



Counselors' Interest in Working With Medicare Beneficiaries

A survey of licensed professional mental health counselors

Report by

Isabel C. Farrell, PhD, LPC, NCC

Assistant Professor of Counselor Education, Wake Forest University

Matt W. Wolff, MS, NCC, LPC, CCTAP

Licensed Psychotherapist and Mental Health Policy Consultant, Texas

Matthew C. Fullen, PhD, MDiv, LPCC (OH)

Assistant Professor of Counselor Education, Virginia Tech

Letitia Johnson, LicSW, BC-TMH, CHT, CMHS

Adjunct Faculty, PhD Candidate, Antioch University, Seattle

Lynn Linde, EdD

*Chief Knowledge & Learning Officer (Staff Counselor Lead),
American Counseling Association*

Brian D. Banks, MA

Chief Government Affairs & Public Policy Officer, American Counseling Association

Guila Todd

Manager, Government Affairs & Public Policy, American Counseling Association

Preface

Before becoming a counselor, I worked for a member of the Texas Legislature for over a decade. During that time, I came to understand how many legislators interpret legislation and how proposals are viewed through multiple perspectives and considerations, such as fiscal impact, disruption to existing norms, and whether solving one problem might unintentionally cause another.

Even when evidence clearly points to the need for legislation to improve a problematic situation, it can be the personal stories of those people who are seeking relief from a flawed system that can be the final nudge for legislators to take action. To that end, I can speak for myself and many counselors I know about the difficulties for clients who are forced to find new providers when they become eligible for Medicare.

The psychotherapeutic relationship is based on interpersonal connection and trust, often developed slowly over time. When an established client who has been making vital progress over weeks or months of hard work loses their private insurance because they have been enrolled in Medicare, they often must discontinue care because licensed counselors, such as myself, are unable to accept their Medicare insurance. This means that these “orphaned” clients have difficulty finding a provider and, too frequently, lose much of the progress they painstakingly achieved. All too often, much of the progress clients have painstakingly made may be erased as they start from scratch with a new provider—or simply cease therapy altogether because there are no suitable providers to be found. Often, our most vulnerable populations depend on Medicare for mental health care. These populations should not be excluded from seeking licensed counselors, and on behalf of the licensed counseling community, I urge Congress to pass the Mental Health Access Improvement Act (S. 828/H.R. 432).

Matt W. Wolff, MS, NCC, LPC, CCTAP

Licensed Psychotherapist and Mental Health Policy Consultant, Texas

Survey Results

Currently, the Medicare program does not provide reimbursement to licensed professional mental health counselors (LPMHCs)¹ but does reimburse for services by licensed clinical social workers, psychiatrists, psychologists, and psychiatric nurse specialists.

The Mental Health Access Improvement Act (S. 828/H.R. 432) would modernize the Medicare program by including LPMHCs and licensed marriage and family therapists (LMFTs) among Medicare providers. We conducted a survey to gauge counselors' interest in working with Medicare beneficiaries and receiving Medicare reimbursement if the Mental Health Access Improvement Act becomes law. We asked participants about their licensure status, whether they would seek to become a Medicare-approved provider (either directly or through their employer), their reasons for not seeking to become a Medicare-approved provider, and barriers they perceive Medicare beneficiaries experience in accessing mental health services.

In this report, we highlight the major findings of the survey and use the results to roughly estimate how many counselors would likely enroll as Medicare-recognized providers, given the opportunity. Currently, there are approximately 160,000 LPMHCs in the United States. Our survey was sent to the over 60,000 American Counseling Association (ACA) members, and it was also open to LPMHCs outside of ACA membership. We received 24,198 responses over a 2-week period. Counselors from all states and some U.S. territories responded to this survey. A total of 17,153 respondents provided their state or territory affiliation, as shown below:

