

AIDS DRUG ASSISTANCE PROGRAM (ADAP) DATA REPORT (ADR) INSTRUCTION MANUAL

Release Date: 07/25/2012

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INTRODUCTION

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87, October 30, 2009) provides the Federal HIV/AIDS programs in the Public Health Service (PHS) Act under Title XXVI flexibility to respond effectively to the changing epidemic. Its emphasis is on providing life-saving and life-extending services for people living with HIV/AIDS across the country and resources to targeted areas with the greatest need.

All Program “Parts” of the Ryan White HIV/AIDS Program (RWHAP) specify the Health Resources and Services Administration’s (HRSA) responsibilities in the allocation and administration of grant funds, as well as the evaluation of programs for the population served, and the improvement of the quality of care. Accurate records of the grantees receiving RWHAP funding, the services provided, and the clients served continue to be critical to the implementation of the legislation and thus are necessary for HRSA to fulfill its responsibilities.

The Ryan White HIV/AIDS Program legislation authorizes a portion of Part B funds to be “earmarked” for the AIDS Drug Assistance Program (ADAP), which primarily provides medications for the treatment of HIV disease. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access, adherence, and monitoring of drug treatments. All 50 States, the District of Columbia and several Territories receive ADAP grants.

The HIV/AIDS Bureau (HAB) currently requires that all ADAPs report aggregate data quarterly using the ADAP Quarterly Report (AQR). However, aggregate data limits HAB’s ability to respond to inquiries from Congress and other stakeholders regarding the ADAP program. To address this limitation, HAB has developed a new data reporting system, the ADAP Data Report (ADR). The ADR will enable HAB to evaluate the impact of the ADAP program on a national level. The ADR will allow HAB to characterize the individuals using the program, describe the ADAP-funded services being used, and delineate the costs associated with these services.

ADAPs will begin collecting data for the ADR in October 2012. However, because the ADR is new, grantees will continue to submit the AQR until they become accustomed to the ADR and the quality of the information provided through the ADR accurately represents the program. At that time, the AQR will be retired.

HAB’s goal is to have a client-level data reporting system that provides data on the characteristics of the ADAPs and the clients served with program funds. The ADAP client-level data submitted will be used to:

- Monitor the clinical outcomes of clients receiving care and treatment through ADAP;
- Monitor the use of ADAP funds for appropriately addressing the HIV/AIDS epidemic in the United States;
- Monitor the support provided by ADAP to the most vulnerable, especially minority communities;
- Address the needs and concerns of Congress and the Department of Health and Human Services (HHS) concerning the HIV/AIDS epidemic and the RWHAP; and
- Monitor the outcomes achieved in response to the National HIV/AIDS Strategy.

NOTE: HAB has taken every measure possible, including the implementation and use of an encrypted Unique Client Identifier, to limit data collection to only that “information reasonably necessary to accomplish the purpose” of the ADAP Data Report.

NOTE: HAB expects all ADAPs to continue submitting AQRs during the transition to client-level reporting. For more information about the AQR, visit <http://hab.hrsa.gov/manageyourgrant/reportingrequirements.html>

About the ADAP Data Report

The AIDS Drug Assistance Program (ADAP) Data Report (ADR) includes two components: the Grantee Report and the Client Report. All ADAPs are required to submit both reports.

The Grantee Report is a collection of basic information about the grantee characteristics and policies. It includes a Programmatic Summary section and an Annual Submission section.

The Client Report (or client-level data) is a collection of one record for each client enrolled in the ADAP. Each record includes the client’s encrypted unique identifier, basic demographic data, and enrollment and certification information. A client’s record may also include data about the ADAP-funded insurance and medication received, including the costs of these services, as well as HIV clinical information.

Who is an ADAP client?

An ADAP client is any individual who is enrolled in the ADAP, i.e., certified as eligible to receive ADAP services, regardless of whether the individual used ADAP services during the reporting period.

During the reporting period, an ADAP client may have:

- Received medications and/or insurance assistance;
- Been placed on the waiting list;
- Been disenrolled; or
- Been eligible, but not received services for clinical or other reasons.

What are the ADAP services?

The ADAP is a State-administered program authorized under Part B of the Ryan White HIV/AIDS Program. Funds are “earmarked” to provide medications for the treatment of HIV disease and for the prevention and treatment of opportunistic infections. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access, adherence, and monitoring of drug treatments. All 50 States, the District of Columbia, and several US Territories receive ADAP grants.

Medication Services

Medication services include the purchase of US Food and Drug Administration (FDA) approved medications for the treatment of HIV disease and the prevention and treatment of opportunistic infections with ADAP funds on behalf of a client.

Insurance Assistance Services

Insurance assistance services include the provision of financial assistance for clients to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, co-payments, and deductibles, as well as Medicare Part D co-insurance, deductibles or donut hole coverage (i.e., True Out Of Pocket – TrOOP expenses).

Services Provided under the ADAP Flexibility Policy

The HAB Policy Notice 07-03 allows grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications.

NOTE: Grantees *must* request approval annually, in writing, to use ADAP funds for services other than medications, insurance assistance, and the flexibility policy.

How is the ADR submitted to HAB?

The ADR is submitted online using HAB’s ADR Web Application. Grantees access the ADR Web Application via the HRSA Electronic Handbooks for Applicants/Grantees (EHBs), a Web-based grants administration system. The EHBs are located at <https://grants.hrsa.gov/webexternal/>.

The ADR Grantee Report is completed by filling out the online forms. After completing the Grantee Report, grantees will upload the Client Report as an XML (eXtensible Mark-up Language) file from within the Grantee Report. For additional information, see the “Submitting Client-Level Data to HAB” section on page 12 of this manual.

Who submits the ADR?

The submission of the ADR is a condition of the Part B grant award. Each grantee of record must complete both components of the ADR. The grantee of record (also referred to as the “grantee”) is the agency that receives ADAP funding directly from HRSA.

What are the reporting periods?

The two reporting periods for the ADR are April 1 – September 30 and October 1 – March 31, representing the first and second halves of the ADAP fiscal year. The ADR reports covering the first half is due in December. The ADR reports covering the second half is due in June. The Annual Submission section of the Grantee Report is provided only once each year, and is due in June.

What are the ADR due dates?

The ADR is submitted twice each year. The ADR Grantee Report Programmatic Summary and Annual Submission are due in June, along with the client-level data file. The second Programmatic Summary Submission and the second client-level data file are due in December (See Figure 1).

