OPEGA
ANNUAL
REPORT

OPEGA Annual Report 2023

January
2024

a report to the
Government Oversight Committee and the Legislature
from the
Office of Program Evaluation & Government Accountability
of the Maine State Legislature

GOVERNMENT OVERSIGHT COMMITTEE OF THE 131ST LEGISLATURE

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(207) 287-1901

PETER SCHLECK
DIRECTOR

MAINE STATE LEGISLATURE

OFFICE OF PROGRAM EVALUATION AND
GOVERNMENT ACCOUNTABILITY

January 5, 2024

The Honorable Craig V. Hickman, Senate Chair
The Honorable Jessica Fay, House Chair
Members of the Government Oversight Committee
82 State House Station
Augusta, Maine 04333

The Honorable Troy D. Jackson, President of the Senate
Members of the 131st Maine Senate
3 State House Station
Augusta, Maine 04333

The Honorable Rachel Talbott Ross, Speaker of the House
Members of the 131st Maine House of Representatives
2 State House Station
Augusta, Maine 04333

Dear Government Oversight Committee Members, Senators and Representatives:

In accordance with 3 MRSA §995(4), I respectfully submit the Office of Program Evaluation and Government Accountability (OPEGA) Annual Report for 2023. OPEGA's service to the Legislature as an independent, non-partisan resource is meant to support the important role of legislative oversight and to help improve the performance of State government. We remain committed to serving Maine's legislators and citizens as a trusted source of objective, credible information.

Sincerely,

Peter Schleck
Director

cc: Darek M. Grant, Secretary of the Senate
Robert B. Hunt, Clerk of the House

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Table of Contents

OPEGA Annual Report 2023

About OPEGA

History

The Office of Program Evaluation and Government Accountability (OPEGA) is a non-partisan, independent legislative office created by Public Law 2001, Chapter 702. The Office first became operational in January 2005. Its authorizing statute is 3 MRSA §§991-1001.

Organization

OPEGA is part of an organizational arrangement within the Legislature that ensures both independence and accountability. This structure is critical to ensuring that OPEGA can perform its function in an environment as free of political influence and bias as possible.

The Legislative Council appoints the Director of OPEGA for a renewable five-year term and sets the Director's salary. OPEGA's activities are overseen by the Government Oversight Committee (GOC), a 12-member bi-partisan and bi-cameral committee appointed by legislative leaders according to Joint Rule. The GOC approves OPEGA's budget and annual work plan and monitors OPEGA's use of resources and performance.

Staffing

OPEGA has an authorized permanent staff of nine full-time positions including the Director, the Administrative Secretary, who also serves as the GOC Committee Clerk, and a group of analysts, senior analysts and a principal analyst. Two of OPEGA's positions were added in 2015 as a result of Public Law 2015, Chapter 344 which added evaluations of tax expenditures as part of an ongoing legislative review process to OPEGA's responsibilities.

Function

OPEGA primarily supports legislative oversight by conducting independent program evaluations of State government programs as directed by the GOC. OPEGA also has authority to perform program evaluations of non-State entities that receive State funds or have been established to perform governmental functions. As legislators perform their oversight function, they often have questions about how policies are being implemented, how programs are being managed, how money is being spent and what results are being achieved.

The GOC and OPEGA address those questions from an unbiased perspective through rigorous program evaluations. The independence and authorities granted in the statute governing the GOC and OPEGA provide the Legislature with a valuable supplement to the oversight conducted by the policy committees. In addition, the GOC and OPEGA examine governmental programs and activities that cut across State agencies and span the jurisdictions of multiple policy committees.

The results of OPEGA's reviews are provided to legislators and the public through formal written reports and public presentations.

Mission

The Office of Program Evaluation and Government Accountability exists to support the Legislature in monitoring and improving the performance of State government by conducting independent, objective reviews of State programs and activities with a focus on effectiveness, efficiency and economical use of resources.

Vision

OPEGA is valued as a credible source of objective information that contributes to good government and benefits Maine's citizens.

Values

OPEGA seeks to be a model for best practices in government and is committed to:

- Independence and objectivity
- Professionalism, ethics and integrity
- Identifying root causes
- Timely, effective communications
- Valuable recommendations
- Continuous improvement
- Using skilled and knowledgeable staff
- Minimizing disruption of operations
- Participatory, collaborative approach
- Measuring its own performance
- Smart use of its own resources

Overall Goals

A. Provide timely, relevant and useful information and recommendations

B. Conduct all work with objectivity and accuracy[1]

C. Communicate regularly on our activities, results and impacts

D. Utilize OPEGA's resources effectively, efficiently and economically

[1] OPEGA adheres as fully as possible to the performance auditing standards issued by the United States Government Accountability Office (GAO), known as the *Generally Accepted Government Auditing Standards (GAGAS)* or "Yellow Book" standards. OPEGA also consults a variety of other professional standards, guides, and best practices, as appropriate. OPEGA strives at all times to ensure its work is objective and accurate and its reported results are supported by evidence.

The Year in Review

During 2023, OPEGA completed five projects, began or continued work on six additional projects, and facilitated the GOC's "closeout" of further work regarding one matter.

Table 1 – OPEGA Project Work in 2023

	Project Approved[2]	Scope of Work Approved	Project Status as of 12/31/23	Report Date
Projects Completed in 2023				
OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding	10/2022	10/2022	Completed	2/2023
Tax Expenditure Evaluation: Tax Benefits for Media Production Companies		6/2022	Completed	3/2023
OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams	10/2022	10/2022	Completed	4/2023
Workplace Culture and Climate Survey of the Fire Marshal's Office and Accompanying Project Recommendation		3/2023	Completed	7/2023
OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding	10/2022	10/2022	Completed	11/2023
Projects in Progress				
Child Protective Services, DHHS/OCFS Reunification	7/2021	7/2022	Resumed, Active	
OCFS Case File Review, Sylus Melvin	10/2022	10/2022	Active	
Tax Expenditure Evaluation: Maine Shipbuilding Facility Investment		4/2023	Active	
Tax Expenditure Evaluation: Paper Manufacturing Facility Investment		4/2023	Active	
Tax Expenditure Evaluation: Major Business Headquarters Expansion		4/2023	Next Up	
Tax Expenditure Evaluation: Major Food Processing & Manufacturing Facilities Expansion		4/2023	Next Up	
Government Oversight Committee Closeout				
Deduction for Contributions to Capital Construction Funds for Maintenance or Replacement of Fishing Vessels	4/2023	6/2022	Reclassified	N/A

[2] Tax expenditure evaluations are required by statute and do not have "Project Approved" dates.

Projects Completed in 2023

1. OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding

The Government Oversight Committee of the 130th Maine State Legislature directed OPEGA to review certain records generated by the Maine Department of Health and Human Services Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. In February 2023, OPEGA published the first of these four case file reviews.

Overall, OPEGA did not conclude that any OCFS safety decisions regarding Hailey Goding were unsound within the framework of the records we reviewed, interviews we conducted, agency policy and practice, and legal authority. There were two primary instances in which a reasonable observer may have questions about the decisions made and actions taken in response to various conditions, concerns, and suspicions.

