-108423.

Out-of-pocket costs can affect beneficiaries' use of specific services for cardiovascular disease prevention, according to representatives GAO interviewed from eight stakeholder organizations. For example, because cardiac rehabilitation typically takes place over 36 sessions, even modest cost-sharing amounts can accumulate, according to a representative from one provider organization. Research also has found that beneficiaries with higher out-of-pocket costs were more likely to discontinue rehabilitation sessions or prescribed medication. In addition, representatives mentioned that patient factors and provider availability can also affect beneficiaries' use of these services.

About 90 percent of beneficiaries with traditional Medicare in GAO's analysis (16.2 million out of 18.1 million) received at least one lipid test from 2021 through 2025, according to Medicare claims data. During that period, beneficiaries received just under 1.3 million lipid tests as Medicare preventive services and 91.6 million as medically necessary services. Relatively few beneficiaries had claims in 2025 for cardiovascular behavioral therapy and the other selected services analyzed by GAO. This may be due to providers' lack of awareness of these services' coverage or because they delivered similar services but did not bill these specific codes, as described by representatives from stakeholder organizations.

Why GAO Did This Study

Cardiovascular disease—which includes coronary heart disease, stroke, and other conditions affecting the heart and blood vessels—has been the leading cause of death for adults in the U.S. for over 100 years. The prevalence of risk factors for cardiovascular disease is highest among older adults, the main population covered by Medicare.

GAO was asked to review issues related to beneficiaries' use of health services for cardiovascular disease prevention. This report describes (1) services covered by Medicare for cardiovascular disease prevention, (2) key factors affecting beneficiaries' use of services, and (3) beneficiaries' use of selected services for cardiovascular disease prevention in traditional Medicare.

GAO reviewed clinical guidelines and recommendations, agency documentation, and applicable laws and regulations. GAO analyzed claims and beneficiary enrollment data to identify the proportion of beneficiaries with claims for four selected services for cardiovascular disease prevention, including lipid testing and cardiovascular behavioral therapy to reduce disease risk. To align with certain Medicare coverage provisions, GAO analyzed claims from 2021 through 2025 (the most recent year available) for lipid testing and claims from 2025 for the three other selected services.

GAO also interviewed agency officials and representatives from nine stakeholder organizations representing health care providers and researchers, and Medicare beneficiaries. To supplement the interviews, GAO conducted a literature search of selected research about factors affecting beneficiaries' use of services for cardiovascular disease prevention.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CVD	cardiovascular disease

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

November 23, 2026

The Honorable Rick Scott
Chairman
Special Committee on Aging
United States Senate

The Honorable Raphael Warnock
United States Senate

Cardiovascular disease (CVD) has been the leading cause of death for adults in the United States for over 100 years.[1] Among adults aged 65 and older, the main population covered by Medicare, the estimated prevalence of CVD in 2020 ranged from about 25 percent to over 35 percent, and this prevalence is predicted to continue rising.[2] CVD is a broad category of diseases that refers to conditions affecting the heart and blood vessels, and it includes diseases such as coronary heart disease and stroke.

CVD deaths are now more likely to be attributed to chronic conditions than to acute events such as heart attacks. This likely reflects advancements in medical and public health interventions over the past 50 years, as well as the rising prevalence of certain CVD risk factors, such as obesity and high blood pressure.[3] The prevalence of CVD risk factors is highest among older adults, highlighting the importance of Medicare-

[1]See Department of Health and Human Services, Centers for Disease Control and Prevention, "Achievements in Public Health, 1900-1999: Decline in Deaths from Heart Disease and Stroke–United States, 1900-1999," *Morbidity and Mortality Weekly Report (MMWR) Rep* 48, no. 30 (1999); and Latha P. Palaniappan et al., "2026 Heart Disease and Stroke Statistics: A Report of US and Global Data from the American Heart Association." *Circulation,* vol. 153, no. 9 (2026).

[2]Medicare also covers certain individuals with disabilities. This study estimated that the prevalence of CVD was approximately 25 percent of adults aged 65 to 79 and over 35 percent for adults aged 80 and older. See Karen E. Joynt Maddox et al., "Forecasting the Burden of Cardiovascular Disease and Stroke in the United States Through 2050—Prevalence of Risk Factors and Disease: A Presidential Advisory from the American Heart Association," *Circulation*, vol. 150 (2024).

[3]See Sara J. King et al., "Heart Disease Mortality in the United States, 1970 to 2022," *Journal of the American Heart Association,* vol. 14, no. 13 (2025).

covered services for CVD prevention.[4] Such services aim to identify and address risk factors in order to prevent the onset of CVD and its progression. Medicare's coverage of these services has changed over time. For example, the Centers for Medicare & Medicaid Services (CMS) operated the Million Hearts® CVD Risk Reduction Model from 2017 through 2021 to test new services that identify and reduce CVD risk among Medicare beneficiaries.[5] Based on model findings, CMS began covering certain services for CVD prevention in 2025, including CVD risk assessments.

You asked us to review issues related to Medicare beneficiaries' use of health services for CVD prevention. This report describes

1. services covered by Medicare for CVD prevention;
2. key factors affecting beneficiaries' use of services for CVD prevention; and
3. beneficiaries' use of selected services for CVD prevention in traditional Medicare.

To describe services covered by Medicare for CVD prevention, we reviewed guidelines and recommendations from relevant clinical associations to identify key services for CVD prevention.[6] We also reviewed CMS documentation (such as coverage determinations) and

[4]See Catharine A. Couch, Rina Mascarenhas, Bryan Stierman, and Cheryl D. Fryar, *Prevalence of Cardiovascular Disease Risk Factors in Adults: United States, August 2021–August 2023*, National Center for Health Statistics Data Brief, no. 540 (Hyattsville, Md.: National Center for Health Statistics, Sept. 2025).

[5]CMS—within the Department of Health and Human Services—administers the traditional Medicare program and oversees the Medicare Advantage program, the private plan alternative. Under traditional Medicare, CMS pays claims for health care services directly to health care providers. In contrast, CMS pays Medicare Advantage plans a fixed monthly payment per enrollee to provide health coverage no matter how many services are provided or how much those services cost.

[6]We reviewed guidelines and recommendations from the U.S. Preventive Services Task Force, American College of Cardiology, and American Heart Association. For purposes of this report, we included both services to prevent disease occurrence and to prevent its progression. This includes services beyond those specifically categorized by Medicare as preventive services that clinical information suggests can support CVD prevention by preventing disease occurrence and progression.

applicable laws and regulations, and interviewed CMS officials to determine Medicare's coverage of these services.[7]

To describe key factors affecting beneficiaries' use of services for CVD prevention, we interviewed representatives from a nongeneralizable selection of nine stakeholder organizations representing health care providers, researchers, and Medicare beneficiaries.[8] We asked organizations about these factors and how they affected beneficiaries in both traditional Medicare and Medicare Advantage. To supplement our interviews, we conducted a literature search of U.S.-based research published since 2015 about factors that affect beneficiaries' use of services for CVD prevention. We reviewed articles that expanded on themes that emerged from our interviews.

To describe beneficiaries' use of selected services for CVD prevention in traditional Medicare, we analyzed Medicare claims data for four services: lipid testing, cardiovascular behavioral therapy, atherosclerotic CVD risk assessment, and atherosclerotic CVD risk management services.[9] We selected these four services based on their role in CVD prevention and broad coverage for Medicare beneficiaries without specific risk factors, symptoms, or diagnoses. We analyzed Medicare claims data to describe use of these services by active Medicare beneficiaries, which we considered to be beneficiaries with at least one service claim in the past 5

[7]Information in this objective generally applies to both types of Medicare because Medicare Advantage plans must cover at least the same services as traditional Medicare. We indicate areas where there may be variation.

[8]We interviewed representatives from the Alliance for Patient Access, American Academy of Family Physicians, American College of Cardiology, American Heart Association, American Society for Preventive Cardiology, Medicare Rights Center, National Patient Advocate Foundation, Partnership to Advance Cardiovascular Health, and Society of Behavioral Medicine.

[9]We analyzed outpatient and carrier claims with the following Healthcare Common Procedure Coding System codes: 80061, 82465, 83718 and 84478 for lipid testing; G0446 for cardiovascular behavioral therapy; G0537 for atherosclerotic CVD risk assessment; and G0538 for atherosclerotic CVD risk management services. We also analyzed use of lipid testing by use of certain other services based on the following Healthcare Common Procedure Coding System codes: 99202 through 99205 and 99211 through 99215 for evaluation and management visits; G0438 and G0439 for annual wellness visits; and G0466 through G0468 for federally qualified health center visits.

years (from 2021 through 2025).[10] To align with certain Medicare coverage provisions, we analyzed lipid testing claims data from 2021 through 2025 (the most recent year of data available) and claims data from 2025 for the other three services.[11] We also analyzed beneficiary enrollment data to describe how the proportion of beneficiaries who used these services varied by different characteristics, such as geographic location and race and ethnicity. Our analysis is descriptive, and any variation likely reflects the combined effect of multiple factors that could affect the use of these services. For more information about these methods, see appendix I.

We assessed the reliability of the claims and enrollment data used for this report by reviewing relevant documentation and interviewing knowledgeable officials. We also performed data tests to identify missing data or obvious errors and checked our analysis for consistency with other published data. We determined the data were sufficiently reliable for the purposes of this report.

We conducted this performance audit from April 2025 to November 2026 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

[10]Specifically, we included beneficiaries with at least one outpatient or carrier claim in the last 5 years. We did not apply this standard to beneficiaries younger than 70 years old because many of those beneficiaries became eligible for Medicare upon turning 65 and thus would not have had the full 5-year period to generate a claim. Therefore, some beneficiaries less than 70 years old may be included in our study population despite not having a claim for services in the past 5 years. In addition, we limited our analyses by service to active Medicare beneficiaries continuously enrolled in both parts of traditional Medicare (i.e., both Parts A and B) for the period of our analyses (2021 through 2025 for lipid testing and throughout 2025 for the three other services).

