

The Medicare Mental Health Coverage Gap: How Licensed Professional Counselors Navigate Medicare-Ineligible Provider Status



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This interpretative phenomenological analysis explored licensed professional counselors' experiences of turning away Medicare beneficiaries because of the current Medicare mental health policy. Researchers used semi-structured interviews to explore the client-level barriers created by federal legislation that determines professional counselors as Medicare-ineligible providers. An in-depth presentation of one superordinate theme, *ineffectual policy*, along with the emergent themes *confounding regulations*, *programmatic inconsistencies*, and *impediment to care*, illustrates the proximal barriers Medicare beneficiaries experience when actively seeking out licensed professional counselors for mental health care. Licensed professional counselors' experiences indicate that current Medicare provider regulations interfere with mental health care accessibility and availability for Medicare-insured populations. Implications for advocacy are discussed.

Keywords: Medicare, interpretative phenomenological analysis, mental health, advocacy, federal legislation

Medicare is the primary source of health insurance for 60 million Americans, including adults 65 years and over and younger individuals with a long-term disability; the number of beneficiaries is expected to surpass 80 million by 2030 (Kaiser Family Foundation, 2019; Medicare Payment Advisory Commission, 2015). According to the Center for Medicare Advocacy (2013), approximately 26% of all Medicare beneficiaries experience some form of mental health disorder, including depression and anxiety, mild and major neurocognitive disorder, and serious mental illness such as bipolar disorder and schizophrenia. Among older adults specifically, nearly one in five meets the criteria for a mental health or substance use condition, and if left unaddressed, these issues may lead to consequences such as impaired physical health, hospitalization, and even suicide (Institute of Medicine, 2012).

Past research demonstrates that Medicare-eligible populations respond appropriately to counseling (Roseborough, Luptak, McLeod, & Bradshaw, 2012). Federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) publish entire guides on how to use counseling to treat depression and related conditions in older adults (SAMHSA, 2011). However, researchers have noted specific challenges that Medicare-eligible populations, such as older adults, face when trying to access mental health services. Stewart, Jameson, and Curtin (2015) described acceptability, accessibility, and availability as three intersecting dimensions that may influence whether an older adult in need of help is able to access care. In contrast to *acceptability*, which focuses on whether older individuals are willing to participate in specific mental health services, accessibility and availability are both supply-side issues that impede older adults' engagement with mental health services. *Accessibility* refers to factors like funding for mental health services and providing transportation support to attend appointments. *Availability* is used to describe the number of mental health professionals who provide services to older adults within a particular community.

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Stewart et al.'s (2015) framework is useful when examining current Medicare policy and its impact on beneficiaries' ability to participate in mental health treatment when needed. Experts have criticized Medicare for its relative inattention to mental health care (Bartels & Naslund, 2013), noting a remarkably low percentage of its total budget is spent on mental health (1% or \$2.4 billion; Institute of Medicine, 2012), as well as a lack of emphasis on prevention services. In terms of accessibility, Congress has made efforts to remove restrictions to using one's health insurance to access mental health treatment. For example, mental health parity laws were passed in 2008 to ensure that Medicare coverage for mental illness is not more restrictive than coverage for physical health concerns (Medicare Improvements for Patients and Providers Act of 2008, 2008). Yet current Medicare policy may restrict the availability of services at the mental health provider level. For example, the Medicare program has not updated its mental health provider licensure standards since 1989, when licensed clinical social workers were added as independent mental health providers and restrictions on services provided by psychologists were removed (H.R. Rep. No. 101-386, 1989). Although counseling is only one mental health care modality available to Medicare beneficiaries, counselors can play a prominent role in the mental health treatment of older adults and people with long-term disabilities.

Meanwhile, there are references in the literature to a provider gap that may influence the ability of Medicare beneficiaries, including older adults, to access mental health services. A 2012 Institute of Medicine report described the lack of mental health providers as a crisis, and experts on geriatric mental health care have decried the lack of mental health professionals who focus their work on older adults (Bartels & Naslund, 2013). Despite these concerns, relatively little attention has been given to the influence of Medicare provider regulations in limiting the number of available providers. Scholars have noted that a significant proportion of graduate-level mental health professionals are currently excluded from Medicare regulations, despite providing a substantial ratio of community-based mental health services (Christenson & Crane, 2004; Field, 2017; Fullen, 2016; Goodman, Morgan, Hodgson, & Caldwell, 2018). Licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) jointly comprise approximately 200,000 providers (Medicare Mental Health Workforce Coalition, 2019), which means that approximately half of all master's-level providers are not available to provide services under Medicare. Since their recognition as independent mental health providers by Congress in 1989, only licensed clinical social workers and advanced practice psychiatric nurses have constituted the proportion of master's-level providers eligible to provide mental health services through Medicare.

