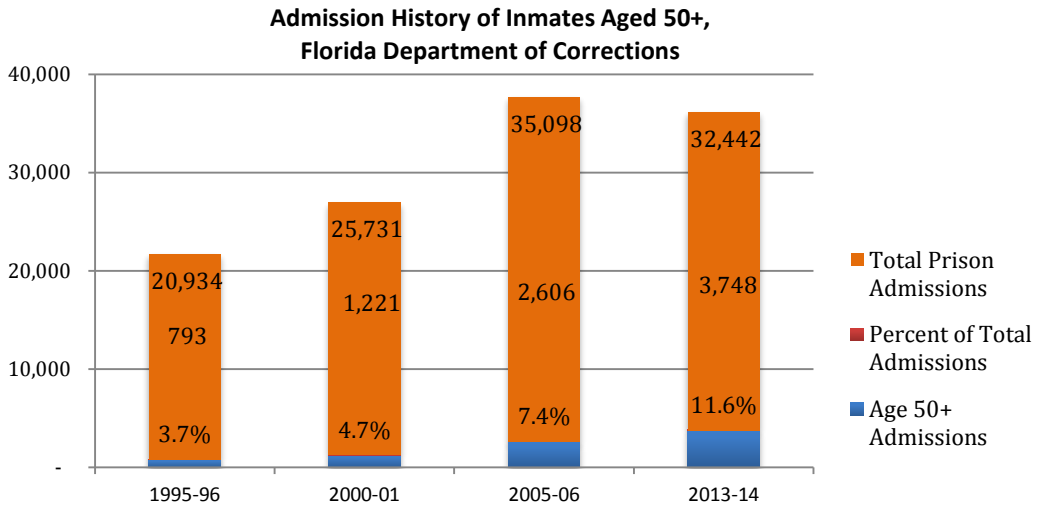
Florida's Aging Inmate Population

The aging inmate population and the impact older inmates have on the state correctional system and Florida's budget is a public policy issue worthy of serious deliberation and continuing scrutiny. Factors such as the increase in length of Florida prison sentences and time served exacerbates the challenge. Notably, Florida is a state where all state prison inmates are required to serve 85% of their sentence. Further, Florida is also a state where, for the vast majority of inmates, parole was abolished in the 1980s.

In Florida, by law (s. 948.8041, Florida Statutes) an inmate who is 50 years of age or older is considered "aging or elderly." This age level threshold is lower than what is considered to be "elderly" in the total general non-incarcerated population and is based on the premise that inmates usually enter the prison system already in poor or declining health due to their life experiences, socio-economic status (including lack of health insurance and preventive care), substance abuse history, and mental health issues.

On June 30, 1999, there were 5,082 elderly inmates (age 50+) in Florida prisons, which are run by the Florida Department of Corrections (hereinafter, the department). On June 30, 2014, that number had increased to 20,753 inmates, more than quadrupling in 15 years.[1]

Interestingly, higher numbers of elderly offenders are also entering the prison system, many (38.2% in 2013-14) **for the first time**. There was a slight decrease (-2.9%) in the number of elderly inmates in FY 2011-2012. However, the total number of inmate admissions that same year also declined (-8%). The increase in FY 2013-14 raised the number of elderly admissions to the highest number (3,748) in 19 years.



Source: Florida Department of Corrections

[1]Florida Department of Corrections, 2013-2014, Agency Statistics Inmate Population, accessed at: http://www.dc.state.fl.us/pub/index.html.

The chart on the previous page illustrates the rise in the number and percentage of elderly inmate admissions. There were 20 inmates aged 76 or older admitted in 2013-14. On June 30, 2014, the department housed three inmates whose age was 92.[1]

This following statement, from the December 2013 Annual Report and Report on Aging Inmates by the Florida Correctional Medical Authority[2] illustrates the situation confronting Florida and other states:

> **"It is evident from the data presented here and in the professional literature, that older inmates have more health problems and generally consume more health care services than younger inmates. Older inmates may also place a greater fiscal strain on correctional systems as they may require additional housing and management needs in a prison setting, secondary to their generalized vulnerability and medical conditions. Many of them will never leave prison because of the length of their sentences. Older prisoners will continue to increase in numbers and in the overall percentage of prisoners, and thus, will continue to consume a disproportionate share of an already limited number of resources available for health care and programmatic enhancements within the correctional setting."[3]**

Quick Look:
Florida's Elderly Inmate Population by Offense

The majority of elderly inmates in Florida prisons as of June 30, 2014, were incarcerated for:

- Sex Offenses (21.6%)
- Murder or Manslaughter (20.8%)
- Drug Offenses (12.9%)

Of the elderly inmates (3,748) admitted to Florida prisons from July 1, 2013 to June 30, 2014, the majority were admitted for:

- Violent Offenses (30.8%)
- Property Crimes (30.5%)
- Drug Offenses (22.4%)

Source: Florida Department of Corrections

In Florida, inmates are classified upon reception and assigned to a prison facility consistent with their physical and medical status and custody level. Age is not the sole factor utilized in determining the institution of assignment. If an inmate is 50 years of age or older and has limitations in the performance of "Activities of Daily Living,"[4] they are assessed by a physician and provided a specialized plan to meet their medical and mental health needs and housed in a prison that is appropriate to their custody level and medical status. Inmates with more serious medical limitations such as blindness, deafness, or requiring a wheelchair or walker, are assigned to institutions specifically designated and equipped to provide appropriate care and custody.

It is important to separate the elderly inmates from the general inmate population to increase their physical safety as well as to consolidate medical resources to optimize

[2] Florida Statute 945.602 authorizes the Florida Correctional Authority. The CMA was created in 1986 by law as part of the settlement of the 1972 *Costello v. Wainwright* case and continues to serve as an independent monitoring body providing oversight of the systems in place to provide health care to inmates in the Department of Corrections.

[3] Florida Correctional Medical Authority, Annual Report and Report on Aging Inmates, December 2013, accessed at ttp://www.flgov.com/wp-content/uploads/pdfs/correctional_medical_authority_2012-2013_annual_report.pdf.

[4] Activities of Daily Living reflects the inmate's ability to move around the compound, bathe, perform hygiene and grooming, dressing, eating, and toileting on their own. See: Florida Department of Corrections, Health Policy Bulletin 15-05-11, Mental Health Services Planning Sheet, accessed at www.dc.state.fl.us/business/docs/8048-15-05-11-appIV.doc.

cost-efficiency. At the time of this report there were six institutions designated to serve, at least in part, elderly and infirm inmates.

