the self-direction center

National MLTSS Health Plan Association



Member-Facing Supports:

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.

This second brief in the series is 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 document identifies the key barriers to realizing each success driver, and offers targeted recommendations for the layers of the MLTSS ecosystem best positioned to address them: **Federal policymakers** (especially the Centers for Medicare and Medicaid Services - CMS), **states** (especially state Medicaid agencies and related operating agencies), **MLTSS health plans** (also called Managed Care Organizations – MCOs), and **companies that support self-direction** (especially financial management service (FMS) agencies).

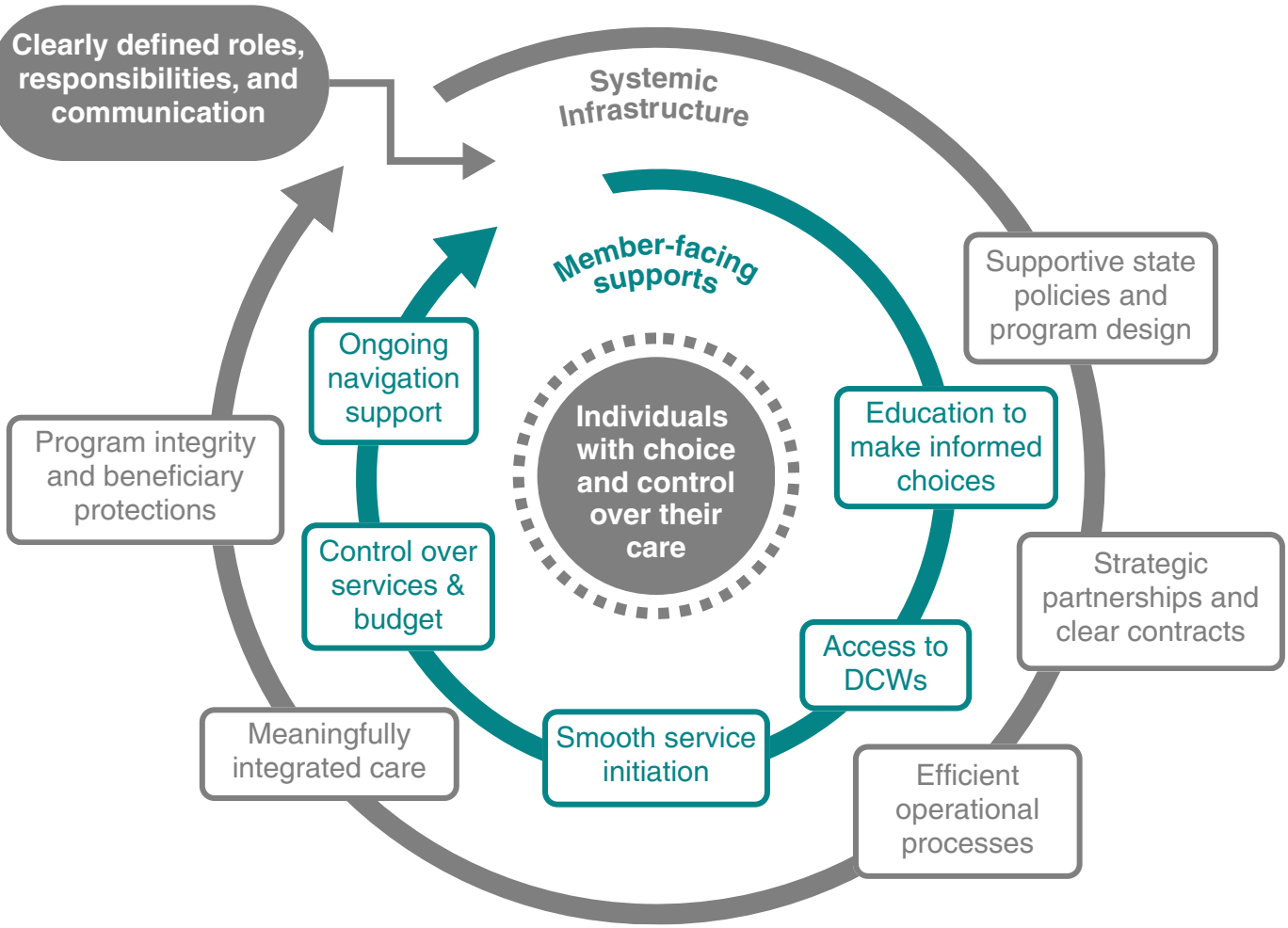
A subsequent brief will discuss the importance of **Systemic Infrastructure** as a necessary foundation for a successful self-direction program, including policies, partnerships and operational processes.

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 increasing risks for self-direction participants. Additionally, improving the Member-Facing Supports is not sufficient alone - program success also depends on the Systemic Infrastructure addressed in the companion document. Stakeholders are encouraged to use both documents together when assessing and strengthening their self-direction programs.

Member-Facing Supports in a Successful MLTSS Self-Direction Program

Most people could be successful in self-direction if they consistently received the right supports - education, access, expediency, training, choice & control, and ongoing navigational assistance. As outlined in the National MLTSS Health Plan Association's recent publication, ***Self-Direction 2.0: Advancing Self-Direction in a Managed Long-Term Services and Supports (MLTSS) Ecosystem***, these specific member-facing supports are vital to ensure the successful implementation of self-directed programs under a managed LTSS construct.