Despite current Medicare reimbursement restrictions, Medicare beneficiaries are likely to seek out services from LPCs. Fullen, Lawson, and Sharma (in press-a) found that over 50% of practicing counselors had turned away Medicare-insured individuals who sought counseling services, 40% had used pro bono or sliding scale approaches to provide services, and 39% were forced to refer existing clients once those clients became Medicare-eligible. When this occurs, the Medicare mental health coverage gap (MMHCG) impacts providers and beneficiaries in several distinct ways. First, some beneficiaries may begin treatment only to have services interrupted or stopped altogether once the provider is no longer able to be reimbursed by Medicare. This can occur because of confusion about whether a particular patient's insurance coverage authorizes treatment by a particular provider type, or when beneficiaries who have successfully used one type of coverage to pay for services transition to Medicare coverage because of advancing age or qualifying for long-term disability.

Most Medicare beneficiaries (81%; Kaiser Family Foundation, 2019) have supplemental insurance, including 22% who have both Medicare and Medicaid. Medicare beneficiaries who are dually eligible for Medicaid may be particularly vulnerable to the MMHCG. In most states, Medicaid authorizes

LPCs to provide counseling services; however, in certain cases when these individuals also qualify for Medicare, the inconsistency in provider regulations between these programs can interfere with client care. A similar problem occurs when the Medicare-insured attempt to use supplemental plans (e.g., private insurance, Medigap) because of Medicare functioning as a primary source of insurance, and supplemental plans requiring documentation that a Medicare claim has been denied. Regardless of the reason for having to terminate treatment prematurely, early withdrawal from mental health treatment has been described as inefficient and harmful to both clients and mental health providers (Barrett et al., 2008).

The MMHCG also can interfere with clients' ability to access services because of a lack of Medicare-eligible providers in a particular geographical region. For example, beneficiaries who reside in rural localities can have more difficulty finding mental health providers because of a general shortage of providers in these areas (Larson, Patterson, Garberson, & Andrilla, 2016). Larson et al. (2016) found that rural communities were less likely to have licensed mental health professionals overall, although these localities were more likely to have a counseling professional than a clinical social worker, psychiatric nurse practitioner, or psychiatrist. Historically, older adults from rural and urban localities experience a comparable prevalence of mental health disorders (Center for Behavioral Health Statistics and Quality, 2018). However, studies consistently describe low rates of mental health services accessibility and availability within rural communities (Smalley & Warren, 2012). Establishing counselors as Medicare-eligible providers can reduce the disparities of mental health services accessibility and availability experienced by older adults in rural communities.

Although it is known that LPCs are currently excluded from Medicare coverage, it is not well understood what sort of impact this has on mental health providers and the Medicare beneficiaries who seek their services. Recent efforts to raise awareness of this issue have emerged in the literature (Field, 2017; Fullen, 2016; Goodman et al., 2018), but there has not yet been an investigation into the phenomenological experiences of mental health providers who are directly impacted by existing Medicare policy. The purpose of this study was to explore the lived experiences of mental health professionals who have turned away clients because of their status as Medicare-ineligible providers. The primary research question for this study was: How do Medicare-ineligible providers make sense of their experiences turning away Medicare beneficiaries and their inability to serve these clients?

Research Design and Methods

This study was executed using interpretive phenomenological analysis (IPA) to guide both data collection and analysis. The study focused on the experiences of Medicare-ineligible mental health professionals as they navigated interactions with Medicare beneficiaries who sought mental health care from them. By using a hermeneutic approach to understand their unique perspectives on this phenomenon, we aimed to remain consistent with the philosophical approach of IPA, which is idiographic in nature (Smith, Flowers, & Larkin, 2009). This study received approval from the Western Institutional Review Board.

