EVALUATION OF THE BEHAVIORAL HEALTH ADMINISTRATION

SEPTEMBER 2026

OFFICE OF PROGRAM EVALUATION AND GOVERNMENT ACCOUNTABILITY

DEPARTMENT OF LEGISLATIVE SERVICES

MARYLAND GENERAL ASSEMBLY

Evaluation of the Behavioral Health Administration

Department of Legislative Services
Office of Program Evaluation and Government Accountability
Annapolis, Maryland

September 2026

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF PROGRAM EVALUATION AND
GOVERNMENT ACCOUNTABILITY
MARYLAND GENERAL ASSEMBLY

September 1, 2026

Senator Shelly Hettleman, Senate Chair, Joint Audit and Evaluation Committee
Delegate Jared Solomon, House Chair, Joint Audit and Evaluation Committee
Members of the Joint Audit and Evaluation Committee

Dear Senator Hettleman, Delegate Solomon, and Members:

At the request of the Executive Director of the Department of Legislative Services, the Office of Program Evaluation and Government Accountability has conducted an evaluation of the Behavioral Health Administration (BHA).

Several recommendations begin on page 16. The response from the Maryland Department of Health is Appendix A.

We wish to express our appreciation for the cooperation and assistance provided by BHA.

Respectfully submitted,

Michael Powell
Director

MP/mpd

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Executive Summary

Overview of Behavioral Health Administration (BHA) Community Services Grants and Contracts

In 2014, the Maryland General Assembly (MGA) merged the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration into BHA within the Maryland Department of Health (MDH). BHA oversees the Public Behavioral Health System (PBHS) in collaboration with local authorities.

This evaluation examines the portion of PBHS services paid for using grants and contracts. From FY 2020 through 2025, BHA Community Services grants and contracts averaged about 8% of total PBHS spending. BHA directs how most of these dollars are used and makes awards to local authorities and other vendors in all 24 jurisdictions.

Maryland in Context: State Comparisons of Behavioral Health Indicators

To put the status of behavioral health in Maryland in context, the Office of Program Evaluation and Government Accountability (OPEGA) reviewed a selection of population-level indicators to compare Maryland to nearby states and the nation. On most available indicators, behavioral health in Maryland compares favorably. For example, Maryland's suicide rate has remained near 10 per 100,000 residents, below the national rate. Maryland's fatal overdose rate has declined faster than the nation. Maryland has dispensed more naloxone per capita than the nation. State comparisons of population-level indicators have limitations, however, because they are affected by many factors outside control of state health departments and are not themselves an evaluation of any specific grant-funded program or initiative.

Monitoring and Management of BHA Grants

BHA generally does not collect client-level outcome data for grant-funded services, and its capacity to assess outcomes has been disrupted over the past decade and is in transition. BHA's client-level Outcomes Measurement System (OMS) was discontinued in 2020 over parity concerns, and two problematic transitions between Administrative Services Organizations (2020 and 2025) lost or delayed the claims data used to measure service quality. As a result, actual Managing for Results (MFR) data for FY 2025 was unavailable to MGA during the 2026 legislative session. The report recommends strengthening BHA's ability to track and analyze outcome data and describes several challenges to doing so.

Oversight of BHA grants and contracts is fragmented. Fiscal monitoring is divided between MDH Finance, BHA, and the Office of the Inspector General for Health (OIGH). OIGH found repeated instances where MDH Finance either failed to complete the reconciliation process for BHA grants or completed it incorrectly. The budget system cannot consistently track funding for one program across multiple grants and contracts. Some local authorities report inconsistent programmatic oversight across BHA divisions. The report recommends streamlining the fiscal oversight process, enabling the budget system to report program spending across grants, and clarifying for all staff and stakeholders how BHA delegates oversight functions to local authorities.

Chapter 1.
BHA Community Services Grants

In 2014, MGA merged the Mental Hygiene Administration and the Alcohol and Drug Abuse Administration to create BHA, within MDH. BHA oversees Maryland's PBHS by planning, setting policy, and allocating combined resources for both mental health and substance use disorder (SUD) services.

Most people directly served through the PBHS are Medicaid participants, but some direct services are not covered by Medicaid, and many public health initiatives potentially benefit all Maryland residents, such as suicide prevention.

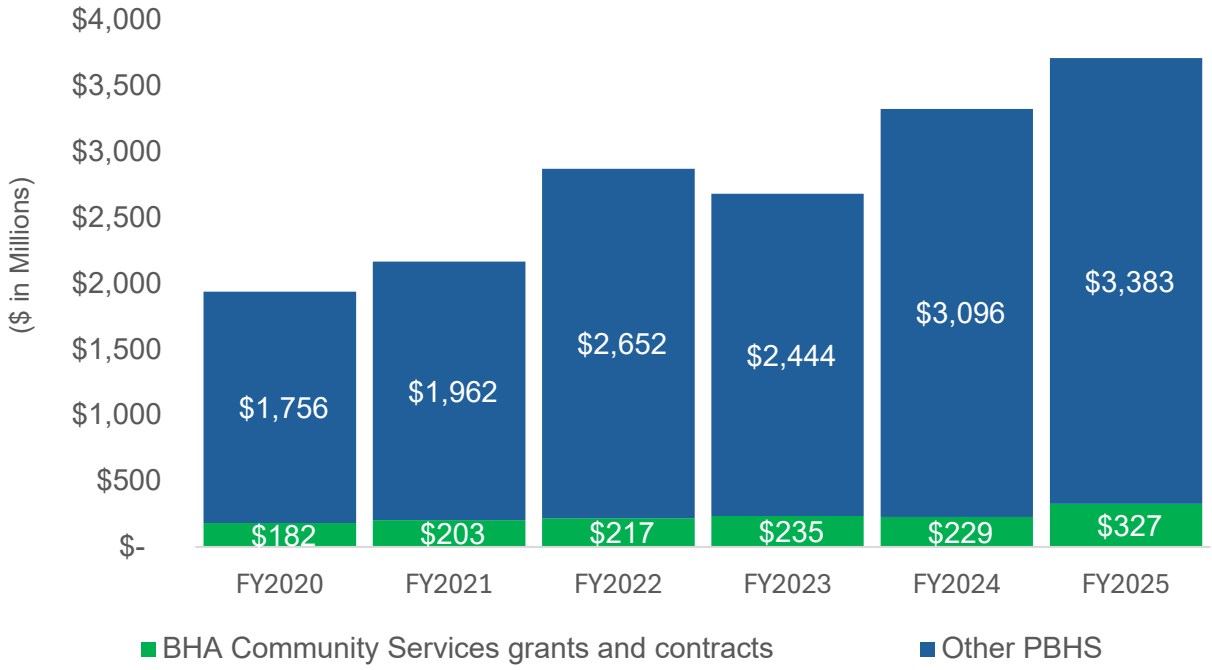
Spending on BHA Community Services grants and contracts has been about 8% of total PBHS spending

PBHS spending nearly doubled from FY 2020 to 2025. Outlays increased from just under $2 billion in FY 2020 to $3.7 billion in FY 2025. Increases were due to many factors including number of people served, greater utilization of intensive, higher-cost services, and provider rates. A full discussion of these factors is outside the scope of this evaluation, which focuses on how BHA manages grants/contracts and the outcomes from grant-funded programs.

