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# Beneficiary and Clinician Perspectives on Medicare and Other Issues: Findings from 2025 Focus Groups in St. Louis, Missouri, and 2021–2025 Rural Focus Groups

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

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

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NORC at the University of Chicago

**FINAL REPORT**
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# Beneficiary and Clinician Perspectives on Medicare and Other Issues:

## Findings from 2025 Focus Groups in St. Louis, Missouri, and 2021–2025 Rural Focus Groups


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# Executive Summary

## Methods

In April and May of 2025, NORC at the University of Chicago (NORC) and the Medicare Payment Advisory Commission (MedPAC) conducted eight focus groups with Medicare beneficiaries and clinicians. Beneficiaries included those with only Medicare coverage (divided into separate groups based on enrollment in traditional Medicare versus Medicare Advantage (MA)) and those eligible for both Medicare and Medicaid (dual eligible beneficiaries). Clinicians included primary care physicians, specialist physicians, and nurse practitioners (NPs). We aimed to recruit mixed advance practice providers practicing in both primary care and specialty settings (nurse practitioners and physician assistants), but only nurse practitioners responded to recruitment outreach.

In this report we summarize findings from eight focus groups completed in 2025: seven in-person groups in St. Louis (n=29), and one virtual focus group with Medicare beneficiaries residing in rural areas across the United States (n=7). In total, 19 Medicare-only beneficiaries (about equal share enrolled in traditional FFS and MA), 10 dual eligible beneficiaries, and 20 clinicians participated in the focus groups. To provide additional perspectives from rural beneficiaries over time, we compile findings from 13 focus groups with 74 Medicare beneficiaries residing in rural areas between 2021 and 2025.

Due to the nature of focus group research, our sample was limited in number and is not representative of Medicare beneficiaries or clinicians in the location where we conducted this research. Therefore, findings cannot be generalized either to the studied community or to the nation as a whole. The benefit of the qualitative approach is that it allowed us to ask questions with answers that cannot be easily put into numbers to understand experience. In addition, it allowed us to understand the “how” and “why” of experiences, including deeper understanding of experiences and context, and provided personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

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

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

# Key Findings from 2025 Focus Groups in St. Louis

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

## Choosing Coverage

### *Understanding Medicare and Plan Choices*

- Most of the Medicare beneficiaries in St. Louis we spoke with described being confused about their Medicare coverage options.
- Some participants described receiving an overwhelming amount of information from insurance companies, especially during open enrollment. Many beneficiaries relied on various sources and help to learn about their Medicare options.
- Several St. Louis beneficiaries used Medicare.gov to review plan options, but few fully relied on it to choose a plan. Most participants had never heard of the State Health Insurance Assistance Program (SHIP) or reported vague familiarity.
- Several beneficiaries sought help from health insurance agents or brokers. Most beneficiaries who used brokers describe receiving multiple plan options from different insurance carriers. Beneficiaries reported that brokers tailored plan suggestions based on their individual health needs, especially medications and clinician preferences. Most beneficiaries reported checking in with their broker annually during open enrollment to reassess their plan.
- Some beneficiaries questioned how agents and brokers are compensated by insurance carriers but most felt their brokers still acted in their best interest.

### *Factors That Affect Beneficiaries' Choice of Coverage*

- Beneficiaries in St. Louis who chose MA mentioned cost as a driver of their decision. A few beneficiaries chose MA because of the supplemental benefits not typically included in traditional Medicare. Several beneficiaries heard about the benefits of MA through friends who had positive experiences.
- Some beneficiaries in St. Louis chose traditional Medicare over MA because they wanted unrestricted access to clinicians, at the advice of their clinician, or due to cost. Other participants had access to high-quality supplemental coverage through former employers, which required them to choose traditional Medicare. Several beneficiaries who chose traditional Medicare cited negative perceptions or experiences with Medicare Advantage.
- Though not a major factor in choosing a plan, a number of beneficiaries enrolled in MA reported receiving in-home health assessments or visits.
- Many dual eligible beneficiaries in St. Louis described the importance of extra benefits not typically included in traditional Medicare, such as flexible-benefit spending cards, vision and dental coverage, when choosing a MA plan. Direct outreach from MA plans influenced plan selection among some dual eligible beneficiaries.
- Several dual eligible beneficiaries with complex health care needs consulted clinicians or other social service professionals about their Medicare options.

- Dual eligible beneficiaries mentioned reliability and low out-of-pocket costs as priorities when selecting their coverage.

### *Satisfaction with Overall Health Care Coverage and Prescription Drug Coverage*

- Overall, beneficiaries who participated in focus groups are satisfied with their Medicare coverage. Eighty-six percent (n=25) of beneficiaries in St. Louis rated their overall health care coverage as good or excellent, including eighty-four percent (n=16) of Medicare-only beneficiaries and ninety percent (n=9) of dual eligible beneficiaries. Fifty-eight percent (n=11) of Medicare-only beneficiaries[1] and all dual eligible beneficiaries (n=10) in St. Louis rated their prescription drug coverage as excellent or good.

### *Switching Plans*

- Three beneficiaries in St. Louis had switched from traditional Medicare to MA, citing reasons including receiving direct outreach from an insurance carrier and perceived affordability.
- One St. Louis beneficiary reported switching from MA to traditional Medicare and another beneficiary switched between MA plans.
- One St. Louis beneficiary with traditional Medicare described switching supplemental plans each year in search of the lowest premium.

## Access to Care

### *Clinicians*

#### *Acceptance of Patients and Insurance*

- The majority of clinicians in St. Louis were accepting new patients, including new Medicare patients. Most clinicians reported accepting MA plans.
- Clinicians in St. Louis reported wait times ranging from a few days to a few months when seeing new patients. Primary care physicians and nurse practitioners were more likely to report an ability to see new patients quickly, while specialists reported varying and longer wait times for seeing new patients. All clinicians reported shorter wait times for established patients.
- Clinicians reported different experiences on whether they consider a patients' insurance coverage before recommending care. Some clinicians reported making decisions based on medical need rather than insurance coverage and described the challenges of working with many different insurance types. Some specialist clinicians reported needing to consider a patient's specific MA plan's coverage when making decisions.
- Clinicians reported some issues working with MA plans, including challenges with prior authorizations and denials for certain care.

[1] One fee-for-service beneficiary did not rate their prescription drug coverage.

### *Beneficiaries*

#### *Access to Primary Care*

- All St. Louis beneficiaries had a primary care provider they saw regularly. A handful of beneficiaries reported having to find a new primary care provider recently.
- Most beneficiaries did not report changing their primary care providers in the last few years, but some beneficiaries reported changing due to their primary care providers retiring, moving locations, or being inattentive to their needs.
- Beneficiaries reported that their primary care providers were physicians. However, beneficiaries saw NPs and PAs occasionally, usually between visits with their primary care physician.
- Beneficiaries in St. Louis did not report long wait times or major issues with seeing their PCP clinicians for routine care. For more urgent issues, beneficiaries reported messaging their clinician on the patient portal or calling the office, and said these strategies led to a resolution.
- In St. Louis, both Medicare-only and dual eligible beneficiaries reported few issues accessing care. However, some beneficiaries enrolled in MA reported delays in care because prior authorization was required.

#### *Access to Specialty Care*

- Beneficiaries in St. Louis reported longer wait times for specialty care than primary care. They reported that they could see clinicians quicker once they were an established patient.

## Organization of Care

### *Working with Other Clinicians*

- Most physicians in St. Louis who participated in focus groups reported working with nurse practitioners and about half worked with physician assistants. Primary care and specialist physicians saw nurse practitioners and physician assistants as interchangeable in their skill sets and did not prefer one over the other.
- Nurse practitioners in St. Louis described a variety of work arrangements with physicians, including seeing more straightforward patients, seeing patients with an acute illness, supporting patients through their treatment phase, and maintaining their own patient panels.

### *Staffing and Hiring*

- Physicians reported that nurses (e.g. registered nurses or licensed practical nurses), medical assistants, and billing staff were the most challenging positions to fill in the current environment.

### *Practice Management and Acquisition*

- A limited number of physician participants in St. Louis were involved in decisions about practice ownership. Increased revenue was the primary reason clinicians explored changes to their practice management or ownership structure.

### *Concierge Medicine*

- Some beneficiaries in St. Louis were familiar with concierge medicine. None indicated that they had joined a concierge practice.
- Many clinicians were familiar with the concierge medicine model being present in the St. Louis area. Some clinicians were aware of primary care practices in the St. Louis area that have gone concierge, but one physician said the percentage of concierge practices was low and seemed to be plateauing.

### *Software as a Service*

- Use of artificial intelligence (AI) in health care was low and limited in scope among physicians in St. Louis. Some physicians were using AI for documenting patient encounters ("AI scribe") with positive results. Some were not using AI at all. Others said AI was coming to their practices but not yet in use. Some specialists noted that certain specialties such as radiology may benefit from AI. Others felt that AI had a long way to go before being useful.

### *Accountable Care Organizations*

- One primary care physician and one nurse practitioner in St. Louis were participating in an accountable care organization (ACO) and another specialist and nurse practitioner had been approached to participate in an ACO. Six clinicians were unsure if they had been approached or were participating. The rest of the clinicians had not been approached and were not participating in an ACO. Specialists and primary care physicians did not think ACOs were a major player in the St. Louis area.

### *Quality Reporting*

- Overall, clinicians in St. Louis reported that the quality measures being used at their organizations were reasonable.

## Prescription Drugs

### *Cost Sharing*

- Clinicians in St. Louis reported that some patients were aware of changes to the Medicare Part D benefit, including a new annual limit of $2,000 in patient cost sharing. Specialists said that even with the updated Part D cost sharing limit of $2,000, some of their patients would not be able to afford all of their prescribed medications.

- Clinicians reported that they do not know what their patients will have to pay for their medications when they prescribe them.

### *GLP-1s*

- Clinicians in St. Louis reported that patients are asking them about GLP-1s for weight loss. Clinicians noted the health benefits of GLP-1s, including decreasing the risk of cancer and other chronic diseases, but despite these benefits, GPL-1s are not always covered or payers require clinicians to submit additional paperwork for approval. GPL-1s are not available at all pharmacies.

### *Medicare Drug Price Negotiation Program*

- Some physicians were familiar with the Medicare Drug Price Negotiation Program, but their knowledge was limited. Many physicians had heard about the program but were not familiar with the details.

### *Pharmacy Use and Filling Prescriptions*

- The pharmacies beneficiaries prefer using include large retail - and mail order - pharmacies. Beneficiaries described sometimes exploring alternatives like Good Rx or buying their prescriptions from Canadian pharmacies, to using their insurance at retail pharmacies.
- Beneficiaries in St. Louis reported that some pharmacies were closing in their communities and it was challenging when it was their closest or most convenient retail pharmacy.
- St. Louis beneficiaries reported that retail pharmacies did not always have medications in stock.
- Some beneficiaries described strong relationships with their pharmacist and pharmacists' important role in their care. Beneficiaries said that some pharmacists work with their clinicians and insurance to sort out administrative challenges related to refilling their prescriptions.
- Beneficiaries reported different approaches to managing expensive prescriptions, including asking their clinician for samples or contacting the pharmaceutical company to inquire about assistance.

## Key Findings from Rural Focus Groups 2021-2025

### *Choosing Coverage*

- Rural beneficiaries with traditional Medicare reported being able to see preferred clinicians without restrictions was an important consideration in their coverage choice. They cited having fewer local clinicians and not wanting to restrict their options by being limited to an MA plan's provider network. A couple of rural participants cited lack of clinician access as a reason they had switched from MA to traditional Medicare.

- Rural beneficiaries with MA also considered access to clinicians when choosing their coverage by ensuring that their preferred clinicians would be in network.
- Some rural beneficiaries were familiar with or had used supplemental benefits offered by MA plans, but generally these benefits did not factor into their coverage decision-making.