The institutions are:

- **Reception and Medical Center** – This prison, in addition to serving as a reception center for inmates sentenced in the northern part of Florida**,** has a 100-bed licensed hospital on site in Lake Butler, Florida, providing nursing care for elderly and chronically ill inmates as well as inmates needing ventilators. In 2011, this facility enhanced staff training and leased specialized medical equipment to treat inmates requiring ventilators. Previously these inmates were transported to community hospitals for treatment and incurred higher costs for the department.

- **The South Unit of the Central Florida Center –** This prison, in addition to serving as a reception center for inmates sentenced in the central part of Florida, is designated to treat special needs inmates, which also includes elderly and palliative care inmates.

- **Zephyrhills Correctional Institution –** This prison, in addition to housing for other inmates has two dorms specifically designated for elderly inmates and inmates with complex medical needs.

- **Lowell Correctional Institution –** This prison housing females has a dorm specifically designated for inmates with complex medical needs, including elderly inmates.

- **South Florida Reception Center –** This prison, in addition to serving as a reception center for inmates sentenced in the southern part of Florida, has one dorm specially designated for elderly inmates and those in need of palliative or long-term care. The facility also provides care for inmates transitioning from hospital stays but not ready for an infirmary level of care at an institution.

Cost of Providing Health Care for Elderly and Infirm Inmates in Florida

The Department of Corrections has a constitutional obligation (as established by the United States Supreme Court in *Estelle v. Gamble*[5]) to provide an acceptable level of health care to inmates. Florida's prison health care, prior to a class action lawsuit filed in 1972 (*Costello v. Wainwright*[6]) was very poor and as late as 1985, a court-appointed

[5] *Estelle v. Gamble,* 420 U.S. 97, 97 S. Ct. 285, 50 L.Ed.2d 251 (1978)
[6] *Costello v. Wainwright*, 430 U.S. 57 (1977)

overseer stated the department exhibited "systematic indifference" to inmate medical care.[7]

The *Costello* case was litigated for 21 years and ultimately resulted in a major shift in the medical care for inmates in Florida prisons. The primary change that finally ended the litigation was the statutory creation of the Correctional Medical Authority (CMA) in 1986 that acted as an independent watchdog over the department's provision of health care services, review of the budget for health care services, and recommendations for changes and improvements in delivery of those services. Another result of the lawsuit was the removal of security staff's role in making health care decisions as well as ensuring that inmates were not providing health care to other inmates.

The United States Supreme Court has established that prisoners have a constitutional right to adequate medical care.[8] Providing health care services to inmates includes a full range of services including: physical, mental health, dental, and pharmacy services. While many of these services are provided in prison facilities, inmates requiring specialized care or emergency care beyond the capability of the prison must be transported to clinics or hospitals in the nearest community providing those services. The transportation of these inmates is expensive, requiring 2-3 correctional officers for security in addition to the cost of the outside medical care. Since 2008, due to legislation tying outside medical services to Medicare rates, the department has been able to secure more favorable contracts with outside medical providers reducing the cost of this care.[9]

While the approximate current cost to house an inmate in Florida for one year is slightly more than $18,000,[10] the cost for elderly inmates cannot be precisely determined. Florida does not provide detailed inmate health costs for elderly inmates as their accounting and information technology systems are currently not designed to capture and monitor such detailed cost data. Senate Bill 7020, currently pending in the Florida Legislature at the time of publication of this report, seeks to address this gap in important data collection by requiring the Florida Department of Corrections to collect and report health costs for elderly inmates.[11]

However, using other information relating to inmate health care in Florida, it can be argued the costs are considerably higher for elderly inmates. In FY 09-10, 16 percent of the Florida elderly prison population accounted for 40.1 percent of all episodes of care

[7]Florida Senate Issue Brief 2011-213, Privatization of Prison Health Services, accessed at: http://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-213cj.pdf.
[8] *Estelle v. Gamble,* 420 U.S. 97, 97 S. Ct. 285, 50 L.Ed.2d 251(1978)
[9] Chapter Law 2009-63 Section 8 (s. 945.6041 Florida Statutes)
[10]Florida Office of Economic and Demographic Research, February 2015 Criminal Justice Estimating Conference.
[11] See Committee Substitute for Senate Bill 7020 at http://www.flsenate.gov/Session/Bill/2015/7020/BillText/e1/PDF.

and 47.9 percent of all hospital days. These inmates had twice the number of sick calls as younger inmates, represented 35 percent of chronic clinic contacts and ambulatory surgeries, and had three times as many drug prescriptions compared to the average inmate (24 percent of all prescription drug costs).[12]

As noted earlier in this report, the percentage of elderly inmates in Florida prisons continues to increase and the impact of this increase is revealed as elderly inmates continue to require a disproportionate share of prison health services. In FY 2012-2013, the incidences of care continued to increase, elderly inmates accounted for 49.4% of all episodes of care and 52.5% of all hospital days despite representing only 19.4% of the total prison population.[13]

Prison Health Service in Other States

Florida currently has the third largest prison system (by population) in the United States. As noted elsewhere in this report, Florida is transitioning from a hybrid system in which the Office of Health Services acts as the administrator of a managed care system with medical services provided by certified and trained medical professionals who are department employees with outside medical professionals utilized for specialty services. Under the newer, current contracts, the private health providers provide comprehensive medical services (currently Corizon, Inc., and Wexford Health Sources).

Comparison of health care costs for elderly inmates between states is difficult due to the variance in state practices, uneven or uncollected data, timeliness of data, and a lack of data from some states. A recent analysis of correctional health care spending by The Pew Charitable Trusts ("Managing Prison Health Care Spending," October 2013[14]) shows significant increases from 2001 through 2008 in 35 of the 44 states reporting data. However, the fiscal data in Pew's report is now six years old and does not separate costs for elderly and/or infirm inmates from the general population. Although health per diem costs for Florida inmates have decreased slightly since 2008 (the year managed care was introduced), the elderly population has increased from 15.1 percent of the inmate population in 2008-2009 to 20.6 percent of the population in 2013-14. As noted previously, elderly inmates are more frequent users of health care services in the department.

[12] State of Florida Correctional Medical Authority, "2009-2010 Annual Report on Aging Inmates," at pp.16, 59-61.
[13] Florida Department of Corrections 2013 Annual Report-Report on Elderly Offenders
[14] The Pew Charitable Trusts, "Managing Prison Health Care Spending," 2013, accessed at: http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2014/PCTCorrectionsHealthcareBrief050814pdf.pdf.

