SCOPING EVALUATION OF THE SOCIAL SERVICES ADMINISTRATION

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OFFICE OF PROGRAM EVALUATION AND GOVERNMENT ACCOUNTABILITY

DEPARTMENT OF LEGISLATIVE SERVICES

MARYLAND GENERAL ASSEMBLY

Scoping Evaluation of the Social Services Administration

Department of Legislative Services
Office of Program Evaluation and Government Accountability
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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF PROGRAM EVALUATION AND
GOVERNMENT ACCOUNTABILITY
MARYLAND GENERAL ASSEMBLY

January 13, 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 Joint Audit and Evaluation Committee, the Office of Program Evaluation and Government Accountability conducted a scoping evaluation of the Social Services Administration (SSA), in the Department of Human Services. This evaluation examines foster care, including foster children who had been staying in hotels.

The report does not contain any recommendations. SSA's response is Appendix A.

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

Respectfully submitted,

Michael Powell
Director

MP/mpd

Contents

Chapter 1. Introduction

The Maryland General Assembly's Joint Audit and Evaluation Committee directed the Office of Program Evaluation and Government Accountability (OPEGA) to conduct a scoping evaluation of the Maryland Department of Human Services' (DHS) Social Services Administration (SSA). SSA is the agency that sets the vision, practice, and policy for child and family well-being and adult services across the state of Maryland. The services are administered by 24 local departments of social services (LDSS).

This evaluation was initiated in response to heightened legislative concern for the State's oversight of children in the foster care system, specifically, the usage of hotels to house children in foster care. To explore these concerns and better understand the associated oversight structure and reporting mechanisms:

- DHS granted OPEGA access to the Child, Juvenile, and Adult Management System (CJAMS), Maryland's statewide case management platform for child welfare;

- DHS provided OPEGA with a list of 45 children housed in hotels at any time between June 1, 2025, and August 31, 2025. This list was provided for research purposes and was not validated by OPEGA. OPEGA randomly sampled 21 of the 45 children to review case information in CJAMS; and

- OPEGA conducted interviews with DHS and SSA leadership as well as several LDSS staff.

The following scoping evaluation identifies preliminary observations and highlights areas that may warrant further evaluation.

Chapter 2. Foster Children in Hotels

Observation: Other states have housed foster children in hotels.

Stays in hotels are not considered placements, but the use of hotels, hospitals, and offices to house foster children is not unique to Maryland. In recent years at least six states have been sued for reasons related to housing foster children in hotels. Many of the judicial decisions or settlement agreements have aimed to reduce or eliminate the housing of foster children in hotels.

Observation: Most of the foster children living in hotels had a history of Child Protective Services involvement.

Out of the 21 children in Office of Program Evaluation and Government Accountability's (OPEGA) sample, 18 had at least one Child Protective Services (CPS) case documented in the Child, Juvenile, and Adult Management System (CJAMS). Maltreatment reported to CPS[1] may include neglect, physical abuse, or sexual abuse. In some cases, a report may identify multiple forms of maltreatment. When a report is made to CPS, the local departments of social services (LDSS) will screen the allegation to determine whether the legal criteria has been met for child maltreatment. According to the Department of Human Services (DHS), screened-in reports are assigned by a supervisor to one of two response pathways.

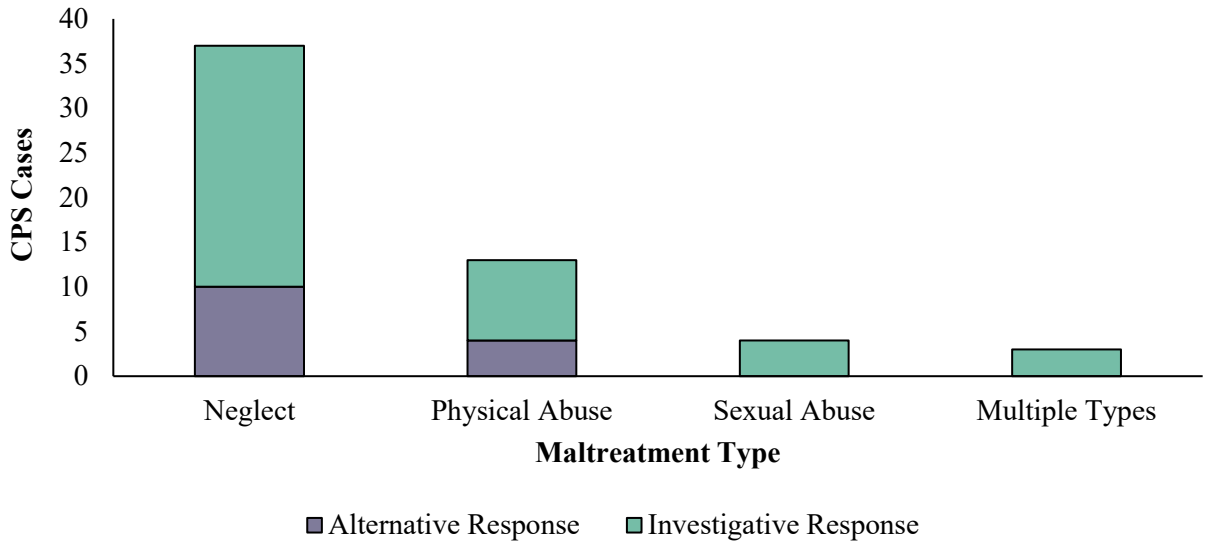
- Alternative Response: Used for lower-risk cases focused on family assessment and support, no formal "finding" of abuse or neglect is made.

- Investigative Response: Used for higher-risk allegations requiring a traditional investigation, this pathway results in a formal "finding" regarding abuse or neglect.

Exhibit 2.1 shows all CPS cases that were screened and reported in CJAMS for the 21 children in OPEGA's sample.

[1] CPS is a service of DHS that assists children believed to be abused or neglected by parents or guardians.

Exhibit 2.1
CPS Case Types and Responses



CPS: Child Protective Services

Note: Multiple Types include cases with more than one type of maltreatment listed: one case of Physical Abuse and Neglect, one case of Physical Abuse and Sexual Abuse, and one case of Neglect and Sexual Abuse.

Source: Department of Human Services; Department of Legislative Services

Children in OPEGA's sample had anywhere from zero to seven CPS cases screened in over the course of their history in CJAMS. In total, 37 reports of neglect were filed for 16 children. Additionally, 13 reports of physical abuse were filed for 9 children, 4 reports of sexual abuse were filed for 3 children, and 3 reports involving multiple types of maltreatment were filed for 2 children. The 3 children in the sample with no CPS history entered foster care after their guardians were unable to meet their needs, prompting the court to issue a Child in Need of Assistance determination and place them in LDSS custody.

