

Tab 1	CS/SB 346 by CJ, Bradley (CO-INTRODUCERS) Brandes, Perry, Diaz, Gruters, Bracy, Rouson; (Compare to H 00259) Criminal Justice						
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The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

**APPROPRIATIONS SUBCOMMITTEE ON CRIMINAL AND
CIVIL JUSTICE**

Senator Brandes, Chair
Senator Bracy, Vice Chair

MEETING DATE: Wednesday, December 11, 2019
TIME: 1:30—3:30 p.m.
PLACE: Mallory Horne Committee Room, 37 Senate Building

MEMBERS: Senator Brandes, Chair; Senator Bracy, Vice Chair; Senators Gainer, Gruters, Harrell, Perry, Rouson, and Taddeo

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	CS/SB 346 Criminal Justice / Bradley (Compare H 259, H 339, S 468)	Criminal Justice; Prohibiting the imprisonment for longer than a certain time for persons who possess, purchase, or possess with the intent to purchase less than a specified amount of a controlled substance; authorizing a court to impose a sentence other than a mandatory minimum term of imprisonment and mandatory fine for a person convicted of trafficking if the court makes certain findings on the record; requiring that a custodial interrogation conducted at a place of detention in connection with certain offenses be electronically recorded in its entirety; revising the circumstances under which a wrongfully incarcerated person is eligible for compensation, etc. CJ 11/12/2019 Fav/CS ACJ 12/11/2019 Fav/CS AP	Fav/CS Yeas 8 Nays 0
2	Presentation on Governor's Fiscal Year 2020-2021 Budget Recommendations: Department of Corrections Department of Juvenile Justice Department of Law Enforcement Department of Legal Affairs/Attorney General Florida Commission on Offender Review State Courts Public Defenders State Attorneys Regional Conflict Counsels Statewide Guardian ad Litem Capital Collateral Regional Counsels Justice Administrative Commission		Presented
3	Presentation on a Study of Health Care Services in the Florida Department of Corrections by Office of Program Policy Analysis and Government Accountability		Presented
4	Presentation on Recommendation of the Appellate Review of County Court Decisions Workgroup		Presented

Other Related Meeting Documents

COMMITTEE MEETING EXPANDED AGENDA

Appropriations Subcommittee on Criminal and Civil Justice
Wednesday, December 11, 2019, 1:30—3:30 p.m.

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Criminal and Civil Justice

BILL: PCS/CS/SB 346 (776730)

INTRODUCER: Appropriations Subcommittee on Criminal and Civil Justice; Criminal Justice Committee; and Senator Bradley and others

SUBJECT: Criminal Justice

DATE: December 13, 2019 REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	<u>Erickson/Cellon</u>	<u>Jones</u>	<u>CJ</u>	<u>Fav/CS</u>
2.	<u>Dale</u>	<u>Jameson</u>	<u>ACJ</u>	<u>Recommend: Fav/CS</u>
3.	_____	_____	<u>AP</u>	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 346 provides that a person who possesses, purchases, or possesses with the intent to purchase less than two grams of a controlled substance, other than fentanyl and related analogs, derivatives, and mixtures, may not be imprisoned for a term longer than 12 months.

The bill also authorizes a court to depart from the mandatory minimum term of imprisonment and the mandatory fine for a drug trafficking offense which does not carry a 25-year mandatory minimum term, if the court finds certain circumstances (specified in the bill) exist.

The bill also requires a custodial interrogation relating to a covered offense (specified in the bill) that is conducted at a place of detention be electronically recorded in its entirety. If the custodial interrogation at the place of detention is not electronically recorded by the law enforcement officer, he or she must prepare a written report explaining the reason for not recording it. The bill provides exceptions to the general recording requirement. The bill further provides:

- If a custodial interrogation is not recorded and no exception applies, a court must consider “the circumstances of an interrogation” in its analysis of whether to admit into evidence a statement made at the interrogation;
- If the court decides to admit a statement made during a custodial interrogation that was not electronically recorded, the defendant may require the court to give a cautionary jury instruction regarding the officer’s failure to comply with the recording requirement;

- If a law enforcement agency “has enforced rules” adopted pursuant to the bill which are reasonably designed to comply with the bill’s requirements, the agency is not subject to civil liability for damages arising from a violation of the bill’s requirements; and
- Requirements relating to electronic recording of a custodial interrogation do not create a cause of action against a law enforcement officer.

The bill also eliminates ineligibility for compensation for wrongfully incarcerated persons who had a violent felony or more than one nonviolent felony before their wrongful conviction and incarceration. However, the bill does not change ineligibility status for persons who: commit a violent felony or multiple nonviolent felonies during their wrongful incarceration; are serving a concurrent prison sentence; or have served the incarcerative part of their sentence and commit a violent felony or multiple nonviolent felonies resulting in revocation of parole or community supervision.

The bill also extends the time for a person who was wrongfully incarcerated to file a petition with the court for a determination of eligibility for compensation. The person will have two years rather than the current 90 days to file the petition. Further, persons who missed the 90 day deadline or who had claims dismissed because of this deadline may file the petition with the court within two years from the bill’s effective date.

The Legislature’s Office of Economic and Demographic Research preliminarily estimates that the bill has a “negative significant” prison bed impact (a decrease of more than 25 prison beds).

Under the bill, more persons are potentially eligible for compensation for wrongful incarceration. Currently, a person who is entitled to compensation based on wrongful incarceration would be paid at the rate of \$50,000 per year of wrongful incarceration up to a limit of \$2 million. Payment is made from an annuity or annuities purchased by the Chief Financial Officer for the benefit of the wrongfully incarcerated person. The Victims of Wrongful Incarceration Compensation Act is funded through a continuing appropriation pursuant to section 961.07, Florida Statutes. The fiscal impact of this provision is indeterminate.

The drug purchase and possession provision of the bill may have an indeterminate county jail bed impact, and the bill’s requirements relating to electronically recording custodial interrogations may have an indeterminate fiscal impact on law enforcement agencies.

The effective date of the bill is July 1, 2020.

II. Present Situation:

Florida’s Controlled Substance Schedules

Section 893.03, F.S., classifies controlled substances into five categories or classifications, known as schedules. The schedules regulate the manufacture, distribution, preparation, and dispensing of substances listed in the schedules. The most important factors in determining

which schedule may apply to a substance are the “potential for abuse”¹ of the substance and whether there is a currently accepted medical use for the substance. The controlled substance schedules are as follows:

- Schedule I substances (s. 893.03(1), F.S.) have a high potential for abuse and no currently accepted medical use in treatment in the United States. Use of these substances under medical supervision does not meet accepted safety standards.
- Schedule II substances (s. 893.03(2), F.S.) have a high potential for abuse and a currently accepted but severely restricted medical use in treatment in the United States. Abuse of these substances may lead to severe psychological or physical dependence.
- Schedule III substances (s. 893.03(3), F.S.) have a potential for abuse less than the Schedule I and Schedule II substances and a currently accepted medical use in treatment in the United States. Abuse of these substances may lead to moderate or low physical dependence or high psychological dependence. Abuse of anabolic steroids may lead to physical damage.
- Schedule IV substances (s. 893.03(4), F.S.) have a low potential for abuse relative to Schedule III substances and a currently accepted medical use in treatment in the United States. Abuse of these substances may lead to limited physical or psychological dependence relative to Schedule III substances.
- Schedule V substances (s. 893.03(5), F.S.) have a low potential for abuse relative to the substances in Schedule IV and a currently accepted medical use in treatment in the United States. Abuse of these substances may lead to limited physical or psychological dependence relative to Schedule IV substances.

Purchase or Possession of a Controlled Substance

Section 893.13, F.S., in part, punishes unlawful purchase and possession of a controlled substance.² The penalty for violating s. 893.13, F.S., depends on the unlawful act committed and the substance involved and, in some instances, the quantity of the substance involved and the location in which the unlawful act occurred.

Purchase or possession with intent to purchase a controlled substance is generally punishable as a first degree misdemeanor,³ third degree felony,⁴ or second degree felony,⁵ depending upon the schedule of the controlled substance purchased or possessed with intent to purchase.⁶ However, purchase or possession with intent to purchase more than 10 grams of certain Schedule I controlled substances is a first degree felony.⁷

¹ Section 893.035(3)(a), F.S., defines “potential for abuse” as a substance that has properties as a central nervous system stimulant or depressant or a hallucinogen that create a substantial likelihood of the substance being: used in amounts that create a hazard to the user’s health or the safety of the community; diverted from legal channels and distributed through illegal channels; or taken on the user’s own initiative rather than on the basis of professional medical advice.

² Section 893.13(1)(a),(c)-(f) and (h), (2)(a) and (b), and (6)(a)-(d), F.S.

³ A first degree misdemeanor is punishable by up to one year in county jail and a fine of up to \$1,000. Sections 775.082 and 775.083, F.S.

⁴ A third degree felony is punishable by up to 5 years in state prison and a fine of up to \$5,000. Sections 775.082 and 775.083, F.S.

⁵ A second degree felony is punishable by up to 15 years in state prison and a fine of up to \$10,000. Sections 775.082 and 775.083, F.S.

⁶ Section 893.13(2)(a), F.S.

⁷ Section 893.13(2)(b), F.S. A first degree felony is generally punishable by up to 30 years in state prison and a fine of up to \$10,000.

“Simple possession” of a controlled substance has been described as “possession of less than a trafficking amount without intent to sell, manufacture or deliver[.]”⁸ Generally, simple possession of a controlled substance is a third degree felony.⁹ However, simple possession of 20 grams or less of cannabis is a first degree misdemeanor,¹⁰ simple possession of a Schedule V controlled substance is a second degree misdemeanor,¹¹ and simple possession of more than 10 grams of certain Schedule I controlled substances is a first degree felony.¹²

Possession with intent to sell, manufacture, or deliver a controlled substance is generally punishable as a first degree misdemeanor, third degree felony, or second degree felony, depending upon the schedule of the controlled substance possessed.¹³ However, punishment is enhanced when the possession occurs within 1,000 feet of certain locations or facilities.¹⁴ For example, possession with intent to sell cannabis is generally a third degree felony¹⁵ but a second degree felony when the possession occurs within 1,000 feet of the real property of a K-12 school.¹⁶

Drug Trafficking

Drug trafficking, which is punished in s. 893.135, F.S., consists of knowingly selling, purchasing, manufacturing, delivering, or bringing into this state (importation), or knowingly being in actual or constructive possession of, certain Schedule I or Schedule II controlled substances in a statutorily-specified quantity. The statute only applies to a limited number of such controlled substances, and the controlled substances involved in the trafficking must meet a specified weight or quantity threshold.

Most drug trafficking offenses are first degree felonies and are subject to a mandatory minimum term of imprisonment and a mandatory fine,¹⁷ which is determined by the weight or quantity of the substance.¹⁸ For example, trafficking in 28 grams or more, but less than 200 grams, of cocaine, a first degree felony, is punishable by a 3-year mandatory minimum term of imprisonment and a mandatory fine of \$50,000.¹⁹ Trafficking in 200 grams or more, but less than 400 grams, of cocaine, a first degree felony, is punishable by a 7-year mandatory minimum term of imprisonment and a mandatory fine of \$100,000.²⁰

⁸ *Tyler v. State*, 107 So.3d 547, 549 (Fla. 1st DCA 2013), *rev. den.*, 130 So.3d 1278 (Fla. 2013).

⁹ Section 893.13(6)(a), F.S.

¹⁰ Section 893.13(6)(b), F.S.

¹¹ Section 893.13(6)(d), F.S. A second degree misdemeanor is punishable by up to 60 days in county jail and a fine of up to \$500. Sections 775.082 and 775.083, F.S.

¹² Section 893.13(6)(c), F.S.

¹³ Section 893.13(1)(a), F.S.

¹⁴ Section 893.13(1)(c)-(f) and (h), F.S.

¹⁵ Section 893.13(1)(a)2., F.S.

¹⁶ Section 893.13(1)(c)2., F.S.

¹⁷ Section 893.135, F.S., provides for mandatory fines which are greater than the maximum \$10,000 fine prescribed in s. 775.083, F.S., for a first degree felony. However, s. 775.083, F.S., which relates to fines, authorizes any higher amount if specifically authorized by statute.

¹⁸ *See* s. 893.135, F.S.

¹⁹ Section 893.135(1)(b)1.a., F.S.

²⁰ Section 893.135(1)(b)1.b., F.S.

Criminal Punishment Code

The Criminal Punishment Code²¹ (Code) is Florida's primary sentencing policy. Noncapital felonies sentenced under the Code receive an offense severity level ranking (levels 1-10).²² Points are assigned and accrue based upon the severity level ranking assigned to the primary offense, additional offenses, and prior offenses. Sentence points escalate as the severity level escalates. Points may also be added or multiplied for other factors such as victim injury or the commission of certain offenses like a level 7 or 8 drug trafficking offense. The lowest permissible sentence is any nonstate prison sanction in which total sentence points equal or are less than 44 points, unless the court determines that a prison sentence is appropriate. If total sentence points exceed 44 points, the lowest permissible sentence in prison months is calculated by subtracting 28 points from the total sentence points and decreasing the remaining total by 25 percent.²³ Absent mitigation,²⁴ the permissible sentencing range under the Code is generally the lowest permissible sentence scored up to and including the maximum penalty provided under s. 775.082, F.S.²⁵

Mandatory Minimum Sentences

Mandatory minimum terms of imprisonment limit judicial discretion in Code sentencing: "If the lowest permissible sentence is less than the mandatory minimum sentence, the mandatory minimum sentence takes precedence. If the lowest permissible sentence exceeds the mandatory sentence, the requirements of the Criminal Punishment Code and any mandatory minimum penalties apply."²⁶ As previously noted, the sentencing range under the Code is generally the scored lowest permissible sentence up to and including the statutory maximum penalty. However, if there is a mandatory minimum sentence that is longer than the scored lowest permissible sentence, the sentencing range is narrowed to the mandatory minimum sentence up to and including the statutory maximum penalty.

With few exceptions (e.g., youthful offender sentencing²⁷ or a reduced or suspended sentence for substantial assistance rendered²⁸), courts must impose the mandatory minimum term of imprisonment applicable to the drug trafficking offense committed.²⁹

²¹ Sections 921.002-921.0027, F.S. See chs. 97-194 and 98-204, L.O.F. The Code is effective for offenses committed on or after October 1, 1998.

²² Offenses are either ranked in the offense severity level ranking chart in s. 921.0022, F.S., or are ranked by default based on a ranking assigned to the felony degree of the offense as provided in s. 921.0023, F.S.

²³ Section 921.0024, F.S. Unless otherwise noted, information on the Code is from this source.

²⁴ The court may "mitigate" or "depart downward" from the scored lowest permissible sentence, if the court finds a mitigating circumstance. Section 921.0026, F.S., provides a list of mitigating circumstances.

²⁵ If the scored lowest permissible sentence exceeds the maximum penalty in s. 775.082, F.S., the sentence required by the Code must be imposed. If total sentence points are greater than or equal to 363 points, the court may sentence the offender to life imprisonment. Section 921.0024(2), F.S.

²⁶ Fla. R. Crim. P. 3.704(d)(26).

²⁷ Section 958.04, F.S. See *Gallimore v. State*, 100 So.3d 1264, 1266-1267 (Fla. 4th DCA 2012).

²⁸ Section 893.135(4) and 921.186, F.S. See *State v. Agerton*, 523 So.2d 1241, 1243 (Fla. 5th DCA 1988), *rev. den.*, 531 So.2d 1352 (Fla. 1988), and *McFadden v. State*, 177 So.3d 562, 566-567 (Fla. 2015). The court cannot *sua sponte* reduce or suspend the sentence because the decision to suspend or reduce a sentence is based upon a motion from the state attorney. The court is not mandated to reduce or suspend a sentence upon a showing of substantial assistance.

²⁹ Mandatory minimum terms under s. 893.135, F.S., do not apply to attempted drug trafficking. *Suarez v. State*, 635 So.2d 154, 155 (Fla. 2d DCA 1994).

State Prison Sentence

Under the Code, any sentence to state prison must exceed one year.³⁰ Notwithstanding s. 948.03, F.S. (terms and conditions of probation), only those persons who are convicted and sentenced in circuit court to a cumulative sentence of incarceration for one year or more, whether the sentence is imposed in the same or separate circuits, may be received by the Department of Corrections into the state correctional system.³¹

Custodial Interrogation

Constitutional Protections and Court Decisions Interpreting and Applying Those Protections

The Fifth Amendment of the United States Constitution states that “[n]o person . . . shall be compelled in any criminal case to be a witness against himself.”³² Similarly, the Florida Constitution extends the same protection.³³

Custodial Interrogation Legal Requirements

Whether a person is in custody and under interrogation is the threshold question that determines the need for a law enforcement officer to advise the person of his or her *Miranda* rights.³⁴ In *Traylor v. State*, the Florida Supreme Court found that “to ensure the voluntariness of confessions, the Self-Incrimination Clause of Article I, Section 9, Florida Constitution, requires that prior to custodial interrogation in Florida suspects must be told that they have a right to remain silent, that anything they say will be used against them in court....”³⁵

The test to determine if a person is in custody for the purposes of his or her *Miranda* rights is whether “a reasonable person placed in the same position would believe that his or her freedom of action was curtailed to a degree associated with actual arrest.”³⁶

An interrogation occurs “when a person is subjected to express questions, or other words or actions, by a state agent that a reasonable person would conclude are designed to lead to an incriminating response.”³⁷

Waiver of the Right to Remain Silent

A person subjected to a custodial interrogation is entitled to the protections of *Miranda*.³⁸ The warning must include the right to remain silent as well as the explanation that anything a person

³⁰ Section 921.0024(2), F.S.

³¹ Section 944.17(3)(a), F.S.

³² U.S. Const. amend. V.

³³ “No person shall be . . . compelled in any criminal matter to be a witness against himself.” FLA. CONST. article I, s. 9.

³⁴ In *Miranda v. Arizona*, 384 U.S. 436 (1966), the Court established procedural safeguards to ensure the voluntariness of statements rendered during custodial interrogation.

³⁵ 596 So.2d 957, 965-966 (Fla. 1992).

³⁶ *Id.* at 966 n. 16.

³⁷ *Id.* at 966 n. 17.

³⁸ See *Miranda v. Arizona*, 384 U.S. 436, 444 (1966).

says can be used against them in court. The warning includes both parts because it is important for a person to be aware of his or her right and the consequences of waving such a right.³⁹

Admissibility of a Defendant's Statement as Evidence

The admissibility of a defendant's statement is a mixed question of fact and law decided by the court during a pretrial hearing or during the trial outside the presence of the jury.⁴⁰ For a defendant's statement to become evidence in a criminal case, the judge must first determine whether the statement was freely and voluntarily given to a law enforcement officer during the custodial interrogation of the defendant. The court looks to the totality of the circumstances of the statement to determine if it was voluntarily given.⁴¹

The court can consider testimony from the defendant and any law enforcement officers involved, their reports, and any additional evidence such as audio or video recordings of the custodial interrogation.

As previously discussed, the courts use a "reasonable person" standard in making the determination of whether the defendant was in custody at the time he or she made a statement.⁴² The court considers, given the totality of the circumstances, whether a reasonable person in the defendant's position would have believed he or she was free to terminate the encounter with law enforcement and, therefore, was not in custody.⁴³ Among the circumstances or factors the courts have considered are:

- The manner in which the police summon the suspect for questioning;
- The purpose, place, and manner of the interrogation;
- The extent to which the suspect is confronted with evidence of his or her guilt; and
- Whether the suspect is informed that he or she is free to leave the place of questioning.⁴⁴

The court will also determine whether the defendant was made aware of his or her *Miranda* rights and whether he or she knowingly, voluntarily, and intelligently elected to waive those rights and give a statement.⁴⁵

Even if the court deems the statement admissible and the jury hears the evidence, defense counsel will be able to cross-examine any witnesses who testify and have knowledge of the circumstances surrounding the defendant's statement. Additionally, counsel may argue to the jury in closing argument that the statement was coerced in some way by a law enforcement officer.

³⁹ *Sliney v. State*, 699 So.2d 662, 669 (Fla. 1997), *cert. den.*, 522 U.S. 1129 (1998).

⁴⁰ *Nickels v. State*, 90 Fla. 659, 668 (Fla. 1925).

⁴¹ *Supra* n. 39 at 667.

⁴² *Supra* n. 36.

⁴³ *Voorhees v. State*, 699 So.2d 602, 608 (Fla. 1997).

⁴⁴ *Ramirez v. State*, 739 So.2d 568, 574 (Fla. 1999).

⁴⁵ *Supra* n. 36 at 668.

Interrogation Recording in Florida

Currently, 26 states and the District of Columbia record custodial interrogations statewide.⁴⁶ These states have statutes, court rules, or court cases that require law enforcement to make the recordings or allow the court to consider the failure to record a statement in determining the admissibility of a statement.⁴⁷ Although Florida is not one of these states, 58 Florida law enforcement agencies have been identified as recording custodial interrogations, voluntarily, at least to some extent.⁴⁸

Wrongful Incarceration Compensation Eligibility

The Victims of Wrongful Incarceration Compensation Act (the Act) has been in effect since July 1, 2008.⁴⁹ The Act provides a process whereby a person may petition the original sentencing court for an order finding the petitioner to be a wrongfully incarcerated person who is eligible for compensation from the state.

The Department of Legal Affairs administers the eligible person's application process and verifies the validity of the claim.⁵⁰ The Chief Financial Officer arranges for payment of the claim by securing an annuity or annuities payable to the claimant over at least 10 years, calculated at a rate of \$50,000 for each year of wrongful incarceration up to a total of \$2 million.⁵¹ To date, four persons have been compensated under the Act for a total of \$4,276,901.⁵²

⁴⁶ *Compendium: Electronic Recording of Custodial Interrogations*, Thomas P. Sullivan, January 2019, National Association of Criminal Defense Lawyers, p. 7, available at <https://www.nacdl.org/getattachment/581455af-11b2-4632-b584-ab2213d0a2c2/custodial-interrogations-compendium-january-2019-.pdf> (last visited November 5, 2019).

⁴⁷ See *Stephan v. State*, 711 P.2d 1156 (AK 1985); Ark. R. Crim. P. 4.7 (2012); Cal. Pen. Code s. 859.5 and Cal. Wel. & Inst. Code s. 626.8 (2013); CO. Rev. Stat. 16-3-601 (2016); CT Gen. Stat. s. 54-1o (2011); D.C. Code ss. 5-116.01 and 5-116.03 (2006); Hawaii was verified by the four departments that govern law enforcement in the state; 705 IL Comp. Stat. Ann. 405/5-401.5; 725 ICOSA 5/103-2.1 (2003, 2005, 2013); Ind. R. Evid. 617 (2009); Kan. Stat. s. 22-4620 (2017); 25 ME Rev. Stat. Ann. s. 2803-B(1)(K) (2007); MD Code Ann., Crim. Proc. ss. 2-402 and 2-403 (2008); MI Comp. Laws ss. 763.7 – 763.11 (2012); *State v. Scales*, 518 N.W.2d 587 (MN 1994); MO Rev. Stat. ss. 590.700 and 700.1 (2009 and 2015); MT Code Ann. ss. 46-4-406 – 46-4-410 (2009); NE Rev. Stat. Ann. ss. 29-4501 – 29-4508 (2008); NJ Court Rules, R. 3:17 (2005); NM Stat. Ann. s. 29-1-16 (2006); NC Gen. Stat. s. 15A-211 (2007, 2011); N.Y. Crim. Proc. Law s. 60.45 (McKinney 2018); OR Rev. Stat. s. 133.400 (2010); RI PAC, Accreditation Standards Manual, s. 8.10 (2013); Tex. Crim. Proc. Code ss. 2.32 and 38.22; Tex. Fam. Code s. 51.095; Utah R. Evid. Rule 616 (2015); 13 V.S.A. s. 5585 (2014); *State v. Jerrell*, 699 N.W.2d 110 (WI 2005); and WI Stat. ss. 968.073 and 972.115 (2005). See also *supra* n. 46 at p. 8.

⁴⁸ *Supra* n. 46 at pp. 40-41.

⁴⁹ Chapter 961, F.S. (ch. 2008-39, L.O.F.). To date, four persons have been compensated under the Act. E-mail and documentation received from the Office of the Attorney General, October 16, 2019 (on file with the Senate Committee on Criminal Justice).

⁵⁰ Section 961.05, F.S.

⁵¹ Additionally, the wrongfully incarcerated person is entitled to: waiver of tuition and fees for up to 120 hours of instruction at any career center established under s. 1001.44, F.S., any state college as defined in s. 1000.21(3), F.S., or any state university as defined in s. 1000.21(6), F.S., if the wrongfully incarcerated person meets certain requirements; the amount of any fine, penalty, or court costs imposed and paid by the wrongfully incarcerated person; the amount of any reasonable attorney's fees and expenses incurred and paid by the wrongfully incarcerated person in connection with all criminal proceedings and appeals regarding the wrongful conviction; and notwithstanding any provision to the contrary in s. 943.0583, F.S., or s. 943.0585, F.S., and immediate administrative expunction of the person's criminal record resulting from his or her wrongful arrest, wrongful conviction, and wrongful incarceration. Section 961.06, F.S.

⁵² E-mail and documentation received from the Office of the Attorney General, October 16, 2019 (on file with the Senate Committee on Criminal Justice).

In cases where sufficient evidence of actual innocence exists, a person is nonetheless *ineligible* for compensation if:

- *Before* the person's wrongful conviction and incarceration the person was convicted of, or pled guilty or nolo contendere to, regardless of adjudication *any single violent felony*, or *more than one nonviolent felony*, or a crime or crimes committed in another jurisdiction the elements of which would constitute a felony in this state, or a crime committed against the United States which is designated a felony, excluding any delinquency disposition;
- *During* the person's wrongful incarceration, the person was convicted of, or pled guilty or nolo contendere to, regardless of adjudication, *any violent felony offense* or *more than one nonviolent felony*; or
- *During* the person's wrongful incarceration, the person was also serving a *concurrent sentence for another felony* for which the person was not wrongfully convicted.⁵³

A person could be wrongfully incarcerated for a crime and then placed on parole or community supervision for that crime after the incarcerative part of the sentence is served.⁵⁴ Section 961.06(2), F.S., addresses this situation in terms of eligibility for compensation for the period of wrongful incarceration. Under this provision, if a person commits a misdemeanor, no more than one nonviolent felony, or some technical violation of his or her supervision that results in the revocation of parole or community supervision, the person is still eligible for compensation. If, however, any single violent felony law violation or multiple nonviolent felony law violations result in revocation, the person is ineligible for compensation.⁵⁵

The term "violent felony" is defined in s. 961.02(6), F.S., by cross-referencing felonies listed in s. 775.084(1)(c)1. or s. 948.06(8)(c), F.S. The combined list of those violent felony offenses includes attempts to commit the crimes as well as offenses committed in other jurisdictions if the elements of the crimes are substantially similar. The violent felonies referenced in s. 961.02(6), F.S., are:

- Kidnapping;
- False imprisonment of a child;
- Luring or enticing a child;
- Murder;
- Manslaughter;
- Aggravated manslaughter of a child;
- Aggravated manslaughter of an elderly person or disabled adult;
- Robbery;
- Carjacking;
- Home invasion robbery;
- Sexual Battery;
- Aggravated battery;

⁵³ Section 961.04, F.S.

⁵⁴ Persons are not eligible for parole in Florida unless they were sentenced prior to the effective date of the sentencing guidelines, which was October 1, 1983, and only then if they meet the statutory criteria. Chapter 82-171, L.O.F., and s. 947.16, F.S. The term "community supervision" as used in s. 961.06(2), F.S., could include control release, conditional medical release, or conditional release under the authority of the Florida Commission on Offender Review (ch. 947, F.S.), or community control or probation under the supervision of the Department of Corrections (ch. 948, F.S.).

⁵⁵ Section 961.06(2), F.S.

- Armed burglary and other burglary offenses that are first or second degree felonies;
- Aggravated child abuse;
- Aggravated abuse of an elderly person or disabled adult;
- Arson;
- Aggravated assault;
- Unlawful throwing, placing, or discharging of a destructive device or bomb;
- Treason;
- Aggravated stalking;
- Aircraft piracy;
- Abuse of a dead human body;
- Poisoning food or water;
- Lewd or lascivious battery, molestation, conduct, exhibition, or exhibition on computer;
- Lewd or lascivious offense upon or in the presence of an elderly or disabled person;
- Sexual performance by a child;
- Computer pornography;
- Transmission of child pornography; and
- Selling or buying of minors.

III. Effect of Proposed Changes:

The bill reduces the punishment for possessing, purchasing, or possessing with the intent to purchase less than two grams of most controlled substances; authorizes a court to depart from most mandatory minimum terms of imprisonment and mandatory fines, if the court finds that specified circumstances exist; requires electronic recording of a custodial interrogation at a place of detention in connection with certain offenses; and revises the circumstances under which a wrongfully incarcerated person is eligible for compensation for wrongful incarceration. A detailed discussion of the bill is provided below.

Purchase or Possession of a Controlled Substance (Section 1)

Section 1 of the bill amends s. 893.13, F.S., which punishes various unlawful acts involving controlled substances, to provide that, notwithstanding any provision of s. 893.13, F.S., chapter 921, which includes the Criminal Punishment Code and the Offense Severity Ranking Chart, or any other law, a person who possesses, purchases, or possesses with the intent to purchase less than two grams of a controlled substance, other than fentanyl and related analogs, derivatives, and mixtures,⁵⁶ may not be imprisoned for a term longer than 12 months. This provision appears to preclude a state prison sentence, which must exceed one year.⁵⁷

⁵⁶ The bill references s. 893.135(1)(c)4.a.(I)-(VII), F.S., which lists the following substances and mixtures that are applicable to “trafficking in fentanyl”: alfentanil; carfentanil; fentanyl; sufentanil; a fentanyl derivative; a controlled substance analog of any of these substances; and a mixture containing any of these substances.

⁵⁷ See ss. 921.0024(2), and 944.17(3)(a), F.S.

Drug Trafficking Mandatory Minimum Terms of Imprisonment and Mandatory Fines (Sections 2 and 6)

Section 2 of the bill amends s. 893.135, F.S., which punishes drug trafficking, to provide that, notwithstanding any provision of this section, a court may impose a sentence for a violation of this section other than the mandatory term of imprisonment and the mandatory fine, if the court finds on the record that specified circumstances exist. However, this departure provision does not apply to a drug trafficking offense which carries a mandatory minimum term of imprisonment of 25 years.

The specified circumstances the court must find on the record include the following:

- The defendant has no prior conviction for a forcible felony as defined in s. 776.08, F.S.⁵⁸
- The defendant did not use violence or credible threats of violence, or possess a firearm or other dangerous weapon, or induce another participant to use violence or credible threats of violence, in connection with the offense.
- The offense did not result in the death of or serious bodily injury to any person.
- The defendant was not an organizer, leader, manager, or supervisor of others in the offense and was not engaged in a continuing criminal enterprise as defined in s. 893.20, F.S.⁵⁹
- At the time of the sentencing hearing or earlier, the defendant has truthfully provided to the state all information and evidence that he or she possesses concerning the offense or offenses that were part of the same course of conduct or of a common scheme or plan.
- The defendant has not previously benefited from the application of this departure provision.

Section 6 of the bill amends s. 893.03, F.S., to correct a cross-reference to s. 893.135, F.S.

Custodial Interrogation (Section 3)

The bill creates s. 900.06, F.S., which creates a statutory requirement, and exceptions to that requirement, that a law enforcement officer conducting a custodial interrogation must electronically record the interrogation in its entirety.

The bill provides the following definitions for terms used in the bill:

- “Custodial interrogation” means questioning or other conduct by a law enforcement officer which is reasonably likely to elicit an incriminating response from an individual and which occurs under circumstances in which a reasonable individual in the same circumstances would consider himself or herself to be in the custody of a law enforcement agency;
- “Electronic recording” means an audio recording or an audio and video recording that accurately records a custodial interrogation;
- “Covered offense” means any of the following criminal offenses:

⁵⁸ Section 776.08, F.S., defines a “forcible felony” as treason; murder; manslaughter; sexual battery; carjacking; home-invasion robbery; robbery; burglary; arson; kidnapping; aggravated assault; aggravated battery; aggravated stalking; aircraft piracy; unlawful throwing, placing, or discharging of a destructive device or bomb; and any other felony which involves the use or threat of physical force or violence against any individual.

⁵⁹ Section 893.20(1), F.S., provides that any person who commits three or more felonies under ch. 893, F.S., in concert with five or more other persons with respect to whom such person occupies a position of organizer, a supervisory position, or any other position of management and who obtains substantial assets or resources from these acts is guilty of engaging in a continuing criminal enterprise.

- Arson.
- Sexual battery.
- Robbery.
- Kidnapping.
- Aggravated child abuse.
- Aggravated abuse of an elderly person or disabled adult.
- Aggravated assault with a deadly weapon.
- Murder.
- Manslaughter.
- Aggravated manslaughter of an elderly person or disabled adult.
- Aggravated manslaughter of a child.
- The unlawful throwing, placing, or discharging of a destructive device or bomb.
- Armed burglary.
- Aggravated battery.
- Aggravated stalking.
- Home-invasion robbery.
- Carjacking.
- “Place of detention” means a police station, sheriff’s office, correctional facility, prisoner holding facility, county detention facility, or other governmental facility where an individual may be held in connection with a criminal charge that has been or may be filed against the individual; and
- “Statement” means a communication that is oral, written, electronic, nonverbal, or in sign language.

The bill requires a custodial interrogation relating to a covered offense that is conducted at a place of detention be electronically recorded in its entirety. The recording must include:

- The giving of a required warning;
- The advisement of rights; and
- The waiver of rights by the individual being questioned.

If a custodial interrogation at a place of detention is not recorded by the law enforcement officer, he or she must prepare a written report explaining the reason for the noncompliance.

If a law enforcement officer conducts a custodial interrogation at a place other than a place of detention, the officer must prepare a written report as soon as practicable. The report must explain the circumstances of the interrogation in that place, and summarize the custodial interrogation process and the individual’s statements.

The general recording requirement does not apply under the following circumstances:

- If there is an unforeseen equipment malfunction that prevents recording the custodial interrogation in its entirety;
- If a suspect refuses to participate in a custodial interrogation if his or her statements are electronically recorded;
- Due to an equipment operator error that prevents the recording of the custodial interrogation in its entirety;

- If the statement is made spontaneously and not in response to a custodial interrogation question;
- If a statement is made during the processing of the arrest of a suspect;
- If the custodial interrogation occurs when the law enforcement officer participating in the interrogation does not have any knowledge of facts and circumstances that would lead an officer to reasonably believe that the individual being interrogated may have committed a covered offense;
- If the law enforcement officer conducting the custodial interrogation reasonably believes that electronic recording would jeopardize the safety of the officer, individual being interrogated, or others; or
- If the custodial interrogation is conducted outside of the state.

Unless a court finds that one or more of the enumerated exceptions applies, the court must consider the officer's failure to record all or part of the custodial interrogation as a factor in determining the admissibility of a defendant's statement made during the interrogation. If the court decides to admit the statement, the defendant may request and the court must give a cautionary jury instruction regarding the officer's failure to comply with the recording requirement.

Finally, if a law enforcement agency has enforced rules that are adopted pursuant to the bill and that are reasonably designed to comply with the bill's requirements, the agency is not subject to civil liability for damages arising from a violation of the bill's requirements. The bill does not create a cause of action against a law enforcement officer.

Wrongful Incarceration Compensation Eligibility (Sections 4, 5, 7, and 8)

Section 4 of the bill extends the time for a person who was wrongfully incarcerated to file the petition with the court for a determination of eligibility for compensation. The person will have two years rather than the current 90 days to file the petition. Further, persons who missed the 90 day deadline or who had claims dismissed because of this deadline may file the petition with the court within two years from the bill's effective date.

Section 5 of the bill amends s. 961.04, F.S., which relates to eligibility for compensation for wrongful incarceration, to eliminate ineligibility for compensation for wrongfully incarcerated persons who had a violent felony or more than one nonviolent felony before their wrongful conviction and incarceration. However, the bill does not change ineligibility status for persons who: commit a violent felony or multiple nonviolent felonies during their wrongful incarceration; are serving a concurrent prison sentence; or have served the incarcerative part of their sentence and commit a violent felony or multiple nonviolent felonies resulting in revocation of parole or community supervision.⁶⁰

Sections 7 and 8 of the bill reenact, respectively, ss. 961.02 and 961.03, F.S., which relate to eligibility for compensation of wrongfully incarcerated persons.

⁶⁰ See s. 961.06(2), F.S.

Effective Date (Section 9)

Section 9 of the bill provides that the bill takes effect July 1, 2020.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

Section 1 of the bill provides that a person who purchases or possesses less than two grams of a controlled substance, other than fentanyl, may not be imprisoned for a term longer than 12 months. This section may have an indeterminate but positive county jail bed impact, if a state prison sanction is precluded. Further, Section 3 of the bill relating to electronic recording of custodial interrogations may result in indeterminate local fund expenditures for equipment, maintenance, and operation. However, these provisions relate to the defense, prosecution, or punishment of criminal offenses, and criminal laws are exempt from the requirements of article VII, subsection 18(d) of the Florida Constitution, relating to unfunded mandates.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

It is possible that more persons will be eligible for compensation under the provisions of the bill. A person who is entitled to compensation under the Victims of Wrongful Incarceration Compensation Act will be paid at the rate of \$50,000 per year of wrongful incarceration up to a limit of \$2 million.⁶¹ Payment is made from an annuity or annuities

⁶¹ Section 961.06(1), F.S.

purchased by the Chief Financial Officer for the benefit of the wrongfully incarcerated person.⁶²

C. Government Sector Impact:

Local Government Impact

The drug purchase and possession provision of the bill may have an indeterminate jail bed impact if defendants who might be sentenced to prison under current law are instead sentenced to jail under the provisions of the bill. The requirements of the bill relating to electronic recording of custodial interrogation may have an indeterminate fiscal impact on local law enforcement agencies if agencies determine that expenditures to purchase recording equipment, retain recorded statements, and store electronic recordings are necessary to comply with the requirements of the bill relating to electronically recording custodial interrogations.

State Government Impact

Prison Bed Impact

The Criminal Justice Impact Conference, which provides the financial, official estimate of the prison bed impact, if any, of legislation has not yet reviewed the bill. However, the Legislature's Office of Economic and Demographic Research (EDR) preliminarily estimates that the bill has a "negative significant" prison bed impact (a decrease of more than 25 prison beds).⁶³ Regarding specific sections of the bill in which impact is noted, the EDR's preliminary estimate is that Section 1 of the bill, which reduces the punishment for purchasing or possessing less than two grams of a controlled substance excluding fentanyl, has a "negative significant" prison bed impact.⁶⁴ Section 2 of the bill, which authorizes a court to depart from most mandatory minimum terms of imprisonment and mandatory fines, if the court finds that specified circumstances exist, has a "negative indeterminate" prison bed impact (an unquantifiable decrease in prison beds).⁶⁵

Compensation for Wrongful Incarceration

More persons are potentially eligible for compensation for wrongful incarceration under provisions of the bill. A person who is entitled to compensation based on wrongful incarceration would be paid at the rate of \$50,000 per year of wrongful incarceration up to a limit of \$2 million. Payment is made from an annuity or annuities purchased by the Chief Financial Officer for the benefit of the wrongfully incarcerated person. The Victims of Wrongful Incarceration Compensation Act is funded through a continuing appropriation pursuant to s. 961.07, F.S.

Although statutory limits on compensation under the Act are clear, the fiscal impact of the bill is unquantifiable. The possibility that a person would be compensated for

⁶² Section 961.06(4), F.S.

⁶³ The EDR's preliminary estimate of SB 346 is on file with the Senate Committee on Criminal Justice.

⁶⁴ *Id.*

⁶⁵ *Id.*

wrongful incarceration is based upon variables that cannot be known, such as the number of wrongful incarcerations that currently exist or might exist in the future. Four successful claims since the Act became effective total \$4,276,901.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 893.03, 893.13, 893.135, and 961.04.

This bill creates section 900.06 of the Florida Statutes.

This bill reenacts the following sections of the Florida Statutes: 961.02 and 961.03.

IX. Additional Information:

- A. **Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Criminal and Civil Justice on December 11, 2019:

The Committee Substitute clarifies that the downward departure to mandatory minimums contemplated by the bill takes precedence over ch. 921, F.S., which includes the Criminal Punishment Code and the Offense Severity Ranking Chart.

CS by Criminal Justice on November 12, 2019:

The Committee Substitute:

- Changes the subject of the bill from “controlled substances” to “criminal justice.”
- Provides that a person who possesses, purchases, or possesses with the intent to purchase less than two grams of a controlled substance, other than fentanyl and related analogs, derivatives, and mixtures, may not be imprisoned for a term longer than 12 months.
- Provides that a person who has been found to have been wrongfully incarcerated will have two years to file a petition with the court for a determination of eligibility for compensation rather than the current 90 days to file a petition.
- Provides that persons who missed the 90 day deadline or who had claims dismissed because of this deadline may file the petition with the court within two years from the bill’s effective date.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



704682

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
12/11/2019	.	
	.	
	.	
	.	

Appropriations Subcommittee on Criminal and Civil Justice
(Bradley) recommended the following:

Senate Amendment

Delete line 52
and insert:
(10) Notwithstanding chapter 921 or any provision of this
section or any

By the Committee on Criminal Justice; and Senators Bradley, Brandes, Perry, Diaz, Gruters, Bracy, and Rouson

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1 A bill to be entitled
2 An act relating to criminal justice; amending s.
3 893.13, F.S.; prohibiting the imprisonment for longer
4 than a certain time for persons who possess, purchase,
5 or possess with the intent to purchase less than a
6 specified amount of a controlled substance; providing
7 exceptions; amending s. 893.135, F.S.; authorizing a
8 court to impose a sentence other than a mandatory
9 minimum term of imprisonment and mandatory fine for a
10 person convicted of trafficking if the court makes
11 certain findings on the record; creating s. 900.06,
12 F.S.; defining terms and specifying covered offenses;
13 requiring that a custodial interrogation conducted at
14 a place of detention in connection with certain
15 offenses be electronically recorded in its entirety;
16 requiring law enforcement officers who do not comply
17 with the electronic recording requirement or who
18 conduct custodial interrogations at a location other
19 than a place of detention to prepare a specified
20 report; providing exceptions to the electronic
21 recording requirement; requiring a court to consider a
22 law enforcement officer's failure to comply with the
23 electronic recording requirement in determining the
24 admissibility of a statement, unless an exception
25 applies; requiring a court, upon the request of a
26 defendant, to give certain cautionary instructions to
27 a jury under certain circumstances; providing immunity
28 from civil liability to law enforcement agencies that
29 enforce certain rules; providing that a cause of

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30 action is not created against a law enforcement
31 officer; amending s. 961.03, F.S.; revising the
32 circumstances under which a wrongfully incarcerated
33 person must file a petition with the court to
34 determine eligibility for compensation; authorizing
35 certain persons to petition the court to determine
36 eligibility for compensation within a specified
37 timeframe; amending s. 961.04, F.S.; revising the
38 circumstances under which a wrongfully incarcerated
39 person is eligible for compensation; amending s.
40 893.03, F.S.; conforming a cross-reference; reenacting
41 ss. 961.02(4) and 961.03(1)(a), (2), (3), and (4),
42 F.S., all relating to eligibility for compensation for
43 wrongfully incarcerated persons; providing an
44 effective date.

45
46 Be It Enacted by the Legislature of the State of Florida:

47
48 Section 1. Present subsection (10) of section 893.13,
49 Florida Statutes, is redesignated as subsection (11), and a new
50 subsection (10) is added to that section, to read:

51 893.13 Prohibited acts; penalties.—

52 (10) Notwithstanding any provision of this section or any
53 other law relating to the punishment for possessing, purchasing,
54 or possessing with the intent to purchase a controlled
55 substance, a person who possesses, purchases, or possesses with
56 the intent to purchase less than 2 grams of a controlled
57 substance, other than fentanyl or any substance or mixture
58 described in s. 893.135(1)(c)4.a.(I)-(VII), may not be

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59 imprisoned for a term longer than 12 months.

60 Section 2. Present subsections (6) and (7) of section
61 893.135, Florida Statutes, are redesignated as subsections (7)
62 and (8), respectively, and a new subsection (6) is added to that
63 section, to read:

64 893.135 Trafficking; mandatory sentences; suspension or
65 reduction of sentences; conspiracy to engage in trafficking.—

66 (6) Notwithstanding any provision of this section, a court
67 may impose a sentence for a violation of this section other than
68 the mandatory minimum term of imprisonment and mandatory fine if
69 the court finds on the record that all of the following
70 circumstances exist:

71 (a) The defendant has no prior conviction for a forcible
72 felony as defined in s. 776.08.