The following information is a brief summary of the types of prison health services in several of the largest prison systems in the United States:

- **Texas**
  - Health services are delivered through a partnership of the Texas Criminal Department of Criminal Justice and University of Texas Medical Branch and the Texas Tech University Health Sciences Center. Both entities utilize a combination of university employees and outsourcing to provide the health care services.[15]
  - In 2010, a budget shortfall led to the University of Texas threatening to pull out of the contracted arrangement. Legislative action relating to the authority for cost controls as well as new fiscal and policy changes averted any changes to the arrangement.
- **California**
  - California's prison and health care system has a long and well-publicized history of trouble dating back to 2001. In that year a federal lawsuit was filed alleging the state's medical care of inmates violated the 8th amendment of the U.S. Constitution and constituted cruel and unusual punishment. Despite a settlement in 2002, the state made little progress and in 2005 the state's prison medical care was placed under, and still remains under Receivership.[16]
  - While there have been four class action lawsuits involving prison health care; only medical care is under receivership. The other three lawsuits involved mental health, dental care (dismissed August 2012), and Americans with Disabilities Act non-compliance.
  - The state delivers health services with state employees including doctors, nurses, pharmacists and administrative staff.
  - California also makes use of telemedicine with trained telemedicine nurses in institutions giving inmates access to many medical specialties.[17]
- **Georgia**
  - Georgia Correctional Health Care, a division of the Georgia Health Sciences University currently manages the healthcare units Georgia's correctional facilities including state prisons, Boot Camps, Probation Detention Centers, Diversion Centers, Pre-Release Centers and Transition Centers. Each facility contains various medical capabilities dependent upon the size and mission of the site. Regional infirmaries provide 24-hour, 7 days per week primary healthcare services at 14 of these sites.[18]

[15] Texas Legislative Budget Board, Issues Brief No. 602: "Correctional Managed Health Care for State Incarcerated Adult Offenders in Texas," February 2013.
[16] California Correctional Health Care Services, Fact Sheet: "What is the Receivership?", November 2014, accessed on March 24, 2015, at http://www.cphcs.ca.gov/docs/resources/factsheet.pdf.
[17] Cisco, "Virtualized Program Reforms California Correctional Health System," accessed on March 30, 2015 at http://www.cisco.com/web/strategy/docs/gov/california_correctionalhealthcareservices.pdf.
[18] Georgia Regents University, "Georgia Correctional Health Care," accessed on March 25, 2015 at http://www.gru.edu/gchc/.

Outsourcing Prison Healthcare in Florida

The outsourcing of inmate health care in Florida has been troubled and controversial. From 2001 through 2006, the Florida Department of Corrections contracted with private health care management companies to deliver full health care services to inmates in 12 Region IV prisons (primarily South and South Central Florida).

The first, a five-year contract with Wexford Health Sources, Inc., was signed in July of 2001. From the beginning, numerous quality issues arose related to internal controls, tracking of specialist consultations, and unacceptable pharmacy systems. Although these issues were addressed and mostly resolved, the 2003-2004 Annual Report by the Correctional Medical Authority (CMA) stated that Wexford was not meeting the terms of the contract specifically related to unaddressed deficiencies identified in a May 2002 survey at South Florida Reception Center. Wexford countered that the needs of the inmate population were far more complex than the contract specified and beyond the service that the company was required to provide.

In 2003, Wexford requested an increase in the per diem payment in the contract that ignited a legal battle between the department and the company. Wexford prevailed in the lawsuit, which awarded the company an increased per diem (but which was offset by liquidated damages for contract non-compliance).

In 2005, the contract become more troublesome still and the Department of Corrections' Office of Health Services recommended termination of the contract. The issue was finally settled via the Florida General Appropriations Act for Fiscal Year 2005-2006 (the Florida budget), which prohibited the expenditure of funds for the existing contract after December 31, 2006, and further directed that a new contract be rebid.[19, 20]

A new contract was awarded to Prison Health Services, Inc. (PHS), to begin on January 1, 2006. Almost immediately, PHS requested modifications of the reimbursement rate due to unexpected costs (note: PHS's bid was $80 million lower than the next lowest bid). By August 2006, PHS gave 90-day notice that the company would terminate the contract due to the unexpected costs.[21]

[19] The Florida Senate, Committee on Criminal Justice, Issue Brief 2011-213, "Privatization of Prison Health Care Services," 2010, accessed at http://www.flsenate.gov/UserContent/Session/2011/Publications/InterimReports/pdf/2011-213cj.pdf.
[20] Chapter 2005-70, Laws of Florida
[21] Florida Senate, Issue Brief 2011-213.

New bids were sought but none of the potential providers met the financial responsibility requirements of the Request for Proposals. As a result, the department initiated a number of one-year contracts with various providers for health services. Although initially some contract management issues surfaced, health services began to improve and the department realized cost savings. These steps included utilization management, staffing initiatives, expanding secure hospital beds, changes to pharmaceutical purchasing and dispensing, and centralized contract procurement. In addition, the Legislature included proviso language in the fiscal year 2008-09 General Appropriations Act limiting hospital charges, which saved approximately $3.6 million from July to October 2008.[22]

In 2012, the Florida Legislature added proviso language to the Florida budget directing the Florida Department of Corrections to advertise bids for the statewide privatization of prison health care services, requiring a minimum savings of 7 percent over the previous year's budget.[23] In response, a lawsuit was filed by public employee unions stating that proviso language alone was not sufficient to make such a change in state policy. This suit eventually became moot as the proviso language expired on July 1, 2012 (proviso language expires one year after approval). Subsequently, in September 2012, at the request of the Department of Corrections, the 14-member Florida Legislative Budget Committee[24] approved a transfer of funds enabling the department to seek bids to privatize all of the Florida prison system's health services. After another lawsuit was filed by unions representing correctional workers and correctional nurses, the Florida First District Court of Appeal ruled that the Legislative Budget Commission had the authority to make the transfer to implement the privatization plan.

In fiscal year 2012-2013, the Florida Department of Corrections implemented a statewide outsourcing of health services for prison inmates. Wexford Health Sources, once again entering an agreement with Florida, was awarded the contract to provide comprehensive health care services at nine prisons in South Florida while Corizon, Inc., was awarded the contract for comprehensive health services in the rest of the state.

