2018 AIDS Drug Assistance Program Report

Prepared By

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Virginia Department of Health

Executive Summary

The Virginia (VA) Acquired Immunodeficiency Syndrome (AIDS) Drug Assistance Program (ADAP) provides access to life-saving medications for the treatment of HIV and related illnesses for low-income clients with no other access to treatment. The Virginia Department of Health (VDH) had 6,701 clients enrolled in ADAP as of March 2018. This is an increase of 342 clients over the past 12-month period. Clients who adhere to treatment for Human Immunodeficiency Virus (HIV) can achieve long-term viral suppression, which results in the best individual health outcomes and prevents sexual transmission of HIV, reducing new infections. VA ADAP uses the most cost-effective strategy for service provision by purchasing health insurance for the majority of enrolled clients. Providing medications through insurance is key to VA ADAP sustainability and prevents waiting lists for clients needing services. Despite changes in the Affordable Care Act (ACA) Marketplace and a shortened enrollment period, VA ADAP had over 75% of clients enrolled in insurance programs as of March 2018. During the 2018 General Assembly session, the Virginia General Assembly enacted legislation to implement Medicaid expansion on January 1, 2019, which will provide health services access to nearly 61% of currently enrolled VA ADAP clients. VDH is committed to continued program transformation to make optimal use of available resources to support improvements in health outcomes for persons living with HIV and in reducing HIV transmission in the Commonwealth.

Introduction

The VDH administers VA ADAP, utilizing a variety of funding sources, to ensure low-income, uninsured and under insured persons living with HIV (PLWH) have access to medications for treatment of HIV/AIDS. VA ADAP currently serves the majority of clients by securing individual health insurance coverage through the ACA Marketplace. Carriers offering individual ACA Marketplace plans made changes to geographic coverage areas and provider

networks for calendar year 2018, which presented numerous challenges to the program. This report provides an overview of VA ADAP service utilization, efforts to ensure coverage and sustainability of ADAP, and the anticipated impact of Medicaid expansion. The changing landscape will require continued analysis of program infrastructure and strong collaborations with other state agencies, federal partners and community stakeholders.

Background

VA ADAP provides access to life-saving medications for the treatment of HIV and related illnesses for eligible clients through direct provision of medications (Direct ADAP) or by paying insurance premiums and/or medication co-payments for the client. Currently, eligible clients must have household incomes at or below 500% of the federal poverty level (FPL), a documented HIV diagnosis, proof of Virginia residency and be ineligible for Medicaid.

The budget cycle for VA ADAP is the Ryan White (RW) Part B grant year, which runs from April 1 to March 31. Grant years (GY) are named for the calendar year that they begin in. During GY 2010, VA ADAP experienced high pharmaceutical expenditures and unprecedented program utilization compared to the previous two grant years due to rising unemployment rates and corresponding loss of insurance, expanded HIV testing efforts, and new HIV treatment guidelines recommending initiation of HIV treatment as early as possible. In November 2010, VA ADAP instituted aggressive cost containment measures in an effort to balance client demand with available resources. These measures included implementation of a waiting list for VA ADAP services, the transition of some clinically stable patients to other sources of medication access, a reduction to the VA ADAP formulary, and enrollment restrictions. Through implementation of a medical triaging process and increased program and pharmaceutical efficiencies, VDH began enrolling new and wait-listed clients in November 2011 and fully eliminated the waiting list in August 2012.

Currently VA ADAP pays health insurance premiums and medication cost shares (e.g. deductibles, co-payments and co-insurance) for ACA Marketplace and Medicare Part D plans. Ramsell, the contracted Pharmacy Benefits Manager, coordinates a network of over 1,200 retail pharmacies and provides a point-of-service mechanism for prescription drug cost sharing for insured clients. VA ADAP covers only medication co-payments for non-ACA private health insurance plans for medications on VDH's formularies, available on-line at www.vdh.virginia.gov/disease-prevention/formulary/.

Client Enrollment and Utilization

VA ADAP enrollment has more than doubled since 2012 with 6,701 clients enrolled in VA ADAP at the end of GY 2017. Over this time period, there has been a significant shift in service provision, with 78% of VA ADAP clients receiving services through all insurance options and only 22% through direct medication access in March 2018.

Health Insurance and Enrollment for 2018 Coverage

VA ADAP provides assistance for clients to enroll in ACA and Medicare Part D plans during the open enrollment period. In 2017, the ACA open enrollment period was shortened from 90 to 45 days for coverage that began January 1, 2018. In preparation for open enrollment, VDH staff communicated with stakeholders by mail, in-person meetings, phone, email, list servs, web site and social media about ACA offerings, enrollment instructions, client eligibility, enrollment sites and events. Use of highly engaged service providers was key to maximizing client enrollment in 2018. VDH provided guidance and reimbursement to service providers, who made initial premium payments for the first time.

Several health insurance carriers changed geographic coverage areas in 2018. In many parts of Virginia, only one carrier was available for clients (see Figure 1) and about 2,400 ACA

Marketplace clients had to switch carriers for 2018. Some carriers initially did not include adequate HIV medical providers in their networks. VDH staff collaborated with HIV medical providers to identify significant gaps in access to HIV specialty care. In some cases, this collaboration resulted in carriers adding HIV medical providers to their network.

