STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

January 4, 2007

The Honorable Ulysses Currie, Chairman
Senate Budget and Taxation Committee
Miller Senate Office Building, 3 West Wing
Annapolis, Maryland 21401-1991

The Honorable Norman H. Conway, Chairman
House Appropriations Committee
House Office Building, Room 121
Annapolis, Maryland 21401-1991

Re: JCR Page 268 (2006) – Development of Independent Housing for Persons with Mental Illness and/or Developmental Disabilities

Dear Chairman Currie and Chairman Conway:

Pursuant to the Joint Chairmen's Report – Capital Budget, 2006 Session, Committee Narrative, Page 268, MA01, the Department of Health and Mental Hygiene (DHMH) presents the attached report on housing for persons with mental illness and/or developmental disabilities.

Thank you for your continued interest in the needs of individuals with mental illness and developmental disabilities. If you have any questions, please contact Elizabeth Barnard, Director of the DHMH Office of Capital Planning, Budgeting, and Engineering Services, at (410) 767-6816.

Sincerely,

Signature on file

S. Anthony McCann
Secretary

Enclosure

cc: Elizabeth Barnard
Chadfield Clapsaddle
Warren Deschenaux
Simon Powell
Anne Hubbard

HOUSING FOR INDIVIDUALS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITIES

During the 2006 legislative session, the Legislative budget committees expressed concern that independent housing projects supported through the Community Health Facilities Grant Program "are both slow to develop and are insufficient to meet demand." Therefore, the committees requested that the Department of Health and Mental Hygiene (DHMH), in consultation with the Departments of Budget and Management, Housing and Community Development, and Disabilities, report on the following: 1) ways to provide incentives for the development of independent housing for clients with mental illness and/or developmental disabilities, 2) ways to widen the pool of vendors willing to provide this housing, and 3) methods for eliminating barriers to the development of this key resource in the provision of community-based care.

EXECUTIVE SUMMARY

There are several thousand individuals in Maryland with disabilities who may be potential candidates for affordable housing. Within this group, there are several subgroups, including populations served by the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA), each competing for housing in the limited affordable housing market. These two sub-groups make up a population of extreme poverty since their main source of income is usually Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). These are both federal programs that provide cash to help recipients meet basic needs.

Disabled populations that rely only on SSI cannot afford any housing, including the "affordable housing" targeted to low-income individuals. Therefore, government agencies must provide housing subsidies for most disabled individuals living on SSI and for some disabled individuals living on SSDI.[1]

There are four *strategic* factors that hinder the expansion and access to subsidized housing for individuals with developmental disabilities or mental illness:

1. **Extraordinary Housing Need: No Comprehensive Housing Plan or Single Point of Responsibility.** A strategic framework is needed that defines housing service model(s) to be developed and identifies priorities regarding the *target* populations to be served. Depending on the level of importance given to housing expansion, consideration should be given to identifying a single point of responsibility for achieving specified outcomes through the expansion of housing.

2. **Housing Costs Exceed Individual's Income: Financing the Gap.** Government subsidies for housing costs are required because individuals with disabilities generally have an income that places them well below the federal poverty guidelines. In essence, this population needs "free"

[1] Individuals on SSDI usually receive more than the $603/month provided to individuals on SSI. Most of these individuals could afford affordable housing in selected areas of the state, especially with a roommate.

housing.[2] Government subsidies in the form of capital are needed to reduce the debt service of a housing unit, and rent subsidies are needed to cover the difference between that debt service or rent and the individual's income.

3. **Paying for Subsidized Housing: Who is Responsible?** Paying the housing costs (i.e., excluding housing under the "full service" model) [3] for this population is not the responsibility of any particular agency, but of multiple agencies (e.g., DHCD, HUD, Public Housing Authorities,) that are not directly involved in serving individuals with disabilities. Given the significant financial gap between the cost of housing and an individual's social security income, an analysis should be done of the financial benefits to each administration if they were to subsidize the housing costs for individuals unable to access "full-service" programs. Reliance on other agencies and resources to pay for housing costs for individuals with disabilities has a significant impact on the rate at which housing becomes available for this population.

4. **DHCD Affordable Housing Production: Increase Units Targeted to Individuals with Disabilities.** The Department of Housing and Community Development **(**DHCD) finances approximately 2,700 affordable housing and rental units each year, 153 of which are targeted for individuals with disabilities.[4] This is only five percent of the units developed. In the future, DHCD expects to increase the production of affordable housing to 3,600 units annually, with an additional 153 rental units per year targeted for individuals with disabilities, for a total of 306 units. This is an opportunity for significant financial benefit to MHA and DDA if rent subsidies were to be provided to individuals in order to occupy these affordable housing units.

There are also three key *operational* factors that slow the expansion and access to housing for individuals with developmental disabilities or serious mental illness:

1. **Establish Links Between Affordable Housing Landlords and Individuals in Need.** Over 600 "set aside" affordable housing units for individuals with disabilities have been developed since 2002 under the Department of Housing and Community Development Federal Low-Income Housing Tax Credit program. An established link between the property managers of affordable housing developments and a specific entity representing the individuals to be targeted for such units is essential. Currently, there is no specific agency or position, which is responsible for connecting individuals to housing, for creating and sustaining such a link with affordable housing developers.

[2] Under federal guidelines, housing costs can be no more than 30% of the person's income. For a person receiving SSI in Maryland, 30% of his or her income equals $2,170 per year available for housing (SSI payment of $603 a month x 30% = $180.90 x 12 months = $2,170.80). Affordable housing is defined as housing costs that do not exceed 30%-50% of the Area Median Income (AMI). In Baltimore City, 30% of AMI is $17,500. Therefore, for a person on SSI in Baltimore City, his or her income is only 12% of AMI, well below what is considered necessary to afford housing.

[3] Both MHA and DDA now espouse a housing model that separates housing from services. This is a shift in philosophy from a "full service" model, in which the administrations reimburse providers for housing and services, to a model in which the administration reimburses for services only. This philosophy shift does not affect existing "full-service" providers unless they choose to voluntarily separate housing and services.

[4] DHCD includes individuals with physical disabilities, as well as those with developmental disabilities and mental illness, in their definition of housing for individuals with disabilities. However, for the purpose of this report, the phrase " individuals with disabilities" refers to those with developmental disabilities or mental illness only.

