MIAMI-DADE HIV/AIDS PARTNERSHIP

WELCOME

Thank you for attending today's

Miami-Dade HIV/AIDS Partnership Meeting

Please sign in to have your attendance recorded.

Scan the QR Code for meeting materials.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Monday, June 1, 2026
10:00 AM – 12:00 PM

Behavioral Science Research Corporation
2121 Ponce de Leon Boulevard, Suite 215, Coral Gables, FL 33134

AGENDA

I.	Call to Order	Harold McIntyre
II.	Introductions	All
III.	Housekeeping	Harold McIntyre
IV.	Floor Open to the Public	Joanna Robinson
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of April 20, 2026	All
VII.	Reports	
	A. Membership	Staff
	B. Committee Reports on Action Items	
	▪ Care and Treatment Committee (16 Motions)	Dr. Diego Shmuels
	▪ Joint Integrated Plan Review Team (Strategic Planning and Prevention Committees) (2 Motions)	Virginia Muñoz
	▪ Executive Committee, Community Coalition Roundtable, and Housing Committee (No Motions)	
	C. Grantee/Recipient Top Line Summaries	
	▪ Ryan White Part A/MAI	Carla Valle-Schwenk
	▪ Ryan White Part B	Report on File
	▪ General Revenue at SFAN	Angela Machado
	▪ AIDS Drug Assistance Program (ADAP)	Dr. Javier Romero
	▪ Housing Opportunities for Persons With AIDS (HOPWA)	No Report
	D. Approval of Reports (1 Motion)	All
VIII.	Standing Business	
	▪ None	
IX.	New Business	
	▪ 2026 Ryan White Conference – Partnership Member Attendance	
	▪ July and August Meeting Dates and Report for Action Briefing Dates	
X.	Announcements and Open Discussion	All
XI.	Next Meetings (Dates pending New Business discussion)	Joanna Robinson
	▪ Report for Action Meeting Briefing via Teams, July 2, 2026	
	▪ Partnership Meeting, July 6, 2026	
XII.	Adjournment	Harold McIntyre

Please mute or turn off all cellular devices.
For more information about the Miami-Dade HIV/AIDS Partnership, please contact Christina Bontempo, (305) 445-1076 x106 or cbontempo@behavioralscience.com.
Follow Us: www.PartnershipMiami.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership

Meeting Housekeeping Miami-Dade HIV/AIDS Partnership

Updated February 2026

Behavioral Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

BEHAVIORAL SCIENCE RESEARCH

Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Please mute all electronic devices.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business fairly.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.
- All attendees may address the board as time allows and at the discretion of the Chair.
- Only Partnership members vote at today's meeting.

Language Matters!

In today's world, there are many words that can be stigmatizing. Here are a few suggestions for better communication.

Remember **People First** Language . . .

People with HIV, ***People*** with substance use disorders, ***People*** who are unhoused, etc.

Please don't say **RISKS** . . . Instead, say **REASONS.**
Please don't say, **INFECTED with HIV** . . . Instead, say **ACQUIRED HIV, DIAGNOSED with HIV,** or **CONTRACTED HIV.**

Please **do not** use these terms . . .

Dirty . . . Clean . . . Full-blown AIDS . . . Victim . . .

Resources

- Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- Today's presentation and supporting documents are online at www.partnershipmiami.org, or by scanning the QR code on your agenda.

Floor Open to the Public

“Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns.

“BSR has a dedicated line for statements to be read into the record. No statements were received.”

Miami-Dade HIV/AIDS Partnership Meeting
Florida Department of Health - Health District Center
1350 NW 14th Street, Conference Room 401B, Miami, FL 33125
April 20, 2026, Minutes

#	Partnership Members	Present	Absent
1	Burks, Laurie Ann	x	
2	Dougherty, James	x	
3	Duberli, Francesco		x
4	Forrest, David		x
5	Gonzalez, Nilda		x
6	Henriquez, Maria	x	
7	Jones, Keddrick	x	
8	Machado, Angela		x
9	McIntyre, Harold	x	
10	Medina, Jesús E.		x
11	Muñoz, Virginia		x
12	Robinson, Joanna	x	
13	Romero, Javier	x	
14	Sarria, Manuel		x
15	Shmuels, Diego	x	
16	Tazoe, Roberto	x	
17	Tramel-McIntyre, Alecia		x
18	**Vacant** Representative of the Affected Community		
19	**Vacant** Representative of the Affected Community		
20	**Vacant** Representative of the Affected Community		
21	**Vacant** Representative of the Affected Community		
22	**Vacant** Representative of the Affected Community		
23	**Vacant** Representative of the Affected Community		
24	**Vacant** Hospital or Health Care Planning Agency Representative		
25	**Vacant** Housing, Homeless or Social Service Provider		
26	**Vacant** Mental Health Provider Representative		
27	**Vacant** Other Federal HIV Program Grantee Representative (SAMHSA)		
28	**Vacant** Ryan White Program Part D Representative		
29	**Vacant** Other Federal HIV Program Grantee (Part F)		
30	**Vacant** MDC Government Representative (Non-RWP)		
Quorum = 7			
Ex-Officio Representatives			
Representative from the Office of the Miami-Dade County (MDC) Mayor			
Representative from the MDC Board of County Commissioners			
Representative from the MDC School Board			

Guests
Belledent, Nelly
Brown, Dedra
Creebsburg, Moniet
Eldanaf, Amal
Ferrer, Luigi
Gonzalez De Obando, Tivisay
Gonzalez, Yvette
Riley, James
Valle-Schwenk, Carla
Vaughn Sannita
Wall, Daniel T.
Wynn, Joey
Staff
Bontempo, Christina
Ladner, Robert
Smith, Terrence A., Esq.

Note: All documents referenced in these minutes were accessible to members and the public prior to and during the meeting, at www.partnershipmiami.org/the-partnership-2/.

I. Call to Order

The Chair, Harold McIntyre, called the meeting to order at 10:09 a.m., and reviewed the agenda topics and meeting documents.

II. Introductions

Mr. McIntyre asked for introductions by members and guests. Those arriving late also introduced themselves.

III. Housekeeping/Meeting Rules

Mr. McIntyre and Vice Chair, Joanna Robinson, read the Housekeeping slides, including reminders of code of conduct, language matters, and resource persons.

IV. Floor Open to the Public

Ms. Robinson opened the floor to the public with the following statement:

"Pursuant to Florida Sunshine Law, I want to provide the public with a reasonable opportunity to be heard on any item on our agenda today. If there is anyone who wishes to be heard, I invite you to speak now. Each person will be given three minutes to speak. Please begin by stating your name and address for the record before you talk about your concerns. BSR has a dedicated telephone line as well as a general email address for statements to be read into the record. No statements were received via the telephone line or email."

There were no comments; the floor was then closed.

V. Review/Approve Agenda

Members reviewed the agenda and there were no changes.

Motion to approve the agenda as presented.
Moved: Keddrick Jones **Seconded: James Dougherty** **Motion: Passed**

VI. Review/Approve Minutes of March 2, 2026

Members reviewed the minutes of March 2, 2026, and there were no changes.

Motion to approve the minutes of March 2, 2026, as presented.
Moved: Dr. Diego Shmuels **Seconded: Keddrick Jones** **Motion: Passed**

VII. Reports

A. Membership

Staff reminded members of the new on-boarding and mentorship process. Every attendee was given a copy of the new Committee Membership application to assist with recruitment. Mr. McIntyre and Ms. Robinson spoke about their experiences attending the March and April Prevention Committee and Strategic Planning Committee meetings and emphasized the need for people living with HIV to be involved in decision-making at those meetings.

James Dougherty offered to send staff information to assist with filling the vacancy for the Grantee Representatives of Other Federal HIV Programs (SAMHSA) seat on the Partnership.

B. Committee Reports

The motions below were brought to the Partnership for their consideration. Additional committee activities were detailed in the *Committee Reports to the Miami-Dade HIV/AIDS Partnership,* distributed to members, and included in the materials posted online. Details regarding the motions were included in the report and are noted *in italics* prior to the motions.

- **Executive Committee**

Ms. Robinson put forward the motions from the Executive Committee.

The Committee has been working on edits to the document for several months. Of note, the Membership Application and On-Boarding Process sections were updated to reflect the changes approved last month; Meetings were updated to include details on cancellation policies; Parking was updated to reflect various meeting locations; references to aidsnet.org were updated to PartnershipMiami.org; and clarifying language and general edits were made throughout as needed. Shared reference copies were available at the meeting, and members passed them around to review.

Motion as accept the Policies and Procedures Manual as presented.
Moved: Joanna Robinson Seconded: Keddrick Jones Motion: Passed

The Committee reviewed and approved the Staff Support FY 2026-27 Scope of Work Deliverables, included as an addendum to BSR's Staff Support contract.

Motion to accept the Staff Support FY 2026-2027 Scope of Work Deliverables as presented.
Moved: Joanna Robinson Seconded: Dr. Diego Shmuels Motion: Passed

- **Care and Treatment Committee**

Dr. Diego Shmuels put forward the motions from the Care and Treatment Committee.

The Committee continued its work on contingency planning in response to ADAP funding cuts, including consideration of recommendations from the Medical Care Subcommittee. The Subcommittee focused contingency planning on changes to the Oral Health Care Formulary. The Subcommittee reviewed utilization data and recommendations from former Oral Health Care Workgroup members. Based on their review, to sustain some oral health services, the Subcommittee made cost containment recommendations addressing the current annual client expenditure cap and implants.

The current annual oral health care expenditure cap is $6,500 per client per year. A range of $1,500 to $2,000 for the cap was discussed. The lower cap ($1,500) is closer to the average cost per client last year. The higher cap ($2,000) would allow clients to access dentures, which are a more costly item. The cap level will be selected depending on what the expenditure level is at the time of implementation.

Since funding levels are expected to be lower than past years, the Committee recommends an allowance for an expenditure cap override for those clients whose treatment may require treatment exceeding the annual cap, subject to funding availability.

It was noted that all the motions refer to Ryan White Program Oral Health Care services.

Motion, as part of the contingency planning to address ADAP changes, to remove implants from the Ryan White Oral Health Care formulary.
Moved: Dr. Diego Shmuels Seconded: James Dougherty Motion: Passed

Motion, as part of contingency planning, to reduce the oral health care cap to between $1,500-$2,000, depending on the rate of expenditures at the time of implementation.
Moved: Dr. Diego Shmuels Seconded: James Dougherty Motion: Passed

Motion, as part of contingency planning and subject to availability of funds, for urgent or emergency circumstances that an annual expenditures cap override be developed by the Office of Management and Budget and that Oral Health Care subrecipients will provide information on whether or not the service is an emergency; if it affects function; the consequences of delay in treatment; and a treatment plan of care.
Moved: Dr. Diego Shmuels Seconded: James Dougherty Motion: Passed

C. Grantee/Recipient Reports

Members received the Top Line Summary Report and copies of the referenced expenditure and utilization reports.

- **Ryan White Part A/Minority AIDS Initiative (MAI)**

Carla Valle Schwenk advised attendees on the FY 2025 Part A/MAI contracts, the FY 2026 Part A/MAI and Ending the HIV Epidemic (EHE) contract extensions, the Health Resources and Services Administration (HRSA) EHE site visit, the Miami-Dade County Ryan White Program Public Outreach Campaign, and the 2026 AIDS Drug Assistance Program (ADAP) changes, as detailed in the Top Line Summary Report.

The County has been authorized to send eight representatives to the National Ryan White Conference in August. The Partnership Chair and Vice Chair, a peer navigator, and County and BSR staff will attend.

Dan Wall reported on the County's response to the ADAP funding crisis. ADAP medication coverage and medication copay and deductible assistance is ongoing for individuals with incomes up to 400% of the Federal Poverty Level. There are stop-gap measures in place to extend coverage through June 2026.

Biktarvy has been removed from the ADAP and Ryan White prescription drug formularies. The County is working with Gilead to make the patient assistance program (PAP) easier to access. People taking Biktarvy are encouraged to submit a letter from their doctor with their PAP documents explaining the importance of them being on that drug. There is also discussion on clarifying that ADAP is not insurance, and clients should not be denied PAP coverage based on ADAP status.

Pending budget decisions from the Florida Department of Health (FDOH) in Tallahassee include lowering the FPL eligibility rate, elimination of Affordable Care Act (ACA) premiums, and removal of Biktarvy.

The state is expected to hold a special budget session to discuss FDOH-Tallahassee's response to the ADAP crisis, including making ADAP whole again; adding language to make FDOH restore ACA coverage; requiring FDOH to provide a monthly report of proposed changes to the ADAP Formulary; and to improve collaboration.

Mr. McIntyre asked about how people leaving jail or prison should go about getting medications. Ms. Valle-Schwenk noted the resources on the County's website and will find out if there is still a jail linkage coordinator working to help formerly incarcerated persons.

Yvette Gonzalez asked about the implications of not getting Biktarvy for pregnant women. Mr. Wall suggested writing a letter to the House and Senate representatives alerting them of this concern as this is not currently part of the discussion.

- **Ryan White Part B and General Revenue (GR) at SFAN**

The Chair called for a motion to defer the reports until the next meeting since the representatives were not present.

Motion to defer the Ryan White Part B and General Revenue (GR) at SFAN reports until the next meeting.
Moved: Dr. Diego Shmuels **Seconded: James Dougherty** **Motion: Passed**

- **AIDS Drug Assistance Program (ADAP) Miami**

Dr. Javier Romero noted ADAP data for March 2026, including the number of clients served, and the cost of pharmacy expenditures. Pharmacy expenditures were higher in February due to clients picking up 3-month supplies of medications in anticipation of ADAP funding cuts. Also noted, there were no payments made in March for ACA premium expenditures since the state has discontinued that funding.

ADAP is sending non-qualification letters to clients to alert them of programmatic changes, though some clients have not received letters. Clients are urged to enroll in the ACA Marketplace during the special enrollment period ending April 30, 2026.

As noted in the Part A/MAI report, legislation and budgeting around ADAP changes is still pending.

- **Housing Opportunities for Persons with AIDS (HOPWA)**

Roberto Tazoe reported that the City received $14.7 million for HOPWA funding which is still a deficit for the upcoming year. Although the City has received $25 million dollars in federal grant funds. Nonetheless, the program is not sustainable at the current housing rates, and the US Department of Housing and Urban Development is not supportive of funds being used towards long-term housing or permanent housing. The White House has suggested to completely eliminate HOPWA funding, and the County and City are monitoring those budget proposals.

The City of Miami Public Hearing on HOPWA funding is being held on April 29; details are posted online.

D. Approval of Reports

Mr. McIntyre called for a motion to approve all reports.

Motion to accept the Membership, Grantee/Recipient, and Committee Reports as presented.
Moved: Joanna Robinson **Seconded: Keddrick Jones** **Motion: Passed**

VIII. Standing Business

There was no standing business.

IX. New Business

- **2026 Ryan White Conference – Partnership Member Attendance**

The Partnership may send two representatives who are people living with HIV to the Ryan White Conference. Generally, representatives are the Chair and Vice Chair of the Partnership. Mr. McIntyre asked if there were any objections to the representatives being himself and Ms. Robinson. As there were no objections, Mr. McIntyre called for a motion.

Motion to approve Harold McIntyre and Joanna Robinson to represent the Partnership at the 2026 Ryan White Conference.
Moved: Dr. Diego Shmuels **Seconded: Keddrick Jones** **Motion: Passed**

- **Revised Minutes of May 12, 2025**

Staff announced that in the review of the approved Minutes of May 12, 2025, an approved motion was missed. Members had a copy of the corrected minutes. Mr. McIntyre called for a motion to approve the minutes as corrected.

Motion to approve the revised minutes of May 12, 2025.
Moved: Maria Hernadez **Seconded: Dr. Javier Romero** **Motion: Passed**

X. Announcements and Open Discussion

Keddrick Jones asked about housing assistance and expressed concerns about the lack of guidance from Salvation Army case managers.

Dedra Brown announced the group Diamonds in the Rough which is in its third year supporting women with HIV. Ms. Brown will send additional details to staff for promotion through the Partnership's website, PartnershipMiami.org.

Staff showed the County's new website and the Support Groups page on PartnershipMiami.org on the meeting screen.

XI. Next Meeting

The next meetings are scheduled for Friday, May 29, 2026, Report for Action Meeting Briefing via Teams; and Monday, June 1, 2026, for the Partnership meeting at the Florida Department of Health – Health District Center, Room 410.

XII. Adjournment

Mr. McIntyre thanked everyone for participating and adjourned the meeting at 11:46 a.m.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Committee Applicant Mentoring Opportunity and Next Steps

1 Complete the Committee Application

Once your application is received, you're ready for the next steps.

2 Request a Mentor

If you want additional guidance before committing, just let us know. You can choose to work with a Community Coalition Roundtable Mentor or a Committee Mentor from your chosen committee for as long as you like until you're ready to join.

3 Save the Date for your Next Meeting

Find the dates of your next meeting on the Partnership Calendar at www.partnershipmiami.org/calendars/, or on the Partnership Webpage at www.partnershipmiami.org/the-partnership-2.

4 RSVP

Let us know you're coming! You can RSVP through the Partnership Calendar, the Partnership Webpage or by sending an email to mdcpartnership@behavioralscience.com.

5 Join

When you're ready to join, please let Partnership Staff or your Committee Mentor know and we'll finalize your on-boarding at your next meeting. Remember to RSVP! *Welcome to the Partnership!*

MIAMI-DADE HIV/AIDS PARTNERSHIP

Committee and Subcommittee Membership Application

This is the membership application for the committees and subcommittees of the Miami-Dade HIV/AIDS Partnership, Miami-Dade County's Ryan White Program Planning Council.

Our vision is to eliminate barriers and disparities, improve health outcomes, and create a healthier, empowered Miami-Dade County for all people living with, impacted by, or vulnerable to HIV. If you share this vision and have a reputation for integrity, community service, and a demonstrated interest in the field of HIV, you are invited to join!

Your commitment for membership includes:

- Monthly meeting preparation, attendance, and participation.
- Completion of Partnership and/or Miami-Dade County training and annual filing requirements.

1. Are you registered to vote in Miami-Dade County?

❑ **Yes.** ❑ **No.** ❑ **I'm not sure.** *Committee and Subcommittee applicants **must be registered to vote** in Miami-Dade County. Please confirm or update your voter status before completing this application.*

2. Contact Information

First Name: _____ Middle Initial: _____ Last Name: _____

Email: _____

Your email will be added to the Partnership listserv and will be used for regular Partnership correspondence.

Home Address: _____

Home or Cell Phone: _____ May we text this phone? ❑ Yes ❑ No

Employer (if applicable): _____

Business Address: _____

Business Phone Number: _____ May we text this phone? ❑ Yes ❑ No

Are you an officer, employee, representative, or consultant to any Ryan White Program Part A funded service provider? ❑ Yes ❑ No ❑ I'm not sure

3. Demographic Information

Sex: ❑ Male ❑ Female

Language(s) I speak: ❑ English ❑ Spanish ❑ Haitian Creole ❑ Other (please specify)_____

Race/Ethnicity: ❑ White/Non-Hispanic ❑ Black/Non-Hispanic ❑ Hispanic ❑ Asian/Pacific Islander ❑ American Indian/Alaska Native ❑ Other (please specify)_____

Date of Birth: _____

Your initials here	I understand that Partnership Staff will use this information to confirm my voter information from the website https://registration.dos.fl.gov/en/CheckVoterStatus/Index.

4. **Committees and Subcommittees of Interest** *Check all that apply.*

- □ Care and Treatment Committee *Service guidelines, Annual Needs Assessment, funding allocations.*
- □ Community Coalition Roundtable *Member recruitment and community engagement.*
- □ Housing Committee *HOPWA housing and related programs.*
- □ Medical Care Subcommittee *Medical standards of care and HIV medications. Seat:_____(e,g, MCM,MD)*
- □ Prevention Committee/Joint Integrated Plan Review Team *HIV/STI testing, prevention activities, integrated planning.*
- □ Strategic Planning/Joint Integrated Plan Review Team *Program assessment, annual reporting, integrated planning.*

5. Disclosure of Personal Health Information Authorization

This authorization shall become valid immediately and shall remain in effect until revoked.

Meaningful involvement of people with HIV/AIDS is a cornerstone of Partnership and committee membership.

- I am applying for membership as a person with HIV. ❑ **Yes** ❑ **No**

  ❑ **I prefer not to disclose my HIV status.** *I understand that I will be considered for membership in other membership categories, provided there is an open seat, and I meet the qualifications for that seat.*

- I, (print your full name) _____, understand that if I wish to be considered for membership as a person with HIV it is necessary to identify my HIV status. By signing this authorization, I willingly disclose my HIV status.

Signature: _____ Date: _____

Your initials here	I understand that this information will become public record and ***may*** be discussed in open, public meetings. The Florida Government in the Sunshine Law requires open discussion in a public forum. In addition, I further understand that by signing this release, I waive any exemptions of the information concerning my HIV status pursuant to Chapter 119.07 of the Florida Statutes. My status will be released to anyone who requests a copy of this document.
Your initials here	I further understand that I may revoke this authorization to disclose my HIV status, in writing, prior to my application being considered at the next committee or subcommittee meeting. However, I understand that the information may have already been disclosed on the basis of this authorization.
Your initials here	I authorize the release and exchange of information about my HIV status among and between the Miami-Dade County Office of Management and Budget-Grants Coordination, the Office of the Mayor of Miami-Dade County, the Miami-Dade County Office of the Inspector General, the Miami-Dade HIV/AIDS Partnership, the United States Office of Inspector General, the United States Department of Health and Human Services, and Behavioral Science Research Corporation.

Cancellation Of Disclosure Authorization

I wish to cancel this Disclosure of Personal Health Information Authorization. I understand that I am entitled to a copy of this canceled Authorization.

Signature: _____ Date: _____

6. Signature and Next Steps

Bring your completed application to a meeting or send by:

- Mail: Behavioral Science Research Corporation (BSR), Attn: Staff Support, 2121 Ponce de Leon Boulevard, Suite 240, Coral Gables, FL 33134;
- Email: mdcpartnership@behavioralscience.com; or
- Fax: (305) 448-3325.

Please contact Partnership staff at (305) 445-1076 or mdcpartnership@behavioralscience.com, if you need assistance.

Upon receipt of your application, BSR staff and/or a Community Coalition Roundtable mentoring member will contact you to review next steps for membership. Following that review, your application will go before the committee or subcommittee to which you have applied. You are required to attend the meeting of that committee or subcommittee to introduce yourself and state your interest in serving as a member.

I, (print your full name) _____, certify I have thoroughly read this application and will abide by the rules and regulations governing the Miami-Dade HIV/AIDS Partnership. I further certify that all the statements made in this application are true and correct.

Signature: _____ Date: _____

Application valid for 6 months from this date.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

May 21, 2026

The Miami-Dade HIV/AIDS Partnership

The official Ryan White Program Planning Council in Miami-Dade County and the Advisory Board for HIV/AIDS to the Miami-Dade County Mayor and Board of County Commissioners.

Opportunities for Ryan White Program Clients

5 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*

Opportunities for General Membership

5 *seats are open to people with HIV, service providers, and community stakeholders who have reputations of integrity and community service, and possess the relevant knowledge, skills and expertise in these membership categories:*

Hospital or Health Care Planning Agency Representative
Housing, Homeless or Social Service Provider
Other Federal HIV Program Grantee Representative (Part F)
Other Federal HIV Program Grantee Representative (SAMHSA)
Non-Ryan White Program Miami-Dade County Representative

Are you a Member?

Thank you for your service to people with HIV!
Be sure to bring a Ryan White client to your next meeting!

Do You Qualify for Membership?

If you answer "Yes" to these questions, you could qualify for membership!

Are you a resident of Miami-Dade County?

Are you a registered voter in Miami-Dade County?
Note: Some seats for people with HIV are exempt from this requirement.

Can you volunteer three to five hours per month for Partnership activities?

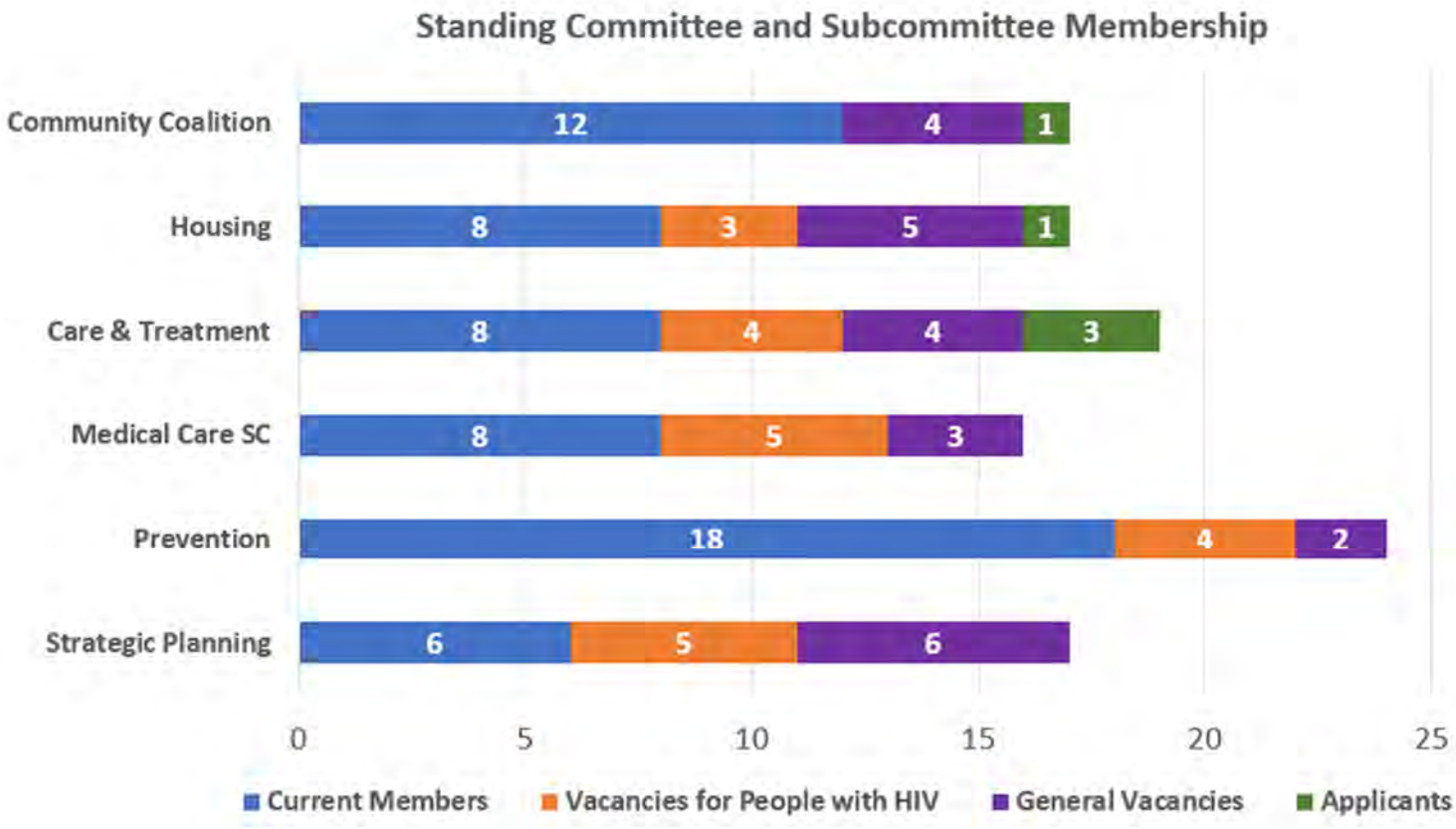
Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

MEMBERSHIP

Committees

Work with a dedicated team of volunteers on these and more Partnership activities to better serve people with HIV in Miami-Dade County!
People with HIV are encouraged to join!

- Allocate more than $27 million in Ryan White Program funds with the **Care and Treatment Committee**
- Develop an Annual Report on the State of HIV and the Ryan White Program in Miami-Dade County with the **Strategic Planning Committee**
- Recruit and train new Partnership members with the **Community Coalition**
- Work with the City of Miami Housing Opportunities for Persons with AIDS Program to address housing challenges for people with HIV/AIDS with the **Housing Committee**
- Oversee updates and changes to medical treatment guidelines for the Ryan White Part/ MAI Program with the **Medical Care Subcommittee**
- Set priorities for Ryan White Program HIV health and support services in Miami-Dade County with the **Care and Treatment**
- Share a meal and testimonials at Roundtables with the **Community Coalition**
- Develop and monitor the official HIV Prevention and Care Integrated Plan with the **Strategic Planning Committee** & **Prevention Committee**
- Develop your leadership skills and be a committee leader with the **Executive Committee**
- Oversee updates and changes to the Ryan White Prescription Drug Formulary with the **Medical Care Subcommittee**
- Develop and monitor local Ending the HIV Epidemic activities with the Florida Department of Health in Miami-Dade County with the **Prevention Committee** & **Strategic Planning Committee**
- Be in the know about the latest HIV activities of the Prevention Mobilization Workgroups with the **Prevention Committee**



Committee Reports to the Miami-Dade HIV/AIDS Partnership for the June 1, 2026, Meeting

This report contains nineteen (19) motions and an overview of each committee's activities for the meeting date(s) indicated. Members are encouraged to review materials in advance.

The complete report is posted online at https://partnershipmiami.org/the-partnership-2/#partnership1.

Partnership members will receive a copy of this report and supporting documents at the meeting.

- Referenced documents/attachments will be included immediately following the corresponding motion(s), with page numbers indicated.
- Documents longer than 20 pages will be made available at the meeting as shared reference copies.

For additional information, contact mdcpartnership@behaviroalscience.com.

CARE AND TREATMENT COMMITTEE *16 MOTIONS*
MAY 14, 2026

Activities

- Heard reports from Parts A and the Medical Care Subcommittee including several motions.
- Heard updates on the Florida Comprehensive Planning Network.
- Discussed special projects, but will focus on monitoring ADAP changes.
- Reviewed several edits to service descriptions that were delayed because of contingency planning.
- Discussed a proposed service description protocol.
- Reviewed and approved recommendations on the carryover request for FY 2026

Removing Biktarvy from the Ryan White Part A Prescription Drug Formulary **(FY 2026-27 Contingency Planning in Response to ADAP Funding Cuts)**	
1	**Background**
	The Subcommittee began reviewing and updating the Ryan White Part A Prescription Drug Formulary, including the removal of discontinued items, addition of new ARV Sulenca per formulary protocol, and edits to some medications. Since the ADAP Formulary has removed Biktarvy, the Ryan White Formulary must also remove the medication since paying for it would rapidly deplete funds allocated for medication assistance. Clients who need assistance paying for Biktarvy are encouraged to ask for samples from doctors and to apply for Patient Assistance Program assistance. The Committee concurred with the Subcommittee and made the motion retroactive to March 1, 2026, when ADAP removed the medication from their formulary. After the meetings, it was announced that Biktarvy may be restored to the ADAP Formulary. Therefore, the motion to remove Biktarvy from the Ryan White Formulary will need to be reconsidered by the committee.
	Motions
	1. Motion to table the removal Biktarvy from the Ryan White Part A Prescription Drug Formulary, retroactive to March 1, 2026, for reconsideration by the Care and Treatment Committee, pending final ADAP funding legislation.

FY 2026-27 Service Descriptions	
2-11	**Background**
	Medical Care Subcommittee and Care and Treatment Committee members reviewed several service descriptions and approved the edits. (Drafts in red-lined versions may appear distorted because of formatting, and they will be corrected in the final draft.) **See the Shared Reference Copy binder.**
	Motions
	2. Motion to accept the FY 2026 Ryan White Program Mental Health Services Description and Substance Abuse Outpatient Care and Substance Abuse Services (Residential) Service Description as presented as presented.
	3. Motion to accept the FY 2026 Ryan White Oral Health Care Service Description as presented.
	4. Motion to accept the FY 2026 Ryan White Program AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program-LPAP) Service Description as presented.
	5. Motion to accept the FY 2026 Ryan White Program Outpatient Ambulatory Health Services Description as presented.
	6. Motion to accept the FY 2026 Ryan White Program Emergency Financial Assistance Service Description as presented.
	7. Motion to accept the FY 2026 Ryan White Program Food Bank Service Description as presented.
	8. Motion to accept the FY 2026 Ryan White Program Medical Transportation Service Description as presented.
	9. Motion to accept the FY 2026 Ryan White Program Health Insurance Service Description as presented.
	10. Motion to accept the FY 2026 Ryan White Program Outreach Service Description as presented.
	11. Motion to accept the FY 2026 Ryan White Program Medical Case Management, including Treatment Adherence Service Description as presented.

Oral Health Care Standards	
12	**Background**
	Edits to the Oral Health Care Service Standards were discussed and were incorporated into the draft that was presented. **See pages 4-9 of this report.**
	Motions
	12. Motion to accept the FY 2026 Ryan White Program Oral Health Care Standards as presented.

Miami-Dade County Ryan White Program
Oral Health Care Standards

Standard 1: Oral health care providers shall ensure that all staff has sufficient education, knowledge, skills and experience to competently serve the ~~HIV/AIDS~~ Ryan White Program client population: initial orientation and training for new staff shall be provided and all staff shall participate in ongoing ~~HIV/AIDS~~HIV- related topics trainings.

	Standards of Care	Measure
Standard 1.1	All oral health care staff will possess appropriate licenses, credentials and expertise; experience working with ~~HIV/AIDS~~Ryan White Program clients is desirable.	• Copy of current license for each staff person, with provider number, as required by Florida law: copies of current required operational licenses as required by Florida law. • Documentation of work experience (letters of recommendation, work references, etc.)
Standard 1.2	Policies and procedures.	Written policies and procedures manuals.
Standard 1.3	Newly hired staff will receive orientation within one month of hire, including training on Ryan White Program eligibility and service requirements.	Documentation of completed orientation on file including documentation of training on Ryan White Program eligibility and service requirements.
Standard 1.4	~~Ongoing a~~Annual ~~HIV/AIDS~~ staff training on HIV topics related to dental care.	Documentation of all completed annual trainings on file.

Standard 2: Clients receiving services meet Ryan White Program eligibility requirements and are informed of their rights per Ryan White Program standards.

	Standard	Measure
Standard 2.1	Ryan White Program client eligibility screening and demographics present.	• Proof of HIV status, financial eligibility, permanent residency in Miami-Dade County OR • Current Ryan White Program In Network Referral or Out of Network referral with documentation. • Demographics include at a minimum: address, phone number, emergency information, age, race/ethnicity and ~~gender~~sex.

Standard 2.2	Ryan White Program required documents present, signed, and dated.	• Signed and dated *Ryan White Program Integrated Consent form in the data management information system)* OR current Ryan White Program In Network Referral • ~~Documentation that *Outreach Consent/Miami-Dade County Notice of Privacy Practices and Composite Consent* were provided.~~
Standard 2.3	General Consent for Treatment	Signed general consent for treatment present.

Standard 3: All clients shall have a completed initial medical history with updates as appropriate; medical conditions and allergies are noted; an oral health history is taken.

	Standard	**Measure**
Standard 3.1	Initial Comprehensive Medical History	• There is an initial comprehensive medical history including medications and conditions affecting diagnosis and management of oral health care. • The initial comprehensive medical history is signed and dated by the client and dentist.
Standard 3.2	Medical History is updated at least once a year.[a]	Medical history is updated every 6 months or at the next appointment after six months (including labs, if needed). An undetectable viral load is not required to provide oral health services.
Standard 3.3.	Medical conditions and allergies are noted.	• Medical conditions and/or medications requiring an alert are flagged. • Allergies/ no known allergies (NKA) are noted.
Standard 3.4	An oral health history is taken and updated at least once a year.[a]	Oral health history is taken that includes problems with or reactions to anesthesia, specific or chief complaints (if any), problems with previous treatment (if any).

Standard 4: Documentation across providers shall reflect, at a minimum, services provided including procedure codes, treatment plans, examinations, charting grids, informed consents, refusal of treatment, and periodontal maintenance.

	Standard	Measure
Standard 4.1	Treatment assessment and planning developed and/or updated at least once a year. [a]	Completed treatment plan is in the progress notes OR a treatment plan form is completed.* **If clients access oral health services for episodic care only, documentation in treatment notes will reflect clients were advised to return for examination and a treatment planning appointment. If client does not present for this appointment, documentation in client's chart of advice to return for planning may serve as treatment plan.*
Standard 4.2	Documentation reflects services provided.	Documentation, at a minimum, includes: • Date of service • Tooth number, if appropriate • Service description • Procedure code billed • Anesthetic used including strength and quantity • Materials used, if any • Prescriptions or medications dispensed, including name of drug, quantity, and dosage • Education provided • Signature and title

Standard 4.3	A comprehensive examination is provided*at least annually. *Not applicable for episodic care, follow up, or problem-focused examinations. **OR** A problem-focused oral examination is performed.	Comprehensive Examination includes: • Cavity charting • Complete periodontal exam or periodontal screening record • Documentation of restorations & prosthesis • Full mouth radiographs, as clinically indicated • Pre-existent conditions • Disease presence • Structural anomalies • Oral hygiene instruction • Prescriptions or medications dispensed including name of drug, quantity, and dosage • Education provided Problem-focused examination includes: • Chief complaint is documented • Problem-focused evaluation is performed • Prescriptions or medication dispensed include name of drug, quantity, and dosage • Radiographs as necessary • Specific oral treatment plan • Education provided • Return for further evaluation documented
Standard 4.4	Charting grids are completed as appropriate.	Charting of the examination findings/treatment is completed in the appropriate tooth grids.
Standard 4.5	Informed specific consents are present for each oral surgery procedure.	A signed, informed, specific consent is present for all oral surgery procedures that includes the risks, benefits, alternatives, and consequences of not having the procedure.

Standard 4.6	Refusal of treatments/radiographs is documented.	• Client refusal for treatment/radiograph is documented (form or in progress note) with licensed dental provider signature, client signature or initials and date; signature and date of witness are present. • Reason for ~~l~~icensed dental provider refusal to perform a requested treatment is documented; signature and date of witness are present.
Standard 4.7	Periodontal screening or examination is done at least once a year.[a]	Charting of the examination findings/treatment is documented in the client record.
Standard 4.8	Periodontal maintenance is regularly performed.* *Not applicable for clients who are "No shows" AND "No show" is documented; not applicable for episodic care.	Periodontal maintenance is performed according to the treatment plan or at the next appointment, if later than six months.
Standard 4.9	Oral health education offered at least once a year.[a]	Education documented in the client record.

Standard 5: Client care and referrals shall be coordinated with other care providers, as appropriate.

	Standard	**Measure**
Standard 5.1	Treatment provided for oral opportunistic infection (when indicated) is coordinated with client PCP.* *Not applicable if no oral opportunistic infection (OI) Dx/treatment documented.	Documentation reflects treatment provided for oral OI and coordination with PCP.
Standard 5.2	Referral and coordination of care.* *Not applicable if no condition documented and no referral made. Tobacco use and referral.* *NA for clients not using tobacco products. Nutritional problems and referral.* *Not applicable when no indication of nutritional problems.	• Documentation in client record of the condition and referral to a specific specialty or ancillary service provider. • Documentation of heavy tobacco use and referral to a tobacco counseling program. • Documentation of nutritional problems and referral to a nutritionist for nutritional counseling.

Standard 6: Clients shall receive education in preventive oral health practices; tobacco, and nutritional counseling as appropriate.

	Standard	Measure
Standard 6.1	Education will be provided in preventive oral health practices[1] including hygiene, nutritional education[2] as related to oral health care and education, as appropriate, concerning tobacco use[3]. [1]Not applicable for episodic care. [2]Not applicable for episodic care. [3]Not applicable if no indication of tobacco use; not applicable for episodic care.	• Documentation of education in preventive oral health practices including hygiene is provided every six months or at next appointment if later than six months. • Documentation of nutritional education as related to oral health. • Documentation of education, as appropriate, concerning tobacco use.

[a] Reflects Health Resources and Services Administration (HRSA) HIV/AIDS Bureau Core Performance Measures for Oral Health Care

Letters of Medical Necessity	
13-14	**Background**
	The Subcommittee reviewed two letters of medical necessity and made edits to both. The Letter of Medical Necessity for Continuous Glucose Monitors included updating language and a review of possible costs for specific devices. Instead of selecting a specific device, just the brand names will be listed with additional language on use of cost-effective options, as shown in the draft. Language on the Letter of Medical Necessity for Extension of Occurrences of Food Bank Services was edited for clarity. The Committee concurred with both motions and approved the documents. **See pages 11-13 of this report.**
	Motions
	13. Motion to accept the FY 2026 Ryan White Program Letter of Medical Necessity for Continuous Glucose Monitors as presented.
	14. Motion to accept the FY 2026 Ryan White Program Nutritional Assessment for Extension of Occurrences of Food Bank Services as presented.

