MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 26, 2024	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Referrals Flowchart	All
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IX.	New Business	
	• Service Descriptions: Outpatient Ambulatory Health and Substance Abuse	All
	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
XI.	Next Meeting**: November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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Meeting Housekeeping Medical Care Subcommittee

Updated September 30,2024
Behavioral Science Research

MIAMI-DADE HIV/AIDS PARTNERSHIP

BEHAVIORAL SCIENCE RESEARCH

Disclaimer & Code of Conduct

- Audio of this meeting is being recorded and will become part of the public record.
- Members serve the interest of the Miami-Dade HIV/AIDS community as a whole.
- Members do not serve private or personal interests, and shall endeavor to treat all persons, issues and business in a fair and equitable manner.
- Members shall refrain from side-bar conversations in accordance with Florida Government in the Sunshine laws.

General Housekeeping

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

About the Partnership

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

Language Matters!

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

Remember **People First** Language . . .
People with HIV, ***People*** with substance use disorders, ***People*** who are homeless, etc.

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

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

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

Meeting Participation

Everyone has a role to play!

- ❑ All attendees may address the board as time allows and at the discretion of the Chair.
- ❑ Please *share your expertise* on the current Agenda topics and motions. Remember to . . .
  - Raise your hand to be recognized by the Chair or added to the queue during discussions.
  - Avoid repeating points previously addressed.

Meeting Terminology

Meetings can be fast-paced and confusing!

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

Meeting Guide

Meetings can be fast-paced and confusing!
These terms and acronyms can help you follow along.

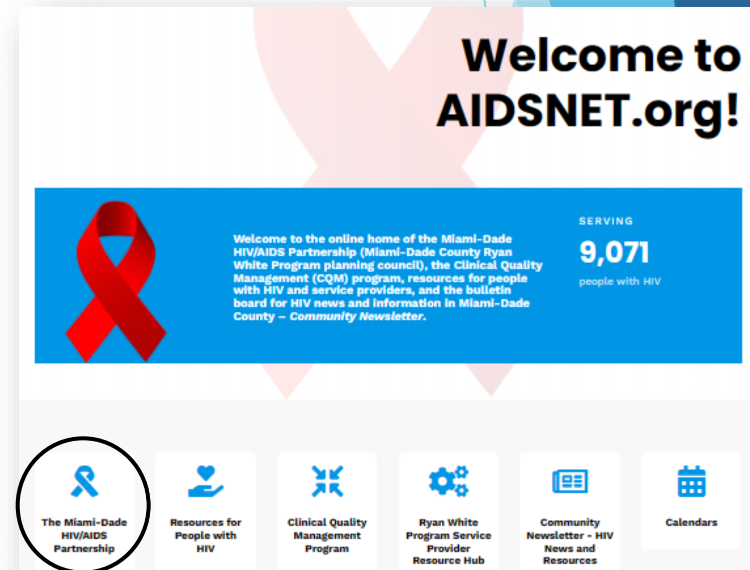
Please raise your hand at any time if you need more information!

ADAP	AIDS Drug Assistance Program
BSR	Behavioral Science Research Corp. (aka, Staff)
EHE	Ending the HIV Epidemic: A Plan for America
EMA	Eligible Metropolitan Area (locally, Miami-Dade County)
FDOH FDOH-MDC	Florida Department of Health in Miami-Dade County
FPL	Federal Poverty Level
HOPWA	Housing Opportunities for People with AIDS Program
HRSA	The Health Resources and Services Administration
IP	The Integrated HIV Prevention and Care Plan
MAI	Minority AIDS Initiative
NHAS	National HIV/AIDS Strategy
PE Miami Provide	Provide Enterprise® by Groupware Technologies (RWP client database system)
RWP RWHAP	Ryan White Program or Ryan White HIV/AIDS Program (Usually referring to Part A/MAI)
The Partnership Planning Council PC	The Miami-Dade HIV/AIDS Partnership - The official Ryan White Program Advisory Board
The Recipient The County OMB	The Miami-Dade County Office of Management and Budget.
TTRA	Test and Treat/Rapid Access

Scan the QR Code for additional acronyms and terminology -
Get on Board Training: Understanding the Language of the Partnership

Resources

- ❑ Behavioral Science Research Corp. (BSR) staff are the Resource Persons for this meeting.
- ❑ See staff after the meeting if you are interested in membership or if you have a question that wasn't covered during the meeting.
- ❑ Today's presentation and supporting documents are online at https://aidsnet.org/the-partnership/#caretreatment2 or by scanning the QR code on your agenda.



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Floor Open to the Public

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

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

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Medical Care Subcommittee Meeting
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Coral Gables, FL 33134

July 26, 2024 Minutes

#	Members	Present	Absent	Guests
1	Baez, Ivet		X	Hermina Rojas
2	Dougherty, James	X		Carla Valle-Schwenk
3	Friedman, Lawrence	X		Karyann Victorew
4	Goubeaux, Robert	X		Ramona N. Washington
5	Miller, Juliet		X	
6	Romero, Javier	X		
7	Serrano-Irizarry, Yendi	X		**Staff**
8	Wright, Sonya	X		Karen Hilton
9	Ysea, Cristhian A.	X		Robert Ladner
Quorum: 4				Marlen Meizoso

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

I. Call to Order *James Dougherty*

James Dougherty, Subcommittee Chair, called the meeting to order at 9:35 a.m. He introduced himself, provided an overview of the work for today's meeting, and welcomed everyone.

II. Introductions *All*

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

III. Meeting Housekeeping *James Dougherty*

Mr. Dougherty reviewed the meeting housekeeping presentation indicating people first language, meeting protocols, and the location of Subcommittee items online

IV. Floor Open to the Public *Cristhian Ysea*

Cristhian Ysea, Vice Chair, 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

DRAFT

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 adopted it as presented.

Motion to accept the agenda as presented.
Moved: Dr. Lawerence Friedman Seconded: Cristhian Ysea Motion: Passed

VI. Review/Approve Minutes of June 28, 2024 *All*

Members reviewed the minutes of June 28, 2024, and approved them as presented.

Motion to accept the minutes of June 28, 2024, as presented.
Moved: Dr. Robert Goubeaux Seconded: Cristhian Ysea Motion: Passed

VII. Reports

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

Carla Valle-Schwenk reviewed the current Ryan White Program expenditures and clients served which were posted online briefly. There is a Part A, Part B, and Subrecipients meeting on Monday to discuss TTRA, changes to the food bank services, reciprocal forms for Part B, and planning for new services. The meeting will be held at the Main Library.

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

Dr. Javier Romero reviewed the June 2024 ADAP report as of July 1, 2024 including enrollments, expenditures, prescriptions, premium payments, and program updates. A copy of the Magellan network pharmacies for the entire state was provided as requested and posted online. As a reminder, pharmacy choice is a client's decision.

Regarding the low Cabenuva usage, ADAP only receives pickup reports from the pharmacies. While pickup numbers were high in October 2023, the current figures are low. Based on a call with the State on this item, there have been complaints about the Cabenuva enrollment process, which is apparently not easy to complete. Some clients do not like having to go to a doctor for the injections (six visits a year for two shots), they do not like needles, it is uncomfortable, or if there are any delays during an appointment,,the medication can become non-viable. There also appears to be some confusion as to the process and qualifications to be a candidate for the medication. Staff will forward the Five Barriers to Cabenuva document developed by the Department of Health.

The State has released the patient surveys on pharmacy satisfaction. Most clients like their services, except for eight who indicated they did not.

DRAFT

The program is monitoring 75 clients who are within the seven-month threshold of turning 65 years old and need to apply to Medicare. Target dates to reach are three months before the six months of birthday, and three months after. Medicare clients can get copay assistance for medication. The Part A program indicated it will check with American Exchange to see if they can assist clients in plan enrollment.

- **Vacancy Report** *Marlen Meizoso*

Ms. Meizoso referenced the membership vacancy report indicating several vacancies on the Subcommittee and on the Partnership. The Subcommittee has five vacancies for members with lived experience and two seats for medical professionals. If anyone knows of any additional individuals interested in membership, they may contact staff, invite them to attend a meeting, or invite them to attend any Partnership training.

The six applications for the Partnership have been approved by the Mayor's office.

VIII. <u>Standing Business</u>

- **Ophthalmology and Medical Conditions List** *All*

The Subcommittee reviewed the current edits to the Allowable Medical Conditions list under Ophthalmology discussed at the last meeting. The Subcommittee recommended two additional edits. In the blue box reword to "optometry or ophthalmological screening for eye health". Reword first sentence in second paragraph to read "Referrals to an optometrist or ophthalmologist for treatment <u>must</u> indicate a condition related to or exacerbated by HIV, comorbidity related to HIV, or complications of HIV treatment." The Subcommittee then made a motion to approve the document with the discussed revisions.