AK	72	0.4%	LA	374	2.2%	OK	244	1.4%
AL	368	2.1%	MA	271	1.6%	OR	335	2.0%
AR	162	0.9%	MD	649	3.8%	PA	952	5.6%
AZ	408	2.4%	ME	110	0.6%	RI	52	0.3%
CA	355	2.1%	MI	559	3.3%	SC	134	0.8%
CO	561	3.3%	MN	191	1.1%	SD	190	1.1%
CT	389	2.3%	MO	31	0.2%	TN	376	2.2%
DC	109	0.6%	MS	376	2.2%	TX	1452	8.5%
DE	56	0.3%	MT	116	0.7%	UT	112	0.7%
FL	785	4.6%	NC	749	4.4%	VA	821	4.8%
GA	546	3.2%	ND	41	0.2%	VT	75	0.4%
HI	46	0.3%	NE	168	1.0%	WA	486	2.8%
IA	217	1.3%	NH	63	0.4%	WI	346	2.0%
ID	186	1.1%	NJ	561	3.3%	WV	87	0.5%
IL	735	4.3%	NM	176	1.0%	WY	76	0.4%
IN	229	1.3%	NV	29	0.2%	Guam	6	<0.1%
KS	86	0.5%	NY	610	3.6%	PR	19	0.1%
KY	282	1.6%	OH	721	4.2%	VI	3	<0.1%

¹The term *licensed professional mental health counselor* (or LPMHC) encompasses all licensed practicing counselors working in the United States, regardless of how licensed counselors are referred to in a particular state.

Description of Respondents' Licensure Status

Of the 24,198 survey respondents, 62.46% (15,114) indicated they are independently licensed as a counselor, 28.95% (7,005) reported they are seeking licensure, and 8.59% (2,079) indicated neither. See Figure 1.

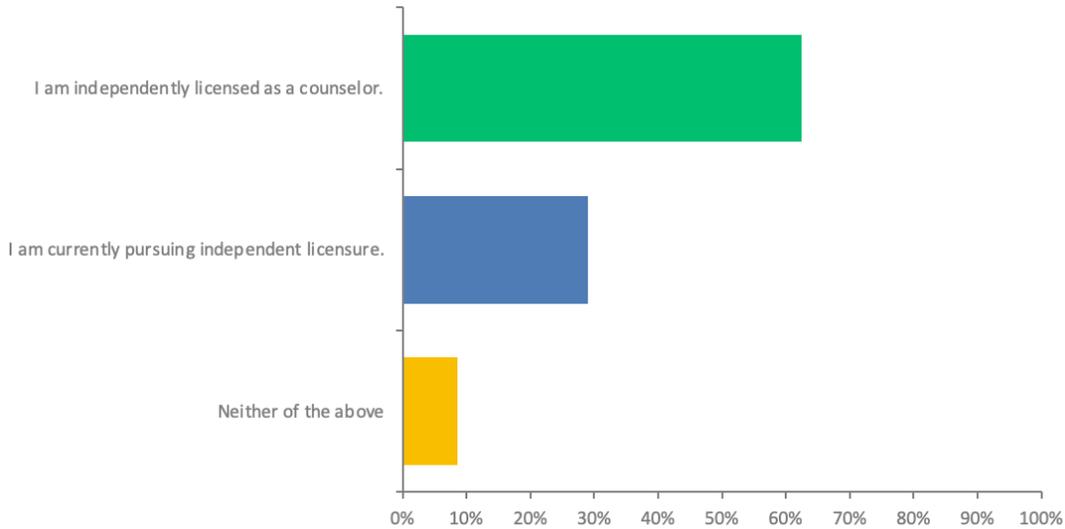


Figure 1 - Licensure Status

LPMHCs' Current Practice Settings

We asked LPMHCs where they currently practice. We obtained 17,294 responses. Of these, 61.54% (10,643) indicated private practice, 19.69% (3,405) indicated a community mental health agency/community service board, 2.49% (430) indicated a hospital, 2.91% (504) indicated a substance use treatment center, 1.68% (290) indicated a federally qualified health center (FQHC)/community health center, 2.24% (388) indicated a K–12 education setting, 2.94% (508) indicated a university education setting, 0.45% (78) indicated an employee assistance program, 0.12% (21) indicated a retirement community, and 5.94% (1,027) indicated other type of setting. Other settings included telehealth, correctional facilities, crisis centers, Department of Defense contractors, eating disorder centers, hospice, shelters, and faith-based organizations. See Figure 2.