Graphic 1. Self-Direction 2.0 Framework: Member-Facing Supports that Drive a Successful Self-Direction Program within Managed LTSS



Members are successful in self-directed programs when they are empowered through: education and exposure to various service and model options to make informed choices; access to qualified direct care workers (DCWs)[1] who align with an individual's person-centered needs, goals, and preferences; seamless processes for initiating services; tools and resources to support personal autonomy and responsible control over one's services and budget; and ongoing assistance to successfully navigate the complexities of self-directing HCBS.

At the center of the model are **Individuals with choice and control over their care**. At its core, self-direction is a model that empowers individuals with the greatest degree of choice and responsibility in directing their own care within the spectrum of HCBS. Member agency is central to self-direction, and that same principle extends to the systemic level, where members must be meaningfully engaged in the design and evaluation of self-direction programs. This is the central guiding principle of our framework - that the role of any professionals operating a self-direction program is not to determine what's best for members, but to equip them to direct that determination themselves.

States have significant discretion in how they design their self-direction programs, and those design decisions have a direct impact on how member-facing supports are delivered. Certain elements are common to all Medicaid-funded self-direction programs – including a person-centered planning process, a care management function, a requirement for some form of financial management services (FMS), and a requirement for some form of information and assistance (I&A)[2]. However, the way these required elements are structured varies across states, with implications for each of the barriers and recommendations included in this brief. It is important to read this brief, as well as the accompanying brief on **Systemic Infrastructure**, within the context of each state's particular program design choices.

Drivers and their Rationale, Barriers, and Recommendations

Driver: Education to Make Informed Choices

Rationale:

"I have the information I need to decide if self-direction is right for me."

All eligible MLTSS members should receive education about self-direction that is timely, relevant, accessible, and meaningful. During person-centered planning, individuals should be encouraged to explore the potential benefits of self-direction based on their own goals and circumstances. Individuals who consider self-directing their care must have the information they need to make informed choices, from deciding whether to initiate self-directed services to maintaining their services and making changes as desired.

[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.

Barriers:

- **Perceived Complexity:** Members and their caregivers may assume that self-direction is "too much work" or "not for someone like them." This may be due to a lack of awareness about resources available to support them; for example, they may not realize that they can appoint a representative or access I&A supports.
- **Limited Staff Capacity:** MLTSS care managers and/or service coordinators, who are responsible for educating members and their families on self-direction models and options, may lack accurate information, substantive training, or the bandwidth to be able to adequately counsel, promote or support members on how to pursue self-direction. Offering the option to participate in self-direction is often one item on a very long list of discussion points that they are required to cover during a member visit.
- **Fatigue:** The process of completing a comprehensive assessment and developing a person-centered plan can take hours, including an overwhelming volume of new information and terminology. MLTSS members may not have the energy to thoughtfully process information about self-direction by the time it is discussed.
- **Insufficient or Inaccessible Resources:** Currently, there are no federal requirements that states provide consistent, structured information about self-direction at the time individuals are found eligible for HCBS, and no universal standards exist to ensure that informational resources for members to facilitate informed choice around self-direction are digestible and accessible. State requirements for MCOs may lack specificity about how information about self-direction is disseminated or use channels that are not sufficiently relevant and accessible. For example, a state may require MCOs to include information about self-direction in their member handbook, a lengthy document that members may not read, or in a member portal that few members access.

Recommendations by Entity:

Federal Policymakers	• **Standardize "Informed Choice" processes and disclosures at the point of HCBS eligibility & intake**. Clearly explain the differences between agency-directed and self-directed models, the rights and responsibilities of each, and how to enroll before an individual's service delivery model is determined. • **Promote a balanced presentation of service delivery options.** Set standards for person-centered service planning to ensure that individuals are educated about and affirmatively offered self-direction and that the individual's preference is documented and honored. • **Mandate plain-language, accessible informed choice materials in multiple formats and languages.** Consider providing model materials through the HCBS Technical Assistance Center to reduce state burden. Require that States review and update materials no less than every two years.

Federal Policymakers	• **Embed informed choice counseling quality in existing state HCBS oversight mechanisms.** Define standards for what constitutes adequate disclosure, documented individual preference, and access to ongoing supports. Require states to report annually on the percentage of HCBS-eligible individuals who were offered self-direction, accepted it, and are actively enrolled, disaggregated by population and program. • **Provide additional funding to enhance AAAs' & CILs' ability to proliferate self-direction awareness and best practices.** Provide additional funding and technical assistance to Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) to expand their capacity to promote self-direction awareness and disseminate best practices across aging and disability networks.
States	• **Require a balanced presentation of service delivery options.** Require as part of their person-centered service planning processes that individuals are educated on and affirmatively offered self-direction and the individual's documented preference was honored. • **Establish clear expectations around self-direction disclosure.** States should embed explicit, auditable requirements into all contracts related to MLTSS self-directed models – specifying when disclosure must occur (at HCBS enrollment, at annual reassessment, and upon any significant change in functional status), who is responsible for such disclosure, what must be covered (available self-direction models, budget methodology, employer responsibilities, and available supports), in what format (plain language, accessible, multilingual), and how it must be documented in the member's record. • **Include self-direction as a required training topic for health plan care managers and define standards for self-direction enrollment counseling.** MLTSS health plans should provide this training to their care managers on an annual basis. Training standards should be informed by feedback from individuals who did and did not choose to self-direct. • **Ensure documentation of outreach and enrollment plans specific to self-directed models.** Beyond disclosure at the point of contact, states should require a self-direction outreach and enrollment plan among MLTSS health plans and any other vendors involved in member outreach and education. States should review and approve these plans as part of the annual contract oversight cycle, ensuring appropriate resources are budgeted to fulfill stated outreach and enrollment activities. • **Review and approve all self-direction member materials.** This review could include choice disclosure documents, orientation packets, care manager orientation script, and employer responsibility guides - prior to distribution and within 60 days of any program change. Materials should meet plain-language

