

ADAP DATA AND RYAN WHITE DATA REPORTING REQUIREMENTS

ADAP collects client and prescription specific data to generate service and expenditure related information. The Department will require the successful bidder to submit electronic data files and hard copy reports regularly as outlined in this appendix. The following items are described within:

- Weekly Electronic File Layouts and Field Definitions
- Quality Assurance Report Requirements
- Quarterly and Annual Report Requirements
- Support File Requirements.

These data and report requirements are subject to change in response to changes in federal and /or State reporting requirements and/or Program needs which may occur during the contract period.

Additional fields or data sets may be required based on state and federal reporting requirements as well as program needs. The names and formats of these fields will be mutually agreed upon.

WEEKLY ELECTRONIC FILE LAYOUTS AND FIELD DEFINITIONS

Weekly data submissions include separate files for client and prescription records. The minimum set of data elements that the Department requires in weekly data submissions include the following.

Weekly Client Data Set Field Definitions

1. IDSTRING

The field IDSTRING is a string of characters combining specific letters of the client's name, birth date, and gender code. In lieu of any client's personal identifying data submitted, the IDSTRING is critical for the preparation of reports that "unduplicates" clients and track utilization patterns. This field is required by the Office of AIDS (OA) to produce unduplicated client counts, track utilization patterns and to subsequently encrypt as the Unique Record Number (URN) for the Health Resources and Services Administration (HRSA) reporting requirements.

- A. Must be eleven upper case letters and numbers composed as follows:
 - Character 1: First letter of legal first name; if unavailable, use digit 9.
 - Character 2: Third letter of legal first name; if unavailable, use middle initial; if no middle initial, use digit 9.
 - Character 3: First letter of legal last name; if unavailable, use digit 9.
 - Character 4: Third letter of legal last name; if unavailable, use digit 9.
 - Characters 5-6: Month of birth as two digits.
 - Characters 7-8: Day of birth as two digits.
 - Characters 9-10: Year of birth as two digits.
 - Character 11: One digit gender code (1 = Male, 2 = Female, or 3 = Other).
- B. The birth date contained in the IDSTRING must be the same as the birth date reported in BDATE.
- C. The month reported must be a value between 01 and 12.
- D. The days of the month reported must be a value between 01 and 31 and must be valid for the month reported.
- E. The year reported should indicate that the client's age is between 18 and 75. If there are exceptions they must be verified and documented.
- F. The gender code contained in the IDSTRING must be the same as the code reported in gender.

2. ZIPCODE

The field ZIPCODE indicates the ZIP Code where the client resides. This field is required by HRSA and OA and is used for density mapping and strategic planning.

- A. The ZIPCODE field must contain 5 numeric characters (0 through 9).
- B. The range of values must be valid for the State of California (majority is between 90001 and 96162).
- C. If the client is homeless then the ZIP Code of the enrollment site must be used.

3. ELGSTART

The field ELGSTART indicates when the current annual eligibility started and must be updated upon a client's recertification. This field is required by OA to determine if a client is eligible to access services.

- A. The range must not be prior to NRLDATE (enrollment date) or more than 13 months prior to the date of service or greater than the last day of the period invoiced.
- B. Unknown date values are not acceptable.
- C. The date value should be reported in the following format MM/DD/YYYY. MM = month, DD = day, and YYYY = year.
- D. The month reported must be a value between 01 and 12.
- E. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.
- F. The year value reported must be within a year's range of the contract period.
- G. This field must be updated at least annually if a client is to continue to receive services. One year after the eligibility start date, a client has 30 days in which to re-certify before they become ineligible.

4. NRLDATE

The field NRLDATE indicates when the client first ever enrolled in ADAP. This field is required by HRSA and OA and is used to determine a client's length of stay in the program.

- A. The date value must be equal or prior to the ELGSTART or the date of the first ADAP covered dispensing as reported in the prescription data set.

- B. The date value must be after October 1, 1987 and not greater than the last day of the period invoiced.
- C. The date value must be reported in the following format MM/DD/YYYY. MM = month, DD = day, and YYYY = year.
- D. The month reported must be a value between 01 and 12.
- E. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.
- F. Unknown date values are not acceptable.

5. BDATE

The field BDATE indicates the client's date of birth. This field is required by HRSA and OA to calculate the client's age. Unless an Exception Request is granted, persons under 18 years of age are ineligible to receive ADAP services.

- A. The birth date contained in BDATE must be equal to the birth date reported in the IDSTRING.
- B. The date value should be reported in the following format MM/DD/YYYY. MM = month, DD = day, and YYYY = year.
- C. The month reported must be a value between 01 and 12.
- D. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.
- E. The year reported should indicate a client's age is between 18 and 75. If there are exceptions they must be verified.
- F. Unknown date values are unacceptable.

6. GENDER

The field GENDER indicates the client's biological sex. This field is required by HRSA and OA.

- A. The gender code must be one of the following numeric values: 1 = male, 2 = female, 3 = male-to-female (transgender), and 4 = female-to-male (transgender).

7. RACE1

The field RACE1 indicates if the client is of Spanish/Hispanic/Latino ethnic heritage. The Department encourages the collection of the most detailed information on racial/ethnic heritage. This field is required by HRSA and OA.

A. The RACE1 code must be one of the following numeric values:

- 000 = No, not Spanish/Hispanic/Latino
- 300 = Spanish, Hispanic or Latino
 - 310 = Mexican/ Mexican American
 - 320 = Cuban
 - 330 = Puerto Rican
 - 340 = Central American
 - 350 = South American
 - 360 = Spanish, Portuguese, Cape Verdean
 - 370 = Other Caribbean
 - 380 = Other Hispanic

8. RACE2

9. RACE3

10. RACE4

The fields RACE2, RACE3 and RACE4 indicate the client's racial/ethnic heritage. Clients will be allowed to indicate the three most significant racial/ethnic codes that apply to them. For a given client, none of the RACE fields can contain duplicate codes.

Unused RACE fields are to be left blank. If the client's racial/ethnic heritage is unknown, then report the unknown race/ethnic code in RACE2 only. If the client indicates only one of the racial/ethnic codes, then indicate the code under RACE2, and leave RACE3 and RACE4 blank. If the client indicates two different race/ethnic codes, then indicate the codes should under RACE2 and RACE3, and leave RACE4 blank.

