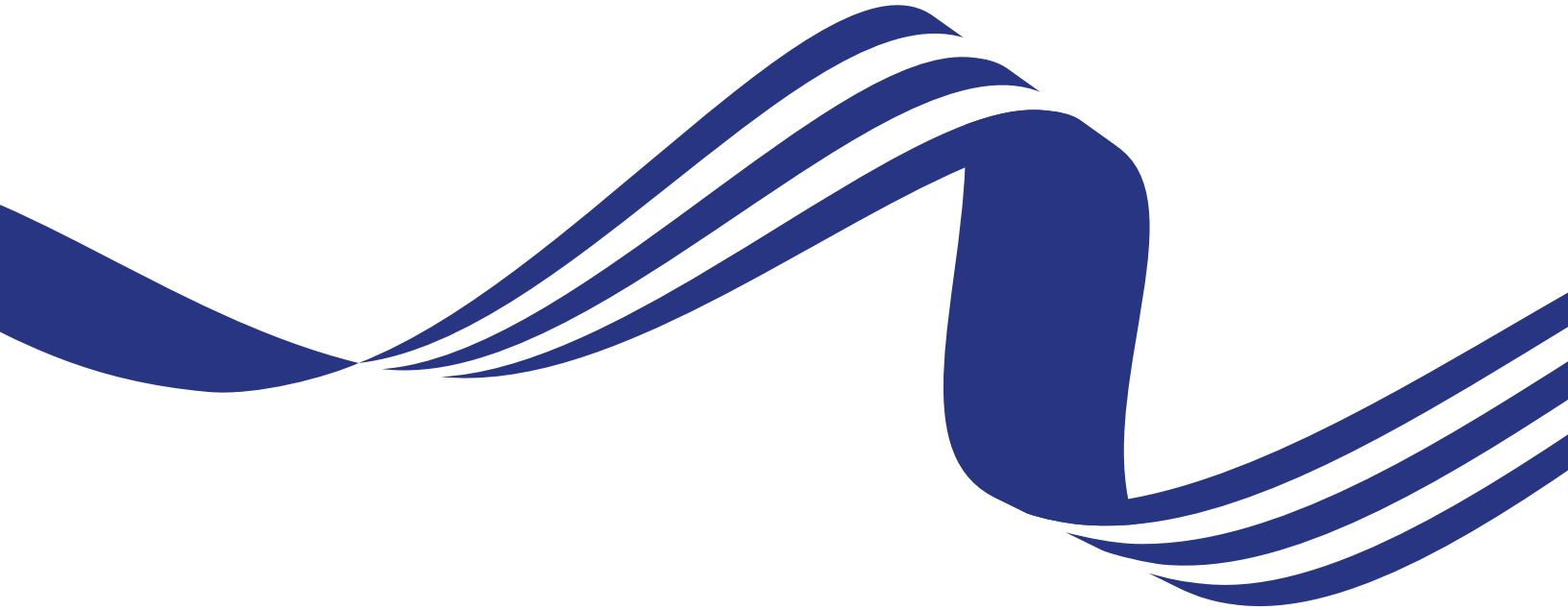
An Environmental Scan of Self-Direction Across UnitedHealthcare Community & State Health Plans

Key Findings and Best Practices

March 2023



United Healthcare

Executive Summary

In 2021, UnitedHealthcare Community & State embarked on a journey to investigate self-direction with a goal of exploring how a consumer might gain access to self-direction. Through the course of a year of research, Community & State found valuable learnings as well as challenges and opportunities within the world of self-direction. In response to those learnings, the decision was made to continue developing the self-direction work and, first, focus on internal practices and experiences.

In 2022, Community & State partnered with the national experts at Applied Self-Direction (ASD). This report is the culmination of a year of surveys, interviews, and research conducted by ASD that identified best practices as well as opportunities for advocacy and further development of best practices that improve meaningful access to self-direction. The findings from ASD will serve to inform how Community & State continues to build access to self-direction and support true consumer choice.

