

Department of Health and Human Services

Listening Session

on

Advancing X12 Transaction Standards to Version 8060

July 1, 2026



Agenda

- Opening Remarks
- X12
- Health Level Seven International (HL7)
- National Council for Prescription Drug Programs (NCPDP)
- National Uniform Claim Committee (NUCC)
- National Uniform Billing Committee (NUBC)
- Dental Content Committee (DECC)
- Workgroup for Electronic Data Interchange (WEDI)
- Closing Remarks

Opening Remarks

- **Shaheen (Shaney) Halim**
- Director, Division of Policy
- Office of Health Technology & Products



X12

Cathy Sheppard

X12 FEEDBACK ON THE 008060 RECOMMENDATIONS

July 01, 2026

Cathy Sheppard, CEO



DISCLAIMER

- This presentation is for informational purposes only
- This presentation does not represent legal advice
- This presentation contains point-in-time content

X12



X12's 008060 Recommendations



008060 GUIDES PUBLISHED

- In September 2025 X12 announced publication of the 008060 versions of the HIPAA-mandated implementation guides
- The updated implementation guides are available in X12's online viewer, Glass

X12 HIPAA RECOMMENDATIONS

- In December 2025, X12 submitted its [recommendation](#) for advancing the version of already mandated HIPAA transactions to version 008060
- Per the HIPAA regulations, we also notified the other organizations named as Designated Standards Maintenance Organizations (DSMOs) and the Workgroup for Electronic Data Interchange (WEDI), which is named as an advisory body

X12 HIPAA RECOMMENDATIONS

→ Included in the recommendation:

- *008060X322 Health Care Claim Payment/Advice (835)*
- *008060X323 Health Care Claim: Professional (837)*
- *008060X324 Health Care Claim: Institutional (837)*
- *008060X325 Health Care Claim: Dental (837)*
- *008060X329 Health Care Claim Status Request and Response (276/277)*
- *008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)*
- *008060X333 Benefit Enrollment and Maintenance (834)*

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X12 HIPAA RECOMMENDATIONS

→ Included in the recommendation:

- *008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)*
- *008060X342 Health Care Services Review – Request for Review and Response (278)*
- *008060X340 Health Care Claim Request for Additional Information (277)*
- *008060X341 Additional Information to Support a Health Care Claim or Encounter (275)*
- *008060X343 Additional Information to Support a Health Care Services Review (275)*

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Background



X12 HIPAA RECOMMENDATIONS

- Previously, X12 submitted a recommendation for advancing the version of already mandated HIPAA transactions to 008020
- Subsequently, the NCVHS stated several concerns and a recommendation that the X12 recommendation not be adopted
- X12's position is that the stated concerns were arbitrary and not based on the merits of the recommendation or the value of the additional functionality supported in version 008020

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X12 WITHDRAWAL OF ITS 008020 RECOMMENDATION

- Based on the time that elapsed between X12's 008020 recommendation and the NCVHS response, and X12's annual update cycle, X12 subsequently withdrew its 008020 recommendation in favor of a later version, 008060
- The 008060 versions of the already mandated HIPAA transactions include enhancements and new functionality requested by industry stakeholders

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Listening Session Feedback



RELATED TO VERSIONS 008020 VS 008060

- Related to whether the 008060 versions address the NCVHS 008020 concerns
- *Although X12 does not concur with the stated concern about compatibility issues related to different versions being mandated for different transactions, we did address this concern by recommending that the full suite of mandate transactions be advanced to version 008060*

RELATED TO VERSIONS 008020 VS 008060

- Related to whether the 008060 versions address the NCVHS 008020 concerns
- *Although it is difficult for a standards development organization to provide detailed cost/benefit analysis information prior to industry assessment of the proposed revisions, X12 provided cost estimates and benefit assessments for the recommended transactions, noting that a more precise analysis can be developed once an NRPM is published and implementers conduct impact assessments*
 - *The ICD-11 concerns are no longer applicable as there is no current action related to the US migrating to ICD-11*

