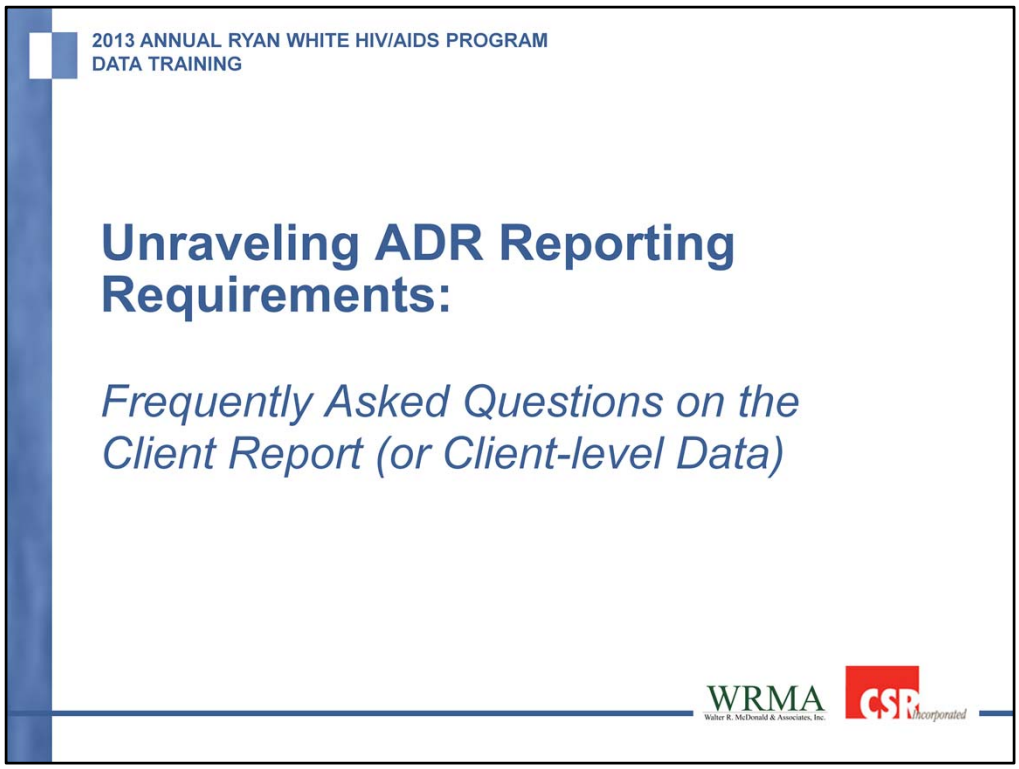
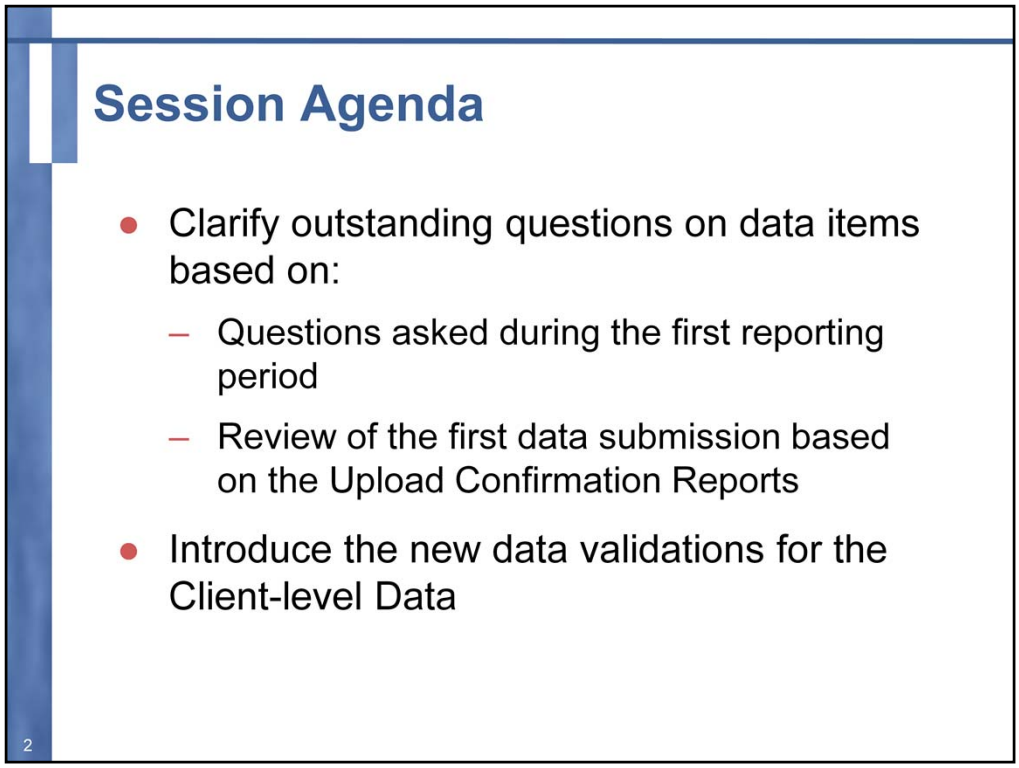


Hello everyone. My name is Imogen Fua and I am with the Data Support team -- the team whom you call or email to ask for assistance on interpreting HAB's reporting requirements. First, let me offer our congratulations to you for a great job on your first submission of the ADR. We know from the calls that the Data Center received, you all were working hard.

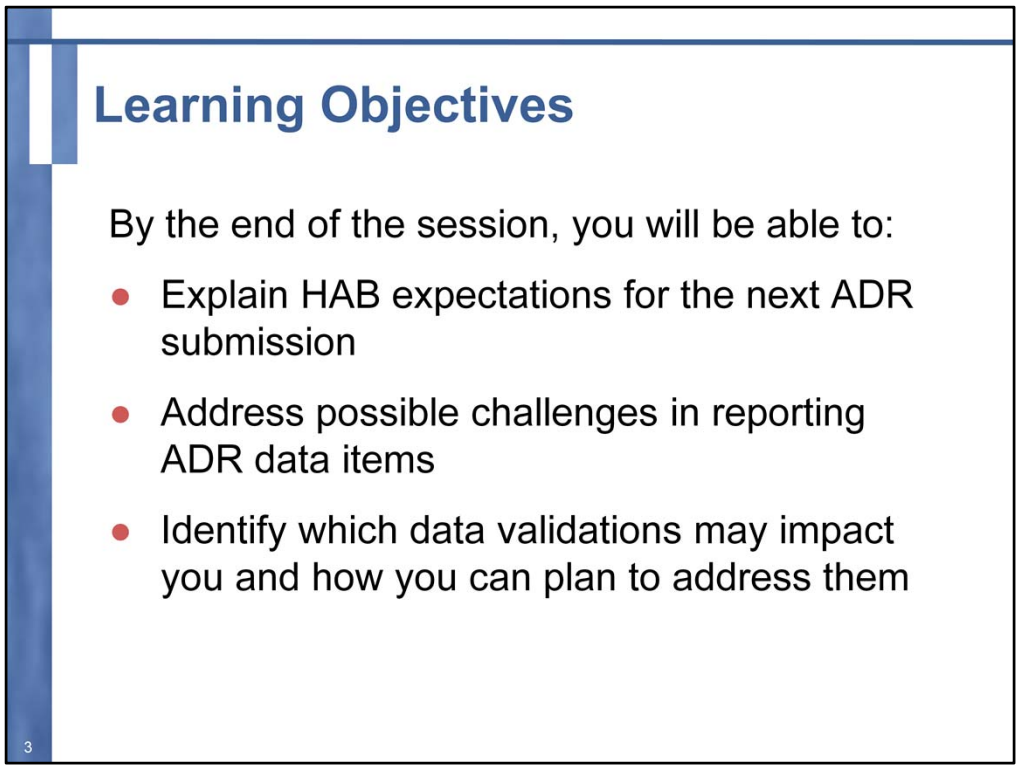


Today, we are going to go over the client-level data items that received the most questions from you during the reporting period and the data elements that we saw from your first Upload Confirmation Reports that we thought also needed some clarification.

I am not going to go through all the data elements. But, please don't feel that you can't ask a question about a data item that we do not go over. On your table should be a copy of the ADR manual for your reference for those data elements.

Finally, we will go over the new data validations for the client-level data.

Throughout the presentation, we will have some questions for you to keep you on your feet. In particular, there is a set of questions that we will be asking you to help inform HAB on future decisions about certain data items.

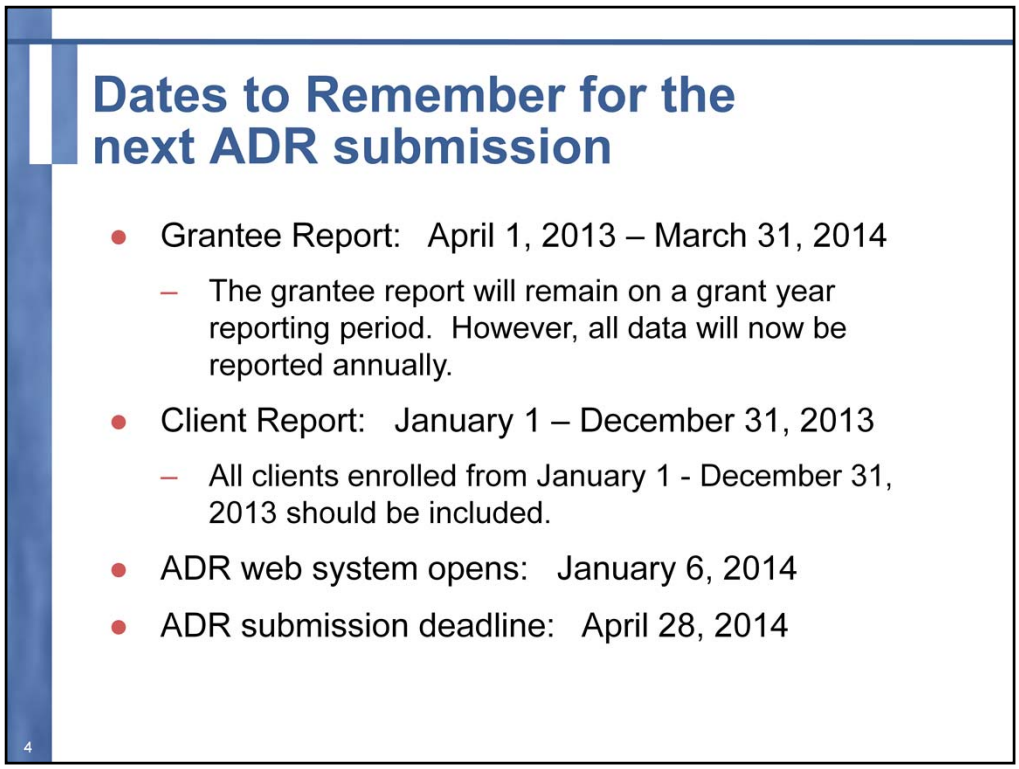


By the end of this session, we hope that you will be able to do three things:

- explain HAB's expectations for the next ADR submission.

- understand and can address the challenges in reporting ADR data items

- and lastly, that you can identify which validations may impact you and that you have an idea or are developing a plan on how to address them.

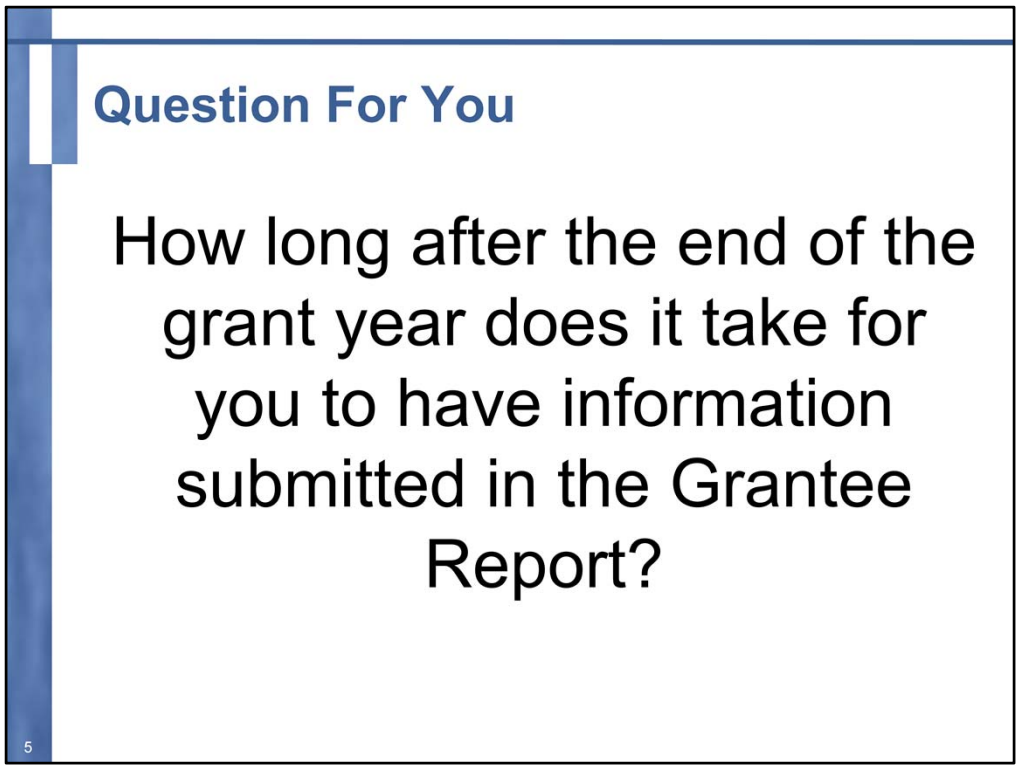


First, I want to reiterate what was said this morning. For the Grantee Report, you will be reporting data based on the grant year reporting period – April 1, 2013 to March 31, 2014. In addition, both the Annual and the Program Summaries will be submitted since you will now be reporting the ADR annually.

