# National Committee on Vital and Health Statistics
# Standards Subcommittee
# Hearing on Requests for New and Updated Transaction Standards and Operating Rules

## Transcript

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Virtual

## SPEAKERS

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| Andrea Preisler | American Hospital Association | Sr. Assoc. Director |
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| Pam Grosze | Cooperative Exchange | Board Chair |
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**Welcome**

Rebecca Hines: Okay, we will get started. Good morning, everyone, members of the public and members of the National Committee on Vital and Health Statistics. We're delighted that you could join us for today's NCVHS Subcommittee on Standards hearing on two requests, two proposals that the committee received for new and updated transaction standards and operating rules.

A warm welcome to everyone joining us here today. Once again, we're meeting virtually, and I hope everyone is keeping well. My name is Rebecca Hines, and I serve as executive secretary and designated federal officer for the committee.

Today, the committee is convening to hear input from stakeholders on two requests received, one from X12, the other from CAQH CORE. Both letters are available on the committee website, I am putting the link in the chat here, if you haven't seen those. Also, the agenda for the meeting is posted on the website, as well. I will put that in the chat here. And then we will take care of roll call up front.

Let's begin with our co-chairs. Tammy Feenstra Banks.

Tammy Banks: Good morning. I'm Tammy Feenstra Banks, chair of the Subcommittee on Standards, member of the Full committee, and have no conflicts.

Denise Love: Denise Love, co-chair of the Standards Subcommittee, member of the Full Committee, and I have no conflicts.

Debra Strickland: Deb Strickland, I'm a member of the Full Committee, and member of the Standards Subcommittee, and I have no conflicts.

Rich Landen: Good morning, Rich Landen, co-chair, member of the Full Committee, member of the Executive Subcommittee. I have no conflicts.

Denise Chrysler: Good morning, everybody. Denise Chrysler. I work for the University of Michigan School of Public Health, and the Network for Public Health Law. I'm a member of the Full Committee and a member of the Privacy, Confidentiality, and Security Committee, and I have no conflicts.

Jamie Ferguson: Good morning. I'm Jamie Ferguson. I work for Kaiser Permanente. I'm a member of the Full Committee and a member of the Subcommittee on Standards. I have no conflicts.

Valerie Watzlaf: Good morning. I'm Valerie Watzlaf. I'm with University of Pittsburgh faculty. I'm a member of the Full Committee, and I co-chair the Privacy, Confidentiality, and Security Subcommittee, and I have no conflicts.

Wu Xu: Good morning. My name is Wu Xu. I'm a member of the Full Committee, I have no conflict.

Rebecca Hines: Thank you. And are there any members that I have missed?

Moving over to staff. Our lead staff today, Lorraine Doo.

Lorraine Doo: Good morning. Lorraine Doo with the Centers for Medicare and Medicaid Services, Health Informatics and Interoperability Group. And as Rebecca said, lead staff to the Subcommittee on Standards.

Rebecca Hines: And from the Assistant Secretary for Planning and Evaluation, Grace Singson. Good morning.

Grace Singson: Good morning. My name is Grace Singson, and I'm an ORISE fellow with ASPE in the Office of Science and Data Policy.

Rebecca Hines: Thank you. Any other staff? Anyone I missed?

All right, very good. So, I want to especially thank those who will be offering your input and feedback today, both the invited panelists and those who participate in public comment. Note on today's agenda, there is a public comment period scheduled for 2:15 p.m. Eastern, and to be maximally useful, the committee is requesting that comments today be focused on today's topic, which is the proposal from X12 for the updated version of the standard.

Just so you all know when it's time for public comment, we will bring up this slide and review the instructions for you to request an open line. Each participant will have three minutes. Here's the slide with the instructions. We will go over that at 2:15. It is possible, we will do our best to stick with the schedule outlined on the agenda -- if you do plan to participate in public comment, please stay tuned 30 minutes prior to 2:15 p.m. Eastern, just in case. We will also have public comment time tomorrow when we address the other topic.

With that, I am delighted to turn it over to Tammy Banks, the new co-chair on this subcommittee. Welcome, Tammy.

**Opening Remarks/Agenda Review**

Tammy Banks: Thank you, Rebecca. Appreciate it. On behalf of Rich Landen, Denise Love, and myself as co-chairs and the esteemed members of the NCVHS subcommittee on standards, I would like to welcome you to the first day of a two-day hearing to gain your input on two requests. One from X12, the subcommittee received in May of last year, to gain input on updated standard transactions, and another in June from CAQH CORE to review updated and new operating rules for standard transactions for potential adoption under HIPAA and the ACA.

To frame our hearing today, I'm sharing the intent and objectives of HIPAA and ACA, since there's been over 10 years since version 5010 was implemented. Transaction standards

adopted under HIPAA are rules to standardize the electronic exchange of patient-identifiable health-related information, which allows the electronic exchange of information from computer to computer without human involvement. Administrative simplification, part of the Affordable Care Act of 2010, has an overarching goal of streamlining administrative interactions between health plans and providers to improve the patient experience and recue costs throughout the healthcare system.

As Rebecca mentioned, this two-day hearing is to gain feedback on how these proposals meet these objectives, and if they should be moved forward for potential adoption. Today we're focused on the X12 proposal and Denise Love will lead the hearing focused on CAQH CORE proposal tomorrow.

With that, let's review the agenda. Please note that the times in the agenda may fluctuate.

First, we are going to have a presentation from X12 to give an overview of their proposal. Then CMS is going to be providing an update on some new and modified standards under HIPAA that were brought forward. We will then have a presentation from Cathy Sheppard of X12 and Patricia Wijtyk regarding the X12 proposal.

We'll then move to an X12 pilot update on the version of 8020, which will be from Tara Rose at Optum. And as I go through these different panels, the order in which the panel member is listed is the order in which we will give the presentations. So you can be on cue when you'll be the next presenter up.

Panel one is the Designated Standard Maintenance Organizations and code content committees. Terrence Cunningham is going to be presenting the position of the DSMO committee, and some of the other DSMOs, if they prefer, may wish to add comments, and that's from HL7, NCPDP, X12, ADA, NUCC, and NUBC.

Then we'll have a break. After the break, Rob Tennant from WEDI will share the excellent work they have performed to gather additional feedback through their advisory committee report. We'll then move to panel 2, which will be the provider perspectives. The presenters will be Andrea Preisler from the American Hospital Association, then we'll hear from Nancy Spector, the American Medical Association, and then Katie Knapp from the Department of Veterans Affairs.

We'll move on to a health plan perspective, which will be the first panel of health plan perspectives, where we'll be honored with Natalie Chalmers, CMS Medicare Dental program, Ferris Marone, Tennessee Medicaid, and Clay Gaddis from Alabama Medicaid.

We'll have another break, and then we'll have the public comment, and just to echo Rebecca's comments, the agenda may fluctuate, so if you have a public comment, we do want to hear from you. Please be sure to jump on a little bit before or after in case that agenda does change.

Panel 4 will continue the health plan perspectives. We'll hear from Gail Kocher from the Blue Cross Blue Shield Association, Ginny Whitman from the Alliance of Community Health Plans, and then we'll hear from Christol Green from Elevance Health.

Then we have our last and final panel, which will be the vendor and clearinghouse perspectives. Pam Grosze from Cooperative Exchange will be kicking it off. Richard Temps from Chiapas EDI Technologies will come next, Stephanie Fetzer from HCL. Sherry Wilson will provide the property and casualty or workers comp perspective from Jopari Solutions. The Healthcare Business Management Association will be presented by Arthur Roosa.

And then we will have time for the subcommittee to discuss and potentially have some additional questions for the presenters at that time.

And then day 2, again, please come back. Denise Love will be moderating day 2, and it'll be the same format where we will have CAQH CORE give an overview. We will also have the CMS providing additional information in regard to the operating rules, and we will go through the same type of format. I won't go through that today, and Denise will cover that very thoroughly tomorrow morning.

With that, Rebecca, since we have a heavy agenda, if we could just kick it off.

Rebecca Hines: A quick note that Margaret Skurka has joined us by phone, so she needs to read into the record. Good morning, Margaret.

(Pause.)

I don't know what happened. We will need to take care of that sometime. Sorry, Tammy, why don't you go ahead and get started.

Tammy Banks: I will begin with slide 2. They just brought it up a little bit early, but the first slide that he will end up bringing up, which is slide 2 after the cover is just really to thank those of you who previously submitted a response to the request for comments on these topics. These comments have been compiled and have been extremely helpful in our deliberations, and the purpose again of this hearing today is to listen to you, the presenters and members of the public, to gain additional stakeholder positions on these proposed updates. This input, along with all the previously gathered comments, will be used to inform our recommendations to the HHS Secretary regarding the potential adoption of this proposal.

After receipt of the X12 and CAQH proposals, we acted in the following review process for both proposals. We invited and heard an overview of the X12 proposal in August from X12, as well as we heard from CAQH CORE on their proposal in July. The subcommittee collaborated with the Workgroup on Electronic Data Interchange, or commonly known as WEDI, to gather additional stakeholder feedback about these proposals. And WEDI will be discussing their results today and tomorrow, and we really look forward to hearing what those results were, as

well as we really appreciate their collaboration on gaining and making sure there's more avenues to gain input on these proposals.

To allow more options for input, the subcommittee again published that request for comment that I had mentioned that had specific questions that were placed on the NCVH website to assist those providing feedback. We received over 600 comments from all different types of stakeholders, which was very, very encouraging, and that those comments have also been placed on the website if you find these to be of interest.

We also drafted additional questions for the presenters' consideration, as they developed their positions. We really wanted to make sure that we gained well thought-out feedback so we could make a very educated decision in regard to the support of the comments.

Additionally, the subcommittee had and will continue to have consultative conversations with CMS Office of Burden Reduction and Health Informatics, CMS National Standards Group, and the Office of the National Coordinator, or commonly known as ONC, throughout this process, since interoperability is a team effort, and we know we need to work together to meet these interoperability objectives.

The two-day virtual hearing is here. And again, just to reiterate for those who came on the call, today is focused on X12 and tomorrow will be focused on CAQH CORE.

As previously mentioned, NCVHS received the request from X12 in May. Their request was to update the current version of 5010 of the X12 837, which is the professional, institutional, and dental claims that are typically submitted by providers to a payer for services performed with the proposed version 8020. Under the current 5010 of the X12 835 electronic remittent advice, typically sent by a payer to a provider with the payment information, and keep in mind, as I mentioned before, version 5010 of these transactions, they were balloted by X12 in 2003 and adopted under HIPAA in 2009 and implemented in 2010. We were able to celebrate the 10-year anniversary again.

And I know in our previous conversations, we really wanted to move these forward quicker, and that may be another conversation for us to have. All other adoption transactions will remain on 5010, and this letter can also be found on the NCVHS website.

Additional part of the proposal X12 has reported that the updated professional claim had over 1,000 enhancements. The institutional claim has over 1,100, and the dental claim has over 300, and the electronic remittance advice has almost 300 enhancements from the version 5010 currently mandated. So we look forward to hearing how those advances will help improve administrative simplification as we move forward.

On the next slide, this is the last part of the proposal. X12 indicated that each of the X12 implementation guides included in their recommendation has a corresponding XML schema definition that supports the direct representation of the transaction using XML syntax. So the X12 is recommending both the 8020 EDI standard representation, the implementation guide we

use today, and the XML representation be named as permitted syntaxes. Not under discussion today, but X12 also indicated that it intends to provide FHIR Crosswalks for the proposed version 8020 transactions submitted for consideration, timed for inclusion in the federal rulemaking process.

Just to set the stage, I want to provide some background on NCVHS' role and responsibilities to assist the Secretary of HHS when these types of requests are received from a standard development organization, NCVHS is expected to consult with appropriate federal and state agencies and private organizations for the updated standards the subcommittee is gathering input from the healthcare industry, including payers, providers, vendors, and other impacted stakeholders, and the individual designated standards maintenance organizations, which include ADA, HL7, NCPDP, NUBC, NUCC, and X12. I know it's an alphabet soup, but it's all the different designated standard maintenance organizations that make the transaction and code sets to promote interoperability.

After review of all the recent input, NCVHS will make recommendation to the Secretary of HHS as appropriate. The Secretary is not bound by our recommendation, but if chooses to move forward, will publish in the Federal Register any recommendations of NCVHS for the adoption of the standard.

While it sounds simple, healthcare stakeholders' role is to provide input, we recognize it is anything but simple. We appreciate all of you who contributed to the 8020 version of these standards, your time spent compiling the thoughtful comments weighing the pros and cons of these modifications, working with your membership to gain feedback, collaboration with organizations, subject matter experts, and others, gaining the appropriate approvals, and finally, sharing this feedback with the subcommittee, all while balancing multiple priorities. Your response, if you or your organization supports moving forward with X12's proposal to adopt the version 8020 claim and remittance advice standard transactions is extremely valuable to us, and we appreciate all your time and effort to compile this information.

If you or your organization agree there is value and could support the proposal, but there are specific concerns that should be addressed prior to adoption, that information, again, is also very valuable. Or you or your organization do not support the proposal for a specific reason that cannot be addressed and is crucial feedback to the review process. Those three positions, and clarification, really helps us in the deliberation in moving the standard forward.

Today, X12 will describe the request and proposal. We will provide its finding from an industry survey and member advisory session. The panelists we identified during the agenda review will provide input in the order listed on the agenda. Panelists have between 5 and 8 minutes. There will be time available for the subcommittee members to ask questions at the end of the panels. Keep in mind the times on the agenda may shift, depending on if we're running ahead or behind, and we expect the public comment period will take place after the afternoon break. Public commenters will receive three minutes to present their positions and comments and are deeply appreciated.

The subcommittee workplan is to gather the industry input consensus from all stakeholder groups, through all the multiple channels we discussed. This input includes the need for proposed changes, updates, costs, benefits, or other valuable information, how support HIPAA and ACA objectives and other considerations that might include burden on providers, health plan, industry subsegments, relation to other terminologies, vocabularies, code sets, interoperability and downstream health data flows, impact on patient and consumers.

Out of scope for this hearing are any disagreements about contractual relationships between stakeholders and non-HIPAA requirements for use of a specific build or standard transactions.

After the hearing, we optimistically plan to review all the oral and written feedback from the request for comments and hearing testimony and provide a recommendation for approval or at least an update at the next full committee meeting. Pending approval, the recommendation would be finalized and sent to the HHS Secretary for consideration.

You can note the NCVHS website URL to access the meeting calendar agenda, recommendations and responses, work product, and hearing materials. There are also a couple work products that inform the subcommittee's version 2.0 work that you may find informative, and as well you will find the letters we received from X12, CAQH CORE, and also a compilation of the numerous comment letters that we received, for your enjoyment.

With that, if you want to turn it back over, we can begin to kick off the day. I believe our first presenter is going to be Dan Kalwa from the National Standards Group.

**Presentation from CMS regarding process to adopt updated and/or modified standards under HIPAA**

Daniel Kalwa: Good morning. Thank you, Tammy.

It is my intention to review just some of the facts of the matter around how HIPAA standards are adopted from the point of view of the National Standards Group, and hopefully give the committee and anyone listening some food for thought about how this process works from our perspective.

As you can see on the screen, I'm the deputy director of the National Standards Group. We are the group within OBRHI, within CMS, that has been delegated the responsibility to adopt standards and enforce standards under HIPAA. So what that effectively means, particularly for you the committee, is your letters and recommendations end up with us, and then it is our organizational unit's responsibility to consider and respond to both your letter and with any rulemaking activities, should we need to undertake any as part of your recommendations.

Some of the things I want to note for the committee, as you're doing your deliberations and reviewing comments, and also for the industry at large and anyone listening, the HIPAA and the associated updates that came in under the Affordable Care Act actually require the Secretary to adopt what it calls implementation specifications for each transaction, and what that means is

that historically, specific reference guides that are required for each defined transaction under HIPAA, and I've included in this as a sort of cheat sheet the ones that were defined in statute for which the Secretary is required to adopt the standard. But the point I would like to make here is that they are required to be specific for the transaction, and they may not exactly meet the same definition of a standard as NSTO uses it, or as is used elsewhere in the industry. Under HIPAA, the implementation specification is the standard as far as the regulations are concerned. So it's possible for an implementation specification to contain multiple things that might otherwise be considered standards or adoptable under HIPAA.

I think the most clear example of this is in both X12 and NCPDP, there's a whole host of code sets that are adopted in the underlying standards and specifically in the implementation specifications that are not directly adopted under HIPAA and don't need to be, because they're in the implementation specification.

One of the things that implementation specifications may or may not include are also operating rules. So there's some overlap here, and I intend to go through it a little bit more in depth during my discussion tomorrow, but I just wanted to note that there can and often is overlap between the implementation specifications that are adopted as a standard for a transaction and the operating rules. I think most are probably aware of the very different approaches between NCPDP and X12 in this regard. So the operating rules only become necessary to the extent that the implementation specifications don't cover the business rules that are needed to actually use the transaction.

As I already mentioned, the recommendations and any consideration and work for proposed rules or rules changes would come to the National Standards Group, and we would be responsible for completing that process. As we make our determinations, one of the things we always have to consider, and I would consider the public and the committee to also consider, is that under the statute, the objective is to reduce administrative costs of providing and paying for healthcare. So despite any other admirable and desired outcomes, that is the first question we are always required to answer. How does this move towards the objective to reduce the administrative costs of providing and paying for healthcare?

I believe Tammy already mentioned this, but the Secretary and therefore NSG is required to rely on the recommendations of NCVHS, but if you all recall perhaps geometry class, maybe a logic class, even though these recommendations are necessary for our work, they're not necessarily sufficient in that the National Standards Group is also required to comply with all other statutes around the adoptions of regulations, particularly things like the Administrative Procedures Act and other statutes that came later, that issue guidance and requirements on how one defines return on investment and costs to the industry and opportunity cost. So that is one of the primary, often overlooked, concerns that the National Standards Group within OBRHI is responsible for should the industry not be able to provide it.

I also want to note, and thank you to the committee and NCVHS at large, for working with us to get some of those questions out to the public. One of the reasons you're seeing changes to

some of these questions is very specifically because we're asking for this information as far in advance as possible.

I want to mention one possible way to get that information. Under HIPAA, when there's always a standard adopted, and there's a proposal to do a new version of that standard, it is referred as a modification to that standard, and there are certain rules and requirements around that. But one of the things you can do when contemplating -- and anyone in industry can theoretically do this -- when contemplating a modification such as the proposed updates to the new version under X12, is to conduct an exception for testing.

I know it's somewhat misunderstood, but there is a baked in under-HIPAA process that contemplates testing all of these standards before or perhaps during the time period where it's being considered for adoption. The important thing to keep in mind is that the expectation for this process is that the exception is necessary because the testers will be using live data and using them in lieu of the HIPAA-required transactions. So the purpose of the exception is merely to have everyone sign on voluntarily so that we as the enforcer and policy creators know and understand that for these specific entities, we've issued them an exception so that we will not be enforcing the compliance requirements. The purpose here is to test the standards and deliver to the Secretary an eventual public report on how that process went.

So if you're interested in looking at that, there's more information in regulation as well as some go-to guidance that we released, I believe it was two years ago now. But I would encourage the industry and the committee to consider that process and consider looking at that process as a way to support collecting the information that the Secretary, CMS, and therefore NSG, will need in order to fully answer all the questions we have to answer regarding a modification to a standard.

I believe I've already covered some of this, but one of the reasons testing and collection of data, even if you're not doing testing, is because when we're doing modifications to standards, we're not comparing it internally to no standard. We're comparing it to what exists as is. So you can imagine, I think, that the considerations become far more complex, because there's already existing infrastructure, there's already been some efficiencies, if it's an existing standard that's already in use, there's already been some efficiencies attained. So we have to understand and be able to relate to the public why is this modification and all the costs, the training, the software development that goes to it, why is this a good thing to spend time on, and what do we gain by doing it?

That is the exception process, as it's called under HIPAA, is one way of doing that, but that is the primary reason why we've been asking NCVHS to start collecting, to the extent that it already exists in the industry, this sort of data. Anything that you can share with regard to return on investment, opportunity cost, implementation cost, in particular training costs, is useful in making a determination.

Some final points, and I may add one or two on here that aren't originally on here. But one thing I wanted to note, I think Tammy already noted, that the proposal is to move forward with

just updating the 837 and the 835. I'm sure those who have been around awhile noted that historically we've been adopting it in batches, that is, the entire transaction set of a new version, at once. I ask should this be true going forward. It appears that some have already been thinking about this, but I wanted to note that there's a no requirement under HIPAA that it has to be adopted in batches. We're going to rely on the industry to instruct us on what is the best approach, at least as far as whether that be some sort of rolling updates or sets of updates, and in what order, and what that should look like.

I also wanted to note that under HIPAA we often use the word standards to mean different things, but what will generally have to happen under HIPAA is that there will not be multiple implementation specifications for the same transaction that do the same thing. So the goal here would be to have one implementation specification for each transaction, but I will note that we do have authority to adopt different implementation specifications for different provider types or perhaps specialties. So that is why you will see, for example, one specification for most things except for the 837, which obviously has three different types for three different types of providers.

I also wanted to note that the timing and any overlap would also be of concern to us, and we would ask that the industry consider and give us advice and guidance on that topic, particularly any requirements for overlap due to claim submission timelines, for example, when would those cutoffs be, what should they look like, and how long should an implementation take?

I'll note for modifications, we have significantly -- we have a relatively more significant leeway in that we cannot require adoption at less than 180 days from the rule going final, but we can and will listen to industry about how much longer than that 180 days an implementation should take.

As we talk about the costs and the updates, I just wanted to note that as we talk about multiple standards and multiple transports and different versions, I believe it's a rather hot topic for the industry and may even come up here, but one of the things we should note is that health plans, under HIPAA, are required to support every transaction that is proposed. So if there are sets, even if they're not widely used, that health plan is still required as a current entity under HIPAA to be able to support that. So that means there are transaction costs and implementation costs regardless of whether they're widely used. It should be noted and considered when making proposals.

Finally, this was not on my slide, but I wanted to note that when we adopt implementation specifications, we expect, and it's normal, for the code sets included in those implementation specifications to be updated. In some cases, they're updated outside of the requirement to adopt a new modification to a standard, but I just wanted to note, particularly with the ERA, if it is proposed, it would not alter the requirements to comply with other HIPAA transaction standards and particularly our requirements around EFT. So merely updating the ERA with additional code sets to support certain technologies would not alter or obviate the health plans' requirements to comply with any standards adopted elsewhere under HIPAA. So it's my understanding that that is of some concern to the industry, so I wanted to mention that.

If you have any questions or are interested in exception, I would encourage the industry or anyone in the public to send questions to the email here, and if you're specifically interested in an exception, we have a separate mailbox for that process. I know running a test itself can be very complicated, but I assure you the exception process is, from our point of view, not terribly complicated so long as we can work together and ensure you have all of the regulatory requirements met when we review the proposal.

With that, I'll turn it back over to Tammy. Thank you.

Tammy Banks: Thank you, Dan. You are extremely clear, and I really appreciate your informative overview of what we should be looking at as we move forward and what the feedback is that we need from the stakeholder.

So with that, I just want to ask if anybody has any questions from the committee. But while we wait, one question came up, why do you feel that multiple standards for a single transaction cannot be supported?

Daniel Kalwa: The point I was trying to make, Tammy, was not that multiple standards cannot be supported, but that the structure of HIPAA does not use standard quite the same way that the industry does. So within an implementation specification, which is the standard that HIPAA adopts, there could be multiple standards, but there wouldn't necessarily be multiple implementation specifications. So when HIPAA says standard, it means that guide that could include everything.

I'll refer to NCPDP, because they put everything in one, essentially one document. Right? So they don't need operating rules because all their business rules are in there. They don't need to talk about transport technology or security, because that is all in there. But all those things are standards, strictly speaking. So the internet transport is a standard, the data elements and the structure is a standard, but under HIPAA the standard is the implementation specification. The guidebook of how to use the transaction, plus anything that is necessary for operating rules -- that is the standard, regardless of what other technical standards are actually included in the implementation specification.

I think we often -- I'll say we sometimes get our wires crossed because we use the word, but we don't mean it exactly the same way. For the committee, I would encourage you to keep that in mind as you propose things. There may be multiple standards, there may be multiple ways to transmit, there may be multiple structures for the data inside an implementation specification, but it wouldn't -- it's not impossible, but you wouldn't necessarily have multiple separate implementation specifications, because that would necessitate separate operating rules and separate modification paths. Under HIPAA, the expectation is one.

