CHANGE HEALTHCARE REGULATORY AND STANDARDS UPDATE

Q2 2020 Update Published: November 13, 2020

Q1 2021 Update Available: February 12, 2021

11.13.2020

CHANGE HEALTHCARE

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Timeline

2019		2020	2021
3/3/2019 21st Century Cure Act Rulemaking begins with publication of ONC and CMS NPRMs on Interoperability, Patient Access, **3/28/2019** CMS launches Compliance Review Program for Health Plans and Clearinghouses.	**4/10/2019** CMS launches Compliance Review Provider Pilot Program. **12/31/2019** HICN (SSN) – MBI transition period ends. Entities must support MBI only. **Ongoing 2019** Initial Review and Comment, plus second Review and Comment for draft X12 7030 TR3s.	**01/01/2020** End of Medicare HICN to MBI Transition Period. MBIs must be used in all administrative transactions. **05/01/2020** Final Rules Issued: ONC and CMS on Interoperability, Patient Access, Information Blocking.	**Anticipated** • X12N finalization of version 8010 TR3s (2020 or early 2021); recommend adoption to CMS • Final Rule Attachments with Acknowledgments • CMS launch Compliance Review Program for Providers.

X12N v7030™ Public Comment/Review and Finalization of TR3s

Withdrawals
10/28/2019 **Final Rule Rescinding the Adoption of the Standard Unique Health Plan Identifier (HPID) and Other Entity Identifier (OEID)** Rule rescinds and deactivates the HPID and OEID as of December 27, 2019.

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Section 1

COVID-19

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Change Healthcare COVID-19 Updates and Resources Hub

- On April 1, Change Healthcare launched our **COVID-19 Updates and Resources Hub**.
- This is an online source of technology, business, and informational resources to give providers and payers guidance on how to maintain administrative, financial, and operational stability during the COVID-19 pandemic.
- Includes archive of Change Healthcare Customer Service Alerts relevant to COVID-19.
- Guidance Specific to Telehealth Benefits: https://www.changehealthcare.com/covid-19/faq-telehealth-benefits-and-coding-for-covid-19
- See the press release.

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Additional COVID-19 Resources

Change Healthcare

http://www.hipaasimplified.com:
Additional information on COVID-19, specifically related to transactions, code sets, and standards, such as general coding guidance.

Federal Government Resource Hub

- https://www.coronavirus.gov/

CDC Resource Hub

- https://www.cdc.gov/coronavirus/2019-ncov/index.html

CMS

- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

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Additional COVID-19 Resources, cont.

CMS Waivers & Flexibilities

- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities

AMA

- https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

AHA

- https://www.aha.org/2020-01-22-updates-and-resources-novel-coronavirus-2019-cov

WEDI

- https://www.wedi.org/2020/03/18/covid-19-resources-information/

(HRSA) COVID-19 Uninsured Program

The Health Resources & Services Administration (HRSA) under the U.S. Department of Health and Human Services (HHS) announced a program to provide claims reimbursement to health care providers and facilities for COVID-19 testing and treatment of the uninsured.

Health care providers who have conducted coronavirus 2 testing or provided treatment for uninsured COVID-19 individuals on or after February 4, 2020 can request claims reimbursement through the program electronically and will be reimbursed generally at Medicare rates, subject to available funding.

Effective May 6, 2020, Change Healthcare is accepting claim submissions to the Health Resources & Services Administration (HRSA) COVID-19 Uninsured Program via Payer ID 95964 - COVID-19 HRSA Uninsured Testing and Treatment Fund.