- A lack of evidence ultimately limited OCFS actions in the wake of a May 2020 fentanyl ingestion by Hailey.
- Activities to locate Hailey's mother were thorough and exhausted the Department's options prior to closing a January 2021 investigation.

Potential Opportunities for Improvement

OPEGA identified two potential opportunities for improvement as a result of the case file review:

1. Establish a Central Resource for Substance-related Questions

   OPEGA noted a lack of clarity regarding the resources child protective services workers might consult to validate or refute the plausibility of a parent's story about exposure to harmful substances like fentanyl. Establishing such a resource would be beneficial to caseworkers in the future as they encounter various drug-related scenarios and questions about methods of exposure, interactions, and presentations.

2. Improve Service Availability and Enhance OCFS's Ability to Ensure Recommended Services Are Provided

   OCFS referred Hailey's mother for mental health and substance use assessment and drug screens. After assessment, she was referred for trauma counseling and case management services. Despite the efforts of the Department, a contract agency, a case manager, and the mother herself, we observed that trauma counseling services were never established nor provided. OCFS's larger charge is the preservation and rehabilitation of families—the success of which may depend heavily on a family's participation in services to improve family functioning and mitigate risks to children.

Mental health, trauma, and substance abuse treatment counseling; parenting and daily living skills classes; and domestic violence intervention programs all appear to be commonly recommended services. However, from our work on this case and other child protective services reviews, we understand that there is a pronounced lack of available services that may vary by geographic location in the state. To the extent that recommended services may improve family functioning and reduce future risk to children, increasing their availability and developing a means for the Department to ensure that families follow through with recommended services presents a potential opportunity for improvement in the broader child protective system.

The website link to this review report is https://legislature.maine.gov/doc/9715.

2. Evaluation of Tax Benefits for Media Production Companies

Maine's visual media (VM) incentives include a tax credit and a wage reimbursement provided for qualifying visual media productions in the state. The tax credit is 5% of non-wage production expenses and is non-transferable, non-refundable and may not be carried forward. The wage reimbursement is 12% of production wages for Maine resident wage earners and 10% for non-resident wage earners. The VM incentives were enacted in 2006 and are jointly administered by the Maine Film Office (MFO), located in the Maine Office of Tourism (MOT) within the Department of Economic and Community Development (DECD) and Maine Revenue Services (MRS).

OPEGA found that Maine's visual media incentives exist among many similar incentives nationally. Many states have identified concerns about the administration and effectiveness of their incentives, and we identified similar concerns in Maine. At present the low usage of Maine's VM incentives has kept costs to the State low, but it has also limited the potential impacts. Looking forward, the issues and recommendations identified are areas that OPEGA thinks the State should address if it intends to retain or amend the VM incentives.

Issue 1: The VM Incentives Have Had Limited Effect and Have Not Been Adequately Administered

At present, Maine's VM incentives have a limited effect. They are not widely used, in part because the tax credit is inaccessible to many taxpayers and the incentive amounts are not competitive with other states. Even if use were increased, the VM incentives lack a publicly-specified purpose and current design is not specific to the achievement of particular goals. Additionally, data collection at present is not adequate to measure program impacts. While the VM incentives are located within the Maine Office of Tourism, the current design of the incentives does not align with the organization.

The issue regarding the effectiveness of Maine's VM incentives has multiple sub-parts detailed below. Altogether, they create a situation where Maine's incentives have had limited effect and are unlikely to become effective without a concerted re-visioning and redesign aimed at achievement of specific goals.

(A) Maine's VM Incentives Are Infrequently Used, Limiting Potential for Impact
Since 2006, there have been nine tax credit claims totaling $37,875 and 95 wage reimbursements totaling $2,180,450. This usage averages to fewer than one tax credit claim per year and roughly 6 wage reimbursement claims per year. Use of Maine's VM incentives is likely impacted by both the existence of more competitive visual media incentives in other states and design features such as the non-refundability and non-transferability of Maine's tax credit. If Maine's VM incentives are not used, they cannot meaningfully deliver results for Maine.

(B) The VM Incentives' Purposes Have Not Been Specified in Statute nor Shared Among Stakeholders, Hindering Efforts to Improve Program Effectiveness

While VM incentive goals were set by the Government Oversight Committee for the purpose of this evaluation, the VM incentives do not have formal goals, intended beneficiaries, or performance measures specified in statute. As a result, the VM incentives have lacked a clear purpose and recent attempts to improve them struggled absent a shared understanding of what the incentives are intended to accomplish.

When OPEGA reviewed public testimony on prior legislative efforts to amend the VM incentives and spoke to stakeholders and administrators, we encountered varying ideas about what the incentives are intended to achieve. For example, some believed the primary purpose was attracting out-of-state production companies, while others felt the growth of the VM industry in the state was most important. Differing purposes of the incentives suggest differing directions regarding improved design.

(C) Current Design is Not Targeted to Specific Goals

At present, Maine's VM incentives are broadly conceived and small, unable to achieve any particular goal well. OPEGA noted that program requirements allow productions to be certified and eligible to receive VM incentives that do not align with all goals set for this evaluation. For example, productions can qualify for VM incentives without filming in Maine—seemingly at odds with the goals of inducing outside spending in the state and inducing tourism in Maine. Productions also can opt out of including on-screen credits recognizing the State of Maine, may not feature Maine and may not be directed at an outside audience, also limiting the potential for tourism impacts.

(D) Existing Data is of Limited Value in Measuring VM Incentive Impacts

At present, there are no performance metrics in statute indicating how program success should be measured. Additionally, program data to measure impacts is lacking: there is no data collected regarding tourism impacts; jobs data collected by MFO cannot be interpreted as there is no specification for how long jobs last; and production expense or spend data is collected inconsistently. Without program metrics or benchmarks or consistently collected and reliable program data, legislators will be unable to assess program performance and make alterations based on their goals.

(E) Given Present Design, VM Incentives Lack Organizational Alignment with MOT

Despite the location of the incentives' administration within the Office of Tourism, the current design and use of the incentives is unlikely to be significantly contributing to tourism in Maine. The incentives have also not been a significant part of the MOT's tourism strategy and DECD has other structures in place for managing economic development incentives.

Issue 2: MFO Has Not Adequately Administered Maine's VM Incentives

Whether or not Maine's VM incentives are amended, the administration of those incentives must be improved to address the issues identified. The Maine Film Office has

not ensured statutory compliance, clarity about program requirements and confidentiality of data, or consistent treatment of program participants. The Maine Film Office has not been able to provide basic incentive records, and annual reports produced by the office have conflated general MFO activity with activity related to the incentives. Additionally, Maine's incentives warrant additional internal oversight in the absence of clear program rules or guidelines.

The issue regarding the administration of Maine's VM incentives also has multiple sub-parts, together creating inadequate administration of the state's incentives.