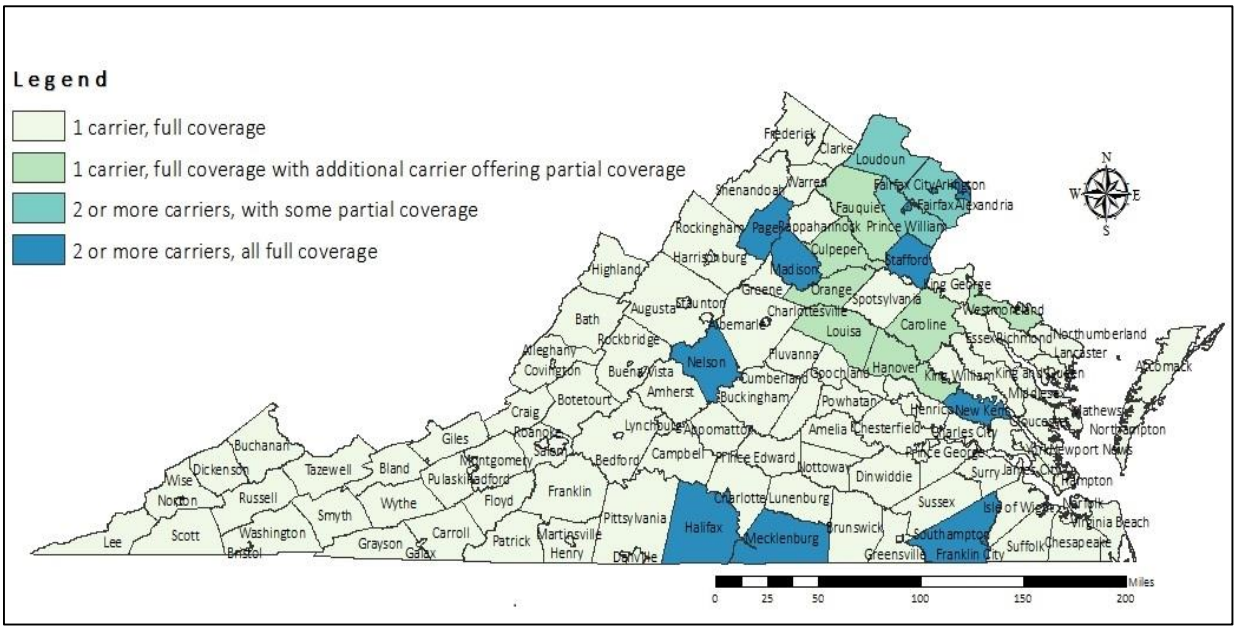

Figure 1: ACA Insurance Plan Coverage by Jurisdiction (2018). Source: Carrier Plan Filings

Due to the shortened enrollment period, VDH prioritized clients who were newly enrolling into ACA and those who were not switching carriers, followed by those who had to switch carriers. Clients who had to switch carriers had a longer, special enrollment period from January 1 through February 28, 2018. At the conclusion of the 2018 open enrollment period, VDH held debriefing sessions to identify best practices, successful remediation of challenges, and improvements for use during the 2019 open enrollment period.

Funding of the VA ADAP Program

GY 2017 VA ADAP funding included the federal formula-based RW Part B and competitive ADAP Emergency Relief Funding (ERF) grants, awarded through the Health

Resources and Services Administration (HRSA), state (general) funds, pharmaceutical rebates and recovery of costs expended for clients that became retroactively Medicaid eligible.

In GY 2017, VA ADAP expended a total of $18.2M for medications, with 62% ($11.2M) of those expenditures supported with federal funds. (Figure 2)

