DATE: November 8, 2007

TO: Mary Mastrandrea, ValueOptions Acting CEO

FROM: Linda Roebuck, Collaborative CEO


This LOD provides clarification for submission, review, findings and response to findings related to the required Behavioral Health Collaborative reports. This process shall be followed for all Collaborative as well as Agency Specific Reports. Please see attached Behavioral Health Required Report Matrix for complete listing of required Collaborative reports.

Expectations for Reports:

1. Reports are reviewed internally by VO for discrepancies and to ensure accuracy before submission to the Collaborative. Reports should not need reformatting before printing. Reports must be clearly identified by title, report number and reporting period.

2. Analyses address identified areas and each analysis is consistent in addressing each of those areas. The areas are as follows: Purpose, Analysis (including tables, graphs, etc.), Comparative Analysis, and Performance Improvement Activities. The analysis should address any trends (changes) with explanation and any abnormalities, irregularities, or exceptions that were found for the quarter with explanations, and any action steps taken to address the issue.

3. Revised reports are submitted with either the report feedback submission or upon identification of errors. The report must clearly note that it is revised and the revision date must be noted in the footer.

4. Reports shall be submitted timely as per the Report Matrix.

5. If a report is not submitted on time, ValueOptions must submit a request for an extension in writing to the Oversight contact person.

1. Submission of Reports:
   - The SE will deliver reports as follows (see attachment for contact persons):
     - four (4) CDs for Collaborative Critical Indicator, Performance Measures, and Director’s Reports,
     - three (3) CDs to HSD/MAD for HSD agency specific reports,
     - two (2) CDs to CYFD for CYFD agency specific reports,
     - two (2) CDs to NMCD for NMCD agency specific reports,
     - two (2) CDs to HSD/BHSD for BHSD agency specific report,
     - two (2) CDs to ALTSD for ALTSD agency specific reports,
     - two (2) CDs to HSD/TANF for all TANF agency specific reports.
• Reports should be identified and organized on disk by report title, number and reporting period.
  o Examples:
    
    CI-09 – Services Utilization Report - Quarterly Analysis
    Qtr 3 FY07 (Jan-March 2007)
    CI-09 – Services Utilization Report – Outliers
    HSD-02 – Detail Denial Report
    Qtr 3 FY07 (Jan-March 2007)

• The SE will submit an index identifying all reports on the disks. If a required report is not on the disk please explain why it is missing.
  o Index:
    ▪ Report title as per the Report Checklist for all reports contained on disk
    ▪ Report number as per Report Checklist
    ▪ Report period
    ▪ Date of submission
    ▪ Explanation, if report is missing and expected date for submission (must still request the extension)

2. Requirements for Reports:
• Report will include:
  o Header Information
    ▪ Reporting period
    ▪ Date of submission
    ▪ Report title and number as provided on the Report Checklist
  o Certification (required for identified HSD/MAD reports as per LOD #7)
  o Narrative or Analysis
  o Narrative: Monthly Reports (See attached Report Matrix for identification of reports requiring narrative)
    Monthly reports will require a narrative, either on the report or as an addendum to the report. The narrative should, at a minimum, contain the following:
    ▪ Summary of the report
    ▪ Identification of any changes since prior submission
    ▪ Identification of any trends (changes) with explanation and any action steps/performance improvement measures to be taken to address the changes
    ▪ Any other additional information pertinent to the report should also be included.
  o Analysis: Quarterly Reports (See attached Report Matrix for identification of reports requiring analysis)
    Some reports will require an analysis (see attached Report Matrix). The analysis should, at a minimum, contain the following:
    ▪ Data elements outlined specific to each report, where appropriate. Include totals and a comparison to any available baseline data.
Identification of any trends with explanation and any action steps/performance improvement measures to be taken to address the changes or a summary of how an action taken is providing desired results.

Discussion of any abnormalities, irregularities or exceptions that were found for the reporting period with explanation, and any action steps to be taken to address the issues.

Any system changes that might have affected the reported data with explanation

Any other additional information pertinent to the reporting period should also be included.

- Data Certification - some reports require a data certification, for a list please refer to LOD #7

- Reports created externally for the SE (bank statements, audit reports, etc.) should include a separate cover sheet that contains all the report Header Information, Index Information, and Data Certification (if applicable).

