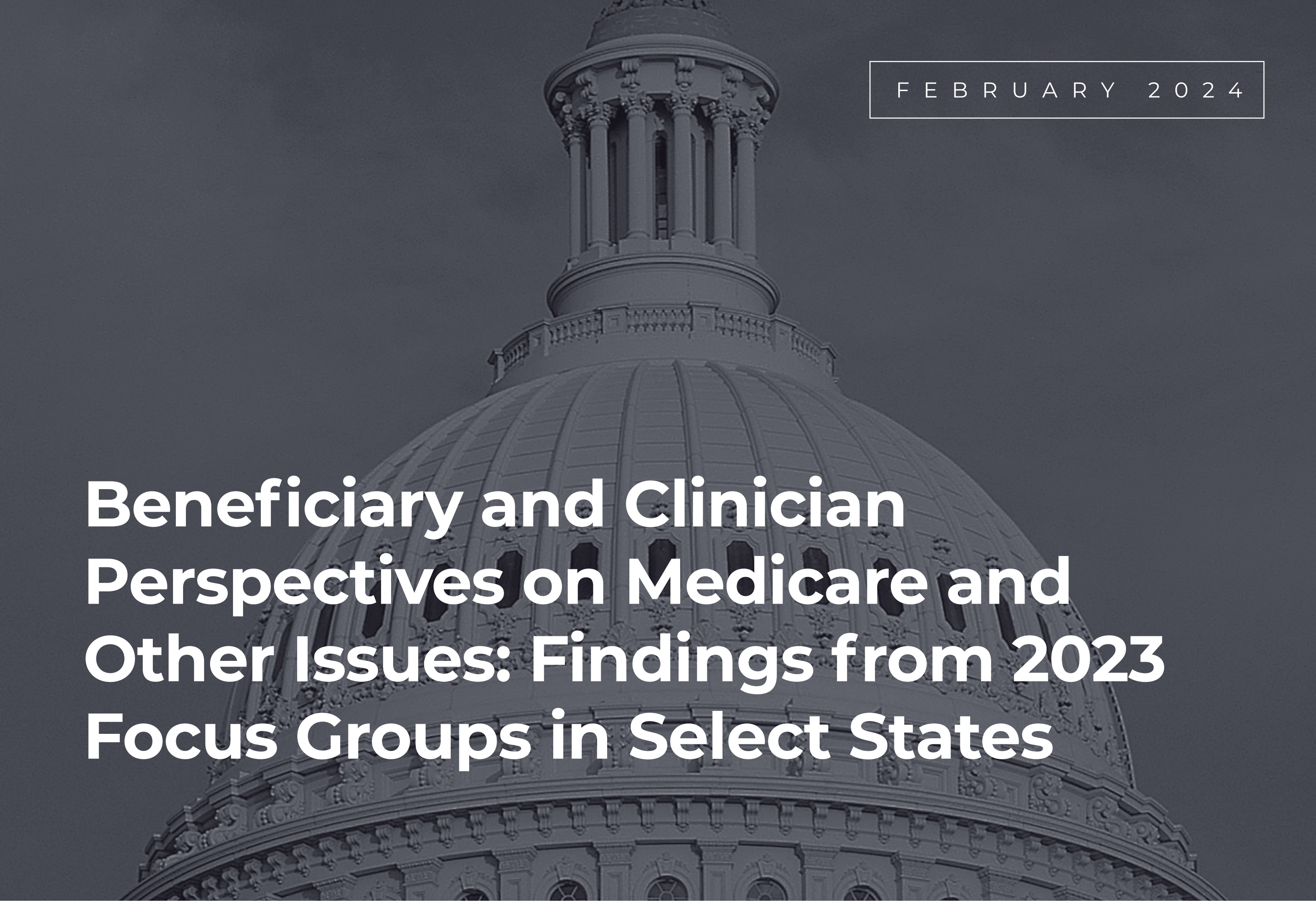

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Beneficiary and Clinician Perspectives on Medicare and Other Issues: Findings from 2023 Focus Groups in Select States

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

MEDPAC
Medicare Payment Advisory Commission

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NORC at the University of Chicago

REPORT

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Beneficiary and Clinician Perspectives on Medicare and Other Issues: Findings from 2023 Focus Groups in Select States

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Summary

This report summarizes findings from 24 focus groups conducted by NORC and MedPAC staff from May through July of 2023. Focus group sessions convened several distinct groups of individuals: 1) Medicare-only beneficiaries, 2) Medicare and Medicaid (dual eligible) beneficiaries, and 3) clinicians (including primary care physicians, specialists, nurse practitioners [NPs], and physician assistants [PAs]). All participants were residents of Baltimore, Denver, Chicago, or rural areas across the United States.

Key Findings

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

Medicare coverage options

- Beneficiaries consulted a variety of information sources when choosing a Medicare plan and generally reported understanding their Medicare choices.
- Key factors for beneficiaries in choosing between Medicare Advantage (MA) and traditional Medicare included choice of providers, the perceived comprehensiveness of the coverage, and cost. Beneficiaries also considered health care costs when choosing Medigap coverage.
- Beneficiaries described supplemental benefits available through MA plans as a perk, but for most, the availability of these benefits was not generally a deciding factor in choosing between MA and traditional Medicare. A subset of beneficiaries noted that supplemental benefits were a deciding factor in choosing their MA plan as opposed to traditional Medicare.
- Beneficiaries were generally satisfied with their coverage. More than 90 percent of focus group participants rated their coverage as “excellent” or “good.”
- Once enrolled, beneficiaries did not often switch between traditional Medicare and MA, but several who had cited cost as the reason. Some beneficiaries said that their MA plans worked for now but were thinking about switching between plans or to traditional Medicare if their coverage needs change in the future. Dual eligible beneficiaries were less likely to report switching between plan options.

Access to care

- Nearly all clinicians (PCPs, NPs/PAs, and specialists) across locations were accepting new Medicare patients. Most clinicians reported that they accepted most or all Medicare Advantage plans.
- When asked whether they had observed a shift in their proportion of MA vs. fee-for-service (FFS) patients in recent years, clinicians commented on a national-level “explosion” of MA enrollment. Clinicians attributed the popularity of MA plans to lower up-front costs and the

inclusion of dental and vision coverage, but cautioned that healthier Medicare beneficiaries were the ones who saw lower costs.

- Clinicians reported that some patients switch between MA plans and traditional Medicare as they experience restrictions, unexpected costs, or challenges with provider coverage.
- Many clinicians expressed frustration with the number of prior authorizations required when providing care to patients with MA coverage, which can cause delays in care and tension between patients and their doctors. Clinician perspectives varied on the comprehensiveness of MA prescription drug coverage, with some describing regular challenges getting approval for necessary medications.
- Nearly all beneficiaries we spoke to, including rural beneficiaries, reported having a usual source of primary care and timely access to primary care. For a routine checkup or follow-up visit, most beneficiaries reported wait times ranging from a few days to 30 days. Many focus group participants reported that they can often be seen by their primary care provider within a few days for acute issues or sick visits.
- Several beneficiaries in our focus groups reported using urgent care or the emergency department (ED) for acute health needs and after-hours care. Beneficiaries who accessed emergency care preferred going to urgent care over the ED because it was more convenient, generally less expensive, and had shorter wait times. Focus group participants provided mixed reviews on the quality of care at urgent care facilities.
- Beneficiaries reported wait times ranging from a few days to six months to see a specialist, depending on the specialty, location, and popularity of the provider. Clinicians reported that their patients can wait up to six months to see certain specialists. Across clinician focus groups, psychiatry and rheumatology were emphasized as specialties that are particularly challenging for Medicare beneficiaries to access. Beneficiaries we spoke to also shared challenges with making appointments with different types of specialty providers, particularly dermatology, neurology, and urology.
- Beneficiaries in rural focus groups spoke about the tension between choosing a rural way of life and the need to access health services quickly, including the resources that help them access needed care. These beneficiaries most often cited provider shortages as the biggest unmet health need in their communities.
- Beneficiaries in rural areas also indicated that if they were experiencing symptoms of a heart attack, they would travel 10 to 25 miles to the nearest hospital or ED to seek care. When asked where they would travel for an injury that may need stitches, beneficiaries listed urgent care, the ED, or the local hospital as options.
- When planning for a serious, but nonemergent procedure (e.g., a hip replacement surgery), rural beneficiaries indicated that they were willing to travel much farther if it meant they could “shop around” for more experienced specialists.

Telehealth

- About 90 percent of clinicians in the focus groups were offering audiovisual telehealth visits, including all PCPs, compared to two-thirds who were offering audio-only visits.
- Clinicians reported that their volume of telehealth visits has reached a somewhat steady state after the swift ramp-up and subsequent very high volumes during the COVID-19 pandemic. Current estimates of telehealth volume vary among clinicians.
- Most clinicians who were seeing patients via telehealth described the decision to hold a visit via telehealth vs. in-person as dictated by patient choice. Some clinicians described how their group or health system's scheduling processes provide patients the choice with or without the clinicians' input.
- Clinicians reported differences between telehealth and in-person visits. Most clinicians who were providing telehealth visits reported that they take less time than in-person care; however, a few reported that telehealth visits are slower, mostly due to connectivity issues.
- Clinicians, like beneficiaries, reported the value of telehealth for follow-up visits and issues or conditions that do not require a physical exam, particularly in behavioral health. Several clinicians expressed the belief that telehealth helps prevent emergency visits, and some pointed out how telehealth helps their patients with mobility issues or conditions that make in-person care challenging. One described how their group planned to use telehealth to maintain access to care in a rural area following closure of a physical office.
- Clinicians explained that audio-only visits often happen due to lack of patient access to a device that can do video—frequently by patients who are older, who are lower-income, and who do not speak English as their first language. Lack of hardware serves as a barrier to audiovisual telehealth for some dual eligible beneficiaries.
- Similar to clinicians, beneficiaries also described moving from audiovisual to audio-only visits when technical issues arose.
- Clinicians appreciated how telehealth visits, particularly those that are audio-only, present an opportunity for them to bill for care they were already providing prior to the public health emergency.
- A number of specialists described how at-home health monitors facilitate some telehealth visits, but there are still needs for in-person exams. Similarly, some clinicians raised concerns regarding what might be missed during telehealth visits.
- Most beneficiaries who experienced a recent telehealth visit (mostly from their primary care providers) said that they were given a choice between an in-person and telehealth visit and chose telehealth because they could make a virtual appointment quicker. Of beneficiaries who had recent telehealth visits, most were with clinicians they had seen before, and were for follow-ups, medication refills, or needing a referral to a specialist. Several beneficiaries described using telehealth successfully for ongoing mental health care. Several beneficiaries described their ability to monitor or measure some vitals at home as facilitating a more comprehensive telehealth experience. Beneficiaries who were asked about whether the time spent with their

clinician via telehealth varied from what they experienced in person reported spending about the same amount of time.

- A few beneficiaries reported that their specialists recently have told them that telehealth is no longer an option.
- When considering the concept of telehealth in general, some beneficiaries expressed hesitation about receiving care in this mode. However, most beneficiaries appreciate having telehealth as a convenient option in certain situations. Most beneficiaries fell somewhat in the middle, wanting telehealth as an option to supplement in-person care, but not replace it.
- When asked about what role they see telehealth playing in their practice moving forward, most clinicians believed that telehealth will continue to be a valuable tool for providing care for some purposes. Clinicians described telehealth as a patient-centered option for care and believed that patients will continue to demand it in some circumstances after experiencing it during the pandemic. Clinicians saw the future of telehealth involving more remote patient monitoring.
- Clinicians identified several administrative and clinical issues that need to be resolved regarding telehealth care, including how to make sure appointments are scheduled in the correct mode, and whether and how to deliver critical results via telehealth.

Organization of care

- When asked why they chose their specialty, a common theme among PCPs was the desire to build and maintain relationships with patients and families over time, and see patients of all ages. PCPs also cited the ability to manage all of a patient’s care and “doing a little bit of everything” as advantages of their specialty.
- Many specialists cited the ability to make a difference and improve their patients’ quality of life as rewarding. Some specialists enjoyed seeing patients and cases that were focused or well defined, with concrete diagnoses confirmed by labs, while others enjoyed the challenge of diagnostics.
- NPs described a desire to move beyond bedside nursing for a better lifestyle and less physically taxing role. Some were also interested in doing more diagnosis and management. PAs described their profession as a shorter path into medicine than medical school. Several mid-level providers also spoke about a desire to represent and serve their communities.
- Physicians described several arrangements for the NPs and PAs in their practices, including maintaining their own patient panels, comanaging patients with physicians, seeing lower acuity patients, performing administrative duties, handling urgent or time sensitive visits, and providing specific types of care (e.g., diabetes management).
- Physician perspectives on the value that midlevel providers bring to the practice varied. Physicians cited midlevel providers’ awareness of their own limitations and years of experience as important factors that contribute to these providers’ success. In general, physicians did not describe preferences or different expectations for NPs vs. PAs.

- Similar to the approach described by some physicians, a few NPs and PAs described a collaborative model for treating patients, while many NPs and PAs reported that they operate fairly independently.
- Overall, NPs and PAs did not describe many challenges related to their scopes of practice.
- Several PAs reported having switched specialties and described the ability to switch specialties as an advantage of their profession.
- When asked about changes in recent years in how their time is spent with patients vs. on administrative functions, clinicians' experiences with changes in the number of visits over time varied. Some clinicians reported more visits, some fewer visits, and some no change. However, the majority of clinicians reported an increase in administrative burden that either comes at the expense of time with patients or is added to it, and often is not reimbursed. Clinicians described increases in their time spent on detailed notes and documentation; communicating with insurance plans on issues including prior authorizations, denials, and changing formularies; and answering questions from patients in the patient portal. A couple of clinicians reported that they do their documentation after visits because of patients' expectations for engagement with their clinician during a visit.
- Clinicians whose practices had been acquired by larger organizations described financial challenges associated with operating a solo or small practice as the primary reason for the decision. Concerns about being acquired included losing autonomy and being held to unrealistic productivity standards.
- Most clinicians were familiar with the concept of an accountable care organization [ACO], but fewer than one-third reported that they were participating in one. When asked about the impact of participating in an ACO, clinicians described benefits including better access to information, improved care coordination, and changes to coding practices. Some clinicians saw the ACO as an opportunity to demonstrate their value and be rewarded for it.
- Clinicians were mixed on whether they think measuring quality improves quality of patient care. Some clinicians reported feeling penalized by quality metrics for patient actions that are out of their control.

Prescription drugs

- Most beneficiaries rated their prescription drug coverage as excellent or good. Those who rated their plan below excellent cited a number of issues with their coverage, with cost being the most common issue.
- Several focus group participants reported not taking prescription medications or taking them less frequently than prescribed to stretch out a prescription fill, due to cost.
- Beneficiaries reported both their clinicians and pharmacists providing ways to reduce prescription drug costs. Many beneficiaries reported using some sort of discount card, most frequently GoodRx®. Beneficiaries also reported shopping around at pharmacies to find the best price for a prescription.

- Clinicians reported frequently discussing the cost of prescriptions with their patients but said that they usually do not have access to the information to know what the cost of a prescription will be for a patient.
- Many beneficiaries reported initiating conversations with their clinicians about reducing their number of prescription medications. In some instances, clinicians initiated the discussion. Many clinicians reported cases when they had deprescribed their Medicare patients' prescription medications.
- Several beneficiaries reported that their clinicians had not adequately identified or discussed drug interactions with them.
- Many clinicians reported being able to access their patients' prescription-filling information. Some clinicians have access to formulary information but noted that it is not always accurate.
- When asked about whether they allow pharmaceutical representatives to visit their offices, some clinicians in our focus groups reported allowing them and described the value in receiving samples of prescription drugs and information about discount programs from them.
- Specialists and other clinicians who were prescribing biologics described an often-multistep process and most saw biologics as very effective treatment for certain chronic diseases. For the most part, they described biosimilars as “filling the gap” rather than replacing biologics.
- Most clinicians were using electronic prior authorizations and prefer them to traditional prior authorizations.
- Many beneficiaries reported that they had tried a mail-order pharmacy, although some had reservations about them. Very few beneficiaries reported using a specialty pharmacy, but those who did had positive experiences.

Methods

For this project, we conducted focus groups that covered topics related to Medicare coverage, access to care, the delivery of care, telehealth, and quality measurement. A team of researchers from NORC conducted a total of 24 focus groups. We conducted in-person groups with participants residing in and around the cities of Baltimore, Maryland; Denver, Colorado; and Chicago, Illinois (seven groups in each city). We also conducted three focus groups virtually with residents of rural areas across the country.

All interview procedures, screeners, and discussion protocols used were reviewed and approved by the institutional review board (IRB) at NORC.

