the self-direction center

National MLTSS Health Plan Association



Systemic Infrastructure:

Advancing Self-Direction in a Managed Long-Term Services and Supports (MLTSS) Ecosystem

Drivers, Barriers, and Recommendations for Federal Policymakers, States, MLTSS Health Plans, and Companies that Support Self-Direction

October 2026

Throughout 2025 and early 2026, the National MLTSS Health Plan Association (MLTSS Association) convened a workgroup to strengthen the use of self-direction within managed long-term services and supports (MLTSS). The group was comprised of experts from the Self-Direction Center, the Association's member health plans and self-direction companies that participate in the MLTSS Association's Partnership Program.

The purpose of this workgroup is to develop and disseminate a comprehensive framework for person-centered, effective and sustainable self-direction programs that operate within MLTSS models, ensuring that the needs, preferences, and autonomy of individuals who self-direct their care remain central. We believe that the recommendations and best practices included in our report will be valuable resources for stakeholders, including health plans and companies that support self-direction, and will also serve as a helpful tool to inform future state and federal policy development. We recognize that the opinions and recommendations included in these briefs represent the perspectives of our workgroup participants, and we welcome collaboration with other stakeholders to continue the discussion of the ideas and challenges raised in this brief.

The first brief in this series introduced the **Self-Direction 2.0 Framework** (Graphic 1) that outlines the essential drivers of a successful self-direction program and illustrates how these components work together within a Managed Long-Term Services and Supports (MLTSS) model. The ultimate goal is for individual MLTSS health plan members to have choice and control over the home and community-based services (HCBS) they receive.

The second brief in this series focused on the **Member-Facing Supports** that empower individuals enrolled in MLTSS health plans with the information, tools, and assistance they need to make informed decisions and seamlessly carry them out.

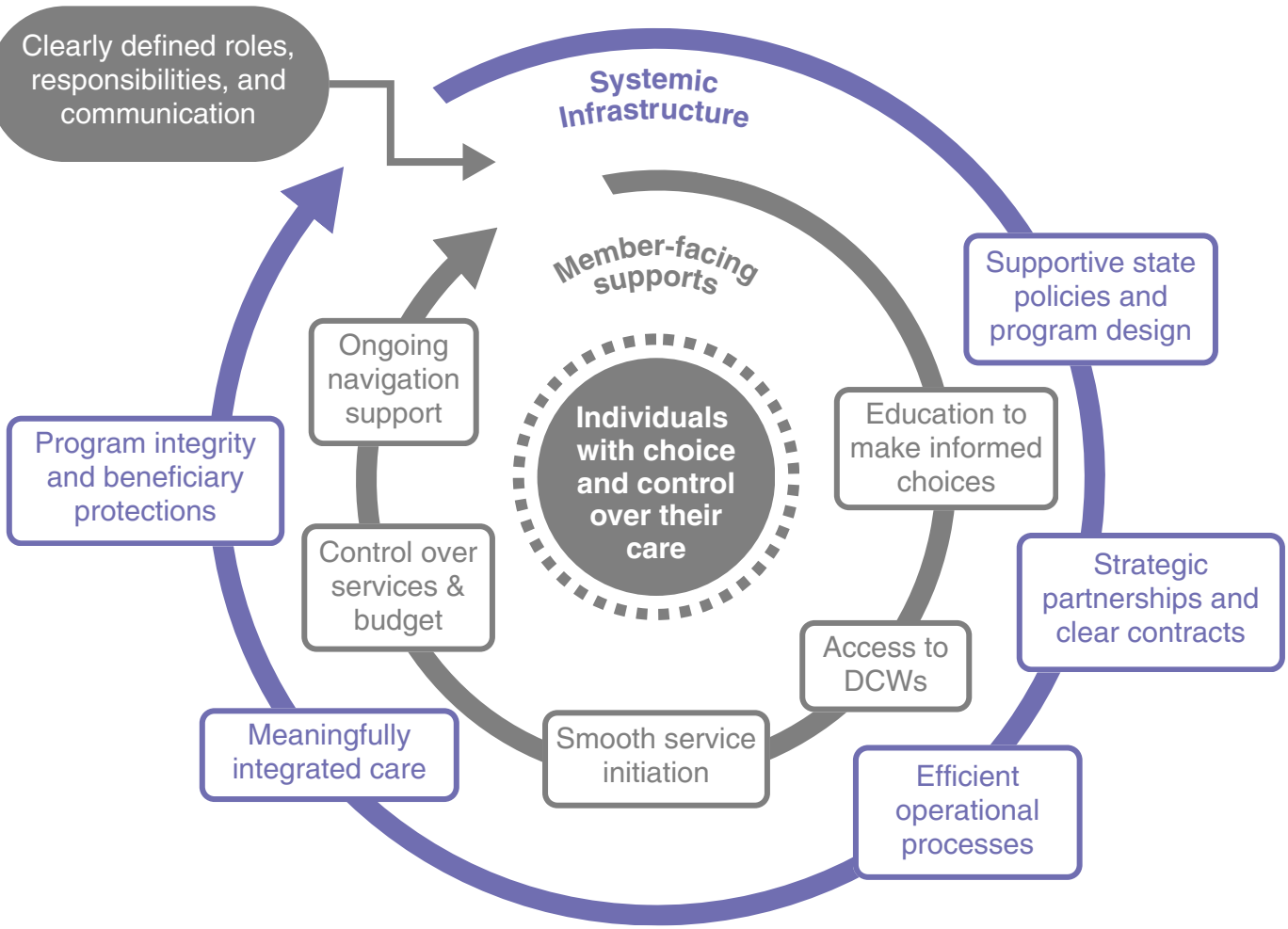
This brief will focus on the third level of the framework, the **Systemic Infrastructure** that supports successful self-direction programs in MLTSS. This infrastructure includes state policies and program design that maximizes self-directed options; strategic partnerships and clear contracts among states, plans, and vendors; efficient operational processes for managing services, payment, and reporting; integrated care for members with multiple payors; and strong program integrity practices that ensure beneficiary protection and compliance. This document identifies the key barriers to realizing each success driver, and offers tailored recommendations for the layers of the MLTSS ecosystem best positioned to address them: **the federal government** (especially the Centers for Medicare and Medicaid Services - CMS), **states** (especially state Medicaid agencies and aging and disability units), **MLTSS health plans** (also called Managed Care Organizations – MCOs), and **companies that support self-direction** (especially financial management service (FMS) agencies).

