Knowledge is Power: An Analysis of Counseling Professionals' Medicare Policy Proficiency

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Abstract

This study examines counseling professionals' knowledge concerning the Medicare program and related advocacy efforts. American Counseling Association members (N = 5,097) answered a series of true-false questions that were intended to measure proficiency in two areas: Medicare policy and the counseling profession's advocacy for provider eligibility. Statistical analyses indicated that members have a wide range of Medicare knowledge. A significant difference in advocacy history knowledge was found when comparing counselor educators, practicing counselors, doctoral students, and master's students. However, no differences in policy knowledge were present among these groups. Implications for the counseling profession and counselor training are discussed.

Keywords: Medicare; Advocacy; Professional Issues; Gerontological Counseling; Professional Counseling

Introduction

Advocacy has been an integral part of the field of counseling nearly since its inception (Kiselica & Robinson, 2001), with some considering social justice and advocacy to be the fifth wave of counseling practice (Ratts, 2009). Despite a growing body of literature on advocacy efforts within counseling, there is a shortage of empirical studies examining the frequency with which counselors engage in advocacy and the efficacy of those efforts. A timely issue through which to view this concern is that of Medicare coverage for counselors. Nearly half of counselors in a recent study had participated in advocacy efforts related to this issue (Fullen et al., 2020b). However, because of the limited information available regarding the quality of this engagement, counseling professionals are limited in their ability to improve advocacy efforts to make social change. The present study explores counseling professionals' knowledge of advocacy efforts and specific policy information regarding Medicare coverage for counselors. This information may help the profession better understand how to provide knowledge to counseling professionals on particular advocacy issues, improve the quality of advocacy efforts, and increase self-efficacy of counseling advocates.

Literature Review

Advocacy is often defined by the actions in which it is encompassed: representation of underprivileged groups, lobbying activities, and challenging institutional powers through actions like protest, among others (Carlile, 2000). Counselors have a longstanding history of serving as advocates for social change, beginning in the early 1900s and continuing into the twenty-first century (Kiselica & Robinson, 2001). In fact, the American Counseling Association [ACA] (2014) Code of Ethics dictates that counselors should engage in advocacy efforts to "address potential barriers and obstacles that inhibit access and/or the growth and development of clients" (p. 5), and the ACA lists advocacy as one of three key drivers in its strategic framework for 2018 – 2021 (ACA, 2018).

Advocacy in Counseling

The Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2015) suggests that counselors should operate from a social justice advocacy perspective in order to truly empower clients at the individual and systemic levels (Ratts & Hutchins, 2009). This coincides with Lee's (1998) statement that "counselors are called upon to channel energy and skill into helping clients challenge institutional and social barriers that impede academic, career, or personal-social development" (p. 8-9). Advocacy in counseling necessarily includes both advocating on behalf of client well-being and advocating on behalf of the profession (Myers, Sweeney, & White, 2002). In both forms of advocacy, counselors may advocate at the individual, community, and systemic or societal levels, as described in the ACA Advocacy Competencies (Lewis, Arnold, House, & Toporek, 2002). These competencies emphasize specific skills necessary to advocate at the individual, community, and systems levels. At the individual level, counselors should advocate on behalf of their clients to assist them in accessing resources, removing barriers, and navigating various systems in their lives (Lewis et al., 2002; Ratts & Hutchins, 2009). At the community level, counselors should engage in systems-level advocacy within community structures, such as agencies and organizations. Finally, at the sociopolitical level, counselors act on the public's behalf by disseminating information about key issues, and when necessary, participating in grassroots lobbying and other political advocacy initiatives.

Participation in Political Advocacy

Although the importance of advocacy has been well-articulated in the extant literature, empirical studies demonstrating counselors' attitudes, behavior, and knowledge about advocacy have been uncommon. In one recent study, 68% of students (including master's students enrolled in a Council for Accreditation of Counseling

and Related Educational Programs (CACREP) accredited clinical mental health program and counseling psychology doctoral students) identified advocacy as "very important" (Ramírez Stege, Brockbery, & Hoyt, 2017, p. 195) to the profession. Ramírez Stege and colleagues (2017) also found that, of the students who participated in the study, 50% reported that they engaged in one or two forms of advocacy, and 28% reported that they engaged in three or four forms. Only 10% of participants engaged in five or more types of advocacy and 13% did not participate in any forms of advocacy. Overall, doctoral students reported statistically significant higher levels of engagement in advocacy than master's students, and 80% of student respondents reported that faculty at their institutions were engaged in advocacy (Ramírez Stege et al., 2017). This study demonstrates that students are participating in advocacy efforts and deem advocacy important to the counseling profession.