Motion to approve the changes to the Allowable Conditions List as discussed.
Moved: Dr. Robert Goubeaux Seconded: Dr. Lawrence Friedman Motion: Passed

- **2025 Planning Activities** *All*

As indicated at the last meeting, all committees and the subcommittee are being polled as part of the annual Partnership staff support budget process. Requests are being solicitated for special projects above and beyond the annual activities supported by the existing staff support budget. These requests will then be prioritized and forwarded to the Executive Committee for review and possible inclusion in the Partnership's budget/scope. Legislative requirements include comprehensive planning, priority setting and resource allocation, assessing efficiency of administrative mechanism, and needs assessment. The Subcommittee had indicated they would like the reports (Ryan White summary, ADAP, Vacancy, and Motions reports) included in the packet. The Subcommittee also discussed holding special focus groups that could be done on HIV and aging. The Subcommittee suggested holding two focus groups. The first group would be for those aged 55 and older to discuss the aging body and health needs. A second group could then be geared towards those age 64 ½ who are aging and transitioning into Medicare. The groups would be held in all three languages (English, Spanish, and Haitian Creole) with a maximum capacity of 15 clients per each group. The Haitian group might be difficult to fill, but if not, the focus group could be turned into key informant interviews with participants. Suggested budget of $7,500 for the six groups. Client incentive of $50. Refreshments and transportation assistance should be included. The intent of the focus group is to clarify issues of access and needs and allow the voice of the clients to be heard.

DRAFT

IX. New Business

Referrals Flowchart

At the last meeting staff volunteered to review the feasibility of a flowchart for referrals. Karen Hilton indicated she is still reviewing replies from agencies and will provide an update on this item at the next meeting.

Service Descriptions: AIDS Pharmaceutical and Mental Health

Per the conversation at the last meeting, drafts of the 2025 AIDS Pharmaceutical and Mental Health service descriptions and Mental Health services were distributed and reviewed both. No edits on any dates or rankings were made since these have not been decided yet. Under the AIDS Pharmaceutical service description, the following edits were recommended:

- Strike "to prolong life, improve health, or prevent deterioration of health" from second paragraph
- Use lower case for professions such as "Licensed Medical Provider, Nutritionist, and Pharmacist"
- Stike from second bullet 2. Client Education and Adherence "including information about state-of-the -art combination drug therapies"
- Fix spacing under additional important notice sec.

The Subcommittee also started reviewing the mental health service description. The following edits were recommended: Add to DSM-"TR"5 and after the name of the book Text Revision, Fifth Edition throughout the document and fix the spacing below "Available at section" on page 36.

These edits will be made and brought to the following meeting.

Ryan White Conference and August 23, 2024, meeting

The next meeting is scheduled for August 23, 2024, but it conflicts with the final day of the National Ryan White Conference which may impact meeting participation. The Subcommittee was polled, and several members were in conflict, so a motion was made to cancel the August meeting. The next meeting would then be September 27, 2024.

Motion to cancel the August 23, 2024, Medical Car Subcommittee meeting.
Moved: Dr. Robert Goubeaux Seconded: Dr. Lawrence Friedman Motion: Passed

X. Announcements and Open Discussion *All*

Mrs. Meizoso announced the next Get on Board training is scheduled for September 4, 2024, and new member orientation will be held September 18, 2024.

No open discussion items were shared.

XI. Next Meeting *Cristhian Ysea*

The next Subcommittee meeting is scheduled for Friday, September 27, 2024, at 9:30 a.m. at BSR, per the earlier motion. Members were encouraged to RSVP for the meeting to ensure quorum.

XII. Adjournment *James Dougherty*

DRAFT

Mr. Dougherty thanked everyone for participating in today's meeting and requested a motion to adjourn.

Motion to adjourn.
Moved: Dr. Robert Goubeaux **Seconded: Dr. Lawrence Friedman** **Motion: Passed**

The meeting adjourned at 11:13 a.m.

DRAFT

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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: **July 2024**

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)	1	17	1	5
Health Insurance Premium and Cost Sharing Assistance	2	1,163	1	757
Medical Case Management	6,657	39,948	3,327	7,374
Mental Health Services	32	285	18	68
Oral Health Care	857	4,348	640	1,909
Outpatient Ambulatory Health Services	1,983	10,608	1,284	3,301
Substance Abuse Outpatient Care	2	14	2	5
Support Services				
Food Bank/Home Delivered Meals	15	4,209	15	583
Medical Transportation	111	1,423	103	486
Other Professional Services	40	184	16	46
Outreach Services	37	176	31	135
Substance Abuse Services (residential)	525	2,799	21	47
TOTALS:	10,262	65,174		

Total unduplicated clients (month): 4,222

Total unduplicated clients (YTD): 8,119

See Service Unit Definitions on page 4

REPORT COMPILED ON: 09/05/2024

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FUNDING SOURCE(S) INCLUDED: Ryan White Part A

FOR THE PERIOD OF: **July 2024**

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	**Year-to-date**	**Monthly**	**Year-to-date**
Core Medical Services				
AIDS Pharmaceutical Assistance (LPAP/CPAP)	1	17	1	5
Health Insurance Premium and Cost Sharing Assistance	2	1,163	1	757
Medical Case Management	5,337	34,227	2,854	6,963
Mental Health Services	30	271	16	60
Oral Health Care	857	4,348	640	1,909
Outpatient Ambulatory Health Services	1,797	9,378	1,170	3,045
Substance Abuse Outpatient Care	2	14	2	5
Support Services				
Food Bank/Home Delivered Meals	15	4,209	15	583
Medical Transportation	95	1,334	87	461
Other Professional Services	40	184	16	46
Outreach Services	36	162	30	122
Substance Abuse Services (residential)	525	2,799	21	47
TOTALS:	8,737	58,106		

Total unduplicated clients (month): 3,818

Total unduplicated clients (YTD): 7,917

REPORT COMPILED ON: 09/05/2024

RYAN WHITE PART A PROGRAM
MIAMI-DADE COUNTY EMA

MONTHLY AND YEAR-TO-DATE SERVICE UTILIZATION SUMMARY

FUNDING SOURCE(S) INCLUDED: Ryan White MAI

FOR THE PERIOD OF: **July 2024**

SERVICE CATEGORIES	Service Units		Unduplicated Client Count	
	Monthly	Year-to-date	Monthly	Year-to-date
Core Medical Services				
Medical Case Management	1,320	5,721	633	919
Mental Health Services	2	14	2	8
Outpatient Ambulatory Health Services	186	1,230	121	479
Support Services				
Medical Transportation	16	89	16	30
Outreach Services	1	14	1	13
TOTALS:	1,525	7,068		

Total unduplicated clients (month): 699

Total unduplicated clients (YTD): 1,189

REPORT COMPILED ON: 09/05/2024

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.

FY 2024 - Part A

RYAN WHITE PART A GRANT AWARD (Grant #: BURW3201)

EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR34

FORMULA AND SUPPLEMENTAL FUNDING

Per Resolution #s: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2024 Part A service months up to July 2024, as of 9/5/2024. This report reflects reimbursement requests that were due by 8/20/2024, and have been paid thus far. Pending Part A reimbursement requests that have been received and are in the review process currently total $4,997,880.30. Four of 18 contracts are pending execution.

Project #: BURW3403	AWARD AMOUNTS	ACTIVITIES	
Grant Award Amount Formula	16,389,150.00	FORMULA	
Grant Award Amount FY22 Formula	2,353.00	PY_FORMULA	
Grant Award Amount Supplemental	6,799,165.00	SUPPLEMENTAL	FY 2024 Award
Grant Award Amount FY22 Supplemental	1,620,086.00	PY_SUPPLEMENTAL	$24,810,754
Carryover Award of FY'23 Formula Funds	795,210.00	CARRYOVER	
Total Award	**$ 25,605,964.00**		

CONTRACT ALLOCATIONS/ FORMULA, SUPPLEMENTAL & CARRYOVER

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations
8	AIDS Pharmaceutical Assistance	15,679.00	
6	Health Insurance Services	378,454.00	
1	Medical Case Management	5,676,584.00	
3	Mental Health Therapy/Counseling	76,690.00	
4	Oral Health Care	3,352,857.00	
2	Outpatient/Ambulatory Health Svcs	8,828,192.00	
9	Substance Abuse - Outpatient	44,128.00	
	CORE Services Totals:	18,372,584.00	

Priority Order	Support Services	Allocations	Carryover Allocations	
12	Emergency Financial Assistance	0.00		
5	Food Bank	972,532.00	795,210.00	1,767,742
13	Medical Transportation	195,280.00		
15	Other Professional Services	88,274.00		
14	Outreach Services	232,059.00		
7	Substance Abuse - Residential	1,868,950.00		
	SUPPORT Services Totals:	3,357,095.00	795,210.00	
	FY 2024 Award (not including C/O)	21,729,679.00		

DIRECT SERVICES TOTAL:		**$ 22,524,889.00**	
Total Core Allocation	18,372,584.00		
Target at least 80% core service allocation	17,383,743.20		
Current Difference (Short) / Over	**$ 988,840.80**		
Recipient Admin. (GC, GTL, BSR Staff)	**$ 2,478,819.00**		
Quality Management	**$ 602,256.00**	3,081,075.00	
(+) Unobligated Funds / (-) Over Obligated:			
Unobligated Funds (Formula & Supp)	$ -		
Unobligated Funds (Carry Over)	$ -	$ -	25,605,964.00