BHA Community Services spending also nearly doubled over the same period; general fund expenditures increased by around $50 million (45%), and federal fund expenditures increased by around $80 million (145%).

Within BHA Community Services, most services, programs, and initiatives are paid for using two basic payment methods: grants/contracts; and fee-for-service (FFS) claims paid via the Administrative Services Organization (ASO). Grants and contracts are the focus of this evaluation. BHA Community Services grants/contracts averaged about 8% of total PBHS spending over FY 2020 through 2025, as shown in **Exhibit 1**.

Exhibit 1: Spending on BHA Community Services grants and contracts within the Public Behavioral Health System



Note: BHA grants/contracts = M00L01.02, Objects 08 + 12, excluding 0830
Source: Department of Legislative Services

BHA Community Services grants pay for a range of public health services that are not reimbursable

Across the PBHS, BHA pays for 59 categories of services, programs, and initiatives which can be grouped by how BHA pays for them. Generally, grants and contracts are used to pay for services, programs, and initiatives that are not suitable for FFS reimbursements or that are intended to connect individuals to FFS treatments.

BHA awards grants to local authorities in all 24 jurisdictions

Grant and contract awards flow from BHA to local authorities in each of Maryland's 23 counties and Baltimore City. Jurisdictions have discretion in how they structure their local authorities and what programs they fund. Each jurisdiction maintains a different portfolio of grant-funded programs. Not all jurisdictions apply for all BHA grant opportunities.

One BHA grant or contract may fund multiple behavioral health programs drawing from multiple fund sources, including state general funds, federal funds, special funds, and reimbursable funds.

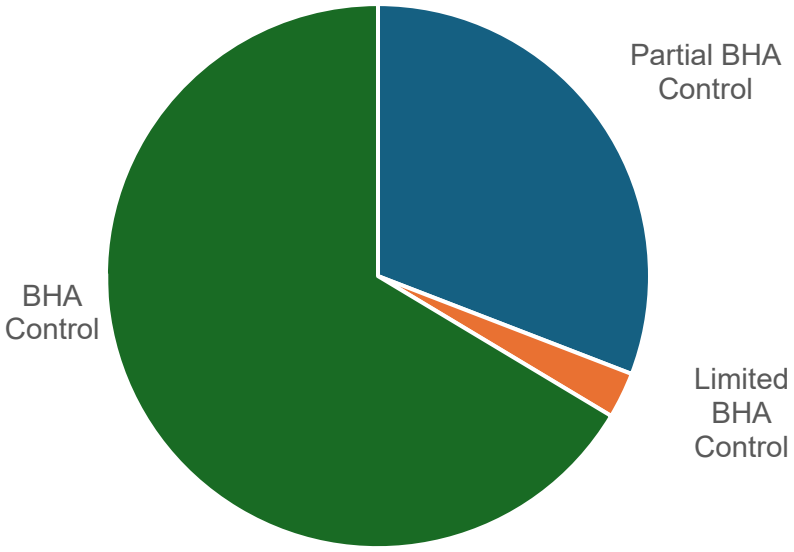
Some local authorities also pay for programs using charitable donations, local funds, or other income. In most cases grantees must use BHA grant awards last, after all other funding sources have been exhausted.

BHA delegates a portion of PBHS management to local authorities. These county-level entities may be governmental or nongovernmental. They may be staffed by county, state, or nongovernmental employees. Most jurisdictions combine SUD and mental health funding into local behavioral health authorities (LBHAs); others use separate core service agencies for mental health grants and local addictions authorities for SUD grants.

BHA controls how most grant dollars are used

While all BHA spending is subject to legislative appropriation, as shown in **Exhibit 2**, most grant spending at the programmatic level is directed by BHA. In FY 2025 two thirds of grant spending was appropriated with BHA controlling grant design, award decisions, funding levels and oversight. Roughly one-third was partially directed through broad appropriation language or constrained federal block grants while the remaining funds, less than 5%, were attached to explicitly directed budget line items specifying program, population, and minimum service requirements.

Exhibit 2: Level of BHA Control Over Grant Spending



Source: Department of Legislative Services

Chapter 2.
Maryland in Context: State Comparisons of Behavioral Health Indicators

Federal agencies, including the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA), publish hundreds of indicators of behavioral health across state populations.

OPEGA reviewed a selection of these available indicators to compare Maryland to nearby states[1] and the nation, prioritizing those that are:

- consistently measured across all states;
- actual counts rather than survey estimates; and
- relevant to BHA Community Services grants and contracts.

Nearby states included in the comparisons are Pennsylvania, Virginia, Delaware, Massachusetts, and New Jersey. On most available indicators, including those not presented in this report, Maryland performs comparably to nearby states and the nation. **Exhibit 3** shows the selected indicators.

Exhibit 3: Behavioral health indicators for state comparison

	Behavioral Health Indicator	Data Source
1	Suicide Mortality	CDC WONDER: death certificate data
2	Penetration rate: number of persons (unduplicated) served by the mental health authority (per 1,000 pop.) in each state	URS, SAMHSA (MHBG table)
3	Fatal Drug Overdoes	SUDORS, CDC
4	Naloxone Distribution (rate per 100 persons)	SUDORS, CDC

SUDORS: State Unintentional Drug Overdose Reporting System
SAMHSA: Substance Abuse and Mental Health Services Administration
URS: Uniform Reporting System
WONDER: Wide-ranging Online Data for Epidemiologic Research
CDC: Centers for Disease Control and Prevention
MHBG: Mental Health Block Grant

Source: Department of Legislative Services

[1] OPEGA selected states for this comparison based on regional similarity.

State comparisons of population–level indicators have limitations

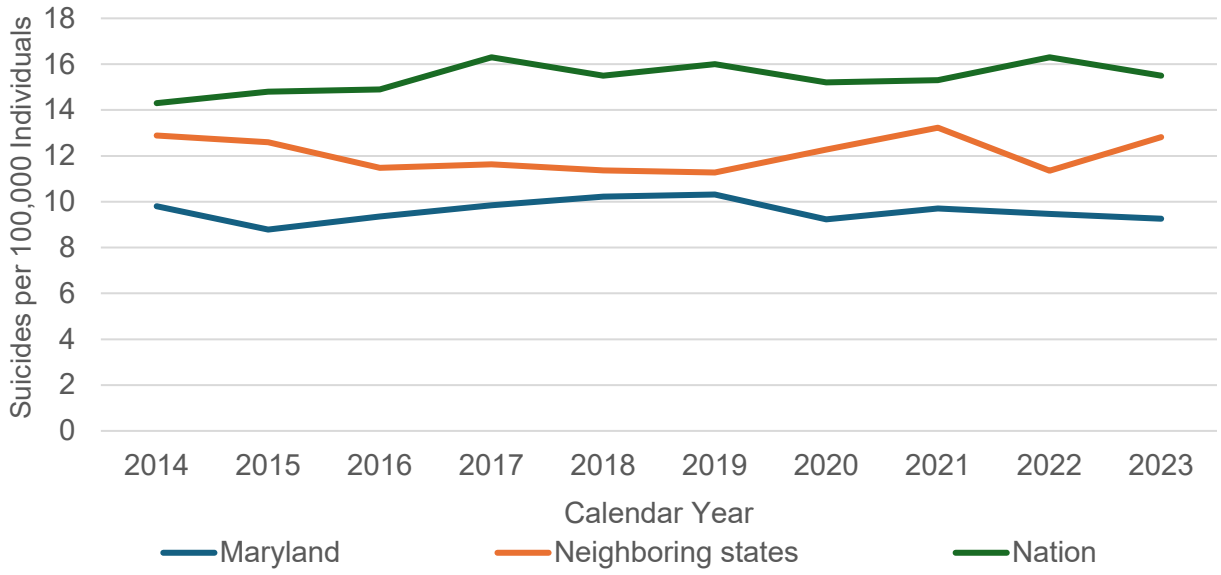
The population-level behavioral health indicators presented here are provided to contextualize the status of behavioral health in Maryland compared to the nation and neighboring states. The indicators themselves are not an evaluation of any specific grant-funded program, initiative, or service. In Maryland, as in all states, population-level trends reflect many factors beyond the control of a state health department, including poverty levels, housing availability, and illicit drug supply chains. Without client-level outcome data, the ability to evaluate the effectiveness of individual grant-funded programs is limited.