Tammy Banks: Anybody have any additional questions for Dan? Or request additional clarifications?

Denise Love: Dan, thank you. Every time I hear you speak I learn a little more. So I appreciate your presentation. Just clarify a little bit on the flexibility for implementation on the timelines of how much flexibility the standards group has for the process of rulemaking. If those can be adjusted, say, from the typical dates like January 1, or the shortened or lengthened timelines. Can you speak to just that process?

Daniel Kalwa: Sure. To clarify, what I was referring to, if I recall correctly, when 5010 was adopted, there was a period where both standards could be used because of the date of submission of claims. And after a certain date, there was a requirement that the claims had to be on the new standard, but the date of service for claims, if I'm recalling correctly. What I was trying to get to was because of the complexity of moving to a new version when one already exists, there is significant flexibility there, depending upon what the best approach is. Is there some period of time that the committee would recommend that both standards be used? I believe, if I recall correctly, that's how it worked in the switchover to 5010. But is that appropriate for both, for neither? How does that work?

And then also, I presume the industry would need direction and guidance on how to integrate that with the older versions, and when and how that would work. So there is no requirement from our point of view that it has to be a particular timeline or a particular overlap. Does that answer your question?

Denise Love: Yeah, that helps. Thank you.

Tammy Banks: Just to add clarity, with the transition to a new standard, there will be two different versions of the standard in play for a certain set of time, and that timeline may be different for a small or large plan, and there also will continue to be multiple versions, because some of the non-HIPAA entities may use a different version. We know workers comp is using 5010. If we move to a different version, those two versions will still be in play. So I think, Dan, what you were doing is just trying to help us view this moving forward in regards to thinking about multiple versions in any other different way. Am I correct?

Daniel Kalwa: Absolutely, and any recommendations that the committee has or recommendations from the industry on what a possible transition would look like would be greatly appreciated.

Tammy Banks: Thank you. Anybody else have comments for Dan or questions or clarifications? Going once, going twice. Dan, I have to echo again, you're always informative, always appreciated, and I hope you'll stay on so you can be a resource moving forward. Thanks, Dan.

Daniel Kalwa: Absolutely. Thank you.

Tammy Banks: Now let's move it over to Cathy Sheppard with X12 and Patricia Wijtyk.

**Presentations from X12 regarding the updated transactions**

Cathy Sheppard: Good morning, everybody. Thank you for having us here today. We can skip to slide 4.

So, there's not time today for me to talk about all my favorite subjects in this regard. We could stay here for a week. But I want to put together some things to help explain where we are, what we're doing, and what we're asking for during this presentation. So let's start from where we began. In 2021, we conducted a survey. It was open to everybody. Approximately 25 percent of the people who responded were not X12 members, and we had responses from implementers, other kinds of trading partners, vendors, clearinghouses, VANs, and consultants.

We asked questions in this survey about what the industry thought about the transactions moving forward, about whether they're important in their business functions today. We're not trying to provide information on all of those, but 85 percent reported that their healthcare claim transactions are an important component of their EDI systems, and 87 percent reported the same for X12's 835 implementation guide.

Trying to adjust to what Dan said about standards and implementation guides as we go.

Seventy-five percent of the people who responded indicated support for moving the newer versions forward for adoption, and 16 percent said they had no opinion, neither way. So only 9 percent were opposed to moving forward, and some of those indicated that that's because they were perfectly satisfied with the transaction functionality that was in place.

Sixty-six percent indicated that they would benefit from new or enhanced functionality that they already know about in the latest versions. Twenty-seven percent said they didn't know anything about any of the enhancements that would be available in a new version of the standard.

We also asked about support for alternate syntaxes in this survey. We asked in particular if people wanted to use FHIR, JSON, XML, or other types of additional syntaxes as part of moving forward to a new standard. So for this question, 16 percent were completely opposed to allowing any alternate syntaxes. They wanted to keep just one syntax, just one version. Forty percent were supportive of an alternative syntax is X12 verifies that the alternative syntax supports the same data content. Rightly, we received a lot of comments indicating that if the alternate syntax doesn't have the same data content, that's in effect making interoperability impossible, between these syntaxes.

Twenty-seven percent were supportive of alternate syntaxes, and they were okay with any ANSI national standards developer verifying that the alternative syntax supports the same data content. So two flavors of who should say the alternate syntax meets the data requirements were explored by the people who completed the survey.

With the survey in mind, we went back to thinking about how we're going to interact with the federal rulemaking process. We worked closely with Dan and his team, with Chris before, to make sure that we understand where we plug in and how this is going. I think no one here will

be surprised that the federal rulemaking process is in the critical path for anybody who is recommending adoption of new versions or new standards, and it's very lengthy, based on the number of steps in the process, requirements for public comments, listening to them, reviewing them, providing responses, and giving implementers an appropriate amount of time to transition to a new version.

The other thing about the federal rulemaking process is it doesn't always operate at an expected cadence. So we can't feed something into the federal rulemaking process and know exactly when the sausage is going to come out the other end.

We publish our standards annually now, which is a big change from when we put forward the 5010 standards, and some of our enhancements in each version are functionality. In other words, things that can't be accomplished with the instructions that are in the previous versions, and a lot of the things that we put into our annual publications are housekeeping. When we're trying to improve consistency and wording or consistency in notes and other kinds of instructions, where we improve our grammar when necessary. A lot of people are really invested in the Oxford commas being exactly correct. So we consider those housekeeping revisions to be of less impact to the industry, because you don't always need to make a change to your application systems that use the X12 transaction if we make one of those housekeeping changes, for example. If we've forgotten an Oxford comma in a situational rule, us adding that grammar does not mean any implementer has to make any change at all.

We also publish supplemental information that assists implementers, and we have numerous kinds of that supplemental information, depending on the transaction set and the different stakeholders that are invested in that functionality.

The two things that we just said where the federal process is lengthy and not always operating at an expected cadence and the fact that X12 now does operate on an expected cadence leaves a big chasm between what the evolving needs of the implementers are and how those get reflected in X12's current standards and then how they get to be allowed or required according to federal rulemaking.

So we have to find a way to balance the timing a little better than we have in the past. I don't think anybody is using the same version of an operating system on their phone as they were 10 years ago or 15 years ago. So some degree of moving forward has to be available so that people can take advantage of changes in the healthcare vertical and also in how people talk to each other in electronic transactions.

So given the timing situation, X12 put our thinking caps on, and we tried to think this time of some different ways that we could approach what we ask for that would allow graceful movement through the federal processes, including these NCVHS preprocesses, and we think that we came up with an idea that works for everyone, and this is the going to be the first time that we've proposed this officially going forward.

So we have a new approach, and it allows the lengthy federal process to get started as soon as possible. It allows healthcare implementers and X12 time to verify or prove out the functionality that we believe we've included and to increase the amount of helpful supporting information that we provide to our implementers.

So we proposed 8020 versions of the four transactions that we're asking to move forward in this group, and what we're suggesting is if the NCVHS recommends these 8020 versions for adoption, we would like Health and Human Services to base the initial steps of the federal rulemaking process on those 8020 versions. We know that just the process of getting ready to start a federal rulemaking process is also controlled by a strict calendar. So there will be time gaps between any NCVHS recommendation and the actual beginning of the federal rulemaking process.

As the recommendations work their way through the federal processes, X12 is going to be working in the background and we expect that many of the organizations represented here today will also be working in the background during that period. So what we will definitely have going is X12 for the first time has gathered enough support for a pilot, which we lovingly call our proof of concept, and we will be executing that proof of concept pilot -- we're executing it now. It's in play. I'm not going to steal Tara's thunder by talking much about it right now, but we are going to continue this proof of concept pilot and we expect that other stakeholders who begin to review the 8020 version in detail will also come up with helpful and clarifying suggestions for improvements to the wording or improvements for other kinds of clarity that will help when this does become a mandate and people need to move forward on a fairly smooth glide path.

We will make the results of this pilot and the stakeholder feedback as the basis of new releases. Remember, now X12 is once a year, as opposed to on a less regular schedule, which means that each annual release has a smaller set of updates that people can more easily define and assign value or assign difficulty levels to as we move forward.

When HHS is ready to issue a notice of proposed rulemaking or the NPRM, we would recommend that we convert to the most recently published version of the implementation guide instead of naming 8020. If it takes -- let's say, best case it takes two to three years to move through the process, X12 will already have published five new versions by the time we're ready for the NPRM. The NPRM is the official place for the public to comment. So people will not have lost value as they move -- if the NPRM names the latest version at the time of the publication.

To repeat, putting the NPRM and the final rule at the most recent version posted means that all the solutions for things identified during the pilot or during stakeholder initial reviews would be included in what is put out for comment during the NPRM. It would allow us to reword or clarify instructions and do some of those housekeeping things that I talked about a few minutes ago. It also gives us time to ensure that there are consistent instructions within and between implementation guides.

And finally, it allows us to add more supporting information which we know the industry is wanting, and that will include crosswalks linking X12 data elements to FHIR resources, which we've already started that process and made that kind of crosswalking information available in our 278 transactions, but we will be adding those crosswalks with the joint effort from HL7 da Vinci project teams and perhaps other HL7 teams as we move forward.

We also want to use this time to make sure that we reference CORE's operating rules as appropriate in the guides that we move forward for a mandate.

To facilitate this, we are committed to providing a list of the revisions that are applied to versions past 8020 at the time of the NPRM and we will suggest that references to that change log be included in the NPRM so that it's easy for people who want to comment or review based on the NPRM itself to find out what the differences are between a version they may have used to scope out the work within their own organizations and the version that does get named in the NPRM.

This alternate approach seems to offer a win for very different groups, but it does seem to offer a win for everybody in that we will be able to move forward the most current version, which includes all the enhancements that the industry has asked for before the NPRM starts, and then we do understand that after we put something out in an NPRM, if we changed the version or made any significant functionality changes, that would trigger a discussion at least in NSG about whether there need to be a new NPRM. So we are not recommending any changes to versions between the NPRM and the final rule, just between this pre-period that we're talking about now and the NPRM that gets published.

So how are we going to move forward in this recommendation plan? As most of you have heard in various venues, X12 is putting out a phased approach based on input from both federal groups, divisions, organizations, and feedback from our stakeholders themselves, that a phased approach is the easiest when considering the other kinds of mandates that are being put on this same audience in different regards. They have requirements coming from different programs and they need to all be worked in. Separating these transaction sets into phased approaches also means that we can spread the cost out over a greater period of time for implementers, and it gives us more time to ensure that we give the exact functionality requirements that people need to move forward.

So each of our phases will be a group of logically related transactions. You can see in this first group it's the claims and the remittances that are associated with those claims. We're moving that forward as a set. However, to speak to something Dan said earlier and that I think all of us who have worked in the industry for an extended period of time understand, the logically related transactions don't preclude operating with different versions for logically related transactions. The phases will allow to say let's do these two things together because they have similar changes. We may put another set together where the enhancements are very limited, and that group could be processed in a much shorter time than some of the more robust transactions would require.

So we will have supporting information for each of these recommendations that we move forward, and the timing of moving them forward depends on several factors: approval of the necessary maintenance on the X12 side, a good description of the functionality enhancements, and the ability to make sure that those functionality enhancements are an outcome of the changes that we make, and the availability of the supporting information.

We also understand that the NSG group may decide that they want to break apart things in different ways or group them back in different ways. Having different recommendations allows them more flexibility as they put their workload and their planned activities into their calendar.

We believe in X12 and everybody on this call has surely heard us say this over the last five to seven years repeatedly, we believe that implementers should be able to exchange consistently defined data using the syntax that best meets their needs. In support of that position, as you heard Tammy say earlier, we're recommending that the rules name both the X12 EDI standard representation and the associated XML representation in the same NPRM. We have a great amount of anecdotal evidence that people in the healthcare industry and organizations in the healthcare industry were wanting to use X12's schema XML patterns that are generated to match our implementation guides, but we were unable to get a strong statement that that would meet the compliance requirement. So we're hoping that we can build that in to start with now so that people can use the syntax that they desire but know that the data content is the same, because that is at the end of the day the only thing that allows interoperability.

So our first set of recommendations that we sent over at the end of May, beginning of June, cover transactions that are already mandated. Some of our recommendations will cover transactions that aren't mandated at this time, but this first set is a straight move forward. So as everyone knows, we're considering asking for consideration of our healthcare claim transactions, professional, institutional, and dental, and also for the healthcare claim payment advice transaction.

So each of the implementation guides has a corresponding XML that I spoke to on the last slide and that you heard about earlier. Those XML syntax XSDs are mechanically produced from the same metadata. So there's not discrepancies between what we put forward in the EDI standard format and what we would put forward in an XSD. So they can't be different, because they're based on the same metadata. We know that's important to the industry and also to the regulators. So we wanted to call that out one more time to say that these XML XSDs are exactly matched to the underlying implementation guide instructions.

Per the HIPAA regulations, we informed the other organizations named as DSMOs of our recommendations in June and we asked the organizations to review the recommended implementation guides, to consult with us if necessary to -- if they needed some other information or some clarifications as part of their review, and to provide feedback on the enhancements.

We did not receive any questions, suggestions, or feedback from the DSMOs in advance of this hearing. So we are expecting that there may be some, but at this moment, we haven't seen it yet. So we can't speak to any of that input at today's meeting.

So let's talk about the functional enhancements. The recommended implementation guides have a great number of enhancements, some of which definitely include claims and remittance processing, and let's talk about some of those. We know that there's been a strong call for device identifiers, especially from our lawmakers in Washington, D.C. This information improves the ability for the healthcare industry to identify risks, reach patients affected by device failures, improve patient outcomes, reducing health risks and enhancing the tracking and reporting. All of that taken together is expected to save taxpayer funds as they implement things and to provide safer and more robust healthcare services, as well.

We have added support for factoring agents which improves a provider's access to short-term capital. We have heard from many providers saying that that's a critical tool in the healthcare environment today and factoring agent information is a great enhancement that gives providers flexibility. We've changed to support longer claim identifiers. This will improve tracking, auditing, and matching functionality through a claim's entire lifecycle as it flows through the different trading partners and stakeholders.

We've added functionality that reduces manual processing for recoupment and other efficiencies and cost savings for both providers and payers.

We have added support for more detailed payment codes in remittances, which will improve a provider's understanding of how claims are adjudicated by payers, reduces the number of phone calls and other individual inquiries, which we all know increases processing costs for all parties. So those efficiencies will be available in the version that we move forward.

We also clarified ambiguities with additional instructions and clearer wording to help reduce inconsistencies and friction and misunderstanding between trading partners. We intend to continue to refine those instructions in nonsubstantial ways in each version as we get more feedback from the industry as to how we can state things more clearly or more efficiently.

So, anybody who has reviewed our recommendations letters knows that there's a big list of individual enhancements as appendices to the letter, which those are available on our website and on some other websites as well, including NCVHS's. That detailed information can be researched at X12 at the URL that's shown on your screen. You can also navigate to that page from our landing page when you go to X12.org.

So those details are available. I do want to make clear that the number of enhancements that are listed in our difference reporting systems, they're on the website and available. They are not all substantive or program related in the programming for IT. Some of those are just housekeeping. We've added more consistency to the wording in situational rules or we had spelling errors that we corrected them. So when you look at the difference lists that are included on our website, you'll be able to filter by your correct level. We've done some

preliminary filtering that says this set of instructions in the difference log is of interest to business analysts in particular, and this group of these differences are of particular interest to a programmer who might not need to understand the business requirements behind it, and we have outlined those kind of housekeeping revisions separately so that you can filter them out and review the more meaningful changes without what some might consider noise of grammar, spelling, and those types of housekeeping cleanups.

So hopefully splitting that out will help in each organization's review of the enhancements that need to be accommodated during this move to a new version.

There are two items that X12 does want to take the time to clarify today, and one of them is that there is an error on the enhancement list that we put out for our institutional 837 implementation guide. There were some misunderstandings as information passed up the organizational hierarchy. So item 14 on the list, which indicates that there's an increased number of prior authorization and referrals at the line level, is one of those things that we will have completed before we move forward with the version at the NPRM time. So we apologize for including something that wasn't actually implemented yet. We have noted it, and we will make sure that that enhancement, which the industry has asked for repeatedly and will find valuable, that will be in play before we would move to an NPRM step in the federal rulemaking process.

We also have been asked to clarify by a number of individual providers and other organizations one of the enhancements listed on our 835 list. That's item 3, which is listed in our appendix as the ability to report remittance information related to card payments, key cards, debit cards, and credit cards, to facilitate auto-posting. There has been concern about the addition of this functionality, how it was vetted and what its impact is on providers. So we wanted to clarify to the best of our ability today.

So, X12 adds and revises functionality based on business needs submitted from various stakeholders. This is true across the board for all the enhancements that we put in that are functional improvements or new functionality. When data is going to be exchanged as part of an enhancement, in certain cases but not universally, we define something that we call a situational rule that sets up the circumstances for when sending the information is appropriate. So support for card payments was added based on a significant amount of industry requests that reflect what is happening today, what is already in use in the healthcare industry. So the request was for us to provide a consistent way to do something that is done inconsistently today.

What happened after that was that X12 conducted a great number of open discussions, some of them would be discussions in a loose manner, because there were strong opinions on both sides. We took in input for several years as part of this enhancement, because there was a great deal of difference of opinion.

But in the end, the group came together and decided that inclusion of the card payment but not requirement of the card payment was the best option for the healthcare industry. We ran

this improvement or this maintenance through our normal approval using our ANSI-accredited consensus-based process, and that availability of the function was moved forward and does exist in the 835 implementation guide instructions that we're asking to be reviewed as part of this activity.

The X332, which is the implementation guide that has the instructions for the remittance advice, does not mandate the exchange of these virtual credit card payments. It only permits them.

So why did we want to have the functionality explained in the guides and available? Well, besides the fact that we know people are actually doing this already, we want to include functionality, including these virtual credit card payments, in a way that ensures consistency so that organizations who are doing those workarounds and other inconsistent solutions to exchanging the data that they find necessary in their business operations, we want to make that consistent so that all payers and providers know how they're going to see that information and what it means when they do see it.

Discussions that have been in play about this functionality that relate to fees or other impacts between a particular payer and a particular provider or set of providers, that's outside the scope of X12's responsibility. Our job in this process and in the healthcare arena, is to provide consistent instructions related to exchanging information between industry stakeholders, not to provide instructions to put new mandates on every trading partner agreement that may be in play.

The next thing I wanted to talk just briefly about this morning is estimated costs. You heard Tammy say something about it; Dan talked about it.

X12 has put forward some high-level cost estimates to be used in consideration, but those cost estimates are mainly to give the National Standards Group a starting place. X12 can't provide the detailed level estimates across the board at this point. We are -- part of the reason that we established our pilot, though, is that we're going -- we are tracking level of effort and other kinds of costs as part of that pilot. That information will also be available to NSG when it's time for them to develop the cost estimates and the cost benefit estimates that they need to move something forward in the federal rulemaking process.

So we're kickstarting this, so to speak, and we have given a reasonable and we believe consistently applied set of considerations to decide how much each cost -- each of the differences costs by category. So, earlier you heard me say that a number of our enhancements are housekeeping. They're correcting a spelling or other kinds of consistency. Those cost estimates are very small compared to the cost estimate associated with adding factoring agents or adding the DI portion of the UDI. So we've ranked the differences as the starting place for NSG's analysis. We will continue to provide information out of our pilot or to share information that our stakeholders share with X12 at various X12 discussion forums.

So, I think I talked fast enough. Maybe I talked too fast. But we wanted to share this information today and give everybody a chance to start processing, that the hope that we can move forward in a different way that will allow more timely meeting of industry needs.

Again, you can go to our informational webpage to get more information on the difference summaries and other details. We'll be keeping this page updated as the processes play out across the federal processes and individual processes.

You can submit questions and suggestions related to the recommendations themselves on our online feedback form, but the online feedback form is not the appropriate forum for asking about functionality. So if you have questions about the instructions in the 820 guides that we're asking the industry to start reviewing in detail, those can be submitted to X12 on our request for information form, because those need to go to our data content and process experts, not to the people who put together the recommendations.

So there are two paths. If you submit to the wrong one, we will funnel your information where it needs to go but remember that questions or suggestions about the recommendations themselves go on our online feedback form and questions about the instructions should be submitted on our request for information form. You can find both of those forms on the main -- from the main landing page.

The last thing that I'll say today is that we encourage everyone who is on this call and also the people that you speak to and talk to, we would like people to get their information direct from the source when possible. We don't want to play the telephone game where I said to person 2 who said to person 4 who said to person 8, and by the time you get to person 300, the answer is nothing like it was when it started. So we ask if you do have questions or concerns that you speak to the source, and we will try to make those kind of questions available to all other implementers by updating our page so that information that we get questions about is clarified for everyone.

And I think that is all I have to say today.

Tammy Banks: Thank you, Cathy. Cathy, I know we're running past time, but we do have a couple of questions that I'd like to share with you, and then we'll move on to Tara where she can discuss the pilot, if that's acceptable.

I think the major question that we're asking, and we have a lot of flavors of this question, is what is the impact of only updating selected standard -- transactions to the 82 version? To give you an example, questions that came up as how do you envision the 835 and different versions, working in a COB situation during the implementation phase, and backward capability and other questions in that regard. Is that anything that you can address?

Cathy Sheppard: Well, I can try not to steal Tara's thunder too much, but that, using different versions of different transactions in the workflow, so to speak, where we start from the

beginning of enrollment and end at the either claim status or claim payment, we are executing that kind of testing in our pilot. So Tara can talk a little bit more about that.

We have begun cross-version testing in that pilot, but we have a lot more that we still need to do. We believe that we will be able to move between versions without sacrificing accuracy for a transition period of time, and we'll have those outcomes and those findings available for everyone to consider as we move forward.

Tammy Banks: Terrific, and so I'll hold any of those other questions until after Tara, in case they're not answered. But the other big question is can the X12 version 8020 support post-coordinated coding in or with ICD-11?

Cathy Sheppard: I am going to say yes. Just don't ask me to give you the technical solution off the top of my head. I cannot tell you the details of that, but, yes, we believe that we have forward proofed, if that's a word, the instructions in these versions.

And again, as things solidify in other areas that impact these EDI messages, switching over to the latest version at the time of the NPRM gives us a lot of opportunities to make sure that emerging functions are included, because we know that this process, it can't be done every year. That's not tenable for the industry. So when we have a chance to move forward, we need to move as much functionality forward as we possibly can.

Tammy Banks: What I am going to do is take two questions, Denise and Rich each have a question, and then we'll go through Tara's slide and then revisit questions as well, and maybe shorten the break, because this is just really important information and we appreciate you responding to these.

Denise?

Denise Love: Don't kick me, because this question may have a long answer, and we may not have time for it. Cathy, thank you for this. The next version, the 8040, any sneak preview what might be in the pipe that you have not mentioned, or is it too soon for you to respond to that?

Cathy Sheppard: I am unprepared to respond to that today, but we can certainly write a high-level summary and put it out on our -- the page where we have information about the recommendations process, and that's a good idea. We can keep those general -- the general benefits, we probably won't go into this code change and this loop change, but the general functionality improvements or changes, we can definitely move those forward. For some transactions, I don't want to speak to these four specifically right now, but for some transactions, moving forward is just a matter of changing the identifiers, kind of just updating to the next software so to speak, if you were on your phone, where Apple says it's time to update to the next version. So some of them are very basic moving forward, and others have functionality. So I will -- I wrote that down, and we'll get something summarized for 8030 and 8040.

Rich Landen: Cathy, I want to follow up on the ICD-11 answer. Can you or someone get back to us with some more detail about how the ICD-11 coding would work in the 8020 version? I'm not seeing that in the implementation guide, but I'm not an expert. So I would appreciate a little bit more detail, because at least in my thinking about the process for ICD-11, which I want to say there is no recommendation to adopt it yet, but given the long lead times for adopting updated versions, I want to make sure whether or not ICD-11, both in general and as the question was phrased specifically, the post-coordination coding, is accommodated in the 8020 and how that would work. So if you could get back to us with a little bit more detail on that, I think that's critical.

Cathy Sheppard: We absolutely can.

Tammy Banks: With that, Cathy, if you can hang ten, we'll move over to Tara and then gather up any additional questions if that works.