### *Access to Care*

- Almost all rural beneficiaries across years (2021-2025) had local access to primary care. Reported wait times for routine primary care ranged from same day to several weeks or a month. Distance traveled to primary care ranged from a few minutes away to up to an hour.
- Some rural beneficiaries had faced challenges finding a new primary care provider. They described limited options and long wait times to identify a new primary care provider.
- Many rural beneficiaries traveled outside their local communities to access specialists. In some cases, this travel was necessary to access a specialty not available locally. In other cases, rural beneficiaries chose to travel to access a specific clinician or hospital due to perceived quality of care.
- For a minor urgent need such as an injury requiring stitches, rural beneficiaries said they would visit their primary care provider or a walk-in clinic, urgent care, or the local emergency department (ED). For other acute needs or a sick visit, beneficiaries described seeking care at the same locations; seeing another clinician in their primary care provider's office; messaging their clinician through an online portal; or having a telehealth visit.
- For a major medical emergency such as a heart attack, rural beneficiaries reported that they would take an ambulance to the nearest hospital and then be transferred to another hospital in an urban area once stabilized. For major, non-emergency care or surgery, beneficiaries said they would shop around for the best or most experienced physician and would travel farther to receive care at a larger hospital.
- Rural beneficiaries were satisfied with their access to care, even when acknowledging that their rural location sometimes affected decisions about seeking care, for example, choosing to delay care for minor issues because it would be inconvenient to access care.

### *Prescription Drugs*

- Beneficiaries in rural areas reported they were generally able to access local pharmacies. Some beneficiaries described limitations with local pharmacies, including longer wait times for medications to be filled, lack of access to specialty medications, or not all drugs being stocked.
- Some rural beneficiaries chose or were encouraged by insurance to use a mail order pharmacy.
- Several rural beneficiaries in 2025 had been affected by pharmacy closures in their areas.

# Methods

The following bullets summarize the methods the NORC team used to conduct this qualitative research study. Methods and findings from the rural focus group are presented in a separate section at the end of this report. Additional details appear in the subsequent subsections.

- **Data collection approach**: Focus groups
- **Data collection timeframe**: April and May 2025
- **Number of focus groups**: 8
  - Seven in person in St. Louis, Missouri
  - One virtually with participants residing in rural areas throughout the country
- **Participants**: Medicare beneficiaries (grouped by enrollment in traditional Medicare and MA), beneficiaries eligible for Medicare and Medicaid (dual eligible beneficiaries), primary care physicians, specialist physicians, and nurse practitioners practicing in primary care and specialty settings
- **Moderating**: NORC senior researchers moderated each focus group
- **Topics discussed**: Enrolling in and using Medicare coverage, access to care, organization of care, use of AI in health care, and prescription drugs
- **Length of focus groups**: Approximately 90 minutes each
- **Institutional review board (IRB)**: NORC's IRB reviewed and approved all focus group procedures, screeners, and discussion protocols

## Location Selection

At the beginning of this project, NORC and MedPAC worked together to choose a location from which to recruit beneficiaries and clinicians for participation in the study. The goal was to conduct research in person in one location:

- With roughly equal traditional Medicare and MA enrollment to facilitate recruitment of beneficiaries enrolled in each Medicare option
- Where MedPAC had not conducted focus groups during the past four years
- With a focus group facility that had the ability to recruit the specific profiles of participants necessary for this project

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

Exhibit 1. Location characteristics

| City | Medicare Advantage Penetration[2] | Percentage of Dual Eligibles[3] | Proportion of Population by Key Race/Ethnicity Subgroups | | |
|---|---|---|---|---|---|
| | | | White, Not Hispanic/ Latino[4] | Black[3] | Hispanic[3] |
| St. Louis County | 58% | 12% | 67% | 25% | 4% |
| St. Louis City | 64% | 35% | 46% | 43% | 5% |

Source: Data provided by MedPAC.

Given the challenges of recruiting for and conducting in-person focus groups in rural areas, and the importance to MedPAC's work to include the experiences and perspectives of beneficiaries residing in rural areas, this project also included one virtual focus group with those beneficiaries. Methods and findings from this focus group are described in a separate section at the end of this report.

# Recruitment

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

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

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

[2] Centers for Medicare & Medicaid Services. March 2025. Medicare Advantage State/County Penetration 2025 03. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration/ma-state/county-penetration-2025-03.

[3] Centers for Medicare & Medicaid Services. 2023 Data. Medicare Geographic Variation—by National, State, & County. Available at: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-geographic-comparisons/medicare-geographic-variation-by-national-state-county.

[4] U.S. Census Bureau. QuickFacts: St. Louis County, Missouri; St. Louis city, Missouri. Available at: https://www.census.gov/quickfacts/fact/table/stlouiscountymissouri,stlouiscitymissouri,US/PST045224.

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

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

- A mix of practice size and ownership profile
- Diversity in terms of length of time in practice
- Demographic diversity (e.g., race/ethnicity)
- A mix of specialties (for groups with specialist physicians, nurse practitioners, and physician assistants)
- Regularly see Medicare patients in an outpatient setting
- A mix of practice types (e.g., solo/private, group, hospital-based)

Since their experience is less relevant to the research questions of this project, we excluded pediatricians[5] as well as clinicians who reported that Medicare beneficiaries made up less than 10 percent of their practice population. In addition, we set out to exclude clinicians who have been practicing for more than 30 years, although in the primary care physician group we allowed these clinicians to participate to fill the group.

When recruiting for focus groups, we often recruited more participants than needed for a discussion, as recruited individuals are often unable or unwilling at the last minute to participate. For that reason, we set out to recruit 10 participants for each in-person focus group, with a goal of conducting groups with 8 individuals. In-person groups ranged in size from 4 to 10 participants, with an average of 7 participants.

To further distinguish differences in experience based on coverage, we held separate focus groups for beneficiaries enrolled in MA and those enrolled in traditional (fee-for-service) Medicare. However, some beneficiary groups included a mix of coverage types due to mistaken beneficiary self-report during screening. Input from beneficiaries was flagged by coverage type during the analysis to ensure all findings are properly attributed in this report.

## Focus Group Participants

We conducted discussions with the following groups:

- **Medicare beneficiaries (n = 19 across the in-person locations)**
  - Individuals enrolled in traditional Medicare (n = 9) or a MA (n = 10) plan
  - Individuals 65 years of age or older

[5] One primary care physician reported seeing a small percentage of Medicare patients in their screener, but in the group, self-identified as a pediatric primary care physician. This individual's responses were not included in this report.

- **Dual eligible beneficiaries**[6] **(n = 10)**
  - Individuals enrolled in both Medicare (all individuals were enrolled in MA) and Medicaid
  - Included a mix of beneficiaries 65 years of age or older and beneficiaries under age 65
- **Clinicians (n = 20)**
  - Primary care physicians[7] (n = 3), including those in family medicine and internal medicine
  - Specialist physicians (n = 8), including cardiology, oncology, psychiatry, endocrinology, rheumatology, and orthopedics
  - Nurse practitioners[8] (n = 9), including individuals who work in primary care and specialty settings, including mental health, gastroenterology, orthopedics and rehabilitation, colorectal care, and oncology

Exhibits 2 and 3 present demographic characteristics of participants in the in-person beneficiary and clinician focus groups. Diversity across demographic characteristics ensured that our focus group participants offered a range of perspectives.

[6] One dual eligible group mistakenly included an individual who was not enrolled in Medicare. This individual's responses were not included in this report.

[7] One primary care physician reported seeing a small percentage of Medicare patients in their screener, but in the group, self-identified as a pediatric primary care physician. This individual's responses were not included in this report.

[8] We aimed to recruit a mixed group of advance practice providers (nurse practitioners and physician assistants) but the group recruited only included nurse practitioners.

Exhibit 2. Beneficiary participant characteristics

| | Medicare-Only (n=19) | Dual Eligible (n=10) | Total (n=29) |
|---|---|---|---|
| **Race** | | | |
| Asian | 0 (0%) | 0 (0%) | 0 (0%) |
| Black | 5 (26%) | 7 (70%) | 12 |
| White | 14 (74%) | 3 (30%) | 17 |
| Other/Multiple Races | 0 (0%) | 0 (0%) | 0 (0%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) |
| **Ethnicity** | | | |
| Hispanic | 0 (0%) | 0 (0%) | 0 (0%) |
| Non-Hispanic | 19 (100%) | 10 (100%) | 29 (100%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) |
| **Age (years)** | | | |
| <65 | 0 (0%) | 9 (90%) | 9 (31%) |
| 65–70 | 11 (58%) | 1 (10%) | 12 (41%) |
| 71–74 | 5 (26%) | 0 (0%) | 5 (17%) |
| 75–80 | 2 (11%) | 0 (0%) | 2 (7%) |
| >80 | 1 (5%) | 0 (0%) | 1 (3%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) |
| **Gender** | | | |
| Female | 10 (53%) | 6 (60%) | 16 (55%) |
| Male | 9 (47%) | 4 (40%) | 13 (45%) |
| Transgender | 0 (0%) | 0 (0%) | 0 (0%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) |

Exhibit 3. Clinician participant characteristics

| | Primary Care Physicians (n=3) | Specialist Physicians (n=8) | Nurse Practitioners (n=9) | Total (n=20) |
|---|---|---|---|---|
| **Race** | | | | |
| Asian | 0 (0%) | 4 (50%) | 0 (0%) | 4 (20%) |
| Black | 0 (0%) | 0 (0%) | 2 (22%) | 2 (10%) |
| White | 3 (100%) | 4 (50%) | 7 (78%) | 14 (70%) |
| Other/Multiple Races | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Ethnicity** | | | | |
| Hispanic | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| Non-Hispanic | 3 (100%) | 8 (100%) | 9 (100%) | 20 (100%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Gender** | | | | |
| Female | 0 (0%) | 2 (25%) | 8 (89%) | 10 (50%) |
| Male | 3 (100%) | 6 (75%) | 1 (11%) | 10 (50%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Years in Practice** | | | | |
| <5 | 0 (0%) | 0 (0%) | 2 (22%) | 2 (10%) |
| 5–15 | 0 (0%) | 3 (37%) | 6 (75%) | 9 (45%) |
| 15–29 | 1 (33%) | 5 (63%) | 1 (11%) | 7 (35%) |
| >30 | 2 (67%) | 0 (0%) | 0 (0%) | 2 (10%) |
| No Response | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| **Practice Setting** | | | | |
| Solo or small practice | 1 (33%) | 0 (0%) | 2 (22%) | 3 (15%) |
| Large group practice | 1 (33%) | 4 (50%) | 0 (0%) | 5 (25%) |
| Practice owned by a hospital or health system | 1 (33%) | 4 (50%) | 7 (78%) | 12 (60%) |
| Other | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |
| No response | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |

# Data Collection

Focus groups were scheduled for 90 minutes, with one of three senior researchers from NORC moderating each discussion. Prior to the start of each group, participants were asked to fill out a brief survey to confirm certain screening criteria (e.g., details about beneficiaries' Medicare coverage profile) and to provide the moderator some context about each group's makeup on key topics (e.g., how many participants received help choosing their plan.)

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

# Analysis

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

- All focus groups were recorded and transcribed.
- NORC developed a list of topic codes based on the moderator guide for the focus groups, as well as on previous analyses and reports. (The topical codes are generally reflected in the headers of the Findings section.)
- NORC loaded transcripts and codes into an NVivo project file.
- We coded each transcript in NVivo, tagging and organizing content based on the topic codes.
- NORC researchers conducted a thematic analysis of the content within each topic code to identify themes, such as areas of agreement and disagreement among participants, and compelling quotations illustrating the identified themes.