For the Client Report, you will be reporting data on clients based on the calendar year, January 1 – December 31, 2013. So you will report on clients enrolled during this period.

The ADR web system will open Jan 6, 2014 so we encourage you to start early. Please don't wait until the day before.

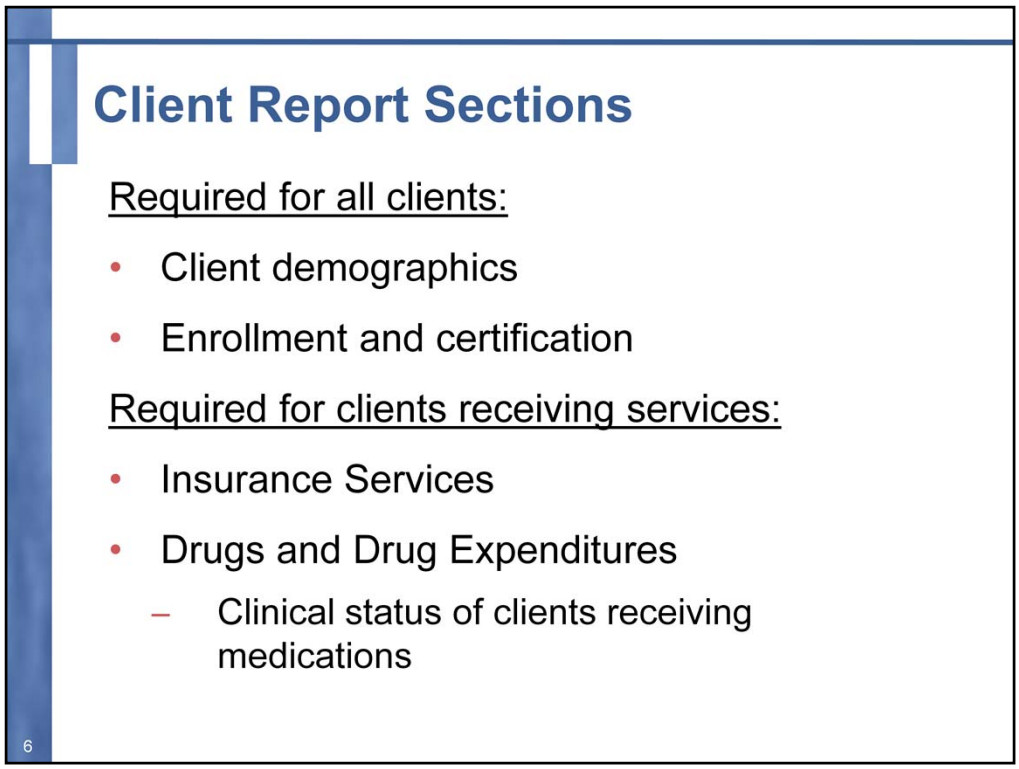
Lastly, the submission deadline is on April 28, 2014



As I mentioned, we are going to be asking you some questions. Here is the first question that will help inform HAB.

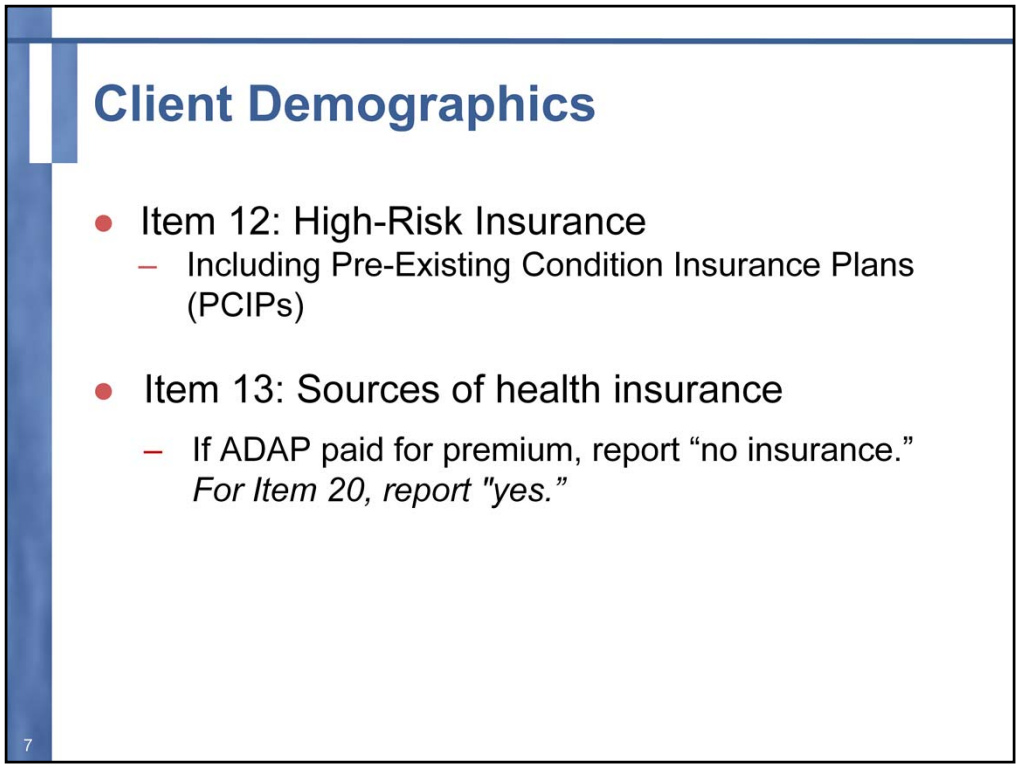
I'm sure some of you have noticed that for the Grantee Report, we are having you report grant year information right after the close of the grant year. The grant year closes March 31 and then we are asking you to submit those data on April 28. We wanted to find out from you if you anticipate any challenges given the short turnaround. In particular, will you have all your expenditures information by the deadline?

How long would it take you after the end of the grant year to have information ready for the Grantee Report?



Here is a brief overview of the ADR Client Report which consists of 5 main sections. The first two sections --the Client Demographics and enrollment and certification data are required that you fill out for every client enrolled in your ADAP, regardless of whether they received services or not during the reporting report.

The insurance section and medication sections are required for clients who received these services. And finally, the clinical data are only required for clients who received medication services.



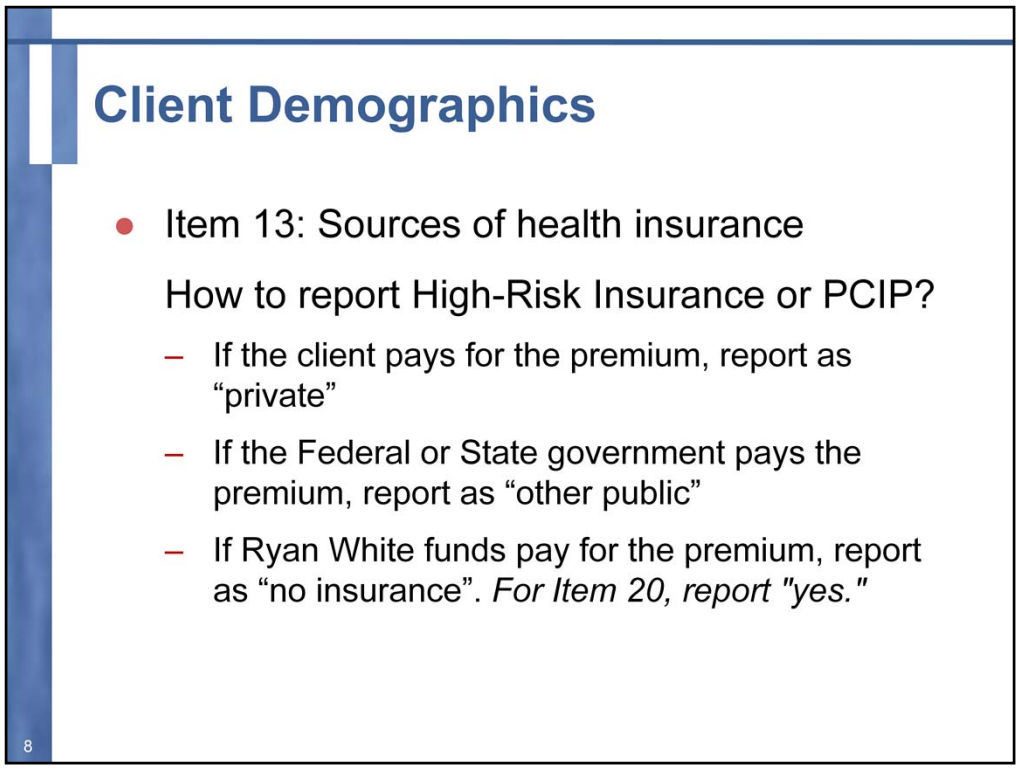
First we’ll go over the demographics section. In this section HAB asks for data on client characteristics such as race, gender, birth year, federal poverty level, etc.

Most of the questions that we got from you during the reporting period have to do with Items 12 and 13, on high risk insurance and sources of health insurance.

For Item 12, we ask you to report whether the client was in a high risk insurance pool at any time during the reporting period. Some of the questions we got from you were whether PCIPs are included here. You would report your PCIPS in this category.

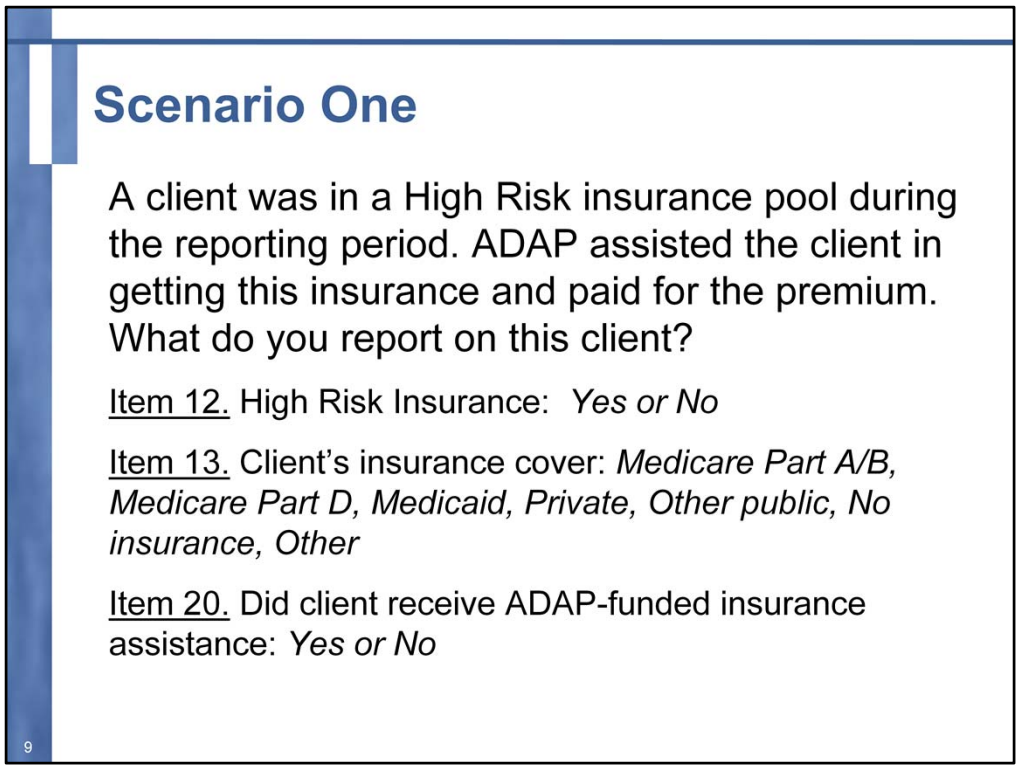
We also received questions on whether certain programs in your state is a high risk insurance pool. So here is the definition of a High Risk Insurance Pool which comes right out of your ADR manual: A high risk insurance pool is a State or Federal health insurance program that provides coverage for individuals 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.

For Item 13 we ask you to report all sources of health insurance coverage that the client has. (Responses are: Medicare Part A/B, Medicare D, Medicaid, private, other public insurance, no insurance, and Other. These options are defined in the ADR manual.) The question from you was if your ADAP paid for the client’s premium, how do you report it in this data element? If ADAP paid for the client’s premium, you should report that the client has “no insurance”. Also in the insurance section, Item 20, you should also report “yes” -- this client received insurance assistance.



