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Beneficiary and Clinician Perspectives on Medicare and Other Issues: Findings from 2024 Focus Groups in Select States

A report by NORC at the University of Chicago for the Medicare Payment Advisory Commission

The views expressed in this report are those of the authors. No endorsement by MedPAC is intended or should be inferred.

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NORC at the University of Chicago

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Beneficiary and Clinician Perspectives on Medicare and Other Issues:

Findings from 2024 Focus Groups in Select States

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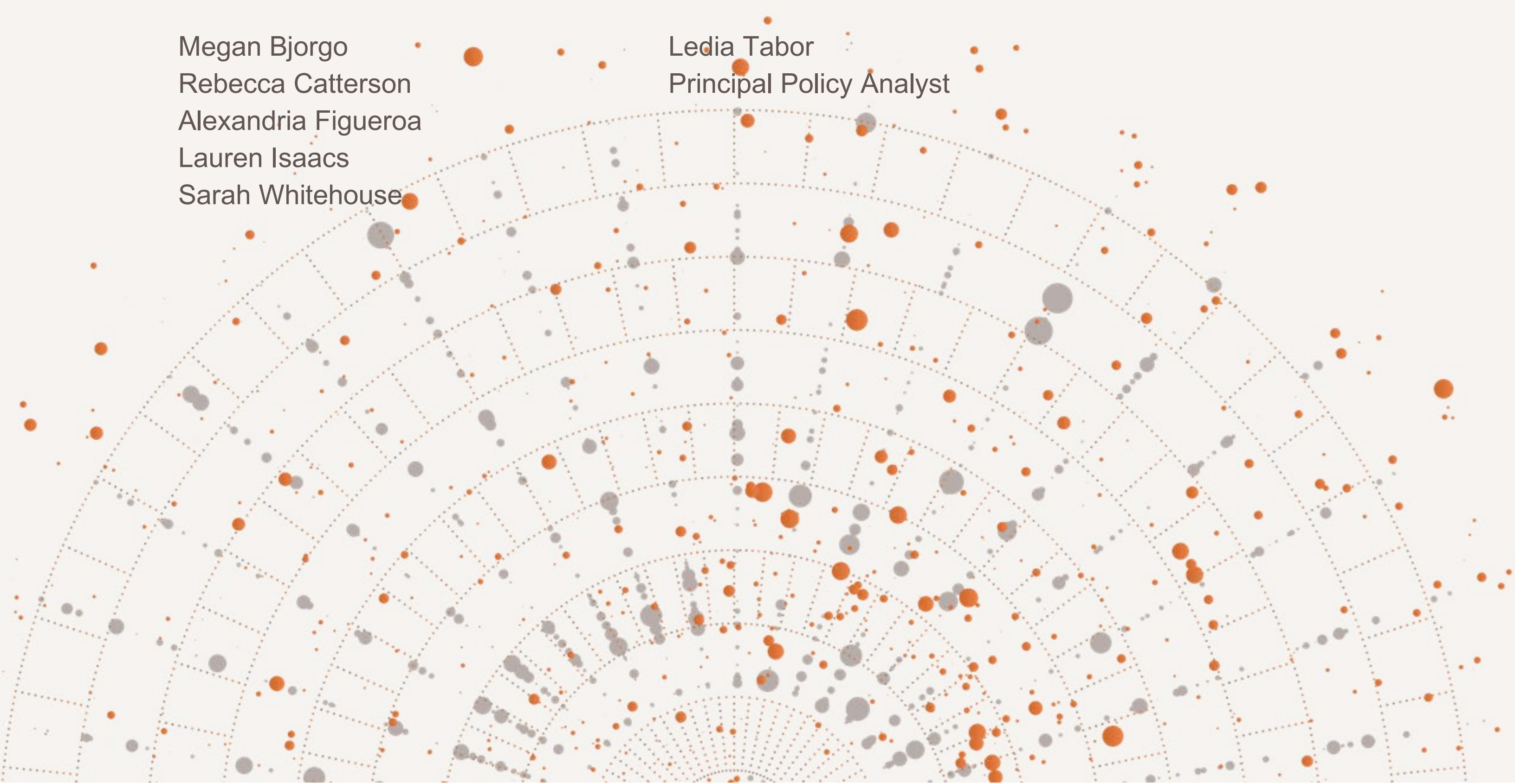

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Executive Summary

Methods

In May and June of 2024, NORC and MedPAC conducted 24 focus groups with Medicare beneficiaries and clinicians. Beneficiaries included those with only Medicare coverage (either through traditional Medicare or Medicare Advantage (MA)) and those eligible for both Medicare and Medicaid. Clinicians included primary care physicians, specialist physicians, nurse practitioners (NPs), and physician assistants (PAs).

We conducted 21 in-person focus groups: seven per location in Philadelphia, Pennsylvania; Phoenix, Arizona; and Dallas, Texas; and three virtual focus groups with Medicare beneficiaries residing in rural areas across the U.S. In total, 73 Medicare-only beneficiaries, 39 dual eligible beneficiaries, and 72 clinicians participated in the focus groups.

Topics discussed in beneficiary groups included the process of choosing coverage, access to primary care and specialty care, telehealth, and prescription drugs. Topics discussed in clinician groups include acceptance of new patients and insurance, working with other clinicians, telehealth, changing organization of medical care, working with insurance and MA plans, quality reporting, accountable care organizations, and prescription drugs.

All focus group procedures, screeners, and discussion protocols were reviewed and approved by NORC's Institutional Review Board.

Key Findings

The findings below highlight major themes that emerged across the focus groups.

Choosing Coverage

- When it came time to enroll in Medicare, beneficiaries were confused about their coverage options, including choosing between traditional Medicare and MA and the plans available under each type of Medicare.
- Beneficiaries relied on numerous sources to learn about Medicare. Many beneficiaries used a broker to select their coverage and several worked with plan representatives. However, very few beneficiaries used their local State Health Insurance Assistance Program (SHIP) to learn about their options. Some beneficiaries reported using the "Medicare & You" handbook and Medicare.gov.

- The cost of coverage, including monthly premiums and out-of-pocket costs, was commonly cited as an important factor for beneficiaries when selecting a plan. Both Medicare Advantage and traditional Medicare beneficiaries also considered prescription drug coverage, including costs and formularies. Many beneficiaries, particularly those enrolled in MA plans, worked with brokers or agents to determine the out-of-pocket costs, premiums, and prescription costs of individual plans when selecting their coverage. Finally, beneficiaries prioritized being able to keep seeing clinicians they already had relationships with.
- Some beneficiaries, including many rural beneficiaries, reported choosing traditional Medicare to have access to a larger network of clinicians than what they perceived they would have through a Medicare Advantage plan.
- Beneficiaries who selected MA over traditional Medicare described MA as an easier and more streamlined option. Beneficiaries who enrolled in MA reported differing views on how supplemental benefits factored into their choice. Most beneficiaries knew about some supplemental benefits and appreciated their access to them, but not all beneficiaries factored these benefits into their coverage selection.
- Dual eligible beneficiaries prioritized keeping their current doctors and reviewed dental, vision, and prescription drug coverage when choosing their plans.
- Some beneficiaries enrolled in MA reported reviewing their coverage options during annual open enrollment; some had switched from one MA plan to another. During open enrollment, a few beneficiaries who were enrolled in traditional Medicare also reviewed their options, both for supplemental plans and MA plans.
- A minority of beneficiaries reported having switched coverage, with most of these beneficiaries having moved from traditional Medicare to MA.
- Overall, beneficiaries with traditional Medicare and beneficiaries with MA were satisfied with their coverage.

Access to Care

- Although most clinicians were accepting new Medicare patients, some were limiting their volume of Medicare patients.
- Clinicians reported that appointment wait times were shorter for established patients than for new patients, with exceptions for new patients with acute issues, patients coming from the emergency department (ED) or being discharged from the hospital, and patients referred by another clinician.
- Several clinicians reported that patients can often get in sooner if they see an NP or PA in the practice instead of a physician.
- Many clinicians indicated that the decision about which MA plans to accept is an organizational decision. A few clinicians noted that the decision is driven by reimbursement.
- A few clinicians saw advantages to working with MA, including lower prescription drug costs for patients and additional resources or benefits.
- Several clinicians also noted that care management from MA plans can benefit their patients.

- When describing disadvantages of working with MA plans, clinicians cited burdensome prior authorization requirements for referrals, procedures, and medications. In addition, there was a perception among some clinicians that MA plans prioritize coding to get higher reimbursement for their patients.
- Some clinicians reported that their patients were confused about the differences between Medicare options available to them. Several clinicians felt that patients have been misled about the benefits of MA.
- Nearly all beneficiaries reported having a regular source of primary care. Beneficiaries reported a mix of physicians, NPs, and PAs as their designated primary care provider (PCP).
- We asked beneficiaries about their experiences with and openness to seeing an NP or PA. Some beneficiaries said it would depend on the type of medical issue or respective wait times for each type of clinician. Some beneficiaries preferred physicians for their higher level of training. Others preferred seeing an NP or PA, citing that these clinicians spent more time during visits and seemed more thorough.
- Most beneficiaries reported that they could access primary care when they needed it. Beneficiaries said that they could typically get in faster for acute issues than for a routine visit.
- Most beneficiaries drove to their PCP; others walked or used public transportation. Most beneficiaries lived within 30 minutes of their PCP.
- Beneficiaries explained that their approach to handling an urgent medical issue would depend on the severity of the issue, the time of day when it happened, and the distance to different options for care. Some beneficiaries said they would call or message their primary care practice for guidance, a prescription, or to get an appointment with someone in the practice. Many beneficiaries said they would go to an urgent care center. Several beneficiaries said they would choose the ED.
- Rural beneficiaries reported being comfortable with accessing care close to home for minor health care needs but would want to travel farther in the event of a serious or life-threatening situation. Rural beneficiaries reported that the distance to major medical facilities was far, but they seem to accept that residing in a rural area often meant foregoing easy access to wide range of health services. Many rural beneficiaries reported that providers in their area had recently retired or left the area.
- In general, beneficiaries reported longer wait times for specialty care than for primary care. Reported specialty care wait times as a new patient ranged from a couple of weeks to multiple months, with the longest wait times being between six and 12 months. Several beneficiaries faced long wait times even when dealing with an acute medical issue. Some beneficiaries noted that it was easier to get in to see a specialist within the same large group practice or health system.
- To find a new PCP or specialist, beneficiaries asked current clinicians for recommendations, asked friends and family, looked within their current practice or health system, consulted their health plan's provider directory, and did online research. Barriers to finding new clinicians included clinicians not accepting new patients, not accepting Medicare patients, being out-of-network, or having long wait times.

- Beneficiaries with MA had mixed experiences with being referred outside of their plan's network. Some beneficiaries had been sent to clinicians who they later realized were not in network. Other beneficiaries reported that their clinicians verified coverage when they made referrals.
- Beneficiaries reported that their plans' provider directories were frequently out of date.
- Beneficiaries had experience with MA prior authorizations for procedures, medications, and referrals, and some had dealt with denials. Some beneficiaries said that prior authorizations were an issue for them, mainly because of the delays or gaps in care that resulted.

Telehealth

- Over three-fourths of clinicians were offering audiovisual telehealth visits and about a third were offering audio-only visits.
- Clinicians reported that the decision to hold a visit via telehealth vs. in person is determined by patient choice.
- Less than one third of beneficiaries had participated in an audiovisual telehealth visit in the past six months.
- Most beneficiaries reported they chose telehealth because they were able to get a virtual appointment faster than one in-person. These visits were typically for follow-ups and medication refills, acute problems, or referrals to specialists, and were with a clinician they had seen before.
- In general, clinicians who provided telehealth visits reported that they spent less time with patients than during in-person visits, with exceptions when patients experience issues with connectivity or using the telehealth software.
- Clinicians agreed that telehealth is best suited for visits that do not require a physical examination. They reported that telehealth increases accessibility for patients who experience transportation barriers, limited mobility, consistent conflicts, or are immunocompromised. They noted that telehealth may not be feasible for patients with complicated health problems or comorbidities.
- Beneficiaries were grateful to have telehealth as an option when they experienced an urgent medical need and appreciated the convenience of telehealth. However, they indicated that in-person visits are preferable for establishing rapport and physical examinations.
- Clinicians believed that they have reached a steady state regarding the proportion of telehealth they are providing compared to in-person care, and they appreciated having telehealth as an option. Likewise, the majority of beneficiaries recognized the value of telehealth for specific circumstances and wanted it as an option in the future.

Organization of Care

- PCPs, NPs and PAs, and specialists faced challenges when referring their patients to specialty care.
- Clinicians who were affiliated with health systems reported that they most frequently refer patients within their own system, but most noted that there was no explicit requirement to do so.

- Physicians worked with NPs and PAs in their practices and relied on them for certain types of care but acknowledged their limitations in knowledge and scope.
- Many physicians reported that their practice had been approached about acquisition. Physicians in physician-owned practices expressed negative feelings about being acquired and believed that private equity firms were decreasing access to and quality of care.
- Fewer than half of clinicians were participating in an accountable care organization (ACO).
- Clinicians in all areas were neutral about their practice's ACO participation and generally did not have a role in the decision to participate. However, a few clinicians who had worked in longstanding ACOs felt the additional burden was high due to the quality reporting requirements and did not see benefits to their patients or financial rewards.
- In general, clinicians felt that quality measures did little to improve patient care and led to unnecessary work. A few clinicians had positive opinions about quality measurement and appreciated seeing data on their performance.

Prescription Drugs

- Beneficiaries enrolled in both traditional Medicare and MA found Medicare Plan Finder on Medicare.gov a helpful resource when selecting their drug plans.
- Eighty-four percent of Medicare-only beneficiaries and 95 percent of dual eligible beneficiaries rated their prescription drug coverage as excellent or good. Beneficiaries who rated their drug coverage below excellent commonly cited the cost of prescriptions as the reason.
- Many clinicians reported discussing the cost of prescriptions with their patients.
- Some Medicare beneficiaries reported having trouble affording out-of-pocket prescription costs. When the cost of a prescription through their drug plan was too high, beneficiaries often used GoodRx. Beneficiaries also used strategies including calling other pharmacies or bypassing their insurance and paying out of pocket.
- Many beneficiaries had a preferred pharmacy, but some reported shopping around for better prices on individual prescription drugs. Some beneficiaries used mail order pharmacies and most were satisfied with them, but a few voiced concerns about security.
- Beneficiaries generally reported being able access their prescriptions when needed, but some had experienced delays or shortages.
- Clinicians reported that the high out-of-pocket cost of biologics for patients was the most common barrier to prescribing them. Clinicians also reported that their treatment choices for biologics and biosimilars were often dictated by insurance companies..
- Some clinicians had access to formularies but reported that the information is often incomplete or inaccurate. Clinicians also reported limited access to beneficiaries' prescription information.
- The majority of clinicians reported that they were using electronic prior authorizations for prescriptions. Although it can simplify the initiation of a prior authorization, clinicians reported that the process is still lengthy and often is not completed electronically.
- Some clinicians, particularly specialists, described pharmaceutical representatives as helpful to their practice.

Methods

The following bullets summarize the methods the NORC team used in conducting this qualitative research study. Additional details appear in the subsequent subsections.

- **Data collection approach**: Focus groups
- **Data collection timeframe**: May and June 2024
- **Number of focus groups**: 24
  - 21 in person in Philadelphia, Pennsylvania; Phoenix, Arizona; and Dallas, Texas
  - Three virtually with participants residing in rural areas throughout the country
- **Participants**: Medicare beneficiaries, beneficiaries eligible for Medicare and Medicaid (dual eligible beneficiaries), primary care physicians (PCPs), specialist physicians, nurse practitioners (NPs), and physician assistants (PAs)
- **Moderating**: Each focus group moderated by NORC senior researchers
- **Topics discussed**: Enrolling in and using Medicare coverage, access to care, organization of care, telehealth, and prescription drugs
- **Length of focus groups**: Approximately 90 minutes each
- **Institutional review board (IRB)**: All focus group procedures, screeners, and discussion protocols reviewed and approved by NORC's IRB

Location Selection

At the beginning of this project, NORC and the Medicare Payment Advisory Commission (MedPAC) worked together to choose locations from which to recruit beneficiaries and clinicians for participation in the study. The goal was to conduct research in person in three locations:

- In different geographic regions of the country
- With varying demographic profiles (particularly race/ethnicity makeup)
- Without traditional Medicare or Medicare Advantage dominating the market (to facilitate recruitment of beneficiaries enrolled in each Medicare option)
- With provider participation in Medicare accountable care organizations (ACO) (to increase the likelihood of recruiting clinicians who can speak to experiences with ACOs)
- Where MedPAC had not conducted focus groups during the past four years

- With focus group facilities that had the ability to recruit the specific profiles of participants necessary for this project

Exhibit 1 presents the three cities NORC and MedPAC selected based on these criteria, as well as several key characteristics related to the study.

Exhibit 1. Location characteristics

City	MA Penetration[1]	ACO penetration[2]	Proportion of Population by Key Race/Ethnicity Subgroups		
			White, Not Hispanic/ Latino[3]	Black[3]	Hispanic[3]
Philadelphia	58%	34%	34%	40%	16%
Phoenix	52%	32%	41%	7%	43%
Dallas	54%	27%	28%	24%	42%

Source: Data provided by MedPAC for the county in which each city is located.

Given the challenges of recruiting for and conducting in-person focus groups in rural areas, and MedPAC's desire to include the experiences and perspectives of beneficiaries residing in rural areas, this project also included three virtual focus groups with beneficiaries.

Recruitment

NORC partnered with a trusted market research organization with focus group facilities in the three study locations to recruit and host the in-person focus groups. This organization had a nationwide database and performed recruitment for the virtual focus groups with rural beneficiaries.

NORC worked with MedPAC to develop the screening criteria that were used for recruitment of beneficiaries, including:

[1] Centers for Medicare & Medicaid Services. February 2024. MA State/County Penetration 2024 02. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/ma-state/ma-state/county-penetration-2024-02.

[2] Centers for Medicare & Medicaid Services. 2022. Number of Accountable Care Organization Assigned Beneficiaries by County. Available at: https://data.cms.gov/medicare-shared-savings-program/number-of-accountable-care-organization-assigned-beneficiaries-by-county/data.

[3] U.S. Census Bureau. QuickFacts: Dallas city, Texas; Phoenix city, Arizona; Philadelphia city, Pennsylvania; United States. Available at: https://www.census.gov/quickfacts/fact/table/dallascitytexas,phoenixcityarizona,philadelphiacitypennsylvania,US.

