

“Bearing the Burden”: Rural Implications of Licensed Professionals’ Exclusion From Medicare


Jonathan D. Wiley, Matthew C. Fullen, and Amy A. Morgan
Virginia Polytechnic Institute and State University

Medicare beneficiaries are unable to access mental health services provided by some licensed master’s-level clinicians, including licensed professional counselors (LPCs). Provider shortages in rural localities, combined with Medicare policy exclusion of these licensed mental health professionals, exacerbates rural mental health care access disparities. Very little is known about the impact of LPC exclusion from Medicare on rural beneficiaries. This study explored the lived experiences of mental health professionals who have turned away clients because of their Medicare-ineligible provider status. Interpretative phenomenological analysis was employed as a qualitative form of inquiry to guide the research design, participant recruitment, data collection, and analysis. Semistructured interviews were conducted with 9 Medicare-ineligible mental health professionals from a single, Mid-Atlantic state in the United States who have turned away clients because of their Medicare-ineligible provider status. Evidence from rural and nonrural practitioners highlighted the contextual implications of Medicare provider exclusion on rural beneficiaries. One superordinate theme, undue burden, is described through three emergent themes from the interview data: geographical disparities, intersectional hardships, and practice constraints. The results suggest that current Medicare provider regulations may create disparities of mental health care availability and accessibility for Medicare beneficiaries from rural communities. The qualitative evidence of this study describes systemic and proximal factors that result in unexpected termination, deterred help-seeking behavior, and untimely treatment for older adults and disabled clients within rural mental health care settings.

Keywords: Medicare, rural health, mental health care, disparity, interpretative phenomenological analysis

Medicare is the second largest social insurance program in the United States, with 58.4 million beneficiaries comprising people age 65

or older and younger individuals with a long-term disability (Centers for Medicare & Medicaid Services, 2018a). By 2030, the total number of Medicare beneficiaries is projected to exceed 80 million (Medicare Payment Advisory Commission, 2015). Nearly 26% of all beneficiaries are diagnosed with some form of a mental health disorder (Center for Medicare Advocacy, 2013), including nearly one in five older adults who experience a comorbid mental health or substance use condition with physical health impairment (Institute of Medicine, 2012). Despite the anticipated growth in the number of beneficiaries along with the elevated prevalence of mental health diagnoses, the Medicare qualification requirements for mental health providers were last updated in 1989 when clinical psychologists and licensed clinical social workers were included (U.S. Congress, 1989). Fur-

 Jonathan D. Wiley and Matthew C. Fullen, School of Education, College of Liberal Arts and Human Sciences, Virginia Polytechnic Institute and State University; Amy A. Morgan, Department of Human Development and Family Science, College of Liberal Arts and Human Sciences, Virginia Polytechnic Institute and State University.

This research was supported in part by a grant from the Virginia Tech Institute for Society, Culture, and Environment.

Correspondence concerning this article should be addressed to Jonathan D. Wiley, School of Education, College of Liberal Arts and Human Sciences, Virginia Polytechnic Institute and State University, 1750 Kraft Drive, Suite 200 Room, 2005, Blacksburg, VA 24061. E-mail: jonwiley@vt.edu

thermore, the original publication of the [Americans with Disabilities Act of 1990](#) defines an undue burden as “significant difficulty or expense.” Contributing factors to an undue burden include the nature and cost of an action along with geographical separateness. Hence, the diversification of the Medicare-eligible mental health workforce can enhance rural Medicare beneficiaries’ access to mental health care.

Medicare beneficiaries are unable to access mental health services provided by licensed professional counselors (LPCs). LPCs are licensed master’s-level clinicians who are designated as critical mental health professionals able to treat mental illnesses by states and the federal government ([Behavioral Health Workforce Research Center, 2016](#)). An LPC license minimally requires (a) a master’s or doctoral degree in counseling from a national or regionally accredited institution of higher education; (b) a minimum of 3,000 hr of postmaster’s degree supervised clinical experience; and (c) a passing score on the National Counselor Examination for Licensure and Certification (NCE) or National Clinical Mental Health Counselors Examination (NCMHCE; [American Counseling Association, 2016](#)). While LPCs are recognized as independent practitioners by Medicaid, the United States Department of Defense Military Health System (i.e., TRICARE), the United States Department of Veterans Affairs, and most private insurers, the Medicare system has yet to include LPCs. Thus, the purpose of this study was to explore how the exclusion of LPCs from Medicare mental health policy impacts rural beneficiaries’ access to mental health care.

Researchers have long recognized the unique mental health difficulties faced in rural communities, but these populations continue to encounter distinct and increased challenges in receiving mental health services ([Smalley, Warren, & Rainer, 2012](#)). Within rural communities, older adults are often a vulnerable and underserved population ([H. Stewart, Jameson, & Curtin, 2015](#)). Additionally, mental health provider shortages exacerbate the existing mental health problems of Medicare beneficiaries who reside in rural localities ([Crowther, Scogin, Wayde, & Austin, 2012](#); [Larson, Patterson, Garberson, & Andrilla, 2016](#)). Although the prevalence of adults with any mental illness or serious mental illness is similar between rural and urban areas ([Center for Behavioral Health Statistics & Qual-](#)

[ity, 2018](#)), research consistently shows lower rates of access to rural mental health services and lower rates of the availability and supply of mental health providers ([Smalley & Warren, 2012](#)). Acceptability, accessibility, and availability have been identified as three factors that potentially influence the delivery of mental health treatment to rural older adults ([H. Stewart et al., 2015](#)). In the absence of Medicare-eligible mental health practitioners, many rural elders receive mental health services from their primary care physician, who may not have specialized training to diagnose and treat mental health problems ([Crowther et al., 2012](#); [E. G. Stewart, 2018](#)).

