

ACA Issue Brief

More Than 30 Years of Mental Health Care Inequity: Restricted Access to Providers for Medicare Beneficiaries

Medicare beneficiaries have fewer choices among mental health providers than enrollees in other health plans. This can limit their access to less costly treatment, disrupt their continuity of care, and further frustrate their efforts to obtain needed mental health care in rural areas already experiencing a shortage of providers. The Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432) would address this inequity by closing the gap in federal law that excludes licensed professional counselors and marriage and family therapists from direct billing and reimbursement under Medicare.

The Medicare Mental Health Coverage Gap

Medicare is the primary insurance provider for about 60 million Americans, providing health and mental health coverage for people age 65 and older (85% of beneficiaries), people under 65 with disabilities (15%), and people with end-stage renal failure (<1%; Kaiser Family Foundation, n.d., 2019). One in five Medicare beneficiaries (20%) lives in a rural area, and 22% have income near or below the poverty level (Medicare Payment Advisory Commission, 2020).

Medicare is expected to cover nearly 80 million people by 2030 (Medicare Payment Advisory Commission, 2020). As younger baby boomers reach eligibility, the proportion of the total U.S. population covered by Medicare (currently 18%) is expected to increase (U.S. Census Bureau, n.d.) and to become more diverse. By 2060, the racial and ethnic distribution of Americans age 65 and older is projected to be 55% White, 21% Hispanic, 13% Black, and 8% Asian (Federal Interagency Forum on Aging-Related Statistics, 2020).

Like private health insurance, Medicare covers mental health care; however, unlike most private insurance, it allows only psychiatrists, psychologists, clinical social workers, and psychiatric nurses to bill directly for services. Licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) are not on Medicare's covered-provider list, which has not been updated by Congress since 1989 (Fullen, Lawson, & Sharma, 2020).

Impact on Beneficiaries

Because LPCs and LMFTs make up an estimated 40% of all master's-level mental health professionals practicing nationwide, their exclusion from Medicare makes it more difficult, and more expensive, for beneficiaries to access care, compared with people who are covered by private health insurance or by Medicaid.

Rural areas. The problem of restricted access is most acute for Medicare beneficiaries in rural areas, where despite higher rates of substance use disorder and suicide, more than 50% of counties do not have any licensed mental health provider, according to a report by the Bipartisan Policy Center (2021). The report, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*, also states that more than 60% of nonmetropolitan counties specifically do not have a psychiatrist, and almost half do

not have a psychologist. Among those mental health providers who do work in rural communities, 59% are counselors (including LPCs, LMFTs, and others), which suggests that counselors play a key role in providing rural mental health services outside of Medicare (Larson et al., 2016, as cited in Fullen, Brossoie, et al., 2020). Without access to mental health professionals, people in rural areas often rely on general practitioners for behavioral and mental health diagnosis and treatment (Medicaid and CHIP Payment and Access Commission [MACPAC], 2021) and, as a result, may not receive the specific treatment needed for their condition (Rural Health Information Hub, n.d.-a).

Medicaid/Medicare. The exclusion of LPCs and LMFTs from Medicare also results in a lack of “program compatibility” between Medicare and Medicaid (Fullen, Brossoie, et al., 2020, p. 247). Licensed counselors whose services were covered under their state’s Medicaid program may be forced to refer a client who becomes covered under Medicare to another provider (Fullen et al., 2019). These dually eligible beneficiaries have found that their inability to produce a claim denial for counseling services under Medicare (because Medicare does not recognize claims from these providers) means Medicaid will not cover the service instead. This can occur even though Medicaid is considered the payer of last resort and might otherwise cover the claim if it were the sole source of coverage. Further, the greater prevalence of serious mental health conditions and negative encounters with the criminal justice system involving some Medicaid beneficiaries battling serious mental illness (MACPAC, 2021) makes any disruptions to their mental health care concerning.

Medical costs. The link between mental health and chronic physical health conditions is widely acknowledged. Lack of access to or noncompliance with behavioral/mental health treatment can cause or exacerbate medical conditions and vice versa (MACPAC, 2015). The interaction between behavioral/mental health and medical conditions makes it difficult for researchers to determine the true cost of providing—or not providing—full and fair access to mental health services.