The new contracts have proved to be troublesome. Recently resigned Florida Department of Corrections Secretary Michael Crews notified Corizon, Inc., on September 26, 2014, that despite audits revealing deficiencies in numerous areas including medical and nursing care, no significant improvement had been forthcoming. The Correctional Medical Authority (CMA) has also become increasingly concerned

[22] OPPAGA Report No. 09-07, "Steps to Control Prison Inmate Health Care Costs Have Begun to Show Savings" (January 2009)
[23] Florida General Appropriations Act FY 2011-12, Conference Committee Report on SB 2000, accessed at
[24] Florida Legislative Budget Committee: The General Responsibilities of the commission, as provided in chapter 216, Florida Statutes, are to receive and review notices of budget and personnel actions taken or proposed to be taken by the executive and judicial branches and shall approve or disapprove such actions.

regarding the inability of the contracted health providers to correct inadequacies noted in the medical surveys performed by CMA.

Additionally, in 2014, there was a 13.4 percent increase the number of inmate deaths (346) compared to 2013. At the time of this writing, the cause of 163 of these deaths had not yet been determined.[25] The media attention to these cases, including ongoing investigative reporting in the *Palm Beach Post* and the *Miami Herald*[26] has attracted the attention of the public, federal and state law enforcement, prison advocacy organizations, and the Florida Legislature.

On February 20, 2015, new Corrections Secretary Julie Jones announced her intention (amid urging from the Florida Senate's Criminal Justice Committee) to rebid the prison inmate health care contracts of Wexford and Corizon that are valued at more than $1 billion and do not currently contain provisions for liquidated damages if the contractors fail to provide the level of care stipulated in the contracts.

In a news article by the news Service of Florida, Secretary Jones stated she is seeking "enhanced elements" to the current contracts that will include, "the ability to ensure that appropriate staffing is provided by our contractors that enables a proper mix of administrative and institutional-level direct care, the presence of medical staff who possess the proper skills and qualifications to provide quality care to our inmate population and clinical oversight and supervision." Jones also noted she wants the contractors to perform internal audits of staffing levels, which will also be monitored by the state Correctional Medical Authority and the department's health-services staff.

Sec. Jones also stated that she intends to demand higher penalties (liquidated damages) for the companies if they fail to meet minimum staffing or standard-of-care levels.[27]

In addition, Senator Greg Evers, Chair of the Senate Criminal Justice Committee, spoke publicly in the Committee's scheduled hearings that he personally observed inadequate medical staffing levels during unannounced visits to prison facilities.

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[25] Florida Department of Corrections, Inmate Mortality, Cause of Death By Gender 2000-2015, accessed on March 24, 2015, at http://www.dc.state.fl.us/pub/mortality/index.html.

[26] For examples of extensive media coverage, see Appendix A of Project on Accountable Justice report, "Recommendations to Advance Public Safety through Increased Transparency, Accountability, and Oversight of the Florida Department of Corrections," at http://iog.fsu.edu/paj/documents/Recommendations%20to%20Improve%20DOC%2011-12-14.pdf.

[27] Kam, Dara. The News Service of Florida. "Florida prisons chief to seek revamp of health care contracts," *Tampa Bay Times*, February 20, 2015, accessed on March 24, 2015, at http://www.tampabay.com/news/politics/stateroundup/florida-prisons-chief-to-seek-revamp-of-health-care-contracts/2218522.

The rebidding of the health care contracts may result in increased medical costs to the department for these services as the vendors will be required to provide additional registered nurses.[28]

Potential Effect of the Affordable Care Act on Inmate Health Costs

The passage of the Federal Affordable Care Act (ACA) allowed states to expand their Medicaid coverage beginning in 2014. As of February 27, 2015, 28 states plus the District of Columbia have opted to participate in the Medicaid expansion authorized under the ACA.[29] Most states and localities have not sought Medicaid reimbursement for the limited class of prisoners, an omission that deprives them of millions of dollars in potential federal reimbursement.[30]

Although the Medicaid reimbursement does not apply to people 65 years[31] and over (except in limited circumstances), it would apply to all inmates up to age 65 meeting the income requirements—which would include a significant number of inmates who are U.S. citizens receiving inpatient hospital care outside prison walls.[32] The new reimbursement rate of 100% under the ACA until 2020 could represent a significant savings to states' prison health care costs for inpatient treatment.

The state of California estimates that by accepting the Medicaid expansion under the ACA, they expect to save nearly $70 million annually though reimbursement for inmate inpatient medical costs (outside prison walls).[33] These costs currently amount to approximately $100 million a year for inmate medical care in California. Several other states, including New Hampshire, Ohio, and Michigan have projected significant savings through utilization of Medicaid for outpatient inmate care. A Pew study cited reports from state health agencies that found Medicaid expansion would save hundreds of millions over a decade from inpatient care in outside health facilities. In Ohio, it is

[28]Kennedy, John, "DOC chief will re-do lucrative private health contracts in wake of deaths," *Palm Beach Post*, February 11, 2015, accessed on March 24, 2015, at : http://postonpolitics.blog.palmbeachpost.com/2015/02/11/doc-chief-will-re-do-lucrative-private-health-contracts-in-wake-of-deaths/

[29] United States Department of Health and Human Services Retrieved February 27, 2015 http://www.hhs.gov/healthcare/facts/bystate/statebystate.html

[30] Vestal, Christine, The Pew Charitable Trusts, "States Missing out on Millions in Medicaid for Prisoners," *Stateline,* June 25, 2013, accessed on March 22, 2015, at: http://www.pewstates.org/projects/stateline/headlines/states-missing-out-on-millions-in-medicaid-for-prisoners-85899485969.

[31] Bazelon Center, "Bazelon Center Fact Sheet: Medicare and Incarceration," accessed on March 24, 2015, at http://www.bazelon.org/LinkClick.aspx?fileticket=1OxXzw1kOBc%3D&tabid=441.

[32]In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. See: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html.

[33] Taylor, Mac, Legislative Analyst's Office, "Obtaining Federal Funds for Inmate Medical Care-A Status Report," February 5, 2013, accessed on February 4, 2014 at http://lao.ca.gov/analysis/2013/crim_justice/inmate-medical-care-020513.pdf.

estimated to be $273 million between 2014 and 2022. In Michigan, it is estimated to be $250 million in the law's first decade.[34]

Geriatric Release of Elderly and Infirm Inmates

Geriatric release of elderly inmates is a process used in a number of states to provide a release mechanism for elderly inmates who are terminally ill or physically or mentally incapacitated. Generally the conditions are very strict and exclude sex offenders, violent offenders, or those serving life sentences.