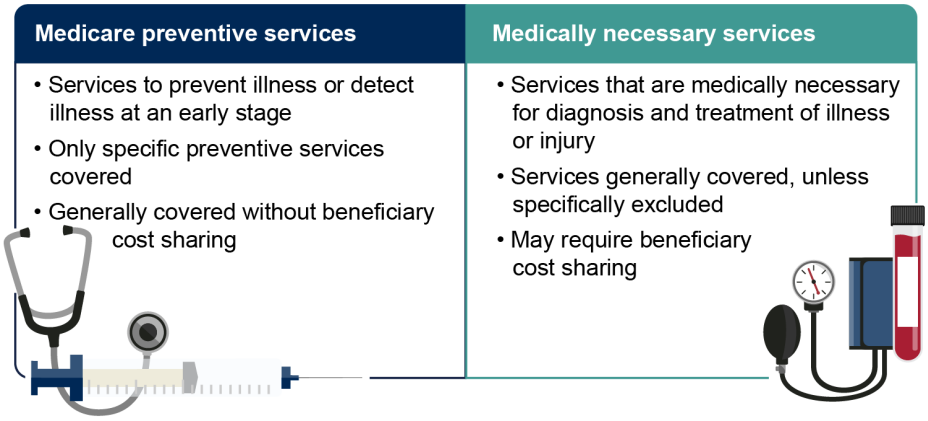
[11]We analyzed lipid testing claims data from 2021 through 2025 because this service is covered every 5 years for all beneficiaries. We analyzed claims data from 2025 for the other three services because cardiovascular behavioral therapy is covered annually for all beneficiaries, and coverage for atherosclerotic CVD risk assessment and atherosclerotic CVD risk management services began in 2025.

Medicare Coverage Related to Prevention

Medicare coverage related to prevention includes both services and medication.

Services. Medicare covers two types of outpatient services for prevention: Medicare preventive services and medically necessary services. As shown in figure 1, Medicare preventive services are covered to prevent the onset of illness or to identify illness early when treatment is most effective, while medically necessary services are covered to diagnose or treat an existing illness. Medically necessary services may still be related to prevention because they can be used to identify a disease early, slow its progression, and treat conditions that may be risk factors for other diseases. To encourage use, Medicare preventive services are generally covered without cost sharing.[12] In contrast, beneficiaries may have to pay cost sharing for medically necessary services.[13]

Figure 1: Types of Medicare Coverage Related to Prevention



Source: GAO analysis of Centers for Medicare & Medicaid Services documents (information and icons). | GAO-27-108423

[12]Medicare has three common forms of cost sharing: deductibles, coinsurance, and copayments. A deductible is the amount that beneficiaries must pay for covered services before Medicare starts to pay for those services. Coinsurance is a set percentage that beneficiaries pay for covered services after any deductible, and copayments are a fixed amount that beneficiaries pay for covered services after any deductible.

[13]In traditional Medicare, beneficiaries generally pay 20 percent coinsurance after the annual deductible ($283 in 2026), though many beneficiaries have some form of additional coverage to help them pay these costs. This includes coverage purchased from private Medigap plans, coverage received by certain retirees through a former employer, and coverage for eligible beneficiaries through Medicaid. In Medicare Advantage, cost sharing varies by plan.

Beneficiaries in both traditional Medicare and Medicare Advantage have coverage for these two types of services for prevention.[14] As of 2026, Medicare covers 29 preventive services, including immunizations, certain disease screenings, and counseling and education, among others.[15] Examples of medically necessary services include visits with primary care providers and specialists, as well as outpatient medical care, such as laboratory and imaging services.

Coverage for Medicare preventive services and some medically necessary services in both traditional Medicare and Medicare Advantage is specified in statutes, regulations, and national Medicare policies known as national coverage determinations (often referred to as NCDs). Coverage for other medically necessary services may vary. In traditional Medicare, coverage for most medically necessary services is set by local Medicare Administrative Contractors that are responsible for processing claims in specific geographic areas. The contractors may cover these services based on specific coverage policies known as local coverage determinations (often referred to as LCDs), or they may cover these services without explicit coverage determinations. In Medicare Advantage, plans must generally apply any existing Medicare criteria to determine coverage, but they may also develop additional internal coverage criteria that is not more restrictive than Medicare criteria. These internal criteria may vary by plan.

While Medicare Advantage plans must cover at least the same services as traditional Medicare, there are some differences in how the programs operate. In Medicare Advantage, beneficiaries generally obtain both preventive and medically necessary services from providers that are within their plan's network.[16]

Medication. Medicare also covers medication, which can play an important role in preventing disease onset and progression. Beneficiaries

[14]Medicare Advantage plans must cover at least the same preventive services and medically necessary services as traditional Medicare.

[15]At its origin, Medicare covered services to diagnose or treat illness and injury but not preventive services. Over time, coverage has expanded to include specific preventive services. For more information about this history, see GAO, *Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations,* GAO-12-81 (Washington, D.C.: Jan. 18, 2012).

[16]Medicare Advantage plans may require prior approval for certain medically necessary services, and in traditional Medicare, prior approval for medically necessary services is rare.

may choose to enroll in optional private plans that offer an outpatient prescription drug benefit. These plans, known as Part D plans, are available to eligible beneficiaries in both traditional Medicare and Medicare Advantage. While plans must meet certain coverage requirements, they can vary in terms of the specific medication covered. They can also vary in monthly premiums and cost sharing.

CVD Risk Factors and Prevention

The most common type of CVD is caused by atherosclerosis, which occurs when a buildup of plaque causes arteries to narrow and reduces the flow of blood to the heart and the rest of the body.[17] Atherosclerosis can lead to cardiac events (such as heart attacks and strokes) and heart failure, a condition in which the heart struggles to pump blood to the rest of the body. It can also cause other types of CVD including peripheral artery disease and atrial fibrillation.

Certain risk factors increase the likelihood of developing CVD. For example, clinical risk factors for CVD include conditions such as high blood pressure, high cholesterol, diabetes, and obesity. In addition, behavioral risk factors include eating an unhealthy diet, being physically inactive, and using substances, such as tobacco. Beneficiaries may be able to reduce these risk factors with health services, medication, or lifestyle changes. However, CVD risk can also be influenced by aspects outside of a beneficiary's control, such as family history, genetics, and age.

CVD prevention comprises a range of interventions. This includes interventions that aim to prevent the onset of CVD, as well as those that help prevent the progression of CVD once it has already occurred.[18] Examples include screening tests that look for a disease before symptoms appear, medication to prevent onset or progression, and lifestyle changes (e.g., dietary modifications and physical activity) to reduce risk factors and improve cardiac health. Interventions to prevent

[17]Examples of other types of CVD not caused by atherosclerosis include congenital heart diseases, which are related to structural problems present at birth, and conditions related to the inflammation of the heart, which are most commonly caused by viruses and bacteria.

[18]Interventions aimed at preventing the onset of disease are considered primary prevention, and those aimed at preventing disease progression are considered secondary prevention.

the progression of CVD are especially important for Medicare beneficiaries, many of whom already have a CVD diagnosis.[19]

Medicare Covers Certain Screenings Related to CVD and Other Services to Address Risk Factors

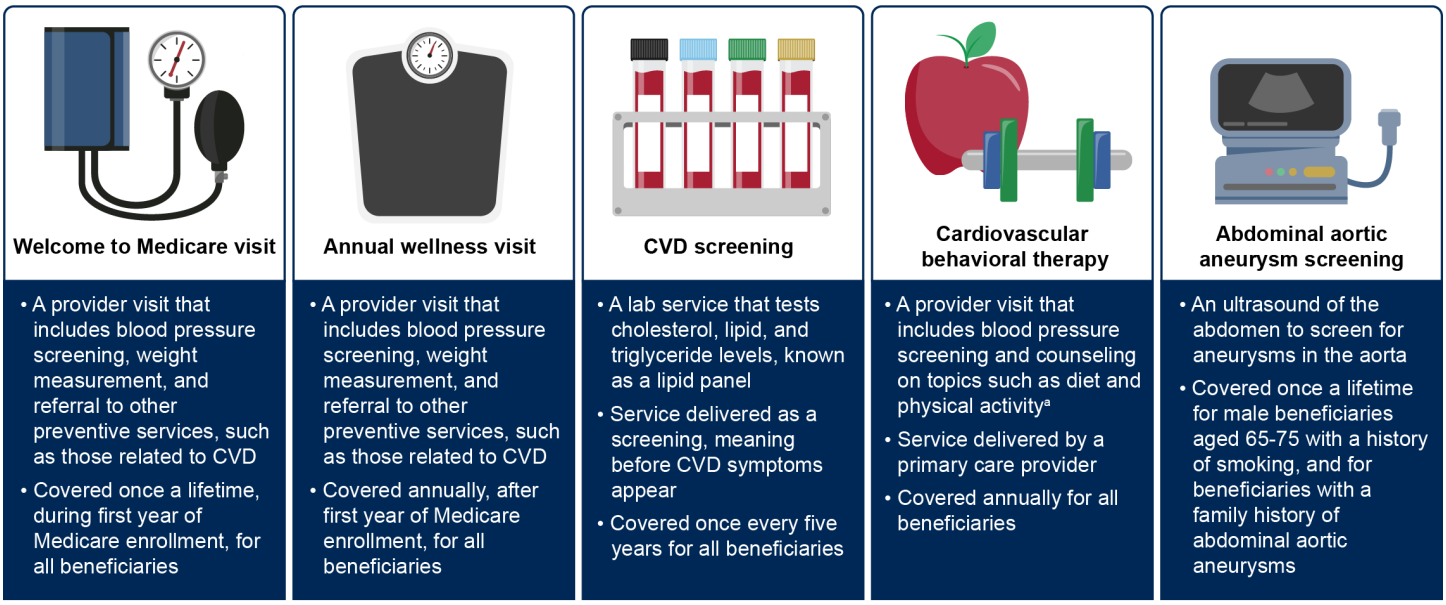
Five Medicare Preventive Services Are Related to CVD, Including Certain Screenings and Behavioral Counseling

Of the 29 Medicare preventive services covered to prevent disease onset or identify disease early, five are specifically related to CVD. These services are (1) the Welcome to Medicare visit, (2) an annual wellness visit, (3) CVD screening through a lipid panel, (4) cardiovascular behavioral therapy to reduce CVD risk, and (5) abdominal aortic aneurysm screening (see fig. 2). Medicare preventive services, including these five services, are generally covered without cost sharing.[20]

[19]See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *The Burden of Cardiovascular Disease in the United States: Patterns and Barriers to Care*, (Washington, D.C.: Aug. 2024).