Focus groups

Focus groups were held in May, June, and July of 2023. Exhibit 1 provides the breakdown by location and participant type. We conducted discussions with the following groups:

- **Medicare beneficiaries (68 participants across all cities and rural areas).** Individuals who are enrolled in traditional Medicare or a Medicare Advantage plan. Individuals were all 65 years of age or older.
- **Dual eligible beneficiaries (52 participants across all cities).** Individuals who are enrolled in both Medicare and Medicaid.
- **Clinicians (62 participants across all cities).** Primary care physicians (PCPs) included those in family medicine, internal medicine, and geriatrics .[1] Specialists represented included cardiology, endocrinology, allergy and immunology, rheumatology, dermatology, neurology, pulmonology, gastroenterology, and orthopedic surgery. NPs and PAs included individuals who work in primary care and specialty settings. Clinicians across groups regularly see Medicare patients in an outpatient setting. Participants were recruited from a variety of practice types (solo/private, group, and hospital-based).

Exhibit 1. Number of Participants by Location and Type of Group

	Baltimore	Denver	Chicago	Rural	Total (All Cities)
Primary care physicians	8	6	3	—	**17**
Specialists	9	9	8	—	**26**
NPs and PAs*	7	5	7	—	**19**

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[1] There was also one obstetrician-gynecologist in an internal medicine practice in one of the PCP groups; this participant should have been screened out.

	Baltimore	Denver	Chicago	Rural	Total (All Cities)
Medicare beneficiaries	10	20	17	21	**68**
Dual eligible beneficiaries	20	16	16	—	**52**

*Some specialty providers were screened into the NP/PA group, including those who work in inpatient settings.

In each city, the seven focus groups consisted of two groups with Medicare-only beneficiaries, two groups with dual eligible beneficiaries, one with primary care physicians, one with specialists, and one with both NPs and PAs. Groups ranged in size from three to 10 participants, with an average of 7.5 participants. In the rural areas, Medicare-only beneficiaries were recruited from across the United States. Recruitment for all focus groups was conducted by a focus group facility with partners in each market area, based on screeners developed by NORC. Screening criteria called for balanced representation by several demographic characteristics. The criteria specified that the majority in each beneficiary group should have looked for a new doctor in the past year. For clinicians, the screening criteria called for a mix of practice types and length of time in practice. For the rural focus groups, the recruiting firm used a list of rural ZIP Codes provided by MedPAC to identify participants. (Rural zip codes include those not in metropolitan and micropolitan core-based statistical areas.)

NORC researchers led the focus groups, with two facilitators per group. The three rural-area groups were conducted using a videoconferencing platform. Discussions lasted approximately 90 minutes. All the sessions were recorded and transcribed. All quotations in this report are taken directly from those transcripts. The in-person groups were also video recorded.

In some of the following sections, we highlight beneficiary and clinician focus group findings by location and beneficiary type (dual eligible and Medicare-only) to draw attention to any differences by geographic region or urban vs. rural location. Due to the nature of focus group research, our sample was limited in number and not representative of Medicare beneficiaries or clinicians. As such, 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. Additionally, it allows us to understand "how" and "why", enables deeper understanding of experiences and context, and provides personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

Location description

Given the differences in the health care delivery systems across the cities we visited, contextual factors underlying our findings were an important consideration. Exhibit 2 presents some of those differences.

Exhibit 2. Location Characteristics*

City	MA Penetration	Number of ACO Assigned Beneficiaries	White, Not Hispanic/Latino	Black	Hispanic
Baltimore	33%	5,997	27%	62%	6%
Denver	60%	643	54%	9%	29%
Chicago	41%	208,819	33%	29%	29%

*Data provided by MedPAC based on the county in which the city is located.

Analysis

We performed our analysis using NVivo qualitative data analysis software. After receiving transcripts from each focus group, we loaded them into an NVivo file, along with a list of topical codes developed based on the moderator guides for the focus groups. (Note that the topical codes are generally reflected in the headers of the Findings section.) Members of the research team then coded each transcript, tagging and organizing content into the aforementioned topical codes. After content was coded, NORC researchers conducted a thematic analysis of the content within each topical code in order to identify themes, e.g., areas of agreement and disagreement among participants, and compelling quotes illustrating the identified themes.

Findings

Choosing coverage

We asked all beneficiaries what type of Medicare coverage they have through a written survey administered before the beginning of each focus group (Appendix I). Across the groups, there was a mix of beneficiaries with traditional Medicare (with and without supplemental coverage) and Medicare Advantage. Some beneficiaries did not fully understand their coverage, however, with some selecting two or more coverage options in the pre-group survey or marking one response on the survey but describing another type of coverage during the focus group discussion.

We also asked about how and why beneficiaries chose their coverage, if they knew about and used supplemental benefits offered by Medicare Advantage, their experiences switching plans, and how they rated their overall coverage.

Deciding on Medicare plans

Beneficiaries consulted a variety of information sources when choosing a Medicare plan. Those who were covered only by Medicare (vs. Medicare and Medicaid), regardless of location, had similar experiences in how they decided on their plan. These participants often used insurance brokers or agents. They also used information from their or their spouse's retirement benefits counselor, Medicare.gov, health plan websites, the "Department of Aging," word of mouth, and rolling into a plan that they were on prior to their or their spouses' retirement. Rural participants echoed these, and some highlighted that they received information from a nonfederal website that compares coverage options. A rural Medicare beneficiary highlighted:

> *I had a lot of experience helping my in-laws and my parents with some Medicare issues. And they all had traditional Medicare with supplement, so that was what I was most familiar with. And I also used a health care broker, and they helped me to make the decision, asking me a whole bunch of questions.*

A few participants across groups mentioned that commercials were a selling point in deciding on their Medicare Advantage plans. Participants mentioned that they "saw commercials about getting money back" and that the commercial explained that "all the extra benefits … at one place" was helpful.

Dual eligible beneficiaries described having various options when deciding. Dual eligible participants used similar resources when choosing a Medicare plan, including brokers, calling the 1-800-Medicare line, and commercials. Some dual eligible participants in Chicago and Baltimore described being "automatically selected" into their Medicare plans when they became eligible for Medicare or were given a few choices by their state Medicaid agency. When asked about their enrollment into Medicare, dual eligible beneficiaries across groups noted that their Medicare plans "[were] automatically selected for me," "could have been an automatic type thing … at social services," and their plan was "chosen by the state" or "Public Services … put me with them."

Dual eligible participants were also more likely than other beneficiaries to report using insurance navigators and case managers. One participant explained, "I went to an insurance navigator appointment with [a health care and social service organization]. They showed me the website where you could compare all the plans. Someone at DHS [Department of Human Services] got me signed up for the QMB [Qualified Medicare Beneficiary] plan and Extra Help. I didn't even know I had to apply for that."

Understanding Medicare and plan choices

Beneficiaries generally reported understanding their Medicare choices. Dual eligible beneficiaries were more likely than other Medicare beneficiaries to report feeling overwhelmed with the process of signing up for Medicare on top of their Medicaid coverage. Many reported receiving help signing up for Medicare through their state's Medicaid office. One participant explained:

> *I have the Medicare with the Medicaid, MMAI [Medicare-Medicaid Alignment Initiative, Illinois's Financial Alignment Demonstration]. I just remember being completely overwhelmed, and I thought my insurance was canceled. I didn't know what the heck was going on … I was like, "Do I have Medicaid? Am I covered?" It went through a couple months like that. [Insurance company] was available to me, and that's what I had with Medicaid before, and that's what I wanted to continue with.*

Another participant noted, "I had the original Medicare, which I was all completely confused on… [since switching to insurance company] I know everything that's going on now."

Factors that affect beneficiaries' choice of coverage

A key factor for beneficiaries in choosing between Medicare Advantage and traditional Medicare included choice of providers. Many participants preferred to see the doctors that they had established relationships with and/or were living close to, and their decision to sign up with Medicare Advantage hinged on whether their doctors were in their plan's network. Participants who had traditional Medicare noted the importance of being able to see the providers that they wanted to see, without restrictions. Participants from rural areas also wanted to ensure they could continue seeing providers who were in close proximity. One rural beneficiary with traditional Medicare noted, "some of the medical providers do not accept the Advantage plan. And so, I went back to traditional Medicare because that was more acceptable in this area."

Beneficiaries' considerations when choosing between Medicare Advantage and traditional Medicare included the cost and the perceived comprehensiveness of the coverage. Some participants described MA as more affordable, and they enjoyed the convenience of having everything covered under one single plan. One beneficiary enrolled in an MA plan mentioned, “the advantage [of Medicare Advantage] is that everything is covered.” However, the out-of-pocket costs turned some beneficiaries away from Medicare Advantage: “There is a premium … you are paying for it because it’s taken out of your [Social] Security payments … plus, the annual deductible.” A dual eligible beneficiary noted that their traditional Medicare costs are “very low” and “when I looked at the cost for some of the other Advantage plans and things like that … they were out of my budget … [and] a higher premium” even though there are “credits to pay down your premium and … offset the cost.” Some participants also wanted dental, vision, and hearing coverage, either through a Medigap plan or as part of their Medicare Advantage plan.

Beneficiaries also considered health care costs when choosing Medigap coverage. Three participants discussed having Plan G to reduce the likelihood of unknown costs throughout the year, with one adding, “I don’t want to see any bills.” Another participant highlighted choosing Plan N due to the lower deductible. However, one beneficiary who had Plan F experienced an increase in premiums and switched to a Medicare Advantage plan with the same company as the supplement, as their overall experience with that company had been positive. A rural beneficiary echoed this sentiment with Plan F and had switched to MA due to the cost of the premiums. This participant found that Medicare Advantage’s copays and hospital stays were too expensive and moved back to traditional Medicare with Plan N.

Beneficiaries described supplemental benefits available through MA plans as a perk, but for most, the availability of these benefits was not the deciding factor in choosing between MA and traditional Medicare. Beneficiaries frequently mentioned over-the-counter medicine coverage and flex cards (e.g., prepaid debit cards that can be used for specific expenses, such as over-the-counter medications, a grocery allowance for healthy food purchases, and copayments for dental, hearing and vision care) as supplemental benefits they enjoyed. They described their ability to use them at the drug stores and via a catalog of items sent by the insurance company. One Medicare beneficiary mentioned, “I [get] 60 dollars a quarter that I can order this big catalog of anything. Thermometers to bandages to regular medicines. And they show up in a day or two.” One dual eligible beneficiary noted, “They give people… like $55 just to buy groceries or prescriptions or like over the counter forms of things or things in Walmart.” Beneficiaries also mentioned that vision and dental coverage being included in their MA plans was convenient and this coverage led some to choose MA. One dual eligible beneficiary noted that their plan has “the best coverage…better than some people who are on [traditional] Medicare…because they cover vision, cleanings, dental, all kinds of stuff.” Another beneficiary echoed the sentiment and highlighted that “you get a lot of free screenings, dental, vision, hearing, those kinds of screenings.”

A subset of beneficiaries noted that the supplemental benefits were the main factor in choosing Medicare Advantage as opposed to traditional Medicare. Some described hearing about these benefits from people they know who were already enrolled in MA plans, and others described seeing advertisements describing extra benefits. One explained, “I actually called [insurance company] and I was like, ‘the lady downstairs gets an extra benefits card, I want that’…. I'm doing the home visit with $20. You get $20 for all that weird stuff, but I’m happy I changed to the Advantage. Like I said, I understand my Medicare way more than I ever did.” One Medicare-only participant noted that they signed up for Medicare Advantage to specifically “get all the benefits they could get” but had not actually used dental, vision, hearing, or gym benefits since enrolling.

There was mixed awareness of MA supplemental benefits among beneficiaries in our focus groups. Many Medicare Advantage enrollees reported that they did not know which additional benefits were available to them until they called their plans. One beneficiary noted:

> *There was another ad on the TV saying, call and find out if you’re eligible.… But I decided to call the company that I had always used, and I liked the company I used anyway. So, I called them, and I explained that I had seen the ad and she’s, “oh yes, you’re eligible for this.” And that was kind of a surprise. I wasn’t really expecting that to be the answer.*

One rural beneficiary noted that their insurer called them post-surgery to explain their food and transportation benefits and explained that they “didn’t know [they] had a lot of these advantages” with their Medicare Advantage plan.

Beneficiaries enrolled in MA plans also mentioned their gym membership benefits when asked about supplemental benefits, but only a subset reported that they or their spouses actually used this benefit. Some rural participants noted that the gyms that were participating in the MA benefit were too far away.

Beneficiaries enrolled in MA plans also described using the transportation benefits. One Medicare-only participant said, “[When I switched to] Medicare Advantage … they asked me, ‘Do you want transportation?’ I’m like, ‘Sure, is it free?’ and he said yes, so I’m like, OK, I can get a ride to the doctor and back.” Non-rural participants who lived farther from their preferred provider reported using their transportation benefits to ensure that they were able to make it to appointments. Some beneficiaries in Chicago and Denver noted that they used their transportation benefits to be seen at the larger academic medical centers.

Rural beneficiaries had fewer experiences with their transportation benefits. One beneficiary mentioned that their doctor told them to look into transportation instead of having a family member take them to appointments, and another mentioned their insurer emphasized using the benefit post-surgery. One beneficiary explained some issues with the transportation service:

> *I have had to use the transportation part of my Medicare Advantage and it’s been kind of an OK and not OK. They changed transportation companies. The one they had was wonderful. They picked me up on time. They got me where I needed to be. One time I had to wait two hours to be picked back up, which didn’t work so good. But in the last few months I’ve traded transport*

> *companies and the new one is just terrible. I've had to cancel my doctor's appointments several times I've had spinal surgery, so I can no longer drive myself anywhere. So that's a big part of what I need since I can't get myself any place. It's wonderful when it works, but it's really a mess when it doesn't.*

Satisfaction with Coverage

Exhibit 4. Overall Insurance Ratings, Medicare-Only and Dual Eligible Beneficiaries

	Medicare-Only		**Dual Eligible**	
	Number	**Percent**	**Number**	**Percent**
Excellent	32	47%	24	46%
Good	32	47%	26	50%
Fair	3	4%	2	4%
Poor	0	0%	0	0%

Beneficiaries were generally satisfied with their coverage (Exhibit 4 above and Exhibit 5 below). Across participants who rated their coverage as excellent, many cited full coverage of their existing health issues as the reason. One participant chose "excellent" because:

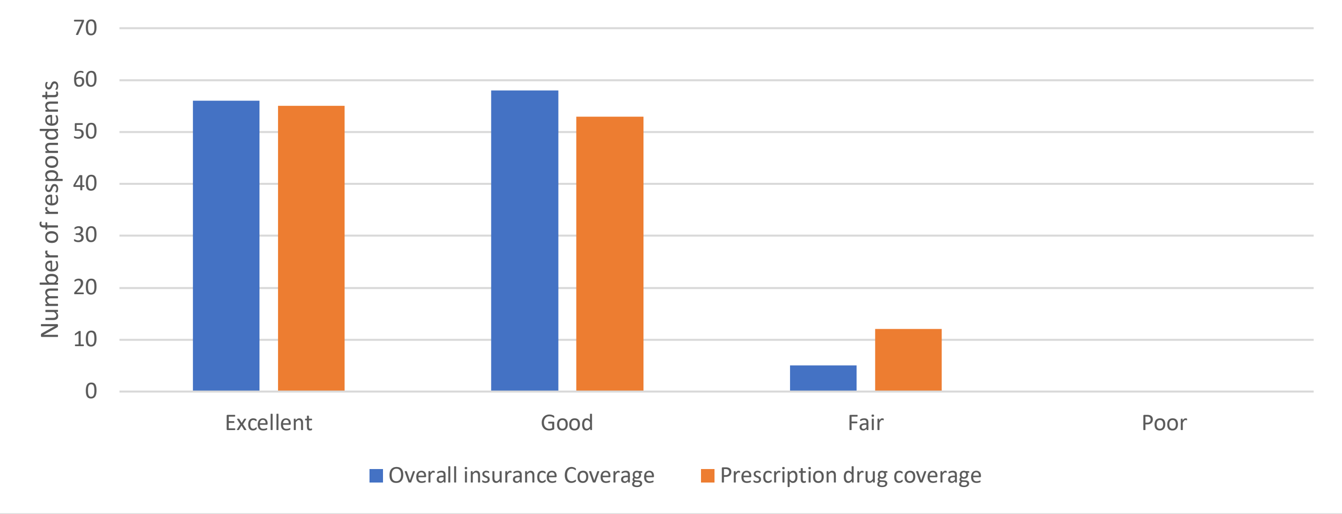
> *I don't pay any bills, I don't see any bills, our Plan F covers everything… that Medicare covers, they will pick up the rest, the rest of your hospital stay. If I need CAT scans, or PET scans or MRIs. They cover it all. And I've got all kinds of specialist doctors, and I just whiz out of their office and make a new appointment or not. And I don't have to worry about paying for anything.*

Another mentioned that the "peace of mind and not have to worry about stuff coming back out to you" is excellent. One participant mentioned that the customer service is excellent.

