**D.C. MEDICAL CARE ADVISORY COMMITTEE (MCAC)**
**Sub-Committee Proposal Form**

All MCAC sub-committee proposals must be submitted for consideration by the MCAC using this form. Proposals must come from the respective sub-committee chair to MCAC Liaison using the dhcfMACandBAC@dc.gov email inbox at least one week in advance of the next scheduled MCAC meeting.

1. **Proposal Title**: Recommendations to Inform High-Quality and Comprehensive Care Coordination and the Related Workforce through DC's Section 1115 Medicaid Demonstration Renewal

2. **Submitting Sub-Committee** *(choose one)*
☒Health System Re-Design (submitted December 2025)
☐Access

3. **Abstract**
*In 100 words or less, explain the proposal being submitted for MCAC's consideration.*

The Health System Re-Design Subcommittee recommends a series of actions to ensure high-quality and comprehensive care coordination, as well as a robust workforce to support connection to care. Both of these features are essential for optimal beneficiary outcomes. Recommendations include creation of a centralized structure to support key functions; engaging in role clarification and supporting the relationships that improve care connection; and structurally and financially incorporating community health workers. These recommendations were derived from themes gleaned during HSR Subcommittee meetings from September 2024-December 2025, including specific meetings focused on care coordination and the related workforce in June and November 2025.

4. **Proposal**
*In 1000 words or less, explain the problem being addressed and propose a discrete and actionable solution for the MCAC's consideration. Include any scheduling and/or budget implications, along with risk and mitigation strategies of this proposal.*

In order for all elements of the District's Section 1115 Medicaid Demonstration Renewal, focused on Health Related Social Needs, to be successful, a focus on decreasing fragmentation, supporting community-based organizations in critical functional areas, ensuring a robust care coordination workforce, and more, will be required. The following recommendations are not in rank order.

**Recommendation 1: Create a Hub or Centralized Structure to Support Health Related Social Needs (HRSN) Service Administration, Care Integration and Coordination, Quality Improvement, and Other Identified Roles**

To optimize the provision of HRSN services, address identified gaps, and further improve the coordination of care, the District would benefit from a centralized entity to support the delivery, and continuous improvement, of waiver services. The following activities were initially identified by Subcommittee members, but the list is not necessarily exhaustive or in rank order:

- *Administrative Resources for Community-Based Organizations (CBOs).* Many CBOs would benefit from a central entity that could support administrative functions, such as payment authorization, Managed Care Plan (MCP) contracting, and/or other duties identified during planning and implementation.
- *Data Utilization to Support Quality Improvement*. A single, neutral entity with responsibility for data aggregation across MCPs and at the population health level would support quality improvement activities.
- *Facilitate Integration of Clinical and Social Care*. Further integration of clinical and social support is necessary, and a centralized structure to serve as a bridge and play a leading role in areas such as value-based contracting, would decrease fragmentation, and increase efficiency and outcomes.
- *Enhance Accountability*. A hub or single entity could provide accountability for overall implementation, which is an overarching need identified by the Subcommittee.

The HSR Subcommittee is cognizant that many states with HRSN waivers that established hubs did so in different economic, funding and policy environments. Additionally, these states, and organizations operating in their jurisdictions, are continuously learning from implementation successes and challenges. The Subcommittee recommends the District continue to identify these lessons learned, and apply them within DC's unique context and in collaboration with stakeholders. If the District is unable to move forward with this recommendation due to funding or other constraints, the Subcommittee urges DHCF to determine what other possibilities may exist to advance discrete functions or activities described above, which have been deemed critical to address.

**Rationale:** Subcommittee participants identified the opportunity for services to be further integrated and coordinated, and that a "shared table" or "human infrastructure" is needed. A hub, as many other states have implemented, or a similar centralized entity, would deliver many benefits, including eliminating silos, and reducing duplication of services. Decreasing administrative obstacles and increasing access to financial and capacity-building resources will allow a more diverse set of CBOs to participate as service providers. A hub provides a foundational opportunity to focus not only on service delivery, but continuous quality improvement, in service of equitable population health outcomes.

**Recommendation 2: Utilize Opportunity for Role Clarity and Structurally Supporting the Relationships that Drive Connection to Care and Outcomes**

The District should utilize the HRSN waiver implementation as an opportunity to further define role clarity amongst the variety of individuals often providing care coordination, case management and/or navigation services, including through Managed Care Plans, and defining who is the "lead." Align with value-based payment frameworks where appropriate. Ensure financial and structural investment in the types of roles that have strong relationships and trust with beneficiaries, and utilize a family-centered approach to care coordination when parents/caregivers and child(ren) are beneficiaries. Maintain multiple entry points for care, with recognition that opportunity exists for care coordination at either the hub and/or at the CBO level. Subcommittee members provided examples, such as community health workers and case managers at social care organizations, as the types of relationship-based roles that should be prioritized. In addition to qualitative data provided by community stakeholders, the District should use available national and/or regional research and evidence to inform decision-making.

**Rationale:** Role clarification decreases duplication of effort and confusion. When care coordination is provided through individuals with whom beneficiaries (and families, when indicated) trust and have built relationships, engagement, connection to care, and overall outcomes are often improved. With recognition that care coordination may be appropriate in a hub structure and/or at CBOs, Subcommittee members voiced that trust with beneficiaries and high amounts of contact are more likely at CBOs.

**Recommendation 3: Implement Necessary Policy and Regulatory Changes to Facilitate Appropriate Service Provision, Billing and Reimbursement by Community Health Workers**

The District should advance the policy changes required to allow community health workers to be a fully integrated workforce to support the provision of HRSN service delivery, within their appropriate scope and training. This will require implementation of certification standards by DC Health, recognition of community health workers as a qualified provider type by DHCF/DC Medicaid, and identification of covered services. If a systemic approach cannot occur due to funding or other constraints, the Subcommittee recommends DHCF and community stakeholders collaboratively determine if other avenues exist for enhanced integration of this workforce within a more narrowly defined scope.

**Rationale:** Community health workers have been identified by Subcommittee members as a crucial segment of the workforce that provides critical services, including care navigation, across virtually all HRSN service domains, and are uniquely trusted by beneficiaries. Community health workers are not a qualified provider type for the purposes of Medicaid reimbursement in DC, and no standardized competencies or certification pathway exists. Advancing policy and financing mechanisms to support systemic integration is vital to an effective 1115 waiver care coordination structure and will support quality outcomes.

**Additional Considerations:**

- Feedback to HSR Subcommittee

- The Subcommittee requests that DHCF provide a future update(s) on how these recommendations were addressed.
- Updates support continued strong engagement with community stakeholders and Subcommittee values of transparency and continuous feedback.
- The Subcommittee recognizes the current approval and implementation timeline, and that updates may not be available until later in calendar year 2026 or calendar year 2027.

**5. Supporting Documentation**

*Any supporting documents should be directly provided as attachments to this proposal, and referenced in section 4 above. Please list below.*

None.