

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland



CENTER FOR MEDICARE

February 26, 2026

CORRECTIVE ACTION PLAN REQUEST

Contract ID: H0137, H2225

Parent Organization Name: CareSource

Legal Entity Name: COMMONWEALTH CARE ALLIANCE, INC.

Katherine Charron
Medicare Compliance Officer
30 Winter Street
Boston, MA 02108

VIA EMAIL: kcharron@commonwealthcare.org

Subject: Corrective Action Plan for Failure to Comply with Prompt Payment Provisions and Failure to Correctly Pay Contracted Providers Under the Terms of Your Contracts

Dear Katherine Charron:

The Centers for Medicare & Medicaid Services (CMS) is issuing this request for a Corrective Action Plan (CAP) to Commonwealth Care Alliance, Inc., which operates the Medicare Advantage Prescription Drug Plan (MA-PD) and the Medicare-Medicaid Plan (MMP) Contract IDs H2225 and H0137, regarding your organization's failure to meet prompt payment provisions and pay contracted providers under the terms of your contracts. On February 29, 2024, CMS issued your organization a warning letter for failure to comply with prompt payment regulations. However, the efforts undertaken to remediate those findings resulted in additional non-compliant activities and a continued failure to comply with prompt payment regulations.

As a result of your organization's pervasive failure to comply with CMS regulations, CMS directs your organization to take corrective action to address the identified areas of non-compliance.

Your organization is non-compliant with the following:

- 42 C.F.R. § 422.520(a)(1), which requires that the contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of "clean claims" within 30 days of receipt if they are claims for services that are not furnished under a written agreement between the organization and the provider.
- 42 C.F.R. § 422.520(a)(3), which states that all other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

- 42 C.F.R. § 422.520(b)(2), which states that the MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.
- 42 C.F.R. § 422.504(a)(16), which requires MA organizations to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial activities related to the delivery of Part C services.

Your organization is out of compliance with these Part C requirements because your organization failed to: (1) pay non-contracted provider clean claims timely; (2) pay contracted providers under payment terms of your contracts with these providers; and (3) maintain sufficient administrative and management capabilities to implement and control financial activities.

On April 1, 2023, your organization transitioned your Part C claims processing vendor from Public Consulting Group to Cognizant. You presented the transition as a major system upgrade that would resolve previously identified compliance issues regarding your organization's failure to timely pay contracted and non-contracted providers in accordance with CMS rules and your contracts with providers. From November 17, 2023, to January 24, 2024, CMS identified new CTMs related to claims processing and discussed these with your organization. Your organization informed CMS that you were addressing the issues and would ensure claims were processed correctly. However, on February 29, 2024, your organization disclosed to CMS that you identified new issues with your updated claims processing system including inaccurate provider data and system misconfigurations such as inaccurate provider classifications, contractual terms, and network status. The inaccuracies resulted in continued inaccurate and untimely claims processing and provider payments.

Physician Classification Inaccuracies

On April 8, 2024, your organization reported that during the April 1, 2023, claims processing system transition some physician classifications were incorrectly showing certain providers as specialists when they should have been listed as primary care physicians (PCP). While the contracts listed above were not impacted by this issue, it led to your organization conducting a comprehensive review of provider data and contract configurations in your claims processing system. Through this review, your organization discovered multiple additional inaccuracies outlined below that impacted the contracts listed above.

Provider Contract Misconfigurations

Your organization reported that some provider contracts were not configured accurately, resulting in the agreed upon contractual rate not being accurately entered into the new claims system. On July 22, 2024, your organization reported to CMS that your system had 511 distinct provider contract misconfigurations, resulting in your organization inaccurately reimbursing contracted providers consistent with the contracted rates between the provider and your organization.[1]

Incomplete and Inaccurate Provider Data

Your organization also identified missing information from provider rosters when they were transitioned into the new claims processing system, resulting in denied and pending claims. You reported that this affected approximately 3,500 contracted providers, five percent of your organization's total providers. The volume of pending claims continued to accumulate until the provider data issue was resolved and the claims could be processed. From May 2023 through December 2024, your organization reported a pending claims backlog that ranged from 10,000 to over 32,000 in September 2024.