Policy Recommendations

Policy experts have consistently recommended including licensed counselors—specifically, LPCs and LMFTs—in the Medicare program. For example, the Interdepartmental Serious Mental Illness Coordinating Committee (2017) recommended that Congress “remove exclusions that disallow payment to certain qualified mental health professionals, such as marriage and family therapists and licensed professional counselors, within Medicare” (p. 83).

Similarly, a Bipartisan Policy Center (2021) task force recommended that Congress expand the mental health provider types covered under Medicare, thereby addressing shortages in rural areas while dissolving some federal reimbursement barriers to integrated primary and mental health care. Better integration of primary and behavioral health care is a cost-effective approach to federal health spending that reduces disparities and improves patient outcomes.

Last, a recent Commonwealth Fund report (McGinty, 2020) recommended that policy makers close the remaining gap in Medicare by allowing reimbursement for mental health services by the more than 140,000 LPCs in the United States and noted that, although LPC participation could increase Medicare costs, mental health services account for only 1% of program expenditures overall.

Legislative Solution

Past Proposals

Since the 1980s, congressional leaders have sponsored legislation that would close the coverage gap. Including the late Sens. Daniel Patrick Moynihan of Massachusetts and Daniel Inouye of Hawaii.

The Seniors Mental Health Access Improvement Act, for example, has been introduced in the House and Senate more than a dozen times since 2002, often with bipartisan support. Such proposals have passed in both chambers but never during the same congressional cycle (Field, 2017, cited in Fullen, Lawson, & Sharma, 2020). Too often, the bills languish in committee until the session is over.

At the beginning of the COVID-19 pandemic, the American Counseling Association (ACA) urged lawmakers to pass the Mental Health Access Improvement Act of 2019 (S. 286/H.R. 945), which would have added LPCs and LMFTs to the list of Medicare-eligible mental health providers. More than 150 legislators cosponsored the legislation.

The Mental Health Improvement Act of 2021

The Mental Health Access Improvement Act of 2021 ([S. 828/H.R. 432](#)) was reintroduced this year with bipartisan support. In brief, this legislation would close the gap in mental health care coverage for Medicare beneficiaries by

- giving more than 140,000 licensed counselors the option to participate in the Medicare network, significantly alleviating current barriers and offering less costly choices to older adults and people with disabilities;
- increasing access in rural areas underserved by currently recognized Medicare providers;
- allowing LPCs and LMFTs to directly bill Medicare for their services, similar to social workers, psychologists, and psychiatrists; and
- lowering the cost of care with early interventions that can improve outcomes before conditions worsen.

The Senate bill, sponsored by Sens. John Barrasso (R-WY) and Debbie Stabenow (D-MI), was referred to the Senate Finance Subcommittee on Health. The House bill, sponsored by Reps. Mike Thompson (D-CA) and John Katko (R-NY), was referred to the Ways and Means and the Energy and Commerce committees.

Behavioral and Mental Health Needs of Medicare Beneficiaries

The Commonwealth Fund estimates that about one in four Medicare beneficiaries has a mental health condition (McGinty, 2020), an estimate that is supported by a new PAN Foundation poll of older adults (Morning Consult, 2021).

The prevalence of mental illness is greatest among beneficiaries under age 65 who qualify for Medicare because of disability (34%), as well as among low-income beneficiaries who are dually eligible for Medicare and Medicaid (30%), according to the Commonwealth Fund's report, *Medicare's Mental Health Coverage: How COVID-19 Highlights Gaps and Opportunities for Improvement* (McGinty, 2020). American Indian/Alaska Native and Hispanic beneficiaries also are more likely to have mental illness relative to other racial and ethnic groups. In addition, beneficiaries enrolled in traditional Medicare (as opposed to Medicare Advantage plans) are more likely to have a serious mental illness that results in significant impairment, such as schizophrenia, bipolar disorder, or major depressive disorder.