Figure 1. ADR Due Dates

Due Date	What's Due	Period Covered in the Report
3 rd Monday in June	Programmatic Summary Submission (Grantee Report)	October 1 – March 31
	Annual Submission (Grantee Report)	April 1 – March 31
	Client-level Data File (Client Report)	October 1 – March 31
3 rd Monday in December	Programmatic Summary Submission (Grantee Report)	April 1 – September 30
	Client-level Data File (Client Report)	April 1 – September 30

A list of key reporting dates is available on the HAB Web site at:

<http://hab.hrsa.gov/manageyourgrant/adr.html>.

Please make sure to visit the Web site at the beginning of each report submission period to obtain up-to-date information regarding the reporting deadlines.

THE GRANTEE REPORT

Each ADAP completes the Grantee Report.

Grantee Contact Information

1. Grantee name (display only): The grantee name must match the organization name on the Notice of Grant Award (NoA). There should be no abbreviations or acronyms unless they are also used in the NoA.
2. Grant number (display only): This is the grant number displayed on your NoA.
3. ADAP number (display only): This is a four-digit State ADAP number assigned by HAB. If you do not know the ADAP number for your program, contact your HRSA Project Officer.
4. DUNS number (display only): This number, assigned by Dun & Bradstreet, indicates the grantee's credit worthiness.
5. Grantee address (display only): This address should match the mailing address of the grantee of record. There should be no abbreviations or acronyms unless they are also used in the NoA.

NOTE: These items show the information on the grantee of record that is stored in the Electronic Handbooks(EHBs). To edit it, you must update your agency information stored there.

6. Reporting period: (display only): This will show the reporting period for which you will be submitting data.

Once you've updated, entered, and/or verified the data on the Grantee Contact Information page, click on "Next" to save the data and advance to the next page, "Programmatic Summary Submission."

NOTE: Navigation buttons appear at the bottom of each page of the online forms within the ADR Web Application. Use the "Next" and "Previous" buttons to save any edits you have made in one or more fields and navigate through the report. The "Save" button will save your edits without changing the page.

Programmatic Summary Submission

This section, consisting of Sub-Sections A through D, should be completed for each six-month reporting period.

A. Program Administration

1. **ADAP Limits:** Indicate whether your program has adopted any of the following limits in order to control costs. You may check as many boxes as applicable (see Figure 2):
 - a. *Waiting list*—A list of clients who have been certified as eligible and have been enrolled to receive ADAP services, but are not receiving ADAP services due to caps on service enrollment or other cost-containment strategies. There may be several reasons why clients are not receiving services, such as limited funding and the number of clients already being served. Clients who have not asked for services are not included in the waiting list.
 - b. *Enrollment cap*—A limit on the maximum number of people who can be enrolled in your program and receive services at any given time.

If your ADAP has an enrollment cap, enter the maximum number of enrollees.
 - c. *Capped expenditure*—A limit on the maximum amount of dollars that can be spent per client.

If your ADAP has capped expenditures, enter the monetary cap per client.
 - d. *Drug-specific enrollment caps for ARVs or Hepatitis C medications*—A limit on the maximum number of clients who can receive a specific medication at any given time.

If your ADAP has adopted drug-specific enrollment caps, indicate the ARV and Hepatitis C medications for which you have enrollment caps and the maximum number of enrollees.

NOTE: If you select “Enrollment cap,” “Capped expenditure,” or “Drug-specific enrollment caps,” you must enter the maximum limit for that option.

**Figure 3. ADR Grantee Report Online Form:
Screenshot of the “Program Summary: Program Administration” Section**

Section 1 - Program Summary (continued)

Section 1 (Items 1–7) should be completed for each six month period. Please review the Instructions for Completing the ADAP Grantee Report to ensure that you respond to each item appropriately.

A. PROGRAM ADMINISTRATION

2. Indicate which of the following developments or changes occurred in your program during this reporting period:
Check all that apply:

Project budget deficit

Change in income eligibility criteria, please specify:

Change in medical eligibility criteria, please specify:

Added medications to the formulary

Deleted medications from the formulary

3. Please indicate the maximum ADAP eligibility requirements as a percentage of Federal Poverty Level (FPL):

4. Please indicate which of the following activities your ADAP uses to coordinate with Medicaid or a State-only Pharmacy Assistance Program:
Check all that apply:

Online interface

Dual application

Coordinated benefits

Retroactive billing

We have no coordination with Medicaid or State-only ADAP

Other, please specify:

Previous
Save
Next

4. **State ADAP coordination with Medicaid and State-only Pharmacy Assistance Programs:** Indicate which methods your ADAP uses to coordinate with Medicaid (see Figure 3). If you use “Other” methods, specify the method. See the Glossary for definitions of methods.

B. Funding

5. **ADAP funding received during the reporting period:** Enter the amount of funding your program received from the sources listed during the reporting period. Report funding *received*, not awarded. Enter “0” if your ADAP did not receive funding from any given source during the period. Do not leave any boxes blank.

C. Expenditures

6. **Expenditures:** Enter the total expenditures for pharmaceuticals, dispensing and other administrative costs, insurance coverage, and the flexibility policy (for adherence, access, and monitoring services) for the reporting period. Administrative costs include items such as shipping and handling and other bulk order fees. The total expenditures for the reporting period will be calculated automatically.

D. ADAP Medication Formulary

7. **ADAP Medication Formulary:** From the list of (a) ARVs, (b) A1-OI's, (c) Hepatitis B, and (d) Hepatitis C treatment medications provided, check the box in Column 1 if your ADAP currently includes the medication in the formulary. Columns 2 and 3 list the generic and brand names of the medication. These columns can also be sorted to easily locate medications on your formulary. For ARVs, column 5 should be checked if the ARV was added to the formulary during the reporting period. The date that the ARV was added should then be entered into column 6.

Annual Submission

This section is completed once each year for the previous 12-month period and is submitted with the first semi-annual report of the fiscal year.

A. Program Administration

8. **Frequency of client re-certification:** Indicate whether your ADAP requires clients to be recertified as eligible to participate in ADAP on a "Semiannual," or "Other" basis. If you select "Other," indicate how often recertification is required.
9. **Clinical criteria required to access ADAP:** Check all of the clinical eligibility criteria for enrolling in the ADAP in your State or Territory. For CD4 count or viral load (VL) medical criteria, indicate the threshold number in the space provided. For "Other" medical criteria, indicate each criterion used and the corresponding threshold number.