Core medical % against Total Direct Service Allocation (Not including C/O): Cannot be under 75%	**84.55%**	**Within Limit**
Quality Management % of Total Award (Not including C/O): Cannot be over 5%	**2.43%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O): Cannot be over 10%	**9.99%**	**Within Limit**

CURRENT CONTRACT EXPENDITURES

DIRECT SERVICES:

Account	Core Medical Services	Expenditures	Carryover (C/O) Expenditures
5606970000	AIDS Pharmaceutical Assistance	0.00	
5606920000	Health Insurance Services	0.00	
5606870000	Medical Case Management	489,866.25	
5606860000	Mental Health Therapy/Counseling	3,510.00	
5606900000	Oral Health Care	476,067.00	
5606610000	Outpatient/Ambulatory Health Svcs	589,176.70	
5606910000	Substance Abuse - Outpatient	870.00	
	CORE Services Totals:	1,559,489.95	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank	529,492.20	0.00	529,492.20
5606460000	Medical Transportation	9,203.95		
5606890000	Other Professional Services	16,578.00		
5606950000	Outreach Services	6,506.32		
5606930000	Substance Abuse - Residential	624,500.00		
	SUPPORT Services Totals:	1,186,280.47	0.00	
	FY 2024 Award (not including C/O)	2,745,770.42		

	TOTAL EXPENDITURES DIRECT SVCS & % :	**$ 2,745,770.42**		**12.19%**
	Formula Expenditure %	**22.89%**		
5606710000	**Recipient Administration**	**756,261.09**		
5606880000	**Quality Management**	**250,000.00**		1,006,261.09
	Grant Unexpended Balance	**FY 2023 Award** 21,058,722.49	**Carryover** 795,210.00	21,853,932.49
	Total Grant Expenditures & %	**$ 3,752,031.51**		**14.65%**

Core medical % against Total Direct Service Expenditures (Not including C/O): Cannot be under 75%	**56.80%**	**Danger!!!!!**
Quality Management % of Total Award (Not including C/O): Cannot be over 5%	**1.01%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O): Cannot be over 10%	**3.05%**	**Within Limit**

Printed On: 9/5/2024

FY 2024 - MAI

RYAN WHITE PART A GRANT AWARD (Grant#: BURW3201)
EARMARK ALLOCATION AND EXPENDITURE RECONCILIATION SCHEDULE YR34
MINORITY AIDS INITIATIVE (MAI) FUNDING
Per Resolution #s: R-1162-21, R-246-20, R-247-20 & R-817-19

This report includes YTD paid reimbursements for FY 2024 MAI service months up to July 2024, as of 9/5/2024. This report reflects reimbursement requests that were due by 8/20/2024, and have been paid thus far. Pending MAI reimbursement requests that have been received and are in the review process currently total $447,407.88

PROJECT #: BURW3403	AWARD AMOUNTS	ACTIVITIES
Grant Award Amount MAI	2,600,572.00	MAI
Carryover Award of FY'23 MAI Funds	1,474,770.00	MAI_CARRYOVER
Total Award	**$ 4,075,342.00**	

CONTRACT ALLOCATIONS

DIRECT SERVICES:

Priority Order	Core Medical Services	Allocations	Carryover (C/O) Allocations	
	AIDS Pharmaceutical Assistance			
	Health Insurance Services			
1	Medical Case Management	903,920.00	107,500.00	1,011,420.00
3	Mental Health Therapy/Counseling	18,960.00		
	Oral Health Care			
2	Outpatient/Ambulatory Health Svcs	1,262,133.00	300,000.00	1,562,133.00
6	Substance Abuse - Outpatient	8,058.00		
	CORE Services Totals:	2,193,071.00	407,500.00	

Priority Order	Support Services	Allocations	Carryover Allocations	
5	Emergency Financial Assistance	0.00		
	Food Bank			
13	Medical Transportation	7,628.00	8,300.00	15,928.00
	Other Professional Services			
7	Outreach Services	39,816.00		
	Substance Abuse - Residential			
	SUPPORT Services Totals:	47,444.00		
	FY 2024 Award (not inlcuding C/O)	2,240,515.00		

DIRECT SERVICES TOTAL:		**$ 2,656,315.00**		
Total Core Allocation	2,193,071.00			
Target at least 80% core service allocation	1,799,052.00			
Current Difference (Short) / Over	**$ 394,019.00**			
Recipient Admin. (OMB-GC)	**$ 260,057.00**			
Quality Management	**$ 100,000.00**	360,057.00	$ 3,016,372.00	
(+) Unobligated Funds / (-) Over Obligated:				
Unobligated Funds (MAI)	$ -			
Unobligated Funds (Carry Over)	**$ 1,058,970.00**	1,058,970.00	4,067,042.00	

Core medical % against Total Direct Service Allocation (Not including C/O): Cannot be under 75%	**97.88%**	**Within Limit**
Quality Management % of Total Award (Not including C/O): Cannot be over 5%	**3.85%**	**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	212,219.15	0.00	212,219.15
5606860000	Mental Health Therapy/Counseling	0.00		
5606900000	Oral Health Care			
5606610000	Outpatient/Ambulatory Health Svcs	74,143.21	0.00	74,143.21
5606910000	Substance Abuse - Outpatient	0.00		
	CORE Services Totals:	286,362.36	0.00	

Account	Support Services	Expenditures	Carryover Expenditures	
5606940000	Emergency Financial Assistance	0.00		
5606980000	Food Bank			
5606460000	Medical Transportation	5,107.55	0.00	5,107.55
5606890000	Other Professional Services			
5606950000	Outreach Services	0.00		
5606930000	Substance Abuse - Residential			
	SUPPORT Services Totals:	5,107.55		
	FY 2024 Award (not inlcuding C/O)	291,469.91		

	TOTAL EXPENDITURES DIRECT SVCS & %:		**$ 291,469.91**	**10.97%**
5606710000	**Recipient Administration**	**1,234.16**		
5606880000	**Quality Management**	**41,666.65**		42,900.81
	Grant Unexpended Balance	**FY 2024 Award** 2,266,201.28	**Carryover** 1,474,770.00	3,740,971.28
	Total Grant Expenditures & % (Including C/O):		**$ 334,370.72**	**8.20%**

Core medical % against Total Direct Service Expenditures (Not including C/O): Cannot be under 75%	**98.25%**	**Within Limit**
Quality Management % of Total Award (Not including C/O): Cannot be over 5%	**1.60%**	**Within Limit**
OMB-GC Administrative % of Total Award (Cannot include C/O): Cannot be over 10%	**0.05%**	**Within Limit**

Printed On: 9/5/2024

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 26, 2024	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Referrals Flowchart	All
	• Service Descriptions: AIDS Pharmaceutical and Mental Health	All
IX.	New Business	
	• Service Descriptions: Outpatient Ambulatory Health and Substance Abuse	All
	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
XI.	Next Meeting**: November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

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October 11, 2024

ADAP Miami-Dade / Summary Report^ – September 2024

Utilization & Expenditures

Month	1st Enrollments	Re-Enrollments	Clients^^	CHD Pharmacy $	RXs	Patients	RX/Pt	Payments	#Premiums	~$ / Premium
Apr-24	93	763	7,182	$1,299,197.75	1,574	759	2.1	$4,760,132.82	2,869	$1,659.16
May-24	99	660	7,358	$1,348,852.85	2,632	781	3.4	$4,661,276.34	2,804	$1,662.37
Jun-24	75	305	7,365	$1,224,156.67	2,319	672	3.5	$4,735,158.01	2,855	$1,658.55
Jul-24	86	268	7,414	$1,281,998.16	2,551	762	3.3	$4,743,763.59	2,867	$1,654.61
Aug-24	72	199	7,495	$1,297,441.51	2,592	744	3.5	$4,715,538.90	2,854	$1,652.26
Sep-24	47	211	7,373	$1,328.957.85	2,666	760	3.5	$4,696,503.85	2,856	$1,644.43
Oct-24										
Nov-24										
Dec-24										
Jan-25										
Feb-25										
Mar-25										
FY24/25	474	2,406	7,373	$7,780,604.74	14,227	4,478	3.2	$28,312,373.51	17,105	$1,655.21

Program Update

*10/01/24: Benefit Level ^	*7,373*	Direct Dispense 56 % *4129* - Premium Plus 44 % *3244 [ACA-MP, Employer Sponsored Insurance, COBRA, Medicare Part-D]*
*10/01/24: Cabenuva ® ^	*245*	Direct Dispense 66 % *161* - Premium Plus 34 % *84*
*10/01/24: Medicare eligible ^	*15*	Under review this month. – *72* uninsured clients within *7-month window around 65th birthday.*
*10/15/24: Medicare	*188*	Open Enrollment. Ends December 7th. Medicare clients can make changes.
*11/01/24: ACA-MP	*2,579*	Open Enrollment. Approved plans [pending]. Ends January 15th.