States	standards and be ADA-accessible. ◦ If the state is responsible for creating member education materials, they must ensure that these materials are high-quality and developed with input from subject matter experts.
MLTSS Health Plans	• **Provide annual comprehensive self-direction training for care managers.** MLTSS health plans should provide all care managers with training content that is responsive to the concerns and barriers care managers themselves may have about introducing self-direction. Training should include: ◦ Instruction on how discussions about self-direction can fit into the person-centered planning process, including any suggested scripts or member-facing resources; ◦ The importance of presenting options and providing information to members in a neutral and unbiased manner; ◦ Clear information on how they can find answers to questions that arise; and ◦ Information on members' option to appoint a representative to manage services on their behalf. • **Develop and maintain comprehensive, accessible self-direction member orientation materials that are reviewed annually.** These materials should include a documented process for the member orientation process, including who is orienting them, what the care manager's role is in the orientation, and what other supports are available. These orientation materials should also include an accessible reference guide for members with answers to commonly asked questions. ◦ It is essential that these materials meet individuals where they are and are not overly burdensome. A standard decision-making tool that can be adjusted to provide different levels of detail based on an individual's readiness may be appropriate. ◦ Member orientation materials could include peer support resources and/or testimonials from individuals who have chosen self-direction. • **Integrate a balanced presentation of self-directed and agency options into the person-centered planning process.** Ensure care managers share realistic timelines for starting self-directed services and explain whether agency services can be used in the interim. MLTSS health plans should follow up with members who expressed interest in self-direction but began with agency services. • **Document and track whether self-direction was offered and the member's stated preference at regular intervals.** MLTSS health plans should also consider tracking data on members' stated reasons for choosing or not choosing self-direction to better understand who is using this model and why

Companies that Support Self-Direction (FMS agencies)	• **Support the entity that holds the primary member education role.** If the FMS entity is not in the primary role for member education, it should seek opportunities to provide support. The goal is to ensure that whoever is introducing self-direction provides sufficient information to empower an individual to make an informed choice about participating in self-direction. FMS agencies can support consistent initial education by creating a fact sheet of commonly asked questions. • **If within the scope of work for FMS/FEA providers within a state's program, provide clear, plain-language materials** explaining each step of the self-direction process, member rights, and budget management, that can be used not only during service orientation but at touchpoints throughout an individual's time self-directing their care. FMS agencies can also provide realistic insight into what it means to be an employer in self-direction.

Driver: Access to DCWs

Rationale:

"There are people available to provide the care I need."

A sufficient supply of DCWs is essential to ensuring that individuals can achieve their goals outlined in their person-centered service plans. While some may choose to employ a family member or someone else they already know, self-direction programs must afford all participants the ability to recruit their own DCWs. Restrictive policies may inhibit individuals' ability to select the worker(s) of their choice and can limit meaningful choice over workers. Instead, self-direction requires adequate wages, employee benefits, and other incentives to attract and retain potential workers.

Barriers:

- **Workforce Shortage:** The nation is struggling with an unprecedented crisis in the HCBS workforce, with too few DCWs to meet the growing needs of an aging population. This crisis may be exacerbated by the implementation of Medicaid work requirements and other Federal policy changes. Members may need DCWs with particular skills and language abilities to meet their needs. Current shortages of DCWs have led to an overreliance on family caregivers, even when this is contrary to the interests or preferences of an individual. Conversely, some states do not permit the hiring of a family member even when it is the individual's choice and the family member is the most appropriate person available to provide support.
- **Insufficient Recruiting Resources:** Members who don't already know of someone that can support them as a DCW often have a hard time finding one. Few self-directed programs possess the infrastructure customized to support members in self-directed models to recruit, identify, and secure qualified DCWs. Most states and plans lack a centralized repository of information for members to learn about available DCWs and provide varied levels of assistance to members in identifying qualified candidates.

- **Lack of Training/Education:** Gaps exist in available training and educational materials for DCWs supporting members who choose to self-direct their services, and a lack of recognition or funding to support member-designed training for DCWs based on person-centered needs, goals and preferences.