10. **Drug pricing cost-saving strategies:** Check all items that apply to your drug pricing program (see Figure 4). If the ADAP uses another cost-saving strategy, check “Other drug discount program (not 340B)” and specify the strategy used in the space provided. Definitions of cost-saving strategies can be found in the Glossary.

**Figure 4. ADR Grantee Report Online Form:
Screenshot of the “Annual Submission: Cost Saving Strategies”
and “Annual Submission: Sources of ADAP Funding” Sections**

Section 2 - Annual Submission (continued)

Section 2 (Items 8–11) should be completed only once each year for the previous 12-month period.

B. COST SAVING STRATEGIES

10. Please check all that apply to your Drug Pricing Program:
Check all that apply:

340B Rebate

Direct purchase

Prime vendor

Alternate Method Demonstration Project

Other drug discount program (not 340B), please specify:

C. SOURCES AND AMOUNTS OF ADAP FUNDING – THIS WILL BE PREPOPULATED BY HAB AND IS FOR REVIEW PURPOSES ONLY.

11. ADAP funding received for this fiscal year from each of the following Ryan White HIV/AIDS program sources:

Funding Source	Amount Received (to nearest dollar)
a. ADAP earmark	<input style="width: 100%;" type="text"/>
b. ADAP Supplemental Drug Treatment Grant Award	<input style="width: 100%;" type="text"/>
c. State Match for Supplemental Drug Treatment Award	<input style="width: 100%;" type="text"/>
ADAP resources received (total of a through c)	<input style="width: 100%;" type="text"/>

11. **ADAP funding** (display only): The funding awarded by HAB to your program under the sources listed for the **previous fiscal year**. This field is already pre-populated from the funding information maintained by HAB on each ADAP (see Figure 4).

Click on “Save” to save the data in the Grantee Report.

After confirming that the data in the Grantee Report are correct, upload your client-level data. The Grantee Report cannot be submitted until the Client Report is uploaded into the ADR Web Application. The Client Report is a collection of ADAP client records that must be submitted in one or more properly formatted client-level data XML files. To learn how to upload the client-level data XML file, see the section “Importing the XML Client File” on page 21.

After completing the ADR Grantee Report and uploading the client-level data, you must validate your report. To validate your report, click “Validate Report” in the ADR Administration menu.

If the validation report contains **errors**, resolve them by revising the data as required. You cannot submit your ADR with errors. Errors in the ADR Grantee Report may be fixed manually using the online form. Errors in the client-level data must be fixed in your local data collection systems. Once you find and fix the client data in your local system, you must re-generate and upload a new client-level data XML file into the ADR.

If your validation report contains **warnings**, you should first try to fix as many of the warnings as possible. Before submitting the report you must add a comment to any warnings that you are unable to fix. If your validation report contains **alerts**, make a note of these data items. You are not required to fix alerts or provide a comment before submitting the report. HAB suggests that you review these because alerts may become warnings or errors in future reporting periods.

When your report is complete, submit the Grantee and Client Reports by clicking on “Submit Report” in the ADR Administration menu and following the instructions on your screen.

THE CLIENT REPORT

Reporting Client-Level Data

The Client Report should contain one record (“row” of data in a database) for each client who was enrolled in the ADAP during the reporting period. An enrolled client is an individual who is certified as eligible to receive services, whether or not the individual actually received ADAP services during the reporting period. See “Appendix A: Required Client-Level Data Elements” to determine the client-level data elements required to be reported for an enrolled client.

Submitting Client-Level Data to HAB

The Client Report (i.e., client-level data set) must be uploaded as an XML file. To learn how to upload the client-level data XML file, see the section “Importing the XML Client File” on page 21. XML is a standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across different computer platforms, languages, and applications.

Grantees need to extract the client-level data elements from their systems into the proper XML format before they can be uploaded to the HAB server. If your ADAP uses CAREWare, no special action will be required to generate the XML file. CAREWare is able to export the data in the required XML format.

If you do not use CAREWare, you will need to write a program that extracts the data from your system and inserts it into an XML file that conforms to the rules of the ADR XML schema. The schema is available on the HAB Web site at <http://hab.hrsa.gov/manageyourgrant/adr.html>.

NOTE: Technical support is available to grantees through the HAB Web site.

Client-Level Data Fields

This section outlines the data fields that will be submitted in the client-level data XML file.

System Variables

The XML file will contain three system fields: reporting period, encrypted Unique Client Identifier (eUCI), and ADAP number.

1. Reporting Period

- 1 = 10/01/2012 – 03/31/2013
- 2 = 04/01/2013 – 09/30/2013
- 3 = 10/01/2013 – 03/31/2014
- 4 = 04/01/2014 – 09/30/2014

2. Encrypted Unique Client Identifier (eUCI)

To protect client information, an encrypted Unique Client Identifier (eUCI) is used for reporting Ryan White client data.

The Unique Client Identifier (UCI) is a unique 11-character alphanumeric code that is the same for the client across all provider settings. The UCI is derived from the first and third characters of a client's first and last name, his or her date of birth (MM/DD/YY), and a code for gender (1=male, 2=female, 3=transgender, 9=unknown). SHA-1, a one-way hashing algorithm that meets the highest privacy and security standards, is used to encrypt the client's UCI resulting in a 40-character alphanumeric code, the encrypted Unique Client Identifier.

It is possible that different clients have identical 40-digit eUCIs. Therefore, each ADAP must add a 41st character at the end of the eUCI to distinguish these clients. If only one client within the ADAP data system has a given UCI, the suffix should be "U" for unique. If more than one client has the same UCI, the final character of the first client's eUCI needs to be "A," the final character of the second client's eUCI needs to be "B," and so on. The suffix prevents multiple clients from having the same eUCI.

The UCI is encrypted with SHA-1 at the provider site BEFORE the data are submitted to HAB. SHA-1 is a trap door algorithm, meaning that the original UCI is unrecoverable from the eUCI. The resulting alphanumeric code, the eUCI, is used to distinguish one Ryan White client from all others in a region.

NOTE: To learn more about the eUCI, view the resources available on the TARGET Center Web site at <http://careacttarget.org/adr.asp>.