- Details of Medicare coverage (e.g., enrollment in Medicare Advantage vs. traditional Medicare; presence or absence of supplemental coverage) to ensure that we recruited Medicare beneficiaries who met specific coverage profiles and that we placed beneficiaries in the correct group
- Demographic information to recruit focus groups that matched as closely as possible the demographic profiles of each city (e.g., race/ethnicity)
- Experience with key discussion topics (e.g., recently looked for a new doctor) to ensure that the groups would have participants who could speak to priority healthcare topics

We considered beneficiaries eligible for virtual rural focus groups if they reported living in a ZIP Code that was not a in metropolitan or micropolitan statistical area.[4]

We excluded participants whose responses to screening questions (and in some cases, subsequent follow-up from recruitment partners) pointed to uncertainty about their Medicare coverage situation (e.g., whether they were enrolled in traditional Medicare vs. Medicare Advantage).

For clinicians, the screening process set out to ensure that groups contained participants with:

- A mix of practice size and ownership profile
- Diversity in terms of length of time in practice
- Demographic diversity (e.g., race/ethnicity)
- A mix of specialties (for groups with specialist physicians, NPs, and PAs)

Since their experience is less relevant to the research questions of this project, we excluded pediatricians and clinicians who reported that Medicare beneficiaries made up less than 10 percent of their practice population. In addition, we set out to exclude clinicians who have been practicing for more than 30 years, although in some markets we allowed these clinicians to participate to fill the groups.

When recruiting for focus groups, we often recruited more participants than needed for a discussion, as recruited individuals are often unable or unwilling at the last minute to participate. For that reason, for in-person focus groups for this study, we set out to recruit 10 participants for each group, with a goal of conducting groups with eight individuals. Because of difficulties moderating larger groups virtually, for the virtual groups with rural beneficiaries, we set out to recruit eight participants, with a goal of conducting groups with six participants. In-person groups ranged in size from five to 10 participants, with an average of eight participants. Virtual groups ranged in size from six to seven participants, with an average of six participants.

[4] Metropolitan statistical areas must have at least one urban area of 50,000 or more inhabitants. Micropolitan statistical areas must have at least one urban area of at least 10,000 but less than 50,000 population. Source: U.S. Census Bureau. July 2023. Metropolitan and Micropolitan: About. Available at: https://www.census.gov/programs-surveys/metro-micro/about.html

This year, for the first time, we held separate focus groups for beneficiaries enrolled in Medicare Advantage and those enrolled in traditional (fee-for-service) Medicare. However, some beneficiary groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase focus group size. Input from beneficiaries was flagged by coverage type during the analysis to ensure that all findings are properly attributed in this report.

In each city, the breakdown of the seven focus groups was as follows:

1. Medicare-only beneficiaries: enrolled in traditional Medicare[5]
2. Medicare-only beneficiaries: enrolled in Medicare Advantage
3. Dual eligible beneficiaries: enrolled in traditional Medicare[6]
4. Dual eligible beneficiaries: enrolled in Medicare Advantage[7]
5. Primary care physicians
6. Specialist physicians
7. NPs and PAs (primary care or specialists).

Focus Group Participants

Exhibit 2 provides the breakdown of focus groups by location and participant type. We conducted discussions with the following groups:

- **Medicare beneficiaries (n = 72 across the three in-person locations and rural areas)**
  - Individuals enrolled in traditional Medicare (n = 31) or a Medicare Advantage (n = 41) plan
  - Individuals 65 years of age or older
- **Dual eligible beneficiaries (n = 39 across the three in-person locations)**
  - Individuals enrolled in both Medicare, either traditional (n = 8) or Medicare Advantage (n = 31), and Medicaid
  - Included a mix of beneficiaries 65 years of age or older and beneficiaries under age 65
- **Clinicians (n = 72 across the three in-person locations)**
  - PCPs (n = 23), including those in family medicine, internal medicine, and geriatrics
  - Specialist physicians (n = 28), including cardiology, endocrinology, allergy and immunology, rheumatology, dermatology, neurology, pulmonology, gastroenterology, and orthopedic surgery

[5] One beneficiary with traditional Medicare in the rural groups joined for the polling questions but did not stay for the group due to technical issues. Their count is not included here but may be included in polling questions.

[6] Some beneficiary groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase turnout.

[7] Some beneficiary groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase turnout.

- NPs and PAs (n = 21), including individuals who work in primary care and specialty settings
- Clinicians across groups who regularly see Medicare patients in an outpatient setting
- Participants recruited from a variety of practice types (e.g., solo/private, group, hospital-based)

Exhibit 2. Number of participants by location and type of group

	Philadelphia	Phoenix	Dallas	Rural	Total (All Cities)
Medicare beneficiaries	17	20	17	19	**73**
Dual eligible beneficiaries	16	11	12	—	**39**
Primary care physicians	10	8	5	—	**23**
Specialists	9	9	10	—	**28**
NPs and PAs	8	7	6	—	**21**

Exhibits 3 and 4 present demographic characteristics of participants in the beneficiary and clinician focus groups. Diversity across demographic characteristics ensured that our focus group participants offered a range of perspectives.

Exhibit 3. Beneficiary participant characteristics

	Medicare-Only	Dual Eligible	Total
Race			
Asian	1	0	1
Black	10	12	22
White	57	23	80
Other/Multiple Races	4	4	8
No Response	1	0	1
Ethnicity			
Hispanic	4	1	5
Non-Hispanic	69	38	107
No Response	0	0	0
Age (years)			

<65	0	20	20
65-70	29	15	44
71-74	23	2	25
75-80	16	2	18
>80	5	0	5
No Response	0	0	0
Gender			
Female	36	20	56
Male	36	19	55
Transgender	1	0	1
No Response	0	0	0

Exhibit 4. Clinician participant characteristics

	Primary Care Physicians	Specialist Physicians	NPs/PAs	Total
Race				
Asian	7	13	0	20
Black	2	0	5	7
White	12	15	13	40
Other/Multiple Races	2	0	2	4
No Response	0	0	1	1
Ethnicity				
Hispanic	3	0	2	5
Non-Hispanic	20	28	19	67
No Response	0	0	0	0
Gender				
Female	5	7	17	29
Male	18	21	4	43
No Response	0	0	0	0
Years in Practice				
<5	0	1	6	7
5-15	1	6	7	14
15-29	16	19	7	42
>30	6	2	1	9

No Response	0	0	0	0
Practice Setting				
Solo or small practice	11	8	9	28
Large group practice	5	14	4	23
Practice owned by a hospital or health system	7	6	6	19
Other	0	0	2	2
No Response	0	0	0	0

Data Collection

Focus groups were scheduled for 90 minutes, with one of four senior researchers from NORC moderating each discussion. Prior to the start of each group, participants were asked to fill out a brief survey to confirm certain screening criteria (e.g., details about beneficiaries' Medicare coverage profile) and to provide the moderator some context about each group's makeup on key topics (e.g., beneficiaries' recent experience with telehealth visits or clinicians' experience with providing telehealth visits.)

A core set of research questions and topics of interest guided the development of discussion guides for all focus groups. Topics discussed in beneficiary groups included the process of choosing coverage, access to primary care and specialty care, telehealth, and prescription drugs. Topics discussed in clinician groups include acceptance of new patients and insurance, working with other clinicians, telehealth, changing organization of medical care, working with insurance and MA plans, quality reporting, ACOs, and prescription drugs.

Analysis

We performed our analysis using NVivo qualitative data analysis software. A summary of the analytic process is as follows:

- All virtual and in-person focus groups were recorded and transcribed.
- NORC developed a list of topic codes based on the moderator guide for the focus groups, as well as on previous analyses and reports. (The topical codes are generally reflected in the headers of the Findings section.)
- NORC loaded transcripts and codes into an NVivo project file.
- We coded each transcript in NVivo, tagging and organizing content based on the topic codes.

- NORC researchers conducted a thematic analysis of the content within each topic code to identify themes, such as areas of agreement and disagreement among participants, and compelling quotations illustrating the identified themes.

In some of the following sections, we highlight beneficiary and clinician focus group findings by location and beneficiary type (e.g., dual eligible and Medicare-only; traditional Medicare and Medicare Advantage) to draw attention to any differences by geographic region, urban vs. rural location, or coverage type. Due to the nature of focus group research, our sample was limited in number and may not be representative of Medicare beneficiaries or clinicians in the locations where we conducted this research. Therefore, findings cannot be generalized either to the studied communities or to the nation as a whole. The benefit of the qualitative approach is that it allowed us to ask questions with answers that cannot be easily put into numbers to understand experience. In addition, it allowed us to understand the "how" and "why" of experiences, including deeper understanding of experiences and context, and provided personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

Findings

The following sections describe what we learned from our analyses of the 24 focus groups. We start by summarizing what we heard from beneficiaries about their experiences with choosing coverage and then discuss beneficiary and/or clinician experiences with access to care, telehealth, organization of care, and prescription drugs.

Choosing Coverage

For the most part, beneficiaries were eager to share their experiences in choosing Medicare coverage. The process of enrolling in Medicare for the first time, even for many older beneficiaries who made those decisions years ago, was viewed as an important one and something about which they easily recalled the details. One theme that we heard across cities and between coverage profiles was how confusing and sometimes overwhelming making decisions about Medicare coverage can be, especially for those aging into the program. Beneficiaries shared these sentiments directly in focus groups, and they also emerged from the data collected through our screening process and pre-focus-group surveys. Beneficiaries' responses to these questions frequently provided conflicting information about their coverage situation or were inconsistent over time and took additional inquires to confirm and clarify beneficiaries' actual coverage situation.

The following subsections detail findings related to beneficiaries' understanding of Medicare, the sources of information they used when making decisions, and how they chose a plan when first enrolling in the program; factors that impacted their enrollment choices; and their experiences with switching plans.

Understanding Medicare and Plan Choices

When it came time to enroll in Medicare, beneficiaries described being confused about their options for coverage, both deciding between traditional Medicare and Medicare Advantage as well as supplemental coverage and Medicare Advantage plans, respectively. Beneficiaries described a lack of understanding about the Medicare program and felt the need to educate themselves (or seek out information) on their options. One said:

> *"When I turned 65, I hadn't prepared myself to educate myself about these plans. As a matter of fact, I just went in thinking, Medicare, all this is going to be short. So … a Medicare agent came to my house and he kind of ran through it and I'm not comprehending all this stuff. He's just throwing all this information at you."*

Another beneficiary noted:

> *"It is very confusing. The book that they send you every year is of absolutely no help. I've got to say, I went through it a million times and all the programs, so many of them seemed exactly*

alike, but with different premium costs. And really, if I hadn't had this broker, I don't know what I would've done truthfully."

Beneficiaries relied on numerous sources to learn about their Medicare options. Beneficiaries used health insurance agents and brokers, representatives from insurance companies, experiences of friends and family, and personal research to learn about their options. One beneficiary who reported conducting their own research to find a supplemental plan reported "Well, I did my own research. I went on this computer and their annual book that they put out, and we picked a supplement because we didn't want to go through a gatekeeper every time we needed somebody, and we wanted to have our own doctors. And it's worked out pretty well." Another beneficiary reported, "We talked to a couple more friends and they said, 'well try this one or try that one.' So right now we're with [plan name] and we're really happy with it."

Few beneficiaries were familiar with the State Health Insurance Assistance Program (SHIP),[8] and only one beneficiary reported using their SHIP to select a plan. This beneficiary explained, "I went to our local [state SHIP] office … they help seniors and disabled people to make decisions about life. Anyhow, so I went there, and we went through the options that were available for me, and that's how I chose it." Notably, this beneficiary was unaware that the service was provided by a SHIP per se and knew about the program based on its state-specific name.

Some beneficiaries, including those enrolled in both traditional Medicare and MA, reported using both the "Medicare & You" handbook and Medicare.gov to inform their coverage selection, but opinions varied on their utility. Some beneficiaries found the handbook a helpful resource, whereas others found it overwhelming and confusing. When asked if they have used Medicare.gov, one beneficiary responded, "I haven't been there, but they send a booklet out.… That big booklet I do [look at] every year. That's where you start looking to see what is in there and what you are getting from the benefits of the plan, and your copays and everything else is listed." On the other hand, another beneficiary reported, "I ended up going online, and then there I was able to compare [plans] side by side. So that was really helpful. The book is confusing. It's huge."

A traditional Medicare beneficiary summarized their experiences with Medicare.gov, "For a government website which we all tend to slam the government, but I have my hats off to Medicare. I think their website is excellent. And if you don't know a freaking thing about Medicare, you go to that. And if you study that website, it'll really guide you on what options you have and the pros and cons."

[8] SHIP is a national program that offers one-on-one assistance, counseling, and education to Medicare beneficiaries, their families, and caregivers to help them make informed decisions about their care and benefits. SHIP services are delivered by state units on aging or state departments of insurance in partnerships with their local area agencies on aging and other community-based partners. Source: Administration for Community Living (ACL): State Health Insurance Assistance Program. Available at: https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship.

Choosing a Medicare Plan

Many beneficiaries who participated in focus groups used a broker to select their plan; several used plan representatives. Many beneficiaries described working with a broker to help them understand the specific plan choices and their associated costs and to ultimately choose their plan. Beneficiaries found the brokers to be helpful for navigating their choices and ultimately selected their plans after discussing options with their broker.[9] One traditional Medicare beneficiary reported, "My agent was independent, and it was a friend of a friend and just someone that was willing to spend time with me and objectively lay out my options for me." Another MA beneficiary reported, "I spoke with an agent as well and I don't know how I found him. I think God sent him. He's wonderful and he represents other companies, but he determined that [plan name] was best for me, and I've been really happy with it."

One beneficiary reported that the broker they worked with to find a plan provided the service for free, but they reported that the broker now charges for their services:

> *"I had a friend who sent me to someone who actually was selling or helping people with the ACA, Affordable Care Act, as well as Medicare plans ... So he was wonderful. That was a free service. However, he is now not doing ACA, he's just doing Medicare, and he is charging about a hundred dollars to sit down and consult with you. But I would say highly worth and do also get newsletters on any changes or anything."*

In addition to using brokers, some beneficiaries described working with representatives from insurance companies after being contacted by them. One beneficiary noted, "I was contacted by a gentleman from [plan name] that actually came out to the house and explained everything and then said when you make your decision, let me know and then we'll go through everything and I'll take care of how it goes through process. So, it was the personal touch." A traditional Medicare beneficiary reported, "Well, I went to a food pantry with my uncle, and there was a booth. And [plan name], and they explained to me everything. … I've been with [plan name] ever since."

Factors That Affect Beneficiaries' Choice of Coverage

Reasons for Choosing Medicare Advantage

The cost of coverage, including monthly premiums and out-of-pocket costs—specifically copays for prescription drugs—was commonly cited as an important factor for beneficiaries when selecting a plan. Several beneficiaries who chose MA described low monthly premiums compared to Medigap plans (i.e., Medicare supplement plans). One beneficiary enrolled in MA summed

[9] A Medicare broker is someone who works with multiple insurers who can provide beneficiaries with a variety of options. An agent works with one insurer and can only offer beneficiaries plans from that insurer. Beneficiaries reported working with both brokers and agents, but we are unable to differentiate between the two in our findings because some beneficiaries used the terms interchangeably. Source: HealthCare.gov. Agent and broker (health insurance). Available at: https://www.healthcare.gov/glossary/agent/.

up this sentiment when asked about important factors in their decision: “I was looking for one that was low cost, and [that] has been [plan name] pretty much ever since because I’m on a plan that has no monthly premium.” Another beneficiary enrolled in an MA plan reported:

> *“Pretty much once we’ve hit our deductible, which fortunately is only $400 a year for anything outside the hospital, they pretty much take care of everything and I was checking in a couple years ago to the [facility name] and the gentleman doing the insurance check, and in comparison, he said, I can’t believe the coverage that you’ve got.”*

Many beneficiaries, particularly those enrolled in MA plans, worked with brokers or agents to determine the out-of-pocket costs, premiums, and prescription costs of individual plans when selecting their coverage. Beneficiaries who selected MA noted that they worked with brokers to have low out-of-pocket costs for all aspects of coverage. In particular, beneficiaries with MA noted that they did not want traditional Medicare and an expensive supplemental plan that they believed they may or may not need. One MA beneficiary noted, “[An agent] came to the house ... and so he went through his plans.… He explained the difference between the A, B, C, D thing about supplemental. I was like, that’s way too much. I don’t want to be fooling around with all that.”

Beneficiaries who selected MA over traditional Medicare described how MA felt like an easier and more streamlined option. These beneficiaries cited confusion around the different Medicare parts (e.g., A, B, D) and options for supplemental coverage. They felt that the single decision and single plan to enroll in Medicare Advantage made the decision less complicated and cumbersome. “And I found Medicare harder to use than having an Advantage plan. And if you have a question and you call Medicare, they won’t answer you. They’ll tell you it depends on the code, but you don’t know what the codes are. And so they can’t tell you whether or not something is covered. And I found that annoying.”

When selecting their coverage, beneficiaries who enrolled in MA and in traditional Medicare both prioritized being able to continue to see the clinicians they already had relationships with. The desire to keep their doctors, especially PCPs, was a common goal among beneficiaries. To ensure that they were able to continue under the care of their current doctors, beneficiaries called their doctors’ offices and asked if they accepted the plans they were considering, worked with their agents, and independently reviewed provider directories. Moreover, although cost was a key consideration for many beneficiaries when choosing Medicare coverage, for some, the ability to keep seeing a particular clinician was primary. One beneficiary reported:

> “*So, I think when it comes to making that decision, you really do have to analyze what’s important. I’ve had this same doctor for the 17 years I’ve been in [city]. I have no reason to leave her. So, for me, it’s worth whatever the copay is for her and my prescriptions because I have so few.”*

Beneficiaries who enrolled in MA plans reported differing views on how supplemental benefits[10] factored into their plan choice. Beneficiaries overall enjoyed their supplemental benefits. Beneficiaries specifically cited that they like using their over the counter (OTC) benefit card in myriad ways, ranging from paying utility bills and buying groceries to other benefits like incentive programs to engage in preventive care or social activities. One Medicare-only beneficiary with MA described how the supplemental benefits factored into their decision:

> *"Every year when the book or the email comes as to how the benefits are going to change, I just go right to there and say which one's better [for me]? ... Whatever gives me the most [supplemental benefits]. And when I say most, the gym, working out, the group exercise and that type of thing first and foremost. And then the doctor coverage. It's all good but to be able to have workout at gyms and special type of training ... I'm surprised what Medicare covers."*

When asked about their supplemental benefits, another Medicare-only beneficiary with MA reported that the supplemental benefits helped support health living by incentivizing them to participate in healthy activities or get preventive care. They explained, "[The supplemental benefits] did [it] for me. I like gymnasium and like I said earlier, I liked preventative maintenance."

Very few dual eligible beneficiaries with MA reported considering supplemental benefits when selecting a plan. Dual eligible beneficiaries with MA more often discussed ensuring their prescription medications and primary care providers were covered by their plans. Of the dual eligible beneficiaries with MA who did consider supplemental benefits when selecting a plan, one reported, "I found out about [plan name] when I became eligible... [my wife] told me about [plan name] and at the time they had a hundred, I think what it was. Now they're offering $157 in terms of food, the OTC benefit. That's huge attraction." One dual eligible beneficiary shared that their MA plan sent a copay card each quarter to cover the cost of specialist visit copays.