To address some of the availability and accessibility disparities in rural communities, models of integrated primary and behavioral health care have received significant empirical attention and support ([Heath, Wise Romero, & Reynolds, 2013](#); [Lambert & Gale, 2012](#)). The combination of providing mental and physical health in one clinical setting may help to lower the stigma associated with mental health, provide more opportunity for collaboration between health care providers, and offer the convenience of a one-stop shop to rural communities ([Hill, Cantrell, Edwards, & Dalton, 2016](#)). While it is increasingly clear that integrated health care settings may be best suited to address the health needs of rural communities, it may not be entirely feasible for all rural communities to establish integrated care clinics due to the rural mental health workforce shortage.

Little is known about the impact of licensed master’s-level clinicians’ exclusion from Medicare on the beneficiaries who seek their services. Although awareness about the exclusion of licensed master’s-level clinicians has increased ([Field, 2017](#); [Fullen, 2016](#); [Goodman, Morgan, Hodgson, & Caldwell, 2018](#)), no single study exists regarding the lived experiences of mental health providers who have turned away beneficiaries due to the current Medicare policy. Also, very little is known about the impact of licensed master’s-level clinicians’ exclusion from Medicare on rural beneficiaries.

This exploratory study aimed to investigate the nature of licensed master’s-level clinicians’ exclusion from the Medicare insurance program among rural clinicians and clients. We elected to explore the nature of this phenomenon through in-depth interviews with Medicare-

ineligible LPCs because of their positionality as intermediaries between policy and beneficiaries. The exploratory design of this study is intended to provide an empirical foundation for future descriptive and explanatory investigations focused on the impact of LPCs' Medicare ineligibility on the rural mental health workforce. This study focused on gaining insights through a well-grounded portrayal of the nuances and complexities of experiences of providers who are qualified, yet unable, to provide mental health care to rural Medicare beneficiaries.

Method

Although the current Medicare provider regulations exclude both LPCs and licensed marriage and family therapists (LMFTs), we selected a purposive homogeneous sample of master's-level clinicians credentialed as LPCs. This study utilized interpretive phenomenological analysis (IPA) to inform data collection and analysis. Specifically, the phenomenological, interpretative, and idiographic methodological approach of IPA allowed for the distinct standpoints of the participants to be understood and described at considerable depth (Smith, Flowers, & Larkin, 2009). Authorization to conduct the study was obtained by the Institutional Review Board and Human Research Protection Program of a large Southeastern public university prior to participant recruitment.

Participants

Eligible participants consisted of LPCs who had recent and direct experience turning away or referring Medicare beneficiaries due to their status as Medicare-ineligible providers. These specific criteria were applied to achieve a purposive homogeneous sample compatible with IPA (Smith et al., 2009) based on a small, relatively homogenous sample ($N = 9$). Because states confer health care provider licenses, we further restricted sample inclusion to mental health professionals who were practicing in a particular Mid-Atlantic state. This provided consistency of requisite training, licensure requirements, and current scope of practice among all participants. All participants in the study were authorized to assess, diagnose, and treat mental disorders in accordance with the scope of practice guidelines of the state from

which this sample was drawn. The mental health professionals who were interviewed all held the highest license available to professional counselors within the Mid-Atlantic state from which the sample of participants was drawn.

Participants in the study were primarily identified after they completed a national survey of Medicare-ineligible mental health providers (Fullen, Lawson, & Sharma, in press). Participants in the national survey indicated their voluntary willingness to participate in individual interviews characterizing their experiences associated with turning away clients as a result of Medicare policy. Seven participants were recruited through the national survey of Medicare-ineligible mental health providers and two participants were identified due to their particular experiences with the study phenomenon (see Table 1 for Participant Information). The sample included four participants who practice in rural communities, and four participants who practice in micropolitan statistical areas that are urban clusters where rural clients receive general and mental health care. One participant practices in a metropolitan region, which provided a negative case analysis. The precise geographic representation for each participant is indicated throughout the narrative reporting of themes in the results section. Differentiated responses between rural and nonrural participants emphasized the disparities of accessibility and availability of rural mental health services attributed to Medicare ineligibility.

The sample size was limited to nine participants to adhere to IPA research standards. Within the particular methodological framework of IPA, sample sizes of eight and above are often considered to be large enough to allow for qualitative data saturation and idiographic design to be maintained (Smith et al., 2009). The sample size of nine participants is appropriate for the aim of this study, which sought to provide a detailed case-by-case analysis of interview transcripts to write precisely about the perceptions and understandings of the participants.

