MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, May 15, 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	Cristhian Ysea
II.	Introductions	All
III.	Meeting Housekeeping	Cristhian Ysea
IV.	Floor Open to the Public	Dr. Lawrence Friedman
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of April 24, 2026	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Allowable Conditions Response to "Dear Colleague" Letter Continued	All
	• Contingency Planning Continued:	
	• Outpatient Ambulatory Health Services Review--Vaccines	All
	• Ryan White Prescription Drug Formulary	All
	• Oral Health Care Item: D6095, Repair of Implant Abutment--discontinued	All
	• 2026 Calendar of Activities	All
IX.	New Business	
	• Special Projects Discussion	All
X.	Announcements	All
	• Get on Board Training, June 3, 2026	
XI.	Next Meeting**: June 26, 2026** at **BSR**	Dr. Lawrence Friedman
XII.	Adjournment	Cristhian Ysea

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Housekeeping Highlights

Meeting is being recorded and are part of public record.

Refrain from side-bar conversations to avoid Florida in the Govemment violations.

Only members of the Subcommittee can vote on items

Members shall **not act in their own private** or **personal interests** and will strive to handle all individuals, matters, and business with fairness and equity.

Raise your hand to be called upon by the chair.

Time limits may be placed on items.

Terms are on the back of the agenda.

Place your cell phone **on mute or vibrate.**
If you must take a call, please excuse yourself from the meeting.

Remember to **use people first language.**

If you did not get meeting materials, you can follow along on the screen or via the QR code on the agenda since materials are posted online.

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

April 24, 2026, Minutes

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

Guests
Alcala, Carolina
Ortiz, Angela
Valle-Schwenk-Carla
Staff
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 9:42 a.m. He introduced himself, provided an overview of the work for the day's meeting, indicated discussions may have time restrictions to complete tasks, 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 streamlined meeting housekeeping summary.

IV. Floor Open to the Public — *James Dougherty*

Mr. Dougherty 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 accepted it as presented.

Motion to accept the agenda as presented.
Moved: Yendi Serrano-Irizarry Seconded: Dr. Lawrence Friedman Motion: Passed

VI. Review/Approve Minutes of March 27, 2026 *All*

Members reviewed the minutes of March 27, 2026, and made a motion to accept the document as presented.

Motion to accept the minutes of March 27, 2026, as presented.
Moved: Yendi Serrano-Irizarry Seconded: Dr. Lawrence Friedman Motion: Passed

VII. Reports

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

Carla Valle-Schwenk provided the Ryan White Program report. The Recipient is continuing to work through the ADAP challenges. Earlier in the week a Ryan White Subrecipient Forum was held and programmatic updates were provided; these will be shared with staff to forward to the Subcommittee. Funding has been provided to the ADAP program to provide direct dispense to clients up to 400% FPL through June. Additional funding is being sought to fill the gap for the remainder of the year. The Recipient is working on the final close out of Fiscal Year (FY) 2025 reimbursements and 95% of the Formula portion of the grant award will likely be spent. The RWP appears to have served fewer clients in FY 2025 than in FY 2024. A partial award was received for the current fiscal year earlier in the year, and the remaining award should be provided in June. The Ending the HIV Epidemic award will likely be received in May. No contingencies have been implemented yet. Solutions to limited access to Biktarvy are still being explored.

- **ADAP** *Dr. Javier Romero*

Dr. Javier Romero shared information from the ADAP report of March 2026, as of April 9, 2026. Between March 2025-April 2026, 8,411 clients were served, which is 111 fewer clients than last year. Total expenditures were $70,224,388 but do not include the direct-dispense clients and those served through the pharmacy benefits manager, which is an additional estimated $3-5 million. Most clients received 90 days of medications. The ADAP database system appears to have problems, since previous viral suppression rates were between 93%-96%, and the current reported rates are between 75%-78%.

- **Vacancy Report** *Marlen Meizoso*

Marlen Meizoso reviewed the April 2026 vacancies, which indicated several membership

opportunities on the Partnership and the Subcommittee. She indicated today was Ivet Baez's last day as a member since she has termed off the Subcommittee, so the Subcommittee is in need of a pharmacist. Currently there are vacancies for a physician, mental health professional, and members living with HIV. Any individuals interested in membership, and who are Miami-Dade County registered voters, may contact staff; prospective members will be invited to attend a meeting or training sessions.

VIII. Standing Business

- **2026 Agenda Item Discussion** *Marlen Meizoso*

In the meeting materials, a copy of the Committee calendar of activities. The Subcommittee had been working on contingency planning in response to the ADAP crisis, and while they will be addressing some deferred items today, several items are still pending: these items will likely not be completed without additional meetings or extending time at meetings. The Subcommittee indicated they would defer continued review of the Primary Medical Care Standards until the Fall, when it would normally take place. Since several members indicated they had a meeting conflict on the next regularly scheduled meeting May 22, 2026, they opted to move the meeting up one week to May 15, 2026, to ensure work continues to be addressed. An updated calendar will be provided at the next meeting.

- **Officer Elections** *All*

Officer elections had been deferred from the meeting in January, and were addressed at the meeting. The election memo previously distributed was reviewed and indicated that the chair and vice chair have served their two-year term. Christhian Ysea indicated he would be interested in serving as Chair and Dr. Lawrence Friedman indicated he was interested in serving as Vice Chair. The Subcommittee moved to elect these two persons to these positions.

Motion to elect Cristhian Ysea, Chair, and Dr. Lawrence Friedman, Vice Chair of the Medical Care Subcommittee.
Moved: Juliet Miller **Seconded: Dr. Vanessa Rojas** **Motion: Passed**

Mr. Dougherty thanked the Subcommittee for the opportunity to serve as Chair over the past two years, and the members thanked him for his service.

- **Service Definitions Deferred: Mental Health, Substance Abuse, Oral Health** *All*

The mental health, substance abuse, and oral health service definitions were deferred items from January. Requested edits from prior meetings were included for review, and were accepted; those elements which do not apply in FY 2026 because of the delayed RFP, such as new service references, were removed and these changes were incorporated into the current drafts. The Subcommittee reviewed each service description and approved all three.

Motion to accept the FY 2026 Ryan White Program Mental Health Service Description as presented.
Moved: Yendi Serrano-Irizarry **Seconded: Dr. Vanessa Rojas** **Motion: Passed**

Motion to accept the FY 2026 Ryan White Program Substance Abuse Outpatient Care and Substance Abuse Services (Residential) Service Description as presented.
Moved: Dr. Lawrence Friedman Seconded: Dr. Javier Romero Motion: Passed

A reference to non-medical case management was erroneously included, and will be stricken from the oral health care service description draft. The Subcommittee approved the service description with the edit.

Motion to accept the FY 2026 Ryan White Oral Health Service Description as edited.
Moved: Juliet Miller Seconded: Dr. Javier Romero Motion: Passed

- **Service Definitions Revisited: Prescription Drugs and Outpatient Ambulatory Health Services** *All*

The prescription drug and outpatient ambulatory health service descriptions were revisited because new services included in the upcoming RFP had not taken place in FY 2025. The current draft has references to those services removed. The Subcommittee reviewed the revised service descriptions and approved them as presented.

Motion to accept the FY 2026 Ryan White Program AIDS Pharmaceutical Assistance (Local Pharmaceutical Assistance Program-LPAP) Service Description as presented.
Moved: Juliet Miller Seconded: Dr. Javier Romero Motion: Passed

Under Outpatient Ambulatory Health Services, the references highlighted in green are Recipient billing references, which will be updated upon receipt of the information.

Motion to accept the FY 2026 Ryan White Program Outpatient Ambulatory Health Services Description as discussed.
Moved: Dr. Lawrence Friedman Seconded: Dr. Juliet Miller Motion: Passed

- **Oral Health Care (OHC) Standards Revisions** *All*

The Oral Health Care Standards revisions were also deferred from January. The requested edits to the Oral Health Care Standards were incorporated into the draft, and the Subcommittee reviewed the document. The following additional edits were recommended:

- Add “Program” after references to Ryan White on pages 1 and 2;
- Add hyphen between HIV relate; and
- Add “d” to relate.

Motion to accept the FY 2026 Ryan White Program Oral Health Care Standards as discussed.
Moved: Juliet Miller Seconded: Yvette Rodriguez Motion: Passed

- **Edits to Letters of Medical Necessity-Continuous Glucose Monitors (CGM) and Food Bank** *All*

Edits to the Letters of Medical Necessity for continuous glucose monitors and food bank were other deferred item. Edits had been made to the continuous glucose monitor letter and estimated cost for expanding or changing glucose monitors was provided. The Subcommittee discussed the impact of picking one device over another, so that the practitioner could select the one that best fits the client and must be cost effective. The Subcommittee made the following edits to the letter:

- Leave the brand name but remove specific device models;
- Keep both references to prescriber without an apostrophe s;
- Change insulin in criteria 1 and 2 to diabetes; and
- Add two clauses to the letter that the most cost-effective option must be selected and that if the client wishes to use their smart phone, no reader is required.

This item can be revisited in six months.

Motion to accept the FY 2026 Ryan White Program Letter of Medical Necessity for Continuous Glucose Monitors as discussed.
Moved: Dr. Vanessa Rojas Seconded: Yendi Serrano-Irizarry Motion: Passed

No changes were being recommended to the nutritional assessment letter for food bank, but the Subcommittee deemed some of the language in the green box of the letter was a little confusing. The letter should have "which will assist with" stricken and replaced with "to".