**It is understood that the SE will advise the Collaborative regarding any unusual/significant findings regardless of narrative/analysis requirements.**

3. **Submission of Revised Reports:**
   - If the revised report does not contain PHI information, the report may be submitted via e-mail to the designated Collaborative contact person; if the report contains PHI, then four disks must be submitted. If revised reports are emailed, note in the subject line that the report(s) are resubmissions. A secure email account/website will be established for the contact person(s); then PHI information may be submitted via email.

4. **Findings/Comments re: Reports (Content)**
   - The report findings/comments by either the Oversight Team or the agency specific contact person(s) will be incorporated into the “Report Feedback Tracking Sheet” (annual/quarterly/monthly) and forwarded electronically to the SE’s report contact person. The tracking sheet will identify any requested information or questions as well as the dates the information is due.

5. **SE Response to Findings:**
   - The SE’s response to the initial feedback will address all items on the Report Feedback Tracking Sheet. The SE will incorporate their responses on the Report Feedback Tracking Sheet and submit to the contact person via email. Any resubmission of reports will follow the same protocol as identified above.
   - Due dates for the SE’s response to the feedback will be as follows – unless otherwise noted in the Feedback Tracking Form:
     - Annual and Quarterly reports: within thirty (30) calendar days of receipt of “Report Feedback Tracking Sheet.”
     - Monthly reports: within five (5) calendar days of receipt of “Report Feedback Tracking Sheet.”
• Resubmitted reports (either on disc or via email) in response to tracking sheet, will include:
  ▪ Index (see above)
  ▪ Header information (see above)
  ▪ Resubmission date
  ▪ Submission by e-mail if non PHI or
  ▪ Submission by CD if PHI.

6. **Follow-up Comments and SE Follow-up Response:**

• The Oversight Team or Agencies may have follow-up comments, based upon responses submitted by the SE. These will be incorporated into the feedback tracking sheet and forwarded electronically to the SE’s report contact person.

• The SE’s follow-up response will be submitted within five (5) working days by e-mail to designated contact person.

• Upon Oversight’s determination that the SE has responded satisfactorily, the Oversight Team or Agency will “close out” the tracking sheet.

7. **Report Checklist:**

• A checklist has been developed (see attachment) that will assist the SE in naming and verifying all reports are present before submitting to the designated contact person. Please submit the checklist with reports.

**Attachments:**

• Report Checklist **(This checklist is provided to VO as a courtesy, however, VO is responsible for the correct report submission.)**
• Report Matrix
• Oversight and Agency Contact List **(subject to change at which time VO will receive an updated list)**
Date: December 15, 2005

To: Pamela Galbraith, CEO
ValueOptions of New Mexico

From: Matthew Onstott
Oversight Team Lead

RE: Letter of Direction # 12 - REVISED
Administrative/Technical Denials

The original Letter of Direction (LOD) provided clarification for the Statewide Entity (SE) under Article 5.9 of the SFY 07 Contract, regarding the processes for Administrative/Technical denials and appeals. The processes described within this LOD are consistent with CMS requirements and Medicaid regulations. THIS REVISED LOD #12 REPLACES THE LOD dated 10/24/06.

Based upon discussions with ValueOptions of New Mexico (VO) and information from the previous MCOs, it has been determined that, upon receipt of a request for a prior authorization, VO will check all available eligibility to determine if a consumer meets criteria for any Collaborative funding source.

Should it be determined that a consumer does not meet eligibility for any funding source, the request shall be sent back to the provider noting that the consumer is not eligible under any funding stream for the service requested. Ineligibility does not constitute an administrative/technical denial.

VO shall establish a Policy & Procedure to address the issue of “ineligibility” and should establish a procedure to track these requests and to implement provider training (as appropriate) to address repetitive errors with providers. VO’s policy should also address assisting the provider in determining client needs and other options for services/funding.

The following information has not been changed from the original LOD:

UM decisions regarding Administrative/Technical Denials and Appeals

Definition:
- Administrative/Technical denial: A denial of authorization for services due to requests for non-covered services or due to provider noncompliance with administrative policies and procedures established by the SE or the Behavioral Health Collaborative, except pharmaceutical services which the formulary process covers.