FY 2026 Carryover Requests	
15-16	**Background**
	The Committee reviewed the FY 2026-2027 Carryover request for Ryan White Part A and Minority AIDS Initiative (MAI) funding. At the time of the Committee's decisions, only estimated total funds were available so percents were allocated. Under Ryan White Part A, the total estimated carryover percent was placed into Food Bank whose allocation for FY 26 was about 35% of the total expended last year. Under MAI, the estimated carryover totals were allocated to top two usage categories, Medical Case Management and Outpatient/Ambulatory Health Services, both of which may need additional funding. **See pages 14-15 of this report.**
	Motions
	15. Motion to allocate 100% of the FY 2026-27 Ryan White Part A Carryover request to Food Bank Services.
	16. Motion to allocate 50% of the FY 2026-27 Ryan White MAI carryover requests to Medical Case Management and 50% to Outpatient/Ambulatory Health Services.

This concludes the Care and Treatment Committee Report.

RYAN WHITE PROGRAM
Letter of Medical Necessity for
Continuous Glucose Monitoring (CGM) Devices
Dexcom ~~G6®~~ or FreeStyle ~~Libre 2®~~

Client's Full Name

~~Prescriber Full Name~~Date of Birth

~~Preferred Name~~Prescriber Full Name

Prescriber License# (M.D., D.O., P.A., A.P.R.N)

~~Date of Birth~~Prescriber Telephone #

~~Prescriber Telephone #~~

I certify my client has the following diagnosis (please check ONE), requires a continuous glucose monitoring device, and meets all the following criteria:

1) Diabetes~~Insulin~~ treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and

2) ~~Insulin~~ Diabetes treatment regimen requires frequent adjustment based on blood glucose meters or continuous glucose monitors; and

3) Six months prior to ordering (CGM), I have had an in-person visit with the client to evaluate their diabetes control.

Type I diabetes mellitus
□ Dexcom* ~~G6~~ or □ FreeStyle* ~~Libre 2~~

Type II diabetes mellitus
□ FreeStyle* ~~Libre 2~~

***The most cost-effective version must be selected. If the client wishes to use their smart phone, no reader is required.**

Every six months following receipt of the initial prescription for the CGM, I will have an in-person visit with the client to assess adherence to their CGM regimen and diabetes treatment plan.

Prescriber Signature and Date

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Services Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and

medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

Approved 5/16/2022;Revised xx/xx/2025~~5~~6

RYAN WHITE PROGRAM
Nutritional Assessment Letter for Extension of Occurrences of Food Bank Services

This letter is required for additional Food Bank occurrences beyond the annual twenty (20) occurrences (visits)
To be completed by licensed medical prescriber or registered dietitian* or licensed nutritionist* (*not associated with the Part A food bank provider)

Client's Full Name:_____

Licensed Medical Prescriber attestation:
As prescriber for this client, it is my professional opinion that they require an extension of food bank services.

_____
Licensed Medical Prescriber Signature and Date

_____ _____
Printed Name of Licensed Medical Prescriber **License # (MD, DO, PAs, APRN)**

OR

Registered dietitian or licensed nutritionist attestation:
As the nutritional professional who has completed an assessment for this client, it is my professional opinion that they require an extension of food bank services.

_____
Registered Dietitian or Licensed Nutritionist Signature and Date

_____ _____
Printed Name of Registered Dietician or Licensed Nutritionist **Registered Dietitian or Licensed Nutritionist License #**

Number of Additional Occurrences Requested (**maximum sixteen (16)** additional occurrences within the current Ryan White Part A fiscal year): _____ ~~which will assist with~~to maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

The client has the following **severe** change of status (check all that apply):

□ New HIV-related diagnosis/symptom (please describe) e.g., OI, AIDS diagnosis, etc._____
□ Wasting Syndrome
□ Protein imbalance
□ Recent chemotherapy
□ Recent hospitalization
□ Other medical reasons:
_____

Please note: All questions should be directed to the Office of Management and Budget-Grants Coordination/Ryan White Program, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee (physician, nurse, registered dietitian, etc.). Pursuant to the most current Professional Services Agreement for Ryan White Program-funded services, the service provider must make available to Miami-Dade County access to all client charts (including electronic files), service utilization data, and medical records pertaining to this Agreement during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

APPROVED:2-28-24;revised x-xx-26

MIAMI-DADE COUNTY - RYAN WHITE PART A

FY 2026-27 (YR 36) CARRYOVER ALLOCATION FUNDING REQUEST

YR 36 RANKING ORDER [1]	SERVICE CATEGORIES	CORE/SUPPORT	YR 36 ALLOCATIONS [2]	CARRYOVER RECOMMENDATIONS (BY PERCENTAGE) [3]
2	MEDICAL CASE MANAGEMENT	**CORE**	$ 5,869,052	
3	AIDS PHARMACEUTICAL ASSISTANCE	**CORE**	$ 88,255	
4	OUTPATIENT/AMBULATORY HEALTH SRVS.	**CORE**	$ 8,847,707	
5	ORAL HEALTH CARE	**CORE**	$ 3,088,975	
6	HEALTH INSURANCE SERVICES	**CORE**	$ 595,700	
7	MENTAL HEALTH SERVICES	**CORE**	$ 132,385	
8	EMERGENCY FINANCIAL ASSISTANCE	SUPPORT	$ 88,253	
9	FOOD BANK	SUPPORT	$ 529,539	100%
10	MEDICAL TRANSPORTATION	SUPPORT	$ 154,449	
12	SUBSTANCE ABUSE OUTPATIENT CARE	**CORE**	$ 44,128	
13	OUTREACH SERVICES	SUPPORT	$ 264,696	
14	SUBSTANCE ABUSE RESIDENTIAL	SUPPORT	$ 2,169,744	
17	OTHER PROFESSIONAL SERVICES (LEGAL)	SUPPORT	$ 154,449	
	SUBTOTAL		**$ 22,027,332**	**$ 364,000**
	CLINICAL QUALITY MANAGEMENT		$ 600,000	
	ADMINISTRATION (10%) [4]		$ 2,514,148	
	GRAND TOTAL		**$ 25,141,480**	**$ 364,000**

	YR 36 Partial Award [5] (Breakdown by Funding Source)
Formula Funding	**$ 6,854,286**
Supplemental Funding	**$0**
MAI Funding	$ 692,181
YR 36 Total 1st Partial Award	**$ 7,546,467**

NOTES:

[1] YR 36 ranking order is based on the Partnership's Needs Assessment allocation for FY 2026 which includes non-funded services. Please see attached for the complete list of prioritized core medical and support services for this jurisdiction.

[2] Provisional award letters currently include contract base amounts approved by the Board of County Commissioners through Resolution NO. R-246-20, as a result of RFP RW-DS-0320; and extended through February 28, 2027 under Resolution No. R-96-26. CORE Services Total = $18,666,202 (85%); SUPPORT Services Total = $3,361,130. (15%).

[3] The Recipient is currently in the grant closeout process, and a finalized carryover amount is not yet available. The estimated amount of carryover is presented above. To assist with this process, we are requesting that percentages and service category allocations be approved during this meeting for application to the final carryover amount, which will be presented at the June 2026 Partnership meeting.

[4] Administration includes Partnership (Planning Council) and Program Support Costs.

[5] The Recipient has received a partial award. Once the final award is received, a reallocation action will be presented to allocate funds up to the final awarded amount.

Updated for: 05/14/2026

MIAMI-DADE COUNTY RYAN WHITE PART A

FY 2026-27 (YR 36) MINORITY AIDS INITIATIVE (MAI) CARRYOVER FUNDING ALLOCATION

YR 36 RANKING ORDER [1]	SERVICE CATEGORIES	CORE/SUPPORT	YR 36 ALLOCATIONS [2]	CARRYOVER RECOMMENDATIONS (BY PERCENTAGE) [3]
1	MEDICAL CASE MANAGEMENT	**CORE**	$ 903,920	50%
3	MENTAL HEALTH SERVICES	**CORE**	$ 18,960	
4	OUTPATIENT/AMBULATORY HEALTH SVS	**CORE**	$ 1,362,753	50%
5	MEDICAL TRANSPORTATION	SUPPORT	$ 7,628	
9	EMERGENCY FINANCIAL ASSISTANCE	SUPPORT	$ 12,087	
12	SUBSTANCE ABUSE OUTPATIENT CARE	**CORE**	$ 8,058	
21	OUTREACH SERVICES	SUPPORT	$ 39,816	
	SUBTOTAL		**$ 2,353,222**	**$ 1,380,000**
	CLINICAL QUALITY MANAGEMENT		$ 100,000	
	ADMINISTRATION (10%)		$ 260,057	
	GRAND TOTAL		**$ 2,713,279**	**$ 1,380,000**

YR 36 Partial Award [5] (Breakdown by Funding Source)

Formula Funding	$ 6,854,286
Supplemental Funding	**$0**
MAI Funding	**$ 692,181**
YR 36 Total 1st Partial Award	**$ 7,546,467**

NOTES:

[1] YR 36 ranking order is based on the Partnership's Needs Assessment allocation for FY 2026 which includes non-funded services. Please see attached for the complete list of prioritized core medical and support services for this jurisdiction.

[2] Provisional award letters currently include contract base amounts approved by the Board of County Commissioners through Resolution No. R-246-20, as a result of RFP RW-DS-0320; and extended through February 28, 2027 under Resolution No. R-96-26. CORE Services Total = $2,293,691 (97%); SUPPORT Services Total = $59,531 (3%).

[3] The Recipient is currently in the grant closeout process, and a finalized carryover amount is not yet available. The estimated amount of carryover is presented above. To assist with this process, we are requesting that percentages and service category allocations be approved during this meeting for application to the final carryover amount, which will be presented at the June 2026 Partnership meeting.

[4] Administration includes Partnership (Planning Council) and Program Support Costs.

[5] The Recipient has received a partial award. Once the final award is received, a reallocation action will be presented to allocate funds up to the final awarded amount.

Updated for: 05/14/2026

JOINT INTEGRATED PLAN REVIEW TEAM (JIPRT) *2 MOTIONS*
(STRATEGIC PLANNING AND PREVENTION COMMITTEES)
MAY 19, 2026

2027-2031 Miami-Dade County Integrated Prevention and Care Plan	
17-18	**Background**
	The Strategic Planning and Prevention Committees completed a read-through of the Integrated Plan Sections 1, 2, 4, 6, and 7. The revised draft and Sections 3 and 5 were posted separately for additional feedback. The draft was updated with the understanding that there will be final formatting and editing prior to the June 30, 2026, submission date. The Letter of Concurrence is included as Section 7 of the Plan and requires the signature of the Partnership Chair. **See the Shared Reference Copy binder for the complete Plan.** **See pages 17-18 of this report for the Letter of Concurrence.**
	Motions
	17. Motion to approve the final draft of the 2027-2031 Miami-Dade County Integrated Prevention and Care Plan in its substantially complete form, subject to final administrative edits.
	18. Motion to approve the Letter of Concurrence as presented and to authorize the Partnership Chair to sign the letter.

This concludes the JIPRT Report.

EXECUTIVE COMMITTEE
MAY 25, 2026

Activities

- Reviewed 4th Quarter FY 2025 Planning Council Expenditures.
- Began review of the *Bylaws*.

HOUSING COMMITTEE AND COMMUNITY COALITION ROUNDTABLE
Both Committees have not met since the April Partnership meeting.

APPROVAL OF REPORTS *1 MOTION*

This motion should be put forward following Grantee/Recipient Top Line Summaries.

Approval of Reports	
19	**Motion**
	Motion to accept the Membership, Grantee/Recipient, and Committee Reports as presented.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Addendum 1

June 1, 2026

Ms. Jenifer Gray
HRSA Project Officer
Division of Metropolitan HIV/AIDS Programs - HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Gray:

The Miami-Dade HIV/AIDS Partnership (Partnership), the local Ryan White Program Planning Council, concurs with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County, Florida (Integrated Plan)*. This submission is in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, for calendar years 2027 through 2031. This concurrence is specific to the local Integrated Plan only and does not provide concurrence with the statewide Integrated HIV Prevention and Care Plan.

The Partnership's Strategic Planning and Prevention Committees met jointly and as stand-alone committees in publicly noticed meetings on November 18, 2025, and January 22, February 17, March 10, March 26, April 14, April 30, and May 19 in 2026, to review Integrated Plan drafts and supporting data, and to recommend revisions. The final draft in its substantially complete form – subject to final minor administrative edits – was presented to the Partnership for ratification on June 1, 2026.

Following discussions and recommendations from these meetings and other feedback opportunities, draft Integrated Plan documents were produced. The Florida Department of Health in Miami-Dade County (FDOH-MDC) and Miami-Dade County Office of Management and Budget Ending the HIV Epidemic initiatives were also incorporated in the Integrated Plan goals and objectives. Drafts were posted for public access and comment throughout this process. Development of this updated Integrated Plan has been an intensive and collaborative effort between the Partnership; FDOH-MDC; OMB - the Ryan White Part A/MAI/EHE Program Recipient; and the local HIV community.

Partnership members, including representatives of the affected community, service providers, and FDOH-MDC representatives, along with OMB representatives have reviewed this *2027-2031 Integrated Plan* prior to its submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being directed to the populations and geographic areas with the highest HIV burden and differences in health outcomes.

Partnership members concur that this *2027-2031 Integrated Plan* submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV/AIDS Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The signatures below confirm concurrence with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County*.

_____	_____
Harold McIntyre Chair, Miami-Dade HIV/AIDS Partnership	Daniel T. Wall Assistant Director, OMB / Ryan White Program Director, Miami-Dade County

c: Matthew James, HRSA EHE Project Officer
Miami-Dade HIV/AIDS Partnership Members

MIAMI-DADE HIV/AIDS PARTNERSHIP

Grantee/Recipient Top Line Summary Reports

As of May 29, 2026

This report includes top line summaries of Grantee/Recipient monthly expenditure and utilization reports.

Complete reports are posted at www.partnershipmiami.org/the-partnership-2/#pshipreports1. You are encouraged to review all reports prior to the meeting. All data are subject to review and editing.

For additional guidance on reading and understanding reports, staff is available to host the Get on Board! Training session on this topic. Contact mdcpartnership@behavioralscience.com to schedule a training.

Ryan White Program Part A /Minority AIDS Initiative (MAI)

MDC Office of Management and Budget Grants Coordination / Ryan White Program (OMB)
Fiscal Year 2025 Close Out and FY 2026 services in April 2026 as of May 28, 2026

Service Utilization

- Fiscal Year 2026 started on March 1, 2026. The first Expenditure Report for FY 2025 is pending. See Program Notes, below, for FY 2025 Final Expenditures and Utilization.

Top Three Services by Clients Served

- **Part A***
  1. 4,048 clients – MCM
  2. 1,529 clients – OAHS
  3. 690 clients – Oral Health Care
- **MAI**
  1. 730 clients – MCM
  2. 106 clients – OAHS
  3. 33 clients – Medical Transportation

* MCM: Medical Case Management, including treatment adherence
OAHS: Outpatient/Ambulatory Health Services
See the posted report for Service Unit Definitions.

Program Notes

- **FY 2025 Part A/MAI Final Expenditures and Closeout:** All FY 2025 grant closeout activities have been completed. Final FY 2025 expenditure reports and reconciliation are included with this month's meeting materials. FY 2025 year-end spending performance improved compared to the prior fiscal year, with the final unobligated balance (UOB) decreasing from 10.57% in FY 2024 to 7.84% in FY 2025. The Miami-Dade County Ryan White Program also plans to request approval to carry over eligible remaining funds into the next fiscal year in accordance with HRSA/HAB requirements, as approved by the Partnership.

- **FY 2025 Part A/MAI Final Service Utilization:** Final FY 2025 Part A/MAI service utilization reports are also included with this month's meeting materials. The total number of clients served decreased slightly - from 9,316 clients in FY 2024 to 9,194 clients served in FY 2025 - representing a 1.3% decrease.

- **FY 2025 MAI Service Utilization:** FY 2025 Minority AIDS Initiative (MAI) programs served significantly more clients compared to FY 2024. While the overall number of clients served through the Ryan White Program remained relatively the same year-to-year, the number of clients receiving

MAI-funded services increased by 61%. The Miami-Dade County Ryan White Program will continue working with MAI-funded subrecipients to support targeted approaches addressing the specific needs of minority populations impacted by HIV.

- **FY 2026 Part A/MAI and EHE Contracts:** The Miami-Dade County Board of County Commissioners previously approved the extension of existing Ryan White Part A, MAI, and EHE contracts through February 28, 2027. This extension will help ensure services continue while a new procurement process is completed. The Miami-Dade County Ryan White Program continues working with subrecipients to finalize FY 2026 contract extensions, including updated service descriptions and budgets. Most, if not all, Part A and MAI contracts are expected to be sent out for final signatures in June 2026. Work to improve the timeliness of contract execution and payments remains ongoing. However, the Miami-Dade County Ryan White Program is further ahead in the contract process compared to this time last year and continues making progress in this area.

- **FY 2026 HRSA Awards:** The Miami-Dade County Ryan White Program has received final FY 2026 awards from the Health Resources and Services Administration (HRSA) for Ryan White Part A, Minority AIDS Initiative (MAI), and Ending the HIV Epidemic (EHE) funding. Compared to FY 2025, Part A and MAI funding decreased by less than 1% overall, while EHE funding increased by approximately 17%. The FY 2026 Part A and MAI award totals approximately $26.5 million, and the FY 2026 EHE award totals approximately $5.2 million. These awards will support continued HIV care, treatment, support services, and Ending the HIV Epidemic activities throughout Miami-Dade County.

- **Public Outreach Campaign:** The Miami-Dade County Ryan White Program's public outreach campaign remains active. The updated website (miamidade.gov/HIVsupport) continues to serve as a central source for program information, client resources, and updates. The website is also being used to share ongoing information related to Florida ADAP changes and their impact on local service delivery. Outreach efforts across transit, digital, and media platforms also remain in place to support community awareness and linkage to care.

- **2026 ADAP Changes:** Current changes to the Florida AIDS Drug Assistance Program (ADAP), including temporary coverage restorations that began on March 24, 2026, remain in effect through June 30, 2026. Medication coverage and assistance with medication copays and deductibles remain available to eligible clients with incomes up to 400% of the Federal Poverty Level. ADAP continues using separate medication formularies for uninsured and insured clients, and monthly health insurance premium assistance remains unavailable. The Miami-Dade County Ryan White Program continues monitoring these changes closely. The Florida Legislature recently directed a statewide evaluation of ADAP to assess program operations, long-term sustainability, and future program planning. Florida legislators are expected to make budget decisions that will shape the future of the Florida ADAP during their meeting on May 29. Additional information will be shared as it becomes available. None of the contingency plans approved by the Miami-Dade HIV/AIDS Partnership since February 2026 are currently in effect. Updates will continue to be shared through the HIV/AIDS Support and Ryan White Program websites and through local Part A Medical Case Managers as they become available.

- **Statewide Needs Assessment Survey:** The Florida Department of Health Statewide Needs Assessment Survey remains open through August 2026. The response rate for Miami-Dade County remains low - as of May 28th, there were 404 survey responses, with some of them incomplete. The local Ryan White Program continues encouraging providers, staff, and community partners to share the survey widely and encourage participation among clients and other people with HIV. The survey portal for responses from Miami-Dade County can be accessed at: https://survey.zohopublic.com/zs/rDB1W7. The survey is available in English only at this link.

However, a hard copy version in English or Spanish can be obtained from BSR. Unfortunately, the state did not provide a version in Haitian Creole. Appropriate bilingual staff are encouraged to assist clients whose preferred language is Haitian Creole. Please continue to promote this survey and encourage complete responses.

- **2026 National Ryan White Conference:** The Ryan White Program is coordinating participation in the 2026 National Ryan White Conference, scheduled for August 4-7, 2026, in Washington, D.C. The Miami-Dade County Ryan White Program team will include Part A and EHE Recipient staff, peers, Planning Council members and staff support, as well as Clinical Quality Management staff.

- **Monitoring Federal Executive Orders:** We continue to monitor recent federal Executive Orders and court rulings. If any changes affect the Ryan White Program, we will notify the Miami-Dade HIV/AIDS Partnership, subrecipients, the HIV community and other stakeholders as soon as we receive confirmation from our funder.

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **April 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	6	13	4	5
Health Insurance Premium and Cost Sharing Assistance	4	18	2	7
Medical Case Management	9,752	19,984	4,547	6,004
Mental Health Services	50	109	29	46
Oral Health Care	994	1,968	690	1,122
Outpatient Ambulatory Health Services	2,717	5,439	1,602	2,582
Substance Abuse Outpatient Care	3	3	2	2
Support Services				
Food Bank/Home Delivered Meals	875	1,614	301	360
Medical Transportation	311	809	192	328
Other Professional Services	0	0	1	1
Outreach Services	74	131	29	49
Substance Abuse Services (residential)	486	925	19	23
TOTALS:	15,272	31,013		

Total unduplicated clients (month): 5,340

Total unduplicated clients (YTD): 6,797

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 05/28/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **April 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	6	13	4	5
Health Insurance Premium and Cost Sharing Assistance	4	18	2	7
Medical Case Management	8,274	15,933	4,048	5,067
Mental Health Services	50	109	29	46
Oral Health Care	994	1,968	690	1,122
Outpatient Ambulatory Health Services	2,577	5,185	1,529	2,487
Substance Abuse Outpatient Care	3	3	2	2
Support Services				
Food Bank/Home Delivered Meals	875	1,614	301	360
Medical Transportation	278	738	159	286
Other Professional Services	0	0	1	1
Outreach Services	70	122	25	41
Substance Abuse Services (residential)	486	925	19	23
TOTALS:	13,617	26,628		

Total unduplicated clients (month): 5,006

Total unduplicated clients (YTD): 6,240

REPORT COMPILED ON: 05/28/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **April 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	1,478	4,051	730	1,453
Outpatient Ambulatory Health Services	140	254	106	168
Support Services				
Medical Transportation	33	71	33	44
Outreach Services	4	9	4	8
TOTALS:	1,655	4,385		

Total unduplicated clients (month): 774

Total unduplicated clients (YTD): 1,498

REPORT COMPILED ON: 05/28/2026

Miami-Dade County Ryan White Part A/MAI Program

Service Unit Definitions

Service Categories	Service Unit Definition
Core Medical Services	
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program; LPAP)	1 filled prescription
Health Insurance Premium & Cost Sharing Assistance	1 health insurance payment (copayment or deductible)
Medical Case Management (MCM; Incl. Treatment Adherence)	1 MCM encounter
Mental Health Services	1 individual or group encounter
Oral Health Care	1 oral health care visit
Outpatient/Ambulatory Health Services	1 medical visit
Substance Abuse Outpatient Care	1 individual or group encounter
Support Services	
Emergency Financial Assistance (limited access)	1 filled prescription
Food Bank	1 bag of groceries
Medical Transportation	1 medical transportation voucher or one-way rideshare trip
Other Professional Services (Legal Assistance & Permanency Planning)	1 hour of legal assistance
Outreach Services	1 individual encounter
Substance Abuse Services-Residential	1 day of residential substance abuse services

NOTE: MAI-funded services are limited to minority clients from priority subpopulations or emerging need subpopulations.

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

FINAL FY 2025 REPORT
(Grant Closeout Complete)

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FUNDING SOURCE(S) INCLUDED:

FOR THE PERIOD OF: **February 2026**

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	8	78	4	8
Health Insurance Premium and Cost Sharing Assistance	193	8,190	167	2,254
Medical Case Management	6,792	120,153	3,009	8,799
Mental Health Services	15	590	6	124
Oral Health Care	418	11,031	319	2,833
Outpatient Ambulatory Health Services	1,520	30,218	922	4,220
Substance Abuse Outpatient Care	0	13	0	4
Support Services				
Food Bank/Home Delivered Meals	601	11,834	244	822
Medical Transportation	448	7,171	218	1,137
Other Professional Services	0	195	0	51
Outreach Services	26	463	18	236
Substance Abuse Services (residential)	236	6,096	15	87
TOTALS:	10,257	196,032		

Total unduplicated clients (month): 3,886

Total unduplicated clients (YTD): 9,194

This final FY 2025 Monthly and Year-to-Date Service Utilization Summary for services through February 2026 is being provided following completion of the FY 2025 grant closeout review process. Reports for the same service period were previously shared during the April 2026 and May 2026 Partnership meetings. The current report, generated on May 28, 2026, reflects finalized utilization data and no changes were identified when compared to the data previously shared on May 11, 2026.

REPORT COMPILED ON: 05/28/2026

See page 4 for Service Unit Definitions

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **February 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	8	78	4	8
Health Insurance Premium and Cost Sharing Assistance	193	8,190	167	2,254
Medical Case Management	4,245	101,023	1,922	8,503
Mental Health Services	15	590	6	124
Oral Health Care	418	11,031	319	2,833
Outpatient Ambulatory Health Services	1,228	27,608	736	4,065
Substance Abuse Outpatient Care	0	13	0	4
Support Services				
Food Bank/Home Delivered Meals	601	11,834	244	822
Medical Transportation	446	6,915	216	1,103
Other Professional Services	0	195	0	51
Outreach Services	17	414	12	207
Substance Abuse Services (residential)	236	6,096	15	87
TOTALS:	7,407	173,987		

Total unduplicated clients (month): 2,913

Total unduplicated clients (YTD): 9,089

REPORT COMPILED ON: 05/28/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **February 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	2,547	19,130	1,269	2,171
Outpatient Ambulatory Health Services	292	2,610	226	731
Support Services				
Medical Transportation	2	256	2	65
Outreach Services	9	49	6	30
TOTALS:	2,850	22,045		

Total unduplicated clients (month): 1,400

Total unduplicated clients (YTD): 2,454

REPORT COMPILED ON: 05/28/2026

Miami-Dade County Ryan White Part A/MAI Program

Service Unit Definitions

Service Categories	Service Unit Definition
Core Medical Services	
AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program; LPAP)	1 filled prescription
Health Insurance Premium & Cost Sharing Assistance	1 health insurance payment (copayment or deductible)
Medical Case Management (MCM; Incl. Treatment Adherence)	1 MCM encounter
Mental Health Services	1 individual or group encounter
Oral Health Care	1 oral health care visit
Outpatient/Ambulatory Health Services	1 medical visit
Substance Abuse Outpatient Care	1 individual or group encounter
Support Services	
Emergency Financial Assistance (limited access)	1 filled prescription
Food Bank	1 bag of groceries
Medical Transportation	1 medical transportation voucher or one-way rideshare trip
Other Professional Services (Legal Assistance & Permanency Planning)	1 hour of legal assistance
Outreach Services	1 individual encounter
Substance Abuse Services-Residential	1 day of residential substance abuse services

NOTE: MAI-funded services are limited to minority clients from priority subpopulations or emerging need subpopulations.

FINAL FY 2025 REPORT
(Grant Closeout Complete)

PART A

RYAN WHITE PART A GRANT AWARD (Grant #: BURW3501)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR35

FORMULA AND SUPPLEMENTAL FUNDING

Per Resolution #s: R-40-25, R-246-20, R-247-20, R-817-19 & R-639-23

This report includes finalized FY 2025 paid reimbursements for Part A service months through February 2026, as of 5/28/2026.

All FY 2025 grant closeout activities have been completed, and the report reflects final FY 2025 Part A expenditures and reconciliation data.

Project #: BURW3501	**AWARD AMOUNTS**	**ACTIVITIES**	
Grant Award Amount Formula	16,176,379.00	FORMULA	
Grant Award Amount FY23 Formula	1,500.00	PY_FORMULA	
Grant Award Amount Supplemental	7,957,734.00	SUPPLEMENTAL	FY 2025 Award
Grant Award Amount FY23 Supplemental	89,039.00	PY_SUPPLEMENTAL	$24,224,652
Carryover Award of FY'24 Formula Funds	800,000.00	CARRYOVER	
Total Award	**$ 25,024,652.00**		

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations
5	AIDS Pharmaceutical Assistance	5,744.00	
9	Health Insurance Services	490,526.00	
2	Medical Case Management	6,377,000.00	
7	Mental Health Therapy/Counseling	54,303.00	
4	Oral Health Care	4,631,775.00	
3	Outpatient/Ambulatory Health Svcs	7,007,729.00	
8	Substance Abuse - Outpatient	3,000.00	
	CORE Services Totals:	18,570,077.00	

Priority Order	Support Services	Allocations	Carryover Allocations	
14	Emergency Financial Assistance	0.00		
6	Food Bank	848,861.00	640,000.00	1,488,861
10	Medical Transportation	62,888.00	160,000.00	222,888
15	Other Professional Services	18,700.00		
13	Outreach Services	140,661.00		
11	Substance Abuse - Residential	1,611,000.00		
	SUPPORT Services Totals:	2,682,110.00	800,000.00	3,482,110
	FY 2025 Award (not including C/O)	21,252,187.00		

DIRECT SERVICES TOTAL:		**$**	**22,052,187.00**
Total Core Allocation	18,570,077.00		
Target at least 80% core service allocation	17,001,749.60		
Current Difference (Short) / Over	**$ 1,568,327.40**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,368,904.00**		
Quality Management	**$ 603,561.00**	2,972,465.00	
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (Formula & Supp)	$ -		
Unobligated Funds (Carry Over)	$ -	$ -	25,024,652.00

Core medical % against Total Direct Service Allocation (Not including C/O):
Cannot be under 75% — **87.38%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **2.49%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **9.78%** — **Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures
5606970000	AIDS Pharmaceutical Assistance	3,110.33	
5606920000	Health Insurance Services	489,755.12	
5606870000	Medical Case Management	6,313,337.80	
5606860000	Mental Health Therapy/Counseling	52,617.50	
5606900000	Oral Health Care	4,513,801.00	
5606610000	Outpatient/Ambulatory Health Svcs	6,971,950.08	
5606910000	Substance Abuse - Outpatient	780.00	
	CORE Services Totals:	18,345,351.83	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	848,717.20	640,000.00	1,488,717.20
5606460000	Medical Transportation	62,229.06	160,000.00	222,229.06
5606890000	Other Professional Services	17,559.00		
5606950000	Outreach Services	122,055.02		
5606930000	Substance Abuse - Residential	1,522,000.00		
	SUPPORT Services Totals:	2,572,560.28	800,000.00	
	FY 2025 Award (not including C/O)	20,917,912.11		

TOTAL EXPENDITURES DIRECT SVCS & % :			**$ 21,717,912.11**	**98.48%**
Formula Expenditure %	**97.61%**			
5606710000	**Recipient Administration**	**2,317,213.43**	**97.82%**	
5606880000	**Quality Management**	**602,153.97**		2,919,367.40
Grant Unexpended Balance		**FY 2025 Award**	**Carryover**	
		387,372.49	**(0.00)**	387,372.49
Total Grant Expenditures & %			**$ 24,637,279.51**	**98.45%**

Core medical % against Total Direct Service Expenditures (Not including C/O):
Cannot be under 75% — **87.70%** — **Within Limit**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **2.49%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **9.57%** — **Within Limit**

Printed On: 5/28/2026

FINAL FY 2025 REPORT
(Grant Closeout Complete)

MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3501)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR35

MINORITY AIDS INITIATIVE (MAI) FUNDING

Per Resolution #s: R-40-25, R-246-20, R-247-20, R-817-19 & R-639-23

This report includes finalized FY 2025 paid reimbursements for MAI service months through February 2026, as of 5/28/2026.

All FY 2025 grant closeout activities have been completed, and the report reflects final FY 2025 MAI expenditures and reconciliation data.

PROJECT #: BURW3501	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	2,563,697.00	MAI
Carryover Award of FY'24 MAI Funds	1,539,152.00	MAI_CARRYOVER
Total Award	**$ 4,102,849.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations		Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures	
	AIDS Pharmaceutical Assistance				5606970000	AIDS Pharmaceutical Assistance			
	Health Insurance Services				5606920000	Health Insurance Services			
1	Medical Case Management	969,689.00	307,830.00	1,277,519.00	5606870000	Medical Case Management	792,192.45	307,830.00	1,100,022.45
6	Mental Health Therapy/Counseling	18,960.00			5606860000	Mental Health Therapy/Counseling	0.00		
	Oral Health Care				5606900000	Oral Health Care			
3	Outpatient/Ambulatory Health Svcs	873,094.63	846,658.37	1,719,753.00	5606610000	Outpatient/Ambulatory Health Svcs	5,204.46	717,453.98	722,658.44
5	Substance Abuse - Outpatient	8,058.00			5606910000	Substance Abuse - Outpatient	0.00		
	CORE Services Totals:	1,869,801.63	1,154,488.37	3,024,290		CORE Services Totals:	797,396.91	1,025,283.98	
	Support Services	**Allocations**	**Carryover Allocations**		**Account**	**Support Services**	**Expenditures**	**Carryover Expenditures**	
8	Emergency Financial Assistance	0.00			5606940000	Emergency Financial Assistance	0.00		
	Food Bank				5606980000	Food Bank			
7	Medical Transportation	14,628.00			5606460000	Medical Transportation	14,281.18		
	Other Professional Services				5606890000	Other Professional Services			
4	Outreach Services	39,816.00			5606950000	Outreach Services	39,816.00		
	Substance Abuse - Residential				5606930000	Substance Abuse - Residential			
	SUPPORT Services Totals:	54,444.00	0.00			SUPPORT Services Totals:	54,097.18	0.00	
	FY 2025 Award (not inlcuding C/O)	1,924,245.63				FY 2025 Award (not inlcuding C/O)	851,494.09		
	Carryover Award		1,154,488.37						
	DIRECT SERVICES TOTAL:		**$ 3,078,734.00**			**TOTAL EXPENDITURES DIRECT SVCS & %:**		**$ 1,876,778.07**	**60.96%**
	Total Core Allocation	1,869,801.63							
	Target at least 80% core service allocation	1,539,396.50							
	Current Difference (Short) / Over	**$ 330,405.13**							
	Recipient Admin. (OMB-GC)	**$ 256,369.00**			5606710000	**Recipient Administration**	**229,726.70**	**89.61%**	
	Quality Management	**$ 100,000.00**	356,369.00	$ 3,435,103.00	5606880000	**Quality Management**	**100,000.00**		329,726.70
	(+) Unobligated Funds / (-) Over Obligated:					**Grant Unexpended Balance**	**FY 2025 Award**	**Carryover**	
	Unobligated Funds (MAI)	**$ 283,082.37**					**1,382,476.21**	**513,868.02**	1,896,344.23
	Unobligated Funds (Carry Over)	**$ 384,663.63**	667,746.00	4,102,849.00		**Total Grant Expenditures & % (Including C/O):**		**$ 2,206,504.77**	**53.78%**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**97.17%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.90%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**10.00%**	**Within Limit**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**93.65%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.90%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**8.96%**	**Within Limit**

Printed On: 5/28/2026

Ryan White Program Part B

April 2026 as of May 21, 2026

- **Top Three Direct Services by Clients Served**
  1. 94 clients – Medical Case Management, including treatment adherence
  2. 49 clients – Emergency Financial Assistance
  3. 21 clients – Mental Health Services - Outpatient

- **Top Three Direct Services by Expenditures**
  1. $16,163.25 – Medical Case Management, including treatment adherence
  2. $13,148.83 – Emergency Financial Assistance
  3. $2,372.50 – Mental Health Services - Outpatient

General Revenue at SFAN

April 2026 as of May 26, 2026

- **Top Three Services by Clients Served**
  1. 890 clients – Medical Case Management
  2. 563 clients – Ambulatory Outpatient Care
  3. 314 clients – Non-Medical Case Management

- **Top Three Services by Expenditures**
  1. $160,925.76 – Ambulatory Outpatient Care
  2. $69,418.65 – Substance Abuse Residential
  3. $17,774.02 – Mental Health Services

- **Program Note:** The report highlights the top 3 services: Medical Case Management served 890 unduplicated clients, Ambulatory Outpatient Care served 563 unduplicated clients, and Non-Medical Case Management served 314 unduplicated clients.

AIDS Drug Assistance Program (ADAP)

- April 2026 ADAP updates are pending. See the Top Line Summary Report of April 16, 2026, for the latest updates.

Florida Department of Health
Expenditure/Invoice Report
Program Name: Patient Care-Consortia
Area Name: AREA 11A
Month: April
Year: 2026-2027
Provider Agency Name: FDOH Miami-Dade County
Contract Name: 2026_2027 FDOH Miami-Dade County Patient Care-Consortia

Contract Service	No. of Clients Served	Units of Service	Approved Budget	Expended this Month	Expended to date	Balance
Administrative Services	0	0	$120446.00	$7003.51	$7003.51	$113442.49
Clinical Quality Management	0	0	$45000.00	$0.00	$0.00	$45000.00
Planning and Evaluation	0	0	$5104.00	$401.04	$401.04	$4702.96
Medical Case Management (including treatment adherence)	94	14055	$127502.00	$16163.25	$16163.25	$111338.75
Mental Health Services - Outpatient	21	73	$25000.00	$2372.50	$2372.50	$22627.50
Emergency Financial Assistance	49	84	$1223431.00	$13148.83	$13148.83	$1210282.17
Non-Medical Case Management Services	6	6	$133366.00	$0.00	$0.00	$133366.00

	This Month	Year To Date
Total Expended:	$ 39089.13	$ 39089.13

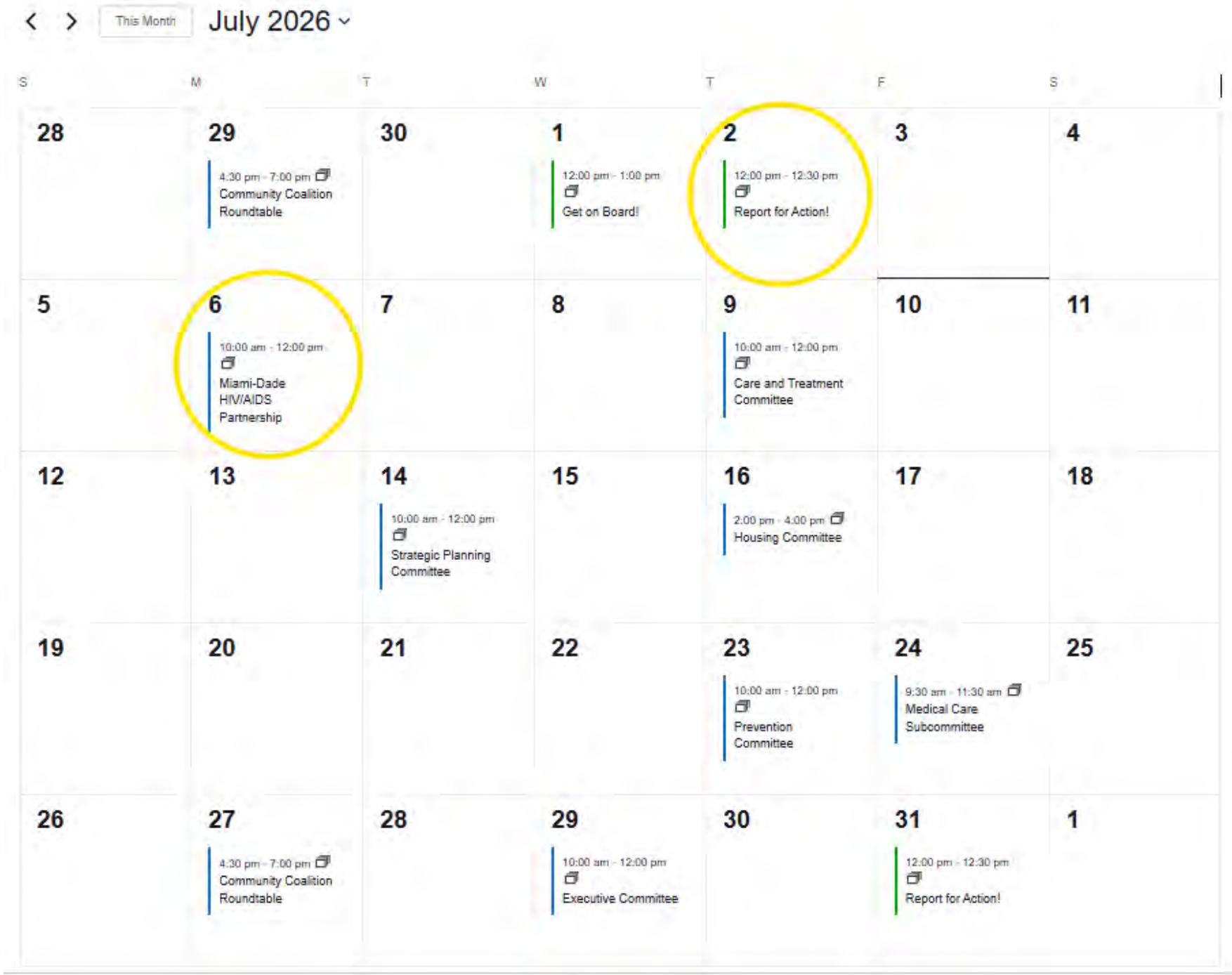
I certify that the above report is a true, accurate and correct reflection of the activities this period; and that the expenditures reported are made only for items which are allowable and directly related to the purpose of this referenced contract.

Ernesto Rodriguez
Signature of Provider Agency Official
Date : 05-21-2026

The report highlights the top 3 services: Medical Case Management served 890 unduplicated clients, Ambulatory Outpatient Care served 563 unduplicated clients, Non-Medical Case Management 314 unduplicated clients.

