



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

**July 1, 2026**

**Presented by:**

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# WEDI's Role

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WEDI is a multi-stakeholder organization representing health plans, providers, clearinghouses, vendors, SDOs, federal/state gov't and patient advocacy groups

WEDI was named as an advisor to the Secretary of HHS in HIPAA Section 1172 (c)

WEDI convenes, collaborates, educates and advises

# Member Position Advisory Process

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

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

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

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

NCVHS stated concerns were:

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

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

# WEDI Response (con't)

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

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

# WEDI Response (con't)

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## NDC Format and Future Version Questions

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

# CMS Questions: Claims Attachments

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## Version 006020 vs. 008060 for Claims Attachments

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

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

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

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

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

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

\*MPA participants highlighted these to support the 837 Health Care Claims

# WEDI Response (con't)

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

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

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

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

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

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

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

# Discussion: ROI

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

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

## Cost Drivers

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

# CMS Question: 008060 Readiness

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

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

# WEDI Response (con't)

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

# CMS Question: Operating Rules

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

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

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

# CMS Question: Alternative Standards

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

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

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

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

# Summation

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## The major points of the MPA discussion were:

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

# Summation (con't)

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



**THANK YOU!**