Motion to accept the FY 2026 Ryan White Program Nutritional Assessment for Extension of Occurrences of Food Bank Services as discussed.
Moved: Dr. Lawrence Friedman Seconded: Yvette Rodriguez Motion: Passed

- **Contingency Planning Continued:**

  - **Outpatient Ambulatory Health Services (OAHS) Review** *All*

    At the last meeting, the OAHS utilization report for FY 2024-2025 was shared: the Subcommittee requested additional details on the outliers (max) column, which was provided and reviewed by the Subcommittee. Additional data were requested exclusively for vaccines, and these data will be presented at the next meeting.

  - **Ryan White Prescription Drug Formulary** *All*

    Staff provided a working draft of the Ryan White formulary (last version) for April 2026 re-sorted by therapeutic classification, then pharmacological classification, then brand name. ARVs because they are coded differently under the therapeutic column, are spaced through the document but highlighted in pink. For review purposes it was suggested to move the ARVs highlighted in pink to the beginning of the document. Since time was running short for the meeting and most members could not stay late, this item will be brought back to the next meeting.

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

This item was also deferred from January, and was one of the primary tasks the Subcommittee was actively working on last year. The Subcommittee determined to review the deferred section and to

review items under dermatology at the next meeting. Staff will post items as quickly as possible, so members have an opportunity to review the documents before the next meeting.

IX. New Business *All*

There were no new business items.

X. Announcements *All*

The next Get on Board training was announced and will take place on May 6, 2026. The training is held on Microsoft Teams and individuals can register via the QR code or click the link imbedded in the notice that was sent out Wednesday.

XI. Next Meeting *James Dougherty*

The next meeting is scheduled for Friday, May 15, 2026, at 9:30 a.m. at the BSR conference room.

XII. Adjournment *James Dougherty*

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

Motion to adjourn.
Moved: Dr. Vanessa Rojas **Seconded: Dr. Lawrence Friedman** **Motion: Passed**

The meeting adjourned at 11:30 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: **February 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

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

Total unduplicated clients (month): 3,886

Total unduplicated clients (YTD): 9,194

This updated FY 2025 Monthly and Year-to-Date Service Utilization Summary for services through February 2026 is being provided as part of ongoing grant closeout activities. Although a report for the same service period was shared in April 2026, the current report reflects the most up-to-date information available as of 5/11/2026. Some monthly and corresponding year-to-date service unit totals decreased due to disallowed services identified during the closeout review process. The total unduplicated year-to-date client count remains unchanged.

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 05/11/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **February 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

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

Total unduplicated clients (month): 2,913

Total unduplicated clients (YTD): 9,089

REPORT COMPILED ON: 05/11/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **February 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

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

Total unduplicated clients (month): 1,400

Total unduplicated clients (YTD): 2,454

REPORT COMPILED ON: 05/11/2026

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

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR35

FORMULA AND SUPPLEMENTAL FUNDING

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

This report includes FY 2025 paid reimbursements for Part A service months through February 2026, as of 5/11/2026. The report reflects reimbursement requests due by 3/20/2026 that have been processed and paid thus far. Pending reimbursement requests currently under review total $282,999.19 for Part A. The Recipient remains in the grant closeout process. Final FY 2025 Part A expenditures will be provided upon completion of grant closeout activities.

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	5,744.00		
6	Health Insurance Services	490,526.00		
1	Medical Case Management	6,377,000.00		
3	Mental Health Therapy/Counseling	54,303.00		
4	Oral Health Care	4,631,775.00		
2	Outpatient/Ambulatory Health Svcs	7,007,729.00		
9	Substance Abuse - Outpatient	3,000.00		
	CORE Services Totals:	18,570,077.00		

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

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

Core medical % against Total Direct Service Allocation (Not including C/O):		
Cannot be under 75%	**87.38%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**2.49%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**9.78%**	**Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

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

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

TOTAL EXPENDITURES DIRECT SVCS & % :		**$ 21,717,912.11**	**98.48%**
Formula Expenditure %	**95.99%**		
5606710000 **Recipient Administration**	**2,056,627.07**	**86.82%**	
5606880000 **Quality Management**	**602,153.97**		2,658,781.04
Grant Unexpended Balance	**FY 2025 Award**	**Carryover**	
	647,958.85	**(0.00)**	647,958.85
Total Grant Expenditures & %		**$ 24,376,693.15**	**97.41%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**87.70%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**2.49%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**8.49%**	**Within Limit**

Printed On: 5/11/2026

MAI

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

This report includes FY 2025 paid reimbursements for MAI service months through February 2026, as of 5/11/2026. The report reflects reimbursement requests due by 3/20/2026 that have been processed and paid thus far. Pending reimbursement requests currently under review total $79,304.11 for MAI. The Recipient remains in the grant closeout process. Final FY 2025 MAI expenditures will be provided upon completion of grant closeout activities.

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	
	AIDS Pharmaceutical Assistance			
	Health Insurance Services			
1	Medical Case Management	969,689.00	307,830.00	1,277,519.00
3	Mental Health Therapy/Counseling	18,960.00		
	Oral Health Care			
2	Outpatient/Ambulatory Health Svcs	873,094.63	846,658.37	1,719,753.00
6	Substance Abuse - Outpatient	8,058.00		
	CORE Services Totals:	1,869,801.63	1,154,488.37	3,024,290

Priority Order	Support Services	Allocations	Carryover Allocations
5	Emergency Financial Assistance	0.00	
	Food Bank		
13	Medical Transportation	14,628.00	
	Other Professional Services		
7	Outreach Services	39,816.00	
	Substance Abuse - Residential		
	SUPPORT Services Totals:	54,444.00	0.00
	FY 2025 Award (not inlcuding C/O)	1,924,245.63	
	Carryover Award		1,154,488.37

DIRECT SERVICES TOTAL:	**$**	**3,078,734.00**
Total Core Allocation	1,869,801.63	
Target at least 80% core service allocation	1,539,396.50	
Current Difference (Short) / Over	**$ 330,405.13**	
Recipient Admin. (OMB-GC)	**$ 256,369.00**	
Quality Management	**$ 100,000.00**	356,369.00
(+) Unobligated Funds / (-) Over Obligated:		
Unobligated Funds (MAI)	**$ 283,082.37**	
Unobligated Funds (Carry Over)	**$ 384,663.63**	667,746.00

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

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures	
5606970000	AIDS Pharmaceutical Assistance			
5606920000	Health Insurance Services			
5606870000	Medical Case Management	792,192.45	307,830.00	1,100,022.45
5606860000	Mental Health Therapy/Counseling	0.00		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	5,204.46	717,453.98	722,658.44
5606910000	Substance Abuse - Outpatient	0.00		
	CORE Services Totals:	797,396.91	1,025,283.98	

Account	Support Services	Expenditures	Carryover Expenditures
5606940000	Emergency Financial Assistance	0.00	
5606980000	Food Bank		
5606460000	Medical Transportation	14,281.18	
5606890000	Other Professional Services		
5606950000	Outreach Services	39,816.00	
5606930000	Substance Abuse - Residential		
	SUPPORT Services Totals:	54,097.18	0.00
	FY 2025 Award (not inlcuding C/O)	851,494.09	

TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 1,876,778.07**	**60.96%**
5606710000	**Recipient Administration**	**185,492.89**	**72.35%**
5606880000	**Quality Management**	**100,000.00**	285,492.89

	FY 2025 Award	Carryover	
Grant Unexpended Balance	**1,426,710.02**	**513,868.02**	1,940,578.04
Total Grant Expenditures & % (Including C/O):		**$ 2,162,270.96**	**52.70%**

Core medical % against Total Direct Service Expenditures (Not including C/O):		
Cannot be under 75%	**93.65%**	**Within Limit**
Quality Management % of Total Award (Not including C/O):		
Cannot be over 5%	**3.90%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O):		
Cannot be over 10%	**7.24%**	**Within Limit**

Printed On: 5/11/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **March 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A
Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	7	7	4	4
Medical Case Management	10,150	10,150	4,724	4,724
Mental Health Services	36	36	19	19
Oral Health Care	958	958	678	678
Outpatient Ambulatory Health Services	2,555	2,555	1,538	1,538
Support Services				
Food Bank/Home Delivered Meals	739	739	294	294
Medical Transportation	476	476	221	221
Outreach Services	56	56	32	32
Substance Abuse Services (residential)	439	439	19	19
TOTALS:	15,416	15,416		

Total unduplicated clients (month): 5,449

Total unduplicated clients (YTD): 5,449

See page 4 for Service Unit Definitions

REPORT COMPILED ON: 05/08/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **March 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White Part A

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	7	7	4	4
Medical Case Management	7,635	7,635	3,681	3,681
Mental Health Services	36	36	19	19
Oral Health Care	958	958	678	678
Outpatient Ambulatory Health Services	2,451	2,451	1,487	1,487
Support Services				
Food Bank/Home Delivered Meals	739	739	294	294
Medical Transportation	438	438	183	183
Outreach Services	51	51	28	28
Substance Abuse Services (residential)	439	439	19	19
TOTALS:	12,754	12,754		

Total unduplicated clients (month): 4,721

Total unduplicated clients (YTD): 4,721

REPORT COMPILED ON: 05/08/2026

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FOR THE PERIOD OF: **March 2026**

FUNDING SOURCE(S) INCLUDED:

Ryan White MAI

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	2,515	2,515	1,199	1,199
Outpatient Ambulatory Health Services	104	104	79	79
Support Services				
Medical Transportation	38	38	38	38
Outreach Services	5	5	4	4
TOTALS:	2,662	2,662		

Total unduplicated clients (month): 1,224

Total unduplicated clients (YTD): 1,224

REPORT COMPILED ON: 05/08/2026

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.