Medicare Beneficiaries 65 and Older

Some recent research on the mental health of older adults has focused specifically on loneliness, depression, and substance use disorder, which can exacerbate or complicate treatment for medical conditions:

- **Loneliness.** Loneliness is a powerful predictor of the use of medications to treat both physical and psychological symptoms in older adults, according to a study by Kotwal et al. (2021). Loneliness in community-dwelling older adults was associated with higher use of pain medications, including opioids and NSAIDs, and more than twice the frequency of use of antidepressants, sleep medications,

and benzodiazepines—all of which have been linked to adverse consequences such as falls, opioid dependence, and cognitive impairment. Use of interventions that address loneliness, such as community support programs, may help clinicians to reduce or avoid prescription of high-risk medications (Kotwal et al., 2021).

- **Depression.** Estimates of depression and anxiety among older adults vary, with many researchers now focusing on rising rates attributable to the effects of the COVID-19 pandemic. A report by the Federal Interagency Forum on Aging-Related Statistics (2020) on the well-being of adults age 65 and older found that at least one in 10 (9% of men and 13% of women) experienced “clinically relevant” (p. xvii) depressive symptoms, defined as four or more symptoms from a list of eight. Older adults reporting depressive symptoms often experience higher rates of physical illness, greater functional disability, higher health care utilization, and dementia.
- **Substance use disorder.** Older adults are particularly vulnerable to the negative effects of substances such as alcohol, yet the warning signs are often overlooked by caregivers. Moreover, people with cognitive conditions such as dementia or mild cognitive impairment may have more difficulty using alcohol or prescription drugs safely, and they are at greater risk of falls and accidents as well as adverse effects from interactions between drugs and alcohol. In a recently updated Treatment Improvement Protocol (TIP) for clinicians, families, and caregivers, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) said that substance abuse is “a serious—and increasing—problem” (p. xiii) among older adults, who are more likely to misuse alcohol than any other substance. Clinicians may fail to identify such disorders in older adults because symptoms can be confused with age-related declines in cognition. Barriers to older adults seeking treatment include lack of information and negative attitudes among providers, families, and caregivers.

Medicare Beneficiaries Under Age 65

People who qualify for Medicare because of disability have a greater prevalence of serious mental disorders. According to the Social Security Administration (2020), six out of 10 such beneficiaries in 2019 were diagnosed with mental disorders. These included autism spectrum disorder, developmental disorder, and childhood or adolescent disorders; intellectual disabilities; mood disorders; neurocognitive disorders; and schizophrenia and other psychotic disorders.

They also have a greater risk for co-occurring substance use disorders. One study found that people hospitalized for opioid/heroin poisoning are more likely to be Medicare beneficiaries with disabilities, ages 50–64, White, and residents of low-income areas (Song, 2017). Although reduced prescribing of opioids for pain is expected to reduce development of new addictions, the public health crisis continues, with more than 70,000 opioid-involved overdose deaths occurring in 2019 (National Institute on Drug Abuse, n.d.).

Dispelling Myths About Medicare Beneficiaries

There is a long-standing myth that older Medicare beneficiaries are not interested in receiving mental or behavioral health services, but research indicates that potentially thousands have sought care only to have their efforts thwarted (Fullen, Lawson, & Sharma, 2020).

The recent PAN Foundation poll of 1,000 Medicare-covered older adults (Morning Consult, 2021) found that 67% said they would be comfortable seeking and receiving mental health care, yet one in five (20%) said their family members, friends, and acquaintances attached

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stigma to seeking treatment for mental health. In addition, a majority (71%) said they had never been screened by their providers for a mental health condition.

Regarding behavioral health, SAMHSA (2020) also counters the belief that older clients are not willing to engage in recovery services and that substance use disorder is a “young person’s disease” (p. xiii). Such myths contribute to low rates of diagnosis, treatment, and services among older people and interfere with their chances of recovery, SAMHSA says.

“Most providers and professionals do not have specialized training in geriatric substance misuse, and most family members and caregivers do not know how to recognize and respond to these problems in older adults,” according to SAMHSA (2020, p. xiii). “The notion that older adults are not interested in or do not respond well to treatment for substance misuse is simply untrue. In fact, when interventions are adapted to the physical, cognitive, and psychosocial needs of older clients, they are likely to be effective” (p. xi).