(A) MFO Has Not Ensured Compliance with Statutory Requirements

MFO has not promulgated required rules (as per 5 MRS §13090-L(3)(E)) nor ensured that program requirements are consistently met. For instance, OPEGA found that MFO certified a production that did not meet the statutory requirement to have planned spending in Maine of at least $75,000. Additionally, MFO was unable to provide documentation to show that program applicants always provided evidence that they were not in default on a loan from the state, that they were fully financed or had provided proof of insurance.

(B) MFO Was Not Able to Readily Provide Basic Program Information to Support Oversight

During this review, it took the Maine Film Office three months, and multiple requests from OPEGA, to provide 81 application forms and 54 final report forms from productions dating back to 2012. Obtaining records from MFO for this evaluation required an unusual amount of time and effort, particularly given the small number of participants and hence limited program records. At the time of this report, it remains unclear if all participant records were provided to OPEGA.

The difficulty OPEGA experienced in obtaining basic program records raises concerns about record keeping, program compliance, and overall administration of the program. The absence of readily-available program data also makes strong oversight of the incentives impossible and creates the conditions where fraud or waste could exist within the program and go undetected.

(C) MFO Has Lacked Clarity About the Confidentiality of Data It Holds

Despite official program forms stating that information collected is not confidential unless an agreement is made between DECD and the production entity, MFO raised concerns about the potential for program information to be confidential at the start of this evaluation. By the evaluation's end, MFO had still not provided a clear policy regarding the confidentiality of VM incentive data held by the office. Participants deserve to know whether or not data they provide will be considered public before applying.

(D) Current Annual Reporting Does Not Provide Adequate Information for Program Performance to Be Accurately Understood

The Maine Film Office has been submitting annual reports to the Taxation Committee on the VM incentives as required by statute. The annual reports have included most of the elements required by statute. However, OPEGA observed that the information provided

has not been sufficient to support oversight, and has sometimes been misleading about incentive performance. Annual reports appear to conflate incentive activity with the general activity of MFO, obfuscating the actual activity of the incentives alone. For example, some productions highlighted in MFO's annual reports—reports required specifically to summarize incentive activity—do not appear to have made use of Maine's VM incentives. In addition, when production spend data has been included in annual reports, the information reported was based on estimated spend prior to production, rather than the actual data required by MFO after certified productions are completed.

(E) MFO Has Not Ensured that Eligibility Criteria are Clear, Transparent, and Consistently Applied; Responsibility for Two Key Program Controls is Not Clear

There are elements of the VM incentive administration that are not clear, and MFO has not sought clarity to ensure consistent and appropriate treatment of applicants. Areas that lack clarity include eligible production types, required project timelines, and eligible expenses. Additionally, statute defines a process and assigns responsibility for the initial certification of productions and for the distribution of benefits. However, between the initial certification and the distribution of benefits, there is a gap in which it is unclear which agency is responsible for 1) ensuring that productions continue to meet eligibility requirements upon completion and 2) determining which production expenses qualify for the tax credit and should be the basis upon which the credit is calculated. This lack of clarity raises risks for incentive benefits being provided to potentially ineligible productions, or in incorrect amounts, and for the inconsistent treatment of participants.

(F) Travel Activities of MFO Do Not Correspond to Incentive Use

MFO has taken 46 out-of-state trips since 2013. However, this out-of-state travel has not appeared to translate to substantial out-of-state use of the visual media incentives. Based on MFO records provided to OPEGA, there have been 81 applications for certification since June 2012 of which 50% came from in-state productions. A number of the out-of-state applications represent continuing seasons of single television shows, not new productions that are being brought to Maine. Additionally, while international outreach efforts are highlighted in every annual report, only one production not based in the U.S. has been certified for the incentives (in 2013). MFO's primary focus on out-of-state versus in-state relationships was also apparent in stakeholder interviews for this review.

(G) Maine's VM Incentives Warrant Additional Internal Oversight

The Maine Film Commission has not been available to fulfill its advisory role to the Maine Film Office, Maine Office of Tourism and DECD since 2019. The Maine Film Office Director was previously the clerk of the Commission during its operation but could not provide meeting minutes to OPEGA from historical meetings, making it unclear to what degree the MFC ever played an advisory role.

In addition to the Commission being unavailable to provide oversight, MFO certification, including decision-making about the treatment of applicants, has been handled by one person. While small incentives might warrant small administration, the absence of any program rules or guidance leaves open the possibility that decisions are not consistently

made according to known standards. The Maine Office of Tourism is not involved in the certification of production companies or the qualification of expenses.

Recommendations

- Legislative Action: If the visual media (VM) incentives remain important policy tools for the State of Maine, they should be revised and modernized to effectively target a clearly defined purpose that reflects current economic and VM industry realities. OPEGA suggests that this effort begin with clarifying what policymakers expect the incentives to accomplish, and memorializing a purpose and goals for the incentives. The structure, or design, of the VM incentives should then be reworked to efficiently target those goals while minimizing administrative burden for participants. Quality data collection should be established to facilitate future oversight of the use and impacts of the incentives.

  OPEGA noted that more resources and perspectives were expected later in 2023. The Department of Economic and Community Development (DECD) commissioned a SWOT (strengths, weaknesses, opportunities, threats) analysis on the Maine VM industry, with a final reported expected by the end of June 2023. The Maine Film Commission is also in the process of being reconstituted. Finally, DECD has contracted for analysis of the economic impacts of a suite of economic development programs, including the existing VM incentives.

- Management Action: Changes should be made to the incentives' administration. DECD should ensure full statutory compliance and that Maine Film Office is a good steward of state resources. Program requirements and processes should be clarified through rule-making and guidance development. Program data should be improved and be available for monitoring program performance.

The website link to this evaluation report is https://legislature.maine.gov/doc/9940

3. OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams

The GOC directed OPEGA to review certain records generated by the Maine Department of Health and Human Services Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. OPEGA presented the second of four OCFS case file reviews to the GOC in April 2023.

OPEGA concluded that OCFS safety decisions regarding Maddox Williams were not unsound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were made. OPEGA identified one Legal Issue, one Practice Issue, and one Resource Issue, all with corresponding recommendations; one Public Policy Consideration; and two Potential Opportunities for Improvement.

Legal Issue: Existing Process May Not Adequately Ensure Robust Documentation of Legal Justifications for Not Filing a Statutorily Mandated Termination of Parental Rights (TPR) Petition

> The reunification of Maddox's half-siblings with their parents spanned over two years, with the children placed in separate foster homes for most of that time. According to statute, the Department shall file a termination of parental right petition (TPR) when a child has spent 15 out of the last 22 months in foster care unless certain legal justification not to do so is present. In this case, a TPR was not filed at that point in the case. While the underlying reasoning for that decision may not have been unsound, we observed this decision to be passive, with no formal decision documented at the 15-month mark, and reunification continued. This is one of the areas where actions in the case of the half-siblings eventually governed some of the results for Maddox's placement.