It's important to note that recommendations included in this brief are intended to be applied in concert with one another. Strengthening any single driver without attention to the others risks creating new gaps in the system, and risks for self-direction participants. Additionally, improving the Systemic Infrastructure is not sufficient alone - program success also depends on the Member-Facing Supports addressed in our companion brief. Stakeholders are encouraged to use both documents together when assessing and strengthening their self-direction programs.

Systemic Infrastructure of a Successful MLTSS Self-Direction Program

Self-direction is a model that allows individuals who need assistance with daily living tasks or their representative to have greater decision-making authority over the delivery of their Medicaid-funded long-term services and supports (LTSS). **Consumer direction**, **participant direction**, and **self-determination** are alternative terms for self-direction. Key elements of self-direction include granting individuals control over the hiring, training, and supervising of their direct care workers (DCWs) as well as managing their personal budget for these services, in alignment with their person-centered service plan. DCW is an umbrella term to include Direct Support Professionals (DSPs), Personal Attendants (PAs), Individual Providers (IPs), and any other paid caregivers providing self-directed services.

Graphic 1. Self-Direction 2.0 Framework: Systemic Infrastructure that Drives a Successful Self-Direction Program within Managed LTSS



Effective self-direction programs do not emerge from good intentions alone. They are built on a foundation of deliberate policy choices, well-structured contracts, efficient administrative systems, and strong safeguards for the people they serve. CMS plays a significant role in setting national guidelines by which state Medicaid programs must operate. CMS also must approve the waivers that govern each state's HCBS offerings, including which HCBS benefits can be administered through self-direction. In turn, each state has considerable discretion in deciding how those self-directed benefits will be implemented, what supports will be available to members and DCWs[1], and the relative roles of the MLTSS plans, FMS agencies, Information and Assistance (I&A) providers[2], Electronic Visit Verification (EVV) vendors, and other entities. Additionally, state determinations about the scope of managed care and number of plan options can especially impact the majority of MLTSS members who are dually-eligible for Medicare and Medicaid. Within each state's guidelines, MLTSS plans, FMS agencies, and other companies that support self-direction make additional determinations about their business arrangements and work processes.

The cumulative effect of all of those decisions impacts the availability and quality of self-direction for MLTSS members with disabilities. In order to make self-direction accessible, it's important to look at the different interdependent layers of infrastructure and how they drive success of the program as a whole, in addition to incorporating feedback from MLTSS members who self-direct.

Drivers and their Rationale, Barriers, and Recommendations

Driver: Supportive State Policies & Program Design

Rationale:

State Medicaid program design choices can significantly impact the success of self-direction programs within MLTSS models. To foster a successful self-direction program, states should implement policies that support individuals' ability to employ and pay their caregivers and manage their own budgets, as well as set data collection, sharing, and evaluation requirements. States should also provide technical assistance to clarify program components and requirements. Within MLTSS programs, states can codify their policies into contract provisions with health plans, creating accountability and helping to ensure consistent implementation across plans. Additionally, states can leverage procurement processes to emphasize program goals, promote innovation, and address system gaps; responses allow states to consider self-direction as they ultimately select the strongest plans and vendors.

Barriers:

- **Benefit limits:** State policies and HCBS waivers establish the parameters for self-direction, including which delivery models (i.e. agency with choice, budget authority), HCBS benefits, and populations can participate. Designing waivers to support a robust self-direction option requires thoughtful consideration of the program framework, benefit structure, and the infrastructure needed to support participant choice and control.

[1] DCW is an umbrella term to include Direct Support Professionals (DSPs), Personal Attendants (PAs), Individual Providers (IPs), and any other paid caregivers providing self-directed services.
[2] Information & Assistance (I&A) supports the participant (or their representative) in arranging for, directing, and managing services. I&A is defined in detail in the first brief in this series.