Data Collection

In accordance with IPA methodology, we conducted semistructured, in-depth interviews of nine LPCs who met the participant inclusion criteria. The research team consisted of two

Table 1
Participant Information

Participant	License type	Rural status	Years of licensed experience
Michelle	LPC	Rural	4 years
Cecelia	LPC	Non-rural	5 years
Mary	LPC	Non-rural	17 years
Roger	LPC	Non-rural	2 years
Aubrey	LPC	Rural	4 years
Donna	LPC	Rural	4 years
April	LPC	Non-rural	.5 years
Robert	LPC	Non-rural	22 years
Brandon	LPC	Rural	5 years

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

LPCs and one LMFT. Interviews were conducted by members of the research team using distance technology to digitally record and transcribe the verbatim interview procedure. Informed consent was obtained from the participants, and pseudonyms were assigned to protect participants' privacy. The elapsed time of each interview ranged between 47 and 66 min.

The interview protocol commenced with two preliminary questions to guide the interview: (a) Have you ever had to refer a potential client to another counselor/therapist/agency due to not being able to accept their Medicare insurance coverage? And (b) Have you ever established a working relationship with a client who later transitioned to Medicare insurance coverage? According to participant responses to these preliminary questions, two grand tour questions followed: (a) Tell me about what typically occurs when someone with Medicare insurance contacts your office in search of counseling? and (b) Tell me about any times when you have had to alter a preexisting working relationship with a client because of their Medicare coverage? Follow-up questions focused on the impact of current Medicare mental health policy on the interviewees, as well as its perceived impact on clients, local communities, other immediate mental health professionals, and their practice settings.

Trustworthiness

Four strategies were used to attend to the credibility and trustworthiness of this analysis. First, the authors have prolonged engagement in the Medicare-ineligible mental health disci-

plines of counseling and marriage and family therapy as licensed professionals. This practice-based background enabled the authors to be aware of the specific contexts of the participants' experiences, take into consideration irregularities in the data, and assisted the interpretative process (Lincoln & Guba, 1985). Second, the authors employed team-based reflexivity through the articulation of personal reflections and group conversations regarding the analytical process of the study (Barry, Britten, Barber, Bradley, & Stevenson, 1999). The third procedure utilized was analyst triangulation (Denzin, 1978; Patton, 1999). All authors contributed to research design, data collection, and data analysis in an attempt to decrease the potential bias of a single researcher conducting each of these tasks individually (Patton, 1999). Each investigator separately interpreted the same data and contrasted their analyses to moderate selective perception and interpretive bias. The fourth procedure applied was negative case analysis to verify, advance, and expand upon codes and emergent themes (Lincoln & Guba, 1985; Patton, 1999).

Data Analysis

An analytic process based on the IPA approach outlined by Smith et al. (2009) was employed during the analysis of the transcribed interviews. The following analytical actions were exercised: a) multiple readings of the transcripts; b) initial noting; c) developing emergent themes; d) pursuing connections among emergent themes; e) shifting to subsequent cases; f)

observing patterns across cases. Consensus agreement was achieved by the authors for each code and theme generated during the analysis of the first transcript. This consensus analysis established the agreed-upon analytical process for the remaining cases. After completing all analytical steps for the remaining interviews, the authors engaged in a group-level analysis of patterns across all interviews. Thematic patterns at this stage were arranged graphically to inspect and merge relationships between the interviews. Linkages detected through this cross-case analysis supported the development of superordinate theme clusters, which resulted in the principal superordinate theme and the corresponding emerging themes summarized in the results section. The individual and cross-case analyses were organized in a format that allowed for analyzed data to be traced from initial comments on the transcript, development of emerging themes, clustering of superordinate themes, and the final structure of themes across all the data through an audit trail.

Results

Three superordinate themes emerged from our interviews with LPCs who have experience turning away clients because of their exclusion from Medicare mental health policy: “Ineffectual policy,” “Difficult transitions,” and “Undue burden.” These superordinate themes reflected patterns of experiences and interpretations across cases. We will discuss one superordinate theme, undue burden, through the cross-case emergent themes geographical disparities, intersectional hardships, and practice constraints. Emergent themes are considered to be intermediate patterns emanating from the initial codes that lead to the development of a superordinate theme (Smith et al., 2009). By presenting a single superordinate theme, we aspire to allow for richness and nuance of participant experiences to be reported. Remaining superordinate themes will be presented elsewhere. Derived from the interviews with mental health professionals, the theme of undue burden involves the significant difficulty and expense related to the geographic separateness of rural localities.

Geographical Disparities: “And Then You Have to Narrow It Down Even Further”

All nine participants expressed concerns regarding the burden of their Medicare ineligibility on treating clients with mental health care needs who live in their communities. All participants from rural localities described the intensified limitations encountered in rural localities due to licensed mental health professionals’ exclusion from providing Medicare behavioral health treatment. Donna, an LPC in a rural locality, explained,

I think that sticks out more because you know from being in more rural areas where there are huge shortages of mental health providers as a whole. And then you have to narrow it down even further, where you can only see one of these two professions. I think that’s why it sticks out more to me because I see such a shortage in rural areas of providers across the board. And then when you have to narrow it down even further to limit who they can see, then that makes it even more difficult for them to get the care that they need.