Recommendations by Entity:

Federal Policymakers	• **Provide technical assistance and funding to states to improve members' access to available DCW workforce.** Continue to partner with the Administration for Community Living to offer technical assistance to states to support the development, expansion, and enhancement of models for matching members in self-direction with qualified workers. • **Explore mechanisms (i.e. allowable budget uses and technical assistance on public authority models) to provide benefits to DCWs.** Identify existing vehicles for states to extend health insurance access, paid leave, and other benefits to self-directed workers without disrupting the participant's employer relationship. • **Allow pre-employment costs to be covered under self-direction budgets.** These pre-employment costs may include costs associated with onboarding DCWs, including background checks. • **Require states to include back-up worker planning.** Include this as a mandatory component of person-centered service plans for all self-directed beneficiaries, with specific guidance on how FMS entities and I&A supports should facilitate this.
States	• **Support members to find qualified DCWs appropriate to their needs & preferences.** Collaborate with MLTSS health plans, FMS, I&A, and other partners to invest in centralized platforms, matching registries, or other digital mechanisms to assist members who wish to self-direct in identifying and recruiting qualified, available DCWs. Provide marketing and outreach to maximize adoption and encourage users to keep their information up-to-date. Ensure that these resources are regularly improved with feedback from individuals who self-direct and DCWs. • **Create peer-to-peer opportunities for members to share DCW recruitment strategies.** States could create programs and opportunities for peers – individuals who self-direct – to share their recruitment strategies with one another. • **Ensure that rates fully cover requirements of DCWs' jobs.** These requirements include the cost of background checks and required DCW trainings, PTO, and other worker benefits necessary to prevent DCW attrition. These benefits are essential to retain DCWs and to encourage additional entrants to the workforce. States should allow self-direction participants to provide additional training and appropriate benefits to their DCWs under their self-directed budgets.

States	• **Allow members under self-direction to secure appropriate training for DCWs.** There should be a vehicle for DCWs under self-direction to access all state-required trainings in a way that is easy to accomplish and not cost-prohibitive. Individual members and their families should be made aware as part of the self-direction enrollment process of the types of training available to paid and informal DCWs. Resources for training should be an allowable expense within a member's self-directed budget. States should consider creating policies that allow individuals to pay an existing DCW while simultaneously paying a new DCW to shadow them, allowing the newer DCW to learn strategies that are most appropriate for that individual. • **Establish clear back-up plan requirements and assign accountability across MCO and FMS.** States should specify in their contracts the entity responsible for developing, documenting, updating, and activating the back-up plan, and within what timeframe. These back-up plans should allow for the use of agency-directed services without requiring the individual to exit self-direction or give up their self-direction eligibility. • **Require rapid-response protocols for self-direction service gaps. S**tates should require and fund MCOs to establish and maintain a rapid-response protocol for self-direction service emergencies, with defined response times, authority to authorize interim agency-directed services as a bridge, and a post-incident review to make permanent service adjustments, as necessary. It is also important that the state has a designated entity and a clear delineation of roles and responsibilities for who will educate the participant about the options available to them when a rapid response is needed - for instance, when they need to use their back-up plan, or when their back-up plan falls through.
MLTSS Health Plans	• **Support members to find qualified DCWs appropriate to their needs & preferences.** Help members consider whether there are individuals in their lives who they may wish to engage as a DCW. Direct individuals to I&A providers, registries, or other resources to locate available DCWs. • **Utilize care managers to identify barriers individuals face in identifying DCWs.** Care managers have a unique perspective into the challenges members face when trying to identify DCWs and can provide additional support in these situations. Opportunities for innovation are likely to emerge from these conversations. • **Streamline processes for documenting and regularly reviewing back-up plans for when workers are unavailable.** These processes should include training for care managers on how back-up plans are created, who to contact for support, and the role of any other entities with respect to the back-up plan.

Companies that Support Self-Direction (FMS agencies)	• **Support members to find qualified DCWs appropriate to their needs & preferences.** I&A providers should offer sample job descriptions, information about appropriate rates, and other tools and guidance necessary for DCW recruitment. • **Support members in understanding the types of DCW training available and how to access or fund them.** FMS agencies should provide clear, accessible information about available training opportunities for DCWs, including any state- or program-required training as well as optional trainings that may help DCWs better support an individual's specific needs. FMS agencies can also help members identify training that is relevant to their specific needs and preferences. • **Support members to change workers or bring on additional workers without gaps in service.** FMS agencies should establish processes that allow members to add, replace, or increase the hours of DCWs as quickly and seamlessly as possible when staffing needs change. Flexible and responsive processes are particularly important because delays in replacing or adding workers can result in missed services or reduced access to needed supports. • **Collect and share data on onboarding and recruitment trends.** FMS agencies have important insights into the challenges that arise around member and DCW onboarding and recruitment. As possible, and within the contractual constraints, FMS agencies should share trends on workforce-related issues with states and MLTSS health plans.

Driver: Smooth Service Initiation

Rationale:

"I can begin self-directing my care through a simple and straightforward process."

The process to initiate self-direction must be simple and member-friendly. Administrative processes such as background checks should be streamlined and efficient, so as not to delay the initiation of care. Individuals should also have the ability to move forward with hiring a DCW even if they have a positive background check, within limits set by the state. This process should allow individuals the opportunity to self-direct a variety of service options, and the flexibility to use hybrid models that allow for both self-direction and agency-directed services on a short-term or long-term basis. The complexity of these service initiation processes must not be an undue barrier for individuals or their families. When service initiation is not timely, members experience a gap in support or enroll in agency services as a default. Delays also affect DCWs, many of whom cannot afford to go unpaid while onboarding is completed.