- **Complex relationships:** State choices about how MLTSS is procured and how FMS and Information & Assistance (I&A) support is structured and delivered (whether as an administrative activity or waiver service, contracted by the state or by health plans) can produce an overabundance of choices with inconsistent quality, or an undersupply of options that leaves members without adequate support. Relationships that are not well-structured can foster role confusion and constrain collaboration and innovation, ultimately impacting member experience.
- **Lack of participant support:** Limited investment in essential participant support infrastructure - specifically I&A services including support brokerage, peer support, financial literacy education, navigator services, and and education on the responsibilities of serving as an Employer of Record, - places a disproportionate burden on participants and health plan care managers and may limit uptake of self-direction among MLTSS members who could otherwise benefit from it.
- **Insufficient workforce:** State rules governing who is permitted to provide services under self-direction — including policies that restrict or prohibit the hiring of family members as paid caregivers — directly limit member options and constrain the available workforce. Geographic challenges can also exacerbate these service and provider availability challenges in certain regions.
- **Funding gaps:** Budget constraints (as well as lack of understanding about the benefits of self-direction) may prevent states and plans from investing in the expansion of self-directed options. Budget methodology and rate-setting practices may undervalue self-directed services or fail to account for administrative costs, creating a financial disincentive for MLTSS plans to promote self-direction.
- **Weak quality infrastructure:** Without standardized measures and sufficient data collection and evaluation capacity, states are unable to assess self-direction program performance, identify disparities in access or outcomes, or make evidence-based improvements. Quality measurement should appropriately reflect the goals and features of self-direction while maintaining a consistent approach to assessing HCBS quality. Many programs also lack meaningful, ongoing opportunities for individuals who self-direct to provide feedback on policy, program design, and other critical decisions that affect their care.

Recommendations by Entity:

Federal Policymakers	• **Provide technical assistance and model policy frameworks to states.** Issue guidance, tools, and model policy frameworks to support states in implementing, structuring, and monitoring self-direction within MLTSS. This should include model waiver language, contract provisions, and program design templates that states can adapt to their specific contexts, and could all be included in a self-direction toolkit for states. States should also offer trainings on self-direction to state Medicaid agency staff to develop state-level self-direction expertise. • **Incentivize standardized self-direction data collection and reporting.** Encourage states to collect and report standardized self-direction data through existing federal reporting mechanisms — including T-MSIS, HEDIS, CAHPS, and NCI/NCI-AD — to enable cross-state comparisons, identify disparities, and support evidence-based policy development.

States	• **Incorporate self-direction into MLTSS procurements.** Include explicit questions about health plan approaches to self-direction during MLTSS procurements, in alignment with state program goals. Use procurement processes to emphasize program goals, promote innovation, and select plans and vendors that have the capacity and commitment to advance self-direction. • **Invest in a state-level self-direction Subject Matter Expert (SME).** State Medicaid agencies should invest in at least one full-time employee (FTE) who can serve as an expert of self-direction program design, rules, FMS capabilities and other essential elements of self-direction. • **Ensure meaningful MCO engagement when the state directly procures FMS and EVV.** When the state chooses to directly procure FMS or EVV vendors, consult with plans on an ongoing basis to monitor quality and enable continuous improvement — ensuring that direct state contracting does not impede effective plan-vendor collaboration. • **Establish adequate rates and budget methodologies for self-direction.** Set MLTSS rates and self-direction budget methodologies that account for the full cost of self-direction, including MCO and FMS administrative expenses and investments in technology and data sharing. Build I&A support infrastructure into program design and ensure that MCO rates are sufficient for members to access I&A, whether provided via care management or offered by network providers, such as support brokers. • **Set data collection and evaluation standards.** Establish data collection processes and standards to track self-direction enrollment (including why individuals decline self-direction or leave the program), onboarding timelines, workforce vacancy rates, outcomes, and equity metrics, aligned with other health plan reporting requirements and timelines. Create meaningful channels for ongoing stakeholder feedback - including from members who self-direct, their families, and caregivers - to inform policy and program improvements and to ensure quality standards do not impose undue burden on members who self-direct.
MLTSS Health Plans	• **Identify gaps and advocate for supportive policies.** Engage actively with state partners to identify gaps in self-direction policy and program design and to advocate for changes that would better support self-direction within managed care. Collect and share data with the state to inform policy decisions. • **Develop internal policies that operationalize state standards consistently.** Build internal policies and workflows that operationalize state self-direction requirements consistently across all service areas and lines of business. Take steps to ensure that member access to self-direction does not significantly vary across regions, member populations, or care management teams.

Companies that Support Self-Direction (FMS agencies)	• **Participate in state stakeholder processes.** Actively participate in state advisory processes and provide practical, operations-informed input on how policy and program design choices affect operational feasibility for FMS vendors and their participants. Collect and share data with the state to inform policy decisions. • **Maintain compliance with current standards.** Invest in the compliance infrastructure, staff training, and quality monitoring necessary to maintain consistent compliance with all applicable state and MCO program standards as they evolve over time.

Driver: Strategic Partnerships & Clear Contracts

Rationale:

Contracts between states, health plans, and vendors serve as the foundation for self-direction programs. When these contracts are specific and comprehensive and include clear expectations for roles and responsibilities across the MLTSS ecosystem, all parties are better equipped to fulfill their responsibilities. In MLTSS programs, states can use contracts as a tool to standardize processes, enforce performance requirements, require data reporting, and create flexibility for health plans to innovate. For example, MLTSS plans can strategically partner with FMS agencies to offer additional supports for members and their workers, improve efficiency in the service initiation process, and enhance data sharing to strengthen program integrity.