In addition to the general disparity of mental health professionals in rural localities, participants described supplementary challenges for Medicare beneficiaries from rural localities to obtain mental health care. Participants openly shared their emotional reactions to the direct impact on clients due to the barrier created by the current Medicare behavioral health policy. Aubrey, an LPC from a geographically isolated area, stated,

Instead, they’re having to drive far. And so, there’s just nowhere close that we could send them. And so, they’re having to drive, if they’re able to, far away to get mental health services and so that’s frustrating on many levels. I guess the bottom line is that [Medicare] is providing a barrier for them to get the services that they need.

Participants from within nonrural settings also described inequalities between client need and local mental health services capacity due to the exclusion of LPCs. Mary and Roger reflected,

And I know equally as far as Medicare is concerned, there are limited professionals in our area who accept Medicare for outpatient, I think we have two people . . . two agencies, we can refer to, maybe three, and so many of the clients do not receive services that they need.

Robert, an LPC who is also credentialed as a LMFT from a nonrural micropolitan area, expressed a similar perspective: “And it limits

consumers' options to get services because I know in my area . . . the service providers who are licensed to accept Medicare really kind of are few and far between, so the consumer really is limited". A constant emergent theme among the participants was the additional burden experienced in rural localities. After discussing the mental health care access limitations incurred by clients in his nonrural locality, Robert stated, "Rural communities probably more than any other . . . it presents issues of geographical accessibility".

Participants, regardless of their geographical representation, perceived the exclusion of LPCs as contributing to increased mental health care access disparities in rural localities. Cecelia, an LPC from a metropolitan region, explained, "I think clients who are in more rural areas where there are fewer providers to choose from, they are the clients that are significantly impacted by that." Mary and Roger, a couple who are both LPCs from a nonrural micropolitan area, stated, "So we have people driving to us from southern more rural counties to receive services because they can't find them anywhere else." These extracts describe the mental health care access disparity created by Medicare policy through the perspectives of providers in nonrural localities. A hermeneutic circle emerged between rural and nonrural mental health professionals regarding the geographical implications of the current Medicare policy. For example, the claims of Mary and Roger, who described an influx of clients from more rural areas into their practice, corroborate the trend reported by Aubrey of clients driving long distances to seek mental health care. This dialogue between rural and nonrural accounts demonstrated the interpretative interplay observed at the group-level analysis across all participants.

A divergent perspective between rural and nonrural localities emerged from participants regarding the client referral process when Medicare-eligible providers are present within local communities. Michelle, an LPC from a rural area stated, "So individuals that are trying to work themselves into the schedule of a licensed clinical social worker, they often wait months before they're actually able to be seen." Cecelia offered an alternative view of the client referral process within an urban context:

And I know for me as a provider and independent practice, I was very intentional about networking and building a referral base and so I know plenty of a good amount of providers that I can refer to, providers that are LCSW [Licensed Clinical Social Worker] or even LCP [Licensed Clinical Psychologist]. That are able to bill for the services and I know that the client is in good hands . . . but again, that's [in a large metropolitan area].

In urban areas, this difficult referral process can be mitigated by the professional network of the provider that may include providers who are able to meet the mental health needs of Medicare beneficiaries. This nonexample demonstrates the strategies available to providers from nonrural metropolitan areas to engage in intentional networking to develop a foundation of mental health care providers approved to serve Medicare beneficiaries.

Intersectional Hardships: "A Lot of Them Rely on Disability"

All participants described the intersectionality among rurality, aging, and disability as leading to exacerbated consequences in rural localities. April, an LPC in a nonrural area, offered a perspective on this phenomenon:

Definitely rural communities because I'm just thinking a lot of them rely on disability. They do not have private pension a lot of times so when they retire they're relying on SSDI you know if they have early retirement kinds of things because of a physical disability. Or they're relying on Medicare to cover health care needs. . . . [Individuals from] rural communities tend to be the ones that work in the more labor-intensive jobs and then if they have a physical disability they have to early retire and then they have Medicare and either lose or do not have a provider.

April's description is characteristic of the effects of the current Medicare policy on clients with a physical disability unable to be served locally. Illustrating the intersection among rurality, aging, disability, and socioeconomics, Mary and Roger explained,

We also have disabled clients who fortunately can get medication because there's a psychiatrist who can provide the services, but again there's a waitlist. They cannot get the [mental health] services because they have Medicare and Medicaid. So, it has a really negative impact on the poor, and on the disabled and on the elderly. They're underserved populations. And growing, as I said, a growing population.

Mary and Roger's explanation is indicative of the intersectional impact of Medicare policy

on a variety of client statuses. Their reference to Medicare and Medicaid dual-eligible clients is an acknowledgment of an administrative limitation where Medicaid may require a denial letter from Medicare prior to reimbursement. However, our participants explained that Medicare does not have a workflow that allows LPCs to submit any documentation, resulting in no services provided.

Several participants provided diagnostic information into the nature of clinical issues experienced by older adults and people with disabilities in rural communities, along with their role in supporting these clients on a pro bono basis. Michelle described,

And I still make phone calls. If they have another clinician then I stop the phone calls. Then like one individual. He has PTSD. That's his diagnosis. And bipolar as well which occasionally those two go hand in hand. But he definitely has a diagnosis of bipolar prior to the PTSD and he'll, he's not seeing another counselor. He'll come in when he's in a manic phase or in a depressive, where it's severe. Either way, and he'll [say], "I just need to talk to you, just need to talk to you," and I make some time in my schedule. Just as long as he comes in during my lunch. Matter of fact, he came in last week, and that is usually what he needs. And if he had the availability of a clinician that he could trust. . . . It's a small area and you end up knowing everybody.