CPS provided an Investigative Response for most neglect and physical abuse reports, and for all reports of sexual abuse or multiple types of maltreatment. These investigations did not always confirm abuse or neglect; some were ruled out or found to be unsubstantiated.

Observation: Nearly all foster children who stayed in hotels had experienced at least one placement in a higher-level care setting.

CJAMS maintains a placement history for each child that may include both legally recognized placement settings and nonlegally recognized statuses, such as hotel stays or periods

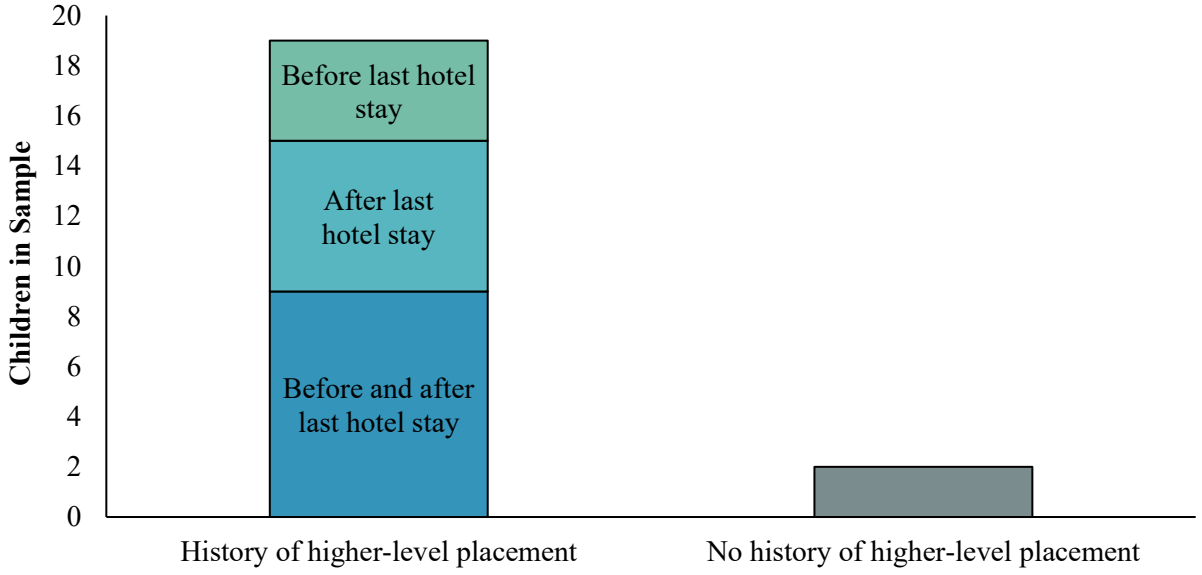
when a child is designated as a runaway. Children in OPEGA's sample had an average of nine separate placements recorded in their CJAMS placement history.

Many of the children in the sample presented behavioral or mental health needs that exceeded what could be supported in a traditional foster care home. As a result, these children were placed in settings designed to accommodate more complex needs or received psychiatric emergency or inpatient care. These higher-level placements included:

- treatment foster care;
- therapeutic group homes; and
- residential treatment centers.

Exhibit 2.2 shows how many children in the sample had at least one higher-level placement and whether those placements occurred before or after their last hotel stay.

Exhibit 2.2
Use of Higher-level Placement Before and After Last Hotel Stay



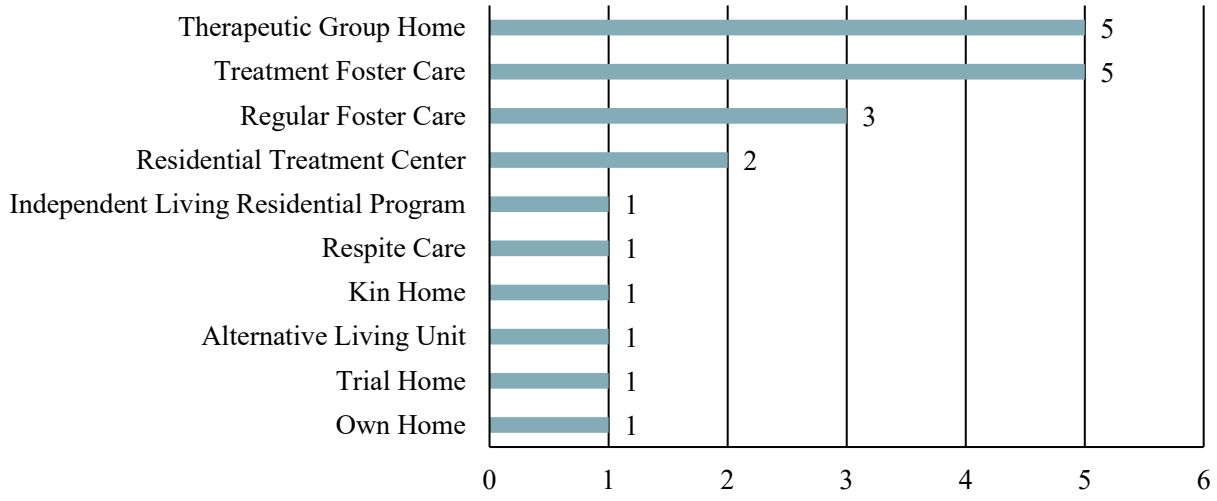
Source: Department of Human Services; Department of Legislative Services

Nineteen of the 21 children in the sample (about 90%) experienced at least one placement in one of these higher-level settings. About one-third (7) of the children spent some time in a

psychiatric emergency room or inpatient facility; 2 children spent over 300 days in this setting. Fifteen of the 21 children (71%) had a higher-level placement after their most recent hotel stay.

Exhibit 2.3 shows where the children in the sample were placed as of December 3, 2025.

Exhibit 2.3
Children's Placement Type as of December 3, 2025



Source: Department of Human Services; Department of Legislative Services

As of December 3, 2025, approximately half of the children in the sample were placed in therapeutic group homes or treatment foster care. Three children were placed in regular foster care, while the rest were distributed across a variety of other placement settings.

Observation: Of the last seven children to leave hotels for placements, three already have new placements.

Exhibit 2.4 shows a synopsis of CJAMS case notes on the seven youth who left their hotel stay after October 1, 2025.