Introduction

Self-direction is a model of long-term care service delivery that helps people of all ages, with all types of disabilities, maintain their independence at home. When a person self-directs, they decide how, when, and from whom their services and support will be delivered. As a model, self-direction prioritizes individual choice, control, and flexibility. In self-direction, each person selects and trains their own staff, develops their staff's schedules, and sets their own standards for how their services will be delivered.[1]

Self-direction is based on the principle that people with disabilities or serious illnesses know their needs best and are in the best position to plan and manage their own services. Nationally, services that are most often self-directed include personal care, transportation, and respite. People who self-direct often choose to hire family members and friends to provide these and other services.[2]

Comparative effectiveness research comparing traditional agency-managed services with self-directed service options has shown that self-direction positively impacts health, care, and cost.[3]

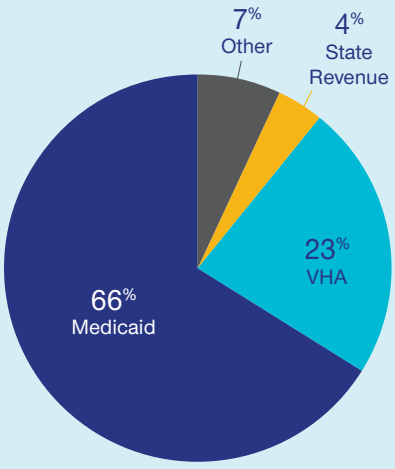
Extensive research has shown that self-direction:

- Improves health outcomes
- Increases life satisfaction
- Significantly reduces unmet personal care needs
- Reduces physical strain for caregivers
- Greatly increases caregivers' overall satisfaction with care
- Does not increase the incidence of fraud and abuse
- Reduces the utilization of high-cost acute services when basic support services are provided[4]

Today, over 1 million Americans self-direct with at least one program available in every state and over 250 programs nationwide. The average self-direction program serves approximately 4,500 people with a range in enrollment from as small as one individual to as high as 300,000 people. Medicaid funds most self-directed services and virtually all Managed Long-Term Services and Supports (MLTSS) programs now offer eligible members options to self-direct.[5]

66%

of self-direction programs are funded by Medicaid



Community & State is committed to advancing self-direction and to making this option available to anyone who wishes to take charge of their own care. To that end, Community & State conducted an environmental scan of its self-direction offerings nationally in 2022 to identify opportunities to further support the growth of this model and highlight best practices.

Approach

Program administrators from Community & State health plans across the country responded to an in-depth survey on self-direction.[6] Topics included:

- Opportunities and challenges for self-direction
- Supports for members who self-direct
- Enrollment
- Quality
- Pandemic impact

Some program administrators were also selected to participate in follow-up interviews to provide further details about the trends, challenges, and opportunities impacting self-direction.