The high cost of providing medical care to elderly prisoners has led some states to change or attempt to change release policies for inmates with chronic or terminal illnesses. One of the more significant costs overlooked in providing medical care to elderly inmates (and inmates in general) is the cost of transportation and providing security by certified correctional officers.

In Florida law, s. 947.149, F.S., defines Conditional Medical Release as a discretionary release mechanism that allows the Florida Commission on Offender Review (FCOR) to release inmates to supervision who are "terminally ill" or "permanently incapacitated" and do not present a danger to others. Under this law, inmates granted a conditional medical release must remain under supervision of the Department of Corrections Community Supervision Officers for the remaining term of their sentence. Inmates released under this law are only permitted to leave their residence for the purposes of receiving medical treatment or to attend religious functions. The process begins with the Department of Corrections' reference of inmates who meet the criteria for Conditional Medical Release to the Commission. The Commission makes the final decision regarding release.

In practice, inmates in Florida released under this law are literally on "death's doorstep" and generally live a short while after release. The following information was provided by the FCOR [35] and details outcomes of the inmates released since 2003 through February 2015:

- Total number of inmates referred for CMR by the Florida Department of Corrections since 2003: 272;
- Total number of referred inmates considered for CMR by the full Commission: 262;

[34] The Pew Charitable Trusts, *Managing Prison Health Care Spending,* October 2013, pp. 18-19.
[35] E-Mail (mollykellogg@fpc.state.fl.us) dated 8/30/13 from Molly Kellogg, Director of Communications, Florida Parole Commission

- Total number of inmates released to supervision under CMR: 129[36]—or 49.2% of total considered for supervision;

- Outcomes of inmates released on Conditional Medical Release as of March 18, 2015:
  - 103 died,
  - 3 currently under supervision (1 is in a medical facility),
  - 2 recovered from illness and returned to prison,
  - 8 returned for violation of the conditions of release (2 were for new offenses),
  - 21 terminated successfully, and
- Number of inmates who died within 60 days of release, 58.

There are a number of obstacles related to creating and operating a more expansive geriatric release program that provides significant cost savings while granting some measure of dignity to ailing prisoners. The criteria for release are often tightly defined, the processes for application and review are time consuming and lengthy, and finding suitable housing for inmates upon release can be problematic. However, more challenging is addressing the historical political aversion of any form of early release for inmates convicted of serious crimes.

The state of Wisconsin provides a good example of the difficulties in addressing the issue of reducing medical costs through geriatric release. Wisconsin originally instituted geriatric and medical parole in 2001 with the decision made by the sentencing court. In 2009 the law was amended to expand eligibility to inmates serving life sentences and those with extraordinary health conditions (previously it was limited to terminal illness) and changing the release decision to an administrative panel of governor appointed members. Fifty-five inmates applied for release and eight were granted parole under the expanded mechanism.[37] Political and public opposition began mounting even prior to implementation and in and in 2010, a newly elected Republican majority in the Assembly, Senate, and Governor's Office and in 2011 the state Legislature repealed most of the changes to the law.[38]

[36]The number of inmates released does not match the outcomes as some inmates appear in more than one category of outcome, per email on March 24, 2015, to PAJ from Molly Kellog-Schmauch, FCOR Director of Communications.

[37] Murphy, N., *Dying to be Free: An Analysis of Wisconsin's Restructured Compassionate Release Statute,* 95 Marq. L. Rev. 1679, 2012, accessed on Febrary 5, 2014, at: http://scholarship.law.marquette.edu/cgi/viewcontent.cgi?article=5139&context=mulr.

[38]Marley, P. and Bergquist, L., "Walker Wins Governor's Race on Promise of Jobs*," Milwaukee Sentinel*, November 3, 2010, accessed on February 5, 2014 at: http://www.jsonline.com/news/statepolitics/106580158.html.

A sampling from several states that recently enacted laws expanding geriatric release illustrates the parameters, limitations, and challenges involved in implementing these release programs:[39]

- Louisiana
  - 2011, expansion of parole for inmates 60 years of age and older
  - Must have served more than 10 years
  - Designated low-risk by Department of Public Safety and Corrections
  - 14 inmates were released on medical parole since implementation of the revised law[40]

- Ohio
  - 2011, passed geriatric parole as part of a cost saving reform package
  - Review of parole eligible inmates 65 years of age or older that have served 80% of sentence and justify why they had not been released
  - Identified 347 eligible inmates
  - None released due to seriousness of offense, subsequent crimes committed while on previous parole, and significant community opposition

- New York
  - 2009, expanded parole eligibility for chronically or terminally ill inmates, or physically or cognitively incapacitated, and served at least half of their sentence.
  - Those convicted of first-degree murder not eligible
  - Since passage, 202 applications for release (as of January 2010)
  - Awaiting response from NY Parole Board on # approved

- California
  - 2010 – expanded rarely used existing compassionate release program for terminally ill inmates by allowing release for incapacitated prisoners
  - Due to public safety concerns, restricted to those inmates requiring 24-hour nursing care
  - As of October 2012, 47 inmates granted release (estimates savings of $20 million)
  - 18 of those 47 had died by October 2012 (this mirrors the Florida situation where a significant number died within a short time of their release.)

[39]The Pew Charitable Trusts, *Managing Prison Health Care Spending,* October 2013, p.23
[40]Louisiana Board of Pardons and Parole, *2012 Annual Report*, accessed athttp://www.doc.la.gov/wp-content/uploads/2014/05/2012-Annual-Report-Pardons-and-Parole-Revised-May-2014.pdf.

More recent developments in California related to severe overcrowding and a federal court order to reduce prison population have placed more urgency on the compassionate release program.

California Governor Jerry Brown's budget proposal release in January of 2014 announced a plan to immediately expand parole eligibility for inmates who are sick or mentally impaired and creates a new program for the elderly. The plan would extend the program to inmates 60 years of age or older who have served at least 25 years and have not been sentenced to life without parole. The inmates' release would still be subject to approval by the state parole commission. The state estimates 250 cases would be eligible for review under this plan in addition to approximately 900 prisoners meeting new medical parole criteria drafted in the summer (2013) for inmates with terminal illnesses. The federal court order permits the Governor to make these changes without legislative approval.[41]

One argument favoring geriatric release is data revealing that older inmates generally have lower recidivism rates than younger inmates upon release.

