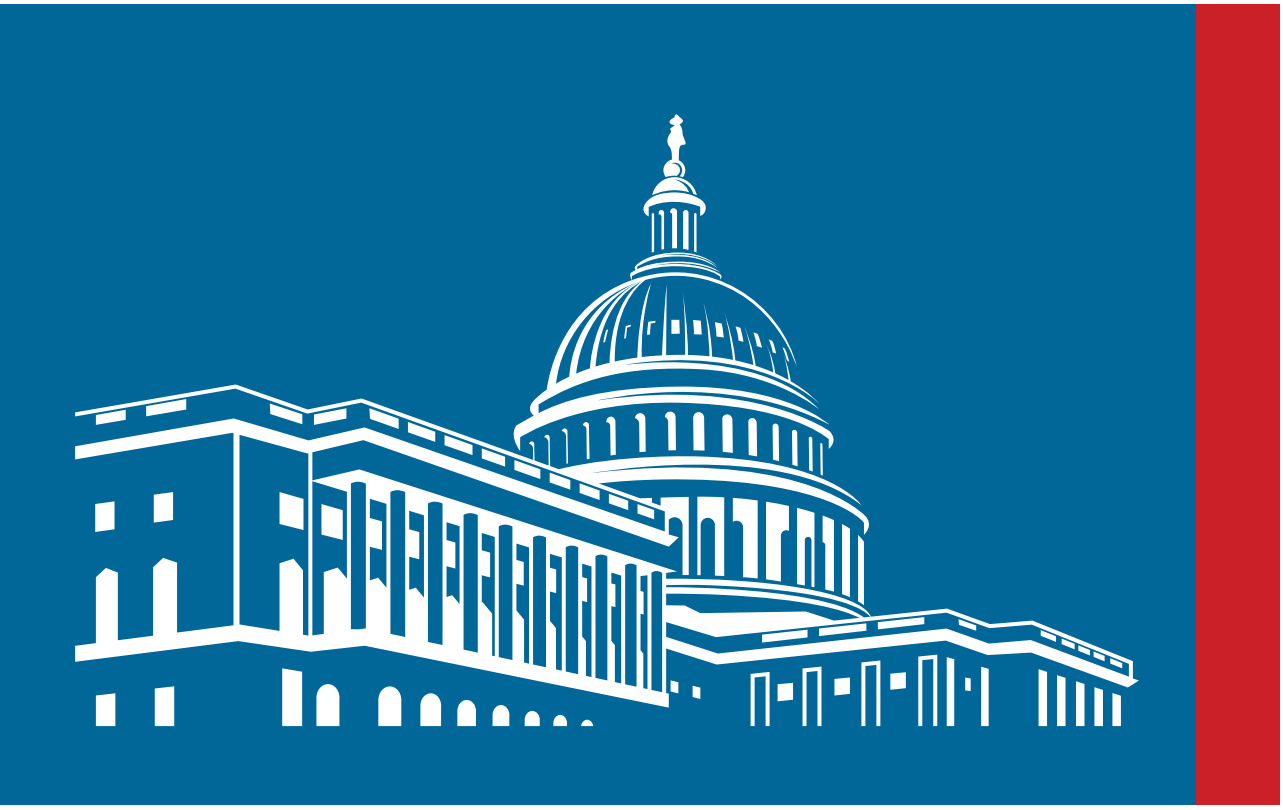

WEDI X12 VERSION 008060

FEDERAL POLICY CONSULTATION REPORT

MAY 2026

INDUSTRY INPUT ON POTENTIAL ADOPTION OF X12 VERSION 008060 UNDER HIPAA

Workgroup for Electronic Data Interchange • 3503 Connecticut Ave, NW, Suite 205
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ABOUT WEDI

The Workgroup for Electronic Data Interchange (WEDI) was formed in 1991 by Secretary of HHS, Dr. Louis Sullivan in an effort to identify opportunities to improve the efficiency of health data exchange. WEDI was named in Section 1172(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation as an advisor to the Secretary. Since that time, WEDI has closely interacted with every subsequent U.S. Administration, including the current one. With its close working relationships with the Centers for Medicare & Medicaid Services (CMS), Office for Civil Rights (OCR), and Office of the National Coordinator for Health Information Technology (ONC), WEDI has the ability to influence all facets of health IT policy.

Today, WEDI drives strong, unified public-private partnerships to improve health information exchange by bringing together organizations from across the health care spectrum including providers, payers, vendors and government. By convening health care leaders and driving consensus-based solutions, WEDI has been successful in resolving current data exchange-related roadblocks and continuously motivates the industry towards administrative automation.

Mission

Provide multi-stakeholder leadership and guidance to the nation's health care system on how to use and leverage the industry's collective technology, knowledge, expertise and information resources to improve the administrative efficiency, quality and cost effectiveness of health care information.

Vision

Better health care at lower cost through collective action.

EXECUTIVE SUMMARY

This report documents the WEDI Federal Policy Consultation (FPC) on X12 Version 008060, convened at the request of the Centers for Medicare & Medicaid Services (CMS) National Standards Group (NSG). CMS NSG is currently considering adoption of Version 008060 and requested that WEDI gather broad, industry-wide input on the potential costs, benefits, opportunities, and challenges of adopting X12's Version 008060 implementation guides, adopted under HIPAA. The report is intended to communicate what WEDI heard from stakeholders. It is not a consensus statement, nor does it include specific WEDI recommendations., The report is made publicly available alongside supporting appendices. WEDI created the FPC process after discussions with CMS identified a need for an organized, repeatable approach to convene stakeholders and collect input before rulemaking. The FPC provides HHS and its agencies with a structured, flexible way to obtain perspectives and data from a wide range of participants (including non-WEDI members). Depending on the topic, WEDI may deploy surveys, written statements, hearings/listening sessions, interviews, virtual meetings, and other methods to collect industry feedback. WEDI's role is to synthesize majority and minority views and provide a factual report of the input received. We note that for the Version 008060 consultation, CMS was initially developing a survey to solicit industry feedback on X12's recommendation to adopt 008060 under HIPAA.

The scope expanded into a full FPC that combined stakeholder education and three primary feedback channels: (1) an industry survey (120 responses), (2) an online written statement submission form, and (3) a virtual public hearing featuring presentations from CMS, X12, and multiple stakeholder panels followed by open discussion. WEDI also supported foundational education to help participants understand the technical and operational nature of the upgrade from the currently mandated Version 005010 (5010) to 008060 (8060).

- WEDI created a HIPAA-dedicated webpage for 008060 resources.
- Recordings from WEDI's 2025 National Conference sessions on 008060 were posted.
- WEDI and X12 joint fact sheets and related papers were shared to support consistent messaging and understanding.

The survey and written statement components were deployed through SurveyMonkey and promoted via the WEDI website, WEDI marketing messages, and outreach through industry partners. Both were open to the public and remained available for approximately four weeks, closing after the hearing. The written statement form asked three broad questions focused on: (1) organizational impacts (costs, benefits, burden reduction), (2) implementation recommendations (timing, sequencing, coordination with other requirements), and (3) any additional considerations. Ten written statements were received; one was identified as a duplicate of a panelist submission, leaving nine distinct written statements summarized in the report and reproduced in full in Appendix G.

Across the written statements, viewpoints ranged from strong support for adopting the full 8060 suite to recommendations for limiting adoption to a subset of transactions (most commonly eligibility and claim status, i.e., 270/271 and 276/277). Supporters emphasized that Version 008060 enables richer and more precise data exchange, improved adjudication and reporting, modernization aligned with evolving program needs, and reduced reliance on workarounds that erode standardization. More cautious respondents emphasized the significant cost and disruption of major upgrades, concerns about overlapping mandates (particularly interoperability initiatives and other CMS rules), uncertainty about return on investment for some transactions, and the practical difficulty of coordinating readiness across vendors and trading partners.

The virtual FPC hearing was structured to maximize input and transparency: CMS and X12 provided

introductory presentations, four stakeholder panels delivered prepared remarks, and a moderated open discussion captured additional verbal and chat-based comments (with WEDI noting that comments would be recorded without attributing them to specific individuals or organizations). CMS emphasized the role of HIPAA administrative simplification and the importance of stakeholder input in the regulatory process, including the need to understand benefits, challenges, and costs before moving forward. CMS also referenced recent final rules related to pharmacy transaction updates and electronic claims attachments/e-signatures, underscoring that multiple regulatory efforts are underway with compliance dates extending into 2028.

X12 described Version 008060 as the product of a large, member-driven standards organization and a formal maintenance process supported by an Annual Release Cycle. X12 highlighted that the 008060 implementation guides were published in September 2025 and that X12 formally recommended adoption later that year, accompanied by supporting resources (change reference documents, benefit summaries, a mechanical comparison report, and educational webinars). X12 emphasized that implementers should independently evaluate impacts and not rely solely on summary tools. Examples of benefits discussed included improved transparency in provider payment adjustments, expanded diagnosis reporting capacity, enhanced coordination of benefits, greater use of external code sets that can be updated more frequently, better support for additional lines of business (including dental and pharmacy), more granular coding for inquiries/requests/adjustments/dates, and improved overall accuracy for adjudication, reporting, and reconciliation.

Panelist themes were consistent with the written submissions but provided additional detail by stakeholder type:

- **Designated Standards Maintenance Organizations (DSMOs):** Generally supported modernization but stressed that "capability" must translate into real-world usability and uniformity. Dental-focused remarks emphasized that the shift from 5010 to 8060 is not incremental for dental workflows and requires enforceable requirements (often via operating rules) so that key eligibility/benefit details are populated and not left blank. Some DSMOs reported reviewing specific transactions without finding "showstoppers," while still requesting adequate time and avoidance of overlap with other major mandates.
- **Payers and providers:** Many expressed conditional support but noted difficulty completing gap analyses or ROI assessments without clearer provider-facing explanations of benefits by transaction and by workflow. Hospitals and physicians emphasized operational disruption, vendor dependence, and capacity constraints, particularly for small and rural providers. Some stakeholders called out promising improvements (especially eligibility enhancements) while still urging caution on broader adoption until value is clearer.
- **Intermediaries/clearinghouses and vendors:** Often supported adoption and highlighted long-standing limitations in 5010 (e.g., unstructured/variable eligibility details, difficulty distinguishing benefits across multiple plans, limited prospective claim support) that 8060 can address. Several noted that end-to-end testing is typically the major cost driver and that intermediary services (e.g., translation/up- or down-conversion during transition) may help mitigate staggered readiness across trading partners.
- **Other stakeholders (e.g., measurement/industry index perspectives):** Emphasized that high electronic adoption does not always mean full automation or realized savings; remaining inefficiencies are often due to data completeness and workflow integration gaps. Updated standards may help address these gaps, but only if implemented consistently and integrated into operational processes.

Several cross-cutting considerations emerged repeatedly across survey/written statements, panel remarks, and the open discussion:

- **Implementation timing and sequencing:** Many stakeholders referenced a need for an extended timeframe (commonly around 24 months from a final rule) and cautioned against compliance dates that coincide with high-risk operational periods (e.g., January 1). Views differed on sequencing: some favored implementing the entire suite at once to avoid repeated testing cycles; others recommended prioritizing the highest impact/most complex transactions (frequently the 270/271) and phasing others later.
- **Coordination with other federal requirements:** Participants highlighted competing demands from interoperability and prior authorization initiatives, (CMS-0057-F), electronic attachments requirements (CMS-0053-F), and other CMS rules. Several comments reflected concern about overlapping resource constraints (particularly because internal teams may be organized by business domain rather than by technical standard), even where X12 and FHIR are viewed as complementary.
- **X12 and FHIR standards:** A recurring theme across written statements, panel remarks, and open discussion at the live event was the relationship between X12 standards and FHIR-based APIs. Stakeholders did not view the two as in conflict, but several reported that mixed signals regarding CMS direction-particularly for prior authorization-are slowing investment decisions. Clear, consistent guidence on the long-term roles of X12 and FHIR was widely requested.
- **Vendor and business associate readiness:** Providers and smaller plans emphasized dependence on practice management/EHR vendors, clearinghouses, and claims administration platforms. Stakeholders noted that vendor development cycles, pricing, and rollout schedules can become the practical pacesetter for industry adoption, and that gaps in structured data capture upstream can limit the usability of richer responses downstream.
- **Testing, parallel operations, and transition services:** End-to-end testing was consistently identified as a major effort and cost driver. Many participants supported comprehensive testing milestones, possible parallel processing periods, and clearer national guidance on testing expectations. Some noted that translation services (e.g., up- or down-conversion) can reduce short-term disruption but may also extend dual-version complexity if not time-limited.
- **"Usability" and data completeness:** A recurring theme—especially for eligibility/benefits—was that improvements only reduce burden if payers consistently populate the new structured fields and if operating rules or other requirements set minimum content expectations where data exists. Otherwise, stakeholders warned, workflows revert to phone calls and portals, undermining administrative simplification.
- **Prior authorization context**: Several stakeholders raised the interaction between Version 008060and concurrent CMS prior authorization ruemaking-both the role of the C12 278 transaction and the relative weight of FHIR-based APIs-as a factor that will shape industry capacity and willingness to invest in 008060 adoption.
- **Need for a comprehensive impementation roadmap and industry leadership**: commenters expressed the need for a clear and actionable implementation roadmap and identified WEDI as a potential industry leader to assist stakeholders transition to new standards.

The remainder of this document provides the detailed record supporting this summary, including an outline of the FPC process, descriptions of the survey and written statement methods, and documentation of the hearing agenda, panel presentations, and the edited open-discussion transcript. The appendices compile key artifacts used during the consultation (WEDI's FPC procedure, marketing and outreach materials, hearing agenda, panel statements and slide decks, transcript, survey data, and full written statements).

OVERVIEW OF WEDI'S FEDERAL POLICY CONSULTATION PROCESS

WEDI, through discussions with the CMS National Standards Group, identified a need for a process in which the industry could be convened prior to regulatory action to collect feedback and data on the benefits, costs, opportunities, and challenges of the specific topic on the industry stakeholders. From those discussions, WEDI, through its Policy Committee and Board of Directors, approved the FPC process.

The purpose of the FPC is to support the Department of Health and Human Services (HHS) and its agencies by proactively convening consultation events prior to regulatory action. The process is set up to ensure that industry-wide stakeholders have an opportunity to provide input and data on the relevant topics that assist WEDI in its statutory role to inform and advise HHS, its agencies, and other appropriate policymaking bodies. This process is not limited to WEDI members.

The FPC process includes various methods through which the information can be collected, including requests for written statements, surveys, virtual and in-person meetings or hearings, interviews, electronic polling tools, and other relevant means. The specific information collection methods may vary based on the subject of the FPC. This flexibility allows for a wider variety of industry organizations to participate thereby giving WEDI greater insights into stakeholder perspectives and concerns.

The FPC process is designed for industry stakeholders to share their perspectives on the topics and issues in which it has knowledge, background, and experience. Through this process, WEDI captures majority and minority perspectives that are reported to HHS or the requesting agency. The FPC report represents the information gathered during the process. The report contains no WEDI recommendations and does not necessarily represent WEDI's own position. The final report is also shared with the public.

OVERVIEW OF X12 VERSION 008060 FPC PROCESS

In January 2026, CMS was working on the development of a survey to gather industry feedback on X12's recommendation to adopt the Version 008060 transactions under HIPAA. (The X12 recommendation letter is available on their website at: https://x12.org/news-and-events/x12-hipaa-recommendations.) CMS requested input from WEDI on the survey and through discussions about CMS' interest and need for industry-wide feedback, the decision was made for WEDI to conduct an FPC on this topic.

WEDI's Policy Committee developed the plan for the FPC, which included:

- Providing level setting education on the X12 Version 008060 transactions through:
  - Launching of a HIPAA-dedicated webpage on the WEDI website
  - Posting of recordings from WEDI 2025 National Conference on X12 Version 008060
  - Posting of WEDI-X12 joint Version 008060 fact sheets on and other relevant WEDI papers

WEDI 2026 Policy Committee

Pamela Grosze
PNC Bank (Chair)

Matthew Albright
Zelis

Denny Brennan
Massachusetts Health Data Consortium

Julie Brown-Georgi
American Medical Association

Terrence Cunningham
American Hospital Association

Rebekah Fiehn
American Dental Association

Rajesh Godavarthi
MCG Health

Steven Johnson
Health Care Service Corporation

Gail Kocher
Blue Cross Blue Shield

Danielle Lloyd
AHIP

Samantha Meklir
Medical Group Management Association

Michael Pattwell
Edifecs, a Cotiviti Business

Cathy Sheppard
X12

Merri-Lee Stine
CVS Aetna

Erin Weber
CAQH

Robert Tennant
WEDI

Nancy Spector
WEDI

- A survey, based on the draft from CMS and modified from input by the WEDI Data Exchange Subworkgroups and Board of Directors
  - Survey to be launched via Survey Monkey and posted on the WEDI website and shared through WEDI marketing messages and industry partners
  - Survey open to the industry and public at large to complete
  - Survey to be open for four weeks starting at the beginning of April and closing after the FPC hearing
- A written statement submission form, including three questions about the potential benefits, costs, and other considerations for the adoption of Version 008060
  - Online submission portal via Survey Monkey and posted on the WEDI website and shared through WEDI marketing messages and industry partners
  - Online submission portal open to the industry and public at large to complete
  - Online submission portal to be open for four weeks starting at the beginning of April and closing after the FPC hearing
- An FPC hearing to be held virtually, and include the following:
  - WEDI Welcome and Introduction
  - Introduction presentation by CMS
  - Overview and Development of Version 008060 presentation by X12
  - Four stakeholder panels:
    - Designated Standards Maintenance Organizations
    - Payer and Provider
    - Intermediary
    - Other Interested Stakeholders
  - Open discussion for comments and questions from attendees

SUMMARY OF THE WEDI X12 VERSION 008060 FPC SURVEY

Survey Development

Following consultation with CMS, it was determined that WEDI would conduct a survey to ascertain the impact of the recommended updates to X12 administrative transactions on the health care system. The development of the questions was a collaboration between CMS and the WEDI HIPAA EDI Transaction Subworkgroups. The goal of the survey was to better understand if and how upgrading the currently mandated HIPAA transactions will improve current business processes.

Questions in the survey asked the respondents to rate the potential business value and implementation cost of the X12 Version 008060 transactions to their organization or constituency. Specific questions addressed current shortcomings with Version 005010, preferred adoption approach, potential to increase the use of electronic transactions, benefits from the changes, and estimated effort to implement Version 008060.

Survey Deployment

The survey, "Potential Benefits and Costs of Moving to HIPAA v008060 Transaction Standards," was launched via Survey Monkey, an online survey tool. The survey was open for the public to complete. Access to the survey was posted on the WEDI website and distributed through WEDI marketing messages, and shared by industry partners.

The survey opened on March 30, 2026. It remained open for four weeks and closed on April 24, 2026, two days following the FPC hearing.

Overview of the Survey

WEDI conducted the survey to assess the anticipated benefits, challenges, costs, and operational impacts associated with transitioning from the current HIPAA v5010 transaction standards to the proposed v008060 standards. The survey gathered 120 total responses across providers, payers, clearinghouses, and vendors, with additional detailed subsections for each stakeholder group.

The survey explored:

- Current use of v5010 transactions
- Organizational characteristics
- Familiarity with v8060
- Existing pain points and workarounds
- Expected implementation strategies and timelines
- Anticipated increases in electronic adoption
- Expected reduction in manual follow-up
- Operational and financial impacts

Respondent Profile and Current Transaction Usage

Organization Types: Payers (42.5%), Vendors (29.17%), Providers (14.17%), Clearinghouses (14.17%). Providers were mostly health systems. Payers included commercial, Medicaid, and Medicare plans. We note that smaller provider organizations are underreprented in the survey.

Market Size: Payers ranged from <1M to >25M covered lives. Vendors were predominantly national. Current v5010 Adoption: Very high for mandated transactions (835, 837P/I, 270/271). Low for attachments (275/277).

SUMMARY OF SURVEY RESULTS

Topic	Finding
Pain Points and Workarounds Under v5010	Top pain points included missing data elements, inconsistent payer responses, reliance on portals and phone calls, need for attachments, and non-standard implementations. Workarounds included manual reconciliation, parsing unstructured text, using APIs to bypass X12 limitations, proprietary reporting, fax-based attachments, and redefining codes.
Familiarity With v8060 and Implementation Strategies	Familiarity levels varied widely. Many respondents expected to implement some standards together and others individually. Economies of scale were expected in testing, software development, and training.
Expected Implementation Timelines and Cost Distribution	Most expected 1–2 years for software development and internal testing, 2–3 years for external testing and training. Many were unsure due to vendor dependency.
Anticipated Impact of v8060 on Electronic Adoption	25–47% expected increased adoption for core transactions. 40–50% expect increased adoption for attachments. Many noted adoption depends on payer and vendor readiness.
Expected Reduction in Manual Follow-Up	25–39% expected reductions in manual follow-up. Strongest optimism was for eligibility, claim status, and attachments.
Manual Follow-Up Rates Under v5010	Manual follow-up remained high: 28–32% for 835, 22–44% for 837, 18–37% for 276/277, 15–44% for 270/271, and 30–37% for attachments.
Themes From Open-Ended Comments	Themes included vendor readiness concerns, need for better standardization, desire for modernization, and heavy operational burden.
Overall Respondent Themes	The transition to v8060 was seen as necessary and beneficial but complex. Success depends on industry coordination. Across the 120 respondents to the survey, written statrements, and comments made at the live event, many stated that the transition is necessary but should not begin without an extended implementation timeline of at least 24 months. Further, respondents urged clear coordination with concurrent CMS regulatory mandates.

OVERVIEW OF X12 VERSION 008060 FPC WRITTEN STATEMENT SUBMISSION FORM

Statement Process Development

For this FPC, the decision was made to include a written statement submission form that could be completed by WEDI members and the industry at large. The intent was to allow a broad range of interested stakeholders to provide their input on the topic of potentially adopting the X12 Version 008060 transactions under HIPAA.

The WEDI Policy Committee finalized the questions included in the written statement submission form and process through which it would be deployed. There was agreement to provide specific questions for submitters to answer, limit the number of questions asked for ease of completion, and have the questions be broad to allow organizations to respond with the information they deemed to be relevant for considering X12 Version 008060 for adoption under HIPAA.

The questions included in the submission form were:

- Q1: How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?
- Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?
- Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Statement Submission Deployment

The written statement submission form was deployed for public review and completion through an online submission portal via Survey Monkey. Access to the submission portal was posted on the WEDI website and shared through WEDI marketing messages and shared by industry partners.

The submission portal opened on March 30, 2026. It remained open for four weeks and closed on April 24, 2026, following the FPC hearing.

Summary of Submitted Written Statements

A total of 10 written statements were submitted. Upon review, one statement was found to be a duplicate of the statement presented by a panelist. It was included in the analysis of the panel statements and not in the written statement analysis.

The following is a summary of the nine statements. The complete statements are included in Appendix G.

Statement #1:

The current Version 005010 transactions meet most industry needs, and that efforts would be better focused on interoperability mandates and modern API-based technologies. They state to limit any implementation to the 270/271 and 276/277 transactions, and that the remaining transactions would add costs without meaningful benefits. Overall, they state the industry does not need to adopt the full suite of transactions, as the existing standards are sufficient and to focus on the 270/271 and 276/277 transactions for adoption.

Statement #2:

Implementing Version 008060 would be a significant cost for organizations, but it is necessary to support evolving health care and reporting requirements. They state support for a staggered implementation schedule or extended timeline for the 270/271 eligibility transaction due to its complexity and number of changes. Overall, they emphasize the need to continue advancing and avoid stagnation.

Statement #3

X12 Version 008060 allows for collection of necessary information, improving claims adjudication and encounter reporting. They state support for implementing all transactions as a suite over a two-year period, emphasizing that while coordination, testing, and collaboration among stakeholders will be required, the underlying infrastructure should not require major changes. Overall, they state interest in the new version and its potential benefits.

Statement #4

Implementing X12 Version 008060 will involve some direct costs, but there are also costs associated with remaining on Version 005010. They state that all transactions should be mandated with a single compliance date and also noted the need for a later update to the next version to support the NDC code change. Overall, they state support for moving forward but caution that regulatory changes and interoperability initiatives may create competing priorities.

Statement #5

The expected costs of implementing X12 Version 008060 will be minimal since it will use existing infrastructure for the Version 005010 transactions, while offering benefits related to modernization and industry-requested improvements, particularly for the 270/271 transactions. They state that preparation is already underway through their vendor. They state appreciation for X12's education sessions and intent to attend additional sessions.

Statement #6

Implementing X12 Version 008060 will involve significant upfront costs for the 270/271 transaction, but these updates are valuable due to several enhancements, while the other transactions are expected to be less costly to implement. They state support for sequencing the 270/271 transaction first to realize benefits and savings earlier, followed by the remaining transactions that may not have as many benefits or cost savings. Overall, they state support for more frequent updates in the future to reduce implementation burden.

Statement #7

Duplicate of the panel presentation.

Statement #8

Implementing X12 Version 008060 is expected to involve both costs and benefits, though no specific details were provided. They state an implementation timeline of December 2027. They state a request for additional information on FHIR and the Version 008060 transaction.

Statement #9

Implementing X12 Version 008060 will require a thorough, coordinated effort involving an impact analysis and collaboration with vendors and other stakeholders. Costs are expected for system upgrades, testing, training, and updates to policies and procedures. At the same time, the implementation is expected to bring improved interoperability, better data integrity, increased consistency, and long-term efficiency gains, though initial transition challenges are acknowledged.

They state support for a phased rollout approach is strongly recommended, supported by comprehensive testing cycles, a parallel processing period, and training, and guidance. The importance of aligning implementation timelines with other regulatory requirements was noted, along with the need for stakeholder engagement through ongoing communication.

Finally, they state the need for collaboration across all stakeholders, special support for resource-constrained providers, standardized national guidance, and leveraging lessons learned from prior X12 upgrades.

Statement #10

Implementing X12 Version 008060 will improve health plans to more efficiently integrate with FHIR APIs and modern core systems from the enhanced data in 8060, reducing their costs. They state support for implementing the transactions in a single rollout, while taking into consideration other regulatory requirements. Additionally, they state potential benefits from Version 008060 with respect to business value from advancing key initiatives.

OVERVIEW OF X12 VERSION 008060 FPC HEARING

Structure of X12 Version 008060 FPC Hearing

The structure of the X12 Version 008060 FPC hearing was set in a manner that would provide as much industry-wide input as possible. The following details the structure of the event.

- Opening with introductory comments by:
  - WEDI, providing a welcome and overview of FPC process
  - CMS with an overview of HIPAA and the standards adoption process
  - X12 with an overview of the development of Version 008060
- Inviting panelists representing a broad range of industry stakeholders to present statements offering comments and recommendations on the potential adoption of X12 Version 008060 under HIPAA
- Dedicating a large portion of the agenda time to a moderated discussion in which attendees were able to orally deliver comments as well as type comments into the chat function that could be viewed by all attendees and moderators

CMS Introduction

Presenters

- Michael Cimmino, Director, CMS National Standards Group
- Chris Wilson, Senior Health Insurance Specialist, CMS National Standards Group

Michael Cimmino welcomed the participants and thanked WEDI for holding the hearing. He emphasized that stakeholder feedback on Version 008060 of the HIPAA-mandated transactions is critical, not only because it is required by statute but because it directly shapes their regulatory priorities and rulemaking efforts. He encouraged attendees to share insights on the benefits, challenges, and costs to help ensure that future standards effectively meet the industry's needs.

Chris Wilson then provided an overview of the role of CMS in overseeing the HIPAA administrative simplification standards across the health care industry. The core components of HIPAA-compliant transactions, including implementation guides, code sets, unique identifiers, and operating rules, promote consistency in administrative data exchange. CMS acts in its capacity to both develop the regulations and oversee compliance with the requirements. In finalizing regulations, they ensure the rulemaking process has been followed, including the receipt of public input.

The presentation concluded with updates on two recent final rules. The first finalizes new requirements for retail pharmacy transactions to improve coordination of benefits, data transparency, harmonization with related standards, and controlled substance reporting. The second rule establishes standards for electronic claims attachments and electronic signatures. Both rules aim to reduce administrative burden and costs through more efficient electronic data exchange, with compliance deadlines set for 2028.

See Appendix D.1 for a more detailed summary of the presentation and the presentation slides.

X12 Overview and Development of Version 008060

Presenter

- Andrew Fitzpatrick, X12 Operations & Licensing

Andrew Fitzpatrick opened his presentation by noting it was informational and subject to change, particularly as new tools supporting Version 008060 continue to be developed. X12 is a large, member-driven organization composed of corporations, associations, government entities, and individuals who actively contribute to creating and maintaining standards. These standards are designed to simplify administrative processes and reduce friction in data exchange between trading partners, reflecting the real-world needs of those who use them.

X12's hierarchical structure relies on volunteer leadership from its membership. The organization consists of

two main components: the Accredited Standards Committee, responsible for developing ANSI-accredited standards, and the Registered Standards Council, which manages related elements, such as external code lists. X12 standards are widely used across multiple industries, including health care, supply chain, and transportation, and support billions of daily transactions, forming a critical foundation for how data is exchanged.

X12's maintenance and development process is supported by maintenance requests that can be submitted by anyone and undergo a rigorous review that considers business needs, technical implications, and stakeholder input. The Annual Release Cycle introduces a predictable schedule for updates, shifting from a scope-driven to a schedule-driven approach.

In September 2025, X12 published Version 008060 of the HIPAA-mandated implementation guides and formally recommended its adoption in December. Supporting resources, including member announcements, change reference documents, benefit summaries, mechanical comparison report, and webinar series information, are available to help stakeholders understand the updates.

The importance of organizations independently evaluating the transition from 5010 to 8060 was emphasized. Several examples of key benefits of the updated version were reviewed, including improved transparency in provider payments, expanded diagnosis reporting, better coordination of benefits, increased use of external code sets, and support for additional lines of business, and enhanced data accuracy, reinforcing the value of adopting the updated standards.

See Appendix D.2 for a more detailed summary of the presentation and the presentation slides.

Summaries of Panelist Statements

American Hospital Association (Payer-Provider)

The American Hospital Association (AHA) supports modernizing HIPAA transactions, including the proposed move to X12 Version 008060, but an evaluation is incomplete due to a lack of clear, provider-friendly information about the changes. Hospitals are not opposed to the transition but need plain-language explanations of how Version 008060 improves on the current Version 005010 transactions and how those changes would impact real-world workflows, costs, and return on investment (ROI). While the technical resources provided by X12, including the change reference documents and the education series, are helpful, providers need more accessible summaries to guide operational and business decisions.

The AHA emphasizes that upgrading revenue cycle transactions will be costly and disruptive, especially for hospitals already under financial strain, including rural providers or those affected by Medicaid cuts. Without clearly demonstrated benefits, the transition risks requiring significant investment without sufficient return. Hospitals do see promise in improvements to the eligibility transaction with better member matching, traceability, and service-based checks, which could enhance workflows and patient access.

Overall, the AHA asks for clearer, more detailed explanations of how Version 008060 solves existing problems and improves administrative processes and recommends continued stakeholder engagement paired with plain-language materials. CMS is also urged to allow reasonable implementation timelines of ideally at least 24 months after a final rule.

American Medical Association (Payer-Provider)

The American Medical Association (AMA) supports modernization of administrative standards to remain current with technology, care delivery, and policy, but believes it is premature to adopt Version 008060 under HIPAA without clear evidence of real benefits, reasonable costs, and feasibility across diverse physician practices. Specific concerns are about the scale and

complexity of the update, and that many practices, specifically small or rural ones, lack the capacity to do this work on their own and must rely heavily on vendors, which increases implementation risks. Competing priorities of other health information technology (IT) initiatives further strain resources.

The priority of standards adoption must be to reduce administrative burden, support clinical workflows, and improve efficiency without creating unintended consequences. Concerns with Version 008060 include gaps in real-world testing, implementation costs, and unclear ROI, which have the potential to increase administrative burden.

Overall, the AMA calls for a cautious, evidence-based approach, urging more robust testing and clearer demonstration that Version 008060 will reduce burden and improve efficiency before moving forward with adoption under HIPAA.

Availity (Intermediary)

Availity strongly supports moving to X12 Version 008060, as it is a necessary modernization of health care data exchange infrastructure. Based on the scale of data exchange for administrative transactions, adopting Version 008060 would improve data accuracy, consistency, interoperability, and operational efficiency across the industry. The updates build on existing infrastructure rather than replacing it, which helps standardize and streamline transactions while reducing downstream rework.

Availity expects benefits from Version 008060, including faster and more accurate data exchange, improved eligibility and authorization workflows, better patient and provider experiences, and stronger alignment with regulatory requirements. Modernization should be treated as an ongoing process supported by change management, training, and industry-wide collaboration.

For implementation, Availity recommends:

- A 24-month transition period
- Avoiding major rollout dates in the first and fourth quarters due to operational conflicts
- Strong industry coordination across payers, providers, vendors, CMS, and states
- Ongoing testing, validation, and education for all stakeholders
- Regular budgeting for system upgrades and enhancements

Overall, Availity believes that successful adoption depends on collaboration, structured timelines, continuous engagement, and long-term benefits of reduced fragmentation, lower administrative burden, improved data quality, and better patient outcomes will be realized.

Blue Cross Blue Shield Association (Payer-Provider)

The Blue Cross Blue Shield Association (BCBSA) supports continued collaboration on X12 standards and acknowledges that Version 008060 includes potentially valuable improvements, but there has not been enough time to fully evaluate the impact.

BCBSA has not yet completed a detailed gap or cost-benefit analysis with their Plans and cannot assess implementation costs or ROI at this time. The adoption of Version 008060 is anticipated to be a large, complex effort affecting multiple systems and requiring significant resources across the industry.

Because of this, careful timing and coordination with other federal requirements must occur. A 24-month implementation timeline is strongly encouraged and cannot be rushed, as past major upgrades, such as going from Version 004010 to Version 005010, required extended timelines and adjustments.

Overall, BCBSA views this process as still in an early evaluation stage and emphasizes the need for further analysis before moving forward with adoption decisions.

CAQH (Other Interested Stakeholder)

CAQH highlights that while the health care industry has made major progress in adopting electronic transactions, significant efficiency gaps remain due to incomplete automation, inconsistent data, and disconnected workflows. High adoption rates with the eligibility and claims transactions have not fully translated into efficiency, leaving billions in additional savings unrealized. Key gaps remain in other areas, including prior authorization and attachments, where low adoption leads to continued manual processes. Overall, an estimated $21 billion in annual savings is still achievable (per the 2025 CAQH Index report-www.caqh.org).

CAQH identifies many of these inefficiencies stemming from limitations in the current Version 005010 standard. Updated standards, such as the X12 Version 008060, introduce improvements in data detail, consistency, and interoperability, which could enhance workflows, reduce manual work, and better support modern billing and care processes. Realizing these benefits, however, depends not just on adopting new standards, but on how effectively they are implemented, integrated, and used across the entire health care ecosystem.

The Cooperative Exchange (Intermediary)

The Cooperative Exchange supports adopting X12 Version 008060, stating it offers meaningful improvements to existing transactions, reduces ambiguity, and helps meet evolving business and regulatory needs. While costs are difficult to estimate, the implementation is expected to involve significant effort, specifically for end-to-end testing, which require clearer testing requirements and timelines. Lessons learned from previous large-scale implementations and new technology tools, such as artificial intelligence (AI), may help reduce some costs.

The Cooperative Exchange recommends:

- Avoiding January 1 compliance dates due to operational challenges
- Targeting the second or third quarter
- Using a single compliance date for all transactions and stakeholders to avoid repeated testing and added burden
- Ensuring vendor participation, especially EHR systems
- Developing a set, predictable 3-year update cycle allowing two versions to coexist, which will enable smoother, incremental changes rather than large, disruptive upgrades.

Overall, The Cooperative Exchange believes Version 008060 delivers net positive value and is an important step toward more efficient, modern health care data exchange.

Dental Content Committee (DSMO)

The dental industry supports the goals of X12 Version 008060 and sees long-term value in improved interoperability, data quality, more modern administrative workflows, and alignment between the electronic claim and ADA Dental Claim Form. Support, however, is conditional on proper implementation, clear guidance, and sufficient time.

The transition to Version 008060 will be a major structural change that will require extensive system rework, multi-year development, and significant costs. Without careful planning, there is risk of revenue disruption, especially for small dental practices. Key concerns include the need for enforceable usability requirements to ensure new data elements are used, stronger linkage between diagnosis and dental services, and defined minimum data expectations to avoid "empty interoperability."

Overall, the Dental Content Committee supports Version 008060's potential benefits but stresses that success depends on adequate time, clear requirements, and strong implementation support to avoid disruption and ensure real-world usability. A longer implementation timeline of 24–36 months, along with robust testing, clear guidance, and accessible documentation tailored to dental stakeholders is strongly recommended.

Edifecs, a Cotiviti Business (Other Interested Stakeholder)

Edifecs supports adopting X12 Version 008060 as it will modernize health care transactions and reduce long-term integration costs for health plans. Payers transitioning from Version 004010 to Version 005010 showed that "mitigation solutions" can allow organizations to continue operating while gradually upgrading core systems, and a similar approach could be used for Version 005010 to Version 008060, enabling phased modernization without disrupting operations.

Edifecs expects that Version 008060's richer data and alignment with Fast Healthcare Interoperability Resources (FHIR) standards could significantly reduce integration complexity. Edifecs estimates that has the potential to lower costs by about 30% for health plans. One example of an improvement in Version 008060 is how it can support workflows under the No Surprises Act and advanced explanation of benefits process.

Overall, Edifecs recommends that CMS adopt Version 008060 based on its benefits outweighing implementation costs and that health plans can manage the transition effectively using modernization strategies and supporting tools.

Health Level Seven International (DSMO)

Health Level Seven International (HL7) supports modernizing HIPAA transaction standards, including X12 Version 008060, and views it as part of broader efforts to improve interoperability across health care systems. Version 008060 includes many incremental updates driven by industry input and are more modern standards that better meet current needs. Successful implementation will depend on careful planning, stakeholder readiness, and coordination with evolving regulatory efforts, including increased use of FHIR-based standards. HL7 highlights key cost considerations, such as the burden of maintaining dual versions of transactions during the transition, the need for fair distribution of implementation costs across stakeholders, and the importance of sharing clear technical guidance. The implementation should be flexible, potentially by grouping or phasing transactions, and supported by sufficient time, testing, and pilot feedback.

Overall, HL7 supports moving toward updated standards like Version 008060 but stresses that success depends on balanced implementation, equitable cost management, and strong collaboration across the health care ecosystem.

Independent Health (Payer-Provider)

Independent Health supports moving forward with X12 Version 008060 and is encouraged by X12's educational efforts, but the full cost and impact analysis is not yet possible due to unknown vendor changes, internal analysis gaps, and pending regulatory decisions. There will be implementation costs, but Version 008060 is expected to require fewer resources than the Version 004010 to Version 005010 transition, since it is an incremental upgrade supported by modern tools and existing interoperability investments. Opportunities exist where improved data could enhance claims processing, eligibility, prior authorization, and analytics.

Independent Health recommends:

- Either delaying Version 008060 to align with other regulatory changes or ensure sufficient lead time
- Implement all transactions at once to avoid a fragmented, costly rollout
- Align the Version 008060 implementation with other regulatory initiatives to avoid conflicts

Overall, Independent Health supports adoption of Version 008060 but stresses coordination, timing, and a unified implementation approach to reduce complexity and maximize value, and moving toward more frequent, smaller, and predictable updates of X12 standards. Additionally, the coexistence of Version 005010 and Version 008060 is not a concern.

Jopari (Intermediary)

Jopari supports adopting X12 Version 008060, and while implementation will require significant investment, the long-term benefits of improved data quality, automation, accuracy, and reduced administrative burden outweigh the costs. Version 008060 delivers important enhancements, especially for the property and casualty sector, and represents a major step forward in modernizing health care transactions.

For implementation, Jopari recommends:

- Setting a coordinated, industry-wide implementation with aligned timelines
- Sequencing adoption after attachments and prior authorization requirements are in place
- Implementing all transactions at once rather than incrementally
- Establishing a single compliance date that avoids high-risk times, such as January 1

Overall, Jopari views Version 008060 as a critical advancement that will improve interoperability and efficiency, provided it is implemented in a well-coordinated and carefully planned manner.

Kunz, Leigh and Associates (Other Interested Stakeholder)

Kunz, Leigh and Associates recommends a structured and coordinated approach to implementing X12 Version 008060, based on past experience with Version 005010 and ICD-10 transitions.

Kunz, Leigh and Associates specific recommendations are to:

- Move all HIPAA transactions to Version 008060 on a single cut-over date to reduce complexity, improve coordination, and avoid multiple overlapping projects
- Use a single HIPAA transaction standard after the transition and eliminate dual versions to simplify operations and ensure consistency
- Encourage payers to provide robust pre-implementation testing environments for trading partners to validate file formats and workflows before implementation

Overall, Kunz, Leigh and Associates emphasizes that a unified rollout, sufficient time, strong testing, and adequate allocated resources are critical to a successful transition and prevention of issues during implementation.

National Council for Prescription Drug Programs (DSMO)

The National Council for Prescription Drug Programs (NCPDP) reports having evaluated the X12 Version 8060 transactions used in the pharmacy sector, including the eligibility and benefits, professional claim, benefits enrollment, and remittance and payment. Relevant pharmacy business requirements were identified as having been incorporated into the updated standards. No major technical issues or barriers to adoption, although a cost-benefit analysis was not conducted due to time and resource constraints.

For implementation, NCPDP recommends:

- Setting at least a two-year timeline from the final rule to production
- Avoiding overlaps with other major federal regulatory changes

Overall, NCPDP sees no critical issues and is generally supportive of Version 008060 but emphasizes the need for sufficient time and careful scheduling to ensure successful implementation.