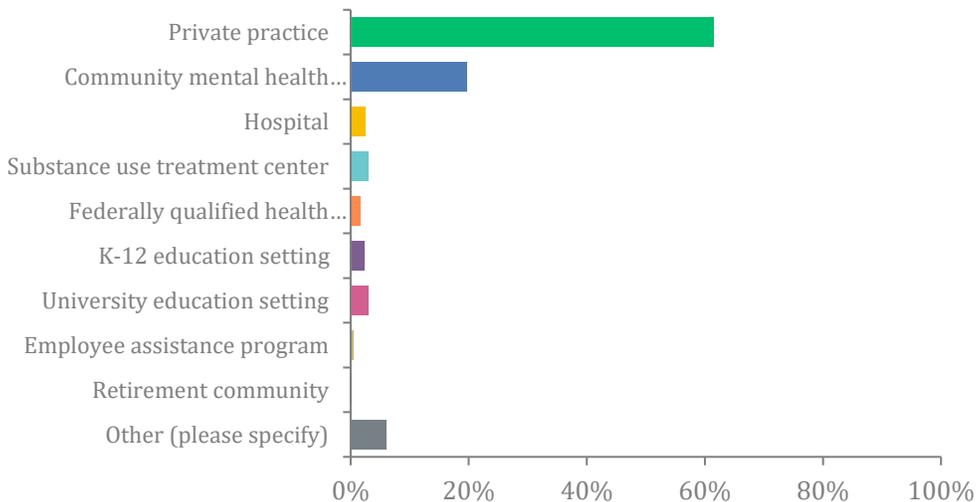


Figure 2 - Practice Settings

LPMHCs' Interest in Becoming a Medicare-Approved Provider

LPMHCs were asked whether they plan to pursue becoming a Medicare-approved provider, either directly or through their employer, in the event the Mental Health Access Improvement Act is passed and counselors become eligible to be reimbursed for providing services to Medicare beneficiaries. We received 21,800 responses. Of these, 72.40% (15,784) indicated they would seek to become a Medicare-approved provider, 6.22% (1,357) indicated they would not become a Medicare-approved provider, and 21.37% (4,659) were unsure. See Figure 3.

