

HHS Listening Session on Advancing X12 Mandated Transaction Standards to Version 8060

July 1, 2026

Executive
and
Comprehensive Summary



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HHS Listening Session on Advancing X12 Mandated Transaction Standards to Version 8060

Summary of Themes and Takeaways from July 1, 2026, DSMO/WEDI Listening Session

Centers for Medicare & Medicaid (CMS), Office of Health Technology and Products (OHTP)

Background:

HIPAA Administrative Simplification, established under subtitle F of title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), directs the Secretary of Health and Human Services (HHS) to adopt national standards for certain electronic health care administrative transactions to improve the efficiency, consistency, and interoperability of electronic health information exchange while reducing administrative burden and costs. These standards apply to covered entities that conduct the applicable transactions electronically.

HHS currently requires covered entities to use Accredited Standards Committee (ASC) X12 (X12) Version 5010 for most HIPAA-adopted administrative transactions. Since Version 5010 was adopted, health care business processes, technology, and industry needs have continued to evolve. In response, X12 has developed Version 8060 implementation specifications to address identified limitations in the current standards, improve support for modern administrative processes, reduce reliance on companion guides and workarounds, and enhance data consistency while maintaining the HIPAA Administrative Simplification framework.

X12 issued a December 22, 2025, letter to HHS recommending the adoption of Version 8060 of the currently mandated transaction standards. HHS began evaluating Version 8060 for potential future rulemaking to modernize the HIPAA Administrative Simplification transaction standards. The contemplated rulemaking (CMS-0061-P) would affect multiple HIPAA-adopted X12 transaction standards, including health care claims, eligibility inquiries and responses, claim status, referral certification and authorization, enrollment and disenrollment, health care payment and remittance advice, premium payments, coordination of benefits, and health care claims attachments, as applicable. The effort supports the Department's longstanding Administrative Simplification objectives while aligning with broader Administration priorities to modernize health information exchange, improve operational efficiency, and reduce unnecessary regulatory burden through updated standards.

The HIPAA Administrative Simplification statute and implementing regulations contemplate that HHS consult with industry stakeholders when considering modifications to adopted standards. In carrying out these responsibilities, HHS relies on recommendations from the National Committee on Vital and Health Statistics (NCVHS), consults with appropriate federal and state agencies and private organizations, and coordinates with the six Designated Standards Maintenance Organizations (DSMOs), including X12, National Council for Prescription Drug Programs (NCPDP), Health Level Seven (HL7), the American Dental Association Dental Content Committee (ADA DCC), the National Uniform Billing Committee (NUBC), and the



National Uniform Claim Committee (NUCC). HHS also engages with organizations such as the Workgroup for Electronic Data Interchange (WEDI) to obtain stakeholder perspectives on implementation readiness and operational considerations.

Consistent with these responsibilities, on July 1, 2026, the Office of Healthcare Technology and Policy (OHTP), on behalf of HHS, convened a listening session with the six DSMOs and WEDI to obtain stakeholder feedback on the potential transition to ASC X12 Version 8060. The session provided an opportunity to gather information on implementation readiness, costs, benefits, sequencing, testing approaches, and potential compliance timeframes, which will help inform development of a future proposed rule.

The 8 Key Topics addressed by Participating Organizations during this Listening Session were:

- Version 8020 vs. 8060 for Claims and Claims/Remittance Advice.
- Version 6020 vs. 8060 for Claims Attachments.
- Prioritization of transaction standards for potential advancement to version 8060.
- Potential Impact of advancing to version 8060 on Manual Processes/Burden.
- Potential Transition Costs.
- Readiness for 8060 Implementation.
- Operating Rules.
- Alternative Standards.



The Participating organizations were:

(See [Appendix A](#) for a list of speakers, their organizations, and submitted materials)

- X12 – Accredited Standards Committee X12
- HL7® – Health Level Seven International
- NCPDP – National Council for Prescription Drug Programs
- NUCC – National Uniform Claim Committee
- NUBC – National Uniform Billing Committee
- DECC – Dental Content Committee
- WEDI – Workgroup for Electronic Data Interchange

Executive Summary of Cross-Cutting Themes from Listening Session

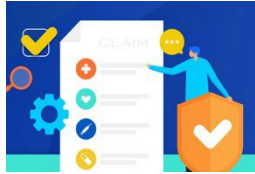
Participants agreed that Version 8060 of the mandated X12 standards addressed the concerns previously raised by NCVHS regarding Version 8020. They also identified significant value in transitioning to Version 8060 and agreed that it represented a meaningful improvement over Version 8020. While participants broadly supported the adoption of Version 8060 as a complete suite of standards rather than a subset, they also raised several considerations that HHS should address in any future proposed rule to support a successful transition. Participants generally did not express concerns regarding International Classification of Disease-11 (ICD-11) readiness but emphasized the importance of incorporating the Food and Drug Administration's new National Drug Code format into the Version 8060 implementation guides by the current 2033 implementation deadline.