In Wisconsin, recidivism data collected and published by the Council of State Governments Justice Reinvestment Project revealed that the percentage of inmates released in 2005 aged 60 and over returning to prison within two years of release was 17% (while it was 29% and higher for all other younger age groups).[42]
An ongoing recidivism study in Florida has been measuring recidivism rates for Florida inmates released from 2004 to 2011.[43]

- The recidivism rate for inmates aged 65 and older within 36 months of release is 15%.
- The recidivism rate for inmates within 36 months of release, aged between 50 and 64 entering prison for the first time is 10%.
- The recidivism rate for inmates within 36 months of release, aged 65 and older and entering prison for the first time is 5%.

A review of the department's prison population by age reveals that **46.2%** of the elderly inmates (age 50+) in Florida prisons are serving their first prison sentence.

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[41]St. John, P., "Gov. Brown's overcrowding plan alters parole for elderly, sick felons," *Los Angeles Times,* January 9, 2014, accessed on February 5, 2014, at: http://www.latimes.com/local/political/la-me-pc-brown-budget-plan-felons-release-20140109, 0,6231565.story#axzz2sSqdx.
[42] Council of State Governments Justice Center, "Justice Reinvestment in Wisconsin, Analyses and Policy Options to Reduce Spending on Corrections and Increase Public Safety," May 2009, accessed on March 30, 2015, at: http://csgjusticecenter.org/wp-content/uploads/2012/12/Wisconsin_Analyses_and_Policy_Options.pdf.
[43]Florida Department of Corrections*, Recidivism Report,* May 2013, accessed on February 5, 2014, at: http://dc.state.fl.us/pub/recidivism/2012/index.html.

The United States Department of Justice Office of the Inspector General (OIG), in April 2013, issued a critical report of the Federal Bureau of Prisons' (BOP) "compassionate release" program. The "OIG found that an effectively managed compassionate release program would result in cost savings for the BOP, as well as assist the BOP in managing its continually growing inmate population and the significant capacity challenges it is facing. However, we found that the existing BOP compassionate release program has been poorly managed and implemented inconsistently, likely resulting in eligible inmates not being considered for release and in terminally ill inmates dying before their requests were decided."44

In a speech to the American Bar Association's House of Delegates by United States Attorney General Eric H. Holder on August 12, 2013, the Attorney General announced major changes in the federal compassionate release program:

- Medical reasons for early release: The new policies allow dying prisoners to seek compassionate release within 18 months of their anticipated death, rather than the previous term of 12 months. A prisoner need not, as before, be completely disabled to be eligible, as long as they have a seriously debilitating medical condition due to illness or injury from which they will never recover.

- Release of a prisoner after the death or incapacitation of a caregiver looking after a member of the prisoner's family: Although this policy previously existed, no inmates have ever been released under this policy. The new policy details specific criteria and procedures in these situations, which could lead to early release decisions in such cases. This change could also apply in a situation which the spouse or registered partner of an inmate has become incapacitated.

- Expansion for elderly prisoners who are not necessarily dying or seriously incapacitated to seek early release: Prisoners 65 and older can now apply for early release if they have served 50 percent or more of their sentences, have chronic or serious medical conditions connected to aging, and experience deteriorating mental or physical capabilities that diminish their ability to function in a correctional facility. Under the new policy, an inmate without such medical conditions aged 65 or older who has served 10 years or 75 percent of his sentence, whichever is greater, may also apply for early release.

[44] U.S. Department of Justice OIG Report, *The Federal Bureau of Prisons' Compassionate Release Program,* April 2013, I-2013-006

Legislative Actions Related to the Aging Inmate Population

In recognition of this issue, the Florida Legislature, in 2000, created Section 944.804, F.S., (Ch. 2000-214, s.2) to provide an elderly correctional facilities program. This section generally provided recognition of the issue and a legislative finding that the number of elderly offenders would be increasing. The law also defined "elderly offender" as a "prisoner aged 50 or older" in a state or private correctional facility. It also estimated the cost of housing an elderly inmate was approximately three times the cost of housing a younger inmate. The section also directed the Florida Department of Corrections to design wellness programs with a bias towards preventative medical care, direct more resources to the elderly inmate population, determine the number of inmates eligible to be considered for these programs, and to designate River Junction Correctional Institution as a geriatric facility for the elderly offender population.

In the same chapter of Florida law, section 3, the Legislature created Section 944.8041, F.S., which required an individually prepared annual report by both the Florida Corrections Commission (no longer in existence45) and the Correctional Medical Authority (an independent and autonomous oversight board created as a result of a lawsuit filed against the state relating to poor medical treatment of inmates (*Costello v. Wainwright*). on the status and treatment of elderly offenders. The law also required a review of promising geriatric policies, practices, and programs currently implemented in other correctional systems in the United States.

In 2004, the Legislature, in s.8, Ch.2004-248, amended Section 944.8041 F.S. by replacing the Corrections Privatization Commission (which was disbanded for improprieties relating to the award of private prison contracts) with the Department of Management Services and also by mandating that the Correctional Medical Authority would have access to the private correctional facilities, the offenders therein, and information required for purposes of collecting data necessary to complete the report.

In 2006, the Legislature, in s. 2, Ch. 2006-32, amended Section 944.8041 F.S. Changing responsibility for submitting the annual report from the aforementioned Florida Corrections Commission to the Department of Corrections.

[45] The Florida Corrections Commission was created by the 1994 Legislature in s. 20.315 (6), F.S., to provide oversight to the Department of Corrections and the criminal justice system more broadly. The Governor-appointed, Senate confirmed 9-member commission was charged with, among duties: providing recommendations on major criminal justice policies, reviewing the department's annual budget request and financial status and to, "evaluate, at least quarterly, the efficiency, productivity, and management of the Department of Corrections."

In 2010, the Legislature, in s.10, Ch.2010-64, amended Section 944.804(2) F.S. and Section 944.8041 F.S. by replacing the language specifically referring to River Junction C.I. permitting the Department to designate any appropriate facilities to house elderly inmates.

At the time these laws were created, Florida's prison system was starting to feel the effects of tougher sentencing policies such as the 1995 requirement that all prisoners serve 85% of their sentence prior to eligibility for release and the enhanced punishments created in the 1998 Florida Criminal Punishment Code which gave judges the discretion to sentence any felony offender to the maximum statutory sentence allowed regardless of the sentence recommended by the sentencing score sheet. Additionally, in 1999 the Legislature created the 10-20-Life laws that created mandatory minimum sentences for felony offenses in which a firearm was possessed, fired, or fired resulting in bodily injury or death.