1. What is the difference between a clinical and administrative denial?

- In general, Utilization Management (UM) decisions must be based on level of care criteria. In addition, Medicaid covered benefits require the determination of medical necessity. There must be enough clinical information provided to make a decision that the clinical services are needed or not. As stated in the definition, an administrative/technical denial is when there is not enough information to make a decision, or when policies and procedures are not followed in requesting clinical services.

- A provider may not file a clinical appeal without the written consent of the consumer.
2. Can a provider file an appeal for an administrative/technical denial?
   - Yes, a provider can file an appeal for an SE decision that resulted from an administrative/technical denial, without the consent of the consumer.
   - In some instances, the provider MUST request an appeal file for an administrative/technical denial, i.e., if a member receives a bill for services that were administratively/technically denied and requests a provider file an appeal on their behalf.

3. Can a provider file an appeal without consumer consent?
   - A provider can file an appeal without consumer consent related to provider payment issues.

**UM decisions regarding Clinical Denials and Appeals**

Definition:
- Clinical denial: A non-authorization decision at the time of an initial request for a service because clinical need was not demonstrated for the requested level of care, except pharmaceuticals services which are covered by the formulary process. The utilization management (UM) staff may recommend an alternative service, based on the client’s need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

1. When can a provider file an appeal for a clinical denial?
   - A provider may not file an appeal for a clinical denial without the written consent of the consumer. A provider, on behalf of the member, may file a clinical appeal either orally or in writing, but must follow an oral filing with written, signed consumer consent.

2. When is the SE required to get consumer written consent for an appeal?
   - Written consumer consent is required when a provider requests an appeal for a clinical denial.
   - Written consent is required if a provider is requesting an appeal on behalf of the consumer for an SE action taken on behalf of the consumer.

**NOTE:** The Medicaid Managed Care definitions for Administrative/Technical denials and Clinical denials have been adopted by the Collaborative. The definitions included in this LOD should be applied across all funding streams.
Date: February 20, 2007

To: Pam Galbraith, CEO
ValueOptions

From: Matthew Onstott
Oversight Team Lead

RE: Letter of Direction # 13
SFY 2007 BHSD Allocation of funding to Santa Fe Rape Crisis and Trauma Treatment Center and Rape Crisis Center of Central New Mexico

This Letter of Direction (LOD) is for clarification to the Statewide Entity (SE) concerning the Behavioral Health Services Division (BHSD) funding, previously allocated to the Santa Fe Rape Crisis and Trauma Treatment Center and Rape Crisis Center of Central New Mexico from the Preventive Health and Health Services (PHHS) Block Grant. The effective date for implementation of the new changes is July 1, 2006.

The SE shall ensure that $22,736.00, previously allocated to the Santa Fe Rape Crisis and Trauma Treatment Center from the Preventive Health and Health Services (PHHS) Block Grant, is now to be allocated solely for outcome evaluation activities in support of the PHHS Block Grant prevention and outreach services funded through the Department of Health/Office of Injury Prevention (DOH/OIP). The SE shall ensure that the Santa Fe Rape Crisis and Trauma Treatment Center complies with the following:

- Hires an outside, independent evaluator to conduct an outcome evaluation, in accordance with accepted principles of effectiveness, of their PHHS funded prevention activities.
- Collaborates with BHSD, DOH/OIP, and the New Mexico Coalition for Sexual Assault Programs (NMCSAP) to develop and outline the outcome measures to be used in the outcome evaluation.
- Collaborates with BHSD, DOH/OIP, and NMCSAP regarding the outcome evaluation process.
- Submits to BHSD, on a quarterly basis (due the 30th of the month following the reporting quarter), a summary report of the outcome activities and outcome data. The final outcome evaluation report is to be submitted to BHSD 90 days after the end of the fiscal year.