2. **Develop a Statewide Strategy to Influence Local Housing Plans and Priorities to Expand Section 8 Vouchers for Individuals with Disabilities.** Section 8 vouchers, controlled by local Public Housing Authorities, are the primary source of rent subsidies for individuals with disabilities. However, the State has no statewide, strategic initiative to influence the local housing plans. It is essential to maximize the number of Section 8 vouchers directed towards individuals with disabilities. The Consolidated Plan (ConPlan) for each PHA is the master plan for affordable housing in each community and the allocation of Section 8 vouchers. A specific plan regarding DHMH housing needs, as well as a strategy for negotiating and influencing the ConPlan in each jurisdiction, should be developed.

3. **Provide Financial Support to Sustain the Future of Mission-Driven Housing[5] Vendors.** If the creation of more mission-driven housing vendors (i.e., housing vendors created specifically to serve the mentally ill and developmentally disabled population) is a desired goal, then financial support is needed. These vendors house individuals with serious mental illness[6] while maintaining a landlord/tenant relationship. These vendors play a necessary role in serving certain populations. However, lack of financial support discourages any expansion. The existing MHA vendors now require ad hoc grants from MHA to survive. If these vendors are to survive and expand grants to the vendor or rent subsidies for individuals are necessary to create a solid financial base.

In summary, given the overwhelming number of individuals in need of fully subsidized housing, and the scarcity of capital and operating resources to meet that need, priorities for housing must be set and a policy established regarding how those housing costs are to be financed. Accordingly, it is recommended that as a foundation to any efforts to increase the availability of subsidized housing and access to that housing, priority target populations be identified and matched with appropriate housing situations, outcomes clearly stated, targeted geographic areas identified, and the responsibility and method for financing housing costs be established and supported at all levels.

[5] A mission-driven housing vendor is a vendor that has incorporated to develop housing only for individuals with disabilities.

[6] In 2006, one mission-driven housing vendor was created to serve individuals with developmental disabilities.

HOUSING FOR INDIVIDUALS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITIES

There are four strategic factors that must be addressed if housing is to be expanded at any appreciable rate for individuals served by the Mental Hygiene Administration (MHA) and the Developmental Disabilities Administration (DDA). Each of these factors must be addressed so that decision-makers can be informed of the economic, as well as social benefits, of pursuing a policy of subsidizing housing costs for individuals with disabilities.

STRATEGIC BARRIERS

I. EXTRAORDINARY NEED FOR HOUSING: NO COMPRENSIVE HOUSING PLAN OR SINGLE POINT OF RESPONSIBILITY

Currently, several different agencies are trying to secure housing through whatever means and resources they can tap into for whomever they are serving. These disparate efforts to expand housing would benefit from a systemic, comprehensive housing plan that provides a focus for housing expansion. Although individual efforts should not be discouraged, there is a need for a comprehensive housing plan to be developed at the State level to help focus these diffuse efforts so that there will be an appreciable increase in affordable housing targeted to specific populations.

Expansion of housing for individuals with disabilities is further hindered by the severe demands on available capital and rent subsidies to provide affordable housing for all of those in need. The Department of Housing and Community Development (DHCD) estimates that by 2014, approximately 157,000 affordable housing units will be needed to house members of the workforce, the elderly, and individuals with disabilities. In this latter category, the estimated need is for 28,800 housing units by 2014. At least 13,000 individuals with developmental or serious mental illness are *potential* candidates for some type of affordable, subsidized housing (see Tables 1 and 2 below). The State cannot meet all these needs. Choices must be made and priority populations targeted for housing. Currently, the populations who manage to access subsidized housing are so diffuse that progress, even if it were tracked, would be negligible compared to the overall number in need.[7] Achievement of any desired outcome is equally elusive.

Therefore, understanding which populations have been given *priority* for subsidized housing, which housing model(s) are to be developed, and who is going to finance the housing costs, makes a significant difference in determining the subsidized housing capacity to be developed, the expected rate of development, and the type of housing vendors to be expanded.

Developmental Disabilities Administration (DDA)

The *demand* for housing for individuals with developmental disabilities is driven by the appropriation of new funds for support services, or by those who need a home and already have sufficient support services. There were 1,075 individuals in crisis waiting for residential services, according to the DDA 2005 waiting list. There are also 1,464 individuals receiving some level of support services who

[7] This is illustrated by the fact that 600 "set aside" affordable housing units have been developed in four years, but there is no data on who has accessed these units or on any progress made in serving targeted populations.

may become candidates for housing in the future. There are also a significant number of individuals (estimated at 15,000) on the full DDA waiting list that are waiting for residential services. Of these 15,000, there are 8,800 waiting for residential services.

Although the need for housing is significant, the *demand* for housing is dependent on annual appropriations for service support funding. When funding does become available, however, there are two factors that can produce the most economical housing situation for individuals, and therefore, allow the limited operating dollars to serve more people. First, affordable housing must be available for use; and (2) individuals should be encouraged to choose the Community Supported Living Arrangement (CSLA) model. Under this model, DDA provides support services, and may pay rent subsidies, if funding is available. This model provides DDA with the most flexibility in matching services to individual needs and in paying for only what is necessary.[8] However, the individual must be matched with an affordable housing unit in order for DDA to benefit from the lower rent subsidies required for an affordable housing unit.

The Developmental Disabilities Administration's vision is for each individual with a developmental disability to have a choice in where he or she lives and in who provides service supports. Therefore, DDA strongly supports the idea of assisting individuals with developmental disabilities who are interested in a living situation that allows the individual to control his or her own home. However, fostering the growth of the "control-your-own-home" model and the development of mission-driven housing vendors to provide such a supply of affordable housing could benefit from the focus of a strategic plan. There is also the need for an administrative infrastructure to match individuals to an affordable housing unit. Given the potential cost savings of this model over traditional "full service" models, the State should develop strategies and incentives to foster the growth of this model.

However, there will continue to be a need for the "full service' model in which DDA reimburses one provider for the residential and support services together. This is a choice of many individuals and their families. However, under this model, the housing tends to be purchased or rented at market rates, which are considerably higher than affordable housing units. To the extent the reimbursement dollars go to housing costs under the "full service" model, there are fewer dollars for services. Further, scarce Section 8 vouchers are sometimes used to supplement the DDA reimbursement, not only reducing the availability of Section 8 vouchers, but also supporting the continued use of high-cost housing. Policies that encourage or provide incentives for these providers to use affordable housing units could produce cost savings in relation to housing.

