MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of November 21, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• Vacancy Report	Marlen Meizoso
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XIII.	Next Meeting**: February 27, 2026** at **BSR**	Cristhian Ysea
XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Meeting Housekeeping Medical Care Subcommittee

Created by *Behavioral Science Research*

Updated January 2026

Disclaimer and Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- 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 in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

Changes Impacting Members in the New Year

- Elections of New Officers
- Updated “Why Was My Meeting Cancelled?” Fact Sheet
- No more paper calendars
- Coming Soon!
  - New Partnership Logo
  - Community Coalition Roundtable – Committee recruitment and mentoring activities
  - New Committee Application process
- Partnership Meetings
  - New Location - Florida Department of Health – Health District Center

Excerpt from Get on Board! Member Enrichment Training, January 7, 2026

Review of Member Responsibilities

All Members

1. RSVP
2. Review meeting materials in advance
3. Attend meetings
4. Complete the Annual Source of Income Form

Other

1. Complete the Assessment of the Administrative Mechanism survey (Partnership members)
2. Complete required training (new members)

Excerpt from Get on Board! Member Enrichment Training, January 7, 2026

Tips to Keep Track of Your Meeting Dates

Find Your Next Meeting Dates

1. “Next Meeting” on each Agenda
2. Meeting Notices
3. Committee pages on PartnershipMiami.org
4. PartnershipMiami.org > Calendars
5. Calendar Invitation (members)

Once you’ve found your dates, add them to your work calendars.

Excerpt from Get on Board! Member Enrichment Training, January 7, 2026

How to Access Meeting Documents

1. Link in Meeting Notice
2. QR Code on Agendas
3. Committee pages on PartnershipMiami.org
4. Link in calendar listing

Documents are posted in PDF format.

A free PDF reader is available at https://get.adobe.com/reader/

Excerpt from Get on Board! Member Enrichment Training, January 7, 2026

General Housekeeping

- You must sign in to be counted as present.
- Place cell phones on mute or vibrate - *If you must take a call, please excuse yourself from the meeting.*
- Eligible committee members should see staff for a travel expense offset at the end of the 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.

About the Partnership

- The Miami-Dade HIV/AIDS Partnership is the official Ryan White Program Planning Council for Miami-Dade County.
- Partnership Members are appointed by the Mayor of Miami-Dade County based on recommendations by the Community Coalition.
- The Medical Care Subcommittee reports to the Care and Treatment Committee. The Care and Treatment Committee is one of six Standing Committees of the Partnership.
- All Partnership and Standing Committee members are volunteers and commit to abiding by the Partnership's Bylaws, including regular meeting attendance and completion of required training and paperwork.
- See staff after the meeting for additional details.

Meeting Participation

Everyone has a role to play!

- All attendees may address the board as time allows and at the discretion of the Chair.
- Please *share your expertise* on the current Agenda topics and motions. Remember to . . .
  - Raise your hand to be recognized by the Chair or added to the queue during discussions.
  - Avoid repeating points previously addressed.
- Only Medical Care Subcommittee members vote at today's meeting.
- Announcements can be made at the end of the meeting as time allows. Announcements should inform or educate the community and must not be used to advance personal interests or any form of financial gain.

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.**

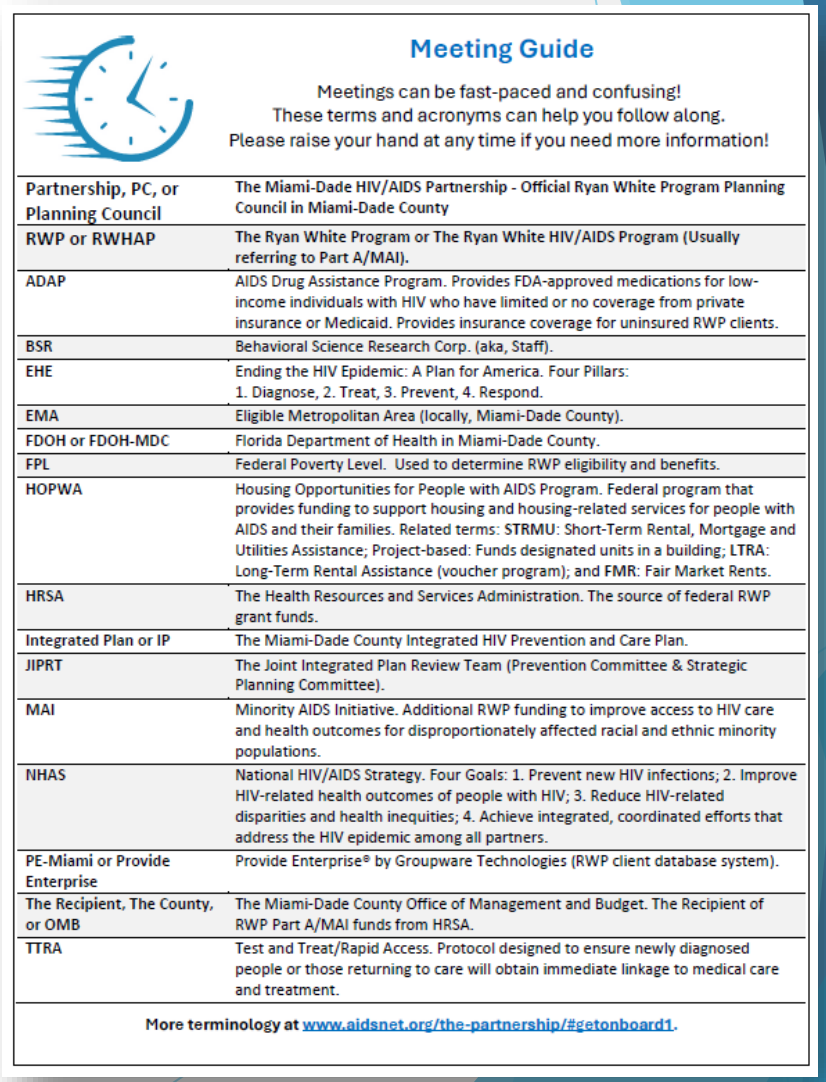
Please **do not** use these terms . . .

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

Meeting Terminology

Meetings can be fast-paced and confusing!

- ❑ Terms and acronyms you might hear at today's meeting are on the back of your Agenda.
- ❑ Please raise your hand at any time if you need more information!



Meeting Guide

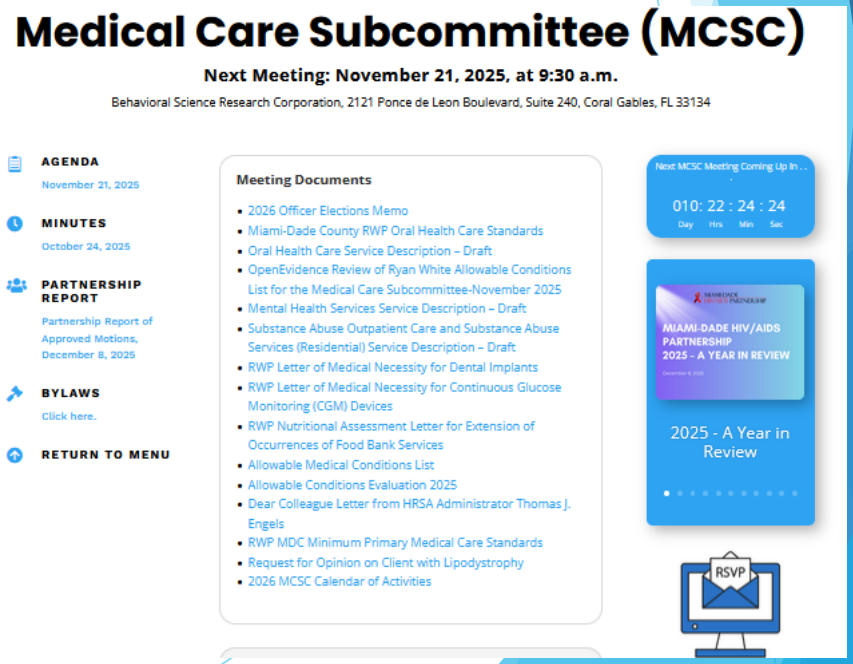
Meetings can be fast-paced and confusing!
These terms and acronyms can help you follow along.
Please raise your hand at any time if you need more information!

Partnership, PC, or Planning Council	**The Miami-Dade HIV/AIDS Partnership - Official Ryan White Program Planning Council in Miami-Dade County**
RWP or RWHAP	**The Ryan White Program or The Ryan White HIV/AIDS Program (Usually referring to Part A/MAI).**
ADAP	AIDS Drug Assistance Program. Provides FDA-approved medications for low-income individuals with HIV who have limited or no coverage from private insurance or Medicaid. Provides insurance coverage for uninsured RWP clients.
BSR	Behavioral Science Research Corp. (aka, Staff).
EHE	Ending the HIV Epidemic: A Plan for America. Four Pillars: 1. Diagnose, 2. Treat, 3. Prevent, 4. Respond.
EMA	Eligible Metropolitan Area (locally, Miami-Dade County).
FDOH or FDOH-MDC	Florida Department of Health in Miami-Dade County.
FPL	Federal Poverty Level. Used to determine RWP eligibility and benefits.
HOPWA	Housing Opportunities for People with AIDS Program. Federal program that provides funding to support housing and housing-related services for people with AIDS and their families. Related terms: **STRMU**: Short-Term Rental, Mortgage and Utilities Assistance; Project-based: Funds designated units in a building; **LTRA**: Long-Term Rental Assistance (voucher program); and **FMR**: Fair Market Rents.
HRSA	The Health Resources and Services Administration. The source of federal RWP grant funds.
Integrated Plan or IP	The Miami-Dade County Integrated HIV Prevention and Care Plan.
JIPRT	The Joint Integrated Plan Review Team (Prevention Committee & Strategic Planning Committee).
MAI	Minority AIDS Initiative. Additional RWP funding to improve access to HIV care and health outcomes for disproportionately affected racial and ethnic minority populations.
NHAS	National HIV/AIDS Strategy. Four Goals: 1. Prevent new HIV infections; 2. Improve HIV-related health outcomes of people with HIV; 3. Reduce HIV-related disparities and health inequities; 4. Achieve integrated, coordinated efforts that address the HIV epidemic among all partners.
PE-Miami or Provide Enterprise	Provide Enterprise® by Groupware Technologies (RWP client database system).
The Recipient, The County, or OMB	The Miami-Dade County Office of Management and Budget. The Recipient of RWP Part A/MAI funds from HRSA.
TTRA	Test and Treat/Rapid Access. Protocol designed to ensure newly diagnosed people or those returning to care will obtain immediate linkage to medical care and treatment.

More terminology at www.aidsnet.org/the-partnership/#getonboard1.

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 https://partnershipmiami.org/the-partnership-2/#mcsc1 or by scanning the QR code on your agenda.



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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.”

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Medical Care Subcommittee Meeting
Behavioral Science Research
2121 Ponce de Leon Boulevard, Suite 240
Coral Gables, FL 33134

November 21, 2025 Minutes

#	Members	Present	Absent
1	Baez, Ivet	X	
2	Dougherty, James	X	
3	Friedman, Lawrence	X	
4	Miller, Juliet	X	
5	Rojas, Vanessa		X
6	Romero, Javier	X	
7	Serrano-Irizarry, Yendi	X	
8	Ysea, Cristhian A.	X	
Quorum: 4			

Guests
Goffe, Ashlee
Gonzalez de Obando, Tivisay
March, Ashley
Nieto, Ana Maria
Valle-Schwenk, Carla
Staff
Ladner, Robert
Meizoso, Marlen

All documents referenced in these minutes were accessible to both members and the general public prior to and during the meeting, at https://partnershipmiami.org/the-partnership-2/#mcsc1.

I. Call to Order

James Dougherty

The Chair, James Dougherty, called the meeting to order at 9:34 a.m. He introduced himself, provided an overview of the work for the day's meeting, and welcomed everyone.

II. Introductions

All

Mr. Dougherty requested that members, guests, and staff introduce themselves.

III. Meeting Housekeeping

James Dougherty

Mr. Dougherty reviewed the meeting housekeeping presentation, including people first language, meeting protocols, location of Subcommittee meeting items online, and identification of resource persons.

IV. Floor Open to the Public

Cristhian Ysea

The Vice Chair, Cristhian Ysea, read the following:

"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 phone line and email for statements to be read into the record. No statements were received."

There were no comments, so the floor was closed.

V. Review/Approve Agenda *All*

The Subcommittee reviewed the agenda and approved it as presented.