RELATED TO VERSIONS 006020 VS 008060

- Related to whether the attachment mandate to implement version 006020 should be advanced to 008060
- *Based on the voluntary implementation of attachments across the industry, including the exchange of several versions of attachment transactions, there is no issue related to pairing different versions of claims or authorizations and attachment transactions*
 - *Given the healthcare industry's stated preference for full-suite advancement, the transactions mandated for attachments should be advanced to 008060 as part of the suite*

RELATED TO VERSIONS 006020 VS 008060

- Related to whether the attachment mandate to implement version 006020 should be advanced to 008060
- *Given the timing of the 006020 mandate and the expected timing of a 008060 mandate, it is more efficient and cost-effective to allow for some version leeway related to mandated attachments*
 - *Organizations that have not yet implemented attachment functionality should be permitted to move directly to the 008060 version*
 - *This is especially important for dental implementers, as version 008060 includes important dental-related enhancements*

RELATED TO VERSIONS 006020 VS 008060

- Related to whether the attachment mandate to implement version 006020 should be advanced to 008060
- *Organizations that have implemented attachments in version 006020 or a later (such as 007030), should be allowed to stay on those versions pending the implementation period for version 008060*

PRIORITIZING THE 008060 TRANSACTIONS

- Related to prioritizing the move to updated mandated versions
- *Based on the healthcare industry's stated preference for full-suite advancement, the recommended transactions should be advanced simultaneously*
 - *If the mandated versions are not rolled out as a suite, X12 will work with NSG to identify logical subsets based on the enhancements available in the 008060 versions and the logical flow of the information across business functions*
 - *All of the transactions recommended for upgrade to 008060 support efficient and effective claim processing and improved patient care*

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LESSONS LEARNED IN THE LAST UPGRADE

- Vendors and clearinghouses recognize that some of the pain points of the previous upgrade were related to their limited cooperation
 - *Vendors and clearinghouses are actively participating in X12's HIPAA testing PoC to ensure a more cohesive approach, which will result in a significantly smoother rollout*
 - *Clearinghouses are also collaborating in Cooperative Exchange activities to ensure consistency that benefits all the stakeholders*

LESSONS LEARNED IN THE LAST UPGRADE

- Some organizations attempted to use a generic analysis of the enhancements and new functions instead of conducting their own detailed analysis based on their computer systems and applications
 - *X12, WEDI, Cooperative Exchange, and other industry associations are encouraging organizations to carefully assess their proprietary systems*

LESSONS LEARNED IN THE LAST UPGRADE

- There was limited sharing of test scenarios and expected results in the previous upgrade
 - *X12's HIPAA testing PoC is developing scenarios to test critical functionality. Those scenarios will be available on X12's example website as the PoC completes testing cycles*
- Overlap of federal requirements has been challenging to the healthcare stakeholders
 - *We urge federal regulators to work together to avoid overlapping and contradictory mandates*

IMPACT ON MANUAL PROCESSES

- Significant increases in the use of several transactions are expected as part of upgrading to version 008060
- Cost savings will be realized across the 008060 suite
 - *The 008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271) implementation guide includes a slew of upgrades that will reduce manual processes, including more frequent updates to Service Type Codes, required support for more and more specific inquiries and responses, and authorization details at both the service type code and procedure code levels*

IMPACT ON MANUAL PROCESSES

*BASED ON THE
CAQH INDEX

X12

Category	2024	2025
Fully executed via 278	95 million 35% of the volume	102 million 38% of the volume
Partially executed via 278	123 million 43% of the volume	126 million 46% of the volume
Fully manual	54 million 15% of the volume	44 million 16% of the volume
Costs the industry avoided with automation	966 Million Dollars	1.2 Billion Dollars

- The number of authorizations processed using X12's Health Care Services Review – Request for Review and Response (278) transaction has been steadily increasing over the past few years
- X12 expects that growth will continue to increase significantly based on the implementation of the 008060X342 version

IMPACT ON MANUAL PROCESSES

- 008060X342 Health Care Services Review – Request for Review and Response (278)
 - *The 008060 version of this implementation guide supports more frequent updates to Service Type Codes, more diagnosis codes, UDI, and Implant/Explant Certifications, which allows for significant automation of high-cost services*