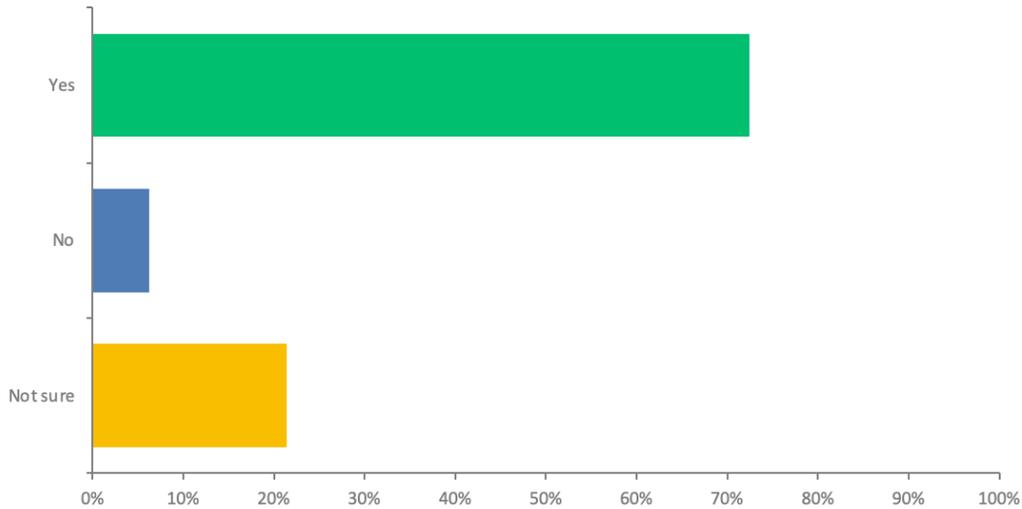


Figure 3 - Plan to Become Medicare Provider

For those respondents who indicated they were not interested or unsure if they would seek to become a Medicare-approved provider, we asked them to cite their reason. We asked them to select all the reasons that applied. We received a total of 5,734 responses. Of these, 45.41% (2,604) indicated that reimbursement is too low, 22.85% (1,310) indicated that their caseload is currently too full, 20.58% (1,180) indicated they only accept out-of-pocket payment/private pay, 26.26% (1,506) indicated that their practice setting does not typically serve Medicare beneficiaries, 20.11% (1,153) indicated that their specialty area does not serve clients aged 65 or older, 9.61% (551) indicated that they do not have sufficient training to work with Medicare beneficiaries, and 20.14% (1,155) indicated other reasons. Among those selecting other reasons, top concerns related to paperwork/documentation required for reimbursement, reimbursement issues, not currently practicing, and upcoming retirement. See Figure 4.

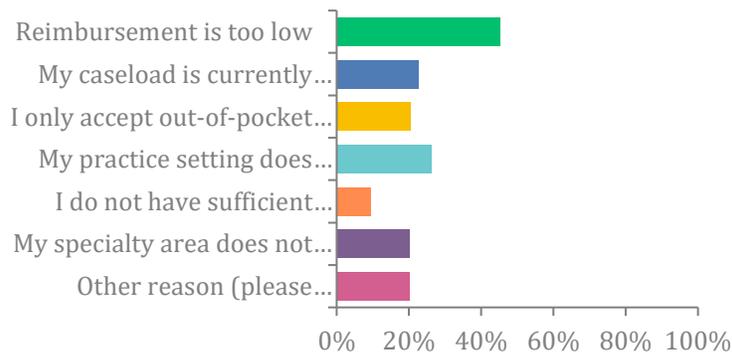


Figure 4 - Reasons for Lack of Plan

Current Response to Medicare Beneficiaries

Because of the current lack of coverage under the Medicare program, LPMHCs often need to make decisions on how to handle requests for services from Medicare beneficiaries. We asked LPMHCs how they typically respond to such requests and to select all that applied. We received 19,036 responses. Of these, 66.54% (12,666) indicated they make referrals to Medicare-eligible providers, 33.35% (6,348) indicated they decline services due to Medicare ineligibility, 29.04% (5,529) indicated they provide services using a sliding scale, 23.95% (4,559) indicated they provide services at an out-of-pocket rate, and 16.97% (3,231) indicated they provide pro bono services. See Figure 5.

In addition, we asked how many Medicare beneficiaries on average contact LPMHCs for mental health care per month. The average number was 11 beneficiaries per month, with responses ranging from 0 to 100 (one outlier of 10,000 was not calculated into the average).

