PROVIDER TRANSITION INFORMATION

commonwealth care alliance®

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CCA + CareSource

- Last year CareSource®, an Ohio-based nonprofit managed care health plan, finalized the acquisition of Commonwealth Care Alliance® (CCA) with the intent to ensure that residents of Massachusetts with complex health needs maintain access to high-quality health care services.
- The affiliation between CareSource and CCA leverages **combined resources** and **expertise** to address the critical needs of members and the broader community. By integrating CareSource's expertise with CCA's specialized programs, members will benefit from **enhanced care coordination**, access to **innovative health solutions,** and a **more robust support network** that prioritizes their unique needs.
- Effective June 28, 2026, CCA Senior Care Options and CCA One Care plans will be operationally supported by CareSource.

MEET CARESOURCE®

commonwealth care alliance®

About CareSource

MISSION DRIVEN

CareSource is a nonprofit, nationally recognized managed care organization with more than 35 years of Medicaid managed care experience and over 2.3 million enrollees. Since its founding in 1989, CareSource administers one of the largest Medicaid managed care plans in the U.S., offering Medicaid, Health Insurance Marketplace (Qualified Health Plans) and Medicare products. As a mission-driven organization, CareSource is committed to enrollee-centric care and transforming health care with innovative programs that address social drivers of health, health-related social needs and access to care.

HEALTH CARE WITH HEART

As a national leader in managed care, CareSource firmly believes the future of health care will be shaped by those who innovate and drive value for consumers and the states they serve.

Operations Performance

Key Performance Indicator (KPI)	Claims First Pass Accuracy	Financial Accuracy	Claim Average Days to Pay	Prompt Pay Timeliness	Encounters Submitted in 14 Days	Encounter Completeness and Accuracy
Current Rate	**99%**	**99.96%**	**10 Days**	**> 100%**	**> 99.9%**	**> 99.9%**

Corporate Headquarters:
Dayton, Ohio

Locations:
Arkansas, Florida, Georgia, Indiana, Massachusetts, Michigan, Mississippi, Nevada, Ohio and Wisconsin

Year Established:
1989

4-STAR
CMS Medicare Rating

More than **7,000 employees** in **46 states**

$39 million invested in nonprofits and communities through the CareSource Foundation

A Partnership with Heart

At CareSource and CCA, we recognize a true partnership can only exist when we listen to and understand your needs. We are dedicated to partnering with you to improve member outcomes and make it easier for you to care for our members.

“The CareSource and Commonwealth Care Alliance partnership ensures residents of Massachusetts with complex health needs continue to have access to high-quality health care.”

Erhardt Preitauer, President and CEO of CareSource

What's Not Changing?

Not everything is new. Some things will remain **exactly the same**.

- Our commitment to our provider partners
- Your Commonwealth Care Alliance® Senior Care Options (HMO D-SNP) and One Care (HMO D-SNP) contract
- Our plans: CCA OneCare and CCA Senior Care Options and associated member benefits
- The CCA Uncommon Care® Model
- Care Management services for all members
- Access to instED mobile acute care services
- Provider Services and Provider Relations — no change to how you reach us
- Provider annual training requirements
- Pharmacy Benefit Manager (PBM) CVS Caremark®
- CCA Senior Care Options and CCA One Care formularies
- Durable Medical Equipment (DME) platform: Tomorrow Health
- Benefit administrators for transportation, routine vision, dental and hearing

NEW INFORMATION FOR CURRENT CCA PROVIDERS

commonwealth care alliance®

Terminology Update | **HMO D-SNP**

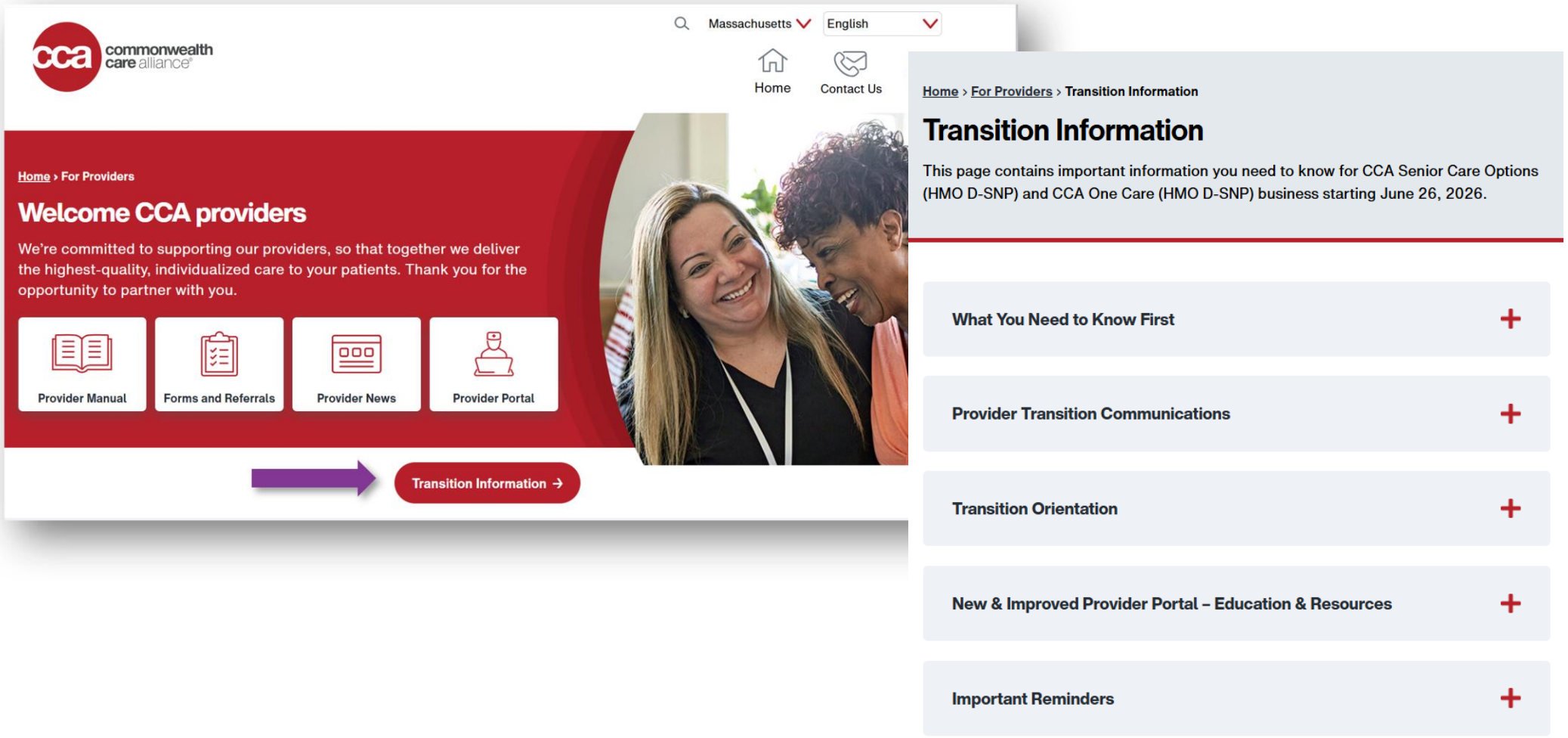
Provider materials

- Over the past year, we have used the term “FIDE-SNP” to describe the CCA OneCare and CCA Senior Care Options plans.
- These dual-eligible special needs plans are also known as HMO D-SNP plans.
- “FIDE-SNP” and “HMO D-SNP” are synonymous industry terms.
- You may see both terms used in provider materials over the next few months.

Member materials

- Since January 1, 2026, member materials have included the HMO D-SNP plan-type only.
- There will be no changes to plan names or types.

Navigating the CCA Provider Website



Visit the Transition Information webpage on the CCA Website

Provider Data Management

Practitioners, provider groups and facilities are responsible for notifying CCA of any changes to provider enrollment information.

- All requests must be sent to the Provider Data Management (PDM) department by email at **PNMDepartment@CommonwealthCare.org** 45 days prior to the change or update.

- Detailed information on changes (e.g., adding and terminating providers, adding and terminating a practice or facility, adding or terminating National Provider Identifiers (NPIs), changes to demographic information and panel status and the appropriate forms needed are located in Section 15 of the Provider Manual).

Please refer to CCA's *Provider Enrollment and Credentialing* (Section 15 of the Provider Manual) for more detail

Electronic Visit Verification (EVV)

CMS requires EVV for Personal Care and Home Health services per the 21st Century Cures Act. Accurate data entry is critical to avoid claim denials. CCA is dedicated to helping providers navigate this process successfully.

To Ensure Compliant Claims:

- Enter correct procedure codes, units, and date of service into the aggregator
- Claim data must match what is reflected in the aggregator
- Verify correct Provider and Member Medicaid IDs in the aggregator
- Confirm the correct payer is listed for the member in the aggregator
- Ensure EVV visit records match submitted claim data

Claims that do not match risk denial.

NEW PROVIDER PORTAL

Provider Portal | **Value**

SAVE TIME AND MONEY

The Provider Portal is a robust, encrypted and secure online tool available to all providers who serve our members. With our secure online Provider Portal, you can:

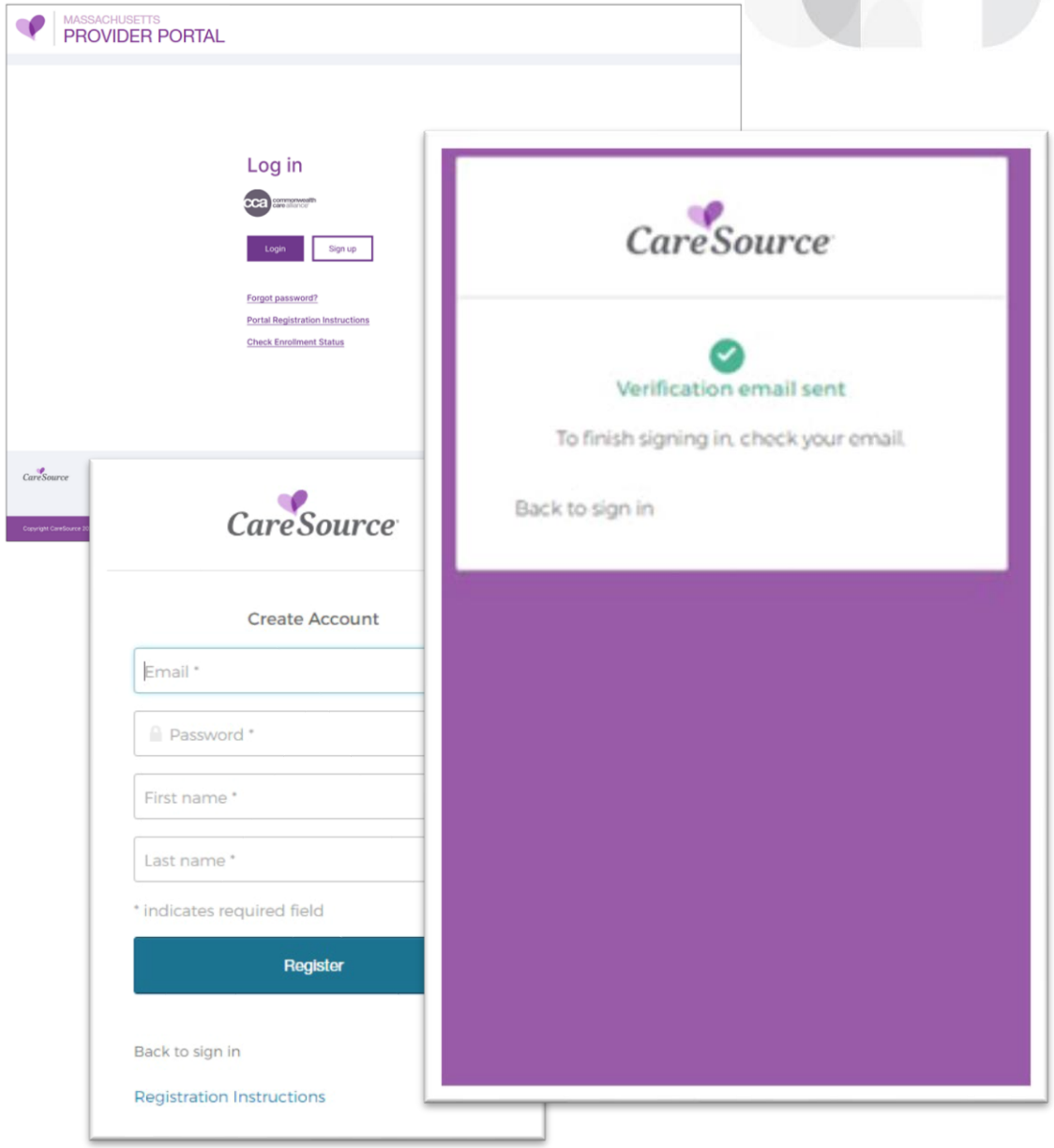
Check member eligibility and benefit limits	Submit claims and verify claim status
Submit prior authorization requests	View and update care management and service plans
Check prior authorization status	Verify/update coordination of benefits
View member gap-in-care alerts	And much more!

Review the content on the **Transition Information** web page under **New & Improved Provider Portal - Education and Resources**.