[20]While Medicare preventive services are generally covered without cost sharing, beneficiaries may be required to pay cost sharing for associated components. For example, a beneficiary may have cost sharing for medically necessary services ordered at an annual wellness visit, even if not for the visit itself. In addition, for beneficiaries in traditional Medicare, if a provider does not accept the Medicare rate as payment in full for a covered service (known as accepting assignment), the beneficiary may have to pay for the service up front while the provider submits a claim to Medicare.

Figure 2: Medicare Preventive Services Related to Cardiovascular Disease (CVD)



Source: GAO analysis of Centers for Medicare & Medicaid Services documents (information and icons). | GAO-27-108423

Note: Medicare preventive services are covered to prevent the onset of illness or to identify illness early when treatment is most effective. As of 2026, Medicare covers a total of 29 preventive services, including immunizations, certain disease screenings, and counseling and education, among others. Coverage for these services is specified in statutes, regulations, and national Medicare policies known as national coverage determinations.

[a]Cardiovascular behavioral therapy may also include counseling on aspirin use if appropriate. Recommendations regarding the use of aspirin to prevent the onset of CVD vary by age and risk level. Since 2022, the U.S. Preventive Services Task Force has recommended against initiating aspirin use for this purpose by adults aged 60 or older.

In addition to the five Medicare preventive services directly related to CVD, some other preventive services are related to risk factors associated with CVD. For example, Medicare also covers obesity behavioral therapy, which is behavioral counseling by a primary care provider to promote weight loss through diet and exercise. Medicare also covers up to eight sessions of tobacco cessation counseling each year. Supplemental benefits offered by some Medicare Advantage plans also extend coverage of certain Medicare preventive services. For example, some Medicare Advantage plans offer nutritional education for all enrollees as well as additional sessions of tobacco cessation counseling.

Medicare does not cover any other CVD screenings as preventive services. These include lipoprotein(a) testing, which measures a specific kind of lipoprotein associated with higher CVD risk, and coronary calcium scans, which identify any buildup of calcium in the arteries. CMS officials

acknowledged that clinical practices around these services are evolving. For instance, in 2026, the American College of Cardiology and American Heart Association updated their clinical guidelines to recommend a one-time lipoprotein(a) screening for all adults, including older adults.[21] However, any CMS determinations to cover additional Medicare preventive services must align with U.S. Preventive Services Task Force recommendations.[22] As of November 2026, the Task Force's most recent evaluations of these services found insufficient evidence to support their coverage.[23]

Medicare Also Covers Services and Medication to Diagnose and Treat CVD Risk Factors and Prevent Disease Progression

Medicare also covers medically necessary services and medication for diagnosing and treating existing conditions that are CVD risk factors and for preventing CVD progression. Because they are not classified as Medicare preventive services, these services and medication generally have beneficiary cost sharing.

Services. Medicare covers medically necessary services for diagnosing and treating conditions that are CVD risk factors (e.g., high blood pressure or high cholesterol) and for preventing progression of CVD itself.

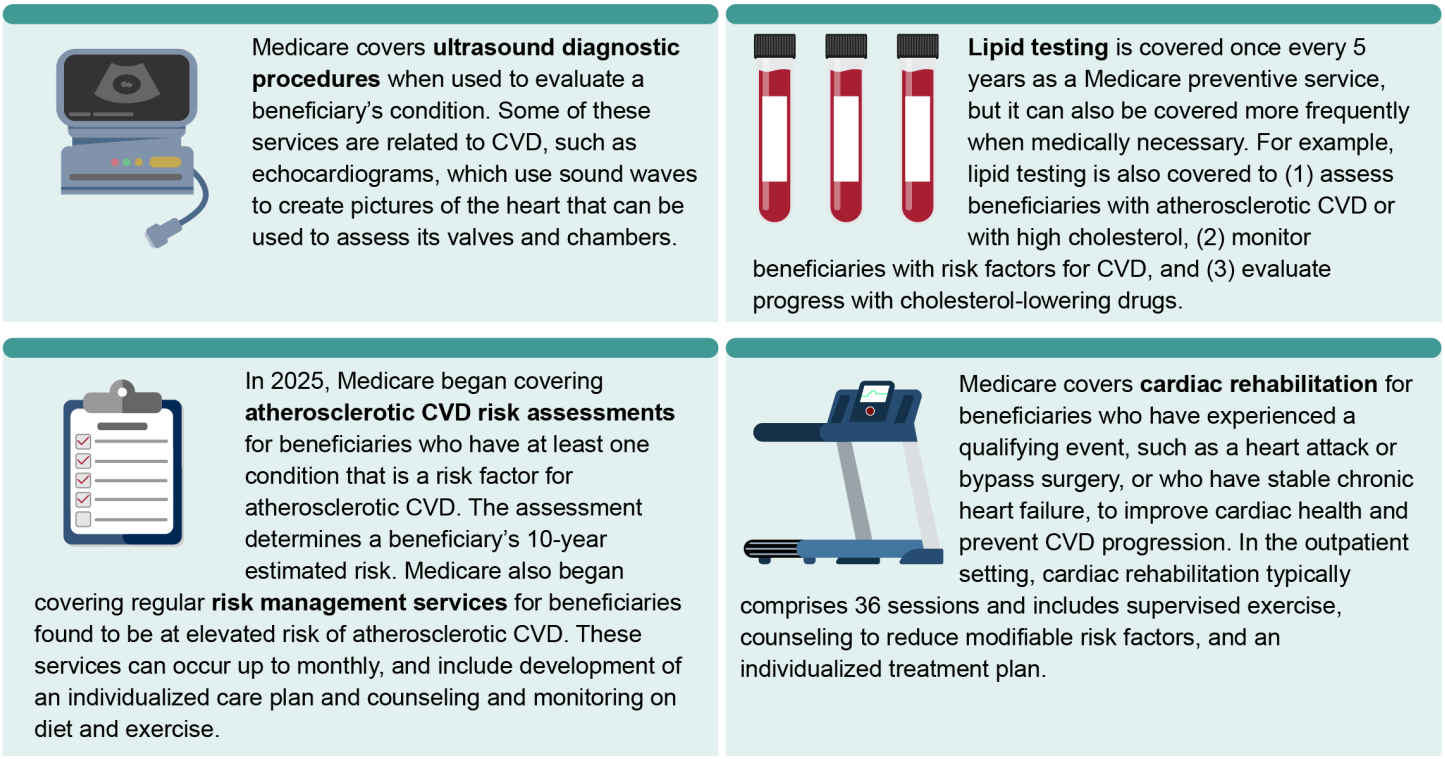
[21]Roger S. Blumenthal et al, "2026 ACC / AHA / AACVPR / ABC / ACPM / ADA / AGS / APhA / ASPC / NLA / PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines," *Journal of the American College of Cardiology*, vol. 87, no. [19] (2026).

[22]The U.S. Preventive Services Task Force is a group of independent, private-sector experts that reviews evidence on the effectiveness of preventive services and issues recommendations for use. The Department of Health and Human Services has the authority to add to Medicare preventive services coverage through national coverage determinations when services are given a grade A or B recommendation by the Task Force and the department determines they are reasonable and necessary for the prevention or early detection of an illness or disability, and appropriate for beneficiaries. See Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 101(a), 122 Stat. 2494, 2496–97 (codified at 42 U.S.C. § 1395x(ddd)).

[23]For the most recent evaluation of lipoprotein(a) testing, see U.S. Preventive Services Task Force, "Using Nontraditional Risk Factors in Coronary Heart Disease Risk Assessment: U.S. Preventive Services Task Force Recommendation Statement," *Annals of Internal Medicine*, vol. 151, no. 7 (2009). For the most recent evaluation of coronary calcium scans, see U.S. Preventive Services Task Force, "Risk Assessment for Cardiovascular Disease with Nontraditional Risk Factors: U.S. Preventive Services Task Force Recommendation Statement," *Journal of the American Medical Association*, vol. 320, no. 3 (2018). As of November 2026, the Task Force's website said that an update to this recommendation was in progress; see "Enhanced Risk Assessment for Cardiovascular Disease: Coronary Artery Calcium Scoring," U.S. Preventive Services Task Force (Sept. 19, 2024), https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/cardiovascular-disease-enhanced-risk-assessment-non-traditional-risk-factors.

Some of these services are covered nationally, with coverage criteria that describe the reasons for and circumstances under which services will be covered. See figure 3 for examples of these services.

Figure 3: Examples of Medically Necessary Services Related to Cardiovascular Disease (CVD) Prevention with National Medicare Coverage Criteria



Source: GAO analysis of Centers for Medicare & Medicaid Services documents (information and icons). | GAO-27-108423

Note: Medicare covers medically necessary services to diagnose or treat an illness. Some of these services are related to CVD prevention because they can be used to identify the disease early, slow its progression, or treat conditions that may be risk factors for CVD. Coverage for the example services in this figure are specified in law or in national Medicare policies. Other services may also be covered, including without explicit coverage criteria.

Medicare coverage for other medically necessary services related to CVD prevention is determined at the local level. Services may be covered without explicit coverage criteria when claims are processed and paid by the local Medicare Administrative Contractor. In some cases, the contractor has a local coverage determination for certain services. For example, one contractor has a local coverage determination for cardiovascular stress testing, a diagnostic test used to gather information

about how the heart responds to exertion.[24] This determination describes the reasons for which this service would be covered as medically necessary. Another contractor has a local coverage determination for cardiovascular nuclear medicine, which uses imaging with a radioactive agent to assess heart and artery function.[25] Because these determinations only apply to the areas served by the specific contractor, coverage may vary depending on where a beneficiary is located.[26]

Beneficiaries may pay cost sharing for medically necessary services related to CVD prevention. Because these services are not designated as Medicare preventive services, beneficiaries in traditional Medicare are generally responsible for 20 percent coinsurance after meeting their annual deductible.[27] Cost sharing for beneficiaries in Medicare Advantage varies by specific plan.

