NORTH CAROLINA PERMANENT SUPPORTIVE HOUSING ASSESSMENT WITH RECOMMENDATIONS TO COMPLY WITH THE *OLMSTEAD* SETTLEMENT

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A. Executive Summary

In April of 2016, the North Carolina Housing Finance Agency (NCHFA) and the North Carolina Department of Health and Human Services (DHHS) embarked on a process to assess affordable housing and supportive services and provide strategic recommendations to create and maximize permanent supportive housing across the state. The goals of this report, *North Carolina Permanent Supportive Housing Assessment with Recommendations to Comply with the* Olmstead *Settlement*, are to accelerate the state's efforts toward meeting its community-based housing placement goals outlined in the *Olmstead* settlement agreement with the U.S. Department of Justice (DOJ), and to guide the state's efforts to create and maximize permanent supportive housing (PSH) for priority consumers identified by DHHS. NCHFA contracted with the Technical Assistance Collaborative, Inc. (TAC), a national nonprofit consulting and technical assistance firm and a recognized leader at the intersection of affordable housing, health care, and human services and systems, to facilitate its process and develop this report.

TAC's analysis revealed several housing and service system and advocacy partners that play critical roles in helping NCHFA and DHHS to achieve meaningful system reform. While the current priority of all partners is successful implementation of the settlement agreement, their overall objective is to ensure that all special needs populations served by DHHS have access to permanent supportive housing. The state's network of Local Management Entity/Managed Care Organizations (LME/MCOs) is largely responsible for implementing the settlement agreement. The LME/MCOs play a significant role not only in locating housing, but also in managing and authorizing appropriate tenancy support and behavioral health services for the settlement population, while also serving the broader population of individuals with mental illness, substance use disorders, and intellectual and development disabilities.

TAC developed eight strategic goals in close consultation with state leadership from NCHFA and DHHS. These goals reflect input from each of the LME/MCOs, key stakeholders and consumers, a review of current housing and supportive services resources, and a PSH gaps analysis. In order to accomplish each of these strategic goals, this report proposes a series of recommendations for the state to implement, in partnership with the LME/MCOs both in the short term (over the next one to two years) and long term (in the next two to five years).

Goal 1: Strengthen a cross-system, coordinated, and collaborative approach to permanent supportive housing policy for all populations.

Goal 2: Maximize existing PSH opportunities with a focus on improving access in six high-value counties.

Goal 3: Increase pipeline of new permanent supportive housing opportunities, initially creating PSH units targeted for the settlement population.

Goal 4: Reinforce development of provider capacity and accountability to deliver person-centered services to the settlement population and expanding across all populations.

Goal 5: Enhance LME/MCO staff core competencies to ensure quality services across all populations.

Goal 6: Further develop Medicaid services for the provision of tenancy supports, initially focusing on individuals in the settlement population.

Goal 7: Clarify and reinforce proper roles and responsibilities in the provision of integrated permanent supportive housing at the state, regional, and local levels to ensure a sustainable infrastructure at all levels.

Goal 8: Invest in robust data collection, reporting, and evaluation systems to improve referral processes and track outcomes effectively.

The NCHFA and DHHS will determine how to prioritize these strategic goals based upon the state's goals and resources; however, we do encourage a focus on maximizing existing and creating new permanent supportive housing opportunities for the settlement population as quickly as possible. We recognize that disaster recovery efforts for communities impacted by Hurricane Matthew will continue to be a consideration in moving forward on these recommendations.

TAC suggests that a PSH leadership steering committee be established to oversee and coordinate implementation of the recommendations outlined in this report. Incorporating these recommendations, the committee should develop and execute a North Carolina Strategic Housing Plan with a detailed action plan. In addition, NCHFA and DHHS should dedicate state-level leadership and staff to support implementation and produce an annual progress report that includes specific benchmarks to measure progress towards full implementation.

The North Carolina Housing Finance Agency and DHHS should work with the LME/MCOs to align their housing plans with the state's Strategic Housing Plan. A range of incentives and support should be offered to LME/MCOs to encourage the use of reinvestment resources for housing-related goals, and to incorporate these within the LME/MCOs' housing plans.

Finally, NCHFA and DHHS should consider implementing an external communications plan to roll out the Strategic Housing Plan and to provide regular updates on its progress. Many of the state's advocacy partners can be helpful with messaging about the affordable housing needs of people with disabilities, the goals of the Plan, and implementation progress to the public and to key stakeholder groups — including entities that control needed housing resources — in order to build ongoing support for successful implementation and sustainability.

B. Introduction/Methodology

Stakeholder Engagement
To help formulate the basis for the strategic recommendations in this report, a multidisciplinary team of TAC consultants with expertise in behavioral health and affordable housing systems met for a kickoff meeting and on several other occasions with:

- NCFHA leadership
- DHHS leadership
- Other housing and services staff

LME/MCO staff members were also actively involved in the strategic assessment process. TAC conducted day-long interviews at each LME/MCO and conducted consumer focus groups at the Smoky, Alliance, and Trillium LME/MCOs (see Appendix II). Key informant interviews were conducted with housing developers, specific provider and advocacy agency staff, University of North Carolina (UNC) at Chapel Hill Assertive Community Treatment (ACT) technical assistance staff, and others.

Additionally, TAC staff received data from DHHS, NCHFA, and SocialServe.com to assist in conducting a housing resource assessment and gaps analysis for the state's existing and needed housing resources.

Identification of the 20 Priority Counties
The state identified 20 priority counties to be the focus of TAC's work: Buncombe, Burke, Cabarrus, Caldwell, Craven, Cumberland, Durham, Forsyth, Gaston, Guilford, Iredell, Johnston, Mecklenburg, New Hanover, Onslow, Pitt, Robeson, Rowan, Wake, and Wayne. Using information from the Transitions database, DHHS determined that these were the counties that consumers who had been granted a housing slot at the time of the study were most likely to have identified as their preferred living location.

Acknowledgments
This report is the result of a truly collaborative process that involved many individuals and organizations across the state of North Carolina. A complete list of stakeholders who played a role is included in Appendix I. We extend special thanks to NCHFA and DHHS staff for their leadership and engagement during this strategic assessment process. Additionally, TAC would like to thank the LME/MCOs for participating in the interview process and making all key staff available.

C. Integrated Permanent Supportive Housing Policy Discussion

Americans with Disabilities Act/*Olmstead*

The inclusion of more integrated PSH options within states is in part attributable to the model's demonstrated effectiveness with individuals who have complex needs, and perhaps more to the recent enforcement of federal community integration law within states. This is especially true in public behavioral health systems where lack of availability or access to integrated PSH options and a corresponding overreliance on congregate or institutional settings has seriously limited the housing choices available to people with mental illness.

Permanent supportive housing, which is recognized as an evidence-based practice by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), combines lease-based, permanent affordable housing in the community with voluntary, flexible, and individualized services to ensure successful tenancies.[1] Research shows that PSH is more cost-effective than institutional or congregate housing options, is better aligned with the individual housing preferences of many people with mental illness, and demonstrates positive outcomes such as reduced hospitalizations and homelessness, increased housing stability, and improved behavioral and physical health. While PSH was previously thought to be successful only for individuals who were "high functioning," several states including North Carolina are now implementing PSH to serve a cross-disability population with some of the most complex challenges, including individuals with severe mental illness and substance use disorders; those coming out of inpatient settings, jails, or correctional facilities; and people who have experienced chronic homelessness.

The U.S. Supreme Court's 1999 *Olmstead* decision upheld Title II of the Americans with Disabilities Act (ADA) and the right of individuals with disabilities to live in the least restrictive, most integrated settings possible.[2] The decision required states to plan affirmatively to serve people in integrated, community-based settings. Since the decision, many states have worked to transition from institutionally-based systems of care that rely on congregate residential settings (e.g. state hospitals, assisted living facilities, residential care, and adult care homes) to more integrated models like PSH. Some states like North Carolina have been sued or have entered into settlement agreements with the DOJ or state legal advocates as a result of an overreliance on segregated settings. PSH is included in such settlements as a primary remedy to serve people in more integrated settings.

Also worth noting is that several recent changes to Medicaid at the federal level are influencing state activities. As states recognize the costs of serving individuals with complex needs in long-term care settings, as well as individuals who are uninsured or underinsured, the Center for Medicare and Medicaid Services (CMS) is working with states to implement

[1] Substance Abuse and Mental Health Services Administration. (2010). *Permanent Supportive Housing Evidence-Based Practices Kit.* Rockville, MD: SAMHSA.

[2] *Olmstead v. L.C.*, 527 U.S. 581

best practices designed to serve people in more integrated, cost-effective settings. CMS has released an Informational Bulletin for state Medicaid directors on ways to pay for housing-related supports with Medicaid funds,[3] and states are increasingly incorporating managed care strategies and services known to produce positive outcomes (e.g. ACT, tenancy support services, and care coordination) into their Medicaid plans.

The State's Role in Creating Integrated PSH for a Cross-Disability Population

Since 2002, NCHFA has partnered with DHHS to facilitate the inclusion of PSH targeted to people with disabilities and homeless populations in Low Income Housing Tax Credit (LIHTC) developments. This resulted in the creation of set-asides of PSH units within new affordable rental housing properties, and a sustained production pipeline of integrated supportive housing for people with disabilities, with approximately 4,400 units created through this Targeting Program. Housing developers with PSH units in their properties are required to receive referrals from the DHHS Regional Housing Coordinator staff who coordinate with local human services agencies to ensure the intended target populations are connected with appropriate community-based services.

North Carolina is considered an early adopter of this integrated permanent supportive housing model for people with disabilities which has been replicated in other states, most notably Louisiana following the hurricanes Katrina and Rita in 2005. DHHS leadership played an important role in the adoption of the Targeting Program within the state's broader housing policy, and was critical to developing strong support for the program within the General Assembly to ensure state revenue to support and sustain the program.

The DHHS, in partnership with NCHFA, has led the Targeting Program through several significant changes over the years, including: the creation of the Key Program to provide project-based rental assistance to make PSH units affordable to extremely low-income (ELI) people with disabilities; the reassignment of waiting list management for Targeting Program units from local service entities to regionally-based DHHS housing coordination staff to ensure long-term program sustainability of the referral process and to allow service agencies to focus on ensuring successful tenancies; and the expansion of Regional Housing Coordinators across the state. The entry of DHHS into its *Olmstead* settlement agreement with the DOJ to move a substantial number of individuals with serious mental illness out of adult care homes (ACHs) into integrated PSH settings served as an added catalyst to expand integrated PSH in the state and to build on the efforts of the Targeting Program. Although the DHHS target population for the Targeting Program units is extremely low-income households with disabilities including frail elders and persons who have been homeless, the state has prioritized people with mental illness living in or at risk of entering ACHs for these units. While this step is necessary to meet the aggressive timelines and benchmarks in the settlement agreement, DHHS will ultimately want to build upon lessons learned from the Targeting Program and continue its housing and service partnerships to create and sustain integrated PSH at both the state and local levels.

[3] CMS (June 2015): http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

Efforts to Meet DOJ Settlement and Community Integration Goals

In 2012, North Carolina reached a settlement agreement with the DOJ to facilitate the transition of adults with serious persistent mental illness from ACHs into more integrated settings. The substantive provisions of the agreement dictate a timeline and benchmarks for transitioning and sustaining eligible individuals in community-based supportive housing slots through in-reach, discharge planning, and transition services, as well as mental health services to include ACT teams, community support teams, case management, peer support, psychosocial rehabilitation services, crisis services, and supported employment.

The state is implementing its plan to meet the terms of the settlement agreement under its Transitions to Community Living Initiative (TCLI). The North Carolina General Assembly has appropriated resources for DHHS to expand supportive services to meet the needs of members of the target population who transition to community-based PSH settings. DHHS also provides state-appropriated funding for tenant-based rental assistance. State agency partners have primarily focused on tenant-based PSH strategies in an effort to meet the aggressive timelines and benchmarks in the agreement, and, as noted above, have prioritized access to Targeting Program units.

Still, the state has fallen short of its requirements for housing placement. DHHS has been relying on the seven LME/MCOs to identify TCLI-eligible individuals and transition them to PSH, and to ensure that ongoing tenancy support services are delivered through the LME/MCOs' provider networks. DHHS has completed a root cause analysis and has begun implementing strategies to address identified barriers to speed up housing placements. DHHS has been working with the LME/MCOs to address barriers to effective service delivery, and is actively exploring modifications to the Medicaid state plan and waiver services to increase the availability of housing-related services for the TCLI and other potential PSH target populations in the future. Recommendations in this report are aimed at clarifying roles and responsibilities, and at building the capacity of both the LME/MCOs and their providers to meet the terms of the settlement agreement.

It is important to note that the focus of this report is the transition of people living in an ACH or state psychiatric hospital to an appropriate housing resource coupled with appropriate services fully integrated into the community. There is also considerable work simultaneously occurring to divert people from even entering an adult care home. DHHS is currently working on a quality improvement initiative specifically focused on diversion activities to ensure people have alternate options and full access to supportive housing, as do those transitioning. While this diversion work is not the focus of this report, it is important to acknowledge the importance of these efforts in attaining meaningful system change in North Carolina.

D. Housing Resources Assessment

TAC reviewed the current array of housing resources in order to identify resources available to individuals living in PSH settings and other resources that could be modified or adapted to create additional PSH opportunities. There are many federal- and state-funded housing resources in North Carolina that could be accessed by people with disabilities, and specifically by individuals within the settlement population. See Appendix III for the complete assessment of key affordable housing resources that could be harnessed to create or sustain PSH, with a focus on the 20 priority counties identified in the settlement agreement.

Here are the key findings from the housing resource assessment:

- The majority of the housing authorities in the six high-value counties utilize waiting list preferences of which settlement population members could take advantage.[4]

- Eleven of seventeen North Carolina jurisdictions used U.S. Department of Housing and Urban Development (HUD) HOME funds to create affordable rental units with approximately 239 units produced.

- The 2016 Continuum of Care (CoC) program Notice of Funding Availability made available relatively higher levels of funding, allowing local CoCs to propose new PSH bonus projects and to reallocate funding from existing projects to new PSH in their communities.

- There are currently 2,715 targeted units in the 20 priority counties.

E. Housing and Supportive Services Capacity and Resources Assessment

There are several housing and service system and advocacy partners that play critical roles in helping NCHFA and DHHS to achieve meaningful system reform. While the current priority of all partners is successful implementation of the settlement agreement, their overall objective is to ensure that all disability populations served by DHHS have access to permanent supportive housing opportunities to enable them to live fully integrated lives in the community.

[4] TAC identified six high-value counties (Buncombe, Guilford, Forsyth, Mecklenburg, New Hanover, and Wake) that represent the highest demand level in terms of choice among consumers covered by the *Olmstead* settlement. Several of them also include private rental markets with the lowest vacancy rates. This is discussed in greater detail in the Housing Gaps Analysis, Appendix V.

Housing Capacity Assessment

An early adopter of creating integrated permanent supportive housing nationally, the state of North Carolina has many housing capacity and partner strengths as it moves to achieve the goals of the settlement agreement. Furthermore, the NCHFA in close collaboration with DHHS has shown success in the production of integrated PSH through the Targeting/Key Program.

Specific to the settlement agreement, each LME/MCO has assembled a transition team that includes transition coordinators and peer specialists responsible for in-reach, diversion, and housing placement activities for those individuals living in an ACH or at risk of entering one. These staff members are also responsible for transitioning individuals to the community in appropriate PSH coupled with services as per their person-centered plans. Each LME/MCO is required to develop a strategic housing plan that includes an inventory of existing housing for all the consumers it serves — including those with mental illness, substance use disorders (SUDs), and Intellectual or Developmental Disabilities (I/DDs) — as well as their housing needs, strategies for filling the gaps between assessed need and available resources, strategies to address any barriers, and an assessment of the plan's implementation.

The LME/MCO staff also includes a housing specialist to assist with housing matters for all populations. Each LME/MCO has chosen to structure its TCLI and housing staff in a different way, with some embedding their housing support within the TCLI team, and others relying on contract positions with nonprofit partners, or housing specialists within another section of the organization. The housing staff works with the transition coordinators to identify the first- and second-choice counties of the consumer and focus the housing search accordingly. During the consumer listening sessions facilitated by TAC, consumers reported that the LME/MCO housing specialists they had worked with were helpful in supporting their housing search and in helping them maintain tenancy.

Department of Health and Human Services Regional Housing Coordinators (RHCs) are also a resource for the LME/MCO housing specialists. The RHCs manage referrals for the targeted units in their regions, for all eligible populations including those individuals who are part of TCLI. The LME/MCO housing specialists and transition coordinators work with the RHCs to submit reasonable accommodation requests when consumers are denied a targeted unit. The LME/MCOs remarked that they were having more success with these reasonable accommodations, especially with projects that did not have large property management companies with lengthy tenant screening policies.

Many of the LME/MCOs are actively involved with their CoC, and this partnership continues to be fruitful, especially for connections within the private market using Transition to Community Living Vouchers (TCLVs). As other housing providers are searching for units to utilize their tenant-based rental assistance, CoC meetings have become a place to share resources among all the providers. Additionally, some LME/MCOs administer their own CoC rental assistance, and gain property owner partners who are willing to work with consumers from the settlement population. Finally, some LME/MCOs have explored options with their local Public Housing Authority (PHA) partners to perform some aspects of the lease-up process in the private market, such as Housing Quality Standards.

Challenges to Housing Resources

The greatest universal challenge to successfully providing housing to consumers with a TCLI voucher is the range of housing partners and property owners across the state. While some LME/MCOs have vast knowledge and a geography rich with housing opportunities and owner networks, others are working within a largely rural geography with a lack of adequate housing opportunities that match the needs of the settlement population who have a TCLI voucher. For instance, in many counties, large single-family homes make up much of the private rental market while the settlement population is mainly seeking one- or two-bedroom units. Furthermore, once units are identified in the private market, at times there are issues with the unit's meeting Housing Quality Standards. Owners who are working with the LME/MCOs and the TCLI subsidy program for the first time are reluctant to make additional repairs. These first-time owners are also hesitant to lease up with consumers who have criminal or credit background check issues, and in some of the high-value counties require an income that is three times the amount of the rent, which is not possible with the settlement population.

Transportation also remains a challenge throughout the state. Within the six high-value counties, 68 percent of the targeted units are within a half mile of public transportation,[5] but the LME/MCO staff explained that it was more difficult to find units in the private market that were as close to public transportation. Outside of the six high-value counties, consumers rely primarily on county community transportation programs, which provide transportation to medical facilities and pharmacies. In listening sessions, consumers reported these systems to be reliable to an extent, but also said that they were expensive and didn't provide routes to other places people wanted to go (e.g. workplaces).

Another issue is the lack of a state PHA or state Community Development Department. The absence of state-level direction leaves all of the priority counties' PHAs (except Asheville's) without a waiting list preference specifically for the settlement population. It should be noted that some PHAs have a general disability preference. Many of the LME/MCOs did not describe a close relationship with their local PHA, further distancing members of the settlement population from one of the most significant housing resources available to them.

Based on interviews with key stakeholders, TAC identified a need for a greater understanding of fair housing requirements and reasonable accommodation practices among frontline property management staff and direct support service staff. As a result, there appears to be potential barriers to access both rental units in the private rental market as well as Targeted/Key properties (e.g. higher application denial rate).

Finally, a significant barrier to discharging or diverting people from an ACH to supportive housing in the community is the involvement of consumer guardians. Many consumers have been adjudicated incompetent and assigned a guardian by the court. The guardian can be private, such as a family member, or a public entity appointed by the court. The guardian is then involved in the decision for the consumer to leave the ACH and move to supportive

[5] Data from RHC spreadsheets on Targeted Units

housing. In a number of cases, the guardian does not agree to the person's leaving the ACH. A consumer may want to leave and be ready to succeed in the community with the proper services and supports, but if the guardian does not agree, the person cannot move. This has been a barrier for the LME/MCOs and has impacted their ability to successfully transition people to the community. When the guardian is a public entity, the transition team makes an effort to reach out to the guardian and educate them in order to facilitate the discharge.

Service System Capacity Assessment

The LME/MCOs across North Carolina bear much of the responsibility for implementing the settlement agreement, and at the same time must ensure that all service recipients, not just those who are the focus of the agreement, have access to appropriate supportive services. The LME/MCOs play a significant role not only in locating housing but also in managing and authorizing appropriate tenancy support and other appropriate behavioral health services. In order to fulfill this responsibility, they must ensure an adequate network of providers to serve their consumers. They are responsible for provider monitoring, network development, consumer choice of providers, access (especially in rural areas), and regular assessment of network adequacy. Each LME/MCO approaches these roles differently, but all have a common goal to ensure that people have access to decent, affordable supportive housing that is integrated in the community. All LME/MCO representatives spoke about their role in locating housing through either private owners or NCHFA's Targeting Program.

The LME/MCO-contracted service providers are crucial to ensuring that consumers who leave ACHs are able to live successfully in the community. The providers' ability to serve people and support them to maintain their housing and manage their mental illness will have an impact on compliance with the settlement agreement. This cannot be stated too strongly, because the services they are contracted to provide make the difference between an individual's being able to maintain community tenure/tenancy or having to return to an adult care home or psychiatric hospital.

In fairness to the providers doing this work, it is important to acknowledge that many are new to this work and would benefit from a training program in the provision of tenancy supports, rehabilitative services, and working with people in supportive housing settings. It would be helpful for providers to understand the tenets of supportive housing service delivery: that it is consumer-focused, voluntary, and flexible. Provider staff should be provided with training opportunities in evidence-based practices (EBPs) such as Motivational Interviewing, Housing First, and Illness Management and Recovery to cite a few examples. Furthermore, and perhaps most importantly, providers should be paid adequately to attract and keep well-trained staff. In the short term, DHHS and the LME/MCOs must meet the terms of the settlement agreement, but overall both should strive to achieve sustainable system change for all populations served by ensuring a well-trained provider base.

Finally, the LME/MCOs are responsible for holding providers accountable through clear contract expectations and related performance measures. LME/MCO contract and quality improvement

staff are responsible for providing regular and consistent feedback, support, and technical assistance to each provider to ensure quality services and good consumer-level outcomes.

Challenges to Service Resources

While there is a rich array of services available to support individuals eligible for TCLI in housing, TAC's discussions with LME/MCOs, providers, advocacy partners, and consumers all pointed to similar challenges with regard to the service system's capacity to support successful community integration and housing tenancy for individuals in need of PSH. The purpose of the services assessment is to determine North Carolina's capacity to meet the service needs of the settlement agreement population across the system. A summary of the assessment and its key findings is provided in this section. Please refer to Appendix IV for the complete Supportive Services Resources Assessment.

The assessment was intended to better inform the state on the availability and access to supportive services dedicated to the TCLI population. Specifically, the assessment considered the following: LME/MCO and provider network capacity to support housing tenure, implementation of evidence-based services required by the settlement agreement, new/expanded tenancy management services, and the provision and viability of Medicaid (b)(3) services.

Based on information collected from the various interviews, the assessment pointed to similar challenges with regard to the service system's capacity to support successful community integration and housing tenancy for individuals in need of PSH. The key findings included in the assessment and highlighted here provide the basis for recommendations outlined later in this report.

There are several challenges that result in quality and access issues that may impact services' effectiveness to support people living in the community. Some of these relate to the adequacy of the provider network, with access particularly limited in rural areas of the state. However, some of the challenges can be attributed to how the LME/MCOs are working with providers, monitoring their contracts, and performing utilization management. Service challenges were raised for both ACT and tenancy support team (TST) services. This could, in part, be attributable to the nature of these services and the fact the TST is a new service area for many of the providers. There were also issues noted about how the LME/MCOs work with the providers to monitor their contracts and service provision. This could be attributable to some confusion among the many roles the LME/MCOs hold and the expectations for the provider staff. Complicating access to some of the services that are required by the settlement agreement to support TCLI-eligible individuals in housing is the requirement to adhere to fidelity measures, for both ACT and supported employment services. Achieving fidelity standards for new services can impact start-up and implementation and present some difficulties for the providers delivering them. Another key factor is that DHHS is currently working to bring the services that support people to maintain independent housing within the community into the Medicaid state plan. There may be some opportunities to further refine this service into a rehabilitation and community support service. Finally, providers and LME/MCOs reported that the rates for

Medicaid (b)(3) services in particular are too low, making it difficult for providers to deliver them.

The findings noted above, while viewed as a challenge, also point to possibilities to make real sustainable changes across the service system. These changes or opportunities are highlighted in the recommendations section.