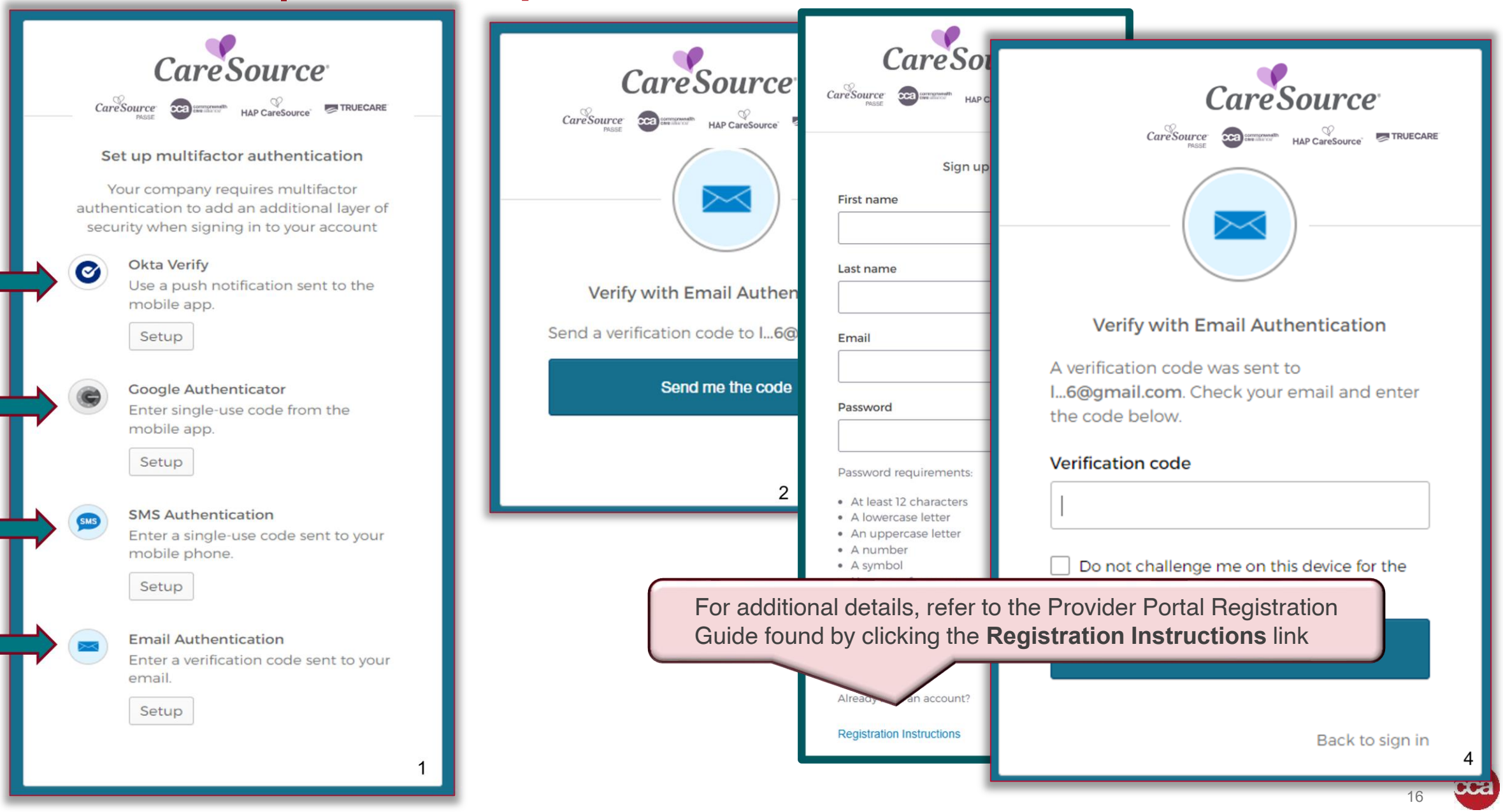
Access the Provider Portal 24 hours a day, seven days a week at ProviderPortal.CareSource.com/GL/User/Login.aspx/.

Provider Portal | **Registration**

1. Visit ProviderPortal.CareSource.com/GL/User/Login.aspx/ and click the **Sign-up** link on the page.
2. Complete the **Create Account/Sign Up** table and click **Register/Sign Up.**
   - Enter the email address you want to associate with your account. You will use this email to log into the portal.
   - Create a **Password** with a minimum of 12 characters.
     - Contain one lowercase and one capital letter
     - One number, one special character (!, @, $ or %) not part of your username (email).
   - Enter **First** and **Last Name.**
   - You will receive an email with a verification code.
3. Enter the verification code you receive per your selected Multi-Factor Authentication method.
4. To associate your account with a **Billing ID**, select the **Provider Type, Practitioner's First Name, Practitioner's Last Name, Tax ID, CareSource Provider Number and ZIP Code** to link a provider to your account and then click Next. Required fields are marked with a red asterisk.

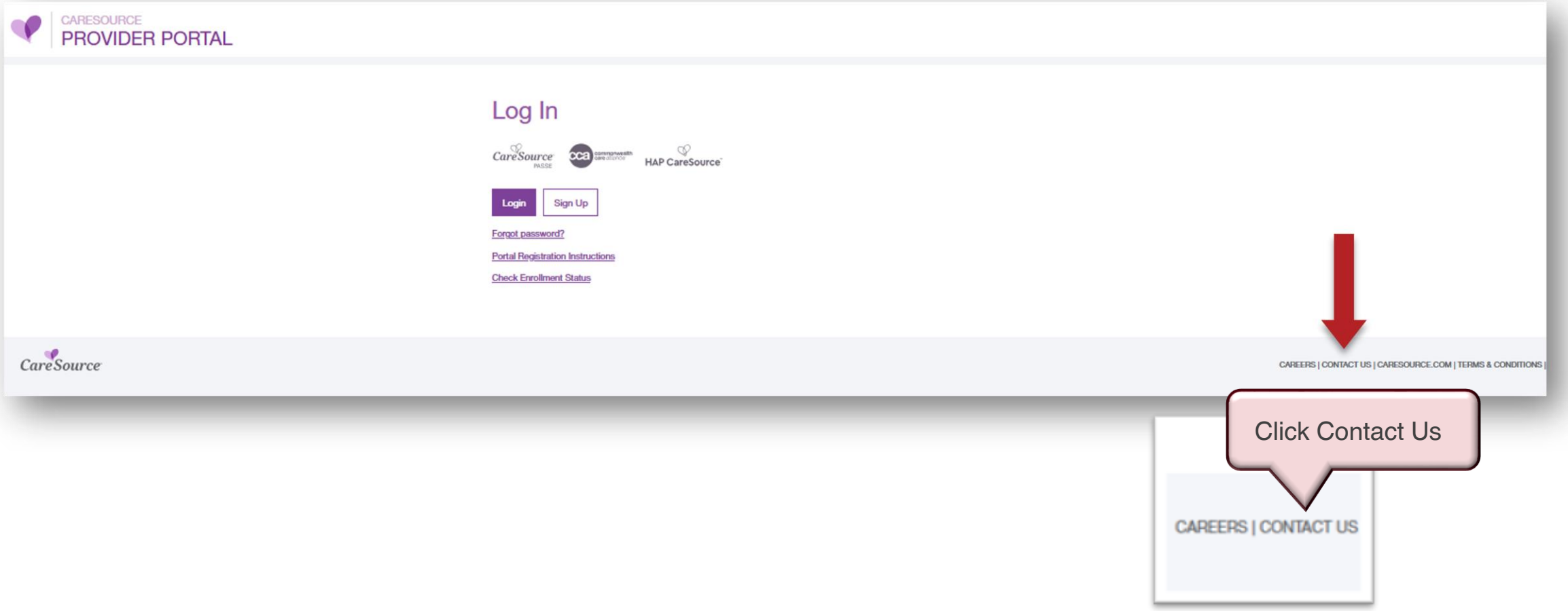


Provider Portal | **MFA Setup**

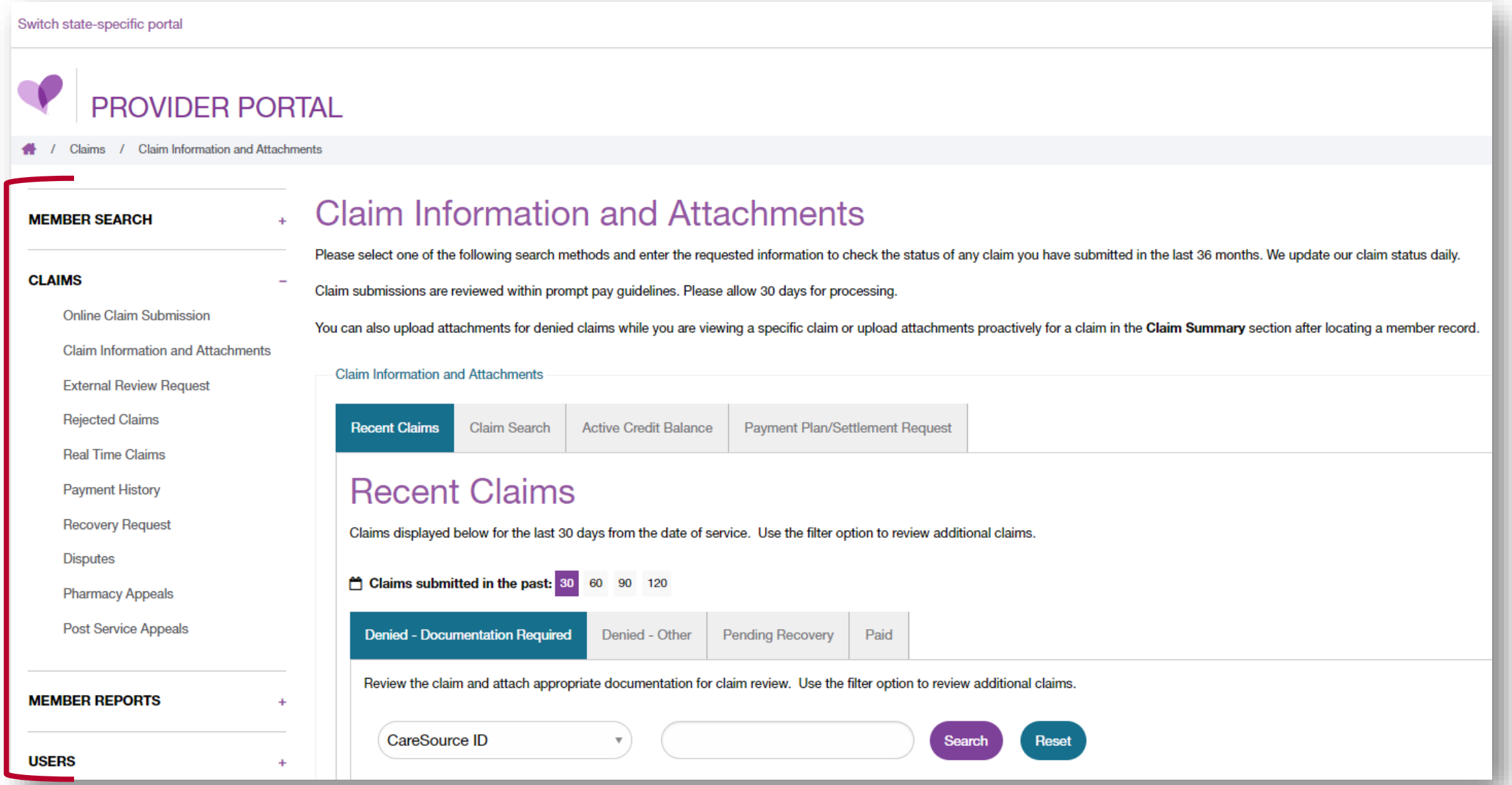


For additional details, refer to the Provider Portal Registration Guide found by clicking the **Registration Instructions** link

Provider Portal | **Contact Us!**

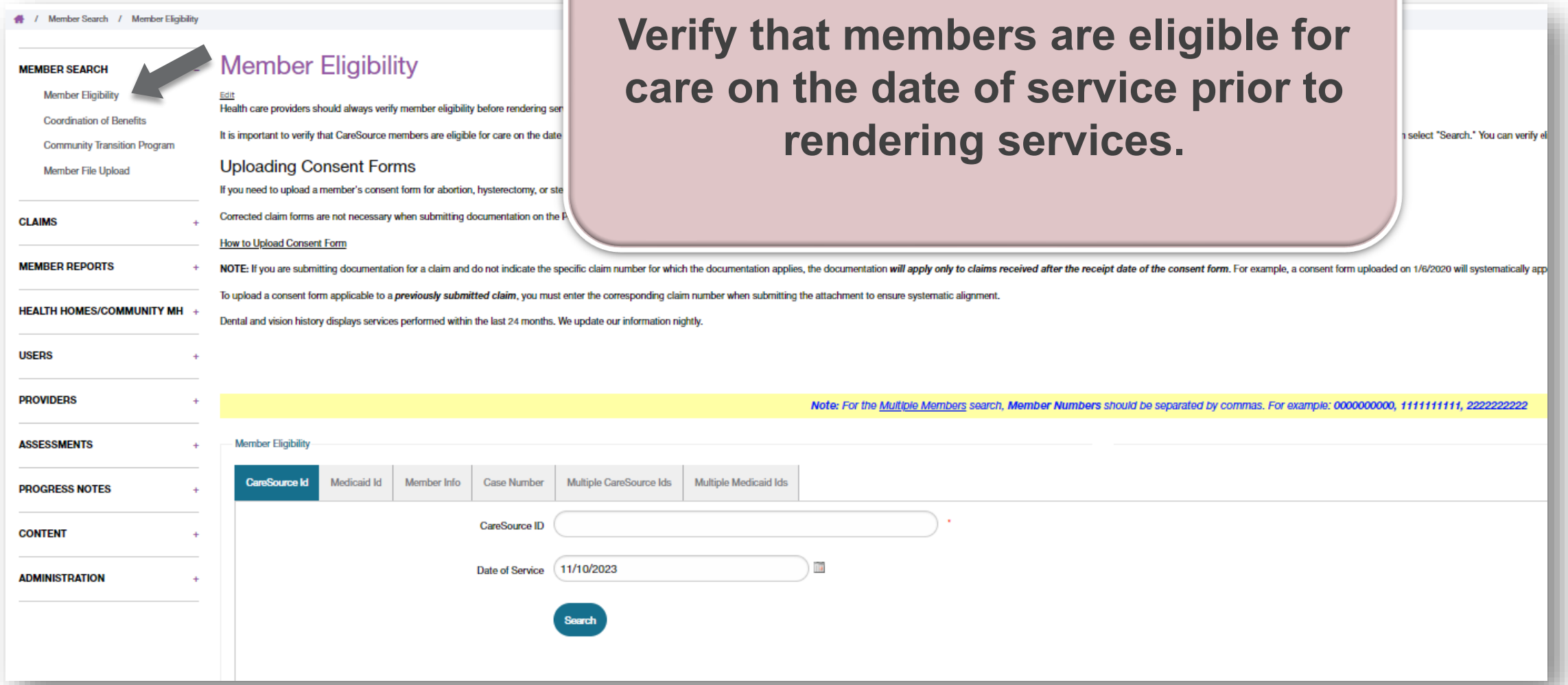


Provider Portal | **Home Page**



Provider Portal | **Eligibility Status**

Verify that members are eligible for care on the date of service prior to rendering services.