The Department encourages the collection of the most detailed information on racial/ethnic heritage. These fields are required by HRSA and OA.

A. The RACE2 code must be one of the following numeric values. RACE3 and RACE4 must be one of the following numeric values except for 999 (unknown) or they must be blank.

- 100 = White (including Caucasian, Middle Eastern, North African)
- 200 = Black or African American
 - 210 = African American Black
 - 220 = Caribbean, (Jamaican, Haitian, Dominican), not Puerto Rican or Cuban
 - 230 = African Black
- 400 = Asian

- 410 = East Asian
 - 411 = Chinese
 - 412 = Japanese
 - 413 = Korean
 - 414 = Taiwanese
- 420 = South Asian
 - 421 = Bangladeshi
 - 422 = Burmese
 - 423 = East Indian
 - 424 = Pakistani
- 430 = Southeast Asian
 - 431 = Cambodian
 - 432 = Filipino
 - 433 = Hmong
 - 434 = Indonesian
 - 435 = Laotian
 - 436 = Malaysian
 - 437 = Singaporean
 - 438 = Thai
 - 439 = Vietnamese
- 500 = American Indian, Aleutian, Native Alaskan, or Eskimo
- 600 = Pacific Islander
 - 610 = Fijian
 - 620 = Guamanian
 - 630 = Native Hawaiian
 - 640 = Samoan
- 999 = Unknown

11. JURIS

The field JURIS identifies the local health jurisdiction where the client was enrolled or was last re-certified. This field is required by HRSA and OA.

A. The jurisdiction code must be one of the following numeric values:

- | | |
|-------------------|----------------------|
| 01 = Alameda | 31 = Placer |
| 02 = Alpine | 32 = Plumas |
| 03 = Amador | 33 = Riverside |
| 04 = Butte | 34 = Sacramento |
| 05 = Calaveras | 35 = San Benito |
| 06 = Colusa | 36 = San Bernardino |
| 07 = Contra Costa | 37 = San Diego |
| 08 = Del Norte | 38 = San Francisco |
| 09 = El Dorado | 39 = San Joaquin |
| 10 = Fresno | 40 = San Luis Obispo |
| 11 = Glenn | 41 = San Mateo |

12 = Humboldt	42 = Santa Barbara
13 = Imperial	43 = Santa Clara
14 = Inyo	44 = Santa Cruz
15 = Kern 45	= Shasta
16 = Kings	46 = Sierra
17 = Lake 47	= Siskiyou
18 = Lassen	48 = Solano
19 = Los Angeles	49 = Sonoma
20 = Madera	50 = Stanislaus
21 = Marin	51 = Sutter
22 = Mariposa	52 = Tehama
23 = Mendocino	53 = Trinity
24 = Merced	54 = Tulare
25 = Modoc	55 = Tuolumne
26 = Mono	56 = Ventura
27 = Monterey	57 = Yolo
28 = Napa	58 = Yuba
29 = Nevada	59 = Long Beach City
30 = Orange	60 = Pasadena City
61	= City of Berkeley

B. The codes 1 through 9 must be preceded with a leading zero.

12. SITE

The field SITE code identifies the enrollment site within a given local health jurisdiction where the client was enrolled or last re-certified. Site codes should be sequentially assigned within a given local health jurisdiction.

A. The codes 1 through 9 must be preceded with a leading zero.

B. The fields JURIS concatenated with SITE must indicate a valid enrollment site code included in the latest enrollment site list supplied to OA.

13. INCOME

The field INCOME identifies the annual federal adjusted gross income reported during the most recent eligibility screening. If the annual income is unavailable, the income provided must be annualized. This field is required to help determine if a client is eligible for the program.

A. This field must be reported as a numeric value.

B. If the client has no income, then report as zero.

- C. Income must not exceed \$50,000.
- D. If the client's income is unknown, then the client is not eligible for services beyond 30 days of the date in ELGSTART.

14. DEPENDS

The field DEPENDS identifies the number of dependents, as filed on the Federal 1040, 1040A, or 1040EZ form. It is used in conjunction with INCOME to determine a client's ADAP share-of-cost.

- A. If a client has no dependents report as zero.

15. MEDICAL

The field MEDICAL indicates the client's Medi-Cal status. This field must be cross-validated with the data reported in MEDSHCST (Medi-Cal share-of-cost in the client file). This field is required by HRSA and OA.

- A. This field must be one of the following numeric values: 1 = yes, 2 = no, 3 = Medi-Cal approval pending spend down, or 9 = unknown.
- B. If the value in MEDICAL = 1, then the amount in MEDSHCST must be greater than zero.
- C. If the value in MEDICAL = 2, 3, or 9, then the amount in MEDSHCST must be zero.
- D. If the value in MEDICAL = 9 (unknown), then the client is only eligible to receive services for 30 days past the date in ELGSTART.

16. PVTINS

The field PVTINS indicates the client's private insurance coverage. This field is required by HRSA and OA.

- A. This field must be one of the following numeric values: 1 = yes, 2 = no, or 9 = unknown.
- B. If the value in PVTINS = 9, then the client is only eligible to receive services for 30 days past the date in ELGSTART.

17. PUBINS

The field PUBINS indicates the client's other public insurance coverage, such as V.A. or CHAMPUS. Public payment or subsidy of private health insurance (i.e., through a Health Insurance Continuation Program) is considered private insurance. This field is required by HRSA and OA.

- A. This field must be one of the following numeric values: 1 = yes, 2 = no, or 9 = unknown.
- B. If the value in PUBINS = 9, then the client is only eligible to receive services for 30 days past the date in ELGSTART.

18. SHAMT

The field SHAMT indicates the client's monthly ADAP share-of-cost as calculated using the co-payment determination worksheet. The data in this field must be cross-referenced with INCOME. This field is required by OA.

- A. If a client has no ADAP share-of-cost, then SHAMT must be zero.
- B. If the client's income exceeds 400% of federal poverty level (FPL), then SHAMT must be greater than zero unless a financial hardship was verified and documented.
- C. If the client's income is less than 400% of FPL, then SHAMT must be zero.
- D. If the value in MEDICAL equals 1, then SHAMT must be zero.

19. MEDSHCST

The field MEDSHCST indicates the client's monthly Medi-Cal share-of-cost. This field must be cross-validated with MEDICAL. This field is required by OA.