Housing and Services Advocacy Partners

DHHS is very fortunate to have an engaged group of stakeholders such as NAMI, the Arc of NC, Disability Rights North Carolina, the NC Justice Center, the NC Housing Coalition, and the NC Coalition to End Homelessness, to name a few. All of these groups were part of the interview process as an initial step to develop this report. These key partners understand the importance of the settlement agreement and the state's move to permanent supportive housing. Several advocacy partners have also played an important role in advising on efforts related to the settlement. For example, the NC Justice Center has actively partnered with NCHFA on fair housing policy development/training efforts. Many groups, however, have some concerns about the availability and adequacy of housing and services to help people live successfully in independent supportive housing settings.

All the stakeholders were very positive about the new direction and very willing to assist and be part of the solution. These advocates could be helpful during rollout and implementation with community engagement efforts to build support for the Strategic Housing Plan among key stakeholders including consumers, local political leaders and officials, affordable housing and private rental market owners, and housing developers. As part of such external communication engagements, these advocacy voices will be important to decrease stigma in regards to persons with mental illness and their ability to live in the community. NCHFA, DHHS, and the LME/MCOs must be cognizant of balancing the housing and services needs of all populations as they plan for the development and implementation of future permanent supportive housing resources for the TCLI population and beyond

F. Housing Gaps Analysis – Overview and Key Findings

The purpose of the housing gaps analysis is to determine North Carolina's capacity to meet the housing demands of the settlement agreement population within the 20 priority counties. A summary of the analysis and its key findings is provided in this section. The complete Housing Gaps Analysis can be found in Appendix V.

The analysis set out to better inform the state on the availability, desirability, and access of affordable housing opportunities appropriate for the TCLI population. Specifically, the analysis considered the following:

- Basic demographics and housing preferences of the TCLI population
- Existing barriers to achieving and maintaining housing stability
- Utilization and characteristics of existing LIHTC properties participating in the Targeting Program
- Utilization and characteristics of existing units receiving TCLI voucher assistance
- Access to accessible units, transportation, medical/behavioral health services, and other general amenities
- Unmet housing needs and priorities

Based on information collected from a variety of sources including the DHHS Transitions Database and NCHFA Asset Management System, the gaps analysis highlights a number of unmet needs and housing gaps facing the settlement population. The key findings included in the analysis and noted here provide the basis for recommendations outlined later in this report.

Notable findings from the analysis include the following:

- The six high-value counties of Buncombe, Guilford, Forsyth, Mecklenburg, New Hanover, and Wake represent the primary county of choice for 39 percent of those statewide who are in transition or have transitioned. It is therefore important to consider specific strategies to ensure the ability of individuals to be placed in these highly desired areas.

- The LME/MCOs in coordination with NCHFA and DHHS have been able to move 75 percent of individuals into the area of their choice. While this is a significant achievement, efforts should be made to increase this rate and ensure that housing placement occurs more quickly.

- While the Targeting/Key Program accounts for 27 percent of all housing placements, the utilization of this valuable PSH resource could be improved. NCHFA and DHHS should continue to collaborate on reviewing the property portfolio to identify the reasons for underutilization by property — such as lack of interest in the location/property or screening and referral process barriers.

- NCHFA in collaboration with the DHHS has been able to market the Targeting/Key Program's expansion to a number of LIHTC properties across the 20 priority counties. Given the low turnover rates at properties located in the six high-value counties, additional focused expansion is necessary.

- The proximity of Targeting/Key Program properties to amenities varies greatly across and within counties. NCHFA in collaboration with DHHS should continue to consider transportation and other amenities as a key factor in the desirability of an LIHTC property and in its decisions about whether to expand Targeting/Key units up to the 20 percent level.

- There is a lack of affordable one-bedroom units in both the Targeting/Key Program portfolio and the private rental market. NCHFA and DHHS should continue to make efforts and enhance strategies to create or increase access to one-bedroom units. TAC's Strategic Recommendations focus additional attention on this issue.

G. Strategic Policy Recommendations

In close consultation with state leadership from NCHFA and DHHS, TAC developed eight strategic goals. We also drew on input from the LME/MCOs, key stakeholders and consumers, a review of current housing and supportive services resources, and the results of a PSH gaps analysis. Each goal is accompanied by a series of recommendations for the state to consider in creating and implementing a housing plan, including actions for both the short term (over the next one to two years) and long term. NCHFA and DHHS should take each of these recommendations into consideration, in consultation with the LME/MCOs and prioritize them as appropriate based upon the state's goals and resources. Within this context, TAC suggests that the state prioritize the specific recommendations that will create new PSH opportunities for the settlement population as quickly as possible.

Strategic Goals

1. Strengthen a cross-system, coordinated, and collaborative approach to permanent supportive housing policy for all populations.
2. Maximize existing PSH opportunities with a focus on improving access in six high-value counties.
3. Increase pipeline of new permanent supportive housing opportunities, initially creating PSH units targeted for the settlement population.
4. Reinforce development of provider capacity and accountability to deliver person-centered services to the settlement population and expanding across all populations.
5. Enhance LME/MCO staff core competencies to ensure quality services across all populations.
6. Further develop Medicaid services for the provision of tenancy supports, initially focusing on individuals in the settlement population.
7. Clarify and reinforce proper roles and responsibilities in the provision of integrated PSH at the state, regional, and local levels to ensure a sustainable infrastructure at all levels.
8. Invest in robust data collection, reporting, and evaluation systems to improve referral processes and track outcomes effectively.

Permanent Supportive Housing (PSH) Policy

Goal 1: Strengthen a cross-system, coordinated, and collaborative approach to permanent supportive housing policy for all populations.

In its efforts nationally, TAC has recognized that state planning for community-based housing often occurs in silos — either in separate systems, or on a project-by-project basis. Often, this can lead to poor coordination, lost opportunities to maximize or leverage funding resources, and challenges with targeting PSH opportunities to the most vulnerable, highest-need consumers.

To strengthen and formalize efforts across state agencies, TAC recommends that NCHFA and DHHS bring together all state agencies, DHHS program offices, and key local PSH practitioners and stakeholders to create a unified, coordinated approach to PSH policies for all populations. This will foster consistency of policy messaging; improve communication across state agencies serving similar populations; minimize fragmentation; and reduce competition among different populations for limited resources.

Recommendation 1A: Establish a PSH policy framework and an interagency PSH leadership steering committee to guide the consistent development of permanent supportive housing.
In order to align and spur efforts to create and sustain permanent supportive housing, a uniform PSH policy framework is necessary. The PSH policy framework should include:

- Adopting common PSH principles and a uniform PSH definition across all state agencies to be consistent with national best practices.

- Adopting major PSH goals including: promoting and advancing the civil rights and community integration goals guaranteed by the ADA and affirmed in the U.S. Supreme Court's *Olmstead* decision; specifically furthering the state's PSH commitments identified in its *Olmstead* settlement with the DOJ; and ending homelessness and chronic homelessness among people with disabilities.

- Defining PSH-eligible populations to further the goals set forth in the *Olmstead* settlement: The state should target all newly created or maximized PSH to disabled households transitioning from adult care homes or psychiatric hospitals as called for by the settlement agreement. After achieving the goals of the settlement agreement, TAC recommends that the state consider prioritizing other populations including homeless and chronically homeless households[6] with disabilities; households with serious and long-term disabilities at risk of homelessness; and households with serious, long-term

[6] The term "household" includes a single individual or a household in which either the head of the household or their spouse is an adult with a serious and long-term disability. This definition includes youth ages 18-21 who have aged out of the state foster care system.

disabilities residing unnecessarily or at risk of residing unnecessarily in public institutions or publicly funded, privately owned 'restrictive settings' such as nursing homes.

- Using a range of PSH models: Best-practice PSH approaches include a variety of evidence-based, flexible models encompassing tenant-based and project-based initiatives. Successful approaches in other states include the mixed-use model and small set-asides of PSH units in multifamily housing developments produced through LIHTC- and bond-financed properties, as well as the single-purpose PSH model.

Standardizing eligibility criteria and prioritization for PSH opportunities as well as ensuring alignment with PSH principles and practices will minimize fragmentation, unify planning, and ensure that PSH housing opportunities are targeted to disabled individuals with the greatest need.

Further, TAC recommends that NCHFA and DHHS create and sustain an interagency PSH leadership steering committee to oversee the coordinated efforts of state government to implement and achieve its PSH strategic goals. Membership of the steering committee should include NCHFA and DHHS executive-level staff. Others to engage would be staff from each of the DHHS program offices, LME/MCOs, the Department of Commerce, the Department of Public Safety (for attention to criminal-justice-involved re-entry efforts) and other key PSH practitioners. The purpose of the PSH leadership steering committee is to align all statewide planning efforts regarding permanent supportive housing. The committee's responsibilities could include: developing and establishing a statewide PSH framework to set statewide policy, sustaining regular planning efforts, meeting on a regular basis, setting and monitoring progress toward short- and long-term goals, coordinating and facilitating efforts among member agencies (including drafting memorandums of agreement), and evaluating outcomes of the state's PSH activities.

It should be a priority for the PSH leadership steering committee to focus on housing and services resource alignment. As part this effort, TAC recommends developing a structured process for NCHFA and DHHS staff to exchange feedback on housing and services/supports funding priorities. In addition, we recommend that a memorandum of agreement be executed between NCHFA and DHHS to further structure and formalize the relationship between the state partners as well as to guide the operations of the PSH leadership steering committee. The memorandum should include the role and responsibilities of each state entity; the steering committee's responsibilities; the frequency with which the committee is convened; an outline of the structured process to offer feedback on housing and services funding priorities; and the frequency with which the senior leadership meets.

Recommendation 1B: Continue growing a strong (disability-neutral) housing infrastructure within DHHS to support and oversee PSH policy implementation.

TAC recommends that DHHS continue its efforts to maintain a permanent supportive housing executive position within the office of the DHHS Secretary. In close collaboration with NCHFA staff and the DHHS program offices, the DHHS housing executive will oversee the development

and implementation of PSH policy. As part of the implementation of a PSH policy, the DHHS housing executive should also focus efforts to eliminate state level bottlenecks and improve efficiencies in order to better support and empower the LME/MCOs' efforts to create and maximize permanent supportive housing.

Recommendation 1C: Add an executive from DHHS or LME/MCOs to the NC Housing Partnership.

TAC recommends that NCHFA and DHHS identify a DHHS or LME/MCO executive to serve on the NC Housing Partnership. Established by North Carolina statute, the NC Housing Partnership Board provides advisory oversight to NCHFA on the development of affordable housing policy and the use of resources from the North Carolina Housing Trust Fund as well as other affordable housing resources controlled by NCHFA. DHHS and LME/MCO appointments to this Board would provide an important policy venue for the needs of PSH consumers to be represented and would allow for the further alignment of policies to reinforce and fully support the state's PSH strategic goals.

Recommendation 1D: Continue creating a state PSH rental assistance system to allow close collaboration and connection between the service and housing systems.

TAC recommends that NCHFA and DHHS continue growing their partnership in administering the state's PSH rental assistance programs and building out its systems. As part of these efforts, NCHFA and DHHS should work to support efforts of the LME/MCOs by offering training and technical assistance to further build out the state's PSH rental assistance system. Cooperation among NCHFA's business groups, DHHS's divisions, and the LME/MCOs will expedite housing provision, tenant crisis intervention, property owner support, and complaint resolution, while minimizing system bottlenecks.

Recommendation 1E: Create a State Housing Plan.

NCHFA and DHHS should collaborate on a State Housing Plan with short- and long-term goals. TAC's housing assessment and recommendations should be considered when creating the plan. They should support and work with the LME/MCOs to update their regional housing plans to complement and mutually reinforce the State Housing Plan. NCHFA and DHHS should also be cognizant of including state advocates and other housing systems in the plan's development.

Housing Access Maximization and Resource Development

North Carolina needs to accelerate its efforts to both *maximize* access to existing permanent supportive housing and *create* additional PSH opportunities in order to meet the housing placement goals set forth in the settlement agreement. TAC recommends that NCHFA, in coordination with DHHS, implement this two-pronged approach to expand access to integrated PSH for the population identified by the settlement. Integrated PSH is defined as permanent supportive housing that represents no more than 20 percent of the units in a multifamily rental property. Based on the findings of our gaps analysis, TAC recommends that NCHFA and DHHS, working in collaboration with LME/MCOs, focus both maximization and production efforts on the six high-value counties.

Goal 2: Maximize existing PSH opportunities with a focus on improving access in six high-value counties.

The Department of Health and Human Services' RHC program manages the waiting list for the Targeting/Key Program properties and facilitates referral to these units at both initial vacancy and turnover. Currently, there are nine Regional Housing Coordinators arrayed geographically across the state with each RHC responsible for a specific portfolio of Targeting/Key Program properties. Over the past year, the RHCs have collaborated closely with LME/MCO transition staff to prioritize referral for individuals covered by the settlement agreement. This prioritization has begun to show results in improving access to these Targeting/Key Program units. However, more progress is needed.

Below are a series of recommendations to maximize existing PSH opportunities:

Recommendation 2A: Consider consolidating housing infrastructure and programs into the DHHS Secretary's office to allow its housing expertise to serve all DHHS Divisions.
TAC recommends consolidating all housing infrastructure including the RHC program into the DHHS Secretary's office. This shift will consolidate housing expertise into one central location with access to executive-level leadership at the Secretary and Program office level. As discussed in Goal 1, the new DHHS housing executive is expected to lead this consolidated housing team as well as coordinate with each of the DHHS Division leads. This will allow DHHS to establish consistent housing policy across DHHS in coordination with the PSH leadership steering committee. The consolidation will also allow for a sustainable, more responsive infrastructure to support DHHS's Divisions and their efforts to meet the housing needs of their priority consumers in order to pursue a cross-disability housing policy over the long term.

Recommendation 2B: Maintain sufficient capacity at the LME/MCOs, NCHFA and DHHS to adequately support the growth of the targeted unit portfolio and tenant-based rental assistance (i.e. TCLV- or reinvestment-financed subsidies) over time.
TAC recommends that DHHS, NCHFA and the LME/MCOs regularly monitor their staffing levels in order to maintain sufficient levels to provide timely referral and tenant liaison services to all Targeting/Key Program properties and tenant-based rental subsidies. Adequate staffing support, at all levels, is critical to the overall success of the Targeting/Key Program and maximization of the tenant-based rental subsidies. Adequate staffing also plays an important role in the capacity to increase the utilization rate of these units and subsidies by individuals with disabilities served by the settlement agreement and to expand to other populations eventually.

Recommendation 2C: Continue to improve on Targeting Program referral infrastructure.
TAC recommends that NCHFA and DHHS continue efforts to enhance and further automate the waiting list and referral process for Targeting/Key properties. Currently, portions of the referral process are not automated which creates challenges for all parties involved in the process (RHCs, LME/MCO transition staff, property managers) and hinders a clear understanding in

"real time" of the status of any given referral. The goal of this web-based platform tool should be to create greater transparency and common understanding for all parties to make it more efficient and ultimately to improve access to Targeting/Key Program units.

Recommendation 2D: Continue exploring and implementing Targeting Program improvements.
The Targeting Program can be enhanced in several ways including through recruiting additional properties, refining property desirability, and tracking referral/application disposition data.

As far as recruitment goes, the RHCs possess very detailed knowledge and understanding of the Targeting Program properties' accessibility and marketability. NCHFA is currently focused on identifying properties that would be interested in increasing their Targeting/Key Program rate to the 20 percent level. TAC recommends that NCHFA coordinate closely with RHCs and the LME/MCO housing specialist staff to identify the best candidates for expansion based on marketability and accessibility. TAC further recommends focusing this targeted engagement on the six high-value counties, especially those with low opt-in rate as highlighted in the Housing Gaps Analysis (e.g. Mecklenburg County where only nine percent[7] of the properties have agreed to increase the Targeting/Key Program level to 20 percent).

TAC recommends re-establishing the "dormant" policy to remove from the active Targeting/Key Program portfolio those LIHTC properties that are not marketable/accessible to disabled households and have not historically received referrals from the RHCs. This would allow for entities engaged in the referral process to focus their energies on the properties that are accessible and desirable for disabled households, and would give state policy planners an accurate representation of the number and location of Targeting Program properties that have the real potential to be utilized.

TAC recommends that NCHFA and RHC staff jointly track information on a regular, ongoing basis on denials from Targeting Program properties for all applicants referred to fill a vacancy, with special attention to individuals served by the settlement agreement. TAC recommends analyzing this data to determine if specific properties and property managers need technical assistance or other corrective action on fair housing and reasonable accommodation. With the assistance of the web-based waiting list and referral platform discussed above, NCHFA and RHC staff may be able to identify an issue with an improper denial in "real time," allowing them to engage the property manager immediately to review the decision and potentially to consider a reasonable accommodation if it is warranted.

Recommendation 2E: Continue enhanced fair housing training and NCHFA compliance efforts[8] in order to reduce denials from Targeting Program properties.
Over the past year, NCHFA has collaborated with the NC Justice Center on updating NCHFA's policy and practices in regard to fair housing law to reflect recent guidance from HUD and to

[7] See Table 3 of the Housing Gaps Analysis in Appendix IV.
[8] As an administrator of federal and state financing of affordable housing, NCHFA works with owners and managers to make sure that properties meet program regulations. For a more detailed description of what program

educate frontline property management and service provider staff. These efforts focused specifically on criminal background checks and have brought about some progress in this area. However, NCHFA should maintain a sustained focus on fair housing to change attitudes and behavior across the Targeting Program housing portfolio to decrease denials and improve access to the Targeting units for disabled households.

Below are recommendations to reinforce and enhance NCHFA's policy, compliance, and technical assistance/training efforts in improving awareness of fair housing principles.

- NCHFA should continue to collaborate with DHHS and the NC Justice Center to provide periodic sustained fair housing training with a focus on housing providers (i.e. owners, regional property managers, frontline property managers) and service providers (LME/MCO housing specialists, transition coordinators, and direct-line service provider staff). Such trainings should cover basic principles of fair housing law and practice and reasonable accommodation best practices. In addition, TAC recommends that NCHFA offer a more advanced level of fair housing training to property owners, regional directors, property management firms, and LME/MCO housing practice management staff to help build the understanding necessary to make timely, proper decisions.

- TAC also encourages NCHFA, DHHS, and the LME/MCOs to incorporate fair housing and reasonable accommodation principles into LIHTC and tax-exempt bond property monitoring procedures for the Targeting Program housing portfolio. The LME/MCO and DHHS monitoring of their supportive service providers should also assess the level at which staff are trained on this subject and their understanding of fair housing principles.

- TAC strongly believes in the effectiveness of technical assistance to resolve most fair housing concerns with multifamily rental property owners and property management firms. However, TAC recommends pursuing an LIHTC compliance finding with high-level engagement between NCHFA and ownership if improvement in access is not seen and fair housing violations continue to be documented without any change in practice. TAC further recommends that such a finding potentially disqualify the owner from applying for LIHTC funding for any new project until the practice has been resolved jointly by the owner and NCHFA.

Recommendation 2F: Continue exploring and implementing Transitions to Community Living Voucher program enhancements.

The LME/MCOs' transition staff have made some gains in developing relationships with private property owners in an effort to persuade them to accept TCLV holders as tenants. However, in several of the 20 priority counties and in most of the six high-value counties, there are very low vacancy rates in the private rental market, with a limited supply of one-bedroom units. Looking

compliance entails, see NCHFA link at: http://www.nchfa.com/rental-housing-partners/rental-owners-managers/program-compliance

ahead, private rental markets seem likely to continue to be a highly competitive environment with limited inventory in desirable areas that are also accessible to public transportation and public amenities. In this environment, it is imperative to strengthen efforts and incentives to increase the pool of owners willing to work with the TCLI program.

Significant enhancements have recently been made to the TCLV program with the goal of increasing access by encouraging new owners to join the TCLI program, reducing average search times for finding housing. TAC recommends that NCHFA, DHHS, and each LME/MCO transition team assess the impact of these changes. Based on this assessment, TAC recommends continued innovation and additional enhancements and efficiencies to the TCLI program in order to retain and grow the private owner pool.

One enhancement to consider is raising the TCLV payment standard to remain competitive with other local rental assistance programs in the six high-value counties. In most of these counties, there exists an intense competition among a range of rental subsidy programs including TCLV, Section 8 housing choice vouchers, veteran housing (i.e. VASH), rapid re-housing programs for veterans and homeless persons, and other tenant-based PSH funded by the local CoC for a small pool of owners willing to accept such a rent subsidy. Many of these urban private rental markets have been impacted by gentrification, causing private rents in some neighborhoods to exceed fair market rent (FMR) and pricing out TCLV holders. In this environment, it is critical to develop a competitive advantage in the effort to develop the private owner pool. In addition, close collaboration between housing navigation staff across systems (i.e. TCLI, CoC and VA) to demonstrate a unified approach with property owners to minimize the risk in driving rents up should also be considered.

The NCHFA and DHHS in close collaboration with the LME/MCOs are currently developing the program structure, policies, and procedures to administer the TCLI tenant-based rent subsidy program, effective in calendar year 2017. TAC recommends a regional approach and structure for TCLI administration. NCHFA and DHHS would establish LME/MCOs as regional rent subsidy administrators. The rent subsidy administrator's functions would include core rental assistance activities such as owner eligibility, execution of rental assistance contracts with owners, rent payment to owners, unit inspections, calculation of tenant rent, administering risk mitigation funds, and conducting annual recertification processes. In addition to these essential rent assistance functions, the LME/MOCs should also be responsible for the housing specific functions of housing search assistance and housing navigation as part of this regional structure. NCHFA could provide important oversight and support for these rent subsidy administrators. To develop a program structure that is sustainable over the long term and potentially past the settlement agreement, the regional rent subsidy administrator would partner with housing organizations that have demonstrated experience administering tenant-based rental assistance (e.g. local PHAs or nonprofit housing agencies) to carry out some of these rental assistance activities.

Recommendation 2G: Continue NCHousingSearch.com enhancements.
The NCHFA and DHHS are currently moving forward with significant enhancements to the NCHousingSearch.com online rental housing search platform available to all affordable housing and private rental market owners. TAC recommends continuing this effort with a focus on creating a vacancy-matching tool that delivers timely notification of rental housing openings to housing search staff. For such a platform to be successful with the private rental market, the system must demonstrate value to both the owner who is taking the time to post the vacancy and the housing search staff members using the tool to match a potential tenant with a vacant unit. User training and external communications about the enhancements to the new system will be essential to demonstrate this value to all users — the owner, the housing search staff, and the TCLV holder. TAC also recommends that the LME/MCOs develop a close working relationship with NCHousingSearch.com staff to take full advantage of these housing search tools to enhance and improve their efficiency in finding timely housing referral and placement.

Recommendation 2H: Encourage the development of a cadre of housing navigators focusing on each of the six high-value counties and potential expansion to other disability subpopulations.
Housing navigators are specialized staff with a deep knowledge of housing and the private rental market who provide dedicated, focused cultivation and support for owners. Expertise is critically important to achieve inroads and grow a pool of owners in highly competitive private rental markets such as those in many of the six high-value counties. Possibly financed through reinvestment or other resources, TAC recommends that DHHS work with each LME/MCO to establish a full-time, dedicated housing navigator to conduct focused owner engagement and cultivation efforts in the six high-value counties.

As a longer-term recommendation, TAC encourages DHHS to build on the successes of the housing navigator model in high cost, low-vacancy rental markets, expanding it to additional disability subpopulations supported by other DHHS Divisions.

Recommendation 2I: Sustain the TCLI program past the period of the Olmstead *settlement to offer a tenant-based rental assistance program for DHHS priority consumers over the long-term.*
TAC recommends that DHHS, NCHFA, and the LME/MCOs work collaboratively to sustain the TCLI tenant-based rental assistance program beyond the period of the settlement agreement. TAC recommends that the TCLI program transition to become a companion tenant-based rent subsidy to the Key Program using a project-based rental assistance approach. This would allow DHHS and NCHFA to offer a real choice for DHHS priority consumers of integrated permanent supportive housing through either a project-based or a tenant-based model. With this type of transition, DHHS and NCHFA will likely be able to achieve administrative efficiencies as the two rental assistance programs are aligned.

Over the long term, sustaining the tenant-based rental assistance approach will provide NCHFA and DHHS with the ability and flexibility to:

- Serve DHHS priority consumers in an expanded cross-disability approach to PSH.

- Align the effort with the Key Program.
- Leverage the RHCs and other DHHS housing expertise and infrastructure.
- Further state PSH goals identified by the PSH leadership steering committee.

Goal 3: Increase pipeline of new permanent supportive housing opportunities, initially creating PSH units targeted for the settlement population.

Recommendation 3A: Focus PSH development in the six high-value counties: Buncombe, Guilford, Forsyth, Mecklenburg, New Hanover, and Wake.