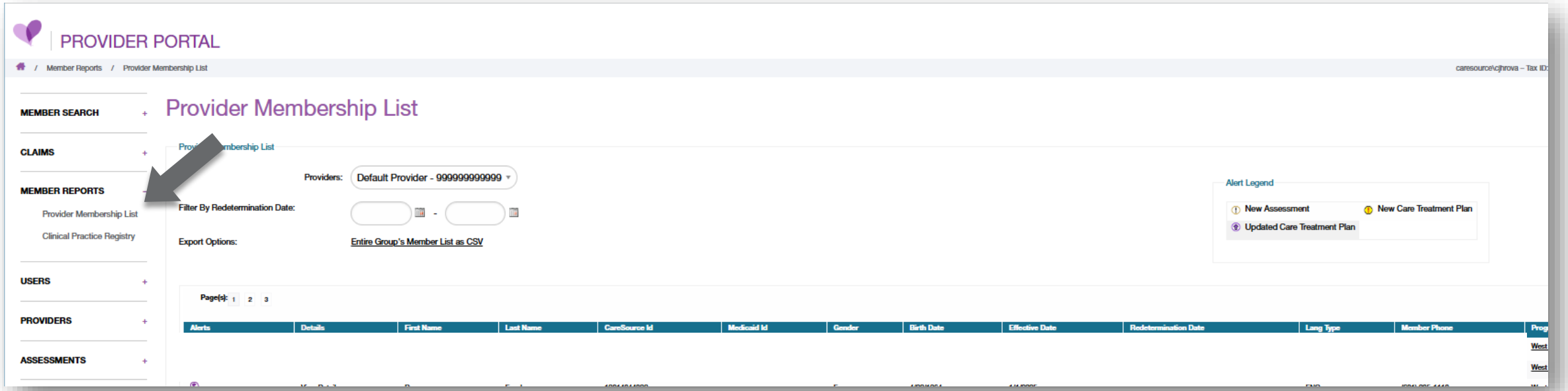
Provider Portal | **Member Eligibility Verification**

Providers are required to confirm member eligibility on a regular basis prior to rendering services, even if prior authorization is on-going.

Of the methods below, the New Provider Portal is the only **NEW** option.

Member Eligibility Verification Resources
New Provider Portal
Availity Essentials Provider Portal* To register, click on ”Get Started” in the upper right corner and follow the instructions
MassHealth Provider Online Service Center
MMIS/Eligibility Verification System (EVS)
NEHEN Provider Portal*
CCA Provider Services at 1-866-420-9332 8 a.m. to 5 p.m., Eastern Time (ET), Monday – Wednesday and Fri; Thursday 8:30 a.m. to 5 p.m., Eastern Time (ET)
**Supports Real Time Eligibility and Benefits Inquiry and response using X12 270/271 transactions.*

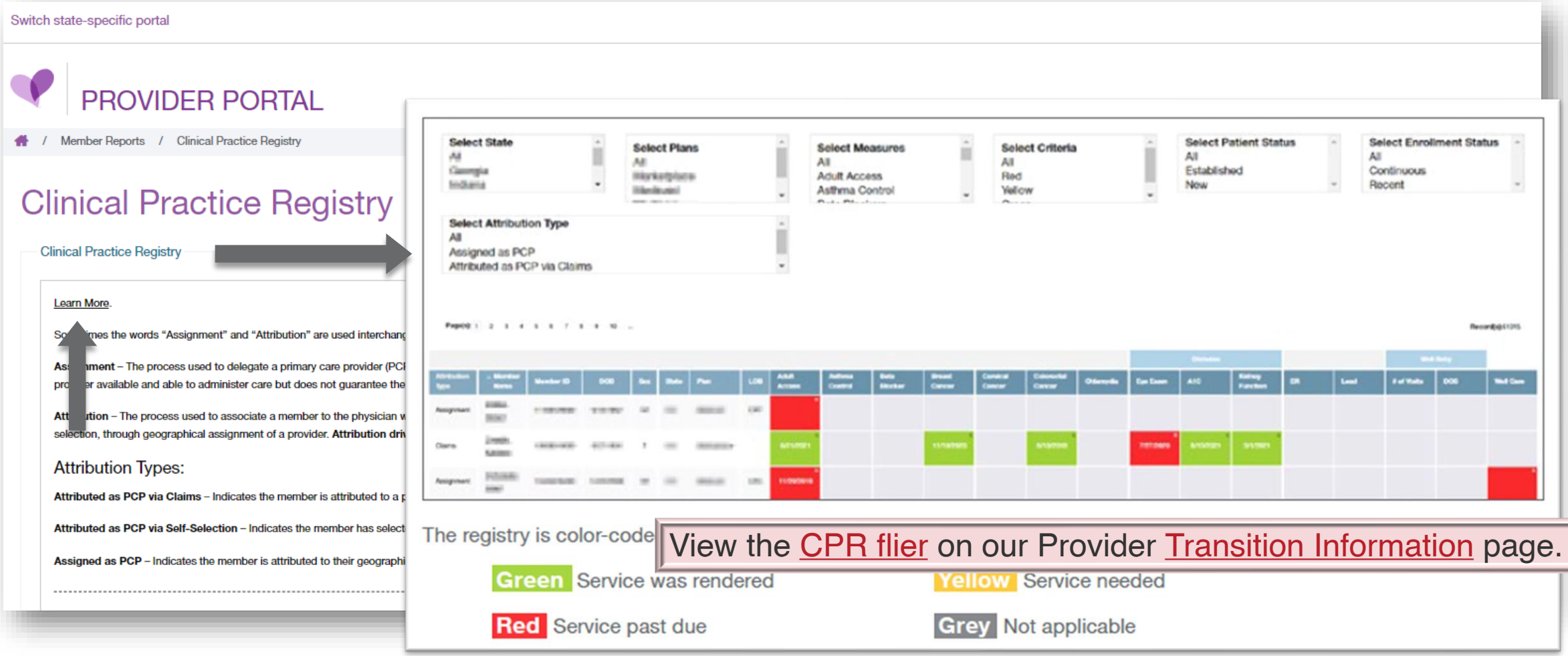
Provider Portal | **Membership List**



To locate member information

1. Select **Provider Membership List** from the menu.
2. Choose the provider's name associated with the member.
   - Note that providers not associated with a group will only see their name.