Motion to accept the agenda as presented.
Moved: Dr. Lawrence Friedman Seconded: Dr. Javier Romero Motion: Passed

VI. Review/Approve Minutes of October 24, 2025 *All*

Members reviewed the minutes of October 24, 2025, and Dr. Romero noted the following corrections on page 2: to strike the sentence, "If tax credits… $15 million" and replace with "Total tax credits for ADAP Miami clients receiving premium assistance for ACA plans in 2025 are estimated at $15 million."

Motion to accept the minutes of October 24, 2025, with the corrections discussed.
Moved: Cristhian Ysea Seconded: Dr. Lawrence Friedman Motion: Passed

VII. Reports

- **Ryan White Program** *Carla Valle-Schwenk*

Carla Valle-Schwenk referenced the October utilization and expenditure reports, posted online, which indicated the Ryan White Program (RWP) is serving over 8,800 clients year to date. At this rate, the total number of clients served by the Ryan White Program Part A/MAI for FY 2025 will be greater than in FY 2024.

Affordable Care Act (ACA) insurance enrollments have started. The Florida Department of Health has shared the 14 ADAP- approved plans for Miami-Dade County. Enrollment in ACA insurance through the RWP is restricted to current ACA clients only: no new clients may be enrolled in ACA. Clients must file taxes and present documentation of income. Clients who file taxes as "married, filing separately" will not be eligible for ADAP subsidies. The cut off for enrolling for a January start date is December 12. Clients can still enroll using the American Exchange site.

- **AIDS Drug Assistance Program (ADAP)** *Dr. Javier Romero*

Dr. Javier Romero reviewed the October 2025 ADAP report as of November 2, 2025, including enrollments, expenditures, prescriptions, premium payments, and program updates. The 14 ACA plans approved for ADAP support for FY 2026 include only gold and silver plans. As cited in the RWP report above, only clients who are currently enrolled in ACA plans are eligible for re-enrollment. If clients lose ADAP eligibility, they will lose premium insurance assistance. Proper paperwork filing will be required. The head of household letter will not be accepted for the ADAP ACA program. The payor of last resort will be enforced, so if a spouse has insurance, the other spouse will need to use it.

- **Vacancy Report** *Marlen Meizoso*

Marlen Meizoso reviewed the November 2025 vacancies, which indicated vacancies on the Partnership and the Subcommittee. If anyone knows of any individuals interested in membership who are Miami-Dade

County registered voters, they may contact staff, and invite them to attend a meeting or training sessions.

VIII. Oral Health Care Items *All*

- Oral Health Care Standards and Oral Health Care 2026 Service Definition Revisions

Staff sent the Oral Health Care Standards and Oral Health Care Service Definition with edits for 2026 to the remaining members of the Oral Health Care Workgroup for comment, but no replies were received. The Subcommittee reviewed both documents and made suggestions as follows to the Oral Health Care Standards:

- In Standard 1, change "HIV/AIDS" to "Ryan White program"; change "HIV/AIDS trainings" to "trainings on HIV related topics".
- In Standard 1.1, change "HIV/AIDS" to "Ryan White".
- In Standard 1.4, strike "ongoing" and change "HIV/AIDS" to "on HIV topic related to dental care".
- In Standard 2.1, add "internal" after "Program" and at the end of the sentence "or out of network referral with documentation".
- In Standard 2.2, add "integrated" before "consent" and strike second bullet
- In Standard 3.2., add "including labs if needed".

Requested edits will be forwarded for additional input to the Oral Health Care Workgroup and provided at the next meeting. The Subcommittee would also like clarification, if necessary, on what labs need to be provided before oral health care treatment and how recent the labs need to be. Additionally, a client does not have to have a suppressed viral load in order to be provided with oral health care services, and this clarification should be included in the standards and service definition.

IX. Standing Business

- Allowable Conditions Response to "Dear Colleague" Letter *All*

The Subcommittee used the revised review tool for the allowable conditions and Open Evidence AI results for the first page and half of conditions. The Subcommittee went item by item checking off the replies for each section. Comments were added and will be incorporated into the next draft as the Subcommittee continues its review.

- Minimum Primary Care Standards Review *All*

Staff indicated they had not had an opportunity to make any additional edits to the minimum primary care standards. Updates will be brought to the next meeting.

- Opinion Request-Update *All*

At the last meeting, the Subcommittee was asked to offer an opinion on whether the Ryan White Program should pay for certain procedures for a particular client. The Subcommittee asked for the service provider to furnish additional details; since that time, the service provider has communicated that the client is no longer going to undergo the procedure. No further action is required.

X. New Business

- 2026 Service Descriptions Revisions-Mental Health and Substance Abuse *All*

The Subcommittee briefly reviewed the 2026 edits to the mental health and substance abuse service definition. Edits to the document included updates to ranking, dates, references, and some wording. On the mental health service description, the following additional comments were made and recommended:

- Removal any reference to harm reduction in this description and throughout the document;
- Change "ARNP" to "APRN";and
- Add "Physician Assistants".

These changes will be made and brought back.

Edits to the 2026 Service Description for Substance Abuse services were briefly reviewed and will be brought back to the next meeting.

Additional time was needed to conclude business items, so the Subcommittee moved to extend the meeting.

Motion to extend the meeting by 10 minutes.
Moved: Cristhian Ysea **Seconded: Juliet Miller** **Motion: Passed**

- Letters of Medical Necessity: Edits for 2026 *All*

The Subcommittee reviewed the letters of medical necessity for dental implants, food bank services, and continuous glucose monitoring (CGM) devices. The dental implant letter was updated in May 2025, and no additional edits were requested. No additional edits were also requested of the food bank letter. On the CGM devices questions were raised as to why only two were listed. Staff will query pharmacy providers for options and possible pricing, bringing the information to the next meeting.

- 2026 Elections *All*

Staff provided a memo reminding the Subcommittee that elections for officers will take place at the January 2026 meeting. Both Chair and Vice-Chair have served for two years and are not eligible for re-election. If anyone is interested in serving as an officer of this Subcommittee, they can indicate their interest now, let staff know in advance of the January meeting, or declare their interest at the January meeting.

- 2026 Calendar of Activities *All*

The proposed 2026 calendar of activities was provided and reviewed, and a motion was made to approve it.

Motion to approve the 2026 calendar of activities as presented.
Moved: Dr. Lawrence Friedman **Motion: Serrano-Irizarry** **Motion: Passed**

XI. Announcements and Open Discussion *All*

Staff projected the QR Code for accessing and completing the State Department of Health Needs Assessment survey, and urged attendees to please share it with clients. The information is also posted online at www.PartnershipMiami.org.

XII. Next Meeting *Cristhian Ysea*

The next Subcommittee meeting is scheduled for Friday, January 23, 2026, at 9:30 a.m. at BSR.

XIII. Adjournment *James Dougherty*

Mr. Dougherty thanked everyone for participating in the meeting, wished everyone happy holidays, and called for a motion to adjourn.

Motion to adjourn.
Moved: Juliet Miller **Seconded: Cristhian Ysea** **Motion: Passed**

The meeting adjourned at 11:40 a.m.

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RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **November 2025**

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)	11	57	5	8
Health Insurance Premium and Cost Sharing Assistance	0	3,892	0	1,751
Medical Case Management	10,831	93,996	5,195	8,592
Mental Health Services	0	471	0	122
Oral Health Care	709	9,028	535	2,613
Outpatient Ambulatory Health Services	2,295	23,219	1,220	3,963
Support Services				
Food Bank/Home Delivered Meals	912	9,784	367	764
Medical Transportation	489	5,631	241	1,031
Other Professional Services	11	152	7	49
Outreach Services	12	413	8	213
Substance Abuse Services (residential)	143	4,676	7	79
TOTALS:	15,413	151,319		

Total unduplicated clients (month): 5,767

Total unduplicated clients (YTD): 8,956

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 01/06/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **November 2025**

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)	11	57	5	8
Health Insurance Premium and Cost Sharing Assistance	0	3,892	0	1,751
Medical Case Management	9,778	81,747	4,761	8,308
Mental Health Services	0	471	0	122
Oral Health Care	709	9,028	535	2,613
Outpatient Ambulatory Health Services	2,181	21,566	1,166	3,839
Support Services				
Food Bank/Home Delivered Meals	912	9,784	367	764
Medical Transportation	462	5,441	214	1,003
Other Professional Services	11	152	7	49
Outreach Services	11	381	7	193
Substance Abuse Services (residential)	143	4,676	7	79
TOTALS:	14,218	137,195		

Total unduplicated clients (month): 5,418

Total unduplicated clients (YTD): 8,841

REPORT COMPILED ON: 01/06/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **November 2025**

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	1,053	12,249	555	1,273
Outpatient Ambulatory Health Services	114	1,653	76	494
Support Services				
Medical Transportation	27	190	27	46
Outreach Services	1	32	1	20
TOTALS:	1,195	14,124		

Total unduplicated clients (month): 585

Total unduplicated clients (YTD): 1,470

REPORT COMPILED ON: 01/06/2026

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 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 reflects year-to-date paid reimbursements for FY 2025 Part A service months through November 2025, as of January 6, 2026. Pending Part A reimbursement requests currently under review total $11,205,860.13 - with a few Part A contracts pending execution.

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
8	AIDS Pharmaceutical Assistance	5,544.00	
6	Health Insurance Services	565,526.00	
1	Medical Case Management	6,547,700.00	
3	Mental Health Therapy/Counseling	46,073.00	
4	Oral Health Care	4,143,775.00	
2	Outpatient/Ambulatory Health Svcs	7,091,929.00	
9	Substance Abuse - Outpatient	6,000.00	
	CORE Services Totals:	18,406,547.00	

	Support Services	Allocations	Carryover Allocations	
12	Emergency Financial Assistance	0.00		
5	Food Bank	734,890.00	640,000.00	1,374,890
13	Medical Transportation	64,088.00	160,000.00	224,088
15	Other Professional Services	24,000.00		
14	Outreach Services	144,362.00		
7	Substance Abuse - Residential	1,828,300.00		
	SUPPORT Services Totals:	2,795,640.00	800,000.00	3,595,640
	FY 2025 Award (not including C/O)	21,202,187.00		

DIRECT SERVICES TOTAL:		**$**	**22,002,187.00**
Total Core Allocation	18,406,547.00		
Target at least 80% core service allocation	16,961,749.60		
Current Difference (Short) / Over	**$ 1,444,797.40**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,418,904.00**		
Quality Management	**$ 603,561.00**	3,022,465.00	
(+) 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% — **86.81%** — **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% — **9.99%** — **Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures
5606970000	AIDS Pharmaceutical Assistance	2,146.14	
5606920000	Health Insurance Services	227,766.01	
5606870000	Medical Case Management	1,396,740.80	
5606860000	Mental Health Therapy/Counseling	21,775.00	
5606900000	Oral Health Care	1,993,413.00	
5606610000	Outpatient/Ambulatory Health Svcs	1,240,915.58	
5606910000	Substance Abuse - Outpatient	0.00	
	CORE Services Totals:	4,882,756.53	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	590,827.20	640,000.00	1,230,827.20
5606460000	Medical Transportation	29,401.19	39,989.40	69,390.59
5606890000	Other Professional Services	13,698.00		
5606950000	Outreach Services	10,174.88		
5606930000	Substance Abuse - Residential	1,167,000.00		
	SUPPORT Services Totals:	1,811,101.27	679,989.40	
	FY 2025 Award (not including C/O)	6,693,857.80		

TOTAL EXPENDITURES DIRECT SVCS & % :		**$**	**7,373,847.20** **33.51%**
Formula Expenditure %	**47.75%**		
Recipient Administration	**1,485,994.24**	**61.43%**	
Quality Management	**450,734.42**		1,936,728.66
Grant Unexpended Balance	**FY 2023 Award** **15,594,065.54**	**Carryover** **120,010.60**	15,714,076.14
Total Grant Expenditures & %		**$**	**9,310,575.86** **37.21%**

Core medical % against Total Direct Service Expenditures (Not including C/O):
Cannot be under 75% — **72.94%** — **Danger!!!!!**

Quality Management % of Total Award (Not including C/O):
Cannot be over 5% — **1.86%** — **Within Limit**

OMB-GC Administrative % of Total Award (Cannot include C/O):
Cannot be over 10% — **6.13%** — **Within Limit**

Printed On: 1/6/2026

MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3501)
EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR35
MINORITY AIDS INITIATIVE (MAI) FUNDING

This report reflects year-to-date paid reimbursements for FY 2025 MAI service months through November 2025, as of January 6, 2026. Pending MAI reimbursement requests currently under review total $630,450.03 - with a few MAI contracts pending execution.