Although not all beneficiaries knew about or factored supplemental benefits into their plan choice, most knew about at least some of them after enrolling and value their access to them. Several beneficiaries reported that they like the option for a gym membership, e.g., Silver Sneakers. However, for the most part, beneficiaries noted that the supplemental benefits were not deciding factors in their choice of a plan. One beneficiary reported, "I just started getting [the supplemental benefit] last year. It was an added benefit, and it is a nice feature, but it wouldn't be the decision-maker for me." Another noted, "It didn't factor into choosing the plan. I think we get $70 a quarter and I don't take many over-the-counter [drugs] because of all the prescriptions I take. So, we struggle to use even half of it every quarter. It was a nonfactor."

[10] Medicare Advantage plans can offer supplemental benefits not covered by traditional Medicare. These include health-related benefits such as dental, vision, and hearing; benefits to reduce avoidable health care use; and benefits to improve or maintain the health or function of chronically ill enrollees. Source: U.S. Government Accountability Office. Medicare Advantage: Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization. January 2023. Available at: https://www.gao.gov/products/gao-23-105527.

Although many beneficiaries enrolled in MA at least in part because of the supplemental benefits, a few were unaware of some or all of the supplemental benefits available through their plans. One reported, "I didn't know there was any part of a fitness [Silver Sneakers]. Like again, I believe been on Medicare little over a year, but I think I was six months in before I found out [about any of these benefits]. … the broker never mentioned it. And I didn't read my 1,200 page book. Couldn't do it."

One beneficiary in a rural area noted that, although the benefits are nice, they are not able to take advantage of them. "And if for me, I'm very rural. I'm out in the middle of nowhere. And the Silver Sneakers program, I don't even recall if it was available to me because of my remote location.... I looked into it, and it was going to be an hour and half drive each way to do it. And now I can walk around my house. I'm in the mountains, and everything's uphill, so I get my own exercise that way."

Reasons For Choosing Traditional Medicare

Some beneficiaries reported choosing traditional Medicare instead of Medicare Advantage because of perceived narrow provider networks under Medicare Advantage plans. Beneficiaries reported that their clinician options felt much more limited with an MA plan than with traditional Medicare. One beneficiary reported that their existing PCP did not accept MA plans. Another beneficiary reported that his spouse was unable to find a specialist in their area that accepted MA plans, and so when it came time for him to enroll in Medicare, he chose traditional Medicare with a supplement. "So right out of the chute, she needs to see a specialist, an orthopedist, and we discovered that not a single orthopedist in the entire [city] area took Advantage. So we did a fast education process. Fortunately, she was able to switch to traditional Medicare, and then we went from there."

Many rural beneficiaries selected traditional Medicare to have access to a larger network of clinicians than what they perceived they would have through a Medicare Advantage plan. Rural beneficiaries explained that they generally have fewer clinician options in their areas and that MA plans with provider networks that could reduce the number of providers even more did not suit many beneficiaries' needs. One rural beneficiary noted, "Well, I used an agent to find my Medigap plan and my Part D. I chose traditional Medicare because we are in a very rural area, and I understand that the other plan is somewhat selective on what doctors you can use. So, we didn't feel like we could take that option."

One rural beneficiary reported that MA met all of their needs, noting, "We went through an agent broker, and kind of where we are, we're more in a rural area so our options were limited. And the Medicare Advantage [plans] seemed to be the best ones."

When selecting plans, both Medicare Advantage and traditional Medicare beneficiaries considered prescription drug coverage, including costs and formularies.[11] Beneficiaries used Medicare.gov and talked to agents and brokers to understand whether their prescriptions were covered and how much they would need to pay out-of-pocket for filling them. One beneficiary said, "The way I landed on [Advantage plan name] was, A, there was no extra cost involved. And B is that all of my doctors, all the prescriptions that I take are within the coverage, and it was just a good fit for me and my wife." Another beneficiary reflected what many beneficiaries reported, that several factors were important to their decision: "The drug plan that covered all the medications that I take and the doctors that I wanted to see were on the plan."

Dual Eligible Beneficiaries' Coverage Choices

Dual eligible beneficiaries prioritized keeping their current doctors and reviewed dental, vision, and prescription drug coverage when choosing their plans. Dual eligible beneficiaries described provider coverage as a key priority when considering health plans. One dual eligible MA beneficiary noted, "I actually studied [plan options] and chose the [plan name] because of all of the different medications… I was taking. That was the best coverage for my needs." Another dual eligible MA beneficiary reported, "I used a broker also… I found that she asked me what doctors I use, what prescriptions I use, and she came up with [plan name] because all of my doctors accepted [plan name], including my dentist. Because sometimes depending, they won't accept certain insurances. So I gave her the name of all of my doctors and found that they accepted [them]."

Satisfaction with Coverage

Overall, both traditional Medicare and MA beneficiaries were satisfied with their coverage. High proportions of participants in focus groups rated their coverage as "Excellent" or "Good" (see Exhibit 5. When describing why they rated their coverage as such, they noted satisfaction with their access to providers, their prescription drug coverage, and their providers themselves. A traditional Medicare beneficiary summed this up well by reporting, "I love traditional Medicare. I've never been refused anywhere as I have an F plan[12] with [plan name] I love it." Beneficiaries enrolled in MA plans frequently mentioned supplemental benefits when describing their satisfaction. One beneficiary enrolled in MA reported, "When I went [on] Medicare, I thought my corporate insurance was far … superior. But then when you start breaking it down, especially the workout part, there's a lot of stuff out there. I found the YMCA [is part of our benefit], I said, OK, this might be kind of cool. And it just blew me away … not only am I working out there. I'm doing yoga six days a week." Similarly, a dual eligible beneficiary enrolled in an MA plan reported, "My coverage is good. Most of my doctors are in network. ... I love that. ... My prescription coverage is great. I just switched over to UBRELVY [Ubrogepant] for migraines. And that stuff's expensive out of pocket, like for 15 pills, it's almost $2,000 a month, and [current plan] covers it

[11] A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Source: HealthCare.gov. Glossary: Formulary. Available at: https://www.healthcare.gov/glossary/formulary/.

[12] Plan F is a type of Medigap plan that covers the Part B deductible; this plan is not available to beneficiaries who turned 65 on or after January 1, 2020. Source: Medicare.gov. Compare Medigap Plan Benefits. Available at: https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits.

for me. They're the first ones that have covered it. I tried to get it back when I had [previous plan], and they refused, absolutely refused to cover it. And [current plan] covers my transportation there, my transportation back. If I had to stay in the hospital for any reason, they cover everything."

Exhibit 5. Beneficiary satisfaction with overall coverage

	Traditional Medicare	Medicare Advantage	Dual Eligible*[13]	Rural (Mixed)	Total
Excellent	13 (54%)	12 (41%)	20 (50%)	8 (42%)	53 (47%)
Good	10 (42%)	17 (59%)	17 (43%)	10 (53%)	54 (48%)
Fair	1 (4%)	0 (0%)	3 (8%)	1 (5%)	5 (5%)
Poor	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0

* We recorded one extra response to the survey that participants filled out prior to the start of each focus group. Therefore, although there were 39 dual eligible participants, the total in this column sums to 40.

Most beneficiaries who rated their plan as "fair" or "poor" primarily reported issues with the high cost of prescriptions (detailed in the section on Prescription Drugs). Although we asked participants to rate their prescription drug coverage separately, most reported their experiences with, and access to, prescription drugs when rating coverage overall. In addition, a few participants identified issues related to access to specialty care or the administrative burdens of working with their plans, e.g., prior authorizations for prescriptions. One traditional Medicare beneficiary reported, "My [coverage] was fine until I lost a child and needed intensive psychiatric help. And there was no one … who would take Medicare." Another dual eligible beneficiary with traditional Medicare noted:

> *"I just got put back on a medication I was on two years ago that worked and it's a very expensive medicine. Something about preauthorization and then this, it's six weeks later, I still don't have it. So I'm so frustrated with them, like I said, and if you go to these doctors, you take your time out of your day, you schlep to the doctor, they can only do so much and then the brick wall goes up because they can't help you on the back end because you have all this paperwork and whatnot from the insurance company. And I just want to feel better."*

Switching Plans

A minority of beneficiaries reported having switched coverage, with most of those moving from traditional Medicare to MA. When beneficiaries switched from traditional Medicare to MA, they reported wanting to save money on their monthly premiums. One beneficiary remarked:

[13] The dual eligible groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase turnout. We have combined them in this exhibit.

> *"In my situation, I actually started out with Medigap, the supplemental program on top of Medicare, but I found a few gaps plus that was pretty expensive. I was spending over a hundred dollars a month and I think now it's gone up even more. Then I checked that with the Advantage program and found that I could get not only the same benefits or better for zero premium. And actually as time progressed, the Medicare Advantage physician provider participation grew tremendously. So just about any specialist, anybody I've been seeing I could get on with, it's become almost a 100% penetration of providers, at least in [state]."*

A few beneficiaries who switched from traditional Medicare to MA expressed interest in switching back but noted that they thought there could be limitations when switching back. When asked about their interest in switching back to traditional Medicare from MA, one beneficiary reported, "I'd heard you could have trouble getting back. But we're healthy, my wife and I both have no issues. So that made it easy. But as I understand it, if you have issues and you try to go back from Medicare Advantage to a supplemental, you're not going get it."

Some beneficiaries enrolled in MA reported reviewing their coverage options annually during open enrollment, and some had switched from one MA plan to another. MA beneficiaries reported exploring other plans to find out if they offered different provider networks and prescription coverage for the same or lower costs. One MA dual beneficiary shared the following description of finding another MA plan after feeling frustrated with her previous plan because her preferred providers were out-of-network:

> *"And so I was like … I'm going to find something else. Well, I did it the hard way. I went on [plan] website and checked to make sure they had every doctor that I wanted to see because when I went to [plan name], they didn't have any of the doctors I was already seeing. I wanted my oncologist. So I went on there and I was like, OK, well, they got the oncologist, they got this one, they got that one, and so I changed."*

Another beneficiary described their experience with switching MA plans:

> *"Well, I've had two Medicare Advantage plans. The first one was working out great. Of course, I wasn't ill, my medications were covered. Then I suddenly became very ill. And for the first three years, anyway, I was in and out of the hospital, in and out of the doctors. My out-of-pocket costs, well, they were just horrible the first year. And so, my daughter and I went online, and we found another Medicare Advantage [plan] that cut my total out-of-pocket cost in half. So, it almost ruined us financially that first year. But then this new one that I got, all my medications are covered, my out-of-pocket costs are half."*

Those who did switch plans did so to ensure that specific providers who were not in-network with the plan in which they were enrolled would be in-network with another plan and/or to reduce their out-of-pocket costs. One rural MA beneficiary who switched said, "I had to switch. The one I had wasn't covering my area anymore because I live in a rural area, so I researched and read and picked [Plan name] because it met all my needs."

During open enrollment, a few beneficiaries who were enrolled in traditional Medicare also reviewed their options—both other supplemental plans and Medicare Advantage plans. A few traditional Medicare beneficiaries reported researching which plans were available to them, including MA plans, to understand how they may improve their out-of-pocket costs. One beneficiary who considered switching reported receiving guidance to stay with their supplemental plan, “I normally, every year or every other year, contact an agent just to have [my plan] reviewed. And undoubtedly, for the last five years now, they’ve said, stay with the supplemental.”

Access to Care

We spoke with clinicians about their perspectives on topics related to access to care, including wait times for appointments, acceptance of new patients and insurance, acceptance of MA plans, and working with MA plans. Similarly, we spoke with beneficiaries about access to primary care, including their regular source of primary care, receiving care from NPs and PAs, their access to primary care, experiences in looking for new providers, and experiences with MA plan networks and prior authorizations. Findings from rural Medicare beneficiary findings are described throughout and separately at the end of this section.

Clinicians

Wait Times

We asked clinicians about how long new and established patients typically had to wait to get an appointment with them. **In general, wait times were shorter for established patients than for new patients**, with exceptions for new patients with acute issues or those who were referred by another clinician, especially when the referral was from a personal connection. Primary care physicians reported new patient wait times that ranged widely—from days up to six months. Among NPs and PAs, most reported new patient wait times from two to six weeks. Most specialists reported new patient wait times ranging from a couple of weeks to three months. In all three locations, clinicians noted that wait times vary by season. In one city, clinicians attributed this to the increase in Medicare beneficiaries who reside in the area during the winter.

Regarding wait times across specialties, one specialist attributed this to perceived workforce shortages, saying, “I think the take-home message here is that in every specialty, we’re starting to see shortage of physicians at every level. We’re seeing it in cardiology, I’m sure other specialties are really seeing the same. And I think [the COVID-19] pandemic … has accelerated [the shortage] tremendously.” Oncology appeared to be an exception to the average of specialist wait times of longer than a month, with several oncologists across locations noting that they tried to get cancer patients in as soon as possible, typically within a week.

Across locations and across specialties, clinicians reported that wait times were shorter when patients had an acute issue, were coming from the ED or being discharged from the hospital, or were referred by another clinician. One primary care physician explained, “So my response [when a referral comes in] is, how urgently do they need to be seen? And they’ll say, oh, there’s nothing urgent. Then OK, maybe it’s going to be three, four, or five months. If like, oh, they have this issue or their diabetes is not well controlled, I’ll work with my schedule or to find a spot sooner. So usually within a three-to-four-month timeframe.” A specialist said, “My buddy, the dermatologist, calls me, I see him that day. They’re calling de novo and it’s a simple chronic problem that can wait, it could be two, three weeks.” An NP explained:

> *“If they come from the emergency room and their discharge paperwork says they need to see the physician within X amount of time, then we will address that issue and then give them a follow-up appointment based on the severity of their issue at the time. But normally, it would take about a month, sometimes two months to get an appointment, but we’re constantly working on trying to narrow that gap for patients to come in, especially if they’re new.”*

Several clinicians reported that patients can often get in sooner if they see an NP or PA in the practice instead of a physician, a finding that was echoed by beneficiaries. Describing his average wait time, one primary care physician explained, “About a month or two out. And we do have nurse practitioners that sometimes they can kind of get in and then get through the back door and then sometimes make a follow-up with me and establish [care].”

A few clinicians reported that a patient’s wait time can be affected by the practice’s scheduling process, with one specialist describing how it can depend on the ability of their administrative staff to judge the degree to which the patient needs an appointment or communicate with clinicians to determine scheduling priority. One NP said, “If they’re able to get back to my MA [medical assistant] or portal message me and they’re having problems, I will work them in somewhere, but if I don’t know about it, then I can’t make that accommodation.”

Acceptance of Patients and Insurance

In our pre-group surveys, we asked clinicians if they were accepting new patients and new Medicare patients (Exhibit 6). The majority were accepting new patients, including new Medicare patients.

Exhibit 6. Clinician acceptance of new patients

Clinician Group	Accepting New Patients	Accepting New Medicare Patients
Primary care physicians	23 (100%)	21 (91%)
Specialists	28 (100%)	28 (100%)
NPs and PAs	20 (95%)	19 (90%)

Although most clinicians were accepting new Medicare patients, several described strategies to limit their volume of Medicare patients. For example, some capped their overall percentage of Medicare patients. One PCP explained, “If you go any more than [30 percent Medicare patient volume], you spend more time with those patients, your productivity goes down, and unfortunately your revenues and your compensation tend to go down also.” Several clinicians reported that they were not accepting new Medicare patients, but they kept current patients as they aged into Medicare. Some also made exceptions when a new Medicare patient was referred by a current patient or another clinician. One NP said, “If someone was a patient and they went on to Medicare, we’re not going to turn them away. But we aren’t taking new Medicare. That was all based on reimbursement, I believe.” A specialist explained, “We don’t advertise that we’re taking [Medicare enrollees] and we’ll accept them if the previous patients that are aging in Medicare or a primary care provider refer them to us. But we try to minimize.”

In all three locations, primary care physicians noted that as they have aged, their panel has aged with them, leading to a growing volume of Medicare patients. One explained, “As aging physicians, the problem is we end up getting a lot of the Medicare patients because they start out at 40 or 50 and then they end up going on Medicare. So our panel ends up going up to 30 or 40 percent as we age.” Another said, “But as you grow older and your patients grow older, you get a geriatric practice.”

Some clinicians observed that their share of MA patients has increased over time relative to traditional Medicare patients. One specialist said, “I do notice the Medicare Advantage plans are much more prevalent now compared to [a] decade ago.”

Clinicians’ Acceptance of Medicare Advantage Plans

The majority of clinicians were accepting MA plans (Exhibit 7).

Exhibit 7. Clinician acceptance of Medicare Advantage plans

Clinician Group	Accepting Medicare Advantage Plans
Primary care physicians	26 (93%)
Specialists	22 (96%)
NPs and PAs	20 (95%)

When asked about deciding which MA plans to accept, many clinicians indicated that this is an organization-level decision that they do not take part in making. One PCP explained, “It depends on which organization you’re affiliated with. Under our contracts, they decide for us what we accept.” Another PCP said, “That’s a decision made at the top level of our system.”

A few clinicians noted that they understood that the decision is driven by reimbursement. One specialist said, “I think it just depends on what the payer contracts are that determines if they usually pay better than regular traditional Medicare. Sometimes it’s more financially advantageous to accept

them, but it depends on the individual's plan." An NP said, "I think that at some point there'll be a discussion or at least looking at, like, reimbursement because there [are] some big ranges as far as reimbursement goes for the different plans."

Some clinicians reported that they accept some MA but are not contracted with all MA plans. In some cases, this was driven by the MA plans. One PCP explained, "It's the insurances that decide who belongs and who doesn't." A few NPs and PAs noted that their contracts can depend on plans' willingness to contract with them. One NP explained, "I take anyone who, my billing person usually signs me up. I'll take anyone who will accept a nurse practitioner.… I try to get on panels sometimes, but again, single practitioner, they don't always want a single practitioner." Another NP said, "I just went through the credentialing and I got to choose which plans that I chose. And so, I just chose everything that was open."

Working with MA

Several clinicians noted that they treat all patients the same, regardless of insurance. One PA reported, "Our office kind of treats all the Medicares the same. Like, we have, we do all the risk adjustments for anyone who's on any Medicare plan. Quality measures the same. That's how our office deals with it there."

A few clinicians saw advantages to working with MA, including lower prescription drug costs for patients and additional resources or benefits. One PCP explained, "If they have a lot more complicated problems, I encourage them to do go with the Advantage plan … Because of the resources and cost of medications." A PA described how a patient's coverage affects their care due to MA plan requirements as well as additional services or benefits available through MA plans. This PA said, "We have more of a system around depending on which Medicare Advantage they are, as far as social work, palliative care, all this stuff that would go with the Medicare Advantage plans that traditional Medicare wouldn't cover." She explained how the MA plan categorized patients based on their level of risk for hospitalization, and patients in the top two of five risk levels have frequent visits, social work services, and nursing staff who review their medications. She explained, "There's a whole checklist that comes with Medicare Advantage.… There's a whole net around them to try and keep them out of the hospital, keep them healthy."