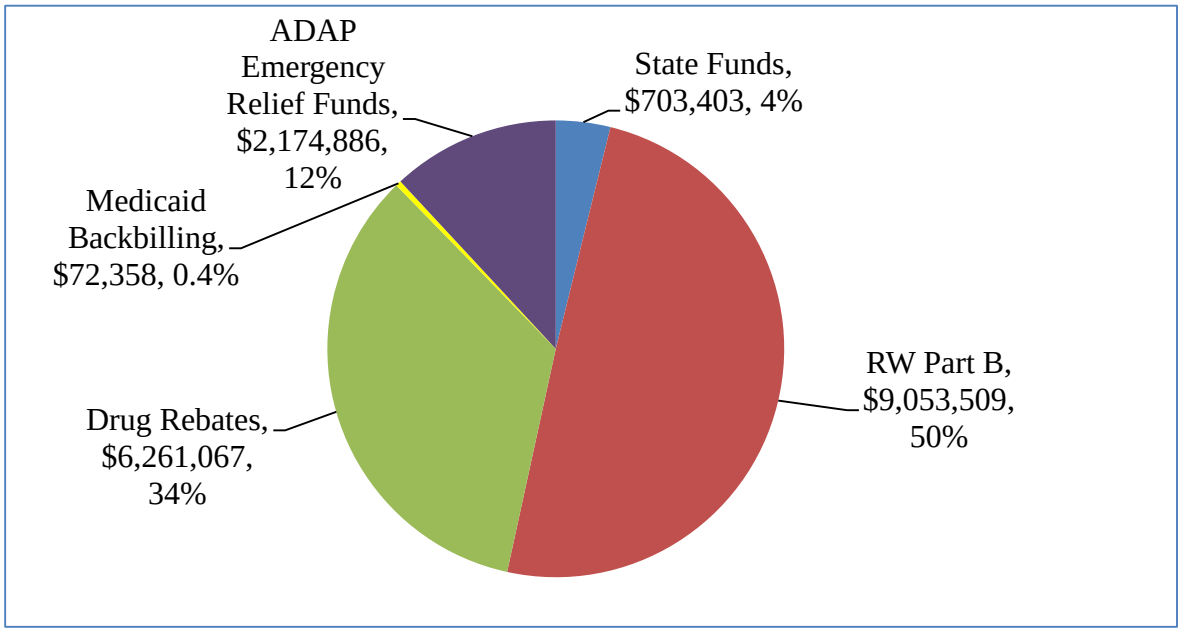

Figure 2. ADAP Medication Expenditures, GY 2017. Source: VA RWHAP B Fiscal Data

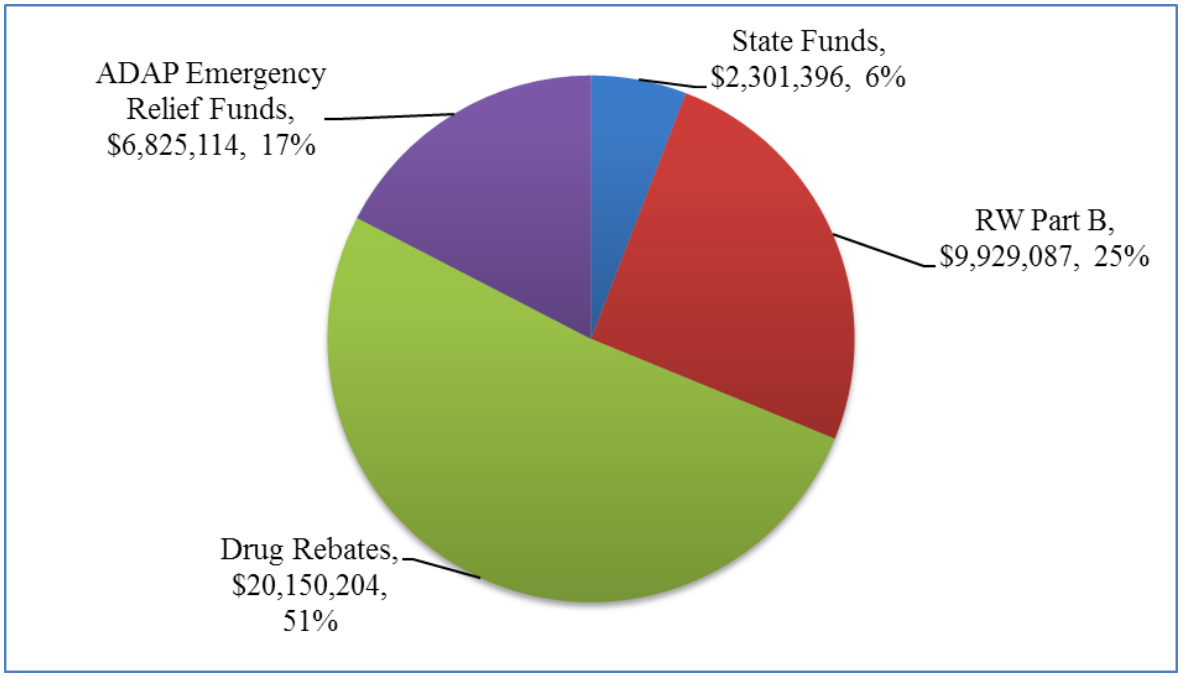

Figure 3. ADAP Insurance Expenditures, GY 2017. Source: VA RWHAP B Fiscal Data

VA ADAP insurance related costs totaled $39.2M in GY 2017. As illustrated in Figure 3, federal funds supported 42% ($16.7M) of insurance-related costs. State funding covered 6% of insurance-related costs, including the $200,000 State Pharmaceutical Assistance Program (SPAP) appropriation. Rebates earned on medication co-payments supported over half of ADAP insurance costs. In response to upcoming Medicaid expansion and changes in the state and federal insurance landscape, continued analysis will be necessary to assess the evolving funding structure supporting VA ADAP.

Program Utilization and Cost Projection

VA ADAP analyzes monthly data on utilization and enrollment for each program option to forecast services and costs. Estimates for future annual client enrollment and services, by GY, use a formula based on a regression analysis of 20 years of historical monthly data. This methodology is necessary to account for variances due to program structure and dis-enrollments. Projections that do not account for monthly variations would result in an under-projection of program costs and over-projection of clients served.

Projections for Medicare Part D and ACA account for the calendar year cost structure of the insurance plans. More specifically, VA ADAP pays higher costs at the beginning of the calendar year and reduced or no costs as the year progresses when deductibles, co-insurance, and maximum out-of-pocket (MOOP) expenditures are satisfied. The projections also account for changes in client eligibility occurring throughout the year and variations in MOOP expenditures based on client income and tax credit eligibility. For example, Medicare Part D has larger client cost outlays in the early part of the calendar year. When clients reach $5,000 in costs for calendar year 2018, the cost outlay reduces to 5% of the medication costs. Most clients with

costly HIV medications reach this limit by March, and Medicare pays 95% of costs for the remainder of the year, resulting in reduced costs to VA ADAP.

ACA cost structures for calendar year 2018 were released in late 2017 and the MOOP expenditures (paid by VA ADAP) for those not receiving any tax subsidies had a ceiling of $7,350 per person annually. Projections for GYs 2018, 2019, and 2020 use the data available for the ACA plans from 2018, as cost structures for 2019, 2020, and 2021 are not yet available. For those currently receiving subsidy tax credits and whose household incomes are between 100% and 250% of the FPL, this MOOP expenditure reduces to a percentage of the client's income and can be as low as $750 annually. Those with incomes between 100% and 400% FPL are eligible for premium subsidies. Those with incomes below 100% FPL and over 400% are not eligible for any subsidies, and ADAP currently pays full premiums and MOOP for those clients. Coverage through insurance is still more cost effective in these cases than purchasing medications due to capped costs and the ability to generate rebates from pharmaceutical companies on medication copayments. With Medicaid expansion, clients under 138% FPL will transition to Medicaid as their source for medications.

VA ADAP used the current FPL distributions of the ADAP population to project subsequent year client cost and utilization. Figure 4 illustrates the FPL distribution by program components in the first four bars (Direct ADAP, MPAP, ICAP and ACA) with the fifth bar showing the distribution for the total ADAP population. The majority of clients for both Direct Purchase ADAP (65.8%) and ACA (54.8%) are at or below 100% FPL.