IPA focuses on the personal meaning-making of participants who share a particular experience within a specific context (Smith et al., 2009). We determined IPA to be the most appropriate method to answer our research question because of the personal impact on LPCs of turning away Medicare beneficiaries because of Medicare-ineligible provider status. Nationally, LPCs share the experience of being unable to serve Medicare beneficiaries because of the current Medicare mental health policy that establishes these licensed mental health professionals as Medicare-ineligible. IPA also is

appropriate for this study because of the positionality of the researchers. The research team consisted of two LPCs and one LMFT who have denied services or had to refer clients because of the current Medicare mental health policy and have engaged in prior research and advocacy related to the professional and clinical implications of the current Medicare mental health policy. We selected IPA for this study because of the shared experience between the researchers and participants as Medicare-ineligible providers. A distinguishing feature of IPA, a variation of hermeneutic phenomenology, is the acknowledgment of a double-interpretative, analytical process: The researchers make sense of how the participants make sense of a shared phenomenon (Smith et al., 2009).

Participants

Participants were screened based on the inclusion criteria of having direct experience with turning away or referring Medicare beneficiaries and holding a mental health license as an LPC. Because states grant licenses to health care providers, we limited participation to LPCs who were practicing in a specific state in the Mid-Atlantic region. This allowed for consistency in licensure requirements, training provided, and current scope of practice across all participants. The nine participants interviewed all held the highest professional counseling license in this state, which allows these individuals to practice independent of supervision after completing 4,000 hours of supervised training. Post-license experience ranged from 6 months to 17 years, and participants practiced in both rural and non-rural settings. Pseudonyms were assigned by the research team (see Table 1 for participant information).

Table 1

Participant Information

Participant	License Type	Rural Status ^a	Years of Licensed Experience
Michelle	LPC	Rural	4 years
Cecelia	LPC	Non-rural	5 years
Mary	LPC	Non-rural	17 years
Roger	LPC	Non-rural	2 years
Aubrey	LPC	Rural	4 years
Donna	LPC	Rural	4 years
April	LPC	Non-rural	0.5 years
Robert	LPC/LMFT	Non-rural	22 years
Brandon	LPC	Rural	5 years

^aThe table displays rural status as designated by the U.S. Department of Health and Human Services Health Resources and Services Administration (2016) according to the practice location of the participant. Non-rural includes metropolitan and micropolitan areas. Rural indicates any locality that is neither metropolitan or micropolitan.

Most participants were identified because of having completed a national survey of mental health providers unable to serve Medicare beneficiaries (Fullen et al., in press-a). Participants in the national survey were provided with a question in which they were able to indicate their openness to participating in follow-up individual interviews regarding their experiences with turning away clients as a result of Medicare policy. Two additional participants had not completed the national survey but were identified

locally because of their unique experiences with the phenomenon under investigation. We selected nine participants in accordance with IPA participant selection and data saturation guidelines (Smith et al., 2009). Although the current Medicare policy excludes both LPCs and LMFTs, we chose to focus on the experiences of LPCs to ensure a purposive and homogeneous sample (Smith et al., 2009).

Data Collection

Semi-structured, in-depth interviews of the nine participants were conducted by the research team. All research team members are LPCs or LMFTs. Individual interviews were conducted by a single member of the team who digitally recorded and transcribed verbatim the interview procedure. Consent was obtained from the participants and pseudonyms were used to ensure participant confidentiality. Also, participants were given the option to stop the interview at any time. The elapsed time of each interview ranged between 47 and 66 minutes. The semi-structured interview protocol began with two initial questions to frame the interview: (a) Have you ever had to refer a potential client to another counselor/therapist/agency because of not being able to accept their Medicare insurance coverage? and (b) Have you ever established a working relationship with a client who later transitioned to Medicare insurance coverage?

Based on participant responses to these initial questions, two grand tour questions followed: (a) Tell me about what typically occurs when someone with Medicare insurance contacts your office in search of counseling? and (b) Tell me about any times when you have had to alter a pre-existing working relationship with a client because of their Medicare coverage? Follow-up questions focused on the impact of current Medicare mental health policy on the interviewees, as well as their perceived impact on clients, local communities, other therapists in the area, and their employment contexts.