General Revenue July 2025 - June 2026
HIV/AIDS Demographic Data for PHT/SFAN

	April 26			Year To Date Data		
	Unduplicated Client Count	Units	Dollar Amt.	Total Dollar Amt. YTD	Budget as of 7-1-25 Annual Budget	YTD Units
Ambulatory - Outpatient Care	563	1,125	160,925.76	1,000,862.26	1,644,600.00	4,767
Drug Pharmaceuticals	22	57	(5,812.79)	232,569.62	288,900.00	361
Early Intervention Services				28,618.64	68,918	19
Oral Health	4	5	3,214.00	6,593.00	50,000.00	19
Home & Community Base Services				3,456.18	12,000.00	47
Home Health Care				5,611.00	24,288.00	186
Mental Health Services	58	74	17,774.02	91,834.83	120,000.00	464
Nutrition Counseling	1	1	138.96	3,086.72	20,000.00	19
Medical Case Management	890	2,064	(288,177.14)	1,375,272.90	1,692,262.00	14,427
Sustance Abuse Services	4	412	7,930.11	25,385.51	93,000.00	1,362
Food Bank/Home Delivered Meals	23	44	1,210.00	17,522.50	35,000.00	637
Non-Medical Case Management	314	318	16,556.27	498,192.26	630,735.00	1,888
Other Support Services / Emergency Fin. Assistance	2	2	1,008.58	21,016.22	192,000.00	8
Psychosocial Support Services	15	1,472	17,715.20	54,964.60	55,000.00	4,336
Transportation	129	166	7,595.81	79,781.06	97,250.00	1,150
Referral for Health Care / Supportive Services	39	151	(5,928.37)	400,955.34	420,820.00	1,437
Substance Abuse Residential	5	255	69,418.65	176,677.27	281,955.00	649
Residential Care - Adult				139,750.00	237,250.00	3,043
Nursing Home Care	2	60	17,176.80	279,174.78	436,785.00	721
Hospital Services				-		
	2,071	6,206	20,745.86	4,441,324.69	6,400,763.00	35,540


This Month
July 2026
S
M
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F
S
28
29
4:30 pm - 7:00 pm
Community Coalition Roundtable
30
1
12:00 pm - 1:00 pm
Get on Board!
2
12:00 pm - 12:30 pm
Report for Action!
3
4
5
6
10:00 am - 12:00 pm
Miami-Dade HIV/AIDS Partnership
7
8
9
10:00 am - 12:00 pm
Care and Treatment Committee
10
11
12
13
14
10:00 am - 12:00 pm
Strategic Planning Committee
15
16
2:00 pm - 4:00 pm
Housing Committee
17
18
19
20
21
22
23
10:00 am - 12:00 pm
Prevention Committee
24
9:30 am - 11:30 am
Medical Care Subcommittee
25
26
27
4:30 pm - 7:00 pm
Community Coalition Roundtable
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10:00 am - 12:00 pm
Executive Committee
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12:00 pm - 12:30 pm
Report for Action!
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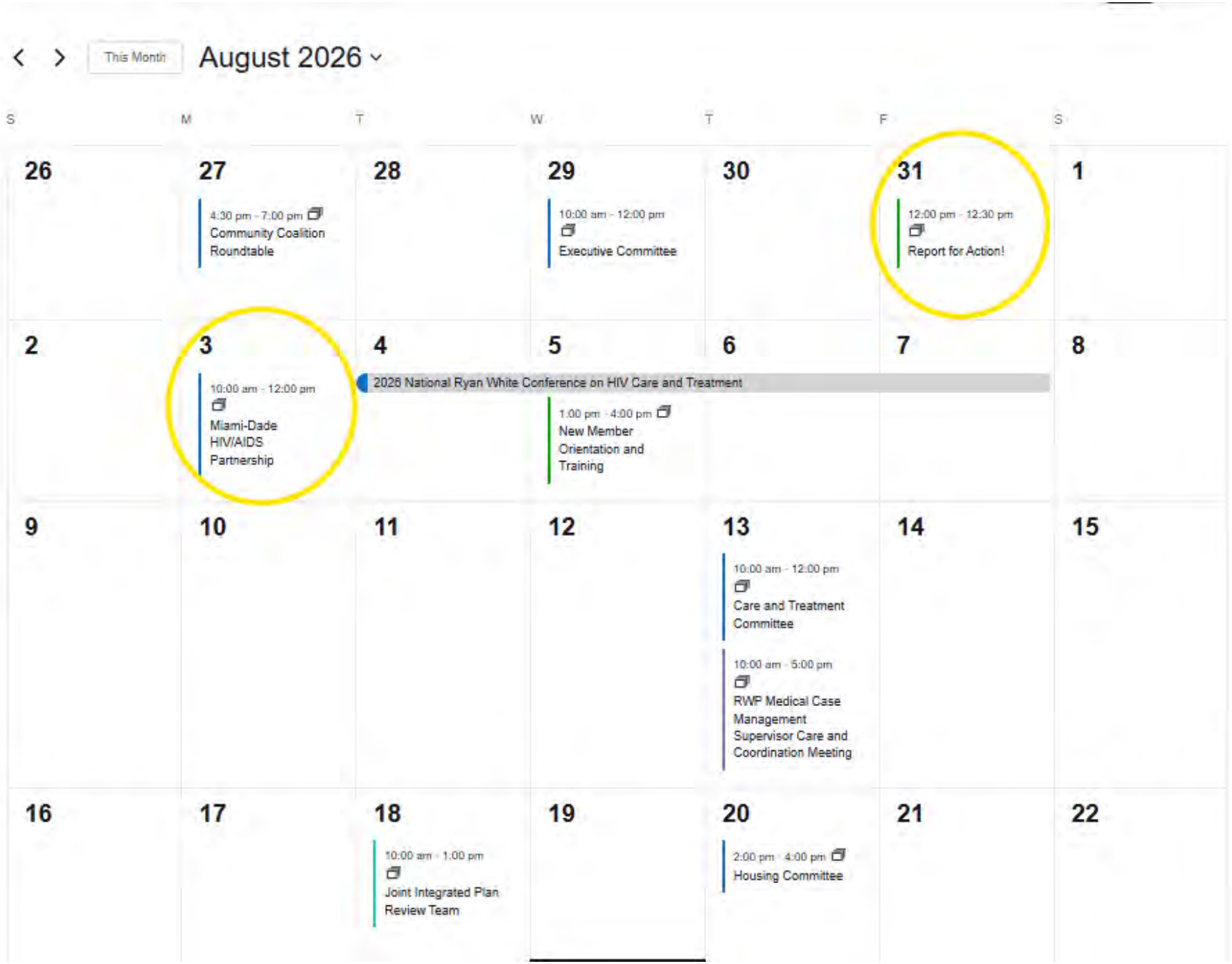
This Month
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Community Coalition Roundtable
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Report for Action!
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10:00 am - 12:00 pm
Miami-Dade HIV/AIDS Partnership
4
2026 National Ryan White Conference on HIV Care and Treatment
5
1:00 pm - 4:00 pm
New Member Orientation and Training
6
7
8
9
10
11
12
13
10:00 am - 12:00 pm
Care and Treatment Committee
10:00 am - 5:00 pm
RWP Medical Case Management Supervisor Care and Coordination Meeting
14
15
16
17
18
10:00 am - 1:00 pm
Joint Integrated Plan Review Team
19
20
2:00 pm - 4:00 pm
Housing Committee
21
22

MIAMI-DADE
HIV/AIDS PARTNERSHIP

GET ON BOARD

Member Enrichment Training

STATION 23:

Ryan White Planning Council Responsibilities and Needs Assessment

WEDNESDAY, JUNE 3, 2026

12:00 P.M. – 1:00 P.M.

VIA MICROSOFT TEAMS

WHAT YOU'LL LEARN

- Overview of the Ryan White Planning Council Responsibilities
- What is involved in Needs Assessment/ PSRA
- View sample data used to support data-driven decision-making
- Why the Needs Assessment/PSRA is essential for Partnership and Committee members

SCAN TO REGISTER!

OR REGISTER AT:

bit.ly/June_3_2026GOB-RWPC_NA

Partnership members, committee members, and community stakeholders are encouraged to attend!

Great job

DRAFT

MENTAL HEALTH SERVICES

(Year 365 Service Priorities: #7 for Part A and #6 3 for MAI)

Mental Health Services are a set of core medical services that consist of counseling and treatment for diagnosed behavioral health disorders. These services are designed to reduce harmful behaviors and episodes of instability and improve mental status and client health outcomes. These Mental Health Services include the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to people with HIV. Services are based on an individualized treatment plan and are conducted in group and individual sessions. All services are provided by mental health professionals licensed or otherwise authorized within the State of Florida to render such services. All clients receiving this service must have at least one mental or behavioral health diagnosis specified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10 1-CM; Codes F01-F99, excluding "Mental and behavioral disorders due to psychoactive substance use" – codes F10-F19).

Mental Health Services require an individualized treatment plan, as noted above. Treatment plans incorporate the findings of assessment and diagnostic tools and specify the goals and objectives to be achieved during the treatment episode. The treatment plan also specifies the recommended clinical interventions and frequency with which these interventions shall be delivered. Mental health providers may use this service category to conduct the assessment and diagnostic steps for the development of a treatment plan. If ongoing mental health services are being provided to a client, it is expected that the client will receives a mental health treatment plan at least every six months.

Psychiatric treatment with medication management and evaluation should be billed and recorded under Outpatient/Ambulatory Health Services. Additional mental health services may be billed under Outpatient/Ambulatory Health Services when provided by a licensed psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner or physician assistant/associate.

Mental Health Services are allowable only for program-eligible clients. This service is not available to family members without HIV. Ryan White Program funds may **not** be used for bereavement support for uninfected family members or friends.

Mental Health Services reimbursed under Part A or MAI of the Ryan White Program are limited to conditions impacting the treatment of the client's underlying HIV disease (e.g., assessing, diagnosing, and treating a mental health condition that hinders HIV treatment adherence) and treated within the context of the client's HIV or AIDS diagnosis. This service is intended to address issues that impact a person's ability to remain engaged in HIV care, strengthen coping skills and self-care, and promote engagement in ongoing medical care and treatment. It is important for the Level I or Level II mental health

professional to regularly gauge and document the client's progress and determine if the client is still in need of the service.

- **Mental Health Services (Level I):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Doctorate degree*** **in psychology or counseling or related field (PhD, EdD, PsyD), and must be *licensed by the State of Florida*** as a licensed clinical psychologist, LCSW, LMHC, or LMFT to provide such services.

- **Mental Health Services (Level II):** This level includes *intensive* mental health therapy and counseling (individual, family, and group) provided solely by *state-licensed mental health professionals*. Direct service providers would possess ***a Master's degree*** **in psychology, psychotherapy or counseling or related field (MS, MA, MSW, or M.Ed.), and must be *licensed by the State of Florida*** as a LCSW, LMHC or LMFT to provide such services. **Direct service providers may also be:** 1) Florida registered interns as defined by Florida Statute (F.S.) 491.0045 (Clinical Social Work Intern, Mental Health Counselor Intern, or Marriage and Family Therapy Intern), or 2) a Psychology Intern, Postdoctoral Resident, or Fellow satisfying Rule 64B19-11.005 of the Florida Administrative Code (F.A.C.). Such interns must provide services under the supervision of a LCSW, LMHC, LMFT or licensed psychologist who is licensed in the State of Florida.

Mental Health Service Components Under Level I and II:

Level I counseling services provided to Ryan White Program clients include psychosocial assessment and evaluation, testing, diagnosis, treatment planning with written goals, crisis counseling, periodic re-assessments, re-evaluations of plans and goals, documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to program-eligible people with HIV (clients) such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing ~~and harm reduction~~ strategies to their clients, if deemed clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Level II counseling services provided to Ryan White Program clients include crisis counseling, re-evaluations of plans and goals, documenting progress, and referrals to psychiatric and/or other services as appropriate. Issues of relevance to program-eligible people with HIV (clients) such as risk behavior, substance abuse, adherence to medical treatments, depression, panic, anxiety, maladaptive coping, safer sex, and suicidal ideation will be addressed. Mental health professionals are encouraged to practice and introduce motivational interviewing ~~and harm reduction~~ strategies to their clients, if deemed

clinically appropriate. Services at this level are provided for clients experiencing acute, sporadic mental health problems and are generally not long term [individual counseling shall not exceed 32 encounters per Fiscal Year and five (5) units (maximum of 2 ½ hours) per session; 1 encounter = 1 day of service].

Group Counseling (Levels I and II) refers to a group of individuals [minimum of three (3) Ryan White Program clients, maximum of fifteen (15) total clients] with similar problems meeting under the expert guidance of a trained mental health professional. Members of the group will be selected by the mental health professional in order to maximize the interaction, learning, and benefits derived from a group dynamic. Group counseling provides therapy in a social context, reduces the feeling of isolation many clients experience, provides an opportunity for clients to share methods of problem-solving, and allows the therapist an opportunity to observe how an individual interacts with others.

A. Program Operation Requirements: Staff must demonstrate knowledge of HIV disease, its psychosocial dynamics, and implications, including cognitive impairment, and generally accepted treatment modalities and practices. Services may be delivered to non-HIV+ family members (as defined by the client) only if the program-eligible client is also being served. Providers will comply with super-confidentiality laws as per State of Florida's guidelines. The ratio of group counseling participants to counselors may not be lower than 3:1 and may not be higher than 15:1, as described above. One visit is equal to one half-hour counseling session.

Clients who are newly diagnosed with HIV or have returned to care should be offered the opportunity to speak with a mental health provider as a routine component of the services available through the local Ryan White Part A Program. An initial mental health visit could be used to identify, assess, or verify mental health conditions that may affect a client's treatment adherence. Subsequent or on-going Mental Health Services under the Ryan White Part A Program require a mental health diagnosis documented in the client's chart. To facilitate this process for newly diagnosed or returned to care clients who are receiving TTRA mental health services are limited to one encounter (all mental health services provided on one day) within 30 days of starting the TTRA protocol, while program eligibility is being determined. For clients following the Newly Identified Client (NIC) protocol, Mental Health Services may be provided with these same limitations.

Tele-mental health services are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

B. Additional Service Delivery Standards: Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV ~~/AIDS~~-related illnesses. (Please refer to Section III of this FY

202~~5~~6 Service Delivery Manual for details, as may be amended.)

C. Rules for Reimbursement: Reimbursement for individual and group Mental Health Services will be based on a half-hour counseling session "unit" not to exceed $32.50 per unit for Level I individual counseling; $35.00 per unit for Level I group counseling; $32.50 per unit for Level II individual counseling; and $35.00 per unit for Level II group counseling. Reimbursement for individual counseling units are calculated for each client receiving the therapy (i.e., number of individual counseling units per client), whereas, reimbursement for group counseling units are calculated for the counselor that provided the group counseling (i.e., number of group counseling units per counselor).

Tele-mental health services are reimbursed as follows:

Billing Code	Description	Flat rate Reimbursement
THMHT1	Tele-Mental Health provided by a Level I provider (individual client only)	$32.50 per 30-minute session
THMHT2	Tele-Mental Health provided by a Level II provider (individual client only)	$32.50 per 30-minute session

D. Additional Rules for Reporting: The unit of service for reporting monthly activity of individual and group Mental Health Services is a one-half-hour counseling session and the unduplicated number of clients served. Providers will report individual and group activity separately for Level I and Level II Mental Health Services.

E. Additional Rules for Documentation: Providers must also maintain certifications and licensure documents of the mental health professionals providing services to Ryan White Program clients and must make these documents available to OMB staff or authorized persons upon request. Client charts **must** include a specific mental or behavioral health diagnosis and detailed treatment plan for each eligible client that includes all required components and the mental health professional's signature and/or the signature of the person supervising the professional.

F. Additional Treatment Guidelines and Standards: Providers of Mental Health Services (Levels I and II) will adhere to generally accepted clinical guidelines for mental health therapy/counseling of people with HIV. The following are examples of such guidelines:

- American Psychiatric Association (APA). HIV Psychiatry-Training and Education, as well as HIV Psychiatry Resources and Publications [e.g., Fact Sheets (Last Updated: 2012): HIV and Clinical Depression; HIV and Anxiety; HIV and Cognitive Disorders; HIV and Delirium; HIV and Substance Use; HIV and People with Severe Mental Illness (SMI); Sleep Disorders and HIV;

and Pain in HIV/AIDS; Publications (including links to other related books and journals, such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision-DSM-5-TR); and additional web-based materials. Available at:

- ~~https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry and~~
  https://www.psychiatry.org/psychiatrists/search-directories-databases
  Accessed 11~~9~~/1~~7~~4/2024~~4~~5.

- American Psychiatric Association. Latest Published and Legacy APA Clinical Practice Guidelines; including, but not limited to, The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition, 2015. Available at:
  https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines
  and https://psychiatryonline.org/guidelines
  Accessed ~~9~~11/1~~7~~4/2024~~4~~5.

ORAL HEALTH CARE

(Year 3~~6~~5 Service Priority: #~~4~~ 5 for Part A

Oral Health Care is a core medical service. This service includes diagnostic, preventive, and therapeutic services provided by a dental health care professional licensed to provide dental care in the State of Florida, including general dentists, dental specialists, and dental hygienists, as well as licensed dental assistants. In accordance with Rule 64B5-9.011 of the Florida Administrative Code, dental assistants who are formally trained or have an appropriate certification (e.g., radiography) meet HRSA's definition of a licensed dental assistant.

This service may include diagnostic, preventive, and restorative services; endodontics, periodontics, and prosthodontics (removable and fixed); maxillofacial prosthetics; limited implant services (i.e., removal, repair, and placement [restricted for edentulous patients only] of implants); oral and maxillofacial surgery; and adjunctive general services as detailed and limited in the most current, local Ryan White Program Oral Health Care Formulary.

A. Program Operation Requirements: Provision of Oral Health Care services for any one client is limited to an annual cap of $6,500 per Ryan White Part A Fiscal Year (March 1, ~~2025~~ 2026 through February 28, ~~2026~~2027). Exceptions to the annual cap may be approved by the County under special circumstances (e.g. implant placement) and the provision of preventive Oral Health Care services with consultation from the Miami- Dade HIV/AIDS Partnership's Medical Care Subcommittee as needed.

When a referral from a dentist to a dietitian is needed, the dentist must coordinate with the client's licensed medical provider (MD, DO, APRN, PAs) to obtain the required referral to nutrition services (i.e., a referral to Ryan White Program outpatient specialty care services). This is necessary to ensure communication between the care team (e.g., licensed medical providers and dentist). The client's medical case manager should also be informed of the client's need for nutrition services.

Viral loads (within the last 6 months) and CD4 count (most current) ~~L~~labs should accompany referrals and additional labs may be requested from licensed medical providers as clinically indicated by the dentist. An undetectable viral load is not required to provide services.

All referrals to Ryan White Part A Oral Health Care services should include the client's licensed medical provider's contact information (name, address, phone and fax numbers, and email if available) and note any known allergies the client may have. This information can be included in the comments section of the referral.

Providers must offer, post, and maintain a daily walk-in slot for clients with urgent/emergent dental issues. Clients who come into or contact the office with urgent/emergent dental issues (e.g., pain, broken tooth, situation requiring immediate treatment, or situation causing client high level of distress) will be triaged by appropriate dental staff; and those clients with substantial issues will be seen as soon as possible, but within 48 hours (i.e., two business days).

Teledentistry services may also be available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details.

B. Additional Service Delivery Standards: Providers of this service will adhere to the most current, local *Ryan White Program System-wide Standards and Ryan White Program Oral Health Care Standards*. (Please refer to Section III of this FY 2026~~5~~ Service Delivery Manual for details.) Providers will be required to demonstrate that they adhere to generally accepted clinical guidelines for Oral Health Care treatment of HIV and AIDS-specific illnesses, upon request and through monitoring site visits or quality management record reviews.

C. Rules for Reimbursement: Providers will be reimbursed for all routine and emergency examination, diagnostic, prophylactic, restorative, surgical and ancillary Oral Health Care procedures, as approved by the Miami-Dade HIV/AIDS Partnership and included in the most current, local Ryan White Program Oral Health Care Formulary using the 202~~5~~6 American Dental Association Current Dental Terminology (CDT 202~~5~~6) codes for dental procedures. Reimbursement is in accordance with the rates indicated in the most current, local Ryan White Program Oral Health Care Formulary; flat fee, no multiplier.

Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details regarding the reimbursement of teledentistry services.

An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding budget narrative.

D. Children's Eligibility Criteria: Providers must document that children with HIV who receive Ryan White Part A Program-funded Oral Health Care services are permanent residents of Miami-Dade County and have been properly screened for other private or public sector funding [i.e., private insurance, Medicaid, Medicaid's expanded dental insurance for its members with Managed Medical Assistance (MMA) or Long-Term Care (LTC) coverage who have LIBERTY Dental or, DentaQuest~~, or MCNA~~ Dental benefits (as may be amended), the Medically Needy Program, Children's Health Insurance Program (CHIP), Florida KidCare, etc.)], as appropriate. While children qualify for and can access private insurance, Medicaid (all programs), or other public sector funding for Oral Health Care services, they will not be eligible for Ryan White Part A Program-funded Oral Health Care services, except those dental procedures excluded by the other funding sources.

E. **Client Eligibility Criteria:** Clients receiving Oral Health Care must be documented as having been properly screened for other public sector funding as appropriate every 366 days. While clients qualify for and can access dental services through other public funding [including, but not limited to, Medicaid, Medicaid Managed Medical Assistance (MMA), or Medicaid Long-Term Care (LTC)], Medicare, or private health insurance, they will not be eligible for Ryan White Part A Program-funded Oral Health Care except for such program-allowable services that are not covered by the other sources or if their related benefits have been maxed out for the benefit period.

Clients referred for Oral Health Care by a Ryan White Part A or MAI Medical Case Manager should use the Ryan White Program In Network Referral process in the Provide® Enterprise Miami data management system. If the client is referred by a non-Part A or non-MAI provider ["Out of Network"(OON) provider] or self-refers because they do not have a Part A/MAI Medical Case Manager, an OON referral form must be submitted accompanied by the required medical, financial, and permanent Miami-Dade County residency documentation as well as all required consent forms and Notice of Privacy Practices. Clients coming without a referral, but with necessary documentation to support Ryan White Part A Program eligibility and viral load and CD4 lab test results within 366 days, are also able to access Ryan White Part A Oral Health Care services, upon completion of a brief intake in the Provide® Enterprise Miami data management system by the Oral Health Care provider agency and the client's signed consent for service

F. **Ryan White Program Oral Health Care Formulary:** Ryan White Part A Program funds may only be used to provide Oral Health Care services that are included in the most recent release of the most current, local Ryan White Program Oral Health Care Formulary. The Formulary is subject to periodic revision.

G. **Letters of Medical Necessity**: Dental Implants require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 202~~5~~6 Service Delivery Manual for copies of the Letter of Medical Necessity, as may be amended).

H. **Rules for Documentation:** Providers must maintain a dental chart or electronic record that is signed by the licensed dental provider and includes a treatment plan, dates of service, services provided, procedure codes billed, and any referrals made. Providers must also maintain professional certifications, licensure documents, and proof of training, where applicable, of the dental staff providing services to Ryan White Program clients. Providers must make these documents available to OMB staff or authorized persons upon request.

I. **Rules for Reporting:** Provider monthly reports (i.e., reimbursement requests) for Oral Health Care must include the number of clients served, billing code for the dental procedures provided, number of units of service provided, and the corresponding reimbursement rate for each service provided. Providers must also develop a method to track and report client wait time (e.g., the time it takes for a

client be scheduled to see the appropriate dental provider after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the dental provider) and to make such reports available to OMB staff or authorized persons upon request.

AIDS PHARMACEUTICAL ASSISTANCE
(LOCAL PHARMACEUTICAL ASSISTANCE PROGRAM – LPAP)

(Year 36 Service Priority: #3 for Part A and 2 for MAI)

A. **AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP)** is a core medical service. The purpose of the **LPAP** component (i.e., prescription drug services) of the AIDS Pharmaceutical Assistance service category, in accordance with federal Ryan White Program guidelines, is "to provide therapeutics to treat HIV/AIDS or to prevent the serious deterioration of health arising from HIV/AIDS in eligible individuals, including measures for the prevention and treatment of opportunistic infections." LPAPs must be compliant with the Ryan White HIV/AIDS Program's requirement of payer of last resort.

This service includes the provision of medications and related supplies prescribed or ordered by a licensed medical provider (MD, DO, APRN, PAs) for people with HIV who are ineligible for Medicaid, Medicare Part D, ADAP, or other public sector funding, or have private insurance with limited or no prescription drug coverage. Supplies are limited to consumable medical supplies necessary for the administration of prescribed medications.

IMPORTANT NOTES: Services are restricted to outpatient services only. Inpatient, emergency room, and urgent care center prescription drug services are not covered. Vaccines provided during a medical office visit are no longer found in the local Ryan White Part A Program Prescription Drug Formulary but may be available under Outpatient/Ambulatory Health Services. Prescription drug copayment assistance is not provided for clients with prescription drug discount cards. LPAP services may not be provided on an emergency basis (defined as a single occurrence of short duration). See the General Revenue Short-term Medication Assistance protocol in Section XII of this FY 2026 Ryan White Program Service Delivery Manual for information on how to access to medications on a short-term, emergency basis.

1. **Medications Provided:** This service pays for injectable and non-injectable prescription drugs, pediatric formulations, appetite stimulants, and/or related consumable medical supplies for the administration of medications. Medications are provided in accordance with the most recent release of the local Ryan White Part A Program Prescription Drug Formulary, with the Ryan White Part A/MAI Program as the payer of last resort. The local Ryan White Part A Program Prescription Drug Formulary is subject to change due to guidance from HRSA, the federal granting agency, and/or the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

2. Client Education and Adherence:

- Providers are expected to educate clients on the importance of adhering to their medication regimen with the objectives of reducing the risk of developing and spreading a resistant virus, and to ensure a healthy life for the client.

- Providers are expected to offer basic education to clients on various treatment options.

- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by licensed medical providers, nutritionists, and pharmacists regarding medication management.

3. Coordination of Care:

- Providers must maintain appropriate contact with other caregivers (i.e., the client's medical case manager, licensed medical provider, nutritionist, counselor, etc.) and with the client in order to monitor that the client adheres to their medication regimen; and ensures that the client receives coordinated, interdisciplinary support for adherence, and assistance in overcoming barriers to meeting treatment objectives.

- Providers will be expected to immediately inform medical case managers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills, misses licensed medical provider visits, or is having other difficulties with treatment adherence).

- Providers are expected to ensure immediate follow-up with clients who miss their prescription refills, licensed medical provider visits, and/or who experience difficulties with treatment adherence.

B. Program Operation Requirements:

- Providers are encouraged to provide county-wide delivery. However, Ryan White Program funds may not be used to pay for the delivery of medications or consumable medical supplies unless one of the following conditions is met by the client, is documented by the client's licensed medical provider, and said documentation is maintained in the client's chart:

1) The client is permanently disabled (condition is documented once);

2) The client has been examined by a licensed medical provider and found to be suffering from an illness that significantly limits the client's capacity to travel [condition is valid for the period indicated by the licensed medical provider or for sixty (60) calendar days from the date of certification].

IMPORTANT NOTE: Medical Case Managers requesting home delivery must have documentation on file that meets one of the conditions listed above.

- Providers must specify provisions for home delivery of medications and related supplies and equipment for eligible Ryan White Program clients who require this service.

- Providers of this service are expected to be Covered Entities authorized to dispense PHS 340B-priced medications either directly, through an allowable subcontract arrangement, or via another federally acceptable affiliation.

  - Clients needing this service may only go to, or be referred to, the pharmacy in which their licensed medical provider is located or affiliated with (e.g., by subcontract, etc.). This is due to PHS 340B Pharmacy drug pricing limitations, and HRSA's requirements that the Ryan White Part A/MAI Program use PHS 340B drug pricing wherever possible.

  - If the provider is a PHS 340B covered entity and the client is enrolled in the Florida ADAP Program, that client is eligible for PHS 340B pricing for prescriptions not covered by the ADAP formulary regardless of whether or not the client is the agency's own client.

- Pharmacy providers are directed to use the most cost-effective product, either brand name or generic name, whichever is less expensive at the time of dispensing. An annual, signed assurance is required from the service provider regarding this directive.

- The LPAP-funded service provider must be linked to an existing medical case management system through agreements with multiple Medical Case Management providers. Providers are contractually required to enter into formal referral agreements that detail responsibilities of both parties and penalties for not complying with the referral agreement.

A Ryan White Program In Network Referral for LPAP Services is not required. However, to access LPAP services, the client must be open at the LPAP-funded agency and must have their Client Service Category Profile in the Provide® Enterprise Miami data management system open to Outpatient/Ambulatory Health Services at the same agency. This is due to 340B covered entity drug pricing requirements.

Ryan White Program-funded LPAP services have a maximum of one year from the date on the prescription.

C. Rules for Reimbursement: Dependent on the type of pharmacy provider, please adhere to the following reimbursement structures.

- Where applicable, providers will be reimbursed for program-allowable prescription drugs based on the PHS 340B price of the prescription provided to the Ryan White client, plus a flat rate dispensing fee. Total costs should include the cost of home delivery, as allowable, and other direct costs associated with the provision of this service. Providers must stipulate the flat rate dispensing fee that will be added to the PHS price. (For example, if the PHS price of a prescription is $185.00, and the provider's proposed flat rate dispensing fee is $11.00, then the total reimbursement amount is equal to $196.00.) An estimate of the number of clients (unduplicated caseload) expected to receive these services must be included on the corresponding budget narrative.

- Reimbursement for consumable medical supplies is limited and must be related to administering medications (e.g., for insulin injection in diabetics, etc.). Approved consumable medical supplies are found in Attachment B of the most current, local Ryan White Program Prescription Drug Formulary.

- No multiplier will be applied to Medicare or Medicaid rates for consumable medical supplies.

D. Additional Rules for Reporting and Documentation: Providers must document client eligibility for this service and report monthly activity (i.e., through reimbursement requests) in terms of the individual drugs dispensed (utilizing a locally-defined drug coding system to be provided by the County), the number of prescriptions filled for each drug, the number of pills or units dispensed, the amount of Ryan White Program funds spent dispensing each drug, and the unduplicated number of clients that received each drug limited to those medications listed in the

most recent release of the local Ryan White Part A Program Prescription Drug Formulary.

Provider monthly reports (i.e., reimbursement requests) for consumable medical supplies must include the number of clients served, medical supply distributions with HCPCS codes as appropriate per client, and dollar amounts per client.

E. **Ryan White Part A Program Prescription Drug Formulary:** Ryan White Program funds may only be used to purchase or provide vitamins, appetite stimulants, and/or other prescription medications to program clients as follows:

- Prescribed medications that are included in the most recent release of the Ryan White Part A Program Prescription Drug Formulary. This formulary is subject to periodic revision; and

- Medications, appetite stimulants, or vitamins that have been prescribed by the client's licensed medical provider. **IMPORTANT NOTE**: Prescriptions for vitamins may be written for a 90-day (calendar days) supply.

F. **Letter of Medical Necessity: Continuous Glucose Monitoring (CGM) Devices** require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 2026 Service Delivery Manual for copies of the Letters of Medical Necessity, as may be amended):

ADDITIONAL IMPORTANT NOTES:

- **Medical Case Managers must work with clients to explore in a diligent and timely manner all health insurance options and evaluate the client's best option to ensure that health insurance premiums, deductibles and prescription drug copayments are reasonable and covered by the appropriate payer source. For Medicare Part D recipients, any client whose gross household income falls below 150% of the 2026 Federal Poverty Level (FPL) must be enrolled in the Low-Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 135% and 150% of the FPL must be enrolled in ADAP for assistance with prescription drug expenses. For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who falls into the "donut hole," must be referred to the ADAP Program.**

- **AS OMB RECEIVES ADDITIONAL INFORMATION FROM FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), HEALTH EXCHANGES, OR ANY SUBSEQUENT HEALTH CARE LAW, THIS MANUAL MAY BE**

REVISED.

OUTPATIENT/AMBULATORY HEALTH SERVICES

(Year 3~~5~~6 Service Priorities: #~~4~~3 for Part A and MAI)

A. **Outpatient/Ambulatory Health Services** are core medical services. These services include primary medical care and outpatient specialty care required for the treatment of people with HIV or AIDS. These services focus on timely/early medical intervention and continuous health care and disease treatment and management over time. Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service (PHS) guidelines. Such care must include access to antiretroviral (ARV) and other prescription drug therapies, including prophylaxis and treatment of opportunistic infections (OI) and combination ARV therapies.

IMPORTANT NOTE: Services are restricted to outpatient services only.

For the outpatient medical services to be considered Ryan White Program allowable, such services must be provided in relation to a client's HIV+ diagnosis, co-morbidity, or complication related to HIV treatment. This program allowable relationship must be clearly documented in the client's medical chart, in the Primary Care Provider's referral to specialty care services, and in any corresponding Ryan White Program In Network Referral or general Out of Network Referral. A list of the most current Allowable Medical Conditions, as may be amended, is included in Section VIII of this FY ~~2025~~ 2026 Service Delivery Manual for reference. For clarity, one or more of the listed conditions along with one of the following catch-phrases should be included in the licensed medical provider (MD, DO, APRN, PAs) notation and related referral, as appropriate:

- Service is in relation to this client's HIV diagnosis.
- Service is needed due to a related co-morbidity.
- Service is needed due to a condition aggravated or exacerbated by this client's HIV.
- Service is needed due to a complication of this client's HIV treatment.
- Routine diagnostic test conducted as a standard of care (SOC)
    - The SOC should be implemented as recommended by established medical guidelines, including, but not limited to, Public Health Service (PHS), American Medical Association, Health Resources and Services Administration; see Minimum Primary Medical Care Standards for Chart Reviews in Section III of this Service Delivery Manual document or other local guidelines, as may be amended.

Telehealth services are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

I. Primary Medical Care

1. Primary Medical Care Definition and Functions: Primary medical care includes the provision of comprehensive, coordinated, professional diagnostic and therapeutic services rendered by a licensed medical provider (MD, DO, APRN, PAs) who is licensed in the State of Florida to practice medicine to prescribe ARV therapy in an outpatient setting. Outpatient settings include clinics, medical offices, and mobile vans where clients in general do not stay overnight. **Emergency rooms are not considered outpatient settings; therefore, emergency room services are not covered by the Ryan White Part A/MAI Program. Inpatient (hospital, etc.) services are also not covered.**

Although HRSA allows for urgent care center services to be payable through the Ryan White Program, non-HIV related visits to urgent care facilities are not allowable or reimbursable costs within the Outpatient/Ambulatory Health Services Category (see HRSA Policy Clarification Notice #16-02). The Miami-Dade HIV/AIDS Partnership, as advised by its Medical Care Subcommittee, has elected not to include this component as an allowable service locally. This decision was made due to the complex logistics involved in limiting this component to the treatment of HIV-related services, as required by HRSA; and the fact that Ryan White Part A/MAI Program-funded Outpatient/Ambulatory Health Services subrecipients are required to maintain procedures (i.e., an accessible phone line for clients to call for assistance) for clients who have urgent/emergent health issues after hours.

Allowable activities include: medical history taking; physical examination; diagnostic testing, including, but not limited to, laboratory testing; treatment and management of physical and behavioral health conditions; behavioral risk assessment, subsequent counseling, and referral; preventive care and screening; pediatric development assessment; prescription and management of medication therapy; treatment adherence; education and counseling on health and prevention issues; and referral to specialty care related to client's HIV diagnosis, co-morbidity, or complication of HIV treatment. Services also include diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, continuing care and management of chronic conditions, and referral to specialty care (including all medical subspecialties if related to the client's HIV diagnosis, co-morbidity, or complication of HIV treatment), as necessary. Chronic illnesses usually treated by primary care providers include hypertension, heart failure, angina, diabetes, asthma, chronic obstructive pulmonary disease (COPD), depression, anxiety, back pain, thyroid dysfunction, and HIV.

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered either billable under Medical Case Management or Outpatient/Ambulatory Health Services, depending on how the visit occurred. Treatment Adherence Services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category (using the appropriate CPT billing code); whereas Treatment Adherence Services provided during a Medical Case Management visit shall be reported in the Medical Case Management service category (using the ADH billing code).

a. New to Care Clients

One (1), initial primary medical care visit may be provided to a newly identified client (i.e., a newly diagnosed client) who has a preliminary reactive test result and a pending confirmatory HIV test result, if the client was properly referred by a Medical Case Manager or Outreach Worker. To be valid for this purpose, the referral must have an indication that the client is a "newly identified client" (NIC). Such initial primary medical care visits must be scheduled and provided within 30 calendar days of referral from the Medical Case Manager or Outreach Worker. Otherwise, a confirmatory HIV test result will be required to obtain further services.

b. Limitations on Specialty Testing

Before prescribing Selzentry (Maraviroc), a Highly Sensitive Tropism Assay (test), formerly known as the Trofile Tropism Assay, must be performed and documented in the client's chart to determine appropriateness of the treatment regimen. The Highly Sensitive Tropism Assay includes the Trofile, Trofile DNA, or Quest Diagnostics Tropism assay. If the cost of the Highly Sensitive Tropism Assay is being covered by any other payer source, clients must access the test through those resources first.

ViiV Healthcare currently covers the cost of the following test at no charge to eligible clients or the Ryan White Program: the HLA-B*5701 screening test. This screening test is available to assist clinicians in identifying clients who are at risk of developing a hypersensitivity reaction to abacavir (Ziagen). Whenever the cost of the HLA-B*5701 screening test can be covered by the ViiV Healthcare or any other source, providers **cannot** bill the local Ryan White Program for reimbursement of this test. As of December 1, 2019, FDOH/ADAP clients do not need certificates for HLA Aware program. They simply use either their designated Quest Diagnostic lab or LabCorp code (that was listed on their certificates) for reimbursement by ViiV Healthcare. Contracted providers that serve FDOH/ADAP clients do not need to send clients to FDOH/ADAP, they just need to enter the appropriate code depending on which lab they use. FDOH already has this code as part of their EHR system. The Ryan White Program must be the payer of last resort. Utilization of the HLA-B*5701 screening test as billed to the local Ryan White

Program will be monitored, and reimbursement may be denied if documentation does not support the use of Ryan White Program funds as a last resort.

2. **Client Education:** Providers of primary medical care services are expected to provide the following basic education as part of client care:

   - Treatment options, with benefits and risks, including information about state-of-the-art combination drug therapies and reasons for treatment;
   - Self-care and monitoring of health status;
   - HIV/AIDS transmission and prevention methods; and
   - Significance of CD4 counts, viral load and related disease aspects, adherence and resistance concepts.

3. **Adherence Education:** Providers of primary medical care services are responsible for assisting clients with adherence in the following ways:

   - Adherence with medication regimens in order to reduce the risk of developing and spreading a resistant virus and to maintain health;
   - Taking medications as prescribed, and following recommendations made by Physicians, Physician Assistants, Advanced Practice Registered Nurses, Nutritionists, and Pharmacists;
   - Client involvement in the development and monitoring of treatment and adherence plans; and
   - Ensuring immediate follow-up with clients who miss their prescription refills, medical appointments, and/or who experience difficulties with treatment adherence.

4. **Coordination of care:** Providers of primary medical care services are responsible for ensuring continuity and coordination of care. They must:

   - Maintain contact as appropriate with other caregivers (medical case manager, nutritionist, specialty care licensed medical provider, pharmacist, counselor, etc.) and with the client in order to monitor health care and treatment adherence;
   - Ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives; and
   - Identify a single point of contact for mMedical cCase mManagers and

other agencies that have a client's signed consent and other required information.

5. Additional primary medical care services may include:

- Respiratory therapy needed as a result of HIV infection.
- Mental health services may be billed under Outpatient/Ambulatory Health Services when provided by a licensed psychiatrist or other licensed medical provider (MD, DO, APRN, PAs), clinical psychologist, clinical social worker, or clinical nurse specialist.