Maryland's suicide rate has been below the national average

Exhibit 4 shows a comparison of suicide mortality rates in Maryland, nearby states, and the national rate from CY 2014-2023. In CY 2014, the first year CDC reports this data, Maryland's suicide rate was 10 per 100,000 residents. Maryland's suicide rate was lower than the national rate and its three closest neighbors (Pennsylvania, Delaware, and Virginia) but slightly higher than New Jersey and Massachusetts.

Over the next 10 years, Maryland's suicide rate fluctuated around 10 per 100,000 residents. The national rate increased slightly, from just under 15 per 100,000 residents to just over 15 per 100,000 residents over the same period (CY 2014-2023). States in Maryland's region generally remained flat as well.

Exhibit 4: Comparison of suicide mortality



Source: Centers for Disease Control and Prevention; Department of Legislative Services

Maryland ranked 20th in workforce availability for behavioral health care

OPEGA consistently heard from stakeholders that behavioral health workforce availability is one of the most severe problems facing PBHS.

Chapters 286 and 287 of 2023 established the Behavioral Health Workforce Investment Fund to support the education, training, recruiting, and retaining of behavioral health care professionals and paraprofessionals in Maryland. As of April 2026, MDH has not fully funded this, and the implementation of recommendations from the Maryland Health Care Commission behavioral health workforce study were in the planning phase.

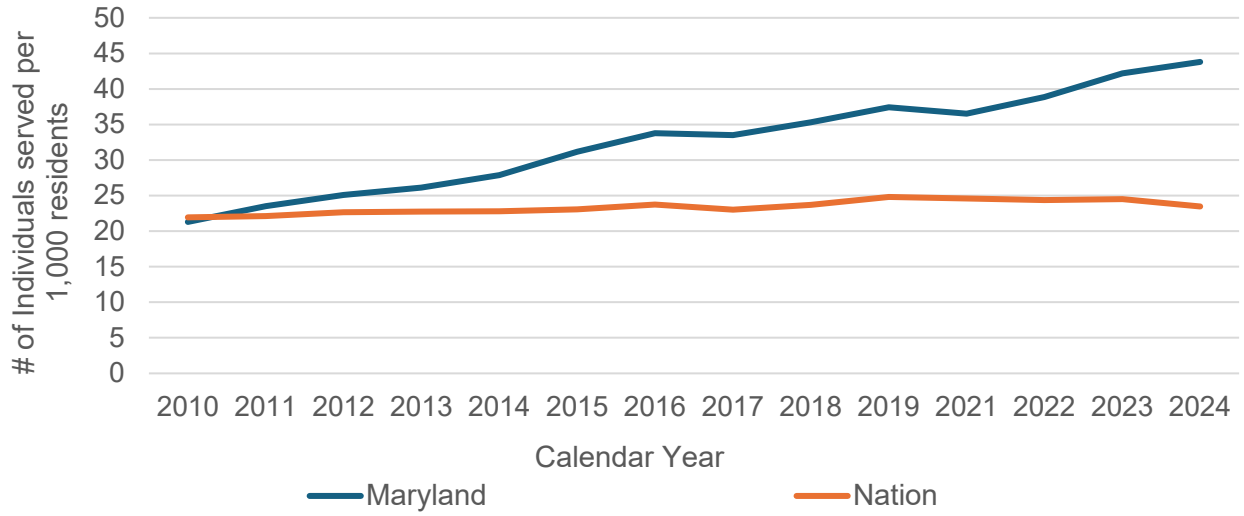
According to the National Provider Identification Registry and Mental Health America, in CY 2024 Maryland's ratio of patients to providers was around 300:1, meaning 300 patients per 1 individual provider. This ratio excludes some behavioral health paraprofessionals such as peer support specialists. In comparison to Virginia, Pennsylvania, Delaware, and New Jersey, Maryland has a larger per patient behavioral health workforce.

More Marylanders are getting publicly funded mental health treatment

The penetration rate for mental health treatment is a commonly used measure that shows the number of people served by the mental health authority (per 1,000 pop.) in each state. Factors affecting a state's penetration rate can include the number of people needing treatment, eligibility criteria, and funding levels, which all vary by state.

Exhibit 5 displays the penetration rate of Maryland's PBHS as compared to the national rate. In CY 2010, Maryland's penetration rate was roughly equal to the national rate. Over the period of CY 2010-2024, the national penetration rate remained around 21 per 1,000 individuals. Over that same period, Maryland's penetration rate has nearly doubled, to around 44 per 1,000 individuals in 2024.