Untimely Payment of Clean Claims

Due to your organization's system inappropriately pending non-contracted claims for 6 months, your

organization repeatedly failed to timely pay 95 percent of clean claims for non-contracted providers within 30 days of receipt. Between January and December 2024, your organization reported timely payment of an average of 92.60% of clean claims to non-contracted providers within 30 days for contract H0137 and an average of 90.46% of clean claims to non-contracted providers for contract H2225. Additionally, for the entire year of 2024, your organization failed to timely pay or deny all other non-contracted provider claims within 60 days from the date of request. Between January and December 2024, on average, your organization reported paying or denying 91.32% of non-contracted provider claims for H0137 and 89.67% of non-contracted provider claims for H2225 within 60 days.

Remediation and Impact

On October 14, 2024, your organization reported implementing standardized processes to automate provider claims processing for claims containing inaccurate or missing information as well as outreach to provider groups to update roster information. As of December 4, 2024, you confirmed all required provider contract reconfigurations had been completed in your claims processing system. On May 2, 2025, you reported that you had completed all necessary reprocessing for impacted claims by April 15, 2025 and that providers were reimbursed by May, 2, 2025. On May 23, 2025, your organization reported the provider impact for inaccurately processed claims was a total overpayment of \$8,000,654 and an underpayment of \$11,177,638 which affected 483,042 claims and 10,425 providers.[2] Your organization reported remediating all outstanding issues and has notified providers to reimburse any cost sharing that was inaccurately charged.

CMS requests that your organization develop and implement a detailed CAP. This CAP should address the corrective actions you will take to remediate your inadequate process for paying non-contracted providers timely, accurately paying contracted providers under prompt payment terms of your contracts with these providers; and maintaining sufficient administrative and management capabilities to implement and control financial activities. This CAP should also include other actions your organization identifies as necessary to correct this problem and prevent it from reoccurring. Because of the complexity and sensitivity of this matter, CMS will review materials and intermediary implementation steps throughout the process.

CMS is issuing this compliance notice pursuant to 42 C.F.R. §§ 422.504(m)(3)(iii) and 422.510(c), which require CMS to afford an organization at least 30 calendar days to develop and implement a CAP to correct deficiencies before taking steps to terminate an organization's Medicare contract. Therefore, by March 30, 2026, please send a timeline for implementing each element of the CAP to your CMS Account Manager. CMS expects that the correction timeline will be no longer than necessary and will reflect an appropriate level of urgency in resolving this matter.

Please be aware that this letter will be included in the record of your organization's past Medicare contract performance, which CMS will consider as part of the review of any application for new or expanded Medicare contracts your organization may submit. CMS determines this instance of non-compliance a Part C issue. CMS considers your organization's efforts in self-reporting information concerning the non-compliant activity as a mitigating factor in determining the severity of this notice.

CMS has the authority to impose sanctions, penalties, and other enforcement actions as described in federal regulations at 42 C.F.R. Part 422 Subpart O. CMS also has the authority to terminate a contract per 42 C.F.R. § 422.510. Should your organization fail to develop, implement, or complete its CAP, CMS may consider intermediate sanctions (e.g., suspension of marketing and enrollment activities), civil money penalties, or termination of your organization's contracts.

If you have any questions about this notice, please contact your CMS Account Manager Em Chapple at: (617)-531-7561 or Emily.Chapple@cms.hhs.gov.

Sincerely,



Jeremy C. Willard, Director
Division of Surveillance, Compliance & Marketing
Medicare Drug & Health Plan Contract Administration Group
Centers for Medicare and Medicaid Services

CC via email:

Emily Chapple, CMS
Christine Reinhard, Theresa Wachter, CMS Baltimore

[1] Since your organization could not determine the impact by contract, the impact described includes contracts not cited in this letter.

[2] Since your organization could not determine the impact by contract, the impact described includes contracts not cited in this letter.