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

# Findings

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

## Choosing Coverage

### Understanding Medicare and Plan Choices and Sources of Information

**Most of the beneficiaries we spoke with described confusion regarding enrolling in Medicare.** These beneficiaries reported that they did not have a clear understanding of the different options for Medicare coverage as they approached enrollment, and some continued to express confusion about the different options. This is particularly true for dual eligible beneficiaries, with one noting, “It was truly, truly confusing and I don’t understand how people who are real seniors, and are beginning to lose touch with, I don’t understand how they do it because it’s confusing for me, and I’m supposed to be relatively smart, I suppose.”

**Many participants described the amount of information they received about Medicare plans as overwhelming**. These participants reported receiving stacks of pamphlets, “constant” phone calls, and frequent mailings from insurance companies, especially during open enrollment. A beneficiary who eventually enrolled in a MA plan said, “Well, before turning 65, I was getting the mail. A little overwhelming at first.... So, I just signed up with that without, you know, thinking too much about it.” Other participants reported receiving many phone calls related to enrolling in Medicare plans with one noting “Why is it—it's like every day, somebody calling you about your insurance? I already did this for this year already” and another estimating the number of calls ““I get five, six a day.”

**Due to confusion over the many options and lack of certainty about the best Medicare coverage option for them, many beneficiaries relied on help with enrolling in Medicare.** Many of these beneficiaries described turning to formal resources for help making these decisions, including agents and brokers, caseworkers, health fairs, and Medicare.gov. Others described relying on guidance and recommendations from less formal sources, including family members and friends.

**Most participants had never heard of the State Health Insurance Assistance Program (SHIP) or reported vague recognition, often confusing it with other services.** When participants were asked if they had ever heard of Missouri’s SHIP (MO SHIP) the majority did not recognize the name, and

some confused it with agent or broker services, or representatives from insurance carriers. Some participants expressed surprise that SHIP had been around for a long time.

**Several beneficiaries described using Medicare.gov to review plan options, though few relied on it as their only source of information when choosing a plan.** A number of beneficiaries who described conducting their own research online reported that one of the websites they visited was Medicare.gov. One beneficiary specifically mentioned using the Medicare PlanFinder tool. One dual eligible beneficiary noted, "I looked at Medicare.gov along with the book." Another beneficiary who enrolled in traditional Medicare picked his plan based on information found on Medicare.gov and explained: "Well, I took out regular Medicare with a supplement.... You put [your information] into your computer, and it'll spit out which plan is best for you. Medicare.gov—the government gives you all of this." Other participants who reported visiting Medicare.gov said they were not sure where to start or how to use the website, or had to check with other resources before making a plan decision. For example, one said, "I went on Medicare.gov. I really wasn't even quite sure. I really didn't have much information. I just went on there, and I found a plan. I have a cardiologist, so I wanted to make sure my cardiologist was in that plan, but I really wasn't quite sure. [I did not find the clinician on Medicare.gov, so] I called just to be sure. And, yeah, [that was] probably simpler." Another reported visiting Medicare.gov to "[look] at what drugs were covered. Like, what levels."

**Several Medicare beneficiaries described seeking a health insurance agent or broker[9] because they needed guidance through the complexity of decision-making.** Most of these beneficiaries described wanting help to sort out the confusion about different Medicare options, including traditional Medicare versus MA, and more specific plan choices under each option. None of the dual eligible beneficiaries described using a broker in this way.

**Most beneficiaries who worked with an agent or broker were referred by family members or friends.** One beneficiary was referred to a broker by a financial advisor and another by someone at their senior center. Each of these sources of referral increased beneficiaries' trust in the process and faith that they would end up with the best Medicare plan for their specific situation.

**Beneficiaries described how their brokers tailored suggestions based on individual health needs, especially medication lists and clinician preferences.** These beneficiaries described comprehensive discussions when establishing a relationship with an agent or broker where they discussed all of the medications the beneficiary was taking, whether there were specific clinicians the beneficiary wanted to be certain were in network, and whether the beneficiary had preferences for hospitals or health systems.

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

**Most of the beneficiaries who used brokers describe receiving multiple plan options from different carriers.** One beneficiary noted: “He presented five or six different companies. And we told him what we wanted” and another reported: “[My broker] looked through all the plans then presented two or three different ones, and I really liked that.” A subset of beneficiaries who describe using an agent or broker noted that the this person recommended a single plan. One participant noted, “[The broker] gave us options. But then he said, ‘Out of all these, this is the one I suggest because it fits you guys better.’”

**When discussing the use of agents or brokers, some beneficiaries questioned how agents and brokers are compensated from insurance carriers though most felt their brokers acted in their best interest.** These beneficiaries questioned whether brokers had financial incentives that might bias their recommendations and whether some plans pay brokers more than others. One noted: “How can you be assured that they have your best interest at heart? Because do they get the same amount of money from every company?” Although participants expressed awareness that brokers are compensated by insurance companies, most felt their brokers still acted in their best interest.

**Most beneficiaries reported checking in with their broker annually during open enrollment to reassess their plan.** A subset utilized brokers for additional services, such as finding travel insurance for cruises or answering questions about coverage changes, but most did not have interactions with their broker outside of open enrollment.

## Factors That Affect Beneficiaries’ Choice of Coverage

Below we describe the factors that affected beneficiaries’ Medicare enrollment. We organize the findings by beneficiaries’ current source of coverage during the focus group—whether they were enrolled in MA, traditional Medicare, or a dual eligible enrolled in both Medicare and Medicaid.

### *Beneficiaries with Medicare Advantage: Choosing Coverage*

**Beneficiaries who chose MA plans mentioned cost as a driver of their decision to enroll.** Several beneficiaries mentioned low or no out-of-pocket expenses or cost-sharing as their primary reason for choosing MA over traditional Medicare. One beneficiary enrolled in MA noted, “It was a good choice. It was basically zero deductible on most doctor visits, hospital stays, etc.” Another noted, “I retired on disability…. I didn’t want ... out-of-pocket [costs].”

**A few beneficiaries were drawn to MA plans because of the additional benefits not typically included in traditional Medicare.** They specifically cited cards to use for over-the-counter items and plans that offered dental and vision coverage. One noted: “I used to get $160 a month for frivolity stuff—toothpaste, aspirin, that kind of stuff.” and another reported: “[One MA plan] wasn’t offering dental care, eye care, or anything…. So I joined [another MA plan] and was able to get what I needed.”

**Though not a major factor in choosing a plan, a number of beneficiaries enrolled in MA reported receiving in-home assessments or visits.** One participant viewed these exams positively and shared his belief that these exams were part of an effort by their MA plan to practice preventive health care, noting: "I understand it. Advantage plans really look at preventative health. And that's why they're doing—I don't wanna be a salesman for it.... They're wanting to catch things before you go in the hospital and spend $200,000. They can afford to send a doctor or nurse practitioner to your home." Others noted how their plans are "always calling" to schedule these visits and questioned the purpose of them, describing them as duplicative or not connected to the care they were getting from established clinicians. They said, "I go to the doctor for an annual checkup. I have a cardiologist I see annually. I don't really need you [the MA plan] to come by and sit." Another mentioned that with the choice of a MA plan, "it was home health nurse out annually for a physical, and even though I still get my Medicare physical at the doctor's office."

**Several participants heard about the benefits of MA through friends who had good experiences.** These participants described turning to friends for advice as they approached Medicare enrollment. One described, "Well, before turning 65, I was getting the mail. A little overwhelming at first. [I was also] talking to friends. [A] close friend of mine told me about [MA] plan. And it turns out several other people that I knew were also on it. So I just signed up with that without, you know, thinking too much about it." Another noted:

> *[Before] I first went on Medicare ... I had two friends who had already enrolled in [MA plan]. I didn't believe them when they told me there was no premium. And I called [the carrier] and the girl came, and she met me at a real restaurant where I lived.... She answered every question. She was very sharp. So anyway, I went with [MA plan], and I've been on it for 10 years and I can't say anything but, you know, good things there. Never had a problem, ever.*

**Others had past experience with insurance carriers that drew them toward—or away from—certain MA plans.** After deciding to enroll in a MA plan, several participants described previous enrollment with specific insurance carriers that helped narrow down their options. One participant described, **"**I had terrible experience with [one carrier], terrible experience with [another carrier]. And so that kind of got those two out of the way quickly. And it was just a matter of looking to see who was left. And I was like: wait a minute, [company] owns [a third carrier]. Bingo."

### *Beneficiaries with Traditional Medicare: Choosing Coverage*

**Many beneficiaries described choosing traditional Medicare over MA because they wanted unrestricted access to clinicians or because their clinician recommended traditional Medicare.** In particular, participants with serious or chronic health conditions, but also those who described themselves as relatively healthy, described choosing traditional Medicare because it allowed them to access a broader range of specialists without needing referrals or facing network restrictions. Several participants noted their physicians steered them in the direction of traditional Medicare. One said, "My doctors, because I need a monthly treatment, wanted all the people who get this treatment to have a traditional Medicare. "

**Some participants had access to high-quality supplemental plans through former employers, which required them to choose or stay on traditional Medicare.** These participants described how the offers through their employers were incompatible with MA or too good to give up. One participant described, "I worked for municipal government, and we had—Plan E was offered. And when you have Plan E, you can't have an Advantage plan. And so, I looked, because mine is heavily [subsidized because of] how many years of work I had. So, I pay very minimal amount for insurance. But then they also offered us the Plan D through [pharmacy benefit manager], I think.… So between my husband and I, it's a no brainer because what I pay for insurance for us for a month doesn't even—it's a drop in the bucket to what other people are paying the cost." Another said, "My former employee [pays] for a supplemental. And so, I had to take traditional Medicare because if I took an Advantage plan, then I'd lose this supplemental. And you can't ever get it back—so once you left the system, if you didn't like, you know, the bank plan that you took. So I've been very happy with Medicare supplemental. I've never had [to pay]."

**Several beneficiaries who chose traditional Medicare cited negative perceptions or experiences with MA.** A few participants expressed distrust or dissatisfaction with MA plans, especially regarding examples they had heard of denials of care. One mentioned, "An Advantage plan is fine as long as you don't get sick. I just had a lady call me. Her husband had a stroke a few months ago. He needs a wheelchair. The plan she has with Advantage won't give it to her. He needs therapy. They won't give it to her."

### *Dual Eligible Beneficiaries' Coverage Choices*

**Many dual eligible beneficiaries described the importance of extra benefits not typically included in traditional Medicare when choosing a MA plan.** All of the dual eligible participants in our focus groups were enrolled in MA plans. These participants frequently mentioned dental, vision, transportation, wellness incentives, and spending cards as key motivators. One participant noted, "My aunt had told me Aetna gives a $250 card that you can pay your bills or your gas with. So, I called them. They set me up." Another explained, "Mine was offering dental, vision, and physical.… I have a lot of health issues so [my priority] was to know what I was covered with.…" A third said, "I can pay for cash bills, healthy food, and that $250 comes handy."

**Direct outreach—via mail and phone calls—played a significant role in influencing selection of MA plans for some dual eligible participants**. Most of the dual eligible participants described being inundated with phone calls and mail from MA plans and ignoring most of them. However, several participants described an instance when they answered the phone or opened the mail and ended up enrolling in that plan. One said, "[Carriers] send a whole lot of pamphlets in the mail.… I just picked [MA plan] because, I don't know, I think they sent the most pamphlets or something." And another said, "I got a phone call from [MA plan].… I think I got a couple phone calls from him, and I talked to him … and then I talked to my caseworker about it."

**Several dual eligible participants with complex health care needs described relying on—or getting advice from—their clinicians or other social service professionals about their Medicare options.** Several participants described receiving help or advice from a caseworker, with one noting, "I looked into it by talking to my caseworker about it." Another described how they were uninsured and had uncontrolled diabetes. Their hospital case worker helped them first enroll in Medicaid and apply for disability, which subsequently led to application and approval for Medicare. A third received advice from her doctors after a significant medical diagnosis: "It was a toll-free number that was referred to me by my doctors. [A]t first, I was very intimidated, but they made it real simple and then transitioned, as long as I knew in the vicinity of who I was gonna really need; and they really got in there, helped me explain all the benefits."