Exhibit 2.4
Case Notes on Select Youth Who Left Hotels

Synopsis
End date of last hotel stay: October 14, 2025 • A 15-year-old child who had been in foster care since they were age 8. They had several living arrangements including fictive kinship[2] care, treatment foster care, respite care, residential group homes, inpatient psychiatric care, regular foster care, trial home visits, and hotels. • Upon leaving the hotel they were placed in treatment foster care, from which they ran away after a month. They were later placed in regular foster care.
End date of last hotel stay: October 21, 2025 • A 12-year-old child who had been in foster care since they were age nine. They spent two months in a therapeutic group home before returning to live at home. A year and a half later they were again removed from their home and lived in a hotel with one-to-one[3] staff. They were assigned two staff at a time due to their special needs. • After six months in a hotel they were placed in a therapeutic group home.
End date of last hotel stay: October 28, 2025 • An 18-year-old child who had been in foster care since they were age 12. They had 14 different living arrangements, including inpatient psychiatric care, residential group homes, intermediate foster care, treatment foster care, therapeutic group homes, and hotels. • Upon leaving the hotel they were placed in an independent living residential program. They lost their one-to-one services because the program did not allow the one-to-one staff to stay with the child.
End date of last hotel stay: October 16, 2025 • A 17-year-old child who had been in foster care for a little over a year. In that year their living arrangements included hotels, therapeutic group homes, juvenile detention, and residential group homes. They were documented as running away twice. • Upon leaving the hotel they were placed in a therapeutic group home.
End date of last hotel stay: October 1, 2025 • A 14-year-old child who entered foster care less than a year ago. They had a number of living arrangements including therapeutic group homes, kinship care, fictive kinship care, regular foster care, hotels, and a homeless shelter. • Upon leaving the hotel they were placed in fictive kinship care but ran away after a day. They lived for over two weeks in a homeless shelter in their own room with their one-to-one staff. Subsequently, they were placed in a therapeutic group home.

[2] Fictive kin are considered relatives but are not related by blood or marriage. In 2024 the definition of kinship care was amended to include fictive kin.

[3] One-to-one staff are people paid to provide individualized supplemental care and supervision to foster children.

Synopsis
End date of last hotel stay: November 6, 2025 • A 16-year-old child who had been in foster care for over a year. They had a number of living arrangements including hotels, therapeutic group homes, and fictive kinship care. They were documented as a runaway eight times. • Upon leaving the hotel they were placed in treatment foster care.
End date of last hotel stay: October 16, 2025 • A 15-year-old child who entered foster care over four years ago. They had a number of living arrangements including inpatient psychiatric care, therapeutic group homes, emergency foster care, regular foster care, respite care, residential group homes, and hotels. • They left the hotel and spent the night in a psychiatric emergency room. Upon discharge they spent almost two weeks at their parent's home before they were placed in regular foster care.

Observation: Hotel stays lasted anywhere from a day to over a year.

Hotels are not included among the licensed placement types authorized for out-of-home care under Maryland regulations. As a result, hotel stays are not considered formal foster care placements but are instead designated as living arrangements in CJAMS placement histories.

Most of the children in our sample were limited to one hotel stay; however, the duration of that one stay ranged from only 1 day in some cases to as many as 433 days. Eight children had more than one hotel stay. One child had three hotel stays with a cumulative total of 462 days. The children in OPEGA's sample stayed in hotels for different reasons, some of which were likely beyond the ability of DHS to prevent.

Observation: Foster children ended up in hotels for a variety of reasons.

Exhibit 2.5 shows some examples of what led to children living in hotels. This is based on a selection of children who had been living in a hotel at some point in summer 2025.

Exhibit 2.5
Examples of What Led to Children Living in Hotels

Synopsis
Summer 2024,[4] a 14-year-old child ended up staying in a hotel with one-to-one staff after they were removed from two different foster homes for assaulting the foster parents. During their months-long stay in the hotel they assaulted their one-to-one workers on multiple occasions and had multiple admissions to psychiatric hospitals. Spring 2025, they were placed in a therapeutic

[4] Records do not indicate this child lived in a hotel the summer of 2025, and it is unclear why DHS included them.

Synopsis
group home with a part-time one-to-one. Within a few months the home asked the LDSS to find another placement because their violent outbursts made staff feel unsafe. They were placed in a residential treatment center.
Summer 2025, a 15-year-old child spent one night in a hotel with their siblings after the court ordered them removed because living at home was contrary to the children's welfare. After that one night they were placed in a nearby family foster home with their siblings.
Summer 2025, a 5-year-old child spent a few nights in a hotel with their fictive kinship foster parent and their three siblings. The foster parent was changing residences, and there was a brief gap between the expiration of their lease and start of a new one. The LDSS arranged for a hotel for the family but later were told it was unnecessary. Later, the LDSS learned the foster parent had moved the whole family into a hotel. The child was later placed in a foster home with one sibling but was removed for their behavior. Their sibling was not removed. They were placed in another foster home without any siblings but were removed for their behavior. Most recently they were placed in a foster home in a different part of the State.
Summer 2023, a 16-year-old child ended up staying in a hotel with one-to-one staff after their guardian was hospitalized for mental health reasons. The guardian was no longer open to the child living in their home. In the prior two years the child had multiple placements for inpatient psychiatric treatment, including multiple out-of-state placements. Their initial placement ended because the treatment center closed. After around six months in the hotel, during which time they assaulted their one-to-one staff and were taken to psychiatric hospitals on multiple occasions, they were placed in an out-of-state treatment center. Less than a year later the center notified the LDSS that they needed to pick up the child within 48 hours due to the center's licensing issues. Fall 2024, after having to leave the out-of-state treatment center, the child ended up living in a hotel with one-to-one staff. The child did not want to live in a group home. Summer 2025, the child, now 18, was ordered by the court to apply for a "transition-aged youth" (TAY) bed. During a seven-day trial period in the TAY bed the child was removed at the request of the program due to their attitude and refusal to engage. Most recently the child was homeless, occasionally staying in shelters, with unknown people, and with their former guardian.
Summer 2025, a 16-year-old child with special needs ended up staying in a hotel with one-to-one staff. They actually had two one-to-one staff at all times due to their special needs. The court had ordered them removed from their home because their parent was unable to keep them safe. The LDSS was unable to find an appropriate placement. Within a month they were placed in a residential home for people with disabilities.

Observation: DHS ended the use of hotel stays for children in foster care on October 22, 2025.