Although some clinicians described advantages of MA, several clinicians felt that patients have been misled about the benefits of MA, describing them as drawn in by low premiums or supplemental benefits. One specialist explained, "I think the premiums for the patients are also low with the Advantage plans and they get the athletic or health benefits of their little perks. But the problem is they need a referral or there's some restrictions or if they travel, they won't have as much freedom as with traditional Medicare. So, they don't realize it upfront. but if they have a high-cost drug … it's going to cost them." Regarding the dental, vision, and hearing benefits offered by some MA plans, one specialist said, "The patients say, well, we are getting much more than regular Medicare … but they're not getting much." An NP summarized, "I feel like a lot of the people that go on the Medicare Advantage

plans think that they're going to have great coverage and then something happens and it's not great.… A lot of times I think that those Medicare Advantage plans are not all that they're cracked up to be for the patients."

Most clinicians did not report receiving meaningful guidance from MA plans. When asked if they received guidance from MA plans about how to manage the care of their enrollees—such as gaps in care, medication management, quality scores, or spending information—clinicians generally did not report receiving meaningful communication from MA plans. One PCP described typical communications: "I'd probably get faxes or emails from them recommending that, oh, your patient is due for the colonoscopy or they're due for their diabetic eye exams. Encourage the standard care for those type of patients. Just reminders." Several clinicians acknowledged that if MA plans were sending this type of guidance to their office, it was not reaching them.

Several clinicians noted that care management from MA plans sometimes benefits their patients, whereas others reported downsides. A specialist reported, "Medicare Advantage plans will give you a lot of free advice and paperwork that they expect you to go through.… I guess they're trying to be helpful because they have their own team looking at the patients that are costing them more." However, this specialist said that their practice sometimes hears from MA plan care managers, explaining:

> *"Usually, it is when they're hospitalized, and our patients get hospitalized a lot. So, we don't like it. So, you get calls from 'have you tried this or that?' And then these letters that your patients move on to stage five or whatever. Sometimes for transplant patients [I get notifications from MA plans that tell me my patients are] not taking their medications or that they haven't filled [their prescriptions], so that's helpful."*

An NP described their communication with an MA care manager, "[My patient] has a care manager who calls me periodically just to sort of keep me up to date as far as, oh, you asked for, you know, an at-home care person, so this is what we're doing, or they saw their primary care, or if they haven't had labs in a while, they'll call me, and based on the medicine that I'm prescribing, that they need certain labs and certain parameters, so I do get some feedback from them." One specialist noted that they only hear from care managers if a patient's treatment is costing them too much money, and that the care manager's priority seems to be managing costs rather than meeting the patient's needs.

Several clinicians reported that some of their patients had received home visits from their MA plans. Clinicians did not describe these home visits as integrated into the care they are providing for these patients. One PCP said, "I don't understand the insurance companies these patients sign up for, I'm their primary. And then the patient comes to the appointment, oh, this nurse practitioner came to my house and did a physical." Other PCPs shared similar experiences and noted that these wellness visits can lead to additional follow-up care and tests based on the insurance's assessment of the patient.

Many clinicians cited disadvantages of working with MA including burdensome prior authorization requirements for referrals, procedures, and medications. One NP explained, “You spend more time being an administrative flunky to all these different plans than you actually do providing patient care. So probably in an eight-hour day, I spent at least four of those eight hours on prior authorizations. Who said I couldn’t have this, the coding wasn’t right with that. It’s really sad.” A specialist said, “I don’t write for any medications that require pre-authorizations anymore. It’s not worth increasing my overhead.” Another specialist cited challenges with making referrals for patients with MA due to narrow networks. Clinicians practicing in solo or small practices reported these administrative disadvantages more than those in larger practices.

A few clinicians had experienced terminations with MA plans in which a contract between a health plan and a health system or provider was terminated, but reported not knowing much about or participating in the process, which took place at higher administrative level in their practice. They reported that plan terminations are difficult for patients, and some primary care providers mentioned that specialist practices seem to have more issues with contract termination than primary care providers.

Some clinicians described the need to have dedicated administrative staff to manage paperwork associated with MA plans. One specialist explained, “I think the problem with that is that we have to hire the staff to accommodate all this. So, the onus is on the provider … the time and the staff and the finances associated with having all that infrastructure.” Another specialist described the administrative burden:

> *“With the Medicare Advantage [plans], we have to do a lot of chart requests, responses. We have to resubmit; we get kick-outs. I don’t know if it’s just maybe this specialty, but there seems to be a distinct problem with the Medicare Advantage administrative processing claims payment side that we see ongoing. It’s not just this one time. We get these blips with Medicare where you don’t get chart requests or you know, a mini-audit or whatever you want to call it. But we get through those and it’s done. This Medicare Advantage just keep on ongoing and it just doesn’t end with … just this continual having to kind of go through the process claim by claim.”*

There was a perception among some clinicians that MA plans prioritize coding to get higher reimbursement for their patients. One PCP said, “And the Medicare Advantage, they do not care for the—what the patient needs. They want a list of diagnoses that can bill more. They can bill more and they get more money. [For example, the MA plan tells us for a] 95-year-old, make sure they got a mammogram in [the] last year.” This PCP also described the oversight by MA plans related to coding: “[The MA plan nurses] come to the office, they looked at the chart and then they try to tell you that you add this, or you delete this or do this. And that’s—they want to make more money out of the same patient.” Another PCP said, “The sicker the patients, so they’re really kind of pushing the PCP to really bill correctly, put as many of the complicated diagnoses as possible and get their—what is it, the RAF [risk adjustment factor] score, I guess it’s called, to the highest level so they can then bill Medicare or payers to get more money.… They’re constantly pushing the doctors in that direction.”

A few clinicians expressed frustration that MA plans sometimes designate them as a patient's PCP even if they have never seen that patient, in some cases affecting their quality scores. One PA in internal medicine explained, "Our ghost patients that we will never see, that we get dinged for, we call them, send them letters, all sorts of stuff, and … you cannot terminate them. And it's hard because, like, on our end … we get dinged basically for not doing stuff when we have tried 20 million ways to reach out to the patient."

Some clinicians reported that their patients were confused about the differences between Medicare plan options available to them. One PCP said, "It's too many products, too many specific products and too many general products, and it's constantly changing. The rules are changing constantly. It's almost like it's designed to confuse people." An NP described trying to help patients compare plans, including supplemental benefits:

> *"When they're trying to actually pick out a plan, I've actually had patients that will trust me to go through their plan with them, and I'm like, well, I don't know actually which one you should choose. So I'm reading through, like, different sections, and I'm like, OK, this looks like this is good, but then they have this over here.… They get this card, they can go to [pharmacy name] and get whatever DME [durable medical equipment] things that they might need. And then you look over here at this one. Well, this one covers more medications. So it just doesn't make any sense to the point where you have all these different plans or these different management companies trying to dictate what perks these people get whenever it should be something that everyone should be able to get anyway."*

Clinicians reported that differences between plans, as well as year-to-year changes, can lead to patients switching plans, making it more difficult to manage their care. One PCP explained, "And there's so many plans and they start competing and then the patient's always changing their insurance to get the—whatever benefit they're chasing, and it drives me crazy because I'm trying to do a referral or get them a DME, but because they have this type of insurance, I can't get them the scooter or the bed or whatever it is that they need, because they switched insurances."

Beneficiaries

Access to Primary Care

Regular source of primary care

Nearly all beneficiaries reported having a regular source of primary care. Several beneficiaries who responded that they did not have a regular source of primary care explained that they did have a designated PCP on paper but did not necessarily have a relationship with that person or were looking for someone new. A few beneficiaries said that they did not regularly or ever seek primary care services.

Many beneficiaries with MA reported that their plans required them to name a PCP, and some beneficiaries had a PCP assigned to them by their plan. We heard this from a number of dual eligible beneficiaries. One dual eligible beneficiary with MA noted, “The companies really steer you to that.… I don’t think we even get to move forward with any of these benefits unless we’re assigned [to a PCP].” One rural Medicare-only beneficiary said that his previous plans had required him to have a PCP, but his current plan (a preferred provider organization [PPO]) did not.

Seeing NPs and PAs

Beneficiaries reported a mix of physicians, NPs, and PAs as their designated PCP. Some beneficiaries go to practices that employ a mix of clinician types and said that they alternate their appointments between different clinicians or see whoever is available.

We asked beneficiaries about their experiences with and openness to seeing an NP or PA. A few people noted that it depends more on the individual person than on the clinician type. **Some beneficiaries said it would depend on the type of medical issue and they may be willing to see the NP or PA for select reasons but would not completely switch their PCP to an NP or PA.** One Medicare-only beneficiary explained, “If it’s something serious, I want to see the doctor. If it’s something minor, I’ll be happy to see a PA or a nurse practitioner.” Similarly, another rural Medicare beneficiary said, “When you don’t have a lot of health issues, the general checkup and just seeing the regular physician assistant or nurse practitioner is fine.” Some beneficiaries who were open to seeing an NP or PA in some circumstances said they would not switch to one as their regular source of care. Several explained that they trusted doctors more due to their training and education. One traditional Medicare-only beneficiary said, “I think medical doctors, MDs, I trust them more. I think they’re more reliable.” Another traditional Medicare-only beneficiary said:

> *“I want a doctor. I don’t want somebody who’s not experienced and not knowledgeable enough. Get the degree, I’ll yield to you... I want somebody who really studied, went through the challenges of being a doctor, especially in today’s day and age. I want to be confident in that. If I got a cold, I don’t mind seeing a physician’s assistant or a nurse practitioner, but if I have a problem, I want to see a doctor, that’s what I’m paying for, that’s what I feel.”*

Several beneficiaries said they had seen, or would be willing to see, an NP or PA because they could get in sooner than with a physician. One traditional Medicare-only beneficiary said, “For me, it’s availability. If I need to get in, the PA is typically going to be more available.” A Medicare-only beneficiary with MA said, “I’ll take it [seeing an NP or PA] if they’ll get me in quicker.”

Some beneficiaries’ preference for seeing their physician rather than an NP or PA was not about the level of training or perceived quality of care, but because they had an established and trusting relationship with that person and valued the continuity of care. One Medicare-only beneficiary explained, “It’s good to have a rapport with the doctor. And if you’ve been going, whether it’s five years or 20 years, at least they know you, they know your situation. They don’t have to sit there for 20 minutes looking at your file to remember what your situation is.” A second rural beneficiary noted, “I

like seeing a doctor for my primary care because I've had a lot of health problems and know she has all my records and she knows my problems." A third Medicare-only beneficiary said:

> *"I've been with my primary care physician for more than 20 years. I'm most comfortable with him.… At times when he's on vacation or sick I'm fine with a [nurse] practitioner. But other than that, I prefer him. And I just kind of stay the course. Because he knows me not only just medically, but kind of personally. He knows all of my information. So I'm more comfortable with him."*

Several beneficiaries preferred seeing an NP or PA over a physician, commonly citing that these clinicians spent more time during visits and seemed more thorough. One dual eligible beneficiary said, "I had a physician's assistant and I liked her much better than I liked the doctor. I think sometimes they take more time. They're more invested, because they're not seeing as many patients." Another dual eligible beneficiary reported, "I enjoy talking to my primary, I mean the physician's assistant, a lot. It's less formal and I feel more connected with him." A Medicare-only beneficiary said, "[The PA] spends hands down more time than the doctor ever did and was much more thorough. And you didn't feel rushed and whatever. That's been my lucky experience."

A few beneficiaries noted that it can be more efficient for the overall practice or system to see an NP or PA for minor issues, thereby allowing physicians to reserve time for more complex cases. Regarding seeing NPs or PAs for minor issues, one Medicare-only beneficiary said, "I feel like it eases the physician to deal with more severe problems of patients when you have strep throat. They [NPs and PAs] can tell something like that." Another traditional Medicare-only beneficiary said, "I felt like because she did it and took less time with the doctor, that you're taking some stress off the doctor, you're also freeing him up to do what he does. And he reviews every chart before they go in the room." Another traditional Medicare-only beneficiary agreed, "The PA spends … way more time with you than the doctor has, and the doctor gets freed up for more important or more critical cases."

One rural Medicare-only beneficiary reported that her plan would not allow her to see an NP:

> *"For some reason, I saw the nurse practitioner, and the insurance call me and tell me I would need to see the doctor, not the nurse practitioner. So, the insurance company made an appointment with me for the doctor. I don't know why.… I didn't mind seeing the nurse practitioner, but for some reason they called me and told me that I wasn't going to be allowed to see her. I would need to see the doctor and they picked this doctor for me."*

Timely Access to Primary Care

We asked beneficiaries about their access to primary care, specifically for routine visits and acute medical issues. **Most beneficiaries responded that they could access primary care when they needed it.** Some beneficiaries said they could get in the same day, next day, or within the week. Others reported waiting times of several weeks, and a couple of beneficiaries reported long waiting times for primary care (two to four months). Beneficiaries reported that they could often get in sooner if they were willing to see another provider in the practice, including other physicians, NPs or PAs, and

residents. **For acute issues, beneficiaries reported that they could typically get in faster than for a routine visit.** One rural Medicare-only beneficiary said, “If it’s something urgent, they will work very hard to get you in that day.” A Medicare-only beneficiary explained, “I think most of them, if it’s something right away, like you said, you wake up and you’re really feeling lousy, they’ll fit you in somehow. Now, for a regular appointment, you might have to wait a week or something.”

Many beneficiaries explained that they typically schedule their next visit during their current appointment. One Medicare-only beneficiary with MA explained, “I do a get physical every year and I get a six-month follow up. And when I go for my six-month follow up, we make the appointment for six months down the road for the physical.” A rural Medicare-only beneficiary said, “I set mine up annually and so I already know when I have to see him again.” A dual eligible beneficiary with traditional Medicare said, “I pretty much get in whenever I need to. But I have a standing [appointment] every three to four months, I’m in there.”

Travel to Primary Care

Most beneficiaries drove to their primary care location. Other modes of transportation included walking and public transportation. Several dual eligible beneficiaries used transportation services covered by their plan and reported mixed experiences with it, citing long wait times to schedule a ride and delayed or no-show rides. Generally, beneficiaries did not cite other issues with their transportation to primary care. One dual eligible beneficiary with Medicare Advantage explained that he drove 20 minutes to see his PCP, but often felt that he was not in a good condition to drive due to his health. Although there was an urgent care center closer to his home, he felt it was important to see his own clinician because of their access to his medical records and familiarity with his condition.

Beneficiaries reported a range of travel times to reach primary care, from five to 10 minutes to an hour. Most beneficiaries lived within 30 minutes of their PCP. A couple of beneficiaries were willing to travel longer distances to see a clinician that they liked and felt it was worth it because their visits were infrequent. One dual eligible beneficiary explained, “I travel too because if you find somebody good.… Maybe once or twice a year I drive and it’s like probably a 40-minute drive. I’ll drive. My primary care doctor was further than that. But I will drive over there because I don’t go that often to them.” Another dual eligible beneficiary said, “Mine is within 20 minutes, but I would travel further because it’s not something you do every week. I would travel up to an hour, I think, to see someone I really like.… [I]t’s not a weekly event, you go a few times a year.”

Urgent Medical Issue

We asked beneficiaries about their experiences dealing with urgent medical issues or how they would handle one in the future. Some beneficiaries explained that their approach would depend on the severity of the issue, when it happened (i.e., during or outside of regular business hours), and the distance to different options for care. A dual eligible traditional Medicare beneficiary said, “I would call my doctor first but if it was something acute like an allergic reaction, whatnot, they’re

closer to me than the emergency room is. If it was a broken bone or something, that would be different. So I think it would depend on the severity."

Some beneficiaries said they would call their primary care practice for guidance, for a prescription, or to see if they could get an appointment with someone in the practice, even if it was not their usual PCP. One traditional Medicare-only beneficiary said, "I call the doctor and ask, should I go to urgent care? If you can't see me, should I go to urgent care?" A rural Medicare-only beneficiary said, "Our clinic system, they would probably say yes, we can't see your primary care doctor, but Dr. X can see if you're fine with it, and they will try and work in, but you might not get your primary care physician." A dual eligible traditional Medicare beneficiary said, "If I had an acute situation where I was sick and I called the doctor, I wouldn't be able to see my primary care, I'd have to see physician's assistant." Several beneficiaries noted that their primary care practice had a walk-in clinic or urgent care on site that they could use. One dual eligible beneficiary with MA said, "My doctor, they also have an urgent care at her office. I might not be able to see her, but I'll be able to see somebody." Another dual eligible beneficiary with MA explained, "Now my primary is one of those facilities where they have same day or next day service. So, they would somehow fit me in, depending on how urgent it was. They would do the triage or something."

A few beneficiaries said they would message their PCP via the patient portal and would possibly opt for a telehealth visit. One dual eligible beneficiary said, "I'm going to use MyChart [patient portal], my app. I'm going to push it because they answer those pretty quick and they'll give you a response within usually 30 mins." Another dual eligible beneficiary said, "I'll just go onto my portal … and then they just either get back to me, like to do a telemed or call something in or whatnot." A traditional Medicare-only beneficiary said, "They also do telemedicine. If you're coughing and whatnot, they don't want you in the office."

Many beneficiaries said they would go to an urgent care center in the case of an urgent medical issue. One dual eligible beneficiary said that urgent care was much closer to her home and said, "I think if I had an urgent matter, I would go to urgent care before I would probably call my doctor because chances are they may be, 'We're full today,' and I need to get help now." A rural Medicare-only beneficiary also said that he would go straight to urgent care without contacting his PCP first, saying, "Probably just go to the urgent care. I guess we've been trained to look at that first and instead of trying to see if your doctor can work to you."

Beneficiaries had mixed opinions on urgent care facilities. One dual eligible beneficiary with MA described how she liked using urgent care facilities because they had more services available than primary care:

> *"One thing good about urgent care is if you go like because you're coughing.… They could x-ray right there.… A couple years ago, I had RSV [respiratory syncytial virus].… They did the testing. They did the x-ray.… They didn't have to send me anywhere. And when you don't feel well, I*

> *find that to be a big plus. If I'd gone to my doctor, she would have sent me to [hospital] to have an x-ray."*

In contrast, another dual eligible beneficiary with MA stated, "Whenever I went to urgent care, they never helped me, and it was always a $40 copay. I had a sinus infection also, and I just wanted an antibiotic. They wouldn't give it to me, and it wouldn't go away.… So, I'm not really big on urgent cares." She said she would rather go to the emergency department [ED], explaining, "It just seemed like whenever we went to urgent care, the ones that treated me they didn't seem like doctors, it just seemed like helpers." A few beneficiaries had never used or were not familiar with urgent care as an option.

