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RESEARCH

"Heartbreaking" Referrals, Professional "Disgrace": The Impact of Medicare Ineligibility on the Counseling Profession

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To better understand the impact of the Medicare mental health coverage gap, the authors analyzed survey data provided by 1,859 members of the American Counseling Association using a conventional qualitative content analysis. One overarching theme, direct impact of Medicare policy on the counseling profession, is presented, along with 3 thematic categories: emotional impact on providers, economic toll on providers, and negative influence on profession's credibility. Implications for the counseling profession are discussed.

Keywords: Medicare, professional issues, advocacy, gerontological counseling, qualitative research

There are roughly 60 million people insured by Medicare (Kaiser Family Foundation, 2019), and estimates suggest that this number will approach 80 million by 2030 (Medicare Payment Advisory Commission, 2015). Those insured by Medicare include people over age 65, who make up approximately 85% of the current total, as well as younger individuals with long-term disabilities (Kaiser Family Foundation, 2019). The Medicare budget is vast—the total spent on Medicare benefit payments totaled $688 billion in 2017 (Kaiser Family Foundation, 2019)—yet the program has been critiqued by mental health experts due to estimates that only 1% of the Medicare budget pays for mental health services (Bartels & Naslund, 2013). Related concerns have been echoed by experts who state that there is a lack of mental health providers equipped

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to work with older adults (Institute of Medicine, 2012), as well as a dearth of providers in rural areas (Larson, Patterson, Garberson, & Andrilla, 2016). Because 10,000 Americans turn 65 and qualify for Medicare each day (Short, 2016), concerns about the lack of eligible providers are unlikely to be abated without major shifts in public policy.

The list of eligible providers was last updated in 1989, when clinical social workers were added to Medicare and restrictions on services provided by psychologists were removed (H.R. Rep. No. 101-386, 1989). In the 30 years since that update, the mental health marketplace has evolved, and currently licensed professional counselors (LPCs) make up a substantial proportion of the clinicians who work in both community-based and private practice settings (Medicare Mental Health Workforce Coalition, 2019). This has resulted in efforts to include LPCs and licensed marriage and family therapists (LMFTs) as eligible providers. Legislative efforts have been made, including successful passage of legislation in a single chamber of Congress (but not both) in 2003, 2005, 2007, and 2009 (Medicare Mental Health Workforce Coalition, 2019). In spite of these efforts, current Medicare regulations continue to exclude LPCs and LMFTs, resulting in inequitable access to counseling services for Medicare beneficiaries compared with individuals insured by other public (e.g., Medicaid, TRICARE) and private plans. Legislation to add LPCs and LMFTs is currently under consideration in Congress (House of Representatives Bill 945, 2019; Senate Bill 286, 2019); however, as of this writing, the majority of lawmakers had not yet cosponsored these bills.

Although Medicare eligibility has been identified as a professional priority (Field, 2017; Fullen, 2016), a review of the extant literature reveals that relatively few scholarly publications have focused on the impact of Medicare ineligibility. Reiner, Dobmeier, and Hernández (2013) and Field (2017) described the importance of Medicare eligibility when it comes to establishing the counseling profession's professional legitimacy, and Fullen (2016) described the historical development of the Medicare program, as well as recommendations for professional advocacy vis-à-vis the legislative process. Meanwhile, there have been far more references to the importance of Medicare reimbursement for counselors within *Counseling Today*, the American Counseling Association's (ACA) trade magazine. Given that the counseling profession has worked on Medicare reimbursement legislation for more than 15 years (Field, 2017), there is a noticeable absence of data among these publications regarding the scope and impact of current Medicare policy.

Recently, members of our team used a survey of ACA members (described in the Procedure section) to establish baseline data intended to quantify and describe the current effects of Medicare provider policy, or what has been described as the Medicare mental health coverage gap (MMHCG; Fullen, Lawson, & Sharma, 2020). We found that 70% of practicing counselors surveyed had been directly affected by the MMHCG, including 50.3% who had turned

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away or referred a new client, 38.8% who had been forced to prematurely cease treatment with an existing client who became Medicare eligible, and 39.9% who had used pro bono or sliding scale approaches to maintain their work with those insured by Medicare. We also found data suggesting that practicing counselors are increasingly likely to experience problems due to the MMHCG the longer they remain in the field and that ACA members who experienced the direct impact of the MMHCG were significantly more likely to participate in Medicare-related advocacy, including efforts to contact lawmakers to inform them about the impact of this policy on Medicare beneficiaries (Fullen et al., 2020). These findings suggest that the scope of the MMHCG is more prevalent than previously understood. What these results do not illuminate is how precisely the MMHCG affects members of the counseling profession. Therefore, the purpose of this study was to understand how ineligibility for Medicare reimbursement affects ACA members residing across the country. Our primary research question was "How does ineligibility for Medicare reimbursement affect the counseling profession?"