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.

MDC-RWP CLINICAL QUALITY MANAGEMENT (CQM) PERFORMANCE REPORT CARD

FY 2025-2026, Cycle 4

REVISION DATE: 04/15/2026 REVISION: A

Disclaimer: Data indicates key HAB/HRSA Care Continuum health outcome measures for Ryan White Program clients. See variable explanation for details on how outcomes were computed.

QM PROGRAM INDICATORS		RWP	
HIV Care Continuum			
C1.	Total RWP Clients		9,256
C2.	In medical care (IMC, TG ≥ 95%)	95%	8,767
C3.	Retained in medical care (RiMC, TG ≥ 90%)	82%	7,616
C4.	RWP Clients w/ suppressed VL (TG ≥ 95%)	88%	8,171
C5.	RWP Clients w/ missing VL data (TG ≤ 5%)	7%	665
Medical Case Management (MCM)			
M1.	Active MCM Clients		7,646
M2.	MCM Clients IMC (TG ≥ 95%)	100%	7,616
M3.	MCM Clients RiMC (TG ≥ 90%)	91%	6,989
M4.	MCM Clients w/ suppressed VL (TG ≥ 95%)	94%	7,224
M5.	MCM Clients w/ missing VL data (TG ≤ 5%)	1%	78
M6.	MCM Clients w/ 2 or more Plans of Care updated/developed 90 or more days apart (TG ≥ 95%)	93%	6,566
M6a.	MCM Clients eligible for M6		7,080
M7.	MCM Clients w/ MCM contact in less than or equal to 90 days (TG ≥ 95%)	86%	6,534
M7a.	MCM Clients eligible for M7		7,554
M8.	MCM Clients receiving oral health care (TG ≥ 50%)	35%	2,705
M9.	MCM Clients without a Gap in HIV VL Measurements	89%	6,085
M9a.	MCM Clients eligible for M9		6,811
M10.	MCM Clients without a Gap in HIV Medical Visits	95%	6,726
M10a.	MCM Clients eligible for M10		7,100
Outpatient/Ambulatory Health Services (OAHS)			
N1.	Active OAHS Clients		6,074
N2.	**OAHS Clients IMC (TG ≥ 95%)**	100%	6,074
N3.	OAHS Clients RiMC (TG ≥ 90%)	91%	5,542
N4.	**OAHS Clients w/ suppressed VL (TG ≥ 95%)**	93%	5,663
N5.	OAHS Clients w/ missing VL data (TG ≤5%)	2%	115
	Oral Health Care (OHC)		
D1.	OHC Clients treated by subrecipients		3,030
D2.	OHC Clients w/ annual oral exam (TG ≥ 75%)	74%	2,248

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MDC-RWP CLINICAL QUALITY MANAGEMENT (CQM) PERFORMANCE REPORT CARD

FY 2025-2026, Cycle 4

REVISION DATE: 04/15/2026 REVISION: A

Health Insurance Premiums and Cost Sharing Assistance (HIPCSA)			
A1.	Active Clients with ACA Insurance		3,234
A3.	ACA Clients RiMC	87%	2,806
A4.	ACA Clients with suppressed VL	93%	3,002
A5.	ACA Clients with missing VL Data	5%	160
H1.	Active Clients Utilizing HIPCSA Service Category	67%	2,179
H3.	HIPCSA Utilizers RiMC	96%	2,089
H4.	HIPCSA Utilizers with suppressed VL	96%	2,090
H5.	HIPCSA Utilizers with missing VL Data	2%	54
G1.	Active HIPCSA Clients Utilizing a GAP Card	96%	2,093
G3.	GAP Card Utilizers RiMC	97%	2,020
G4.	GAP Card Utilizers with suppressed VL	96%	2,009
G5.	GAP Card Utilizers with missing VL Data	2%	49

RYAN WHITE PROGRAM: CLINICAL QUALITY MANAGEMENT INDICATOR DESCRIPTIONS	
Health Insurance Premiums and Cost Sharing Assistance (HIPCSA)	
A1.	**Active Clients with ACA Insurance:** Number of unduplicated RWP Clients (C1) with ACA Insurance.
A3.	**ACA Clients RiMC:** Percent of ACA Clients (A1) retained in medical care (as defined in C3).
A4.	**Total ACA Clients with a suppressed VL:** Percent of active ACA Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All active ACA Clients (A1). **Numerator:** All active ACA Clients with a documented suppressed VL in the most recently reported lab test, in the 12-month reporting period.
A5.	**ACA Clients w/ missing VL data:** The percent of ACA Clients that did not have a VL test in the reporting period, regardless of outcome. **Denominator:** All active ACA Clients (A1). **Numerator:** All active ACA Clients that did not have 1 or more VL test(s) in the 12-month reporting period.
H1.	**Active Clients Utilizing HIPCSA Service Category:** Number of unduplicated RWP Clients (C1) who utilized the HIPCSA Service Category during the reporting period.
H3.	**HIPCSA Utilizers RiMC:** Percent of HIPCSA utilizers (H1) retained in medical care (as defined in C3).
H4.	**HIPCSA Utilizers with a suppressed VL:** Percent of active HIPCSA Service Category Utilizing Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All active HIPCSA Utilizing Clients (H1). **Numerator:** All active HIPCSA Utilizing Clients with a documented suppressed VL in the most recently reported lab test, in the 12 month reporting period.
H5.	**HIPCSA Utilizers w/ missing VL data:** The percent of HIPCSA Utilizing Clients that did not have a VL test in the reporting period, regardless of the outcome. **Denominator:** All active HIPCSA Utilizing Clients (H1). **Numerator:** All active HIPCSA Utilizing Clients that did not have 1 or more VL test(s) in the 12-month reporting period.
G1.	**Active Clients Utilizing the GAP Card:** Number of unduplicated RWP Clients (C1) who utilized a GAP Card during the reporting period.
G3.	**GAP Card Utilizers RiMC:** Percent of GAP Card utilizers (G1) retained in medical care (as defined in C3).
G4.	**GAP Card utilizers with a suppressed VL:** Percent of active GAP Card Utilizing Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All active GAP Card Utilizing Clients (H1). **Numerator:** All active GAP Card Utilizing Clients with a documented suppressed VL in the most recently reported lab test, in the 12-month reporting period.
G5.	**GAP Card utilizers w/ missing VL data:** The percent of GAP Card Utilizing Clients that did not have a VL test in the reporting period, regardless of outcome. **Denominator:** All active GAP Card Utilizing Clients (H1). **Numerator:** All active GAP Card Utilizing Clients that did not have 1 or more VL test(s) in the 12-month reporting period.

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RYAN WHITE PROGRAM: CLINICAL QUALITY MANAGEMENT INDICATOR DESCRIPTIONS

HIV Care Continuum

C1.	**Total RWP Clients:** Number of unduplicated RWP Clients receiving at least one billed RWP service from any subrecipient during the 12-month reporting period. Subrecipient totals are based on all billed events at that agency during the reporting period.
C2.	**Total Clients In Medical Care (IMC: Target goal ≥95%):** Percent of active RWP Clients in medical care. **Denominator:** All RWP Clients (C1). **Numerator:** RWP Clients receiving one or more medical visits with any RWP provider with prescribing privileges, or VL test, or medical visit copay during the 12 month reporting period.
C3.	**Total Clients Retained in Medical Care (RiMC: Target goal ≥90%):** Percent of RWP Clients retained in medical care. **Denominator:** All RWP Clients (C1). **Numerator:** RWP Clients receiving 2 or more: medical visits with a provider, VL test, or medical visit copay, 90 or more days apart, in the past 12 months.
C4.	**Total Clients with a suppressed VL (Target goal ≥95%):** Percent of RWP Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All RWP Clients (C1). **Numerator:** RWP Clients with a documented suppressed VL in the most recently reported lab test.
C5.	**Total RWP Clients w/ missing VL data (Target goal ≤5%):** The percent of RWP Clients that did not have at least one VL test in the reporting period, regardless of outcome. **Denominator:** All RWP Clients (C1). **Numerator:** All RWP Clients who did not have one or more VL test(s) in the 12-month reporting period.