National Uniform Billing Committee (DSMO)

The National Uniform Billing Committee (NUBC) reports reviewing the X12 Version 8060 updates related to institutional claims, including updates for payment adjustments, backward dating, dental reporting, and pay-to factoring. These items were not raised as major concerns and the committee has not fully assessed their impact.

The NUBC questions whether the benefits of moving to a new version justify the cost, effort, and industry disruption, especially since current standards already function well. A clearer cost-benefit analysis and more detailed review is needed before supporting adoption.

The NUBC expresses interest in reviewing X12's benefit summaries and further analyzing the changes to better understand their value and encourage continued collaboration with CMS to modernize standards development and implementation practices.

National Uniform Claim Committee (DSMO)

The National Uniform Claim Committee (NUCC) supports moving to X12 Version 008060 for professional claims and sees it as a chance to improve data quality and reduce manual work in the claims process.

The main goal is maintaining a nationally uniform, clear, and usable professional claim data set, since gaps in standards today often lead to workarounds, such as portals, phone calls, and resubmissions. The value in the Version 008060 enhancements, however, depend on careful, coordinated implementation and strong testing.

The NUCC's key positions include:

- Maintaining the paper 1500 form but not requiring it to incorporate all Version 008060 enhancements
- Supporting end-to-end testing, pilots, and defined readiness criteria
- Allowing a time-limited dual-use transition period, but not permanent dual standards

Overall, the NUCC supports adoption of Version 008060 if it is implemented in a coordinated way that preserves national data uniformity, reduces manual work, and avoids introducing new variation into the system.

Stedi (Intermediary)

Stedi strongly supports adopting X12 Version 008060 and expanding standardized HIPAA transactions to include the acknowledgment standards. While Version 005010 works, it is outdated and lacks structured data needed for modern health care workflows forcing providers to rely on phone calls, portals, or inconsistent free-text responses, increasing cost and inefficiency. The enhancements reduce administrative burden, improve transparency for patients, and lower costs for both providers and payers.

Stedi highlights key improvements in Version 008060, including:

- Structured eligibility data and more detailed benefit information
- Support for multiple plans and benefit groupings in a single transaction
- Better dental information
- Expanded support for prospective claims to accommodate good faith estimates and cost transparency

Overall, Stedi encourages rapid CMS adoption of Version 008060 with a shift toward more frequent, smaller version updates in the future to avoid large disruptive transitions, and broad industry collaboration to ensure successful implementation.

Key Topics from FPC Hearing Open Discussion

1. Care Delivery Evolution Driving Need for Version 008060: Standards must reflect modern care models (home-based, outpatient, real-time care)

Raised by: Commenters #1 and #2

- Shift to home-based care (e.g., electronic visit verification, infusion at home) requires more granular data (e.g., multiple daily visits)
- Current standards (Version 005010) cannot fully support these use cases
- Version 008060 enables more accurate representation of care delivery patterns
- Cost framing: Upfront implementation cost vs. downstream savings (reduced inpatient stays)

2. "If Not Now, When?" vs. Readiness and Roadmap Concerns: Urgency to modernize vs. lack of a clear long-term roadmap

Raised by: Commenters #3, #4, and #6

- Concern that delaying adoption increases future disruption and complexity
- Lack of clarity on:
  - What comes after Version 008060
  - How future versions will be introduced
- Proposal for predictable release cycles (e.g., every 3 years) to reduce disruption
- Suggestion for pilot implementations and real-world ROI examples

3. Resource Constraints and Competing Regulatory Timelines: Limited IT capacity across stakeholders

Raised by: Commenters #2 and #10

- Health plans organize teams by business domain (e.g., prior auth, eligibility), not technology
- Simultaneous mandates (e.g., CMS rules, FHIR, X12 updates) create resource conflicts
- Organizations struggle to:
  - Prioritize initiatives
  - Allocate budget
  - Build multi-year roadmaps

4. X12 vs. FHIR: Perceived Conflict vs. Coexistence: Industry confusion on direction of standards

Raised by: Commenters #2, #6, #9, #10, and #11

- Perception of "mixed signals" from CMS:
  - Push toward FHIR/APIs (e.g., prior auth, CMS-0057)
  - Continued reliance on X12 (e.g., claims, attachments, Version 008060)
- Some organizations are pausing X12 investments (e.g., 278) anticipating FHIR replacement
- Counterpoint:
  - X12 and FHIR are complementary, not conflicting
  - X12 remains foundational for high-volume transactions

5. ROI, Cost Justification, and Equity Concerns: Uneven financial impact across stakeholders

Raised by: Commenters #6, #9, #10, and #11

- ROI varies significantly by:
  - Organization size
  - Market segment (e.g., Medicaid, behavioral health, dental)
- Smaller providers and safety-net systems:
  - Face disproportionate cost burden
  - May lack vendor and IT resources
- Strong call for:
  - Real-world ROI case studies
  - Clear articulation of who benefits vs. who pays

6. Vendor Dependency and Ecosystem Readiness: Vendors are a critical component

Raised by: Commenters #5, #10, and #11

- Heavy reliance on:
  - EHR and practice management vendors
  - Clearinghouses
  - Claims and payment vendors
- Challenges:
  - Vendor upgrade timelines
  - Additional costs for upgrades
  - Sequencing across trading partners
- Risk of long-tail lag in adoption due to vendor readiness

7. Administrative Burden Reduction Depends on Full Data Exchange: Partial adoption undermines value

Raised by: Commenters #5, #7, and #8

- Example: 270/271 eligibility transactions
  - Value depends on complete data inclusion
  - Missing data results in fallback to phone, portal, fax
- Call for:

  - Operating rules to mandate data completeness
- Concern about regulatory misalignment limiting intended benefits

8. External Code Sets and Increased Flexibility: Structural improvements in Version 008060

Raised by: Chat participants

- Moving code sets external to implementation guides enables:
  - More frequent updates (e.g., quarterly)
  - Greater flexibility and responsiveness

9. Social Determinants of Health (SDOH) and Expanded Data Capture: Version 008060 enables richer data for population health

Raised by: Commenters #2 and #12

- Expanded:
  - Diagnosis codes (up to 99)
  - Demographic attributes
- Supports:
  - SDOH programs
  - Alignment with U.S. Core Data for Interoperability data models

10. Industry Fragmentation and Uneven Adoption Risk: Risk of "two systems of care"

Raised by: Commenters #10 and #11

- CMS mandates do not cover all stakeholders resulting in uneven adoption
- Example: dental industry
  - High percentage of small, private practices
  - Limited participation in federal programs
- Risk of:
  - Dual workflows (FHIR vs. legacy systems)
  - Increased fragmentation

11. Monetization and Cost of Transactions: Financial incentives may distort adoption

Raised by: Commenter #11

- Concern that:
  - Non-mandated transactions (e.g., APIs) become fee-based add-ons
  - Providers may face increased costs regardless of direction (X12 or FHIR)

12. Need for Industry Implementation Roadmap and Measurement: Strong support for WEDI taking leadership role

Raised by: Commenters #5 and #6

- Request for:
  - Step-by-step implementation roadmap
  - Integrated timeline across regulations
  - Progress tracking against milestones
- Reference to WEDI's Strategic National Implementation (SNIP) initiative as a starting point. SNIP was deployed by WEDI during the implementation of Version 004010, Version 005010, and the International Cassification of Diseases, Tenth Revision, educate on the new standards, survey stakeholders, assist the industry identify and address business issues, and coordinate testing.

Appendices

Appendix A: WEDI FPC Procedure
Appendix B: Marketing Message for X12 Version 008060 FPC Components
Appendix C: WEDI X12 Version 008060 FPC Hearing Agenda
Appendix D: FPC Hearing Panel Presentations and Statements
Appendix E: FPC Hearing Open Discussion Edited Transcript
Appendix F: FPC Hearing Chat Edited Transcript
Appendix G: X12 Version 008060 Submitted Written Statements
Appendix H: X12 Version 008060 Survey Data

Appendix A: WEDI FPC Procedure

The following is the WEDI FPC Procedure as included in the WEDI Policy & Procedure Manual, effective February 24, 2026.

3.9 Federal Policy Consultation

3.9.1 Policy

The purpose of the Federal Policy Consultation (FPC) process is to be an information gathering process to ensure that industry stakeholders have an opportunity to provide input and data proactively or reactively on relevant topics that assist WEDI in its statutory role to inform and advise HHS, its agencies, and other appropriate policymaking bodies.

The FPC is differentiated from the MPA process by the following:

- The process could be requested by a federal agency or policymaking body
- The process could be proactively initiated by WEDI
- The process will typically occur prior to the release of a proposed rule
- The process will permit and solicit participation from non-members
- The process is not aimed at developing consensus-based recommendations but rather synthesizing the information presented to WEDI
- The process will result in a report on the findings from WEDI to the appropriate federal entity
- The report will be made public

This process may include requests for written statements, surveys, virtual and in-person meetings or hearings, interviews, electronic polling tools, and other means to gather the necessary input. The goal of the FPC process is to offer options for information collection through which industry stakeholders can share perspectives with WEDI on topics and issues of importance. This flexibility has the potential for a wider variety of industry organizations to participate thereby giving WEDI greater insights into stakeholder perspectives and concerns.

The FPC is designed for industry stakeholders to share their perspectives on the topics and issues in which it has knowledge, background, and experience and WEDI to capture all majority and minority perspectives in a report on the findings to the appropriate entity. The report will be shared with the WEDI Board of Directors for review prior to sending to the appropriate entity. The Board of Directors' responsibility is to ensure that the report accurately reflects all feedback shared during the FPC process.

The FPC report represents what WEDI hears from the industry and does not necessarily represent WEDI's own position. Implementing an FPC does not preclude WEDI from submitting its own position on an issue or issues, separate from the FPC report, once approved by the Board of Directors.

The overall goal of the FPC process is to provide the appropriate entity the information they need to make informed decisions.

3.9.2 Initiating the FPC

A FPC may be initiated for a variety of reasons including, but not limited to, any official request from a government entity, such as ASTP/ONC, CMS, OCR, or other policymaking entity for industry feedback. Once the request is received, the Executive Committee shall determine if the FPC process is to be initiated.

3.9.3 FPA Process

1. If the FPC is invoked, the Vice Chair of Policy will work with the Policy Committee and WEDI staff to establish the format (including charge, timing, method of information solicitation, facilitators, etc.).
2. The Policy Committee may delegate the activity of the FPC to a task group of volunteers, existing workgroup or subworkgroup, WEDI staff, or another group as deemed appropriate. The Policy Committee will continue to oversee and remain responsible for the FPC.
3. The process of collecting stakeholder perspectives may depend on:
    a. The type of response being developed, e.g., report, letter, testimony, or other response
    b. Submission deadline
4. WEDI leadership will discuss and coordinate with the appropriate policymaking entity options for how to communicate the FPC process to the public.
5. The FPC will be open to non-members to attend and participate. WEDI will deploy a dedicated effort to communicate to and engage with non-members.
6. The FPC may also include any one or more of the following to receive input:
    a. Conduct a hearing or listening session
    b. Request to submit written position statements
    c. Survey to solicit input on specific questions
    d. Interviews with specific stakeholders
    e. Electronic voting tools to obtain feedback on support
    f. Additional tools and methods for obtaining input
7. WEDI staff will provide the Policy Committee, or delegated group, with a summary of comments, and positions made by WEDI in previous letters and testimony relevant to the current request. The Policy Committee, WEDI staff, or delegated group, may use this information to develop FPC materials, survey questions, meeting materials, interview questions, etc.
8. After the FPC format is decided, the Policy Committee, working with WEDI staff, or other delegated group, will determine the rules or guidelines to be used.
9. The FPC will be conducted.
10. The Policy Committee, WEDI staff, or delegated group, will collect and analyze the information and data received from the FPC participants. The analysis will include identifying

any gaps in input from any stakeholder groups, if that gap is relevant for the final report being developed, and how that gap should be addressed.

11. The Policy Committee, WEDI staff, or delegated group, will draft a preliminary draft of the report that will be sent to the Policy Committee (if drafted by WEDI staff or a delegated group) and then to the Board of Directors for review. If timing is an issue, the Executive Committee may complete the review of the report.
12. The WEDI Executive Committee may decide to publicly release the draft report for additional public input. WEDI staff will incorporate that feedback into the draft report.
13. Based on feedback from the Executive Committee and Board of Directors, WEDI staff will draft the final version of the report for final approval by the Board of Directors.
14. Following finalization of the report, it is submitted to the appropriate federal entity, released publicly, and published on the WEDI website.

3.9.4 Evaluation of the FPC

The Policy Committee, with the assistance of WEDI staff, will track the use of the FPC including dates, format used, comments and impressions by the Policy Committee at the time the process was conducted, etc. The Policy Committee will periodically conduct an evaluation of the FPC process and report its findings to the Board of Directors.

3.9.5 Example

The following is a hypothetical example showing how the FPC can be used to respond to, for example, a federal agency request. The range of days are estimates and not meant to establish requirements.

Day 1 – 4: A request is received. The WEDI Executive Committee discusses the request and determines that WEDI will convene a FPC and the Board of Directors is notified. The Vice Chair of Policy raises the issue with the Policy Committee and determines the process to be used.
Day 5 – 7: WEDI staff is notified and provides summaries of any relevant documents, previous recommendations, comments, and positions made by WEDI on the topic of the FPC.
Day 8 – 10: The Policy Committee reviews the summaries and decides the format of the FPC, for example, a virtual meeting preceded by participants submitting written statements answering specific questions.
Day 11 – 15: The Policy Committee, working with WEDI staff, develops a list of questions for the FPC participants to submit prior to the virtual meeting. The WEDI staff schedule the virtual meeting to be held on Day 30.
Day 16: The plans for the virtual meeting and questionnaire are released to the public to register and participate.
Day 17 – 29: The Policy Committee completes planning for the virtual meeting, which includes:

- Deciding on the rules for the FPC participants to follow during the virtual meeting.
- Compiling the results of the submitted questionnaires and developing slides with the content and draft recommendations or comments to be reviewed during the meeting.
- Developing voting questions to be used during the virtual meeting.

- Sending participants materials for the virtual meeting.

Day 30: The virtual meeting is held.
Day 31 – 40: WEDI staff analyzes the input received and results of any voting during the virtual meeting. During the analysis, specific topics are identified that were not covered during the virtual meeting or specific stakeholders did not participate. WEDI staff develop a plan to address any gaps.
Day 41 – 45: WEDI staff begins writing a preliminary draft of the report that synthesizes and summarizes findings.
Day 45: The Policy Committee reviews the preliminary draft of the report, WEDI staff incorporate edits identified, and the revised report is sent to the Board of Directors for review.
Day 45 – 50: The Board of Directors or Executive Committee reviews the analysis and provides feedback.
Day 51 – 54: WEDI staff draft the final version of the report.
Day 55: The report is submitted to the appropriate federal entity. The report is also released publicly and posted on the WEDI website.

Appendix B: Marketing Message for X12 Version 008060 FPC Components

WEDI has launched a Federal Policy Consultation (FPC) process. This new initiative is designed to proactively engage industry stakeholders on emerging federal health care policies and regulatory priorities.

WEDI's first FPC will cover the new X12 Version 008060 HIPAA transactions and offer an opportunity for the health care industry to share insights into the potential benefits and costs associated with this new version of the HIPAA transaction standards. Following the completion of the survey and the live event, WEDI will issue a public report to HHS, providing a detailed overview of stakeholder perspectives and recommendations.

Take advantage of these three opportunities to engage and share perspectives on HIPAA Version 008060:

- Access the WEDI HIPAA resource page. WEDI has developed a resource page that includes background on HIPAA and its supporting regulations as well as recorded sessions on Version 008060. X12 also has educational resources on Version 008060.
- Complete a survey. The questionnaire, developed by WEDI leaders, seeks to determine the impact implementing Version 008060 administrative transactions would have on the health care system.
- Participate at the FPC live event April 22, 12-4 pm ET and share your perspectives and recommendations on the potential implementation of Version 008060. The event is free and open to all.

Appendix C: X12 Version 008060 FPC Hearing Agenda

X12 Version 008060 Federal Policy Consultation
Wednesday, April 22, 2026
12:00 – 4:00 PM ET

Agenda

Time (ET)	Topic	Speaker
12:00 pm	Welcome and Overview of WEDI	Robert Tennant, WEDI Executive Director
12:10 pm	Overview of WEDI's Federal Policy Consultation Process	Pam Grosze, WEDI Vice Chair of Policy
12:15 pm	Centers for Medicare & Medicaid Services Introduction	Michael Cimmino, Director, National Standards Group Chris Wilson, Senior Health Insurance Specialist, National Standards Group
12:30 pm	Overview and Development of Version 008060	Andrew Fitzpatrick, X12 Operations & Licensing
12:45 pm	Designated Standards Maintenance Organization Panel • Dental Content Committee • Health Level Seven • National Council for Prescription Drug Programs • National Uniform Billing Committee • National Uniform Claim Committee	Moderator: Nancy Spector, WEDI Senior Director of Federal Affairs
1:15 pm	Payer and Provider Panel • American Hospital Association • Blue Cross Blue Shield Association • Independent Health • American Medical Association	Moderator: Denny Brennan, WEDI Chair-Elect
1:40 pm	Break	
1:55 pm	Intermediary Panel • Jopari Solutions • Stedi • The Cooperative Exchange • Availity	Moderator: Robert Tennant
2:20 pm	Other Interested Stakeholders Panel • CAQH • Edifecs, a Cotiviti Business • Kunz, Leigh & Associates	Moderator: Pam Grosze
2:40 pm	Attendee Comment Period *Open discussion for attendees to make comments and ask questions*	Moderators: Denny Brennan and Pam Grosze
3:50 pm	Wrap Up and Next Steps	Robert Tennant

Panelists

Designated Standards Maintenance Organizations Panel

- Arna Meyer, Committee Member, Dental Content Committee
- Daniel Vreeman, Chief Standards Development Officer and Chief Artificial Intelligence Officer, Health Level Seven
- Margaret Weiker, Vice President of Standards Development, National Council for Prescription Drug Programs
- Terrence Cunningham, Chair, National Uniform Billing Committee
- Julie Brown-Georgi, Chair, National Uniform Claim Committee

Payer and Provider Panel

- Andrea Preisler, Senior Associate Director of Administrative Simplification, American Hospital Association
- Gail Kocher, National Standards Senior Business Lead, Blue Cross Blue Shield Association
- Christopher Gracon, Solution Architect, Independent Health
- Dino Gerousis, Director of Informatics, American Medical Association

Intermediary Panel

- Jamie Mosteller, Director of Regulatory Affairs, Jopari Solutions
- Nick Radov, Technical Product Manager, Stedi
- Pam Grosze, Past Chair and Education Committee Chair, The Cooperative Exchange
- Michelle Barry, Director, Expert Health Plan Provider Lifecycle Solutions, Availity

Other Interested Stakeholders Panel

- Michael Phillips, Director, Advisory & Insights, CAQH
- Kevin Day, Principal Business Advisor, Edifecs, a Cotiviti Business
- Chuck Veverka, Senior Consultant, Kunz, Leigh & Associates

Appendix D: FPC Hearing Panel Presentations and Statements

D.1: Centers for Medicare & Medicaid Services
D.2: X12
D.3: Dental Content Committee
D.4: Health Level Seven
D.5: National Council for Prescription Drug Programs
D.6: National Uniform Billing Committee
D.7: National Uniform Claim Committee
D.8: American Hospital Association
D.9: Independent Health
D.10: American Medical Association
D.11: Jopari Solutions
D.12: Stedi
D.13: The Cooperative Exchange
D.14: Availity
D.15: CAQH
D.16: Edifecs, a Cotiviti Business
D.17: Kunz, Leigh & Associates

D.1: Centers for Medicare & Medicaid Services

Presenters
Michael Cimmino, Director of CMS National Standards Group
Chris Wilson, Senior Health Insurance Specialist in CMS National Standards Group

Presentation

Michael Cimmino welcomed the participants and thanked WEDI for holding the hearing. He emphasized that stakeholder feedback on Version 008060 of the HIPAA-mandated transactions is critical, not only because it is required by statute but because it directly shapes their regulatory priorities and rulemaking efforts. He encouraged attendees to share insights on benefits, challenges, and costs to help ensure that future standards effectively meet the industry's needs.

Chris Wilson then provided an overview of the role of CMS in overseeing the HIPAA administrative simplification standards across the health care industry. CMS works with a wide range of stakeholders, including providers, health plans, clearinghouses, and vendors, to standardize electronic health care transactions. This effort extends beyond Medicare and Medicaid programs to ensure consistency and efficiency across the entire system. Administrative simplification focuses on standardizing how health care data is exchanged to enable automation, reduce manual work, and improve efficiency. HIPAA is not a technology but a legislative framework that governs how standards are developed, adopted, and maintained. HIPAA-covered entities must comply with standardized transaction requirements, as well as business associates through contractual agreements.

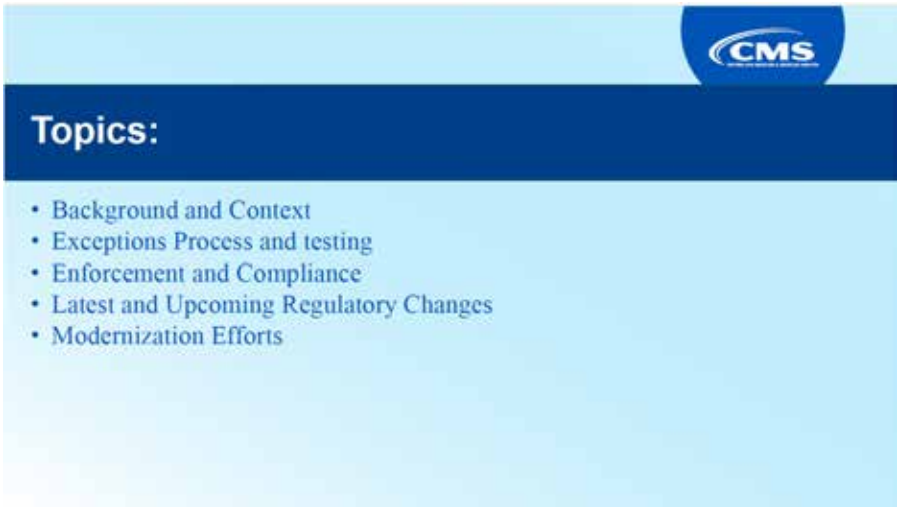
The four key components of HIPAA-compliant transactions are: (i) Implementation guides that define the data structure and data elements; (ii) Code sets, such as those for diagnoses and procedures; (iii) Unique identifiers, such as NPI; and (iv) Operating rules that govern business processes. Together, these elements promote consistency in the use of the transactions across the health care system.

The regulatory and rulemaking process for adopting and updating standards follows a timeline. Standards are first developed by standards development organizations, such as X12, Health Level Seven (HL7), and the National Council for Prescription Drug Programs (NCPDP). Recommendations to adopt standards are then reviewed by the National Committee on Vital and Health Statistics (NCVHS), which then issues its recommendation to the Secretary of the Department of Health and Human Services (HHS). If recommended, CMS then adopts the standards through a formal rulemaking process that includes publishing a proposed rule, gathering public comments, and issuing a final rule based on stakeholder feedback.

The CMS National Standards Group also oversees the HIPAA Exceptions process that can be used to test a modified adopted standard to determine if it improves efficiency, improves effectiveness, or reduces costs for the business scenario and standard(s) being tested. They also oversee the enforcement of the HIPAA requirements through complaint-driven and compliance review processes.

The presentation ended with an overview of two recently published final rules. The first finalizes new requirements for retail pharmacy transactions, including enhancements to improve coordination of benefits processes, prescriber validation fields, plan benefit transparency, codification of clinical and patient data, harmonization with related standards, and controlled substance reporting. Covered entities must comply with these new requirements by April 14, 2028. The second finalizes requirements for the electronic exchange of clinical and administrative attachments data for claims transactions, as well as for electronic signatures necessary for claims attachments. These changes are aimed at reducing paperwork, administrative burden, and lowering costs across the health care system by making the electronic exchange of data more efficient. The compliance date for meeting these requirements is May 26, 2028.

Slides



What is Administrative Simplification?

- Standardizes business processes and how information is communicated
- When transactions are conducted the same way between entities it allows for automation
- HIPAA is the framework for bringing standardized transactions to the industry
  - It ensures we're all using the same language and same syntax

Who's Covered?

HIPAA and Administrative Simplification Requirements

Who's affected? (Covered entities)

Health care providers that transmit transactions electronically

Health plans

Clearinghouses

CMS

HIPAA Standard Transaction

CMS

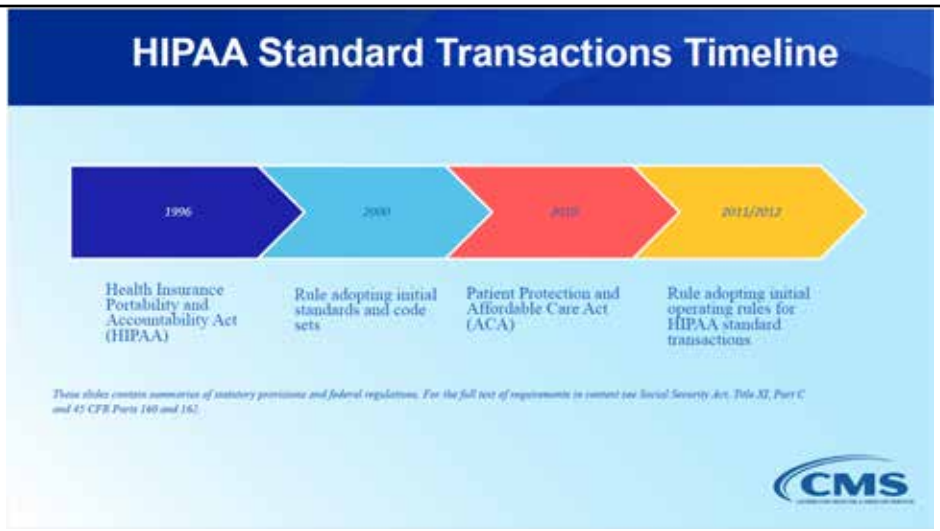
Implementation Guides (Standard) Set the data content and format requirements for the electronic exchange of information

Code Sets
Mandate which code sets must be used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes as directed by an implementation guide

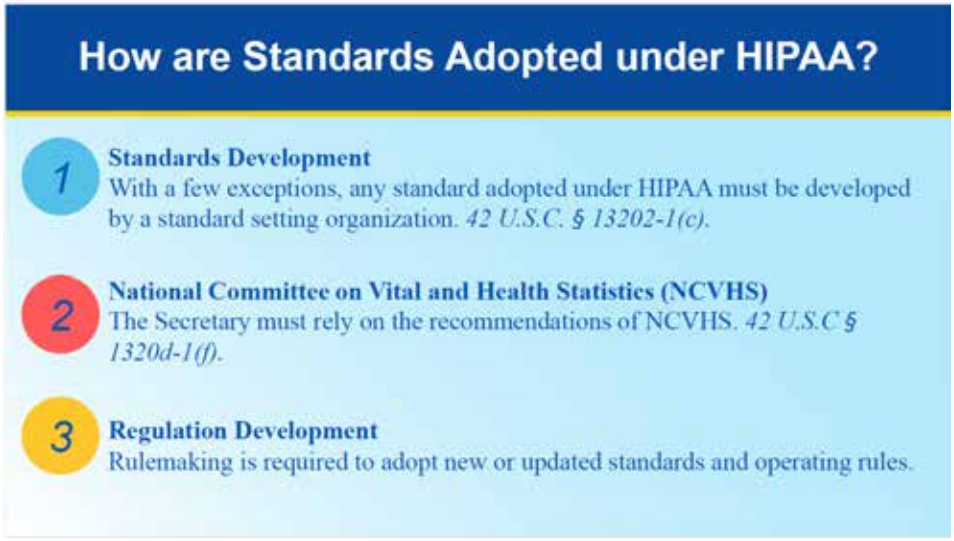
HIPAA Standard Transaction

Unique Identifiers
Mandate how entities are identified within standard transaction as directed by an implementation guide

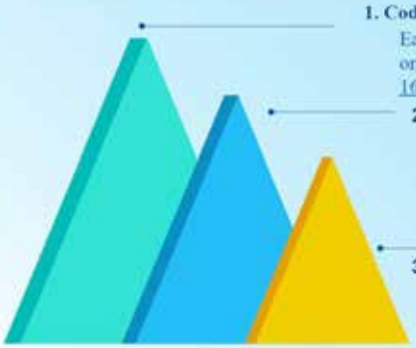
Operating Rules
Set the business rules and guidelines for electronic exchange of information that are not defined by an implementation specification


HIPAA Standard Transactions Timeline
1996
2000
2010
2011/2012
Health Insurance Portability and Accountability Act (HIPAA)
Rule adopting initial standards and code sets
Patient Protection and Affordable Care Act (ACA)
Rule adopting initial operating rules for HIPAA standard transactions
These slides contain summaries of statutory provisions and federal regulations. For the full text of requirements in context see Social Security Act, Title XI, Part C and 45 CFR Parts 160 and 162.
CMS


CMS
Administrative Simplification Overview: HIPAA Standard Transactions
42 U.S.C. § 1320d–2(a)
Health Care Claims or Equivalent Encounter Information
Health Claims Attachments
Enrollment and Disenrollment in a Health Plan
Eligibility for a Health Plan
Health Care Payment and Remittance Advice
First Report of Injury
Health Claims Status
Referral Certification and Authorization
Electronic Funds Transfers
Other financial and administrative transactions determined appropriate by the Secretary of the Department of Health and Human Services (the Secretary)


How are Standards Adopted under HIPAA?
1
Standards Development
With a few exceptions, any standard adopted under HIPAA must be developed by a standard setting organization. 42 U.S.C. § 13202-1(c).
2
National Committee on Vital and Health Statistics (NCVHS)
The Secretary must rely on the recommendations of NCVHS. 42 U.S.C § 1320d-1(f).
3
Regulation Development
Rulemaking is required to adopt new or updated standards and operating rules.

Changes to Adopted Standards



1. **Code Set Maintenance**
   Each code set is valid within the dates specified by the organization responsible for maintaining that code set. 45 CFR § 162.1000
2. **Standards Maintenance**
   Maintain or Maintenance refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set.
3. **Modification/Updates**
   Substantive changes to an already adopted implementation specification requiring a new version or edition of a standard or operating rule must be adopted through regulatory action.

CMS

The Exceptions Process

- If a covered entity believes there is a need to modify an adopted standard, they may request an exception from the Secretary to test a proposed modification.
- The purpose is to test whether the modification improves the efficiency and effectiveness of the health care system by leading to cost reductions or improvements in benefits from electronic transactions.
- Additional guidance on the topic may be found in the Guidance Letters section of our website.

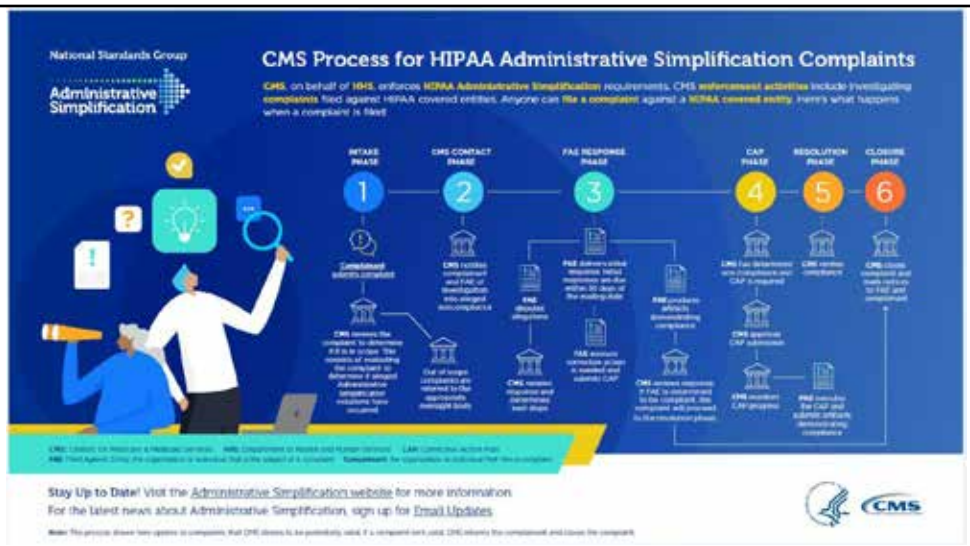
45 CFR § 162.940

CMS

Enforcement and Compliance: Complaint Management

- Passive Approach
- Anyone who believes a HIPAA covered entity is not complying with transaction, code set, unique identifier, or operating rule requirements can **file a complaint**.

CMS



Enforcement and Compliance: Compliance Review Process

- In 2019, NSG expanded our enforcement work to include compliance reviews
- Focuses on health plans and clearinghouses
- Assists covered entities in identifying vulnerabilities in achieving compliance with standards and operating rules
- Currently we've increased our annual volume of reviews from 15 to 100

CMS

Overview CMS-0056F

- The rule finalizes new requirements for retail pharmacy transactions.
- Updates include enhancements to improve coordination of benefits processes, prescriber validation fields, plan benefit transparency, codification of clinical and patient data, harmonization with related standards, and controlled substance reporting.
- All covered entities must comply no later than 12:00 a.m. in your local time zone on April 14, 2028.

Update on CMS-0053-F: Attachment Standards

- This rule will adopt a set of standards for the electronic exchange of clinical and administrative healthcare attachments data as well as for electronic signatures typically used in healthcare attachments.
- These changes are aimed at reducing paperwork, administrative burden, and lowering costs across the health care system by making the electronic exchange of data more efficient.
- The final rule is targeted for publication in first quarter of 2026.

Overview of HIPAA Modernization

- Aims to streamline and speed up the development and adoption process for HIPAA standards through the following efforts:
  - Increasing collaboration
  - Taking a more strategic regulatory approach
  - Promoting voluntary testing and use of the Exceptions Process


Thank you!
CMS
• For more information about Administrative Simplification requirements, visit the go.cms.gov/adminsimp.
• For the latest news about Administrative Simplification, sign up for Email Updates.
• To send questions, comments and feedback on Guidance Letters, Informational Bulletins, and FAQs, and any other related matters, please address them to the AdministrativeSimplification@cms.hhs.gov mailbox.
• Informational videos:
• Submitting a complaint of noncompliance: https://www.youtube.com/watch?v=4foLDmgBwlk
• Introduction to Administrative Simplification: https://youtu.be/nTLXK8aBs0I

D.2: X12

Presenter
Andrew Fitzpatrick, X12 Operations & Licensing

Presentation

Andrew Fitzpatrick, X12 Operations & Licensing, thanked WEDI for the opportunity to speak on behalf of X12. He started with a disclaimer saying that the presentation is for informational purposes only. It is point-in-time information, and the content is subject to revision, specifically for the tools that X12 is in the process of providing related to the Version 008060.

X12 has hundreds of members and thousands of member representatives, that include corporations, stakeholder associations, other organizations, government entities, and individual members. X12's expertise comes from the participants that contribute to the development and maintenance of these standards, and these are the people that use these standards. The standards are developed with the goal of administrative simplification and removing friction for data exchange between trading partners.

X12's organizational structure is hierarchical. Member representatives fill the leadership positions as volunteers. The Board of Directors is voted on by the members. There are two parts to the organization. The first is the Accredited Standards Committee that develops the American National Standards Institute (ANSI) accredited standards. The second part is the Registered Standards Council (RSC) which oversees the development and maintenance of other components that are related to the standards, such as external code lists.

Billions of transactions are exchanged daily using X12 standards, and not just in the health care industry. There are also standards in supply chain, transportation, and other industries, and they have been used extensively for more than 40 years. Most of these transactions establish the infrastructure for how data is exchanged with the industry.

X12's maintenance request process and its annual release cycle follow specific procedures. Development of changes, updates, and new transactions begin with a suggestion that can be submitted by anyone from the public through a form on X12's website. It goes through X12's process, which includes deliberations on the business need, implications and technical aspects of the chang. Work is completed within the subcommittee developing the solution and X12's Technical Assessment Subcommittee. The Annual Release Cycle (ARC) provides a more predictable schedule for updated versions. Historically, new versions were released when the scope is complete, and the scope drove the schedule. X12's ARC is set up for the schedule to drive the scope. This development process is rigorous to ensure that changes are well vetted. Stakeholders have several opportunities to provide feedback and to participate.

In September 2025, X12 published the Version 008060 of the current 005010 version HIPAA-mandated implementation guides. In December, X12 submitted its recommendation for advancing the Version 008060 set and notified all the other members of the Designated Standards Maintenance Organizations and the related entities. The recommendation letter is available on X12's website.

Additional resources are available on X12's website, including member announcements, change reference documents, benefit summaries, mechanical comparison report, and webinar series information. The change reference documents require creating a free X12 log-in. The benefit summaries describe in plain English the expected benefits and high value changes to each transaction between Versions 005010 and 008060. The mechanical comparison report is a machine generated comparison between Version 005010 version and the 008060 counterpart for what has changed. These documents are lengthy but will be helpful for an implementer to see everything that needs to be covered. The webinars talk about the benefits and specific changes at a relatively high level, but with some more details. Three webinars have been held and the presentations are being posted as they are delivered. Additional webinars will be held.

It is critical for each organization to review the changes between Versions 005010 and 008060 independently. The tools are a reference, but additional evaluation is necessary for an organization to understand the details and potential impact on its systems.

The following are a few examples of benefits from the changes in Version 008060:

- Streamlining providers' revenue cycle through additional information from the health plan on adjustments to billed services giving the provider more transparency and accurate information
- Expanding diagnosis reporting
- Enhancing coordination of benefits for primary, secondary, tertiary payers
- Expanding use of external code sets allowing for more frequent updates
- Improving accuracy for adjudication, reporting, and reconciliation
- Supporting additional lines of business, such as dental and pharmacy
- Supporting more granular use of codes for inquiries, requests, adjustments, and dates
- Supporting digital member ID cards.

X12's next standing meeting is being held June 7-11 in Philadelphia. Registration is free for X12 members. Non-X12 members can complete the non-member registration form and will receive information on how to attend.

Learn more about X12 on its website. Feedback for X12 can be submitted to X12.org/feedback.