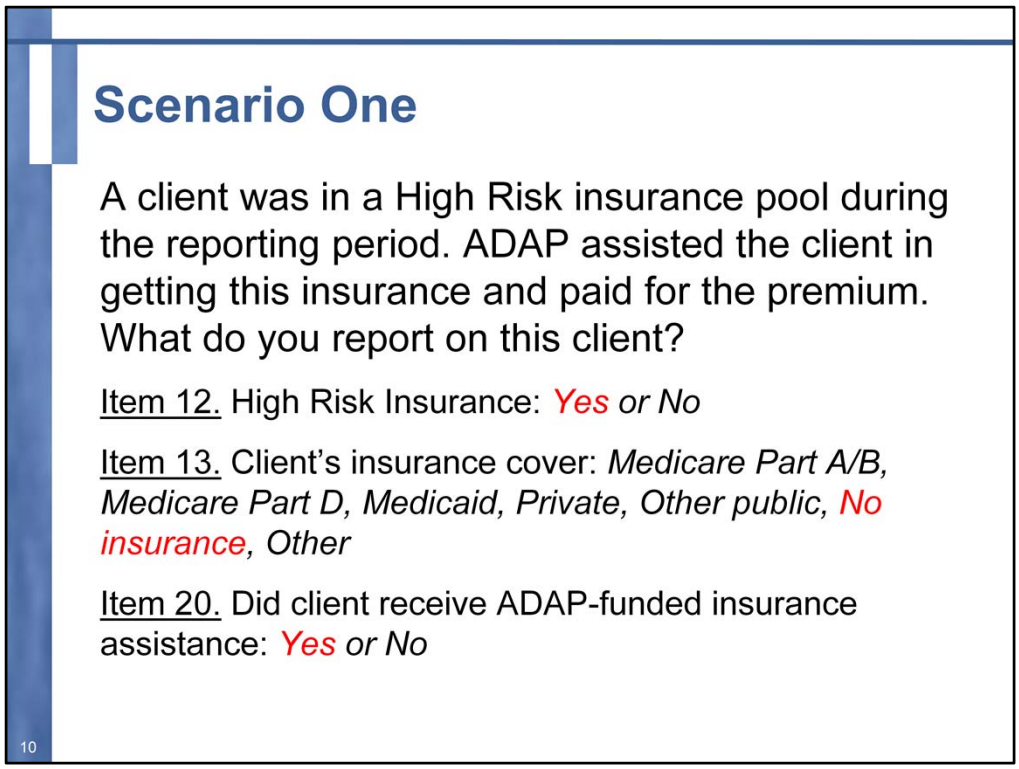
Another question we received from you on item 13 was how to report high risk insurance and PCIPs under the insurance data item. Here is the guidance on that.

- If the client is paying the premium for the insurance, then that insurance should be reported as private.
- If the Federal or State government is paying, then report the insurance as "other public"
- Again, if ADAP is paying for the premium, we want you to report this as "no insurance". And report Yes to the data element, Item 20 under the insurance section that asks if the client received ADAP insurance assistance.



Here is another activity for you that you'll also see throughout the presentation. I'm going to give you a scenario and your job is to figure what what should be reported in the ADR. So I'll read the scenario and you can consult with your other fellow ADAPs at your table to decide what's the right answer.

I'll just give you a couple of minutes.

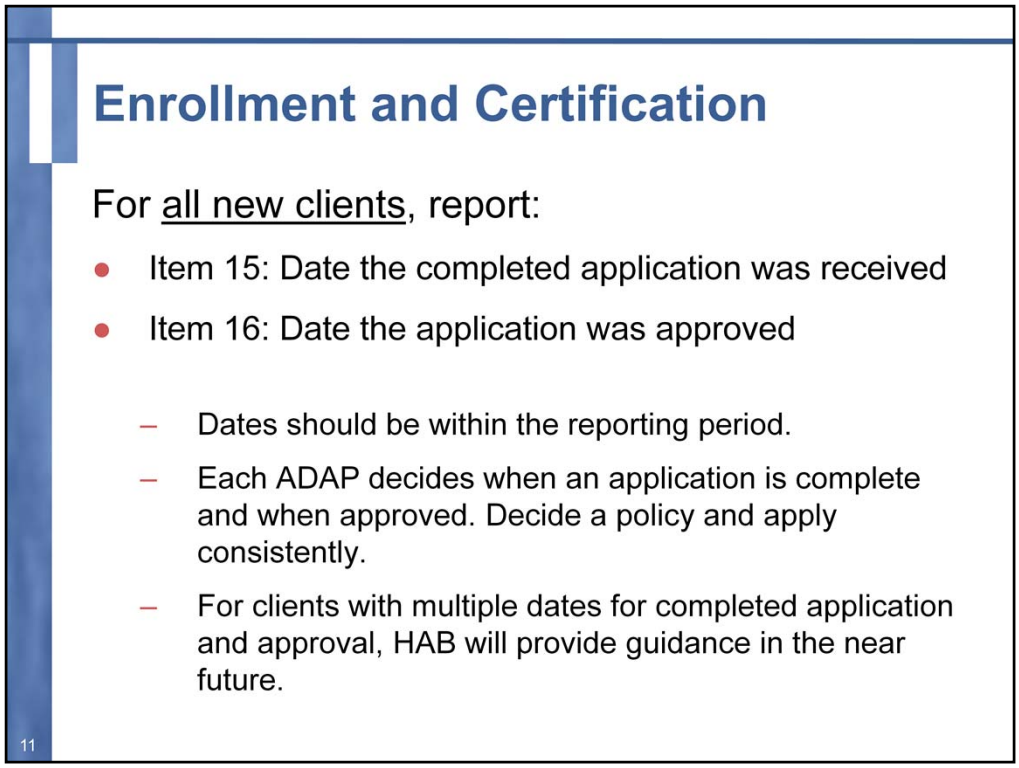


Item 12 asks if person is in a high risk insurance pool. The answer is yes.

Item 13 what is the client's insurance? HAB's guidance is that if ADAP paid for the premium then you report, "no insurance." In this case, ADAP did pay for the premium, so we do report, "no insurance".

Don't forget item 20. Whenever you answer no insurance to Item 13, you need to answer Yes to Item 20.

If ADAP DID NOT pay for the premium – you would answer Item 13 according to who paid for the insurance. If client paid for the insurance, then it's private insurance, if Federal or State government paid the premium, report as "other public."



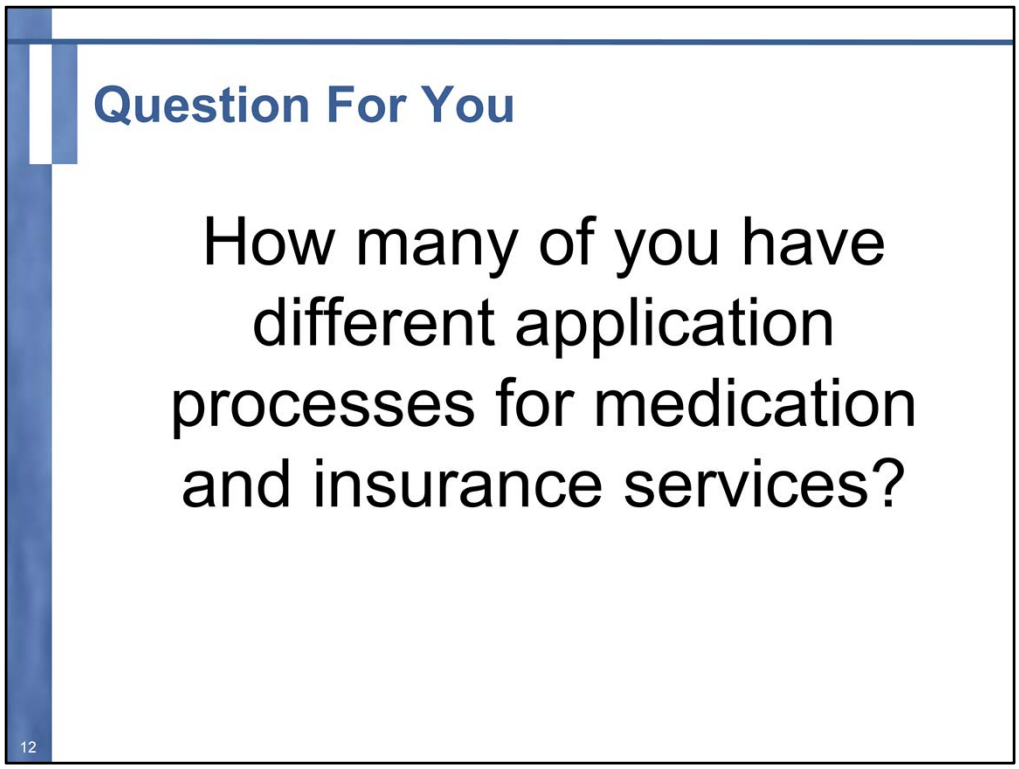
Next we move on to enrollment and certification. This section collects data on the status of your client – are they new? Existing? What was their enrollment status at the end of the reporting report? Remember that you will report all enrolled clients whether or not they are receiving services or not.

This section also asks for dates - when the application was received, when it was approved, and when the client was recertified, if applicable.

First I'm going to talk about Items 15 and 16. As you can see the underline here – these data elements are for new clients. From your first submission, we received dates that were before the reporting period. If they weren't data entry errors, these clients most likely weren't new clients. For these data items, we are asking for new clients that were newly enrolled clients within the reporting period. So for these items, we shouldn't see dates outside of the reporting period.

We've also received many questions and scenarios from ADAPs on how to determine these dates. When does HAB consider an application received or completed? HAB's guidance is that each ADAP can decide when an application is completed and approved and then apply it consistently to all applicants. Remember a completed and approved application means that the client is enrolled and can receive services.

We also got information that your clients may have more than one date for completed application or approval date – whether you have two different application processes for medication services or insurance services or perhaps a client applied to the program more than once within a reporting period. Currently, you cannot report more than one date for these data elements. HAB is reviewing this and will provide more guidance in the future.

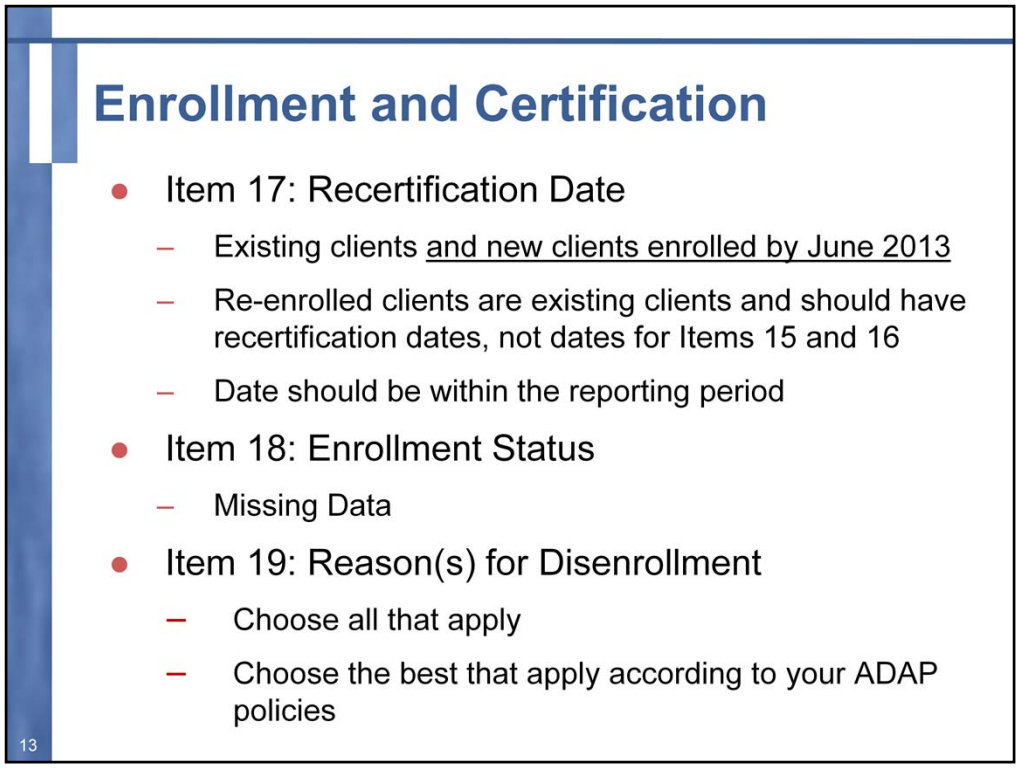


So here we have another question for you pertaining to that issue of multiple dates for application and approval processes.

First, the current data system was developed based on input obtained during the vetting process. It is based on the assumption that each ADAP has one application process for both insurance and medication services. We'd like to get a better understanding of how many of you have different application processes (and therefore different dates) for medication and insurance services.

How many of you have two different applications for medication and insurance services? We'd like to get a count, so 1 hand per ADAP, please.

Why and how does it work? What's different about the applications? Different requirements?