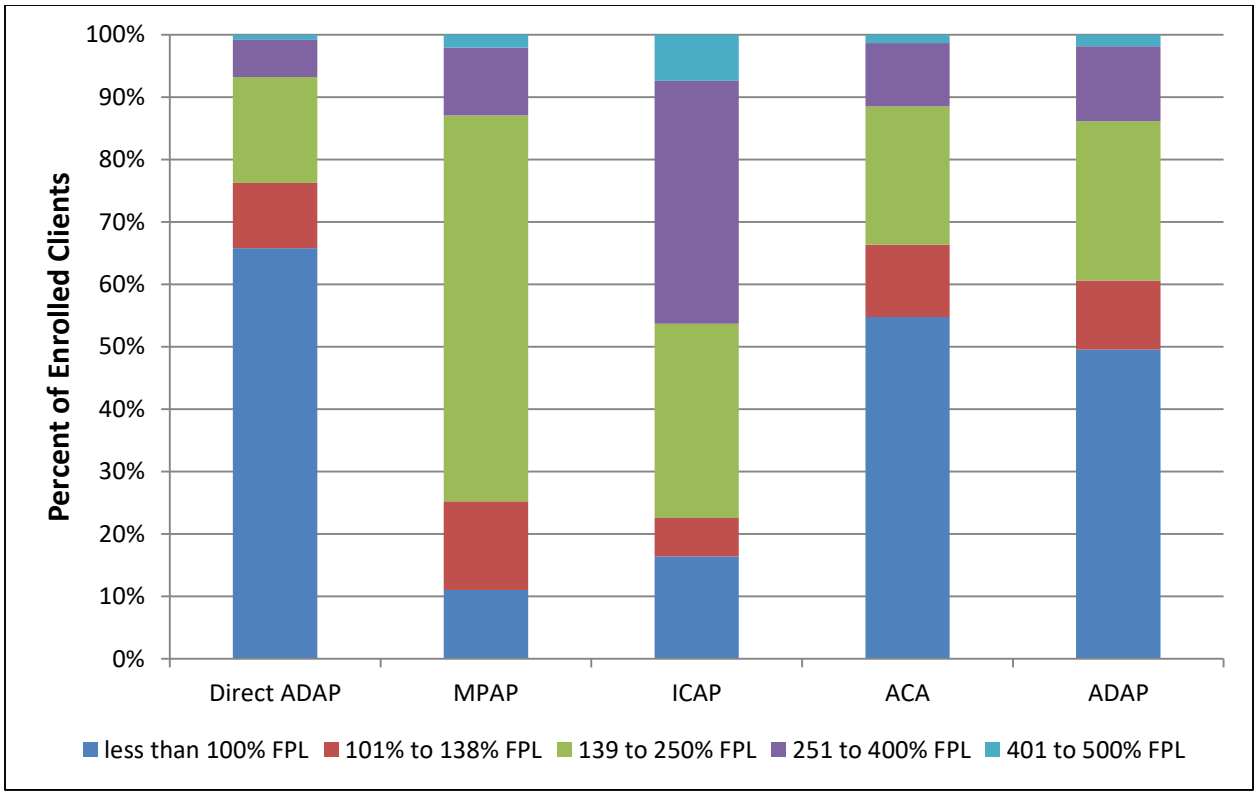

Figure 4: ADAP Enrollment by Program and Income, March 2018. Source: VA ADAP Data

Using the average 2018 ACA costs from the plans supported by VA ADAP, average annual costs for the population below 100% FPL would be $14,061 per client per year ($7,350 out-of-pocket + $6,711 premiums). Pharmaceutical rebates received on cost shares paid for medications reduce this annual cost. The explanations below highlight the assumptions for receiving rebate revenue.

Rebates

Rebates are paid by pharmaceutical companies to state ADAPs through voluntary agreements where full rebates are currently received on partial payments for medications purchased through insurance cost shares with ADAP funding. Rebate terms are negotiated between the ADAP Crisis Task Force, a representative group of state ADAPs, including Virginia, led by the National Alliance of State and Territorial AIDS Directors (NASTAD). Rebates made up 35% of national RW Part B funding in GY 2017 (NASTAD, 2018) and

constituted 46% of VA ADAP medication and insurance-related expenditures in the same period. Additionally, Virginia uses rebates for data systems, staff, service contracts, service expansion projects and other HIV program infrastructure.

Calculating revenue projections from rebates is challenging. Medication prices, the basis for rebates, are proprietary information and pharmaceutical companies do not release this information. There is also a significant lag time in receiving rebates after the initial cost outlay by ADAP. VDH can receive pharmaceutical rebates anywhere from 3 to 18 months after the initial co-payment. These factors make it difficult to project rebate revenue and to determine whether the revenue will be available within a specific grant year.

Cost Projections

VDH completed cost projections for GYs 2018, 2019 and 2020 for 3 different scenarios. Costs associated with ACA plans for the next three calendar years are unknown and will influence projections and subsequent budget needs. The first quarter of the calendar year, which is also the final quarter of the GY, is when the program incurs increased costs due to medication co-payments prior to meeting out-of-pocket limits.

The three scenarios show the impact of potential changes in payer source for ADAP clients. These include: Scenario 1) continuation of ACA in its current form with 10% premium increases in 2019, 2020, and 2021; Scenario 2) implementation of Medicaid expansion in 2019; and Scenario 3) discontinuation of ACA and other insurance, except for Medicare Part D in 2018, with the majority of VA ADAP clients on direct purchase medications. Scenario 1 includes the assumption that overall VA ADAP enrollment will continue to grow at the same rate as in GY 2017, which is a net average of 46 new persons enrolled per month. Scenario 2 assumes that persons eligible for Medicaid, 60.6% of the VA ADAP population, will move to

that program during January through March of 2019 and that growth for VA ADAP will continue at a similar rate, but for a reduced population size, with 17 new persons enrolled per month. Scenario 3 assumes that all persons enrolled in ACA and private insurance switch to direct medication access in April 2019 with Medicare Part D remaining the only insurance option for a limited number of VA ADAP clients.

In GY 2017, one large pharmaceutical company changed the required billing schedule and format for rebates. Figure 5 shows the differences over GY 2018, 2019 and 2020 by month of rebates earned and rebates realized for each scenario, assuming a 12-month lag between the time rebates are earned and when they are realized. Solid lines reflect rebates earned in a month while dotted lines represent rebates realized.