Date: 10/11/24. - Source: Provide Enterprise & Pharmacy Systems. - ^ All data subject to review & editing. ^^ *Open + Active Pts.* – NOTE: *Expenditures* *__not__* *included for 335 WP uninsured clients.*

Direct Dispense access

	__Current__ Ongoing CHD Pharmacy **Services**	
1	FDOH CHD Pharmacy @ Flagler Street	On Site – 90 days
2	FDOH CHD Pharmacy @ Flagler Street	Mail service
3	FDOH ADAP Program @ West Perrine	CVS Specialty Mail Order

__Additional__ __Pharmacies__ - Magellan RX PBM Miami-Dade – As of 07/01/24		
AIDS Healthcare Foundation	Community Health of SF - CHI	Walgreens
Borinquen Healthcare Ctr	CVS Specialty Mail Order	Fresco Y Más
Miami Beach Community HC	Navarro Specialty Pharmacy	Pharmco RX

__Pharmacy Selection__: It is the client's choice. ADAP Miami assists clients with the pharmacy selection process.

For additional information: www.ADAPMiami.com or ADAP.FLDOHMDC@flhealth.gov

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	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
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Membership Report

October 21, 2024

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

6 *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
Mental Health Provider Representative
Housing, Homeless or Social Service Provider
Other Federal HIV Program Grantee Representative (Part F)
Other Federal HIV Program Grantee Representative (SAMHSA)

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?

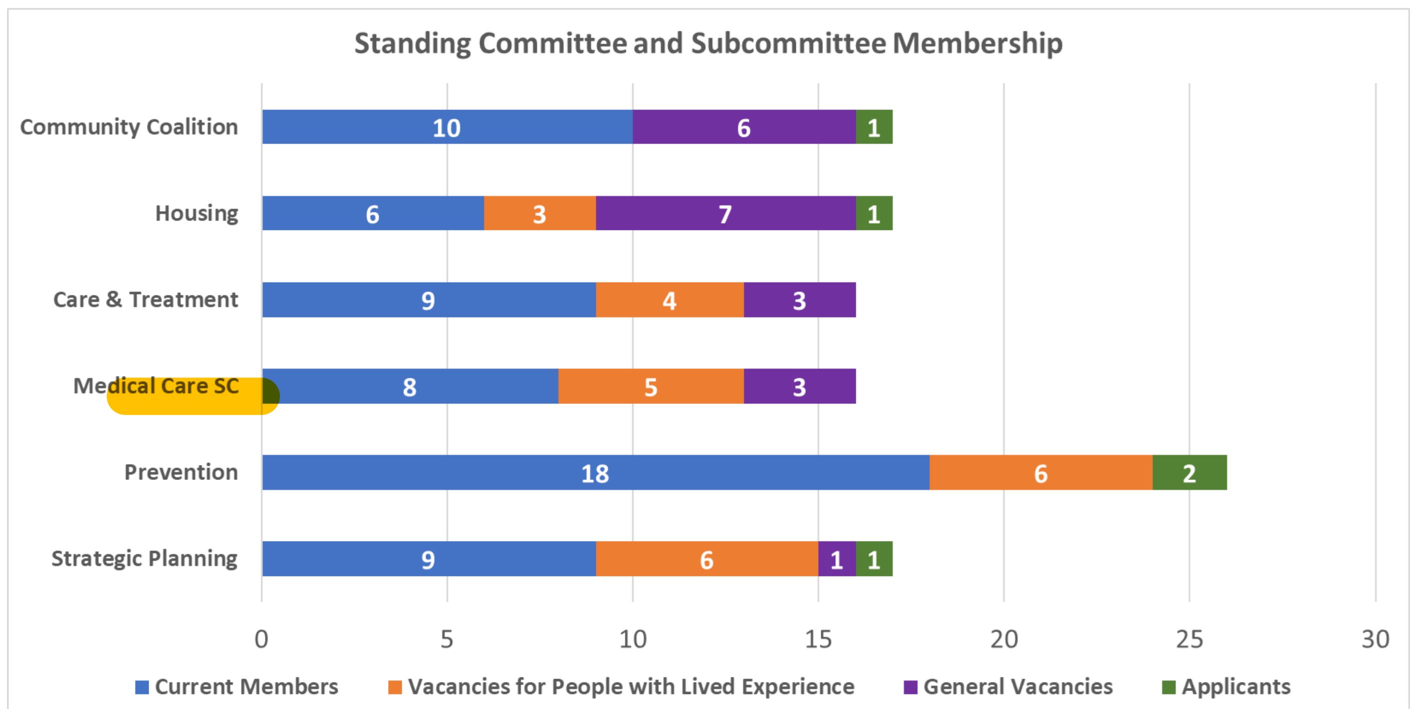
Get Started Today!
Scan the QR Code or contact
mdcpartnership@behavioralscience.com.

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**

Visit www.aidsnet.org/the-partnership/ for the complete list of applications and details on Partnership and committee membership opportunities. Contact us at mdcpartnerhsip@behavioralscience.com or 305-445-1076 for assistance.



MIAMI-DADE HIV/AIDS PARTNERSHIP

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AIDS PHARMACEUTICAL ASSISTANCE
(LOCAL PHARMACEUTICAL ASSISTANCE PROGRAM – LPAP)

(Year 3~~4~~5 Service Priority: #~~8~~5 for Part A)

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

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

IMPORTANT NOTES: Services are restricted to outpatient services only. Inpatient, emergency room, and urgent care center prescription drug services are not covered. Vaccines provided during a medical office visit are no longer found in the local Ryan White Part A Program Prescription Drug Formulary but may be available under Outpatient/Ambulatory Health Services. Prescription drug copayment assistance is not provided for clients with prescription drug discount cards. LPAP services may not be provided on an emergency basis (defined as a single occurrence of short duration). See the General Revenue Short-term Medication Assistance protocol in Section XII of this FY 2024 Ryan White Program Service Delivery Manual for information on how to access to medications on a short-term, emergency basis.

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

DRAFT

2. **Client Education and Adherence:**

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

- Providers are expected to offer basic education to clients on various treatment options~~, including information about state-of-the-art combination drug therapies~~.

- Clients must be encouraged to take medications as prescribed, as well as to follow the recommendations made by l~~L~~icensed m~~M~~edical p~~P~~roviders, n~~N~~utritionists, and ~~P~~pharmacists regarding medication management.

3. **Coordination of Care:**

- Providers must maintain appropriate contact with other caregivers (i.e., the client's m~~M~~edical c~~C~~ase m~~M~~anager, l~~L~~icensed m~~M~~edical p~~P~~rovider, n~~N~~utritionist, c~~C~~ounselor, etc.) and with the client in order to monitor that the client adheres to their medication regimen; and ensures that the client receives coordinated, interdisciplinary support for adherence, and assistance in overcoming barriers to meeting treatment objectives.

- Providers will be expected to immediately inform m~~M~~edical c~~C~~ase m~~M~~anagers when clients are not adhering to their medication regimen (i.e., the client misses prescription refills, misses licensed medical provider visits, or is having other difficulties with treatment adherence).

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

B. Program Operation Requirements:

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

DRAFT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **Letter of Medical Necessity: Continuous Glucose Monitoring (CGM) Devices** require a completed Ryan White Letter of Medical Necessity (LOMN) (See Section V of this FY 2024 Service Delivery Manual for copies of the Letters of Medical Necessity, as may be amended):

ADDITIONAL IMPORTANT NOTES:

- **Medical Case Managers must work with clients to explore in a diligent and timely manner all health insurance options and evaluate the client's best option to ensure that health insurance premiums, deductibles and prescription drug copayments are reasonable and covered by the appropriate payer source. For Medicare Part D recipients, any client whose gross household income falls below 150% of the 2024 Federal Poverty Level (FPL) must be enrolled in the Low-Income Subsidy (LIS) Program. In addition, for Medicare Part D recipients, any client whose gross household income falls between 135% and 150% of the FPL must be enrolled in ADAP for assistance with prescription drug expenses. For Medicare Part D recipients, any client whose gross household income falls above 150% of the FPL or does not qualify for the LIS and who falls into the "donut hole," must be referred to the ADAP Program.**

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 26, 2024	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Referrals Flowchart	All
	• Service Descriptions: AIDS Pharmaceutical and Mental Health	All
IX.	New Business	
	• Service Descriptions: Outpatient Ambulatory Health and Substance Abuse	All
	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
XI.	Next Meeting**: November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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

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MENTAL HEALTH SERVICES

(Year 345 Service Priorities: #37 for Part A and #63 for MAI)

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

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

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

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

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

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

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

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

<u>**Mental Health Service Components**</u>**:**

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

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

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

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

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

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

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

B. Additional Service Delivery Standards: Level I and Level II providers must adhere to generally accepted clinical guidelines for psychological treatment of persons with HIV/AIDS-related illnesses. (Please refer to Section III of this FY 2024 Service Delivery Manual for details, as may be amended.)

