Payments Data & Exchange Standards: Gravity Project Discovery Findings

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Executive Summary

Beginning in February 2024, the Gravity Project convened more than 20 cross-sector stakeholders to complete a six-week discovery project regarding social care payments data and exchange standards. The project sought to understand and define the existing landscape for community-based organization (CBO) reimbursement and identify the components of the CBO reimbursement process that would benefit from national standards to be developed by the Gravity Project.

All Gravity Project member organizations were invited to participate in the Discovery Committee, which included leaders from the healthcare, social services, and technology sectors. In order to provide ample representation for and capture the perspective of CBOs in states with existing CBO reimbursement programs, additional CBOs representing such states were invited to participate. Over six weeks, the Discovery Committee discussed funding types, activities, actors, existing resources, and gaps in the CBO reimbursement process. This report contains a summary of those discussions and the recommendations the Committee makes based on its discovery.

The recommendations in this report focus on the reimbursement framework for health-related social needs (HRSN) services under Medicaid. While CBOs receive funding from multiple sources—ranging from governmental allocations to philanthropic grants to healthcare reimbursements—the success of any effort to standardize payments data depends on industry readiness. The Discovery Committee unanimously agreed that the Medicaid HRSN reimbursement framework is a prime candidate for immediate standardization. Just last year, the Centers for Medicare & Medicaid Services (CMS) issued guidance alongside the White House's Social Determinants of Health (SDOH) Playbook, outlining fifteen specified HRSN services eligible for investment through a variety of Medicaid authorities, including state plan authorities, Section 1915 waivers, managed care in lieu of services and settings (ILOSs) and Section 1115 demonstrations. These waivers and initiatives are operational or in development across a large number of states, significantly impacting both CBOs and Medicaid beneficiaries. The best opportunity for a national standard is where requirements and activities have the most alignment. Consequently, this report's recommendations focus initially on standardizing HRSN service reimbursement within Medicaid, with subsequent extension to other funding streams. While other funding sources may follow the same or a similar set of activities, these are out of scope at this point in time.

The Discovery Committee reviewed the following activities that are commonly implemented within the context of Medicaid HRSN service reimbursement: eligibility verification, enrollment, authorization, service documentation, and claim submission/remittance. This report represents a landscape analysis of these activities at present, and contains an in-depth review of each

activity, its associated actors, existing resources, and pain points, along with several recommendations based on this discussion.

At the end of the discovery phase, the Committee identified several activities to prioritize in the initial phase of standardization: enrollment, service documentation, and claim submission/remittance. This recommendation is driven by the significant administrative burden and challenges faced by CBOs in meeting diverse payer requirements and data formats. Addressing these foundational activities is critical, as they directly impact program enrollment to ensure that Medicaid members can access the new benefits for which they are eligible, as well as the timely reimbursement of CBOs, ensuring their continued ability to participate in HRSN reimbursement programs.

Background

Across the country, momentum has grown among states and payers for the reallocation of healthcare funds to address HRSNs. In its SDOH Playbook, for example, the White House explained that supporting flexible funding to address social needs improves health outcomes: “Increasing funding flexibility and offering technical assistance that empowers organizations to utilize funding from a variety of sources will better equip them to address unmet social needs.”

The success of these reimbursement programs requires the existence of exchange and data standards that serve the interests of all stakeholders. At present, the relative novelty of social care reimbursement programs within the broader healthcare landscape has resulted in a lack of uniformity in stakeholder implementation and subsequent variance in standards across states, payers, and CBOs. As these programs gain traction, the standard permutations will multiply—and there is a pressing need for standardized frameworks to mitigate the burden and absorbed cost on CBOs tasked with navigating this evolving landscape.

During the discovery period of this project, payers and CBOs spanning different geographies, sizes, specialty populations of focus, and service areas testified to the level of complexities that exist as these benefits roll out today. For each activity described below—eligibility verification, enrollment, authorization, service documentation, and claim submission/remittance—payers are implementing and CBOs are responding to requirements differently. Across these activities, CBOs and payers described common pain points that have presented challenges that have made it difficult for them to meet the HRSN reimbursement programs’ full potential.

For CBOs, the time and effort it takes to navigate these activities can delay members’ access to benefits. One CBO explained that it had experienced delays of over thirty days for approval of their authorization requests, as had other CBOs in its community. But by the time these requests had been approved, they had expired because they were submitted over thirty days prior—causing the CBO to restart the authorization process from the beginning. Such delays

present a serious hurdle for members to access the benefits to which they are entitled, and add further unfunded administration costs to CBOs.

To help address these delays, several CBOs have worked with payers to develop “presumptive eligibility” guidelines around certain service thresholds (quantity), price, and/or specific diagnoses. Thresholds were developed through conducting data analysis and identifying which service authorizations had low denial rates. These CBOs explained that such guidelines empower them to provide a reimbursable HRSN service prior to receiving payer approval, which helps members access services more quickly. Indeed, one agency explained that using eligibility guidelines has improved the timeliness of service provision, and, consequently, significantly reduced emergency department readmissions for the clients they serve.