73 (b) The defendant did not use violence or credible threats
74 of violence, or possess a firearm or other dangerous weapon, or
75 induce another participant to use violence or credible threats
76 of violence, in connection with the offense.

77 (c) The offense did not result in the death of or serious
78 bodily injury to any person.

79 (d) The defendant was not an organizer, leader, manager, or
80 supervisor of others in the offense and was not engaged in a
81 continuing criminal enterprise as defined in s. 893.20.

82 (e) At the time of the sentencing hearing or earlier, the
83 defendant has truthfully provided to the state all information
84 and evidence that he or she possesses concerning the offense or
85 offenses that were part of the same course of conduct or of a
86 common scheme or plan.

87 (f) The defendant has not previously benefited from the

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88 application of this subsection.

89

90 A court may not apply this subsection to an offense under this
91 section which carries a mandatory minimum term of imprisonment
92 of 25 years.

93 Section 3. Section 900.06, Florida Statutes, is created to
94 read:

95 900.06 Recording of custodial interrogations for certain
96 offenses.—

97 (1) As used in this section, the term:

98 (a) "Custodial interrogation" means questioning or other
99 conduct by a law enforcement officer which is reasonably likely
100 to elicit an incriminating response from an individual and which
101 occurs under circumstances in which a reasonable individual in
102 the same circumstances would consider himself or herself to be
103 in the custody of a law enforcement agency.

104 (b) "Electronic recording" means an audio recording or an
105 audio and video recording that accurately records a custodial
106 interrogation.

107 (c) "Covered offense" includes:

108 1. Arson.

109 2. Sexual battery.

110 3. Robbery.

111 4. Kidnapping.

112 5. Aggravated child abuse.

113 6. Aggravated abuse of an elderly person or disabled adult.

114 7. Aggravated assault with a deadly weapon.

115 8. Murder.

116 9. Manslaughter.

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117 10. Aggravated manslaughter of an elderly person or
118 disabled adult.

119 11. Aggravated manslaughter of a child.

120 12. The unlawful throwing, placing, or discharging of a
121 destructive device or bomb.

122 13. Armed burglary.

123 14. Aggravated battery.

124 15. Aggravated stalking.

125 16. Home-invasion robbery.

126 17. Carjacking.

127 (d) "Place of detention" means a police station, sheriff's
128 office, correctional facility, prisoner holding facility, county
129 detention facility, or other governmental facility where an
130 individual may be held in connection with a criminal charge that
131 has been or may be filed against the individual.

132 (e) "Statement" means a communication that is oral,
133 written, electronic, nonverbal, or in sign language.

134 (2) (a) A custodial interrogation at a place of detention,
135 including the giving of a required warning, the advisement of
136 the rights of the individual being questioned, and the waiver of
137 any rights by the individual, must be electronically recorded in
138 its entirety if the interrogation is related to a covered
139 offense.

140 (b) If a law enforcement officer conducts a custodial
141 interrogation at a place of detention without electronically
142 recording the interrogation, the officer must prepare a written
143 report explaining why he or she did not record the
144 interrogation.

145 (c) As soon as practicable, a law enforcement officer who

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146 conducts a custodial interrogation at a location other than a
147 place of detention shall prepare a written report explaining the
148 circumstances of the interrogation and summarizing the custodial
149 interrogation process and the individual's statements.

150 (d) Paragraph (a) does not apply:

151 1. If an unforeseen equipment malfunction prevents
152 recording the custodial interrogation in its entirety;

153 2. If a suspect refuses to participate in a custodial
154 interrogation if his or her statements are to be electronically
155 recorded;

156 3. If an equipment operator error prevents recording the
157 custodial interrogation in its entirety;

158 4. If the statement is made spontaneously and not in
159 response to a custodial interrogation question;

160 5. If the statement is made during the processing of the
161 arrest of a suspect;

162 6. If the custodial interrogation occurs when the law
163 enforcement officer participating in the interrogation does not
164 have any knowledge of facts and circumstances that would lead an
165 officer to reasonably believe that the individual being
166 interrogated may have committed a covered offense;

167 7. If the law enforcement officer conducting the custodial
168 interrogation reasonably believes that making an electronic
169 recording would jeopardize the safety of the officer, the
170 individual being interrogated, or others; or

171 8. If the custodial interrogation is conducted outside of
172 this state.

173 (3) Unless a court finds that one or more of the
174 circumstances specified in paragraph (2)(d) apply, the court

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175 must consider the circumstances of an interrogation conducted by
176 a law enforcement officer in which he or she did not
177 electronically record all or part of a custodial interrogation
178 in determining whether a statement made during the interrogation
179 is admissible. If the court admits into evidence a statement
180 made during a custodial interrogation that was not
181 electronically recorded as required under paragraph (2) (a), the
182 court must, upon request of the defendant, give cautionary
183 instructions to the jury regarding the law enforcement officer's
184 failure to comply with that requirement.

185 (4) A law enforcement agency in this state which has
186 enforced rules adopted pursuant to this section which are
187 reasonably designed to ensure compliance with the requirements
188 of this section is not subject to civil liability for damages
189 arising from a violation of this section. This section does not
190 create a cause of action against a law enforcement officer.

191 Section 4. Paragraph (b) of subsection (1) of section
192 961.03, Florida Statutes, is amended to read:

193 961.03 Determination of status as a wrongfully incarcerated
194 person; determination of eligibility for compensation.—

195 (1)

196 (b) The person must file the petition with the court:

197 1. Within 2 years ~~90 days~~ after the order vacating a
198 conviction and sentence becomes final and the criminal charges
199 against the person are dismissed if the person's conviction and
200 sentence is vacated, or the person is retried and found not
201 guilty, on or after July 1, 2008. If a person had a claim
202 dismissed or did not file a claim because of the former 90-day
203 petition filing period under this subparagraph, he or she may

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204 file a petition with the court within 2 years after July 1,
205 2020.

206 2. By July 1, 2010, if the person's conviction and sentence
207 was vacated by an order that became final before ~~prior to~~ July
208 1, 2008.

209 Section 5. Section 961.04, Florida Statutes, is amended to
210 read:

211 961.04 Eligibility for compensation for wrongful
212 incarceration.—A wrongfully incarcerated person is not eligible
213 for compensation under the act if any of the following apply:

214 ~~(1) Before the person's wrongful conviction and~~
215 ~~incarceration, the person was convicted of, or pled guilty or~~
216 ~~nolo contendere to, regardless of adjudication, any violent~~
217 ~~felony, or a crime committed in another jurisdiction the~~
218 ~~elements of which would constitute a violent felony in this~~
219 ~~state, or a crime committed against the United States which is~~
220 ~~designated a violent felony, excluding any delinquency~~
221 ~~disposition;~~

222 ~~(2) Before the person's wrongful conviction and~~
223 ~~incarceration, the person was convicted of, or pled guilty or~~
224 ~~nolo contendere to, regardless of adjudication, more than one~~
225 ~~felony that is not a violent felony, or more than one crime~~
226 ~~committed in another jurisdiction, the elements of which would~~
227 ~~constitute a felony in this state, or more than one crime~~
228 ~~committed against the United States which is designated a~~
229 ~~felony, excluding any delinquency disposition;~~

230 (1)(3) During the person's wrongful incarceration, the
231 person was convicted of, or pled guilty or nolo contendere to,
232 regardless of adjudication, any violent felony.†

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233 (2)~~(4)~~ During the person's wrongful incarceration, the
234 person was convicted of, or pled guilty or nolo contendere to,
235 regardless of adjudication, more than one felony that is not a
236 violent felony.~~;~~~~or~~

237 (3)~~(5)~~ During the person's wrongful incarceration, the
238 person was also serving a concurrent sentence for another felony
239 for which the person was not wrongfully convicted.

240 Section 6. Paragraph (c) of subsection (3) of section
241 893.03, Florida Statutes, is amended to read:

242 893.03 Standards and schedules.—The substances enumerated
243 in this section are controlled by this chapter. The controlled
244 substances listed or to be listed in Schedules I, II, III, IV,
245 and V are included by whatever official, common, usual,
246 chemical, trade name, or class designated. The provisions of
247 this section shall not be construed to include within any of the
248 schedules contained in this section any excluded drugs listed
249 within the purview of 21 C.F.R. s. 1308.22, styled "Excluded
250 Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical
251 Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted
252 Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt
253 Anabolic Steroid Products."

254 (3) SCHEDULE III.—A substance in Schedule III has a
255 potential for abuse less than the substances contained in
256 Schedules I and II and has a currently accepted medical use in
257 treatment in the United States, and abuse of the substance may
258 lead to moderate or low physical dependence or high
259 psychological dependence or, in the case of anabolic steroids,
260 may lead to physical damage. The following substances are
261 controlled in Schedule III:

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262 (c) Unless specifically excepted or unless listed in
263 another schedule, any material, compound, mixture, or
264 preparation containing limited quantities of any of the
265 following controlled substances or any salts thereof:

266 1. Not more than 1.8 grams of codeine per 100 milliliters
267 or not more than 90 milligrams per dosage unit, with an equal or
268 greater quantity of an isoquinoline alkaloid of opium.

269 2. Not more than 1.8 grams of codeine per 100 milliliters
270 or not more than 90 milligrams per dosage unit, with recognized
271 therapeutic amounts of one or more active ingredients which are
272 not controlled substances.

273 3. Not more than 300 milligrams of hydrocodone per 100
274 milliliters or not more than 15 milligrams per dosage unit, with
275 a fourfold or greater quantity of an isoquinoline alkaloid of
276 opium.

277 4. Not more than 300 milligrams of hydrocodone per 100
278 milliliters or not more than 15 milligrams per dosage unit, with
279 recognized therapeutic amounts of one or more active ingredients
280 that are not controlled substances.

281 5. Not more than 1.8 grams of dihydrocodeine per 100
282 milliliters or not more than 90 milligrams per dosage unit, with
283 recognized therapeutic amounts of one or more active ingredients
284 which are not controlled substances.

285 6. Not more than 300 milligrams of ethylmorphine per 100
286 milliliters or not more than 15 milligrams per dosage unit, with
287 one or more active, nonnarcotic ingredients in recognized
288 therapeutic amounts.

289 7. Not more than 50 milligrams of morphine per 100
290 milliliters or per 100 grams, with recognized therapeutic

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291 amounts of one or more active ingredients which are not
292 controlled substances.

293

294 For purposes of charging a person with a violation of s. 893.135
295 involving any controlled substance described in subparagraph 3.
296 or subparagraph 4., the controlled substance is a Schedule III
297 controlled substance pursuant to this paragraph but the weight
298 of the controlled substance per milliliters or per dosage unit
299 is not relevant to the charging of a violation of s. 893.135.
300 The weight of the controlled substance shall be determined
301 pursuant to s. 893.135(7) ~~s. 893.135(6)~~.

302 Section 7. For the purpose of incorporating the amendment
303 made by this act to section 961.04, Florida Statutes, in a
304 reference thereto, subsection (4) of section 961.02, Florida
305 Statutes, is reenacted to read:

306 961.02 Definitions.—As used in ss. 961.01-961.07, the term:

307 (4) "Eligible for compensation" means that a person meets
308 the definition of the term "wrongfully incarcerated person" and
309 is not disqualified from seeking compensation under the criteria
310 prescribed in s. 961.04.

311 Section 8. For the purpose of incorporating the amendments
312 made by this act to section 961.04, Florida Statutes, in
313 references thereto, paragraph (a) of subsection (1) and
314 subsections (2), (3), and (4) of section 961.03, Florida
315 Statutes, are reenacted to read:

316 961.03 Determination of status as a wrongfully incarcerated
317 person; determination of eligibility for compensation.—

318 (1) (a) In order to meet the definition of a "wrongfully
319 incarcerated person" and "eligible for compensation," upon entry

591-01351-20

2020346c1

320 of an order, based upon exonerating evidence, vacating a
321 conviction and sentence, a person must set forth the claim of
322 wrongful incarceration under oath and with particularity by
323 filing a petition with the original sentencing court, with a
324 copy of the petition and proper notice to the prosecuting
325 authority in the underlying felony for which the person was
326 incarcerated. At a minimum, the petition must:

327 1. State that verifiable and substantial evidence of actual
328 innocence exists and state with particularity the nature and
329 significance of the verifiable and substantial evidence of
330 actual innocence; and

331 2. State that the person is not disqualified, under the
332 provisions of s. 961.04, from seeking compensation under this
333 act.

334 (2) The prosecuting authority must respond to the petition
335 within 30 days. The prosecuting authority may respond:

336 (a) By certifying to the court that, based upon the
337 petition and verifiable and substantial evidence of actual
338 innocence, no further criminal proceedings in the case at bar
339 can or will be initiated by the prosecuting authority, that no
340 questions of fact remain as to the petitioner's wrongful
341 incarceration, and that the petitioner is not ineligible from
342 seeking compensation under the provisions of s. 961.04; or

343 (b) By contesting the nature, significance, or effect of
344 the evidence of actual innocence, the facts related to the
345 petitioner's alleged wrongful incarceration, or whether the
346 petitioner is ineligible from seeking compensation under the
347 provisions of s. 961.04.

348 (3) If the prosecuting authority responds as set forth in

591-01351-20

2020346c1

349 paragraph (2) (a), the original sentencing court, based upon the
350 evidence of actual innocence, the prosecuting authority's
351 certification, and upon the court's finding that the petitioner
352 has presented clear and convincing evidence that the petitioner
353 committed neither the act nor the offense that served as the
354 basis for the conviction and incarceration, and that the
355 petitioner did not aid, abet, or act as an accomplice to a
356 person who committed the act or offense, shall certify to the
357 department that the petitioner is a wrongfully incarcerated
358 person as defined by this act. Based upon the prosecuting
359 authority's certification, the court shall also certify to the
360 department that the petitioner is eligible for compensation
361 under the provisions of s. 961.04.

362 (4) (a) If the prosecuting authority responds as set forth
363 in paragraph (2) (b), the original sentencing court shall make a
364 determination from the pleadings and supporting documentation
365 whether, by a preponderance of the evidence, the petitioner is
366 ineligible for compensation under the provisions of s. 961.04,
367 regardless of his or her claim of wrongful incarceration. If the
368 court finds the petitioner ineligible under the provisions of s.
369 961.04, it shall dismiss the petition.

370 (b) If the prosecuting authority responds as set forth in
371 paragraph (2) (b), and the court determines that the petitioner
372 is eligible under the provisions of s. 961.04, but the
373 prosecuting authority contests the nature, significance or
374 effect of the evidence of actual innocence, or the facts related
375 to the petitioner's alleged wrongful incarceration, the court
376 shall set forth its findings and transfer the petition by
377 electronic means through the division's website to the division

591-01351-20

2020346c1

378 for findings of fact and a recommended determination of whether
379 the petitioner has established that he or she is a wrongfully
380 incarcerated person who is eligible for compensation under this
381 act.

382 Section 9. This act shall take effect July 1, 2020.

The Florida Senate
COMMITTEE VOTE RECORD

COMMITTEE: Appropriations Subcommittee on Criminal and Civil Justice
ITEM: CS/SB 346
FINAL ACTION: Favorable with Committee Substitute
MEETING DATE: Wednesday, December 11, 2019
TIME: 1:30—3:30 p.m.
PLACE: 37 Senate Building

FINAL VOTE		SENATORS	12/11/2019 Amendment 704682 1 Bradley		Yea	Nay	Yea	Nay
Yea	Nay		Yea	Nay				
X		Gainer	X					
X		Gruters	X					
X		Harrell	X					
X		Perry	X					
X		Rouson	X					
X		Taddeo	X					
X		Bracy, VICE CHAIR	X					
X		Brandes, CHAIR	X					
8	0							
Yea	Nay	TOTALS	RCS Yea	- Nay	Yea	Nay	Yea	Nay

FINAL VOTE

CODES:	FAV=Favorable	RCS=Replaced by Committee Substitute	TP=Temporarily Postponed	WD=Withdrawn
	UNF=Unfavorable	RE=Replaced by Engrossed Amendment	VA=Vote After Roll Call	OO=Out of Order
	-R=Reconsidered	RS=Replaced by Substitute Amendment	VC=Vote Change After Roll Call	AV=Abstain from Voting

S00346
GENERAL BILL/CS by CJ; Bradley; (CO-INTRODUCERS) Brandes; Perry; Diaz; Gruters; Bracy; Rouson; (Compare H 00259, H 00339, S 00468)
Criminal Justice. EFFECTIVE DATE: 07/01/2020.
11/18/19 S Now in Appropriations Subcommittee on Criminal and Civil Justice
12/02/19 S On Committee agenda-- Appropriations Subcommittee on Criminal and Civil Justice, 12/11/19, 1:30 pm, 37 Senate Building
12/11/19 S Subcommittee Recommendation: CS/CS by Appropriations Subcommittee on Criminal and Civil Justice; YEAS 8 NAYS 0

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12-11-19
Meeting Date

346
Bill Number (if applicable)

Topic Sentencing

Amendment Barcode (if applicable)

Name Greg Newburn

Job Title Florida Director

Address PO Box 142933

Phone 352-682-2542

Street

Gainesville

FL

32614

Email gnewburn@famm.org

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing FAMM

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

Meeting Date

346

Bill Number (if applicable)

Topic Criminal Justice

Amendment Barcode (if applicable)

Name Ida V. Eskomani

Job Title Public Affairs

Address 726 N Mills Ave

Phone 4073764801

Street Orlando FL 32801

City State Zip

Email ida.eskomani@gmail.com

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing New Florida Majority + Organize Florida

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19 Meeting Date

346 Bill Number (if applicable)

Topic Criminal Justice

Amendment Barcode (if applicable)

Name Pamela Burch Fort

Job Title

Address 104 S. Monroe Street

Phone 850-425-1344

Tallahassee FL 32301 City State Zip

Email Tcglobby@aol.com

Speaking: For Against Information

Waive Speaking: In Support Against (The Chair will read this information into the record.)

Representing ACLU of Florida

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Dec 11 2019
Meeting Date

346
Bill Number (if applicable)

Topic SB 346

Amendment Barcode (if applicable)

Name DIEGO ELHEVERRI

Job Title Legislative Liaison

Address 200 W College Ave
Street

Phone 813-767-2084

TLH FL
City State Zip

Email decheverri@afphg.org

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing Americans For Prosperity

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19 Meeting Date

346 Bill Number (if applicable)

Topic

Amendment Barcode (if applicable)

Name Ken Kniepmann

Job Title FLORIDA CONFERENCE CATHOLIC BISHOPS

Address 201 W Park Street

Phone

City

State

Zip

Email

Speaking: For Against Information

Waive Speaking: In Support Against (The Chair will read this information into the record.)

Representing FLORIDA CONFERENCE CATHOLIC BISHOPS

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

Meeting Date

SB 346

Bill Number (if applicable)

Topic CRIMINAL JUSTICE

Amendment Barcode (if applicable)

Name CHRISTIAN MINOR

Job Title EXECUTIVE DIRECTOR

Address 1300 N. ADAMS ST.
Street

Phone 321-223-4252

TALLAHASSEE FL 32309
City State Zip

Email cmminor@fjia.org

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing FLORIDA JUVENILE JUSTICE ASSOCIATION

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19
Meeting Date

SB 346
Bill Number (if applicable)

Topic CJ

Amendment Barcode (if applicable)

Name Chelsea Murphy

Job Title Florida State Director

Address 605 Middlebrooks Circle

Phone 954-557-0016

Street

Tallahassee

FL

32312

Email cmurphy@rightoncrime.com

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing Right on Crime

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19
Meeting Date

SB346
Bill Number (if applicable)

Topic SB346 - Criminal Justice

Amendment Barcode (if applicable)

Name Dr. Adina Thompson

Job Title Innocence Project of Florida - Intake Coordinator

Address 1100 East Park Avenue

Phone 850-561-6767

Street

Tallahassee

FL

State

32301

Zip

Email Athompson@FloridaInnocence.org

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

Meeting Date

346

Bill Number (if applicable)

Topic Criminal Justice

Amendment Barcode (if applicable)

Name Nancy Daniels

Job Title Legislative Consultant

Address 103 N Gadsden St.

Phone 850-488-6850

Street

Tallahassee

Florida

32301

Email ndaniels@flpda.org

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing Florida Public Defender Association

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/2019
Meeting Date

SB 346
Bill Number (if applicable)

Topic CRIMINAL JUSTICE

Amendment Barcode (if applicable)

Name CESAR GRAJALES

Job Title COALITIONS DIRECTOR

Address 200 W COLLEGE AVE
Street

Phone 786-260-9283

TALLAHASSEE FL 32307
City State Zip

Email cgrajales@belibre.org

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing THE LIBRE INITIATIVE

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19 Meeting Date

346 Bill Number (if applicable)

Topic Criminal Justice

Amendment Barcode (if applicable)

Name Scott McCoy

Job Title Policy Director

Address P.O. Box 10788 Street

Phone 334-224-4309

Tallahassee FL 32302 City State Zip

Email

Speaking: For Against Information

Waive Speaking: In Support Against (The Chair will read this information into the record.)

Representing Southern Poverty Law Action Fund

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19
Meeting Date

346
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Sal Nuzzo

Job Title Vice President of Policy

Address 100 N Duval Street
Street

Phone 850-322-9941

Tallahassee FL 32301
City State Zip

Email snuzzo@jamesmadison.org

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing The James Madison Institute

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

Meeting Date

346

Bill Number (if applicable)

Topic Crim Justice Reform

Amendment Barcode (if applicable)

Name Dan Hendrickson

Job Title president, TALLAHASSEE VETERANS LEGAL COLLABORTIVE

Address 319 E Park Ave

Phone 850/570-1967

Street

Tallahassee

Fl

32301

Email danbhendrickson@comcast.net

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing TALLAHASSEE VETERANS LEGAL COLLABORATIVE

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/2019

Meeting Date

Bill Number (if applicable)

Topic SB 0346 - MANDATORY MINIMUM DEPARTURES

Amendment Barcode (if applicable)

Name TRACY JOHNSON

Job Title RETIRED ASAC

Address 6084 W W KELLEY ROAD

Phone _____

Street

TALLAHASSEE

FL

32311

Email _____

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing FLORIDA CARES

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

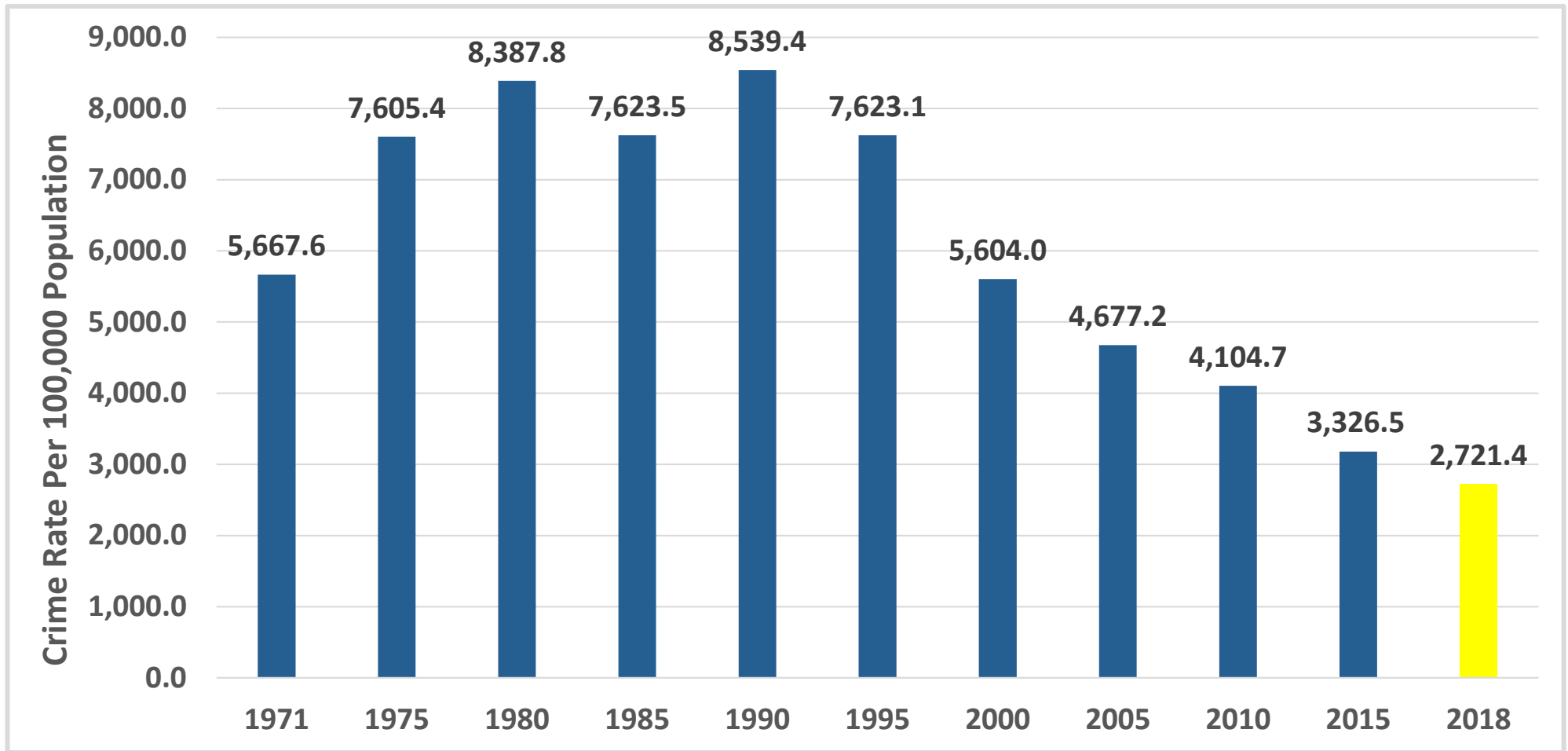
GOVERNOR RON DESANTIS

**A BOLDER, BRIGHTER,
BETTER FUTURE**

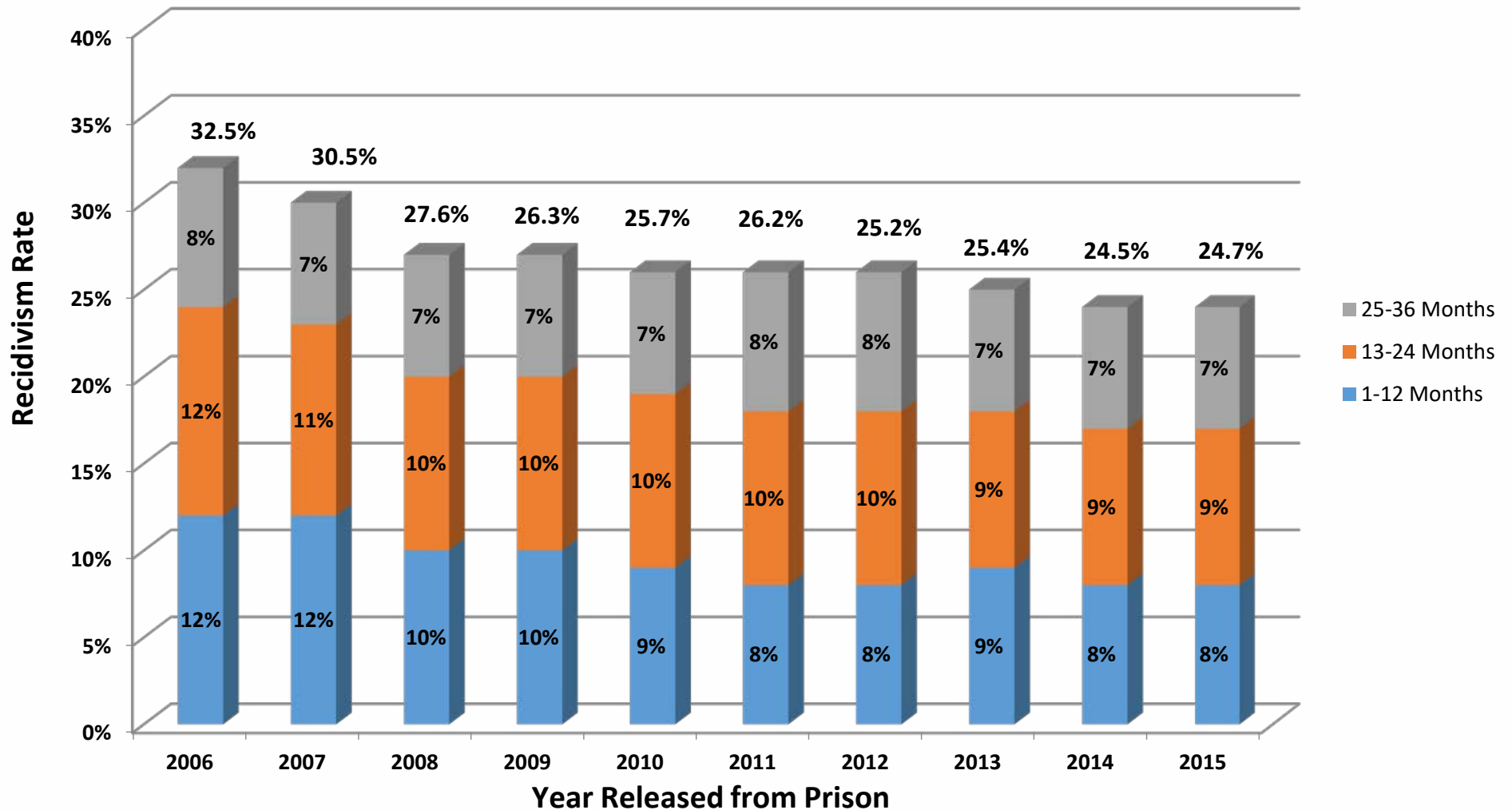


2020-2021 BUDGET & POLICY RECOMMENDATIONS

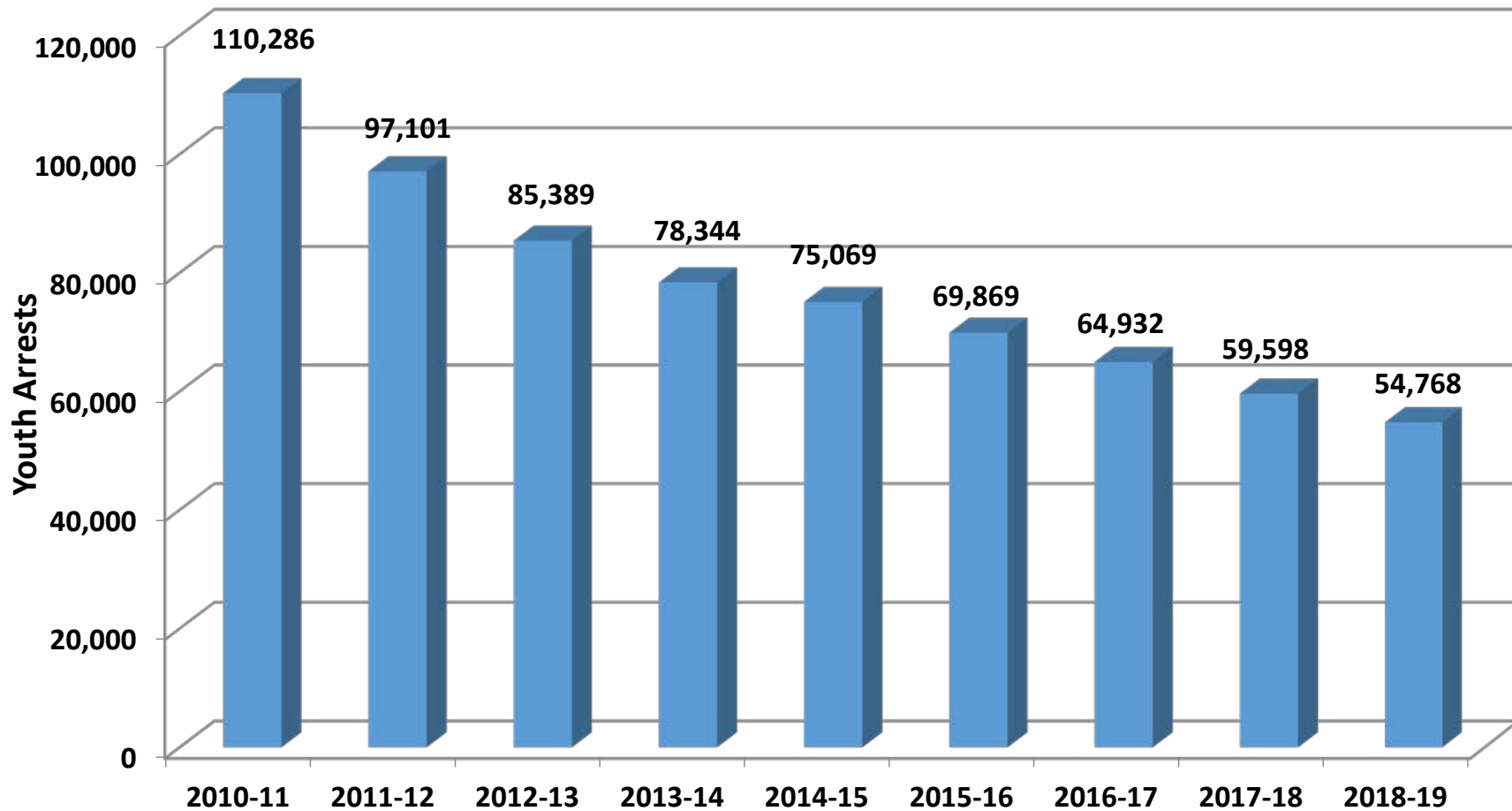
Lowest Crime Rate in 48 Years



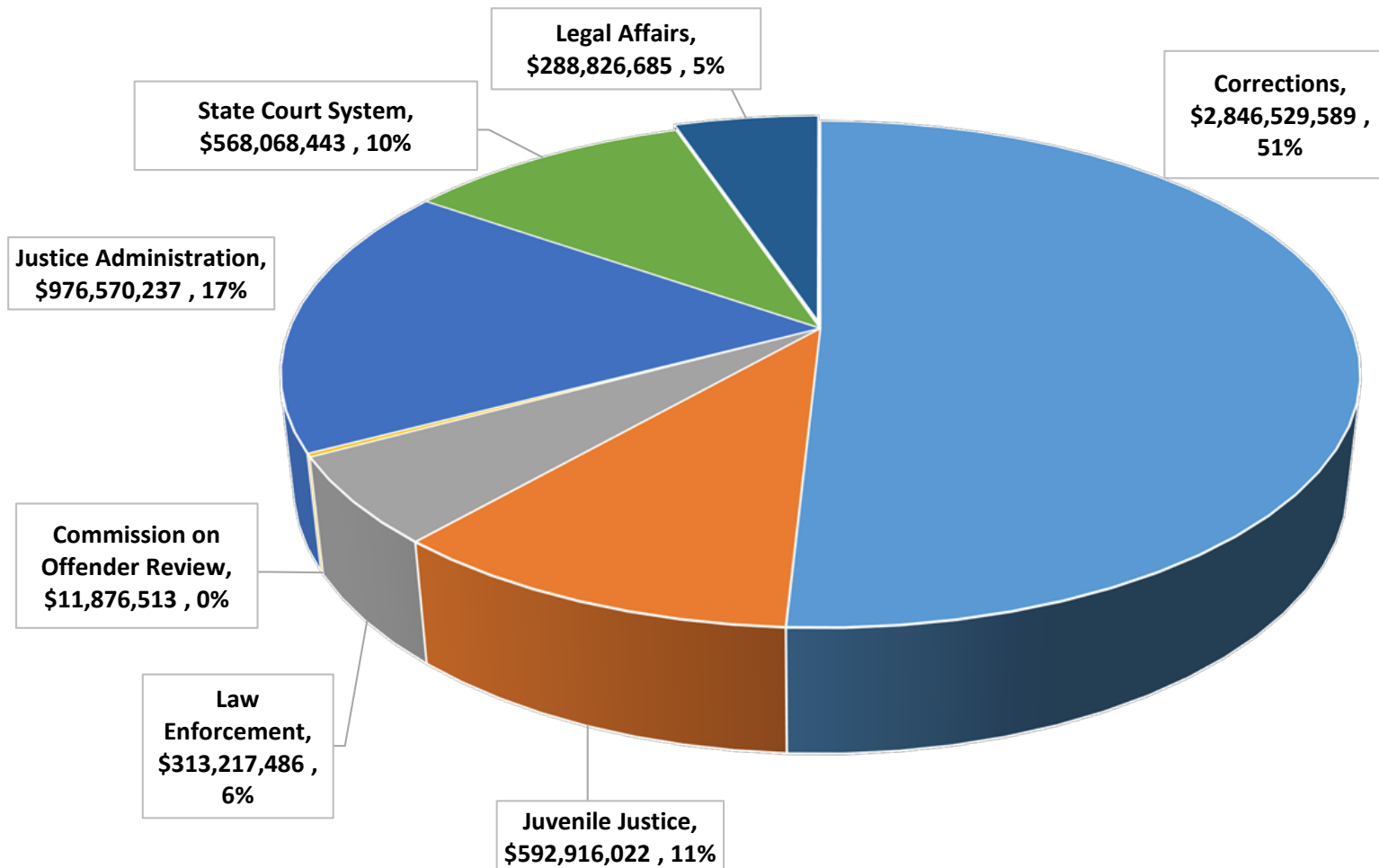
Reducing Recidivism



Lowest Juvenile Arrest Rate in 44 Years



FY 2020-21 Budget Recommendation \$5.6 Billion



Department of Corrections

Major Issues Funded	Amount
8.5 Hour Shifts	\$29 Million; 292 FTE
Retention Pay Plan	\$60.6 Million
Reentry Programming	\$9.3 Million; 34 FTE
Security Threat Group	\$2.2 Million; 364 FTE
Inspector General	\$1.5 Million; 20 FTE
Maintenance and Repair / Fleet	\$15 Million / \$2.6 Million
Lake CI Mental Health Hospital	\$11.9 Million
Electronic Medical Records	\$4.2 Million



Department of Juvenile Justice

Major Issues Funded	Amount
Special Risk for Juvenile Detention Officers	\$6.2 Million
Enhanced Residential Services	\$4.2 Million
Prevention Programs	\$1.1 Million
Maintenance and Repair	\$5 Million
Medical Services Oversight	\$608,000; 6 FTE
Comprehensive Evaluations	\$222,000



Other Priority Issues

Major Issues Funded	Amount
FDLE – Threat Assessment Strategy	\$8.3 Million; 20 FTE
FDLE – Crime Databases	\$14.5 Million; 2 FTE
DLA – IT Modernization	\$6.4 Million
DLA – Cyber Fraud Initiative	\$1.7 Million; 16 FTE
FCOR – Clemency Database	\$376,000
State Courts – Problem Solving Courts	\$102,000; 1 FTE
State Courts – Virtual Interpreting Services	\$273,000
GAL – Case Manager FTE	\$2 Million; 35 FTE



Public Safety Unit

Office of Policy and Budget

Katie Cunningham, Policy Coordinator
(850) 717-9512



THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

n/a

Meeting Date

Bill Number (if applicable)

Topic Governor's Recommended Public Safety Budget

Amendment Barcode (if applicable)

Name Katie Cunningham

Job Title Public Safety Policy Coordinator

Address 1802 Capitol

Phone 850-717-9512

Street

Tallahassee

FL

32399

Email katie.cunningham@laspbs.state.fl.us

City

State

Zip

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing Governor DeSantis

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19
Meeting Date

Bill Number (if applicable)

Topic Governor's Budget Recommendations

Amendment Barcode (if applicable)

Name Marks Inch

Job Title Secretary

Address 501 South Calhoun Street
Street

Phone (850) 717-3030

Tallahassee Florida 32399
City State Zip

Email marks.inch@fdk.myflorida.com

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing Florida Department of Corrections

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19
Meeting Date

Bill Number (if applicable)

Topic Gov. Rec. Budget

Amendment Barcode (if applicable)

Name Simone Marshall

Job Title Secretary, DJJ

Address _____
Street

Phone _____

City _____ State _____ Zip _____

Email _____

Speaking: For Against Information

Waive Speaking: In Support Against
(The Chair will read this information into the record.)

Representing DJJ

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

Study of Correctional Health Care in Florida Department of Corrections

Presentation to Florida Senate Appropriations Subcommittee on Criminal and Civil Justice
December 11, 2019



Project Background

- Project initiated to fulfill proviso requirements of Chapters 2019-117, Laws of Florida passed during 2019 legislative session.
- Legislation required Office of Program Policy Analysis and Government Accountability to contract with independent consultant to *“conduct a review of inmate health care services in order to compare the cost effectiveness of alternative methods of delivering the services.”*
- CGL was selected to conduct the project in July 2019.



Required Scope of Project

- OPPAGA directed the following research tasks:
 - Describe current provision of inmate health care services in FDC.
 - Assess alternative models for delivering health care services.
 - Insourcing
 - Outsourcing
 - Hybrid Insourcing/Outsourcing
 - University Model
 - Compare cost-effectiveness of alternative models.



Project Approach

- Reviewed FDC health care data.
- Conducted extensive interviews with FDC administrative staff and prison medical staff.
- Toured correctional facilities with major medical missions.



Presentation Agenda

- Recent history of health care in FDC.
- Current FDC health care system.
- Alternative Health Care Delivery Comparison
 - Insourced Model
 - Outsourced Model
 - Hybrid Model
 - University Model



FDC Health Care History



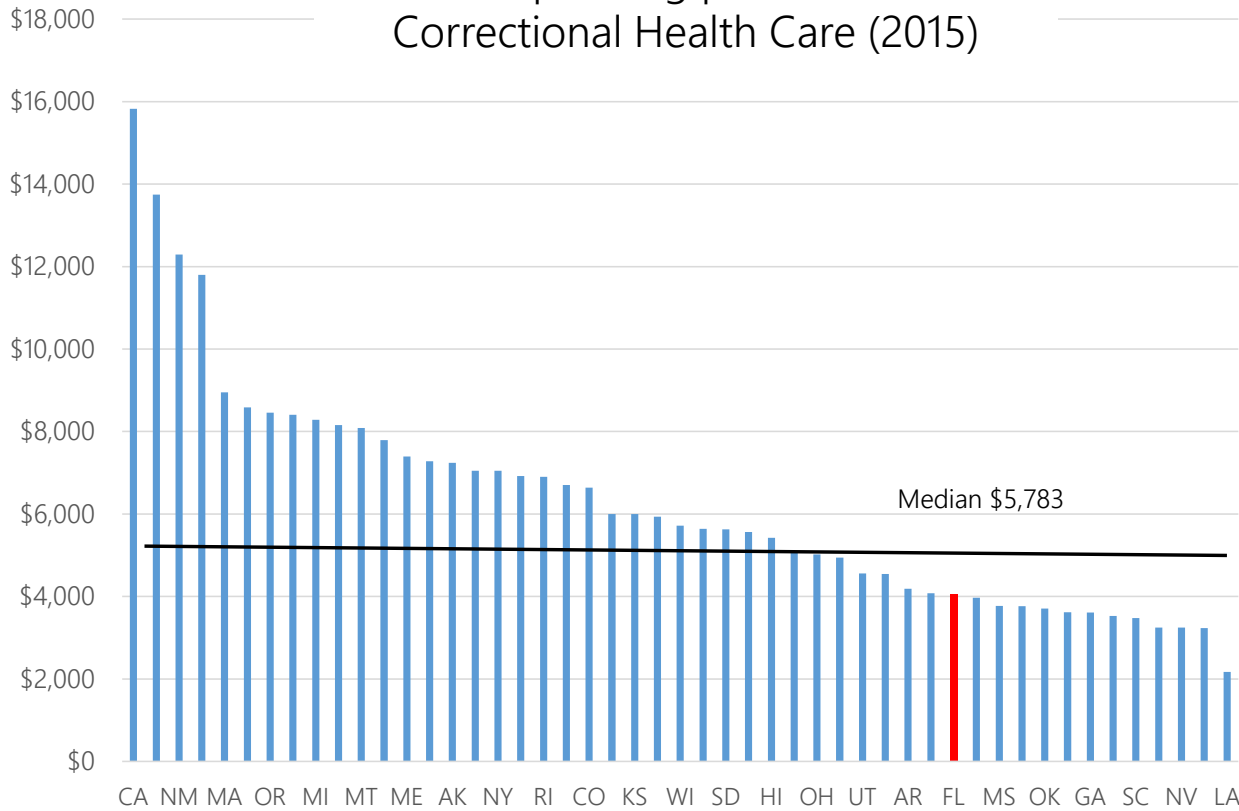
FDC Health Care History

- History of provision of Health Care in FDC has been complicated.
 - 1979 - Costello v. Wainwright lawsuit filed
 - 1986 - Corrections Medical Authority established
 - 2001 – First out-sourcing occurred (FDC Region 4 Wexford). Other Regions remain in-sourced.
 - 2007 – Region 4 returned to insourced system
 - 2012 – Entire system out-sourced
 - Outsourcing has had mixed results in FDC, with multiple contract terminations by vendor or by State.
 - Private vendor contracts initially were capitated model, but currently is cost-plus.