Barriers:

- **Inefficient Administrative Processes:** Once DCWs have been identified, often care is still delayed due to various administrative hurdles that must be overcome before workers can begin providing services. Administrative processes such as background checks often take several weeks or months to complete, delaying the member from beginning to receive care.
  - Background check processing time is typically the largest source of delay. In states that require a unique identifier for the worker or employer (e.g., an NPI or state-specific ID), obtaining one can add further time. Members who were previously issued an Employer Identification Number (EIN) may not realize they have one and must recover it from the IRS, which can be a lengthy process. These delays can make agency-directed services the more practical choice even for members who prefer self-direction, since in some states agencies can hire workers provisionally and begin services within days.
- **Volume and Complexity of Documentation:** The complexity of required documentation, especially when services are first initiated, creates undue barriers for members and potential DCWs. Required forms may be in inaccessible formats and use unfamiliar terminology. DCWs and members may be required to provide significant personal and financial information, which can be difficult to gather and uncomfortable to share. As a result, members and/or DCWs may decline to move forward.
- **Lack of Support:** Many members and DCWs need help understanding the requirements that must be met and troubleshooting if there is an issue in the process. This is difficult to navigate without sufficient I&A support and timely assistance from the FMS vendor.
- **Coordination Delays:** In order to initiate services, all of the entities involved (health plans, FMS, I&A, and EVV vendors) typically need to exchange information (e.g., authorizations, eligibility status). Each organization may have a different timeline for doing so; in aggregate, this can significantly delay service initiation.
- **Limited Portability During Transitions:** When a member changes health plans or FMS agencies, or a DCW begins working for a new employer, a full new enrollment packet is typically required. Whether background checks carry over varies by state. When these requirements are not aligned with continuity of care requirements, DCWs may provide services unpaid until clearance is complete, creating back pay complications and financial hardship for workers.

Recommendations by Entity:

Federal Policymakers	• **Establish a minimum floor on onboarding & service initiation.** Provide Federal policy guidance regarding timelines for completing background checks, onboarding approved DCWs, and initiating services. • **Provide technical support & share strategies with states.** Provide technical assistance and training to States on promising practices and innovative approaches to streamlining background checks and onboarding processes for self-direction.

Federal Policymakers	• **Create a federal "right to return to self-direction".** Issue guidance that requires states to fast-track reinstatement into self-direction for individuals who were previously enrolled, with a maximum 30-day reinstatement period and interim service protections. • **Include timely service initiation as a core performance metric.** Enrollment completion, authorization transmission, worker onboarding, and first payment timelines are practical indicators of whether the infrastructure is working for participants and workers.
States	• **Establish minimum floor for onboarding & service initiation.** Administrative processes such as background checks should be streamlined and efficient, so as not to delay the initiation of care. Include requirements as part of state contracts regarding timelines for completing background checks, onboarding approved DCWs, and initiating services. • **Require a structured onboarding protocol for new self-directing members.** States should require a documented onboarding protocol for members newly electing self-direction, including a timeline for completing each step (e.g., FMS enrollment, worker hiring, budget confirmation), assigned responsibility for each step across the MCO, FMS, and I&A entity, with a designated MCO point of contact for onboarding questions. These entities should then be contracted to share and report data collectively on average onboarding completion times to the state quarterly. • **Establish requirements for standardized orientations for individuals as the self-directing employer.** This standard orientation would help to improve compliance and reduce errors. This orientation should include: ◦ EVV; ◦ Program requirements; ◦ Abuse/neglect reporting; ◦ Documentation requirements; and ◦ Member rights. Alternatively, states could offer asynchronous orientation materials, such as videos, a website, or a written guide. • **Ensure a right-to-switch option for members to change service delivery models.** States should establish a contractual right for members to request a change in service delivery model at any point, with a defined maximum processing timeline, and ensure that any such transition requested is fulfilled without requiring a full re-assessment if no significant change in functional status has occurred. This contractual right should also allow individuals to use both service delivery models at once.

States	• **Allow DCWs provisional approval to work, pending background check completion.** Allowing DCWs to begin working pending the completion of their background check supports worker retention and timely access to services. Within limits set by the state, members should be able to choose their DCW even with a positive background check, and members with a pre-existing relationship with the worker should be able to waive background check results up front so services are not delayed. States may retain standard protections when members hire workers with no prior relationship, such as through a registry. • **Invest in faster background check processing.** States should invest in the capacity of the systems that process DCW background checks so results are returned quickly. • **Align continuity of care requirement with reprocessing requirements.** States should ensure that new paperwork or background check requirements during transitions do not prevent DCWs from being paid for services provided during continuity of care periods.
MLTSS Health Plans	• **Designate a liaison to monitor and troubleshoot any issues with transferring authorizations to the FMS.** MLTSS health plans should designate a point of contact responsible for monitoring the transition from service authorization to FMS implementation and resolving issues that could delay service initiation. The liaison should coordinate with the member, FMS agency, and relevant plan staff when authorization information is incomplete, inaccurate, or not received by the FMS, and should help resolve discrepancies without requiring the member to navigate multiple entities. • **Ensure smooth transfers for individuals moving from another health plan.** MLTSS health plans should have systems in place to smoothly transition new members who self-direct their care from other health plans. This includes coordinating with the FMS to minimize repeat paperwork and ensure DCWs continue to be paid during continuity of care periods. • **Monitor onboarding time and consider including a performance standard in FMS contracts.** MLTSS health plans should track the amount of time between authorization and successful FMS onboarding, including the time required for authorization information to be transferred and for an individual's DCW(s) to complete necessary enrollment and onboarding requirements. Plans should use this information to identify recurring sources of delay and opportunities to improve the service initiation process. Where appropriate, states and health plans should consider establishing a defined performance standard for FMS onboarding in contracts, with expectations for timely processing and mechanisms for monitoring performance and addressing persistent delays.