Cathy Sheppard: That sounds great. Thank you.

Tammy Banks: Tara?

**X12 Pilot Update on use of version 8020**

Tara Rose: First, hello, everyone. This is my first time presenting to NCVHS, so I wanted to take a moment to introduce myself. My name is Tara Rose, and I am the X12N Insurance Subcommittee Chair, and a capability manager at Optum working on the Optum transaction validation team. I'm excited to be here today to provide additional details about the X12 proof of concept pilot and a high-level overview of why Optum is excited to participate in the pilot and how Optum will execute the pilot plan for testing the recommended transactions.

So, what is the X12 POC pilot? The X12 proof of concept POC pilot, it was created to verify the expected business benefits of the new versions while better understanding the transition cost. The pilot is focused on showing that the benefits of the versions and transactions are not only achievable but to help identify also any unforeseen obstacles and adjust the plans accordingly.

It's also to establish a baseline of expected implementation cost, and we will be working directly with X12 to report those, as well as the other stakeholders. The participants do include clearinghouses, software vendors, payers, and providers. There are currently about 12 to 15 active stakeholder organizations involved. X12 did assemble these participants across the industry stakeholders to ensure the handoffs and touchpoints are verified as well as the function enhancements.

Each of the pilot participants is willing to work in cooperation with others for the greater good of the industry. We are all enthusiastically determined to smooth the implementation highway for the rest of the stakeholders, because it will reduce costs and increase implementation successes across the industry, which improves patient care and outcomes.

The pilot gives us the opportunity to verify the impact, all benefits, opportunities, and potential costs, to upgrade from the current versions to the proposed future versions. It also allows us to understand the intentions and implications of changes between the current HIPAA 5010 mandated transactions and the proposed new versions of 80next. Opportunities to collaborate with trading partners, service and software vendors from the inside. In this collaborative workspace, we can share our findings without violating independent stakeholder intellectual property, share successes and obstacles, and provide valuable feedback to X12 on the recommended transactions.

We also receive early access to the new X12 standards, derivatives, and related content, participants are provided with early access to the EDI standards and derivatives to ensure that instructions are clear and concise so implementation is easier for other stakeholders within the industry.

So, let's talk about the testing approach. The testing approach includes end-to-end testing of deidentified real scenarios and synthetically generated test data. Testing includes testing the X12 standard validation, the implementation guide validation, balancing and inter-segment validation, code set validation, and cross-version compatibility, which we were talking about just moments ago.

The participants are also provided with the artifacts, resources, and insights needed to participate in the pilot. We are provided with additional and any resources for the online implementation guides, which is in Glass, the X12's online viewer, of those guides, and the different summaries which can be located out on X12.org under the recommendations to NCVHS.

We also receive the table data and the XML schema definitions for loading and for testing, and we also receive test data and files, which is provided by X12, and we all have the same data.

Switching hats, from an Optum perspective, Optum saw the POC pilot participation as a great opportunity to implement the recommended versions early and provide fact-based feedback on the transactions to X12 and other participating partners. Additional reasons for Optum's decision to participate are it gives us the ability to develop early and have more time for analysis and implementation. The participation will allow the teams to report time spent on development, testing, implementation, which will give us all insight to potential costs of implementing the 80next transactions. It provides an inside look at what a timeline can be for the other transactions as well. It provides an opportunity for Optum to train our resources before a mandate is near coming. So we're prepared to implement anything that is mandated.

X12 is also going to acknowledge participants in marketing materials. This gives Optum the opportunity to early market to customers when Optum is ready so that we can say we were early adopters of the new 80next transactions. And again, early adopters do receive early access to all the X12 resources without additional costs. That includes Glass licenses that we have, the table data that we do download and that we use for editing purposes.

Optum did start the process of implementing the recommended versions in November 2022 after leadership approval. Optum is utilizing an agile based process for implementing these recommended versions.

Optum's plan to implement is we start with the gap analysis and the HIPAA edit analysis, which includes the import of the table data. We're doing them in sequential order. So we have started the analysis of the 837 P, and when that is complete we will move that to development and testing and then the BA work will continue for the institutional 837, dental 837, and then onto the 835 remittance advice.

Some of the steps that we're taking, and this is some and not limited to just these, is we have to do the gap analysis between 5010 and 8020, and the edit review to determine which HIPAA edits need to be changed or updated to meet the 80next needs. We will import the table data and create the databases associated with that data. Then it will move into development and QA testing.

We will review all output with X12, including hours and level of effort from a BA perspective, a development perspective, a QA perspective, so that we can report the true level of effort that it took for Optum to complete implementation of these first set of recommended standards.

And then we will implement these transactions into the OTVM system, which is the Optum transaction validation manager, and then Optum transaction integrity, which is OTI, which is formally known as Clarity, and that is part of our testing system and also transformation systems.

We are currently in the full throes of the gap analysis and HIPAA edit analysis and the loading of the table data for the 837 Professional, and we will report back to X12 the time that it took to complete the professional as we move into the institutional.

I know I went quick. So I hope I didn't leave anything out. I will open it up to questions for both Cathy and myself.

Tammy Banks: Thank you, Tara. While the NCVHS committee members determine if there's additional questions, I do want to ask one for you, Tara. Obviously Optum has -- delighted you're here, by the way. Nice to see you again. The question for you is I know Optum has invested in a lot of resources in order to do this pilot test. Can you give a high level value analysis or ROI that Optum did in regards to this transaction to help us understand the reason for moving forward, because I'm assuming you're supporting the moving forward of this transaction to the investment.

Tara Rose: Yes, we are. I can tell you that to date, and these numbers do not hold true going forward, because they obviously will change, we have put in approximately 40 hours in development time and close to 80 hours in gap analysis and the HIPAA edit analysis. Those -- and I will not speak for the velocity BA on how far that they have gotten on completing the actual edit analysis, but I have almost completed the gap analysis between 5010 and 8020,

because while we do have the differences summaries out there and they're incredibly helpful and give us a good direction, we need to make some business decisions. So it's important that we complete our own gap analysis between those two versions. It also helps with what we consider transformations, which the clearinghouse does do, so we can map 5010 to 8020 and vice versa.

So that's where we are today. We will have more and we will report it to X12, who will come out with a full analysis, cost analysis, and value analysis, based on all stakeholders, not just Optum.

Cathy Sheppard: Tammy, can I jump in for one second? I wanted to tie this back to what Dan was talking about so that everybody sees how we're kind of weaving these strings together. We hope that the result of the pilot, which is based on manufactured data or deidentified data, we hope we can feed that into an exception process later, after we have some results, but we also didn't need an exception for this pilot, because we're not using production data and we're not actually processing the claims through anyone's adjudication system. So we hope to tie those two opportunities together, but the first step is for us to get our pilot up and executed so we're ready to know what to ask for for an exception.

Tammy Banks: Thank you, Cathy and Tara, and with that, since I'm seeing no other questions from the NCVHS committee members, I'll move on to Terrence.

Cathy Sheppard: Tammy, I'm sorry, I need to clean up one of my answers, if that is okay. Rich, I apologize. I have a lot of change requests in my head and different stages. So the ICD-11 that I was speaking about is a solution we're still working on and is not in 8020. So I misspoke there, but we will give you -- we can still answer to you as to our plan for ICD-11 as it moves forward into use. I'll still give you an answer. It just won't be that it's there in 8020.

Tammy Banks: Cathy, just to add on that, do you foresee that being an enhancement in any updated version before the proposed rule is dropped? Of course, we don't know the timing, or is this something that would require a different version?

Cathy Sheppard: It would require a different version, but with our new process, we believe that we can keep up with decisions about not just ICD-11, but other things that are pending in different verticals in the healthcare industry. So we'll be able to adjust quickly when there's firm requirements where in the past we might not have been able to adjust that quickly.

Tammy Banks: Understood, and, Cathy, I really wish we had more time, because there's always a lot of good questions and good feedback in regards to the work you're doing over at X12. So you know, of course, that we would probably circle back with you at some point with more questions.

But with that, I'll transfer it over to Terry so he can continue the conversation.

**Panel 1: Designated Standards Maintenance Organizations and Code Content Committees**

Terrence Cunningham: Thank you so much, Tammy, and thank you all for having me. My name is Terry Cunningham, and I'm here to speak on behalf of the Designated Standards Maintenance Organizations. The members of the Designated Standards Maintenance Organizations thanks the NCVHS Subcommittee on Standards for inviting our input on X12's June 7 proposal to adopt updated healthcare claim professional, institutional, and dental claims and the healthcare claim payment advance remittance advance transactions.

The following commentary reflects the views of DSMO, but we do note that X12, HL7, and the dental content committee do not share in this collective viewpoint.

Some background. On August 17, 2000, the Secretary of HHS named six entities as the DSMO under HIPAA. The organizations include three standards setting organizations, which are X12, HL7, and the National Council for Prescription Drug Programs, and three data content committees, the Dental Content Committee of the American Dental Association, the National Uniform Billing Committee, and the National Uniform Claim Committee. HIPAA regulations established that, quote, the Secretary considers a recommendation for a proposed modification of an existing standard or a proposed new standard only if the recommendation is developed through a process that provides for the following: one, open public access and, two, coordination with other DSMOs amongst others.

In order to ensure adequate coordination, DSMO participants have historically submitted new or updated standards to the DSMO, who would formally review the material and then issue a recommendation to NCVHS, when we add to the specific X12 recommendations. Inconsistent with these established processes, the DSMO organizations were notified of the X12 transactions submission on June 8, 2022, which is the day after the recommendations were sent to NCVHS.

X12's DSMO notification failed to include a copy of the actual standard, nor a usable changelog displaying the updates that it was proposing. As a result, unlike previous recommendations to NCVHS, these submissions were not subject to a coordinated review analysis in advance of their submission to NCVHS. While we strive to address DSMO coordination dynamics, we do encourage NCVHS to support the DSMO efforts to reinforce the consultation requirement found in Public Law 104-192 and the related subsequent relations.

Over the past few months, the DSMO and its participant organizations have engaged in a review and analysis of the X12 20 claims in electronic remittance advance transactions. Three major themes arose from such review. First is that the standards need additional pilot testing to ensure that the transactions will function properly and meet industry needs. Second is that the industry should not move to adopt new versions of the claim remittance advance transaction without significantly greater cost/benefit analysis. And three, the industry needs additional clarity about the NCVHS recommendations that multiples of versions or standards be permitted simultaneously.

I'll address these each in order. One, the need for additional pilot testing of transactions. As of the date of the request for consideration, there has not been any real-time pilot testing of the proposed transactions. Such testing is an essential step in evaluating the effectiveness of a new

standard, as it will also aid efforts to identify accurate impact analysis and reveal the benefits of adopting the proposed upgrades.

In addition to enabling the evaluation of the specific standards, the pilot testing needs to ensure that the transactions can work across versions because of the piecemeal rollout process. The 8020 claim and remittance transactions must successfully function when being inserted with the other 5010 transactions that will remain in effect until X12 proposes their next round of updates to these transactions.

Such a rollout process necessitates substantial cross-version piloting before stakeholders can adequately engage in a cost/benefit analysis. Further underscoring the need for robust cost/benefit analysis in subsequent testing is the need to avoid claim and remittance disruptions, particularly at a time in which many industry participants are experiencing financial strain resulting from the multiyear effects of the COVID-19 pandemic.

Next, the cost/benefit analysis and return on investment. In the letter recommending adoption, X12 provides estimated implementation costs for each of the offered standards. The DSMO strongly agrees that clear implementation costs and benefit estimates are essential parts of an actionable recommendation. But we do not believe that the offered estimates provide sufficient clarity to support a recommendation at this time.

Specifically, the X12 estimates generalize across all stakeholders and sizes, treat all enhancements as equal to one another, when providing a per enhancement estimate, and fail to detail exactly how the estimates were created. As a result, we don't believe that these estimates are reliable or usable for the stakeholders at this time.

We believe a cost/benefit analysis is extremely important in order to determine whether to update these standards. This analysis needs to review information gathered from pilot testing so that the industry can accurately understand how much the transactions will cost to support, how much time and resources they will save, and ultimately what the return on investment, whether quantitative or qualitative, will be for each stakeholder group.

Such analysis will ensure confidence in a recommendation for adoption, and we'll make rollout and explanation easier.

Finally, the need for clarity on the NCVHS proposal for multiple standards and/or versions. In a July 28, 2022 letter titled Recommendations to Modernize Adoption of HIPAA Transaction Standards, NCVHS recognized that new drivers of transformation in healthcare data exchange are within HHS's purview. NCVHS recommended HHS update relevant HIPAA policies to allow the adoption and use of more than one standard per business function. Additionally, the letter calls for HHS to enable HIPAA-covered entities to support one or more versions of adopted standards for business functions. HHS has yet to respond to these recommendations.

We believe the significant unanswered factor in a prospective cost/benefit analysis is whether more than one version of a standard's implementation specification or more than one standard

per business function will be allowable and/or required. Should stakeholders be required to support multiple implementation guide versions or standards simultaneously, the tools and framework needed to support the adopted standards may increase costs for stakeholders.

However, in the absence of federal policy response to the idea, impacts are unclear in assessing costs and benefits derived. Moreover, should the standard-setting organizations advance modification recommendations every year or every other year, covered entities and their vendors may need to hire fulltime teams to review and implement new versions of implementation guides, which would necessitate a sustained capital investment.

In conclusion, as a result of these aforementioned concerns, the DSMO finds that the X12 transactions have not undergone adequate testing and piloting to ensure that the proposed updates to the currently mandated standards will produce legitimate benefits and not have unintended consequences for the industry.

Furthermore, HHS insights regarding recommendations for multiple standards and implementation specification versions is crucial to engage in necessary industry review of proposed standard updates. As a result, the DSMO does not recommend NCVHS pursue adoption of the proposed standards until completion of real-world pilot testing demonstrates their functionality, completion of a more detailed cost/benefit analysis occurs, and we have greater clarity on whether multiple standards or versions for the same business function will be allowed.

Thank you. That's all I have. And I will open it up to questions. Thanks.

Tammy Banks: Thanks, Terrence. I just want to unpack your recommendation a little bit, and then I have one question if I could.

First of all, it's been 10 years since X12 brought forward a proposal. So I'm sure you guys were engaging with them every couple of years to find out where their status was, and so getting a proposal was very exciting at this point in time. The question I have for you is after hearing Tara Rose commitment to do the proof of concept, you heard Dan comment about multiple versions, that that is not in play in this proposal except for the traditional transitioning phase, right, where you'll have two versions in play, and I think the third point was really understanding what the gap analysis is since there is just the professional and the payment remittance advice being moved forward, does that impact your position in regards to moving this forward for the Secretary's consideration for a proposed rule?

Terrence Cunningham: Obviously, I encourage other DSMO members, I know you're all probably online, I encourage you to speak if you are able to. I will say that it doesn't necessarily -- I think one thing that Dan said, and he was particularly important, was this is unlike where it's comparing existing standards to no standard at all, this is do we replace an existing standard that's already in place, and I think it's great to hear that Tara Rose is proposing that they're going to engage in all this testing, and I think the time in which we might feel more comfortable is after that testing occurs and we're able to review, oh, this is why this transaction is going to

help the industry. We can see, it's going to save time in the long run. It's going to make this process easier. It's going to do X, Y, and Z.

I think that's what we were looking for when we talk about pilot testing, because it's difficult to roll this out to an industry and say we recommend this transaction before, because it's going to save you time, it's going to save you this, until we know whether or not it actually will. So I agree and love to hear that there is pilot testing being proposed and it's going to occur. I think because of the nature of replacing existing standard that for all intents and purposes is working pretty well, the claim transaction, there's obviously upgrades that could occur. But I think before we can recommend its replacement, we need to make sure that we can realize what the benefits are of replacing it and do an actual cost/benefit analysis.

Tammy Banks: Okay, and words are important. So I just want to, again, dissect what your position is. Are you saying not to adoption or not to move this forward for consideration for a proposed rule? Recognizing the proposed rule, you have your fiscal analysis, you'll have your proof of concept completed, and then that additional review will occur.

Terrence Cunningham: I think it would be -- as the experts in this field, I think it would be more practical for us to have the opportunity to review actually to -- I think we should have some real-world testing available before we're making any recommendations. Obviously, there will be the cost -- future analysis that might occur. But I think in our role as the kind of gatekeepers of the new standards, it's important to have a better understanding as to how these standards will function before we make any recommendation on them.

Tammy Banks: Okay, I appreciate that, Terrence, and just for our edification, obviously, your internal processes within the DSMO committee is not under our purview, but the question I have is what is your process for when standards come to you to review? I mean, NCPDP, did you require them to do a pilot test? Did you review the cost analysis? Did you use the same criteria as you are for the X12 proposal coming forward?

And the same with the 5010, right? Was that same criteria utilized? Just for consistency so we know what to expect.

Terrence Cunningham: Right. So there was this -- again, the process was always that you would receive the recommendation and you would go through kind of like a discussion where the various industry participants were able to kind of weigh in and have these discussions about do we think in this -- this has the potential to disrupt? Let's discuss do we need to have a cost/benefit analysis.

I can't speak for the 5010. I encourage others obviously, as you said, that occurred quite a long time ago, and it was replacing nonstandard with standard. So it might have been a little bit different of a coordination. But the DSMO process has always been a change request when there's an update to a standard, would come into the DSMO, the DSMO would have these types of internal discussions, talk them through with the proposing stakeholder, then centralize on kind of a recommendation and make that recommendation to NCVHS.

So kind of the whole process has been different. I don't think the change request processes necessarily occurred. I will note that we have as a DSMO discussed and we plan on -- I think the DSMO has not been utilized nearly as much in recent years. This is again there hasn't been as much changes and there's been -- so we do have a plan to really sit down as the core members of the DSMO and discuss do we need to update procedurally and figure out how do we get this so it is easier to use, functions best, and potentially get it so it can function more.

So that's something, future conversations to occur.

Tammy Banks: So basically, this is a new process that you put in play.

Terrence Cunningham: This is not a new process here. There will be future conversations for a new process. This is not new. This was not a change request review. This was you asked DSMO to respond. There was never a formal change request, right? Because it never came into us before it went to you, at the stage it went to NCVHS, the change request had already occurred.

Tammy Banks: I think we are talking apples and oranges. All I'm asking is in regard to proposals to move forward the recommendation in this process for a standard, and like NCPDP is a standard. So we put in a recommendation for the Secretary to consider making that change in the standard. Same with 5010. So I'm not talking about change request. I understand that's under your purview. I'm just asking in regard to a standard when you get a recommendation, all you're --

So my question is, I'm asking why it seems inconsistent with previous recommendations, and so I'm trying to understand a little bit further why the different review. Is it your internal processes? You guys have conversations to be had moving forward and that is getting interjected into this proposal or your response? Anyway, I'm just trying to alleviate that confusion, because this is just a little inconsistent.

Terrence Cunningham: I don't know. Again, I think this is just different, and I think it's really the wholesale reviewing whether or not -- I think the role of the DSMO is to review the potential implications of implementing a new standard. Do we have a checklist that says let's do this, this? No. But I think in this, given the environment into which this standard would be moved, these were pressing considerations that cropped the top of everyone's mind. So can I say exactly like, oh, we had five checkboxes for when NCPDP proposed something and they needed to meet A, B, C, and D? No. But I think reviewing kind of the dynamic of changing this process and ensuring that it functions, especially given we're in a little bit of uncharted territory with the one transaction versus a whole suite of transactions, like 5010. And so I think -- I don't think we have a set process like these are the specific factors that need to take place, but in our role of being good stewards of making proper recommendations to NCVHS and giving our expertise, these are the issues that cropped up during our discussions.

Tammy Banks: Okay. I just want to give another opportunity to those DSMOs that are on the phone. Do you have anything to add or would you like to share your positions in regard to this recommendation?

Nancy Spector: This is Nancy Spector, as chair of the National Uniform Claim Committee, and I had actually wanted to expand or add to what Terry was just saying there. So, looking back with the previous DSMO review of the request to adopt 5010 when that request came in to the DSMO, so that was a request that came into the DSMO. I didn't look at the timeline, but it was probably around 2008, and the process that occurs per what's required per our memorandum of understanding is that the request comes into the DSMO and then each of the six DSMO organizations separately review that request within their committees or their organization and then come back with their response to that request and then the DSMO as the steering committee collectively comes to an agreement as to how to adjudicate that, approve, disapprove, and then that recommendation gets forwarded to NCVHS.

So I think what Terry was explaining, I know it's sort of outside of your purview, but that did not occur in this request for the adoption of 8020. What I wanted to say in addition to that is that the state of the industry now versus when that request was being considered in 2008, it's very different. We've got so many more moving pieces with other requirements, regulations, standards, that are in the process of being proposed for adoption, and I think that is why the cost/benefit analysis is so critical right now.

It's always been a part of the proposed rules, and that's not to say that it hasn't been, but I feel, I personally feel, that having that information now is more critical for the industry as we try to balance what the needs are, what the resources that the individual organizations and stakeholders in general have to put into the changes that are being brought forward, and recommended.

And then to your question about NCPDP and when their requests were brought forward, their request did come to the DSMO, and again, I hadn't looked it on up the fly here, but I believe that they had included in their request or at least verbally we were told that there was cost/benefit analysis information that they had done. But I feel as though that was part of what we knew about at the time their request had come forward.

Tammy Banks: Thank you, Nancy.

Alix?

Alix Goss: Thank you. Building on some of Nancy's points, I wanted to clarify HL7's position in regard to the written testimony. We elected to abstain on the proposed written testimony. While we support both the collaborative process of the DSMO and X12's efforts to advance the use of more current versions of their standard and technical reports, we are concerned with the overall expectations and industry strain that pragmatically limits its capacity to accomplish real-world pilot testing and develop robust cost/benefit analyses. These are not new concerns, nor

are they specific to any SDO, as many organizations have noted in years of testimony to NCVHS's Subcommittee on Standards.

Enabling the industry to test and validate newer versions necessitates industry obtaining an exception request. Obtaining an exception request to a named HIPAA standard to prove out new versions or alternate standards requires significant industry investment. Whether EDI or FHIR-based standards, exception processes bring substantial efforts to engage, orchestrate, and fulfill the exception-related processes, projects, and reporting functions.

As a member of the DSMO and as has been noted already this morning, we look forward to upcoming meetings to evolve the DSMO coordination and consultation activities. Thank you.

Tammy Banks: Thank you, Alix. Appreciate that. Any other DSMO representatives that wish to provide a comment or position?

I saw your hand up, Cathy, but I think you took it down, right?

Cathy Sheppard: I did take it down. I will say, though, it sounds -- some statements were made that make it sound as if X12 was trying to sneak something by. That is not the case. The DSMO hasn't met effectively for many years. There's no accommodation to allow the submission of a change request through these procedures that are being called out today or these traditional processes, and all of that entire DSMO function has been the subject of many NCVHS discussions about relevancy and productivity.

So I think that it's nice to hear concerns. I think the group should understand that six opinions were rendered on this letter. Three did not support it and three did. So it's not a strong majority in any way.

We believe that we have gone further in addressing cost/benefits and also pilots than we've done in the past and it's a big step forward for X12. We did that based on information that was discussed at NCVHS over many, many years. So I just think we should keep perspective.

Tammy Banks: Thank you, Cathy. Appreciate that. I know we are running over time, but I'm just going to give one more callout to the NCVHS committee members to see if there's any follow-up comment.

(Pause.)

All right, with that, Rebecca, is it all right if I announce a break? I'm thinking that we still could come back at 12:35. Would you be in agreement?

Rebecca Hines: I think that works. Good plan.

Tammy Banks: All right. We will see you back at 12:35 and we'll have a report-out by WEDI. Thank you.

(Lunch Break.)

Rebecca Hines: Tammy, whenever you're ready.

Tammy Banks: Excellent. Thank you. Next is Rob Tennant from the Workgroup on Electronic Data Interchange. Rob, just before you kick it off, I just want to say thank you to you and WEDI for all of your excellent work and collaboration with us as we really seek to get input from across the stakeholders. So again, I just want to share our appreciation and let you go for it. I'm excited to hear the outcome.

**Advisory Committee Report – WEDI Member Survey and Advisory Event Outcome**

Robert Tennant: Thank you, Tammy, and thank you for the opportunity to present to the subcommittee today. As Tammy said, we've had a wonderful and productive collaborative relationship between our two organizations. So we're very pleased to be able to present today.