Slides


X12 UPDATE
April 22, 2026
Andrew Fitzpatrick
X12 Operations
& Licensing
X12


DISCLAIMER
This presentation is for informational purposes only
This presentation does not represent legal advice
This presentation contains point-in-time content and is subject to revision
X12


The X12 Organization


THE X12 ORGANIZATION
X12 is comprised of a handful of staff, hundreds of members, and more than a thousand member representatives
Members include corporations, associations, organizations, government entities, and individuals
Member representatives include experts from health care, insurance, transportation, finance, government, supply chain and other industries
X12


X12 ORGANIZATIONAL STRUCTURE
Board of Directors
X12 Member Representatives
ASC Steering
Governance Panel
RSC Council
X12
X12


MEMBER REPRESENTATIVES
Member representatives are individuals employed by an X12 member who participate in X12 activities on the member's behalf
X12 has established three types of member representatives
Primary representative - All members must name a primary representative
Alternate representative
Designated representative
X12


X12 MEMBERSHIP
What it means to be a member
Represent your company's interests with respect to suggested changes and new aspects of X12 work in an antitrust-friendly consensus driven forum
Influence change by participating in group discussions, collaborations, and ballots
Network with decision makers and technology professionals
How to become a member
Review the membership categories online and register to apply
X12

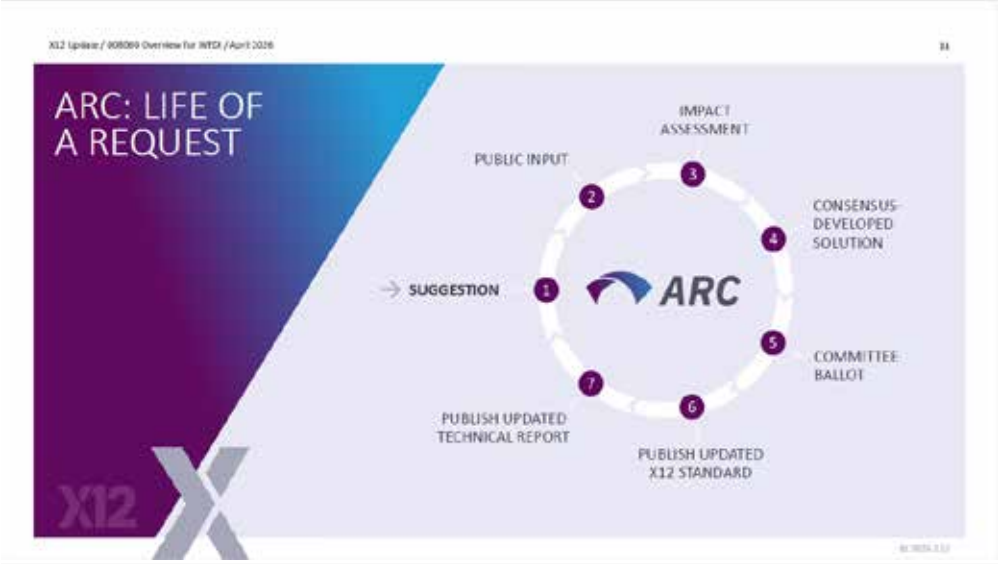
X12 IMPLEMENTATION BASE

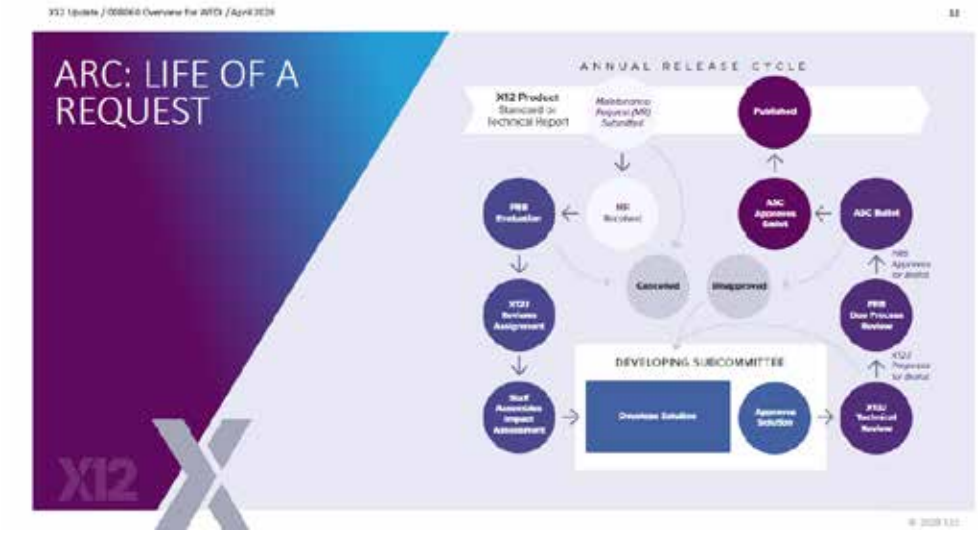
- Billions of transactions based on X12 standards are utilized daily across various industries including finance, government, health care, insurance, supply chain, transportation, and others
- Millions of entities around the world have an **established infrastructure** that supports X12 transactions, representing a significant investment in a stable and effective infrastructure
- The data exchanged in X12 transactions is well-defined and has been use-tested in production systems for over 40 years

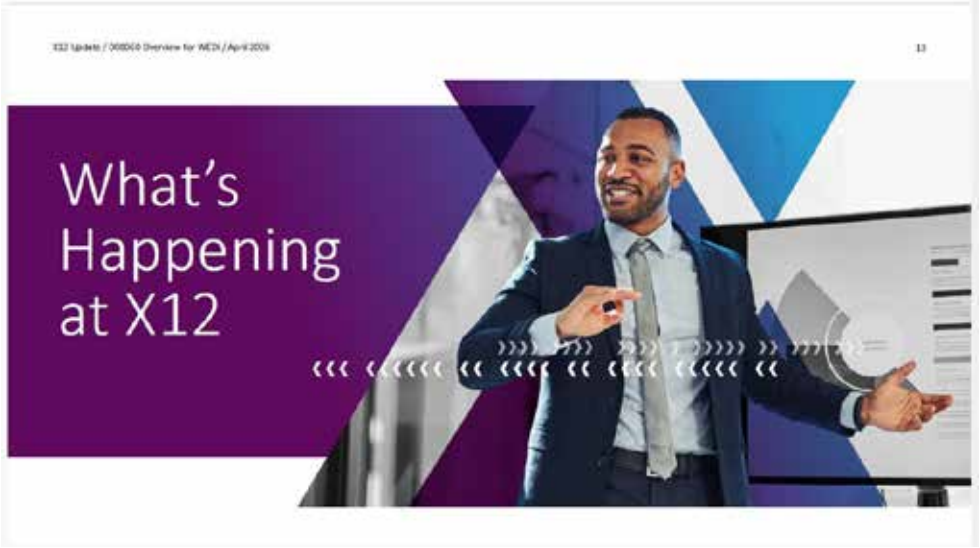
Maintenance Requests and the ARC

WHY HAVE AN ANNUAL CYCLE

- ARC – Annual Release Cycle
- MR – Maintenance Request
- Supports rapid implementation of solutions to new and evolving business needs and federal/state regulations
- Supports a predictable update schedule for X12 work products that improves planning, scheduling, and budgeting for implementers and regulators
- Supports incremental revisions on a more frequent basis

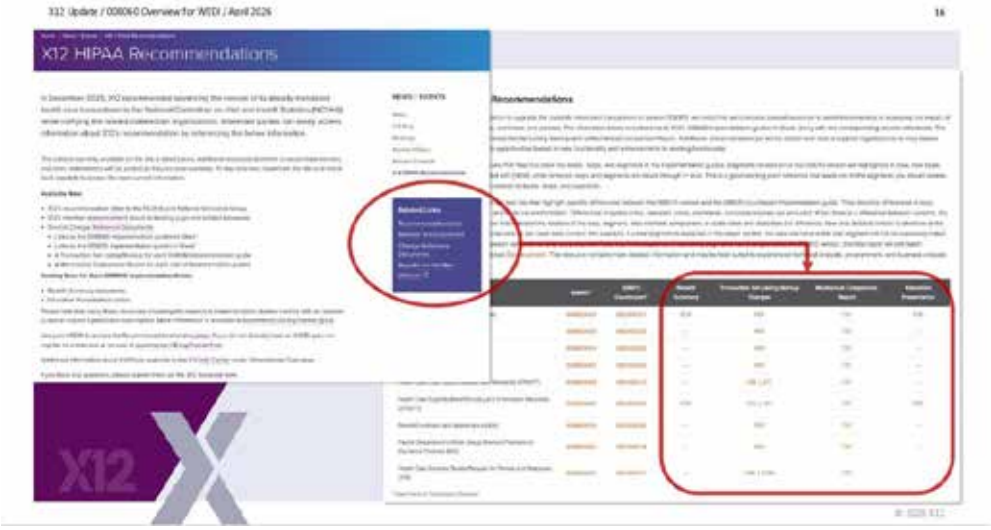

ARC: LIFE OF A REQUEST
IMPACT ASSESSMENT
PUBLIC INPUT
CONSENSUS-DEVELOPED SOLUTION
SUGGESTION
ARC
COMMITTEE BALLOT
PUBLISH UPDATED TECHNICAL REPORT
PUBLISH UPDATED X12 STANDARD
X12

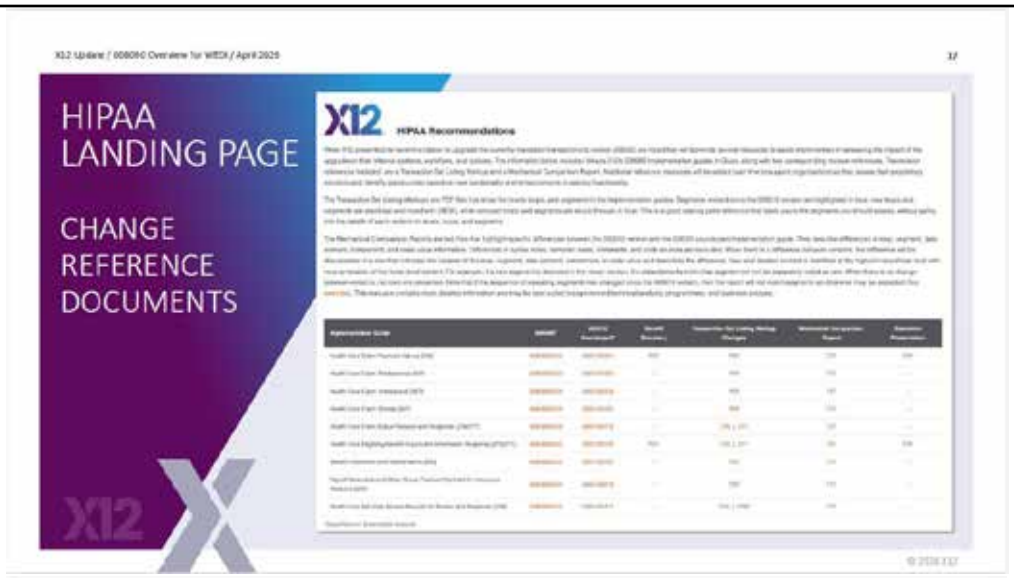

ARC: LIFE OF A REQUEST
ANNUAL RELEASE CYCLE
X12 Product
Published
DEVELOPING SUBCOMMITTEE
X12


What's Happening at X12


X12 Update / 008060 Overview for WEDI / April 2026
008060 GUIDES PUBLISHED
In September X12 announced publication of the 008060 versions of the HIPAA-mandated implementation guides
In December 2025, X12 submitted its recommendation for advancing the version of already mandated HIPAA transactions
X12


X12 Update / 008060 Overview for WEDI / April 2026
HIPAA LANDING PAGE
A new Recommendations Landing Page
X12 HIPAA Recommendations
X12


X12 Update / 008060 Overview for WEDI / April 2026
X12 HIPAA Recommendations
X12


X12 Update / 008060 Overview for WEDI / April 2026
17
HIPAA LANDING PAGE
CHANGE REFERENCE DOCUMENTS
X12
HIPAA Recommendations


X12 Update / 008060 Overview for WEDI / April 2026
18
GENERAL INFORMATION
→ Critical exercise for each organization will be the onus for those organizations to review the changes between 005010 and 008060 independently
→ The 008060 revisions should be considered with respect to your proprietary systems and processes so you can realize the intended benefits
X12


X12 Update / 008060 Overview for WEDI / April 2026
19
EXAMPLES OF BENEFITS
→ Streamlining Providers' Revenue Cycle
• Replacing the CAS Segment with the RAS Adjustment Information Segment
• Expanded Diagnosis Reporting – additional principal, admitting, external cause, and other diagnoses
• Coordination of Benefits enhancements for allowed amounts, health care remark codes, and subrogation support
• Expanded and external code sets
X12


EXAMPLES OF BENEFITS
Improving Accuracy for Adjudication, Reporting, and Reconciliation
Reporting invalid procedure and modifier codes
Supporting identification of the payee tax identification number, unique device identifier, and tooth information
Ability to report other insurance coverages, reducing rebilling, and manual follow-up
Supporting Property & Casualty coverage and reporting
X12


EXAMPLES OF BENEFITS
Supporting Additional Lines of Business and Extending Automation
Specific guidance for electronic prescribing (Pharmacy) and the dental community
Cascading searching and matching for coverage
More granular usage of codes for inquiries, requests, adjustments, and more
Extended support for dates as far back as timely filing for claims
Support for digital member ID cards
X12


EDUCATION/ INFORMATION SERIES
Education/Information Series:
March 31st - X332: Health Care Eligibility/Benefit Inquiry and Information Response (270/271)
April 9th - X322: Health Care Claim Payment/Advice implementation guide (835)
April 21st - X323, X324, and X325: Health Care Claim Series covering the Professional, Institutional, and Dental implementation guides
Sessions for other guides and more will be scheduled in the coming weeks
X12

EDUCATION/ INFORMATION SERIES

- You must register for each session
- The link to the registration form is on the recommendations landing page
- We plan to offer most sessions several time over the course of this year, based on attendance and requests
- After the initial webinar for each implementation guide, the presentation slides will be available on the recommendations landing page

Wrap up

Next Standing Meeting

June 7 - 17, 2026

Next Corporate Meeting

June 8, 2026

Sonesta Philadelphia Rittenhouse Square

Registration is now open

x12.org/news-and-events/meetings/summer-2026-standing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→ Stay informed by following X12
@x12standards
#X12 on LinkedIn
X12


FEEDBACK
IDEAS
QUESTIONS?
WE WANT TO HEAR IT
X12.ORG/FEEDBACK
X12

D.3: Dental Content Committee

Presenter
Arna Meyer, Committee Member, Dental Content Committee

Statement

Industry Support for Modernization

The dental industry understands the modernization goals of X12 version 008060 and recognizes its potential to significantly improve interoperability, data quality, and alignment with modern administrative workflows. Stakeholders see real long-term value in enhanced clinical data structures, improved harmonization with operating rules, and convergence of administrative standards with the ADA Dental Claim Form.

However, this support is conditional. The industry's position is clear: the success of 008060 for dental depends not just on technical capability but also on enforceable usability, sufficient time, and meaningful implementation guidance.

The Transition Is Non-Incremental and Resource-Intensive

From the dental industry's perspective, the move from 5010 to 8060 represents a fundamental structural change, not an incremental version update.

Key realities include:

- Introduction of entirely new segments and expanded data elements
- Significant re-engineering of claims, eligibility, payment, attachment, and status workflows
- Rewriting of edit libraries and validation logic
- Concurrent support for multiple X12 versions during migration

For dental payers and vendors, this translates to multi-year development cycles and material financial investment. For providers, particularly the long tail of small and solo practices, the risk of revenue disruption during transition is substantial if timelines are compressed or guidance is insufficient.

Dental-Specific Usability Must Be Mandated, Not Optional

A central concern raised across the industry is that structural capability alone does not guarantee interoperability.

The dental industry has prior experience with optional fields in 5010 transactions, particularly in eligibility and benefit responses, that technically exist but are frequently left unpopulated by payers, or omitted from vendor implementations entirely as they were perceived as unused by dental. There is strong concern that, without clear requirements, 008060 could repeat this pattern at a greater scale.

1. **Diagnosis-to-Service Line Linkage**
   When diagnosis codes are reported, the ability to link them meaningfully to dental service lines must be required, not situational. This linkage is essential to preserve alignment with the ADA Dental Claim Form and to enable consistent adjudication and analytics.
2. **Minimum Data Content Expectations**
   Where the 008060 schema enables tooth-level, surface-level, or benefit detail, operating rules or implementation requirements must define minimum response content when such data exists in payer systems.
3. **Avoiding "Empty Interoperability"**
   Without enforceable requirements, dental stakeholders fear an environment where new segments exist in theory but are left blank in practice undermining the promise of the standard.

Adoption Timeline

There is strong consensus across the dental industry that an extended adoption timeline is essential.

Stakeholders consistently indicate that:

- 18 months may be feasible for early adopters or niche vendors
- 24 to 36 months is necessary for broad, safe, and equitable industry adoption
- Longer timelines are critical for vendors serving small practices and for large payers coordinating across multiple lines of business

The industry urges NSG to recognize that compressed timelines increase the likelihood of production instability, inconsistent implementation, and revenue disruption, especially in dental, where margins and technical resources are often thinner than in medical.

Access to Guidance and Industry-Wide Testing Is Essential

The dental industry cannot succeed in this transition without clear, accessible, and dental-specific guidance.

Industry stakeholders strongly request:

- Consolidated, plain-language change summaries
- Far more robust dental examples across all affected transactions
- Clear guidance on phased or staged migration approaches
- Industry-wide testing opportunities that include payers, vendors, and clearinghouses
- Clarification that change documentation can be broadly shared, not limited by membership status

Readiness depends as much on information access and education as it does on technical specifications.

Risks to Providers Must Be Actively Mitigated

Finally, the dental industry asks NSG to consider provider impact as a first-order concern.

Dental providers—particularly small practices—have limited cash reserves to absorb:

- Claim processing delays
- Eligibility or benefit mismatches
- Payment disruptions during cutover periods

Without adequate timelines, testing, and data completeness requirements, the operational risk of transition will fall disproportionately on providers least able to absorb it.

Closing

In closing, the dental industry's position is not one of resistance, but of measured, experience-based caution.

We believe X12 version 008060 can:

- Significantly improve dental interoperability
- Enable richer clinical and administrative data exchange
- Reduce long-term administrative burden

But only if adoption is supported by:

- Sufficient time
- Mandated dental usability requirements
- Robust, accessible guidance and testing infrastructure

D.4: Health Level Seven

Presenter

Daniel Vreeman, Chief Standards Development Officer and Chief Artificial Intelligence Officer, Health Level Seven

Statement

HL7 Statement

WEDI Federal Policy Consultation: Potential Costs and Benefits Associated with Moving to the HIPAA Version 008060 Transaction Standards

Overview and Introduction

On behalf of HL7 International and its over 1,600 members, we thank you for the opportunity to share HL7's perspective on the potential costs and benefits associated with adoption of the X12 Version 008060 transactions under the Health Insurance Portability and Accountability Act (HIPAA). I am Dr. Daniel Vreeman, and I serve as HL7's Chief Standards Development Officer and Chief Artificial Intelligence Officer.

HL7 is an ANSI-accredited Standards Development Organization (SDO) dedicated to empowering interoperability of healthcare data globally. Our members include healthcare delivery organizations, government agencies, payers, pharmaceutical companies, and technology vendors who are directly involved in the electronic exchange of health care data, and many of which would be affected by a transition from version 005010 (v5010) to version 008060 (v8060). Our comments today reflect HL7's experience bringing these diverse stakeholders together to create innovative interoperability standards that improve health.

V8060 Transition Perspectives and Benefits

HL7 is deeply committed to international and domestic standards collaborations. As one of the U.S. Designated Standards Maintenance Organizations (DSMOs), we work collaboratively with X12, whose standards are being discussed here.

We appreciate X12's foundational efforts that have advanced the aims of the Administrative Simplification provisions of HIPAA. Compared to the currently adopted versions, the v8060 standards represent thousands of incremental updates based on change requests from industry stakeholders. In general, HL7 supports the adoption of modern standards that best meet the current interoperability needs of the industry.

Prior industry hearings and National Committee on Vital and Health Statistics (NCVHS) recommendations -- such as the February 2019 Predictability Roadmap and July 2022 Recommendations to Modernize Adoption of HIPAA Transaction Standards-- have emphasized the challenges inherent in our current approaches to named transaction standards and versions.

In its recent CMS-0053-F final rule, the Centers for Medicare and Medicaid Services (CMS) adopted standards for healthcare claims attachments including version 6020 of the X12N 275 and 277 and HL7's Consolidated Clinical Document Architecture and Digital Signature Implementation Guide. Additionally, we note that CMS-0062-P, if finalized, would adopt HL7 FHIR-based implementation guides as the standards for three prior authorization transaction types: referral certification and authorization (dental, professional, and institutional); "eligibility for a health plan" transactions associated with prior authorization; and prior authorization attachments.

Implementation

Three options for implementing v8060 were framed in the recent WEDI survey: (1) Implement all v8060 transactions as a group; (2) Implement v8060 by individual standard (transaction by transaction); or (3) Implement certain standards by group and others individually.

In considering these options, we encourage the Committee to account for the current regulatory landscape and implementer readiness, both of which have evolved considerably since prior version transitions.

We also highlight the importance of implementer feedback--including testing and pilot learnings-- as essential for driving virtuous cycles of standards development. And a measured, reasonable implementation timeframe is needed for diverse stakeholder success. For its part, HL7 is committed to supporting the effective use of FHIR wherever it coexists with X12 standards.

Costs

The marketplace is diverse in capabilities and resources, so HL7 highlights three cost considerations relevant to v8060 adoption:

- Dual-version support during any industry transition has advantages, but also carries significant cost;
- The distribution of upgrade costs among key stakeholders should be both well-understood and accommodated, so no stakeholder is at a notable disadvantage; and
- Transitions to newer standards--especially significant upgrades--are aided by broadly sharing technical learnings from trusted resources, such as the SDO and key federal and non-federal partners.

Conclusion

In conclusion, HL7 supports thoughtful advancement to modern standards for HIPAA transactions while recognizing today's complex environment of attachment standards, interoperability mandates, and this potential v8060 transition. Success will require balancing innovation with implementer readiness, incorporating stakeholder feedback, and equitably managing costs across the ecosystem.
Through our relationships with the DSMOs, government leaders, and industry stakeholders, HL7 stands ready to help chart a pragmatic path forward. Thank you.

D.5: National Council for Prescription Drug Programs

Presenter
Margaret Weiker, Vice President of Standards Development, National Council for Prescription Drug Programs

Statement

RE: WEDI X12 Version 008060 Federal Policy Consultation (FPC)
DSMO Panel

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit American National Standards Institute (ANSI) Accredited Standards Developer (ASD) consisting of more than 1,300 members representing entities including, but not limited to, claims processors, data management and analysis vendors, federal and state government agencies, insurers, intermediaries, pharmaceutical manufacturers, pharmacies, pharmacy benefit managers, professional services organizations, software and system vendors and other parties interested in electronic standardization within the pharmacy services sector of the healthcare industry. NCPDP provides a forum wherein our diverse membership develops business solutions, including ANSI-accredited standards and guidance for promoting information exchanges related to medications, supplies and services within the healthcare system.

NCPDP convened the WG45 834/835 FAQ Task Group, the WG45 DSMO Change Request Task Group and the WG1 P&C/WC Monitoring, Billing and Education Task Group to evaluate the X12 Version 008060 270/271, 837P, 834 and 835 transactions. These are the transactions mostly used in the pharmacy sector.

Task group members used the X12 generated mechanical comparison report to do their evaluation and analysis. I'm happy to report there were no "showstoppers", negative impacts or obstacles discovered. NCPDP acknowledges and thanks the members of the X12 work groups for incorporating our modifications and business requirements into these implementation guides.

Regarding an implementation timeline, the task group members require at least two years from the effective date of the final rule to be in production and the implementation timeframe not overlap other major federal final rules. The task group members did not have the time or bandwidth to complete a cost/benefit analysis.

Respectfully,
/s/ Margaret Weiker

mweiker@ncpdp.org
Vice President, Standards Development
National Council for Prescription Drug Programs (NCPDP)

D.6: National Uniform Billing Committee

Presenter
Terrence Cunningham, Chair, National Uniform Billing Committee

Statement

Thank you so much to everyone for having me. It is my pleasure to provide the perspective of the National Uniform Billing Committee as part of this panel.

The National Uniform Billing Committee was convened and formed by the American Hospital Association in 1975. The main purpose was to bring together all the stakeholders that would be involved in an institutional claim and would have an interest in the institutional claim and develop a standard and single billing form and standard data set to be used by providers and plans for institutional claims.

Subsequently, the NUBC was recognized under the HIPAA regulations as the data content authority for institutional claims and is also a member of the Designated Standards Maintenance Organizations, as you might suspect, because I'm on this panel. As such, our review of developing standards is often largely focused in terms of the claim and the related standards to the claim. This is our area of expertise in terms of the committee members and the area of focus as we convene our groups.

As we approached this panel, we had the opportunity last week during a recent meeting to receive additional insight in terms of the specific changes that are being made and updated as it relates to the claim. Specifically, Jamie Mosteller, who is our X12 representative, provided insight largely in line with what you would have seen if you saw the X12 presentation yesterday. He provided an overview of some changes, such as the switch from CAS to RAS segments, the supporting of backwards dating of claims, the tooth reporting information, and the ability to support pay-to factoring agents. These issues did not necessarily generate a significant amount of discussion. They have not necessarily been issues that have been raised to us as major areas of concern. That being said, I am not saying that these are not issues that are important. It is just a way of me saying that I do not think the committee has had an opportunity to really gauge the specific need or impact for this.

One of the large questions we have as we approach this, as we approach something similar to this, is now the time to move to a new version of the standards. Is the juice worth the squeeze to use a potentially overused metaphor?

As mentioned earlier, these standards work. We agree with that. What we want to know is to what degree do these standards work better than what we already have working? And, to what degree is the investment of resources? How do we ensure that the investment of resources and the time both is worth it, as well as how do we roll a new standard out in a way that we are not overwhelming the industry?

We have not done a cost benefit analysis, but we encourage CMS to just carefully consider these issues. I do intend to review the X12 benefit summaries. It will be my intention to make sure this is reviewed by the committee in a more focused opportunity, so that we can have this kind of informed perspective in

terms of why this is such a benefit that we need to move this forward with the industry. I know there was a request for a cost benefit analysis, and we have not had the ability or sufficient time to conduct that, but certainly something we look forward to doing moving forward.

The last thing I will note is, as a DSMO, it has been a pleasure recently to work with CMS on trying to update and modernize the existing DSMO process. I look forward to continuing that work. A few years ago, when X12 presented the 8020 version, it became clear that the existing DSMO processes needed to be updated based on industry practices. The NUBC looks forward to continuing that work, particularly to develop an approach that can enable us to provide our expert commentary on emerging standards and to be able to provide our collective voice that this group potentially can have, and the ability to make sure there is industry perspective. I appreciate WEDI for convening this, because I think this is an opportunity to get some of that perspective as well.

With that, we really look forward to seeing some of the more specifics and having the opportunity to analyze some of the additional changes and trying to figure out that cost benefit analysis. We look forward to seeing exactly how CMS intends to roll this out in terms of timing and balance to make sure that this fits within the larger industry implementation concerns. Thanks so much.

D.7: National Uniform Claim Committee

Presenter
Julie Brown-Georgi, Chair, National Uniform Claim Committee

Statement

Thank you to WEDI, CMS, X12, and the industry participants for convening us for this discussion. And kudos to WEDI for holding their first Federal Policy Consultation.

I am Julie Brown-Georgi, Chair of the NUCC, and I am going to be speaking from the perspective of the National Uniform Claim Committee. NUCC's upbringing and charge is extremely similar to the NUBC. Our core interest is not simply whether the industry can translate one EDI version to another. Our concern is whether the professional claim data set remains nationally uniform, clear, and usable for physicians, suppliers, payers, clearinghouses, and the systems that connect them.

Version 05010X222A1 has served the industry for many years. There are pain points in processing as technology is imperfect so when a standard has trouble with that, there may not necessarily be issues in the standard to fix. When the standard cannot carry the data clearly, the industry still needs the data. It moves to companion-guide workarounds, portals, attachments, manual notes, phone calls, claim splitting, and resubmissions. From NUCC's perspective, that is the central area to address within our purview. Non-uniformity re-enters the process through the back door, and our goal is to secure uniformity.

Version 008060X323 offers an opportunity to move some of that manual work back into the standard transaction. For professional claims, we see particular value in stronger data areas such as longer claim identifiers; device identifiers; service date and time for electronic visit verification and multiple same-day services; and more consistent patient-weight reporting.

Those changes can reduce manual work, but only if implementation is coordinated. Is it tested before moving forward?

Additionally, we are in an interesting spot with the 1500 paper claim form. NUCC believes the paper and electronic environments must be handled carefully. The 1500 claim form remains important, but we've transitioned to electronic professional claim can and should carry data that will not fit neatly on the paper form. NUCC would not recommend forcing every electronic enhancement into a new paper form field. Instead, we could update NUCC instructions and the 1500-to-837P mapping to distinguish data that belongs on the 1500 form, data that belongs in the electronic 837P only, and data that must be captured upstream in EHR, practice-management, authorization, remittance, device, or pharmacy-related systems. While there is opportunity for the NUCC to support the transition in the aforementioned ways, when it comes to our bread and butter, which is the data on the paper claim form, we have a space constriction.

On transition planning, NUCC supports a defined dual-use period for testing and migration, but not indefinite support for two adopted standards. Permanent dual standards would increase the variation NUCC is designed to reduce. It is prohibitively difficult to support dual standards permanently and for them to coexist seamlessly. We recommend pilots, transparent readiness criteria, strong end-to-end

testing, and a compliance timeline that recognizes small practices, vendors, clearinghouses, Medicaid agencies, Medicare, commercial plans, and property-and-casualty users.

Finally, there are economies of scale if the industry treats 008060 as shared platform modernization: common translator upgrades, common validation rules, common code-list governance, shared testing scenarios, coordinated trading-partner certification, and national training. NUCC can contribute by maintaining uniform professional claim instructions, updating the 1500-to-837P map, and helping the industry separate true national data needs from payer-specific local preferences.

In summary, NUCC sees 008060X323 as a meaningful opportunity to modernize the professional claim data set. We support moving forward, provided the transition is coordinated, time-limited, workflow-tested, and focused on reducing manual work while increasing return on investment rather than creating a new layer of variation.

Thank you.

D.8: American Hospital Association

Presenter
Andrea Preisler, Senior Associate Director of Administrative Simplification, American Hospital Association

Statement

Over the past several years, the American Hospital Association has engaged actively and constructively in discussions regarding updates to HIPAA administrative transactions, including proposals to transition multiple transactions to X12 Version 8060. We appreciate X12's continued engagement with stakeholders and their efforts to modernize the standards environment.

At the outset, I want to be clear that hospitals support modernization when it is purposeful, well-sequenced, and meaningfully advances administrative simplification. Our position is not opposition to transition. Rather, our assessment of the proposed X12 8060 transactions remains incomplete, as hospitals still need clearer, provider-ready information to understand the real-world impacts of a transition of this magnitude.

For hospitals, a critical input to that assessment is widely available, plain-language information explaining how 8060 enhances the currently mandated 5010 transactions. We appreciate the Change Reference documents and recognize their technical value. However, hospitals also need a clear, provider-facing summary that explains what has changed, why it matters, and how daily workflows and administrative processes would improve in practice.

Without that level of clarity, it is difficult for providers to evaluate costs, operational impacts, workflow changes, and return on investment—particularly given that the transition of this magnitude spans multiple transactions, vendors, and trading partners.

We have also appreciated the X12 8060 Education Series, which has been helpful in raising awareness and walking through proposed changes. Efforts like these are valuable, especially if they're paired with accessible written resources that hospitals could share internally and use to support operational and business-level decision-making.

These considerations apply across the full suite of 8060 transactions, but they are especially important because a version upgrade across revenue cycle transactions will inevitably be disruptive and costly. A mandate to upgrade without a clearly demonstrated need for the new functionality risks creating a significant investment without visible return. And, in that context, transparency around provider-relevant benefits is essential.

This concern is amplified for rural hospitals and other providers under financial strain, including those experiencing the impacts of Medicaid cuts and coverage disruptions. As most of you know, many hospitals are already operating on thin margins, and large-scale technology and process upgrades can introduce additional strain to those finite resources. For these providers in particular, it's really imperative that the need for updated functionality—and the value it delivers—be clear and compelling.

At the same time, there are areas where hospitals do see meaningful potential. For example, we find the updates to the eligibility transaction to be promising and worthy of investment. Providers are encouraged by enhancements such as smarter member matching, improved traceability, and clearer prior auth indicators. I'll also highlight that the ability to perform eligibility checks based on service type or stage of care is a significant advancement that could materially improve front-end workflows for providers and increase timely patient access. So we are really pleased to see those enhancements in that transaction.

However, overall, we still would really like to see more granular, provider-facing explanations of how the enhancements made on the multiple transactions that providers use work together in practice and if and how they address current roadblocks and headaches.

Hospitals are therefore asking What specific problems does X12 8060 solve, and how will those solutions materially improve administrative processes for providers? X12 has undertaken meaningful work to advance these transactions, and we welcome continued engagement that helps translate that work into clear workflow outcomes.

Looking ahead, we think a reasonable path forward is to continue pairing engagement efforts—like the Education Series and Change Reference documents—with widely available plain-language summaries of enhancements that clearly articulate the value proposition of 8060, particularly in comparison to 5010. This will better position hospitals to complete their assessments and plan responsibly for potential transition.

Ultimately, the AHA remains committed to modernization that delivers real administrative simplification. Hospitals are open to transition and interested in improvement. At the same time, given the cost and disruption associated with upgrading the full revenue cycle of transactions—especially for those hospitals under financial pressure—it is essential that the need for updates and the ROI of the improved functionality be clear and visible. To that end, we welcome additional information from X12 as I outlined and, to CMS, we urge reasonable timelines in any proposed transition, ideally 24 months from publication of a final rule.

D.9: Independent Health

Presenter
Christopher Gracon, Solution Architect, Independent Health

Statement

As a payer and an active member of X12, I am so glad to see that we are finally moving ahead.

So appreciative of X12 for starting an educational series on 8060 by transaction set. People should be on the lookout for future sessions and review the materials from the previously held ones.

Answering questions on impact:

a. There will be costs. The costs are unknown due to
    i. Not having info from our software vendors what their changes will be to accommodate 8060
    ii. Not having done our own analysis. We can figure out what processes we might need to change or somewhat how to map to/from the 8060 transactions but not knowing the changes to the software interfaces we need to map to/from would limit any analysis
    iii. Unknown on effects of CMS-0062-P on the 8060 NPRM, or absent moving ahead with a 8060 NPRM what it means to the current processes under 5010
b. Currently focused on Run the Business efforts and Interoperability
    i. Interoperability has 25 % of our IT department working on it, not to mention those on the business side. With an unlimited budget we might have been able to bring in some outside resources to help us, to have fewer existing staff focus on this instead of other work, but we do not have unlimited money.
    ii. Upgrading to 8060 will have fewer IT and business people working on it than are currently on Interoperability as Interoperability was greenfield work and required a ton of learning about the data structures, technology and modifications on the business end. For 8060 it will be an incremental change to handle any differences, determining business opportunities that the changes present, and mainly testing internally and externally. I foresee that we can do this within our existing staffing and taking fewer people than we needed to go from 4010 to 5010, especially with newer mapping and testing tools.
c. There are the unknown opportunity costs, either additional costs we pay now or living with challenges that have been factored into daily work or costs for things we do not have. For example:
    i. What could payers or APCDs be able to find out via analysis of claims to be able to be more proactive with having additional diagnosis codes or having the DI of the UDI
    ii. Being able to have claims adjudicate instead of being denied for having multiples of the same service on the same day

iii. How much easier would it be for payers to administer FSA/HSA enrollments within a standard structure in the 834
iv. Help clear up timely filing issues with providers submitting the date the claim was sent which could be different from when the payer received it, and similarly payers reporting the clean claim date if different from the receipt date
v. Payers being able to send greater specificity in the 271 in regards to prior authorization or referrals, and first dollar coverage

Recommendations

a. Timing
   i. With recent Attachments Final Rule, either skip moving these new transactions to 8060 saving that for the next upgrade, or have a later date so that there is time to establish Attachments within the industry and business processes
b. Roll out
   i. I think the entire suite of the current Standard Transactions should be done at one time. With all the current regulatory/legal initiatives going on in Health IT, we do not have time to spread the implementation out
c. Other regulatory requirements
   i. Need to work with Interoperability timings, though CMS-0062 could collide with this if it is not coordinated particularly due to the proposed retirement of the 278 and stripping of some functionality from the 270/271
   ii. With the upcoming NDC change, NSG could either plan to have the next upgrade scheduled immediately after this one or potentially name the most recently published version of the guides when the Final Rule comes out as the accommodation of the NDC change should be in place by then

Finally

a. I don't foresee issues of a 5010 and 8060 coexistence phase
b. Looking forward to more frequent smaller, quicker updates of X12 version in the future. The industry needs to look forward to a regular cadence of upgrades especially now that X12 is publishing these guides annually. Having a regular cadence could be needed to be able to get to reporting the NDC code changes, or any future new government regulatory or legal changes.

Supplemental information:

Things I am looking forward to from the 8060 versions

837

- Space for many more additional diagnosis codes, and pointers
- Splitting out decimal/non-decimal value codes which having them in a single field has been a pain point
- Collection of the Device Identifier of the UDI. Could be very useful for spotting trends in a payer or more particularly in an All Payer Claims Database

- Allowing for times to be reported on Service Date at the line level to demonstrate that a service is not a duplicate but was performed multiple times in a day
- Absent in 8060 - NDC qualifier for March 7, 2033, smaller step to go with 8060 and then move to version for new NDC

835

- Source of Payment Typology to allow the payer to better specify under what arrangement the claim was paid
- Allows for explicit naming of DRG methodology used, and therefore could be better validated
- RAS presentation of adjustments than CAS

834

- Ability to send FSA/HSA information. This could be particularly helpful to our affiliate which administers FSA benefits so that the FSA info could come with the rest of the enrollment information.

270/271

- External code sets, especially for Service Type Codes
- Greater detail being presented, both upon the request and the response

820

- Revised the structure of information to mirror the data in the 834 to facilitate association

D.10: American Medical Association

Presenter
Dino Gerousis, Director of Informatics, American Medical Association

Statement

AMA Position on Modernization and Adoption Readiness, Complexity, Capacity, and Vendor Dependence, Testing Gaps, Costs, and Return on Investment, Path Forward and Evidence-Based Decision-Making

The American Medical Association supports the ongoing evolution of administrative standards and recognizes that modernization of electronic transactions is necessary to keep pace with changes in health care delivery, technology, and policy. Standards such as X12 play a critical role in enabling interoperability and administrative efficiency across the health care system. However, the AMA's role is to ensure that modernization efforts translate into meaningful, practical benefits for physicians and medical practices that must implement these standards in day-to-day operations.

With respect to X12 Version 008060, the AMA believes it would be premature to support adoption under HIPAA at this time without clearer evidence that the changes will provide tangible value to providers, can be implemented at a reasonable cost, and are feasible across the diversity of physician practices. This position is consistent with the AMA's prior testimony to the National Committee on Vital and Health Statistics in 2022 and 2023 regarding earlier X12 version updates, where similar concerns were raised about timing, readiness, and return on investment.

While Version 008060 introduces structural and technical enhancements intended to modernize transactions, the scale and breadth of the update raise important questions about whether the provider community is sufficiently prepared to absorb these changes alongside other ongoing health IT initiatives. The AMA emphasizes that modernization alone is not enough; standards must be implemented in a way that reduces administrative burden, supports clinical workflows, and improves efficiency without creating unintended consequences. Until providers have clearer, evidence-based information about the benefits, costs, and operational impacts of Version 008060, the AMA urges a cautious and data-driven approach to any consideration of HIPAA adoption.

One of the most significant provider concerns related to X12 Version 008060 is the overall scope and technical complexity of the transaction suite. The update spans multiple transactions and introduces changes that require careful analysis, development, testing, and coordination across trading partners.

For many physician practices, particularly small, rural, and independent practices, there is limited internal capacity to directly engage with X12 implementation details. As a result, physicians and practice staff are often reliant on vendors to interpret requirements, prioritize development work, and determine implementation timelines.

While vendors play an essential role, this dependence can limit providers' visibility into how changes affect workflows, data capture, and downstream administrative processes. At the same time, experienced X12 subject matter expertise remains limited across the industry, which can create bottlenecks and increase implementation risk. These challenges are compounded by the fact that providers are simultaneously managing other significant demands, such as electronic health record optimization, quality reporting, cybersecurity requirements, and broader interoperability initiatives.

Against this backdrop, the scale of Version 008060 raises concerns about whether practices have the capacity to implement changes without disruption to clinical or administrative operations. From the AMA's perspective, any move toward adoption should take into account the uneven distribution of resources across the provider community and avoid assumptions that all practices can absorb large-scale standards changes at the same pace or with the same level of support.

Adequate testing and a clear understanding of costs and benefits are essential prerequisites for successful standards adoption. Providers continue to express concern that updates to X12 transactions, including those in Version 008060, are not always tested sufficiently in real-world provider environments before being considered for regulatory adoption. Testing that occurs primarily in controlled or limited settings may fail to capture the operational realities of physician practices, including staffing constraints, workflow variability, and interactions with multiple payers and vendors.

In parallel, implementation costs for providers are concrete and immediate. These costs can include software upgrades, interface development, internal and external testing, staff training, and workflow redesign. For many of the transactions included in Version 008060, the return on investment for providers remains unclear, particularly when benefits may accrue more directly to other stakeholders in the system.

Providers also continue to raise specific concerns about certain data expansions, such as the inclusion of virtual credit card information on the 835 Health Care Payment, which is associated with additional fees, reconciliation challenges, and increased administrative burden. Without clearer evidence that Version 008060 will reduce manual work, streamline processes, or improve financial operations for practices, it is difficult for providers to justify the level of investment required to implement these changes.

Slides

AMA VIEWS ON X12 VERSION 008060

AMA Position on Modernization and Adoption Readiness

Support for Modernization

AMA supports evolving administrative standards to align with healthcare delivery, technology, and policy changes.

Concerns on Adoption Timing

AMA finds adoption of X12 Version 008060 premature without clear evidence of practical benefits and feasible costs for physicians.

Implementation Impact

Standards must reduce administrative burden, support clinical workflows, and improve efficiency without negative effects.

Data-Driven Approach Needed

AMA urges evidence-based evaluation before HIPAA adoption to ensure benefits, costs, and operational impacts are clear.

Complexity, Capacity, and Vendor Dependence

Technical Complexity of X12

X12 Version 8060 introduces extensive technical changes requiring detailed analysis and coordination among partners.

Limited Internal Capacity

Small and rural physician practices often lack resources to engage directly with X12 implementation challenges.

Vendor Dependence

Providers rely heavily on vendors for interpreting requirements and managing implementation timelines.

Industry Expertise and Risk

Limited X12 expertise and competing demands increase bottlenecks and implementation risks for providers.

Testing Gaps, Costs, and Return on Investment

Testing Challenges

Real-world testing of X12 Version 8060 often misses operational realities like staffing and workflow variability.

Implementation Costs

Costs include software upgrades, interface development, testing, staff training, and workflow redesign.

Uncertain ROI

Return on investment remains unclear, especially as benefits often favor other stakeholders more directly.

Data Expansion Concerns

Inclusion of virtual credit card data raises additional fees, reconciliation challenges, and administrative burdens.

D.11: Jopari Solutions

Presenter
Jamie Mosteller, Director of Regulatory Affairs, Jopari Solutions

Statement

1. How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?

Jopari acknowledges that implementation of the X12 Version 008060 transactions will require meaningful investment across the industry, including system upgrades, testing, and trading partner coordination. However, these costs are outweighed by the significant long-term benefits and operational efficiencies introduced in the 8060 enhancements.

Notably, the 8060 version includes critical improvements that the industry, particularly the Property & Casualty sector, has been anticipating, enabling better data exchange, improved clarity, and reduced reliance on manual processes and workarounds. These enhancements are expected to drive burden reduction, increase automation, and improve overall transaction accuracy and timeliness.

To fully realize these benefits, Jopari recommends a coordinated, industry-wide rollout and adoption strategy. A common implementation framework, including aligned timelines and consistent requirements across payers, will minimize fragmentation, reduce duplicative effort, and support a more efficient and scalable transition for all stakeholders.

2. What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

Jopari strongly recommends that the implementation of the X12 Version 008060 transactions be deliberately sequenced to ensure successful industry adoption and minimize disruption. The industry should first complete implementation of Attachments and Prior Authorization requirements before initiating the 8060 upgrades, allowing stakeholders to focus resources and avoid overlapping regulatory burden.