DHS issued a memo on the use of unlicensed settings (*e.g.*, hotels, motels, office buildings) on October 22, 2025. The memo directed all LDSS to:

- immediately stop facilitating stays in unlicensed settings for children experiencing out-of-home care; and

- move all children currently in a hotel stay to a placement appropriate to their needs no later than November 24, 2025.

DHS stated in the memo that unlicensed settings are not in a child's best interest and that temporarily placing children in such settings is inconsistent with State and federal law, as well as departmental standards and policies.

No youth in the OPEGA sample were moved into a hotel after October 8, 2025, and all youth were removed from their hotel stay by November 6, 2025.

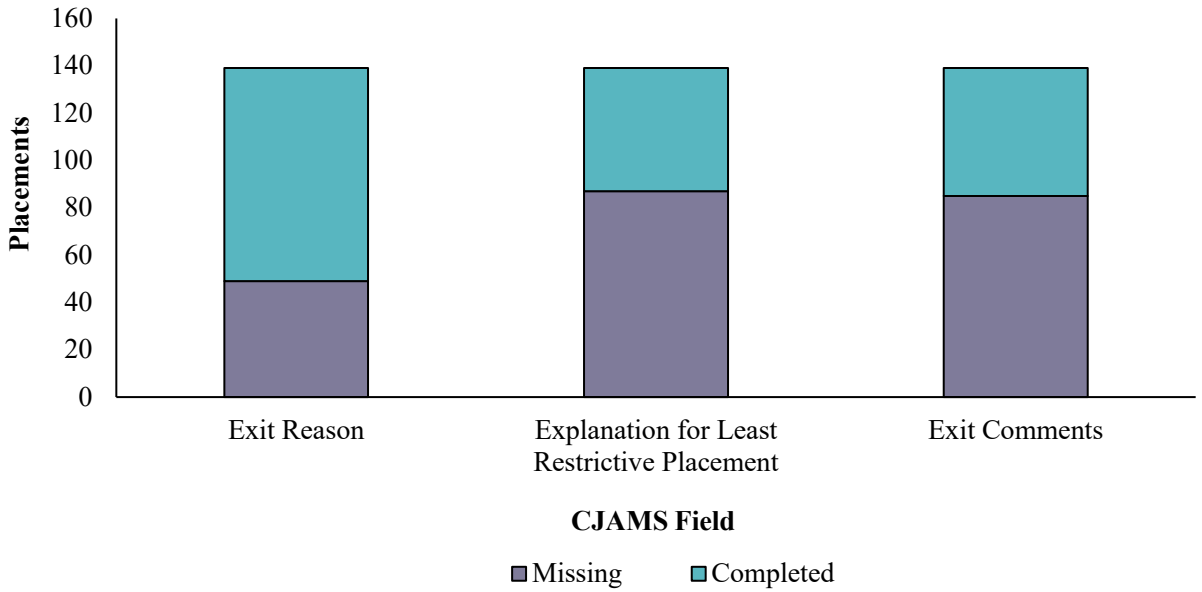
Observation: Placement histories in CJAMS frequently lacked required details and rationale.

CJAMS captures a wide range of information. For this analysis, OPEGA mainly looked at placement, CPS, and medical histories, as well as caseworker notes. There are many fields that capture the same information in CJAMS. The Social Services Administration (SSA) provides caseworkers with how-to guides to help them enter information correctly. These guides are updated whenever CJAMS is revised.

Placement histories provide a detailed record of a child's whereabouts throughout their time in DHS custody. Each time a placement begins the caseworker should describe why that placement is the least restrictive for the child's needs (COMAR 07.02.11), and each time a placement ends, the caseworker should document an exit reason.

Exhibit 2.6 compares the number of missing and completed fields for Exit Reasons, Explanations for Least Restrictive Placements, and Exit Comments for placements in OPEGA's sample.

Exhibit 2.6
CJAMS Placement History Fields for Children in OPEGA's Sample
September 2022 to December 2025



CJAMS: Child, Juvenile, and Adult Management System
OPEGA: Office of Program Evaluation and Government Accountability

Source: Department of Human Services; Department of Legislative Services

Placements beginning before September 2022 were excluded due to changes in the SSA how-to guide requiring explanations for least restrictive placements. Active placements were also excluded because they do not have exit reasons. An exit reason was missing for 35% of the placements in this sample. Exit comments, which are intended to supplement the exit reason, were also frequently missing.

Explanations in the "least restrictive placement" field were often missing. When the field was completed, the content often duplicated the exit reason or exit comment rather than providing a rationale for why the placement was appropriate for the child. According to SSA's how-to guides, completion of the least restrictive placement field is required for provider placements. In contrast, this requirement is not mandatory for placements classified as Living Arrangements – such as hotels, psychiatric emergency rooms, inpatient psychiatric hospitals, respite care, relative or fictive kin homes, and trial visit homes.

Information explaining why a placement ended or why a child required a higher level of care was sometimes found in other sections of CJAMS outside of Placement History. LDSS staff

noted that the explanation for a least restrictive placement is required but may instead appear in a child's permanency plan. Additionally, contact notes sometimes described the challenges caseworkers face in placing children with complex needs, providing further context for why certain placements ended and why children were moved to higher-level care settings.

Observation: Case workers update health records twice; for a paper file, and for an electronic file.

LDSS staff reported that the data entry requirements for health information place a burden on caseworkers, contributing to an increase in the number of hours spent on data entry outside of regular working hours. This process is said to be especially time-consuming for children with extensive medical histories, as caseworkers must re-enter certain health records when a placement changes.

Initially, caseworkers complete a written health passport for the child upon their first placement, ensuring that carbon copies are made for both the foster care provider and LDSS. The foster care provider is responsible for retaining their copy and returning it to the caseworker when the child leaves the provider's home or facility. The health passport must remain with the child wherever they are placed throughout their time in the foster care system. Each time the child is moved to a new placement, and there is a change in medical provider, the caseworker must update the health passport by transferring any changes from FORM 631-A to a new form, ensuring both previous and new information are accurately recorded.