Exhibit 5: Rate of Marylanders served by PBHS versus the national rate

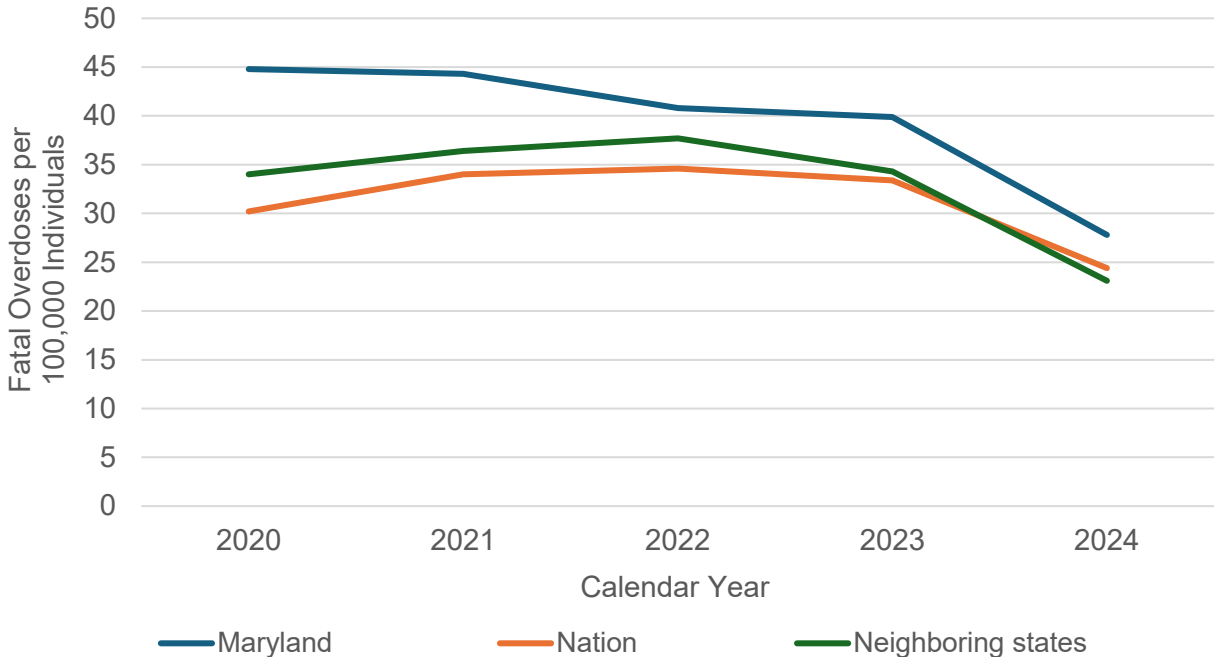


Note: Penetration rate: = number of persons (unduplicated) served by the mental health authority (per 1,000 pop.) in each state.
Source: SAMHSA URS; Department of Legislative Services

Maryland's overdose death rate is declining

Exhibit 6 depicts the fatal overdose rate for Maryland, neighboring states, and the national rate over CY 2020 through 2024. Maryland's fatal overdose rate, defined as the number of overdoses per 100,000 individuals, has been consistently higher than the national rate but overdose fatalities are decreasing faster than nationally and nearby states. From CY 2020 to 2024, Maryland's fatal overdose rate declined by 40% while the national rate declined by 20%.

Exhibit 6: Comparison of fatal drug overdose rates



Source: CDC WONDER; Department of Legislative Services

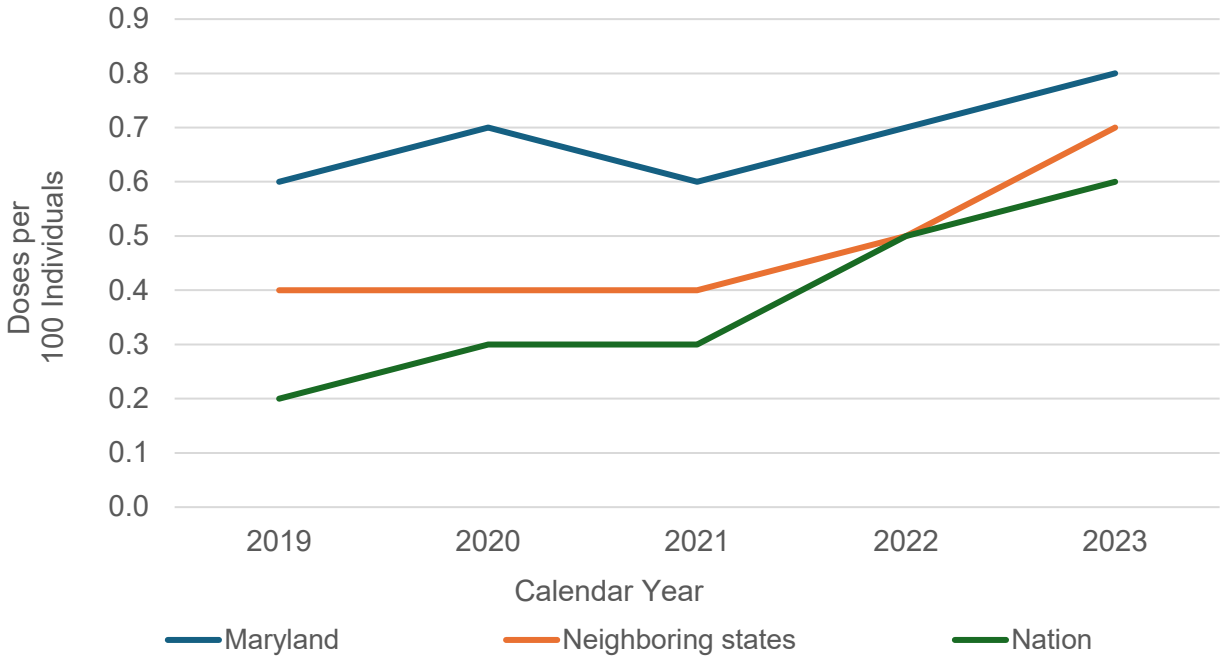
Maryland's percentage of fatal overdoses involving individuals in SUD treatment remained around 10-12% from CY 2020-2024, twice the national rate.

Maryland has dispensed more naloxone per capita than the nation

Naloxone reverses opioid overdoses and is one of the most utilized and effective public health tools in combating fatal overdoses. Naloxone works by blocking the effects of opiates on the brain and by restoring breathing. Promoting the availability of naloxone is a core service of BHA's SUD programs.

Exhibit 7 shows the naloxone dispensing rate for Maryland, neighboring states, and the nation. Maryland's dispensing rate was around 0.6 doses per 100 individuals in CY 2019 and rose to around 0.75 doses per 100 individuals in CY 2023, the most recent year of available data from the CDC. Maryland's dispensing rate has largely remained around twice that of the national rate and higher than most neighboring states, although the national dispensing rate has increased faster than Maryland's dispense rate in recent years.

Exhibit 7: Comparison of naloxone dispensing per capita



Note: Dispensing is done by pharmacies.
Source: CDC WONDER; Department of Legislative Services

Chapter 3. Monitoring and Management of BHA Grants

For most BHA Community Services grants and contracts, BHA sets annual policy priorities, solicits proposals, awards funds, and then evaluates vendor implementation. The annual life cycle of BHA community services grants and contracts has five broad steps:

1. **Planning:** Local authorities (which may be a Local Behavioral Health Authority, Core Service Agency, or Local Addictions Authority) send their annual reports and strategic plans to BHA. Informed by local input, BHA prepares the statewide plan, sets annual policy, and allocates resources among grant-funded programs/initiatives.

2. **Solicitation:** BHA defines the scope of work, the deliverables, and the required performance measures to be reported by vendors.

3. **Awards:** BHA awards grants and contracts to local authorities and other vendors to implement dozens of programs and initiatives.

4. **Implementation:** BHA delegates implementation of most community services grants and contracts to local authorities, as outlined in the BHA Manual for Managing the PBHS (2024). A local authority is an agent of the jurisdiction and functions under the Secretary of Health's authority. It is typically both a grantee and a grantor in that it manages its own

sub-vendors. Local authorities report regularly to the state, sending fiscal reports to MDH Finance and programmatic reports to BHA divisions.

5. **Evaluation:** BHA evaluates the specific performance measures reported by vendors and the statewide indicators of behavioral health to prepare for and inform the next cycle of grant planning, solicitations, and awards.

Key characteristics of this annual process are that BHA shares some functions with local authorities, and fiscal and programmatic oversight functions are carried out by different units inside and outside MDH.

Fiscal oversight of grants is fragmented

Fiscal oversight of BHA grants and contracts is split among MDH Finance units, BHA, and the independent OIGH. BHA program managers do not routinely see MDH fiscal reports. MDH Finance and BHA divisions require separate end-of-year reports from vendors that ask for duplicative information.

One grant/contract may include awards for multiple programs/initiatives, and funds for one program/initiative may be awarded across multiple grants/contracts. The MDH budget system does not consistently track funding for programs/initiatives across multiple grants and contracts, making it harder for BHA division directors and program managers to evaluate the cost effectiveness of specific grant-funded programs/initiatives difficult.