II. Outpatient Specialty Care

1. Outpatient Specialty Care Definition and Functions: This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for program-eligible clients who are referred by a primary care provider through a Ryan White Program In Network Referral, OON referral, or prescription referral. Specialty medical care includes cardiology, chiropractic, colorectal, clinical psychiatry, dermatology, ear, nose and throat/otolaryngology, endocrinology, gastroenterology, hematology/oncology, hepatology, infectious disease, orthopedics/rheumatology, nephrology, neurology, nutritional assessments or counseling (performed by a Registered Dietitian), obstetrics and gynecology, ophthalmology/optometry, pulmonology, respiratory therapy, urology, and other specialties **as related to the client's HIV diagnosis, co-morbidities, or complications of HIV treatment (see Allowable Medical Conditions List in Section VIII of this FY 202~~5~~6 Service Delivery Manual).**

Additional medical services, which may be provided by other Ryan White Program subrecipients, may include outpatient rehabilitation, podiatry, physical therapy, occupational therapy, and speech therapy as related to the client's HIV diagnosis, co-morbidities, or complications of HIV treatment. Pediatrics and specialty pediatric care are included in the list of specialties above. A Mental Health Services provider may also make referrals to clinical psychiatry. (**IMPORTANT NOTE**: Referrals to outpatient specialty care services for ongoing treatment must include documentation or a notation to support the specialty's relation to the client's HIV diagnosis, co-morbidity, or complication of HIV treatment.)

a. Other Specialty Care Limitations or Guidelines:

i. **Chiropractic services** under the Ryan White Program are limited to services in relation to the client's HIV diagnosis. These services may relate to pain caused by the disease itself or pain that is a consequence of HIV medications. Chronic pain is also considered a co-morbidity to HIV and may also be treated when appropriate. Chiropractors affect the nervous system and immune system by utilizing spinal adjustments and physiotherapy to the spine and body that may assist the nervous system in operating to the best of its ability to fight HIV-related infection, disease, and symptomatology. Chiropractic physicians may adjust, manipulate, or treat the human body by manual, mechanical, electrical or natural methods; by the use of physical means or physiotherapy, including light, heat, water, or exercise, or by the administration of foods, food concentrates, food extracts, and items for which a prescription is not required. Chiropractic services for non-HIV related injuries or conditions are not covered. Examples of non-HIV related injuries or conditions are slip and falls, car accidents, sports injuries, and acute pain.

ii. **Podiatry services** under the County's Ryan White Program are limited to services in relation to a client's HIV diagnosis or co-morbidity (e.g., diabetes). The local Ryan White Part A/MAI Program will reimburse providers for the diagnostic evaluation of foot and ankle pain. Podiatry services for the treatment of peripheral neuropathy, HIV-related medication side effects (e.g., HAART/protease inhibitor medication regimens may cause ingrown toenails), onychomycosis, and diabetic foot care due to circulatory problems will be covered by the County's Ryan White Program. Conditions such as hammer toes, bunions, heel spurs may be covered if related to neuropathies. Sprains or fractures are not covered unless a direct connection to neuropathies is present. Furthermore, general podiatry services for non-HIV-related or non-diabetic-related foot injuries or conditions are not covered by the County's Ryan White Program.

iii. **Optometry and ophthalmology services** under the Ryan White Program are also limited to services in relation to a client's HIV diagnosis or co-morbidity. An annual eye exam solely for the purpose of routine eye care (especially for vision correction with glasses or contact lenses) is not covered by the local Ryan White Part A/MAI Program. In accordance with the most current local Ryan White Part A Program's Allowable Medical Conditions list, as may be amended, clients must

meet at least one of the following criteria to access ophthalmology/optometry services:

- Client has a low CD4 count (at or less than 200 cells/mm^3 *currently*
- Client has a comorbidity (e.g., diabetes, hypertension, STI, etc.)
- Client has a prior diagnosis of cytomegalovirus retinitis (CMV)
- Client has Immune Reconstitution Syndrome

Furthermore, referrals to an optometrist or ophthalmologist must indicate a condition attempting to rule out complications of HIV. See the Allowable Medical Conditions List in Section VIII of this Service Delivery Manual for a list of conditions that would apply, such as manifestations due to opportunistic infections, visual disturbances to rule out complications of HIV, and history of sexually transmitted infections (STI) or complications of STI.

iv. Per Federal guidelines, **acupuncture services** are not covered under this service category, as Ryan White Program funds may only be used to support limited acupuncture services for program-eligible clients as part of substance abuse treatment services.

v. **Obstetric services:** Although the selection of a Ryan White Program-funded service provider is based on client choice, pregnant women should be referred to the University of Miami OB/GYN Department (Ryan White Part D Program, etc.) whenever possible due to its specialized care for this HIV population.

vi. **Pediatric, adolescent and young adult services:** Whenever possible and also based on client choice, providers are strongly encouraged to refer clients who are 13 to 24 years of age to the University of Miami's pediatric and adolescent care departments due to their specialized care for this HIV population and age group.

IMPORTANT NOTE: Under the local Ryan White Part A/MAI Program, primary medical care provided to people with HIV is not considered specialty care.

2. Client Education: Providers of specialty care services will be expected to provide the following basic education as part of client care:

- Basic education to clients on various treatment options offered by the specialist;

- Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the primary care or HIV licensed medical providers; and

- Educating clients about HIV/AIDS and its relationship to the specialty care service being provided.

3. **Coordination of Care:** The specialist must communicate, as appropriate, with the primary care licensed medical care provider and client for results, follow-up, and/or to re-evaluate the client in order to coordinate treatment.

The following subsections B. through I. are for both Primary and Specialty Care, unless otherwise noted:

B. Program Operation Requirements:

- Providers must offer, post, and maintain walk-in hours to ensure maximum accessibility to Outpatient/Ambulatory Health Services, to ensure that medical services are available to clients for urgent/emergent issues;

- Providers must demonstrate a history and ability to serve Medicaid and Medicare eligible clients; and

- **For Primary Medical Care Only:** Providers must ensure that medical care professionals: 1) have a minimum of three (3) years of experience treating HIV clients; or 2) have served a high volume of people with HIV (i.e., >50% of individual caseload per practitioner) in the past year. Certification from the American Academy of HIV Medicine (AAHIVM) is encouraged, but not required.

- **For Outpatient Specialty Care Only:** A referral from the client's Primary Care Providers or HIV Physician is required for all program-allowable specialty care services. Referrals to Outpatient Specialty Care services must be issued through the Provide® Enterprise Miami data management system and must indicate whether the referral is for a diagnostic appointment/test or for ongoing medical treatment. If the specialty care referral is for ongoing medical treatment the referrals must include supporting documentation that the ongoing care is HIV-related, comorbidity-related, and related to a complication of HIV treatment, as detailed in the most current, local Allowable Medical Conditions list.

C. Additional Service Delivery Standards: Providers of Outpatient/Ambulatory Health Services will also adhere to the following guidelines and standards, as may be amended (please refer to Section III of this FY 202~~5~~6 Service Delivery Manual for details):

- Public Health Service Clinical Guidelines for the Treatment of AIDS Specific Illnesses (as amended and current); also see Section I, below.
- Minimum Primary Medical Care Standards.

D. Rules for Reimbursement: Providers will be reimbursed for program allowable outpatient primary medical care and specialty care services as follows, unless a procedure has been disallowed or discontinued by the Miami-Dade County Office of Management and Budget-Grants Coordination:

Commented [MM1]: The items in this section are updated by OMB-GC, as available.

- Reimbursements for medical procedures and follow-up contacts to ensure client's adherence to prescribed treatment plans will be no higher than the rates found in the "2023 Florida Medicare Part B Physician Fee Schedule (Participating, Locality/Area 04), revised/modified January 9, 2023." Codes 99205 and 99215 remain discontinued under this local Ryan White Part A/MAI Program. Code 99201 was also discontinued.

- Reimbursements for lab tests and related procedures will be based on rates no higher than those found in the "2023 Medicare Clinical Diagnostic Laboratory Fee Schedule, Calendar Year (CY) 2023 Quarter 1 (Q1) Release, added for January 2023, modified January 12, 2023."

- Reimbursements for injectables will be based on rates no higher than those found in the "2023 Medicare Part B Drug Average Sales Price (ASP) Drug Pricing Files, Payment Allowance Limits for Medicare Part B Drugs, updated January 30, 2023 (payment limit column)."

- Reimbursements for medical procedures performed at Ambulatory Surgical Centers (ASC) will be no higher than the rates found in the "2023 Florida Medicare Part B ASC Fee Schedule, by HCPCS Codes and Payment Rates,

PDF dated January 5, 2023, electronic file modified January 11, 2023; for Core Based Statistical Area 33124 (Miami, FL)." (Applies only to organizations with on-site or affiliated Ambulatory Surgical Centers).

- Reimbursements for medical procedures performed at Outpatient Hospital centers will be no higher than the rates found in the approved "Medicare Addendum B Outpatient Prospective Payment System (OPPS) by HCPCS Code for CY 2023 (January 2023), corrected January 20, 2023 (note "b.01.20.23" in file name)." (Applies only to organizations with on-site or affiliated outpatient hospital centers).

    - Opposite to Medicare's procedure guidelines, the local Ryan White Program discontinued the use of HCPCS code G0463 (hospital outpatient clinic visit). It is necessary for the local Ryan White Program to track the level of service provided to clients; therefore, providers of OPPS-APC services should continue to use CPT codes 99202-99204 or 99211-99214, as applicable to the services provided, instead of G0463.

- Evaluation and management visits and psychiatric visits will be reimbursed at rates no higher than the Medicare "allowable" rates times a multiplier of up to 2.5.

- If the client is eligible for ADAP, that program should be accessed for genotype and phenotype testing if available.

- No multiplier will be applied to reimbursement rates for laboratory tests and related procedures, for non-evaluation and management procedures, for injectables, or for supplemental procedures.

- Medical procedures with an active Current Procedural Terminology (CPT) code that are excluded from the Medicare Fee Schedules may be provided on a supplementary schedule, upon request from the provider to the County for review. A flat rate along with a detailed description of the procedure and a cost justification for each supplemental procedure must be included in the provider's submission request for review and approval by the County.

- Consumable medical supplies are limited and are only covered when needed for the administration of prescribed medications. Allowable consumable medical supplies are available only through the local Ryan White Program's

AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program – LPAP) service category. A list of allowable consumable medical supplies can be found as an attachment to the most current, local Ryan White Program Prescription Drug Formulary (i.e., Attachment B of the referenced Formulary).

- Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for details regarding the reimbursement of telehealth/telemedicine services.

E. **Rules for Reporting:** Providers' monthly reports (i.e., reimbursement requests) for Outpatient/Ambulatory Health Services must include the number of clients served, billing code for the medical procedures provided, number of units of service provided, and the corresponding reimbursement rate for each service provided. Providers must also develop a method to track and report client wait time (e.g., the time it takes for a client be scheduled to see the appropriate medical provider after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the medical provider) and to make such reports available to OMB staff or authorized persons upon request.

F. **Additional Rule for Reimbursement:** Requests for reimbursement of primary and/or specialty medical care services that are not submitted to the County within four (4) calendar months from the date of service may be denied.

G. **Additional Rules for Documentation:** Providers must ensure that medical records document services provided (e.g., medical visits, lab tests, diagnostic tests, etc.), the dates and frequency of services provided, as well as an indication that services were provided for the treatment of HIV infection, a co-morbidity, or complication of HIV treatment. Clinician notes must be signed by the licensed provider of the service and maintained in the client chart or electronic medical record. Providers must maintain professional certifications and licensure documents of the medical staff providing services or ordering tests and must make them available to OMB staff or authorized persons upon request. Providers must ensure that chart notes are legible and appropriate to the course of treatment as mandated by Florida Administrative Code 64B8-9.003; and pursuant to Article VII, Section 7.1, of the provider's Professional Services Agreement with Miami-Dade County for Ryan White Program-funded services.

H. **Additional Client Eligibility Criteria:** Clients receiving Outpatient/Ambulatory Health Services must be documented as having been properly screened for other public sector funding as appropriate annually, every 366 days. ~~(NOTE: The recertification period for ADAP and Part A is expected to be updated within this grant fiscal year, with no less than 30 calendar days' notice.)~~ While clients qualify for and can access medical services through other public funding [including, but not limited to, Medicare, Medicaid, Medicaid Managed Medical Assistance

(MMA), or Medicaid Long-Term Care (LTC)], or private health insurance, they will not be eligible for Ryan White Part A Program-funded Outpatient/Ambulatory Health Services, except for such program-allowable services that are not covered by the other sources.

I. Additional Treatment Guidelines and Standards

Guidelines: Providers will adhere to the following federal approved ~~clinicial~~clinical practice guidelines for HIV/AIDS~~clinical guidelines for treatment of HIV/AIDS specific illnesses~~ (which can be found at https://clinicalinfo.hiv.gov/en/guidelines, ~~unless otherwise noted below~~):

- ~~Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv; pp 1-604; updated March 23, 2023. Accessed 11/13/2023.~~
- Adult and Adolescent ARV
- Adult and Adolescent Opportunistic Infections
- Pediatric ARV
- Pediatric Opportunistic Infections
- Perinatal HIV Clinical Guidelines
- Guidelines for Caring for People with HIV Displaced by Disasters
- ~~Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv; pp 1-671; updated April 11, 2023. Accessed 11/13/2023.~~

- ~~Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs During Pregnancy and Interventions to Reduce Perinatal HIV Transmission in the United States. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/perinatal; pp 1-614; updated January 31, 2023. Accessed 11/13/2023.~~

- ~~Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association, and Infectious Diseases Society of America. 2023. Available at:~~

~~https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections; pp 1-670; updated September 25, 2023. Accessed 11/13/2023.~~

- ~~Panel on Opportunistic Infections in Children with and Exposed to HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Children with or Exposed to HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-pediatric-opportunistic-infections/updates-guidelines-prevention; pp 1-485; updated September 14, 2023. Accessed 11/13/2023.~~

- ~~Guidelines Working Groups of the NIH Office of AIDS Research Advisory Council. Guidance for COVID-19 and People with HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/guidance-covid-19-and-people-hiv/guidance-covid-19-and-people-hiv; pp 1-19; updated February 22, 2022. Accessed 11/13/2023.~~

- ~~U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau. Clinical Care G0uidelines/Protocols, including the following, as appropriate: Guide for HIV/AIDS Clinical Care (2014), A Guide to the Clinical Care of Women with HIV (2013), A Guide for Evaluation and Treatment of Hepatitis C in Adults Coinfected with HIV (2011); and reference guides to help health care professionals as their aging population grows (e.g., "Incorporating New Elements of Care" and "Putting Together the Best Health Care Team". Available at: https://ryanwhite.hrsa.gov/grants/clinical-care-guidelines-resources#clinical-protocols. Date Last Reviewed: February 2022. Accessed 11/13/2023.~~

- Additional Education Materials (e.g., fact sheets, infographics and glossary) on HIV Overview; HIV Prevention; HIV Treatment; Side Effects of HIV Medicines; HIV and Pregnancy; HIV and Specific Populations; HIV and Opportunistic Infections, Coinfections and Conditions; and Living with HIV (including but not limited to finding HIV treatment services; Mental Health; Nutrition and Food Safety; and Substance Use). Available at: https://hivinfo.nih.gov/understanding-hiv/fact-sheets Accessed 10~~1~~/09~~13~~/2023~~2~~5.

- In addition, providers will adhere to other generally accepted clinical practice guideline standards, as follow:

  Standards:

  - Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC.

- ~~T~~Providers will inform clients as to generally accepted clinical guidelines for pregnant women with HIV, treatment of AIDS specific illnesses,

  clients infected with tuberculosis, hepatitis, or sexually transmitted infections, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.

~~clients infected with tuberculosis, hepatitis, or sexually transmitted diseases~~infections~~, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.~~

- ~~Providers will screen for TB and make necessary referrals for appropriate treatment. In addition, providers will follow Universal Precautions for TB as recommended by the CDC. Providers will also screen for hepatitis, sexually transmitted diseases, and other priorities identified by the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee.~~

IMPORTANT NOTE: FEDERAL FUNDERS AND/OR STATE LEGISLATIVE BODIES REGARDING IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), HEALTH EXCHANGES, OR ANY SUBSEQUENT HEALTH CARE LAW, THIS MANUAL MAY BE REVISED.

EMERGENCY FINANCIAL ASSISTANCE

(Year ~~35~~ 36 Service Priorities: #~~14~~ 8 for Part A and #~~9~~8 for MAI)

Emergency Financial Assistance is a support service. Under the local Ryan White Part A and MAI Programs, Emergency Financial Assistance provides limited one-time or short-term provision of approved formulary HIV/AIDS-related medications only, either directly or through a voucher program, while a client's eligibility for medication assistance is pending with a third-party payer. Subrecipients must be a Ryan White Part A or MAI Program-funded subrecipient also receiving AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program) funding and must have a current Public Health Service 340B certification from the federal Office of Pharmacy Affairs. It is expected that all other sources of funding in the community for emergency assistance will be effectively used and that any allocation of Ryan White Part A or MAI Program funds for these purposes will be as the payer of last resort, and for limited amounts, use and periods of time.

Currently, these funds are limited to short-term medication support for Test and Treat Rapid Access (TTRA). Funding under this service category is **limited**.~~-~~

A. Test and Treat Rapid Access (TTRA) Medications

~~t~~The provision of short-term access to antiretroviral medications (ARV) for clients participating in the Test and Treat / Rapid Access (TTRA) protocol. In such instances, these services would only be used when the Florida Department of Health's financial resources for ARV medications under the local TTRA protocol have been depleted and the client is not yet enrolled in ADAP. Only clients whose gross household income is at or below 400% of the Federal Poverty Level and have a pending application with a third-party payer (e.g., ADAP or private insurance) are eligible for this assistance. Emergency Financial Assistance must occur as a direct payment to an agency or through a voucher program. Direct cash payments or reimbursements to a program client are not permitted.

Medications in the TTRA protocol, as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

- Biktarvy®
- Descovy® + Prezcobix®
- Dovato®
- Symtuza®
- Tivicay® + Descovy®

Medications in the TTRA protocol for women of childbearing potential (or for women presenting with pregnancy potential on inadequate contraception), as may be amended based on guidance from the Florida Department of Health in Miami-Dade County, include:

• Tivicay® + Truvada®
• Tivicay® + Descovy®
• Prezista® + Norvir®

IMPORTANT NOTES:

1) Tivicay® (dolutegravir) replaced Isentress® as a regimen appropriate and recommended for women at all stages of pregnancy – conception to birth. Tivicay® may be used with either Truvada® or Descovy®. The Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission (the Panel) recommends dolutegravir (DTG) as a Preferred antiretroviral (ARV) drug throughout pregnancy and now also recommends DTG as a Preferred ARV for women who are trying to conceive. (2/10/2021)

2) Dovato® (dolutegravir/lamivudine) has clinical data on use in the Test and Treat scenario (STAT clinical trial). Dovato® samples or vouchers can be obtained from ViiV Healthcare pharmaceutical representatives for use in subrecipient clinic(s). As such, the Florida Department of Health cannot be invoiced for this medication.

3) Symtuza®; subrecipients / service providers may prescribe this medication, but they must use the voucher provided by Janssen Pharmaceuticals to cover the cost of this medication. As such, the Florida Department of Health cannot be invoiced for this medication.

4) Should the need arise (i.e., when Florida Department of Health's TTRA medication funds are depleted) to implement this service category, the funds available under this service category may increase through the Reallocations/Sweeps process. Furthermore, if this service category is implemented, the rules under AIDS Pharmaceutical Assistance (Local AIDS Pharmaceutical Assistance Program) apply, except for the allowable medications which are limited to the most current, loc ally-approved medications for the TTRA protocol.

~~4)~~

FOOD BANK

(Year ~~35~~ 36 Service Priority: #~~6~~ 9 for Part A

Food Bank is a support service. The Food Bank program is a central distribution center providing actual food items (groceries), and personal hygiene products when available, for low-income persons living with HIV. Groceries are distributed in cartons or bags of assorted products to eligible Ryan White Program clients. Local Food Bank assistance will be provided on a temporary, as needed basis to eligible clients to help maintain their health by providing a balanced, adequate diet.

Food Bank providers must offer nutritional counseling to all Food Bank clients through qualified staff supervised by a Licensed Dietitian or Nutritionist. A referral to a Registered Dietitian under a Ryan White Program-funded Outpatient/Ambulatory Health Services provider (specialty care; a core medical service) may also be made for nutritional services to meet this requirement. Proof of the provision of nutrition services from the Food Bank provider, or a referral for nutrition services to an appropriate provider, or the client declining such service must be documented in the client's record.

Ryan White Program funds for Food Bank services may not be used for water filtration/purification systems in communities where issues of water safety do not exist, household appliances, pet foods, or other non-essential products.

A. Program Operation Requirements:

A.1 Standard Provisions

Food Bank services may be provided only on an **emergency basis**. For this program, an emergency is defined as an extreme change of circumstance: loss of income (i.e., job loss or departure of person providing support), loss of housing, or release from institutional care (substance abuse treatment facility, hospital, jail, or prison) within the last two weeks. Duration of Food Bank service provision is to be **temporary**. Other emergencies, as defined by the client's Medical Case Manager, must be documented in the client's chart (or in the Client Profile in the Provide® Enterprise Miami data management system) as they arise. A severe change to the client's medical condition, as defined below under the provision for additional occurrences, may also be considered an emergency.

Medical Case Managers must conduct initial and ongoing assessment of each client to determine if the client is eligible for food-related services under any other public and/or private funding source, including food stamps or other charity care food banks and food distribution events.

Unless otherwise approved by the Miami-Dade County Office of Management and Budget, the provision of this service will be limited to twenty (20) occurrences within the Ryan White Part A Fiscal Year (March 1, ~~2025~~ 2026 through February 28, ~~2026~~2027). One (1) occurrence is defined as all Food Bank services provided within one (1) calendar week. For example, a client could receive Food Bank services once a week every week for five (5) months, or twice per month for ten (10) months, in the grant Fiscal Year or any variation thereof, with the limit of twenty (20) occurrences in the grant Fiscal Year.

Groceries, including personal hygiene products when available, can be picked up on a weekly or monthly basis. If groceries will be picked up on a **weekly** basis, the client will be limited to groceries valued at $85.00 per week at each pick-up. A client accessing Food Bank services on a weekly basis may not pick up groceries sooner than seven (7) days from the prior pick-up day.

If the client chooses to pick up groceries on a **monthly** basis, the client will be limited to groceries valued at $85.00 per week multiplied by the number of times the original day of pick-up occurs in the month. A client accessing Food Bank services on a monthly basis may not pick up groceries in a new month prior to the same pick-up day from the previous month.

Providers must make every effort to obtain matching funds, donations, or any supplemental assistance for the program and these efforts should be documented. Providers must also be familiar with and capable of referring clients to other community, faith-based, and/or neighborhood Food Bank sites when the client is not in an emergency situation and/or has reached their Food Bank allowance limit.

Providers must be able to provide ethnic foods and foods suited to special client dietary needs.

A.2. Initial Referral and Additional Occurrences

A letter of medical necessity is NOT required for a referral to Food Bank services for the client's first twenty (20) occurrences during the grant fiscal year; however, the circumstances justifying the referral to Food Bank services should be clearly documented in the client's chart and a Ryan White Program In Network Referral should be generated by the Medical Case Manager. A completed Out of Network Referral is also acceptable for this support service. Once the client's initial twenty (20) occurrences are exhausted, the client may NOT receive additional Food Bank services during the same Ryan White Part A Fiscal Year (i.e., March 1, ~~2025~~ 2026 through February 28, 202~~6~~7) **without a Ryan White Program Nutritional Assessment Letter for Food Bank Services**

A **severe** change to the client's medical condition (i.e., new HIV-related diagnosis/symptom, wasting syndrome, protein imbalance, recent chemotherapy, recent hospitalization, etc.) may warrant additional occurrences of Food Bank services. When needed for the additional occurrences, the **Ryan White Program Nutritional Assessment Letter for Food Bank Services** must be completed by a licensed medical provider **OR** a Registered Dietitian or Licensed Nutritionist not associated with the Ryan White Part A Program-funded Food Bank provider. The client must be reassessed for the medical condition justifying additional Food Bank services every four (4) months. The Physician or Registered Dietitian or Licensed Nutritionist must specify the frequency and number of additional Food Bank visits (occurrences) that should be allowed for the client (maximum of sixteen (16) additional occurrences).

A.3. Provision for Families

In addition to the maximum amount defined above for groceries available per week to eligible clients, each additional adult who is a person with HIV and lives in the same household is eligible to receive $85.00 per week in groceries, subject to the same service guidelines. Each dependent (i.e., minors under 18 years of age and living in the same household as the client who is a person with HIV) is also eligible to receive $26.00 per week in groceries, subject to the same service guidelines above. The client must provide documentation to prove the dependent's age and place of residence.

B. Rules for Reimbursement:

Providers will be reimbursed based on properly documented invoices reflecting the distribution of weekly bags of groceries, including personal hygiene products, plus a dispensing charge to be agreed upon between the provider and the Miami-Dade County Office of Management and Budget-Grants Coordination (OMB-GC). The cost of the weekly bag of groceries will not exceed $85.00. Providers will also submit a quarterly reconciliation of actual expenditures for food costs, staffing expenses, and other line items as listed on the approved budget.

C. Additional Rules for Reporting:

Providers must report monthly activities according to client visits (i.e., weekly occurrences). Providers must also submit to OMB an assurance that Ryan White Program funds were used only for allowable purposes in accordance with the contract agreement, and that the Ryan White Program was used as the payer of last resort. Providers must also submit an assurance regarding compliance with all federal, state, and local laws regarding the provision of Food Bank services, including any required licensure and/or certifications.

D. Additional Rules for Documentation:

Providers must maintain documentation of the amount and use of funds for purchase of non-food items; and make this documentation available to OMB staff upon request.

E. Special Client Eligibility Criteria:

A Ryan White Program In Network Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service; and must be entered in the Provide® Enterprise Miami data management system. Current referrals expire automatically on February 28th of each Fiscal Year (or February 29th if a leap year). Each Medical Case Management referral must document the number of eligible dependents (i.e., minors). For additional occurrences, the client must be reassessed for the medical condition justifying additional Food Bank services every four (4) months. Providers must document that clients who receive Ryan White Part A Program- funded Food Bank services have gross household incomes that do not exceed **250%** of the 2025~~5~~6 Federal Poverty Level (FPL).

Clients who fall between **251% to 400% FPL** should be referred to the **Ryan White Part B Program** to access Emergency Financial Assistance resources, as funding allows; or to other resources in the community.

Clients receiving Food Bank services must be documented as having been properly screened for Supplemental Nutrition Assistance Program (SNAP) (formerly known as the Food Stamp program) benefits, home-delivered meal services through Medicaid's Long-Term Care (LTC) program, other community food bank programs, or other public sector funding as appropriate. Medical Case Managers must document a client's need for food services in the client's Plan of Care (POC) and indicate if the client is eligible to access food services under other available programs, with the understanding that the Ryan White Program-funded Food Bank services are provided on an emergency basis and as payer of last resort. If the client is eligible to receive food service benefits from another source, the Medical Case Manager will assist the client in applying to such program(s). If the client already receives SNAP benefits when requesting Ryan White Program-funded Food Bank services, the client must submit a copy of their SNAP award/benefit letter as documentation that the award is $250.00 or less per month in nutrition assistance benefits per person in the household; unless otherwise adjusted by the Office of Management and Budget-Grants Coordination/Ryan White Program with written notification to subrecipients. If the client applied for Food Stamp benefits and was denied, a copy of the denial letter must be scanned into the Client Profile in the Provide® Enterprise Miami data management system.

While clients reside in institutional settings (i.e., nursing home or a substance abuse residential treatment facility) they will not qualify for Ryan White Part A Program-

funded Food Bank services. Similarly, while clients qualify for and can access other public funding for food services, they will not be eligible for Ryan White Part A Program-funded Food Bank services, unless the provider is able to document that the client has an emergency need, or has applied for such benefits and eligibility determination is pending (a copy of benefit application must be kept in the client's chart).

MEDICAL TRANSPORTATION

(Year 3~~5~~6 Service Priorities: #10 for Part A and #~~7~~ 5 for MAI)

Medical Transportation is a support service. Medical Transportation is the provision of non-emergency transportation services that enables an eligible client to access or be retained in core medical and support services. Locally, this service is limited to specially-designated, discounted EASY Tickets (transportation vouchers) from the Miami-Dade County Department of Transportation and Public Works (DTPW~~; formerly Miami-Dade Transit Agency-MDTA~~) to program-eligible people with HIV attending medical and/or social service appointments. Daily, weekly and monthly discounted EASY Tickets are available when using the discounted EASY Tickets option. Alternative methods (such as ride-sharing services like Uber, UberHealth, Lyft, etc.) may be available, where requested by a Part A/MAI-funded subrecipient and approved by the Miami-Dade County Office of Management and Budget-Grants Coordination.

Providers of discounted EASY Tickets must demonstrate coordination with Miami-Dade County transportation agencies and services, Medicaid Special Transportation, Miami-Dade County Special Transportation Services (STS), and other existing transportation programs to avoid duplication of services. In addition, providers of transportation tickets are encouraged to apply annually to the Miami-Dade Transit Agency's Transportation Disadvantaged Program (http://www.miamidade.gov/transit/transportation- disadvantaged-program-guidelines.asp) in order to obtain assistance for clients who are eligible under that program, where applicable. As a reminder, in all cases, the Ryan White Program must be used as the payer of last resort.

A. Program Operation Requirements: Discounted EASY Tickets are available to program-eligible clients who meet the requirements of this service category, for unlimited trips during the calendar month. These specially-designated EASY Tickets will not be usable in other months and are not "re-loadable."

These monthly transportation tickets should be distributed in a timely manner in order to maximize ticket usage. Unused discounted EASY Tickets (transportation vouchers) **cannot** be returned to the DTPW for credit. Unused or undistributed discounted EASY tickets **cannot** be charged to the Ryan White Program.

Providers must inform clients that this type of assistance is **not** an entitlement. Therefore, the level of assistance provided to individual clients is based on relative need and voucher availability. Clients must also be informed that the availability of transportation tickets is contingent upon funding availability and, therefore, the continuance of this type of assistance is not guaranteed.

Multiple instances of reduced fare transportation assistance per client per month are **NOT** allowed regardless of circumstance, payer source, and/or government assistance program that is using/providing the subsidized fare. As payer of last resort, the Ryan White Program can only reimburse subrecipients (service providers) for EASY Ticket fares (vouchers) distributed to eligible clients that are **NOT ELIGIBLE** to receive subsidized transportation assistance or fares under **ANY OTHER** program. This restriction will be closely monitored by the County's DTPW and the Office of Management and Budget (OMB) as a condition of the Ryan White Program having program access to the discounted EASY Tickets. Lost or stolen EASY tickets **cannot** be replaced by the local Ryan White Part A Program and replacements will not be considered by DTPW.

Regular reconciliation through a secure data system match of clients receiving discounted EASY Tickets through the Ryan White Part A Program will be conducted on a quarterly basis between the County's authorized OMB and DTPW staff, to ensure clients are not receiving more than one (1) instance of reduced fare transportation assistance per month. Clients found to be receiving duplicative discounted transportation services may be banned from receiving any additional assistance from one or both sources (the County's Ryan White Program or DTPW). **Medical Case Managers and Medical Transportation subrecipients must inform clients of this restriction and the reconciliation process.**

Prior to distributing these transportation vouchers, **subrecipients of Medical Transportation services must ensure that clients**: 1) review and sign the "Miami-Dade County Ryan White Part A Program Acknowledgement to Receive Monthly Transportation Assistance" attesting to their understanding of this restriction, including consent for the reconciliation data system match; 2) indicate that they have not received other discounted transportation assistance for the same month; and 3) indicate that they do not qualify to receive free or subsidized transportation assistance (fare) from any other program. This client acknowledgement/consent form is required prior to the client receiving a discounted EASY Ticket **each month**. A copy of the acknowledgement for each month of service must be maintained in the client's record/chart at the Medical Transportation subrecipient's site.

Providers must document criteria, policies, and procedures utilized to determine transportation EASY Tickets allotments for clients that must take into account not only minimum requirements, but also consideration for those clients who demonstrate the greatest need for these services. This documentation must be provided to the Miami-Dade County Office of Management and Budget-Grants Coordination upon request.

Documentation of at least one (1) monthly medical and/or social service appointments must be submitted by the client to the Medical Case Manager before the client can receive transportation assistance, unless otherwise directed by the County. **Note: The appointment to pick up the medical transportation pass does NOT count as a visit.**

The number of required appointments is subject to change at the County's discretion with no less than thirty (30) days' written notice to all Part A/MAI- funded subrecipient agencies. Attendance at Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings also count towards the monthly appointment total. Any combination of medical, social service, AA, and/or NA appointments will count towards the required monthly total.

If allowable appointments are appropriately documented in the Client Profile in the Provide® Enterprise Miami data management system for each month of service, the Ryan White Program will not restrict the total number of months in which the client can receive transportation services during the grant Fiscal Year. Service providers will monitor the consistency of client attendance at these monthly medical and/or social service appointments to ensure compliance with the requirement for use of transportation vouchers under this program. If clients are non-adherent to appointments this must be documented and service providers will have the discretion, on a case-by-case basis, to not issue a voucher to continually non-compliant clients. "Non-compliant" is defined herein as two missed appointments in two consecutive months (e.g., two months in which two or more appointments have been missed each month without acceptable excuse or cancellation for cause by client would be considered non-compliant). Miami-Dade County Office of Management and Budget-Grants Coordination staff will also monitor compliance with this restriction.

IMPORTANT NOTE: Alternative methods of Medical Transportation service delivery are only available at select subrecipient agencies as a result of the corresponding Request for Proposals Process and subsequent contract negotiations.

Rules for Reimbursement: Discounted EASY Tickets cost $56.25 per monthly ticket (1-Month Pass), $14.60 per weekly ticket (7-Day Pass), and $2.80 per daily ticket (1-Day Pass); and these rates may be subject to change. The number of discounted EASY Tickets available for distribution should be consistent throughout the duration of the contract period, unless the cost of these EASY Tickets changes, and must take into consideration the total budget request, agency capacity, client eligibility, and demand for this service. Ride-share services will be reimbursed based on the cost of each one-way trip. Providers will be reimbursed based on properly documented service utilization reports from the Provide® Enterprise Miami data management system, indicating the date of discounted EASY Ticket distribution or ride-share trip, client CIS number, and dollar amount including dispensing charge. Dispensing charges, not to exceed 15% (or as may be adjusted

by the County due to formula calculations on the budget form), will be reimbursed after services have been provided, client utilization and disbursement information is submitted to the County, and vendor payment has been documented. This service is subject to audit by the Office of Management and Budget-Grants Coordination. Discounted EASY Ticket orders, invoices, and payments, as well as monthly distribution logs and acknowledgement of program limitations signed by the client and scanned into the Provide® Enterprise Miami data management system, or ride-share logs where applicable, will be reviewed.

The following billing codes shall be used:

- **TRANSPORTATION VOUCHERS FOR PUBLIC TRANSIT (DISCOUNTED EASY TICKETS)**
    - Service Name = "EASY Ticket – Monthly Pass" with Service Code = "**EASYM**"
        - A maximum of one (1) may be distributed per client per service month; no exception. **Lost, stolen or damaged tickets are not replaceable.**
    - Service Name = "EASY Ticket – Weekly Pass" with Service Code = "**EASYW**"
        - A maximum of three (3) weekly tickets may be distributed per client per service month. If another week is/was needed, a monthly pass should be used.
    - Service Name = "EASY Ticket – Daily Pass" with Service Code = "**EASYD**"
        - A maximum of four (4) daily tickets may be distributed per client per service month. If more days are/were needed, a weekly or monthly pass should be used.
- **RIDE-SHARE:**
    - Service Name – "Uber/Lyft Ride" with Service Code = "RIDE"
        - Uber/Lyft Ride – Home to Provider
        - Uber/Lyft Ride – Provider to Home
        - Uber/Lyft Ride – Provider to Provider
    - **IMPORTANT NOTES**:
        - In the Provide® Enterprise Miami data management system, a pop-up warning will appear if two of the same ride types are entered for the same day for a given client. The warning will suggest the user document the reason for the potential "duplicate"

service in the Comments field to prevent the County from rejecting the service in the monthly payment request.

- Medical case management (MCM)/Non-medical case managment staff cannot use MCM encounter billing codes for time spent scheduling ride-share (e.g., Uber, UberHealth, Lyft, etc.) trips for a client with the ride-share transportation company. This activity is part of the dispensing fee allowable under the Medical Transportation service category if line items other than purchasing ride-share trips are included in the Medical Transportation budget.

B. Additional Rules for Reporting: Providers must report monthly activity according to the type and dollar amount of the tickets issued, the number of tickets distributed, date of distribution per client, and the unduplicated number of clients served; or number of one-way ride share trips per client, where applicable. As stated above in Medical Transportation section A above, a reconciliation data system match will be conducted of all clients receiving discounted EASY Tickets through the Ryan White Part A Program. This reconciliation review will be conducted by the County's authorized Ryan White Program Recipient (OMB) and DTPW staff.

C. Special Client Eligibility Criteria: A Ryan White Program In Network Referral or an Out of Network Referral (a non-certified referral accompanied by all appropriate supporting documentation) is required for this service and must be updated annually, every 366 days. Clients receiving Ryan White Part A Program-funded Medical Transportation assistance must be documented as having gross household incomes below 400% of the 2026 Federal Poverty Level (FPL). Clients receiving discounted EASY Tickets (transportation vouchers) must be documented as having been properly screened for other public sector funding as appropriate annually, every 366 days. While clients qualify for and can access other public funding [including, but not limited to, Medicaid, Medicaid Managed Medical Assistance (MMA), or Medicaid Long-term Care (LTC) transportation services; or the County's Golden Passport program, Mobility EASY card program or Community-Reduced Fare program etc.) for transportation services], they will not be eligible for Ryan White Part A Program-funded Medical Transportation (discounted EASY Tickets or limited ride-share) assistance.

HEALTH INSURANCE PREMIUM AND COST SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS (HEALTH INSURANCE ASSISTANCE)

(Year 36 Service Priority: #6 for Part A only)

Health Insurance Premium and Cost Sharing Assistance for Low-income Individuals (Health Insurance Assistance) is a core medical service category. This service category includes the provision of financial assistance paid on behalf of eligible clients with HIV to maintain continuity of health insurance or to facilitate receiving medical and pharmacy benefits under a health care coverage program (health insurance policy). As funded by the local Ryan White Part A Program, this service is available to assist low income, program-eligible clients with cost sharing out-of-pocket health insurance expenses (i.e., copayments and deductibles), where program-allowable and as defined herein. In all cases, a complete financial assessment and disclosure from the client are required. No payments or reimbursements can be made directly to a client.

For clients to obtain Ryan White AIDS Drug Assistance Program (ADAP)-funded health insurance premium assistance, the local Ryan White Part A Program must ensure that clients are selecting health coverage that, at a minimum, includes at least one U.S. Food and Drug Administration (FDA) approved medicine in each, drug class of core antiretroviral medicines outlined in the U.S. Department of Health and Human Services (DHHS) Clinical Guidelines for the Treatment of HIV, as well as appropriate HIV outpatient/ambulatory health services. The local Ryan White Part A Program must also assess and compare the aggregate cost of paying for the health insurance option versus paying for the full cost for medications and other appropriate HIV Outpatient/Ambulatory Health Services to ensure that purchasing health insurance is cost effective in the aggregate, and allocate funding to this service category only when determined to be cost effective.

In Miami-Dade County, Health Insurance Assistance is divided into two (2) major categories: 1) limited assistance with private health insurance, employer-sponsored health insurance, or ADAP Premium Plus wraparound assistance for clients with COBRA coverage, which is identified in program components I, III, and IV directly below; and 2) assistance with the Federal Health Insurance Exchange [i.e., Affordable Care Act (ACA) Marketplace], which is identified in program component II (II.A. through II.C.) directly below. Federal funding under this service category may not be used to supplant existing federal, state, or local funding for health insurance premium and cost-sharing assistance.

Locally, stand-alone dental insurance assistance is not covered under this service category.

Health Insurance Assistance under this service category is available to program-eligible people with HIV (clients) only. If a Family Plan is selected, the Ryan White Program will only provide assistance, where applicable, for the program-eligible person with HIV (client) . No HIV negative persons in a Family Plan will receive this assistance.

Additionally, all costs in a Family Plan must be separated out, so that the costs specific to the person(s) with HIV [client(s)] are clearly indicated.

A Ryan White Program In Network Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service and must be updated prior to the end of the client's health insurance policy year. The client's insurance policy information including benefits, policy number, and billing ID number is required in order to process the request for Health Insurance Assistance.

For Medicare Part D recipients, any client whose gross household income falls below 150% of the 2025 Federal Poverty Level (FPL) must be enrolled in the Low Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 135% and 150% of the FPL must be enrolled in ADAP for assistance with prescription drug expenses. For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who falls into the "donut hole," must be referred to the ADAP Program.

The following information below is inactive and included for reference only at this time.

I. – III. ADAP PREMIUM PLUS (INCLUDING COBRA), EMPLOYER-SPONSORED INSURANCE, PRIVATE HEALTH INSURANCE

I. ADAP Premium Plus Program

The ADAP Premium Plus program is a Florida Department of Health (FDOH) AIDS Drug Assistance Program (ADAP) service for eligible clients who need help paying their health insurance premiums, as well as medication copayments and deductibles for medications on the Florida ADAP Formulary at https://www.floridahealth.gov/diseases-and-conditions/aids/adap/adap-formulary.html

This assistance is available through ADAP to clients who meet ADAP eligibility requirements, are subsequently enrolled in ADAP, and continue to re-certify their eligibility in ADAP every twelve (12) months; and is subject to Florida ADAP rules, requirements, and limitations. (NOTE: The recertification period for ADAP and Part A is expected to be updated within this grant fiscal year, with no less than 30 calendar days' notice.)

