

A photograph of two people, a man and a woman, in a grocery store. The man, on the left, is wearing a black jacket over a blue and white striped shirt and glasses. The woman, on the right, is wearing a red puffer jacket. They are both looking at a box of food that the woman is holding. In the background, there are shelves stocked with various grocery items. A shopping cart is visible in the foreground.

Self-Direction 2.0 Framework:

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

October 2026

Throughout 2025 and 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 policy development. We recognize that the positions included in these briefs represent the perspectives of our workgroup, and we welcome collaboration with other stakeholders to continue the discussion of the ideas and challenges raised.

Defining Self-Direction

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.

In Medicaid-funded home and community-based services (HCBS), there are two prevailing models of self-direction: Employer Authority and Budget Authority, and states may choose to operate programs with one or both models. The Center for Medicare and Medicaid Services (CMS) defines these models as: ¹

Employer Authority	Budget Authority
- Under Employer Authority, the participant is supported to recruit, hire, and direct the workers who furnish supports. - The participant functions as the common law employer or the co-employer of these workers. - When employer authority is utilized, the participant, rather than a waiver provider agency, carries out employer responsibilities for workers.	- Under Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. - Depending on the dimensions of the budget authority that are specified in the waiver or state plan amendment/benefit, this authority permits the participant to make decisions about the acquisition of waiver/benefit goods and services that are authorized in the waiver/benefit service plan and to manage the dollars included in a participant-directed budget.

¹ [Understanding Budget Authority in Self-Directed Home and Community-Based Services | CMS](#)

As individuals or their representatives take on greater control and responsibility in self-direction programs, they receive support in the form of **Information & Assistance (I&A)** and **Financial Management Services (FMS)**. CMS requires states to provide or arrange for the provision of I&A to support individuals – in accordance with their needs and desires – to develop a person-centered service plan and budget, manage their services and DCWs, and perform their responsibilities as an employer². FMS providers serve as fiscal intermediaries, providing administrative support and ensuring program integrity. In addition to handling payroll, FMS agencies must assist beneficiaries in understanding their billing and documentation responsibilities, benefits services, purchasing goods and services, and monitoring the beneficiary's self-directed budget.³

What is Information and Assistance?

I&A supports the participant (or their representative) in arranging for, directing, and managing services. Typically, it includes providing information on recruiting, hiring, and managing workers as well as ensuring participants understand the responsibilities involved with directing their services. States decide whether I&A will be provided within the scope of care management, as its own waiver service, or as an administrative activity.¹ In MLTSS, depending on the state's chosen structure, this could mean that plan care managers may be asked to play this role, plans may include I&A entities (such as Support Brokers) as part of their provider network, they may contract with an FMS to provide I&A in addition to their other services, or plans may offer it as a value-added benefit.

There are also two primary models of delivering FMS in self-direction programs - **Fiscal/Employer Agent (F/EA)** or **Agency with Choice (AWC)**:^{4,5}

Fiscal/Employer Agent	Agency with Choice
• The individual self-directing their services is the legal employer of their DCW(s). • The individual is responsible for performing employer-related tasks, including hiring, supervising, and firing their employees. • The FMS agency supports the individual by processing DCW payroll and taxes.	• The FMS agency is the legal employer of the DCW(s), and the individual self-directing their services is the co-employer (or managing employer). • The individual manages the day-to-day activities and the FMS is responsible for processing payroll and taxes, and may perform tasks including DCW recruitment, interviewing, training, and management.

² [Key Components of Self-Directed Services - HCBS Self-direction Series | CMS](#)

³ [Chapter 5: Self-Direction for Home- and Community-Based Services | MACPAC](#)