It was noted that it was premature to estimate the value or return on investment for Version 8060. It was suggested that a more meaningful assessment would likely be possible following publication of a Notice of Proposed Rulemaking. Views were mixed on adopting Version 8060 for health care attachments alongside the health care claims standards, with some supporting the transition, particularly for dental providers, and others recommending adoption only if supported by a clear operational need.

Participants emphasized that successful implementation would require clear and well-defined implementation timelines, comprehensive end-to-end testing, strong vendor readiness, and early coordination across industry stakeholders. They also cautioned that HHS should account for and be aware of the full implementation burden. Participants identified both specific IT and non-IT factors as significant cost drivers including end-to-end testing, workflow mapping, coding, operational costs, workflow changes, staffing impacts, and temporary increases in manual processes. Small, rural, and underserved providers were identified as requiring targeted transition support to reduce implementation challenges.

Finally, participants highlighted lessons learned from prior X12 transitions, emphasizing the importance of coordinated planning, robust testing, and engaging stakeholders from the beginning. Generally, participants did not believe alternative standards were ready to replace X12 standards and supported retaining the existing X12 standards for Health Insurance Portability and Accountability Act of 1996 transactions until broader industry readiness and evidence supported future adoption of alternative approaches.

Summary of Themes and Takeaways from July 1, 2026, DSMO/WEDI Listening Session



Topic 1: Version 8020 vs. Version 8060 for claims and claims/remittance advice:

Context: On June 14, 2023, the National Committee on Vital and Health Statistics (NCVHS) provided a recommendation that HHS “not adopt” Version 8020 of the X12 transaction standards for health care claims and claim/remittance advice.¹ HHS requested feedback on whether participants and their organization agreed that Version 8060 of these standards address the concerns stated by NCVHS.

DSMO listening session participants agreed that Version 8060 addresses most of the concerns NCVHS identified in 2023 regarding Version 8020 of the X12 transaction standards. Participants concurred that Version 8060 resolves compatibility concerns and emphasized that these issues would be further remediated by advancing the entire suite of the X12 transaction standards to Version 8060 rather than a subset of it. It was noted that moving the entire suite of transactions standards at the same time reduces concerns over mixed-version environments and preserves end-to-end consistency across the revenue cycle. Participants emphasized that claim formats and their related transactions are deeply interconnected, that payers and providers often rely on multiple claim types simultaneously, and that dental, medical, and other workflows frequently overlap. Because of these dependencies, advancing only some of the standards would weaken the overall return on investment and introduce unnecessary operational complexity. Additionally, mixed version processing (e.g., 5010 claim paired with 8060 remittance) could lead to confusion and these inconsistencies would have an impact on analytics, downstream systems, and business rules.

Participants also stressed that while many issues are resolved with the adoption of Version 8060, successful implementation will require additional evidence, testing, and coordinated transition planning to ensure real-world usability and reduction of burden.

Overall Takeaway: Version 8060 substantially addresses the concerns NCVHS identified with Version 8020, particularly the compatibility issue which can be mitigated by advancing the full suite of X12 transaction standards to Version 8060, rather than a subset. Remaining issues can be addressed through testing and coordinated transition planning to support successful implementation and burden reduction.

¹ [Recommendation Letter-Updated Version of X12 Standard for Claims and Electronic Remittance Advice Transactions](#)

There was consensus across the listening session that meaningful cost and value data regarding a transition to Version 8060 remain limited. Several participants noted that accurate cost and value assessments are only possible once a Notice of Proposed Rulemaking (NPRM) is issued and implementers can conduct real-world analyses. One participant emphasized the wide variation in technical capabilities and resources across the health care industry as a significant cost driver. This variation could potentially shape three major cost-related considerations: (1) the substantial burden of supporting two versions of standards during transitional periods, (2) the need for transparent and equitable distribution of upgrade costs across all stakeholders, and (3) the importance of openly shared technical learnings to ease the transition.

The discussion underscored that a future transition to Version 8060 will require comprehensive cost and impact analyses at both the organizational and ecosystem levels, supported by sufficient, well-targeted investment and support.