Florida ADAP's Premium Plus program offers the following two (2) types of services:

- Assistance with Medication Copayments and Deductibles (ADAP Formulary medications only):
    - Available to eligible individuals enrolled in ADAP with the following

insurance types only:

- Medicare Part D
- Medicare Advantage
- Employer-sponsored insurance (group health insurance)
- Affordable Care Act (ACA) Marketplace health insurance policies where the premiums are paid by ADAP

- Full Benefit Assistance:

  - Assistance with premium payments and ADAP formulary drug copayments and/or deductible costs. ADAP offers full benefit assistance for individuals with the following insurance types only:

    - Employer-sponsored insurance (group health insurance)
    - COBRA (Consolidated Omnibus Budget Reconciliation Act)*
    - ADAP-approved ACA Marketplace health insurance plans*

***IMPORTANT NOTES:**

- The local Ryan White Part A Program does not provide premium or deductible assistance to clients in the ADAP Premium Plus program.

- Limited Part A copayment assistance is available only to ADAP Premium Plus clients with a COBRA or ADAP/Part A-approved ACA Marketplace health insurance plan. See Section II.A. through II.C. below.

  - This limited copayment assistance includes program-allowable doctor office visit copayments, lab and diagnostic copayments, and non-ADAP formulary prescription drug copayments (as long as the medication is on the local Ryan White Part A Prescription Drug Formulary); and within Part A Program limitations.

  - Clients with COBRA coverage (whether or not the COBRA plan is an ACA plan) or an ADAP/Part A-approved ACA Marketplace health insurance plan who need Part A assistance with these copayments may do so following the guidelines in Section II.B. ADAP/PART A ACA Wraparound Copayments, directly below. A Ryan White Program In Network Referral from a Ryan White Program Medical Case Manager, or an Out of Network Referral (with supporting documentation), is required to obtain this assistance. With such referral, a GAP Card reflecting "Premium Plus" wraparound coverage will be provided to eligible clients to facilitate the process.

  - The following billing codes must be used for ADAP Premium Plus

clients where Part A is paying the following program-allowable copayments or deductibles:

- ADAP Premium Plus – Non-ADAP drugs, use billing code **APPDRG**
- ADAP Premium Plus – Doctor Office Visit, use billing code **APPOV**
- ADAP Premium Plus – Lab & Diagnostics, use billing code **APPLAB**

II. Local Implementation of the Affordable Care Act (Federal Health Insurance Exchange)

According to the Affordable Care Act (ACA), the current Federal healthcare law (which is subject to change), individuals must have healthcare coverage that meets Minimum Essential Coverage. Minimum Essential Coverage (MEC) is defined as the type of coverage an individual must have to meet the individual responsibility requirement under the ACA. More information regarding the MEC's "10 essential health benefits" can be found at the following web page: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

Ryan White Part A/MAI Program Medical Case Managers will continue to facilitate the process of identifying clients who are eligible to enroll in an ACA Marketplace health insurance plan. Once an ACA-eligible client is identified, wherever applicable and in order to ensure the Ryan White Program is the payer of last resort, the Medical Case Manager will inform the client that they are eligible to enroll in an appropriate, cost-effective health insurance plan during the open enrollment period, or at other allowable times due to a qualifying event (see www.healthcare.gov for details). The Medical Case Manager will also explain the benefits of enrolling in a health insurance plan and inform the client of any assistance for which they may qualify. The Florida AIDS Drug Assistance Program (ADAP) will be paying the ACA Marketplace health insurance premiums for the calendar year. In order to obtain this assistance, clients will need to enroll in ADAP, re-certify their eligibility in ADAP every 366 days, and remain adherent to their ARV treatment plan. (The Medical Case Manager will assist with the local Part A Program-approved enrollment process and will make appropriate referrals for Wraparound assistance to the contracted Ryan White Part A Health Insurance Assistance subrecipient (currently Miami Beach Community Health Center, Inc.) who will complete the process and make appropriate copayment and deductible payments on behalf of ACA-eligible/enrolled clients.

Medical Case Managers are expected to discuss and complete all of the necessary Ryan White Part A Program paperwork with the ACA-eligible client and assist with the enrollment following the local Part A Program-approved enrollment process.

Medical Case Managers of ACA-eligible clients will assist their clients in clearly communicating the client's health care needs (e.g., HIV status, specialty care needs, licensed medical provider preferences, prescribed medications, etc.), using the local ACA Assessment form. Once completed, this form will be submitted to the designated Centralized Enrollment Specialist (currently American Exchange LLC) for assistance with evaluating the health care plan options that meet the client's individual needs and are cost effective; then, identifying the best option(s) for the client.

Until further notice, it is important to note that the Ryan White Program's Federal funding source, the Health Resources and Service Administration (HRSA), requires Ryan White Programs to "vigorously pursue" enrolling eligible clients in an ACA Marketplace health insurance plan. Furthermore, HRSA requires Ryan White Programs to "vigorously pursue" reconciliation of any Advanced Premium Tax Credits in relation to any Ryan White Program financial assistance provided to maintain access to such health insurance benefits. For this reason, clients receiving this assistance are required to file Federal income tax returns, where applicable, and submit copies of these returns and reconciliation reports to their Medical Case Manager for possible repayment to the Ryan White Program (Part A or ADAP). Clients who are not required to file an annual federal income tax return must submit to their Medical Case Manager at the time of ACA enrollment proof that they are not required to file taxes. For purposes of compliance with Federal mandates related to the Affordable Care Act, "vigorously pursue" includes the following:

- Identify clients who are eligible to enroll in the ACA Marketplace, or identify clients who qualify for an ACA exemption;
  - Note: Per local requirements, clients eligible to participate in the ACA Marketplace will need to enroll with the Florida AIDS Drug Assistance Program (ADAP for assistance with health insurance premium payments for 2025 and 2026 plan policies.)
- Inform ACA-eligible clients of the requirements to have Minimum Essential Coverage;
- Discuss the benefits of having health insurance with the ACA-eligible clients;
- Assist ACA-eligible clients with enrollment in the ACA Marketplace [accomplished locally through the designated Centralized Enrollment Specialist (i.e., currently, through American Exchange LLC)];
- Document ACA enrollments and non-enrollments; and
- Reconcile Advanced Premium Tax Credits with any related tax refunds.

If a client is found to be ACA-eligible but chooses not to enroll in a health insurance plan, the Medical Case Manager must document the client's reason for not enrolling, based on the client's completion of the local ACA Decline form in the client's own words. This communication with the client must be documented by

the Medical Case Manager in the individual progress notes in the client's chart and in the Provide® Enterprise Miami data management system.

Clients must also be informed that the Ryan White Part A Program is not allowed to assist the clients with paying any fees/penalties from prior years that are associated with the client not having health insurance.

Clients are strongly encouraged not to enroll in an ACA Marketplace health insurance plan on their own and not to allow the ACA Marketplace to automatically reenroll them. Clients who enroll on their own or allow the ACA Marketplace to automatically re-enroll them may inadvertently choose a plan that is not cost effective, does not sufficiently cover their needs, or does not meet the ADAP program guidelines or limitations for assistance. Furthermore, ADAP clients who enroll on their own in the ACA Marketplace may lose all access to ADAP assistance with ADAP prescription drugs, ACA premiums, and ACA drug copayments; and may lose access to Wraparound assistance with allowable copayments and deductibles from the Ryan White Part A Program.

The following documents provide additional guidance related to local implementation of and assistance with the ACA (See Section IX, Local Implementation of the Affordable Care Act Requirements, of this FY 2025 Ryan White Part A Program Service Delivery Manual):

- ACA Matrix
- ACA Assessment tool
- ACA Acknowledgment form
- ACA Decline form, when applicable (i.e., when a client chooses not to enroll in the ACA, use this form ONLY AFTER the benefits of obtaining health insurance have been fully explained to the client)
- ACA GAP Card
- Policy on Reconciliation of Advanced Premium Tax Credits
- Policy on Refunds

Referrals to Ryan White Part A Program Health Insurance Assistance (each component) will expire annually on the date the policy period ends. The client's assigned Medical Case Manager will receive a reminder prior to expiration of the referral.

Local Ryan White Part A Program assistance for ACA Marketplace health insurance plans is limited to Wraparound, program-allowable copayment and deductible assistance. No exceptions.

IMPORTANT NOTE: It is critical that all Ryan White Program Medical Case Managers: 1) follow proper and consistent directions from the Recipient (i.e., Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan

White Program) when screening clients for ACA participation, and 2) share a clear and appropriate message with clients regarding the local health insurance program's rules and limitations.

II.A. ADAP/Part A ACA Wraparound Project General Limitations and ADAP-approved ACA Plans

- Eligibility for this component extends to ADAP clients with incomes between 50% and 400% of the Federal Poverty Level (FPL) for plan year 2025; for HIV-related, co-morbidity related and complications of HIV treatment related conditions only.

- Part A does **not** assist with these ACA premium payments, as these premiums are paid by the Florida ADAP.

- For Plan Year 2025, Part A has limited ADAP/Part A ACA Wraparound assistance to the following sixty-two **(62)** ADAP/Part A-approved plans only:

  - These 62 ACA health plans identified by the Florida Department of Health will be available for selection in Miami-Dade County, **but** final plan selection is limited to a plan from this list that best meets the needs of individual clients, based on each individual's responses included in the local ACA Assessment Tool, and are cost effective:

Issuer Name	Plan Marketing Name
Ambetter from Sunshine Health	Complete Gold
Ambetter from Sunshine Health	Complete VALUE Gold
Ambetter from Sunshine Health	Complete VALUE Silver
Ambetter from Sunshine Health	Elite Bronze
Ambetter from Sunshine Health	Elite VALUE Bronze
Ambetter from Sunshine Health	Enhanced Diabetes Care Silver with $0 Drug Options
Ambetter from Sunshine Health	Everyday Gold
Ambetter from Sunshine Health	Focused Silver

Issuer Name	Plan Marketing Name
Ambetter from Sunshine Health	Focused VALUE Silver
Ambetter from Sunshine Health	Standard Expanded Bronze
Ambetter from Sunshine Health	Standard Expanded Bronze VALUE
Ambetter from Sunshine Health	Standard Gold
Ambetter from Sunshine Health	Standard Gold VALUE
Ambetter from Sunshine Health	Standard Silver
Ambetter from Sunshine Health	Standard Silver VALUE
Florida Blue (BlueCross BlueShield FL)	BlueOptions Bronze 24J01-17
Florida Blue (BlueCross BlueShield FL)	BlueOptions Bronze 24J01-18s
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J01-09
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J01-12
Florida Blue (BlueCross BlueShield FL)	BlueOptions Gold 24J0I-20S
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-05
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-08*
Florida Blue (BlueCross BlueShield FL)	BlueOptions Plantinum 24J0I-21S
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-03
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-07
Florida Blue (BlueCross BlueShield FL)	BlueOptions Silver 24J01-19S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Bronze 2139
Florida Blue (BlueCross BlueShield FL)	BlueSelect Bronze 2342S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 1535
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 1835
Florida Blue (BlueCross BlueShield FL)	BlueSelect Gold 2344S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 1451
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 1457
Florida Blue (BlueCross BlueShield FL)	BlueSelect Platinum 2345S
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 1443
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 1456
Florida Blue (BlueCross BlueShield FL)	BlueSelect Silver 2343S

** BlueOptions Platinum 24J-01-08 is only available for clients who were enrolled with this plan prior to 2025 due to cost effectiveness concerns. These clients should be asked to review their options and select a different plan this year. Clients on this plan should also be informed that the plan may not be supported in 2026.

Issuer Name	Plan Marketing Name
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Bronze 24K02-23
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Bronze 24K02-26S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Gold 24K02-20

Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Gold 24K02-28S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Plantinum 24K02-15
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Plantinum 24K02-29S
Florida Blue HMO (a BlueCross BlueShield FL company)	BlueCare Silver 24K02-21
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2129
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2312S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Bronze 2329
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Connect Care Silver 24M03-70
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Gold 2314S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Gold 24M05-74
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Platinum 24M05-00S
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Platinum 24M05-75
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Silver 2237
Florida Blue HMO (a BlueCross BlueShield FL company)	myBlue Silver 2313S
Molina Healthcare	Bronze 4
Molina Healthcare	Bronze 8
Molina Healthcare	Gold 1
Molina Healthcare	Gold 8
Molina Healthcare	Silver 1
Molina Healthcare	Silver 12 with First 4 Primary Care Visits Free
Molina Healthcare	Silver 8
Molina Healthcare	Silver 9

NOTE: These plans change annually. FDOH will only provide premium and ARV copayment assistance for ADAP-approved plans, by county.

II.B. ADAP/PART A ACA Wraparound Copayments

This health insurance component covers limited copayment assistance for eligible clients who are enrolled in ADAP and Part A AND have an active ACA Marketplace health insurance policy where the premium is paid by ADAP, where applicable and within program limitations as detailed below.

A. Program Operation Requirements:

- ADAP covers the prescription drug copayments for all medications on the most current Florida ADAP Formulary, for eligible ADAP/clients who have an active ACA Marketplace health insurance policy under ADAP/Part A-approved health insurance plans indicated above. The following web page includes a list of the most current Florida ADAP Formulary medications: https://www.floridahealth.gov/diseases-and-conditions/aids/adap/adap-formulary.html
- Through the Ryan White Part A Program's "ADAP/Part A ACA Wraparound Project" component, eligible ADAP/Part A clients who have an active ACA Marketplace health insurance policy or a policy through COBRA (Consolidated Omnibus Budget Reconciliation Act), where ADAP pays the premiums for one of the ADAP- approved plans indicated above or pays the premium for a COBRA policy, may receive assistance with the following copayments, if the medical services are IN-NETWORK, OUTPATIENT/AMBULATORY, AND related to the client's HIV care and treatment needs, related co-morbidity, or complication of HIV treatment:
    - Licensed medical provider or medical practitioner office visit copayments
    - Laboratory/Diagnostic copayments
    - Prescription drug copayments
        - Part A assistance is limited to medications found on the most current, local Ryan White Part A Program Prescription Drug Formulary. See the following web page, at the Prescription Drug Services section: https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715
        - This Part A assistance does **not** include medications found on the most current Florida ADAP Formulary.
        - Medications not available through the client's health insurance policy that are found on the most current, local Ryan White Part A Program Prescription Drug Formulary can be covered by the Part A Program. In such cases, the client's Medical Case Manager or external case manager must issue a Ryan White Program In Network Referral or

Out of Network (OON) Referral (with appropriate back-up documentation), respectively, for the Part A Program health insurance assistance copayment component.

- **Prescription drug copayment assistance is not provided for clients with prescription drug discount cards.**

- **Part A ACA copayment assistance is limited to program-allowable services rendered within the geographic boundaries of Miami-Dade County, with the exception of mail order for prescription drug copayments, where applicable.**

- **Providers and services that are Out-of-Network for the insurance plan are not covered.**

- **See Section IX of this Service Delivery Manual for information regarding the use of the GAP Card to facilitate access to ACA Wraparound copayment assistance. Note the deadline for submitting claims to the Part A Program.**

B. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per ACA copayment per client, plus a dispensing rate*. Furthermore:

- Billing code **ACADRG** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable prescription drug copayments (i.e., non-Florida ADAP Formulary medications).

  Billing code **ACALAB** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable laboratory and diagnostic copayments.

- Billing code **ACAOV** must be used for ADAP/Part A ACA Wraparound clients for whom Part A is paying their allowable doctor/medical practitioner office visit copayments.

C. **Additional Rules for Reporting:** Monthly activity reporting for this service must be in dollars *per ADAP/Part A ACA Wraparound copayment per client*. Providers must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

II.C. ADAP/Part A Wraparound Deductible Assistance

This health insurance component is available to help maintain a client's ACA Marketplace health insurance coverage by paying the annual deductible, thereby minimizing the client's reliance on the Ryan White Part A Program for related core medical services.

A. Program Operation Requirements: The Ryan White Part A Program may assist with ACA Marketplace health insurance deductible payments for an eligible client. The Ryan White Program will cover deductibles under Part A as payer of last resort if and where ADAP is unable to cover the deductible expense. Note that ADAP only pays deductibles related to medications on its prescription drug formulary.

B. Rules for Reimbursement: Providers will be reimbursed for dollars expended *per ACA deductible per client plus a dispensing rate.* Billing code **ACADED** must be used for Ryan White Part A Program clients who have an ACA Marketplace health insurance plan AND ARE ADAP clients enrolled under the ADAP/Part A ACA Wraparound Project (i.e., where ADAP is paying the premiums).

C. Additional Rules for Reporting: Monthly activity reporting for this service must be in dollars *per ACA deductible per client*. Providers must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

III. Health Insurance Deductibles

This health insurance component is available to help maintain a client's existing (non-ACA) private or employer-sponsored health insurance coverage by paying the annual deductible, thereby minimizing the client's reliance on the Ryan White Part A Program for related core medical services (e.g., Outpatient/Ambulatory Health Services, Mental Health Services, and Substance Abuse Services).

A. **Program Operation Requirements:** Under no circumstances shall payment be made directly to clients who receive this assistance. A complete financial assessment and disclosure are required.

B. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per deductible per client, plus a dispensing rate.* Billing code **DED** must be used for this non-ACA health insurance component, when applicable.

C. **Additional Rules for Reporting:** Monthly activity reporting for this non-ACA service must be in dollars expended *per deductible per client*. The service provider must also report the number of unduplicated clients served each month.

D. **Additional Rules for Documentation:** Providers must maintain proof that the health insurance policy provides comprehensive primary care and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

IV. Prescription Drug Copayments and Co-Insurance

This health insurance component is available to eligible clients with (non-ACA) private or employer-sponsored health insurance who are required to pay a copayment or co-insurance for their medications but are financially unable to pay such expense.

A. **Program Operation Requirements:** Assistance for both (non-ACA) prescription drug copayments and co-insurance is restricted to those medications on the most current, local Ryan White Part A Program Prescription Drug Formulary, even if the medication is also on the ADAP Formulary. **Prescription drug copayment assistance is not provided for clients with prescription drug discount cards.**

B. **Rules for Reimbursement:** Providers will be reimbursed for dollars expended *per prescription drug copayment/co-insurance per client, plus a dispensing rate.* Billing code **COP** must be used for this non-ACA health insurance component, when applicable.

C. **Additional Rules for Reporting:** Monthly activity reporting for this non-ACA service must be in dollars *per prescription drug copayment/co-insurance per client*. The service provider must also report the number of unduplicated clients served each month.

D. Additional Rules for Documentation: Providers must maintain proof that the health insurance policy is cost effective, provides comprehensive primary care, and has a formulary with a full range of ARV medications. Providers must also issue an annual assurance that funds were not used to cover costs of liability risk pools or social security.

OUTREACH SERVICES

(Year 365 Service Priorities: #13 for Part A and #421 for MAI)

I. Definition and Purposes of Outreach Services

Ryan White Program **Outreach Services** are support services. Ryan White Part A/MAI Outreach Services in Miami-Dade County will use targeted approaches to locate people with HIV who are in need of assistance accessing HIV care and treatment who are:

- Newly diagnosed with HIV ~~or AIDS~~, not receiving medical care;
- People with HIV, formerly in care, currently not receiving medical care (lost to care);
- People with HIV, at risk of being lost to care; or
- People with HIV, never in care.

Ryan White Program Outreach Services are directed to those persons known to have HIV and consist of activities to: a) engage and enroll newly diagnosed clients into the system of care; b) assist people with HIV who are lost to care with re-entry into the care and treatment system; and c) assist people with HIV who are determined to be at risk of being lost to care with their retention and access to ongoing medical care and treatment.

Outreach programs must be: 1) conducted at times and in places where there is a high probability that people with HIV and/or persons exhibiting high-risk behavior will be nearby; 2) designed to provide quantified program reporting of activities and outcomes to accommodate local evaluation of effectiveness; 3) planned and delivered in coordination with local and state HIV prevention outreach programs to avoid duplication of effort; and 4) targeted to populations known, through local epidemiologic data or review of service utilization data or strategic planning processes, to be at disproportionate risk for HIV infection.

With implementation of the Early Identification of Individuals with HIV/AIDS (EIIHA) initiative and in collaboration with the Florida Department of Health in Miami-Dade County's (FDOH-MDC) Early Intervention Program, newly diagnosed clients are the primary focus of service provision for Outreach Workers. Clients testing positive at state-licensed testing and counseling sites who sign an outreach consent form at the time they receive their preliminary reactive test result (Referral/Consent for Outreach Linkage to Care) will be contacted by Part A or MAI Outreach Workers for linkage to care either through m~~M~~edical ~~–~~ ~~C~~case m~~M~~anagement, , or o~~O~~utpatient/~~A~~ambulatory ~~H~~health ~~S~~services. Outreach Workers will enter all demographic and program-related information in the Provide® Enterprise Miami data management system for every client contacted, including those not eligible for Ryan White Program-funded medical care. Thirty (30) and sixty (60) day follow-ups from the date of initial appointment with a medical provider and/or m~~M~~edical ~~C~~case m~~M~~anager must be documented in the outreach progress note and labeled as a 30- and 60-day follow-up in the Provide® Enterprise Miami

data management system. Once a lost-to-care or at risk of being lost-to-care client is located, or a newly diagnosed and/or never in care person with HIV is located, The Outreach Worker may assist the client in obtaining necessary documentation to receive services and may accompany the person to a point of entry into the system of care. Outreach Workers must follow-up on each referral to ensure that the client is enrolled in mMedical Ccase Mmanagement and/or Ooutpatient/aAmbulatory Hhealth Sservices. The outcome (e.g., connection to care or inability to locate the client) must be documented in the Client Profile in the Provide® Enterprise Miami data management system.

IMPORTANT NOTE: Outreach Services (e.g., connecting a newly diagnosed client to oOutpatient/aAmbulatory hHealth sServices or Mmedical Ccase mManagement services) may be provided to clients with a preliminary positive result while a confirmatory HIV test result is pending, for the purpose of rapidly linking the client to care. However, it is still necessary to obtain a confirmatory HIV test result within thirty (30) calendar days, **Time spent by Outreach Workers with clients who have a preliminary reactive test result and a pending confirmatory HIV test result is limited to a total of up to three (3) encounters within a 30-calendar day period, after which time a confirmatory HIV test result is required to continue serving the client. If the HIV positive status cannot be confirmed or the result is negative, any services provided to the client must be disallowed.**

Referrals to Ryan White Program ~~Part A or MAI~~ funded Outreach Services from state-licensed counseling and testing sites may only be initiated if there is a valid outreach-specific consent (Referral/Consent for Outreach Linkage to Care) signed by the client and filed in the client's chart or scanned into the Client Profile in the Provide® Enterprise Miami data management system.

IMPORTANT NOTE: Outreach Workers are required to pick up the Ryan White Program Referral/Consent for Outreach Linkage to Care within 24 hours of notice that a signed consent is waiting AND must make an initial attempt to contact the client within 48 hours (i.e., 2 business days) of such notice. During a public health emergency or extreme weather event the process to pick up the consent forms may be altered by the Florida Department of Health and/or the Miami-Dade County Office of Management and Budget-Grants Coordination. In such cases, outreach service providers will be notified in writing.

The Outreach Referral end date is thirty (30) calendar days from the initial referral date. At least one encounter must be provided within this 30-day period. Additionally, an Outreach Episode of Care must be opened in the Provide® Enterprise Miami data management system to coincide with the first date of Outreach Services and the period covered by the related referral. Final Outreach Services must be provided within ninety (90) calendar days of the initial referral date. After the ninety (90) calendar day period, the Outreach Episode of Care must be closed in the Provide® Enterprise Miami data

management system. New and lost to care clients who are served by Ryan White ~~Part A/MAI~~ Program Outreach Workers apart from the FDOH linkage process and are not successfully connected to care within ninety (90) calendar days should have their case closed unless there is a well-documented, reasonable justification for keeping the case open.

Newly diagnosed clients who are referred to the Ryan White ~~Part A or MAI~~ Program through the Florida Department of Health (FDOH) linkage referral process who are not successfully contacted by a Ryan White Program Outreach Worker within thirty (30) calendar days of receiving a signed consent shall be referred to FDOH-MDC Linkage Specialist or Disease Intervention Specialist for appropriate follow up.

A. Newly Diagnosed or Never in Care Person with HIV

1. Linkage agreements form the basis of collaborative relationships between providers. Outreach providers must have formal referral and linkage agreements with one or more of the eleven (11) key points of entry to the system of care listed below for the purpose of receiving referrals for program-eligible clients identified at key points of entry.

    - Florida Department of Health (FDOH) in Miami-Dade County's ~~(M-DC)~~ Sexually Transmitted Disease (STD) clinics
    - FDOH state-licensed HIV counseling and testing sites
    - Hospitals/emergency room departments/urgent care centers
    - Hospital discharge clinics/departments
    - Substance abuse treatment providers/programs
    - Mental health clinics/programs
    - Adult and juvenile detention centers
    - Jail and/or correctional facilities, including, but not limited to, re-entry programs
    - Homeless shelters
    - Detoxification centers
    - Federally Qualified Health Centers (FQHCs)

    Linkage agreements must include the Outreach Worker's contact information, work schedule availability, geographic areas of the County covered, and a description of the o~~O~~utreach s~~S~~ervices offered. Clients referred from a key point of entry will be assisted to obtain necessary documentation for enrollment in the service system, will receive a referral to the primary medical care and/or m~~M~~edical ~~C~~case m~~M~~anagement service provider of their choice, may be accompanied to the initial appointment and must be followed-up to ensure that they are connected to care. Ryan White Program-funded outreach providers shall cooperate with the FDOH-MDC's Early Intervention Counseling and Testing initiatives."

.–Under the EIIHA mandate it is the responsibility of Ryan White Program-funded outreach/linkage to care workers to connect every new positive who has signed a Referral/Consent for Outreach Linkage to Care to mMedical cCase mManagement and/or oOutpatient/aAmbulatory hHealth sServices; this includes connecting clients who are not eligible for Ryan White Program-funded services to appropriate care under other funding sources. The Outreach Worker must provide the client with provider information and track the client to ensure, through 30- and 60-day follow- ups from the date of initial appointment with a medical provider and/or mMedical cCase mManager, that the client is actually linked to a mMedical cCase mManager and/or a medical provider.

B. Outreach to People Lost to Care or at Risk of Being Lost to Care

1. Outreach Workers must work with service providers, including Mmedical Ccase Mmanagers, to locate people lost to medical care or Mmedical Ccase Mmanagement and bring them back to care. The Mmedical Ccase Mmanager, or pharmacy staff, after three (3) repeated attempts to contact the client by phone and/or mail without success, may refer the case through a Ryan White Program In Network Referral in the Provide® Enterprise Miami data management system to an Outreach Worker. Jail linkage and prison re- entry coordinators may refer a client to an Outreach Worker if they have a signed document with permission for a Ryan White Program ~~Part A or MAI~~ Outreach Worker to contact them; such documents must be included with the OON referral and the supporting documentation being sent to the outreach provider. There must be clear documentation in the client chart at the referring agency and recorded in the Ryan White Program In Network Referral, of (a) at least three (3) repeated attempts by the Mmedical Ccase Mmanager, pharmacy staff, or jail linkage/prison re-entry coordinator to contact the client, and (b) the reason why the case is being referred to an Outreach Worker. A Ryan White Program In Network Referral with last known contact information on the client indicating the reason for the outreach referral must be provided to the Outreach Worker and be maintained in both the Mmedical Ccase Mmanagement and outreach client charts. In instances where it is clearly documented that a client has a history of non-compliance or clear documentation of extenuating circumstances, such as homelessness, repeated non-compliance with their treatment regimen, mental health issues, and/or a history of substance abuse, referrals to an Outreach Worker may be made after one or two attempts at contacting the client.

2. A licensed medical provider (MD,DO, APRN, PAs) may immediately and directly request Ooutreach Worker assistance for a client who meets any of the conditions listed directly below in Section B.3., or for similar circumstances

(e.g., abnormal lab results, ~~significant risk~~significant risk of non-adherence to treatment regimen, etc.). Such circumstances must be clearly documented in the client's chart and indicate that the assistance of an Outreach Worker was requested (i.e., the licensed medical provider writes a prescription for the needed outreach and documents such in the client's medical record).

~~2.~~3. Examples of clients considered lost to care or at risk of being lost to care, which require a valid consent for outreach and three (3) documented attempts by the referring agency to reach the client, include:

- Missing two (2) consecutive medical appointments;
- Having no contact with a m~~M~~edical ~~C~~ case m~~M~~anager for more than three months;
- Checking out of residential substance abuse treatment without a post-discharge treatment plan;
- Not ~~"~~reporting to ~~"~~ residential substance abuse treatment when this referral has been made;
- Missing the first medical care appointment after hospital discharge and/or referral to care;
- ~~Missing~~Not ~~–~~picking up prescription medications at the pharmacy, or ~~– or –~~ prescription referrals from a pharmacy or a ~~M~~medical ~~C~~case m~~M~~anager;
- Missing an appointment with the jail linkage or prison re-entry coordinator; and/or
- Missing a medical or social service appointment that the jail linkage or prison re-entry coordinator has scheduled.

IMPORTANT NOTE: Clients lost to care or at risk of being lost to care may be contacted after one or two unsuccessful attempts at communication ONLY IF extenuating circumstances as outlined above are clearly documented in the individual client chart and are recorded in the Ryan White Program In Network Referral or OON Referral from the Jail Linkage or Prison Re-entry programs

Outreach providers must work with and establish formal linkages with Ryan White Program medical providers and m~~M~~edical ~~C~~case ~~M~~management sites in order to receive outreach referrals from these providers who will identify clients who are lost to care or at risk of being lost to care. Outreach Workers will then try to locate these clients and assist them in returning to ongoing medical care and treatment.

C. One Time Referrals

~~C.~~

If in the course of outreach activities, Outreach Workers encounter a high-risk person with no documentation of HIV+ status, a referral should be made to an HIV testing site and/or appropriate prevention program to determine the client's HIV status. The goal of this one-time referral is to assist with the coordination to an HIV

testing site and for the outreach worker's efforts to be recorded into the Provide® Enterprise Miami data management system in the Outreach Registration screen. This is a **secondary** outreach function that will be monitored by OMB and should not supersede the primary goals of connecting newly diagnosed (newly identified)clients to care, as well as locating and reconnecting to the service system those clients who have been lost to care or who are at risk of becoming lost to care

D. Allowable Outreach Activities

1. Ryan White ~~Part A/MAI~~Program-funded Outreach Workers may provide services to clients in the following situations to link or retain clients in HIV care: 1) for their agency's own clients; 2) upon receipt of a Ryan White Program In Network Referral for a particular client, for whom the referring agency has a valid informed outreach-specific consent signed by the client and filed in the client's chart; 3) upon receipt of a signed, completed Consent/Referral for Linkage to Care from state-licensed Counseling and Testing sites; 4) a prescription from a licensed medical provider; or 4) by a letter or OON Referral from a jail linkage or prison re-entry coordinator as indicated in Section B above.

2. Outreach Workers may engage in the following activities, if the activity is properly documented and filed in the client's chart at the referring agency and at the receiving agency where applicable:

    - Obtain from the client all required consents for the Outreach Worker to access client-related information in the Ryan White Program's Provide® Enterprise Miami data management system;
    - Conduct brief intakes for new clients referred from a state-licensed Counseling and Testing Site, jail linkage or prison re-entry coordinator and enter data into the Provide® Enterprise Miami data management system outreach registration screen;
    - Upon receipt of a proper referral, review data in the Provide® Enterprise Miami data management system for existing clients who are lost to care or are at risk of falling out of care;
    - Complete assessments and document new clients' barriers to accessing care and lost-to-care clients' reasons for falling out of care;
    - Contact the service provider of the client's choice to coordinate appointments and obtain required documentation for services;
    - Accompany newly diagnosed, lost to care, or otherwise unconnected program-eligible people with HIV (clients) to the initial l~~L~~icensed m~~M~~edical ~~P~~provider appointment and/or m~~M~~edical c~~C~~ase m~~M~~anagement appointment for the
        - purpose of reconnecting them to care or enrolling them in service;
    - Accompany clients, as necessary, for the purpose of assisting them

to obtain necessary documents for entry into the service system;

- Contact clients who have a history or are at risk of falling out of care (i.e. substance abuse history, homelessness, mental illness) during the 30- and 60-day follow-up period with the end of increasing retention in care;
- Conduct home visits to meet with a client for the purpose of connecting them to care;

  ➢ **IMPORTANT NOTES**:

  - If ~~a~~ the ~~Part A/MA~~Ryan White Program~~I~~-funded outreach service provider has an established agency policy not to send staff to conduct home visits, and it is determined that a home visit is necessary for successful linkage, the client's case **must** be transitioned to another ~~Part A/MAI~~ funded Ryan White Program outreach provider that is able to conduct home visits;

  - In cases of transfer due to the home visits, the new outreach provider agency replaces the previous outreach provider agency;

- Maintain tracking and contact logs for new to care and lost to care clients;
- As a safety precaution, Ryan White Program Outreach Workers who must locate clients in high-risk areas or very rough neighborhoods may go out in two-person teams. In this scenario, both Outreach Workers should document the activity in the client chart or outreach log, making note that they went to a high-risk area, with one of the Outreach Workers clearly stating that they went along as a safety back-up and should use the OSFT safety back-up code to record the service. Both Outreach Workers may reflect the time they spent on the encounter and have their agency or respective agencies report for the time and be reimbursed accordingly. However, in the Provide® Enterprise Miami data management system the encounter should only be counted/recorded (i.e., OFFE, OTEL, ORFL, etc.) by the main Outreach Worker/agency that received the referral;

  ➢ **IMPORTANT NOTE:** If a Peer Educator is the safety back-up, the Peer Educator must use the corresponding safety encounter code, PSFT, under the PESN billing category.

- Provide education on available care and treatment options and services for people with HIV who receive outreach services via a

Ryan White Program In Network Referral, Jail linkage referral, Department of Corrections Certification or a Referral Consent Linkage to Care form with the goal of directly empowering and enabling the client to access existing HIV/AIDS service programs, including Counseling & Testing sites;

- Provide out-stationed linkage and coordination to care services at key points of entry, including but not limited to counseling and testing facilities and other facilities with a high percentage of people with HIV as identified by the counseling and testing facility and verified by the Ryan White ~~Part A/MAI~~ Program;
- Coordinate and participate in planned outreach/testing initiatives in cooperation with the FDOH-MDC;
- Conduct 30-_ –and 60-day follow-ups from the date of initial appointment with a medical provider or ~~M~~medical c~~C~~ase ~~M~~manager to ensure the client (regardless of whether the client is receiving services through the Ryan White Program) remains connected to care.

E. Inappropriate Outreach Activities

Funds awarded under Part A and MAI of the Ryan White HIV/AIDS Treatment Extension Act of 2009 may not be used for outreach programs that exclusively promote HIV education and prevention programs, condom distribution, and/or case finding that have as their main purpose broad-based or general HIV prevention education. Additionally, broad-scope awareness activities about HIV services that target the general public (i.e., poster campaigns for display on public transit, TV or radio public service announcements, health fairs directed at the general public, etc.) will not be funded.

Ryan White ~~Part A/MAI~~ Program funds may not be used to pay for HIV counseling or testing under this service category. Ryan White ~~Part A/MAI~~ Program Outreach Services must be planned and delivered in coordination with local HIV prevention programs to avoid duplication of effort.

Outreach Workers may <u>not</u> conduct random searches in the Provide® Enterprise Miami data management system for clients who are not enrolled at the Outreach Workers' assigned agency, or for clients for whom they do not have a Ryan White Program In Network Referral. Searches conducted in the Provide® Enterprise Miami data management system to identify clients lost to care must be initiated by the Medical Case Manager or medical or pharmacy staff of the referring agency.

Ryan White Program-funded outreach activities are not to be used for general recruitment of clients to the Outreach Worker's agency.

F. Documentation of Outreach Activity

All Outreach Workers must maintain documentation which includes the following:

- Name of Outreach Worker;
- Name, signature, and consent of client;
- Client's date of birth;
- Client's gender;
- Client's race and ethnicity;
- Client's address or follow-up information;
- Date of diagnosis and site of diagnosis;
- Date of the encounter;
- Type of encounter (i.e., telephone, face-to-face, collateral, travel, referral, or coordination of care);
- Description of the encounter with a client and/or work done on behalf of the client;
- Time spent on the encounter in minutes;
- Total units documented;
- For newly diagnosed clients, a Referral/Consent for Linkage to Care;
- For clients lost to care, a Ryan White Program signed outreach consent to be contacted (found at the top of the County's Notice of Privacy Practices form);
- Site where client was identified (i.e., last known contact information, a specific geographic region, and/or key point of entry into the system of care in Miami-Dade County);
- One-time referral to a testing site for a high-risk client without documentation of HIV status;
- Document "initial contact" and all "follow-up" contacts;
- Maintain call logs and tracking logs for new-to-care and lost-to-care clients;
- If lost to care or identified as at risk of being lost to care, a copy of the initiating agency's referral to outreach;
- An individualized assessment of the client's barriers to care or reasons for falling out of care;
- Documentation that explanation of service system and choice of provider agency were provided;
- A copy of a Provide® Enterprise Miami In Network referral or documented attempt to make a referral by the Outreach Worker to a Medical Case Management agency and/or medical provider of the client's choice;
- Documentation of 30- and 60-day (calendar days) follow-up on referrals to ensure that the client is enrolled in medical care and treatment;

- Final disposition of the client must be documented in the Provide® Enterprise Miami data management system, the client's chart or service log indicating whether or not the client was connected to care (i.e., referral was made; client was taken to a medical provider or Medical Case Manager) or if the case was closed with a statement as to why it was closed; and

- Contact with the referring agency to communicate the client's final disposition.

II. Outreach Worker Incentives, Program Operation Requirements, and Staff Training Requirements

As incentives for productivity, providers are encouraged to provide Outreach Workers with educational training opportunities. The Ryan White Program also has educational and training requirements for Outreach Workers to improve productivity.

A. Program Operation Requirements:

1. **Staff Training.** Outreach Workers must possess at least a High School diploma or GED. All staff providing Outreach Services must complete the FDOH's "HIV/AIDS 101 – Know Your HIV Status" video training [this training is available on-line at https://knowyourhivstatus.com/hiv-resources/] and FDOH's HIV/AIDS 500 and 501 Online Prerequisite Courses available at ~~.~~ https://www.testmiami.org/providers.html. ~~Outreach Workers must attend periodic training provided by the Ryan White Program's Clinical Quality Management and Training Program provided by BSR.~~ In addition, effective ~~June 1, 2018~~x,xx,2026, any new hire Outreach Worker or Outreach Supervisor under the Ryan White ~~Part A or MAI~~ Program~~s~~ must complete all ~~13~~ 9 of the Southeast AIDS Education and Training Center (SE-AETC)~~'s (SE-AETC)~~ IMPART Learning Management Systems ~~web-based Medical Case Management Curriculum and Cultural Co~~https://www.seaetc.com/find-impart-courses/medical-case-managment-mcm-curriculum) ~~mpetency Curriculum modules~~ as required and as may be amended by the local ~~Ryan White Part A Program~~Recipient **prior to** being approved for Provide® Enterprise Miami User Access. ~~These curricula modules are indicated on the local Ryan White Program's AETC Training Module Checklist and the modules can be accessed at the following website: https://www.seaetc.com/modules/.https://seaetc.reach360.com/login or other AETC curriculum as determined by the recipient.~~ Time spent completing the SE-AETC training modules **cannot** be charged to the local Ryan White Part A/MAI Program~~s~~.

   Outreach providers must ensure that Outreach Workers are knowledgeable about resources and providers of medical care, substance abuse treatment, ~~M~~medical ~~C~~case ~~M~~management, and other core medical and support services. At a minimum, the outreach provider should have reference material on hand which provides information on services offered, intake requirements, hours

of operation, and contact personnel information. Outreach Workers must also have on hand Ryan White Program consent forms available for signature by clients lost to care or at risk of being lost to care.

2. **Hours.** Outreach Services must be offered during non-traditional business hours, 10 hours at a minimum per week, per agency. Traditional business hours are defined as 9:00 a.m. to 5:00 p.m., Monday through Friday. Each Ryan White Program-funded outreach provider must have written procedures in place to address on-call coverage to reach an Outreach Worker after traditional business hours. The written procedures should include steps for contacting an on-call medical provider and/or ~~M~~medical c~~C~~ase m~~M~~anager, where immediate intervention is necessary.

3. **Cultural Sensitivity.** Providers are encouraged to be creative in developing outreach programs that are culturally sensitive and that meet the specific needs of the identified target subpopulations (i.e., substance abusers, illiterate persons, hard of hearing, sex workers, etc.). It is desirable that Outreach Workers reflect the community in which they are working and/or are targeting.