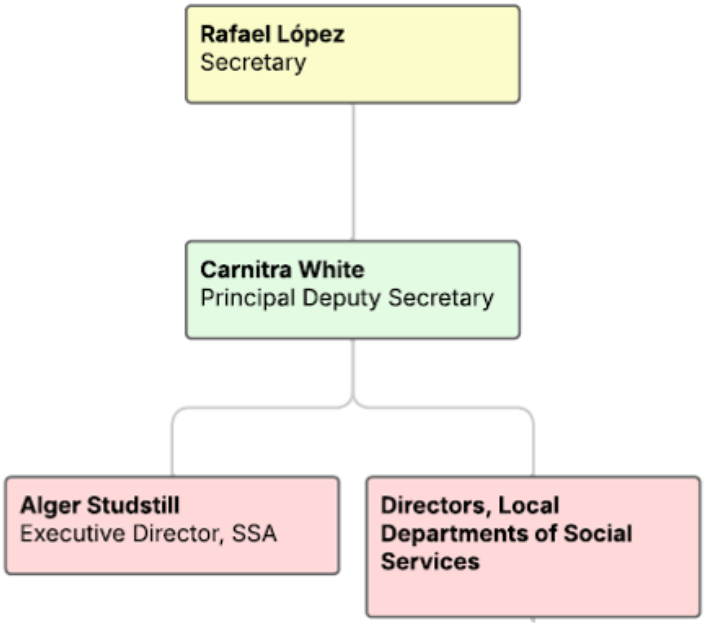
CJAMS includes a medical history section that captures much of the same information captured in the written health passport. The fields include developmental status, prenatal history, hospitalizations, immunizations, family history, current health providers, chronic conditions, medications, allergies, special needs, and more. Whenever new medical information becomes available, the caseworker is expected to update both the paper copy and the online health passport.

Chapter 3. Communication and Authority

Observation: The Social Services Administration (SSA) monitors the local departments of social services (LDSS) operations; both SSA and the LDSS are part of the Department of Human Services (DHS).

The 24 LDSS are the local arms that administer the day-to-day social service operations under State supervision. LDSS directors report to the Secretary of Human Services, and the Principal Deputy Secretary as designee. During our discussions with four LDSS directors, they all demonstrated a clear understanding of the DHS chain of command and who they report to – the DHS Principal Deputy Secretary. **Exhibit 3.1** is a snapshot of a DHS Organizational Chart that depicts this relationship.

Exhibit 3.1
DHS, SSA, LDSS Organizational Framework



Note: The Montgomery County LDSS Director is a direct report to the DHS Secretary, and reports to the Montgomery County Director of Health and Human Services.

DHS: Department of Human Services
LDSS: local departments of social services
SSA: Social Services Administration

Source: Department of Human Services

An LDSS director can be removed from office with the concurrence of the DHS Secretary and the appropriate level local executive authority. Since February 2023, two LDSS directors have been removed, and each action was taken with the concurrence of both the DHS Secretary and the respective local executive authority.

During fiscal 2025, the DHS Principal Deputy Secretary conducted performance evaluations for all 24 LDSS directors, of which 83% received a satisfactory rating and 17% received an outstanding rating. The average rating of the LDSS directors was 2.5 (satisfactory) on a 3.0 (outstanding) to 1.0 (unsatisfactory) scale. There were no glaring deficiencies or issues with how the LDSS directors are performing.

Human Services Article § 4-204(b), gives SSA the statutory authority to monitor the social service activities of the 24 LDSS. SSA can require the LDSS to provide plan of actions (POAs), attend technical assistance (TA) meetings, and meet with DHS/SSA executive leadership for unresolved areas of concern.

Observation: LDSS directors noted that communication and information sharing between DHS and SSA is good.

The DHS Principal Deputy Secretary holds monthly check-in meetings with each individual LDSS director as well as bimonthly Executive Leadership Team (ELT) meetings with senior DHS/SSA leadership and LDSS directors. The check-in meetings review performance metrics, address operational or strategic concerns, and provide guidance on DHS initiatives. The DHS ELT meetings cover operational updates, policy implementation, emerging challenges, opportunities for improvement, and alignment between local and State operations.

SSA facilitates 23 meetings related to child welfare and foster care. **Exhibit 3.2** shows the 13 SSA meetings that involve the LDSS. During interviews with a sampling of LDSS directors, all commented on how effective the communications channels are between DHS, SSA, and LDSS leadership. The local directors noted there are ample mechanisms and opportunities to voice opinions and concerns. New initiatives from SSA such as Lunch and Learns and the SSA Monthly Newsletter received positive feedback from the LDSS.

Exhibit 3.2
SSA Facilitated Meetings

Meeting	Frequency	Purpose
Advisory Board	Every 4 months	Advise and serve as a formal stakeholder feedback loop.
LDSS (with Directors and Assistant Directors)	Monthly	Communicating relevant and time-sensitive updates.
Policy Network Group (PNG)	Monthly	Oversee and guide the policy-making process at SSA. Separate PNGs for child welfare and adult services.
Prevention and Child Safety Implementation Team	Quarterly	Improve outcomes for children and families utilizing data to understand the nature or extent of the issues.
Placement & Permanency Implementation Team Meeting	Monthly	Improve the quality of foster care placements and improve permanency outcomes.
Independent Living Coordinators Meeting	Monthly	Facilitate the monthly Independent Living Coordinator's (ILC) Workgroup with the 24 LDSS's ILCs.
Health Workgroup	Monthly	Discuss Health issues occurring with foster children. How to increase annual and dentals being completed.
SENs Multi D	Monthly	Discuss how to partner better and any Substance Exposed Newborns (SENs) issues.
Continuous Quality Improvement Network Meeting	Monthly	Communicate, manage, advise, and serve as a stakeholder in the development/enhancement of strategic vision for Maryland's children and families.
Kinship Navigation Peer Support Meeting	Monthly	Facilitate exchange of information, tackle practice challenges, address emerging trends in supporting kinship families in all 24 jurisdictions through collaboration w/LDSS Kinship Navigators. Foster peer-to-peer support among Kinship.
Kinship Navigator Family First Workgroup	Quarterly	Collaborate and coordinate efforts to enhance support for kinship families by resource provision, community outreach, effective stakeholder engagement; strengthen partnerships w/stakeholders and contribute insights to enhance the Kinship Navigation program.
Permanency Enhancement Meetings	Monthly	Improve permanency outcomes for youth in out-of-home care.
Placement Reform Workgroup	Monthly	Address complex challenges for children in placement disruption, hospital overstays, hotel.

LDSS: local departments of social services
SSA: Social Services Administration

Source: Department of Human Services; Department of Legislative Services

Observation: SSA monitors LDSS compliance with federal and State policies and requires corrective action when deficiencies are identified.

The following is a listing of performance data and tools SSA uses to inform DHS, SSA, and LDSS leadership on performance and adherence to federal and State benchmarks.