IMPACT ON MANUAL PROCESSES

→ Implementation of the attachment transactions is also expected to significantly reduce manual processing

- *008060X340 Health Care Claim Request for Additional Information (277)*
- *008060X341 Additional Information to Support a Health Care Claim or Encounter (275)*
- *008060X343 Additional Information to Support a Health Care Services Review (275)*

IMPACT ON MANUAL PROCESSES

→ Specific improvements also include

- *Federal and state requirements related to data quality and data sharing will benefit all healthcare stakeholders*
- *Enhancements to remittance data that improve the level of detail transmitted between trading partners*
- *Full support of the dental requirements on the ADA claim form and improvement to the related predetermination processes*

EXPECTED BURDEN

- As is always the case, small, rural, and underserved area providers are impacted heavily by mandates
- This is not specific to X12-based mandates; it is true across the board
- Clearinghouses and vendors could play an important role in easing the burden on these stakeholders

POTENTIAL TRANSITION COSTS

- There will be transition costs with any business functionality upgrades, whether mandated or not
- *These doing-business costs must be considered based on the big picture, the costs of not enhancing and upgrading business messaging, and a normal expectation of upgrading technology over time*
 - *Federal and state mandates tend to be initiated in silos but need to be evaluated consistently to ensure that the most efficient, effective, and cost-effective solutions are available to stakeholders so they can determine the most advantageous methodologies for their organization*

POTENTIAL TRANSITION COSTS

- As with any technology migration with a deadline, poor planning and a lack of detailed analysis and impact assessment will increase transition costs
- *Starting early and involving trading partners as soon as possible can reduce transition costs significantly*
 - *Delaying based on other priorities or an expected extension that doesn't materialize will be expensive not only for that organization but for all its trading partners*

POTENTIAL TRANSITION COSTS

- It is very important that stakeholder organizations complete a detailed analysis of their own systems and applications early in the rulemaking process
- *The volume of enhancements and new functionality, and the associated complexity, is on a completely different scale than the 004010 to 005010 upgrade*
 - *005010 implementation costs should not be the basis of an organization's cost projections*
 - *It's important for stakeholder organizations to provide feedback and set expectations based on real analysis, not generalities or casual assertions*

POTENTIAL TRANSITION COST AVOIDANCE

- These upgraded versions will be supported by existing, mature infrastructure, which is a transition savings that can balance other implementation costs
- Many organizations have developed a library of testing scenarios, data, and expected results over the 005010 implementation period, which will equate to transition savings
- X12 has published high-level and detailed explanatory materials that organizations can build on; this can also result in savings

READINESS

- The 008060 implementation guides have been available to healthcare stakeholders for almost a year
- The healthcare stakeholders have been discussing anticipated upgrades for more than 4 years
- X12 has published helpful and informative collateral, conducted informational webinars, and presented at numerous industry events to encourage stakeholders to engage and initiate their assessments

READINESS

- Previous delays and extensions related to federal mandates can make stakeholders complacent
- NSG can assist with industry readiness by creating timelines and expectations and being clear that stakeholders must meet those benchmarks
- Mandates moved forward by federal agencies should be considered with the same rigor and should have similar prerequisites related to timing, testing, and upgrades

READINESS

→ Feedback on readiness must be reasonable

- *It's not feasible to demand pilot testing or end-to-end demonstrations prior to a mandate if stakeholders are not willing to incur costs until there is a mandate or a clear indication that an NRPM is likely to result in a mandate*
- *Organizations that have chosen to take no action on preparing for a potential upgrade mandate should not be able to claim later that they aren't ready to move forward*

OPERATING RULES

- Most of the mandated data content operating rules have been incorporated into the 008060 implementation guides
- Other mandated operating rules may still be useful to ensure consistency across the industry
- X12 plans to put forward guidance similar to operating rules to assist the stakeholders during the transition period that follows the Final Rule

PENDING X12 RECOMMENDATIONS

- X12 is preparing to move forward with recommendations for additional mandates, including but not limited to Acknowledgments
- Watch for more information in the coming months