FDC Health Care Cost Comparison

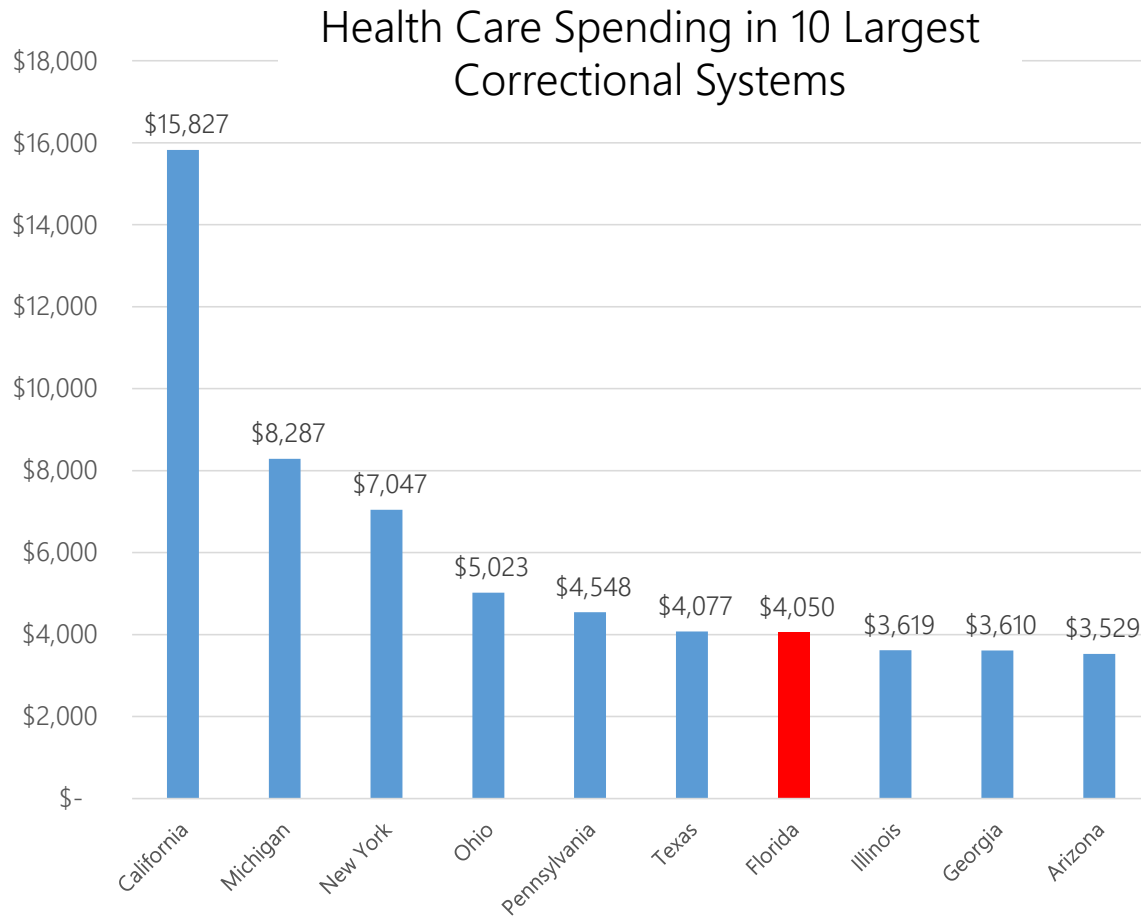
State Spending per Inmate on Correctional Health Care (2015)



- FDC ranked at the low end of average correctional health care spending by state.
- FDC spending was below average (median) level for 49 states surveyed.

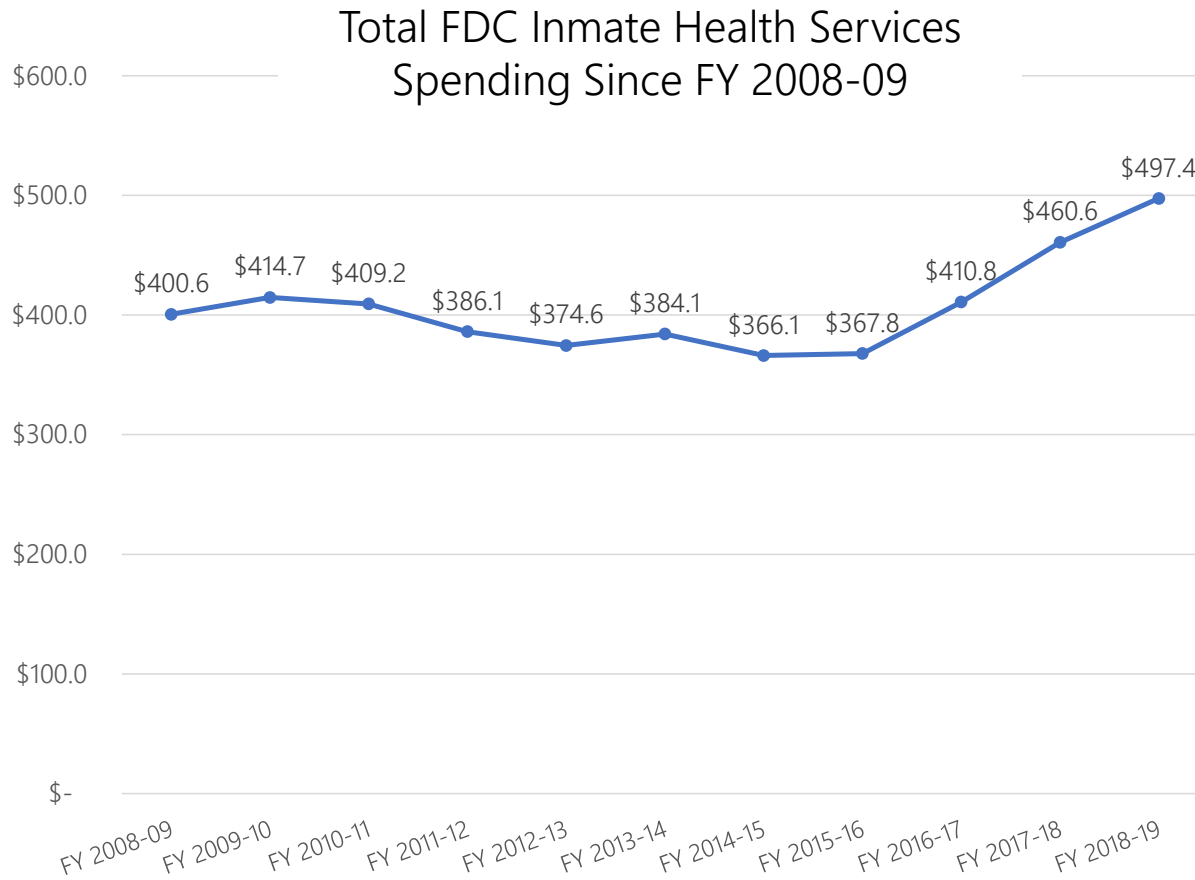


FDC Health Care Cost Comparison



- FDC spent \$4,050 per inmate for health care in 2015
- FDC health care spending is comparable to other large states.

FDC Health Care Cost Trends

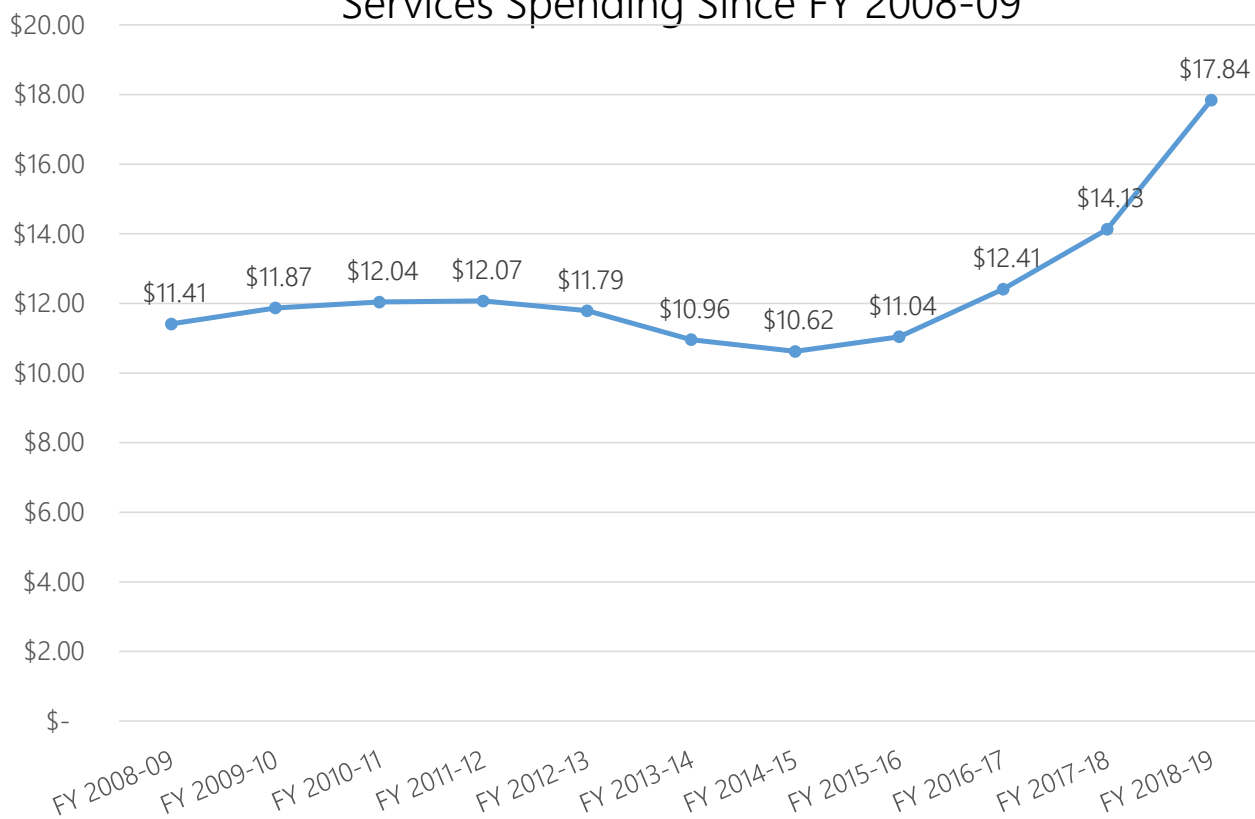


- Health care spending dropped by 9% from FY 2008-09 to FY 2014-15
- Spending has increased steadily since FY 2014-15
- Since FY 2015-16, health care spending in FDC has increased by 54%



FDC Health Care Cost Trends

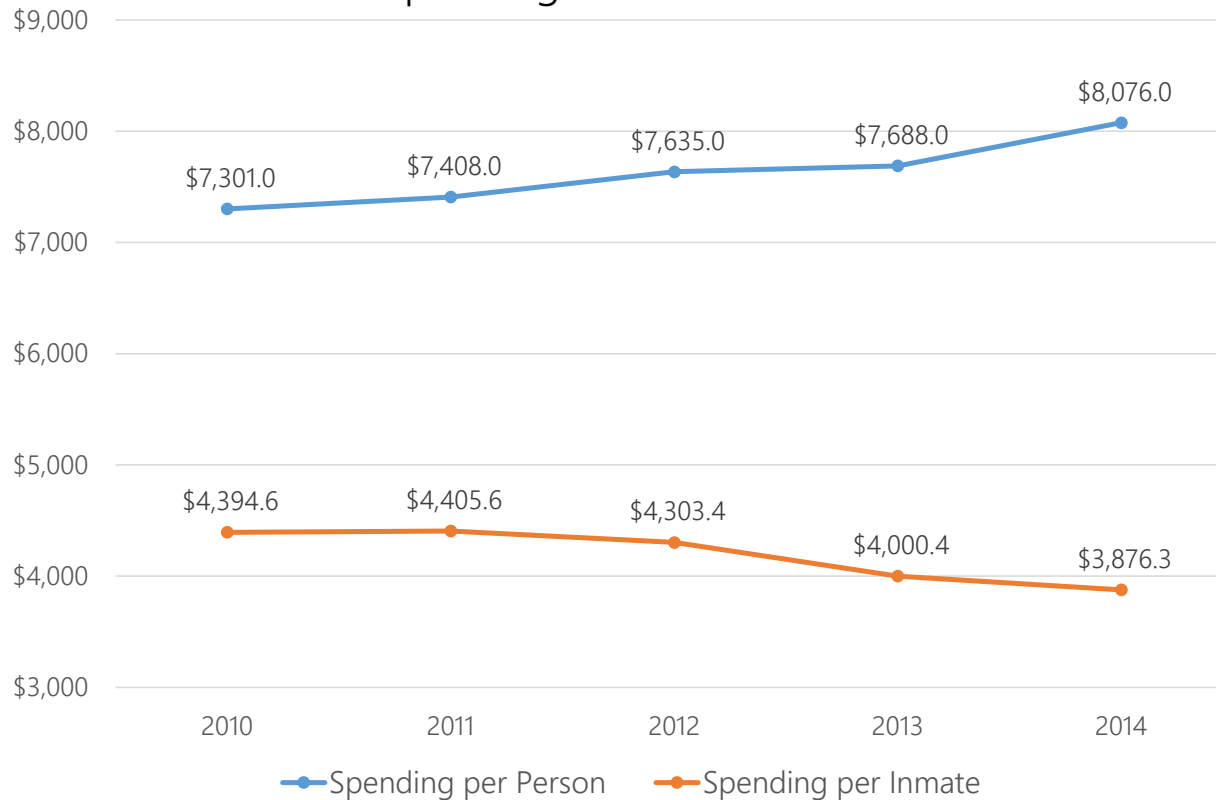
Per Capita FDC Inmate Health Services Spending Since FY 2008-09



- Per capita health care spending in FDC follows similar trend.

FDC Health Care Cost Trends

Annual Community vs Inmate Per Diem Spending in Florida 2010- 2014

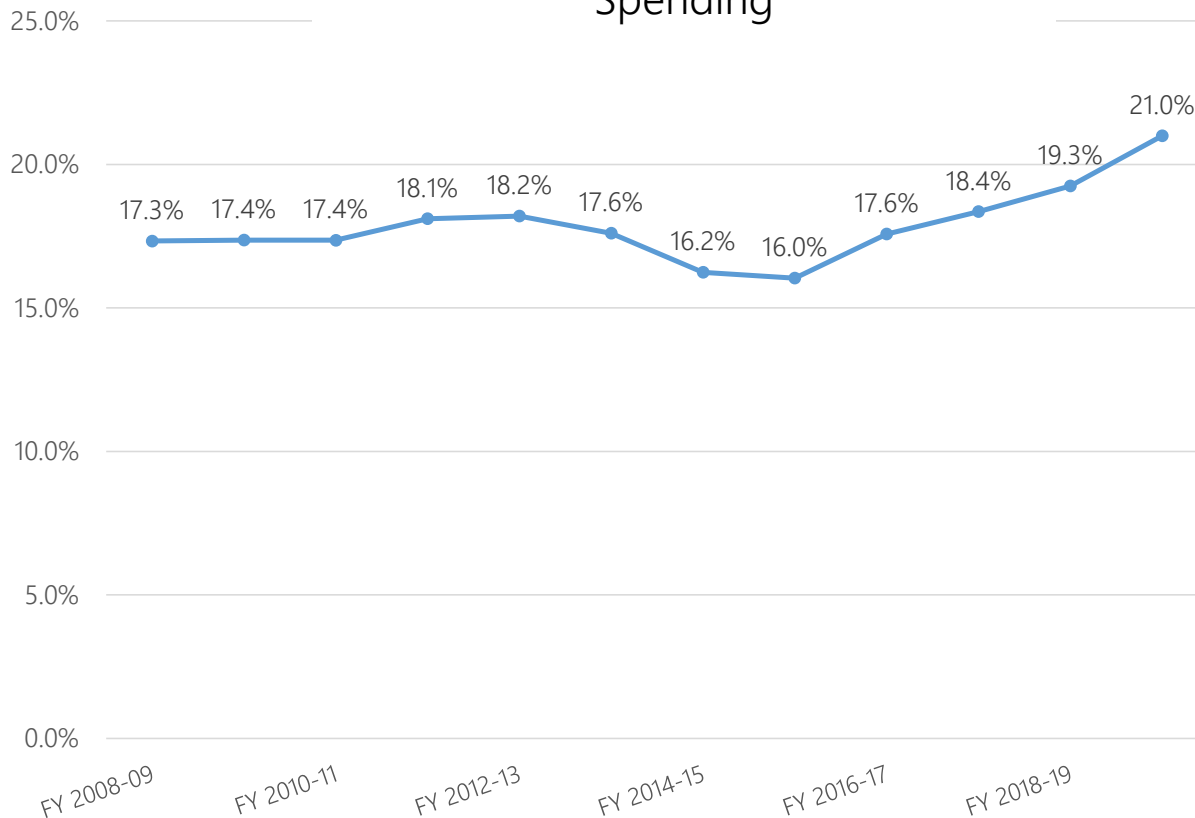


- Between 2010 and 2014 health care spending by average Florida citizen rose by 13%.
- During same period, health care cost per inmate in FDC fell by 12%.
- In 2014, inmate health care spending in Florida was 48 of the personal spending on health care.
- Primary factor driving this reduction was privatization of FDC health care.
- While costs were reduced, significant service issues resulted.



FDC Health Care Cost Trends

Inmate Health Services as a % of FDC Spending



- Inmate health services spending has increased to more than 1/5 of FDC overall budget in FY 2019-20.



Cost Drivers

- Several factors are driving recent increases in FDC health care costs:
 - **Past misalignment between funding levels and service needs.** Previous capitated contracts resulted in reduced service levels and led to backlog of medical/mental health issues.
 - **Litigation:** Consent decrees and ongoing litigation have increased FDC health care costs. Three recent lawsuits have a \$39 million impact on its FY 2019-20 budget.
 - **Aging population:** Older inmates have much higher medical needs. The number of inmates over 50 in FDC has increased by 78 percent since 2009. Currently these older inmates represent 27% of FDC's total population, but over 50% of hospital admissions, prescriptions dispensed, and clinical contacts.
 - **Increasing Drug Costs:** Drug costs are increasing by more than \$60 million in the FY 2019-2020 budget.



Current FDC Health Care System



Current Service Provision Status

- FDC has contract with Centurion for medical, mental health and dental services in all 4 Regions.
- FDC manages its own pharmacy.
- Centurion's contract is structured a "cost-plus" model. It receives compensation for all approved health care expenditures, plus a percentage of actual expenses to cover administrative costs and profit.
- Current Centurion contract compensation is \$421 million for current year and each of next 2 years. For FY2019-20 this represents 74% of all health care spending in FDC.



Findings on FDC's Health Care System

- FDC has a high incidence of chronic medical and mental illness. This is increasing and placing growing pressure to increase levels of service.
- FDC's health care program design is consistent with contemporary professional standards. The system and its Office of Health Services provide strong oversight of health care services in the agency.
- Recent litigation has increased health care costs within the system.



Alternative Health Services Delivery Models

INSOURCING - Overview

- **Insourced Model Definition:** All those who provide health care services are employees of the state.
- No state has a solely insourced health care system. Some contracting is required for outpatient care, diagnostic procedures, hospital care and other specialty services. Therefore, for the purposes of our analysis, we are defining these systems as “primarily insourced”.
- State correctional agency maintains management and staffing of majority of health care services.
- 18 states currently use a primarily insourced health services model.

INSOURCING - Benefits

- **Stability:** Provides greater continuity and consistency of staffing and services.
 - Benefit package for employees is typically better than private firms.
 - Contract vendor transitions don't require wholesale rehiring of staff which increases staff turnover.
- **Accountability:** Allows for clearer lines of accountability running directly from state employee facility staff through central office administration.



INSOURCING - Challenges

- **Lack of Personnel Flexibility:** State agencies lack the flexibility of private firms in hiring, salary and incentive packages to entice employees. This is especially true in FDC with the need to incentivize filling of mental health positions. As a result, there are significant challenges to recruiting and retaining professional staff in an insourced system.
- **Limited In-House Expertise:** Managing health services in a state correctional system requires a high level of in-house administrative resources and experience not always available.



INSOURCING - Impact in FDC System

- Could be more cost effective, reducing annual costs by 46.2 million over current model. The following table provides a listing of estimated cost savings.

Projected Savings Impact of Insourcing

	\$ millions
Elimination of Vendor Administrative positions	\$ 3.2
Convert Vendor positions to state employees	\$ 6.5
Eliminate vendor administration/profit fee	\$ 37.3
Additional HR costs	\$ (0.8)
Total Savings	\$ 46.2

OUTSOURCING - Overview

- **Outsource Model Definition:** State contracts with vendor to manage and provide health care services.
- Current FDC service model is partially outsource with private contractor (Centurion).
- 20 states currently have outsourced health services model. Approaches differ state-by-state.
- Two types of outsourced vendor contracts:
 - **Capitated:** Most common approach. State pays fixed per-inmate rate for all individuals under their care.
 - **Cost-Plus:** Vendor passes through all costs of health care services to the state, plus additional charges for administration and profit.



OUTSOURCING - Benefits

- **Professional Expertise:** Systems that lack internal resources or professional staff can benefit by outsourcing as it provides means to leverage professional expertise of vendor.
- **Economies of Scale:** Outsourcing can allow small correctional systems to access procurement advantages of large, national corporations in purchasing pharmaceuticals and supplies.
- **Staffing:** Private companies have much more flexibility in setting salary and benefit levels, and can also use this flexibility to better recruit and retain critical medical staff.
- **Cost Savings:** In the case of capitated contracts, there are strong incentives to reduce costs in order to ensure profits.
- **Meta-data regarding health care spending.** In cost-plus models, the state reviews every health care expense, allowing it to collect and analyze granular data regarding these costs. This level of data collection could better inform the more efficient use of future treatment of the inmate population.

OUTSOURCING - Challenges

- **Limited Competition:** There are very few vendors with the capacity to provide services for a system as large as FDC. FDC's past procurement experience reflects this as only one vendor was responsive to its most recent ITN. The lack of competition puts the State in a weakened negotiating position.
- **Capitated Model Challenges:**
 - Managing level of care: FDC's history with capitated contracts have resulted in quality of service issues
 - Several other states have experienced serious service issues with outsourced capitated contracts. This includes excessive staff vacancies, failure to refer inmates for off-site treatment and long wait times for on-site treatment.
 - Strong contract monitoring systems must be implemented to ensure outsourced capitated models
- **Cost-Plus Model Challenges:**
 - More costly: The state pays a vendor to manage the system without offsetting incentives to achieve efficiencies. There often is a duplication of comparable positions between the state and the vendor. As a result a cost-plus outsourcing model is more expensive than capitated model or insourcing, hybrid or university models.



OUTSOURCING - Impact in FDC System

- **Cost-Plus Model Only Outsource Approach Available to FDC:** Given its history, the cost-plus model appears to be the only means available to privatize system-wide.
- Service quality levels attained over past years should continue.
- **Cost impact varies by type of contract.** As FDC has experienced, capitated contracts typically bring lower initial costs while cost-plus are typically more expensive. In the long term, capitate contracts can result in higher costs if service quality reduces thus delaying inmate care and increasing litigation costs. The following table provided Centurions contract caps FY 2017-18 to FY 2021-22

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	Average Annual Increase
Centurion Contract Cap	\$321	\$375	\$421	\$421	\$421	6.2%



HYBRID MODEL - Overview

- Hybrid health care systems come in several varieties:
 - Only select facilities or regions are outsourced, while others are insourced
 - Only certain services are outsourced while others are insourced
- Existing FDC system is similar to a hybrid model, with medical, mental health and dental services outsourced and pharmacy insourced.

HYBRID MODEL - Benefits and Challenges Model

- Benefit: Allows for Customized Approach to Meet Needs: In larger systems, specific needs may vary by facility/region. A hybrid system allows service models to be customized to meet varying needs.
- Challenges:
 - Creates a more complex and difficult to manage requiring the Department develop plan to manage both insourced programs and at the same time create and manage a procurement process in other facilities/regions.
 - Creates potential for cost shifting between state and vendors

HYBRID MODEL - Impact in FDC System

- Would be administratively complex to manage compared to other models.
- Establishing fair allocation of healthy and sick inmates across institution would require strong headquarters oversight
- Depending on the extent of insourcing, a hybrid model could result in cost savings over the existing outsourced model.

UNIVERSITY MODEL - Overview

- State university medical schools would partner to provide health care services to inmate population.
- Has been effective option for addressing critical health care litigation in states such as Texas, New Jersey and Georgia.

UNIVERSITY MODEL - Benefits

- **Increased Credibility:** Affiliation with a recognized medical school signals commitment to service quality and provide state correctional health care programs with increased credibility.
- **Improved Recruitment:** Medical school partnership provides improved access to qualified clinicians and recruiting to work for a state medical school is often easier than recruiting to work in a prison.
- **High Quality of Care:** Medical schools generally have well-developed quality assurance programs, excellent access to data on best practices and treatment. Services provided under university run medical in correctional systems has been found to be high.
- **Lower Costs:** Medical school model contracts are generally structured in cost-plus model by absent the vendor profit margin, thus reducing costs. Additionally, universities often have access to discount drug pricing not available to vendors or correctional agencies.



UNIVERSITY MODEL - Challenges

- **Lack of Interest in Florida:** FDC administration indicated they have approached several of the state's medical schools but have been unable to generate interest.
- **Would require longer-term implementation schedule:** Compared to other options, developing an agreement with a state medical school would likely take a longer time to implement.

UNIVERSITY MODEL- Impact in FDC System

- Lower Costs: CGL estimates using a University Model would lower overall costs by 40.5 million annually. The following table details where those savings would be realized:

Projected Savings Impact of a University Management Model

	\$ millions
340b discount for Hepatitis C drugs	\$ 11.3
Reduce vendor administration/profit fee	\$ 29.2
Total Savings	\$ 40.5

Summary of Major Findings

Findings

- Outsourcing has had mixed results in FDC.
- Limited outsourcing competition impacts ability to reduce costs.
- Florida's spending on inmate health care is low relative to national averages, but comparable on per diem levels in six of the ten largest correctional systems.
- The costs of the current contract are a predictable result of the required service levels and outcome targets.

Findings (continued)

- The current cost-plus approach is the only available means to privatize on a system-wide scale.
- FDC has the internal capacity and expertise to manage inmate health care delivery. However recruiting and retaining professional staff would be challenging.
- A hybrid insourced/outsourced approach could reduce costs by \$46 million from current outsourced model.
- The university model is an attractive option and would reduce costs, but requires active interest from a medical school.



Health Care Study: Florida Department of Corrections

November 13, 2019

Prepared by:



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Executive Summary

This report examines the use of the following alternative approaches to the delivery of inmate health care in the Florida Department of Corrections (FDC):

- Insourcing, in which Department staff are directly responsible for managing health care and delivering services in facilities, while still contracting out for services delivered by providers in the community;
- Outsourcing, in which the Department contracts a private company to provide health care service management, staffing, and coordination of off-site care;
- A hybrid insourcing/outsourcing approach which uses elements of both models; and
- University medical school management of correctional health care.

The report describes the current provision of inmate health care services in the Florida Department of Corrections and compares the cost-effectiveness of these alternative models in delivering inmate health care services. Key report findings include:

Florida has a high incidence of chronic medical and mental health illness in the inmate population.

With the rapid growth in the geriatric offender population, growing awareness of the needs of mentally ill offenders, and changing standards in the treatment of infectious diseases such as Hepatitis C, the system has experienced growing pressure to increase the levels of service and program performance. This in turn is driving the cost of health care in the prison system higher.

The Florida Department of Corrections' (FDC) health care program design is consistent with contemporary professional standards. Health care policies and procedures are based upon generally accepted professional standards promulgated by the American Correctional Association, the National Commission on Correctional Health Care, the Florida Agency for Health Care Administration Licensure, and best practices developed in other state correctional systems. The FDC oversees delivery of a comprehensive set of medical, mental health, and dental services for state prison system inmates. The FY 2019-20 budget for health care services totals \$566.9 million.

The FDC has previously used a hybrid approach in managing inmate health care. During the time in which state employees were used to deliver facility health care services, the Department still maintained an extensive network of contracts with practitioners, hospitals, and vendors to provide off-site health care services in the community.

The Department of Corrections has attempted outsourcing with mixed results over the years. While privatization provided costs savings in the short-term, vendors were unable to provide consistent service that met contract performance standards at the funding levels they had bid. This led to a turbulent period of vendor terminations, transitions, and multiple attempts to attract additional vendors. Service quality issues at the time produced high levels of staff vacancies, decreased access to off-site care, increased inmate grievances, and costly litigation. In its most recent procurement, the

FDC received one responsive proposal for medical services after issuing multiple Invitations to Negotiate.

The current contract for inmate health services follows a cost-plus model. Under the Department's contract with Centurion, the vendor is reimbursed for the actual costs of care provided and paid an additional fee in the amount of 11.5 percent of program costs that cover administration and profit. The annual contract is capped at \$421 million for the three years from FY 2019-20 through FY 2021-22. Pharmacy services are not part of the contract but are instead managed directly by the Department.

Florida's spending on inmate health care is low relative to national averages but is comparable to per diem spending levels in six of the ten largest correctional systems. Per inmate spending levels in Florida are close to those of Texas, Illinois, Georgia, and Pennsylvania.

After declining in the period Fiscal Year 2010-11 through Fiscal Year 2014-15, inmate health care costs increased by 36 percent over the past four years, an annual average increase of 9 percent. The increases appear attributable to misalignment between contract funding and service requirements in the initial outsourcing initiatives. Recent litigation on mental health services, Hepatitis C treatment, and hernia repair accounts for nearly \$39 million in increased funding in the Fiscal Year 2019-20 budget. The ongoing increase in the geriatric population also continues to increase demand for medical services. The projected annual cost of providing health care for an inmate in a state-managed facility is \$6,511 for FY 2019-20.

Correctional systems with insourced delivery systems provide on-site care in prison with state employees in 18 states, including three of the five largest state correctional systems. However, these systems still contract for hospitalization, outpatient, and specialty services provided outside prison.

Outsourcing provides managed health care through contracted providers in 20 state correctional systems. The two primary forms of outsourcing are 1) capitated models in which the vendor assumes primary financial risk for required service delivery and is paid a per diem fee per inmate to cover all program costs; and 2) cost-plus models in which the state reimburses the vendor for program costs and assumes financial risk for required service delivery.

Hybrid models which combine different aspects of both insourcing and outsourcing to meet system needs are used in eight states. Basic hybrid models privatize the management of health care in select facilities while maintaining state management of health care in other system facilities.

University-managed systems rely on a state medical school or health sciences university to manage all or some significant component of correctional health care services. Four correctional systems use the university model, including the Texas prison system, the largest correctional system in the United States.

Insourcing inmate health care services in Florida is feasible and would produce savings from the current system. The FDC has the internal expertise and management infrastructure to adopt an

insourced model for inmate health care. However, recruitment and retention of health care staff would be a significant challenge requiring substantial advance planning. The Department would also require an improved approach in the management of off-site care. This could be accommodated by contracting with an insurance company or health care organization to manage all off-site care, utilization review, and claims management. Implementation of an insourced system could reduce FDC health care spending by an estimated \$46 million, primarily through elimination of vendor profit and administration costs.

The current cost-plus approach used by the FDC appears to be the most realistic means available to outsource on a system-wide scale. The cost-plus model is currently used by the FDC because the only vendor in the last procurement cycle willing to work with the Department made it a condition of the contract. By most reports, the current vendor is performing reasonably well under the current cost-plus contract. However, this approach to privatization does not encourage efficiency and appears to be the most expensive service delivery model, as the FDC must pay a significant fee to the vendor to cover overhead and profit, in addition to paying all direct costs. However, the contract is capped at \$421 million for the next three years and will provide the FDC with an electronic medical record system, which is a significant benefit.

A capitated approach to outsourcing could produce savings by incentivizing vendors to achieve efficiencies, particularly in the management of off-site care. However, this approach to outsourcing works best in a competitive procurement with multiple viable bidders competing on price and service quality. There are very few vendors who can provide services on the scale required in Florida with a record of acceptable service delivery. Moreover, the high degree of financial risk makes attracting enough bidders to facilitate a competitive environment difficult. Assuming vendors willing to work in Florida on a capitated basis, estimated annual savings of \$5.5 million, largely in the management of off-site care, may be possible.

A hybrid insourcing/outsourcing approach would require outsourcing services on a capitated basis for a region or group of select facilities, while insourcing the rest of the system. This approach increases administrative complexity and creates potential issues of equity in apportioning risk and inmates in need of health care among multiple vendors and state facilities. It also assumes that credible vendors are willing to bid on capitated contract services for smaller groups of contracts. If viable, the limited experience with this approach in one of the few states that use this model suggests savings could be achieved roughly equivalent to the level achieved with insourcing.

The university model of health care management has attractive features but requires active cooperation from a medical school. Elimination of profit, reduced administrative costs, and discounted pharmaceutical prices could produce potential annual savings of over \$40 million. However, no Florida medical school has indicated any interest in partnering with the FDC to manage inmate health care. One potential approach to building interest in such a model could be partnering with a university to take on one aspect of the correctional health care program, such as management of off-site care for a region or group of facilities.

1. INTRODUCTION

In July 2019, the Office of Program Policy Analysis and Government Accountability (OPPAGA), a joint entity of the Florida Legislature, was required to solicit a contract with an independent consultant for a Study of Correctional Health Care in the Florida Department of Corrections (FDC). The goal of the study was to fulfill requirements of proviso language in the 2019 General Appropriations Act (Ch. 2019-117, Laws of Florida). The language states:

From the funds in Specific Appropriation 2754, the Office of Program Policy Analysis and Government Accountability is directed to contract with an independent third party consulting firm to conduct a review of inmate health care services in order to compare the cost-effectiveness of alternative methods of delivering the services.

OPPAGA directed that the Study address the following key research tasks:

- Describe the current provision of inmate health care services in the Florida Department of Corrections.
- Assess alternative models of delivering inmate health care services in the Florida Department of Corrections.
- Compare the cost-effectiveness of alternative models of delivering inmate health care services.

The proviso language required the review to consider at least the following options: (a) full insourcing of inmate health services, (b) insourcing of outpatient health services provided within state operated correctional facilities and outsourcing inpatient services, and (c) continuation of full outsourcing with modified contract terms imposing appropriate cost controls.

Methodology

In support of our analysis, we requested FDC health care expenditure data, as well as information on service delivery, utilization, and system performance. We also requested performance and activity measure data, planning documents, management reports, and other documentation of operations and programs.

We supplemented the written documentation and data provided by the FDC with information gained from interviews with program administrators and on-site observation of daily operations at the key FDC facilities identified below.

Exhibit 1: On-Site Facility Reviews

Facility	Location	Capacity	Mission
Florida Women's Reception Center	Ocala	1,345	Female offender reception, general population, and in-patient mental health
Lake Correctional Institution	Clermont	1,093	Male offender general population and inpatient mental health
Lowell Correctional Institution	Ocala	1,456	Female offender general population
Reception & Medical Center (RMC)	Lake Butler	1,503	Male offender reception, 120-bed hospital, 34-bed infirmary, surgical unit, dialysis unit, and inpatient mental health
Suwanee Correctional Institution	Live Oak	1,502	Male Youthful Offender Unit, Close Management Unit, inpatient mental health

The CGL team conducted an in-depth tour of all medical/mental health functions at each visited facility. This included observation of sick call, dispensing of medication, observation of chemotherapy and dialysis treatment (at RMC), and group therapy. We toured all health care facilities at these institutions, including the 120-bed hospital at the Reception and Medical Center. Members of the project team observed the intake process, sick call, and mental health service planning.

We selected these facilities, with input from the FDC Office of Health Care Services, to observe the high level of health services and the operational challenges presented. Staff interviews included FDC central office administrators as well as direct service contract staff. These interviews centered on the challenges facing the FDC in delivering effective health care to the inmate population. Staff interviewed were open and candid regarding the challenges and issues associated with the provision of health care in the current system.

2. CURRENT SYSTEM OVERVIEW

A review of different models to provide inmate health care begins with developing an understanding of the current service delivery system. This first requires an analysis of the Florida Department of Correction's (FDC's) health care program goals and how these goals produce the professional standards and policies that guide the system. We next describe the FDC's current system of correctional health care services, utilization of services by the inmate population, and how inmate population characteristics drive service requirements. The final section of the chapter describes the history of the FDC's evolving approaches to management of inmate health care services.

Standards

The FDC bases its health care policies and procedures upon generally accepted professional standards promulgated by the American Correctional Association, the National Commission on Correctional Health Care, the Agency for Health Care Administration Licensure, and best practices developed in other state correctional systems. The Department regularly updates policies and standards to reflect care guidelines recommended by the Centers for Disease Control and other recognized public health research organizations.

The FDC organizes its health care policies in 162 Health Services Bulletins (HSBs). These bulletins include multiple memos, information sheets, forms, orientation information, appendices for clinical care, guidelines, fact sheets, and policies. These bulletins provide direction on topics such as chronic illness monitoring (HSB 15.03.05), conditional medical release (HSB 15.02.14), and medical emergency response planning (HSB 15.03.06). In addition to HSBs, the Department has 30 custody-related policies which pertain to services such as therapeutic diets, medical transfers, health services for inmates in special housing, nursing sick call, and medication administration.

The FDC is responsible for providing a level of health care service to inmates consistent with constitutional standards, as determined by the federal courts, in accordance with Sections 945.025(2), and 945.6034, Florida Statutes. These standards, as established by the United States Supreme Court in *Estelle v. Gamble*¹, provide inmates the right to be free from deliberate indifference to their health care needs and that inmates have a right to the same standard of health care as available in the community. In subsequent rulings and case law, the courts have established three key elements of constitutional health care in correctional facilities: 1) the right to access to care, 2) the right to care that is ordered, and 3) the right to a professional judgement.²

A 1972 class action lawsuit against the FDC, *Costello v. Wainwright*, resulted in a finding that inadequate health care in the correctional system amounted to cruel and unusual punishment. The case further refined standards for health care delivery in the FDC and resulted in the creation of the

¹ *Estelle v. Gamble*, 420 U.S. 97, 97 S. Ct. 285, 50 L.Ed.2d 251 (1978)

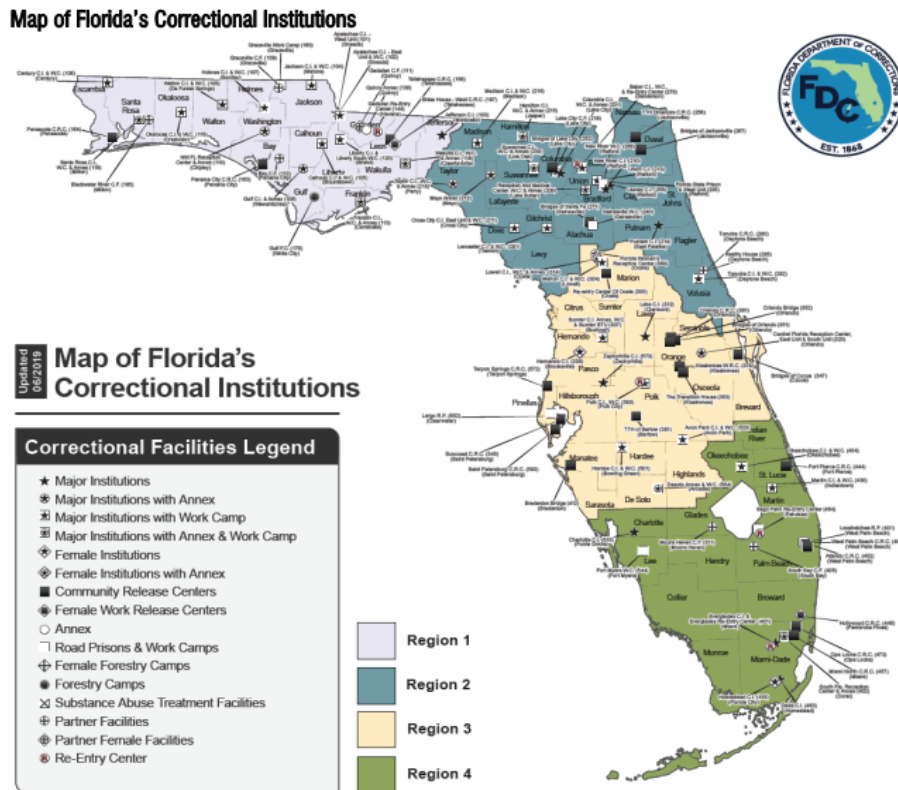
² B. Jaye Anno, *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*, National Commission on Correctional Healthcare, (2001:43).

Correctional Medical Authority (CMA) to provide independent monitoring of health care services.³ The responsibilities of the CMA include inspection of the delivery of medical and mental health services in FDC facilities, annual reporting on inmate health care delivery to the Governor and the Legislature, and monitoring compliance with consent decrees. More recent litigation that has informed the development of FDC health care standards include *Osterbock v. McDonough*, *Disability Rights Florida, Inc. v. Jones*, *Hoffer v. Jones*, and *Copeland v. Jones*.⁴ These cases addressed requirements for mental health programs, Hepatitis C treatment, hernia care, and other services.

Services

Consistent with these standards, the FDC oversees delivery of a comprehensive set of medical, mental health, and dental services for over 95,000 state prison system inmates in 145 facilities located in four regions throughout the state.

Exhibit 2: Florida Correctional Institutions



Source: Office of Program and Policy Analysis and Government Accountability, Florida Correctional Facilities, Report NO. 19-08, October 2019.

³ *Costello v. Wainwright*, 3 430 U.S. 3425, 51 L.Ed.2d 372, 97 S. Ct. 1191 (1977)

⁴ *Osterbock v. McDonough* 549 F.Supp.2d 1337 (M.D. Fla. 2008); *Disability Rights Florida, Inc. v. Jones*, Case No. 3:18-cv-179-J-25JRK; *Hoffer v. Jones* Case No. 4:17- cv-214-MW-CAS; *Copeland v. Jones* Case No. 4:18-cv-452RH/CAS

The Department's *Comprehensive Health Services Plan*⁵ describes the specific services provided. The FDC uses a managed care approach to provide these programs, contracting with a private vendor, Centurion of Florida, LLC.

Medical. The medical program at FDC institutions focuses on primary care. These services include sick call, infection control, immunizations, chronic disease clinics, health education, physical examinations, screenings, and urgent care services. Centurion provides full and part-time physicians, nurse practitioners, nurses and support staff in support of these functions at each state-run facility.

Like other states with large prison populations such as California and Texas, Florida operates a large, licensed hospital to provide inpatient care within a secure facility. Under Centurion management, the Reception and Medical Center (RMC) at Lake Butler supports 120 inpatient beds, as well as a licensed laboratory, same-day surgery center, dialysis treatment, chemotherapy and radiation treatment.

Inmates in need of more serious or advanced treatment may receive care from specialists subcontracted by Centurion, both in the facility or in the community. Inmates also receive inpatient and outpatient care in community hospitals as needed for emergency care or if the RMC has no beds available. Community hospitals are also utilized for specific types of specialty care such as orthopedics or cardiac care. If facility vendor staff cannot provide the services an inmate needs, the inmate is transported to a local hospital or provider's office for offsite care. The FDC has agreements with hospitals that receive a significant volume of inmates, establishing dedicated secure units to support FDC patients. These include Memorial Hospital of Jacksonville and Larkin Community Hospital in Miami. Use of other local community hospitals in non-secure wards requires 24 hour supervision of the inmate patient by two department correctional officers.

A Centurion Utilization Management team reviews all requests for specialty consults and hospital services, including those provided at the RMC. The team reviews and approves all hospital admissions and discharges using evidenced-based clinical criteria to ensure efficient use of resources.