METHOD

Participants

A total of 1,859 respondents provided data that were used to answer our research question. This amounts to a response rate of 28.38% of the broader survey sample; however, it amounts to only 3.6% of all ACA members who were invited to participate. Participant demographic data indicate that the average age of respondents was 48 years; however, ages ranged from 22 to 96 years. A total of 83.5% described their race/ethnicity as White/non-Hispanic, followed by Black/African American (6.1%), Hispanic/Latinx (3.9%), multiracial (2.5%), Asian/Pacific Islander (1.3%), American Indian/Native American (0.5%), and other (2.1%). Additionally, 81.0% of these respondents identified as female, 17.1% identified as male, and 1.9% identified as gender fluid, nonbinary, transgender male, transgender female, or other. In terms of professional status, approximately three quarters (76.5%) of respondents were practicing counselors, followed by master's students (13.7%), counselor educators (4.9%), and doctoral students (3.2%). A total of 1.6% of respondents did not respond to this item. When asked about their primary specialization within the counseling field, clinical mental health counseling was the majority choice (82.0%), with addictions counseling (5.6%) and couples and family counseling (5.6%) as the next most popular responses. An additional 6.4% selected from a range of alternative specialties, and 0.2% did not respond. When asked to identify the primary age range for their clients, responses varied across the life span, with 25–44 years the most prevalent response (55.5%), followed by 45–64 (17.9%), 15–24 (14.5%), 0–15 (8.7%), and 65+ (2.4%). A total of 1.2% of respondents did not answer this question. (Some percentages do not total 100 because of rounding.)

Procedure

We obtained data regarding the impact of current Medicare mental health provider policy through a multimethod questionnaire that was completed by 6,550 ACA members. A request to participate in this study was sent to the full ACA member database ($N = 51,221$), and all members were eligible to participate. The full survey was completed online using the Qualtrics platform, and it included questions about the impact of Medicare ineligibility, engagement in advocacy, knowledge about Medicare policy, and opinions about who is responsible for Medicare advocacy. A more complete description of the survey can be found in Fullen et al. (2020).

Participants were invited to describe their experiences related to Medicare ineligibility. Their responses, which came in the form of responses to two open-ended questions, provided the data for the current study. The first question asked, "Have you ever had to deny/refer potential or existing clients because of a lack of Medicare reimbursement? (Check all that apply.)" Respondents had the opportunity to choose among predetermined categories (i.e., turned away new/potential clients; referred existing clients; worked with clients pro bono or on sliding scale; other; none of the above; not sure). Those who selected *other* were given the opportunity to provide an open-ended response, and these responses are included in the current study. The second question stated, "If you would like to share more details about your experience of turning away/referring client(s) due to Medicare reimbursement policy, please use the space below." This question was made available only to respondents who did not select *none of the above* or *not sure* in the preceding question. A total of 1,859 respondents answered one or both open-ended questions. Given the high degree of overlap between responses to these questions, all data were collapsed prior to the analysis. There were no character limits, and responses varied in length. In total, the data available to answer the research question exceeded 100 pages. This study was approved under the exempt category by the institutional review board.

Data Analysis

To better understand the impact of Medicare ineligibility on the counseling profession, we performed a conventional qualitative content analysis. Rather than quantifying how many times specific terms or concepts were used by respondents, we employed a qualitative analytical strategy due to the absence of presupposed categories or theoretical perspectives (Hsieh & Shannon, 2005). Qualitative content analysis is useful when trying to understand and describe a phenomenon when there is a lack of existing empirical research (Hsieh & Shannon, 2005).

Consistent with recommendations for increasing empirical rigor (Fereday & Muir-Cochrane, 2006), we used both inductive and deductive coding schemes during data analysis. This analytical approach allowed us to integrate both inductive (i.e., atheoretical category development) and deductive (i.e., code

manual) approaches in the same study (Hsieh & Shannon, 2005; Kondracki, Wellman, & Amundson, 2002). Initially, we examined data without a priori categories to ensure that data interpretation was grounded in respondent descriptions (Kondracki et al., 2002). First, qualitative descriptions from all 1,859 respondents were arranged into a database, and a 200 respondent pilot sample was identified using a random number generator. Four members of the research team coded the pilot sample to establish intercoder reliability through consensus agreement on which codes to employ. This process resulted in the development of a code manual, which was used to organize the data thematically (Fereday & Muir-Cochrane, 2006).

