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ADVOCACY

Medicare Advocacy for the Counselor Advocate

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Medicare reimbursement for counselors would expand older adults' access to mental health services and increase counselors' professional opportunities. To enhance advocacy efforts, the author reviews Medicare's current role in meeting older adults' mental health needs, examines the program's unique political development, and identifies contemporary values that may influence Medicare's future. Implications for counselor advocacy efforts are discussed.

The number of older Americans requiring mental health treatment is growing. Between 2000 and 2030, the proportion of Americans 65 years and older will grow from 13% to 20% of the U.S. population (Bartels, Blow, Brockmann, & Van Citters, 2005). Much of this growth is a result of the members of the baby boom generation—those born between 1946 and 1964—turning 65. Currently, approximately 5.6 to 8 million older adults have one or more mental health or substance use disorders, and this number is projected to increase to 10.1 to 14 million by 2030 (Institute of Medicine [IOM], 2012). The IOM (2012) described the burden of mental illness among older adults as a "crisis" (p. ix), identifying a wide-ranging negative effect that includes "emotional distress, functional disability, reduced physical health, increased mortality, suicide, high rates of hospitalization and nursing home placement, and high costs" (p. 4). In fact, older adults, specifically older White men, have one of the highest rates of suicide of any age-group (Drapeau & McIntosh, 2015).

Medicare is the primary source of health insurance for 50 million Americans, most of whom are older than 65 years. Despite the growing number of older adults needing mental health treatment, experts have criticized Medicare for the program's lack of attention to mental health care (Bartels & Naslund, 2013; IOM, 2012). Currently, Medicare beneficiaries seeking mental health care face restricted access to services. For example, approximately 175,000 master's-level

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psychotherapists are licensed professional counselors (LPCs) or marriage and family therapists (MFTs; American Counseling Association [ACA], n.d.). However, older adults are unable to use Medicare to access services provided by LPCs and MFTs. Clients who transition to Medicare may face discontinuity of care caused by having to change providers.

Currently, members of the counseling profession are mobilizing to increase awareness of the mental health needs of older Americans. In 2014, dozens of counselors and counselor educators traveled to Capitol Hill to meet with elected officials and their staffs to advocate for Medicare and other key issues (ACA, 2015). A recent article in *Counseling Today* encouraged counselors to contact their elected officials, share why inclusion in Medicare is important, and promote the work being done by the counseling profession (Terrazas & Todd, 2014). Legislation adding LPCs and MFTs as approved Medicare providers is currently under consideration in the House of Representatives (H.R. 2759; Mental Health Access Improvement Act, 2015) and the U.S. Senate (S. 1830; Seniors Mental Health Access Improvement Act, 2015). The attempt to expand older adults' access to mental health services recently received the endorsement of AARP (Rogers, 2014).

Although these efforts demonstrate progress, more support is needed to move the legislation forward. As of December 2015, House of Representatives Bill 2759 and Senate Bill 1830 had 38 and 14 cosponsors, respectively (U.S. Congress, 2015a, 2015b). Many states do not have a congressperson endorsing the legislation, which indicates that more counselors are needed to contact lawmakers and shape public opinion within their respective states. However, although counselors advocate on behalf of individual clients, they may lack experience promoting the counseling profession in the public arena (Lee & Rodgers, 2009; Myers, Sweeney, & White, 2002; Ratts & Hutchins, 2009). Furthermore, many counselors who engage in advocacy efforts may not perceive themselves as knowledgeable about the history and political values of Medicare. Therefore, to enhance advocacy efforts, this article describes how Medicare addresses older adults' mental health, summarizes the history and political structure of Medicare, describes how Medicare fits within an evolving American health care system, and identifies implications to guide the counseling profession's advocacy efforts.

MEDICARE AND MENTAL HEALTH

Experts in older adults' mental health have criticized Medicare for the small percentage of overall expenditures used for mental health treatment, as well as its resistance to innovative approaches to mental health care delivery (Bartels & Naslund, 2013; IOM, 2012). Currently, mental health services account for only 1% of Medicare expenditures (Bartels & Naslund, 2013). Moreover, prior to 2008, Medicare beneficiaries were responsible for a 50% copay for mental

health outpatient services, compared with only 20% for most other medical services. Beginning in 2014, with the full implementation of the Medicare Improvements for Patients and Providers Act (MIPPA; 2008), Medicare now pays for these mental health services at the same rate as medical services. However, a lifetime limit on inpatient services at psychiatric hospitals remains, a rule that does not exist with any other inpatient medical services (Graham, 2013). Regarding mental health expenditures, in 2009, Medicare paid for only 52.5% of the cost of services for older adults' mental disorders, with the remaining 47.5% paid out of pocket (18.3%) or by Medicaid (11.4%); private insurance (11.7%); and other sources, including the U.S. Department of Veterans Affairs, state and local health departments, state programs other than Medicaid, and community and neighborhood clinics (6.1%; IOM, 2012).