Overall Takeaway: *Return on investment (ROI) is difficult to establish and reliable cost and value assessments regarding a transition to Version 8060 are more likely to take place when an NPRM is issued. Early planning, equitable cost-sharing, and robust impact assessments will be critical for a successful transition.*

Across participants, there was broad consensus that International Classification of Disease-11 (ICD-11) is not influencing current U.S. standards decision-making, and, thus, concerns about incorporating it into Version 8060 of the X12 standards are minimal. This is due to the withdrawal of the U.S. from the World Health Organization (WHO), as such the U.S. is unlikely to adopt ICD-11 nor migrate to the new classification system. It was noted by one participant, however, that the transition to Version 8060 should not be delayed due to unresolved ICD-11 issues, particularly given the absence of federal direction or supporting data to justify such a pause.

Although participants expressed few concerns about ICD-11, they identified another important modernization dependency: the Food and Drug Administration (FDA) finalized a rule requiring updates to the National Drug Code (NDC) format by 2033. Participants noted that Version 8060 implementation guides (IGs) will need to support the new NDC format and X12 is aware of this dependency and is working on a future solution as the current implementation guides do not yet support the new format.

Overall Takeaway: *ICD-11 is viewed as irrelevant to current U.S. standards advancement, with no anticipated adoption and no reason to delay the Version 8060 regulation. Support for the FDA's new NDC format by 2033 was identified as an important factor to be addressed in Version 8060 IGs by 2033.*



Topic 2: Version 6020 vs. Version 8060 for claims attachments:

Context: HHS recently adopted Version 6020 of the claims attachments standard.

a. HHS requested feedback on whether to consider proposing Version 8060 of the newly adopted claims attachments standards to be used with Version 8060 of the health care claim transaction standard.

Perspectives varied on whether HHS should propose using Version 8060 of the newly adopted claims attachments standards (X12 275/277) alongside Version 8060 of the health care claim transaction standard. One participant expressed no concerns about pairing different versions and noted that the industry already supports multiple versions in practice. Given the broader industry preference for advancing the entire Health Insurance Portability and Accountability Act of 1996 (HIPAA) transaction suite together, it was noted the attachments standards should move forward to Version 8060 as part of a coordinated update. There was support from a dental perspective for transitioning the attachments standards to Version 8060. Meaningful improvements were cited for dental claims, particularly around date-of-service issues that participants noted are more effectively addressed in Version 8060 than in Version 6020. Another participant said their stakeholders had different views. Some preferred to keep Version 6020 until Version 8060 is formally mandated, and others, particularly in the dental community, said that Version 8060 addresses important limitations in Version 6020.

Participants also urged caution. It was advised that HHS avoid disrupting the newly established claims attachments standards pathway without a clear operational rationale or need. End-to-end testing was recommended to ensure Version 6020 attachment transactions correctly reference and link to Version 8060 claims data if HHS advances the X12 professional claims standards to Version 8060. To address incompatibility, it was suggested that HHS consider synchronized advancement of both claims and claims attachments transactions standards. Additionally, there was a lack of clarity around the value of transitioning the claims attachments standards from Version 6020 to Version 8060 soon after the recent adoption of the claims attachments standards. Participants cautioned HHS against initiating another transition without a compelling benefit.

It was noted that the CMS Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges proposed rule (CMS-0062-P), if finalized, would layer Fast Healthcare Interoperability Resources® (FHIR®)-based standards for several prior authorization transaction standards, further shaping how attachments function across the workflow.

Overall Takeaway: *Views on advancing the claims attachments transaction standards to Version 8060 were mixed. Some supported alignment with the broader standards suite and improvements for dental workflows, while others cautioned against revising the recently adopted claims attachments standards without a clear need or rationale. Commenters also highlighted recent proposals by CMS to adopt the FHIR standard for prior authorization transactions.*

b. HHS also requested feedback on whether a transition period should be considered during which Version 6020 or Version 8060 of the health care claims attachments standards could be used.

Most participants supported some form of transition flexibility, though for different reasons. One organization was in favor of allowing version “leeway” due to the close timing between the Version 6020 mandate and potential future adoption of Version 8060. Multiple participants noted that implementers, particularly those who have not yet implemented Version 6020, should be allowed to move directly to Version 8060 and bypass Version 6020 entirely. It was suggested that entities already using Version 6020 or later, particularly dental providers, be allowed to remain on those versions during the Version 8060 implementation period to avoid short-term interim upgrades, reduce duplicative effort, and better align with operational realities.