Medical Case Management (MCM)

M1.	**Active MCM Clients:** Number of unduplicated RWP Clients (C1) with at least one MCM billed encounter in reporting period; excludes clients whose cases were closed (MCM Client Service Category Profile must currently be Open), and identified Out-of-Network Clients. The number of clients attached to a site is based on their assigned MCM Site, according to Provide.
M2.	**MCM Clients IMC (Target goal ≥95%):** Percent of MCM Clients (M1) in medical care (IMC), as defined in C2. **Denominator:** Total active MCM Clients (M1). **Numerator:** MCM Clients IMC.
M3.	**MCM Clients RiMC (Target goal ≥90%):** Percent of total MCM Clients (M1) who were retained in medical care (as defined in C3).
M4.	**Total Clients with a suppressed VL (Target goal ≥95%):** Percent of active MCM Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All active MCM Clients. **Numerator:** All active MCM Clients with a documented suppressed VL in the most recently reported lab test, in the 12 month reporting period.
M5.	**MCM Clients w/ missing VL data (Target goal ≤5%):** The percent of active MCM Clients that did not have at least one VL test in the reporting period, regardless of outcome. **Denominator:** All active MCM Clients (M1). **Numerator:** All active RWP Clients that did not have one or more VL test(s) in the reporting period.
M6.	**MCM Clients w/ 2 or more Plan of Care updated/developed 90 or more days apart:** Number of MCM Clients who had an Action Plan (e.g. POC) updated or developed 2 or more times AND were 90 or more days apart in the reporting period. **Denominator:** See M6a. **Numerator:** Clients with a POC developed or updated 2 or more times AND were 90 days or more apart in the reporting period. (A plan of care update is defined by a POC billed service)
M6a.	Eligible Clients for M6a: MCM Clients with any billed MCM service in the first 6 months of the reporting period.
M7.	**MCM Clients w/ MCM contact in 90 or less days:** MCM Clients who have had an MCM or PESN client contact, in person or virtual, in 90 or less days prior to the end of the reporting period. **Denominator:** See M7a. **Numerator:** MCM Clients that had an MCM and/or PESN contact in 90 or less days prior to the end of the reporting period (A client is considered to have been contacted if any of the following service codes were billed: ADH, FFE, TEL, THM, THP)
M7a.	**Eligible Clients for M7:** MCM Clients with any billed MCM service in the last 6 months of the reporting period.
M8.	MCM Clients receiving RWP Oral Health Care services: MCM Clients who had 1 or more billed RWP dental service in the 12-month reporting period. **Denominator:** All active RWP MCM Clients (M1). **Numerator:** MCM Clients incurring charges for any dental services in the reporting period, at any RWP OHC provider. **(Formerly M9 in previous Report Card iterations)**
M9.	**MCM Clients without a gap in HIV VL Measurements:** MCM Clients who had a viral load measurement during the first and last 6 months of the 12-month reporting period. **Denominator:** See M9a. **Numerator:** Clients that have a recorded viral load measurement in PE during the first and last 6 months of the reporting period.
M9a.	**Eligible Clients for M9:** MCM Clients with a VL measurement in the first 6 months of the reporting period.
M10.	MCM Clients without a gap in HIV Medical Care Visits: MCM Clients receiving medical care during the first and last 6 months of the 12-month reporting period. **Denominator:** See M10a. **Numerator:** RWP Clients receiving 1 or more: medical visits with a provider, VL tests, or medical visit copays, in the first and last 6 months of the reporting period.
M10a.	Eligible Clients for M10: MCM Clients with a VL test, medical visit, or medical visit copay, in the first 6 months of the reporting period.

MDC-RWP CLINICAL QUALITY MANAGEMENT (CQM) PERFORMANCE REPORT CARD

RYAN WHITE PROGRAM: CLINICAL QUALITY MANAGEMENT INDICATOR DESCRIPTIONS

Outpatient/Ambulatory Health Services (OAHS)

N1.	**Active OAHS Clients:** Number of unduplicated RWP Clients (C1) with at least one face-to-face (FFE) OR telehealth OAHS visit, OR Copay (Service Code: ACAOV OR APPOV) billed to a RWP subrecipient in the 12 months prior to the end of reporting period. Agency assignment is based on the site where the most recent OAHS service of the reporting period was billed. Excludes Clients whose cases were closed in the reporting period, or identified out-of-network Clients.
N2.	**OAHS Clients IMC (Target goal ≥95%):** Percent of OAHS Clients (N1) in IMC (as defined in C2). **Denominator:** Total active OAHS Clients (N1). **Numerator:** OAHS Clients IMC.
N3.	**OAHS Clients RiMC (Target goal ≥90%):** Percent of OAHS Clients (N1) retained in medical care (as defined in C3).
N4.	**Total Clients with a suppressed VL (Target goal ≥95%):** Percent of active OAHS Clients with a suppressed viral load (VL) (<200 copies/mL). **Denominator:** All active OAHS Clients (N1). **Numerator:** All active OAHS Clients with a documented suppressed VL in the most recently reported lab test, in the 12 month reporting period.
N5.	**OAHS Clients w/ missing VL data (Target goal ≤5%):** The percent of OAHS Clients that did not have at least one VL test in the reporting period, regardless of outcome. **Denominator:** All OAHS Clients (N1). **Numerator:** All active OAHS Clients that did not have one or more VL test(s) in the 12 month reporting period.

Oral Health Care (OHC)

D1.	**OHC Clients treated by subrecipients:** Number of Clients who received ANY oral healthcare service (includes teledentistry) in the reporting period. Clients are assigned to OHC sites based on most recent OHC visit in the 12 month reporting period.
D2.	**OHC Clients w/ annual oral exam (TG ≥ 75%):** Number of OHC Clients that received a clinical oral examination (COE)in the reporting period. A COE is defined by the following RWP Oral Health Care Formulary Codes: D0120, D0150, D0160, D0170, and D0180 (D0140 is purposefully EXCLUDED). **Denominator:** D1. **Numerator:** RWP Clients with at least 1 billed Clinical Oral Examination within the last 12 months. Clients are assigned to OHC sites based on most recent COE OHC visit in the reporting period.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, May 15, 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	Cristhian Ysea
II.	Introductions	All
III.	Meeting Housekeeping	Cristhian Ysea
IV.	Floor Open to the Public	Dr. Lawrence Friedman
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of April 24, 2026	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Allowable Conditions Response to "Dear Colleague" Letter Continued	All
	• Contingency Planning Continued:	
	• Outpatient Ambulatory Health Services Review--Vaccines	All
	• Ryan White Prescription Drug Formulary	All
	• Oral Health Care Item: D6095, Repair of Implant Abutment--discontinued	All
	• 2026 Calendar of Activities	All
IX.	New Business	
	• Special Projects Discussion	All
X.	Announcements	All
	• Get on Board Training, June 3, 2026	
XI.	Next Meeting**: June 26, 2026** at **BSR**	Dr. Lawrence Friedman
XII.	Adjournment	Cristhian Ysea

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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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Membership Report

April 24, 2026

The Miami-Dade HIV/AIDS Partnership

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

Opportunities for Ryan White Program Clients

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

Opportunities for General Membership

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

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

Are you a Member?

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

Do You Qualify for Membership?

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

Are you a resident of Miami-Dade County?

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

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

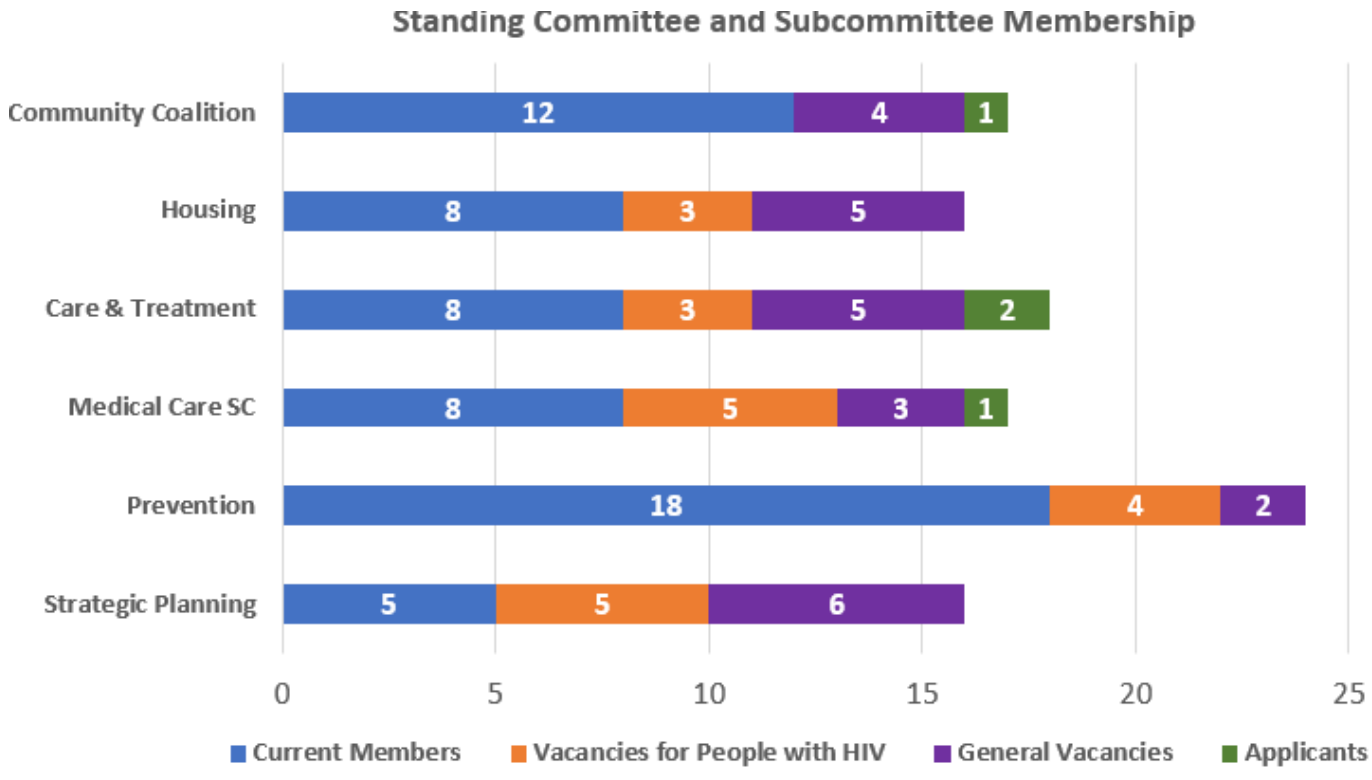
Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