Fullen et al. (2020b) surveyed more than 6,550 members of the American Counseling Association (including students, practicing counselors, and counselor educators) and found that advocacy participation among respondents varied somewhat by specific issue. Approximately half (i.e., 49.3%) of counseling professionals had participated in Medicare-related advocacy, for example, which was comparable to rates of advocacy for issues such as licensure portability (49.4%), and was a bit higher than rates for advocacy related to banning conversion therapy (45.0%), increasing opioid treatment funding (44.1%), addressing Veterans Affairs hiring practices (43.5%), and school counseling funding (36.2%). Participation was operationalized as contacting a lawmaker via automated technology (e.g., VoterVoice), phone, email, in-person meeting, or attending a town hall, and the authors noted that participation varied substantially by professional type, with 63.3% of counselor educators participating in Medicare-related advocacy, as compared to 57.0% of doctoral students, 54.0% of practicing counselors, and 32.5% of master's students.

Although these studies provide a rough estimate of the number of counselors and counselor trainees who are engaged in sociopolitical advocacy, it is more difficult to discern the quality of that engagement. Lee and Rodgers (2009) describe advocacy at the sociopolitical level as a "process for creating change" (p. 285), and in this process advocates are encouraged to articulate their concerns about a particular policy directly to elected officials or related stakeholders. In order to effectively lobby on behalf of a particular issue, counselors must have a foundational knowledge of specific public policy initiatives (Kiselica & Robinson, 2001; Lee & Rodgers, 2009; Lewis et al., 2002; Steele, 2008). In fact, national advocacy organizations highlight the importance of providing accurate, well-cited information when discussing issues of concern with lawmakers (ACA, n.d.; American Psychological Association [APA], 2014), and a lack of well-informed policy knowledge has been cited by scholars as a deterrent to psychology students actively engaging in advocacy (Heinowitz et al., 2012).

Medicare: Policy and Professional Advocacy

Of particular salience to the counseling profession currently is the issue of Medicare coverage for counseling services. The Medicare program is a federally-funded insurance program that covers approximately 60 million Americans (Kaiser Family Foundation, 2017), and enrollment is projected to grow to 80 million people by 2030 (Medicare Payment Advisory Commission, 2015). People over the age of 65, younger people with disabilities, and people with end-stage renal disease are eligible for Medicare coverage (U.S. Department of Health and Human Services, 2014).

Almost one in four Medicare beneficiaries have a documented mental health and/or substance use diagnosis (Institute of Medicine, 2012; Loftis & Salinsky, 2006; Ostrow & Manderscheid, 2009), and Medicare is the largest single-payer for opioid overdose hospitalizations (Song, 2017). Currently, very few mental health providers are prepared to work with older adults (Institute of Medicine, 2012), who comprise approximately 85% of the Medicare population (Kaiser Family Foundation, 2019). This is in spite of the fact that older adults, specifically white males over age 85, consistently have one of the highest rates of suicide (Drapeau & McIntosh, 2019). The dearth of providers available to treat Medicare beneficiaries creates a significant barrier to human growth and development for this population. Notably, although Medicare accounted for 15 percent of total

federal spending in 2017 (Kaiser Family Foundation, 2019), only about one percent of the Medicare budget is spent on mental health services (Bartels & Naslund, 2013).

The most recent substantive additions to the Medicare mental health workforce were made in 1989, when clinical psychologists and clinical social workers were made eligible for Medicare reimbursement as part of the *Omnibus Budget Reconciliation Act of 1989* (U.S. Congress, 1989). Since that time, the makeup of professionals in the mental health field has significantly changed. Approximately 200,000 master's-level clinicians (i.e., LPCs and LMFTs) are currently ineligible to serve the Medicare-insured (Medicare Mental Health Workforce Coalition, 2019), a figure which comprises nearly half of all master's-level mental health providers nationwide (Fullen, 2016).