Effects of COVID-19 Pandemic on Older Adults

The COVID-19 pandemic has negatively impacted the mental health of many older Americans, who have experienced more social isolation, loneliness, and bereavement. With eight in 10 deaths so far occurring in people age 65 and older, the Centers for Disease Control and Prevention (2021) continues to recommend that older Americans limit their in-person interactions with others as much as possible.

Kaiser Family Foundation’s COVID-19 health tracking polls show that during the pandemic period from March to August 2020, 24% of older adults (one in four) reported anxiety and depression, up from the 11% who reported depression and anxiety in a similar 2018 Medicare beneficiary survey (Koma et al., 2020). These polls of older, community-dwelling adults showed greater prevalence of depression and anxiety among women (28%), Hispanics (33%), and beneficiaries with very low income (37%). Older adults in poor health were the most likely to report depression and anxiety (48%).

Barriers to Mental Health Care

Cost and Access to Care

Mental health care may be unaffordable for many older adults, particularly for the 6 million beneficiaries who do not have supplemental coverage for cost-sharing under Medicare, according to the Kaiser Family Foundation (Koma et al., 2020). The PAN Foundation poll, for example, found that 32% of responding older adults said cost was an obstacle to ongoing therapy; 16% said the cost of therapy would be the largest obstacle for them (Morning Consult, 2021).

Furthermore, many health care providers limit their number of Medicare patients because of lower reimbursement rates compared with private insurance. Psychiatrists are the most likely of any physician specialty to opt out of Medicare (Koma et al., 2020). In 2014–2015, only 62% of psychiatrists accepted new patients with Medicare or private insurance, and only 36% accepted patients on Medicaid (Holgash & Heberlein, 2019). Given that 40% of the mental health workforce already cannot provide services to Medicare beneficiaries, this suggests that the shortage of mental health providers is even greater than estimated."

As discussed, this shortage of providers may be particularly burdensome for beneficiaries in rural areas (Fullen, Brossoie, et al., 2020), where there are shortages of providers and higher rates of behavioral and mental health disorders. Some research also indicates there is a lack of culturally competent mental health care in rural areas, particularly those with large Native American or immigrant populations where diversity of culture and language are likely (Rural Health Information Hub, n.d.-a).

Although primary care providers in rural areas handle some of their patients' behavioral and mental health needs, those providers report "feeling overwhelmed, ill-equipped, and underpaid" (Bipartisan Policy Center, 2021, p. 11). Adding licensed counselors to the list of Medicare mental health providers would help to relieve this strain on primary care in rural areas, particularly those that lack access to adequate technology (Rural Health Information Hub, n.d.-b).

Experiences of Counselors

In a landmark study of ACA members, Matthew C. Fullen and colleagues at Virginia Tech (Fullen, Lawson, & Sharma, 2020) found that 70% of 3,392 practicing counselors surveyed had experienced Medicare reimbursement barriers, with 50.3% turning away new or potential clients, 38.8% referring existing clients to Medicare-covered providers, and 39.9% agreeing to see a Medicare-enrolled client pro bono or on a sliding scale (e.g., because of ethical concerns about transitioning a vulnerable client to alternative care or no care). Not only did practicing counselors report clients being adversely affected, but so did counselor educators and students (see Table 1), who often provide community counseling as part of their training program.

"These findings suggest the Medicare mental health coverage gap is far more prevalent than we previously understood," Fullen says (personal communication, August 10, 2021). "Presently, many Medicare beneficiaries are prevented from utilizing mental health services in spite of the availability of qualified professionals. Closing this gap would provide older adults and people with long-term disabilities equitable access to counseling when it is most critically needed."

Fullen and colleagues also found differences based on whether counselors practiced in rural or nonrural localities (Fullen, Brossoie, et al., 2020). For example, 78% of the rural counselors (as designated by the Health Resources & Services Administration) reported being directly impacted by the Medicare payment policy, compared with 68.6% of nonrural counselors. The rural counselors were even more likely than the nonrural counselors to have referred an existing client or provided pro bono services.

These and related studies provide strong evidence that the coverage gap is a barrier to treatment for Medicare beneficiaries. The coverage gap also represents an "untimely barrier to increasing the number of mental health professionals who are interested in working with older adults" (Fullen, Brossoie, et al., 2020, p. 249).