The SE shall ensure that $21,809.00, previously allocated to the Rape Crisis Center of Central New Mexico from PHHS Block Grant, is now to be allocated solely for outcome
evaluation activities in support of the PHHS Block Grant prevention and outreach services funded through DOH/OIP. The SE shall ensure that the Rape Crisis Center of Central New Mexico complies with the following:

- Hires an outside, independent evaluator to conduct an outcome evaluation, in accordance with accepted principles of effectiveness, of their PHHS funded prevention activities.
- Collaborates with BHSD, DOH/OIP, and NMCSAP to develop and outline the outcome measures to be used in the outcome evaluation.
- Collaborates with BHSD, DOH/OIP, and NMCSAP regarding the outcome evaluation process.
- Submits to BHSD, on a quarterly basis (due the 30th of the month following the reporting quarter), a summary report of the outcome activities and outcome data. The final outcome evaluation report is to be submitted to BHSD 90 days after the end of the fiscal year.
Date: July 6, 2007

To: Pamela Galbraith, CEO
ValueOptions of New Mexico

From: Matthew Onstott
Oversight Team Lead

Re: Letter of Direction #14
Fee-for-Service Reimbursement in School-Based Health Centers

This Letter of Direction (LOD) is to notify the Statewide Entity (SE) for behavioral health services that the Medicaid fee-for-service (FFS) program now provides reimbursement to Medicaid-approved school-based health centers (SBHCs). Historically, SBHCs have been able to access Medicaid reimbursement for direct behavioral health services provided only to clients enrolled in Medicaid managed care. However, SBHCs began enrolling as FFS providers on July 1, 2007.

The FFS scope of services for SBHCs remains the same as under managed care, with the exclusion of the T1016 service code. The FFS scope of services shall include:

- 90801 – Psychiatric diagnostic interview examination
- 90804 – Individual psychotherapy, 20-30 minutes
- 90805 - Individual psychotherapy, 20-30 minutes, with medical evaluation and management
- 90806 – Individual psychotherapy, 45-50 minutes
- 90807 – Individual psychotherapy, 45-50 minutes, with medical evaluation and management
- 90808 – Individual psychotherapy, 75-80 minutes
- 90847 – Family psychotherapy
- 90853 – Group psychotherapy
- 90862 – Pharmacologic management

As under managed care, these services are exempt from prior authorization when provided in an SBHC. To ensure that minors may consent to receive these services confidentially and without parental notification, these services are also exempt from Medicaid third-party liability (TPL) rules and from inclusion in the SE’s consumer satisfaction survey.

SBHCs that are not affiliated with a federally-qualified health center (FQHC) will be enrolled in the Medicaid FFS program as provider type 321, which has been redefined as “School-Based Health Center”. To qualify as a FFS provider, all SBHCs must meet the documentation and facility credentialing standards established by the Human Services Department/Medical Assistance Division (HSD/MAD), together with the Department of Health/Office of School & Adolescent Health (DOH/OAH), the SE, and the Salud! managed care organizations (MCOs).
Policy regulations defining the SBHC/Medicaid program will be issued in the Fall, 2007.

If the SE has any questions concerning implementation of this Letter of Direction, please do not hesitate to contact Kari Armijo at (505) 827-3199 or, via e-mail, at kari.armijo@state.nm.us.
DATE: September 10, 2007

TO: Pamela Galbraith, CEO
ValueOptions of New Mexico

FROM: Matthew Onstott, Lead
Collaborative Oversight Team

RE: Letter of Direction #15
Responsibility for Behavioral Health Services for Recipients Eligible for both Medicare and Medicaid

This Letter of Direction (LOD) delineates the payment responsibility of ValueOptions of New Mexico regarding dually eligible Medicaid and Medicare eligible recipients.

ValueOptions is not responsible for paying the co-insurance or deductible on “Medicare cross over claims”. However, ValueOptions does have responsibility for paying other claims for dually eligible recipients because the definition of a Medicare cross over claim is very narrow.

A Medicare crossover claim is one that has been paid by a Medicare Part A intermediary or a Medicare Part B carrier and the only remaining payment due to the provider is the “patient responsibility” calculated by Medicare as the co-insurance, deductible, and psych reduction. The psych reduction is the amount deferred by Medicare when paying only 50% of an allowed charge rather than the more common 80% as with physical health services.

Medicare crossover claims usually automatically “crossover” to ACS as an electronic claim from Medicare and become the responsibility of ACS. In the instances where a Medicare claim does not crossover automatically, the provider must submit a copy of the claim electronically or on paper to ACS. If the provider files a Medicare crossover claim with ValueOptions, ValueOptions should deny the claim telling the provider to file it with ACS.