Based on the results of the housing gaps analysis and reinforced by stakeholder discussions, TAC recommends that development engagement and activity focus on the six high-value counties identified above. However, this focus should not be exclusive. NCHFA, in close partnership with DHHS and the LME/MCOs, must retain flexibility to engage and support proposals that uphold priorities set forth by the state.

Recommendation 3B: Create and sustain a PSH funders collaborative composed of NCHFA, DHHS, and LME/MCO staff to align and leverage resources, maximize partners' strengths and expertise, and set and monitor PSH goals to encourage the production of integrated permanent supportive housing.

TAC recommends creating and sustaining a PSH funders collaborative whose membership would include NCHFA, DHHS, LME/MCO housing staff. Over the long term, TAC recommends possibly including other systems (e.g. a Continuum of Care, PHA, or VA) that can conditionally commit their funds to the PSH funders collaborative. The collaborative could develop a predictable process for pooling and leveraging housing development, housing operating assistance, and access to necessary supportive services and supports, as well as identifying new development partners, setting goals, and monitoring progress. The collaborative would offer an efficient way for developers and owners of affordable and private rental market properties to propose integrated PSH projects, reducing the costs of assembling multiple applications.

As part of this process, the collaborative would conduct a joint review of project applications and make collective funding recommendations to better align and maximize existing capital resources. TAC recommends that the collaborative leverage each member's skills and competencies in the review of PSH applications. To effectively identify potential PSH project applications, the LME/MCOs should initiate the engagement and assessment with local developers regarding potential PSH projects. DHHS, with the support and technical expertise of NCHFA staff, should provide ongoing support and technical assistance to develop LME/MCO housing staff expertise to play this role at the local level. This sustained support will assist LME/MCOs in successfully engaging key local housing stakeholders including housing developers, local community development officials, and Public Housing Authorities to participate and support the funders collaborative as well as supporting the broader goals of the strategic housing plan.

In order to fully leverage the resources available to create integrated PSH, TAC recommends that the members of the collaborative pool development resources from NCHFA's Community

Living Housing Fund, the Supportive Housing Program, and reinvestment resources from the LME/MCOs as well as Key Program project-based operating assistance, to support the set-aside PSH units. In order to market the program effectively and cultivate interest, TAC recommends a deliberate, retail-focused engagement effort with key stakeholders such as North Carolina Housing Coalition, trade associations, rental property owners/developers, and community development officials.

TAC recommends that the PSH funders collaborative develop specific PSH production targets for the next five years. These goals should be based on a review of the housing development resources available — both capital and operating assistance — and an initial assessment of production opportunities based on further discussions with key stakeholders including owners of affordable housing and private rental properties. In addition, as part of establishing these PSH production targets, NCHFA and DHHS should consider the number of PSH production opportunities needed to meet the placement goals of the settlement, factoring in the PSH opportunities created by TCLI. NCHFA and DHHS should continually assess their success in ensuring that the PSH placements needed to meet the goals of the settlement equal the PSH production and TCLI targets. The collaborative should play a role in periodically reviewing progress towards the PSH development goals including identifying and addressing barriers in meeting production benchmarks, reviewing plans for future collaborative funding rounds, and collectively leveraging future funding opportunities.

Recommendation 3C: Pursue a PSH production strategy with the tax-exempt bond portfolio/pipeline to create set-aside PSH units in a timely and cost-efficient manner.

Based on feedback from discussions with NCHFA staff, an opportunity exists with the portfolio of tax-exempt, bond-financed multifamily properties awarded in 2014 and 2015 that do not have targeted PSH units, as well as the 2016 awards that currently have 10-percent targeting requirements. TAC recommends that the funders collaborative offer reasonable capital incentives linked with Key Program project-based rental assistance in exchange for set-aside PSH agreements for up to 20 percent of the units within the property. Since these projects either already exist or are currently in the development pipeline, significantly less time is needed to implement this strategy and potentially make PSH targeted units available than would be required for a new development strategy.

TAC conducted a review of the 2014 to 2016 tax-exempt, bond-financed properties/projects funded by NCHFA. Of 24 multifamily properties comprising 3,915 affordable units, 14 properties (58 percent of the portfolio), comprising 2,284 units, are located in the six high-value counties.

Recommendation 3D: Pursue a rehabilitation strategy with existing rental housing stock to created targeted PSH units.

To complement the tax-exempt bond production strategy, TAC recommends a focus on engaging current affordable and private rental market property owners with an offer of capital assistance to support minor- to moderate-level rehabilitation as well as Key Program project-based rental assistance in exchange for establishing PSH set-aside units. Engagement efforts

should be concentrated on the six high-value counties as well as specific "marketable" areas with limited PSH inventory identified by the PSH funders collaborative. The rehabilitation strategy may be most cost-effective and could deliver PSH set-aside units quickly. It could be modeled on the past experience and lessons learned from NCHFA's Preservation Loan Program.

Recommendation 3E: Continue to explore and adopt LIHTC/tax-exempt bonds to spur new permanent supportive housing development.

Nationally, the LIHTC program is the primary driver of new affordable rental housing development. Through the Qualified Allocation Plan (QAP) that governs how LIHTC resources are administered, NCHFA continues to require all LIHTC proposals to set aside 10 percent of the total units in the project as PSH-targeted units with the option of receiving Key Program rental assistance as well. This policy creates approximately 200 new targeted units annually. TAC believes that NCHFA in coordination with DHHS should consider adopting additional incentives within the QAP to encourage the creation of targeted units in the six high-value counties with the greatest need for PSH housing opportunities.

TAC conducted a review of the NCHFA's 2017 QAP with an eye towards accelerating efforts in this area. We recommend that NCHFA consider adopting the following incentives to sustain a PSH development pipeline over the long term through LIHTC/Tax Exempt bonds:

- Increase the metro percentage for the new construction set-aside in order to increase development activity in the six high-value counties. TAC recognizes that NCHFA will need to balance the need to increase development activities in these metro areas with the fact that this will take away LIHTC resources from other parts of the state.

- Incorporate a requirement for the use of National Housing Trust Fund resources to include 20 percent targeted units in the multifamily LIHTC projects. As a matter of definition, PSH is also ELI housing, generally serving disabled households with SSI incomes that are approximately 18 percent of area median income (AMI). Given the NHTF's mandate to produce ELI housing, an alignment between NHTF funding and creation of PSH through the Targeting Program makes sense from a housing policy perspective. TAC further recommends that NCHFA sustain this policy to link NHTF resources with the option of adding the enhanced level of target units over the long term as a permanent feature of its state housing policy. NCHFA might consider structuring this targeted unit requirement as an NCHFA "option" reserving the right to either accept or lower the level of targeted units based on a further analysis of the marketability of the proposed LIHTC property based and on discussion with both the RHC and the LME/MCO's housing specialist.

- Incorporate incentives for future LIHTC and tax-exempt bond projects to incorporate 20 percent targeted units. TAC recommends incorporating a tiered point incentive in both the QAP and the tax-exempt bond solicitation to encourage developers to increase their targeted units to the 20 percent level with an emphasis on both the six high-value

counties and the 20 priority counties. TAC encourages offering this incentive to all LIHTC and tax-exempt bond proposals. The 2017 QAP does not have any incentives or options for a developer to propose more than the 10 percent level of targeted units. NCHFA could structure this incentive to allow NCHFA the option to accept the 20 percent level for the targeted units or lower the level to 10 percent based on marketability analysis of the proposed LIHTC property and discussions with both the RHC and the LME/MCO's housing specialist.

- Enhance the one-bedroom incentive by offering a higher tier for up to 20% of the total units being one-bedrooms. TAC commends NCHFA for adopting a one-bedroom incentive as part of the Olmstead settlement initiative section of its 2016 QAP. NCHFA should enhance and sustain its one-bedroom incentive within the QAP and the tax-exempt bond project solicitation.

- Encourage development in the DHHS priority counties by offering additional points for projects proposed in these counties.

Recommendation 3F: Explore and implement the use of reinvestment resources for new permanent supportive housing development.

Reinvestment funding is the result of savings by the LME/MCOs in both medical and administrative expenses. Each LME/MCO has reinvestment savings available to develop additional services that support its system. These reinvestment funds may be used for a range of housing activities.

Through the PSH funders collaborative proposed above, TAC recommends that DHHS and NCHFA work with each of the LME/MCOs to leverage reinvestment resources in conjunction with NCHFA and DHHS funding for housing. Based on initial conversations with DHHS as noted in the Corrective Action Plan to the US Department of Justice dated June 3, 2016, the LME/MCOs have informally committed $8-10 million to support housing-related activities.

Based on TAC's regional assessments, we recommend that the LME/MCOs focus reinvestment resources on the following housing activities:

- **Capital Resources:** Contribute to the PSH funding collaborative to create PSH units.

- **Master Leasing Assistance:** Secure PSH units in private rental market apartments and make them affordable to individuals served by the settlement agreement.

- **Housing Navigation:** Fund or contract with designated professionals with deep knowledge of housing and real estate market to provide dedicated, focused support to cultivate relationships with private rental market property owners with the goal of managing a pool of private rental units available to individuals served by the settlement agreement. Key areas of focus may include: oversee ongoing relationship management

with private landlords, coordinate timely referrals of households to landlord upon vacancy of a rental unit, negotiate tenant screening criteria with landlords to enable greater access to these units; mediate with landlords to sustain an individual tenancy; coordinate re-housing effort on a timely basic if necessary to preserve the tenancy and the relationship with the landlord; and coordinate timely access to funds to repair damages in an effort to cultivate a sustained relationship with the landlord.

- **Housing Contingency Fund:** Provide resources for housing deposits and pre-tenancy move-in assistance and other one-time, unexpected housing related expenses.

- **Tenant-Based Rental Assistance**: Provide resources to provide tenant-based rental assistance for a time-limited basis with the goal of "bridging" to a permanent rental assistance subsidy. LME/MCOs should target the provision of bridge rental assistance to fill specific gaps in need among the settlement population followed by other priority consumers identified by the LME/MCO. LME/MCOs should consider adopting the bridge rental assistance model to take advantage of success in establishing a preference for the Section 8 Housing Choice Voucher program with their local Public Housing Authority.

TAC recommends that DHHS, in collaboration with NCHFA, support LME/MCOs' process to create a reinvestment housing plan that supports the overall State PSH Plan and specifically the individual LME/MCOs' regional PSH plans. TAC further encourages the LME/MCOs to sustain their commitment to use reinvestment funds to create dedicated PSH set-asides through the PSH funding collaborative after the successful resolution of the settlement agreement. A sustained reinvestment strategy will allow the LME/MCOs to identify other priority consumers (e.g. individuals with an SUD or I/DD as well as consumers not eligible for other PSH programs) to target for dedicated PSH units.

As the PSH funders collaborative is formed, TAC recommends that both NCHFA and DHHS be mindful of the need to offer sufficient incentives to the LME/MCOs to partner in a meaningful way by committing reinvestment resources to these housing activities. To focus new integrated PSH opportunities in the six high-value counties, TAC also recommends that NCHFA and DHHS consider opportunities to layer state housing resources with reinvestment-funded housing activities sponsored by the LME/MCOs.

In developing their housing reinvestment plan and determining which housing activities should be targeted for reinvestment resources, TAC recommends that LME/MCOs assess their capabilities and needs within the current housing activities in order to identify priority needs, with a special focus on housing navigation services and housing contingency funds.

Recommendation 3G: Continue to engage with PHAs and pursue an Olmstead*-related preference.*

TAC recommends that NCHFA and DHHS collaborate closely with the LME/MCOs to engage local PHAs throughout the 20 priority counties, with emphasis on the six high-value counties. As

specified in the Housing Resources section of this report, there are 38 PHAs administering 37,245 HCVs and 24,334 public housing units in the 20 priority counties. Many of these PHAs' waiting lists for both HCVs and public housing units are very long or are currently closed. Despite these challenges, TAC believes it is still of value to continue to engage and develop meaningful collaboration with PHAs across the state.

Below are two suggestions to support the goal of sustaining a PSH development pipeline through engagement with PHAs:

- Pursue endorsement from HUD for a statewide *Olmstead*-related preference that local PHAs could adopt for their Section 8 HCV and public housing waiting lists. Initial steps have been made in North Carolina, with NCHFA and DHHS requesting HUD endorsement in September 2016. TAC recommends continued engagement with HUD officials in order to obtain this endorsement as quickly as possible.

- Once HUD has endorsed the preference, proactively engage PHA leadership to adopt the preference to create access to long-term housing subsidies —with a focus on the PHAs serving the six high-value counties. Each of these eight PHAs manages both the Section 8 HCV program and public housing. There may also be an opportunity to explore establishing an *Olmstead*-related preference in conjunction with either privately owned properties participating in HUD's Rental Assistance Demonstration Project or existing targeted units using Section 8 project-based vouchers from the PHA.

Supportive Services

Our discussions with LME/MCOs, providers, advocacy partners, and consumers all pointed to similar strengths and challenges with regard to the service system's current capacity to support successful community integration and housing tenancy for individuals in need of PSH. The goals and recommendations below build on these responses.

Goal 4: Reinforce development of provider capacity and accountability to deliver person-centered services to the settlement population and expanding across all populations.

It will be important to develop an overall message of accountability, beginning with DHHS and including the LME/MCOs and providers. This accountability should encompass the settlement agreement, contracts, infrastructure, and utilization management.

Recommendation 4A: Enhance communication with LME/MCOs and stakeholder groups.

The state should continue to communicate regularly and consistently with LME/MCOs, providers, consumers, families, and other stakeholders. DHHS should consider the development of a TCLI Consumer and Family Advisory Committee for this purpose. Such a group could meet monthly as it begins its work to receive timely and regular updates and to ensure an ongoing communication loop. Appropriate DHHS staff should also meet with each LME/MCO monthly to review all operational areas such as care coordination, utilization management, quality, and

fiscal/data and to discuss provider and consumer issues, trends, and settlement agreement progress. This practice should start immediately and, again, occur monthly. Assuming progress is made, targets are reached, and all terms of the agreement are met, this meeting could eventually change to a quarterly schedule. Agendas should be developed and notes documented.

The Department of Health and Human Services should facilitate communication and accountability among Division, LME/MCO, and provider staff to ensure consistent service delivery and good consumer outcomes while also meeting the terms of the agreement. In order to be clear in its expectations, DHHS should prioritize clarifying and defining roles and responsibilities of the LME/MCO TCLI and housing specialist staff, housing staff in the Department of Mental Health, the Regional Housing Coordinators, and provider staff.

Recommendation 4B: Review current LME/MCO contracts to ensure settlement agreement requirements are clearly delineated.

The Department of Health and Human Services has a strong commitment from the current Secretary as well as the two previous Secretaries to meeting the terms of the settlement agreement. This was evident in TAC's interview with the current Secretary for this assessment. The general feeling of the stakeholders, however, was that there is a general lack of accountability at all levels. In order to reinforce and clearly communicate the DHHS commitment, DHHS should review its contracts with the LME/MCOs and ensure that each requirement in the settlement agreement is clearly delineated. It is important to note that another consultant, independent of this report, reviewed the LME/MCO contracts to measure the level of accountability the state provides for implementation of the settlement agreement.[9] The contracts should continue to be monitored on a monthly basis through the current Interagency Monitoring Team meetings, with an enhanced focus on the TCLI indicators.

It is important to note that there are now Critical Performance Indicators in both the Medicaid and Mental Health contracts with the LME/MCOs. The LME/MCOs will have to meet these indicators to fully meet the terms of their contract. DHHS staff will need to monitor this very closely, as stated above. Another existing mechanism to review the contracts is the annual External Quality Review Program (EQRP). The EQRP is required by the settlement agreement and includes an external annual review of the LME/MCO policies and processes of the state's mental health services system. Again, there should be an enhanced focus on the TCLI indicators to ensure progress and timely attention to any issues that arise.

In order to provide this oversight, DHHS will need adequate staff at the Division/Department level to monitor the LME/MCO contracts and adherence to the settlement agreement. This may require advocating to the Governor's office for additional staff to perform these functions. Adequate staffing for DHHS is crucial to come into compliance with the agreement and achieve overall system reform, and these changes and additions should be implemented immediately.

[9] Preliminary Review of NC DMH/DD/SAS and DMA Contracts for LME/MCOs, Croze Consulting, 7/26/16

Recommendation 4C: Work collaboratively with the LME/MCOs to review current provider contracts to ensure that all settlement agreement requirements are delineated.

The Department of Health and Human Services could also recommend the LME/MCOs review their current provider contracts for compliance with service provision related to the TCLI indicators as documented in the settlement agreement. A side-by-side comparison would be helpful in identifying areas that may need to be strengthened. It would be beneficial to delineate provider responsibilities clearly to assist the LME/MCOs in monitoring performance, providing incentives, and, as a last resort, take corrective steps if necessary. DHHS could also work with the LME/MCOs to develop a template provider contract to ensure consistency and compliance with the settlement agreement requirements. This could be an area for DHHS to be more accountable, to the settlement agreement, by providing more guidance, oversight and assistance to the LME/MCOs. An example of a contract requirement, for the LME/MCOs to consider is the hiring of a housing specialist for each ACT team or adhering to the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity scale. It should be noted that increased contract monitoring has recently begun by adding TCLI indicators to the job responsibilities of the LME/MCO Quality Monitoring staff. The Quality Monitoring staff review these indicators at regular quality management meetings and now have the ability to address issues as they arise.

Recommendation 4D: Work collaboratively with LME/MCOs to develop provider monitoring systems, with an emphasis on ACT and TSM and the transition process.

Based on service definitions, eligibility requirements, and the ACT fidelity model, DHHS should work with the LME/MCOs to develop appropriate provider quality and performance monitoring systems for all tenancy support services, particularly ACT and TMS. DHHS should also work with the LME/MCOs to map the transition process of individuals from ACH's to supportive housing in order to develop ways to streamline the process and decrease the amount of time to 90 days in accordance with the settlement agreement.

Recommendation 4E: Collaborate with LME/MCOs to strengthen utilization management procedures to avoid unnecessary duplication of services and ensure that consumers are neither overserved nor underserved.

Based on our interview with the independent reviewer, 50 percent of individuals involved with TCLI are approved for ACT and the other 50 percent receive a patchwork of services. ACT is the highest-level ambulatory service, with specific eligibility requirements and caseload sizes. LME/MCOs should review each person approved for ACT to ensure that this level of service is needed. As stated previously, one LME/MCO staff person remarked that individuals do better with tenancy supports and other behavioral health services wrapped around than with ACT, an observation that highlights the need to re-evaluate current consumers receiving ACT. Reinforced utilization management procedures would better position LME/MCOs to make appropriate and cost-effective use of all their services, avoiding unnecessary duplication (e.g. by layering on other services to assist with housing location, transition, or ongoing tenancy support that the ACT teams should be able to handle.)

Recommendation 4F: Implement training and support for providers.

Provider training and support should be implemented, emphasizing ACT and tenancy support services to ensure that providers possess the necessary skills to assist people in maintaining housing in the community. DHHS could develop training as outlined below, and in addition could facilitate sharing among the LME/MCOs about effective provider TA and training approaches they have employed in the areas of tenancy supports and incentivizing providers to participate in related workforce development activities. It will be vitally important for DHHS to provide structure and guidance and reinforce best practices to each of the LME/MCOs in the provision of ACT and tenancy support services as well as all behavioral health services. DHHS bears this responsibility and, through the LME/MCOs, must ensure the provider base is well trained and compensated adequately.

As discussed in the supportive services resource assessment in this report, there are many issues with the current provision of ACT services in North Carolina. The current contract with UNC has focused primarily on conducting fidelity reviews. While this is important, providers are in need of more hands-on training and coaching. The contract should be expanded, or a new RFP issued, to provide hands-on training to develop staff core competencies. The training should provide side-by-side coaching with an emphasis on skill-building and rehab supports. DHHS requested additional state dollars, in the current budget, for UNC to hire two additional fidelity reviewers. This would allow UNC to increase/enhance training to the ACT providers.

Additionally, DHHS should review the scope of work of the current UNC contract to make sure it includes the appropriate elements for tenancy management services training. Throughout the LME/MCO interviews, it was reiterated that providers are struggling with providing this service. The training should emphasize coaching, skill-building and skill transfer, engagement techniques, use of EBPs such as Motivational Interviewing, wellness and recovery, community integration, and crisis planning. DHHS, through the LME/MCOs, must reinforce these best practices to ensure a well-trained provider network. The contract should provide hands-on training and assistance for both direct care and supervisory staff. It is also critical to train supervisors to offer support and coaching to their staff. The training curriculum should be adaptable as a web-based module, with YouTube videos for staff modeling, and the possibility should be explored of using shadow sites similar to those in supported employment.

Finally, each LME/MCO should continue to invest in periodic training for service providers on specific EBPs such as PSH, Housing First models, and Motivational Interviewing that support individuals in achieving stable housing, community integration, and recovery in the community. It will be critical for provider staff to be adequately trained in EBPs in order to not only ensure fidelity to the ACT model and compliance with the settlement agreement but also to ensure consistent service delivery. This has a direct impact on delivering services and on people's access to those services. Trainings could model or build upon any tenancy support training that already offered through TCLI, and cover topics such as working with property owners, fair housing/tenant-owner law, and incorporating housing into person-centered planning. These trainings can be somewhat expensive but the LME/MCOs could consider using reinvestment dollars to fund them.

Recommendation 4G: Develop a training program for providers who will be implementing the new supportive living service definition under the I/DD Innovations Waiver.

The Department of Health and Human Services should develop a new RFP to solicit contractors to develop a curriculum specific to individuals with I/DD. This new service is very different from any of the currently funded waiver services. The focus should be on skill-building and teaching tenancy support services such as being a good tenant, lease responsibilities, paying rent, and other money management and household maintenance activities. It is important to note that the NC Council for Developmental Disabilities recently released an RFA to solicit proposals for developing a training curriculum for the new service definition, so DHHS should work with them to avoid duplication.

Goal 5: Enhance LME/MCO staff core competencies to ensure quality services across all populations.

Recommendation 5A: Provide training to LME/MCO staff on evidence-based practices.

Staff members at LME/MCOs should receive training in EBPs related to supporting tenancy in addition to understanding ACT and TST services. Such training should take place prior to monitoring by the LME/MCOs, because until they have a firm grasp of the EBPs, they cannot hold their providers accountable. Over time, all staff will acquire a base knowledge of the supports and some specialization could be allowed for implementation of specific EBPs as well. This training will be crucial in order for both DHHS and the LME/MCOs to meet the terms of the settlement agreement, reinforce best practices for consistent service delivery and to ensure an adequate and well-trained provider network.

Recommendation 5B: Provide training to LME/MCO staff on the new supportive living definition for the I/DD waiver.

The Department of Health and Human Services should work with the LME/MCOs or a private contractor to develop training on the new supportive living definition for individuals with intellectual/intellectual disabilities. Similar to providing appropriate oversight and utilization management for ACT and TSM services, the LME/MCO staff must understand the new service and how it should be implemented in order to ensure the ability of individuals with I/DDs to live in the community in supportive housing. Providers will need ongoing support as this service is rolled out, so the LME/MCO staff must be adequately trained to work closely with them.

Goal 6: Further develop Medicaid services for the provision of tenancy supports, initially focusing on individuals in the settlement population.

Recommendation 6A: Complete and evaluate a Medicaid crosswalk and update policy as documented in the NC State Plan, waivers, and vendor agreements through an established inter-office work group. Develop a State Plan Amendment (SPA) via the rehab option to develop a recovery based skill building service.

The Department of Health and Human Services, led by Medicaid, should complete and further evaluate a crosswalk to determine the types of housing services and supports that the state is

currently providing across populations and where gaps in coverage exist, so as to plan future expansion of these services beyond the TCLI population. DHHS is now working on an SPA, through the Rehabilitation option, to bring housing services and supports into its Medicaid State Plan. The current service definition is a stand-alone tenancy support service that would be available to individuals with a mental illness, SUD, or I/DD who are not on the waiver. The state should consider developing a community service that is recovery-based, focuses on skill-building, and includes peer supports and training to:

- Promote the restoration of community living skills.
- Promote the development of a crisis plan and crisis services.
- Develop community resources.
- Attain and maintain housing.
- Provide illness management and recovery training.

Recommendation 6B: Maximize Medicaid reimbursement in order to utilize state revenues for services not covered by Medicaid, housing resources, and people not eligible for Medicaid.

Another important point is that DHHS will be able to maximize federal financial participation through Medicaid funding once the SPA is approved by CMS. The state is currently using state general funds for housing services and supports for individuals who are part of TCLI. By bringing tenancy supports into the state plan, the state can leverage its state resources and in so doing garner savings. These savings could be used to serve individuals not part of TCLI as well as those who are ineligible for Medicaid. As DHHS expands to serving other individuals with complex needs in PSH (e.g., homeless or SUD populations) other savings may be realized for reinvestment back to the community to further North Carolina's system reform efforts.