OIGH has found repeated instances where MDH Finance either failed to complete the reconciliation process for BHA grants and contracts or completed reconciliation incorrectly.

The MDH *Human Service Agreements Manual* (HSAM) which governs fiscal oversight is out of date. It does not reflect the current MDH organizational structure, the integration of the Mental Hygiene Administration (MHA) and the Alcohol and Drug Abuse Administration (ADAA) into BHA, or the role of the independent OIGH.

Some LBHAs report inconsistent management and oversight by BHA

Some local authorities reported to OPEGA that BHA program monitoring has been inconsistent across BHA divisions in recent years. Local authorities expressed that BHA divisions and specific program monitors have had varying interpretations of how or when BHA should share PBHS management functions with local authorities. Some local authorities believe the inconsistent interpretation of how state and local partners should collaborate has eroded the ability of local authorities to manage the PBHS in their jurisdiction.

The BHA *Manual for Managing the PBHS* outlines four primary roles for local authorities to manage the PBHS at the local level:

1. **Leadership**. Collaborate to develop a comprehensive continuum of behavioral health services for the PBHS at the local level; engage with public and private-sector partners to promote and support behavioral health in the context of whole person health; and, where possible, develop innovative approaches that could be replicated in other jurisdictions.

2. **Management**. Assess, plan, design, and manage needed behavioral health programs and services for the PBHS at the local level, while supporting BHA to carry out statewide initiatives when needed.

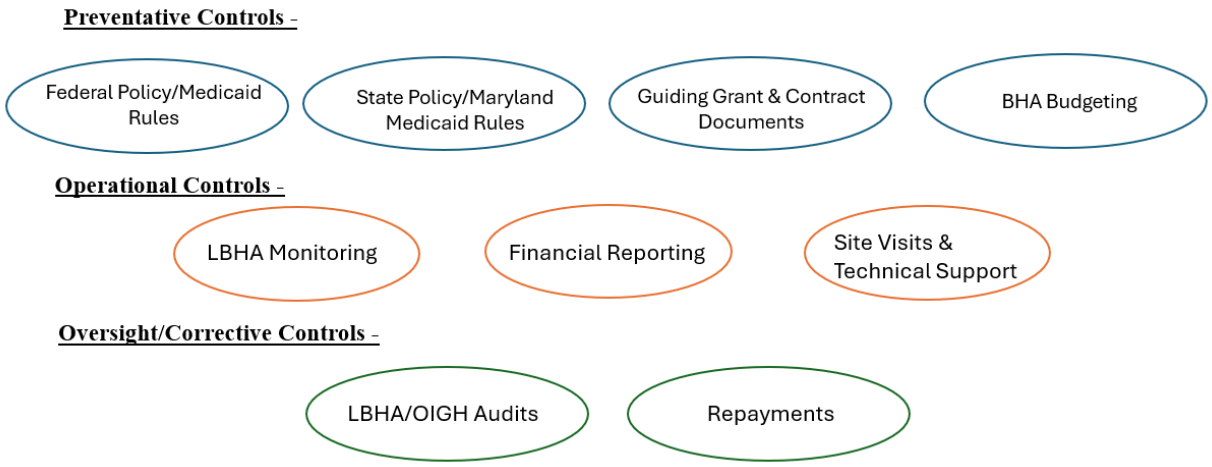
3. **Oversight**. Promote quality within the local system of care and partner with regulating authorities in PBHS, including ASO, to enable compliance with statewide standards at the local level.

4. **Operations**. Be good stewards of public funds by efficiently, equitably, and cost effectively managing operations and administrative functions of the local authority.

BHA has controls in place to prevent improper use of grant funds

BHA has controls in place to prevent improper use of grant funds to pay for services that are reimbursable through insurance or other funding. As shown in **Exhibit 8**, these controls are built into different stages of the grant/contract lifecycle. There are policies at both the federal and state level that prescribe policies and procedures to prevent misuse of funds. These are supplemented by the grant agreements and contracts, as well as the budgeting process at BHA. During the term of the grant/contract local authorities monitor vendors via financial reporting, site visits, and technical supports.

Exhibit 8: Controls on grant spending by BHA



BHA: Behavioral Health Administration
LBHA: Local Behavioral Health Administration
OIGH: Office of the Inspector General for Health

Source: Department of Legislative Services

Performance measure data from grantees focuses on outputs

MDH guidance documents focus on vendor performance measures of outputs and process, which are critical for overseeing if vendors are delivering the services paid for, rather than on outcomes.[2]

[2] Local Health Department Funding System Manual; Human Services Agreements Manual.

The performance measures required in the grant/contract documents OPEGA reviewed typically do not ask vendors to report client-level data to BHA. Realistically, vendors often cannot track longer-term outcomes for the individuals they have directly or indirectly served, such as whether clients who received drug test strips had fewer overdoses than they would have had without the test strips, or whether a caller to the 988 Lifeline was alive 12 months after the call.

In recent years, BHA has required vendors/grantees to collect more performance measures, but local authorities reported that there has been no corresponding funding for the added staff time required for data collection and reporting.

BHA has been developing a Uniform Reporting Form (URF) to more consistently collect and compile performance measures from vendors. Not all performance measures being tracked are currently captured in URF. It is also unclear how BHA uses vendor performance measures data for evaluation or planning. No MFR performance measures for BHA Community Services are based on performance measures from grants and contracts; all are drawn from ASO data on FFS claims (when such data has been available). We observed that since FY 2025, BHA's vendor contracts require more performance measures overall, more measures focused on outcomes, and more frequent data reporting. BHA officials reported they have been working with vendors and local authorities to place greater focus on outcomes. But these efforts have not yet been implemented by BHA long enough to see a clear impact on evaluation or planning. Additionally, some local authorities reported they would like more feedback from BHA about how the new data they have been reporting has yielded insights to inform evaluation and planning.

BHA's capacity to assess outcomes has been disrupted and is in transition

Over the last decade, structural changes to the PBHS, the discontinuation of the OMS in 2020, and two ASO transitions that lost or delayed claims data have disrupted BHS's ability to assess outcomes in a continuous and consistent way. BHA has responded by developing alternative assessment approaches, and those efforts are ongoing.

In 2015, BHA had the following outcome assessment tools:

- A client-level OMS for outpatient mental health services, operational 2006-2020.
- Performance reporting required by grants/contracts, which was still the payment method for most community services.
- A contract with a new ASO which was to provide for outcome-based standards incentivized by damages of up to 0.5% of total contract value if standards were not met.
- An MFR system for reporting performance measure data.

As of April 2026, these tools had been diminished or become unavailable, impacting oversight by both BHA and MGA. Several concurrent changes dismantled tools that once provided useful outcome data.

Since 2015, the erosion of BHA capacity to assess outcomes has had multiple causes:

Moving grant–funded services to a fee-for-service model reduced reporting compliance*.* In 2015, the Department of Legislative Services (DLS) reported to MGA the following: "[…] as the State moves toward the proposed ASO model […] for mental health and substance abuse services, providers are not entering patient data into the [data] system. Further, grant funding was closely tied to reporting [...]. With more individuals having Medicaid coverage, this also appears to be limiting compliance with reporting requirements. This reporting, however, should improve in future fiscal years now that the ASO has taken over for both the payment and reporting structures for substance abuse services."