Legislative efforts to address the shortage of Medicare-eligible clinicians began over fifteen years ago, when professional organizations representing counselors (such as the ACA, National Board for Certified Counselors [NBCC], and American Mental Health Counselors Association [AMHCA]) began to support Medicare reimbursement for counselors (Field 2017). LPCs have national accreditation standards that guide many counselor training programs (CACREP, 2015), and licensure in 50 states (ACA, 2016). Additionally, LPCs have formal recognition from every third party insurer aside from Medicare (Medicare Mental Health Workforce Coalition, 2019). During the past fifteen years of professional advocacy, legislation to add LPCs as Medicare-eligible providers has previously passed in both the House of Representatives and U.S. Senate, though never simultaneously.

The Present Study

Leading counseling professional organizations have called for their members to notify Congressional lawmakers about the need for Medicare reimbursement of LPCs (Medicare Mental Health Workforce Coalition, 2019), thus creating an opportunity for counselor advocates to participate in what Lee and Rodgers (2009) described as sociopolitical advocacy. However, it is not currently known whether counseling professionals have sufficient knowledge about Medicare advocacy, both in terms of how the Medicare program operates and the history of the counseling profession's advocacy efforts. In light of previous literature suggesting that advocacy interventions should be evidence-based and data-driven (MSJCC; Ratts et al., 2015), it is important to understand better whether counseling professionals are knowledgeable about basic facts associated with Medicare advocacy.

The current study was guided by two research questions: 1) What do ACA members know about Medicare? and 2) Does knowledge differ by professional type?

Methods

Participants

A set of questions related to Medicare knowledge was disseminated by email to 51,221 members of the ACA using the Qualtrics delivery platform. A total of 629 emails were returned as undeliverable, resulting in 50,592 possible respondents. The number of responses to the Medicare knowledge questions used in the current study ranged from 5,097 to 5,146, with a total of 5,097 individuals who responded fully to the Medicare Knowledge Quiz (MKQ) questions described below. Due to the small proportion of respondents with missing data (N = 49; 0.95%) and the large sample size, only the 5,097 respondents who completed the quiz in its entirety were used to answer the research questions. This resulted in a response rate of 10.07%.

Most participants identified as female (79.5%), followed by male (18.7%), and the remaining 1.8% identifying as gender fluid, nonbinary, transgender male, transgender female, or other. The majority of participants were White/Non-Hispanic (77.8%), followed by Black/African American (10.0%), Hispanic/Latinx

(4.7%), Multiracial (2.7%), Asian/Pacific Islander (2.1%), American Indian/Native American (0.6%), Other (2.0%), and 0.2% who did not provide information. A total of 76.7% stated that they had or would graduate from CACREP-accredited training programs, with 23.2% stating that they had not or would not, and 0.1% declining to respond to this item. In terms of experience, 18.6% reported a total of 15+ years in the profession, followed by 14.1% with 8 to 14 years experience, 18.2% with 4 to 7 years, 21.2% with 2 to 3 years, and 15.8% with 0 to 1 year. A total of 12.1% of respondents did not provide this information. In terms of professional status, 63.7% of respondents were practicing counselors, followed by 24.0% master's students, 6.0% counselor educators, 4.0% doctoral students, and 2.3% who responded Other or omitted their professional type.

Procedures

Data related to Medicare knowledge were collected from a larger survey on counseling profession advocacy. Before disseminating the cross-sectional survey, a pilot version was disseminated to a group of graduate students and licensed professional counselors affiliated with the authors' institution. We also provided a copy of the full survey to the American Counseling Association for its review. Upon approval of the comprehensive survey by an appropriate ACA designate, temporary access to a membership list was provided and authorized for use to conduct the survey. The study included items intended to gauge the following: experiences related to Medicare ineligibility, participation in legislative advocacy, opinions about who is responsible for Medicare reimbursement advocacy, attitudes about aging, knowledge about Medicare, and demographic items. A description of the survey has been published elsewhere (Fullen et al., 2020a). Although data related to Medicare knowledge were retained exclusively for the current study, quantitative analyses stemming from the national survey were conducted and reported elsewhere (Fullen et al., 2020a; Fullen et al., 2020b). The survey and research design were approved via exempt status by the Western Institutional Review Board. All ACA ethical guidelines were followed in the execution of this research.