The Department of Health and Human Services recently received approval from CMS and is working to implement a new supportive living service definition to the Innovations waiver for individuals with I/DDs, which it planned to launch in December 2016. This would allow people with I/DDs currently living at home or in a group home to move to a more independent setting like supportive housing. Providers will need to be part of the discussions of this new service including the consideration of rates and associated regulations. DHHS and each LME/MCO will also need to provide appropriate training for agency staff to ensure there is an adequate provider network to provide this service. DHHS could also work with or incentivize the LME/MCOs to utilize reinvestment funding to develop tenancy services and supports for individuals with I/DDs who are living either at home or in group or supervised living but who wish to move to supportive housing.

Recommendation 6C: Work with LME/MCOs to fund certain in-lieu-of services and use savings to reinvest in additional 1915(b)(3) housing services and supports, specifically housing navigation services.

The Department of Health and Human Services should work with the state's LME/MCOs to fund certain in-lieu-of services and use savings to reinvest in additional 1915(b)(3) housing services and supports. Housing navigation, for example, is not currently a Medicaid- or state-funded

service; either the LME/MCO housing specialist or the provider responsible for tenancy management services performs this function. However, housing navigation is a specific skill that requires a background in real estate, knowledge of fair housing laws/practices, experience in working with property owners, and knowledge of available housing resources. Developing this as a specific service or embedding it within the housing specialist role can allow the TCLI Coordinators and provider staff to concentrate on the transition process and ongoing required services. Reinvestment savings could also be used to develop and provide training in the above noted areas. This would enable a more efficient and coordinated process that should increase the pace of transitions to the community to meet the terms of the settlement agreement.

Roles and Responsibilities

In order to successfully implement the recommendations in this report, state and local leaders must commit time and energy in a focused manner. Identifying and continuing to reinforce proper roles and responsibilities is essential both at the state level with PSH policy development and at the regional/local level with the development and provision of integrated permanent supportive housing.

Goal 7: Clarify and reinforce proper roles and responsibilities in the provision of integrated permanent supportive housing at the state, regional, and local levels to ensure a sustainable infrastructure at all levels.

In Strategic Goal 1, TAC recommended the development of a memorandum of agreement between NCHFA and DHHS to clarify and specify the roles and responsibilities of each entity in state PSH policy development. This recommendation will support the achievement of Goal 7 as well. Below are four additional recommendations to accomplish this goal:

Recommendation 7A: Continue efforts to standardize and align roles and responsibilities in order to create a more efficient process to place TCLI individuals in housing.

The North Carolina Housing Finance Agency and DHHS have made efforts to specify roles and responsibilities for the transition and housing staff in their agencies and in the LME/MCOs in the delivery of the TCLI program. These roles and responsibilities have been developed in a way that allows some flexibility to the LME/MCOs to design and adapt their TCLI staffing models. TAC believes this approach is sound and encourages creativity and innovation at the local level. However, it is important to recognize the importance of the proper incentives to standardize and align roles and responsibilities in order to develop a more efficient process. In our discussions at both the state and local levels, there was recognition by staff that there are still areas within the TCLI process that could be streamlined or improved.

Therefore, TAC recommends continued collaborative efforts between DHHS and LME/MCO staff to reinforce current standards and better align roles and responsibilities of staff who provide support to the TCLI program and to the TCLI transition teams. Greater efficiencies in the process can decrease the time needed to identify and move into housing, improve the level of pre- and post-tenancy supports to TCLI individuals, and ensure long-term, sustained

tenancies in housing. In addition, the Department of Health and Human Services should prioritize clarifying and defining roles and responsibilities of the LME/MCO TCLI and housing specialist staff, the DMH housing staff, the RHCs, and provider staff. Positions, related duties, and exact points for transfer of cases should be clearly outlined as these relate to transition or diversion of individuals from ACHs, psychiatric hospitals, and homelessness. DHHS should develop these roles and responsibilities with input from the LME/MCOs and providers and formalize them in written documents such as Memoranda of Agreement or Understanding.

Recommendation 7B: Identify and disseminate LME/MCO best practices focused on maintaining and enforcing proper roles and responsibilities.

During our conversations at the local level with the LME/MCO transition teams, TAC recognized several promising practices among staff and the teams that improved the TCLI process itself or enabled greater efficiencies in how the teams operated. For example, the LME/MCOs who had housing support embedded within the TCLI team structure seemed to have greater success with permanent housing placements of the settlement population. As the LME/MCO transition teams continue to mature and build their skills, best practices and innovations will continue to emerge that should be shared and adopted across LME/MCOs.

In order to take full advantage of the growth within the LME/MCO transition teams, TAC recommends that DHHS collaborate with NCHFA staff to identify and disseminate LME/MCO best practices, with a focus on maintaining proper roles and responsibilities. DHHS provides periodic opportunities for the LME/MCO transition teams to convene as a group. These meetings offer the opportunity to further develop a "community of practice" in which the TCLI transition staff can share innovations and best practices. Over the long term, DHHS in collaboration with the LME/MCOs should consider ways to leverage and redirect the TCLI transition teams in order to sustain this collective staff capacity and experience across the system as the state moves beyond the settlement agreement. Further, TAC recommends integrating the transition teams into the core housing practices of each of the LME/MCOs serving all their populations.

Recommendation 7C: Dedicate NCHFA staffing to coordinate PSH development activities and to provide technical assistance on fair housing and rental assistance to owners, property managers, LME/MCOs, and service provider staff to improve access and decrease denials to targeted units.

The staff of NCHFA possess essential affordable housing expertise as well as mature, time-tested partnerships with housing developers and local community development officials across the state. NCHFA commitment and dedicated staff support will be critical to the success of the Strategic Housing Plan especially in the areas of PSH development and fair housing technical assistance. NCHFA and DHHS should continue to align and coordinate their efforts leveraging their respective skills and capabilities. In support of this effort, TAC recommends that NCHFA dedicate staff support to coordinate PSH development through the PSH funders collaborative and provide technical assistance in coordination with DHHS on fair housing and rental

assistance to Targeting/Key Program owners, property managers, LME/MCO housing and transition staff, and service provider staff.

Data Collection and Performance Measurement

In order to successfully implement and effectively assess progress of the state's Strategic Housing Plan, NCHFA and DHHS staff must continue to develop and support a data collection, report, and evaluation system for the state's integrated PSH efforts (both the Targeting/Key and TCLV programs). The goals of this robust system would be twofold: to provide frontline staff with a useful tool to improve the referral process; and to offer the PSH leadership steering committee a tool to assess overall system outcomes and progress in reaching the goals laid out in this report. Currently, NCHFA and DHHS collect and track data separately for their respective PSH activities. Efforts are underway to integrate and enhance these data collection platforms and reporting functionality. TAC recommends that NCHFA and DHHS continue their focused, collaborative efforts to reach the goal below.

Goal 8: Invest in robust data collection, reporting, and evaluation systems to improve referral processes and track outcomes effectively.

Recommendation 8A: Implement policies and procedures to ensure timely data entry and data quality within systems.

In order to further formalize and improve the current PSH data and tracking systems, TAC recommends the implementation of clear policies and procedures targeting the "end use" of the system, focused on timely entry of data and improving the overall quality of the data. As part of this effort, TAC also recommends following up with ongoing training and support for users to develop a clear understanding of expectations in data entry. With the development of a new web-based referral system to track the Targeting/Key Program units, improvement in timeliness of data and quality will likely result in quicker referrals to owners and improved access to these units for individuals served by the settlement.

Recommendation 8B: Improve collection of Targeting/Key Program unit referral outcome data.

Efforts are underway by NCHFA and DHHS through the RHC program to implement this new web-based platform for the Targeting/Key Program units. Based on the capabilities described, this new data system has the potential to improve efficiency of the referral process itself and ultimately to improve access to these units. The system will also allow NCHFA and RHC staff to use referral outcome data (i.e. acceptance and denials) to focus technical assistance and support for both property managers and service providers in regards to fair housing, as recommended in the Fair Housing section of Strategic Goal 2.

Recommendation 8C: Enhance database user and reporting capabilities where possible.

As part of these data system enhancement efforts which will result in the new Emphasys data management system for both the Targeting/Key Program and TCLI, TAC recommends developing user-friendly functions and reporting capabilities for frontline staff. Training and support must be offered regularly for staff members who use these systems, allowing them to

understand the power and functionality of the systems and to see how they can be used to make their jobs easier, as well as improving efficiency and the quality of the service.

Recommendation 8D: Establish specific reports to be shared by NCHFA and DHHS on targeted units and TCLI data; use this data to inform system changes.

TAC recommends the development of a PSH dashboard to track key outcomes and trends in access to the Targeting/Key Program units and utilization of TCLI rental assistance, to be provided to the PSH leadership steering committee. This information will help them to track system trends and will inform the development of PSH policy and future funding priorities. A state-level PSH dashboard report should include the following data/outcomes: Targeting/Key Program acceptance and denial rates; success rates of the Targeting/Key Program at initial lease-up; average housing search duration by county for individuals covered by the settlement; and overall housing retention rates for PSH tenants overall and for tenants serviced by the settlement, broken down by county.

H. Implementation

Implementation of Strategic Goals — Creating the North Carolina Strategic Housing Plan

As discussed earlier, TAC recommends that NCHFA and DHHS take each of the recommendations in this report into consideration and prioritize them for implementation as appropriate based upon the state's goals and resources. We encourage the state to prioritize the specific recommendations that will create new permanent supportive housing opportunities for the settlement population as quickly as possible. In the short-term, the state's current disaster recovery efforts for communities impacted by Hurricane Matthew will continue to be a consideration.

TAC recommends that the first Strategic Housing Plan adopted act as a corrective action plan in response to DOJ findings. In drafting this corrective action plan, TAC recommends that the NCHFA/DHHS select strategically from the above recommendations, prioritizing those that will create new permanent supportive housing opportunities for the settlement population as quickly as possible. The plan should set out the implementation, sequencing, and prioritization of strategic activities. Consideration should be given to how the plan will be monitored and evaluated. Sustained and committed statewide leadership will be necessary for the state's goals (including PSH production) to be achieved.

The North Carolina Housing Finance Agency and DHHS will need to coordinate with the LME/MCOs to align their LME/MCO housing plans with the state's Strategic Housing Plan in order to take full advantage of the strategies and resources offered by this report. As identified in our Housing Gaps Analysis, many of the LME/MCOs face understandable housing barriers, and to address them, coordinated and targeted effort is required. Each LME/MCO should

review the county-specific information within the Gaps Analysis to understand how it can better target its housing specialists to fill those gaps.

The North Carolina Housing Finance Agency and DHHS should consider implementing an external communications plan to support the rollout of the Strategic Housing Plan. Many advocacy organizations mentioned as housing and services partners, such as NC Housing Coalition, NC Justice Center, Disability Rights NC, NC NAMI, and the NC Coalition to End Homelessness, have the skills to deliver important messaging. These organizations may already have strong relationships with the partners that NCHFA, DHHS, and the LME/MCOs will need to connect with in order to achieve the settlement goals, such as PHAs, regional apartment associations, and local leaders and officials.

NCHFA and DHHS should consider using existing structures to leverage external stakeholders and advocates in order to build ongoing support for the Plan, and should communicate regularly on progress. A baseline level of transparency will be necessary to keep the public and key stakeholder groups abreast of progress. Once partners are engaged with the NCHFA and DHHS, they can help build support for the Plan and its goals, giving it a broader support network and the best chance for success and sustainability.

Appendices

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Appendix I: Summary of TAC's Interview Activities

As part of the assessment phase, TAC conducted interviews and focus group sessions with a range of stakeholders at the state and local levels. Below is a summary of those activities, including who was interviewed and when the interviews took place:

1. May 24-26, 2016

Patricia Amend, Jennifer Olson, Fredrika Cooke, Paul Kimball, Heather Dominique, Scott Farmer, Margrit Bergholz, Bob Kucab (NCHFA)
Jessica Keith, Drew Kristel, Rick Brajer (DHHS)
Marti Knisley (DOJ Reviewer)
Ellen Blackman and Heather Burkhardt (Division of Aging and Adult Services)
Corye Dunn & Yasmin Farati (Disability Rights NC)
Tara Peele (SocialServe.com)
Samuel Gunter (NC Housing Coalition)
Denise Neunaber (NC Coalition to End Homelessness)
Jack Register and Nicolle Karin (NAMI NC)
Ken Edminster and Angela Harper-King (DMHDDSAS)
Bill Rowe (NC Justice Center)

2. June 28-30, 2016

Patricia Farnham (Consultant on MFP/Transitions)
Tamara Smith, Janie Shivar, and Stacy Smith (DMHDDSAS, TCLI Office)
Jeff Dillman and Jack Holtzma (Fair Housing Project, NC Justice Center)
Rob Robinson, Ann Oshel, Tinya Ramirez, and Malcolm White (Alliance Behavioral Healthcare)
Regional Housing Coordinator Meeting – Jim Yates and Liz Stewart observed
Durham Landlord Event – Jim Yates observed

3. August 2-4, 2016

Staff at Partners, Cardinal, and Smoky LME/MCOs

4. August 9-11, 2016

Staff at Sandhills, Eastpointe, and Trillium LME/MCOs

5. September 12-14, 2016

Consumer focus groups conducted at Smoky, Alliance, and Trillium LME/MCOs

6. List of Phone Interviews:

Dionne Nelson (Laurel Street Residential)
Debra King and Jess Brandes (CASA)
Margaret Gurling (The Arc of NC)

Lorna Moser (UNC Training Institute)
Dave Richard (Medicaid Director)
Pam Lloyd and Jennifer Pleasants (DVR-ILP)

7. Draft Recommendations Presentations by TAC:

8/29/16	DHHS & NCHFA executive staff
9/2/16	NCHFA Executive Director& DHHS Secretary (Sec. was unavailable)
9/15/16	DHHS Secretary & NCHFA Executive Director
10/7/16	LME/MCOs
10/7/16	NC Advocates
10/10/16	DOJ representatives

Appendix II: Summary of North Carolina Consumer Focus Groups September 12-14, 2016

1. Methodology for Consumer Focus Groups

Four focus groups were held at local management entity/managed care organizations (LME/MCOs) across the state (one at Smoky Mountain, one at Alliance, and one within each of Trillium's northern and southern regions) at locations and times amenable to consumers to facilitate engagement and attendance. In addition to the consumers, representatives from the Department of Health and Human Services (DHHS) and the North Carolina Housing Finance Agency (NCHFA) and managers and workers from the local LME/MCOs were present. A total of 22 consumers were interviewed across the four groups.

2. Summary of Findings

During the facilitation of the focus groups it became apparent that consumers were disadvantaged both by high needs and by low levels of resources. Below is a summary of findings in four categories:

- **Personal factors** such as preferences, skills, and "status" (e.g., educational, health, criminal, and military);
- **Social network and personal assets** to which a person has regular access, including family and income;
- **Resources targeted to groups** based on their eligibility for certain programs, such as Medicaid, Social Security;
- **Housing resources** related to availability, affordability, access and quality.

Personal Factors

Preferences — While participants recognized that personal housing preferences would vary, strong themes emerged. Participants generally wanted:

- Privacy — a space they could call their own, without being bothered by other tenants;
- Not to have roommates;
- Not to live away from the geographical community they are most familiar with;
- Access to reliable transportation;
- A home in a structure separate from others, i.e., not an apartment building;
- Basic utilities that work;
- Accessibility inside and outside for people with physical disabilities. For people with mobility and other chronic conditions this often included first-floor apartments and apartments without stairs.

Criminal records placed limitations on people's (perceptions of their) ability to access housing. Expungement may have been an option for many, but they said it was very expensive with regard to lawyers available.

Physical disabilities limited their home access, transportation options, and capacity to work.

Consumers typically lacked knowledge of resources that might help them with their housing (see "Housing Resources" below), but they otherwise seemed capable of conducting a housing search and maintaining housing.

Social Network and Personal Assets

Family was generally not in the picture for the focus group participants. Family can help with the search for housing, transportation, and accessing resources, but can hinder by being unreliable or discouraging.

Income, resources — Participants were relying on some sort of disability payment (e.g., SSDI) which did not cover most rents. Since they didn't work, that was their only income. Subsidies made the difference for them to find a "low-quality" place or move to another area. They found themselves at times choosing between rent and co-pays, food, or transportation. For example, the two dollars for disability transportation was a drain on their resources.

Transportation — Participants could not afford cars and found public transportation unreliable or challenging, since it could take four hours to get to a job or appointment going from one county to another.

Computer/internet — Most participants did not use computers or the internet regularly. Newspapers seemed to be more accessible for them. The government-funded cell phones they had typically did not have Internet capacity.

Resources Targeted to Groups

LME housing support workers — Participants who worked with LME housing workers found them very personable and helpful in supporting their housing search and maintenance. Workers appeared to be most helpful in finding housing for people; they also tried actively to support people in their tenancy, but owners could be resistant with regard to reasonable accommodations and basic maintenance. LME workers could also help them access health services, including Medicaid supports such as mobility equipment. Of note:

- The LMEs seemed to vary greatly in terms of resources dedicated to housing searches and supports.
- Participants, unless approached or otherwise connected, seemed unaware of what the LMEs had to offer.

State sponsored housing search websites — North Carolina offers websites for consumers to identify housing options, but the degree to which these cover independent living (versus

supervised living) is unclear. A housing availability database is also made available to LMEs and others. Neither seem to be used by group participants.

Mental health services — For our participants, mental health services and supports did not factor into their housing needs.

Transportation services for people with disabilities were seen as reliable to an extent, but also expensive and not providing direct routes to places people wanted to go (jobs, appointments), taking many hours for what could be a 20-minute drive.

Peer specialist — Several participants extolled the inspiration and knowledge of peer specialists working for the LMEs.

Legal Services for poor and disabled persons were not accessed by either consumers or LME supporters (related to reasonable accommodation concerns or criminal expungements)

Housing Resources

Affordability

- Current income and subsidies are not enough for good housing.
- The areas' economic vitality is further crowding people with disabilities.
- Need for rent often balanced against filling prescriptions, buying food, etc.

Availability

- Not enough one-bedroom apts., too many two bedroom apartments.
- Rent for desired communities is higher than for more rural communities.
- Waitlists are often extensive.

Drug use and dealing in apartment complexes is common. Consumers we talked to were able to "segregate" themselves in their apartments to avoid obvious drug dealing and solicitations. But it's clear that for people in substance abuse recovery there would be extensive challenges. On the other hand, it is the poor quality of property management that makes the units "affordable."

Working utilities — As noted above, poor property management makes apartments affordable, which means that the equipment supporting utilities is not always functioning well, and the owner's response may be very slow.

People don't know what housing is available, or its quality. Participants found their housing often on their own or through LME supports. But they would have preferred profiles of the unit prior to moving in so they could make an informed choice. Useful information might include an assessment of the unit's comfort, responsiveness of owner to issues, and environment of shared spaces (e.g., no drug trafficking).

Appendix III: Housing Resources and Partners Assessment

TAC reviewed the current array of housing resources in order to identify resources currently available to individuals living in permanent supportive housing settings and other resources that may be modified or adapted to create additional permanent supportive housing opportunities. Below is a summary of the key affordable housing resources with a focus on the 20 priority counties identified in the settlement agreement that could be harnessed to create or sustain permanent supportive housing in the state.

1. Public Housing Authority Resources

The State of North Carolina does not operate, own, or manage any public housing units. In North Carolina, Public Housing Authorities (PHAs) in the larger suburban and metropolitan areas own and manage public housing developments. Within the 20 priority counties, 38 PHAs administer 37,245 housing choice vouchers (HCVs) and 24,334 public housing units. Table 1 shows the distribution of HCVs, special purpose vouchers, and public housing units by PHA.

Table 1: Public Housing Authority Resources in 20 Priority Counties

PHA	Housing Choice Vouchers[10]	Public Housing Units	Special Purpose Vouchers[11]
Asheville Housing Authority	3199	96	75
Ayden Housing Authority	0	175	-
Belmont Housing Authority	0	50	-
Benson Housing Authority	0	173	-
Charlotte Housing Authority	5171	5841	275
Concord Housing Authority	541	174	-
Durham Housing Authority	2791	2005	200
East Spencer Housing Authority	239	0	-
Eastern Carolina Human Services Agency, Inc.	739	0	75

10 HUD Housing Choice Voucher and Public Housing information was obtained at https://pic.hud.gov/pic/haprofiles/haprofilelist.asp

11 Includes NED/NED Category 2 and Mainstream Vouchers

PHA	Housing Choice Vouchers[10]	Public Housing Units	Special Purpose Vouchers[11]
Eastern Carolina Regional Housing Authority	0	735	-
Fairmont Housing Authority	0	50	-
Farmville Housing Authority	0	174	-
Fayetteville Housing Authority	1972	1440	-
Gastonia Housing Authority	1255	400	100
Goldsboro Housing Authority	237	1298	-
Greensboro Housing Authority	3375	1481	550
Greenville Housing Authority	751	714	-
High Point Housing Authority	1504	1300	50
Johnston County Housing	619	0	-
Lumberton Housing Authority	596	729	-
Mooresville Housing Authority	0	106	-
Morganton Housing Authority	0	250	-
Mount Olive Housing Authority	0	20	-
New Bern Housing Authority	0	260	-
Pembroke Housing Authority	0	243	-
Piedmont Triad Regional Council	842	0	-
Raleigh Housing Authority	3915	1445	-
Robeson County Housing Authority	0	291	-
Rowan County Housing Authority	688	194	-
Salisbury Housing Authority	0	465	-

PHA	Housing Choice Vouchers[10]	Public Housing Units	Special Purpose Vouchers[11]
Selma Housing Authority	0	183	-
Smithfield Housing Authority	0	205	-
Statesville Housing Authority	704	546	-
Twin Rivers Opportunities, Inc.	880	0	-
Valdese Housing Authority	0	121	-
Wake County Housing Authority	530	345	100
Wilmington Housing Authority	2012	1012	55[12]
Winston-Salem Housing Authority	4685	1813	-
TOTAL	34,454	22,329	1,275

While the state has significant HCV and public housing resources, Table 2 below shows that the majority of the waiting lists at the largest public housing authorities in the six high-value counties are closed. Furthermore, the waiting lists that remain open have long waits. In 2015, households statewide spent an average of 13 months on a waiting list for public housing, and 40 months on a waiting list for an HCV.[13]

[12] Wilmington Housing Authority administers 50 Non-Elderly Disabled (NED) and 5 NED Category 2 vouchers. The NED Category 2 vouchers are specifically for people in nursing homes or psychiatric facilities who could live on their own with support services. This program is operated in partnership with North Carolina's Money Follows the Person program.

[13] From HUD PD&R *Picture of Subsidized Housing* database: https://www.huduser.gov/portal/datasets/picture/about.html

Table 2: Waiting List Status and Preferences at the PHAs in the Six High-Value Counties[14]

County	Waiting List Status for Housing Choice Voucher program (HCV) and public housing (PH)	Current Waiting List Preferences
Buncombe		
Asheville HA[15]	HCV: Open	Preference for applicants for its tenant-based vouchers who are non-elderly disabled and ready to move from a group home, care facility, or other supportive housing program to a community-based setting with community-based supports
Forsyth		
Winston-Salem HA	HCV: Closed PH: Open	Preference for people with disabilities
Guilford		
Greensboro HA	HCV: Closed PH: Closed	Preference for people with disabilities
High Point HA	HCV: Closed PH: Open	Preference for people with disabilities
Mecklenburg		
Charlotte HA	HCV: Closed PH: Open	Preference for people with disabilities
New Hanover		
Wilmington HA	HCV: Closed PH: Closed	Preference for people with disabilities
Wake		
Raleigh HA	HCV: Open PH: Open	Preference for people with disabilities
Wake County HA	HCV: Closed PH: Closed	N/A

The majority of the housing authorities in the six high-value counties utilize waiting list preferences that could benefit the settlement population. For example, Asheville Housing

[14] Data from contact with PHAs

[15] Asheville Housing Authority has one combined waiting list for the Housing Choice Voucher program, which now includes both project-based (former public housing) and tenant-based vouchers.

Authority maintains a preference for applicants for its tenant-based vouchers who are non-elderly disabled and ready to move from a group home, care facility, or other supportive housing program to a community-based setting with community-based supports. The Housing Authorities in Charlotte, Greensboro, High Point, Raleigh, Wilmington, and Winston-Salem also utilize a preference for people with disabilities; although the settlement population would qualify for this preference, it is not as specialized as a preference focused specifically on the settlement population.