Data Analysis

The IPA process outlined by Smith et al. (2009) was employed to analyze the transcribed interview data. The following steps were employed throughout the analysis process: (a) reading and re-reading of transcripts, (b) initial noting, (c) developing emergent themes, (d) searching for connections across emergent themes, (e) moving to the next case, and (f) looking for patterns across cases. Codes and themes developed at each stage of the first transcript analysis required consensus agreement among the authors. After re-reading, initial noting, developing emergent themes, and clustering of superordinate themes for each of the remaining interviews, the authors proceeded to engage in a group-level analysis process of looking for patterns across all interviews. Patterns across all interviews were organized into a concept map to synthesize connections and relationships between the interviews. Connections and relationships identified through this cross-case analysis led to the identification of a group-level clustering of superordinate themes that resulted in the identification of the primary themes.

Trustworthiness

The authors attended to the credibility and trustworthiness of this analysis using four strategies. First, the authors have prolonged engagement in the fields of counseling and marriage and family therapy as licensed professionals. This prolonged engagement has allowed the authors to be situated to the contexts of the participants, account for abnormalities in the data, and transcend their own observations (Lincoln & Guba, 1985). Second, the authors engaged in a team-based reflexive process through the sharing of personal reflections and group discussions about emerging issues (Barry, Britten, Barber, Bradley, & Stevenson, 1999). Third, negative case analysis was used in the analytical process of this study to develop, broaden, and confirm themes that emerged from the data (Lincoln & Guba, 1985; Patton, 1999). The fourth strategy was analyst triangulation (Denzin, 1978; Patton, 1999). All three authors participated in the development of the study, data collection, and data analysis to

reduce the potential bias that can emerge from a single researcher performing each of these tasks (Patton, 1999). Each researcher independently analyzed the same data and compared their findings throughout data analysis to check selective perception and interpretive bias.

Results

Three superordinate themes emerged from our interviews with nine mental health professionals who have experience with the Medicare coverage gap: ineffectual policy, difficult transitions, and undue burden. We will discuss one superordinate theme, ineffectual policy, with the emergent themes of confounding regulations, programmatic inconsistencies, and impediment to care. By presenting a single meta-theme, we hope to provide increased depth and the nuanced experiences that our participants shared (see Levitt et al., 2018 for a discussion on dividing qualitative data into multiple manuscripts).

All nine participants expressed concerns about the ineffectiveness of current Medicare policy when it comes to treating people with mental disorders who live in their communities. The disconnect between Medicare's intended aim—to provide sound health care to beneficiaries—and the present outcome for clients seeking out counseling led us to describe the policy as ineffectual or not producing the intended effect. Our participants perceived that the policy had severe shortcomings in terms of providing access to mental health care, which they viewed as a serious problem with cascading consequences for their clients, communities, and themselves.

Confounding Regulations

Several participants described the Medicare coverage gap as “confusing” and “frustrating” for mental health providers and Medicare beneficiaries who are seeking mental health services. Brandon, an LPC who serves as a director within a Federally Qualified Health Center, stated, “Most people are pretty shocked to realize we are not part of Medicare.” He went on to explain that most medical providers, including psychiatrists, were not aware of LPCs' Medicare ineligibility when making client referrals. Participants described how the confusion interferes with referrals between medical providers and clients seeking mental health services.

Other participants described how frustrating the policy is, both for themselves and their clients. Robert, an LPC who also is credentialed as an LMFT, stated that “as a provider, it's frustrating to turn people away,” and “it's especially concerning for older people who can't afford to pay out of pocket.” Michelle, who works as an LPC in a rural community, described how the MMHCG influences clients' views of the larger Medicare system, stating, “[Clients are] very angry—not directed towards me, just the system . . . they're on Medicare now [and] they have to leave. They paid into a system and then still can't see the clinician that they want to see.” According to interviewees like Michelle, current Medicare provider regulations do not account for the preponderance of LPCs who provide care, particularly in rural communities. Regulations are then perceived by clients as an additional barrier to getting help at a time when they may be vulnerable.

In fact, in certain cases, current Medicare policy may result in all Medicare beneficiaries within a particular community losing access to mental health care. Brandon described a 4-month period when his Federally Qualified Health Center was unable to serve any Medicare beneficiaries because of job turnover: “[It] took us four months to find an LCSW. . . . We specifically had to weed out some very qualified licensed mental health professionals because they weren't LCSWs.” Brandon went on to explain that during this 4-month period, his clients were unable to access mental health care at the community clinic. He concluded, “It was pretty disruptive to their care.”