For more information and to get started, visit:

- COVID-19 Claims Reimbursement Website: https://coviduninsuredclaim.linkhealth.com/
- COVID-19 Uninsured Program Portal User Guide: https://chameleoncloud.io/review/2957-5e98adf692326/prod
- Frequently Asked Questions: https://www.hrsa.gov/coviduninsuredclaim/frequently-asked-questions

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Section 2

STATE POLICY UPDATE

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State Policies – What to expect in 2021 Sessions

- The Nov. 3rd elections produced no changes in party control, despite significant campaign spending and tight election outcomes. Regardless of political control, state governors and legislators will be focused on:
  - Budget deficits – all states report projected deficits for 2021, ranging from one percent (Colorado, Idaho) to as high as 26 percent (Nevada); deficits are projected for all 50 states through 2022 as well. Program cuts (eligibility, services, reimbursement) to Medicaid are likely to be considered in many states as a result;
  - Response to COVID-19 pandemic – state public health programs will be increasingly challenged by increasing COVID-19 cases and pressures on health care systems and state economies. Returns to higher levels of restriction are likely and legislators are expected to focus on a range of public health policy proposals.
- California continues to lead the nation in consumer data privacy legislation:
  - California Privacy Rights Act (CPRA) ballot measure passed on Nov. 3rd with a 15 percent majority – new law updates and clarifies provisions of the 2018 California Consumer Privacy Act (CCPA) and subsequent legislation;
  - Washington State, Texas, Oregon, Wisconsin and potentially other states are expected to consider similar privacy bills in January.

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State Policies - What to expect in 2021 Sessions, cont.

- Considering what **telehealth** waivers made part of the PHE will/should be made permanent
- States will need to addressing significant revenue losses and will likely make **budget cuts** and seek cost savings/containment initiatives in high-cost programs like healthcare; e.g., cost growth targets, APCDs, price transparency, etc.
- **Public health** response will continue to be a focus, including vaccine distribution and infrastructure needs; e.g. workforce, technology, etc.
- **Mental health** policies likely to be a focus, including increased access and reducing barriers; e.g. parity policies, coverage, etc.

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Section 3

ASC X12N VERSION 7030™ PUBLIC REVIEW AND COMMENT PERIOD

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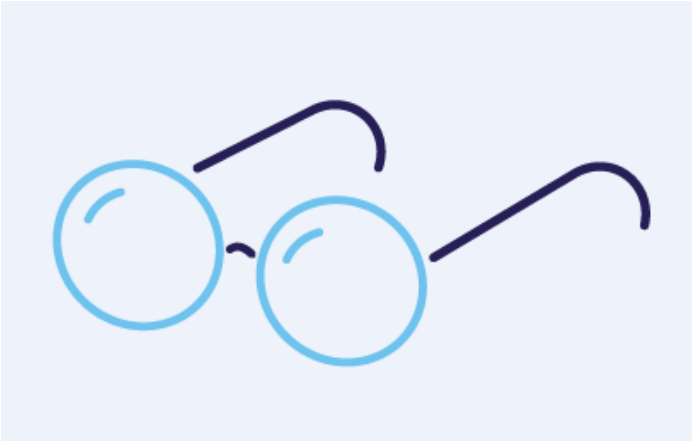
X12N Version 7030™ – Overview

X12N v7030™ Public Comment and Finalization



- Staggered public review and comment periods for version 7030™ of the X12N Type 3 Technical Reports (TR3s) began in the fall of 2016.
- Due to substantive changes resulting from comments received during the initial public comment periods, many TR3s have gone out or will go out for a second public comment period.
- It is anticipated that the functionality developed within the version 7030™ TR3s will be recommended to CMS for adoption.