Provider Portal | **Clinical Practice Registry (CPR)**

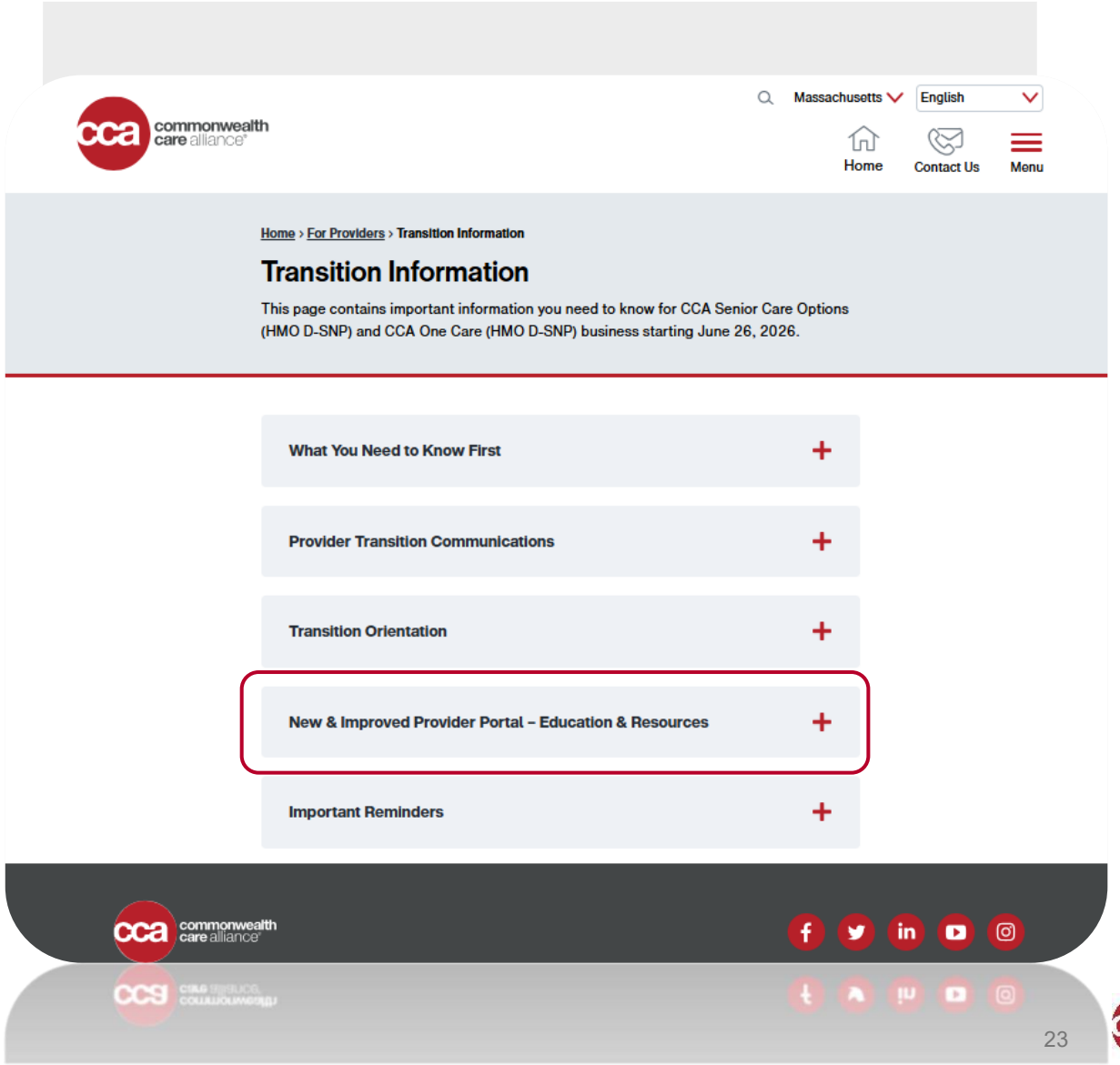


Provider Portal | **Training Resources**

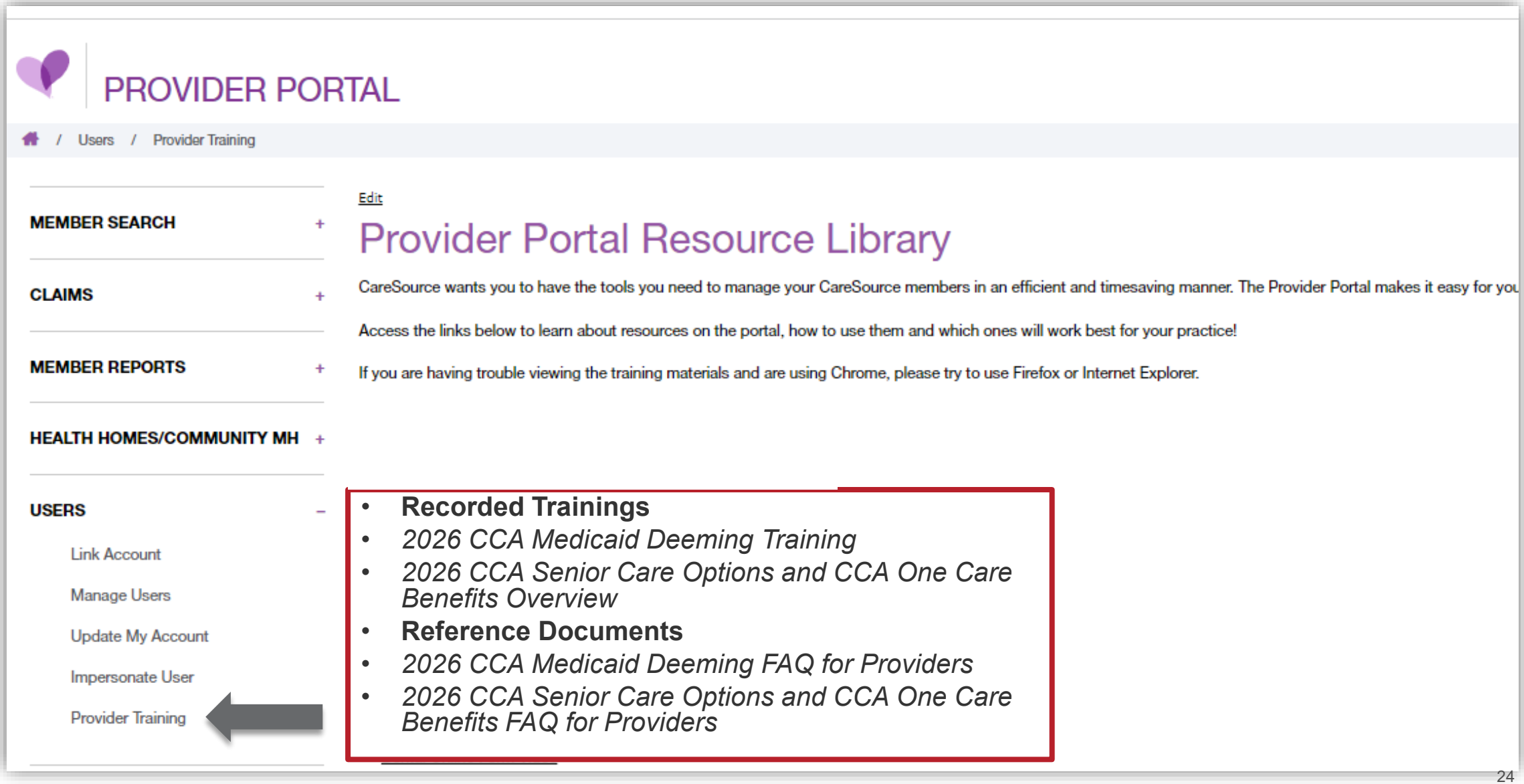
The **New** Provider Portal is a robust, secure and encrypted online tool available for all providers who serve our members.

- Available Documents
  - Provider Portal Solutions
  - Clinical Practice Registry Flier
  - Provider Portal User Guide
  - Provider Portal Quick Start Guide
  - Provider Portal Registration Guide
- Available Training Videos
  - Portal Overview
  - Provider Portal: Service Plan Reviews Prior Authorizations
  - Provider Portal: Managing User Access
  - Provider Education Series: Provider Portal Service Plan Review

Visit the Transition Information page at CCA's website to access these resources.



Provider Portal | **Training**



- **Recorded Trainings**
- *2026 CCA Medicaid Deeming Training*
- *2026 CCA Senior Care Options and CCA One Care Benefits Overview*
- **Reference Documents**
- *2026 CCA Medicaid Deeming FAQ for Providers*
- *2026 CCA Senior Care Options and CCA One Care Benefits FAQ for Providers*

PRIOR AUTHORIZATION SUBMISSION

Prior Authorization | **2026 Plan Operational Changes**

For 2026, CMS reduced the timeframes for decisioning standard prior authorization requests.

- **Standard Requests are now decisioned within seven calendar days**
  - Previously decisioned within 14 calendar days
  - Rationale: Faster response improves care coordination
- **Expedited Requests (no change)**
  - Decision within 72 hours
  - For cases where delay may cause serious harm

Submit Prior Authorizations via:

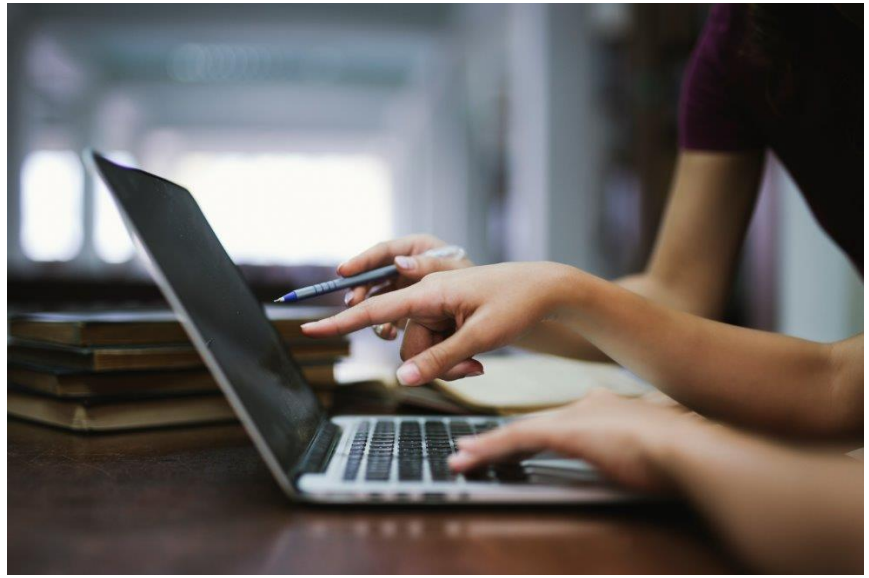
- **New Provider Portal** ProviderPortal.CareSource.com/GL/User/Login.aspx/ - **preferred method**
- Select Providers > Prior Authorizations and Notifications

Alternative Methods via:

- Phone: 1-866-420-9332
- Fax: 1-855-341-0720

Please refer to CCA's *Prior Authorization Requirements* (Section 4 of the Provider Manual) for more detail.

Prior Authorization | **Submission Requirements**



All <u>retrospective</u> authorization requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract. The only exception is a Coordination of Benefits (COB) denial. In this case we allow 90 days from the other insurance notification. Providers must submit rationale for retrospective authorizations.

Remember to include:

- Member name and CCA ID number
- Provider name and NPI
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, treatment or service(s) requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent or emergency, admitting diagnosis, symptoms & plan of treatment

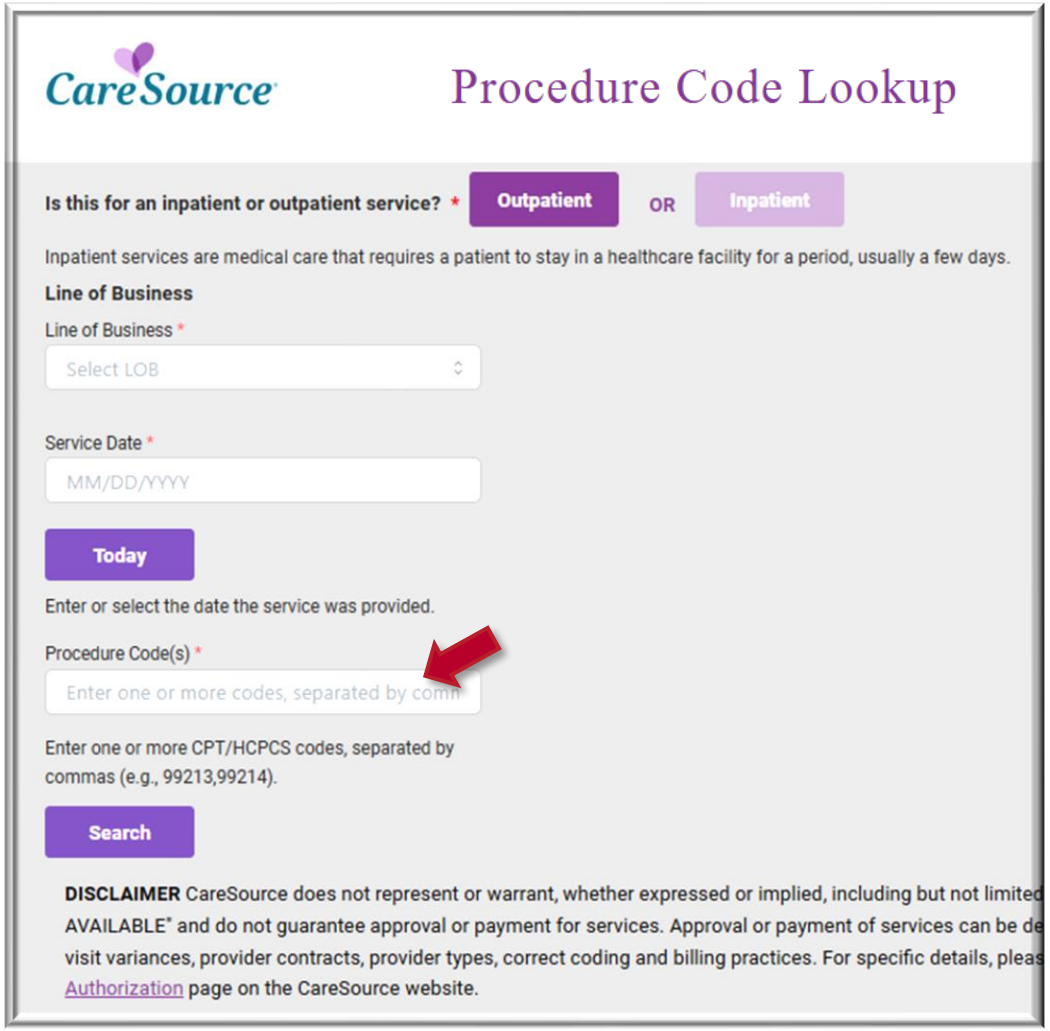
Prior Authorization | **Procedure Code Lookup Tool**

Utilize the **Procedure Code Lookup Tool** to verify prior authorization requirements before entering your request for an outpatient or inpatient procedure.

1. Visit ProcedureLookUp.CareSource.com.
2. Select service type
3. Select plan
4. Enter date of service
5. Enter procedure code

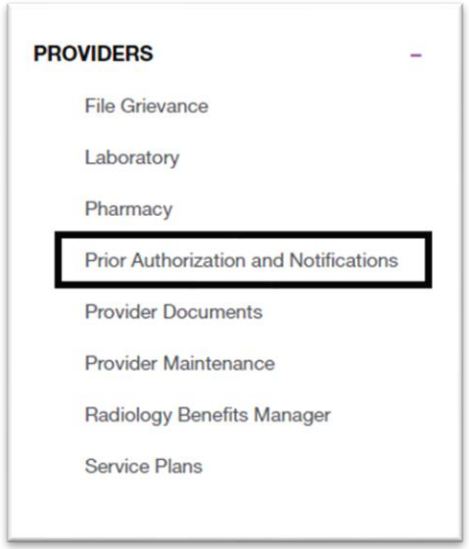
The Procedure Lookup Tool will identify requests that need to be submitted to **TurningPoint**, our Third-Party Administrator (TPA) for Cardiac & Musculoskeletal procedures. It will also identify the codes that need to be submitted to our other UM TPA partners. See slide #39.

If you have any additional questions or would like additional training on Prior Authorization Submission, email **CiteAutoAssistance@CareSource.com**

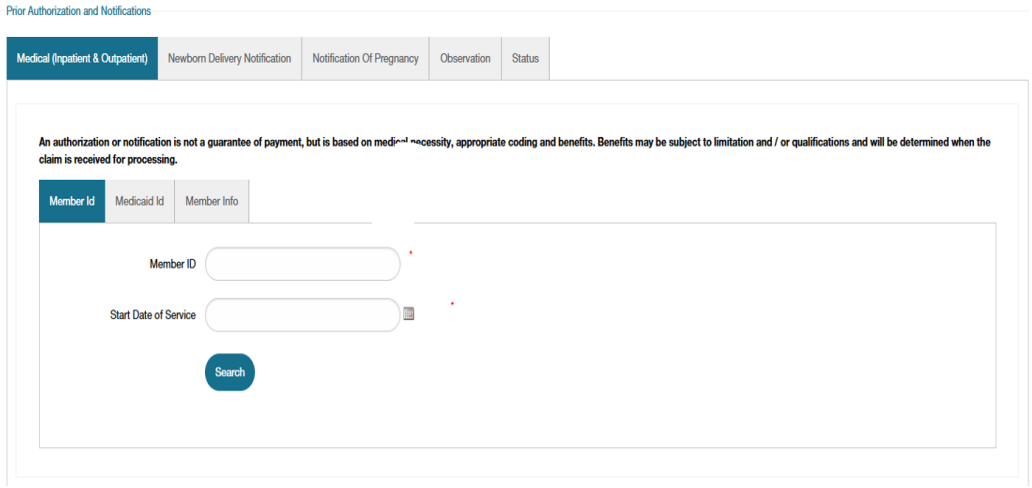


Prior Authorization | **Submission via the Provider Portal**

Select **Providers** > **Prior Authorization and Notifications** from the left-hand navigation menu.