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**



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	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?**	
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	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	

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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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
DERMATOLOGY:											
dermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
eczema/seborrheic dermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
eosinophilic folliculitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
impetigo	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Methicillin-resistant Staphylococcus aureus (MRSA)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
molluscum contagiosum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
photodermatitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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Anesthesia term							**general anesthesia?**	**IV/monitored sedation?**	**regional anesthesia?**	**local anesthesia?**	
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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
ENDOCRINOLOGY:											
diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
hypogonadism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

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.
Leading Journal

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.
Kerr AR, Ship JA.
American Journal of Clinical Dermatology. 2003;4(10):669-80. doi:10.2165/00128071-200304100-00002.
Leading Journal

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]

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Condition	Related to HIV?	Comorbidity/Complication of HIV?	Complication of HIV Treatment?	Addressing Promotes Viral Suppression?	Addressing Improves Quality of Life?	Diagnostic Procedure Required (Specify)	Anesthesia Needed (Specify)	References
Dermatitis	Yes — more prevalent in PWH; correlates with lower CD4 counts	Yes — comorbidity; increased prevalence with immunosuppression	Possible — ART-related drug rashes (NNRTIs, especially nevirapine/efavirenz) can present as dermatitis	Indirectly — ART initiation reduces dermatitis prevalence independent of CD4 count; managing ART-related rash prevents treatment discontinuation	Yes — reduces discomfort, pruritus, and visible skin disease	Clinical diagnosis; skin biopsy if atypical (local anesthesia)	Local anesthesia if biopsy needed	[1-5]
Eczema / Seborrheic Dermatitis	Yes — seborrheic dermatitis is one of the most common HIV-associated dermatoses (prevalence up to 83% in advanced disease)	Yes — comorbidity; marker of immunodeficiency; worsens with declining CD4	No — not a direct ART complication; improves with ART	Yes — HAART showed 84% regression of seborrheic dermatitis vs. 41% without HAART; ART reduces eczema prevalence independent of CD4	Yes — reduces visible facial/scalp disease, pruritus, and social stigma	Clinical diagnosis; KOH prep to exclude tinea; biopsy rarely needed (local anesthesia if performed)	Local anesthesia if biopsy needed	[1, 3, 6-8]
Eosinophilic Folliculitis	Yes — strongly associated with HIV; occurs at CD4 200–300 cells/μL; considered an HIV-specific dermatosis	Yes — complication of advanced immunosuppression	Possible — can flare as immune reconstitution inflammatory syndrome (IRIS) after ART initiation	Yes — has become rare in the modern ART era due to immune reconstitution; ART is the primary treatment	Yes — intensely pruritic; treatment reduces significant morbidity	Skin biopsy required (punch biopsy) to differentiate from bacterial folliculitis; histology shows eosinophilic infiltrate (local anesthesia)	Local anesthesia for punch biopsy	[9-13]
Impetigo	Yes — bacterial skin infections (S. aureus) are more common in PWH	Yes — comorbidity; increased frequency with immunosuppression	No	Indirectly — treating bacterial infections prevents complications that could impair care engagement; low CD4/high viral load	Yes — reduces pain, spread of infection, and secondary complications	Clinical diagnosis; wound culture and sensitivity if recurrent or treatment-resistant	None typically required	[1, 14-16]

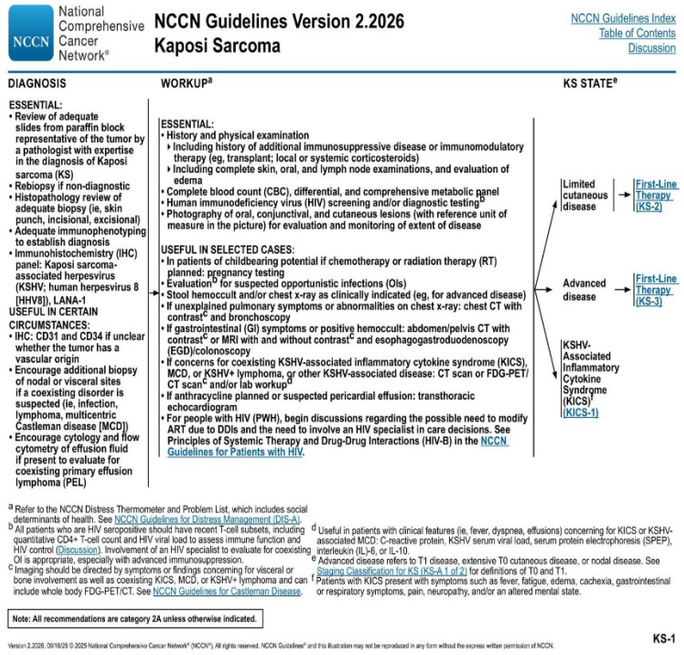
Condition	Related to HIV?	Comorbidity/Complication of HIV?	Complication of HIV Treatment?	Addressing Promotes Viral Suppression?	Addressing Improves Quality of Life?	Diagnostic Procedure Required (Specify)	Anesthesia Needed (Specify)	References
				are risk factors for SSTIs				
MRSA	Yes — PWH have increased MRSA colonization (prevalence ~7–10% in the Americas) and SSTI rates (69.8% of S. aureus isolates were MRSA in a Houston cohort)	Yes — comorbidity; low CD4 and high viral load are independent predictors of SSTI incidence	No — not a direct ART complication	Yes — ART is associated with reduced MRSA colonization/infection risk (OR 0.71); SSTI incidence declined ~40% from 2009–2014 with improved HIV care	Yes — reduces recurrent painful abscesses, cellulitis, and risk of bacteremia	Wound culture and antibiotic susceptibility testing; nasal/skin swab for colonization screening	Incision and drainage under local anesthesia if abscess present	[15, 17-21]
Molluscum Contagiosum	Yes — opportunistic infection in advanced HIV (CD4 200); more extensive and treatment-resistant in PWH	Yes — complication of advanced immunosuppression; may signal uncontrolled HIV	No	Yes — ART-mediated immune reconstitution leads to resolution; lesions serve as a clinical marker of immune status	Yes — reduces disfiguring widespread lesions and social stigma	Clinical diagnosis; biopsy if atypical to exclude other infections (e.g., cryptococcosis, histoplasmosis) (local anesthesia)	Local anesthesia for cryotherapy, curettage, or biopsy	[1, 3, 6, 14, 22]
Photodermatitis	Yes — prevalence ~5.4% in PWH; associated with advanced immunosuppression (CD4 200); African American ethnicity is an independent risk factor (OR 6.68)	Yes — comorbidity; can be a presenting feature of HIV infection	Yes — HAART use is independently associated with photosensitivity (OR 2.82); efavirenz specifically causes photo-distributed drug eruptions	Indirectly — managing photodermatitis may require ART modification, which should maintain viral suppression	Yes — reduces chronic, disfiguring photo-distributed dermatitis	Clinical diagnosis; phototesting (MED-UVA/UVB) if chronic actinic dermatitis suspected; biopsy if atypical (local anesthesia)	Local anesthesia if biopsy needed	[13, 23-26]

Condition	Related to HIV?	Comorbidity/Complication of HIV?	Complication of HIV Treatment?	Addressing Promotes Viral Suppression?	Addressing Improves Quality of Life?	Diagnostic Procedure Required (Specify)	Anesthesia Needed (Specify)	References
Pruritus (Xerosis, Psoriasis, Scabies, etc.)	Yes — pruritus is an early symptom of HIV; xerosis, psoriasis, and scabies are all more prevalent in PWH; HIV gp120 has direct pruritogenic effects on neurons	Yes — comorbidity; xerosis and psoriasis worsen with declining CD4; scabies can present as crusted (Norwegian) scabies in advanced HIV	Possible — some ART agents can cause pruritus/drug eruptions	Yes — ART reduces prevalence of xerosis, psoriasis, and pruritic papular eruptions; scabies treatment prevents secondary infections	Yes — pruritus significantly impairs sleep, daily function, and psychological well-being	Clinical diagnosis for most; skin scraping/mineral oil prep for scabies; biopsy for atypical psoriasis or prurigo nodularis (local anesthesia)	Local anesthesia if biopsy needed	[1, 3, 11-13, 22]
Skin Conditions/Symptoms (Appendages/Oral)	Yes — oral candidiasis, oral hairy leukoplakia, gingivitis, and hair/nail changes are common HIV manifestations	Yes — comorbidity/complication; oral candidiasis is an early marker of immunodeficiency	Possible — ART-related oral ulcers and drug eruptions can occur	Yes — ART leads to regression of oral candidiasis and hairy leukoplakia; oral health impacts ART adherence	Yes — improves nutrition, oral comfort, and social functioning	Clinical exam; KOH prep/culture for candidiasis; biopsy for persistent oral lesions to exclude malignancy (local anesthesia)	Local anesthesia for oral biopsy	[1, 6-8]
Warts (HPV-Related)	Yes — HPV-related conditions remain clinically significant even with suppressive ART and preserved CD4 counts; linked to increased risk of anogenital cancers	Yes — comorbidity; persistent HPV infection leads to extensive, treatment-resistant warts and increased malignancy risk	No — not a direct ART complication; ART does not reliably clear HPV	Partially — ART may reduce HPV-related dysplasia but does not eliminate HPV; warts persist despite viral suppression	Yes — reduces disfigurement, discomfort, and cancer risk through treatment and surveillance	Clinical diagnosis; biopsy if atypical or persistent to exclude dysplasia/malignancy (local anesthesia); anoscopy for anal warts	Local anesthesia for cryotherapy, excision, or biopsy	[1, 14, 22, 27]
Kaposi Sarcoma	Yes — AIDS-defining malignancy; caused by HHV-8/KSHV; SIR ~214-fold elevated in PWH	Yes — complication of HIV/immunosuppression; associated with advanced disease	No — rare with effective ART; can flare as IRIS after ART initiation	Yes — ART alone can achieve KS remission in limited cutaneous disease; viral suppression is	Yes — reduces disfiguring lesions, edema, visceral	**Biopsy required** — histopathology with IHC for HHV-8 LANA-1; imaging (CT, bronchoscopy, EGD) for visceral	Local anesthesia for skin punch/excisional biopsy; sedation or general anesthesia for bronchoscopy/endoscopy	[4, 18, 27-28]