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X12N Version 7030™ – Upcoming Public Reviews

Initial Public Review Pending

- **Application Reporting for Insurance (824)**: TBA

Second Public Review Pending

- **Implementation Acknowledgment for Health Care Insurance (999)**:
  TBA
- **Health Care Eligibility Benefit Inquiry and Response (270/271):**
  TBA
- **Code Value Usage in Eligibility Benefit Inquiry and Subsequent Response (TR2)**:
  TBA

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X12N Version 7030™ – Finalized/Published

- Benefit Enrollment and Maintenance (834)
- Health Insurance Exchange: Enrollment (834)
- Health Insurance Exchange Related Payment (820)
- Health Care Claim/Payment Advice (835)
- Health Care Claim Pending Status Information (277P)
- Health Care Claim Acknowledgment (277CA)
- Health Care Claim Status Request and Response (276/277)
- Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

- Additional Information to Support a Health Care Claim or Encounter (275)
- Health Care Services Request for Review and Response (278RR)
- Health Care Services Review Inquiry and Response (278IR)
- Health Care Services Review – Notification and Acknowledgment (278NA)
- Additional Information to Support a Health Care Services Review (275)
- Health Care Claim: Professional (837P)
- Health Care Claim: Institutional (837I)
- Health Care Claim: Dental (837D)
- Health Care Service: Data Reporting (837R)

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X12N Version 7030™ Informational Forums

- X12N holds public Informational Forums for each draft TR3 once the public comments received during their public comment periods have been adjudicated.
- Each Informational Forum gives an overview of the number of comments received and how the comment was adjudicated.
- Resolution of substantive comments are discussed in detail.
- All Informational Forum presentations are available to X12 members at https://x12.imeetcentral.com in the X12N Insurance Workspace. To gain access to this site, email info@X12.org.

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X12N Version 7030™ – Participation

Change Healthcare Encourages Your Participation

- Change Healthcare is actively participating in the v7030™ Public Review and Comment process and we encourage all entities to participate
- For updates to the public-comment period timeline, watch: www.x12.org

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Promotion of Version 7030™ TR3s to Version 8010™

For more information on the Version 8010™ promotion and on the Annual Release Cycle, watch www.X12.org

- The membership of the X12N Insurance Subcommittee has approved promoting the Version 7030™ TR3s to Version 8010™ immediately after they have been published.
- The published 8010™ TR3s for the HIPAA transactions will be recommended for adoption under HIPAA, rather than the 7030™ versions.
- The promotion to version 8010™ will align the X12N TR3s with the base X12 Standard version 8010™, which is the most recent base standard released by X12.
- From a functional perspective, there will be no substantive changes to the 7030™ TR3s, and no loss of or change to functionality added with 7030™.
- The promotion of versioning also positions X12 to begin their proposed Annual Release Cycle, tentatively slated to begin in 2021.

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X12 Annual Release Cycle

- X12 is in the process of implementing an Annual Release Cycle (ARC) for X12 products, including the X12N Insurance Subcommittee TR3s.
- The new release cycle will allow X12 to be responsive to today's rapidly-changing business environment.
- Each annual release of the TR3s will be aligned with the base X12 standard, also released annually.
- Releases will occur at the end of each calendar year.
- Public commenting on published versions will be accepted following each publication. Suggested changes will be considered for the next annual release.

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Section 4

ATTACHMENTS NPRM

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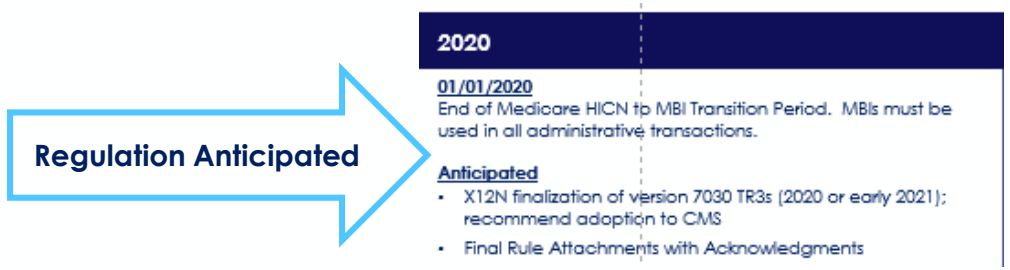
Attachments – Overview



- The Administrative Simplification provisions under the ACA include adoption of transaction standards and operating rules for Attachments.
- Electronic Attachments are electronic transactions that support the transmission of clinical documentation for claims and prior authorizations which require additional clinical information to in order to adjudicate, such as:
  - Health Care Claims/Encounters (837)
  - Health Care Services Review-Request for Review and Response (278)
  - Health Care Services Review-Notification and Acknowledgment (278)
- **A proposed rule establishing Attachment Standards and Operating Rules was scheduled for September 2020, per the Unified Agenda of Regulatory and Deregulatory Actions** (RIN 0938-AT38).