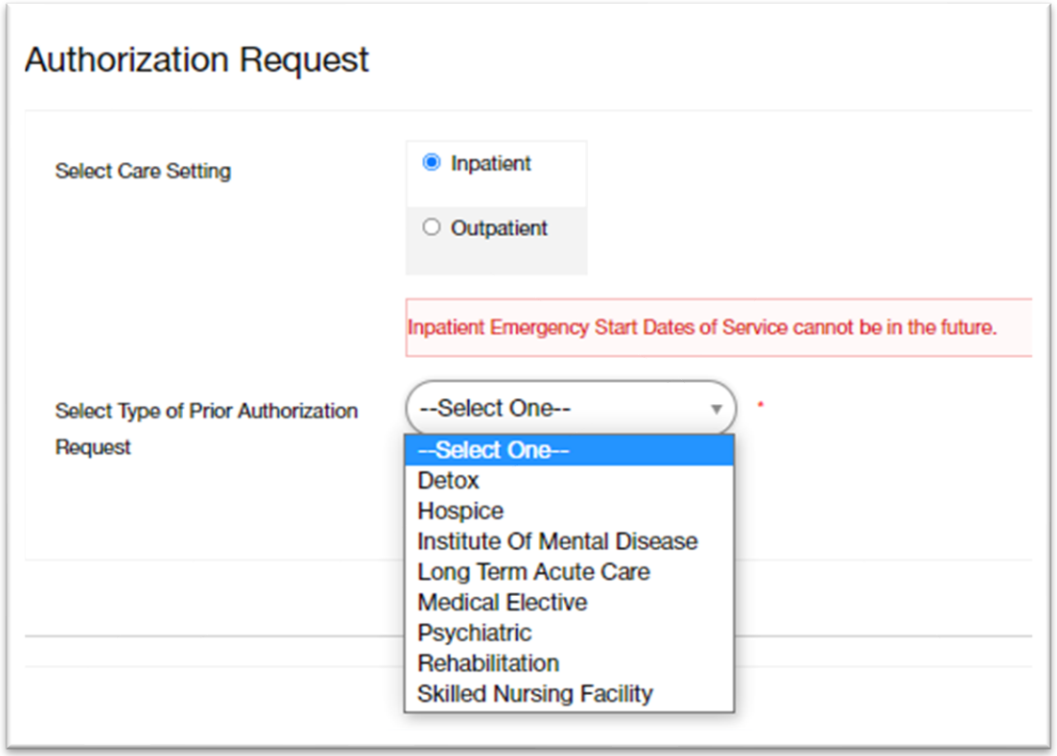


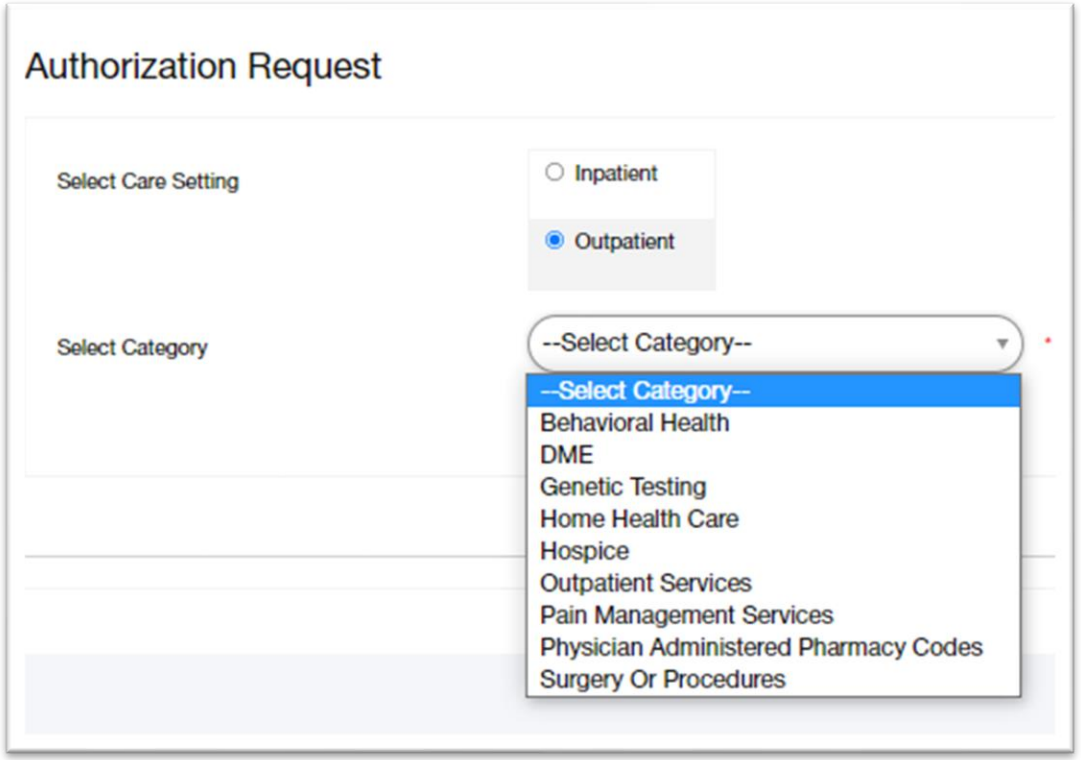
Enter the member's CCA ID and Start Date of Service in the fields provided. Click **Search**. Confirm eligibility and click **Verified**.



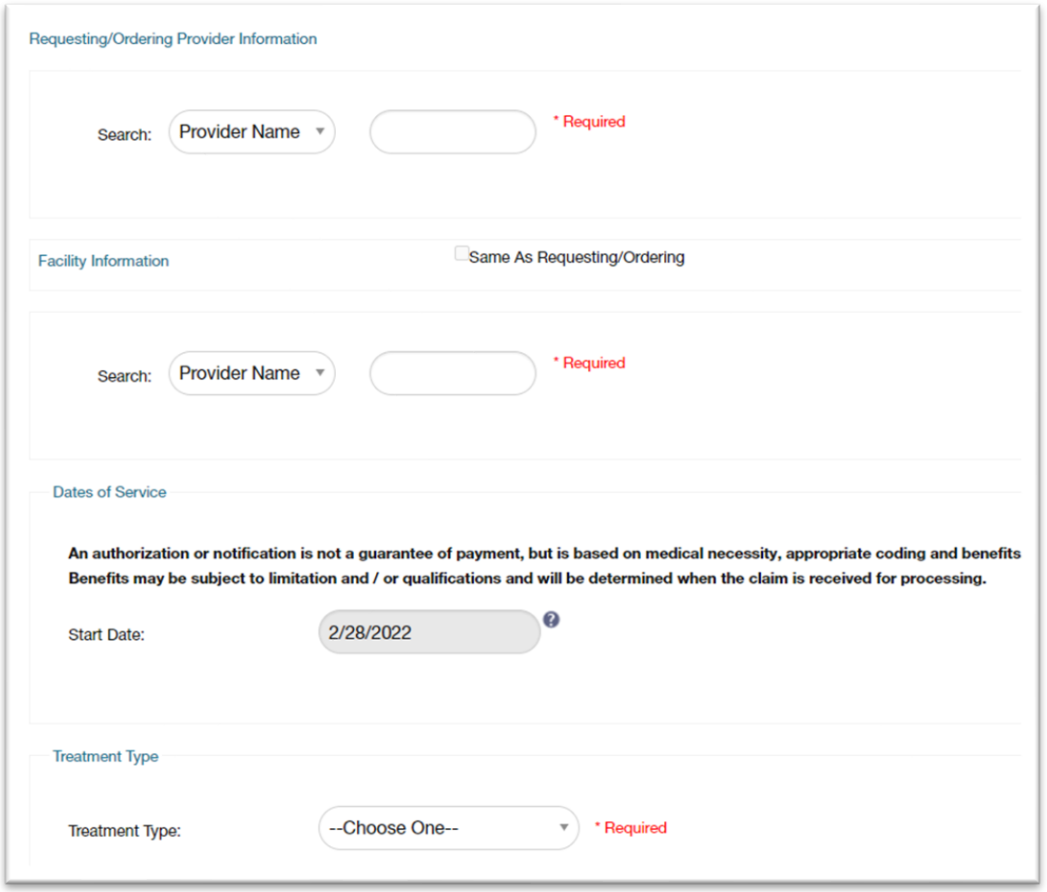
Prior Authorization | **Select the Care Setting**

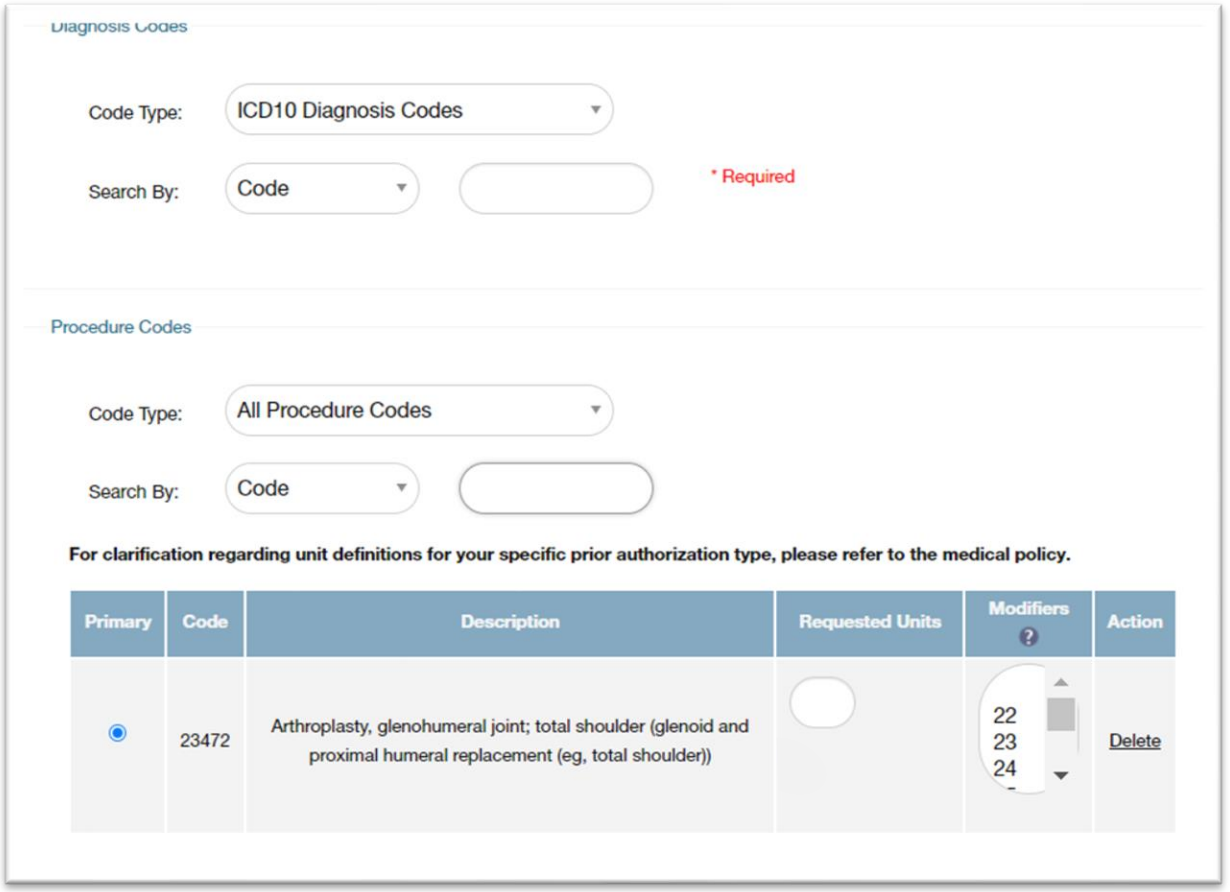
Select the Care Setting and enter the authorization details based on the type of request.





Prior Authorization | **Complete the Required Fields**

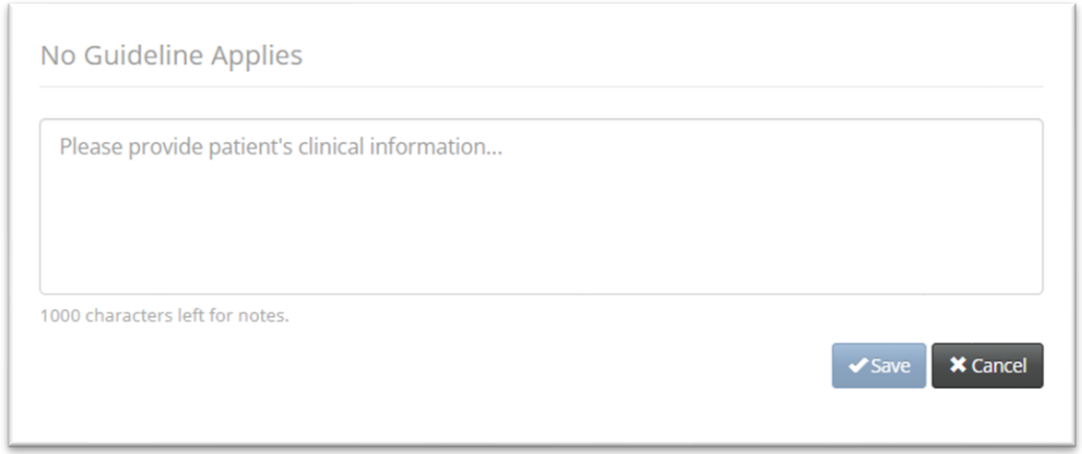




Prior Authorization | **Add the Guideline**

If unable to answer review questions at time of entry, or appropriate guideline not listed, click **Document Clinical** and **add** for No Guideline Applies.