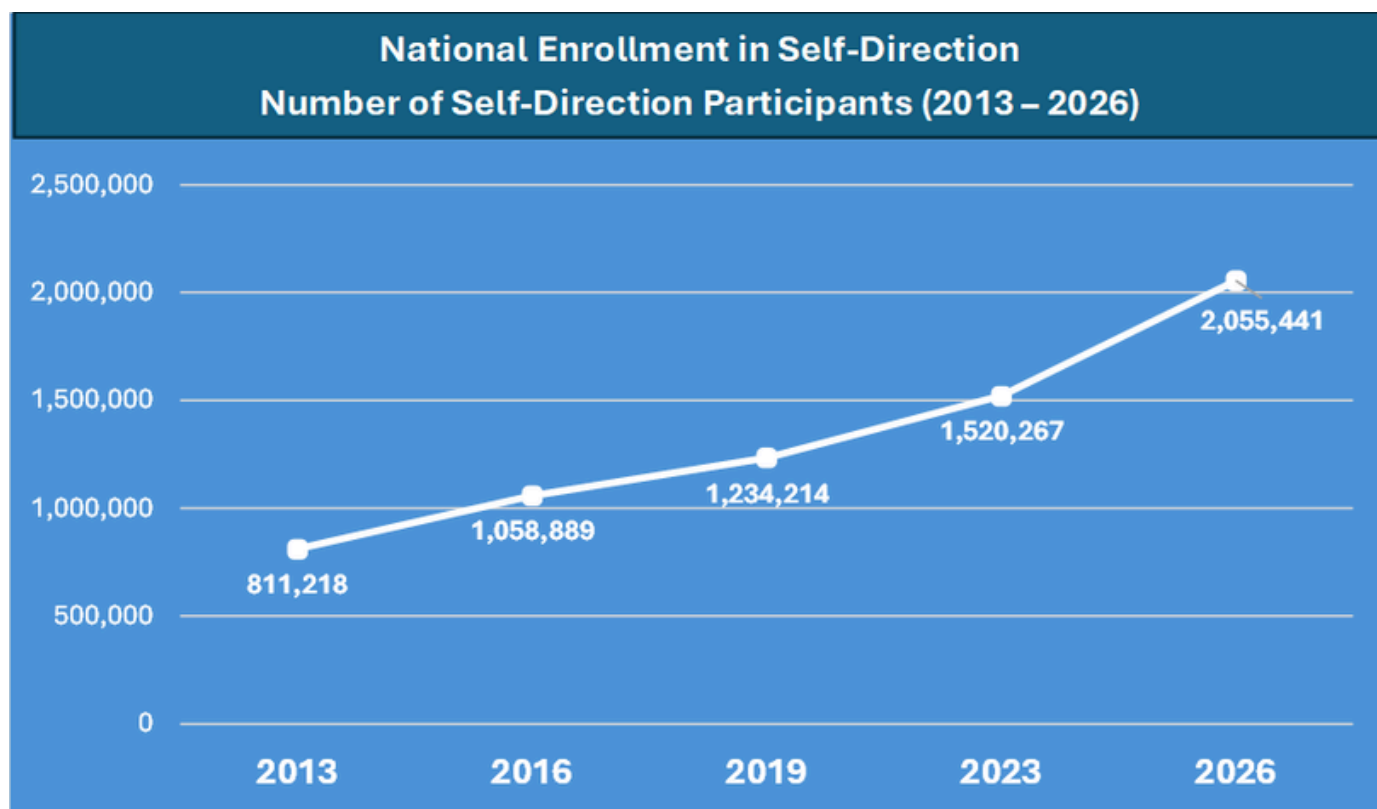
⁴ [Chapter 5: Self-Direction for Home- and Community-Based Services | MACPAC](#)

⁵ [Fiscal/Employer Agent \(F/EA\) Core Standards | Applied Self-Direction](#)

Growth of Self-Direction

Self-direction emerged from the success of the Cash and Counseling demonstration, which ran in 15 states between 1996 and 2013. This program began as an 1115 waiver demonstration in which HCBS-eligible participants received an allowance for personal assistance services instead of agency-directed services. Evaluations of this demonstration showed that participants reported higher satisfaction and quality of life than individuals receiving agency-directed services ⁶, and that the demonstration expanded participants' access to paid caregiving services, and increased income and outcomes for family caregivers – with only modest overall increases in Medicaid spending that were partially offset by decreased costs on nursing facility services and home health services. ⁷

Enrollment in self-directed models has doubled over the past 10 years – from 811,218 individuals in 2013 to over 2 million in 2026. ⁸ New flexibilities introduced during the COVID-19 Public Health Emergency (PHE) made self-direction more feasible for individuals and contributed to this growth in program participation.