A Medicare crossover claim can be recognized by an attached Medicare EOB showing the co-insurance and/or deductible. On an electronic claim, the other payment source will be shown as Medicare.

ValueOptions is responsible for processing all other claims for dually eligible recipients that meet the definition of a behavior health claim. These situations include the following:
a) Medicare has denied the claim or service for a non-administrative reason.

- A non-administrative reason is a denial reason that is not due to the error of the provider. Examples are that the patient was not eligible for Medicare on the date of service; that the Medicare benefits have been exhausted; or that the service or provider is not covered by Medicare.

- These do not meet the definition of a crossover claim because there is more to be paid on the claim than the Medicare co-insurance, deductible, or psych reduction.

- Administrative denial reasons are ones that imply provider error or that the provider needs to correct the problem and re-file the claim with Medicare. Examples are that a procedure or diagnosis code is invalid; that no charges were stated on the claim; or that the provider did not submit the claim within the filing limit.

- ValueOptions should deny a claim or service that Medicare denies for an administrative reason.

b) The recipient has chosen a Medicare replacement plan, also known as a Medicare Advantage Plan.

- A Medicare recipient can choose from a number of HMO plans rather than traditional Medicare. When this has occurred, the claim is processed by the HMO Medicare Advantage Plan and not by the traditional Medicare Part A intermediary or Part B carrier. These claims can be recognized by the payer because a co-payment is calculated rather than a co-insurance or deductible.

- ValueOptions is responsible for the claim or service if the Medicare Advantage Plan denies the claims for a non-administrative reason or if there is a co-payment due.

c) A service or provider is not covered by Medicare

- This is essentially the same as (a) above but does not require the provider to file a claim with Medicare to obtain a denial before ValueOptions processes the claim because it is known that Medicare does not cover the service or does not cover the level of BH provider.

d) A recipient is only eligible for Medicare Part B and the service rendered is a Part A type service.

- Some recipients who do not have sufficient work quarters credited to them will never be eligible for Medicare Part A but are enrolled in Medicare Part B.

- When ValueOptions has an inpatient hospital claim for a “Medicare Part B Only” recipient, Medicare will typically pay only lab and radiology on that inpatient claim.
• **ValueOptions** would pay the inpatient hospital claim and apply any Medicare payment for lab and radiology as if it were an insurance payment.

• These claims can be recognized by requiring the provider to use a type of bill that begins with a 12, such as 121, 122, 123, or 124.

• The recipient Medicare HIC number typically ends with a T or M suffix. Also, the information sent to ValueOptions on the enrollment file does give Medicare eligibility for both A and B. A Medicare Part B Only individual will have only Medicare Part B and not Part A.

If you need further information on how to recognize and evaluate claims for Medicare responsibility vs. ACS responsibility vs. ValueOptions responsibility, MAD would certainly be willing to go into more detail with you and your staff.

We would also like to remind you that in making payment for coordinated care recipients, payment of co-payments, co-insurance, and deductibles are only made to the extent that the prior payment plus the amount paid by ValueOptions does not exceed the Medicaid fee schedule.

Should you have any questions, please contact Robert Stevens, Bureau Chief, Benefits Bureau of the Medical Assistance Division of HSD at 827-6207.
DATE: October 3, 2007

TO: Pamela Galbraith, CEO
   ValueOptions of New Mexico

FROM: Linda Roebuck, CEO
   Behavioral Health Collaborative

RE: Letter of Direction #16
    Reimbursement of Interns in Provider Agencies

This Letter of Direction (LOD) provides direction to ValueOptions (VO) on the reimbursement of interns in provider agencies by all Collaborative agencies providing funding to VO.

In response to queries on the use of master's level interns by provider agencies, the Collaborative has taken the position that standards for all agencies will be consistent with Medicaid regulations, which are as follows:

Medicaid Regulation 8.310.16 F NMAC states “Mental health professional services must be provided directly to the recipient by the licensed mental health professionals listed in Subsection A of 8.310.8.10 NMAC*. Services performed by supervised master's level providers, nurses, bachelor's level and other health professionals cannot be billed by the licensed supervisors even though the services may have been furnished under their direction.”