Results of the initial open coding process were discussed and compared to achieve consensus agreement of the initial code manual. Next, an additional pilot sample of 200 responses, which was independent from the first pilot sample, was coded to establish intercoder reliability further and to adjust the code manual for the remaining analysis. At this stage, we attained consensus agreement on the codes used in the code manual, and then we coded the remaining 1,659 responses (inclusive of the initial 200-respondent pilot sample). Half of these responses (approximately 825) were coded by two coders and the other half by a single coder. Once this process was complete, the four members of our research team who engaged in this process met in person to engage in reflexive dialogue regarding the coding process to further refine the coding scheme and thematic categories (Kuckartz, 2014). Three supplementary codes were developed through this process and were integrated into the coding scheme for the study. The final study sample was recoded to incorporate these three codes. After a meeting of the four coders in which consensus agreement on the coding scheme was reached, approximately half (50.5%) of the coded qualitative descriptions were forwarded to an auditor who did not participate in the coding process. Categories were identified by exploring patterns among the data to establish and interpret related codes. The emergent categories were organized into clusters that resulted in the thematic categories reported in the results based on exemplar codes and categories from the data. The following Results section reports the final distillation of the inductive analytical processes employed through this qualitative conventional content analysis.

Efforts to maintain trustworthiness. We employed a systematic method during data collection, coding, and reporting to establish the trustworthiness of this study. Contributing to credibility, we engaged in prolonged engagement, triangulation, negative case analysis, checking of interpretations against raw data, and peer debriefing. Transferability is evident through the rich descriptions of the excerpts contained in the Results section, where the reader can determine judgments about the convertibility of findings to various practice settings. A multistage audit procedure was employed to establish dependability and confirmability. A single auditor, who did not participate in the coding process, reviewed the application of the codebook and provided a comprehensive evaluation of

the analytical process to refine the coding and category development strategy. A pilot sample of the data was used to establish intercoder reliability among the authors. Within the final study sample (N = 1,659), only responses independently assigned consensus codes were used as exemplars for each category identified from the data.

Positionality of the researchers. Our research team consisted of five LPCs with a range of professional clinical experience. At the time of the analysis, two research team members were counselor educators, and three were doctoral students pursuing a degree in counselor education and supervision. We are all associated with the same large, southeastern state university. All authors are members of ACA and acknowledge the relevance of expanding older adults' and other Medicare beneficiaries' access to counseling services. Multiple authors have denied or had to refer clients due to the current Medicare mental health policy. Additionally, all authors have engaged in prior research and advocacy related to the professional and clinical implications of the current Medicare mental health policy that excludes LPCs.

Our interest in this study is situated in a broader concern for the inclusion of LPCs in Medicare mental health policy. Given the currently proposed legislation that adds LPCs and LMFTs into Medicare mental health policy (House of Representatives Bill 945, 2019; Senate Bill 286, 2019), we are interested in better understanding to what extent the MMHCG affects LPCs' ability to serve older adults and persons with a long-term disability. These perspectives contributed to the inductive development of the initial coding scheme and categories as well as application of the code manual.

RESULTS

Four major thematic categories emerged from our qualitative content analysis of responses to questions about current Medicare policy: Medicare ineligibility (a) has a detrimental impact on the counseling profession, (b) encumbers those insured by Medicare, (c) creates a unique hardship on specific subpopulations, and (d) results in various outcomes when Medicare beneficiaries seek services from counseling professionals. In this article, we discuss one of these overarching themes—Medicare ineligibility's detrimental impact on the counseling profession—along with three thematic categories: (a) emotional impact on providers, (b) economic toll on providers, and (c) negative influence on profession's credibility. By focusing on a single overarching theme and its relevant subthemes, we hope to provide a highly detailed account of respondent descriptions. This approach has been used in other forms of qualitative research (Križaj, Warren, & Slade, 2018), and it is consistent with recommendations on how to provide in-depth presentations of large amounts of qualitative data (Levitt et al., 2018). Additional themes were presented elsewhere (Fullen, Jordan, Sharma, Wiley, & Lawson, 2019).

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When we asked respondents to describe their experiences related to the Medicare program, there were numerous references to the negative effect of the current policy on the emotional and economic well-being of counselors, as well as to the detrimental consequences on the profession's standing in the broader mental health marketplace. Respondents used strong and evocative language to express their frustration, embarrassment, and confusion over their exclusion from the Medicare program. In certain cases, these expressions were directly related to employability, along with concerns about the long-term viability of counseling within specific contexts. The accounts that follow are intended to represent the most salient themes that emerged from our data. (Note that some minor edits to respondents' answers were made to improve readability. Brackets indicate the location of edits within direct respondent quotes.)