⁶ [Chapter 5: Self-Direction for Home- and Community-Based Services | MACPAC](#)

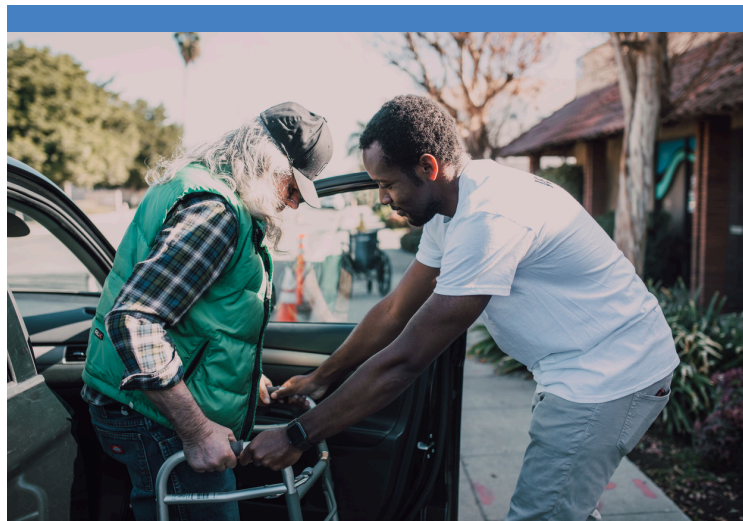
⁷ [Commentary: Social Experimentation at Its Best: The Cash and Counseling Demonstration and Its Implications | PMC](#)

⁸ [National Inventory of Self-Directed Long-Term Services and Supports Programs, 2026 | AARP](#)

As states continue to balance limited budgets with the need to provide high-quality HCBS to a greater number of eligible individuals, self-direction will continue to be a vital tool for ensuring that people with disabilities can access the services they need when they need them.

Self-Direction within MLTSS

MLTSS is the predominant service delivery model for LTSS in the United States, with programs in about half of states, accounting for almost 60% of Medicaid-funded LTSS users. Within the MLTSS model, individuals have access to care managers who help them navigate services, develop person-centered plans, and connect them to needed community resources. These care managers serve as an added layer of support – helping individuals understand their options and make informed decisions about their care, including exploring whether they would like to participate in self-direction.



MLTSS programs offer more opportunities for robust data collection and reporting across LTSS, acute, and behavioral health services compared to traditional fee-for-service models. Because MLTSS health plans are often accountable for the total cost of care for their members, they have financial and operational incentives to utilize the data they collect to provide high-quality and cost-effective care. In many states, MLTSS has emerged as a primary mechanism to rebalance their LTSS expenditures from institutional care to home and community-based settings. Self-direction can further support this movement to community-based care by expanding caregiving options available to individuals outside of institutional settings.

