Policy and Procedure No: MC IT 107.3	**Revision No: 3**
Division: Care Management	
Department: IT Data Management	
Title: PHP Medicare Part C and D Reporting Data Validation Standards	
Effective Date: 1/1/2020	
Supersedes Policy No: 96001, IT 7.0, MC IT 107.0, MC IT 107.1, MC 107.2	
Reviewed/Revised by: Sandra Holzner	**Review/Revision Date: 7/8/2025**
Approving Committee: Compliance Committee	**Date: 12/15/2025**
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To define and enforce standards for the accurate production, validation, and submission of Medicare Part C and Part D reports that are subject to Centers for Medicare & Medicaid Services (CMS) data validation requirements.

Policy:

PHP California (the Health Plan) has core standards outlined in this policy to ensure all CMS submitted reports are complete, accurate, and aligned with applicable regulatory requirements. These standards apply to all CMS-reportable data sets under Medicare Part C and Part D.

Procedure:

Core Standard 1:

Data Fields required for compiling and producing CMS Part C and Part D reports are accurately captured and properly documented through the following methods:

1. Identify and document the authoritative source systems and data fields used to generate each report.

2. Ensure all data extraction programming accurately reflects the intent of the required data elements and CMS specifications.

3. Maintain reproducibility of pulled data, ensuring that all extracted data sets can be secured, retrieved, and validated at any time.

4. Archive all documentation, including data definitions, source logic, and the programming code used in report generation, along with the applicable CMS specifications.

Core Standard 2:

Reporting data elements are accurately identified, processed and calculated through the following procedures:

1. All terms used in reporting will be properly defined pursuant to CMS guidance, regulations and Data Validation Reporting Technical Specifications.

2. The Compliance Officer or their designee collaborates with the assigned IT resource and various subject matter experts, in each applicable operational area to map the required data elements to available data fields for creation of a query that compile each measure for each reporting area.

3. Each Data Validation measure that is generated shall apply the following criteria for each applicable reporting measure:

    a. The appropriate date ranges will be captured according to specified reporting periods.

    b. Data will be assigned to the appropriate CMS contract and benefit package.

    c. Reporting deadlines as set forth by CMS shall be met.

    d. The number of expected counts (e.g., number of members, number of claims, number of grievances, etc.) will be verified which may include all calculations will be verified; any missing data will be properly addressed and/or explained; verification that reporting output matches source documents; reported data elements are version controlled; Quality Assurance checks or thresholds are applied to detect outlier or erroneous data prior to data submission.

Core Standard 3:

All CMS data reports and/or measures are accurately uploaded or entered into HPMS, matching source documentation, as verified by the Compliance Officer, prior to and after upload/entry.

All source, intermediate and final stage data sets relied upon to enter/upload data to HPMS are archived and retained for a minimum of (10) years.

Core Standard 4:

The applicable operational business owner or their designee regularly monitors the timeliness, content and quality of CMS Part C or Part D Reports produced by the Plan's delegated entities.

The Plan's delegated entity data validation reports are reviewed prior to submission by the business owner and the Compliance Department, to HPMS for accuracy and compliance with all pertinent technical specifications. Once the reports are approved and finalized, the operational business owner, Compliance Department, or the assigned IT resource shall upload or enter the data into HPMS.

After data is uploaded to HPMS, the Compliance Department downloads all submitted data from HPMS. The data is sent to the business owner(s) for a secondary quality check to ensure all data is accurate. This is completed prior to resubmission deadlines as set forth by CMS.

Definitions:

1. CMS: Centers for Medicare & Medicaid Services

2. HPMS: Health Plan Management System

Monitoring:

The Compliance Department, utilizing CMS guidance, regulations, and Data Validation Reporting Technical Specifications, will review the application of these standards to CMS Part C and Part D reporting procedures no less than annually with assigned IT resource and subject matter experts.

Reference(s):

1. Medicare Part C and Part D Reporting Requirements Data Validation Procedure Manual.