Guidelines for Collecting and Recording Client Names

Grantees should develop business rules/operating procedures outlining the method by which client names should be collected and recorded. For example:

- Enter the client's entire name as it normally appears on documentation such as a driver's license, birth certificate, passport, or social security card.
- Follow the naming patterns, practices, and customs of the local community or region (i.e., for Hispanic clients living in Puerto Rico, record both surnames in the appropriate order).
- Avoid the use of nicknames (i.e., do not use Becca if the client's full name is Rebecca).
- Avoid using initials.

Grantees should instruct their staff on the correct entry of client names. Client names must be entered in the same way every time in order to avoid false duplicates.

3. ADAP Number

The ADAP number is the unique 4-digit organization number that HAB has historically assigned to each State ADAP.

Client Demographics

The purpose of the Client Demographics section is to describe the socio-demographic characteristics of all clients enrolled in the ADAP, regardless of whether they received services.

Reporting Client Race and Ethnicity

Office of Management and Budget (OMB) Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity provides a minimum standard for maintaining, collecting, and presenting data

on race and ethnicity for all Federal reporting purposes. The standards were developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies.

The standards have five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. There are two categories for data on ethnicity: “Hispanic or Latino” and “Not Hispanic or Latino.” The racial category descriptions, defined in October 1997, are required for all Federal reporting, as mandated by the OMB. For more information, go to: <http://www.whitehouse.gov/omb/fedreg/1997standards.html>

HAB is required to use the OMB reporting standard for race and ethnicity. However, all ADAPs should feel free to collect race and ethnicity data in greater detail. If the agency chooses to use a more detailed collection system, the data collected should be organized so that any new categories can be aggregated into the standard OMB breakdown.

NOTE: All Ryan White HIV/AIDS Program grantees are expected to make every effort to obtain and report race and ethnicity based on each client’s self-report. Self-identification is the preferred means of obtaining this information. Grantees should not establish criteria or qualifications to use to determine a particular individual's racial or ethnic classification, nor specify how someone should classify himself or herself.

4. Ethnicity

Indicate the client’s ethnicity based on his or her self-report.

- *Hispanic/Latino(a)*—A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish origin” can be synonymous with “Hispanic or Latino.”
- *Non-Hispanic*—A person who does not identify his or her ethnicity as “Hispanic or Latino.”
- *Unknown* indicates the client’s ethnicity is unknown or was not reported.

5. Race (Select one or more)

Indicate the client’s race based on his or her self-report.

- *American Indian or Alaska Native*—A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- *Asian*—A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- *Black or African American*—A person having origins in any of the black racial groups of Africa.
- *Native Hawaiian or Other Pacific Islander*—A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- *White*—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- *Unknown*—Indicates the client’s racial category is unknown or was not reported.

NOTE: Multiracial clients should select all categories that apply. Select *Unknown* only if no other options are selected.

6. Current Gender

Indicate the client's current gender (the socially and psychologically constructed, understood, and interpreted set of characteristics that describe the current sexual identity of an individual) based on his or her self-report. Gender cannot be missing; one of the options below must be reported for current gender.

- *Male*—An individual with strong and persistent identification with the male sex.
- *Female*—An individual with strong and persistent identification with the female sex.
- *Transgender*—An individual whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes the term is used as an umbrella term encompassing transsexuals, transvestites, cross-dressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be male or female.
- *Unknown*—Indicates the client's gender category is unknown or was not reported.

7. Transgender

If the client is reported as "Transgender" in Item 6, indicate the following:

- Male-to-Female
- Female-to-Male
- Unknown

8. Pregnancy Status

For HIV+ women only: Indicate whether the client was pregnant at any time during the reporting period.

- No
- Yes
- Not applicable
- Unknown

9. Year of Birth

Indicate the client's birth year in the form YYYY. This data element is required.

NOTE: Even though only the year of birth will be reported to HAB, ADAPs should collect the client's full date of birth. The client's birth month, day, and year are used to generate the UCI.

10. HIV/AIDS Status

Indicate the HIV/AIDS status of the client at the end of the reporting period.

- *HIV-positive, not AIDS*—Client has been diagnosed with HIV but has not been diagnosed with AIDS.
- *HIV-positive, AIDS status unknown*—Client has been diagnosed with HIV. It is not known whether the client has been diagnosed with AIDS.

- *CDC-defined AIDS*—Client is an HIV-infected individual who meets the CDC AIDS case definition for an adult or child. For additional information, see: http://www.cdc.gov/nchs/ahcd/ahcd_database.htm.
- *Unknown*—A client whose HIV/AIDS status is unknown or was not reported.

NOTE: Once a client has been diagnosed with AIDS, he or she is always counted in the CDC-defined AIDS category regardless of changes in CD4 counts.

11. Poverty Level

Report the client’s annual household income as a percent of the Federal poverty measure at the end of the reporting period. See Appendix B: Calculating Client Income Percentage of the Federal Poverty Measure Using HHS Federal Poverty Guidelines.

- Equal to or below the FPL
- 101–200% of the FPL
- 201–300% of the FPL
- 301–400% of the FPL
- 401–500% of the FPL
- More than 500% of the FPL
- Unknown/unreported

If your organization collects this information early in the reporting period, it is not necessary to collect it again at the end of the reporting period. Report the latest information on file for each client.

NOTE: There are two slightly different versions of the *Federal poverty measure*—the poverty thresholds (updated annually by the U.S. Bureau of the Census) and the poverty guidelines (updated annually by the HHS.) If your agency already uses one of these measures, use that to report this data item. Otherwise, HAB recommends and prefers that your organization use the HHS poverty guidelines to collect and report it. For more information on poverty measures and to see the 2012 HHS Poverty Guidelines, go to <http://aspe.hhs.gov/poverty/12poverty.shtml>.

12. High Risk Insurance

Indicate whether the client was in a High Risk Insurance Pool, including a Pre-existing Condition Insurance Plan (PCIP), at any time during the reporting period. A High Risk Insurance Pool is a State or Federal health insurance program that provides coverage for individuals who are denied coverage due to a preexisting condition or who have health conditions that would normally prevent them from purchasing insurance coverage in the private market.

- No
- Yes
- Unknown

13. Health Insurance

Report all sources of health insurance the client had for any part of the reporting period. If the client did not have any health insurance of any kind throughout the entire reporting period, report “No insurance.” For individuals enrolled in a high-risk insurance pool or PCIP, insurance should be reported based on who pays the premium for the insurance. For example, if the client pays the

premiums for their insurance, select “private.” If the Federal or State government pays, select “other public (Select one or more).