The SSA Quality, Policy, and Performance Management Team is responsible for monitoring compliance of the LDSS, improving child and family outcomes through performance management, providing data and data analysis, and guiding policy development to enhance the work of the LDSS. The team is comprised of three units: Audit, Compliance, and Quality Improvement (ACQI); Continuous Quality Improvement (CQI); and Policy. SSA monitors performance data of each LDSS by using tools such as: Qlik Reports; Headline Indicators/Child Family Services Review (CFSR) Measures; ACQI Weekly Reports; and Family Matters Reports.

ACQI weekly reports are pulled by SSA's data team every Monday and disseminated to LDSS on Wednesday to allow for LDSS to see its status and correct any areas out of compliance. **Exhibit 3.3** shows the types of weekly reports with associated indicators and benchmarks.

Exhibit 3.3
SSA ACQI Weekly Reports

Weekly Report	Indicator/Benchmark
Foster Care Milestone Report	• Timely Initial Medical Exam / 90% • Timely Comprehensive Medical Exam / 90% • Annual Exam / 90% • Semiannual Dental Exam / 90% • Education Enrollment / 90%
CPS Milestone Report	• Timely Initial Face to Face / 95% • Case Closure within 60 days / 90%
SEN Milestone Report	• Timely SEN Initial Face to Face / 90% • Timely SEN Safe–C / 90% • Timely SEN MIFRA / 90%
Caseworker Visitation Report	• Completed Monthly Visitation / 95%

ACQI: Audit, Compliance, and Quality Improvement
CPS: Child Protective Services
MIFRA: Maryland Family Risk Assessment
SSA: Social Services Administration
SEN: Substance Exposed Newborns

Source: Department of Human Services; Department of Legislative Services

The SSA ACQI notification process consists of a notice issued to an LDSS when they fall below the expected compliance standard. Notifications occur monthly and are tracked and monitored according to notification level protocol. There are three levels of notifications:

- **Notification 1**
    - LDSS must provide a POA for all areas they are out of compliance within seven days, which will be reviewed and approved by ACQI.
    - In order to resolve a notification (any level), the LDSS must be in compliance in that area for two consecutive months.
    - Escalation to the next notification level occurs if the notification has not been resolved within three months.
- **Notification 2**
    - LDSS must attend a TA meeting with ACQI for the escalated area(s) within two weeks.
    - LDSS must provide an updated POA for the escalated area(s) within seven days, which will be reviewed and approved by ACQI.
    - Escalation to the next notification level occurs if the notification has not been resolved within three months.
    - LDSS must attend monthly TAs with ACQI until notification is resolved.
- **Notification 3**
    - Executive leadership is notified of unresolved areas of noncompliance.
    - LDSS must meet with executive leadership monthly until notification is resolved.

The SSA Quality Assurance (QA) Reviews are conducted quarterly. The LDSS are provided with randomized sample cases opened within the designated review period to check compliance in areas not currently tracked in the notification process. **Exhibit 3.4** is a screenshot of the SSA QA review period.

Exhibit 3.4
SSA QA Review Period

Service Area	Review Cases Open During:	QA Review Months	QA Review to be Completed By:
CPS	October, November, December	January, February, March	March 16
	January, February, March	April, May, June	June 16
	April, May, June	July, August, September	September 16
	July, August, September	October, November, December	December 16
Family Preservation	October – March	April, May, June	June 16
	April – September	October, November, December	December 16
Foster Care	October – March	April, May, June	June 16
	April – September	October, November, December	December 16
Resource Home	October – March	April, May, June	June 16
	April – September	October, November, December	December 16

SSA: Social Services Administration
QA: quality assurance

Source: Department of Human Services

The QA review results are utilized by DHS and SSA to develop best practice guidance and monitoring solutions. Additionally, the following actions are taken once the results are provided to the LDSS:

- results are added to the QA POA Tracking Sheet in order to determine which LDSS were out of compliance for which indicators;
- LDSS must provide a POA for all areas they are out of compliance within seven days, which will be reviewed and approved by ACQI;
- barriers identified in the POA's, such as issues in policy interpretation by locals or procedural implementation, are analyzed with programs staff for solution and TA; and
- a TA meeting is provided to discuss the findings of the QA and provide assistance in areas of need to the LDSS.

The SSA CQI team works closely with the LDSS to help improve child welfare services statewide. The team conducts a CFSR of the 24 LDSS within a three-year review cycle. CFSR is a federal requirement which involves conducting interviews and focus groups with children,

families, LDSS staff, resource providers, and community stakeholders. The SSA CQI Team reviews 65 LDSS cases every six months – 40 foster care cases and 25 in-home care cases. Federal partners review 40% of the CQI cases during the CSFR. The team conducts a reviewer's debrief with the LDSS to discuss best practices learned and assist in the development of a Continuous Improvement Plan (CIP). The CQI Team monitors the implementation and progress of the CIP every six months. Recommendations for course corrections are offered to ensure trends are moving in the right direction.

Not every LDSS has a dedicated QA staff member to receive and process the various reports from the SSA ACQI Team. During discussions with some LDSS directors, they all stated the need for a dedicated QA staff member at the local level. One LDSS created a QA position by repurposing a different position, and another LDSS was provided a QA position by their county. The LDSS directors stated that receiving the ACQI reports is helpful and provides a gauge on how the staff/caseworkers are performing.

Chapter 4. Additional Topics

Observation: Some foster children need more supervision than can be provided in traditional foster homes.

Children who need additional care and supervision can receive it through one-to-one services. The Department of Human Services (DHS) defines one-to-one services as "direct, continuous supervision, where an individual caregiver is assigned to a single person for close monitoring and specialized support." According to DHS, the number of children needing one-to-one services at any point during the year varies widely by jurisdiction, ranging from about 1 to about 40 (see **Exhibit 4.1**).

Exhibit 4.1
Average Number of Children Requiring One-to-one Services at Any Given Time in the Year

Jurisdiction	Avg. Number of Children	Jurisdiction	Avg. Number of Children
Caroline County	1–2	Worcester County	4
Garrett County	1–2	Cecil County	5
Queen Anne's County	1–2	Prince George's County	6
Talbot County	1–2	Dorchester County	7
St. Mary's County	2	Anne Arundel County	8
Allegany County	2–3	Frederick County	8
Charles County	2–3	Harford County	10–12
Kent County	2–3	Montgomery County	10–15
Somerset County	2–3	Baltimore City	15–25
Howard County	2–4	Washington County	20–30
Wicomico County	3	Baltimore County	40
Calvert County	3–5	Carroll County*	Unk.