An original, 12-item Medicare Knowledge Quiz (MKQ) was developed for the survey. The items were intended to measure factual knowledge about: (a) the Medicare program (six items) and (b) the history of Medicare advocacy within the counseling profession (six items). Items were developed by the first author, and efforts were made to establish the validity of the quiz items. Regarding construct validity, the quiz items were drawn from existing research on Medicare reimbursement for counselors (e.g., Fullen, 2016), key sources of information about the Medicare program (e.g., Kaiser Family Foundation, 2017), and professional literature related to Medicare advocacy (c.f., Medicare Mental Health Workforce Coalition, 2019). Regarding content validity, the items were intended to reflect basic knowledge about: 1) the Medicare program as it pertains to counselor reimbursement advocacy, and 2) key components of the counseling profession's history of professional advocacy on this issue. Therefore, the items were exploratory in nature and not intended to capture the full extent of participant knowledge on Medicare policy. In regard to the complete survey disseminated to ACA members, a pilot version was provided to several graduate students and licensed professional counselors affiliated with the authors' institution. Additionally, a full version of the survey was provided to ACA prior to its dissemination. Specific items pertaining to the Medicare program and professional advocacy are reported in Table 1 and Table 2, respectively.

The internal consistency of the MKQ was calculated using SPSS (Version 26). Cronbach's α was used to measure the reliability of the full quiz, as well as within each subset of items. Overall, internal consistency of the full quiz was low (α = .29), albeit slightly higher than when breaking down the quiz by MKQ: Program (α = .23) and MKQ: Profession (α = .15). The low reliability values suggest that individual item responses have low correlation with one another, which may be evidence that the 12-item MKQ was too brief, as Cronbach's α is sensitive to the number of test items. Alternatively, low reliability may indicate that participant knowledge about the Medicare program and/or Medicare advocacy varies widely and unsystematically among ACA members. Due to the exploratory nature of the MKQ, we proceeded with our analysis. However, performance

on individual quiz items should be viewed as more reliable than performance on the full quiz or sub-sections (i.e., MKQ: Program/MKQ: Profession).

Analytical Strategy

Respondents were asked to respond True or False, which provided a total score out of 12 for each participant. Descriptive statistics were calculated to identify total group means by professional type, as well as scores on both the MKQ: Program and MKQ: Profession sub-tests. Percentages of correct scores were calculated for each quiz item by professional type, and a one-way ANOVA was used to measure group differences based on professional type. Item-level analyses were also used to identify variation in how knowledgeable counseling professionals were, and chi-square analyses were used to identify statistically significant differences in performance on specific MKQ items based on professional type. Statistical assumptions for each of these tests were satisfied, including for the ANOVA (i.e., independence, homogeneity of variance) and chi-square goodness-of-fit test (i.e., independence of observations and adequate expected frequency) (Lomax & Hahs-Vaughn, 2012).

Results

The average score across all groups on the MKQ was 7.32 (SD = 1.54) out of a possible total of 12. Total means were similar between the MKQ: Program (M = 3.69, SD = 1.099) and MKQ: Profession (M = 3.62, SD = 1.038). Performance on specific items (N ranging from 5082 to 5096) reveals the current level of knowledge among counseling professionals regarding the Medicare program and the profession's history of Medicare advocacy. For example, 82.3% of respondents knew that Medicare is paid for and implemented at the federal level, 79.2% knew that greater than 15% of Medicare beneficiaries are under age 65 and living with permanent disabilities, and 66.1% knew that less than 10% of the Medicare budget is spent on mental health. In contrast, roughly half of respondents (i.e., 52.6%) knew that fewer than 15% of Medicare recipients live in long-term care facilities (in fact, it is only 3%; Kaiser Family Foundation, 2019), only 45.1% knew that Medicare does not cover long-term services and supports, dental services, eyeglasses, and hearing aids, and only 44.2% knew that Medicare is the largest single-payer for opioid overdose hospitalization.