Practice Issue**:** Custodial Arrangements Were Not Explored for All Children in the Home

> In a departure from OCFS policy, we noted that the father of one of the half-siblings was not interviewed in the course of a domestic violence incident investigation. Although there was initial confusion surrounding which children were present for the incident under review, the caseworker did identify the correct children and, per the record, does learn about the eldest's child's custodial arrangement. Not contacting and interviewing this parent represents a missed opportunity for the caseworker to have potentially learned more about family functioning and additional risk and safety concerns within the home. The caseworker also could have sought permission from the father to interview the child when the child returned to his home.

Resource Issue: Staff Vacancies May Impact Casework

This same domestic violence incident investigation did not include an exhaustive exploration of all potential forms of child abuse and neglect. The caseworker had 15 additional cases at the time of this investigation. The approach to the investigation was similar to that which we observed in our 2022 Child Protective Services Investigations report, in which we identified the issue of high workloads impacting the thoroughness of investigation casework. We found four factors that impacted overall workload: the number of investigations, staffing levels, the number of investigative tasks, and investigative timeframes.

In order to comprehensively evaluate the risks posed to children, workloads must be manageable for caseworkers. Persistent staffing vacancies create higher workloads and a need to triage cases to meet minimum required expectations and to address the cases in which children are at the highest and most immediate risk. Though the Legislature has approved additional staffing positions and a pay increase in recent years, vacancies and the recruitment and retention of staff remain a challenge.

Public Policy Consideration: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS

Throughout our review of the child protective services system, OPEGA has observed a disconnect between what the public expects the system is (or should be) doing and what the system is actually doing or capable of doing (as informed by law and policy). The field of child welfare exists as an array of competing interests that strike a delicate balance. Not everyone will agree as to what best serves a child, but it is a topic worthy of further discussion. We do note that the Department has not requested any changes to their current legal authority.

Potential Opportunities for Improvement

1: Continue OCFS Research into Identifying Risk Factors Related to Targeted Children

In discussions with OCFS management, an observation was shared that the Marissa Kennedy, Kendall Chick, and Maddox Williams cases all involved children who resided in or were cared for in homes with multiple children, yet only one child was the victim of physical abuse. OCFS management is currently researching the concept of targeted children, including a focus on attachment between parents and child victims of abuse. OCFS should continue current research into this area and, if possible, consider how to incorporate any evidence-based approaches to this situation into future training, policies, practices, and/or risk assessments.

2: Increase Availability of CODE Resources

The court-ordered diagnostic evaluation (CODE) program provides forensic child maltreatment risk and needs assessments of parents, guardians, other caregivers, children, and their families. Through interviews with the Department, we have learned that there is a lack of CODE evaluators throughout the state. Our understanding is that there are three evaluators covering the state. While OPEGA has not fully evaluated the capacity of CODE evaluations and is not in a position to opine on the merits of these evaluations, the Department has indicated a lack of available evaluators statewide and a lack of internal resources to assist in the recruitment of evaluators. We were unable to assess the reasons for the lack of CODE evaluators as part of this review, but OCFS management indicated that more resources allotted to this program could provide an opportunity to better recruit and retain evaluators.

3: Persistent Disconnect Between Public Expectations for the CPS System and the Current Legal and Policy Framework and Capabilities of OCFS

Throughout our review of the child protective services system, OPEGA has observed a disconnect between what the public expects the system is (or should be) doing and what the system is actually doing or capable of doing (as informed by law and policy). The field of child welfare exists as an array of competing interests that strike a delicate balance. Not everyone will agree as to what best serves a child, but it is a topic worthy of further discussion. We do note that the Department has not requested any changes to their current legal authority.

Recommendations

- OCFS should look to better formalize and more robustly document the decision about whether to file a Termination of Parental Rights petition after a child has been in foster care for 15 of the past 22 months. It should prompt staff to make this decision according to the timeframe specified in statute in an effort to promote permanency for children in foster care.
- OCFS should provide guidance to supervisors and caseworkers on the practice of exploring custodial arrangements of the identified children in the household. Understanding the composition of the household, including any out of home parents and their custodial arrangements (such as when the child will be residing with the other parent), may be a means of obtaining better information about the family and any risk and safety concerns. It also may be a means of gaining permission to interview or observe children who are otherwise prevented from being accessed by one parent. OCFS should reinforce this practice through communication and training of staff, amend the investigations policy and pursue any related forms to ensure this investigative task is always completed by caseworkers.

- OCFS should conduct a comprehensive examination of CPS caseworker vacancies to identify and propose new strategies to recruit and retain staff. Resulting strategies should be specifically targeted and focused on child protective caseworker positions to address the staffing vacancies within this area of social work. This examination should include the following:

    - continue to determine the underlying reasons for CPS caseworker vacancies through exit and stay interviews and how concerns of child protection caseworkers specifically may be alleviated;
    - examine the fundamental structure of caseworker and supervisor jobs, and assess whether any restructuring would promote staff retention;
    - explore changes to the retirement system and other incentives specific to child protective services casework to promote staff retention and longevity (The Department notes that the work of OCFS field staff is substantially analogous to that of other first responders, including law enforcement, but these staff do not benefit from the same treatment in statute and policies.)
    - examine the Department's current requirement that caseworkers be licensed social workers;
    - work with the State Board of Social Worker Licensure to develop a means of getting otherwise qualified applicants the requirements they need to become licensed; and
    - report back to the Legislature on the status of these efforts and the current number of vacancies.

The website link to this review report is https://legislature.maine.gov/doc/9997.

4. Workplace Culture and Climate Survey of the Fire Marshal's Office and Accompanying Project Recommendation

In March 2023 the GOC voted to allow the OPEGA Director to conduct an initial interview series to gather more information on worker dissatisfaction and workplace culture in the Office of State Fire Marshal. OPEGA consulted Maine statute and policy relevant to the Fire Marshall's office, reviewed recent legislative hearings on these issues, and developed a series of questions to be posed, confidentially, to current employees of the Fire Marshal's Office willing to meet with us. The majority of current staff (33 of 39 employees or 85%) participated in interviews, including 16 of 18 investigations staff, 16 of 20 inspections and office support staff, and the Fire Marshal.

OPEGA summarized themes that emerged from the interviews such as disagreement about the mission of investigations, workload imbalance concerns, dissatisfaction with support from human resources, pressure from politically connected individuals to reconsider inspector findings, a divide between inspectors and investigators, and disagreement about how well the office meets the needs of community fire departments.

It was clear to OPEGA that lingering concerns remain about the work culture and climate in the Fire Marshal's Office, which will require sustained effort and initiatives to overcome and resolve. These matters include internal controversy with respect to the fundamental mission of the office, whether and how previous leadership acted on employee concerns, and the details and demands of day-to day work scheduling and deployment of resources, much of which is the subject of collective bargaining and the processes for resolving employee complaints or management-initiated disciplinary action in that context.[3] There were also examples of prior statements alleged to have been made within the office that, if true, would be deemed entirely inappropriate in light of prevailing workplace standards. OPEGA was also told of other purported statements by employees to one another that do not comport with standards of conduct and professionalism. It will be incumbent upon office leadership, including and up to the new Fire Marshal and the Public Safety Commissioner, to ensure that going forward, there is no place within the Fire Marshal's office for such statements or attitudes.