2. HOME Partnership Program

The NCHFA and sixteen municipalities and counties administer the U.S. Department of Housing and Urban Development's (HUD) HOME Investment Partnerships (HOME) program in North Carolina. The HOME statute permits the use of these funds to create renewable, two-year, tenant-based rental assistance programs, which could be targeted to permanent supportive housing (PSH). Statewide, NCHFA uses HOME funds for several programs, including homeownership rehabilitation, affordable homeownership, and the Rental Production Program, which finances the development of LIHTC rental units[16]. As shown in Table 3 below, according to the HOME Dashboard reports, eleven of seventeen North Carolina jurisdictions used HOME funds in FY 2016 to create of affordable rental units with approximately 239 units produced[17].

Table 3: FY 2016 HOME Program Allocations

Name	HOME	Percentage Used for Rental Housing (Jan-June 2016)	Net Increase of Units (Jan-June 2016)
Asheville	$961,627	42%	22
Charlotte	$2,311,846	20%	64
Concord	$949,193	25%	4
Cumberland County	$279,302	0%	-
Durham	$801,800	29%	8
Fayetteville	$586,788	11%	2
Gastonia	$585,547	0%	-
Goldsboro	$159,629	0%	-
Greensboro	$1,229,643	39%	24

[16] 2016 ConPlan: https://www.nccommerce.com/Portals/2/Documents/ConPlan/2016-2020%20Con-Plan/2016-2020%20Con-Plan.pdf

[17] Data from HOME Dashboard reports: https://www.hudexchange.info/programs/home/home-dashboard-reports/

Name	HOME	Percentage Used for Rental Housing (Jan-June 2016)	Net Increase of Units (Jan-June 2016)
Greenville	$328,801	50%	2
High Point	$362,151	0%	-
Lenoir	$793,802	0%	-
Raleigh	$1,055,103	91%	10
Wake County	$582,983	100%	21
Wilmington	$486,760	100%	60
Winston-Salem	$948,577	0%	-
State of North Carolina	$12,370,523	8%	22

3. Low Income Housing Tax Credit Program

The NCHFA administers the Low Income Housing Tax Credit (LIHTC) program, using funds to create affordable rental housing across the state. Successful applications are awarded tax credits equal to nine percent of the qualified cost of building or rehabilitating the property. Over the past three years in the six high-value counties, NCHFA has sponsored the development, on average, of 17 affordable housing projects per year. In 2016, the Qualified Allocation Plan (QAP), which governs the use of the LIHTC program, awarded one point to projects proposed in the 20 priority counties. This additional point resulted in more units being developed in the 20 priority counties, including a significant increase in production in the six high-value counties.[18] Table 4 below shows where the current 39,303 LIHTC units and targeted units can be found in the 20 priority counties.

Table 4: Low Income Housing Tax Credit Units in 20 Priority Counties

County	Total Number of LIHTC Units	Total Number of Targeted Units
Buncombe	1,616	176
Burke	320	35
Cabarrus	1,238	76
Caldwell	509	46
Craven	683	40
Cumberland	2,266	355
Durham	3,864	161
Forsyth	2,267	124
Gaston	1,329	95
Guilford	3,254	215

[18] From 2013-2015, the six priority counties were awarded an average of 13 projects totaling 451 units. In 2016, the six priority counties were awarded 22 projects totaling 2,484 units.

County	Total Number of LIHTC Units	Total Number of Targeted Units
Iredell	833	58
Johnston	1,126	93
Mecklenburg	6,742	277
New Hanover	1,737	101
Onslow	1,163	89
Pitt	478	88
Robeson	1,045	67
Rowan	760	69
Wake	7,452	501
Wayne	621	49
TOTAL	**39,303**	**2715**

Tax-Exempt Bond Financing

Qualified LIHTC applicants also have the opportunity to apply for tax-exempt bond financing. Tax-exempt bonds combined with 4% tax credits are an alternative to traditional 9% tax credits and provide long-term, below-market financing for the construction and rehabilitation of affordable rental housing. The bond is issued by a government entity (state, regional, or local housing authority; county; or city) and proceeds are lent to the private entity. According to the 2016 QAP, the state has prioritized the multifamily portion of its bond authority allocation in the following order:

1. Projects that serve as a component of an overall public housing revitalization effort.
2. Rehabilitation of existing rent-restricted housing.
3. Rehabilitation of projects consisting of entirely market-rate units.
4. Adaptive reuse projects.
5. Other new construction projects.

Bonds and tax credit rules require that at least 40 percent of the units be rented to families whose income is not more than 60 percent of area median income (AMI); remaining units can be market rent (but no tax credits on those units). The following cities within the priority counties have at least one tax-exempt bond/4% housing project: Asheville, Cary, Charlotte, Concord, Durham, Fayetteville, High Point, Raleigh, and Wake Forest.

4. National Housing Trust Fund

Authorized by the Housing and Economic Recovery Act of 2008, the National Housing Trust Fund (NHTF) is a rental housing production and preservation program created by Congress specifically to address the nation's critical shortage of rental housing units dedicated to extremely low-income (ELI) households. In December of 2014, the Federal Housing Finance Agency lifted its six-year suspension of Fannie Mae's and Freddie Mac's obligation to contribute to the NHTF, allowing the program to begin functioning. North Carolina has received an allocation of $3.28 million, and NCHFA has been named to administer these funds. Several features of the NHTF statute make it an important resource for new PSH development:

- NHTF is a permanent program on the mandatory side of the federal budget, with dedicated sources of funding not subject to the annual appropriations process.
- HUD will use the NHTF statutory formula to determine the amount of NHTF resources allocated to each state; each state must receive a minimum of $3,000,000.
- At least 80 percent of NHTF funding must be directed to the production, preservation, rehabilitation, and operation of rental housing.
- At least 75 percent of the rental funds must benefit ELI households.
- Two kinds of rental housing activities are authorized: capital for rental housing development, rehabilitation, and preservation; and operating subsidies or operating reserves.

5. Continuum of Care Program

HUD has offered historically low levels of funding for the Continuum of Care (CoC) program in its recent competitive funding rounds, resulting in very little opportunity to fund new PSH projects. This funding environment forced many local CoCs to reduce funding for existing projects. However, the 2016 CoC program NOFA made available relatively higher levels of funding, allowing local CoCs to propose new PSH bonus projects and to reallocate funding from existing projects to new PSH in their communities. As seen in Table 5 below, there is a CoC operating in each of the 20 priority counties, accounting for a CoC-funded PSH stock of 2,671 units for families and 3,439 units for individuals.

Table 5: Continuum-of-Care-Funded PSH Beds in Priority Counties[19]

Name of CoC	Families	Individuals
Asheville/Buncombe	62	567
Balance of State CoC	875	615
Charlotte/Mecklenburg County	315	660
Durham City/Durham County	130	190
Gastonia/Cleveland, Gaston, Lincoln Counties	93	148
Greensboro/High Point/Guilford County	343	198
Raleigh/Wake County	414	561
Fayetteville/Cumberland County	189	107
Wilmington/Brunswick/New Hanover/Pender County	18	131
Winston-Salem/Forsyth County	232	262
TOTAL	**2671**	**3439**

[19] Data from Housing Inventory Count reports on HUD Exchange

While numerous PSH resources exist within these CoCs, many of the people transitioning from adult care homes and other institutional settings are not eligible under CoC rules due to their housing status. For instance, in the FY2015 CoC program competition, to be eligible for PSH resources, participants had to come directly from a place not meant for human habitation, the streets, or emergency shelter, or be fleeing a domestic violence situation. There is potential for transitional housing to be used as bridge housing between an institutional setting and permanent supportive housing through a targeted unit or a Transitions to Community Living Voucher (TCLV); however, this bridge housing would not be a permanent housing destination.

6. Community Living Program

The NCHFA offers several programs to provide access to affordable apartments and rental assistance for people with disabilities, including the Targeting Program, Key Program rental assistance, and TCLVs.

Targeting Program

Established in 2002, the Targeting Program is a partnership between NCHFA and DHHS to provide access to affordable housing for people with disabilities and people experiencing homelessness with very low incomes. All housing tax credit projects awarded since 2004, and many in the preceding two years, have been required to set aside between 10 and 20 percent of their units and make them available for eligible participants as identified by DHHS. Applicants are referred to the program by a participating agency via the DHHS Regional Housing Coordinator. To be eligible, applicants must be disabled or homeless and have an income below 50 percent of AMI. DHHS is afforded 30 days to refer eligible households to available units or negotiate a hold on the unit if the property has not met its targeting goal. If DHHS does not have any referrals, the property owner can take the next otherwise eligible household from its primary waiting list. Currently, there are 2,715 targeted units in the 20 priority counties.

Key Program Rental Assistance

The Key rental assistance program is only available in properties participating in the Targeting Program. Key Program rental assistance provides project-based rent subsidies to ensure that targeted units are affordable to persons with extremely low-incomes who are disabled or homeless. The Key Program can also pay for security deposits and certain costs incurred by the property owners. Currently, the Key Program is available at 256 properties in the Targeting Program.

Transitions to Community Living Vouchers

TCLVs provide tenant-based rental subsidies to individuals with serious mental illness based on the following categories per the settlement agreement:

- Individuals with Serious Mental Illness (SMI) who reside in adult care homes (ACHs) determined by the State to be an IMD

- Individuals with Serious and Persistent Mental Illness (SPMI) who are residing in ACHs licensed for at least 50 beds and in which 25% or more of the resident population have a mental illness

- Individuals with SPMI who are residing in ACHs licensed for between 20 and 49 beds and in which 40% or more of the resident population have a mental illness

- Individuals with SPMI who are or will be discharged from a State Psychiatric Hospital and who are homeless or have unstable housing

- Individuals not diverted from entry into ACHs pursuant to the pre-admission screening and diversion provisions established by the state

The rent subsidy, combined with support services, enables tenants to live independently and makes up the housing portion of a broader program known as the Transitions to Community Living Initiative (TCLI). The voucher operates as a partnership between DHHS and the state's network of behavioral health managed care organizations. TCLVs not only provide rent assistance, but can also help pay for security deposits and certain costs incurred by property owners.

Community Living Housing Fund

The Community Living Housing Fund is established within NCHFA to pay for the transition of individuals who qualify under the settlement population from institutional settings to integrated, community-based supported housing and to increase the percentage of targeted housing units available to individuals with disabilities. Since fiscal year 2014, any unexpended, unencumbered balance of the amount appropriated to the Transitions to Community Living Fund must be transferred to the Community Living Housing Fund. In 2016, $5.5 million was transferred to NCHFA.

7. Supportive Housing Development Program

The objective of the NCHFA's Supportive Housing Development Program (SHDP) is to increase the supply of permanent supportive housing in the most integrated settings appropriate to the needs of proposed residents. Traditionally, this program has produced developments whose units are primarily restricted for persons with disabilities. However, during the 2016 funding cycle, SHDP established a preference for housing developments which contribute to meeting the state's goals under the settlement agreement. Additionally, projects with other project-based rental assistance may be eligible for SHDP funding if they contribute to the settlement agreement. NCHFA expects approximately $3.5 million annually, with a maximum of 25 units funded for development annually beginning in FY 2017.

8. Other State Housing Resources

State Housing Trust Fund

The North Carolina Housing Trust Fund is the only state-funded and state-designed resource for financing affordable housing. Administered by NCHFA, it finances home ownership and rental apartments, new construction, rehab, and supportive housing. The 2017 state budget includes $7.66 million for the North Carolina Housing Trust Fund, which is level funding from the previous year.

Appendix IV: Supportive Services Resources Assessment

TAC reviewed the current array of service resources in order to identify the types of services currently available to individuals who are part of TCLI and living in permanent supportive housing settings. While there is a rich array of services available to individuals eligible for TCLI, TAC's discussions with LME/MCOs, providers, advocacy partners and consumers all pointed to similar issues in the service system's capacity to support successful community integration and housing tenancy for individuals in need of PSH. Below is a summary of the key services available and challenges identified.

LME/MCO and Provider Network Capacity to Support Housing Tenure

Services and supports to promote successful tenancy are available to TCLI participants within the system. However, there are service access and quality issues that may have an impact on their effectiveness. Some of these relate to the ability of the provider network to make these services available, with access particularly limited in rural areas of the state. However, some of the issues are attributable to how the LME/MCOs are working with providers, enforcing their contracts, and performing utilization management. However, in balancing this with the importance of the role of DHHS, it is equally important for DHHS to assist the LME/MCOs in performing these functions by providing support and clear expectations. The LME/MCOs are responsible, in large part, for the implementation of the settlement agreement. Therefore, in order to ensure the success of the LME/MCOs and ultimately coming into compliance with the agreement, it is incumbent upon DHHS to provide effective oversight and support to each of them. This cannot be emphasized enough given the myriad responsibilities that have been given the LME/MCOs.

ACT and tenancy support services are available within the system and that is very positive. However, ACT is a very clinically oriented service, while tenancy support is a very new service, and this has led to some quality issues for both. ACT services in particular can be difficult to deliver and teams were reported to do drive-by appointments, to provide services only during normal business hours, and not to accept individuals with challenging behaviors. One LME/MCO noted a disconnect between ACT fidelity and best practice. Some teams focus on attaining a certain fidelity score but aren't spending appropriate clinical time in direct service with the consumers. Reportedly, teams also need more training on skill-building and transferring skills as opposed to just doing tasks for the consumers. LME/MCOs also talked about consumers choosing ACT and then not being able to receive other services. In fact, there is a set of criteria for someone to receive ACT and this should be the basis for providing the service. ACT is a very clinically-oriented service with specific eligibility requirements, and is designed to serve hard-to-engage consumers with high acuity. A person who is receiving ACT should be able to live in PSH and not need other services. This lack of clarity could point to a gap in how services are authorized and should be examined very carefully.

Another key theme that arose during the stakeholder interviews was the lack of provider accountability. As stated above, given the number of responsibilities LME/MCOs have in order

to comply with the settlement agreement, as well as to maintain their daily operations, this is not a surprising finding. That being said, throughout the LME/MCO interview process, there were repeated statements about what a provider was willing or unwilling to do. As an example, one LME/MCO TCLI Transition Coordinator was performing all of the following tasks: assisting with the move and lease signing, explaining the lease process, assisting with furniture and household shopping, and facilitating family outreach and transportation. From this conversation, it was not clear what the TST provider was doing. This appears to point to an opportunity to clarify appropriate roles and responsibilities and DHHS should assist the LME/MCOs in providing this kind of clarity. For example, the LME/MCOs could consider ensuring a clear hand-off to the service provider, with the Transition Coordinator concentrating on identifying and preparing individuals to transition to the community and the provider taking on housing preparation duties with the consumers. These responsibilities could be enforced through clear provider contract requirements and appropriate LME/MCO monitoring and oversight.

Implementation of Evidence-Based Services Required by Settlement Agreement

Assertive Community Treatment and Supported Employment are two EBPs that are required by the settlement agreement to support TCLI-eligible individuals in housing. Therefore, both services must also adhere to fidelity measures as EBPs. This added requirement appears to have posed start-up problems and to have delayed the implementation of supported employment services in particular. As stated above, is has also created a disconnect between ACT fidelity and best practice. Some teams are focusing on attaining a certain fidelity score but aren't spending appropriate clinical time in direct service with consumers. This has resulted in some quality issues in the provision of ACT services. Much work has been done with the supported employment providers to ensure they are meeting fidelity. This was accomplished through a learning collaborative model and shadow sites. Shadow sites were provided by well-performing supported employment teams, allowing teams that were not performing with fidelity to shadow staff as they provided the service. This model could also be followed for ACT team development, as stipulated in the current UNC contract. This would serve a dual purpose of increasing quality and increasing adherence to the fidelity measure chosen by DHHS.

New/Expanded Tenancy Management Services

The Department of Health and Human Services is currently working to bring tenancy management services (TMS) into the Medicaid state plan and is refining the service definition before submitting the amendment to CMS. This is an opportunity for DHHS to develop a recovery-based service focused on skill-building activities. This change could provide opportunities for additional people to receive services, i.e., those not part of the settlement agreement, which is the long-term intention of DHHS. It can also allow the state to claim federal financial participation (FFP) on state expenditures currently funding TMS, freeing up funds for housing resources, services for people not eligible for Medicaid, and non-Medicaid services.

Once TMS is approved, DHHS would be well-positioned to work with the LME/MCOs to prevent duplication with other services. For example, TMS provides pre-tenancy and transition services, as well as housing-sustaining services. It is critical that the services available be complementary and not duplicative, and DHHS can play a leadership role in mapping out how TST and other housing-related services and supports may best be used. The authorization process should be flexible and easily adapted to changing needs; for instance, the LME/MCOs' utilization management staff monitoring of TST will have to be timely to ensure that the service is titrated as people acquire skills and become more independent.

Medicaid (b)(3) Service Rates

Providers and LME/MCOs reported that the rates for Medicaid (b)(3) services in particular are too low, making it difficult for providers to deliver them. The (b)(3) option has been used to provide some tenancy support services and there may be opportunities for DHHS to increase the current level of funding. Some LME/MCOs said they had provided rate increases to address this issue. Providing rate increases is within the administrative function of the LME/MCO, though it must take financial constraints into consideration. The LME/MCOs may also be able to fund other in-lieu-of services that can assist people living in supportive housing while helping to avoid in-patient hospitalizations. Critical Time Intervention is an example of an in-lieu-of service currently funded by a few LME/MCOs. Another specific service discussed is housing navigation, which is not currently funded by Medicaid or state funds but is crucial in helping people to locate housing. Housing navigation requires a specific skill set that includes a real estate background, knowledge of fair housing laws and practices, ability to work with property owners, and knowledge of housing resources. A promising housing navigation model has emerged in a partnership between a LME/MCO and a local housing partner. The Sandhills LME/MCO and Partners Ending Homelessness (PEH) in Guilford County collaborate to offer a dedicated housing navigation staffer at PEH that provides owner contacts and housing opportunities to the housing staff at Sandhills for Guilford County. As a follow up, Guilford staff make subsequent contact with the owner on behalf of the consumer. This partnership has expanded the housing options available to those consumers utilizing the TCLI rental assistance in the private market, and has increased transitions to Guilford County, a priority county.

Appendix V: Housing Gaps Analysis

1. Overview & Methodology

The overall purpose of this housing gaps analysis is to determine North Carolina's capacity to meet the housing demands of the settlement agreement population within the 20 priority counties. The North Carolina Transitions to Community Living Initiative Twenty-County Housing Stock Gap Analysis performed by DHHS in 2015 highlighted that there is sufficient affordable housing stock to meet TCLI housing demand statewide and to meet the need in a majority of the 20 priority counties. However, as DHHS noted, the ability of the settlement population to access this stock depends on a number of factors including actual unit turnover, property desirability, timing of transitions, and competition with other low-income renters. Our analysis sets out to better inform the state on the availability, desirability, and access of affordable housing opportunities dedicated to the TCLI population. Specifically, this analysis will consider the following:

- Basic demographics and housing preferences of TCLI population
- Existing barriers to achieving and maintaining housing stability
- Utilization and characteristics of existing LIHTC-targeted properties
- Utilization and characteristics of existing units receiving TCLI voucher assistance
- Access to accessible units, transportation, medical/behavioral health services, and other general amenities
- Unmet housing needs and priorities

To prepare this analysis, TAC analyzed existing data and gathered new information from a variety of sources, including:

- DHHS Transitions Database and internal records
- 2015 North Carolina TCLI Quality of Life Survey
- NCHFA Asset Management System
- GIS Data from ReferenceUSA, NC GeoSpatial Data Portal, and county-level GIS portals
- U.S. Census Bureau

2. Population Profile and Housing Needs

The settlement population consists of individuals with serious mental illness who currently reside in or are at risk of entry to an ACH or state psychiatric hospital. As of October 2016, the state had provided housing slots to 1,290 households within the settlement population.[20] Of these, 987 had transitioned with a housing slot and 303 were currently in transition status. Of the 1,290 households, 97 percent were single-person households (1,253 individuals). The

[20] DHHS Transitions database and internal records

average monthly income of those who had transitioned was $779 per month or $9,348 per year. This is well below the 2016 federal poverty level of $11,880 for single-person households.

As part of their transition planning process, individuals are asked to identify the primary counties in which they want to live. A review of counties preferred by those who are in transition or have transitioned showed that the 20 priority counties outlined in the 20 County Housing Stock Gap Analysis continue to make up the majority preference (62 percent). In addition, the top six counties identified are the same as those identified in the 2015 20 County Housing Stock Gaps Analysis. These six counties in order of preference are Mecklenburg, Wake, Guilford, New Hanover, Forsyth, and Buncombe, which together account for the primary county of choice for 39 percent of people statewide who are in transition or have transitioned with a housing slot (See Table 1). For the purposes of this analysis, TAC has designated these six counties as high-value due to the fact that they represent the highest demand level in terms of choice, as well as the fact that many of them include private rental markets with the lowest vacancy rates (discussed in greater detail below).

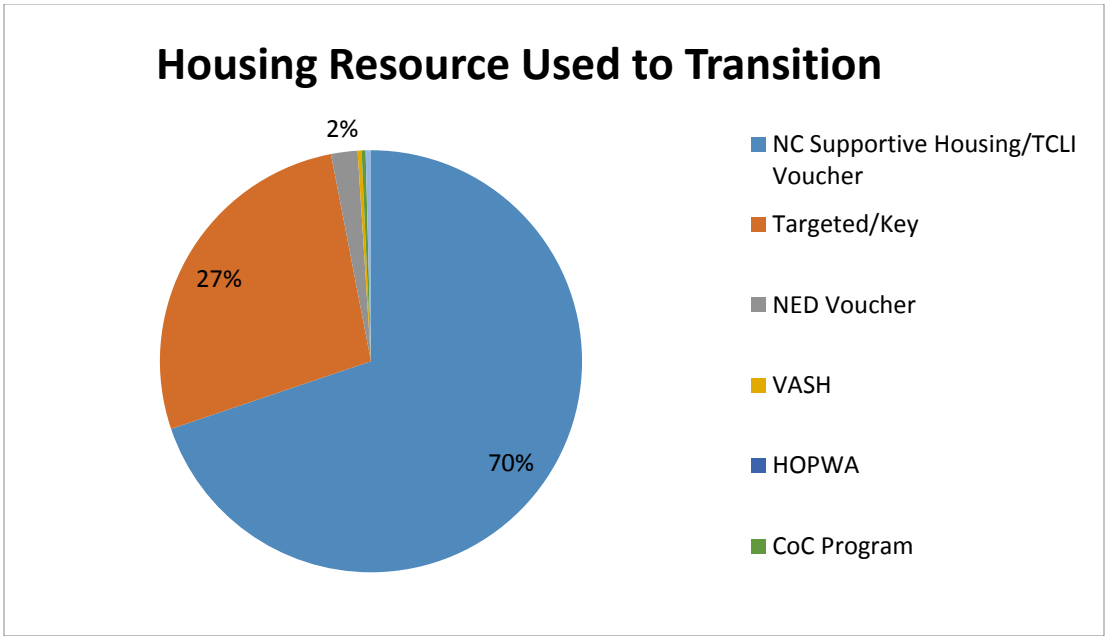
Table 1: Primary Choice Counties for People Transitioning to Permanent Supportive Housing

Primary Desired County	Persons In Transition to Primary Desired County	Persons Transitioned to Primary Desired County	Persons In Transition or Transitioned to Primary Desired County	Percentage of Persons in Transition or Transitioned who made this county their primary choice
Mecklenburg	26	95	121	9.38%
Wake	41	55	96	7.44%
Guilford	12	72	84	6.51%
New Hanover	7	69	76	5.89%
Forsyth	4	64	68	5.27%
Buncombe	15	40	55	4.26%
Iredell	12	25	37	2.87%
Burke	10	23	33	2.56%
Cumberland	14	19	33	2.56%
Cabarrus	6	23	29	2.25%
Durham	20	7	27	2.09%
Gaston	14	10	24	1.86%
Robeson	2	19	21	1.63%
Onslow	2	18	20	1.55%
Wayne	6	12	18	1.40%

Johnston	6	10	16	1.24%
Pitt	1	14	15	1.16%
Rowan	6	9	15	1.16%
Craven	1	8	9	0.70%
Caldwell	2	4	6	0.47%
Total	**207**	**596**	**803**	**62.25%**

According to DHHS records, 75 percent of households that have transitioned have been able to move into their first-choice county.[21] A large majority of households transitioned into the community using a TCLI voucher as a housing resource (70 percent or 688 households). The second most utilized resource has been the Targeting/Key units as shown in Figure 1 below.