In addition, because of its fee-for-service structure, Medicare does not cover services such as transportation to mental health services, participation in support groups, or job training that is not directly linked to mental health treatment. When a patient is hospitalized, Medicare does not cover private duty nursing, a phone or television in the room, or personal items such as toothpaste, razors, or socks (Centers for Medicare and Medicaid Services, 2014). This payment structure also limits coordination of care between providers, which is particularly problematic when older adults have chronic conditions, including depression, that transcend both physical and psychological domains. For example, the IOM (2012) stated that treatment of depression is most effective when care includes "(1) systematic outreach and diagnosis; (2) patient education and self-management support; (3) provider accountability for outcomes; and (4) close follow-up and monitoring to prevent relapse" (p. 10). The fee-for-service payment structure lacks these elements.

Furthermore, the fee-for-service structure leaves both Medicare and mental health providers vulnerable to frequent changes to the payment schedule. These changes can result in providers refusing to accept Medicare beneficiaries because of concerns that payments are insufficient compared with those of private health insurance plans. For example, a study published in *JAMA Psychiatry* found that the number of psychiatrists accepting Medicare declined by 19.5% between 2005–2006 and 2009–2010 (Bishop, Press, Keyhani, & Pincus, 2014). Bartels and Naslund (2013) found that only 4.2% of psychologists focus on geriatric care in clinical practice, and the American Psychological Association (2014) reported that Medicare payments to psychologists for psychotherapy have dropped 35% since 2001, after adjusting for inflation. Concerns about reimbursement rates may be partially to blame for the lack of physicians and psychiatrists with advanced training in geriatrics (Bartels & Naslund, 2013), as well as the dearth of other mental health professionals with specific training in geriatrics (IOM, 2012). Finally, attempts to improve diagnosis and treatment of mental health conditions face limitations caused by the fee-for-service model. Although there are innovative, evidence-based mental health treatments for

older adults, "Medicare payment policy, lack of infrastructure, and a dearth of trained personnel have prevented widespread implementation for older adults" (IOM, 2012, p. 248). For example, the Medicare annual wellness visit, which includes screening for depression and cognitive impairment, takes steps toward preventive mental health, but does little to provide additional resources for treatment (Bartels & Naslund, 2013).

Medicare's restrictions have persisted despite alarming numbers of beneficiaries requiring mental health treatment. Currently, approximately 26% of all Medicare beneficiaries, or more than 13 million Americans, have a mental disorder (Center for Medicare Advocacy, n.d.). A recent report identified 7.4 million community-living older adults receiving services for mental disorders at a total cost of $17.1 billion (excluding older adults in nursing homes, prisons, or jails), making mental disorders the eighth most expensive condition for older adults in the United States (IOM, 2012). As the older adult population increases, greater numbers of older adults with mental health conditions will rely on Medicare for access to treatment. For example, in 2009, Medicare paid for 52.5% of the $17.1 billion spent on mental health services, which included outpatient services, home health services, prescriptions, physician and medical provider office visits, and hospital and emergency department services (IOM, 2012). Older adults with mental health or substance use conditions are some of the most costly Medicare beneficiaries (Alecxih, Shen, Chan, Taylor, & Drabek, 2010). Furthermore, geriatric mental health experts have long believed that the baby boom cohort will utilize greater rates of mental health and substance use services than previous generations of older adults (Koenig, George, & Schneider, 1994). Because baby boomers have entered adulthood in a period when mental health treatment is more widely accepted compared with preceding generations, some experts have hypothesized that as they age, baby boomers will be more likely to seek psychotherapy services for anything from stress management to treating substance use disorders (Bartels et al., 2005). Furthermore, there is some evidence that may suggest increasing rates of mental health concerns among this age cohort. For example, between 1999 and 2004, the suicide rate for adults ages 45 to 54 years increased by 19.5% (Centers for Disease Control and Prevention, 2007) and illicit drug use nearly doubled (from 5.1% to 9.4%) among adults ages 50 to 59 years between 2002 and 2007 (IOM, 2012).

