

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Suite 106-900
Dallas, TX 75202



Drug & Health Plan Operations

February 02, 2026

WARNING LETTER

Contract ID: H3924, H3954

Parent Organization Name: Risant Health, Inc.

Legal Entity: GEISINGER HEALTH PLAN, GEISINGER INDEMNITY INSURANCE COMPANY

Deborah Marine
Medicare Compliance Officer
Geisinger Health Plan
100 North Academy Avenue
Danville, PA 178223220

VIA EMAIL: dlmarine@thehealthplan.com

RE: Failure to Provide Plan Benefits and Adjudicate Claims at Point of Sale

Dear Deborah Marine:

The Centers for Medicare & Medicaid Services (CMS) is issuing this warning letter to [legal entity name], GHP, which operate(s) the Medicare Advantage Prescription Drug Plan (MA-PD) Contracts ID(s) H3924, and H3954 regarding your organization's failure to charge correct cost-sharing, and adjudicate claims at the point of sale in compliance with CMS standards; as well as, the failure to oversee PBM's execution of new year business.

Pursuant to:

- 42 C.F.R. § 423.104(a), Part D sponsors must provide their enrollees with coverage of plan benefits that have been approved by CMS. Part D sponsors must also adjudicate claims in a timely efficient manner by means of a point of service system, including charging correct cost-sharing, pursuant to 42 C.F.R. § 423.505(b)(17).
- 42 C.F.R. § 423.505(b)(17), states the Part D plan sponsor agrees to provide benefits by means of point of service systems to adjudicate in drug claims in a timely and efficient manner in compliance with CMS standards.
- 42 C.F.R. § 423.104(g), says that a Part D sponsor is required to provide its Part D enrollees with access to negotiated prices for covered Part D drugs included in its Part D plan's formulary.
- 42 C.F.R. § 423.505(i)(1), states that Part D sponsors are responsible for the actions of their first tier, downstream, and related entities.

Your organization is out of compliance with Part D requirements because your organization failed to charge the correct cost sharing at POS and did not oversee your PBM's implementation of new year business and therefore did not timely identify the issue.

On July 23, 2024, GHP notified CMS that it discovered inaccurate cost-sharing claims processing at the point of service, (POS.) GHP's Pharmacy team identified the issue on April 11, 2024, when they were evaluating pricing of a new drug to potentially add to the formulary. GHPS found that its PBM, Navitus charged incorrect cost sharing (both overpayments and underpayments) for some medications. GHP determined that there were 22,520 negatively impacted members, details below:

- 18,703 members were overcharged, with a total amount of \$137,936.25.
- 3,419 members were undercharged, and GHP attempted to recoup a total of \$19,321.29.

GHP reported that the maximum refund issued was \$598.32 and maximum amount GHP attempted to recoup was \$2,230.52. To minimize financial impact to pharmacies, and after discussing with CMS, GHP reprocessed claims in smaller batches over several weeks, beginning September 23, 2024, and ending January 31, 2025. All refunds and recoupment requests were issued by February 21, 2025, with the exception of three impacted members who were mailed refunds on March 17, 2025.

GHP reported that the root cause of the inaccurate cost-share claims processing was due to a Navitus automatic system comparison logic error. On May 23, 2024, Navitus manually performed all network updates including a peer review process to verify accuracy and discontinued the automated configuration logic.

To ensure no additional errors were in place, Navitus conducted a full audit of GHP's network data which concluded on June 13, 2024. The review identified two additional inaccurate claim processing issues tied to rates.

The first issue impacted 22 members, details below:

- 14 members were overcharged, resulting in refunds totaling \$50.26
- 8 members were undercharged and GHP attempted to recoup a total of \$16.08

Navitus corrected the carve out rates on June 4, 2024, and all impacted members received either a refund or a letter requesting recoupment by February 21, 2025.

The second issue was specifically related to inaccurate CVS pharmacy network rates. 5,745 members were affected, with \$22,460.84 overpaid and \$11,621.31 underpaid. GHP reported that the maximum refund was \$220.35 and the maximum amount attempted to recoup was \$101.69.

The issue impacted 5,745 members, details below:

- 2,000 members were overcharged which resulted in refunds totaling \$22,460.84
- 3,596 members were undercharged. GHP attempted to recoup \$11,621.31

The audit revealed the root cause of the issues was due to late return by contracting pharmacies of their contracts. Navitus was unable to confirm that it notified GHP that the carve-out rates for the CVS network were not loaded. Navitus updated the rates for CVS on February 2, 2024.

All impacted members received either a refund or a letter requesting recoupment which was completed February 21, 2025.

GHP reported that it has the following internal controls in place to ensure that these issues will not reoccur.

- GHP's pharmacy team conducts weekly, monthly, and quarterly calls with Navitus, and a compliance staff member participates in the weekly calls, where priority items, auditing, process improvements, and upcoming changes are discussed.
- Pre- and post-implementation testing of PBM changes.
- Multiple auditing teams in GHP Pharmacy Operations conduct daily, weekly, and monthly audits of various Part D aspects to ensure we are not solely relying on PBM assurances.

Finally, the PBM relationship is managed with quarterly meetings with the Navitus account team and the Pharmacy Department to review benchmarks, trends, and metrics for Medicare. There are regular meetings with Pharmacy Leadership and Navitus Executive Leadership as well for escalation and transparency.

In January 2025, Navitus began conducting a post-configuration audit for all new network configurations. Navitus now conducts a comprehensive audit of contracted rates on a quarterly basis.

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 our review of any application for new or expanded Medicare contracts your organization may submit. CMS determines this instance of non-compliance a Part D 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.

If you have any questions about this notice, please contact your CMS Account Manager, Toni Duplain at: (214) 767-4433, or toni.duplain2@cms.hhs.gov.

Sincerely,



Verna Hicks, Director
Division of Medicare Plan Management
Medicare Plan Management Group

Toni Duplain, CMS
Arianne Spaccarelli, CMS Baltimore