Emotional Impact on Providers

When considering the impact of current Medicare policy, many counseling professionals described it as having an emotional impact. Respondents expressed frustration about how the policy disrupts their work with existing clients, some of whom they have worked with for several years. As one participant explained,

> Having to explain to clients why Medicare won't pay me is very difficult and almost embarrassing. Long-term clients who reach 65 present the most difficult challenge. Often, they cannot pay out of pocket, and I have to make an ethical decision to refer or go [pro bono]. I've done both and neither is satisfying.

Some respondents described making efforts to maintain continuity of care by working with clients pro bono or on a sliding scale, or referring them to a Medicare-eligible provider. However, respondents described the costliness of this transition to both counselors and their clients:

> The client and I were very saddened by this and I had to refer to another clinician. . . . It was hard on the client and myself due to the client [feeling] discouraged to continue therapy and my lack of being able to serve the client's needs.

Respondents even described situations in which the transition from one public insurance to another resulted in a gap in coverage:

> In community mental health, one of the most heartbreaking things is when a client transitions to Medicare from Medicaid. It is especially frustrating because many would benefit from continued counseling and case management, but these services are often not covered by basic Medicare plans.

Respondents expressed discontentment with the current policy's inefficiency, especially when other health care professionals refer clients directly to counselors, only to have this referral thwarted by the policy. As one participant described,

> It is very difficult to tell a potential client who has been specifically referred to me by their medical professional that I cannot help them during their time of distress. It is very difficult to find a social worker who is accepting new clients and can get them scheduled in a timely manner. It is unacceptable to turn people away when they are seeking much-needed mental health care!

This statement emphasizes not only the inefficiency of the current policy but also the emotional consequences for counselors when they are unable to meet clients' presenting clinical needs due to their exclusion from Medicare mental health policy.

Advocacy on behalf of clients. In certain cases, respondents described client advocacy efforts that ranged from calling clients' insurance companies to contacting their elected officials. Yet, in many instances, these efforts were not successful, which was particularly distressing to counseling professionals. One professional outlined their experience spending hours trying to attain treatment authorization for a client:

> A most frustrating case involved a former Cigna-insured client who went on Medicare. I [spent] hours on the phone educating the insurance company that I could not provide services because I was not eligible. And, then, I could not even contact Medicare to coordinate services because [I was] not a provider. I do not think the general public is aware that [licensed] counselors [cannot] provide services to Medicare clients.

According to respondents, legislative advocacy efforts have also been slow to resolve the issue. As one participant explained,

> I have advocated with our U.S. senator for inclusion in Medicare provider coverage for licensed professional counselors. This gap in coverage has been distressing to several potential and former clients. I have unsuccessfully tried every way possible to qualify for reimbursement with an LPC license to no avail. This is so frustrating, especially with talk of universal Medicare coverage.

Respondents were equally dismayed by the effect of the MMHCG on their clients. Once again, evocative language used by respondents was indicative of the emotional impact borne by providers. One participant put it plainly: "It is really frustrating to see someone in need of assistance, to know you can help, but not

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be able to provide services." Another added, "It has been frustrating to witness the disappointment time and again when people have had a need for counseling and have reached out to me, and I tell them I cannot submit claims to Medicare."

Burden borne by older adults and other special populations. The fact that the MMHCG uniquely disadvantages older adults was pointed out by several respondents. As one participant stated,

> Very frustrating for the client as well as this clinician. Many elderly clients needing mental health services continue to go without treatment due to the Medicare rules for reimbursement. They are not comfortable with the services offered at the larger mental health facilities, or have tried the services and it has not been a good match. The elderly clients do not feel they have options for care.

Another respondent linked their specialization in grief work to missed opportunities to support Medicare beneficiaries:

> Since I live and practice in a community that is largely retirees, I will turn away or refer at least three to four clients a month. It is very frustrating for them and for me when a large part of my practice is grief work, I miss a large part of this population due to my inability to [accept] Medicare.

Making a reference to their own age, one participant explained the difficulty of not being able to help people navigate challenges associated with later life:

> One of the greatest disappointments I experience as a clinician is my lack of ability to assist clients who rely solely on Medicare coverage. At a time in life when therapy is essential, I feel as though I am neglecting members of my own age cohort who are seeking out a mature therapist.

Although the impact of the MMHCG on older adults was clear to many respondents, references to additional Medicare-insured subpopulations were also described. For example, one participant explained how the policy burdens people referred for substance use treatment:

> It is always sad to let a potential client know who was referred for therapy for substance use that I [cannot] participate with their insurance due to being LPC and not LCSW [licensed clinical social worker]. Clients are often completely [perplexed] as to how it is possible for one field to be reimbursed and not another extremely similar field.

