Health System Re-Design (HSR) Subcommittee
DHCF Medical Care Advisory Committee (MCAC)
November 13, 2025

1115 Waiver Care Coordination Needs – Breakout Group 1

1. Gaps and Opportunities in Supporting DC's 1115 Waiver Services

Exploring a Single Hub for Care and Payment

- Participants noted that having multiple MCOs under a single 1115 waiver can create a fragmented experience, and lead to gaps in care coordination when viewed across the full population rather than by individual MCO. They emphasized the need to align all waiver service providers around shared quality improvement goals.
- Some participants expressed interest in a statewide hub model that aggregates data across MCOs and supports centralized functions.
- Other participants discussed whether DC should have a single hub given its relatively small size, and whether the HIE could serve that role.
- A participant with experience in New York's hub model suggested it could help build provider networks and facilitate payment.
- Participants emphasized the value of centralizing payment—particularly in the doula space—to reduce administrative burden, noting that smaller CBOs often lack dedicated billing staff and could benefit from hub-based support for billing and contracting.

Improving Data Coordination and Referral Visibility

- A participant asked whether CRISP is coordinating data in a way that enables all users to view existing referrals.

2. Coordination Needs and Integration Strategies

Clarifying Roles for Care Coordination and Navigation

- Participants noted that non-health case workers, those who help individuals access healthcare, often serve as the most consistent point of contact. However, there's an assumption that healthcare entities and MCOs have the most contact with participants.
- One participant noted that identifying the "primary" case manager can be challenging when individuals have frequent interactions with community-based organizations, while also receiving outreach from MCO representatives who are unfamiliar to them.
- Several participants emphasized that non-health case managers face challenges in coordinating medical care. While they welcome collaboration with medical case managers, they stressed the need for clearer role definitions and responsibilities.
- A recurring theme was the lack of clarity around "who is playing what role" in helping participants navigate services across health and social domains.

- A participant also shared that when a single case worker attempts to coordinate all aspects of care, it can be difficult to secure financial coverage for other needed services.

Building Upon Existing Case Management Structures

- Several participants shared that they do not want a separate, parallel case management program. Instead, they prefer that new case management opportunities build upon the existing structure and include more individuals already participating in it
- Participants also asked whether individuals who already have case management would be included in new case management programs.

Defining Care Coordination and Workforce Requirements

- Multiple participants called for a clear definition of care coordination and clarification on whether the supporting workforce should be nonclinical.
- Participants noted that the absence of a formal community health worker certification in the District of Columbia makes it difficult to build and sustain this workforce.

3. Strengthening Care Coordination for Vulnerable Populations

Coordinating Care for Aging and Dual-Eligible Populations

- A participant noted challenges in securing adequate casework support for the aging population and cited the Medicaid primary care navigation programs at George Washington University and Georgetown University as potential preliminary models.
- A participant asked how care coordination efforts would apply to dual eligibles, particularly those not enrolled in the District Dual Choice program.
- Another participant emphasized the need for improved education around the benefits available to the dual-eligible population.