Participants emphasized the need for predictable implementation timelines and clearly defined, time-limited transition periods, citing challenges experienced during the extended transition from Version 4010 to Version 5010. Participants emphasized that the transition period should support an orderly migration to the final standard and avoid prolonged dual-version support or operational ambiguity.

Overall Takeaway: *Generally, there is support for a flexible, time-limited transition to Version 8060 that allows organizations to bypass or phase out Version 6020 as appropriate. Transition periods must be clearly defined, time-limited and justified by demonstrable value to avoid repeating prior industry burdens and unnecessary costs/efforts, and move toward a single, permanent standard.*

c. Additionally, HHS requested feedback on potential operational inconsistencies if Version 6020 of the claims attachments transaction standards (X12 275 and 277) were to be used with Version 8060 of the health care claim transaction standard (X12 837).

Views differed on whether pairing Version 6020 of the claims attachments transaction standards with Version 8060 of the health care claims transaction standards would create operational inconsistencies, but several points of agreement emerged. One participant noted that organizations already using Version 6020, or even later versions such as Version 7030, should be allowed to continue doing so until HHS adopts Version 8060. They cited their practical

experience in the field, where attachment workflows at varying version levels already coexist without major disruption.

Another participant identified potential operational ambiguities arising from mismatches between Version 6020 claims attachments standards and Version 8060 claims standards. They emphasized the need to ensure attachment requests can accurately identify the associated claim, service line, procedure or service code, provider role, and required documentation. They stressed the importance of preserving claim and service-line identifiers across versions and cautioned that reintroducing payer-specific, attachment request processes might reintroduce nonstandard attachment requirements.

***Overall Takeaway:** There were differing views on whether using Version 6020 of claims attachments transaction standards alongside Version 8060 of claims transaction standards would create operational inconsistencies; however, it was generally agreed that the attachments environment is evolving across multiple standards and regulatory pathways. While continuity for organizations using Version 6020 or later versions was supported, potential alignment challenges, including claim-to-attachment linkages and payer-specific documentation variability, must be addressed to ensure a smooth transition.*



Topic 3: Prioritization of transaction standards for potential advancement to Version 8060:

Context: Given the volume of transactions for which Version 8060 is now available, HHS requested feedback on which health care transaction standards should be prioritized when proposing more advanced versions of the current standards.

Across participants there was broad agreement that standards advancement move forward as a coordinated suite rather than adopt only subset of the standards. One participant emphasized that the health care industry has consistently expressed a preference for full suite advancement of HIPAA standards and noted that advancing the recommended transactions together would best support efficient claims processing and improved patient care. A system-level perspective was also emphasized by a participant who recommended that administrative transaction standards be advanced together as a coordinated suite because they are interdependent across the full revenue cycle.

Another participant expressed support for moving the entire standards suite forward, but noted that if prioritization is required, HHS should focus on the following standards: X12N 835, X12N 837P, X12N 270/271, and X12N 834 and noted that these transaction standards are critical to pharmacy-related services. Another participant recommended prioritization of the following standards: X12N 837 (all claim types), X12N 270/271, X12N 835, and X12N 276/277, which they identified as essential to supporting the full claim cycle.

Overall Takeaway: *HHS should prioritize advancing the full suite of interdependent administrative transaction standards together particularly those that support the professional claim lifecycle to avoid misalignment, workflow disruptions, and diminished value from isolated upgrades.*

- a. HHS also requested feedback on what supporting transaction standards should be advanced in order to appropriately support Version 8060 of the X12 837 should it be proposed in future rulemaking.**

One participant emphasized the importance of aligning interdependent transactions and recommended that HHS evaluate the broader claims transaction lifecycle, including claim status, attachments, and acknowledgements or validation workflows to ensure professional claims do not advance in isolation. They cautioned that if Version 8060 of the X12N 837 standard could carry more professional service line data (i.e., line-level supervising provider, service time, or other line specific professional claim information), but related status, attachment, remittance, or acknowledgement workflow could not distinguish the professional claim, professional service line or professional procedure or service code at issue, the receiving system may not be able to determine the appropriate action. This could result in a generic claim-level message, manual lookup, phone call, portal follow-up, or unnecessary resubmission. For that reason, the participant recommended against prioritizing the professional claim standard without evaluating the transactions that must receive status, request information for, adjudicate, and reconcile the professional claim. The implementation plan should identify where version differences could break the professional claim workflow and should test those points before compliance is required.

Another participant suggested that other standards that should be advanced to support X12N 837 would include: X12N 835 and X12N 276/277. These were highlighted by this organization's stakeholders as essential to supporting the full claim lifecycle.