Mental Health. Mental health treatment consists of a range of services dependent upon the care level required by the inmate. FDC policy establishes five levels of treatment, beginning with outpatient care and progressing through more intensive, structured inpatient programs to stabilize and treat inmates with more severe conditions. Inmates receiving inpatient mental health treatment all receive structured out-of-cell therapeutic services. Mental health program staffing provided by Centurion, includes psychiatrists, psychologists, licensed mental health professionals, nurses, and support staff. The FDC manages a continuum of mental health services with each facility's staffing scaled to meet its specific program needs. The FDC also operates a Cognitive Treatment Unit at the Wakulla Annex for inmates with dementia or traumatic brain injury.

Dental. Dental services include examinations, extractions, and emergency treatment at the time of their admission into the correctional system. On an as-needed basis, inmates with less than six months

⁵ Florida Department of Corrections, *Comprehensive Health Services Plan for the Continued Improvement of the Delivery of Health Care for Inmates, 2019-2024* (2019)

of time to serve may receive decay control, limited cleaning, and denture repairs. Inmates with more than six months to serve may receive dental exams with x-rays and periodontal screening. If clinically indicated, inmates with at least four months of incarceration time remaining may be provided dentures or non-emergent endodontic therapy. Advanced dental services are available on a limited basis depending upon need. Centurion provides dentists, dental assistants and dental hygienists in support of these services at all facilities except for reentry centers.

Pharmacy. The FDC manages the delivery of pharmacy services with 84 state employees, outside of the Centurion contract. The State pharmacy staff dispense over 1.5 million prescriptions annually from three regional pharmacies and the RMC in response to orders from medical staff at state prisons.⁶ Centurion staff then administer medications to patients. Nurses provide unit dose prescriptions of prescribed medications at a pill line for general population inmates, at cell front for inmates in confinement or close management, and bedside in the hospital. Inmates are also allowed to keep common medications such as antihistamines or analgesics on their person (KOP) for use as specified by the prescription. Finally, inmates in dorms, special housing, and work squads may be provided over the counter medications (OTC) such as ibuprofen or antacid on an as-needed basis.

The FDC receives discounted medications for HIV/AIDs and STDs under the Florida Department of Health (DOH) through the 340b program. The 340b program is a US federal government pricing system that requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly reduced prices. The 340b program provides discounts of up to 40 percent from market rate prices. The Department also participates in the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), a purchasing organization for government institutions that negotiates reduced pharmaceutical prices for member organizations.

Due to the level of drug price purchasing discounts achieved by the FDC, past efforts at potential privatization of the pharmacy program have not shown savings, resulting in retention of the current system of state management of the program.

Exhibit 3 summarizes the key services available to inmates and where they are provided.

⁶ Florida Department of Corrections, Comprehensive Health Services Plan for the Continued Improvement of the Delivery of Health Care for Inmates, 2019-2024 (2019).

Exhibit 3: FDC Health Care Service Summary

	Medical	Mental Health	Dental	Pharmacy
Prison On-Site Services	Primary care Chronic care Screenings Urgent care Inpatient care* Medication management Specialty clinics Surgery* Dialysis* Cancer treatment* Long-term care housing Physical therapy Respiratory therapy	Group counseling Individual counseling Medication management Crisis stabilization Infirmary Transitional Care Inpatient hospitalization	Examinations Extractions Cleaning Dentures & repair	Keep on Person (KOP) Unit dose Over the Counter (OTC)
Community Services	Specialist visits Emergency room visits Surgery Inpatient hospitalization	Psychiatric emergency care	Advanced dental surgery	

*Available only at Reception & Medical Center

Source: Florida Department of Corrections, Comprehensive Health Services Plan, 2019-2024, May 13, 2019.

The Department manages this system through the Office of Health Services (OHS). The OHS sets policy for the system, monitors contract performance, provides training, reviews grievance appeals, assesses clinical-legal issues, manages the overall budget for health care services, and reviews contractor spending. OHS has 62.5 employees assigned to these functions.

Inmate Patient Profile

The FDC provided health care to an average daily population of approximately 87,000 inmates in state-operated facilities in FY 2018-19.⁷ This does not include health care services provided by vendors that operate the seven private correctional facilities under contract with the Department of Management Services (DMS)⁸. Over 28,000 inmates have been admitted to the state prison system in

⁷ Florida Department of Corrections, Bureau of Research and Data Analysis.

⁸ These facilities include Bay Correctional Facility, Blackwater River Correctional Facility, Gadsden Correctional Facility, Graceville Correctional Facility, Lake City Correctional Facility, Moore Haven Correctional Facility, and South Bay Correctional Facility.

the last 12 months.⁹ Each new admission receives a thorough health screening and assessment, which may result in a prescribed treatment plan as indicated.

Inmates in U.S. prisons enter correctional systems with higher incidence of medical and mental health issues than found in the general population. Chronic disease is prevalent with higher rates of tuberculosis, HIV, Hepatitis B and C, arthritis, diabetes, and sexually transmitted disease compared to the general population.¹⁰ Over half of prison inmates have a mental health disorder, and many of these offenders also have a history of substance abuse.¹¹

The Florida correctional system population exhibits these same characteristics. In FY 2018-19, the FDC offender population included¹²:

- 57,826 inmates requiring treatment in chronic disease clinics
- 2,561 inmates diagnosed and treated for HIV
- 6,314 inmates diagnosed and treated for Hepatitis C
- 118 inmates with renal failure requiring dialysis treatment
- 4,000 inmates with hearing, mobility, or vision impairments or disabilities

In FY 2018-19, inmates had over 126,000 contacts with clinics for treatment of chronic conditions, with the largest number requiring cardiac or respiratory treatment.

⁹ Florida Department of Corrections, Quarterly Inmate Admissions Reports, October 1, 2018 to September 30, 2019.

¹⁰ National Institute of Corrections, "Solicitation for a Cooperative Agreement—Evaluating Early Access to Medicaid as a Reentry Strategy," Federal Register 76, no. 129 (2011): 39438-39443; Ingrid Binswanger, Nicole Redmond, and LeRoi Hicks, "Health disparities and the criminal justice system: an agenda for further research and action," Journal of Urban Health 89, no. 1 (2012): 98–107; and Laura Maruschak, Medical Problems of Prisoners (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 2008), , <https://www.bjs.gov/content/pub/pdf/>

¹¹ Doris James and Lauren Glaze, Mental health problems of prison and jail inmates, (Washington, DC: US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, September 2006) , <https://www.bjs.gov/content/pub/pdf/mhppji.pdf/>

¹² Florida Department of Corrections, Bureau of Research and Data Analysis.

Exhibit 4: FY 2018-19 FDC Inmate Clinic Contacts

Type of Treatment	Number of Clinic Contacts
Cardiac	49,775
Endocrine	17,719
Gastro-intestinal	19,729
Immune System	8,516
Renal	12
Neurology	5,342
Cancer	1,785
Respiratory	12,166
Tuberculosis	6,316
Miscellaneous	4,723
TOTAL	126,083

Source: Florida Department of Corrections, Office of Health Services

Demographic characteristics of the population also contribute to health care service needs. The FDC incarcerates nearly 5,000 female offenders. Incarcerated women report histories of alcohol and drug abuse, sexually transmitted infection, sexual and physical abuse, and mental illness, at a much higher rate than incarcerated men, and as a result require a more intensive level of health care services. Moreover, female offenders also have gender-specific health needs such as gynecological care that create additional demands for health services.¹³ In FY 2018-19 female offenders in Florida accounted for 12.8 percent of clinic encounters for chronic diseases despite representing 6.9 percent of the inmate population.¹⁴

The number of geriatric offenders in the correctional system also drives demand for health care services. Due to higher risk lifestyle choices and infrequent or irregular access to health care over their lives, many inmates physically age much more quickly than their chronological age would suggest. The National Commission on Correctional Healthcare and at least 20 state correctional systems define as geriatric any inmate over age 50.¹⁵ Older prisoners cost approximately three times as much as younger prisoners to incarcerate, largely due to health care costs.¹⁶

¹³ National Commission on Correctional Healthcare, *Women's Health Care in Correctional Settings*, 2019 <https://www.ncchc.org/womens-health-care>.

¹⁴ Florida Department of Corrections, Office of Health Services.

¹⁵ It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release. New York, NY: Tina Chiu, The Vera Institute of Justice; 2010. March, <https://www.vera.org/publications/its-about-time-aging-prisoners-increasing-costs-and-geriatric-release>

¹⁶ Williams, B. A., Goodwin, J. S., Baillargeon, J., Ahalt, C., & Walter, L. C. (2012). Addressing the aging crisis in U.S. criminal justice health care. *Journal of the American Geriatrics Society*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923>.

As of June 30, 2019, over 27 percent of the FDC inmate population was age 50 or older. In fact, the system housed 1,775 inmates aged 70 or over. The proportion of the Florida inmate population that is geriatric exceeds that of the other three largest state correctional systems.

Exhibit 5: Geriatric Populations in Large State Correctional Systems

	Inmate Population	Number of Inmates Age 50+	Percent of Inmates Age 50+
Texas	145,019	31,876	22%
California	129,417	30,298	23%
Florida	95,502	25,732	27%
New York	52,344	10,140	19%

Sources: Texas Department of Criminal Justice, Fiscal Year 2018 Statistical Report; California Department of Corrections and Rehabilitation, Offender Data Points Report, June 2018; Florida Department of Corrections, Bureau of Research and Data Analysis; Office of the New York State Comptroller, New York’s Aging Prison Population, April 2017.

The total number of geriatric inmates housed by the FDC has grown by 77 percent over the last ten years, despite a decline in the overall prison population during this period. Older inmates, like older individuals in society, have much greater health care needs than younger inmates. This change in the population has had a profound impact on the demand for health care services in the state correctional system.

Health Care Service Delivery History

The FDC has a long and complicated history in contracting for the delivery of health care to inmates. Exhibit 6 summarizes past FDC health care contracts. Exhibit 7 presents a timeline for the Department’s experience with outsourcing.

Exhibit 6: FDC Health Care Contract Summary

Contract Term	Vendor	Services
2001-2006	Wexford	Region 4 comprehensive health care
2006	Prison Health Services (PHS)	Region 4 comprehensive health care
2006-2007	Correctional Medical Services (CMS)	Region 4 staffing (after termination of PHS contract)
2006-2009	MHM	Region 4 mental health
2009-2014	Corizon (formerly CMS)	Region 4 mental health
2012-2016	Corizon	Regions 1, 2, & 3 comprehensive health care
2012-2017	Wexford	Region 4 comprehensive health care
2016-2017	Centurion (formerly PHS and MHM)	Regions 1, 2, & 3 comprehensive health care
2017-2018	Centurion	Add Region 4 comprehensive health care
2018-2019	Centurion	Statewide comprehensive health care
2019-2022	Centurion	Statewide comprehensive health care

Source: Florida Department of Corrections, Bureau of Procurement

Exhibit 7: Florida Department of Corrections Health Care Contracting History



Source: Florida Department of Corrections

Prior to and through the period of the *Costello v. Wainwright* litigation during the 1980's, the FDC managed health care services within the prison system with state employees, supplemented by individual contractors as needed. State-managed service included the management and staffing of the RMC's secure medical hospital. Private providers in the community and local hospitals or clinics provided specialty treatment, outpatient care, and inpatient hospitalization. The Department negotiated individual contracts and price agreements with these private providers.

One of the issues the system faced was difficulty in keeping health care staff positions filled, particularly in the Region 4, South Florida area. This is one of the primary challenges associated with insourcing correctional health care and has been a significant factor in the development of alternative approaches to staffing facility health care programs. That said, vendor performance in filling positions has been similar to that experienced by the state.

During this time, the first private company managed care providers specializing in correctional health care emerged onto the market, providing an alternative solution for systems seeking to improve prison health care services and/or reduce costs. In 1996 both the Correctional Medical Authority and the Office of Program Policy Analysis and Government Accountability (OPPAGA) recommended that the FDC consider privatizing correctional health care service for one region to better assess the viability and potential benefits of this approach.¹⁷ The Department did not implement these recommendations, and in 2000, the Florida Legislature enacted legislation on the issue. The bill required the FDC to issue an RFP for inmate health care provided at all Region 4 correctional facilities, with an explicit goal of achieving cost savings.¹⁸

The subsequent RFP attracted bids from 4 vendors and resulted in the award of a five-year contract with Wexford Health Sources, Inc. for Region 4. The contract used a capitated model in which the vendor assumes financial risk in exchange for enhanced discretion in managing services to achieve efficiency. In this approach the vendor charges a per diem rate multiplied by the average monthly inmate population as compensation. The contract also called for 3 percent annual per diem rate increases.

Correctional Medical Authority (CMA) monitoring of health service delivery under the contract consistently indicated significant vendor service issues, including lack of internal management controls, poor or nonexistent tracking mechanisms, inadequate control and/or tracking of specialty consultations, and an unacceptable pharmacy system.¹⁹ These issues eventually resulted in the FDC assessing financial penalties against Wexford. For their part, the vendor contended that the inmate population in the region contained a higher number of

¹⁷ Corrections Medical Authority 1995-1996 Annual Report; OPPAGA Report No. 96-22, "Review of Inmate Health Services Within the Department of Corrections" (November 1996)

¹⁸ Chapter 2000-166, Laws of Florida

¹⁹ Florida Senate, Committee on Criminal Justice, Privatization of Prison Health Care Services, Issue Brief 2011-213, October 2010.

inmates with medical and mental health issues than their bid assumed, and as a result requested a 10 percent increase in the contract per diem rate. Litigation between Wexford and the FDC followed. While Wexford prevailed in the lawsuit, which forced an increase in payment, continued service quality issues resulted in the Department terminating the contract in 2005.

The Department then issued a new Invitation to Bid (ITB) for Region 4 health care services which produced three bids, including one from Wexford. The FDC awarded a five-year contract to Prison Health Services (PHS) in January 2006. The PHS bid was more than \$80 million less than the next lowest bidder.²⁰ The vendor however soon indicated that they had underbid the contract due to the lack of adequate information on service volume during the bid process and requested an increase in contract compensation. In response to the Department's denial of this request, PHS provided notice and terminated the contract eleven months after its commencement.

The Department issued a subsequent ITB for Region 4 in 2007 which received no proposals that met the terms of the procurement. In response, the FDC reverted to an "insourced" system in Region 4, providing institution-based health care services with state employees, while contracting with a network of individual private providers for services provided in the community. This mirrored the approach used by the FDC in managing health care services in Regions 1, 2, and 3. Ultimately the number of contracts between the Department and private providers would exceed 200 across the state.

In 2011 the Legislature directed the FDC to privatize all inmate health services statewide into two contracts, one for Regions 1, 2, and 3; and a separate contract for Region 4.²¹ The legislation specifically required that the contractor achieve cost savings of at least seven percent below the Department's FY 2009-10 health care expenditures.²² The Department issued an RFP for comprehensive health services for all four regions, and in 2012 awarded contracts to Corizon, LLC for Regions 1, 2, and 3; and a contract to Wexford Health Sources, Inc. for Region 4. The total value of these contracts was \$1.1 billion for Corizon for 2012-2016, and \$237.9 million for Wexford for 2012-2017. The Department adopted a similar approach for these contracts as it had used for previous comprehensive health care contracts, in which the vendor assumes all financial risk and retains maximum flexibility in managing services; with compensation based on a per diem rate applied to the average daily inmate population.

The transition to statewide privatization was difficult. State employee unions sued the Department to block implementation of the contracts. The Department ultimately prevailed in court, but the case delayed contract implementation until 2013. During that time, many state health care staff resigned in

²⁰ Ibid.

²¹ Laws of Florida, Chapter 2011-69.

²² Florida Department of Corrections RFP, Comprehensive Healthcare Services in Regions I, II, and III, Solicitation 11-DC-8324, http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=98603

anticipation of losing their positions, forcing the Department to rely on overtime and temporary staff to assure continued services. While both contracts achieved required savings levels (and in fact surpassed the seven percent savings requirement), the vendors in many cases initially reduced spending by maintaining lower health care staffing levels. According to FDC staff, this in turn led to serious performance issues in both contracts.

In response to these issues, the Department issued a new procurement solicitation for inmate health care services in December 2015. The Department adopted a new procurement model, an Invitation to Negotiate (ITN) for this solicitation. Under the RFP format, prospective bidders had limited information on contract scope and very little opportunity for questions and discussion on the services to be provided. Office of Health Services staff indicated that the prior vendors selected by the Department through the RFP process attributed their difficulties in providing services at the prices they bid to the lack of information available in the procurement process, which led them to underprice their proposals. The ITN process differs from an RFP procurement in that it specifically allows for sharing of information with the vendor and answering questions throughout the negotiation process. This generally results in a better understanding of the client's requirements on the part of the vendor.

The Department also made a substantial change in scope of work under the ITN approach. The scope of previous RFPs was for the comprehensive delivery of inmate health services in specific FDC regions. Through several rounds of RFPs this approach attracted a relatively small group of the same companies. None of the companies selected had performed at a level considered satisfactory by the Department. In a new approach under the ITN model, the Department defined scope by discipline, issuing four ITNs for statewide medical services, statewide mental health services, statewide dental services, and operation and administration of the Department's inpatient hospital at RMC. By dividing the scope of health care delivery in this manner the Department hoped to increase competition and attract new vendors. The ITNs also specified provisions to increase accountability and oversight of vendor performance.

As the Department entered into the ITN solicitation, Corizon provided notice that it was terminating their contract for health care services in Regions 1, 2, and 3 effective May 2016. In response to FDC concerns regarding staffing levels and vendor performance, Corizon indicated that the terms of its contract were too constraining to address the Department's concerns. This action forced the Department to seek an emergency procurement to replace Corizon. The procurement resulted in the selection of Centurion of Florida, LLC to provide services in the regions formerly under contract with Corizon. However, because of the risk in assuming this contract, Centurion required the Department to change the contract model to a "cost plus" approach. In this model, the vendor is reimbursed for all expenses related to the provision of required services and paid a management fee in addition to these costs. The cost plus approach effectively eliminates vendor financial risk. This initial contract with Centurion established the management fee at 13.5 percent of service costs.

As the FDC initiated the ITN process, CMA inspections in 2017 documented serious performance issues at the South Florida Reception Center, leading the Department to terminate Wexford's contract for Region 4. Due to the emergency nature of the circumstances, the Department added Region 4 to

the Centurion contract, resulting in the vendor assuming complete statewide responsibility for medical and mental health service delivery up through the original terms of the Corizon and Wexford contracts. This was an emergency action to assure continued service while the Department continued its attempt to procure new vendors through the ITN process.

The ITN solicitations attracted limited vendor responses.

- Medical Services ITN - produced two bidders, one of which (Wexford) dropped out of the process, leaving the Department with one vendor, Centurion, to negotiate a contract. The Department reissued the ITN to attract more responders, but again received only one proposal from Centurion.
- RMC Hospital ITN - resulted in one bidder, Centurion.
- Mental Health ITN - resulted in two bidders, Centurion and Correct Care Solutions.
- Dental Services ITN - attracted two responses from Centurion and Smallwood Prison Dental Services.

Based on the results of the ITNs, in 2018 the Department negotiated a one-year contract with Centurion in the amount of \$375 million to provide statewide inmate health care services. The contract has since been amended to extend the term to three years through FY 2021-22.

Current Service Model

As described above, the FDC currently contracts with Centurion to provide inmate health care services at all FDC-operated facilities. Centurion supply the staff who provide treatment at the facilities, coordinates the care of inmates who must receive specialist or hospital services outside the facility, and manages the overall system of care through a system of regional administration, quality assurance, and utilization management.

The current system, however, is not completely outsourced. The Department retains management of the pharmacy system which provides medications to state inmates. Previous efforts to privatize this function failed to demonstrate cost savings, and in fact would have increased the cost of medications to the FDC. The Department's low costs for pharmacy service is primarily due to price discounts it receives for medications purchased through the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), a purchasing organization for government institutions that negotiates reduced pharmaceutical prices for member organizations. Other state correctional systems that participate in MMCAP include North and South Carolina. The Department also receives substantial discounts on medication for HIV/AIDS and sexually transmitted disease through interagency agreements with the Florida Department of Health and five local health departments for treatment of offenders with these conditions. Accordingly, the current service model is more accurately described as a hybrid, combining out-sourced vendor management and delivery of health care services with an in-sourced pharmacy program.

The contract is structured in a "cost plus" model. The vendor receives compensation in two components: 1) reimbursements for all approved health care expenditures; and 2) a percentage of

actual expenses to cover administrative expenses and profit. In effect, the contract passes through the cost of incurred health care expenses to the vendor, which receives a fee for administering the program. The administrative fee in the current contract is 11.5 percent of incurred expenses. The contract contains an overall annual cap on compensation paid out under the contract. The current contract compensation cap is \$421 million for the current fiscal year and each of the next two fiscal years. Finally, as part of the services to be provided under the three-year contract term, the vendor will provide the FDC with an Electronic Medical Records system (EMR). This system will modernize FDC management of inmate health care information, enabling substantial efficiencies in patient care management and providing advanced metrics on health care work processes and management. The Centurion contract expires June 30, 2022.

The contract is “outcome-based” in that the vendor is held accountable through its level of achievement on a series of performance measures detailed in the contract. The contractor reports on their compliance with these performance measures quarterly. The level of compliance with performance measure requirements determines whether any financial penalties may be assessed against the vendor. While the vendor is reimbursed for actual expenses incurred, it may be subject to financial penalties if mandated outcomes are not achieved. The contract contains 70 performance measures and 135 pages of program standards covering every element of service and calls for an overall compliance rate of 80 percent for each standard as applicable, consistent with CMA standards. Each performance measure contains a specific financial consequence for non-compliance. Contract monitoring reports provide the basis for imposing these penalties.

Exhibit 8: Centurion Contract Performance Metrics

Measure No.	Description	Expectation	Measurement Duration	Financial Consequence
PM-007	From the time an inmate submits a sick call request form until the request form is triaged by an RN and determined to be either emergent, urgent or routine, shall be no longer than 24 hours.	80% compliance, per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: \$2,000 per institution; 60%-69.99%: \$4,000 per institution; Less than 60%: \$6,000 per institution
PM-008	From the time the request is triaged, sick call requests categorized as emergent should be seen by a Licensed Nurse as soon as possible, not to exceed 60 minutes.	80% compliance per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: \$3,000 per institution; 60%-69.99%: \$6,000 per institution; Less than 60%: \$9,000 per institution

Measure No.	Description	Expectation	Measurement Duration	Financial Consequence
PM-009	From the time the request is triaged, sick call requests categorized as urgent should be seen by a Licensed Nurse within 24 hours.	80% compliance per institution	Quarterly	For performance below 80%, consequences will be assessed as follows: 70%-79.99%: \$2,000 per institution; 60%-69.99%: \$4,000 per institution; Less than 60%: \$6,000 per institution

Source: FDC Contract C2930, Amendment 2.

The FDC and the vendor jointly determine the staffing required to satisfy these performance measures, although this staffing pattern is not a part of the contract and vendor compliance is not monitored. Centurion’s current staffing plan has 3,127.9 FTEs, assigned to the following disciplines:

Exhibit 9: Health Care Contract Staff by Discipline

	July 2019 Contract Staffing Plan	Percent of Total Staffing
Medical	1,531.3	49.0%
Mental Health	887.5	28.3%
Dental	228.2	7.3%
Administration	480.9	15.4%
Total	3,127.9	100%

Source: Florida Department of Corrections, Office of Health Services

Staffing levels, however, are not a part of the contract. While maintenance of adequate staffing levels is implicit in the required achievement of the contract performance measures, the contract does not specify staffing requirements or hold the vendor accountable for maintenance of program staffing levels. Provided they do not exceed the overall contract spending cap, the vendor is free to add staff if necessary, to reach standards, or conversely not fill positions without consequence, if they are able to meet the performance standards with lower staffing levels.

Office of Health Services

The FDC Office of Health Services administers the system’s health care program. Responsibilities include development of policies, review of grievance appeals, budget management, contract management, and operation of the state pharmacy program. The OHS has 175 authorized positions assigned to Administration, Medical, Mental Health, Dental, Nursing, and Pharmacy offices.

Contract monitoring is a key OHS responsibility. The OHS has 18 monitors who perform contract monitoring. There are three teams each consisting of an administrator leader, two nurses, one mental health monitor, and one data analyst. On a state-wide basis there is one pharmacist and two dental

monitors. In addition, two teams of mental health professionals conduct risk management assessments to identify potential issues and provide solutions in mental health program delivery.

Monitoring visits can be scheduled or unscheduled, announced or unannounced. The monitors use several methodologies in monitoring contract performance including:

- Desk review of any records or documents related to service delivery; this can be a random or statistical sampling
- On-site review on any records
- Interviews
- Reviews of grievances
- Review of monitoring, audits, investigations, evaluations or other reviews of external agencies (CMA, DOH, ACA)

OHS audit teams conduct facility reviews in the first and third quarters of each fiscal year, with each facility self-reporting audit results in the second and fourth quarters. The Department changed its audit instrument in 2019. Where previously there were 262 performance measures, the new audit system contains 70 performance measures, consistent with contract requirements. These measures are similar in nature to prior measures albeit reduced in number. The FDC reduced the number of measures to facilitate more efficient monitoring of the contract.

These measures are Yes/No type compliance questions. The measures contain an outcome and an expected compliance rate for each measure. Ten to 20 records are reviewed based on a random sampling. Examples of monitoring metrics include:

- Within 10 calendar days of arrival at a reception center, an inmate received on medication from county jail will be evaluated by psychiatry.
- A baseline Mammography study will be performed for female inmates at 50 years of age, and every two (2) years thereafter until the age of 74.
- Acute illness patients were assessed by a nurse every eight (8) hours, including vital signs, and documented the evaluation on form DC4-684, Infirmary/Hospital Daily Nursing Evaluation.

3. HEALTH CARE COSTS

This chapter describes the cost of correctional health care in Florida, including the different elements of health care spending, trends, and key drivers of current and future costs. We also look at how Florida costs for health care compare nationally.

Spending on Inmate Health Care

The FDC appropriation for inmate health care services in FY 2019-20 totals \$566.9 million. Appropriations for health care make up 21 percent of the FDC budget, ranking second behind correctional staffing in magnitude of spending. Assuming a stable inmate population through the current fiscal year, this will roughly equate to a cost of \$17.84 per day per inmate, or \$6,511 annually. Exhibit 10 summarizes the FY 2019-20 budget for inmate health care.

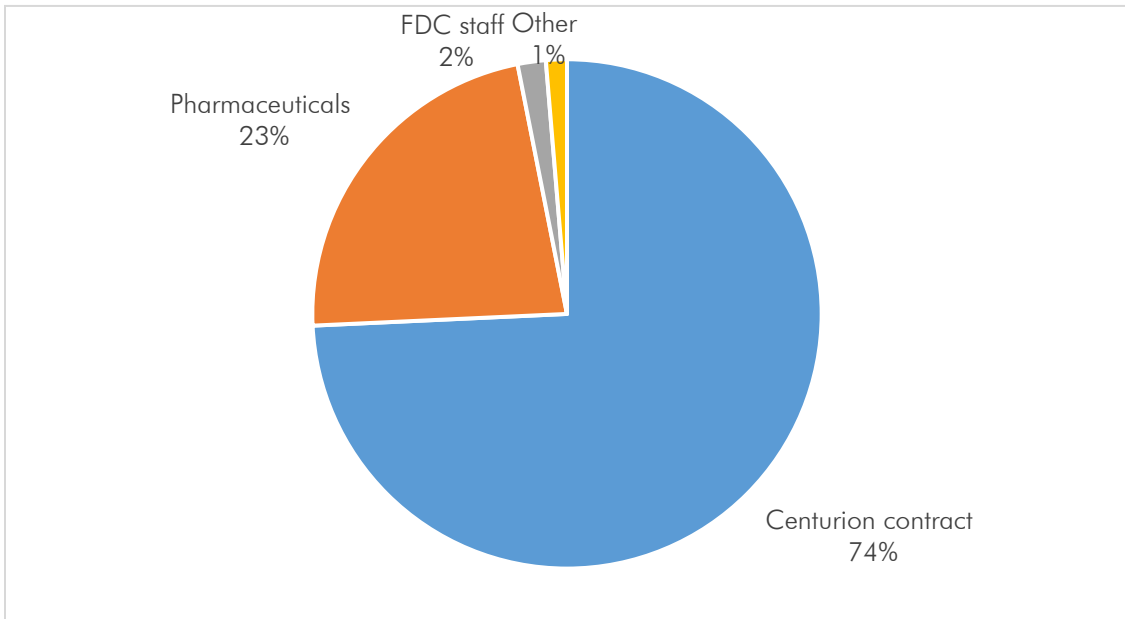
Exhibit 10: FDC FY 2019-20 Inmate Health Care Appropriations

Office of Health Services	FY 2019-20 All Funds Appropriations (\$ 000)
Centurion Contract	421,000.0
Pharmaceuticals	128,222.9
OHS Employee Salaries & Benefits	9,721.6
Contracts	4,367.2
Other	3,554.9
TOTAL	566,866.7

Source: Florida Department of Corrections

The state's contract with Centurion for statewide facility health care services makes up 74 percent of health care spending. FDC expenditures for infectious disease, psychotropic, and general medications make up another 23 percent of the budget. The cost of state employees to administer the system and manage the pharmacy program is roughly 2 percent of the budget.

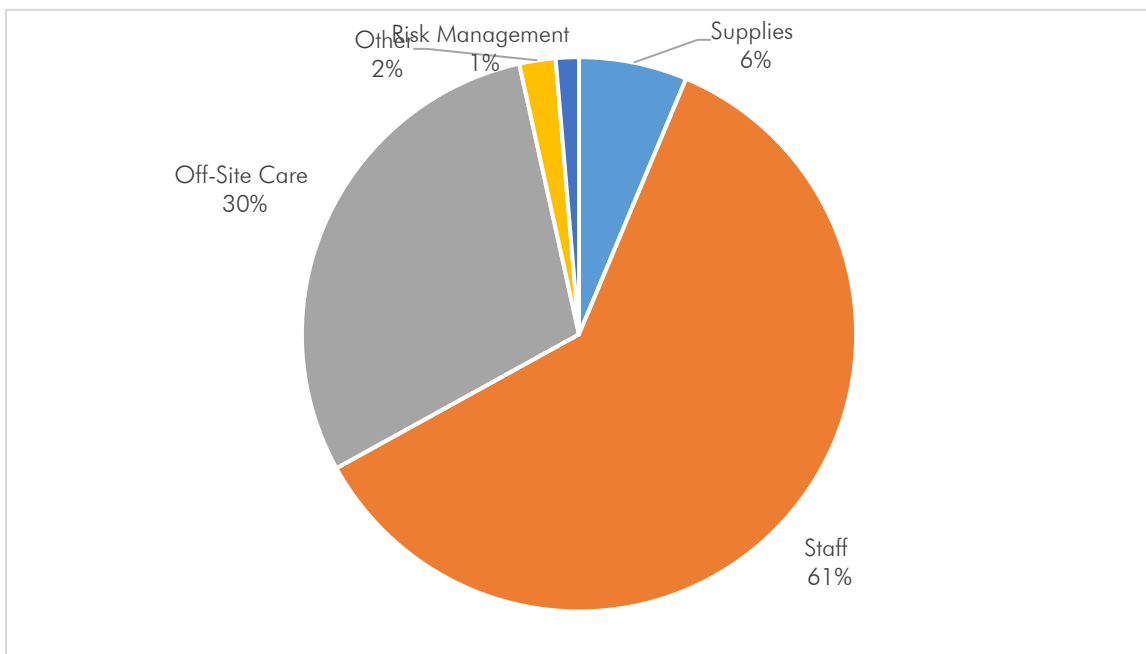
Exhibit 11: Inmate Health Services Expenditures Components



Source: Florida Department of Corrections

In FY 2018-19 Centurion expenditures under the contract for inmate health care totaled \$355 million. Approximately 61 percent of expenditures were for health care staff in FDC facilities. Off-site care by hospitals and specialist clinicians made up 30 percent of vendor spending, with supplies and other expenses accounting for less than 10 percent of expenses.

Exhibit 12: FY 2018-19 Centurion Health Care Expenditures

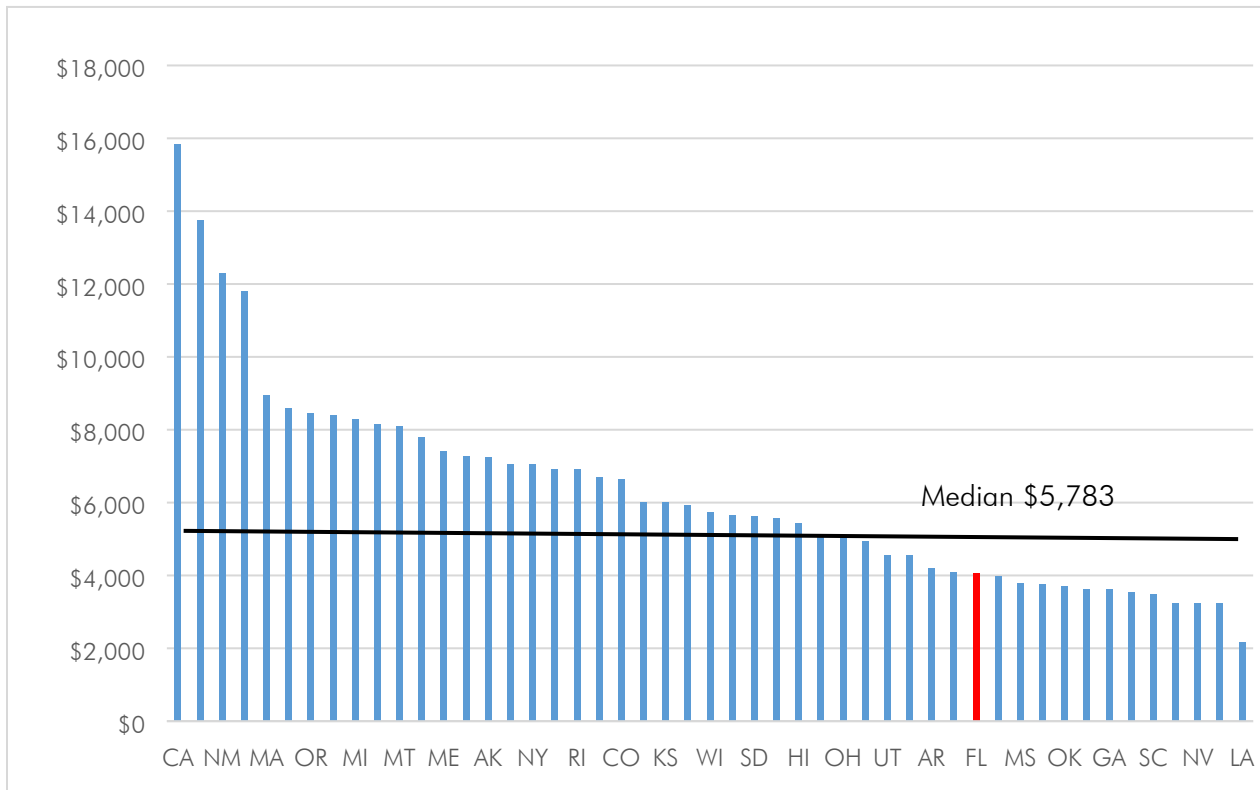


Source: Florida Department of Corrections

Comparison with Other States

A comparison of Florida’s spending with the most recent data available for other state correctional systems shows FDC expenditures per inmate for health care in the bottom quartile of states with the lowest spending levels. A comprehensive review of 2015 correctional system spending in 49 states²³ by the Pew Charitable Trusts documented that annual spending on correctional health care ranged from a high of \$15,827 in California to a low of \$2,173 in Louisiana.²⁴

Exhibit 13: State Spending Per Inmate on Correctional Health Care in 2015



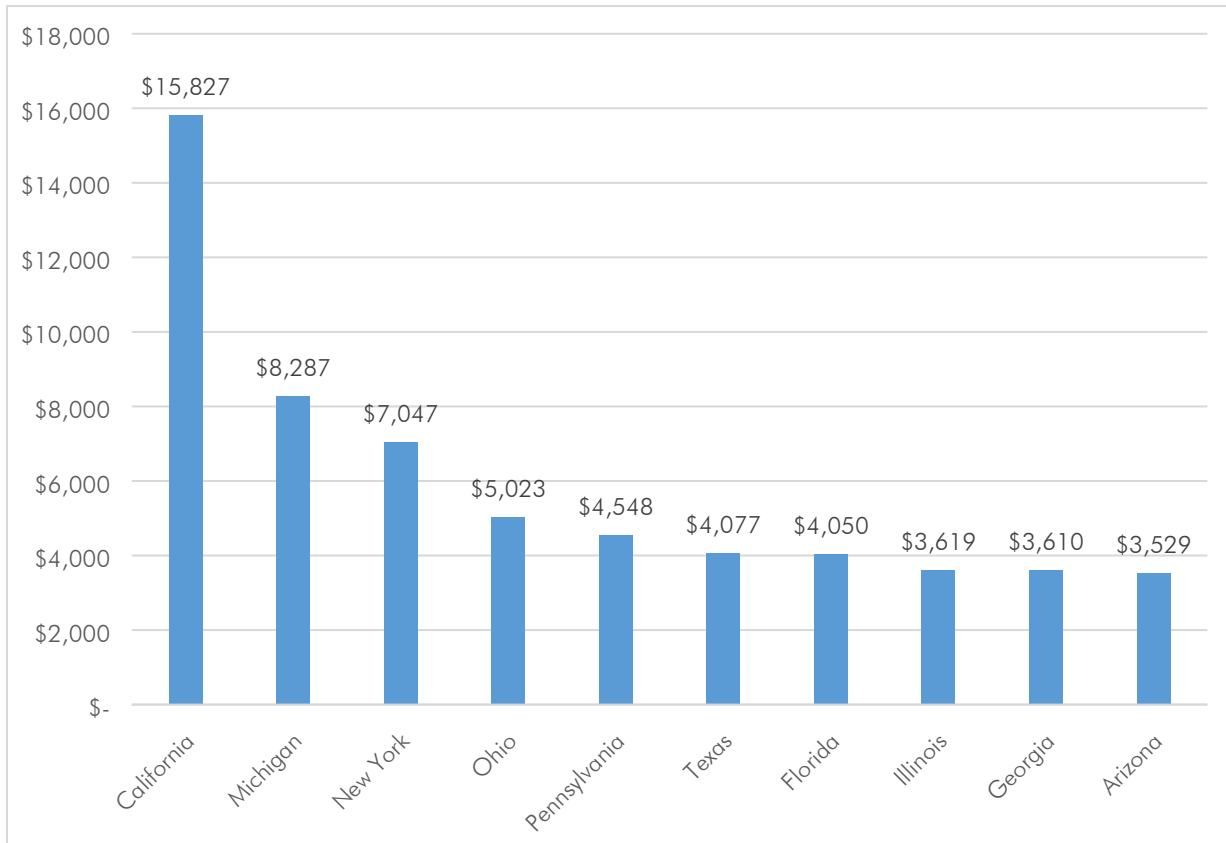
Source: Pew Charitable Trusts, Prison Health Care: Costs and Quality, 2017

Although California is an outlier, most of the states with relatively high spending levels are very small, and their higher costs may reflect a lack of resources or economies of scale. Spending levels for the ten largest correctional systems showed Florida ranked seventh. However, the degree of difference in spending level among the six systems with the lowest average spending level was small. The data shows Florida to have a somewhat lower spending level that is however still comparable to most large state correctional systems, as shown in Exhibit 14.

²³ Pew Charitable Trusts conducted a national survey of state correctional systems. All states except New Hampshire responded to the survey.

²⁴ Pew Charitable Trusts, Prison Health Care: Costs and Quality, October 2017, <https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality>.

Exhibit 14: 2015 Correctional Health Care Spending – Ten Largest State Prison Systems

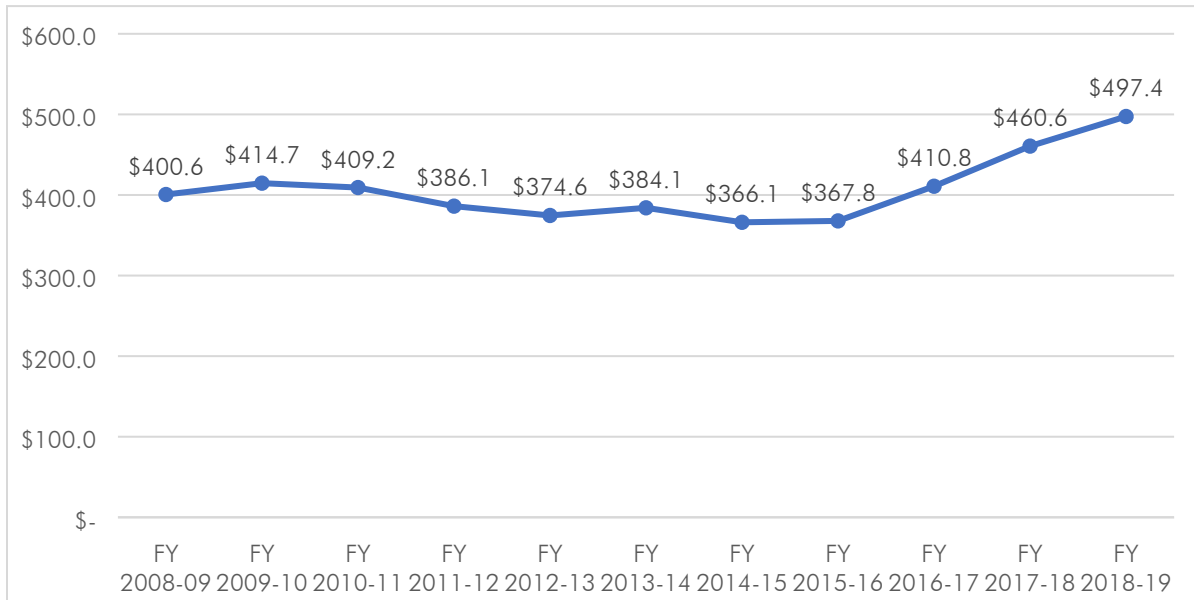


Source: Pew Charitable Trusts, Prison Health Care: Costs and Quality, 2017

Cost Trends

More recent trends show the level of FDC spending on inmate health care accelerating since 2016. As shown in Exhibit 15, the amount of funding allocated to inmate health care dropped by 9 percent in the period from FY 2008-09 through FY 2014-15 but has since steadily escalated. The FY 2019-20 budget represents a 54 percent increase over FY 2015-16 spending.

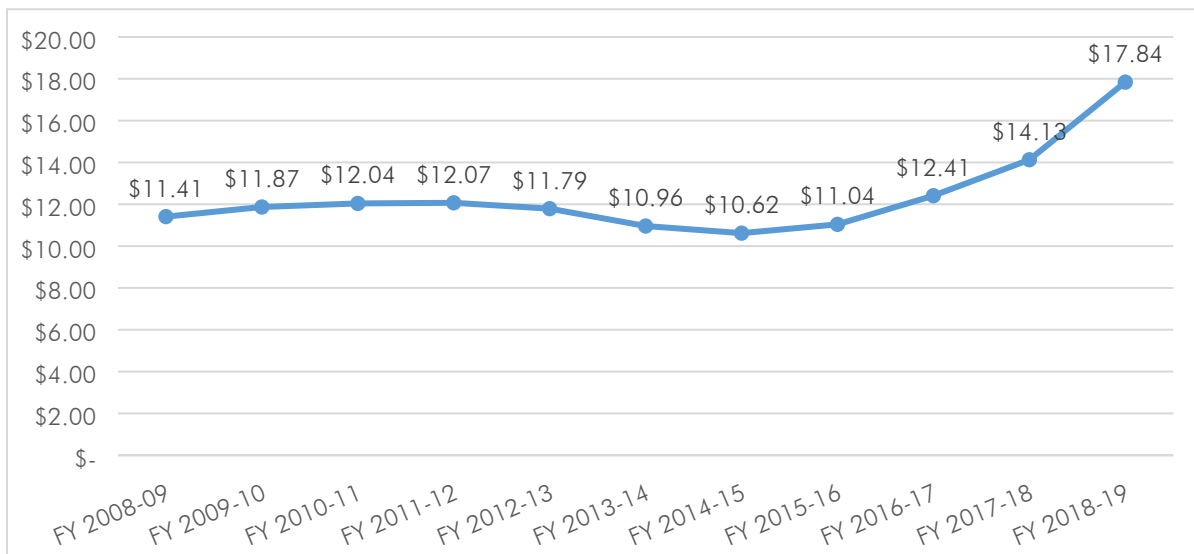
Exhibit 15: Inmate Health Services Spending FY 2008-09 to FY 2018-19



Source: Florida Department of Corrections

Examining per diem spending levels factors in the impact of changes in the average daily inmate population on total health care expenditures. This is a significant factor in evaluating cost trends as the actual average daily inmate population in the Florida correctional system has declined by 6.7 percent since FY 2008-09 from an average daily population of 93,270 in state-operated facilities in FY 2008-09 to 87,032 in FY 2018-19. The per diem cost trend, shows a steady decline through FY 2014-15, followed by significant increases.