Recommendation

OPEGA recommended that the GOC transmit these survey results to the CJPS Committee, the Commissioner of Public Safety, and the Fire Marshal, with a request that they review and consider the results, and that the Commissioner and the Fire Marshal be invited to provide updates at regular public intervals to the CJPS Committee and the GOC on the status of any plans or actions to address matters and ensure an appropriate workplace climate. OPEGA recommends that such reporting intervals, at a minimum, be at 6 months and one year following the receipt of these results, or as otherwise deemed appropriate by the CJPS Committee.

[3] In December 2023, the Maine Labor Relations Board issued a decision regarding a number of these concerns: 23-PPC-07.pdf (maine.gov)

5. OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Case of Jaden Harding

The GOC directed OPEGA to review certain records generated by the Maine Department of Health and Human Services Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. OPEGA presented the third of four OCFS case file reviews to the GOC in November 2023.

During Jaden Harding's life, there was no CPS involvement with his family. Prior to his birth, however, his family had a history of CPS involvement dating back to 2014, when his oldest half-sibling was born. As prior actions and safety decisions can potentially impact the safety of a child born later—and in the interest of identifying areas that may lead to improved outcomes for children—OPEGA reviewed this family's larger CPS history.

OPEGA assessed whether decisions made by OCFS were sound in light of prevailing child protection policy and practice, the laws governing such matters, and the information known (or that should have reasonably been known) to authorities when the decisions were made. Overall, OPEGA identified two instances in which we concluded unsound safety decisions were made regarding the safety of children other than Jaden. Additionally, OPEGA identified two overarching practice issues, eight specific practice issues, one systems issue, and three potential opportunities for improvement.

Unsound Safety Decisions

Unsound Safety Decision 1: No Additional Interventions or Safety Planning to Ensure the Safety of the Children (Prior to Jaden's Birth) from the Man Living in the Home

> Following the report that one of the children had sustained an ear injury that was allegedly inflicted by a man living in the home, OCFS did not adequately address concerning information discovered during the background check, including a documented history of domestic violence. A safety plan to remove the man from the home pending a thorough assessment of the man's safety was warranted, but did not occur.

Unsound Safety Decision 2: No Additional Interventions or Safety Planning when Out-of-State Relatives Leave Mother's Home

> The mother was investigated following the death of an adult family member in her home, after law enforcement reported concerns about her mental health and ability to care for her children. A preliminary safety decision determined that the children could remain in the home. The presence of out-of-state relatives to help care for the children was reportedly the most significant factor in determining the children were safe in the home.

It was noted that they would be leaving in a few days. This fact warranted additional interventions or a safety plan (such as additional supports, the required presence of a safe adult in the home or increased monitoring) to ensure the children's safety. We did not see any evidence that such actions occurred or were even considered.

Practice Issues

Throughout our review of this family's CPS involvement, it became apparent that, over time, certain practice issues, mistakes, and missed details and connections all contributed to the Department not fully understanding some risk factors and safety threats that were present in the home. Consequently, as caseworkers and supervisors would not be able to act upon what they did not know, the children's safety was compromised at some specific points in the timeline. We discussed these points with OCFS staff: what was known, what could have been known, and what caseworkers and supervisors would have done had they better understood the risk factors and safety threats. They indicated that with that additional knowledge at those points, different safety decisions and additional interventions would have been warranted. The two practice issues that contributed to much of what occurred are described below.

Overarching Practice Issue 1: Important Connections Missed by OCFS Across Multiple Investigations Regarding the Risks Posed by a Relative

Throughout this family's history of CPS involvement, caseworkers were informed of the recent presence of one of the mother's relatives, but were unable to recognize that this relative was the same relative who was the alleged sexual abuser of the children in March of 2019. We found that this inability was often the result of either a mistake, a systems issue, a lack of comprehensive review of the family's history, simply not seeing the connection or some combination (often compounding) of any of these factors. Ultimately, it resulted in the Department never fully understanding that the mother was allowing the alleged sexual abuser of her children to reside in her home with those very same children on two later occasions that either overlapped or directly preceded CPS investigations.

Overarching Practice Issue 2: No Comprehensive Review of the Family's Prior CPS Involvement That Would Have Shown a Pattern of the Mother Allowing Unsafe Individuals Around Her Children

At multiple points in the timeline, caseworkers appeared to only consider and respond to the specific incidents identified in their assigned reports, and did not have a full understanding of the family's prior CPS involvement, including previously identified safety risks and concerns that would continue to be relevant. We conclude that these incident-based responses also prevented caseworkers from identifying inconsistencies in information provided by critical case members over time, and hindered caseworkers' ability to identify patterns of concerning behavior that, cumulatively, may have warranted further CPS intervention.

Specific Practice Issue 1: Extremely Overdue Investigation with Periods of No Investigative Activity

A CPS investigation began in early April 2018 after a law enforcement report of a domestic violence incident at the home. A caseworker interviewed the adults and observed the children within three days. With no immediate safety concerns, the investigation remained open with no further contact until intake received a report at the end of June that one of the children was injured at another home. The caseworker met with the mother and observed the three children, who had no apparent injuries. Again, the case was not worked or closed for several months. In early October, a friend reported that the mother was struggling to care for the children. After several failed attempts to contact the mother, the case was closed in early December with no findings of child abuse or neglect.

Specific Practice Issue 2: Inadequate Efforts to Locate the Family

The caseworker's attempts to contact the mother consisted of only a pair of phone messages. Caseworkers are expected to make every effort to locate all critical case members using the strategies contained within the Activities to Locate tool, and to document those efforts. They should search OCFS records and other state agency records; contact relatives, friends, providers, employers, landlords, etc.; and perform internet searches.

There were several actions that one would expect the caseworker to potentially take: make an in-person visit to the family shelter where the mother had been staying; contact the mother's biological parents; contact her former partner; and contact her adoptive family members. We did not see any evidence that any of these actions were undertaken, which was confirmed by the caseworker and supervisor. Given the workload issues at the time, the apparent relative safety of the children, the nature of the allegation, and the length of time that the investigation had been open, the caseworker and supervisor determined that closing the case was a better choice than continuing to make efforts to contact the mother.

Specific Practice Issue 3: Incorrect Identification of Alleged Abuser by Intake

In March 2019, a report was made by a medical provider with concerns about possible sexual abuse of one of the children by a relative. The relative was identified only by their familial relationship, as the referent did not know the relative's name. This report was screened in for an investigation. Intake caseworkers used the familial relationship and the mother's CPS history as a youth to determine the name and identity of the relative. This was the relative's birth name rather than the adoptive name that they currently used. This error soon made an impact as the caseworker performed background checks that did not

return any records—which did not accurately reflect the relative's actual criminal and motor vehicle histories. The relative's actual criminal history contained multiple domestic violence convictions (threatening, terrorizing, and assault), a history of violating conditions of release and/or probation violations, and a variety of other offenses—which would have warranted additional scrutiny and, possibly, eventual further action by OCFS.