Barriers:

- **Ambiguity and/or inflexibility:** Contracts among the state, MLTSS plans, and vendors may lack specificity around self-direction requirements, leading to role confusion, process gaps, or inconsistent performance. Conversely, contracts may be overly prescriptive in ways that limit flexibility and stifle innovation.
- **Misaligned incentives:** Misaligned incentives among the state, plans, and vendors can negatively affect member access and program uptake, particularly when financial arrangements do not reward quality, timeliness, or efficiency in self-direction operations.
- **Structural limitations:** When the state contracts directly with FMS and/or EVV vendors, individual plans lack the authority or infrastructure for effective collaboration or to incentivize innovative practices beyond minimum state requirements. When plans contract directly with FMS and/or EVV vendors, state requirements may not flow down consistently across all vendor relationships, leaving gaps in the implementation of critical program requirements.
- **Volume of organizations involved in self-direction:** In addition to contracts between the state, multiple MLTSS health plans, and potentially many FMS and EVV vendors, there can be additional organizations to be considered in delineating each entity's contractual responsibilities, such as support brokerages or I&A entities and delegated care management or service coordination entities.
- **Unique nature of self-direction:** Successful implementation of self-direction in MLTSS requires MCOs to develop unique contract provisions and performance standards, data sharing agreements, and value-based arrangements that differ from other vendor or provider agreements the MCO typically implements.

Recommendations by Entity:

Federal Policymakers	• **Issue model MLTSS contract language on self-direction.** Develop and disseminate model contract language and a compendium of recommended MLTSS contract provisions related to self-direction, including standards for FMS subcontracting, informed choice, budget methodology, performance reporting, and data sharing. • **Provide technical assistance on minimum self-direction access and performance standards.** Support states in incorporating minimum self-direction access and performance standards into MLTSS managed care contracts, ensuring that plans and their subcontractors are held to consistent expectations for quality, timeliness, and member experience. • **Incorporate self-direction in state rate setting guidance for MLTSS.** Provide guidance and technical assistance to states to ensure that MLTSS rates properly account for the full costs of self-direction, including MCO and FMS administrative expenses, support broker services, and care coordination.
States	• **Incorporate specific self-direction provisions into MCO contracts.** Include explicit contract requirements, aligned with current waiver language, covering informed choice processes, budget methodology, FMS, I&A, and EVV subcontracting or collaboration requirements, data reporting, performance standards, and grievance and appeals processes for self-directing members. Provide additional support to plans through state policy documents and/or manuals and offer technical assistance as needed. • **Require MCOs to flow down requirements to FMS subcontractors while preserving room for innovation.** Establish clear expectations that plans will pass state self-direction requirements down to their FMS and EVV subcontractors — while deliberately leaving sufficient flexibility for individual plans to form innovative partnerships, build value-based payment structures, and develop other practices that go beyond minimum standards. • **Clarify roles and responsibilities in contracts.** Clearly delineate in all relevant contracts the core roles and responsibilities of the MCO, FMS, I&A, and EVV entities, and other parties involved in self-direction, reducing role confusion and preventing gaps in service delivery.
MLTSS Health Plans	• **Ensure FMS subcontracts include robust performance and reporting standards.** Include clear performance requirements, reporting obligations, and compliance standards in all FMS subcontracts, ensuring alignment with the plan's state contract. Identify opportunities to align vendor rates and contracts to performance goals**.**

MLTSS Health Plans	• **Establish joint operating committees with FMS vendors.** Develop joint operating committee structures with FMS vendors to monitor contract performance, share data, resolve issues proactively, and identify opportunities for continuous improvement. • **Develop MOUs where formal contractual relationships do not exist.** Where there is no formal contractual relationship between the plan and an FMS or EVV vendor contracted directly by the state, develop Memoranda of Understanding (MOUs) that establish shared expectations for communication, timeliness, data-sharing, and issue escalation.
Companies that Support Self-Direction (FMS agencies)	• **Negotiate subcontracts that clearly define roles and escalation procedures.** Work with MLTSS plan partners to ensure that all subcontracts clearly define roles, operational timelines, reporting requirements, and escalation procedures — creating a shared foundation for accountability and continuous improvement. • **Develop MOUs where formal contractual relationships do not exist.** When the FMS is contracted directly with the state and there is no formal contractual relationship with the MLTSS plans and/or EVV vendor, develop MOUs that establish shared expectations for communication, timeliness, data-sharing, and issue escalation. • **Educate plans about available capabilities beyond state requirements.** Proactively communicate with MCO partners about the full range of services and supports your organization can offer — including capabilities and innovations that go beyond minimum state requirements — so that plans can make informed decisions about program design and vendor partnerships.

Driver: Efficient Operational Processes

Rationale:

In an ideal MLTSS self-direction model, operational processes within and between the state, plans, and vendors are efficient, transparent, and well-coordinated. These back-end processes support successful self-direction by minimizing administrative barriers for MLTSS members and their caregivers/DCWs. A successful program relies on well-organized processes for service planning and authorization, worker onboarding and time tracking, claims submission and payment, and reporting. Accurate information on member enrollment/eligibility, authorizations, claims, and Electronic Visit Verification (EVV), must flow seamlessly and enable timely action. Communication and data-sharing processes should be continuously improved, protect confidential information, and ensure all necessary consent has been provided.