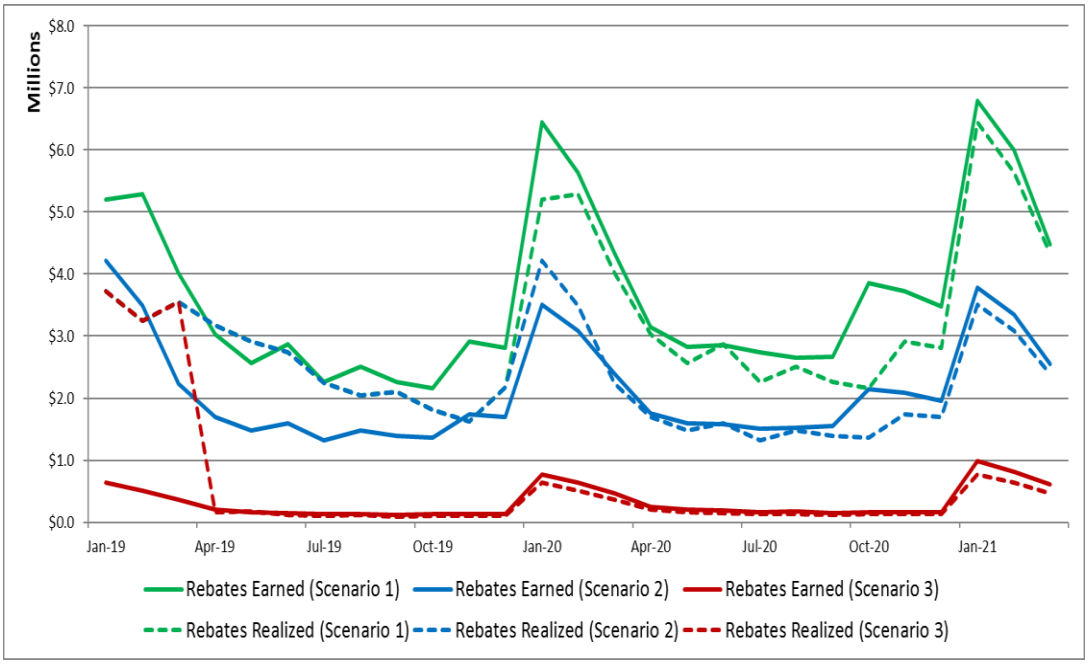

Figure 5: Projected Rebates Earned and Realized, 2019 to 2021. Source: VA ADAP Data

Rebate revenue is highest in Scenario 1 where a significant number of VA ADAP clients remain enrolled in ACA. Rebates earned are reduced in Scenario 2 in 2019 and 2020, with the reduction in rebates realized not occurring until 2020, because of the lag time to receive the rebate funds. This difference will become even more significant in 2021 as fewer people have

insurance under VA ADAP in Scenario 2. Rebates earned and realized in Scenario 3 are significantly lower than the other scenarios because only persons enrolled in Medicare Part D will generate rebate revenue.

Figures 6a, 6b, and 6c show GY costs for each scenario for rebates earned, rebates realized, and costs before rebates. As VA ADAP enrollment decreases from Scenario 1 to Scenario 2, the overall costs decrease in all three GYs, with a decrease of $17.1M in GY 2020 using the rebates earned scenario. Scenario 3 is the costliest with overall program costs after rebates earned of $63.7M in GY 2020. Costs before rebates, shown in Figure 6c, demonstrate a different pattern, with Scenario 1 being the most expensive at $79.4M in GY 2020, demonstrating the importance of rebates in sustaining the program. In all three figures, Scenario 2 is the least costly, as over 60% of the VA ADAP population moves to Medicaid in 2019.

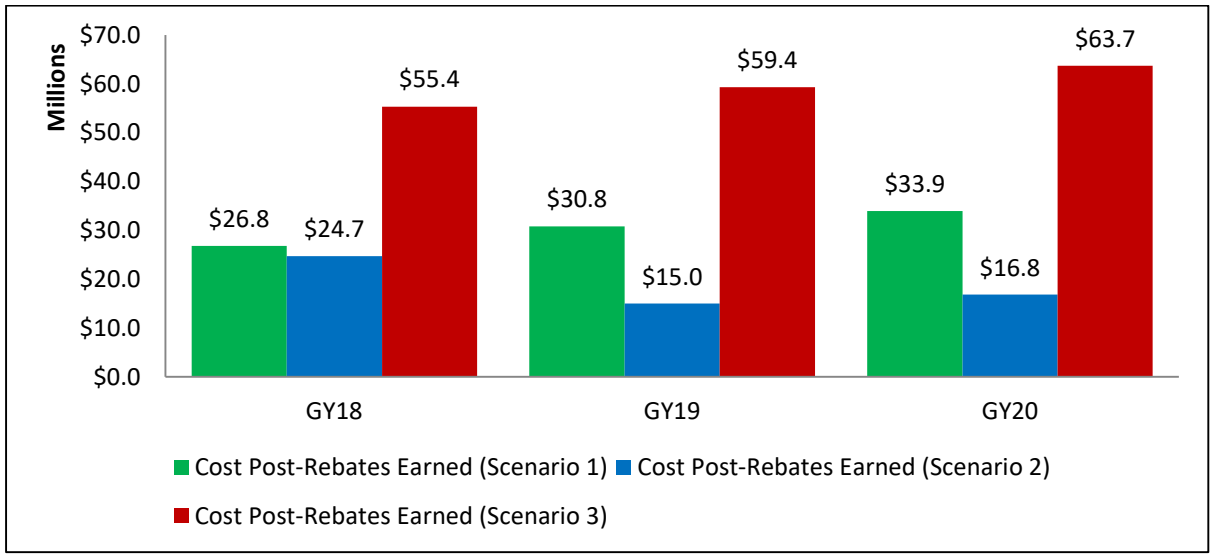

Figure 6a. Projected Costs, Post-Rebates Earned GY 2018 to GY 2020.