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Attachments – Regulatory Roadmap

- NCVHS hearing was held on February 16, 2016, with NCVHS Letter of Recommendation sent to HHS on July 5, 2016.
- Unified Agenda (RIN 0938-AT38) indicate that a proposed was scheduled for September 2020, with Public Comment Period.
- Proposed Rule is expected to:
  - Adopt standards for health care attachments transactions and electronic signatures to be used in conjunction with health care attachments transactions.
  - Adopt operating rules that require acknowledgments to be used for the eligibility for a health plan, health care claim status, and health care electronic funds transfers (EFT) and remittance advice transactions.
  - Adopt acknowledgments transactions standards for the health care claim status, enrollment and disenrollment in a health plan, health plan premium payments, coordination of benefits, referral certification and authorization, and health care attachments transactions.
  - Modify the standard for the referral certification and authorization transaction from ASC X12 version 5010 to ASC X12 version 6020.

Attachments – Recommendations

On February 16, 2016, the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, conducted hearings on the Attachment standards. The following summary recommendations were made by NCVHS to the Secretary of Health and Human Services in a letter dated July 5, 2016:

- Adopt one standard definition of "Attachment," and establish the scope of the transaction.
- Adopt a set of mature, implementable electronic standards for the health care industry to execute the Attachments transaction.
- Define a series of transaction process requirements, including consistency with adopted privacy laws and regulations.
- Take an incremental, flexible implementation approach in no less than five years inclusive of rulemaking.
- Broaden the testing, education, outreach and compliance efforts.
- Ensure alignment of the Attachment standard's regulatory requirements with those adopted for use with Electronic Health Records under the Office of the National Coordinator (ONC) for Health Information Technology's 2015 Edition Certification of Health Information Technology program (i.e., Meaningful Use) and the Medicare Access CHIP Reauthorization Act of 2015 (MACRA)/Merit-Based Incentive Payment System (MIPS).

To see the NCVHS Letter to the Secretary – Recommendations for the Electronic Health Care Attachment Standard, click here.

Attachments – Publications

- HL7 Publications:
  - HL7 CDA® R2 Attachment Implementation Guide: Exchange of C-CDA Based Documents, Release 1 Standard for Trial Use
  - HL7 CDA ® Release 2 Implementation Guide: Exchange of C-CDA Based Documents; Periodontal Attachment, Release 1
  - HL7 CDA® R2 Implementation Guide: Orthodontic Attachment, Release 1 – US Realm (awaiting publication)
- X12, HL7, and the Workgroup for Electronic Data Interchange (WEDI) White Paper:
  - **Guidance on Implementation of Standard Electronic Attachments for Healthcare Transactions**, provides guidance on the implementation of standard electronic attachments for healthcare transactions. See the Resources page at www.wedi.org.

Attachments – Change Healthcare Readiness

- On January 13th, 2020, Change Healthcare announced breakthrough all-payer medical attachments capability that gives providers the ability to dramatically reduce administrative burden associated with document and data exchange with payers.
  - Press Release
  - Podcast
- For more information regarding Change Healthcare's attachments solutions visit:
  - Medical Attachments
  - Dental Attachments

Section 5

CAQH® CORE® OPERATING RULES

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CAQH® CORE® Operating Rule Restructure

This summer, CAQH® CORE® released a restructuring of their Operating Rules from *Phased*-based rule sets to a *Business Transaction*-based model.