**Some dual eligible participants sought reliable coverage and low or no out-of-pocket costs for expensive treatments or prescriptions**. Several dual eligible participants described needing to ensure they would have a larger quality of expensive health care covered without cost-sharing and sought out plans that fulfilled this need. One dual eligible beneficiary mentioned, "I had one medication that was $6,000 a month, and I was out of pocket.… I was trying to find what could offer me more out of pocket."

## Satisfaction with Coverage

**Overall, beneficiaries who participated in focus groups are satisfied with their coverage**. Most beneficiaries rated their overall coverage as good or excellent (Exhibit 4). We asked beneficiaries who did not rate their coverage as excellent how it could be better. One participant who rated their coverage as fair cited the reduction in their out-of-pocket spending card as the rational for their rating. The other participants who rated their coverage as "fair" or "poor" did not explain why.

Exhibit 4. Beneficiary satisfaction with overall coverage

| | Traditional Medicare Only | Medicare Advantage Only | Dual Eligible[1] | Total |
|---|---|---|---|---|
| **Excellent** | 4 (44%) | 3 (30%) | 4 (40%) | 11 (38%) |
| **Good** | 2 (22%) | 7 (70%) | 5 (50%) | 14 (48%) |
| **Fair** | 2 (22%) | 0 (0%) | 1 (10%) | 3 (10%) |
| **Poor** | 1 (11%) | 0 (0%) | 0 (0%) | 1 (3%) |

[1]All dual eligible participants in our focus groups were enrolled in MA plans.

**Several focus group participants reported never rating anything as excellent and rated their plans as "good" with no specific rationale for how it could be better.** A subset of participants mentioned issues with accuracy of their provider directory and what they described as one-off issues with calling their plan for help or to ask questions and not getting the help they needed.

**Though not reported in response to the question about plan rating, a number of beneficiaries enrolled in MA plans reported dissatisfaction with a reduction in some of their extra benefits this year.** When describing their coverage situation or their extra benefits, a number of beneficiaries noted they are receiving fewer funds on their flexible-benefit cards (e.g., over-the-counter spending cards). One said, "I used to get $160 a month for stuff—toothpaste, aspirin, that kind of stuff. And now it's down to $40 or $45. And now I'm coming out of pocket. I'm diabetic, so I'm coming out of pocket. Not so much for those meds, but I'm also on a couple different ones that I'm out of pocket on that I haven't been in the past." Another said, "Yeah… They've got this great $250—at first, it was $400 or something, and then they cut it in half."

## Switching Plans

**Three beneficiaries described switching from traditional Medicare to MA.** One dual eligible who switched from traditional Medicare to a MA plan did so after receiving direct outreach from a carrier:

> *I keep getting calls, and I guess one time [the plan representative] talked to me. I actually listened, and I talked to my kids… about it and said it was a deal. And then I looked over what they offered, the benefits... It had the extra benefits card, the vision, zero copay, I guess 30 rides one way to medical appointments, stuff like that, that I just decided to switch—it offer[s] more than the standard Medicare.*

Another Medicare-only beneficiary enrolled in traditional Medicare but did not have a supplemental plan and faced high cost-sharing, so she switched to MA because she believed it was more affordable. She described:

> *I unfortunately turned 65 during COVID and, you know, with so much happening, ... and I was inundated, but I didn't pay attention to anything. I was like, "Medicare? I'm not that old. What's going on?" I'm like, "What's happening?" And I got traditional Medicare.... I had to go to my doctor, did the mask and everything else. Came away and got a bill, and... I was just shocked, you know. They didn't have any offices open, and the phone calls were really hard to get through and get any kind of valuable information. So, I got more information from the doctor's office, and I realized [traditional Medicare] is not the way to go.*

The third beneficiary reported:

> *I talked to a guy. He had a kiosk set up, of all places, in Schnucks, one of the primary supermarkets here. And after talking to [him] a couple of times and looking online, he had some information there. I really didn't investigate that. I just wanted to get off traditional Medicare. Well, I retired on disability because I've had three rotator cuff surgeries, and they're talking shoulder replacement. I asked the doctor that I was seeing at that time: "Well, you've got to go to a specialist, and you've got to do this and this and this." And that's all well and good. But out of pocket I didn't want to come out of pocket at that point in my career because I still don't have any money, but I had less money then. So that being said—that's why I moved over, thinking it would be more [cost-effective].*

**One participant each described switching from MA to traditional Medicare, or between MA plans.** One dual eligible beneficiary originally chose a MA plan but quickly switched to traditional Medicare at the advice of her doctor: "My doctors … wanted all the people who get this treatment to have a traditional Medicare. So, I had to revisit it.…" Another participant described switching between MA plans, saying:

> *I first got on Medicare: I joined [MA plan], and I was on [the plan] for years. Loved it. Then I needed some additional stuff because [the plan] wasn't offering dental care, eye care, or anything, so I needed dental care. So I stayed in a senior building, and they had a broker to come in there. So they had, like, one from [another MA plan] and then one from [a third MA plan], and she was able to bring up my information and compare and see, and it wasn't much of a comparison because—like I said—[the original plan] wasn't giving me the dental, and that's what I was looking for. So I joined [the third MA plan] and was able to get what I needed.*

Another beneficiary enrolled in an MA plan described their plan to switch to another MA plan during the next open enrollment period:

> *I had some dental work coming up, some other things that it made a whole lot of sense to switch to a plan that covered more of that. And I did switch.*

**One participant enrolled in traditional Medicare described switching supplemental plans each year in order to get the best deal**.[10] This participant described how he:

> *... took out regular Medicare with a supplement, which is the best you can get right now. And I took the G instead of the F because it was cheaper. And it covered the exact same thing. And all supplement plans are exactly the same. You have to call every year because the only difference is the price they're charging you. So, you have to check every year. And the same thing with Medicare D. They change plans all the time. Take your drugs out of your formulary. So, you got to check on this and go through it, and you put it into your computer, and it'll spit out which plan is best for you.*

## Access to Care

We spoke with clinicians about their perspectives on topics related to access to care, including wait times for appointments, acceptance of new patients and insurance, acceptance of MA plans, and working with MA plans. Similarly, we spoke with beneficiaries about access to primary care, including their regular source of primary care, receiving care from nurse practitioners and physician assistants, their access to specialty care, experiences looking for new primary and specialty clinicians, and experiences with MA plan networks and prior authorizations.

[10] MO anniversary rule: Individuals who terminate a Medicare supplement policy within 30 days of the annual policy anniversary date may obtain the same plan with no health questions asked for a period of 63 days after the termination of their existing policy, from any issuer that offers that plan. This would include Medicare supplement and select plans.

# Clinicians

## *Acceptance of Patients and Insurance*

In our pre-group surveys, we asked clinicians if they were accepting new patients generally as well as new Medicare patients (Exhibit 5). Nearly all clinicians (19 of 20) were accepting new patients and of those accepting new patients, all were accepting new Medicare patients.

Exhibit 5. Clinician acceptance of new patients

| Clinician Group | Accepting New Patients | Accepting New Medicare Patients |
|---|---|---|
| **Primary care physicians** | 3 (100%) | 3 (100%) |
| **Specialist physicians** | 8 (100%) | 8 (100%) |
| **Nurse practitioners** | 8 (89%) | 8 (89%) |

**Clinicians in St. Louis were generally accepting new patients, regardless of insurance.** Clinicians we spoke to reported that the decision to accept various plans was made by management at their group or health system.

**Clinicians reported wait times ranging from a few days to a few months when seeing new patients.** Primary care physicians and nurse practitioners were more likely to report seeing new patients quickly —within a few days to a few weeks. Specialists reported varying wait times for new patients—from two days (cardiology and oncology) to three months (rheumatology). Some specialists noted that in their experiences referring patients further, there can be a few months' wait for certain subspecialties, such as spine surgery, rheumatology, or dermatology.

Generally, acuity was the defining factor on how quickly the patient can be seen. A cardiologist explained they try to get the patient in within 48 hours, adding: "For cardiology, you're not going to sit at home." One nurse practitioner in a specialty practice mentioned that "now a lot of the new referrals kind of fall to myself and another [advance practice provider] within the practice because the rule is don't turn anybody away unless there's a good reason. At least that's what our direction is within our division."

**Clinicians reported shorter wait times for established patients, and they crafted their schedules to accommodate same-day appointments.** For returning patients, one primary care physician kept a few open slots for acute issues. They were aware that "the establishment that I work for doesn't like that fact" but kept those spaces open for their patients' well-being. "I think if you have a physician that you can't see when you're sick for several weeks ... what good is that? I like [to] be able to get somebody in." Specialists noted that if patients miss their appointments or the clinician's schedule changes last minute, they will offset a longer wait time by having the advance practice providers (nurse practitioners and physician assistants) see the patient.

We asked focus group participants about their experiences referring patients to other clinicians. **Referral experiences varied by clinician type. Multiple nurse practitioners noted that they feel pressured to refer patients to clinicians in the same health system network in which they worked.** One nurse practitioner described getting a list of all of her out-of-system referrals and feeling pressure to refer within the health system. Some nurse practitioners noted that the referral piece is part of their electronic health record, and they click a button, and the system makes a referral. Other nurse practitioners noted that the geography of the patient plays a big role in their referral approach because they do not want the patient to struggle with getting to the new clinician. None of the primary care physicians and few of the specialty physicians felt any pressure to refer their patients to clinicians within their health system network.

### *Clinicians' Acceptance of Medicare Advantage Plans*

All clinicians reported accepting MA Plans (Exhibit 6), but some clinicians reported that they do not see all MA plans in their area.

Exhibit 6. Clinician acceptance of Medicare Advantage plans

| Clinician Group | Accepting Medicare Advantage Plans |
|---|---|
| **Primary care physicians** | 3 (100%) |
| **Specialist physicians** | 8 (100%) |
| **Nurse practitioners** | 9 (100%) |

**Clinicians we spoke to reported different experiences on whether they consider a patients' insurance coverage before recommending care.** Some clinicians reported making decisions based on medical need rather than insurance coverage. Some clinicians also mentioned that working with various MA plans creates challenges because they cannot recommend the same treatment options for all patients. One specialist explained, "The moment I take ownership of [what insurance the patient has], I'm going to be providing substandard care of one person to the other. Once you go down that slippery slope, you're doomed. I'd never have looked at who has what insurance." Primary care physicians reported that they usually do not look at the patient's insurance, unless they need to ensure they are using the correct code for a patient's plan. Another specialist said, "If you start looking at the insurances, it will … drive you crazy."

However, some specialist clinicians reported needing to consider the type of Medicare coverage when making decisions. One said, "You have to do it, though.… Or if you do [the procedure], you tell the patient up front that your insurer is not going to pay for that because they aren't. That's just one small example." A nurse practitioner recalled their experience with MA plans, explaining:

> *If they need ... training or something after they get a new prosthetic [care] plan, as soon as I see you have a MA plan, I'm like, well that kind of curtails what I'm going to talk to you about when it*

> *comes to what therapy could be offered. And a lot of that's kind of the big wall that we run into when we see our patients. Because yes, of course we're going to see the MA folks, but if they need therapy afterwards, if they need certain equipment needs afterwards, that's where we find, like, we run into a stop almost immediately. Or we already know well they have a MA plan, so we're going to have to go through all the x, y, z hoops in order to get that potentially for them. And even then, after an appeal or after a letter from us, it's still not guaranteed. So that's kind of where we see a lot of frustration around it. As well as if we're covering, say, an inpatient rehab on campus, those MA plan folks—if they're coming from the main hospital—they're not going to get a room to go or to somewhere like that. It won't deter them from seeing us in clinic for what their needs are, but there's lots of other walls that kind of pop up in our specialty.…*

**Clinicians reported various issues when working with MA plans, including challenges securing prior authorizations on behalf of patients and receiving denials for care they thought was needed.** Nurse practitioners noted that they "fight a little harder" with MA plans to get medications and therapies covered and often have to revise their visit notes to ensure certain phrases are used. One nurse practitioner noted that they have set up their electronic health record with shortcuts for prewritten words or phrases for their MA patients, to reduce the amount of back and forth with the insurer. Specialists reported that prior authorizations are "cumbersome beyond belief," especially for newer technologies, such as newer versions of pacemakers. One specialist reported that they have gone to court for two of their patients to get the MA plans to approve the cardiac device, adding, "One patient quit MA and went to back to straight Medicare so we could get the device."