Condition	Related to HIV?	Comorbidity/Complication of HIV?	Complication of HIV Treatment?	Addressing Promotes Viral Suppression?	Addressing Improves Quality of Life?	Diagnostic Procedure Required (Specify)	Anesthesia Needed (Specify)	References
	even in the ART era			critical for KS control and survival	disease, and mortality	disease (local anesthesia for skin biopsy; sedation/general for visceral procedures)		
Skin Cancers (BCC, SCC, Melanoma)	Yes — SCC risk elevated ~2.8–5.4-fold in PWH; BCC risk ~1.8-fold; Merkel cell carcinoma SIR 3.15; melanoma data varied but ~1.5-fold in some studies	Yes — comorbidity; low nadir CD4 is associated with increased SCC risk; HIV/AIDS listed as immunosuppression risk factor for melanoma by NCCN	Possible — ART-associated photosensitivity may contribute to UV-related skin cancer risk	Yes — HAART use associated with lower rates of non-AIDS-defining cancers (OR 0.21); viral suppression reduces cancer-related mortality	Yes — early detection and treatment reduce morbidity and mortality	**Biopsy required** — shave, punch, or excisional biopsy with histopathology; Mohs surgery for treatment of certain lesions (local anesthesia)	Local anesthesia for biopsy and Mohs surgery; general anesthesia for extensive excisions	[6, 29-36]
Onychomycosis	Yes — more prevalent in PWH; associated with injection drug use and immunosuppression	Yes — comorbidity; prevalence increases with declining immune function	No	Indirectly — ART reduces overall fungal infection burden; however, onychomycosis may persist despite immune reconstitution	Yes — improves nail appearance, reduces secondary bacterial infection risk, and improves foot health	KOH preparation and fungal culture of nail clippings; PAS staining of nail biopsy if culture negative (no anesthesia for clippings)	None for nail clippings; local anesthesia if nail biopsy needed	[1, 3, 6, 37]

Key synthesis points:
Relationship to HIV: All listed conditions occur at higher rates in PWH compared to the general population, driven by immunosuppression, altered skin microbiome, and co-infection with oncogenic viruses. [1-2] The HIVMA/IDSA 2024 guidelines specifically list seborrheic dermatitis, psoriasis, molluscum contagiosum, onychomycosis, folliculitis, Kaposi sarcoma, and condylomata as conditions requiring focused attention on physical examination. [6]

ART and viral suppression: For most HIV-associated dermatologic conditions, ART initiation and viral suppression lead to significant improvement or resolution. The Women's Interagency HIV Study (a U.S. multicenter cohort) demonstrated that HAART independently reduced the prevalence of eczema, folliculitis, and xerosis regardless of CD4 count. [3] Kaposi sarcoma can regress with ART alone in limited cutaneous disease. [4][28] However, HPV-related warts and skin cancers may persist or even increase despite effective ART, reflecting cumulative viral exposure and prolonged survival. [1][27]
Diagnostic procedures: Most conditions are diagnosed clinically, but biopsy is essential for Kaposi sarcoma (with HHV-8 IHC), skin cancers, and atypical presentations of folliculitis, warts, or molluscum. [10][14][18][28][30][33] MRSA requires wound culture with susceptibility testing. [15] Onychomycosis requires KOH prep and fungal culture for confirmation before systemic antifungal therapy. [37]
Quality of life: Dermatologic disease remains a significant source of morbidity in PWH even in the modern ART era, with 49.4% of a large Washington, DC cohort having at least one dermatologic diagnosis. [2] Visible skin disease can compound HIV-related stigma and impair care engagement, making dermatologic management an integral component of comprehensive HIV care. [6][38]
Images:



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Kaposi Sarcoma

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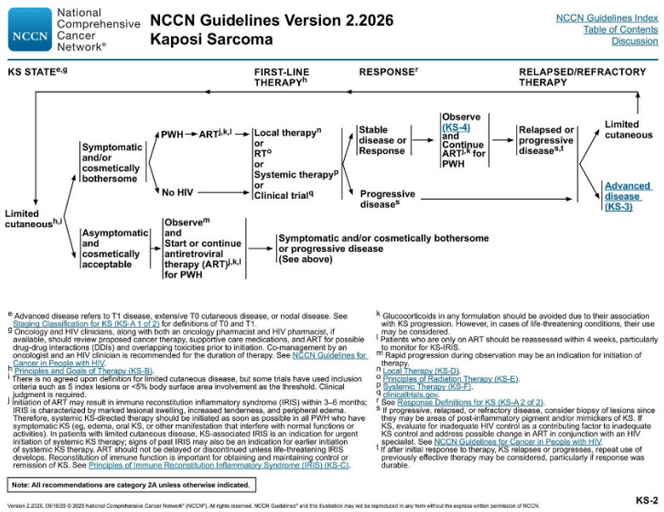
DIAGNOSIS	WORKUP[a]	KS STATE[e]
ESSENTIAL: • Review of adequate slides from paraffin block representative of the tumor by a pathologist with expertise in the diagnosis of Kaposi sarcoma (KS) • Rebiopsy if non-diagnostic • Histopathology review of adequate biopsy (ie, skin punch, incisional, excisional) • Adequate immunophenotyping to establish diagnosis • Immunohistochemistry (IHC) panel: Kaposi sarcoma-associated herpesvirus (KSHV; human herpesvirus 8 [HHV8]), LANA-1 **USEFUL IN CERTAIN CIRCUMSTANCES:** • IHC: CD31 and CD34 if unclear whether the tumor has a vascular origin • Encourage additional biopsy of nodal or visceral sites if a coexisting disorder is suspected (ie, infection, lymphoma, multicentric Castleman disease [MCD]) • Encourage cytology and flow cytometry of effusion fluid if present to evaluate for coexisting primary effusion lymphoma (PEL)	**ESSENTIAL:** • History and physical examination › Including history of additional immunosuppressive disease or immunomodulatory therapy (eg, transplant; local or systemic corticosteroids) › Including complete skin, oral, and lymph node examinations, and evaluation of edema • Complete blood count (CBC), differential, and comprehensive metabolic panel • Human immunodeficiency virus (HIV) screening and/or diagnostic testing[b] • Photography of oral, conjunctival, and cutaneous lesions (with reference unit of measure in the picture) for evaluation and monitoring of extent of disease **USEFUL IN SELECTED CASES:** • In patients of childbearing potential if chemotherapy or radiation therapy (RT) planned: pregnancy testing • Evaluation[b] for suspected opportunistic infections (OIs) • Stool hemoccult and/or chest x-ray as clinically indicated (eg, for advanced disease) • If unexplained pulmonary symptoms or abnormalities on chest x-ray: chest CT with contrast[c] and bronchoscopy • If gastrointestinal (GI) symptoms or positive hemoccult: abdomen/pelvis CT with contrast[c] or MRI with and without contrast[c] and esophagogastroduodenoscopy (EGD)/colonoscopy • If concerns for coexisting KSHV-associated inflammatory cytokine syndrome (KICS), MCD, or KSHV+ lymphoma, or other KSHV-associated disease: CT scan or FDG-PET/CT scan[c] and/or lab workup[d] • If anthracycline planned or suspected pericardial effusion: transthoracic echocardiogram • For people with HIV (PWH), begin discussions regarding the possible need to modify ART due to DDIs and the need to involve an HIV specialist in care decisions. See Principles of Systemic Therapy and Drug-Drug Interactions (HIV-B) in the NCCN Guidelines for Patients with HIV.	Limited cutaneous disease → First-Line Therapy (KS-2) Advanced disease → First-Line Therapy (KS-3) KSHV-Associated Inflammatory Cytokine Syndrome (KICS)[f] (KICS-1)

[a] Refer to the NCCN Distress Thermometer and Problem List, which includes social determinants of health. See NCCN Guidelines for Distress Management (DIS-A).
[b] All patients who are HIV seropositive should have recent T-cell subsets, including quantitative CD4+ T-cell count and HIV viral load to assess immune function and HIV control (Discussion). Involvement of an HIV specialist to evaluate for coexisting OI is appropriate, especially with advanced immunosupression.
[c] Imaging should be directed by symptoms or findings concerning for visceral or bone involvement as well as coexisting KICS, MCD, or KSHV+ lymphoma and can include whole body FDG-PET/CT. See NCCN Guidelines for Castleman Disease.
[d] Useful in patients with clinical features (ie, fever, dyspnea, effusions) concerning for KICS or KSHV-associated MCD: C-reactive protein, KSHV serum viral load, serum protein electrophoresis (SPEP), interleukin (IL)-6, or IL-10.
[e] Advanced disease refers to T1 disease, extensive T0 cutaneous disease, or nodal disease. See Staging Classification for KS (KS-A 1 of 2) for definitions of T0 and T1.
[f] Patients with KICS present with symptoms such as fever, fatigue, edema, cachexia, gastrointestinal or respiratory symptoms, pain, neuropathy, and/or an altered mental state.