Barriers:

- **System fragmentation:** Fragmented IT systems and inconsistent work processes across MCOs, FMS vendors, EVV vendors, and state agencies create data silos and service and payment delays. Members who switch MLTSS plans or FMS agencies often have to duplicate onboarding tasks. When states directly contract with FMS and EVV vendors, health plans often have limited opportunities to integrate data and collaborate on process improvements.
- **Provider data discrepancies:** Because HCBS delivery systems often rely on multiple disconnected platforms (i.e. EVV, claims, care management), discrepancies can persist across systems without clear accountability for remediation. Lack of standardized provider data governance also creates downstream challenges for claims adjudication and program integrity. Most states lack a consistent methodology to identify and track direct care workers (DCWs) who often work across multiple MLTSS plans and vendors.
- **EVV limitations:** Inconsistent EVV implementation and variable data formats impede cross-system interoperability and automated payment processes. Differences across states and programs can include standards for handling exceptions, manual edits, live-in caregiver exemptions, and soft-launch enforcement periods. CMS training materials emphasize that EVV requirements confirm where and if a visit occurred but do not validate whether services were delivered in accordance with the authorized plan of care or whether services were appropriate for the member's needs.
- **Limited access to technology:** FMS agencies without sufficient technology resources may require manual or paper-based processes that place a high administrative burden on participants and/or DCWs.

Recommendations by Entity:

Federal Policymakers	• **Develop data exchange standards for self-direction.** In collaboration with national trade associations for MLTSS plans and vendors, develop and promote data exchange standards that support interoperability and seamless information flow across the MCO, FMS, EVV, and state agency systems that together form the operational backbone of self-direction. • **Promulgate standards for states to develop unique DCW identifiers.** Federal guidance and technical assistance can support states to develop consistent DCW identifiers that allow for better oversight across plans and vendor systems. Use of NPIs is not recommended as it would place an undue burden on DCWs participating in self-direction. Further, CMS could promote best practices for cross-state verification.
States	• **Include a review of self-direction processes during health plan readiness reviews.** Ensure that readiness reviews conducted during new MCO implementation or contract renewal include a structured review of self-direction policies, procedures, and related technology — including FMS and EVV system capabilities.

States	• **Standardize data-sharing agreements and reporting templates.** Develop and require standardized data-sharing agreements and reporting templates across all plans and vendors, ensuring that members do not lose services or face duplicative documentation requirements when they change plans or vendors. State Medicaid agencies should also develop continuity of service and record portability standards for worker credentials, service authorizations, budget information, and participant records to support members during plan and/or FMS transitions. • **Fund technical assistance to support smaller FMS vendors.** Invest in technical assistance and capacity-building support for smaller FMS vendors that may need help meeting program requirements or adopting the technology necessary to participate fully in an MLTSS environment. • **Clearly define EVV compliance standards.** Clearly outline what constitutes compliance and non-compliance for EVV standards within their self-direction programs. Currently, a lack of structure and clear requirements can create confusion for members, MCOs, and FMS providers. These compliance standards should be focused on creating progressive corrective action plans to address individual barriers to EVV compliance. These standards should include: ◦ What constitutes non-compliance; ◦ Progressive enforcement requirements; ◦ Remediation expectations (include corrective action plans); and ◦ Member and worker education requirements before limitations or terminations are implemented by MCOs.
MLTSS Health Plans	• **Provide real-time information to FMS vendors.** Ensure that FMS vendors have timely access to accurate enrollment, authorization, and claims data — reducing delays in worker onboarding, service initiation, and payment processing. • **Reduce duplicative documentation.** Work with FMS vendors, I&A entities, and care managers to identify and eliminate duplicative documentation requirements, reducing the administrative burden on members and caregivers/DCWs. • **Collaborate with vendors on process improvement.** Establish ongoing processes, including routine evaluation/feedback standards, for identifying and implementing operational improvements in collaboration with FMS and EVV vendors, leveraging data to prioritize changes that will most benefit member experience and program outcomes.
Companies that Support Self-Direction (FMS agencies)	• **Build systems capable of bi-directional data exchange.** Invest in technology infrastructure that supports bi-directional communication and data exchange with MCO and state systems — ensuring that enrollment, authorization, EVV, and payment data flows accurately and in a timely manner across all relevant parties.

Companies that Support Self-Direction (FMS agencies)	• **Invest in technological infrastructure to improve member and DCW experience.** FMS providers should invest in their technology platforms to support members and DCWs through mobile applications, electronic signatures, real-time budget and service unit visibility, and linguistic and disability accessibility. • **Proactively flag issues to prevent service disruptions.** Establish internal protocols for proactively identifying and communicating potential service disruptions, payment delays, or data discrepancies to MCO partners and the state — preventing problems from compounding before they affect members or caregivers. • **Collaborate with plans on process improvement.** Establish ongoing processes for identifying and implementing operational improvements in collaboration with plans and other vendors, leveraging data to prioritize changes that will most benefit member experience and program outcomes.