Figure 1: Housing Resources Used to Transition to PSH



Access to these housing resources is crucial for the settlement population to be able to live independently in the community as rents are sometimes more than the entire monthly income of a TCLI participant. In addition to a lack of affordability, many members of the settlement population face other housing barriers that may limit their access to suitable housing, such as histories of homelessness, negative credit histories, criminal histories, lack of unit accessibility,

[21] Additional data is needed to determine how many of these households had chosen a high-demand county.

and lack of transportation. Table 2 below captures data from the Transitions database detailing the housing barriers experienced by individuals who have transitioned.

Table 2: Housing Barriers Faced by Settlement Population Households

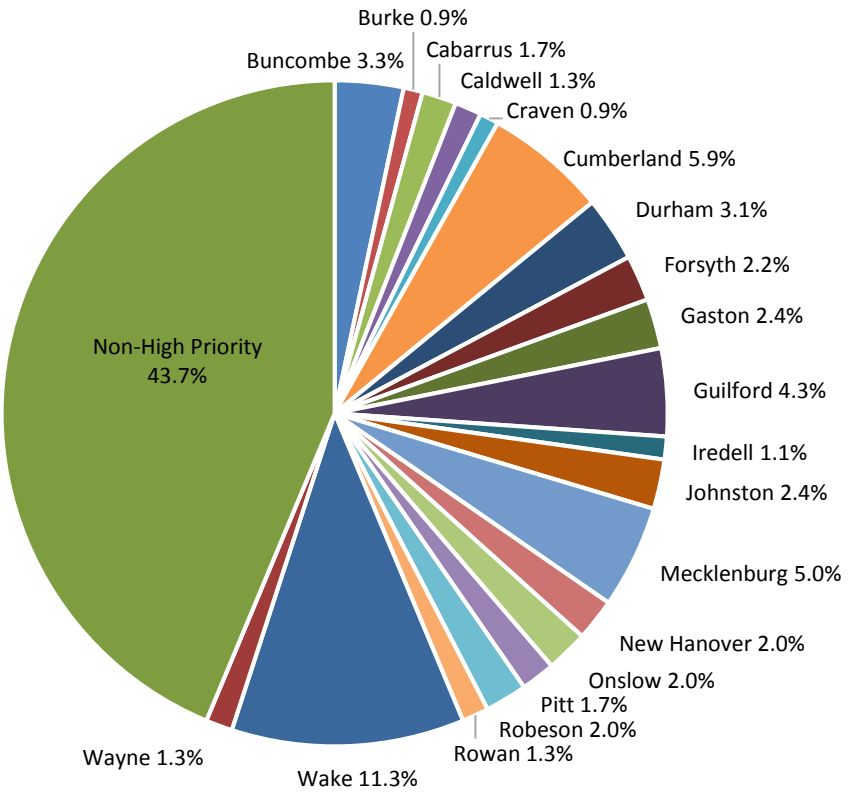
Housing Barriers	Number of Transitioned Households with Barrier	% of Transitioned Households with Barrier
Accessibility Needs	87	9%
Transportation Needs	29	3%
Negative Credit	48	5%
Criminal History	91	9%
History of Homelessness	Unknown	Unknown

Based on discussions with DHHS, LME/MCOs, stakeholders, and consumer focus groups, these figures are most likely low, and do not represent the true number of individuals with housing barriers. In fact, anecdotal evidence suggests that the vast majority of the individuals served by TCLI have negative credit or criminal histories. In addition, the 2015 North Carolina TCLI Quality of Life Survey found that as many as 34 percent of all respondents indicated that "lack of transportation interferes with community integration, that they are dissatisfied with transportation options where they live, or that transportation is an additional support they need and do not currently have."

3. Targeting/Key Program Properties

The Targeting/Key Program properties in the NCHFA LIHTC portfolio represent a significant affordable housing resource for the settlement population. Statewide, there are over 4,000 units throughout 540 properties across North Carolina with executed Targeting agreements. Of these properties, 304 are located in the 20 priority counties representing 56 percent of targeted properties and 64 percent of targeted units in the portfolio (see Figure 2 below).

Figure 2: Percentage of Targeted Properties in 20 Priority Counties



The average utilization rates for targeted units statewide and for all 20 priority counties are similar at approximately 52 percent. However, there is a fairly significant range at the individual county level with the highest utilization in Gaston county at 80 percent and the lowest utilization in Burke with 23 percent. Within the six high-value counties, the highest utilization rate is in Mecklenburg County at 67 percent and the lowest is in Wake County at 44 percent.

As noted during discussions with DHHS, NCHFA, and the LME/MCOs, the utilization rate of targeted units within each county and at each property may be affected by a number of factors. These include lack of suitable referral at initial vacancy, lack of interest in the property, property management screening policies, and the influence of “expansion units” that are currently occupied by non-targeted households.

In order to determine fully the reasons behind low utilization rates, it is necessary to consider specific factors at the individual property level. For example, high vacancy rates and low utilization may denote properties situated in less desirable locations for both the general and settlement populations. On the other hand, if the vacancy rates are average or low but there

are only a small number of targeted units utilized, this may indicate either a lack of desirability specific to the settlement population (e.g. not near services) or the inability of the settlement population to access these units due to property screening.

Another factor to consider is expansion efforts by the state to increase targeted units to 20 percent of the unit total within LIHTC properties. Table 3 outlines the percentage of properties in each of the 20 priority counties that have expanded to make 20 percent of their units targeted.[22]

Table 3: Expansion to 20 Percent Targeted Units

Priority County	Percentage of Properties that have Expanded to 20% Targeted Units	Priority County	Percentage of Properties that have Expanded to 20% Targeted Units
Buncombe	75%	Pitt	33%
Cumberland	68%	Burke	25%
Wayne	60%	Craven	25%
Rowan	50%	Gaston	25%
Onslow	45%	Forsyth	22%
Guilford	43%	Robeson	18%
Johnston	43%	Caldwell	14%
Iredell	40%	New Hanover	13%
Wake	39%	Cabarrus	9%
Durham	33%	Mecklenburg	9%

As shown in Table 3 above, only one of the six high-value counties has achieved expansion above 50 percent of the targeted unit portfolio in that area. Of particular note, Mecklenburg, which is the county most frequently preferred by the settlement population, currently has the lowest number of properties that have expanded, at only nine percent.

The state's continued effort to expand the Targeting/Key Program portfolio to 20 percent is an important strategy to increase the availability of affordable housing opportunities for the settlement agreement population and other persons with disabilities. Given the lack of affordability across the 20 priority counties, there is extreme competition for affordable units. With the average turnover rate in some counties as low as 12 percent and vacancy rates as low as 1.3 percent, additional units are needed in order to meet the need. As can be seen in the Table 4 below, four of the six high-value counties have turnover rates lower than 20 percent and vacancy rates below three percent, providing another indication of the tight rental housing market conditions in these areas.

[22] Based on property expansion information provided by NCHFA. This does not include expansion properties awarded under FY 15 LIHTC round.

Table 4: Turnover and Vacancy Rates

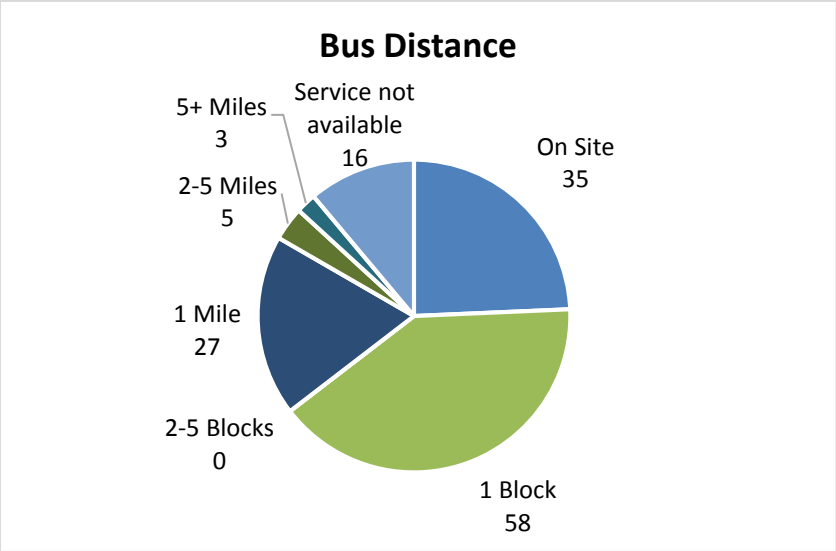
Targeting/Key Program	Average Property Turnover Rate	Average Property Vacancy Rate
Gaston	21%	1.3%
Mecklenburg	15%	1.8%
Cabarrus	16%	1.8%
Buncombe	15%	1.9%
New Hanover	15%	2.2%
Rowan	22%	2.8%
Johnston	28%	2.8%
Wayne	14%	2.8%
Iredell	14%	2.8%
Wake	16%	2.9%
Burke	16%	2.9%
Robeson	28%	3.4%
Cumberland	25%	3.8%
Forsyth	18%	4.0%
Onslow	24%	4.5%
Durham	12%	4.6%
Caldwell	34%	4.8%
Pitt	24%	4.8%
Craven	16%	6.1%
Guilford	21%	8.4%
Statewide	20%	3.4%

Proximity Analysis

One of the key areas of this analysis is to determine the availability of housing opportunities with access to transportation, medical/behavioral health services, and other general amenities. Through discussions with the LME/MCOs and focus groups, it is evident that access to essential health services is necessary but that integration within the larger community is just as important to a person's wellbeing and their ability to maintain housing. Information from the NC Housing Search database was reviewed to determine the proximity of Targeting/Key Program properties in the priority counties to community amenities and transit. Figures 4 through 7 and Table 5 below show the information available on these targeted properties and their proximity to specific amenities such as bus service, groceries, hospitals, and pharmacies.

There are 144 Targeting/Key Program properties with bus distance information provided. As Figure 4 below shows, 65 percent have bus service within one block of the property. An additional 19 percent are within one mile of bus service.

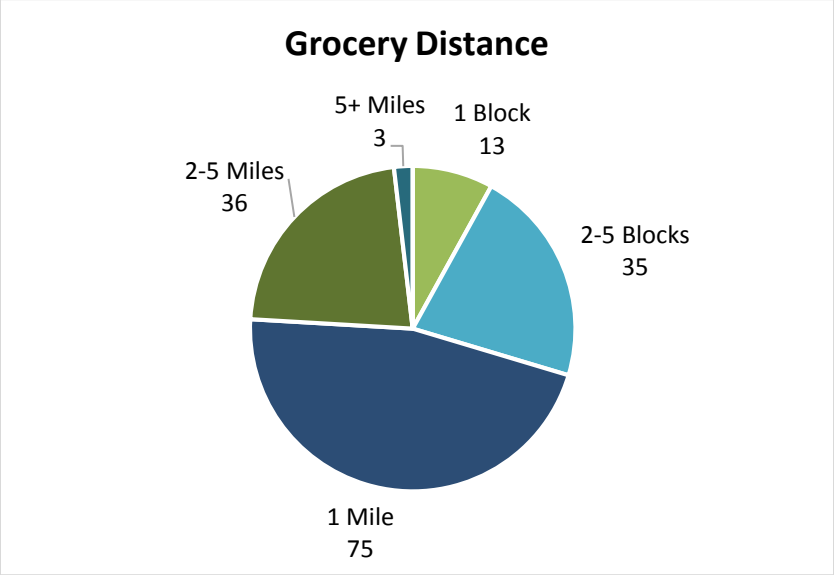
Figure 4: Targeting/Key Program Properties: Proximity to Bus Service



Distance	Number	Percentage
On Site	35	24.3%
1 Block	58	40.3%
2-5 Blocks	0	0.0%
1 Mile	27	18.8%
2-5 Miles	5	3.5%
5+ Miles	3	2.1%
Service not available	16	11.1%
Total	144	100.0%

There are 162 Targeting/Key Program properties with grocery distance information provided within the 20 priority counties. Of those, 30 percent are within two to five blocks of a grocery store, as shown in Figure 5 below. An additional 46 percent are within one mile of a grocery store.

Figure 5: Targeting/Key Program Properties: Proximity to Groceries

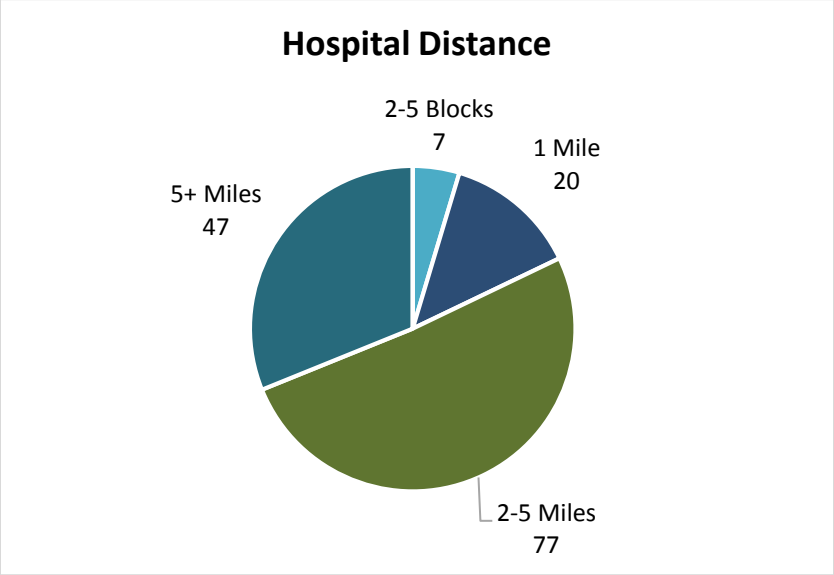


Distance	Number	Percentage
On Site	0	0.0%
1 Block	13	8.0%
2-5 Blocks	35	21.6%
1 Mile	75	46.3%
2-5 Miles	36	22.2%
5+ Miles	3	1.9%
Service not available	0	0.0%
Total	162	100.0%

Hospitals were also included in the proximity analysis as this information is captured within the NC Housing Search database and specific necessary health care services are provided in hospitals. However, it is expected that many health services including behavioral health services should be available within the community outside of hospital care. Behavioral health services are not included as a data point in NC Housing Search and were not included in the 20 priority county proximity analysis. However, behavioral health services proximity information is captured in the high-value counties through GIS data as shown in Table 5 further below.

There are 151 Targeting/Key Program properties with hospital distance information provided within the 20 priority counties. Of these, as seen in Figure 6 below, 18 percent are within one mile of a hospital. An additional 51 percent are within two to five miles of a hospital.

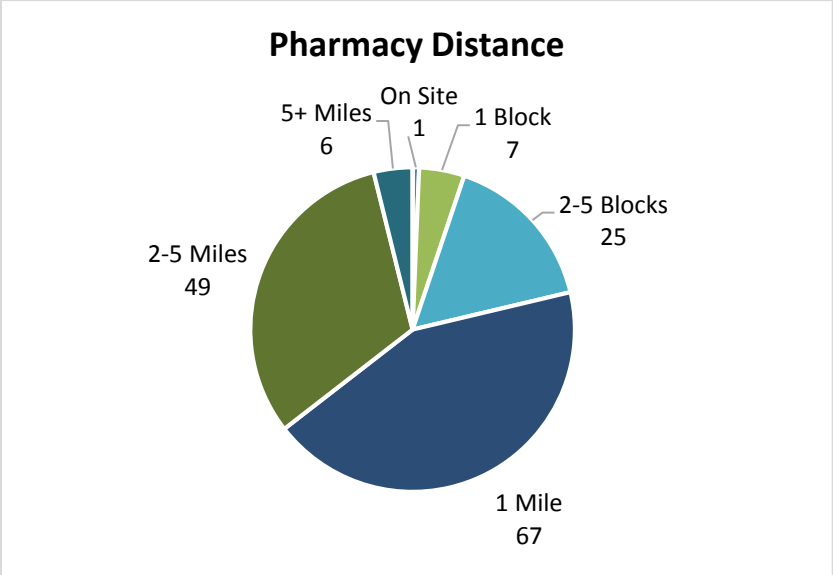
Figure 6: Targeting/Key Program Properties: Proximity to Hospitals



Distance	Number	Percentage
On Site	0	0.0%
1 Block	0	0.0%
2-5 Blocks	7	4.6%
1 Mile	20	13.2%
2-5 Miles	77	51.0%
5+ Miles	47	31.1%
Service not available	0	0.0%
Total	151	100.0%

There are 155 Targeting/Key Program properties with pharmacy distance information provided within the 20 priority counties. Of those, as shown in Figure 7 below, 21 percent are within two to five blocks of a pharmacy. An additional 43 percent are within one mile of a pharmacy.

Figure 7: Targeting/Key Program Properties: Proximity to Pharmacies



Distance	Number	Percentage
On Site	1	0.6%
1 Block	7	4.5%
2-5 Blocks	25	16.1%
1 Mile	67	43.2%
2-5 Miles	49	31.6%
5+ Miles	6	3.9%
Service not available	0	0.0%
Total	155	100.0%

Additional analysis was conducted on each of the six high-value counties to determine the number of Targeting/Key Program properties in the county that are within one-quarter mile (a five- to seven-minute walk) of amenities, making them highly pedestrian friendly. Table 5 below show the results, based on GIS data. GIS maps were also developed to show all Targeting/Key Program properties within the high-value counties and their relation to amenities. These maps are included in Appendix IV of the North Carolina Affordable Housing Assessment and Permanent Supportive Housing Recommendations.

Table 5: Proximity of Targeting Key Program Properties to Amenities in Six High-Value Counties

Buncombe County			
Amenity	**Distance**	**Number**	**Percentage**
Bus Service	0.25	9	43%
Grocery	0.25	3	14%
Bank	0.25	1	5%
Behavioral Health	0.25	0	0%
Hospital	0.25	0	0%

Forsyth County			
Amenity	**Distance**	**Number**	**Percentage**
Bus Service	0.25	Not Available	Not Available
Grocery	0.25	4	29%
Bank	0.25	2	14%
Behavioral Health	0.25	0	0%
Hospital	0.25	0	0%

Guilford County			
Amenity	**Distance**	**Number**	**Percentage**
Bus Service	0.25	14	52%
Grocery	0.25	4	15%
Bank	0.25	6	22%
Behavioral Health	0.25	49	4%
Hospital	0.25	0	0%

Mecklenburg County			
Amenity	**Distance**	**Number**	**Percentage**
Bus Service	0.25	30	91%
Grocery	0.25	13	39%
Bank	0.25	8	24%
Behavioral Health	0.25	1	3%
Hospital	0.25	0	0%

New Hanover County			
Amenity	**Distance**	**Number**	**Percentage**
Bus Service	0.25	11	92%
Grocery	0.25	3	25%
Bank	0.25	2	24%
Behavioral Health	0.25	2	17%
Hospital	0.25	0	0%

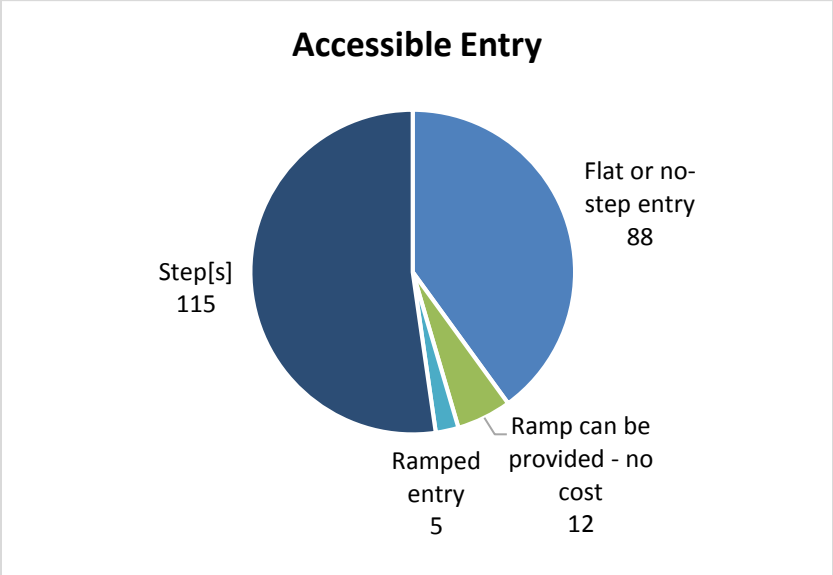
Wake County			
Amenity/Service	**Distance**	**Number**	**Percentage**
Bus Service	0.25	36	53%
Grocery	0.25	24	35%
Bank	0.25	9	13%
Behavioral Health	0.25	4	6%
Hospital	0.25	0	0%

Based on the data obtained, there is significant range in the accessibility of various amenities across the Targeting/Key Program portfolio. With transportation identified as a key need by members of the settlement population, those properties in close proximity to bus service are likely in higher demand. Four of the six high-value counties have transportation access within .25 miles of 50 percent of their properties. Across the portfolio, other services such as behavioral health services or hospitals are not in such close proximity and this highlights the increased need for access to transportation and access to those properties near it.

Property/Unit Accessibility

In addition to reviewing proximity to amenities, TAC also examined information on property and unit physical accessibility. Although data was not available on how many accessible units are currently occupied by Targeting/Key Program households, NCHFA requires a specific percentage of all LIHTC units that are new construction or adaptive reuse to be handicap accessible. The NCHFA policy requires that five percent of the units must be fully accessible to people who are mobility-impaired, in addition to the five percent required under federal law, for a minimum of ten percent. Additional information on property entry accessibility was obtained from NC Housing Search. Figure 8 below shows the accessibility information provided for 220 Targeting/Key properties located within the 20 priority counties.

Figure 8: Entry Accessibility for Targeting/Key Properties in 20 Priority Counties



Entry Type	Number	Percentage
Flat or no-step entry	88	40.0%
Ramp can be provided - no cost	12	5.5%
Ramped entry	5	2.3%
Step[s]	115	52.3%
Total	220	100.0%

The LME/MCOs noted that full accessibility features were not needed by the majority of the settlement population but that for those who did need a fully accessible unit, this requirement represented a major barrier to finding suitable housing.

Unit Size

Based on discussions with the LME/MCOs and a review of the Targeting/Key unit information, there is a clear need for additional one-bedroom units. As noted earlier, 97 percent of TCLI participants who are in transition or have transitioned are one-person households. The most appropriate number of bedrooms for one-person households is one, except for reasons related to reasonable accommodation. However, due to the lack of one-bedroom units in the LIHTC portfolio, many one-person households are placed in two-bedroom units. The Key Program subsidy policy allows for single-person households to lease two-bedroom units at properties built without one-bedrooms. Additionally, there are unit size waivers available for single-person households to rent two-bedroom units under certain circumstances. Although this policy is reasonable given the current portfolio, the overhousing of Targeting/Key households increases the expense of the housing subsidy that would generally be needed for a one-person household.

Accessing Targeting/Key Opportunities

Ensuring that all affordable housing resources are maximized will assist the state in meeting the goals of the settlement agreement and continuing to address the housing needs of persons with disabilities. The Targeting/Key Program is a critical resource in the state and it is important that available properties not be underutilized.

As discussed earlier, there are a number of reasons why Targeting/Key Program units may not be utilized fully. Some properties may be located in areas with limited access to transportation and other amenities, making them less desirable. Other properties may have additional restrictions such as age restrictions which limit the number of persons who will be eligible. However, many LME/MCOs also noted that screening for criminal/credit activity was still a barrier to accessing Targeting/Key units. Specific data on denials for Targeting/Key units is not consistently tracked at the program/property level by NCHFA or DHHS. The DHHS Regional Housing Coordinators have used their own spreadsheets to track denials by persons referred, but have not aggregated this data at the property level. One annual report provided by DHHS showed that on average 28 percent of referrals across all LME/MCOs resulted in placements into Targeting/Key Program units.[23] NCHFA did release a Tenant Selection Plan policy in July providing guidance to management companies to reduce the use of credit and criminal screening criteria where possible.[24]

4. Private Rental Housing Market

Use of the tenant-based TCLI voucher has accounted for 70 percent of the housing placements statewide to date. One of the primary benefits of the TCLI voucher is that it allows flexibility to assist individuals in the private market where they choose to reside. However, even with this valuable rent subsidy source, there are still barriers to housing all individuals in the destination of their choosing. Table 7 below indicates placements to date within the 20 priority counties for all subsidy types (Targeting/Key, TCLI, VASH, etc).