Two services related to CVD prevention—lipid testing and electrocardiograms—can be covered as a medically necessary service or as a screening before symptoms appear, depending on whether it is part of a Medicare preventive service. Lipid testing is covered every 5 years for all beneficiaries as a Medicare preventive service; however, it may be covered more frequently for specific purposes, such as to monitor patients with high lipid levels. Additionally, an electrocardiogram, which is a reading of the heart's electrical activity that can be used to identify various types of CVD, is covered as a screening only when ordered at a beneficiary's Welcome to Medicare visit.[28] Otherwise, it is only covered as a medically necessary service to diagnose an illness when there are

[24]First Coast Service Options, Inc., *Cardiology Non-emergent Outpatient Stress Testing*, L38396 (Apr. 25, 2021).

[25]Wellpoint Federal, *Cardiovascular Nuclear Medicine*, L33560 (Apr. 1, 2026).

[26]As another example, in April 2026, CMS established a new billing code for the use of artificial intelligence to detect and quantify coronary calcium on chest computed tomography scans (commonly known as chest CT scans) ordered for other reasons, such as for lung cancer screening. However, the establishment of a new billing code is separate from any establishment of coverage. Because there is no national coverage determination for this service, local Medicare Administrative Contractors will be responsible for determining its coverage.

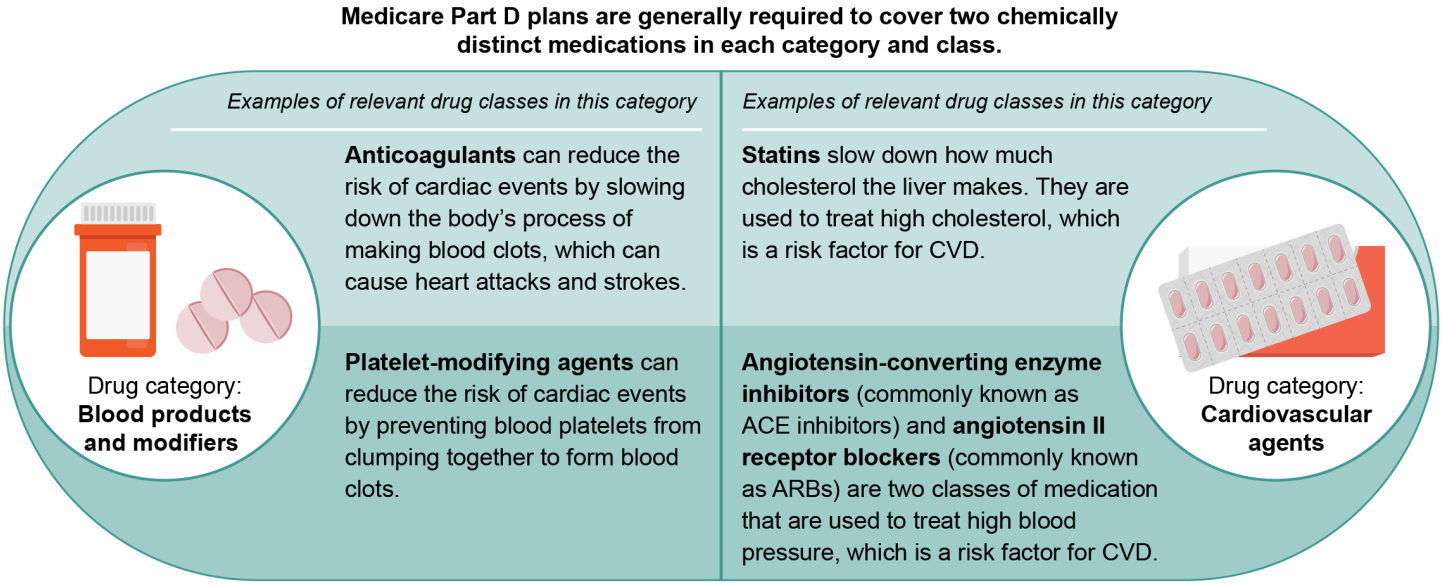
[27]An exception is diagnostic laboratory tests, such as lipid testing. Beneficiaries in traditional Medicare generally do not pay cost sharing for clinical laboratory services.

[28]An electrocardiogram generally has 20 percent cost sharing in traditional Medicare, regardless of why it is ordered.

documented signs and symptoms. Providers indicate the reason for use with certain codes submitted on the claim.

Medication. Medicare Part D plans are required to cover two categories of prescription medication related to CVD prevention: (1) blood products and modifiers and (2) cardiovascular agents.[29] Within each category, there are several classes of medication, examples of which are shown in figure 4.

Figure 4: Categories and Classes of Prescription Medication Related to Cardiovascular Disease (CVD) Prevention Covered by Medicare Part D



Source: GAO analysis of U.S. Pharmacopeial Convention and MedlinePlus documentation (information and icons). | GAO-27-108423

Note: Drug categories and classes are defined by the U.S. Pharmacopeial Convention. Blood products and modifiers and cardiovascular agents are the two categories related to CVD prevention. Medicare Part D plans may vary in the specific drugs covered.

Coverage for specific medications for CVD prevention varies by Part D plan. This is because while every plan is generally required to cover at least two chemically distinct medications in each category and class, each category and class is often made up of several different medications. For example, there are seven different types of FDA-

[29]Some prescription medication may be covered as an outpatient service if administered by a provider, including medication related to CVD prevention. For example, one cholesterol-lowering drug is delivered as a provider-administered injection and therefore covered as a medically necessary service.

approved medications in the statins class. This means beneficiaries have different coverage based upon their plan: one beneficiary may have coverage for a certain statin, such as atorvastatin or fluvastatin, and another beneficiary with a different Part D plan may have coverage for another statin instead. Additionally, beneficiaries have different out-of-pocket costs for the same medication for CVD prevention across Part D plans. This is because plans vary in both the cost of their monthly premiums and in their cost-sharing arrangements.

Out-of-Pocket Costs, Patient Factors, and Provider Availability Can Affect Beneficiaries' Use of Services for CVD Prevention

Out-of-Pocket Costs

Out-of-pocket costs for services and medication for CVD prevention can affect beneficiaries' use of those services and medication. According to representatives from the stakeholder organizations we interviewed and selected research we reviewed, beneficiaries may face unexpected cost sharing for specific services and medication, and beneficiaries that experience higher out-of-pocket costs are more likely to discontinue prescribed treatment.

Out-of-pocket costs—specifically cost sharing—for specific services for CVD prevention can deter beneficiaries' use of those services, according to representatives from eight stakeholder organizations. For example, because cardiac rehabilitation typically takes place over 36 sessions in 12 weeks, modest cost-sharing amounts can accumulate and deter participation, according to a representative from a provider organization. If a beneficiary is responsible for a $20 copayment for each session, for

instance, that would add up to a total out-of-pocket cost of $720.[30] Researchers in this area have found that patients, including Medicare beneficiaries, who paid higher out-of-pocket costs for their first cardiac rehabilitation session attended fewer subsequent sessions than those without these costs, based on an analysis of 2016 to 2020 data.[31]

Cost sharing for medication can also increase out-of-pocket costs and affect beneficiaries' use, according to representatives from four stakeholder organizations. For example, beneficiaries with CVD are often managing multiple comorbidities, according to representatives from two provider organizations, which can include high blood pressure and diabetes. They may need four to five different medications to treat all of their conditions, which leads to additional cost sharing for each medication, according to representatives from one organization. Even small copayments for generic medications can be challenging for certain beneficiaries, according to a representative from one provider organization. Researchers have also looked at the potential effect of out-of-pocket costs on the use of medication for CVD prevention. For example, a 2023 study of Medicare beneficiaries who started anticoagulant medication to treat a type of CVD called atrial fibrillation found that those with increased out-of-pocket costs were more likely to discontinue their medication than those who received financial assistance.[32]

Finally, beneficiaries may experience confusion about their out-of-pocket costs for services and medication for CVD prevention, which can affect their use. Representatives from two organizations said that beneficiaries

[30]This is a hypothetical example. Cost-sharing amounts for cardiac rehabilitation vary across several factors, including enrollment in traditional Medicare or Medicare Advantage and the cost-sharing arrangements of specific Medicare Advantage plans. Additionally, many traditional Medicare beneficiaries have some form of additional health care coverage that helps them pay for out-of-pocket costs. This includes private Medigap plans and Medicaid.

[31]Researchers analyzed commercial and Medicare supplemental claims for adults aged 18 through 75. See Alexandra I. Mansour, Ushapoorna Nuliyalu, Michael P. Thompson, Steven Keteyian, and Devraj Sukul, "Out-of-Pocket Spending for Cardiac Rehabilitation and Adherence Among U.S. Adults," *American Journal of Managed Care,* vol. 30, no.12 (2024).

[32]This study looked at Medicare beneficiaries aged 65 and older between 2015 and 2019. The entire study population was prescribed a direct oral anticoagulant, for which less costly generic versions were generally not available. See Tabassum Salam et al., "Unintended Consequences of Increased Out-of-Pocket Costs During Medicare Coverage Gap on Anticoagulant Discontinuation and Stroke," *Advances in Therapy*, vol. 40 (2023).

may delay service use, including for CVD prevention, if they do not understand their service coverage or fear the possibility of unexpected costs. As previously mentioned, Medicare generally covers preventive services related to CVD without cost sharing, whereas medically necessary services include cost sharing. For example, a representative from one provider organization said that a beneficiary may come in for a preventive service but may have to pay cost sharing because of a specific diagnosis or additional service received.[33]

Patient Factors

Different types of patient factors—including socioeconomic, demographic, and clinical factors—affect beneficiaries' use of services for CVD prevention. According to representatives from stakeholder organizations we interviewed and selected research reviewed, beneficiaries who are on fixed incomes or managing multiple comorbidities, among other things, may experience challenges accessing services.

Socioeconomic factors, including income and food supply, may limit beneficiaries' use of services for CVD prevention. Specifically, beneficiaries may face challenges managing additional expenses associated with the use of these services, such as transportation, according to representatives from seven organizations.[34] These additional expenses can be particularly challenging for beneficiaries on fixed incomes. For example, a representative from one of those organizations explained that, in addition to any cost sharing, a beneficiary who is on a fixed income and starting a cardiac rehabilitation program would have to consider transportation or parking expenses, and any accompanying caregiver's potential loss of income for each session. A representative from another provider organization noted that beneficiaries without sufficient food supply face challenges following providers' dietary recommendations to manage CVD risk.