Several beneficiaries said they would choose the ED for an urgent issue. A dual eligible beneficiary with MA explained, "I made a decision to go to the ER, rather than the urgent care, because I thought if there's something that you really have to do, I wanted to be in the emergency room." Another dual eligible beneficiary with traditional Medicare also expressed a preference for the ED, citing their serious medical condition.

A few beneficiaries said they would use walk-in clinics, such as those available at some drugstores. One Medicare-only beneficiary with MA said, "I ask for an appointment when I'm sick and they'll tell me it'll be a week or two. And that's when I'm in the Minute Clinic."

Finding a New Primary Care Provider

Some beneficiaries had experience with looking for a new PCP for reasons including their former PCP leaving the area or practice, retiring, no longer being in network, switching to a concierge model, or because of organizational changes such as a practice acquisition that negatively affected their experience of care. One dual eligible beneficiary with Medicare Advantage explained, "The previous doctor I had about three years ago was no longer with the plan. So, I had to get reassigned." He explained that it was a challenge to find someone who was accepting new patients. A dual eligible beneficiary with traditional Medicare explained how she had to take initiative when her provider left the practice:

> *"I had to advocate for myself. My primary moved and she was out of [the practice] and no one called me. I got a MyChart notice saying that she was going to leave but there weren't any options. No one called me, there was no 'we have these five candidates and here's their background, pick one.' And I wouldn't have one now if I didn't pick up the phone [and call the practice] and say, 'Hey, what's going on?'"*

This beneficiary ultimately ended up switching to another provider in the same practice, as did several other beneficiaries when they needed to find a new PCP.

When they needed to find a new PCP, beneficiaries asked current clinicians for recommendations, looked within their current practice or health system, consulted their health plan's provider directory, and did online research. When doing online research, beneficiaries

consulted Medicare's Care Compare, did Google searches, and looked at health care ratings websites. They checked whether providers were in network and looked at providers' ratings, reviews, educational background, and years of experience; one beneficiary noted that he looked into details including malpractice history. Several searched by location to find clinicians who were nearby or based at a particular facility. One dual eligible beneficiary with MA described her process of identifying a new PCP:

> *"I did a lot of research.… [The new physician I found] actually specializes also in rheumatology. I have rheumatoid arthritis. And so she just happened to have that specialty as well and I was like, well, that's perfect. So I looked up her reviews and everything and then her practice and it's got great reviews and I just wanted to make sure everything looked good. They've got great nurses, they've got great everything, they're fairly close and I was like, awesome. And then I had to make sure that with the insurance and everything and it was just a super easy process actually."*

A Medicare-only beneficiary with MA described how she asked other clinicians for recommendations when her former PCP stopped accepting Medicare:

> *"I did change [my primary care provider] not long ago, because where I was going that was convenient for me and had come recommended, they stopped taking Medicare altogether.… Don't see Medicare people at all. Because they're a relatively small practice. And it was the paperwork and the follow-up and everything that was involved in processing the claims and the fact, of course, they don't pay them very well. So, they simply notified me that they were no longer going to be handling any Medicare patients. So, I went out to my other doctors and got recommendations, and I'm very happy with the one that I'm with now."*

A few beneficiaries highlighted the importance of having a long-term relationship with a PCP who knows their medical history and explained that when researching new clinicians, they considered their ages and looked for people who would not be retiring soon.

Barriers to finding a new PCP included clinicians not accepting new patients, not accepting Medicare patients, or being out-of-network, even if they were listed in the plan's provider directory. One dual eligible beneficiary with MA explained, "I was calling offices just based on what was in the book in [plan name] and online. And a lot of them were at capacity. They weren't taking any more patients with the type of insurance I had.… When I told them the [plan name dual special needs plan [D-SNP]), no, we're not accepting patients with that particular insurance." A traditional Medicare-only beneficiary said, "If you have a supplement and you're looking for a new doctor, they don't all take Medicare.… I guess because of the lower payments that Medicare pays relative to some other plans, that some doctors won't take Medicare patients." Another traditional Medicare-only beneficiary said, "The impression I have is that Medicare Advantage is often not accepted. Medicare is, with a rare exception.… The ones that are generally being shut out are the Advantage customers."

Beneficiaries reported that their plans' provider directories were frequently out of date. One dual eligible beneficiary with MA said, "A lot of the providers that they [list in the directory], they're not really providers. Once you call, they say, we're not a participant." Another dual eligible beneficiary with MA

explained that he had called practices that were not accepting any new patients or were not accepting his plan, saying, “We don't accept any more [plan] patients, I was getting that. Or we’re not accepting any new patients. And they would be on the list unfortunately because the list wasn’t real up to date.… It wasn’t dynamic.” Another dual eligible beneficiary with MA had faced issues with providers only accepting one of her two plans.

A handful of beneficiaries had PCPs who had switched to a concierge or direct primary care model.[14] One rural Medicare-only beneficiary continued to see her PCP after she switched to a direct primary care model. This beneficiary paid a monthly fee and was satisfied with her access to and quality of care. For specialty care, she continued seeing clinicians who accept Medicare. Several other beneficiaries did not stay with their PCP after they moved to a concierge model. One explained: “My primary care became … a concierge doctor. They pay $3,000 a year upfront and then you pay him more every time you go, but he’s there for you and he’ll talk to you all day long and give you a coffee and rub your feet or I don’t know what they do for that kind of money.”

Medicare Advantage Plan Networks

Beneficiaries with Medicare Advantage had mixed experiences with being referred outside of their plan’s network. Some beneficiaries described being sent to clinicians who they later realized were not in network. One dual eligible beneficiary described how she was sent by her surgeon to another clinician that she did not realize was out of network. She said, “There was a lot of arguing going back and forth and it was hard. It was scary because I don’t want all these bills.” Another dual eligible beneficiary had a similar experience:

> *“The doctor, they … supposedly did call the insurance. But then when I got there, they obviously didn’t do something. Because then they says, no, we’re not in network. And they’re expecting me to pay.… I even went back to my doctor and I’m saying, no, you’re going pay this, not me. Because you sent me here.… You’re telling me they’re in network and actually they’re not. And then you’re expecting me to go through the appointment and then pay just for showing up.”*

Other beneficiaries reported that their clinicians always verified coverage when they made referrals. One dual eligible beneficiary said, “[My doctor] always makes sure that wherever I’m going, they’re going to be in the network. I don’t even worry about that.” Another dual eligible beneficiary explained how this process was made easier by staying within one large group practice, “I’m pretty aware that large practice that my primary is in, all the specialists he refers to are covered. And early on he would say, I’ll make sure it’s covered by your insurance.”

[14] Direct primary care is a model that charges patients a monthly membership fee for most or all primary care services. Direct primary care practices do not accept insurance or participate in government programs. Concierge practices charge patients a higher monthly or annual membership fee and may continue to accept insurance plans and government programs. Concierge practices cater to higher income populations. Source: American Academy of Family Physicians. Direct Primary Care. Available at: https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/direct-primary-care.html

A few beneficiaries had seen providers outside their plan's network when they were traveling or because they needed to see a specific provider outside their plan's network. Several beneficiaries said that their plan networks were robust enough that they never had a problem with staying in network. One rural Medicare-only beneficiary reported, "[Plan name] has a large network.… So I haven't had to go out of network. Most doctors in this area participate with [plan name]." A dual eligible beneficiary had used two different health plans and said, "I would say for both of those companies, my experience is their networks are broad and deep."

Access to Specialty Care

In our pre-group survey, we asked beneficiaries how many specialists they were seeing. Medicare-only and dual eligible beneficiaries reported seeing an average of two specialists; however, in the course of discussions, beneficiaries frequently recalled forgetting to count one specialist or another. The maximum number of specialists that a beneficiary was seeing was eight. Every group, except one, had at least one beneficiary who saw no specialists.

When asked about specialties that were especially difficult to access, beneficiaries in at least two locations reported rheumatology, dermatology, endocrinology, pulmonology, neurology or neurosurgery, pain management, and psychiatry or mental health.

Timely Access to Specialty Care

We asked beneficiaries about wait times to see a specialist. **In general, beneficiaries reported longer wait times for specialty care than for primary care.** One traditional Medicare-only beneficiary said, "It's not like the PCP where you can see them later this afternoon or tomorrow morning. You're usually waiting a week or two or three or sometimes." **Reported wait times as a new patient ranged from a couple of weeks to multiple months, with the longest wait times being between six and 12 months.** One traditional Medicare-only beneficiary said, "I think I had to wait six months to get in [to the rheumatologist]. It was somebody that was recommended to me. And I called every day to see if they had a cancellation." Beneficiaries also faced wait times of six to 12 months for dermatology, endocrinology, and mental health.

Several beneficiaries reported access challenges for pain management. One rural Medicare-only beneficiary noted that her pain management practice has a waiting time policy. A couple of dual eligible beneficiaries with Medicare Advantage also faced challenges and waiting periods to access pain management. A dual eligible beneficiary with Medicare Advantage said, "To get my pain meds, the appointments are booked as far as two months out."

Several beneficiaries faced long wait times for specialty care even when dealing with an acute medical issue. A traditional Medicare-only beneficiary reported, "After I had a TIA [transient ischemic attack], it took me—the soonest I could find a neurologist was two and a half months. And it wasn't the first one I wanted to see.… [The wait time for the other neurologist] would have been five months. And I

said, ‘well, wait a minute, this is something I need somebody right away.’ Two months was even crazy.” Some beneficiaries described how wait times for tests or procedures could be even longer because they first had to wait to see the specialist and then wait even longer for the test or procedure. A dual eligible beneficiary with MA said, “They say don’t use an ER as your primary thing, but when you need a specialist sometimes that’s all you can do. It’s the only way you'll get to see one.”

Many beneficiaries reported that wait times as a new patient tended to be much longer than as an established patient. One Medicare-only beneficiary with MA explained, “Once you’re in, you’re fine. But it’s just a delay for that initial workup.” A rural Medicare-only beneficiary said, “The first one’s usually a problem. I think I waited seven months, and when I was there they decided that they put me on an every three month basis.… Each time I go, they book another one onto the end. So, it’s not that much of a problem after the initial visit.” A dual eligible beneficiary with traditional Medicare echoed this: “It depends on the specialty. But once you get [in], you’re not a new appointment patient anymore. You’re actually in the system. They just generate the automatic three months or six months. And you know, you set the appointment prior to leaving. So that kind of gets the ball rolling. Once you get in, it’s a lot easier.” One rural Medicare-only beneficiary explained that specialists usually visit the rural hospital once or twice a week, and he can usually get an appointment within a week or two when needed.

Finding a Specialist

We asked beneficiaries about their experiences in finding a specialist as a new patient. **Similar to the process of finding a new PCP, beneficiaries reported that they asked their current clinicians for recommendations or referrals to a specialist and also asked friends and family. They also did online research, consulting similar sources of information** and looking into metrics such as the number of procedures performed. One Medicare-only beneficiary with MA described how she relied on recommendations from her existing doctors:

> *“I have some of my other doctors that I’ve been with for 15, 20 years, and I look to see, you know, who’s available perhaps geographically conveniently, and also that’s on the plan. And then I check with them, because I will not deal with the doctor that does not come recommended by one of the ones that I trust.… if [my doctor] doesn’t recommend them, they don’t happen.*

Some beneficiaries got referrals from their PCPs to see a specialist, often as a requirement. Some beneficiaries’ providers made appointments for them. A Medicare-only beneficiary with MA said, “I have to go through my primary to get a referral.” He explained, “We just call the primary, and he sends a referral to the doctor that he’s suggesting and then within a week, they call me and make an appointment.” A dual eligible beneficiary with MA said, “I didn’t have to do anything. My doctor told me he was going to refer me to the transplant clinic at the place where I would go to the hospital. And the next thing I knew they were calling me with an appointment. So I didn’t touch anything, call anybody, didn’t need anything.” Another Medicare-only beneficiary with traditional Medicare was not required to have a referral, but still used her PCP to expedite the process: “I cheat a little bit. When I needed to get

into an endocrinologist, I called my PCP, and he called her and said I need her.… In four days, I had an appointment."

Some beneficiaries reported barriers, including specialists not being in network, not taking new patients, or having long wait times. One dual eligible beneficiary with Medicare Advantage said, "It's hard to find the doctors that are in network." Some beneficiaries were aware of specialists who were not taking new Medicare patients but would keep their existing patients as they aged into Medicare. A traditional Medicare-only beneficiary said, "If you're Medicare and you're already a patient, they will continue. Most of those will. But they won't take new patients." This beneficiary shared, "I have rheumatoid arthritis. I was diagnosed with my disease six or seven years ago, and the doctor told me, it'll take you a while to get into a rheumatologist. And I thought, wow, well, number one, he did some looking and found out that half of the rheumatologists didn't take Medicare, and the other half, I finally got into the rheumatologist three months later, but they didn't take Medicare."

Some beneficiaries noted that it was easier to get in to see a specialist within the same large group practice or health system where they are already receiving care. One dual eligible beneficiary with MA stated, "I think that's an advantage of group practices of any sort, that you have much better chance [than waiting to see an outside specialist]." A Medicare-only beneficiary with MA said, "I'm surrounded by [health system] facilities so it's fairly easy to get appointments."

Medicare Advantage Plan Networks

Beneficiaries had care disrupted when their current specialists became out of network. When the subject of an ongoing dispute between an MA plan and a local health system came up, a traditional Medicare-only beneficiary cited this as one reason he had chosen traditional Medicare, saying, "The networks change, too. Sometimes that's a problem. That's why we don't want to do [MA].… your doctor may be on a certain network, and the next year he may not be on that network." One dual eligible beneficiary shared that he had had cataract surgery and had learned upon arriving for the procedure in his second eye that his provider no longer accepted his insurance, leading to a delay in care.

Beneficiaries reported that provider directories were often out of date, making their search for specialists challenging. One dual eligible beneficiary with traditional Medicare described her experience with trying to find a new specialist:

> *"The majority of the time I asked my primary for referral and then just recently a caseworker called me back with a list of potential doctors for me to contact, local in the area and then a few times I called the actual insurance company and then they sent me out this telephone book like this to try and find a network provider. And two years later I'm still looking.… The numbers that I did call were … not in business anymore. So they were never updated or there was like a six-month waiting list."*

A dual eligible beneficiary described his experience with receiving a list of specialists from his MA plan. He explained, "They'll send you, email you a whole list, but you can get online and find it yourself. But

what I found out is, the lists are so antique … 90 percent of the people, the doctors that you find, that [plan name] says are in the network, are not. So, it's a lot of work to find them." Another dual eligible beneficiary shared a similar experience:

> *"I literally contacted my insurance company on the phone.… And I would ask her, can you give me a list of doctors in my area that I was looking for at that time.… And she'd give me the names and the phone numbers of these doctors and she said, you'd have to call them and see if you can if they're accepting new patients or whatever. So, I would call them and she'd give me a list, say 10, maybe six of them weren't even in the network."*

Prior Authorizations

Beneficiaries had experience with MA prior authorizations for procedures, medications, and referrals, and some had dealt with denials. When faced with a denial, beneficiaries described strategies including continuing to call and escalate the issue and using a different medication or a generic alternative when a medication was denied.

Some beneficiaries said that prior authorizations were an issue for them, mainly because of the delays or gaps in care that resulted. One rural Medicare-only beneficiary described the process needed for each step of treatment following a knee injury, from having a magnetic resonance imaging (MRI) to meeting with an orthopedist: "It had to have the prior approval first each step of the way.… every prior approval took forever. And I don't know if it was the doctor sending it in or the insurance dragging their feet. I don't know where the process lagged down, but it was a problem." Another Medicare-only beneficiary described how she ended up getting the test she needed in the ED when her MA plan would not approve it:

> *"Instead of a stress test, I needed a nuclear stress test. And I waited, I made the appointment, and then we had to cancel, because it took six weeks to get it turned down. And in the meantime I ended up in the emergency room and they said we're going to do a nuclear stress test and I said, no you can't the insurance just turned it down they said don't worry about it. So I ended up in the emergency room to get the same test that they had just turned down."*

One dual eligible beneficiary reported the perception that his MA plan was not authorizing services because they did not keep up with medical advances:

> *"If you look at some of these new procedures that these doctors are performing, it's helping a lot of people and it's doing a lot of good things. But if you look at your insurance company because it's so new, they won't accept it. And I don't think that's fair. I just don't. I mean, you're paying for a service depending on and everything changes over time, especially with the medical field. You're so far more advanced today than what you were 10 years ago. And it doesn't seem like the insurance companies are staying up with the changes."*

Rural Access to Care

In the rural focus groups, we asked beneficiaries how they would access care in minor urgent situations, major medical emergencies, and major nonemergency surgeries.

Rural beneficiaries reported being comfortable with accessing care close to home for minor health care needs but would want to travel farther distances in the event of a serious or life-threatening situation. For something like stitches or a minor urgent need, most beneficiaries said they would visit their nearest health care facility or clinic, which were anywhere from five to 30 minutes away. One beneficiary mentioned that their closest medical center is now “basically a referral center” and they would go to the next closest community hospital about an hour away for “anything more than a cut.” For an emergency like a heart attack, beneficiaries said that they would visit the closest ED but would expect to be transferred via ambulance or airlift to the nearest major city. One beneficiary explained that there is an airlift zone for medical flights in their area, so they would likely meet with an airlift team at that site via ambulance. For a nonemergent but serious medical issues like a hip replacement, rural beneficiaries also reported that they would schedule their procedure in the nearest major city.

Rural beneficiaries did not report any issues with accessing their prescription drugs. Rural beneficiaries used their local clinic, pharmacy, grocery store, and mail order pharmacies. One beneficiary noted that they have a “small town pharmacy and they don’t stock as much as a big pharmacy somewhere.… I know there was something that [her family member] needed, and they didn’t have it today, but they got it for her tomorrow. So, it wasn’t anything urgent, but I think that’s just one of those things that happens with small pharmacies.”

Rural beneficiaries reported that the distance to major medical facilities was far, but they expected this when choosing to live in a rural area. When asked how they get to their appointments, almost all beneficiaries mentioned driving themselves, having a family member or friend drive them, or calling transportation services. In general, distances to primary care providers were shorter than specialty care providers, with many noting that their primary care office was in their town or the next town over. Their travel times for primary care ranged from a few minutes to an hour away. Most rural beneficiaries did not see an issue with the timing of their medical appointments and would visit an urgent care center or call their doctor’s office for something urgent outside business hours.

When asked about more specialized care, rural beneficiaries reported traveling greater distances, often more than 100 miles. They mentioned combining these visits with other errands they had to run in the large towns, like shopping, visiting family and friends, and other medical appointments. One beneficiary mentioned that they travel more than 250 miles to a major city for their care, and although it is time-consuming, they appreciate the level of care received through this health care system and would prefer to keep their doctors due to the complexity of their condition. However, many agreed that that is the way of life in rural areas, with one beneficiary explaining, “For urgent needs [the distance is] a problem.

But for routine or scheduled things, no, it's not a problem.… The decision to live remotely came with that risk and it's something I'm willing to take."