Table 6: TCLI Voucher Housing Placements

County	Number of TCLI Participants Transitioned	Percentage of all TCLI Participants who Transitioned in North Carolina
Guilford	90	13%
Mecklenburg	85	12%
New Hanover	66	10%
Wake	64	9%
Forsyth	62	9%
Burke	35	5%

[23] Data provided as part of annual data collection request by Court Monitor for the DOJ *Olmstead* settlement

[24] See NCHFA Tenant Selection Plan policy here: http://www.nchfa.com/sites/default/files/page_attachments/TenantSelectionPlanPolicy.pdf

County	Number of TCLI Participants Transitioned	Percentage of all TCLI Participants who Transitioned in North Carolina
Buncombe	34	5%
Iredell	31	4%
Robeson	30	4%
Gaston	28	4%
Cabarrus	22	3%
Cumberland	22	3%
Pitt	21	3%
Onslow	21	3%
Wayne	19	3%
Durham	15	2%
Craven	13	2%
Johnston	12	2%
Rowan	10	1%
Caldwell	9	1%

As shown above, the highest percentages of placements have been in the six high-value counties, which are also those most likely to be the primary choice to live in. However, it is unknown whether the placements shown here represent the same people who indicated a desire to live in these counties. Statewide, 75 percent of households that have transitioned have been able to move into the county of their choice. While this is a significant achievement, it currently takes an average of 143 days for a household to transition after receiving a housing slot, indicating some difficulty accessing suitable rental housing in the county of choice. There are a number of factors that contribute to this, including participant-specific barriers to housing as well as market conditions.

The statewide rental vacancy rate in North Carolina is seven percent.[25] As shown in Table 7 below, the major cities in three of the high-value counties have significantly lower rental vacancy rates, indicating a more competitive rental market. Discussions with LME/MCOs highlighted that high-demand market conditions such as these make the housing search process take longer and require more referrals to different landlords.

[25] According to data obtained from U.S. Census Bureau 2015 American Community Survey 1-Year Estimates**.** See Table DP04: Selected Housing Characteristics.

Table 7: Rental Vacancy Rates

County	City	Rental Vacancy Rate	Percentage of Housing Units that are 1-Bedroom
Buncombe	Asheville	6.8%	9.6%
Forsyth	Winston-Salem	11.5%	11.3%
Guilford	Greensboro	12.2%	11.5%
Mecklenberg	Charlotte	6.0%	12.6%
New Hanover	Wilmington	5.9%	13.0%
Wake	Raleigh	5.4%	13.0%

Table 8 also shows that one-bedroom units do not make up a sizable portion of the housing stock in these areas. The lack of affordable one-bedroom units is not only seen in the LIHTC portfolio but in the private market as well. Of the 689 households that have transitioned within the 20 priority counties, over 50 percent have been housed in two-bedroom units.

5. Housing Gaps Analysis Estimate

The State of North Carolina and all relevant partners will need to place approximately 3,000 households in integrated PSH by 2020 in order to meet the goals of the settlement agreement. Based on the number of individuals who want to live in the 20 priority counties, the State will need to provide access to approximately 1,130[26] PSH units over the course of the next four years in these priority counties. Table 8 below shows the expected new Targeting/Key Program units coming online in 2017 and 2018 from LIHTC and tax-exempt bond awards.[27] The table also offers an estimate of the gap between the units needed and availability in each county. This estimate assumes a conservative utilization rate of 60 percent for the new Targeting/Key Program units that come online. It's important to note that the largest gaps in 2017 and 2018 are represented by high-value counties.

Additional units may become available through turnover and expansion in the Targeting/Key Program. However, these potential increases are not likely to significantly narrow the housing gaps within all the priority counties. Closing the housing gap will depend on the ability to access private market rental units with TCLI rental assistance and on the creation of additional PSH opportunities through activities laid out in the recommendations section of the Report.

[26] Assumes 1200 households transitioned by 12/31/16 with 1800 remaining placements required Statewide.

[27] LIHTC must be placed in service by end of calendar year. Bond projects do not have this requirement so unit estimates may be lower.

Table 8: Housing Gap in 2017 and 2018

	2017 Housing Need/Gap				2018 Housing Need/Gap				
	2015 LIHTC Committed Targeted Units	Estimated Units Utilized	Units Needed	Gap	2016 LIHTC Committed Targeted Units	2016 Bond Committed Targeted Units	Estimated Units Utilized	Units Needed	Gap
Buncombe	0	0	22	-22	12	0	8	22	-14
Burke	2	2	13	-11	0	0	0	13	-13
Cabarrus	26	16	12	4	6	0	4	12	-8
Caldwell	0	0	3	-3	6	0	4	3	1
Craven	13	8	4	4	0	0	0	4	-4
Cumberland	36	22	13	9	20	0	12	13	-1
Durham	29	18	11	7	0	0	0	11	-11
Forsyth	0	0	27	-27	15	11	16	27	-11
Gaston	6	4	10	-6	8	40	29	10	19
Guilford	23	14	34	-20	14	0	9	34	-25
Iredell	0	0	15	-15	8	0	5	15	-10
Johnston	8	5	7	-2	8	0	5	7	-2
Mecklenburg	39	24	48	-24	33	51	51	48	3
New Hanover	0	0	31	-31	18	20	23	31	-8
Onslow	0	0	8	-8	6	0	4	8	-4
Pitt	8	5	6	-1	6	0	4	6	-2
Robeson	6	4	9	-5	0	0	0	9	-9
Rowan	0	0	6	-6	8	0	5	6	-1
Wake	41	25	38	-13	26	48	45	38	7
Wayne	0	0	7	-7	5	0	3	7	-4
Totals	237	147	323	-176	199	170	227	323	-96
2016 GAP				**-176**	**2017 GAP**				**-96**

6. Key Findings

Although there has been definitive progress towards reaching the goals of the settlement, there are still a number of unmet needs and housing gaps facing the settlement population. Several issues highlighted in this housing gaps analysis can be addressed by focusing both PSH production and maximization efforts within the six high-value counties.

Notable findings:

- The six high-value counties of Buncombe, Guilford, Forsyth, Mecklenburg, New Hanover, and Wake represent the primary county of choice for 39 percent of those statewide who are in transition or have transitioned. It is therefore important to consider specific strategies to ensure the ability of individuals to be placed in these highly desired areas.

- The LME/MCOs in coordination with NCHFA and DHHS have been able to move 75 percent of individuals into the area of their choice. While this is a significant achievement, efforts must be made to sustain this rate and ensure that housing placement occurs more quickly.

- While the Targeting/Key Program accounts for 27 percent of all housing placements, the utilization of this valuable PSH resource could be improved. NCHFA and DHHS should continue to collaborate on reviewing the property portfolio to identify the reasons for underutilization by property — whether it is due to lack of interest in the location/property or due to screening or referral process barriers.

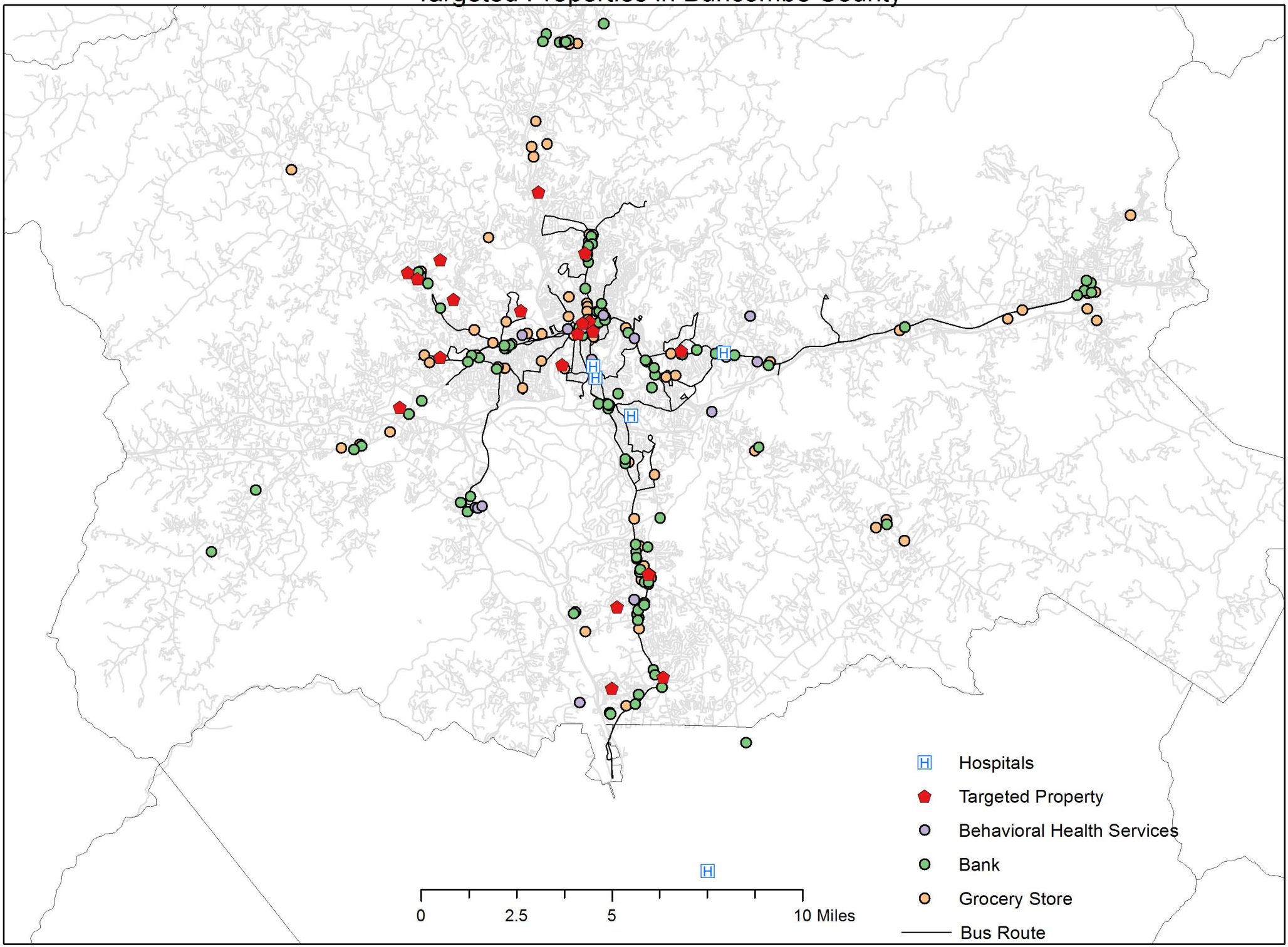
- NCHFA in collaboration with the DHHS has been able to market the Targeting/Key Program expansion to a number of LIHTC properties across the 20 priority counties. Given the low turnover rates at properties located in the six high-value counties, additional focused expansion is necessary.

- The proximity of Targeting/Key Program properties to amenities varies greatly across and within counties. NCHFA in collaboration with DHHS should continue to consider transportation and other amenities as a key factor in the desirability of an LIHTC property and in decisions about whether to expand Targeting/Key units up to the 20 percent level.

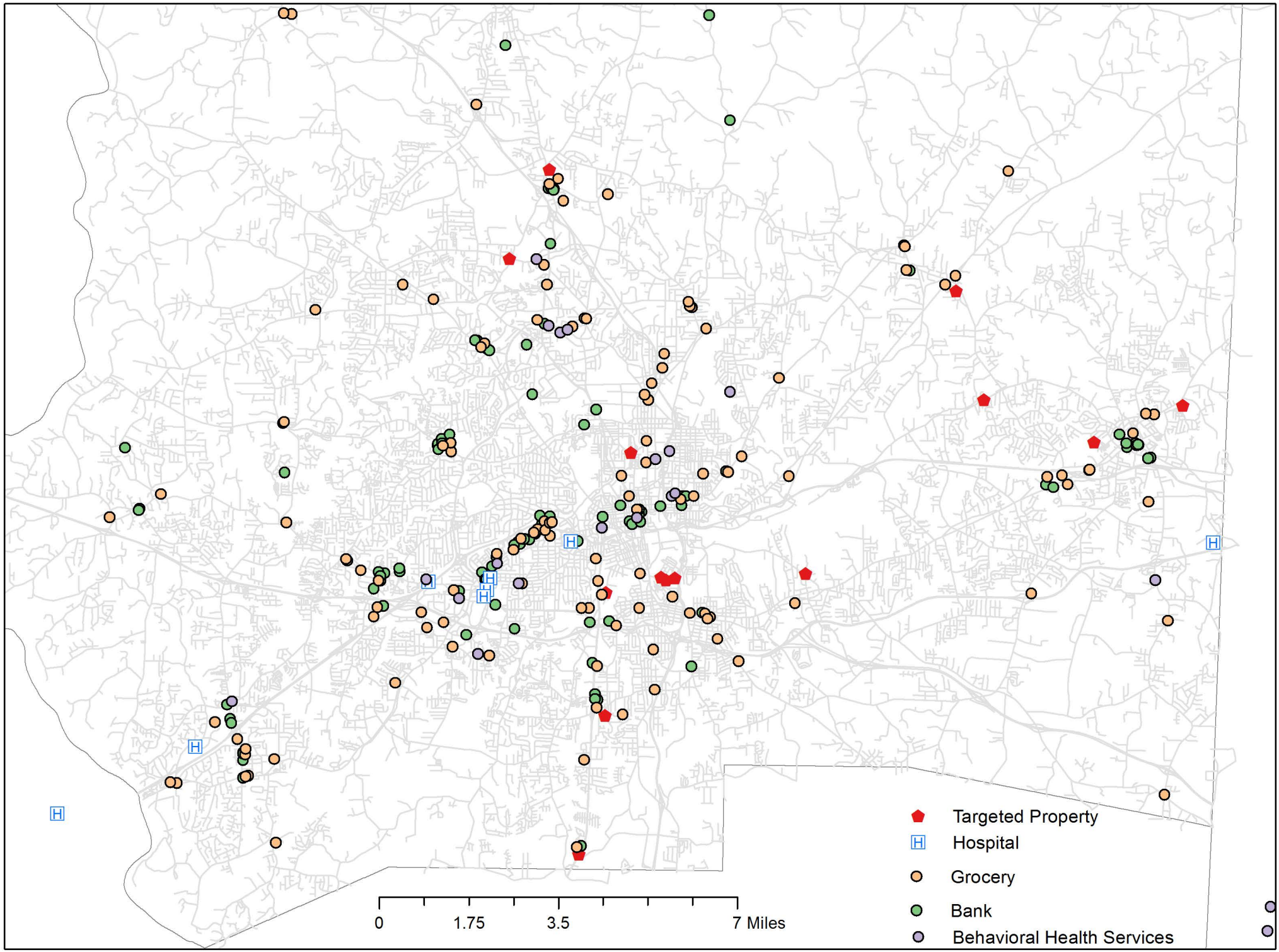
- There is a lack of affordable one-bedroom units in both the Targeting/Key Program portfolio and the private rental market. NCHFA and DHHS should continue to make efforts and enhance strategies to create or increase access to one-bedroom units. TAC's Strategic Recommendations focus additional attention within this area.