- A. For a client to be eligible for services, the amount in MEDSHCST must be greater than zero if the value in MEDICAL equals 1.
- B. The amount in MEDSHCST must be zero if the value in MEDICAL equals 2, 3, or 9.

20. HIVDXYR

The field HIVDXYR indicates the reported year when the client tested seropositive for HIV. This field is required by OA.

- A. If the year is unknown, then this field must be reported as 9999.
- B. The date value should be reported in the following format YYYY, where YYYY = year.
- C. For clients enrolled after January 1, 1998 with an HIVDXR reported as 9999, the client is only eligible to receive services for 30 days past the date in ELGSTART.
- D. The year reported must not be before 1984 or greater than the year reported in NRLDATE, ELGSTART, or the year reported in the invoice period.

21. AIDSTAT

The field AIDSTAT indicates the most recent HIV/AIDS diagnosis. Applicants are required to provide a letter of diagnosis signed by a practicing and licensed California physician and this document must be kept in the applicant's ADAP file. This field is required by OA.

- A. The field AIDSTAT must contain one of the following numeric values: 1 = Asymptomatic HIV, 2 = Symptomatic HIV, 3 = AIDS diagnosed, or 9 = Unknown.
- B. If the value in AIDSTAT is equal to 9, then the client is only eligible for 30 days past the date in ELGSTART.
- C. The value in AIDSTAT must be equal to 3 if the value in CD4COUNT is ever less than 200. Once a client has been AIDS diagnosed (3) then the diagnosis must not revert to HIV (1 or 2) even if later CD4 counts exceed 200.

22. AIDSDXR

The field AIDSDXR indicates the month and year associated with the most recent HIV/AIDS diagnosis. This field is required by OA.

- A. If the value in AIDSTAT is equal to 9, then the value in AIDSDXR must be reported as 99/9999.
- B. This field must contain a valid month and year if the value in AIDSTAT is equal to a 1, 2, or 3.
- C. The date value should be reported in the following format MM/YYYY. MM = month and YYYY = year.
- D. The year reported must not be before 1984 or greater than the year reported in NRLDATE, ELGSTART, or the year reported in the invoice period.

23. CD4COUNT

The field CD4COUNT indicates the most recent CD4 count. This field is required by OA.

- A. If a CD4 test has not been performed, then the value must be reported as 9998.
- B. If the results of the CD4 test are unknown, then the value must be reported as 9999.
- C. If the value in CD4COUNT is less than 200, then the value in AIDSTAT must be reported as a 3.
- D. The range of values should be between 0 and 1,500.

24. CD4DATE

The field CD4DATE indicates the month and year associated with the most recent CD4 count reported. This field is required by OA.

- A. If the value in CD4COUNT is equal to 9999 or 9998, then the value in CD4DATE must be reported as 99/9999.
- B. If the month and year reported in CD4DATE is greater than 2 years from the date in ELGSTART, then the date must be verified.

25. CD4COUNT1

26. CD4DATE1

27. CD4COUNT2

28. CD4DATE2

29. CD4COUNT3

30. CD4DATE3

The fields CD4COUNT1, CD4COUNT2, and CD4COUNT3 indicate the client's previous CD4 count(s) reported if available. These values are based on previous information from the client files obtained over time during initial enrollment or re-certification. The fields CD4DATE1, CD4DATE2, and CD4DATE3 are the corresponding month(s) and year(s) associated with the CD4 count(s). These fields can be blank or contain missing values if no historic values are available.

31. VLOAD

The field VLOAD indicates the most recent viral load count. This field is required by OA.

- A. If a viral load test has not been performed, then the value must be reported as 99999998.
- B. If the results of the viral load test are unknown, then the value must be reported as 99999999.
- C. The range of values should be between 0 and 10,000,000.
- D. The format of this field allows for 9 numbers, but only 8 will be used. The first number will be left blank.

32. VLDATE

The field VLDATE indicates the month and year associated with the most recent viral load count reported. This field is required by OA.

- A. If the value in VLOAD is equal to 99999999 or 99999998, then the value in VLDATE must be reported as 99/9999.
- B. If the month and year reported in VLDATE is greater than 2 years from the date in ELGSTART, then the date must be verified.

33. VLOAD1

34. VLDATE1

35. VLOAD2

36. VLDATE2

37. VLOAD3

38. VLDATE3

The fields VLOAD1, VLOAD2, and VLOAD3 indicate the client's previous viral load count(s) reported if available. These values are based on previous information from the client files obtained over time during initial enrollment or re-certification. The fields VLDATE1, VLDATE2, and VLDATE3 are the corresponding month(s) and year(s) associated with the viral load count(s). These fields can be blank or contain missing values if no historic values are available.

39. CONSENT

The field CONSENT indicates that the client has signed an informed consent form for release of information. This field is required by OA.

- A. This field must contain one of the following numeric values: 1 = yes or 2 = no.
- B. All clients enrolled or re-certified after January 1, 1998, must sign a consent form to be eligible.
- C. If the value in CONSENT is equal to, 2 then the client is not eligible for services 30 days after the date in ELGSTART.

40. LANG

The field LANG indicates which language a client would prefer to receive printed materials regarding ADAP. State Legislation mandates this information.

- A. This field must contain one of the following numeric values: 1 = English, 2 = Spanish, 3 = Tagalog, 4 = Cantonese/Mandarin, or 5 = Other.

41. UNDOC

The field UNDOC indicates whether or not the client is undocumented.

- A. This field must contain one of the following numeric values: 0 = no, or 1 = yes.

42. ELIGEND

The field ELGEND indicates when the current annual eligibility ends and must be updated upon a client's recertification. This field is required by OA to determine when a client needs to re-certify to continue to access services.

- A. The range must not be prior to NRLDATE or ELGSTART.
- B. Unknown date values are not acceptable.
- C. The date value should be reported in the following format MM/DD/YYYY. MM = month, DD = day, and YYYY = year.
- D. The month reported must be a value between 01 and 12.
- E. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.

- F. The year value reported must be within a year's range of the contract period.
- G. This field must be updated at least annually if a client is to continue to receive services. After the eligibility end date, a client has 30 days in which to re-certify before they become ineligible.

43. GRSTATUS

The field GRSTATUS indicated whether or not the client is on a 30-day grace period.