Some participants who rated their coverage as good noted that they have not used it enough to rate it as excellent or nothing "extreme" has happened to warrant an excellent rating, and others said things like, "I hate to say something is excellent," or "there's probably room for improvement on anything." Other participants rated their plans as good due to quality of doctors in their networks. Reasons given for rating their coverage as good but not excellent included: the process of finding a specialist was difficult, care coordination between doctors was minimal for their level of care, prescription coverage was not broad enough, bad customer service experiences, and calling the insurance companies for MA was often a tedious and time-consuming process.

Participants who rated their coverage as fair noted that they had dealt with denials for procedures and that they received "the runaround" when trying to confirm coverage for a specific medication. No participants rated their coverage as poor.

Exhibit 5. Beneficiary Coverage Ratings, Overall and Prescription



For details on beneficiaries' ratings of their prescription drug coverage, see the Prescription Drugs section below.

Switching Plans

Once enrolled, beneficiaries did not often switch between traditional Medicare and MA, but several of those who did cited cost as the reason. One Medicare-only beneficiary noted that when switching from MA to traditional Medicare that, "cost was the main thing. I still was able to do what I needed to do and instead of Medicare Advantage, I did [traditional] Medicare and a prescription drug plan so that worked for me." Another Medicare-only beneficiary noted when switching from traditional Medicare to MA:

> *The main reason I really switched is because when I had Medicare, I noticed what I get monthly as far as my benefits, when I would get my check, I'm noticing insurance…. Then when I did call, I talked to about eight different people, and they says, "You've got to pay for this, you've got to pay for that." Then I got tired of that happening, so I switched to Medicare Advantage; they don't take anything out of my monthly check."*

Two rural beneficiaries noted that when their spouses passed, they switched from traditional Medicare to Medicare Advantage because that was more affordable for them.

Dual eligible beneficiaries were less likely to report switching between plan options. Two dual eligible beneficiaries switched Medicare Advantage plans because their preferred health system stopped taking their plan and they wanted to continue seeing their doctors. Dual eligible beneficiaries also reported being switched automatically due to statewide Medicaid managed care models. One dual eligible beneficiary said that their "insurance did get switched on me by the state…. It's this new thing that was happening in Illinois for people on Medicare and Medicaid in particular. You had to call to opt out." This participant opted out of this plan to keep their traditional Medicare. Another said, "the state tried to switch me to [insurance company]."

Some beneficiaries said that their Medicare Advantage plans worked for now, but they were thinking about switching between plans or to traditional Medicare if their coverage needs change in the future. One dual eligible beneficiary mentioned that they may switch MA plans due to their doctor retiring but were waiting to see if they liked another doctor in the current office. A Medicare-only beneficiary stated that they were thinking of switching from MA to traditional Medicare due to a new treatment not being covered by their insurer. Another Medicare-only beneficiary who had previously switched explained how they were thinking about switching back to traditional Medicare again:

> *We had [insurance company] as a supplement insurance policy for a long time and we didn't use it. It was—we were feeling I guess healthy for the time and we decided why not try this for a year? We gave it the year. And then we saw that it wasn't doing us any damage at this point. So, we signed on for the second year and again, I repeat, we might switch back as we get older.*

Some beneficiaries acknowledged that MA's lower premiums and benefits were attractive, but the coverage might not be adequate if they had more advanced health needs. A rural beneficiary noted, "...the Advantage Plan, I would always be concerned that certain doctors or specialists may not accept it in case of a medical emergency. So, again, that's why I chose to go back to original Medicare." A dual eligible beneficiary who moved from Medicare Advantage to traditional Medicare highlighted that their needs were changing, and the MA referral process was tedious.

> *I just chose [traditional Medicare so] I didn't have to deal with…getting referrals... I see a whole lot of specialists as well so…. I didn't like [having to go back and forth to my primary care doctor to get referrals] so I [switched].*

Another beneficiary noted that they signed up for an MA plan because "it covered a lot" but "I'd be open to change later." When asked if that future change was due to their health status, they said yes and that they would go with traditional Medicare in the future if their needs change. A beneficiary with traditional Medicare said that they chose traditional Medicare with a Medigap plan because, "I just wanted to be covered as comprehensively as I could. As you get older, chance of getting sick are greater, at some point you're probably going to get really sick."

Access to care

In our clinician focus groups, we asked about clinicians’ acceptance of new patients and specific types of insurance, as well as their experiences working with MA plans. We asked beneficiary focus groups about their access to primary and specialty care, including their ability to make appointments with primary and specialty care clinicians and to find a new primary care provider or specialist. In the rural focus groups, we provided several scenarios with specific medical situations and asked the beneficiaries about their access to care in those situations.

Clinicians’ acceptance of patients and insurance

Nearly all clinicians (PCPs, NPs/PAs, and specialists) across locations were accepting new Medicare patients. One provider who stated they were not taking new patients cited a full patient panel as the reason they were temporarily closed off. Some clinicians expressed dissonance between their practice or health system’s acceptance of new patients and the long waiting lists of patients hoping for an appointment. One PCP explained, “I don’t know what they’re doing because [my panel] was closed for seven or eight years and then this started adding new patients. So I have no idea.... I’m booked [two months out] right now and there’s a wait list of 60 people, so I don’t know how they’re getting in anyway.”

In addition, some providers reported that their health system or practice had limits on the number of Medicaid patients they would accept. One specialist in Denver reported that 20 percent to 25 percent of their patients had Medicaid coverage, but that their health system administration did not want to accept more than that due to low reimbursement rates from Medicaid.

Providers’ acceptance of Medicare Advantage plans

Across focus groups, most clinicians reported that they accepted most or all Medicare Advantage plans, but that the decision of which MA plans were accepted was often up to their practice or health system administration. A few clinicians shared that their practice or health system had implemented policies that they would no longer accept specific, and in a few cases any, MA plans. Citing experiences of MA being restrictive for services like medication coverage, clinicians suspected that decisions made by their health system administration to no longer accept MA plans were driven by reimbursement issues. One said, “That was a big change recently, January of this year across the entire health system … we no longer took [insurance company], which ultimately impacted a big subset of our patients … a good couple of hundred that we’ve been seeing for years.”

Change in proportion of Medicare Advantage vs. FFS patients

When asked whether they had observed a shift in their proportion of MA vs. fee-for-service (FFS) patients in recent years, clinicians commented on a national-level “explosion” of MA enrollment, and predicted that MA plans will soon have a much larger share of coverage than

traditional Medicare. Physicians in Denver reported that more than half of their patient panels have MA coverage. One clinician in Baltimore estimated that Maryland has seen a smaller "jump" in Medicare Advantage enrollment, but expected that proportion to increase as the population ages.

Clinicians pointed to MA as increasingly popular among patients due to lower up-front costs and dental and vision coverage, but cautioned that healthier Medicare beneficiaries were the ones who saw lower costs. For sicker Medicare beneficiaries who have more complex care needs and see multiple specialists, physicians described MA as "limiting" and more expensive for both the patients and health systems. One explained:

> *I think a lot of our patients are not as insightful, maybe don't understand the nuances. And I think part of the problem is that it's salespeople that dupe our elderly citizens into choosing Medicare Advantage. They cold-call them and promise them the world, oh, you'll keep all your same doctors. Oh, you can go anywhere you want or you can do this, you need that. And then you don't realize, see a specialist now's 50 bucks—to a senior citizen who's on limited financial means. And then they said, well, I didn't know this.*

Another clinician said, ""I have brought it up that the term Medicare Advantage is really a term that is not really representative necessarily as an advantage. It is frankly a replacement, and patients don't really know what they're getting and it's completely different coverage."

In addition, clinicians observed that many of their patients would "switch back and forth" between MA plans and traditional Medicare as they experienced restrictions, unexpected costs, or challenges with provider coverage. A clinician explained, "People try Advantage, they don't like this. They move to traditional, or vice versa, they think it's too expensive, they move to Advantage." Another clinician suggested that a patient's decision to stick with one version of coverage vs. the other hinged on whether a given plan would cover the providers the patient wanted to see.

Working with Medicare Advantage vs. FFS

Many clinicians expressed frustration with the number of prior authorizations required when providing care to patients with MA coverage, with several noting that their practices have hired dedicated staff members to alleviate the administrative burden of prior authorizations from insurance companies. One said:

> *For the past year to two years, we went from a manageable amount of prior authorizations or denials to an absurd amount of denials right off the bat, which is really impacting…. We've had to hire staff just to deal with [authorizations] and denials. Most of the time, it's coming from these Advantage plans that flat out deny, and you can't appeal until you essentially get on a peer-to-peer, and oftentimes that's not easily accessible during the course of the day, either.*

One specialist in Chicago shared that the "red tape" of prior authorizations from MA plans can cause inordinate delays in care and tension between patients and their doctors, noting:

> *[The patient] had a lung mass that I needed to biopsy, and I had to do the robotic navigational protocols. And she showed up to get her scan, and she was very nervous. And then they said, "Your insurance actually denied it." And so, she was lost to follow-up for me for eight months, because she was so frustrated that she worked up the courage to go for the scan, and then they said, "Sorry, it's not worked out yet with your insurance." Eight-month delay in her care.*

One PCP shared that they preferred working with their health system's internal MA plan because it streamlined referrals to specialists**.**

Some midlevel providers reported that MA plans provide comprehensive drug coverage for their patients, but most clinicians across focus groups described regular difficulties obtaining approval for needed medications. These clinicians discussed offering patients different, and often less appropriate, services or medications to their patients based on what their MA plan would authorize. One said, "I like to call them Disadvantage. My patients can't get any of the medicine once they sign up."

Access to primary care

Primary care

We asked beneficiaries a series of questions related to their access to primary care providers and services.

Regular source of primary care

Nearly all beneficiaries we spoke to, including rural beneficiaries, reported having a usual source of primary care. Although most beneficiaries had a physician as their designated primary care provider, in most groups a few beneficiaries saw an NP or PA as their primary care provider. Some beneficiaries in the focus groups said they often saw an NP or PA in their primary care provider's practice on an as-needed basis, such as when they had an urgent health issue, or their physician did not have any available appointments. Those who had an NP or PA as their regular primary care provider cited a variety of reasons, including switching from a physician to an NP or PA as their primary care provider when their physician retired, choosing to see an NP in their practice when they had communication issues with their physician, or generally preferring NPs/PAs to physicians. A rural beneficiary noted, "I feel like I get more attention from my [general practitioner's] PA. She just seems to take more care and pay more attention to what's going on with me. My doctor just seems jammed and perfunctory, so I prefer to see his PA. She is really good." Many rural beneficiaries in the focus groups also reported that their primary care provider has admitting privileges at the local hospital.

Only a few beneficiaries we spoke to reported not having a primary care provider, often because their provider had retired or left the practice and the beneficiary had not found a new one yet. One dual eligible beneficiary from Chicago noted that while they have a primary care provider, they rarely see them because, "I have so many specialists I can get most of my stuff done without seeing a primary care [provider]."

Ability to access timely primary care

Across focus groups, beneficiaries generally reported having timely access to primary care. For a routine checkup or follow-up visit, beneficiaries reported wait times ranging from a few days to 30 days, with some exceptions. A dual eligible beneficiary in Baltimore reported that it had taken up to six months to schedule an appointment with her regular primary care provider, although she can be seen earlier if she is willing to see another doctor in the health system. In Chicago, a few beneficiaries reported months-long wait times when trying to make appointments with primary care providers affiliated with a major hospital or because their provider left their practice. Rural beneficiaries we spoke to generally reported wait times that ranged between a few days and a few weeks for routine visits, with some beneficiaries noting that they usually are seen immediately because of the low population density in their town, while others expressed challenges in making appointments at their small local clinics due to high patient volume.

Across focus group locations, beneficiaries reported that they scheduled their next routine checkup or follow-up visit as a part of the checkout process of a previous appointment (e.g., scheduling appointments two to six months in the future). A dual eligible beneficiary in Denver noted that they receive a call from their primary care provider's office to schedule an appointment if they have not been seen in three months. Across locations, beneficiaries also reported using patient portals like MyChart to check for next available appointments.

Many focus group participants reported that they can often be seen by their primary care provider within a few days for acute issues or sick visits, with some exceptions. While noting that they are able to get into their PCP for a "regular" visit without any issues, one beneficiary described more difficulty making an appointment for any issue that they wanted to be seen quickly for:

> *The regular visits are not a problem. It's just that, when something unexpected comes up, that's where the problems come. You just can't walk in to see your doctor. If you do, you'll be waiting probably all day long and hope you get lucky enough to see them.*

Other beneficiaries reported calling their provider when they have an acute issue, and a nurse or provider often triages over the phone and determines whether they need to be seen in the office, urgent care, or the ED.

Beneficiaries across locations, including rural, shared similar strategies for more quickly accessing primary care, including messaging their provider directly in the patient portal or checking the portal for cancelations, choosing a telehealth visit, or taking the next available appointment at the practice with another provider, such as an NP or PA. A rural beneficiary reported going straight to their pharmacist when they have an acute health issue, noting, “I live in a little rural community as well, and our pharmacist is terrific. They’re almost as good as the doctors, actually. So, I’ll go to them to see if they can give me something to help me get over the illness.” A few rural beneficiaries reported going to the ED if they are unable to be seen by their primary care provider.

Travel time to primary care

Most beneficiaries reported that it takes 30 minutes or less to travel to their primary care provider, with some noting it can take up to an hour, depending on traffic. Across focus groups, many of the beneficiaries who traveled farther distances did so voluntarily to stay with their primary care provider after they moved locations. A dual eligible beneficiary from Chicago noted:

> *When I first became disabled all my doctors… were at University of Chicago. I moved to be closer. Now they are everywhere because I decided that I’d rather travel a little bit further to get a good doctor than have them all in the same place. Now with MyChart if you give them the access, they can all look at the other charts between hospitals. You don’t even have to get the stuff sent over.*

To travel to primary care appointments, focus group participants in Baltimore and Denver primarily drove, whereas focus group participants in Chicago primarily walked or took public transportation. Some dual eligible beneficiaries described using Medicaid’s transportation benefit, as did beneficiaries in some MA plans. One beneficiary in Denver reported negative experiences with their medical transport, noting that the service has trouble finding them in their mobile home park. In Baltimore, one beneficiary reported that their insurance covered a certain number of trips via ride-share apps or taxis that they used to travel to their primary care office.

Finding a new primary care provider

Many beneficiaries reported seeking a new primary care provider in recent years, and their experiences varied in terms of the ease of identifying a new clinician. The beneficiaries we spoke to often described looking for a new primary care provider because their provider retired or left the practice. In fewer cases, beneficiaries chose to seek out a new provider because they had issues with their current provider or they moved to a different area. In Denver, multiple beneficiaries we spoke to reported losing their primary care provider when a large health system in the area stopped working with a major MA carrier. One beneficiary who had this experience noted that the MA carrier’s website was not up to date when they tried to use it to find a new provider. A few other individuals in Denver reported discordant information across communication streams (insurance websites, health systems, brokers, and so forth) regarding which doctors were taking new patients and accepting Medicare. One beneficiary in Denver reported that their primary care provider stopped taking traditional Medicare:

> *They weren't taking Medicare anymore...I've worked at a doctor's office for a short period of time, and I wanted to go back to them because I liked the doctor there. But while I was there, they quit taking Medicare, they said it was too hard for them to get Medicare to pay them. And I've seen it because I worked at the front desk. So it's a bit disheartening, turning away a lot of seniors.*

In Baltimore, beneficiaries generally faced minimal issues finding a new primary care provider. One Medicare-only beneficiary noted that they had a list of providers to choose from in their area and they chose one with free parking. In Chicago, although several beneficiaries reported no issues with finding providers close to home, one Medicare-only beneficiary reported that their primary care provider retired and they were having challenges finding a new provider, noting, "I don't know where to call. I was thinking of going to Walgreens, you know they have the walk-in clinics?" A dual eligible beneficiary in Chicago reported long wait periods when trying to find a new primary care provider but stated that they were willing to wait in order to stay in the same health system. A few rural beneficiaries reported challenges with finding primary care providers who were taking new patients. One rural beneficiary reported that they had to look for primary care providers in three different towns before finding one.

To identify a new primary care provider, beneficiaries we spoke to described looking online, calling new practices to try to make an appointment, asking a current provider or friends for referral, and in a few cases, seeking out NPs and PAs, who often have more availability than physicians.