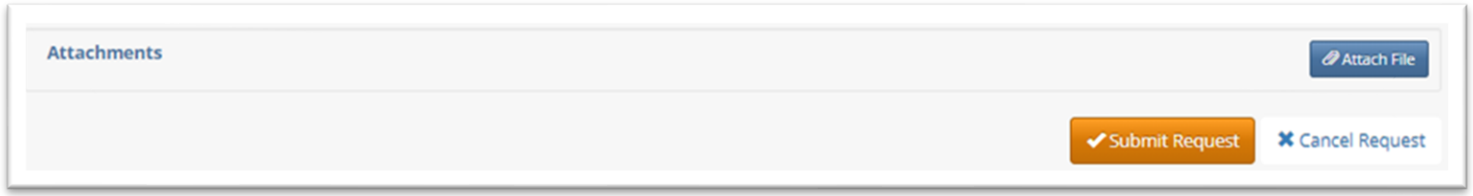
Enter comment in field, click **Save**.



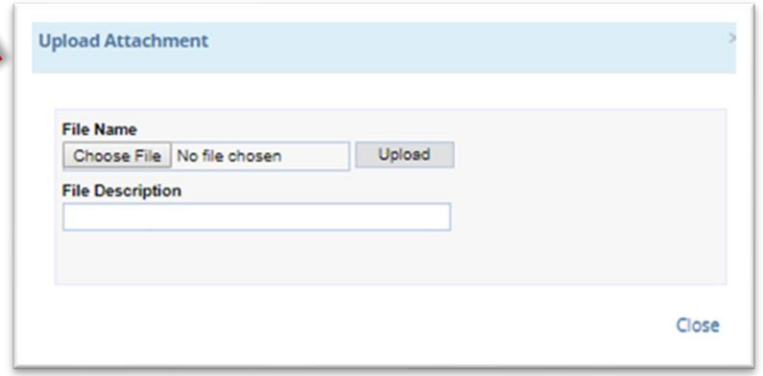
Proceed with attaching supporting documentation.

When Clinical Review Questions are Not Required

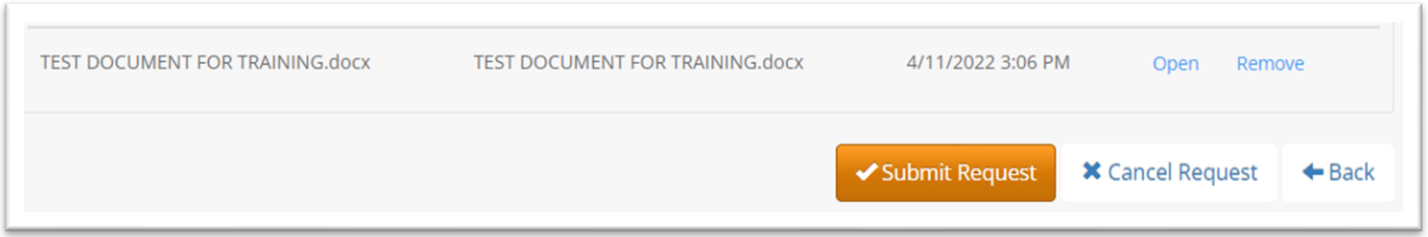
Click **Attach File**.



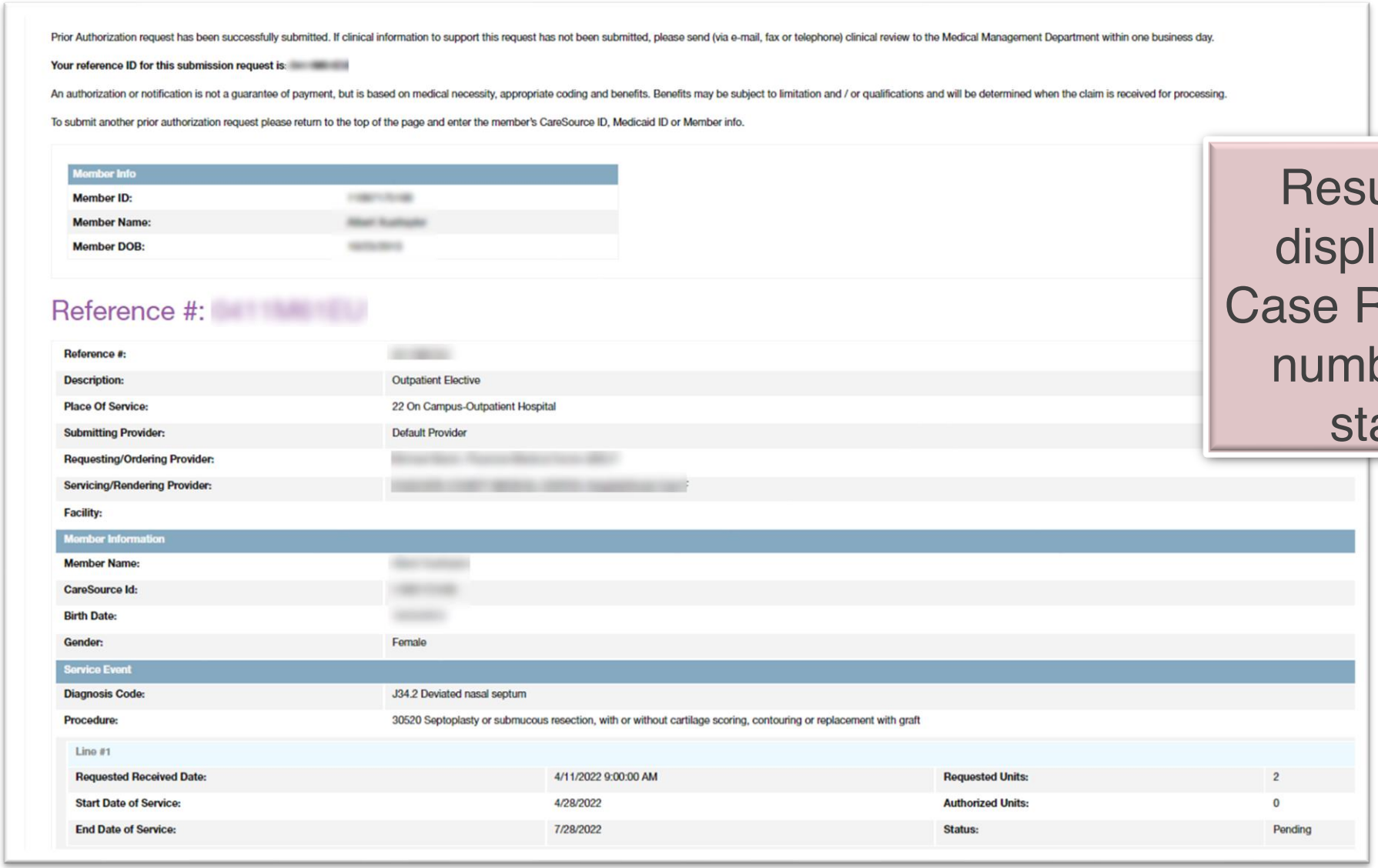
Click **Choose File** to locate document. Click **Upload** to attach to case and close.



File Name will show. Repeat process to add additional files. Click **Submit Request** to process.



Prior Authorization | **Results Screen**



Prior Authorization request has been successfully submitted. If clinical information to support this request has not been submitted, please send (via e-mail, fax or telephone) clinical review to the Medical Management Department within one business day.

Your reference ID for this submission request is: [redacted]

An authorization or notification is not a guarantee of payment, but is based on medical necessity, appropriate coding and benefits. Benefits may be subject to limitation and / or qualifications and will be determined when the claim is received for processing.

To submit another prior authorization request please return to the top of the page and enter the member's CareSource ID, Medicaid ID or Member info.

Member Info	
Member ID:	[redacted]
Member Name:	[redacted]
Member DOB:	[redacted]

Reference #: [redacted]

Reference #:	[redacted]
Description:	Outpatient Elective
Place Of Service:	22 On Campus-Outpatient Hospital
Submitting Provider:	Default Provider
Requesting/Ordering Provider:	[redacted]
Servicing/Rendering Provider:	[redacted]
Facility:	

Member Information	
Member Name:	[redacted]
CareSource Id:	[redacted]
Birth Date:	[redacted]
Gender:	Female

Service Event	
Diagnosis Code:	J34.2 Deviated nasal septum
Procedure:	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

Line #1			
Requested Received Date:	4/11/2022 9:00:00 AM	**Requested Units:**	2
Start Date of Service:	4/28/2022	**Authorized Units:**	0
End Date of Service:	7/28/2022	**Status:**	Pending

Results will display with Case Reference number and status.

Prior Authorization | **Checking Status**

Select **Prior Authorization and Notifications**.

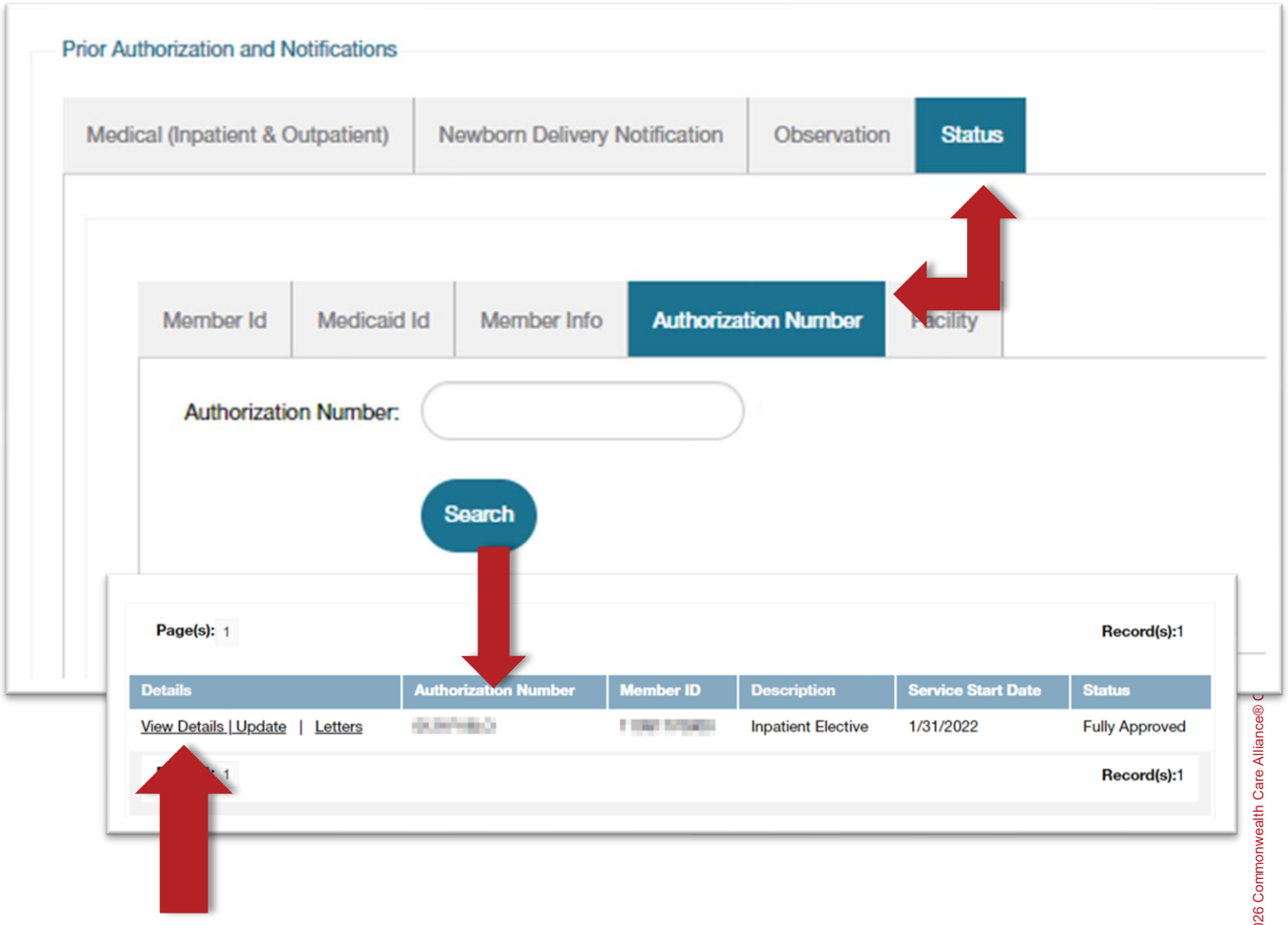
Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

Click **View Details | Update** to review case information.

You may also search Prior Authorization status by facility.

1. Under the **Status** tab select **Facility**.
2. Use the drop-down menu to **Select the Facility**.
3. Choose your **Start** and **End Dates**, and all prior authorizations that are associated with the facility during the given date range will populate.