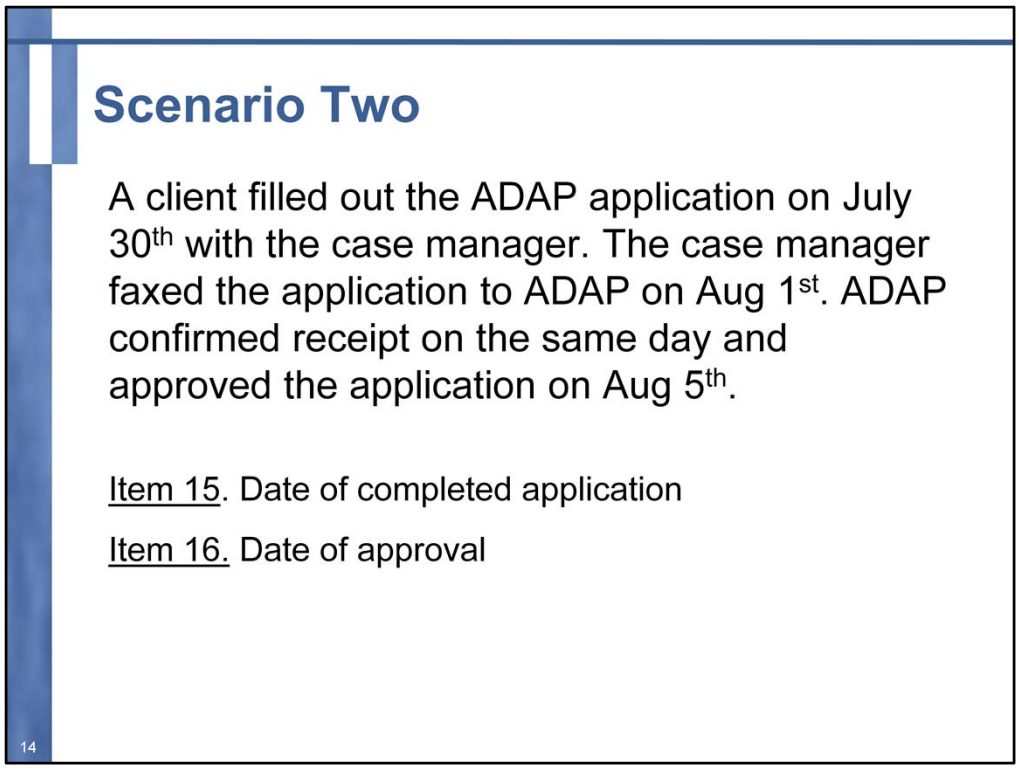
Item 17 ask for the recertification date. Before, you received guidance from us that this should only refer to existing clients – since new clients wouldn't need recertification when the reporting period was only 6 months. But now that your reporting period covers a 12 month period, you should also have recertification dates for some of your new clients who have been enrolled for at least 6 months. Remember HAB's expectation is that you recertify clients every 6 months.

Also remember that our definition of an existing client is someone who has been enrolled in your State ADAP at any time – so if a person has been disenrolled and has re-enrolled during the reporting period, that re-enrollment date is actually their recertification date. Do not enter any dates in Items 15, date of completed application or 16, date of application approved.

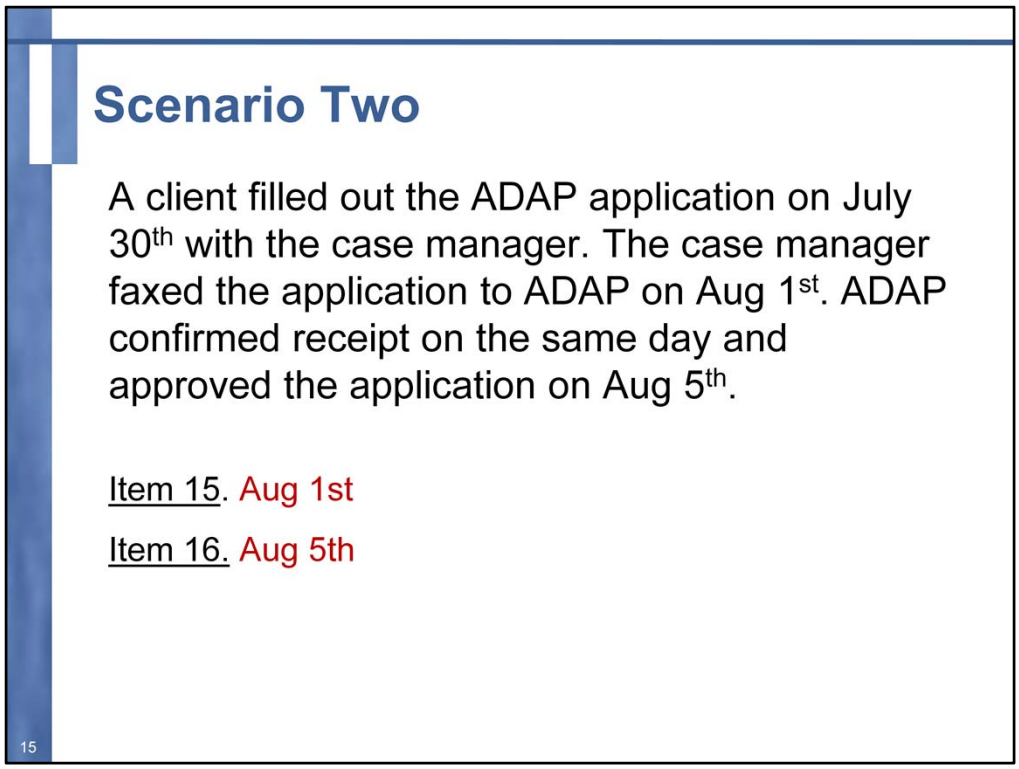
From the Upload Confirmation reports, we also saw a lot of dates outside the reporting period. We want you to report recertification dates for clients who were recertified within the reporting period. So, if a client was not recertified within the reporting period, you do not need to report that date.

We haven't gotten many questions from you on Item 18, where you report your client's enrollment status. However, it was a popular Data Element to be missing in the Upload Confirmation Reports. This should be something you should look into – Check your Completeness Report and talk to us if you need assistance in figuring out how to resolve this issue.

Lastly, we received a lot of questions on how to determine a client's disenrollment status. The list of reasons offered under this Item are actually what you agreed upon during the vetting of the Client Report. Your program should determine which reason or reasons best applies to the client. Remember that you can also choose all that apply.

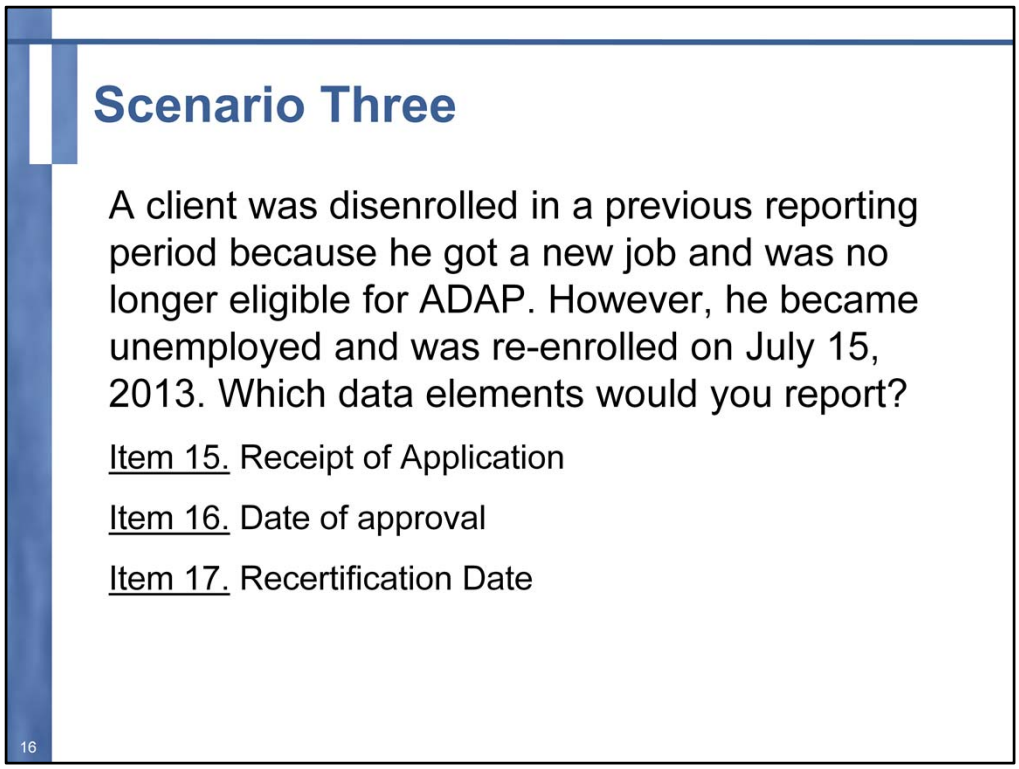


Here is another scenario.

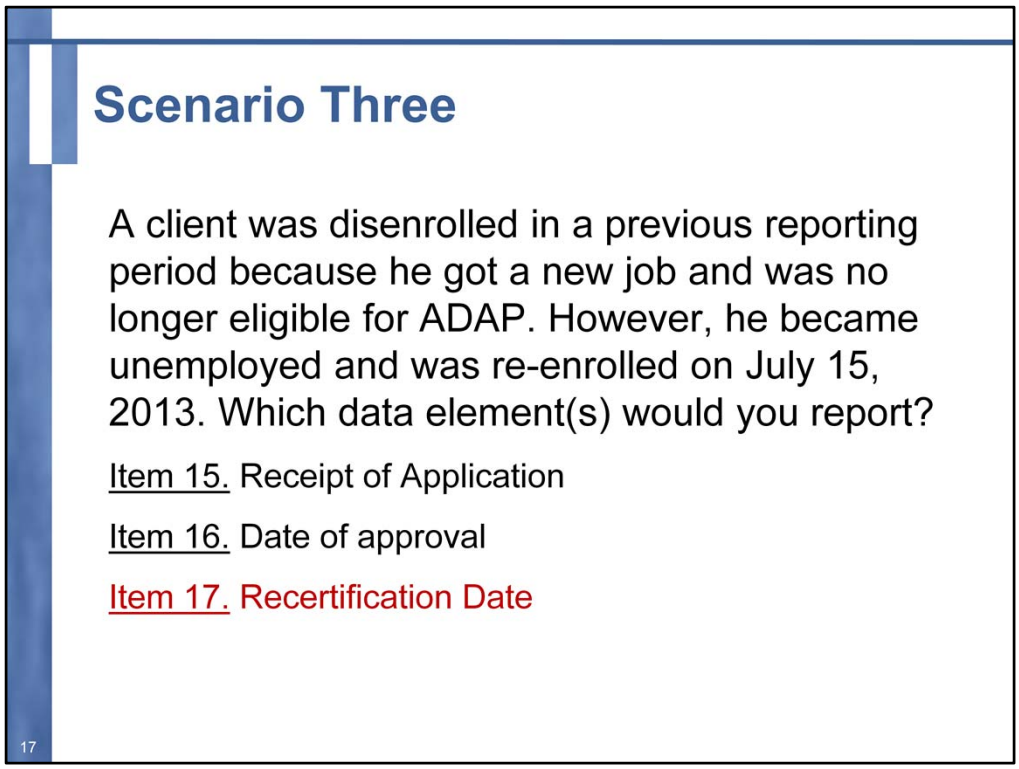


For Item 15, the date is Aug 1st . The date that should be reported is the date that the ADAP received the completed application, not the date that the case manager completed the application.

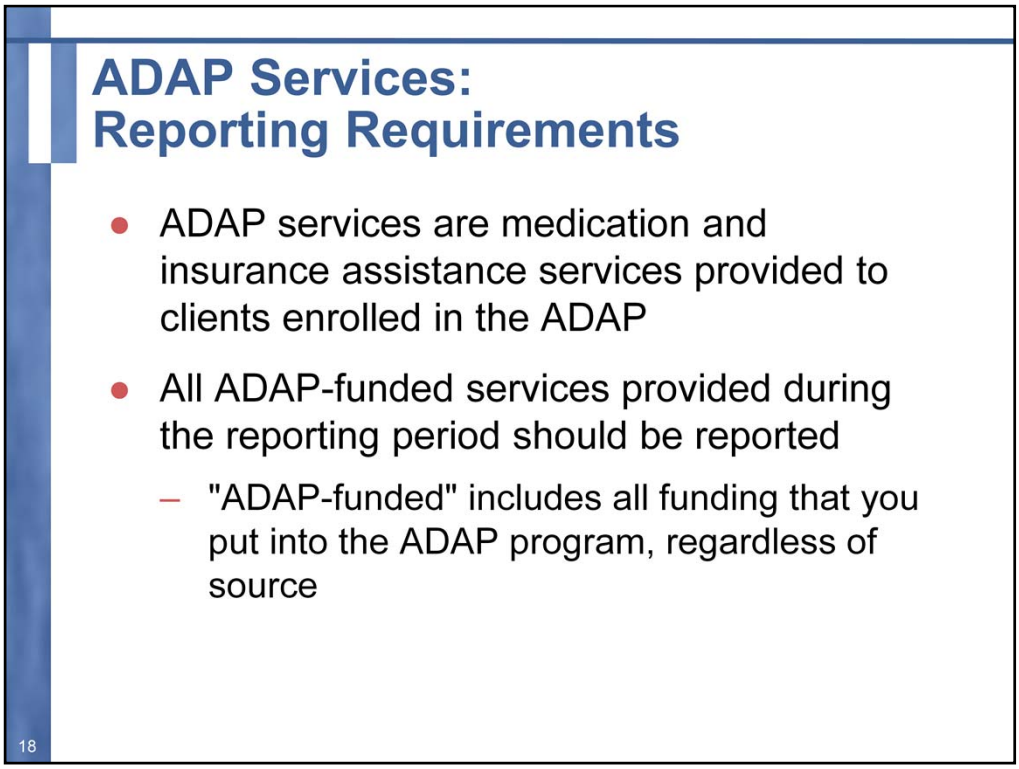
For Item 16, the date is Aug 5th when ADAP approved the application.