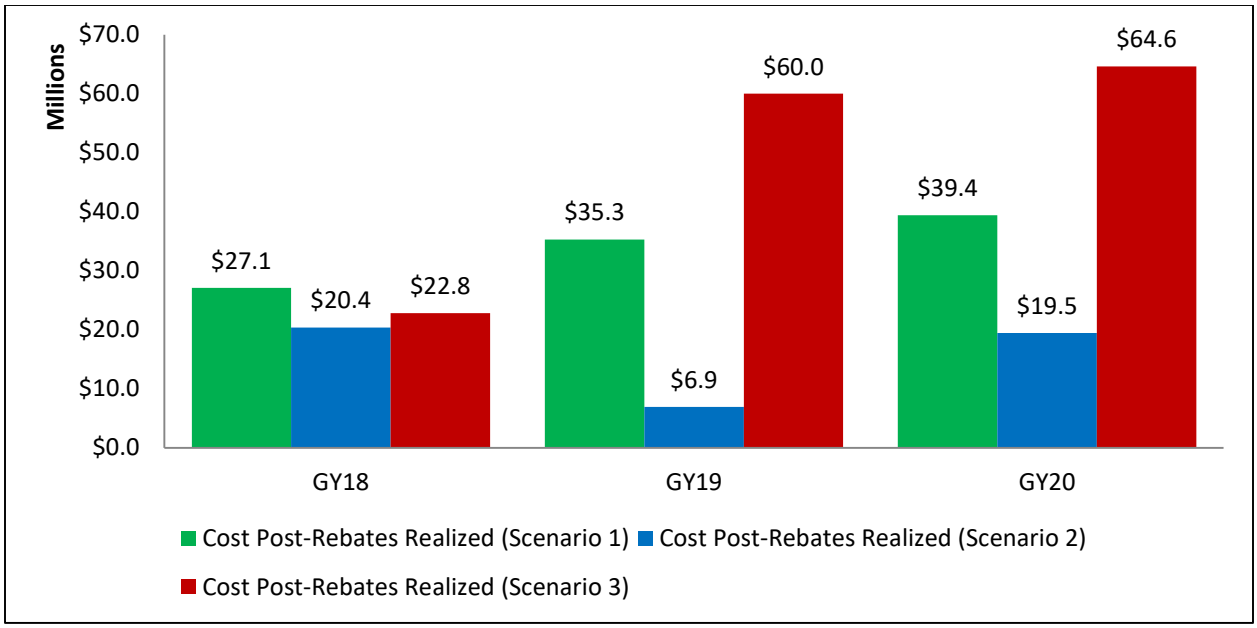

Figure 6b. VA ADAP Projected Costs, Post-Rebates Realized GY 2018 to GY 2020.

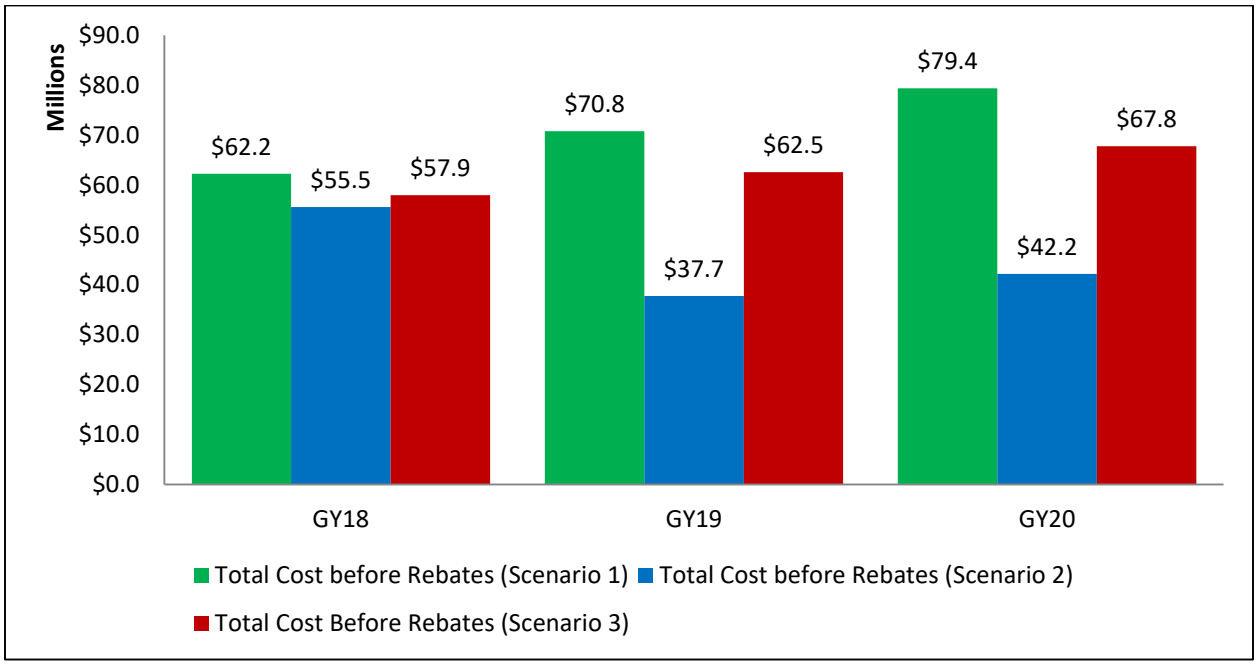

Figure 6c. VA ADAP Projected Costs Before Rebates GY 2018 to GY 2020.
Figure 6a-6c. Source: VA ADAP Data

Monitoring and analytical efforts will continue to support programmatic changes needed to ensure financial stability of the VA ADAP.

Findings

Challenges in the ACA Marketplace

No single carrier provided statewide coverage (see Figure 1) in 2018. Premiums for all carriers increased an average of $200 per month per client from 2017 to 2018. Multiple carriers imposed restrictions limiting accessibility, such as excluding RW service providers from networks and limiting coverage to specific hospitals or facilities. VA ADAP evaluated off-Marketplace coverage and determined it did not offer any advantages over Marketplace plans. Additionally, off-Marketplace plans do not offer tax credits or subsidies.

A carrier asked VDH for additional RW Part B funds to offset costs for providing insurance coverage to ADAP clients. VDH denied the request because HRSA prohibits using RW or ADAP funds to support administration of a health insurance program. Another carrier requested an exclusion to eliminate medical and prescription drug services to clients who received services through government programs, such as ADAP. VA ADAP leadership collaborated with the VA Bureau of Insurance (BOI) and provided guidance indicating these actions were not allowable.

VA ADAP encountered challenges when paying premiums to carriers. Some carriers accepted premium payments but did not apply the payment to the client's account. Carriers changed allowable payment methods (e.g. not accepting credit card payments, restricting the number of client accounts paid by one card) without timely notification. These changes made it extremely difficult for third party payers such as VA ADAP and other RW service providers to make premium payments on behalf of clients. This led to termination of coverage or limited reinstatement opportunity prior to the end of the enrollment period. Carriers eliminated or reduced payment grace periods and provided conflicting information about effective dates for

client policies and premium amounts, resulting in cancelled coverage. VDH will continue to collaborate with stakeholders and other state and federal partners to assess and respond to changes in the ACA Marketplace.