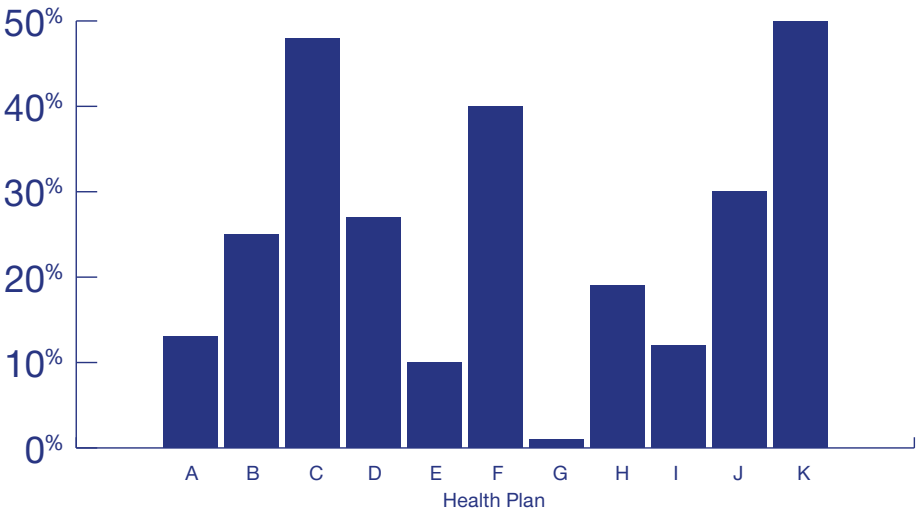
Key Findings

The following are key findings and lessons learned from this environmental scan of self-direction.

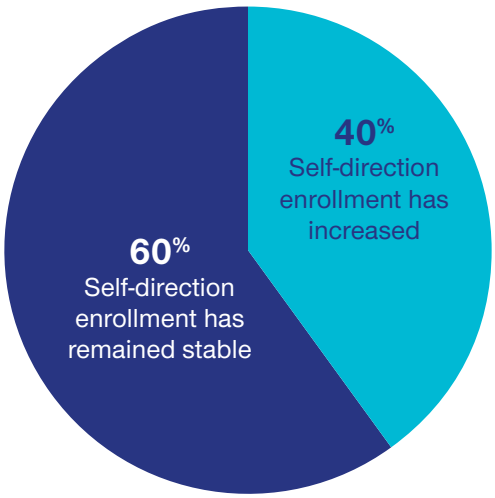
Engagement

According to the estimates reported by each plan, approximately 22,300[7] UnitedHealthcare members currently utilize self-direction. Member engagement in self-direction varies widely with anywhere from 50% to 0.45% of the eligible LTSS population self-directing.

Percentage of Members Self-Directing by Health Plan



The majority of UnitedHealthcare health plans (60%) reported that self-direction has remained stable while some health plans (40%) noted a recent increase in self-direction enrollment since the pandemic. No UnitedHealthcare health plans reported a recent decrease in self-direction enrollment.



Benefits

In their survey responses, Community & State health plan leaders described numerous benefits of self-direction for members, including:

> ***"The biggest advantage is giving members the autonomy to choose who they want as their service providers and designing what they want the providers to do for them."***

- Flexible choice of direct care worker
- Greater control and autonomy
- Ability to set the rate of pay
- Lower cost compared to traditional services
- Improved coverage in rural settings
- Avoid institutionalization
- Mitigate labor shortages

Some Community & State health plan leaders have observed that members who self-direct utilize less acute care compared to those who utilize traditional services. One health plan cited a representative sample of older adults and adults with physical disabilities self-directing used 20% less acute care.

> ***"Individuals in rural areas may gain better access to care when self-directing as it is often difficult for providers to support rural areas, though personal networks are typically strong in these areas making self-direction a more suitable option."***

Challenges

Community & State health plan leaders also identified numerous challenges and barriers to the expansion of self-direction, including:

- Worker scarcity particularly for those members who do not already know someone they wish to hire
- Complex requirements to get started
- Competition with agency-based programs that in some cases offer higher pay, better benefits, and/or offer more options for backup care.
- Burdensome electronic visit verification (EVV) requirements

Many Community & State program administrators observed that a major barrier to self-direction is the perception by members that it is too burdensome or time-consuming and some noted that members have complained about issues with payroll and payment delays. Another common challenge was that members typically encounter longer wait times to access self-direction than traditional services. Common reasons for a longer wait included difficulty finding a worker and time-intensive documentation requirements, particularly for criminal background checks.

Half of the Community & State health plans reported that the impact of workforce shortages is less severe for self-direction as compared to traditional services, while the others noted no difference. The potential to mitigate the impact of workforce shortages is an important benefit of self-direction but it is critical to note that self-direction does not eliminate the challenges of workforce shortages.

Best Practices

Across all the Community & State health plans, certain key attributes, strategies, or actions consistently appear to support the success of self-direction, including:

A commitment to the belief that any member can succeed in self-direction with appropriate support, including involving authorized representatives or providing tools and resources to aid in recruiting workers.