Use of the emergency department and urgent care

When focus group beneficiaries were asked about going to urgent care or the emergency department (ED), several reported doing so under the following scenarios:

- *Acute health needs.* Some beneficiaries across groups reported going to urgent care instead of seeing their primary care provider when they had acute but nonemergent health needs. In a few cases, beneficiaries reported that they went straight to urgent care because they knew there would be a long wait time at their primary care provider's office. In other cases, they would call their primary care provider who would encourage them to go to urgent care if they had no immediate available appointments. A Medicare-only beneficiary in Chicago shared that because her provider is an hour away, it was more convenient to go straight to urgent care when she was dealing with an acute issue with her foot.

- *After hours.* Using urgent care or the ED outside of business hours was a common scenario shared by beneficiaries. If the primary care provider's office was closed (usually at night or on the weekend) and the beneficiary had an urgent need like an upper respiratory infection, a sprained ankle, or injury that they believed required stiches, they would seek immediate care through urgent care or the ED.

Several beneficiaries also described seeking emergency care in the ED or urgent care due to a true emergency or a situation that required tests or labs not available at some PCP offices (e.g., x-rays).

Beneficiaries who accessed emergency care preferred going to urgent care over the ED because it was more convenient, generally less expensive, and had shorter wait times. A Medicare-only beneficiary in Baltimore emphasized the issues with long wait times at the ED by noting, "Around here, it'll be quicker just to wait till the next day to see your doctor than trying to get seen in the emergency room." A few beneficiaries in Denver shared stories of being discharged from the ED too early or in the middle of the night with no transportation options. One dual eligible beneficiary reported that they were discharged immediately after receiving oxycodone for pain, noting, "I was discharged stoned. I was so out of it. It was like, couldn't you at least keep me in the room or something until I come down?"

Only a few individuals across focus groups reported going to the ED for non-emergencies. A dual eligible beneficiary in Baltimore reported going straight to the ED with a bad sinus infection, because if she went to her primary care provider, she believed she would have to wait longer to receive medication. A few rural beneficiaries reported that they were likely to go to the ED rather than primary care for something like stitches.

Focus group participants provided mixed reviews on the quality of care at urgent care facilities vs. their primary care providers. Some reported that the care quality was comparable to their primary care provider, whereas others noted that it depends on the location or the severity of the issue. Across locations a few beneficiaries reported misdiagnoses by urgent care providers, long wait times, and rushed visits. A dual eligible beneficiary in Chicago shared that they spent hours waiting at an urgent care only to be told that they needed to go to the emergency room, whereas a Medicare-only beneficiary in Chicago recounted long delays at urgent care last year when she needed to get the COVID-19 vaccine. A dual eligible beneficiary in Baltimore shared that urgent care visits are not "comprehensive" like primary care provider appointments and it is unlikely for urgent care providers to address multiple issues at the same time. A few Medicare-only beneficiaries in Baltimore, however, reported that urgent care is more efficient than their primary care provider due to their ability to be a "one-stop shop" for onsite X-rays and lab tests. In Denver, multiple beneficiaries we spoke to expressed satisfaction with the quality of care at an urgent care affiliated with a large health system in the area, with a few emphasizing that the quality had improved dramatically in recent years. A rural beneficiary reported that they have an established provider at their local urgent care, so they feel comfortable going there when their primary care provider does not have an available appointment:

> *I do have a physician at urgent care that I see if I need to see one, I see the same person. So, I have established a physician at the urgent care clinic along with my regular physician. So, I feel comfortable. I had my medical records transferred between both the physicians. I know I can't have two PCPs, but this one would come in second, I guess. So, but I use that person when I can't get into my PCP office.*

Access to specialty care

Beneficiary experiences

We asked beneficiaries about their access to specialty care, including what types and how many specialists they were seeing, and their experiences getting appointments to see a new specialist.

Beneficiaries in our focus groups were seeing a variety of specialists, including dermatology, psychiatry, ophthalmology, oncology, neurology, rheumatology, urology, endocrinology, orthopedics, cardiology, and otolaryngology. The number of types of specialists seen by participants varied by group. Across the focus groups, Medicare-only beneficiaries reported seeing between zero and six specialists, and dual eligible beneficiaries reported seeing between one and nine specialists in a given year. The Medicare-only beneficiaries we spoke to who reported only seeing one or two specialists most often noted seeing dermatologists and ophthalmologists.

Beneficiaries' experiences varied, with reported wait times ranging from a few days to six months, depending on the specialty, location, and popularity of the provider. Multiple Medicare-only and dual eligible beneficiaries in Baltimore and Denver reported wait times of six to eight months for dermatology, even when they had a concerning issue they wanted addressed. One described:

> *I went to my regular doctor, and I had little growth on my earlobe. And she said, "You ought to get your dermatologist to look at that." I said, "OK." I called up their office. This was in March. She said, "Well, I can fit you in September." And I said, "Well, my doctor thinks it should be looked at right away. She thinks it might not be benign." "Well, maybe I can get you in July." I said, "Well, I might be dead by July." And that's all she could do.*

Across focus groups, beneficiaries also shared stories of long wait times for urology. A beneficiary in Chicago shared that there is a local specialty urologist with a year-long waiting list, whereas a few beneficiaries in Baltimore reported urology wait times up to three months "unless it's an emergency." A few rural beneficiaries also noted access issues with urology. One rural beneficiary noted that there are no longer any available urologists within an hour of their home, while another beneficiary described long delays despite needing immediate care due to a cancer diagnosis:

> *Urology is a nightmare. It takes at least six weeks to get an appointment…. I was diagnosed with…prostate cancer. It was a rapidly growing type and it took them four weeks to get an MRI done after they had done the biopsy. And then they were trying to schedule surgery literally three months after that. I had to threaten that I was going to go to another doctor and another hospital. And miraculously, they got me into surgery within four weeks. So it was pretty scary, and the cancer had spread as a result.*

In Baltimore, dual eligible beneficiaries reported generally being able to get appointments with their established specialists when needed. A few Medicare-only beneficiaries from Baltimore and Denver, however, reported that it takes one to two months to make appointments with most of their current specialists. A dual eligible beneficiary in Chicago reported wait times of three to four months with their specialists. Some beneficiaries reported that when a specialist visit is more “urgent” they can sometimes be seen more quickly. Across focus groups, many beneficiaries reported it often takes months to be seen for a first visit with a new specialist, but those wait times often decrease once they become established patients.

Across focus groups, beneficiaries reported that wait times differ depending on a particular specialist’s popularity. One Medicare-only beneficiary said he considers his cardiologist to be his primary care provider but “he’s tough to get an appointment with because he’s constantly busy, that’s how good he is,” noting that his next available appointment was in six months.

Focus group participants shared a few strategies to be seen quicker by a specialist, including receiving a referral through a primary care provider, sending a message to the provider directly in MyChart, or scheduling an appointment with an NP or PA in the same practice if there are more immediate needs. One dual eligible beneficiary in Chicago noted the importance of persistence when calling a specialty provider’s office in attempts to obtain an earlier appointment:

> *I’ll call every week and say, “Do you have any sooner openings?” Or you can go to your primary care doctor and have them message them and say, “Look, it’s more urgent. Can you fit him in?” That’s an inconvenience, because I got to wait till October to see this one doctor…. They said, “Just call every week, and there’s a chance maybe somebody cancelled.” Why can’t they just call and let us know?*

Clinician experiences

Clinicians reported that their patients wait up to six months to see certain specialists. Across focus groups, clinicians attributed challenges with specialty care access to shortages and providers not taking certain types of insurance.

Across clinician focus groups, psychiatry and rheumatology were emphasized as specialties that are particularly challenging for Medicare beneficiaries to access. For psychiatry, focus group participants shared that practice closures and providers not taking insurance contribute to access issues. A clinician in Denver noted, “a psychiatrist that takes insurance is just a pipe dream,” while a clinician in Chicago said, “I work in the suburbs, good luck needing psych. There’s literally nobody around that will take you for months because all of the places closed down and the few that remained open, the wait time is many, many months for a new patient.” For rheumatology, an NP in Chicago attributed access challenges to a lack of providers in the area.

Across focus group locations, clinicians reported issues in which specialists or entire health systems were no longer accepting major MA plan carriers. A specialist in Chicago reported that there is a lot of “cherry picking” from specialists not taking MA patients, whereas an NP in Chicago noted, “I know some specialists are not crazy about taking Medicare or Medicaid, because I know the wait time and the capitation in terms of reimbursement. I know there have been some places I've had patients to go, and they'll just say we're not taking any more."

Clinicians emphasized the time burden associated with specialist referrals, including extensive paperwork and phone calls. Multiple clinicians we spoke to reported that they had to hire full-time referral coordinators to lead the process and navigate among which providers take different types of insurance. An NP in Chicago noted that a Spanish-speaking nurse in their practice helps their Spanish-speaking patients schedule appointments with specialists in the community who speak the language. Other clinicians described the benefits of electronic referrals through electronic health records (EHRs).

Many clinicians we spoke to reported that they were able to help their patients access specialty care quicker if they had a personal relationship with the specialist and could call or text them. One provider in Chicago acknowledged the benefits of working for a federally qualified health center (FQHC) when making specialty appointments, noting, "you have specialties right in there. You have psych, you have behavioral health, you have GYN."

A few clinicians reported that hospital or clinic leadership "encourage" specialty referrals within their own health system, while others simply noted that it is much easier to refer to other clinicians within the same health system or group. One explained, "You have to write a referral, then it has to go upstairs, it has to get approved, that patient has to call next week, see if he's approved. It's like a ping-pong game, a little bit sometimes. It's time-consuming, it takes time. Much easier to refer within the group."

Rural needs and access to care

For beneficiaries in rural areas, we posed several medical scenarios and asked where participants would go and how far they would need to travel to access different kinds of care. We also asked these beneficiaries for their assessment of the biggest health care need in their area.

Beneficiaries spoke about the tension between choosing a rural way of life and the need to access health services quickly, including the resources that help them access needed care. Although many beneficiaries in the rural focus groups spoke positively about living and accessing care in rural areas, they also had experiences of delaying visits to their doctor, or not going at all, because of the distance to care. One beneficiary shared that they transferred from their longtime physician (30-minute drive) to a new doctor in a nearer office (five-minute drive) to ensure that they could more easily access routine care when they felt sick. Some beneficiaries praised the speed and training of local emergency services to provide critical care and transportation in the event of an emergency, while others shared experiences where it would have ultimately been faster to drive themselves or a loved one to emergency care rather than wait for an ambulance. One beneficiary pointed to the availability of helipads for helicopter transport to larger hospitals as a key resource for connection to emergency care. One beneficiary summarized the trade-offs of living in a rural area:

> *We live out in the middle of nowhere as well. We do have a few doctors. And thank God, they have a cancer center here now, which is wonderful. But most of my doctors are like an hour away. I guess there's nothing you can do about that if you want hospitals and doctors and where we live, that was our choice.*

Beneficiaries in rural areas indicated that if they were experiencing symptoms of a heart attack, they would travel 10 to 25 miles to the nearest hospital or ED to seek care. Many beneficiaries reported that they could seek care at a nearby hospital for symptoms of a heart attack, but that they would likely need to be stabilized and transferred to a larger facility to receive continued, specialized care. One beneficiary shared that they once chose to drive 35 miles to a larger hospital, rather than a hospital 10 miles away, when they were having symptoms of a heart attack because they knew they would need to be transferred anyway. One said:

> *Now talk about my husband with his heart condition. His [cardiologist] is three hours away in Hershey. And he told him, "Go to the nearest hospital, have them stabilize [you] and have them put you on a helicopter and get you to Hershey." That's the way it is here. You're either going by air transport or ground transport ambulance.*

When asked where they would travel for an injury that may need stitches, beneficiaries listed urgent care, the ED, or the local hospital as options. Many beneficiaries reported living within 15 miles of one or more urgent care centers, with one beneficiary living as close as five minutes away from an urgent care. Beneficiaries not living near urgent care centers suggested that they could go to an ED or their local hospital, which ranged from 10 to 35 miles away.

When planning for a serious, but nonemergent procedure (e.g., a hip replacement surgery), rural beneficiaries indicated that they were willing to travel much farther if it meant they could "shop around" for more experienced specialists. One beneficiary said that their local hospital was affiliated with larger academic health systems in their area, which gives them more "leeway" for specialized care options within a "reasonable distance." However, most beneficiaries stated that they would seek care in larger cities and in bigger hospitals when planning for an important procedure, often 60 to 80 miles away from their homes in major metropolitan areas. One explained, "I would check round to see who had a lot of experience doing that, you know, I just wouldn't go to the first hospital and let them experiment."

Beneficiaries in the rural focus groups most often cited provider shortages as the biggest unmet health need in their communities. Across focus groups, these beneficiaries cited a need for more and better health care providers in their communities and reported a variety of factors contributing to this need. Reasons included doctors retiring without being replaced, hospital closures, and aging populations in need of more specialty care for conditions like heart disease and diabetes. One beneficiary suggested that the quality of care provided by physicians in their area was poorer because "the rural doctors out here are doctors that were let go from other hospitals." Most beneficiaries reported that they did not know of people moving out of the area to be closer to health care but did say that provider shortages force people to travel farther for treatment.

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.

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.

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 see and 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 6 and 7 present responses across all focus groups. **Nine in ten clinicians were offering audiovisual telehealth visits, including all PCPs, compared to two-thirds who were offering audio-only visits.**

Exhibit 6. Clinician Focus Group Respondents Offering Audiovisual Telehealth Visits

	Primary Care Physicians	Specialists	NPs and PAs	Total
Yes	17 (100%)	24 (92%)	15 (79%)	**56 (90%)**
No	0 (0%)	2 (8%)	4 (21%)	**6 (10%)**
Total (all locations)	**17**	**26**	**19**	**62 (100%)**

Exhibit 7. Clinician Focus Group Respondents Offering Audio-Only Visits

	Primary Care Physicians	Specialists	NPs and PAs	Total
Yes	13 (87%)	17 (65%)	10 (53%)	**40 (67%)**

	Primary Care Physicians	Specialists	NPs and PAs	Total
No	2 (13%)	9 (35%)	9 (47%)	**20 (33%)**
Total (all locations)	**15**	**26**	**19**	**60 (100%)**

Clinicians reported that their volume of telehealth visits has reached a somewhat steady state after the swift ramp-up and subsequent very high volumes during the COVID-19 pandemic. Current estimates of telehealth volume vary among clinicians. PCPs reported conducting 10-20 percent of their visits via telehealth. Among specialists there was more variation with some specialists not conducting any care via health (0 percent) and others reported conducting up to 50 percent of their visits by telehealth. Clinicians reported that they believe that current volumes of telehealth visits are what they expect to see for the foreseeable future after volumes of in-person care have returned to roughly pre-pandemic levels. When it comes to specialists, there is variation in current telehealth volume. For example, one dermatologist reported seeing no patients via telehealth, whereas an endocrinologist cited doing 50 percent of visits virtually:

> *I actually love [telehealth visits] for the most part. In our practice, we're 50/50 telehealth and in person. Because in endocrinology a lot of our work can be done virtually. Even new patient consultations, especially if you do video so that you're actually seeing them even though you're not touching them. For osteoporosis, or hypothyroidism, there's a lot of endocrine conditions that work well. But there are obviously things that we can't. We can't biopsy a nodule, we can't touch a diabetic's foot. Those things we can't do virtually. So, there are obviously needs for in-person care as well, but I think a lot of what we do is patient preference, in the confines of if you meet the criteria to do it virtually, do you want to? We have a lot of patients who want virtual care.*

Another specialist noted "We technically offer it. Again, we don't encourage it. It would have to be the patient requested it. Hardly any of them ever do, but they could. One PCP reported "at one point, we had 100% telehealth, and now maybe like 5-10%. Not as much, but I think we always reserve some appointments for those patients, and sometimes they call and say, 'Can I change my appointment to telehealth, because I cannot come?'"

Most clinicians who are seeing patients via telehealth described the decision to hold a visit via telehealth vs. in-person as dictated by patient choice. For the most part, these clinicians require new patients to first be seen in person (however, there are exceptions, such as the aforementioned endocrinologist) but offer established patients the option of telehealth. One explained:

> *Like for our new patients, we never do any telemedicine. Those are always in person. But then after that, like I'd say probably more than half of my telemedicine visits are more kind of acute*

> *visits. And I usually will have like one or two spots in my schedule each day that are kind of open. And so if a patient calls in for like an issue that same day, then a lot of times they'll put them on my schedule as like a telemedicine visit. And then sometimes I kind of screen them try to beforehand to see if it's appropriate to do telemedicine, because sometimes those types of visits aren't appropriate for that. But I'd say like probably half or a little bit more than half are for that.*

Although many acknowledged advantages to telehealth for some types of visits (discussed in detail below), a number of clinicians also described how their group or health system's scheduling processes provide patients the choice with or without the clinicians' input. Some have administrative checks to make sure the patient and reason for the visit are appropriate for telehealth, including a request for a telehealth visit coming directly to the clinician's EHR for approval, or a less formal (and effective) front-office staff person reviews the schedule and moves appointments from telehealth to in-person. One clinician described, "For our practice, the patient schedules it. We have nothing to say about what kind of visit. Sometimes it's not appropriate, so we might have to cut it short and have them reschedule in person, where we need to see, hear, touch."