Many rural beneficiaries reported that providers in their area recently retired or left the area. One beneficiary had followed their provider to a new practice since the distance was reasonable but was unable to follow them again when they opened a new practice on the other side of the state. When their providers left, beneficiaries either switched to someone else in the practice or had to find a new provider in a new system. Many beneficiaries were aware that some clinicians served rural clinics as part of a rotation[15] for the larger hospital networks in their state, and one beneficiary mentioned that providers were often in the community for a few years to help pay off their loans,[16] but then left once their obligation was fulfilled. Some beneficiaries reported struggled to find a new doctor that provided high-quality care when a local doctor retired. Several mentioned that older or sicker members of their community have moved to areas with better access to medical care, but no beneficiaries we spoke with had moved themselves to be closer to medical care.

Beneficiaries who only sought care for regular checkups and did not have chronic or serious health issues reported little personal impact but were aware of the issue. One beneficiary who had not experienced the strain personally noted that "it certainly has affected my community and that's always a concern for me.… [I]t has affected a lot of [the] members of my community, who are now not getting healthcare because of this." Another beneficiary added that they have also not felt the strain personally but know that other community members are waiting three to six months to see a specialist, which really shows "the loss of the amount of physicians available."

Telehealth

In response to the public health emergency (PHE) declared in late January 2020 caused by the COVID-19 pandemic, Medicare temporarily expanded coverage of telehealth services to urban areas and to beneficiaries in their homes. Congress has continued this temporary expansion of telehealth, beyond the PHE, until December 2024.[17]

Throughout this report, we refer to telehealth visits as real-time audiovisual visits with a clinician and differentiate when we are referring to audio-only or phone visits.

[15] Most medical schools allow students to spend weeks or months in a rural location of their choice. There are also rural residency programs available. Source: The RTT Collaborative. Rural Rotations for Medical Students. Available at: https://rttcollaborative.net/students/rural-rotations/.
[16] The National Health Services Corps is a loan repayment program in exchange for two years of service at a health professional shortage area (HPSA). A large share of HPSAs include CMS-certified rural health clinics, community outpatient facilities, critical access hospitals, and federally qualified health centers. Source: Health Resources & Services Administration. NHSC Loan Repayment Program. July 2024. Available at: https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program.
[17] Source: Telehealth.HHS.gov. Telehealth Policy Updates. November 2023. Available at: https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates.

We asked clinician and beneficiary focus group participants a series of questions about their telehealth experiences within the past six months and about the role they want telehealth to play in the future.

Telehealth Delivery and Experiences Among Clinicians

In all clinician focus groups, we asked participants whether they were currently offering audiovisual telehealth visits to their Medicare patients and whether they were offering telephone-only visits to their Medicare patients. Exhibits 8 and 9 present responses across all focus groups. **Over three-quarters of clinicians were offering audiovisual telehealth visits, compared to about a third who were offering audio-only visits.**

Exhibit 8. Clinician focus group respondents offering audiovisual telehealth visits

	Primary Care Physicians	Specialists	NPs and PAs	Total
Yes	21 (91%)	21 (75%)	14 (67%)	**56 (78%)**
No	2 (9%)	6 (21%)	6 (29%)	**14 (19%)**
Total (all locations)	**23**	**27***	**20***	**72**

*One participant each in a specialist group and in an NP/PA group did not respond to this question.

Exhibit 9. Clinician focus group respondents offering audio-only visits

	Primary Care Physicians	Specialists	NPs and PAs	Total
Yes	6 (26%)	11 (39%)	5 (24%)	**22 (31%)**
No	17 (74%)	17 (61%)	16 (76%)	**50 (69%)**
Total (all locations)	**23**	**28**	**21**	**72**

Clinicians offering telehealth reported that the decision to hold a visit via telehealth vs. in person is determined by patient choice. Most clinicians explained that they require new patients to be seen in person for the first visit, whereas established patients may be given the option of telehealth. Clinicians reported that most of their patients above age 65 prefer in-person visits, whereas patients below age 65 are more likely to prefer telehealth. One explained: “It’s usually like older. Usually, the individuals that are maybe like in their teens or early 20s, they’ll maybe push for a telehealth versus someone who’s maybe 45, 50, 55, they’re more traditional they want to come in and see a physician.”

Most clinicians reported more actively offering the option of telehealth for established patients who need an appointment for something that does not require a physical examination. Examples of these types of visits include those for mental health care, follow-up on a previous visit, communicating lab results, addressing certain acute illnesses like an infection (e.g., pink eye or influenza), and providing referrals or prescription refills. They also reported that telehealth visits are a good fit for patients who are a long distance away, including students who are out of town for college. One noted, "I think there are definitely roles for [telehealth] ... just because college kids and like a teen who live far away." Clinicians agreed that telehealth is best suited for visits that do not require a physical examination. One explained:

> *"If it's like something like it's common cold and flu. If they even want to do a prescription refill, something like that, a nurse practitioner can even do that over the telehealth. And they can ask questions to see if their disease is progressing, or what they need refill for, et cetera. So something more minor versus something you can diagnose possibly over the computer versus somewhere you have to do maybe some tests or you just talk to those would take a little bit longer than maybe 15, 20 minutes."*

A few clinicians noted that they continued to evaluate how to handle telehealth visits in their daily workflow. Clinicians described the challenges of switching between in-person visits and telehealth during the workday, including frustrations with getting behind schedule for in-person visits when telehealth visits are delayed due to technical issues. Some practitioners noted that designated blocks of time or days for telehealth may work best. One explained:

> *"Some of the providers, some of the physicians in my practice actually have afternoon whole sessions that are dedicated to tele-visits. So we've actually established that as an option for patients. And one of the physicians I work with, his Tuesday afternoons are dedicated to tele-visit[s], so we've made a point to [provide] telehealth."*

For the most part, clinicians who provided telehealth visits reported that they spent less time with patients than during in-person visits; however, a few reported that telehealth visits are longer when patients experience issues with connectivity or using the telehealth software. When asked, most clinicians reported that telehealth visits were quicker than in-person visits in terms of length. They also acknowledged a benefit of their patients spending less time and effort overall when experiencing a telehealth visit rather than coming into the clinic. One noted, "Because that whole process of them getting to our office, checking in, getting back, that could be an hour and a half or 45 minutes. So it's helpful for certain scenarios."

Clinicians noted the importance of designing user-friendly telehealth platforms for both clinicians and patients. Ease of use for patients and seamless integration of telehealth into a clinician's EHR would help to address some of the lingering issues with telehealth-related inefficiencies. One clinician explained:

> *"Like at [health system], we have a portal where they just log in and they just pop up in my list of patients and I see them in there. And they just get in the room, I'm in the room, and it's super*

simple. In my private practice, I use Doximity [telehealth platform] and I rarely had any problems with patients getting access, even my 70-year-old patients. So I think in the future, moving in a direction where people have access for this service is very helpful."

Multiple clinicians reported that telehealth increases accessibility to patients who experience transportation barriers, limited mobility, immunocompromise, or consistent conflicts. This includes but is not limited to patients who would have to travel long distances, experience difficulties with walking or other mobility barriers, or patients who are immunocompromised and are at risk for developing severe illness from exposure, including COVID-19. Telehealth is also convenient for patients who have demanding work schedules or take care of family.

Challenges Related to Using Telehealth

Clinicians noted that telehealth may not be feasible for patients with complicated health problems or comorbidities. Clinicians believed that these patients typically required some aspect of physical examination or lab work. One explained:

"They are trying to get us to do more telehealth, but it is really not that feasible because some people you really have to touch… and feel because they have such complicated comorbidities. You know, they'll try to tell you something about their diabetes, their hypertension, their HIV, … all at the same time on a telehealth visit. Like, oh, by the way. So I just don't see it progressing because people are actually getting sicker because they're living longer."

Telehealth Usage and Experiences among Beneficiaries

In the beneficiary focus groups, we asked participants whether they had had an audiovisual telehealth visit with a health care provider within the past six months. Exhibit 10 presents responses across all focus groups. **Almost of third of beneficiaries reported participating in an audiovisual telehealth visit in the past six months.**

Exhibit 10. Participation in audiovisual telehealth visits among beneficiaries in the past six months

	Traditional Medicare	Medicare Advantage	Dually eligible*[18]	Rural (Mixed)	Total
Yes	3 (13%)	10 (34%)	18 (45%)	3 (16%)	34 (30%)
No	21 (88%)	19 (66%)	22 (55%)	16 (85%)	78 (70%)

* We recorded one extra response to the survey that participants filled out prior to the start of each focus group. Therefore, although there were 39 dual eligible participants, the total in this column sums to 40.

[18] The dual eligible groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase turnout. We have combined them in this exhibit.

Beneficiaries who reported a recent telehealth visit said that they were given the option to choose in-person or telehealth care. The most common reason for choosing telehealth was because they were able to get a virtual appointment faster than one in person. One beneficiary noted, “In my case it was about I called to see to go into the office, but she couldn’t see me that day. And she said, how about if we do a telemedicine call? And actually I was happier because I didn’t have to go there. I didn’t feel that well. All I had to do was go get my scripts. So it worked out. It worked out fine.”

Beneficiaries who reported a recent telehealth visit described how these visits were for follow-ups and medication refills, acute problems, or referrals to specialists, and were a clinician they had seen before. Beneficiaries described that they drove the decision about whether the appointment would take place via telehealth rather than in person and did so because they believed the purpose of the visit did not require a physical exam. One explained:

> *“I'm going to say that I think telehealth should be something that’s used especially if you’re only getting results. I see a lot of times you’re going back to the doctor’s office for results. You’re sitting in a waiting room and going through all of that. But then they say, OK, the X-ray shows it’s extreme arthritis on that right shoulder. OK. And I came here, I drove.… So, I think [telemedicine] has real value especially when it comes to really just getting results.”*

Several beneficiaries stated their preference for conducting mental health appointments via telehealth. Given the nature of some mental health conditions, several beneficiaries also noted the benefits of feeling safer and more comfortable conducting these appointments at home. One said:

> “*I used to go in person, not with her, but with another facility.… And then they’d get loud and it would set off my [post-traumatic stress disorder]. And I literally start shaking and I’d have to go outside and talk to myself and get calmed down.… So, telehealth is so much easier for me, more comfortable. And I feel safer to talk to them in the comfort of my home. I feel safer explaining things and from the comfort of my home.”*

Beneficiaries were grateful to have telehealth as an option when they experienced an urgent medical need, like an acute illness or accident. They noted how telehealth is perfect for when they feel too sick to go in person or when a health issue pops up and they need care quickly. One beneficiary said:

> *“I had a really positive experience. I only used it one time, but I had a flight to Disney World, and I was throwing up that morning and definitely ill. And I didn’t want to not go on that trip. I did do the [telehealth company], and it was extremely helpful. I was able to get a prescription for nausea, which is what I needed, and was able to get on that plane. Without that, I just don’t think I would have made it.”*

Several beneficiaries appreciated the convenience of telehealth, citing how it saved time and hassle and was a good option in inclement weather. We heard how the process of getting care via

telehealth was quicker compared to an in-person visit. Beneficiaries liked the experience of not needing to spend time traveling and looking for parking, spend money on gas and parking, or spend time waiting in the office. One beneficiary described, "They were quick.... It wasn't, you know, it wasn't a long, drawn-out thing. But it was, you know, I enjoy going in to seeing, seeing him at the same time, but I enjoy just getting it done over the phone as quick as possible as opposed to having travel." Other beneficiaries noted how they appreciated the option of changing an appointment from in-person to telehealth in the event of a potentially dangerous weather situation such as a heat advisory or snow.

Although beneficiaries reported circumstances for which telehealth is a welcome or more efficient option, they also cited cases when in-person care is preferred over telehealth. Beneficiaries described how relationships with clinicians are established in person. They also noted the importance of physical examinations. One explained, "I guess I'm more tactile and just, I enjoy going to whoever the provider or the pharmacist system [is]."

Audio-Only Visits

Although most clinicians reported offering and conducting audiovisual visits, fewer than half reported offering and conducting audio-only visits. Clinicians mentioned that they aim for audiovisual visits but will do audio-only if needed, i.e., for technology issues. One noted, "We'll only do audio if they're having issues with the link and we try like four or five times and I need to move on to the next patient." Clinicians also mentioned phone calls are common for non-billing visits, e.g., calls to discuss their patient's lab work or medication. But they don't consider those calls "telehealth." As mentioned above, clinicians' perspectives on telehealth, including audio-only visits are in part dependent on whether they believe they can bill for these visits. This sentiment extends to audio-only visits, with multiple clinicians noting that they cannot bill for audio-only visits.

Most beneficiaries who reported recent telehealth use had participated in audiovisual visits, while a few reported audio-only. Some beneficiaries who had used audio-only mentioned sending pictures of their symptoms to augment the visit. They said that audio-only is a good alternative if they do not have the proper hardware for video or if they encounter technical problems.

Future of Telehealth

Clinicians reported believing that they have reached a steady state regarding the proportion of telehealth they are providing compared to in-person care. They believed the future looks much like the present, appreciated having it as an option to offer to their patients, and hoped that they could continue to get paid for providing care via telehealth. When one clinician was asked about the future of telehealth, they summed up some of the positive aspects:

> *"I think it's convenient for patient[s], those with transportation issues. If it's quick follow-up, at least in my field from an injection, they don't want to take time off of work. I can spend 10 minutes on a phone and video and how's your knee feeling? This and that. So it's a win-win situation. It's a quick visit, it doesn't inconvenience the patient, NPs can do it, PAs can do it, and*

> *so it's those routine things so we can concentrate on the more demanding patients, complex cases, things of that nature."*

One clinician made the business case for continuing to offer telehealth. They expressed the belief that for their practice to stay competitive, they must meet patient demand for telehealth, implying that patients would leave a practice that did not offer it. One explained:

> *"And now most practices, no matter what your specialty is, it seems like you have to offer telehealth to some extent to stay competitive because patients expect it now. So, if they don't have it, they're just having to go see these other people because they do telehealth and they can see me tomorrow."*

Clinicians' perspectives on telehealth are dependent in part on whether they believe they can bill for these visits. Although many of our focus group questions were framed to ask specifically about working with Medicare beneficiaries, clinicians often answered more broadly (or did not know the nuances) between experiences related to Medicare beneficiaries and those covered by other payors. Although Medicare continues to allow billing for telehealth visits, including some audio-only visits, a number of participants in our focus groups believed that they could not be paid for these visits. One noted, "We can only bill for video visits. During COVID we could bill for telephone and video, and then after COVID they revamped that, and now we can only bill for the tele[health] visits… And then the phone calls, we do tons of those. We just document that we've done them, but we can't bill for those."

The majority of beneficiaries recognized the value of telehealth for specific circumstances and wanted it available as an option in the future. One noted, "But in the beginning instead of waiting three days or a week or a month to get advice from a medical professional, you can do it within 10 minutes by phone or by Zoom. I think that's the future for the initial, general, wide part of the funnel healthcare." On the other hand, a minority of beneficiaries reported not being interested in telehealth in the future under any circumstances and preferred in-person visits with their clinicians.

Electronic Patient Monitoring

A few PCPs reported that some of their patients were monitoring their conditions at home, including blood pressure and weight. They also reported that patient monitoring could allow for more efficient visits. One PCP noted, "I think we should all continue to strive to do more telehealth because it's faster, patients take their vitals, they send their vital signs. I can do a telehealth visit in 10 to 15 minutes, and normally that visit would take 30 minutes in the office." Another PCP noted, "Or like blood pressure. If it was a little off in the office, I'll have them monitor it or blood sugars, I can adjust things like via that and then I'd still have them come in office. But I don't need to have them come in every week to see where their sugars are at." For the most part, even clinicians who reported patients participating in electronic monitoring did not describe much personal engagement in the data or the process.

A few beneficiaries mentioned using electronic patient monitoring for conditions like blood pressure. One noted, "I've got a little portable EKG, blood pressure cuff that does it all…. It sends it to my phone." However, like clinicians, they did not report much engagement between themselves and their providers with regard to the data.

Portal Messaging

Clinicians reported using portal messaging for prescription refills or monitoring health conditions. Clinicians reported that it is useful to provide a response to a specific question or concern, and it can be more efficient than communication via phone. One noted, "And it's sometimes if you go back and forth on the telephone, it's like the bad game of telephone where things just don't get relayed properly. If I know I have a patient that really likes the portal and utilizes it well, it's nice to just really send a clear response." Clinicians also acknowledged that messaging can help avoid some in-person care, with one noting, "Sometimes like a medication, pharmacy doesn't get it on our end. We show in our system, it's sent and so instead of playing this back-and-forth game, they can just message me." However, they acknowledged frustrations in circumstances when they believed patients tried to use the portal to avoid coming in for a visit when they probably needed to. One clinician noted:

> *"Sometimes ... people try to use a portal to ... negate a visit ... I've really had to say, this needs to be an office visit because I don't have the time, like I'm booked. And we don't have administrative time hardly. So a lot of times I'll have to say we really need to discuss this, but it is helpful for this.... If I know I have a patient that really likes the portal and utilizes it well, it's nice to just really send a clear response but then of course there's a lot of patients, a lot of our 80-year-old patients don't want to use the portal. So that's still a phone call."*

Many beneficiaries reported using and, for the most part, appreciating portal messaging. They reported liking the access to their clinicians and efficiency in communication. One noted:

> *"I think it's really convenient, because there are times that I might call and leave a message for my doctor, and she always calls me back. But, which I really appreciate, but she's really busy, and if it's not something that's pressing, I can just sit down at my computer and type her out a message real quick. And I know within a couple of days, usually it's sooner, usually it's within one day. She's going to write me back, and I've got what I need. Rather than having to call and send a message with one of the girls at the front, and then having to take the time to call me back."*

On the other hand, a few beneficiaries noted inefficiencies and frustrations. One described not getting a response back after sending messages:

> *"You send a message, ask for a prescription, under their prescription page, it just dies right there. So the industry as a whole could use a training in IT or something to get their act together to respond to their patients. I mean, I found that to be irritating. But the patient portal, in my experience, has been a waste of time."*

Organization of Care

We asked clinicians about aspects of the organization and processes of their practices, including referrals, roles of NPs and PAs, practice acquisition, quality reporting, and accountable care organizations (ACOs). NPs and PAs were also asked about their experiences in working with other clinicians.

Referrals

Clinicians who were affiliated with health systems reported that they most frequently refer within their own system, but most noted that there was no explicit requirement to do so. Clinicians mentioned that the driving factors for in-system referrals were ACOs, reimbursement models, and convenience. One PCP noted that there are sometimes clinicians in their personal network they would rather have their patient see but will often refer in-system first to avoid perceived additional burden to the patient. Overall, clinicians prioritized the best care for their patients, with one specialist explaining, "All systems prefer that you stay within the network, right? You stay within the system. But if my patient I think is going to get better care outside the system, that's where I'm going to send them." A primary care physician noted, "So, when you belong to a group, which I did, they made you—that's what your stipulation is. You got to refer in the group. And sometimes you didn't like the physicians, but you were forced to in a way."