Specific Practice Issue 4: Reported Allegations and Safety Threats Unexplored by Caseworkers

Several reports that were screened in by intake in 2018 and 2019 included allegations of safety threats to the children that were never explored by caseworkers, including that the mother was leaving the children alone with potentially unsafe people in unsafe environments, that the mother was not supervising the children and was not taking them to medical appointments, and that a relative threatened to abuse one of the children.

Specific Practice Issue 5: Inconsistent and Sometimes False Information Unexplored by Caseworker

During the February 2020 investigation of one child's ear injury that was allegedly inflicted by a man living in the home, the caseworker obtained police reports indicating that the man's current partner had taken out a protection from abuse order (PFA) against him and that he had recently violated that PFA. We did not see any evidence that the caseworker explored these inconsistencies. Similarly, during the March 2020 investigation of one of the children being found unattended by the side of the road, it was learned that a relative had been staying at the home until the relative was removed from the premises by law enforcement. The mother then claimed that she had filed a PFA so that the relative could not be around her, her children, or the home. When the caseworker requested a copy of the PFA, the District Court reported that it could not be found. We did not see any evidence that this inconsistency was ever explored or discussed with the mother.

Specific Practice Issue 6: Status of Bangor Police Department Investigation Unexplored by Caseworker

In the closing letter following the March 2019 investigation of the alleged sexual abuse of two of the children noted that a criminal case was opened and ongoing with the police department. In early 2020 the same caseworker was assigned two more investigations of the family, yet never followed up on the status of that prior Bangor PD investigation, even after learning that the alleged abuser had been around the children. In both of these later investigations, we believe the results and status of the relative's criminal investigation would have been relevant to the caseworker's assessment of the family's safety, and the mother's protective capacity.

Specific Practice Issue 7: Installation of Child Safety Locks Not Verified by Caseworker

After one of the children was found unattended by the side of the road, the mother stated in her initial interview with the investigating caseworker that she would be installing child safety locks on the doors and windows of her home. That same day, the preliminary safety decision was made that the children were safe while the Department continued its investigation. That preliminary safety decision, as documented by the caseworker's supervisor, included the next steps to be taken by the caseworker to complete the investigation. One such step was to verify that the mother either installed child safety locks on the doors of the home or used the existing locks. We did not see any evidence in the record that caseworker returned to the home or verified that child safety locks were installed or that existing locks were being used appropriately.

Specific Practice Issue 8: Mr. Harding's Safety Never Assessed

After the closure of a June 2020 investigation, a family team meeting/transfer meeting was held in early August to officially transfer the family to Alternative Response Program (ARP) for additional services. The mother disclosed that she was pregnant and in a relationship with Ronald Harding. We did not see any evidence that Mr. Harding's safety was ever assessed even though he met OCFS's definition of a household member; in fact, had the mother's pregnancy and relationship with Mr. Harding been known before the closure of the investigation, the OCFS caseworker would have been expected to assess the safety of Mr. Harding. Although the discovery of the pregnancy and Mr. Harding's existence occurred after the investigation closed and during the transfer to ARP for a particular set of services, we did not see any documentation that suggested the OCFS caseworker and the ARP worker discussed whether Mr. Harding should be assessed, and, if so, by whom. This was later confirmed in an interview with the former caseworker.

Systems Issue: Multiple Profiles for the Same Individual

One relative in this case had two separate, incomplete child protection system records. Staff explained that OCFS's Comprehensive Child Welfare Information System (CCWIS) and the Office of Family Independence's Automated Eligibility System (ACES) use a common client repository to share client demographics across the two systems. ACES is the system of record for client demographic information, but duplicate clients can be created between ACES and CCWIS if staff fail to properly screen new individuals into the system (i.e. not determining that a person is already in the system). This relative had multiple profiles under both their birth and adoptive names, resulting from improper screening. When the caseworker selected one of these profiles, the caseworker saw only the CPS history that was attributed to that specific profile and not the entirety of the relative's CPS history that existed across multiple profiles. This

resulted in the caseworker not having complete information about this family member and sometime household resident at times when they had to make decisions about the children's safety.

Potential Opportunities for Improvement

1: Identifying and Providing Appropriate Levels of Services for Families

Jaden's family exhibited a number of risk factors that generally hovered near the threshold for Departmental intervention. In those instances when the family's risk level was at or exceeded that threshold, various services would be provided to the family to mitigate some of those risks and to help the family in its day-to-day functioning. To some extent, the family would experience success in services—often just enough to end CPS's involvement with the family; however, when those services ended (or the family otherwise stopped participating), the family would regress. Conditions would eventually worsen until another report would be made to CPS—and the process would start over again. In discussing this cycle with OCFS staff, they expressed the need for a better means of conducting individual, parent, and family function analyses to be in a better position to recommend the most appropriate types and levels of services needed. Identifying those services would only be one component of that challenge; services would need to actually be available, which is beyond the complete control of OCFS.

2: Information Sharing Between OCFS, Law Enforcement, and the Courts

Over the six-year period in which this family had various, intermittent CPS involvement, we noted times in which law enforcement had information that would be valuable to OCFS considering the family's history. As our work related to these information gaps is quite limited, we have no specific recommendations. However, we encourage the parties involved to consider how information might be better shared or accessed so that OCFS and caseworkers can identify and appropriately respond to concerns as they emerge—particularly when those concerns involve families with high levels of risk and frequent CPS involvement. Reviewing the extent and manner of communication and information exchange among these parties represents a potential opportunity for improvement.

3: Feedback and Management Expectations

Throughout these reviews, we have spoken to members of OCFS management who performed comprehensive reviews of the CPS histories in these cases. Management had certain practice expectations for caseworkers and supervisors, such as analyses of information, investigative actions taken (or not taken), and conditions that would warrant further investigation or even Departmental intervention. We noted that caseworkers' and supervisors' practice expectations sometimes varied from that of higher management. As a result, we began asking whether caseworkers and supervisors had received any

feedback from higher management related to the specific investigations that they had conducted. We were told that this had not occurred. We believe this represents a potential opportunity for improvement as management should share their perspectives on what occurred in these investigations, as well as their expectations, directly with the caseworkers and supervisors who performed the work.