Brandon's description elucidates the cascading impact of the current policy on clients, community agencies that provide mental health services, and counselors seeking work. When specific providers are excluded from servicing Medicare beneficiaries, older adults with mental health conditions are vulnerable to gaps in coverage, such as the 4-month period that Brandon described.

Programmatic Inconsistencies

Several interviewees referenced confusion about how Medicare interfaces with other insurance programs. Roger and Mary, a couple in joint practice, explained how confusion among clients and health providers in their community is exacerbated by inconsistencies between Medicare and Medicaid, including the fact that in their state LPCs are eligible for reimbursement from Medicaid, but not Medicare. Roger explained, "[The] confusion is not just with clients who have low SES. It's agency people, it's case managers in the community, doctors that would make referrals, there really is a misunderstanding . . . and sometimes a disbelief." They went on to describe their frustration in having to explain to referral sources that Medicare ineligibility has nothing to do with a lack of training. Roger concluded, "Yes, we are trained and . . . virtually every other insurance company accepts licensed professional counselors."

Mary's and Roger's statements are indicative of the confusion that current policy creates among providers and clients. Several interviewees expressed annoyance that they had to explain to prospective clients that they possessed the requisite license and training required by the state to provide counseling and that they were recognized providers by non-Medicare insurance providers (i.e., Medicaid, Tricare, private insurance providers).

Related to the inconsistency between Medicaid and Medicare, several interviewees alluded to the fact that the very circumstances that qualify individuals for government-funded insurance (e.g., poverty, disability) may inadvertently restrict the mental health care that is available to them. Michelle described this phenomenon in the context of having to address clients who were referred to work with her by the local community mental health agency. She alluded to a particularly challenging cycle in which clients who were diagnosed with schizophrenia would be referred to her for counseling while they were also applying for long-term medical disability. She described the challenges of working with these clients, only to have to refer them elsewhere once they became eligible for disability benefits (which include Medicare). Describing her clients, she stated, "[They] applied for disability, they received disability, and now they have to, even though they have established the relationship with me . . . transition over to a different therapist." Michelle then highlighted what occurs after this transition is initiated: "[One] individual . . . has continued to see me because with that particular diagnosis, he doesn't trust anyone else. . . . [Another] individual . . . just chooses not to see anyone . . . and then she ends up having to be hospitalized every so often."

Beyond being discouraged or exasperated, Michelle's capacity to remain stoic in the face of such a paradox was telling. As she described it, this sequence had happened on multiple occasions and would likely happen again save for a federal policy change. Michelle also alluded to the potential economic detriments of current policy. By foregoing outpatient counseling because of the barriers described above, her patient with schizophrenia must be intermittently hospitalized, which is a much more expensive form of treatment.

Policy-level inconsistencies were confusing to providers as well. April, an LPC who attained her independent license within the past year, stated, "It feels like handcuffs. It's like here you have this

credential that the state says you have earned, but it's only a half credential because you can't [accept] one of the main government sponsored programs." Cecelia, an LPC working in a metropolitan area, expressed similar sentiments as she explained how clients with Medicare and secondary insurance plans are turned away: "I initially bill Anthem first and my claims continue to get denied." She explained, "Basically what they want me to do is submit the claims to Medicare, allow Medicare to deny the claim, and then submit the claim to them with the denial from Medicare and then they'll provide reimbursement." However, Cecelia stated that this process has been halted when Medicare refuses to issue a denial letter because of her status as an LPC. She put it this way: "The struggle that I found with Medicare is that because I'm an LPC, Medicare won't even recognize me to even allow me to submit a claim . . . so I cannot provide Anthem with the denial that they're looking for."

Cecelia's description of the inconsistency between Medicare and private insurance reflects a particularly problematic experience for her clients. Although they had paid for supplemental private insurance plans to augment their Medicare coverage, they were unable to use these benefits without a denial letter from Medicare. Ironically, according to Cecelia, the Medicare office could not provide the denial to a Medicare-ineligible provider in the first place.