- A. This field must contain one of the following numeric values: 0 = no, or 1 = yes.
- B. If the value in GRSTATUS = 1, then the client is only eligible to receive services for 30 days past the date in ELGSTART.

44. HOMELESS

The field HOMELESS indicates whether or not the client is homeless.

- A. This field must contain one of the following numeric values: 0 = no, or 1 = yes.

45. SOURCE

The field SOURCE indicates the original source of the client's data.

46. MEDICARE

This field Medicare indicates whether or not the client is on Medicare

- a. This field must contain one of the following numeric values: 1 = yes or 2 = no

47. WORK

This field indicates whether or not the client has work as a source of income

- a. This field must contain one of the following numeric values: 1 = yes or 2 = no

48. MEDVELIG

This field indicates the client's Medi-Cal eligibility verification status

- a. This field must contain one of the following numeric values: 1 = not verified; 2 = no recorded eligibility; 3 = Medi-Cal SOC; 4 = Medi-Cal no SOC; 5 = CMSP; 0 = unspecified

49. MEDVDATE

This field indicates the client's Medi-Cal eligibility verification date.

- a. This field is represented as mm/dd/yyyy.

50. PBM_ID

This is the client's unique identification number

51. GRPNO

This is the client's current group number detailed in variable 20 in the weekly prescription file.

NOTE: The client fields cannot be blank or contain missing values with the exception of RACE3, RACE4, CD4CNT1, CD4DATE1, CD4CNT2, CD4DATE2, CD4CNT3, CD4DATE3, VLOAD1, VLOAD2, VLOAD3, and VLOAD4.

Note: Character type fields with numeric picture clauses (e.g., NDC, JURISITE, RXNUM) are to be left padded with leading zeros (e.g., 01, 02, 10, 11, etc.).

Weekly Prescription Data Set Field Definitions**1. IDSTRING**

Refer to the IDSTRING (Field # 1) in the Client Data Set above.

- A. For all IDSTRINGs reported in the Prescription Data Set, there must be a corresponding IDSTRING in the Client Data Set.

2. NPINABP

The field NPINABP indicates the dispensing pharmacy's unique number assigned by the National Provider Identifier/National Association Board of Pharmacies. The NPINABP is required to generate ADAP 340B Rebate Reports.

- A. This field must contain a valid numeric value that uniquely identifies all entities contracted by the PBM to dispense ADAP medications as contained in the pharmacy listing file.
- B. This field must be left padded with leading zeros.

3. NDC

The field NDC indicates the 11-digit numeric National Drug Code of the drug product

dispensed. The NDC is required to produce ADAP 340B Rebate Reports, fulfill HRSA reporting requirements, track prescriptions and their related expenditures and identify drug utilization trends.

- A. The NDC must be included in the ADAP formulary. Claims for non-ADAP formulary drugs will be rejected and payment denied.
- B. This field must contain 11 digits or numbers.
- C. This field must be left padded with leading zeros.

4. GPI

The field GPI indicates a product as either a generic-priced drug product or as a more expensive brand-priced product.

- A. This field must contain one of the following numeric values: 1 = generic-priced drug, or 2 = not generic-priced drug or non-drug item.

5. PHSFLAG

The field PHSFLAG indicates if a product was dispensed by an entity that participates in the Public Health Service purchasing program. This field is used in adjusting the ADAP 340B Rebate Reports.

- A. This field must contain one of the following numeric values: 1 = PHS drug, or 2 = non-PHS drug.
- B. All transactions for a given NPINABP must be uniformly coded as PHS or non-PHS.
- C. Transactions identified by either code (PHS or non-PHS) must be invoiced to OA according to its contracted rate.

6. NETCOST

The field NETCOST indicates the net cost of the drug product excluding any dispensing fees. This information is vital for producing rebate reports and projecting program expenditures.

- A. For transactions paid 100% by ADAP, this field is equal to UNITS multiplied by the MRA (Field #10 below).
- B. For transactions with only an ADAP share-of-cost, this field is equal to the amount of UNITS multiplied by the MRA less the ADAP share-of-cost applied.

- C. For transactions where ADAP pays the client's co-payment amount (Medi-Cal or private insurance), this field is equal to the co-payment amount paid by ADAP. This amount should not exceed the MRA multiplied by the UNITS.
- D. For transactions where ADAP pays the client's co-payment amount (Medi-Cal or private insurance) and the client also has an ADAP share-of-cost, this field is equal to the amount of the co-payment less the ADAP share-of-cost applied.
- E. This field does not include dispensing fees.
- F. This field must not be a negative amount.

7. NETUNITS

The field NETUNITS indicates the calculated number of drug units associated with the net cost of the drug. It is calculated by dividing the net cost of the drug with the MRA. This field is required to determine the number of units to be reported for rebate.

- A. For transactions paid 100% by ADAP, NETUNITS will be equal to UNITS. For all other transactions NETUNITS is calculated by dividing NETCOST by MRA.
- B. This field must not be a negative amount.

8. UNITS

This field represents the actual number of drug units the client received at the pharmacy to fill this particular prescription.

- A. For transactions paid 100% by ADAP or with only an ADAP share-of-cost, UNITS will be equal to the actual number of drug units the client received at the pharmacy.
- B. For transactions where the contractor is able to determine the actual number of drug units dispensed, regardless of other payers, then UNITS should represent the total number of units the client received at the pharmacy.
- C. In some cases, the actual number of units the client received at the pharmacy is transparent to the contractor (e.g., cases where the transaction is split billed), and then UNITS will be equal to NETCOST divided by the MRA.
- D. This field must not be a negative amount.

9. DAYS

This field identifies the days supply associated with the transaction dispensed.

- A. For transactions paid 100% by ADAP or with only an ADAP share-of-cost, DAYS will indicate the number of days supply for the actual number of drug units the client received at the pharmacy.
- B. For transactions where the contractor is able to determine the actual number of drug units dispensed, regardless of other payers, then DAYS should represent the total number of days supply for the actual number of drug units the client received at the pharmacy.
- C. In some cases, the actual number of units the client received at the pharmacy is transparent to the contractor (e.g., cases where the transaction is split billed), and then DAYS should indicate the number of days supplied for the number of UNITS reported to OA.
- D. This field must not contain negative values.