- All Operating Rules, including those adopted under federal regulation, have been assigned new Rule numbers and have been repurposed to eliminate references to Phases.
- There were no substantive content changes to any Rules.

For details, see the CAQH® CORE® website at https://www.caqh.org/core/new-operating-rule-structure.

CAQH® CORE® Final Operating Rules – Overview

Former Phase	Applicable Transactions	Rules Define:	Under Regulation *
I	270/271	Infrastructure, connectivity, response time, companion guide, acknowledgments, and data content	Y
II	270/271 276/277	270/271: Expanded data content, AAA error reporting, name normalization. 276/277: Infrastructure, connectivity, response time, companion guide, acknowledgments	Y
III	835 EFT	835: Infrastructure, connectivity, response time, companion guide, acknowledgments; provider enrollment form standardization and online support; 835/EFT reassociation	Y
IV	Remaining HIPAA transactions	Infrastructure, connectivity, response time, companion guide, acknowledgments. Includes final determination timeframe for 278 Request for Review and Response (Prior Authorization)	N
V	278 Request for Review/Response	Data content, proprietary web portal standardization	N

* Regulations exclude acknowledgment-related requirements.

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Change Healthcare Operating Rules Readiness

Change Healthcare clearinghouse services are **CORE Phase III Certified.** To become CORE Phase III certified entities must be CORE-certified on the earlier phases. Our CORE Phase III certification serves as Change Healthcare's exhibit of Operating Rule readiness.

The CAQH Committee on Operating Rules for Information Exchange (CAQH® CORE®) certifies and awards CORE® Certification Seals to entities that create, transmit or use the administrative transactions addressed by applicable Operating Rules. CORE Certification means an entity has demonstrated that its IT system or product is operating in conformance with a specific phase(s) of the Operating Rules.

- Change Healthcare is CORE® Phase I, Phase II, and Phase III certified, as evidenced by our Phase III seal.
- Link to Change Healthcare's CORE Phase III Seal.
- Link to our CORE Voluntary Certification (Clearinghouses tab).
- Additional information regarding the Change Healthcare Operating Rules program can be found on www.hipaasimplified.com.

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NCVHS Hearing on Proposed Rules for Federal Adoption

On August 26-26, the Standards Subcommittee of the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, held hearings to consider federal adoption of three CAQH® CORE® operating rules[1]:

Prior Authorization & Referrals (278) Data Content Rule vPA 1.0 (formerly from Phase V v5.0.0)**:**

This operating rule specifies data content requirements for patient identification, error/action codes, communicating with providers regarding needed information and clinical documentation, status/next steps, and decision reasons to streamline the review and adjudication of prior authorization requests and facilitate faster response times.

Prior Authorization & Referrals (278) Infrastructure Rule vPA 2.0 (formerly Phase IV v4.1.0)**:**

This operating rule specifies prior authorization requirements for response times, system availability, acknowledgements, and companion guides. Specifically, this rule sets response time limits for health plans to request supporting information from providers and make final determinations on prior authorization requests.

Connectivity Rule vC3.1.0 (formerly Phase IV v4.0.0)**:**

This operating rule establishes consistent connectivity requirements for data exchange across the HIPAA Administrative Simplification transactions. Specifically, this rule improves security through stronger authentication requirements and reduces complexity by requiring a single envelope standard. CAQH CORE is proposing that this rule replace the existing CAQH CORE Connectivity Rules v1.1.0 and v2.2.0 and apply across the HIPAA Administrative Simplification transactions including eligibility, claim status, electronic remittance advice (ERA), and prior authorization and referrals.

Look here for additional meeting information.

The recommendation from NCVHS to HHS has not yet been issued.

[1] Rule descriptions quoted from the Letter to NCVHS of 2/24/2020 and the Update Letter dated 6/26/2020.