Michelle's description depicts the complex interactions with clients that result from not being able to regularly provide mental health care to clients in rural communities.

An additional phenomenon identified by participants focused on the impact of the opioid epidemic in rural localities. Specifically, the opioid epidemic emerged as an additional representation of the impact of clinical concerns within rural localities. All the participants described a wide variety of individual clinical concerns including posttraumatic stress disorder, depression, anxiety, and schizophrenia. Substance abuse was described by participants as having a systemic impact on not only the local community but also on the lived experiences of older adults and people with disabilities within rural localities. Aubrey described the multisystemic burden of the opioid epidemic on older adults in rural areas:

And it's for many reasons, but one of the biggest ones is the increase in our area of the opioid epidemic and a lot of parents are in jail or a lot of parents are just not able to take care of their kids. So, we do see a lot of

those concerns of older adults coming in and needing support because of their responsibilities and the burdens, and that's the other thing.

In addition to a multisystemic influence, there is a multigenerational impact of the opioid epidemic in rural localities. Aubrey stated,

It's affecting our younger population, but what we see in our older population is that they are bearing the burden of raising their grandchildren and their great-grandchildren and then dealing with the grief and the concern that they have for their children.

Aubrey offered a rich description of her perspective on how the opioid epidemic interacts with mental health care disparities within rural localities. Including LPCs in Medicare mental health policy may support the clinical response to the opioid epidemic in rural communities. Aubrey concluded,

I do not really see a lot of relief even though I know there's a lot of money funneled into this right now [and] I know that they're trying a lot of different types of supports, it's a very frustrating situation here and I do not know when we're going to see the tide turn.

Practice Constraints: "Rural Communities Probably More Than any Other"

All participants from rural localities referenced the relationship between Medicare policy and integrated care. LPCs can be employed in integrated care settings but are unable to provide reimbursable services to Medicare beneficiaries. Brandon, an LPC who serves as a clinical director within a Federally Qualified Health Center (FQHC) in a rural locality, described how having a small number of Medicare-approved mental health providers employed by his organization impacts the local community:

We have more people on our sliding scale fee which means we have to eat a lot more cost and write off a lot more bad debt. I do not know about a lot more. We have to write off more bad debt and use our sliding scale fee more . . . which makes us rely even more on federal dollars which we, you know . . . or grant money, you know, local state grant money. It . . . limits our ability to expand our behavioral health care services in general. Because half or two thirds of licensed mental health providers in our community we cannot hire.

Some participants described the consequences of not being able to be hired into integrated care settings because of the incongruence between their professional training in integrated behavioral health and the realities of the mar-

ketplace. Brandon explained, “I know counselors, personally, who have left the profession because of an inability to be hired in healthcare settings because they can’t accept Medicare.”

Donna described her specific experiences navigating employment within a practice setting that transitioned from a free clinic model to billing for services as an FQHC. This transition to an FQHC limited her professional role within the clinic, and she eventually left this employment in integrated care because “the growth there was just getting a little stagnant.” Reflecting on her desire to return to integrated care, Donna explained,

I do still have a really strong passion for integrated care, and I love being in medical clinics. So that’s something I hope in the future to get back into, but that seems to be very difficult to do as an LPC for the reason of not being able to bill Medicare.

Donna’s experiences represent a variation of the phenomenon Brandon described of LPCs leaving integrated care settings. The incongruence between professional training and marketplace realities related to Medicare policy is described by Donna:

I did my internships, ironically, with hospice. So, I did a lot of work with the older adult population. And that’s really where my heart is. I do not know that I’ve really noticed anything in particular that I feel like has impacted my ability to work with that population, other than just that barrier.

In addition to challenges associated with integrated care, several participants described using creative solutions to serve the mental health needs of Medicare beneficiaries despite not being able to receive reimbursement. This theme was described through attempts to include Medicare-approved providers into their practice settings to serve older adults and clients with disabilities. However, these attempts were sometimes unsuccessful due to the challenges associated with finding Medicare-eligible providers in rural areas. Aubrey attempted to open an independent practice in a rural locality but was unable to continue this practice due to not being able to hire a Medicare-approved provider. Illustrating the consequences of not being able to extend her practice to a more geographically isolated area, Aubrey described,

We lost a lot of those clients because they did not want to drive and I mean it was, you know, it takes money for them to drive over there, and also because the

waiting list was long for them to get in to see the current LCSW there. So, I still have some clients that are driving and paying, they’re just paying to see me, but those are the ones that can afford to do so. And that was very frustrating that I had to back out of that just because I couldn’t bill their insurance. And they could not afford to pay me, and I couldn’t afford to stay open. You know with that amount of money so that’s an issue and doctors from [geographically isolated area] still refer to us in [rural locality], which is like I said it’s an hour away and they’re still referring to us.