Appendix VI: GIS Mapping of the Six High-Value Counties

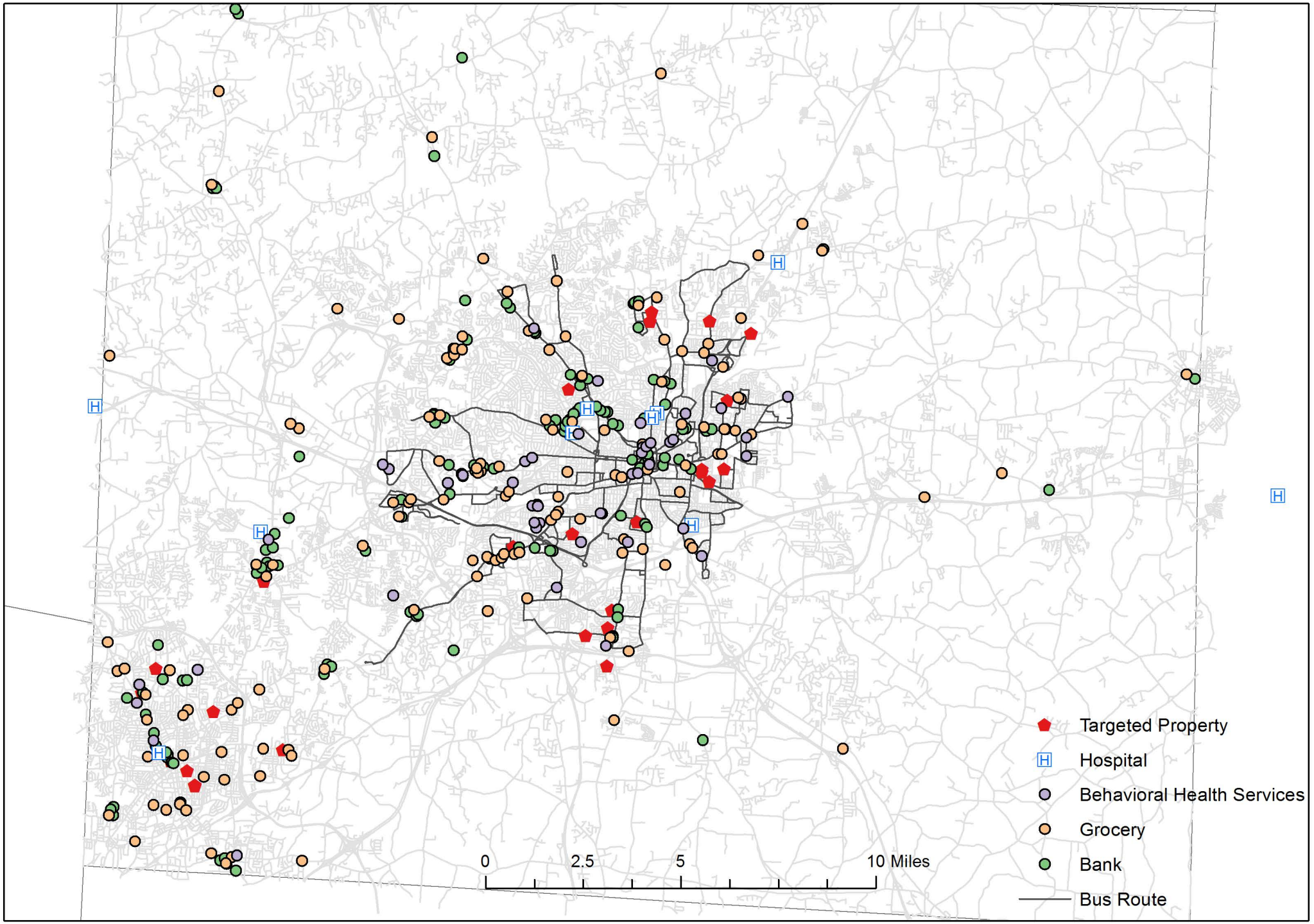
Targeted Properties in Buncombe County



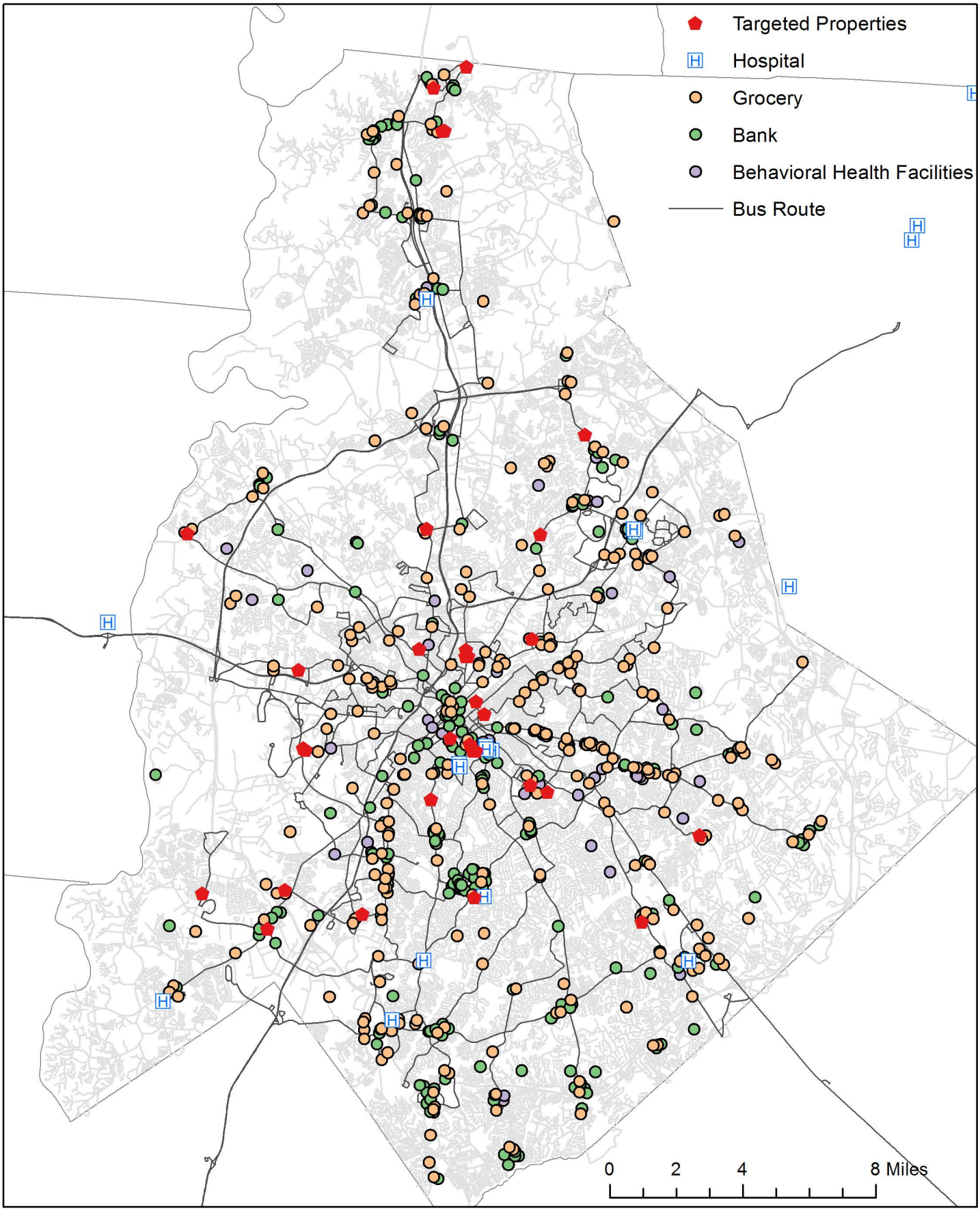
Targeted Properties in Forsyth County



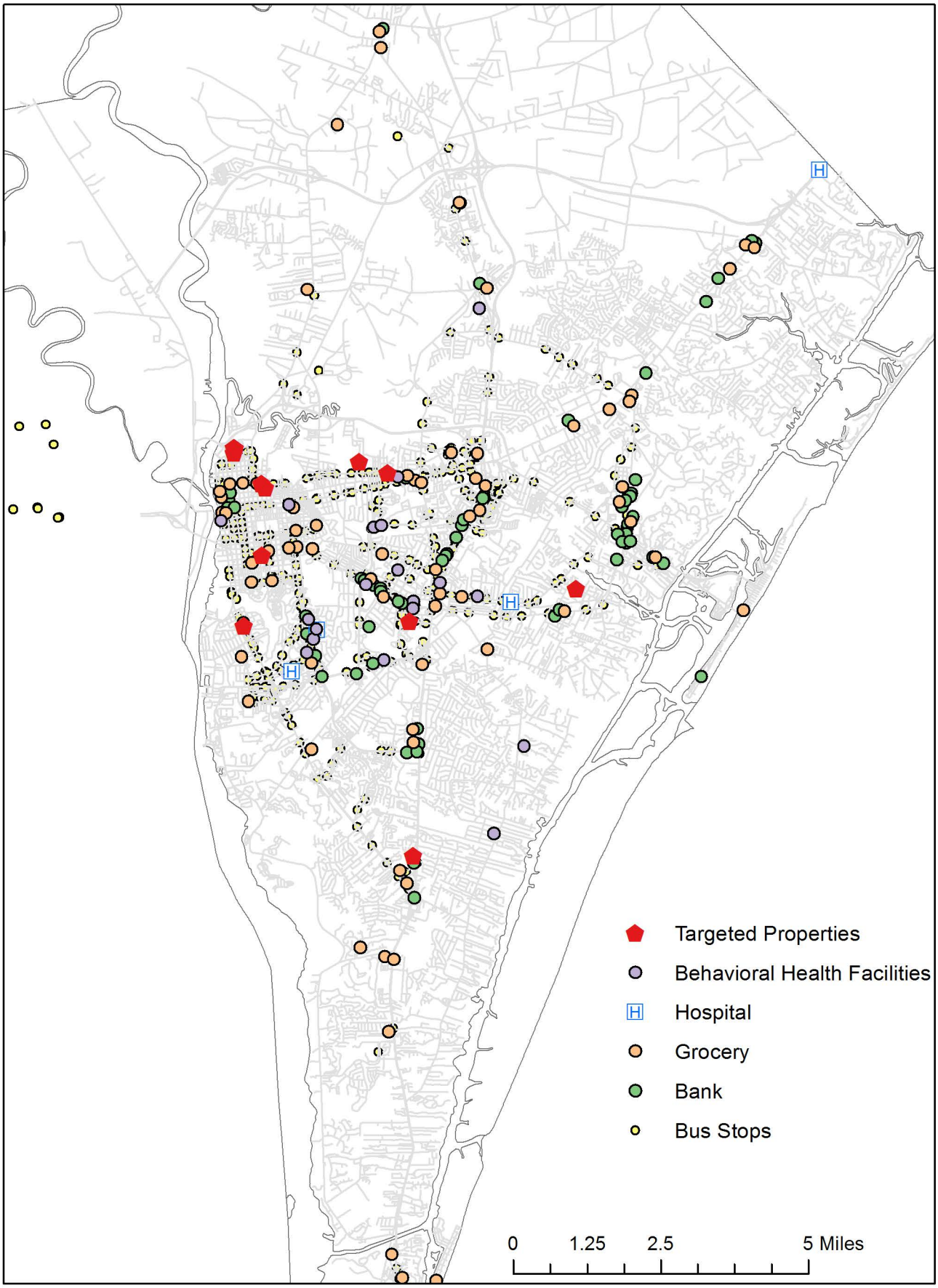
Targeted Properties in Guilford County



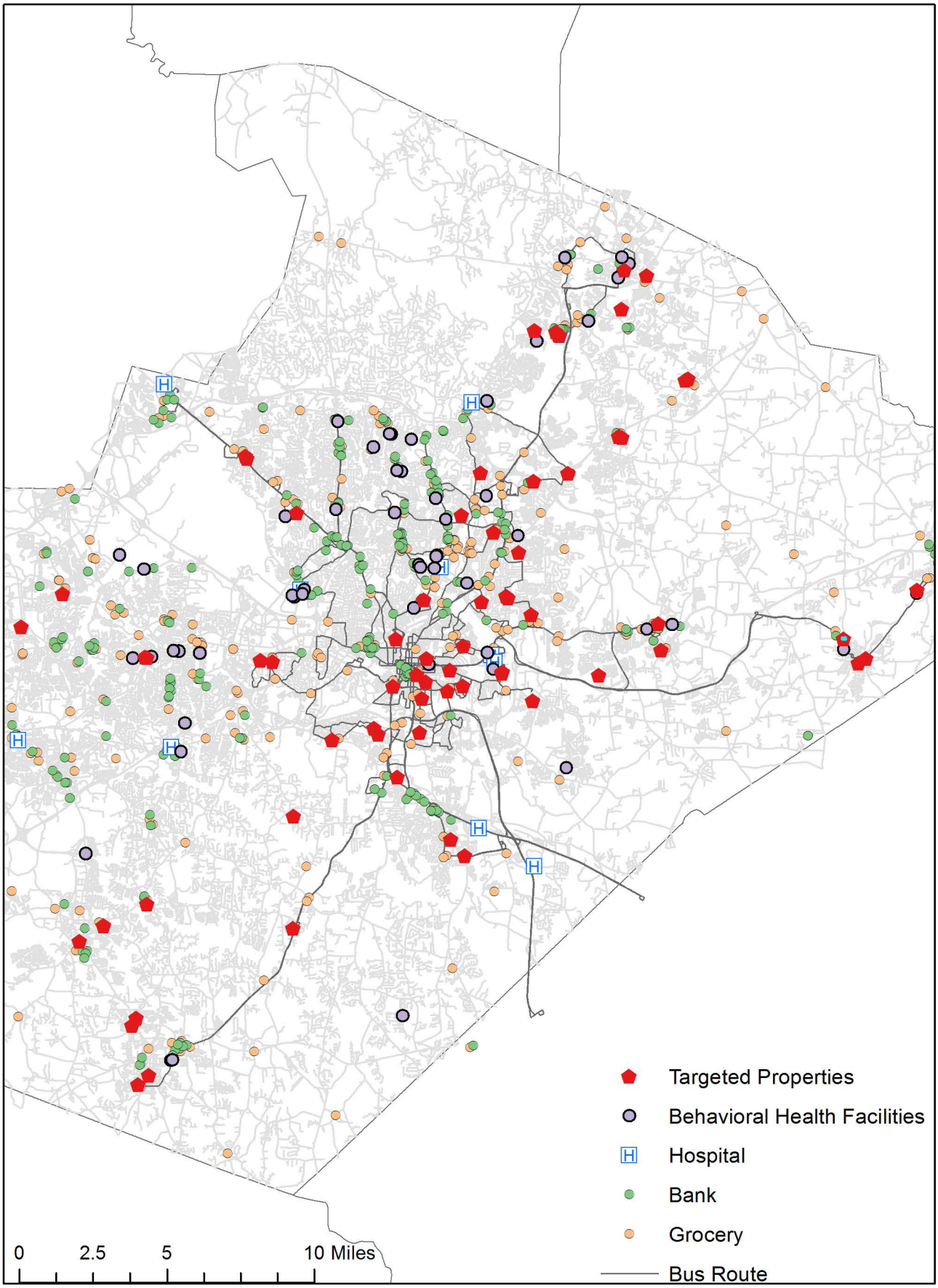
Targeted Properties in Mecklenburg County



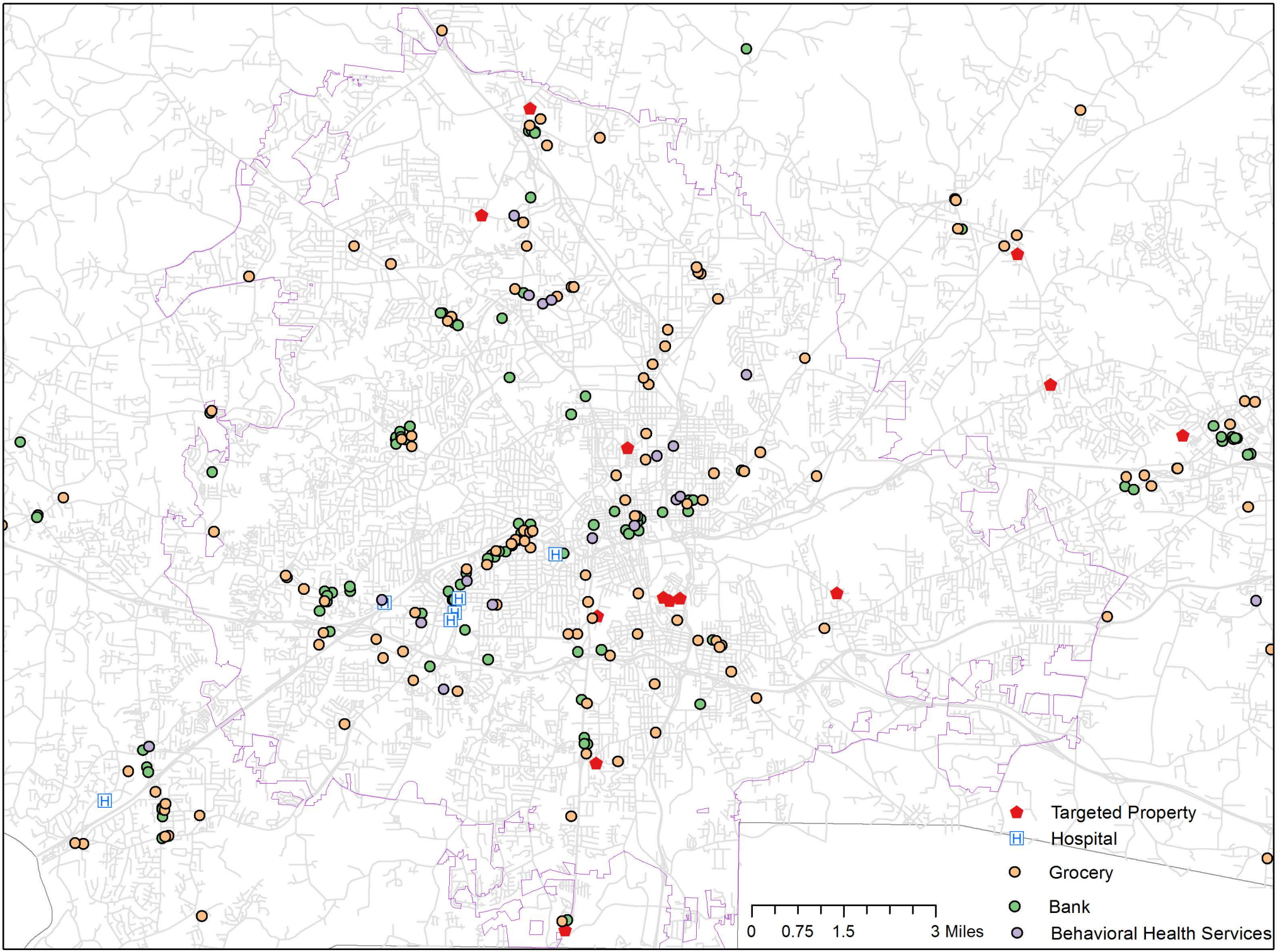
Targeted Properties in New Hanover County



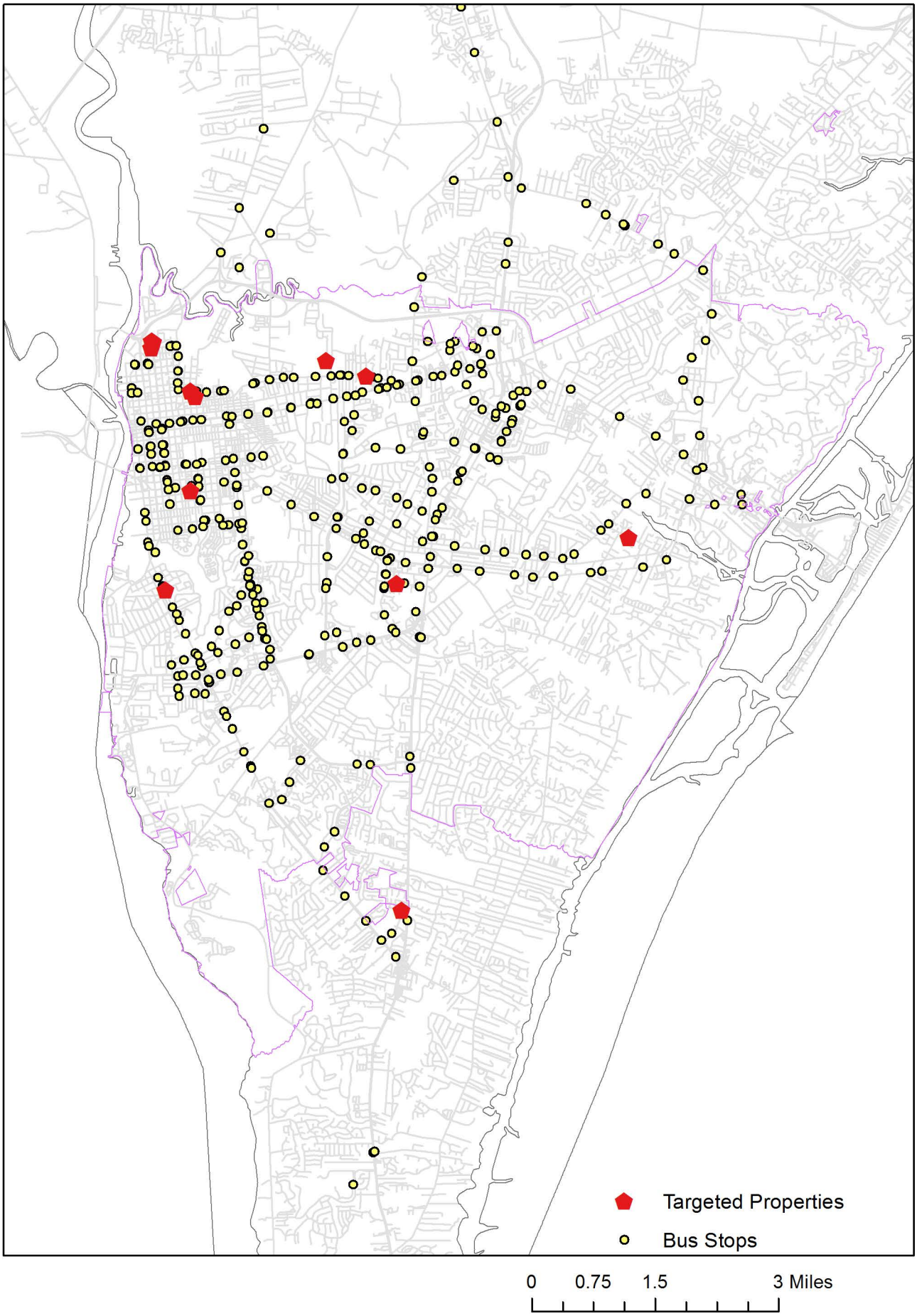
Targeted Properties in Wake County



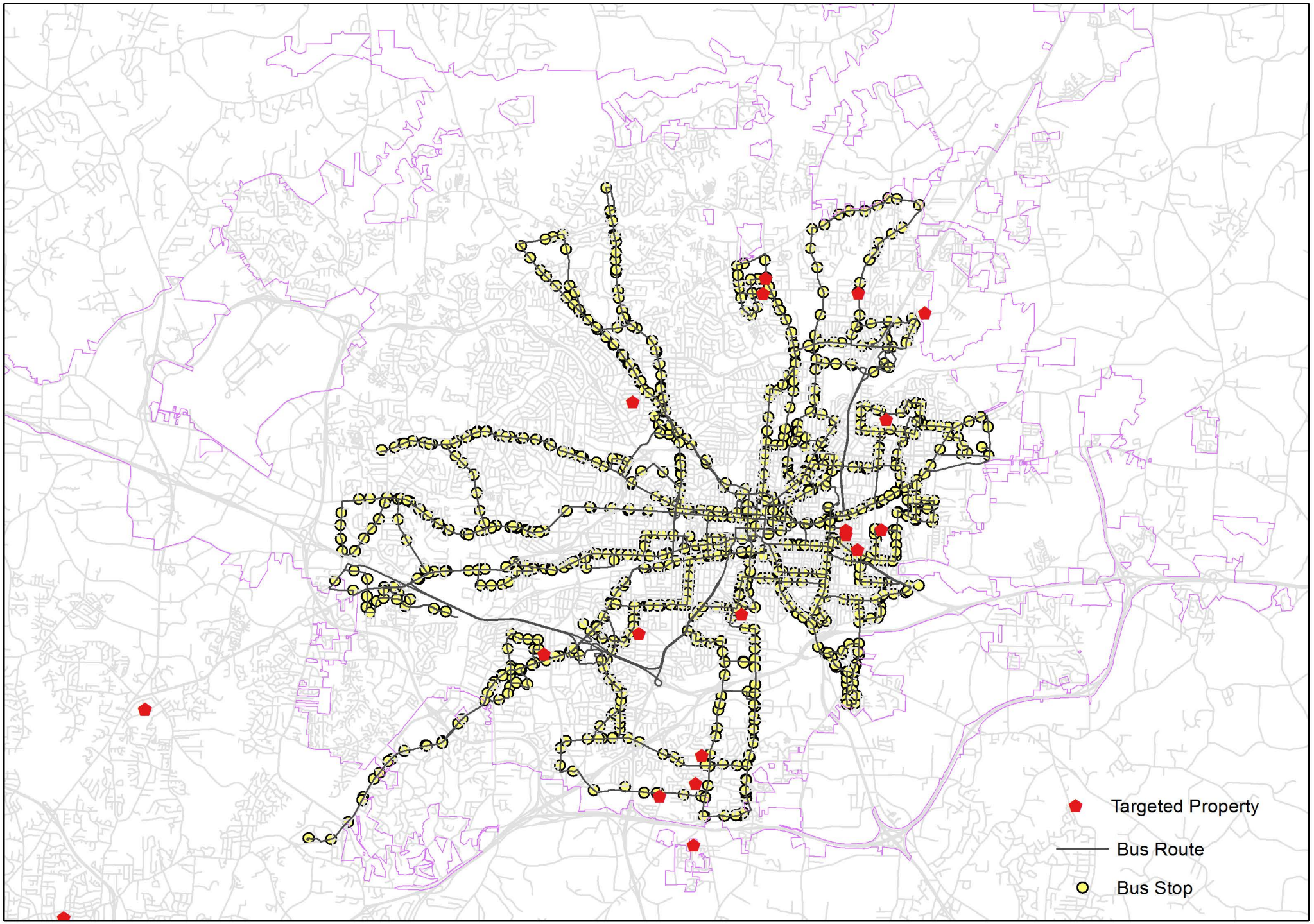
Targeted Properties in Winston-Salem, Forsyth County



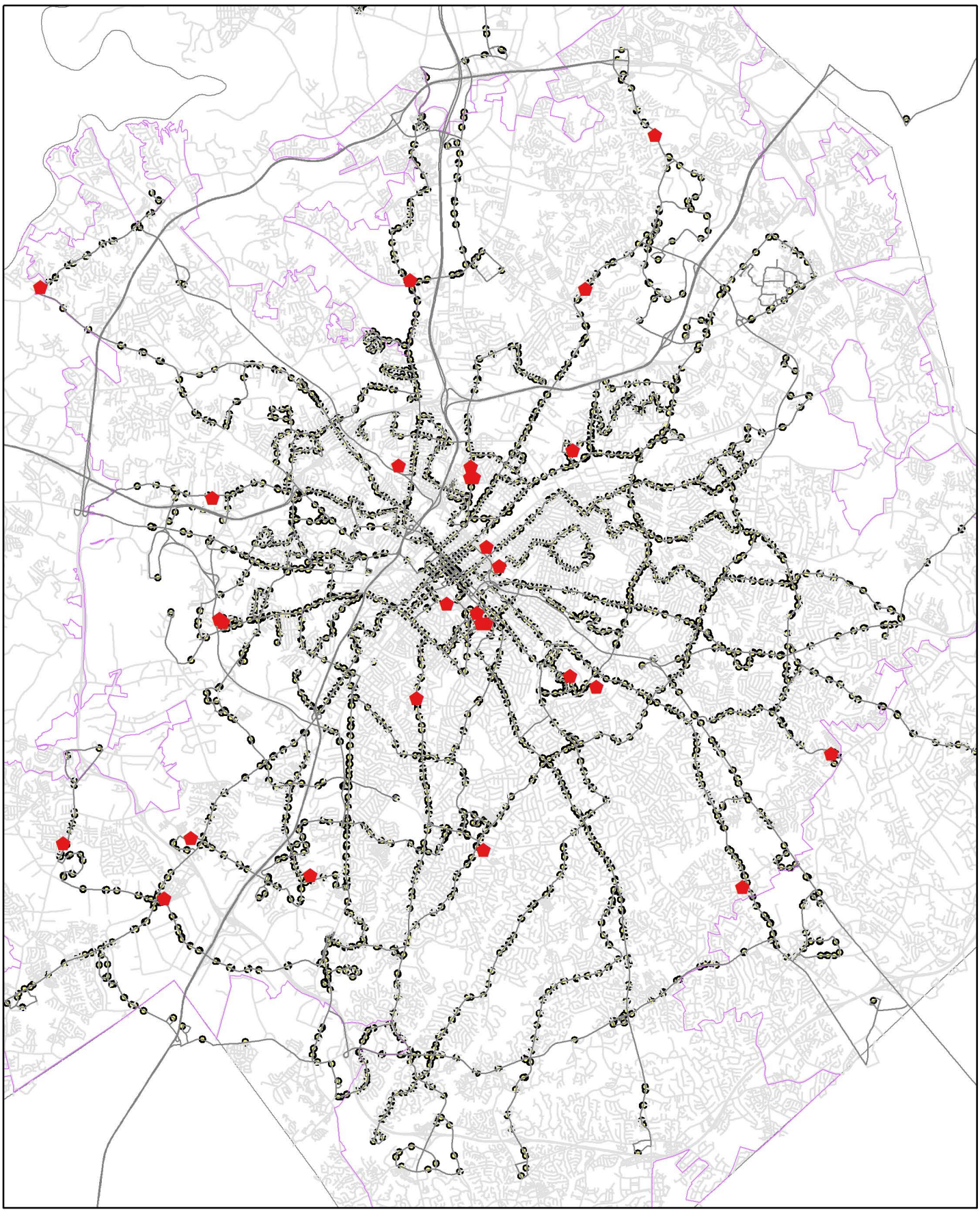
Targeted Properties in Wilmington, New Hanover County



Targeted Properties in Greensboro, Guilford County



Targeted Properties in Charlotte, Mecklenburg County

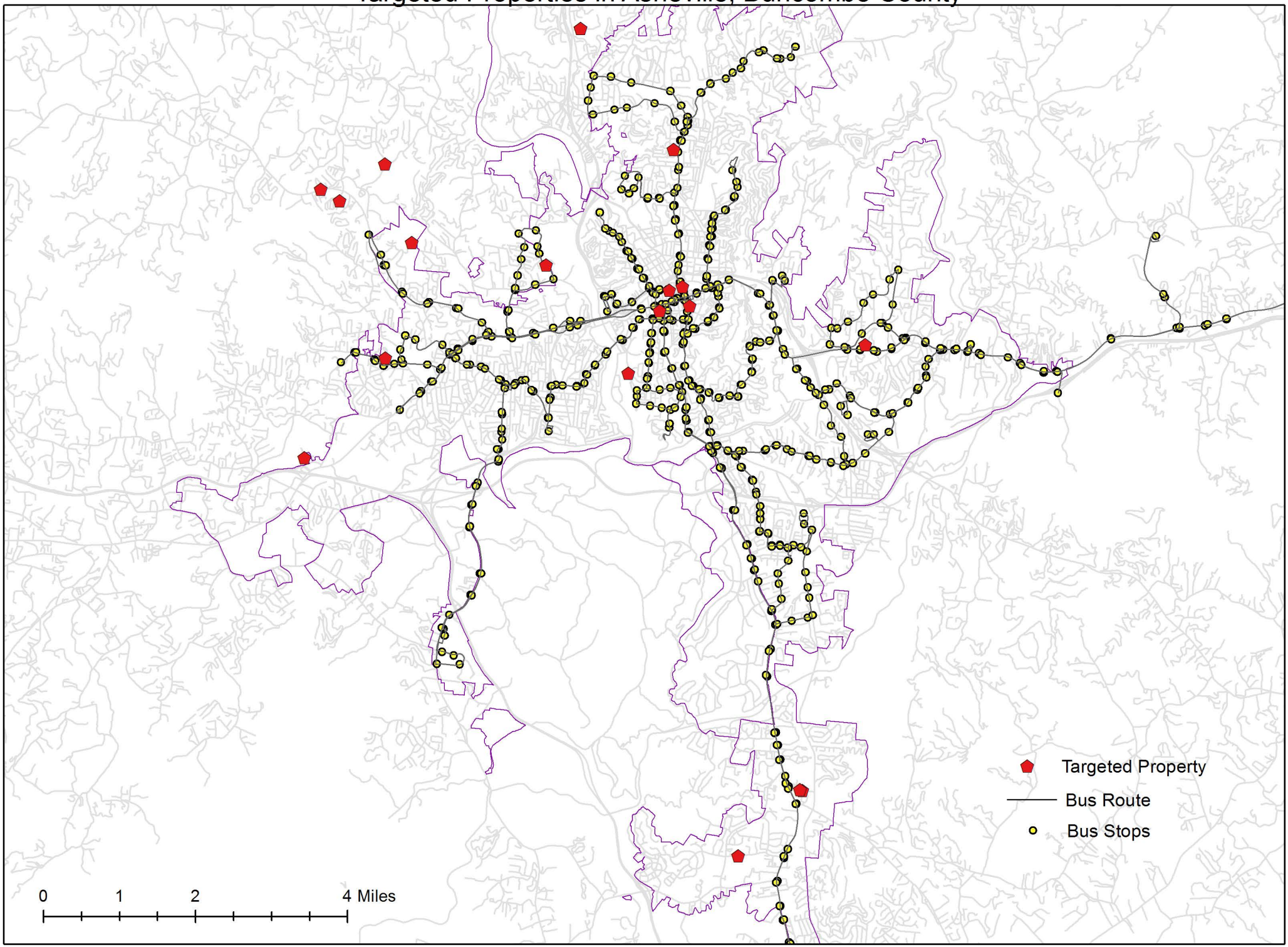


0 1.25 2.5 5 Miles

Targeted Properties

Bus Route

Targeted Properties in Asheville, Buncombe County



Targeted Properties in Raleigh, Wake County