Overall Takeaway: *To avoid workflow breakdowns, particularly for the X12N 837P transaction standard, Version 8060 updates must be evaluated and tested across all interdependent transactions—alignment across claim, attachment, status, acknowledgement, and remittance workflows were identified as critical to maintaining end-to-end functionality and avoiding operational gaps.*

- b. HHS solicited discussion of lessons learned from implementing the transition from Version 4010 to 5010 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).**

Across participants, there was agreement that the transition from Version 4010 to Version 5010 of the X12 transaction standards offers important lessons that should guide any future

move to more advanced health care transaction standards. One participant noted that a major challenge during the previous upgrade stemmed from limited coordination among vendors and clearinghouses. In response, these groups are now engaging more proactively through X12's HIPAA testing proof-of-concept and Cooperative Exchange efforts to ensure a more unified industry approach. One participant emphasized that organizations must conduct system-specific impact assessments rather than rely on generic analyses of new functionality, as this was not done consistently during the previous transition. Limited sharing of test scenarios among stakeholders also hindered the last advancement, prompting X12 to develop common testing scenarios that will be available for public dissemination. Finally, the participant cautioned that overlapping or conflicting federal mandates complicated the last transition and urged regulators to coordinate future requirements to avoid unnecessary burden.

Other participants echoed similar themes. The reality of competing priorities and budget constraints was highlighted with reminders for policymakers to consider the cumulative regulatory load when proposing new standards. Another participant emphasized that publishing an IG alone does not equal operational readiness, particularly for small practices dependent on multiple vendors. To avoid repeating past mistakes, the organization stressed the need for realistic testing periods, clear payer and vendor milestones, updated and consistent companion guides, and strong education for smaller provider organizations. They also warned that even if a transaction technically passes rules checks, differences between versions can still cause problems that translate to real-world practical scenarios. They emphasized end-to-end testing as essential to ensure operational viability.

Another participant advised against underestimating the amount of work required for a version change, noting that even if advancing to Version 8060 appears less extensive than the shift from Version 4010 to Version 5010, it will still demand substantial changes to data elements, workflows, mappings, and business rules. As noted earlier, many organizations may not conduct full gap analyses until an NPRM is released, even if organizations are aware that significant resource commitments will likely be required. Another organization echoed previous thoughts on timelines and noted that stable, predictable timelines with no shifting deadlines are crucial, and that HHS should acknowledge the real-world challenges associated with supporting dual versions during transitions.

Lastly, one participant summarized the lessons learned as practical steps for successful implementation: (1) advance all transaction standards together; (2) identify environment-specific impacts; (3) publish a clear implementation roadmap; (4) form cross-functional teams; (5) engage IT and operational groups from the beginning; (6) bring in trading partners at the outset; (7) conduct a comprehensive gap analysis; (8) identify impact on edits and business rules; (9) focus on testing real-world trading partner scenarios; (10) establish dedicated communication and outreach; (11) document timeframes and test expectations from the beginning; (12) build regression testing into the process; and (13) test throughout implementation.

Overall Takeaway: Lessons from the Version 4010 to Version 5010 transition highlighted the need for coordinated implementation planning, comprehensive impact and cost assessments, robust end-to-end testing, clear and well-defined implementation timelines,

and early engagement across vendors, payers, providers, and trading partners to support a successful transition to advanced standards.



Topic 4: Potential impact of advancing to Version 8060 on manual processes/burden:

Context: The goal of HIPAA's Administrative Simplification provisions is to reduce burden, eliminate manual processes, and streamline administrative healthcare transactions.

- a. **HHS solicited feedback on which manual processes in claims, eligibility, or Electronic Funds Transfer/Electronic Remittance Advice are most likely to be automated or streamlined with Version 8060.**

Across the listening session, participants voiced the expectation that Version 8060 could meaningfully reduce manual processes in claims, eligibility, and payment workflows but cautioned that these benefits depend on coordinated implementation and strong vendor readiness. One participant highlighted that the Version 8060 suite includes major upgrades, particularly in the eligibility (X12N 270/271) and authorization (X12N 278) transaction standards, which should automate many tasks currently handled through phone calls, portal checks, and manual validation. Another participant noted a similar improvement for the professional claims standard (X12N 837P), where expanded diagnosis reporting, clearer line-level provider detail, improved service timing, and longer identifiers could reduce common workarounds such as claim splitting, manual matching, phone calls, resubmissions, and payer specific documentation requests.