CBOs also described pain points in the documentation and claim submission/remittance portion of their activities. Several CBOs mentioned that payers typically require documentation to be provided in different formats and submitted through different mechanisms. CBOs in one state where HRSN service reimbursement is available explained that they were being asked to submit payment requests in a portal that created no traceable submission records to which they could later refer. Then—sometimes months later—the CBOs would receive a denial letter via paper mail if a code had been entered incorrectly. Without a traceable submission record, the CBO would be unable to rectify and resubmit the payment request. In other cases, CBOs were able to cross reference submissions with the denials, the reconciliation sometimes took 2-4 resubmissions in an attempt to be reimbursed for services provided, and in many cases those resubmissions never resulted in a payment. In response, one CBO was forced to terminate its contract as it was unable to receive reimbursement for the services it provided. One CBO indicated they know of smaller CBOs within their community that are pulling out of the program entirely due to the amount of time it takes to receive accurate reimbursement for their services. In several instances, CBOs reported only 50%-70% of claims submitted received successful reimbursement for services provided to members, due to denied claims. These many barriers to successful reimbursement further widens the equity gap for members, as many of the smaller CBOs designed to meet the needs of specific marginalized groups are not able to absorb the financial risk and unpaid administrative burden to contract with health plans. CBOs also noted that payers were not always set up to support CBO’s having claims issues; for example some payers assume that CBO’s have “medical billing departments,” or it would take several months of escalations before a resolution or guidance could be provided by the payer.

Like CBOs, payers also described concerns with their current reimbursement processes. In some states, payers must develop both internal and external plans to implement HRSN reimbursement without much guidance from the state on technical standards. Payers’ diligent efforts to fit new benefits into their own existing systems and structures lead to payer-specific

standards and workflows that can impede payer collaboration—and ultimately make it more difficult for states to implement and evaluate successful waiver programs.

Even in states with more standardized HRSN reimbursement processes, pain points exist. Payers in one such state described a speed to execution problem in reporting information to the state for value based benchmarks and baselines. Without much time to review and implement the state's standards for time-bound waiver programs, payers faced difficulty in quickly implementing complex reporting requirements.

Payers also explained that they are frequently also responsible for evaluating the success of these programs (e.g., ILOS). In such cases, payers may require additional data elements that are different from traditional clinical intervention evaluation measures in order to assess the long-term impact of social care interventions.

For both payers and CBOs, unified exchange and data standards across the reimbursement process would help ameliorate these concerns. The CBOs that are the backbone of any HRSN reimbursement program are under a tremendous amount of pressure to quickly adopt Medicaid rules and regulations, and the payers that fund them are likewise under pressure to operate at high volumes and adapt existing healthcare-specific processes to efficiently participate in and pay for these services. CBOs cannot continue to absorb the upfront costs they are accruing in order to participate due to long processing and dispute delays, and we are seeing them pull out in some instances where there are no standards. Additionally, access to infrastructure funding for CBOs to adopt and successfully implement standards is a key barrier for participation. The ability for these reimbursement programs to succeed is inextricably tied to the ability to effectively link these two sectors and enable transparency, traceability, and near real-time communication. Rather than medicalizing CBOs or requiring that payers use manual processes, the solution should involve accessible standards that can bridge these two sectors.

Resources Landscape Analysis & Recommendations

The Discovery Committee completed discovery across the following five activities, conducted a standards landscape analysis and associated Gravity Project and/or structural recommendations for each activity, as detailed below. After reviewing the feasibility and structural barriers for implementation within each activity, the Discovery Committee recommends that Gravity Project prioritizes work towards two initiatives:

1. Terminology development for CBO payment and reporting activities.
2. Continued implementation discovery for Service Documentation and Claim Submission/Remittance activities with key state Medicaid agency, payer, and CBO stakeholders where 1115 Medicaid waivers are implemented or are in implementation.

Medicaid Eligibility Verification

Use Case	A **payer, provider,** or **CBO** confirms the member's Medicaid eligibility and enrollment status.
Actors	Payer, CBO, Provider, Care Manager, State
Existing Exchange Standards	X12 EDI 270/271
Existing Coding/Data Standards	National Provider Identifier (NPI)/Atypical Provider Identifier (API) requirement for X12 EDI 270/271
Identified Opportunities	The Discovery Committee recommends assessing opportunities for collaboration with existing standards development organizations (e.g., X12) to evaluate and build upon eligibility verification standards.
Structural Recommendations	The Discovery Committee recommends ensuring that CBOs are enabled to electronically interoperate, whether through new, existing, or expanded methods. This includes a significant amount of infrastructure funding needed in order for CBOs to drive development, adopt, and implement these standards.