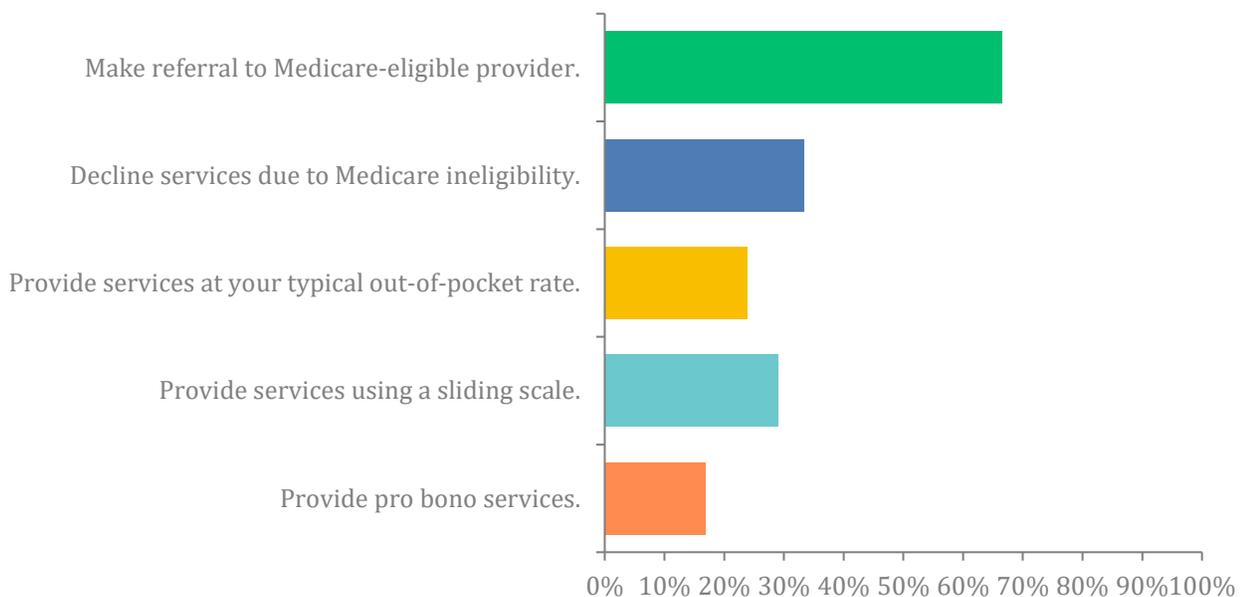


Figure 5 - Responses to Medicare Beneficiaries Seeking Services

Additional Barriers to Care for Medicare Beneficiaries

Medicare beneficiaries may not seek mental health services for a variety of reasons other than lack of access to providers. We asked LPMHCs which additional barriers they believed might cause clients not to seek needed mental health services on a consistent basis and to select all that applied. We received 17,842 responses. Of these 72.60% (12,954) indicated that there are not enough providers to access services in a timely manner, 56.11% (10,011) indicated that beneficiaries cannot afford both medications needed and mental health services, 51.41% (9,172) indicated stigma concerns, 42.79% (7,635) indicated lack of telehealth support, 34.15% (6,093) indicated providers that are not counselors are too far away from an individual's place of residence, 29.50% (5,264) indicated services by non-LPMHCs are too expensive, and 11.85% (2,115) indicated other reasons—chiefly, cost of care and lack of providers who accept Medicare. Regarding cost of care, respondents noted that Medicare clients either cannot afford the copay or, for those with a supplemental plan, cannot afford to pay until after they

have met their (high) deductible. Other commonly cited barriers were the client’s own culture and stigma around seeking mental health care, needing to find a culturally competent counselor (especially for clients who are Black, Indigenous, or people of color), and lacking transportation. See Figure 6.