4. **Documentation of Units of Service.** Providers are required to document in the client's chart each unit (15-minute encounter) of outreach service performed (including the time spent) as a face-to-face encounter, telephone contact, collateral encounter on behalf of the client, coordination of care, travel, or referral activity on behalf of a client. Use the appropriate code from the following table to record outreach services (listed in alphabetical order by code):

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Collateral Contacts	**OCOL**	Use this code to record all activities related to **coordination of care** for clients, including communication with other care providers, such as telephone contacts or other electronic methods of communication (e.g., email or fax). This code also includes other coordination of care activities that are conducted for or on behalf of the client, such as **referral activities** that are not face-to-face with the client and obtaining completed documents for the client from another (outside) care provider. This code should NOT be used for internal agency activities that are unrelated to the coordination of care for clients with outside providers. Examples of inappropriate use of this code include pulling a chart to copy documents for a client's personal use or filing for chart maintenance.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Consultation	**OCON**	Only Outreach Supervisors may use this OCON code. This code shall be used to record activities associated with consulting with outreach staff on Ryan White Program-related client, supervisory, or quality management issues.
Documentation	**ODOC**	Use this code to record activities related to documenting any encounter in the Provide® Enterprise Miami data management system, such as the client's care plan, progress note, face-to- face encounter, telephone contact, etc. This service code also includes time spent filing or organizing the client chart or pulling the chart to make copies that are unrelated to coordination of care for the client. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.
Face to Face Encounter	**OFFE**	This encounter is defined as any time the Outreach Worker or Outreach Supervisor has direct contact with the client in person. The OFFE encounter includes activities that are conducted face-to-face with the client where no other encounter code is appropriate. OFFE may also include referral activities if done face-to-face with the client.
Chart Review Activity	**OREV**	Only Outreach Supervisors may use this OREV code. This code should be used to record activities associated with chart review processes to ensure that outreach staff is in compliance with this service definition, and with the Ryan White Program System-wide Standards of Care. As of May 1, 2018, there is no longer a required number of hours of OREV code use. **IMPORTANT NOTE**: See subsection II.D. below regarding "Applicability to Local Ryan White Program Requirements" for staff supervising Ryan White Program-funded Outreach Workers.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Referral Activity	**ORFL**	Use this code to record outreach referral activities that do not fit in any other outreach encounter/ activity in this list.
Safety Back-up	**OSFT**	Ryan White ~~Part A/MAI~~ Program-funded Outreach Workers who as a safety precaution accompany a Ryan White Program Outreach Worker when locating clients in high-risk areas or very rough neighborhoods, as indicated in Section I.D.1 above, should use the OSFT safety back-up code to record the service. In this scenario, if applicable, both Outreach Workers should document the activity in the client chart or outreach log, making note that they went to a high- risk area, with one of the Outreach Workers clearly stating that they went along as a safety back-up. Both Outreach Workers may reflect the time they spent on the encounter and have their agency or respective agencies bill for the time and be reimbursed accordingly. However, in the Provide® Enterprise Miami data management system the other outreach billing code (i.e., OFFE, OTEL, ORFL, etc.) should only be counted or recorded by the main Outreach Worker/agency that received the referral.
Outreach Telephone Encounter	**OTEL**	Use this code to record telephone contacts.
Outreach Contact Travel Time	**OTVL**	Use this code to document travel time with or on behalf of the client that is specific to care coordination, linkage to care, retention or retention in care activities. In such cases, documentation in the client chart must include reason for travel in relation to care coordination, linkage to care, or retention in care.
Data to Care	**D2C**	Activities related to Date to Care project.
Take Control Miami events	**TCM**	Use this code to record outreach activities conducted at authorized "Take Control Miami" events.

Outreach Services		
Activity	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Training	**TRN**	Use this code to record and bill for time spent attending authorized Ryan White Program trainings (TRN), such as Outreach Worker trainings, County-approved Provide® Enterprise Miami data management system trainings, and Ryan White Program Subrecipient (Service Provider) Forums. The TRN code may **not** be used to bill for any training that is not a Ryan White Program training; for example: use of the TRN code **cannot** be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, on-site BSR technical assistance visits; appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, AETC training modules, or other employer-required training. Travel time is not included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may not use the TRN code.

4.5. **Connection to Care.** Providers are expected to document the client's connection(s) to care in the Provide® Enterprise Miami data management system as evidenced by documentation on file at the outreach provider agency that at least fifty percent (50%) of people contacted and billed for are actually returned to primary medical care and/or mMedical Ccase mManagement services or that a case was closed, and at least fifty percent (50%) of the people contacted and billed for are new to primary medical care and/or mMedical Ccase Manmanagement services, on a quarterly basis. Connections to care will also be monitored by the County on a quarterly basis through the Provide® Enterprise Miami data management system and/or analysis of outreach data conducted by BSR, as a Clinical Quality Management Program activity.

B. **Rules for Reimbursement:** Providers will be reimbursed 1/12th of the contract total, subject to penalties for non-performance (i.e., reduced payment based on not meeting the required percentage of connections to care), as detailed below. Under this service category, Payment Requests

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(invoices) submitted (via mail, email or the Provide® Enterprise Miami data management system) without any recorded services will not be processed for payment without the County's prior approval. In months where this occurs, the County will automatically apply a 1/12th penalty for the month without services and will not take into consideration this month for purposes of the quarterly performance review.

Reimbursement will be performance-based. Initially, payment will be made in equal monthly installments of the contract award for this service, as may be amended through Reallocation/Sweeps awards or reductions. Subrecipients' performance under this service category will be reviewed quarterly to ensure effective service delivery; whereby at least 50% of the clients contacted through Outreach Services during the quarter must be connected for the first time (for new to care clients) or re-connected (for lost to care clients) to oOutpatient/Aambulatory h Health Sservices and/or mMedical Ccase mManagement services. Failure to reach this 50% quarterly performance goal will result in penalties (i.e., payment reductions), as follows:

% of Unduplicated Outreach Clients who were Connected / Re-connected to Care During the Quarter Reviewed	% of Quarterly Reimbursement Totals Subrecipient is Authorized to Retain (i.e., no penalty applied) *
50% or more	100%
45 – 49%	90%
40 – 44%	80%
35 – 39% 70%	70%
30 – 34%	60%
25 – 29%	50%
20 – 24%	30%
0 – 19%	0%

IMPORTANT NOTES:

1) Adjustments (e.g., reductions, disallowances, etc.) will be made to

reimbursements in monthly invoices following the quarter reviewed. Any adjustment will be made to one or more monthly reimbursement invoices in the subsequent months of the same grant fiscal year until the full amount of the penalty is recouped. For example, if only 36% of the outreach clients contacted/served in Quarter 1 – March to May – were connected to medical care and/or medical case management, the subrecipient would keep (retain) 70% of the amount reimbursed during that period and the amount of the penalty (i.e., 30% of amount reimbursed during the quarter) would be deducted from invoices between June and February until the full amount of the penalty is recouped.

2) Special circumstances (e.g., new hires, complexity of care for subpopulation served, ~~COVID-19 restrictions,~~ etc.) may be considered at the County's sole discretion for adjustments to any penalty reductions indicated in the table directly above.

3) Each Outreach Worker must be an approved user/provider in the local Ryan White ~~Part A~~ Program's MIS system (e.g., Provide® Enterprise Miami data management system) BEFORE their first service date. Approvals will no longer be made retroactively for this service category.

4) Reallocations/Sweeps actions will also be prospective, not retroactive.

5) If an Outreach Services budget includes a staff vacancy and that vacancy is not filled by the end of the next quarter reviewed, a proportionate amount will be deducted from the total award to reduce the amount allocated to the vacant position.

6) Sweeps requests for additional funds cannot be used to cover prior penalties.

7) These new percentage rates (see table directly above) will be closely monitored by the Recipient (i.e., Miami-Dade County) for effectiveness and may be subject to change.

C. Additional Rules for Reporting: Monthly activity reporting for this service will be on the basis of an outreach contact in comparison with the amount of time and effort billed to the program for each Outreach Worker.

Reimbursement requests will be continuously evaluated on the basis of productivity; in particular, people contacted and connected to primary medical care or mMedical Ccase Mmanagement services. A sufficient level of Outreach Services must be provided and a corresponding bill generated through the Provide® Enterprise Miami data management system on a monthly basis in order for reimbursement to be approved by the County. The County maintains the right to assess the sufficiency of the services provided before reimbursement for services is made.

Outreach staff must follow all applicable requirements of this service category in the Provide® Enterprise Miami data management system which include the following: managing an Outreach Episode of Care; ensuring that an In Network or OON referral is opened for a client;

updating all client appointments evidencing connections to care; creating progress notes which fully document the client encounter; opening the Client Service Profile Record under the correct funding source; ensuring only eligible clients are served.

It is required that all staff working on Outreach Services review and become familiar with the Provide® Enterprise Miami user guides (manuals) titled "Outreach Services Program" and "Referrals: In Network Service and Out of Network" as part of their new outreach staff orientation and prior to providing outreach services. This practice will guide staff as they navigate and follow the requirements of this service category in the Provide® Enterprise Miami data management system with the goal of limiting unbillable services, which can affect the amount of reimbursement approved by the County if the service(s) entered cannot count towards the performance standards detailed above.

D. Applicability to Local Ryan White Program Requirements: If a staff person has a Ryan White Program outreach service caseload, even one client, they will be required to adhere to the local Ryan White Program Service Delivery Manual, System-wide Standards of Care, and Clinical Quality Management Program activities. This requirement is applicable whether or not the outreach staff person appears on the program's line item budget and regardless of the percentage of time and effort spent performing Ryan White Program outreach activities. Similarly, if provider's staff supervises any Ryan White Program outreach staff, whether or not they are on the budget for such, they also must follow the requirements in the local Ryan White Program Service Delivery Manual, System-wide Standards of Care, and Clinical Quality Management Program activities.

MEDICAL CASE MANAGEMENT, INCLUDING TREATMENT ADHERENCE SERVICES

(Year 3~~5~~6 Service Priorities: #2 for Part A and #1 for MAI)

Medical Case Management, including Treatment Adherence Services (hereinafter referred to as Medical Case Management) are core medical services. The local Ryan White Program Medical Case Management service category has two (2) distinct components: **Medical Case Management and the Peer Education and Support Network (PESN)**. *Subrecipient providers ("providers") are required to offer both components of this service category.* Medical Case Management services help clients improve health outcomes. As such, Medical Case Management providers should be able to analyze the care that a client receives to ensure that the client is obtaining the services necessary to improve his, her or their health outcomes.

The Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) defines Medical Case Management as a range of client-centered activities focused on improving health outcomes in support of the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers. Medical Case Management includes all methods of encounters (e.g., face-to-face meetings, phone contact, and any other documented forms of communication). Key activities include: 1) initial assessment of service needs (including review of medical, financial, social, and other needs, upon intake); 2) development of a comprehensive, individualized service plan (including coordination of services required to implement the plan); 3) timely and coordinated access to medically appropriate levels of health and support services and continuity of care; 4) continuous client monitoring to assess the efficacy of the care plan; 5) re-evaluation of the care plan at least every six months with adaptations as necessary or more often as needed; 6) ongoing assessment of the client's and other key family members' needs and personal support systems; 7) treatment adherence counseling to ensure readiness for and adherence to complex HIV treatments; and 8) client-specific advocacy and/or review of utilization of services. In addition to providing the medically oriented services above, Medical Case Managers may also provide benefits/entitlement counseling and referral activities (to core medical and support services) by assisting eligible clients in obtaining access to other public and private programs for which they may be eligible (e.g., Medicaid, Medicare, Medicare Part D, State AIDS Drug Assistance Program, Pharmaceutical Manufacturer's Patient Assistance Programs, other state or local health care and supportive services, and insurance plans through the ACA Health Insurance Marketplaces/Exchanges).

Visits to ensure readiness for and adherence to complex HIV treatments shall be considered either billable under Medical Case Management or Outpatient/Ambulatory Health Services, depending on how the visit occurred. Treatment Adherence Services provided during a Medical Case Management visit shall be reported in the Medical Case Management service category (using the ADH billing code indicated below); whereas,

Treatment Adherence services provided during an Outpatient/Ambulatory Health Service visit shall be reported under the Outpatient/Ambulatory Health Services category (using the appropriate CPT billing code).

The purpose and objectives of Medical Case Management are: 1) to maintain the client in ongoing medical care and treatment to improve client health outcomes; 2) to coordinate services across funding streams; 3) to reduce service duplication across providers; 4) to assist the client with accessing needed services; 5) to use available funds and services in the most efficient and effective manner; 6) to increase the client's adherence to the care plan (i.e., medication regimen) through counseling; 7) to empower clients to remain as independent as possible; and 8) to control costs while ensuring that client needs are properly addressed.

MEDICAL CASE MANAGEMENT COMPONENTS

I. ***Medical Case Management:*** Medical Case Managers must be knowledgeable about the diversity of programs and be able to develop service plans from various funding streams. They are responsible for helping clients access needed services, not just Ryan White Program-funded services. Medical Case Managers will continue to have a training emphasis on addressing client housing issues (e.g., instability, homelessness, etc.) and identifying available housing assistance programs in Miami-Dade County, among other training topics.

Locally, in addition to the key activities indicated above, Medical Case Managers are responsible for performing the following functions: 1) conducting the initial intake; 2) managing and coordinating referrals, assisting with initial appointments, and coordinating services identified in the care plan, etc.; 3) monitoring client adherence to the care plan and medication regimens, as well as ensuring that service providers involved in the client's care are rendering services as requested; 4) evaluating services provided to the client by all funding sources to determine consistency with the established care plan; 5) conducting secondary prevention; and 6) closing client cases when warranted and documenting the reason for case closure. Medical Case Managers should regularly use special client-related views and reports in the Provide® Enterprise Miami data management system to identify any clients who may be at risk for falling out of care, and follow-up as appropriate (including a referral to Outreach Services if allowable) to locate the client and bring them back into care.

Medical Case Managers are expected to review, understand, and comply with the related case management activities indicated throughout the service definition as stated above in the Health Insurance Assistance section of this Service Delivery Manual.

II. ***Peer Education and Support Network (PESN):*** At the option of the client, the Medical Case Management agency will assign a Peer (variously designated as PESN, Peer Educator, Peer Navigator, or Case Aide) who is a person with HIV to provide "peer support," including client orientation and education about health and social service delivery systems. These Peers may assist with initial client intake, paperwork and applications for financial and medical eligibility, educating new clients on the process of accessing core and support services, encouraging treatment adherence, as well as accompanying clients to initial appointments for medical care and other services. These Peers may also make phone calls or send mail, including electronic mail, (where authorized by the client) to clients for the purpose of reminding them of medical appointments, in order to improve the client's attendance and reduce no- shows. These Peers are restricted from completing Ryan White Program In-Network Referrals, Plans of Care, and Health Assessments, as these are functions of a Medical Case Manager. These Peers may also provide basic stress management guidance to their clients. For a description of PESN Essential Functions, see Section VII of this Service Delivery Manual.

Support group meetings and related activities are not an allowable function of the local PESN services.

The Peer will have basic knowledge of HIV/AIDS services and receive the necessary training on HIV funding streams from the Peer's Medical Case Management agency and other resources.

As incentives for productivity, PESN subrecipient providers are encouraged to provide the Peer with educational opportunities, as well as a standard living wage and medical benefits.

If the client decides not to access the PESN services, then the Medical Case Manager will also be responsible for providing the following services: 1) presentation of information regarding the HIV service delivery system across funding streams, and 2) assistance to clients in preparing applications for other benefit programs.

The following requirements apply to both Medical Case Management and PESN services (including Minority AIDS Initiative services) as indicated:

A. **Program Operation Requirements:** Subrecipient providers must ensure that Medical Case Management services include, at a minimum, the following: peer support, assessment, follow-up, direction of clients through the entire system of health and support services, and facilitation and coordination of services from one service provider to another. Subrecipient providers of Medical Case Management services are expected to educate clients on the importance of complying with their medication regimens.

Medical Case Managers and Peers operate as part of the clinical care team and must maintain frequent contact with other providers (the client's Licensed Medical Provider, other medical practitioner, Nutritionist, Pharmacist, Mental Health or Substance Abuse Counselors, HOPWA Housing Specialist, etc.) and with the client in order to assure the client adheres to medication regimens and ensure that the client receives coordinated, interdisciplinary support for adherence, attendance at medical care appointments, picking up prescriptions and re-fills, and assistance in overcoming barriers to meeting treatment objectives.

Medical Case Management providers are expected to empower clients to be actively involved in the development and monitoring of their treatment and adherence plans, and to ensure that immediate follow-up is available for clients who miss their prescription refills, licensed medical provider visits, and/or who experience difficulties with adherence. Medical Case Management providers must ensure that the client is knowledgeable about HIV/AIDS; understands CD4 count, viral load, adherence and resistance concepts; understands the reason for treatment; identifies and addresses the possible factors or barriers affecting treatment adherence; and understands his/her/their treatment regimen to the best of the client's ability.

1. Medical Case Manager Qualifications:

Providers of this service will adhere to the educational and training requirements of staff as detailed in the *Ryan White Program System-wide Standards of Care* and the *Ryan White Program Medical Case Management Standards of Service* (see Section III of this FY 2025 Service Delivery Manual), as may be amended.

2. Provider Requirements:

a) Providers will be expected to report to Miami-Dade County the following, in the contract scope of services and/or upon request:

- An explanation of the training – including RWP Basic Training, cultural sensitivity training, and other trainings as may be required by the RWP Recipient – that has been and will be offered to Medical Case Managers, MCM Supervisors, and Peers. CQM trainings are not billable under MCM or PESN.

- An explanation of how a client's adherence to treatment will be monitored and how adherence problems will be identified and resolved.

  An explanation of how the provider will serve clients who speak English, Spanish, and Haitian Creole or who have limited language proficiency. **Medical Case Management providers**

must budget for the following expenses or otherwise accommodate client needs for: American Sign Language interpreter, foreign language interpreter, Braille, and other materials to accommodate clients with disabilities, limited English language proficiency, and/or low literacy levels.

- A description of linkage agreements in place with other HIV/AIDS service providers.

- As the Ryan White Program is the payer of last resort, clients who have Medicaid Managed Medical Assistance (MMA) or Long-Term Care (LTC) plans are not eligible to receive case management or referral services from the local Ryan White Part A/MAI Program. The MMA and LTC plans are contractually required to provide their clients with case management/care coordination.

b) **Required Forms.** Medical Case Management staff will utilize Ryan White Program standardized forms, as approved by the Miami-Dade HIV/AIDS Partnership and the County, for all Medical Case Management functions.

c) **Referrals.** All referrals made by Part A or MAI-funded Medical Case Managers to Ryan White Program services must be made utilizing the Ryan White Program In Network Referral process, which is available through the Provide® Enterprise Miami data management system. Referrals **cannot** be made for services not documented in the client's Action Plan (formally referred to as the Plan of Care; billing code to use remains POC – see below). However, in the case of emergency, an Action Plan may be amended within two (2) business days to allow for the referral. Referrals for non-Part A or non-MAI services made by Part A/MAI Medical Case Managers will use the general certified referral form in the Provide® Enterprise Miami data management system. Referrals made to Part A/MAI services by non-Part A or non-MAI funded case managers will use the Out of Network (OON) referral form available from the County's Office of Management and Budget-Grants Coordination – Ryan White Program. The OON Referral must be accompanied by appropriate supporting documentation and signed consents.

All referrals from Medical Case Management services to Ryan White Part A Program Oral Health Care services should include the client's licensed medical provider (MD, DO, APRN, PAs) contact information (name, address, phone and fax numbers, and email if available) and note any known allergies the client may have. This information can be included in the comments section of the referral.

d) **Caseload.** Medical Case Managers should have an active caseload of no more than 70 clients.

e) **Peer schedules.** Providers are reminded that some Peers may be eligible for disability income and/or other supplemental income. Consequently, a part-time work schedule should be well- planned to meet the needs and benefits of the Peer employee.

f) **Health Assessments.** Medical Case Managers are expected to complete a Health Assessment annually for each client as may be amended via formal written notification from the Recipient (i.e., Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program). Updates to the Health Assessment should be conducted as needed during the year.

g) **Progress Notes.** Services must be documented in progress notes in a timely manner, preferably within 24 hours of service, but no later than 48 hours (i.e., 2 business days) after occurrence, unless the timeframe is suspended by the Miami-Dade County Office of Management and Budget during declared emergencies at the state or local level (e.g., during public health emergencies, hurricanes, etc.) or at the discretion of the County. Any Medical Case Management or Peer Education and Support Network encounter not properly recorded in the Provide® Enterprise Miami data management system within 48 hours (i.e., 2 business days) will be rejected in the system, unless the timeframe is suspended as noted above. When needed, requests for an override related to this type of rejection may be submitted to Miami-Dade County-Office of Management and Budget/Ryan White Program for review through the Provide® Enterprise Miami data management system. A reasonable justification for the delay in recording an encounter must be included for review of related override requests. Depending on the agency's reason for the delay, the County may opt to disallow the encounter.

A reasonable justification for the delay in entering a timely progress note would include the following, if such reason caused the Medical Case Manager, Peer, or the Medical Case Management Supervisor to miss the 48-hour time limit for entering progress notes:

- An event beyond the Medical Case Manager, Peer, or Medical Case Management Supervisor's control, such as an illness, proven data system (e.g., Provide® Enterprise Miami

data management system or provider's electronic medical record data system) access issues, public health emergencies, or extreme weather events directly affecting program operations.

- A documented and previously approved event such as the aforementioned staff persons' vacation or attendance at a Ryan White Program meeting or training.

h) **Staff Training.** Medical Case Management staff (Medical Case Managers, Peers, and Medical Case Management Supervisors) must attend periodic training provided by the Ryan White Program's Clinical Quality Management and Training Program provided by BSR. In addition, effective ~~April 7, 2017~~xx,x,2026, any new Medical Case Managers, Peers, and Medical Case Management Supervisor hires under the Ryan White Part A or MAI Programs must complete all ~~13~~ 9 of the Southeast AIDS Education and Training Center's (SE- AETC) IMPART Learning Management System (https://www.seaetc.com/find-impart-couses/medical-case-managmenet=mcm-curriculum/) ~~web-based Medical Case Management and Cultural Competency curricula~~ as required and as may be amended by the local Recipient **prior to** being approved for Provide® Enterprise Miami User Access. ~~These curricula modules are indicated on the local Ryan White Program's AETC Training Module Checklist, and the modules can be accessed at the following website: https://www.seaetc.com/modules/.~~ Time spent completing the SE-AETC training modules **cannot** be charged to the local Ryan White Part A/MAI Programs.

B. **Additional Service Delivery Standards:** Providers of this service will adhere to the *Ryan White Program Medical Case Management Standards of Service.* (Please refer to Section III of this FY 2026~~5~~ Service Delivery Manual for details, as may be amended.)

C. **Rules for Reimbursement:** The units of service used for Medical Case Management and PESN reimbursements are as follows. ***(IMPORTANT NOTE:*** *except for MCM and PESN (when referring to staff or service category), OMB, HIV/AIDS, and HIPAA, all acronyms used in this section are billing codes.)*

1. *Medical Case Management (MCM) Services* are reimbursed by unit cost, where one unit equals one minute of actual time, at rates not to exceed $1.15 per unit/minute. See table below.

2. *Peer Education and Support Network (PESN) Services* are reimbursed by unit cost, where one unit equals one minute of actual time, at rates not to exceed $0.65 per unit/minute. See table below.

3. Providers are required to document each unit of service performed (including the type of encounter and length of time spent) as face-to-face encounters, tele-medical case management, plan of care, adherence counseling, or other activities conducted with or on behalf of a client. These units [i.e., service code(s) and time spent] shall be entered in the Provide® Enterprise Miami data management system when documenting each client's progress log and for billing purposes. Units of service must be documented and reported separately for PESN and Medical Case Management services.

4. Client eligibility screening for voucherable services (e.g., Medical Transportation vouchers) is billable as a unit of service depending on the amount of time spent with the client. Costs related to the ***actual distribution of voucher services*** should be covered under the dispensing charge allowed for handling of vouchers under the Medical Transportation service category (i.e., discounted transportation EASY Tickets or limited ride-share).

   Medical case management staff cannot use MCM encounter billing codes for time spent scheduling ride-share (e.g., Uber or Lyft) trips for a client with the ride-share transportation company. This activity is part of the dispensing fee allowable under the Medical Transportation service category if line items other than purchasing ride-share trips are included in the Medical Transportation budget.

   Adherence and care coordination efforts to secure the medical or social service (e.g., appointment with a provider) a client uses ride-share services to attend may be billed by Medical Case Management staff using the appropriate code (e.g., ADH, POC, COL, etc.) from the table directly below. In such cases, medical case management staff should take this opportunity to ask if the client was satisfied with the medical or social service appointment, if the client understood what was covered during the appointment, and if other care coordination or referral is needed as a result of the appointment.

5. No two Peers can bill for the same time and for the same client when specifically using the Face-to-Face (FFE) and Adherence (ADH) services codes.

6. The following table reflects MCM and PESN encounter/activity billing codes (in alphabetical order **by code**) that are active in FY 2025:

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Affordable Care Act (ACA) Health Insurance Marketplace	**ACA**	This code includes any and all activities with or on behalf of the client, such as researching health insurance plans, discussing plan options, assisting with the application process, communicating with American Exchange LLC on behalf of the client, and documenting all efforts, related to the client's enrollment in private insurance through the Affordable Care Act Health Insurance Marketplace. This code also includes time spent explaining the health insurance plan to client, how it works, what documents the client is required to present, as well as what benefits and restrictions the client has under the plan. Do NOT use this ACA code to record time spent actually enrolling a client on-line in an ACA Marketplace health insurance plan overseen by American Exchange or other third-party ACA enrollment agents. Time spent navigating or enrolling clients online at www.healthcare.gov are not billable to the local Ryan White Program.
Adherence Counseling	**ADH**	This code includes adherence activities with the client such as medication counseling, risks and benefits of treatment, compliance with treatment regimen, education on medication resistance, compliance with medical and other core service appointments, and review of HIV case management portal information. Do NOT use this ADH code to record time spent by a licensed medical provider) providing adherence counseling, as this would be billed under the Outpatient/Ambulatory Health Services category. **UPDATE (12/8/2023): ALL medical case management interactions with clients should have an adherence counseling component (i.e., use of the ADH billing code with related progress log note). Case management without adherence counseling is not Ryan White Program Medical Case Management.**

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Case Closure Activity	**CCA**	This code includes activities related to closing a client's case at the medical case management agency and in the Provide® Enterprise Miami data management system. The limit for this activity per client is 30 units (i.e., 30 minutes; see "Definition of a Unit" above).
Collateral Contacts	**COL**	This code is to be used by Peers and Medical Case Management Assistants **only** to record communication with other care providers **inside** and **outside** of the Peer or Medical Case Management Assistant's own agency for **all** coordination of care activities conducted on behalf of the client. This includes telephone contacts or other electronic methods of communication (e.g., email or fax) with the outside or inside agency to obtain or provide additional information for the client's care. This code may also be used to document travel time with or on behalf of the client that is specific to care coordination, linkage to care, or retention in care activities conducted by Peer Educators or Medical Case Management Assistants. In such cases, documentation in the client chart must include reason for travel in relation to care coordination, linkage to care, or retention in care. This code **cannot** be used when pulling a chart to copy documents for a client's personal use or for filing documents. Instead, use the DOC billing code for pulling a chart or filing. Medical Case Managers and Medical Case Management Supervisors **cannot** use the COL code. Medical Case Managers and Medical Case Management Supervisors must use POC for **all** Plan of Care and coordination of care activities. See POC section below.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Consulting w/ Staff	**CON**	This code includes activities related to case consultation with internal staff. This code may **only** be billed by the agency's OMB-authorized Medical Case Management Supervisor or Lead Medical Case Manager.
Documentation	**DOC**	This code includes activities related to documenting any encounter in the Provide® Enterprise Miami data management system, such as preparing the progress note to detail a face-to-face encounter, telephone contact, etc. This service code also includes time spent organizing the client record or filing, looking up, or pulling documents to make copies that are unrelated to coordination of care for the client. This code also includes conducting peer reviews of client charts. **Do <u>not</u> use this DOC code to record documentation of activities related to the client's care plan or preparing referrals. Instead use POC to record <u>any</u> Plan of Care activity conducted by the Medical Case Manager or Medical Case Management Supervisor.** **Supervisors should NOT use this DOC code when advised by Miami-Dade County's Ryan White Program staff as part of a billing or site visit review that a progress note needs to be reviewed, corrected and resubmitted.** **UPDATE (12/8/2023):** When recording documentation activities: • Any DOC encounter billed for **15 minutes or less** does NOT require an explanation in the progress log of the activity. • Any DOC encounter billed for **more than 15 minutes** requires a progress log note that indicates exactly which DOC activity was conducted (e.g., organizing the client record, scanning / copying documents to upload in PE Miami, documenting an encounter, entering the progress note in PE

		Miami, or copying records for the client's personal use for purposes unrelated to coordination of care.)
Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Eligibility Specialist (with Bachelor's Degree)	**EDE**	This code is only for use by OMB-authorized Eligibility Specialists who have educational qualifications similar to a Ryan White Program Medical Case Manager (i.e., Bachelor's degree) (billable at $1.15 per minute). This code is to be used only by authorized persons completing Ryan White Program eligibility and facilitating the financial eligibility review process at Jackson Health System for purposes of assisting eligible clients in obtaining a Jackson Health System/Jackson Memorial Hospital "J card" with the "IO1" designation of the Ryan White Program as the payer source.
Adherence Encounter by Eligibility Specialist (no degree)	**ENA**	This code is only for use by OMB-authorized Eligibility Specialists who do NOT have a Bachelor's degree (billable at $0.65 per minute, similar to a peer or medical case management assistant). This code is to be used only by authorized persons when communicating the importance of treatment adherence to clients during a corresponding Eligibility Specialist encounter. For treatment adherence activities conducted by Medical Case Managers, Peers, or Medical Case Management Supervisors, use the ADH code.
Eligibility Specialist (no degree)	**ENE**	This code is **only** for use by OMB-authorized Eligibility Specialists who do NOT have educational qualifications similar to a Ryan White Program Medical Case Manager (i.e., no degree) (billable at $0.65 per minute). This code is to be used only by authorized persons completing Ryan White Program eligibility and facilitating the financial eligibility review process at Jackson Health System for purposes of assisting eligible clients in obtaining a Jackson Health System/Jackson Memorial Hospital "J card" with the "IO1" designation of the Ryan White Program as the payer source.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Face-to-Face Encounter	**FFE**	This encounter is defined as any time the Medical Case Manager, Peer Educator, or Medical Case Management Supervisor has direct contact with the client in person. In consultations with a child and one or more adults, encounters are billed for one family member only who must be HIV+ and eligible for Ryan White Program-funded services. The FFE encounter includes activities that are conducted face-to-face with the client where no other encounter code is appropriate. FFE may also include referral activities if done face-to-face with the client. FFE may also be used to record travel time for the purpose of attending a medical appointment or social service appointment, only when traveling with the client. If travel is included in a FFE encounter, the appropriate reason and length of time must be documented in the client chart. A brief face-to-face encounter may be included with a POC activity to indicate that a client contact occurred on the same day as a POC activity. In such cases, a few minutes of the FFE code would be acceptable. This circumstance must be clearly explained in the progress notes.
Insurance Coordination and Retention	**ICR**	This code is **only** for use by OMB-authorized staff with special insurance coordinator roles (i.e., Users.IBM and Users.MCM.OpenNR) in the Provide® Enterprise Miami data management system. Approved activities include following up on health insurance policies to ensure clients are active or troubleshooting any issues where clients are dropped from an insurance policy, including where recoupment of funds may be needed (billable at $1.15 per minute).
Electronic Override Activity	**OVR**	This code may **only** be used by authorized Medical Case Management Supervisors or Lead Medical Case Managers. The limit for this activity per client is 30 units (i.e., 30 minutes; see "Definition of a Unit" above).

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Plan of Care (i.e., Action Plan)	**POC**	This code is **only** to be used by Medical Case Managers, Lead Medical Case Managers, and Medical Case Management Supervisors to record **all** Plan of Care activities (including initial development of the Plan of Care, ongoing updates, follow-up, communication with other providers **within** the Medical Case Manager, Lead Medical Case Manager, or Medical Case Management Supervisor's own agency **or with an outside agency** for coordination of care). This includes face-to-face encounters related to the Plan of Care, as well as phone conversations, emails, faxes, and related referrals. If a telephone conversation is specifically related to a Plan of Care activity, the POC code should be used. The TEL code should be used for general telephone contacts. Please see the FFE and TEL comments sections for additional POC-related guidance. Peer Educators and Medical Case Management Assistants are **NOT** authorized to create or update the Plan of Care; and, therefore, are restricted from using this POC code. **NOTE:** the Plan of Care is referred to as the Action Plan in the Provide® Enterprise Miami data management system.

Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Safety Backup (PESN only)	**PSFT**	As a safety precaution, Ryan White Program Outreach Workers who must locate clients in high-risk areas or very rough neighborhoods may go out in two-person teams. In this scenario, a Peer/Peer Educator/Peer Navigator (Peer) may accompany the Outreach Worker; and the Peer should document the activity in the client chart, making note that they went to a high-risk area with an Outreach Worker and clearly stating that they went along as a safety back-up. The Peer should use the PSFT safety back-up code to record the entire service. Both the Peer and the Outreach Worker may reflect the time they spent on the encounter and have their agency or respective agencies report for the time and be reimbursed accordingly. The Peer **cannot** use any other encounter code or billing code for this activity on the same day.
Chart Review	**REV**	This code includes activities related to reviewing client charts for quality management purposes, to ensure proper documentation and coding. This code may **only** be billed by the agency's OMB-authorized Medical Case Management Supervisor or Lead Medical Case Manager.
Telephone Encounter	**TEL**	This code includes general telephone contacts with the client or the client's representative or leaving a voice message for the client. This activity does not include telephone contacts with other care providers. **IMPORTANT NOTE**: Telephone contacts with other care providers, for the purpose of coordinating care for clients, should be recorded as a collateral (COL) encounter if conducted by a Peer or Medical Case Management Assistant. Use the Plan of Care (POC) code if the telephone contact was done by a Medical Case Manager or the Medical Case Management Supervisor for the purpose of coordinating care. See COL and POC above for additional guidance. A brief general telephone encounter may be included with a POC activity to indicate that a client contact occurred on same day as a POC activity. In such cases, a few minutes of the TEL

		code would be acceptable. This circumstance must be clearly explained in the progress notes.
Medical Case Management & PESN		
Activity (with Limitation, if applicable)	**Encounter/ Activity Billing Code**	**Comment, Limitation, etc.**
Tele-Medical Case Management (MCM)	**THM**	This code includes Tele-Medical Case Management services provided by Medical Case Manager, Medical Case Management Supervisor or Eligibility Specialist (with at least a Bachelor's degree). This is billable at $1.15 per minute.
Tele-Medical Case Management (PESN)	**THP**	This code includes Tele-Medical Case Management services provided by Peer, Medical Case Management Assistant, or Eligibility Specialist (with no degree). This is billable at $0.65 per minute.
RW-Approved Training	**TRN**	This code includes time spent at local Ryan White Program-approved training for Medical Case Managers, Peers/Peer Educators/Peer Navigators, Medical Case Management Supervisors, and Outreach Workers (using OTRN), such as quarterly case management supervisor trainings, County-approved Provide® Enterprise Miami data system trainings, and Ryan White Program Provider Forums. The TRN code may NOT be used to bill for any training that is NOT a Ryan White Program-specific training. For example: use of the TRN code **cannot** be used to bill for staff attendance at Miami-Dade County HIV/AIDS Partnership and Committee meetings, on-site technical assistance provided by Behavioral Science Research Corporation (the Program's contracted clinical quality management provider), appreciation luncheons, agency-specific staff development activities, HIPAA refresher training, confidentiality training, SE-AETC on-line training modules, or other employer-required training. Travel time or lunch (if time on your own) is NOT included when billing the TRN code. Billing staff, data entry staff, and other administrative staff may NOT use the TRN code.

ADDITIONAL IMPORTANT NOTES:

1) There is no special billing code or activity code for ADAP-related services. ADAP-related services should be coded with the appropriate code from the table above.

2) MCM Supervisor direct service duties include activities related to, with, or on behalf of a client such as maintaining their own client case load, conducting case consultation with the Medical Case Manager for complex client issues or problems, and assisting the Medical Case Manager or client with the client's treatment adherence issues and/or other problems related to appropriate care.

3) MCM Supervisor administrative duties include staff scheduling, payroll, performance evaluations, general supervision, training unrelated to Ryan White Program activities, and other non-client related services. Do NOT use the billing codes above to record general administrative activities.

D. Rules for Reporting: Providers of PESN and Medical Case Management services must report, separately, their monthly activities according to one-minute "Face-to-Face" encounters and one-minute "Other" encounters. In addition, providers must report the number of unduplicated clients served. Providers must develop a method to track and report client wait time (e.g., the time it takes for a client to be scheduled to see a Medical Case Manager after calling for an appointment; and upon arrival for the appointment, the time the client spends waiting to see the Medical Case Manager and the wait time reaching a live person for assistance by telephone) and to make such reports available to OMB staff or authorized persons upon request.

E. Applicability to Local Ryan White Program Requirements: If a staff person of a Ryan White Program-funded service provider has a Ryan White Program Medical Case Management caseload, even if only one client, they will be required to adhere to the local Ryan White Program Service Delivery Manual, Medical Case Management Standards of Service, and Clinical Quality Management Program activities, whether or not they appear on the program's line item budget and regardless of the percentage of time and effort spent performing Ryan White Program Medical Case Management activities. Similarly, if any person on a provider's staff supervises any Ryan White Program Medical Case Management staff, whether or not they are on the budget for such, they also must follow the requirements in the local Ryan White Program Service Delivery Manual, Standards for Medical Case Management Supervisors, and Clinical Quality Management Program requirements.

F. Additional Rules for Documentation: Providers must also maintain documentation to support educational requirements in the personnel records for Medical Case Management staff and ensure that such documentation is available

for review by authorized persons.

Miami-Dade County 2027-2031 Integrated HIV Prevention and Care Plan

A collaboration between the Miami-Dade HIV/AIDS Partnership, the Florida Department of Health in Miami-Dade County, the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program, and community partners.

TABLE OF CONTENTS

ACRONYMS AND TERMINOLOGY

Section I: Introduction of Integrated Plan and SCSN

I.1. Introduction

For over a decade, the Miami-Dade County (MDC) Eligible Metropolitan Area (EMA) has been a national HIV/AIDS hot spot. Despite substantial progress with prevention and care efforts and significant improvements in health outcomes, the EMA continues to lead the state of Florida in the total number of people with HIV (HIV prevalence). A total of 30,074 people with HIV – almost 23% of the entire state's population of people with HIV – lived in the EMA in calendar year (CY) 2024, the latest year of complete surveillance data available from the Florida Department of Health (FDOH).

Florida's 2022 Statewide Coordinated Statement of Need (SCSN) identified four key areas of need in the EMA. The revised SCSN is expected to be released later in 2026 and the EMA's Integrated Plan may be updated to reflect any identified changes to key areas.

Key Areas Identified in the 2022 SCSN:

- **HIV Prevalence:** Florida continues to have one of the highest rates of new HIV diagnoses in the United States.
- **Differences in Health Outcomes:** The epidemic continues to have a greater impact (poorer health outcomes) in Black/African American, Hispanic/Latino, and Haitian communities.
- **Barriers to Care:** Social determinants of health, including high rates of poverty, lack of transportation, food insecurity, housing instability, mental health issues, and substance use disorders add significant challenges to effective prevention and care efforts.
- **Service Gaps:** There is still a need for expanded access to pre-exposure prophylaxis (PrEP), mental health services, and means to address HIV-related population vulnerabilities.

For the past three years, the EMA has been guided by the 2022-2026 Integrated HIV Prevention and Care Plan (2022-2026 Plan) goals. The Miami-Dade HIV/AIDS Partnership (Partnership), the EMA's Ryan White Program Planning Council, has taken the lead on 2022-2026 Plan evaluation, monitoring, updating, and reporting. The Partnership's Strategic Planning and Prevention Committees have reviewed data and further evaluated and refined the activities. The committees meet independently and as a combined group, known as the Joint Integrated Plan Review Team (JIPRT).

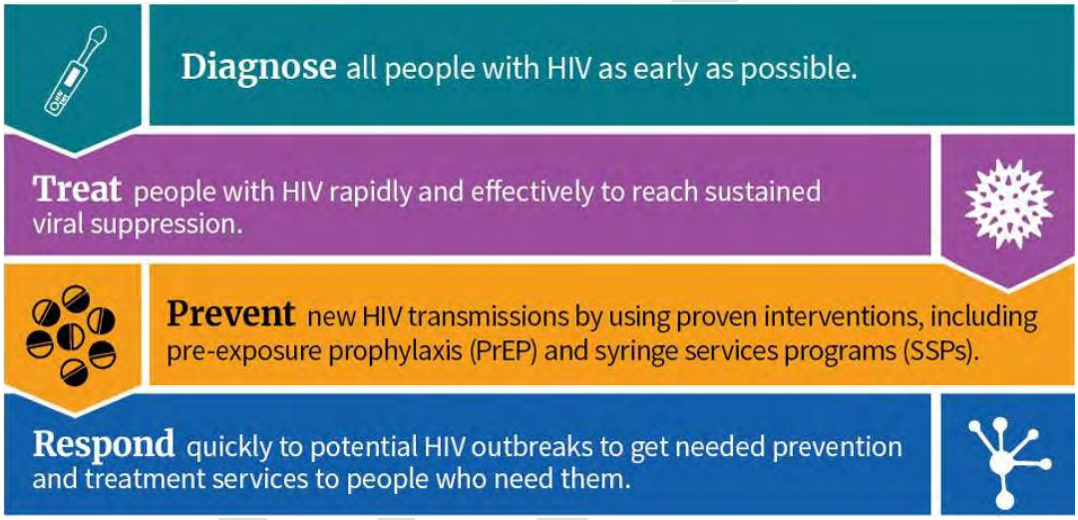
Both qualitative and quantitative data were used in the 2027-2031 Integrated HIV Prevention and Care Plan (Plan) to describe the impact of HIV in the EMA; determine service gaps and barriers to care; identify prevention and treatment areas; as well as refine goals and objectives to ensure access to HIV prevention and care across the service delivery system, as detailed in **Section III: Contributing Data Sets and Assessments**, of this Plan (see below).