Responding to open-ended survey questions, counselors invited to describe their experiences referring or turning away clients used words such as "heartbreaking" (Fullen, Wiley, et al., 2020, p. 9) and "sad" (p. 11), with some saying they had contacted insurance companies or elected officials to advocate for their clients. "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," wrote one surveyed counselor (Fullen, Wiley, et al., 2020, p. 10).

Counselors also commented on how the lack of standing with Medicare affected their credibility as professionals, with one noting that "this distinction continues to make the public think we are less than social workers" (Fullen, Wiley, et al., 2020, p. 15).

Table 1. Percentage of 5,930 American Counseling Association Members Affected by Medicare Mental Health Coverage Gap by Professional Type

Experience Level	Total Affected	Turned Away Clients	Referred Existing Clients	Pro Bono/ Sliding Scale
Practicing counselor	70.0	50.3	38.8	39.9
Counselor educator	48.3	24.4	22.7	29.1
Doctoral student	48.8	23.8	23.3	33.3
Master's student	20.9	8.2	8.2	12.7

Note. From “Analyzing the Impact of the Medicare Coverage Gap on Counseling Professionals: Results of a National Study,” by M. C. Fullen, G. Lawson, & J. Sharma, 2020, *Journal of Counseling & Development*, 98(2), p. 212 (<https://doi.org/10.1002/jcad.12315>). Copyright 2020 by the American Counseling Association.

Why Include Counselors in Medicare?

Counselors Cost Less

Although the rising cost of Medicare is regularly noted by policy makers, it makes little sense to exclude LPCs and LMFTs on that basis. Either professional would likely be paid less than 60% of a psychologist’s rate for mental health services, and timely, accessible care would help to ensure that mental health and substance use problems are addressed before more costly interventions are required. Fullen, Lawson, and Sharma (2020) cited research showing that the reimbursement rate for a single day of inpatient psychiatric hospitalization is equivalent to approximately twelve 45-minute counseling sessions.

Wages. According to the U.S. Bureau of Labor Statistics (BLS, n.d.-a), the mean hourly wage for LPCs in general practice is just \$24.42 compared with \$48.14 for psychologists (see Table 2).

Table 2. Comparison of Hourly and Annual Earnings Among Mental Health Professions, May 2020

Provider	Hourly Rate	Annual Earnings
Psychiatrist	\$104.38	\$217,100
Psychologist	\$48.14	\$100,130
Social worker	\$31.22	\$64,940
LMFT	\$27.35	\$56,890
LPC	\$24.42	\$50,800

Labor forecasts. In its *Occupational Outlook Handbook*, BLS (n.d.-b) describes a future need for more mental health professionals who specialize in working with Medicare beneficiaries, stating that psychologists in particular “will be needed to provide services to an aging population, helping people deal with the mental and physical changes that happen as they grow older” (para. 2). The forecasted shortage dates back nearly a decade to the Institute of Medicine (IOM, 2012) report that the workforce prepared to care for the mental and behavioral health needs of older adults was “inadequate in sheer numbers, with the growth of the population threatening to exacerbate this” (p. 224). Medicare coverage of counseling services provided by LPCs and LMFTs would help to fill this need.

Counselors Have Education, Training, Licensure, and Cultural Competency

Since the list of Medicare-eligible providers was last updated in 1989, all 50 states have enacted laws establishing licensing standards for professional counselors, and undergraduate and graduate-level counseling education and training programs can now meet standards for accreditation (Fullen, Lawson, & Sharma, 2020).

Accreditation is the primary process through which higher education institutions and programs ensure quality to the public (IOM, 2012). Accreditation of counseling programs helps to ensure that graduates have the competencies to counsel clients from diverse racial, ethnic, and religious backgrounds across all life stages for a broad range of mental health conditions. Such competencies effectively position the counseling profession to meet the needs of an increasingly diverse Medicare population, particularly in rural and low-income areas. In addition, counselors are trained to work with clients who are prescribed psychotropic treatments or who have substance use disorders and to refer them for more specialized evaluation and care when warranted.

Licensure is regulated by the states and is required for individual practitioners (IOM, 2012). Many states specify that, to obtain licensure, counselors must have graduated from an accredited program, in addition to meeting other requirements, such as standards for ethical and professional behavior. The Mental Health Access Improvement Act of 2021 would add only licensed counselors to the list of Medicare providers.