Brandon made a similar statement about the inconsistency in provider regulations between Medicare and Tricare, specifically referencing his own training levels: "I'm shocked. . . . We're some of the most qualified licensed mental health professionals in the business to provide psychotherapy and treatment for psychiatric diagnoses . . . and yet somehow that doesn't count . . . somehow we're not included." Citing the growing number of insurance providers that do recognize LPCs, including Tricare, he concluded, "So, literally Medicare is the last holdout that I'm aware of." By describing Medicare as "the last holdout," Brandon implies that Medicare is the only federal program that has not updated its provider regulations to match the current mental health marketplace. Echoing Brandon, the sentiment that Medicare provider regulations were not in line with the current state of mental health practice was common among our interviewees.

Impediment to Care

The therapeutic working alliance has been shown to be one of the key factors that positively impacts counseling treatment (Wampold, 2015). When existing clients become eligible for Medicare, whether because of increasing age or qualifying for a long-term disability, current policy appears to interfere with continuity of care. Aubrey, an LPC who practices in a rural locality, describes it this way: "I will tell you where the problem arises . . . if I'm assigned a client, and I have the rapport with them, and we're working together and they become eligible for Medicare . . . then I have to transfer them." Because of the emphasis within counseling on the working relationship, Aubrey suggested that after building a strong working relationship with a counselor, even referrals within an agency can be disruptive to patient care.

Additionally, several interviewees described the challenges associated with referring Medicare beneficiaries to alternative providers. Some alluded to clients who made an effort to continue working with an LPC, despite not being able to use their Medicare coverage. Eventually, disparities in clients' financial circumstances resulted in some clients having to forego receiving mental health care. Brandon explained the difficulty that current Medicare policy brings to communities, particularly those in which there are relatively few Medicare-eligible providers relative to LPCs. He described monthly meetings with community private practice providers this way: "[They are] all booked up. There's just not enough . . . licensed mental health providers in town to see everybody. And . . . because only half of those people

can accept Medicare, it has a very particular impact on Medicare recipients.” Citing the shortage of providers, Brandon emphasized the additional burden faced by the Medicare-insured because of having a smaller available provider pool.

The shortage of alternative mental health providers was a common theme among interviewees, especially for those who practiced in rural communities. Michelle explained that there is a misperception that Medicare-eligible providers are available when Medicare beneficiaries seek out help: “I hear . . . there are so many licensed clinical social workers in this area, but there aren’t.” As a consequence, “[individuals] that are trying to work themselves into the schedule of a licensed clinical social worker, they often wait months before they’re actually able to be seen.”

Donna, an LPC who also works in a rural community, expressed a similar concern about the lack of options facing beneficiaries who live in rural areas: “I see such a shortage in rural areas of providers across the board. And then when you have to narrow it down even further to limit who they can see, then that makes it even more difficult for them to get the care that they need.”

In fact, the expense of mental health care when insurance coverage is unavailable was a factor that several interviewees described. Robert told the story of a client he had seen for several years who tried to pay out of pocket but could no longer make that financially viable: “[It] was really disappointing because she really wasn’t finished. . . . We had a great working relationship and it was sad to have her stop just because of reimbursement reasons.”

Brandon made a similar comment about an individual who was deterred from seeking treatment because of the cost of paying out of pocket when his Medicare insurance was unable to be used: “I let him know . . . I can’t accept Medicare. And he asked how much it would be. [I said] anywhere from \$75 to \$125, and . . . he was pretty disheartened by that.”

Mary noted how the MMHCG can result in Medicare beneficiaries not seeking out necessary services. She emphasized that turning people away at the point when they have elected to ask for help can be disconcerting: “Right at a time when they’re willing to reach out and ask for [help]. That’s the worst part. Because I think . . . that discourages clients from seeking services—they have to work too hard . . . finding a provider.” April added a similar sentiment: “It’s heartbreaking . . . [my] emphasis is on those most vulnerable and those most in need of services . . . it is my worst nightmare for a client to walk away . . . because I want them to know they are my priority.” In each of these examples, participants expressed concerns that current policy acted as a deterrent to accessing necessary mental health services because of the burdensome process of having to locate a Medicare-eligible provider.