Aubrey’s account is indicative of the perplexity the current Medicare mental health policy creates among referring health care providers within the community along with the physical barrier of geography to receiving mental health care, as well as the confusion the current Medicare policy creates among referring health care providers within the community. All participants reported challenges to either the expansion of their current practice settings or their own professional development as mental health professionals related to their exclusion from Medicare.

Discussion

Our findings provide an account from the perspectives of Medicare-ineligible licensed mental health professionals on how their current exclusion from Medicare mental health policy impacts rural beneficiaries’ access to mental health care. Nine Medicare-ineligible mental health providers were interviewed to understand their experiences turning away clients who sought out their services. Participants conveyed a sense that LPCs and clients in rural localities experience notable challenges and costs to receive mental health treatment under the current Medicare policy. Notably, what was communicated through these interviews is that these clients are proactively seeking or currently involved in mental health treatment. In a national survey of practicing counselors, over 50% stated that they had turned away Medicare beneficiaries who sought mental health treatment, nearly 40% reported the use of pro bono/sliding-scale billing strategies to provide treatment, and 39% indicated that they had been required to refer existing clients who became eligible for Medicare (Fullen, Lawson, & Sharma, *in press*). This observation advances a unique addition to conversations regarding the accessibility and availability of mental health

treatment for older adults in rural areas (Crumb, Mingo, & Crowe, 2019; H. Stewart et al., 2015). Previous explanations regarding obstacles to mental health treatment for older adults have concentrated primarily on systemic determinants such as rural geography (Kim et al., 2013) or mental health stigma (Chapin et al., 2013). However, these studies do not provide evidence of individual-level barriers that result in unexpected termination or deterred help-seeking behavior, and possible untimely treatment due to extended wait lists when clients have to be referred to eligible providers. The perspectives offered through this study represent a distinctive contribution to broader discussions of mental health care accessibility and availability through an exploration of systemic and proximal factors contributing to rural mental health care disparities.

Integrated behavioral and primary health care treatment approaches have been shown to be more effective than treatment as usual for treating mental health symptoms and improving client holistic functioning (Lenz, Dell'Aquila, & Balkin, 2018; Schmit, Watson, & Fernandez, 2018). The majority of participants in this study described the difficulties of LPCs to serve older adults and clients with long-term disabilities within rural integrated care settings. Participants reported challenges related to obtaining and maintaining employment in integrated behavioral and primary health care treatment settings. Although LPCs and LMFTs can work in integrated care settings that depend on Medicaid and private insurance, the professional capacity of these providers is limited in integrated care settings where there is a high preponderance of Medicare-insured clients. They also identified the current Medicare policy as the primary obstacle to LPC integration into models of integrated care. These findings support previous claims regarding Medicare provider status as fundamental to the incorporation of these licensed mental health providers into integrated care contexts (Field, 2017).

Participants from rural localities described FQHCs as settings that primarily serve a clientele of older adults and individuals with disabilities. Current Medicare policy appeared to limit the ability of FQHCs to serve rural communities' provision of mental health care. Practical solutions to circumvent this barrier to community treatment are somewhat limited. One nota-

ble exception is the "Incident to Services" provision (Centers for Medicare & Medicaid Services, 2018b). This provision permits otherwise ineligible mental health professionals (i.e., LPCs, LMFTs, etc.) to provide treatment as an integral extension of a Medicare-eligible physician's treatment (Centers for Medicare & Medicaid Services, 2018b). Those providing services under this provision must be under the direct supervision of the physician, and the physician must be located on site and immediately available to provide assistance at the time of treatment delivery (Centers for Medicare & Medicaid Services, 2018b). Under current Medicare policy, this provision appears to be the most promising approach to integrating LPCs and LMFTs in FQHCs, ensuring sufficient provider coverage in rural communities. However, the requirement for direct supervision and immediate on-site availability by the Medicare-eligible physician may not be practical or financially viable for community treatment settings, and indeed may present a significant barrier to enacting this provision.

Limitations

The research team comprises LPCs and a LMFT. We acknowledge possessing a professional interest and investment in seeing these mental health professions included in the Medicare mental health policy. We contextualize this concern as a social justice advocacy issue regarding the disparities in access for older adults and clients with permanent disabilities across rural and nonrural localities. The intentional use of a group reflexive practice was designed to moderate willful analyses of the participants' interpretations.

Another principal limitation of this study is the generalizability of the results. We purposefully selected a relatively homogenous sample to understand how LPCs make sense of their inability to provide mental health treatment to Medicare beneficiaries. The findings of this study offer a narrative account of how these licensed mental health professionals make sense of and respond to the experience of not being able to serve Medicare clients due to their exclusion from Medicare mental health policy. The use of IPA has allowed for nuanced, subtle, and complex themes to emerge from the semi-structured interviews with our participants. This

particularity allows for a localized description and interpretation of how licensed mental health provider exclusion from Medicare impacts the accessibility and availability of mental health treatment for older adults and people with disabilities in rural communities.