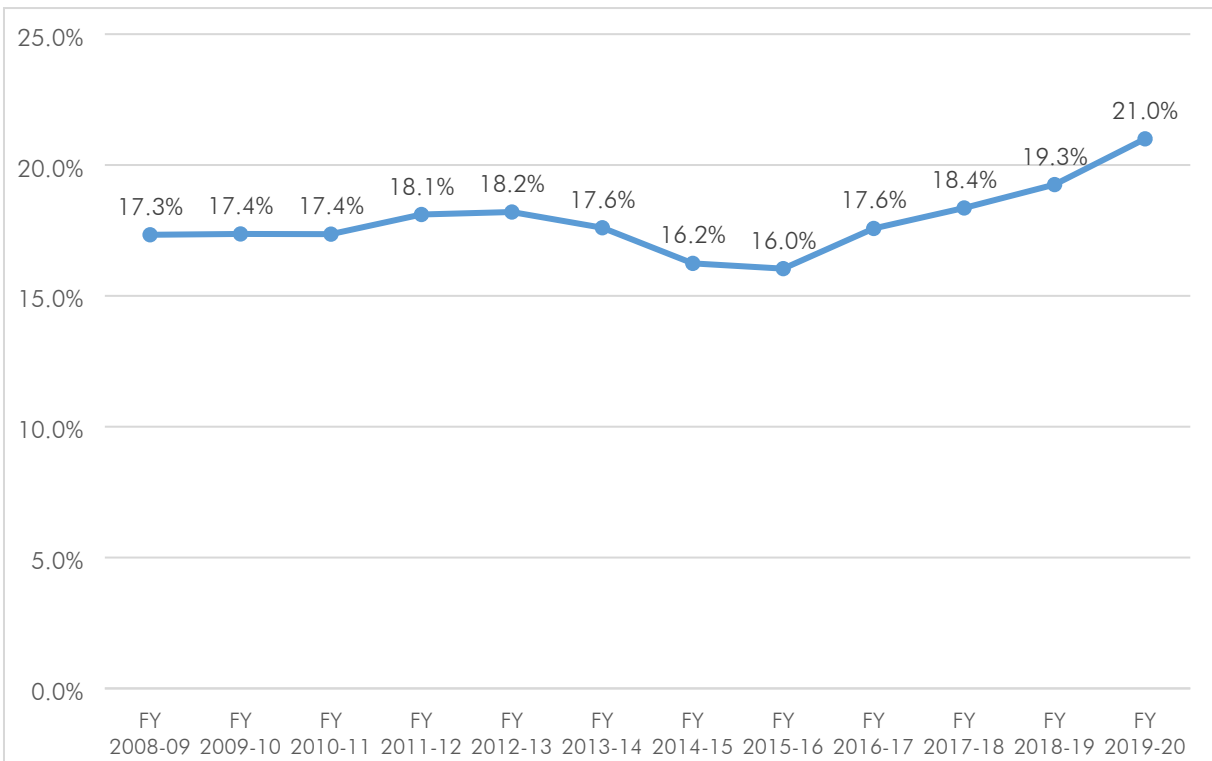
Exhibit 16: Inmate Health Services Per Diem Costs FY 2008-09 to FY 2018-19



Source: Florida Department of Corrections

The proportion of the FDC budget allocated to inmate health care reflects the increase in reported spending in the last four years. Following several years of decline, by FY 2015-16 the Department was spending 16 percent of its budget on inmate health care. The proportion of the budget allocated to health care has grown more recently in parallel with recent increases in spending.

Exhibit 17: Inmate Health Services as a % of FDC Spending

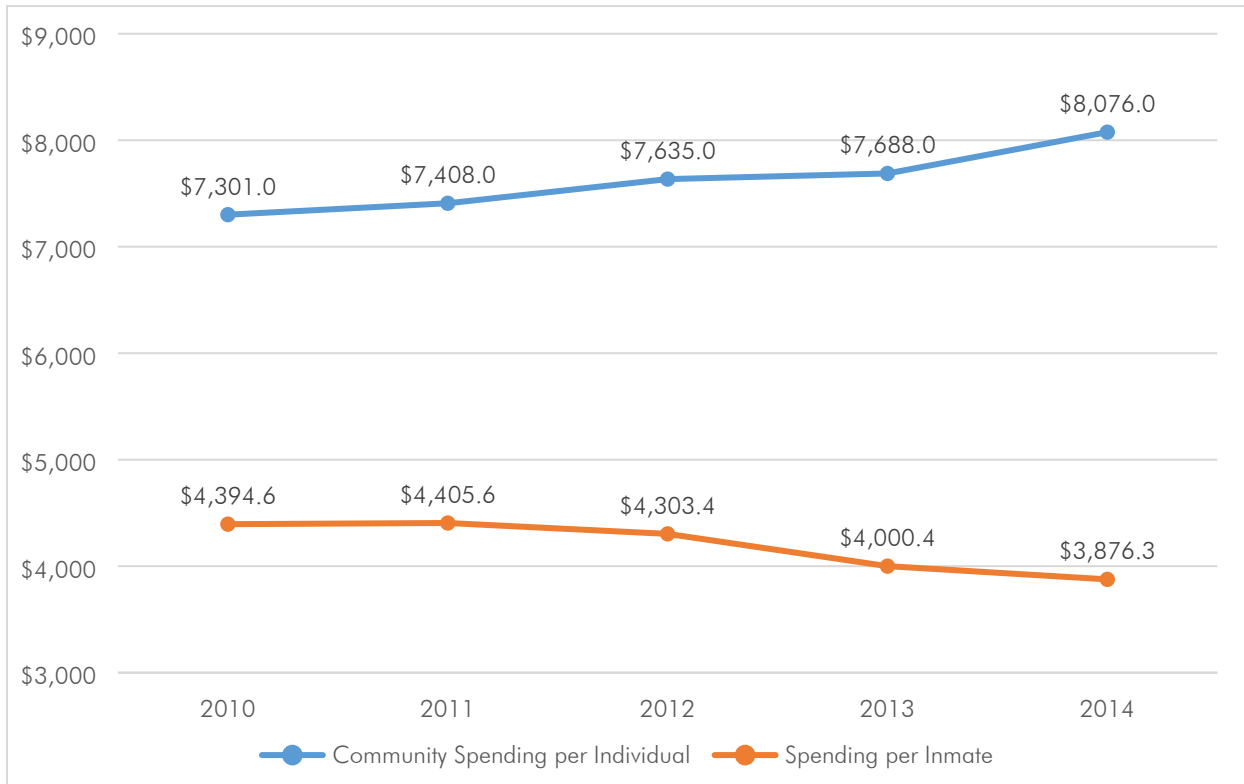


Source: Florida Department of Corrections

The two most notable factors from this review of spending trends are the significant decline in health care spending from FY 2008-09 to FY 2015-16, followed by the rapid growth in spending that has occurred since that time. This pattern does not follow the overall trend for health care costs in Florida. Annual spending for health care per inmate in the FDC dropped by 12 percent from FY 2008-09 to FY 2014-15. By contrast, according to the Centers for Medicare and Medicaid (CMS), the average cost for personal health care in the state increased by 13 percent over the same period.²⁵ In 2010, annual per inmate spending on health care was approximately 60 percent of the average level of spending on personal health care. By 2014, inmate health care spending had dropped to 48 percent of the level of personal spending on health care.

²⁵ Centers for Medicare and Medicaid Services, Health Expenditures by State of Residence, 2017, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html>.

Exhibit 18: Annual Community and Inmate Per Diem Spending for Health Care, Florida 2010-2014



Source: Centers for Medicare and Medicaid; Florida Department of Corrections

The primary factor driving this reduction in per inmate spending appears to be the privatization of inmate health care and subsequent decline in the quantity and quality of care provided during this period. The health care contracts with Wexford and Corizon in total reduced the cost of services by 11.2 and 12.9 percent respectively from the Department’s FY 2011-12 and FY 2010-11 expenditures. Implementation of these contracts resulted in reductions in staffing, dramatic decreases in episodes of outside care, and increases in the number of grievances submitted by inmates about the poor quality of health care service. CMA inspections noted extensive system-wide areas of concern with the level of medical and mental health care provided.²⁶ Both vendors later claimed they were not provided enough information to accurately project costs, which resulted in the service issues that developed. Both vendors were unable to provide the level of service required by the Department and did not complete the terms of their contracts.

²⁶ Correctional Medical Authority, Annual Report and Update on the Status of Elderly Offenders in Florida’s Prisons, 2014-15, 2015-16, <https://fleog.sharepoint.com/sites/CMA/Documents/Forms/AllItems.aspx?originalPath=aHR0cHM6Ly9mbGVvZy5zaGFyZXBvaW50LmNvbS86Zjovcy9DTUEvRWdpbjdpWDNUTHhHanR5ekU2bzVCNEFCREIBbGVpVTI2VjBZcTdPMDI5NW5qdz9ydGltZT1LSy1SNTZ0YjEwZw&id=%2Fsites%2FCMA%2FDocuments%2FCMA%2FAnnual%20Reports%2FCorrectional%20Medical%20Authority%20%2D%202015%2D2016%20Annual%20Report%2Epdf&parent=%2Fsites%2FCMA%2FDocuments%2FCMA%2FAnnual%20Reports>.

Cost Drivers

After declining in the period FY 2010-11 through FY 2014-15, inmate health care costs increased by 36 percent over the next four years, an annual average increase of 9 percent. Several factors appear to be driving this trend, including a misalignment between contract funding and service requirements, litigation, the increasing number of geriatric inmates, and increased pharmaceutical spending.

Misalignment between Contract Funding Amounts and Service Requirements. As described above, the Corizon and Wexford contracts reduced state funding for inmate health care. However, this lower funding level did not support a minimally adequate level of service. Accordingly, the reduced levels of spending achieved under these contracts are not an appropriate basis for comparison for contemporary budgets. Increases in funding from the levels required by these contracts need to be viewed in the context of restoring resources to get back to acceptable program performance levels.

Spending on inmate health care by the FDC in FY 2017-18 totaled \$460.6 million. Although this represents a substantial \$93 million increase from FY 2015-16, using a longer timeframe produces a different conclusion. As shown in Exhibit 15, the FY 2017-18 spending level is only \$46 million more than the Department experienced in FY 2009-10. This represents annual growth of 1.3 percent over the eight year period compared with an annual increase in the cost of medical care nationally of 3.6 percent from July 2009 through June 2018.²⁷

Much of the apparent increase in spending for inmate health care is attributable to an artificially low baseline spending level experienced by the Department after privatization. Costs went down to levels that could not sustain an adequate level of service. Subsequent increases in spending largely represent a return to levels necessary to support required service levels. Using a longer historical period to evaluate spending levels shows that recent growth in spending levels since FY 2015-16 represents a moderate overall rate of growth in the context of Department spending on health care prior to the privatization initiative of 2013. Further, misalignment between service needs and services provided by the vendors led to a backlog of medical/mental health issues, contributing to subsequent litigation and increased health care spending.

Litigation. Consent decrees and judgements from ongoing litigation on the adequacy of health care services have escalated Department resource needs. The following exhibit summarizes litigation-related increases in the Department's FY 2019-20 budget from the most significant cases that the Department has settled.

²⁷ U.S. Bureau of Labor Statistics, Chained Consumer Price Index for Medical Care, All Urban Consumers, 1999-2019.

Exhibit 19: Impact of Litigation on FY 2019-20 Inmate Health Care Budget

Case	Description	Funding Increase (\$ millions)
<i>Disability Rights Florida, Inc. v. Jones</i> ; Year 2 implementation of Inpatient Mental Health consent decree	308 staff phased in through the year, including Psychiatric staff, Nursing, Psychologists, Mental Health Professionals, Behavioral Health Technicians and clerical support for expansion of the Suwanee inpatient mental health units.	\$16.6
<i>Disability Rights Florida, Inc. v. Jones</i> ; <i>Copeland et al v. Jones</i> ; <i>Keohane v. Jones</i> ; additional staffing	139 staff needed to comply with litigation related to hernia treatment (2 FTEs), gender dysphoria treatment (3 FTEs), the treatment of inmates with disabilities (40 FTEs), as well as additional mental health positions (94 FTEs) included outpatient and inpatient services. In addition, this funds market rates adjustments needed to fill certain positions, such as psychiatrists and psychologists.	\$13.4
<i>Hoffer et al v. Jones</i> ; Hepatitis C treatment	16 FTEs to provide labs and other medical tests such as Genotyping, Liver Ultrasounds, and Endoscopies. Up to 45,000 screenings and subsequent follow up tests for those testing positive. This does not include the cost of medication.	\$8.7

Source: Florida Department of Corrections

Increasing Number of Geriatric Inmates. The number of inmates over the age of 50 has increased from 14,486 on June 30, 2009 to 25,732 on June 30, 2019, an increase of 78 percent over the ten years. As in the community, geriatric patients are disproportionate users of health care. As shown below, despite composing 27 percent of the total inmate population, elderly inmates make up most hospital admissions, inpatient days, outpatient events, and prescriptions dispensed. Department data indicate that when admitted to a hospital, geriatric inmates have a 22 percent longer length of stay than inmates under the age of 50.

Exhibit 20: Department of Corrections FY 2018-19 Health Care Utilization

	50 Years & Older		Under 50 Years	
	Number	% of Total	Number	% of Total
Total Population	25,732	26.9%	69,770	74.1%
Hospital Admissions	1,496	53.7%	1,290	46.3%
Inpatient Days	10,084	63.7%	5,736	36.3%
Outpatient Events	18,319	57.8%	13,370	42.2%
FDC Prescription Dispensed	746,931	57.3%	573,917	42.7%
DOH Prescriptions Dispensed*	18,937	52.3%	17,241	47.7%
Cardiovascular Clinic Contacts	15,163	55.0%	12,360	45.0%
Endocrine Clinic Contacts	5,290	58.5%	3,751	41.5%

*DOH dispense prescriptions for HIV/AIDS and STDs under the 340b program

Source: Florida Department of Corrections

Nearly every prison system in the United States faces this same issue of increasing health care costs driven by the growth in the geriatric inmate population. As described earlier, the size of this population in Florida appears larger and growing at a faster rate than that of other large state correctional systems. This trend will continue to place strong upward pressure on inmate health care spending.

Drug Costs. Another significant cost driver is the increasing cost of prescription medications. The FY 2019-20 budget contains a \$34.6 million increase for Hepatitis C medications, bringing total Department spending for these drugs to \$48.4 million in the upcoming fiscal year. Price increases for other medications account for a \$13.9 million increase in the budget. Higher drug costs are a significant growth factor in other state correctional systems as well. For example, increased spending on medications accounted for 33 percent of the growth in spending by the Virginia Department of Corrections from FY12-FY17.²⁸

²⁸ Joint Legislative Audit and Review Commission, Commonwealth of Virginia, Spending on Inmate Health Care, 2018.

4. Alternative Service Delivery Models

This chapter examines alternative models for delivering correctional health care and their relative utility for the FDC. Models reviewed include insourcing inmate health services, insourcing of outpatient health services provided and outsourcing inpatient services, continuation of the current model of full outsourcing with modified contract terms imposing appropriate cost controls, and management by a third-party public health institution or agency.

Insourcing

An insourced approach to inmate health care management retains management and staffing of the health care services program internally in a state correctional agency and provides as much treatment as possible within the secure facilities of the correctional system. However, not all health care can be provided within a prison. An inmate in need of treatment by a specialist not on staff at the prison will require off-site care with a physician contracted to provide that care, or a contracted specialist to come on site. Similarly, diagnostic procedures that require equipment not maintained in a prison health care unit such as an MRI, will require outpatient care outside the correctional system. Finally, advanced procedures such as heart surgery must be provided in community hospitals that can safely support such treatment. As a result, a completely insourced inmate health care system is not feasible, and in fact virtually all correctional systems since the 1970's have relied on some level of contracting to provide required inmate health care.²⁹ Accordingly, for the purposes of this analysis, an "insourced" model refers to an approach that maximizes the use of government management and staff in the delivery of services, but still retains the use of contracts for specific services and treatment.

The degree to which a correctional system may rely on insourcing depends upon available resources. Systems that maintain prison hospitals or ambulatory surgical facilities, such as the Federal Bureau of Prisons, Texas Department of Criminal Justice, and California Department of Corrections and Rehabilitation have the capability to provide more services in-house. Florida falls in this category as well. The availability of internal resources reduces the need to take inmates out into the community for health care, diminishing a significant burden on custody staff.

Today, 18 state correctional systems use a primarily insourced model for health care delivery.

Exhibit 21: States with Insourced Delivery Systems

Alaska	North Carolina	Oregon
California	North Dakota	South Carolina
Connecticut	Nevada	South Dakota
Hawaii	New York	Utah
Iowa	Ohio	Washington
Nebraska	Oklahoma	Wisconsin

Source: Pew Charitable Trusts

²⁹ Pew Charitable Trusts

Insourcing is used by large correctional systems (California, New York, Ohio) as well as systems with very small inmate populations (Alaska, Hawaii, North Dakota), in every part of the United States. While these systems do contract for inpatient and outpatient care in the community, services in correctional facilities are primarily provided by state employees. The typical exception is for advanced mental health treatment. In almost all cases, psychiatric services are provided by independent contractors, as state personnel systems do not accommodate hiring specialized professionals in high demand.

An insourced system requires substantial internal expertise in correctional health care management and service delivery. Maintaining effective performance in an insourced system requires that a correctional system establish professional care protocols, retain a staff complement with adequate capacity and expertise, and design rigorous systems for monitoring cost and quality of services provided. If these requirements are met, insourcing can meet required standards for correctional health care and provide the following benefits:

- **Stability.** Use of government employees as service providers and managers provides greater assurance of continuity and consistency in staffing and service approach. The benefit package, particularly for retirement, for a state employee is typically superior to the benefits offered by private companies and acts as an incentive for long-term careers as a correctional system employee. Administrators in insourced systems such as California, Alaska, and Washington report relatively low turnover rates for facility health care staff. A recent report from Arizona indicates health care workers may prefer employment with a state agency, as opposed to a vendor.³⁰

Insourcing also avoids the disruptive transitions in management and employment status that can occur in the change from a government-run health care program to one managed by a private contractor, or in the transition from one vendor to another. In Florida, prior to each privatization initiative, the Department suffered a significant loss of experienced health care staff due to uncertainty regarding their employment status and future compensation level under a vendor. During each subsequent change in vendors, facility health care staff had to transition to a new employer and in most cases lost benefits they had accrued with their prior employer. Moreover, such transitions are highly complex events that place added strain on assuring continuity of adequate care. An insourced system avoids these issues.

- **Accountability.** The lines of accountability for assuring adequate health care delivery are quite clear in an insourced system, running directly from state employee facility staff and managers up through central office administrators. Contracting, however, transfers operational control to vendors, even while the state retains ultimate liability and responsibility for providing services. This adds a layer of complexity to system management. Similarly, lines of communication and

³⁰ Marc Stern, Federal Rule 706 Expert, Case 2:12-cv-00601, Report to the Court in the Matter of *Parsons v. Ryan, et al.*, October 2, 2019.

direction are straightforward in a government-run system. Coordination with custody staff is simpler when both health care staff and correctional officers are in the same command structure. Moreover, vendor staff are not directly accountable to state administrators, which can hamper responsiveness.

Problems inherent with insourcing relate to the relative lack of flexibility of government organizations compared to the private sector regarding personnel management. If, for example, a facility experiences chronic high staff vacancy levels, a private vendor generally has the discretion to quickly adjust salary levels or offer signing bonuses to adjust to market conditions. Private vendors generally have more sophisticated staff recruitment systems and a wider range of incentives in attracting employees. Staff with specific skillsets for critical functions such as utilization review and quality assurance may not be readily available within government. Vendors also may quickly redeploy staff as needed to meet operational needs. Finally, private vendors have much greater discretion in terminating staff that do not meet performance standards. State agency deficiencies in hiring and deploying staff to meet correctional system needs is one of the most often cited arguments for privatization.³¹

Another issue with insourcing is that while state agencies may have some expertise in managing facility health care staff and programs, the degree of difficulty associated with effective management of all the various facets of health care delivery is substantial. Few correctional systems have the level of in-house administrative resources and experience required to coordinate outside care and manage multiple contracts with outside providers. Specialized functions such as utilization management and invoice review are far outside the core competency of most state correctional agencies and add a layer of complexity that many systems may have difficulty in managing.

Outsourcing

An outsourced service model relies on a contracted vendor to manage and provide inmate health care services for the state correctional system. In its purest form, the state turns over all aspects of health care service delivery to the vendor.

Until the late 1970s, every state provided prison health care directly in an insourced delivery model. However, widespread litigation following *Estelle v. Gamble* produced judgements that required many states to immediately address significant deficiencies in correctional health care, often requiring that additional clinicians and nurses be hired as soon as possible. Private companies were formed to meet this need. In Illinois for example, in order to meet the need to hire additional staff required under the *Lightfoot v. Walker* consent decree, Illinois Department of Corrections administrators actively solicited a physician's group to help them meet their needs. The company formed by these physicians ultimately became Correctional Medical Services, one of the first companies to specialize in correctional health care, and one of the founders of Corizon Health.

³¹ Pew Charitable Trusts.

These early companies soon moved beyond simply providing staffing to provide comprehensive services on a managed care model to both prison systems and jails throughout the United States. Today, 20 states provide most of their inmate health care services using an outsourcing model.

Exhibit 22: States with Outsourced Delivery Systems³²

Alabama	Kansas	Tennessee
Arizona	Kentucky	Vermont
Arkansas	Massachusetts	West Virginia
Delaware	Maryland	Wyoming
Florida	Maine	
Idaho	Missouri	
Illinois	Mississippi	
Indiana	New Mexico	

Source: Pew Charitable Trusts.

The approach to service delivery in these states differs in terms of the range of services provided, the extent to which they provide system management in addition to clinical services, and whether one or multiple vendors provide services throughout the system. For example, Maryland contracts with separate private companies to provide different services: medical, dental, behavioral health, and pharmaceutical. Illinois has contracted with different vendors to provide comprehensive services to different regions of the state. Massachusetts requires vendors to use a state-managed hospital and pharmacy procurement system. Florida purchases medications and provides pharmacy services with state employees.

There are many specific approaches to outsourcing. The basic distinction lies in how to manage risk, both in terms of service quality and cost. Most outsourced contracts follow either a capitated or cost-plus approach.

Capitated Contracts. The most common approach to outsourcing is the use of a capitated contract. In this model, the state and the vendor agree to a fixed per-person payment rate for all individuals under their care. This vests all risk with the vendor. The intent of the model is to leverage vendor expertise to provide required services at a lower, stable cost.

The fixed per-person rate covers direct care at the facility as well as any specialty or off-site services that may be required. The vendor is responsible for providing contracted services for the number of inmates covered at the agreed rate, regardless of the actual cost. The capitated rate must cover all regular projected costs, a risk premium to cover potential additional liabilities, and a fee to cover administrative costs and profit. If the vendor can reduce costs, it can directly increase profits. If, however, the rate does not account for projected expenses and risks, or if the number of persons covered under the contract falls, the vendor stands to lose money. The state, for its part receives a predictable, stable price for inmate health care.

³² Pew Charitable Trusts.

A capitated approach requires that the vendor be able to accurately assess the health status of the inmate population, their need for service, and risk factors that may drive up costs. Absent this information, the vendor in a competitive procurement may underbid the contract. The long-term consequences of underbidding are typically either unanticipated requests for additional contract funding, reduced services, or termination of the contract. Outsourcing initiatives in Florida using a capitated model have encountered all these issues.

Cost-Plus Contracts. In this approach the vendor manages health care services but passes through all costs of these services to the state, plus an additional charge for administration and profit. The state assumes all financial risk, while at the same time ceding management control over the program to the vendor. Florida, Pennsylvania, Montana, and Vermont report using the cost-plus model.³³

This model is often used in systems that either lack data to provide projections of future costs or which have high perceived risks for unforeseen costs. Where the capitated model encourages an aggressive approach to managed care, the cost-plus is more akin to a “fee-for-service” model. The vendor simply manages the health care program and passes along the cost to the state. The primary advantage to the state is the transparency provided in that it reviews and approves all expenses. The contract can also more explicitly focus on service quality and performance as primary objectives. The disadvantage is that it provides little incentive for the vendor to control costs.

In either outsourcing approach, the primary challenge for the state is monitoring the contract to ensure compliance with performance requirements and other contract provisions. In effect outsourcing changes the focus from managing health care operations and services, to managing the contract and vendor performance.

Outsourcing Benefits and Challenges. Both approaches to outsourcing can provide benefits to clients, as well as certain issues. Commonly described benefits of outsourcing include:

- **Professional Expertise.** For systems that lack internal resources or professional staff, outsourcing provides a means to leverage the professional expertise of a vendor that specializes in correctional health care. Health care is not a core competency of many correctional systems, particularly in areas such as utilization review, quality assurance, network management, and electronic medical records systems. Contracting for health care services provides a relatively straightforward strategy to import these skills, improving performance and allowing correctional administrators to focus on other issues.
- **Economies of Scale.** Outsourcing can allow small correctional systems to access the economies of scale and more flexible procurement systems used by large, national companies in purchasing pharmaceuticals and supplies. This however is not a significant benefit for larger systems.

³³ Pew Charitable Trusts.

- **Staffing.** As described in the section on insourcing, private companies often have much more flexibility in setting salary and benefit levels to reflect market conditions in specific areas, and so can more effectively recruit and hire health care staff. This is particularly true in specialized areas such as mental health treatment. To the extent that civil service systems slow hiring or do not offer competitive salary levels, outsourcing provides a potential means to better keep service provider positions filled.
- **Cost Savings.** At least in the case of capitated contracts, outsourcing provides strong incentives for vendors to reduce costs in order to assure profits. The competitive bidding environment for an outsourcing procurement also tends to promote efficiency and attention to cost savings strategies.

Challenges associated with outsourcing generally revolve around managing performance goals in context with the imperative to control costs. With the capitated model, the vendor will always have the incentive to reduce costs to increase profits. To the extent that cost reduction is achieved through reduced services rather than increased efficiency, the model does not support overall correctional system goals. The disconnect between the vendor responsible for providing care and the state which is legally accountable if care is not adequate can lead to system dysfunction and contract failure. State systems that have experienced serious service issues with outsourced services under capitated contracts include Arizona, Virginia, Illinois, Idaho, and Florida. These issues include excessive number of staff vacancies, failure to refer inmates for off-site treatment, and long wait times for on-site treatment. Strong contract monitoring systems with clear performance metrics are essential to manage these issues.

The cost-plus approach by contrast presents issues of efficiency. The state pays the vendor to manage the system without any offsetting incentives to achieve efficiencies in service delivery. The state must maintain staff to monitor vendor performance against the contract and in addition will typically have an administrative office to provide overall program direction. The vendor however also has a cadre of administrative staff to oversee and coordinate service delivery, in some cases duplicating positions maintained by the state. In a cost-plus contract the state pays for its own administrative staff, covers the cost of the vendor administrative staff assigned to the contract, and then pays the vendor a fee to cover overhead and profit.

A recent review of the Arizona Department of Corrections highlighted this issue. “The vendor has monitors to make sure they comply with the Performance Measures and other requirements of the contract; the Arizona Department of Corrections has monitors to do the same. The vendor has a contract manager and statewide medical director; the Arizona Department of Corrections has a contract overseer and a medical director. The vendor has staff to follow and manage the costs of the contract; the Arizona Department of Corrections has staff to follow and manage the costs of the

contract. The vendor has lawyers to draw up, modify, and deal with issues related to the contract; the Arizona Department of Corrections has lawyers to do the same.”³⁴

Hybrid Insourcing/Outsourcing

A hybrid service delivery model combines different aspects of both insourcing and outsourcing to meet system needs. As noted earlier, all insourced correctional systems rely on some use of contracts to provide community outpatient services, specialist care, and hospitalization. Hybrid systems go beyond this limited approach to develop more blended systems. Basic hybrid models include outsourcing all care that takes place outside of a secure correctional facility, privatizing the management of health care in select facilities while maintaining state management of other facilities, mixing facility vendor and state staff under the management of state health care administrators, and designating specific disciplines such as mental health, pharmacy, or dental as either state or vendor managed within the context of a outsourced or insourced system.

Historically, hybrid models have evolved as systems experimented with outsourcing on a limited basis to address specific systemic or facility issues. Currently the eight states that use hybrid models which mix state employee and vendor management of health care include Colorado, Louisiana, Michigan, Minnesota, Montana, Pennsylvania, Rhode Island, and Virginia.

The variety of different approaches to hybrid insourced/outsourced models and the relatively small number of states that use this model makes it difficult to draw conclusions as to specific advantages or disadvantages to the approach. Rather, it appears that each state has attempted to develop a customized approach to best meet its unique needs. Michigan for example had a specific challenge in contracting with clinicians and managing off-site care. Their model uses state employee nurses and dentists, while contracting for doctors, psychiatrists, and off-site care with a capitated approach. Colorado uses state employees to provide on-site services but outsources all off-site care. Virginia outsources all health care at select facilities that are difficult to staff or that provide specialized services such as dialysis, while insourcing health care services in its other facilities.

University Management

A final alternative model for the delivery of inmate health care is contracting system management to a state medical school or health sciences university. The model is like more conventional outsourcing but removes the cost of profit and relies on existing university administrative infrastructure to reduce expenses. Currently Texas, Georgia, and New Jersey contract with state universities to manage inmate health care. In these cases, the state approached the medical schools for assistance in response to lawsuits mandating improvement in the delivery of inmate health care services. Connecticut, Louisiana, and Massachusetts have also recently experimented with forms of this approach, ranging from full university management of inmate health care services, to providing certain specified services.

³⁴ Stern.

Illinois and Virginia maintain more limited contracts for use of state medical school hospitals with secure inpatient units.

This model offers several advantages to state correctional systems. Affiliation with a recognized medical school signals a commitment to service quality and provides state correctional health programs with increased credibility. Medical school partnership also provides much improved access to qualified clinicians. Recruiting physicians to work for a state medical school is often easier than recruiting a physician to work for a prison health care company. In New Jersey, the vacancy rate for correctional facility physicians dropped well below 10 percent following establishment of a contract with Rutgers University.³⁵ University medical schools also generally have well-developed quality assurance programs, excellent access to contemporary data on best practices in treatment, and well-developed electronic medical records programs. The contracts are generally structured in a cost-plus model, but absent the private vendor profit margin, thereby reducing cost. Finally, affiliation with a university can facilitate access to 340b discount pricing on pharmaceuticals. As described earlier the 340b program provides outpatient drugs to covered entities at significantly reduced prices.

For universities, the primary benefit of such a relationship is the delivery of treatment to a historically underserved population, inmates. The fact that nearly all inmates eventually reenter the community also makes treatment of chronic and infectious diseases in prison a significant component of a comprehensive approach to public health promotion. Also, the inmate population, with its high incidence of pathology provides a medical school with unique professional training opportunities.

³⁵ R. Reeves, A. Brewer, L. DeBillo, C. Kossof, and J. Dickert, "Benefits of a Department of Corrections Partnership with a Health Sciences University: New Jersey's Experience," *Journal of Correctional Health Care*, 2014. Vol. 20(2), https://www.researchgate.net/publication/261035318_Benefits_of_a_Department_of_Corrections_Partnership_With_a_Health_Sciences_University_New_Jersey's_Experience/link/5592c71a08ae1e9cb42978ef/download.

5. Alternative Service Delivery Models in the FDC

This chapter assesses the application of each of the service models described in Chapter 4 to the delivery of inmate health care services in the Florida Department of Corrections (FDC). There is no consensus in current research on which model is most effective in supporting effective system performance while containing costs.³⁶ Instead, it appears that each model can work well depending upon the specific characteristics of the correctional system. This analysis examines the degree to which each of these alternatives provides an effective approach to managing the issues and needs of the FDC.

Insourcing

The feasibility of insourcing inmate health care services in the FDC is well established through the history of the Department. Except for an outsourced contract for Region 4 facilities from 2001-2007, the FDC managed a largely insourced system until the privatization of the system in 2013. The effectiveness of insourcing as a future service delivery model for the Department depends upon the Department's internal resources to effectively manage and support this approach.

FDC Internal Capacity to Support Insourcing

Requirements for successful management of an insourced correctional health care system include internal subject matter expertise, readily available data on key system metrics, an effective management infrastructure, and understanding of program spending and cost drivers.

Subject Matter Expertise. The lack of in-house clinical and management experts in correctional health care is a primary factor motivating correctional systems to privatize their health care delivery systems. The FDC does not have this problem. Senior leadership in the Department's Office of Health Services (OHS) has extensive correctional health care management experience dating back to the period of FDC insourcing of health care, and has taken an aggressive, hands-on approach to monitoring contractor performance. Staff are well-versed in contemporary professional standards and best practices as prescribed by the National Commission on Correctional Health Care and the American Correctional Association.

On the clinical side, OHS employs a Chief of Medical Services, a Senior Physician, a Chief and Assistant Chief of Dental Services, a Chief of Mental Health Services with two Assistant Mental Health Chiefs, a Chief of Nursing Services, and a Chief of Pharmacy Services. The Department also has a Chief Clinical Advisor that serves as the final professional authority for clinical decisions.

The Department appears to have ample in-house management and clinical expertise to support an insourced delivery system.

³⁶ Pew Charitable Trusts.

Data. Modern health care systems rely heavily upon ready access to data to facilitate effective patient treatment and for use of performance analytics to more effectively manage system outcomes. This requires systemwide use of an Electronic Medical Record (EMR) system. Unfortunately, the FDC relies on a legacy system of non-integrated databases that do not communicate with each other, are cumbersome to use and maintain, and that falls far short of contemporary standards. This can impair treatment (e.g. lack of standardization of the record, issues with continuity of care) and quality reviews.

With an EMR, information required for quality reviews, statistics, and audit data could be easily gathered. Currently, due to the number of audits (e.g. American Correctional Association (ACA), legal settlement agreement monitoring) staff spend a great deal of time gathering information to provide to the auditors. This paperwork burden could potentially be reduced with an EMR. In addition, an EMR would allow for benefits such as easier scheduling, alerts regarding the need for follow up appointments, and medication specific protocols so that required laboratory examinations are not missed. The lack of an EMR would impair the effectiveness of any future insourced system, but also handicaps the Department in managing vendors in any type of outsourced model.

Under the current Centurion contract, the vendor has committed to developing a comprehensive EMR for the Department within its contracted annual budget of \$421 million for each of the next three years. This project will commence in June 2020 and should be completed by June 2022. Continued support and development of this project will be a key to future improvements in system performance and should be a top Department priority.

Management Infrastructure. The OHS has well-developed systems for oversight, policy development, and contract monitoring. The 18 staff assigned to contract monitoring could readily be reassigned to operational oversight and compliance in an insourced system. The Department's existing Quality Management (QM) program would also transition well to insourcing. The QM program supports ongoing reviews performed by institutional and regional staff to ensure efficient operations by the contractor. Activities include chart reviews of clinical functions such as chronic illness clinics, care reviews, medication/treatment administration, dental care, and mental health care; as well as site visits to monitor and assure proper health care system performance.

The Department also maintains a Behavioral Risk Management Team to provide operational stabilization and clinical integrity of the mental health delivery system. Multidisciplinary committees established at the institution, region, and statewide levels make recommendations for program service improvements, and evaluate corrective actions. It appears that the Department has ample administrative infrastructure to support management of an insourced system.

The primary administrative impact of insourcing would be in personnel management. The Department's Office of Human Resources would require 12 additional positions to support the hiring and personnel actions required to add and maintain over 2,000 new staff. This estimate is based on the increased workload across all areas of Human Resources and Staff Development and the number

of positions dedicated to these functions that were abolished after privatization. These staff would be assigned to recruitment, labor relations, classification, payroll, and staff development. The estimated annualized cost of these additional staff is \$774,371.

Exhibit 23: Additional FDC Human Resource Staff Required for Insourcing

Title	Duties	FTE	Salary/Benefit Annual Cost
Human Resource Specialist	Manage position movement, shift changes, supervisor changes and classification	1	\$ 67,086
Personnel Services Specialist	Labor/Employee Relations	1	\$ 59,546
Personnel Services Specialist	Recruitment	4	\$ 238,186
Personnel Technician III	Payroll	2	\$ 114,191
Research & Training Specialists	Staff Development	3	\$ 205,073
Human Resource Manager	Staff Development	1	\$ 90,288
TOTAL		12	\$ 774,371

Source: Florida Department of Corrections, Humans Resources Bureau

Insourcing could also potentially affect procurement workload, depending upon the approach taken by the Department in managing those contracts for off-site care that would still be required in an insourced model. The Department’s past practice of establishing and managing over 200 individual contracts for off-site services created substantial internal procurement and management workload. An alternative approach, centralizing coordination and management of off-site care under a single contract is discussed later in this analysis.

Budget Management. Lack of information on spending components and inadequate understanding of cost drivers is a significant risk faced by systems transitioning from an outsourced model to insourcing. While capitated models provide low risk and predictable funding requirements for clients, they do not typically offer any detail on their actual costs for the components of service they provide, such as outpatient treatment, hospitalization, and medication. This deprives correctional systems of detailed knowledge of the characteristics of their spending requirements.

However, the cost-plus model used in the current Centurion contract provides near total transparency on costs, as the Department reviews and approves every expenditure made by Centurion under the contract. This provides excellent data on spending trends and equips the Department with an understanding of projected costs in an insourced system.

Impact of Insourcing Inmate Health Care Performance and Cost

As the Department appears to have the internal capability to manage an insourced health care program, an argument can be made for insourcing as a superior model of service delivery if it provides improved performance and/or lower costs in the core functional areas of inmate health care: on-site facility health care services and treatment, off-site care, and pharmacy services.

Facility Health Care Services. The central element of the inmate health care services provided on-site is the health care staff who manage the program and provide treatment. As of July 2019, Centurion's staffing plan included 2,953.4 FTEs. The key dimensions of an analysis of the FDC's ability to transition to insourced inmate health care include staff retention and recruitment, staff resources requirements, and staffing costs.

Staff Retention/Recruitment. When a correctional health care vendor transition occurs, the employees of a prior vendor typically remain. If the state chose to insource, it is likely most current staff would prefer to remain. Anecdotal reports indicate that many current facility health care staff are former state employees who transitioned to working for vendors with the implementation of privatization. FDC management indicates that many of the staff would welcome an opportunity to return to state employment. Facility managers reported that staff have told them they would take a pay cut to return to state employment. State employment, particularly due to the health insurance and retirement benefits, appears to be an attractive option for at least some vendor staff. The Reception and Medical Center (RMC) in fact lost many medical staff when the first outsourcing occurred as state employees left to find employment in other state agencies.

However, the fact is that the vendor currently pays higher salaries than the state for many staff positions, and still has trouble competing with local hospitals and community health care providers in hiring staff. Centurion has particular difficulty in recruiting and retaining nursing and mental health staff. During our visit to Lowell Correctional Institution, we noted the facility staffing plan called for four psychiatrists and two psychiatric nurse practitioners. Instead the facility had two full time psychiatrists working on the inpatient program and one psychiatric nurse practitioner splitting time between the inpatient and outpatient programs.

The challenge of recruiting and retaining staff will be a significant concern in an insourced service delivery model. If insourcing appears a viable option, the FDC needs to devote significant attention to a strategy to address the issue of recruiting and retaining professional staff. Financial pay differentials and bonuses may be required to sustain required staffing levels. In addition, the FDC would require development of a sophisticated recruitment strategy that includes nursing schools, social media, and community job fairs. A major difficulty will be in hiring and maintaining qualified professional physician and psychiatric staff. Realistically, many of these positions will require salary levels well beyond what is available to a state employee. As a result, even under an insourced service delivery model, many of these positions will have to be contracted out to individual practitioners.

Staffing Levels. Current facility staffing levels have been determined by the current vendor, in consultation with the Department, as the number needed to enable achievement of the service level

and program outcomes required by the contract. A high level review of current facility staffing does not indicate any apparent opportunities to reduce employee levels, given the number of inmates served and the level of services required. To test this conclusion, we compared overall health care program staffing levels in Florida with national staffing trends.

A 2017 nation-wide review of health care staffing in state prisons documented a median staffing level of 40.1 FTEs per 1,000 inmates³⁷. The July 1, 2019 staffing plan for Centurion shows total contract staffing of 2,831.4 employees. Adding in OHS management and pharmacy staff of 168 positions, total correctional health care staffing in Florida is 2,999.4 staff. Based on the FDC's reported average daily inmate count of 87,032 for FY 2018-19 in state-operated facilities, this equates to 34.5 FTEs per 1,000 inmates in 2019, 14% below the national median number of FTEs per 1,000 inmates in prisons nationwide.

Correctional Medical Authority (CMA) audits for FY 2017-18 included 16 institutions with a total inmate population of 24,333.³⁸ These facilities had 16 physician positions. This equates to one doctor for every 1,520 inmates. CGL team member physicians, recognized as national experts in correctional health care, indicate a more typical ratio in most prison systems would be one doctor for every 800 inmates. CMA noted understaffing as a concern in their annual report as indicated by failure to follow up on diagnostic testing on a system wide basis, and recommended reviewing staffing levels for physical health staff including physicians, mid-level practitioners, and nursing staff as a possible cause of these failures.

Health care staffing is a complicated issue and the observations noted above are not conclusive regarding specific FDC staffing needs. However, a high level review shows no evidence of opportunities to reduce facility health care staffing under an insourced model. This is further supported by the increased staffing required of the Department under recent litigation to raise service levels to meet constitutional requirements. Prior to any change in service delivery models, the FDC should commission a detailed analysis of facility health care staffing to determine the level and composition of staffing required to meet performance expectations.

However, a transition to an insourced model would enable the elimination of many vendor administrative positions which are paid for under the contract. In most cases these positions either duplicate existing department OHS staff positions, have duties which can be absorbed by OHS, or would no longer be necessary. We reviewed Centurion regional and statewide administrative staffing and identified 37.5 statewide administrative positions that could potentially be eliminated under an insourced model:

	<u>FTE</u>
Statewide Dental Director	1.0
Regional Dental Director-Region I	0.5
Regional Dental Director-Region II	0.5

³⁷ Pew Charitable Trusts

³⁸ CMA

Regional Dental Director-Region III	0.5
Regional Dental Director-Region IV	0.5
Quality Management Program Director	1.0
Data Analyst	0.5
Administrative Coordinator	1.0
Administrative Assistant	2.0
Offender Based Information Specialist	1.0
Continuous Quality Improvement Program Director	1.0
Continuous Quality Improvement Program Coordinators	4.0
Pharmacy Director	1.0
Reentry Director	1.0
Regional Reentry Coordinators	4.0
Data Analyst	1.0
Administrative Coordinator	1.0
Administrative Assistants	7.0
Referral Specialist	3.0
Human Resource Administrator	2.0
Senior Human Resource Business Partner	1.0
Human Resource Business Partner	3.0

Elimination of these positions under an insourced service model would save an estimated \$3.2 million. We do note that some vendor administrative FTEs should be retained, including those assigned to the electronic medical record (EMR) project, Information Technology, Utilization Management, Health Education, Infection Control, and Regional Mental Health.

Staffing Cost. Assuming the same level of facility staffing as provided under the current contract, the cost to the state of these staff will change somewhat, given the FDC’s lower salary scale and higher benefit package. To determine the impact of such a change, using the payroll titles that were used by the FDC when it last insourced health care services, we attempted to convert existing vendor staff titles to comparable Florida state position titles. Using the midpoint of the pay grades as a salary assumption and applying the state’s benefit package for Career and Selected Exempt Service (SES) employee categories, we developed an estimate of the annual cost of the current facility vendor staff if converted to state employees. We then added a 2 percent differential to address potential issues of recruitment and retention in a competitive market for health care workers. We made a separate calculation for the cost of senior clinical positions such as psychiatrists on the assumption that these positions would have to be contracted out to meet market compensation levels.

The results of this analysis show a projected cost of insourced facility health care staffing of \$199.2 million. This compares to a Fiscal Year 2018-19 payroll and benefit cost for vendor staff under the Centurion contract of \$209 million. Adjusting the Centurion payroll amount to take out the administrative positions recommended for elimination reduces Centurion’s cost to \$205.7 million, approximately \$6.5 million or 3.3 percent above projected insourced costs for the same staffing plan. While this cost estimate will require further refinement, the level of cost difference is consistent with reports of the variance between vendor and state salary and benefit levels. The following tables summarize our projected cost of insourcing current vendor health care staff.