Outcome-based standards for the first ASO were never implemented. The MDH contract for the first ASO ("ASO #1") required use of outcome-based standards based on Healthcare Effectiveness Data and Information Set measures, incentivized by damages if standards were not met. But DLS reported to MGA that those outcome-based standards were never implemented by ASO #1 and proved unenforceable by MDH.

Two ASO transitions disrupted data availability. BHA and LBHAs used ASO claims data for provider oversight. In 2020, MDH had a problematic transition to a second ASO ("ASO #2"). Among other downstream effects, MDH lost access to key claims data used to measure outcomes and service quality. In a 2020 response to a *Joint Chairmen's Report* request for potential performance measures, MDH proposed 16 possible quality measures, but these could not be implemented because all measures required ASO claims data which was unavailable.

Additionally, until 2020, the ASO #1 gave BHA and local authorities on-demand access to "high-cost consumer" reports used to monitor service costs and quality. After the 2020 ASO transition, these reports were no longer available. Multiple local authority officials identified the loss of these ASO reports as a significant barrier to their ability to monitor service cost and quality.

In 2025, MDH transitioned to a third ASO ("ASO #3") resulting in a new data blackout which continues as of this writing. The 2026 DLS analysis reported to MGA that BHA was unable to submit its standard MFR data measures for FY 2025 due to data quality issues from the ASO #2 to ASO #3 data transfer. Fiscal 2025 actual MFR data was unavailable to MGA during the 2026 legislative session.

MDH discontinued BHA's OMS in 2020. During the challenging transition to ASO #1 OMS had continued to generate evidence of outcomes for outpatient mental health services. MDH discontinued OMS in 2020 over concerns it might violate a federal parity law. No other comprehensive client-level outcome assessment has replaced it. BHA reported to OPEGA that they are building more program–specific systems.

Exhibit 9 shows an example of how OMS-generated data enhanced MGA oversight. The 2018 DLS operating budget analysis reported to MGA that most of the OMS data "for the adult mental health population remains positive with a notable improvement in the net improvement of functioning, which fell dramatically in fiscal 2015 to 4.5%, but has since recovered to 11% in fiscal 2017. Net improvement for children, however, is in its second straight year of decline, down to 13.2%."

In July 2024, MDH launched the current Overdose Data Dashboard which publicly reports data trends for: fatal overdoses; non–fatal opioid overdose–related emergency department visits;

Emergency Medical Service (EMS) naloxone administration encounters; and overdose prevention through distribution of naloxone and drug test strips.

Since 2025, BHA has added performance measures for specific vendors. BHA is now collecting more performance measures through new vendor contract requirements and is standardizing the collection of them through a URF. These vendor requirements, however, generally do not provide client level tracking over time.

Some BHA vendors are developing their own client-level tracking systems Currently, providers, local authorities, and BHA have limited ability to track client-level outcomes over time, a capability lost with discontinuation of OMS. Examples of assessment tools used by various providers and researchers we spoke with include the PHG–9, GAD–7, PSC–17, and DLA–20. None of these, however, are being used by all providers in PBHS.

No stakeholders interviewed by OPEGA advocated for restoring OMS specifically. In general, providers told us they would prefer successor assessment tools that are as streamlined as possible, allow insight into client functional outcomes, and allow for tracking client-level outcomes at the clinician, provider organization, county, and state levels. Some vendors are developing their own in-house data warehouse systems to monitor clients, with client permission, to offer support or services if the client has a crisis. These efforts are not standardized or used by BHA or local authorities.

Exhibit 9: Example of OMS data used by DLS in 2018

Outcome Measurement System Data
Fiscal 2013-2017

	Reported in 2013	Reported in 2014	Reported in 2015	Reported in 2016	Reported in 2017
Adult Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.3%	14.4%	4.5%	8.1%	11.0%
Increase in Employment Between Observations	-0.1%	0.4%	-1.5%	-0.6%	0.3%
Persons Unemployed in Both Observations	63.1%	61.5%	59.9%	59.5%	57.8%
Homelessness in Both Observations	5.0%	4.7%	4.6%	3.7%	3.5%
Children and Adolescents Mental Health Outcomes					
Net Improvement in Functioning (Percent of Total Observations)	14.1%	14.6%	14.6%	13.7%	13.2%

Source: Maryland Department of Health

Source: Department of Legislative Services

BHA faces several challenges in measuring outcomes of grant-funded programs

BHA administers a wide range of grant-funded programs for different purposes and for serving different populations. Measuring whether a given program has produced a desired outcome (such as fewer suicides, fewer overdoses, or less stigma around certain treatments) is difficult for the following reasons.

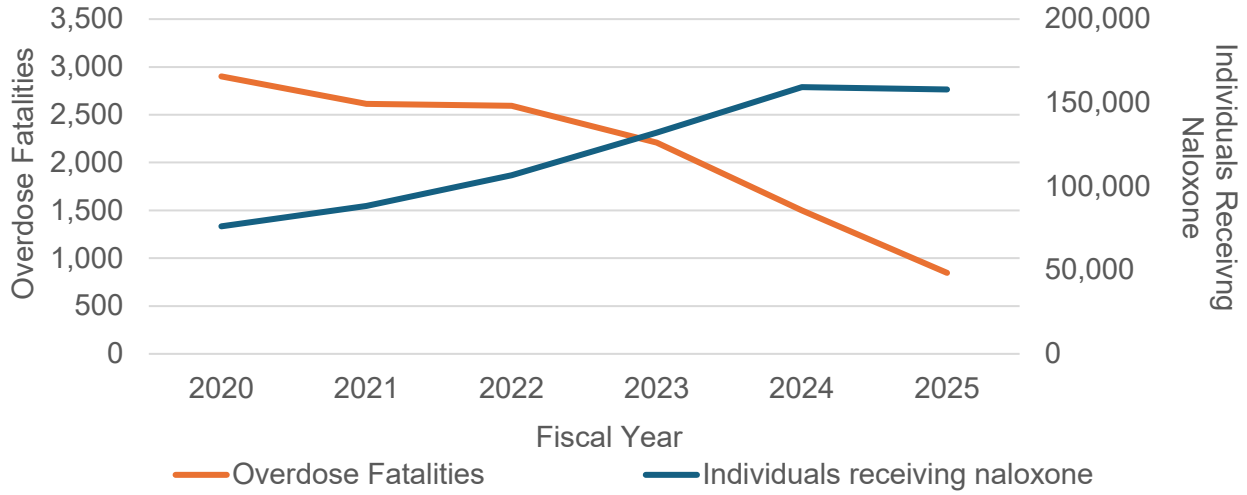
Some grant-funded programs are not designed to generate client-level data. Unlike FFS treatment, where an individual claim is produced as a byproduct of billing, many grant-funded programs deliver services that are broadly accessible, low-barrier, or anonymous. These features can help reach people but they can also preclude tracking outcomes for individual participants. As examples, callers to the 988 Lifeline can remain anonymous, and collecting identifying information for harm reduction services could discourage participation. Other grants fund prevention or public awareness and are not intended to collect individual-level data. As a result, BHA often has fewer opportunities to link grant-funded services directly to client-level outcomes.