10. MRA

This field identifies the contracted maximum reimbursement rate associated with the date the transaction was dispensed.

- A. The MRA grouped by PHSFLAG for a given NDC must be consistent except when pricing changes occur as reflected in the formulary file.
- B. This field must not contain negative values.

11. D_FEE

This field indicates the contracted dispensing fee invoiced to OA.

- A. This field must be consistent for all records.
- B. This field must not contain negative values.

12. PROC FEE

This field indicates the processing fee invoiced to State.

13. DISPDATE

This field indicates the date the prescription was filled by a pharmacist; and for mail-order drugs, this is the date when drugs were mailed to a client.

- A. The range must not be prior to NRLDATE, as contained in the Client Data Set for this client, or greater than 13 months from the ELGSTART date, or the last day of the period invoiced.

- B. The month reported must be a value between 01 and 12.
- C. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.
- D. The date value should be reported in the following format MM/DD/YYYY. MM = month, DD = day of month, and YYYY = year.

14. INVDATE

This field indicates the date the transaction was invoiced to OA.

- A. The INVDATE must be consistent for all records contained in a given weekly submission.
- B. The month reported must be a value between 01 and 12.
- C. The days of the month reported must be a value between 01 and 31 and be valid for the month reported.
- D. The date value should be reported in the following format MM/DD/YYYY. MM = month, DD = day of month, and YYYY = year.

15. JURISITE

This field indicates the client's current local health jurisdiction code concatenated with the enrollment site code. See Client Data Set for code definitions (Field # 11). Site codes should be sequentially assigned within a given local health jurisdiction. This field is required by HRSA and OA.

- A. The first two characters must be a value between 01 and 61.
- B. The last two characters must be a valid enrollment site within the corresponding local health jurisdiction.
- C. The local health jurisdiction and enrollment site segments of this code containing the values 1 through 9 must be preceded with a leading zero.
- D. The field JURISITE must indicate a valid enrollment site code included in the latest enrollment site list supplied to OA.

16. ADPCOPAY

This field represents the client's ADAP share-of-cost payment towards the claim.

- A. If a client does not have an ADAP share-of-cost, then the amount in this field must be zero.
- B. The absolute value of the amount in this field cannot exceed 100% of the program's cost of the drug dispensed.
- C. The absolute value of the total of all co-payments for drugs dispensed during a given month cannot exceed the amount of the SHAMT field in the Client Data Set.
- D. If not zero, this field will contain negative values because the client is paying that amount towards the cost of the drug, and it is deducted from the net cost of the drug.

17.MDCOPAY

This field represents the Medi-Cal co-payment amount invoiced to ADAP.

- A. If a client is 100% ADAP or only has an ADAP share-of-cost, then the amount in this field must be zero.
- B. The amount in this field should not exceed 100% of the program's cost of the drug dispensed.
- C. This field must not contain negative values.

18.OTH COPAY

This field represents the private insurance or other public insurance co-payment amount invoiced to ADAP.

- A. If a client is 100% ADAP or only has an ADAP share-of-cost, then the amount in this field must be zero.
- B. The amount in this field should not exceed 100% of the program's cost of the drug dispensed.
- C. This field must not contain negative values.

19.RXNUM

This field indicates the pharmacy-specific prescription number. This field is required for the ADAP 340B Rebate Reports.

- A. This field must be left padded with leading zeros.

20. GRPNUM

This field indicates the client's assigned 5-digit group code. The first two characters represent the enrollment county. See Client Data Set for code definitions (Field # 11). The last three characters represent the ADAP Group Numbers or client coverage (i.e., Medi-Cal, private insurance, etc.).

- A. The first two characters must be a value between 01 and 61.
- B. The last three characters must be one of the following ADAP Group Numbers:

Group numbers with the following codes require prior authorization.

- 011 = ADAP clients with *private insurance* coverage including prescription drug benefits with a co-payment.
- 013 = ADAP clients who have *Medi-Cal* with a *share-of-cost*.
- 113 = ADAP clients who have *Medi-Cal* with a *share-of-cost plus private insurance* that covers prescriptions.
- 213 = ADAP clients who have *Medi-Cal* with a *share-of-cost plus private insurance* that covers prescriptions with an *Assignment of Benefits (AOB) to the PBM*.
- 313 = ADAP clients who are *Medi-Cal* pending and have private insurance coverage including prescription drug benefits with a copayment.
- 813 = ADAP client who have *Medi-Cal* with *no share-of-cost*.
- 015 = Clients who have an *ADAP share-of-cost*.
- 115 = Clients who have an *ADAP share-of-cost plus private insurance*.
- 215 = Clients who have an *ADAP share-of-cost plus private insurance* that covers prescriptions with an *AOB to PBM*
- 613 = Clients previously identified as a *Medi-Cal* share of cost client who have experienced a disruption in *Medi-Cal* eligibility.
- 019 = Clients who have Medicare Part D.
- 119 = Clients with Medicare Part D and private insurance coverage that has been determined "creditable insurance".
- 093 = Dual Eligible Medicare Clients – clients who have *Medi-Cal* with a share of cost plus Medicare.
- 915 = Clients with Medicare Part D and an ADAP share of cost.
- 893 = Full Benefit Dual Eligible Medicare clients – clients who have *Medi-Cal* with no share of cost plus Medicare.
- 219 = Clients with Medicare Part D and private insurance coverage that has been determined "creditable insurance" and *Medi-Cal* with no share of cost.

Group numbers with the following codes do not require prior authorization, except for formulary dispensing policies

- 010 = ADAP with no other payer.
- 012 = Insurance prescription benefit plan that has been exceeded.

- 014 = ADAP Rx services with AOB to the PBM.
- 017 = Kaiser prescription benefit plan that has been exceeded. (Can be filled by and Provider Pharmacy.)
- 018 = Incarcerated clients.
- 117 = Kaiser patients who have not exceeded their Kaiser prescription benefit plan for the calendar year. (Must be filled by Kaiser Pharmacies or Kaiser contracted pharmacies.)
- 317 = Kaiser patients whose Kaiser Prescription Plan does not have a benefit cap. (Must be filled by Kaiser Pharmacies or Kaiser contracted pharmacies.)
- 417 = Kaiser with no Rx coverage.
- 713 = County Medical Service Program (CMSP) clients.
- 913 = ADAP clients who are Medi-Cal pending (up to 120 days).
- 719 = Clients with Medicare Part D who are in the coverage gap (donut hole).