Most clinicians who are providing telehealth visits reported that they take less time than in-person care; however, a few say that telehealth visits are slower, mostly due to connectivity issues. When asked, most clinicians reported that telehealth visits were quicker than those in-person. One said, "I feel like those visits are quicker, kind of more efficient and you can do more of them."

Some clinicians noted that they do not have the same number of support staff engaged (e.g., a medical assistant who "rooms" a patient) when conducting a telehealth visit but instead connect with the patient directly. Those clinicians are spending more time on the visit. Others have staff members who are involved in setting up the connection and preparing the patient for the clinician: "We have someone that their job is to kind of talk to the patient and try and troubleshoot like if there's any issues connecting, because normally it's not like an issue on our end."

A few noted that the time it takes to connect to patients when there are technological issues can increase the full amount of time to more than they would have spent in-person. One clinician said, "You get to the problem, you talk about it and you're done. As long as the technology's working." Another reported:

> *I think that it takes more time because a lot of times you're ready do the telehealth [and] they have technical difficulties. The whole 20 minutes is gone getting connected and then you finally get a click and then you're converted to a phone call and it's a mess. Unless they really know what they're doing.*

Several clinicians described how they were still figuring out how telehealth fits into their daily workflow. They described a struggle to go back and forth between in-person visits and those conducted virtually during the course of a workday. Several added that dedicated telehealth days or blocks of time worked better than bouncing between telehealth and in-person visits. One explained:

> *We've been struggling with that because like I have a dedicated telehealth session, like one morning a week, but then they're allowed to schedule. But when they're kind of scattered in between my in-person, I feel like one, I'm going back and forth, and then I'm like… I didn't even realize I had one.*

Advantages of telehealth

Clinicians, like beneficiaries, reported the value of telehealth for follow-up visits and issues or conditions that do not require a physical exam, particularly in behavioral health. One reported, "If it's a problem or a complaint that doesn't need a physical exam, then I feel like the telemedicine is a good option." Another clinician noted "Most mental health things are great for it, following up on a psych med, following up on their Adderall® [amphetamine/dextroamphetamine]. There's nothing to examine. I think it's fantastic for that." Another clinician noted:

> *It's really, really convenient and useful for psych ... unless you're prescribing certain medications where you need a blood pressure. Otherwise, you don't need to listen, to touch anybody. So, it can be easily done. You can see their behavior. You can assess whether they're suicidal or not, things like that, over video, too.*

Another clinician who also referenced treatment for substance use disorder along with mental health care reported: "And behavioral health and substance abuse are huge. Yeah. I mean, oh my gosh. The fact that these people have a hard time just showing up, and so now they don't have to do any of the extras to get there."

One clinician spoke specifically about telehealth as a facilitator for access to mental health care by beneficiaries living in rural areas:

> *Offering access to people that may not have a lot of mental health [care options]. They can access a provider in a place that's an hour or an hour and a half away. Especially in rural areas, they just don't have the mental health providers to be able to just go on and do a telehealth visit. It's very attractive for patients that are in that situation.*

Clinicians described telehealth as a patient-centered option for care and believed that patients will continue to demand it in some circumstances after experiencing it during the pandemic. One noted, "I would say, now it's definitely patient-centered. Especially during COVID, that idea, they experienced it and they liked it. Elderly people, people with transportation issues or time constraints." Another said, "Telehealth has given us a lot of opportunities to establish care, and continuity of care as well. It's, of course, patient-centered, and patients sometimes prefer it. It's really life-saving to see them on video or tele-visit."

A clinician who is providing care via telehealth offered experience about how to ensure that older patients can connect to telehealth appointments and avoid technological issues. One clinician described a policy in their practice to facilitate successful care via telehealth for older and less technologically savvy patients:

> *I think patients love it. I don't think it should ever go away…. In our practice is we've actually got an authorization from our elderly patients for their children to actually help them facilitate the video calls. We do them in the evenings or early mornings, and their son will have their phone on via telemedicine and elderly patients love it.*

Several clinicians expressed the belief that telehealth helps prevent emergency visits. These clinicians described how many of their patients who receive care via telehealth would have been forced to go to the ED if telehealth had not been an option for them. One explained:

> *The more access a patient has to our practices, telephone, televideo, or in person, the less chance they will be to go to an emergency room or a hospital. So they can sit and, and worry about our $20, $40, $80, whatever the doctor said. But the honest truth is one ER visit is 20 times that amount. One hospitalization is 40 times that amount.*

A number of clinicians pointed out how telehealth helps their patients with mobility issues or conditions that make in-person care challenging. Clinicians spoke about how telehealth serves as an access-facilitator for their patients with mobility issues, with one noting, "It's just ... super convenient. It helps with patients who have transportation issues, mobility issues, all those kind of things." Another reported:

> *[I]t's really hard if you have mobility issues. My patients, they can't afford [transportation], a lot of times they don't have a way to get [to in-person appointments] and they have to pay for public transportation or they have to wait for tel-a-ride and then it's like an all-day thing because they pick you up three hours early and then you wait around and it's really tough.*

A pulmonary critical care specialist shared:

> *We'll manage ventilators from home often on telehealth, that's been a great benefit since COVID, that now we can have these options, because it's just basically impossible for the families to bring their loved ones in the home. And sometimes we'll start palliative medications on telehealth visits for patients to go home with end-stage ALS [amyotrophic lateral sclerosis] before hospice takes over. [Telehealth is] a really nice adjunctive option, when transportation issues based on the patient's clinical condition is prohibitive. But that's not the only scenario, but*

> *that's one that we've found particularly helpful. Because...it was, "We can't help you" prior to the telehealth approval.*

One clinician who worked for a group that was closing a physical location in a rural area described how telehealth will maintain some access to care despite the closure of a physical location. This clinician anticipated an increase in telehealth visits to accommodate the population of patients who will no longer have a convenient physical location to access care. They described, "I think we're anticipating to pick ours up a little bit and feeling comfortable with actually closing one of our rural clinics knowing that we can push a lot of that into telehealth."

Clinicians appreciate how telehealth visits, particularly those that are audio-only, present an opportunity for them to bill for care they were already providing. A number of clinicians described how, prior to the pandemic, they were already spending significant time providing care over the phone. Examples they cited included discussions of lab or other test results and addressing issues that did not require a physical exam. One clinician reported, "Our practice used to like order labs, and then spend like all this time talking with [the patient] on the phone, discussing [results]. We did not bill patients for all of that time. And I think we should." Another clinician noted:

> *The other thing I think that's been tremendous about telehealth is that we don't usually make people come back necessarily just to get lab results or stuff. So we spend a lot of time on the phone doing stuff that we don't get reimbursed for at all. And now, with some of those, I think you could say, let's do a telephone visit and we can bill for it, which has been ... huge.*

Challenges related to providing care via telehealth

A number of specialists described how at-home health monitors facilitate some telehealth visits, but there are still needs for in-person exams. Several specialists described how at-home health monitors provide them with helpful and necessary information when providing care via telehealth, with one clinician noting, "I'll have patients check their blood pressure at home, maybe check an oxygen sat at home." However, several of these clinicians acknowledged that what can be currently collected at home is often not enough to provide the whole picture of a patient's health or clinical status. One cardiologist said:

> *We're doing a lot of remote patient monitoring [for] heart failure and arrhythmias. [I]t really became evident that we were missing a lot on the physical exam that played a big role. Whether that's looking at an EKG [electrocardiogram], listening to breath sounds, [conducting a] physical exam. Then we found that patients were really strongly preferring the inpatient look, they didn't really want to talk to a cardiologist without them listening to their heart. So, now we have a very small subset of patients that will offer tele-visits to mainly just blood pressure, check-ins on their blood pressure. Titrating certain medications or going over test results and things like that. But*

> *predominantly, most patients will prefer to come in as would we to have them come in for an evaluation.*

While acknowledging the value of telehealth to facilitate access, some clinicians raised concerns regarding what might be missed during telehealth visits. Several clinicians who provide care via telehealth appreciated how it could be used to expand access, but also did express concern about clinical issues that would be uncovered in person but not virtually. One clinician noted, "I think patients may underestimate a little bit of how much value we do get out of looking at them and examining other and getting some of that data even just like for our heart rate and their weight and swelling and their oxygen level." Another clinician described:

> *I was anti-telemedicine and telehealth just at the start of my career, and then the pandemic came and you just sort of realize that there's this need for it, just to open access. Then I've come to believe after a few years practice that saying 90% of your diagnosis comes from patient history is kind of true.... I think of the one-off stories.... I had a lady that had a blood pressure of 200 plus and I was the third provider she saw to try to get her birth control. Another woman who came in for a UTI and I'm listening to her lungs, and she has pneumonia. She's like, "well, about my UTI?" I'm like "lungs first, we'll treat both." But those are the types of things that are a little scary to know if you've missed with a phone visit.*

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 8 presents responses across all focus groups. Approximately three in ten beneficiaries reported experiencing an audiovisual telehealth visit in the past six months.

Exhibit 8. Participation in Audiovisual Telehealth Visits among Beneficiaries in the Past Six Months

	Medicare-Only	**Dual Eligible**	**Total (Duals and Medicare-Only)**
Yes	13 (19%)	21 (40%)	**34 (29%)**
No	54 (81%)	31 (60%)	**85 (71%)**
Total (all locations)	**67 (100%)**	**52 (100%)**	**119 (100%)**

Most beneficiaries who experienced a recent telehealth visit (mostly from their primary care providers) said that they were given a choice between an in-person and telehealth visit and chose telehealth because they could get an appointment quicker. . One noted, "So I think it was very helpful if you can't get in to see your primary care doctor immediately, opt for either phone call or audio visit. And I was surprised at myself. I was able to work out the audio." Another noted that they had a telehealth visit "because it was sooner. I could see someone sooner by going telehealth."

Of beneficiaries who had recent telehealth visits, most were with clinicians they had seen before, and were for follow-ups, medication refills, or needing a referral to a specialist. Beneficiaries who reported seeing a clinician for the first time via telehealth said that this was because they could see a new clinician sooner than their regular provider. Beneficiaries described opting for telehealth for follow-up care that they believed did not require a physical exam, or issues that they believed would be relatively simple to diagnose or address.

Beneficiaries who were asked about whether the time spent with their clinician via telehealth varied from what they experienced in person reported spending about the same amount of time. Several who expressed satisfaction with their telehealth experience noted how the whole visit process was quicker.

Several beneficiaries described their ability to monitor or measure some vitals at home as facilitating a more comprehensive telehealth experience. These patients described various forms of remote patient at-home monitoring and discussing results during their virtual visit. One reported, "And they'll ask for my - can you take your blood pressure? Can you tell me your temperature? Can you tell me a little bit about what's going on?" Another said, "I had my own blood pressure machine there. And I took my own blood pressure and gave it to her, told her what it was."

Some beneficiaries expressed hesitation about the concept of telehealth in general. A number of beneficiaries described appreciating in-person care for specific circumstances—particularly when they perceive the need for a new diagnosis or physical exam—and noting how relationships between them and their clinicians are established in person. One person commented:

> *It almost feels like it's just laziness on everyone's part because we just don't see our doctors like we're supposed to. That doctor-patient relationship is meant to be a certain way. But I do think that it's more convenient for people to be, "I kind of can do it that way." It's working for a lot of people, including me, so it does work out.*

Of those who expressed the desire to be seen in person due to limitations in what can take place virtually, one beneficiary described a need to visit their orthopedist: "I wanted her to physically see me, and not on video.... My mobility was compromised.... I wanted her to make sure she knew that I was having a hard time with my knees." Another who perceived limitations of telehealth also expressed frustration about needing to come for an in-person visit after a telehealth appointment, saying:

> *I had some nerve pain…. I wasn't particularly interested in [telehealth]. You're basically just answering a questionnaire. They can't diagnose anything. They can't look at anything. They're*

> *basically asking you a bunch of yes and no questions. So I don't see how it helped that much other than the doctor just wrote out an appointment for me to come in. But I didn't see what it accomplished much.*

However, most beneficiaries—including those who generally want to receive their care in person—appreciate having telehealth as a convenient option in certain situations. One dual eligible beneficiary explained their mixed views:

> *Yeah, I'm not a big fan of telehealth ... it depends. [It's ok] for some things, like follow-up, or just talking about some test result. I prefer in-office, because if something comes up, then they can say, "OK, well let's get you blood results," and you just get it right there. Or maybe there's something they want to look at. Some of these, they say, "We can see it through our camera and that's good technology where we can see that." They're trying to really leverage telehealth, obviously because it's cheaper for them and they can get more revenue. I'm not saying it's all a conspiracy. I think there's a lot of advantages. Plus, it's like, even though we all have Medicare and Medicaid, still someone's getting charged for it. It feels sometimes like they're getting away with getting all this money for not doing anything. Plus, I like when they go in and they take my blood pressure and check me out, and things come up in conversations.*

Others cited examples of times telehealth facilitated their access to care. One beneficiary noted, "Sometimes it's actually preferable, like when I was sick. It's like, I don't want to go in." Another said, "You don't have to leave the house. Nobody's running behind," and still another said, "The only reason I switched [from in-person to telehealth] was because it was snowing outside, and I didn't want to get on the bus. So it was actually easy to switch from an in-person visit to a telephone visit to get around that day."

Several beneficiaries described using telehealth successfully for ongoing mental health care. Beneficiaries who receive mental health care via telehealth appreciated not needing to travel frequently (e.g., weekly) for in-person care for this purpose and felt that receiving care at home was more comfortable. One said:

> *For me, I see a psychiatrist every month or every three months. I usually do it just over video chat, because for one, it's more comfortable for me just to be at home. Sometimes I'll be late, so it just makes it—get there on time. I'm just very comfortable with her. Also, just waiting wherever I go, it's a lot. Here, where they want you to be 15 minutes early and then you still sit an extra 30.*

A few beneficiaries reported that their specialists recently have told them that telehealth is no longer an option. The beneficiaries who noted that their specialists were no longer participating in telehealth appointments indicated that this change reflected something about the broader policy environment and whether insurers would pay. One person said:

> *The same thing happened to me with my psychiatrist. She said, it's going to end. This was last year. She said, it's going to be ending soon. You're going to have to come in, and then it changed. She said, [name], your insurance isn't going to pay anymore and then it changed. And then so we never had to go in. And we're still doing just a quick appointment. I like saving the gas.*

Lack of hardware serves as a barrier to audiovisual telehealth for some dual eligible beneficiaries. A number of dual eligible participants described not having a computer or a smartphone in response to questions about telehealth experience. One who had been offered a telehealth visit said, "I told them I don't have a computer at home and I can't do it at the library because it's loud." Another noted, "You're talking about people on Medicaid and Medicare. We never had computers and stuff like that.... And whenever you went to the doctor, you saw the doctor in person. So seeing him on screen I don't feel as good as seeing her in person."

One beneficiary who lived in a rural area described not being able to receive care via telehealth from their providers across state lines. This beneficiary had to drive across state lines to conduct a telehealth visit: "Since I live in Nebraska, I was having a telehealth conference with the doctors that I visit in Colorado. And I had to literally drive into Colorado because he could not do a telehealth conference with me in Nebraska. So, I had to cross the state line."

Audio-only visits

Clinicians explained that audio-only visits often happen due to lack of patient access to a device that can do video—frequently by patients who are older, who are lower-income, and who do not speak English as their first language. Some clinicians expressed that an audiovisual visit was preferred to audio-only, but they reported that audiovisual was not possible for some of their patients. One noted, "I think again, telephone is better than nothing because at least people do have access who otherwise would not have access." And another said, "80% of my telephone call visits are patients who cannot do the audio-visual." One clinician stated that requiring audiovisual telehealth visits for full reimbursement was unfair and discriminated against physicians with older patient populations: "It's sort of ageist to insist that video, telehealth, be done on elderly patients who do not have ... the latest cell phone ... and who just still have a phone that you dial." When rationalizing why many of their telehealth visits were audio-only, one clinician reported:

> *But my problem is I work with a very like low-income elderly population that often don't speak English as their first language. And most of them have never used a computer. They don't know what the internet; like most of them have never been on Google. They don't know how to use a smartphone. And so it's a completely non-internet savvy [population]. And I think trying to get this particular patient population to navigate, even when it's just a link and you send it and*

> *you're like, just click on…. But some of them … only have flip phones too and so they can't do it. So we offer both, even though I know we can't bill as high; we do audio-only.*

A number of beneficiaries described moving from audiovisual to audio-only visits when technical issues arose. These beneficiaries did not indicate that this switch affected either the quality of their care or their satisfaction, but noted the need to be somewhat technologically savvy to successfully navigate telehealth.