For those folks that aren't familiar with WEDI, we were formed in the early 1990s by then Secretary of the U.S. Department of Health and Human Services, Dr. Louis Sullivan. He created the Working group for Electronic Data Interchange. They developed some reports in the early- and mid-1990s that led to HIPAA. They were able to fold those reports into the legislation, and WEDI was named in HIPAA as an advisor to HHS. Ever since, we've been a multi-stakeholder membership group. We represent health plans, providers, vendors, standards development organizations, as well as state and federal government.

We have very productive relationships. In fact, CMS and ONC both serve on our board of directors. We get most of our work done through our workgroups, sub-workgroups, task groups, including, we have a subgroup on claims and one on remittance, advice, and payment. Our role is of course to convene, collaborate, educate, and influence.

So I wanted to talk a little bit about the process that we went through to collect information in response to the request for comment put out by NCVHS. We have what we call the membership position advisory process, or MPA, and that's designed to solicit WEDI member input on topical issues, on proposals, government regulations, that sort of thing, including of course the request for comment put out by NCVHS. This process advises our board of directors as it develops the official response that WEDI submits.

We collect our information through our workgroup discussions, through surveys, and our virtual events. In the next slide I'll explain the three tactics we use to develop our comments. We had very robust discussions in our claims and remittance and payment sub-workgroups.

We did hold a virtual event November 9 which we got about 75 participants who discussed the various questions raised by NCVHS, and we conducted a number of polls during that event, and I'll share those as part of my testimony today.

We also conducted an industry survey raising a lot of questions that NCVHS had raised during its RFC process. We received 77 responses. I did want to say, we are in no way representing

this survey as a definitive scientific approach. What it is, though, is a good snapshot of the industry. I do note that the provider response was low, but we did receive a number of responses from provider associations that represent thousands of providers.

What you'll see is a very strong percentage of the respondents to the survey had a good understanding of the X12 proposals. They were either X12 members and participated in the standard development process, or they had reviewed the proposals thoroughly. So not everybody did, but it was a good, I think, cross-section of the industry.

If you go to the next slide, what we'll do is we'll talk about some of the results that we received both from the survey and also through our MPA virtual event in November. So in terms of the 837 institutional claim, 51 percent responded that adding the ability to transmit the device identifier of the unique device identifier would have a positive or strong positive impact. Fifty-nine percent responded that increase in the number of prior authorizations and referrals that can be reported at the line lab will have a positive or strong positive impact.

Seventy-one percent said that replacing the CAS segment with the RAS segment to support the association of the adjustment reason codes and remark codes would have a positive or strong positive impact. And 72 percent said that adding support for transmitting coordination of benefits allowed amounts would have a positive or a strong positive impact.

On the professional claim, 63 percent suggested that increasing the maximum number of diagnosis codes from 12 to 24 would have a positive or a strong positive impact. Sixty-five percent responded that increasing the number of diagnosis code pointers from 8 to 12 per service line would have a positive or strong positive impact. Seventy-two percent stated that adding support for transmitting COB allowed amounts would have a positive or strong positive impact, and 74 percent said that greater focus on reducing ambiguity throughout the implementation guide would have a positive or a strong positive impact.

For the dental claim, two thirds said adding a data element used for coordination of benefits when a claim is adjusted would have a positive or strong positive impact. Sixty-nine percent stated that revised to reporting of claim level remark codes not associated with an adjustment reason code would have a positive or strong positive impact.

Seventy-two percent said that revising the support line level prior authorizations where no authorization is sent at the claim level, which would reduce the need to split claims, would have a positive or strong positive impact. Finally, 72 percent said that revising to support the transmission of allowed amounts received on the primary claim would have a positive or strong positive impact.

In terms of the remittance advice, 835, 71 percent said that adding information that will aid in automating the posting of remittance advice and information would have a positive or strong positive impact. Seventy-two percent said that standardizing and adding clarity for reporting COB adjudication information would have a positive or strong positive impact. Seventy-three

percent said that standardizing the forward balance and overpayment recovery processes would have a positive or strong positive impact.

And 73 percent said adding the ability to re-associate a recovery amount with specific claim to reduce manual processes would have a positive or strong positive impact. So overall, very positive support for the changes that would come with the 8020 version.

So we did ask a question during our live event, when participants would be conducting an analysis of the impact on your organization of these new X12 transactions, and I think it's very telling that a large percent said that they would be either doing it next year, 38 percent said that they will be conducting an analysis only when the agency issues a proposed rule, and 21 percent said that they had no plans to conduct an analysis.

We do note that without a proposed rule, many entities will not conduct an ROI analysis in part because it is difficult to allocate the resources necessary when there hasn't been a target implementation date and, again, we ask specifically, but no provider organization had yet to conduct any cost impact analysis.

So in terms of the schema and the UDI, we did ask the MPA participants, do you support the proposal to adopt the 8020 EDI standard and the XML representations as permitted syntaxes? Over half, 58 percent, replied yes; 8 percent no; and 33 percent replied don't know.

When we asked them to rate the level of potential additional value that the DI and UDI provide as data elements in the updated version of the claim transaction, 36 percent said that there was significantly or somewhat improved value, 12 percent replied no change in value, 8 percent replied a significant decrease in value, and the largest group said don't know.

So in terms of overall adoption support, we did ask the question overall should WEDI recommend adoption of the proposed 8020 837, the dental, institutional, and professional claims, 62 percent answered yes, 17 percent no, and 21 percent don't know. We also asked about should WEDI recommend adoption of the proposed 835 8020 version of the remittance? Forty-six percent said yes, 21 no, and 33 percent stated don't know.

So we did ask a number of questions about general implementation issues. I think a lot of them have been discussed during the morning session. In terms of implementation timeframe, we asked should the window be longer than two years from publication of the final rule? Only 6 percent said yes, 44 percent said no, and the largest amount, 50 percent, said don't know.

We do note, as NCVHS did in the RFC, that the government has generally stipulated a January 1 implementation date for new standards, but there was a lot of discussion at our virtual event around the idea that January 1 is often the compliance date for other contractual obligations, and we do recommend exploring an alternative date for implementation of any new standards.

We also asked how important it was that new or updated administrative transactions be implemented on a regular schedule, so for example, every two years? Forty-two percent said it

was very important or important, 21 percent said somewhat important, 11 percent said somewhat unimportant, 16 percent said very unimportant, and 11 percent don't know.

So simultaneity, I think the big question there, and we discussed it already this morning, and that is if standards are adopted as bundles and not as a full suite of transactions, there is some concern that the effective dates could be different, and these out of sync compliance dates could be confusing to the industry. We do note that there are clear interactions between the various transactions and operating rules and there may be unknown and unanticipated impacts based on these interactions.

At the same time, WEDI believes that each standard is to be evaluated on its own merits, and it's important to note that some transactions go naturally together like a claim and claim payment and remittance advice. These would best be bundled together.

We also asked our MPA participants, would the industry benefit from being able to use either the version 8020 or version 5010 for some extended period of time versus having a definitive cutover date? Just 25 percent said yes, 54 percent said no, and 17 percent stated unsure, and 4 percent stated don't know. So clear support, I think, for the idea of having a definitive cutover date.

In terms of multiple standards again, we did ask on our survey should the government permit industry use of multiple versions of one standard? And again, very similar, 70 percent stated no. We do note that if multiple standards for the same business use are allowed, we recommend that they be semantically equivalent and interoperable. Overall, WEDI members tend to support moving forward with the full suite of transaction standards, but at a minimum, transactions that interact with each other should move forward as a bundle. We do not support moving forward transaction by transaction.

A few additional recommendations, and again, some of the concepts have been discussed already, but there is a clear support for pilot testing and establishing a return on investment. We did ask a survey question, rate your level of support for not moving forward with an administrative transaction until a pilot test is conducted and the results indicate a clear return on investment for the industry. Almost 60 percent supported or strongly supported that statement. Twenty percent neither supported nor opposed, and 20 percent opposed the statement.

We also believe that there is a lot of value to establishing a known and predictable standards schedule. It has taken a long time to move from 5010 to 8020, and I think there is a lot of support for after the transition to a new baseline set of standards has taken place. We urge the development of a known and predictable upgrade cycle. When the industry has moved to an incremental yearly or perhaps bi-yearly upgrade schedule, changes to the transactions should be based on their established value to the industry.

I think we heard this as well earlier today, but there is a clear need to develop a comprehensive health IT roadmap. The current landscape is complex, challenging, changing all the time. We have requirements for new and upgraded HIPAA administrative standards and operating rules.

These compete with the 21st century Cures Act interoperability requirements, No Surprises Act data exchange provisions, and other federal mandates. They all compete for very scarce human and financial resources, so we strongly urge the development of a comprehensive and achievable roadmap that prioritizes these health IT requirements and at the same time recognizes the many implementation challenges faced by the industry stakeholders.

With that, Tammy, if you go to the next slide, I will say that if you would like to read our full response to the NCVHS RFC, it's available at wedi.org. With that, Tammy, I'll turn it back to you.

Tammy Banks: All right, thank you, Rob. Could you just summarize for me quickly, I know you've got a good portion of your membership responded to your request for feedback. For WEDI as an organization, what is your overall position? I know it's all on the slides. Could you just summarize that for me?

Robert Tennant: Yes, so WEDI supports moving forward with the new transactions, but recognizes that there is a clear need to establish a return on investment, and I think there is clear support for pilot testing and it was great to hear from Tara that pilot testing is going to occur, but there is a lot of concern, because there are a lot of great unknowns.

Without an organization doing a cost/benefit analysis, it won't know what the impact of these standards will be on the organization. So I think having that done ahead of time certainly benefits the industry. I'm going to suggest it benefits NCVHS, but I think that's something to consider going forward.

Tammy Banks: I appreciate that, Rob. So you know exactly where I'm going to go and why I asked that question. When in the slides your members identified 16 changes that have a positive or very positive impact, and we know from Cathy's presentation that there have been over 1,000 changes, does that mean that the rest of the changes are minimal, or have a neutral or negative impact?

Again, we understand a cost/benefit analysis hasn't been done, but we do need to recognize value in order to move this forward. So if you could help me with that, it would be appreciated.

Robert Tennant: Yes, you're absolutely right. The number of changes with the 8020 version is staggering, and as Cathy said, a lot of them are simple commas or wording changes, but there are still a lot. We tried to extract what we felt were some of the key ones to try to keep this survey at a reasonable length. It was still way too long. I think it impacted the response rate, but we tried to highlight some of what we felt were the key elements.

Really, it was driven by our sub-workgroup co-chairs and members to try to again identify what the key changes were to the transactions.

Tammy Banks: Were there any fixes in the 8020 that were mentioned in any of the other conversations that we should be aware of or were the 16 basically the bread and butter value adds?

Robert Tennant: They were the key ones. I think we had a few other minor ones included in our survey, but I think the 16 were what we considered to be the key ones.

Tammy Banks: Excellent. I appreciate that information. With that, I'd like to pass it over to the NCVHS members to see if they have any questions, and I see Denise is ready to give you a question.

Denise Love: Thanks, Rob. Your survey is very informative and I appreciate WEDI implementing the survey to help us deliberate.

You may not be the one to ask, but as I sit here I am trying to figure this out on my own, so I'm throwing it out there into space. What is the industry appetite, capability, or feasibility of real-world testing in the absence of an NPRM? I mean, it seems to me like there is this conundrum between moving forward with investing and testing with the uncertainty of not knowing what the final rule is going to be and how does that reconcile, or does it?

Robert Tennant: That's a fantastic question. I think what I had heard from Tara was that she felt that there was some value to Optum, and I think that's one of the key things. If you can show some value to those willing to invest in the pilots, I think that is going to drive additional testing. But when it's something new, especially when we haven't had a change for more than ten years and especially, Tara mentioned, industry is coming off or still in the public health emergency, you have to establish a benefit.

It was also heard by Dan that it's going to be one of their measuring sticks whether or not to move forward. So I think pilots are essential, and I think as well, because there is a cost involved, it's something perhaps for CMS to consider, is there an opportunity for the government to step up and help fund some of these studies to defray the costs for those participating and maybe encourage those that don't have the means to test.

Tammy Banks: Thank you, Rob. Appreciate you sharing your member input that helped WEDI determine what their position was. So thank you again for all the work that you've done.

Now we would like to move on to the provider panel. It will be Andrea from American Hospital Association, Nancy from American Medical Association, and then Katie from Department of Veterans Affairs. So Andrea, if you don't mind kicking it off.

**Panel 2: Provider Perspective on proposed updates to X12 transaction standards**

Andrea Preisler: Sure. Thank you. Good morning or good afternoon to you all. Thank you for the opportunity to participate on this panel. I am Andrea Preisler from the American Hospital Association, and I will be outlining AHA's assessment of the proposed standards.

So from the provider perspective, there are two broad considerations that we're evaluating regarding 8020. Those are cost and operational considerations, as well as functional considerations. So how might adoption of 8020 help or hinder the provider workflow? As you can see, within each of those overarching categories, there are specific concerns we're thinking about.

Regarding cost and operational considerations, we're particularly interested in how version 8020 impacts the current state of hospital finances, looking at the implementation timeframe and implementation and simultaneity.

Then as far as functional considerations, we're interested in how version 8020 affects the unique device identifier, the use of virtual credit cards, and the compilation of good faith estimates and advanced explanation of benefits for patients.

So before I get into the specifics, I want to explain where we are in terms of version 8020 evaluation. Unfortunately, as we've discussed, there has been little pilot testing conducted, making it really difficult to identify operational effectiveness and the challenges that version 8020 and its corresponding implementation may present.

This also makes it difficult to accurately predict upgrade costs. Additionally, a significant question we have is the uncertainty around the compatibility of transactions on different versions.

The current landscape of hospital finances is front of mind as we're evaluating this new version. Since the onset of the COVID-19 pandemic in 2020, our hospitals and health systems have coped with intense staffing and financial pressures. Since that time, hospital expenses have increased significantly. For example, as you can see, 2022 expenses are projected to represent an increase of nearly $135 billion over 2021, and labor expenses are projected to increase by $86 billion and keep rising.

These financial pressures highlight how critical it is to avoid claim and remittance disruptions at this time. Also, undertaking a significant IT transition at this time without adequately delineating and quantifying its benefits and savings potential would likely have a profound financial toll on hospitals already struggling to care for our communities.

So regarding implementation timeframes, we are generally in favor of maintaining a two-year implementation window for health plans and providers following publication of a final rule. However, when considering the appropriate timeframe, we want to be very mindful of lessons learned from the 5010 transition. So that transition included testing delays, which when coupled with limited staff and finite budgets really strained hospital resources. And at that time, hospitals expressed concerns that testing delays encroached on their ability to implement necessary system changes.

So these lessons learned underscore the need to create and maintain the least disruptive pathway to implementation and ensure that the industry is balancing health IT initiatives with

the need to acquire sufficient resources, educate stakeholders, and provide the time to adequately test with trading partners. We also note that staggering implementation of the various transactions could lead to the need to constantly test and implement, which would likely necessitate providers hiring fulltime teams to manage those transitions, therefore representing a substantial investment.

Regarding NCVHS's recommendation to allow for the concurrent use of multiple versions of a standard, the AHA is uncertain of the intended benefits, and we have significant concerns of the potential need to support multiple versions at once, since we anticipate this would represent a substantial administrative burden and cost to providers.

You know as the industry, we adopt standards to allow for a single approach to communicating among one another, and this increases efficiency, it drives down cost, and it supports patient care. Therefore, we really question whether the allowance of more than one version furthers the goal of ensuring uniformity and predictability across our industry. That said, should the industry decide to move forward with allowing multiple standards or versions of transactions, robust testing becomes even more critical.

Additionally, the NCVHS consideration of each HIPAA transaction individually, rather than as part of a comprehensive suite of transactions, furthers the need for additional testing to ensure that versions are cross-compatible with one another. Therefore, we urge that NCVHS exercise caution in moving forward with recommending variation into the standards environment.

As for the potential functional considerations of 8020, the AHA is interested in changes to the unique device identifier or UDI. We strongly support the improvement of medical device safety and recognize that there has been a considerable amount of progress in medical device safety reporting, particularly substantial work that's been undertaken to insert this information into clinical records and EHRs.

Ultimately, the AHA is unsure that there is significant value in inserting UDI information into the claim. We want to better understand how the information is going to be used, especially since we do not have a list of high-risk implantables, nor payers that have volunteered to collect and process this information. So in light of the advances in clinical systems interoperability, we would like to get an updated understanding of where this all fits into a surveillance system in today's healthcare environment.

Another functional consideration is the 8020 835 enabling payers to send compliant remittance information for virtual credit cards. While we recognize the utility of remittance transactions supporting these payments, we have significant reservations about health plan implementation of virtual credit cards. Our members are constantly indicating that health plans are switching to virtual credit card payments without provider authorization, leading to processing fees and reduced payment receipts for providers.

So in order to safeguard payment legitimacy, the AHA urges that we only proceed with further legitimization of virtual credit cards if proactive steps are taken to ensure that the plans are not

inappropriately switching providers to these costly virtual credit card payment methods without the required advanced agreement from the provider.

Additionally, to aid the AHA in its cost/benefit analysis of updating the current healthcare claims standard, we are particularly interested in how adopting the updated version could help implement the advanced explanation of benefits, otherwise known as the AEOB, price transparency provisions of the No Surprises Act. For example, the AHA strongly supports leveraging existing provider and health plan workflows, standards, and technology, for claim submission and adjudication to support the creation of AEOBs. To the extent that adoption of version 8020 is necessary to properly complete predetermination, we would consider this functionality to be extremely beneficial.

However, we are uncertain that utilization of 8020 transaction would be necessary in this situation, as version 5010 already seems to include the capability of completing predetermination of benefits. So as a result, we would welcome insight from X12 into whether 5010 in fact has the claims pre-adjudication capability that could be leveraged for transmitting good faith estimates to health plans, as well as any additional functionality that could be realized from version 8020 for this process.

So where does that leave us for hospitals and health systems regarding support for recommended 8020 transactions? At this time, the AHA is concerned that the transactions have not undergone adequate testing and piloting to ensure that they will produce legitimate benefits and not have unintended consequences for the industry.

Therefore, we recommend X12 conduct pilots and tests demonstrating that there will not be unforeseen technical issues of implementation, provide detail about the manner in which X12 envisions rollout occurring, and sufficiently articulate how the updated transactions proposed benefits will further the goal of administrative simplification. Additionally, we recommend that NCVHS pursue additional clarifications surrounding its recommendations that would allow multiple standards and versions to exist simultaneously, as again, doing so would have significant impacts on the industry.

As a result, the AHA does not support NCVHS recommending adoption of the proposed standards at this time. With that, I would like to thank you all for your time and thank the committee for having me.

Tammy Banks: Thank you. Nancy?

Nancy Spector: Thank you. I am Nancy Spector here today representing the American Medical Association where I am the coding and HIT advocacy director. We thank the subcommittee for the opportunity to present our comments on this X12 request.

The AMA is the convener of more than 190 state and specialty medical societies representing physicians with a unified voice and all key players in healthcare. We are a long-time champion of administrative simplification and the important role it plays in achieving the quadruple aim.

We are a long-time advocate for the adoption of electronic transactions and code set standards to reduce administrative burdens. We're also a long-time active participant in standards development and other cross-industry multi-stakeholder initiatives focused on advancing health IT to solve business needs.

We applaud the significant progress the healthcare industry has made in reducing administrative costs through the implementation of the HIPAA-mandated transactions. At the same time, we recognize that many physicians, particularly those working in small or rural practices or serving minoritized or marginalized communities, face challenges in updating their health IT systems due to limited resources. Acknowledging this reality, we use the following core principles when we evaluated the version 8020 837 and 835.

Recognize, preserve, and enforce successful transaction and code set standards. Prioritize identifying and addressing unmet industry business needs. Rigorously evaluate and test any new standard transactions prior to a federal mandate to ensure the maturity, viability in real-world settings, and overall value, and adopt only one transaction standard for a particular business function. So from these principles, we did conclude that it is premature for us to support the implementation of the version 8020 837s and 835.

In terms of the costs and operational impacts, the AMA doesn't have any information to provide on cost benefits or operational impacts of the 8020 837s, and 835 at this time. We did a preliminary query of some state medical associations and national medical specialty societies, and we found that none of them begun any analysis to the degree that would draw conclusions on the cost, benefits, and impacts.

X12 did provide the difference reports as we were hearing about earlier, but the information provided on the changes in these reports is really vague. The report will say things like updated segment note or element length increased, but physician practices are unable to evaluate the impact of that change without knowing the specifics of what that change is. From past HIPAA implementations, we know that cost of physicians vary widely and are dependent on factors such as size of practice, current IT systems in place, current version of software in place, vendor readiness, changes impacting their services, and training needs, just to name a few.

We need more real-world data about the changes and work to implement them as needed before physicians can provide any estimates of the cost. More time is also needed to fully analyze the changes before making any assessment of the benefits or impacts they will have on current operations of workflows. So we urge NCVHS to hold any recommendation about the adoption of version 8020 837s and 835 until after results of the X12 pilot testing are made available to the industry.

With implementation, we are not supportive of NCVHS's recommendation to allow concurrent use of multiple versions of a standard over an extended period of time or to allow multiple standards for the same business function. We appreciate hearing earlier from CMS and their assessment that multiple versions of the same standard are not allowed under HIPAA. We believe that allowing multiple versions or multiple standards abandons the basic tenets

underlying the HIPAA administrative simplification provisions by reverting to the time when health plans used different formats and physicians were forced to accommodate them all. A lack of single standard and version will increase cost, cause major inefficiencies, and disrupt patient care.

Besides the high cost and burdens of supporting multiple versions or multiple standards, we don't know if they even function together, and there has been no testing to see if multiple versions or multiple standards will work together. We also caution against viewing a clearinghouse or other vendors as an easy solution to the versioning issues that physician practices would face.

The use of vendors for translation services comes at a substantial financial and administrative cost to physicians and the entire healthcare system as a whole. Physicians must balance limited resources and their primary focus is on the delivery of patient care. They would rather be investing money in patient care instead of administrative tasks. We're also particularly sensitive to the limited resources of small, solo, and rural clinics which often serve marginalized and minoritized communities.

So if the recommendation is to go forward with adoption of the version 8020 837s and 835, the AMA would support a two-year implementation timeframe, but we also want to recognize that there are a number of regulations impacting health IT in various stages of development and implementation, and we hope that any implementation timeframe decided on at the time of the finalizing of the rule will take into account these other obligations or requirements and lessen any overlaps as much as possible.

In terms of the benefits of the version 8020 837s and 835, we did look at that, we looked at the list that X12 provided of the benefits. We weren't able to conduct any type of an in-depth analysis of the impact of these changes, but we did have some specific points that we wanted to make about some of those benefits that were listed.

The changing of the CAS segment to the RAS segment for coordination of benefits will have a significant technical business impact for all covered entities. We are concerned about how physicians will handle the change in this information and analyzing the adjustments and amounts. We recognize that in many cases, the utility of that information being provided to practices will be dependent on how their vendors are able to provide that information to them.

The new functionalities that were provided as benefits, predetermination, UDI, factoring agent, and tooth segment, we see them as having limited use cases, and it's unclear what the industry's adoption is going to be of those new functions. Revisions for reporting property and casualty data, allowing subrogation of non-Medicaid payers, and reporting drug information will have limited use by most physicians as well.

The increasing of the diagnosis codes and diagnosis pointers, this is one where we do see a benefit for the SDOH and risk adjustment needs for those specialties where these are factors,

but it isn't clear to us yet if health plans will be accepting or using this additional information, and then how the expansion of that data will impact data storage needs as well.

The additional clarifications and updated language are good, but it's not necessary for those that already know how to use version 5010. Then there are many qualifier changes and changes in lengths of data fields will have significant technical and business impacts.

So overall, we don't have a definitive opinion on the benefits of the version 8020. We believe that real-world testing of 8020 is necessary to quantify its benefits.

The unique device identifier, again, while we support medical device safety surveillance, we have serious concerns about the inclusion of the UDI for high-risk implanted medical devices in the claim transaction. We were very active in X12's work reviewing the request to include UDI in the claim transaction. We, along with many other organizations, opposed the inclusion of UDI in the claim. In our response to the RFC, we did provide that full list of concerns that we expressed during X12's work and we continue to have today.