Recommendations

- OCFS should develop a process and standard for identifying which families' CPS histories should be subject to a more comprehensive review. Additionally, OCFS should ensure that any staff assigned this work have the time and resources needed to conduct them.
- OPEGA recommends that the Department take a thoughtful, measured approach to future policy changes with a focus on potential workload impacts to avoid risks—especially as the Department experiences difficulties in the recruitment and retention of caseworkers.
- As the Department continues to update its investigations policy and any related documents, we recommend that the "Activities to Locate" tool continue to be used and caseworkers continue to be trained in its application.
- OPEGA recommends that OCFS consider implementing a mechanism to denote instances in which intake—and not the referent—has identified a critical case member. In denoting these individuals, caseworkers should be cognizant of the need to verify the accuracy of the identities provided solely by intake.
- OCFS should clarify and communicate its expectations for what caseworkers should do when an "FYI report" that would otherwise be screened out is added to an open investigation. For other screened-in reports containing multiple allegations, supervisors should ensure that caseworkers, at a minimum, discuss all allegations with the parents/caregivers.
- OCFS should make efforts to communicate and reinforce its expectation that caseworkers identify and challenge inconsistencies in the information provided to them by families.
- Following up on the results and status of earlier criminal investigations can provide valuable information to caseworkers. As such, OCFS should consider developing guidance for closing summaries specifying how caseworkers are to document that there are ongoing criminal investigations when the investigation closes and establishing expectations for what subsequent caseworkers are to do if new reports are screened in for investigation.
- OCFS should consider the development of a process to ensure that any tasks identified as next steps to complete the investigation as part of the preliminary safety decision are revisited by the caseworker and supervisor prior to the closure of the investigation. Any steps that are determined to still be relevant, but not yet performed, should be performed before the investigation is closed.
- OCFS should establish appropriate CPS history search guidance to mitigate the risks associated with multiple profiles. This guidance could include more thorough search

criteria, such as verifying date of birth or social security number. The Department should also review its current guidance related to screening people into the Department's various systems to ensure that there is a process that appropriately addresses the risks associated with entering multiple profiles for a single individual.

- OCFS should consider revising its investigations process and related checklists to require caseworkers to confirm a family's living arrangements and that all household members have been identified when nearing the end of an investigation to ensure that the safety of all individuals residing in the home with access to the family's children is assessed before the investigation is closed. This is particularly relevant as it appears the living arrangements and household compositions of the families that the Department works with can change often.

The website link to this review report is https://legislature.maine.gov/doc/10422

Projects In Progress and Up Next

During 2023, OPEGA conducted work on the following projects.

1. Child Protective Services: Reunification

OPEGA's review of Family Reunification work within the Office of Family and Child Services, Child Protective Services (CPS) was the expected third phase of OPEGA CPS reviews initiated by the GOC in 2021. The first two phases, Oversight and Investigations, were completed in 2022. In September 2022, the GOC voted to pause work on Reunification and prioritize the four child death case file reviews. This May, the GOC authorized OPEGA to restart work on Reunification when possible, while prioritizing completion of the child death case file reviews.

2. Four Tax Expenditure Evaluations

OPEGA conducts reviews of tax expenditures in accordance with Title 3 §998 and §999. Tax expenditures are defined by Title 5 §1666 as "state tax revenue losses attributable to provisions of Maine tax laws that allow a special exclusion, exemption or deduction or provide a special credit, a preferential rate of tax or a deferral of tax liability." The GOC, in consultation with the Joint Standing Committee of the Legislature having jurisdiction over taxation matters, assigns a category to tax expenditures and establishes a prioritized schedule for the reviews. In April, the GOC approved evaluation parameters for OPEGA's full evaluation of four tax expenditures. Two of these evaluations are expected to be reported out in the first quarter of 2024; while the remainder are expected later in 2024.

Credit for Maine Shipbuilding Facility Investment

This credit was enacted to create and retain jobs in the shipbuilding industry in this State by providing an income tax credit to reduce the cost of investments in shipbuilding businesses and thereby encourage investment in shipbuilding businesses and improve the competitiveness of this State's shipbuilding industry. OPEGA completed fieldwork on this expenditure in 2023 and is drafting the report for an expected first quarter of 2024 release.

Credit for Paper Manufacturing Facility Investment

This credit provides incentives for the revitalization of paper manufacturing facilities in counties with high unemployment and to create or retain high-quality jobs in the State by encouraging paper manufacturers to modernize their paper manufacturing equipment to better compete in the marketplace. OPEGA completed fieldwork on this expenditure in 2023 and is drafting the report for an expected first quarter of 2024 release.

Credit for Major Food Processing & Manufacturing Facilities Expansion

The purposes of this credit are to: 1) create high-quality jobs in the State by encouraging major businesses to locate or expand their food processing and manufacturing facilities in this State and to encourage the recruitment and training of employees for these facilities; and 2) directly and indirectly improve the overall economy of the State including the agricultural economy, small businesses, employment in rural areas and expansion of the tax base.

Credit for Major Business Headquarters Expansion

This credit was enacted to create and retain high-quality jobs in the State by encouraging major businesses to locate their headquarters in the State or to expand their headquarters in the State.

3. Maine's Veterans Homes

In February, concerns were first brought to the GOC about possible financial control weaknesses within Maine Veterans' Homes (MVH). The GOC Chairs sent a letter to the MVH Board of Trustees asking that OPEGA be provided the status and results of any internal investigation of the concerns that had been raised. MVH produced the results of a confidential internal investigation to OPEGA. In March, OPEGA reported that the concerns raised had not been fully addressed, in OPEGA's judgment. The GOC voted to add Maine Veterans' Homes to the OPEGA workplan, with an initial scope of examining allegations made by the former Controller of that organization. From March to June, MVH produced documents in stages and OPEGA conducted an initial review. In August, OPEGA met with the MVH CEO and Chair of MVH's Board of Trustees.

In September, OPEGA reported to the GOC that questions remain about the strength of certain MVH financial internal controls. The GOC voted to approve OPEGA's recommendation to continue work by assessing MVH's internal controls over spending in relation to budgetary limits and related processes, working in tandem with the office of the State Auditor, as deemed necessary. OPEGA field work is expected to commence in the second quarter of 2024, based on current GOC priorities regarding child protection matters.

4. CPS Case File Review #4: Safety Decisions and Actions Taken in the Case of Sylus Melvin

The GOC directed OPEGA to review certain records generated by the Maine Department of Health and Human Services Office of Child and Family Services (OCFS) to better understand the safety decisions and actions taken by the Department during its involvement in the lives of four Maine children who died in 2021. OPEGA has been releasing separate reports on each case, including as related court proceedings and sentencing took place. This is the last of these case file reviews and it is expected to be completed in 2024.

Tax Expenditure Review Reclassification

Deduction for Contributions to Capital Construction Funds for Maintenance or Replacement of Fishing Vessels (FISH)

On April 28, the GOC voted to reclassify the Deduction for Contributions to Capital Construction Funds for Maintenance or Replacement of Fishing vessels from a Full Evaluation to an Expedited Evaluation, as defined under 3 MRS §998. This deduction was originally classified for evaluation purposes as a Business Incentive and scheduled for a Full Evaluation. OPEGA initially recommended this classification as part of a high-level effort to categorize hundreds of tax expenditures. After beginning work on the review, OPEGA discovered that the deduction was implemented as a matter of conformity with the federal tax code. Consequently, OPEGA recommended that a Full Evaluation of the deduction should not be completed. Instead, OPEGA recommended the deduction be reclassified for evaluation with other federal conformity matters for Expedited Review under the Rationale category of Conformity with Internal Revenue Code.