* An estimate for Carroll County was not provided in request for proposals, where this data was sourced.

Source: Department of Human Services; Department of Legislative Services

Children who need one-to-one services may not receive the full level of care they need from their placement settings due to several reasons:

- beds were not available in settings that could meet the children's needs;

- children could be rejected from settings that could meet their complex needs; or

- children's need for additional services is expected to be short term (*e.g.*, during transition periods between placements).

Based on discussions with local departments of social services (LDSS) staff, one-to-one services are generally requested by the child's caregiver, reviewed with the child's case management team, approved by LDSS leadership, and, finally, approved by the Social Services Administration (SSA). SSA approval is reportedly required for (1) the initial request for one-to-one services and (2) continuation of services if one-to-one care is needed for more than 30 days.

Observation: There was no State-level procurement of one-to-one services prior to December 2024.

Despite SSA requiring approval for the use of one-to-one services, historically, SSA has not been proactive in helping LDSS obtain them. Prior to 2024, one-to-one services were managed locally; each LDSS was responsible for identifying and obtaining one-to-one services on their own if a child in their jurisdiction required them. This led to differences across the State in how these services were obtained and limited the State's oversight and monitoring of them. Based on discussions with some LDSS staff, some jurisdictions had contracts with one-to-one service providers, which enabled some county oversight, whereas other jurisdictions did not. Attempts to remedy this issue began in 2024.

- **January 2024:** DHS issued, on behalf of Anne Arundel County and Baltimore City, a request for proposal (RFP) for one-to-one services. The selected offerors, six in total, and associated service contracts were approved without discussion by the Board of Public Works on September 10, 2025.

- **December 2024:** DHS issued an RFP to procure one-to-one services for "children placed in out-of-home care statewide" excluding those placed by Anne Arundel County and Baltimore City.

The most recent RFP seemed to improve upon the former by including staffing requirements related to criminal and child welfare histories, education, experience, training/certification, and supervision. However, there are still likely opportunities for improvement.

Observation: Three teenaged foster children have died in the past three years.

Nine foster children have died since the beginning of 2023. Most of them died young, many of them from medical complications they were born with. Three teenaged children died, all by

suicide. One was placed in a therapeutic group home when they died, another was living in a hotel, and the third was in an adoptive resource home[5].

Observation: New Jersey could serve as a model state for reforming access to children's behavioral health services.

Lack of access to behavioral health services for children who need them is a risk factor for involvement in both child welfare and juvenile justice systems. New Jersey was noted by some LDSS staff as being a good model for behavioral health services for children with complex needs.

Through New Jersey's single-access model for children's behavioral health, called Children's System of Care, families of children with complex needs can contact one organization (*i.e.*, a "one-stop shop") to receive service referrals and authorizations. Depending on children's needs and eligibility, services could involve:

- assessments to determine children's needs;
- referrals to counseling services;
- mobile response to stabilize crisis situations;
- family support for education and advocacy;
- care management for intense and complex needs;
- behavioral supports for activities of daily living;
- respite services for families; and
- substance use treatment.

New Jersey's Children's System of Care is generally associated with positive child outcomes, including a reduction in the number of children placed in out-of-state behavioral health treatment settings and a 50% reduction in the number of children served in out-of-home settings.

Comparison to Maryland

Child Trends estimated that in 2018, about 50% of children in Maryland's foster care and 49% of children in New Jersey's foster care had complex needs. Before New Jersey developed its

[5] An adoptive resource home is a placement in a licensed home where the child has been there for at least six months and is in the process of being adopted.

statewide system in 2001, access to behavioral health services was similar to Maryland's – the services available to children and the way children accessed them varied based on which system they were involved in (*e.g.*, child welfare, juvenile justice).

Exhibit 4.2 compares the state performance of both Maryland and New Jersey to the national average of seven child welfare outcomes from the Child and Family Services Reviews. As shown, New Jersey was either on par with or performed significantly better than the national average in child welfare outcomes related to child safety and permanency.

Exhibit 4.2
Maryland and New Jersey's Performance on Select CFSR Indicators Compared to the National Average

CSFR Child Welfare Indicators	Maryland	New Jersey
Maltreatment in foster care	Worse	Better
Recurrence of maltreatment	Worse	Better
Placement stability	Same	Better
Reentry to foster care in 12 months	Same	Same
Permanency in 12 months for:		
Children entering foster care	Worse	Same
Children in foster care 12 to 23 months	Worse	Same
Children in foster care 24 months or more	Worse	Same

CFSR: Child and Family Services Reviews

Note: Data was analyzed and reported by the Children's Bureau; state performance is categorized as being significantly "worse" than the national average, significantly "better" than the national average, or the "same" as (neither better nor worse than) the national average.

Source: Children's Bureau; Department of Legislative Services

In June 2025, the Maryland Department of Health (MDH) published a roadmap to strengthen Maryland's public behavioral health system for children. One of the recommendations in the roadmap was for the State to "identify and formalize a structure for cross-agency collaboration, coordination, and decision-making" to help improve coordinated, streamlined care. The roadmap identified the following systems that families needing services often interact with, underscoring the need for cross-agency collaboration:

- MDH, including the Behavioral Health Administration, Medicaid and Healthcare Financing, Public Health Services, and the Developmental Disabilities Administration;

- the Maryland State Department of Education;
- the Maryland Department of Human Services; and
- the Maryland Department of Juvenile Services.

Appendix A. Response from the Department of Social Services

Maryland
DEPARTMENT OF HUMAN SERVICES
Wes Moore, Governor · Aruna Miller, Lt. Governor · Rafael López, Secretary

January 7, 2026

Michael Powell, Director
Office of Program Evaluation and Government Accountability (OPEGA)
Department of Legislative Services, Maryland General Assembly
90 State Circle
Annapolis, Maryland 21401

Re: OPEGA evaluation of the Maryland Department of Human Services' (DHS) Social Services Administration (SSA), January 2026

Dear Director Powell:

We welcome the partnership with the Department of Legislative Services in our joint efforts to improve service delivery in our Social Services Administration (SSA) in the Office of Program Evaluation and Government Accountability's (OPEGA) SSA Evaluation in Fall - Winter 2025.

Based on the final evaluation report, please see our response attached, and our briefing document to the General Assembly's Joint Audit and Evaluation Committee with more information on this subject.