- *Medicare Part A/B* is a public health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Part A (hospital insurance) covers inpatient care in hospitals and hospice and home health care. Part B (medical insurance) covers medically necessary services and supplies provided by Medicare such as outpatient care, doctor's services, physical or occupational therapists, and additional home health care.
- *Medicare Part D* is a stand-alone prescription drug coverage insurance.
- *Medicaid* is a jointly funded, Federal-State health insurance program for certain low-income and needy people.
- *Private* means health insurance plans such as BlueCross/BlueShield, Kaiser Permanente, and Aetna.
- *Other public* means other Federal, State, and/or local government programs providing a broad set of benefits for eligible individuals. Examples include State-funded insurance plans, military health care (TRICARE), State Children’s Insurance Program (SCHIP), Indian Health Services, and Veterans Health Administration.
- *No insurance* means the client did not have insurance to cover the cost of services at any time during the reporting period, the client self-pays, or services are covered by ADAP or other RWHAP funds.
- *Other* means client has an insurance type other than those listed above.

NOTE: If the No Insurance option is reported, no additional options may be reported. Grantees may report the Medicare Part A/B, Medicare Part D, Medicaid, Private, and/or Other public insurance options; OR the *No Insurance* option.

Enrollment and Certification

The purpose of the Enrollment and Certification section is to describe client enrollment patterns and certification processes. Report the applicable data elements in this section for all clients that were enrolled in the ADAP during the report period, whether or not they received services.

14. Was the client a new or existing client?

Report whether the client was new or existing as of the beginning of the reporting period, even if the client was disenrolled at the end of the period.

Newly enrolled client refers to individuals who meet all of the following criteria:

- Applied to your state ADAP for the first time ever;
- Met the financial and medical eligibility criteria of the ADAP during the period for which you are reporting data

Examples of clients who should **NOT** be included in this number are the following:

- Clients who have been recertified as eligible or clients who have been re-enrolled after a period of having been decertified/disenrolled;
- Clients who have moved out of the State and then returned; and
- Clients who move on and off ADAP because of fluctuations in eligibility for a Medicaid/Medically Needy program, based on whether they met spend-down requirements.

Existing client refers to individuals who meet the following criteria:

- Enrolled in your ADAP in a previous reporting period; or
- Continue to be enrolled in the current reporting period, regardless of whether they ever used ADAP services.

NOTE:An individual enrolled in ADAP (new or existing client) may or may not use services. Use of services is not required to be an enrolled client.

If the client is an existing client, skip to Item 17.

15. Date Completed Application Received

For all newly enrolled clients, report the date that the completed application was received by the ADAP program. Indicate this date in the form MM/DD/YYYY.

16. Date Application Approved

For all newly enrolled clients, report the date that the client was first approved to begin receiving ADAP services. This is when the client was first enrolled in the ADAP program. Indicate this date in the form MM/DD/YYYY.

17. Date of Recertification

Report the date that the client was determined to be eligible to continue to receive ADAP services. Indicate this date in the form MM/DD/YYYY. Clients newly enrolled during the reporting period are not required to be recertified during the same reporting period. Use this as the date of certification for clients who are re-enrolled.

NOTE: All individuals enrolled in ADAP, regardless of whether or not they receive services, must be recertified every six months. This includes clients on a waiting list. The minimum activities for recertification according to the Part B Program Monitoring Standards include documentation of HIV-status, residency, medical necessity for HIV-related medications, and low-income status. For more information on recertification and to see the Part B Program Monitoring Standards, go to <http://www.hab.hrsa.gov/manageyourgrant/granteebasics.html>.

18. Enrollment Status

Indicate the enrollment status of the client as of the end of the reporting period.

- The client is enrolled in ADAP but did not need/request any services
- The client is enrolled in ADAP but is on a waiting list

- The client is enrolled in ADAP and received ADAP-funded medications or insurance services during the reporting period
- The client was disenrolled from ADAP

If the client is currently enrolled, skip to Item 20.

19. Reason(s) for Disenrollment

Indicate all reasons for disenrollment/discharge. If the reason is unknown, please report under “Other/unknown.”

- Ineligible due to change in ADAP program Federal Poverty Level requirements
- Ineligible for ADAP, and is now eligible for Medicaid
- Ineligible for other reason
- Did not recertify
- Did not fill prescription
- Deceased
- Dropped out, no reason given
- Other/unknown

ADAP Insurance Services

The purpose of the ADAP Insurance Services section is to describe ADAP-funded insurance assistance services and expenditures. ADAP-funded insurance assistance includes premiums, co-pays and deductibles. Co-pays and deductibles for medications should also be reported in this section.

Report the ADAP-funded insurance services your clients received during the reporting period based on when the premiums, deductibles, co-pays, etc. were paid, **not according to the coverage period**. Definitions for these services can be found in the “What are the ADAP Services?” section on page 2 of this instruction manual.

20. Receipt of Insurance Services

Indicate whether the client received ADAP-funded insurance assistance during the reporting period including premiums, deductibles or donut hole coverage (i.e., True-Out-Of-Pocket (TrOOP) expenses) paid on behalf of the client.

If the response is “No,” skip to Item 25.

21. Amount Paid for Premiums

Indicate the total amount of insurance premiums (excluding premiums paid for Medicare Part D) paid on behalf of the client during the reporting period. This includes any premium paid during the reporting period, regardless of the time frame that the premium covers (i.e., if the time frame covered extends outside the reporting period).

22. Months Coverage of Premiums Paid

Indicate the total number of months of coverage for which the insurance premium in Item 20 was paid. Include all months, even if they fall outside of the reporting period.

23. Amount Paid for Co-pays and Deductibles

Indicate the total amount of insurance deductibles and co-pays paid on behalf of the client (excluding Medicare Part D deductibles and co-pays) during the reporting period. This includes any deductibles and co-pays paid during the reporting period, regardless of when the services were delivered.

24. Amount Paid for Medicare Part D

Indicate the total amount of Medicare Part D co-insurance premiums, deductibles or donut hole coverage (i.e., True-Out-Of-Pocket (TrOOP) expenses) paid on behalf of the client during the reporting period. The amount reported should be based on the date that the co-insurance, deductibles or donut hole coverage amount was paid.

Drugs and Drug Expenditures

The purpose of the Drugs and Drug Expenditures section is to describe the ADAP-funded medications (ARV, Hepatitis B, and Hepatitis C medications) dispensed to clients during the reporting period and the total expenditures for those services. This section is only for clients who were dispensed ADAP-funded medications that were **paid for in full by ADAP** (i.e., not clients for whom only the medication co-pay or deductible was paid, or clients whose medications were paid for through ADAP-funded insurance).