Activities Related to Past OPEGA Reports

Each year, OPEGA and the GOC conduct follow-up work as needed related to previously completed projects. Notable activities during 2023 in this regard included:

1. Child Protective Services

OPEGA continued to assist the GOC with ongoing oversight activities related to child protective services, including coordinating presentations by a range of agency or legislative officials, as well as a series of public hearings in November and December at which stakeholders shared their experiences working with the Office of Child and Family Services (OCFS). At its October 18 meeting, DHHS and OCFS staff presented to the GOC about call wait times and a recent report on federal performance measures. GOC members agreed that they were not satisfied with the performance of OCFS and that the Committee had not done enough to improve child safety. They agreed to hold extra meetings focused on child protective services for the rest of the year.

2. Prior Year Tax Expenditure Evaluations

In preparation for a November presentation to the Taxation Committee on five prior year tax expenditure evaluation reports, OPEGA staff reached out to administering agencies for updates on any actions taken in regards to report recommendations and compiled the updates. The administering agencies are the Department of Economic and Community Development (DECD), Maine revenue Services (MRS), Maine Historic Preservation Commission, and the Finance Authority of Maine (FAME).

Support to the GOC and the Legislature

1. Staffing of the Government Oversight Committee

OPEGA provides staffing services for the Government Oversight Committee. Staff support includes coordinating and giving notice of meetings and agendas, developing and distributing written meeting materials, and preparing written summaries of the meetings. In 2023, OPEGA staffed 19 GOC meetings. The OPEGA director and staff made the following presentations to the GOC:

- GOC Orientation
- *OPEGA Annual Report 2022*
- 2023-2024 OPEGA Work Plan
- OPEGA FY2023-24 Budget
- *OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Hailey Goding*
- *Tax Expenditure Evaluation: Tax Benefits for Media Production Companies*
- *OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Maddox Williams*
- *Workplace Culture and Climate Survey of the Fire Marshal's Office and Accompanying Project Recommendation*
- Description of Tax Expenditure Process Modifications per P.L. 2023 c.417
- Tax Expenditure Classification & Review Schedule
- *OCFS Case File Review: Safety Decisions and Actions Taken in the Case of Jaden Harding*

2. Support for GOC Consideration of Review Requests

Each year, OPEGA performs research and gathers information and documentation to support and facilitate the GOC's consideration of potential topics for OPEGA review projects. To be presented to the GOC for consideration, a request for an OPEGA review must be initiated or sponsored by a Legislator and must be submitted in writing. In 2023, OPEGA and the GOC worked together on designing and reviewing preliminary research on Maine Veterans' Homes and the Fire Marshal's Office.

OPEGA assisted the GOC in processing Legislative requests to review four other topics, which did not ultimately move to OPEGA's Work Plan:

1. DHHS public program call wait times
2. Maine's environment and natural resources agencies
3. Maine Health Insurance Marketplace, CoverMe.gov
4. Staff safety at Riverview Psychiatric Center and Dorothea Dix Psychiatric Center

OPEGA also fields letters, phone calls and emails throughout the year from a number of individuals seeking information or inquiring about the potential for an OPEGA review of a topic of concern to them. OPEGA responded to individuals who contacted the office for this purpose and conducted follow-up work to provide information and guidance by telephone, e-mail or other written communication.

3. Presentation of OPEGA Tax Expenditure Reviews

Annual Tax Expenditure Review Categorization with the GOC

In October, OPEGA presented its recommendations to the GOC for changes to the Tax Expenditure Classification and Evaluation Schedule according to 3 MRS §998. Tax expenditures are assigned to three different review categories: Category A is a full evaluation for expenditures that are expected to provide an incentive for specific behaviors, that provide a benefit to a specific group, or for which measurable goals can be identified; Category B is expedited review for tax expenditures that implement broad tax policy goals that cannot be reasonable measured; and Category C is no review, for expenditures with less than $50,000 in impact on state revenue or than otherwise do not warrant a full or expedited review.

Based on statute changes in the first regular and first special sessions of the 131st Legislature, OPEGA recommended adding the newly enacted Dirigo Business Incentive Program Tax Credit to Category A, and deleting the recently repealed Property Tax Stabilization Program and Pine Tree Development Zones Program. OPEGA suggested adding two recently enacted expenditures to Category B: the Cannabis Business Expense Modification and the Service Provider Tax Exemption for Nonprofit Housing Development Organizations. OPEGA suggested promoting the Electricity Used for Net Billing Tax Exemption from Category C to Category B, and adding another new expenditure, the Maine Income Tax Provisions for Certain Indian Tribes and Tribal Members, to Category C. The GOC approved these recommendations.

Presentations to the Taxation Committee

In April, OPEGA provided a full presentation of the Research Expense Tax Credit (R&D Credit) to the Taxation Committee in support of their work processing related legislation. In November, the Taxation Committee held a meeting dedicated to processing previous OPEGA tax expenditure evaluations according to 3 MRS §999(4). For this meeting, OPEGA prepared supporting materials and presented five reports dating back to 2020. The presentations covered OPEGA evaluations of:

- Visual Media Incentives (2023)
- Research Expense Tax Credit (2022)
- Historic Rehabilitation Tax Credit (2021)
- Maine Seed Capital Tax Credit (2021)

- Business Equipment Tax Reimbursement (BETR) & Business Equipment Tax Exemption (BETE) (2020)

Also at the November Taxation Committee meeting, OPEGA reviewed its recommendations for 2023 tax expenditure evaluation categorization and scheduling changes, allowing that Committee to affirm to the GOC that it agreed with the proposed changes.

Presentation to the Appropriations and Financial Affairs Committee

In January, OPEGA's Director provided an overview of OPEGA's tax expenditure review categorization and evaluation process for the Appropriations and Financial Affairs Committee.

OPEGA's Budget

Table 2. OPEGA's Budget and Expenditures by Fiscal Year – As of 12/31/2023			
	FY2022	FY2023	FY2024
Total General Fund budget	$1,521,825	$1,566,846	$1,762,028
Total General Fund dollars expended	$1,256,022	$1,291,864	$939,283
Dollar variance of expenditures to budget	($265,803)	($274,982)	($822,745)
% variance of expenditures to budget	(17%)	(18%)	(53%)

Prior year balances:

Personal Services - $709,324
All Other - $620,783

Total - $1,330,107

The prior year balances have accumulated over the course of several years. Balances in the All Other line are mostly related to the unused portion of the $85,000 baseline budget intended for consultants. Balances in the Personal Services (PS) line in recent years are mostly due to the health premium holidays and lower than projected premium rates for health insurance, vacancies, and changes in staff.

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- Department of Economic and Community Development
- Law and Legislative Reference Library
- Maine Revenue Services
- Office of the Attorney General
- Office of the Executive Director of the Legislative Council
- Office of Fiscal and Program Review
- Office of Legislative Information Technology
- Office of Policy and Legal Analysis
- Office of the State Auditor
- Office of the State Controller