Jopari further recommends that the full suite of 008060 transactions be implemented concurrently rather than through a fragmented transaction-by-transaction rollout. A unified implementation approach will promote consistency across trading partners, reduce operational complexity, and accelerate industry-wide standardization.

While early adopter programs may provide valuable implementation insights, Jopari recommends the establishment of a single, mandated compliance date for all payers to ensure alignment and prevent prolonged dual-version processing environments. This compliance date should be strategically selected

to avoid high-risk operational periods (e.g., the start of the calendar year), thereby reducing implementation risk and supporting a more stable transition.

3. Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Jopari is highly encouraged by the transition to X12 Version 008060 and the opportunity it represents for the industry to modernize administrative transactions. The move to 8060 reflects more than 15 years of thoughtful enhancements, industry collaboration, and lessons learned since prior versions, resulting in a more robust, flexible, and capable standard.

These enhancements are expected to significantly improve data quality, expand support for evolving business needs, and reduce reliance on proprietary workarounds that have developed over time. For many stakeholders, particularly within the Property & Casualty sector, 8060 represents a long-awaited advancement that better aligns transaction capabilities with real-world operational requirements.

Jopari believes that this transition is not simply a version upgrade, but a critical step forward in advancing interoperability, reducing administrative burden, and enabling more efficient, accurate, and scalable healthcare data exchange. With appropriate coordination and implementation planning, the industry is well-positioned to fully realize the benefits of the 8060 standard.

D.12: Stedi

Presenter
Nick Radov, Technical Product Manager, Stedi

Statement

My name is Nick Radov, I'm a Technical Product Manager at Stedi which is a programmable clearinghouse processing millions of HIPAA X12 5010 transactions for digital health providers. I'm also Stedi's X12 representative and a co-chair of WEDI's Emerging Technology workgroup, but today I'm speaking for Stedi and not on behalf of WEDI.

- Stedi strongly supports upgrading to X12 8060 across all HIPAA standard transactions, and perhaps adding additional standard transactions including 999 for general acknowledgments and 277CA for claim acknowledgments.
- Overall, version 5010 transactions are working well, but version 8060 will deliver key improvements for providers, payers, and patients.
- There are too many improvements in 8060 to cover in 5 minutes but I wanted to highlight a few of the key limitations 5010 has and how 8060 solves them.
- Maybe the biggest area for improvement is in the 5010 version's 271 response.
- 5010 was first published in 2009. Health plan structures have evolved significantly since then.
- Some current nuances, like a provider's in-network or out-of-network status or things like tooth data or shared frequency limitations for dental, can't be represented as codified fields in version 5010's 271 eligibility responses.
- Instead, providers are forced to parse unstructured text – when sent at all – that varies between health plans.
- In cases where that text isn't returned by the payer – or the provider just gives up – the provider has to call the payer or log into a proprietary web portal to get benefit details.
- In many cases, it would be easier and more cost-effective for the payer to have the provider get this information in the 271 response.
- Another issue is that in 5010's 271 responses, all benefits are sent as a single flat list.
- In situations where a patient is covered by multiple health plans issued by a single payer, it's hard for providers to determine which benefit falls under which plan.
- As before, many providers resort to just calling the payer or logging into the payer's proprietary portal.
- Shortcomings aren't limited to eligibility checks.
- Version 5010 doesn't support prospective 837P and 837I claims for Good Faith Estimates; those can be done for dental but not professional or institutional claims.
- This information is becoming more and more important as co-pays and deductibles continue to rise, and aligns with the policy focus on transparency in coverage.

While not a panacea, version 8060 introduces several improvements that directly address these issues:

- 8060 adds structured fields that both payers and providers want added to 271 eligibility responses.
- Payers will be able to explicitly state whether they consider the provider to be in or out of network with a coded field.
- And they can send different benefits for multiple tiers of participating network providers rather than just in or out of network.
- Payers will be able to send multiple groups of benefits in a single 271 transaction.
- This will be useful when members have multiple active plans under a single member ID. For example, a medical and dental plan, or an individual Medicare Advantage plan plus an employer-sponsored commercial group plan.
- For dental plans, payers will be able to send multiple discrete ADA CDT procedure codes in a single benefit line, which allows expressing shared frequency limitations.
- For example, many dental plans only pay for one set of x-rays per year, but dentists might bill that under several different CDT codes.
- Payers will also be able to send tooth-specific data.
- Expansion of prospective claims to cover 837P (Professional) and 837I (Institutional) will allow providers to ask health plans exactly how much they will reimburse for a course of treatment, and how much the remaining patient responsibility will be.
- These prospective claims let providers give patients who are covered by health plans Good Faith Estimates for out-of-pocket costs for treatment, letting the patient make an informed decision about their care.

Together, these improvements reduce provider abrasion, lower administrative costs for payers, and prevent surprise bills for patients.

- At Stedi, we're looking forward to supporting version 8060 as soon as CMS mandates it.
- We also encourage CMS to adopt a more frequent X12 version upgrade cadence.
- 8060 is a significant update after nearly 15 years without a major version change.
- Smaller, more regular updates will be less disruptive for everyone.
- We look forward to working with WEDI, CMS, X12, Cooperative Exchange, and all trading partners to make this upgrade a success.
- Thanks again to WEDI for allowing us to share our perspective today.

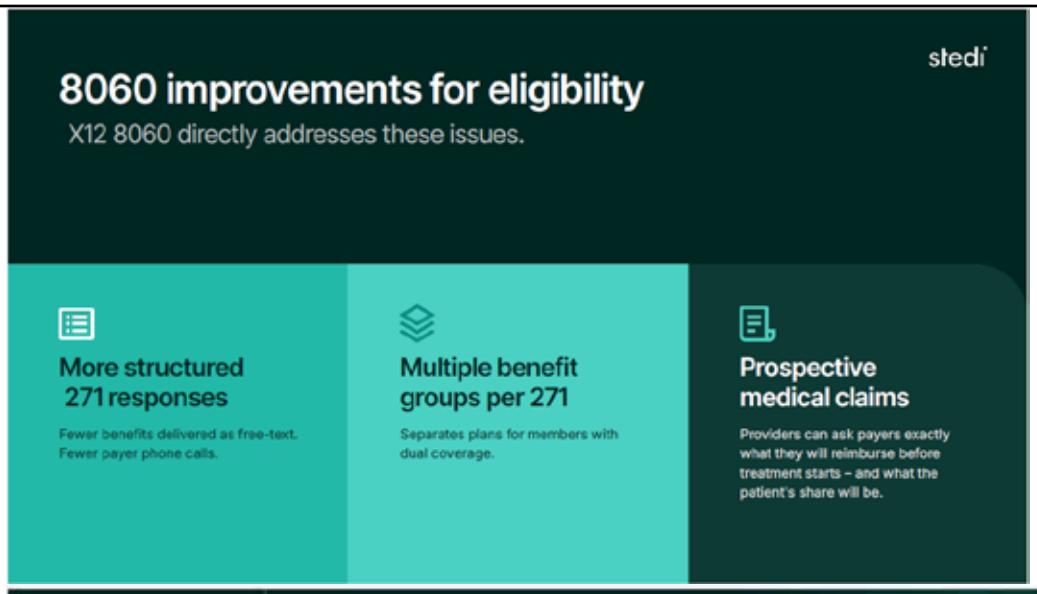
Slides


stedi
HIPAA Version 8060:
Stedi's Perspective
Nick Radov
Technical Product Manager @ Stedi
WEDI Emerging Technology co-chair
wedi


stedi
Stedi strongly supports
upgrading to X12 8060


Where X12 5010
falls short
stedi
271s can't represent modern plans
Providers have to parse free-text fields or call payers.
Provider in- or out-of-network status and common
dental benefits are often missing.
271 benefits arrive as a flat list
Payers return benefits from multiple plans per check,
leaving providers to sort them out.
No prospective medical claims
837P and 837I don't support prospective claims.
Providers can't give reliable Good Faith Estimates.

45


stedi
8060 improvements for eligibility
X12 8060 directly addresses these issues.
More structured 271 responses
Fewer benefits delivered as free-text. Fewer payer phone calls.
Multiple benefit groups per 271
Separates plans for members with dual coverage.
Prospective medical claims
Providers can ask payers exactly what they will reimburse before treatment starts – and what the patient's share will be.


stedi
CMS should adopt a more frequent X12 upgrade cadence.

D.13: The Cooperative Exchange

Presenter
Pam Grosze, Past Chair and Education Committee Chair, The Cooperative Exchange

Statement

I am Pam Grosze, past Board Chair and Chair of the Education Committee for The Cooperative Exchange, the National Clearinghouse Association. Thank you for this opportunity to provide input into the updates to the HIPAA transactions to the next version.

The Cooperative Exchange is composed of twenty member organizations[1], representing over 90% of the clearinghouse industry that supports over 1 million provider organizations, through more than 7,000 payer connections and 1,000 Health Information Technology (HIT) Vendors, and processes over 6 billion healthcare transactions annually; representing *the U.S. healthcare electronic data interstate highway system* enabling connectivity across all lines of healthcare eCommerce in the United States. This association supports HHS's efforts to streamline healthcare and create a more efficient and effective healthcare eco-system for the American people.

In their recommendation letter to CMS and supporting documentation, X12 has outlined dozens of significant enhancements that were made to the existing HIPAA transactions, including the 837 professional, institutional, and dental claim and 835 remittance advice transactions based on evolving business needs voiced by healthcare industry stakeholders. The Cooperative Exchange agrees that these and other enhancements will satisfy new business requirements and resolve significant gaps in business processes and administrative functions and will assist the industry with aligning with current and upcoming regulations.

The Cooperative Exchange also supports the non-substantive updates which decrease misinterpretation and ambiguity and promote precision in deployment across all stakeholders, thus reducing the overall operational costs to support the updated implementation guides.

Costs for making these updates is difficult to quantify at this time. Many entities will not evaluate costs until a proposed rule is in place and the exact requirements are more clearly defined. Clearinghouses find it is hard to compare the cost of this upgrade to the upgrade from version 4010 to 5010 due to the changes in system configurations and length of time that has elapsed since that last conversion, but all agree that the process of end-to-end testing will be significant and will encompass a major portion of the cost (as it would be with any change to any standard).
We do have lessons learned from previous conversions and now have the benefit of AI that can assist with development and internal testing, thus reducing the cost (but again, difficult to quantify at this time).

[1] The views expressed herein are a compilation of the views gathered from our member constituents and reflect the directional feedback of the majority of its collective members. CE has synthesized member feedback, and the views, opinions, and positions should not be attributed to any single member and an individual member could disagree with all or certain views, opinions, and positions expressed by CE.

The Cooperative Exchange recommends that WEDI review the end-to-end testing process to define testing requirements and milestones, and share those with CMS so that expectations and timing are clearly understood across all trading partners.

When looking at the question of timing of the mandate and roll-out of the multiple transactions, the Cooperative Exchange would like to emphasize that a compliance date of January 1 is very problematic. Many activities are happening at the end of the year, so incorporating changes of this magnitude at that same time becomes very challenging. A compliance date in the second or third quarter would be more manageable.

Some transactions must be implemented together due to their relationship with each other. The Cooperative Exchange is in favor of a single compliance date for all transactions and all entities. We do not see a benefit in having multiple rounds of implementations, and in fact, repeating the end-to-end testing process would be complex, costly, and burdensome. Including provider vendors, especially EMR/EHR vendors in this requirement is especially important as well to ensure the ability of providers to meet the compliance dates.

The Cooperative Exchange has long advocated for a change to the current regulatory review and rulemaking process and its known challenges and supports a federally established known and predictable version update cycle, under a federal guidance framework that allows two versions of a standard to co-exist.

Transitioning from the current "federal effective date" cycle that requires a cumbersome and time-consuming regulatory review and rulemaking process -to- a federally established known and predictable cycle of every 3 years would allow the industry to realize innovation and apply version updates in smaller incremental changes vs. huge steps / major changes due to long regulatory timeframes -> **evolutionary vs. revolutionary**.

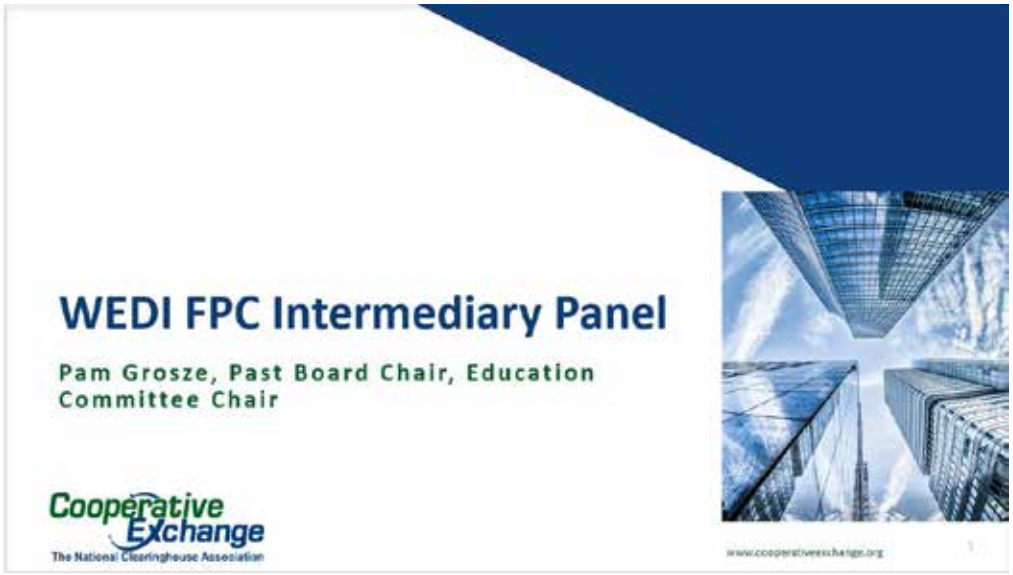
Using this predictable cycle, industry stakeholders would become acclimated to the framework process/requirements providing a consistent means for stakeholders to participate and comment on proposed standards or operating rule updates. A known and predictable version update cycle would also allow affected stakeholders to plan, budget, and resource effectively and introduce changes in a flexible cadence as their business needs warrant, while also, by nature of the process, advance the industry forward to continuously improve and modernize applicable standards and supportive operating rules.

The Cooperative Exchange has an illustration of a hypothetical 3-year implementation cycle showing how standards can consistently and predictably move to more current versions while requiring the industry to support no more than two versions at one time, and this illustration is provided with our written comments (see below). Moving the X12 transactions forward to the latest version is the first step towards establishing that framework and beginning the predictable cycles.

The Cooperative Exchange is supportive of the v8060 standards and concludes there is a net positive value in the significant updates made to the guides over the 20+ year time period since the v5010 guides

were initially published which will allow the industry to more effectively meet current business practices and comply with current and upcoming regulatory requirements.

Slides



Cooperative Exchange, the National Clearinghouse Association

- 20 clearinghouse members representing over 90% of the nation's clearinghouse organizations
- Our members process over 6 billion healthcare claims, reflecting over 2 trillion dollars in billed services annually
- Our association members enable nationwide connectivity between over 1 million provider organizations, more than 7,000 payers, and 1,000 Health Information Technology (HIT) vendors
- The Cooperative Exchange truly represents ***the U.S. healthcare electronic data interstate highway system*** enabling connectivity across all lines of healthcare eCommerce in the United States.

Cooperative Exchange member clearinghouses[1] support both administrative and clinical industry interoperability by:

- Managing tens of thousands of entities and connection points
- Exchanging complex administrative and clinical data content in a secure manner
- Supporting both real-time and batch transaction standards
- Enabling interoperability by normalizing disparate data to industry standards
- Delivering flexible solutions to accommodate varying levels of stakeholder readiness (low tech to high tech)
- Providing strong representation and participation across all national healthcare standard and advocacy organizations with many of our members holding leadership positions

[1]The Cooperative Exchange (CE) is comprised of 20 of the leading clearinghouses in the US. The views expressed herein are a compilation of the views gathered from our member constituents and reflect the directional feedback of the majority of its collective members. CE has synthesized member feedback and the views, opinions, and positions should not be attributed to any single member and an individual member could disagree with all or certain views, opinions, and positions expressed by CE.

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Benefits of adopting updated X12 standards

- In their recommendation letter to CMS, X12 outlines dozens of significant enhancements that were made to the 837 professional, institutional, and dental claim and 835 remittance advice transactions based on evolving business needs voiced from healthcare industry stakeholders. The Cooperative Exchange agrees that these and other enhancements will satisfy new business requirements and resolve significant gaps in business processes and administrative functions.
- The Cooperative Exchange also supports the non-substantive updates which decrease misinterpretation and ambiguity and promote precision in deployment across all stakeholders, thus reducing the overall operational costs to support the updated implementation guides.
- The Cooperative Exchange is supportive of the v8060 standards and concludes there is a net positive value in both the substantive and non-substantive updates made to the guides over the significant time period since the v5010 guides were initially published.

Opportunities

Regardless of the underlying SDO or syntax, the federal regulatory process has made it extremely difficult for healthcare industry stakeholders to embrace innovation and realize change, whether operational, technical, or editorial, in support of administrative simplification and efficiency.

The alternative lies not with a potentially different standard, syntax, or data exchange method, but with fixing the cumbersome and time-consuming regulatory review and rulemaking process which continues to stifle innovation and advancement of our industry.

The Cooperative Exchange strongly advocates for a change to the current regulatory review and rulemaking process and its known challenges and supports a federally established known and predictable version update cycle, under a federal guidance framework that allows two versions of a standard to co-exist.

Transitioning from the current "federal effective date" cycle that requires a cumbersome and time-consuming regulatory review and rulemaking process -to- a federally established known and predictable cycle of every 3 years would allow the industry to realize innovation and apply version updates in smaller incremental changes vs. huge steps / major changes due to long regulatory timeframes -> **evolutionary vs. revolutionary**.

Supporting Multiple Versions

The Cooperative Exchange supports allowing early adoption of new functionality via updated standards, as well as permitting continued use of existing standards, to ease burden and allow additional time to implement updated standards. With that said, allowing up to **only two versions** of a standard to coexist is strongly recommended. More than two increases the complexity significantly from both a technical and operational perspective. This would allow industry flexibility as a new standard is introduced (per established consistent & predictable cycle).

This process would present some challenges. If a version update is not backwards compatible, clearinghouses and payers would be required to support two distinct workflows over a period of time to allow the legacy version to run out its legacy lifecycle. Software vendors acting as a business associate of a provider would be required to accommodate updated versions in their software solutions and transition their provider customers to updated standards within the effective cycle window for a given version. These same challenges are applicable regardless of the underlying standard (e.g., HL7, HL7 FHIR, NCPDP, X12, or other).

Clearinghouses would continue to fulfill a pivotal role enabling both low- and high-tech stakeholders to transition to updated standards and versions between cycle updates.

Supporting Multiple Effective Dates

The Cooperative Exchange does not support multiple regulatory effective dates for sets of logically grouped transactions for a given version of a standard. Traversing and maintaining a "phased" regulatory approach for logically grouped transactions for a given version would be very costly, complex, and confusing across the entire industry. Interdependencies and compatibility between logical groupings across multiple effective dates would need to be continually analyzed for each newly introduced grouping and version.

We continue to advocate that with a federal SDO/ORAE guidance framework in place under a federally established known and predictable version update cycle, industry stakeholders would become acclimated to the framework process/requirements providing a consistent means for stakeholders to participate and comment on proposed standards or operating rule updates. A known and predictable version update cycle would also allow affected stakeholders to plan, budget, and resource effectively and introduce changes in a flexible cadence as their business needs warrant, while also, by nature of the process, advance the industry forward to continuously improve and modernize applicable standards and supportive operating rules.

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Illustration of a hypothetical federally established known and predictable version update schedule

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Cooperative Exchange

D.14: Availity

Presenter
Michelle Barry, Director, Expert Health Plan Provider Lifecycle Solutions, Availity

Statement

Thank you. Good afternoon, everyone. Just want to say thank you for allowing all of us to get together today. Thank you to WEDI, CMS, and our partners in the industry spanning from every agency to clearinghouses, intermediaries, and our partners. We appreciate the time today to talk about the move, or the next advantage of moving to the X12 standards.

Some important information when we talk about connecting the health care infrastructure, there is about over 95% direct payer connectivity. To understand the importance and the complexity behind really driving data and information, over 3.4 million connected providers that we participate and engage with regarding transactions, transactional information, data exchange, and over 17,000 connected business-to-business, which allows us to look at $4.5 trillion in billed claims annually.

When you think about the collaboration, the network, and innovation, I want you to know that is the level specifically of information that I obtained and wanted to share today so that we had some concrete, real-time statistics.

A couple of other things that are engaging and important to understand. From an Availity perspective, implementing the next version, the 8060 version, or the next version would be very meaningful and impactful across our whole entire systems. I say systems because we look at infrastructures and we are looking at that connectivity and driving long-term benefits of moving to the next version.

Data accuracy, making sure that there is less complexity and improve data quality with those modifications and changes to the 8060 version.

Keeping in mind transparency when we look at realizing operational effectiveness. I gave you some statistical data that is real, and introducing near-term implementation costs.

We want to make sure that incrementally, we look at this as near-term implementation. Some folks would recognize it as a project versus a program and vice versa. This is ongoing. It is ever flowing. It is continuing. That is where the change management process comes into play. When we talk about what does that look like and having those voices echo and author some of these changes. Authoring the newest implementation guides and sitting down with the industry and making the real-world examples and use cases. We want to make sure, collectively, that everyone is together and making decisions.

Importantly, understanding implementing X12 8060 is not driven by the need for new or green-field infrastructure but rather enhancing to more modern and scalability of transactions. Making sure that information is readily available, it keeps up with the newest and latest requirements from our CMS partners and making sure that we have the level of information needed to offer the industry what is best in class, best in business.

Benefits and value, real-world benefits, and value. First, optimize the use of existing infrastructure. This is not tech debt. This is taking infrastructure build that is currently existing that is working well and moving data at rapid speeds and engaging the industry operational effectiveness. It is making sure that information continues to evolve and sunset some of the older versions of the transactions, and bringing that more modern, consolidated landscape into the complexity that we have.

Keeping information going, moving faster, quicker, more accurately. Standardizing the information with completeness. Consistency is the key and having voices to drive the data standardization, completeness, and complexity of some of the data information that is currently in the newer version.

Exchanging that level of information to where it is interpreted and can be parsed in ways that can explain to a health plan payer, provider, vendor, and reducing any type of downstream rework.

Engagement, interoperability, and really driving innovation. Being that thought leader and driving to the next level of federal regulatory requirements and building upon the infrastructure that we have in place today. We are all transacting levels of information. Patient and provider experience improvements are another win-win-win for everyone in the industry. The partnership, the relationship, such as having the eligibility and benefits available when an inquiry is needed. Faster approvals on authorizations, referrals, notifications, and certifications that are incorporated in the 278 transaction that is used today.

We lead into the return on the investment with the implementation considerations. A recommendation would be to look at from an industry perspective an actual timeframe that is beneficial for everyone to implement. For example, July 1st or October 1st seem to be the good times for CMS and team to really look at implementations. You do not want to do the fourth quarter of every calendar year, because that does have additional complexities, such as with the Department of Insurance for some state laws that are coming into play as of January 1st the following year. We also want to make sure we are not doing implementations at the first of every year because of eligibility and benefits. We also have claims timely filing, and so we want to avoid the fourth quarter and first quarter of every calendar year for implementation. Our recommendation is to really look at either July 1st timeframe, or October 1st.

Operational changes and making sure from a change management point of keeping training and that process continual. Making it available for everyone to join is engaging for not just providers, but health plans payers, our CMS partners, our Department of Insurance partners, and our state partners. Engaging in education that is specific to the transition of information in the 8060 version, or the next version. So again, there is a pattern here. We want to make sure there is timeliness. We want to make sure there is readiness. We want to make sure training is available for everyone.

Having a 24-month period for implementation seems to resonate with majority of our health plan payers at Availity. We wanted to list that as an option for an opportunity to suggest what we are seeing and what we are hearing. Keeping in mind for the small, mid-sized providers, we need to make sure that we continue to work with them to reduce burden and make sure they have the support that they need, not only from an education, but from a technology perspective, whether it be testing, validation, or regression testing. The recommendation would be to continue moving in that direction and keep our small to mid-sized providers in mind as we move forward.

Our overall assessment has two main categories, the first being transition and the long-term benefits. We believe that planning and making sure we have a designated timeframe, looking at that timeframe and making sure it is not fourth quarter or first quarter of a calendar year, and making sure there is no

other implementations, federal regulatory implementations that are needed. Make sure that thought leadership and subject matter experts are engaged with these transaction transitions because they make the process very smooth.

For investment, budgeting annually as a regular line item needs to continue to be included. From an investment perspective, a budget that includes a regular line item for enhancements and transitions and then the added value will come, and that investment will be realized.

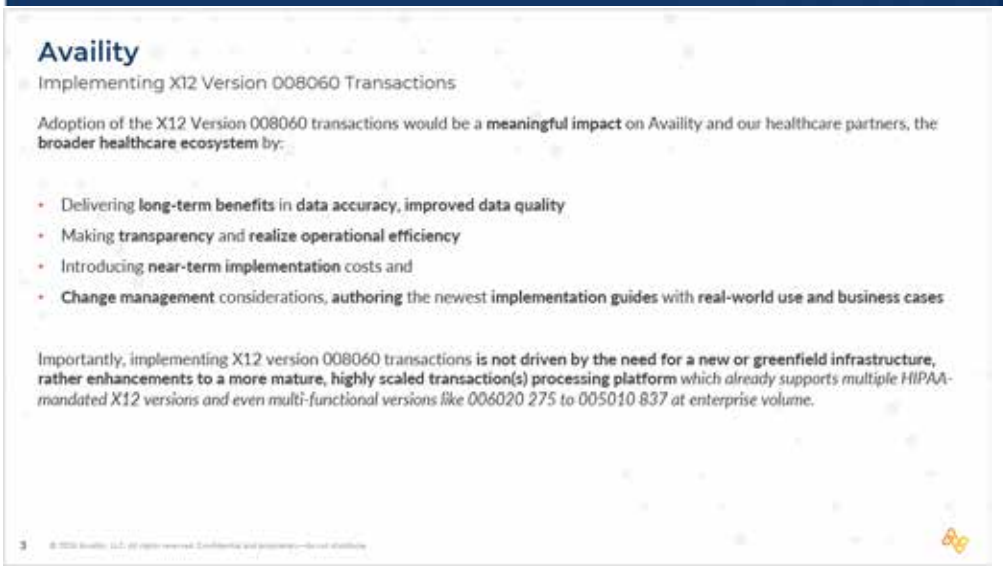
Collection and collaboration across the entire industry requires not just talking to providers, health plans, clearinghouses, or vendors, but engaging everyone, including X12 in those testing real-world scenarios, regression testing, and continual regulatory review. Insight into feedback as to what is working well and best practices is needed so we know what is working well. We can establish that feedback during the comment period.

Long-term benefits reduce fragmentation. In the industry today, there are different definitions of this term, but I think we all can agree that it is important for us to continue to reduce costs, reduce burden, and come together with a recommendation that we all could implement timely and improve data quality. Just improve data quality, improve patient data exchanges, and patient quality outcomes.

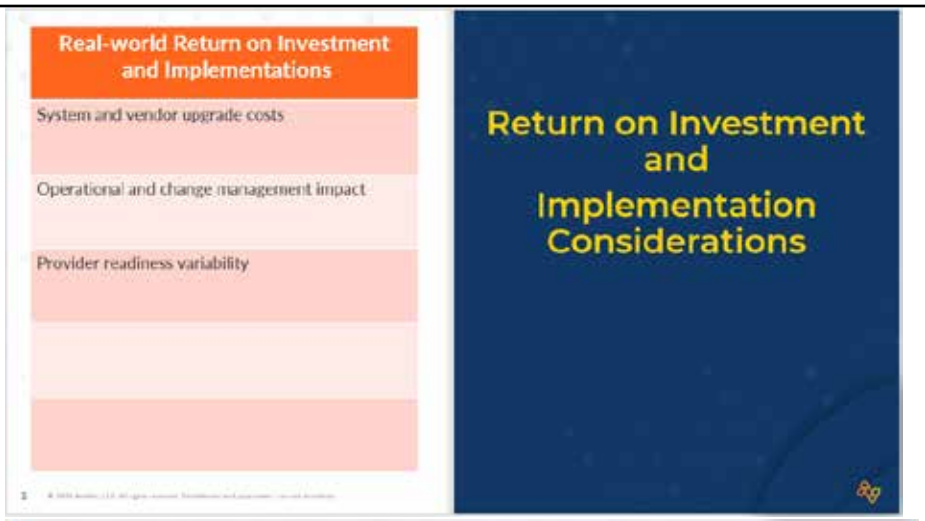
That was it. Thank you.

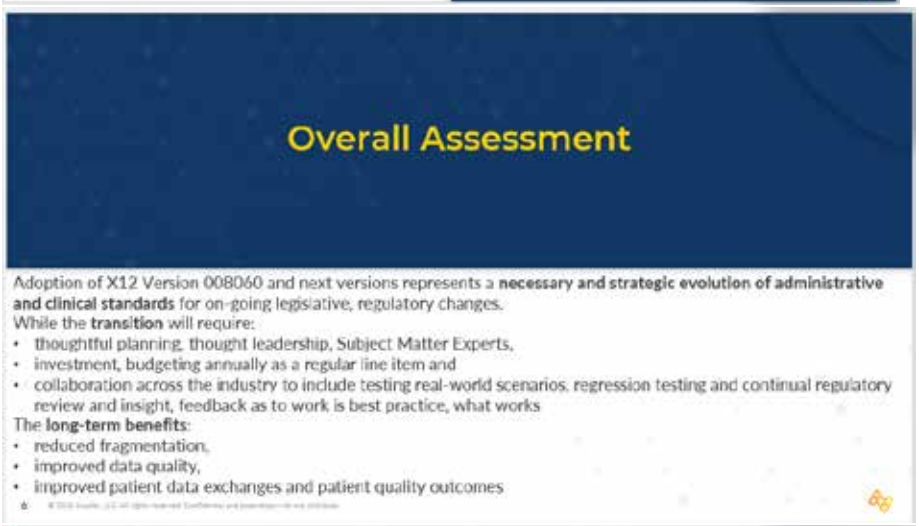
Slides


Availity is Where Healthcare Connects
As the nation's largest dual-sided, real-time healthcare network, Availity brings unparalleled scale & reach
Michelle Barry, Director, Expert Health Plan Provider Lifecycle Solutions
2


Availity
Implementing X12 Version 008060 Transactions
Adoption of the X12 Version 008060 transactions would be a meaningful impact on Availity and our healthcare partners, the broader healthcare ecosystem by:
Delivering long-term benefits in data accuracy, improved data quality
Making transparency and realize operational efficiency
Introducing near-term implementation costs and
Change management considerations, authoring the newest implementation guides with real-world use and business cases
Importantly, implementing X12 version 008060 transactions is not driven by the need for a new or greenfield infrastructure, rather enhancements to a more mature, highly scaled transaction(s) processing platform which already supports multiple HIPAA-mandated X12 versions and even multi-functional versions like 006020 275 to 005010 837 at enterprise volume.
3


Benefits and Value
4
Real-world Benefits and Value
Optimized use of existing infrastructure
Operational efficiency
Improved data quality and consistency
Improved data standardization and completeness
Enhanced transparency and innovation
Reduced administrative burden
Patient and provider experience improvements


Real-world Return on Investment and Implementations
System and vendor upgrade costs
Operational and change management impact
Provider readiness variability
Return on Investment and Implementation Considerations


Overall Assessment
Adoption of X12 Version 008060 and next versions represents a **necessary and strategic evolution of administrative and clinical standards** for on-going legislative, regulatory changes.
While the **transition** will require:
• thoughtful planning, thought leadership, Subject Matter Experts,
• investment, budgeting annually as a regular line item and
• collaboration across the industry to include testing real-world scenarios, regression testing and continual regulatory review and insight, feedback as to work is best practice, what works
The **long-term benefits**:
• reduced fragmentation,
• improved data quality,
• improved patient data exchanges and patient quality outcomes


THANK YOU
Availity

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D.15: CAQH

Presenter
Michael Phillips, Director, Advisory & Insights, CAQH

Statement

Introduction:
Good afternoon, and thank you for the opportunity to join today's discussion.

My name is Mike Phillips, Director of Advisory & Insights at CAQH.

At CAQH, the focus is on powering a more connected and efficient healthcare system through trusted data. We work across the healthcare ecosystem to enable better data exchange, reduce administrative complexity, and support more streamlined, end-to-end workflows.

This approach helps reduce industry costs by improving automation and efficiency, while also keeping care at the center by simplifying the business side of healthcare. By enabling more accurate and timely data sharing, CAQH supports more effective operations such as credentialing, directory management, and coordination of benefits.

Importantly, this work also provides visibility into how administrative processes are performing in practice, offering a data-driven perspective on where the industry is making progress and where opportunities remain.

Progress Is Clear, Value Is Not Fully Realized

According to the 2025 CAQH Index, the industry continues to make meaningful progress as the medical industry avoided approximately $251 billion in administrative costs, and the dental industry avoided $7 billion, bringing the total to $258 billion in costs avoided through standardization, automation, and electronic transactions.

That reflects decades of collective effort across the industry.

At the same time, the Index is clear that high adoption does not always translate to fully efficient workflows, and that distinction is important.

Take eligibility and benefit verification. At 96% electronic adoption among medical plans, it is one of the most widely adopted transactions. Yet gaps in data completeness, consistency, and integration continue to create measurable friction. When eligibility is fully automated, medical providers save about 13 minutes per transaction, which translates to an estimated $9 billion in remaining annual savings opportunities for medical providers. In other words, high adoption has not yet resulted in fully realized value.

Claim submission tells a similar story. Medical plan adoption is the highest among the transactions we measure at 98%. Still, there are approximately 7 minutes saved per transaction when fully automated, with $4.6 billion in remaining savings opportunities for medical providers . The infrastructure is in place, but the efficiency gap remains.

Where the Gaps Remain

Prior authorization presents a different picture. Fully electronic adoption among medical plans reached 40% in 2024, representing the largest year over year increase of any workflow tracked. That is encouraging progress, but it also means the majority of transactions still involve manual touchpoints. The data reflects that reality. Full automation can save medical providers about 15 minutes per transaction, with an estimated $363 million in remaining savings opportunities for providers.

Attachments remain the most significant gap, with adoption at 24% for medical plans. This has direct implications for workflows that depend on documentation, particularly claims and prior authorization. When attachments are not electronic, manual workarounds persist and limit the efficiency gains achieved elsewhere.

Across all transaction types, the CAQH Index estimates approximately $21 billion in remaining annual savings opportunity. The challenge is not the absence of infrastructure. Rather, partial automation, uneven adoption, and disconnected workflows continue to limit efficiency, and some of those limitations are tied to the constraints of the v5010 standard.

5010 to 8060

Since v5010, X12 standards have continued to evolve to better support the level of detail, specificity, and interoperability required in today's administrative workflows.

That evolution matters because many of the inefficiencies reflected are not simply about whether a transaction is electronic, but whether the underlying data supports complete, accurate, and connected workflows across systems and stakeholders.

In eligibility and benefits, newer standards expand support for service type codes, improve reporting for tiered benefit structures, and introduce more detailed information related to prior authorization requirements. These enhancements can improve how benefit information is conveyed and acted on at the point of care, particularly around coverage, patient responsibility, and pre-service requirements.

In prior authorization workflows, updated standards support more detailed status information along with additional clinical and demographic data. This creates the potential for clearer communication and may help reduce manual follow up, repeated outreach, and administrative rework.

For claims and attachments, the progression since v5010 includes stronger linkage between claims and supporting documentation, expanded support for service level prior authorizations and referrals,

increased diagnosis capacity, and improved handling of adjustments. These updates better align with current billing practices, coordination of benefits, and value-based payment models.

More broadly, there has been an effort to improve consistency across the standards, including aligned field structures and the integration of certain operating rule requirements directly into the technical specifications. For organizations already aligned with the development of these requirements, this may support a more integrated implementation path.

Taken together, these updates reflect an effort to strengthen the structure, clarity, and usability of administrative data so that transactions can better support real world workflows. This helps justify and support practical considerations of implementation, like the necessary capital investments to facilitate System updates, trading partner coordination, testing, and workflow changes.

The CAQH Index helps frame why that discussion matters: the opportunity is not only in adopting updated standards, but in how effectively those standards are implemented across the full workflow so that the operational value can be realized.

Closing

The data points to both meaningful progress and clear remaining opportunities.

The next phase will depend on how consistently these capabilities are implemented, how broadly they are adopted, and how effectively they are integrated into day-to-day operations.

Thank you.

Slide

D.16: Edifecs, a Cotiviti Business

Presenter
Kevin Day, Principal Business Advisor, Edifecs, a Cotiviti Business

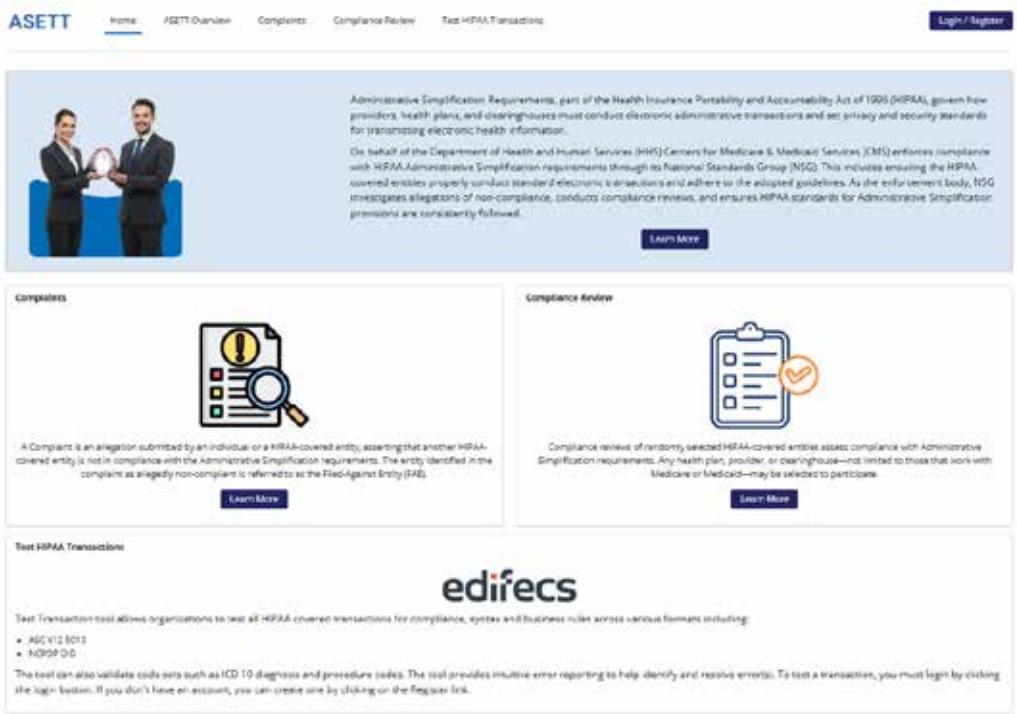
Statement

Introduction: “Good afternoon and thank you for the opportunity to provide WEDI with comments today on this subject under consideration by CMS.

My name is Kevin Day, and I am a Principal Business Advisor at Cotiviti having previously worked at Edifecs for over 20 years, assisting over 100 commercial health plans and dozens of state Medicaid programs architect and implementing their EDI systems and supporting compliance to the HIPAA Transaction Set specifications as well as their own business requirements. Today’s FPC is concerning a topic of great interest to entirety of the U.S. healthcare system, one which will help advance the U.S. healthcare ecosystem, but which also comes at a cost. My comments today address both aspects.”

1) **Market Presence**

"Edifecs has been providing the US Payers HIPAA compliance services for **over 25 year**s."
"Our HIPAA validation Service, XEngine, is used by **100s** of payers to ensure their core systems adhere to the HIPAA Implementation Guides.“
"This includes **dozens** of state Medicaid agencies and participation in CMS-administered programs, such as their ASETT program."



"Our HIPAA validation engine is also used by intermediaries in the healthcare ecosystem, including Availity who previously provided their comments during the Intermediary Panel."

2) **Recap 4010 to 5010**

“When the US payers community was previously faced with the need to upgrade their core systems to support the HIPAA x12 5010 transaction sets, Edifecs developed and implemented a HIPAA transaction mitigation solution to support those organizations during that transition period. The solution enabled payers receiving inbound 5010 versions of all the HIPAA transactions the ability to translate those transactions to the 4010 release level for internal consumption while preserving the original submission. The outbound response transaction(s) produced by their core system in 4010 would be up translated back to the 5010 format, supplemented with original inbound data elements where needed.”

“By implementing our Core System HIPAA upgrade mitigation solution, payers were able to modernize elements of their Core Systems including Claim Adjudication functions on a timeline consistent with the compliance date set by CMS and beyond.”

3**) 5010 to 8060 considerations**

“With respect to the current upgrade path being considered 5010 to 8060, cost again is at the forefront of payers’ minds and concerns. Cotiviti believes that a similar operational approach can be applied.”

“The benefits of this approach would allow health plans to modernize their Core Systems at a pace in which they can optimally follow. “

“Further, we believe that health plans, once their Core Systems are modernized or supported through a solution such as I described to support 8060 transactions, will be enabled to more cost effectively integrate those systems with several standard FHIR APIs reducing overall modernization cost. “

“The 8060 version of the HIPAA transactions is more expressive and has greater data richness. We predict health plans that implement the common HL7/DaVinci IGs would see on average a meaningful reduction in cost to integrate with their core system by approximately 30%.