Note: All recommendations are category 2A unless otherwise indicated.

KS-1



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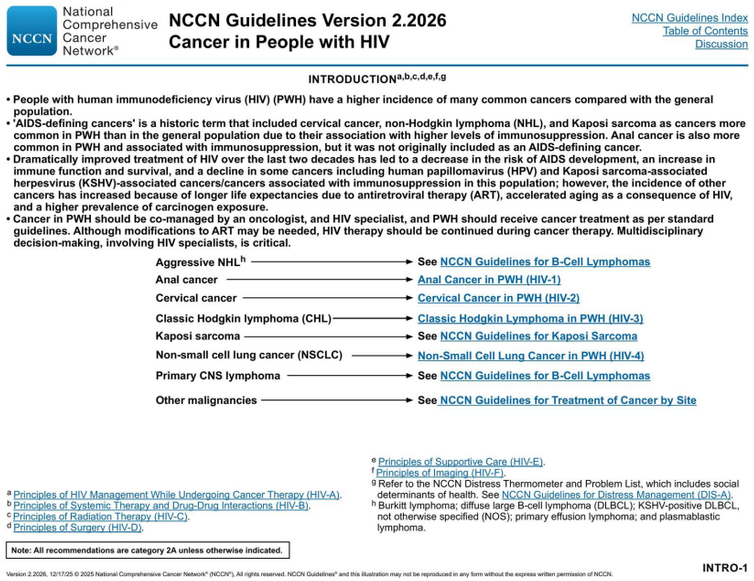
KS STATE[e,g] | FIRST-LINE THERAPY[n] | RESPONSE[r] | RELAPSED/REFRACTORY THERAPY

Limited cutaneous[h,i]
- Symptomatic and/or cosmetically bothersome
  - PWH → ART[j,k,l] → Local therapy[n] or RT[o] or Systemic therapy[p] or Clinical trial[q]
    - Stable disease or Response → Observe (KS-4) and Continue ART[j,k] for PWH
      - Relapsed or progressive disease[s,t] → Limited cutaneous / Advanced disease (KS-3)
    - Progressive disease[s] → Advanced disease (KS-3)
  - No HIV → Local therapy[n] or RT[o] or Systemic therapy[p] or Clinical trial[q]
- Asymptomatic and cosmetically acceptable
  - Observe[m] and Start or continue antiretroviral therapy (ART)[j,k,l] for PWH → Symptomatic and/or cosmetically bothersome or progressive disease (See above)

[e] Advanced disease refers to T1 disease, extensive T0 cutaneous disease, or nodal disease. See Staging Classification for KS (KS-A 1 of 2) for definitions of T0 and T1.
[g] Oncology and HIV clinicians, along with both an oncology pharmacist and HIV pharmacist, if available, should review proposed cancer therapy, supportive care medications, and ART for possible drug-drug interactions (DDIs) and overlapping toxicities prior to initiation. Co-management by an oncologist and an HIV clinician is recommended for the duration of therapy. See NCCN Guidelines for Cancer in People with HIV.
[h] Principles and Goals of Therapy (KS-B).
[i] There is no agreed upon definition for limited cutaneous disease, but some trials have used inclusion criteria such as 5 index lesions or <5% body surface area involvement as the threshold. Clinical judgment is required.
[j] Initiation of ART may result in immune reconstitution inflammatory syndrome (IRIS) within 3–6 months; IRIS is characterized by marked lesional swelling, increased tenderness, and peripheral edema. Therefore, systemic KS-directed therapy should be initiated as soon as possible in all PWH who have symptomatic KS (eg, edema, oral KS, or other manifestation that interfere with normal functions or activities). In patients with limited cutaneous disease, KS-associated IRIS is an indication for urgent initiation of systemic KS therapy; signs of past IRIS may also be an indication for earlier initiation of systemic KS therapy. ART should not be delayed or discontinued unless life-threatening IRIS develops. Reconstitution of immune function is important for obtaining and maintaining control or remission of KS. See Principles of Immune Reconstitution Inflammatory Syndrome (IRIS) (KS-C).
[k] Glucocorticoids in any formulation should be avoided due to their association with KS progression. However, in cases of life-threatening conditions, their use may be considered.
[l] Patients who are only on ART should be reassessed within 4 weeks, particularly to monitor for KS-IRIS.
[m] Rapid progression during observation may be an indication for initiation of therapy.
[n] Local Therapy (KS-D).
[o] Principles of Radiation Therapy (KS-E).
[p] Systemic Therapy (KS-F).
[q] clinicaltrials.gov.
[r] See Response Definitions for KS (KS-A 2 of 2).
[s] If progressive, relapsed, or refractory disease, consider biopsy of lesions since they may be areas of post-inflammatory pigment and/or mimickers of KS. If KS, evaluate for inadequate HIV control as a contributing factor to inadequate KS control and address possible change in ART in conjunction with an HIV specialist. See NCCN Guidelines for Cancer in People with HIV.
[t] If after initial response to therapy, KS relapses or progresses, repeat use of previously effective therapy may be considered, particularly if response was durable.

Note: All recommendations are category 2A unless otherwise indicated.

KS-2



National Comprehensive Cancer Network®

NCCN Guidelines Version 2.2026
Cancer in People with HIV

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INTRODUCTION[a,b,c,d,e,f,g]

- **People with human immunodeficiency virus (HIV) (PWH) have a higher incidence of many common cancers compared with the general population.**
- **'AIDS-defining cancers' is a historic term that included cervical cancer, non-Hodgkin lymphoma (NHL), and Kaposi sarcoma as cancers more common in PWH than in the general population due to their association with higher levels of immunosuppression. Anal cancer is also more common in PWH and associated with immunosuppression, but it was not originally included as an AIDS-defining cancer.**
- **Dramatically improved treatment of HIV over the last two decades has led to a decrease in the risk of AIDS development, an increase in immune function and survival, and a decline in some cancers including human papillomavirus (HPV) and Kaposi sarcoma-associated herpesvirus (KSHV)-associated cancers/cancers associated with immunosuppression in this population; however, the incidence of other cancers has increased because of longer life expectancies due to antiretroviral therapy (ART), accelerated aging as a consequence of HIV, and a higher prevalence of carcinogen exposure.**
- **Cancer in PWH should be co-managed by an oncologist, and HIV specialist, and PWH should receive cancer treatment as per standard guidelines. Although modifications to ART may be needed, HIV therapy should be continued during cancer therapy. Multidisciplinary decision-making, involving HIV specialists, is critical.**

Aggressive NHL[h]	See NCCN Guidelines for B-Cell Lymphomas
Anal cancer	Anal Cancer in PWH (HIV-1)
Cervical cancer	Cervical Cancer in PWH (HIV-2)
Classic Hodgkin lymphoma (CHL)	Classic Hodgkin Lymphoma in PWH (HIV-3)
Kaposi sarcoma	See NCCN Guidelines for Kaposi Sarcoma
Non-small cell lung cancer (NSCLC)	Non-Small Cell Lung Cancer in PWH (HIV-4)
Primary CNS lymphoma	See NCCN Guidelines for B-Cell Lymphomas
Other malignancies	See NCCN Guidelines for Treatment of Cancer by Site

[a] Principles of HIV Management While Undergoing Cancer Therapy (HIV-A).
[b] Principles of Systemic Therapy and Drug-Drug Interactions (HIV-B).
[c] Principles of Radiation Therapy (HIV-C).
[d] Principles of Surgery (HIV-D).
[e] Principles of Supportive Care (HIV-E).
[f] Principles of Imaging (HIV-F).
[g] Refer to the NCCN Distress Thermometer and Problem List, which includes social determinants of health. See NCCN Guidelines for Distress Management (DIS-A).
[h] Burkitt lymphoma; diffuse large B-cell lymphoma (DLBCL); KSHV-positive DLBCL, not otherwise specified (NOS); primary effusion lymphoma; and plasmablastic lymphoma.

Note: All recommendations are category 2A unless otherwise indicated.

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Clinical Infectious Diseases : An Official Publication of the Infectious Diseases Society of America. 2021. Thompson MA, Horberg MA, Agwu AL, et al.