Here's another scenario.

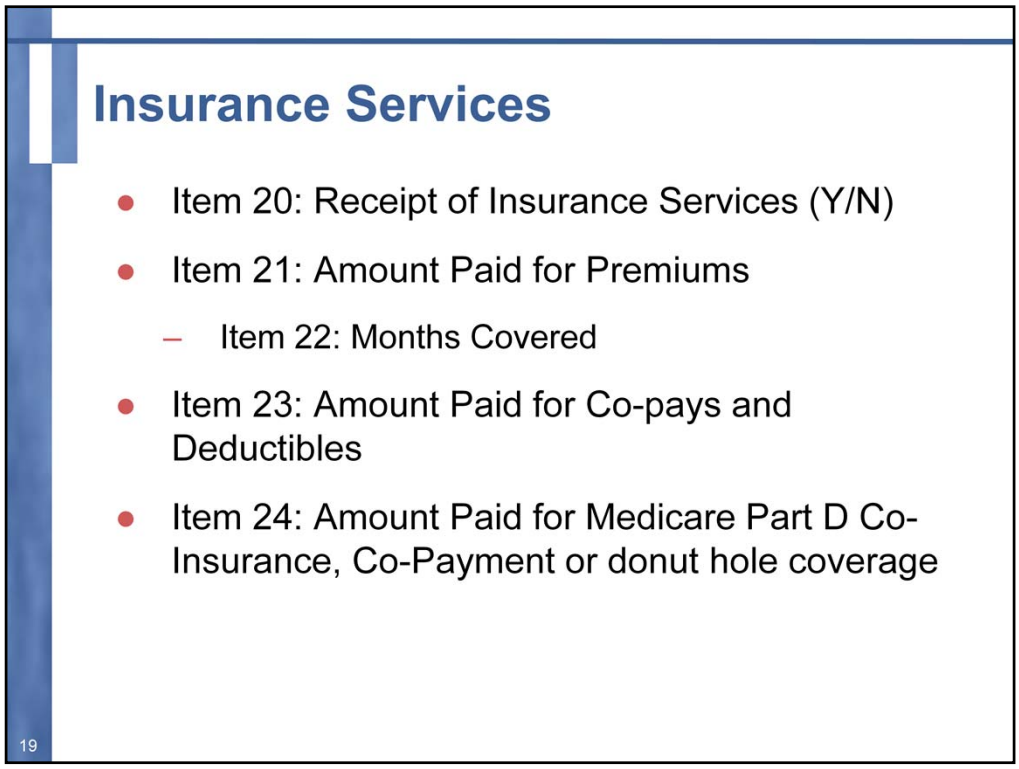


Because this client was enrolled in a previous reporting report, the client is an existing client. So you would enter his recertification date. His re-enrollment process was his recertification process.



The bulk of the questions we received from you are regarding clarification of reporting requirements for the ADAP services. So I will go over all the data elements for each section. ADAP services are the medication and insurance services, which were paid with ADAP funds. Services that your client received whether medication and/or insurance services during the reporting period need to be reported in these sections.

Remember that “ADAP funds” includes all funding that you put into the ADAP program, regardless of the source. This may include State funds or Part A funds. Any service provided by the ADAP is then considered an ADAP-funded service.



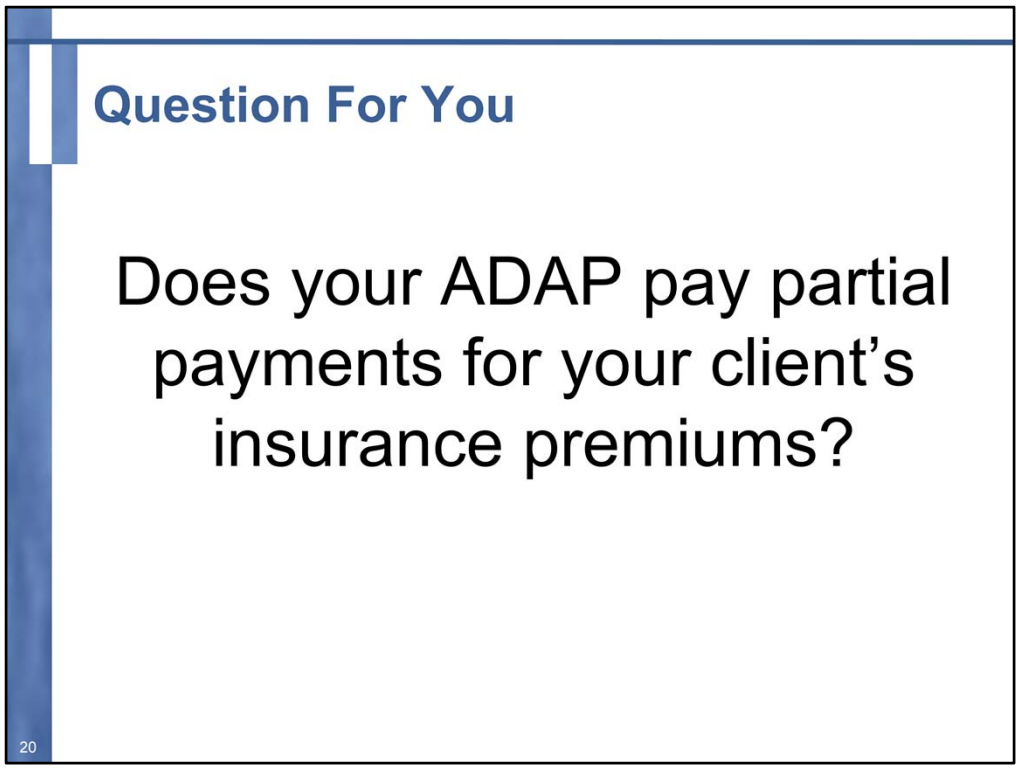
First we'll review the ADAP Insurance Services section. This section will tell HAB if a client received ADAP insurance services and what those expenses were.

For Item 20, you report whether ADAP paid for the client's insurance expenses. Then it asks that you to report each expense as one of three types: 1) premiums; 2) copays and deductibles; and finally 3) Medicare Part D Co-Insurance, Co-Payment or donut hole coverage.

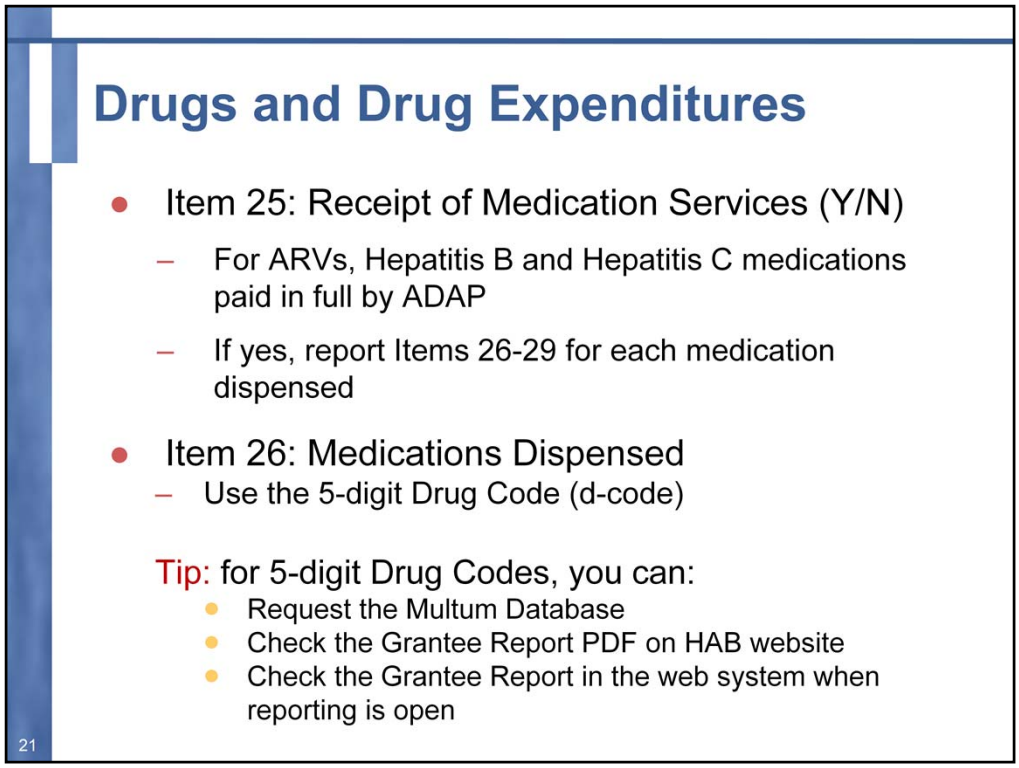
Item 21 and 22 ask about premiums. Item 21 asks what was that amount was paid for the premium? You should include all premiums paid during the reporting period, regardless of the time frame the premium covers. Then Item 22 follows up with how many months does that premium cover. So, if you report item 21, then you also need to report item 22.

Then Item 23 asks you to enter the total amount of any copays and deductibles that ADAP paid for the client during the reporting period.

The next common question is the last data item which asks the total amount that ADAP paid for Medicare Part D. Payments towards Medicare Part D includes co-insurance, or co-payment, or donut hole coverage. Any payments towards Medicare Part D during the reporting period are all captured in this data element. You should not include any payments towards Medicare Part D in the previous data elements.



Once again, we'd like to take this opportunity to ask you a question. In one of our last webinars we were asked what to do with partial payments for insurance premiums. Again we'd like to get a sense of how many ADAPs pay partial payments for insurance premiums. We'd like to get a count so please raise your hand if your answer is yes. One hand per ADAP, please.



The next section is the medication services. These medications should only include ARVs, Hep B and C medications.

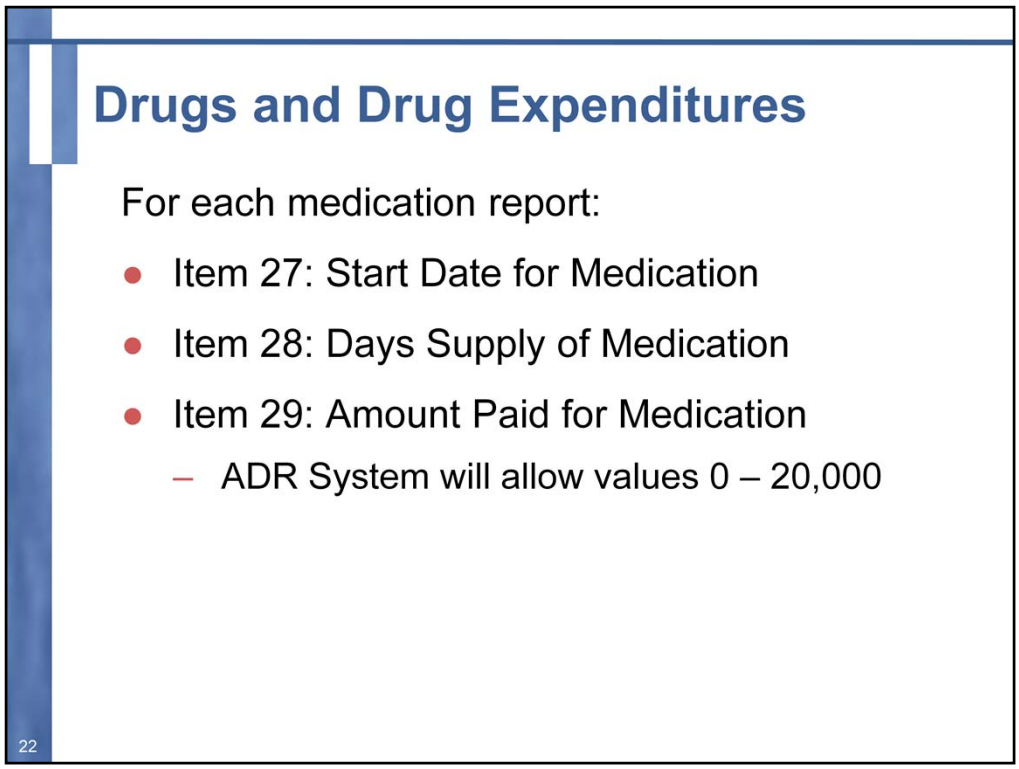
For Item 25, you will indicate yes for clients who received medication services during the reporting period --- meaning the client's prescriptions were fully paid by ADAP. You will then need to report items 26-29 for each medication dispensed to the client.

Under Item 26, you will enter each ADAP-funded medication that your client received using the 5 digit drug code.

If you need the dcode, you can access the Multum Database which was discussed this morning.

Or you can look at your Grantee Report's list of medications which lists the drug codes of all ARVs, Hep and C medications. However, this resource is only available when the data system opens for submission.

The other source is the HAB website which has a PDF of the Grantee Report and includes the list of medications with their drug codes. This PDF will be updated before the next submission period for any new drug codes.