Demographic factors can also affect who uses services for CVD prevention. Representatives from three stakeholder organizations said beneficiaries may experience challenges accessing services for CVD prevention based on their age, sex, race and ethnicity. There is also some research on demographic factors based on data from 2003 to 2007.

[33]Providers also experience challenges staying aware of beneficiaries' coverage and out-of-pocket costs for services and medication related to CVD prevention, according to representatives from four organizations.

[34]Additional expenses include any expenditure associated with the use of health care services and medication. In contrast, out-of-pocket costs include direct costs for health care services and medication, such as deductibles, coinsurance, and copayments.

In that study, researchers looked at individuals ages 45 through 75 with chronic obstructive pulmonary disease (which elevates the risk for CVD) and found that Black and White women were less likely than White men to receive statin medication, as recommended by clinical guidelines.[35] Additionally, a representative from one provider organization said beneficiaries may experience health care stigma, such as feeling as though their symptoms, concerns, or health behaviors are judged by providers. These interactions may deter beneficiaries' willingness to seek care or lower use of services for CVD prevention, according to this representative.

Finally, clinical factors also affect beneficiaries' use of services for CVD prevention. For example, having multiple comorbidities can complicate beneficiaries' care related to CVD prevention, according to representatives from two provider organizations. Researchers have also studied the effect of an individual's comorbidity diagnosis on the prescription of medications for CVD prevention. Specifically, one study of individuals over 75 years of age with atherosclerotic CVD in a large regional health system from 2007 to 2018 found they were more likely to receive prescriptions for recommended levels of statin medication if they had certain comorbidities, such as hypertension or diabetes. Individuals were less likely to receive prescriptions if they had certain other comorbidities, such as heart failure or dementia. Researchers noted that statin prescription in this population requires special considerations of their comorbidities and use of multiple prescription medications.[36]

Provider Availability

Beneficiaries' use of services for CVD prevention also can be affected by limited provider availability. Representatives from stakeholder organizations we interviewed and selected research described several factors affecting provider availability, including workforce shortages and limitations on telehealth services.

[35]See Jamuna K. Krishnan et al., "Disparities in Guideline-Concordant Statin Treatment in Individuals With Chronic Obstructive Pulmonary Disease," *Chronic Obstructive Pulmonary Diseases: Journal of the COPD Foundation*, vol. 10, no. 4 (2023). This research analyzed data collected from participants enrolled in a cohort study designed to examine geographic and racial variations in care and outcomes from 2003 to 2007.

[36]See Gabriela Spencer-Bonilla, Sukyung Chung, Ashish Sarraju, Paul Heidenreich, Latha Palaniappan, and Fatima Rodriguez, "Statin Use in Older Adults with Stable Atherosclerotic Cardiovascular Disease," *Journal of the American Geriatrics Society,* vol. 69, no. 4 (2021).

Workforce shortages, including in certain specialties, affect providers' availability and beneficiaries' use of services for CVD prevention. Representatives from eight organizations spoke about this effect generally, and representatives from three organizations spoke about this effect for specific specialties that deliver services for CVD prevention. For example, a representative from one organization said workforce shortages limit both the delivery of these services in the primary care setting and referrals to specialists for additional services. A representative from a provider organization said a shortage of technologists who perform imaging services has led to delays in services such as echocardiograms.

Shortages of primary care physicians and specialists, as well as cardiac rehabilitation facilities, in certain geographic areas can also limit beneficiaries' use of services for CVD prevention. Beneficiaries in rural and underserved metropolitan areas experience challenges locating and accessing nearby providers for CVD prevention, according to representatives from six organizations. In areas with shortages of cardiac rehabilitation facilities, some beneficiaries may have to travel 20 to 40 miles to attend in-person sessions up to three times per week, according to a representative from a provider organization, and the distance can negatively affect participation.[37] Additionally, according to representatives from two organizations, beneficiaries in Medicare Advantage plans may experience additional challenges finding nearby services because beneficiaries generally have to obtain these services from providers within their network.

Representatives from stakeholder organizations also mentioned the limitations of telehealth in addressing shortages in the availability of certain services such as cardiac rehabilitation. In particular, representatives from four organizations mentioned cardiac rehabilitation provided through a telehealth platform in a beneficiary's home, for which coverage began during the COVID-19 public health emergency and is

[37]Research also suggests longer travel times are challenging for beneficiaries and affect the use of cardiac rehabilitation services. For example, one study found that the most elderly beneficiaries treated in Department of Veterans Affairs' hospitals from 2016 to 2019 for acute coronary events were less likely to subsequently participate in cardiac rehabilitation if their drive time exceeded 90 minutes. See Arianne K. Baldomero et al., "Drive Time and Receipt of Guideline-Recommended Screening, Diagnosis, and Treatment," *JAMA Network Open,* vol. 5, no. 11 (2022).

currently extended through December 2027.[38] According to these representatives, this type of coverage reduces the transportation burden for in-person sessions, thereby improving access. However, representatives from two provider organizations also noted that, because Medicare's coverage of cardiac rehabilitation provided in the home is currently time limited, providers may not want to invest in the expansion of these telehealth programs.

Stakeholder organizations also mentioned that utilization management, such as prior authorization, adds administrative requirements that may delay beneficiaries' receipt of services for CVD prevention. Prior authorization is a process where health plans, including Medicare Advantage and commercial plans, require providers to request and receive approval before delivering certain services. Representatives from six organizations said providers experience challenges with the use of prior authorization to approve requests for certain services and medications before treatment. In particular, representatives from two of these organizations said documentation requirements for prior authorization requests are time consuming and may reduce the amount of time providers have to see beneficiaries. Researchers have also examined this topic. For example, one study found that Medicare beneficiaries diagnosed with atrial fibrillation between 2015 and 2018 and prescribed anticoagulants were more likely to delay starting medication by more than three months if their coverage required prior authorization.[39]

[38]Permanent telehealth provisions support rural beneficiaries' access to Medicare services, including cardiac rehabilitation and other services related to CVD prevention, according to CMS officials. These provisions include restrictions on the delivery of telehealth services. For example, the beneficiary is generally required to travel to a local facility, such as a rural health clinic, for the telehealth visit. See Section 1834(m) of the Social Security Act (codified at 42 U.S.C. § 1395m(m)). Statutes waived some of these restrictions during the COVID-19 public health emergency and later extended the waiver through December 2027. See Consolidated Appropriations Act, 2026, Pub. L. No. 119-75, § 6209, 140 Stat. 173, 648. In addition, statutory provisions temporarily expanded Medicare's coverage of cardiac rehabilitation services by allowing Medicare beneficiaries to receive telehealth services for cardiac rehabilitation in their home through December 2027. Pub. L. No. 119-75, § 6211, 140 Stat. at 652 (codified at 42 U.S.C. § 1395x(eee)).

[39]In the study, researchers assessed the timing of medication initiation among beneficiaries who were newly diagnosed with atrial fibrillation and prescribed anticoagulants. Prior authorization requirements applied to 19 percent of the beneficiary sample prescribed anticoagulants. See Xuemei Luo, Jose Chaves, Amol D. Dhamane, Feng Dai, Dominick Latremouille-Viau, and Aolin Wang, "Delayed Treatment Initiation of Oral Anticoagulants Among Medicare Patients with Atrial Fibrillation," *American Heart Journal Plus: Cardiology Research and Practice*, vol. 39 (2024).

Beneficiaries Used Different Levels of Selected Services for CVD Prevention in Traditional Medicare

Medicare claims data show variation in the use of four selected services for CVD prevention: lipid testing, cardiovascular behavioral therapy, atherosclerotic CVD risk assessment, and atherosclerotic CVD risk management services. While most beneficiaries received at least one lipid test from 2021 through 2025, comparatively few beneficiaries had claims in 2025 for the other three selected services we reviewed, though this may reflect other factors, such as low awareness of coverage.

Most Beneficiaries Received at Least One Lipid Test from 2021 through 2025

Approximately 90 percent of beneficiaries in our analysis, or 16.2 million out of 18.1 million, received at least one lipid test from 2021 through 2025, according to Medicare claims data.[40] In total, these beneficiaries received 92.9 million lipid tests during this time period. Of those tests, just under 1.3 million were covered as Medicare preventive services, while the other 91.6 million were covered as medically necessary services. The most cited diagnoses associated with medically necessary lipid tests were high blood pressure and high cholesterol.

Lipid Testing

Lipid testing measures the different types of lipids in the blood, including cholesterol and triglycerides. High levels can increase the risk of cardiovascular disease. Medicare covers lipid testing in two ways: (1) as a Medicare preventive service for all beneficiaries once every 5 years, and (2) as a medically necessary service when needed for beneficiaries with specific clinical indications. For example, a beneficiary may receive annual lipid testing to monitor borderline or high cholesterol levels.

Source: GAO analysis of Centers for Medicare & Medicaid Services documents. | GAO-27-108423

We analyzed lipid test use based on whether the beneficiary had received certain other services, such as an annual wellness visit or other office visit. Among beneficiaries who had not received a lipid test from 2021 through 2025, 81 percent had a claim for at least one office visit during the same time period.