Discussion

Our findings illuminate how current Medicare mental health policy impacts Medicare beneficiaries’ access to counseling treatment for mental health conditions. Nine mental health providers who are not Medicare-eligible were interviewed to learn about their experiences interacting with Medicare beneficiaries who sought their services. The central phenomenon that all interviewees responded to—their inability to work with Medicare beneficiaries in the same manner that they work with clients who use other forms of insurance—has infrequently been referenced in the extant literature. This phenomenon provides a unique contribution to discussions about the accessibility and availability of mental health services to older adults (Stewart et al., 2015) and people with long-term disabilities. Particularly compelling about what was reported in these interviews is the fact

that these individuals were actively seeking out or currently engaged in mental health treatment at the time when they were turned away. In the past, explanations about barriers to mental health care for Medicare-insured populations have focused on systemic factors such as rural geography (Kim et al., 2013) or stigma about mental health (Chapin et al., 2013). While these are certainly relevant factors that provide a broad explanation for why older people are less likely to receive mental health services, the current study illuminates several proximate point-of-service barriers that result in providers having to cease treatment with clients, deny care to clients who were actively seeking it out, or refer clients to relatively long wait-lists in lieu of more prompt treatment by available providers. Given the lack of scholarly attention focused on the MMHCG, the perspectives offered by these participants contributes to a broader discussion about how to increase access to mental health services for older adults, as well as for individuals with long-term disabilities.

Among our interviewees, there was a noticeable amount of concern for how the MMHCG impacts individuals in the community in need of mental health care. Participants' concerns about the consequences of the MMHCG on their clients may be related to their awareness that mental illness influences other key indicators of well-being. For example, depression reflects a relatively common mental health condition that responds well to treatment but can be problematic for clients when left untreated. Although depression was only one of several types of mental illness described by participants, clinically relevant depressive symptoms affect 10% of males over 65 and 15% of females over 65, and the presence of depressive symptoms is correlated with greater functional disability, dementia, higher rates of physical illness, and higher health care resource utilization (Federal Interagency Forum on Aging-Related Statistics, 2016). As the number of Medicare beneficiaries grows, it is reasonable to assume that there will be corresponding growth in the number of people who meet the criteria for mental health conditions, including depression. Echoing the concern voiced by our participants, we state that the current Medicare policy extends the risk of mental health needs going unmet among Medicare-insured populations.

Additionally, the economic consequences of untreated or undertreated mental illness are worth considering. Each participant described instances of unmet client mental health needs because of a combination of (a) practitioner inability to submit for Medicare reimbursement, (b) client's inability to pay a sliding scale rate, and (c) lack of follow-through on referrals to mental health providers eligible for Medicare coverage. For example, some participants described this undertreatment as resulting in potential inpatient psychiatric hospitalization because of clients' inability to utilize their Medicare benefits to seek care within their local communities. Undertreatment of mental health conditions can lead to inefficient administration of health care, including an over-reliance on more expensive mental health services when outpatient services could have been more appropriate. For example, the reimbursement rate for 45 minutes of counseling is \$84.74 for doctoral-level providers (see American Psychological Association, 2015, for a critique of this rate), and the rate for master's-level providers is estimated at 75% of this amount (\$63.56). This is in contrast to the cost of *a single day* in an inpatient psychiatric facility, which is \$782.78, or approximately 12 times higher than a single counseling session (Centers for Medicare & Medicaid Services, 2019). Having adequate outpatient services available within a community is traditionally a sound strategy for reducing high-cost treatment; yet this is not occurring as regularly as is needed when Medicare beneficiaries are involved. Although not every person who may be at risk for inpatient hospitalization will benefit solely from weekly outpatient services, several cases referenced by our interviewees (e.g., Michelle's work with clients with schizophrenia) fit this category. Considering that a single day of inpatient treatment costs the same as a 12-session course of counseling from a master's-level provider, it stands to reason that there are economic benefits to re-examining current Medicare mental health policy.