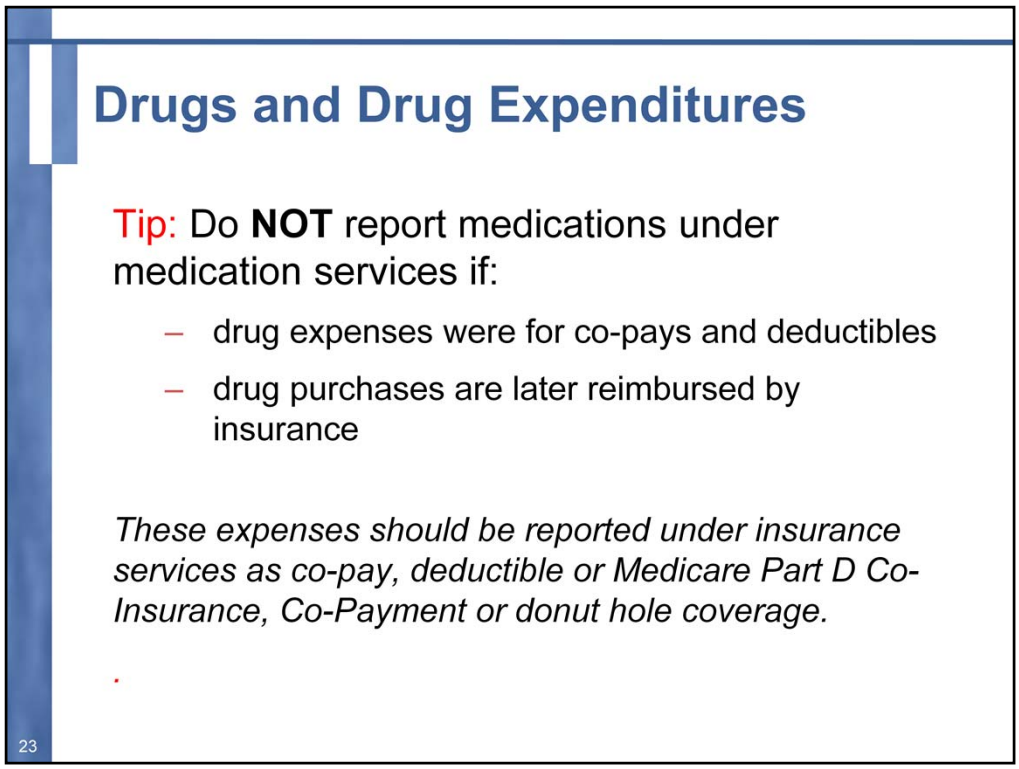


For each medication dispensed that ADAP fully paid for, not only will you report the D-code, but also the start date, days of supply, and the amount paid for each prescription.

We've received a lot of clarification questions on the start date, Item 27. This start date refers to the date during the reporting period that the medication was dispensed to the client. So we're not asking for when they ever started the medication – we are looking for the dispensed date.

Under days supply, you will need to report the number of days the medication was dispensed. We've also been told that some ADAPs only collect the quantity of the medication and not the days supply. You should be working towards changing your medication data collection to get days supply. You can also divide the dosage into the quantity to get days supply. If you do not collect dosage data, HAB is working on getting you this data.

Lastly, for amount paid for medication, the ADR system will only allow values from 0-20,000. The system will not allow for negative numbers. So, don't report any medication reversals. You should only report medications that were actually picked up by the client.



Here are a couple tips on what NOT to report these as medication services.

These two examples should be reported under insurance services.

Remember that if your ADAP paid a co-pay or deductible for your client's medication, that is an insurance service, not a medication service. Only report fully-paid medications under medication services.

If your ADAP purchases a client's medication in full and then bills insurance and you know it's going to be reimbursed by insurance, then you should report this as an insurance service, and not a medication service. Then you will need to report it accordingly as a co-pay, deductible or Medicare Part D.

Scenario Four

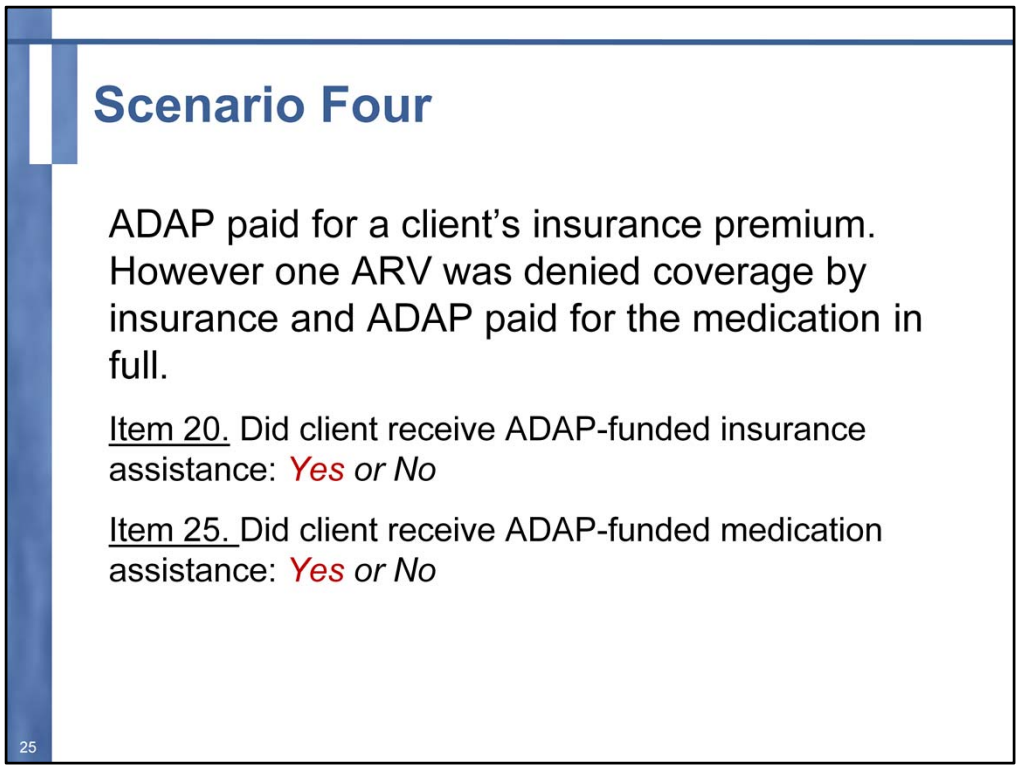
ADAP paid for a client's insurance premium. However one ARV was denied coverage by insurance and ADAP paid for the medication in full.

Item 20. Did client receive ADAP-funded insurance assistance: *Yes or No*

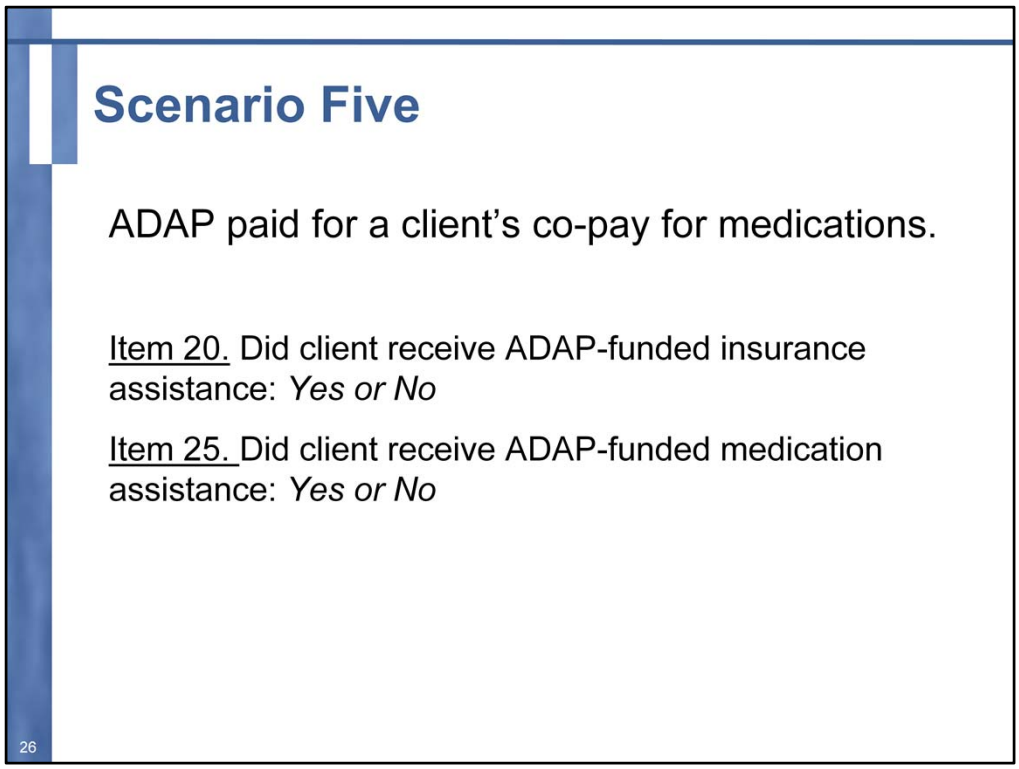
Item 25. Did client receive ADAP-funded medication assistance: *Yes or No*

24

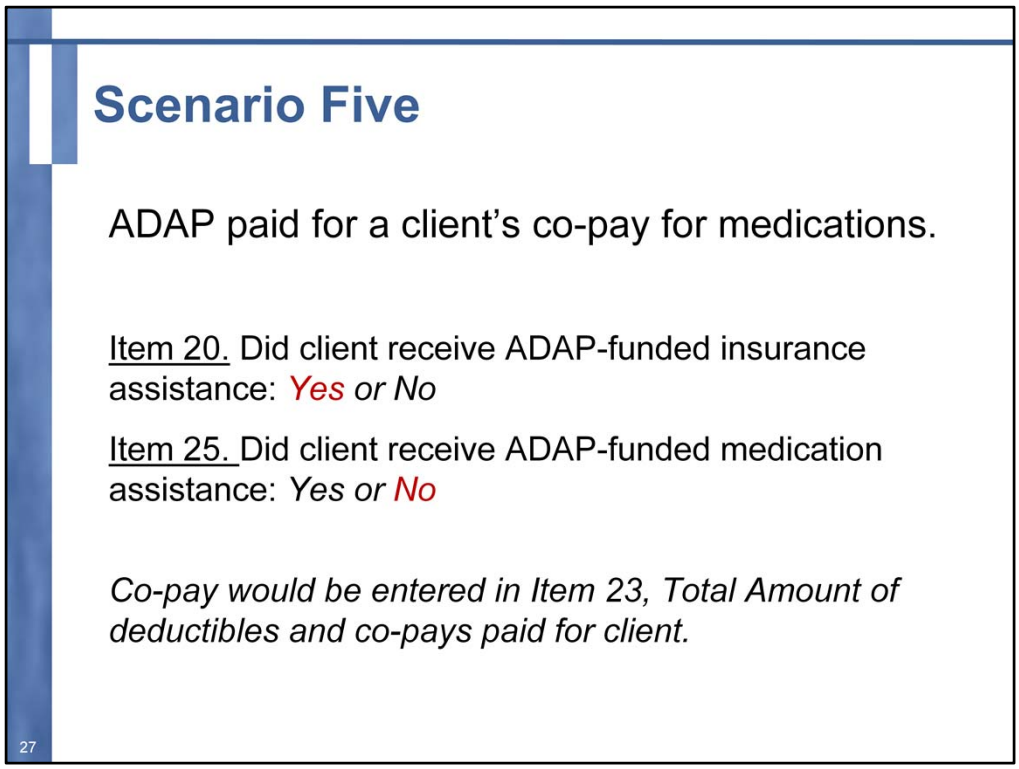
Here we have another scenario.



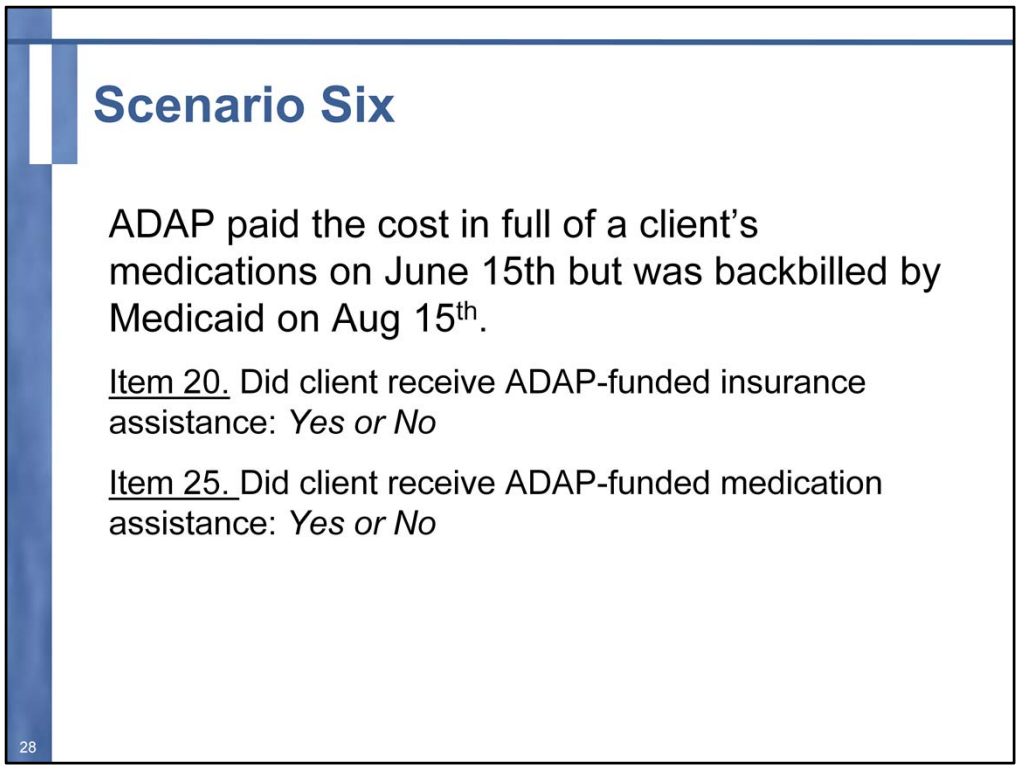
This client received both insurance and medication services because ADAP paid for the insurance premium and then paid a medication in full because insurance denied to pay it.