Most clinicians reported personal experience with prior authorizations and calling MA plans to deal with prior authorizations, but some clinicians noted that their practices hired staff whose full-time job is to work on prior authorizations. Even among those with dedicated staff, clinicians reported spending significant amounts of time with their prior authorization specialists to get the information required by MA plans for approval. One specialist noted that they no longer prescribe medications or therapies they know will not be covered by the MA plan their patient is enrolled in after seeing many patients deal with denials from their MA plan. Clinicians also described experiences when drugs were not covered and patients chose to not fill their prescription rather than pay out of pocket, resulting in negative effects on their health. They explained:

> *If they can't afford it ... they don't notify you that they didn't take it. They just come back ... and the sugars are still high [and say], "I couldn't afford it. So, I just didn't take it." So ... you do have to look at what type of plan they're on. [I]f you know it's not going to be covered because you've had several people [go through this] and that particular drug wasn't covered; it's not even worth [prescribing] it because at that point it's not going to be covered. They're not going to pay for it.… Some of them really can't afford it, and they won't do it. They can't do it.*

A small number of nurse practitioners reported receiving guidance around improving screening rates from MA plans, explaining that "sometimes there's some guidance depending on which Advantage. They're like, 'We're really interested in improving this for you, and they're kind of giving you a handout

as to go back and check x, y, z, and then we'll look [at] it" and added, "That's been somewhat of a positive [of working with MA plans], but I know that doesn't balance out [the frustration of prior authorizations]."

# Beneficiaries

## *Access to Primary Care*

### *Regular Source of Primary Care*

**All participants in the focus groups reported having a primary care provider that they saw regularly, and a handful of beneficiaries reported having to find a new primary care provider recently.** A dual eligible beneficiary described changing primary care providers within the last few years because they felt that the clinician was rushing through their appointments, and they found a new clinician who was both familiar with their health conditions and attentive to their needs as a patient. Another dual eligible beneficiary noted that their clinician left the practice, and after seeing a different clinician at that office, they were able to go back to their original clinician at the new practice. They added, "Luckily, I was able to find [them in] the same network.… It's a bigger database to keep up with." Several fee-for-service Medicare beneficiaries reported a delay in getting a new appointment when their primary care providers retired or left the practice, with one traditional Medicare beneficiary reporting it took them six months to get a new appointment after finding a clinician who was accepting new patients.

### *Seeing Nurse Practitioners and Physician Assistants*

**Beneficiaries reported mixed feelings on designating a nurse practitioner or physician assistant as their primary care physician but were generally open to the idea of seeing these clinicians occasionally or between visits with their primary care physician.** Medicare-only beneficiaries were open to the idea of nurse practitioners and physician assistants and noted that they understood they had to see them due to changes in their clinician's schedule or needing to be seen last minute. Only one beneficiary noted concern on the educational quality of NP and PA programs in comparison to MD training. A few Medicare-only beneficiaries reported they had better experiences with nurse practitioners and physician assistants and felt their quality of care was more thorough, caring, and communicative. One beneficiary said:

> *Because a doctor, when they come in the room, they got their hand on the door waiting to go out. They're only allowed to spend X amount of time with you. A nurse practitioner or a physician assistant has got more time to spend with you. You get actually better quality care from them than you do from the primary care.*

Some dual eligible beneficiaries had strong feelings on not intentionally seeing a nurse practitioner or physician assistant, especially as their assigned primary care provider, and one beneficiary noted that they do not want to see "lackeys." Some beneficiaries expressed the belief that the training or quality of

NPs and PAs is inferior to that of physicians. One of these beneficiaries, enrolled in an MA plan, quipped “somebody graduates at the bottom of the class, and that's a nurse practitioner because you couldn't make it to be an MD.”

**Beneficiaries expressed a desire to see their specialist physicians more frequently than the NP or PA in the practice.** One beneficiary noted, “I see him [the cardiologist], and then the next month I’d see his assistant. And then all of a sudden, I was just seeing her. And I just felt like she knew her stuff, but that’s not who I initially signed up to see. And I think that, to me, that was almost like they’re pushing you off, and I didn’t like that.”

### *Timely Access to Routine and Urgent Care*

**For routine care, beneficiaries did not report long wait times or major issues with seeing their clinicians.** Wait times ranged from a few days to a month. Beneficiaries regardless of Medicare coverage profile reported using the electronic health record’s messaging system to get ahold of their primary care provider. One dual eligible beneficiary said they can send a note to their primary care provider and receive an answer within 48 hours, and another added, “Instead of sending messages to the doctors because they never look at their emails or their messages, I send it to the nurse that’s in charge of all of that stuff. And we have a pretty good rapport. So, she’ll get on it and get me seen or whatever I need.”

**For more urgent care, beneficiaries used a variety of resources to be seen in a timely manner.** Beneficiaries reported messaging their clinician on the patient portal or calling the office when urgent issues came up and that these messages led to a resolution of their issue. One dual eligible beneficiary noted that they will send a message in the portal with a request for an appointment and their symptoms, and the clinician will either set up an appointment or send in a prescription to the patient’s preferred pharmacy. Beneficiaries also reported going to urgent care if they knew their clinician could not see them in a timely manner. One dual eligible beneficiary explained, “I’ll call the office, tell them what’s going on, and if it’s something that they think [is] cold, flu, something like that … they’ll call in the script for me. But if it sounds heavier than that, they’ll tell me to go to … the urgent care first.”

### *Medicare Advantage Plan Networks*

**In St. Louis, both Medicare-only and dual eligible beneficiaries enrolled in MA reported few issues with their MA plans, though some beneficiaries reported delays in care due to the processing of prior authorizations.** Some dual eligible beneficiaries reported being proactive about prior authorization if it was taking too long, and one beneficiary described their experience of following up with the doctor’s office when prior authorization for their diabetic supplies was delayed.

Medicare-only beneficiaries with MA did not report issues with ensuring their referrals were in-network. They reported trying to keep all of their care in the same health care system, where they were confident

their care would be covered in-network. One beneficiary noted, “I don’t think they’ve ever asked [about my coverage]. I may have asked them [when] following it up or calling before I go.”

### *Access to Specialty Care*

In our pre-group survey, we asked beneficiaries how many specialists they were seeing. Medicare-only and dual eligible beneficiaries reported seeing an average of three specialists. The maximum number of specialists that a beneficiary reported seeing was 10. All but one group had at least one beneficiary who saw no specialists.

**Beneficiaries in St. Louis reported longer wait times for specialty care than primary care, but once they were an established patient, they were able to see the clinician quicker.** Beneficiaries reported the first visit can take months to a year to happen, but a few mentioned being able to see the specialist right away if their primary care provider facilitated the referral. One beneficiary explained, “It was a four- or five-month wait [for the specialist].” They said that once they were seen by the clinician, their wait time was much shorter, adding that “And then I asked about a procedure and its cost because it’s not covered by insurance. They said, ‘Well, you won’t have to wait as long as you did because you are established patient. So, the appointment is four weeks off.’” One beneficiary mentioned that they moved from a community-based clinic to a hospital-based system due to wait times at the clinic, and explained that at the community-based clinic, “I was having a lot of issues coming up all at once and getting the referrals was taking forever. And I was sick.... My urgency was being ignored.”

## Organization of Care

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

### Physicians: Working with Nurse Practitioners and Physician Assistants

In our pre-group survey, we asked physicians whether they worked with nurse practitioners and physician assistants in their practice. Ten physicians (91%) worked with nurse practitioners, and six physicians (55%) worked with physician assistants.

**Physicians noted nurse practitioners and physicians assistants practice in a variety of roles from maintaining their own panel of patients to seeing patients for an acute event to supporting patients through the maintenance phase of their treatment.** They also felt that patients did not consider physician assistants or nurse practitioners as “their” clinician. Some of the nurse practitioners and physician assistants they work with have their own patient panels that are mainly individuals who are less sick than others. One primary care doctor explained, “In general, their [the nurse practitioners’] patients aren’t as complex. Sometimes they get their patients because the patients want them to be

their primary care doctor. Other times, I have a patient who's pretty simple, and they decide just to kind of transfer them over to the NP or PA." One specialist shared how he sees the specialty moving to more advance practice providers:

> *So what we do is not as high stakes as interventional cardiology, and so in our discipline, I would say NPs are the future of the discipline because there's just not enough [physicians] to go around and most of the conditions are mundane and self-limited, and you don't necessarily need to see a surgeon. So, it's unquestionably the future, aside from AI, the future of the discipline is NPs and PAs.*

Another specialist described how nurse practitioners see patients in her practice: "It's more like putting them in cruise control. The MD puts the patient in cruise control, and then the NPs can kind of just make sure everything's went well, and then periodically the MD will see them back again. And that's what, how we're using NPs."

**Primary care and specialist physicians saw nurse practitioners and physician assistants as interchangeable in their skill sets and did not prefer one over the other.** One primary care physician shared, "I view them as pretty much equal in family practice. If there is a difference, I'm not sure what it is." One specialist noted, "They're [nurse practitioners and physician assistants] interchangeable in my practice." However, one primary care doctor noted, "St. Louis is kind of a nurse practitioner town anyway."

## Nurse Practitioners: Working with Physicians

**There are state-level differences in how nurse practitioners practice.**[11,12] Some nurse practitioners worked in offices with another nurse practitioner or physician assistant but with no physician at the office with them on a regular basis. One nurse practitioner working in this arrangement explained that her collaborating physician cosigns her charts and is available by phone as needed for questions. In some cases, the nurse practitioners described serving as gatekeepers to the physicians – they see patients first and determine if the patient needs to see the physician based on acuity or level of complexity of the situation. The nurse practitioners would see more straightforward patients or patients with an acute illness, freeing up physicians for more complex patients. All the nurse practitioners noted that they felt like if they needed support or if they had questions they could connect with a physician to discuss their questions and concerns.

**Nurse practitioners in Missouri are assigned a collaborating physician.** We heard that many of the nurse practitioners were assigned to a specific physician who reviews their charts and care plans. Some nurse practitioners noted that their collaborating physicians needed to sign off on 15–20 percent of their charts. Physicians in Missouri can collaborate with up to three advance practice providers. Even though the nurse practitioners we spoke with have an assigned collaborating physician, many of them

[11] Nurse practitioners have restricted practice in Missouri: https://www.aanp.org/advocacy/state/state-practice-environment

[12] Nurse practitioners have reduced practice in Illinois: https://www.aanp.org/advocacy/state/state-practice-environment

noted that they felt comfortable reaching out to any of the physicians in their practice. These nurse practitioners reported seeing patients from a variety of physicians and that their patients are not limited to their collaborating physician's patient panel.