Overall Takeaway: *Version 8060 is expected to reduce manual administrative processes across claims, eligibility, and payment workflows by improving automation and data quality. Realizing these benefits will depend on coordinated implementation, vendor readiness, and effective adoption across trading partners.*

- b. **HHS requested examples of current manual interventions that Version 8060 is specifically designed to address.**

One participant noted that Version 5010 has long required manual interventions and repeated corrections, and it has a history of inconsistent payer responses, reliance on portals, parsing through unstructured text, reliance on application programming interfaces (APIs) to bypass X12 limitations, and proprietary reporting. The participant noted that Version 8060 could address many of the gaps previously listed. Another participant anticipated a reduction in phone calls and emails about claims adjustments through remittance explanation. Two participants agreed that continued progress toward electronic workflows should continue to lower costs and reduce administrative effort, particularly in eligibility verification, where more granular data will reduce burdensome calls and portal volume.

Overall Takeaway: Version 8060 is expected to improve electronic workflows and reduce longstanding administrative burdens associated with manual interventions, claims adjustments, and eligibility verification.

c. HHS requested information on whether Version 8060 could potentially introduce any new manual processes.

Multiple participants cautioned that Version 8060 could introduce new manual steps if systems could not capture or process expanded data. Unclear mappings, inconsistent companion guides, or downstream transactions that cannot preserve claim and line context could reduce the expected automation gains. During transition periods, organizations may need to support parallel workflows, temporary administrative complexity, version mapping, exception handling, and increased manual reviews. Mixed-version environments could also create new translator needs, up/down conversion logic, payer-specific version management, and analytic inconsistency.

Overall Takeaway: Version 8060's automation benefits will depend on effective implementation, as transition challenges such as data mapping gaps and mixed-version environments could temporarily increase operational complexity and manual effort.

d. HHS further requested feedback on whether small, rural, or underserved-area providers might face additional burdens in adopting Version 8060.

Concerns were highest about the impact on small, rural, and underserved-area providers who do not directly manage X12 implementation, yet experience the consequences through rejected claims, delayed payments, costly vendor upgrades, workflow disruptions, staff retraining, and cash flow instability. Participants stressed that small practices cannot absorb the same implementation complexity as major health systems or national payers. For these providers, readiness depends on timely vendor updates, robust payer-vendor testing, clear guidance for both paper and electronic formats, and reliable national education supports. A time-limited dual use period may help but must be clearly defined so that the system ultimately converges on a single standard. Several participants noted that without targeted support, resource-constrained providers may struggle to absorb implementation costs and remain dependent on manual processes.

Overall Takeaway: Small, rural, and underserved providers may require targeted support, including vendor readiness, testing, guidance, and transition assistance to mitigate implementation burden and avoid prolonged reliance on manual processes.



Topic 5: Potential transition costs:

Context: HHS seeks to estimate transition costs in its proposed regulations.

- a. HHS requested information regarding what specific cost categories tend to be underestimated (e.g., trading partner testing, internal rework, vendor delays), and how covered entities might anticipate these early in the implementation process.**

Across participants, there was broad agreement that transitioning to Version 8060 would carry significant costs, many of which are historically underestimated. While transition expenses accompany any major system upgrade, organizations stressed the need to evaluate these investments against the rising cost of not modernizing and noted that federal and state mandates must be aligned to avoid duplicative spending. Participants echoed concerns about cost distribution and noted that dual-version support can be expensive and that financial burden must be shared equitably. One participant also highlighted IT specific costs such as the burden of maintaining mappings, code sets, terminology, IGs, and infrastructure in a multi-standard environment.

In addition to general transition expenses, organizations highlighted a wide range of specific cost categories that must be anticipated at the beginning, including data transformation between versions, internal workflow redesign, vendor delays, and reliance on clearinghouses.

Overall Takeaway: Transitioning to Version 8060 is expected to require significant investment, with costs spanning technology, workflows, vendor readiness, and version management. Effective planning coordinated mandates and equitable cost-sharing were identified as critical to managing the financial impact.

- b. HHS requested information on hidden or downstream costs for implementers that should be taken into consideration in planning for Version 8060.**

Hidden and underestimated cost categories include extensive trading-partner testing, workflow redesign, claim-edit updates, provider education, help desk support, dual-version operations, rejected claim remediation, vendor deployment sequencing, and cash flow impacts from rejected claims. Participants noted that unclear or inconsistent guidance often translates directly into manual rework, one of the most expensive hidden costs for providers, clearinghouses, and payers.

It was also noted that establishing ROI can be challenging, since many of the benefits stem from reduced manual burden and improved capability rather than direct financial offsets. Downstream and longer-term costs were highlighted, and participants urged organizations to begin implementation planning in the beginning and not rely on extensions. They emphasized that the complexity and volume of changes in Version 8060 far exceeds the changes that occurred in the transition from Version 4010 to Version 5010.