In the end, the organizations opposing the addition of UDI were outvoted during the X12 process, and it was added. But at this time, we're requesting that NCVHS include in any recommendation it makes to have the version 8020 837P and 837I adopted that they recommend that language be added to those guides, the relevant sections, to state that the reporting of UDI is not a HIPAA-mandated use. This is language that is similar in the guide for reporting of data for subrogation and property and casualty purposes.

Really, the purpose of adding this language, in many ways it doesn't change the fact that it's still a situational data element, segment, that's available for use, but what it would prevent would be a payer from circumventing the need to go into a trading partner agreement with a practice by telling practices that they must report all HIPAA-mandated data. So keeping it vague like that could force physicians into having to report the UDI without a trading partner agreement. So that's what we are hoping to prevent by adding that note that it's not a HIPAA-mandated use.

The virtual credit cards, again, we've talked about this a little bit so far today. We know that the 8020 835 adds the ability to report the remittance advice for virtual credit cards. We've heard from some physicians who have concerns that this addition will serve as an enabler for these payments. We're also aware that the subcommittee received hundreds of messages from individual providers expressing concerns about adding virtual credit cards in the 835 about the ability to report that information. The AMA has offered numerous testimonies and comments at NCVHS, CMS, HHS, over the past nine years expressing our concerns about the harmful impacts and course of business tactics associated with virtual credit cards.

The AMA recognizes that this version 8020 835 will not require physicians to accept virtual credit cards, but it is a change that could lead to significant financial hardships and administrative burdens for physicians. So for that reason, we believe it is premature to

recommend adoption of the 8020 835 without fully understanding how this change could impact physicians.

Conclusions, we believe it is premature to support the implementation of the version 8020 837s and 835, and more industry-wide data is needed about costs, benefits, and value before a decision can be made. We also harbor strong concerns about the potential cost of implementing these updated transactions given the fact that the version 5010 837 electronic claim is the most widely adopted HIPAA-mandated transaction at 97 percent for the 2021 CAQH index.

We question if implementing version 8020 of this transaction is the best use of physician practices' limited resources for health IT updates, particularly when other revenue cycle transaction desperately need a viable standard technological solution, and that work will require significant investments across the industry. Examples include the recently released proposed rules for the much needed attachment standards and the electronic prior authorization standards.

So with that, I just want to thank you again for inviting the AMA to present our comments on X12's request, and I'm happy to answer any questions that you have.

Tammy Banks: Thank you, Nancy. Appreciate the comments. Katie is going to go next and then Jamie Ferguson is going to take over the Q&A.

Katherine Knapp: Good afternoon. I am Katie Knapp. My remarks represent the Department of Veterans Affairs as a provider. As the largest integrative healthcare system in the United States, the VA has sent and received over 80 million electronic healthcare transactions in 2022. VA is committed to implementing and the continued monitoring of the HIPAA-mandated electronic transactions to ensure the benefits of administrative simplification are realized across the healthcare industry. These benefits have been and will be continued to be passed on to the nation's veterans.

The testimony addresses the questions posed by NCVHS for the proposed updates to the adopted X12 standards specifically for the 837s and 835 transactions. Responses are organized into the two following categories: first, VA's comments on specific 837s and 835 updates to the X12 standard, and the second group is VA's view on moving forward with the full suite of updates for the X12 standards.

First, VA's comments on specific 837 and 835 updates to the X12 standards. VA's experience implementing electronic transactions under HIPAA demonstrates VA's commitment to proactive development of internal software solutions to meet electronic standards. VA has been participating in reviewing updates to the 5010 standard over the course of the last 10 years and when reviewing these two transactions in detail, VA has no specific reservations about the changes proposed.

The industry has taken many years to craft these updates and VA strongly believes it is time to move forward and implement the next version. VA stands ready to make the necessary system changes to comply with the new standards.

Second, VA's view on moving forward with the full suite of updates to the X12 standards. As mentioned, VA is supportive of moving forward with the proposed updates to the 837 and 835 transactions. Further delay would complicate operational use and would add scope to the development of software solutions necessary to maintain the standards. However, how the industry moves forward with the updates is a concern for VA.

The concern for VA involves the distinction between one, the software development, and two, the implementation of the new transactions. As NCVHS makes the recommendation to the Secretary, VA's position is to approve the transactions, allowing providers, payers, and healthcare clearinghouses to complete the software development, but hold the implementation until the full suite of transactions is ready and approved.

Holding the implementation of the transactions until after the full suite approval allows the VA to incrementally develop each transaction, focusing on just one at a time. Spreading out the development life cycle in a measured approach would help organizations to better justify the IT investment required to implement these updates.

In this scenario, organizations would be able to develop software solutions to meet industry changes, but then place these software upgrades in a dormant state until all transactions are ready to be put forward to the Secretary.

When the 837s and 835 transactions were put forward to NCVHS to implement first, VA appreciated the opportunity to focus on this smaller subset of transactions. In past NCVHS hearings, testifying on the entire suite of X12 updates was overwhelming. So in that regard, VA supports the structured incremental approach proposed.

Moving forward with a few transactions at a time as is currently proposed could potentially create major operational challenges. VA experienced problems with trading partner exchanges that impacted operations as it transitioned from version 4010 to 5010. VA believes even more challenges would be created by proceeding with implementing only two transactions instead of the full suite. The challenges from the last conversion were seen across payer and clearinghouse operations which created downstream impacts to veterans.

Implementing different versions of different transactions will require extra internal development to ensure capability forwards and backwards, thus potentially creating challenges across the industry, challenges that may occur each time a transaction set is released. If NCVHS were to move forward recommending the implementation of transactions separately, it would be advantageous to solicit industry feedback as to the best order in which to move the transactions forward. For example, VA foresees major operational issues if the 837 updates were adopted before the 270 and 271 transactions. Operational issues around selected

implementation would not only result in a loss of revenue, but ultimately negatively impact the nation's veterans.

Finally, VA wants to take the opportunity to comment on moving forward with the adoption of multiple versions of each individual standard. As the largest healthcare organization, VA interacts with thousands of payers nationwide in multiple clearinghouses. It is nearly impossible to maintain a list of payers and clearinghouses and which transaction version is being accepted at any given time. The only way the VA feels this recommendation would be successful is if the decision on which version is being sent and received is provider-driven with clear implementation and compliance dates assigned.

VA remains committed to the benefits of HIPAA's electronic transactions. The updates to these transactions are recommended and supported in the hopes that it will bring more robust exchanges of data and ultimately result in a better experience for veterans. Thank you for this opportunity to comment.

Jamie Ferguson: I want to thank you all very much for your input. I would like to lead off with just a couple of questions and then ask for additional questions from the committee members.

Katie, you just addressed in VA's position the impact that might have to update only these selected transactions to the 8020 version but leaving the bulk of the transactions in 5010. I would also like to ask Nancy and Andrea, if you could respond, what are the pros and cons or costs and benefits of this strategy and how would it have an impact on providers?

Nancy Spector: I think the issue here is that, again, we haven't had any testing. We haven't operated where there have been multiple versions in play at the same time. So it's hard to understand or put numbers around what would be costs and benefits of that without knowing that it would actually work and how we would navigate a system, as Katie was saying, where you've got to track who is on what version, and just how that all impacts the physician's workflow.

Andrea Preisler: I think to piggyback on Nancy's point, I think a big question we have is exactly functionality. How does this impact the physician's workflow, and does it help or hinder that? I think we need to see continued testing to help identify.

Jamie Ferguson: Thank you both very much for that. I want to switch to another question. This is about timing. So as you know, HIPAA provides a two-year window for health plans and providers to implement the new specifications after a final rule is published.

Most likely, that would equate to at least another four years elapsed after a recommendation. So what's the implication of that timeline? We're thinking about the rapid pace of change in healthcare technology. So is there an ideal period for adoption of new versions? What timing would you recommend for adoption and implementation?

Nancy Spector: I think what concerns us is that right now, what we're seeing is a timeline being proposed that would be based on these different, I think Cathy called them, phases. Right now we're looking at the 837s and the 835 and then the next phase is supposed to be I think the 276, 277, 834, 8020, and then there's the 2070, 2071. I forget how many total phases there are, seven or eight.

So if we're just talking right now and we've been this far into talking about the first phase, and then you're looking at putting out a proposed rule, addressing all of those comments in a proposed rule, getting out a final rule, we could be another year-ish. Then we haven't even seen the next phase coming out. It was supposed to come out in August. I think the website now says January.

We don't know when the next phases are even going to be brought out. So we're talking about what could be a pretty long extensive rollout of all of these different phases and adoption if we were to do each phase as an adoption. We would be back around to then probably wanting to make updates to the claim before we even get to the final phase of what we're trying to do with 8020.

This again I think is where we just haven't really vetted out the scenario of what we're looking at to understand where does that leave the industry through all of this work?

Jamie Ferguson: Thank you. Katie or Andrea, would you care to talk at all about the timing?

Katherine Knapp: From our perspective, the two years of implementation makes sense. It's a lot of the unknown from today until that final rule comes out that really, it's just really hard to help predict and to know what else is going to come during those years while we wait for the final rule to come out.

So the two-year timeline is something that makes sense to us in our development, but it's really all the waiting until we get to that final rule, and like Nancy said, is something else going to come up during that time, will we then have to backtrack and make sure that what we talked about today is talked about with that one? And just finding the cadence of how these are going to happen and what we can predict.

The two years after the final rule, I think in my mind, all of the hard work comes in during that part, but it makes sense because we need that time to internally develop and test externally, but it's all of the unknowns leading up to that that really creates some confusion on our side for really where we're going.

Andrea Preisler: I agree. We need that time to test with industry, with trading partners. Again, I think uniformity is key and predictability is key when we're talking about these standards and making sure we're ready for go live.

Jamie Ferguson: Thank you. I do want to ask one more, and I realize we're running over just a little bit on this section, but I do want to ask one more question before turning it over to

committee members for their questions. Any of you can jump in on this one. Are there any what you would consider to be must-have fixes that this version has that the industry needs in order to improve the workflow for providers for these transactions?

Nancy Spector: I know that some of our specialty societies would really like to see the increased number of diagnosis codes and in the increase in the diagnosis pointers. Specialties where they are more involved with the SDOH data, that would definitely be a benefit for them.

Andrea Preisler: I think from the AHA perspective, again, as I mentioned in my presentation, we're really interested in how 8020 could help with No Surprises Act implementation. But as Nancy mentioned in her presentation, the 837 already works very well. Adoption is very high. So I want to make sure that we're putting resources where they're needed and not in places that are already working very well.

Jamie Ferguson: Great. Anything else to add, Katie?

Katherine Knapp: No. I agree with what they said.

Jamie Ferguson: Thank you. Let me first turn it over to other committee members to see if you have additional questions for this panel. Seeing none, and other hands that were raised have gone down, so I am going to now turn it over to Denise, who is going to lead us into the next panel. Thank you, all three of you, very much.

Katherine Knapp: Thank you.

**Panel 3: Health Plan Perspective on Proposed Updates to X12 Transaction Standards**

Denise Love: Thank you and I think some of the committee members who have questions will circle back later. So don't lose those questions. But now, in the spirit of moving on, we have the next panel, our payer panels.

The first one is the public payer or the CMS Medicare Dental Program, Tennessee Medicaid, and Alabama Medicaid. We will go to break. The second payer panel will then commence and that will include Blue Cross Blue Shield, Alliance of Community Health Plans, and Elevance Health. You have their names on the agenda.

So I think we will go in the order that these payers are listed on the agenda starting with CMS Medicare Dental Program, Natalia Chalmers.

Natalia Chalmers: Hi, everyone. It is a pleasure to be here, and before I start my remarks, I want to begin by extending my heartfelt thank you to all of the providers who have continuously supported our beneficiaries through this pandemic and all of you who made their day-to-day operations easy.

Many of you are familiar with the impact of CMS and our programs, but today we touch close to 158.5 million people, the majority of them through Medicaid and CHIP, about 90 million, 83 in Medicaid, 7 in CHIP, and the remainder in Medicare and Marketplace.

In Medicare, about 65 million people in fee-for-service, 35 you can see in Medicare Advantage. Through the Marketplace, 14.5 million individuals get access to care.

I wanted to start with recognizing the CMS vision is to improve, be a trusted partner and steward dedicated to advancing health equity, expanding coverage, and improving health outcomes. We cannot improve health outcomes if our patients have poor oral health.

You will see here that in a given year, this is 2018, the majority in the United States, a lot of people have both medical and dental visits, in the center, and 28 million people only have access to the dental delivery system or touch the healthcare system through their dental visits.

So it presents a unique opportunity, but also a challenge of how providers communicate to provide the best coordinated care that will result in these improved clinical outcomes. Of course, we also recognize that about 64.7 million people don't have access to either.

Just note that in about 9 percent only receive dental care of all beneficiaries, of U.S. citizens, Medicaid about 34, and 37 for dental and medical. We will go to the next slide and look at 2019 and how that varies across payers. I think this really gets to the heart of some of the challenges.

So the first bar graph on the very left, you see again these numbers I highlighted for you, 9, 37, 33, 20, this is overall. But when you look at that and how it breaks by payer, you see a huge difference, especially in the brown bar meaning those patients who had access both to their dental and medical provider, and also some notable differences in the blue bar which is again the only point of access to the healthcare system is through the dentist.

In the public space, we see that there are people, children, adults, and seniors who only have a touch with the dental system.

Coverage is really important, and I think my colleagues will highlight the importance of coordinating the care, but I wanted to highlight an important fact, that regardless of coverage in children under Medicaid have access to dental services, we see a tremendous geographical variation of how many children receive dental services in a given year. Yes, this is COVID, but some of these geographical differences existed in 2019 and continue in 2021.

So this is to appreciate that, in addition to the coordination of care information or exchange challenges, there's significant variations in how many children, 1 to 20, access dental services.

For adults in Medicaid, dental is an optional benefit, and states have flexibility to offer these benefits. Some choose to provide an extensive coverage and others only offer emergency or a very limited number of services. We've looked at if you don't have access to the dental delivery

system, you will end up going to the hospital and the emergency department, and sometimes you have to be admitted.

So on average, an emergency department visit is around $900, and all that it provides is palliative care -- antibiotics, opioids, combinations of the two, and patients are asked to find a dentist. And again, the lack of connectivity between the hospital systems and the dental providers becomes a real challenge and a burden to the healthcare system of coordinating this care.

And yearly this is about $2.7 billion that are wasted just because of lack of access and coordination. And again, you can see that in some states close to 4 percent of Medicaid adults go to the emergency department for visits. We also have a full report diving into the patient admissions, and again, there you would appreciate the cost of that, $10,000, $20,000, $15,000, for a single patient, really it provides a huge opportunity to reduce the burden and improve operational effectiveness.

In Medicare, this is the percentage of Medicare beneficiaries living in the community who had a dental exam in 2019. Very far on the right, you see on average, it's about 42 percent. But just note the first set of yellow bars on the left, the huge racial disparities that exist. And again, this is really to highlight that oral health is about health equity and improving access to dental services and care coordination advances health equity. In the middle yellow bars, you will see that income actually has a huge role to play in the ability to access dental services, for those seniors with an income of over $50,000 enjoying one of the best access to dental services in the whole healthcare system.

Recognizing this, I wanted to highlight a recent policy change reflected in the final physician fee schedule 2020 rule. As many of you are probably aware, there is a statutory dental exclusion where no payment may be made under part A and B, where such expenses or services in connection with the care, treatment, filling, removal, or replacement with the teeth and structures directly supporting the teeth.

The rationale for the 2023 physician fee schedule is that we recognize that in some instances there are medical services that are necessary to diagnose and treat individuals' underlying medical conditions and clinical status may require the performance of certain dental services. We believe that there are instances where dental services are so integral to other medically necessary services that they really are not in connection with care, treatment, filling, removal, and replacement of teeth.

Let me give you a point of reference. Look at the palm of your hand. If you had periodontal disease, and a lot of U.S. adults do, and 66 percent of U.S. seniors do, if they had periodontal disease, the level of inflammation present in their body would be the equivalent to the size of your palm. So we don't manage any conditions when there is such inflammation present.

We looked at that and actually looked at our Medicaid manuals and the provisions that were already existent related to dental and oral health services, and prior to this rule, these are some

of the examples that we covered. For example, if you had inpatient reconstruction of the jaw in connection with an accidental injury, that would be covered. An oral examination but not the treatment performed prior to a kidney transplant or cardiac valve replacement. The reconstruction of a ridge, the wiring of the teeth when it's done, again, with reduction of jaw fracture, and the extraction of teeth to prepare the jaw for radiation treatment in neoplastic disease.

And what we finalize in the 2023 rule is we codified these certain aspects that are already covered with our policies when the service is an integral part of a specific treatment of the beneficiary's primary medical condition. Other clinical scenarios under which Medicare part A and part B payment can be made for dental services include the dental exam and -- and -- necessary treatment prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures. So these are codified in the 2023 physician fee schedule rule.

And then most importantly, we establish a process through which we can review, we consider public recommendations, for Medicare payment for dental services that are potentially analogous. We also, effective calendar year 2024, finalized Medicare payment for dental exam and necessary treatments prior to the treatment of head and neck cancers.

Denise Love: Natalia, we are running low on time, so if you can --

Natalia Chalmers: This is the last one. We also had a lot of information and comments, and I think if we go -- people will have access to the slides, so they can read it.

These are the changes in Medicare that will really prompt the necessity for care coordination and exchange of information between dental providers and the broader healthcare system.

Denise Love: You've provided so much valuable information, and it's amazing what you do. I'm assuming that given your presentation that your position is in support of the X12 proposal?

Natalia Chalmers: In the actual final rule we say that the exchange and facilitating the exchange of information between the dental and medical providers is key to this process. In order for that to be successful, yes, anything that makes this easy for both parties and the providers, who are at the heart of this, and we mentioned multiple times, such a key -- it's so important to have the standards implemented.

Denise Love: I have to correct myself, I had an old agenda. We have two presentations before break. Rebecca, did you want to read Margaret into the record before I go on?

Rebecca Hines: Why don't we do it right before the break to keep the integrity of the session?

Denise Love: Thank you so much. Ferris Marone, from Tennessee Medicaid, is the next presenter in this session.

Ferris Marone: Thank you for the opportunity to present from TennCare, Tennessee Medicaid's point of view.

A little background on me. I've been with the state for five years, and I was a consultant to the state as a contractor for about 10 years, 12 years, before that. Before that I worked at clearinghouses, I worked at providers, and I worked at payers, implemented 4010, implanted 4010-A1, implemented 5010.

Looking forward to implementing a new standard, a few reservations. I am functioning under a state government, so before we can do a cost/benefit analysis, you have to have that final rule published, and then we can start the cost/benefit analysis. Speaking strictly from my experience, implementing 5010 here at the state of Tennessee, at TennCare, we found the implementation to be very resource- and cost-intensive, going from 4010 to 5010. So I anticipate we'll have the same thing going from 5010 to 8020.

I appreciate everyone's comments on how we can do this in phases. As we all know, the last change of standards was big bang, and we use a lot of those standards. I just -- I'm a little hesitant to say from a TennCare perspective that we endorse that we endorse that way of doing things. We've never done it before, so we don't know. We never support two standards at the same time.

My questions are more around interoperability, and claims and ERAs, 837s and 835s, are a huge undertaking in my humble opinion. To get claims and encounters in version 5010 and issue an 835 in version 8020 is going to require us to do a lot of changes.

So I'm new to supporting two versions of the standard, and I remember back in the day, we used national standard format version 2, and we went from national standard format version 1 to national standard format version 2. It was quite challenging back then, but we're looking forward to being able to serve our population better and getting that cost/benefit analysis, and are we really providing better care? Because that's our goal. Provide quality healthcare for all of our members.

Denise Love: Thank you, Ferris. Could you repeat that one part about the 837 and 835? Did you say they were different -- I may not have heard that right. On the different versions.

Ferris Marone: So, having a provider, or having a clearinghouse, send us 5010 claims, 837s, P, I, and D, claims, and responding with an 8020 835, would pose some challenges.

Denise Love: Okay, that helps. I am assuming we would have the same version, but that's duly noted that that would cause some disruption if they were not the same version. I think that's what I heard.

Ferris Marone: Yes, and we would specify in our trading partner agreement with the specific provider organization, provider association in Tennessee that they're going to do version 5010 or version 8020. Of course we need the cost/benefit analysis so that we're using our funds --

Denise Love: Right. I just had a question, and I may -- this may run into the next panel. I think we're running into break time soon. But Ferris and maybe Natalia as well, there are costs to

advancing to a new standard. That's clear. We're hearing that today. But what is the cost of not moving forward, for your programs? Because are there opportunity costs and functionalities lost that you cannot do, given your new business needs and new technologies and the current standards?

Natalia Chalmers: I think that is an excellent question. Yeah, go ahead, Ferris. I think you already hinted at this.

Ferris Marone: Like I said before, we can't do the cost/benefit analysis. We can't even start doing that. Fortunately, we've been looking at the 8020 transactions, the 837 and 835, to see what the changes are, and I know all about errata versions and addenda's, right? I think we all do. Addenda's and errata versions. So I just, I'm cautious.

Natalia Chalmers: We heard this I think from all the presenters. We need to put patients, our patients and beneficiaries, at the heart of this, thinking what are the studies that need to show that we will improve outcomes for patients. We need to be very aware of how this will impact providers in positive and negative ways. So if it's possible and easier to exchange information, that has costs and opportunity for improving clinical outcomes, and then for the healthcare system as a whole. I think really what I heard in the comments is this needs to be evaluated with a very systematic approach, keeping the patient at the center, the provider at the heart of it all, and recognizing that outcomes and the cost are very important, but are any of these going to help us to improve health equity? Because we have a very inequitable healthcare system and so to me, there is that piece that is just as important, improve outcomes for our beneficiaries and patients.

It's been really very insightful to hear all the perspectives shared today. So again, thank you for the invitation.

Denise Love: Thank you. Are there any questions from my fellow committee members before we move on? Both of you, I respect and appreciate all you do for your programs and for the populations you serve, and it's a critical piece of our healthcare fabric. So thank you for taking the time.

Rebecca, do I need to turn it over to you for any administrative duties?

Rebecca Hines: Yes, thank you. Margaret Skurka, I see that you -- thank you, Ferris, thank you, Dr. Chalmers, we really do appreciate your input. It's very essential to round out all of the perspectives.

Margaret Skurka, it looks like you are unmuted. Could you please -- since we had the little mix-up this morning during rollcall, can you please, you and then followed by Vickie Mays, read yourself into the record, your name, your organization, and any conflicts please?

Margaret Skurka: Thank you, Rebecca. I've been here all day. But happy to be on the record here. My name is Margaret Skurka. I'm a professor emerita at Indiana University. I am a

member of the full committee, and I am a member of the Standards Subcommittee. I also have no conflicts.

Rebecca Hines: Thank you, Margaret, and Vickie Mays?

Vickie Mays: Thank you. Vickie Mays, University of California Los Angeles. I'm a professor of psychology and health policy management. I'm a member of the Full Committee and also a member of Privacy, Confidentiality, and Security, and I have no conflicts.

Rebecca Hines: Thank you. To our co-chairs, Denise Love and Tammy Banks, it's a couple minutes after 2. How would you like to handle the break? Come back at 2:16?

Denise Love: I would say 2:16 so we can keep moving, because we've got some panels coming up.

Rebecca Hines: Very good. Okay, we will return in about 12 minutes or so, and when we come back, we will open it up for public comment.

(Break.)

**Public Comment: Updates to X12 standards**

Rebecca Hines: So, we will now move to the public comment period. For members of the public, this is your opportunity to provide comments on the request from X12 for an update to the standard.

On behalf of the committee, we request that today, if you would please focus your comments on the subject matter of today, which is the proposal from X12 for certain transactions. And as you can see there is going to be a timer available, and we will open the line. But first I believe Tammy, did you have a word, a preface before we open the line?

Tammy Banks: If I may. I just wanted to give out a little more information. Since some of you may not have had the opportunity to hear the X12 presentation this morning, I would like to provide just a brief update. X12 shared that when a data is exchanged in certain cases but not universally, X12 defines a situational rule that defines a circumstance for which the information is appropriate. Support for card payments was added based on industry requests that reflected business practices already in use in the healthcare industry.

And so just as a courtesy, and to inform the content of the presentation from our colleagues at X12, we wanted to provide you a little bit more information, with the appropriate resources and contact information at CMS for additional information on this topic.