> *The technology is not my forte. But even though I was given everything to call ahead to get on a Zoom, it didn't work. We ended up on phone, which was fine with my primary because I could trust her. So, it wasn't an issue. But technically speaking, when it's that vulnerable and if it had been something that was so valuable for her to see, I felt sort of undermined.*

Another noted:

> *So one [telehealth visit] that I do every month [is] a check-in and to get refills on prescriptions.... I have a webcam and a desktop computer, and he, the doctor or doctor's assistant, he has a webcam and a computer. For the past few months, we've been having technical problems with the video system and doing it. It's not a big deal, but he just calls me on the phone, and we do it by phone. But it comes in handy, it's easy to do if you're computer-savvy, you know how to do it, you just hook it up.*

Future of telehealth

Clinicians

When asked about what role they see telehealth playing in their practice moving forward, most clinicians believed that telehealth will continue to be a valuable tool for providing care for some purposes. As described above, most clinicians value telehealth as a way to increase access to care for patients whose mobility, clinical condition, or access to convenient or affordable transportation does not allow for easy in-person care. For the most part, and except for clinicians in a few specific specialties, they also noted how telehealth is clinically appropriate for many follow-up visits or treatment for certain conditions (e.g., mental health). One explained:

> *I love telehealth. I hope it doesn't go away. I think it's really value added for myself, my staff, and for patients. So there's a lot of convenience that's associated with that. There's often times where I'm usually running anywhere from 15 to 30 minutes behind schedule and my patients will be at work or be at home and they're able to do something. And so they didn't have to drive there and sit and wait in the waiting room and then wait for me to walk into the room.*

Clinicians saw the future of telehealth involving more remote patient monitoring. Several clinicians mentioned that they hope and expect to see more remote patient monitoring, which would facilitate care via telehealth. One clinician explained, "I think we still have a lot of opportunity with telehealth and the world that we live in. So glucometers, the readings, remote patient monitoring there's a lot of access to those tools. It's going to get more and more and more."

Clinicians reported several administrative and clinical issues that need to be resolved regarding telehealth care—including how to make sure appointments are scheduled in the correct mode—and whether and how to deliver critical results via telehealth. As mentioned previously, clinicians who **provide** care via telehealth reported that for most of them, patient choice dictated whether the appointment was going to take place in person or via telehealth. A minority described successful administrative policies or procedures to ensure that patients who needed to be seen in person were not engaging in a telehealth visit.

Responding to a discussion about the value of telehealth for delivering test results, one clinician raised the issue of delivering sensitive news via telehealth, and highlighted the need for clinical advice about when it is and is not appropriate to do so:

> *Before, let's say I did a procedure on someone, and then two days later we get the result that it's cancer. The patient has to ride three city buses to come back for that appointment. It's not really a phone call conversation. But at the same time, it's really cumbersome for the patient to come back in to just get those results. We're sometimes utilizing the telehealth for like delivering critical results. I would say, we're still trying to like figure out where it works. But unfortunately, I don't see doing away with it completely, even though there's the limitations just mentioned.*

Beneficiaries

Most beneficiaries fell somewhat in the middle, wanting telehealth as an option to supplement in-person care, but not replace it. When asked about preferences around telehealth use in the future and how they see telehealth ideally fitting into their health care landscape, most beneficiaries wanted telehealth as an option when they or their providers thought it was appropriate. As noted above, beneficiaries would like to continue using telehealth for reasons such as medication refills, follow-ups or receiving test results, for mental health care, or convenience—e.g., in case of bad weather, not feeling well enough to get to an appointment, or when worried about getting or spreading a communicable disease (e.g., COVID-19 or the flu). One noted, "I think it should be an option. From here on out. I mean, we [have] been exposed to it now. We were kind of forced to do it for a while. And just like wearing a mask, it's become our new normal." Another said:

> *I like having the option, because sometimes, like I said, I forget to make my ride appointment to—I mean write a reservation—and it's like, oh no. And then I really don't have to be here in person. I can talk to her…. And you can switch at any moment, it doesn't have to be like a day before, two days. You can do it that same day. You just can't switch back.*

Some beneficiaries expressed stronger views about how telehealth should and should not fit into the health care system moving forward. Those who were opposed to any telehealth cited the importance of the doctor being able to touch and physically assess them while providing care, while others noted issues with privacy: One person commented, “You want your body going over the internet? That’s what occurred to me.” A minority of beneficiaries believed that “it’s ‘the future’ of medicine” and that the proportion of care delivered via telehealth would only grow over time.

Organization of care

We asked clinician focus group participants a series of questions about the organization of medical care, including why they chose their specialties, the roles of physicians and NPs/PAs and how they work together, workforce shortages, how much of clinicians’ time is spent on administrative functions vs. patient visits, experiences with their practices being acquired by another organization, participation in accountable care organizations (ACOs), and quality reporting.

Professional decisions

We asked all clinicians in our focus groups why they chose their specialties. **A common theme among PCPs was the desire to build and maintain relationships with patients and families over time, and see patients of all ages** One said, “I love building relationships. I like knowing the families. It adds to the value of the relationships. I love continuity of care and just really getting to know people and establishing relationships over periods of time with them.” Another explained,

> *Primary care I think it's about relationships. I think it's the longer I do it, the more I love what I do. So I think the first year, two years, maybe three years of primary care are really tough. You haven't built relationships, but I think as you go on in time, it's a pleasure to see the same patient for the last 10, 15, 20 years. You can go in absolutely. You don't have to open up your EMR, you don't have to look at anything. Could you look and see Mrs. Smith and you know exactly what's going on, whether you see 10 members of their family, and it's really a pleasure to take care of people who value you and trust you over the continuum of time. I don't think you get that in many other specialties.*

A couple of PCPs contrasted their practice with specialties such as anesthesiology and emergency medicine where it is common to have only one encounter with a patient.

PCPs also cited the ability to manage all of a patient’s care and doing a little bit of everything as advantages of their specialty. One said, “And I like variety. That's why I chose primary care. I like doing everything. I don't want to get bored. I think you can in primary care.” Another explained, “I think I like all of the specialties a little bit, but don't want to do just one thing.”

Specialists provided a range of reasons why they chose their specialties. Several enjoyed seeing patients and cases that were focused or well defined, with concrete diagnoses confirmed by labs. One gastroenterologist explained, “And I chose my specialty because I don't want to have the guesswork. There's much guess[work] in internal medicine. I did it with the scope, take biopsies, do other things.” **However, other specialists enjoyed the challenge of diagnostics,** with one endocrinologist describing themself as a “detective” and another saying, “Chose the specialty because it enables you to become a diagnostician.” Similarly, a rheumatologist described their work as a “cognitive specialty” as opposed to a “practical specialty.”

Many specialists cited the ability to make a difference and improve their patients’ quality of life as rewarding. A cardiologist explained, “Not always but often you can come to a diagnosis with the right workup and really improve patients’ lives and kind of turn around their disease state. So, I find the work fascinating and fun.” **Another advantage described by specialists was the range of cases they saw**, ranging from simple to complex, conservative to operative, acute and chronic, and in settings including the office and the operating room. Some specialists also cited lifestyle as a factor that contributed to their professional decision-making. Finally, a few specialists described how their interests or previous experience, through research or personal history, led them to choose their specialty.

Among mid-level providers, a common theme included the desire to advance their careers and do something more meaningful, especially among those who had changed careers to enter nursing or medicine. **NPs described a desire to move beyond bedside nursing for a better lifestyle and less physically taxing role. Some were also interested in doing more diagnosis and management.** One NP explained, “And then after nursing I was like, I kind of want to get into more diagnosis and management than rather bedside care, so got into NP.” Another said, “I was a nurse and thoroughly enjoying it, but it does get a bit monotonous after eight years, nine years. And so diagnosis and treatment was so much more interesting.” **PAs described their profession as a shorter path into medicine than medical school,** which was especially relevant for those who pursued the career later in life. One explained, “By the time I decided to go into medicine, I was going to go to med school, and I was going to be really old when I got out, so I just decided to go and I wasn't a nurse at the time being a physician assistant was the best path to get working.” Another stated, “That’s part of why I chose PA, because it was a short time period that I’d have to go to school for. I was like 30 at the time, so the thought of medical school was a little too daunting for me.” One PA described the flexibility of the profession as an advantage, explaining, “And for PAs, being quite flexible and being able to change specialty and get on the job training, that was a pretty big win for me.”

Finally, several mid-level providers spoke about a desire to represent and serve their communities. One explained, “I just decided I wanted a career change and I wanted to help the underserved communities, because they need to see people like me who are like them, who can help them and not feel afraid to ask questions.” Another said, “I’m trans identified, and I noticed a lot of health disparities with that group. So, I wanted to mirror that. I feel like it’s so important. We need to have a shared identity between patients and providers, so I thought being a PA would really impact my own community. By providing primary care, it's so broad. You can always make an impact providing primary care."

Physicians: Working with NPs and PAs

We asked physicians whether they worked with NPs and PAs in their practice (Exhibit 9). The majority of physicians were working with NPs (70 percent) and PAs (65 percent), with a higher percentage among PCPs compared to specialists.

Exhibit 9. Physician Collaboration with NPs and PAs

	Work with NPs		Work with PAs	
	Yes	No	Yes	No
Primary care physicians	13 (76%)	4 (24%)	12 (71%)	5 (29%)
Specialist physicians	17 (65%)	9 (35%)	16 (62%)	10 (38%)
Total	**30 (70%)**	**13 (30%)**	**28 (65%)**	**15 (35%)**

We asked physicians what roles these NPs and PAs play in their practices and about their attitudes toward working with midlevel providers.

Physicians described several arrangements for the NPs and PAs in their practices. Some reported that the midlevel providers in their practice see their own patient panels. Several physicians described comanaging patients with midlevel providers. One PCP explained their approach: "So if [our PA] see[s] the patient once, the physician sees them next. We work together as a team, we communicate. If I'm not available, the PA's there. If he's not available, I'm there. We just take care of the patient together." A specialist described a similar arrangement in which care is transferred to the PA after an initial physician visit: "We alternate with them. The new patient appointment is with the doctor and then from whatever whim on our end, we book the follow-ups with the PAs to offload because otherwise we wouldn't have enough room in our schedules to see more new patients."

Some physicians were using midlevel providers for lower-acuity issues or for administrative roles such as phone calls and refills. One PCP noted the value of having these providers answer calls, explaining, "I think it's important that you have a clinical person doing the triage. They have a better idea of what's acute, what needs to go to the emergency room, what can be seen or what can wait. That's why they're taking more of the burden of calls."

In some practices, midlevel providers were handling urgent, overflow, or time-sensitive appointments such as hospital follow-up visits. Several physicians described midlevel providers' value in maintaining appointment availability and reducing wait times. One PCP explained, "They see a lot of the acute patients who need to be seen quickly. They're very competent and they function independently most of the time unless there's some question. But it allows our group to see more people and there be less wait time." A specialist described a similar approach: "We do have our PA that's available for urgent calls or easier kind of follow[-up] that does free us up for more of the complex care."

Several physicians reported that their midlevel providers provide certain types of care, with diabetes care commonly cited as an example. One specialist reported that their PA was seeing a lot of the "bread-and-butter patients" with conditions like "basic diabetes," and said that their NP also did a lot of diabetes management. One specialist explained, "Some of them have been doing diabetes as long as I have and they're just as good. The patients like them."

Physician perspectives on the value that midlevel providers bring to the practice varied. Some physicians described them as valuable extenders who help keep the practice moving. One specialist explained:

> *They're a tremendous help. And I think most physicians will tell you their most limited commodity is time.… The way I've worked it now, one of them is always with, well, they're in clinic with me every day so we can see more patients. So it makes more availability.… And they offload a lot of phone calls for me, which again goes back to the time commodity. So I think it doesn't generate income, but it's very helpful on both sides.*

However, physicians also described limitations in the abilities of midlevel providers and, relatedly, concerns about NPs and PAs functioning independently. Even while praising their midlevel providers, two specialists expressed doubts that they could ever operate comparably to physicians, with one explaining, "She can't make those higher-level decisions, even though she has been there for 20 years, and she's probably one of the smarter PAs around. She's not as efficient." Another said, "Ours [NP] works great for us, but there's no amount of training that would ever get her to the point where she can see complex subspecialty patients independently." Regarding practicing independently, one PCP said, "I don't think nurse practitioners should be having their own independent practices. I think working collaboratively with us is great, I support it 100 percent. I don't think they're trained well enough to have their own independent practices." A specialist summed up their concern in simple terms: "It's a huge liability. It's so scary."

Physicians cited midlevel providers' awareness of their own limitations and years of experience as important factors that contribute to these providers' success. One PCP said, "But he's [PA] great because he knows kind of his limit and if he has a question, he'll ask it, which I definitely appreciate. Not all extenders know that." Another PCP said, "I would say it's really variable. I work with one who is amazing. She knows what she doesn't know and she knows to ask questions, and I would send a family member to her. The other one, I would never send a family member to, and I think he doesn't know what he doesn't know."

For NPs in particular, physicians noted the difference between NPs with years of experience working as nurses vs. those who had only completed their studies and lacked practical experience. Some physicians raised concerns about large classes of NPs graduating from school with insufficient clinical hours, a change that one specialist attributed to loosening of training requirements during COVID, saying: “Unfortunately, licensing bureaus have cut down their requirements. They used to have 2,000 mandatory clinical hours. They cut down to like half of this, or less during COVID. And they have hyper-produced this huge amount of nurse practitioners with minimal training, minimal.” A PCP raised a similar concern about the number of NPs graduating from online programs without adequate clinical experience:

> *My issue with NPs now is they’re churning them out too quickly and too much. So I don’t have an issue with a nurse practitioner coming from a brick and mortar school.… I have an issue with these nurse practitioners who do these online courses… and they don’t have real world clinical experience and I’m hiring them. Taking care of my patients and they’re learning on the job. That’s a big issue I have.*

One PCP expressed concerns about the expectation that they refer their complex patients to midlevel providers who may be less experienced than the PCP:

> *I think it’s so variable.… Some of them are great. And some of them having been doing in their fields for years and I will reach out to them for help with problems, and the others, I feel, just started and they’ve been doing endocrine for three months and I’m supposed to be sending my patients that are too complicated for me to take care of to them, and they’re just basically telling me they run through everything through their attending.*

To address the need for on-the-job training among some midlevel providers, one PCP described how their practice onboards PAs: “[The internist] works with [PAs] for probably three to six months. He’s making sure that they’re comfortable with protocols and/or any weaknesses. And then after the six months, then they’re independent for the most part, and/or he’s available and the rest of the internists are available for questions.”

In general, physicians did not describe preferences or different expectations for NPs vs. PAs. As one specialist put it, “I agree with everybody that I don’t think for us it matters what the, whether they’re a nurse practitioner or a physician assistant. I think it’s the personality. Are they going to spend time with the patients?” One specialist described a difference in orientation between the two fields, with PAs more closely aligned to physicians: “There’s a dictum in medical school, doctors diagnose, nurses treat. And if you begin as a nurse, you kind of follow through with the mentality that you started with. And the PAs, I think received training or along the lines of what we’ve gotten.”

NPs and PAs: Working with physicians

We asked NPs and PAs about their roles and how they work with physicians. Similar to the approach described by some physicians, a few NPs and PAs described a collaborative model for treating patients. One explained, “I share my patient panel with my supervising physician. We kind of like work as a team. We like alternate and seeing the patients most of the time, like they see me, they see him, and they kind of go back and forth.” NPs and PAs described other types of engagement with their collaborating physicians, including asking questions or consulting on patients and undergoing required chart reviews on a regular basis.

Many NPs and PAs reported that they operate fairly independently. One NP explained,

> *In my place, we’re the same. There’s no difference. I have my independent practice, so we don’t have collaborators. You always feel like you’re on your own. There’s nobody that’s breathing down your neck. The physician that is there, she’s the nicest lady ever. I feel like she’s treating us NPs just like her. There’s no difference. Nobody is talking down to you. They don’t delegate anything. I feel like she treats us like equals.*

Another described a similar atmosphere in which midlevel providers and physicians work side by side: “They don’t say, oh, what’s the level of knowledge or acuity? Does this patient need to see an NP or a PA or is it more complex? No. It’s—there’s no, I guess, hierarchy in that sense.” Likewise, other NPs and PAs reported that the types of patients they see do not differ from those the physicians see: “We don’t cherry-pick one type of patient over the other. We just take whoever gets put on our schedule.”