If the data allow it, Medicare clients should be further identified in the following groups:

- ✱ Standard deductible, 25% co-insurance
- ✱ Standard in donut hole
- ✱ Standard in catastrophic coverage
- ✱ Partial LIS
- ✱ Non-Dual Full LIS
- ✱ No SOC Dual, Full LIS
- ✱ SOC Dual, Full LIS
- ✱ SOC Dual, no LIS
- ✱ SOC Dual, no LIS, in Donut Hole

21. CLAIM_NO

This field represents the uniquely assigned claim number (18 characters) for each prescription dispensed by ADAP.

- A. This field must be left padded with leading zeros.

22. BACKOUTNUM

This field represents the uniquely assigned backout number (18 characters) for each prescription dispensed by ADAP. This number is used for

- A. This field must be left padded with leading zeros.

23. ADAPSOC

This field represents the client's monthly share-of-cost that the client is obligated to pay on a monthly basis.

- A. If a client does not have an ADAP share-of-cost, then the amount in this field must be zero.
- B. The amount in this field cannot exceed 100% of the program's cost of the drug dispensed.
- C. The total of all co-payments for drugs dispensed during a given month cannot exceed the amount of the SHAMT field in the Client Data Set.
- D. This field will not contain negative values.

24. NTR

This field represents the client's Notice of re-enroll transaction

- a. This field must contain one of the following numeric values: 1 = yes or 2 = no

25. SHIPPING

This field represents any shipping and handling fees

26. SUSP_CD

This field represents the suspend code.

27. TRANSDATE

This field represents the transaction date must be in mm/dd/yyyy; hh:mm:ss format

28. NET_ID

This field identifies the pharmacy network type.

29. CL_CAT

The field identifies the client category (i.e., Medi-Cal share of cost, Medicare, Young Women, Young Men, All Other Women, All Other Drugs)

30. ALT_MRA

This field indicates any alternate reimbursement rate associated with transaction.

31.ALT_NETCST

This field indicates any alternate net cost per RFP.

32.ALT_D_FEE

This field indicates any dispensing fee per RFP.

33.NETDIFF

This field indicates the net cost difference between RFP and actual (reference fields 31 and 6).

34.WAC_PRICE

This field represents the Wholesale Acquisition Cost.

35.DEANO

This field represents the prescribing doctor's DEA #.

36.DOCNAMEL

This field represents the prescribing doctor's last name.

37.DOCNAMEF

This field represents the prescribing doctor's full name.

38.DUECNT

This field represents the total number of drug utilization encounters (DUE).

39.DUERESP1, 2 and 3

These fields represent the 1st, 2nd, and 3rd DUE response code.

40.DAWCODE

This field DAWCODE represents the Dispense as Written code as follows:

- 1 = No substitution per prescriber
- 2 = Patient Requested Product
- 3 = Pharmacist Selected Product
- 4 = Generic Drug Not in Stock

- 5 = Dispensed Brand as Generic
- 6 = Override
- 7 = Brand Drug Mandated by Law
- 8 = Generic Drug Not Available
- 9 = Other
- 0 = Not Available

41. PBM ID

This field represents the client's PBM ID (if different from IDSTRING)

42. TOTDISC

This field represents the total difference between state and pharmacy-negotiated rate.

43. PMT_TYPE

This field represents the type of payment received from the client: co-insurance vs. co-payment.

NOTE: The prescription fields cannot be blank or contain missing values.

Monthly Client File Data

The Monthly Client File is a comprehensive eligibility file of all clients. The following variables are not included in either the client or prescription file and will be collected from: ADAP application; screening forms; any other sources. The following is a listing of these variables: (this list is subject to modifications as identified on page 1)

- Patient's Social Security number
- Client's last name.
- Client's first name.
- Client's middle initial.
- Client's physical residing street address.
- Client's mailing address, if different from primary address.
- Client's telephone information.
- Client's preferred language for printed material: English, Spanish, Tagalog, Cantonese/Mandarin, Other.
- Identify if the client is an eligible immigrant.
- Client's identification code.
- Residency documentation.
- Identify whether the client grants information access to another individual (yes or no).
- The most recent date of
- Identify whether the client is an active client.
- Client's adherence rating.

- Number of scripts in adherence rating.
- Employment income amount (need to have separate variables for self-employment income; SSDI income; State disability income; general assistance/relief income; private disability income; unemployment insurance income; retirement/pension income; Worker's Compensation income; investment/interest income; VA benefits income; alimony/child support income; any other sources of income).
- Frequency of income received per year (all sources identified above).
- Client's total gross annual income.
- The client's original enrollment date.
- The client's last eligibility period begin date.
- The client's last eligibility end date.
- The client's Medi-Cal status code.
- The client's Medi-Cal eligibility/denial date.
- The client's Medi-Cal application/referral date.
- The client's Medi-Cal share of cost balance.
- The client's Medi-Cal BIC#.
- Code for whether the client applied for Medi-Cal (yes/no).
- Client's Medi-Cal ineligibility reason code.
- Client's Medi-Cal ineligibility proof code.
- Any other Medi-Cal ineligibility proof code description.
- Identify whether the client qualifies for Medicare within 12 month cycle.
- Client's SSDI income code.
- Client's Medicare Health Insurance Claim number.
- Client's Medicare Part D Premium Payment Program Status
- Client's Medicare Part D Premium Payment Program start date.
- Client's private insurance prescription coverage code.
- Identify whether the client's Creditable Coverage Letter was received.
- Identify the Medicare Plan Year to which Creditable Coverage Letter applies.
- Creditable Coverage Letter date.
- Identify the coordination of benefits (yes/no).
- Identify the COB Match verification status.
- Identify the COB match verification date.
- Identify the eligibility confirmation requested date.
- Identify the eligibility confirmation received date.
- Identify the coordination of benefits with SOC (yes/no).
- Identify and pill splitting (yes/no).
- Identify if the client has ADAP share-of-cost (yes/no).
- Identify the share-of-cost effective date.
- Identify the share-of-cost amount.
- Identify the share-of-cost balance.