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	919,689.00	307,830.00	1,227,519.00	5606870000	Medical Case Management	267,873.35	174,017.25	441,890.60
3	Mental Health Therapy/Counseling	18,960.00			5606860000	Mental Health Therapy/Counseling	0.00		
	Oral Health Care				5606900000	Oral Health Care			
2	Outpatient/Ambulatory Health Svcs	1,206,177.00	388,576.00	1,594,753.00	5606610000	Outpatient/Ambulatory Health Svcs	5,204.46	172,844.27	178,048.73
6	Substance Abuse - Outpatient	8,058.00			5606910000	Substance Abuse - Outpatient	0.00		
	CORE Services Totals:	2,152,884.00	696,406.00	2,849,290		CORE Services Totals:	273,077.81	346,861.52	
	Support Services	**Allocations**	**Carryover Allocations**		**Account**	**Support Services**	**Expenditures**	**Carryover Expenditures**	
5	Emergency Financial Assistance	0.00			5606940000	Emergency Financial Assistance	0.00		
	Food Bank				5606980000	Food Bank			
13	Medical Transportation	14,628.00			5606460000	Medical Transportation	5,625.00		
	Other Professional Services				5606890000	Other Professional Services			
7	Outreach Services	39,816.00			5606950000	Outreach Services	0.00		
	Substance Abuse - Residential				5606930000	Substance Abuse - Residential			
	SUPPORT Services Totals:	54,444.00	0.00			SUPPORT Services Totals:	5,625.00	0.00	
	FY 2025 Award (not inlcuding C/O)	2,207,328.00				FY 2025 Award (not inlcuding C/O)	278,702.81		
	Carryover Award		696,406.00						
	DIRECT SERVICES TOTAL:		**$ 2,903,734.00**			**TOTAL EXPENDITURES DIRECT SVCS & %:**		**$ 625,564.33**	**21.54%**
	Total Core Allocation	2,152,884.00							
	Target at least 80% core service allocation	1,765,862.40							
	Current Difference (Short) / Over	**$ 387,021.60**							
	Recipient Admin. (OMB-GC)	**$ 256,369.00**			5606710000	**Recipient Administration**	**112,632.74**	**43.93%**	
	Quality Management	**$ 100,000.00**	356,369.00	$ 3,260,103.00	5606880000	**Quality Management**	**74,999.97**		187,632.71
	(+) Unobligated Funds / (-) Over Obligated:					**Grant Unexpended Balance**	**FY 2024 Award**	**Carryover**	
	Unobligated Funds (MAI)	$ -					**2,097,361.48**	**1,192,290.48**	3,289,651.96
	Unobligated Funds (Carry Over)	$ **842,746.00**	842,746.00	4,102,849.00		**Total Grant Expenditures & % (Including C/O):**		**$ 813,197.04**	**19.82%**

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**97.53%**	**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%	**97.98%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**2.93%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**4.39%**	**Within Limit**

Printed On: 1/6/2026

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of November 21, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• Vacancy Report	Marlen Meizoso
VIII.	Special Discussion:	
	• 2026 Changes to ADAP and Impact	All
IX.	Oral Health Care Items: OHC Standards and Oral Health Care 2026 Service Definition Revisions	All
X.	Standing Business	
	• 2026 Service Definition Revisions-Mental Health and Substance Abuse	All
	• Allowable Conditions Response to "Dear Colleague" Letter	All
	• Minimum Primary Care Standards Review	All
	• Edits to Letters of Medical Necessity-CGM and Food Bank	All
XI.	New Business	
	• 2026 Elections	All
XII.	Announcements and Open Discussion	All
XIII.	Next Meeting**: February 27, 2026** at **BSR**	Cristhian Ysea
XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

January 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

4 *seats are available to Ryan White Program Clients who are not affiliated or employed by a Ryan White Program Part A funded service provider.*
(1 applicant pending)

Opportunities for General Membership

7 *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
Part D Grantee Representative
Mental Health Provider Representative *(1 applicant pending)*

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?

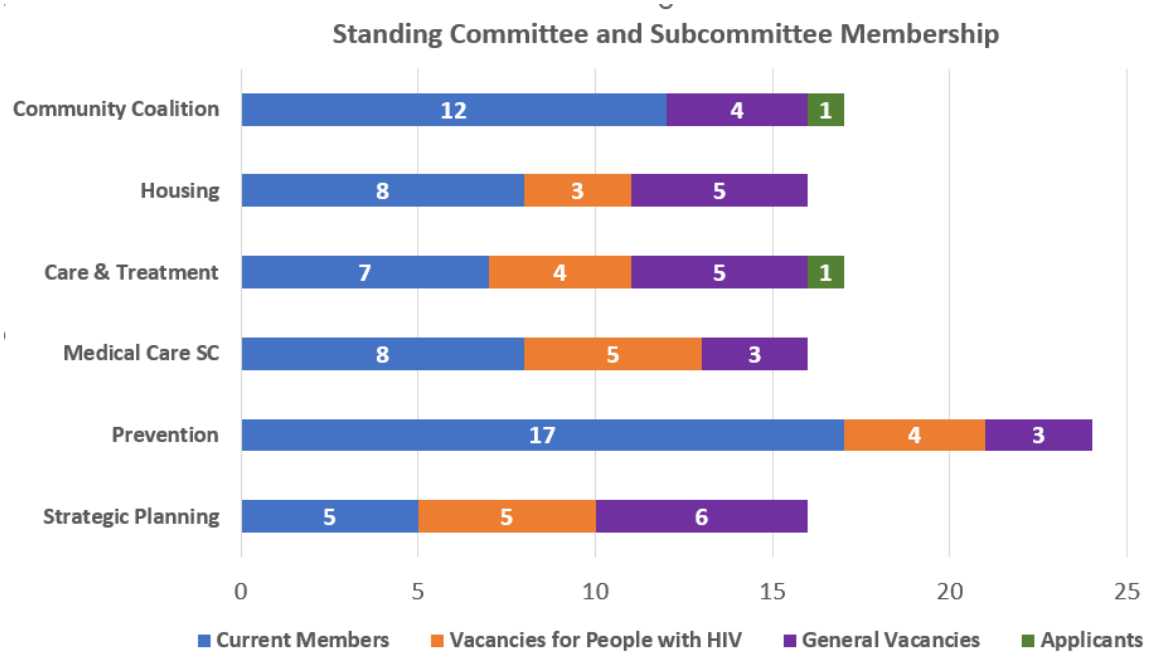
Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

when you say Yes! good things happen.

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 Committee**
- 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***



* Prevention Committee activites and new member opportunities are on hold.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
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From: Choe, Ulyee <Ulyee.Choe@flhealth.gov>
Sent: Thursday, January 8, 2026 3:26:58 PM
Subject: ADAP Formulary Changes

Dear Colleagues,

As you are probably aware, ADAP will be moving to a financially sustainable model to benefit the largest population of ADAP clients. We will continue to support the current model (direct dispense, CVS Caremark and insurance) for a two month period to ensure ADAP clients have ample time to seek insurance and medication assistance, if no longer eligible to receive ADAP services through the department. Following this transition period, we will move to direct medication dispensing, capping the eligible federal poverty level at 130%, as well as implementing ADAP formulary changes starting March 1, 2026.

Regarding the formulary changes, Biktarvy will be removed and Descovy will be restricted to only those with renal insufficiency (CrCl <60). All other current ART medications including Tivicay will be available. However, we will monitor cost closely and adjust if needed. A few actions to consider:

- Upon follow up visits, transition to new ART regimen such as Tivicay plus Truvada, other Truvada-based or NRTI-based regimen in combination with integrase inhibitors, or alternative class outside of integrase inhibitors. Please refer to the treatment guidelines: Initiation of Antiretroviral Therapy | NIH.
- For patients on those Biktarvy or Descovy, ensure they have adequate medication until their next clinical visit prior to March 1st.
- For Descovy, providers are required to document the reason: due to CrCl <60 or renal insufficiency on the prescription note section.

Will keep you posted on any additional changes. As always, please reach out if you have any questions.

Bcc: DL DOH CHD Administrators Directors, DL CHD Medical Directors; DL CHD Nursing Directors Only; DL CHD Clinical Providers

Ulyee

Ulyee Choe, DO
Director
Florida Department of Health in Pinellas County
County Health Systems Statewide Medical Director
205 Dr. Martin Luther King Jr. St. N
St. Petersburg, FL 33701
(727) 824-6921
www.PinellasHealth.com

MIAMI-DADE HIV/AIDS PARTNERSHIP

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9:30 a.m. – 11:30 a.m.
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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 relate 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 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 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 licensed 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

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

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ORAL HEALTH CARE

(Year 35 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/non-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, 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/Non-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 2025~~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.

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MENTAL HEALTH SERVICES

(Year 36~~5~~ 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-1~~0~~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 receive~~s~~ a mental health treatment plan at least every six months.

Psychiatric treatment with medication management and evaluation is a billed under this service category.~~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. Level MD provides psychiatric treatment with medications management and evaluation.

- **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 Services (Level MD)**: This level is provided by a licensed medical professional (MD, DO, APRN or PAs) who will provide medication management and evaluation.

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

Level **MD reimbursement** will follow outpatient/ambulatory health services guidance with evaluation and management visits and psychiatric visits reimbursed at rates no higher than the Medicare "allowable" rates times a multiplier of up to 2.5.

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 119/1~~7~~4/2024~~5~~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
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SUBSTANCE ABUSE OUTPATIENT CARE
AND
SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

(Year ~~35~~ 36 Service Priorities: #~~8~~ 12 for outpatient Part A ~~and #5 for MAI;~~ and #1~~1~~ 41 for Part A residential only)

Two types of substance abuse counseling and treatment services are included in this section: Outpatient and Residential. **Substance Abuse Outpatient Care** is a **core medical service**. **Substance Abuse Services (Residential)** is a **support service**. Both of these substance abuse service components shall comply with the following requirements:

A. **Program Operation Requirements:** Providers are encouraged to provide services that are highly accessible to target populations.

Providers are also encouraged to demonstrate linkages with other service providers relevant to the needs of people with HIV in substance abuse treatment programs. Providers should especially demonstrate linkages with other services relevant to the needs of people in substance abuse treatment programs including housing and shelter programs.

Service must be provided in settings that foster the client's sense of self-determination, dignity, responsibility for own actions, relief of anxiety, and peer support.

Providers are encouraged to offer program services to families to support the family unit. However, substance abuse services may be provided to members of a client's family in an outpatient setting only (i.e., non-HIV family members may not stay in the residential facility), and only if the program-eligible individual served (client) is also being served. A family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.A. of this service definition on the following page for details). ***IMPORTANT NOTE****: For the purpose of this service, family members are defined as those individuals living in the same household as the client.*

Individual treatment plans must be documented in the client's chart and linked to the provision of primary medical care.

Providers must ensure that clients adhere to their treatment plan, including prescription drug regimens.

Providers of substance abuse services must offer flexible schedules that accommodate the client's nutritional needs in order to facilitate client compliance with medication regimens.

Providers are encouraged to practice and incorporate motivational interviewing ~~and harm reduction~~ strategies to their clients, if deemed clinically appropriate.

A residential substance abuse episode is not a pre-requisite to access Substance Abuse Outpatient Care. However, clients stepping down from or completing Substance Abuse Services (Residential) are encouraged to transition to Substance Abuse Outpatient Care. Furthermore, providers shall attempt a warm hand off to Substance Abuse Outpatient Care, where appropriate.

I. Substance Abuse Outpatient Care

Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders. This service includes medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting by a ~~L~~licensed m~~M~~edical ~~P~~provider or under the supervision of a p~~P~~hysician, or by other qualified personnel as indicated below. This program provides regular, ongoing substance abuse monitoring and counseling on an individual and/or group basis in a state-licensed outpatient setting.

Services include screening, assessment, diagnosis and/or treatment of substance use disorder. Allowable substance use disorder treatments include: pre-treatment/ recovery readiness programs; ~~harm reduction;~~ behavioral health counseling associated with substance use disorders; outpatient drug-free treatment and counseling; medication assisted therapy; psychopharmaceutical interventions; substance abuse education; and relapse prevention. Services may also include mental health counseling to reduce depression, anxiety and other disorders associated with substance abuse; conflict resolution; anger management; and relapse prevention. All clients receiving this service must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis of substance use disorder.