Overall Takeaway: *Version 8060 implementation costs extend beyond system changes to include hidden impacts such as testing, workflow redesign, education, dual-version operations and claim remediation. Early planning and clear guidance are critical to reducing rework and realizing long-term value.*

- c. **Additionally, HHS requested information regarding the percentage of total transition costs that are not direct IT costs (e.g., operations, training, workflow redesign).**

Several participants emphasized that a substantial portion of transition costs falls outside traditional IT and that these non-IT costs are both significant and frequently underestimated. In addition to training, operational adjustments, provider outreach, remittance and adjudication changes, and manual remediation, participants identified a wide range of non-IT cost drivers that must be incorporated into planning for Version 8060. Non-IT cost drivers include education, governance activities, dual processing, operational support, staff retraining, and workflow adjustments, all of which can create significant administrative burden during implementation.

Overall Takeaway: *Version 8060 transition planning should account for significant non-IT costs, including training, operational adjustments, outreach, and administrative support, which are often underestimated.*



Topic 6: Readiness for Version 8060 implementation:

Context: HHS understands that implementation guides are necessary for successful implementation of updated standards.

- a. **HHS requested information on how far in advance health IT vendors need final IGs to ensure consistent deployment.**

Most participants agreed that successful implementation of Version 8060 will depend heavily on early access to IGs, clear federal timelines, and strong vendor participation. One participant noted that Version 8060 IGs have been available for nearly a year and the industry has discussed these upgrades for several years, suggesting that many stakeholders should already be preparing for implementation. However, another emphasized that vendors need at least three years between a final rule and compliance, noting that a January 1 go-live date would be particularly challenging due to annual enrollment cycles, formulary updates, and staffing shortages. A different participant supported a full 24-month implementation window and noted the heavy regulatory load already placed on providers.

Participants next pointed to today's multi-standard environment, where organizations must simultaneously support X12, FHIR, and NCPDP standards. Participants urged HHS to consider how a transition to Version 8060 aligns with national priorities like value-based care, digital health, patient empowerment, and API-driven interoperability, and they called for HHS to avoid disrupting ongoing FHIR adoption. Participants emphasized a measured timeline, strong communication, robust technical assistance, and financial support for mapping and infrastructure as essential factors for organizational readiness.

Overall Takeaway: Successful implementation of Version 8060 will require clear timelines, early guidance, vendor readiness, and adequate transition support while accounting for existing regulatory demands and evolving interoperability priorities.

b. HHS requested feedback on whether participants anticipate that major health IT vendors, clearinghouses, and billing intermediaries will be fully ready to implement Version 8060 approximately three years from now.

A participant cautioned that past delays in other mandates have made some stakeholders complacent and readiness will depend on clearly enforced expectations. Another participant echoed this concern and underscored that the mere existence of IGs does not equal readiness. Vendor deployment schedules, payer testing environments, standardized edits, small-practice education, and a clearly bounded dual-use period will all influence whether the ecosystem can transition smoothly to Version 8060. Additionally, there may be differences in readiness across vendor sectors and others noted that vendor readiness is closely tied to CMS finalizing mandates.

Overall Takeaway: Successful adoption of Version 8060 will require clear enforcement, coordinated ecosystem readiness, and sufficient transition support rather than solely relying on the availability of IGs.

- c. **HHS requested discussion of potential challenges that may result should vendor readiness vary significantly across trading partners.**

Participants warned that uneven vendor readiness could create operational bottlenecks, including inconsistent transaction quality, extended dual-standard operations, delayed efficiencies, and post-cutover rework. Many organizations (particularly providers), cannot proceed until their vendors do, making vendor coordination a major dependency. Participants emphasized the need for realistic milestones, robust piloting, and avoiding overlapping regulatory deadlines that compete for the same resources.

Overall Takeaway: *Vendor readiness was identified as a critical dependency for advancement to Version 8060 requiring coordinated milestones, robust testing, and aligned timelines to avoid operational disruptions and delays.*



Topic 7: Operating rules:

Context: Many of the previously adopted operating rules have now become part of Version 8060 of the respective standards.

- a. **HHS requested feedback on whether participants and their organization believe that the operating rules embedded in Version 8060 of the standards are sufficient.**

Participant perspectives varied on whether the operating rules embedded in Version 8060 are sufficient, but most agreed that operating rules remain an important complement to the transaction standards. Participants noted that operating rules and standards should evolve together. It was noted that most mandated data-content operating rules are already incorporated into Version 8060 IGs, though additional operating rules may still help to ensure consistency across industry. One participant noted that CMS should clarify whether current operating rules sufficiently support Version 8060 of the X12 standards and additionally identify who is responsible for updating these rules, if needed.