[8] The CSLA model is very similar to a "supportive housing" model that is being espoused nationally. This model has several benefits: (1) it optimizes individual choice and promotes self-determination; (2) it introduces cost savings over traditional facility-based service model (i.e., ALU, group home) because unbundled services in this model allow for the purchase of only those services needed and take advantage of existing low-cost/no cost community resources; (3) this model shifts housing costs to other sources, thereby freeing administrations' dollars to fund additional individuals; and (4) this model does not require "moving" the individual when the individual's needs change. The support services funded change as the individual's needs change, but the individual remains in the same living situation. (O'Hara, Ann, Day, Stephen, (Technical Assistance Collaborative), *Olmstead and Supportive Housing: A Vision for the Future*, Center for Health Care Strategies, Inc., December 2001, page 8.)

Mental Hygiene Administration

The Mental Hygiene Administration has had a long-standing goal of increasing the availability of "independent" housing for individuals with mental illness. The stated priority for independent housing has been for individuals with serious mental illness who no longer need residential rehabilitation program (RRP) level of care, individuals with serious mental illness (SMI) who are homeless, individuals awaiting discharge from the State hospitals, and those in unstable housing situations. The estimated number of individuals is shown on Table 1.

Although MHA has limited the development of new RRP beds since 2000, MHA has used "targeted expansion" of RRP beds for special populations, such as transition-age youth and patients discharged from MHA hospitals and Crownsville Hospital Center. It was anticipated that RRP beds would become available when individuals in RRPs no longer needed the RRP level of care and who could move on to independent housing, thus freeing an RRP service for someone awaiting discharge from a State hospital.

However, even with the turnover in RRP beds, an estimated 600 individuals, or 25 percent of those currently occupying one of the 2,464 RRP beds, are considered ready for an "independent" housing arrangement. Since most of these individuals require "free" housing, which is not readily available, they continue to occupy an RRP bed and receive a level of services that may no longer be medically necessary. These are the individuals who are supposed to be the primary recipients of housing units developed with State community bond funds, although there are no specifics links to ensure that this occurs. In fact, it does not happen often, but there is one notable exception. [9]

Although the movement of individuals from RRP beds to independent housing is a priority for MHA, there is no specific funding plan to finance rental subsidies to ensure that individuals move in any significant number. A major issue identified in interviews with housing vendors and Core Service Agencies (CSA) was the lack of economic incentives for "full service" providers to encourage individuals to move on to "independent" housing.[10] Without financial incentives or disincentives, it is unlikely that there will a significant shift of the estimated 600 individuals in RRP beds to "independent" housing or some other unbundled housing model.

[9] In FY 2006, a special initiative was made in Montgomery County to move ten individuals out of Springfield Hospital Center and into an RRP. This effort linked an RRP provider, an independent housing provider, and Springfield Hospital Center. To discharge ten individuals from Springfield, ten individuals vacated RRP slots and moved to independent housing. It should be noted the independent housing provider made a *special exception* to its policies to take the individuals from the RRP, since these individuals were not on the housing provider's waiting list.

[10] In addition to the lack of housing, there are several other reasons why a person may remain in an RRP bed. These reasons include lack of funding to pay for housing subsidies, possible loss of Medicaid benefits upon discharge from an RRP bed, reluctance by the individual to move, and family opposition to a move.

Table 1
MHA Estimate of Individuals with SMI in Need of Affordable Housing by County
2005

County	State Hospital Assisted Living Units	General Hospital/ State Hospital	Individuals in Current RRP (25%)[1]	Case Management	Homeless SMI Only[2]	Total
Central Region Totals	**50**	**200**	**291**	**2,277**	**4,879**	**7,697**
Baltimore City		100	88	1,203	4,264	5,655
Anne Arundel		100	65	253	141	559
Baltimore			83	359	166	608
Carroll			14	116	158	288
Harford			15	246	80	341
Howard			26	100	71	197
Eastern Shore Totals	**0**	**0**	**52**	**326**	**274**	**652**
Caroline			2	37	8	47
Cecil			10	9	115	134
Dorchester			5	46	25	76
Kent			10	11	2	23
Queen Anne			3	13	0	16
Somerset			2	40	3	45
Talbot			2	28	11	41
Wicomico			17	67	40	124
Worchester			1	75	70	146
Southern Maryland Region Totals	**0**	**0**	**19**	**339**	**203**	**561**
Calvert			5	65	47	117
Charles			4	120	91	215
St. Mary's			10	154	64	228
Washington Suburban Totals	**50**	**200**	**177**	**229**	**719**	**1,375**
Montgomery		100	85	0	485	670
Prince George's		100	92	229	234	655
Western Maryland Region Totals	**0**	**0**	**63**	**232**	**471**	**766**
Allegany			8	41	63	112
Frederick			45	43	141	229
Garrett			2	32	21	55
Washington			8	116	246	370
Total	**100**	**400**	**602**	**3,403**	**6,547**	**11,052**

1 MHA estimates that 25% of the individuals currently receiving Residential Rehabilitation Program (RRP) services are ready for discharge
2 DHCD, Maryland's Consolidated Plan, 2005, Estimates of Homeless Seriously Mentally Ill (SMI), pages 21-22

II. HOUSING COSTS EXCEED INDIVIDUAL'S INCOME: FINANCING THE GAP

Full Price Housing

There is a significant gap between the cost of housing and the income of individuals served by DDA and MHA. This gap is greatest for housing units purchased or rented at market prices. Table 3 shows the financing gap between the monthly debt service for the purchase of a statewide average median-cost house and a person on SSI. For a person on SSI, the average gap to be financed with government subsidies would be $795, assuming that two individuals, each with SSI income, occupy a housing unit. If a mission-driven housing vendor were to use a State capital grant to assist in 75 percent of the acquisition cost of a median-priced home, a subsidy of $202/month is still required to cover the housing vendor's monthly mortgage, overhead costs for administration, reserve, maintenance, and insurance.[11] Utility costs must also be funded and are not included in the monthly subsidy.

If a person on SSI were to rent a unit on the open market at the statewide average median rental price, the financing gap would average $254 per person, assuming a two-person household, each with SSI. The average median rental cost in Montgomery County is $1,787. Assuming a household with two individuals, the financial gap to be subsidized is $713/month in Montgomery County. The tables in Attachment 1 shows the range of subsidies needed for individuals on SSI by region of the state for median priced purchase of housing, for median-priced rental units, or for purchase of a home with a capital grant assisting in 75% of the acquisition costs.