You're going to find in the chat a URL, and that URL will get you to a CMS guidance document that was published March 2021, on behalf of health plans payment or health care claims using virtual credit cards and adopted HIPAA standards for HIPAA for healthcare, electronic funds transfers, and remittent advice transactions, strongly encourage you to review that guidance.

It was published on the CMS website, again at the link that you're going to see posted. And if you have any additional questions about the guidance document or use of the HIPAA standards, the National Standards Group has a mailbox to receive questions on the guidance document. The address for that mailbox is AdministrativeSimplification@CMS.HHS.Gov. Back to you, Rebecca.

Rebecca Hines: Thank you so much. I see we have four participants ready to have their line open. You can see on the slide to raise your hand, you've already done that. For those who for whatever reason don't want to speak live, you can also send your comments by email to NCVHSMail@CDC.Gov as noted here, and these will be shared directly with the members to have available after the hearing.

So Damon, can you open up the line for Cindy Leonard please? When Cindy begins start the timer for three minutes, please. Please also state your title and your organization, that would be helpful for the record. Thank you, Cindy.

Cindy Leonard: Hello, I am Cindy Leonard, and I am the Chief Operating Officer for Arizona Advanced Surgery. We are a private practice group of 70 surgeons and about 20 midlevels in 17 locations in the greater metro Phoenix area. We have been aware and making all efforts to push back against these EFT and VCC fees and uses that we are now realizing to the tune of close to $40,000 last year. So we do not support the adoption of this standard, and it just raises cost and we have not seen any benefits for it.

Rebecca Hines: Thank you very much. Damon, can you please open the line for Joan Melendez? And Joan, please also share your organization and title, where you are. And you can unmute yourself now.

Joan Melendez: Thank you very much. My name is Joan Melendez. I'm from Xcelrate UDI. We appreciate the opportunity to share our view on the utilization of UDI in the claim form. Xcelrate UDI is a leading global provider of bar code scanning solutions and patient safety based solutions that drive effective decision making and outcomes.

The recommendations from us really, the UDI element, the data element represents a critical medical device information essential to patient safety. The UDI is currently required in ONC cert regulations for providers, and FDA UDI regulations for both providers and medical device manufacturers. It is the vital next step for the inclusion of UDI for your consideration. Again, thank you so much for your time.

Rebecca Hines: Thank you Joan, I appreciate it. Next up we have on the list Ana Castro. Ana, remember to please state your organization and title. And you can unmute yourself now.

Anna Castro: Hi, my name is Anna Castro, I'm the Practice Manager at New York Urology Specialists. We do not support the adoption of new standards or standards modifications, as they do not lower the cost of healthcare due to failure of the National Standards Group to

enforce compliance. There is rampant non-compliance with already adopted standards. The proposed standards are not equitable to healthcare providers.

HIPAA standards for electronic transactions is a bait and switch. While the standards are adopted and sold to healthcare providers with the promise of cost savings and administrative simplifications, because of rampant non-compliance and CMS failure to enforce standards, the promise of cost savings does not live up to the promise.

CMS National Standards Group created HIPAA Administrative Simplification requirements enforcement with what they call an informal compliance mechanism. But you are smart enough to know that when something is informal, voluntary, or without repercussions, there is no compliance. CMS National Standards Group has not imposed a single penalty for non-compliance with adopted standards. In fact, it would not even call a violation a violation.

CMS's own data shows that for the eight health plans that completed a full audit of 835 transactions there is a greater than 100 percent non-compliance rate as there are numerous violations of the standard.

Health plans are not compliant with the 8010 version of 835. We have not received the promised benefits. CMS failed to enforce standards. CMS closed thousands of valid complaints, and continues to receive hundreds of new complaints monthly, eight years after the 2014 due date for compliance.

Unless CMS creates a real enforcement mechanism for transactions that are already adopted as the standard for the past eight years, there are no justification for adopting these costly revisions and new standards going forward.

The informal compliance mechanism is a sham that holds billion-dollar health plans immune from punishment and repercussions. It is public knowledge that CMS closes 80 percent of valid complaints as invalid.

Mr. Dan Kalwa, the interim Director of CMS Division of National Standards at the CMS Office of Burden Reduction imposes onerous burdens on healthcare providers to file complaints, requiring that an 835 source file is presented within 10 days, and closes complaints without resolution.

On the other hand, Mr. Kalwa at the CMS accepts verbal reassurance from health plans that they are compliant. No validation of health plan compliance is required.

We do not support the adoption of any new standards or standards modification until existing standards are meaningfully and fairly reinforced. Thank you.

Rebecca Hines: Thank you very much for your comment. Next we have Alex Shteynshlyuger. Alex, if you could please state your organization and title. And your line is unmuted.

Alex Shteynshlyuger: Thank you. My name is Dr, Alex Shteynshlyuger, I'm the Director of Urology at New York Urologist Specialists, a sole business proprietor. I'm an advocate of HIPAA Administrative Simplification Requirements and an advocate of national standards. However, we do not support the adoption of X12 proposed standards or standard modifications, as they do not lower the cost of healthcare. They're unwanted and unneeded.

The proposed standards are not equitable to healthcare providers. As you are well aware, over 500 comments opposing the X12 proposed addition of card payments information to 835 transactions were received from practicing physicians and medical practices. Card payments means virtual credit cards.

As a Change Healthcare study that we submitted for your review demonstrates, fewer than two percent of healthcare providers would choose to accept card payments as a payment method. And that's before they even know the true cost of accepting card payments. Yet somehow X12 managed to push this proposal through the so-called consensus adoption process. How could a proposal that is unwanted by 98 percent of providers be a consensus?

But yet X12, XL7, and WEDI came out advocating for this unwanted, unneeded, and illegal addition to 835 standards. Worse than that, and more shameful, is that XL7 submitted with the comments to NCVHS endorsing the addition of card payments to 835 transactions.

I ask you to ask the following question to XL7: what expertise does HL7 have about the 835 transactions or card payments for that matter? Why is HL7 even advocating this change? What is the basis for HL7 recommendations to adopt the addition of card payments to the 835 transactions? It seems that it is part of an organized RICO-type conspiracy, because there are no buyers for card payments. No healthcare provider wants that. It is important to remember that United Healthcare, Optum, Vpay, is a center of unwanted upcount virtual credit cards, with a seat on X12, WEDI, and NCVHS.

Zelis is another center of unwanted credit cards, a board member of WEDI. Change Healthcare, now part of United Healthcare Optum is another vendor of virtual credit cards in partnership with Echo Health and PCM Bank which also holds board seats at WEDI and are represented on X12. I think you will agree that it is very curious that despite the fact that X12, and curiously enough Hl7, vigorously advocate for the adoption of this addition, not a single health plan or vendor came out in support of it.

This raises a question: What is the function of standards organizations? How do they manage to propose consensus based recommendations that no-one will publicly endorse, take ownership of, or stand behind? What interests do the standards organization represent? Whose interests? The X12 proposal to add card payments information to 835 is the biggest crime perpetrated by the capture of standards setting organizations by private interests.

Rebecca Hines: Thank you. Your three minutes is up. I'm sorry, I need to cut you off. Looks like our next person up is Christopher Gracon. Please state your organization and title please and unmute yourself.

Christopher Gracon: Thank you. My name is Christopher Gracon, I'm with Independent Health, a payer out of western New York, and also our organization member of the X12 and a participant within X12. I would like to argue for, as a payer, the advancement of these standards, including for the additional data fields like UDI, the additional remark codes. But also for the increase of number of diagnosis codes that we'll see, particularly as we need to be able to get more things like SDOH data. That's it for my comments, thank you.

Rebecca Hines: Thank you very much. And I see we have a panelist with a hand up. That would be Christol Green.

Alix Goss: It is not Christol Green. This is Alix. We were getting ready for her next testimony as a number of the press are here. But formally, for the record, this is Alix Goss, the Chair of the Policy Advisory Committee of HL7. I just wanted to clarify that our submission in the request for comment indicated that the X12 835 was updated to support different payment models, including virtual card. The 835 has many front matter revisions to support COV and recoupments.

These two developments alone are significant pain points for the industry, and suggested updates will help streamline the use of it in reporting. Overall, we are not necessarily an advocate of virtual cards, but I think we also need to understand that industry has the ability to participate in the consensus-based processing. We encourage all key stakeholders to actively engage in all standards development organizations. Thank you.

Rebecca Hines: Thank you Alix. And again, if there is anyone else who would like to make a public comment, please raise your hand. I'm checking the email box, and I do not see anything new. So we'll wait another 30 seconds. Anyone else? Does anyone else have a comment for today's hearing? And again, if for whatever reason you don't want to make a live comment, you can also send them to NCVHSMail@CDC.Gov.

It looks like we are done with public comment for today. Thank you all for your very valuable input. We will also have public comment tomorrow, in which we ask that you focus your comments on tomorrow's topic, which is new and updates to CAQH core operating rules. So with that I can turn it over to Denise.

**Panel 4: Health Plan perspective on proposed updates to X12 transaction standards**

Denise Love: Thank you. So we are now entering the session of panel four, part two of hearing the payer perspective on the proposed 8020 standards. As mentioned before, we will start with Blue Cross, Blue Shield, Gail Kocher. We will move on to Ginny Whitman at the Alliance of Community Health Plans. And we will end this session presentation with Elevance Health, and then open it up to the committee members for any clarifications or questions. So Gail, I'll turn it over to you.

Gail Kocher: Thanks Denise. I am Gail Kocher, Director of National Standards at the Blue Cross Blue Shield Association, which is a national federation of 34 independent community-based and

locally operated Blue Cross and Blue Shield companies or plans that collectively provide healthcare coverage for one in three Americans.

For more than 90 years Blue Cross and Blue Shield companies have offered quality healthcare coverage in all markets across America, serving those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare, and Medicaid. On behalf of BCBSA and the plans we would like to thank you for the opportunity to respond to the Subcommittee On Standards' questions and provide our perspective on the proposed updates to X12 standards transactions.

We continue to strongly support the goals of HIPAA administrative simplification to promote efficiency and reduce the cost of administrative transactions. I will comment specific to the questions that you sent to us. Regarding how the updates would reduce administrative burden and/or cost which could benefit covered entities and any workarounds that have been implemented to address workflow.

Unfortunately, the different summaries that are available do not provide the level of information that we would need to provide an answer for this question. We along with plans would need to conduct a detailed GAP analysis, which means we would need to use the TR3 from the X12's Glass tool to determine what updates would have such impacts to further reduce administrative burden, and whether there are additional benefits, and weigh that against any estimated cost to implement.

We have not identified any specific workarounds implemented by the association or blue plans related to the claim or claim payment transactions. And we obviously cannot speak to any workarounds that our trading partners might be using.

The question around the general readiness of the industry to begin planning for updates to systems and operations, we believe that readiness is really a bit cautious at this juncture, specifically until it is clear to the industry whether one version could be named in a version of proposed rulemaking, and another in a final rule.

Planning for updates to systems and operations for future versions of the claims and remittance advice is not an inconsequential task. It really requires creation of a project, resource allocation, determination of what teams must be included, including identifying funding.

Given the current set of requirements under the consolidated appropriations act, interoperability rules, and other federal and state requirements, along with strategic initiatives, the industry as a whole is very active already with implementation. Absent formal mandates, obtaining resources to do even preliminary planning will be difficult, especially when it's unclear if the version could change from an NPRM to a final rule.

Regarding cost/benefit and ROI for the updated, and if that's available now, and if not when it might be available, as I noted just a second ago, there's really not enough information available at this point where we can provide detailed cost/benefit and return on investment.

We would have to conduct a detailed GAP analysis of the version that would be intended for adoption against current systems. Covered entities need to know the exact standard which are intended in order to begin an accurate review to determine its cost/benefits and ROI. This effort to result in accurate and valuable information can only be done as a project or initiative which requires resources, both dollars and people.

In terms of whether we support the recommendation, while the currently available list of updates is limited in detail, and I cannot identify anything that we are looking to have updated in the standard, we are not opposed to moving forward these standards for consideration of adoption under the federal rulemaking process. I would again note however that we have significant concerns with the concept of reviewing and commenting on one version under an MPRM and having another standard named in a final rule.

We are aware that there are changes in these versions being brought forward that other trading partners would like to have available for use, as it may provide additional information to them related to benefit application during claims processing.

And then finally, was there anything else that the committee should consider? I want to just be clear that all of these comments are specific to the standards that we were asked to cover today, claims and remittance advice. We are supportive of any ability to normalize the publication and adoption of cycles for updating the standards, noting that the revisions need to be based upon a business need, not just change predicted on the need for content to fill an established cycle for issuing updates.

Even routine updates to systems and processes utilize budget and other resources, which when updates are being made absent business need or gain detract from using those resources for other resources initiatives need or wish to make.

We support the work of NCVHS related to adoption of standards and operating rules under HIPAA, but we also support that the establishment of a roadmap to ensure the limitation of private expenditures being imposed on stakeholders in order to comply with administrative simplification regulations. This roadmap should balance and account for all federal and state mandates, not just administrative simplification, but other mandates such as CAA and the consumer transparency, as well as other potential regulatory requirements, in order to work towards avoiding bottlenecks and overlapping resource commitments for all stakeholders. We appreciate the opportunity to supply comments, and I'm happy to answer any questions. Thank you.

Denise Love: Thank you Gail. We will proceed with this panel, and we'll go on to Ginny Whitman, and then again at the end of this committee members will have an opportunity to ask questions. So Ginny, it's all yours.

Ginny Whitman: Thank you. My name is Ginny Whitman, I'm the Senior Manager of Public Policy here at the Alliance of Community Health Plans, and I have the pleasure of overseeing

our policy portfolio and development for health IT related issues. That includes interoperability, price transparency, prior authorization, and a host of other health IT related topics.

For those who are unfamiliar with the Alliance of Community Health Plans, we represent a unique nonprofit partnership model in healthcare, bringing together plans and providers on behalf of the patients and communities they serve. ACHP advocates for practical solutions that make healthcare better, with high value coverage and care for all.

I am please to be representing our member companies on this panel today. Thank you for inviting us. And we are looking forward to sharing our perspectives on the X12 updated standards.

For interest, this is a map of ACHP member plans across the US. We can move on to the next slide. So ACHP is generally supportive of the direction of the X12 updates. There are a number of updates that we feel will improve health plan processes. So we admittedly flagged a few concerns for the committee.

As it relates to administrative processes or operationalization, I've noted a number of times already today, the rapid evolution of policy and technology within the health IT space is a significant operational challenge for health plans, one that has the potential to get worse without intervention.

ACHP therefore looks forward to consistent and rolling updates for standards and rulemaking that can incorporate the ever-changing nature of this policy arena, and we look forward to evaluating in future years the recommended X12 annual updated process to see if this will help and address concerns.

As it relates to implementation and timeline, while we appreciate the need to update these standards, ACHP does anticipate that implementing these updates will be a significant lift for our member companies, especially when taken into consideration the number of other interoperability efforts currently underway or slated over the next several years.

This list of health plans bearing the burden for data standards was noted earlier this morning, and it speaks to the larger shift of health plans becoming the arbiters of all health data. And all that that will eventually entail and currently entails in fact.

I will also note that this may be a particular challenge for smaller health plans that need to make strategic decisions about how resources are allocated to ensure they are best serving their beneficiaries. We've also heard from a number of our members that they continue to face staffing challenges as they attempt to find appropriate personnel to help implement and operationalize the growing demands of this health IT space.

ACHP also has some concerns with the timing of X12 updates related to other regulatory initiatives. Again, this has been noted already throughout the day. The new clinical attachments proposed rule and the electronic prior authorization proposed rule are just the most recent

examples. We are particularly concerned that these new versions, by the time that they are officially adopted and required to be implemented, may already be over four years old. And then by the time new standards are in place, a host of other health IT requirements will either be completed or underway with then outdated standards.

We echo the comments made by WEDI earlier today regarding a comprehensive strategy to allow health plans to prioritize and manage the varying personnel and financial resources required in this space.

The early steps to ICD11 are another example of how the misalignment of standards development and rulemaking will cause issues in the future. We do recognize that as X12 has acknowledged there is a plan to address this, but it remains a concern until we have a better understanding of what the plan from X12 will look like.

If these standards are to be adopted, we would support sufficient lead-time for implementation from publication to a final rule. We also think it would be valuable to allow for a time during which both current and new versions of the standards are allowed concurrently, for a more effective and less disruptive transition. And ACHP would also support largescale pilots during the first year of transition, to identify, troubleshoot, and resolve any unforeseen issues.

Specific feedback on some of the X12 updates noted here on the slide, as it relates to FHIR and the FHIR crosswalk. ACHP supports the administration's progress towards a FHIR-based healthcare system. Key to the success of this progression are the FHIR crosswalks that will be necessary for a host of payer-related exchanges.

Candidly, our members have mixed reactions to the transition to FHIR due to the lack of maturity, and their familiarity and ability to pilot and test changes within X12 right now. While crosswalks has the potential to address these concerns, their development and testing will be crucial to ensure payers are not incurring additional burden, as opposed to achieving administrative simplification.

As it relates to value-based payment arrangements or alternative payment models, ACHP member companies anticipate that the proposed updates to 835 could be beneficial to how health plans capture and relay provider reimbursements.

While health plans can support value-based payment arrangements via the traditional claim transactions, we are optimistic that the ability to access and receive supplemental data on encounters will be critical in our health plan's ability to make innovative strides in value based payment arrangements. Value based payment arrangements in particular are priority for the Alliance of Community Health Plans as an organization, as well as many of our members.

Lastly, on diagnosis codes, ACHP appreciates that the proposal includes an increase from 12 diagnoses to 24. We believe that this increase will be good for providers' ability to adequately report social determinants of health measures, particularly as the administration is looking towards improving methods for capturing this essential information. Addressing social

determinants of health is also a high priority for the Alliance of Community Health Plans and our members.

That concludes my feedback, or ACHP's feedback on the updates to the X12 standards. Thank you all for the opportunity to provide this feedback. And I will turn it over to the next panelist.

Denise Love: Thank you. We will move on to Christol.

Christol Green: Well, thank you to members of the committee to allow me to testify today concerning our proposed X12 rules for 8020 claims and remittance advice transaction. We provide our testimony with the goal of providing information to NCVHS to accomplish its task of assisting and advising the Secretary of the US Department of Health and Human Services in implementation of the Administrative Simplification Provisions under HIPAA. We have also filed a more inclusive written testimony with the subcommittee.

On behalf of Elevance Health, I would like to thank you for the opportunity, and respond to the subcommittee questions and provide our perspective on the X12 proposed rules. My name is Christol Green, and I'm with Elevance health, I'm in e-solutions under the Enterprise Shared Solutions team.

At Elevance Health we are elevating whole health and advancing health beyond healthcare. We nearly have 100,000 associates serving more than 1.19 million people at every stage of healthcare. I've been working on HIPAA administrative simplification and am active in integrating healthcare electronic transactions for over 20 years.

We are members of WEDI, X12, HL7, CAQH CORE, AHIP, Blue Cross Blue Shield Association, and other related healthcare industries.

Many of my industry engagements include being a liaison for CAQH CORE and HL7. I also sit as a cochair at HL7 on the Payer-Provider Information Exchange Workgroup, the US Realm Steering Committee as a payer at large, and operating committee member for Da Vinci and Fast Accelerators. I also have a post on the steering committee for the e-solutions exchange, which is a Blues collaborative, and WEDI Health Plan Board Director, also with X12 participation since early 2000.

We hope that sharing our experience and recommendations with NCVHS will help improve efficiency, usage of electronic healthcare transaction, which ultimately supports improved healthcare experience and outcomes for our members.

So we are going to start with costs. Cost impacts are dependent on the actual changes proposed through the Notice of Proposed Rulemaking, and we plan to conduct a cost assessment once it is published. For example, the NPRM may recommend the most recently published version, which may be different from the version currently being analyzed.

Systems may change between now and then, and the rulemaking stage. The cost will hinge on whether there is more than one allowable version. We recommend that NCVHS provide

additional time to learn from anticipated pilot testing and implementation plans before submitting the cost and value estimates.

We also intend to conduct an operational assessment once the NPRM is published. However, we do not have any operational assessment or workflow analysis to provide at this time.

There was mention to XML schema. Standards should not be limited to XML. Any alternate format should consider FHIR, which allows representation in multiple formats natively. HL7 FHIR includes other syntaxes that would be able to include, like JSON.

If there are multiple syntaxes allowed, they should be semantically interoperable. X12 FHIR crosswalks assist with newer technology so that these tables may be included within HL7 FHIR implementation guides. For example, the prior authorization support and clinical data exchange.

FHIR Crosswalks. Dependable mapping would be helpful for implementation. May decrease the cost incurred by stakeholders, and ideally would enable more rapid, efficient development. We note that everything must be fully built and tested. FHIR transactions are under rapid development and may change. It's imperative that X12 and HL7 work together to ensure accurate and robust mapping.

The use of unique identifier, UDI, inclusion of specific device information on claims, provides opportunities for additional data analysis. This will allow clients to uniquely identify a device and tie it to a specific member to track patient outcomes, device defects, and recalls, ideally improving our member experience. However we note primarily responsibility for device recall activity should remain with the manufacturers so this information can appropriately get the information to our patients.

So for alternate payment models, value-based payments can use the same set as non-value-based claims. Thus the 8020 version would inherently support value-based payments. Alternatively, payment model support is provided by using existing claim data elements, such as diagnosis codes, procedure codes, provider identification, et cetera.

Around implementation time we would encourage an implementation window of at least two years after publication of a final rule, which would allow sufficient time for development, implementation, and adoption. We recommend inclusion of a safe harbor in case of testing issues, as they have arose in the past.

Regarding a start date, we recommend an alternate date rather than January 1st, which may be preferable due to the number of programs and other changes that always go live at the first of the year. If an alternate day is selected, for example April 1st, we recommend that the two year implementation window be maintained, and not truncated due to any staggered start date.

We recommend that entities have the option as voluntary practice to adopt concurrent standards. We note that mandating both the use of version 8020 and version 5010 would

require additional maintenance, resulting in unnecessary burden for our health insurance providers.

Also, newer X12 versions tend to address unique claim scenarios and data needs, and plans may not be able to fully support and return needed information on the response transaction in a compliant manner.

For example, the X12 837 8020 supports additional business scenarios that would benefit from the use of using the 8020 277 CA that supports the return of the information beyond standard code set values. Plans would lose that opportunity early in the implementation of any 8020, if the 837 is forced to use an older version of our claims response, the 277 CA transaction.

Transactions that are closely aligned should use similar implementation schedules to ensure data elements that can be discussed are consistent. For instance, if X12 paired transactions at the same version would be required. Claims, remittances, COB information, all using the same version. That could also include attachments.

Specifically, if the provider and primary payers are operating at the elevated version level, and the process claim information needs to be sent to a third-party organization, that is operating on the previous version. Ramifications to the ecosystem is unknown.

So that really ends our comments for today on the X12. We thank you for allowing us this opportunity to provide our testimony today to the subcommittee. Thank you so much.

Denise Love: Thank you. Thank you to all the panelists in session four and three. I will open it up to committee members for any clarifications or questions that you might have. Just raise your hand. And I have a question that I think Christol and perhaps Ginny alluded to. State reporting and value-based purchasing are really, their business needs are exceeding the cadence of the standards.

And in the public health world there is a certain sense of urgency to increase the number of diagnosis codes and capabilities for other types of reporting. Do you have anything to say about that, if the standard is not advanced or adopted at this time? What are those workarounds, or how will those reporting needs be met?

Ginny Whitman: I will go first. So, should the standards not be adopted, I think as I mentioned our plans are able to appropriately capture value-based payment arrangements within the current claims standards. So I think that they can continue to do so.

Admittedly, having those updates available would just be able to provide them additional opportunities to capture related information for specific value-based payment arrangements that would be beneficial for providers receiving that information.

As it relates to social determinants of health, diagnosis code reporting, for us that benefit there is really in the social determinants of health space. We recognize that there are a lot of new

codes that are going to be likely used. The codes in particular for social determinants of health, though I think being able to capture that information on a claim is really important.

Again, as I noted, especially as we prioritize capturing that type of information for our beneficiaries, not just on an industry level, but ACC members in particular, again as I noted this is a big priority for them, making sure that they're able to meet the social needs of their communities and their beneficiaries.

So I think they are important updates. Again, should it not go through that they can't have 24 codes reported on a claim, I don't think it would be the end of the world, but again they would make do, but it would certainly help if they had additional space.