Driver: Meaningfully Integrated Care

Rationale:

More than half of individuals who receive Medicaid-funded HCBS are also eligible for Medicare.[2] Many MLTSS health plans also offer companion Medicare Advantage plans for dually eligible individuals, known as Dual Eligible Special Needs Plans (D-SNPs), that integrate Medicare and Medicaid benefits. Alignment between the MLTSS health plan and a companion D-SNP allows plans to coordinate the delivery of LTSS with acute and behavioral health care. This integration is especially necessary during care transitions or when an individual experiences a change in their health or functional status. In an ideal self-direction model within MLTSS, integrated care reduces fragmentation across Medicaid and Medicare and promotes holistic person-centered planning, inclusive of the opportunity and support to self-direct. Such aligned enrollment models further ensure that systemic savings generated by strong HCBS supports, continuity of care, and care coordination accrue accordant to the parent entities responsible for the investment, allowing for greater re-investment in innovations as well as enhancing fiscal sustainability for strong self-direction programs overall.

Barriers:

- **Fragmented care coordination:** Structural separation between Medicare and Medicaid plans creates fragmented care planning, especially during transitions, and limits plans' ability to understand the impact of self-direction on member health outcomes. Self-direction options may not be preserved or communicated during care transitions (e.g., hospital discharge, functional change) or when members change plans or experience changes in eligibility — creating gaps that can interrupt established caregiver relationships and undermine continuity of care. In addition, D-SNP care coordinators may not have sufficient knowledge of self-direction options.

[3] Who Uses Medicaid Long-Term Services and Supports? | KFF

- **Duplication of efforts:** D-SNP and MLTSS plan care coordination processes are difficult to align, even when operated under the same parent company, due to differences in program requirements, funding streams, and care management structures. Members are often required to complete multiple assessments - which may generate different results - and develop a Medicare care plan that may not align with their LTSS service plan.
- **Benefit carve-outs:** Behavioral health and LTSS integration remains underdeveloped in many Medicaid programs, with behavioral health benefits frequently carved out to a separate managed care entity — further complicating holistic, person-centered planning for members who self-direct.
- **Lack of access to timely data:** Medicare data on admissions, discharges, and transfers (ADT) can be difficult for Medicaid and self-direction stakeholders to access in a timely manner, limiting the ability to identify and respond to care transitions proactively. Health Information Exchanges (HIEs) may not be accessible to FMS vendors.

Recommendations by Entity:

Federal Policymakers	• **Promote models that improve Medicare-Medicaid alignment.** Support models — such as auto-enrollment into aligned D-SNP and MLTSS plans — that improve the alignment of Medicare and Medicaid coverage for dually-eligible individuals. Such alignment has been shown to strengthen care coordination, improve member experience, and improve outcomes for individuals receiving HCBS, including those who self-direct. • **Require D-SNP Models of Care to address coordination with self-directed services.** Require that Models of Care explicitly address how D-SNPs will coordinate with self-directed LTSS, particularly during care transitions, and ensure that self-direction preferences are preserved and communicated when members transition between care settings or plans.
States	• **Improve integration between Medicaid and Medicare.** States can take steps during Medicaid procurements to align Medicaid and Medicare plan options so dually-eligible individuals have more opportunities to receive services from within the same parent company. Integrated care has been shown to strengthen care coordination, improve member experience, and improve outcomes for individuals receiving HCBS, including those who self-direct. • **Improve integration between physical and behavioral health and LTSS.** If Behavioral Health is delivered through different entities, require formal collaborative agreements among plans and care coordination entities to support holistic person-centered planning, including the option to participate in self-direction. Facilitate cross-organizational collaboration and shared accountability such as by aligning performance measures across programs to prioritize independence and quality of life.

States	• **Align State Medicaid Agency Contracts (SMACs) with self-direction program goals.** For example, SMACs could require D-SNP plans to train staff and provide information specifically about self-direction (in addition to Medicaid/LTSS more broadly). Such training could include understanding the philosophy and benefits of self-direction, as well as the specific services, entities, and administrative processes involved. As another example, companion D-SNP and MLTSS plans could be required to develop unified care plans that document and preserve self-direction preferences. • **Enable self-direction stakeholders to access timely data.** Enable MCOs and FMS vendors to participate in statewide health information exchange (HIE) infrastructure and/or access D-SNP admission, discharge, and transfer data (ADT) to support unaligned duals during care transitions.
MLTSS Health Plans	• **Align Interdisciplinary Care Team processes across D-SNP and MLTSS lines of business.** For dually-eligible members enrolled in both a companion D-SNP and an MLTSS plan, align Interdisciplinary Care Team (ICT) membership, care planning processes, and documentation requirements across both lines of business — ensuring that self-direction preferences are reflected and preserved in all care plans. With the members' agreement, consider including the members' DCWs and/or Support Broker as part of the holistic care-planning process. • **Ensure D-SNP staff are informed about self-direction options.** Train D-SNP care coordinators and other relevant staff on the self-direction options available through Medicaid, including related member resources such as support brokers and I&A services and where to refer members for more information. Training should also include the philosophy and benefits of self-direction, including informed choice and dignity of risk.
Companies that Support Self-Direction (FMS agencies)	• **Build lines of communication with behavioral health and D-SNP plans, in addition to MLTSS plans.** In collaboration with the MLTSS plans, identify the other relevant stakeholders and care coordination entities directly engaged with members who self-direct. Such organizational relationships could facilitate data exchange and proactive communication during transitions of care or when there are concerns about a specific member. • **Maintain continuity of employer-agent and budget management functions during care transitions.** Ensure that employer-agent and budget management functions remain intact during and after care transitions — providing stability for participants and their caregivers at some of the most vulnerable points in the self-direction experience.