Another elaborated on the link between geography, socioeconomic status, and diagnosis:

> I work in a rural area which has a limited number of licensed clinicians and a high level of poverty. It feels sad to turn away someone that needs, wants, and is asking for help—which timing is lifesaving in considering the short window opportunity to get someone into treatment for substance use disorders.

The link between clients' inability to access care and the emotional impact this has on providers was summed up well by one participant: "I live in an extremely remote area where there are very few counselors, so it is heartbreaking to turn clients away because I can't take Medicare."

Economic Toll on Providers

In addition to the emotional impact on providers, many respondents pointed out that existing Medicare policy has implications for client care decisions, including the need to balance professional ethics related to termination and financial ramifications of being unable to secure reimbursement for services rendered. Upstream, the economic toll of existing policy was described in terms of employability, particularly within certain employment contexts. Respondents described the nuanced manner in which Medicare, a federal mental health policy, affects referral patterns and hiring decisions that occur within local communities. Participants' descriptions of these phenomena highlighted the economic toll of the current Medicare policy on members of the counseling profession.

Ethical decisions related to continuity of care. At the level of client care, some providers described an ethical pull between ensuring clients receive care and their inability to be reimbursed for their time. One participant described the challenges of navigating these complex decisions:

> I worked at a nursing home for 1 year, but was only able to provide services to those with Medicaid or commercial insurance. Staffing shortages were such that there was no social worker or psychologist available to see Medicare residents who were referred for therapy—and I could have provided counseling, but I was not permitted to because Medicare does not contract with LMHCs [licensed mental health counselors]. Now in my private practice, I have had to turn away clients who have Medicare only for the same reason. And I've seen an elder veteran for about a year, and was billing his secondary insurance, but then his secondary insurance changed, and I was not able to bill either his primary (Medicare) or his secondary [private insurance named]. I offered to refer him to another provider, but this was very distressing to him, given the therapeutic relationship we have established, so I have continued to see him for the cost of his previous copay, which is not sustainable for me in terms of earning a living.

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In this excerpt, the participant described weighing fundamental principles of ethical practice, such as nonmaleficence, beneficence, and fidelity.

Negative impact on referrals. Although this account offers a description of the economic toll once a therapeutic relationship is established, there were many references to how current Medicare policy limits counselors from commencing treatment with new clients, as well as more systemic effects, such as reduced employability and the relative value of holding a counselor credential compared with related professions. Respondents working in a variety of employment settings described the financial impact of existing Medicare policy on their livelihood. At a basic level, some respondents identified how ineligibility for Medicare reimbursement resulted in confusion among clients and fewer clients seeking their services. One participant described how the MMHCG deters clients from accessing care, with a resultant loss of income:

> [Clients] are confused and upset as they often think I am choosing to not accept Medicare reimbursement. We are a community with few providers, and I am one of only a couple of providers in our community who provide both addiction and mental health counseling. This also results in a deficiency in services we can provide to people in our community and in a significant loss of revenue for the providers.

Notably, these limitations at both the provider and agency levels interfered with referral patterns in the community as well. Several respondents referenced a scenario in which local medical professionals would refer Medicare-insured individuals to a counselor for mental health services, only to have this referral obstructed by the current Medicare policy. Situations like these require counselors to consider denying treatment to the referred individual, which may have a bearing on future referrals, or accommodating the client by changing their fee structure. One participant explained, "Clients have been referred by their primary physician, and I have had to reduce my fee or refer them out. The clients were not happy because the referral was from their PCP [primary care provider]!" The barrier to referrals that was described seems to impede efficient administration of integrated health care, particularly for client populations who are most likely to use Medicare. This situation was highlighted by one respondent:

> I had a key referral source who works with the geriatric population in a memory care setting and a practice of primary care providers who routinely wish to refer Medicare patients to me. I have had to turn them all away unless they can . . . afford private pay.

Constraints to employability. Respondents described how the cascading influence of existing policy also affected their employability, at least within particular

contexts. Certain respondents alluded to specific sectors in which they believe they were turned down for jobs due to their inability to be reimbursed by Medicare. One respondent asserted that they had "not been considered for jobs in integrated medical settings due to inability to bill Medicare," and another added, "I have been unable to work in acute care facilities and emergency rooms due to the lack of Medicare reimbursement policy." Although it is not possible to verify specific reasons why jobs were not made available to these respondents, the pattern of responses across our data suggests that ineligibility for Medicare reimbursement may be a contributing factor.