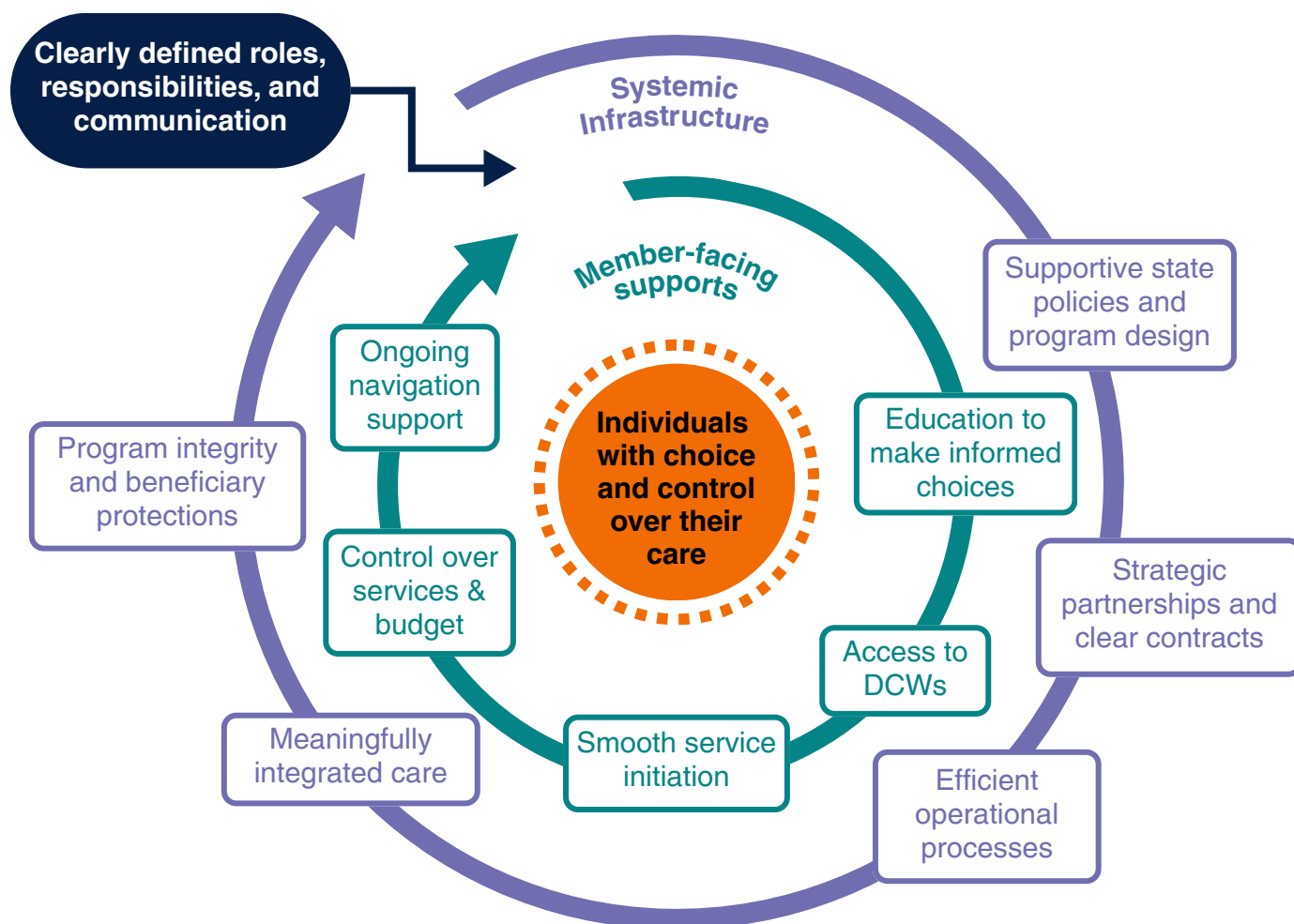
Managed care also creates opportunities to deliver innovative and flexible solutions to support individuals who self-direct their care. MLTSS health plans can offer value-added benefits or additional supports beyond what is required. MLTSS health plans frequently invest in workforce development and training within the communities they serve, helping to strengthen and expand the direct care workforce. Additionally, value-based arrangements between MLTSS health plans and FMS agencies offer new avenues to reward high-quality services, improve outcomes, and create incentives that do not exist under traditional fee-for-service models..

Self-direction empowers individuals to have more control over how their care is delivered, resulting in care that is more tailored to the individual's needs and preferences. Importantly, this personalized care also serves as a deterrent to potential fraud, waste, and abuse (FWA). As opposed to a traditional agency-directed model, within self-direction, the individual receiving services is at the center of care planning and service delivery, providing a layer of direct oversight. If there are issues with their services, the individual self-directing their care is empowered to take immediate action, with additional support available from their MLTSS health plan. MLTSS health plans have also embedded significant program integrity protections into their HCBS programs, including self-direction.

Self-Direction 2.0 Framework

The MLTSS Association's workgroup developed the framework below that outlines the essential components of self-direction and illustrates how these components work together to drive the program's success.

This framework is intentionally structured to keep the **individual at the center of all decision-making**; the ultimate goal is for individuals who need LTSS to have choice and control over their care. All aspects of this framework are aligned with the principles of person-centeredness and intended to ensure access to high-quality HCBS. The second circle in this framework includes the **Member-Facing Supports** required to empower individuals with the information, tools, and assistance they need to make informed decisions and seamlessly carry them out. The outer circle in this framework includes the **Systemic Infrastructure** that supports successful self-direction programs, including policies, partnerships and operational processes. Running across the entire self-direction framework is the need for **clearly defined roles, responsibilities, and communication** across states, MLTSS health plans, FMS and I&A agencies, DCWs, families, and the individual self-directing their services.