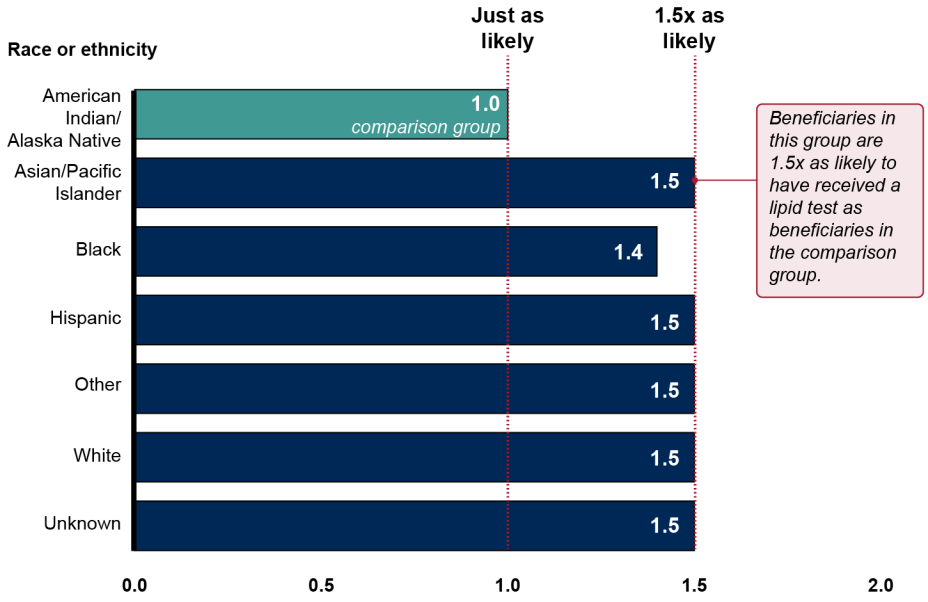
We also analyzed lipid test use across different beneficiary characteristics and observed some of the largest variation across race and ethnicity, and among different geographic areas. See appendix I for additional data on lipid testing across other beneficiary characteristics.

Race and ethnicity. We observed differences in the likelihood of beneficiaries having received a lipid test from 2021 through 2025 by race

[40]For more information about our analysis, including the study population, see appendix I.

and ethnicity.[41] For example, American Indian/Alaska Native beneficiaries were the least likely to have received a lipid test during this time period; beneficiaries of most other races and ethnicities were 1.5 times more likely to have received a lipid test (see fig. 5).

Figure 5: Beneficiaries' Receipt of Lipid Testing in Traditional Medicare, by Race and Ethnicity, 2021-2025



Source: GAO analysis of Centers for Medicare & Medicaid Services enrollment and claims data. | GAO-27-108423

Notes: The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare from 2021 through 2025.

The likelihood of receiving a service is calculated as a relative risk ratio versus the comparison group, which was the group least likely to receive the service. The relative risk ratio indicates how much more likely a beneficiary in each group is to have received the service than a beneficiary in the comparison group.

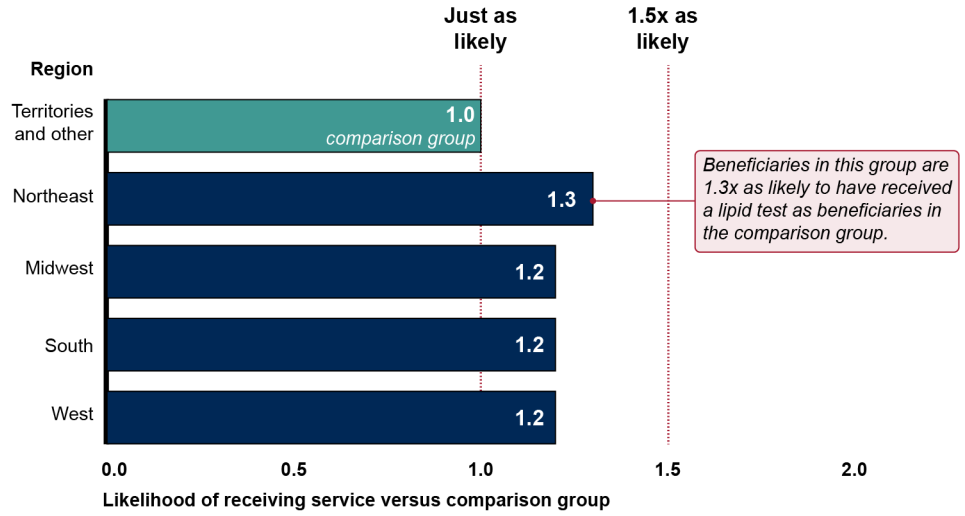
To improve the accuracy of the race and ethnicity data, GAO used an alternative CMS variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location. Beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic. For more information about our analysis, including this and other variables used, see appendix I.

Region. We also observed differences in the likelihood of beneficiaries having received a lipid test from 2021 through 2025 by region. For example, beneficiaries in the territories and other locations were the least

[41]To improve the accuracy of the race and ethnicity data, we used a CMS variable that applied an algorithm to beneficiaries' race and ethnicity data. For more information on this and other variables used, see appendix I.

likely to have received a lipid test during this time period. In comparison, beneficiaries in the Northeast were 1.3 times more likely to have received a lipid test (see fig. 6).

Figure 6: Beneficiaries' Receipt of Lipid Testing in Traditional Medicare, by Region, 2021-2025



Source: GAO analysis of Centers for Medicare & Medicaid Services enrollment and claims data. | GAO-27-108423

Note: The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare from 2021 through 2025. For more information about our analysis, including this and other variables used, see appendix I.

The likelihood of receiving a service is calculated as a relative risk ratio versus the comparison group, which was the group least likely to receive the service. The relative risk ratio indicates how much more likely a beneficiary in each group is to have received the service than a beneficiary in the comparison group.

Few Beneficiaries Had Claims for Cardiovascular Behavioral Therapy, Risk Assessment, and Risk Management Services in 2025

In 2025, relatively few beneficiaries had Medicare claims for the three other selected services for CVD prevention that we analyzed: cardiovascular behavioral therapy, atherosclerotic CVD risk assessment, and atherosclerotic CVD risk management services.[42] These services are generally delivered by providers in the primary care setting and are focused on identifying and modifying CVD risk, with an emphasis on behavioral change. Additional beneficiaries may have received similar services without appearing in the claims data due to low provider awareness of these services' coverage, among other reasons.

[42]For more information about our analysis, including the study population, see appendix I.

Cardiovascular behavioral therapy. Approximately 1.5 percent of beneficiaries in our analysis, or about 390,000 out of 25.3 million, had a claim for cardiovascular behavioral therapy in 2025. This relatively low use may have two possible explanations.

Cardiovascular Behavioral Therapy

Cardiovascular behavioral therapy is a Medicare preventive service covered annually for all beneficiaries without cost sharing. This 15-minute primary care visit includes screening for high blood pressure and counseling on topics such as diet and exercise.

Source: GAO analysis of Centers for Medicare & Medicaid Services documents. | GAO-27-108423

First, some providers and others may not be aware of Medicare coverage for this specific service. Representatives from five stakeholder organizations we spoke with were unfamiliar with this service or billing code. A representative from one provider organization explained that providers often have multiple clinical priorities to balance during primary care visits, particularly with Medicare beneficiaries, such as managing comorbidities, coordinating with specialists, and providing screening services. As a result, they may not prioritize delivering the service if they are unaware of this code and not prompted by their information technology systems to use it.

Second, providers may deliver similar services to beneficiaries without billing the specific code, such as during a regular office visit. In some cases, this may be because only primary care providers are authorized to bill for cardiovascular behavioral therapy.[43] Representatives from four stakeholder organizations mentioned this limitation. A specialist provider from one organization said these services are part of essentially every patient visit in that specialty, but those services would not appear in the claims data.

Although overall claims for cardiovascular behavioral therapy were low across all beneficiary characteristics, we observed some variation, particularly across race and ethnicity and region. For example, American Indian/Alaska Native beneficiaries were the least likely to have a claim for cardiovascular behavioral therapy, and Asian/Pacific Islander beneficiaries, the most likely. Additionally, beneficiaries in the Midwest were the least likely to have a claim for this service, and beneficiaries in

[43]According to CMS, it is important that primary care providers be the ones to provide this service because they are uniquely positioned to provide a comprehensive and coordinated approach that enhances the benefits of this service. See Centers for Medicare & Medicaid Services, *Coverage Decision Memorandum for Intensive Behavioral Therapy for Cardiovascular Disease*, CAG-00424N (Baltimore, Md.: Nov. 8, 2011).

the South, the most likely. See appendix I for additional data on this service across these and other beneficiary characteristics.

Atherosclerotic CVD risk assessment and risk management services. In 2025, Medicare began covering two new services related to CVD prevention: atherosclerotic CVD risk assessment and atherosclerotic CVD risk management. During that first year of coverage, approximately 101,000 out of 25.3 million beneficiaries in our analysis had a claim for an atherosclerotic CVD risk assessment. Additionally, approximately 32,000 beneficiaries had a claim for at least one subsequent risk management service.

Atherosclerotic Cardiovascular Disease (CVD) Risk Assessment and Risk Management Services

Medicare's coverage of these new services was based on findings from the Centers for Medicare & Medicaid Services' Million Hearts® CVD Risk Reduction Model, which found that the use of atherosclerotic CVD risk assessment and risk management services reduced the rate of death by lowering heart attacks and strokes among Medicare beneficiaries.

The atherosclerotic CVD risk assessment is covered for beneficiaries with at least one predisposing condition for CVD, such as obesity, high blood pressure, high cholesterol, or prediabetes, among others. The risk assessment must calculate a beneficiary's 10-year atherosclerotic CVD risk based on risk factors, demographic factors, and current lipid levels. If they are found to be at medium- or high-risk, beneficiaries are eligible for atherosclerotic CVD risk management services, which are covered once per month. These services are intended to reduce a beneficiary's risk by developing and monitoring an individual care plan that addresses blood pressure and cholesterol management and behavioral risk factors, such as physical activity and nutrition.

Source: GAO analysis of Centers for Medicare & Medicaid Services documents. | GAO-27-108423

One reason for this relatively low use may be that some providers are not yet aware of the new billing codes that can be used for these services. Representatives from seven stakeholder organizations we interviewed were unfamiliar with this new coverage. Specifically, representatives from three provider organizations mentioned that one challenge related to awareness of Medicare's coverage is that these new billing codes were not yet operationalized in the electronic health record or other systems that they used. Despite this, representatives from two of these organizations said that beneficiaries may still be receiving these services, noting that they regularly provide these services without billing the new codes.