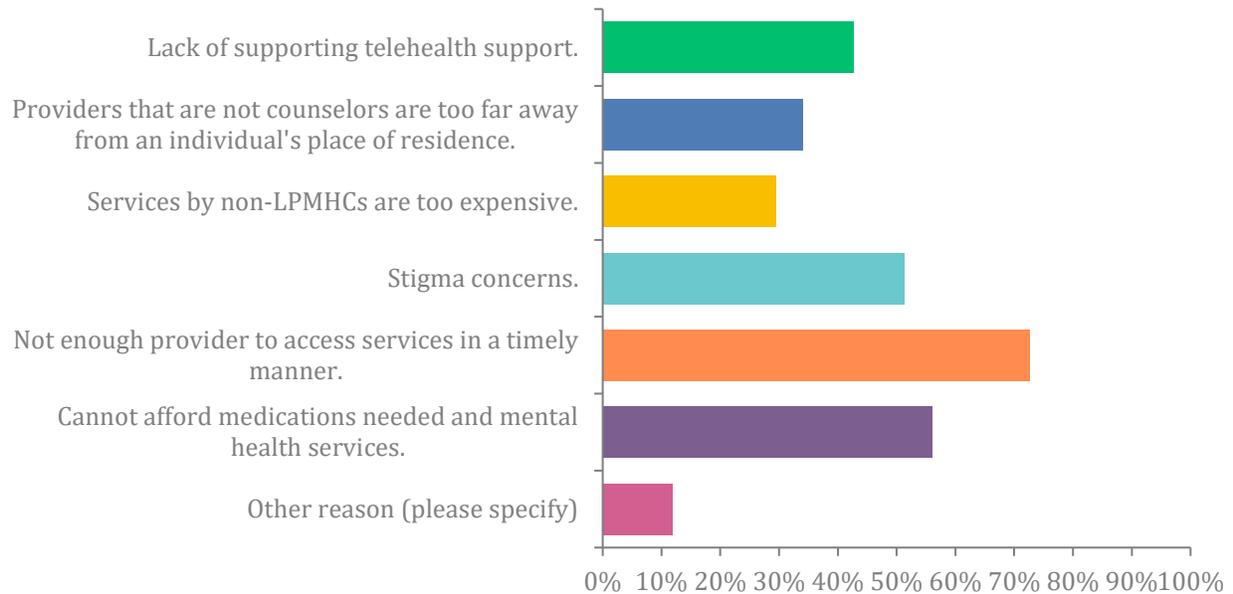


Figure 6 - Barriers to Care

Potential Cost Savings to Medicare

Under the Mental Health Access Improvement Act, both LPMHCs and LMFTs would be reimbursed at a rate equivalent to that of licensed clinical social workers. This rate is estimated at approximately 75% of what Medicare pays doctoral-level providers, which means that the average cost of a therapy appointment for Medicare recipients would *decrease*.

As an example, we can use the hypothetical case of John, a Medicare recipient who currently has only one doctoral-level provider in his community, who is providing diagnostic and treatment services at a cost to Medicare of \$100 for a visit. Under the proposed legislation, John would have more choices among providers. If John elects to work with Tony, an LPMHC, the cost to the Medicare program would be only \$75, which represents a 25% savings. Adding LPMHCs and LMFTs to the Medicare program creates more choices for consumers like John and decreases the average per patient cost to the Medicare program for mental health visits.

Under current Medicare policy, Tony is excluded from providing mental health services. If John is unable to find another mental health provider, he may end up seeking crisis services from his local hospital or emergency department, or he may require treatment in a psychiatric hospital setting. The Mental Health Access Improvement Act would provide John access to more services earlier in his process of seeking help. Access to affordable health care services at the time when they’re needed most results in a better treatment experience for John and more efficiency in the Medicare program.

Including LPMHCs and LMFTs among Medicare providers also would ensure that Medicare beneficiaries have the same access to mental health services as those who rely on private insurance, the Veterans Health

Administration, TRICARE, and Medicaid. Increasing the availability of providers would be particularly beneficial in mental health professional shortage areas and communities where LPMHCs and LMFTs currently make up a large proportion of the workforce.