Existing knowledge about the profession's Medicare advocacy ranged as well. On one hand, 88.1% of respondents knew that there is currently legislation under consideration to add LPCs as Medicare-eligible providers, 85.4% knew that Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses to provide outpatient mental health services, and 82.5% were correct in stating that Medicare is not the only payment mechanism for counselors to work with people over 65. Alternatively, only 56.2% of respondents knew that bills authorizing Medicare reimbursement for counselors have previously passed both the Senate and House, albeit on separate occasions, and merely 34.4% correctly answered that State-level politics (e.g., Governor, state legislature) are not directly related to Medicare reimbursement. Particularly revealing was the fact that only 15.9% of respondents knew that professional organizations (e.g. ACA, NBCC, AMHCA) have been supporting Medicare reimbursement for counselors for more than five years, when in fact, professional advocacy on this issue dates back over fifteen years (Field, 2017).

On the *MKQ: Program*, a one-way ANOVA was performed on the 4,977 respondents who provided information about their professional type. This analysis indicated that there was no significant difference in average scores depending on professional type ($F(3,4974) = .113$, $p = .953$). Group averages for practicing counselors (M = 3.70, SD = 1.092), counselor educators (M = 3.70, SD = 1.111), doctoral students (M = 3.68, SD = 1.067), and master's students (M = 3.68, SD = 1.114) were very similar. This indicates that knowledge about the Medicare program did not differ depending on professional type.

However, in terms of the *MKQ: Profession* sub-test, group differences were found. Using data from the 4,964 respondents who responded to both a question about the professional type and the quiz questions for this sub-test, a one-way ANOVA revealed significant group differences ($F(3,4961) = 28.865$, $p < .001$). Group averages for counselor educators ($M = 3.87$, $SD = 1.040$), practicing counselors ($M = 3.68$, $SD = 1.022$), doctoral students ($M = 3.55$, $SD = 1.007$), and master's students ($M = 3.41$, $SD = 1.045$) revealed more variation. Post-hoc Tukey's analysis indicated that counselor educators were significantly more knowledgeable than master's students ($p < .001$) and doctoral students ($p = .004$) in regard to knowledge about the counseling profession's Medicare advocacy. Practicing counselors were more knowledgeable than master's students ($p < .001$), and somewhat less knowledgeable than counselor educators ($p = .017$).

Item-level analyses were also illustrative of critical differences depending on the professional type. For example, on the MKQ: Program sub-test, chi-square analysis revealed group differences in performance based on professional type. For example, whereas 84.2% of counselor educators knew that over 15% of the Medicare-insured are under 65 and living with long-term disabilities, only 75.2% of master's students were aware of this (X^2 (3) = 20.402, $p < .001$). Similarly, whereas roughly half of counselor educators, doctoral students, and master's students correctly answered that Medicare is the largest single-payer for opioid overdose hospitalizations, only 41.3% of practicing counselors answered this correctly, which amounted to a significant difference (X^2 (3) = 33.178, $p < .001$). Results by professional type are listed in Table 1.

Table 1. *Medicare Knowledge Quiz: Program,* % Correct by Professional Type

Professional type	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6
Practicing counselor (N = 3,247)	83.7%	80.6%	53.4%	45.6%	65.8%	41.3%
Counselor educator (N = 304)	79.9%	84.2%	51.3%	41.8%	63.7%	49.5%
Doctoral student (N = 205)	83.4%	78.5%	50.9%	41.5%	64.4%	49.3%
Master's student (N = 1,221)	79.0%	75.2%	51.2%	45.0%	68.3%	50.0%
Total across groups (N = 4,977)	82.3%	79.4%	52.6%	45.0%	66.3%	44.2%
X^2 (df=3)	14.952	20.402	2.750	2.794	3.756	33.178
p	.002	< .001	.432	.424	.289	< .001

Quiz items (CORRECT RESPONSE)

Item 1: Medicare is paid for and implemented at the federal level. (TRUE)

Item 2: Greater than 15% of Medicare beneficiaries are under age 65 and living with permanent disabilities. (TRUE)

Item 3: Greater than 15% of Medicare recipients live in long-term care facilities. (FALSE)

Item 4: Medicare does not cover long-term services and supports, dental services, eyeglasses, and hearing aids. (TRUE)

Item 5: Greater than 10% of the Medicare budget is spent on mental health services. (FALSE)

Item 6: Medicare is the largest single-payer for opioid overdose hospitalizations. (TRUE)

NOTE: X^2 calculation based on only respondents identifying as practicing counselor, counselor educator, master's student, doctoral student.