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Rules in Development and Priority Issues

Want to get involved?

Email core@caqh.org

or visit
www.caqh.org/core

Connectivity Rule:
The Connectivity and Security Work Group has developed a revised Safe Harbor Rule that aligns with the latest technologies, is payload agnostic, and supports the ONC and CMS Interoperability final rules. The revised rule was approved via ballot within the Work Group in September 2020 and will progress through the full CAQH® CORE® voting process thereafter, with balloting of the full membership occurring in November 2020.

Electronic Attachments Rule (Prior Authorization Use Case):
The Attachments Subgroup has begun rule development on Attachments as related to Prior Authorizations, based on rule opportunities identified by the Attachments Advisory Group. Rule development will occur through Q1 2021. Look here for additional information.

Value-Based Payments:
In 2019 CAQH® CORE® launched their Value-Based Payments Advisory Group, which identified five opportunity areas. Three of these opportunity areas will be considered by a CAQH® CORE® Value-based Payments Subgroup or via a pilot launching this fall. Look here for additional information.

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Section 6

NCVHS DRAFT RECOMMENDATIONS PREDICTABILITY ROADMAP

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History

- The Patient Protection and Affordable Care Act (ACA) of 2010 authorized the Secretary of the Department of Health and Human Services (HHS) to establish a Review Committee responsible for evaluating the adopted transaction standards and operating rules. The Secretary designated the National Committee on Vital and Health Statistics (NCVHS), advisory body to HHS, to act as the Review Committee.
- June 2015 testimony gathered from industry stakeholders – including the Standards Development Organizations (SDOs) and the Operating Rules Authoring Entity (ORAE) – indicated that that HIPAA named transaction standards and operating rules are significant steps towards achieving greater administrative efficiencies.
- However, concerns expressed resulted in a letter to HHS with a set of recommendations including the need to*:
  - **Explore the feasibility of expanding the definition of HIPAA covered entities.**
  - **Broaden education.**
  - **Ensure consistency.**
  - **Enforce compliance.**
  - **Adopt the acknowledgment transaction.**
  - **Provide predictability in the adoption of standards, code sets, identifiers and operating rules.**
  - **Ensure responsiveness to evolving changes in health care.**
- After further information gathering, the Standards Subcommittee of the NCVHS developed the **Draft Recommendations for the Predictability Roadmap,** presented to the full committee on September 14, 2018.

*See **Roadmap Narrative**

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Timeline

Change Healthcare supports the draft recommendations of the NCVHS in their February and December 2019 letters to the HHS Secretary.

- **October-November 2018:** Industry stakeholders reviewed the **Draft Recommendations for the Predictability Roadmap**.
- **December 13-14, 2018:** The NCVHS Standards Subcommittee conducted a hearing to hear testimony on these recommendations and incorporated feedback through January 2019
- **February 6-7, 2019:** The full NCVHS reviewed and approved revised draft recommendations.
- **February 13. 2019:** NCVHS issued *letter of recommendation* to HHS.
- **June 4, 2019:** CMS issued response to the NCVHS recommendations.
- **July 10-11 2019:** The NCVHS Standards Subcommittee conducted a visioning session to further discuss barriers to adopting and implementing updated versions of standards and operating rules on a predictable, reliable, and timely basis.
- **December 10, 2019:** NCVHS Recommendation Letter - HHS Actions to Improve the Adoption of Standards Under HIPAA.
- **March 15,2020:** NCVHS 2020 Convergence Project – Initiative to develop recommendations to support convergence of clinical and administrative data with initial focus on the prior authorization transactions and workflow.