Prior Authorization | **Request for Change or Update**

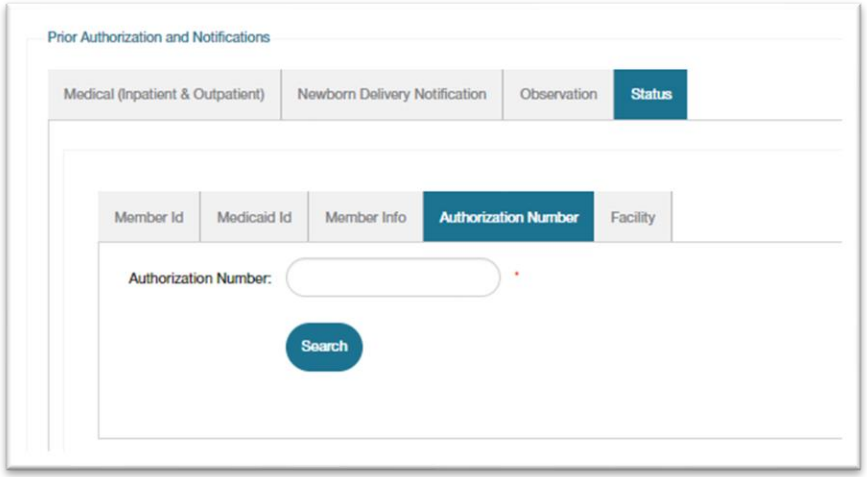
Select **Prior Authorization and Notifications**.

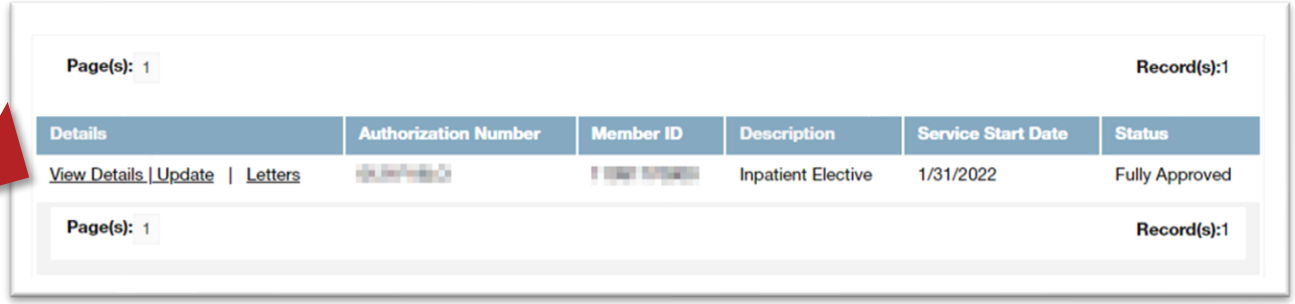
Click **Status** tab, then select the **Authorization Number**. Click **Search**.

Case will display at bottom of screen.

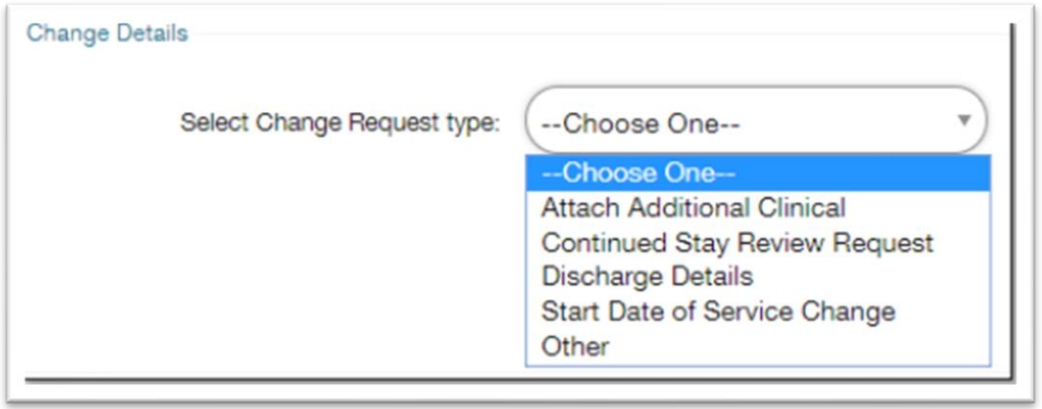
Click **View Details | Update**.

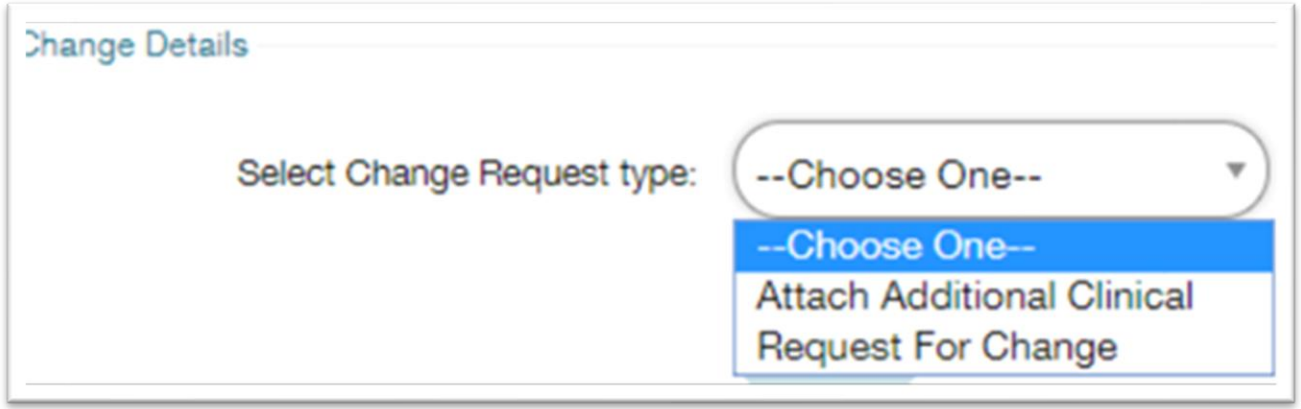
Access is restricted to those authorizations affiliated with each Tax ID number.





Prior Authorization | **Change Details**





- Use drop-down to select **Change Details**.
- Complete changes and required fields. Click drop-down to select type of attachment.
- Choose **File** and locate electronic saved copy (no limit on number of attachments).
- Click **Submit**. The request will be sent to UM to review case and complete process.

Change requests for approved authorizations are accepted when the service intent is the same/similar and does not require a new medical necessity review.

Note that if the case status is Denied or Voided, you will be unable to update the case.
You must submit a new case.

Prior Authorizations | **Cardiac & Musculoskeletal Surgery**

CCA utilizes **TurningPoint** to implement cardiac and musculoskeletal surgical procedures.

TurningPoint Authorization	Turnaround Times	Required Information
Phone: 1-304-603-4673 1-855-578-7350 Fax Intake Form: 1-304-553-7061 1-844-472-0481 TurningPoint Portal	• Standard non-urgent = seven calendar days • Expedited Requests = 72 hours • Retrospective requests = 30 calendar days from the date on which the vendor received the authorization request	• Provider information • Facility information • Anticipated surgery date • Health plan information • Member demographics • Requested procedures/diagnosis • Clinical Information
Turning Point Customer Service Phone: 1-866-422-0800 Email: ProviderSupport@tpshealth.com		

See CCA and TurningPoint announcement for additional information.

Please contact CCA directly for appeals and claims

CLAIM SUBMISSION

Claims | **Billing Overview**

CCA accepts electronic (EDI), provider portal and paper claim submissions.

- Electronic billing is preferred. Use Payer ID **A2793.**
- Mail paper claims to: Commonwealth Care Alliance
  P.O. Box 1127
  Dayton, OH 45401-1127
- Contracted providers must file claims no later than 90 days from date of service unless the filing limit is otherwise stipulated in their contract.

Provider shall not seek or accept payment from a CCA member for any covered service if the member is wholly enrolled and eligible for both Medicare and MassHealth.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Submissions**

ELECTRONIC CLAIM SUBMISSIONS

- It is encouraged to use electronic claim submission as the primary submission method.

Portal Submission

- Providers can submit claims through our **NEW** secure, online Provider Portal at CCA Provider Homepage | Commonwealth Care Alliance MA > Provider Portal. Here, providers can submit claims along with any documentation, track payments and more.

CLEARINGHOUSES

- For electronic data interchange (EDI) transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can also use their existing clearinghouse if they are configured to accept the CCA Payer ID (A2793). Providers can find a list of EDI vendors online at: availity.com/ediclearinghouse.

Claims | **Electronic Funds Transfer**

ELECTRONIC FUNDS TRANSFER (EFT)

ECHO Health offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. [Default] Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

It is encouraged to use electronic claim submission as the primary submission method. We partner with ECHO Health for electronic funds transfer (EFT). You must enroll with ECHO Health to participate. Find the enrollment form for ECHO Health online at: enrollments.echohealthinc.com/. For questions, call ECHO Support at: 1-888-485-6233.

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Transition Information webpage at **CommonwealthCareAlliance.org/ma/providers/** for additional information about getting paid electronically and enrolling in EFT.

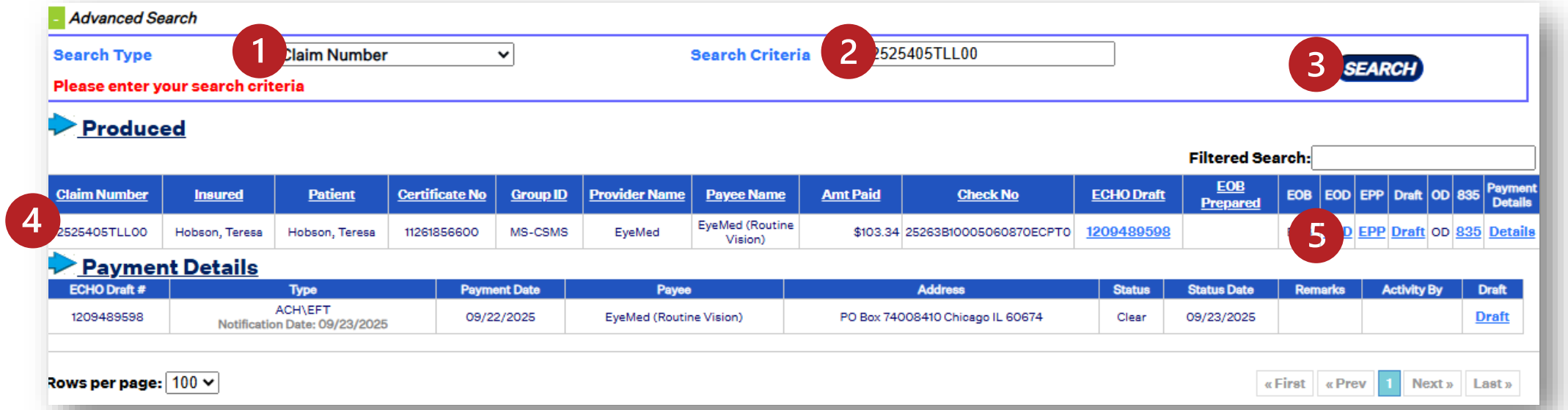
Enroll to complete your enrollment online. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the Provider Portal.

Notice: Email notifications are not sent when a deposit/payment is made. Deposits/payments are made twice weekly.

EPP | ECHO

1. Click the **Search Type** drop-down list and choose appropriate search criteria.
   - The below search options may provide the best results:
     - **ECHO Draft Number**: this is the payment check number on the Remittance tab on the claim.
     - **Provider ID**: the provider's tax ID number.
     - **Claim Number**: CareSource's claim number.
2. Input the appropriate information in the **Search Criteria** field.
3. Click **Search**.
4. Locate the appropriate payment.
5. Click **EPP**.



Claims | **Transition Impact**

Transition Impacts

- EPP format
- Accessing EOPs/835/EPP
- Portal Submission Options
- Recovery Letter format
- Claims/Payment Policy Updates
- Application of CMS Claim Standards
  - FQHC Standardization
  - Therapy limits
  - Adult Daycare
  - And others… *be sure to follow CMS submission guidelines to ensure no interruption in claim processing*
- Mailing Addresses *(in some cases)*

Not Impacted

- Deeming
- Benefits
- Opt-Out/Medicaid Run Out
- Payor ID
- Wholesale Policy
- Accessing Payment Policies Online

Find more Claims Transition Information training at commonwealthcarealliance.org/ma/providers/transition-information/

Claims | **Appeals and Disputes**

ALL CLAIMS APPEALS MUST BE:

- Submitted within 60 calendar days from the date of the claim denial unless it is a COB denial. COB denials must be submitted 60 days from the date of the COB denial (the retro-authorization policy must still be followed). The appeals process is applicable to non-contracted providers. Non-contracted providers must include a signed Waiver of Liability form holding the member harmless regardless of the outcome of the Appeal.
- Submitted via one of these methods

  Provider Portal

  Mail: Commonwealth Care Alliance

  P.O. Box 1947

  Dayton, OH 45401-1947

  Fax: 857-453-4517

CLAIM DISPUTES

CCA also offers a claim payment dispute process. Additional information pertaining to claim appeals and claim payment disputes can be found in the Provider Manual.

****Note: An appeal or dispute is not a retro-authorization request.****

- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- As a CCA provider, you may submit a dispute or appeal for a member.
- Providers must obtain a member's written consent to appeal an Adverse Benefit Determination on their behalf.
- We may contact you to obtain documentation when a member has filed a request for one of these reviews. CCA does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.
- For additional information, contact Provider Services at 1-866-420-9332.

Claims | **Payment Disputes**

Contracted Providers may file a payment dispute for CCA's reconsideration if they disagree with CCA's decision of denial or reimbursement of a claim.

- Disputes must be submitted via fax, portal or mail. Disputes should be sent to:
  - Mail:

    Commonwealth Care Alliance
    Attn: Appeals Department
    P.O. Box 1947
    Dayton, OH 45401-1947

    Fax: 1-937-531-2398

  - Payment dispute requests will be considered when received within 90 days from the original payment or denial date, as indicated on the EPP, with supporting documentation and the *Request for Claim Review* form.