MEDICARE'S DEVELOPMENT

Medicare policy experts have described "the politics of benefits" (Oberlander, 2003, p. 11) as an important part of understanding Medicare. Historically, there has been a gap between public perception of Medicare as comprehensive social health insurance and the limited benefits it actually offers. Prior to Medicare officially becoming law in 1965, significant debate took place

between those who desired universal health care and those who valued a strong private insurance market. Therefore, when President Lyndon B. Johnson signed Medicare into law in 1965, politicians on both sides of the aisle believed that it was a successful political compromise. Since its inception, Medicare was touted as social insurance based on the political principle of universality. Lawmakers wanted Medicare to apply equally to all older adults, regardless of income and financial means. By modeling its programmatic structure after the successful Social Security system, lawmakers promoted Medicare as a health benefit that beneficiaries earned by paying into the system throughout their younger years. By using this strategy, Medicare pleased members on both sides of the political aisle. However, to create a program that provided health care benefits for all older adult citizens, lawmakers elected to restrict which benefits the Medicare program would include. Medicare Part A was intended to pay for hospital stays and physician services, whereas Part B added access to additional outpatient providers through a separate financing structure. Although Medicare increased access to health care substantially, the policy never intended to cover the entire range of health care needs that older adults might incur.

The decision by lawmakers to create a benefit that was universal but limited in scope resulted in seemingly contradictory reports of Medicare providing too little and costing too much to remain viable (Oberlander, 2003). Despite the perception that older adults rely exclusively on Medicare for health care benefits, advocacy groups have noted that high deductibles and copays, as well as the lack of coverage for long-term care or dental services, result in the majority of older adults having to maintain supplemental health coverage (Kaiser Family Foundation, 2014). In fact, a recent survey indicated that 93% of Medicare beneficiaries had supplemental coverage or participated in Medicare managed care (Medicare Payment Advisory Commission, 2013).

Political compromise affected the development of Medicare, and policy makers settled on a system of benefits that was both broad and constrained. Medicare's central goal was "to bring the elderly into the mainstream of American medicine" (Oberlander, 2003, p. 31). In 1965, this meant that Medicare would base its programmatic structure on three principles: (a) enlisting physicians and a limited number of specialists, (b) paying them using a fee-for-service payment structure, and (c) providing acute care services that would limit expenditures. More than 50 years later, these principles continue to exert significant influence on Medicare, including its provision of mental health services to older adults.

HEALTH CARE'S CHANGING LANDSCAPE

Medicare's financial and political future is grounded within the greater context of the American health care system (Marmor, Oberlander, & White, 2011).

Currently, there is a sharp contrast between Medicare's commitment to the acute care model and health care experts' increasing recognition of factors such as chronic illness, comorbid physical and mental health conditions, and the use of a wellness model to improve health. In 1965, policy makers crafted Medicare as protection for older adults against unforeseen hospital and physician costs, and, at the time, it was standard practice in the private health insurance market to cover acute care services. Little attention was paid to chronic conditions, and home health and nursing home care were restricted to short-term rehabilitation services. Services for long-term care, such as nursing home benefits, were eschewed by lawmakers because of the fear that providing such services would "open a bottomless budgetary pit" (Vladeck, as cited in Oberlander, 2003, p. 39). Thus, in the 50-plus years since its inception, Medicare policy has almost exclusively focused on diagnosing and treating patients according to an acute care model. In fact, much of the U.S. health care system has origins in the early 20th century "when health care problems were typically acute and life expectancy was significantly shorter than today" (IOM, 2012, p. 10). However, because an estimated 89% of older adults have at least one chronic condition (Alecxih et al., 2010), the acute care orientation is "not appropriate for much of geriatric care" (IOM, 2012, p. 10).

Furthermore, there is a growing awareness of the interaction between mental and physical health. Physical conditions complicate the treatment of older adults' mental health, and vice versa. The World Health Organization (WHO; 2015) identified depression as the "leading cause of disability worldwide" ("Key Facts," para. 1), and it estimated that by 2030 depression will have the greatest disease burden worldwide (WHO, 2011). Increasingly, geriatricians have recognized that many older adults with mental health conditions also have acute or chronic physical health conditions, not to mention cognitive and functional limitations (IOM, 2012; Qiu et al., 2010). For example, one study of adults 60 years and older with depressive disorders found a high rate of comorbidity with a variety of physical conditions, including chronic lung disease (23%), hypertension (58%), diabetes (23%), arthritis (56%), hearing or vision loss (55%), heart disease (28%), chronic pain (57%), cancer (11%), gastrointestinal disease (21%), urinary tract and prostate disease (39%), and neurological conditions (8%; Noel et al., 2004).

As health advocates become more aware of the prevalence and costliness of chronic conditions, there is an increasing emphasis on wellness and prevention efforts. Proponents of the wellness movement have explained that by increasing awareness of unhealthy behaviors and providing access and incentives for health promotion, chronic health conditions can be prevented (Granello, 2013). At its core, the wellness movement is based on three theoretical assumptions. First, health should be conceptualized holistically, with attention paid by both clients and practitioners to numerous domains of personhood and how these domains contribute to health outcomes. Second, prevention and health promotion are

important strategies to change health behavior. Finally, the strengths and assets that each client possesses should be leveraged by the health care provider to enhance treatment. One example is the growing prevalence of employer-sponsored wellness programs to promote healthy behaviors and reduce health care expenditures for employees. In fact, in 2012, 87% of companies with 500 or more employees intended to initiate wellness programs or improve those that already existed (Tjoa, Ling, Bender, Brittenham, & Jha, 2012).