Affordable Housing Market

The Department of Housing and Community Development's affordable housing production programs offer low-interest, deferred-payment loans, and low-income housing tax credits (LIHTC's) to qualified developers of affordable housing. The debt service on these DHCD-financed affordable housing units is lower than the debt service on units on the open market. For example, the financing on a typical 100-unit affordable housing development includes $7 million in LIHTC's and $3 million in loans. The debt service is $108,000/year for the 100 units, far less than conventional terms of $2 million cash down and $575,000/year debt service. On average, for an affordable housing unit using LIHTC, a person on SSI needs a rent subsidy of $49/month, assuming a two-person household (Table 2).

[11] To assist in 75% of the acquisition cost ($197,910), using state capital funds, of a statewide average median-cost home, the debt service to the State is $1,464/month. When the capital costs to the State are factored in, the actual cost to the state is $644/person/month. ($1,464/2 = $732 +202 [rent subsidy per person in two-person household] = $934 --see Table2.)

Table 2

Financing Option	Average Monthly Cost of Housing Unit[1]	Operating/ Administrative Overhead (Average)[2]	Total Cost per Housing Unit[3]	30 Percent of SSI Income per Individual	Gap Financing (Rent Subsidy) Needed Per Person
Statewide Average Median-Cost Purchase[4]	$1,582	$368	$1,950	$180	$795
Median-Cost Purchase-Capital Grant Pays 75% of Purchase Price[5]	$396	$368	$764	$180	$202
Statewide Average Median-Cost Rental[6]	$868	$0	$868	$180	$254
Affordable Rental Unit Under LIHTC[7]	$90	$368	$458	$180	$49
Affordable Housing Unit with No Debt Service	$0	$368	$368	$180	$0

[1] Costs based on the average monthly debt service or rent attributed to each option.

[2] DHCD estimates overhead costs of $4,200 per year/per unit, plus a $2,100 reserve.

[3] A housing unit assumes a two-person household.

[4] Statewide average median-cost housing is $263,880 (Published 2003 figure, Maryland Association of Realtors, inflated to 2005)

[5] Assumes a capital grant for 75% of the purchase price of a median-cost home. Monthly cost reflects the vendor's 25% share. Borrowing costs to the State for 75% of the acquisition cost is $1,464 per month or $12,456 annually is not reflected in the gap. Assumes 4% interest over 15 years.

[6] Statewide average median cost rental is $868. (Published 2000 figure inflated to 2003, Fair Market Rent data USHUD, inflated to 2006.)

[7] DHCD estimate based on a 100-unit affordable housing development financed with $7 million in LIHTC. Includes debt service, overhead expenses and a reserve.

Given the substantial difference in subsidies needed, depending on how the housing unit is financed, the economics argue for maximizing use of affordable housing units financed with LIHTC's. The State should also consider the most economical balance between state capital funds and general funds to finance the number of housing units desired.

Resources to Subsidize Housing Costs

Housing costs can be subsidized through capital subsidies that reduce the debt service on a housing unit or through ongoing cash rent subsidies. At the State level, the most significant source of

capital subsidies is provided through the Department of Housing and Community Development. Over $200 million dollars are leveraged through DHCD revenue bonds and LIHTC's for affordable housing.

The other State program available to reduce the debt service on a housing unit is the Department of Health and Mental Hygiene community bond program. DHMH finances housing units for mission-driven housing vendors through the Community Health Facilities Bond Program. To date, these housing units have consisted only of housing for individuals with mental illness. In 2006, the first DDA mission-driven housing vendor was created.[12] Over the last 20 years, eight MHA mission-driven housing vendors have been created, and a total of 252 housing units for 504 individuals have been developed through the DHMH community bond program.

However, expansion has been slow, and in recent years the rate of expansion has slowed from an average of 17 units a year to 10 units a year. Although the capital grant lowers the debt service of a housing unit to a range manageable for an individual on SSI, the housing vendor still needs funds to cover operating expenses and administrative costs, and these funds are not readily available.[13] Without a recognized and agreed upon financing method to cover the overhead costs of these mission-driven vendors, there will be little or no expansion of vendors or housing units.

Cash rent subsidies are the other major source of subsidies for those who cannot afford housing. The vast majority of these rent subsidies come from federal HUD programs, administered by local public housing authorities. Section 8 vouchers are by far the largest source of rent-subsidy dollars. However, Section 8 vouchers are now extremely difficult to secure.

The Developmental Disabilities Administration and the Mental Hygiene Administration provide housing subsidies but only to those individuals who are in the "full service" programs provided by each administration. For MHA, this includes the Residential Rehabilitation Program (RRP), which reimburses providers for both housing and service costs. The housing and service costs are separated in order to maximize federal funds for the service component. The housing costs are reimbursed $11.70 per day with State general funds. RRP service providers are reimbursed $2,580 per month for intensive psychiatric rehabilitation program (PRP) services and $1,074 per month for general PRP services. In order to reduce the State's costs, the PRP provider is required to collect a portion of the consumer's income (usually SSI or SSDI) to apply against the cost of the RRP services. In addition, MHA funds housing subsidies to individuals with serious mental illness so that these individuals can afford affordable housing. The housing subsidies are provided with State general funds to Montgomery, Harford, Anne Arundel, Prince George's and Washington counties and Baltimore City. MHA has also implemented a Housing First model using Assertive Community Treatment teams to support individuals in independent housing. Through contracts with CSAs, MHA funds security deposits and other one-time only expenses to support individuals moving to independent housing.

DDA reimburses providers for housing and services under the Alternative Living Unit (ALU) model. A DDA service provider receives $328/month reimbursement for housing, other capital costs, and administrative overhead costs, plus $375/month from the individual's SSI check for room and board, for a total of $703 per month for each individual. It is assumed up to $500 to $600 of this monthly amount is applied toward the housing costs, including utilities for the individual. The reimbursement assumes a three-person ALU; therefore, a provider has available up to $1,500 to $1,800 per month for housing costs

[12] This vendor, the Housing Opportunities Commission of Montgomery County, formed a partnership with a DDA service provider. The cost of the 3-person home is projected to be $656,000, including renovation. This is $ 218,666 per person.

[13] MHA nonprofit housing vendors must rely on contracts from MHA to the CSA to assist with oversight and management of subsidized housing.

for a three-bed ALU. As shown on Table 2, these funds are sufficient to cover median-priced housing costs in most areas of the State.