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

Tele-mental health services are reimbursed as follows:

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

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

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

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

- American Psychiatric Association (APA). HIV Psychiatry - Training and Education, as well as HIV Psychiatry Resources and Publications [e.g., Fact Sheets (Last Updated: 2012): HIV and Clinical Depression; HIV and Anxiety; HIV and Cognitive Disorders; HIV and Delirium; HIV and Substance Use; HIV and People with Severe Mental Illness (SMI); Sleep Disorders and HIV; and Pain in HIV/AIDS; Publications (including links to other related books and journals, such as the Diagnostic and Statistical Manual of Mental

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Disorders, Fifth Edition, Text Revision-- DSM-5-TR); and additional web-based materials. Available at:

- https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv-psychiatry https://www.psychiatry.org/psychiatrists/practice/professional-interests/hiv- psychiatry and https://www.psychiatry.org/psychiatrists/search-directories-databases Accessed 911/137/20234.

- American Psychiatric Association. Latest Published and Legacy APA Clinical Practice Guidelines; including, but not limited to, The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition, 2015. Available at:

  https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines and https://psychiatryonline.org/guidelines
  Accessed 119/137/20234.

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
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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OUTPATIENT/AMBULATORY HEALTH SERVICES

(Year 345 Service Priorities: #23 for Part A and- MAI)

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

IMPORTANT NOTE: Services are restricted to outpatient services only.

For the outpatient medical services to be considered Ryan White Program allowable, such services must be provided in relation to a client's HIV+ diagnosis, co-morbidity, or complication related to HIV treatment. This program allowable relationship must be clearly documented in the client's medical chart, in the Primary Care Provider's referral to specialty care services, and in any corresponding Ryan White Program In Network Referral or general Out of Network Referral. A list of the most current Allowable Medical Conditions, as may be amended, is included in Section VIII of this FY 20245 Service Delivery Manual for reference. For clarity, one or more of the listed conditions along with one of the following catch-phrases should be included in the Llicensed mMedical pProvider (MD, DO, APRN, PAs) notation and related referral, as appropriate:

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

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

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I. Primary Medical Care

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

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

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

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

a. New to Care Clients

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

b. Limitations on Specialty Testing

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

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

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

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

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

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

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

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

- Maintain contact as appropriate with other caregivers (m~~M~~edical c~~C~~ase ~~M~~manager, n~~N~~utritionist, s~~S~~pecialty c~~C~~are l~~L~~icensed m~~M~~edical ~~P~~provider, ~~P~~pharmacist, ~~C~~counselor, etc.) and with the client in order to monitor health care and treatment adherence;
- Ensure that the client receives coordinated, interdisciplinary support for adherence and assistance in overcoming barriers to meeting treatment objectives; and

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- Identify a single point of contact for Medical Case Managers and other agencies that have a client's signed consent and other required information.

5. Additional primary medical care services may include:

- Respiratory therapy needed as a result of HIV infection.

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

II. Outpatient Specialty Care

1. Outpatient Specialty Care Definition and Functions: This service covers short-term ambulatory treatment of specialty medical conditions and associated diagnostic procedures for program-eligible clients who are referred by a primary care provider through a Ryan White Program In Network Referral, OON referral, or prescription referral. Specialty medical care includes cardiology, chiropractic, colorectal, clinical psychiatry, dermatology, ear, nose and throat/otolaryngology, endocrinology, gastroenterology, hematology/oncology, hepatology, infectious disease, orthopedics/rheumatology, nephrology, neurology, nutritional assessments or counseling (performed by a Registered Dietitian), obstetrics and gynecology, ophthalmology/optometry, pulmonology, respiratory therapy, urology, and other specialties **as related to the client's HIV diagnosis, co-morbidities, or complications of HIV treatment (see Allowable Medical Conditions List in Section VIII of this FY 2024 Service Delivery Manual).**

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

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a. Other Specialty Care Limitations or Guidelines:

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

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

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

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

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

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

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

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

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

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

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

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

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- Taking medications pertaining to specialty care treatment as well as adhering to treatment recommendations made by the p~~P~~rimary ~~C~~care or HIV l~~L~~icensed m~~M~~edical ~~P~~providers; and

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

3. **Coordination of Care:** The specialist must communicate, as appropriate, with the ~~P~~primary c~~C~~are l~~L~~icensed m~~M~~edical c~~C~~are ~~P~~provider and client for results, follow-up, and/or to re-evaluate the client in order to coordinate treatment.

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

B. Program Operation Requirements:

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

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

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

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

C. Additional Service Delivery Standards: Providers of Outpatient/Ambulatory Health Services will also adhere to the following guidelines and standards, as may be amended (please refer to Section III of this FY 2024 Service Delivery Manual for details):

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

- HAB HIV Performance Measures to include the following, as may be amended: (https://ryanwhite.hrsa.gov/grants/performance-measure- portfolio)
  - Frequently Asked Questions
  - Core
  - All Ages
  - Adolescent/Adult
  - Children
  - HIV-Exposed Children
  - Medical Case Management (MCM)
  - Oral Health [Care]
  - ADAP [AIDS Drug Assistance Program]
  - Systems-Level

- Minimum Primary Medical Care Standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Additional Treatment Guidelines and Standards

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

- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv; pp 1-604; updated March 23, 2023. Accessed 11/13/2023.

- Panel on Antiretroviral Therapy and Medical Management of Children Living with HIV. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection. Department of Health and Human Services. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv; pp 1-671; updated April 11, 2023. Accessed 11/13/2023.

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

- Panel on Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. National Institutes of Health, Centers for Disease Control and Prevention, HIV Medicine Association, and Infectious Diseases Society of America. 2023. Available at: https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections; pp 1-670; updated September 25, 2023. Accessed 11/13/2023.

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

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

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

- Additional Education Materials (e.g., fact sheets, infographics and glossary) on HIV Overview; HIV Prevention; HIV Treatment; Side Effects of HIV Medicines; HIV and Pregnancy; HIV and Specific Populations; HIV and Opportunistic Infections, Coinfections and Conditions; and Living with HIV (including but not limited to finding HIV treatment services; Mental Health; Nutrition and Food Safety; and Substance Use). Available at: https://hivinfo.nih.gov/understanding-hiv/fact-sheets
Accessed 11/13/2023.

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

  Standards:

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

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

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

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

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MIAMI-DADE
HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 26, 2024	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Referrals Flowchart	All
	• Service Descriptions: AIDS Pharmaceutical and Mental Health	All
IX.	New Business	
	• Service Descriptions: Outpatient Ambulatory Health and Substance Abuse	All
	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
XI.	Next Meeting**: November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership/

SUBSTANCE ABUSE OUTPATIENT CARE
AND
SUBSTANCE ABUSE SERVICES (RESIDENTIAL)

(Year 345 Service Priorities: #8 for outpatient Part A and #65 for MAI; and #711 for Part A residential only)

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

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

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

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

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

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

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

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

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

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

I. Substance Abuse Outpatient Care

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

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

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

Providers of this service must specify the maximum number of clients expected to be enrolled in a group counseling session. The minimum amount of group participants is three (3) Ryan White Program clients per group and should be no higher than fifteen (15) total persons per group. The ratio of group counseling

participants to Counselors should be no lower than 3:1 and no higher than 15:1. One unit is equal to one half-hour counseling session.

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

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

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

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

- **Tele-substance abuse outpatient care services** are also available. Please see Section XVI, Additional Policies and Procedures, of this Service Delivery Manual for more details.

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B. **Additional Service Delivery Standards:** Providers of these services will also be required to adhere to generally accepted clinical guidelines for substance abuse treatment of persons with HIV/AIDS. (Please refer to Section III of this FY 20245 Service Delivery Manual for details, as may be amended.)

C. **Rules for Reimbursement:** Reimbursement for individual and group Substance Abuse Outpatient Care will be based on half-hour counseling sessions (i.e., 1 unit) not to exceed $30.00 per unit for Level I individual counseling; $34.00 per unit for Level I group counseling; $27.00 per unit for Level II individual counseling; and $30.00 per unit for Level II group counseling. Reimbursement for individual sessions is calculated for each client and/or family member(s) receiving the counseling, whereas, reimbursement for group sessions is calculated for the Counselor that provided the group counseling. Documentation activities are included in the Substance Abuse Outpatient

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

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

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

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

E. **Linkage/Referrals:** Providers of Substance Abuse Outpatient Care must document the client's progress through the treatment program, maintain linkages with one or more residential facilities, appropriate community services, including 12-step programs, and be able to refer or place clients in a residential program, in collaboration with the client, Medical Case Manager, and Licensed Primary Care Provider when that is found to be appropriate. Providers are required to determine if the client is currently receiving Medical Case Management services; if not, the provider must seek enrollment of the client in a Medical Case Management program of the client's choice while the client is still receiving substance abuse treatment/counseling. A linkage agreement with the Medical Case Management provider must be established in order to ensure coordination of services while the client remains in treatment.