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, May 15, 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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VI.	Review/Approve Minutes of April 24, 2026	All
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	• Ryan White Program	Carla Valle-Schwenk
	• ADAP	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Allowable Conditions Response to "Dear Colleague" Letter Continued	All
	• Contingency Planning Continued:	
	• Outpatient Ambulatory Health Services Review--Vaccines	All
	• Ryan White Prescription Drug Formulary	All
	• Oral Health Care Item: D6095, Repair of Implant Abutment--discontinued	All
	• 2026 Calendar of Activities	All
IX.	New Business	
	• Special Projects Discussion	All
X.	Announcements	All
	• Get on Board Training, June 3, 2026	
XI.	Next Meeting**: June 26, 2026** at **BSR**	Dr. Lawrence Friedman
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OAHS Vaccine Service Summary — FY 2024					
On ADAP	Service Name	Total Cost	Units	Unique Clients	Cost per Unit
X	9VHPV VACC 2/3 DOSE SCHED IM USE	$75,296.52	351	233	$214.52
X	AIIV4 VACC INACTIVATED PRSRV FR 0.5ML DOS IM USE	$154.72	2	2	$77.36
X	CCIIV4 VACCINE PRESERVATIVE FREE 0.5 ML IM USE	$1,127.61	33	33	$34.17
X	HEPA VACCINE ADULT DOSE FOR INTRAMUSCULAR USE	$4,777.68	68	59	$70.26
	HEPATITIS B IMMUNE GLOBULIN HBIG HUMAN IM	$2,068.35	15	11	$137.89
X	HEPB VACCINE ADULT 2 DOSE SCHEDULE FOR IM USE	$28,209.28	176	132	$160.28
X	HEPB VACCINE ADULT 3 DOSE SCHEDULE FOR IM USE	$5,841.54	83	67	$70.38
X	HEPB VACCINE PED/ADOLESC 3 DOSE SCHEDULE IM	$215.39	7	6	$30.77
X	HZV ZOSTER VACC RECOMBINANT ADJUVANTED IM NJX	$25,635.03	181	149	$141.63
X	IIV VACCINE PRESERV FREE INCREASED AG COUNT IM	$5,798.60	79	77	$73.40
X	IIV4 VACC PRESRV FREE 0.5 ML DOS FOR IM USE	$648.15	29	29	$22.35
X	MCV4/MENACWY CONJ VACC GRPS ACYW-135 IM USE	$25,218.81	207	154	$121.83
X	MENACWY-TT CONJ VACC SEROGROUPS ACWY FOR IM USE	$9,515.92	68	62	$139.94
X	MENB-4C RECOMBNT PROT & OUTER MEMB VESIC VACC IM	$693.90	2	2	$346.95
	PCV13 VACCINE FOR INTRAMUSCULAR USE	$773.97	3	3	$257.99
X	Pcv20 vaccine im	$96,989.76	336	336	$288.66
X	PPSV23 VACCINE 2 YRS OR OLDER FOR SUBQ/IM USE	$1,201.23	9	9	$133.47
X	RIV4 VACC RECOMBINANT DNA PRSRV ANTIBIO FREE IM	$146.80	2	2	$73.40
X	TD VACCINE PRSRV FREE 7 YRS OR OLDER FOR IM USE	$91.02	3	3	$30.34
X	TDAP VACCINE 7 YRS/> IM	$9,845.67	257	252	$38.31
	Total	**$294,249.95**	**1,911**	**1,621**	

Green Sheet

OAHS Vaccine Service Summary — FY 2024

Service Name	Total Cost	Units	Unique Clients	Cost per Unit
HEPA VACCINE ADULT DOSE FOR INTRAMUSCULAR USE	$3,794.04	54	49	$70.26
HZV ZOSTER VACC RECOMBINANT ADJUVANTED IM NJX	$23,793.84	168	138	$141.63
Pcv20 vaccine im	$86,598.00	300	300	$288.66
TDAP VACCINE 7 YRS/> IM	$8,274.96	216	213	$38.31
MCV4/MENACWY CONJ VACC GRPS ACYW-135 IM USE	$22,538.55	185	142	$121.83
IIV4 VACC PRESRV FREE 0.5 ML DOS FOR IM USE	$581.10	26	26	$22.35
RIV4 VACC RECOMBINANT DNA PRSRV ANTIBIO FREE IM	$146.80	2	2	$73.40
9VHPV VACC 2/3 DOSE SCHED IM USE	$68,002.84	317	216	$214.52
HEPB VACCINE ADULT 2 DOSE SCHEDULE FOR IM USE	$25,644.80	160	121	$160.28
IIV VACCINE PRESERV FREE INCREASED AG COUNT IM	$5,431.60	74	72	$73.40
MENACWY-TT CONJ VACC SEROGROUPS ACWY FOR IM USE	$7,836.64	56	51	$139.94
PPSV23 VACCINE 2 YRS OR OLDER FOR SUBQ/IM USE	$1,067.76	8	8	$133.47
PCV13 VACCINE FOR INTRAMUSCULAR USE	$773.97	3	3	$257.99
HEPB VACCINE PED/ADOLESC 3 DOSE SCHEDULE IM	$184.62	6	5	$30.77
HEPB VACCINE ADULT 3 DOSE SCHEDULE FOR IM USE	$5,137.74	73	59	$70.38
TD VACCINE PRSRV FREE 7 YRS OR OLDER FOR IM USE	$91.02	3	3	$30.34
MENB-4C RECOMBNT PROT & OUTER MEMB VESIC VACC IM	$693.90	2	2	$346.95
CCIIV4 VACCINE PRESERVATIVE FREE 0.5 ML IM USE	$1,025.10	30	30	$34.17
AIIV4 VACC INACTIVATED PRSRV FR 0.5ML DOS IM USE	$154.72	2	2	$77.36
HEPATITIS B IMMUNE GLOBULIN HBIG HUMAN IM	$1,654.68	12	8	$137.89
Total	**$263,426.68**	**1,697**	**861**	

MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, May 15, 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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IV.	Floor Open to the Public	Dr. Lawrence Friedman
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of April 24, 2026	All
VII.	Reports	
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VIII.	Standing Business	
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	• Contingency Planning Continued:	
	• Outpatient Ambulatory Health Services Review--Vaccines	All
	• Ryan White Prescription Drug Formulary deferred	All
	• Oral Health Care Item: D6095, Repair of Implant Abutment--discontinued	All
	• 2026 Calendar of Activities	All
IX.	New Business	
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X.	Announcements	All
	• Get on Board Training, June 3, 2026	
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XII.	Adjournment	Cristhian Ysea

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Medical Care Subcommittee
Calendar of Activities 2026

Month	Officer Elections	Conflict of Interest Forms/Financial Disclosure Forms	Outpatient/Ambulatory Medical Care Standards	Allowable Medical Conditions (reviewed as needed)	Ryan White Prescription Drug Formulary (reviewed as needed)	Oral Health Care Items (reviewed quarterly)	Special projects discussion	Committee Items (added as needed)	Notes
	Activities								
January 23, 2026								x	All standing business items deferred because of contingency planning.
February 6, 2026								x	Emergency meeting-contingency planning
February 27, 2026								x	Contingency planning
March 27, 2026		x						x	Contingency planning; disclosure forms requested
April 24, 2026	x	x				x	x	x	Source of income forms completed for missing members; continue special project discussions; OHC items, as applicable; address deferred items; contingency planning
May 15, 2026		x				x	x	x	Conclude special projects discussion ;continue review of allowable conditions review; contingency planning-vaccines; OHC code discussion; formulary discussion-deferred
June 26, 2026								x	Continue review of allowable conditions review; contingency planning, as applicable
July 24, 2026						x		x	OHC items, as applicable; Continue review of allowable conditions review
August 28, 2026								x	Continue review of allowable conditions review; contingency planning, as applicable
September 25, 2026			x					x	Primary Medical Care Standards review begins; AIDS Pharma and Outpatient/Ambulatory Service Descriptions review begins
October 23, 2026			x			x		x	Primary Medical Care Standards review continued; Service Descriptions review continued Mental Health and Substance Abuse; OHC items as applicable
November 20, 2026			x					x	Primary Medical Care Standards review continued; Service Descriptions Continued; OHC service description and standards review; nomination of officers; planning for 2027

Comments:

The Subcommittee does NOT meet in December and all items are subject to change.

N=no meeting

MIAMI-DADE HIV/AIDS PARTNERSHIP

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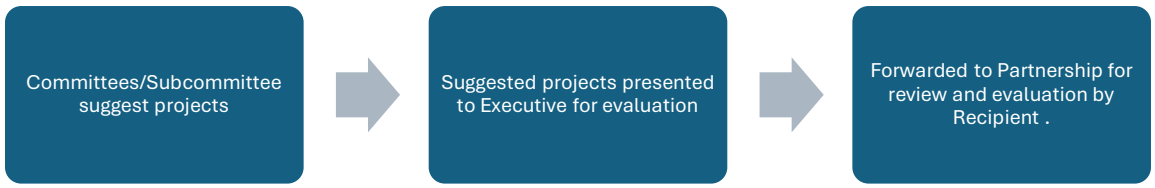
2027 Special Projects

As part of the annual staff support budget process approved in 2024, the committees and the subcommittee are being polled for any request for support of special projects above and beyond the annual activities such as the needs assessment, comprehensive planning, PSRA, and the efficiency of administrative mechanism. After projects are elaborated, they will be vetted by the Executive Committee and forwarded for recommendation.



This year the Integrated Plan is under development and due by June 2026.

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MIAMI-DADE
HIV/AIDS PARTNERSHIP

GET ON BOARD

Member Enrichment Training

STATION 23:

Ryan White Planning Council Responsibilities and Needs Assessment

WEDNESDAY,
JUNE 3, 2026

12:00 P.M. – 1:00 P.M.

VIA MICROSOFT TEAMS

WHAT YOU'LL LEARN

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

SCAN TO REGISTER!

OR REGISTER AT:

bit.ly/June_3_2026GOB-RWPC_NA

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

MIAMI-DADE HIV/AIDS PARTNERSHIP

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