Driver: Program Integrity & Beneficiary Protections

Rationale:

Strong safeguards are necessary to protect MLTSS members and ensure compliance with program requirements, while preserving member autonomy. Effective oversight will prevent fraud, waste, and abuse, while ensuring individuals receive necessary services, without creating barriers to participation. States and plans must have clear pathways for investigating and escalating concerns about member safety.

Program integrity and beneficiary protection are closely related but have distinct functions. Program integrity focuses on ensuring services are authorized, delivered, documented, and billed in accordance with program requirements, including prevention, detection, and correction of fraud, waste, and program-related financial abuse. Beneficiary protection focuses on identifying and addressing concerns related to member health, safety, welfare, neglect, abuse, or exploitation. Effective self-direction programs require strong processes in both areas, with clear pathways for coordination when concerns overlap.

Within MLTSS models, health plans have access to analytical tools and data on service authorizations, utilization, and payment to ensure that services are delivered in compliance with program requirements. Particularly when they contract directly with FMS and EVV vendors, MLTSS health plans often have access to more timely data than in fee-for-service programs, allowing quicker action to address errors or potential fraud. Additionally, MLTSS health plan care managers make in-home visits and can be trained to identify issues to ensure members are getting the care they need without being exploited or harmed.

Barriers:

- **Unique characteristics of the self-direction model:** By design, self-direction is unlike other healthcare and LTSS benefits that are administered and delivered by professional organizations. Empowering individuals to manage their own services inherently requires program integrity measures to be implemented in a flexible and thoughtful manner. When program requirements compromise the member's autonomy or create significant administrative burdens for members, they will be deterred from participating in self-direction.
- **Data fragmentation:** Fragmented communication and data across the state, health plans, and vendors impedes program oversight and can delay identification of potential issues – particularly when no single entity has a complete view of a member's services, authorizations, and payment history. With multiple plans and vendors having separate systems and inconsistent data, it is difficult to identify overlapping shifts and/or duplicate billing. Additionally, as individual MLTSS plans report concerns about a provider or DCW, that information may not be shared timely with other plans, especially if there is a lengthy investigation.
- **Data timeliness:** Visit-level EVV data is not always transmitted to health plans in real-time. This limits plans' ability to conduct pre-payment validation, identify outliers or other utilization patterns that require additional review, and prevent improper payments to DCWs before claims are adjudicated.

Barriers:

- **EVV limitations:** Inconsistent implementation and enforcement of EVV requirements can complicate and delay health plan investigations into improper payments, as well as reduce health plans' ability to build scalable interfaces and best practices across markets. The lack of consistent unique identifiers for EVV records can lead to conflicts that are difficult for health plans to identify. Current federal regulations do not require the use of a unique personal identifier for individuals who provide personal care services, and in most states, EVV systems do not require an individual's full Social Security Number (SSN). Network providers typically use NPIs; requiring NPIs for individual DCWs would plan an undue administrative burden on the worker.
- **Limited workforce capacity:** Overly burdensome documentation requirements can deter workers from serving as DCWs, particularly as many DCWs are family caregivers with limited administrative capacity. In aggregate, workforce gaps will increase which can leave MLTSS members without essential services.
- **Limited support capacity:** When there is insufficient funding or resources for I&A, confusion about program rules, problematic arrangements, and documentation errors are more likely to persist. Strong I&A can often prevent issues before they become compliance matters. While MLTSS care managers can help identify issues through home visits and escalate concerns about member safety or program integrity, they are not well-positioned to provide the full range of I&A supports a member may require. Additionally, trainings and policies regarding the identification of abuse, neglect, or exploitation may not adequately account for the unique context of self-direction, in which the member is both the employer and the service recipient.
- **Lack of member education:** Participants may be unaware of their rights or protections, limiting their ability to report concerns about service quality, payment accuracy, or potential exploitation.

Recommendations by Entity:

Federal Policymakers	• **Build on EVV minimum standards.** EVV revolutionized Medicaid program integrity protections for HCBS. However, now that EVV requirements have been in place for over 5 years, there is an opportunity to build upon this platform to strengthen, modernize, and refine program integrity protections in the program. CMS can engage with states, health plans, FMS providers, national associations, individuals who self-direct, and other stakeholders to develop updated federal guidance that leverages existing EVV infrastructure while preserving flexibility to accommodate the unique structure of self-direction. • **Promulgate standards for states to develop unique DCW identifiers.** Federal guidance and technical assistance can support states to develop consistent DCW identifiers that allow for better oversight across plans and vendor systems. Use of NPIs is not recommended as it would place an undue burden on DCWs participating in self-direction. Further, CMS could promote best practices for cross-state verification.