Exhibit 24: Projected Cost of Insourcing Facility Staff

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Medical					
Administrative Assistant	Secretary Specialist	67.0	\$ 28,303	\$ 40,541	\$ 2,716,253
Advanced Registered Nurse Practitioner	Advanced Practice Registered Nurse	80.8	\$ 67,502	\$ 96,691	\$ 7,812,595
Assistant Health Services Administrator	Executive Nursing Director	1.0	\$ 67,502	\$ 96,691	\$ 96,691
Clerk	Clerk Specialist	36.0	\$ 25,029	\$ 35,852	\$ 1,290,668
Director of Nursing	Executive Nursing Director	69.0	\$ 67,502	\$ 96,691	\$ 6,671,647
Registered Nurse Supervisor	Registered Nurse Supervisor	20.0	\$ 67,502	\$ 96,691	\$ 1,933,811
Health Support Aide	Health Support Aide	45.0	\$ 24,282	\$ 34,781	\$ 1,565,158
Licensed Practical Nurse	Licensed Practical Nurse	348.6	\$ 35,330	\$ 50,607	\$ 17,641,445
Medical Technician	Health Support Technician	282.5	\$ 28,303	\$ 40,541	\$ 11,452,859
Health Information Specialist	Health Information Specialist	1.0	\$ 37,000	\$ 52,998	\$ 52,998
Medical Director	Medical Executive Director	92.2	\$ 155,854	\$ 223,246	\$ 20,583,249
Medical Records Clerk	Clerk Typist Specialist	88.4	\$ 26,049	\$ 37,313	\$ 3,298,452
Medical Records Supervisor	Health Information Systems Supervisor	59.0	\$ 38,217	\$ 54,742	\$ 3,229,798
Assistant Director of Nursing	Registered Nurse Supervisor	15.0	\$ 67,502	\$ 96,691	\$ 1,450,358
Registered Nurse Educator	Registered Nurse	1.0	\$ 45,039	\$ 64,513	\$ 64,513
Registered Nurse-Infusion/Chemotherapy	Registered Nurse Specialist	3.0	\$ 56,185	\$ 80,479	\$ 241,437
Emergency Medical Technician	Health Support Specialist	1.0	\$ 33,628	\$ 48,169	\$ 48,169
Respiratory Therapist	Respiratory Care Specialist	4.2	\$ 43,401	\$ 62,167	\$ 261,101
Laboratory Technician	Laboratory Technician	4.0	\$ 30,878	\$ 44,230	\$ 176,920
Clinical Risk Manager	Clinical Associate	1.0	\$ 63,635	\$ 91,150	\$ 91,150
Lead Inventory Coordinator	Clerk Specialist	4.0	\$ 25,029	\$ 35,852	\$ 143,408

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Nurse Manager	Registered Nurse Supervisor	7.0	\$ 67,502	\$ 96,691	\$ 676,834
Registered Nurse/CQI	Registered Nurse	372.5	\$ 45,039	\$ 64,513	\$ 24,031,155
Secondary Screener	Clerk Specialist	10.0	\$ 25,029	\$ 35,852	\$ 358,519
Executive Nursing Director	Executive Nursing Director	1.0	\$ 67,502	\$ 98,284	\$ 98,284
Hospital Administrator	Program Administrator	1.0	\$ 79,624	\$ 114,053	\$ 114,053
Infection Control Nurse	Advanced Practice Registered Nurse	1.0	\$ 67,502	\$ 96,691	\$ 96,691
Phlebotomist	Med Tech 1	4.0	\$ 37,000	\$ 52,998	\$ 211,993
Resp. Therapist Supervisor	Resp. Care Specialist	1.0	\$ 43,401	\$ 62,167	\$ 62,167
Registered Nurse-CQI- Medication Practice	Registered Nurse	1.0	\$ 45,039	\$ 64,513	\$ 64,513
Scheduler	Clerk Specialist	6.0	\$ 25,029	\$ 35,852	\$ 215,111
Transcriptionist	Clerk Typist Spec.	2.0	\$ 26,049	\$ 37,313	\$ 74,626
	subtotal	1,630.2			\$ 106,826,627
Mental Health					
Advanced Registered Nurse Practitioner/Physician Assistant- Mental Health	Advanced Practice Registered Nurse	32.70	\$ 67,502	\$ 96,691	\$ 3,161,781
Behavioral Health Activity Technician	Behavioral Specialist	44.00	\$ 48,894	\$ 70,035	\$ 3,081,556
Certified Nursing Assistant - Mental Health	Medical Technician 2	34.80	\$ 38,839	\$ 55,632	\$ 1,936,009
Mental Health Clerk	Clerk Specialist	96.40	\$ 25,029	\$ 35,852	\$ 3,456,122
Mental Health Director	Psych I Services Director	16.00	\$ 80,584	\$ 115,429	\$ 1,846,859
Mental Health Licensed Practical Nurse	Licensed Practical Nurse	68.20	\$ 35,330	\$ 50,607	\$ 3,451,367
Mental Health Professional	Human Services Counselor	290.60	\$ 41,036	\$ 58,780	\$ 17,081,606
Mental Health Registered Nurse	Registered Nurse Specialist	100.80	\$ 56,185	\$ 80,479	\$ 8,112,286

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Mental Health Administrator	Program Administrator	1.00	\$ 79,624	\$ 114,053	\$ 114,053
Mental Health Assistant Director of Nursing	Senior Registered Nurse	4.00	\$ 67,502	\$ 96,691	\$ 386,762
Mental Health Director of Nursing	Registered Nurse Supervisor	4.0	\$ 67,502	\$ 96,691	\$ 386,762
Reentry Specialist	Human Services Counselor	29.70	\$ 41,036	\$ 58,780	\$ 1,745,780
<i>Mental Health subtotal</i>		722.20			\$ 44,760,944
Dentist	Dentist	72.35	\$ 105,214	\$ 150,709	\$ 10,903,786
Dental Assistant	Dental Assistant	126.75	\$ 29,505	\$ 42,264	\$ 5,356,901
Dental Hygienist	Dental Hygienist	26.50	\$ 37,000	\$ 52,998	\$ 1,404,454
<i>Dental subtotal</i>		225.60			\$ 17,665,141
Infection Control	Registered Nurse Specialist	4.0	\$ 56,185	\$ 80,479	\$ 321,916
Dental Director North	Senior Dentist	1.0	\$ 111,646	\$ 159,921	\$ 159,921
Dental Director South	Senior Dentist	1.0	\$ 111,646	\$ 159,921	\$ 159,921
Regional Director of Nursing	Executive Nursing Director	4.0	\$ 67,502	\$ 96,691	\$ 386,762
Electronic Health Record Project Manager	Program Administrator	1.0	\$ 79,624	\$ 114,053	\$ 114,053
Electronic Health Record Liaison	Health Information Specialist	2.0	\$ 37,000	\$ 52,998	\$ 105,997
Electronic Health Record Information Technology/Offender Based Information System Specialist	Health Information Specialist	4.0	\$ 37,000	\$ 52,998	\$ 211,993
Information Technology Support Specialists	Government Operations Consultant	4.0	\$ 59,119	\$ 84,683	\$ 338,730
Information Technology Support Lead	Government Operations Consultant	1.0	\$ 64,687	\$ 92,658	\$ 92,658

Contract Title	State Title	FTEs	State Salary	Salary + Benefits	State Cost
Regional Director of Nursing – Mental Health	Executive Nursing Director	1.0	\$ 67,502	\$ 96,691	\$ 96,691
Mental Health Nurse Educator	Registered Nurse Specialist	1.0	\$ 56,185	\$ 80,479	\$ 80,479
Mental Health Educator	Reg. Mental Health Consultant	1.0	\$ 80,584	\$ 115,429	\$ 115,429
Nurse Educator	Registered Nurse Specialist	1.0	\$ 67,502	\$ 96,691	\$ 96,691
Administration subtotal		31.0			\$ 2,744,531
TOTAL		2,609.0			\$ 171,997,243

Professional Contract Positions Required Under Insourcing

State Title	FTE	Contract Salary	Cost
Optometrist	9.0	\$ 165,605	\$ 1,490,445
Physician	16.2	\$ 253,625	\$ 4,108,725
Orthopedic Surgeon	1.0	\$ 299,048	\$ 299,048
Psychiatric Director	1.0	\$ 317,408	\$ 317,408
Psychiatrist	23.1	\$ 317,408	\$ 7,332,125
Psychologist	46.6	\$ 165,605	\$ 7,717,193
Psychology Intern	4.0	\$ 76,616	\$ 306,464
Residents	4.0	\$ 110,325	\$ 441,300
Regional Psychiatrist	1.0	\$ 431,453	\$ 431,453
Regional Psychologists	4.0	\$ 165,605	\$ 662,420
Regional Psychologists - Sp. Projects	1.0	\$ 165,605	\$ 165,605
Total Contracts	110.9	\$ 440,840	\$ 23,272,186

State Employee & Contract Position Costs	\$195,269,429
Total State Insourcing Cost for Personnel	\$3,905,388
Total State Insourcing Cost for Personnel	\$199,174,817

Pharmacy. Insourcing would entail no change in pharmacy services as the Department already manages this function. Based on past attempts to privatize, insourcing is the most cost-effective means to provide the service.

Off-site care management. Coordination and management of off-site care was a substantial challenge for the Department when the system was insourced. A 2005 performance review of the Department found the following and recommended that the Department contract out management of all off-site care to a professional managed care firm³⁹:

- Office of Health Services (OHS) staff managed over 170 major contracts
- Most contracts were with providers with long-term relationships with the Department, were exempt from bidding, and were renewed annually
- Staff were primarily oriented toward maintaining service levels, not necessarily toward holding contractors accountable
- Contract terms did not provide adequate monitoring terms or performance measures
- Monitoring of contractor performance by regional staff was perfunctory
- Contractor invoices were generally processed by clerical staff without meaningful review

OHS managers acknowledged the system of contracting and coordinating off-site care used by the Department was cumbersome to administer and did not achieve effective performance. Insourcing management of off-site care using this same system would defeat the purpose of increasing operational efficiency.

A 2017 study of this issue by the consulting group North Highland projected that in the event of insourcing, a restoration of the Department's former status quo method of managing contracts for off-site care would likely increase costs by 20 percent. In order to maintain costs at the more efficient level achieved under the outsourced health services contract, North Highland recommended that the Department contract with a managed care organization such as a Preferred Provider Organization (PPO) or Third Party Administrator (TPA).

Health care network administration and these related functions are not a core competency of correctional systems. These are complex functions that require a high degree of technical expertise in a very specific field to perform well. This is a classic example of specialized work that can be performed more efficiently by private organizations with appropriate skillsets and experience. Serious consideration of any insourcing scenario should incorporate outsourcing of off-site health care services to achieve maximum efficiency.

³⁹ MGT of America, Performance Review of the Florida Department of Corrections, 2005.

In this approach, the correctional system contracts with outside health care or insurance company to manage its offsite care network for a flat, fixed fee per inmate on top of actual utilization. The PPO or TPA would then administer the Department's hospital and specialty provider network, provide claims adjudication and processing, conduct utilization management reviews, and develop data analytics on network performance.⁴⁰ Network efficiencies and negotiated discounts could more than offset the cost of the contract. This approach has been used successfully in the Virginia Department of Corrections.⁴¹ Based on the North Highland analysis, this approach should enable the Department to maintain offsite care costs at approximately the same level as now experienced under Centurion management.

Administration. Given the history of OHS with insourced system management and the experience of the current senior management, the reconfiguration of its responsibilities from a policy direction/contract monitoring role, to insourced system manager can be accommodated with existing resources, augmented by select retained vendor administrative positions and contracting out for offsite care management. This approach will require ongoing investment in development of internal management resources.

Custody Support. Whether the medical program is insourced or outsourced, effective provision of correctional health care services requires support from across FDC operations. While correctional officer staffing levels present many serious issues across the entirety of FDC operations, shortfalls in staffing can have a serious impact on access to care. As of November 4, 2019, the FDC had 2,305 correctional officer vacancies, placing severe stress on operations in nearly all its facilities. The project team's limited review of FDC facility operations indicated that the availability of correctional officer staff to escort inmates to treatment is a significant issue. The demand on staffing for outside transportation can also be substantial. For example, movement and supervision of severely mentally ill offenders in need of hospitalization requires the assignment of three officers, 24 hours per day, seven days per week. Facility administrators and staff appear to appropriately prioritize custody support for health care but are handicapped by chronic shortages in correctional officer staffing.

Technology. Telemedicine has huge potential application in the FDC, particularly in the delivery of psychiatric services. However, while telepsychiatry is available, there are limitations in availability. Many facilities have network bandwidth problems that severely limit telemedicine capacity. For example, at Lowell Correctional Institution, the technology to allow for the provision of telepsychiatry was available for outpatient treatment only. Staff at the facility were unable to utilize telepsychiatry on the inpatient units due to technology infrastructure issues.

The FDC should augment its cable and wiring infrastructure to accommodate a robust telemedicine program. This type of upgrade will be needed to support the electronic medical record (EMR) system as well. Some of the advantages of an EMR going forward will be expedited electronic submission of

⁴⁰ North Highland, Health Services Study of the Florida Department of Corrections, FY 2017-18, 2017.

⁴¹ Stephen Weiss, "Medical Care Provided in State Prisons – Study of the Costs," Joint Commission on Health Care, October 5, 2016, at <http://jchc.virginia.gov/4>. Medical Care Provided in State Prisons CLR.pdf

medical orders, improved accuracy and access to patient records, and monitoring of the delivery of health care services statewide. There will also be potential operational efficiencies as clinicians and nurses directly enter data into the system instead of handing off encounter forms to a data entry operator/medical records clerk. Again, this is an issue that should be addressed irrespective of the future service delivery model adopted by the Department.

Implementation. The timeline for actual implementation of a transition to insourcing needs to address the short-term transition of current vendor staff to state employment as well as development of a long-term strategy to address the long-term challenge of recruiting and retaining health care staff in a competitive labor market.

Assuming that most vendor staff would transition to state employment if offered, FDC Human Resource staff indicate that the hiring and onboarding of these employees would take approximately 60 days. This process would entail establishing standardized selection criteria and guidelines for each position title, verifying staff credentials and conducting background checks. The Department would bring on six temporary Personnel Technicians to facilitate the transition at a one-time projected cost of \$238,794.

The next phase in the implementation process would be filling remaining vacant positions, which will require an aggressive recruitment campaign using Jobs.myflorida.com, colleges and universities job placement programs, social media advertising/ Indeed.com, and regional/local job fairs. The final step would be development of a long-term strategy to address future recruitment and retention issues.

Planning an effective approach to address recruitment and retention is the biggest challenge facing the FDC in the implementation of insourcing. In the past, the Department has experienced issues in keeping health care positions filled and attracting a stable pool of applicants. Vendors have experienced the same issues. A transition to insourced health services will require an intensive review of possible strategies to address this issue over an extended time period. While the FDC has successfully managed transitions from insourced to outsourced services and multiple transitions to different vendors without serious operational disruptions, a change to an insourced service delivery model will require more intensive preparation to assure successful implementation.

Cost-Effectiveness. This analysis has examined the impact of insourcing on the primary components of the inmate health care delivery system. To summarize, insourcing appears to reduce staffing costs by \$3.3 million through eliminating vendor administrative positions and \$10.4 million by converting contract positions to state employees. With the use of a contracted provider to manage off-site care, costs for these services should be equivalent to the level experienced under Centurion. Pharmacy costs would remain unchanged. The Department already pays the actual costs of ancillary items such as laboratory expenses, supplies, and equipment, under the current cost-plus contract and these expenses would remain unchanged. The administrative burden of hiring and retaining over 2,000 new staff would create additional ongoing human resource expenses for the Department, totaling \$774.3 thousand along with a one-time cost of \$238.8 thousand to manage the initial hiring/transition process.

The final and most significant savings element associated with in-sourcing is elimination of the administration/profit fee paid annually to the vendor. The rate for this fee under the contract is set at 11.5 percent of reimbursable expenses, which are essentially the direct expenditures for service on behalf of the FDC. The FDC is reimbursed for direct expenditures for service and pays a fee in the amount of 11.5 percent of these expenses to the vendor to cover overhead and profit. The administrative/profit fee paid against Centurion’s contract for Fiscal Year 2018-19 totals \$37.3 million. Insourcing eliminates this expense.

In summary a transition to an insourced model of inmate health care delivery could reduce FDC annual spending by \$46.2 million.

Exhibit 25: Projected Savings Impact of Insourcing

	\$ millions
Elimination of Vendor Administrative positions	\$ 3.2
Convert Vendor positions to state employees	\$ 6.5
Eliminate vendor administration/profit fee	\$ 37.3
Additional HR costs	\$ (0.8)
Total Savings	\$ 46.2

Source: CGL analysis

The FDC has the internal capability and expertise to manage inmate health care delivery. Insourcing the delivery of on-site facility health care serviced throughout the correctional system is feasible, although the FDC would face substantial challenges in recruiting and retaining staff. The Department, however, would require substantial improvement in management of off-site care. This could be accommodated by contracting with an insurance company or health care organization to manage all off-site care, utilization review, and claims management for the FDC. The resulting approach would move the FDC closer to a hybrid insourcing/outourcing model.

Outsourcing

As described earlier, the FDC has experimented with a variety of different approaches to outsourcing over the last eighteen years. Early efforts to use outsourcing to drive health care costs lower appear to have had some success, but also produced substantial problems in service delivery, including reduced staffing levels, dramatic decreases in episodes of outside care; increases in health care grievances; and a proliferation of litigation.

These performance issues have been addressed in more recent contracts. However, growth in program spending has accelerated. The overall utility of outsourcing as a future service delivery model for the Department depends upon achieving a balance between efficiencies in cost management and adequate program quality.

FDC Internal Capacity to Support Outsourcing

Effective management of an outsourced health care system requires that a correctional system take a pro-active stance toward accountability and oversight of the vendor. The FDC over the course of its experience with privatization has developed a sound management infrastructure for outsourcing.

Components of this infrastructure include:

- Policies – the Office of Health Services has a comprehensive set of policies, bulletins, and procedures to provide clear direction to a vendor on the expectations and parameters for health care delivery.
- Contract – the outcome-based format of the contract establishes clear standards and metrics that directly relate to policies and service quality objectives.
- Monitoring – FDC monitoring teams and protocols provide a ready means to assess vendor performance and enforce contract terms. Its QM program provides clinical reviews of service delivery systems and outcomes. Department monitoring is also supplemented by external reviews of service delivery by the Correctional Medical Authority.

The FDC, both through the Office of Health Services and its administrative bureaus, supports effective use of outsourcing. The one notable area of need is timely access to data documenting program activity and performance. The lack of an electronic medical record (EMR) system hampers management access to quality reviews, statistics, and audit data and requires a labor-intensive process to gather data for review. The plans for EMR development under the current contract with Centurion will ultimately address this need.

Outsourcing Impact on Cost and Performance

The impact of outsourcing on health care service cost and quality depends upon the outsourcing model employed. The FDC has used both risk-based and cost-plus models in its history with privatization. This analysis first examines the impact of the current outsourcing model.

Cost. The FDC's current contract with Centurion follows a cost-plus model. The Department reimburses Centurion for direct health care costs up to a designated cap, including staffing, and pays the vendor a fee to cover its overhead and profit. The contract has recently been amended to provide a three-year extension at an annual funding cap of \$421 million for each of the contract years. As described earlier, the increase in funding for FY 2019-20 covers over 460 additional staff required to comply with the terms of recent litigation, maintenance of current staffing and service levels, an 11.5 percent administrative fee, and development of an EMR system.

After several years of significant increases in health care spending, the FDC is now assured of annual contract spending that will remain stable at no more than \$421 million for each of the next three years. The contract will not entail any additional administrative workload or cost on the Department. Other than additional potential costs associated with litigation and increased costs for

pharmaceuticals, the Department should experience relatively constant overall health care costs under this contract through FY 2021-22.

Exhibit 26: Actual and Projected Cost-Plus Health Care Annual Contract Caps, FY 2017-2022
(\$ millions)

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	Average Annual Increase
Centurion Contract Cap	\$321	\$375	\$421	\$421	\$421	6.2%

Source: Florida Department of Corrections

Performance. Service quality levels attained under this contract approach should be comparable to the Department’s experience with Centurion over the last two years. This experience has been relatively positive, particularly when contrasted with the FDC’s experience with prior contractors. Central office and facility administrators indicated improvements in service have been achieved under the cost-plus model. This is a feature of the cost-plus approach, in that the vendor has no incentive to reduce services to lower costs and manage risk. Any additional costs that may be incurred to achieve required service levels are simply passed on to the client. However, there are two areas where modifications in the model could facilitate improved service quality, staffing and performance measurement.

Maintaining adequate facility staffing levels is a critical component of health care service quality. Most cost-plus contracts make detailed facility staffing plans part of the contract and monitor vacancy levels. The FDC contract with Centurion is somewhat unique in that it does not specify or require monitoring of facility staffing levels. As an outcome-based contract, in the current model vendor performance is assessed solely based on program results. This assumes that these performance measures completely convey the quality of vendor services provided.

The impact of staffing levels on services however is so significant that it arguably should be tracked, and the vendor held accountable for providing agreed levels. This can be seen in recent consent decrees entered by the Department where the plaintiffs have required that the Department add specific numbers and types of staff to facilities, rather than only require attainment of specific outcome measures.

A reliable facility health care program that consistently produces good results requires a stable cadre of full-time professional staff. Vacancies need to be filled in a timely manner. However, under the Department’s current cost-plus approach, the vendor may choose to use registry, temporary contract, or locum tenens staff to fill vacancies for extended periods of time rather than recruit and hire permanent replacements. This has an impact on service quality, as temporary staff do not generally provide the same level of performance. Additionally, under this approach costs are typically higher than hiring replacement staff. Tracking and holding the vendor accountable for compliance with an agreed staffing plan would provide the department with an additional, valuable tool for managing vendor performance.

Another approach to improving vendor performance under the cost-plus model would be to shift the focus of the current contract measures away from process or compliance measures, to more qualitative metrics. Internal monitoring should be linked to the quality management program. FDC monitoring teams are now attempting to evaluate identified problems and to train staff so that there can be improvement. Many health care organizations are utilizing lean manufacturing and six sigma techniques in their quality improvement programs. The California prison system has a robust six sigma and quality improvement program utilizing these techniques.

The following compliance monitoring items should be considered in addition to current compliance questions.

- Percent of all types of scheduled appointments (nurse sick call, physician on-site appointments, off-site consultations and diagnostic testing, dental appointments, mental health appointments, mental health programming) kept with reasons for no show
- Time to triage health service requests
- Time to nursing assessment appointments for health service requests
- Percent of patients who require nurse sick call for a health request and who are evaluated within 72 hours
- Percent of ordered doses of medication that patients receive in a timely manner
- Percent of patients who failed to receive their first dose of ordered medication within 24 hours of the order
- Percent of patients who failed to have intake screening done within 24 hours
- Percent of patients who failed to have intake physical examination within a week
- Number and percent of patients who missed intake screening
- Percent of patients in need of screening who obtained tuberculosis screening
- Percent of patient admitted to infirmaries who have an nurse intake note within two hours of admission
- Percent of patients admitted to infirmaries who have a provider admission note within 24 hours and have a discharge summary completed the day of discharge
- Percent of off-site diagnostic test results and consultation reports that are scanned to the record within 3 business days
- The number and percent of patients who failed to meet time tables for specialty care appointments as determined by clinical necessity

- The number and percent of urgent appointments occurring within 14 days and routine appointments occurring within 45 days
- Percent of patients who receive immunizations as indicated by the Advisory Committee on Immunization Practices (ACIP)
- Percent of patients with diabetes who have hemoglobin A1c at 7 or below (considered good control)
- Percent of patients with diabetes who have hemoglobin A1c above 9 (considered poor control)
- Percent of patients with hypertension who have blood pressure controlled below 140/90
- Percent of diabetics who have an annual eye examination
- Percent of diabetics who are annually screened for nephropathy (with micro-albumin)

Compliance measures can be displayed on a shared intranet as a dashboard as is done in California.⁴² Dashboards are a concise display of compliance type process measures that are a component of the quality program. Integrated into the electronic record system, this approach will free up quality improvement and monitoring time for other purposes.

One additional quality monitoring function should include safety/sanitation/administrative checklist tours that verify that every institution has adequate clinical space, supplies, equipment, and sanitation. These rounds can result in scoring and corrective action plans.

A second additional function of the quality management program is to institute clinical quality review. Almost all physician care at the institutions is primary care. Board certified primary care physicians⁴³ (or at a minimum, physicians who completed residency training in primary care) should perform clinical quality record reviews. These should include mortality reviews, sentinel event reviews, and potentially preventable hospitalizations. Health organizations nationwide, including the Mayo Clinic, have robust mortality review processes that assist in improvement of clinical care and process improvement.

Nursing reviews should also be performed for potentially serious complaints on health requests; for emergency evaluations; and for care on the infirmary unit.

These clinical quality reviews should have an aim of identifying opportunities for improvement and detection of systemic errors. These reviews can also provide professional performance evaluations (peer review). The clinical quality reviews and compliance monitoring should be incorporated into

⁴² The California prison dashboard can be found at <https://cchcs.ca.gov/reports/#dashboard>

⁴³ A primary care physician is a physician who completed residency in internal medicine or family practice. In some cases physicians who completed residency in emergency medicine is adequate.

the quality improvement program. The program should track the number of clinical quality reviews that result in identification of opportunities for improvement.

A process improvement strategy like the lean manufacturing or six sigma model would provide the data needed by the quality management team to reduce cost and improve quality.

Alternative Approaches to Outsourcing. The primary alternative to the cost-plus outsourcing model is the capitated approach in which the vendor is paid at a per diem rate per inmate to manage all health care services. This approach shifts all financial risk to the vendor and has the greatest potential for achieving cost savings as it incentivizes the vendor to maximize efficiency in order to achieve profits. In fact, the primary basis for the Department's initial adoption of an outsourcing model was potential cost savings. The capitated contract approach used by the Department in its initial approach to outsourcing was entirely consistent with this goal.

Impact of Capitation on Cost. A change to a capitated model could reduce costs if potential vendors in the market perceive an opportunity to leverage their expertise to achieve efficiencies in service delivery. The two primary areas to achieve potential efficiencies with a significant impact on cost are staffing and off-site services. Due to the transparency of the Department's current cost-plus contract, current levels of expenditures in these areas is readily available.

Fiscal Year 2018-19 expenditures for staff salary and benefits under the Centurion contract totaled \$209 million. This amount will increase with the additional staff provided in the FY 2019-20 budget to address litigation requirements. Comparisons with national data on health care staffing suggests that current facility health care staffing levels are below levels maintained in other states.⁴⁴ Our high-level review on facility staffing plans and onsite operational reviews provided no indications of excess or inefficient use of staff in the system.

Under a capitated approach, the vendor can reduce staffing costs by eliminating positions, leaving vacancies open, or reducing compensation and benefits levels. Eliminating positions and keeping vacancies open directly reduces services, while lowering compensation levels would exacerbate issues in maintaining adequate staffing. None of these measures is advisable and all would likely have a very negative impact on service quality. In fact, any shift to a capitated outsourcing model would likely need to be accompanied by strong contract monitoring provisions that provide a means to hold the vendor accountable for maintaining required staffing levels. Accordingly, significant cost savings from current contract levels in the area of facility staffing levels are unlikely in a change to a capitated approach.

Off-site health care services under the Centurion contract totaled \$109 million in FY 2018-19. Approximately 52 percent of this amount was for inpatient hospitalization, 23 percent for outpatient services, 14.6 percent for specialist care, and 4.9 percent for emergency room treatment. While

⁴⁴ Pew Charitable Trusts

Centurion does provide utilization and invoice review, the fact that these costs are simply passed through to the FDC indicates at least a potential for an incentivized vendor to identify savings.

There are no studies of the relative impact on health care costs in correctional systems of a cost-plus versus capitated approach to off-site care management. However, there has been substantial research on the impact of managed care programs compared to fee-for-service plans under Medicaid, which is in many respects analogous to the capitated health care program management versus the cost-plus model. One meta-review of the research on this topic found that managed care plans in 24 studies showed savings ranging from 1 percent to 20 percent from fee-for-service plans.⁴⁵

The median of the savings identified in these studies is 10.5 percent. Applying this rate of savings to all the off-site care paid for under the Centurion contract in FY 2018-19 results in potential savings under a capitated model of \$11 million. How much of the savings achieved under the contract are passed back to the client versus retained as profit is an open question. Assuming the vendor passed 50 percent of the savings achieved back to the client, this model could achieve a potential cost reduction of \$5.5 million.

Impact of Capitation on Service. The risk assumed by the vendor in the capitated model places added stress on service quality. Adverse utilization experience or cost exposure incentivizes reduction in services to mitigate the negative financial consequences for the vendor. This describes much of the FDC's experience with capitated health care outsourcing from 2001-2017. While privatization provided costs savings in the short-term under the capitated model, vendors were unable to provide consistent service that met contract performance standards at the funding levels they had bid. This led to a turbulent period of vendor appeals for additional funding, contract terminations, and multiple vendor transitions. For its part, the FDC experienced reduced facility staffing levels, reduced access to off-site care, increased inmate grievances regarding health care services, and ultimately significant costly litigation.

To avoid this scenario, any change in outsourcing approaches needs to be accompanied by a very robust system of contract monitoring, thorough vendor understanding of program service requirements, and a realistic sense of program funding needs. The capitated Wexford and Corizon contracts which the FDC entered in 2013 produced substantial cost savings, but also had a pronounced negative impact on service quality. Future outsourcing initiatives need to balance these objectives.

Impact of Modified Contract Terms. An alternative to cost-plus or capitated models is to incorporate cost containment mechanisms into the current framework. The Department's current cost-plus contract does include an overall cost containment measure in the annual cap that it places on total compensation to the vendor. This provides the Department with certainty regarding overall contract expenditures. Additional cost containment measures commonly found in correctional health care contracts are variations on approaches to lower vendor risk. If the vendor is responsible for managing

⁴⁵ The Lewin Group, Medicaid Managed Care Cost Savings: A Synthesis of 24 Studies. Prepared for America's Health Insurance Plans, (March 2009).

all health care costs, as under the capitated model, they typically must include a substantial risk premium as insurance against adverse experience. By sharing or reducing this risk, states can reasonably expect lower per diem cost proposals. Vendors can effectively price the more routine care and will not build in the additional cost to cover the major cases that might occur. Common approaches to mitigating vendor risk include:

- Stop Loss – Require the vendor to cover off-site care costs subject to a stop-loss cap, either on a per case basis or in aggregate. This eliminates the risk premium that vendors must build in to cover catastrophic losses and shifts risk to the state. In effect the state self-insures the vendor.
- Shared Risk – The vendor and the Department establish a framework for sharing off-site care costs above a certain threshold, typically on a per case basis. For example, the vendor may be 100 percent responsible for care up to \$50,000 per case, share 50 percent of the cost up to \$100,000, and the state assumes responsibility for costs above \$100,000. This approach diminishes vendor risk on an escalating scale, while preserving some incentive for their management of costs up to a catastrophic level.
- Condition Exemptions – Many states will exclude the cost of care for certain treatments or conditions to reduce vendor risk. Common exemptions include the cost of treatment of HIV/AIDS, Hepatitis C, hemophilia, or organ transplants.

These approaches all entail a trade-off in the price reduction to the state realized through reducing vendor risk and the increased cost to the state in assuming some level of responsibility for catastrophic or high treatment cost cases. The projected impact of any of these measures on cost relies upon how vendors use these provisions in pricing their services in a competitive bid process. Any cost savings again would accrue only to the off-site care expenses covered under the contract. A further 5 percent reduction in the contract price covering off-site care would lower up-front contract costs to the Department by an additional \$5.5 million. These savings would be offset at least to a partial degree, depending upon the level of shared financial risk assumed by the Department.

Implementation. The Department has signed a contract extension with Centurion that covers the next three years, through FY 2021-22. Adopting a new outsourcing model would require development of an ITN or RFP, evaluation of responses, and negotiation of a contract. Based upon the Department's experience with the ITN process, the entire process to select a vendor under a new outsourcing model could take approximately 12 months, allowing time for ITN development, solicitation, evaluation, negotiation, and rebidding if necessary. At the same time, the Department would provide Centurion with notice of intent to terminate the contract, a minimum of 60 days.

Outsourcing Competitive Environment. Outsourcing works best in a procurement environment where there is ample competitive pressure on potential bidders to produce better quality proposals at lower prices. Competition is unfortunately limited in Florida. The high degree of financial risk makes attracting enough bidders to facilitate a competitive environment extremely difficult. This degree of risk also makes the use of capitated contracts a strong disincentive for potential vendors.

In its ITN process, the Department made multiple attempts to attract additional vendors in order to create competition on price and service level for a capitated outsourcing model. The process culminated in only one vendor proposing to contract with the Department to provide its required services. Further, that vendor required the Department to adopt a cost-plus model to minimize its risk exposure.

There are few vendors who can provide services on the scale required by FDC, which also diminishes competition. Nationally, there are only three vendors that have managed entire state correctional health care systems: Centurion, Wexford, and Corizon. The FDC has substantial negative experience with both Corizon and Wexford. Centurion was the only responsive bidder to the FDC's most outsourcing procurement. This level of vendor interest makes obtaining competitive proposals unlikely.

Based on this experience, any discussion of alternative approaches to outsourcing appear to be hypothetical. The size of the system, the level of risk inherent in assuming responsibility for cost and service management, and the very limited number of vendors capable of delivering this service diminishes competition to a level where the benefits produced by outsourcing are substantially reduced.

The current cost-plus approach appears to be the only means available to the FDC to privatize on a system-wide scale. Efforts to achieve savings by instituting shared risk provisions or stop losses in a future contract will likely result in higher vendor cost proposals as they factor increased risk into their budgets. Because there is no competition for this contract, the FDC has little choice but to accept the current contract approach if it wants to continue to use outsourcing. By most reports, the current vendor is performing reasonably well, and quality of care has improved under the current cost-plus contract. However, this approach to privatization does not incentivize efficiency and requires the FDC pay a significant administration/profit to the vendor in addition to paying all direct costs.

Hybrid Systems

Because there are several different forms of hybrid systems, it is important to define the form to be reviewed here. As described earlier, the FDC in effect has always operated a hybrid system. During that time where the Department provided on-site services with a largely state employee workforce, it still maintained an extensive network of contracts for off-site care. In this report, we have defined this approach as a form of insourcing. Similarly, the current service model is a hybrid in that the Department manages its substantial pharmacy program with state employees while contracting for all other services. In this report, we have defined this approach as outsourcing.

As used here, a hybrid system refers to an approach where the Department manages some facilities with state employees and their own network of off-site contracts, while also outsourcing other facilities in the correctional system to vendors that provide comprehensive health care services. The Department in effect used this approach during that time in which Region 4 health care services were outsourced while all other facilities provided services with FDC employees.

Cost. The primary factor in favor of a hybrid approach is the fact that smaller contracts, centered on a region or facility, should be more manageable for smaller firms than a large statewide contract, and therefore may attract more competition, which should have a favorable impact on price and service quality. The counter-argument is that the smaller contractors that bid on these contracts may lack the economies of scale to achieve efficient procurement of services such as pharmaceuticals. Moreover, the smaller population bases of these contracts provide less margin against risk of catastrophic cases. The cost of high cost cases may be better managed against a larger population base in order to spread the risk across a broader revenue base.

There is very little research on the cost performance of this hybrid model versus more conventional insourcing and outsourcing approaches. The one study that has been conducted examined the cost performance of privately contracted health care for correctional facilities relative to state-provided healthcare in the Virginia correctional system. Approximately 50 percent of the state's prison population is housed in facilities that receive outsourced health care services from two vendors, Armor Correctional Health Services and Mediko Correctional Healthcare. Outsourcing was used for these facilities primarily because of their specialized mission, providing intensive, specialized health care services such as dialysis, advanced infirmary care, and specialized behavioral health services.⁴⁶ Because of these services, these facilities require larger numbers of more specialized health care professionals. The Virginia Department of Corrections used a capitated outsourcing model in contracting for all health care services in these facilities.

The Virginia Joint Legislative Audit and Review Commission conducted a sophisticated statistical analysis of correctional health care spending over three fiscal years in outsourced and insourced Virginia Department of Corrections facilities, controlling for inmate demographics including age and race, as well as health characteristics such as mental health status and chronic disease diagnoses. The analysis found no evidence that outsourced facilities had lower costs for inmate health care than facilities that provided services with Virginia Department of Corrections staff. Insourced facilities in a hybrid system experienced the same levels of health care cost as the outsourced facilities.⁴⁷

Applying the results of this study to Florida, a hybrid system which relies both on insourced and outsourced capitated health care can be expected to have a cost profile in which contracted facilities have the same level of cost as insourced facilities. With no difference in cost between outsourced and insourced facilities, the system would in effect have the same overall cost as an entirely insourced model. Our previous analysis showed that insourcing would provide approximately \$46.2 million in savings from the current cost-plus model used by the FDC. The Virginia study of health care costs in that state's correctional system suggests that a hybrid system would have a similar cost profile and consequently, would provide the same level of savings. This assumes that private companies would be willing to bid on smaller capitated contracts for regions or groups of facilities.

⁴⁶ Virginia Joint Legislative Audit and Review Commission.

⁴⁷ Ibid

Performance. The primary issue with hybrid systems is establishing a fair allocation of healthy and sick inmates for the different insourced and outsourced facilities. In Florida's experience with a hybrid model, the vendor responsible for outsourced health care in Region 4 charged that the FDC was sending them the sickest inmates, allocating healthier inmates to insourced health care programs in state-managed health care programs. This seems unlikely, particularly given that the Reception and Medical Center, operated by the FDC, housed the sickest inmates in the system. However, the issue of cost shifting between facilities and regions becomes significant considering the extreme difficulty in achieving an even distribution of inmate health care needs among facilities managed by different vendors. Perceived inequities in health care requirements can create contract disputes, or efforts by vendors to reduce service levels to compensate for these perceived inequities.

The administrative complexity of managing multiple vendors can also make partial outsourcing on a facility basis a less effective approach. The transfer of inmates between facilities managed by different companies and state employees necessarily requires a higher level of coordination to assure continuity of care.

The Virginia Department of Corrections addressed this issue by explicitly assigning outsourced health care contracts to facilities with specific health care missions. These vendors had an expectation that they would serve populations with more intensive health care needs and structured their proposals accordingly. This suggests that transparency and access to population and utilization data are effective means to address this issue. As with other models, a robust system of quality assurance monitoring, focused on qualitative performance metrics provides the best approach to assuring adequate service quality under a hybrid model.

Implementation. Transitioning to a hybrid system is a more complex process than implementation of other models. The multiple approaches to health care delivery require that the Department develop a plan to both insource programs at facilities or regions to be determined, and at the same time conduct a procurement process for capitated contracts at other facilities or regions. The resulting transition to different management models in different parts of the state would also be challenging.

A phased approach would require a longer implementation period but would facilitate management of these issues. In the first phase, the Department would develop a plan that identifies which facilities or regions would be insourced or outsourced. The next step could be procurement and implementation of capitated outsourcing in the facilities or regions designated. If successful, the Department could then proceed with implementation of insourcing in remaining facilities or regions. Alternatively, if the outsourcing initiative fails to attract bidders at anticipated prices, the Department could proceed with insourcing of the entire system. The entire process could take up to 12- 16 months.

University Model

In this model, the FDC would develop partnerships with one or more of the state's medical schools such as the University of Florida, Florida State University, or the University of Miami. The structure of

such a partnership could be similar to the Department's current cost-plus contract but could be initiated as a pilot program covering a smaller number of facilities. The university health system would be responsible for management and staffing for onsite care in the facility and assume responsibility for offsite care and prescription drugs. This can be done as a contract with each agency as is done in Texas or by development of an independent entity that then contracts with the prison system as is done in Georgia.

Among other state correctional systems using this approach, Texas has the most comprehensive system, with two universities, the University of Texas Medical Branch and Texas Tech University, managing the delivery of all inmate health care. The Texas correctional health care system is widely recognized as one of the most effective in the United States and provides services with a lower cost per inmate than Florida. New Jersey also contracts with the state university medical program for comprehensive health care delivery. Several other states including Ohio and Illinois have partial contracting agreements. The University of Ohio contracts with the Ohio prison system for specialty care and telemedicine care for HIV. The University of Illinois at Chicago medical school contracts with the Illinois Department of Corrections for HIV and hepatitis C care via telemedicine.

Cost. The cost structure of a university-operated model using the same approach as Texas, combines elements of the outsourced cost-plus and insourced models. Facility health care staff would be employees of the university medical system, with a compensation cost comparable to that of an insourced model. For off-site care, the University would provide managed care services to coordinate contracted services in addition to providing services at university-operated inpatient and outpatient facilities. Costs should be comparable to levels achieved through outsourced models. As a public sector organization, a university model would still charge an administrative fee to cover indirect and overhead costs, but this would not include the profit built into the administrative fee paid under the FDC's current cost-plus contract. The University of Texas Medical Branch charges the Texas Department of Criminal Justice a 2.75 percent fee to cover administrative costs. This compares with an 11.5 percent administrative fee charged by Centurion under the FDC's current outsourcing model. Substituting this rate for the administration/profit fee of paid by the FDC would reduce this fee from \$37.3 million to \$8.1 million.

Because a University operates the entire medical program, it is also possible to obtain 340b pricing for all pharmaceuticals. Significant savings can accrue when the entire pharmacy budget is subject to 340b pricing. Department pharmacy expenditures in 2018-19 were \$85 million of which approximately 60% were for "infectious disease drugs". Part of the infectious disease component would be for Hepatitis C drugs which are not part of the 340b pricing discount currently received by the FDC through the Department of Health. This discount allows from 23 – 40 percent discounts on outpatient medications. Due to the consent agreement on Hepatitis C, many more additional inmates can be expected to require treatment, increasing demand for the medications. The projected cost of Hepatitis C drugs in the FY 2019-20 budget is \$49.2 million. Applying a 23 percent discount factor to these drugs alone would reduce costs by \$11.3 million.

Potential savings provided by University Management model total \$40.5 million, as shown below.

Exhibit 28: Projected Savings Impact of a University Management Model

	\$ millions
340b discount for Hepatitis C drugs	\$ 11.3
Reduce vendor administration/profit fee	\$ 29.2
Total Savings	\$ 40.5

Source: CGL analysis

Performance. As discussed earlier, the quality of care under the University model appears to be high. University medical school programs also have more professional prestige than state prison systems and can be expected to have more success in recruiting and retaining professional staff. The other significant benefit to a University program is that medical schools credential physicians appropriately, requiring physicians to work only in areas for which they have residency training. A University program can also effectively coordinate the use of telemedicine including primary care.

Implementation. FDC managers indicated they have approached several of the state’s medical schools but have been unable to generate any interest in the concept of university-managed correctional health care. Absent cooperation from one of the state’s university medical programs, the potential application of this model in Florida is moot.

In order to further this concept in Virginia, the state legislature has considered legislation creating a pilot project in which Virginia Commonwealth University (VCU) would build on its current relationship of providing inpatient hospital services to the state correctional system, to assume authority for comprehensive management of health care delivery at one prison. The Department of Corrections and VCU are currently in discussions for further development of the concept. A similar approach in Florida could pilot an interim model in which a university agrees to take on one aspect of the correctional health care program, such as management of off-site care for a region or group of facilities.

The implementation of such an approach is realistically a long-term alternative at best. However, as more states experience problems with conventional outsourcing with private vendors, interest in this concept will likely grow.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/2019 Meeting Date

Bill Number (if applicable)

Topic Study of Health Care Services in Florida Department of Correction

Amendment Barcode (if applicable)

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Waive Speaking: In Support Against (The Chair will read this information into the record.)

Representing CGL Companies

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/2019

Meeting Date

Bill Number (if applicable)

Topic Study of Health Care in Florida Department of Corrections

Amendment Barcode (if applicable)

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Representing CGL Companies, Inc

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.