25. Receipt of Medication Services

Indicate whether ADAP-funded medications were dispensed to this client during this reporting period. ADAP-funded medications are ARVs, Hepatitis B or Hepatitis C medications included in your ADAP formulary that were paid for in full with ADAP funds.

If the response is “No,” this is the end of this client’s record.

26. Medication(s) Dispensed

Report each ADAP-funded medication dispensed to the client during the reporting period. Use the five-digit drug code (d-xxxxx) of the medication. Drug codes are unique 5-digit codes assigned by the MULTUM Lexicon drug database. To get a D-code to NDC crosswalk, go to <https://performance.hrsa.gov/HAB/ADRFiles/>

27. Start Date for Medication

Indicate the start date for each ADAP-funded medication listed in Item 26. Indicate this date in the form MM/DD/YYYY. The start date is the same as the date the medication was dispensed.

28. Day(s) Supply of Medication

Indicate the number of days for which each medication listed in Item 26 was dispensed to the client during the reporting period. Report the number of days in 30-day increments (i.e. 30, 60, 90, etc.) Anything less than 30 days should be reported as the actual number of days supplied (e. g. 14 days).

29. Amount Paid for Medication

Indicate the total cost of each ADAP-funded medication listed in Item 26 that was dispensed to the client during the reporting period. Include the total costs paid during the reporting period, even if the medication prescription period extended beyond the reporting period.

30. Payment of Separate Dispensing Fees

Indicate whether medication dispensing fees were paid separately from other fees, such as administrative fees.

31. Amount Paid for Separate Dispensing Fees

If the response to Item 30 is “Yes,” indicate the total costs for all dispensing fees for medications paid on behalf of the client during the reporting period. Include all dispensing fees paid during the reporting period, even if the medication prescription period(s) extended beyond the reporting period.

Clinical Information

The purpose of the Clinical Information section is to describe the clinical characteristics of ADAP clients who received ADAP-funded medications. Clinical information is required to be reported for each client who was dispensed ADAP-funded medications (as reported in Item 25) during the reporting period. Clinical information must come from labs, other clinical sources or from the State Surveillance Program, not from client self-report.

32. CD4 Count Date

Report the date of the most recent CD4 count test administered to the client during the 12 months prior to the end of the data collection period. The date must be in the form MM/DD/YYYY. The CD4 cell count measures the number of T-helper lymphocytes per cubic millimeter of blood. It is a good predictor of immunity. As CD4 cell count declines, the risk of developing opportunistic infections increases. The test date is the date the client’s blood sample is taken.

33. CD4 Count Value

Indicate the value of the most recent CD4 count test for the client during this reporting period.

34. Viral Load Date

Report the date of the most recent viral load test administered to the client during the 12 months prior to the end of the data collection period. The date must be in the form MM/DD/YYYY. Viral load is the quantity of HIV RNA in the blood and is a predictor of disease progression. Test results are expressed as the number of copies per milliliter of blood plasma. The test date is the date the client’s blood sample is taken.

35. Viral Load Value

Indicate the value of the most recent viral load test for the client during this reporting period. If a test result is undetectable, report the result in accordance with the guidelines provided in the Data Dictionary. The Data Dictionary can be found on the HAB Web site at <http://hab.hrsa.gov/manageyourgrant/adr.html>.

Importing the XML Client File

To upload a client-level data XML file, open your ADR Grantee Report. From within the ADR Grantee Report, click the “Import Clients” link in the ADR Administration menu (near the upper left-hand corner of the Grantee Report Web pages). This will open another window. Then, follow the on-screen instructions.

NOTE: Grantees may upload more than one client-level data file to “build” the Client Report. Before uploading multiple client-level data XML files, grantees should understand the ADR Web Application’s data merge rules. To learn more about the ADR Web Application merge rules, see the article *Understanding Client-Level XML Import Rules for Merging Records* at http://www.careacttarget.org/library/RSR_In_Focus_Rules_for_Merging_3.pdf.

Grantees should generate and review a Client-level Data Upload Confirmation Report (Upload Confirmation Report) before they submit their ADR, including their client-level data. The Upload Confirmation Report is available for users only after they have uploaded their client-level data into the ADR Web application. The Upload Confirmation Report is an aggregate report that can be used to verify that the counts and totals reported in your Client Report match data stored in your source system(s), i.e., the correct number of clients, services, medications, and expenditures are being reported. To run this report, select the “Upload Confirmation Report” link in the ADR Administration menu on the left hand side of the Grantee Report Web pages. The Upload Confirmation Report will open in a separate window.

APPENDIX A: REQUIRED CLIENT-LEVEL DATA ELEMENTS

Field #	Client-Level Data Elements	Type of Client, by Services Received		
		All Enrolled Clients	Insurance Services	Medication Services
System Variables				
1	Reporting Period	●		
2	Encrypted UCI	●		
3	ADAP Number	●		
Client Demographics				
4	Ethnicity	●		
5	Race	●		
6	Gender	●		
7	Transgender	●		
8	Pregnancy Status	●		
9	Year of Birth	●		
10	HIV/AIDS Status	●		
11	Poverty Level	●		
12	High Risk Insurance	●		
13	Health Insurance	●		
Enrollment and Certification				
14	New or Existing Client	●		
15	Date Completed Application Received (new only)	●		
16	Date Application Approved (new only)	●		
17	Date of Recertification	●		
18	Enrollment Status	●		
19	Reason(s) for Disenrollment	●		
ADAP Insurance Services				
20	Receipt of Insurance Services	●		
21	Amount Paid for Premiums		●	
22	Months Coverage of Premiums Paid		●	
23	Amount Paid for Co-pays and Deductibles		●	
24	Amount Paid for Medicare Part D		●	
Drugs and Drug Expenditures				
25	Receipt of Medication Services	●		
26	Medications Dispensed			●
27	Start Date for Medication			●
28	Days Supply of Medication			●
29	Amount Paid for Medication			●
30	Payment of Separate Dispensing Fees			●
31	Amount Paid for Separate Dispensing Fees			●
Clinical Information				
32	CD4 Count Date			●
33	CD4 Count Value			●
34	Viral Load Date			●
35	Viral Load Value			●

● Report this data element

APPENDIX B: CALCULATING CLIENT INCOME AS A PERCENT OF THE FEDERAL POVERTY MEASURE USING HHS FEDERAL POVERTY GUIDELINES

Calculation Steps

Here are five easy steps you can use to determine a client's income as a percent of the Federal poverty measure using the U.S. Department of Health and Human Services Federal poverty guidelines (FPG):

1. Count the client's family size.
2. Add up the family income.
3. Look up the FPG for the family size, year, and geographic location.
4. Calculate the family income as a percent of the family FPG:

$$\text{family income} / \text{guideline} * 100 = \% \text{ family FPG}$$

5. Use the percent of the family FPG to report the client percent of the Federal poverty measure for Item 12 of your ADR Client Report.