Other health care contexts were cited as well, particularly contexts in which older adults and people with long-term disabilities composed a larger proportion of the patient population. One respondent stated, "I have been turned down for employment at local hospitals and nursing homes due to an inability to bill for services," and another described a similar experience:

> I am handcuffed when it comes to trying to find employment. I cannot be employed by a hospice group (I have been offered a job and had to explain that Medicare will not pay me because my credentials do not have "SW" in them. I cannot be employed by hospitals (for the most part) for [the] same reason.

Community-based settings were also cited by some respondents as contexts in which Medicare eligibility was influencing hiring decisions. One respondent described the link between client care, the ability to bill for services, and their long-term employability:

> I live in a rural area that has a shortage of therapists, especially Medicare-approved therapists. As an intern, I saw many Medicare clients [pro bono], but once I received my limited license, I had to transfer all those clients to social workers. I have had clients who became very upset and quit treatment when I was no longer allowed to see them. I have helped clients through the process of applying for disability only to have to stop treatment because I can no longer see them. . . . I was told that my local [agency] would not even consider hiring me because I wasn't a social worker.

Other respondents described how Medicare ineligibility influenced their ability to pursue work with specialized populations. As one individual stated, "I am newly licensed and desire to work with [older adults] but lack of reimbursement is a barrier to employment." Another said, "I have not been able to work in my preferred area (hospice counseling)." A third respondent explained, "I have not moved into specialties in which I have experience and desire because I cannot bill Medicare (dementia patients and families)." Perhaps owing to the

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cumulative effect of these concerns about employment and the ability to work with specialized populations, one respondent voiced a somewhat ominous conclusion: "The facility I work for is terminating its outpatient LPCs, replacing with LCSWs. . . . I am looking into a social work program."

Negative Influence on Profession's Credibility

The emotional and economic toll of existing Medicare policy led some respondents to conclude that Medicare ineligibility undermines the counseling profession's legitimacy in the broader mental health marketplace. Some respondents articulated the concern that Medicare ineligibility suggests that counselors are less qualified than other mental health professionals, even though respondents defended the legitimacy of their own training. Strong language was used to describe the dissatisfaction respondents experienced (e.g., "disgrace" or "embarrassment") when explaining to clients, colleagues in other professions, or potential employers that they were unable to participate in the Medicare program.

In fact, embarrassment was the sentiment most commonly referred to, typically accompanied by concerns about client welfare. One respondent stated, "It is an embarrassment to the counseling profession to turn away Medicare clients due to LPCs not being reimbursed by Medicare. One client was so desperate to see someone she paid full price out of pocket!" Another respondent used the term *disgrace* to describe the existing state of affairs:

> I feel that it is a disgrace to our profession and honestly makes me [embarrassed] to be part of the profession in this regard. Many people who need assistance with their mental health or addiction/substance abuse cannot afford insurance and are on state aid or pay out of pocket. These are the individuals we should be helping, not turning away.

A third added, "It's more than a bit frustrating and professionally embarrassing given our knowledge, skills, and training. Worse, it disallows a client from getting quality mental health care from a licensed, competent, and experienced mental health professional."

Undermines profession's standing. Concerns about the impact on clients were coupled with an awareness that Medicare ineligibility undermines the profession's standing in the eyes of the public. One respondent said that the current policy "makes the profession seem like LPCs are not qualified or lacking as a profession," a concern that prompted another participant to state, "This distinction continues to make the public think we are less than social workers." The perception that existing policy is inequitable in terms of which professional licenses are recognized was a common sentiment. One respondent stated, "I am frustrated by Medicare not recognizing LCPCs but does recognize LCSWs. It makes no sense to me, and potential clients have to be turned away." Links

between our thematic categories made it clear that frustration about professional equity was directly linked to concerns about clients' access to care. As one participant explained, "I practice in a rural community with limited access to counselors who can take Medicare. It is frustrating to me that my colleague with social work credentials can provide service to this population."