One oncology nurse practitioner shared:

> *Missouri, historically, is like one of the most restricted states for nurse practitioners. So, there's a lot of legislation on nurse practitioners in Missouri, where Illinois has a lot more lax legislation. [W]e can't prescribe a lot of scheduled drugs. For me I can't prescribe chemo. I can sign off on it after they've already received their first cycle of chemo or dose. I can adjust it, but their first cycle that they get, that has to be done completely by the physician. I think it needs to be cosign, though, when I do—like if I do a dose reduction—but nurse practitioners could not prescribe first doses.*

While some of the nurse practitioners who practiced in Illinois noted that they could do more practicing in Illinois versus Missouri, one nurse practitioner practicing in Illinois discussed a limitation in her scope:

> *Diabetic shoes. We can't sign for diabetic shoes and foot supplies. [For] some reason, it has to go to the physician. Which isn't always convenient since he's not in our building, not even in our town. So that's kind of a pain. But I can write any narcotic I want. So [laughter] diabetic shoes get you every time*[13]*.*

**There is variability in the types of patients that nurse practitioners see compared to each other and to physicians.** A few of the nurse practitioners we spoke with discussed seeing patients with an acute issue while the physicians in their practice focused on individuals with chronic conditions or who are sicker. Other nurse practitioners were seeing patients over the course of an illness and had long-term relationships with those patients. Some nurse practitioners maintained their own patient panels, while other participants did not have their own patient panels but saw any patient at their practice as needed.

## Staffing and Hiring

**Physicians reported that nurses-primarily RNs, medical assistants, and billing staff were the most challenging positions to fill in the current environment.** One primary care physician noted that he wished he had more medical assistants and billing staff in his office. Regarding hiring medical assistants, he said, "That's been very difficult. They just don't come back after three or four days or they go through training for a week, which costs a lot of time and money, and then they're supposed to come back. They don't go back, never. And I don't know if they go back to their old job or they're using us to leverage more money where they're at, I don't know." Specialists noted that nurse practitioners are in demand in the area. One clinician mentioned using a "broker" to fill open nurse practitioner positions at his office: "We have to pay for it, but it's been very worthwhile. We can go through a lot of candidates. It's a lot more reliable. A lot of times when we hired in the past it was word of mouth, but when we

[13] Your Medicare Therapeutic Shoes & Inserts: https://www.medicare.gov/coverage/therapeutic-shoes-inserts

expanded, we needed two or three NPs right away, and that was well worth the $10,000 a pop we paid."

## Practice Management and Acquisition

**Increased revenue was the primary reason clinicians explored changes to their practice management or ownership structure.** A limited number of the physician participants were involved in decisions about ownership; others were not involved. The physicians with a role in the management of their practice discussed how they "crunched the numbers" when reviewing offers to change their practice management or ownership.

One specialist mentioned being approached by hospitals and private equity and deciding that the practice was better off going it alone. Autonomy was a big concern as well when considering new management or organizational structures.

One specialist described how his practice had been part of a system but separated into a private group. He noted his reasoning: "[The health system's] inflexibility and their attitude towards physicians [was why I left and joined a private group]. And I made a bad decision just to having been in a physician group that had a primary service area and [the health system] insisted we would become employed, and I made a bad decision to become employed and regret it. And I'll regret it for the rest of my life." Other specialists noted that they had heard similar stories from friends, such as: "A friend of mine's dad who still has to work at age 70-something because he was hooked up with [health system] for a while."

## Concierge Medicine

**Some beneficiaries in St. Louis were familiar with concierge medicine.** However, they saw it as an expensive option for care, and none indicated that they had joined a concierge practice.

**Many clinicians were familiar with the concierge medicine model being employed in the St. Louis area.** Clinicians noted there are primary care practices in the St. Louis area that have gone concierge, but the number of concierge practices seems to be plateauing. One clinician explored going concierge and shared, "I've seen primary care guys go concierge. We thought of having one of our divisions go concierge. I think to some degree the market is saturated in St. Louis. Someone said, yeah, it is like we'll lose 90% of our patients if we do that, and someone says, good. But no, financially it really wouldn't make a huge difference. We looked at it, but yeah, people have definitely done it, but I think it's plateauing." Clinicians did not think that concierge practices in the area were limiting patient access to primary care because they believed the percentage of concierge practices was very small.

## Software as a Service (Artificial intelligence)

**Physicians were mixed on their use of AI in their practices and AI use was limited in scope.** Some clinicians noted they were not using AI at all. One primary care physician mentioned their organization may be using AI, saying, "I would say we don't use it, but I know we probably do. It's in the systems built in already. So, but I'm not aware of it directly. And I make no effort to use it." Other primary care physicians noted that the use of AI was coming to their practices, but it was not being used yet. Some physicians noted they were using AI for clinic interviews and scribing with positive results, while others felt that the AI results had a long way to go before being really useful. Some specialists noted there may be some specialties that benefit greatly from AI, like radiology. One physician noted, "For some of the things, AI may be better than some things in reading a chest x-ray because it's going to go through the whole algorithm of all those things. No offense to any of my friends who are radiologists but sometimes it's like, 'Yes, that looks normal,' and they might have missed something. They only look at it for a few seconds." Another specialist noted some benefits of AI: "The point is, it's been proven that AI performs better than physicians in a lot of tasks; it's been proven that AI can even be more empathetic than physicians; it can write better patient handouts than physicians can. I don't know, I think it's going to be revolutionary, but it's just a matter of time." This same physician noted that he will have to "check himself" when using AI because AI can reproduce errors introduced by clinicians.

## Accountable Care Organizations

Accountable care organizations (ACOs) are groups of doctors, hospitals, and other clinicians who provide coordinated care to their Medicare patients. There are several Medicare ACO programs, including the Medicare Shared Savings Program.[14] In each clinician group, we asked if clinicians were familiar with ACOs, and if they were participating in an ACO. To those with ACO experiences, we asked if they were involved in the decision to join, how the ACO affected their practice processes, financial rewards, and leaving an ACO (if applicable). One primary care physician and one nurse practitioner were participating in an ACO, and one specialist and one nurse practitioner had been approached to participate in an ACO. Six clinicians were unsure if they had been approached or were participating. The rest of the clinicians had not been approached and were not participating in an ACO.

**Specialists and primary care physicians did not think ACOs were playing a major role in health care delivery for the St. Louis area.** One specialist noted one system as a possible ACO in the area but thought the ACO was limited in scope. A nurse practitioner shared that some of her patients were in an ACO and had special supports like nurses and staff that reached out to them. She described how she is made aware of her patients interacting with ACO nurses or staff:

> *I don't know who these people are or where they are, but I see it in the computer. The ACO nurse reached out to whatever patient.... Sometimes I don't know why they call them. Sometimes I'm not really sure why; sometimes I will get a note saying that this patient's going to*

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

> *come in, this is an ACO patient. And they'll have this whole thing documented. It'll say click make me the author, trying to basically write my note. So there's certain things they want you to include on your notes on these patients.*

When describing the ACO, the nurse practitioner was not entirely clear on structure of the organization or how it was affiliated with her practice, but she shared, "I think it's at-risk pool and saving money, cost savings and all of that."

### Quality Reporting

We asked primary care physicians and nurse practitioners about their experiences with and opinions about quality reporting.

**Many clinicians reported there were quality reporting efforts at their organization and thought that the quality measures were reasonable.** Some clinicians receive regular updates on quality measures, but the feedback to clinicians was variable. Some of the quality measure clinicians reported receiving were patient satisfaction, ED admissions, smoking cessation, blood pressure control, statin use, hospital readmissions, colonoscopies, and A1C control. One clinician highlighted the challenge of eye exams for diabetes. He noted, "The biggest problem is eye exams for diabetics. Unless we walk the patient to the eye doctor and pay for the exam, how are we supposed to be responsible for them seeing an eye doctor?" Many of the clinicians felt like measures were reasonable, while noting that they are not able "to force people to do stuff."

### Evaluation and Management Visit Complexity Add-On Code

**We asked primary care physicians about familiarity with and experiences using the G2211 add-on codes,**[15] supplemental codes for physicians or practitioners in an outpatient office setting who are treating an ongoing illness and have a relationship with their patient. One of the primary care physicians who is in an independent practice explained, "If you're a physician who has got a relationship with a patient and you're caring for a chronic problem, it's an ongoing issue, you can add it to your normal code … and get some additional payment." One of the primary care physicians described using it regularly. Another primary care physician was surprised to hear the code existed.

## Prescription Drugs

We asked beneficiaries to rate their prescription drug coverage and spoke to them about the rationale behind their ratings, drug costs, pharmacy use, and ability to fill prescriptions. We also talked to

[15] Source: Centers for Medicare & Medicaid Services (CMS). Frequently Asked Questions (FAQs) About Office/Outpatient (O/O) Evaluation and Management (E/M) Visit Complexity Add-On HCPCS Code G2211. Retrieved from: https://www.cms.gov/files/document/hcpcs-g2211-faq.pdf

clinicians about their experience in prescribing, including prescribing GLP-1s,[16] the Medicare Drug Price Negotiation Program, and the cost of drugs for their patients.

## Clinicians

**Clinicians shared that some patients were aware of changes to the Medicare Part D benefit, including a new annual limit of $2,000 in patient cost sharing,** but other patients were not. One nurse practitioner noted:

> *Patients either, number one, didn't know about the change or number two, if they do know about it, they're, like, excited because at some point in the year they call, and they're like, 'I'm going to stop taking my [medicine] because it's too expensive.' And I'm like, wow, poor choice. But I understand that because it's like a thousand dollars or something. So I feel like we're going have less of those conversations. They just stay on their medicine that they're supposed to take. So some people are very excited about it.*

Another nurse practitioner noted, "I knew about it, but I haven't really heard anything from the patients about it."

**Many specialists were familiar with the changes to Medicare Part D but noted that some of their patients would not be able to afford all of their prescribed medications because $2,000 is more than many can afford.** One specialist shared:

> *But, like, I had a patient, and she has RA [rheumatoid arthritis]; she wants to control it. She came after a year. She's like, "I couldn't afford your copay. I couldn't afford the gas. I moved in with my daughter. And now I am taking less medicine to drag it out longer because at least I'm getting some medicine." So, I think these are real people who truly can't afford the medicine. It's not that they're entitled. They just don't have the cash flow.*

Another specialist noted, "I mean, when insulin went so high, there were people who were taking half their dose, and they were just running high[blood sugar]."

**Even with the updated Part D cost sharing limit of $2,000, clinicians expected that beneficiaries will struggle to afford medicine while balancing other essential expenses.** One specialist shared, **"**So it's not a bad thing, but it's not enough. There's plenty of people who $2,000 is too much money for them for the year. Even if you prorate it out, and it's $167 to $200 a month, that's their decision of whether they're going to pay the electric or the gas that month."

[16] Glucagon-like peptide-1 (GLP-1) agonists are a class of medications that mainly help manage blood sugar (glucose) levels in people with Type 2 diabetes. Some GLP-1 agonists can also help treat obesity. Source: Cleveland Clinic. GLP-1 Agonists. Retrieved from https://my.clevelandclinic.org/health/treatments/13901-glp-1-agonists.

### *Cost of Medications*

**Clinicians are not sure what their patients will have to pay for their medications when they are prescribing them a drug.** Some clinicians discuss the costs of the drugs they are prescribing up front with their patients when they know the medicine will be expensive. **"**Usually just up front I'm like, this medication is expensive. [For] some people, it's free. [For] some people, it's thousands of dollars. You just let me know if it's something you're uncomfortable with that we can get it here and out." Many clinicians noted they do not know what their patients will pay for their prescriptions. One said:

> *It's hard because I don't know what their insurance is. But I feel like especially at the beginning of the year there was a lot of changes to the manufacturer or pharmacy that patients were having to get their meds from. And that created a lot of chaos, I feel like, in the beginning of the year because patients either were paying more; the pill looked different. They had to get it, like I said, a different way.…*

Clinicians noted they are more likely to hear about the cost of their patients' medications from their patients after the patient has gone to the pharmacy to fill the prescription and realized its cost.