Achievements

VDH automated some functions during the 2018 open enrollment period including electronic submission of insurance enrollment data by contractors and electronic data exchanges for payments. Improved coordination between VDH's Office of Financial Management and Office of Epidemiology Administration facilitated rapid reimbursement to entities that paid the initial premium payments on behalf of VA ADAP clients.

For the first time, VA ADAP issued a request for proposals and contracted with a statewide provider, Benalytics, for large-scale insurance enrollment assistance. Benalytics leadership have more than 25 years of experience in the insurance industry, which enabled them to proactively solve problems such as payment logistics and reinstatement of clients who had coverage incorrectly terminated. Benalytics is also working to improve collaborations with insurance carriers. VA ADAP's Healthcare Reimbursement Specialist developed and instituted a quality assurance process to enhance the accuracy and timeliness for initial premium payments and for ongoing monthly premium payments.

In response to reductions in carriers' HIV medical provider networks, VDH developed a "hybrid model" using RW funds and insurance coverage to avoid disruption of care and improve medication access and adherence. This model is utilized when there is inadequate provider capacity in carrier networks, a waiting list for new clients, and/or the client's travel time exceeds an hour. This HRSA approved approach preserves continuity of care in areas where carrier restrictions created coverage gaps.

Continued work to improve program infrastructure and processes will occur to achieve program compliance with federal requirements, provide clear, consistent guidance to expedite medication access, insurance enrollment, etc., and improve communication within the VA ADAP team and with key partners and clients.

ADAP Sustainability

Multiple factors impact ADAP sustainability including Medicaid expansion, carrier participation in the ACA Marketplace, premium costs, formulary adequacy and pharmaceutical manufacturers' rebates to VA ADAP. VDH monitors changes in insurance medication access (formularies, exception processes, and preauthorization requirements), rebate structure and availability of HIV-related services on a weekly basis to determine whether resources will meet VA ADAP needs. Based on current resources and projected need, VA ADAP has adequate resources to serve all eligible ADAP clients through March 31, 2020.

Medicaid Expansion in Virginia

Medicaid expansion will provide an opportunity for Virginia to increase service access for the prevention and treatment of HIV and co-occurring conditions. Medicaid and RW funded services address many of the social determinants of health, which contribute to preventing new HIV infections. Several facets of Medicaid expansion need assessment to manage the impact on VA ADAP clients. VA ADAP will collaborate with the Virginia Department of Medical Assistance Services (DMAS) on the following:

- Assessment of the impact of any potential work requirement for beneficiaries who have life-threatening, communicable diseases such as HIV or tuberculosis;
- Coordination of Medicaid enrollment to ensure all eligible ADAP clients transition without interruption to access to HIV care and treatment; and,

- Coordination of services to ensure RW can cover services not provided by Medicaid.

VDH senior leadership and DMAS are sharing information on formulary adequacy, HIV specialty care provider networks, numbers of clients to transition and their current insurance enrollment status, and data exchange for medication utilization and HIV outcomes.

Action Steps for VDH towards Medicaid Expansion

VDH is assessing and planning for the fiscal impact of Medicaid expansion on ADAP. Current projections show Medicaid expansion will result in an approximate $17.2M decrease in pharmaceutical rebates earned in GY 2019 (a decrease from $39.9M to $22.7M). VDH will need to leverage all available resources to assure comprehensive HIV-related service provision, including funding for services, such as HIV specific case management, not covered by Medicaid. Case management services for PLWH are a complex set of actions for care coordination to assist clients in accessing quality services and adhering to treatment for optimal health outcomes. Case managers identify client needs and eligibility through a detailed client-centered assessment process. The client and case manager work together to develop the client's care plan. Case managers also educate clients about HIV disease progression, treatment adherence, chronic disease management including the importance of engagement in care, and service availability (VDH, Virginia Department of Health Ryan White Part B Case Management Standards, 2016). VA ADAP anticipates the need to allocate additional funding to support case management. VDH will focus on services that address social determinants to reduce health disparities and inequities related to service access and health outcomes.

VA ADAP will continue to utilize insurance coverage by purchasing ACA-compliant insurance plans for eligible clients and will not support plans that do not offer essential health benefits and adequate formulary coverage. Maintaining insurance enrollment is key to

VA ADAP sustainability because rebates earned on medication co-payments are used to support the program. The program will continue best practices for insurance enrollment including use of enrollment assisters, collaborating with HIV service providers to make initial premium payments for clients, and continuing the use of electronic data exchange for insurance enrollment, premium payments and drug co-payments. VA ADAP is considering paying premiums for private insurance plans, typically provided through employers. Some pharmaceutical manufacturers will not allow rebates unless VA ADAP pays the client's premium.

VDH will continue to request a waiver from HRSA that exempts the program from the legislative requirement to spend 75% of funding for core medical services (e.g. ADAP, medical care). The waiver permits using greater than 25% of funds for support services (e.g. housing, residential substance abuse treatment, food, psychosocial support, and emergency financial assistance) as long as the state can demonstrate that core medical services are covered by other entities in the state without waiting lists. Similarly, VDH will request increased flexibility in use of federal ADAP funds. When a state can demonstrate that medication access needs are met, up to 10 percent of ADAP funds may be used to improve and monitor adherence to HIV treatment medications.

VDH will build ADAP capacity by seeking technical assistance and expert consultation. VDH has requested technical assistance from HRSA and initiated contact with a state operating a similar sized ADAP that recently expanded Medicaid. This peer support helps Virginia assess the impact on programmatic structure, services, and funding, as well as identify best practices for utilizing RW and Medicaid funding. VDH will also contract with a nationally recognized ADAP expert to assess current program policies, procedures and staffing; make recommendations to strengthen current operations and position the program to respond to changes in enrollment and

service needs resulting from Medicaid expansion. The consultant will also work with the program to improve the eligibility and recertification process.