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

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

II. <u>Substance Abuse Services (Residential)</u>

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

In accordance with HRSA Policy Clarification Notice #16-02, Substance Abuse Services (Residential), as part of a substance use disorder treatment program funded under the Ryan White HIV/AIDS Program, are permitted **only** when the client has received a written referral from a clinical provider. In Miami-Dade County's Ryan White Part A/MAI Program, this requirement shall be met if the client is accessing the service based on a Ryan White Program In Network Service Referral or Out of Network Referral as a result of a comprehensive health assessment conducted by a Medical Case Manager or other case manager or in response to a court-ordered directive to a residential treatment program. Upon arrival at the residential treatment center and PRIOR TO final enrollment in the treatment program, an assessment MUST be conducted by the residential clinical staff (e.g., Medical Director, Psychologist, Licensed Therapist, etc.) as appropriate using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) assessment

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

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

Residential treatment programs shall comply with the following requirements:

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

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

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

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

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

E. **Special Client Eligibility Criteria:** A Ryan White Program In Network Service Referral or an Out of Network Referral (accompanied by all appropriate supporting documentation) is required for this service. Clients receiving Ryan White Program Part A or MAI-funded Substance Abuse Services (Residential) must be documented as having gross household incomes below 400% of the 20245 Federal Poverty Level (FPL).

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

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

III. Additional Standards and Guidelines

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

- American Society of Addiction Medicine. *The ASAM Principles of Addiction Medicine,* Sixth Edition; November 2, 2018.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 10/07~~25~~/2024.

- American Society of Addiction Medicine (ASAM). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* Fourth Edition.
  Available at: https://www.asam.org/publications-resources/textbooks
  Accessed 10/07~~25~~/2024.

- American Society of Addiction Medicine. Current and archived public policy statements related to the treatment of substance use disorder.
  Available at: https://www.asam.org/advocacy/public-policy-statements
  Accessed 10/~~25~~07/2024.

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

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

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

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

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MIAMI-DADE HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
III.	Meeting Housekeeping	James Dougherty
IV.	Floor Open to the Public	Cristhian Ysea
V.	Review/Approve Agenda	All
VI.	Review/Approve Minutes of July 26, 2024	All
VII.	Reports	
	• Ryan White Program	Carla Valle-Schwenk
	• ADAP Program	Dr. Javier Romero
	• Vacancy Report	Marlen Meizoso
VIII.	Standing Business	
	• Referrals Flowchart	All
	• Service Descriptions: AIDS Pharmaceutical and Mental Health	All
IX.	New Business	
	• Service Descriptions: Outpatient Ambulatory Health and Substance Abuse	All
	• Minimum Primary Medical Care Standards	All
	• 2025 Meeting Dates	All
X.	Announcements and Open Discussion	All
	• New Member Orientation 6, 2024	
XI.	Next Meeting**: November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

Please turn off or mute cellular devices – Thank you

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

Follow Us: www.aidsnet.org | facebook.com/HIVPartnership | instagram.com/hiv_partnership/

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

Statement of Intent: *All local Ryan White Program—funded practitioners are required by contract to adhere, at a minimum, to the Public Health Service (PHS) Guidelines. These standards serve as the minimum standards by which practitioners will be measured.*

I. Requirements

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

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

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

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

Practitioner must:

- Be a Physician (MD or DO), Advanced Practice Registered Nurse, or Physician Assistant/Associates with current and valid license to practice medicine within the State of Florida.
- Have a minimum experience treating 20 HIV+ clients over the past two years or currently working and under supervision of a practitioner meeting these qualifications.
- Treat and monitor patients in adherence with current DHHS Guidelines and other standards of care, to include, but not limited to:
  a. **American College of Cardiology/American Heart Association Guideline on the Treatment of Blood Cholesterol**
  https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625
  b. **Adult Immunization Schedule**
  https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html
  c. **American Association for the Study of Liver Diseases**
  https://www.aasld.org/practice-guidelines
  d. **American Cancer Society Guidelines for the Early Detection of Cancer**
  https://www.cancer.org/healthy/find-cancer-early/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html
  e. **American Medical Association Telehealth Quick Guide**

https://www.ama-assn.org/practice-management/digital/ama-telehealth-quick-guide

f. **Department of Health and Human Services (DHHS) Clinical Guidelines**
https://clinicalinfo.hiv.gov/en/guidelines

g. **Hepatitis (HEP) Drug Interactions University of Liverpool**
https://www.hep-druginteractions.org/

h. **HIV Drug Interactions University of Liverpool**
https://hiv-druginteractions.org/

i. **HIV Prevention with Adults and Adolescents with HIV in the US**
https://www.cdc.gov/hiv/guidelines/recommendations/personswithhiv.html

j. **Health Resources and Service Administration (HRSA) HIV Care for People Aging with HIV**
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-new-elements.pdf
https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/aging-guide-best-team.pdf

k. **Infectious Disease Society of America Primary Care Guidance for Persons with HIV**
https://www.idsociety.org/practice-guideline/primary-care-management-of-people-with-hiv/

l. **Miami—Dade County Ryan White Program (including Telehealth Policy and Test and Treat/Rapid Access [TTRA] program)**
https://www.miamidade.gov/global/service.page?Mduid_service=ser1482944607068715

n. **National HIV Curriculum**
https://www.hiv.uw.edu/alternate

o. **PrEP, nPEP and PEP guidelines below (Although not paid for by the Ryan White Program):**
https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2021.pdf
https://www.cdc.gov/hiv/clinicians/materials/prevention.htmlhttps://www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf

q. **United States (US) Preventive Taskforce**
https://uspreventiveservicestaskforce.org/uspstf/home

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

II. Assessments and Referrals

1. Annual – At each annual visit:

a. Adherence to medications
b. Age-appropriate cancer screening
c. Behavioral risk reduction
d. Gynecological exam per guidance for females
e. Interval changes in vital signs addressed, especially trend in weight/BMI over time
f. Mental health and substance abuse assessment
g. Physical examination, including review of systems
h. Preconception counseling for men and women

i. Rectal examination
j. Safer sex practices – discussions may include PrEP, PEP, nPEP, for sexual partners and should include condom usage
k. Sexually transmitted infection assessment
l. Update comprehensive initial history, as appropriate
m. Vital signs, including weight, BMI, height (no shoes)
n. Wellness exam for females

Assess and document health education on:

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

2. **Additional Charting/Documentation at least annually:**
   a. Allergies list complete and up to date
   b. Immunization list complete and up to date
   c. Medications list complete with start and stop dates, dosages
   d. Problem list complete and up to date

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

3. **Initial** – At initial visit:
   a. Access to stable housing, food, and transportation
   b. Adherence to medications
   c. Age-appropriate cancer screening
   d. Behavioral risk reduction
   e. Comprehensive initial history
   f. Dates of last: mammogram, bone density, colonoscopy, abnormal aortic aneurysm screening, dental visit, and dilated eye exam
   g. Education that they should never run out of ART medications and need to call the FDOH—MDC clinic if they cannot obtain ART
   h. Gynecological exam per guidance for females
   i. If enrolled as Test and Treat/Rapid Access (TTRA) client (patient), follow TTRA protocol for visit
   j. Mental health and substance abuse assessment
   k. Physical examination, including review of systems

l. Pregnancy Planning:
   1) Preconception counseling for men and women
   2) Contraceptive counseling for men and women including assessment and type of birth control method

m. Rectal examination

n. Safer sex practices — discussions may include PrEP, PEP, nPEP for sexual partners and should include condom usage

o. Sexually transmitted infection assessment as appropriate including at a minimum GC, Chlamydia at anatomical sites of potential exposure, RPR, and for females trichomoniasis NAAT of vaginal secretions.

p. Social supports and disclosure history

q. Targeted initial history and physical examination with expectation that a complete history and physical examination will be completed within 3 months.

r. Vital signs, including weight, BMI, height (no shoes)

s. Wellness exam for females

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

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

5. **Telehealth**

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

III. Assessments at Incremental Visits

General Health including Labs

1. **ALT, AST, Total Bilirubin** [i] – Entry into care; ART initiation or modification; 4-8 weeks after ART initiation or modification; every 6 months; or if ART initiation is delayed, every 6-12 months; or if clinically indicated.

2. **Annual wellness visit** (females) [iv] – Should include screenings for anxiety, breast cancer, cervical cancer, interpersonal and domestic violence, obesity prevention (midlife women), sexually transmitted infections, urinary incontinence, and contraception. For those who are pregnant, lactation support and screenings for diabetes mellitus (including post-pregnancy), as applicable.

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

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

5. **CBC w/ differential** [i] – Entry into care; ART initiation or modification; every 3-12 months if monitoring CD4 count (if required by lab); or when clinically indicated. CBC with differential should be done when a CD4 count is performed. When CD4 count is no longer being monitored, the recommended frequency of CBC with differential is once a year. More frequent monitoring may be indicated for persons receiving medications that potentially cause cytopenia [e.g., trimethoprim-sulfamethoxazole (TMP-SMX)].