However, the ALU model is an expensive model, compared to housing purchased with a capital grant. For example, if a mission-driven housing vendor were to purchase a home using a capital grant for 75% of the acquisition costs, the monthly cost of the median-cost housing would be $764. Assuming a two-person household, with each person contributing $180 of his or her SSI check, the remainder to be subsidized would be $202 per person, significantly less than the $550 to $600 a provider receives per person for housing under the "full service" ALU model. With the capital grant model, there is the added benefit that the individual keeps a greater portion of his or her SSI check. The savings is even greater if an affordable housing unit is secured. Clearly, there are significantly different financial consequences for the State, depending on the housing model used and the type of housing used (i.e., full priced vs. subsidized).

III. PAYING FOR SUBSIDIZED HOUSING: WHO IS RESPONSIBLE?

There has been a shift in housing philosophy by the administrations from that of providing housing and services as one bundled and reimbursed package to a concept of unbundled housing and services, known as "independent housing," "supportive housing," etc. Individuals with serious mental illness request independent housing that is separate from services, which research has demonstrated is a more effective approach to supporting individuals in the community. Individuals are more likely to stay in the housing. This movement to de-couple housing and services has unwittingly shifted the paradigm regarding who should *pay* the housing costs for individuals with disabilities. This shift has resulted in a huge increase in the need for subsidized housing. The entire populations served by DDA and MHA (not just those ready for "independent" housing) now "need" subsidized housing unbundled from services.

To date, it has been an operational assumption that the cost of the housing portion of these unbundled housing models would be financed through entities such as Section 8 vouchers, DHCD-financed affordable housing, or mission-driven housing vendors.[14] Populations, who would have had bundled housing and services paid for by the administrations,[15] are now being encouraged to seek housing subsidies through other means, with the administrations continuing to provide reimbursement for the person's service needs.[16]

This has unintentionally established a *de facto* financing policy that has shifted housing costs for individuals with disabilities to other agencies. Without a clear statewide policy regarding who should pay for housing, and how housing costs should be financed, individuals with disabilities must compete for very scarce HUD housing subsidies. This slows the expansion of subsidized housing, as well as access to it.

[14] Both MHA and DDA have sought creative ways to expand services given the limited funds and great need of the population that each serves. Tapping other resources for the housing costs has been the one focus of those efforts. However, this coincided with the shift in housing model philosophy (i.e., unbundled housing and services), which has created a huge need for subsidized housing without attention to how it will be financed.

[15] MHA has limited the development of RRP slots; DDA, while still financing new ALU slots, has begun to encourage individuals to select the CSLA model and to secure housing separately.

[16] Current RRP providers and ALU providers are exempt from this shift in philosophy although each administration is encouraging providers of these services to divest themselves of the housing portion of their business. Economically, this is probably not a viable option for the providers.

IV. INCREASING USE OF DHCD AFFORDABLE HOUSING PRODUCTION

The Department of Housing and Community Development has significant resources available for the production of affordable housing. Demands for those resources are, however, equally significant. DHCD produces 2,700 affordable housing and rental units each year, but an estimated 157,000 units are needed over the next ten years. Out of the 2,700 units developed through DHCD programs, an average of 153 are targeted and marketed to individuals with disabilities, only 5 percent of the total.

The most significant source of funds is the Federal Low-Income Housing Tax Credit (LIHTC) program. In FY 2007, Maryland received a $90-$100 million federal allocation of tax credits leveraged with $10.6 million in State funds. These tax credits are sold to *raise private equity (cash)* for affordable housing development. ***Maryland's $10.6 million federal allocation of LIHTC's raises $90 to $100 million in private funds for affordable housing annually.*** This is a huge source of private capital to subsidize housing for Marylanders.

Under the auspices of the Department of Disabilities (formerly the Office for Individuals with Disabilities) the Department of Housing and Community Development partnered with DDA and MHA to create a "set-aside" program for housing units developed under the LIHTC program. Affordable housing developers receive extra points if their application states that 10 percent of the units to be developed will be "set aside" for individuals with disabilities. The developer must agree to "target and market" to all disabled populations and offer the "set aside" units at 30 percent of the average median income for the area. However, if the unit is not occupied within 30 days, the unit can be rented to anyone. Attachment 2 provides a list of affordable housing units set aside by jurisdiction since 2002. A total of over 600 "set aside" units have been created. Unfortunately, the use of these units is not monitored extensively to ensure compliance with the "set-aside" commitment, and it is not known how may units actually went to individuals with mental illness or developmental disabilities.

OPERATIONAL BARRIERS

The following three o*perational* factors also have the effect of slowing the expansion of, and access to, subsidized housing for individuals with developmental disabilities or serious mental illness:

I. NO ESTABLISHED LINK BETWEEN THE AFFORDABLE HOUSING LANDLORD AND THE INDIVIDUAL IN NEED

The affordable housing produced through the DHCD Low-Income Tax Credit program is a market that may not be fully accessed by individuals with disabilities. The lack of coordination between the individual in need and the larger affordable-housing market is a significant missed opportunity to provide housing for individuals with disabilities.[17]

Although DHCD gives extra points to developers who will set aside units for the disabled, there is no established link to connect those units with the individuals who need them. No agency maintains a database of available units or a database of individuals seeking housing. There is also no established link

[17] Interviews conducted for this report determined that one affordable housing developer had several "set aside" units at two locations in the State; however, the developer could not find people to fill them. Core Service Agencies in those areas were contacted in an effort to make a match. The developer was seeking individuals with disabilities who are non-ambulatory and on the eligible list for a Section 8 subsidy. At present, although the need is great, the demand is unknown and the match is ad hoc.

to match individuals with the available housing. Further, even if an agency were to track the availability of these units, all of the other required components would have to be in place when the unit becomes available. That is, the individual in need of housing would have to have a Section 8 voucher or be eligible, as well as funded support services, and be ready to enter into a lease at the appropriate time.

Formal mechanisms should be developed to create a strong link between individuals with disabilities in need of housing and the availability of housing units. Identification of an agency to maintain a "real-time" database of available units and an entity that can readily identify individuals in need is required. These two must be strongly linked on a day-to-day working basis.