Supreme Court of Florida

500 South Duval Street
Tallahassee, Florida 32399-1925

CHARLES T. CANADY
CHIEF JUSTICE
RICKY POLSTON
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C. ALAN LAWSON
BARBARA LAGOA
ROBERT J. LUCK
CARLOS G. MUÑIZ
JUSTICES

JOHN A. TOMASINO
CLERK OF COURT

SILVESTER DAWSON
MARSHAL

November 8, 2019

Interested Parties

Dear Interested Party:

The Workgroup on Appellate Review of County Court Decisions (Workgroup) was established under the Judicial Management Council to make recommendations regarding circuit court appellate practices. In summary, the Workgroup was charged with:

- Studying whether the circuit courts should be uniformly required to hear appeals in panels;
- Reviewing a proposed provision allowing intra- and inter-circuit conflicts in circuit court appellate decisions to be certified to the district courts of appeal (DCAs); and
- Considering whether other changes to the process for appellate review of county court decisions would improve the administration of justice.

The Supreme Court has considered the Final Report of the Workgroup (report enclosed). A summary of the actions taken by the Court (underlined text below) with respect to each of the Workgroup's three recommendations follows.

Recommendation 1: Approve the proposal of statutory amendments to transfer the circuit courts' appellate and related extraordinary writ authority to the DCAs in county civil cases, including non-criminal violations, county criminal cases, and administrative cases. If the new

law is adopted during the 2021 Regular Legislative Session, an effective date of January 1, 2022, is recommended to allow time to make operational changes for the court system and to adopt conforming amendments to the Florida Rules of Court.

The Supreme Court supports the Legislature's consideration of proposed legislation during the 2020 Regular Session to transfer the referenced circuit court appellate and related extraordinary writ authority to the DCAs. Further, the Supreme Court supports an effective date for the legislation that is no earlier than January 1, 2021, to allow adequate time for implementation.

Recommendation 2: Direct the Commission on District Court of Appeal Performance and Accountability and the Commission on Trial Court Performance and Accountability to consider impacts on workload, data collection, and other issues related to the implementation of Recommendation 1.

The Supreme Court will refer the referenced issues to the commissions.

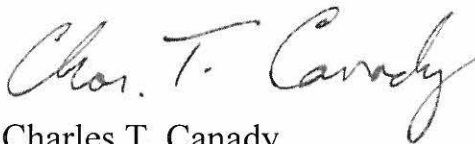
Recommendation 3: Encourage circuit courts to conclude pending appeals within 24 months following the transfer of circuit court appellate jurisdiction to the DCAs to prevent these cases from remaining open and continuing to require the exercise of circuit court appellate jurisdiction for an extended period.

The Supreme Court approves the recommendation with the exception that pending appeals should be concluded within 12 months following the transfer.

Interested Parties
November 8, 2019
Page 3

If you have any questions regarding this information, please contact State Courts Administrator Elisabeth Kiel at (850) 922-5081.

Sincerely,



Charles T. Canady

CTC:tw

Enclosure

cc: Elisabeth Kiel

Judicial Management Council

**Workgroup on Appellate Review of
County Court Decisions**

Final Report

October 10, 2019

Workgroup Members
Judge Robert Morris, Chair
Judge Jonathan Gerber
Judge Angela Cowden
Judge Ronald Ficarrota
Judge Renatha Francis
Judge Mark Jones
Judge David Denkin
Judge Robert W. Lee
Ms. Rachel Nordby
Ms. Courtney Brewer
Ms. Marynelle Hardee

Note: The recommendations specified in the "Executive Summary" have been updated to include the actions taken by the Supreme Court in November 2019.

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Executive Summary

Workgroup Creation and Charges

The Workgroup on Appellate Review of County Court Decisions was established under the Judicial Management Council by Administrative Order SC19-3 in January 2019 to:

- Study whether the circuit courts should be uniformly required to hear appeals in panels;
- Review a proposed provision allowing intra- and inter-circuit conflicts in circuit court appellate decisions to be certified to the district court of appeal (DCA); and
- Consider whether other changes to the process for appellate review of county court decisions would improve the administration of justice.

Present Situation

Relevant Appellate Jurisdiction: The State Constitution provides that Florida’s circuit courts may hear appeals as established by general law and petitions for extraordinary writs. State statutes authorize circuit courts to review certain administrative actions and final and nonfinal decisions from county courts in civil and criminal cases, except for appeals of county court decisions that have an amount in controversy exceeding \$15,000, that invalidate a state statute or constitutional provision, or that are certified to be of great public importance. The excepted appeals are heard by the DCAs.

Other States: Florida is one of only five states that has a court of general jurisdiction, such as a circuit court, simultaneously exercising general and appellate jurisdiction. The hearing of appeals in general jurisdiction courts was largely abandoned with the creation of intermediate appellate courts.

Circuit Court Appellate Practices: Twenty-four counties use three-judge panels to hear appeals while 31 do not. Of the remaining counties, one uses a three-judge panel if requested by a party and 11 use a hybrid model wherein only some appeals are heard by a panel. The publication of appellate decisions varies by circuit. Only nine circuits post some or all appellate opinions online.

Case Data: The Workgroup attempted to determine the number of appeals and petitions for writs heard annually by circuit courts; however, the only data available are the numbers of appeals of county court civil decisions and appeals of and petitions for writs in county court criminal decisions. This data indicates an average of 1,867 appeals and petitions filed annually in the circuit courts during the past 10 years. This data does not include the number of administrative appeals and petitions for writs in civil appellate cases. Further, the data, as discussed below, appears to have some inaccuracies.

Intra- and Inter-Circuit Court Appellate Conflict / Review: Although the appellate decisions of a circuit court are binding on all county courts in a circuit, the decisions are not binding on a judge or panel in that circuit when considering a subsequent appeal. Consequently, intra- and inter-circuit conflict arises. Certiorari is the only review available to a DCA for a circuit court appellate decision. This review may address only an error that is “a departure from the essential requirements of law.” Under case law, conflict in circuit court appellate decisions does not, by itself, meet this standard. Thus, issues in conflicting circuit court appellate decisions frequently go unaddressed.

Workgroup Discussion and Findings

To address its charges, the Workgroup considered two options.

Option 1 – Fix the Circuit Court Appellate Process: To fix the process, the Workgroup determined that the following issues would need to be addressed:

- **Publication of Circuit Appellate Decisions:** To know whether conflicting decisions are being issued, all circuit appellate decisions must be published. A rule of court could be adopted to require electronic publication. Most circuits do not publish all opinions online and, as such, would likely incur fiscal and workload impacts to establish publication processes and modify websites.
- **Three-Judge Panels:** Requiring three-judge panels would make the circuit appellate process more uniform and likely reduce conflicting decisions; however, for counties that do not currently use panels, it will increase judicial workload and likely increase the time to resolve appeals. Further, the use of three-judge panels alone will not prevent conflicting circuit appellate decisions.
- **Intra- and Inter-Circuit Court Appellate Conflict:** To resolve intra-circuit court appellate conflict, en banc review could be authorized. This process would reduce conflict in a circuit, but will also increase circuit judicial workload and may be difficult to coordinate. Further, the process can still result in 20 conflicting circuit appellate decisions unless DCAs are authorized to resolve inter-circuit appellate conflict.

DCAs could be authorized to review intra- and inter-circuit court appellate conflict through an expansion of certiorari or, if constitutional, circuit court certification of conflict. Although either solution would reduce conflict, the Workgroup notes that both will increase DCA workload while maintaining circuit appellate workload. Additionally, not all conflicting decisions will be resolved as these approaches are contingent on the filing of a petition for certiorari or on the circuit's decision to certify conflict. Thus, the possibility for conflict among and within the 20 circuits remains; whereas, under Option 2, conflicting decisions can exist among only the state's five districts and circuit appellate workload is eliminated.

Option 2 – Transfer Circuit Court Appellate Authority to the DCAs: Under the State Constitution, all circuit court appellate jurisdiction is controlled by the statutes, except for the authority to issue extraordinary writs. The statutes can be amended to repeal circuit court appellate jurisdiction, thereby transferring that jurisdiction to the DCAs. With respect to extraordinary writs, circuit courts may only issue writs for cases in which they have original or appellate jurisdiction. If circuit court appellate jurisdiction is transferred to the DCAs, circuit courts will no longer have writ authority in those appellate cases.

The Workgroup recognizes that implementation of this option is exclusively within the authority of the Legislature and Governor and that it will require considerable operational changes to the court system; however, the Workgroup believes that the following anticipated benefits outweigh the implementation challenges: a) intra- and inter-circuit conflict will no longer exist; b) over time the number of appeals in county court and administrative cases will likely decrease as issues are resolved by the DCAs; and c)

many aspects do not have to be modified, i.e., DCAs currently publish their decisions, use three-judge panels, and have appropriate expertise and staffing.

Recommendations

The Workgroup recommends that the Florida Supreme Court:

1. Approve the proposal of statutory amendments to transfer the circuit courts' appellate and related extraordinary writ authority to the DCAs in county civil cases, including non-criminal violations, county criminal cases, and administrative cases. If the new law is adopted during the 2021 Regular Legislative Session, an effective date of January 1, 2022, is recommended to allow time to make operational changes for the court system and to adopt conforming amendments to the Florida Rules of Court.

The Supreme Court supports the Legislature's consideration of proposed legislation during the 2020 Regular Session to transfer the referenced circuit court appellate and related extraordinary writ authority to the DCAs. Further, the Supreme Court supports an effective date for the legislation that is no earlier than January 1, 2021, to allow adequate time for implementation.

2. Direct the Commission on District Court of Appeal Performance and Accountability and the Commission on Trial Court Performance and Accountability to consider impacts on workload, data collection, and other issues related to the implementation of Recommendation 1.

The Supreme Court will refer the referenced issues to the commissions.

3. Encourage circuit courts to conclude pending appeals within 24 months following the transfer of circuit court appellate jurisdiction to the DCAs to prevent these cases from remaining open and continuing to require the exercise of circuit court appellate jurisdiction for an extended period.

The Supreme Court approves the recommendation with the exception that pending appeals should be concluded within 12 months following the transfer.

Workgroup Creation, Charges, and Considerations

Supreme Court Opinion

On October 25, 2018, the Supreme Court issued its opinion for In re Amendments to Fla. Rules of Appellate Procedure-2017 Regular-Cycle Report.¹ In this case, The Florida Bar Appellate Court Rules Committee (“ACRC”) had proposed amendments to the Rules of Appellate Procedure that would have required circuit courts to hear appellate matters in panels of three judges, with the concurrence of two judges necessary to a decision.²

The ACRC provided research indicating that appeals to the circuit court are handled differently across the state, with some circuits requiring most or all appeals to be heard by a panel of circuit judges and others not using panels. The ACRC argued that “requiring panels of three judges to decide appeals in the circuit court, similar to the way appeals are heard in the district courts of appeal, would serve as an important safeguard to the rights of litigants” and that “such review promotes better decision making, reduces mistakes, eliminates extremes and bias, and promotes stability and fairness.”³

The chief judges of the Second and Sixteenth Circuits filed comments in the case expressing concern that a rule requiring panels would result in an increased workload for judges, judicial assistants, and court staff; would ultimately make the timely disposition of appeals more challenging; and would be particularly burdensome on the smaller or less populous circuits with fewer judges.⁴ The Supreme Court stated “Significantly, we note that the comment from the Chief Judge of the Second Circuit represents that the chief judges from every circuit urge this Court to allow the circuit courts to retain discretion to determine whether or when to utilize appellate panels.”⁵

Finding merit in the ACRC's argument that appeals to the circuit court should be handled more uniformly, but determining that the issue required further study, the Supreme Court declined to adopt the proposed rule and held that a workgroup should be established to review the issue.^{6, 7}

“We do find merit in the Committee's argument that appeals to the circuit court should be handled in a more uniform manner across the state.”

In re Amendments to Fla. Rules of Appellate Procedure-2017 Regular-Cycle Report, 256 So. 3d 1218, 1220 (Fla. 2018).

¹ In re Amendments to Fla. Rules of Appellate Procedure-2017 Regular-Cycle Report, 256 So. 3d 1218, 1219 (Fla. 2018).

² Id.

³ Id.

⁴ Id. at 1219-20.

⁵ Id. at 1220.

⁶ Id.

⁷ Justice Pariente dissented from the Court's decision to not adopt the rule, stating that she urged “the workgroup to study only the logistics of concerns raised by the smaller circuits and not the merits or wisdom of uniformly employing three-judge appellate panels in the circuit courts across the State. ... [R]equiring three-judge appellate panels at the circuit court level is essential to protecting litigants' due process rights, including the right to meaningful appellate review. This is particularly clear when considering the limited scope of the second-tier review of those decisions by the district courts of appeal. As the Committee explains, this amendment ‘would not only make the appellate process consistent in the circuit and district courts’ but would also ‘alleviate concerns that a review by a single circuit judge could be perceived as simply substituting one judge's opinion for another.’” Id. at 1223-24.

Work Group on County Court Jurisdiction

While the Supreme Court was considering whether to adopt the rule requiring three-judge panels in the above-discussed case, the Work Group on County Court Jurisdiction, which was formed under the Judicial Management Council on August 1, 2018,⁸ was studying whether the county court civil and small claims jurisdictional limits should be adjusted. In its report dated November 30, 2018, the Work Group recommended increasing both jurisdictional limits. Recognizing that this recommendation could increase the number of appeals of county court decisions that would be heard by the circuit courts, the Work Group expressed concern regarding the potential for an increase in conflicting intra- and inter-circuit appellate decisions. The Work Group stated:

An increase in the county court jurisdictional amount is anticipated to result in more appeals to the circuit court, raising insurance, condominium, and other civil issues that have produced conflicting circuit court rulings. To assure uniformity of decisions throughout the districts and state, and to provide published opinions that are readily available to attorneys and business interests, the Work Group recommends that such a certification procedure be developed. It is directly analogous to the manner in which the district courts of appeal certify a conflict in decisions to the Florida Supreme Court.

The members also discussed en banc review of such conflicts but determined any proposal for intra-circuit or inter-circuit en banc review to resolve conflicts within a district would be fraught with both logistical and legal difficulty. Coordination of nine, 10, or even more circuit judges for an en banc panel, for example, would be very difficult in both: (a) heavily-populated circuits with panel members working from multiple courthouse locations; and (b) sparsely-populated circuits with multiple counties and greater distances between the panel members. Communication among the circuit judges on such a panel, with their already busy schedules and no staff attorneys specifically assigned to those judges, would also be difficult. For these reasons, the Work Group proposes the resolution of such conflicts by certification to the district courts of appeal rather than in a circuit court en banc procedure.⁹

Based on the above reasoning, the Work Group adopted Recommendation 2.3 providing “that any modification to the [county court] jurisdictional amount [should] include a provision allowing intra- and inter-circuit conflicts in circuit court appellate decisions within the same district to be certified to the district court of appeal for that district.”¹⁰

Workgroup on Appellate Review of County Court Decisions

On January 4, 2019, the Workgroup on Appellate Review of County Court Decisions (“Workgroup”) was established under the Judicial Management Council by Administrative Order SC19-3,¹¹ for purposes of reviewing the three-judge panel issue raised in In re Amendments to Fla. Rules of Appellate Procedure-2017 Regular-Cycle Report and the recommendation for certification of intra- and inter-circuit conflict by the Work Group on County Court Jurisdiction.

⁸ See Administrative Order [SC18-39](#).

⁹ Work Group on County Court Jurisdiction, Recommendations from the Judicial Management Council’s Work Group on County Court Jurisdiction, page 16, November 30, 2018.

¹⁰ Id. at 6.

¹¹ See Administrative Order [SC19-3](#).

The Workgroup's charges are:

- Study whether the circuit courts should be uniformly required to hear appeals in panels and propose appropriate amendments to the Rules of Judicial Administration or the Rules of Appellate Procedure if the Workgroup determines that such amendments are necessary.
- Review Recommendation 2.3 made by the Work Group on County Court Jurisdiction and propose appropriate amendments to law or rule if the Workgroup determines that such amendments are necessary.
- Consider whether other changes to the process for appellate review of county court decisions would improve the administration of justice. If so, the Workgroup may propose any revisions in the law and rules necessary to implement such recommended changes.

In addressing the charges, the Workgroup considered the information in this report and was mindful of the following considerations:

1. Fair, equitable, and consistent justice across counties and circuits;
2. Fiscal, geographical, human resource, and workload constraints;
3. Branch governance concerns (chief circuit judges are given the responsibility to assign judges);
4. The need to minimize unnecessary delay in appellate matters; and
5. Impacts on litigants and attorneys.

The Workgroup was also cognizant that changes to the state's system for circuit court appellate review will impact circuit and district court judicial caseloads. Caseloads and associated workload were Workgroup considerations and were discussed during its deliberations. Ultimately, however, it was determined that this issue can be addressed through caseload analyses and judicial certification processes, and that it should not impact the Workgroup's determination of which appellate review policies will best serve the state.

Present Situation

Florida Circuit Court and District Court of Appeal ("DCA") Jurisdiction / Other States

Circuit Court: Florida's circuit courts function as both trial¹² and appellate courts. With respect to appellate authority, the State Constitution provides that circuit courts may review appeals as established by general law¹³ and petitions for extraordinary writs.¹⁴ State statutes authorize circuit

¹² Circuit courts have exclusive original jurisdiction of all actions not cognizable by the county courts and specifies other categories of exclusive original jurisdiction for circuit courts. § [26.012](#), Fla. Stat.

¹³ Circuit courts "shall have ... jurisdiction of appeals when provided by general law. ... They shall have the power of direct review of administrative action prescribed by general law." [Article V, § 5\(b\)](#), Fla. Const.

¹⁴ Circuit courts "shall have the power to issue writs of mandamus, quo warranto, certiorari, prohibition and habeas corpus, and all writs necessary or proper to the complete exercise of their jurisdiction." [Id.](#)

courts to review final judgments and certain nonfinal orders from county courts in civil¹⁵ and criminal¹⁶ cases, subject to three exceptions discussed below, and certain administrative actions.¹⁷

DCA: Florida's DCAs are authorized by the State Constitution to:

- Hear appeals that may be taken as a matter of right from final judgments or orders of trial courts, including those entered on review of administrative action, that are not directly appealable to the Supreme Court or a circuit court.¹⁸
- Review interlocutory orders in such cases to the extent provided by rules adopted by the Supreme Court.¹⁹
- Directly review administrative action as prescribed by general law.²⁰
- Issue writs of habeas corpus, mandamus, certiorari, prohibition, and quo warranto, and other writs necessary to complete exercise of its jurisdiction.²¹
- Exercise the appellate jurisdiction of the circuit courts to the extent necessary to dispose of all issues in a case properly before the DCA.²²
- Certify the following for review to the Supreme Court: a question of great public importance or conflict with a decision of another DCA.²³

With respect to appeals of county court cases, the statutes provide the following three exceptions to the circuit court's statutory appellate jurisdiction, and, as such, the DCA has appellate jurisdiction for these county court cases under the State Constitution:

- Appeals of county court orders or judgments where the amount in controversy is greater than \$15,000, until January 1, 2023, at which time this exception is repealed.
- Appeals of county court orders or judgments declaring invalid a state statute or a provision of the State Constitution.
- Orders or judgments of a county court which are certified by the county court to the DCA to be of great public importance and which are accepted by the DCA for review.²⁴

¹⁵ Circuit courts have jurisdiction of appeals from county subject to three exceptions. § [26.012\(1\)](#), Fla. Stat.

¹⁶ Circuit courts have jurisdiction of appeals from final judgments, and appeals by the state of certain nonfinal orders, in misdemeanor cases. §§ [924.07](#), [924.071](#), and [924.08](#), Fla. Stat.; [State v. Ratner](#), 948 So. 2d 700, 704 (Fla. 2007).

¹⁷ State statutes do not generally confer appellate jurisdiction to the circuit courts over administrative actions; instead, they grant such authority based on the type of action or entity taking action. For example, §§ [26.012\(1\)](#) and [162.11](#), Fla. Stat., authorize appeals of final administrative orders entered by local government code enforcement boards.

¹⁸ [Article V, § 4\(b\)\(1\)](#), Fla. Const.

¹⁹ [Id.](#); see Fla. R. App. P. [9.030\(b\)\(1\)\(b\)](#), [9.130](#), and [9.140](#) (specifying categories of nonfinal orders by circuit courts that may be appealed to the DCAs), and Fla. R. App. P. [9.030\(b\)\(2\)\(A\)](#) (providing that nonfinal orders by lower tribunals that are not specified in court rule may be reviewed by the DCAs pursuant to their constitutional certiorari jurisdiction).

²⁰ [Article V, § 4\(b\)\(2\)](#), Fla. Const.; see, e.g., §§ [120.68](#), [350.128](#), and [440.271](#), Fla. Stat. (authorizing DCAs to review final agency action under the Administrative Procedure Act and the First DCA to review certain actions of the Public Service Commission actions and orders of judges of compensation claims, respectively).

²¹ [Article V, § 4\(b\)\(3\)](#), Fla. Const.

²² [Id.](#)

²³ [Article V, § 3\(b\)\(4\)](#), Fla. Const.

²⁴ [Article V, § 4\(b\)\(1\)](#), Fla. Const.; §§ [26.012\(1\)](#), [34.017](#), and [35.065](#), Fla. Stat.

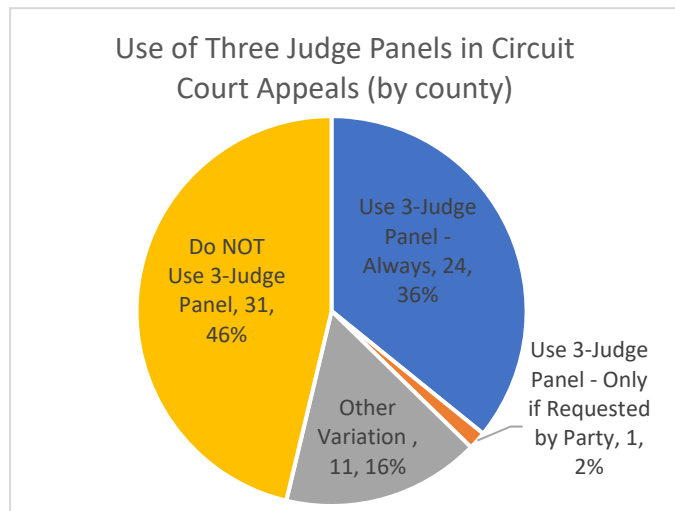
Other States: Florida, California, Maryland, Massachusetts, and Pennsylvania are the only states that have a court of general jurisdiction, such as a circuit court, simultaneously exercising general and appellate jurisdiction. In two other states, New York and New Jersey, judges of general jurisdiction courts may be elevated to the appellate division semi-permanently or permanently. The appellate divisions in those two states have their own clerks and sitting locations and the judges assigned to those divisions do not hear trial cases, focusing solely on appeals. The practice of hearing appeals in general jurisdiction courts was largely abandoned with the creation of intermediate appellate courts across the country.²⁵

Circuit Court Appellate Practices and Case Data

Practices: Circuit courts across Florida lack uniformity with respect to their circuit practices for hearing and publishing decisions in cases falling within their appellate jurisdiction.

Currently, 24 counties always use three-judge panels to hear appellate cases, 31 counties do not use three-judge panels, one county uses a three-judge panel only if requested by a party, and 11 counties use a hybrid model wherein a single judge hears some appeals while a panel hears other appeals.

Publication of circuit court appellate decisions on judicial circuit websites varies widely. Staff research found that only nine of the 20 Judicial Circuits post all or some of their circuit court appellate opinions online. Specific opinions can be difficult to find as some of these websites lack search features.



Source: Trial Court Administrators

The Florida Law Weekly (“FLW”) Supplement publishes “significant opinions [of circuit appellate courts, circuit and county courts, and public agencies] made available to [the company].”²⁶ According to data from a representative of the FLW Supplement, 193 circuit court appellate opinions from 13 circuits were published during the six-month period between March and August 2019. This number includes appeals of county court and administrative decisions and petitions for extraordinary writs. Previous research by the ACRC indicated that Westlaw and LexisNexis may be willing to publish circuit court appellate opinions if they are text searchable and published to the circuit court’s website.

²⁵ This information was provided by Dr. William Raftery, Senior Knowledge Information Services Analyst for the National Center for State Courts.

²⁶ See FLW Supplement, How to Submit Opinions, <http://www.floridalawweekly.com/flwonline/view/submitopinions.view.php> (stating “Decisions of Florida’s circuit and county courts are not routinely distributed to publishers as are those of appellate courts. Readers are invited to submit court decisions to us for publication in FLW Supplement. **Please note: Lower court orders that do not contain adequate substantive information to inform readers of the court’s reasoning generally will not be published.**”) (last accessed on Sept. 11, 2019).

Data: Complete and reliable data are not available for the total number of appeals and petitions for writs that are filed in the circuit courts. Based on the data that is available from the Summary Reporting System (“SRS”), as shown in Table 1, an average of 1,867 cases were appealed to the circuit courts annually during the past 10 years. However, this data includes only appeals of county court civil decisions and appeals of and petitions for writs in county court criminal decisions. The data does not include administrative appeals or petitions for writs in civil appellate cases. These latter appeals and petitions are included in the “Circuit Civil Other, Other” subcategory in the SRS, which is comprised of all civil matters and other civil case types not falling in another defined subcategory. Some examples include: declaratory judgements, administrative agency appeals, habeas corpus proceedings, forfeitures, and others.²⁷ Due to the limitations of the SRS, this subcategory cannot be further disaggregated for reporting purposes.

Table 1			
Number of Appeals to Circuit Court (does not include administrative appeals or petitions for writs in civil appellate cases)			
Fiscal Year	County Civil	County Criminal	Total
2009-10	980	717	1,697
2010-11	1,438	749	2,187
2011-12	1,190	522	1,712
2012-13	924	455	1,379
2013-14	1,068	487	1,555
2014-15	1,400	491	1,891
2015-16	1,683	499	2,182
2016-17	1,512	455	1,967
2017-18	1,601	388	1,989
2018-19	1,609	501	2,110
Total	13,405	5,264	18,669
Average	1,341	526	1,867

Source: Summary Reporting System, August 2019

1. Fiscal year 2009-10 through 2017-18 data are from a static data set and represent the official trial court statistics.
2. Fiscal year 2018-19 data as of August 23, 2019, are from a dynamic data set and may be amended at a later date by the clerks or court.

When reviewing a subset of the above-described SRS data for fiscal year 2016-17, which had been disaggregated by county and circuit, several Workgroup members expressed concern that the numbers appeared inaccurate. For this reason, the Workgroup requested circuit-level appellate data from each of the 20 Trial Court Administrators and 67 Clerks of Court for fiscal year 2016-2017.²⁸ This inquiry uncovered further data discrepancies when the SRS data was compared to the requested data,²⁹ i.e., there were slight variations of county court appeals recorded across nearly all circuits and significant variations among the circuits in South Florida (11th, 15th, and 17th).

Intra- and Inter-Circuit Court Appellate Conflict / Review

Intra- and Inter-Circuit Court Appellate Conflict: Although the appellate decisions of a circuit court are binding on all county courts within the circuit,³⁰ such decisions do not operate as binding precedent on a circuit appellate judge or panel when considering a subsequent appeal.³¹ Consequently, intra-

²⁷ See State Court System, [SRS Manual – Circuit Civil](#) at 4-17.

²⁸ See Appendix A entitled “County Court Appeals to Circuit Court by Circuit and County (FY 2016-17).”

²⁹ See Appendix B entitled “Number of Appeals Recorded by Entity (SRS, Clerk of Court, and Court Administration) by Circuit for FY 2016-17,” which specifies data by circuit.

³⁰ [Fieselman v. State](#), 566 So.2d 768, 770 (Fla. 1990).

³¹ See, e.g., [Massani v. City of Miami Gardens](#), 27 FLW Supp. 220, 221 n.4 (Fla. 11th Cir. App. May 2, 2019) (“This Court is aware of three Circuit Appellate Panel decisions that interpret the same statutes at issue [. . .]. Those opinions are not binding on this Court, and this Court respectfully disagrees with their analysis.”).

circuit conflict in appellate decisions arises, as, of course, does inter-circuit conflict. According to a Florida Bar Journal article:

Florida decisional law contributes to the existence of intra-circuit conflicting opinions. For example, the Fifth District Court of Appeal held that a “circuit court sitting in its appellate capacity was required *to consider* all decisions of the circuit court in the Ninth Circuit when searching for precedents upon which to base its decision, and, in the absence of a rule of procedure to resolve conflicts among the decisions, to make its independent decision.” *State v. Lopez*, 633 So. 2d 1150 (Fla. 5th DCA 1994), only requires that a circuit appellate court consider other intra-circuit decisions but does not require that a circuit court follow an appellate decision issued by another circuit judge or panel within the same judicial district.

The Fifth District's *Lopez* decision impacts circuit appellate courts. Appellate panels within the 11th Judicial Circuit acknowledge that one panel's decision does not operate as binding precedent upon another panel, thus, occasionally declining to follow an opinion issued by another panel. For example, one circuit panel stated that it must consider the decisions from its appellate division when “searching for precedents” but clearly noted they could “make an independent decision when ... disagree[ing] with another panel.”³²

Review of Circuit Court Appellate Decisions: The only mechanism to review a circuit court appellate decision is certiorari review by a DCA. This jurisdiction is commonly referred to as “second-tier certiorari,” which is certiorari review by a DCA of an order by a circuit appellate court to review:

- Final decisions of the county court. The DCA may review the circuit court appellate decision only if the error departs from the essential requirements of the law.
- Decisions by administrative or other governmental agencies. The inquiry for the DCA in determining whether it may review the circuit court appellate decision is whether the circuit court: a) afforded procedural due process; and b) applied the correct law. Although this standard is stated differently than the standard, above, the Supreme Court has stated that a) and b) “are merely expressions of ways in which the circuit court decision may have departed from the essential requirements of the law. In short, we have the same standard of review as a case which begins in the county court.”³³

Regarding the phrase “departure from the essential requirements of law,” the Supreme Court has explained that it:

[S]hould not be narrowly construed so as to apply only to violations which effectively deny appellate review or which pertain to the regularity of procedure. In granting writs of common-law certiorari, the district courts of appeal should not be as concerned with the

³² J. Sebastien Rogers, [The Chasm in Florida Appellate Law: Intra-Circuit Conflicting Appellate Decisions](#), Fla. B.J., April 2018, at 52 (footnotes omitted); see *State Farm Fire & Cas. Co. v. Suncare Physical Therapy, Inc., a/a/o Henrisma*, 18 Fla. L. Weekly Supp. 776a (Fla. 11th Cir. Ct. July 13, 2011) (citing *Lopez*, 633 So. 2d at 1150-1151), pet. dis., No. 3D11-2147 (Fla. 3d DCA Oct. 5, 2011) (circuit panel stated that it must consider the decisions from its appellate division when “searching for precedents” but indicated they could “make an independent decision when ... disagree[ing] with another panel.”).

³³ *Nader v. Fla. Dep't of Highway Safety & Motor Vehicles*, 87 So. 3d 712, 723 (Fla. 2012); Philip J. Padovano, *Florida Appellate Practice* § 19.9 (2018 ed.).

mere existence of legal error as much as with the seriousness of the error. Since it is impossible to list all possible legal errors serious enough to constitute a departure from the essential requirements of law, the district courts must be allowed a large degree of discretion so that they may judge each case individually. The district courts should exercise this discretion only when there has been a violation of a clearly established principle of law resulting in a miscarriage of justice. It is this discretion which is the essential distinction between review by appeal and review by common-law certiorari.³⁴

According to the Florida Appellate Practice guide, identifying the kinds of errors that qualify as a departure from the essential requirements of law “is not an easy task.”³⁵ Appellate courts have held that failing to follow the binding precedent of a DCA can constitute an essential departure from the law in a circuit court’s decision for an appeal from county court,³⁶ as can a failure to apply a controlling statute in a circuit court’s decision for an appeal from an administrative action even if the circuit court was following DCA precedent that misconstrued the statute.³⁷ Appellate courts “are in agreement that an error in applying the law to the facts of the case is not a departure from the essential requirements of the law.”³⁸

Regarding intra-circuit conflicting appellate opinions, the Third DCA has held that it lacked jurisdiction under the “departure from the essential requirements of the law” standard to grant second-tier certiorari to resolve direct conflict among four appellate opinions in the Eleventh Circuit. In this opinion, the Third DCA certified the following question as one of great public importance:

DOES A DISTRICT COURT OF APPEAL HAVE JURISDICTION TO GRANT A PETITION FOR SECOND-TIER CERTIORARI IN A CASE IN WHICH THERE IS DIRECT CONFLICT ON A DETERMINATIVE ISSUE AS BETWEEN (A) THE CIRCUIT COURT APPELLATE DIVISION CASE WHICH IS THE SUBJECT OF THE SECOND-TIER PETITION, AND (B) A DECISION BY A DIFFERENT CIRCUIT COURT APPELLATE DIVISION PANEL WITHIN THE SAME DISTRICT, WHEN EACH OF THE CONFLICTING DECISIONS WAS RENDERED IN THE ABSENCE OF A CONTROLLING DECISION BY THE DISTRICT COURT FOR THAT DISTRICT?³⁹

The question, however, was never addressed by the Supreme Court as the parties did not invoke the Court’s jurisdiction.

In a concurring and dissenting opinion, Judge Logue agreed with the majority’s certification of the question, but disagreed with its decision that second-tier certiorari jurisdiction could not be exercised in the case. According to Judge Logue, “an incorrect circuit court appellate decision in these circumstances—an incorrect legal decision that treats litigants differently than the same circuit court treated other similarly situated litigants—constitutes a departure from the most essential requirement

³⁴ Combs v. State, 436 So. 2d 93, 95-96 (Fla. 1983).

³⁵ Padovano, Florida Appellate Practice § 19.8.

³⁶ Id.

³⁷ Department of Highway Safety & Motor Vehicles v. Nader, 4 So. 3d 705 (Fla. 2d DCA 2009), decision approved, 87 So. 3d 712 (Fla. 2012); see Nader, 87 So. 3d at 727 (holding that a DCA “may exercise its discretion to grant certiorari review of a circuit court decision reviewing an administrative order, so long as the decision under review violates a clearly established principle of law resulting in a miscarriage of justice, even if the circuit court decision was based on precedent from another district.”).

³⁸ Padovano, Florida Appellate Practice § 19.8.

³⁹ Allstate Fire & Cas. Ins. Co. v. Hallandale Open MRI, LLC, 253 So. 3d 36, 41 (Fla. 3d DCA 2017).

of law: equality before the law. It results in exactly the type of miscarriage of justice without other remedy which certiorari exists to correct.”⁴⁰

Further, Judge Logue made the following points:

- A defect in our court system exists that results in county court “litigants in the exact same circumstances filing in the exact same county court receiv[ing] different outcomes based on conflicting case law.” “A properly functioning system of appellate courts will necessarily produce conflicting decisions. And a properly functioning system of appellate courts will necessarily have a method to resolve those conflicts.”⁴¹
- Certiorari is flexible enough to review conflicts. The Supreme Court historically used certiorari to settle conflicting appellate opinions before its certiorari jurisdiction was abrogated in 1980. Further, the Supreme Court has held that the writ of certiorari is available to obtain review when no other method of appeal is available. “Just as common law certiorari can be used to provide a required but missing plenary appeal ..., it can be used to provide a less-than-plenary review based on an express conflict when necessary to avoid the current situation in which ‘there may never be clearly established principles of law governing a wide array of county court issues.’”⁴²
- Using certiorari to resolve conflict in circuit court appellate opinions is not a second appeal because the focus is on resolving the conflict in the law, not the dispute between the parties. Such use of certiorari “is no more the granting of a second appeal than the Supreme Court’s exercise of conflict jurisdiction to resolve conflicts among district court decisions.”⁴³
- The county court’s ability to certify a question of great public importance to the DCA is inadequate to resolve this issue. “The Second District in Stilson and the Florida Supreme Court in Ivey both acknowledged the existence of the county court’s authority in this regard, and they both still concluded that ‘there may never be “clearly established principles of law” governing a wide array of county court issues, including PIP issues.’ ... Unless one finds acceptable the idea that ‘there may never be “clearly established principles of law” governing a wide array of county court issues, including PIP issues,’ the inescapable conclusion is that county court certification is simply not an adequate remedy for circuit court appellate conflicts.”⁴⁴

Workgroup Discussion and Findings

To address its charges, the Workgroup discussed two options: 1) fix the circuit court appellate process; or 2) transfer circuit appellate authority to the DCAs.

Option 1 – Fix the Circuit Court Appellate Process

To fix the process, the Workgroup determined that the following issues would need to be addressed: 1) publication of circuit appellate decisions; 2) three-judge panels; 3) intra-circuit conflict; and 4) inter-circuit conflict.

⁴⁰ [Id.](#) at 41-42, 46-47.

⁴¹ [Id.](#) at 42.

⁴² [Id.](#) at 42-43.

⁴³ [Id.](#) at 44-45.

⁴⁴ [Id.](#) at 48.

Publication of Decisions: To know whether conflicting decisions are being issued within or among the circuits, it will be necessary to publish circuit appellate decisions. As discussed above, only nine circuits currently publish all or some of their decisions on their websites, some of which have no search capability. Moreover, only decisions deemed “significant” are published in the FLW Supplement. Uniform reporting requirements for circuit appellate decisions would need to be adopted by rule. The ACRC currently intends to propose the following amendment to Fla. R. App. P. 9.040(b), as part of its 2020 Regular-Cycle Report Amendments:

(j) Public Availability of Written Opinions. Except for written opinions determined to be confidential under Florida Rule of Judicial Administration 2.420, the court shall make publicly available on the court’s website all written opinions entered on an appeal or petition. Each written opinion made publicly available shall be text searchable and in a Portable Document Format (“PDF”) file.⁴⁵

The Workgroup believes this requirement is feasible but recognizes that it will require the adoption of new processes and the revamping of websites by the significant majority of circuits, which is likely to have a fiscal impact and increase circuit workload.

Three-Judge Panels: The Workgroup recognizes that requiring three-judge panels would make the statewide circuit court appellate process more uniform, promote fairness, reduce mistakes, provide more meaningful review, and likely reduce the number of conflicting circuit appellate decisions. Although it is technically possible for the circuits to implement such a requirement, the Workgroup also recognizes that, in circuits that do not currently require three-judge panels, this requirement:

- Will increase the number of circuit judges required for each appellate decision from one to three.
- Is likely to increase the time required for circuit judges to resolve the appeal.
- Is likely to require the use of conferencing technology to participate in oral arguments or to facilitate the interaction of the three judges, particularly in smaller circuits, if the judges elect to confer with one another regarding a decision. Such electronic interaction may not be as valuable as the potentially more meaningful and collegial in-person interaction that is more readily available to DCA judges and Supreme Court justices.
- May be considered by some circuit chief judges as an infringement on their current authority to discretionarily determine whether appellate issues should be heard in panels.

Further, the use of three-judge panels will not, by itself, resolve conflict. Additional processes will have to be developed to resolve intra- and inter-circuit conflicting appellate opinions.

Review of Intra-Circuit Court Appellate Conflict: To resolve intra-circuit court appellate conflict, at least two approaches exist: 1) authorizing en banc review of conflicting decisions; or 2) authorizing DCA review of conflicting decisions.

⁴⁵ See ACRC, Memorandum entitled “2020 Regular Cycle Rule Amendments,” [https://lsg.floridabar.org/dasset/cmdocs/cm205.nsf/c5aca7f8c251a58d85257236004a107f/713727942eeec409852577fa0049b4c5/\\$FILE/ACRC%20BOG%20Packet%202020%20Regular-Cycle%20Report.pdf](https://lsg.floridabar.org/dasset/cmdocs/cm205.nsf/c5aca7f8c251a58d85257236004a107f/713727942eeec409852577fa0049b4c5/$FILE/ACRC%20BOG%20Packet%202020%20Regular-Cycle%20Report.pdf), at p. 18.

First, an en banc review process like that used by the DCAs could be established by a rule of court. The ACRC currently intends to propose the creation of Fla. R. App. P. 9.332, as part of its 2020 Regular-Cycle Report Amendments, to establish such a process. Under the proposed rule:

- Each chief judge in the circuit must establish an en banc panel consisting of at least five circuit judges or all active circuit judges.
- A majority of the en banc panel may order that a proceeding be determined en banc.
- An en banc hearing or rehearing may be ordered only if necessary to maintain uniformity in the circuit court's appellate decisions.
- A majority vote of the en banc panel is necessary for a decision.⁴⁶

The proposed rule is substantively the same as Fla. R. App. P. 9.331, governing en banc proceedings by DCAs, except that DCAs are authorized to order that a case proceed en banc not only based on uniformity, but also if the case is of exceptional importance.

The Workgroup recognizes that en banc review could serve to significantly reduce conflicting appellate decisions within a circuit; however, it also notes that this solution will increase circuit judicial workload and, as expressed by the Work Group on County Court Jurisdiction, will be difficult to coordinate in large and small circuits with members potentially working from multiple courthouse locations that may be separated by significant distance. Additionally, this process alone can result in 20 different circuit court appellate decisions on an issue unless DCAs, as discussed below, are authorized to resolve inter-circuit conflict.

Second and alternatively, to resolve intra-circuit conflict, DCAs, as discussed below, could be authorized to address such conflict by certiorari or, if constitutional, by certification of conflict.

DCA Review of Intra- and Inter-Circuit Court Appellate Conflict: This option could be implemented through at least two approaches: 1) expansion of the DCAs' certiorari review; or 2) authorizing circuits to certify intra- and inter-circuit court appellate conflict to the DCAs (note: it is unclear, however, as to whether the second approach is constitutional).

First, the Supreme Court could consider authorizing intra- and inter-circuit court appellate conflict to be cognizable by DCA certiorari review in either an opinion or by amendment of Fla. R. App. P. 9.030(b)(2), addressing DCA certiorari jurisdiction. This suggestion was endorsed by several DCA judges, including Judge Logue, who wrote the dissent in Allstate discussed above, during the review conducted by Work Group on County Court Jurisdiction.⁴⁷

Under this approach, it would be necessary for an opinion or an amendment of court rule to recognize that intra- and inter-circuit court appellate conflict constitutes a "departure from the essential requirements of law." The grounds for such recognition could be based on Judge Logue's reasoning, which is discussed at length above. In short, this reasoning indicates that it is a "departure from the

⁴⁶ Id. at 139-140.

⁴⁷ During the final conference call of the Work Group on County Court Jurisdiction, the Work Group discussed whether the certiorari jurisdiction of the DCAs to review circuit court appellate decisions could be expanded to allow consideration of conflicting circuit court appellate decisions. Following that call, several DCA judges provided a written analysis. See Memorandum to former State Courts Administrator Patricia (PK) Jameson from Tina White, November 30, 2018 (on file with staff of the Office of the State Courts Administrator).

essential requirements of law” for “litigants in the exact same circumstances filing in the exact same county court [to] receive different outcomes based on conflicting case law.”⁴⁸

Second and alternatively, consideration could be given to Recommendation 2.3 by the Work Group on County Court Jurisdiction suggesting that a procedure be adopted allowing intra- and inter-circuit conflicts in circuit court appellate decisions within the same district to be certified to the applicable DCA. It is not clear, however, whether it is constitutionally permissible to amend the statutes or court rules to provide for this procedure. While explicit constitutional authority exists for the Supreme Court to review conflict certified by a DCA,⁴⁹ similar constitutional authority does not exist for a DCA to review conflict certified by a circuit court. Further, the State Constitution does not authorize the Legislature to adopt statutes prescribing the appellate jurisdiction of the DCAs, except in the case of direct review of administrative action.⁵⁰ Finally, case law squarely resolving this issue has not been located, but a related issue has been discussed.

In Nader, which involved a circuit court appellate decision relating to an administrative action, the Supreme Court directed the ACRC to “consider whether a circuit court should be able to certify a question of great public importance to the district court in circumstances where it is reviewing a decision of an administrative agency, similar to a county court's authority by rule to certify final orders to the district.”⁵¹ The ACRC concluded that such a rule would be advisable, but “determined that Article V of the Florida Constitution does not provide the district courts of appeal with jurisdiction for such review unless it is first ‘prescribed by general law.’”⁵²

In reaching this conclusion, the ACRC found that:

- Jurisdiction for the circuit courts to review administrative action is provided by the State Constitution and statutes and may occur through appellate jurisdiction or certiorari review.
- Unlike county courts, the statutes do not provide circuit courts with a “pass through” mechanism to certify questions to the DCA.
- Jurisdiction for a DCA to directly review an administrative action is conferred by the State Constitution, but only when prescribed by general law.
- At least one DCA has held that circuit courts have no constitutional or statutory authority to certify questions to the DCAs; instead, only county courts are statutorily authorized to certify questions to DCAs.⁵³

According to the ACRC, “[g]iven the different types of review of an administrative matter in the circuit courts (by certiorari or by appeal as provided by statute), it would seem that Chapter 26, Fla. Stat. (and possibly Chapter 34) would need to be amended to provide for the type of ‘pass through’ jurisdiction authorized in § 34.017 (and delineated in Florida Rule of Appellate Procedure 9.160).”⁵⁴ Further, it was

⁴⁸ [Allstate Fire & Cas. Ins. Co.](#), 253 So. 3d at 42.