Acupuncture therapy may be allowable under this service category only when, as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, it is included in a documented plan. Acupuncture therapy must be provided by an acupuncturist who is licensed in the State of Florida to provide such service.

Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White Program clients per group and should be no higher than fifteen (15) total persons per group. The ratio of group counseling participants to Counselors should be no lower than 3:1 and no higher than 15:1. One unit is equal to one half-hour counseling session.

Substance Abuse Outpatient Care levels are specific to the education level of

the provider of the service, as indicated below, and are not interchangeable:

- **Substance Abuse Outpatient Care (Level I) - Professional Substance Abuse Counseling.** Level I services include *general and intensive* substance abuse therapy and counseling (individual, family, and group) provided by trained mental health or certified addiction professionals. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Direct service providers for Level I must possess at least a *doctorate or postgraduate degree* (PhD or Master's degree) in the appropriate counseling-related field, and preferably be licensed as a *certified addiction professional* (CAP), lL~~L~~icensed cC~~C~~linical P~~p~~sychologist, LCSW, LMHC, or LMFT to provide such services.

- **Substance Abuse Outpatient Care (Level II) - Counseling and Support Services.** Level II services include supportive and crisis substance abuse counseling by trained and supervised Counselors (who may possess Bachelor's degrees or have related experience, and may not be licensed), peers, and facilitators. Activities include forming or strengthening support groups, development of understanding of treatment options, holistic or alternative therapies (meditation, visualization, stress reduction, etc.), and other areas appropriate for individual and group socio-emotional support. Non-certified personnel providing this Level II service will be supervised by professionals with appropriate Level I substance abuse counseling credentials.

- **Tele-substance abuse outpatient care 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:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (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 Substance Abuse Outpatient Care will be based on half-hour counseling sessions (i.e., 1 unit) not to exceed $30.00 per unit for Level I individual counseling; $34.00 per unit for Level I group counseling; $27.00 per unit for Level II individual counseling; and $30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the counseling, whereas, reimbursement for group sessions is calculated for the

Counselor that provided the group counseling. Documentation activities are included in the Substance Abuse Outpatient Care unit of service and are not to be billed as a separate encounter. Substance Abuse Outpatient Care may be provided to members of a client's family in an outpatient setting if the program-eligible person with HIV (client) is also being served. The client must be currently receiving such services; and preferably, but not necessarily, the family member may be served on the same day as the client.

Tele-substance abuse outpatient care services are reimbursed as follows:

New Code	Description	Flat rate Reimbursement
THSAC1	Tele-Substance Abuse Outpatient Care provided by a Level I provider (individual client only)	$30.00 per 30-minute session
THSAC2	Tele-Substance Abuse Outpatient Care provided by a Level II provider (individual client only)	$27.00 per 30-minute session

D. **Additional Rules for Reporting:** The unit of service for reporting monthly activity of individual and group counseling is a *one half-hour counseling session* provided to the client and the number of unduplicated clients served. Providers must also report, on a monthly basis, the number of group counseling units provided by each Counselor.

E. **Linkage/Referrals:** Providers of Substance Abuse Outpatient Care must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, m~~M~~edical c~~C~~ase m~~M~~anager/non-medical case manager, and l~~L~~icensed ~~P~~primary c~~C~~are ~~P~~provider when that is found to be appropriate. Providers are required to determine if the client is currently receiving m~~M~~edical c~~C~~ase m~~M~~anagement/non-medical case management services; if not, the provider must seek enrollment of the client in a ~~M~~medical c~~C~~ase ~~M~~management/non-medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the Medical Case Management provider must be established in order to ensure coordination of services while the client remains in treatment.

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

F. **Additional Rules for Documentation:** Providers must submit an assurance to OMB that Substance Abuse Outpatient Care services are only provided in an outpatient setting. Providers must maintain professional certifications and licensure documents as required by the State of Florida for staff providing residential substance abuse treatment services to Ryan White Program clients and must make these documents available to OMB staff or authorized persons upon request. Providers must also submit to OMB a copy of the staffing structure showing supervision by a lLicensed Mmedical Ppprovider or other qualified personnel. Providers must also maintain client charts that include treatment plans with all required elements, including but not limited to measurable goals and timelines for completion. Documentation in the client chart must also clearly indicate that services were provided as allowable under the local Ryan White Program service definition, and include the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

II. Substance Abuse Services (Residential)

This program offers substance abuse, including alcohol addiction and/or addiction to legal and illegal drugs, treatment and counseling, including HIV specific counseling, to program-eligible people with HIV (clients) on a short-term basis. Medication-Assisted Treatment (MAT) is also covered as part of the residential treatment services. **Substance Abuse Services (Residential)** provides room and board, in a secure, drug-free, state-licensed residential (non-hospital) substance abuse treatment facility, and, when necessary, detoxification. Detoxification services are allowable, if offered in a separate licensed residential setting (including a separately-licensed detoxification facility within the walls of an inpatient medical or psychiatric hospital). HRSA RWHAP funds may not be used for inpatient detoxification in a hospital setting unless the detoxification facility has a separate license. Proof of the separate license is required for detoxification services.

In accordance with HRSA Policy Clarification Notice #16-02, Substance Abuse Services (Residential), as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, are permitted **only** when the client has received a written referral from a clinical provider. In Miami-Dade County's Ryan White Part A/MAI Program, this requirement shall be met if the client is accessing the service based on a Ryan White Program In Network Service Referral or Out of Network Referral as a result of a comprehensive health assessment conducted by a mMedical Ccase mManager or other case manager or in response to a court-ordered directive to a residential treatment program. Upon arrival at the residential treatment center and PRIOR TO final enrollment in the treatment program, an assessment MUST be conducted by the residential clinical staff (e.g., mMedical dDirector, p Psychologist, Llicensed Ttherapist, etc.) as appropriate using the

Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) assessment

tool (e.g., ASAM Criteria®, a Level of Care determination tool) for diagnosis of a substance use disorder or International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) tools. Services will then be provided by or under the supervision of a lL~~L~~icensed mM~~M~~edical pP~~P~~rovider or by other qualified personnel with appropriate and valid licensure and certification as required by the State of Florida.

If the client is participating in a residential treatment program, the client's family member may visit the facility and participate in the counseling sessions, but the family member may not physically live in the residential facility with the client during the treatment process. As a reminder, a family member's participation in the substance abuse counseling sessions is included in the per day cost charged to the Ryan White Program (See Section II.B. of this service definition on the following page for details).

Residential treatment programs shall comply with the following requirements:

B. **Rules for Reimbursement:** The unit of service for reimbursement of Substance Abuse Services (Residential) is a *client-day* of care up to a maximum amount of $250.00 per day. The final, maximum rate is negotiated between the County's Office of Management and Budget-Grants Coordination division and each funded subrecipient. **Under normal circumstances clients may not be enrolled in any Ryan White Program-funded Substance Abuse Services (Residential) program for longer than 180 calendar days within a twelve-month period. Twelve months begins on the very first day of a client's residential treatment and restarts every 12 months based on that original start date for Ryan White Program-funded residential substance abuse treatment services. No exceptions, unless approved by the Miami-Dade County Office of Management and Budget for extreme circumstances (e.g., public health emergencies such as COVID-19 or extreme weather events such as hurricanes). Override requests may be considered on a case-by-case basis and would be approved or denied at the discretion of Miami-Dade County Office of Management and Budget-Grants Coordination/Ryan White Program (OMB-GC/RWP) management. Please contact the OMB-GC/RWP office for pre-approval prior to extending residential care past the 180-day cap. The length of stay for existing clients will be closely monitored by the County's OMB/Ryan White Program.**

Residential substance abuse treatment providers are strongly encouraged to check the Provide® Enterprise Miami data management system order to determine how many days of residential treatment service have already been billed for the client, and how many days are remaining in the client's 180-day/12-month period. In addition, providers should call or email the client's previous Substance Abuse Services (Residential) provider, if applicable, to inquire if any services are pending to be entered or compiled in the Provide Enterprise® Miami data management system. This will affect the actual number of available days versus those that

appear in the Provide® Enterprise Miami data management system.

C. **Additional Rules for Reporting:** Monthly activity reporting (i.e., reimbursement requests) for Substance Abuse Services (Residential) is per *client-day* of care and number of unduplicated clients served. Providers will indicate in the Provide® Enterprise Miami data management system the client's disposition after Substance Abuse Services (Residential) has ended (e.g., treatment completed, client referred to outpatient substance abuse counseling, client withdrew from treatment, etc.). This process is facilitated by the review and managing of the "RSA Disenrollment Report" available in the Provide® Enterprise Miami data management system. Service providers are required to print this report on a monthly basis and disenroll clients who are no longer in active care. Once all residential treatment disenrollments for the month are completed, a final "RSA Disenrollment Report" must be printed and uploaded along with the monthly reimbursement request that is uploaded in the Provide® Enterprise Miami data management system.

D. **Linkage/Referrals:** Providers of Substance Abuse Services (Residential) must document the client's progress through the treatment program, maintain linkages with one or more outpatient facilities and appropriate community services, including 12-step programs, and be able to refer or place clients in an outpatient program, in collaboration with the client, mMedical cCase MManager/non-medical case manager, and the Llicensed Pprimary Ccare pProvider when that is found to be appropriate. Providers are required to determine if the client is currently receiving mMedical Ccase MManagement/non-medical case management services; if not, the provider must seek enrollment of the client in a mMedical Ccase mManagement/non-medical case management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the mMedical Ccase MManagement/non-medical case management provider must be established in order to ensure coordination of services while the client remains in treatment. **A client's Ryan White Program- funded mMedical Ccase MManager/non-medical case manager will receive an automated "pop-up" notification through the Provide® Enterprise Miami data management system upon the client's discontinuance or release from, completion of, and/or relapse in residential substance abuse treatment.**

IMPORTANT NOTE: referrals from residential substance abuse services to outpatient counseling facilities should only occur when there is a need for HIV specific counseling not offered by the residential facility, or once the client has completed or left their residential treatment program.

E. **Special Client Eligibility Criteria:** A Ryan White Program In Network Service Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Clients receiving Ryan White Program Part A or MAI funded Substance Abuse Services (Residential) must be documented as having gross household incomes below 400% of the 20256 Federal

Poverty Level (FPL).

~~E.~~

~~F.~~ **Additional Rules for Documentation:** Providers must also maintain professional certifications and licensure documents as required by the State of Florida for staff providing residential substance abuse treatment services to Ryan White Program

clients and must make these documents available to OMB staff or authorized persons upon request. Providers must submit to OMB a copy of the staffing structure showing supervision by a Licensed Medical Provider or other qualified personnel, and an assurance that all services are provided in a short-term residential setting. Providers must also maintain client charts that include individual treatment plans with all required elements and document that services were provided as allowable under the Ryan White Program service definition, the quantity, frequency and modality of treatment services, the date treatment begins and ends, regular monitoring and assessment of client progress, and a signature of the individual providing the service or the supervisor as applicable. If acupuncture services were provided, a copy of the written referral from the primary health care provider must be in the client chart.

III. Additional Standards and Guidelines

Guidelines: Outpatient and residential substance abuse treatment and counseling providers will adhere to generally accepted clinical guidelines for substance abuse treatment of people with HIV. The following are examples of such guidelines:

- American Society of Addiction Medicine. *The ASAM Principles of Addiction Medicine,* Seventh Edition; April 8, 2024.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 1~~1~~0/~~1~~9<u>2</u>7/202<u>4</u>5.

- American Society of Addiction Medicine (ASAM). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* Fourth Edition.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 1~~1~~0/<u>2</u>7~~1~~9/202<u>4</u>5.

- American Society of Addiction Medicine. Current and archived public policy statements related to the treatment of substance use disorder.
  Available at: https://www.asam.org/advocacy/public-policy-statements
  Accessed 1~~1~~0/<u>2</u>7~~1~~9/202<u>4</u>5.

- Rules governing the treatment of physically drug dependent newborns, substance exposed children, and/or children adversely affected by alcohol and the families of these children that are consistent with the administrative regulations promulgated in Chapter 65 of the Florida Administrative Code by the State of Florida Department of Children and Family Services, as may be amended.

- Rules governing the provision of substance abuse treatment services consistent with the regulations promulgated by the State of Florida's Alcohol Prevention and Treatment (APT) and Drug Abuse Treatment and Prevention (DATAP) programs, as may be amended.