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Section 7

FEDERAL POLICY UPDATE

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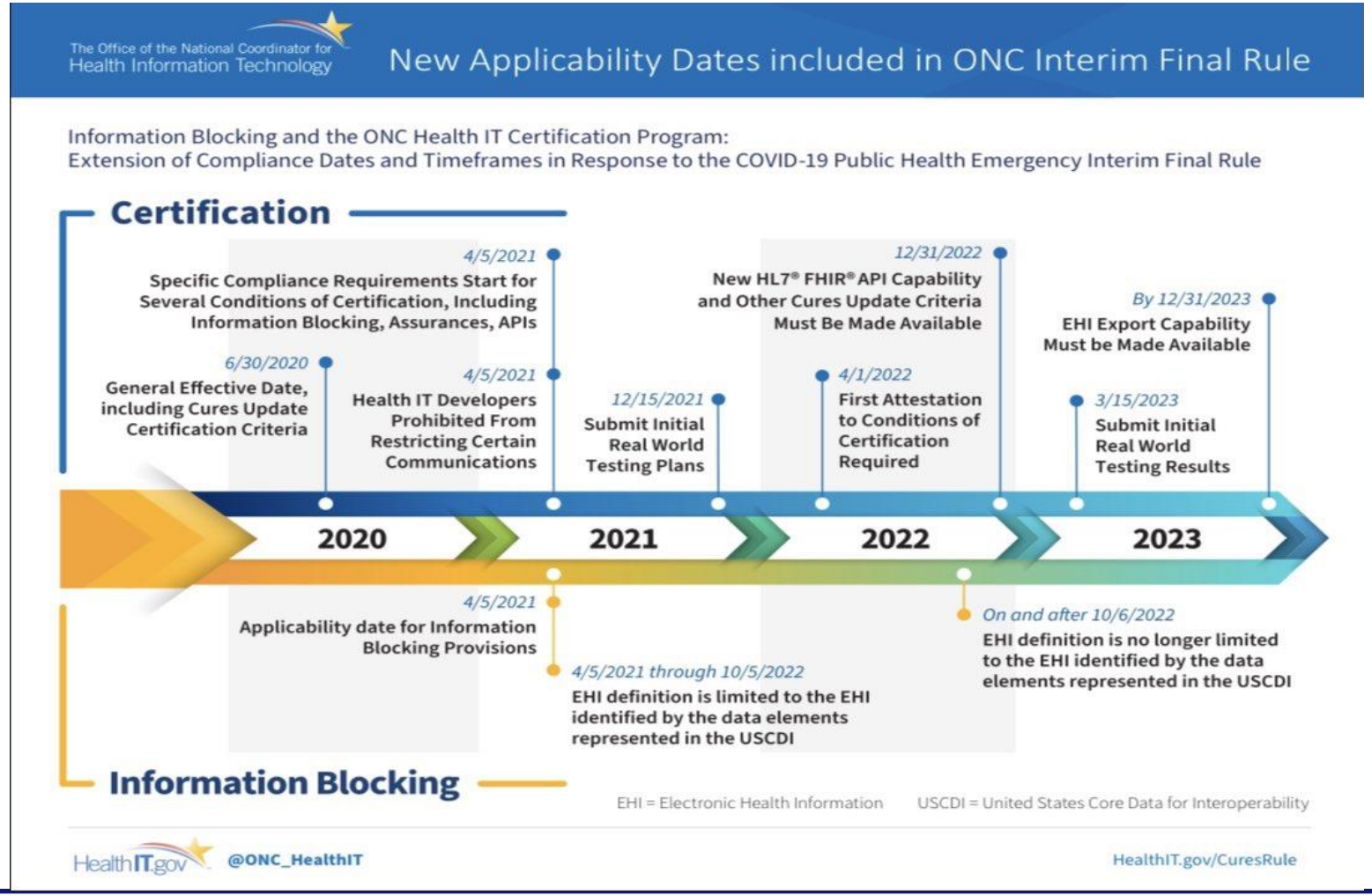
CMS Announces Transparency in Coverage Rule for Payers