According to the IOM (2012), the counseling specialties most relevant to geriatric mental health and substance use counseling are mental health, substance abuse, rehabilitation, gerontological, and pastoral counseling. These counseling specialties are reflected among the 18 ACA divisions, including the Association for Adult Development and Aging, the American Rehabilitative Counseling Association, the International Association of Addictions and Offender Counselors, and the Association for Spiritual, Ethical, and Religious Values in Counseling.

Counselors Can Help Medicare to Innovate

With Medicare projected to spend \$688 billion in fiscal year 2021 (Congressional Budget Office, n.d.), the Centers for Medicare & Medicaid Services (CMS) is developing and testing new payment and service delivery models to provide cost-effective quality care.

Inclusion of licensed counselors in Medicare could help this effort. Counselors in Maryland, for example, are seeking to participate in a CMS Innovation Total Cost of Care Model, which will set a per capita limit on federal payment of Medicare costs in the state. The model is intended to work by creating greater incentives for providers, including nonhospital providers, to coordinate with each other in providing patient-centered care.

CMS expects the model could save Medicare over \$1 billion by the end of 2023. Adding LPCs and LMFTs to the list of Medicare-covered providers would remove an obstacle that could otherwise inhibit them from contributing to efforts to provide more cost-effective, quality health care.

Conclusion

The exclusion of professional counselors from the list of covered providers under Medicare unnecessarily limits the options beneficiaries have when choosing among mental health providers. This year, Congress again has an opportunity to close this gap. The Mental Health Access Improvement Act of 2021 (S. 828/H.R. 432) would significantly alleviate current barriers to care and offer less costly choices to older adults and people with disabilities by giving more than 200,000 licensed counselors the option to participate in the Medicare network. It would increase access in rural areas underserved by currently recognized Medicare providers and lower the cost of care with interventions that can improve both physical and mental health outcomes. Now is the time to take this important step toward ensuring equitable access to quality mental health care for all Americans.

References

- Bipartisan Policy Center. (2021). *Tackling America's mental health and addiction crisis through primary care integration*. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/03/BPC_Behavioral-Health-Integration-report_R03.pdf
- Centers for Disease Control and Prevention. (2021, July 3). *COVID-19: Older adults*. <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>
- Congressional Budget Office. (n.d.). *Health care*. <https://www.cbo.gov/topics/health-care>
- Federal Interagency Forum on Aging-Related Statistics. (2020). *Older Americans 2020: Key indicators of well-being*. https://agingstats.gov/docs/LatestReport/OA20_508_10142020.pdf
- Fullen, M. C., Brossoie, N., Dolbin-MacNab, M. L., Lawson, G., & Wiley, J. D. (2020). The impact of the Medicare mental health coverage gap on rural mental health care access. *Journal of Rural Mental Health, 44*(4), 243–251. <http://www.doi.org/10.1037/rmh0000161>
- Fullen, M. C., Lawson, G., & Sharma, J. (2020). Analyzing the impact of the Medicare coverage gap on counseling professionals: Results of a national study. *Journal of Counseling & Development, 98*(2), 207–219. <https://www.doi.org/10.1002/jcad.12315>
- Fullen, M. C., Wiley, J. D., Jordan, J., Sharma, J., & Lawson, G. (2020). "Heartbreaking" referrals, professional "disgrace": The impact of Medicare ineligibility on the counseling profession. *Adultspan Journal, 19*(1), 3–21. <https://www.doi.org/10.1002/adsp.12084>
- Fullen, M. C., Wiley, J. D., & Morgan, A. A. (2019). The Medicare mental health coverage gap: How licensed professional counselors navigate Medicare-ineligible provider status. *The Professional Counselor, 9*(4), 310–323. <https://www.doi.org/10.15241/mcf.9.4.310>
- Holgash, K., & Heberlein, M. (2019, April 10). *Physician acceptance of new Medicaid patients: What matters and what doesn't*. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20190401.678690/full>
- Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* <https://www.doi.org/10.17226/13400>
- Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The way forward: Federal action for a system that works for all people living with SMI and SED and their families and caregivers*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