One such example involves workflows related to the No Surprises Act and the requirement to produce an Advanced EOB. Currently, as stated during CMS policy listening sessions in 2024, on the subject which I attended, it was stated by health plan representatives that many of the health plans utilize their current Claims Adjudication system to produce an AEOB by way of creating a fictious 837 transaction and representing the 835 produced as an AEOB. However, there were issues with this approach, which was addressed in the 8020 version of X12 with the addition of the x370 Good Faith Estimate transaction. Although it’s not a named HIPAA transaction, a Core Claims system which upgrades to supporting 8060 could more easily adopt that transaction which aligns more accurately with the PCT FHIR structure, reducing the overall cost of implementing the PCT IG integration. “

4) Summary Recommendation

"In summary, we advise CMS to proceed with adoption of the 8060 version of the X12N transactions as the named HIPAA transaction set."

"We believe that benefits to the industry outweigh the cost and have demonstrated the means by which payers are able to remediate the speed at which their core systems can support the updated versions."

"Thank you for your time today and welcome any questions"

D.17: Kunz, Leigh & Associates

Presenter
Chuck Veverka, Senior Consultant, Kunz, Leigh & Associates

Statement

My thanks to CMS and WEDI for providing an opportunity to comment on this major issue. Chuck Veverka here, I am a senior consultant with Kunz, Leigh and Associates, based in Okemos, Michigan. KL&A is a consulting and software development enterprise, with 35 years' experience in business and information technology solutions for both the private and public sectors.

My comments are based on my team's experience during the 5010 implementation, subsequent ICD-10 conversion; and our ongoing Partner data exchange testing for a large payer.

We do not have enough time in this session for in-depth background discussion, but I expect there will be lively dialogue on these and related topics as we plan for, and move towards, 8060.

I am offering three items today; the first two actually build toward, and simplify, delivery of the third. These require time and people, and these resources represent a cost for implementation of the v8060 standard.

Recommendations:

1. Migrate all HIPAA transactions to the 8060 standard on a single cut-over date.
2. Use a single HIPAA transaction standard after migration.
3. Payers should offer partners a B2B file format/syntax test environment before implementation.

In order to achieve this, CMS should include time in any schedule to encourage sufficient B2B testing duration before go-live.

First, migrate all HIPAA transactions on a single cutover date. This reduces administrative overhead posed by sequential projects for individual groups of HIPAA transactions. It ensures transaction version compatibility. It encourages industry coordination under a single schedule. It focuses each organization's internal efforts on a common goal. This is going to help bridge across internal functional silos. It will reduce multiple project and budget approval administration efforts. It is going to encourage teamwork, as we will all have the same target.

Secondly, use a single HIPAA transaction standard after migration. This maintains version consistency for processing interaction between transactions. It establishes a common industry starting point for new X12 version cadence. It reduces complexity and maintenance efforts for our individual organizations business operation, EDI, and IT teams.

Thirdly, payers should offer partners a B2B file format/syntax test environment before implementation. This will have to start off with provider and payer contact re-verification to address missing contact

information. It requires careful planning for test and response file exchange using special file naming conventions, because we do not want to commingle test and production data files. It provides an additional testing sandbox for any late adopters of recent transaction mandates. At the point in time when, we would be doing 8060, we should have already completed the 278, 275, and 277 modifications that have been recently regulated. This activity will expose any file exchange or processing problems prior to go-live, which allows us to fix them before we actually get into production on day one. This approach has been used before, and it will significantly reduce problems during implementation.

Thank you, and I also suggest that folks refer to the WEDI Archives for information on the version 5010 and ICD-10 migrations.

Appendix E: FPC Hearing Open Discussion Edited Transcript

Moderators:

- Denny Brennan, WEDI Chair-Elect
- Pam Grosze, WEDI Vice Chair or Policy
- Robert Tennant, WEDI Executive Director

[Robert Tennant]
I wanted to remind you that this is a unique opportunity for you to share your perspectives. All comments will be captured and included in our report, but we do not attribute any comments, questions, or recommendation to any individual or organization.

And with that, I'm going to turn it back to Denny and Pam to moderate our open discussion.

[Pamela Grosze]
Just a reminder, you do have the option of putting comments in the chat, or you can raise your hand to be unmuted and discuss your question or comment verbally.

[Denny Brennan]
We have hand raised.

Commenter #1
Yes, thank you. I wanted to comment on the 8060 edition of the DTM segment and a comment that was made about the specific use case of that. The introduction of technology to allow people to stay home is huge. We commonly refer to that as the electronic visit verification. It allows patients to leave the hospital sooner and get home to where they recover more comfortably. But to make that work, we have to allow home visits multiple times a day. And currently, we can't do that in the 5010 version. We require the 8060 version in order to make that a visit at 8 a.m., a visit at noon, and a visit at 8 pm. So, when considering the cost association with 8060, it also needs to be balanced against the cost of those patients staying in an intensive care unit where they can get that kind of ongoing care. My organization is particularly keen on reducing costs of patients in hospitals by sending them home where they're going to be happier and recover better. Thank you.

[Denny Brennan]
Thank you. We got a couple of thumbs up for you. We also got another comment.

Commenter #2
Thanks for the opportunity. I absolutely agree with that with the move in the industry to reduce cost. Not only are they moving toward more outpatient services, they're actually moving many of the post-acute services to the home. So, you're doing infusion services, and so on. There's a lot more at-home services going on, and with that, the ecosystem needs to adjust to that. So how do we deal with the patients now receiving and service providers submitting claims in this type of environment? Where the system was set up when 4010 was first created. The makeup of the ecosystem was very different back then than it is now. It's evolved and the 8060 provides the mechanisms to provide the list of electronic means to encapsulate that evolution.

[Denny Brennan]

Thank you. We have another question. If not now, then when? And what will additional time benefit? We won't continue to create additional challenges. Do you want to add more to that, or round your question out, or are you ready for us to take comments on that?

Commenter #3
We've been in these decisions to change the 8060 to the standard that we've all been working on over the past 10 plus years. Again, if not now, when? The longer we delay, is that going to create even more challenges, disruptions, etc.? For the adoption of any standard, what does the long-term roadmap look like, because Commenter #1 has a great point. But to have to do a whole new version. To support that, what's next? How are we able to go along with this rollout, or the process in order to meet ever-changing requirements.

[Denny Brennan]
Great question. Any comments from members of our audience?

Commenter #2
I had a sidebar with somebody during this call about this exact subject, which is that health plans tend to have their staff domain-oriented versus technology-oriented. In other words, it's the same group that's implementing the 278 transactions, or the same group that's also implementing the PAS FHIR IG. Because of that, that they're domain specified, they tend to get into conflicts when it comes to resource allocation in order to support these various regulations coming down from CMS. I think that's what Commenter #3 is getting at, which is how do we handle the number of and timing behind these regulations with limited it staff. And how do you mitigate that?

[Denny Brennan]
We have some raised hands.

Commenter #4
Thank you. So just to comment on the last statement, this goes back to the information from the perspective of the Cooperative Exchange and the proposed scheduled release of updates every 3 years. It's something that could be adopted by the industry, and then it's not such a huge change. We make changes frequently when we're trying to keep up with policy or new programs, and we might institute the use of a segment that we didn't use before, or the data element that we didn't use before, and so we have to make those changes, but adopting that scheduled release of updates for 8060 to 80 next, or 90 whatever in a planned and expected release cycle. Then the changes are not so significant and can be planned into a budget moving forward.

[Denny Brennan]
Thank you for those comments.

Commenter #5
I was coming to make similar remarks. I think it would be remiss of me if I didn't point out that the way that we're structuring reimbursement policy should not be impacting access to care, and a deficiency of a way of transmitting that information between payers and providers is a constraint. And so, as the mechanisms and the policies that we have around reimbursement are evolving, we need a healthy standards ecosystem to keep up with those changes so that we can deliver care in what's the best way for the patients. This needs to be centered on what is best for our patients and the delivery of the care that suits them. All the work that we're doing should be in service of that end goal, regardless of how

payment is remitted, regardless of how information is transmitted. I think we just have to keep that as our North Star.

[Denny Brennan]
Well said.

Commenter #3
Those are great comments, and I 100% agree with them, but to play a little devil's advocate. We've proven that our current course based on historical reality that by the time the standard is ready to be released and goes through the approval process and gets mandated takes too long. I don't hear anything about addressing changing those facts. To me, that's what we need to address. How does this become a sustainable process that organizations aren't waiting until it's mandated for them to do it. One of my suggestions would be for government funds and resources be used to build black box solutions, or interoperability gateways that can be upgraded so that everybody is compliant, and we're just working on interfaces to that black box with our internal systems. There's probably a lot of other ideas that could happen but our current course, and what was mandated back in the original HIPAA, although worked real well to get people on electronic transactions, we're dealing with a different goal and objective now.

[Denny Brennan]
Do you have comments or thoughts in terms of how today is differing from 20 years ago or so, is going to impact the rate at which 8060 will be adopted at some point. Any thoughts from you on that?

Let's see, we have some comments in the chat. Who should be responsible for doing the multiple requests for ROI, return on investment? It will be very different from entity to entity. Do you have some ideas or some hypotheses about how this particular thorny issue might be resolved?

Commenter #6
It really would take some specific examples of people to move ahead and do a specific return on investment to serve as a guide for others. You're not going to be able to measure the ROI for every physician office or every health plan, but if we could get a couple of folks to sort of step forward and almost pilot test this and present that return on investment, whether that's done after the proposed rule or final rule is published or before is an interesting question. We can only hypothesize what's good and what's bad about the standards and make guesses about the costs, but until somebody actually goes through the process you won't be able to do that. I think it's unfair to expect X12, for example, to do a benefit-cost analysis, because again, the impact is so different from folks to folks. But if we can get some examples, that would be great. I'm not sure who would volunteer for that, but it would be nice to see some.

[Denny Brennan]
That's a great question.

[Pamela Grosze]
And we do have a comment in the chat stating it's an additional advantage for 8060 moving to external code sets. There's so many more external code sets within 8060 and this means that the X12 standards can be more nimble. Today, the code sets are static because they're inside the implementation guides, moving them externally means that we can introduce new identifiers quarterly and be more flexible and be more reactive to changes in the industry.

[Denny Brennan]
We also have a good question, which is, how would the planned release be affected by the addition of FHIR IG operations, as named HIPAA transactions? Do you want to elaborate on that question, and then we can throw it out to the group for comments?

Commenter #2
I don't think it's a surprise to anybody that CMS has been looking at for some time now of adopting specific sets of the HIPAA or the FHIR-based IGs, specifically, they were concentrating last fall on the prior auth of actually naming those versus having currently covered entities have to have to have an exception in order to utilize the FHIR-based approach for a prior authorization via FHIR. And it's my understanding that that they were looking at just naming that either the PAS IG, I don't know the specifics behind it, but either the PAS IG or its operations as named HIPAA covered operations. So, if that's the case, and they include that now we're intertwining planning around HIPAA X12 transaction sets and FHIR-base transactions. And my point earlier is that it is my experience that most health plans, at least have IT staff that's domain-specific. Whether or not you're working on a prior auth that's FHIR-based exchange, or X12-based exchange, they're the prior off staff. They're the eligibility staff. So anytime that there's an intertwining of technologies, the health plans then are strapped for resources if they overlap. That's where I was going with this. I love the idea of the planned approach and saying let's plan for every 3 months. Let's make this more nimble. That's a great idea if we were looking at only it being X12 are the code sets that are referenced by external transaction sets. But now that if we start looking at the FHIR-based work, and more so if they literally start looking at adopting some of these FHIR IGs as name transactions. It's going to get even more complex. I think that's the growing concern, at least within the health plans that I speak with.

[Denny Brennan]
Thank you.

[Pamela Grosze]
And, another comment. If health plans fully implement X12 8060 270/271 eligibility checks and use all the new fields intended, then that will cut down on phone calls to check the details of patient benefits.

And there was a reply, agreed, I would strongly encourage operating rules that mandate the inclusion of all the information in the 271 response.

Do you want to expand on that comment or on your response about operating rules?

Commenter #5
Speaking on behalf of the dental community in particular, whilst this does impact all of medicine, the dental community has a high degree of need for the information that is returned in a 271 response. The inclusion of that information can't be optional. Any omission of eligibility data will drive administrative staff to a portal, to a phone call, to a fax back, which goes against the spirit of exactly what we're trying to do here with the administrative burden reduction. Um, so the way that this is handled traditionally is through the operating rules. We can't make things required in the TR3, because they're not always going to be variance at a plan level, but to the extent that a plan has that information available, and it's part of their policy structure, the operating rules, if we could have operating rules that require the disclosure that information in the electronic transaction, is the only way we're going to get off these sunk cost technologies of payer portals and other tertiary means of getting this information. Everybody wants this, and so as we're doing a build, it just makes sense that we have the supporting infrastructure both in the

standard and in the supplemental operating rules to mandate this disclosure because. We can't have forked workflows. We're spending so much time and money on this.

[Pamela Grosze]
There is a reply as well. Worried that cutting back some of the usage of the 270/271 as proposed in CMS 0062 will limit the benefits of some of the changes made in these transactions in 8060. Would you like to expand on that?

Commenter #7
As I'd seen from the presentation X12 had made on the 270/271, the increased information that was going to be able to be presented about referrals or prior authorizations was one of the great benefits of what they have done. And yet, from the little I've been able to get through on the CMS 0062, it seems to be that any potential usage of information having to do with prior authorization is going to get pulled out of that, which is one of the great things you're now going to be able to get from this. So I'm just worried, depending upon how that all comes out, that we're not going to get all was put into the work to improve the 270/271.

Commenter #8
I think there might be a little bit of a misunderstanding. In the CMS 0062 rule, there's really not much overlap between the HL7 FHIR Da Vinci prior authorization burden reduction standards versus the X12 270/271. You still need to do a 270/271 to check patient eligibility and get all the benefits details and coverage. The Da Vinci prior auth burden reduction is really focused on prior authorization. And so there is a slight bit of overlap in that the 270/271 will tell you at a very high level, potentially, whether prior auth is required or not for particular services. There's a slight bit of overlap there with CRD, but really, we should look at these as complementary standards that can be used together during an entire course of patient care.

Commenter #7
Yes, but my concern was not that there's overlap, but that the way that at least it seemed to be in the proposed rule that it said that you couldn't be using the 270/271 for some information having to do with prior authorization or certain questions about that. And that's what I was worried about. Just the way it's broadly written in the proposed regulation. And then so therefore, what does that mean to an 8060 NPRM?

Commenter #8
Yeah, I think that might be a misunderstanding, and maybe we should take that offline or to a different discussion. But I don't think there's anything in that rule which prohibits using the 270/271 in its entirety. You can continue to use it to check this patient benefits, including checking to see whether prior authorization is required for particular a specific billing code.

[Pamela Grosze]
This sounds like it might be a really good discussion item for our eligibility and benefits subworkgroup to compare and contrast and discuss the two different rules and what overlap there might be. That's a recommendation that I can make to the subgroup as well.

Commenter #9
I have been six years working in behavioral health and I do claims adjudication. We bring the claims in, we do real-time claims adjudication, 100% automated. There's nothing that anybody has to do. We do

value-based, inline, real-time. So we're real unusual. It's Medicaid-based. It is for behavioral health. My providers are the poorest of the poor. This 8060 implementation is going to hit us hard. There's no doubt about it. The providers have almost no money for anything towards vendors. 5010 was a train wreck. I'm just going to say it for implementation. We have them stable. Everything works. We don't have workarounds. They're able to do amazing things. We have good quality data that goes back to our state. I look at this, and now we're working in interoperability. We really want to do FHIR. We want to move forward and have this to be interoperability. We're really interested in making sure that everything that we invest dollars in from an IT perspective is something that's going to have benefit for our providers at the end of the day. This is a plea to standards development that everything we do makes sense for our provider community, because everything we do is to put care dollars back into our system. That's what we do. That's the goal of our system. Every decision we make needs to be for care dollars. It's not about, if it's X12 or it's HL7. It's about making the right decision for our providers across the industry at the end of the day. What's the best thing for them? And I think that's the most poignant thing, and I agree with Stanley. We've got to do ROI. We've got to look at is this the best thing moving forward. Are we making the right decisions as an industry? Is this the right thing to do? You look at the legislation that's out there right now, and it looks like we have competing things going on, and we've got duality. It looks like CMS is trying to move us towards API and FHIR, and now we have X12, which is not API and FHIR enabled. I'm going to say to everybody on this call. What are we doing? Are we doing mixed messages? Are we giving mixed messages? Are we giving vendors things just to implement? Or are we doing the right thing as leaders of this industry?

Commenter #2
That's the whole, the whole point. The industry is getting mixed messages from CMS to be to be very candid. They're pushing all the FHIR regulations or adoption of FHIR. But then they come out with the claims attachment final rule. They're talking about 8060. And my point was, is that the health plan is sitting there saying, all right, which direction are we moving toward? Because we've got a limited set of IT staff and again, they tend to be domain-specific. Not technology stack specific. And we have to lay out all these regulations with dates to say, how do these line up? How do I set up my project plan for the next 3 years to be able to accomplish what I have to because my compliance office staff is going to be making sure that we're meeting all the CMS compliance rules, so we don't get audited. I think that's one thing. I would also say this back to your point, to make matters worse, my advice to everybody is take a look at what CMS is doing themselves. They're the largest payer that there is in the US between Medicare, Medicaid, all the payments, ACA, and all that. They released an RFI in January and then a month ago, an RFP called their core claims. And that's all about modernizing and consolidating the four different payment systems, claim adjudication systems into a singular platform. And part of that, is they want to move it toward modernization. That means they want to move toward real time claims submissions, adjudication, and payments. But it also means upfront things such as fraud detection and benefits checks. They're pushing toward this environment, and they're going to expect the rest of the payers within the US to follow suit. But how do you do that? Are we going to stick with X12 and then move X12 toward a real-time exchange? Is that what we're going to do when your real-time claims coming in via an 837P, an 8060 into my adjudication system. And then, what does that mean for a service or a health system, a billing provider? I'm looking for the remittance. Am I expecting a remittance 30 seconds later? I guess that's where there’s some confusion on where CMS is wanting the health plans to go. I won't speak for the health systems themselves.

[Denny Brennan] 15:22:31
Thank you.

Commenter #6
I don't think there's a conflict here at all. I think it is clear that with a lot of the clinical data that's being exchanged, the industry is attempting to move towards FHIR for certain communications, and it looks like those transactions probably will work. We haven't had a lot of experience with a lot of them, but little by little, FHIR transactions are being implemented and are working in the situations with which they have been put. At this point, the X12 transactions are working for the HIPAA transactions. They're working well in a very large scale. I think X12 has worked to enable real-time transactions for transactions, the claim and others. The problem is not with the exchange of information. The problem has always been whether a health plan can actually do the necessary reconciliation and provide a real-time answer. But I would say there is no conflict. I'm not even sure there are mixed messages. We can be moving towards FHIR in certain situations. We can also be upgrading X12 in the appropriate situations. No real conflict here. We applaud CMS for putting out that RFP. The RFP does talk about using X12 transactions. Whether they'll be able to move towards real-time adjudication, we don't know, but I don't see conflicts or confusion here. The only confusion is that there are different transactions that may be required to be implemented at the same time. That's the little bit of conflict, but there's no problem using FHIR and X12 at the same time.

[Denny Brennan]
Next.

Commenter #10
Good afternoon, everyone. This has been great discussion so far and thank you for taking my question here. A couple of things I wanted to thank Commenter #2 for his comments about what we're seeing in terms of all of these different standards going back and forth. I am not only a compliance resource working at a health plan payer, but I'm constantly getting questions about the conflicts, perceived conflicts, of the messaging of HL7 and FHIR versus X12. We're seeing some things that come out that, yes, we're absolutely growing FHIR and going in this direction. But there's places where maybe a provider can continue to submit X12 if they want to. Then we have a new set of rules that come out that does say this is all going to be FHIR for eligibility in this particular instance. This goes back to CMS 0062. Now we finally got the final rule for standards, and I'm assuming getting 275 adopted as a standard was necessary in order to advance it going forward to eventually bring it into the suite of 8060 or beyond because up until this point, we haven't had a defined standard for 275 attachment transactions. But what does that all mean? I'm getting pushback from our organization in terms of, tell us where we need to put our budget. Do we have to dedicate this all now to APIs and FHIR standards? Because that's where the industry seems to be signaling that it's going for all transactions. But now we need to take a look at probably moving forward with 8060, again, without that kind of cost analysis. And what's around the corner? So what do we do with our limited budget? What do we do with perceived conflicting regulation and information that we're getting? And even on this call, we're hearing sort of a split of the vendor community, clearinghouse community, sort of being in support of moving 8060, but we're also kind of hearing on the provider side through the AMA and so forth. Well, maybe not because you have to show us what this in, you know, what the real ROI investment and benefit of all of this is going to be, so… Just wanted to share those thoughts of confusion and also sort of looking for direction and all of this, but looking for real information that I can take back to my enterprise stakeholders, so that they can make some reasonable decisions of where they're going to put our limited budget and resource time, and what we'll concentrate on.

[Denny Brennan]
Very good points.

[Pamela Grosze]
There is a comment in the chat that CMS mandates don't cover all payers and providers. We'll end up creating two systems of care that have to be sustained. There are entire segments with zero practical FHIR adoption.

Commenter #11
I think one of the things that we have to consider is, at least for the dental industry, we're looking at very low participation, and depending on cuts and things like that, decreasing participation in CMS programs. 73% of dental offices are private small businesses, and we have real evidence of the business need to move to 8060. Now, I understand the need to move towards a FHIR, maybe in the future, but I don't think we have to meet people where they are now. That's my concern, if we in the talking points when we say that we've seen what CMS has done, or CMS providers and CMS as the biggest payer has done. That still leaves more than 50% of all dentistry out of those conversations. And I know dentistry is not the only one.

[Pamela Grosze]
Commenter #2 also added to the chat. Let me clarify my message. I firmly agree with Stanley's statements. However, 0057F was a litmus test for the industry. I know of some health plans that have stated putting their development work on implementing 278s on hold.

Commenter #2
Some of the health plans are reading the tea leaves, if you would, and they're anticipating CMS pushing more toward adopting FHIR as means for administrative functions. The 0057F is administrative function. Prior authorization is an administrative function. It's an operations. It's not a clinical. There's clinical information involved, but it's an administrative function. It's a pre-adjudication of a claim. And the point being is that it was a litmus test in the industry by saying, if we can get the industry to adopt FHIR for the purposes of one of the most sought-after pain points in the industry affecting health systems, the providers, the payers, and more importantly, the patients. But the point being is that because there's no controversy on the importance of modernizing, reducing the burden across the board, and they use an administrative function. So if they do that for that one, the question is then, well, what's next? And specifically around the 278s, these health plans are saying we're just not going to work on the 278 because we're just going to move purely to FHIR based for prior authorizations as HIPAA covered to eliminate the current situation. It's not officially HIPAA, but they just did discretionary enforcement. Then the question is, if you're going to do that, then why would I implement a 278-based exchange? And then the next question is what administrative exchange of data is next on the list, I guess. Yes, the CRD is not the same thing as a 270, but who's to say that they don't decide to move in that direction, too, and move to a real time FHIR based exchange for eligibility checks.

[Denny Brennan]
We've also heard that in the 0062P proposed rule that the FHIR implementation guides will go from being highly recommended to required. We're seeing a stake in the ground when it comes to prior authorization. And with that comes prior authorization support, PAS, that’s going to reduce the demand for 278s, especially as people have been given enforcement discretion to use the PAS instead of the 278. I think as we look at it now, and this is one opinion and I work in both the EDI and the FHIR worlds, but we don't see our health plans in our marketplace moving to aggressively adopt the 278. We find that the adoption, as was shared by CAQH, hovers around the 40-60% range, depending on who you talk to, unlike the other more well-established transactions. And with PAS being a required IG for prior

authorization, it seems that there's going to be further downward pressure on using the 278 for prior authorization. So, that's what we see in the regulations. Obviously, we're all going to comment, and we're all going to weigh in on that, but I think there's this administration leaning into FHIR, and they're leaning into finding places where FHIR can be implemented, but also they recognize that the wheels of commerce run on EDI and X12. I think for many of us, the discomfort is going to be living with one leg in one camp and the other leg in the other, for some period of time while the industry starts to resolve how it wants to do these things going forward, but I fully suspect we'll see ourselves working on both simultaneously.

[Pamela Grosze]
There is a comment in the chat that as an employer that runs a health plan for our employees and their families, it will be very difficult to adopt 8060 because we're totally dependent on vendors, including clearinghouse, claims administration, claims processing software, and payment fulfillment vendor. I don't think any of my vendors are attending this meeting and I suspect that they would charge us a significant fee to do any of this work. I did spend 25 years with a very large clearinghouse and went through the 4010 to 5010 implementation. The biggest challenge then was getting the payers ready and I believe that the payers' vendors are slow to participate and respond to these initiatives.

[Pamela Grosze]
The commenter makes a very important point, which is the reliance on vendors from both ends of the spectrum, provider vendors, including EMR and EHR vendors, clearinghouses that sit in the middle, and then payers' business associates as well. There's a significant dependence on vendors who are not specifically covered entities unless they're designated as a business associate. There's challenges there as we have these dependencies for the vendors to become compliant and then work with their trading partners to then do testing, etc.

I can certainly speak to that. That was one of the challenges in the past update was trying to complete end-to-end testing while some of the trading partners waited on their vendors to get them updated.

I see several other comments coming in on that. There are several clearinghouses represented at this meeting and I think that piece of the industry will be prepared to support 8060 in time for any deadline. One commenter says, I see business associates being a bigger gap for implementation. Another commenter stating that they were able to mitigate that situation now as well as in 4010 to 5010. I don't know if there's any other comments around the dependency on vendors or challenges there.

Commenter #5
I do see the business associates who aren't named as designated covered entities, but do play a huge part in administrative transactions, and namely non-certified EHRs, practice management software, ambulatory software that is used to collect administrative, clinical and claims data, and to prepare the case to be translated across to a clearinghouse and then receive that information. A lot of them don't have, even at the 5010 level, the structured data elements in their database to be able to post full scope responses from payers. If they're not collecting that information, everything here has to be structured. We have to be able to collect the information and transmit it through the full chain of custody and back. If we can't collect those core data elements at the point of care, then we've got a massive gap. That's a big key to all of this, and it's something that needs to be addressed very early in the stage. If 8060 is named, we need our business associates to be aware of this and to start adding that information in, because I know in dentistry, we're still on server-based software, and so the development cycles for those are three to six months just to get a product out, and then another six months before it's

considered stable. And that's 12 months of a 24-month implementation rollout. They're crucial to this whole process.

[Denny Brennan]
Excellent points.

[Pamela Grosze] 15:39:23
Another comment that if the entire industry is moving forward, vendors will need to get on board to keep their business. As was stated, we have previously seen vendors may be on board, but then there's an implementation schedule for that to roll out to all their trading partners. It's great that your vendor may have an updated version, but, number one, you may have to pay for that updated version, and you may or may not want to pay that fee. And number two, you're all excited to get updated, but you're number 867 on the list, and your date is next year. It definitely introduces some challenges.

Commenter #5
Not to mention the change management of workflow optimization that comes with trying to train an entire industry to collect a piece of information that was previously not collectible.

[Pamela Grosze]
And another comment, your FHIR APIs don't meaningfully reduce burden unless providers can actually use them. From the provider perspective, the real obstacle isn't whether payers expose standardized APIs, it's whether practice management systems and EHR vendors build usable workflow and integrated tools to connect to them.

So again, bringing those vendors back into the mix and making sure they incorporate the new standards, and that they are implementable by the providers is a key part of the entire process.

Commenter #11
I'm going to say this as gently as I can, is the issue of monetization of the transmission method. The cost on what is a HIPAA-mandated transaction versus what will be perceived if it's not HIPAA mandated transaction and as an add-on service, that's where it's going to hit providers doubly, because we will see the cost of our technical solutions go up no matter which way they go. If it's an add-on service, because it's not HIPAA mandated we're going to be paying for that again is the way I see it.

[Pamela Grosze]
A comment is that some clearinghouses may automatically upgrade or downgrade X12 transaction versions in flight in order to accommodate provider legacy systems that haven't upgraded to 8060 yet. That was a common value-added service during the previous upgrade from 4010 to 5010.

Yes, that's really part of the functionality of clearinghouses, changing a non-standard version to standard version. We did see that very prevalent during the previous upgrade in upconverting and down-converting to facilitate the varying stages of readiness that different trading partners have.

A commenter added that the SNIP edits will need to be updated.

[Denny Brennan]
A commenter says, I'm surprised I haven't heard much about the benefits of social determinants of health programs and that the upgrade would assist.

Commenter #2
I think it was starting with 8020, there were additional attributes added that dealt with collecting more demographic information that could feed into your SDOH programs. Then the claims expanded it. I recall reading an analysis that dealt with some social determinants of health programs that that the additional attributes associated with the patient would feed into it because the release level of X12 has to basically correlate to the USCDI, right? Because that's the overriding data set the industry works off of. Then the question is what USCDI version does the 8060 map to? Because that's where the intersection between FHIR and X12 comes into play. The common denominator is the USCDI, and specifically around social determinants of health with the updated versions, they added attributes around member or patient demographics that could be then be encapsulated during enrollment so then we can put them into some kind of an SDOH program due to knowledge that we have around living conditions, or whatever types of SDOH aspects that were encapsulated during enrollment.

[Denny Brennan]
Thank you.

[Pamela Grosze]
A comment mentions that the SDOH use case was mentioned yesterday in the X12 837 presentation with regards to more diagnosis and procedure codes.

Commenter #12
I just want to mention that the potential use case of social determinant of health and the ability or the need to capture more diagnosis codes and procedures for the patients was part of the analysis when the diagnosis codes were increased. It is in 8060 that you can now send up to 99 diagnosis codes in many cases.

[Pamela Grosze]
Thank you. A commenter asked a question that might be a good one for discussion for maybe our last question. Do you think it would be valuable for WEDI to develop an overall industry timeline with step-by-step implementation, for example, analysis, system development, internal testing, external testing, etc. Any thoughts on that?

[Robert Tennant | WEDI]
That is something that WEDI took on as a task through our Strategic National Implementation Process. I could see us doing exactly what is suggested. I think there's going to be a need not only the timeline and step-by-step with 8060, but also maybe building in some of the other federal mandates and timelines there as well.

Commenter #6
Not only would it be a good guide for the industry, but if there's a set deadline, we can measure industry progress against that set deadline and at least give CMS some feedback about how well the industry is meeting, the step-by-step, and whether we're really going to be ready for the implementation date.

[Robert Tennant | WEDI]
I completely agree, and as we're doing now with the 0057 rule with a survey every few months to gauge where the industry is critical.

[Denny Brennan]
Next

Commenter #5
What I'm about to say is in conflict with someone else's comments earlier today in regards to the recommendation that this advancement of a standard wait until other timelines have passed. Whilst I am very passionate about the dental industry, I just want to highlight the need for this to harmonize our claim form back to the standard, and we cannot wait until 2028 to explore a standard. If we're going to name a new standard and have the EDI transactions matching our claim form, we are going to as an industry, need to be sitting with multiple implementation timelines and that's where WEDI could really be beneficial to help structure all of these rollouts simultaneously.

And then I do have a question that may not be appropriate just yet around now that the 275 and the 277 are named under the HIPAA mandated transactions, will they be included in version upgrades? I am lacking clarity around that, but that's something that I don't need answered today.

[Pamela Grosze]
We've reached the end of our time here. Thank you all very much for the great discussion. Denny, do you have any closing comments?

[Denny Brennan]
None, Pam, thank you.

Appendix F: FPC Hearing Chat Edited Transcript

- Is there a comparison or summary of changes between X12 835 versus 5010 versus X12 8060?
- The .PDF Summary, the Transaction Set change document the Technical changes documents and education presentations can be downloaded. The full Implementation Guides are licensed documents and are not available except through a Glass license.
- Replying to "Can those be downloaded..." I can answer this- the library is constantly expanding. The table data is available for download, and some PDF docs are now generated. Please note- I am not affiliated with X12 beyond being a workgroup member, but am constantly in the 008060 guides right now.
- What is the likelihood 8060 will be mandated and maybe a potential year?
- I would like to see more concrete, objective data on the usage of these standards/transactions and major variations therein, counts and $$ involved, anonymized, macro/national to micro level - Prescriber NPI by state/county/zip.
- Will version 8060 be enforced for all trading partners? For example, in 5010, the guidance states that the Servicer Facility loop should not be sent if it is the same as the Billing Provider loop. However, some payers require both loops to be populated even when the information is identical. While ANSI guidelines indicate that it should not be sent, when this is raised with the payer, the response is often that this is simply how their system is designed to work.
- The standards and associated operating rules apply to covered entities- Payers, Clearinghouses. The initial CMS remarks addressed this, so once the recording is distributed, you may want to revisit that section for CMS guidance
- Bigger question is with all the technology, changes and advancement is X-12 the right specification and format going forward? Are we hampered in the specific HIPAA carve out trying to stay aligned with the other important Industry bedrock of X12?
- The decision to use X12 as the initial standard when we first adopted HIPAA was correct (and successful) but it this the correct standard and format for now. Can it be consumed and updated and roll-out at pace? This is not a critique of X12 at all they have met there charter and obligations to the industry as best they can, and we continue to realize the benefits and enablement of interoperability today. Just wonder if the years long of delays, we will spend more years trying to justify a new version for even longer.

- Replying to "Will version 8060 be enforced for all trading partners? For example, in 5010, the guidance states that the Servicer Facility loop should not be sent if it is the same as the Billing Provider loop. However, some payers require both loops to be populated even when the information is identical. While ANSI guidelines indicate that it should not be sent, when this is raised with the payer, the response is often that this is simply how their system is designed to work." But if the trading partner is not following the standards will CMS step in to make them? It seems with 5010 they look the other way on some Trading partners.
- The comment "The initial CMS remarks addressed this" is that from "this" zoom call? i was having trouble hearing some folks, so wanted to make sure what you are suggesting to revisit is within this. Thank you
- They do! https://asett.cms.gov/asett-overview Obviously, the happy path is to coordinate with the trading partner directly, but the ASETT platform is a tool available to the industry as well.
- Obviously, the happy path is to coordinate with the trading partner directly, but the ASETT platform is a tool available to the industry as well." with
- Question - who is responsible for conducting ROI, testing, etc.
- As I understand it, CMS will be required to perform a cost analysis or at least reference those conducted by other organizations such as was done in the CMS-0053 where they referenced previous cost studies performed by organizations such as MITRE and CAQH.
- Jan 1 of a calendar year is the highest volume transaction processing date for 270/271 transactions. I would advise we do not choose that as a compliance date
  Its very close to the highest volume time for 834's as well. (Multiple attendees agreed with this statement)
- True as it's a close second behind October for employee enrollments
- My input is "If not now then when?" and what will additional time will benefit that a continual delay will not create additional challenges?
- One question I do have. Who should be responsible for doing the multiple requests for ROI? It will be very different from entity to entity.
- If we continue with this Strategy what does the long term roadmap look like? Are we looking past 8060? What other innovations or changes will require the next version?
- This highlights the need for constant development and adoption of standards

- The additional advantage of moving to external code sets means X12 standards can more nimble. Today the code set is static to the standard. 8060 - can introduce new identifiers quarterly
- How would that planned release be affected by the addition of FHIR IG Operations as named HIPAA transactions?
- Do we have any idea of when to anticipate this to be finalized? As was mentioned earlier, with CMS-0057 and potential CMS-0062, this does provide a financial and resource burden to meet the expected completion dates. I would encourage with providing as much clarity as possible to avoid unnecessary confusion.
- That's a question for CMS. It's speculation on anyone else's part when an NPRM would be published concerning updated x12 transactions as named HIPAA.
- If health plans fully implement X12 version 8060 270/271 eligibility checks and use all of the new fields as intended then that will cut down on phone calls to check the details of patient benefits.
- Do we anticipate new transactions to be named other than the 5010 versions currently in place?
- Agreed. I would strongly encourage operating rules that mandate the inclusion of all this information in the 271 response
- There are named 006020 versions for 275 and 277R as well as the 005010 sets.
- At the specific CDT procedure level! STCs aren't sufficient.
- Worried that cutting back some of the usage of the 270/271 as proposed in CMS-0062 will limit the benefits of some of the changes made in these transactions in 8060.
- Tooth level data is required~!
- Missing tooth clauses are based on specific teeth
- FYI, CMS-0062-P (Proposed Rule) Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/2026-cms-interoperability-standards-prior-authorization-drugs-proposed-rule
- I have some commentary about the 835 TOO segment benefits, too.
  Dental uses 837D Predeterminations. Information is remitted via 835.
- A common occurrence is all 4 wisdom teeth extractions. The current 005010 835 cannot differentiate the tooth level data for benefits, but that is necessary information for reconciliation.
- We as an industry asked for attachment standards to align with the standard of the corresponding transaction I.e. claims attachment in X12 prior auth in FHIR

- CMS mandates don't cover all payers/providers. We will create two systems of care that have to be sustained. There are entire segments with zero practical FHIR adoption.
- Very happy to hear some provider voices on this call, for any providers interested in joining the X12 Provider Caucus, please send me a message at dgerousi@ama-assn.org, we welcome more participation. Thank you!
- Let me clarify my message. I firmly agree with the previous statements. However, 57F was a litmus test for the industry
- I mentioned to another attendee offline that I know of some health plans that have stated they are putting their development work on implementing 278s on hold
- Replying to "If health plans fully implement X12 version 8060 270/271 eligibility checks and use all of the new fields as intended then that will cut down on phone calls to check the details of patient benefits." I do think that many in the industry ask for ROI for X12 transactions much more than for the FHIR or EHR certification requirements.
- Transport is not the same as authority/decision. The information needs to move regardless of the standard used.
- The practical reality is that we need X12 now, and FHIR may very well be the future.
- …"meet providers where they are" - I enthusiastically agree. Though the informal name is "Axe the fax", the intent is that IF a provider is prepared to send X12 6020, that option is open to them. Plans need a standard to build to, now there is one. But if a provider still needs to go to the library to connect to a portal to submit files, and the plan supports that, that will continue.
- .. and then is the next slippery slope the other transactions?
- As an employer that runs a Health Plan for our employees and their families, it will be very difficult to adopt 8060 because we are totally dependent on vendors (Clearinghouse vendor, Claims Administration/Claims Processing software and Payment Fulfillment vendor). I don't think any of my vendors are attending this meeting. I suspect that they would charge us a significant amount to do any of this work. I did spent 25 years with a very large clearinghouse and went through the 4010 and 5010 implementations. The biggest challenge then was getting the payers ready and I believe that the payers' vendors are slow to participate and respond to these initiatives.
- Replying to "As an employer that ..." There are several clearinghouses represented on this meeting (including my employer) and I think that piece of the industry will be prepared to support X12 version 8060 in time for any CMS deadline.

- Replying to "As an employer that ..." I see business associates being a bigger gap for implementation
- Replying to "As an employer that ..." Happy to tell you how we can mitigate that situation just as we did when we went from 4010 to 5010.
- Payer FHIR APIs don't meaningfully reduce burden unless providers can actually use them. From the provider perspective, the real obstacle isn't whether payers expose standardized APIs—it's whether practice management systems (PMS) and EHR vendors build usable, workflow-integrated tools to connect to them.
- If the entire industry is moving forward, vendors will need to get on board to keep their business.
- Replying to "As an employer that ..." Some clearinghouses may automatically upgrade/downgrade X12 transaction versions in flight in order to accommodate provider legacy systems that haven't upgraded to 8060 yet. That was a common value-added service during the previous upgrade from 4010 to 5010.
- I'm surprised I haven't heard much about the benefits of SDOH programs that the upgrade would assist
- Will we need a similar SNIP Edits framework/group for 8060 versions, and specifically the step up/step down timelines
- If Policy is established that reduces the need for providers to require a prior authorization will that decrease the value of implementing these solutions?
- Replying to "Will we need a simil..." Correct. the SNIP Edits will need to be updated
- I have worked for a clearing house for 25 years now. I have seen 3051 to 4010 to 5010. 410 to 5010 was crazy where every payer was not read and had to roll back. As a clearing house we had to do what that payer wanted to get provider claim in and paid. but so many payers were not ready for 5010.
- The SDOH use case was mentioned yesterday in the X12 837 Presentation in regards to more Diagnosis and Procedure Codes
- Replying to "As an employer that runs a Health Plan for our employees and their families, it will be very difficult to adopt 8060 because we are totally dependent on vendors (Clearinghouse vendor, Claims Administration/Claims Processing software and Payment Fulfillment vendor). I don't think any of my vendors are attending this meeting. I suspect that they would charge us a significant amount to do any of this work. I did spent 25 years with a very large clearinghouse

and went through the 4010 and 5010 implementations. The biggest challenge then was getting the payers ready, and I believe that the payers' vendors are slow to participate and respond to these initiatives." Do you think it would be valuable for WEDI to develop an overall industry timeline for step-by-step implementation (e.g. analysis, system development, internal testing, external testing, etc.

- Replying to "As an employer that ..." It might be good to add in touch points to 0057 as well.

Replying to "As an employer that ..." The key was to retain the original inbound transaction.

Appendix G: X12 Version 008060 Submitted Written Statements

Statement #1

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

The 5010 versions are satisfying the needs of the industry for most transactions. Interop mandates and modern technology APIs are where we should be focusing.

Q2: **What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?**

Only move forward with the 270/271 and 276/277. The other transactions would only provide cost with no benefit.

Q3: **Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.**

We do not need to move forward as a suite of products. The current version works fine for most transactions. Only move forward with the 270/271 and 276/277 guides.

Statement #2

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

It is a large cost to any organization that processes healthcare data, but we must be able to move forward with new requirements as healthcare and reporting needs evolve.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

I would not be opposed to a staggered implementation schedule or just an extended requirement date for eligibility (270/271) since it has the most revisions, it would be beneficial to be able to allow the submission of 5010 or 8060 for an extended period of time for this transaction.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Staying stagnant is not good for the industry, we need to be able to continue to advance our processes in an agile way.