This Plan is structured around the overarching goals of the National HIV/AIDS Strategy (NHAS). It also incorporates the four pillars of the Ending the HIV Epidemic initiative (EHE), the key areas identified in the Statewide Coordinated Statement of Need (SCSN), and the Ryan White Program's 2030 goals and strategies. These elements are reflected throughout both the Plan's Goals and Objectives and the Situational Analysis sections. Although the NHAS is no longer included as required guidance for the 2027–2031 Plan, we remain committed to structuring this Plan around the national objectives supported by CDC and HRSA. Accordingly, our focus continues to include:

- Preventing the transmission of HIV.
- Strengthening health outcomes for people with HIV who are engaged in care.
- Addressing and reducing inequities in HIV-related outcomes.
- Promoting coordinated, collaborative efforts across partners to more effectively respond to the HIV epidemic.

The 2027-2031 Plan goals also evolved to align with the Four Pillars of Ending the HIV Epidemic (EHE) in the U.S.:

The Four Pillars of EHE



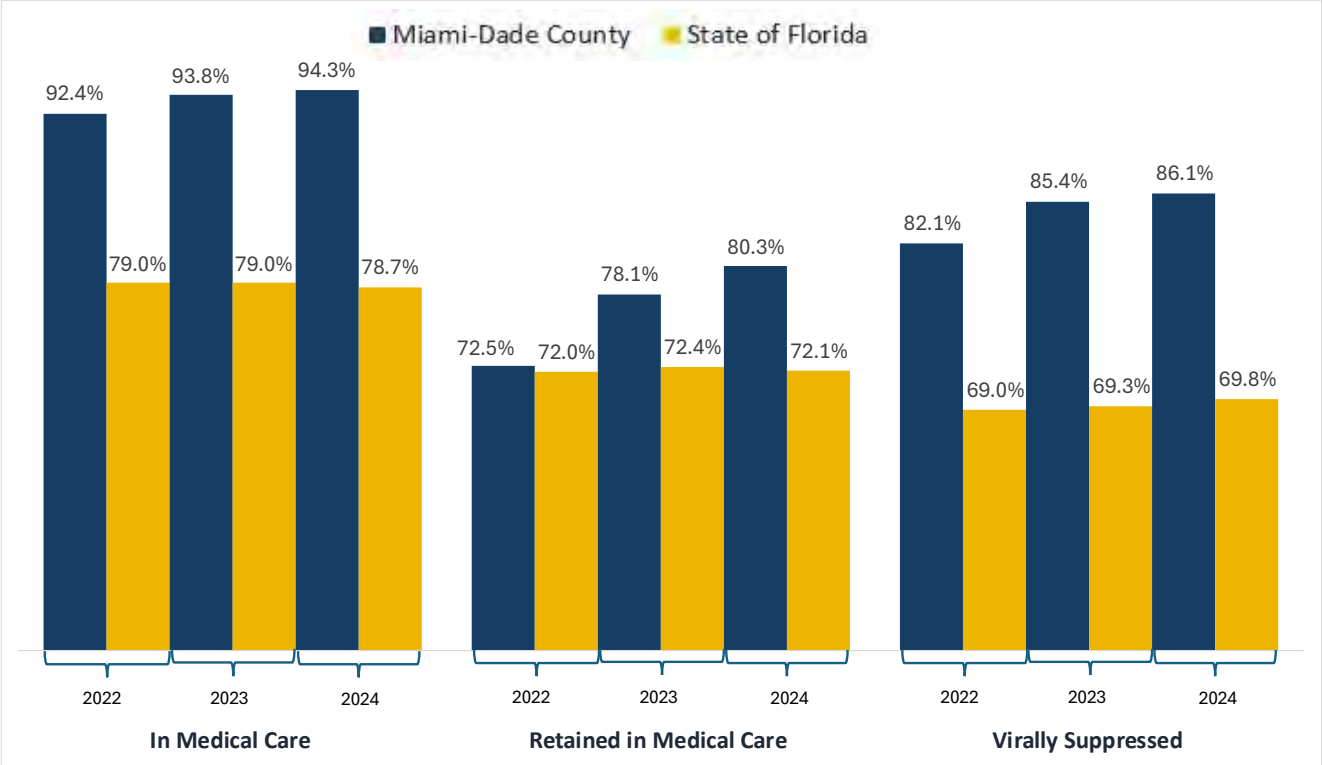
This Plan also incorporates the flexibilities of the EHE Initiative to advance the Ryan White Program 2030 goals. These goals emphasize continuing high-quality care for current Ryan White Program clients while expanding access to HIV care for people who are out of care or not virally suppressed, ensuring that no one is left behind in efforts to end the HIV epidemic. Continued progress depends on reaching people with HIV who are not engaged in care and supporting HRSA HAB's vision to strengthen partnerships, focus interventions, and engage the HIV community.

Key Ryan White Program 2030 goals and strategies reflected in this Plan include:

- Rapid initiation of HIV treatment;
- Community-based outreach;
- Treatment as prevention;
- Leveraging partnerships; and
- Using data-driven approaches to identify populations with the greatest unmet needs.

Additionally, HIV Care Continuum data are monitored and continue to show progress for RWHAP clients, particularly in comparison to state trends, as shown below.

HIV Care Continuum Comparison: Miami-Dade County and State of Florida (2021–2024)



Representatives from the Partnership and the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program – the Ryan White Program Part A/Minority AIDS Initiative and EHE Recipient (the Recipient), serve on the Florida Comprehensive Planning Network (FCPN); and Partnership staff served on the Statewide Integrated HIV Prevention and Care Plan (IPC) Workgroup and the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) Advisory Board. Regular reporting and feedback on statewide updates relevant to local planning and program administration were intended to be included in the 2027-2031 Plan development. However, FDOH's Statewide Integrated Planning group disbanded abruptly in March 2026 and there have been no further communications about the Statewide Plan. The FCPN meeting scheduled for May 2026 was also abruptly canceled and has not yet been rescheduled.

This Plan is truly a living document which will continue to be monitored for updates to meet changing legislative requirements, respond to local policy changes, and consider the implications of new data as they become available. Responsibility for monitoring and reporting on Plan progress will continue to be a collaboration between the Partnership, the Recipient, the Florida Department of Health in Miami-Dade County (FDOH-MDC), the local prevention funding grantee, and other stakeholders as identified in this Plan.

I.1.a. Approach to Preparing the Integrated Plan

This 2027-2031 Plan modifies and enhances the existing 2022-2026 Plan, with additional documents as needed. Contributors to the 2027-2031 Plan development, monitoring, and updating include Ryan White Program (RWHAP) clients, peer educators/navigators, and other community advocates with HIV; and representatives from RWHAP Parts A, B, C, and D; the AIDS Drug Assistance Program (ADAP); FDOH-MDC Community Mobilization Workgroups; the Florida Agency for Health Care Administration (Medicaid); the Recipient; FDOH-MDC; HIV prevention providers; the Partnership; and other collaborators as detailed in **Section II: Community Engagement and Planning Process**, of this Plan (see below). Throughout the development process, the 2027-2031 Plan was presented to the JIPRT and other Partnership committees at well-advertised, public meetings. All meeting documents, including meeting minutes, Plan drafts, supporting documents referenced in the Plan, and relevant presentations, are posted on the Partnership's website, www.PartnershipMiami.org. The Partnership approved the final draft of the 2027-2031 Plan in June 2026.

I.1.b. Documents Submitted to Meet Requirements

Data were drawn from the source documents listed below. Hyperlinks are provided for items available on www.PartnershipMiami.org or elsewhere online.

- 2022-2026 Integrated HIV Prevention and Care Plan for Miami-Dade County;
- 2022-2026 State of Florida Integrated HIV Prevention and Care Plan;
- 2024 Annual Report – HIV in Miami-Dade County, prepared by the Partnership;
- 2025 Annual Partnership Needs Assessment;
- 2025 State of Florida HIV Care Needs Survey for Area 11a; provided by The AIDS Institute (locally translated into Spanish and Haitian Creole);
- 2026 Survey on HIV Prevention in Miami-Dade County (in English and Spanish);
- CDC/HRSA 2027-2031 Integrated Plan Guidance (February 2025);
- Data on service gaps, provided by the FDOH-MDC and the RWHAP;
- FDOH Epidemiological data, CY 2024;
- Florida Community Health Assessment Resource Tool Set (CHARTS);
- HIV and STD testing data provided by the FDOH-MDC;
- Letter of Concurrence (see **Section VII** of this Plan, below);
- Results from listening sessions, interviews, community input sessions, and online surveys;
- RWHAP Client Satisfaction Survey, (administered in English, Spanish, and Haitian Creole), with data provided by BSR for 2022-2025;
- RWHAP utilization data provided by BSR, 2022-2025;
- The Health Council of South Florida District 11 Health Profile (January 2025); and
- Work Plan CDC-RFA-PS20–2010, Integrated HIV Programs for Health Departments to Support Ending the HIV Epidemic in the United States, FDOH-MDC.

Section II: Community Engagement and Planning Process

II.1. Jurisdiction Planning Process

Meetings to develop the 2027-2031 Integrated Plan (Plan) began in January 2025 during the Miami-Dade HIV/AIDS Partnership's (Partnership) Joint Integrated Plan Review Team (JIPRT) meeting. Members were provided with a copy of the guidance and expectations for draft review and completion dates were established. Partnership staff coordinated with the Recipient and the Florida Department of Health in Miami-Dade County (FDOH-MDC) to gather data and promote Plan development opportunities. JIPRT meetings were ongoing quarterly through May 2026 to establish SMART goals, review data, and give feedback on the narrative sections of the Plan. Each month, draft documents were publicly available, meetings were publicly noticed, progress was reported to the Partnership and JIPRT, and input gathered at meetings was incorporated into the Plan draft.

Webinars and other meetings related to Integrated Planning were widely advertised and attended by Partnership members and staff. Updates and relevant information were shared with the JIPRT throughout the Plan's development. Webinars included topics such as Plan development, the impacts of changing legislation on Plan development, gathering feedback from other jurisdictions and programs, and the development of the State of Florida Integrated Plan, as follows:

- HRSA/CDC Integrated HIV Prevention and Care Planning – April 30, 2025;
- Fast-Track Cities Town Halls – June 25, 2025, and October 29, 2025;
- Community Forum to Reduce HIV Infection in Miami-Dade County (in person meeting championed by Senator Rene Garcia, Miami-Dade County Commissioner) – August 5, 2025;
- Get on Board! The Partnership's Member Enrichment Training Series – Station 21: The Integrated Plan and You! – September 15, 2025;
- Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) Advisory Board Meeting – September 15, 2025;
- University of Miami Support Group Presentation (in person) – October 7, 2025;
- IHAP TAC Integrated Planning 3.0 - Virtual Office Hours – October 21, 2025;
- IHAP TAC IP Development - Virtual Office Hours – December 10, 2025;
- IHAP TAC Advisory Board Meeting – February 23, 2026; and
- IHAP TAC Countdown to Integrated Plan Submission - Virtual Office Hours – February 24, 2026.

Partnership staff and Recipient representatives were invited to participate in the Statewide Integrated HIV Prevention and Care Plan Workgroup which met virtually via Zoom in 2025 on November 12 and 19, and December 3 and 17; and in 2026 on January 7 and 21, February 4 and 18, and March 4, 18, and 25. Unfortunately, this did not result in a meaningful collaboration. After 11 meetings, the group abruptly disbanded in March 2026, and there has been no further communication regarding the Statewide Plan. In addition, a high-level overview of the Statewide Plan was supposed to be presented to the Florida Comprehensive Planning Network (FCPN), whose members include the Partnership, prevention service providers, the Recipient, FDOH-MDC, and the other Part A and EHE jurisdictions across Florida. However, the FCPN meeting scheduled for May 2026 was also suddenly canceled a few days prior to the meeting, "due to unforeseen circumstances."

While planning and coordination between FDOH-MDC (prevention) and RWHAP (care) administrators and communication with the Planning Council remain consistently strong, active, and ongoing, with open

dialogue and collaborative problem-solving, the lack of open communication from the State has made it difficult to ensure our goals and objectives are in alignment.

Groups involved in Plan development, as noted in **Section I: Introduction**, of this Plan, above, included Ryan White HIV/AIDS Program (RWHAP) clients, peer educators/navigators, and other community advocates with HIV; and representatives from RWHAP Parts A, B, C, and D; the AIDS Drug Assistance Program (ADAP); FDOH-MDC Community Mobilization Workgroups; the Florida Agency for Health Care Administration (Medicaid); the Recipient; FDOH-MDC; the Partnership; and other collaborators. These contributors include Partnership and committee members as well as other community members who participated as meeting guests or subject-matter experts.

The primary goal-setting groups were the Partnership's Strategic Planning and Prevention Committees, meeting individually and collectively as the JIPRT. The JIPRT made concerted efforts to ensure all activities had a data source and a designated person responsible for providing the data. Where activities could not be tracked by a data source, those activities are included in other sections of this Plan as either future activities or aspirational goals.

A major part of Plan development was establishing a database for tracking progress on the Plan. Behavioral Science Research Corporation (BSR), the Partnership Part A staff support subrecipient, designed an Excel-based Integrated Plan Monitoring and Reporting System (IPMRS) as a functional tool to track progress for the next five years. The database was presented at local and statewide meetings to gather input on design, formatting, and what data should be captured. Details about the database are outlined in **Section VI: Situational Analysis**, of this Plan, below.

Aside from reference documents noted in **Section I: Introduction**, of this Plan, above, the key data sources available to the EMA include client-level data from Provide Enterprise® Miami (PE Miami), the Miami-Dade County Ryan White Program data management system; testing and community engagement data from the FDOH-MDC; and other surveys and community input sessions.

Community engagement activities are ongoing and include meetings, training, surveys, and promotion of Integrated Plan guides, documents, and resources intended to reach a broad range of community stakeholders and to gather information from persons both inside and outside the Partnership, RWHAP services system, and FDOH-MDC.

II.1.a. Entities involved in the process.

The primary planning team was comprised of staff from the Miami-Dade County Office of Management and Budget (OMB; the Part A/MAI/EHE Recipient), FDOH-MDC, and BSR. This core group determined the timeline for completion of each section, reviewed survey results and data, and posted, distributed, and/or presented Plan drafts and related reports at JIPRT and Partnership meetings. Throughout Plan development, meeting dates were widely advertised. All documents were available for review by Partnership members and the general public via the Partnership's website and promoted to the Partnership's email listserv of more than 1,300 people. Entities involved in the process are further detailed in sections **II.1.b**. and **II.1.c** of this Plan, below.

II.1.b. Role of the RWHAP Part A Planning Council – The Partnership

Partnership members were involved in every aspect of Plan development. The Integrated Plan Guidance was posted on the Partnership's website and distributed at Partnership and Committee meetings beginning in December 2024, with updates distributed in February 2025. Draft narrative sections were reviewed and

revised by the Strategic Planning and Prevention Committees in stand-alone meetings, and at JIPRT meetings. All drafts were publicly available on the Partnership's website. Members were regularly reminded of completion deadlines to keep on track for submission of the final Plan to HRSA in June 2026.

Review of data collection on the previous plan activities demonstrated that for many activities there was no measurable data and it was not always clear how the activities were connected to the plan goals. Members of the JIPRT met in October 2025, and at stand-alone Prevention Committee and Strategic Planning Committee meetings in March and April 2026 to make significant revisions to ensure inclusion of meaningful and measurable objectives and activities. Specifically, we reduced the number of objectives to align with the guidance recommendation to identify three objectives per goal. However, to ensure all important activities were captured, in some cases there may be more than three activities within the objectives. The review of 2022-2026 Plan goals also resulted in ensuring only SMART goals were included in the 2027-2031 Plan. The resulting goals, objectives, activities, and measurements are detailed in **Section V: Goals and Objectives**, of this Plan, below. JIPRT members also met in February 2026 to review and revise narrative sections of the Plan, with this activity ongoing in stand-alone meetings in March and April 2026.

All meetings where these deliberations took place were broadly advertised and open to the public. All Partnership meetings were conducted in person at centrally located meeting sites accessible by public transportation, with details on how to get to meetings included on the Partnership's website. Efforts were made throughout Plan development to gather feedback from representatives of the affected community; and these are primarily incorporated in **Section IV: Situational Analysis**, below, and in **Section V: Goals and Objectives**, below, where concerns could be tied to measurable activities.

As noted above, the Partnership's JIPRT was the primary group who reviewed and provided feedback and edits to Plan drafts. On May 19, 2026, the JIPRT conducted a read-through of Sections I, II, IV, VI, and the Letter of Concurrence, and voted to advance the Plan to the Partnership for final review with the allowance for Partnership and Recipient staff to make final edits. Included in the motion was the understanding that Sections III and V would be posted online with the opportunity to provide additional feedback prior to the Partnership meeting. The JIPRT presented their recommendations to the Partnership on June 1, 2026. The Partnership put forth several motions, including the approval of the Plan with the allowance for Partnership and Recipient staff to make final edits; the approval of the Miami-Dade County Letter of Concurrence for the 2027-2031 Maimi-Dade County Integrated HIV Prevention and Care Plan; and authorization for the letter to be co-signed by the named signatories. The Recipient received the approved Plan well in advance of the June 30, 2026, deadline for submission. The deliberations of the JIPRT and the Partnership are recorded in the approved minutes of each meeting. All minutes are part of the public record and approved minutes of the most recent ten meetings are posted on the Partnership's website. Records of prior meetings are archived.

The key stakeholders represented as voting members of the Partnership and its committees include:

- Persons with HIV, both RWHAP and non-RWHAP clients;
- Peer educators/navigators;
- RWHAP Parts A, B, C, D, and F (ADAP) representatives;
- FDOH-MDC representatives;
- FDOH and RWHAP Ending the HIV Epidemic (EHE) representatives and data managers;
- State of Florida General Revenue representative;
- Local private and university researchers;
- Prevention providers;
- Patient/client advocacy groups;
- Advocates for victims of sexual abuse and human trafficking;

- Local hospital representatives; and
- RWHAP subrecipients providing one or more of these services:
  - Medical Case Management,
  - Outpatient Ambulatory Health Care,
  - Oral Health Care,
  - Mental Health Services,
  - Substance Use Disorder Treatment (Outpatient and Residential),
  - Medical Transportation,
  - Outreach Services, and
  - Health Insurance Premium and Cost Sharing Assistance.

II.1.c. Role of Planning Bodies and Other Entities

In the EMA, the RWHAP Part B and HIV/STD Prevention programs are under the jurisdiction of the FDOH-MDC. EHE initiatives are funded through FDOH-MDC and the RWHAP Recipient. As noted above, both FDOH-MDC and the Recipient were involved in every part of creating this Plan, including scheduling and coordination of efforts, data collection, goals and activities development, and final draft submission.

EHE goals and activities have been incorporated into the Plan, with the funding source and responsible entities noted. The Plan was designed in this way to build on the strength of existing EHE activities, and to align with national EHE Initiative to diagnose, treat, prevent and respond. CDC's strategies and activities required to support high impact HIV prevention and the key Ryan White Program 2030 goals, as detailed in **Section I, Introduction**, above, are also incorporated to avoid duplication of efforts, and promote a more cohesive and collaborative approach to prevention and care planning and implementation.

Partnership staff developed a brief survey to gain community insights into HIV prevention needs, challenges, and successful strategies in Miami-Dade County. Those results contributed to development of **Section IV: Situational Analysis** and **Section V: Goals and Objectives**, of this Plan, below.

In order to gather input from other entities who may otherwise not be involved in integrated planning efforts, feedback from the Florida Comprehensive Planning Network's 2025 State of Florida HIV Care Needs Survey was considered. As of May 2026, a total of 402 surveys were collected, representing people with HIV in more than 65 ZIP Codes within the EMA. The survey collected feedback on service availability and the reasons for not accessing needed services. The survey was still open at the time this Plan was developed, and further results will be analyzed after the survey closes in August 2026. The final survey results are intended to be used to update the SCSN. However, communication with the State is troubled and there has not been an update on how they are using the survey results or when we can expect to have the updated SCSN. Nonetheless, we have continued to promote the survey at Ryan White Part A and Part B-funded subrecipient agencies and meetings, Partnership meetings and community engagement activities, and through the Partnership's social media, bi-weekly newsletter, website postings, and listserv.

II.1.d. Collaboration with RWHAP Parts – SCSN Requirement

The Partnership's JIPRT includes member representatives from RWHAP Part B, Part C, and Part D and Minority AIDS Initiative (MAI). The Partnership's Care and Treatment Committee, which conducts the Annual Needs Assessment, and whose members were solicited for feedback on Plan development, includes representatives from RWHAP Part C, and ADAP. All those members are also members of the Partnership and had a vote on this Plan prior to final submission. Additionally, though representatives of RWHAP Part

A are not voting members on any committee, they participated as meeting guests and subject matter experts, and ensured the Plan was aligned with legislative requirements.

II.1.e. Engagement of People with HIV – SCSN Requirement

Challenges: Efforts to gather feedback from a broad group of participants continues to be a challenge for the EMA. Some of the obstacles include the need to provide materials in English, Spanish, and Haitian Creole. While some translations can be done using AI tools, the translations need to be vetted and there are not full time interpreters on staff. Further, the 2025 State of Florida HIV Care Needs Survey which was intended to gather feedback from across the state was only produced in English, leaving jurisdictions responsible for making their own translations, which may or may not use the same exact survey language in the translated versions. Additionally, lack of funding for incentives for participation in surveys and in-person meetings was a challenge, particularly since the Partnership is a County advisory board and must conduct all meetings in person only and there are no funds to support transportation assistance. The Partnership and FDOH-MDC Community Mobilization Workgroups continue to face challenges in recruiting new members due to conflicts from employment and personal responsibilities, which leads to deprioritizing HIV community participation.

Successes: Even in light of the challenges, people with HIV were included in all stages of planning, through JIPRT and Partnership membership, participation in the annual Client Satisfaction Survey, and by completing the 2025 State of Florida HIV Care Needs Survey. As Partnership members and meeting guests, people with HIV were encouraged to contribute feedback and lived experiences at all meetings. It is our expectation that people with HIV and other community stakeholders will continue to be engaged as meaningful participants in all ongoing facets of Plan implementation, monitoring, evaluation, and improvement. People with HIV are encouraged to join meetings as voting members, if eligible, or as contributing guests. Reference materials are available to all interested parties at www.PartnershipMiami.org. Printed copies of materials are distributed at meetings and available by request.

Also, FDOH-MDC conducts meetings in person, virtually, or hybrid, and those may offer more opportunities for meaningful engagement, provided persons have access to virtual participation technology.

All told, the champions of this Plan are people with HIV who contribute at meetings, share their real-life experiences, and continue to promote opportunities to be involved in the process.

II.1.f. Priorities

On the 2025 State of Florida HIV Care Needs Survey, 92% (325 of 353 respondents to the question) said they “Always” take their HIV medication. This finding is consistent with the high levels of viral load suppression reported among RWHAP clients in Miami-Dade County and supports our overarching priorities to maintain high levels of VL suppression and retention in medical care, and to ensure access to life-saving HIV medications.

Strengths, challenges, and needs were identified and are outlined in detail in **Section IV: Situational Analysis**, of this Plan, below, based on the 2025 State of Florida HIV Care Needs Survey findings, the 2026 HIV Prevention Needs Survey, the 2025 Client Satisfaction Surveys, and community meeting input.. Where challenges can be quantified through an identified data source, these are incorporated into **Section V: Goals and Objectives**, of this Plan, below. Where concerns are not quantifiable or measurable, these are addressed elsewhere in the Plan. For all identified concerns, Plan monitoring will include reviewing measurable activities and reassessing other challenges on an ongoing basis and, as much as possible,

aligning our Plan with the State Plan, as described in **Section VI: 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up**, of this Plan, below.

II.1.g. Updates to Other Strategic Plans Used to Meet Requirements

This Plan incorporates updated goals and objectives from the 2022-2026 Integrated Plan, the RWHAP EHE Plan, and the FDOH-MDC EHE plan.

1. The Partnership's Care and Treatment Committee conducts a complete annual Needs Assessment including prioritization of all RWHAP Part A/MAI services. Although the EMA does not fund all service categories available under HRSA Policy Clarification Notice (PCN) #16-02 through Part A/MAI, the entire roster of services was considered during the priority setting process. For each service category listed in HRSA PCN #16-02, members considered funding sources outside of RWHAP Part A/MAI. For instance, Home Health Care and non-Medical Case Management are also funded by the State of Florida General Revenue.

   There is no direct correlation between the funding and ranking of Part A/MAI services and Integrated Plan development in the EMA. However, both activities consider epidemiological data, comprehensive review of EMA HIV funding, utilization data, viral load suppression data, and unmet needs in decision making. Furthermore, several members of the JIPRT participate in the Needs Assessment process and share information between those two activities.

2. As previously noted, ongoing input from people with HIV and other stakeholders is gathered through broadly advertised public meetings, open access to all draft and final reference documents posted online, and active encouragement for members and guests to participate in all meetings. As the Plan is finalized and submitted to HRSA, the completed Plan – along with its implementation and ongoing monitoring – will be shared with the groups, including people with HIV, that contributed to its development to ensure continued community engagement.

3. Updates to the Plan are based on compliance with federal executive orders and incorporate community input as noted throughout this document.

4. The EMA used the same planning process as in previous years.

Section III: Contributing Data Sets and Assessments

This section is available as a separate document.

Section IV: Situational Analysis

Strengths, challenges and identified needs were drawn from the previous Plan, survey results, and community review at several meetings.

IV.1. Strengths

Miami-Dade County benefits from a long-standing, highly experienced HIV prevention and care infrastructure that has continuously evolved and strengthened over the past 36 years. Overseeing the "care" components of this infrastructure, the Miami-Dade County Office of Management and Budget Grants Coordination/Ryan White Program serves as the Ryan White Program Part A/Minority AIDS Initiative and Ending the HIV Epidemic (EHE) Recipient. The Florida Department of Health in Miami-Dade County (FDOH-MDC) functions as the local prevention funding administrators. Across this system of care, direct service providers bring sustained expertise in helping people with HIV achieve optimal health outcomes. Their work begins with effective prevention efforts and spans the full HIV Care Continuum, including diagnosis, linkage to care, retention in care, and viral suppression.

The EMA benefits from active involvement and dedication of various stakeholders engaged in needs assessment; client satisfaction surveys; prevention, care, and treatment planning; and priority setting and resource allocation activities. Recipients and subrecipients are in ongoing daily communication to help ensure quality services are provided to people with HIV.

Miami-Dade County has one of the most robust HIV testing programs in the state with upwards of nine hospitals routinizing HIV testing in their Emergency Departments; more than 100 testing sites conducting HIV tests in the community; and most of the Federally Qualified Health Centers (FQHC) in the EMA offering routinized HIV testing.

The ADAP and RWHAP prescription drug formularies provide a wide array of available antiretroviral therapy (ART) medications, including both oral medications and long-acting injectables, creating additional opportunities to improve treatment adherence, viral suppression, and treatment as prevention outcomes.

The Recipient, FDOH-MDC, and the Partnership maintain comprehensive websites and social media accounts which provide resources for people with HIV, service providers, and the general public:

- In 2026, the Recipient launched an expanded media campaign to better inform the community about available HIV treatment resources and related services. Information and resources are available on the County's website at www.miamidade.gov/global/initiatives/hiv-support/home.page. This site includes client eligibility information for service programs, information on available services and service providers, and links to the County's social media accounts. The information is subject to change following results of an upcoming competitive solicitation/procurement process, funding levels, and other programming changes.
- Local prevention resources are available through the Florida Health website at www.miamidade.floridahealth.gov/. This site includes an overview of FDOH programs and services, infectious disease services overview, HIV/AIDS resources, and links to FDOH-MDC social media accounts.
- The Partnership's website is www.PartnershipMiami.org, and includes Partnership meeting and membership information, resources for people with HIV, resources for RWHAP service providers, Clinical Quality Management Program resources, the Partnership's Community Newsletter, and links to the Partnership's social media accounts.

IV.2. Challenges

The ADAP Crisis: People with HIV in Florida are facing treatment uncertainty due to severe proposed funding cuts impacting ADAP, ACA insurance premium payments, and affordable access to HIV medications. In January 2026, the Florida ADAP program announced several drastic and unexpected changes to its service provision throughout the state. These changes were disruptive to program planning and service provision throughout the state, with the largest number of clients impacted in the Miami-Dade EMA. Changes included restricting access to ART medications to clients whose gross household income was at or below 130% of the Federal Poverty Level (FPL), removing Biktarvy® from the ADAP Direct Dispense Formulary, restricting Descovy® to clients with renal problems, and discontinuing insurance premium assistance for clients enrolled in the Affordable Care Act (ACA) through ADAP. Although the Florida legislature blunted the immediate impact of some of these changes such as delaying the decreased FPL requirement until June 30, 2026, planning for HIV care and treatment service delivery beyond that date has been enormously challenging.

The EMA has developed contingency plans in the event the most drastic changes take effect after June 30, 2026, with the understanding that these changes will severely impact the existing provision of RWHAP services and complicate integrated planning. If funds must be redirected to address the ongoing impacts of ADAP changes – likely higher demand on Outpatient/Ambulatory Health Services and Local Pharmaceutical Assistance Program services – the consequences would be severe. Critical services – such as Medical Case Management, Oral Health Care, Residential Substance Abuse Services, Food Bank Services, Medical Transportation, and Outreach Services – could face significant reductions. Due to Florida ADAP administrators' lack of transparency and community engagement in the planning process, clients and service providers have been forced to navigate an already complex service system with added uncertainty.

Unless the Florida Legislature takes action to protect access to HIV medications for people with HIV who are at or below 400% of the Federal Poverty Level, health insurance premium assistance, and effective antiretroviral medications – including single-tablet regimens such as Biktarvy® and Descovy® – the drastic changes to Florida ADAP are expected to have severe negative effects on health outcomes for people with HIV in the EMA and across Florida. This situation represents both an urgent challenge and a growing crisis.

Other Funding Cuts: Significant concerns remain regarding pending and ongoing funding reductions including cuts affecting HIV direct client services; prevention activities, such as condom distribution, HIV testing availability, and PrEP access; HIV, mental health, and substance use disorder research; as well as workforce capacity, Ryan White Program services, and overall service sustainability.

Local and Statewide Legislation in Florida: It is difficult to plan effective HIV prevention strategies when the regulatory and funding landscape is constantly changing. FDOH-MDC distributes condoms at events and through mobile units with limited capacity to service providers or send condoms via mail. Providers must purchase condoms – often with 340B rebates – which may put additional strains on already destabilized or limited resources. Other legislation and policies restrict prevention activities in the public school system, specifically testing and sexual education. This lack of comprehensive sexual health education and limited opportunities to provide age-appropriate sexual health information, HIV prevention education, and HIV/STI testing in school settings limits the EMA's ability to address prevention needs among the youth.

Changes to the HRSA Funding Formula: Changes in RWHAP funding are being implemented under HRSA's new Formula Award calculation, which bases client counts on the most recent address rather than the address at diagnosis. The timing and method used to capture these updated addresses remain unclear,

creating uncertainty about how HRSA will determine future client counts. Even with this lack of clarity, Miami-Dade County has already been notified of funding losses to its Ryan White Part A Program exceeding $200,000 per year for the next five years.

Several key aspects of the new formula methodology which remain unclear include:

- **Documentation accepted:** It is not specified whether HRSA will rely solely on addresses recorded via lab reports (e.g., CD4 or viral load) or if alternative forms of verification are required.
- **Reporting mechanism:** The guidance does not clarify whether addresses must be reported through the CDC, HRSA directly, or another entity.
- **Timing:** There is no defined timeframe for when the address will be "snapshot" for reporting – whether at the start or end of a calendar year, or some other period.
- **Update frequency:** It remains undefined how often HRSA will recalculate the formula parameters (e.g., case counts and updated addresses) during the five-year phase-in from FY 2026-2030.

Additional Challenges identified through planning meetings and findings from surveys listed in **I: Introduction**, above, include:

- People aging with HIV continue to experience compounded challenges related to stigma, social isolation, chronic conditions, treatment fatigue, mobility limitations, and increased healthcare and insurance costs.
- Service delivery and administrative fatigue for service providers, subrecipients, recipients, and an aging workforce continue to threaten the long-term sustainability and effectiveness of HIV prevention and care systems.
- Preauthorization for PrEP continues to impair patients' ability to access PrEP medications including long-acting injectable medications, and scarce messaging about PrEP and nPEP may not effectively reach intended audiences.
- Inability to adequately measure or address stigma, combined with insufficient People First messaging and service delivery (i.e., people experiencing homelessness vs. homeless people), continues to create roadblocks for people who might otherwise seek testing and treatment.
- A better understanding of the challenges faced by people with HIV who are released from incarceration is needed in order to ensure positive health outcomes.
- Maintaining a focus on healthcare amid stigma issues, socio-economic factors, and social determinants of health, is especially challenging in underserved populations.

IV.3. Identified Needs

This Plan acknowledges difficulty in measuring activities to bring awareness to stigmatizing behavior throughout the service system. While reducing stigma remains an overarching priority in the EMA, activities specific to this goal are not tracked in the Provide® Enterprise Miami database.

Also, funding may not be sufficient to address all the needs identified in this Plan, and tracking retention in medical care (RiMC) and viral load (VL) suppression data outside the RWHAP represents a challenge due to not having access to client-level data funded under other programs.

During planning meetings and through surveys listed in **I: Introduction**, above, community members and respondents indicated the need for:

- Transitional housing, short-term housing, or emergency housing assistance to counter housing instability;

- Help to pay for private insurance costs, e.g., employer-sponsored or ACA premiums, copays, and deductibles;
- Oral health care beyond regular checkups, e.g., dentures, oral surgery, implants for edentulous clients, etc.;
- Limited, one-time, or short-term assistance to obtain medications not covered by AIDS Drug Assistance Program (ADAP), and for utilities, food, or transportation;
- Limited, one-time, or short-term assistance to pay for utilities and transportation;
- Reliable and consistent access to food through food bank services, grocery certificates, home-delivered meals, and nutritional supplements;
- Services directed to specific groups that may face barriers to care, including younger individuals and people aging into Medicare, particularly regarding issues such as stigma and access to services;
- In home services such as labs and medication delivery, consumable medical supplies, and durable medical equipment, particularly for the aging population and those with limited mobility;
- Access to informational resources in multiple languages; and
- Meaningful interventions to address stigma, specifically related to HIV testing and PrEP.

IV.4. Analysis of Structural and Systemic Issues Impacting People and Communities Disproportionately Impacted by HIV

Each of the four Ending the HIV Epidemic (EHE) Pillars are addressed below, including a brief analysis, further outlined throughout this Plan, and related strategies which are detailed in **Section V: 2027-2031 Goals and Objectives** of this Plan, below.

Regarding structural and systemic issues impacting populations disproportionately impacted by the HIV epidemic in the EMA, see **Section III: Contributing Data Sets and Assessments** of this Plan, below, which details uneven distribution of outcomes across communities, high rates of poverty, the difficulties for people experiencing homelessness or who are unstably housed, challenges of navigating a complex service system of core medical and support services, stigma and fear of disclosure of HIV status, and addressing implicit and explicit biases.

Because development of this Plan was an integrated process, key partners are consistent and redundant across all pillars, including:

- Partnership members, specifically members of the Prevention Committee and Strategic Planning Committee;
- FDOH-MDC and partners among FDOH-MDC Community Mobilization Workgroups;
- RWHAP Recipients, subrecipients, and front-line service providers;
- Partnership and CQM support staff; and
- Other community stakeholders, such as community activists, pharmaceutical representatives, and representatives of transitional housing programs.

The Partnership's Prevention Committee is guided by the activities of the FDOH-MDC; and the Strategic Planning Committee is guided by responsibilities for Part A Planning Councils in coordination with the Recipient. It is the intention of the two committees – working together as the Joint Integrated Plan Review Team (JIPRT) – to expand community stakeholders and continue to engage the broadest scope of partners throughout the implementation of this Plan. At the same time, this Plan is intended to integrate efforts without unnecessary duplication of effort.

IV.4.a. Diagnose

Testing is the key to diagnosing people and making them aware of their HIV status. For people with negative results, the goal is to develop a personalized prevention plan; and for people with a positive test result, the goal is to link them to care as soon as possible. According to Florida CHARTS, Miami-Dade County ranked as the Florida county with the most HIV diagnoses for each of the five years from 2020 to 2024. As noted in **Section III: Contributing Data Sets and Assessments** of this Plan, below, the EMA has the highest concentration of people with HIV in the state of Florida, and high rates of new HIV diagnoses.

This Plan's Prevention strategies related to diagnosing individuals who are unaware of their HIV status are intended to improve health outcomes for all people with HIV. The EMA historically had a robust and widely promoted HIV testing program which included on-site rapid testing, after-hours rapid testing, mobile unit rapid testing, opt-out testing in emergency rooms and clinics, and at-home testing. Marketing of testing availability was developed in English, Spanish, and Haitian Creole. However, as detailed above in **IV.2. Challenges,** above, recent prevention and care funding cuts are negatively impacting the availability and success of previously effective programs, services, and outreach strategies.

FDOH-MDC continues to review concerns about how "newly diagnosed" cases are counted. Individuals are classified as newly diagnosed when they receive HIV testing through FDOH, even if they were previously diagnosed outside the U.S. and only sought retesting to obtain documentation. Only people whose first U.S. diagnosis occurred within the EMA should be included in the EMA's newly diagnosed count. Cross-system record review is needed to verify the original diagnosis date and location, since misclassifying these cases inflates the EMA's new diagnosis numbers and affects the ability to demonstrate progress in prevention efforts.

IV.4.b. Treat

The local FDOH-MDC/RWHAP rapid start protocol, referred to as Test and Treat/Rapid Access (TTRA), is the basis for same-day access to medical care and ART medication, along with rapid linkage to ongoing care. The protocol has demonstrated success in linking newly diagnosed persons to care, with a linkage rate of 83% in 2024. Persons who enter the RWHAP service system through TTRA and those who are enrolled in RWHAP and ADAP can be monitored to ensure they are connected to and accessing available needed services.

IV.4.c. Prevent

Within the geographic boundaries of Miami-Dade County, a wide array of evidence-based HIV prevention strategies is available. These include access to PrEP and PEP, free condoms, routine HIV/STI screening, targeted testing in higher-incidence neighborhoods, Test and Treat rapid-start approaches, Undetectable=Untransmittable (U=U) treatment-as-prevention, and community-based prevention programs. Outreach initiatives and targeted prevention efforts in high-incidence communities continue to strengthen HIV prevention efforts and improve engagement throughout the EMA. Prevention initiatives are conducted via face-to-face and virtual interventions, mobile testing units, social media platforms, and print, radio and television advertising. The Florida Health website at www.miamidade.floridahealth.gov/ promotes PrEP, condom distribution, at-home HIV testing kits, and HIV testing sites, with links to locate prevention services throughout the EMA.

The initiative also leverages academic detailing to strengthen clinical practice. Through this approach, trained detailers offer clinicians information on routinized HIV testing, PrEP/PEP, and Test and Treat, as well as resources that support implementation.

Stakeholders and community members continue to demonstrate strong support for expanding affordable and accessible PrEP services, increasing HIV education efforts, improving prevention messaging, and strengthening prevention engagement opportunities across Miami-Dade County.

The IDEA Exchange Syringe Services Program (SSP) at the University of Miami Miller School of Medicine, launched in December 2016, is the innovative SSP established in Miami-Dade County and now serves as a statewide model for reducing HIV transmission associated with injection drug use. No federal funds are used to support SSP services.

Even with prevention initiatives designed for various communities and populations, along with broad public access to prevention messaging and resources, the latest update from CDC's Estimated HIV Incidence and Prevalence in the United States, 2018–2022, indicates that more than 2,400 individuals in the EMA in 2022 have HIV but are not aware of their status. This figure highlights the importance of the strategies and activities in this Plan aimed at identifying these individuals, encouraging testing to make people aware of their HIV status, and connecting them to ongoing resources – additional prevention, access to PrEP, or linkage to HIV care – depending on their status.