Implications and Future Research

This study describes disparities in the delivery of Medicare services for rural beneficiaries who seek treatment for mental disorders. Our data suggest that current Medicare policy limits access to mental health services for rural Medicare beneficiaries by locking out rural providers who are licensed as LPCs. The [Substance Abuse and Mental Health Services Administration \(2019\)](#) recently reported a widespread shortage within the geriatric mental health workforce, and this discrepancy is anticipated to expand as the older adult population continues to increase. Expanding the geriatric mental health workforce would likely require multidisciplinary efforts, including advocacy that focuses on the mental health needs of people in rural communities. One potential solution to developing the geriatric mental health workforce would be to update the Medicare provider regulations so that they align with current practice trends within rural communities. As demonstrated through the narrative accounts of the participants of this exploratory study, LPCs are available within rural communities to treat the mental health conditions of older adult clients. However, in spite of many rural mental health treatment settings employing LPCs, currently, LCSWs and psychiatric nurse specialists are the only master's-level clinicians able to participate as Medicare-eligible providers. Rural mental health providers, including FQHCs and other community-based agencies, might consider whether increasing the number of Medicare eligible would be advantageous in terms of making mental health care more available and accessible. Findings suggest that excluding LPCs from Medicare mental health policy presents further challenges to mental health providers and clients seeking treatment in rural contexts in addition to those previously identified by rural mental health researchers ([Cohn & Hastings, 2013](#)). Revisions to Medicare mental health policy allowing LPCs and LMFTs to provide treatment to Medicare beneficiaries may lessen the

disparities of accessibility and availability in rural localities.

Changing Medicare policy requires Congressional action. At the time this article was developed, concurrent legislation had been introduced in the House of Representatives ([Mental Health Access Improvement Act, 2019a](#)) and the Senate ([Mental Health Access Improvement Act, 2019b](#)) of the United States Congress that, if passed, would add LPCs and LMFTs as Medicare-eligible providers. The Mental Health Access Improvement Act aims to amend title XVIII of the Social Security Act to provide for the coverage of LPCs and LMFTs under part B of the Medicare program. Of particular relevance to the context of rural mental health, this legislation would update the Social Security Act by specifically adding LPCs and LMFTs as approved providers who can contribute to the workforce of Rural Health Clinics and Federally Qualified Health Centers.

Although the current study provides an exploratory analysis of the experiences of Medicare-ineligible providers, additional investigation is needed. Future studies utilizing qualitative and quantitative methods that permit more generalizability of findings may contribute additional understanding about this phenomenon. Medicare is a national insurance program, which leads us to believe that similarities between the phenomena described by our interviewees and what occurs in other states may be similar. Regardless, further research is required to more comprehensively investigate the impact of Medicare mental health policy on rural beneficiaries. An empirical investigation into the experiences of Medicare beneficiaries from rural communities who have been unable to utilize their insurance due to Medicare mental health policy exclusion may help to better understand this phenomenon. This study, and other subsequent studies focused on diminishing disparities of mental health treatment accessibility and availability for rural Medicare beneficiaries, may assist efforts toward establishing greater rural health equity.

References

American Counseling Association. (2016). *Licensure requirements for professional counselors: A state-by-state report*. Alexandria, VA: American Coun-