Statement #3

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

New versions will allow collection of necessary information to better adjudicate claims and report claim / encounter data to CMS

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

All transactions should be rolled out as a suite. 2 years to full implementation. Migrating from one version to the next will require coordination, testing, and cooperation among vendors but the infrastructure supporting the transactions shouldn't need significant change.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Truly excited about the potential this new version will offer.

Statement #4

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

There will be some cost to implement, including required software upgrades to accommodate the changes. What can not be counted is the opportunity costs we have now from 'living with' 5010 when we could have more or better data exchanges. This includes things like additional diagnosis codes and accurately reporting the DRG code used in adjudication if it was not MS-DRG.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

All the transactions should be mandated with the same compliance date. There will need to be an upgrade in version for the transactions which can contain NDC due to the recent NDC code announcement so we will need to get 8060 in place and then still have time to do a post-8060 upgrade for those transactions.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

We need this as soon as possible but also will need a lot of clarification on the impact to this upgrade from the CMS-0062-P NPRM. More Interoperability, especially expanding it, will get in the way for doing 8060 work in terms of priorities, people and costs. Many of the same systems may need changes for both initiatives.

Statement #5

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

As the X12 8060 transactions are leveraging the current messaging and processing infrastructure as the currently mandated 5010 transactions the costs to upgrade are expected to be minimal. The benefits of the upgrade are expected to be significant for modernization and industry requested improvements - especially for the 270/271.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

We are already preparing for the new transactions as our vendor has been supplying draft versions of the new transactions for several years.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Thank you X12 for providing technical prep sessions for 8060. We have already attended the 270/271 and 835 virtual sessions and are looking forward to the 837 P&D&I session next week. The information available to the industry from X12 is both useful and timely.

Statement #6

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

Upfront costs would be significant for 270/271, but not as high for the other transactions. The benefits offered in v8060 270/271 are a push in the procedure and diagnosis code support, ID card support, tiered benefit support, and more overall usability clarity.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

As 270/271 would be the heaviest lift, and in some organizations, different verticals support the different transactions, starting with the 270/271 would offer the benefit value early, and savings would be had earlier, while building the other transactions which may not have as much benefit or savings associated with the changes.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Waiting ~15 years since the last version was mandated brings with it a larger set of changes and increases the lift when so many year's worth of changes are bundled at one time. We need a way to bring change earlier so the lift / cost is not as significant.

Statement #7

Duplicate of Panel presentation

Statement #8

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

costs, benefits

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

Dec 2027

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Not specifically but we would like to more detailed about FHIR and 8060

Statement #9

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

The implementation of the X12 Version 008060 transactions will require a comprehensive review and impact analysis, followed by targeted staff training to ensure organizational readiness and compliance. Coordination meetings will be necessary with vendors, Managed Care Organizations (MCOs), and

providers—including independent providers, hospitals, and smaller entities—to confirm system readiness, support implementation timelines, and validate the ability to accept and process the updated transaction standards.

This effort will also require robust planning, including regression and interface testing, to ensure alignment across all trading partners and to mitigate risks associated with transition and deployment.

Impacts:

Costs: Training for internal staff and external stakeholders (including providers), system enhancements, internal and external testing (including regression and interface testing), and stakeholder communication to ensure accurate implementation and outcome validation. Additional costs may include updates to policies, procedures, and supporting documentation. Smaller providers may experience increased burden due to limited technical and financial resources.

Benefits: Compliance with updated federal and industry standards, improved interoperability across systems and trading partners, enhanced data integrity and consistency, and increased efficiency and accuracy in transaction processing.

Burden Reduction: Standardization of transaction formats may reduce manual intervention, streamline workflows, and improve communication across stakeholders. Over time, this may result in increased operational efficiency, though initial adoption may present challenges for smaller providers.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

A phased and well-coordinated implementation approach is recommended for the X12 Version 008060 transactions to ensure successful adoption across all stakeholders. Comprehensive instructional guides should be developed and distributed nationally, providing clear, standardized direction for implementation, testing, and compliance.

Adequate time must be allocated for stakeholder training, including internal staff, vendors, Managed Care Organizations (MCOs), and providers (independent, hospital-based, and small entities), to ensure readiness and minimize disruption.

It is also critical to allow sufficient time for system updates, end-to-end testing, and interface validation across trading partners. This includes regression testing and parallel processing periods to validate data interactions and outcomes prior to full production implementation.

Recommendations:

Phased Rollout: Implement transactions in phases to allow stakeholders to gradually adapt, test, and resolve issues before full deployment.

Testing & Validation: Require comprehensive testing cycles, including unit, integration, and end-to-end testing, with defined validation criteria.

Parallel Processing Period: Establish a transition period where both current and new transaction versions can be processed to ensure continuity and accuracy.

Training & Guidance: Develop and distribute detailed implementation guides and provide role-based training for all impacted stakeholders.

Regulatory Alignment: Synchronize implementation timelines with other federal and state regulatory requirements to avoid conflicting mandates and reduce implementation burden.

Stakeholder Engagement: Maintain ongoing communication and coordination with vendors, MCOs, and providers to monitor readiness, address risks, and ensure alignment.

• Updates to Remittance Advice, potential RA code changes

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

Successful implementation of the X12 Version 008060 transactions will require early and ongoing collaboration across all stakeholders, including state agencies, vendors, Managed Care Organizations (MCOs), and providers. Clear governance structures, defined roles and responsibilities, and strong project management oversight will be critical to ensure alignment, accountability, and timely execution.

Special consideration should be given to providers—particularly independent, rural, and small entities—who may face resource and technical constraints. Providing targeted outreach, technical assistance, and extended support timelines will be essential to promote equitable adoption and minimize disruption to operations.

Additionally, establishing standardized national guidance, including implementation checklists, testing strategies, and performance metrics, will help ensure consistency across states and trading partners. Leveraging lessons learned from prior X12 version upgrades can further reduce risk and improve implementation outcomes.

Finally, ongoing monitoring and post-implementation support should be incorporated to quickly identify and address issues, ensuring system stability, data integrity, and continued compliance with federal and industry standards.

Statement #10

Q1: **How would the implementation of the X12 Version 008060 transactions impact your organization or members related to costs, benefits, burden reduction, etc.?**

We believe that health plans, once their Core Systems are modernized or supported through a core system mitigation solution to support 8060 transactions, will be enabled to more cost effectively integrate those systems with several standard FHIR APIs reducing overall modernization cost. The 8060 version of the HIPAA transactions is more expressive and has greater data richness. We predict health plans that implement the common HL7/DaVinci IGs would see on average a meaningful reduction in cost to integrate with their core system by approximately 30%.

Q2: What are your recommendations for the implementation of the X12 Version 008060 transactions related to timing, roll out of transactions, synchronization with other regulatory requirements, etc.?

Timing of the implementation is critical and needs to be weighed with the overall regulatory landscape covered entities are facing. Our recommendation is that all HIPAA transactions be rolled out in tandem. However, the timing of compliance date must take into consideration resource constraints.

Q3: Please provide any additional information you would like to share about the potential implementation of the X12 Version 008060 transactions.

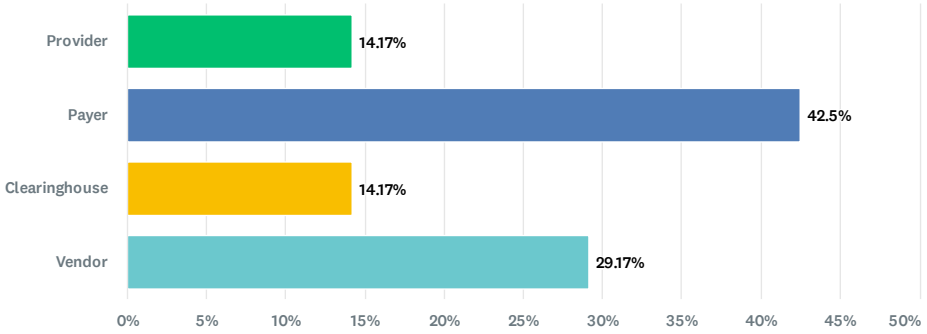
We believe that in addition to aiding the reduction of modernization cost, advancement to the x12 version 008060 transactions would provide greater business value to advance key business initiatives such SDOH programs which are currently hindered by the lack of necessary data elements not present in the current 005010 version of the transactions, specifically those found in the 834 and 837I, 847P and 837D.

Appendix H: X12 Version 008060 Survey Data

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Q1 120 responses

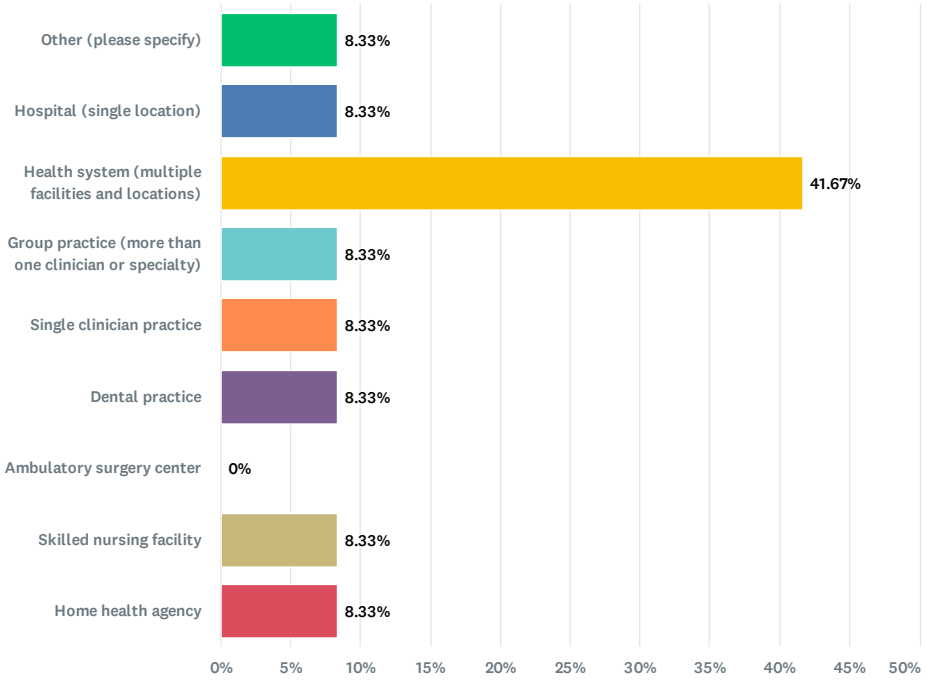
Which of the following best identifies the type of organization you represent? Choose one. If your organization conducts functions of more than one category below, please complete the survey separately for each function. For example, a payer that has a clearinghouse should complete the survey twice, answering for the payer and the clearinghouse separately.



Answer Choices	Percentage	Responses
Provider	14.17%	17
Payer	42.50%	51
Clearinghouse	14.17%	17
Vendor	29.17%	35
Total		**120**

Q2 12 responses

Which of the following best describes your organization?

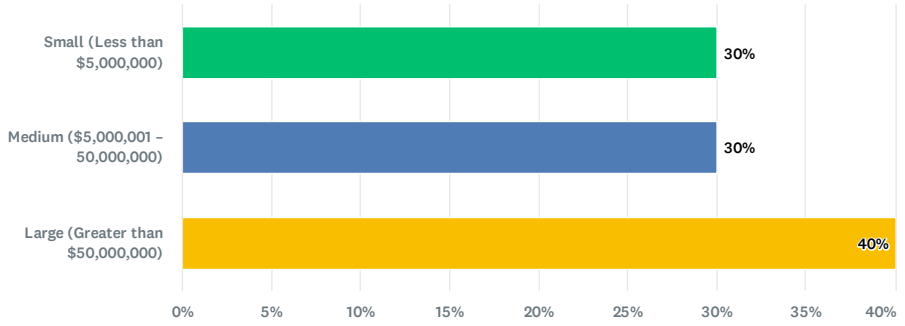


Answer Choices	Percentage	Responses
Other (please specify)	8.33%	1
Hospital (single location)	8.33%	1
Health system (multiple facilities and locations)	41.67%	5
Group practice (more than one clinician or specialty)	8.33%	1
Single clinician practice	8.33%	1
Dental practice	8.33%	1
Ambulatory surgery center	0%	0
Skilled nursing facility	8.33%	1
Home health agency	8.33%	1
Total		**12**

#	OTHER (PLEASE SPECIFY)	DATE
1	Responding as a third-party billing company submitting on behalf of multiple provider organizations	4/24/2026 11:11 AM

Q3 10 responses

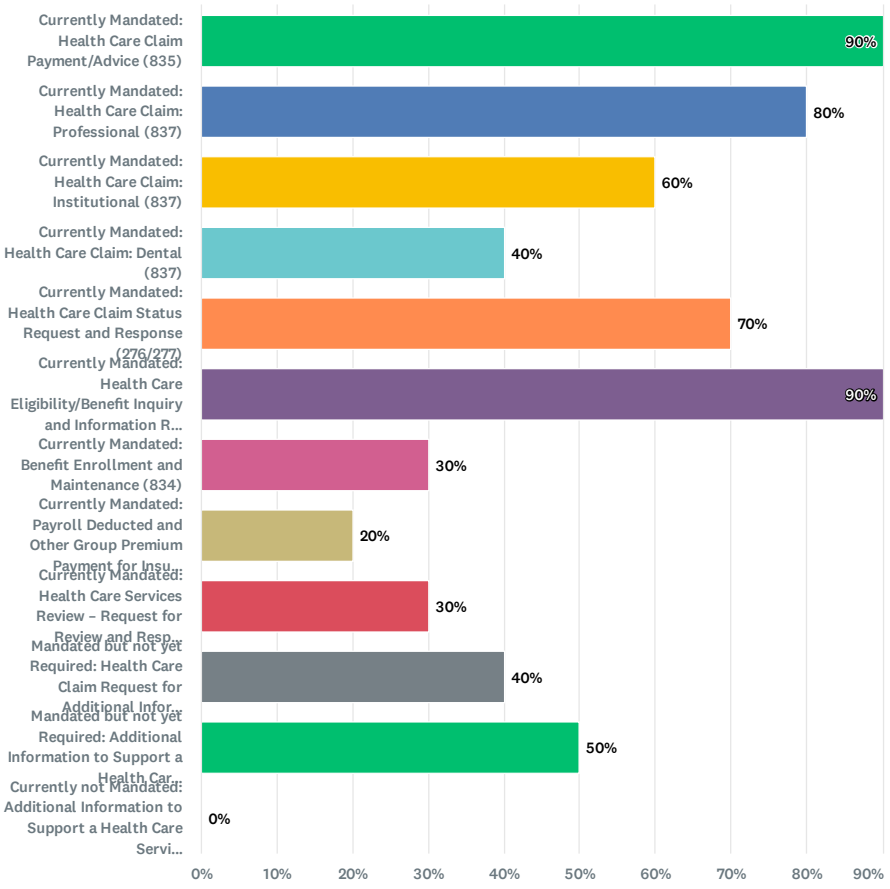
What are your approximate yearly billing charges?



Answer Choices	Percentage	Responses
Small (Less than $5,000,000)	30.00%	3
Medium ($5,000,001 – 50,000,000)	30.00%	3
Large (Greater than $50,000,000)	40.00%	4
Total		**10**

Q4 10 responses

What v5010 transactions does your organization currently conduct?



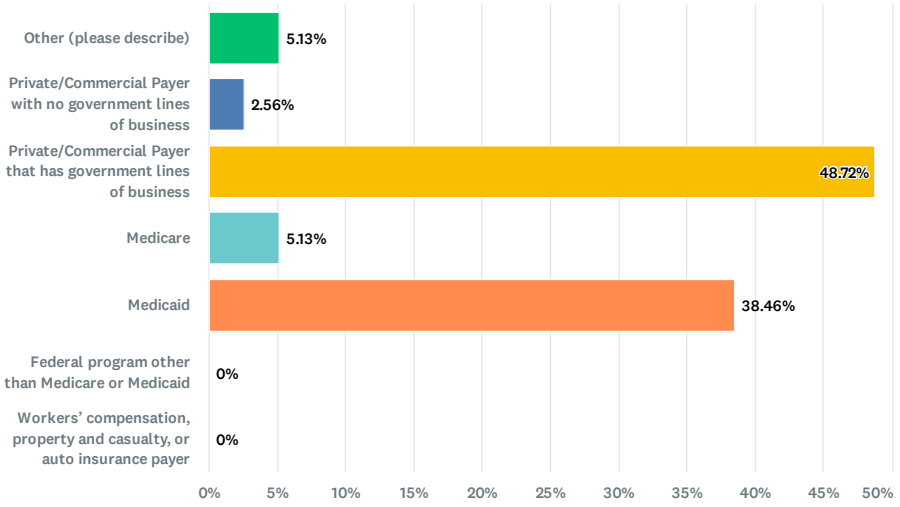
Answer Choices	Percentage	Responses
Currently Mandated: Health Care Claim Payment/Advice (835)	90.00%	9
Currently Mandated: Health Care Claim: Professional (837)	80.00%	8
Currently Mandated: Health Care Claim: Institutional (837)	60.00%	6
Currently Mandated: Health Care Claim: Dental (837)	40.00%	4
Currently Mandated: Health Care Claim Status Request and Response (276/277)	70.00%	7
Currently Mandated: Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	90.00%	9
Currently Mandated: Benefit Enrollment and Maintenance (834)	30.00%	3
Currently Mandated: Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	20.00%	2
Currently Mandated: Health Care Services Review – Request for Review and Response (278)	30.00%	3
Total		**60**

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Answer Choices	Percentage	Responses
Mandated but not yet Required: Health Care Claim Request for Additional Information (277)	40.00%	4
Mandated but not yet Required: Additional Information to Support a Health Care Claim or Encounter (275)	50.00%	5
Currently not Mandated: Additional Information to Support a Health Care Services Review (275)	0%	0
Total		**60**

Q5 39 responses

Which of the following best describes your payer organization?

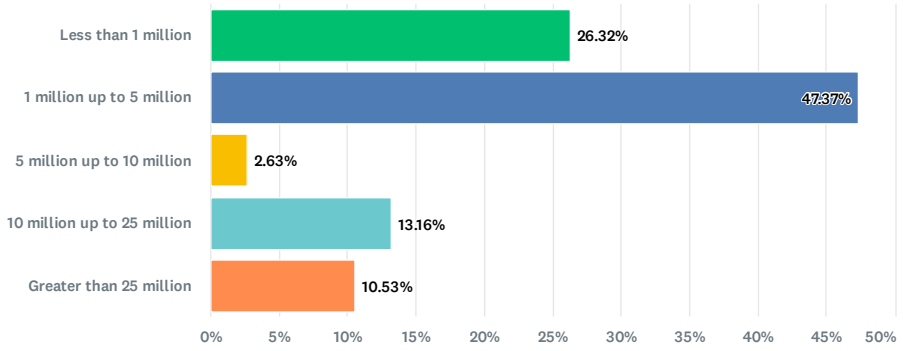


Answer Choices	Percentage	Responses
Other (please describe)	5.13%	2
Private/Commercial Payer with no government lines of business	2.56%	1
Private/Commercial Payer that has government lines of business	48.72%	19
Medicare	5.13%	2
Medicaid	38.46%	15
Federal program other than Medicare or Medicaid	0%	0
Workers' compensation, property and casualty, or auto insurance payer	0%	0
Total		**39**

#	OTHER (PLEASE DESCRIBE)	DATE
1	Structure as HMO (Medicare, Medicaid, and Commercial)	4/23/2026 5:15 PM
2	Medicare, TRICARE, and Commercial	4/13/2026 4:18 PM

Q6 38 responses

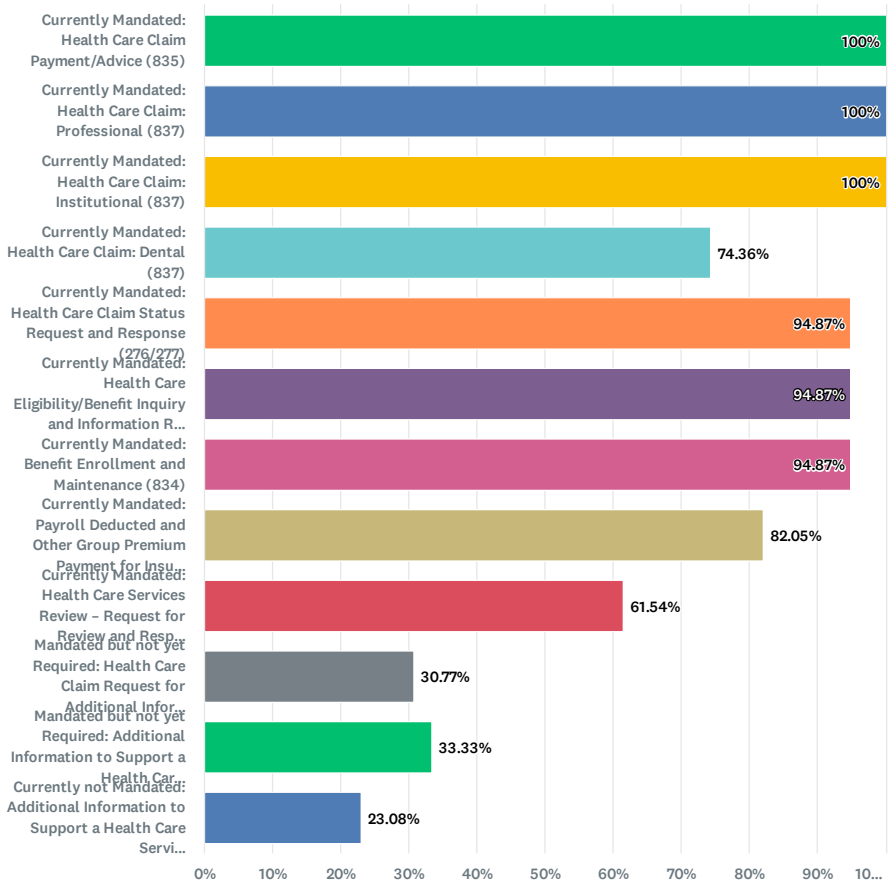
Number of covered lives?



Answer Choices	Percentage	Responses
Less than 1 million	26.32%	10
1 million up to 5 million	47.37%	18
5 million up to 10 million	2.63%	1
10 million up to 25 million	13.16%	5
Greater than 25 million	10.53%	4
Total		**38**

Q7 39 responses

What transactions does your organization conduct?



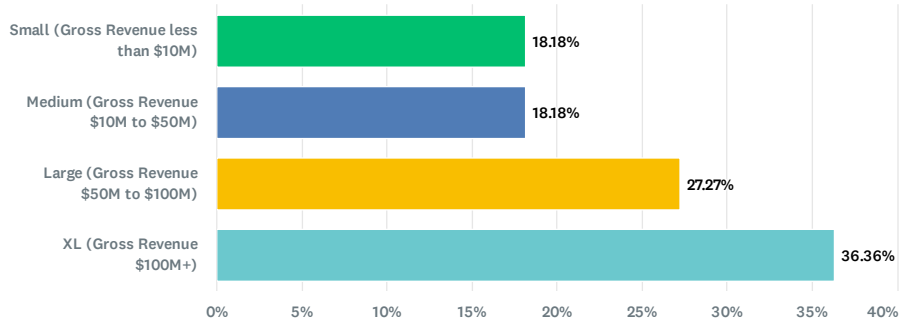
Answer Choices	Percentage	Responses
Currently Mandated: Health Care Claim Payment/Advice (835)	100.00%	39
Currently Mandated: Health Care Claim: Professional (837)	100.00%	39
Currently Mandated: Health Care Claim: Institutional (837)	100.00%	39
Currently Mandated: Health Care Claim: Dental (837)	74.36%	29
Currently Mandated: Health Care Claim Status Request and Response (276/277)	94.87%	37
Currently Mandated: Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	94.87%	37
Currently Mandated: Benefit Enrollment and Maintenance (834)	94.87%	37
Currently Mandated: Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	82.05%	32
Currently Mandated: Health Care Services Review – Request for Review and Response (278)	61.54%	24
Total		**347**

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Answer Choices	Percentage	Responses
Mandated but not yet Required: Health Care Claim Request for Additional Information (277)	30.77%	12
Mandated but not yet Required: Additional Information to Support a Health Care Claim or Encounter (275)	33.33%	13
Currently not Mandated: Additional Information to Support a Health Care Services Review (275)	23.08%	9
Total		**347**

Q8 11 responses

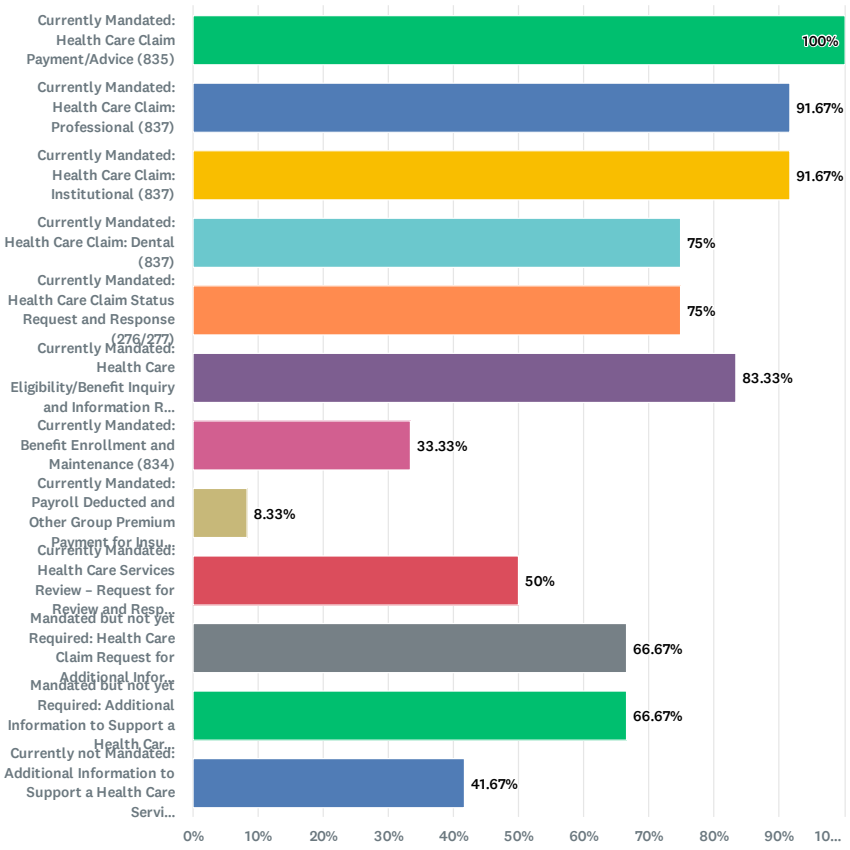
What is your annual gross revenue?



Answer Choices	Percentage	Responses
Small (Gross Revenue less than $10M)	18.18%	2
Medium (Gross Revenue $10M to $50M)	18.18%	2
Large (Gross Revenue $50M to $100M)	27.27%	3
XL (Gross Revenue $100M+)	36.36%	4
Total		**11**

Q9 12 responses

What transactions does your organization conduct?



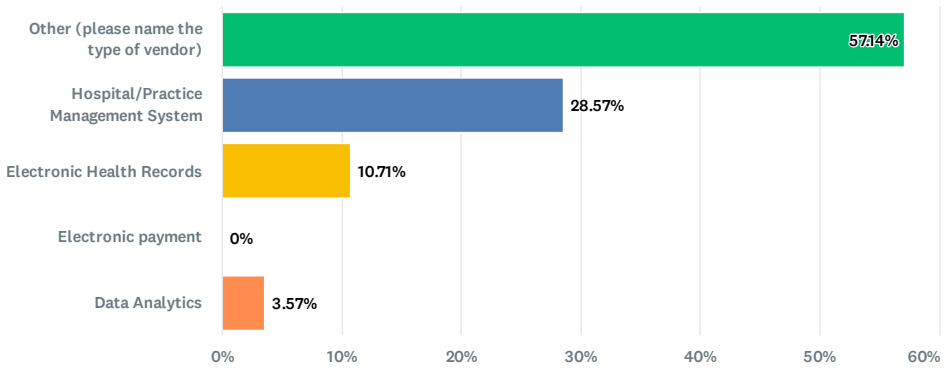
Answer Choices	Percentage	Responses
Currently Mandated: Health Care Claim Payment/Advice (835)	100.00%	12
Currently Mandated: Health Care Claim: Professional (837)	91.67%	11
Currently Mandated: Health Care Claim: Institutional (837)	91.67%	11
Currently Mandated: Health Care Claim: Dental (837)	75.00%	9
Currently Mandated: Health Care Claim Status Request and Response (276/277)	75.00%	9
Currently Mandated: Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	83.33%	10
Currently Mandated: Benefit Enrollment and Maintenance (834)	33.33%	4
Currently Mandated: Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	8.33%	1
Currently Mandated: Health Care Services Review – Request for Review and Response (278)	50.00%	6
Total		**94**

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Answer Choices	Percentage	Responses
Mandated but not yet Required: Health Care Claim Request for Additional Information (277)	66.67%	8
Mandated but not yet Required: Additional Information to Support a Health Care Claim or Encounter (275)	66.67%	8
Currently not Mandated: Additional Information to Support a Health Care Services Review (275)	41.67%	5
Total		**94**

Q10 28 responses

What type of vendor best describes you?

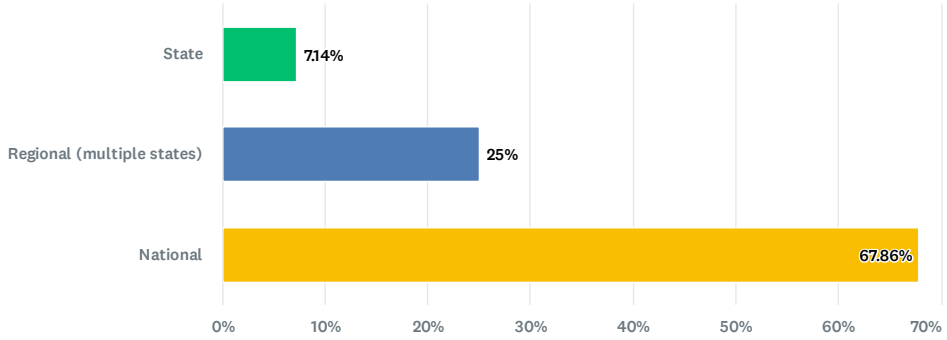


Answer Choices	Percentage	Responses
Other (please name the type of vendor)	57.14%	16
Hospital/Practice Management System	28.57%	8
Electronic Health Records	10.71%	3
Electronic payment	0%	0
Data Analytics	3.57%	1
Total		**28**

#	OTHER (PLEASE NAME THE TYPE OF VENDOR)	DATE
1	Repricing Organization	4/24/2026 10:42 AM
2	Consultant	4/22/2026 12:12 PM
3	Emergency Preparedness and HIPAA Safeguards Compliance platforms	4/21/2026 9:19 PM
4	Compliance and Integration	4/21/2026 8:55 PM
5	Premium Calculations, Claims Adjudication and Payment, member management software.	4/21/2026 5:22 PM
6	Implementation Consultant	4/21/2026 4:00 PM
7	analytics, VBC Consulting	4/21/2026 11:30 AM
8	Clinical Claim Scrubbing	4/20/2026 2:11 PM
9	RCM vendor	4/16/2026 10:09 AM
10	consultant	4/15/2026 4:36 PM
11	National EHR Network for all Patients	4/14/2026 4:35 PM
12	All of the above	4/13/2026 2:48 PM
13	Consultant	4/13/2026 2:11 PM
14	BPASS	4/8/2026 11:23 AM
15	RCM Outsourcing	4/3/2026 2:50 PM
16	Medical Management System	3/30/2026 10:35 PM

Q11 28 responses

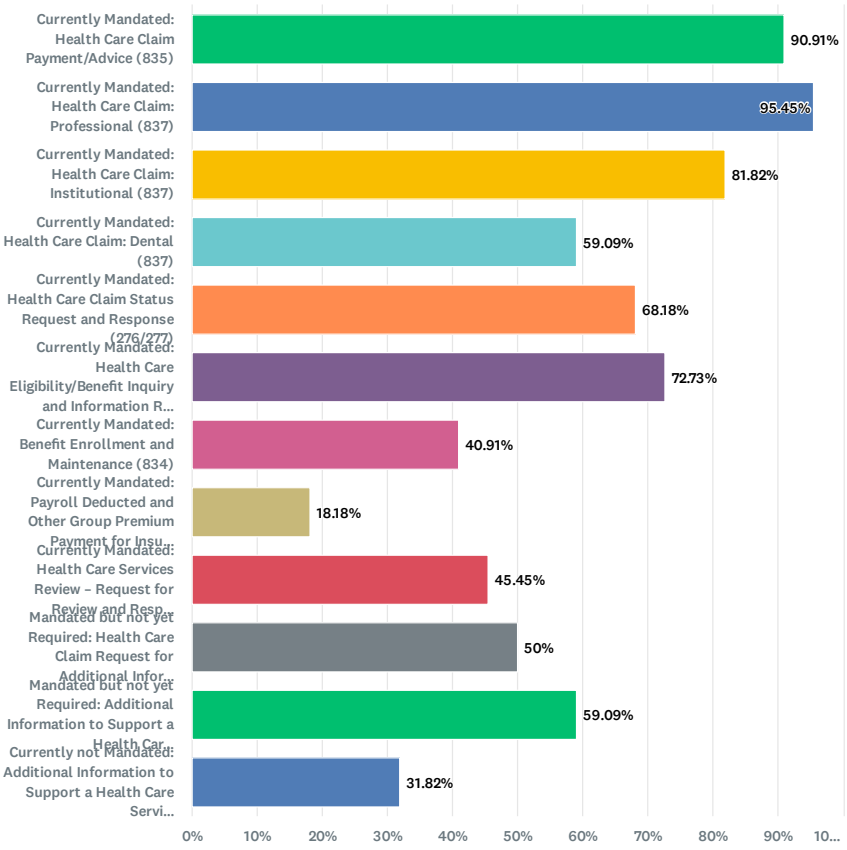
What is your footprint in the market?



Answer Choices	Percentage	Responses
State	7.14%	2
Regional (multiple states)	25.00%	7
National	67.86%	19
Total		**28**

Q12 22 responses

What transactions does your organization conduct/support?



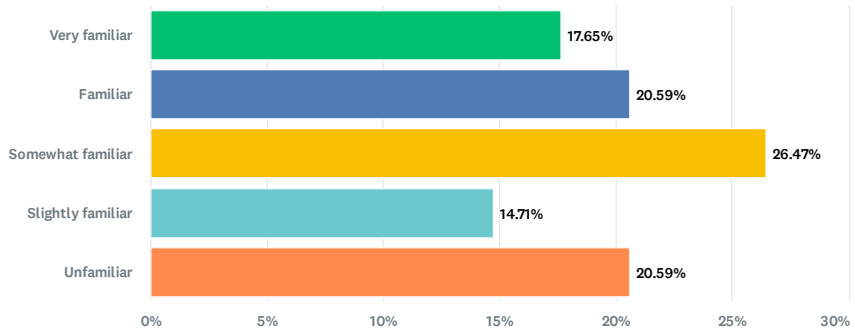
Answer Choices	Percentage	Responses
Currently Mandated: Health Care Claim Payment/Advice (835)	90.91%	20
Currently Mandated: Health Care Claim: Professional (837)	95.45%	21
Currently Mandated: Health Care Claim: Institutional (837)	81.82%	18
Currently Mandated: Health Care Claim: Dental (837)	59.09%	13
Currently Mandated: Health Care Claim Status Request and Response (276/277)	68.18%	15
Currently Mandated: Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	72.73%	16
Currently Mandated: Benefit Enrollment and Maintenance (834)	40.91%	9
Currently Mandated: Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	18.18%	4
Currently Mandated: Health Care Services Review – Request for Review and Response (278)	45.45%	10
Total		**157**

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Answer Choices	Percentage	Responses
Mandated but not yet Required: Health Care Claim Request for Additional Information (277)	50.00%	11
Mandated but not yet Required: Additional Information to Support a Health Care Claim or Encounter (275)	59.09%	13
Currently not Mandated: Additional Information to Support a Health Care Services Review (275)	31.82%	7
Total		**157**

Q13 34 responses

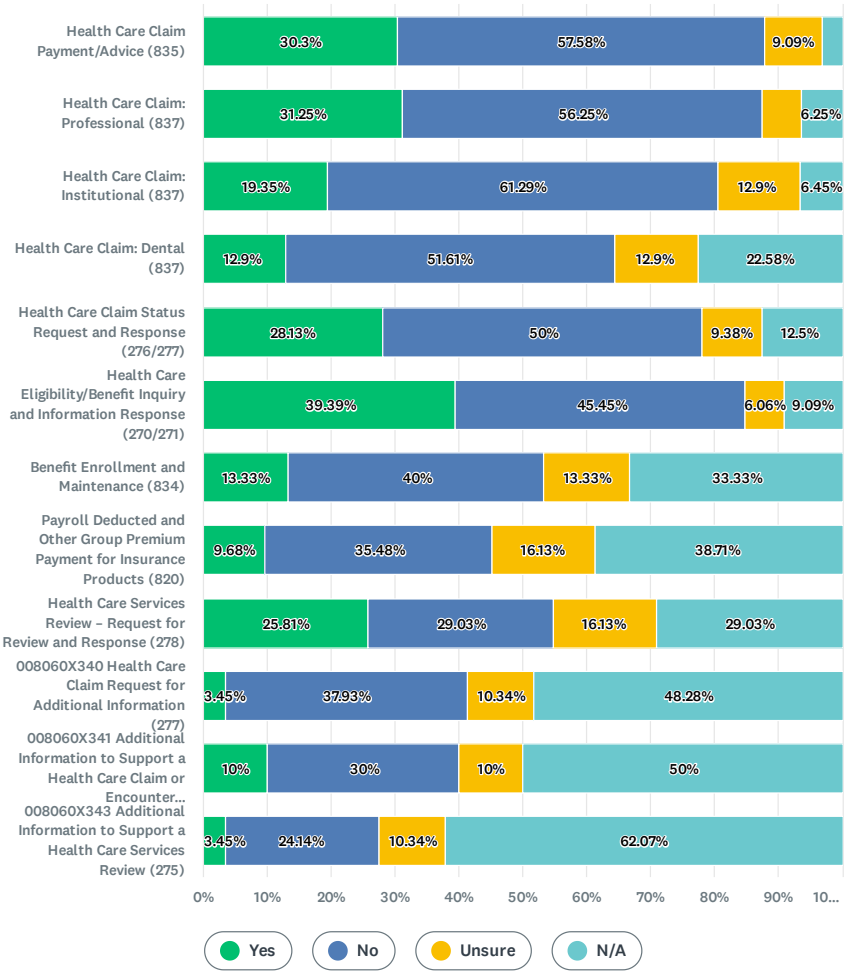
Rate your familiarity with the v8060 transactions.



Answer Choices	Percentage	Responses
Very familiar	17.65%	6
Familiar	20.59%	7
Somewhat familiar	26.47%	9
Slightly familiar	14.71%	5
Unfamiliar	20.59%	7
Total		**34**

Q14 33 responses

Has your organization implemented any administrative "work arounds" (a non-standard process or manual step taken to bypass a transaction limitation) for any of the following v5010 transactions?