### *GLP-1s*

**Clinicians reported that patients are asking them about GLP-1s for weight loss.** One nurse practitioner shared:

> *I would venture to say that 85% of our patients a day ask about it, whether or not they're there for who knows what. They're like, "Oh, what about that weight loss medicine?" And you will prescribe it to anybody, but they have to know: if it's not covered, it's going to be expensive. And half of our patients don't care, they'll just pay the money. But everyone wants it. Everyone.*

Clinicians noted there is patient demand for the GLP-1 drugs, but because it is mainly covered by commercial insurance, there are a lot of patients who are not able to access these medications even if it would improve their current and long-term health. Medicare covers GLP-1s for specific conditions like type 2 diabetes but does not cover GLP-1s for weight loss.

**Clinicians see the health benefits of GLP-1s, including decreasing the risk of cancer and other chronic diseases.** Clinicians discussed how the benefits to their patients' overall health could be improved if they were able to access GLP-1s. Clinicians expressed frustration that their patients were not able to access these medications, even though the medications are effective and can reduce comorbidities, because the GLP-1s are not covered for their diagnosis and too expensive if patients have to pay out of pocket. One clinician noted, "I think there's a big stigma around it [GLP-1s], too, and I don't—and maybe at first I saw that stigma—but, like I said, now I feel like it has also been shown to decrease risks of other cancers."

**Despite the health benefits of GPL-1s, these medications are not always covered, or payers require clinicians to submit additional paperwork before the prescription is approved.** One nurse practitioner noted:

> *We would say we submitted the prior auth; it's denied. "Well, can you submit it again and tell them I've had this?" It doesn't really work like that. "Well, now I want you to put this as the primary diagnosis, so now I want you to put that and that." They don't quite understand insurance and then they get frustrated. They feel like we're being lazy and keeping it from them or not doing—because they'll call the insurance company. And the insurance company's like, "Oh, yeah. They just got to do this and this and this."*

Clinicians across the groups echoed their frustration with insurance companies denying their GPL-1 prescriptions and the administrative burdens that fall on clinicians to override their denials.

**GPL-1s are not available at all pharmacies.** In some cases, pharmacies were not able to keep up with the patient demand for GPL-1s. Clinicians were not clear whether the shortage of GPL-1s at some pharmacies was due to high demand or if some pharmacies were choosing not to stock them because carrying GPL-1s was a hassle for them.

### *Medicare Drug Price Negotiation Program*

Some physicians are familiar with the Medicare Drug Price Negotiation Program, but their knowledge is limited. Many of the physicians noted they had heard about the program but were not familiar with the details of the program. One primary care physician asked, "They didn't do that before?" In the specialist group, the discussion quickly pivoted to some specific medications, drug prices in general, and the role of drug samples.

## Beneficiaries

**Most beneficiaries rated their prescription drug coverage as good or excellent (Exhibit 7).** Sixty-one percent of Medicare-only beneficiaries and all dual eligible beneficiaries rated their coverage as excellent or good. No beneficiaries rated their coverage as poor.

Exhibit 7. Beneficiary satisfaction with prescription drug coverage

| | Traditional Medicare Only† | Medicare Advantage Only | Dual Eligible | Total† |
|---|---|---|---|---|
| **Excellent** | 3 (33%) | 2 (20%) | 6 (60%) | 11 (38%) |
| **Good** | 1 (11%) | 5 (50%) | 4 (40%) | 10 (34%) |
| **Fair** | 4 (44%) | 3 (30%) | 0 (0%) | 7 (24%) |

| | Traditional Medicare Only† | Medicare Advantage Only | Dual Eligible | Total† |
|---|---|---|---|---|
| **Poor** | 0 (0%) | 0 (0%) | 0 (0%) | 0 (0%) |

† Percentages do not sum to 100% because one beneficiary did not respond to this question.

### *Pharmacy Use*

**Beneficiaries noted that convenience is a key factor when they are selecting a pharmacy for filling their prescriptions.** Beneficiaries mentioned retail pharmacies like Walgreens, Costco, and CVS as their preferred pharmacies. In some cases, they expressed a specific location that they prefer to use while others discussed going to different branches of the same pharmacy, based on convenience, experience, and availability of their medications. Other beneficiaries shared their preference for receiving their prescriptions by mail through their health plan's pharmacy benefit manager or services like Amazon PillPack. One beneficiary who uses Amazon PillPack shared:

> *[My prescriptions] come right to my door in a nice, little, pretty box. And each prescription is in a tab in a packet, and I take one off, and I tear it off, and I stick in my bra, and I run out the door. And I love it. I would not have any other prescription company other than them. For me, it works because I take multiple medications. I had got to the point where I wasn't sure whether I took this medicine this morning or not, and I overdosed myself a couple of times on my different meds. And I was undertaking blood pressure meds or overtaking it. And so, I just was looking at the TV one night and saw the little commercial come on for Amazon PillPack.… And it's perfect for me because I don't get confused.*

One beneficiary noted, "I'm hesitant about getting it in the mail, because the post office is so unsteady." For beneficiaries who use mail order services for most of their prescriptions, they also discussed having a retail pharmacy that they rely on for acute or one-off prescriptions.

**Some beneficiaries reported having strong relationships with their pharmacist and described pharmacists' important role in their care.** Some beneficiaries said they talk to their pharmacist every month, and their pharmacists remind them how and when to take their medications. Some pharmacists reach out to clinicians to streamline patients' prescription process. One beneficiary shared how her pharmacist helped with her prescriptions:

> *Any time I had a problem with any prescription, I could talk to him, and he would get it fixed. He did leave probably about two years ago, but he opened up his own pharmacy out in [city] which is too far for me to drive. And our pharmacist that I've been dealing with since then has been really great, too. When I finally told him about the problem with the pain medicine, he goes, "We faxed them asking for them to check the box. If we don't hear from them, and I'll get on it." I said, but if this happens, call me and let me know so I can get on it, instead of waiting three or four days for a text to come through saying my medicine's there, and it's never coming. You know, and he did that.*

Another beneficiary noted how important their relationship with their pharmacist is: “I know the pharmacist; they talk to me. I can ask them any kind of questions, and if I don’t come in, they will call me and ask me if I’m OK. When I went into hospital and I was gone for a while, they were concerned. So, I like them.” No beneficiaries in our groups reported experiencing pharmacists spending less time working with them.

**Beneficiaries in St. Louis reported that pharmacies are closing in their communities.** A number of beneficiaries discussed how their preferred, and often closest, pharmacy had closed. The examples reported were local branches of national chains. Sometimes the pharmacy closures made it challenging for beneficiaries to get the medication they needed. This was particularly true for controlled substances. One participant shared, “Doctor has to send them a script specifically. They cannot transfer controlled substances.”

**Beneficiaries described exploring alternatives to using their insurance to pay for prescriptions at retail pharmacies.** They mentioned using GoodRx instead of their prescription drug coverage. One beneficiary described how he decides whether he will fulfill his prescription at a retail pharmacy or through a mail order service: “Well, the downside is, if it’s not a generic, we use GoodRx. And I found that one time when I had insurance, using GoodRx was cheaper for my glaucoma medicine than with insurance.” Another patient mentioned, “The other thing you can do is go to pharmacy checker out of Canada, and you’ll get a list of all the companies in Canada and the prices of your drug. And it’s very simple. They’re always cheap.”

**Some beneficiaries said Medicare Advantage plans limit the pharmacies their members use.** One beneficiary shared, “I’m supposed to go to [specific retail pharmacy] too with [MA plan], but I think if I go to [another retail pharmacy], they will fill it and just charge me. I can still go to another place, but they’re going to upcharge me.” Other beneficiaries noted that they only go to certain pharmacies, but that it was not a problem for them. One beneficiary said she chose a plan based on being able to go to any pharmacy:

> *I picked a plan that I can go to any pharmacy that I wanted to. Because I didn’t want to be looped into just going to [INAUDIBLE], and the pharmacy I go to is the neighborhood pharmacy, and they know you, and like I was telling the people, if I go there, because some of my medicine is expensive, and I don’t have the money right then, they will still let me have the medicine.*

### *Ability to Fill Prescriptions*

**Beneficiaries discussed how some pharmacists work with their clinicians and insurance to sort out administrative challenges with refilling their prescriptions.** In some cases, the pharmacist would nudge the beneficiary’s clinician on their behalf, and at other times, they would let the beneficiary know if the clinician had not taken action so the beneficiary could follow up with the clinician.

**Retail pharmacies do not always have the medications in stock, and beneficiaries reported not knowing why or when their medication would be available.** One beneficiary discussed how her

normal pharmacy did not have her medicine, and "They had to go send me to another pharmacy to get it because they couldn't get it. They didn't know when they'd get it, but they called around, thank goodness, and they found one that had it." Similar experiences were echoed by other beneficiaries. One noted, "It's always out. It's always extra two or three days." Beneficiaries describe calling around to other pharmacies to find one that has their medicine in stock. In some cases, it could take patients days or weeks to get the medicine they were prescribed. For some beneficiaries, shortages were related to manufacturing delays. One beneficiary shared how she handled not being able to collect her prescription, "I called my doctor and told them it wasn't available, and the pharmacies didn't know when it would be available, and they just prescribed something different."

**Beneficiaries shared different approaches to managing expensive prescriptions.** One shared, "I had a new one. It's like $800 a month, and it's like, I'm not paying it. I beg my doctor for some samples, which is what I'm taking when I run out. I'm going to go back for some more." Another beneficiary discussed calling the drug company directly to see if the company could offer any deals on their prescription as an option.

**Medicare beneficiaries reported concerns about reaching the Medicare "donut hole" or coverage gap phase.**[17] Participants had experienced the donut hole before and reported that it was confusing and hard to navigate. One beneficiary said, "I don't understand what you are putting out, what your Medicare's putting out, and what your gap insurance is putting out, all combined. It's like you're penalized for what you've already paid out. I don't get it. It doesn't make sense to me." Beneficiaries had a level of uncertainty when they were picking up their prescriptions because they were not always clear about the cost of their prescriptions and whether they had reached the donut hole.

# Findings from Focus Groups with Medicare Beneficiaries in Rural Areas, 2021–2025

## Introduction

This section of the report summarizes findings from virtual focus groups that were conducted from 2021 to 2025 with Medicare beneficiaries residing in rural areas of the United States. We present findings in three areas: rural considerations in choosing Medicare coverage; access to care in rural areas; and prescription drug access in rural areas. We focus on findings where there were specific considerations for beneficiaries given their rural location or where there were differences between rural and non-rural beneficiaries.

[17] The Medicare coverage gap phase was eliminated in 2025, resulting in standard Part D coverage consisting of a three-phase benefit: a deductible phase, an initial coverage phase, and a catastrophic phase. Source: Centers for Medicare & Medicaid Services (CMS). July 2024. CMS Releases 2025 Medicare Part D Bid Information and Announces Premium Stabilization Demonstration. Retrieved from: https://www.cms.gov/newsroom/fact-sheets/cms-releases-2025-medicare-part-d-bid-information-and-announces-premium-stabilization-demonstration

## Methods

From 2021 to 2025, we held a total of 13 focus groups with 74 participants who resided in rural areas of the United States (Exhibit 8). Focus groups were held annually in the spring or summer. All focus groups were conducted virtually using a videoconferencing platform. We used the same recruitment process as described in the Methods section above (i.e., using a screener and aiming for representation across demographic characteristics). To best moderate the virtual focus groups, we set out to recruit eight participants, with a goal of having six to seven participants in each group.