MLTSS Health Plans	• **Clearly define background check responsibilities in FMS contracts.** Where provisional hiring is allowed, contracts should specify that the FMS is responsible for monitoring results and pausing or stopping payment if a worker is disqualified.
Companies that Support Self-Direction (FMS agencies)	• **Develop clear onboarding checklists for members and their DCWs.** FMS agencies should provide members and DCWs with simple, accessible checklists that outline each step required to begin employment, including required forms, identification numbers, background checks, training, timesheet or EVV requirements, payroll enrollment, and any other applicable program requirements. • **Prioritize prompt processing of background checks and payroll setup to prevent service delays.** FMS agencies should establish processes to initiate and process required background checks, employment documentation, and payroll setup as quickly as possible once a member selects a DCW. Agencies should communicate any outstanding requirements to the member and DCW and proactively address issues that could delay clearance or payroll enrollment. • **Communicate status updates to members, MCO care managers, and I&A entities/support brokers throughout the process.** FMS agencies should provide timely updates on the status of DCW enrollment and identify any outstanding requirements or barriers to service initiation. Communications should identify what steps have been completed, what actions remain outstanding, who is responsible for the next step, and when the next update can be expected. • **Monitor background check results for provisionally hired workers and promptly pause or stop payment if a worker is disqualified, notifying the member and health plan.** Where state requirements permit DCWs to begin providing services while a background check is pending, FMS agencies should establish processes to monitor the status and results of those checks. If a worker is determined to be ineligible to provide services, the FMS agency should promptly follow applicable requirements to stop or pause payment, notify the individual and MLTSS health plan, and provide guidance about the steps needed to address the situation and maintain continuity of authorized services. • **Maintain data on onboarding time; analyze trends and make process changes as needed.** FMS agencies should track key measures of the onboarding process, such as the time from receipt of an enrollment request to completion of background checks, payroll setup, and authorization to begin billing. FMS agencies should use these findings to make targeted process improvements and share relevant performance information with states and MLTSS health plans as appropriate.

Driver: Control Over Services & Budget

Rationale:

"I have control over how my care is delivered."

In self-direction, individuals in employer authority have decision-making authority over who provides their care, whereas in budget authority individuals have the ability to allocate more or less funding toward certain services, set higher wages, and mix and match services within the available resources. Under all self-direction program structures, individuals must be supported to exert the control and responsibility afforded to them to ensure that they receive the care they need.

Barriers:

- **Social Barriers to Self-Determination:** Members may face pressure from family members, guardians, care teams, or broader system norms that influence service and spending decisions. When the preferences of others are prioritized over the individual's goals and choices, which should be included in their person-centered care plan, members may have limited ability to exercise meaningful control over their services and accept reasonable levels of risk consistent with self-direction.
- **Lack of Accessible Service Management Tools:** To maintain control and make informed decisions, members need real-time, accessible ways to track their services and expenses relative to available hours and/or budget dollars.
- **Limited Flexibility in Service Delivery Models:** Few states allow members who wish to self-direct some but not all services the flexibility to use hybrid models (self-directed + provider-managed) on a short-term or long-term basis. The lack of hybrid options and flexibility can restrict MLTSS care managers and members' ability to tailor services to the members' needs, goals, and preferences.
- **Administrative Complexity and Disruptions:** Missed reassessments, delayed renewals, payroll errors, and documentation mistakes drive unintended disenrollment from self-direction. Without a federally required onboarding period when individuals first elect self-direction, members may not understand key processes in maintaining control of their self-directed care, leading to errors on timesheets, daily service logs, and plan documentation.



Recommendations by Entity:

Federal Policymakers	• **Provide technical assistance to states on improving person-centered planning processes and service models for members who self-direct.** CMS should share examples of state practices that emphasize self-determination in person-centered planning processes, support care managers in mediating conflicts of interest in the planning process and offer flexibility to members to self-direct some services while simultaneously relying on some traditional provider models. • **Establish proactive outreach requirements to support participants when facing administrative disruption.** Require that individuals be notified of upcoming administrative deadlines at least 60 days in advance and offered I&A support in completing required documentation. Also, prohibit service termination based solely on administrative non-compliance without documented outreach attempts. • **Strengthen grievance, appeals, and advocacy access for self-directing members.** Require states to establish grievance tracks specific to self-direction, with defined timelines, accessible formats, and a requirement that individuals be offered support broker or independent advocate assistance when filing a grievance or appeal.
States	• **Strengthen the person-centered planning process.** States should assess their current person-centered planning processes to identify areas of strength and weakness. States should focus on the areas in the process that could be strengthened to ensure that the social barriers to self-direction are identified and addressed. • **Assess the service code array for usability.** States should review their current service codes to ensure they have the most succinct array of service codes possible, and assess how their service array affects usability and accessibility for individuals who self-direct. • **Create member-friendly guides on service options and budget planning resources.** The state should create resources that MLTSS health plans and FMS agencies can disseminate to their members on service options and budget planning. Having these resources created by the state ensures that the information provided is consistent across health plans, programs, and FMS agencies. • **Require accessible, real-time service and budget management tools.** The state should establish systems that provide individuals with real-time, accessible ways to track their services, and an easy-to-use budget process. States can create these tools and systems themselves or include these services in contracts with MLTSS health plans and/or FMS providers.