- Rules governing the provision of residential and outpatient substance abuse treatment services with regards to licensure and regulatory standards that are consistent with the administrative regulations promulgated in Chapter 65D-30, Substance Abuse Services Office, of the Florida Administrative Code under the State of Florida Department of Children and Families, as may be amended.

~~**IV. Best Practices Compilation Search** provides interventions that improved outcomes: https://targethiv.org/bestpractices/search?keywords=substance%20abuse&page=1~~

Commented [MM1]: Website no longer accessibe, deleted

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of November 21, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• Vacancy Report	Marlen Meizoso
VIII.	Special Discussion:	
	• 2026 Changes to ADAP and Impact	All
IX.	Oral Health Care Items: OHC Standards and Oral Health Care 2026 Service Definition Revisions	All
X.	Standing Business	
	• 2026 Service Definition Revisions-Mental Health and Substance Abuse	All
	• Allowable Conditions Response to "Dear Colleague" Letter	All
	• Minimum Primary Care Standards Review	All
	• Edits to Letters of Medical Necessity-CGM and Food Bank	All
XI.	New Business	
	• 2026 Elections	All
XII.	Announcements and Open Discussion	All
XIII.	Next Meeting**: February 27, 2026** at **BSR**	Cristhian Ysea
XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

	Local Justification		HHS Criteria								
			A	B	C	D	D.1	D.2	D.3	D.4	
Check all that apply if yes for each condition and add any comments, as applicable.	**Is this condition HIV related?**	**Is this condition a comorbidity or complication related to HIV?**	**Are there evidence-based interventions to combat HIV?**	**Does addressing the condition promote viral suppression?**	**Does addressing the condition improve quality of life?**	**For this condition, will a diagnostic procedure be required ?**	**If a diagnostic procedure is required, will any of the following be needed:**				**Comments**
Definition of terms sample based on American Society of Anesthesiology							*Anesthesia for surgeries in which you loose consciousness e.g. open-heart .*	*Sedation for minimal invasive procedures e.g. colonoscopy.*	*Anesthesia for region such as those used during childbirth, or nerve-blocks.*	*Anesthesia for local procedures such as stiches, mole removal that numbs a small area.*	**No conditions/treatments are covered: inpatient requiring hospitalizations, at emergency rooms or at urgent cares.**
Anesthesia term							**general anesthesia?**	**IV/monitored sedation?**	**regional anesthesia?**	**local anesthesia?**	
CHIROPRACTIC/PHYSICAL MEDICINE:											
HIV-related chronic arthralgia	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
peripheral neuropathy	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
COLORECTAL:											
abnormal anal Pap smears	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
fistulas	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
hernias	☐	☐	☐	☐	☑	☑	☐	☐	☐	☐	
COLORECTAL and ONCOLOGY:											
anal cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DENTAL (ORAL HEALTH CARE):											
giant aphthous ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DENTAL (ORAL HEALTH CARE); and EAR, NOSE and THROAT (ENT)/OTOLARYNGOLGY:											
human papillomavirus associated oral lesions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DENTAL (ORAL HEALTH CARE); EAR, NOSE and THROAT (ENT)/OTOLARYNGOLGY; and ONCOLOGY:											
dental cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
oral cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

	Local Justification		HHS Criteria								
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Check all that apply if yes for each condition and add any comments, as applicable.	**Is this condition HIV related?**	**Is this condition a comorbidity or complication related to HIV?**	**Are there evidence-based interventions to combat HIV?**	**Does addressing the condition promote viral suppression?**	**Does addressing the condition improve quality of life?**	**For this condition, will a diagnostic procedure be required ?**	**If a diagnostic procedure is required, will any of the following be needed:**				**Comments**
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Anesthesia term							**general anesthesia?**	**IV/monitored sedation?**	**regional anesthesia?**	**local anesthesia?**	
BONE AND JOINT DISEASES (E.G., ORTHOPEDICS/RHEUMATOLOGY):											
osteoarthritis	☐	☑	☐	☐	☑	☐	☐	☐	☐	☐	Diagnostics covered to rule out other complicating conditions.
BONE AND JOINT DISEASES (E.G., ORTHOPEDICS/RHEUMATOLOGY) and CHIROPRACTIC/PHYSICAL MEDICINE:											
avascular necrosis of hip, knee, etc. (Stage 1 or 2 only for CHIROPRACTIC/PHYSICAL MEDICINE)	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	Coverage limited up to joint replacement/surgical interventions; Coverage in RW may include diagnostics, physical therapy, medications, limited to outpatient procedures or no anesthesia. Anything beyond this would require a case review.
fibromyalgia	☐	☑	☐	☐	☑	☐	☐	☐	☐	☐	
myopathy/myalgia, HIV-related (chronic for CHIROPRACTIC/PHYSICAL MEDICINE)	☑	☑	☐	☐	☑	☐	☐	☐	☐	☐	
osteopenia/osteoporosis	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
rheumatic diseases	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
CARDIOLOGY:											
atherosclerosis	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	Coverage in RW may include diagnostics, medications, limited to outpatient procedures or no anesthesia.
coronary artery disease	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
heart disease	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
hyperlipidemia	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	Coverage in RW limited to medications
peripheral artery disease	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	Coverage in RW may include diagnostics, medications, limited to outpatient procedures or no anesthesia.
peripheral vascular disease	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	
phlebitis	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	

	Local Justification		HHS Criteria								
			A	B	C	D	D.1	D.2	D.3	D.4	
Check all that apply if yes for each condition and add any comments, as applicable.	**Is this condition HIV related?**	**Is this condition a comorbidity or complication related to HIV?**	**Are there evidence-based interventions to combat HIV?**	**Does addressing the condition promote viral suppression?**	**Does addressing the condition improve quality of life?**	**For this condition, will a diagnostic procedure be required ?**	**If a diagnostic procedure is required, will any of the following be needed:**				**Comments**
Definition of terms sample based on American Society of Anesthesiology							*Anesthesia for surgeries in which you loose consciousness e.g. open-heart .*	*Sedation for minimal invasive procedures e.g. colonoscopy.*	*Anesthesia for region such as those used during childbirth, or nerve-blocks.*	*Anesthesia for local procedures such as stiches, mole removal that numbs a small area.*	**No conditions/treatments are covered: inpatient requiring hospitalizations, at emergency rooms or at urgent cares.**
Anesthesia term							**general anesthesia?**	**IV/monitored sedation?**	**regional anesthesia?**	**local anesthesia?**	
DERMATOLOGY:											
dermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
eczema/seborrheic dermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
eosinophilic folliculitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
impetigo	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Methicillin-resistant Staphylococcus aureus (MRSA)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
molluscum contagiosum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
photodermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
pruritus (as a symptom of undiagnosed xerosis, psoriasis, scabies, lymphoma, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
skin conditions and symptoms, including skin appendages and oral mucosa	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
warts	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DERMATOLOGY and GENITOURINARY (GU)/ GYNECOLOGY (GYN)/OBSTETRICS (OB):											
tinea infections	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DERMATOLOGY and INFECTIOUS DISEASES:											
herpes simplex virus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DERMATOLOGY and ONCOLOGY:											
Kaposi's sarcoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
skin cancers (squamous cell carcinoma, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DERMATOLOGY and PODIATRY:											
onychomycosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
EAR, NOSE AND THROAT (ENT)/OTOLARYNGOLOGY:											
chronic sinusitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
oral human papillomavirus	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
oral candidiasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

4.Primary Care Guidance for Providers of Care for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America.
Horberg M, Thompson M, Agwu A, et al.
Clinical Infectious Diseases : An Official Publication of the Infectious Diseases Society of America. 2024;:ciae479. doi:10.1093/cid/ciae479.

Anal Cancers

1. Is anal cancer a condition related to human immunodeficiency virus (HIV)?Yes. **Anal cancer is strongly related to HIV infection, with people living with HIV (PWH) having a 15- to 35-fold increased risk compared to the general population**. The risk is especially high among men who have sex with men (MSM) with HIV, but is elevated in all PWH regardless of sex or risk group.[1-4]

2. What comorbidities or complications are associated with HIV in the context of anal cancer?

Persistent high-risk HPV infection, low CD4 count, history of anal HSIL, prior genital dysplasia, smoking, and longer duration of immunosuppression are key comorbidities and risk factors. Anal cancer in PWH is often multifocal and may be associated with other HPV-related cancers (cervical, vulvar, vaginal).[1][5] Poor performance status may be due to HIV, cancer, or other comorbidities.

3. Are there any complications of HIV treatment relevant to anal cancer?

Drug-drug interactions between antiretroviral therapy (ART) and cancer therapies are important considerations. ART should be continued during cancer treatment, but modifications may be needed to avoid interactions, especially with chemotherapy, radiation, or immune checkpoint inhibitors. ART may improve performance status and reduce hematologic toxicity risk.[1-2] Some evidence suggests ART may reduce progression of high-grade AIN to cancer, but has not significantly reduced anal cancer incidence.[2]

4. Does addressing anal cancer promote viral suppression in HIV-positive patients, and does it improve quality of life?

Treating anal cancer does not directly promote viral suppression. However, **maintaining ART and viral suppression is associated with better cancer outcomes and lower mortality.**[6] **Addressing anal cancer and its precursors (HSIL) improves quality of life by reducing morbidity, preventing progression, and improving survival.**[1-2]

5. Is a diagnostic procedure required for anal cancer? Yes. **Diagnosis requires clinical evaluation, digital anorectal examination (DARE), anal cytology, high-resolution anoscopy (HRA), and biopsy of suspicious lesions. Imaging (CT, MRI, PET) is used for staging.**[1-2][7]

6. Is anesthesia needed for the diagnosis of anal cancer?

No anesthesia is needed for routine screening (DARE, cytology, HRA). Local anesthesia may be used for biopsy of suspicious lesions, but general anesthesia is not required for diagnosis.[1-2][7]

7. Is anesthesia needed for the treatment of anal cancer?

Yes, anesthesia is often required for surgical procedures (e.g., excision, ablation, or tumor resection).

- **Topical therapy and office-based ablation may use local anesthesia.**
- **Major surgery (e.g., abdominoperineal resection) requires general anesthesia.**
- **Chemoradiation, the mainstay of treatment, does not require anesthesia.**

Treatment should follow standard NCCN Anal Carcinoma guidelines, with no modifications solely based on HIV status.[1-2]

In summary: Anal cancer is highly related to HIV, with increased risk due to immunosuppression and persistent HPV infection. Comorbidities include low CD4 count, prior dysplasia, and multifocal HPV disease. ART interactions and toxicity are relevant during cancer treatment. Diagnosis requires clinical and procedural evaluation, with local anesthesia for biopsy. Treatment may require anesthesia for surgery, but not for chemoradiation. Addressing anal cancer improves quality of life but does not directly affect viral suppression; maintaining ART is critical for optimal outcomes.