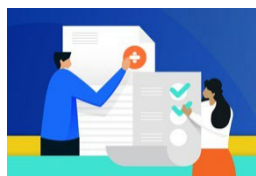
Some participants urged caution. One noted that it is too early to determine whether the embedded rules are adequate, highlighted limited past support for claim-specific operating rules, and recommended careful consideration before introducing new requirements. Another participant emphasized that, although Version 8060 incorporates some operating-rule content, transaction standards alone cannot address issues such as response times and implementation expectations. Participants recommended that any new operating-rule discussions be tied to specific, clearly identified issues affecting data content or definitions.

Overall Takeaway: While Version 8060 incorporates many operating-rule elements, participants agreed that standards alone cannot ensure consistent, predictable industry operations. Additional operating-rule guidance may be necessary particularly for response expectations and transition behavior but should be approached cautiously and only to address clearly defined gaps.

b. HHS further requested feedback on whether additional operating rules may be necessary for Version 8060 of the transaction standards at this time.

Regarding whether additional operating rules are needed, one participant indicated plans to provide transition guidance similar to operating rules once a final rule is issued. Participants reaffirmed that operating rules remain relevant in areas where standards alone cannot guarantee predictable or uniform industry behavior. A participant noted that claim related rules have not been updated specifically for Version 8060 and stressed that there was not broad industry support when claim operating rules were previously considered.

Overall Takeaway: Operating rules were viewed as a potential tool to support consistent implementation where standards alone may not ensure predictable industry behavior. Additional transition guidance and evaluation of claim-related rules will be needed as Version 8060 adoption progresses.



Topic 8: Alternative Standards:

Context: In the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule (CMS-0062-P), HHS proposed replacing the current X12N 5010 278 standard for referral certification and authorization with the HL7 FHIR Prior Authorization Support standard (and other standards to be used in conjunction with it).

HHS requested feedback on whether there are alternative standards for any of the remaining HIPAA health care transactions that the Secretary should consider adopting at this time?

Participants expressed a range of views on whether additional standards beyond those proposed in CMS-0062-P should be considered for remaining HIPAA transactions, but no broad support emerged for replacing X12 standards outside of prior authorization. Several participants noted and emphasized that X12 standards are already widely implemented and continue to expand, reiterating that consistent data requirements matter more than syntax and should remain flexible for implementers.

One participant endorsed the FHIR standard proposed in CMS-0062-P and noted that its proposal is a meaningful step toward scalable, API-based interoperability. The participant highlighted the transformative benefits of FHIR for reducing burden and improving patient and provider experience and pointed to a broader ecosystem of FHIR IGs, such as the Da Vinci CDex IG, that complements administrative workflows, though does not necessarily replace HIPAA transactions at this stage.

Participants urged caution and noted that no alternative standard is currently ready and feasible to replace the X12N 837P standard nationwide. One participant stressed that such a shift would require extensive testing, mapping updates, and a robust transition plan. Overall, participants warned against moving away from well-established and well-implemented standards without compelling justification, especially given that X12 standards exhibit wide industry adoption.

Another participant underscored that any alternative standard must support dental data and workflows, something FHIR does not yet fully provide, making broad replacement of X12 standards premature. Overall, participants acknowledged that the move to FHIR for prior authorization reflects unique circumstances including federal regulatory momentum, industry alignment around API-based exchange, and addresses specific pain points. However, participants agreed that a general shift away from X12 for other HIPAA transactions is premature.

Overall Takeaway: Outside of prior authorization, stakeholders do not believe any alternative standards are ready to replace X12 transaction standards. While FHIR offers transformative potential in targeted areas, the industry overwhelmingly supports retaining existing X12 standards for claims and other HIPAA transactions until compelling evidence, testing, and readiness justify broader change.

Supporting materials submitted by participating organizations are available in the accompanying Appendix document.

Appendix A: Organizations and Speakers

Organization	Speaker
Accredited Standards Committee X12	Cathy Sheppard
Health Level Seven International	Viet Nguyen
National Council for Prescription Drug Programs	Margaret Weiker
National Uniform Claim Committee	Julie Brown-Georgi
National Uniform Billing Committee	Terrence Cunningham
Dental Content Committee	Stephen Morgan
Workgroup for Electronic Data Interchange	Robert Tennant