RELATED TO CMS-0062-P

*BASED ON THE
CAQH INDEX

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Costs the industry avoided with automation	966 Million Dollars	1.2 Billion Dollars

- *We talked about this slide a few minutes ago, but it is relevant here too*
- *Despite claims to the contrary, X12's authorization transaction has been implemented across the industry, and the number of authorizations being exchanged continues to grow*
- *X12 continues to believe that consistent data requirements are key, and implementers should be able to choose the syntax based on their organizational assessments*

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WRAP UP



HIPAA LANDING PAGE

→ HIPAA Recommendations Landing Page

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X12 HIPAA Recommendations

In December 2025, X12 recommended advancing the version of its already mandated health care transactions to the National Committee on Vital and Health Statistics (NCVHS) while notifying the related stakeholder organizations. Interested parties can easily access information about X12's recommendation by referencing the below information.

The content currently available on the site is listed below. Additional resources to inform or assist implementers and other stakeholders will be posted as they become available. To stay informed, bookmark the site and check back regularly to access the most current information.

Available Now:

- X12's recommendation letter to the NCVHS and National Standards Group
- X12's member announcement about its landing page and related resources
- Several Change Reference Documents:
 - Links to the 008060 implementation guides in Glass*
 - Links to the 005010 implementation guides in Glass*
 - A Transaction Set Listing Markup for each 008060 implementation guide
 - A Mechanical Comparison Report for each pair of implementation guides

Coming Soon for Each 008060 Implementation Guide:

- Benefit Summary documents
- Education Presentations slides

Please note that many Glass resources, including the respective Implementation Guides marked with an asterisk (*) above require a paid Glass subscription. More information is available at ecommerce.x12.org/license/glass.

Use your X12iD to access the Recommendations landing page. If you do not already have an X12iD, you can register to create one at no cost at ecommerce.x12.org/license/free.

Additional information about X12iDs is available in the [X12 Info Center](#) under Informational Overviews.

If you have any questions, please submit them via the [X12 feedback form](#).

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X12 HIPAA Recommendations

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HIPAA LANDING PAGE

CHANGE REFERENCE DOCUMENTS



HIPAA Recommendations

When X12 presented its recommendation to upgrade the currently mandated transactions to version 008060, we noted that we'd provide several resources to assist implementers in assessing the impact of the upgrade on their internal systems, workflows, and policies. The information below includes links to X12's 008060 implementation guides in Glass, along with four corresponding revision references. The revision references included are a Benefit Summary, Transaction Set Listing Markup, Mechanical Comparison Report, and slides from an Education Presentation. Additional content and resources will be added over time to support organizations as they assess their proprietary solutions and identify opportunities based on new functionality and enhancements to existing functionality.

The Benefit Summary outlines the key enhancements introduced in the context of related transaction requirements and through the lens of their organization's proprietary software solutions.

The Transaction Set Listing Markups are PDF files that show the levels, loops, and segments in the implementation guides. Segments revised since the 005010 version are highlighted in blue, new loops and segments are also blue and noted with (NEW), while removed loops and segments are struck through in blue. This is a good starting point reference that leads you to the segments you should assess, without going into the details of each revision to levels, loops, and segments.

The Mechanical Comparison Reports are text files that highlight specific differences between the 005010 version and the 008060 counterpart implementation guide. They describe differences in loop, segment, data element, component, and code value information. Differences in syntax notes, semantic notes, comments, and code sources are excluded. When there is a difference between versions, the difference will be documented in a row that indicates the location of the loop, segment, data element, component, or code value that indicates the location of the loop, segment, data element, component, or code value and describes the difference. New and deleted content is identified at the highest hierarchical level with no enumeration of the lower-level content. For example, if a new segment is detected in the newer version, the data elements within that segment will not be separately noted as new. When there is no change between versions, no rows are presented. Note that if the sequence of repeating segments has changed since the 005010 version, then the report will not match segments as otherwise may be expected ([See example](#)). This resource contains more detailed information and may be best suited to experienced technical analysts, programmers, and business analysts.