IV.4.d. Respond

To effectively implement the EHE Initiative's Respond Pillar, it is important to understand the following operational definitions:

- **Outbreak:** Rapid transmission of HIV in a well-defined geographic area.
- **Transmission Network (formerly Cluster Detection and Response):** Groups of molecularly linked people with HIV at the < 0.5% viral variance level.
- **Rapidly growing:** When there are five (5) or more people in a transmission network diagnosed within a rolling 12-month time frame.

FDOH RESPONSE – RAPIDLY GROWING TRANSMISSION NETWORKS

While the EMA currently has no identified or reported outbreaks of HIV, the local system of care has the capability and experience to quickly respond to such events. In prior years, FDOH-MDC and the RWHAP Recipient in the EMA collaboratively mobilized responses to Mpox, meningococcal disease, Hepatitis A, and COVID-19 outbreaks. Materials alerting the community to these outbreaks and available resources were produced in English, Spanish, and Haitian Creole, the top three languages of clients in the local HIV community. This information was widely distributed throughout the EMA, through printed flyers, social media campaigns, email messages to RWHAP Medical Case Management teams, and on various websites. HIV prevention and care resources are widely available throughout the EMA, and many of those partners were instrumental in disseminating information about other disease outbreaks. Strengthening and expanding community partnerships will further enhance our capacity to respond rapidly and effectively to future HIV outbreaks.

Police departments and first responders, domestic violence prevention organizations, Business Responds to AIDS (BRTA), and celebrity and social media personalities, are potential collaborators who will need to be identified to understand the importance of reporting potential outbreaks. Coordination across funding streams is also important to avoid delays in reacting to outbreaks.

The EHE Mobile GO Teams initiative uses mobile clinics to further support Miami-Dade County's ability to rapidly respond to HIV transmission clusters using the local Test and Treat/Rapid Access model. The EHE Recipient and subrecipients funded under this initiative collaborate with FDOH-MDC and are poised to respond to HIV clusters and hotspots.

IV.5. People and Communities with Higher Rates of HIV and Related Challenges

The designated populations in the EMA who are facing the greatest HIV burden and the lowest health outcomes as measured by RiMC and VL suppression are Blacks/African Americans and Haitians. Plan activities will focus on tracking and reporting RWHAP client RiMC and VL suppression rates for those subpopulations. Quality Improvement projects at the RWHAP subrecipient level may be designed to address low RiMC rates or low VL suppression rates. Additionally, health outcomes for people with HIV who are 50 years of age and older, and women with HIV, are areas of focus in this Plan.

Section V: Goals and Objectives

V.1. Goals and Objectives Description

Development of goals, objectives, activities, and measurements was a major focus of Plan development. This section includes goals, objectives, activities, measurements, key partners to accomplish each objective, the responsible party for providing data, data sources, and challenges, if any. This structure is in alignment with the Behavioral Science Research Corporation Integrated Plan Monitoring and Reporting System database (IPMRS). As detailed in **Section VI: 2027-20321 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up**, populating the IPMRS with baselines and targets will be the focus of the Partnership's Joint Integrated Plan Review Team (JIPRT) throughout the remainder of 2026 in order to begin implementation in 2027. Continuing to identify key partners will be ongoing throughout the life of the Plan.

We have also included social determinants of health and other concerns below. However, in accord with SMART goal-setting, those are not included in the IPMRS for data tracking since they have no identified data source. Therefore, we have not assigned measurable activities to those concerns. If a data source is identified throughout the life of the Plan, those concerns may be moved to the database for semi-annual data tracking. Regardless, we have included them here and in **Section IV: Situational Analysis** to ensure we do not lose sight of those needs, particularly since they were expressed as concerns in multiple community meetings and through survey findings.

Please see **Acronyms**, above, for guidance.

Goal 1: Prevent New HIV Transmission

□ **Objective 1.1: Increase knowledge of HIV status to 95% by ensuring all people with HIV receive a diagnosis as early as possible.**

- **Activity 1.1.1:** Implement HIV testing in health care settings, including routine opt-out HIV screenings. Promote and conduct routine opt-out HIV screening in health care settings (outpatient clinics, emergency departments, urgent care, inpatient hospitalization, county hospitals, correctional facilities, FDOH, and FQHC).

  - **Measurements:**

    1.1.1.1 Number of healthcare facilities educated on routine opt-out HIV testing in MDC.
    1.1.1.2 Number of healthcare facilities conducting routine opt-out HIV testing in MDC.
    1.1.1.3 Number of routine opt-out HIV tests in health care settings.
    1.1.1.4 Number of HIV positive people identified through routine opt-out testing in health care settings.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC and organizations with an MOUs, private practices, FOCUS, FQHC, Quick Connect, and HCN.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** CTLS, FOCUS Reports, and UDS (FQHCs).

- **Activity 1.1.2:** Implement HIV testing, including HIV self-testing, in non-health care community settings.

  - **Measurements:**

    1.1.2.1 Number of non-healthcare community settings conducting HIV testing.
    1.1.2.2 Number of people tested for HIV at non-healthcare community settings.
    1.1.2.3 Number of HIV positive people identified at non-healthcare community settings via preliminary testing.
    1.1.2.4 Number of newly diagnosed HIV positive identified at non-healthcare community settings.
    1.1.2.5 Number of HIV self-test kits distributed; or Number of people who received a self-test kit.
    1.1.2.6 Number of preliminary HIV positive people identified through self-test kits.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, mobile units, and contracted FDOH-MDC prevention providers.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** CTLS, FOCUS Reports, and UDS (FQHCs).

- **Activity 1.1.3:** Support integrated screening of HIV in conjunction with STIs, TB, viral hepatitis (HCV), and mpox for a syndemic and person-centered approach.

  - **Measurements:**

    1.1.3.1 Number of healthcare facilities conducting screening for HIV, STIs and HCV.
    1.1.3.2 Number of HIV tests conducted in conjunction with an HCV test within healthcare facilities.
    1.1.3.3 Number of people with a positive HCV identified through integrated screening at healthcare facilities.
    1.1.3.4 Number of HCV tests conducted at non-healthcare settings in conjunction with rapid or confirmatory HIV testing.
    1.1.3.5 Number of people with a positive HCV identified through integrated screening at non-healthcare facilities.
    1.1.3.6 Number of HIV tests conducted in conjunction with a Syphilis test within healthcare facilities.
    1.1.3.7 Number of people with a positive Syphilis identified through integrated screening at healthcare facilities.
    1.1.3.8 Number of Syphilis tests conducted at non-healthcare settings in conjunctions with HIV testing.
    1.1.3.9 Number of people with a positive Syphilis identified through integrated screening at non-healthcare facilities.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, FQHCs, private providers, hospitals and urgent care centers, ObGYNs, and FOCUS /FQHC.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** FOCUS, CTLS, UDS, FLPortal, and HIP Reports.

□ **Objective 1.2: Prevent HIV transmission by increasing PrEP coverage to 50% of estimated people with indications for PrEP, increasing PEP services, and supporting HIV prevention, including condom distribution, prevention of perinatal transmission, harm reduction, and syringe services program (SSP) efforts.**

- **Activity 1.2.1:** Support and promote awareness and access to PrEP and PEP services.

  - **Measurements:**

    1.2.1.1 Number of PrEP educational sessions conducted for the community.
    1.2.1.2 Number of educational sessions conducted specifically to health care providers.
    1.2.1.3 Number of providers offering PrEP services.
    1.2.1.4 Number of clients with ongoing risk of HIV acquisition referred to PEP and PrEP services.
    1.2.1.5 Estimated percentage (or number) of people who are prescribed PrEP (PREP coverage).
    1.2.1.6 Estimated percentage (or number) of PrEP prescriptions written.
    1.2.1.7 PrEP to Need ratio in MDC.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC, CBOs, ASOs, FQHCs, and private sector.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** FDOH-MDC MOUs, Gilead, ViiV, CTLS, HIP reports, STARS, PrEP Referral Platform, University of California of San Diego, AIDSVu, and AHEAD Dashboard.

- **Activity 1.2.2:** Conduct condom distribution.

  - **Measurements:**

    1.2.2.1 Number of condoms distributed by Zip Code (report using Zip Code map).
    1.2.2.2 Number of Business Responds to AIDS (BRTA) sites.

  - **Key Partners to Accomplish the Objective:** CBOs, ASOs, FQHCs, private businesses, and BRTA sites.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Source:** HIP reports.

- **Activity 1.2.3:** Support harm reduction services, including the IDEA Exchange syringe services programs (SSPs), and whole-person approach to HIV prevention services. Note: There are no Federal funds supporting this activity.

  - **Measurements:** Under development.

  - **Key Partners to Accomplish the Objective:** FDOH-MDC and Idea Exchange.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Source:** IDEA Exchange.

  - **Challenges:** Determining what data should be gathered to demonstrate meaningful progress toward the objective; maintaining the anonymity of IDEA Exchange clients.

- **Activity 1.2.4:** Conduct perinatal, maternal, and infant health prevention and surveillance activities and support maintaining the national goals of perinatal HIV incidence of < 1 per 100,000 live births and a perinatal transmission rate of < 1 %.

  - **Measurements:**

    1.2.4.1 Number of educational sessions conducted virtually and in person with providers and hospitals promoting routine HIV testing of all pregnant persons and diagnostic HIV testing for HIV-exposed infants.
    1.2.4.2 Number of educational sessions conducted virtually and in person with providers and hospitals to promote awareness and responsibility of utilizing the High-Risk Pregnancy Notification and Newborn Exposure Notification forms.
    1.2.4.3 Percent of birthing people with HIV who were linked to HIV care and prenatal care within 30 days of receiving the High-Risk Pregnancy Notification and Newborn Exposure Notification form.
    1.2.4.4 Percent of birthing people with HIV who received post-partum care which may include Family Planning Services.
    1.2.4.5 Percent of breastfeeding people with HIV who receive documented nursing-led lactation counseling within 24 hours of delivery.
    1.2.4.6 Percent of pregnant birthing people living with HIV who initiated breastfeeding and had continued at 6 months postpartum.
    1.2.4.7 Number of infants born to mothers who are HIV positive.
    1.2.4.8 Number of infants exposed to HIV from their HIV positive mother.
    1.2.4.9 Number of infants who contracted HIV from their HIV positive mother.

  - **Key Partners to Accomplish the Objective:** UM-HIV Perinatal Services.

  - **Responsible Party for Providing Data:** FDOH-MDC.

  - **Data Sources:** DIS documentation and PeriApp Database.

Goal 2: Improve HIV-Related Health Outcomes for People with HIV

- **Objective 2.1: Increase the percentage of newly diagnosed and previously diagnosed people with HIV (i.e., new to local Ryan White HIV/AIDS Program (RWHAP) or lost to care) who are linked to comprehensive HIV care and treatment within 30 days of initiating or re-engaging in care from [baseline]% to 95%.**

  - **Activity 2.1.1:** Identify, standardize, and implement best practices to facilitate rapid access to antiretroviral therapy (ART) medication, including updating local protocols and training staff on related workflows to improve timely linkage to care.

    - **Measurement:**

      2.1.1.1 Training on current local TTRA protocol and process flowchart provided to front-line staff (medical case managers, peers, outreach workers).

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

  - **Activity 2.1.2:** Implement and monitor local rapid access to antiretroviral therapy (ART) protocols (e.g., TTRA) to ensure newly diagnosed people with HIV initiate treatment within seven (7) days of diagnosis.

    - **Measurements:**

      2.1.2.1 Number of newly diagnosed people with HIV enrolled in local RWP through TTRA process only.
      2.1.2.2 Percentage of newly diagnosed people with HIV who complete a medical visit and receive an ART prescription on the same day as diagnosis through the TTRA process.
      2.1.2.3 Percentage of newly diagnosed people with HIV who complete a medical visit and receive an ARV prescription within 7 days of diagnosis through the TTRA process.
      2.1.2.4 Percentage of newly diagnosed people with HIV who received medical services through the TTRA process and are retained in HIV (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
      2.1.2.5 Percent of newly enrolled RWP clients enrolled in ADAP or other ARV payer source within 30 days of receipt of first ARV medication.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

- **Activity 2.1.3:** Implement and monitor local rapid access to ARV protocols (e.g., TTRA) to ensure previously diagnosed people with HIV (i.e., new to local RWHAP and those who were lost to care) restart antiretroviral therapy (ARV) within seven (7) days of contact with a TTRA team.

  - **Measurements:**

    2.1.3.1 Number of previously diagnosed people with HIV enrolled in local RWP through TTRA process only.
    2.1.3.2 Percentage of previously diagnosed people with HIV who complete a medical visit and receive an ART prescription on the same day as re-linkage to care through the TTRA process.
    2.1.3.3 Percentage of previously diagnosed people with HIV who have a medical visit and ARV prescription within 7 days of re-linkage to care through TTRA process.
    2.1.3.4 Percentage of previously diagnosed people with HIV enrolled through the TTRA process who are retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.1.3.5 Percentage of previously diagnosed people with HIV enrolled through the TTRA process who are virally suppressed (≤ 200 copies/mL).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.1.4:** Provide up to three encounters (days) of Medical Case Management (MCM) services, including treatment adherence counseling, to RWP clients served through the TTRA process to support linkage to ongoing HIV care (medical care and medications) within 30 days of ARV initiation or restart.

  - **Measurements:**

    2.1.4.1 Number of RWHAP clients who received MCM services within 30 days of initiating or re-engaging in care through the TTRA process.
    2.1.4.2 Percentage of RWHAP TTRA clients who received MCM assistance to enroll in ADAP or another ARV payer source within 14 days of ARV initiation or restart.
    2.1.4.3 Percentage of RWHAP TTRA clients who received MCM assistance to enroll in ADAP or another ARV payer source within 30 days of ARV initiation or restart.
    2.1.4.4 Percentage of RWHAP clients enrolled through the TTRA process who are retained in MCM at 60 days post enrollment.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.1.5:** Provide a Mental Health Services (MHS) counseling encounter within 30 days of ARV initiation or re-engagement in care for RWHAP clients served through the TTRA process. The encounter includes a behavioral health screening, assessment, and referral (if needed), to address mental health barriers that may affect retention in care.

  - **Measurements:**

    2.1.5.1 Number of RWHAP clients initiating or re-engaging in care through the TTRA process.
    2.1.5.2 Percentage of RWHAP clients who received a MHS encounter within 30 days of initiating or re-engaging in care through the TTRA process.
    2.1.5.3 Percentage of RWHAP clients who received a MHS encounter within 60 days of initiating or re-engaging in care through the TTRA process.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, BSR, HIV testing providers.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

□ **Objective 2.2: Increase the percentage of RWHAP clients receiving MCM, Outpatient/Ambulatory Health Services (OAHS), or Peer Education and Support Network (PESN) who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 2.2.1:** Implement standardized MCM to eligible clients, including development of a care plan, routine treatment adherence counseling, and monitoring of client needs and health outcomes.

  - **Measurements:**

    2.2.1.1 Number of RWHAP clients receiving MCM.
    2.2.1.2 Percentage of MCM clients with a documented adherence counseling encounter at each encounter.
    2.2.1.3 Percentage of MCM clients with documented viral load suppression.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.2:** Ensure medical case management (MCM) staff utilize available data, PE Miami 60-day no-contact alert system, and care coordination partners to identify and assist clients who are out of care or who are at risk of being out of care with staying connected to HIV care.

  - **Measurements:**

    2.2.2.1 Number of RWHAP MCM clients.
    2.2.2.2 Percentage of MCM clients with a 60-day no-contact flag.
    2.2.2.3 Percentage of MCM clients with no contact for 90 days.
    2.2.2.4 Percentage of MCM clients with no contact for 90 days who are re-engaged in care within 60 days.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.3:** Clinical staff and care coordinators implement proactive retention strategies for clients, including appointment reminders, outreach after missed visits, transportation support, and comprehensive care planning coordination.

  - **Measurements:**

    2.2.3.1 Number of RWHAP clients receiving MCM.
    2.2.3.2 Percentage of MCM clients retained in care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.3.3 Number of RWHAP clients receiving OAHS.
    2.2.3.4 Percentage of OAHS clients retained in care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.4:** Provide peer support services through peer support staff and certified peer specialists to improve retention in medical care and viral load suppression among RWHAP clients.

  - **Measurements:**

    2.2.4.1 Number of RWHAP clients receiving peer support services.
    2.2.4.2 Percentage of RWHAP clients served by peer support staff retained in medical care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.4.3 Percentage of RWHAP clients served by peer support staff who are virally suppressed (<200 copies/mL).
    2.2.4.4 Number of RWHAP subrecipient staff certified as peer specialists.
    2.2.4.5 Number of RWHAP clients receiving certified peer support services.
    2.2.4.6 Percentage of RWHAP clients served by certified peer specialists retained in medical care (≥2 medical visits, VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.2.4.7 Percentage of RWHAP clients served by certified peer specialists who are virally suppressed (<200 copies/mL).

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 2.2.5:** The RWHAP Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among MCM and OAHS clients.

  - **Measurements:**

    2.2.5.1 QI projects developed addressing improving VL suppression among RWP MCM clients.
    2.2.5.2 QI projects developed addressing improving VL suppression among RWP OAHS clients.
    2.2.5.3 QI projects developed addressing improving retention in medical care among RWP MCM clients.
    2.2.5.4 QI projects developed addressing improving retention in medical care among RWP OAHS clients.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

- **Objective 2.3: Increase the percentage of people with HIV receiving Ending the HIV Epidemic (EHE) Initiative services who are linked to care within 30 days from [baseline]% to ≥90%, and achieve viral suppression from [baseline]% to ≥90%, through expanded use of Quick Connect Services (HIV education and rapid access to ARV), HealthTec Services (telehealth), Housing Stability Services (housing assistance), Mobile GO Teams Services (mobile health clinics).**

  - **Activity 2.3.1: Quick Connect Services:** Update and distribute clear, understandable HIV educational materials to non RWHAP funded clinics and testing sites to support access to HIV resources and services for newly diagnosed and re- engaging clients.

    - **Measurements:**

      2.3.1.1 Number of non-RWHAP-funded clinicians/clinics visited to provide academic detailing in HIV education and resources.
      2.3.1.2 Number of HIV education materials (packets) distributed to non-RWHAP-funded clinicians/clinics.

    - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

    - **Responsible Party for Providing Data:** EHE Recipient.

    - **Data Source:** PE-Miami.

  - **Activity 2.3.2: Quick Connect Services:** Expand EHE Quick Connect services across hospitals, clinics, and community settings to ensure rapid access to ARV and linkage to ongoing care.

    - **Measurements:**

      2.3.2.1 Number of people with HIV contacted by or initiating contact with an EHE Quick Connect team.
      2.3.2.2 Number of EHE Quick Connect clients linked to HIV medical care.
      2.3.2.3 Number of EHE Quick Connect clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
      2.3.2.4 Number of EHE Quick Connect clients with viral load suppression at most recent VL test.

    - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

    - **Responsible Party for Providing Data:** EHE Recipient.

    - **Data Source:** PE-Miami.

- **Activity 2.3.3: HealthTec Services:** Provide access to telecommunication devices (smart phones or tablets) and internet services, along with basic instructions and connectivity support, to help people with HIV overcome barriers to care and engage in HIV services through telehealth.

  - **Measurements:**

    2.3.3.1 Number of clients enrolled in EHE HealthTec Services.
    2.3.3.2 Number of EHE HealthTec Services clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.3.3 Number of EHE HealthTec Services clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

- **Activity 2.3.4: Housing Stability Services:** Provide housing stability services, including short-term, transitional, emergency, and supportive housing assistance, along with housing navigation and supportive case management services, to help people with HIV remain in HIV care and overcome housing-related barriers.

  - **Measurements:**

    2.3.4.1 Number of clients enrolled in EHE Housing Stability Services.
    2.3.4.2 Number of EHE Housing Stability Services clients retained in care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.4.3 Number of EHE Housing Stability Services clients retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period) at 6 months following enrollment.
    2.3.4.4 Number of EHE Housing Stability Services clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

- **Activity 2.3.5: Mobile Go Teams Services:** Deploy Mobile GO Teams Services using a mobile clinic to deliver healthcare services and provide access to ARV in high priority and underserved areas, reducing barriers to HIV care engagement and supporting improved health outcomes for people with HIV.

  - **Measurements:**

    2.3.5.1 Number of clients enrolled in EHE Mobile GO Teams Services.
    2.3.5.2 Number of EHE Mobile GO Teams clients retained in HIV care (≥2 medical visits, CD4 or VL lab results, or insurance copays at least 90 days apart within the measurement period).
    2.3.5.3 Number of EHE Mobile GO Teams clients with viral load suppression at most recent VL test.

  - **Key Partners to Accomplish the Objective:** EHE Recipient and subrecipients, and BSR.

  - **Responsible Party for Providing Data:** EHE Recipient.

  - **Data Source:** PE-Miami.

Goal 3: Address HIV-Related Health Outcomes for Groups Experiencing Higher HIV Impact

- □ **Objective 3.1: Increase the percentage of women in RWHAP care receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

  - **Activity 3.1.1:** Monitor viral load and retention in medical care rates among women in MCM and OAHS care to identify outcomes that fall behind established targets.

    - **Measurements:**

      3.1.1.1 Number of women in MCM care.
      3.1.1.2 VL Suppression among women in MCM care.
      3.1.1.3 Retention in Medical Care among women in MCM care.
      3.1.1.4 Number of women in OAHS care.
      3.1.1.5 VL Suppression among women in OAHS care.
      3.1.1.6 Retention in Medical Care among women in OAHS care.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

  - **Activity 3.1.2:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among women.

    - **Measurements:**

      3.1.2.1 QI projects developed addressing improving VL suppression among women.
      3.1.2.2 QI projects developed addressing improving RiMC among women.

    - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

    - **Responsible Party for Providing Data:** BSR.

    - **Data Source:** PE-Miami.

□ **Objective 3.2: Increase the percentage of adults aged 50+ in RWHAP care receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 3.2.1:** Monitor viral load and retention in medical care rates among adults aged 50+ in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.2.1.1 Number of adults aged 50+ in MCM care.
    3.2.1.2 VL Suppression among adults aged 50+ in MCM care.
    3.2.1.3 Retention in Medical Care among adults aged 50+ in MCM care.
    3.2.1.4 Number of adults aged 50+ in OAHS care.
    3.2.1.5 VL Suppression among adults aged 50+ in OAHS care.
    3.2.1.6 Retention in Medical Care among adults aged 50+ in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.2.2:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among adults aged 50+.

  - **Measurements:**

    3.2.2.1 QI projects developed addressing improving VL suppression among adults aged 50+.
    3.2.2.2 QI projects developed addressing improving retention in medical care among adults aged 50+.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.2.3:** Ensure eligible clients aged 65+ are enrolled in Medicare.

  - **Measurements:**

    3.2.3.1 Number of RWP MCM clients over age 65.
    3.2.3.2 Percent of RWP MCM clients over age 65 with a Medicare marker in PE Miami.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

□ **Objective 3.3: Increase the percentage of RWHAP clients experiencing higher HIV impact (Black/African American males, Black/African American females, and Haitian males and females), receiving MCM and OAHS who achieve viral load (VL) suppression (<200 copies/mL) from [baseline]% to ≥95%, and improve retention in medical care from [baseline]% to ≥90%.**

- **Activity 3.3.1:** Monitor viral load and retention in medical care rates among Black/African American males in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.1.1 Number of Black/African American males in MCM care.
    3.3.1.2 VL Suppression among Black/African American males in MCM care.
    3.3.1.3 Retention in Medical Care among Black/African American males in MCM care.
    3.3.1.4 Number of Black/African American males in OAHS care.
    3.3.1.5 VL Suppression among Black/African American males in OAHS care.
    3.3.1.6 Retention in Medical Care among Black/African American males in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.3.2:** Monitor viral load and retention in medical care rates among Black/African American females in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.2.1 Number of Black/African American females in MCM care.
    3.3.2.2 VL Suppression among Black/African American females in MCM care.
    3.3.2.3 Retention in Medical Care among Black/African American females in MCM care.
    3.3.2.4 Number of Black/African American females in OAHS care.
    3.3.2.5 VL Suppression among Black/African American females in OAHS care.
    3.3.2.6 Retention in Medical Care among Black/African American females in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.3.3:** Monitor viral load and retention in medical care rates among Haitian males and females in MCM and OAHS care to identify outcomes that fall behind established targets.

  - **Measurements:**

    3.3.3.1 Number of Haitian males and females in MCM care .
    3.3.3.2 VL Suppression among Haitian males and females in MCM care.
    3.3.3.3 Retention in Medical Care among Haitian males and females in MCM care.
    3.3.3.4 Number of Haitian males and females in OAHS care.
    3.3.3.5 VL Suppression among Haitian males and females in OAHS care.
    3.3.3.6 Retention in Medical Care among Haitian males and females in OAHS care.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

- **Activity 3.3.4:** The Ryan White Program Clinical Quality Management Steering Committee (CQMSC) will establish quality improvement (QI) initiatives to address gaps and differences in outcomes in VL suppression and retention in care among clients experiencing higher HIV impact.

  - **Measurements:**

    3.3.4.1 QI projects developed addressing improving VL suppression among Black/African American males.
    3.3.4.2 QI projects developed addressing improving retention in medical care among Black/African American males.
    3.3.4.3 QI projects developed addressing improving VL suppression among Black/African American females.
    3.3.4.4 QI projects developed addressing improving retention in medical care among Black/African American females.
    3.3.4.5 QI projects developed addressing improving VL suppression among Haitian males and females.
    3.3.4.6 QI projects developed addressing improving retention in medical care among Haitian males and females.

  - **Key Partners to Accomplish the Objective:** RWHAP Recipient and subrecipients, CQMSC, and BSR.

  - **Responsible Party for Providing Data:** BSR.

  - **Data Source:** PE-Miami.

Goal 4: Achieve Integrated, Coordinated Efforts the Address the HIV Epidemic Among All Partners and Collaborators

- **Objective 4.1: Respond quickly to HIV transmission networks and outbreaks to address gaps and inequities in services for communities who need them.**

  - **Activity 4.1.1:** Develop and maintain a cross-program Transmission Network Detection Response (TNDR) leadership and coordination group to oversee TNDR activities.

  - **Activity 4.1.2:** TNDR Group: Communicate and collaborate about TNDR.

  - **Activity 4.1.3:** TNDR Group: Detect and prioritize transmission networks.

    - **Key Partners to Accomplish the Objective:** FDOH-MDC and TNDR group.

    - **Responsible Party for Providing Data:** FDOH-MDC.

    - **Data Source:** FDOH surveillance data.

Future Objectives and Activities

These concerns and activities will be included in data tracking pending identifiable data sources.

□ **Increase access to services addressing key social determinants of health, including housing, food, transportation, and health insurance/benefits, among newly enrolled and re-engaged RWHAP clients, and improve retention in medical care from [baseline]% to ≥95.**

- Assess and address health insurance and benefits needs by providing navigation and enrollment support to newly enrolled and re-engaged RWHAP clients.
- Address treatment adherence barriers by providing transportation assistance to newly enrolled and re-engaged RWHAP clients to support access to HIV medical care and services.
- Assess and address food insecurity by connecting newly enrolled and re-engaged RWHAP clients to food and nutrition services (e.g., food banks, meal programs, nutrition support).
- Assess housing status and coordinate access to housing services (e.g., HOPWA, emergency housing, transitional housing) and related services (e.g., employment and life skills training) for newly enrolled and re-engaged RWHAP clients to support treatment adherence and housing stability.
- Develop guidelines and procedures for RWP MCMs to identify and address the impact of social determinants of health (e.g., childcare, housing, food insecurity, domestic violence, discrimination and other issues) on client clinical outcomes.
- Coordinate access to services addressing social determinants of health (e.g., housing, food, transportation, health insurance/benefits, and social support) for newly enrolled and re-engaged RWHAP clients to improve retention in care and viral load suppression.
- Address stigma and social support needs by connecting newly enrolled and re-engaged RWHAP clients to peer support, support groups, and related services.

V.1.a. Updates to Other Strategic Plans Used to Meet Requirements

This Plan incorporates updated goals and objectives from the 2022-2026 Integrated Plan, the RWHAP EHE Plan, and the FDOH-MDC EHE plan, as detailed in **Section II: Community Engagement and Planning Process**, above.

Section VI: 2027-2031 Integrated Plan Implementation, Monitoring, and Jurisdictional Follow Up

Implementation, monitoring, evaluation, and improvement will begin January 1, 2027, and continue through December 31, 2031, as outlined below. All processes will involve members of the affected community including Ryan White Program (RWHAP) clients and others, Partnership's Joint Integrated Plan Review Team (JIPRT) members, as well as RWHAP, Florida Department of Health in Miami-Dade County (FDOH-MDC), and EHE teams. Additional collaborators will participate in Partnership and Committee meetings and, as positions are available, will be invited to join as voting members.

The JIPRT has made significant effort to ensure the development of SMART goals and activities as detailed in the local Integrated Plan Monitoring and Reporting System (IPMRS), as designed by Behavioral Science Research Corporation, the contracted subrecipient for Planning Council Staff Support services. This effort includes specifying key individuals who will be accountable for implementing Plan activities and strategies, identifying data sources, as well as ensuring and establishing timelines for activity reporting and completion. Plan progress will be monitored quarterly to identify areas of the Plan that reflect optimal performance and that have challenges and lack progress. Status updates will be shared with the listed participants during the quarterly JIPRT meetings, where progress and issues will be reviewed, recommendations for improvement will be determined, and next steps will be identified.

VI.a. Implementation

Community stakeholders, specifically RWHAP-, FDOH-MDC-, and EHE-funded recipients and subrecipients have been instrumental in development of the Plan and are expected to take the lead on their assigned activities as detailed in the IPMRS. People with HIV are in leadership and supporting roles in the Partnership and its Committees and will continue to be active in the implementation of the Plan. No delays are expected in launching the 2027-2031 Plan on January 1, 2027. A smooth transition from the 2022–2026 Plan is anticipated.

However, recent funding cuts and new legislative restrictions have made it increasingly difficult to bring new partners into the integrated planning process. Even so, as key collaborators and subject matter experts are identified, they are encouraged to attend the appropriate meetings. All meetings are publicly noticed, and all related materials are available on the Partnership's website, www.PartnershipMiami.org.

VI.b. Monitoring

This Monitoring section outlines the structured processes we will use to assess program performance, ensure compliance with RWHAP requirements, and track progress toward improving health outcomes for people with HIV. Through routine data review, site visits, subrecipient monitoring, and continuous quality improvement activities, we aim to identify strengths, address gaps early, and support a responsive, equitable, and client-centered system of care.

The JIPRT is the primary forum for monitoring and reporting progress of the Plan, determining response strategies, and engaging collaborators. JIPRT meetings are held in person and publicly noticed through multiple channels. Members of the affected community participate as JIPRT members and as meeting guests.

The IPMRS is designed to support accountability by ensuring activities are SMART and organized under overarching Plan goals.

This structure brings forward continuously relevant themes from:

- The National HIV/AIDS Strategy
  - Preventing HIV transmission,
  - Strengthening health outcomes,
  - Addressing differences in health outcomes, and
  - Promoting coordinated and collaborative efforts to effectively respond to the epidemic;
- The EHE Pillars:
  - Diagnose,
  - Treat,
  - Prevent, and
  - Respond;
- The Statewide Coordinated Statement of Need;
- The HIV Care Continuum stages:
  - Diagnose,
  - Linkage to care,
  - Retention in care, and
  - Viral suppression; and
- Ryan White Program 2030 goals:
  - Rapid initiation of HIV treatment,
  - Community-based outreach,
  - Treatment as prevention,
  - Leveraging partnerships, and
  - Using data-driven approaches to identify populations with unmet needs.

The IPMRS database is the primary monitoring tool to track progress towards these goals based on related objectives, activities, and measurements. FDOH-MDC and RWHAP staff will work with subrecipient organizations and other stakeholders who have been assigned reporting tasks to confirm program progress. Data sources may include Provide Enterprise® Miami (PE Miami), FDOH-MDC local data, FDOH statewide data as available, and the HIV.org Americas HIV Epidemic Analysis Dashboard (AHEAD). A designated group of users will regularly enter information into the IPMRS as data become available. The IPMRS is maintained in a shared Microsoft OneDrive environment so users can collaborate in a single database concurrently. Client confidentiality is protected as no Protected Health Information (PHI) or other client identifying information is included in the IPMRS.

A sample of the IPMRS is presented directly below. The image includes various public-facing fields and administrative fields, as described below.

Sample IPMRS Database with Two Data Indicators

Goal

Objective 1.1	Sample											
Activity 1.1.1	Sample								See corresponding tabs for details			
Measurement #	Measurement	Baseline	Status	Summary Data	Target	Notes	Jan 1, 2027-Jun 30, 2027	Jul 1, 2027-Dec 31, 2027	Key Contact Person	Key Partners	Monitoring Data Source	Funding Sources
1.1.1.1	Sample	December 2026: 100	Activity Not Started	Cumulative Total: 37	December 2030: 500		12	25				
1.1.1.2	Sample		Activity In Progress	Average: 22.5			25	20				
1.1.1.3	Sample		Activity Suspended	Most Recent Measurement: 20			25	20				
1.1.1.4	Sample		Activity Complete	No Data								

Public-Facing Fields

- **Goal** – Four Goals built upon the National HIV/AIDS Strategy, then further evolved to align with the four pillars of EHE and the Ryan White Program 2030 goals.
- **Objective** – Each Objective corresponds to the Goal and has a unique number related to the Goal.
- **Activity** – Each Activity corresponds to the Objective and has a unique number related to the Objective.
- **Measurement #** – Each Measurement corresponds the Activity and has a unique number related to the Activity.
- **Measurement** – Indicates a quantifiable amount for which there is a known data source.
- **Baseline** – Indicates the most recent data available before January 1, 2027, with referenced date and value (i.e., December 2026: 100).
- **Status** – Programmed to provide quick visual clues as to the progress of Activities for reference during monitoring. Progress colors are:
  - **Blue: Activity Not Started** (Activity and/or data collection has not begun);
  - **Yellow: Activity in Progress** (Activity and data collection has begun and is ongoing);
  - **Red: Activity Suspended** (Activity began and was suspended; reason for the suspension would be in the Administrative Field "Notes" section, see below); or
  - **Green: Activity Complete** (Activity complete and no further action needed).
- **Summary Data** – This field is calculated to capture data as either:
  - Cumulative Total;
  - Average;
  - Most Recent Measurement; or
  - No Data.
- **Target** – Indicates the end date for completing the Activity and the Target Measurement (i.e., December 2030: 100).
- **Dashboard** of graphs, tables, and charts to demonstrate progress in a user-friendly format.

Administrative Fields

- **Notes** – User notes to track any peculiarities (e.g., reason for suspension, clarifications, etc.) of the related Activity.
- **Measurement Periods** – There are ten 6-month measurement periods – January through June, and July through December – for each of the Plan years.

- **Key Contact Person** – The go-to person for data; this field corresponds to a tab to collect the Key Person's contact information, including title, in case of changes in staffing.
- **Key Partners** – Community organizations related to the Activity (e.g., RHWAP subrecipients); this field corresponds to a tab to collect organization names and contacts, including URLs.
- **Monitoring Data Source** – The database from which data are drawn to quantify the Activity; this field corresponds to a tab to collect the database name, related key contacts, and URLs.
- **Funding Source** – Funding stream(s) related to the Activity; this field corresponds to a tab which indicates the source of funds, years of funding, and related URLs.
- **All administrative sections** will be continually updated as we identify new collaborators and funding sources.

VI.c. Evaluation

A robust evaluation process is essential to ensuring that the Integrated Plan remains effective, accountable, and responsive to emerging needs. To support this, the IPMRS is designed to collect performance data in six-month measurement periods, providing a structured foundation for ongoing assessment. The JIPRT convenes quarterly to review progress, identify areas where measurements are not on track, and recommend corrective actions. Over the life of the Plan, the JIPRT is expected to meet approximately 20 times, ensuring consistent opportunities for evaluation, refinement, and accountability. While the Plan will continue to evolve as needed, every effort has been made to develop SMART goals, objectives, and activities that support meaningful measurement and analysis of progress.

Beginning in July 2026, JIPRT meetings will focus on establishing performance Targets; completing the Key Contact Person, Key Partners, Monitoring Data Source, and Funding Source fields; and determining Baselines. As additional Key Partners are identified, we anticipate expanded collaboration across the EMA to strengthen implementation and monitoring efforts.

VI.d. Improvement

A strong improvement process is vital to ensuring that evaluation results translate into meaningful action. Throughout implementation of the Integrated Plan, the JIPRT will serve as the primary forum for reviewing data and results, recommending modifications, and elevating improvement strategies to the Partnership and stakeholders. The JIPRT will be responsible for identifying weaknesses in implementation, measurement, and operational processes; flagging activities that fall behind established targets; and requesting technical assistance when needed. In alignment with the JIPRT schedule, meetings will alternate between data review and follow-up on the Challenges and Identified Needs outlined in **Section IV: Situational Analysis** of this Plan, see above.

Although many of the Challenges and Identified Needs in **Section IV: Situational Analysis** cannot be linked to measurable outcomes and therefore are not included in the IPMRS, they remain important to the overall health of the system. The Partnership will continue to identify resources, gather stakeholder feedback, and elevate these issues to ensure they remain visible and are addressed through community collaboration and problem-solving.

VI.e. Reporting and Dissemination

Transparent and consistent reporting is essential to maintaining accountability, strengthening stakeholder engagement, and ensuring shared ownership of the Plan's progress. To support this, updates on the implementation and execution of the Integrated Plan will be presented at quarterly JIPRT meetings, incorporated into the regular Partnership committee reporting process, and shared with other Partnership

committees and subrecipients as appropriate. FDOH-MDC workgroups, community collaborators, and other stakeholders will also receive updates and will be encouraged to contribute to ongoing planning, implementation, and evaluation efforts. Special presentations may be provided to community partners when appropriate or upon request.

The Partnership's website includes dedicated pages for both the JIPRT and the Integrated Plan, where all meeting materials – including progress reports – are posted for public access. Printed copies of reports are distributed to JIPRT members during regular meetings and are available to others upon request. Evaluation results will also be integrated into the Annual State of HIV Report, produced by the Partnership's Strategic Planning Committee in collaboration with FDOH-MDC and the RWHAP Recipient, and provided to the Miami-Dade County Mayor, Board of County Commissioners, and Partnership members.

VI.f Updates to Other Strategic Plans Used to Meet Requirements

The 2027-2031 Plan is largely drawn from the 2022-2026 Plan since the latter was well-received and comprehensive. This Plan varies most markedly from the earlier version in that the activities for 2027-2031 are much more complete, and this Plan accounts for significant legislative and funding changes, as detailed in previous sections.

This 2027-2031 Plan represents a strong collaboration between the RWHAP Planning Council and Recipient, and FDOH-MDC to ensure our mutual activities are captured and coordinated, and we look forward to future collaborations with the State FDOH.

[LETTERHEAD]

Addendum 1

June 1, 2026

Ms. Jenifer Gray
HRSA Project Officer
Division of Metropolitan HIV/AIDS Programs - HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Gray:

The Miami-Dade HIV/AIDS Partnership (Partnership), the local Ryan White Program Planning Council, concurs with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County, Florida (Integrated Plan)*. This submission is in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention and HRSA's HIV/AIDS Bureau for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need, for calendar years 2027 through 2031. This concurrence is specific to the local Integrated Plan only and does not provide concurrence with the statewide Integrated HIV Prevention and Care Plan.

The Partnership's Strategic Planning and Prevention Committees met jointly and as stand-alone committees in publicly noticed meetings on November 18, 2025, and January 22, February 17, March 10, March 26, April 14, April 30, and May 19 in 2026, to review Integrated Plan drafts and supporting data, and to recommend revisions. The final draft in its substantially complete form – subject to final minor administrative edits – was presented to the Partnership for ratification on June 1, 2026.

Following discussions and recommendations from these meetings and other feedback opportunities, draft Integrated Plan documents were produced. The Florida Department of Health in Miami-Dade County (FDOH-MDC) and Miami-Dade County Office of Management and Budget Ending the HIV Epidemic initiatives were also incorporated in the Integrated Plan goals and objectives. Drafts were posted for public access and comment throughout this process. Development of this updated Integrated Plan has been an intensive and collaborative effort between the Partnership; FDOH-MDC; OMB - the Ryan White Part A/MAI/EHE Program Recipient; and the local HIV community.

Partnership members, including representatives of the affected community, service providers, and FDOH-MDC representatives, along with OMB representatives have reviewed this *2027-2031 Integrated Plan* prior to its submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being directed to the populations and geographic areas with the highest HIV burden and differences in health outcomes.

Partnership members concur that this *2027-2031 Integrated Plan* submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV/AIDS Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance. The signatures below confirm concurrence with the submission of the *2027-2031 Integrated HIV Prevention and Care Plan for Miami-Dade County*.

Harold McIntyre Chair, Miami-Dade HIV/AIDs Partnership	**Daniel T. Wall** Assistant Director, OMB / Ryan White Program Director, MDC	**Kira Villamizar** Public Health Services Manager, FDOH-MDC

c: Matthew James, HRSA EHE Project Officer
Miami-Dade HIV/AIDS Partnership Members