PCPs, NPs and PAs, and specialists all described facing significant challenges when referring their patients to specialty care. Most clinicians depended on specialists in their personal network or health system to refer their patients for specialty care, but despite this, reported that their patients were not getting appointments in "reasonable" timeframes. These clinicians noted that relying on personal connections can occasionally help get patients appointments more quickly. Several clinicians also reported that they were struggling with specialty practices not accepting patients covered by Medicare. One specialist said that "fewer and fewer [are] accepting Medicare," while one PCP said. "I had a lot of patients who I could not get into specialists because of Medicare.… They're not in that network."

A few clinicians also noted that there is a shortage of some specialists, making it difficult to refer their patients. Specialties that were mentioned as the most difficult for referrals included psychiatry, neurology, endocrinology, and rheumatology. One specialist explained, "And here it just seems like we have a shortage. So, everyone seems to have enough work. Everyone is looking to hire someone; everyone is trying to expand because our population is expanding." When discussing referring to specialists, one NP remarked that "the wait times, the lack of providers that are taking new patients, that have office hours that are flexible and offer a variety of office hours, evening, weekends, that sort of thing … it's very, very difficult."

Clinicians use other referral processes outside of their personal networks. Several NPs and PAs, as well as PCPs, usually first refer patients to the provider suggested by their EHR. Clinicians explained

that they would prefer to pick a certain specialist for the referral, but sometimes refer to the clinician suggested by their EHR to ensure there are no issues with coverage. One specialist noted:

> *"You just got to go the path of least resistance and just say start with your insurance company, find out who's on your plan, and then go from there. Because the more you try to help sometimes, the more you dig yourself in your own quicksand. You just got to sometimes really find the path of least resistance. And the referral process I think has really kind of come to that."*

Primary care providers noted that they will often take on more acute mental health conditions due to the difficulty of referring to psychiatry. A PCP said:

> *"And I think with family practice, I'm sure internal medicine, I'm prescribing a lot more [psychiatric] meds than I ever thought … we continue to learn, but psych, I'm using all kinds of atypical[s] now, things that I would have sent to a specialist years ago. I'm treating bipolar, which I didn't treat 20 years ago because [there] were psychiatrists."*

Another PCP added, "With the pandemic, we lost three out of four psychiatrists. So, we have to, as primary care, take over and do something for the psychiatrists." Other participants in that group noted that many psychiatrists are moving to self-pay, leading to PCPs' caring for acute mental health conditions.

Primary Care Providers' and Specialists' Experiences Working with NPs and PAs

Physicians in our focus groups worked with NPs and PAs in their practices and relied on them for certain types of care but acknowledged limitations in their knowledge and scope of practice.[19] Overall, many physicians utilized both NPs and PAs in their practices, with the primary care providers who participated in our focus groups less likely to work with PAs (Exhibit 11).

Exhibit 11. Use of NPs and PAs by physicians

Clinician Group	Work with NPs	Work with PAs
Primary care physicians	16 (70%)	9 (39%)
Specialists	19 (83%)	17 (74%)

Generally, physicians noted that the NPs and PAs they worked with did not have specific limitations on which patients they see, but some physicians restricted their NPs and PAs to seeing patients with acute illnesses, as well as urgent needs, vaccines, and follow-ups. One PCP said, "I see more of the annual

[19] In Arizona, NPs have full practice; in Pennsylvania NPs have reduced practice; and in Texas, NPs have restricted practice. In all three states, PAs cannot practice independently and must work under supervision of a physician. Sources: American Association of Nurse Practitioners. State Practice Environment. September 2024. Available at: https://www.aanp.org/advocacy/state/state-practice-environment.; American Medical Association. Physician Assistant Scope of Practice. 2018. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/state-law-physician-assistant-scope-practice.pdf.

exams, the new Medicare wellness physicals, and all that stuff, whereas my nurse practitioners and PAs tend to do more of the acute colds, flus, strains, pains, and things like that." Other PCPs in the group agreed with that statement. Sometimes, providers deferred the choice to the patient, as patients comfortable with seeing an NP or PA can often get an appointment sooner. A primary care provider noted that patients will sometimes see an NP for something acute, but for their general primary care, they prefer to see a physician. Most physicians preferred to give NPs and PAs as much independence as possible unless training is needed and communicated with NPs and PAs as needed for chart reviews or approvals.

Physicians explained that they provide various degrees of training for their NPs and PAs upon hire. Some clinicians reported that their health system and/or practice provides around one year of structured training, while others noted that there is continuous learning offered by their system based on the NPs' or PAs' interests or the cohorts that NPs and PAs are put into internally. One PCP explained that the first year's training includes oversight by a specific clinician mentor—usually their supervising physician—as well as signing off on all patient notes. Another PCP noted that the NP's or PA's supervising physician will review the EHR, patient cases, discuss work-life balance, and ensure they are acquainted with the practice.

Some physicians reported instituting a more extensive training process for NPs and PAs who joined right after graduation, as they mentioned that their knowledge was still quite limited. A specialist explained, "There's no end point for our training, there's no end point for their training. They have a lot longer to learn the same skill sets than we have." Some physicians regarded NPs as more experienced than PAs due to their backgrounds in the clinical setting as practicing nurses. Specialists noted that PAs were more likely to be interested in procedural work at their practices and often played a role in the physician's surgical specialties. Some providers noted that the NPs and PAs were seen as extenders and do more of the "rote" work. One specialist said, "I'm on a procedure-based field. So when I'm doing procedures, my NP see patients and helps feed the procedure stream. So it makes me more efficient if I'm not in the office, somebody's there to handle it, kind of situation. So I think it's helpful in that way as well."

Overall, physicians did not report much of a difference in capabilities between NPs and PAs. Most providers mentioned that there is "no difference" in their expectations for NPs versus PAs and they need to provide similar levels of training to all mid-level staff who join the practice, however several voiced preferences for working with one type of clinician over another. One primary care provider preferred working with PAs and said that "I thought that the nurse practitioner would be better than a PA because they have more experience but actually, in real life, I have found that the PAs have a better knowledge-base and they tend to be a little bit better practitioners than other practitioners." Another primary care physician in a different location noted that they prefer NPs slightly, adding, "I think they're pretty interchangeable, I would say preference, maybe lean NP just because a lot of them have worked in the nursing field for a number of years before they went back to school."

We asked clinicians about workforce challenges related to NPs and PAs. Physicians had not experienced significant turnover by NPs and PAs in their offices. When asked about whether they had hired an NP or PA recently, one specialist said, "I just wanted to make a point that [with] the current shortage of physicians, I think we need to embrace the mid-levels. And I don't think that our medical system will work without them." Providers noted that NPs and PAs often have more negotiating power due to their field being in higher demand amid the physician shortage.

Providers who did not work with NPs and PAs reported that they did not see "a lot of value add with them," that they were slower on certain procedures, or did not trust them to do certain procedures like administer infusions or biologics.

NPs' and PAs' Experiences in Working with Other Clinicians

We observed a disconnect in the way that NPs and PAs described their collaborations with physicians and the ways that physicians described these relationships. Physicians, especially specialists, expressed reluctance to allow NPs and PAs to deliver care without oversight or restrictions on the types of services they could deliver or the patients they could see. In contrast, NPs and PAs described operating with autonomy and few or no restrictions on their practice.

Most NPs and PAs had positive experiences and felt like valued members of their practice. Most were very positive about their experiences and felt integrated into the practice. Some NPs and PAs described the general culture of their practice, at all levels, to be more collaborative than at other practices, so they felt useful as a whole. Many felt that they had an appropriate amount of independence, with one NP wishing that their supervising physician provided more collaboration, saying, "Sometimes you want to check in with them more. Hey, this seems a little bit like maybe we should work a little bit more together on this." Another NP said, "The main physician I work with just returns tomorrow and has been gone for two weeks. No one covered his practice except for me. That's a lot on [me, and] I have access to all the other providers in the practice because I can ask, people will help me, whatever. But that says something, right? It's a lot."

Despite reporting that they operated with autonomy in their daily practice, NPs' and PAs' activities were affected by their legal scopes of practice, with one nurse practitioner noting that it was a "red tape game" to determine their signing and billing abilities, whether it be by the state, the practice, or payer. Many NPs and PAs did not describe having a specific range of patients they were able to see. One nurse practitioner noted:

> *"I've always had an independent license and it's been a while since I had any sort of attitude from a physician or another person about like my role and like what I should and should not be able to do. But I still hear that every once in a while. Whereas like, I shouldn't be managing complicated cases or you should be referring that to a doctor to handle. I think that at least from what I experience, it is very independent. Like I make my decisions about what I want to do clinically and then if there is something that I don't want or can't handle, then I refer that to somebody else."*

Some NPs and PAs noted that they usually see more stable patient cases but did not mind seeing urgent or acute issues in their practices.

Practice Acquisition

Many physicians reported that their practice had been approached regarding acquisition. Most physicians who participated in focus groups and were practicing in physician-owned practices or independent groups had been approached and declined the acquisition offer. Some of these physicians held positions in their practice that necessitated their participation in the decision-making about acquisition offers, and others reported broader awareness about these offers. Acquisition requests were predominantly by private equity firms to become part of a larger private network or to become concierge practices.

Clinicians in our focus groups had limited remarks on hospital or health system acquisition. One primary care physician noted that their practice was a subsidiary of the major hospital system that eventually took over their group, saying, "I think from a beneficiary perspective, there were so many more resources that we had access to being in a larger group model than what you wouldn't have access to individually." Primary care physicians in another location reported being approached by hospital systems in their area, and they all noted that referrals would become easier based on discussions with these systems, but they have not agreed to join a larger hospital or health system.

Physicians who worked in practices that were acquired recently did not have a role in the decision or did not report strong feelings about the acquisition. One PCP explained that they accepted the deal when their independent practice was facing financial difficulties and said that it was "not as painful as I thought it could be."

Physicians in physician-owned practices expressed negative feelings about being acquired and believed that private equity firms were decreasing access to and quality of care, under the belief that they are driven by profits and not patient care. Physicians also commented on the management structure of larger organizations, noting a tradeoff with reduced decision-making power when employed at a larger organization. A PCP who had not joined a hospital system said, "The first couple years is sort of like the honeymoon," and added that after this period, there are additional patient visit quotas and strict rules for receiving bonuses. A specialist explained, "The private equity group realize[s] what the asset is in healthcare, that it is actually a business and … [they] can make some money off of it. But we as physicians that are in the trenches keep on getting cut back down and down and down and down and down." One specialist noted:

> *"It's just I don't want to have to report to anybody. I don't want anybody directing me. I'm fortunate I can maybe do that and just have that luxury, but I just don't want to get into something where there's somebody else that's going to be basically assuming your power and you're just going to be a cog in the wheel. I'm just not interested."*

Accountable Care Organizations

Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health care providers who provide coordinated care to their Medicare patients. There are several Medicare ACO programs, including the Medicare Shared Savings Program.[20] In each clinician group, we asked if clinicians were familiar with an ACO, if they were participating in an ACO, if they were involved in the decision to join, how the ACO affected their practice processes, financial rewards, and leaving an ACO.

Direct experiences with ACOs were limited. Almost all clinicians were familiar with ACOs, but fewer than half of clinicians were participating in an ACO (Exhibit 12). Regarding the decision to participate, one specialist said, “We were a private practice, but we had a very good relationship with the [ACO] doctors. Or some of the doctors would refer to us and they would when we decided to join the [ACO], it was sort of like everyone was going to do this.” Participating clinicians noted that ACOs have changed the way they work through additional monitoring and rules, but they saw few benefits for their patients and minimal financial rewards. A few specialists noted that they do not have information on what ACO a patient is in.

One clinician noted that their organization had just joined an ACO, and they hoped for positive outcomes and additional revenue. Other clinicians who had been in ACOs longer were less positive and noted that they were often not seeing any additional money despite working hard to improve specific quality metrics. One clinician said, “I get paid less and less by working more and more and [ACOs are] just less efficient.”

Exhibit 12. Clinician participation in ACOs

Clinician Group	Approached to participate in an ACO	Participating in an ACO
Primary care physicians	13 (57%)	9 (39%)
Specialists	7 (25%)	8 (28%)
NPs and PAs	6 (26%)	7 (33%)

Note: 5 primary care providers, 11 specialists, and 4 NPs and PAs were unsure if they were approached to participate in an ACO or if they were participating in an ACO.

[20] For more information, see: Centers for Medicare & Medicaid Services. Shared Savings Program. Available at: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos

Quality Reporting

Overall, clinicians felt that quality measures[21] did little to improve patient care and led to unnecessary work. Clinicians noted that quality measures and the reimbursement they receive often do not reflect their patients' complexity. A specialist said, "We find that a lot of these metrics don't really adequately adjust for the complexity of the medical situation [another participant] alluded to. So we have those metrics for us are tied into a reimbursement, so we follow them. But it's very complex data to analyze and very hard to adjust to get for some of the complexities that some of these patients come with."

Both specialists and primary care providers felt that they were doing as much as they could but struggled to control the health-related behaviors of their patients, and related quality measures would not show change if the patient did not comply. One PCP said, "You can take the horse to the water … but you can't make them drink the water." They also felt affected by factors outside of their control, such as medication adherence due to affordability. One primary care provider said, "Maybe they don't take the meds or they can't afford the meds or whatnot. And you see them again. It's like, well I couldn't do this because of X, Y, Z."

Specialists felt more strongly than PCPs that their ACO quality metrics were hurt by external factors, such as a patient being hospitalized for COVID-19. One specialist also noted that some measurement "forces us to do things that we wouldn't have done because someone comes with a test that was inappropriately ordered and I wouldn't have ordered it, but I have to deal with the result." Another specialist explained:

> *"Say, well, this was the patient that has the most cost associated with them. And for instance, that could be a patient that was hospitalized for a non-nephrological issue. It could be, let's say COVID or something. And you don't know how to really control those aspects. And so I feel like sometimes it's not relevant to exactly what you treat, but specifically it gets attributed to your name because you're a person that is caring for that particular patient from your specialty side. So I think that's where it's very complicated because you have no way of controlling that."*

A few clinicians had positive experiences with quality measurement, noting that it was helpful to receive reports on their progress on Merit-Based Incentive System (MIPS),[22] Consumer Assessment of Healthcare Providers and Systems (CAHPS),[23] and Healthcare Effectiveness Data and Information Sheet (HEDIS)[24] measures and that they are seeing improvement in some measures. These clinicians

[21] Quality measures are tools that help "measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care." CMS uses quality measures for quality improvement, public reporting, and pay-for-reporting programs for health care providers. Source: Centers for Medicare & Medicaid Services. Quality Measures. May 2024. Available at: https://www.cms.gov/medicare/quality/measures

[22] For more information, see: Centers for Medicare & Medicaid Services. Quality Payment Program: Traditional MIPS Overview. Available at: https://qpp.cms.gov/mips/traditional-mips.

[23] For more information, see: Agency for Healthcare Research and Quality. About the CAHPS Program and Surveys. July 2024. Available at: https://www.ahrq.gov/cahps/about-cahps/index.html.

[24] For more information, see: National Committee for Quality Assurance (NCQA). HEDIS and Performance Measurement. Available at: https://www.ncqa.org/hedis/.

had EHR systems that they believed more seamlessly tracked their quality data without much additional work.

Prescription Drugs

We asked beneficiaries to rate their prescription drug coverage and spoke to them about the rationale behind their ratings, use of a real-time benefit tool, drug costs, pharmacy use, and ability to fill prescriptions. We also talked to clinicians about their experience in prescribing, including prescribing biologics, use of electronic prior authorization, and experience with pharmaceutical representatives.

Beneficiaries

Most beneficiaries rated their prescription drug coverage as good or excellent (Exhibit 13). Eighty-four percent of Medicare-only beneficiaries and 95 percent of dual eligible beneficiaries rated their coverage as excellent or good. Five beneficiaries rated their coverage as poor.

Exhibit 13. Beneficiary satisfaction with prescription drug coverage

	Traditional Medicare	Medicare Advantage	Dual Eligible*[25]	Rural (Medicare-Only)†	Total
Excellent	9 (38%)	13 (45%)	25 (63%)	11 (58%)	58 (52%)
Good	11 (46%)	13 (45%)	13 (33%)	4 (16%)	41 (37%)
Fair	2 (8%)	1 (3%)	2 (5%)	2 (11%)	7 (6%)
Poor	2 (8%)	2 (7%)	0 (0%)	1 (5%)	5 (5%)

* We recorded one extra response to the survey that participants filled out prior to the start of each focus group. Therefore, although there were 39 dual eligible participants, the total in this column sums to 40.
† Percentages do not sum to 100% because one rural beneficiary did not respond to this question.

Beneficiaries who rated their plan below excellent cited several reasons, with the cost of prescriptions being the most common. Beneficiaries reported that they were paying too much for prescription drugs. One traditional Medicare beneficiary said, “I don’t have a problem with the drug

[25] The dual eligible groups included a mix of coverage types due to mistaken beneficiary self-report during screening or as a method to increase turnout. We have combined them in this exhibit.

plan. It's not that they've refused any drugs. It's that we're paying more for each drug than I thought we should or my wife thought we should have." A beneficiary enrolled in MA said, "I'm not happy with the drug [coverage] at all.… I have several drugs that I have to pay a lot of money for each month. They're every three months. I have to go price-check every company out there."

A few beneficiaries rated their plan below excellent because they perceived their prescription drug out-of-pocket costs and premiums as very high. One traditional Medicare beneficiary explained, "I'm not happy with my prescription plan. When I got into Medicare, again, I thought everything was free. Then I found out they're talking about discounts and whatever when you go to get them. And they were just minimal. And the prescription costs were just killing me."

Real-Time Comparison Tool and Plan Finder

Most beneficiaries have not used a real-time comparison tool,[26] but those who had found it to be useful. Beneficiaries were generally unaware of these tools but, upon learning about them, thought they sounded like a helpful resource. One beneficiary said, "When faced with an expensive prescription, a cost comparison tool would be very good." Beneficiaries who reported using a real-time comparison tool reported comparing multiple drugs and found the process and information helpful. "I have asthma, so inhalers are so expensive, and that's my main thing.… I looked on there, and what I was paying before … it was seamless. You have to do the math, and they let you put every drug you take into the way that they figure it all out." Although some beneficiaries thought that a tool like this would be useful, one pointed out that it may be difficult for seniors or less tech-savvy individuals to navigate: "Again, the resources are there. But I understand that a lot of seniors won't use them."

Beneficiaries enrolled in both traditional Medicare and MA found Medicare Plan Finder on Medicare.gov a helpful resource when selecting their drug plans. Many beneficiaries were familiar with Medicare Plan Finder and reported that they used it as a resource when trying to find a prescription drug plan. One rural beneficiary reported, "It's easy to compare on [Medicare.gov]."