II. LIMITED USE OF LOCAL HOUSING PLANS AND PRIORITIES TO EXPAND SECTION 8 VOUCHERS FOR INDIVIDUALS WITH DISABILTIES

Currently, the primary sources for rent subsidies are the HUD Section 8 voucher program, the HUD Section 811 program, and the Shelter Plus Care program, all of which are federal programs, and two of which are operated through local Public Housing Authorities. The competition for these vouchers and subsidies is extraordinary. Section 8 vouchers are controlled by the local Public Housing Authorities, many of which have waiting lists so long that no new names are being accepted. Further, Section 8 vouchers have been level funded by the federal government over the last few years, which has had the effect of diminishing the number of vouchers available.

The Section 811 program requires a separate application process, which is long and complex and is directly between a vendor and HUD.[18] Maryland is allotted approximately 40 Section 811 slots per year. The Shelter Plus Care is a good program with a high success rate in retaining individuals in housing, but its funding is subject to annual appropriations.[19] MHA has been successful in applying for and receiving Shelter Plus Care for individuals with serious mental illness who have been in local detention centers and who are homeless.

The State also provides some limited rent subsidies. A recently created demonstration project, The Bridge Subsidy, provides rent subsidies to about 75 individuals with developmental disabilities, mental illness, or other disabilities. The housing subsidies last for three years, and the individuals will then be given a Section 8 voucher.[20] However, to date, DHCD is the only agency providing financing for these subsidies, although MHA is funding one-time-only costs for security deposits, furnishing, etc.

The Public Housing Authority's Master Housing Plan and Consolidated Plan are the vehicles for increasing the number of Section 8 vouchers for individuals with disabilities. A coordinated, well-defined statewide strategy to ensure input into these plans, as well as to influence the allotment of Section 8 vouchers for the disabled, is needed. Otherwise, the allocation of Section 8 vouchers is based on the relationship between a provider and the local housing authority. Further, without a concerted effort, an increase in the number of vouchers is unlikely.

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[18] Section 811 is a HUD housing production program that funds the development of affordable housing and on-site support services for low-income individuals with disabilities.

[19] The Shelter Plus program provides grant funding for permanent housing assistance to homeless individuals with disabilities, or disabled individuals at risk of being homeless. The main premise is that housing and services need to be linked in order to assure stability for this hard-to-serve population.

[20] The three-year, interagency (DHMH, DHCD, Aging) initiative known as the Bridge Subsidy was implemented in FY 2006. This initiative provides an individual with a rent subsidy for three years. The local Public Housing Authority has to agree to provide a Section 8 housing voucher to the individuals involved at the end of the three years. The program is not targeted to any particular group so measuring outcomes for the demonstration project will be difficult.

III. FINANCIAL SUPPORT IS NEEDED TO SUSTAIN THE FUTURE OF MISSION-DRIVEN HOUSING VENDORS

There are three major barriers to developing additional mission-driven housing vendors:

(a) Lack of financial support for start-up, working capital, and ongoing administrative costs.

The nonprofit housing vendors do not have the financial resources or administrative infrastructure to sustain a housing organization, provide property management services, grapple with special landlord/tenant relations, or expand on an appreciable scale. In order to survive financially, MHA nonprofit housing vendors must rely on contracts from MHA to the CSA, subsidies from a parent nonprofit service provider, financial and in-kind support from the Core Service Agency, and/or fund raising.

(b) Need for training, and technical assistance regarding housing development, financing, landlord/tenant relations, and property management.

Existing MHA housing vendors report that training in housing development and a mentoring program are needed. Training/mentoring programs must address financing, development, landlord/tenant relations, and property management. Given the lack of financial support for start-up vendors, the opportunity to learn these aspects of the business from others would be very valuable.

(c) Lack of sufficient service coordination and support services for tenants.

Since these housing vendors are serving special populations, the vendors (i.e., landlords) frequently find it necessary to provide tenant oversight and ensure effective service coordination. In many cases, it is other tenants or the maintenance workers who notify the landlord of a tenant who may have increased psychiatric symptoms. MHA housing vendors emphasize that individuals with a disability require *effective* and flexible support services. Because insufficient support services can jeopardize placements, the MHA housing vendors identified guaranteed support services for individuals in "independent" housing as a must. One housing vendor stated that he would no longer accept tenants who did not come with fully funded support services. In addition, the symptoms of mental illness may fluctuate and require services to be flexible and accessible during the period when the individual is in need.

RECOMMENDATIONS

METHODS TO ELIMINATE STRATEGIC BARRIERS

I. Extraordinary Housing Need: No Comprehensive Housing Plan or Single Point of Responsibility

a. Develop a comprehensive housing plan to guide the activities of agencies and individuals in a coordinated manner to reach the desired outcome.

A comprehensive housing plan should be a document that reflects policy *decisions* made regarding the housing models to be supported in the service-delivery system for individuals with disabilities, determination of the economic and social importance of subsidizing housing costs, the roles

and responsibilities of various agencies, and the rate at which the state wants to provide subsidized housing for individuals with disabilities. Decision makers should be provided with choices regarding options for meeting the housing needs of individuals with disabilities so that a direction and the *level* of effort desired to produce and access affordable housing can be established.

The plan should include reasoned economic incentives and disincentives designed to engage the nonprofit service community in achieving desired outcomes. Because current policies do not appear to have been successful in achieving desired results, motivating these organizations to change behaviors to meet established outcomes may best be achieved with economic incentives and disincentives.

b. Specify priority target populations for subsidized housing, by geographic area, including numeric goals for affordable housing production for those populations.

Because the estimated need for subsidized housing exceeds the available financial resources of the State, identifying priority, targeted populations for subsidized housing is an essential first step. Without a definitive statement regarding the priority populations and the targeted geographic areas, there can be no clear numeric goals for the amount of subsidized housing to be produced or the rate at which it will be produced.

A study conducted by the Corporation for Supportive Housing, *Laying a New Foundation: Changing the Systems that Create and Sustain Supportive Housing*, emphasized that the key to success, and therefore progress, is to bring a *small* group of key players together that can focus on a particular problem, design a specific product or project, and work toward a final solution. It is recommended that the State consider pursuing this model and contract with an entity such as the Corporation for Supportive Housing to provide the necessary technical assistance to produce a product that solves a problem. [21]

Several other states have been successful in developing a significant number of housing units for homeless individuals with mental illness and other disabilities[22] using this model.

II. Housing Costs Exceed Individual Income: Financing the Gap

Determine the best economic model(s) for financing the gap between housing costs and income for individuals with disabilities.