- seling Association Center for Counseling Practice, Policy, and Research.
- Americans with Disabilities Act. (1990). *The Americans with Disabilities Act of 1990 and revised ADA regulations implementing Title II and Title III*. Retrieved March 10, 2015, from http://www.ada.gov/2010_regs.htm
- Barry, C. A., Britten, N., Barber, N., Bradley, C., & Stevenson, F. (1999). Using reflexivity to optimize teamwork in qualitative research. *Qualitative Health Research, 9*, 26–44. <http://dx.doi.org/10.1177/104973299129121677>
- Behavioral Health Workforce Research Center. (2016). *Understanding billing restrictions for behavioral health providers*. Ann Arbor, MI: University of Michigan School of Public Health.
- Center for Behavioral Health Statistics and Quality. (2018). *2017 National Survey on Drug Use and Health: Detailed tables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Medicare Advocacy. (2013). *Medicare and mental health*. Retrieved from <https://www.medicareadvocacy.org/medicare-and-mental-health/>
- Centers for Medicare & Medicaid Services. (2018a). *2018 annual report of the boards of trustees of the federal hospital insurance and federal supplementary medical insurance trust funds*. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>
- Centers for Medicare & Medicaid Services. (2018b). *Medicare payments for Part B mental health services*. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0816.pdf>
- Chapin, R. K., Sergeant, J. F., Landry, S., Leedahl, S. N., Rachlin, R., Koenig, T., & Graham, A. (2013). Reclaiming joy: Pilot evaluation of a mental health peer support program for older adults who receive Medicaid. *The Gerontologist, 53*, 345–352. <http://dx.doi.org/10.1093/geront/gns120>
- Cohn, T. J., & Hastings, S. L. (2013). Building a practice in rural settings: Special considerations. *Journal of Mental Health Counseling, 35*, 228–244. <http://dx.doi.org/10.17744/mehc.35.3.12171572424wxhll>
- Crowther, M. R., Scogin, F., Wayde, E., & Austin, A. L. (2012). Providing mental health services for older adults and caregivers in rural areas. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices* (pp. 297–309). New York, NY: Springer.
- Crumb, L., Mingo, T. M., & Crowe, A. (2019). “Get over it and move on”: The impact of mental illness stigma in rural, low-income United States populations. *Mental Health & Prevention, 13*, 143–148. <http://dx.doi.org/10.1016/j.mhp.2019.01.010>
- Denzin, N. K. (1978). *Sociological methods*. New York, NY: McGraw-Hill.
- Field, T. A. (2017). Clinical mental health counseling: A 40-year retrospective. *Journal of Mental Health Counseling, 39*, 1–11. <http://dx.doi.org/10.17744/mehc.39.1.01>
- Fullen, M. C. (2016). Medicare advocacy for the counselor advocate. *Adultspan Journal, 15*, 3–12. <http://dx.doi.org/10.1002/adsp.12015>
- Fullen, M. C., Lawson, G., & Sharma, J. (in press). Analyzing the impact of the Medicare coverage gap on counseling professionals: Results of a national study. *Journal of Counseling and Development*.
- Goodman, J. M., Morgan, A. A., Hodgson, J. L., & Caldwell, B. E. (2018). From private practice to academia: Integrating social and political advocacy into every MFT identity. *Journal of Marital and Family Therapy, 44*, 32–45. <http://dx.doi.org/10.1111/jmft.12298>
- Heath, B., Wise Romero, P., & Reynolds, K. (2013). *A review and proposed standard framework for levels of integrated healthcare*. Washington, DC: SAMHSA–HRSA Center for Integrated Health Solutions. Retrieved from https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf
- Hill, S. K., Cantrell, P., Edwards, J., & Dalton, W. (2016). Factors influencing mental health screening and treatment among women in a rural South Central Appalachian primary care clinic. *The Journal of Rural Health, 32*, 82–91. <http://dx.doi.org/10.1111/jrh.12134>
- Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* Washington, DC: National Academies Press.
- Kim, G., Parton, J. M., DeCoster, J., Bryant, A. N., Ford, K. L., & Parmelee, P. A. (2013). Regional variation of racial disparities in mental health service use among older adults. *The Gerontologist, 53*, 618–626. <http://dx.doi.org/10.1093/geront/gns107>
- Lambert, D., & Gale, J. A. (2012). Integrated care in rural areas. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices* (pp. 131–148). New York, NY: Springer.
- Larson, E. H., Patterson, D. G., Garbersson, L. A., & Andrilla, C. H. A. (2016). *Supply and distribution of the behavioral health workforce in rural America* (Data Brief #160). Seattle, WA: WWAMI Rural Health Center, University of Washington.
- Lenz, S. A., Dell’Aquila, J., & Balkin, R. S. (2018). Effectiveness of integrated primary and behavioral healthcare. *Journal of Mental Health Counseling,*

- 40, 249–265. <http://dx.doi.org/10.17744/mehc.40.3.06>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage. [http://dx.doi.org/10.1016/0147-1767\(85\)90062-8](http://dx.doi.org/10.1016/0147-1767(85)90062-8)
- Medicare Payment Advisory Commission. (2015). *Report to the Congress: Medicare and the health care delivery system*. Retrieved from <http://www.medpac.gov/docs/default-source/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-june-2015-report-.pdf?sfvrsn=0>
- Mental Health Access Improvement Act of 2019, H. R. 945, 116th Cong. (2019a).
- Mental Health Access Improvement Act of 2019, S. 286, 116th Cong. (2019b).
- Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 34*, 1189–1208. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089059/>
- Schmit, M. K., Watson, J. C., & Fernandez, M. A. (2018). Examining the effectiveness of integrated behavioral and primary health care treatment. *Journal of Counseling & Development, 96*, 3–14. <http://dx.doi.org/10.1002/jcad.12173>
- Smalley, K. B., & Warren, J. C. (2012). The current state of rural mental health. In K. B. Smalley, J. C. Warren, & J. P. Rainer (Eds.), *Rural mental health: Issues, policies, and best practices* (pp. 3–16). New York, NY: Springer.
- Smalley, K. B., Warren, J. C., & Rainer, J. P. (2012). *Rural mental health: Issues, policies, and best practices*. New York, NY: Springer.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Thousand Oaks, CA: SAGE Publications.
- Stewart, E. G. (2018). *Mental health in rural America: A field guide*. New York, NY: Routledge. <http://dx.doi.org/10.4324/9781315189857>
- Stewart, H., Jameson, J. P., & Curtin, L. (2015). The relationship between stigma and self-reported willingness to use mental health services among rural and urban older adults. *Psychological Services, 12*, 141–148. <http://dx.doi.org/10.1037/a0038651>
- Substance Abuse and Mental Health Services Administration. (2019). *Older adults living with serious mental illness: The state of the behavioral health workforce*. Retrieved from https://store.samhsa.gov/system/files/new_older_adults_living_with_serious_mental_illness_final.pdf
- U.S. Congress. (1989). H. R. 3299: Omnibus Budget Reconciliation Act of 1989. Retrieved from <https://www.congress.gov/bill/101st-congress/house-bill/3299>
- U.S. Department of Health and Human Services, Health Resources and Services Administration. (2016). *FORHP Rural Areas* [Data file]. Retrieved from <https://data.hrsa.gov/data/about#DataUsage>

Received April 4, 2019

Revision received August 30, 2019

Accepted September 19, 2019 ■

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at <https://my.apa.org/portal/alerts/> and you will be notified by e-mail when issues of interest to you become available!