- On October 29 CMS released this final rule, which has a goal of bringing greater competition to the private health care industry
  - Requires most group health plans, health insurance issuers in the group & individual market to disclose price & cost-sharing information to participants, beneficiaries, & enrollees
  - An initial list of 500 shoppable services (determined by CMS) will be required to be available via the internet based self-service tool for plan years beginning on or after January 1, 2023.
    - The remainder of all items & services will be required for these self-service tools for plan years that begin on or after January 1, 2024.
  - Most non-grandfathered group health plans or health insurance issuers offering non-grandfathered health insurance coverage in the individual & group markets will be required to make publicly available three separate machine-readable files including detailed pricing information
    - Negotiated rates for all covered items and services between the plan or issuer & in-network providers
    - Historical payments to & billed charges from out-of-network providers
    - Detail the in-network negotiated rates & historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level
- More information on the rule can be found here

ONC Information Blocking Rule - New Compliance Deadlines



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ONC Information Blocking – Interim Final Rule & Compliance Date Changes

Additional information is available at:
https://www.healthit.gov/curesrule/resources/fact-sheets

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SAMHSA

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SAMHSA 42 CFR Part 2 Revised Rule

42 CFR Part 2 regulations (***Part 2***) protects patient records created by federally assisted programs for the treatment of substance use disorders (SUD)

- Part 2 recently revised to further facilitate better care coordination while maintaining confidentiality protections against unauthorized disclosure and use

- **What has not changed?**
  - Continues to prohibit law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order
  - Continues to restrict the disclosure of SUD treatment records without patient consent – outside of the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on appropriate court order

SAMHSA 42 CFR Part 2 Revised Rule (cont.)

- **Highlights of what is new**
  - **Applicability, Re-disclosure**
    - Treatment records created by non-Part 2 providers based on their own patient encounter(s) are explicitly not covered by Part 2, unless any SUD records previously received from a Part 2 program are incorporated into such records
  - **Consent Requirements**
    - SUD patient may consent to disclosure of Part 2 treatment records to an entity (e.g., the Social Security Administration), without naming a specific person as the recipient for the disclosure
  - **Disclosures and Consent**
    - Disclosures for the purpose of "payment and health care operations" are permitted with written consent
  - **Medical Emergencies**
    - Declared emergencies resulting from natural disasters (e.g., hurricanes) that disrupt treatment facilities and services are considered a "bona fide medical emergency," for the purpose of disclosing SUD records without patient consent under Part 2

Section 8

CMS COMPLIANCE REVIEW PROGRAM

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CMS Compliance Review Program

- In late 2017, CMS launched its Optimization Pilot in preparation for a full-scale Compliance Review program

Change Healthcare was selected to participate in the Optimization Pilot and was awarded our Certificate of Completion on October 4, 2018. See Change Healthcare Accreditations & Certifications for details.

- In April 2019, CMS began its formal Compliance Review program by selecting nine HIPAA-covered entities for compliance reviews. Any health plan or clearinghouse, not just those working with Medicare or Medicaid, can be selected

- Also in April, CMS launched a volunteer Provider Pilot Program to test the process for reviewing HIPAA Administrative Simplification rules compliance among providers.

For additional information, see https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Enforcements/Compliance-Review-Program.html

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Section 9

CHANGE HEALTHCARE ACCREDITATIONS & CERTIFICATIONS

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HHS Optimization Program Certification

- On October 4, 2018, The U.S. Department of Health and Human Services (HHS), Division of National Standards (DNS) within the Centers for Medicare & Medicaid Services (CMS), recognized Change Healthcare for successfully completing the HHS Optimization Program Pilot of Administrative Simplification transaction standards, code sets, unique identifiers, and operating rules.
- Certificate of Completion

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Change Healthcare Accreditations & Certifications

To demonstrate our continued commitment to assure that applicable Change Healthcare products and services meet industry and regulatory requirements and expectations, we maintain several industry recognized and trusted accreditations and certifications.

Click HERE for more information.

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