The most economical way to finance the gap between housing costs and an individual's SSI is to match a LIHTC housing unit with a rent subsidy. It is the option that should be pursued for all housing for individuals with disabilities. However, there is not a sufficient supply of LIHTC affordable housing units to meet such a demand, nor are units in affordable housing developments necessarily the best choice for all individuals. Other economical models for financing the gap need to be considered.

Therefore, if Maryland is to commit to a policy of financing housing subsidies for individuals with disabilities, an economic analysis of the cost and benefits of various options to finance the gap should be completed. This should include an analysis of the most economical means of balancing State and private capital funds and operating funds. The current "full service" model used by the administrations for reimbursing housing should be included in the analysis. The analysis would serve as the foundation for a statewide financing policy for subsidized housing for individuals with developmental disabilities or serious mental illness.

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[21] Grieff, Debbie, Proscio, Tony, Wilkins, Carol, *Laying a New Foundation Changing the Systems that Create and Sustain Supportive Housing*, Corporation for Supportive Housing, July 2003, page 19.
[22] States include CA, CN, IL, MA, MI, MN, NJ, NY, OH, PA.

III. Paying for Subsidized Housing: Who Is Responsible?

Establish a financing policy for subsidized housing that addresses the role and contribution of each agency.

At the most basic level, incentives to produce more subsidized housing, widen the pool of housing vendors, and access existing vendors are funding and financing issues. In shifting from a housing model that provides a "full service" program to a model that separates housing and services, MHA and DDA have created a large market for subsidized housing. Although DDA supports individuals using CSLA services with rent subsidies or by encouraging individuals to team up with roommates to cover housing costs, and MHA provides rent subsidies to certain counties, the need is still great. The separation of housing and services has placed an additional burden of paying the housing costs for these special populations on an already overburdened market for affordable housing.

Key decision makers should determine if this is the intended financing policy for covering housing costs for targeted populations. And if this is the intended policy, is the current rate of expansion and accessing of subsidized housing units acceptable? If this is not the intended financing policy, then the parties who should be responsible for paying for subsidized housing should be identified.

IV. DHCD Affordable Housing Production: Increase Units Targeted To Individuals with Disabilities

Currently, approximately 153 affordable housing units are "set aside" for individuals with disabilities. If DHCD increases affordable housing production to 3,600 units annually, there is the potential for 306 units to be "set aside." Although this is not a significant amount in comparison to the need for over 13,000 subsidized housing units, it may be enough to meet an as- yet-to-be-defined demand. Given the low rent subsidies needed in an average-cost LIHTC affordable housing unit, it is the most economical way to meet a greater portion of the housing costs for MHA and DDA populations over current models. If rent subsidies from MHA and DDA are available, there is the potential to achieve significant inroads in providing subsidized housing for the MHA and DDA populations. The issue becomes the number of units to "set aside" for individuals with disabilities. A "fair share" of LIHTC units for individuals with disabilities should be determined.

METHODS TO ELIMINATE OPERATIONAL BARRIERS

I. Establish a systemic link between the landlords of affordable housing developments and service-related agencies in each county or region.

a. Create an administrative infrastructure to support a systemic and ongoing link between affordable housing units and individuals in need of such units. The following should be included:

- Identify specific agencies at the State and local level, and positions, with the express responsibility for monitoring the affordable housing market, identifying individuals needing the units, and linking available units to individuals in need. Consideration should be given to using the MHA Core Service Agencies and the DDA Regional Offices, if PINS and funding are available.

- Develop specific actions to monitor affordable housing developers' compliance with their commitment to "target and market" 10 percent of the units in a development to individuals with disabilities. These actions should be developed in conjunction with the affordable housing developers. A specific position in DHCD should be assigned responsibilities for monitoring and compliance.

b. Maximize use of existing and future affordable "set aside" housing units for individuals with developmental disabilities and mental illness. The following should be included:

- DHCD should monitor affordable housing units for turnover and maintain a "real time" registry of available units. The registry must be easily and widely accessible and well advertised to the community of individuals with disabilities, families and advocates, and specifically to the position in each jurisdiction responsible for linking individuals to housing. Consider incentives for reporting the status of units to the registry by the affordable housing property managers. Consider disincentives for failing to report.
- Continue to financially support DHCD's Partnership Rental Program, which provides additional financing (i.e., grants) to further reduce the debt service of a LIHTC unit. In exchange for the additional financing, the housing unit must be restricted for occupancy to individuals with disabilities or special needs.
- Evaluate a proposal to earmark funds from the Community Bond program to provide financing to reduce the debt service of a LIHTC unit. The developer would have to commit to leasing the unit only to individuals with developmental disabilities or mental illness.
- Develop an initiative to link LIHTC units with permanent rent subsidies so that individuals with disabilities can take full advantage of affordable housing units and the developer has an incentive to make the units available to these individuals.

II. Develop a strategy to systematically review and influence Local Housing Plans in order to expand Section 8 vouchers and other HUD and local housing programs for individuals with disabilities.

Section 8 vouchers, controlled by local Public Housing Authorities (PHA's), are the primary source of rent subsidies for individuals with disabilities. However, there is no statewide, strategic initiative to maximize the number of Section 8 vouchers directed toward this population. There is also no agency or position with the responsibility of coordinating with local PHA's or monitoring local housing plans. The Consolidated Plan (ConPlan) for each PHA is the master plan for affordable housing in each community. There needs to be a specific housing plan for each jurisdiction that can provide a basis for negotiation and influencing the ConPlan in each jurisdiction. It has been suggested that the ConPlan can be used "to demand that individuals with disabilities receive their fair share of federal housing funds distributed through the ConPlan process."[23]

Local housing plans can also be influenced to further a long-term commitment to an adequate supply of affordable housing. The *Governor's Commission on Housing Policy, Final Report 2004,* recommended partnerships with local jurisdictions that would focus on influencing land-use and zoning policies to support continued expansion of affordable housing. It was recommended that the Development Capacity Task Force MOU, executed by the Maryland Municipal League, the Maryland Association of Counties, and the Maryland Department of Planning, be used as the mechanism for facilitating the development of a housing plan for each jurisdiction. There should be follow-up regarding

[23] *Priced Out in 2004,* Technical Assistance Collaborative, Inc., September 2005, page 19.

the status of this recommendation and a plan to ensure that the housing needs of individuals with disabilities are adequately addressed.