VDH will increase collaboration with providers and clients to improve knowledge about Medicaid and health literacy. The community-based providers and clients took the lead in forming a workgroup focused on preparing for Medicaid expansion. The workgroup will consider strategies used in other states to incentivize Medicaid providers to improve HIV viral load suppression rates. In 2017, 76% of clients receiving RW services (including ADAP) were virally suppressed, compared to 55% of all PLWH in VA. (see Figure 7).

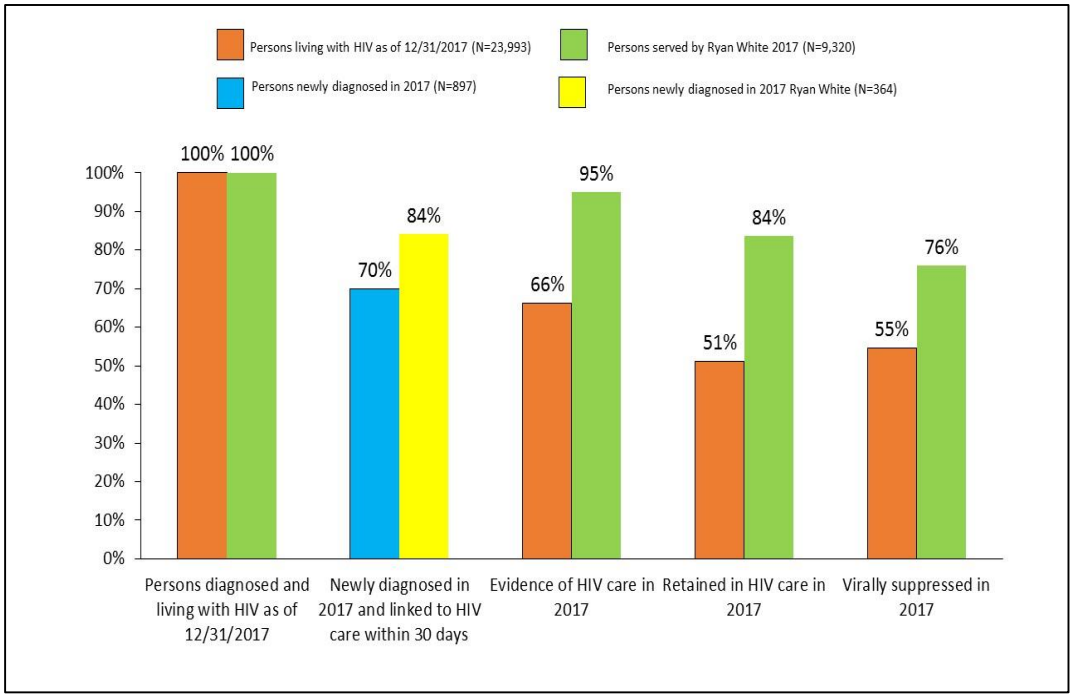

Figure 7: Continuum of Care: PLWH and Ryan White Clients in VA, 2017.
Source: VDH HIV Care Markers Data

Recommendations

Leveraging the resources of both ADAP and Medicaid will improve access to HIV treatment, address social determinants of health, reduce barriers to care, and sustain conditions that support health and well-being. Effective HIV treatment prevents the spread of disease, as those who sustain viral suppression do not transmit the virus through sexual activity. Because of

the increased access it provides, Medicaid expansion is an important step in responding to the HIV epidemic. VA ADAP is working closely with the DMAS to ensure persons living with HIV will not encounter barriers to uninterrupted treatment and care.

Continued, cost-effective health insurance coverage is important for VA ADAP sustainability. Carrier coverage limitations have had an adverse impact on medication and medical services access for PLWH. The VA ACA Marketplace will require robust monitoring and ongoing collaboration between VDH and the BOI to assure access to HIV care, acceptance of all appropriate and allowable payment options for insurance coverage, and to prevent actions that destabilize or negatively affect insurance coverage options for Virginia residents who are living with HIV disease.

Other stakeholders can contribute to the stabilization of essential provider networks for quality HIV care. VDH will continue to confer with the HRSA to encourage all cross-part RW providers to register as essential community providers that are typically included in insurance carrier provider networks.

Comprehensive analysis of VA ADAP is necessary to transform the program to best address the challenges and opportunities of expanded Medicaid, ACA insurance plans and available resources and to achieve maximum operational efficiencies. Effort is needed to ensure resources properly align with program need, essential operations are documented and occur consistently, systems are compliant with agency and federal requirements, and client and stakeholder needs are met.

Conclusion

VA ADAP continues to have a steady growth and currently supports medication access for 6,701 clients living with HIV in Virginia. Medicaid expansion is an excellent opportunity to

improve access to life saving medications and health services for all eligible persons living with HIV. The RW program, including VA ADAP, is needed to provide essential services that Medicaid does not cover, such as oral health services, housing, and case management and to provide coverage if persons become Medicaid ineligible. RW clients have higher rates of retention in care and HIV viral load suppression than other PLWH. Achieving the goal of eradicating HIV/AIDS in Virginia will require senior agency and executive leadership, as well as robust partnerships and cooperation by VDH, HRSA, RW providers, DMAS, clients, insurance carriers, regulatory entities, and other provider agencies.

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List of Acronyms

ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immunodeficiency Syndrome
BOI	Bureau of Insurance
DMAS	Department of Medical Assistance Services
ERF	Emergency Relief Funding
FPL	Federal Poverty Level
GY	Grant Year
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRSA	Health Resources and Services Administration
ICAP	Insurance Continuation Assistance Program
M	Million
MOOP	Maximum Out-Of-Pocket
MPAP	Medicare Part D Assistance Program
NASTAD	National Alliance of State and Territorial AIDS Directors
PLWH	People living with HIV
RW	Ryan White
RWHAP B	Ryan White HIV/AIDS Program Part B
SPAP	State Pharmaceutical Assistance Program
VA	Virginia
VA ADAP	Virginia AIDS Drug Assistance Program
VA RWHAP B	Virginia Ryan White HIV/AIDS Program Part B
VDH	Virginia Department of Health