- ✱ Identify the diagnosis documentation code.
- ✱ Identify the doctor's internal ID.
- ✱ Identify the grace period begin date.
- ✱ Identify the grace period length in days.
- ✱ Identify the notice-to-reenroll period issued.
- ✱ Identify the notice-to-reenroll begin date.
- ✱ Identify the notice-to-reenroll period length in days.
- ✱ Code for income documentation (may be multiple variables).
- ✱ Federal adjusted gross income.
- ✱ Number of dependents.
- ✱ Eligibility worker code.
- ✱ Public insurance code (i.e., Medicare, Emergency Medi-Cal, Veterans Benefits, Campus, Other, etc).
- ✱ Private insurance code (i.e., Kaiser, Health Net, Blue Cross, Blue Shield, Secure Horizons, Aetna, Cigna, etc.).
- ✱ Eligibility notes (and notes from eligibility worker).

QUALITY ASSURANCE REPORT REQUIREMENTS

In addition to weekly prescription data, the Department will require weekly quality assurance reports that must be reviewed and signed by the contractor. These reports will include the IDSTRING, the name of the data field containing the out-of-range, missing or invalid values, the data contained in that field, and an appropriate error message. Upon execution of the contract, the Office of AIDS may meet with the Contractor to establish acceptable value ranges for additional variables (for example: whether the client has work as a source of income; the client's Medi-Cal eligibility verification status; the pharmacy network type; the suspend codes for a claim; etc.) The report should be listed by the data element reviewed and then by the IDSTRING. Additional data fields that were used to cross-validate the data field reviewed should also be listed. At a minimum, the following fields and conditions should be reviewed (some conditions are unavoidable due to the nature of the program):

A. Client Data Quality Assurance Report

1. **IDSTRING:** If the identification string (a) has less than 9 valid characters, (i.e. first 4 are letters, next 6 represent a known valid birth date, and gender is known), (b) is listed in the Prescription Data Set but not contained in the Client Data Set, or (c) has changed since the last invoice.
2. **ZIPCODE:** If the zip code (a) has less than 5 numeric digits, or (b) is out of the California zip code range (90001 and 96162).
3. **ELGSTART:** If the eligibility start date (a) is over 30 days expired yet received prescriptions for this reporting period, (b) predates the NRLDATE, or (c) antedates the current reporting date.
4. **NRLDATE:** If the enrollment date (a) antedates the current report date, or (b) predates October 1, 1987.
5. **BDATE:** If the birth date (a) does not match the birth date reported in characters 5-10 of the IDSTRING, (b) indicates the client's age is less than 18 or over 75, or (c) has invalid values for the month, day, or year.
6. **GENDER:** If the gender code (a) is not coded as 1, 2, 3, or 4, or (b) does not match the gender component of the IDSTRING.
7. **RACE1:** If the race code (a) is invalid for RACE1, or (b) is coded as a single digit.
8. **RACE2:** If the race code (a) is invalid for RACE2, or (b) is coded as a single digit.
- 9 & 10. **RACE3 & RACE4, respectively:** If the race code in RACE3 or

RACE4 is the same code reported in RACE1 or RACE2.

11. **JURIS:** If the jurisdiction code (a) does not match the jurisdiction component of JURISITE in the Prescription Data Set for the same reporting period, (b) is coded as a single digit, (c) is not included in the most current enrollment site list submitted to OA, or (d) is greater than 61.
12. **SITE:** If the site code (a) does not match the site component of JURISITE in the Prescription Data Set for the same reporting period, (b) is coded as a single digit, or (c) is not included in the most current enrollment site list submitted to OA.
13. **INCOME:** If the income is coded as -1 or greater than \$50,000.
14. **DEPENDS:** None.
15. **MEDICAL:** If the Medi-Cal code (a) is invalid, (b) has a value of 1 but MEDSHCST is reported as zero, or (c) has a value of 2, 3, or 9 but MEDSHCST is reported as an amount greater than zero.
16. **PVTINS:** If the private insurance is invalid.
17. **PUBINS:** If the public insurance is invalid.
18. **SHAMT:** If the ADAP share amount (a) is reported as zero and INCOME is greater than 400% of the FPL, (b) is reported at greater than zero and INCOME is less than 400% of the FPL, or (c) is reported at greater than zero and MEDICAL equals 1.
19. **MEDSHCST:** None.
20. **HIVDXYR:** If the HIV diagnostic year (a) predates January 1982, or (b) antedates the INVDATE or NRLDATE.
21. **AIDSTAT:** If the AIDS status code is reported as 1, 2, or 9 and the CD4COUNT is less than 200.
22. **AIDSDXYR:** None.
23. **CD4COUNT:** If the CD4 count is out-of-range (not between 0 and 1,500).
24. **CD4DATE:** If the CD4 date (a) is reported with a valid date associated with a missing or unknown CD4COUNT, or (b) is reported with a date that predates the ELGSTART by 2 years.
- 25, 26, 27, 28, 29, & 30. **CD4COUNT1, CD4DATE1, CD4COUNT2,**

CD4DATE2, CD4COUNT3, & CD4DATE3, respectively: None.

31. **VLOAD:** If the viral load count is out-of-range (not between 0 and 10,000,000).
32. **VLDATE:** If the viral load date (a) is reported with a valid date associated with a missing or unknown VLOAD, or (b) is reported with a date that predates the ELGSTART by 2 years.
- 33, 34, 35, 36, 37, & 38. **VLOAD1, VLDATE1, VLOAD2, VLDATE2, VLOAD3, & VDATE3, respectively:** None.
39. **CONSENT:** If the signed consent form code (a) is reported other than 1 or 2, or (b) is reported with the value of 2 after 30 days past the ELGSTART.
40. **LANG:** If the language code is not reported as 1, 2, 3, 4, or 5.
41. **UNDOC:** If the undocumented code is not reported as 0 or 1.
42. **ELIGEND:** If the eligibility end date (a) is over 30 days expired yet received prescriptions for this reporting period, or (b) predates the NRLDATE or ELGSTART.
43. **GRSTATUS:** If the grace status is not reported as 0 or 1.
44. **HOMELESS:** If the homeless code is not reported as 0 or 1.
45. **SOURCE:** If the source code is not reported as 0, 1, 2, or 3.