III. Provide financial support to sustain the future of mission-driven housing vendors.

Every individual with a disability is not necessarily a candidate for a housing unit in an affordable housing development. For example, some individuals may not wish to live in this type of housing, or an individual in need of an intensive level of supports may not have the level of independence required for a unit in an affordable housing development. In addition, those individuals with Section 8 vouchers who are evicted from their living situations are no longer eligible for a Section 8 voucher. A subsidized housing alternative is needed. The mission-driven housing vendor provides a necessary, subsidized alternative to affordable housing developments, and a choice for individuals. For this reason, these vendors should be supported so that the number of vendors and housing units can be increased.

However, if these vendors are to become viable entities, long-term financial assistance in the form of grants or rent subsidies to their tenants is required. Without sound financial assistance that is available in a consistent, reliable manner, these vendors are unlikely to expand. The administrations should decide the role of the mission-driven housing vendors including recommendations regarding a commitment to a financial model that supports these vendors. Training/mentoring opportunities for these vendors should also be explored, if these vendors are to expand.

Average Median-Price Purchase Cost for Housing by Region

Average Monthly Cost, Including Operating Expenses

	Median Acquisition Cost of Home	Average Monthly Payment Per Unit[1]	Monthly Average Operating Costs[2]	Average Monthly Cost Per Person TOTAL[3]	Average Available Income Per Person	Financing Gap Per Person (Rental Subsidy)[4]
Ownership[4]						
Maryland Average	$263,880	$1,582	$368	$1,950	$180	$795
Regional Average						
- Western Maryland	$202,762	$1,216	$368	$1,584	$180	$612
- Eastern Shore	$215,307	$1,291	$368	$1,659	$180	$650
- Baltimore City	$142,003	$851	$368	$1,219	$180	$430
- Central	$350,808	$2,103	$368	$2,471	$180	$1,056
- Montgomery County	$760,916	$4,562	$368	$4,930	$180	$2,285
- Prince George's County	$293,709	$1,761	$368	$2,129	$180	$885
- Southern Maryland	$281,433	$1,687	$368	$2,055	$180	$848

[1] Assumes acquisition costs borrowed at a fixed 30-year mortgage @ 6%.

[2] Ownership costs include insurance, maintenance repairs, reserve, and property management. Utilities not included.

[3] Assumes each residential dwelling will house two people.

[4] Number based on a two-person household, each with SSI.

[5] Source: Workforce Affordable Housing Maryland, December 2004, page 14. Median home prices based on published 2003 data, Maryland Association of Realtors and inflated 41% based on growth in Median Home Sales Prices, Blueprint Maryland, Volume 3 Issue 9, September/October

Average Monthly Median-Cost of a Rental Unit by Region

	Median Monthly Payment	Average Available Income Per Person	Financing Gap Per Person (Rental Subsidy)[1]
Rental			
Maryland Median Cost	$868	$180	$254
Regional Median Cost			
- Western Maryland	$745	$180	$192
- Eastern Shore	$684	$180	$162
- Baltimore City	$820	$180	$230
- Central	$1,070	$180	$355
- Montgomery County	$1,787	$180	$713
- Prince George's County	$1,427	$180	$534
- Southern Maryland	$1,115	$180	$378

Source: Workforce Affordable Housing in Maryland, December 2004, page 24.
The rent for a median household dwelling is based on the 2000 census data and 2000-2003 inflation rates for the regional rental market by USHUD inflated 12.3% (2003-2006) based on Consumer Price Index BLS.

[1] It is assumed that each residential dwelling will house two people, each with SSI.

Median-Priced Housing with a Grant for 75% of Acquisition Costs
Average Monthly Cost per Unit by Region

	Median Acquisition Cost of Home	25% of Acquisition Cost[1]	Average Monthly Payment	Monthly Average Operating Costs[2]	Average Monthly Cost TOTAL	Average Available Income Per Person	Financing Gap Per Person (Rent Subsidy)[3]
Ownership[4]							
Maryland Average	$263,880	$65,970	$396	$368	$764	$180	$202
Regional Average							
- Western Maryland	$202,762	$50,691	$304	$368	$672	$180	$156
- Eastern Shore	$215,307	$53,827	$323	$368	$691	$180	$166
- Baltimore City	$142,003	$35,501	$213	$368	$581	$180	$111
- Central	$350,808	$87,702	$526	$368	$894	$180	$267
- Montgomery County	$760,916	$190,229	$1,141	$368	$1,509	$180	$575
- Prince George's County	$293,709	$73,427	$440	$368	$808	$180	$224
- Southern Maryland	$281,433	$70,358	$422	$368	$790	$180	$215

[1] Assumes Vendor borrows 25% of acquisition costs borrowed at a fixed 30-year mortgage @ 6%. 75% of cost is a capital grant from the State.

[2] Ownership costs include insurance, maintenance repairs, reserve, property management, and utilities. DHCD estimates $4,200/year plus reserve and utilities for large affordable housing vendors. Small vendors may have higher expenses.

[3] Assumes residential dwelling is occupied by two individuals, each with SSI.

[4] Source: Workforce Affordable Housing in Maryland, December 2004, page 14. Median home prices based on published 2003 data, Maryland Association of Realtors and inflated 41% based on growth in Median Home Sales Prices, *Blueprint Maryland,* Volume 3 Issue 9, September/October 2006.

DHCD Low-Income Housing Tax Credits Program
Number of "Set-Aside" Units Targeted to Individuals with Disabilities by Jurisdiction FY 2002-2006

Project Location	2002	2003	2004	2005	2006	Total
Central Region						
Baltimore City	44	22	10	32	67	**175**
Anne Arundel		14	28			**42**
Baltimore County		49	7	9		**65**
Carroll		14	12			**26**
Harford		13			13	**26**
Howard	7		9	6		**22**
Eastern Shore						
Caroline						
Cecil		22			8	**30**
Dorchester	15	8	4		19	**46**
Kent						
Queen Anne						
Somerset						
Talbot						
Wicomico	15	7	6	25		**53**
Worchester	6					**6**
Southern Maryland Region						
Calvert		3				**3**
Charles			10			**10**
St. Mary's		4			3	**7**
Washington Suburban						
Montgomery	4				15	**19**
Prince George's				17	7	**24**
Western Maryland Region						
Allegany	16					**16**
Frederick				12	8	**20**
Garrett		6	3		3	**12**
Washington		10	14			**24**
Total	**107**	**172**	**103**	**101**	**143**	**626**