There are several factors to consider in response to concerns about the cost of adding more mental health providers to the Medicare program. First, as our survey results show, not all providers will enroll, for various reasons. Second, because most LPMHCs are not trained to specialize exclusively on working with Medicare beneficiaries (due in part to historically being excluded from participation in Medicare), it is likely that most counselors who choose to enroll in Medicare would serve only a select number of Medicare clients, with relatively few shifting all or most of their caseload to Medicare. Third, it is also worth noting that many LPMHCs and LMFTs work in private practice or agency settings, rather than in the hospitals, treatment centers, and FQHC/rural health clinics that more commonly serve Medicare clients, largely because of their co-located medical services. Therefore, it may take time for these settings to adjust, whether that means private practices/agencies marketing their services to Medicare recipients or hospitals, treatment centers, or FQHC/rural health clinics offering more services from an expanded mental health workforce.

Executive Summary

We found that 72% of counselors who responded to our survey question on willingness to participate in Medicare are interested in doing so. If that proportion reflects the level of interest among all counselors, we can estimate that up to 115,000 LPMHCs would pursue enrollment as Medicare-eligible providers. Conversely, our survey results suggest that an estimated 45,000 LPMHCs would be unlikely to enroll or uncertain about their interest in enrolling.

Adding the estimated 115,000 LPMHCs as Medicare providers would not only expand the available mental health workforce but also create more opportunities for cost-effective services and help to keep Medicare beneficiaries out of more expensive treatment settings, such as hospitals and emergency rooms. The addition of “timely, accessible care would help to ensure that mental health and substance use problems are addressed before more costly interventions are required” (ACA, 2021, p. 7). Expanding the available workforce may increase cost savings as well. Fullen et al. (2020) noted that, under the Medicare program, the cost of a day of inpatient psychiatric hospitalization cost was equivalent to twelve 45-minute counseling sessions. Because LPMHCs would be reimbursed at 75% of the rate of psychiatrists/psychologists, there are likely to be additional savings to the program over time. Utilization of LPMHCs in the Medicare system would ensure cost-efficient care is available for beneficiaries in a lower cost setting.

When considering the potential impact of adding LPMHCs to Medicare, it is also worth considering factors that may impede their ability to take on large numbers of Medicare beneficiaries, at least initially. Survey respondents who expressed reservations about participating in Medicare acknowledged several barriers to their participation, including reimbursement rate, not accepting any third-party insurance, and not having space on their

caseload. It is possible that even among those survey participants who are interested in participating, these factors may end up limiting the extent of their participation in the Medicare program. For example, concerns around reimbursement rates or already having a full caseload may result in providers who enroll with Medicare reserving only a small number of spaces on their caseload for Medicare beneficiaries.

The average caseload of an LPMHC varies by location, employment setting, client population served, and other preferences. However, the number of counselors who would work exclusively with Medicare beneficiaries currently is not large, so it is unlikely that those respondents who said they would enroll in Medicare would devote all or most of their caseload to Medicare alone. It is also worth highlighting that a large proportion of survey respondents work in private practice, as opposed to hospitals, treatment centers, or FQHC/rural health clinic settings.

Whereas hospitals, treatment centers, or FQHC/rural health clinics may be more accustomed to serving Medicare beneficiaries for broad health care needs, private counseling practices have not historically had strong inroads within Medicare-serving populations. Therefore, the use of mental health counseling services by Medicare beneficiaries may develop slowly.

Conclusion

If the Mental Health Access Improvement Act (S. 828/H.R. 432) becomes law, the Medicare program enrollment can be expected to expand by an estimated 115,000 LPMHCs nationwide. Most representation will be at the private practice and community mental health agency level. However, based on responses from the survey (i.e., concerns with eligibility, reimbursement rate, and reimbursement issues), we anticipate the use of mental health LPMHC services by Medicare beneficiaries would develop gradually.

Beyond LPMHCs not being approved Medicare providers, the main barrier for seeking mental health services by Medicare beneficiaries may be lack of access to Medicare-covered professionals. Utilization of LPMHCs in the Medicare system would ensure cost-efficient care is available for beneficiaries in a lower cost setting..