Similarly, on the MKQ: Profession, there were several differences in group performance. In general, counselor educators were more knowledgeable about past and present professional initiatives related to Medicare. Most notably, 91.1% of counselor educators knew that Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses to provide outpatient mental health services,

whereas only 75.7% of master's students were aware of this, which contributed to a significant difference on this item (X^2 (3) = 133.230, $p < .001$). A total of 94.4% of counselor educators knew about current Medicare legislation, compared to 85.3% of master's students (X^2 (3) = 22.130, $p < .001$). Approximately two-thirds of counselor educators (68.2%) correctly identified that Congressional bills adding counselors to the Medicare program have previously passed, albeit never in both the House and Senate in the same year, whereas scores on this question among master's students (53.1%) and practicing counselors (56.0%) were somewhat lower (X^2 (3) = 22.590, $p < .001$). The only question on the MKQ: Profession in which counselor educators did not score higher than the other groups was related to the role of state-level politics indirectly applying to Medicare legislation. On this question, 36.8% of practicing counselors answered correctly, followed by 29.1% among master's students and counselor educators, and 27.0% among doctoral students (X^2 (3) = 27.928, $p < .001$). Results by professional type are listed in Table 2.

Table 2. *Medicare Knowledge Quiz: Profession*, % Correct by Professional Type

Professional type	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6
Practicing counselor (N = 3,238)	36.8%	88.7%	15.8%	56.0%	82.5%	88.8%
Counselor educator (N = 302)	29.1%	94.4%	20.7%	68.2%	83.6%	91.1%
Doctoral student (N = 204)	27.0%	88.3%	14.6%	57.6%	80.0%	87.8%
Master's student (N = 1,220)	29.1%	85.3%	14.8%	53.1%	82.1%	75.7%
Total across groups (N = 4,964)	34.2%	88.2%	15.8%	56.1%	82.4%	85.7%
X2 (df=3)	27.928	22.130	6.616	22.590	1.186	133.230
p	< .001	< .001	.085	< .001	.756	< .001

Quiz items (CORRECT RESPONSE)

Item 1: State-level politics (e.g., Governor, state legislature) are directly related to Medicare reimbursement. (FALSE)

Item 2: There is currently legislation under consideration to add mental health counselors as Medicare providers. (TRUE)

Item 3: Professional organizations (e.g. ACA, NBCC, AMHCA) began supporting Medicare reimbursement for counselors in the past five years. (FALSE)

Item 4: Historically, bills authorizing Medicare reimbursement for counselors have passed both the Senate and House, albeit on separate occasions. (TRUE)

Item 5: Medicare is the only payment mechanism for counselors to work with people over 65. (FALSE)

Item 6: Medicare currently recognizes psychiatrists, psychologists, clinical social workers, and psychiatric nurses to provide outpatient mental health services. (TRUE)

NOTE: X^2 calculation based on only respondents identifying as practicing counselor, counselor educator, master's student, doctoral student

It should be noted that in regard to answering Research Question Two, due to a small subset of respondents (N = 119) who selected Other or omitted a professional type, only data from respondents who clearly indicated a professional type of counselor educator, practicing counselor, doctoral student, or master's student was utilized. We compared this sub-group to the larger group of those with relevant professional type data to ensure that no group differences were apparent. No group differences were significant at $p < .05$, except for one item: *MKQ: Profession*, item six (X2 = 9.424, $p = .002$). This accounts for the slight discrepancy between the full sample and the professional type sample in regard to correctly answering this item (85.7% vs. 85.4%).

Other negligible discrepancies may appear between the results calculated to answer each of the research questions due to the slight in how the sample composition was determined.

Discussion

The present study was guided by two research questions: 1) What do ACA members know about Medicare? and 2) Does knowledge differ by professional type? Our results illuminate current levels of Medicare knowledge among ACA members, both in terms of knowledge about the fundamentals of the Medicare program, as well as insight into the counseling profession's history of Medicare advocacy. Across all groups, participants correctly answered half of the questions related to policy knowledge. This finding calls into question whether counseling professionals currently possess the necessary knowledge to effectively lobby on behalf of Medicare coverage for LPCs and LMFTs.