In summary, master's level interns may NOT bill directly for services they render, even when under the auspices of a supervisor, unless they are independently professionally licensed. Supervisors may not bill for services furnished by master's level practitioners.

Medicaid regulation also addresses the use and reimbursement of doctorate level students, interns, residents and fellows. Medicaid Regulation 8.310.2.9 states:

“Physicians who participate in medical training programs as students, interns, residents, fellows or any other training capacities may furnish medical services. These providers may not bill directly for services, unless they are licensed as physicians and are furnishing services within the scope of their medical education.” Reimbursement for services furnished by intern or residents in hospitals with approved teaching programs or services furnished in other hospitals that participate in teaching programs is made through institutional reimbursement (8.310.2.19).

In summary, doctorate level interns may NOT bill directly for services unless they are licensed as physicians furnishing services within the scope of the medical education or unless, as part of an approved teaching program, the institution bills for their services.

The regulations identified above have been in place for Medicaid, but will be adopted by other agencies under the Collaborative effective November 1, 2007.

*MD; PhD, PsyD or EdD; LPCC; LSW; LMFT; or CNS or CNP (certified in psychiatry). All must be licensed in New Mexico.
Date: October 12, 2007

To: Pam Galbraith, CEO
Value Options New Mexico
PO Box 30650
Albuquerque, NM 87109-0650

Jay Czar
NM Mortgage Finance Authority
344 4th SW
Albuquerque, NM

From: Linda Roebuck, Collaborative CEO

Re: Letter of Direction #17
Supportive Housing Appropriation FY08

Dear Ms. Galbraith and Mr. Czar:

This Letter of Direction describes requirements related to the FY08 legislative appropriation for supportive housing, which will be implemented through Value Options New Mexico (VONM) and the New Mexico Mortgage Finance Authority (MFA).

Purpose

This letter lays forth the plan for disbursement and management of the $750,000 legislative allocation for supportive housing as approved by the Behavioral Health Collaborative (Collaborative) at its meeting on May 24, 2007.

Collaborative Responsibilities

1. Through the Technical Assistance Collaborative (TAC), provide ongoing consultation, training, and oversight of the pilot projects to be implemented as a result of the FY08 legislative appropriation.
2. Work closely with TAC consultants and staff teams at VONM to establish services plan and protocol for the rental assistance pilot; train VO staff; conduct monthly feedback sessions with VONM’s Recovery & Resiliency Department and Regional staff involved with housing.
3. Work closely with VONM to develop VONM policies and practice guidelines for outreach, tenant selection, and supportive services.
4. Assist VONM with the training of service providers in targeted communities
5. Provide a single point of contact at the Collaborative regarding project matters
6. Provide current information regarding project requirements
7. Attend planning and implementation meetings as appropriate.
8. Establish evaluation criteria and approve housing tracking system.
VONM Responsibilities

1. Implement Services Plan as part of the Rental Assistance Pilot in target communities during FY08 and in coordination with MFA. Working with TAC consultants and the state point of contact:
   - Establish services plan/protocol in concert with Rental Assistance Program.
   - Establish policies/practice guidelines for tenant selection, referral, screening and service coordination in collaboration with MFA and formalized in Memorandum of Understanding with MFA.
   - Assign, train and oversee staff as primary tenant selection, referral and services liaison contacts for the Rental Assistance Pilot in both the Recovery and Resiliency Department and Regional Offices in designated pilot communities.
   - Train identified providers in selected communities and implement procedures for coordination and delivery of community and housing services and tenant liaison.
   - Coordinate services with identified housing providers through provider contracts and identified incentives.

Budget for this component of the Supportive Housing implementation is $54,000 ($50,000 for services and $4,000 as 8% administrative fee).

2. Work with the Collaborative’s point of contact, MFA, and TAC regarding development of quarterly and year-end reports regarding all phases of the Rental Assistance Pilot.