6. **Colon and Rectal Cancer Screening** [v] – Colorectal cancer screening recommended for individuals between 45-75 years of age. For ages 76-85 screening should be based on personal preference, life expectancy, overall health, and prior screening history. Those over 85 years old should no longer get colorectal cancer screening. Discussion should take place earlier (1) for those with a personal history of colorectal cancer or certain types of polyps, (2) for those with a family history of colorectal cancer, (3) for those with inflammatory bowel disease (ulcerative colitis or Crohn's disease), (4) for those with confirmed or suspected hereditary colorectal cancers syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC), or for those for with a

personal history of getting radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

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

8. **Gynecological Exam** [vi] (females) – In women and adolescents with HIV, initiation of cervical cancer screening with cytology alone should begin within one year of onset of sexual activity, or if already sexually active, within the first year after HIV diagnosis but no later than 21 years of age. Cervical cancer screenings in women who are infected with HIV should continue throughout a woman's lifetime (i.e., not stopping at age 65 years). In women infected with HIV who are younger than 30 years, if the initial cytology screening result is normal, the next cytology screening should be in 12 months. If the results of three consecutive annual cervical cytology screenings are normal, follow-up cervical cytology screening should be every 3 years. Co-testing (cervical cytology and human papillomavirus [HPV] screening) is not recommended for HIV-infected women younger than 30 years. Women infected with HIV who are 30 years and older can be screened with cytology alone or co-testing. After women screened with cytology alone have had three consecutive annual test results that are normal, follow-up screening can be every 3 years. Women infected with HIV who have one negative co-test results (normal cytology and HPV negative) can have their next cervical cancer screening in 3 years. In women with HIV infection, co-testing results that are cytology negative, but HPV positive are managed as in the general population. Women with HIV who have cervical cytology results of low-grade squamous intraepithelial lesions or worse should be referred for colposcopy. For women with HIV infection who are 21 years or older and have atypical squamous cells of undetermined significance (ASC-US) test results, if reflex HPV testing results are positive, referral to colposcopy is recommended. If HPV testing is not available, repeat cervical cytology in 6-12 months is recommended, and for any result of ASC-US or worse on repeat cytology, referral to colposcopy is recommended. Repeat cytology in 6-12 months, but not HPV testing, is recommended for HIV-infected women younger than 21 years with ASC-US test results. Although not explicitly stated in the Panel guidelines, women with HIV infection who have ASC-US, HPV-negative results (whether from reflex HPV testing or co-testing) can return to regular screening.

9. **Hepatitis A Screening** [ii] – At initial screening, if non-immune, offer vaccination and after vaccination received do postvaccination serologic testing 1 or 2 months or at the next scheduled visit. After the second vaccine to assess for immunogenicity. A repeat vaccine series is recommended in those who remain seronegative.

10. **Hepatitis B Serology (HBsAb, HBsAg, HBcAb total)** [i] – At entry into care; at ART initiation or modification, in patients not immune to hepatitis B (HBV), consider retesting if switching to a regimen that does not contain tenofovir disoproxil fumarate (TDF) or tenofovir alafenamide (TAF); as clinically indicated including before starting hepatitis C direct-acting antiviral (HCV DAA). If patient has HBV infection (as determined by a positive HBsAg or HBV DNA test result), TDF or TAF plus either emtricitabine (FTC) or lamivudine (3TC) should be used as

part other ART regiment to treat both HBV and HIV infections. If HBsAg, HBsAb, and HBcAb test results are negative, hepatis B vaccine series should be administered. Most patients with isolated HBcAb have resolved HBV infection with loss of HBsAb. Consider performing an HBV viral load test for confirmation. If the HBV viral load test is positive, the patient may be acutely infected (and will usually display other signs of acute hepatitis) or chronically infected. If the test is negative, the patient should be vaccinated. Refer to the HIVMA/IDSA's Primary Care Guidance for Person with HIV and the Adult and Adolescent Opportunistic Infection Guideline for detailed recommendations.

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

12. **Lipid Profile** [i] – Entry into care;4-8 weeks after ART initiation or modification; consider 1-3 months after ART initiation or modification ; every 12 months if normal at baseline but with cardiovascular risk. If normal at baseline, every 5 years or if clinically indicated. If random lipids are abnormal, fasting lipids should be obtained. Consult the American College of Cardiology/American Heart Association's 2018 Guideline on the Management of Blood Cholesterol for diagnosis and management of patients with dyslipidemia.

13. **Lung Cancer Screening** [x] – Annually with low-dose computer tomography (LDCT) for patients aged 50-80 and in fairly good health, and currently smoking or have quit in the past 15 years, and have at least a 20 pack-year smoking history (e.g. 1 pack a day x 20 years or 2 packs a day x 10 years).

14. **Mammogram (**females) [vii] – Starting at age 40, screening recommended annually. After age 55 every 2 years or can continue yearly screening. Screenings should continue as long as a woman is in good health and is expected to live at least 10 more years.

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

16. **Prostate-specific antigen (PSA) Screening** [viii] (males) – PSA testing is an individualized decision to be made by clinician and patient based on current guidelines.

17. **TB Testing** [ii] – Entry into care or anytime there is concern of a recent exposure. Annual TB test is recommended if patient is deemed high risk (repeated or ongoing exposure to known active TB, after incarceration, after living in congregate setting, active drug user or other risk

factor for TB). If tested when CD4 < 200, repeat after CD4 increases to above 200. Testing using either tuberculin skin test or interferon—γ release assay.

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

HIV Specific

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

20. CD4 cell count [i] – Entry into care; at ART initiation or modification; every 3-6 months during the first 2 years of ART, or if viremia develops while patient is on ART, or if CD4 count is <300 cells/mm^3; every 12 months after 2 years on ART with consistently suppressed viral load, CD4 count 300-500 cells/mm^3, if CD4 count >500 cells/mm^3: CD4 monitoring is optional; if ART initiation is delayed monitor every 3-6 months; if treatment failure or if clinically indicated. *In accordance with the HRSA HAB performance measures, the local program defines consistently suppressed viral load as <200 copies/ml.*

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

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

23. HIV viral load [i] – Entry into Care; at ART initiation or modification; 4-8 weeks after ART initiation or modification if HIV RNA is still detectable, repeat testing every 4-8 weeks until viral load is suppressed to <50 copies/mL. Thereafter, repeat testing every 3-6 months. For

patients on ART, viral load typically is measured every 3-6 months. More frequent monitoring may be considered in individuals having difficulties with ART adherence or at risk for nonadherence. However, for adherent patients with consistently suppressed viral load and stable immunologic status for more than 1 years, monitoring can be extended to 6-month intervals; if ART initiation is delayed, repeat testing is optional; or if treatment failure or if clinically indicated.

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

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

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

Immunizations

Document in medical record carrying data forward to most current volume

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

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

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

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

31. **Influenza vaccination** [ix] – Offer IIV4 or RIV4 annually.

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

33. **Mpox vaccination** – Vaccinate per CDC guidance. See https://www.cdc.gov/poxvirus/monkeypox/vaccines/vaccine-basics.html

34. **Pneumococcal vaccination** –Vaccinate per guidelines**.** For guidance on which pneumococcal vaccine should be used to: www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumoapp.html.

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

36. **Varicella** [ix] – Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 percentage <15% or CD 4 count <200 cells/mm^3.

37. **Zoster vaccination** [ix] — Use 2-dose series recombinant zoster vaccine (RZV, Shingrix) 2-6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon). See vaccination guidelines for detailed information and considerations**.**

STI Screenings

38. **Anal Dysplasia Screening** [iii] – For all patients with HIV ≥35 years old, see information at https://www.hivguidelines.org/guideline/hiv-anal-cancer/?mycollection=hpv-care

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

Footnotes

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[i] Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-arv/whats-new-guidelines. Accessed on August 3, 2023.

[ii] Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV. https://clinicalinfo.hiv.gov/en/guidelines/hiv-clinical-guidelines-adult-and-adolescent-opportunistic-infections/whats-new. Accessed on August 4, 2023.

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[iv] Women's Preventive Service Guidelines. https://www.hrsa.gov/womens-guidelines. Accessed August 3 2023.

[v] American Cancer Society Recommendations for Colorectal Cancer Screening. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed August 4, 2023.

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[viii] American Cancer Society Recommendations for Prostate Cancer Early Detection. https://www.cancer.org/cancer/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html. Accessed August 4, 2023.

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MIAMI-DADE
HIV/AIDS PARTNERSHIP

Medical Care Subcommittee
Friday, October 25, 2024
9:30 a.m. – 11:30 a.m.
Behavioral Science Research
2121 Ponce de Leon Blvd., Ste. 240
Miami, FL 33134

AGENDA

I.	Call to Order	James Dougherty
II.	Introductions	All
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V.	Review/Approve Agenda	All
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	• New Member Orientation 6, 2024	
XI.	Next Meeting: **November 22, 2024** at **BSR**	Cristhian Ysea
XII.	Adjournment	James Dougherty

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Proposed 2025 Meeting Dates

All Dates/Locations are subject to change

Medical Care Subcommittee

9:30 a.m. to 11:30 a.m.