Background, Definitions, and Notes

To find the **Poverty Guidelines** and more information on poverty measurement, go to the HHS Poverty Guidelines, Research, and Measurement Web page at <http://aspe.hhs.gov/POVERTY/>.

The Federal poverty guidelines are dollar amounts that vary according to family size and are used to determine poverty status. HHS issues them each year in the *Federal Register*.

There are separate guidelines for the contiguous 48 States, Alaska, and Hawaii.

Family size is the number of family members who live together. An individual living alone (or with only non-relatives) counts as a family of one.

Family income is the sum of income of all family members who live together.

- It includes pre-tax money (or "cash") income (earnings; unemployment compensation; Social Security; public assistance; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; rents; royalties; income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources)
- It excludes non-cash benefits (e.g., food stamps, housing subsidies) and capital gains (or losses)

All family members have the same poverty status; thus all family members have the same income as a percent of the Federal poverty measure.

APPENDIX C: GLOSSARY

ADAP	<i>AIDS Drug Assistance Program</i> —A State-administered program authorized under Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.
ADAP client	See newly enrolled client, existing client and disenrolled client.
ADAP Earmark	Federal funds specifically designated to be used for the State/Territory ADAP.
ADAP Flexibility Policy	HIV/AIDS Bureau's (HAB) Policy Notice 07-03 provides grantees greater flexibility in the use of ADAP funds and permits expenditures of ADAP funds for services that improve access to medications, increase adherence to medication regimens, and help clients monitor their progress in taking HIV-related medications. Please note that grantees <i>must</i> request approval annually, in writing, to use ADAP dollars for services other than medications, insurance assistance, and the flexibility policy.
ADAP Supplemental Drug Treatment Grant Award	Federal funds awarded to an ADAP with demonstrated severe need based on established criteria, in addition to the earmark fund.
ADR Web application	HAB's online ADR Web Application is where grantees submit their ADR. Grantees access the ADR Web Application via the HRSA Electronic Handbooks for Applicants/Grantees (EHBs), a Web-based grants administration system.
Administrative costs	Administrative costs for medication purchases include items such as shipping and handling, and other bulk order fees.
AIDS	<i>Acquired immune deficiency syndrome</i> —A disease caused by the human immunodeficiency virus.
Alternative Method Demonstration Project	A program of the Office of Pharmacy Affairs that allows for a formal process of testing alternative methods of participating in the 340B drug discount program. New methods of accessing discounted drugs in successful time-limited demonstrations are incorporated into the 340B program's published guidelines.
ARV	Antiretroviral. A drug that interferes with the ability of a retrovirus, such as HIV, to make more copies of itself.
Capped expenditure	A limit on the amount of money to be spent on one service or client per month or per year.
CAREWare	CAREWare is a free, scalable software used for managing and monitoring HIV clinical and supportive care and producing reports.
CDC	Centers for Disease Control and Prevention. The U.S. Department of Health and Human Services agency that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among others. The CDC is responsible for monitoring and reporting infectious diseases, administers HIV surveillance grants, and publishes epidemiologic reports such as the HIV/AIDS Surveillance Report.

CD4 or CD4+ cells	Also known as “helper” T-cells, these cells are responsible for coordinating much of the immune response. HIV’s preferred targets are cells that have a docking molecule called “cluster designation 4” (CD4) on their surfaces. Cells with this molecule are known as CD4-positive (CD4+) cells. Destruction of CD4+ lymphocytes is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.
CD4 cell count	The number of T-helper lymphocytes per cubic millimeter of blood. The CD4 count is a good predictor of immunity. As the CD4 cell count decreases, the risk of developing opportunistic infections increases. The normal range for CD4 cell counts is 500 to 1,500 per cubic millimeter of blood. CD4 counts should be rechecked at least every 6 to 12 months if CD4 counts are greater than 500/mm ³ . If the count is lower, testing every 3 months is advised. A CD4 count of 200 or less indicates AIDS.
Combination therapy	Two or more drugs or treatments used together to achieve optimum results against HIV infection and/or AIDS. For more information on treatment guidelines, visit http://www.aidsinfo.nih.gov/ .
Confidential information	Information that is collected on the client and whose unauthorized disclosure could cause the client unwelcome exposure, discrimination, and /or abuse.
Coordinated benefits	The provision of services by either ADAP or Medicaid, but not both, so that clients do not receive duplicated services.
Co-insurance	A form of medical cost sharing in a health insurance plan that requires an insured person to pay a percentage of medical expenses received.
Co-payment	A fee charged to an individual per visit or per prescription.
Deductible	An annual fixed dollar amount that an insured person pays before the health insurance starts to reimburse or make payments for covered medical services.
Dispensing fees	The cost to pharmacies to dispense drugs which is then transferred as a fee to the buyer.
Dispensing of pharmaceuticals	The provision of prescription drugs to prolong life or prevent the deterioration of health.
Direct Purchase	A prescription drug purchasing model in which State ADAPs purchase drugs directly from a manufacturer or wholesaler at the 340B pricing schedule. ADAPs then distribute the drugs using a centralized State system or through their own pharmacies.
Donut hole coverage	The coverage gap of the Medicare Part D plan where, after a certain point, the beneficiary is 100% responsible for the costs of the medication.
Drug formulary	A list of pharmaceuticals than can be or should be preferentially prescribed within a reimbursement (insurance) program.
Drug pricing cost strategies	See 340B, direct purchase, prime vendor and Alternative Method Demonstration Project
Dual Application	One application form for assistance that is used by both the ADAP and Medicaid, such that clients only need apply once and may receive services from both ADAP and Medicaid.