Although many beneficiaries found Medicare.gov a helpful resource, a few found it difficult to navigate. On the topic of comparing drug costs, one rural beneficiary who was a licensed social worker reported "I was very frustrated by the Medicare.gov and also the other websites that help you compare things. I found them very confusing, and I kept thinking of the clients that I worked with who don't have a lot of computer access. Trying to imagine someone doing that on a phone is impossible."

A few beneficiaries reported working with a broker who used Medicare.gov to better understand their prescription drug needs and, subsequently their best plan options. One beneficiary with traditional

[26] As part of the Contract Year 2022 Medicare Advantage and Part D Final Rule (CMS-4190-F2), Part D plans were required to offer a real-time benefit comparison tool starting January 1, 2023, so that enrollees can obtain information about lower-cost alternative therapies under their prescription drug benefit plan. Source: Centers for Medicare & Medicaid Services Newsroom: Changes to Medicare Advantage and Part D Will Provide Better Coverage, More Access and Improved Transparency for Medicare Beneficiaries. January 2021. Available at: https://www.cms.gov/newsroom/press-releases/changes-medicare-advantage-and-part-d-will-provide-better-coverage-more-access-and-improved.

Medicare described how they found using Medicare.gov on their own very challenging, but were able to successfully work through the website with their insurance agent to find a plan that made coverage more affordable.

Drug Costs

Some Medicare beneficiaries reported having trouble affording out-of-pocket costs when filling prescriptions. As mentioned above, some beneficiaries reported facing high costs at the pharmacy when filling a prescription. For the most part, these were beneficiaries enrolled in Medicare only (as opposed to Medicare and Medicaid). When asked about the cost of their prescriptions, one traditional Medicare beneficiary reported, “I didn’t rate it terrible, because I get four or five medications that are zero. But I have one that, you know, starts out at $100, and then by the end of the year, it’s $500 a month.” In contrast, dual eligible beneficiaries reported paying nothing or very little for prescriptions. One said, “I have high blood pressure, that’s it. So, I take one pill and when I see what they would normally charge for that pill, a three-month supply would be over a thousand dollars, and all I pay is $1.40.”

When the cost of a prescription through their prescription drug plan was too high, beneficiaries commonly reported using GoodRx[27] to afford their prescriptions. One beneficiary noted, “I’ve had some occasions where GoodRx was better than the drug plan.” This was particularly evident for traditional Medicare beneficiaries. A few beneficiaries also reported relying on GoodRx when they hit the Medicare “donut hole.”[28] One MA beneficiary explained, “Like drugs for my rheumatologist, I do through GoodRx. They don’t go through my insurance. It slows down how quickly I go into the donut hole.”

Beneficiaries also employed other strategies when faced with high costs at the pharmacy, including calling different pharmacies or bypassing their insurance and paying out of pocket to afford prescriptions. One beneficiary explained, “I find that my insurance company is often much higher, three, four times as much higher, than I can get just myself by making a couple phone calls. Sometimes the cost that [pharmacy name 1] will give you or [pharmacy name 2] will give you, right off the bat, is way cheaper than my insurance company. So, I tell my pharmacist, do not fill any new prescription on my insurance unless I tell you to.” In some cases, beneficiaries asked a provider to prescribe a generic instead of a brand-name drug. One beneficiary said, “In my case it was just a switch in medications. I said my plan won’t cover this at any reasonable price and doctor said, ‘OK, how about you write this one?’ And I got another script.”

[27] GoodRx cannot be used in combination with Medicare coverage, but beneficiaries can use it in place of Medicare. Source: GoodRx. Yes, You Can Use GoodRx If You Have Medicare. August 2021. Available at: https://www.goodrx.com/corporate/business/yes-you-can-use-goodrx-if-you-have-medicare.

[28] Medicare Part D’s “donut hole,” or coverage gap, is the phase of Part D benefit an individual reaches after the initial coverage phase. In 2024, an individual with the basic Part D benefit reached the coverage gap phase once spending by the individual and his or her drug plan totaled $5,030.

Source: Medicare.gov. Costs in the Coverage Gap. Available at: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap.

Some beneficiaries reported using discount programs with a regional grocery chain or "big-box warehouses" to find better prices for their prescriptions. A traditional Medicare beneficiary reported:

> *"I use [big-box warehouse] all the time for my drugs. I had to get a recent new prescription for pain medication called it in, got it at [big-box warehouse]. And at the window [the pharmacy tech] said, 'Well, your insurance shouldn't cover this.… So I'm going to put you on our system so that if your insurance, if your Medicare doesn't take, your insurance doesn't take a medication, you automatically get the [big-box warehouse] discount.' It was half [of the expected price]. So it's automatic."*

When asked in the focus groups, only one beneficiary reported not taking a prescription because of the cost: "I've had some situations where the drug that they recommended was very expensive. And then I would check with GoodRx to see if there was a substitute type situation. Nothing, I just didn't take it."

Many beneficiaries reported being aware of the price of a prescription before they filled it. Beneficiaries reported that they generally knew the cost of a prescription before they filled it based on previous experience. When filling new or one-time prescriptions, beneficiaries were less likely to know the cost ahead of time. One beneficiary explained, "On the routine one, I kind of know. But the new ones pop up, I don't know beforehand."

A few beneficiaries noted that the price of their prescriptions changes based on the quantity. These beneficiaries reported that some of their prescriptions were free as a 90-day supply, but when they switched to a 30-day supply, they were required to pay more: "I have a lot of chronic things. And my wife does, too. So, we get 90-day supplies. A 90-day supply is $0 for most of the drugs that we get. A 30-day supply for the same drug is very expensive."

Pharmacy Use

Many beneficiaries had a preferred pharmacy, but some reported shopping around for better prices on individual prescription drugs. Beneficiaries reported that different pharmacies, including mail order, have different prices for the same prescription. One beneficiary explained, "I look and I see where it's cheaper. I get the two that I can mail order. But the others I think whatever one, each month I have to go three months I go to different locations. Another beneficiary said:

> *"I started out with [pharmacy name 1] , and then I found out their prices [were] more expensive than other places. And a friend told me about [pharmacy name 2], and they do have a nice program. So, I went there and then they stopped using the GoodRx. I said, boy, that's a problem. Then I switched to [pharmacy name 3], and then their prices were OK but a little higher than [pharmacy name 2]. Then eventually [pharmacy name 2] came back."*

Some beneficiaries discussed that a major pharmacy in their area closed which impacted their ability to access their prescriptions. However, many of these beneficiaries reported that they were able to adjust

how they received their prescriptions including by going to a different pharmacy in the area or switching to mail-order prescriptions.

Some beneficiaries reported using mail order pharmacies, and most were satisfied, but a few voiced concerns. Several beneficiaries reported that they received prescriptions through the mail and were happy with that option and had had no issues. In particular, rural beneficiaries reported mail order was a helpful option for them. One said, “I get 90-day supplies, and they get mailed right to me. Being in such a rural area, it’s kind of a pain to drive 30-mile round trip just to go to the pharmacy and pick up a prescription, so it’s nice they just come to my mailbox.”

However, a few beneficiaries were uncomfortable with that option. One said, “I just don’t like the business of my medicine coming through the mail.” Another reported:

> *“Where I live, I’ve gotten people’s medicine in my mailbox…. It just so happens they lived next door, so I took it up there and gave it to them. Well, then I had another guy that lived up on the third floor. Well, somebody delivered the medicine to his house, and he’s I guess we’ll call him partially blind; he can’t see well. They delivered it to his door, and he thought it was his. So, he ended up taking … some other lady’s medicine.”*

Ability to Fill Prescriptions

Beneficiaries generally reported being able access their prescriptions when needed, but some had experienced delays or shortages. When this happened, beneficiaries were usually able to access the prescription at another pharmacy, pick it up within a few days, or have their provider write a different prescription. One shared, “It was some problem, and it was unavailable. So, we had to call our doctor, and we had to pick another alternative. And then order that, then it worked out.”

A few beneficiaries described their experiences accessing semaglutide, a class of prescription medication for the treatment of type 2 diabetes that was affected by a shortage as of May 2023.[29] Beneficiaries’ experiences with accessing this drug were mixed. One noted:

> *“[Ozempic] was out of stock everywhere because people were taking it for weight loss. I was fortunate that I found a small neighborhood pharmacist near my doctor … and that guy was able to give me. People were using it for weight loss and people would want to get their blood sugar under control, which is what I was doing. You don’t need to wait. You need it. I got lucky.”*

Beneficiaries also described strategies including using a compounding pharmacy or being put on a higher dose: “I got the doctor to put me on the highest dose, and that made it easier to find.”

[29] U.S. Food & Drug Administration. Medications Containing Semaglutide Marketed for Type 2 Diabetes or Weight Loss. January 2024. Available at: https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/medications-containing-semaglutide-marketed-type-2-diabetes-or-weight-loss.

One beneficiary reported that during the COVID-19 pandemic they were unable to access hydroxychloroquine[30] to treat their lupus. This beneficiary was unable to find an alternative and went without the prescription for months.

Clinicians

Prescribing

Many clinicians reported discussing the cost of prescriptions with their patients. They noted that prescription drug costs are a major concern for their patients. When asked whether they speak to beneficiaries about drug costs, one clinician responded, “Every single day. Every single moment. Every single patient. I’m trying to find what option is easier for them to the extent that I’m showing them that on my phone, how to use GoodRx and teaching them during the visit. This says it all.” Clinicians described prescribing generics to help alleviate costs for beneficiaries. One reported, “I prescribe generics only. And then when the patient complains at that generic was a hundred dollars, I say … you know, like I am trying to give you the cheapest drug I think I can give you.”

Clinicians expressed frustration that Medicare beneficiaries are unable to use drug discounts or copay assistance.[31] One said, “So instead of all the coupons that they give to the commercial clients, you can’t use it on a Medicare.” Another noted, “The average person can get a copay card to make the drug $5, but a Medicare beneficiary who really needs it can’t use that card. And for them you know it’s whatever, a lot more expensive.”

Clinicians or staff in their practices spent a large amount of time on prior authorizations for prescriptions. One noted, “I have a person in my office whose sole job is prior authorizations. I mean, it’s getting to point now where I need to, before I even when I prescribe something, I have to go to her and say, this is patient’s insurance. What can I prescribe and not what I want to prescribe, first and foremost is what the insurance will pay for.” The time is exacerbated in instances where there are requirements for step therapy in which clinicians must begin with the plan’s preferred drug therapy before progressing to other therapies:

> *“I think one of the most frustrating things, though, is like you’ll have the med in mind that you want, and you’ll send it out, and then you’ll send it back to me, but no, you need to try A, B, C, D, E first.… And then they’re not even, like a psych provider, but a person who’s, like you’re talking to for prior auth… It’s a game.”*

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[30] In March 2020, the U.S. Food and Drug Administration (FDA) allowed emergency use of hydroxychloroquine and chloroquine to treat COVID-19. In June 2020, the FDA ended the emergency use of hydroxychloroquine and chloroquine for treatment of COVID-19. Source: U.S. Food & Drug Administration. FDA News Release: Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine. June 2020. Available at: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-chloroquine-and.

[31] Federal statutes, including an anti-kickback law, limit the use of coupons and manufacturer donations in conjunction with federal health care programs, including the Medicare Part D prescription drug benefit. Source: Congressional Research Service. Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs). June 2017. Available at: https://crsreports.congress.gov/product/pdf/R/R44264/5.

One nephrologist described challenges with prior authorization for Ozempic for kidney transplant candidates, explaining:

> *"I've been trying to write Ozempic you know, because of the obese patients to facilitate transplant and my dialysis nurses and my medical assistant said they're not going to help me anymore with that.… It's just too much of paperwork and [insurance companies] don't want to pay. So, but they can't get a transplant if they don't lose that weight and it's not happening."*

Some clinicians have access to formularies but reported that the information is often incomplete or inaccurate. Clinicians reported that certain EHRs facilitate access to formularies. One clinician shared, "So for us, it's built into our EMR [electronic medical record]. So anytime we like take medication in, it'll tell us like tier formulary, nonformulary. Not always accurate though." Another clinician explained:

> *"In my practice, the EMR has built in if you prescribe a medication, it's outside of the patient's formulary drug coverage based on the insurance that's in the chart and get flagged. But that's frustrating too, because then insurance companies will change what's on formulary or not formulary, and it doesn't update in the EMR."*

Clinicians reported limited access to beneficiaries' prescription information. A few clinicians reported that they can see both what is prescribed and what prescriptions were filled. One reported, "We go to our EMR [and can] look at all medicines filled at pharmacies, and you can see all their prescription, [and] who wrote it." Some clinicians reported that they were able to see through the EMR whether a prescription was filled. One reported, "When you look at the drug list, it'll tell you.…You click on the drug and it will tell you if it was filled." However, a few clinicians reported that they are not able to see any prescription information through EHRs or other means. Clinicians noted limitations in their access to patients' records when they received care at other systems. When discussing access to patient's prescriptions, one clinician reported, "I think the problem is we're relying on the patients to report it to us. And somebody goes to [one health system] for this and they go to [another health system] for another thing, and you don't have all the records. You're getting part of the story."

Clinicians reported that drug shortages are affecting their patients. To mitigate the impact of shortages, clinicians described calling pharmacies or prescribing different prescriptions or generics. One clinician reported, "I probably called a dozen pharmacies, and I finally, like, would start asking the pharmacist, like, what are the options, and they told me to send them to the emergency room, because they would have it.… Like, nobody had it, so their alternative was that. I found it an hour away from their house, and so that was what they did, but that's crazy." Another noted, "I've had a shortage of naltrexone for a while, too, so it's been like generics for the most part, and it does seem to be like some pharmacies have it, some doses are available in some places and some not, but I think stimulants was the biggest thing, especially through COVID, at least within psychiatry." A few clinicians reported patients being affected by the Ozempic shortage, describing it as a "big problem."

Biologics

We asked clinicians about their experiences with prescribing biologic medications, i.e., therapies that are derived from biological sources, such as vaccines, blood and blood components, allergenics, somatic cells, gene therapy, tissues, and recombinant therapeutic proteins.[32] Biologics are used to treat a wide range of conditions. More than half of clinicians who participated in the focus groups reported that they prescribed biologics in their practice.

Clinicians reported that the high out-of-pocket cost of biologics for patients was the most common barrier to prescribing them. Many clinicians reported that biologics are cost-prohibitive for beneficiaries, even when they are covered by their insurance. One specialist reported, “Most of them will be covered, but the copay is very high.” When asked whether they prescribe biologics, another clinician reported:

> *“So [the] problem for Medicare patients, they are not allowed to use copay cards. The people that they have fixed income, so they rely on foundation assistance through the drug company has contacts and they have limited funds. Or they’ll say, this is covered, but your copay is $500 a month. And if somebody has a fixed income, they’re on social security, they can’t really afford it. So sometimes they have to find something else and they go without. Medicare is really hard.”*

Clinicians reported using different approaches to make biologics more affordable for beneficiaries, including changing the route of administration between infusion and injectable, as the route of administration can determine whether the drug is covered by Part B or Part D, which may affect patient cost sharing.[33] When asked about prescribing biologics, one clinician reported, “Commercial’s fine, access is fine. Medicare, the only problem is if it’s an infusible medication because then the cost of them for the infusion each time is very expensive. So, they are better with like a self-injectable or something like that.”

Clinicians reported that their treatment choices for biologics and biosimilars were often dictated by insurance companies.[34] Clinicians were asked about their experiences with prescribing biosimilars. Regarding the effectiveness of biosimilars, one clinician said, “Well, whatever the quality is the quality, I’ll just put it that way. Certainly they have biologic effect and they do work, but these drugs are approved with less studies than the other drugs. But basically the insurance won’t allow the other drugs…. It’s like we don’t even offer the other ones anymore because this was the only option.” Another said, “Humira was the number one written drug for a long time. And there are eight biosimilars [of Humira] now. Eight. And we’re expected to know which one, which plan. It is going to be a disaster.” A majority of clinicians reported that they prefer biologics and typically prescribe biosimilars only when

[32] U.S. Department of Health and Human Services. Toolkit for Patient-Focused Therapy Development. Biologic. Available at: https://toolkit.ncats.nih.gov/glossary/biologic/.
[33] Centers for Medicare & Medicaid Services. Part B Drugs and Biologicals. June 2023. Available at: https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/part-b-drugs.
[34] Biosimilars are biologic medications made from the same types of sources as their original biologics. They are highly similar to their original biologics and have the same treatment risks and benefits. Source: U.S. Food & Drug Administration. Biosimilars Basics for Patients. Available at: https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients.

required by insurers. One explained, "If the insurance recommending [the biosimilar] is the one they're going to pay first. So otherwise still we are choosing biologics."

Clinicians described frustration with plans for switching preferred biologics and biosimilars each year. Clinicians who prescribe biologics reported that Medicare drug plans annually switch which prescriptions, including biologics, are covered. Some plans move from covering biologics to biosimilars. As noted above, clinicians generally preferred to prescribe biologics and find that these annual switches impede their ability to treat patients. Specifically, clinicians reported that these frequent changes can negatively affect beneficiaries' health when they are forced to switch from an effective therapy if it is no longer preferred. One said:

> *"So one [patient], for example, was on a brand name biologic, and switched to a biosimilar, which is like a generic. And the patient's flaring, but you know, insurance made us change. And so now she's having a flare of her disease, and now I'm trying to get her back on, and now she has to go on steroids, and it's just, I really don't like that they're forcing us to change when a patient is in, she just had a colonoscopy, she was in remission, and now she's flaring. And so that kind of stuff, it drives me crazy. And so it's very frustrating, and they do change year to year on which ones they prefer."*

Electronic Prior Authorizations

A majority of clinicians reported that they were using electronic prior authorizations for prescriptions. Of the clinicians who have used electronic prior authorizations, they reported that it simplifies the initiation of a prior authorization, but that the process can still be lengthy and frequently is not completed electronically. One clinician reported that they still need to make phone calls and follow up with insurers when using electronic prior authorization. Another provider noted that it makes some parts of the process easier, specifically by shortening the approval timeline. "I think there are parts of it, they're a little bit easier.… Within 24 hours you'll know that you're denied and then you figure out what you want to do."

Pharmaceutical Representatives

Some clinicians, particularly specialists, perceived pharmaceutical representatives as helpful to their practice. Approximately half of the clinicians in the focus groups reported engaging with pharmaceutical representatives and said that they provide useful services, such as coupons or samples of prescriptions. One clinician noted that pharmaceutical representatives have better information about formularies than health plans: "They're actually sometimes more helpful when it comes to formulary status than the actual insurance carriers." However, clinicians also noted that pharmaceutical representatives' motives differ from their own: "Well, I like to learn from [them], don't get me wrong. But I just think their motivation's different than our motive. I think everyone in this room wants to help their—I don't know if they really care if they help the patients as long as they sell their product." A few clinicians (PCPs and NPs/PAs) reported that pharmaceutical representatives are not allowed to visit their practices.