Exhibit 8. Overview of rural focus groups, 2021–2025

| Year | Participants (n) | Number of groups (n) | Recruitment region | Recruitment partner |
|---|---|---|---|---|
| 2021 | 11 | 3 | Beneficiaries residing in Idaho, Montana, Nebraska, North Dakota, South Dakota, and Wyoming | National recruitment firm and NORC's AmeriSpeak panel |
| 2022 | 16 | 3 | Beneficiaries residing in Alabama and Mississippi (two groups) and West Virginia (one group) | Local recruitment firms |
| 2023 | 21 | 3 | Beneficiaries residing in rural areas nationwide, defined as a ZIP code not in a metropolitan or micropolitan statistical area[18] | National recruitment firm |
| 2024 | 19 | 3 | | |
| 2025 | 7 | 1 | | |
| **Total** | **74** | **13** | | |

All rural focus groups were recorded and transcribed. We coded and analyzed transcripts using the approach described in the Methods section above. Findings from the 2021 to 2024 rural focus groups were summarized in reports to MedPAC each year. We used the 2021 to 2024 reports and the 2025 transcript to develop this section of the report.

## Choosing Coverage

We asked rural participants how they chose between traditional Medicare and MA.

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

### *Access to Clinicians*

**Beneficiaries with traditional Medicare reported that being able to see preferred clinicians without restrictions was an important consideration in their coverage choice.** They cited having fewer local clinicians and not wanting to restrict their options by being limited to a MA plan's provider network. A 2024 participant noted, "I chose traditional Medicare because we are in a very rural area, and I understand that the other plan is somewhat selective on what doctors you can use. So, we didn't feel like we could take that option." Similarly, in 2025, a participant with traditional Medicare explained, "They [local hospital and affiliated clinic] do not accept MA, any of the MA plans. So for anyone living in our area, that really is not an option." Another 2025 participant with traditional Medicare said, "I had read something that in the area where I live, it can be very restricted, the doctors that you can see. So that, that didn't work for me because we, my husband's care is at [health system] mostly, and I like what happens there with him. So I want the option of going there as well." She later added, "That's one of the advantages of the [Medi]gap program, that you can go wherever.… I was able to just go to any physician I wanted to.… I've been very, very happy with being able to, I guess, go anywhere in the country, to whatever doctor."

**A couple of rural participants cited clinician access as a reason they had switched from MA to traditional Medicare.** A 2021 participant explained, "For me, the Medigap works much better because I don't have any unexpected out-of-pocket expenses at all, and I get to choose which doctor I go to, where with my Advantage plan you know there were limitations on what—it was more of a network of doctors you can see." A 2023 participant with traditional Medicare said, "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."

**Rural beneficiaries with MA also considered access to clinicians when choosing their coverage.** In 2024, one participant describing her MA plan said, "[Plan name] has a large network.… Most doctors in this area participate with [plan name]." A 2025 participant explained:

> *That was one of the things that really make me go [MA plan], because we don't have very many doctors in this area. And I did check to see if she was going to be on that list of people, and luckily she was. So that was something that really made me determine who I was going to go with for my health care.*

### *Supplemental Benefits*

**Some rural beneficiaries were familiar with or had used supplemental benefits offered by MA plans, but generally these benefits did not factor into their coverage decision-making.** A few beneficiaries had used transportation benefits offered by their plans. Several explained that, due to their rural location, they could not access their plan's gym membership benefit. One 2024 participant said:

> *I'm very rural. I'm out in the middle of nowhere. And the Silver Sneakers program, I don't even recall if it was available to me because of my remote location.... I looked into it, and it was going*

*to be an hour and half drive each way to do it. And now I can walk around my house. I'm in the mountains, and everything's uphill, so I get my own exercise that way.*

## Access to Care

We asked rural beneficiaries about their access to primary and specialty care and what they would do in various medical scenarios.

### *Availability and Quality of Local Clinicians*

#### *Primary Care*

**Almost all beneficiaries across years had local access to primary care**. Reported wait times for routine primary care ranged from same day to several weeks or a month. Distance traveled to primary care ranged from a few minutes away to up to an hour.

**Some rural beneficiaries had faced challenges finding a new primary care provider.** A 2021 participant described how a primary care provider had left their area, and a permanent replacement had not been found: "We are now being served by a kind of a rotation of PAs, and they're not there every day. So, we're kind of in limbo out here." In 2025, a participant explained it had taken her a year to find a new primary care provider, saying, "I had a lot of difficulty finding a PCP.… When you're in a rural area, it's really difficult."

#### *Specialty Care*

**To access specialty care, some rural beneficiaries took advantage of arrangements in which specialists made routine (e.g., weekly or monthly) visits to their local hospital.** In 2025, one participant explained, "And as far as specialists, it's only a situation where in certain specialties they may have a visiting specialist that comes once a month. But otherwise it's up to you to seek specialists that are a considerable driving distance from where we live, which is not unique in Montana."

**Many rural beneficiaries traveled outside their local communities to access specialists. In some cases, this travel was necessary to access a specialty not available locally.** A 2025 participant said, "I have several specialists, and I have to go over an hour to get to each and every one of them, to get good care, and that specialized care, because in our community, we just don't have that: it's very rural." She later explained:

*I've had several times when I've had to [travel]. They actually weren't my choice, but they were the only choice available for transplants.… I've had three different transplants that, they were critical, and if I, if I had gone to a hospital nearby, I would not have been able to receive that transplant. So these transplants were taking place, you know, several hundreds of miles away from my home. And it, it was my only option.*

**In other cases, rural beneficiaries chose to travel to access a specific clinician or hospital due to perceived quality of care.** For example, in 2021, a beneficiary reported traveling 3,000 miles to see an orthopedic surgeon who was an expert in their health issue, despite the option to access closer specialists. In 2022, multiple beneficiaries said that they would choose to travel longer distances to a medical facility if they knew it had better quality care. A 2024 participant chose to travel more than 250 miles to receive care at a health system and with clinicians that they trusted to manage their complex condition. In 2025, a participant explained:

> *I go to a specialist who is about an hour and a half away. He's a gastroenterologist, and I go to a cardiologist who's two hours away, and that was my choice. They're in network, but they were, after some—a lot of research, they were the best, and recommendations. So, I've chosen to travel, to see what I consider the better doctors.*

Another 2025 participant chose to travel two hours for a specialist, explaining, "I wanted a second opinion.… [Health system] has a very good reputation. My husband gets his care there. It's been wonderful. That's why I chose them." A third 2025 participant described how he would seek care at a hospital other than his local facility: "My PCP knows that, assuming I'm not comatose, if I'm able to make a decision, that I will not be a[n] inpatient at this facility because of quality-of-care issues. And so I would AMA [against medical advice] out of the emergency room and go to about 125 miles from here, probably, for the care that's needed."

### *Accessing Care in Different Medical Scenarios*

We asked rural beneficiaries how they would access care in different medical scenarios. For a minor urgent need such as an injury requiring stitches, beneficiaries said they would visit their primary care provider or a walk-in clinic, urgent care, or the local emergency department (ED). For other acute needs or a sick visit, beneficiaries described seeking care at the same locations; seeing another clinician in their primary care provider's office, including a nurse practitioner or physician assistant; messaging their clinician through an online portal; or having a telehealth visit. In 2021, a participant explained, "If we had a PA or a nurse practitioner at the clinic that particular day, they would probably work me in. Otherwise, I'd have to head 68 miles to an urgent care, same-day care or an ER." A 2025 participant said, "So if there's a situation where you can't, you know, like you wake up feeling sick and you need to see somebody and you can't get in to see the primary or even a nurse practitioner, you just walk right into the clinic there, in the hospital and they see you right away."

For a major medical emergency such as a heart attack, many beneficiaries reported that they would take an ambulance to the nearest hospital and then be transferred to another hospital in an urban area once stabilized. A 2023 participant explained:

> *Now, talk about my husband with his heart condition. His [cardiologist] is three hours away in [city]. 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 [city]." That's the way it is here. You're either going by air transport or ground transport ambulance.*

For major, non-emergency care or surgery, such as a hip replacement, beneficiaries said they would shop around for the best or most experienced physician and would travel farther to receive care at a larger hospital.

### *Rural Health Care Needs and Changes*

**In general, rural beneficiaries seemed satisfied with their access to care, even when acknowledging that their rural location sometimes affected decisions about seeking care**. A 2021 participant said, "If access to care is inconvenient, that could mean that I would delay care. But if the medical condition became significant enough, then the distance would not preclude my seeking care." Rural beneficiaries described access barriers as a tradeoff of their decision to live in a rural area. A 2024 participant explained, "For urgent needs [the distance is] a problem. But for routine or scheduled things, no, it's not a problem.… The decision to live remotely came with that risk, and it's something I'm willing to take."

We asked beneficiaries about changes to their local health care landscape and about their communities' unmet health care needs. Rural beneficiaries described the need for more access to urgent care facilities, emergency departments, and hospitals, or for more resources and specialists at local hospitals. A 2022 participant explained, "Speaking about the local hospital… They do not maintain regular staff. They don't appear to be trained to do very much other than basic stuff, and they don't have any specialists at all here. That is the challenge here. No specialists locally. No operations, no surgeons, nothing but aspirin and maybe a shot." Others mentioned long wait times for ambulances in an emergency, the need for more medical transportation options, and the need for more specialty care to meet the needs of aging populations. A 2023 beneficiary said, "You'll find that emergency services are severely lacking out here. It'll take 45 minutes to get an ambulance to us out here." Another 2023 beneficiary explained, "Our population up here is getting older… and with an older population, we don't have the number of even volunteers when you're talking about an ambulance. I mean, my husband was having a heart attack and I had to call twice to get an ambulance out here… I could have thrown him in the car and driven him the 25 miles faster than the ambulance came." Some participants' communities had unmet needs as local clinicians had retired and not been replaced, or because local hospitals had closed. In 2024, one beneficiary's primary care provider had switched to a direct primary care model; she decided to pay the monthly fee to continue seeing this clinician and was satisfied with her access to and quality of care.[19]

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

## Prescription Drugs

**Beneficiaries in rural areas reported they were generally able to access local pharmacies.** Across years, most rural beneficiaries said they were able to fill prescriptions at their local pharmacy, including independent and retail chain pharmacies. In 2021, one beneficiary reported that their local pharmacy did not take their Part D plan, so they got prescriptions from a larger pharmacy about a four-hour drive away.

**Some beneficiaries described limitations with local pharmacies, including longer wait times for medications to be filled, lack of access to specialty medications, or not all drugs being stocked.** A beneficiary in 2022 explained, "You can call your prescriptions in and then they will fill it, but sometimes it takes forever for them to do that because it is a local pharmacy. I guess they have a lot of patients or whatever, but it takes a while sometimes." A beneficiary in 2024 described a family member's experience waiting a day for a medication to be available, saying she had a "small town pharmacy, and they don't stock as much as a big pharmacy somewhere.… I think that's just one of those things that happens with small pharmacies."

**Some rural beneficiaries chose to, or were encouraged by insurance to, use a mail order pharmacy or did so because of convenience.** A beneficiary in 2025 explained that they were compelled by insurance to use a mail order pharmacy: "For cost reasons, you're pretty much beholden to getting your chronic drugs through that arrangement [mail order pharmacy benefit manager]. On my acute drugs and my wife's acute drugs, we get them through a local pharmacy here, which is excellent." In 2024, one beneficiary described the ease of this option: "I get 90-day supplies, and they get mailed right to me. Being in such a rural area, it's kind of a pain to drive 30-mile round trip just to go to the pharmacy and pick up a prescription, so it's nice they just come to my mailbox." Another beneficiary in 2025 relied on mail order for most prescriptions but used a local pharmacy for some medications: "I do use a mail order pharmacy, and I have a local pharmacy that's really small. It's an independent pharmacy for anything that's, you know, like a one-off script from my regular doc."

**Several beneficiaries in 2025 had been affected by pharmacy closures in their areas.** One beneficiary's local outpost of a national pharmacy chain closed on the weekends, so they had to switch to another national pharmacy chain in order to pick up prescriptions when it was convenient for them. Another beneficiary's location of the same national chain closed completely, forcing them to choose between two other national pharmacy retailers for weekend pharmacy access. A third beneficiary's regional grocery store pharmacy closed, leaving two local choices.