NMMFA Responsibilities

Value Options will disburse project funds ($696,000) to the Mortgage Finance Authority (MFA), including administrative fees in the amount of $34,800 or 5%, to for each of the following programs for the following purposes:

1. Capacity Building in the Housing Delivery System ($250,000): MFA through the New Mexico Supportive Housing Coalition will enhance and expand the internal capacity of the NM Supportive Housing Coalition in order to provide appropriate assistance to other non-profit organizations with the potential for building program and production capacity for supportive housing related projects. MFA will insure project implementation by 6/30/07 and on going monitoring of project progress. Quarterly program reports will be required.

2. Housing Pre-Development ($146,000): Administered through MFA for non-profit developers as they begin projects. MFA will develop criteria for pre-development projects and provide monitoring of compliance related issues prior to disbursement of agency contracts. Pre-development funds may be used for any activity related to the planning, design and cost associated with implementing supportive housing projects. MFA will insure project implementation and completion prior to 6/30/09. Quarterly Reports will be required.

3. Rental Assistance Pilot ($300,000): MFA will provide overall administration and oversight of the Behavioral Health Collaborative’s Voucher Program for housing providers. MFA in coordination with VONM and TAC will develop policies, and program detail for this Pilot
project. MFA in consultation with TAC will develop, advertise, review, and recommend for approval by the MFA Board of Directors an RFP for the selection of service areas and housing providers for the BHC Voucher program. Selected area sites and housing providers will be forwarded for approval to the Collaborative and VONM. Policies, procedures, and protocols for administration of the Rental Assistance Pilot will be developed jointly by MFA, VO, and TAC. Quarterly reports and coordination meetings will be facilitated by the Collaborative. MFA will cooperate in mutually agreed upon evaluation and tracking protocol.

4. MFA in consultation with TAC will develop and deliver housing provider agencies contracts. MFA will monitor provisions and provide quarterly reports of ongoing contract activity.

5. MFA will train identified housing providers in selected communities and implement procedures for coordination and delivery of housing services and tenant liaison services

Sincerely,

[Signature]

Linda Roebuck, Collaborative CEO

cc: Pamela Hyde, J.D., Collaborative Co-Chair
    Dorian Dodson, Collaborative Co-Chair

By my signature below, I acknowledge my understanding of, and agreement with, the direction provided by this letter.

Pamela Galbraith, CEO
Value Options New Mexico

Jay Czar, Executive Director
NM Mortgage Finance Authority
Date: February 8, 2008

To: Mary Mastrandrea
Chief Operating Officer
ValueOptions New Mexico

From: Linda Roebuck
Chief Executive Officer
New Mexico Behavioral Health Collaborative

Re: LOD #17 Addendum Direction for the Supportive Housing Appropriation FY08 Related to the Rental Assistance Program

This memorandum will serve as an addendum to the Letter of Direction #17, dated October 12, 2007, from the NM Behavioral Health Collaborative that will guide Value Options New Mexico (VONM) in its oversight responsibilities for the housing and support services for the Rental Assistance Program. This addendum clarifies the disbursement and management of the $54,000 allocation for supportive services housing related to the Rental Assistance Program [aka Linkages], as has been informally discussed previously by representatives of the Behavioral Health Collaborative (Collaborative), the Technical Assistance Collaborative (TAC), New Mexico Mortgage Finance Authority (MFA) and VONM personnel.

VONM Responsibilities

1. Implement the Services Plan as part of the Rental Assistance Pilot (aka Linkages) in target communities during FY 08 in coordination with MFA by working with TAC consultants, the Behavioral Health Supportive Housing Coordinator and the state point of contact to: a) oversee, coordinate and ensure that appropriate services are provided to all Linkages clients as needed regardless of funding source eligibility status, (per Section 7.4, pg 113 of Statewide Behavioral Services Contract); and, b) provide appropriate quality assurance and oversight on contractual relationships.