The Education Presentation slides are from the respective sessions X12 has offered as part of its Education/Information Series in an effort to help industry stakeholders understand the enhancements represented in the new versions.

Please note that the Benefit Summary and Education Slides for the three Health Care Claim guides are included in single documents with a single link to each PDF, encompassing the changes for all three guides.

Additionally, a summary of the mandated Operating Rules published by CAQH CORE that were integrated into the corresponding 008060 X12 implementation guides is available [for review](#).

Implementation Guide	008060*	005010 Counterpart*	Benefit Summary	Transaction Set Listing Markup Changes	Mechanical Comparison Report	Education Presentation
Health Care Claim Payment Advice (835)	008060X322	005010X221	PDF	PDF	TXT	PDF
Health Care Claim: Professional (837)	008060X323	005010X222	PDF	PDF	TXT	PDF
Health Care Claim: Institutional (837)	008060X324	005010X223		PDF	TXT	
Health Care Claim: Dental (837)	008060X325	005010X224		PDF	TXT	
Health Care Claim Status Request and Response (276/277)	008060X329	005010X212	PDF	276 277	TXT	—
Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	008060X332	005010X279	PDF	270 271	TXT	PDF
Benefit Enrollment and Maintenance (834)	008060X333	005010X220	PDF	PDF	TXT	—
Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	008060X334	005010X218	PDF	PDF	TXT	—
Health Care Services Review Request for Review and Response (278)	008060X342	005010X217	PDF	278 278R	TXT	PDF

*Glass Premium Subscription Required

EDUCATION/ INFORMATION SERIES

- X12 has offered several webinars on the recommended 008060 implementation guides
 - *Additional sessions are planned, based on demand*
- You must register for each session
 - *The link to the registration form is on the [recommendations landing page](#)*
- After the initial webinar for each IG, the slides are posted on the Change Reference Documents web page

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INFORMATION & EDUCATION

- X12 also maintains a library of informational presentations, position papers, and related documents
- Visit X12's [Info Center](https://x12.org/info-center) at x12.org to review the offerings
- More content is added to the site on a regular basis, so bookmark it and check back often



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FEEDBACK IDEAS QUESTIONS?

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Health Level Seven International (HL7)

Viet Nguyen

National Council for Prescription Drug Programs (NCPDP)

Margaret Weiker

National Uniform Claim Committee (NUCC)

Julie Brown-Georgi

National Uniform Billing Committee (NUBC)

Terrence Cunningham

Dental Content Committee (DECC)

Stephen Morgan

Workgroup for Electronic Data Interchange (WEDI)

Robert Tennant

A graphic on the left side of the slide. It features a magnifying glass held over a blue-tinted background of a person in a white lab coat. Overlaid on this are several white hexagonal icons: a nurse's cap, a syringe, a person with a stethoscope, and a medical monitor. The background is split diagonally from the top left to the bottom right, with a light blue upper half and a dark blue lower half.

CMS Listening Session: Advancing X12 Mandated Transaction Standards to Version 008060

July 1, 2026

Presented by:

Robert Tennant

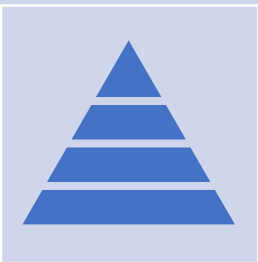
WEDI Executive Director



Multi-stakeholder organization representing payers, providers, clearinghouses, vendors, SDOs, federal/state government and patient advocacy groups



Named as an advisor to the Secretary of HHS in HIPAA Section 1172 (c)



WEDI convenes, collaborates, educates and advises

WEDI's Member Position Advisory Process



MPA Purpose: Ensure members can provide input and data to assist the WEDI Board in developing recommendations, comments and positions that reflect the views of WEDI's diverse members.



Listening Session MPA: WEDI held our MPA on June 6 to discuss the CMS 008060 Listening Session questions. More than 150 members participated, representing our major stakeholder groups.

CMS Question: Version 008020 vs. 008060

On June 14, 2023, the NCVHS provided a recommendation that HHS not adopt version 008020 of the X12 transaction standards for health care claims and claim/remittance advice.