The inefficiency of current Medicare policy was highlighted when several participants alluded to inconsistencies between insurance programs, including certain cases in which having Medicare precluded clients from using other forms of insurance (e.g., Medicaid, Tricare, private supplemental plans) that would otherwise cover mental health treatment by LPCs. This feature of the MMHCG has important ramifications given that 81% of Medicare beneficiaries possess a supplemental health plan (Kaiser Family Foundation, 2019), including more than 12 million Americans who are dually covered by Medicare and Medicaid (Centers for Medicare & Medicaid Services, n.d.). For this latter group, dual-eligible adults are more likely to have functional or cognitive impairments, chronic conditions, or conditions that frequently coincide with mental health conditions. In fact, among dual-eligible individuals, 59% of those with disabilities and 20% of those who are 65 years or older self-reported diagnosis of a mental health disorder (Donohue, 2006). This means that some of the most vulnerable Medicare beneficiaries are particularly burdened by current Medicare mental health policy.

Implications for Professional Advocacy

Regarding advocacy on behalf of clients, these findings suggest that Medicare reimbursement for LPCs is urgently needed in order to provide Medicare-insured populations with access to mental health services. Currently, efforts to change Medicare regulations through the legislative process have support from a broad range of professional interest groups, many of which comprise the Medicare Mental Health Workforce Coalition (Medicare Mental Health Workforce Coalition, 2019). Further, there is currently legislation under consideration in both the U.S. Senate (S. 286; Mental Health Access Improvement Act, 2019) and U.S. House of Representatives (H.R. 945; Mental Health Access Improvement Act, 2019) that would include LPCs and LMFTs as Medicare-eligible providers. As of November 2019, these bills had 29 and 96 cosponsors, respectively (U.S. Congress 2019a, 2019b). Despite these efforts, more than half of counseling professionals recently surveyed had not participated in advocacy related to Medicare reimbursement (Fullen, Lawson, & Sharma, in press-b). Therefore, additional work is needed to educate members of the counseling profession about the consequences of current Medicare mental health policy on clients from underserved populations. Fullen et al. (in press-a, in press-b) describe several strategies that can be used to strengthen advocacy efforts among members of the counseling profession, including counselor educators, master's and doctoral students, and practicing counselors.

Limitations and Future Research

A primary limitation of this study relates to the generalizability of the results. This study reports on a specific and localized account of how Medicare mental health policy impacts Medicare beneficiaries' access to counseling treatment in a single state. We intentionally focused on a homogenous sample purposefully selected to explore how LPCs are making sense of their inability to provide counseling services to Medicare beneficiaries based on their professional status as Medicare-ineligible. The findings present a narrative account of how these licensed mental health providers make sense of and respond to the experience of not being able to serve Medicare clients because of professional limitations contained within Medicare mental health policy. The utilization of IPA has allowed for the detection of nuance, subtlety, and complexity within the data from the semi-structured interviews with our participants. This specificity allows for an understanding that shows how the coverage gap created by the exclusion of counselors impacts Medicare beneficiaries' access to counseling services.

An additional limitation of our study is the use of prolonged engagement as a strategy to establish credibility and trustworthiness. Prolonged engagement, traditionally employed in ethnography and participant observation, requires that researchers spend sufficient time in the field to learn or

understand the experiential phenomenon of the study (Lincoln & Guba, 1985). Though we did not spend time with participants within their specific practice settings, we each have practice experience as Medicare-ineligible providers within the field of professional counseling. In a more ethnographic study on the MMHCG, we would be able to employ a more traditional application of prolonged engagement.

Future research should focus on additional qualitative and quantitative data sets that allow for more generalizability of findings. By nature, Medicare policy is consistent across the United States, which leads us to believe that there are likely similarities between the phenomena described by our interviewees and what occurs in other states. Nonetheless, additional inquiry is needed to probe the impact of MMHCG more comprehensively. An empirical investigation into the perspectives of Medicare-insured individuals who have been unable to utilize their Medicare benefits because of the MMHCG may lend an additional lens toward understanding the impact of Medicare mental health policy on clients. Ultimately, this study and subsequent studies focusing on diminishing coverage gaps for Medicare beneficiaries can support progress toward diminishing health inequities because of health care policy restrictions.

Conclusion

This study highlights an existing gap in the administration of Medicare services for clients seeking counseling treatment for mental health conditions. By attending to the theme of ineffectual policy, we have attempted to illuminate how current policy impacts the Medicare-insured, as well as LPCs who are involved in their mental health care. Based on our analysis of the MMHCG, future revisions to Medicare policy allowing for the inclusion of LPCs to provide counseling treatment to Medicare-insured individuals may contribute to a more equitable health care system for Medicare beneficiaries.

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