In one case, a participant described challenges associated with being asked to manage patients who were too complex, caused in part by an influx of patients seeking psychiatric care in the primary care setting. They explained, “There’s new people like me who are newly graduated and don’t have 20 years of experience and are being asked to manage bipolar and schizophrenia.… There was a lot of pressure to see everything and see it quickly, and we all pushed back on that. All the PAs and NPs were saying we don’t feel comfortable doing this.”

Overall, NPs and PAs did not describe many challenges related to their scopes of practice. They noted a few specific limitations, including signing home health orders and ordering diabetic shoes. One described a requirement for the physician to see a Medicare patient at least once a year for any type of visit, even if the midlevel provider is designated as their primary care provider.

Switching specialties

Several PAs reported having switched specialties and described the ability to switch specialties as an advantage of their profession. One explained, “It’s nice that you can switch. We [PAs] take our certification exam and when we do that, you have to know all the areas. You still keep up. You still keep current, and you keep up with the latest or just the standard practices of care. So, you don’t lose it.” They said that as long as someone was willing to take the chance on hiring them, they could build on their training and gain the necessary on-the-job training to function in the new specialty. One explained, “PAs are trained as generalists, meaning that we know a little bit about a lot of stuff. The assumption is that if you’re bringing on a PA, they’ve got the foundation of knowledge, so they can build off of that.” Another said, “You can just switch, and you get a lot of on-the-job training and then once you feel competent, then you start doing a lot more independently. That was definitely what drew me." Among those who had switched specialties, several had switched from surgery to outpatient settings, citing work-life balance (better hours and flexibility) as a primary motivator.

The ease of switching specialties that NPs and PAs cited as a benefit to their career paths, however, was cited as a concern by physician focus group participants. One described a recent applicant who was looking to switch from neurosurgery to primary care, explaining, "That's nuts that you can just do that. It's not like I could go work in neurosurgery, I'd kill somebody, even if I wasn't doing the surgery. But the fact that they're able to do that—we had another NP at the hospital who switched from doing mostly transgender primary care to podiatry and it's just so weird to me."

Staffing shortages

Clinicians reported high turnover with medical assistants. This turnover was attributed to medical assistants finding other jobs that have higher pay and or getting an advanced degree to do higher-level work. One explained, "And I feel like the ones that are really good decide to go on and get their nursing degree because they, kind of, move on or they get promoted. Same with our front-desk staff, the really good ones."

Changes in productivity

When asked about changes in recent years in how their time is spent with patients vs. on administrative functions, the majority of clinicians reported an increase in administrative burden that either comes at the expense of time with patients or is added to it, and often is not reimbursed. One PCP noted that responsibilities of physicians have changed over time as they have been expected to take on increasing administrative duties:

> *I also think the health systems that have employed us have saved a ton of money because they've basically given us somebody else's job that they don't have to pay us for. Someone who used to do all that data entry, suddenly the doctors and PAs have to do it for free. So it's like taking a job that was done by two people and you do both, but we're not going to pay any more.*

One specialist explained, "There's no way to cut down or increase your patient time to make up for the other things that you have to do. You just have to keep sacrificing more and more of your 'me time.'"

Clinicians described increases in their time spent on detailed notes and documentation; communicating with insurance plans on issues including prior authorizations, denials, and changing formularies; and answering questions from patients in the patient portal. One specialist said,

> *I think a lot of unpaid work is what's been happening because direct patient care, you spend time in your office and you get reimbursed for. And then what happens on the back end with the*

> *prior [authorizations] and the phone calls and the MyChart messages and all of that. It has gone up tremendously. That burden has increased. I spend probably three hours each day after my workday. That is additional without any reimbursement.*

Clinicians often described their EHR as burdensome, noting that there are often specific requirements for which boxes are checked or what phrases are used that can affect whether treatment is reimbursed. One PCP explained, "Night and day we spend so much time documenting and quality measures and clicking boxes, and especially for the Medicare wellness exam. You have to check every single little box."

A couple of clinicians reported that they do their documentation after visits because of patients' expectations for engagement with their clinician during a visit. One specialist explained, "And so I add to my workday, like you said, I spend time with the patient and then I'll dictate my note after the course of the day. Because otherwise, you're losing out on that patient encounter that face-to-face, that rapport that you really need to have them buy into your treatment plan." A PCP also noted the importance of communicating with patients during visits: "It's a lot of paperwork, referral, and notes.... It's time consuming. I particularly don't have time to do this during the visit, I need to talk, otherwise patients tell me, 'You don't see me. You look at the computer all the time.'" One PCP cited EHRs as a reason burden has increased: "I'm going to blame this all on electronic medical records, too. You spend less time talking face-to-face with the patients. I've worked it so that I can see them and sort of input my data at the same time, because it's very important to see how they interact, how they react. But I'd say I spend less time, because I have to do more paperwork."

Clinicians' experiences with changes in the number of visits over time varied, with some clinicians reporting more visits, some fewer visits, and some reporting no change. Regarding the length of visits, some clinicians described spending less time with patients because of the need to spend more time on documentation, whereas others described an increase in visit lengths as patients bring more medical concerns to a single visit. One specialist provided an example: "[They] want to discuss their other health issues. You're seeing their asthma, and today the man wanted me to discuss his heart and look at his rash on his knees."

Practice acquisition

We asked focus group participants about their experiences with their practice being approached or acquired by organizations such as a hospital system, private equity firm, or venture capital company, and what factored into their decision-making.

Clinicians whose practices had been acquired by larger organizations described financial challenges associated with operating a solo or small practice as the primary reason for the decision. As one PCP said, "I was part of a small practice, maybe about five to six doctors. Our overhead was really—It was difficult. We had to cover insurance. Not only our insurance, but the office's insurance, office workers, just overhead was so high that when this other group came to acquire

US, it did seem like a lifeline. I guess that was sort of a positive, because if not, we would have had to make hard decisions." A specialist explained, "So the reality is like it was said earlier, private practice, regardless of specialty, is a year-over-year mounting challenge.… From a financial standpoint, having the backing of the health system made it financially better for us." Another specialist, whose private practice is part of a large management group, explained, "We saw the benefit because as a lonely, tiny practice in the sea, we can't go to every insurance company and fight for a rate. We don't have any bargaining power and it's time-consuming. We don't know what we're doing."

A few participants noted that approaching retirement age contributed to clinicians' willingness to sell their practice. One PCP who is working in the practice he sold explained, "My partner and I got old and we were [in] private practice. And my partner said, I don't want to work [so] hard anymore. And I said, I do. And so we sold, we just, we reached [our] late sixties and, and we thought that was our best [option]." A specialist whose practice had considered selling but ultimately decided not to explained:

> *We were approached by several private equity firms, all private equity, no academic, and we seriously entertained the idea. We had two retiring partners who wanted a golden egg buyout before their retirement. But we ended up not doing it ultimately and remaining independent. However, we're faced with rising overhead costs, so kind of how do we maintain our salaries and our income and our lives?*

Concerns about being acquired included losing autonomy and being held to unrealistic productivity standards. One specialist explained,

> *The sense is you're going to lose autonomy. Medicine's a business. There's no doubt about it. There's a profit and loss, but we don't like to see it as business. And then when you get bought out by a venture capital or when you get absorbed by a large health care system, then you're accountable to that, especially when they become majority owner. So, you take a bit of—you get an initial payout, but then there are strings attached to that.*

Another specialist described similar concerns: "And they wanted to tell us how to practice medicine and that those were some of our concerns, was how much are your businesspeople changing the way the physicians practice medicine and there were many examples of you can't do that. You can't do that." Regarding productivity, one PCP explained their decision to leave their former practice after it was acquired by a large, multispecialty group that operated in three states: "I was working hard. I even showed them that my RVUs [relative value units] were up. But they set certain standards, where even though my RVUs are up, they weren't up enough to stay where I'm at. And that meant a cut. And I was just frustrated with that." A specialist described similar concerns: "They say we're going to streamline that, we're going to take over all those things. But none of it looks appealing and it gets you into these RVUs and I've already been there and I've tried that and it was miserable. It was not a sustainable model for me personally."

Guidance from health plans

When asked about guidance received from Medicare Advantage plans, clinicians described minimal communication with plans, noting that sometimes they received information on care management, prior authorizations, appeals, or utilization trends.

Accountable care organizations (ACOs)

We asked clinicians whether they were familiar with the concept of an ACO, whether they had been approached to participate in an ACO, and whether they were currently participating in one (Exhibit 10). Less than one third (29 percent) of clinicians were participating in an ACO.

Exhibit 10. ACO Participation by Clinician Type*

	Yes	No	Unsure
Primary care physicians	9 (53%)	3 (18%)	5 (29%)
Specialist physicians	5 (19%)	14 (54%)	7 (27%)
NPs and PAs	4 (20%)	8 (40%)	8 (40%)
Total	**18 (29%)**	**25 (40%)**	**20 (32%)**

*Totals may not match the total number of clinicians due to some participants selecting multiple responses.

Most clinicians were familiar with the concept of an ACO, but fewer than one-third reported that they were participating in one. When asked about the decision to participate, several clinicians said that the decision was made at the corporate level. One explained, “They made the decision, I had no part of it. And I don’t know the details of it.” Others described motivations including profit and negotiating better rates with insurance companies as a group with different specialties. One specialist reported that the decision was driven by the desire to not lose patients: “We knew we’d lose probably 20 percent of our patient population, because there’s a lot of [organization] patients in the area.… If we didn’t join [organization], they would all go to the other group. We wanted to kind of stay in the game, for those patients.” One clinician described the decision to participate as being motivated to learn how to do value-based care, which they described as “the future of health care,” so that they would not be negatively affected in the future.

When asked about the impact of participating in an ACO, clinicians described benefits including better access to information, improved care coordination, and changes to coding practices. One PCP explained, “What the ACO model does is it provides you with information, it provides you with technology support. It provides you with assistance.” Another PCP said, “What I like about it is the back-end data that we get about patients and the ability to get data.” A third PCP said, “Before an accountable care organization, I didn’t know how many patients I had with diabetes. I mean part of it’s EMR, part of it’s having a data analytics now that we didn’t have back then, we just did paper charts that were sitting in some cabinets. But now I can tell you how many are controlled, who needs to come in, who hasn't been there." As one NP/PA put simply, "The ACO pretty much tells us how to chart, essentially." A primary care physician explained:

> *We're kind of able to identify and code properly the sicker patients. Able to provide services to them. And you know we are also moving from volume to value, which is—now we are trying to spend more time with a particular patient rather than just keep running them like clockwork. So definitely it's given a big change with the ACOs. So I think it's made us more efficient. I don't think it's changed the way we practice medicine because I think we were all good doctors, I don't need an ACO to tell me how good. I think they provide tools that make me, they provide me data and information that I wouldn't have otherwise known, but I don't think it's changed the way we practice.*

Regarding impacts on practice, one NP/PA said, "It has helped coordinate care, I can tell you that, it has … helped with meeting criteria for certain screenings or certain ages and just transitional care." A few clinicians reported that their referral patterns had changed as a result of being in an ACO, as they referred within the ACO. One PCP explained, "I hate to say it, but it does change my practice. I mean we get bonuses for mammograms and colonoscopies, so I'm really pushing people to get the mammograms and the colonoscopies."

Some clinicians saw the ACO as an opportunity to demonstrate their value and be rewarded for it. One PCP explained, "If we work hard, provide metrics, show that we're doing a great job, getting our annual wellness visits in, keeping them out of the ER and the hospital, hopefully we'll make retrospectively, some shared savings. And I think that's better than not having any opportunity to have shared savings for the good work we're already doing anyway." Another said,

> *We are undervalued and this is a way that we actually get to show some value. I really appreciate knowing my population.… And getting paid for that work and understanding it—I love it. I think it's great. I love the care management aspect of it. I love the different things that it has brought to us that has given us some of these different tools that help as far as our patients.*

Several clinicians reported that they had received financial bonuses as a result of being in an ACO.

Quality reporting

Clinicians were mixed on whether they think measuring quality improves quality of patient care. Some clinicians thought that the metrics they report on do improve quality by keeping important factors front of mind. One said, "It improves, because at least it keeps it in the mind whether the catheters, whether all that stuff, and you're putting the rating of hospitals, rating of practice, rating of everything. This is improved care." Other clinicians said that the measures do not have an impact on quality, or only impact what is being measured. One explained:

> *Thirty-day readmissions for heart failure. Big one, hospitals get dinged. Provider level will get dinged. And so hospitals over the past several years have put in a lot of money into decreasing your 30-day readmissions, opening up heart failure clinics, paying nurses to go to the house, etc. But they don't, most patients, most people, most hospital centers don't care what happens on day 31. So, the 6-month readmission rate hasn't changed in the country in years, but the 30 days has certainly gotten better.*

Other clinicians reported that the measures do not take individual-level factors into account, with one saying, "And the other thing is standards, that there's, the government, well if you're over 80 you shouldn't have a colonoscopy. Or you shouldn't have a PSA level - a man. Well, if you're a healthy 80 you're damn right you're going to get one, and if you're a healthy man who's 80 you're going to get a PSA level."

In some cases, clinicians reported that it is common practice to "polish a chart" to ensure that a practice is hitting their quality measures: "They'd find like 10 people I didn't do anything about smoking, they let you go back in and change it. You don't have to call the patient.… People basically go back and polish up the charts. And everybody pretends like that doesn't happen, but it's true. It happens all the time."

Clinicians reported feeling penalized by quality metrics for patient actions that are out of their control. Several clinicians reported that the quality measures they report on assess actions taken by their patients that they have no control over and that the clinician gets "dinged" for the patient action (or lack of action). One said, "They're good measures but the way they're measured is the frustrating part. So classic example is I get penalized when somebody doesn't do a colonoscopy even though I've told them 5,001 times to do it. So yeah, so that's where it's frustrating."

In some cases, these measures place extra burden on already stretched clinics, such as federally-qualified health centers (FQHCs). One clinician stated:

> *So same issue, I cannot, who is going to chase down their eye reports? Who is going to do that? Who's going to chase down their podiatry? Who is going to go and call, did you get your colonoscopy? Did you get your colonoscopy? Mammograms are pretty easy, more people are willing. But that's it. And I understand our medical director will be like well, you're measured against other FQHCs. And that may be true. But I think it's a poor measure of what we do.*

In some cases, clinicians said they observed quality measures that were at odds with delivering efficient patient care that is covered by insurance. One explained, "They're like opposing factors. They want them to be under control, but then they also want you to use more generics. And, unfortunately, a lot of the newer diabetic drugs aren't generic. And actually, some of the older drugs, I think they're more harmful than helpful."

A few clinicians reported that reimbursement for reaching quality measure goals was meaningful for their practices. One said, "The drug medication reconciliation, you've got to do every single visit, check off this box. You got to have like 100% compliance, there's no wiggle room.… It takes a lot [of] extra time. But I do it for that 2.1% raise." Another reported, "We get a bonus if we meet our quality standards as an organization. They'll pay out a big chunk of change."

Prescription drugs

We asked beneficiaries to rate their prescription drug coverage (Exhibit 11).

Exhibit 11. Part D Ratings by Source of Coverage

Coverage Rating	Medicare-Only Beneficiaries		Dual Eligible Beneficiaries	
	Count	Percent	Count	Percent
Excellent	30	44%	25	48%
Good	33	49%	20	38%
Fair	5	7%	7	13%
Poor	0	0%	0	0%
Total	**68**	**100%**	**52**	**100%**

Most beneficiaries rated their plan as excellent or good. Ninety-three percent of Medicare-only beneficiaries and 87 percent of dual eligible beneficiaries rated their plan as excellent or good. No beneficiaries rated their plan as poor in either the Medicare-only or dual eligible beneficiary focus groups.

Those who rated their plan below excellent cited a number of issues with their coverage, with cost being the most common issue. Several beneficiaries cited the high cost of prescription drugs or hitting the "donut hole" as the rationale for their lack of satisfaction with the prescription drug plan. One said, "I have one drug, one of my diabetic drugs that is ridiculous. When I had private insurance, it was $25 a month. Now with Medicare it's $150 a month."

Another issue that beneficiaries cited was coverage of particular drugs. Some beneficiaries noted that some of their prescriptions were not covered by their plan, with one explaining, "My prescription drug plan really doesn't cover all of my medicine. Some of my stuff they won't even pay for.... As far as dermatology cream and stuff, one of them costs like $300 or $400." Others noted that they were frustrated when coverage of a specific prescription "ping-ponged" year to year (going from being covered to not being covered, to being covered again): "I was taking one inhaler for a while and then they said, 'We're not carrying that anymore,' and gave me another one. Then now we are back to the old one."

