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

1115 Waiver Care Coordination Needs – Breakout Group 2

1. Gaps and Opportunities

Coordinating Infrastructure

- Participants stressed the need for an entity that connects clinical care, community, and social supports to streamline access, reduce duplication, and improve collaboration.
- A participant noted that CRISP DC offers a strong foundation for care coordination via tools like patient alerts and shared data. However, technology alone isn't enough—effective coordination also requires strong human connectivity and collaboration.
- One participant noted that social support providers—especially those focused on food security—value having access to a central entity to support coordination with managed care organizations (MCOs) and ensure accountability for successful service connections.

Functions Needed for Coordination

- Participants outlined core functions to support effective care coordination, which could include:
    - A centralized hub that streamlines access to services across government and core agencies, while simplifying MCO contracting, billing, and care coordination.
    - Cross-agency alignment to avoid penalizing individuals over eligibility differences.
    - Multiple entry points with shared access and representation from all sides of care.
    - Real-time visibility into services to coordinate care, avoid duplication, and spot gaps.
    - Monitoring of provider performance to ensure accountability in service delivery.

Barriers to Care Coordination

- Participants identified key barriers that hinder effective care coordination:
    - Administrative challenges, including Medicaid enrollment, shifting MCO contracts, and billing confusion.
    - Fragmented clinical and social services with poor follow-up.
    - Lack of clarity in provider roles and titles across organizations.
    - No centralized system to track existing services, leading to duplication.
    - Limited Medicaid reimbursement for navigation services.
    - Complex billing systems can be difficult for CBOs unfamiliar with navigating them.
    - Navigation is less effective for persons who are unhoused without added supports.
    - Varied provider roles and titles make identifying the right contact more difficult.

2. Coordination Needs and Integration Strategies

Clinical-Community Partnerships

- Participants emphasized a "no wrong door model," allowing individuals to access 1115 waiver services through multiple organizations and provider roles.
- One participant noted that existing clinical-community partnerships offer strong potential for scaling and enhancement.
- A CBO participant described its navigation model in which staff—trained through partnerships with two universities—support individuals by scheduling appointments, providing reminders, offering transportation, and accompanying them to specialty care visits. This hands-on approach has led to a high appointment completion rate and has likely helped empower those served to be more engaged in managing their health.

Effective Care Coordination Teams

- A participant noted that the navigator role could be employed by CBOs or by the hub.
- A participant emphasized the value of trust and frequent contact in care coordination.
- A participant preferred CBO-based navigators who have the trust of their community.
- One participant asked whether any systematic literature reviews or comparative effectiveness research exist to guide the development of effective care teams.
- A participant noted that the CMS Accountable Health Communities program is likely the largest researched model of coordinated social and clinical care, achieving a 3% drop in healthcare costs and a 4–6% reduction in inpatient admissions and ED visits among participating Medicaid beneficiaries who received navigation.
- Another participant stressed engaging frontline public health workers like navigators and community health workers (CHWs), citing strong ROI evidence for CHWs.