Denise Love: Thank you for that insight.

Christol Green: This is Christol. The other opportunity, and I'm sure many are aware that there is a lot of work going on in HL7 around Da Vinci and value-based care. So we're seeing a lot of that work done today. There are also other accelerators around the standard.

Social determinants of health, it is being worked interoperable so that we can move into another realm, getting away from the asynchronous. We're also looking at USCDI as a set. And I think some of those things are opportunities other than if you're just talking about X12 claims, gathering this information and sharing this information.

Denise Love: Thank you. Any other comments, or questions from the committee themselves? Hearing none, I think we're right on time for panel five.

**Panel 5: Vendor and clearinghouse perspective on proposed updates to X12 transaction standards**

Tammy Banks: Thank you Denise. We are going to move on to the vendor clearinghouse. First up is Pam Grosze from the Cooperative Exchange.

Pamela Grosze: Thank you. I am Pam Grosze, I am the Board Chair of the Cooperative Exchange. Thank you very much for the opportunity to provide information to the subcommittee.

Just so everyone is aware, the Cooperative Exchange is a national clearinghouse association. We represent over 90 percent of the nation's clearinghouse organizations, who process over six billion claims annually, and facilitate connectivity between industry stakeholders nationwide, helping to facilitate exchange of information between all of the healthcare industry stakeholders, including administrative and clinical data, batch and real-time.

Clearinghouses enable interoperability by normalizing disparate data to industry standards and providing flexible solutions to enable data exchange between stakeholders that have varying technology abilities. Some are low tech, some are high tech, and clearinghouses facilitate that data exchange to ensure that each stakeholder sends and receives the data in the manner they need to.

These are the CHH core slides, so that's actually not the correct deck. So I will proceed. It is unfortunate, because I do have a diagram.

Debra Strickland: Rebecca, can we get the right deck up for her, please?

Rebecca Hines: So please open Deck J. There we go.

Pamela Grosze: Okay. So, in terms of adopting the updated X12 standards, we do recognize that X12 provided some information about the changes that are included in the standards. There are a significant number of changes included in both the 837 and 835. And as has been discussed earlier today, a good portion of those are what X12 calls housekeeping changes, but there are also some substantive changes that the Cooperative Exchange feels are very beneficial, that will help satisfy new business requirements, and resolve some significant gaps in current business processes and administrative functions. So we definitely agree that the updates that have been made would be very beneficial to the industry.

But in addition to that the non-substantive changes, the housekeeping changes that have been made are also beneficial because they help decrease misinterpretation and ambiguity in the guide. They promote precision and deployment across all stakeholders. They just help decrease the misunderstandings that happen, or the different interpretations that some stakeholders may have. So refining the wording that's there, while it may seem minor, can really be beneficial in helping to facilitate data exchange between stakeholders.

So the Cooperative Exchange is supportive of the 8020 standards and both the 837 and 835, and we do feel that there is a net positive value in these updates that have been made, again considering that it has been a very significant amount of time since the version that we're currently supporting was created. So the Cooperative Exchange does support adopting the updated standards.

So we do feel like there are some opportunities. Outside of the idea of what standard we're talking about, or what version of the standard that we're talking about, the process used to update the standards has made it extremely difficult to embrace innovation and realize change, and to move forward to make sure that we can handle the new business needs that come out over time within the industry.

We feel like taking a look at that process and moving towards a known and predictable update cycle would be very beneficial towards getting us into what we call an evolutionary versus revolutionary process, having a consistent and predictable cycle of updates that is not so cumbersome, not so time consuming, would be extremely beneficial from the industry, because it would allow us to know exactly when updates are happening, know exactly what versions are needed to be supported, and be able to plan for updating those versions on a regular cycle.

And we're throwing out three years here just as a hypothetical time period, but again having a predictable cycle lets us understand exactly what's going to happen, it lets us all as stakeholders

plan for making changes, and helps us to understand what exactly is included in those changes that are going to be a smaller and less impactful as we make those changes.

NCVHS recently recommended potentially allowing multiple versions of a standard. The Cooperative Exchange feels like allowing only two versions of a standard to coexist is really recommended. And really what we are talking about here is basically what we did with 4010 to 5010, current version and one previous version.

So we are supporting two versions, but it's not unlimited, and it's not for an unlimited period of time. We do acknowledge that as we transition to a new version, supporting that previous version is very beneficial, because we have to have that transition time. But we also need to have a time limit on when that previous version is allowed.

So supporting two versions for a specific time period we feel like would be very beneficial to allow flexibility as the new standards are introduced, and allow us to work through that consistent and predictable update cycle that we had just discussed. It would present some challenges.

We need to make sure that as we move forward in versions of the standards, they are backward-compatible. That we don't have to support multiple workflows for different versions. Vendors would have to support these, et cetera. But these challenges are applicable regardless of the underlying standard that we're talking about.

And clearinghouses play really a pivotal role in this situation as I mentioned. We enable both low-tech and high-tech stakeholders to move through the process at their own pace, facilitating that data exchange and supporting both the low-tech and the high-tech stakeholders to exchange data.

Now, the Cooperative Exchange does not support multiple effective dates for sets of logically grouped transactions. Moving forward, only some small number of transactions, and then at a later time moving additional transactions, we feel like that phased approach would be very costly, it would be very complex, the industry would have to understand what are the effective dates for each of the groups of transactions, and would really add a lot of complexity to the process, as well as adding a lot of cost.

So we continue to advocate that if we can move to a guidance framework that puts us in a predictable update cycle, then all stakeholders understand when versions are going to be updated. We have a predictable cadence of updates, and by virtue of the nature of the process everyone can research what is coming up, update their systems as they are able, and continuously move forward with improvements that help facilitate meeting the industry's business needs.

So we've put together a diagram, again hypothetical, with just some hypothetical time periods in here and hypothetical versions, but trying to demonstrate how we envision that this might

work. The green on the slide is showing the current mandated version, the yellow is the previous version that would be going through its sunset period or cycling out period.

Once it turns red that version is no longer allowed, and the white is where a new version has been published that the industry then has the opportunity to do research, proof of concept, and testing that has been discussed significantly over today.

So as you can see as we look at the date across the top and the versions along the side, we are currently in a period where 5010 is the currently allowed version, and theoretically we might have in 2025 8020 become the mandated version.

And then you can see in yellow that 5010 is still allowed but would be in its sunset period. So entities have the option of moving to 8020 during that time period at any time during the time period, and then they would be cycling out of 5010.

As we get into the 2028 time period you can see the next version, which was previously published back in 2025, and the industry had the opportunity to do testing and research on, that then becomes the mandated version. 5010 is no longer allowed at all, but 8020 then is going through its sunset period.

So you can see we have a predictable cycle of which version we would be moving towards, a specific time period where we are supporting two versions as we sunset out the previous version, and the third version that we had previously been supporting would no longer be allowed.

So again, it gives us a predictable cadence, allows the industry to know exactly what is going to happen, we can all plan and budget for making sure that we're able to manage these transitions, and the transitions will be much smaller because we are moving through them at a more predictable cadence and more frequently.

So again, it is an evolutionary process rather than revolutionary that allows us to make small steps forward rather than the big bang that we have been experiencing up till now. And this is the end of my presentation. Thank you very much for the opportunity to share.

Debra Strickland: Thank you so much. Next up is Richard.

Richard Temps: Hello everyone. I am Richard Temps, Founder of Chiapas EDI Technologies. We are a healthcare integration software vendor founded in 2010, and our licensees use our software to create custom in-house EDI solutions with a minimal learning curve. We have been a commercial licensing partner with X12. And when we had the opportunity to join in the 8020 proof of concept program, we were actually excited to join in.

We have incorporated the 8020 technical materials. We've created and parsed a few 8020 EDI files and XML files, and even exchanged a few files with some of the other participants within that program. So it is based off of that experience that we have a few things to share with all of you, and we're going to have more of a nuts and bolts presentation here.

The biggest question we had when we were starting this is, exactly how hard is this to implement? How much work needs to be done to update to the new proposed standards? So we are going to approach this problem by comparing a very basic EDI claim file, as we see here. This is the 5010.

And then go ahead to the next slide. This is what we saw before was the 5010, this is the equivalent simple claim file in the 8020. So we have a single claim, we have a single service line. These highlights here show exactly what is changed between the two files, going from a 5010 file to an equivalent 8020 file. One claim, one service line, as basic as it gets.

So the top three highlights here are static headers, that indicate what information is actually contained within the file. Further down, the first real change is the new required segment, called the original claim creation date. In the current state, in 5010, this date is pulled from the header fields.

And since these headers can change when the claim gets repackaged or rebundled, the actual original claim creation date gets lost. In the new proposed standard this problem is solved by storing a copy of the claim creation date within each and every claim, so that no matter how the claim gets rebundled or repackaged the information always travels with it.

Below that you see the highlighted ABF, and that's just a small change to the syntax around the primary diagnosis element. Below that, on the service line we see that a few elements that were situational in the current 5010 standard are now required in the 8020, things like family planning indicators, things like that. And then finally at the bottom, you see the 28 that's highlighted, that just says that the new segment increases the whole total of segment counts by one.

So for many providers sending fairly basic claims to a payer, these changes I would say are not really difficult to implement. But of course, this is going to depend on the complexity of the claim and the services. So you could consider this the most basic scenario for a provider, payer, a claim exchange.

Now once the payer adjudicates the claim, they're going to send a remittance advice file back that tells the provider how and if the claim was paid. In the current state this information is split across multiple segments, with the MOA segment giving the remittent advice reason code, and the CAS segment giving the claim adjustment reason codes. And they're actually split into different places.

In the proposed future state, it is all tied together in one place with the RAS segment. And actually by joining the information together like this the providers will get more information, more detail as to how exactly claims are being paid. So we could consider this a quality of life improvement for providers.

In addition to the updated transaction sets, X12 is also making the recommendation for an official X12 branded XML schema. And don't try to say that too fast. That can be used to

transport the same information, but in a way that is easier to parse. In a normal EDI file you need to create a parser with all of the 8020 rules in order to know exactly which information each element defines.

With this new XML format, the same contents are packaged in a way that links each element to an exact page within the HIPAA implementation guides without actually having to create a brand new EDI parser. It is still required to have a bit of technical skill to create a valid XML transaction, as the actual data contents of the XML file are the same as an 8020 EDI file, but it has friendlier packaging. And this actually can make it easier to change, make the transition for many trading partners.

So in summary, for many basic billing scenarios, providers will be able to send 8020 with fairly minor changes on the outbound. Parsing the new inbound remittance advice files will take some additional work, as it now has some additional information.

For non-basic scenarios this will definitely require deeper engineering on both provider and payer systems to handle the new data elements. Finally, the new proposed XML format can make it easier to make the switch, because with it there is not a need to syntactically parse every single EDI element.

So given all of the above, what is the justification to mandate a new set of standards? We feel the simplest reason is the 5010 implementation guides were authored almost 17 years ago, and in order to ensure that our national EDI infrastructure meets the needs of the United States public that it serves, it needs to be maintained to reflect the current business needs of the healthcare industry.

We consider the EDI infrastructure to be a national superpower. It is an infrastructure that connects payers and providers at a national scale. But it is much more than a financial ecosystem. The same claim files that are used to bill for services are also used to determine things like childhood immunization rates. They're used to analyze trends in patient outcomes. They're used by state and federal agencies to help regulate the whole healthcare industry.

So when we update the standards we are increasing the utility of the entire infrastructure. One of the main purposes of HIPAA is to improve the efficiency of the healthcare industry. And we feel that these new standards can do that, but only if everyone is on the same page. And for that a mandate is necessary. So thank you very much for this opportunity for presentation, and that concludes. Thank you very much.

Debra Strickland: Thank you so much. And now we have Stephanie is our next speaker.

Rebecca Hines: Stephanie, did you send us your deck? I don't have a record of it.

Stephanie Fetzer: Yes, I did. And I got a reply back.

Rebecca Hines: That must have come in recently. I don't know whether this team has it. If you have it handy and can share your screen, that would probably be the most efficient way to get it up.

Stephanie Fetzer: I am Stephanie Fetzer. I work for Actian, a division of HCL Software. We are also an X12 licensing partner, and we are also an 8020 POC Pilot participant. I am speaking today on behalf of HCL Software.

My product, I'm a product manager, is called IBM Sterling Transformation Extender. I no longer work for IBM, but I still do manage that line of products, and we are translation software. We are in many industries, including healthcare. I worked on the initial implementation of my product, back when it was called Mercator in the late 1999s.

So I've been through 4010, 4010 addendum, and 5010. It's not my first potential rodeo here. I am also a volunteer with X12. I participate in X12 C, Communications and Control, the people that love their acks. I am also the current X12 Chair of the Board of Directors.

I added this slide primarily for color but to show that in addition to the core of the HIPAA transactions, most of our customers have an ecosystem or an infrastructure that involves other X12N or X12 insurance transactions, and also it is not uncommon, especially with the clinical attachments, to use versions other than 5010. We have users who use 4010 addendum, 5010, and 6020 versions of those attachments. In some other industries, such as generic supply chain, it is very uncommon for those users to only use one version of the X12.

The benefits from the recommendation that we see is stability. It's building on the existing plumbing and transactions that are currently in use. And it is allowing for progress. We have heard a lot today about the functional needs that have addressed, and those refinements, Kathy mentioned those additional changes of rule that allow additional clarity. And I had a slide on that coming up.

Also, innovation. We've just heard from Richard. The benefit of going almost last is that there is so much less to say, because people have already said it. But we have customers very excited about the potential use of XML schemas outside of the organization. Approximately 25 percent of our customers order are using the schemas for EDI in some way internally. We also have customers playing with FHIR. Customers starting to use the newer, less neutral FHIR standards, and they are very anxious to make sure that they do have the rules for using them along with X12. So innovation is a big part of it.

One of the costs that may not be apparent to anyone but vendors and implementors when they're in the heat of implementation of HIPAA, is the request for interpretation portal. So one of the superpowers of the HIPAA standard since the TR3 specifications that represent HIPAA is that they're so specific. And Kathy did mention the situational rules.

And there is some amount of interpretation that has happened to these rules over the years. And you would think, 15 years roughly in, there shouldn't be any more questions, there

shouldn't be any fresh, how does this work, is this allowed in this case, is this disallowed, how do I sum this?

But all those refinements that have come in, through the HIPAA standards that are coming out in this next version, I like to call them the 80Xs because we're starting with 8020 and anticipating that 20 will be X-ed out and increment over time. But all of those incremental clarifications are found in this RFI portal.

And it is amazing how many hours of developer time, these are my higher level developers, spent going through the RFI portal so that they can answer questions from our new business partners, a new implementation of HIPAA with an upgrade for an existing customer. And it is very rich with information because these situational rules are complex, and they need to be complex, so that everyone is using the standard in the same way. But it is expensive not to upgrade the standard and incorporate that, because we get the same question for the same situational rule every four months. It is a process of redoing that same work. And we could have those developers doing new and innovative things, implementing other versions of the standards.

So the implementation cost, what will this cost? Anything new comes with time, risk, and dollars. So time, I believe that the recommendation of X12 to go incrementally and build on top of the existing infrastructure and not create new transactions based on different transactions of the X12 standard will save time.

As we saw from Richard, the majority of those changes are relatively minor from a vendor perspective to implement. They are incremental changes, which helps keep down risk, because it is a phased approach, and we are expecting that it will give us time and give our customers time to stabilize between each drop of the standard, new set of transactions that will be going forward.

And then dollars. Any change costs money. And this will allow the vendors to spread out that development time and kind of even out the number of resources that are going to be necessary. In other words, we won't have to hire 15 people for 15 months, we can have the same people incrementally developing the standard as time goes on, and working on that next batch.

From an HCL perspective, we have already implemented as a test set in our product the 8020 versions of the HIPAA mandated transactions. So they are there already for our customers to start testing. So this process for us has already started. It will accelerate of course, once there is a timeline and it has been accepted. So we are looking forward to that.

Another different view of a vendor perspective is that this proposal from a purely monetary standpoint wouldn't be a vendor's first choice. Most vendors would prefer that the whole set of standards be replaced with some new, exciting technology. More work, and newer, scarier technology is more opportunity for a vendor.

However, we know we need to balance what is going on. I'm a healthcare consumer as much as a vendor. So we want to make sure that all of our infrastructure for healthcare payments stands up to whatever has changed. So even though big bang, big splash, all at once in many ways would all be appealing, our customers' success is our top priority, and we are strongly in support of the current proposal for the HIPAA update. Thank you.

Debra Strickland: Thank you very much for your presentation. The next up is Sherry Wilson with Jopari.

Sherry Wilson: Good afternoon members of the Subcommittee. I'm Sherry Wilson, Executive Vice President, Chief Compliance Officer for Jopari Solutions. And I would like to thank you for the opportunity to present testimony today from a property and casualty perspective.

Jopari is a clearinghouse and is recognized within the property and casualty industry as a leader, and processes over 60 percent of the claims, attachments, and remittance advice transactions. We are also engaged in the standard setting and professional organization.

To level set the context of our recommendation, I want to provide just a brief background on property and casualty. It is a legal versus a healthcare system. It includes workers' compensation and auto lines of insurance.

It is state regulated, not covered under HIPAA, and many of the P&C stakeholders are the same entities that are processing X12 5010 transactions today under HIPAA. States that have adopted electronic claims attachment and payment standards have done so by statutes and administrative rule, using the X12 5010 transaction sets, and developing companion guides to address state specific business use cases and data content requirements that are not supported in the X12 5010 version.

So the X12 versions represent over 15 years of stakeholder efforts to address new business use cases, workflow automation gaps, and administrative financial efficiencies across all lines of business with a significant value to property and casualty.

So the 8020 version addresses our property and casualty business needs that are not supported, as I stated earlier, in the 5010 version. And they do this by eliminating the need for individual state companion guides, reducing administrative burden to comply with multiple state electronic building mandates, and automates regulatory data content requirements, which eliminates workaround and provides user clarification.

I'll just give some examples. We have value across all transactions. Just an example in the remittance advice. Though it accommodates state jurisdictions, explanation of benefit and statement ID, state labor co-statute reference, and also identification of alternative payment methods. This is important because several states have alternative payment regulations. So the importance of this is it standardizes implementation across all stakeholders, property and casualty, commercial and government, resulting in increased workflow automation, increased administrative efficiency, and property and casualty stakeholder adoption.

Just additional considerations on the XML schema. We do support the X12 recommendation that HHS permits both the X12 8020 EDI standard, an XML representation, and both be named in regulations as permissible syntaxes. However we also recommend it allows other industry applications such as JSON, based on industry business needs. And also the schema allows stakeholders to manipulate data with APIs and other tools that accommodate different business use cases and facilitates workflow automation, thus really modernizing the process.

We also support the X12 recommendation to implement FHIR Crosswalks for the proposed X12 8020 version to accommodate different stakeholder business needs, workflows, and allow for interoperability between the two standards.

In terms of implementation timeframe, based on our experience, industry feedback, and to allow for stakeholder EDI readiness from low tech to high tech, we do recommend a three-year implementation time frame. We recommend a June or July implementation timeline to accommodate other regulatory and business priorities that occur in the beginning of the year.

For perception of value for property and casualty, we do recommend the adoption of the X12 8020 version, the XL schema, and FHIR Crosswalks to address industry property and casualty needs and ensuring standardized implementation across all stakeholders to effectively remove unnecessary administrative costs and facilitate interoperability between lines of business. We also recommend a GAP analysis be conducted to identify data content and other industry business use cases that could be impacted in using other X12 5010 transactions simultaneously with the X12 version of 8020.

We also just want to call attention that states may choose to remain on X12 5010 and/or adopt X12 8020 version. However, a change X12 8020 will require regulatory changes.

And lastly, we support the recommendation to streamline industry regulatory process to accommodate new and/or updated HIPAA transactions as referenced in the NCVHS March 30, 2022 Letter to HHS on Modernization Aspects of HIPAA and Other IT Standards. With that I would like to thank you for the opportunity to talk about property and casualty today. This change being discussed represents a major transformation for our industry. Thank you.

Debra Strickland: Thank you Sherry. Next up we have Arthur.

Arthur Roosa: Good afternoon all and thank you to the committee for giving us a chance to give you our thoughts. I am joined on this call by Steven Sundrud who is the Vice President of Software Development for SyMed Corporation, which is a revenue cycle management that is headquartered in California. I am representing the Healthcare Business Management Association on their government relations committee, and I'm the former chair of that committee. HBMA is a not-for-profit professional trade association, and we're a major voice in the revenue cycle management industry.

A couple of presenters ago, Stephanie mentioned that she had a benefit of almost going last. I've got the benefit of going last. And as such, many of the things that I had intended to say

have been already said, and some of it has been expanded upon. But I'll touch on the things which I feel are most important. I won't spend a lot of time talking about them, but I do want to get them into the record.

For the RCM industry, we are very reliant on the 837/835 transaction set. And so changes around that area are critical to us, and important to our ability to perform our services. That being said, we are generally supportive of these changes.

That there are a number of things that are in the specifications, but some of them have been mentioned. One which has not, which happens to be important for the RCM industry, is the extended provider assignment claim identifier. It seemed to be flying under the radar. But in an environment such as ours, where we could receive multiple providers or multiple legal entities back in a single 835 transaction, it will help in being able to realign the payment information with the claims that were submitted.

We are also very much supportive of the CAS statement segment being exchanged with the RAS segment, which will greatly identify the reason for a particular action on a claim.

Additionally, we support most of those changes to the 835. And listening to Rob Tennant's presentation on WEDI, I was sort of using it myself that if there were 100 respondents to his survey, we would be adding a one percent to every one of those support or family support totals, as most of those changes in the 835 we would strongly support.

So we would support overall moving forward with the 820 standard implementation, with the primary caveat that there would be adequate time for testing and piloting the standard before it is put into place.

The ROI consideration, there has been discussion on that. We take I guess a longer term look at the ROI. Part of it is that as an industry mostly we are sheltered. That is to say that most of the development cost in making these changes is going to be borne by vendors that we use. There are some RCM companies that do their own IT, and they would be therefore carrying that burden. But for most of the industry it is really about the vendors that industry is using.

However, I would want to point out that though the ROI may not pencil if you are looking at it over a period of one or two years, I think it may be more useful to look at it out five to ten years in terms of whether or not it makes sense to invest that money. If you pick any point in history and look at how we were dealing with information exchange at that point in time, it is hard to argue that we are not better off now than then, and if there isn't an investment made now, then those improvements will never occur.

Supporting a roadmap idea however so that those changes are predictable and somewhat you can budget for them in a meaningful way. And there is always the concern, and we have it, and people who have spoken before me had it, that we know exactly what those changes would look like before we really do get into determining what the exact ROI may be.

We have a concern about multiple formats and multiple versions, recognizing that as you're moving from one version to another there has to be an overlap, there has to be a period of time when you can exchange data in either version. But when we're looking at multiple formats, such as XML or EDI, that has an issue with interoperability.

Although I am a supporter, and the industry would be a supporter of being able to use multiple formats, I think it is important that there is a decision that a particular format is the floor, is the safe harbor, where if you in fact exchange data in this format it will be read by whatever trading partner that you are using.

And before I get to the final statement, I would be remiss if I didn't mention the virtual credit cards. I know that other folks have mentioned them, and I also know that X12 is making the strong statement that they're not in support of it particularly, it's just simply that they're being used, and so we're just finding a way to support a business need that's out there.

Also reading the link that was provided before, indicating that there's nothing in the regulations that prevent virtual credit cards. The argument still is that it certainly is not in the spirit of electronic transfer of funds, it's just something that was determined that well if we do it this way we can make more money this way, as there is often a two percent or so hit on that transaction. It is not something which providers support, and although NCVHS can't really change this, there are CMS representatives on the call, and I think that should be looked at, and looked at very closely. It reminds me of the same thing, that if you're having a tax refund, a two percent takeback on that tax refund would not be appreciated.

And finally, is enforcement. None of what we have talked about works unless there is an effective enforcement message. There are, just using another analogy, certainly if you have a highway that has a 65 mile per hour speed limit on it, if there is no enforcement, most of those folks are still going to go 65 because it's a safety issue.

But there will be folks that are going 95. And that can't be prevented unless there is enforcement of that speed limit. So the speed limit does not matter if there is no enforcement of it. All of these changes and rules do not matter unless there is enforcement. So that concludes my remarks. Thank you again to the committee.