1.Cancer in People with HIV.
National Comprehensive Cancer Network
Updated 2025-09-05

2.Anal Carcinoma.
National Comprehensive Cancer Network
Updated 2025-10-31

3.Cancer Prevention and Early Detection Facts & Figures.
Rick Alteri, Deana Baptiste, Emily Butler Bell, et al
American Cancer Society (2025)
Practice Guideline

4.Anal Cancer: Emerging Standards in a Rare Disease.
Eng C, Ciombor KK, Cho M, et al.
Journal of Clinical Oncology : Official Journal of the American Society of Clinical Oncology. 2022;40(24):2774-2788. doi:10.1200/JCO.21.02566.
Leading Journal

5.Clinical Predictors and Outcomes of Invasive Anal Cancer for People With HIV in an Inception Cohort.
Cachay ER, Gilbert T, Qin H, Mathews WC.
Clinical Infectious Diseases : An Official Publication of the Infectious Diseases Society of America. 2024;79(3):709-716. doi:10.1093/cid/ciae124.
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6.Primary Care Guidance for Providers of Care for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America.
Horberg M, Thompson M, Agwu A, et al.
Clinical Infectious Diseases : An Official Publication of the Infectious Diseases Society of America. 2024;:ciae479. doi:10.1093/cid/ciae479.
Practice Guideline
Leading Journal

7.Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV.
Constance Benson, John Brooks, Shireesha Dhanireddy, et al
Infectious Diseases Society of America; Office of AIDS Research Advisory Council (2025)

Giant Aphthous Ulcers

1. Are giant aphthous ulcers related to HIV infection?

Yes. **Giant (major) aphthous ulcers are strongly associated with HIV infection.** People living with HIV (PLWH) experience more frequent, severe, and persistent aphthous ulcers—including major (giant) forms—compared to immunocompetent individuals. These ulcers can also occur in other mucosal sites (esophagus, rectum, anus, genitals) in HIV-positive patients.[1-4]

2. What comorbidities or complications are associated with HIV in the context of giant aphthous ulcers?

Comorbidities include advanced immunosuppression (low CD4 count), nutritional deficiencies (vitamin B12, folate, iron, zinc), and other oral conditions (candidiasis, herpes simplex, Kaposi sarcoma). Giant aphthous ulcers in HIV can lead to significant pain, dysphagia, secondary malnutrition, and impaired oral intake, which may worsen overall health status.[2-4] These ulcers may also be associated with similar ulcerations in other mucosal sites.[1]

3. Are there any complications of HIV treatment relevant to giant aphthous ulcers?

Yes. **Some antiretroviral therapies (ART) may cause oral side effects, but the main complication is drug-drug interactions when immunomodulatory agents (e.g., thalidomide, corticosteroids) are used to treat severe ulcers.** Thalidomide, while effective, can increase HIV viral load and has notable toxicity risks (somnolence, rash, neuropathy).[4-5] ART generally improves immune status and may reduce ulcer severity, but does not eliminate risk.[4]

4. Does addressing giant aphthous ulcers promote viral suppression or improve quality of life in people living with HIV?

Treating giant aphthous ulcers does not promote viral suppression. However, **effective management significantly improves quality of life by reducing pain, improving oral intake, and preventing malnutrition**.[1][4-6] Thalidomide and topical agents have demonstrated efficacy in healing ulcers and improving pain and function.[5-6]

5. Is a diagnostic procedure required for giant aphthous ulcers?

Diagnosis is primarily clinical, based on history and examination. However, **biopsy is recommended for non-healing or atypical ulcers to exclude deep fungal infection, viral infection, or neoplasm**.[1][3-4] Laboratory tests may be used to rule out nutritional deficiencies or other systemic causes.[3]

6. Is anesthesia needed for diagnosis or treatment of giant aphthous ulcers?

No anesthesia is needed for routine diagnosis. Local anesthesia may be used for biopsy of non-healing ulcers, but general anesthesia is not required.[1][3-4] **Treatment is usually topical or systemic and does not require anesthesia.** Only rarely, for extensive procedures, would local anesthesia be considered.[1][4]

Summary:

- **Giant aphthous ulcers are related to HIV and are more severe in PLWH.**
- **Comorbidities include immunosuppression and nutritional deficiencies; complications include pain and malnutrition.**
- **HIV treatment may interact with ulcer therapies; thalidomide can increase HIV viral load.**
- **Treating ulcers improves quality of life but does not affect viral suppression.**
- **Diagnosis is clinical; biopsy may be needed for non-healing ulcers.**
- **Anesthesia is not needed for diagnosis or routine treatment.**

References:[1-6]

1.Management Strategies for HIV-associated Aphthous Stomatitis.
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2.Oral Ulceration in HIV Infection: Investigation and Pathogenesis.
MacPhail LA, Greenspan JS.
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Human Papillomavirus Associated Oral Lesions, Dental Cancers, and Oral Cancers

Overview of HIV and HPV-Associated Oral Lesions, Dental Cancers, and Oral Cancers

HPV-associated oral lesions, dental cancers, and oral cancers are all recognized as HIV-associated cancers by the National Comprehensive Cancer Network (NCCN) and are more common in people with HIV (PWH) in the United States. PWH have a higher incidence of HPV-driven oral and oropharyngeal cancers, with increased risk and earlier onset compared to the general population.[1-5]

Relationship to HIV

There is a clear epidemiologic link between HIV and these cancers. PWH have a higher prevalence of oral HPV infection, increased risk of persistent infection, and a greater likelihood of developing HPV-associated oral lesions and cancers, including oropharyngeal squamous cell carcinoma. These cancers are classified as HIV-associated by the NCCN.[1-5]

Comorbidities and Complications

Common comorbidities include low CD4 count, persistent high-risk HPV infection, tobacco and alcohol use, and co-infection with other oncogenic viruses (e.g., EBV, HBV, HCV). PWH are at increased risk for aggressive disease, poorer outcomes, and higher cancer-specific mortality.[1-3][6-10]

Complications of HIV Treatment

Antiretroviral therapy (ART) can interact with cancer therapies, requiring careful management of drug-drug interactions, as outlined by NCCN.[1] ART may also cause oral side effects and complicate administration during head and neck cancer treatment.[1][11]

Impact of Disease Management on Viral Suppression and Quality of Life

Treating these cancers does not directly promote viral suppression. However, maintaining ART and viral suppression is associated with improved cancer outcomes and lower mortality in PWH.[1][12] Multidisciplinary management improves quality of life and survival.[1][10][12]

Diagnostic Procedures

Diagnosis requires a thorough oral examination, biopsy of suspicious lesions, imaging (CT, MRI, PET as indicated), and sometimes HPV typing, per NCCN and IDSA guidelines.[1-2][13] Routine oral health exams are recommended for PWH.[12]

Anesthesia for Diagnosis and Treatment

Most diagnostic procedures do not require anesthesia; local anesthesia may be used for biopsy.[2][13]

- HPV-associated oral lesions: Usually managed with topical or minor procedures, rarely requiring anesthesia. [2]
- Dental cancers: Surgical treatment may require local or general anesthesia, depending on extent. [1]
- Oral cancers: Surgery and some ablative procedures require anesthesia; chemoradiation does not.[1][3]

Gaps

Recent US-based studies and ASCO abstracts confirm that PWH with oral cancers have poorer outcomes, especially in early-stage disease, and may have unique tumor biology (e.g., lower CD8 T cell infiltration).[10] Data on dental cancers specifically in HIV are limited.

In summary, HPV-associated oral lesions, dental cancers, and oral cancers are more common and often more aggressive in PWH, require specific diagnostic and therapeutic approaches, and benefit from ongoing ART and multidisciplinary care to optimize quality of life and outcomes.[1-3][10][12]

1.Cancer in People with HIV.
National Comprehensive Cancer Network
Updated 2025-09-05

2.Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents With HIV.

Constance Benson, John Brooks, Shireesha Dhanireddy, et al
Infectious Diseases Society of America; Office of AIDS Research Advisory Council (2025)
Practice Guideline

3.The Effect of Non-Aids-Defining Cancers on People Living With HIV.
Chiao EY, Coghill A, Kizub D, et al.
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Leading Journal

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New Research

5.The Epidemiology and Risk Factors of Anal and Oropharyngeal Human Papillomavirus (HPV) in Males Living With Human Immunodeficiency Virus (HIV): A Protocol for Systematic Review and Meta-Analysis.
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6.Viruses and Oral Diseases in HIV-infected Individuals on Long-Term Antiretroviral Therapy: What Are the Risks and What Are the Mechanisms?.
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Khoury ZH, Meeks V.
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Horberg M, Thompson M, Agwu A, et al.
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Practice Guideline
Leading Journal

13.Oral Lesions Associated With Human Immunodeficiency Virus Disease.
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Dental Clinics of North America. 2013;57(4):673-98. doi:10.1016/j.cden.2013.07.005.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of November 21, 2025	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• Vacancy Report	Marlen Meizoso
VIII.	Special Discussion:	
	• 2026 Changes to ADAP and Impact	All
IX.	Oral Health Care Items: OHC Standards and Oral Health Care 2026 Service Definition Revisions	All
X.	Standing Business	
	• 2026 Service Definition Revisions-Mental Health and Substance Abuse	All
	• Allowable Conditions Response to "Dear Colleague" Letter	All
	• Minimum Primary Care Standards Review	All
	• Edits to Letters of Medical Necessity-CGM and Food Bank	All
XI.	New Business	
	• 2026 Elections	All
XII.	Announcements and Open Discussion	All
XIII.	Next Meeting**: February 27, 2026** at **BSR**	Cristhian Ysea
XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

Miami-Dade County Ryan White Program
Minimum Primary Medical Care Standards*

Statement of Intent: *All local Ryan White Program—funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines. These standards serve as the minimum standards by which practitioners will be measured. All clients, regardless of viral load levels, must have viral load tests at a* ***minimum every 6 months*** *per the DHHS/HRSA standards or more frequently as medically necessary.*

I. Requirements

Requirements for New Practitioners (Physicians, Advanced Practice Registered Nurse, and Physician Assistants/Associates):

- New practitioners should be linked to existing Ryan White Program providers, AIDS Education and Training Center (AETC) or through an American Academy of HIV Medicine (AAHIVM) specialist to support the new provider.
- New providers will receive a chart review within 6 months by supervising physician, medical director or agency team.
- When a new practitioner is working with a contracted practitioner, new practitioner is encouraged to comply within one year to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits.

Requirements for All Practitioners (Physicians, Advanced Practice Registered Nurse, and Physician Assistants/Associates):

- Practitioners are strongly encouraged to complete at least 30 hours of HIV-related Continuing Medical Education (CME) Category 1 credits within a period of two years.

Practitioner must:

- Be a Physician (MD or DO), Advanced Practice Registered Nurse, or Physician Assistant/Associates with current and valid license to practice medicine within the State of Florida.
- Have a minimum experience treating 20 HIV+ clients over the past two years or currently working and under supervision of a practitioner meeting these qualifications.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
  a. **American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol**
  https://www.ahajournals.org/doi/10.1161/CIR.0000000000001172
  b. **Adult Immunization Schedule**
  https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html

*These standards are current as of x/xx/xx and are subject to change to be in compliance with EXECUTIVE ORDERS.

c. **American Association for the Study of Liver Diseases**
https://www.aasld.org/practice-guidelines
d. **American Cancer Society Guidelines for the Early Detection of Cancer**
https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
e. **American Medical Association Telehealth Quick Guide**
https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide
f. **Department of Health and Human Services (DHHS) Clinical Guidelines**
https://clinicalinfo.hiv.gov/en/guidelines
g. **Hepatitis (HEP) Drug Interactions University of Liverpool**
https://www.hep-druginteractions.org/
h. **HIV Drug Interactions University of Liverpool**
https://hiv-druginteractions.org/
i. ~~**HIV Prevention with Adults and Adolescents with HIV in the US**~~
~~https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html~~
HIV Nexus: CDC Resources for Clinicians (includes PrEP, nPEP and PEP guidelines-Although not paid for by the Ryan White Program)
https://www.cdc.gov/hivnexus/hcp/guidelines/index.html
j. **Health Resources and Service Administration (HRSA) HIV Care for People Aging with HIV**
https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/special-populations-hiv-and-older
~~https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf~~
~~https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf~~
k. **Infectious Disease Society of America Primary Care Guidance for Persons with HIV**
https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/
l. **Miami—Dade County Ryan White Program (including Telehealth Policy and Test and Treat/Rapid Access [TTRA] program)**
https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715
m. **Florida Telehealth Registration and Licensing**
https://flhealthsource.gov/telehealth
n. **National HIV Curriculum**
https://www.hiv.uw.edu/alternate
o. ~~**PrEP, nPEP and PEP guidelines below (Although not paid for by the Ryan White Program):**~~
~~https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf~~
~~https://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf~~
~~https://www.cdc.gov/hivnexus/hcp/resources/?CDC_AAref_Val=https://www.cdc.gov/hiv/clinicians/materials/prevention.html~~
~~q.~~ **United States (US) Preventive Taskforce**
https://uspreventiveservicestaskforce.org/uspstf/home

- Follow an action plan to address any areas for performance improvement that are identified during quality assurance reviews.

All items under sections II and III are arranged alphabetically.

II. Assessments and Referrals

1. Annual – At each annual visit:

a. Adherence to medications
b. Age-appropriate cancer screening
c. Behavioral risk reduction
d. Gynecological exam per guidance for females
e. Interval changes in vital signs addressed, especially trend in weight/BMI over time
f. Mental health and substance abuse assessment
g. Physical examination, including review of systems
h. Preconception counseling for men and women
i. Rectal examination
j. Safer sex practices – discussions may include PrEP, PEP, nPEP, for sexual partners and should include condom usage
k. Sexually transmitted infection assessment
l. Update comprehensive initial history, as appropriate
m. Vital signs, including weight, BMI, height (no shoes)
n. Wellness exam for females

Assess and document health education on:

o. Advance Directives (completion or review)
p. Birth control
q. Domestic violence
r. Drugs/Alcohol/Tobacco (including smokeless) assessment/care
s. Exercise
t. Frailty screening, as appropriate
u. Mental Health assessment (particularly clinical depression, care, mood, libido, sleep patterns, concentration, and memory)
v. Neurology and/or neuropsychology referral for assessment of neurocognitive disorders, dementia, and focal neuropathies, as appropriate
w. Nutritional assessment/care (including appetite), as appropriate
x. Oral health care

2. Additional Charting/Documentation at least annually:

a. Allergies list complete and up to date
b. Immunization list complete and up to date
c. Medications list complete with start and stop dates, dosages
d. Problem list complete and up to date

Item to be covered by subrecipient staff: If a client knows of others who need PrEP or Test and Treat / Rapid Access, information and referral are offered.