Ultimately, passing the Mental Health Access Improvement Act has the potential to create federal health program cost savings in both the short and long term. Short-term savings would be achieved by creating opportunities for LPMHCs to provide services that are relatively more affordable, and long-term savings would be achieved by keeping Medicare beneficiaries out of more expensive treatment settings. Including LPMHCs in the Medicare program is a strategy to optimize cost-effective solutions by creating equitable access for beneficiaries.

Acknowledgments

The authors extend special thanks to HPSO Liability Insurance for assisting in distribution of the survey to LPMHCs and to Amy Smith and Joan M. Flynn of ACA for assisting in preparation of the survey and presentation of the results.

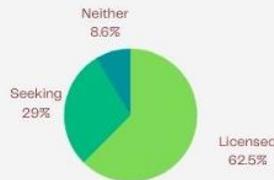
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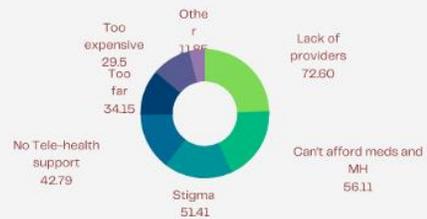
LPMHCs' interest in working with Medicare recipients

Licensure Status

62.46% indicated they are independently licensed as a counselor, 28.95% seeking licensure, and 8.59% neither of the above.



Barriers to Care



72.60% not enough providers, 56.11% recipients cannot afford both medications needed and mental health services, 51.41% stigma concerns, 42.79% lack of tele-health support, 34.15% providers are too far away, 29.50% services by non-LPMHCs are too expensive, and 11.85% other reasons.

Interest in Becoming a Provider



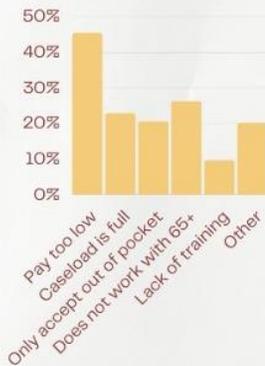
72.40% indicated they would seek to become a Medicare-approved provider, 6.22% indicated they would not, and 21.37% were unsure.

Monthly average of Medicare recipients that request mental health services from LPMHCs = 11



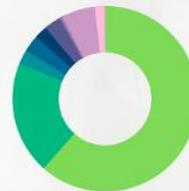
Reasons for non-enrollment

45.41% reimbursement is too low, 22.85% caseload is currently full, 20.58% only accept out of pocket payment/private pay, 26.26% practice setting does not typically serve Medicare recipients, 20.11% specialty area does not serve clients aged 65 or older, 9.61% they do not have sufficient training to work with Medicare recipients, and 20.14% indicated other reasons.



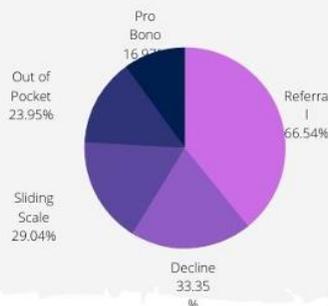
LPMHCs Current Practice Locations

61.54% private practice, 19.69% community mental health agency/community service board, 2.49% hospital, 2.91% substance-use treatment center, 1.68% federally qualified health center/community health center, 2.24% K-12 Educating setting, 2.94% university educational setting, 0.45% employee assistance program, 0.12% retirement community, and 5.94% other type of setting.



Current Response to Medicare Recipients

66.54% make referrals to Medicare-eligible provider, 33.35% decline services due to Medicare-ineligibility, 29.04% provide services using a sliding scale, 23.95% provide services at an out of pocket rate, and 16.97% provide pro bono services.



Other settings included tele-health, correctional facilities, crisis centers, DoD contractors, eating disorder centers, hospice, shelters, and faith-based organizations.

Potential annual short-term savings of over 81 million dollars plus additional long-term savings by keeping Medicare recipients out of more expensive treatment settings.