Another reason for this relatively low use may be the documentation and cost sharing required for these services. Representatives from three stakeholder organizations said that the documentation required to bill the codes may deter use. For example, a representative from one organization said that the billing department at the institution where she practices medicine had determined that, based on the documentation required, it would not bill for these new services and therefore did not publicize them among its providers. Additionally, representatives from

three other organizations said that beneficiary cost sharing may also deter use. Because these new services are not designated as Medicare preventive services, which generally do not have cost sharing, beneficiaries in traditional Medicare receiving them may have to pay 20 percent coinsurance.[44] Representatives from one organization noted that beneficiaries may be used to receiving these types of services as part of their office visits before and may not want to receive them if they are charged separately.

Although overall claims for atherosclerotic CVD risk assessment and risk management services were low across all beneficiary characteristics, we observed some variation, particularly across region and race and ethnicity. For example, beneficiaries in the territories and other locations were the least likely to have a claim for risk assessment or risk management services, while beneficiaries in the South were the most likely to have a claim for risk assessment and beneficiaries in the Northeast, the most likely to have a claim for risk management. Additionally, American Indian/Alaska Native beneficiaries were the least likely to have a claim for risk assessment or risk management services and beneficiaries of unknown race, the most likely.[45] See appendix I for additional data on these services across these and other beneficiary characteristics.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services for review and comment. The Department of Health and Human Services provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at https://www.gao.gov.

[44]Many traditional Medicare beneficiaries have some form of additional health care coverage that helps them pay for out-of-pocket costs. This includes private Medigap plans and Medicaid.

[45]Based on CMS source data, beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic. See Department of Health and Human Services, Office of Inspector General, *A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data*, OEI-02-21-00101 (Washington, D.C.: June 2023).

If you or your staff have any questions about this report, please contact me at GordonLV@gao.gov. Contact points for our Offices of Congressional Relations and Media Relations may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.

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Leslie V. Gordon
Director, Health Care

Appendix I: Methods and Data on Beneficiaries' Use of Services for Cardiovascular Disease Prevention

This appendix provides further detail on the methods used in our analysis and additional data on beneficiaries' use of four selected services for cardiovascular disease (CVD) prevention in traditional Medicare. These four services are lipid testing, cardiovascular behavioral therapy, atherosclerotic CVD risk assessment, and atherosclerotic CVD risk management services. We selected services based on their role in CVD prevention and broad coverage for Medicare beneficiaries without specific risk factors, symptoms, or diagnoses. Specifically, we analyzed outpatient and carrier claims with the following Healthcare Common Procedure Coding System codes: 80061, 82465, 83718 and 84478 for lipid testing; G0446 for cardiovascular behavioral therapy; G0537 for atherosclerotic CVD risk assessment; and G0538 for atherosclerotic CVD risk management services.[1] We also analyzed beneficiaries' use of lipid testing by use of certain other services, using the following Healthcare Common Procedure Coding System codes: 99202 through 99205 and 99211 through 99215 for evaluation and management visits; G0438 and G0439 for annual wellness visits; and G0466 through G0468 for federally qualified health center visits.

We analyzed Medicare claims and enrollment data to describe use of these services by active Medicare beneficiaries, which we considered to be beneficiaries with at least one outpatient or carrier claim in the past 5 years (from 2021 through 2025). However, we did not apply this 5-year standard to beneficiaries younger than 70 years old because many of those beneficiaries became eligible for Medicare upon turning 65 and thus would not have had the full 5-year period to generate a claim. Therefore, some beneficiaries less than 70 years old may be included in our study population despite not having a claim for services in the past 5 years.

In addition, our study population was limited to Medicare beneficiaries continuously enrolled in both parts of traditional Medicare (i.e., both Parts A and B) for the period of our analyses. For lipid testing, this time period was 2021 through 2025 (the most recent year of data available) to align

[1]Carrier claims data include claims submitted by providers such as physicians, nurse practitioners, and physician assistants and by some organizational facilities such as independent clinical laboratories. It does not include claims submitted by institutional outpatient providers.

with certain Medicare coverage provisions; for the other three services, the time period of our analysis was 2025.[2]

We also used claims and enrollment data to analyze the proportion of beneficiaries with these claims and to analyze service use by beneficiary characteristics, including those listed below.

- **Age.** Beneficiary age as of January 1, 2025.
- **Sex.** Beneficiary sex.
- **Race and ethnicity.** Beneficiary race as determined by a Centers for Medicare & Medicaid Services variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location.[3]
- **Dual eligible status.** Beneficiary enrollment in both Medicare and Medicaid, the joint federal-state program that provides health care coverage for individuals with low income, at any point during the study's time period.
- **Medicare entitlement.**[4] Beneficiary original reason for entitlement to Medicare.
- **Rurality.** Beneficiary residence in an urban or rural zip code.
- **Region.** Beneficiary residence based on Census region.

Additionally, we calculated the relative risk ratio by beneficiary characteristic to assess the likelihood of a beneficiary having a claim for a

[2]Specifically, lipid testing is covered every 5 years for all beneficiaries, cardiovascular behavioral therapy is covered annually for all beneficiaries, and coverage for atherosclerotic CVD risk assessment and atherosclerotic CVD risk management services began in 2025.

[3]Although based on the best available data, Medicare enrollment race and ethnicity data are known to have some limitations. For example, see Department of Health and Human Services, Office of Inspector General, *Data Brief: Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability to Assess Health Disparities*, OEI-02-21-00100 (Washington, D.C.: June 2022). In an effort to improve its data, the Centers for Medicare & Medicaid Services uses this algorithmic variable, which is considered more accurate for Asian/Pacific Islander and Hispanic beneficiaries, though still less accurate than self-reported data. See Department of Health and Human Services, Office of Inspector General, *A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data*, OEI-02-21-00101 (Washington, D.C.: June 2023).

[4]Medicare is available to three groups of people: (1) individuals aged 65 years or older; (2) individuals entitled to Social Security benefits due to disability; and (3) individuals with end-stage renal disease (i.e., with permanent kidney failure requiring dialysis or a transplant).

given service across characteristics. Specifically, this ratio indicates how much more likely a beneficiary in each group is to receive a service than a beneficiary in the group that was least likely (i.e., the comparison group). The comparison group has a relative risk ratio of 1.0. For example, if a group has a relative risk ratio of 2.0, that means beneficiaries in that group were twice as likely to receive a service as the comparison group. However, our analysis of use by these characteristics is descriptive; there are multiple factors that could influence the use of these services, which we did not control for in our analysis.

Additional Data on Lipid Testing

Lipid testing is a lab service that measures the different types of lipids in the blood, including cholesterol and triglycerides. High levels can increase the risk of cardiovascular disease. Medicare covers this service in two ways: (1) as a Medicare preventive service for all beneficiaries once every 5 years, and (2) as a medically necessary service when needed for beneficiaries with specific clinical indications.

As shown in table 1, approximately 90 percent of beneficiaries in our analysis, or 16.2 million out of 18.1 million, received at least one lipid test from 2021 through 2025. In addition, when analyzing lipid test use across different beneficiary characteristics, we observed the largest variation across race and ethnicity, and among different regions and ages. For example, American Indian/Alaska Native beneficiaries were the least likely to have received a lipid test in those 5 years; beneficiaries of most other races and ethnicities were 1.5 times more likely to have received a lipid test.

Table 1: Beneficiaries' Receipt of Lipid Testing in Traditional Medicare, by Beneficiary Characteristic, 2021-2025

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of receiving service versus comparison group[a]
All beneficiaries	Not applicable	16,159,353	89.5	Not applicable
Age	<65 (comparison group)	1,012,626	73.2	1.0
	65-69[b]	454,089	84.0	1.1
	70-74	4,796,213	90.7	1.2
	75-79	4,475,324	91.0	1.2
	80-84	2,851,885	92.5	1.3
	>85	2,569,216	90.4	1.2
Sex	Female	9,230,622	91.4	1.1
	Male (comparison group)	6,928,730	87.0	1.0

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of receiving service versus comparison group[a]
Race or ethnicity[c]	American Indian/Alaska Native (comparison group)	47,296	58.6	1.0
	Asian/Pacific Islander	446,401	90.4	1.5
	Black	885,154	84.2	1.4
	Hispanic	705,299	85.2	1.5
	Other	136,919	88.7	1.5
	White	13,532,626	90.2	1.5
	Unknown	405,658	90.2	1.5
Dual eligibility[d]	Dual-eligible (comparison group)	1,970,258	84.4	1.0
	Not dual-eligible	14,189,095	90.3	1.1
Medicare entitlement[e]	Age	13,720,745	91.3	1.1
	Disability or end-stage renal disease (comparison group)	2,438,608	80.5	1.0
Rurality	Urban	12,102,253	90.1	1.0
	Rural (comparison group)	4,052,427	87.8	1.0
Region	Northeast	3,041,240	91.2	1.3
	Midwest	3,489,945	89.6	1.2
	South	6,269,373	90.4	1.2
	West	3,323,725	86.5	1.2
	Territories and other (comparison group)	35,070	72.5	1.0

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) enrollment and claims data. | GAO-27-108423

Note: GAO analyzed claims from 2021 through 2025 (the most recent year of data available) to align with Medicare coverage of lipid testing as a Medicare preventive service once every 5 years. The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare from 2021 through 2025.

[a]The likelihood of receiving a service is calculated as a relative risk ratio, which indicates how much more likely a beneficiary in each group is to receive a service than a beneficiary in the group that was least likely (i.e., the comparison group). The comparison group has a relative risk ratio of 1.0. For example, if a group has a relative risk ratio of 2.0, that means beneficiaries in that group were twice as likely to receive a service as the comparison group.

[b]There is a relatively low number of Medicare beneficiaries aged 65-69 in this analysis because it is restricted to beneficiaries who were continuously enrolled in traditional Medicare from 2021 through 2025. Beneficiaries with Medicare entitlement based on age would not have been continuously enrolled in Medicare during the entire time period.

[c]To improve the accuracy of the race and ethnicity data, GAO used an alternative CMS variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location of the beneficiary. Beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic.

[d]Dual-eligible beneficiaries are individuals enrolled in both Medicare and Medicaid, a joint federal-state program that provides health care coverage for individuals with low incomes. For purposes of this analysis, the dual-eligible group includes beneficiaries with at least one month of dual-eligible enrollment from 2021 through 2025.

[e]Medicare is available to three groups of people: (1) individuals aged 65 years or older; (2) individuals entitled to Social Security benefits due to disability; and (3) individuals with end-stage renal disease (i.e., with permanent kidney failure requiring dialysis or a transplant).