Enrollment

Use Case	Pathway 1: A **payer** wants to send a list of eligible members to a **CBO** to be enrolled in their HRSN reimbursement program. Pathway 2: A contracted and/or non-contracted **CBO** wants to understand requirements and request enrollment for a payer's Medicaid member to be enrolled in the **payer's** HRSN reimbursement program. Both the **payer and CBO** need to access standardized benefit structure and required documentation to communicate enrollment in HRSN reimbursement programs.
Actors	Payer, CBO, Provider, Care Manager
Existing Exchange Standards	X12 EDI 834
Existing Coding/Data	LOINC, SNOMED

Standards	There are no existing coding or data standards for enrollment because enrollment requirements differ across HRSN programs and waivers.
Identified Opportunities	Participants described challenges experienced by CBOs and agencies evaluating a client for eligible HRSN benefits, and for payers to receive enrollment information and process requests in a structured way across programs. An opportunity exists to codesign enrollment processes along with community referral pathways. The Discovery Committee recommends defining standards for payers, dependent upon government entities to codify HRSN benefit structure for benefit inquiry, so that both payers and CBOs can easily identify the benefits a member can access due to enrollment in different program(s) and states.
Structural Recommendations	The Committee recommends federal and state authorities to codify HRSN benefit structure for benefit inquiry in order to enable stakeholders to adapt existing exchange standards for social care.

Authorization

Use Case	A **payer** authorizes the amount and duration of services to be provided by a contracted **CBO** that are eligible for reimbursement. A **CBO** receives the authorization information before delivering services to a client.
Actors	Payer, CBO
Existing Exchange Standards	X12 EDI 278 CMS-0057-F Prior Authorization Application Programming Interface (API) recommended Implementation Guides: HL7 FHIR Da Vinci Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), Prior Authorization Support (PAS)
Existing Coding/Data Standards	ICD-10 Z-codes, screening resources (e.g., FHIR resources and standardized screeners), LOINC
Identified Opportunities	The Discovery Committee recommends assessing and testing existing standards for CBOs to structure query requests and documentation, and for payers to codify HRSN authorization responses.

Structural Recommendations	Existing coding standards are of limited utility due to a wide array of interventions mapped to HRSNs. The Committee recommends federal and state authorities to codify social care benefits, by creating a taxonomy similar to healthcare diagnostic and procedural codes, in order to enable stakeholders to adapt existing exchange standards for social care. The Committee recommends education specifically in support of HRSNs under the CMS-0057F standardized Prior Authorization Decision Timeframes, and create channels for feedback for revised authorization timelines based on real-world application. Also, the Committee further recommends exploring opportunities for pass through or presumptive eligibility, as developed in North Carolina and California, across identified services that have high rates of successful authorization and require immediate action.

Service Documentation

Use Case	A **CBO** needs to document the encounter-level information for an HRSN service they provide to a Medicaid member for the purpose of data collection and coding for reimbursement.
Actors	CBO
Existing Exchange Standards	For referrals: ServiceRequest.Read (FHIR) For documentation: Encounter and Procedure (FHIR)
Existing Coding/Data Standards	Z-codes, HCPCS, HCPCS modifiers, CMS Place of Service codes, SNOMED-CT
Identified Opportunities	The Discovery Committee recommends establishing a standard payer framework and requirements for documentation by CBOs, including information regarding supporting documents that payers can leverage to ensure services were delivered by contracted CBOs. The Committee recommends aligning payers and CBOs on required minimum viable data for service documentation to support reimbursement. Additionally, ensure alignment with requirements in the Gravity Referral IG around clinical diagnosis specifically related to social needs.
Structural Project Recommendations	The Committee recommends that CBOs document ICD-10 Z codes to articulate SDOH-related diagnoses, when

	appropriate, as a part of their documentation of services rendered to the client. The Committee further recommends against requiring CBOs to provide and document ICD-10-CM clinical diagnostic codes as a requirement for social care reimbursement. Instead, if clinical diagnostic codes are required for reimbursement, payers or clinical referral sources provide those codes as part of the authorization process.

Claim Submission/Remittance

Use Case	A **CBO** needs to submit the encounter documentation to a **payer** for an HRSN service they provided to a member for the purpose of getting reimbursed. A **payer** needs to receive the encounter documentation from a **CBO** for the purpose of reimbursement. A **CBO** needs to receive a notification from the **payer** indicating if their submission was successfully received and acknowledged, then approved or denied, and the reason for the denial for the purpose of reconciliation.
Actors	Payer, CBO, Network Lead/Community Care Hub (Optional)
Existing Exchange Standards	X12 EDI 837/835 CMS-1500 form Also Available: Procedure (FHIR), Encounter (FHIR), ClaimResponse (FHIR)
Existing Coding/Data Standards	ICD-10-CM, HCPCS, HCPCS modifiers, CMS Place of Service codes, National Provider Identifier (NPI)/Atypical Provider Identifier (API)
Identified Opportunities	CBOs do not generally have the resources necessary to manage or adapt to the complexity of integrating these systems and reimbursement does not typically cover those administrative costs, furthering the equity gap by creating more barriers to participating in new reimbursement schema. It would be beneficial to improve potential field mapping for social care claims so that both payers and CBOs have a standard set of billing elements that are applicable to social care and can still be used within payer's existing systems.

	The Committee further recommends exploring standardized remittance advice information regarding expected payment, timeliness of payment, and denial information (if applicable) to ensure transparency for participating CBOs.
Structural Project Recommendations	The Committee recommends regulatory review of NPI and other requirements that potentially serve as downstream barriers for CBOs to participate in HRSN reimbursement programs and generate 837 encounters.