Legislative and Agency Proposals Related to the Aging Inmate Population

In recognition of the increasing fiscal and human resource burden placed on the department by the increase in the elderly inmate population, there have been legislative and agency proposals in the last few years to address the issue through various release mechanisms.

The legislative proposals in 2010 and 2011 focused on releasing inmates at least 50 years of age (another bill set the age at 60) who had served at least 25 years in prison, had not been sentenced for a capital felony, were not otherwise eligible for release, were not serving any portion of a minimum mandatory sentence, and had a clean disciplinary record for the last 6 months.

Similarly, both the Department of Corrections and the Florida Parole Commission considered proposals to modify the existing restrictions on Conditional Medical Release, a period of supervision granted to an inmate who, because of an existing medical or physical condition, is determined to be permanently incapacitated or terminally ill. The offender is released for the remainder of his sentence, with no diminution of sentence for good behavior, and must undergo periodic medical evaluations as determined by the Florida Parole Commission. Very few of these releases are granted and these inmates are grievously ill and do not survive for a significant period of time after release. If their condition were to improve, they are returned to prison. These proposals were subsequently withdrawn as there were public safety concerns raised by the Governor's Office during the discussion period (2011-12).

Florida Commission on Offender Review FCOR (formerly Florida Parole Commission (FPC)

The Commission has submitted legislative proposals on three occasions (the 2010, 2011, and 2012) to the Governor's Office seeking to expand the pool of inmates eligible for early release from state prison by amending s. 947.149, Florida Statutes, (Conditional Medical Release).

As proposed by the Commission, the law excluded inmates convicted of murder or sexual offenses.

The proposal sought to add the term "chronically ill" to s.947.149, F.S., and expand the pool to include inmates with chronic conditions. "Chronically ill" was defined as suffering from a disease, infirmity, or ailment of long duration or frequent recurrence which is expected to require costly continuous care or treatment.

The proposals were crafted very narrowly to anticipate concerns relating to public safety and would have only added an estimated 100 inmates to the eligible pool of inmates. Despite this small pool of inmates, savings were estimated to be $1.1 million if all these inmates were accepted for release in the next fiscal year.

Ultimately, in 2009 and 2010, the Governor’s policy staff did not approve the proposal for inclusion in the Governor’s Agency Legislative package while the Commission withdrew their 2011 proposal.

Subsequently, in the years 2013, 2014, and the current 2015 Legislative Session, the Commission did not put forth another proposal related to elderly inmate release.

Florida Department of Corrections

While the Department of Corrections did not directly respond to a request for legislative proposals, information provided by the Governor's Information Office indicated the department did not submit any proposals relating to release of elderly inmates during the time period requested.

Office of the Governor

The Office of the Governor has not proposed nor supported legislation relating to any type of early release for inmates, regardless of age.

Florida Legislature

2011 Session

In the 2011 Legislative Session, there were two identical bills (HB 1177 and SB144) filed relating to elderly inmates.

The bills created the Elderly Rehabilitated Inmate Supervision Program and were designed to create a means for release of inmates aged 50 and over (the originally filed version set the age criteria as 60 years of age). In order to be eligible for this new type of release, the inmate would have been required to demonstrate "rehabilitation" and served at least 25 years of their current commitment. The program was to be administered by the Florida Parole Commission and also required the Department of Corrections to develop a pilot program using restorative justice principles including classroom instruction focusing on the effect of crime on victims.

In addition to the above criteria, the inmate:

- Could not have been sentenced for a capital felony,
- Was not otherwise eligible for parole or conditional medical release,
- Was not serving a minimum mandatory sentence, and
- Had not received a disciplinary report in the previous six months.

Participation in the release program would be completely voluntary; therefore, an inmate meeting the criteria could petition the Commission to participate in the supervised release program. The petition would have required the inmate to provide the following information:

- Proposed release plan
- Documentation of the inmate's relevant medical history including a current prognosis,
- The inmate's prison experience and criminal history (to include any claim of innocence, the degree to which the inmate accepted responsibility for his acts, and how that claim affected the inmate's feelings of remorse,
- Documentation of the inmate's history of substance abuse and mental health,
- Documentation of disciplinary action against the inmate
- Documentation of the inmate's participation in prison work programs, and

- Documentation of the inmate's renunciation of gang activity.

The bills also set forth an administrative procedure similar to the parole interview process setting time parameters for the filing of the petition and review by a parole examiner and the Commission. The language also provided for input from the victims or their family and required the Commission's decision to be made in a meeting open to the public.

In making the decision, the Commission would have been required to review and consider the items provided in the inmate's petition. Additionally, the Commission would have been required to find there is a reasonable probability that the inmate would live and conduct himself as a respectable and law abiding person and the release would be compatible with the inmate's own welfare and the welfare of society.

If approved for release, the inmate would be required to live under community supervision for the period of time otherwise remaining on the originally committed prison sentence.

According to the bill, the Commission would set the conditions of the supervision, to include:

- 10 hours of community service for each year served in prison,
- Electronic monitoring for at least one year,
- Reparation or restitution to the victim for any damage or loss caused by the offense.

The bill also specified four specific special conditions the Commission could impose:

- Pay any debt due to the state or any attorney's fees and costs owed to the state pursuant to Florida law,
- Not leave the state of a defined area with the state without the Commission's consent,
- Not associate with persons engaged in criminal activity, and
- Carry out the instructions of the supervising probation officer.

In addition, the Commission could also impose any other special conditions it deemed necessary.

Similar to all other community supervision in Florida the release would be supervised by a Department of Corrections state certified correctional probation officer. The bill also amended the portions of Florida statute providing for a statutory process for addressing violations of supervision and authorizing law enforcement to arrest a program

participant if there were reasonable grounds to believe the releasee had violated the conditions in a material respect.

The bill also contained a provision for the original sentencing court to retain jurisdiction over the offender to review a release order for a third of the sentence.

Finally, the bill required the Department of Corrections to develop a pilot program patterned after the Neighborhood Restorative Justice Centers previously established in Florida law. Inmates that were eligible for the Elderly Rehabilitated Inmate Program would have been given priority for participation in the restorative justice programming.

According to data compiled by the Department of Corrections, approximately 91 inmates would have met the bill criteria for inclusion in the program over the next five years. It appears that some of the tentatively eligible might have been disqualified due to their having been convicted of violent offenses.