Should you have any questions, please contact Justin Hayes, Acting Director of Government Affairs at justin.hayes1@maryland.gov.

In service,

Rafael López
Secretary

Cc: Webster Ye, Chief of Staff, DHS
Dr. Alger Studstill, Executive Director, Social Services Administration
Marva Sutherland, Inspector General, DHS
Larry Handerhan, Assistant Secretary for Programs, DHS
Justin Hayes, Acting Director of Government Affairs, DHS

DHS Response by OPEGA Report Chapter Number to the Report on the Maryland Department of Human Services' Social Services Administration (SSA)

Chapter 2. Foster Children in Hotels

DHS Response: We generally agree with OPEGA's observations regarding foster youth in hotels. We issued a directive on October 22, 2025 that clarified that we will not facilitate the use of hotels or other unlicensed settings for youth experiencing out-of-home care. As of November 20, 2025, no youth are in a hotel stay.

More broadly, the challenges identified in the OPEGA evaluation, along with the Department of Legislative Services' Office of Legislative Audits' September 2025 report on the Social Services Administration, require identifying and adopting systemic changes that address the root causes that lead to safety concerns. To do that, we launched an Audit Resolution Committee in November 2025 aimed at systemic practice reform to address findings and provide consistency and statewide accountability.

We have implemented a number of system reforms over the past several months that will continue to deliver in years to come, including:

- Over the course of 2025, we have implemented Family Matters, out-of-home care rate reforms, and worked to rapidly update SSA policies and related regulations. In 2026, we will release for public comment, through the Maryland Register, updated out-of-home placement, guardianship, and adoption regulations to shift statewide placement policy to a kin-first model that centers young people's familial relationships – whether their family is related by blood or by choice. This aligns with research, national best practice, and common sense.

- On July 16, 2025, the Board of Public Works approved a contract for Binti software services. Implementation of this software will allow for consistent Family Finding across Maryland as we work to build on our Family Matters work and ensure that children are placed with family by blood or choice whenever reasonably possible. All of this work had been previously done manually across all 24 local departments with no centralized, statewide approach or insight.

- On August 27, 2025, the Board of Public Works approved a contract for OpenGov software services, which will facilitate comprehensive tracking of contracts and grants from initial solicitation creation through approval. This software will also incorporate a robust contract and performance management module and ensure seamless integration with an invoice management module to guarantee timely bill payments.

- On December 3, 2025, the Board of Public Works approved a contract for electronic health passport software, Tetrus Carelink, that will allow for more consistent health recordkeeping, and medical appointment and care adherence.

We are also urgently pursuing the following actions:

- SSA is working to enhance the Audit, Compliance, and Quality Improvement (ACQI) team to serve as a Quality Assurance team that will not only complete ongoing performance reviews for data accuracy but will also be assessing child welfare practice in real-time to allow for course correction to occur while a case is still open. This includes improving our case workers' efforts to provide completed case notes, including exit reasons/Explanation for Least Restrictive Placement/Exit notes, and reduce redundancies in our Child, Juvenile, and Adult Management System (CJAMS) that will save staff time and ensure better case tracking.

- SSA will be issuing guidance at the beginning of 2026 that clarifies case documentation expectations which will include a specific directive that the fields pertaining to exit reasons and least restrictive placement must be completed, even for a living arrangement, as noted in the OPEGA report.

We look forward to partnering with the General Assembly in the 2026 session to deliver further improvements to better serve children and their families. Marylanders deserve nothing less.

Chapter 3. Communication and Authority

DHS Response: We generally agree with OPEGA's observations regarding communication and authority. We continuously work to improve communication and ensure local office compliance with federal and state policies, and ensure corrective action through our Social Services Administration (SSA), and our Office of the Inspector General (OIG).

To align with the Moore-Miller Administration's priorities—moving urgently and being data-driven and heart-led—SSA is currently enhancing the ACQI team to serve as a Quality Assurance team. This effort is focused on assuring compliance while intentionally overseeing the quality of casework and practice. As part of this effort, we are assessing how to expand the Quality Assurance team's staff capacity using existing resources, which will allow the team to truly embody these core values, and have a presence regionally across the state.

We have empowered OIG with recent legislative changes (Senate Bill 230 of 2025). We have also strengthened OIG by creating a personnel recruitment pipeline to ensure that our improvement work does not stop.

Chapter 4. Additional Topics

DHS Response: We concur with the observations about one-to-one providers, and are finalizing an award recommendation to acquire high-quality one-on-one services statewide to the Maryland Board of Public Works for action this winter based on a request for proposals. A separate set of contracts were approved by the Maryland Board of Public Works on September 10, 2025 as DGS Agenda Item 47-S for Anne Arundel County and Baltimore City, covering approximately 40% of youth receiving these services. Taken together, these contracts will create the foundation for greater statewide visibility and provider accountability.

Our hearts break for any child who dies, as in the three cases highlighted by OPEGA. We envision a Maryland where all children are safe from abuse and neglect, thriving in permanent homes, and surrounded by loving families. The safety and well-being of Maryland's children are our highest priorities.

We are active partners with the Maryland Department of Health to implement the Roadmap to Strengthen Maryland's Public Behavioral Health System to ensure youth in foster care are prioritized with preventative services and getting the support they need. This includes higher utilization of 988 crisis intervention services to provide support outside of a hospital setting, leveraging Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to identify behavioral health issues early and connect to care, and strengthening the 1915(i) program for children and youth with the most significant and complex behavioral health needs to facilitate access to intensive care coordination in-home.

In addition, we look forward to partnering with stakeholders to further discuss improvements to children's behavioral health services, including examining models that work in other states.

Appendix B. Evaluation Request Letter

THE MARYLAND GENERAL ASSEMBLY
ANNAPOLIS, MARYLAND 21401-1991

JOINT AUDIT AND EVALUATION COMMITTEE

October 24, 2025

Mr. Michael Powell
Director, Office of Program Evaluation and Government Accountability
Department of Legislative Services
90 State Circle
Annapolis, Maryland 21401

Dear Mr. Powell:

Consistent with §2-1234 of the State Government Article, we are directing the Office of Program Evaluation and Government Accountability to conduct a scoping evaluation of the Social Services Administration in the Maryland Department of Human Services.

Thank you for your attention to this matter.

Sincerely,

Senator Shelly Hettleman
Senate Chair

Delegate Jared Solomon
House Chair

SH:JS/DB/bal

cc: Joint Audit and Evaluation Committee, Members and Staff
Victoria L. Gruber
Ryan Bishop