2. Upon implementation of the Linkages program in February 1, 2008, disburse the Support Services Capacity funds, i.e. $54,000 ($50,000 for services and $4,000 as 8% administrative fee to VONM) to the participating support services organizations in the following manner:
<table>
<thead>
<tr>
<th>Linkages Site</th>
<th>Payee</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 5: Southwest New Mexico</td>
<td>Border Area Mental Health Services, Inc. (administer 10 vouchers)</td>
<td>$16,666</td>
</tr>
<tr>
<td>Santa Fe</td>
<td>The Life Link (administer 10 vouchers)</td>
<td>$16,666</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>First Nations Community Healthsource (administer 8 vouchers)</td>
<td>13,334</td>
</tr>
<tr>
<td></td>
<td>Albuquerque Healthcare for the Homeless (administer 2 vouchers)</td>
<td>3,334</td>
</tr>
<tr>
<td></td>
<td><strong>Total Disbursement</strong></td>
<td>$50,000</td>
</tr>
</tbody>
</table>

3. Work with the Collaborative’s point of contact, the Behavioral Health Supportive Housing Coordinator, MFA and TAC regarding the development of necessary monthly, quarterly and year end reports regarding all phases of the Rental Assistance Pilot.

Cc: Jay Czar, Mortgage Finance Authority
    Joseph Montoya, Mortgage Finance Authority

By my signature below, I acknowledge my understanding of, and agreement with, the direction provided by this letter.

Mary Mastrandrea, Chief Operating Officer
Value Options New Mexico
Date: February 8, 2008

To: Jay Czar
   Executive Director
   New Mexico Mortgage Finance Authority

From: Linda Roebuck
   Chief Executive Officer
   New Mexico Behavioral Health Collaborative

Re: LOD #17 Addendum - Direction for the Supportive Housing Appropriation FY08 Related to the Capacity Funds for Housing Delivery System

This memorandum will serve as an addendum to the Letter of Direction #17, dated October 12, 2007, from the NM Behavioral Health Collaborative that will guide the New Mexico Mortgage Finance Authority (MFA) in their oversight responsibilities for the disbursement of the Capacity Building Funds in the Housing Delivery System ($250,000).

NMMFA Responsibilities

Value Options has previously disbursed project funds ($696,000) to the Mortgage Finance Authority (MFA), including administrative fees in the amount of $34,800 or 5%, for each of the following programs for the following purposes:

Capacity Building in the Housing Delivery System ($250,000): MFA will disburse these funds to qualified housing development organizations based on the New Mexico Behavioral Health Collaborative’s supportive housing policy direction, consistent with the Long Term Supportive Housing Plan, in order to enhance and expand the internal capacity of those organizations with proven production capacity to produce additional supportive housing related projects. MFA will insure project implementation by 5/31/08 or earlier; and, on going monitoring of project progress. Quarterly program reports will be required.

Items 2, 3, 4, 5 will remain as worded in the original Letter of Direction.
By my signature below, I acknowledge my understanding of, and agreement with, the direction provided by this letter.

Jay Czar, Executive Director
NM Mortgage Finance Authority

Cc: Mary Mastrandrea
    Chief Operating Officer
    Value Options New Mexico
DATE: February 20, 2008

TO: Jay Czar  
Executive Director  
New Mexico Mortgage Finance Authority

FROM: Linda Roebuck, CEO  
New Mexico Behavioral Health Collaborative

RE: Direction for Primero Loan Program for Pre-Development  
and Housing Capacity Development Funds  
Addendum to LOD#17 for Supportive Housing Appropriation FY08

This letter will serve as an addendum to the Letter of Direction #17, dated October 12, 2007, from the New Mexico Behavioral Health Collaborative that will guide the New Mexico Mortgage Finance Authority in its oversight responsibilities for the implementation of the Pre-Development and Housing Capacity Development Funds for the Supportive Housing program.

Based on action taken at the May 24, 2007 Behavioral Health Collaborative meeting, the Collaborative elected to focus its initial supportive housing investments in addressing two target populations – the severely mentally ill population and transitioning youth who are aging out of the foster care system or exiting the juvenile justice system. Therefore it is requested that the $150,000 in Pre-Development funds and $250,000 for Housing Capacity Development funds, as identified in LOD #17, and funded by the Collaborative, be used for supportive housing units that serve these two population groups only. In addition, to ensure that the rental units are affordable for these populations, the prospective developer should be advised that the rents offered for these supportive housing units should be at or below 30% of the participant tenant’s income.

By my signature below, I acknowledge my understanding of, and agreement with, the direction provided in this letter.

[Signature]

Jay Czar, Executive Director  
New Mexico Mortgage Finance Authority

Cc: Jane L. McGuigan  
Supportive Housing Coordinator