3. **Initial –** At initial visit:
   a. Access to stable housing, food, and transportation
   b. Adherence to medications
   c. Age-appropriate cancer screening
   d. Behavioral risk reduction
   e. Comprehensive initial history
   f. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam
   g. Education that they should never run out of ART medications and need to call the FDOH—MDC clinic if they cannot obtain ART
   h. Gynecological exam per guidance for females
   i. If enrolled as Test and Treat/Rapid Access (TTRA) client (patient), follow TTRA protocol for visit
   j. Mental health and substance abuse assessment
   k. Physical examination, including review of systems
   l. Pregnancy Planning:
      1) Preconception counseling for men and women
      2) Contraceptive counseling for men and women including assessment and type of birth control method
   m. Rectal examination
   n. Safer sex practices — discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
   o. Sexually transmitted infection assessment as appropriate including at a minimum GC, Chlamydia at anatomical sites of potential exposure, RPR, and for females trichomoniasis NAAT of vaginal secretions.
   p. Social supports and disclosure history
   q. Targeted initial history and physical examination with expectation that a complete history and physical examination will be completed within 3 months.
   r. Vital signs, including weight, BMI, height (no shoes)
   s. Wellness exam for females

   Item to be covered by subrecipient staff: Documented HIV education, including transmission, reduction of morbidity/mortality with ART; resistance; compliance with ART and office visits and lab monitoring; life expectancy; divulging HIV status and state statute.

4. **Interim Monitoring and Problem-Oriented visits** – At every visit:
   a. Adherence to medications and lab and office visits for monitoring
   b. In women of childbearing age, assessment of adequate contraception
   c. Interval changes in vital signs addressed, especially trend in weight over time
   d. Interval risk for acquiring STD and screening as indicated
   e. Physical examination related to specific problems, as appropriate
   f. Risk reduction
   g. Safer sex practices – discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage
   h. Vital signs, including weight/BMI – may not occur every time with telehealth

5. **Telehealth**
   Telehealth may be used in place or in conjunction with an office visit. Necessary assessments will be conducted as needed and follow-ups will be scheduled, as appropriate.

III. Assessments at Incremental Visits

General Health, including Labs

Laboratory testing schedule monitoring before and after ARV initiation.

1. **ALT, AST, Total Bilirubin** [i] – At entry into care; at ART initiation or modification; at 4-8 weeks for people with preexisting conditions, or at risk for laboratory changes after ART initiation, or with HBV coinfection ~~or modification~~; every 6-12 months; ~~or if ART initiation is delayed, every 6-12 months~~; or if clinically indicated.

2. ~~**Annual**~~ **Wellness visit (females)** [iv] **–** Should include screenings for anxiety, patient navigator and screening services for breast cancer and cervical cancer, at recommended intervals, screening and counseling for ~~interpersonal~~ intimate partner and domestic violence, obesity prevention (midlife women), sexually transmitted infections, urinary incontinence, and contraception. For those who are pregnant, lactation support and screenings for diabetes mellitus (including post-pregnancy), as applicable. See https://www.hrsa.gov/womens-guidelines for additional details.

3. **Basic metabolic panel** [i] – At entry into care; at ART initiation or modification; at 4-8 weeks for people with preexisting conditions, or at risk for laboratory changes after ART initiation ~~or modification~~; ~~every 6 months; if ART initiation is delayed,~~ every 6-12 months; or if clinically indicated. Serum Na, K, HCO_3, Cl, BUN, creatinine, glucose, and creatine-based estimated glomerular filtration rate. Serum phosphorus should be monitored in patients with chronic kidney disease who are on tenofovir disoproxil fumarate (TDF)-containing regimens. Consult the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV for recommendations on managing patients with renal diseases. More frequent monitoring may be indicated for patients with evidence of kidney diseases (e.g., proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g., patients with diabetes, hypertension).

4. **Bone Densitometry** [iii] – Baseline bone DEXA should be performed in all postmenopausal women and men greater than or equal to 50 years old.

5. **CBC w/ differential** [i] – At entry into care; at ART initiation or modification; every 3-4 months when monitoring CD4 count (if required by lab); every 6 months when monitoring CD4 count (if required by lab); every 12 months ~~if monitoring CD4 count (if required by lab)~~when no longer monitoring CD4 count; or when clinically indicated. CBC with differential should be done when a CD4 count is performed. When CD4 count is no longer being monitored, the recommended frequency of CBC with differential is once a year. More

frequent monitoring may be indicated for persons receiving medications that potentially cause cytopenia [e.g., trimethoprim-sulfamethoxazole (TMP-SMX)].

6. **Colon and Rectal Cancer Screening** [iii] – Colorectal cancer screening recommended for individuals between 45-75 years of age if average risk (including personal and family history). For ages 76-85, individualized screening based on overall health and prior screening. Consider screening earlier if first-degree relatives are diagnosed with colon cancer prior to age 50. Screening tests include: stool based screening (gFOBT, FIT, FIT-DNA) every year, or colonoscopy every 10 years if normal, or more frequently if polyps are identified.

7. **Glucose (Random or Fasting)** [i] – At entry into care; at ART initiation or modification; or if clinically indicated. If random glucose is abnormal, fasting glucose should be obtained. HbA1C is no longer recommended for diagnosis of diabetes in person with HIV on ART, see American Diabetes Association Guidelines.

8. **Gynecological Exam** [iii] (females) – ~~In women and adolescents with HIV, initiation of cervical cancer screening (Pap) should be conducted within one year of onset of sexual activity, but no later than 21 years of age. For those age 21-29, Pap should be done at diagnosis of HIV, repeated yearly for 3 years, then if all normal, Pap every 3 years. For those less than 30 years, no HPV testing unless abnormalities are found on Pap test. For those over 30 years old, Pap at diagnosis of HIV, repeat yearly x 3 years, then if all normal, Pap every 3 years or Pap with HPV testing, if both negative then Pap with HPV every 3 years. Abnormal Pap and/or HPV follow-up similar to general population; in general, continue screening past 65 years.~~
Age <21 years: Pap test within 1 year of sexual activity, no later than age 21 years. Age 21–29 years: Pap test at diagnosis of HIV, repeat yearly × 3, then if all normal, Pap test every 3 years. Age <30 years: no HPV testing unless abnormalities are found on Pap test. Age ≥30 years: Pap test only, same as age 21–29 years. Or Pap test with HPV testing, if both negative, then Pap test with HPV every 3 years. Abnormal Pap test and/or HPV follow-up similar to general population. Note: In general, continue screening past age 65 years.

9. **Hepatitis A Screening** [ii] – ~~At initial screening, if non-immune, offer vaccination and after vaccination received do postvaccination serologic testing 1 or 2 months or at the next scheduled visit. After the second vaccine to assess for immunogenicity. A repeat vaccine series is recommended in those who remain seronegative.~~
Hepatitis A vaccination is recommended for all people with HIV, including during pregnancy, who are HAV total (IgG plus IgM) antibody negative. Among people with HIV with CD4 counts <200 cells/mm3, responses to the hepatitis A vaccine are reduced. Antibody response should be assessed at least 1 month after vaccination is complete. If total HAV antibody (anti-HAV) immunoglobulin (IgG and IgM) is negative, people should be revaccinated when their CD4 count is >200 cells/mm3.

10. **Hepatitis B Serology (HBsAb, HBsAg, HBcAb total)** [i] – At entry into care; at ART initiation or modification, in people not immune to hepatitis B (HBV), repeat testing if switching to a regimen that does not contain tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF); as clinically indicated before starting hepatitis C direct-acting antiviral (HCV DAA) in people not immune to HBV and at high risk for HbV, periodic testing may be considered. If a

patient has HBV infection (as determined by a positive HBsAg or HBV DNA test result), TDF or TAF plus either emtricitabine (FTC) or lamivudine (3TC) should be used as part of the ART regiment to treat both HBV and HIV infections. If HBsAg, HBsAb, and HBcAb test results are negative, hepatis B vaccine series should be administered. Refer to the HIVMA/IDSA's Primary Care Guidance for Person with HIV and the Adult and Adolescent Opportunistic Infection Guideline for detailed recommendations.

11. **Hepatitis C Screening (HCV antibody or, if indicated, HCV RNA)** [i] – At entry into care; every 12 months, for at-risk patients—injection drug users, people with a history of incarceration, men with HIV who have unprotected sex with men, and people with percutaneous/parenteral exposure to blood in unregulated settings are at risk for hepatitis B (HBV) or C (HCV) infection; or when clinically indicated. The HCV antibody test may not be adequate for screening in the setting of recent HCV infection (acquisition within the past 6 months), or advanced immunodeficiency (CD4 count <100 cells/mm^3). HCV RNA screening is indicated in persons who have been successfully treated for HCV or who spontaneously cleared prior infection. HCV antibody-negative people with elevated ALT may need HCV RNA testing.

12. **Lipid Profile** [i] – At entry into care; at ART initiation or modification; after ART initiation or modification at 3-6 months once viral suppression reached; every 12 months if aged ≥40 years or a statin. Every 1-2 years if aged ≤40 years and not on a statin. When climatically indicated if there are changes in cardiovascular risk factors. If random lipids are abnormal, fasting lipids should be obtained. Consult the American College of Cardiology/American Heart Association's 2018 Guideline on the Management of Blood Cholesterol for diagnosis and management of patients with dyslipidemia.

13. **Lung Cancer Screening** [iii] – ~~Annually with low-dose computer tomography (LDCT) for patients aged 50-80, who are currently smoking or former smokers with a 20 or more pack-year smoking history. Additional information at: https://www.cancer.org/cancer/types/lung-cancer.html.~~
Those aged between ages 50 and 80 years who have ≥20 pack-years of smoking and are current or former smokers should have an annual low-dose computed tomography scan of the lungs.

14. **Mammogram** (females) [iii] – ~~From ages 40-49, inform of the potential risks and benefits of screening and offer screening every 2 years. From ages 50-75, mammography performed at least every 2 years. Additional information at: https://www.cancer.org/cancer/types/breast-cancer.html.~~
Age 40–49 years: inform of the potential risks and benefits of screening and offer screening every 2 years. Age 50–75 years: mammography performed at least every 2 years.

15. **Pregnancy test** [i] (For people of childbearing potential) – At entry into care; at ART initiation or modification or when clinically indicated.

16. **Prostate-specific antigen (PSA) Screening** [iii] (males) – ~~For ages 55-69 digital rectal exam, should be considered primary evaluation before PSA screening. For those age 50-69, they~~

~~discuss the risks and potential benefits of PSA screening. For those ages 70 and older, PSA screening is not recommended. The impact of HIV on prostate cancer risk is not yet known. African Americans and people with a relative with prostate cancer have a higher burden of prostate cancer. Clinicians should follow USPSTF or American Cancer Society guidelines and consider patient wishes. Additional information at: https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html~~.
Digital rectal exam: considered primary evaluation before PSA screening; consider for patients aged 55–69 years. PSA screening: Age 50–69 years: discuss risks and potential benefits with patient. Age ≥70 years: PSA screening is not recommended. The impact of HIV on prostate cancer risk is not yet known. African Americans and people with a relative with prostate cancer have a higher burden of prostate cancer. Clinicians should follow US Preventative Services Task Force or American Cancer Society guidelines and consider patient wishes.

17. **TB Testing** [iii] – Perform annually in persons at risk for tuberculosis, either with a tuberculin skin test or IGRA.

18. **Urinalysis** [i] – At entry into care; or if clinically indicate e.g., in people with chronic kidney disease (CKD) or diabetes mellitus (DM). Consult the HIV Medicine Association of the Infectious Diseases Society of America's (HIVMA/IDSA) Clinical Practice Guidelines for the Management of Chronic Kidney Disease in Patients Infected with HIV for recommendations on managing patients with renal disease. More frequent monitoring may be indicated for patients with evidence of kidney disease (e.g., proteinuria, decreased glomerular dysfunction) or increased risk of renal insufficiency (e.g., patients with diabetes, hypertension). Urine glucose and protein should be assessed before initiating tenofovir alafenamide (TAF)-or tenofovir disoproxil fumarate (TDF)-containing regimens and monitored during treatment with these regimens.