NOTE: The report for the client fields will include the number of missing or unknown values for all fields with the exception of RACE3, RACE4, CD4CNT1, CD4DATE1, CD4CNT2, CD4DATE2, CD4CNT3, CD4DATE3, VLOAD1, VLDATE1, VLOAD2, VLDATE2, VLOAD3, and VLDATE3.

B. Prescription Data Quality Assurance Report

1. **IDSTRING:** Refer to the IDSTRING (Field # 1) in the Client Data Quality Assurance Report above.
2. **NPINABP:** If the pharmacies' NPINABP number is not included in the most current pharmacy listing file submitted to OA.
3. **NDC:** If the NDC (a) contains less than the 11-digit numeric, or (b) is not included in the most current formulary file submitted to OA.
4. **GPI:** If the GPI code is not reported as 0, 1, 2, or 3.

5. **PHSFLAG:** If the public health service price code is not reported as a 1 or 2.
6. **NETCOST:** If the net cost of the drug (a) is less than \$.01, or (b) is greater than 5% of the MRA multiplied by NETUNITS.
7. **NETUNITS:** if the net units of the drug covered by ADAP (a) are less than .5 units, or (b) greater than a 90 day supply.
8. **UNITS:** If the total units of the drug dispensed (a) is less than .5 units, (b) less than NETUNITS, or (c) greater than a 90 day supply.
9. **DAYS:** If the number of days supplied is greater than 90.
10. **MRA:** If the maximum reimbursement amount (a) is 5% above or below the median PHS or non-PHS price, whichever applies, for a given NDC, or (c) is less than \$.01.
11. **D_FEE:** If the dispensing fee (a) is not equal to the contracted rate.
12. **DISPDATE:** If the dispensing date (a) antedates the current reporting date, or (b) predates the current reporting date by six months.
13. **INVDATE:** If the invoice date (a) antedates the date of submission, or (b) extends beyond the contract period.
14. **JURISITE:** If the concatenated jurisdiction and site code (a) is reported without the appropriate leading zeros, or (b) is not included in the latest enrollment site list supplied to OA.
15. **ADPCOPAY:** If the absolute value of the ADAP share-of-cost is of a combined sum greater than the COPAY amount in the Client Data Set dispensed and reported in the same month.
16. **MDCOPAY:** If the MDCOPAY is over \$2,000.
17. **OTHCOPAY:** If the OTHCOPAY is over \$2,000.
18. **RXNUM:** If the prescription number is reported with less than 10-digit number.
19. **GRPNUM:** If the group number reported is not reported as one of the valid codes in the Prescription Data Set Field Definitions (Field #19).
20. **CLAIM_NO:** If the claim number has less than 18 valid characters.

21. BACKOUTNUM: If the backout number has less than 18 valid characters.

22. ADAPSOC: If the ADAP share-of-cost is of a combined sum greater than the COPAY amount in the Client Data Set dispensed and reported in the same month.

NOTE: The report for the prescription fields will include the number of missing or unknown values for all fields.

QUARTERLY AND ANNUAL REPORT REQUIREMENTS

Quarterly (January through March, April through June, July through September and October through December) and fiscal year (July through June) summary reports are required. A copy of this report will be due to the Department 45 days after the last day of the period being reported. These reports should all reconcile to the weekly invoices. At a minimum, these reports must contain the following information:

- Unduplicated number of clients
- Number of clients by gender
- Number of clients by race/ethnic category
- Number of clients by age category
- Number of clients by drug category
- Number of clients by income category
- Number of clients by HIV status
- Number of clients by AIDS status
- Number of clients with Medi-Cal coverage
- Number of clients with private health insurance coverage
- Number of clients with other health insurance coverage
- Expenditure by drug category
- Total expenditures
- Total premiums collected from private insurance
- Total premiums collected from other Insurance
- Total clients ADAP share-of-cost collected
- Number of clients on combination therapy (refer to the Federal Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents for the current definitions of Preferred, Alternative, Not generally Recommended and Not Recommended)
- Number of clients enrolled but never received ADAP services to date

SUPPORT FILE REQUIREMENTS

Electronic support files need to be supplied to the Department at least quarterly. These files include an enrollment site list, a participating pharmacy list, an eligibility worker identification list and the formulary. The formulary should consist of two separate files, one for drug descriptions and one for drug pricing history. As the drug prices change, a new entry should be made in the drug pricing history file indicating the start date for the new price and the previous entry should be modified to indicate the end date for the old price. Drug pricing should be based upon one of three measurements, EACH for tablets and capsules, milliliter (ML) for liquids and gram (GM) for solids. Careful attention must be paid to drug items that are not dispensed in whole units such as a .5 ML vial. Although the drug pricing history file contains the price for 1 whole ML and a client only received one .5 ML vial, then the price invoiced to the Department must be cut in half to reflect the actual amount of drug dispensed. At a minimum these files should contain the following information:

- A. Enrollment Site List
 - 1. JURISITE code (see Client Data Set and Prescription Data Set)
 - 2. Name of site
 - 3. Full street address
 - 4. City
 - 5. State
 - 6. Zip code
 - 7. Telephone number
 - 8. Fax number
 - 9. Contact name
 - 10. Start date
 - 11. End date

- B. Pharmacy Site List
 - 1. NPINABP
 - 2. Name of pharmacy
 - 3. Full street address
 - 4. City
 - 5. State
 - 6. Zip code
 - 7. Telephone number
 - 8. Fax number
 - 9. Contact name
 - 10. Hours of operation
 - 11. PHS indicator (1 = Yes, 2 = No)
 - 12. PHS start date
 - 13. PHS end date
 - 14. JURIS code (county)
 - 15. Start Date
 - 16. End Date

C. Eligibility Worker Identification List

1. Eligibility worker identification number
2. Last name
3. First name
4. Enrollment site
5. Start date
6. Last training date
7. End date
8. Phone number
9. Fax number

D. Drug Descriptions

1. NDC
2. Generic name
3. Brand name
4. Pricing unit (EACH for tablets, capsules; ML for liquids; GM for solids)
5. Dose form (tablet, capsule, patch, vial, etc.)
6. Route of Administration (oral, transdermal, intravenous, topical, etc.)
7. Package size

E. Drug Pricing History

1. NDC
2. Drug pricing
3. Generic indicator
4. Contract price for non-PHS drug unit (see Drug Descriptions, number 4)
5. Contract price for PHS drug unit
6. Price start date
7. Price end date