➤ *Do you and your organization agree that version 8060 of these standards address the concerns stated by NCVHS?*

NCVHS stated concerns were:

- 1. Unknown compatibility issues with adopting a subset of 008020 transactions vs. the entire suite*
- 2. Lack of sufficient cost and value data, along with burden, opportunity, and efficiency for proposed standards upgrades*
- 3. Lack of accommodating ICD-11 and modified NDC format*

- In December 2025, X12 recommended adoption of the full-suite of transactions
- WEDI members discussed whether a full-suite upgrade or piecemeal approach was preferred
- A recurring theme from our MPA was that moving the **entire suite** of transactions at the same time had the following benefits:
 - Reduces concerns regarding mixed-version environments
 - Preserves end-to-end consistency across the revenue cycle
- (It was emphasized during the MPA that clearinghouses will support both payers and providers with the full suite of transactions and translating transaction versions.)

WEDI Response (con't)

- Additional reasons to move to the **full transaction suite** included:
 - Claim formats and related transactions are interconnected
 - Payers and providers and often use multiple claim types together
 - Dental, medical, and other workflows overlap
 - Partial adoption weakens ROI for the broader standard
 - Piecemeal implementation increases operational complexity
- There was also discussion of whether **dental** could be evaluated separately, but many participants argued that doing so would create more problems than it solves, as:
 - Dental care can intersect with medical claims
 - Dental uses more than just 837D

- A recurring concern with **mixed-version processing** was the potential challenges when trading partners adopt different standards at different times. Examples included:
 - 005010 claim with 008060 remittance
 - 008060 claim with 005010 remittance
 - Secondary claims spanning different versions
 - Coexistence of transactions with different levels of detail
 - Consequences for analytics, downstream systems, and business rules
- Many members noted that **coexisting versions create complexities** such as:
 - New translators
 - Up-conversion/down-conversion logic
 - Payer-specific version management
 - Uneven data availability
 - Broader analytic inconsistency

NDC Format and Future Version Questions

- **NDC format Accommodation.** Responses from the MPA discussion included:
 - That X12 will be ready by the next version of the transactions-time for the NDC deadline with the initial transition being **March 2033**
 - It was noted that 008060 may already accommodate relevant functionality in some areas
- **ICD-11 Accommodation.** Important to remember:
 - The United States officially completed its withdrawal from the World Health Organization (WHO) on January 22, 2026
 - Unlikely that the US would move to ICD-11 anytime soon
- Note: we will discuss ROI/burden issues later in our testimony

CMS Questions: Claims Attachments

Version 006020 vs. 008060 for Claims Attachments

On March 24, 2026, HHS finalized version 6020 of X12's 275 and 277 transactions as the standards to be used for the electronic transmission of health care claims attachments under HIPAA. CMS questions:

- *Should HHS propose version 8060 of these newly adopted claims attachment standards to be used with version 8060 of the health care claim?*
- *Should a transition period be considered during which version 6020 or 8060 of the health care claims attachment standards could be used?*
- *Would there be operational inconsistencies if version 6020 of the X12 275 & 277 were used with version 8060 of the health care claim transaction standard (X12 837)?*

WEDI Response

- MPA participants stated:
 - That **006020 attachments are already being implemented**, and some suggested keeping them in place until 008060 is mandated.
 - Others—especially from dental—argued that **008060 resolves important shortcomings** that 006020 does not
 - If there is a final rule for 008060, covered entities should be allowed to adopt **008060 attachments directly instead of moving to 006020 briefly and then upgrading again**, because: (i) It avoids a short-lived interim upgrade; (ii) Reduces duplicate implementation burden; and (iii) Aligns better with industry practicality
- 008060 275 supports identifying attachments for **pre-determination claims** and the **ISX (Interchange Syntax Extension)** segment

CMS Question: Advancement Prioritization

HHS adopted the current version 5010 on March 17, 2009. On December 10, 2025, NSG received a letter from X12 with recommendations to advance most of the current standards from version 5010 to version 8060. CMS questions include:

- *Which health care transaction standards should HHS prioritize when proposing more advanced versions of the current standards?*
- *If HHS proposes version 8060 of the health care claim (X12 837), what other transaction standards should be advanced in order to appropriately support the 837?*
- *What are some lessons learned from implementing the 4010 to 5010 transition that should be considered when proposing advanced versions of the health care transaction standards (e.g. best practices, incorrect assumptions, failure points, testing opportunities, partner coordination)?*

- In terms of which health care transaction standards should HHS prioritize when proposing more advanced versions of the current standards, **MPA participants identified:**
 - The 837 (Health Care Claims, Professional, Institutional, Dental)
 - The 270/271 (Health Care Eligibility/Benefit Inquiry and Information Response)
 - The 835 (Health Care Claim Payment/Advice)*
 - The 276/277 (Health Care Claim Status Request and Response)*
- *MPA participants highlighted these to support the 837 Health Care Claims

WEDI Response (con't)

Lessons Learned from Prior Implementation Transitions- especially 004010 to 005010, included:

1. Move all transactions to same standard at same time
2. Identify specific impacts in each environment
3. Establish and publish an implementation roadmap
4. Form cross-functional implementation teams
5. Consult IT and operational teams early
6. Engage trading partners early
7. Create a comprehensive gap analysis

- 8. Identify impact on edits and business rules
- 9. Focus testing on real-world trading partner scenarios
- 10. Establish a dedicated communications and outreach effort
- 11. Document timeframes and test expectations early
- 12. Build regression testing into the process
- 13. Test early and often

CMS Questions: Potential Impact on Processes/Burden

- *Which manual processes in claims, eligibility, or EFT/ERA are most likely to be automated or streamlined with version 8060?*
- *What are some current manual interventions that version 8060 is specifically designed to address?*
- *Which eliminated manual processes will translate to measurable cost saving vs. just shifting efforts elsewhere?*
- *Could version 8060 introduce any new manual processes? What burdens might small, rural, or underserved-area providers face in adopting 8060?*

- **Top manual pain points identified by WEDI members included:**
 - Missing data elements
 - Inconsistent payer responses
 - Reliance on portals and phone calls
 - Need for attachments
 - Non-standard implementations
- **Workarounds included:**
 - Manual reconciliation
 - Parsing unstructured text
 - Using APIs to bypass X12 limitations
 - Proprietary reporting
 - Fax-based attachments
 - Redefining codes

- **Missing data drives today's workarounds:** Participants repeatedly described 005010 as forcing manual interventions, portal use, repeated claim corrections, workarounds, and incomplete automation because the current version lacks needed data elements
- **Manual burden reduction is expected:** Examples cited included better support for denial handling, overpayment recovery, richer remittance information, improved coordination of benefits, and more complete claims/remittance exchanges
- **Dental stakeholders were especially strong advocates:** The dental community argued 008060 fixes real gaps affecting ADA claim form harmonization, attachments, predetermination workflows, and dental-specific use cases, making the case that dentistry has an especially urgent need for the upgrade

- Smaller practices and physicians working in rural communities **may face the most challenges** implementing 008060. A question discussed during the MPA was “**is the “juice worth the squeeze”?**” especially for providers like behavioral health
- It was noted that moving to 008060 would be part of the “**big picture**” of the regulations that all organizations are required comply with
- It was also noted that any change, regardless of the type or standard, will require smaller, less-resourced organizations to incur expense and challenges.

- **ROI remains the hardest issue to establish.** Many participants said the biggest barrier is not proving technical feasibility, but proving **cost, value, and return on investment**, especially before a proposed rule is released
- **Costs are real but hard to quantify.** Stakeholders emphasized that implementation costs vary widely by entity
- **Value may be broader than direct ROI.** Participants also argued the more important question is not just “What is the ROI of upgrading?” but “What is the cost of not upgrading?” - including ongoing manual workarounds, data gaps, claim friction, and inability to support newer capabilities

CMS Questions: Potential Transition Costs

- *What specific cost categories tend to be underestimated (e.g., trading partner testing, internal rework, vendor delays), and how might covered entities anticipate these earlier?*
- *What hidden or downstream costs should be taken into consideration in planning for 8060?*
- *What percentage of total transition costs typically comes from outside direct IT (e.g., operations, training, workflow redesign)?*