HIV Specific Timepoint or Frequency of Testing

19. **ARV therapy is recommended and discussed** [i] – Risks and benefits are discussed including reduced morbidity and mortality and prevention of HIV transmission to others and if treatment initiated, follow-up with adherence. If refused, document in record and refer to ARTAS and or Department of Health Treatment Adherence Specialist.

20. **CD4 cell count** [i] – At entry into care; at ART initiation or modification; ~~every~~ 3 months (after ART initiation only);every 3-4 months if CD4 count is <300 cells/mm^3 ; every 6 months during the first 1-2 years of ART and with viral suppression, if CD4 count is ≥300 cells/mm^3;; if after 1-2 years on ART with consistently suppressed viral load and CD4 count ≥300 cells/mm^3, optional unless clinically indicated; monitor CD4 count every 3-6 months if treatment failure or if clinically indicated. *In accordance with the HRSA HAB performance measures, the local program defines consistently suppressed viral load as <200 copies/ml.*

21. **Genotypic Resistance Testing (PR/RT Genes)** [i] – At entry into care; at ART initiation or modification; if treatment failure or clinically indicated. Standard genotypic drug-resistance testing in ART-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP, PEP, or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the integrase gene. In people who are ART-naïve patient and who do not immediately begin ART, repeat testing before initiating of ART is optional if drug-resistance testing was performed at entry into care. In people with virologic suppression who are switching therapy because of toxicity or for convenience, viral amplification will not be possible; see the Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

22. **Genotypic Resistance Testing (Integrase Genes)**[i] – At entry into care, if transmitted INSTI resistance is suspected or if there is a history of cabotegravir long acting (CAB-LA) use for PrEP or INSTI use for PEP; at ART initiation or modification, if transmitted INSTI resistance is suspected or if there is a history of INSTI use; at treatment failure if there is a history of INSTI use for treatment or prevention; or clinically indicated. Standard genotypic drug-resistance testing in ART-naïve persons should focus on testing for mutations in the PR and RT genes. If transmitted INSTI resistance is a concern, or if a person has a history of INSTI use in PrEP, PEP, or treatment, or a person presents with viremia while on an INSTI, providers also should test for resistant mutation in the integrase gene. In people who are ART-naïve patient and who do not immediately begin ART, repeat testing before initiating of ART is optional if drug-resistance testing was performed at entry into care. In people with virologic suppression who are switching therapy because of toxicity or for convenience, viral amplification will not be possible; see the Drug-Resistance Testing section for a discussion of the potential limitations and benefits of proviral DNA assays in this situation. Results from prior drug-resistance testing should be considered because they can be helpful in constructing a new regimen.

23. **HIV viral load** [i] – Entry into Care; at ART initiation or modification; 4-8 weeks after ART initiation or modification if HIV RNA is still detectable, repeat testing every 4-8 weeks until viral load is suppressed to <50 copies/mL. Thereafter, repeat testing every 3-6 months. For patients on ART, viral load typically is measured every 3-6 months. More frequent monitoring may be considered in individuals having difficulties with ART adherence or at risk for nonadherence. However, for adherent patients with consistently suppressed viral load and stable immunologic status for more than 1 year, monitoring can be extended to 6-month intervals but is still necessary for stable patients; if ART initiation is delayed, repeat testing is optional; or if treatment failure or if clinically indicated.

24. **HLA-B*5701** [i] – At ART initiation or modification if considering start of abacavir (ABC) performed once and keep results in health record. *(Currently not paid for by the Ryan White Program due to payer of last resort restrictions; must access ViiV sponsored testing directly through labs. For LabCorp, HLA-AWARE HLA-B*5701 ViiV code #006940 and for Quest Diagnostic ViiV HLA-B*B5701 test code #19774).*

25. **Treatment of opportunistic infections and prophylaxis for opportunistic infections** [ii] – Specifically, but not limited to, Mycobacterium avium complex (MAC), Pneumocystis jirovecii pneumonia (PCP), and Toxoplasmosis (Toxo) prophylaxis per DHHS Guidelines.

26. **Tropism testing** [i] – At ART initiation or modification if considering a CCR5 antagonist; or for treatment failure if considering a CCR5 antagonist, or upon virologic failure on a CCR5 antagonist; or if clinically indicated. If performed, record carried forward to most current volume.

Immunizations

Document in medical record carrying data forward to most current volume

27. **COVID-19 vaccination** [v] – Vaccinate per CDC guidance.

28. **Hepatitis A vaccination** [v] – Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hep A IgG antibody or Hep A Total antibody.

29. **Hepatitis B vaccination** [v] – Offer vaccination if not immune per guidance. Assess for response 30-60 days after vaccination by performing Hepatitis B surface antibody quantitative (anti-HBs).

30. **Human Papillomavirus (HPV) Vaccine** [v] – HPV vaccination as indicated by current guidelines.

31. **Influenza vaccination** [v] – Offer IIV3 or RIV3 annually.

32. **Meningococcal vaccination** [v] – Use 2-dose series Menveo or MenQuadfi at least 8 weeks apart and revaccinate every 5 years if risk remains. See vaccination guidelines.

33. **Mpox vaccination** [v] – Vaccinate per CDC guidance. Additional information at: https://www.cdc.gov/mpox/hcp/vaccine-considerations/index.html

34. **Pneumococcal vaccination** [v] –Vaccinate per guidelines**.** For guidance on which pneumococcal vaccine should be used go to: https://www2a.cdc.gov/vaccines/m/pneumo/pneumo.html.

35. **Tetanus, diphtheria, pertussis (Td/Tdap)** [v] – One dose Tdap, then Td or Tdap booster every 10 years.

36. **Varicella** [v] – Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD4 count <200 cells/mm^3.

37. **Zoster vaccination** [v] — Use 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2-6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). See vaccination guidelines for detailed information and considerations: https://www.cdc.gov/shingles/hcp/vaccine-considerations/immunocompromised-adults.html**.**

STI Screenings

38. **Anal ~~Dysplasia~~ Cancer Screening** [iii] – ~~All patients with HIV should have digital anorectal exam performed at least annually if asymptomatic. Anal pap: screen transgender women and men over 35 years of age who have sex with men, and all other people with HIV over 45 years of age, with anal Pap smears if there is access to, or ability to, refer for high-resolution anoscopy and treatment. Abnormal anal Pap should prompt referral for high-resolution anoscope. Additional information at:~~
~~HIV Clinical Guidelines Now Recommend High Resolution Anoscopy as Part of Anal Cancer Screening Program for People with HIV | National Institutes of Health~~
Digital anorectal exam: perform at least annually if asymptomatic. Anal Pap: screen individuals >35 years who have sex with men and all other people with HIV aged >45 years, with anal Pap smears if there is access to or ability to refer for high-resolution anoscopy and treatment. Abnormal anal Pap tests should prompt referral for high-resolution anoscopy.

39. **Bacterial STIs (Syphilis**, **N. gonorrhoeae** (GC), **C. trachomatis** (Chlamydia) and **parasitic STIs (Trichomoniasis)** [ii] – At the initial HIV care visit, providers should test all sexually active persons with HIV infection for curable STDs (e.g., syphilis, gonorrhea, and chlamydia) and perform testing at least annually during the course of HIV care. More frequent screening might be appropriate depending on individual risk behavior and the local epidemiology. Additional information at https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Footnotes

[i] Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines. Accessed on November 13, 2024.

[ii] Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new. Accessed on December 16, 2024.

[iii] Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2024 Update by the HIV Medicine Association of the Infectious Diseases Society of America. https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciae479/7818967. Accessed November 13, 2024.

[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines. Accessed November 13, 2024.

[v] Recommended Adult Immunization Schedule for Ages 19 years or older, United States, 2025. https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-schedule-vaccines.html. Accessed December 16, 2024.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, January 23, 2026
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

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II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
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XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com

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

Client's Full Name

~~Preferred Name~~**Prescriber's Full Name**

~~Date of Birth~~**Prescriber Telephone #**

~~Prescriber Full Name~~**Date of Birth**

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

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

2) Insulin 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

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

Continuous Glucose Devices
Pricing Estimates

Device Names	Sensor Life	Device costs range	Sensor costs range for month^	Comments
Free Style Libre 2	14 days	$71-$84	$147-173	Uses FreeStyle Libre 2 reader or smart phone app
Free Style Libre 2 Plus	15 days		$158-186	Uses FreeStyle Libre 2 reader or smart phone app. Each sensor for this product comes with its own single-use applicator in the box.
FreeStyle Libre 14 day	14 days		$147-173	
FreeStyle Libre 3	14 days	$72-88	$147-173	Uses FreeStyle Libre 3 reader or smart phone app
FreeStyle Libre 3 Plus	15 days		$158-186	Uses FreeStyle Libre 3 reader or smart phone app
*Dexcom G6**	10 days	$386-456 +transmitter cost	$382-485	Requires transmitter which needs replacing every 3 months (at an additional cost)
Dexcom G7	10 days	$302-$374	$381-727	All in one sensor and transmitter

Notes:
^Depending on device, month range is from 28-30 days.
List derived from: https://pro.aace.com/cgm/toolkit/cgm-device-comparison
Costs are rounded to whole number and do not include dispensing fee.

MIAMI-DADE HIV/AIDS PARTNERSHIP

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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 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:
_____

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APPROVED: 2-28-24

MIAMI-DADE HIV/AIDS PARTNERSHIP

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Memo

To: Medical Care Subcommittee Members

From: Marlen Meizoso

Date: November 21, 2025

Re: 2026 Officer Nominations and Elections

Nominations for the Medical Care Subcommittee Chair and Vice Chair (Officers) will take place during the Medical Care Subcommittee meeting November 21, 2025. Elections are scheduled for the January 23, 2026, meeting.

Serving as an Officer is an excellent opportunity to strengthen your leadership skills, enhance your resume, and take a more active role within the Planning Council.

Committee Officers work with support staff to develop meeting agenda, lead committee discussions, and serve as members of the Executive Committee. Comprehensive training and ongoing support are provided for all Officers.

For your reference, below are the Officers qualifications are outlined in Section 5.1 of the Miami-Dade HIV/AIDS Partnership:

- Each standing committee, subcommittee, or workgroup shall elect a Chair and a Vice-Chair from among its members; they shall serve at the will of the standing committee, subcommittee, or workgroup.
- Officers shall be full voting members.
- At least one (1) officer of each standing committee must be a Partnership member who shall be designated to report committee activities to the Partnership.
- Standing committees, committees, and workgroups shall strive to elect at least one (1) officer who is a person with HIV.
- No individual shall serve concurrent terms as an officer of the Partnership and an officer of a standing committee or subcommittee. The exception to this rule is for officers of workgroups, which may be led by the Chair as Chair or Vice-Chair of the committee under whose purview the workgroup was authorized.

You are encouraged to submit your name as a nominee in advance of the meeting; however, nominations will also be taken from the floor at the January 23, 2026, meeting. Current Officers who have served less than two years are eligible and encouraged to seek re-election. If you are interested in this opportunity or if you have any questions, please contact me at (305) 445-1076 or by email at marlen@behavioralscience.com.

MIAMI-DADE HIV/AIDS PARTNERSHIP

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MIAMI-DADE
HIV/AIDS PARTNERSHIP

New Member Orientation

Orientation is a requirement for new members and a great opportunity to learn about the Partnership - Miami-Dade County's Ryan White Planning Council!

February 4, 2026

1:00 pm to 4:00 PM

Register via QR Code or at:
https://bit.ly/Feb_04_2026NMO

MIAMI-DADE HIV/AIDS PARTNERSHIP

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IX.	Oral Health Care Items: OHC Standards and Oral Health Care 2026 Service Definition Revisions	All
X.	Standing Business	
	• 2026 Service Definition Revisions-Mental Health and Substance Abuse	All
	• Allowable Conditions Response to "Dear Colleague" Letter	All
	• Minimum Primary Care Standards Review	All
	• Edits to Letters of Medical Necessity-CGM and Food Bank	All
XI.	New Business	
	• 2026 Elections	All
XII.	Announcements and Open Discussion	All
XIII.	Next Meeting**: February 27, 2026** at **BSR**	Cristhian Ysea
XIV.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

For more information, regarding the Miami-Dade HIV/AIDS Partnership's Medical Care Subcommittee please contact Marlen Meizoso at 305-445-1076 or marlen@behavioralscience.com