Key Drivers of an Ideal MLTSS Self-Direction Program

Below, we provide additional context for each of the key components that drive towards an ideal self-direction program within MLTSS:

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.

Member-Facing Supports

Education to make informed choices

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. This information must be provided to all eligible individuals without bias.

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

Access to DCWs

A sufficient supply of DCWs is essential to ensuring that individuals can choose workers to achieve the 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 and workforce gaps may inhibit individuals' ability to select the worker(s) of their choosing. Instead, self-direction requires adequate wages, employee benefits and other incentives in order to attract and retain potential workers.

“There are people available to provide the care I need.”

Smooth service initiation

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. 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.

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

Control over services and budget

In self-direction, individuals in employer authority have decision-making authority over who provides their care, and in budget authority, how their budgeted funding is allocated. 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.

“I have control over how my care is delivered.”

Ongoing navigation support

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 are professionals selected by the individual to assist them in navigating the self-direction process.⁹ States may direct MLTSS plans to include I&A providers in their network, deliver I&A through their care management team, 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 be in service of assisting the individual to achieve their person-centered goals and must be flexible enough to change over time as the individual’s needs change.

“I have access to assistance when questions or challenges arise”

Systemic Infrastructure

Supportive state policies and program design

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 DCWs 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.

Strategic partnerships and clear contracts

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.

⁹ [Chapter 5: Self-Direction for Home- and Community-Based Services](#) | [MACPAC](#)

Efficient operational processes

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 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.



Meaningfully integrated care

More than half of individuals who receive Medicaid-funded HCBS are also eligible for Medicare.¹⁰ 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.

Program integrity and beneficiary protections

Strong safeguards are necessary to protect MLTSS members and ensure compliance with program requirements, while preserving member autonomy. Effective oversight will prevent and protect against fraud, waste, and abuse, while ensuring individuals receive necessary services safely, without creating barriers to program participation. 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. MLTSS health plan care managers make in-home visits and are trained to identify issues to ensure members are getting the care they need without being exploited or harmed. States and plans must have clear pathways for investigating and escalating concerns about member safety.

¹⁰ [Who Uses Medicaid Long-Term Services and Supports? | KFF](#)

Clearly Defined Roles, Responsibilities, and Communication

An understanding of and commitment to the philosophy of self-direction across all stakeholders is the foundation of successful self-direction programs. With this understanding, stakeholders can clearly define and execute their roles and responsibilities, as codified in state contracts and downstream arrangements among plans and agencies providing FMS, I&A, and EVV. Communication pathways must provide opportunities for individuals to provide feedback on their experiences in self-direction to inform the evolution of the program. Structured, ongoing feedback channels identify opportunities for continuous improvement.



Conclusion

Successful self-direction in MLTSS depends on addressing all elements of this framework through intentional planning and strong collaboration among individuals self-directing, states, plans, and vendors. While approaches vary from state to state, for MLTSS health plans, the ultimate goals of self-direction are to provide individuals with the greatest amount of autonomy over their care, while remaining good stewards of taxpayer dollars and adhering to program requirements.

Looking Ahead

Future publications in this series will explore in more detail the Member-Facing Supports, Systemic Infrastructure, and Clearly Defined Roles, Responsibilities, and Communication that enable successful self-direction in MLTSS. Each issue brief will identify the barriers to operating a successful self-direction model and provide specific recommendations for federal policymakers, states, MLTSS health plans, and companies that support self-direction (particularly FMS agencies). Additionally, we will publish an issue brief analyzing the results of an inventory of self-direction policies across MLTSS states. A final comprehensive report will incorporate promising practices from MLTSS health plans and companies that support self-direction.

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 ¹¹. 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. ¹²

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.

¹¹ 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

¹² [What is Integrated Care](#) | [Medicare Messenger](#)

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Contributors

Self-Direction Workgroup Co-Chairs:

T.K. Small
David Rogers
Beth Peterson

MLTSS Association Staff:

Mary Kaschak
Emily Schutz
Rowen Lee
Saumini Shah

Subject Matter Experts:

Laura Chaise
Serena Lowe

Self-Direction Center Staff:

Molly Morris
Brenda Vitale

MLTSS Association Member Organizations



MLTSS Association Partnership Program Members