Some programs could collect outcome data on an ongoing basis but have not been set up to do so. For example, over the 2020-2025 period, BHA funded grants to expand the number of inpatient psychiatric and specialized inpatient beds available and reduce wait times. MDH operates a Hospital Care Coordination Dashboard which posts inpatient psychiatric and specialized inpatient bed availability. Hospitals update the registry three times per day. As this data dashboard is currently designed, however, it cannot be used as a source of historical data to determine changes in bed availability and wait times for people seeking urgent behavioral health care.

Even where client-level outcome data exists, it is hard to determine whether (or how much) to attribute a change in outcomes to a specific program or level of funding. Behavioral health outcomes are shaped by many factors, including housing stability, poverty, the prevalence of mental health conditions, changes in the illicit drug supply, and others. Individuals also commonly receive services from multiple sources at once or over time, such as grant-funded programs, FFS treatment, and programs funded by entities outside BHA. Isolating the contribution of one grant-funded program to any individual- or population-level trend is therefore a challenge.

For example, as shown in **Exhibit 10**, between FY 2020 and FY 2025, naloxone distribution increased and overdose deaths declined in Maryland, which is consistent with the goals of BHA's harm reduction programs, but collected data cannot show how much the distribution of naloxone contributed to the overdose decline.

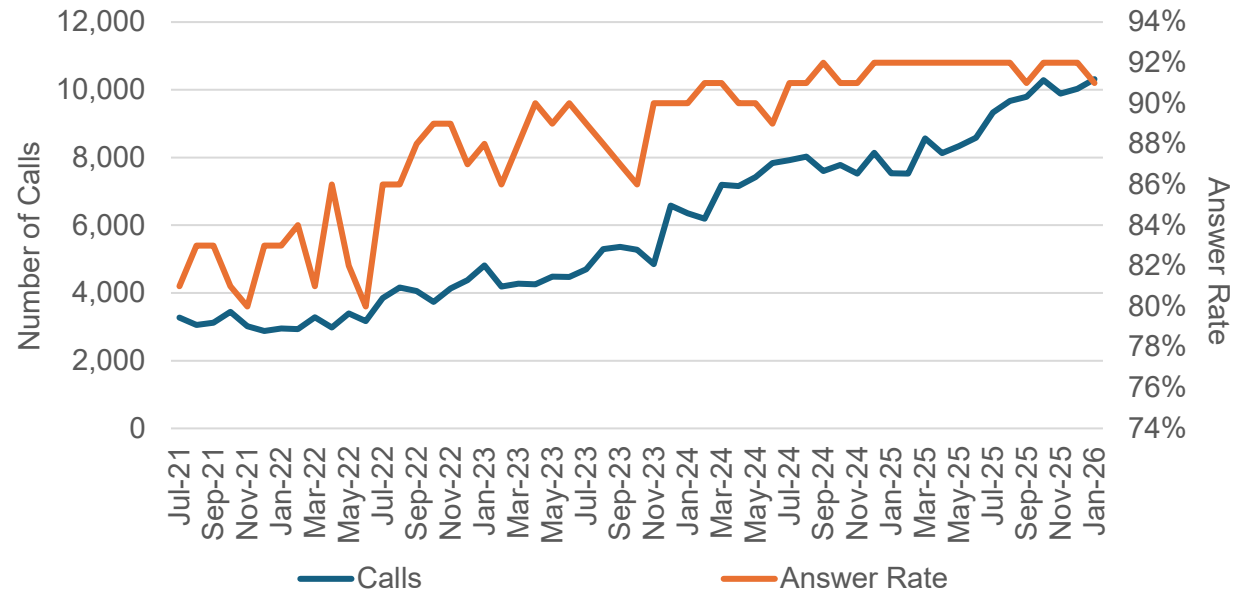
Exhibit 10: Fatal drug overdoses and naloxone distribution



Note: Distribution refers to the number of individuals receiving naloxone, as reported by MDH.
Source: Maryland Department of Health; Department of Legislative Services

As another example, the 988 Suicide & Crisis Lifeline provides 24/7, free and confidential support via call, text, or chat for individuals experiencing mental health, substance use, and/or suicidal crises. BHA spending on 988 grants grew from roughly $200,000 in FY 2022 to more than $15 million in FY 2025. As shown in **Exhibit 11,** from July 2021 to January 2026, monthly call volume more than tripled and the answer rate improved. At the same time, suicide rates remained steady. These concurrent trends cannot, however, establish how much, if any, of the suicide rate or other behavioral health outcomes of callers is attributable to 988 grants.

Exhibit 11: 988 call volume and in-state answer rates



Source: 988 Lifeline; Department of Legislative Services

More recent BHA-required vendor performance measures put more emphasis on outcomes, but data is not yet available.

For example, a comparison of the FY 25 and FY 26 awards to the Harford Co. CSA for mobile crisis services shows that the FY 26 award contains clearer and more specific performance measures with more emphasis on outcomes. However, these new performance measures have not yet been implemented long enough to generate data for planning or evaluation purposes.

Because of these challenges, measures of output (such as services delivered) rather than measures of outcome (such as suicide or overdose rates) are often the main basis for assessing grant-funded programs.

Recommendations

BHA should consider collecting more individual-level outcomes data on individuals receiving grant-funded services.

Over the last decade, BHA has experienced disruptions in its capacity to assess outcomes, driven by discontinuation of BHA's OMS and two problematic ASO transitions, resulting in less data for oversight previously available to BHA, local authorities, and MGA. While BHA generally does not collect client-level outcome data on individuals receiving grant-funded services, BHA has reported that it has begun collecting more of such data for crisis services. Collecting more individual-level outcomes focused data can improve BHA's ability to assess the impact of grant-funded services.

BHA and MDH Finance should streamline end-of-year vendor reporting to avoid redundant requirements.

Fiscal oversight of BHA grants and contracts is fragmented, vendors must report performance measures to both BHA and MDH Finance, and BHA program managers do not routinely see fiscal reports from other MDH units or OIGH.

The MDH budget system should be revised to enable BHA divisions to consistently track spending on programs/initiatives across multiple grants and contracts.

The MDH budget system is vendor-based and does not consistently track programs or initiatives across multiple grants and contracts, making it difficult for BHA division directors and program managers to evaluate the cost effectiveness of grant-funded programs/initiatives.

To promote consistent oversight, BHA should conduct joint training with BHA and local authority staff to clarify how BHA delegates oversight functions to local authorities.

Some LBHAs report inconsistent programmatic oversight across BHA divisions, with varying interpretations of the delegated PBHS management functions described in the *Manual for Managing the PBHS*. To promote consistent oversight, BHA should conduct joint refresher training with BHA and local authority staff based on the *Manual for Managing the PBHS* (or an updated version revised in consultation with local authorities), with the opportunity to discuss perceived ambiguities in delegated authorities.

MDH should update HSAM to reflect the current organizational structure, BHA integration, and OIGH role.

MDH HSAM which governs fiscal oversight is out of date. It does not reflect the current MDH organizational structure, the integration of MHA and ADAA into BHA, or the role of the independent OIGH.

BHA should store and analyze current data on behavioral health crisis beds.

MDH now has a Hospital Care Coordination Dashboard that monitors inpatient psychiatric and specialized inpatient bed availability in near real time. BHA should consider storing and periodically analyzing this data to assess trends in bed availability and regional needs.