	Yes	No	Unsure	N/A	Total
Health Care Claim Payment/Advice (835)	30.30% 10	57.58% 19	9.09% 3	3.03% 1	33
Health Care Claim: Professional (837)	31.25% 10	56.25% 18	6.25% 2	6.25% 2	32
Health Care Claim: Institutional (837)	19.35% 6	61.29% 19	12.90% 4	6.45% 2	31
Health Care Claim: Dental (837)	12.90% 4	51.61% 16	12.90% 4	22.58% 7	31
					372

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

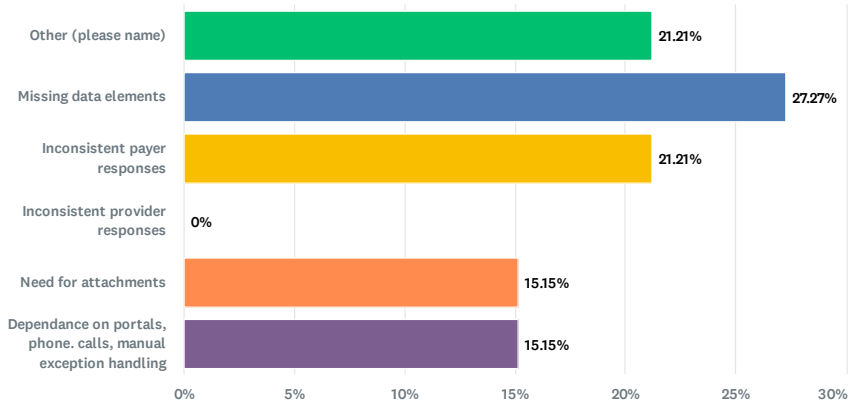
	Yes	No	Unsure	N/A	Total
Health Care Claim Status Request and Response (276/277)	28.13% 9	50.00% 16	9.38% 3	12.50% 4	32
Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	39.39% 13	45.45% 15	6.06% 2	9.09% 3	33
Benefit Enrollment and Maintenance (834)	13.33% 4	40.00% 12	13.33% 4	33.33% 10	30
Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	9.68% 3	35.48% 11	16.13% 5	38.71% 12	31
Health Care Services Review – Request for Review and Response (278)	25.81% 8	29.03% 9	16.13% 5	29.03% 9	31
008060X340 Health Care Claim Request for Additional Information (277)	3.45% 1	37.93% 11	10.34% 3	48.28% 14	29
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	10.00% 3	30.00% 9	10.00% 3	50.00% 15	30
008060X343 Additional Information to Support a Health Care Services Review (275)	3.45% 1	24.14% 7	10.34% 3	62.07% 18	29
					372

#	PLEASE DESCRIBE THESE ADMINISTRATIVE WORK AROUNDS IN THE COMMENT BOX BELOW	DATE
1	We regularly receive 835s and quite often have to fight to get secondary and even primary payer 835s in the first place, that cannot be auto-posted and require manual intervention. Common issues include: (1) missing or unrecognizable payer identifiers that prevent automatic matching to the correct insurer record; (2) claim-level adjustments applied to claims containing multiple service lines, where the adjustment cannot be programmatically allocated back to the appropriate service; (3) denial messages with insufficient information to determine the actual reason for denial or the appropriate next action; (4) claims adjudicated at the wrong payer processing level — e.g., processed as primary when the payer should have processed as secondary; (5) missing "forwarded to" information on primary 835s, which leaves us unable to distinguish cases where the payer has actually forwarded the claim (including HSA/crossover scenarios) from cases where no forwarding occurred. Each of these requires manual research against payer portals, EOBs, or direct payer contact to resolve and post correctly.	4/24/2026 5:13 PM
2	We have and to parse out data elements such as CDT codes from unstructured text in the 271 MSG segment.	4/24/2026 1:15 PM
3	Modifications to standard format from the RCM to then submit in the standard format to the payer. In some cases, the use of API's that are offered by the Third Parties, such as Availity.	4/21/2026 12:54 PM
4	Lack of patient demographic information, identifying institutional versus professional payments, needing the TIN in all 835s, providing a compliant 835 for a virtual card payment	4/21/2026 9:46 AM
5	270/1:Returning tiering information in the MSG segment, inclused/excluded proprietary provider types, when benefits or services apply to all places of services (key word, all); 276/277 has limited valuable information re: the claim and how it was paid or not paid which requires our org to support a proprietary claim status transaction that is more flexible and provides alot more detail; 275 have to verify membership exists within our system because the sub ID and name is not enough to get to a particular policy when sub ID matches more than one person and name is not enough or more than one policy exists.	4/17/2026 11:23 AM
6	We extended the use of the 278 to include features and capabilities in a future, non-mandated version to meet our use-case needs.	4/16/2026 12:40 PM
7	For the 270/271 we have to put a lot of text into the MSG	4/13/2026 5:58 PM
8	The code sets embedded in the transaction limit our ability to communicate new information to our plans and our trading partners. We choose codes from the available list and then document a 'different meaning' in our Companion Guides because that is the only option at this time.	4/13/2026 12:29 PM
9	For the 270/271 and 276/277 - Some benefit plans and claim status information we are not able to provide all of the details through the X12 standard so we use the MSG segment quite a bit to communicated custom information today. We don't have the capability to provide the information being requested in the 278 transaction today so those that are submitted via BX	4/10/2026 12:46 PM

	that we are required to respond to, we do in the X12 standard with a MSG segment communicating to call our customer service line.	
10	835 - we provide a proprietary batch response report in PDF format that has more detailed information on the financial cycle. 837 - we provide fax cover sheets for providers to submit additional/supporting documentation. 278 we provide fax cover sheets for providers to submit additional/supporting documentation	4/10/2026 10:31 AM
11	implemented various data mapping work arounds due to inconsistency on how payers utilize various segments. These work arounds require the need for a complex EDI parsing application with high over head maintenance costs.	4/10/2026 10:16 AM

Q15 33 responses

What currently is your v5010 biggest pain point?

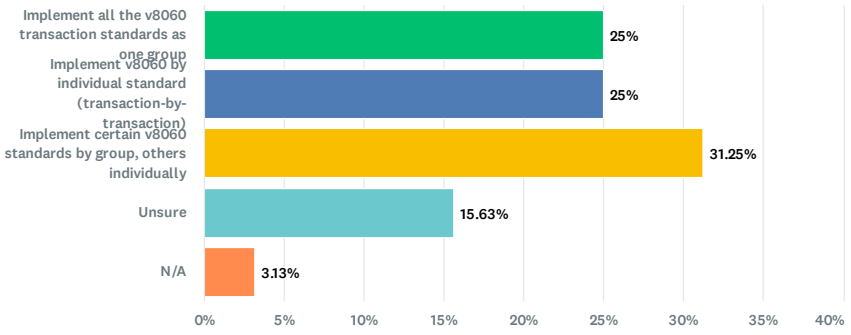


Answer Choices	Percentage	Responses
Other (please name)	21.21%	7
Missing data elements	27.27%	9
Inconsistent payer responses	21.21%	7
Inconsistent provider responses	0%	0
Need for attachments	15.15%	5
Dependance on portals, phone. calls, manual exception handling	15.15%	5
Total		**33**

#	OTHER (PLEASE NAME)	DATE
1	All of the above	4/24/2026 12:23 PM
2	The software vendors that support Payers like us (Self Insured and we pay our own claims) have software that doesn't meet the standards. We have had 2 claim vendors and they do not completely meet the 5010 standards - the problems we have this is small, but I have great concerns about our vendors being ready to support the new 8060 transactions.	4/21/2026 12:13 PM
3	There are no batch painpoints. The 270/271 painpoints relate to being unable to return codified benefit variables. We must rely heavily on MSG segments.	4/14/2026 12:57 PM
4	CMS not inforcing ANSI Rules. ANSI is not Standardas every payer read the ANSI guide and does not follow the rules. A good example is the Service Facility loop. ANSI say do not send if it is the same as teh billing provider yet some payer require it even if it is the same or they will not pay the claim.	4/14/2026 11:11 AM
5	We are still on 5010 when more recent versions have better ways to handle data.	4/13/2026 5:58 PM
6	The inability to update code sets and keep up with new Federal regulations.	4/13/2026 12:29 PM
7	None	4/6/2026 11:25 AM

Q16 32 responses

Based on your review of v8060 and/or based on your implementation of v5010, how would your organization approach implementation of the v8060 transactions (inclusive of planning and analysis, hardware and software procurement and costs, software development, testing, user training and education, transmission and new data collection costs)?

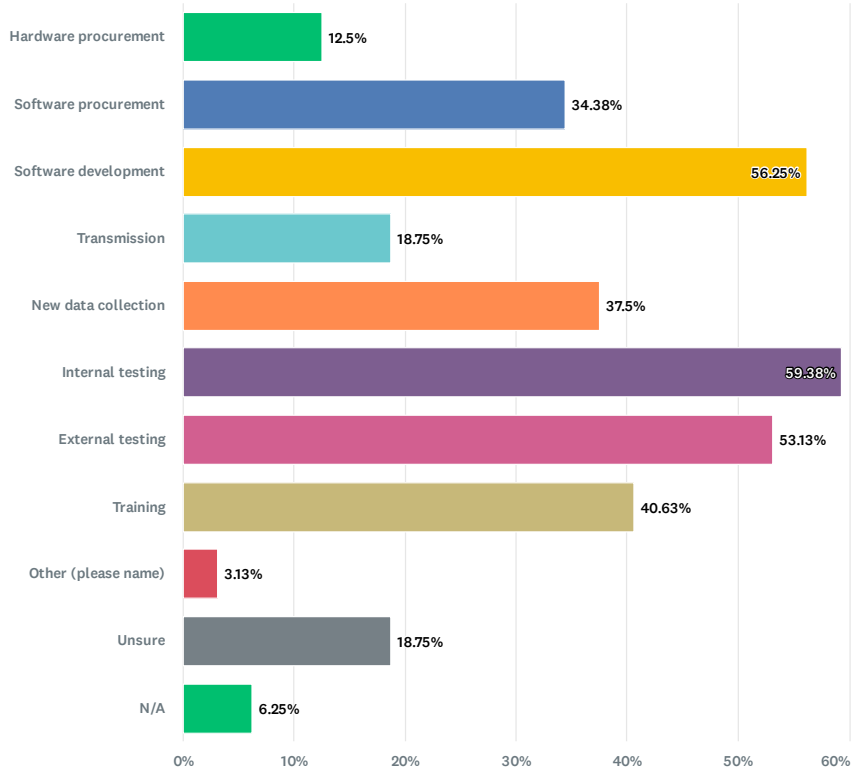


Answer Choices	Percentage	Responses
Implement all the v8060 transaction standards as one group	25.00%	8
Implement v8060 by individual standard (transaction-by-transaction)	25.00%	8
Implement certain v8060 standards by group, others individually	31.25%	10
Unsure	15.63%	5
N/A	3.13%	1
Total		**32**

#	COMMENT BOX	DATE
1	We will deploy based on the Regulatory Final Rule implementation timelines	4/23/2026 7:11 PM
2	Our implementation is totally Vendor dependent. We would need our Clearinghouse (SDS) vendor, our claims process / claims administration vendor (Plexis and VBA) and our payment vendor (ECHO Health) to change their software in order for us to implement the 8060 transactions. eed. And our payment vendor (ECHO Health).	4/21/2026 12:13 PM
3	It would be very difficult to implement updates by individual standard or by group as it would require tasks to be repeated over and over instead of one time, and dependent transactions may not be updated at the same time	4/21/2026 9:46 AM
4	Like to see 837s, 835 and 276/277 together, separate from 270/271, and 834/820 together but all three groups staggered. 270/271 Group 1; 837/835/276_7 Group 2; 820_834 Group 3.	4/17/2026 11:23 AM
5	Don't understand option 3	4/14/2026 12:57 PM
6	Dependant on the TPA, and Payor readiness	4/13/2026 2:50 PM
7	We would implement all at once unless mandated to just implement 835 & 837	4/10/2026 10:31 AM

Q17 32 responses

If there are economies of scale when implementing changes to multiple transaction standards for your organization, where do you anticipate those would lie (select all that apply)?



Answer Choices	Percentage	Responses
Hardware procurement	12.50%	4
Software procurement	34.38%	11
Software development	56.25%	18
Transmission	18.75%	6
New data collection	37.50%	12
Internal testing	59.38%	19
External testing	53.13%	17
Training	40.63%	13
Other (please name)	3.13%	1
Unsure	18.75%	6
Total		**109**

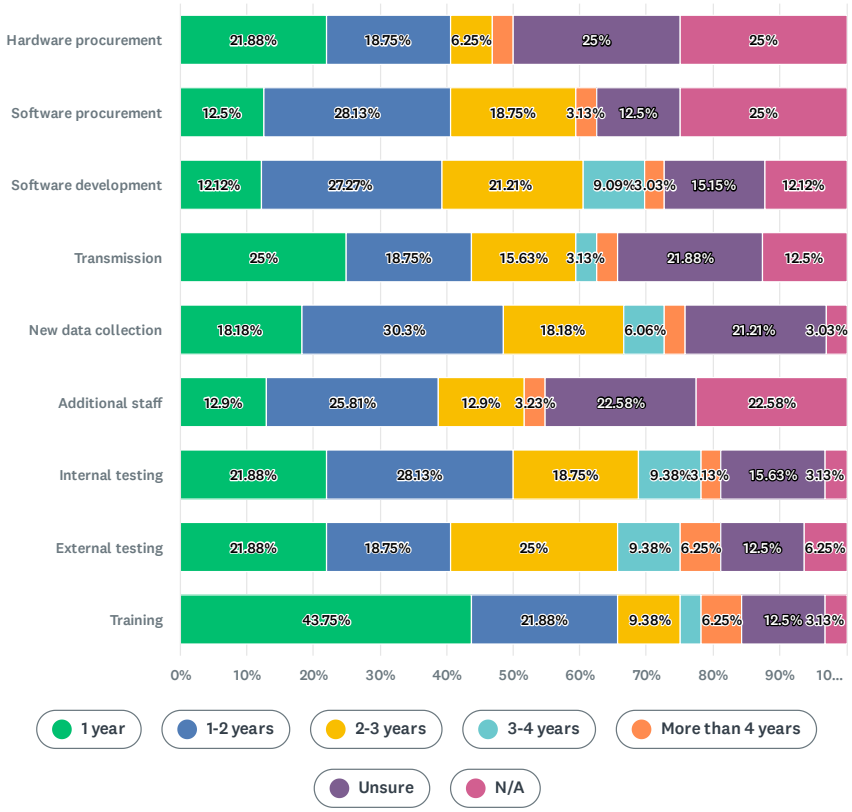
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

Answer Choices	Percentage	Responses
N/A	6.25%	2
Total		**109**

#	COMMENT BOX	DATE
1	It took us almost 2 years to implement the QPA (Qualified Payment Amount) on our claims and EPPs (for Providers). Our vendors really did not know what they were doing and that make senses to some extent because the QPA is not part of the transaction standards, but our vendor were very behind in just understand what QPA and NSA (No Surprises Act) was all about. Knowledge is the problem with vendors. Their staffs are not very knowledgeable. It is shocking to me after being in the industry for 40 years.	4/21/2026 12:13 PM
2	Internal education on changes leading up to implementation; interpretation alignment on requirements	4/17/2026 11:23 AM
3	We do not wish to implement the entire suite. We are in support of moving forward with at minimum the 270/271 TR3 and perhaps 276/277.	4/14/2026 12:57 PM

Q18 33 responses

Based on your analysis of v8060 and/or your experience implementing v5010, what is the anticipated timeline for incurring v8060 implementation costs? Assign one of the following answer options to each of the implementation issues:(i) 1 year; (ii) 1-2 years; (iii) 2-3 years; (iv) 3-4 years; (v) more than 4 years; (vi) unsure; and (vii) N/A



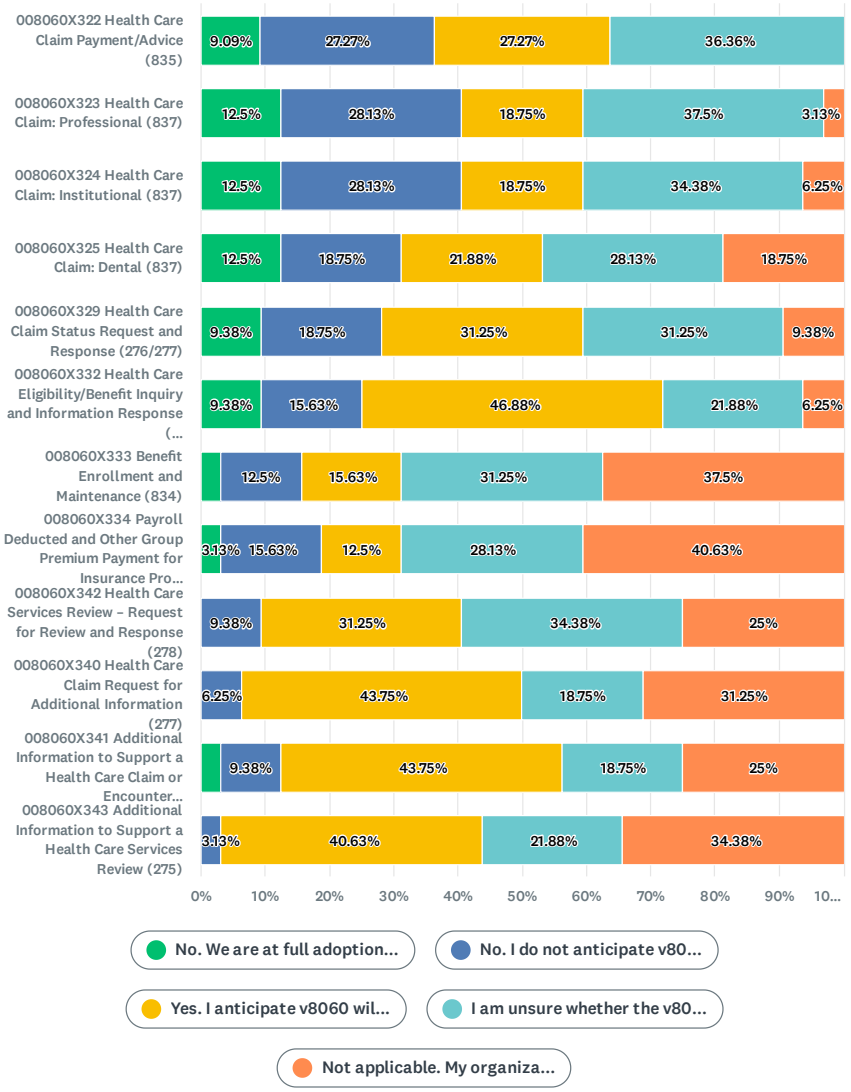
	1 year	1-2 years	2-3 years	3-4 years	More than 4 years	Unsure	N/A	Total
Hardware procurement	21.88% 7	18.75% 6	6.25% 2	0% 0	3.13% 1	25.00% 8	25.00% 8	32
Software procurement	12.50% 4	28.13% 9	18.75% 6	0% 0	3.13% 1	12.50% 4	25.00% 8	32
Software development	12.12% 4	27.27% 9	21.21% 7	9.09% 3	3.03% 1	15.15% 5	12.12% 4	33
Transmission	25.00% 8	18.75% 6	15.63% 5	3.13% 1	3.13% 1	21.88% 7	12.50% 4	32
New data collection	18.18% 6	30.30% 10	18.18% 6	6.06% 2	3.03% 1	21.21% 7	3.03% 1	33
								289

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	1 year	1-2 years	2-3 years	3-4 years	More than 4 years	Unsure	N/A	Total
Additional staff	12.90% 4	25.81% 8	12.90% 4	0% 0	3.23% 1	22.58% 7	22.58% 7	31
Internal testing	21.88% 7	28.13% 9	18.75% 6	9.38% 3	3.13% 1	15.63% 5	3.13% 1	32
External testing	21.88% 7	18.75% 6	25.00% 8	9.38% 3	6.25% 2	12.50% 4	6.25% 2	32
Training	43.75% 14	21.88% 7	9.38% 3	3.13% 1	6.25% 2	12.50% 4	3.13% 1	32
								289

Q19 33 responses

Do you anticipate that the enhancements under v8060 will result in more transactions conducted electronically as opposed to non-electronically by your organization?



	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X322 Health Care Claim Payment/Advice (835)	9.09%	27.27%	27.27%	36.36%	0.00%	385
008060X323 Health Care Claim: Professional (837)	12.5%	28.13%	18.75%	37.5%	3.13%	385
008060X324 Health Care Claim: Institutional (837)	12.5%	28.13%	18.75%	34.38%	6.25%	385
008060X325 Health Care Claim: Dental (837)	12.5%	18.75%	21.88%	28.13%	18.75%	385
008060X329 Health Care Claim Status Request and Response (276/277)	9.38%	18.75%	31.25%	31.25%	9.38%	385
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (...	9.38%	15.63%	46.88%	21.88%	6.25%	385
008060X333 Benefit Enrollment and Maintenance (834)	0.00%	12.5%	15.63%	31.25%	37.5%	385
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Pro...	3.13%	15.63%	12.5%	28.13%	40.63%	385
008060X342 Health Care Services Review – Request for Review and Response (278)	9.38%	31.25%	34.38%	25%	0.00%	385
008060X340 Health Care Claim Request for Additional Information (277)	6.25%	43.75%	18.75%	31.25%	0.00%	385
008060X341 Additional Information to Support a Health Care Claim or Encounter...	9.38%	43.75%	18.75%	25%	0.00%	385
008060X343 Additional Information to Support a Health Care Services Review (275)	3.13%	40.63%	21.88%	34.38%	0.00%	385

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X322 Health Care Claim Payment/Advice (835)	9.09% 3	27.27% 9	27.27% 9	36.36% 12	0% 0	33
008060X323 Health Care Claim: Professional (837)	12.50% 4	28.13% 9	18.75% 6	37.50% 12	3.13% 1	32
008060X324 Health Care Claim: Institutional (837)	12.50% 4	28.13% 9	18.75% 6	34.38% 11	6.25% 2	32
008060X325 Health Care Claim: Dental (837)	12.50% 4	18.75% 6	21.88% 7	28.13% 9	18.75% 6	32
008060X329 Health Care Claim Status Request and Response (276/277)	9.38% 3	18.75% 6	31.25% 10	31.25% 10	9.38% 3	32
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	9.38% 3	15.63% 5	46.88% 15	21.88% 7	6.25% 2	32
008060X333 Benefit Enrollment and Maintenance (834)	3.13% 1	12.50% 4	15.63% 5	31.25% 10	37.50% 12	32
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	3.13% 1	15.63% 5	12.50% 4	28.13% 9	40.63% 13	32
008060X342 Health Care Services Review – Request for Review and Response (278)	0% 0	9.38% 3	31.25% 10	34.38% 11	25.00% 8	32
						385

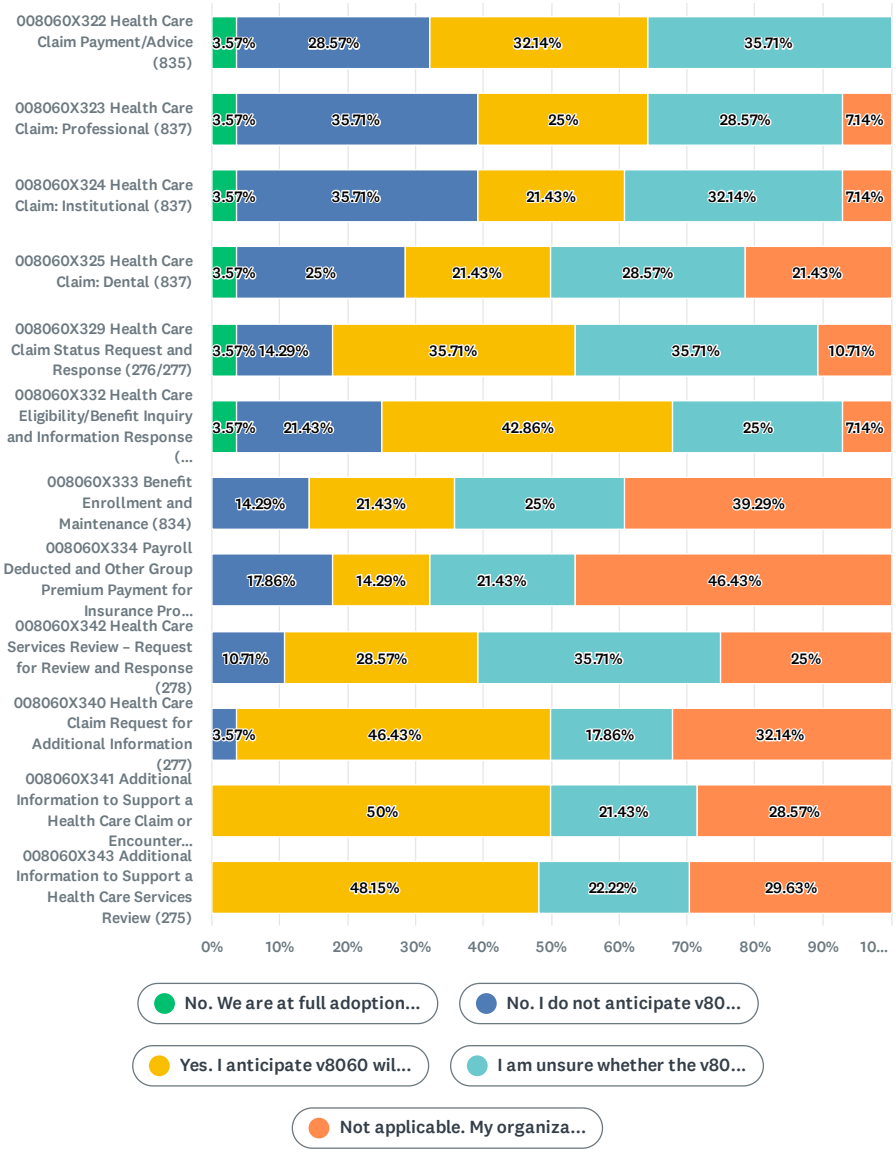
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X340 Health Care Claim Request for Additional Information (277)	0% 0	6.25% 2	43.75% 14	18.75% 6	31.25% 10	32
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	3.13% 1	9.38% 3	43.75% 14	18.75% 6	25.00% 8	32
008060X343 Additional Information to Support a Health Care Services Review (275)	0% 0	3.13% 1	40.63% 13	21.88% 7	34.38% 11	32
						385

#	COMMENT BOX	DATE
1	I oversaw the implementation of the 4010 for very large clearinghouse and now I understand why it was so challenging. The payers do not have vendors for their software that can respond in a timely fashion. We need for vendors to get their software ready (1-2) years and then providers and payers can start their part of the implementation. In the two previous implementations for 4010 and 5010 and UB04, the payers used up all the time due to their software vendors inefficiencies. I now understand that because I work for payer that wants to be compliant and we want to pay claims in no more than 7 to 10 days from receipt of that claim.	4/21/2026 12:13 PM
2	We are at full adoption except for attachments and supporting documentation. CMS-0057 & CMS-0053 are helping a lot toward full adoption.	4/10/2026 10:31 AM

Q20 28 responses

Do you anticipate that the enhancements under v8060 will result in more transactions conducted electronically as opposed to non-electronically by your organization?



	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X322 Health Care Claim Payment/Advice (835)	3.57%	28.57%	32.14%	35.71%		335
008060X323 Health Care Claim: Professional (837)	3.57%	35.71%	25%	28.57%	7.14%	335
008060X324 Health Care Claim: Institutional (837)	3.57%	35.71%	21.43%	32.14%	7.14%	335
008060X325 Health Care Claim: Dental (837)	3.57%	25%	21.43%	28.57%	21.43%	335
008060X329 Health Care Claim Status Request and Response (276/277)	3.57%	14.29%	35.71%	35.71%	10.71%	335
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (...	3.57%	21.43%	42.86%	25%	7.14%	335
008060X333 Benefit Enrollment and Maintenance (834)	14.29%	21.43%	25%	39.29%		335
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Pro...	17.86%	14.29%	21.43%	46.43%		335
008060X342 Health Care Services Review – Request for Review and Response (278)	10.71%	28.57%	35.71%	25%		335
008060X340 Health Care Claim Request for Additional Information (277)	3.57%	46.43%	17.86%	32.14%		335
008060X341 Additional Information to Support a Health Care Claim or Encounter...			50%	21.43%	28.57%	335
008060X343 Additional Information to Support a Health Care Services Review (275)			48.15%	22.22%	29.63%	335

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X322 Health Care Claim Payment/Advice (835)	3.57% 1	28.57% 8	32.14% 9	35.71% 10	0% 0	28
008060X323 Health Care Claim: Professional (837)	3.57% 1	35.71% 10	25.00% 7	28.57% 8	7.14% 2	28
008060X324 Health Care Claim: Institutional (837)	3.57% 1	35.71% 10	21.43% 6	32.14% 9	7.14% 2	28
008060X325 Health Care Claim: Dental (837)	3.57% 1	25.00% 7	21.43% 6	28.57% 8	21.43% 6	28
008060X329 Health Care Claim Status Request and Response (276/277)	3.57% 1	14.29% 4	35.71% 10	35.71% 10	10.71% 3	28
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	3.57% 1	21.43% 6	42.86% 12	25.00% 7	7.14% 2	28
008060X333 Benefit Enrollment and Maintenance (834)	0% 0	14.29% 4	21.43% 6	25.00% 7	39.29% 11	28
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	0% 0	17.86% 5	14.29% 4	21.43% 6	46.43% 13	28
008060X342 Health Care Services Review – Request for Review and Response (278)	0% 0	10.71% 3	28.57% 8	35.71% 10	25.00% 7	28

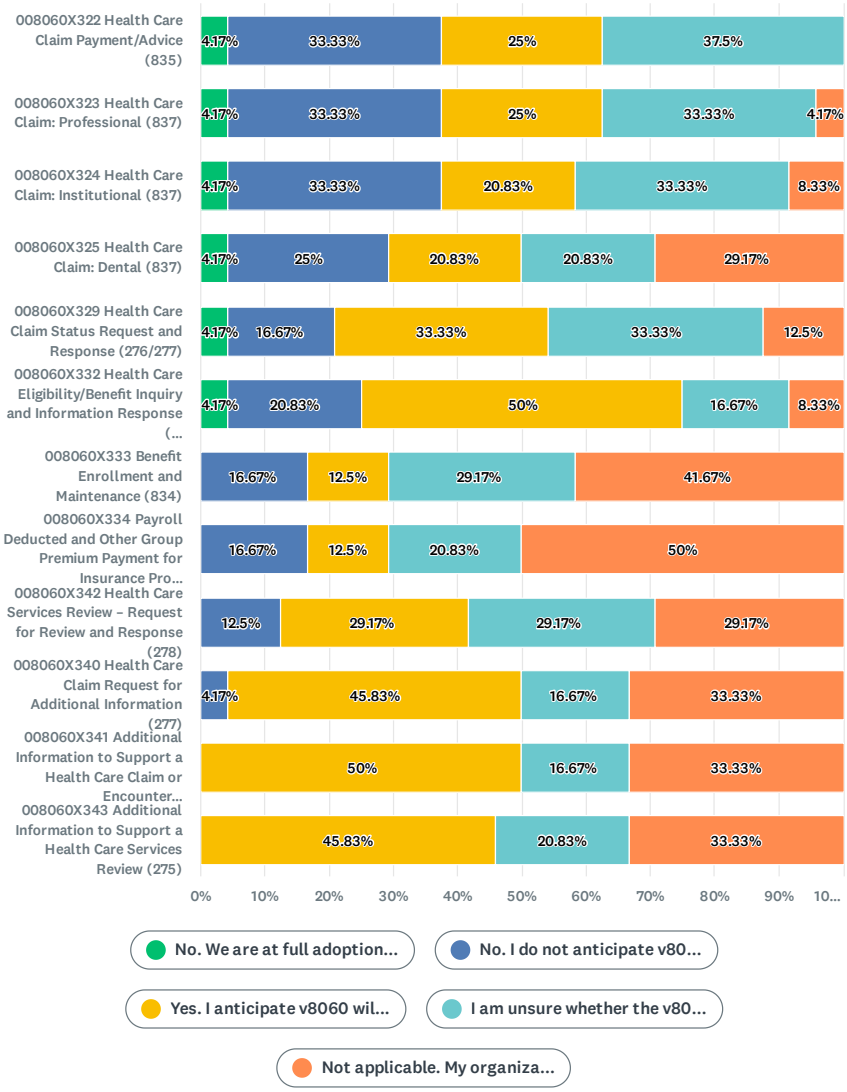
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X340 Health Care Claim Request for Additional Information (277)	0% 0	3.57% 1	46.43% 13	17.86% 5	32.14% 9	28
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	0% 0	0% 0	50.00% 14	21.43% 6	28.57% 8	28
008060X343 Additional Information to Support a Health Care Services Review (275)	0% 0	0% 0	48.15% 13	22.22% 6	29.63% 8	27
						335

#	COMMENT BOX	DATE
1	same question?	4/24/2026 5:13 PM
2	Very dependent upon the payers supporting these transactions.	4/21/2026 12:54 PM
3	I still see providers like Dentists and small medical providers still doing claims on paper.	4/21/2026 12:13 PM
4	Duplicate question	4/14/2026 12:57 PM
5	Was this a duplicate of #11?	4/13/2026 12:29 PM

Q21 24 responses

Do you anticipate that the enhancements under v8060 will result in more transactions conducted electronically as opposed to non-electronically by your organization?



	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
						288

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X322 Health Care Claim Payment/Advice (835)	4.17% 1	33.33% 8	25.00% 6	37.50% 9	0% 0	24
008060X323 Health Care Claim: Professional (837)	4.17% 1	33.33% 8	25.00% 6	33.33% 8	4.17% 1	24
008060X324 Health Care Claim: Institutional (837)	4.17% 1	33.33% 8	20.83% 5	33.33% 8	8.33% 2	24
008060X325 Health Care Claim: Dental (837)	4.17% 1	25.00% 6	20.83% 5	20.83% 5	29.17% 7	24
008060X329 Health Care Claim Status Request and Response (276/277)	4.17% 1	16.67% 4	33.33% 8	33.33% 8	12.50% 3	24
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	4.17% 1	20.83% 5	50.00% 12	16.67% 4	8.33% 2	24
008060X333 Benefit Enrollment and Maintenance (834)	0% 0	16.67% 4	12.50% 3	29.17% 7	41.67% 10	24
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	0% 0	16.67% 4	12.50% 3	20.83% 5	50.00% 12	24
008060X342 Health Care Services Review – Request for Review and Response (278)	0% 0	12.50% 3	29.17% 7	29.17% 7	29.17% 7	24
						288

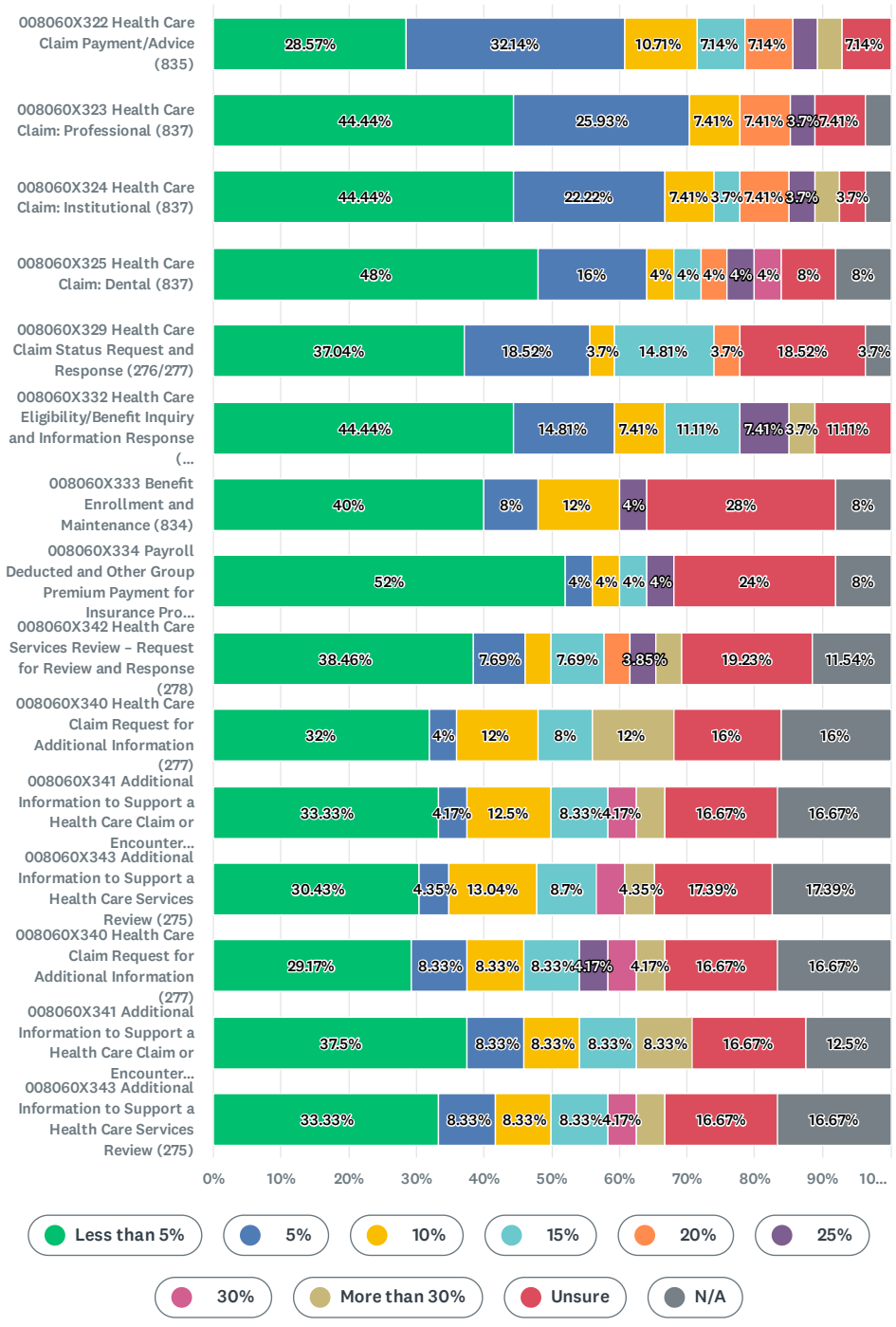
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. We are at full adoption with no room for growth.	No. I do not anticipate v8060 will increase the adoption of this transaction electronically.	Yes. I anticipate v8060 will result in more use of this transaction electronically.	I am unsure whether the v8060 will result in more use of this transaction electronically.	Not applicable. My organization does not conduct this transaction.	Total
008060X340 Health Care Claim Request for Additional Information (277)	0% 0	4.17% 1	45.83% 11	16.67% 4	33.33% 8	24
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	0% 0	0% 0	50.00% 12	16.67% 4	33.33% 8	24
008060X343 Additional Information to Support a Health Care Services Review (275)	0% 0	0% 0	45.83% 11	20.83% 5	33.33% 8	24
						288

#	COMMENT BOX	DATE
1	Is this the same as the question above?	4/24/2026 1:15 PM
2	This question appears to be a duplicate of question #12.	4/24/2026 12:23 PM
3	This question is a repeat	4/21/2026 12:54 PM
4	duplicate question	4/14/2026 12:57 PM
5	Was this a duplicate of #11 and #12?	4/13/2026 12:29 PM

Q22 30 responses

Based on your experience with v5010, for each X12 transaction that your organization conducts electronically, provide the approximate percentage of current electronic submissions that require manual follow-up by your staff. (Manual follow-up refers to any action taken by staff to progress or resolve a task outside of automated workflows.)



WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Less than 5%	5%	10%	15%	20%	25%	30%	More than 30%	Unsure
008060X322 Health Care Claim Payment/Advice (835)	28.57% 8	32.14% 9	10.71% 3	7.14% 2	7.14% 2	3.57% 1	0% 0	3.57% 1	7.14% 2
008060X323 Health Care Claim: Professional (837)	44.44% 12	25.93% 7	7.41% 2	0% 0	7.41% 2	3.70% 1	0% 0	0% 0	7.41% 2
008060X324 Health Care Claim: Institutional (837)	44.44% 12	22.22% 6	7.41% 2	3.70% 1	7.41% 2	3.70% 1	0% 0	3.70% 1	3.70% 1
008060X325 Health Care Claim: Dental (837)	48.00% 12	16.00% 4	4.00% 1	4.00% 1	4.00% 1	4.00% 1	4.00% 1	0% 0	8.00% 2
008060X329 Health Care Claim Status Request and Response (276/277)	37.04% 10	18.52% 5	3.70% 1	14.81% 4	3.70% 1	0% 0	0% 0	0% 0	18.52% 5
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	44.44% 12	14.81% 4	7.41% 2	11.11% 3	0% 0	7.41% 2	0% 0	3.70% 1	11.11% 3
008060X333 Benefit Enrollment and Maintenance (834)	40.00% 10	8.00% 2	12.00% 3	0% 0	0% 0	4.00% 1	0% 0	0% 0	28.00% 7
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	52.00% 13	4.00% 1	4.00% 1	4.00% 1	0% 0	4.00% 1	0% 0	0% 0	24.00% 6

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Less than 5%	5%	10%	15%	20%	25%	30%	More than 30%	Unsure
008060X342 Health Care Services Review – Request for Review and Response (278)	38.46% 10	7.69% 2	3.85% 1	7.69% 2	3.85% 1	3.85% 1	0% 0	3.85% 1	19.23% 5
008060X340 Health Care Claim Request for Additional Information (277)	32.00% 8	4.00% 1	12.00% 3	8.00% 2	0% 0	0% 0	0% 0	12.00% 3	16.00% 4
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	33.33% 8	4.17% 1	12.50% 3	8.33% 2	0% 0	0% 0	4.17% 1	4.17% 1	16.67% 4
008060X343 Additional Information to Support a Health Care Services Review (275)	30.43% 7	4.35% 1	13.04% 3	8.70% 2	0% 0	0% 0	4.35% 1	4.35% 1	17.39% 4
008060X340 Health Care Claim Request for Additional Information (277)	29.17% 7	8.33% 2	8.33% 2	8.33% 2	0% 0	4.17% 1	4.17% 1	4.17% 1	16.67% 4
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	37.50% 9	8.33% 2	8.33% 2	8.33% 2	0% 0	0% 0	0% 0	8.33% 2	16.67% 4
008060X343 Additional Information to Support a Health Care Services Review (275)	33.33% 8	8.33% 2	8.33% 2	8.33% 2	0% 0	0% 0	4.17% 1	4.17% 1	16.67% 4

#	COMMENTS FOR "008060X322 HEALTH CARE CLAIM PAYMENT/ADVICE (835)"	DATE
1	It depends on the payer and the provider specialy. Eye care claims hit up against split plans which can be complex.	4/24/2026 5:13 PM

2	The question is about current version 5010 electronic transactions but the row labels are for version 8060. Was that intentional?	4/24/2026 1:15 PM
3	N/A, no manual work during automation	4/23/2026 7:11 PM
4	Most of our issues are from our claims processing / claims administration system translating their data into 835 or our Payment vendor not truly understanding the transactions. Knowledge with the vendors is a keep problem.	4/21/2026 12:13 PM
5	Unsure - we do not process claims directly.	4/16/2026 12:40 PM
6	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X323 HEALTH CARE CLAIM: PROFESSIONAL (837)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	Most of our issues are claims that were data entered by our Clearinghouse vendor. Or the fact that some of vendors have interpreted the transaction incorrectly.	4/21/2026 12:13 PM
3	Unsure - we do not process claims directly.	4/16/2026 12:40 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X324 HEALTH CARE CLAIM: INSTITUTIONAL (837)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	Most of our issues are claims that were data entered by our Clearinghouse vendor. Or the fact that some of vendors have interpreted the transaction incorrectly.	4/21/2026 12:13 PM
3	Unsure - we do not process claims directly.	4/16/2026 12:40 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X325 HEALTH CARE CLAIM: DENTAL (837)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	Most of our issues are claims that were data entered by our Clearinghouse vendor. Or the fact that some of vendor have interpreted the transaction incorrectly.	4/21/2026 12:13 PM
3	Unsure - we do not process claims directly.	4/16/2026 12:40 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X329 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE (276/277)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	Our main method of 276/277 is via 3rd party API's as the standard transaction was poor in adoption/quality	4/21/2026 12:54 PM
3	Unsure - we do not process claims directly.	4/16/2026 12:40 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X332 HEALTH CARE ELIGIBILITY/BENEFIT INQUIRY AND INFORMATION RESPONSE (270/271)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X333 BENEFIT ENROLLMENT AND MAINTENANCE (834)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	We do not use this transaction.	4/16/2026 12:40 PM
3	unsure	4/14/2026 12:57 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X334 PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT FOR INSURANCE PRODUCTS (820)"**	**DATE**
1	N/A, no manual work during automation	4/23/2026 7:11 PM
2	We do not use this transaction.	4/16/2026 12:40 PM
3	unsure	4/14/2026 12:57 PM
4	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
#	**COMMENTS FOR "008060X342 HEALTH CARE SERVICES REVIEW – REQUEST FOR REVIEW AND RESPONSE (278)"**	**DATE**
1	Our providers do not send us 278 transactions they prefer our Portal.	4/14/2026 10:51 AM
2	Not used at this time.	4/13/2026 12:29 PM
#	**COMMENTS FOR "008060X340 HEALTH CARE CLAIM REQUEST FOR ADDITIONAL INFORMATION (277)"**	**DATE**
1	I cannot find accurate information for this question by the time this survey needs a response.	4/14/2026 10:51 AM
2	Not used at this time. We use 277CA but not 277RFAI. Adoption would drive implementation	4/13/2026 12:29 PM

and usage.