Our finding that close to half (i.e., 47.4%) of respondents incorrectly assumed that more than 15% of Medicare beneficiaries live in long-term care facilities reflects a misunderstanding of who is served by the Medicare program. This finding may suggest that respondents rightly associate Medicare with older adulthood, but wrongly assume that older adulthood is equivalent to living in a nursing home. In fact, only 3% of Medicare recipients reside in a long-term care facility (Kaiser Family Foundation, 2019). Pior work suggests that Medicare ineligibility interferes with beneficiaries accessing counseling in outpatient community settings, including private practice, integrative behavioral healthcare settings, and community mental health agencies (Fullen et al., 2019). Therefore, the current data indicates a potential incongruence between how the Medicare population is perceived by counseling professionals and the realities of existing barriers to accessing mental health care.

Additionally, our data indicates that a minority of respondents (i.e., 44.2%) knew that Medicare is the largest single payer for opioid overdose hospitalizations. Without this knowledge, counseling professionals, including those with specialized training in addictions, may not fully understand that the majority of people who have been hospitalized for opioid overdoses have medical insurance that does not reimburse services of LPCs. It was notable that practicing counselors were more likely to answer this question incorrectly than the other groups, suggesting that this sub-group was particularly unaware of the close link between Medicare and addiction hospitalization. Likewise, a lack of knowledge about the link between Medicare, age, disability, and the opioid epidemic may result in a missed opportunity to articulate to lawmakers that adding LPCs as Medicare-eligible providers may be a sound strategy for addressing the increasing need for opioid treatment.

Another notable trend in our data is that there was no difference in scores between the four groups of respondents on questions relating to the Medicare policy itself. Therefore, practicing counselors, counseling students at the master's and doctoral level, and counselor educators all possessed roughly the same degree of factual knowledge about the program. This finding raises questions about why greater policy expertise did not correspond with advanced education (e.g., counselor educators) or direct clinical experience (e.g., practicing counselors). This finding suggests that the counseling profession as a whole, rather than only its newest members, possess limited policy literacy regarding Medicare. Without policy literacy, counseling professionals may be missing vital information necessary to communicate to lawmakers the importance of expanding coverage of Medicare to include LPCs and LMFTs and therefore impede lobbying efforts.

In total, counseling professionals also failed to correctly answer about half of the questions related to professional advocacy for Medicare-eligibility. It was particularly concerning that only one-third (i.e., 34.2%) of respondents knew that state legislatures are not involved in Medicare reimbursement, with only 29.1% of counselor educators and master's students, and 27.2% of doctoral students answering this question correctly. Although it is possible that respondents misinterpreted the question, perhaps confusing the Medicare program with Medicaid (which is mostly operated at the state level), the data casts doubt on how well state-federal political dynamics are understood by respondents. This finding may suggest a misunderstanding of how to

effectively advocate on behalf of Medicare reimbursement for LPCs and LMFTs. It may lead to inefficient efforts, such as contacting state-level legislators about a national concern.

Even more alarming was the vast minority (i.e., 15.8%) of respondents who were aware that professional organizations have been working to address the Medicare coverage gap for more than five years. The historical efforts of organizations such as ACA, NBCC, and AMHCA were not well known by participants in the study. Without a historical understanding of previous efforts to advocate on behalf of Medicare reimbursement, counseling professionals risk continuing ineffective efforts, repeating prior mistakes, and missing opportunities to collaborate with stakeholders and existing advocates on this important issue.

Finally, counselor educators and practicing counselors knew more than master's students and doctoral students regarding professional advocacy efforts on Medicare coverage. This finding suggests that, despite the low scores across all four groups related to professional advocacy knowledge, more seasoned members of the profession know more about professional advocacy efforts than newer members. A greater length of time in the field may expose professionals to more information regarding professional advocacy efforts. This result is especially encouraging because it suggests that master's students and doctoral students may learn this information over time in the field, thus preparing them to be more effective advocates.

Implications for the Counseling Profession

Our findings suggest that counseling professionals may require more basic knowledge about specific policies and a more nuanced understanding of the counseling profession's advocacy history to improve advocacy efforts on Medicare coverage for LPCs and LMFTs. In spite of the ACA advocacy competencies (ACA, 2003), and many innovative developmental models of advocacy, there remains a challenge in disseminating basic information about specific policies to counselors, counselor educators, and counselor trainees. Lacking basic knowledge about the subject of advocacy (i.e., Medicare in this case) may influence how willing counseling professionals are to participate in sociopolitical advocacy.