The bill analysis of the Florida Senate Criminal Justice Committee noted several technical deficiencies in the filed bill:

- Although the bill states appeared to apply retroactively for inmates previously sentenced, this clause would have been problematic in that the Florida Constitution (Article X, section 9) provides that " Repeal or amendment of a criminal statute shall not affect prosecution or punishment for any crime previously committed."
- There were inconsistencies related to whether the 25-year eligibility period was for cumulative sentences or consecutive years,
- Concerns with the Commission's authority on setting special conditions, and
- Technical concerns with regarding redundancy of language in Section 2 of the proposed legislation.

Both the House and Senate versions of the bills died in their respective Criminal Justice Subcommittees without any votes taken.

2012 Session

In the 2012 Legislative Session, HB 439 and SB 426 were filed creating the Elderly Rehabilitated Inmate Supervision Program. These bills were virtually identical to the bills filed in the 2011 Session relating to the same issue. The only significant difference was to raise the age of consideration from years to 60 years before the inmate could be eligible for program consideration.

Both of these bills met a similar fate as the 2011 versions, dying in committee before introduction on the floor of either chamber. Notably, the Senate version did receive a vote in the Senate Criminal Justice Committee, which was reported favorably by a vote of 4-2.

2013 and 2014 Sessions

There was no significant legislation introduced in the 2013 and 2014 Legislative Sessions relating to elderly inmates and early release.

2015 (Current Session)

On February 17, 2015, House Bill 785 was filed relating to Aged Prison Inmates.

This bill would require the Department of Corrections to consider the needs of inmates older than 50 years of age and adopt health care standards specifically for that population. It also introduces a new program entitled Supervised Conditional Elderly Release.

This program will:

- Provides criteria for program eligibility;
- Authorizes the arrest of any inmate who has been released under supervised conditional elderly release program and violates the conditions;
- It defines “elderly & infirm inmate” as an inmate
    - That has no current or prior convictions for capital or first degree felonies,
    - Who has no current or prior convictions for sexual offenses or offenses against children,
    - Who is 65 years of age or older, and
    - Who has a condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, renders the inmate infirm or physically impaired to the extent that the inmate does not constitute a danger to himself or herself or others
- The bill also permits inmates 65 and over to serve less than 85% of their sentences if they are granted certain forms of release and requires them to serve a lower minimum percentage (50%) of their sentences;
- It also expands eligibility for conditional medical release to include elderly & infirm inmates.

The effective date of the legislation is July 1, 2015.

The bill has not been heard in any committees as of this writing and was referred on February 26, 2015, to the House Criminal Justice Subcommittee, Justice Appropriations Subcommittee, and the Judiciary Committee. It is currently in the House Criminal Justice Subcommittee.

A bill analysis has not been completed as of this writing.

On January 26, 2015, Senate Bill 7020 was filed, a comprehensive reform package relating to Corrections. This bill, in addition to numerous other reforms related to the Department of Corrections also includes four provisions related to the elderly inmate population. These provisions:

- Require the Department of Corrections, in establishing minimum health care standards, to establish standards of care criteria for the needs of inmates over age 50,
- Expands the existing conditional medical release program to include elderly and infirm inmates which would allow the Commission on Offender Review to consider the release of elderly and infirm inmates,
- Requires the department to collect and report inmate health cost information for elderly inmates, and
- Requires the Criminal Justice Estimating Conference to project prison admissions for elderly felony offenders.

The bill was reported favorably in the Senate Committee on Criminal Justice and a Committee Substitute in the Senate Appropriations Subcommittee on Criminal and Civil Justice was also reported favorably. Both were by unanimous votes.

On March 18, 2015, the bill passed out of the Senate Appropriations Committee by a unanimous vote of 18-0 and is currently under consideration of the full Senate.

The Florida House of Representatives' companion bill, HB 7131, passed its first committee of reference unanimously, but is a much less ambitious piece of legislation, generally. Specifically, of the four potential revisions enumerated above in the Senate package, the House bill only includes the last one, requiring the Criminal Justice Estimating Conference to project prison admissions for elderly felony offenders.

Conclusion

Florida prisons are on a steady trajectory to become the world's largest nursing homes, holding thousands of aging and infirm prisoners—a destination never intended. Currently, the percentage of prisoners aged 50+ is roughly 20% of the total inmate population, with projections of this population growing.

Numerous requests for raw data were made by the authors and other research partners at the Claude Pepper Center at Florida State University for a period of more than a year to the DOC in order to examine Florida's state prison population more fully, including detailed historical demographic, medical, and offense information for a joint study. These data are still being sought. In the absence of this detailed information, it is difficult to estimate the potential effect, cost savings, and the efficacy of different policy and administrative recommendations with specificity. However, the partners have identified several acute challenges, including expense and safety, Florida faces in meeting the constitutional threshold of health care to this growing and aging segment of Florida's state prison population.

A fundamental question is whether Florida will opt into Affordable Care Act (ACA) participation, which answers to what extent the cost of care for a growing aging population of prisoners may be shifted away from the state budget, were Florida to begin a more concerted effort to examine and expand release mechanisms. Moreover, Florida must ensure first that any alternatives considered—including expanded supervision options—would keep Floridians safe. Florida must also continue to examine the state's movement to privatize medical services, which raises questions of system stability, service limitations, and quality of care, particularly highlighted through recent media attention and record number of inmate deaths. There are any number of potential changes Florida may wish to undergo—expanding compassionate/medical parole, intermediate sanctions such as house arrest and electronic monitoring, and more broadly, the development of new models of care. But the state must first acknowledge the situation, and then look to build consensus going forward.

This Project on Accountable Justice report was written by
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ABOUT FSU PROJECT ON ACCOUNTABLE JUSTICE: The mission of the Florida State University Project on Accountable Justice (PAJ) is to advance public safety through evidence-based practices and policies in Florida and beyond. PAJ is a collaborative public policy research laboratory determined to find answers through data and across a spectrum of academic disciplines for practical application in juvenile and criminal justice policy deliberations. With a distinguished Executive Committee guiding the operation, PAJ facilitates research, public education and dialogue to provide reform options that turn Florida and the nation from a trajectory of expensive and outmoded practices of mass incarceration and poor performance to stopping victimization, turning countless lives around, rebuilding families, saving billions of taxpayer dollars and, ultimately, enhancing safety and vitality in communities across our country.

PAJ is a partnership of Florida State University, Baylor University, St. Petersburg College, and Tallahassee Community College.

Any findings, opinions, or recommendations expressed herein are that of the authors and do not necessarily reflect the opinion of the Executive Committee, partners, or supporters of the Project on Accountable Justice.

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