Appendix A.
Response from the Maryland Department of Health

Behavioral Health Administration

Response to the Office of Program Evaluation and Government Accountability (OPEGA) Audit

Office of Program Evaluation and Government Accountability Audit Recommendations

1. **BHA [the Behavioral Health Administration] should consider collecting more individual-level outcomes data on individuals receiving grant-funded services.**

BHA agrees with this recommendation. Collecting individual-level outcomes data strengthens the Administration's ability to assess the effectiveness and value of grant-funded services and supports continuous quality improvement. To advance this objective, BHA has made significant investments in expanding client-level data collection and reporting across several priority service areas.

As noted in the report, BHA has implemented client-level data collection for the 988 Suicide & Crisis Lifeline and Mobile Crisis Response and Stabilization services These systems include client and program-level outcome measures as well as automated dashboards that support ongoing performance monitoring, program management, and quality improvement. In addition, BHA has developed and implemented a comprehensive data collection and reporting system for the State Opioid Response (SOR IV) Grant, the Administration's largest grant-funded program. This system captures monthly program performance data from all SOR-funded providers and collects client-level information through the SAMHSA Uniform Performance Reporting Tool (SUPRT), including client demographics, diagnostic and service indicators, and outcome measures. The reporting platform includes automated dashboards that enable BHA program staff and monitors to routinely assess program performance, compliance, and client outcomes.

Beyond these existing initiatives, BHA will continue to prioritize expansion of client-level outcomes reporting in programs where it is most feasible, impactful, and aligned with federal and State reporting requirements in FY27. Specifically, BHA plans to implement a client-level data collection and reporting system for the Assisted Outpatient Treatment (AOT) program in FY27. Drawing on lessons learned from this and other existing BHA reporting systems, BHA will evaluate opportunities to extend client-level reporting to additional grant-funded programs where feasible in FY28. BHA is committed to enhancing data infrastructure and reporting tools to improve analysis and performance monitoring; standardizing outcome measures across programs where appropriate; and working with grantees to strengthen data collection processes and reporting capabilities.

2. **BHA and MDH Finance should streamline end-of-year vendor reporting to avoid redundant requirements.**

BHA agrees with this recommendation. BHA has been working to streamline end-of-year vendor reporting across its program and fiscal teams. Currently, local authorities submit their end-of-year fiscal reporting to the Maryland Department of Health (MDH) Finance rather than directly to BHA, which can create inefficiencies in the reporting and review process.

As part of its efforts to improve this process, BHA convened a workgroup with several local authorities, hosted two BHA/LBHA Office Hours, and conducted eight individual meetings with local health departments (LHDs) to better understand their reporting and expenditure processes and identify opportunities for improvement.

BHA plans to further streamline reporting in FY27 in alignment with this recommendation. In response to feedback elicited directly from local authorities through the workgroup, Office Hours, and meetings, BHA will issue guidance directing local authorities to submit their end-of-year fiscal reports directly to BHA concurrently with their submission to MDH Finance. This change will streamline the reporting process, improve the timeliness of financial oversight, and eliminate the need for separate requests for the same information.

3. **The MDH budget system should be revised to enable BHA divisions to consistently track spending on programs/initiatives across multiple grants and contracts.**

While BHA and MDH operate within the broader Maryland State Budget System, BHA agrees with the value of consistent tracking of spending on programs/initiatives across multiple grants and contracts; and is committed to exploring ways to improve its grant framework to allow each BHA division to consistently track program expenditures within its dedicated service areas.

In FY25, BHA introduced the Universal Reporting Form (URF) to establish standardized collection of baseline program-level information and ensure consistent monitoring of contractual, financial, and service delivery requirements across grant-funded programs. Following an internal assessment of the URF process, BHA initiated a significant modernization effort by transitioning from an Excel-based reporting process to a web-based Qualtrics platform. This enhanced system will improve data quality and performance monitoring through automated validation, standardized reporting, and real-time notifications for missing or out-of-range data. BHA has already demonstrated the effectiveness of this approach through successful implementation within the Urgent and Acute Care Divisions and the State Opioid Response Grant. In FY27, BHA will expand use of this enhanced Qualtrics platform to additional grant-funded programs, and will continue to refine this system based on feedback and lessons learned from staff.

4. **To promote consistent oversight, BHA should conduct joint training with BHA and local authority staff to clarify how BHA delegates oversight functions to local authorities.**

BHA agrees with this recommendation and recognizes the importance of clearly defining roles and responsibilities, standardizing processes where appropriate, and providing comprehensive staff training to promote consistent grant and contract oversight. As part of these efforts, training and guidance should clearly distinguish the respective responsibilities of BHA and the State's Local Authorities. Local Authorities are responsible for the oversight of their service provider grants, while BHA provides statewide oversight and management of grants awarded to the Local Authorities.

BHA supports standardizing programmatic oversight across divisions wherever feasible and views existing resources, including the *Manual for Managing the Public Behavioral Health System (PBHS)*, as a strong foundation for clarifying roles, responsibilities, and oversight expectations. To advance internal consistency, BHA established an SOP Development Committee in SFY26 and, in SFY27, developed a standardized template to guide the creation of standard operating procedures across all divisions, with an initial focus on grant and contract management. These efforts will strengthen administrative consistency, improve coordination across programs, and establish a common framework for oversight activities.

At the same time, BHA recognizes that some variation in oversight is appropriate based on program design and funding requirements. While consistent oversight principles should apply across programs, certain high-intensity services, such as Assertive Community Treatment, or programs operating under specific federal requirements may require specialized monitoring approaches that differ from a single standardized model.

These standardization and modernization efforts build upon BHA's broader work over the past year to strengthen engagement and collaboration with Local Behavioral Health Authorities and other local partners. In FY27, BHA will utilize current recurring forums (LBHA Directors' Roundtables, BHA/LBHA Office Hours, etc) to conduct joint trainings with local authority staff to further clarify how BHA delegates oversight functions, in addition to continuing to use these forums to share legislative and regulatory updates, discuss performance data and emerging trends, and incorporate feedback from local partners to continuously improve oversight processes and program administration.

5. **MDH should update HSAM to reflect the current organizational structure, BHA integration, and OIGH role.**

BHA agrees that updating the Human Services Agreement Manual (HSAM) is important to ensure it accurately reflects the current organizational structure, clarifies roles and responsibilities, and incorporates other necessary revisions.

Because the HSAM establishes policies and procedures that apply across the Maryland Department of Health (MDH), any revisions require department-wide coordination. The manual is maintained under the oversight of the Division of Cost Accounting and Receivables) (DCAR), which is outside of BHA. MDH will work with the Office of Audits and OIGH (an independent agency) to make these updates to the manual.

6. **BHA should store and analyze current data on behavioral health crisis beds.**

BHA concurs with the value and need to store and analyze current data on behavioral health crisis beds. BHA is currently implementing this recommendation through the development of **Maryland Behavioral Health Connect**, a statewide bed registry and referral platform. The system will provide real-time information on the availability of inpatient psychiatric and crisis beds, support referrals across the behavioral health system, and generate data to monitor bed capacity, availability, utilization, and patient flow. For FY2027, BHA's anticipated progress steps on this multi-year project includes establishment of a provider service directory and enrollment of hospital providers in the registry platform.