Federal Policymakers	• **Develop model beneficiary rights notices for self-directing participants.** In collaboration with states, health plans, FMS providers, individuals who self-direct, and other stakeholders, create and disseminate model plain-language beneficiary rights notices tailored specifically to the context of self-direction, ensuring that participants understand their rights, responsibilities, and available protections.
States	• **Adopt best practices.** Collaborate with plans and vendors to strengthen EVV requirements, identify and resolve process gaps, and adopt up-to-date technologies. • **Aggregate data to identify systemic issues.** Require aggregation of data across plans and FMS vendors to identify systemic discrepancies, patterns of potential fraud or abuse, and disparities in program outcomes — enabling proactive policy and program adjustments. • **Include self-direction-specific program integrity standards in all relevant contracts.** Incorporate self-direction-specific program integrity requirements — including audit and oversight protocols, EVV implementation standards, and escalation procedures — into contracts with MCOs and FMS vendors. Develop standard procedures for modifying or removing the option of self-direction in cases of consistent overuse and/or failure to follow program rules. • **Ensure grievance and appeals pathways are fully accessible to self-directing members.** Require that grievance and appeals processes be structured and communicated in ways that are fully accessible to self-directing members and their authorized representatives, including members who may face literacy, language, or disability-related barriers. • **Require up-to-date training on abuse, neglect, and exploitation for all self-direction entities.** Mandate that staff from all entities involved in self-direction — including MCOs, FMS vendors, and I&A providers such as support brokers — receive training on identifying and reporting abuse, neglect, and exploitation in home-based settings, with content tailored to the specific context of self-direction. • **Collaborate with MLTSS plans as well as EVV and FMS vendors to create standards and data-sharing processes that allow for real-time validation of claims.** These processes would enable timely and accurate payment while ensuring adherence to program requirements.

MLTSS Health Plans	• **Use data analytics to detect anomalies without creating access barriers.** Leverage authorization and utilization data to identify anomalies in self-directed service delivery, while designing detection approaches that do not inadvertently create barriers to access or increase administrative burdens on members and caregivers. • **Conduct targeted in-home visits for members at elevated risk.** Conduct additional in-home visits for members identified as being at elevated risk, ensuring that care managers conducting these visits have specific training in self-direction models and are equipped to identify potential concerns without undermining member autonomy. • **Ensure members understand their rights and resources.** During the initiation of self-direction and on a regular basis (such as during all person-centered planning conversations), ensure that all members receive plain-language, accessible explanations of their rights, responsibilities, and available protections — equipping them to identify and report concerns and to make informed decisions about their self-directed services.
Companies that Support Self-Direction (FMS agencies)	• **Maintain comprehensive internal compliance programs.** Build and sustain internal compliance programs that cover payroll accuracy, DCW eligibility verification, budget reconciliation, EVV data integrity, and fraud detection — providing the foundation for trustworthy, reliable fiscal management of self-directed services. • **Implement proactive monitoring and escalation processes.** Establish risk-based processes to identify and address potential discrepancies, billing irregularities, or documentation concerns before payment whenever feasible. • **Provide workers with clear information about their rights and responsibilities.** Ensure that all DCWs receive plain-language, accessible explanations of their rights, responsibilities, and available protections — confirming that they understand all program rules and documentation requirements and know how to identify and report concerns. • **Provide real-time data and proactively communicate potential program integrity concerns.** Share timely, accurate data with MCO partners and the state to identify unusual billing patterns, duplicative services, or other indicators of potential fraud, waste, or improper payments as early as possible.

Next Steps

When the right infrastructure is in place, self-direction can flourish in a managed LTSS ecosystem. Policymakers at the state and federal level can work with MLTSS plans to develop productive structures and processes that enable participants to operate with autonomy as they oversee their own services. MLTSS health plans provide unique capabilities that are not available in a fee-for-service environment, such as the capacity and flexibility to:

- Identify policies and best practices in self-direction from other states;
- Form strategic partnerships with vendors;
- Integrate care with Medicare; and
- Leverage member feedback and data for process improvements and program integrity.

High-performing FMS vendors can partner with MLTSS plans in numerous ways to continuously improve the infrastructure and make self-direction a more feasible option for more individuals with disabilities.



About the National MLTSS Health Plan Association

The National MLTSS Health Plan Association (MLTSS Association) represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS), including home and community-based services (HCBS), provided under Medicaid[4]. Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible.

MLTSS Association members are also leaders in integrated care - a system that aligns the delivery, payment, and administration of Medicare and Medicaid benefits for individuals who are dually eligible for both programs.[5]

Our members currently cover the large majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

Learn more at www.mltss.org.

About the Self-Direction Center

The Self-Direction Center is a nonprofit organization focused on strengthening and supporting the self-direction model nationally. The Center elevates participant voices in policy and practice discussions, bridges advocates, states, and other stakeholders, and demonstrates the value and impact of self-direction across systems. The Center is led by a board of directors comprised of over 50% members with lived experience self-directing, and follows an ecosystem approach that centers people with lived experience while engaging all stakeholders to advance self-direction.

Each year, the Center hosts the National Self-Direction Conference, bringing together self-directing individuals, family caregivers, state and health plan administrators, and provider organizations to advance the field.

The Self-Direction Center provides subject matter expertise to the MLTSS Association and plays a critical role in supporting ongoing dialogue on self-direction — including the perspectives of people with lived experience self-directing and other stakeholders beyond this workgroup.

Learn more at www.selfdirectioncenter.org.

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[4] As of August 2026, members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, LA Care, Lakeland Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community Health Choices

[5] What is Integrated Care | Medicare Messenger

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MLTSS Association Member Organizations

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AmeriHealth Caritas
CareSource
CENTENE Corporation
Elevance Health
Humana
independent living systems
Florida community care
L.A. Care Health Plan
LAKELAND CARE
MOLINA HEALTHCARE
Neighborhood Health Plan of Rhode Island
VNS Health
United Healthcare
UPMC Community HealthChoices

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