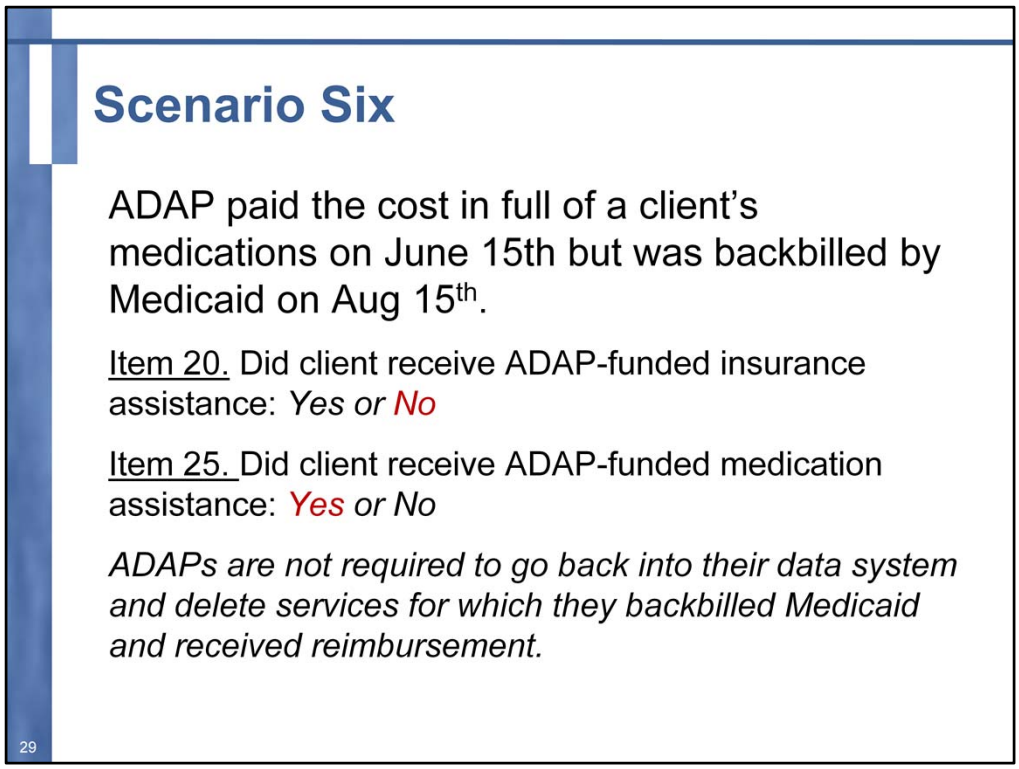
Here is another scenario.



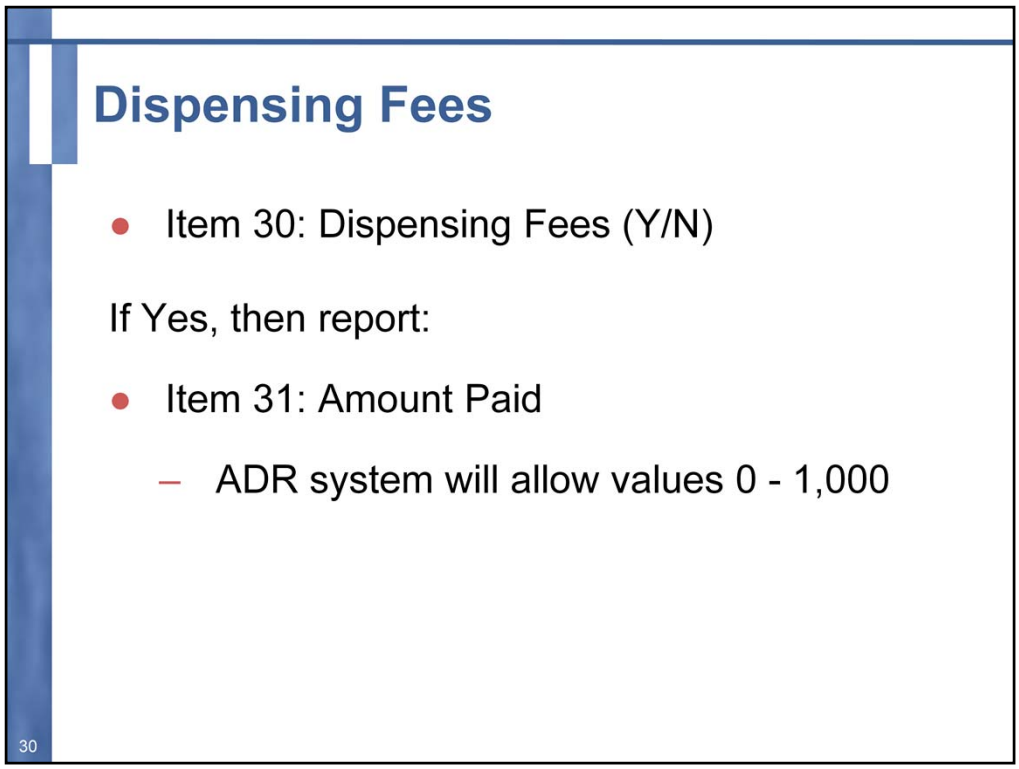
As we said earlier, co-pays for medications is an insurance service, not a medication service.



Here is another scenario.

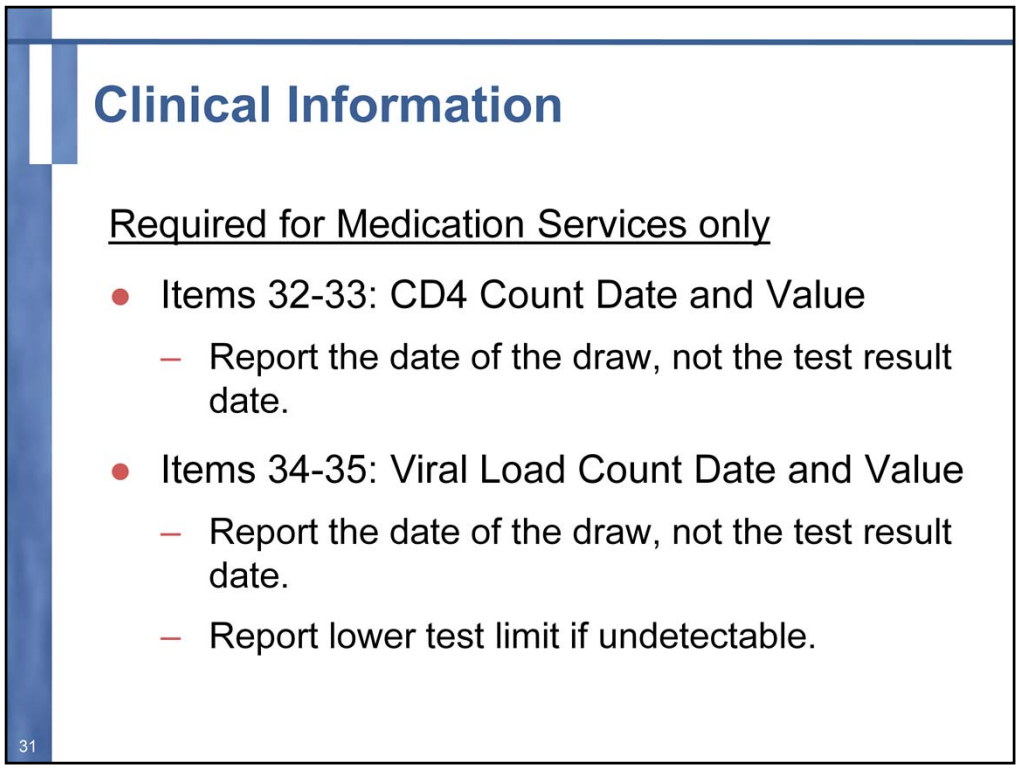


Here, we have medications that was backbilled by Medicaid. In this situation this client was waiting for approval by Mediciad and in the meantime, ADAP paid for their medications in full. HAB does not require you to go back into your system to delete services for which you backbilled Medicaid and received reimbursement, so in this instance, you would go ahead and report this as a medication service.



Finally the last two data elements of this section have to do with dispensing fees. For Item 30, you will report whether your ADAP paid for dispensing fees for the client – and this is separate from other fees, such as administrative fees or PBM fees.

The second data element asks for the amount paid. This amount should be the total costs for all medication dispensing fees for this client during the reporting period. The ADR system will only allow values 0-1,000. Again, you cannot report a negative number for dispensing fees. You should work with your PBM to report only these values.



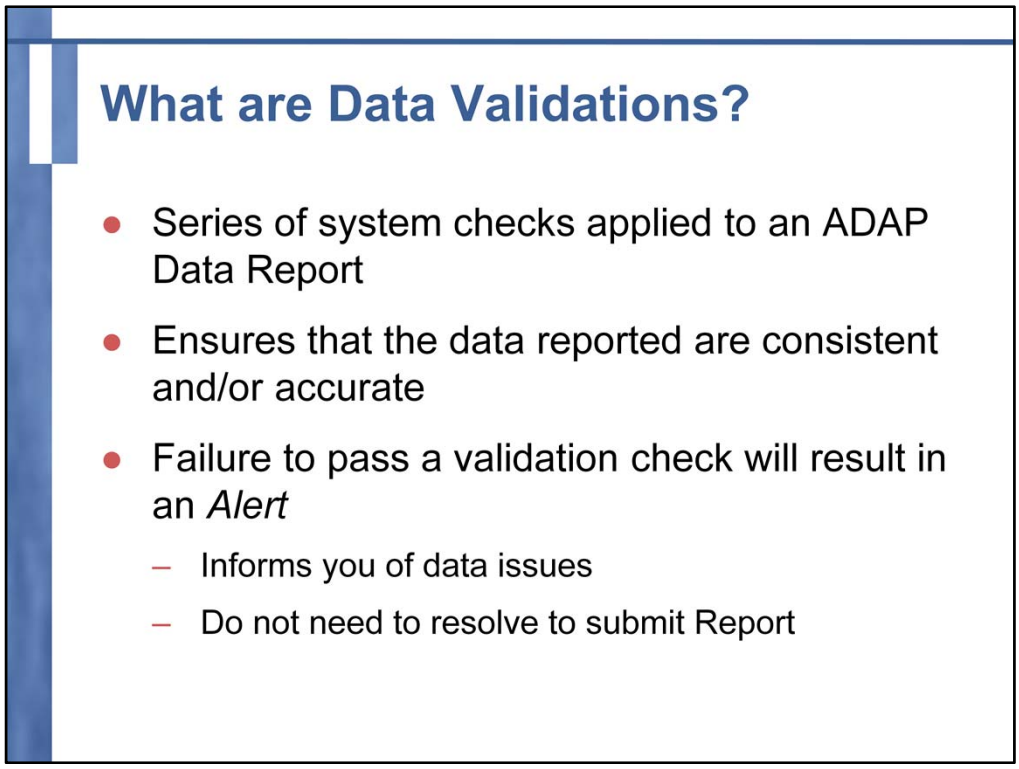
The final section of the Client Report is the clinical data. It describes the clinical characteristics of ADAP clients who receive ADAP-funded ARVs, Hepatitis B and Hepatitis C medications. These data must come from a lab report or similar document where a prescribing clinician has signed off on. It can also come from your state surveillance program.

For clinical data, you will report the most recent CD4 Count and Viral Load Count test dates and values.

Values will be accepted as long as they occur within the 12 months preceding the end of the reporting period. So, for example, this second reporting period ends on Dec 31, 2013; so the CD4 and Viral Load tests must have occurred no earlier than Dec 31, 2012.

Some of you have asked about how to report undetectable viral load values. In you data dictionary, there is guidance to make sure your developers use the “is detectable” attribute. They should set that attribute to “false” and report the lower test limit for the viral load.

Lastly, medication services is only required of clients who received medication services. We saw from the Confirmation Report that a lot of you also uploaded clinical information on your insurance services. This is something that some of you will need to focus on in your next submission – to work with your PBM or IT staff on filtering out clinical data of your insurance clients when submitting your Client Report. Again, you can approach us if you need assistance to do that.