Cost Drivers

- The biggest cost drivers are usually **not transaction maps themselves**, but rather:
 - Vendor upgrades
 - Trading partner testing
 - State reporting changes
 - Encounter processing changes
 - Business rule remediation
 - Provider outreach and education
 - Governance and project management
 - Dual-processing periods
 - Staff training
 - Operational support
 - Claim adjudication/remittance changes
 - Hidden downstream mapping/conversion issues

CMS Question: 008060 Readiness

- *How far in advance do health IT vendors need final implementation guides to ensure consistent deployment?*
- *Do you anticipate that major health IT vendors, clearinghouses, and billing intermediaries will be fully ready to implement 8060 approximately 3 years from now?*
- *What challenges do you foresee if vendor readiness varies significantly across trading partners?*

- **Implementation success:** Participants stressed that success will likely depend on clear milestones, realistic timelines, testing windows, and early action. Too many organizations waited until the last minute during prior implementation transitions
- **Vendor readiness is a major risk:** A recurring concern was that providers and payers often cannot move forward until practice management, RCM, and vendor systems are ready, making vendor coordination essential
- **PoC helpful:** Several commenters emphasized that the X12 proof-of-concept (PoC) work is helpful-that X12 tested the interaction of different versions with no negative impacts
- **Piloting:** Implementing real-world production pilots and end-to-end testing would serve to build industry confidence (We also note that some participants urged CMS to support full-scale pilots)

- **Post-cutover issues are often underestimated:** Participants warned that many costs only emerge **after go-live**, when gaps in testing, education, and trading partner readiness create rework requirements, increased phone calls, and required production fixes
- **Overlapping mandates could impact adoption:** Participants also noted that overlapping regulatory efforts—especially around FHIR APIs, prior authorization, and other modernization rules—could compete for the same business and technical resources

CMS Question: Operating Rules

Many of the Operating Rules previously adopted by HHS under HIPAA appear to have been incorporated into version 8060 of the transaction standards.

- *Do you and your organization believe that the operating rules embedded in version 8060 of the standards are sufficient?*
- *Are any additional operating rules necessary for the 8060 version of the transaction standards at this time?*

- **Operating rules still matter:** Participants stated that while some operating-rule content has been folded into 008060, that not everything is solved by the transaction standard itself, especially issues like response times and implementation expectations
- **Need for updated rule alignment:** Participants suggested that operating rules and standards should evolve together, and that there may be a need to review and update rules in light of 008060

CMS Question: Alternative Standards

In CMS-0062-P, HHS proposed replacing the current X12 5010 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it).

- *At this time, are there other standards for any of the remaining HIPAA health care transactions that the Secretary should consider?*

- There was significant support for including **acknowledgments** in the suite of upgraded transactions.
- These would include:
 - 999
 - 277CA
 - 824

- On the question of alternative standards beyond prior authorization: **No strong push for replacing other HIPAA transactions**
- WEDI members did **not identify any additional candidates** ready to replace other X12 transactions, though attachments and some FHIR-related questions were flagged for further exploration

Summation

The major points of the MPA discussion were:

1. Many participants favored moving to the full transaction suite
2. Difficult to establish clear 008060 ROI prior to an NPRM
3. The current X12 PoC process demonstrates technical feasibility
4. Cross-version complexity is a major concern
5. Attachments are a high-priority area where direct 008060 adoption may be preferable to an interim 006020 step
6. Implementation costs are driven more by operational, and ecosystem change

7. Small providers and resource-constrained organizations need special consideration
8. As with previous transitions, clearinghouses are expected to play a key support role for both payers and providers
9. Adding acknowledgments and appropriate supporting operating rule infrastructure should be considered
10. Lessons from earlier version transitions strongly support early planning, broad coordination, and frequent and wide-scale testing



THANK YOU!

Closing Remarks

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Thank you!

This concludes today's session.

<https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/hipaa/evnts-latest-news#events>