DISCUSSION

Implications for the Counseling Profession

Our analysis of qualitative data provided by 1,859 ACA members revealed several key themes, including responses related to the question, What is the direct impact of this policy on the counseling profession? In regard to the thematic category emotional impact on providers, respondents' use of strong language (e.g., "embarrassing," "heartbreaking") is evidence of counselors' commitment to their clients' well-being, as well as the consequences of forming a strong therapeutic relationship only to have the work undermined by current Medicare provider regulations. Although frequency counts were not included in the current investigation, previous research indicates that 39% of practicing counselors have had to make a referral due to an existing client qualifying for Medicare (Fullen et al., 2020). With this in mind, our respondents' references to their own experience of hurt were striking and may reflect the prioritization among counseling professionals to build strong therapeutic relationships with their clients. The integral role that the therapeutic relationship plays in helping clients achieve treatment goals has been well-established (Luedke, Peluso, Diaz, Freund, & Baker, 2017; Norcross & Wampold, 2018). Although aspects of the detrimental impact of Medicare policy on clients have been described elsewhere (Fullen, Wiley, & Morgan, 2019), we were struck by the affective descriptions of respondents in the current study. In light of counseling theories such as relational cultural theory, in which the impact of the therapeutic relationship is described as a two-way process in which both counselor and client invest deeply in the formation of a professional relationship (Jordan, 2017; Lenz, 2016), perhaps the results described herein should not be surprising.

Furthermore, respondents were particularly perturbed by the systemic inefficiencies related to Medicare ineligibility, such as the disparate provider regulations between Medicaid and Medicare, or the inability to accept referrals from other medical professionals. Beyond merely conveying annoyance at the inconvenience related to intraprogram inconsistency, respondents had strong opinions about what some perceived as a social injustice (e.g., "It is unacceptable"). The counseling profession has a strong commitment to multicultural and social justice competencies, and within these competencies there are references to marginalization that occurs when people experience oppression based on age or disability status (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). Although counseling scholars urge members of the profession to address systemic

barriers that affect clients (Ratts & Greenleaf, 2018), to the best of our knowledge, Medicare policy has not been described in the literature in terms of social injustice.

The link between client marginalization and respondents' strong reactions to existing policy appeared to be grounded in respondent concerns that clients would be denied mental health care. Many respondents described circumstances in which beneficiaries were actively seeking out counseling services, only for these efforts to be thwarted due to reimbursement policy. Rather than making a referral and trusting that care would be provided by a Medicare-eligible provider, in many cases, respondents questioned whether that referral would be fruitful, either due to a lack of alternative providers in their geographic area, long wait lists for other providers, or skepticism that the client would move forward with the referral. Respondents were particularly concerned that specific client populations (i.e., older adults, people with disabilities, rural communities) would be negatively affected by the lack of Medicare-eligible providers. These concerns are consistent with previous research in which the unavailability of providers has been cited as a reason for mental health care disparities among older adult (Institute of Medicine, 2012; Stewart, Jameson, & Curtin, 2015) and rural populations (Larson et al., 2016).

The category economic toll on providers was illustrative of the expansive impact that Medicare ineligibility appeared to have on respondents' livelihoods, marketability, and access to jobs. The preponderance of practicing counselors who have used a pro bono or sliding scale approach to working with Medicare beneficiaries (i.e., 39.9%; Fullen et al., 2020) indicates that many counseling professionals find themselves in the precarious situation of having to choose between reduced-fee approaches and premature termination of an existing client. Walking a thin line between ethical practice and economic realities may increase the risk of using questionable practices to maintain continuity of care.

Larger agencies that provide counseling services may be able to employ Medicare-eligible providers alongside LPCs, thus creating a partial solution to problems described by respondents. However, there may be challenges related to hiring Medicare-eligible providers (Fullen et al., 2019), or agencies may have a select number of Medicare-eligible providers with long wait lists. Each of these circumstances has economic consequences for agencies. In fact, some respondents referred to having trouble attaining employment due to Medicare ineligibility. In light of the economic impact of current Medicare policy on agencies, the tendency for agencies to overlook LPCs in favor of hiring Medicare-eligible providers appears to be a response to economic realities instead of the quality of provider training or client care. In fact, in a related study, an agency director suggested that LPCs were turned down for a job solely because of current Medicare policy (Fullen et al., 2019).

Given these economic realities, it would seem that the scenarios described here would result in inefficient mental health care service delivery. Medicare provider regulations, last updated in 1989 (H.R. Rep. No. 101-386), do not appear to be in sync with the current mental health marketplace. These inefficiencies appear to be particularly out of line with the integrated behavioral health care paradigm,

which has been shown to improve mental health care outcomes (Schmit, Watson, & Fernandez, 2018). Data from the Health Resources and Services Administration (2019) indicate that integrated centers provided over 9.8 million mental health visits in 2017, and the emphasis on integrated care within the federal government (i.e., Substance Abuse and Mental Health Services Administration, n.d.) suggests this number will increase moving forward. Although counselors are well-equipped to work within integrated behavioral health, several of our respondents emphasized that Medicare ineligibility is a major barrier for being hired within these settings.