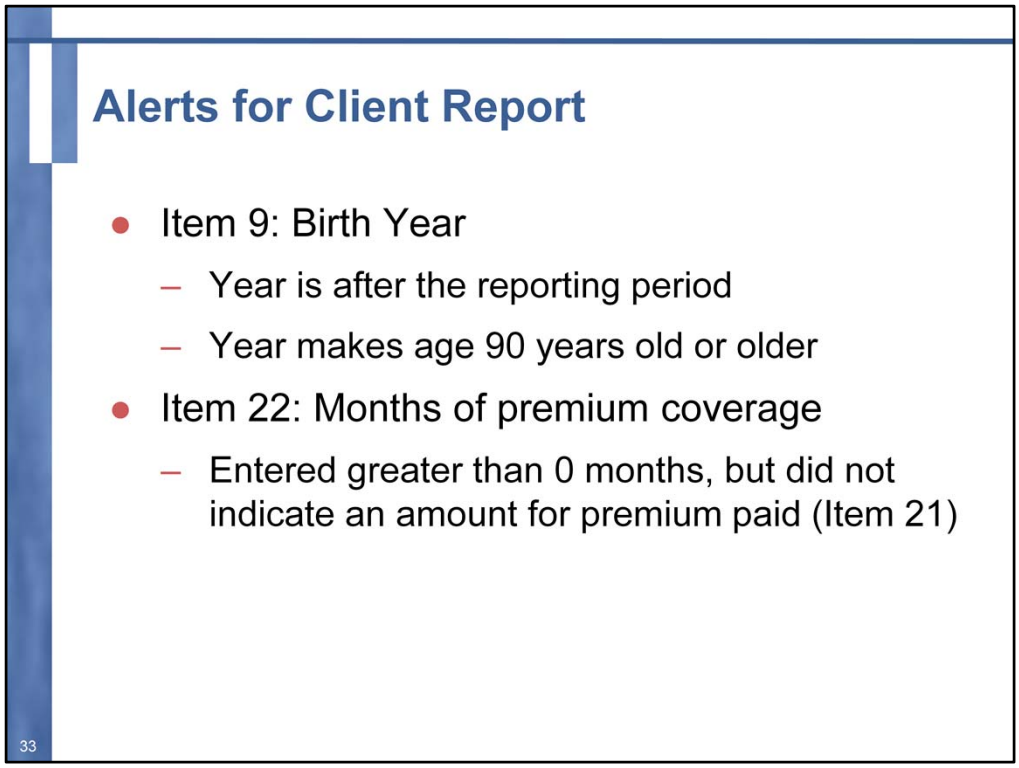


Now, we will go over data validations. Don't get too nervous about these data validations. They are all Alerts, so they are meant to be informative. In the last submission, there weren't any validations in the Client Report and now there are a limited number of them. And as you will see they are merely to help raise your attention to data quality issues.

What are Data validations? Data validations is a process that compares your data with the data requirements outlined by HAB. Validations can also check if the data make sense. This process helps ensure that the data you provide for your clients are complete and makes sense.

For the next ADR submission, if your data do not comply with the data requirements, you will receive an Alert. An alert will let you know that you have some potential issues in your data.

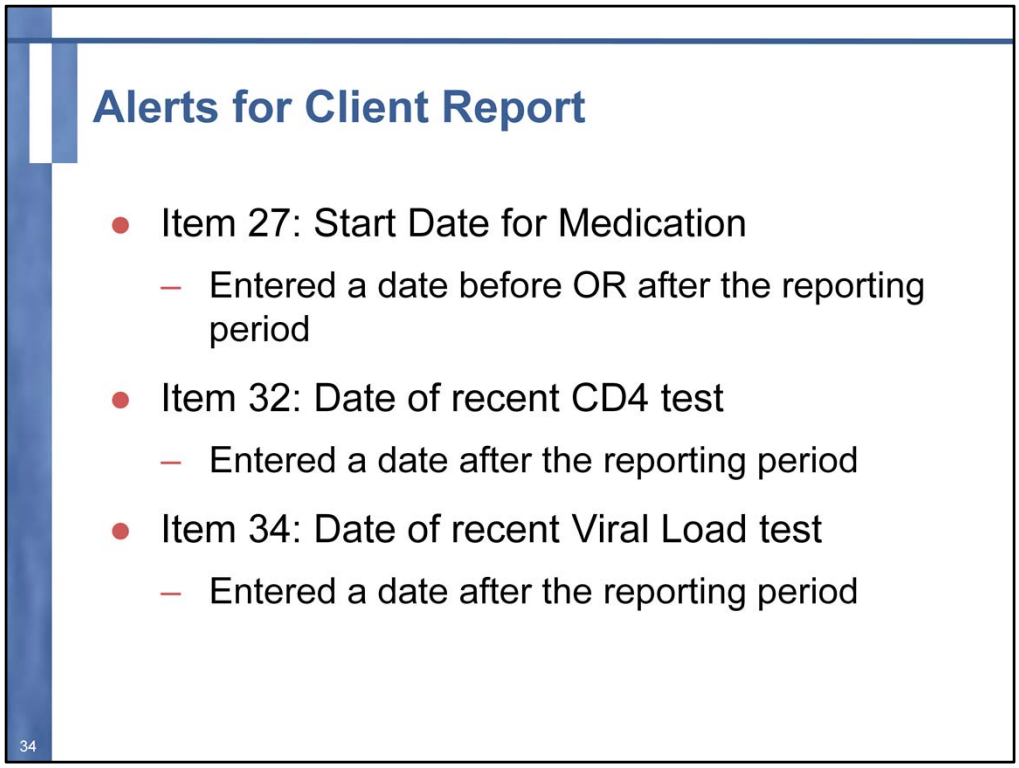
You will want to review these issues and if able to, correct them. However, for now, HAB will not require that you correct these data issues in order to submit your data. The ADR may be submitted with unresolved alerts.



For this reporting period, you will find that in 5 of the data elements, you can receive such an alert.

The first data item where you can encounter an alert is in regards to Item 9 which requires you enter the client's birth year. If you entered a year after the reporting period (so, in the future) such as 2014 or later, you will get an alert. If you enter a year that makes the client 90 years old or older, you will also get an alert. The age 90 or above could be the correct age for your client; however, since it may be less common to have a client that age, we just want to draw your attention to it so that you can double check that it is correct.

The second alert is for Item 22 which asks for the number of months that the premium, that ADAP paid for, covers. You entered a number for this item; but you didn't indicate in Item 21 the amount that ADAP paid.

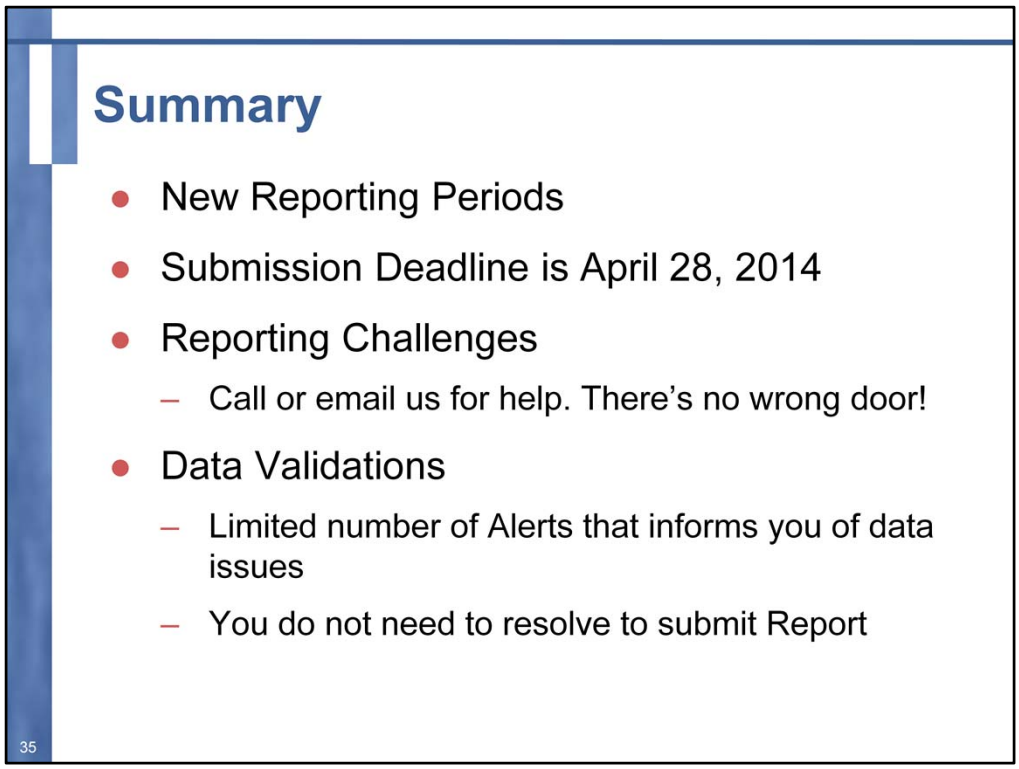


The next three alerts have to do with dates.

The first one is for Item 27 which asks you to enter the start date for the medication dispensed that ADAP fully paid for during the reporting period. You will receive an ALERT if the date you entered is outside, before or after, the reporting period.

The next and last two alerts are in the clinical data section regarding the test dates for the CD4 count and the viral load. As previously mentioned, both require that the test dates occur within the 12 months preceding the end of the reporting period. If you enter a date AFTER the reporting period, you will receive an alert. (However, you will not get an alert if date is before the 12 months.)

That is all the data validations that you will have to worry about for the next submission.

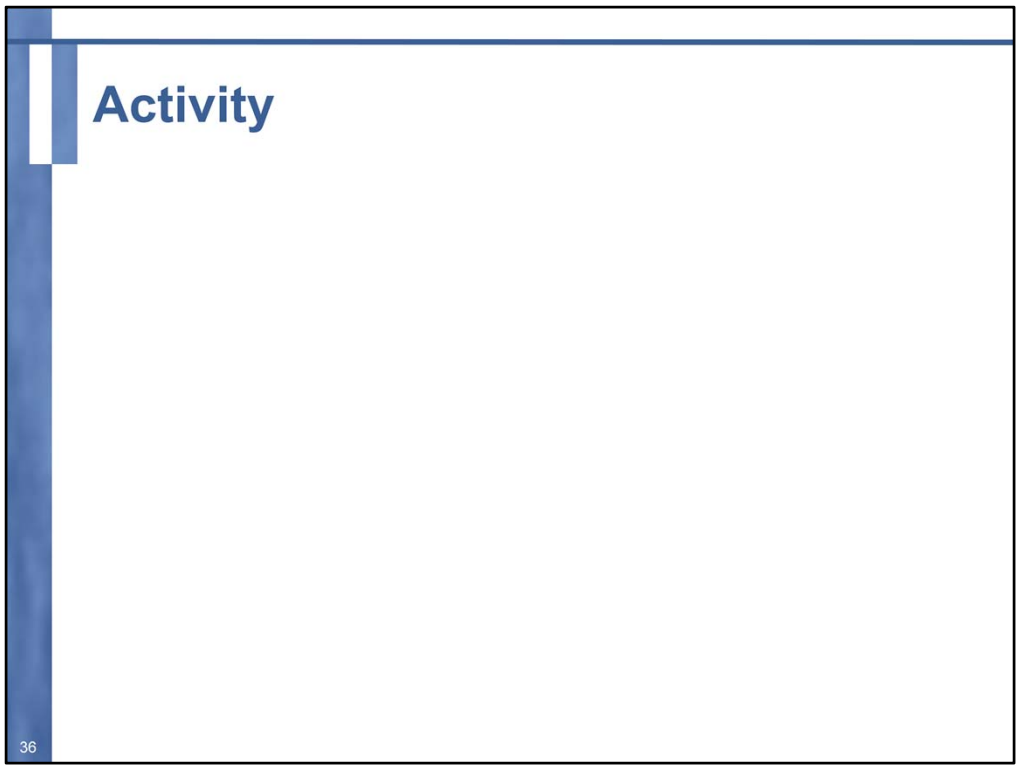


Before we go to the group activity I just want to summarize some of the main take-aways for this session.

First, there are new reporting periods and a new submission deadline – there is a sheet in your binder that outlines all of this.

And if you have further questions about reporting requirements that come up when you return to your ADAP, don't hesitate to pick up the phone or email us.

Finally, the data validations for the next submission is limited to a few ALERTs which you do not need to resolve in order to submit your Report.



In your binder you should have two carbon copy sheets – Exercise 1 and 2.

For Exercise 1, you will be doing individually. From the Completeness Report session and what you learned in this session, including the data validations, jot down the data elements that you will need to spend some time on in getting it to align with HAB's requirements. I'm going to give you 5-10 minutes to do that.

Now take out Exercise 2. First, I want you to pick one data element from Exercise 1 that you want to start thinking about today and developing a plan to resolve that quality issue. Exercise 2 is a group exercise - we'd like to give you the opportunity to talk with other ADAP who may have similar issues. All tables are designated a section of the Client Report. So if you want to address something in demographics – find the demographics table so you can meet and talk with other ADAPs who may be in the same boat or who can help you out. For this exercise, I'll give you 15-20 minutes.

Please share your plans with the whole group.

For More Information

- HAB Project Officer
  - Division of State HIV/AIDS Programs (Part B): 301-443-0031
  - Division of Metropolitan HIV/AIDS Programs (Part A): 301-443-9371
  - Division of Community HIV/AIDS Programs (Part C and Part D): 301-443-0493

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Technical Assistance Resources

- Data Support (WRMA/CSR):
  - (888) 640-9356, 9:00 AM–5:30 PM ET
  - ryanwhitedatasupport.wrma@csrincorporated.com
- DART Team (Cicatelli/Mission/Abt):
  - Data.TA@caiglobal.org
- HRSA Contact Center:
  - (877) 464-4772
  - CallCenter@HRSA.gov

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Technical Assistance Web Resources

- HAB Website:
  - http://hab.hrsa.gov
  - Instructions, Forms, and HAB Information E-mails/Policy Notices
- TARGET Center Website:
  - http://www.careacttarget.org
  - Important Notices, Dates to Remember, Training Materials

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