#	COMMENTS FOR "008060X341 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE CLAIM OR ENCOUNTER (275)"	DATE
1	We do not use this transaction.	4/16/2026 12:40 PM
2	we do not use this transaction	4/14/2026 10:51 AM
3	Not used at this time. Adoption would drive implementation and usage.	4/13/2026 12:29 PM

#	COMMENTS FOR "008060X343 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE SERVICES REVIEW (275)"	DATE
1	We do not use this transaction.	4/16/2026 12:40 PM
2	n/a	4/14/2026 12:57 PM
3	we do not use this transaction	4/14/2026 10:51 AM
4	Not used at this time.	4/13/2026 12:29 PM

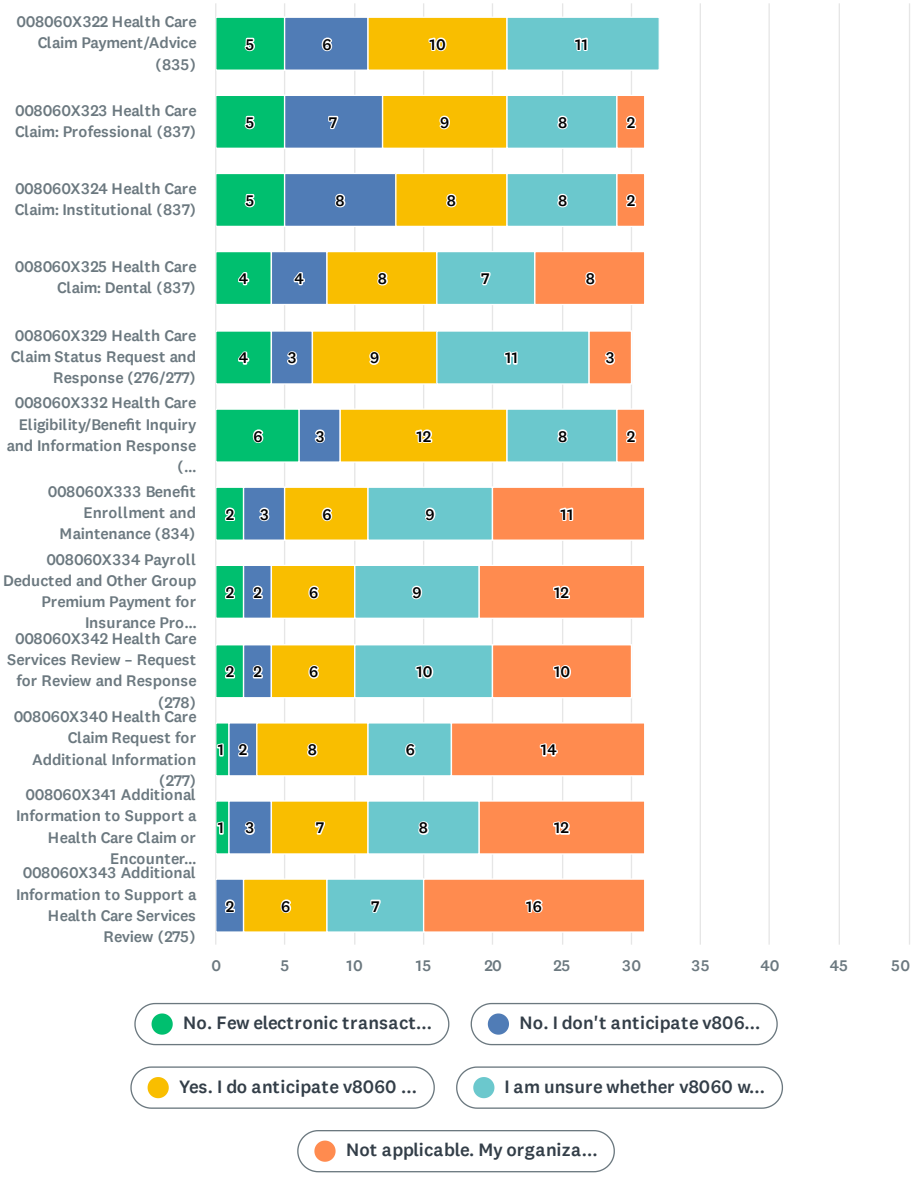
#	COMMENTS FOR "008060X340 HEALTH CARE CLAIM REQUEST FOR ADDITIONAL INFORMATION (277)"	DATE
1	n/a	4/14/2026 12:57 PM
2	we do not use this transaction	4/14/2026 10:51 AM
3	We use the 277CA but not the 277RFAI at this time. Is this a duplicate question?	4/13/2026 12:29 PM

#	COMMENTS FOR "008060X341 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE CLAIM OR ENCOUNTER (275)"	DATE
1	We do not use this transaction.	4/16/2026 12:40 PM
2	we do not use this transaction	4/14/2026 10:51 AM
3	Not used at this time. Is this a duplicate question?	4/13/2026 12:29 PM

#	COMMENTS FOR "008060X343 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE SERVICES REVIEW (275)"	DATE
1	We do not use this transaction.	4/16/2026 12:40 PM
2	we do not use this transaction	4/14/2026 10:51 AM
3	Not used at this time. Is this a duplicate question?	4/13/2026 12:29 PM

Q23 32 responses

Based on your analysis of v8060 and/or your experience implementing v5010, do you anticipate that the enhancements under v8060 will reduce the percentage of electronic transactions that require manual follow-up?



	No. Few electronic transactions require manual follow-up so there is little room for reduction.	No. I don't anticipate v8060 will reduce the % of electronic transactions requiring manual follow up.	Yes. I do anticipate v8060 will reduce the % of electronic transactions requiring manual follow up.	I am unsure whether v8060 will reduce the % of electronic transactions requiring manual follow up.	Not applicable. My organization does not conduct this transaction electronically.	Total

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. Few electronic transactions require manual follow-up so there is little room for reduction.	No. I don't anticipate v8060 will reduce the % of electronic transactions requiring manual follow up	Yes. I do anticipate v8060 will reduce the % of electronic transactions requiring manual follow up.	I am unsure whether v8060 will reduce the % of electronic transactions requiring manual follow up.	Not applicable. My organization does not conduct this transaction electronically.	Total
008060X322 Health Care Claim Payment/Advice (835)	15.63% 5	18.75% 6	31.25% 10	34.38% 11	0% 0	32
008060X323 Health Care Claim: Professional (837)	16.13% 5	22.58% 7	29.03% 9	25.81% 8	6.45% 2	31
008060X324 Health Care Claim: Institutional (837)	16.13% 5	25.81% 8	25.81% 8	25.81% 8	6.45% 2	31
008060X325 Health Care Claim: Dental (837)	12.90% 4	12.90% 4	25.81% 8	22.58% 7	25.81% 8	31
008060X329 Health Care Claim Status Request and Response (276/277)	13.33% 4	10.00% 3	30.00% 9	36.67% 11	10.00% 3	30
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	19.35% 6	9.68% 3	38.71% 12	25.81% 8	6.45% 2	31
008060X333 Benefit Enrollment and Maintenance (834)	6.45% 2	9.68% 3	19.35% 6	29.03% 9	35.48% 11	31
						371

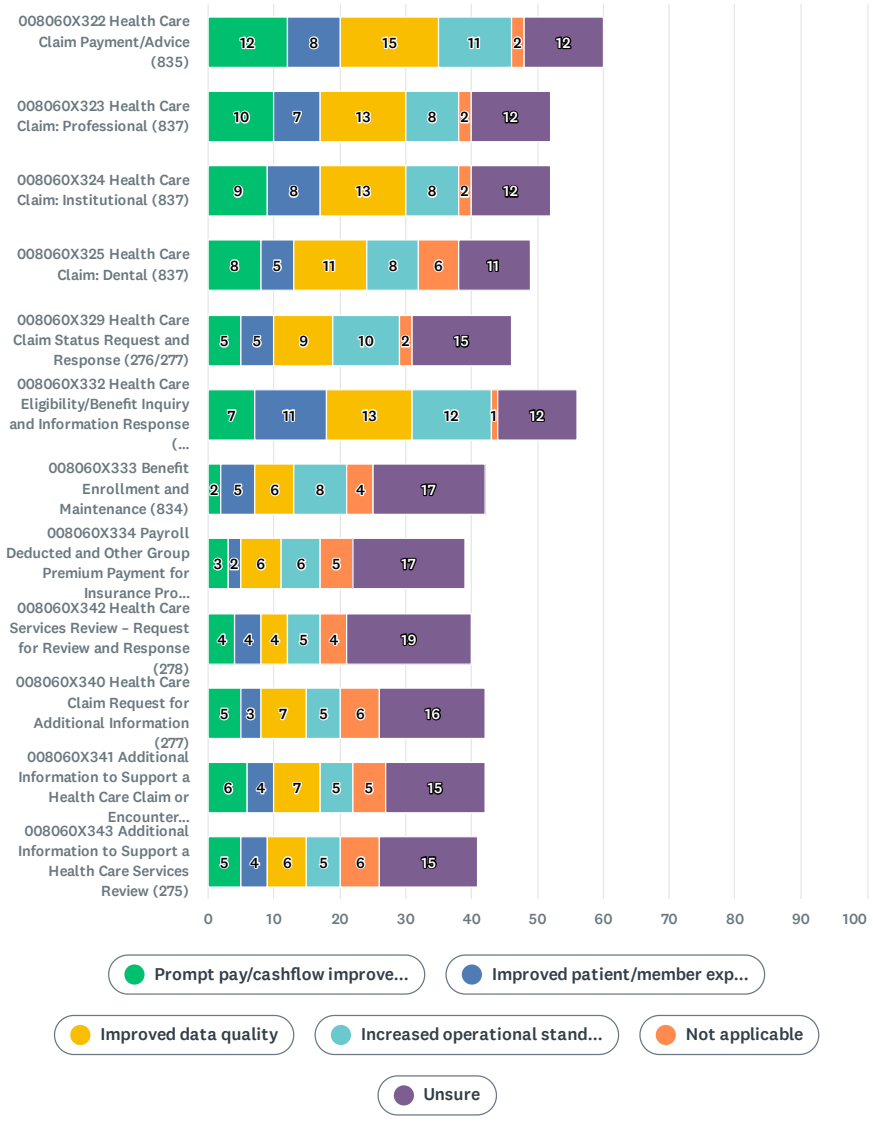
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	No. Few electronic transactions require manual follow-up so there is little room for reduction.	No. I don't anticipate v8060 will reduce the % of electronic transactions requiring manual follow up	Yes. I do anticipate v8060 will reduce the % of electronic transactions requiring manual follow up.	I am unsure whether v8060 will reduce the % of electronic transactions requiring manual follow up.	Not applicable. My organization does not conduct this transaction electronically.	Total
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	6.45% 2	6.45% 2	19.35% 6	29.03% 9	38.71% 12	31
008060X342 Health Care Services Review – Request for Review and Response (278)	6.67% 2	6.67% 2	20.00% 6	33.33% 10	33.33% 10	30
008060X340 Health Care Claim Request for Additional Information (277)	3.23% 1	6.45% 2	25.81% 8	19.35% 6	45.16% 14	31
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	3.23% 1	9.68% 3	22.58% 7	25.81% 8	38.71% 12	31
008060X343 Additional Information to Support a Health Care Services Review (275)	0% 0	6.45% 2	19.35% 6	22.58% 7	51.61% 16	31
						371

#	COMMENT BOX	DATE
1	• Limited support for diverse payment methods (e.g., credit card and other payment types). • Gaps in standardized reporting for key reimbursement classifications (e.g., DRG-related reporting not consistently supported across transactions). • Inconsistent capture and communication of procedure coding details, limiting the ability to identify and return coding issues in a standard way. • Insufficient coordination-of-benefits (COB) data support, requiring manual handling when prior payer allowed amounts and related payer details aren't available in the transaction. • Reliance on free-text notes to convey required details, due to a lack of appropriate structured fields in the transaction. • Incomplete support for specialty-specific data elements (e.g., dental tooth-level details), forcing information exchange outside the standard transaction. • Need for supplemental documentation beyond the original claim submission, requiring follow-up requests for additional information.	4/24/2026 12:23 PM

Q24 32 responses

Based on your analysis of v8060, do you anticipate that the v8060 enhancements to the following transactions will result in benefits to your organization? Check all that apply.



	Prompt pay/cashflow improvements	Improved patient/member experience	Improved data quality	Increased operational standardization	Not applicable	Unsure	Total
008060X322 Health Care Claim Payment/Advice (835)	37.50% 12	25.00% 8	46.88% 15	34.38% 11	6.25% 2	37.50% 12	60
							561

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Prompt pay/cashflow improvements	Improved patient/member experience	Improved data quality	Increased operational standardization	Not applicable	Unsure	Total
008060X323 Health Care Claim: Professional (837)	33.33% 10	23.33% 7	43.33% 13	26.67% 8	6.67% 2	40.00% 12	52
008060X324 Health Care Claim: Institutional (837)	30.00% 9	26.67% 8	43.33% 13	26.67% 8	6.67% 2	40.00% 12	52
008060X325 Health Care Claim: Dental (837)	26.67% 8	16.67% 5	36.67% 11	26.67% 8	20.00% 6	36.67% 11	49
008060X329 Health Care Claim Status Request and Response (276/277)	16.67% 5	16.67% 5	30.00% 9	33.33% 10	6.67% 2	50.00% 15	46
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	23.33% 7	36.67% 11	43.33% 13	40.00% 12	3.33% 1	40.00% 12	56
008060X333 Benefit Enrollment and Maintenance (834)	6.67% 2	16.67% 5	20.00% 6	26.67% 8	13.33% 4	56.67% 17	42
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	10.00% 3	6.67% 2	20.00% 6	20.00% 6	16.67% 5	56.67% 17	39

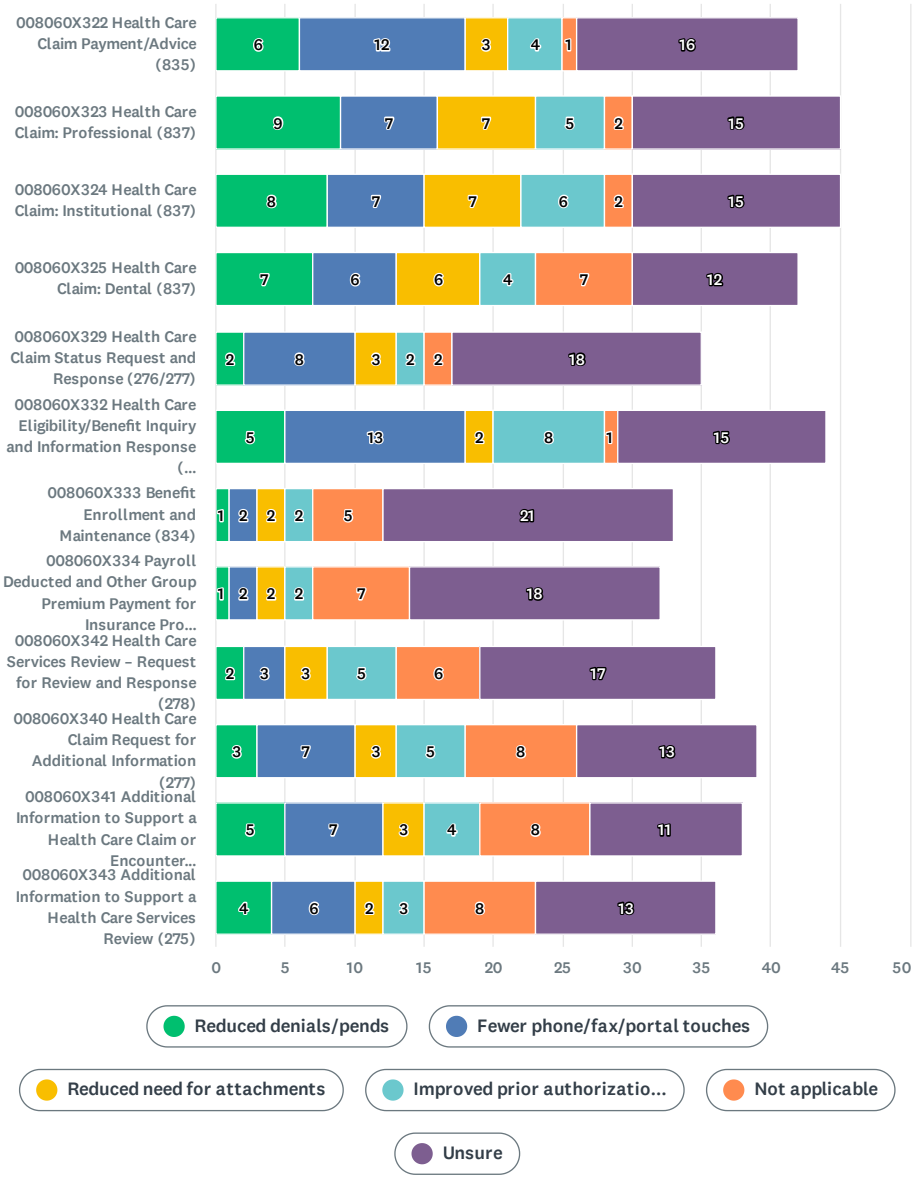
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Prompt pay/cashflow improvements	Improved patient/member experience	Improved data quality	Increased operational standardization	Not applicable	Unsure	Total
008060X342 Health Care Services Review – Request for Review and Response (278)	13.33% 4	13.33% 4	13.33% 4	16.67% 5	13.33% 4	63.33% 19	40
008060X340 Health Care Claim Request for Additional Information (277)	16.67% 5	10.00% 3	23.33% 7	16.67% 5	20.00% 6	53.33% 16	42
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	20.00% 6	13.33% 4	23.33% 7	16.67% 5	16.67% 5	50.00% 15	42
008060X343 Additional Information to Support a Health Care Services Review (275)	16.67% 5	13.33% 4	20.00% 6	16.67% 5	20.00% 6	50.00% 15	41
							561

#	PLEASE USE THE COMMENT BOX TO PROVIDE ADDITIONAL DETAILS FOR THE BENEFIT(S) YOU SELECTED, OR STATE OTHER BENEFITS NOT LISTED ABOVE	DATE
1	I have not been able to read the rule in full as we are buried under the Interoperability project right now.	4/14/2026 10:51 AM

Q25 30 responses

Continued. Based on your analysis of v8060, do you anticipate that the v8060 enhancements to the following transactions will result in benefits to your organization? Check all that apply.



	Reduced denials/pends	Fewer phone/fax/portal touches	Reduced need for attachments	Improved prior authorization/utilization management workflows	Not applicable	Unsure
008060X322 Health Care Claim Payment/Advice (835)	20.00% 6	40.00% 12	10.00% 3	13.33% 4	3.33% 1	53.33% 16

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Reduced denials/pends	Fewer phone/fax/portal touches	Reduced need for attachments	Improved prior authorization/utilization management workflows	Not applicable	Unsure
008060X323 Health Care Claim: Professional (837)	31.03% 9	24.14% 7	24.14% 7	17.24% 5	6.90% 2	51.72% 15
008060X324 Health Care Claim: Institutional (837)	27.59% 8	24.14% 7	24.14% 7	20.69% 6	6.90% 2	51.72% 15
008060X325 Health Care Claim: Dental (837)	24.14% 7	20.69% 6	20.69% 6	13.79% 4	24.14% 7	41.38% 12
008060X329 Health Care Claim Status Request and Response (276/277)	6.90% 2	27.59% 8	10.34% 3	6.90% 2	6.90% 2	62.07% 18
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	17.24% 5	44.83% 13	6.90% 2	27.59% 8	3.45% 1	51.72% 15
008060X333 Benefit Enrollment and Maintenance (834)	3.45% 1	6.90% 2	6.90% 2	6.90% 2	17.24% 5	72.41% 21
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	3.45% 1	6.90% 2	6.90% 2	6.90% 2	24.14% 7	62.07% 18

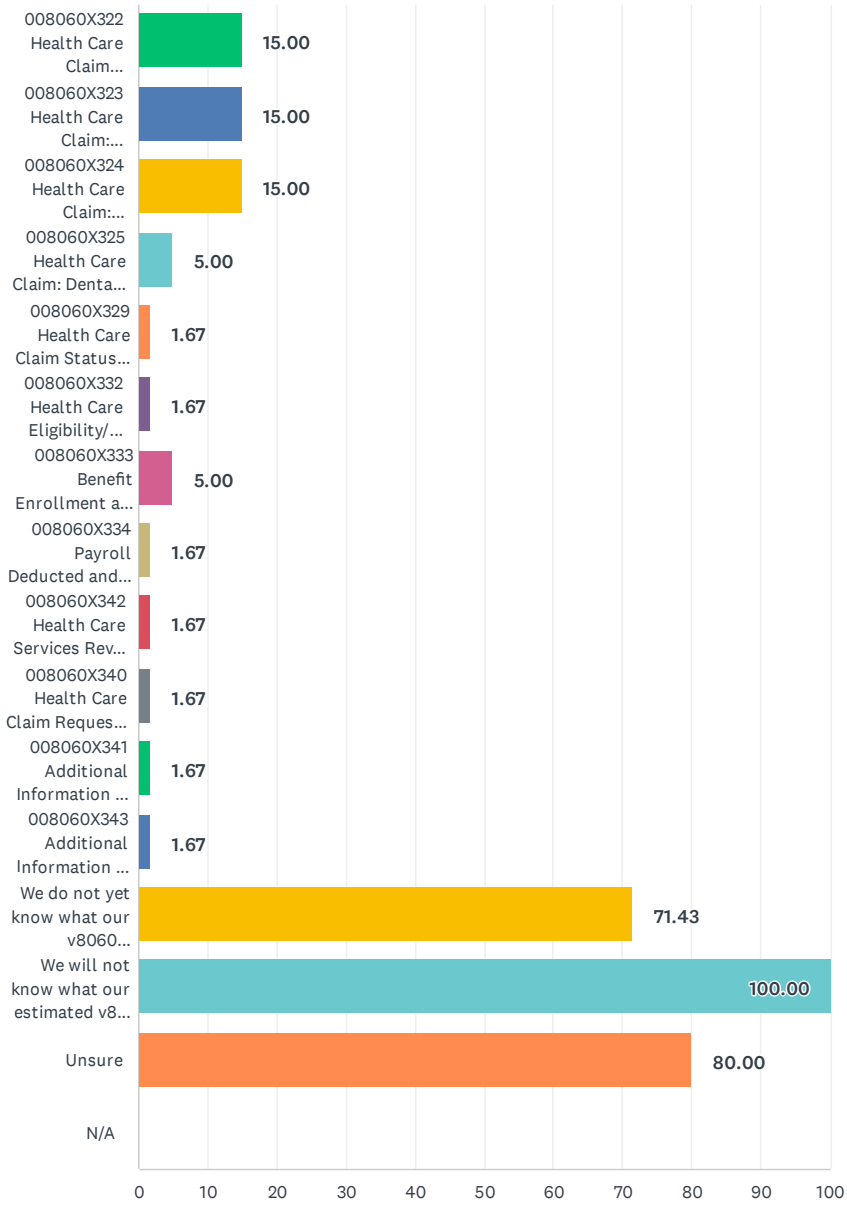
WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	Reduced denials/pends	Fewer phone/fax/portal touches	Reduced need for attachments	Improved prior authorization/utilization management workflows	Not applicable	Unsure
008060X342 Health Care Services Review – Request for Review and Response (278)	6.90% 2	10.34% 3	10.34% 3	17.24% 5	20.69% 6	58.62% 17
008060X340 Health Care Claim Request for Additional Information (277)	10.71% 3	25.00% 7	10.71% 3	17.86% 5	28.57% 8	46.43% 13
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	17.24% 5	24.14% 7	10.34% 3	13.79% 4	27.59% 8	37.93% 11
008060X343 Additional Information to Support a Health Care Services Review (275)	13.79% 4	20.69% 6	6.90% 2	10.34% 3	27.59% 8	44.83% 13

#	PLEASE USE THE COMMENT BOX TO PROVIDE ADDITIONAL DETAILS FOR THE BENEFIT(S) YOU SELECTED, OR STATE OTHER BENEFITS NOT LISTED ABOVE	DATE
1	I have not been able to read the rule in full as we are buried under the Interoperability project right now.	4/14/2026 10:51 AM

Q26 Based on your specific analysis of v8060, provide your best estimate of the implementation cost attributable to implementing each of the following v8060 transactions.

Answered: 18 Skipped: 102



WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

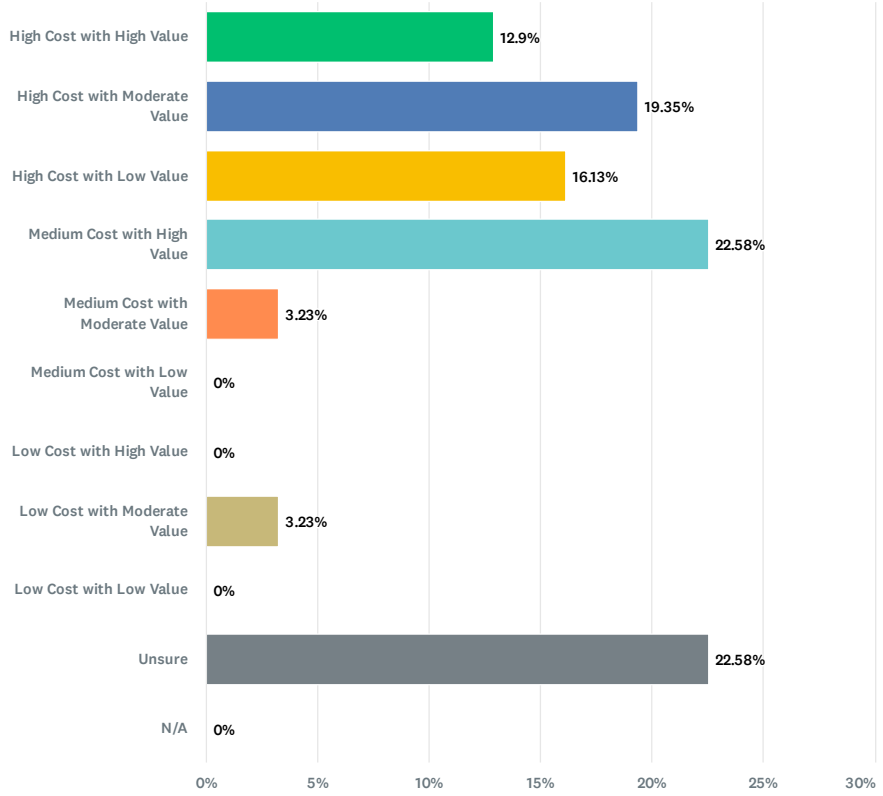
ANSWER CHOICES	AVERAGE NUMBER	TOTAL NUMBER	RESPONSES
008060X322 Health Care Claim Payment/Advice (835)	15	45	3
008060X323 Health Care Claim: Professional (837)	15	45	3
008060X324 Health Care Claim: Institutional (837)	15	45	3
008060X325 Health Care Claim: Dental (837)	5	15	3
008060X329 Health Care Claim Status Request and Response (276/277)	2	5	3
008060X332 Health Care Eligibility/Benefit Inquiry and Information Response (270/271)	2	5	3
008060X333 Benefit Enrollment and Maintenance (834)	5	15	3
008060X334 Payroll Deducted and Other Group Premium Payment for Insurance Products (820)	2	5	3
008060X342 Health Care Services Review – Request for Review and Response (278)	2	5	3
008060X340 Health Care Claim Request for Additional Information (277)	2	5	3
008060X341 Additional Information to Support a Health Care Claim or Encounter (275)	2	5	3
008060X343 Additional Information to Support a Health Care Services Review (275)	2	5	3
We do not yet know what our v8060 implementation costs will be	71	500	7
We will not know what our estimated v8060 implementation costs will be until after a proposed rule is published	100	700	7
Unsure	80	400	5
N/A	0	0	1
Total Respondents: 18			

#	008060X322 HEALTH CARE CLAIM PAYMENT/ADVICE (835)	DATE
1	15	4/21/2026 9:41 PM
2	30	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X323 HEALTH CARE CLAIM: PROFESSIONAL (837)	DATE
1	15	4/21/2026 9:41 PM
2	30	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X324 HEALTH CARE CLAIM: INSTITUTIONAL (837)	DATE
1	15	4/21/2026 9:41 PM
2	30	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X325 HEALTH CARE CLAIM: DENTAL (837)	DATE
1	15	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X329 HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE (276/277)	DATE
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X332 HEALTH CARE ELIGIBILITY/BENEFIT INQUIRY AND INFORMATION RESPONSE (270/271)	DATE
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	008060X333 BENEFIT ENROLLMENT AND MAINTENANCE (834)	DATE

1	5	4/21/2026 9:41 PM
2	10	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**008060X334 PAYROLL DEDUCTED AND OTHER GROUP PREMIUM PAYMENT FOR INSURANCE PRODUCTS (820)**	**DATE**
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**008060X342 HEALTH CARE SERVICES REVIEW – REQUEST FOR REVIEW AND RESPONSE (278)**	**DATE**
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**008060X340 HEALTH CARE CLAIM REQUEST FOR ADDITIONAL INFORMATION (277)**	**DATE**
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**008060X341 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE CLAIM OR ENCOUNTER (275)**	**DATE**
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**008060X343 ADDITIONAL INFORMATION TO SUPPORT A HEALTH CARE SERVICES REVIEW (275)**	**DATE**
1	5	4/21/2026 9:41 PM
2	0	4/13/2026 7:23 PM
3	0	4/10/2026 10:16 AM
#	**WE DO NOT YET KNOW WHAT OUR V8060 IMPLEMENTATION COSTS WILL BE**	**DATE**
1	100	4/21/2026 12:54 PM
2	100	4/16/2026 12:40 PM
3	100	4/14/2026 10:51 AM
4	0	4/13/2026 7:23 PM
5	100	4/13/2026 5:58 PM
6	100	4/13/2026 12:29 PM
7	0	4/10/2026 10:16 AM
#	**WE WILL NOT KNOW WHAT OUR ESTIMATED V8060 IMPLEMENTATION COSTS WILL BE UNTIL AFTER A PROPOSED RULE IS PUBLISHED**	**DATE**
1	100	4/24/2026 1:00 PM
2	100	4/24/2026 12:23 PM
3	100	4/19/2026 8:52 AM
4	100	4/17/2026 11:23 AM
5	100	4/14/2026 11:11 AM
6	100	4/13/2026 6:15 PM
7	100	4/10/2026 10:16 AM
#	**UNSURE**	**DATE**
1	100	4/22/2026 6:46 PM
2	100	4/21/2026 12:13 PM
3	100	4/21/2026 9:46 AM
4	100	4/13/2026 4:47 PM
5	0	4/10/2026 10:16 AM
#	**N/A**	**DATE**
1	0	4/10/2026 10:16 AM

Q27 31 responses

Please describe the expected opportunity cost/benefits associated with the overall implementation of v8060.



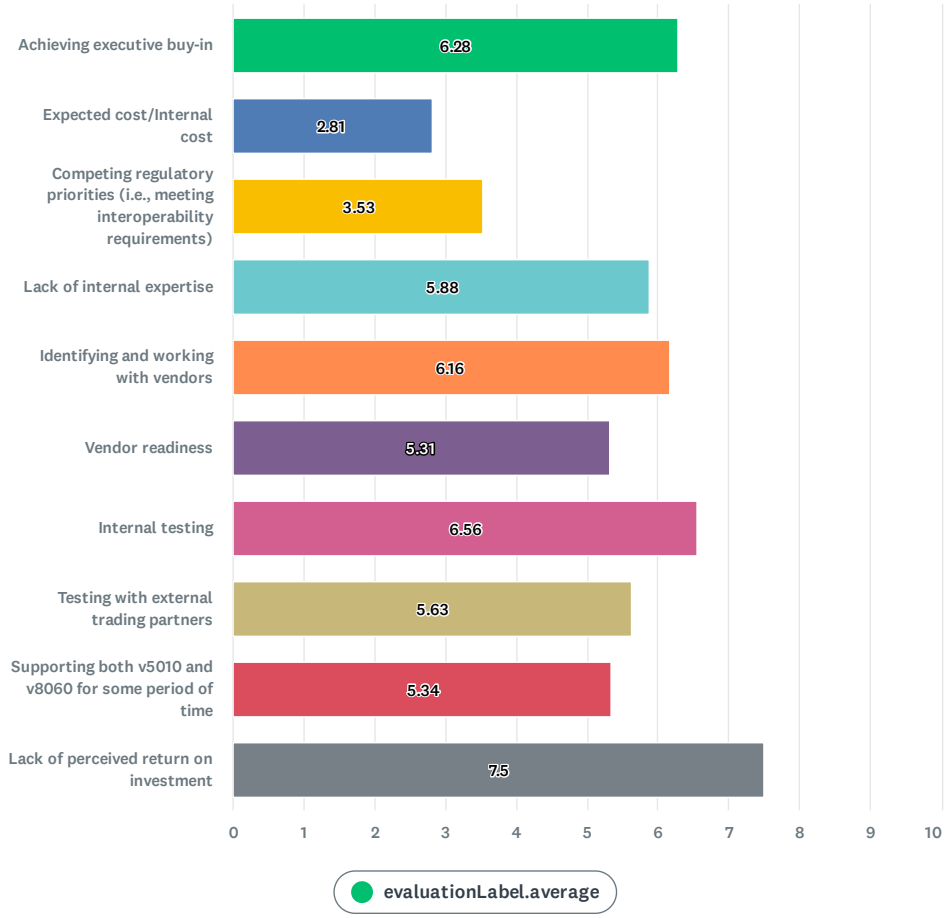
Answer Choices	Percentage	Responses
High Cost with High Value	12.90%	4
High Cost with Moderate Value	19.35%	6
High Cost with Low Value	16.13%	5
Medium Cost with High Value	22.58%	7
Medium Cost with Moderate Value	3.23%	1
Medium Cost with Low Value	0%	0
Low Cost with High Value	0%	0
Low Cost with Moderate Value	3.23%	1
Low Cost with Low Value	0%	0
Unsure	22.58%	7
N/A	0%	0
Total		**31**

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

#	COMMENT BOX	DATE
1	no financial analysis currently	4/23/2026 7:11 PM
2	Our vendors will probably charge is a lot of money. And our time is also costly while working with vendors that are very deficient in their knowledge.	4/21/2026 12:13 PM
3	This answer varies depending on the implemented transaction. High value for 270/271, lower for others.	4/14/2026 12:57 PM
4	I have not been able to read the rule in full as we are buried under the Interoperability project right now.	4/14/2026 10:51 AM
5	My guess would be low cost with High Value since we anticipated changing versions when writing the current contracts.	4/13/2026 12:29 PM

Q28 32 responses

Rank your top three challenges your organization faces in implementing v8060?



	1	2	3	4	5	6	7	8	9
Achieving executive buy-in	0% 0	6.25% 2	3.13% 1	21.88% 7	12.50% 4	12.50% 4	9.38% 3	12.50% 4	3.13% 1
Expected cost/Internal cost	37.50% 12	18.75% 6	15.63% 5	6.25% 2	9.38% 3	6.25% 2	0% 0	6.25% 2	0% 0
Competing regulatory priorities (i.e., meeting interoperability requirements)	18.75% 6	18.75% 6	18.75% 6	12.50% 4	12.50% 4	9.38% 3	6.25% 2	0% 0	3.13% 1
Lack of internal expertise	6.25% 2	9.38% 3	6.25% 2	12.50% 4	9.38% 3	18.75% 6	3.13% 1	3.13% 1	25.00% 8

WEDI Survey: Potential Benefits and Costs of Moving to the HIPAA Version 008060 Transaction Standards

	1	2	3	4	5	6	7	8	9
Identifying and working with vendors	3.13% 1	3.13% 1	3.13% 1	6.25% 2	25.00% 8	12.50% 4	18.75% 6	18.75% 6	3.13% 1
Vendor readiness	12.50% 4	12.50% 4	6.25% 2	9.38% 3	3.13% 1	12.50% 4	18.75% 6	9.38% 3	15.63% 5
Internal testing	0% 0	12.50% 4	0% 0	12.50% 4	6.25% 2	9.38% 3	15.63% 5	18.75% 6	15.63% 5
Testing with external trading partners	9.38% 3	6.25% 2	12.50% 4	9.38% 3	3.13% 1	15.63% 5	12.50% 4	15.63% 5	12.50% 4
Supporting both v5010 and v8060 for some period of time	9.38% 3	9.38% 3	18.75% 6	9.38% 3	9.38% 3	3.13% 1	6.25% 2	12.50% 4	15.63% 5
Lack of perceived return on investment	3.13% 1	3.13% 1	15.63% 5	0% 0	9.38% 3	0% 0	9.38% 3	3.13% 1	6.25% 2

Q29 Please add any additional comments on the potential benefits and costs of implementing v8060.

Answered: 14 Skipped: 106

#	RESPONSES	DATE
1	Trying to quantify potential costs is largely pointless because there is no consistency in estimation methodology or cost allocation across organizations. Rather than waiting many years between each update of HIPAA adopted standards, CMS should put those updates on a predictable cadence (perhaps every 2-4 years) that all covered entities can plan around. That will allow for consistent, stable budgeting and more efficient project management than the current unpredictable start/stop process.	4/24/2026 1:15 PM
2	na	4/24/2026 1:00 PM
3	It is concerning for Claim Attachments, as the standard was just set as 6020 yet exploring 8060 before the standard is even adopted. If this goes anything like the Prior Auth FHiR Standards are going-good luck to us all. Payers are no where near ready for testing the CMS-0057 goes into effect Jan 2027.	4/21/2026 12:54 PM
4	My greatest concern is vendor readiness. I was a vendor for 30 years (Clearinghouse and claims processing for providers). As a small payer, I am shocked by the vendors in the payer space and their lack of knowledge of the transactions and claims processing and payments in general.	4/21/2026 12:13 PM
5	NA	4/21/2026 11:43 AM
6	Moving to 8060 sets the stage for regular, predictable updates to the HIPAA transactions, which is needed to allow the industry to perform updates with lower effort and cost. Also, updating to the latest X12 version provides the updates and flexibility needed in the transactions to meet current and future regulatory guidelines.	4/21/2026 9:46 AM
7	There will need to be another round of this survey after X12 and WEDI have concluded its education, and organizations have had more time to look more closely at the changes in each guide. Some organizations have the same group that would be point for all updates to all guides, others will have dedicated workstreams to support individual transactions and they need more time to evaluate each of the TR3s/2s in greater detail. For the costs section: Guestimate would be 5-7.5M +/- 50% but need to thoroughly review the new guides, separating the must supports from the may support and decide how much of the 'may support' makes sense to do.	4/17/2026 11:23 AM
8	Do not recommend implementing as a full suite.	4/14/2026 12:57 PM
9	I cost will be lower if all payer follw the same rule that hte ANIS states. We know not every payer will fully upgraded there systems in time for this 8060 version as with 4010 to 5010 there were payer that would convert the 5010 to 4010, process the files and then convert the responses to 5010.	4/14/2026 11:11 AM
10	I have not been able to read the rule in full as we are buried under the Interoperability project right now.	4/14/2026 10:51 AM
11	When must the 8060 version be implemented to be compliant?	4/13/2026 7:23 PM
12	Looking forward to this so we can make smaller steps to upgrade to future version in the future, and to upgrade more frequently. Will need to upgrade post-8060 to handle the recently announced NDC changes so this will be the first step to getting there.	4/13/2026 5:58 PM
13	For many years the healthcare industry has moved forward with new treatments, new drugs, new procedures, new types of services and facilities but the transactions to bill and report these are not available because the transactions haven't kept up with the industry. i.e. simple payment to a credit card or VABs provided on a card, reporting of 'allowed amount' was removed when moving from 4010 to 5010 but is required to be reported to CMS on the TMSIS data. Information that can't be collected makes it difficult to report.	4/13/2026 12:29 PM
14	Leave 5010 alone. There isn't a need to move except for profit by vendors and clearinghouses.	4/6/2026 11:25 AM

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