IMPLICATIONS FOR ADVOCACY

Policy making is described as a struggle over competing values and ideas (Stone, 2011). To maximize advocacy efforts related to Medicare inclusion, counselor advocates must understand Medicare's central values, engage the ideas about older adults' mental health that are important to the public, and persuade lawmakers that including counselors in the Medicare program represents a solution to an otherwise unaddressed social problem. Therefore, counselor advocates should consider the use of three themes when participating in Medicare advocacy: (a) mental health parity, (b) long-term program savings, and (c) the wellness paradigm. By focusing on these values, counselor advocates will make the case to lawmakers and the general public that including counselors in Medicare is in the best interest of older adults.

In the case of Medicare, historical political values such as universality of coverage and restriction of benefits create ongoing tensions in Medicare policy. However, there is increasing societal awareness of the need for mental health parity laws that require mental health services to be covered at a rate equal to other medical services. For example, despite Medicare's staunch resistance to expanding benefits, parity legislation passed in 2008 (MIPPA, 2008). Counselor advocates may wish to communicate to others, including lawmakers, that under current circumstances, Medicare violates the spirit of mental health parity by restricting older adults' access to more than 175,000 licensed mental health professionals, including those with whom a Medicare beneficiary may already have a therapeutic relationship (Terrazas & Todd, 2014). This restriction is occurring at a time when increasing numbers of older adults need mental health services (IOM, 2012). Thus, to achieve true parity of access to mental health services, Medicare should allow its beneficiaries to seek treatment without unnecessary restrictions. Therefore, counselors should frame advocacy efforts by pointing to the unmet mental health needs of older adults and identifying the counseling profession as a solution to this problem.

Next, counselor advocates should be aware of the long history of political concerns about Medicare's financial solvency. For those lawmakers and members of the public who express concerns about adding more mental health services, it is important to identify both short- and long-term financial consequences of including LPCs and MFTs as Medicare providers. For

example, expanding the number of available mental health providers would likely result in a short-term increase in Medicare dollars spent on mental health services. However, current legislation stipulates that LPCs and MFTs would be reimbursed at the same rate as clinical social workers, which is currently 75% of what is paid to psychologists and psychiatrists. Therefore, adding LPCs and MFTs at the current proposed rate provides the possibility of cost savings when compared with the services of other providers. In addition, greater access to services such as counseling may result in reduced utilization of costlier expenditures, such as psychiatric hospitalizations. This could result in net savings for the Medicare program.

Finally, counselor advocates should be aware that although Medicare has long valued the acute care model, there is evidence indicating that a paradigm shift is under way. Many American health care leaders are pointing to the prevalence of chronic illnesses, the effect this will have on treatments, and the need for treatments that are oriented toward wellness (IOM, 2012). For example, the Patient Protection and Affordable Care Act (2010) mandates that Medicare increase resources devoted to prevention and wellness efforts (Cogan, 2011). This mandate was the impetus for the recent addition of an annual wellness visit benefit that includes screenings for depression and cognitive impairment. Furthermore, in early 2014, the Medicare policy manual was updated to expand preventive services for chronic conditions such as multiple sclerosis, Parkinson's disease, and Alzheimer's disease (Jaffe, 2014). This change indicates that Medicare is evolving, although it remains to be seen how its openness to prevention and wellness will be applied to mental health services. When dialoguing with lawmakers and the public about older adults' mental health, counselor advocates should be aware of this changing paradigm and describe the counseling profession's long-held commitment to wellness and prevention (Myers, 1992). Counselor advocates can identify themselves as mental health professionals who specialize in providing clinical services that take into account the developmental needs of older adults and attend to their needs for integrated wellness. Although these concepts are not new to the counseling profession, they represent values that are increasingly important to the public.

CONCLUSION

Medicare reimbursement is an important issue for both the counseling profession and older Americans. To enhance advocacy efforts, counselor advocates need to understand how Medicare addresses older adults' mental health, the unique political development of Medicare, and the contemporary values that may influence how lawmakers and the public wish to shape the future of Medicare. By framing advocacy efforts within the discussion of key issues such as mental health parity, net program costs, and the wellness paradigm, counselor

advocates can express the need to increase older adults' access to mental health services through the inclusion of counselors in Medicare.

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