The third thematic category, negative influence on profession's credibility, corresponded with respondents' concerns that their training or license were devalued in the eyes of the public due to Medicare ineligibility. Counseling scholars have previously noted that Medicare reimbursement is linked to the counseling profession's ongoing evolution as a discipline (Field, 2017; Reiner et al., 2013). In spite of the developmental nature of gaining public and governmental credibility, current Medicare ineligibility was viewed as detrimental to this goal by many respondents. Previous research indicates the public is less knowledgeable about the counseling profession than about related disciplines such as psychiatry, psychology, and social work (MacLeod, McMullen, Teague-Palmieri, & Veach, 2016). Furthermore, members of the public may be confused by intraprofessional differences (e.g., the use of disparate terminology for counselor licensure; Sheperis, Korani, Milan-Nichols, & Sheperis, 2019), thus contributing to uncertainty about the role counselors play in the broader mental health marketplace. Although the precise connection between public perception and Medicare ineligibility has not been examined, our respondents suggested that exclusion from the Medicare program exacerbates public perceptions about the quality of training or skill held by counselors in contrast to Medicare-eligible mental health professions. The reference to embarrassment by several respondents suggests that reimbursement policy is more than merely an inconvenience or economic barrier, but influences counselors on a much more affective level.

Embedded within this thematic category were additional references to client care, suggesting that concerns about professional credibility are ultimately couched in a desire to provide sound care to clients. Previous research indicates that a counselor's work with clients is a foundational aspect of counselor professional identity (Moss, Gibson, & Dollarhide, 2014; Rønnestad & Skovholt, 2003). In fact, Moss et al. (2014) stated that "across all levels and work settings, work with clients was most meaningful to counselors' professional identity development" (p. 8). The commitment of counselors to forming and nurturing strong therapeutic relationships with clients appears to be both a vital aspect of counselor professional identity and a potential source of pain when barriers to client care are experienced.

The consequences of Medicare ineligibility on the counseling profession may be more complex than previously established, resulting in several implications. Previous allusions to the role of Medicare eligibility in the profession's ongoing development (Field, 2017; Reiner et al., 2013) reference the policy's importance, but do not detail the scope of the problem, nor its direct impact on the emotional

or economic well-being of counselors. In fact, there have been very few references to Medicare within the counseling profession's corpus, particularly in contrast to the attention the policy has received within *Counseling Today*. We have suggested elsewhere that this may be evidence of a bifurcation between research and practice within the counseling profession (Fullen et al., 2020).

Additionally, this study suggests that legislative advocacy related to the inclusion of professional counselors as Medicare providers should continue to be a professional priority. This study demonstrates that not only would passage of proposed legislation (House of Representatives Bill 945, 2019; Senate Bill 286, 2019) expand access to counseling services for those insured by Medicare, but it would be likely to benefit the counseling profession in numerous ways. At the very least, the legislative change would be expected to improve the ability of counselors to be hired, particularly within integrated behavioral health care settings; expand the public's familiarity with the counseling profession; and reduce the negative emotional impact associated with untimely referrals and premature termination of existing working relationships with clients. More broadly, passage of the legislation could be expected to improve the efficiency of the mental health marketplace by remedying workforce shortages, particularly in rural areas (Larson et al., 2016), and expanding the provider choices available to clients and agencies.

Limitations

There were certain limitations in this study. The qualitative data used in this analysis reflect only the perspectives and experiences of the 1,859 ACA members who responded. Although this is a robust sample, it amounts to only a small fraction of total ACA membership, and an even smaller proportion of all counseling professionals nationwide. Prior research indicates that the sample from which these data were drawn is similar in certain ways to the entire ACA membership (Fullen et al., 2020); nevertheless, it is possible that those who participated did so due to unique experiences related to Medicare ineligibility. Additionally, our understanding of the practice contexts occupied by each of the respondents in this study is limited. The diversity of experiences related to Medicare ineligibility cannot be comprehensively interpreted from our results. Furthermore, this study largely does not capture the direct experiences of those insured by Medicare, nor does it fully illuminate why LPCs and LMFTs have thus far remained ineligible for Medicare reimbursement. Given these limitations, the purpose of this study was to develop and extend knowledge of the impact of the current MMHCG on counselors.

CONCLUSION

The impact of existing Medicare policy on the counseling profession was described in light of the results of a conventional qualitative content analysis. Respondents illuminated a variety of ways in which the inability to receive reimbursement from Medicare interferes with their work with clients. When

this occurs, counseling professionals experience a negative emotional impact; the economic toll of lost wages, reduced fees, and barriers to employment; and professional embarrassment that seems discordant with their training and ability to work effectively with clients. The far-reaching consequences of Medicare ineligibility should continue to be probed to improve counseling professionals' ability to engage in advocacy on behalf of clients, their communities, themselves, and the counseling profession.

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