Additional Data on Other Selected Services

The other three selected services are generally delivered by providers in the primary care setting and are focused on identifying and modifying CVD risk, with an emphasis on behavioral change.

- **Cardiovascular behavioral therapy** consists of a 15-minute primary care visit that includes screening for high blood pressure and counseling on topics such as diet and exercise. This service is a Medicare preventive service covered annually for all beneficiaries without cost sharing.
- **Atherosclerotic CVD risk assessment** calculates a beneficiary's 10-year atherosclerotic CVD risk based on risk factors, demographic factors, and current lipid levels. This service is covered for beneficiaries with at least one predisposing condition for CVD, such as obesity or high blood pressure, among others.
- **Atherosclerotic CVD risk management services** include developing and monitoring an individual care plan that addresses blood pressure and cholesterol management and behavioral risk factors, such as physical activity and nutrition. This service is covered once per month for beneficiaries found to be at medium- or high-risk of atherosclerotic CVD.

As shown in tables 2 through 4, relatively few beneficiaries had claims for these three services in 2025, though additional beneficiaries may have received similar services without appearing in the claims data.[5] We observed some variation across beneficiary characteristics, particularly across race and ethnicity and region.

Table 2: Claims for Cardiovascular Behavioral Therapy in Traditional Medicare, by Beneficiary Characteristic, 2025

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of having a claim versus comparison group[a]
All beneficiaries	Not applicable	390,309	1.5	Not applicable
Age	<65 (comparison group)	13,786	0.6	1.0
	65-69	73,899	1.4	2.2
	70-74	104,424	1.7	2.6

[5]For example, providers may deliver similar services to beneficiaries without billing the specific code, such as during a regular office visit.

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of having a claim versus comparison group[a]
	75-79	93,779	1.8	2.7
	80-84	57,236	1.7	2.7
	>85	47,185	1.6	2.4
Sex	Female	221,348	1.6	1.1
	Male (comparison group)	168,961	1.5	1.0
Race or ethnicity[b]	American Indian/Alaska Native (comparison group)	344	0.3	1.0
	Asian/Pacific Islander	20,901	2.6	8.3
	Black	20,349	1.3	4.0
	Hispanic	18,356	1.3	4.2
	Other	3,805	1.8	5.7
	White	315,328	1.5	4.9
	Unknown	11,226	1.6	5.1
Dual eligibility[c]	Dual-eligible	42,311	1.2	1.0
	Not dual-eligible (comparison group)	347,998	1.6	1.4
Medicare entitlement[d]	Age	350,354	1.7	1.7
	Disability or end-stage renal disease (comparison group)	39,955	1.0	1.0
Rurality	Urban	316,403	1.7	1.4
	Rural (comparison group)	73,859	1.2	1.0
Region	Northeast	63,280	1.4	2.7
	Midwest (comparison group)	27,945	0.5	1.0
	South	200,308	2.1	4.1
	West	97,743	1.8	3.4
	Territories and other	1,033	1.4	2.7

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) enrollment and claims data. | GAO-27-108423

Note: Beneficiaries may have received similar services as cardiovascular behavioral therapy under different billing codes and therefore may not be captured in this analysis. The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare throughout 2025.

[a]The likelihood of having a claim is calculated as a relative risk ratio, which indicates how much more likely a beneficiary in each group is to have a claim than a beneficiary in the group that was least likely (i.e., the comparison group). The comparison group has a relative risk ratio of 1.0. For example, if a group has a relative risk ratio of 2.0, that means beneficiaries in that group were twice as likely to have a claim for the service as the comparison group.

[b]To improve the accuracy of the race and ethnicity data, GAO used an alternative CMS variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location of the beneficiary. Beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic.

[c]Dual-eligible beneficiaries are individuals enrolled in both Medicare and Medicaid, a joint federal-state program that provides health care coverage for individuals with low incomes. For purposes of this analysis, the dual-eligible group includes beneficiaries with at least one month of dual-eligible enrollment in 2025.

[d]Medicare is available to three groups of people: (1) individuals aged 65 years or older; (2) individuals entitled to Social Security benefits due to disability; and (3) individuals with end-stage renal disease (i.e., with permanent kidney failure requiring dialysis or a transplant).

Table 3: Claims for Atherosclerotic Cardiovascular Disease (CVD) Risk Assessment in Traditional Medicare, by Beneficiary Characteristic, 2025

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of having a claim versus comparison group[a]
All beneficiaries	Not applicable	101,205	0.40	Not applicable
Age	<65	4,147	0.19	1.4
	65-69	26,725	0.51	3.7
	70-74	34,250	0.54	4.0
	75-79	25,354	0.48	3.5
	80-84	6,609	0.20	1.5
	>85 (comparison group)	4,120	0.14	1.0
Sex	Female	60,701	0.44	1.2
	Male (comparison group)	40,504	0.36	1.0
Race or ethnicity[b]	American Indian/Alaska Native (comparison group)	100	0.09	1.0
	Asian/Pacific Islander	2,799	0.35	3.8
	Black	6,366	0.40	4.3
	Hispanic	4,061	0.29	3.2
	Other	716	0.34	3.7
	White	83,935	0.41	4.5
	Unknown	3,228	0.46	5.0
Dual eligibility[c]	Dual-eligible (comparison group)	6,367	0.17	1.0
	Not dual-eligible	94,838	0.44	2.5
Medicare entitlement[d]	Age	90,890	0.43	1.7
	Disability or end-stage renal disease (comparison group)	10,315	0.25	1.0
Rurality	Urban	83,162	0.44	1.5
	Rural (comparison group)	18,033	0.28	1.0
Region	Northeast	18,513	0.40	7.4
	Midwest	13,592	0.25	4.6
	South	49,880	0.52	9.6
	West	19,180	0.35	6.4
	Territories and other (comparison group)	40	0.05	1.0

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) enrollment and claims data. | GAO-27-108423

Note: Beneficiaries may have received similar services as the atherosclerotic CVD risk assessment under different billing codes and therefore may not be captured in this analysis. The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare throughout 2025.

[a]The likelihood of having a claim is calculated as a relative risk ratio, which indicates how much more likely a beneficiary in each group is to have a claim than a beneficiary in the group that was least likely (i.e., the comparison group). The comparison group has a relative risk ratio of 1.0. For example, if a group has a relative risk ratio of 2.0, that means beneficiaries in that group were twice as likely to have a claim for the service as the comparison group.

[b]To improve the accuracy of the race and ethnicity data, GAO used an alternative CMS variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location of the beneficiary. Beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic.

[c]Dual-eligible beneficiaries are individuals enrolled in both Medicare and Medicaid, a joint federal-state program that provides health care coverage for individuals with low incomes. For purposes of this analysis, the dual-eligible group includes beneficiaries with at least one month of dual-eligible enrollment in 2025.

[d]Medicare is available to three groups of people: (1) individuals aged 65 years or older; (2) individuals entitled to Social Security benefits due to disability; and (3) individuals with end-stage renal disease (i.e., with permanent kidney failure requiring dialysis or a transplant).

Table 4: Claims for Atherosclerotic Cardiovascular Disease (CVD) Risk Management Services in Traditional Medicare, by Beneficiary Characteristic, 2025

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of having a claim versus comparison group[a]
All beneficiaries	Not applicable	32,019	0.13	Not applicable
Age	<65 (comparison group)	919	0.04	1.0
	65-69	7,197	0.14	3.2
	70-74	10,798	0.17	4.0
	75-79	8,897	0.17	3.9
	80-84	2,556	0.08	1.8
	>85	1,652	0.05	1.3
Sex	Female	18,518	0.13	1.1
	Male (comparison group)	13,501	0.12	1.0
Race or ethnicity[b]	American Indian/Alaska Native (comparison group)	19	0.02	1.0
	Asian/Pacific Islander	867	0.11	6.2
	Black	1,874	0.12	6.7
	Hispanic	1,383	0.10	5.7
	Other	262	0.12	7.1
	White	26,551	0.13	7.4
	Unknown	1,063	0.15	8.7
Dual eligibility[c]	Dual-eligible (comparison group)	1,973	0.05	1.0
	Not dual-eligible	30,046	0.14	2.6

Characteristic	Category	Number of beneficiaries with claim	Percent of beneficiaries with claim	Likelihood of having a claim versus comparison group[a]
Medicare entitlement[d]	Age	29,024	0.14	1.9
	Disability or end-stage renal disease (comparison group)	2,995	0.07	1.0
Rurality	Urban	28,240	0.15	2.5
	Rural (comparison group)	3,774	0.06	1.0
Region	Northeast	7,790	0.17	8.3
	Midwest	3,968	0.07	3.6
	South	14,412	0.15	7.4
	West	5,834	0.11	5.2
	Territories and other (comparison group)	15	0.02	1.0

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) enrollment and claims data. | GAO-27-108423

Note: Beneficiaries may have received similar services as the atherosclerotic CVD risk management services under different billing codes and therefore may not be captured in this analysis. The study population included active Medicare beneficiaries continuously enrolled in traditional Medicare throughout 2025.

[a]The likelihood of having a claim is calculated as a relative risk ratio, which indicates how much more likely a beneficiary in each group is to have a claim than a beneficiary in the group that was least likely (i.e., the comparison group). The comparison group has a relative risk ratio of 1.0. For example, if a group has a relative risk ratio of 2.0, that means beneficiaries in that group were twice as likely to have a claim for the service as the comparison group.

[b]To improve the accuracy of the race and ethnicity data, GAO used an alternative CMS variable that applied an algorithm to beneficiaries' race and ethnicity data based on their last name and location of the beneficiary. Beneficiaries of unknown race are more likely to be American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic.

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Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Corissa Kiyan-Fukumoto (Assistant Director), Caitlyn Leiter-Mason (Analyst-in-Charge), Camille McKenzie, and Noelle Miesfeld made key contributions to this report. Also contributing were Joycelyn Cudjoe, Laura Elsberg, Ariel Landa-Seiersen, Daniel Lee, Sang Lee, Jeanne Murphy-Stone, Eric Peterson, Mike Soressi, and Roxanna Sun.

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