States	• **Establish a "no wrong door" approach for back-up plan creation and updates.** Within self-direction, all stakeholders should be prepared and able to engage with individuals to develop, review, and update their back-up plans. States should establish an expectation that there will be a "no wrong door" approach to these conversations – if an individual engages with someone from their MLTSS health plan or FMS agency to discuss back-up planning, there must be systems in place to ensure those decisions are captured.
MLTSS Health Plans	• **Train care managers on the roles, tools and resources that support budget and employer authority.** MLTSS health plans should ensure that care managers know where and how to access existing tools and can direct members to them as necessary. Care managers should educate members on how to access I&A support (such as through a support broker) in navigating these authorities. Care managers should be trained to identify when there are social barriers to self-determination and address these barriers during the person-centered planning process. • **Ensure individuals have access to their person-centered service plan so they understand which services have been approved and can track their usage relative to the units/dollars authorized.** Individuals should also understand who to contact when they need help, especially if the correct contact is not their care manager. • **Educate individuals on how to create and update their back-up plans.** MLTSS health plan care managers should educate members on what is included in their back-up plan, how to access and update it, and who to contact with updates. There should be a "no wrong door" approach to making updates to back-up plans - if a member reaches out to their care manager or other contact with the MLTSS health plan to discuss or update their back-up plan, there should be systems in place to make those updates. MLTSS health plans should review back-up plans with members on a quarterly basis to confirm the plan is still viable. • **Support delivery and distribution of member education materials on service options and planning resources.** MLTSS health plans should work with their states to disseminate state-developed resources on service options and budget planning.

Companies that Support Self-Direction (FMS agencies)	• **Provide members with clear, ongoing communication about budget status, payroll processing, and upcoming deadlines.** FMS agencies should provide members with timely, easy-to-understand information about their available budget, expenditures, payroll status, outstanding documentation, and upcoming deadlines or requirements. FMS agencies should use multiple communication methods, as appropriate to member preferences and needs, to ensure that members have the information necessary to make informed decisions about their services and budget. • **Provide members with a real-time view of available authorized hours and/or dollars.** FMS agencies should provide members with accessible, up-to-date information about their authorized service hours and/or budget, amounts already committed or spent, and remaining availability. Whenever feasible, members should be able to access this information electronically in real time rather than relying on periodic statements or contacting the FMS agency. Information should be presented in a way that enables members to understand how current spending and staffing decisions affect their remaining budget and capacity to maintain services. • **Alert the MLTSS health plan care manager promptly when a member is at risk of disruption due to administrative issues.** FMS agencies should establish processes to identify and promptly communicate situations that could jeopardize a member's ability to receive authorized services, such as insufficient available funds, missing documentation, payroll problems, unresolved enrollment issues, or other administrative barriers. • **Support workers and members to resolve issues or inconsistencies in EVV and payroll data.** FMS agencies should provide timely, accessible assistance to members and DCWs when EVV records, timesheets, authorized hours, or payroll information do not align. FMS agencies should explain the source of discrepancies, identify any action required to correct them, and establish processes for resolving issues without unnecessary delays in payment or interruption of services. • **Support delivery and distribution of member education materials on service options and planning resources.** FMS agencies should work with their states to disseminate state-developed resources on service options and budget planning. • **Implement a "no wrong door" policy for updating back-up plans.** If a member reaches out to the FMS agency to discuss or update their back-up plan, there should be systems in place to make those updates.

Driver: Ongoing Navigation Support

Rationale:

"I have access to assistance when questions or challenges arise"

Individuals who self-direct their care must have available support from others, who may include trusted friends or family members, care managers, and/or support brokers. Support brokers, who may also be referred to as a "coach," "counselor," or "consultant," are I&A professionals selected by the individual to assist them in navigating the self-direction process. States may direct MLTSS plans to include I&A providers in their networks, deliver I&A through their care management teams, or contract with an FMS vendor to offer I&A. Other health plan staff, including member advocates, member services representatives, and community health workers, may also offer assistance. However it is administered, the support provided must assist the individual to achieve their person-centered goals and must be flexible enough to change over time as the individual's needs change.

Barriers:

- **Insufficient I&A in Program Design:** States are not required to provide a minimum level of I&A support to members and families for navigating self-direction. As a result, members may not have adequate access to support brokerage and other I&A resources. State choices about whether I&A will be offered, how it will be offered (e.g., as its own waiver service, within the scope of care management, or as an administrative activity), and how it will be funded constrain what MLTSS plans can offer. For example, when I&A is offered as a waiver service and it is optional, individuals may choose not to use it even when they would benefit substantially - because they would rather prioritize their budget dollars for staff time. It is important to investigate if I&A is designed in such a way that people can actually use it without feeling that they are making a very difficult trade-off, and if it is robust enough to deliver what individuals need.
- **Inconsistent Quality of I&A Support:** There are no universal minimum qualifications, training standards, or competency frameworks for the support broker role, nor a clear standardized scope of practice. Combined with varying state approaches and contract limitations, MLTSS plans often do not have quality oversight and network management options for I&A to ensure consistent, high-quality member support. As a result, members will not receive the responsive, competent assistance they need.
- **Conflicting Incentives:** FMS vendors may be tasked to provide I&A to support members' decisions around services, in addition to core financial management functions. Additionally, MLTSS plans or care management entities may be tasked to both authorize covered services and provide I&A. Such overlapping roles can create a structural conflict as the entity helping a beneficiary navigate their services also approves or financially manages those services. Members who need help working through a complicated situation may be encouraged to switch to an agency-directed model or make other service changes.