Robust, consistent training for all program administrators and case managers on the philosophy and operations of self-directed services.

Consistently well-documented procedures to introduce the self-direction option to all eligible members.

Intentional efforts to improve and enhance information and assistance resources available to self-directing members

Cultivation of strong community partnerships both with Financial Management Services (FMS) entities and other community organizations that support program operations (e.g., self-advocates, advocacy groups, CILs, and AAAs).

Where state policy permits, empowering members to oversee the training of their workers and providing training resources as an option, rather than a requirement.

Proactive engagement with self-directing members regularly to solicit feedback on their individual experience as well as their overarching feedback on ways to improve the program.

Advocacy Opportunities

Opportunities exist for states to advance self-direction. They include:

- Examine enrollment processes and remove obstacles to accessing self-directed services. For example, this could include adjusting background check requirements for self-direction in states where current background check requirements add weeks or even months of delays to receiving care. Slow turnaround times for background checks also exacerbate workforce shortages because potential workers may be unable to wait for an extended period before receiving their first paycheck. There are no federal minimum requirements for background checks in self-direction so these requirements may be changed at the state's discretion.
- Provide equitable access to health care benefits for workers in self-direction and agency workers
- Increase wage ranges in self-direction to be more competitive with agency-based wages.
- Allow the provision of personal care during hospitalization so long as services do not duplicate any that should be provided and billed for by the hospital. There are no federal requirements preventing states from making this an option and multiple states have reported the delivery of self-directed services while a member is receiving in-patient care as the most common form of fraud in self-direction. In most cases, such cases of unintentional cases of fraud may result from a legitimate necessity for ongoing personal care support that hospitals and acute care settings are not designed to provide.
- Implement budget authority through self-direction to allow members to raise pay rates without necessarily increasing costs.
- Make any new flexibility during the pandemic permanent to allow family members to be paid caregivers.
- Provide standardized guidance on self-direction implementation, including a program manual and/or formal regulations.
- Expand the services that can be self-directed by amending the waiver application.
- Increase reimbursement rates for FMS providers to better reflect the size and scope of their responsibilities.
- Reduce or simplify requirements for EVV implementation within the requirements of federal law.

Conclusion

Self-direction is guided by the simple ethos that all people have the right to exert genuine choice and control over their own lives. While operationally complex to implement, the self-directed model offers a crucial pathway toward quality care, lower rates of worker turnover than agency services, and high satisfaction among members who need support in their homes and communities. According to examination of internal data, self-direction has demonstrated its ability to achieve cost savings for health plans by reducing member utilization of acute care services. Most promisingly, self-direction mitigates the ongoing and worsening home- and community-based services (HCBS) workforce shortage by creating sustainable alternate caregiving arrangements through friends, family, and other individuals personally recruited by the member. Due to its unique advantages, self-direction is well worth the considerable effort to implement.

Sources

[1] https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html

[2] https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html

[3] https://www.rwjf.org/en/library/research/2013/06/cash—counseling.html, https://www.mathematica.org/publications/cash-and-counseling-improving-the-lives-of-medicaid-beneficiaries-who-need-personal-care-or-home-and-communitybased-services

[4] https://www.rwjf.org/en/library/research/2013/06/cash—counseling.html, https://www.mathematica.org/publications/cash-and-counseling-improving-the-lives-of-medicaid-beneficiaries-who-need-personal-care-or-home-and-communitybased-services

[5] https://appliedselfdirection.com/resources/2019-national-inventory-self-direction-programs

[6] Participating Community & State health plans included Arizona, Florida, Hawaii, Kansas, Massachusetts, New Jersey, Ohio, Tennessee, Texas, and Virginia.

[7] Please note this total does not include UnitedHealthcare members in TX as the state did not report an estimated number of members, only the approximate percentage of eligible members who self-direct.