Contracted providers may file a dispute for CCA's reconsideration if they believe CCA is paying an amount different than contractually agreed upon.

- Please direct correspondence to *CCAContracting@commonwealthcare.org*.

For additional questions on provider Payment Disputes or Appeals, please contact CCA Provider Services at 1-866-420-9332 from 8 a.m. to 5 p.m. ET Monday, Tuesday, Wednesday, and Friday, and from 8:30 a.m. to 5 p.m. ET Thursday.

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Corrected Claims**

- To modify a paid, denied, or rejected claim, providers must submit a corrected claim electronically or on paper.
    - If the correction requires additional information such as an invoice or prescription, the corrected claim can be submitted on paper or in the **new Provider Portal**.
- Corrected claims submissions should include:
    - Original claim number
    - Any necessary modifications from the original claim
    - CMS-1500/HCFA-1500 or UB-04 paper claim with the corrections
    - Any required supporting documentation
- Mailing address for corrected and rejected paper claims: Commonwealth Care Alliance

  P.O. Box 1127
  Dayton, OH 45401-1127

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for more detail.

Claims | **Contact & Billing Support**

Provider Claims, Billing Support, and EDI Support
CCA Provider Services at 1-866-420-9332 Weekdays, excluding Thursday, 8 a.m. to 5 p.m., ET and Thursdays, 8:30 a.m. to 5 p.m., ET
EDI Support by Availity Client Services at 1-800-282-4548 8 a.m. to 8 p.m., Monday to Friday
Availity Essentials Provider Portal To register, click on ”Get Started” in the upper right corner and follow the instructions

Please refer to *CCA's Claims and Billing Procedures* (Section 7 of the Provider Manual) for detail.

Claims | **Key Reminders**

Additional items to remember as of July 1, 2026

Member IDs

Current CCA members will not receive new cards in 2026. Members will have either a 10- or 11-digit ID number, there is no significant difference to the digit count; other than the date they became a CCA member.

Opt Out Medicaid Run Out

Term ended December 31, 2025, run out continues based on timely filing rules.

Deeming

All deeming related processes will remain the same. Eligibility sweeps will be in effect to look for retro-eligibility.

Payment Policies

Payment policies may be changing. All updated policies are located at the CCA website> For Providers> Policies and Guidelines.

CMS Standards

In enforcing CMS claim rules adjustments may be required to ensure accurate and clean claim submission.

Payments outside of claims will be addressed directly with providers.

KEY CCA CONTACTS AND UPDATES

commonwealth care alliance®

Key CCA Contacts

Member Services: 1-866-610-2273 (TTY 711) MemberServices@CommonwealthCare.org

- April 1 to Sept 30: Monday-Friday 8 a.m. to 8 p.m., ET; 8 a.m. to 6 p.m., Saturday and Sunday
- Interpretation services are available

Provider Services: 1-866-420-9332 ProviderServices@CommonwealthCare.org

- Monday, Tuesday, Wednesday, and Friday 8 a.m. to 5 p.m., ET and Thursday 8:30 a.m. to 5 p.m., ET)
- Providers can call with inquiries about covered services, authorization status, service denials, claims, and benefits
- For clinical concerns or to contact the care partner team, select option

Provider Relations: ProviderRelations@CommonwealthCare.org

- Email us with questions and inquiries
- Send us an email to be added to the Provider News

Contracting: CCAContracting@CommonwealthCare.org

- Providers can email with inquires and questions related to their contract

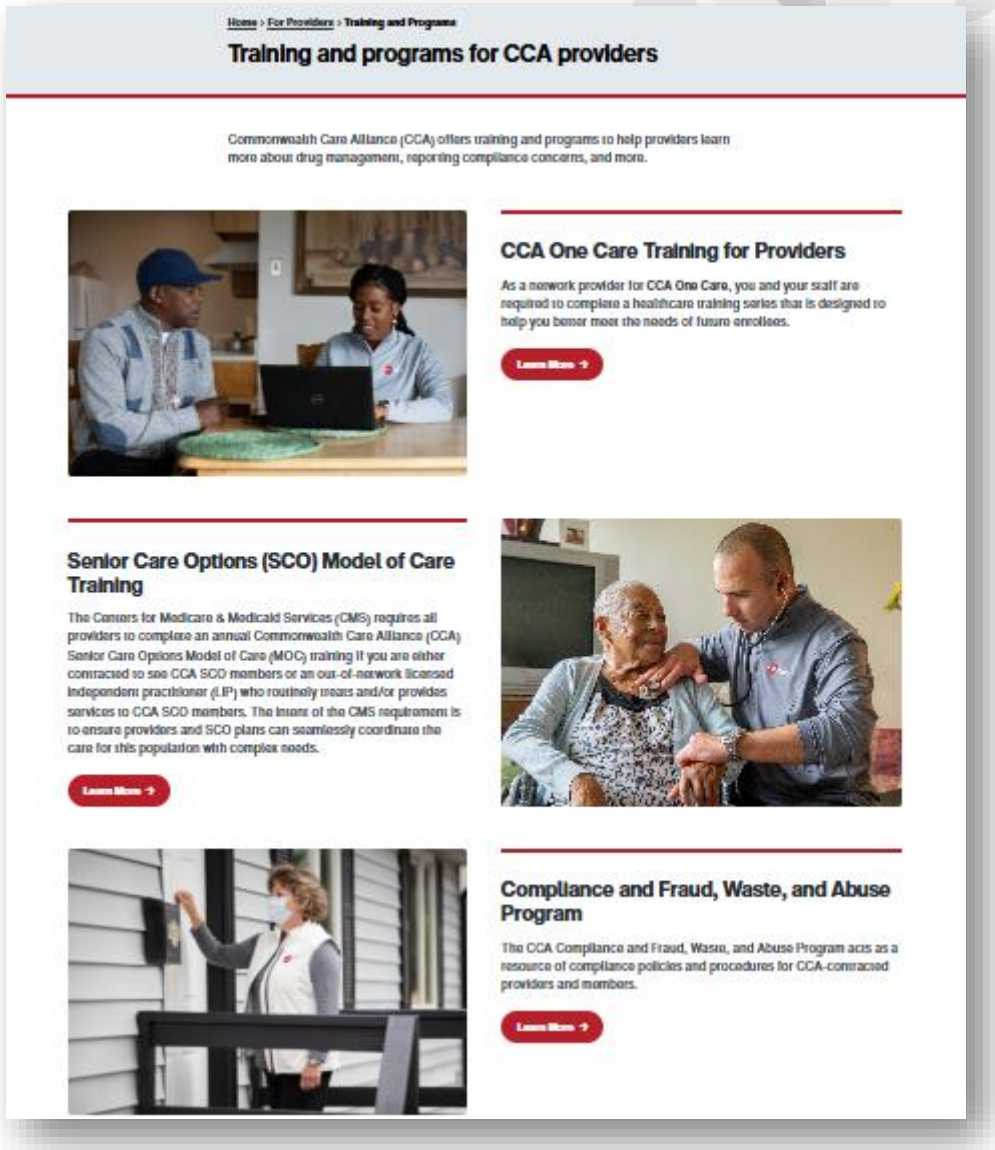
Provider Training

CCA provides several trainings to our contracted providers to support quality of care, safety and compliance.

CCA's required and recommended trainings can be found on our website in the *For Providers* > *Training and Programs* and *Language Services Cultural Support Resources for Providers* sections.

Trainings that require completion include:

- Fraud, Waste, and Abuse
- Compliance
- Cultural Competency
- CCA Senior Care Options and CCA One Care Model Of Care
- CCA One Care Specific Training for Providers Serving on Interdisciplinary Care Teams

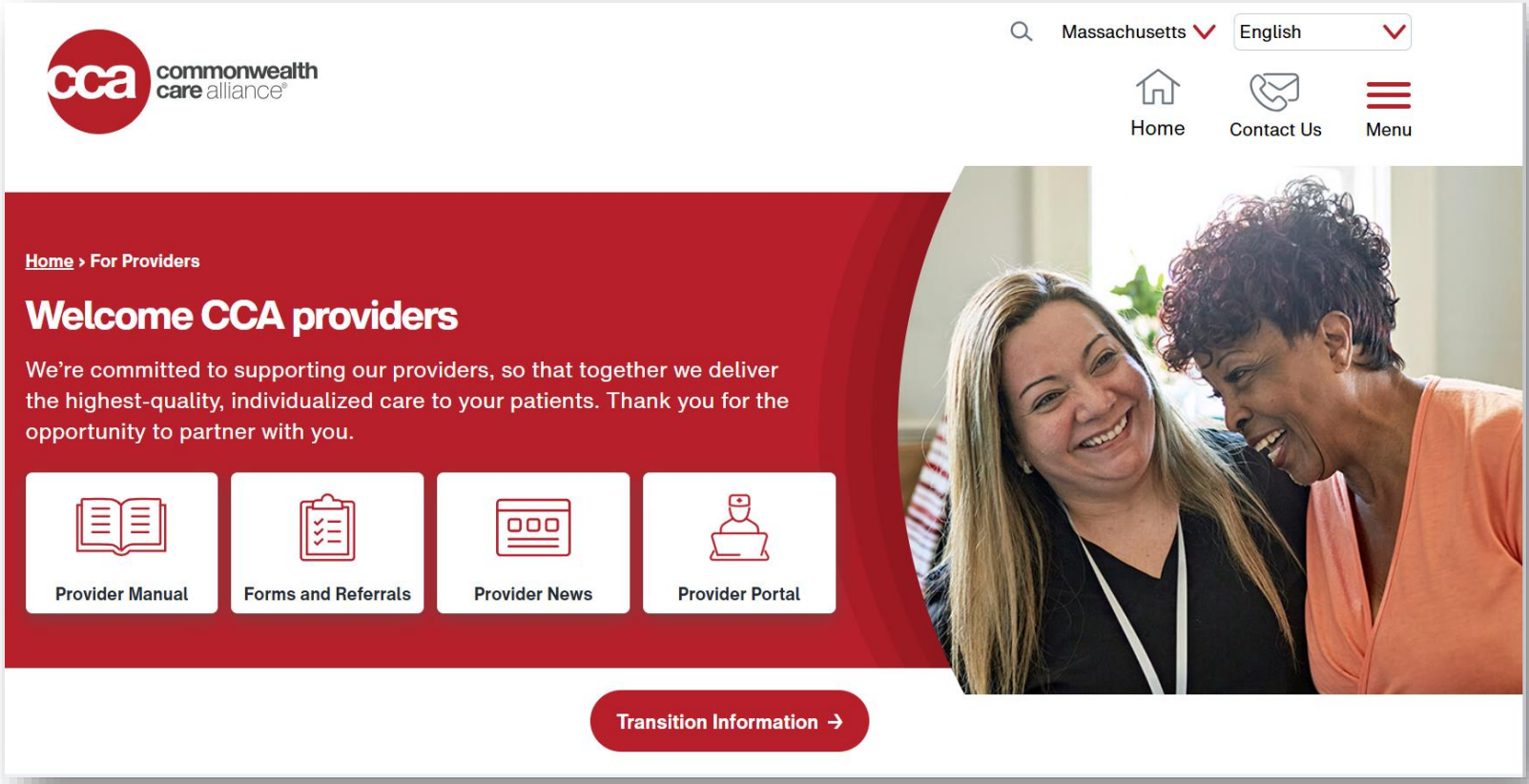


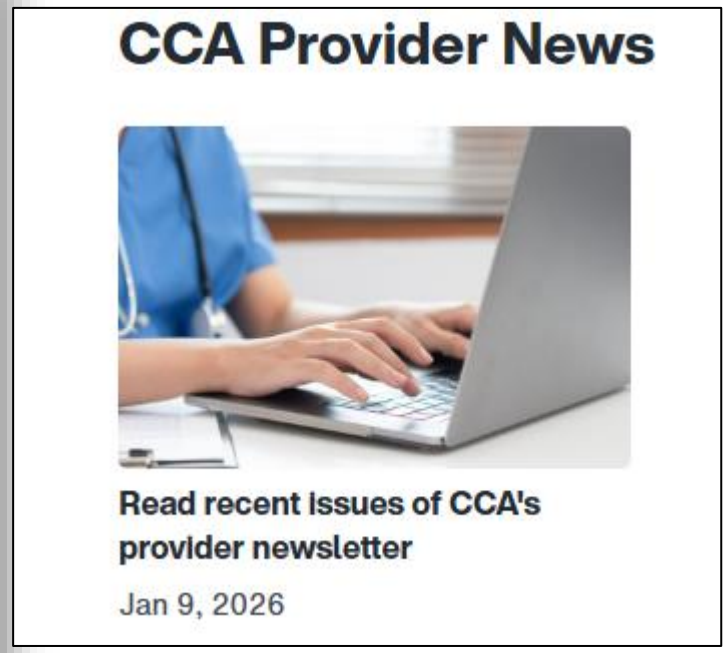
Please refer to *CCA's Provider Training Requirements* (section 18 of the Provider Manual link) for more detail.

Provider News and Updates

CCA communicates with providers through *Provider News* and *Provider Updates* to highlight the unique role our organization, network team and providers play in delivering quality care. We also use these tools to communicate about key policy changes, program updates, operational guidance and time-sensitive announcements that may require action.

View current and archived news and sign up for email distribution preferences at the CCA Provider Homepage.





Thank you!