Debra Strickland: Thank you very much Arthur, and all of the vendors and clearinghouses. I do have a follow-on question, I think just one, because you guys have covered all of the material so well. So, no pressure, but the heat is on.

I know some of you are doing the pilot, which is awesome, it gives you a really good start to the 8020 to 5010 transition. So assuming that you're doing the 8020 at this point, how many of you have done at least a fair amount of the GAP analysis between the two?1

Stephanie Fetzer: Yes, we have done the GAP analysis as well as looked at others GAP analysis for the 837s and the 835.

Debra Strickland: Are you finding that this is sort of maybe a bigger leap than between 4010 or 5010, or do you think that it's sort of the same thing that we would expect from that?

Stephanie Fetzer: We are finding it very similarly from the 4010 addendum, 5010 as now. To us it's roughly about the same, maybe a little bit less in the 837P.

Debra Strickland: I am going to open up questions until my little head thinks of anything else that I'd like to ask you guys, to my colleagues, to see if anyone on the committee has any questions that they would like to ask of this panel. Tammy, go ahead.

Tammy Banks: The question that I have is, because you guys are really looking at the implementation aspects of it, and we can see what the changes are. I know you talked about it in your presentation, but what is the big value that you see that you can bring to your clients or your members through the implementation of the upgraded 8020? For obviously claims and ERA.

Sherry Wilson: I think the real value is the upgrade to the 8020 really enables workflow automation, including workers' compensation in auto, and that was not implementing that, we'd still be on a paper intense business process. So tremendous value for automating workflow.

And then that integration or interoperability between all lines of business, right now property and casualty is like the stepchild, where it's not really included. And so now a provider especially can use across all lines of business the same transactions, 837 and 835. So it really enables that interoperability between lines of business, and increases adoption for industry.

Debra Strickland: Thank you Sherry. Pamela?

Pamela Grosze: Thank you. I want to mention that we talked about some of the individual changes that have been brought in, for example the CAS to RAS and the 835, it has a significant benefit to providers in providing all of the information related to an adjustment at one time.

And both the adjustment codes and the remark codes giving a complete message to the providers about the information for an adjustment. That's a significant benefit. Changes in the provider level adjustment, making that at the claim level, et cetera. There have been some significant benefits to the providers in the changes that have been made.

I think also as it has been pointed out multiple times the length of time that we've been using 5010 and the changes that have happened in the healthcare industry over that time, and so 8020 really is responding to what's happened in the healthcare industry over that period of time, bringing in what has been put in the RFI portal that was mentioned.

But other business needs that have been brought to X12 over time during those 15-plus years as the healthcare industry has continued to change and evolve in meeting new regulatory requirements like the GFE and AEOB, all of the new things that are coming about that we're trying to respond to in bringing in these new versions of the transaction, and then allowing us

to continue to move forward as the healthcare industry continues to evolve, continuing to build on that.

So we need to bring up our baseline so that we are meeting the needs that the healthcare industry has already let us know are there, and bring us to that baseline where we can then continue to respond in that regular, predictable cadence, to the new needs that need to be brought forward. So there is a lot of significant benefits in the specific changes that are there, as well as what it can continue to allow us to bring forward as we move forward, meeting the industry need.

Debra Strickland: Thank you. Arthur?

Arthur Roosa: There are some subtle effects on patient care and patient experience, but I think in a direct sort of way, particularly within our industry, the CAS to the RAS segment with the additional identifier, the clear identifying of what has happened to a claim, it is much less likely that the patient will have to get involved in that process.

Buyers will make fewer calls, I know that RCM companies will be making fewer calls to patients, and certainly not asking them for either their participation in the payment of a claim or asking them for actual dollars to supplement payment of a claim. So I think that will have an impact.

Debra Strickland: Thank you so much. Any other questions from the standards subcommittee?

Tammy Banks: Arthur, that is exactly where I was going. And Pam and Sherry, you really answered it. We look at the technical changes, and people like myself, who are more business focused, really try and figure out what is the workflow, and will there be reduction in manual touch. Because we want to get this to be automated. And I think though that CAS and RAS what you're saying is that you can truly automate some of these backend processes so they don't have to be manually touched. Do I have that right, Arthur?

Arthur Roosa: Yes.

Tammy Banks: That wasn't my question, I just wanted to clarify that. And I know with workers' comp that's where Sherry was going. Now, this is kind of an off the wall comment, but it's one that I think is important. It is in regard to the proposed attachment rule, which is for prior auth, but again it will also, in my humble opinion, help with claims.

Now, do you see this 8020 version being of a benefit, to be a companion with that attachment rule, or does 5010 suffice with where that attachment rule is going? And Sherry, I know you live and breathe with attachments, as well as Pam. If you could help me out with that.

Sherry Wilson: I think first of all, people who are doing attachments to move from the 5010 also to the X12 6020 with the 275 attachment, so the link between 6020 to 8020 is very minimal impact on changes to move to that level. And also from the 5010 to the 6020 there's not a huge lift to be able to utilize those transactions. So it is a very complementary, going from 5010 to

8020, the changes that we've implemented those, but except 8020 are quite minimal to be able to achieve that compatibility.

Tammy Banks: So you are saying the 5010 or the 8020, the same ROI would be realized if that proposal goes forward.

Sherry Wilson: Absolutely.

Tammy Banks: And then based on your comments to my first question, I'm going to put you on the spot, because I know there is no benefit analysis performed, but again when you look at it from a workflow perspective, which I think Arthur, you live and breathe workflow with the revenue cycle companies, but looking at what you're realizing in 5010, if we stayed at 5010 and didn't move to 8020, would the CAS/RAS be enough of a difference in the backend automation to justify what we're anticipating the cost will be to implement? Because the last thing we want to do is have to pay more to get just a little bit of automation from a provider perspective.

Arthur Roosa: That is a difficult assessment to make on the fly. My thinking was more about the entire movement of the industry forward, that at some point those changes will need to be made, at some point we will need to move the technology forward. And a concern that I have is whether or not we wait on it because it may not completely pencil in now. But at the time that we decide to do it, it will become significantly more expensive than it would have been had we done it incrementally.

So the CAS to the RAS probably is not all by itself something that justifies the move, although it is very useful. And again, for us the expansion of the provider identifier is very useful. So there are things in there that are very useful, but probably not if you're looking at a strict ROI, I doubt that it would pencil by themselves. But taking the longer view, at some point you are going to have to make those changes, and you are going to have to move the technology forward, and it may be more expensive later than now.

Tammy Banks: So as a baseline, 5010, 8020 would be a better baseline to move in order to really think about additional interoperability innovations.

Arthur Roosa: I think RCM accounting would support that.

Tammy Banks: Sherry or Pam, any comments on that?

Pamela Grosze: I have a comment on that. I think when you look at the totality of the changes that are made in 8020, the CAS/RAS in and of itself may not provide enough ROI, but when you look at the totality of the changes that are made in both the 837 and 835, there are some significant improvements that reduce the manual efforts that are required for providers. Even if you only look at the CAS/RAS, that significantly reduces some of the manual effort required by providers.

The changes in the provider level adjustment segment that today has to be tracked manually by providers, but the changes in 8020 allow that to provide more information and reduce that

manual effort. All of the efforts that have been made, the focus is towards increasing automation and reducing manual effort on both the claim end and the remittance advice.

I think there is significant improvement there to reduce the manual efforts and increase automation, but I completely agree with the statement about changing our baseline, bringing us up to a point where it steps us up for the regular, repeatable updates that are made, and increasing our ability to stay current with what's happening in the industry and respond with flexibility and rapidity to the updates that need to be made, rather than responding once every 17 years.

Tammy Banks: I have got one more question, and then I'll be quiet, Deb, sorry. Today we are really trying to pull out what is that value, is there a cost benefit from the value. We understand that the official cost analysis hasn't been done. And it seems to be really hard when you're looking at technical changes to really see the business workflow value, where in that workflow is there going to be change and there's going to be value.

So as vendors, obviously you need to educate your clients on these changes if we would move to 8020. What do you need in order to have that conversation with your clients to show them the value to move to an upgraded standard that we could learn from today?

Sherry Wilson: I think as far as value and looking at our stakeholders, it allows, especially all stakeholders going across, to leverage existing IP investments and resources that we have already done in 5010. But allows us then to really do this automation.

And when I talk about interoperability between lines of business, that is critical, and that a provider moving to 8020 or stakeholder, they can press one button and across all lines of business be able to do the claims, be able to do the remittance advice, and to be able to do a very effective automated data exchange, and without this we have a gap in workflow automation.

Tammy Banks: Thank you Sherry.

Debra Strickland: Any other questions? This was a very interesting panel, very good information. I thank you so much. And I think I am turning it over to Rebecca.

**Subcommittee Discussion/Q&A**

Rebecca Hines: Actually, this is now time for the co-chairs, Tammy and Denise and Rich, any follow-up discussion or Q&A from the members to our panelists who are still with us?

Tammy Banks: Rebecca, we asked X12, Kathy and Tara Rose to come onboard so we can ask some questions. The first question that I wanted to ask was, just a second, I've got to get my act together here. What are your thoughts, after listening to the panel presentations, we heard a lot of variation in positions, whether it be concern, support. Is there any overview or any comments that you would like to make in general in relation to the day before we ask you specific questions?

Cathy Sheppard: I think there are maybe four specific things that I'm going to take them back today, we're going to think about them again. As I said, what seems like four days ago, this morning, we decided on the phased approach based on a lot of feedback and input from people. Not all of them are here today.

So I think it may be that, similar to other situations that we have, it's the chicken and the egg. Some people think that it is better to break it up, because some of the transaction sets will have minimal changes, and they will require very little reprogramming or testing. And some are more intricate.

So I think we will definitely go back and think about that, and we may reach out to people who gave us feedback on the other side. And we'll talk more about that. I will also talk to NSG and others to see what they're thinking on their side.

I think we also heard a lot about I want a trial, I want guaranteed facts. Also we heard a lot of I'm not going to do this until there's an imperium or a mandate. Again, that's the same situation where we're talking about phased or not phased, it's the chicken and it's the egg.

And it may come down to 5050 on either side of that, or maybe it comes 8020. Those are things that we are going to have to talk about as well. I think maybe lost in the wistfulness of a perfect world, this is the first time that we've had a pilot plan, this is the first time that we've tried to get some rubber on the road.

Every single person that is participating in the pilot came together at the first meeting with the same thought, and that was there were a lot of starts and stops in 5010, and we don't want that to happen again, because that makes everybody leery of advancing the version. So there will be a lot more real data than we've had about usefulness, about barriers.

But the problem is if we wait until that is complete to move anything forward then we're talking maybe three to five years before the federal rulemaking process goes into place. The value of waiting until we had more facts at the beginning gets lost in a four-year calendar. So competing importance is definitely going to be a problem for everybody. I'm not going to do any work until there's an NPRM, and I'm not going to move an NPRM until there's more work, somewhere that has got to fall on one side or the other.

I was also a little bit surprised today that nobody talked about one benefit to moving forward, and that is we have a lot, in 5010 we have a number of code sets that are internal code sets. That means they are locked in for the life of the implementation guide. But as we move forward to later versions, many of those code sets are becoming external code sets, which means we can make updates to those code sets without publishing a new implementation guide.

So I don't know if that got lost in the other big priorities and people's thoughts, but that is something that is a real value, especially talking about having different ICD coding structures or having different types of partners as the bill of care options evolve. So I think just at a high level those are the things that I have written down to follow up on. X12 is meeting next week so I'll

have a good opportunity to speak to a lot of people in person and see where we want to go from there too.

Tammy Banks: Thank you Cathy. I've got a list of questions. But before I do, do any of the other subcommittee members have any questions for Cathy to get clarification on points made today?

Denise Love: This may be one of your questions, but I think some issue around when the 276 or 277 version might be in the pipeline. Because we heard, or I thought I heard, some recommendation that it be part of the 835 and 837 updates. Can you talk about that, Kathy, a little bit? 276 and 277?

Cathy Sheppard: I can. I am a little on the spot because I don't have notes on all these things. But I believe that is part of the next recommendation, which people heard today some statements about the facts that we had a different date for set two. Clearly, as we heard more, I don't want to say grumbling, that's not the right word, but as we heard that there may be other opinions about the phased approach, we didn't want to just keep barreling down that path.

So we have held up the rest of the recommendations waiting to see what people had to say today. But I am pretty sure that claim status is in the next set. That is a set that doesn't have huge changes in every transaction. So hopefully it will go smoothly and quickly.

And we don't know how they're going to be put together once they get to NSG either. But if we hand them off differently than the National Standards Group can scope them and figure out which ones they can accomplish in which timelines as individuals, and they'll work with us to make sure that the connected things get put together.

Tammy Banks: Anybody else have any questions to ask Cathy? I know you have several and you're just formulating how you're going to say them, so I'll give you a little more time. Cathy, again, not to put you on the spot, but obviously we heard a lot about the benefit cost analysis.

As we're thinking this through, and by all means I commend you and the entities that are coming forward and investing their resources in order to do this proof of concept, this is fabulous. But when do you think results from that kind of POC study would be made available, as we think about moving this forward or holding this until afterwards. Can you kind of help me with that timeline?

Cathy Sheppard: I could, vaguely. We are not planning to give just one report of here, we finished everything in the free world, and here is the results. So what I think is that we will be able to give updates on we were specifically looking at this from this perspective and here's what we found. So I don't think that there is going to be one full set of results offered first.

I think we will try to put information out as the people in the pilot believe that they have completed an assessment of something, whether it is an exchange of 8020 claims and 5010,

835, or whether it's about 17 different complex sets of claims that could come in for a very large treatment plan.

So I think that's what we will see. Because we plan to keep this pilot running until we are at the end of the transactions. Unless we wear out our partners we will be trying, like I said earlier, to smooth the road so that some of the pitfalls that we had last time can be avoided.

Tammy Banks: So with these POCs, are they looking at implementation cost and looking at the business workflow improvements as well? Will it be well rounded? Because I understand if it's just one or the other.

Cathy Sheppard: I don't think, I could be wrong, I might have to get clarification, but I don't think we're trying to decide on business process improvements, we're trying to verify that we can start at the beginning of a normal flow and go through our entire transaction workflow to the end.

We definitely want to make sure that we test some of the things that people had concerns about today, like if you don't have everything on the same version. I think you heard Stephanie say that I'm testing that successfully now. So some of the things we may be able to speak to sooner.

Debra Strickland: I was wondering where will we find this information? Is there going to be something on X12.org that says pilot progress or something like that, that we can go in and take a peek and see where things are going?

Cathy Sheppard: Yes. The website that I pointed out a couple of times this morning is where we're going to store, it may be in other places as well, but we're going to have links to all the things that people who are interested in these recommendations and moving new versions forward can find it in one stop shopping, so to speak.

Tammy Banks: Is there any way that folks can feed potential scenarios or business use cases into the process, or even technical uses of the transaction that they'd like to see be tested with rigor through the pilot?

Cathy Sheppard: I would just say that the pilot participants themselves want to test everything from the dawn of creation until the end of the world, so I think the problem we're having is keeping the scope small enough that we can actually have bits out.

But I think if you feel strong enough about something, I'm probably going to regret this, but if you feel strongly about something you can put it on the feedback forum, and depending on the volume of how many people put things in, we may not be able to get back to everybody, but I can feed those into the pilot and at least let the pilot participants know what people are very vested in.

Denise Love: Cathy, thank you for hanging out here and answering questions. I'm looking through notes. And, can you talk a little more about how you will work with HL7 to validate any

future crosswalks to FHIR, how that would be done in our plans? I wrote it in my notes, but I didn't get detailed.

Cathy Sheppard: What we did with the first round of crosswalks was staff on each side did the initial cross walking, and then we fed them on both sides back to our subject matter expert groups, and I wouldn't say that we ever finished, because the FHIR side is still very much a work in progress. So I think those crosswalks are going to need to change on a different timescale than we're used to on the X12 side of things.

*But that is how we're doing, we're trying to do some of the heavy lifting without the volunteers, and then just letting the subject matter experts weigh in to make sure that the work that has been done is properly mapped. And those crosswalks are also pointing out some places where there's discrepancy in the assessment of need.

For example, there were a few things that on the Da Vinci side they didn't think they were going to need in the 278, but after working on the mapping we all agreed that they needed to be in there. And there may be a few things on our side that don't need to be in there, we're talking all that under advisement. But the cross walking is proving valuable on more than one level.

Denise Love: I appreciate all the heavy lifting that you're doing, it sounds daunting, and I appreciate you sharing with us today.

Tammy Banks: Anybody else have any questions?

Rebecca Hines: Alix Goss has put a note in the chat to everyone, HL7 and X12 have a collaborative process to develop and test these crosswalks. We thank X12 for this partnership.

Cathy Sheppard: And back at HL7 too. We have been working together well on this.

Tammy Banks: Cathy, just like I said to Terry of the DSMOs, obviously any comment I'd like to solution. So I do want to insinuate there needs to be any change in X12 process. But I just want to brainstorm with you, so take it in that light.

Like at X12, you have your technical experts and you have your business experts, is there any opportunity, and again this may not be X12's role, maybe this is a WEDI role or another role. Is there also an ability to have another document regarding business use impact or workflow impact? Because we have the technical changes, which are great. But it is really hard to visualize.

And I am sure that when people come to present, hopefully they are sharing the impact on the workflow. Is there any opportunity in any space in the healthcare ecosystem that works on these standards to get that kind of document for those who are more business workflow savvy? People are struggling to pull the value out of these standards. And that's the question I guess I'm trying to figure out for me.

Cathy Sheppard: We have a visual that flows through what you can consider the lifecycle of enrolling someone all the way through to they were paid or they got a claim status. But it's not cross-SDO. So I don't think it would be out of the question that we could take something like that and plug in all the different interactions across the SDOs as well.

And I do think probably it would be better to do that as a collaborative group of the SDOs, and maybe a couple of other organizations, because if we just outsourced it completely, like WEDI adds very valuable input, but if we just sourced it out to them it might not end up masking on all of the SDO sides. So I think that's something that we can talk about. We've been trying to get together more often as the SDOs and WEDI and the Operating Rules Entity Core to talk about a higher level messaging and how we satisfy needs. So I can put that on the agenda.

Tammy Banks: And I'm not trying to make more work, but when were' talking about CAS and RAS, to be honest with you, if that information is reported accurately, you can really auto post, you can do a lot of back-end work that would remove the manual review. But it is really hard to see how that would impact, in order to figure out what is the actual value from a provider perspective. Because you've got your installation cost, and then you're looking at the tech field.

And so that gap, maybe it's not a gap for anybody else, I'm just thinking that it may be easier for others to review and look at this from a benefit perspective, not necessarily cost, because that has to have the full POC, if those types of materials will be made available after the changes are made. What are your thoughts on that?

Cathy Sheppard: It becomes a little bit challenging because there are so many variations of internal systems that use the data that we're feeding back and forth. There may be some trading partners that don't care about the RAS segment at all. And so it becomes a very targeted list. If you try to explain everything to everybody, I feel like that would be overwhelming. But I'm sure that we can do a better job of siloing so to speak enhancements that a certain group might care about. I bet we can figure something out.

Tammy Banks: Like WEDI took however many capsulized down to 16 priority items. What kind of impact would that have to a provider, could have depending on the vendor systems they choose. And it may be more work, but I know that we've heard in the testimony, and I've heard from others, looking at Glass and looking at it from a technical perspective, it is kind of like glazed, because you weren't there for the testimony, when people were saying this is what we need, this is why we need it, this is the impact it will have, and that's why it was put in. If that kind of information could be shared, it might be a little easier to understand and comprehend the value, and what's missing from the original version. Again, maybe nothing, but that would help me.

Cathy Sheppard: Great. I think that is clear today, because Arthur, poor guy, had to bring up the end of the train there, but he brought up several things that nobody had said for the rest of the day as major benefits in his perspective. So we had a lot of really smart people talking today, but there were distinctions in all of them. But we could definitely, I think there's nothing that we can't do better about in some way.

Tammy Banks: Again, it is just a discussion point. How do we, we have the same issues that came up today that we did on previous versions. And so where do we address them so that we have that easier conversation rather than continue to repeat it. And this will be the same conversation we'll have for anything that gets put forward, unless we figure out a streamlined process and be able to convey the information in a way that can be received. And I don't know the answer, I just wanted to raise the idea.

Cathy Sheppard: I can put it back the other way a little bit also. If we had a cadence that we all knew about, if every other year we were going to have a new version, it would be a lot easier for X12 to keep track of at a detail level every enhancement and who it might benefit. But if we're talking about once every ten years it is very difficult to do that.

Tammy Banks: I remember the conversation, in ACA we had every two or three years, now we're at ten. But we're going to fix that, right?

Cathy Sheppard: We have to fix something if we want this to be a workable process.

Tammy Banks: I think we all want that. I think we're all onboard in figuring out the way to make that happen. Are there any other subcommittee members that have any questions? Lorraine, do you have any questions?

Lorraine Doo: I have been taking copious notes and have a number of items that I can compile together for when the subcommittee meets to discuss. I don't have any. I had one question actually for Kathy that as far as I understand it with version 8020, if there were to be an additional situational note, that has to be in the next version. There's nothing to update about 8020 now, it is what it is.

Cathy Sheppard: We have offered in the past an RFI solution that explains how something is going to be solved in the future or changed in the future, but it doesn't retroactively change something that has already been approved and published.

Lorraine Doo: This was great. Thanks to all the panelists and presenters who have agreed to present today, thank you so much for doing so. We know you have a lot of other commitments. I think it was whoever at WEDI coined the term it's raining regs, we know we have given you a lot to do and thank about, so god bless you for participating today.

Debra Strickland: A quick question, Kathy. So if we're talking, so you guys are putting forward 8020, and I know you have phases. What is the version of the guides that are in sort of the final phases right now? Is it 8030, 8040? So what is sort of actively being finished up?

Cathy Sheppard: I can't answer that question and be certain that I'll get it exactly right, but we do still have maintenance requests that need to be applied for a couple of the transactions before we're ready to say this version takes care of the big rocks and we need to move it forward.

Debra Strickland: Are you still moving all of them forward to a version at one time, or are you doing it in single or group or whatever they come in?

Cathy Sheppard: Everybody else except the nerds will have their eyes glaze over. But we're doing what we've always done with the standard, whatever is finished and approved by the end of the cycle goes into the next cycle. If a maintenance request takes longer than that it might not be in the next cycle after it's assigned.

But that is our goal, we're trying to get things, everything that gets accomplished in one cycle, which is a year but not a calendar year, will be in the next version. We're improving our processes on the back end, so it will be easier and easier for us to produce the technical reports. But the standard itself is on a clear cadence, it's updated once a year, and all of the approved work from the cycle before is included in that. That's where we're headed for the implementation guides as well.

Debra Strickland: Thank you. It's the last one, I promise.

Cathy Sheppard: That is OK, it is my favorite subject.

Tammy Banks: I think I have all my questions answered, unless anyone else has anything else. Cathy, Tara, anything in addition that you wish to contribute?

Cathy Sheppard: No, only that we are always here. Myself, Garry, Tara. We're always willing to talk to people about things that they don't know or we don't know that they do know. So we don't have to wait for a hearing to have a communication.

Tammy Banks: Rebecca, I forgot to ask, do you have any questions?

Rebecca Hines: No, I don't. not specific to this wrap-up for today. We'll be right back at it tomorrow, focused on the operating rules.

Tammy Banks: Before we close though I do want to really, I can't even express the appreciation to Rebecca and Lorraine, who have been wearing more hats than I've ever worn, and I've worn a lot of hats. I really appreciate your dedication to administrative simplification and the work that's being done for NCVHS overall, as well as the standard. So really appreciate that. And Denise, thank you for volunteering to run the session tomorrow, and Jamie --

Denise Love: And you'll be right by my side.

Tammy Banks: Denise, you did a fabulous job. And I have nothing else to add, but I do just really want to say, I mentioned before about the stakeholders' role to provide input. You guys that presented today have extremely well thought out presentations that are really thoughtful, and it is so appreciated. And I know we all want interoperability to work, and all these viewpoints is what's going to get us to where we need to be in the long run. So thank you. Does anybody else have anything else to add? Denise? Otherwise --

Denise Love: Same time tomorrow.

Rebecca Hines: Yes, 10:00 AM Eastern tomorrow, Thank you everybody.

(Whereupon the meeting was adjourned at 4:30 p.m.)