Behavioral Science Research

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Miami, FL 33134

January	24	2025
February	28	2025
March	28	2025
April	25	2025
May	23	2025
June	27	2025
July	25	2025
August	22	2025
September	26	2025
October	24	2025
November	21*	2025

*moved up because of holiday(s)

Medical Care Subcommittee
Calendar of Activities 2024

All items subject to change

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)	Committee Items (added as needed)	Notes
January 26, 2024								
February 23, 2024								
March 22, 2024	N	N	N	N	N	N	N	
April 26, 2024	N	N	N	N	N	N	N	
May 24, 2024	N	N	N	N	N	N	N	
June 28, 2024								Medical Conditions list (Ophthalmology)
July 26, 2024								AIDS Pharma/Mental Health reviewed
August 23, 2024	N	N	N	N	N	N	N	Service Descriptions AIDS Pharma/Mental Health and Outpatient/Ambulatory
September 27, 2024	N	N	N	N	N	N	N	
October 25, 2024								Standards Review begins; final revisions AIDS Pharma/Mental Health; review Outpatient/Ambulatory and Substance Abuse
November 22, 2024								Service Descriptions Continued; OHC service description and standards
December	N	N	N	N	N	N	N	

Comments:
N=no meeting

MIAMI-DADE
HIV/AIDS PARTNERSHIP

Memo

To: Medical Care Subcommittee Members

From: Marlen Meizoso

Date: October 25, 2024

Re: 2025 Officer Nominations and Elections

Annual nominations for the Medical Care Subcommittee Chair and Vice Chair (Officers) are scheduled for the November 22, 2024, Medical Care Subcommittee meeting. Elections will be held at the January 24, 2025, meeting.

Serving as an Officer provides you a great opportunity to enhance your leadership skills, add a new title to your resume, and become a more involved planning council member!

Committee Officers develop agendas with support staff, lead committee meetings, and serve as members of the Executive Committee. Staff provides comprehensive training for all Officers.

For your reference, I am providing the qualifications for Officers as they relate to this Committee, from the Miami-Dade HIV/AIDS Partnership Bylaws (Section 5.1):

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

You are encouraged to add your name as a nominee in advance of the meeting; nominations will also be taken from the floor at the January 24, 2025, meeting. Current Officers who have served less than two years are eligible and encouraged to add their name to the ballot. If you are interested in this opportunity or if you have any questions, please contact me at (305) 445-1076 or by email at marlen@behavioralscience.com.

MIAMI-DADE HIV/AIDS PARTNERSHIP

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HRSA
Health Resources & Services Administration
HIV/AIDS Bureau
5600 Fishers Lane
Rockville, MD 20857

September 18, 2024

Dear Ryan White HIV/AIDS Program Colleagues,

September 18 is National HIV/AIDS and Aging Awareness Day (NHAAD), a day that brings attention to people aged 50 or older who are aging with HIV. Since its inception in 2008, NHAAD has been a day to raise awareness about HIV, address stigma, barriers to care, and encourage people aged 50 or older to get tested and know their status. People with HIV are now able to live long, full lives because of highly effective treatments. Currently more than 50% of Americans with HIV are 50 or older.

Like their counterparts not living with HIV, older Americans with HIV are likely to have at least one chronic health condition, such as cardiovascular disease, diabetes, and osteoporosis. Chronic inflammation caused by HIV can increase the risk of some of these conditions. For example, more than half of the cohort aged 50 or older from the Centers for Disease Control and Prevention's (CDC) HIV Outpatient Study (HOPS) had a heart age at least 10 years older than their actual age. And, people with HIV aged 60 or older have, on average, four co-occurring, non-AIDS-related chronic co-morbidities, which is higher than the non-HIV population in the U.S.[1] Disability is also more common in older adults with HIV than in the general population, affecting an estimated six out of every 10 people with HIV aged 65 or older, and half of those aged 45-64.[2]

In addition to physical health conditions, people aged 50 or older with HIV may have unique mental health needs. For example, cognitive disorders and depression can be exacerbated by the social isolation, loneliness, lack of social support, and stigma sometimes experienced by older people with HIV.[3] In addition, managing HIV and co-morbidities may require taking daily medication, placing people aged 50 or older at risk of polypharmacy, or taking multiple medications at the same time. According to CDC's Medical Monitoring Project (MMP), one in four older adults who had been living with HIV for more than 25 years had been prescribed an average of nine medications.[4]

[1] *Palella FJ, Hart R, Armon C, Tedaldi E, Yangco B, Novak R, Battalora L, Ward D, Li J, Buchacz K; HIV Outpatient Study (HOPS). Non-AIDS comorbidity burden differs by sex, race, and insurance type in aging adults in HIV care. AIDS. 2019;33(15):2327-2335. doi: 10.1097/QAD.0000000000002349.*
[2] *Chowdhury PP, Beer L, Shu F, Fagan J, Luke Shouse R. Disability among adults with diagnosed HIV in the United States, 2017. AIDS Care. 2021 Dec;33(12):1611-1615. doi: 10.1080/09540121.2020.1842318.*
[3] *HRSA Recognizes National HIV/AIDS and Aging Awareness Day | HIV.gov*
[4] *Centers for Disease Control and Prevention. Medical Monitoring Project. Example social messaging* infographic-resilience-50-or-older.jpg (4500×4500) (cdc.gov). *[Accessed 9 September 2024]*

The five 2025 quality of life (QoL) goals set by the National HIV/AIDS Strategy (NHAS) are monitored through five indicators: self-rated health, unmet needs for mental health services, unemployment, hunger or food insecurity, and unstable housing or homelessness. Indicator goals help increase good or better self-rated health to 95% and decrease all other indicators by 50% from their respective baselines by 2025. Recent data as of the 2022 MMP cycle show that more work is needed to reach the five QoL goals for people aged 50 and older with HIV. Multi-sectorial strategies to address these indicators are needed to meet NHAS goals.[5]

Supporting people aged 50 or older with HIV requires a comprehensive, multidisciplinary, and integrated whole-person approach to health care.

CDC works towards optimal and equitable HIV prevention for all who could benefit, treatment for all living with HIV, and quality of life among people living with HIV across their lifespan. To do this CDC conducts and provides:

- Data collection to inform programs, guidance, policies, research, and innovations in program or implementation science, and to translate data into effective programs and care.
- Support for jurisdictions and other partners to conduct surveillance and monitoring, and implement programs and pilots of innovative interventions for HIV prevention and care.
- Capacity building with technical assistance for states and other jurisdictions, and for community-based organizations through funding opportunities and additional technical assistance.
- Communication and education for providers and persons with risk factors for or living with HIV, including community engagement, social marketing, and more directed mechanisms.

The Health Resources and Services Administration's (HRSA) is deeply committed to addressing the unique needs of people aging with HIV through its Ryan White HIV/AIDS Program. Through this program, HRSA ensures that people aging with HIV receive comprehensive, responsive care that addresses both their medical and social needs. The program's ongoing success is helping individuals live longer and healthier lives.

As the population of people aged 50 or older with HIV grows, the Ryan White HIV/AIDS Program provides critical support across a range of core medical and support services to meet their complex health and social needs. These include:

[5] *Centers for Disease Control and Prevention. Progress toward achieving* National HIV/AIDS Strategy *goals for quality of life among people with diagnosed HIV aged ≥50 years—Medical Monitoring Project, United States, 2017-2023. MMWR 2024; 73(36);781–787.*

- Addressing multiple chronic conditions, medication management, and the challenges of social isolation.
- Developing and disseminating effective strategies to improve the well-being of older adults with HIV through the Special Projects of National Significance Program's Aging with HIV Initiative.
- Offering essential training and resources on HIV in older adults with the AIDS Education and Training Center Program's National Coordinating Resource Center.

In collaboration with federal partners, including the Administration for Community Living (ACL), HRSA leverages existing resources and expertise to support the aging HIV population. HRSA collaborates with grantees from the ACL aging network to this end. Over 600 Area Agencies on Aging (AAA) and more than 11,000 senior centers serve as community hubs that provide services and supports like nutrition, transportation, caregiver support, insurance counseling and more.

Aging and Disability Resource Centers (often housed in AAAs) provide unbiased, person-centered counseling on long-term care as a part of the "no wrong door" system to people of all ages and their families and caregivers. Additionally, State Units on Aging are responsible for planning aging services statewide and work closely with the community to ensure they are meeting the needs of diverse state populations. HRSA also encourages Ryan White HIV/AIDS Program recipients to utilize available aging-related services through ACL's Eldercare Locator and to access tools and resources provided on TargetHIV.org.

CDC and HRSA are committed to addressing people aging with HIV this NHAAD. Please help us to promote this special day by sharing CDC's digital toolkit and by using the hashtags #NHAAD.

For more information on aging with HIV, please see the resources below:

Related HIV and Aging Resources
[Link to issue brief, if ready]
SAGE (Advocacy & Services for LGBTQ+ Elders)
  SAGE: HIV/AIDS Resources
  SAGE: LGBTQ+/HIV Long-Term Care Bill of Rights Toolkit
Center for HIV Law and Policy (CHLP): Aging & HIV: An Introduction to Legal Issues Facing People Living and Aging with HIV
O'Neil Institute: Better Integration Between HIV and Aging Systems is Critical

Sincerely,

/Robyn Fanfair/

Robyn Neblett Fanfair, MD, MPH
Captain, USPHS
Division Director
Division of HIV Prevention
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
www.cdc.gov/hiv

/Laura Cheever/

Laura Cheever, MD, ScM
Associate Administrator
HIV/AIDS Bureau
Health Resources and Services Administration

/Jonathan Mermin/

Jonathan Mermin, MD, MPH
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Director
National Center for HIV, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
Stay connected: @DrMerminCDC & Connections

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