Additionally, there may be a lack of uniformity in the way that counselor education programs teach, promote, and model advocacy. It may be necessary to create an advocacy model of universal criterion for CACREP-accredited programs. It may additionally be helpful for counselor training programs to incorporate policy and professional advocacy effort knowledge in multiple courses to provide a well-rounded framework of advocacy early in one's professional training. Existing advocacy models may also benefit from emphasizing specific policy and professional advocacy effort knowledge within their current frameworks to help counseling professionals, regardless of their level of professional development, become more efficacious in advocacy efforts. As evidenced by the current study, these changes should emphasize the importance of public policy and professional advocacy knowledge.

Implications for Counselor Training

These findings also call into question whether the proliferation of advocacy training models (Goodman et al., 2009; Hof et al., 2009) has adequately prepared members of the counseling profession for more in-depth engagement on specific advocacy issues. A possible way to rectify this concern is to address Medicare advocacy through the lens of these models. For example, in Goodman and colleagues' (2009) Relationship-Centered Advocacy Model, counselors would internally grapple with their awareness of themselves and others concerning the advocacy and social justice issues presented by lack of LPC and LMFT coverage by Medicare. Counselors would then develop empathy for Medicare beneficiaries, learn to respect the goals of their advocacy partners (such as existing Medicare advocacy groups and professional counseling organizations), and offer and receive emotional support. Through this work, counselors would enter a third stage in which they integrate Medicare advocacy as a part of their professional identities through developing insight into the social justice barriers

presented by a lack of mental health providers for Medicare beneficiaries. They would learn specific advocacy interventions from their advocacy partners at this stage.

Another model is the T.R.A.I.N.E.R. model (Hof et al., 2009). This seven-step process is intended to guide social and, by extension, professional advocacy for professional counselors. In the first step, counselors would conduct a needs assessment of Medicare beneficiaries to determine the best ways in which to address barriers presented by the limited coverage of mental health professionals by Medicare. The second step of the model, responding, would require counselor advocates to identify the specific advocacy competencies to implement in the barrier identified in the first step through a training. In the third step, counselors would develop a plan of action to address the development and implementation of the needed advocacy competencies to address Medicare coverage at the institutional level and to create a logistical plan to provide training on these competencies. Counselors would then evaluate the needs of the group during the training and to adapt the content of the sessions as needed to meet the goals of its attendees. Counselor advocates would facilitate group interactions at the training in the fifth step, networking. The sixth step of the model, evaluating, follows the training. This step provides valuable information about the impact of the instruction on the identified Medicare advocacy goals immediately and over time. Finally, counselors would retarget by reviewing the impact of their training. Counselor advocates would utilize data from the evaluation stage to determine how well advocacy competencies were implemented and the degree of change to the barriers identified by lack of Medicare coverage.

Limitations & Future Directions

There are several limitations associated with our analysis. First, the MKQ is an exploratory instrument and has not yet been validated. It is possible that respondents had difficulty in interpreting specific items. In light of the low Cronbach's α statistics, performance on the full quiz or sub-samples (i.e., MKQ: Program/ MKQ: Profession) should be interpreted cautiously. Additional work is needed to improve the MKQ's utility as a measure of broad Medicare knowledge. Similarly, no formal analysis into the factor structure of the MKQ has been performed. Another limitation is related to the nature of True/False quiz questions. The True/False format provides respondents with a 50% chance of answering correctly regardless of knowledge. The development of more sophisticated measures may be useful as the counseling profession continues to examine policy knowledge among its members.

Additionally, the response rate (10.08%) was modest and may not be a representative sample of practicing counselors, counseling students, and counselor educators. Our respondents may represent a more engaged sample compared to the whole of counseling professionals. If the sample in the study is representative of a more engaged segment of the counseling professional populace, counseling professionals as a whole may be even less knowledgeable about the Medicare program and professional advocacy efforts than is suggested by our findings. Additional research is needed in which a randomized sample of counseling professionals is used.

Finally, there is no empirical evidence that program or professional knowledge directly affects advocacy outcomes. Although a link between knowledge and the quality of advocacy appears logical on the surface, additional research is needed to substantiate the relationship between program and professional knowledge and increased advocacy effectiveness.

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