- **Lack of Peer Support:** Lived experience is among the most effective tools for informed decision-making and troubleshooting issues that arise, yet peer support specialists are rarely formally embedded in I&A infrastructure. Unfortunately, MLTSS peer support and member advocate positions are often underfunded or seen as discretionary.
- **Generic Escalation Paths:** The HCBS waiver application requires states to outline a fair hearing process and indicate whether they will include a dispute resolution process and grievance system. However, grievance processes specific to self-direction — including disputes over budget calculations, denials of self-direction eligibility, or FMS payment delays — are inconsistently structured across states. Members may lack effective resolution avenues that reflect the inherent nuances and policy details involved in self-direction.

Recommendations by Entity:

Federal Policymakers	• **Establish competencies and training requirements for I&A professionals.** At a minimum, require states to train I&A professionals on the full suite of HCBS authorities available in the state, employer of record responsibilities, person-centered planning, conflict of interest recognition, and crisis navigation. • **Define minimum competency standards for I&A support entities.** Fund training infrastructure, clarify allowable roles, and offer clear guidance to prevent conflicts of interest between I&A, care management, and FMS functions. • **Include peer support specialist roles within I&A infrastructure.** Explicitly authorize peer support specialist roles as an allowable Medicaid I&A activity and provide technical assistance on how states can fund and credential this role.
States	• **Specify I&A professional qualifications and training standards.** Define the minimum competency standards for I&A professionals, including knowledge of all self-direction programs available in the state, person-centered planning principles, employer of record responsibilities, and conflict of interest recognition. • **Provide access to I&A resources that are independent of the MCO and FMS.** States should ensure that members who elect self-direction have access to I&A support that is independent of the MLTSS health plan and FMS agency, whether through separate contracted entities or with appropriate firewalls and staffing in place. MLTSS health plans should have discretion to contract with qualified I&A providers, or at a minimum, be included in the state's process to select state-contracted I&A vendors.

States	• **Require proactive administrative deadline management for self-directing members.** States should require proactive outreach systems that notify self-directing members and their representatives of upcoming administrative deadlines at least 60 days in advance, offer care manager or support broker assistance in completing required actions, and document outreach attempts. • **Conduct annual self-direction member experience surveys.** States should ensure that a member experience survey that covers self-direction is administered annually. This survey should ascertain whether members felt adequately informed about self-direction, whether they felt they could change their service model if desired, whether I&A support was accessible and helpful, and whether administrative processes were manageable. • **Create pathways to embed peer support within self-direction program design.** Individuals who self-direct should have access to peer support specialists with lived experience where feasible, whether through their health plan or I&A entity, or both. Such support should be considered in setting rates for MLTSS health plans and/or I&A entities.
MLTSS Health Plans	• **Train care managers on navigation support resources.** Care managers should be aware of what I&A looks like in their particular program, who delivers it, and who their members should contact for support. The MLTSS health plan care manager should be responsible for facilitating a warm referral to the I&A entity within a specified timeframe, with documentation that the connection was made. Care managers should also know when to contact the I&A entity directly and how to include I&A personnel in the person-centered planning process. • **Monitor I&A/support broker availability and responsiveness to inform vendor/network changes;** if support brokers are contracted directly with the state, escalate access issues and share performance data with the state. • **Train staff who are involved in the complaints, appeals, and grievances processes on the nuances of self-direction.** Ensure staff have access to self-direction subject matter experts and know when and how to contact the I&A and FMS agencies. Document policies and procedures and consider auditing processes to continuously improve.

Companies that Support Self-Direction (FMS agencies)	• **Ensure appropriate firewalls are in place to avoid conflicts of interest.** If an FMS agency contracts to provide both FMS and I&A services, ensure adequate firewalls are in place to avoid conflicts of interest. • **Provide robust training and sufficient access/staffing for customer service representatives.** Robust training will help ensure customer service responsiveness when issues arise. Responsiveness should be measured, and FMS providers should collect feedback on whether customer service is actually working well for members. • **Train FMS staff to recognize when a member needs additional navigational support and make appropriate referrals to support brokers or MLTSS health plan care managers.** FMS staff should also proactively escalate any significant concerns about member safety and/or capacity to continue self-directing.

Next Steps

When the right member-facing supports are in place, members can successfully self-direct their services within an MLTSS ecosystem. All self-direction programs benefit from direct member engagement in program development and continuous improvement efforts. Such engagement is beneficial at all levels of the system – informing state program design, MLTSS health plan policies, and vendor processes. Inconsistent policies across states, passed through to MLTSS health plans, result in inconsistent member access to and experience with self-direction.

Policymakers at the state and federal levels can work with MLTSS plans and self-direction vendors to ensure that:

- All members have the information they need to make informed choices about participating in self-direction, onboarding workers, and managing their services and budgets;
- Essential member resources, such as I&A support and accessible tools and materials, are sufficiently funded to support member access and control;
- Administrative processes, especially during service initiation, balance the need for documentation and oversight while minimizing burden on members and their DCWs; and
- Members receive high-quality support from all individuals and vendors involved in their self-directed services.

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[3]. 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.[4]

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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[3] 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

[4] What is Integrated Care | Medicare Messenger

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