Finally, some beneficiaries cited customer service as their largest issue with their drug coverage. Beneficiaries cited having to make multiple calls or spend long periods of time on the phone, trying to find out coverage information. One said, “You call. You have to make four to five calls before you get somebody who’s knowledgeable, and that takes a large chunk out of your day. Even though I don’t work, I don’t want to spend all my time on the phone.” Another stated, “Yeah, it just really, it’s the hardest part for me. I like the other aspects of Medicare, like being able to see really great doctors in Chicago, but I don’t like all the—they just don’t cover a lot of drugs for me.”

Drug costs—beneficiaries

Several focus group participants reported not taking prescription medications or taking them less frequently than prescribed to stretch out a prescription fill, due to cost. One beneficiary reported, “I went to Giant to pick up the first—the first two prescriptions, they gave me a discount card. So I only paid maybe $20. But when I went to pick up the third month, and Giant said it was $380, I said, ‘You can keep it.’ I'll have to deal with my dry eye and use over-the-counter stuff.” Specifically, beneficiaries reported not paying for prescriptions if they were quality-of-life medications. “I stretched the medication. It’s not a life-threatening; it’s a quality of life.” Several beneficiaries reported being unable to afford their prescriptions once they hit the “donut hole” and chose not to take their medication until the following year. “My COPD [chronic obstructive pulmonary disease] already went up $47 a month, but right before the end of the month I had to get refilled again and they said now I’m in the donut hole so I have to pay $125. I didn’t even get it. I just waited until the end of the year.” In some cases, beneficiaries were able to negotiate another option with their clinician, such as taking a generic.

A few beneficiaries reported a change in their prescription costs in the middle of the year, but experiences were mixed on whether the costs went up or down. One beneficiary reported “Yes, mine just changed recently in the last couple months because before I was paying out of the pocket a cost. So now it’s no cost.” These changes often took beneficiaries by surprise, as another said, “That’s a big problem is communication between us and like when they change something—with mine I had no idea. I was so mad.” When costs went up, beneficiaries reported frustration with the change, with one commenting, “When you’re used to getting them for free or cheap. You could be kidding. I paid for it anyways because I needed it.”

Beneficiaries reported both their clinicians and pharmacists providing ways to reduce prescription drug costs. They described how clinicians provided them with coupons, free drug samples, and/or connected them directly with the drug manufacturer. One explained, “And I talked to the doctor, and he told me to call the manufacturer, and you could get it for free.” Beneficiaries also described how pharmacists provided them with coupons or information about using discount cards, such as GoodRx®. One beneficiary said, “I know in the past I’ve—this was like free Medicare—that I’ve had the pharmacist, when you’re lucky and you get a patient one. They’ll go through a whole bunch of terms with you, till they find a good price for you.”

Drug costs—clinicians

Clinicians reported frequently discussing the cost of prescriptions with their patients. Clinicians reported that they talk to their patients about the cost of prescription drugs “a lot” and with “almost everyone.” However, they reported that even if they know how to reduce the price of a prescription, they often do not have the time to walk through the information with their patients, with one explaining, “Because it’s just easier to let them do some of the legwork than to—I mean it would probably take me 15 minutes to show somebody where to go get their medicine and how to save money, and to know if it's covered. But it’s 15 minutes per medicine per patient.” However, clinicians still worked with their patients on strategies for reducing costs. One said, “If I suggest something and then they’re like, oh, no, I know that’s not going to be covered. Or, while I’m in the office, can I check and see what it’s going to cost me. I can’t tell you how many times I say, well, let’s check GoodRx® also.”

Clinicians reported that they usually do not know what the cost of a prescription will be for a patient. Several clinicians reported that information about the out-of-pocket costs that beneficiaries pay for prescription drugs is a “black box.” One said, “The only way to ever know is for me to prescribe [a drug] and see what happens when you try to pick it up.” In some cases, clinicians coach their patients to call their insurance companies and find out what is covered. One clinician noted that they “coach them to call their insurance company and find out what’s on tier and what are the alternatives. What are the brand names and what are the generics.”

Discount cards

Many beneficiaries reported using some sort of discount card, most frequently GoodRx®. Beneficiaries reported significant savings from using GoodRx®. One said, “And it could be $50, but the GoodRx® makes it $6.” Overall, beneficiaries were happy with discount cards. They reported using discount cards for prescriptions that they take on a regular basis as well as short-term prescriptions. Aside from GoodRx®, several beneficiaries reported using Mark Cuban’s Cost Plus Drugs program to save on out-of-pocket spending on prescription drugs.

Many beneficiaries reported shopping around at pharmacies to find the best price for a prescription. Some beneficiaries reported doing this on their own, whereas others described how a spouse or caregiver helps them with comparing prices. One explained:

> *What I’ve done is I’ve gone actually online to CVS and Walmart and pulled up whatever medications I was on and saw the pricing that each one of those, because those are the two closest to me. And OK, depending on who had which price, that’s the way I went. And they said if I had gone to CVS, it would’ve been something like, not exorbitant amount, like $20 a month with Walmart, it cost me $10 for three months. Huge difference.*

Another reported, “All my drugs that really matter are free. But I take some drugs that prescribe for my dermatologist, and for some reason they’re not covered at all. But you can hunt ... [to] find that the best discounts, and they’re relatively very reasonable if you use the right card.”

Some beneficiaries reported confusion about discount cards. Some beneficiaries thought they were ineligible to use a discount card because they had insurance coverage. One said, “I was told you can’t use it if you have insurance.” Other beneficiaries reported that they use insurance for some prescriptions, and a discount card for others, with one explaining, “I use GoodRx ® only because the particular prescription that was prescribed was very expensive through insurance, so I got it cheaper through GoodRx ®. I didn't have to worry about insurance. I mean, it didn't matter.” Others wanted more information on how to use this type of discount card: “I wish they would offer you more information on how to use it. Because do I need a separate prescription? I assume there’s going to be times where something might be less expensive.” Another beneficiary reported concerns about the GoodRx® business model: “That was my concern why I never tried it because I don’t know, I felt like there must be some kind of gimmick to it.”

Reviewing and deprescribing medications

Many beneficiaries reported initiating conversations with their clinicians about reducing their number of prescription medications. In some instances, clinicians initiated the discussion. Beneficiaries reported the cost of prescription medications, side effects of their prescriptions, poor drug interactions, and feeling that they were on too many medications as reasons for wanting to take fewer medications. One explained, “I was having some bad side effects with one of my medicines and I just—it was real bad. Really, really bad. And they just keep throwing meds at you. I’m like, don’t do that to me anymore.”

Beneficiaries generally had positive experiences with these discussions, but some had mixed results. One beneficiary reported, “I talked to my PA who was treating me and said, take me off this, take me off this, take me off this, and it’s been great. Actually been doing really well.” Another beneficiary reported that they believed that a doctor took away a necessary medication as part of deprescribing:

> *He took away the medicine I was supposed to be on the rest of my life, because he doesn’t know me. I said, “Well, I have to have that.” He had to reinstate it. I had to go through an issue of putting messages in the portal, and threatening to report him if he didn’t give me my medicine back. He just didn’t know me to be able—I had just started with him.*

Another beneficiary reported that he raised concerns about side effects of his medications, and his doctor responded, “Well you know, [name], even aspirin has side effects.”

Several beneficiaries reported that their clinicians had not adequately identified or discussed drug interactions with them. In one instance, a pharmacist caught an interaction that a clinician did not: “My pharmacy caught one, like, the interactions with my medicine. [They said], ‘You know, you’re not supposed to take these two together. You’re not supposed to have this with this.’” Beneficiaries reported doing their own research on interactions to feel safe; as one reported: “There’s several websites that you can put in your medicines, and it’ll come back and tell you if they interact and on what level, … but it's out there and I found it very useful. And I had to bring it forth to the doctor but I don't think that's enough where, some doctors do and some doctors don't look for side effects interactions."

Many clinicians reported cases when they had deprescribed their Medicare patients' prescription medications. Beneficiaries frequently reported wanting to be on fewer prescription medications. Clinicians also described working with patients to reduce the number of prescriptions when appropriate, but acknowledged that this can be challenging or not clinically indicated for patients with chronic conditions on multiple medications. In these cases, clinicians found it helpful to have all of the medication information in one place, such as an EHR when deprescribing, with one explaining: "I do medical reconciliation. I guess that's the one good thing about our EMR, is that we can put everything on one page, and I'll just go over it with the patients, and I'll click, 'You shouldn't be taking this.' But let's say they have 12 medicines, you can stop two."

Clinicians reported that deprescribing can be a time-consuming process and noted the importance of coordination between a PCP and specialist when deprescribing. They noted that deprescribing is more difficult for patients with multiple comorbidities. One explained:

> *Well, I just think it's hard because we have ... guideline-driven care, and so if someone has diabetes and hypertension and heart failure and you know some CKD [chronic kidney disease], suddenly you know there's just a lot of meds. And so, patients will come sometime and they're like I'm tired of taking all these pills. It's hard to figure out like which ones you can get rid of. I mean sometimes we can and there's stuff we'll try to get rid of but oftentimes it's really tough.*

Access to prescription information

Many clinicians reported being able to access their patients' prescription-filling information. Some clinicians reported only seeing prescription fills and do not have access to a full list of what was prescribed in their EHR. One explained, "But in all fairness, you see what's filled. You don't see what's prescribed. If they went to pulmonary and they got a TRELEGY [fluticasone, umeclidinium, and vilanterol] prescription, and they never filled it, I will never know." Although clinicians acknowledged that this is not a perfect system, they reported that it is better than nothing. Clinicians whose patients are all in one health system reported having comprehensive access to what drugs are prescribed and when and how the prescriptions were filled. Clinicians also reported asking beneficiaries directly about the prescription medications they are taking. One said, "I periodically ask them to bring in medications, if they're older Medicare patients, 'Bring me your pill bottles, make sure that you take them right,' so I know that they [are taking their prescription drugs]." The majority of clinicians also reported asking about over-the-counter drugs when discussing medications with their patients.

Some clinicians have access to formulary information, but noted that it is not always accurate. One said, "Our EMR is supposed to be showing us what's covered, but I feel like it's wildly inaccurate." Clinicians reported that the best way to find out about coverage for patients is to call a pharmacy. Sometimes, clinicians have the pharmacy do formulary checks for their patients. One explained, "You give them more than one [prescription] and have them do a formulary check at the pharmacy."

Clinicians cited frequently changing formularies or patients switching insurance plans as some reasons for inaccurate formulary information.

Pharmaceutical representatives

Some clinicians in our focus groups reported allowing pharmaceutical representatives to visit their offices and described the value in receiving samples of prescription drugs and information about discount programs from them. One explained, “They bring us lunch. And samples. And [discount] cards. That’s very helpful, for especially Medicare patients. I find it very helpful.” Others did not have drug representatives visit their practices. One said, “I was in private practice, internal medicine for a year prior to this job. And same, it was like we had a cabinet full of samples from drug reps that would come and bring us samples [every] week… but in [practice name], we don’t have any drug reps.”

Biologics

Specialists and other clinicians who were prescribing biologics described an often multistep process. Clinicians reported that they often have to prove to an insurer that the biologic is the only option after trying several other drugs that have not worked. Even after going through this process, it is not always guaranteed that biologics will be covered. One clinician explained, “We have a horrible time with Dupixent® [dupilumab]. Medicare doesn’t want to cover Dupixent®. You’re having to prove they’ve failed this one and failed this one and failed this one. I turn a lot of my patients to the manufacturer programs to get that covered, because it’s just so hard.” Because of the process of prescribing biologics, some clinicians reported hiring a staff member whose role it is to coordinate biologics prescribing between insurers and patients; one clinician referred to their “biologics coordinator.”

Clinicians saw biologics as very effective treatment for certain chronic diseases. One stated:

> *I can’t remember the last time I had an asthma or COPD admission. And why is that? Because of Breo [fluticasone furoate/vilanterol] and TRELEGY. I haven’t had a PE [pulmonary embolism] patient forever because of Eliquis® [apixaban] and stuff like that, but nobody made the connection, and say, “You know what? This drug is expensive, but it’s keeping people out of the hospital.… Their $200,000 ICU [intensive care unit] stay is going to hurt Medicare also, so pay for the drugs.*

Clinicians described finding workarounds to help get their patients access to biologics. For example, one explained, “I discovered if [biologic] doesn’t get covered by a Part D plan, then I have to send them to the infusion center to get [it] under Part B.”

Clinicians generally described biosimilars as “filling the gap” rather than replacing biologics. Some clinicians, specialists in particular, expressed hesitation about switching from biologics to biosimilars, because they do not see them as effective. They reported that insurers push biosimilars because of their lower cost compared to biologics. One clinician explained, “[Biosimilars are] essentially being forced upon [us] by the insurance company because there’s such a big price differential.” However, some clinicians acknowledged that biosimilars are “better than nothing.” NPs and PAs were more open to prescribing biosimilars, with one explaining, “if [a biologic] is not being covered and it’s onerous to the patient to pay, then [a biosimilar] is worth a try.”

Electronic prior authorizations

Most clinicians were using electronic prior authorizations and prefer them to traditional prior authorizations. Clinicians reported that they themselves typically do not work on prior authorizations, but that their practices have medical assistants who do and believe the process is more efficient for their office. One explained, “I think it’s more rapid. I think we got a quicker response, but it is very time consuming, and I have my system do it, or the triage, or the nurse practitioner.”

Mail-order pharmacy

Many beneficiaries reported that they had tried a mail-order pharmacy, although some had reservations about them. Most beneficiaries who had used a mail-order pharmacy saw them as a net positive. Beneficiaries cited convenience, low cost, and the automatic nature as the biggest benefits. One said, “Well, it’s easier, especially if you have automatic refills. You don’t have to think about it.” Other beneficiaries discussed how they were uncertain at first regarding mail-order pharmacies, but now they like the option. One explained, “I was a little apprehensive at first; I just started about a year ago.” Other beneficiaries described mail-order pharmacies as reducing the burden on themselves or family members in getting to and from the pharmacy on a regular basis. One said, “It makes it easier for me because I’m always asking my sisters to take me to Walgreens. They sit out in the car just like, why do you take so long? It’s the line is long.” Notably, most beneficiaries reported only having one option for their mail-order pharmacy.

Beneficiaries who had concerns about mail-order pharmacies cited the possibility of the package getting lost in the mail or someone taking the package. One said, “No, that’s not worth it coming in the mail, to me.” Another drawback cited by beneficiaries was the lack of connection with a pharmacist. Finally, other beneficiaries who had concerns noted that they had received prescriptions before they needed a refill from a pharmacy, with one explaining, “They’re actually a little too ahead…. ‘We’re going to send you this,’ and I’m not even ready for it. I accept it anyway, because they mail it to you.”

Specialty pharmacy

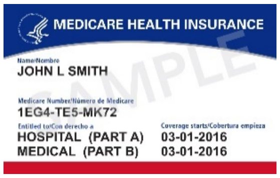
Very few beneficiaries reported using a specialty pharmacy, but those who did had positive experiences. The beneficiaries who used a specialty pharmacy felt that they received a very individual level of attention, with one noting, “So they’re wonderful. They know me.” Those who used a specialty pharmacy had the option to use a mail-order pharmacy but were hesitant because they were told they would be responsible if a medication got lost in the mail. One said, “I learned if it gets lost, I have to pay again, and they would be sending three months’ worth. At that time through my employer, I think it was about $150 for a months’ worth.”

Appendix I

What kind of insurance coverage do you have? [choose one]

☐ Medicaid and Original Medicare

- You likely have more than one insurance card.
- You can get Part D prescription drug coverage separately.
- You can see any provider.
- You probably use more than one card:



MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a	Coverage starts/Cobertura empieza
HOSPITAL (PART A)	03-01-2016
MEDICAL (PART B)	03-01-2016

SAMPLE

Part D
drug plan

☐ Medicare Advantage and Medicaid

- Private plans that take over administering all of your Medicare benefits as long as you're enrolled, including prescription drugs.
- The plan might offer additional benefits (e.g., eyeglasses, dental cleanings, gym memberships, transportation to doctor's appointments).
- You have a limited network of doctors that you can go to.
- Examples in your area include: Wellcare Dual Access Open, United Health Care Dual Complete, Aetna Medicare Dual Preferred Plan, and Cigna TotalCare.

How would you rate your insurance coverage overall?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

How would you rate your prescription drug coverage?

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you had an audio or video telehealth visit with a health care provider this year?

☐ Yes ☐ No