- Kaiser Family Foundation. (n.d.). *Medicare beneficiaries with end-stage-renal disease (ESRD)—Timeframe: 2019*. <https://www.kff.org/medicare/state-indicator/enrollees-with-esrd/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- Kaiser Family Foundation. (2019, February 13). *An overview of Medicare*. <https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/>
- Koma, W., True, S., Biniek, J. F., Cubanski, J., Orgera, K., & Garfield, R. (2020, October 9). *One in four older adults report anxiety or depression amid the COVID-19 pandemic*. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/>
- Kotwal, A. A., Steinman, M. A., Cenzer, I., & Smith, A. K. (2021). Use of high-risk medications among lonely older adults: Results from a nationally representative sample. *JAMA Internal Medicine*. Advance online publication. <https://doi.org/10.1001/jamainternmed.2021.3775>
- McGinty, B. (2020, July 9). *Medicare's mental health coverage: How COVID-19 highlights gaps and opportunities for improvement*. Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/jul/medicare-mental-health-coverage-covid-19-gaps-opportunities>
- Medicaid and CHIP Payment and Access Commission. (2015, June). *Report to Congress on Medicaid and CHIP*. <https://www.macpac.gov/wp-content/uploads/2015/06/June-2015-Report-to-Congress-on-Medicaid-and-CHIP.pdf>
- Medicaid and CHIP Payment and Access Commission. (2021, June). *Report to Congress on Medicaid and CHIP*. <https://www.macpac.gov/publication/june-2021-report-to-congress-on-medicaid-and-chip/>
- Medicare Payment Advisory Commission. (2020, July). *A data book: Health care spending and the Medicare program*. http://www.medpac.gov/docs/default-source/data-book/july2020_databook_entirereport_sec.pdf?sfvrsn=0
- Mental Health Access Improvement Act of 2019, S. 286, 116th Cong. (2019). <https://www.congress.gov/bill/116th-congress/senate-bill/286?q=%7B%22search%22%3A%5B%22S.+286%22%5D%7D&s=2&r=1>
- Mental Health Access Improvement Act of 2021, S. 828, 117th Cong. (2021). <https://www.congress.gov/bill/117th-congress/senate-bill/828?q=%7B%22search%22%3A%5B%22s828%22%5D%7D&r=1&s=3>
- Morning Consult. (2021, May). *Mental health concerns among seniors with chronic illnesses*. PAN Foundation. <https://www.panfoundation.org/app/uploads/2021/05/PAN-Mental-Health-Analysis.pdf>
- National Institute on Drug Abuse. (n.d.). *Trends & statistics: Overdose death rates*. <https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates>
- Rural Health Information Hub. (n.d.-a). *Barriers to mental health treatment in rural areas*. <https://www.ruralhealthinfo.org/toolkits/mental-health/1/barriers>
- Rural Health Information Hub. (n.d.-b). *Telehealth use in rural areas*. <https://www.ruralhealthinfo.org/topics/telehealth#challenges>
- Social Security Administration. (2020). *SSI annual statistical report, 2019*. https://www.ssa.gov/policy/docs/statcomps/ssi_asr/

- Song, Z. (2017). Mortality quadrupled among opioid-driven hospitalizations, notably within lower-income and disabled White populations. *Health Affairs*, 36(12), 2054–2061. <https://www.doi.org/10.1377/hlthaff.2017.0689>
- Substance Abuse and Mental Health Services Administration. (2020). *Treating substance use disorder in older adults: Updated 2020* (Publication No. PEP20-02-01-011). Treatment Improvement Protocol TIP 26. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-011%20PDF%20508c.pdf
- U.S. Bureau of Labor Statistics. (n.d.-a). *May 2020 occupation profiles*. https://www.bls.gov/oes/current/oes_stru.htm#19-0000
- U.S. Bureau of Labor Statistics (n.d.-b). *Occupational outlook handbook: Psychologists*. <https://www.bls.gov/ooh/life-physical-and-social-science/psychologists.htm#tab-6>
- U.S. Census Bureau. (n.d.). *Current Population Survey health insurance: Tables 2018–forward*. <https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi/hi.html>