D-Codes	A five-digit drug identification number developed by Multum Cerner® to identify groups of medications. D-codes have the format d#####, and may also be referred to as ‘d-codes’ or ‘HRSA codes.’
Electronic Handbook (EHB)	The HRSA Electronic Handbooks for Applicants/Grantees (EHBs) is a web-based grants administration system. The EHBs are located at https://grants.hrsa.gov/webexternal .
Eligibility criteria	The standards set by a State ADAP, usually through an advisory committee, to determine who receives access to ADAP services. Financial eligibility is usually determined as a percentage of the Federal Poverty Level (FPL), such as 200% FPL. Medical eligibility is most often a positive HIV diagnosis. Eligibility criteria vary among ADAPs.
Epidemic	A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.
Fee-for-service	The method of billing for health services whereby a physician or other health service provider charges the payer (whether it be the patient or his or her health insurance plan) separately for each patient encounter or service rendered.
Fiscal Year	The Part B Ryan White Program grant year of April 1 – March 31
Fixed co-payment	A set fee charged to all clients per prescription filled.
Grantee of record	The official Ryan White HIV/AIDS Program grantee that receives funding directly from the Federal government (HRSA).
HAART	<i>Highly active antiretroviral therapy</i> —An aggressive anti-HIV treatment including a combination of three or more drugs with activity against HIV whose purpose is to reduce viral load to undetectable levels. Currently, antiretroviral therapies include several classes of drugs.
HAB	<i>HIV/AIDS Bureau</i> —The Bureau within the Health Resources and Services Administration (HRSA) of HHS that is responsible for administering the Ryan White HIV/AIDS Program.
HIP	Health Insurance Program. A program of financial assistance for eligible individuals living with HIV to enable them to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
HIV disease	Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.
HRSA	<i>Health Resources and Services Administration</i> —The HHS agency that is responsible for directing national health programs that improve the Nation’s health by ensuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, provide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. HRSA is also responsible for administering the Ryan White HIV/AIDS Program.

Hybrid	A prescription drug purchasing model in which State ADAPs utilize both Direct Purchase and Rebate Models in purchasing and distributing medications under the 340 pricing schedule.
Manufacturers' rebates	Dollars received from drug manufacturers, which represent a percentage of the cost of the drug.
Medicaid	A jointly funded, Federal-State health insurance program for certain low-income and needy people.
Medicaid/Medically Needy Program	The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan.
Medication Protocol	A document developed to ensure that medications are prescribed appropriately. This document describes specific medical criteria that must be met before clients can be prescribed a specific medication(s).
Monetary cap	A limit on the amount of money to be spent on one service or client per month or per year.
NDC	<i>National Drug Code</i> —The identifying drug number maintained by the FDA. For purposes of the Section 340B Drug Discount Program, the NDC number is used, including labeler code (assigned by the FDA and identifies the establishment), product code (identifies the specified product or formulation), and package size code when reporting requested information.
OMB	<i>Office of Management and Budget</i> —The office within the executive branch of the Federal Government that prepares the President's annual budget, develops the Federal Government's fiscal program, oversees administration of the budget, and reviews Government regulations.
Online interface	A shared intranet or Web site between the State's ADAP and Medicaid program.
Other negotiated rebates	Discounts negotiated between ADAP officials and drug companies on the price of medications.
Part B	The part of the Ryan White HIV/AIDS Program that authorizes the distribution of Federal funds to States and Territories to improve the quality, availability, and organization of health care and support services for individuals with HIV disease and their families. The Ryan White HIV/AIDS Program emphasizes that such care and support is part of a continuum of care in which all the needs of individuals with HIV disease and their families are coordinated. The funds are distributed among States and Territories based, in part, on the number of AIDS cases in each State or Territory as a proportion of the number of AIDS cases reported in the entire United States.
Premium	The amount paid for health insurance by an individual and/or plan sponsor such as an employer.
PHSA	<i>Public Health Service Act</i>
PLWHA	<i>People living with HIV/AIDS</i>

Prime Vendor	A voluntary program of 340B-covered entities in which the prime vendor handles price negotiation and drug distribution responsibilities for members. Since the prime vendor has the potential to control a large volume of pharmaceuticals, it can negotiate favorable prices and develop a national distribution system that would not be possible for covered entities to obtain individually.
Prophylaxis	Treatment to prevent the onset of a particular disease (primary prophylaxis) or recurrence of symptoms in an existing infection that has been brought under control (secondary prophylaxis).
Rebate	A prescription drug purchasing model in which State ADAPs reimburse a broad network of retail pharmacies for costs associated with filling prescriptions for eligible clients. ADAPs then submit rebate claims to the manufacturer at the 340B pricing schedule.
Retroactive billing	Billing for services previously rendered rather than at the time of delivery.
Retrovirus	A type of virus that, when not infecting a cell, stores its genetic information on a single-stranded RNA molecule instead of the more usual double-stranded DNA. HIV is an example of a retrovirus. After a retrovirus penetrates a cell, it constructs a DNA version of its genes using a special enzyme, reverse transcriptase. This DNA then becomes part of the cell's genetic material.
RWHAP-funded service	A service paid for with Ryan White HIV/AIDS Program funds.
Ryan White HIV/AIDS Program (RWHAP)	Ryan White HIV/AIDS Treatment Extension Act of 2009—The Federal legislation created to address the health care and service needs of people living with HIV/AIDS (PLWHA) disease and their families in the United States and its Territories. The Ryan White HIV/AIDS Program was enacted in 1990 (Pub. L. 101-381), reauthorized in 1996 as the Ryan White CARE Act Amendments of 1996, in 2000 as the Ryan White CARE Act Amendments of 2000, and in 2006 as the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The most recent reauthorization was in 2009 as the Ryan White HIV/AIDS Treatment Extension Act of 2009.
Section 340B Drug Discount Program	Administered by the Office of Pharmacy Affairs, this provision indicates that as a condition for participation in Medicaid, drug manufacturers must sign a pharmaceutical pricing agreement with the Secretary of the Department of Health and Human Services. This agreement States that the price charged for covered outpatient drugs will not exceed the statutory ceiling price (the average manufacturers' price reduced by the Medicaid rebate percentage).
Sliding scale co-payment	A fee charged to clients for filled prescriptions that varies based on the income of the client.
State Match for Supplemental Drug Treatment Award	Funding and/or resources from the State budget that matches, in part or in whole, the ADAP Supplemental Drug Treatment Grant Award.
XML	eXtensible Markup Language . A standard, simple, and widely adopted method of formatting text and data so that it can be exchanged across all of the different computer platforms, languages, and applications

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