⁴⁹ [Art. V, § 3\(b\)\(3\) and \(4\)](#), Fla. Const.

⁵⁰ [Article V, § 4\(b\)\(3\)](#), Fla. Const.

⁵¹ [Nader](#), 87 So. 3d at 727.

⁵² See “Appellate Court Rules Committee Administrative Law Practice Subcommittee – Final Subcommittee Report re: Referral No. 12-AC-06: [Nader v. Fla. Dep’t of Highway Safety and Motor Vehicles](#), 87 So. 3d 712 (Fla. 2012),” at 1 (on file with staff of the Office of the State Courts Administrator).

⁵³ [Id.](#) at 2-7.

⁵⁴ [Id.](#) at 7-8.

stated that, “[b]ecause jurisdiction cannot be created by rule, and because there is no general law that authorizes the type of review contemplated in the referral, the Subcommittee is without authority to take further action at this time.”⁵⁵

The certification procedure at issue in Nader relates to certified questions arising from a circuit court’s appellate review of administrative action. The State Constitution clearly states that a DCA may directly review administrative action as prescribed by general law. Accordingly, as indicated by the ACRC, it appears that statutory authorization for the type of certified questions contemplated in Nader may be constitutionally permissible.

A similar constitutional provision does not exist for DCAs with respect to review of county court decisions; instead, DCAs may constitutionally hear those cases only if they are not directly appealable to the Supreme Court or a circuit court. In the case of certified circuit court appellate conflict, the county court cases would have already been appealed to the circuit court; thus, it may be questionable whether a statutory conflict certification procedure in this context would be constitutionally permissible.

The Workgroup recognizes that either approach above could serve to significantly reduce conflicting appellate decisions within and among circuits; however, it also notes that this solution will increase DCA judicial workload while maintaining circuit court appellate workload. Additionally, not all conflicting decisions will be resolved by these procedures given that: the first approach will always be contingent on the discretionary filing of a petition for certiorari and the DCA’s acceptance of that petition; and the second approach will always be contingent on the circuit’s discretionary decision to certify conflict. Accordingly, the possibility for conflicting decisions among and within the 20 circuits remains; whereas, in contrast, if the circuit court’s appellate authority is transferred to the DCAs, conflicting decisions can exist only among the state’s five districts and circuit court appellate workload is eliminated.

Option 2 – Transfer Circuit Court Appellate Authority to the DCAs

Under the State Constitution, all circuit court appellate authority is controlled by general law, except for the circuit court’s authority to issue extraordinary writs. Pursuant to current statutes, circuit courts are authorized to review final judgments and certain nonfinal orders from county courts in civil⁵⁶ and criminal⁵⁷ cases and certain administrative actions.⁵⁸ To transfer this authority to the DCAs, it is necessary to amend the statutes to remove the circuit courts’ appellate authority. Upon amendment, the DCAs would then have jurisdiction under [Article V, § 4\(b\)\(1\), Fla. Const.](#), which provides that the DCAs shall hear appeals that may be taken as a matter of right from final judgments or orders of trial courts, including those entered on review of administrative action, that are not directly appealable to the Supreme Court or a circuit court. If such statutory amendments were adopted, conforming amendments to the Florida Rules of Appellate Procedure would also be necessary.

⁵⁵ Id. at 8.

⁵⁶ See Footnote 15.

⁵⁷ See Footnote 16.

⁵⁸ See Footnote 17.

Regarding extraordinary writs, the constitutional power of the:

- Circuit courts to issue such “writs, unlike all other forms of appellate review by the circuit courts, may be exercised in the absence of a statutory grant of jurisdiction.”⁵⁹ This jurisdiction, however, is limited to addressing substantive issues in controversy that are within the circuit courts’ subject matter jurisdiction; that is, “A circuit court may issue an extraordinary writ only where it has original or appellate jurisdiction.”⁶⁰ “As an illustration of this point, a circuit court judge could not issue an extraordinary writ to an administrative agency governed by the Administrative Procedure Act because the [DCA] would have exclusive jurisdiction over the substantive issues on appeal from the final order in such a case.”⁶¹
- DCAs “to issue an extraordinary writ generally follows jurisdiction to review an order by appeal. Therefore, a party who seeks to obtain an extraordinary writ directed to a lower court must file the petition in the appellate court that would have jurisdiction over the issue if it were presented in an appeal. For example, a party who is attempting to obtain a writ of prohibition to a county court must file the petition in the circuit court and not in the [DCA] because the circuit court would have direct appellate jurisdiction if the matter were appealed. This general rule is subject to at least one exception. In habeas corpus proceedings, the jurisdiction of the appellate court is determined exclusively by the location of the person detained regardless of jurisdiction on appeal from the final judgment.”⁶²

Accordingly, if the statutes are amended to remove circuit court appellate jurisdiction, the circuit courts would no longer have constitutional authority to issue extraordinary writs in those cases; instead, the DCAs would have the authority to issue writs in those cases as the DCAs would have appellate jurisdiction in the cases. Circuit courts would retain their constitutional extraordinary writ authority for cases in which they have original jurisdiction.

The chart set forth in Appendix C, entitled “Transfer of Circuit Court Authority to the District Courts of Appeal,” provides a more detailed discussion of relevant laws, rules, and case law, as well as a discussion of how to implement the transfer, for each category of circuit court appellate and writ jurisdiction. To transfer all circuit court appellate jurisdiction to the DCAs, numerous sections of law will need to be amended. Additionally, the Florida Rules of Appellate Procedure will need significant amendment.

The Workgroup recognizes that implementation of this option is exclusively within the authority of the Legislature and Governor and that it will require considerable operational changes to the current State Court System; however, the Workgroup believes that the following anticipated benefits outweigh any implementation challenges:

- Intra- and inter-circuit court appellate conflict will no longer exist. Conflict, which can be addressed by the Supreme Court, will only be possible among the five districts.
- Over time the number of appeals in county court and administrative cases is likely to decrease significantly as issues are resolved by the DCAs. An anecdotal report by one of the judges on the Workgroup indicated that over 100 pending appeals of county court PIP decisions arguing the same issue became moot on the day that the DCA issued an opinion resolving the issue.

⁵⁹ Padovano, *Fla. Appellate Practice* § 5.6.

⁶⁰ *Wovas v. Tousea Homes, Inc.*, 940 So. 2d 1166, 1167 (Fla. 2d DCA 2006).

⁶¹ Padovano, *Fla. Appellate Practice* § 5.6.

⁶² *Id.* at § 4.9.

- The DCAs currently have a decision publication process, use three-judge panels, and have an appropriate staffing complement in place dedicated solely to appeals. DCA judges have expertise in appellate cases and related issues and do not have trial court demands competing for time or resources. Moreover, the DCAs have the necessary foundational infrastructure and practices and procedures to handle appeals from county court and administrative decisions in a uniform manner. With this option, none of the many operational and legal issues discussed under Option 1 will exist.

The Workgroup also notes that with this option Florida would join the significant majority of 45 other states in having an appellate system implemented only by judges who exclusively focus on appeals.

Implementation challenges for this option include:

- A fundamental shift of this magnitude will require significant statutory and court rule revisions.
- Operational changes will be required in both the circuit and appellate courts to accommodate the new flow of cases. Circuit court clerks and DCA appellate clerks will have workload impacts as the workload is shifted.
- Self-represented litigants or other parties who may have grown accustomed to appeals being heard within the same local courthouse may be resistant to litigating in a DCA or may be inconvenienced by a DCA courthouse location that is further away. Given e-Filing, however, these parties should be affected by the location issue only when required to attend an oral argument, which is rarely ordered.⁶³
- An increase in workload may be experienced in the DCAs resulting in the need for additional resources to address the increase in cases. A projected appellate judge certification impact is provided in Table 2 below. A preliminary estimate, based on likely unreliable data that does not include administrative appeals and civil writ petitions, shows that the Fourth DCA may need three new judges to address the increase in workload. The estimate projects that all other DCAs could absorb the impact within current resources. Performance measures for the DCAs for fiscal year 2018-19 are included as Appendix E for reference.⁶⁴

Table 2						
Average Number of Cases Per DCA Judge by DCA (cases per judge based on a 3-year avg.)	1 st DCA	2 nd DCA	3 rd DCA	4 th DCA	5 th DCA	Average
Current Estimated Number of Cases Per Judge	268	281	237	339	310	287
Estimated Number of Cases Per Judge If Appeals Are Shifted to the DCAs	284	309	262	399	337	318

- The estimates above are based on the official trial court statistics from the SRS and on a three-year average workload from fiscal year 15-16, 16-17, and 17-18, certification opinion methodology.
- Additional judgeships are based on the presumptive need of a 315-case, average weighted workload per judge after the application of the additional judgeship(s). Based on the estimate above, the Fourth DCA

⁶³ See Appendix D entitled “Percent of DCA Cases with Oral Argument Scheduled.”

⁶⁴ See Appendix E entitled “Performance Measures – DCAs for Fiscal Year 2018-2019.”

would need three new judges and all other DCAs could absorb the impact within current resources. (Fourth DCA - plus 1 judge=368, plus 2 judges=342, plus 3 judges=319)

- The estimates assume that county court appeals will be disposed on the merits: in five case types (Civil Final, Civil Non-Final, Judgement and Sentence, Post-Conviction Summary, and Post-Conviction Non-Summary); and at the same rate as circuit court appeals to the DCA. Approximately 65 percent of appeals from circuit court decisions are heard by a DCA judge and disposed on the merits. The remaining appeals are disposed by the clerk.
- The numbers of administrative appeals and petitions for writs in civil appellate cases, which are currently filed in circuit court, are not included in this estimate as this data is not available.
- A fiscal impact is anticipated for litigants filing an appeal if all appeals are transferred to the DCAs. The appellate filing fee will increase from a circuit court cost of \$281.00 to a DCA cost of \$400.00. Other fiscal impacts to the Clerks of Court, State Courts Revenue Trust Fund, and general revenue, as a result of shifting all appeals to the DCAs, are illustrated below in Table 3.

Table 3		
Revenue Impact Estimate from Shifting County Court Appeals from Circuit Court to District Court		
	Fee Distribution	Revenue Impact Based on 1,609 Appellate Cases
Revenue Generating Appellate Cases Filed in DCAs		
Clerks of Court	\$80.00	\$128,720
State Courts Revenue Trust Fund	\$50.00	\$80,450
General Revenue	\$270.00	\$434,430
Total	\$400.00	\$643,600
Revenue Generating Appellate Cases Filed in Circuit Courts		
Clerks of Court	\$260.00	\$418,340
State Courts Revenue Trust Fund	\$1.00	\$1,609
General Revenue	\$20.00	\$32,180
Total	\$281.00	\$452,129
Difference		
Clerks of Court		-\$289,620
State Courts Revenue Trust Fund		\$78,841
General Revenue		\$402,250
Total		\$191,471

- Based on the estimates of appellate cases filed in fiscal year 2018-19 (1,609 civil cases, which required a filing fee), the fiscal impact above details the difference in total revenue collected and distribution of the revenue if civil cases originating in the county court were appealed to the DCAs.
- The number of administrative appeals and petitions for writs filed in circuit court are indeterminate. Therefore, a fiscal impact from a change in the distribution of revenue from those filings is also indeterminate.

Recommendations

Based on the Workgroup's findings discussed above, the Workgroup recommends that the Florida Supreme Court:

1. Approve the proposal of statutory amendments to transfer the circuit courts' appellate and related extraordinary writ authority to the DCAs in county civil cases, including non-criminal violations, county criminal cases, and administrative cases. If the new law is adopted during the 2021 Regular Legislative Session, an effective date of January 1, 2022, is recommended to allow time to make operational changes for the court system and to adopt conforming amendments to the Florida Rules of Court.
2. Direct the Commission on District Court of Appeal Performance and Accountability and the Commission on Trial Court Performance and Accountability to consider impacts on workload, data collection, and other issues related to the implementation of Recommendation 1.
3. Encourage circuit courts to conclude pending appeals within 24 months following the transfer of circuit court appellate jurisdiction to the DCAs to prevent these cases from remaining open and continuing to require the exercise of circuit court appellate jurisdiction for an extended period.

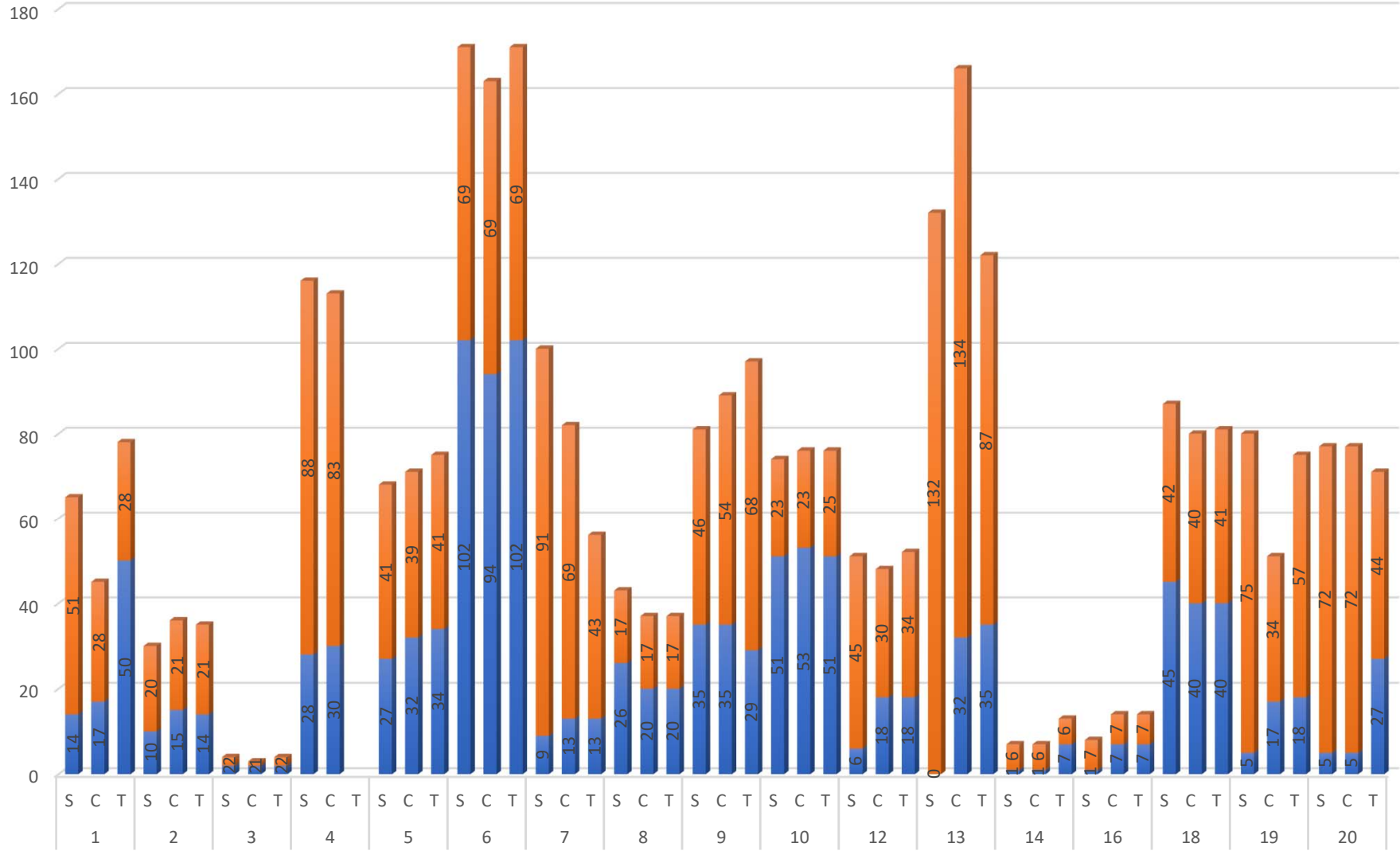
Summary Reporting System
Fiscal Year 2016-17

County Court Appeals to Circuit Court by Circuit and County				
Circuit	County	County Court Criminal Appeals to Circuit Court	County Court Civil Appeals to Circuit Court	Total Appeals
1	Escambia	0	20	20
	Okaloosa	0	27	27
	Santa Rosa	12	2	14
	Walton	2	2	4
	Circuit Total	14	51	65
2	Franklin	0	1	1
	Gadsden	0	0	0
	Jefferson	1	0	1
	Leon	9	19	28
	Liberty	0	0	0
	Wakulla	0	0	0
	Circuit Total	10	20	30
3	Columbia	1	0	1
	Dixie	0	1	1
	Hamilton	1	1	2
	Lafayette	0	0	0
	Madison	0	0	0
	Suwannee	0	0	0
	Taylor	0	0	0
	Circuit Total	2	2	4
4	Clay	2	3	5
	Duval	24	80	104
	Nassau	2	5	7
	Circuit Total	28	88	116
5	Citrus	2	6	8
	Hernando	2	13	15
	Lake	0	14	14
	Marion	18	7	25
	Sumter	5	1	6
	Circuit Total	27	41	68
6	Pasco	34	16	50
	Pinellas	68	53	121
	Circuit Total	102	69	171
7	Flagler	0	31	31
	Putnum	1	0	1

Circuit	County	County Court Criminal Appeals to Circuit Court	County Court Civil Appeals to Circuit Court	Total Appeals
	St.Johns	4	15	19
	Volusia	4	45	49
	Circuit Total	9	91	100
8	Alachua	25	13	38
	Baker	0	0	0
	Bradford	0	1	1
	Gilchrist	1	1	2
	Levy	0	2	2
	Union	0	0	0
	Circuit Total	26	17	43
9	Orange	14	32	46
	Osceola	21	14	35
	Circuit Total	35	46	81
10	Hardee	0	0	0
	Highlands	5	5	10
	Polk	46	18	64
	Circuit Total	51	23	74
11	Miami-Dade	47	113	160
	Circuit Total	47	113	160
12	DeSoto	0	1	1
	Manatee	6	14	20
	Sarasota	0	30	30
	Circuit Total	6	45	51
13	Hillborough	0	132	132
	Circuit Total	0	132	132
14	Bay	0	4	4
	Calhoun	0	0	0
	Gulf	0	0	0
	Holmes	1	1	2
	Jackson	0	0	0
	Washington	0	1	1
	Circuit Total	1	6	7
15	Palm Beach	41	0	41
	Circuit Total	41	0	41
16	Monroe	1	7	8
	Circuit Total	1	7	8
17	Broward	0	572	572
	Circuit Total	0	572	572
18	Brevard	14	27	41
	Seminole	31	15	46
	Circuit Total	45	42	87

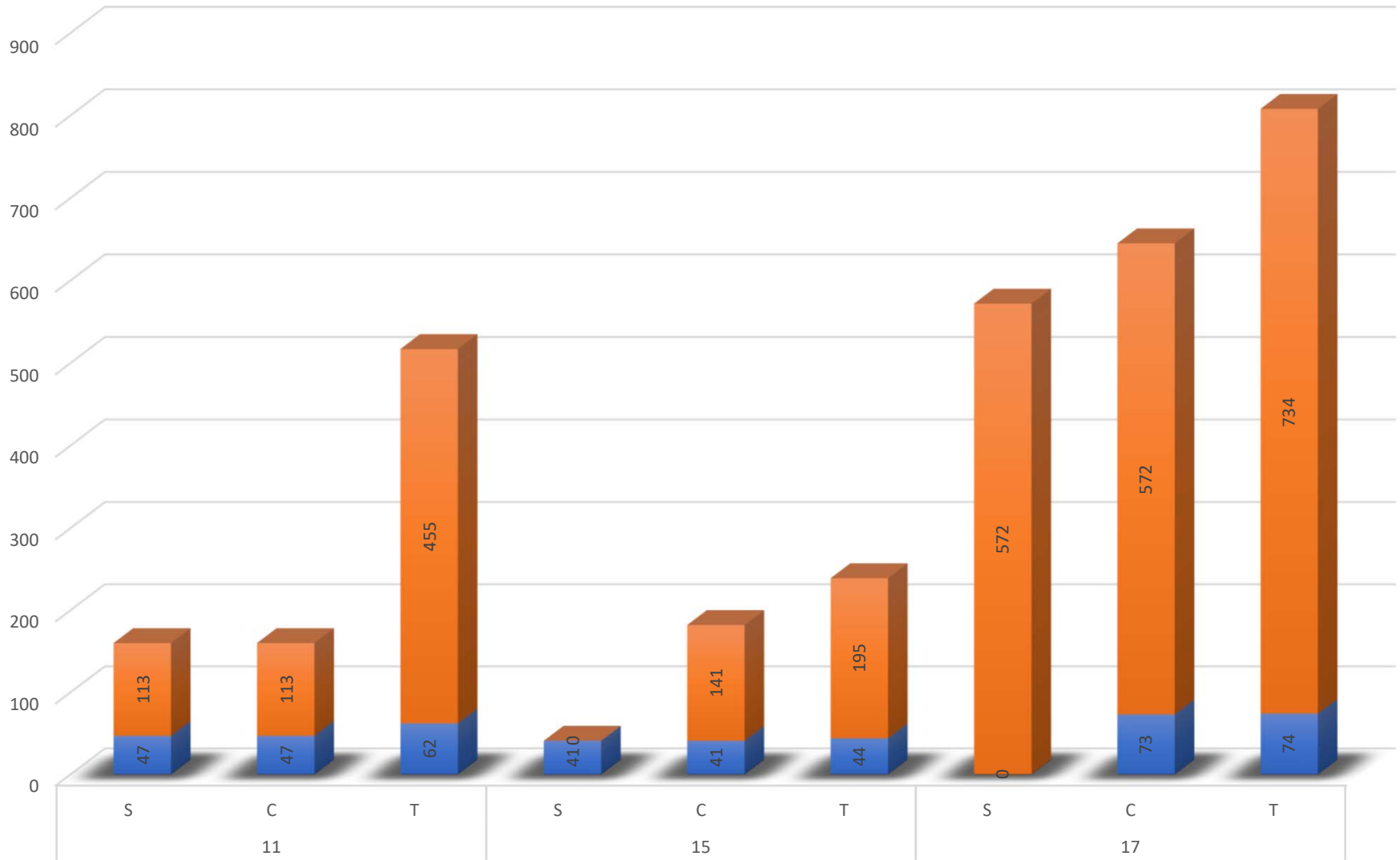
Circuit	County	County Court Criminal Appeals to Circuit Court	County Court Civil Appeals to Circuit Court	Total Appeals
19	Indian River	0	0	0
	Martin	4	18	22
	Okeechobee	0	0	0
	St.Lucie	1	57	58
	Circuit Total	5	75	80
20	Charlotte	0	15	15
	Collier	5	32	37
	Glades	0	0	0
	Hendry	0	0	0
	Lee	0	25	25
	Circuit Total	5	72	77
	State Total	455	1512	1967

Number of Appeals Recorded by Entity (SRS, Clerk of Court, and Court Administration) by Circuit for FY 2016-17



S = Stateside Summary Reporting System (SRS), C = Clerk of Court Correction, T = Trial Court Administrator, Court Administration

Number of Appeals Recorded by Entity (SRS, Clerk of Court, and Court Administration) by Circuit for FY 2016-17



S = Stateside Summary Reporting System (SRS), C = Clerk of Court Correction, T = Trial Court Administrator, Court Administration

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
Appeals of county court <u>final</u> orders or judgments in <u>civil</u> cases	<p>Circuits courts “have jurisdiction of appeals when provided by law.” Article V, § 5(b), Fla. Const.</p> <p>District Courts of Appeal (DCAs) “have jurisdiction to hear appeals, that may be taken as a matter of right, from final judgments or orders of trial courts, including those entered on review of administrative action, not directly appealable to the supreme court or a circuit court.” Article V, § 4(b)(1), Fla. Const.</p>	<p>Circuit courts have jurisdiction of appeals from county courts except:</p> <ol style="list-style-type: none"> Appeals of county court orders or judgments declaring a statute or constitutional provision invalid; or Orders or judgments of a county court which are certified by the county court to the district court of appeal to be of great public importance and which are accepted by the district court of appeal for review. § 26.012(1), Fla. Stat. 	<p>Circuit courts shall review by appeal: “final orders of lower tribunals¹ as provided by general law.” Fla R. App. P. 9.030(c)(1)(A).</p>	<p>To transfer circuit court authority to hear the referenced appeals, repeal that authority in § 26.012(1). Upon repeal, the DCA will have jurisdiction for the appeals under Article V., 4(b)(1), Fla. Const.</p> <p>Amend rule to conform to the repeal of statute.</p>
Appeals of county court <u>final</u> orders or judgments in <u>criminal</u> cases	“	<p>Circuit courts have jurisdiction of appeals from final judgments in misdemeanor cases. § 924.08, Fla. Stat.</p>	“	<p>To transfer circuit court authority to hear the referenced appeals, repeal that authority in § 924.08, Fla. Stat. Upon repeal, the DCAs will have jurisdiction for the appeals under Article V, 4(b)(1), Fla. Const.</p>

¹ [Fla. R. App. P. 9.020\(e\)](#), defines “lower tribunal” as “[t]he court, agency, officer, board, commission, judge of compensation claims, or body whose order is to be reviewed.”

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
				Amend rule to conform to the repeal of statute.
Appeals of county court <u>nonfinal</u> orders in <u>civil</u> cases	Under Article V, § 5(b), Fla. Const. , a circuit court may review a nonfinal order only if authorized by statute. In contrast, under Article V, 4(b)(1), Fla. Const. , a DCA may review a nonfinal order only if authorized by court rule.	<p>In the civil context, the statutes do not enumerate the types of nonfinal, civil county court orders that may be reviewed by circuit courts.² Instead, § 26.012(1), Fla. Stat., confers appellate jurisdiction on the circuit courts without reference to whether the county court order is final or nonfinal.</p> <p>Whether such jurisdiction includes circuit court appellate authority for nonfinal orders in civil county cases has not been uniformly construed.³ For example, the Fourth DCA has held that “Circuit Courts do not have any general jurisdiction under the appellate rules to review nonfinal orders—such as the entry of a default without a final judgment.”⁴ Similarly, according to a Florida Bar Journal article, circuit courts in the Seventh and Eleventh Judicial Circuits have held that they do not have appellate jurisdiction over nonfinal orders.⁵ Conversely, the Eleventh and Twentieth Judicial Circuits have held that § 26.012(1), Fla. Stat., confers appellate jurisdiction for nonfinal orders because the statute’s enumeration of two exceptions, without mention of nonfinal orders, means that the</p>	<p>Circuit courts shall review by appeal: “nonfinal orders of lower tribunals as provided by general law.” Fla R. App. P. 9.030(c)(1)(B).</p> <p>The types of noncriminal, nonfinal orders that may be reviewed by a DCA are enumerated in Fla R. App. P. 9.130(3). If an order is not enumerated, a party may seek only certiorari or other extraordinary review in the DCA.</p>	<p>To remove any circuit court authority that may exist for the referenced appeals, repeal that authority in § 26.012(1), Fla. Stat. Upon repeal, the DCAs will have jurisdiction for such appeals only to the extent authorized by court rule under Article V, 4(b)(1), Fla. Const.</p> <p>Consider whether the DCAs’ authority to hear nonfinal civil appeals in Fla R. App. P. 9.130(a)(3), needs to be revised. Amend other rule provisions, if necessary, to conform to the repeal of statute.</p>

² Heather M. Kolinsky, [Navigating the Differences in Circuit Court Appellate Jurisdiction for Nonfinal Orders](#), Fla. B.J., January/February 2019, at 56.

³ [Id.](#) at 57.

⁴ [Shell v. Foulkes](#), 19 So. 3d 438, 440 (Fla. 4th DCA 2009).

⁵ See Footnote 3.

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
		Legislature did not mean to except nonfinal orders from circuit court appellate jurisdiction. ⁶		
Appeals of county court <u>nonfinal</u> orders in <u>criminal</u> cases	“	In the criminal context, a defendant does not have a statutory right to appeal nonfinal orders entered before the judgment; instead, the defendant may appeal only the final judgment and certain post-judgment orders. § 924.06, Fla. Stat. In contrast, the State, may appeal specified nonfinal, final, and post-judgment orders. §§ 924.07 and 924.071 , Fla. Stat. Statutorily authorized appeals by the State of nonfinal county court orders in a misdemeanor case are to be heard by the circuit court. ⁷	Circuit courts shall review by appeal: “nonfinal orders of lower tribunals as provided by general law.” Fla R. App. P. 9.030(c)(1)(B) . “The state as provided by general law may appeal to the circuit court nonfinal orders rendered in the county court.” Fla R. App. P. 9.140(c) .	To remove circuit court authority for the referenced appeals, repeal that authority in § 924.08, Fla. Stat. Upon repeal, the DCAs will have jurisdiction for such appeals only to the extent authorized by court rule under Article V, 4(b)(1), Fla. Const. Consider whether the DCAs’ authority to hear nonfinal appeals in Fla R. App. P. 9.140(c)(1) , needs to be revised. Amend other rule provisions, if necessary, to conform to the repeal of statute.
Appeals of county court determinations relating to non-criminal violations ⁸	Circuits courts “have jurisdiction of appeals when provided by law.” Article V, § 5(b), Fla. Const.	The following statutes authorize appeals of certain county court decisions relating to noncriminal violations (also sometimes referred to as “noncriminal infractions”) to the circuit court: (a) §§ 318.16 and 318.33 , Fla. Stat., relating to traffic law infractions; (b) § 327.73, Fla. Stat. , relating to	Circuit courts shall review by appeal: “final orders of lower tribunals as provided by general law.” Fla	To transfer circuit court authority to hear the referenced appeals, repeal that authority in the cited statutes. Upon repeal, the DCAs will have jurisdiction for the appeals under Article V., 4(b)(1),

⁶ [Id.](#)
⁷ [State v. Ratner](#), 948 So. 2d 700, 704 (Fla. 2007).

⁸ The term “noncriminal violation” means “any offense that is punishable under the laws of this state, or that would be punishable if committed in this state, by no other penalty than a fine, forfeiture, or other civil penalty. A noncriminal violation does not constitute a crime, and conviction for a noncriminal violation shall not give rise to any legal

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
	DCAs “have jurisdiction to hear appeals, that may be taken as a matter of right, from final judgments or orders of trial courts, including those entered on review of administrative action, not directly appealable to the supreme court or a circuit court.” Article V, § 4(b)(1), Fla. Const.	<p>vessel law infractions; (c) §§ 376.065, 376.07, 376.071, and 376.16, Fla. Stat., relating to pollutant law infractions; (d) §§ 379.401, 379.4015, and 379.412, Fla. Stat., relating to fish and wildlife conservation law infractions; (e) § 556.107, Fla. Stat., relating to underground facility infractions; and (f) § 569.005, Fla. Stat., relating to operating with a retail tobacco products dealer permit infractions.</p> <p>Preliminary research by staff did not locate any statutes or case law discussing review of nonfinal orders in the context of non-criminal infractions. For purposes of this chart, nonfinal orders in this context will be treated in the same manner as nonfinal orders in the county court civil order context; i.e., if authority for appeals relating to non-criminal infractions is transferred to the DCAs, court rule would have to authorize the review of nonfinal orders by DCAs in such cases if it is the intent to authorize such nonfinal appeals.</p>	<p>R. App. P. 9.030(c)(1)(A).</p> <p>Circuit courts shall review by appeal: “nonfinal orders of lower tribunals as provided by general law.” Fla R. App. P. 9.030(c)(1)(B).</p> <p>The types of noncriminal, nonfinal orders that may be reviewed by a DCA are enumerated in Fla R. App. P. 9.130(3). If an order is not enumerated, a party may seek only certiorari or other extraordinary review in the DCA.</p>	<p>Fla. Const., as long as statute continues to provide for such appeals as a matter of right.</p> <p>Consider whether the DCAs’ authority to hear nonfinal civil appeals in Fla R. App. P. 9.130(a)(3), needs to be revised. Amend other rule provisions, if necessary, to conform to the repeal of statute.</p>

disability based on a criminal offense. The term ‘noncriminal violation’ shall not mean any conviction for any violation of any municipal or county ordinance. Nothing contained in this code shall repeal or change the penalty for a violation of any municipal or county ordinance.” [§ 775.08\(3\), Fla. Stat.](#)

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
Appeals of administrative action ⁹	<p>Circuit courts “have the power of direct review of administrative action prescribed by general law.” Article V, § 5(b), Fla. Const.</p> <p>DCAs “have the power of direct review of administrative action, as prescribed by general law.” Article V, § 4(b)(2), Fla. Const.</p>	<p>The majority of agency¹⁰ action at the state level is appealable under the Administrative Procedure Act (APA) to the DCAs pursuant to § 120.68, Fla. Stat., providing for appeals of final agency action as well as nonfinal agency action if review of the final action would not provide an adequate remedy.</p> <p>For other types of administrative action, there is no general statute conferring appellate jurisdiction to the circuit courts or DCAs over quasi-judicial actions¹¹ issued by local government and non-APA agencies. Instead, statute grants such authority based on the specific type of action or entity taking action. For example, the following appeals may be filed in circuit court: (a) §§ 26.012(1) and 162.11, Fla. Stat., authorize appeals of final administrative orders entered by a local government code enforcement board; (b) § 316.0083, Fla. Stat., authorizes appeals of final administrative orders entered by local governments in red-light camera cases; and (c) §§ 489.127 and 489.531, Fla. Stat., authorize appeals of final administrative orders entered by an enforcement board, a licensing</p>	<p>Circuit courts shall review by appeal: “administrative action if provided by general law.” Fla R. App. P. 9.030(c)(1)(C).</p> <p>DCAs shall review by appeal: “administrative action if provided by general law.” Fla R. App. P. 9.030(b)(1)(C).</p>	<p>To transfer circuit court authority to hear the referenced appeals to the DCAs, amend the statutes to substitute the DCAs for the circuit courts.</p> <p>Amend rule, if necessary, to conform to the repeal of statute.</p>

⁹ [Fla. R. App. P. 9.020\(a\)](#), provides that, “‘Administrative action’ shall include: (1) final agency action as defined in the Administrative Procedure Act, chapter 120, Florida Statutes; (2) nonfinal action by an agency or administrative law judge reviewable under the Administrative Procedure Act; (3) quasi-judicial decisions by any administrative body, agency, board, or commission not subject to the Administrative Procedure Act; and (4) administrative action for which judicial review is provided by general law.”

¹⁰ “Agency” includes specified officers and governmental entities in the executive branch and multi-county entities. See [§ 120.52\(1\), Fla. Stat.](#) (setting forth the full definition of “agency” for purposes of [Chapter 120, Fla. Stat.](#), entitled the “Administrative Procedure Act”).

¹¹ Only quasi-judicial actions by such entities may be reviewed. A decision that is legislative in character may not be judicially reviewed. Philip J. Padovano, [Fla. Appellate Practice § 5.4](#) (2018 ed.).

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
		<p>board, or a designated special magistrate in contracting enforcement or licensing cases.</p> <p>The right to appeal an administrative action by non-APA agencies is limited to final orders. Nonfinal orders may be reviewed only by writ of certiorari.¹²</p>		
Extraordinary writs	<p>Circuit courts “have the power to issue writs of mandamus, quo warranto, certiorari, prohibition and habeas corpus, and all writs necessary or proper to the complete exercise of their jurisdiction.” Article V, § 5(b), Fla. Const.</p> <p>A DCA “may issue writs of habeas corpus returnable before the court or any judge thereof or before any circuit judge within the territorial jurisdiction of the court. A district</p>	<p>“The constitutional power of the circuit courts to issue extraordinary writs, unlike all other forms of appellate review by the circuit courts, may be exercised in the absence of a statutory grant of jurisdiction.”¹³ This jurisdiction, however, is limited to addressing substantive issues in controversy that are within the courts’ subject matter jurisdiction; that is, “A circuit court may issue an extraordinary writ only where it has original or appellate jurisdiction.”¹⁴ “As an illustration of this point, a circuit court judge could not issue an extraordinary writ to an administrative agency governed by the Administrative Procedure Act because the district court of appeal would have exclusive jurisdiction over the substantive issues on appeal from the final order in such a case.”¹⁵</p>	<p>Circuit courts have original jurisdiction to “issue writs of mandamus, prohibition, quo warranto, common law certiorari, and habeas corpus, and all writs necessary to the complete exercise of the courts’ jurisdiction.” Fla R. App. P. 9.030(c)(3).</p> <p>DCAs have original jurisdiction to “issue writs of mandamus,</p>	<p>The circuit courts’ constitutional power to issue writs cannot itself be statutorily transferred to the DCAs. Absent a constitutional amendment, circuit courts will have writ authority for any case in which they have original or appellate jurisdiction. What can be statutorily modified, however, are the types of cases for which statute grants appellate jurisdiction to the circuit courts. If the circuit courts’ statutory authority to hear appeals of:</p> <ol style="list-style-type: none"> a. County court final orders is repealed, the DCAs will have that appellate jurisdiction pursuant to Article V,

¹² [Id.](#)
¹³ Philip J. Padovano, [Fla. Appellate Practice § 5.6](#) (2018 ed.).
¹⁴ [Wovas v. Touse Homes, Inc.](#), 940 So. 2d 1166, 1167 (Fla. 2d DCA. 2006).
¹⁵ Philip J. Padovano, [Fla. Appellate Practice § 5.6](#) (2018 ed.).

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
	<p>court of appeal may issue writs of mandamus, certiorari, prohibition, quo warranto, and other writs necessary to the complete exercise of its jurisdiction. To the extent necessary to dispose of all issues in a cause properly before it, a district court of appeal may exercise any of the appellate jurisdiction of the circuit courts.” Article V, § 4(b)(3), Fla. Const.</p>	<p>For DCAs, “Jurisdiction to issue an extraordinary writ generally follows jurisdiction to review an order by appeal. Therefore, a party who seeks to obtain an extraordinary writ directed to a lower court must file the petition in the appellate court that would have jurisdiction over the issue if it were presented in an appeal. For example, a party who is attempting to obtain a writ of prohibition to a county court must file the petition in the circuit court and not in the district court of appeal because the circuit court would have direct appellate jurisdiction if the matter were appealed. This general rule is subject to at least one exception. In habeas corpus proceedings, the jurisdiction of the appellate court is determined exclusively by the location of the person detained regardless of jurisdiction on appeal from the final judgment.”¹⁶</p> <p>Numerous statutes authorize the filing of petitions for various writs in the circuit courts. For example, a petition for a writ of certiorari may be filed in the circuit court pursuant to: (a) § 163.3215, Fla. Stat., for review of a decision by a local government to grant or deny an application for a development order; (b) § 171.081, Fla. Stat., for review of a decision by a local government relating to municipality boundaries; and (c) § 322.31, Fla. Stat., for review of certain final orders and rulings</p>	<p>prohibition, quo warranto, and common law certiorari, and all writs necessary to the complete exercise of the courts' jurisdiction; or any judge thereof may issue writs of habeas corpus returnable before the court or any judge thereof, or before any circuit judge within the territorial jurisdiction of the court.” Fla R. App. P. 9.030(b)(3).</p>	<p>4(b)(1), Fla. Const., and, in turn, writ authority in those cases.</p> <p>b. County court nonfinal orders is repealed, the DCAs will have that appellate jurisdiction if authorized by court rule pursuant to Article V, 4(b)(1), Fla. Const., and, in turn, writ authority in those cases.</p> <p>c. Administrative orders is repealed, statute may be amended to transfer that appellate jurisdiction to the DCAs pursuant to Article V, 4(b)(2), Fla. Const.; thereby, conferring writ authority to the DCAs in those cases.</p> <p>It is unknown whether <u>all</u> the statutes that confer writ authority to the circuit courts for specific types of decisions or orders may be amended to substitute DCAs for circuit courts. Although the Legislature is constitutionally authorized to</p>

¹⁶ Philip J. Padovano, [Fla. Appellate Practice § 4.9](#) (2018 ed.).

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
		relating to denials, cancellations, suspensions, or revocations of drivers licenses. Additionally, some statutes confer authority for the filing of a petition for a writ without specifically referencing the court in which the petition should be filed.		<p>prescribe the jurisdiction of circuit courts for appeals and for direct review of administrative action, the Legislature is constitutionally authorized to prescribe only the jurisdiction of DCAs for direct review of administrative action. The Legislature cannot adopt statute prescribing the jurisdiction of DCAs to hear appeals generally. Instead, the Constitution empowers the DCAs to hear appeals that “may be taken as a matter of right, from final judgments or orders of trial courts, including those entered on review of administrative action, not directly appealable to the supreme court or a circuit court.” Article V, § 4(b)(1), Fla. Const.</p> <p>Accordingly, statutes conferring writ jurisdiction may be amended to substitute the DCAs for the circuit courts to the extent that those statutes relate to review of administrative action; however, it may not be constitutionally</p>

Transfer of Circuit Court Appellate Authority to the District Courts of Appeal				
Appellate/Writ Authority of Circuit Courts	Florida Constitution	Statute	Rules	Implementation of Transfer
				authorized to similarly amend statutes relating to non-administrative matters. Based on current research, it appears most of the statutes at issue here relate to administrative action.

Percent of District Court of Appeal Cases with Oral Argument Scheduled

Fiscal Year	District	Cases Filed	Oral Argument Scheduled	% of Cases with OA Scheduled
2015-16	1	5,906	229	4%
	2	5,754	477	8%
	3	3,021	575	19%
	4	4,574	222	5%
	5	4,483	254	6%
	State Total	23,738	1,757	7%
2016-17	1	5,550	172	3%
	2	5,536	427	8%
	3	2,881	575	20%
	4	4,224	194	5%
	5	4,307	264	6%
	State Total	22,498	1,632	7%
2017-18	1	5,526	226	4%
	2	5,009	416	8%
	3	2,622	548	21%
	4	3,895	183	5%
	5	4,146	254	6%
	State Total	21,198	1,627	8%

Information from the appellate court eFACTS case management system.

Performance and Accountability

Performance Measures - DCAs

Fiscal Year 2018 - 2019

Item	Measure	Statistic					
		First	Second	Third	Fourth	Fifth	Statewide
1	Total Filings	<u>4972</u>	<u>4980</u>	<u>2590</u>	<u>3878</u>	<u>3863</u>	20283
2	Total Dispositions	<u>5032</u>	<u>4956</u>	<u>2838</u>	<u>3784</u>	<u>3955</u>	20565
3	Total Clearance Rate	101.2 %	99.5 %	109.6 %	97.6 %	102.4 %	101.4 %
4	<u>Notice of Appeal Filings</u>	<u>3978</u>	<u>3745</u>	<u>2005</u>	<u>2987</u>	<u>3035</u>	15750
5	<u>Petition Filings</u>	<u>994</u>	<u>1235</u>	<u>584</u>	<u>891</u>	<u>826</u>	4530
7	Criminal Filings	<u>2951</u>	<u>3091</u>	<u>1010</u>	<u>1977</u>	<u>2479</u>	11508
8	Criminal Dispositions	<u>2926</u>	<u>3040</u>	<u>1040</u>	<u>1877</u>	<u>2519</u>	11402
9	Criminal Clearance Rate	99.2 %	98.4 %	103 %	94.9 %	101.6 %	99.1 %
10	Non-Criminal Filings	<u>2021</u>	<u>1889</u>	<u>1580</u>	<u>1901</u>	<u>1384</u>	8775
11	Non-Criminal Dispositions	<u>2106</u>	<u>1916</u>	<u>1798</u>	<u>1907</u>	<u>1436</u>	9163
12	Non-Criminal Clearance Rate	104.2 %	101.4 %	113.8 %	100.3 %	103.8 %	104.4 %
13	Pending Cases	<u>3662.3</u>	<u>3838.5</u>	<u>1549.8</u>	<u>2128.7</u>	<u>2142.7</u>	13321.8
14	Criminal Notices of Appeal - Median Days from Filing to Disposition	<u>316</u>	<u>317</u>	<u>173</u>	<u>197</u>	<u>179</u>	270
15	Criminal Petitions - Median Days from Filing to Disposition	<u>93</u>	<u>43</u>	<u>8</u>	<u>35</u>	<u>45</u>	47
16	Percentage of Criminal Cases Disposed within 180 Days of Conference/OA	<u>90 %</u>	<u>97.9 %</u>	<u>97 %</u>	<u>99 %</u>	<u>98.6 %</u>	96.3 %
17	Non-Criminal Notices of Appeal - Median Days from Filing to Disposition	<u>157</u>	<u>260</u>	<u>217</u>	<u>204</u>	<u>202</u>	210
18	Non-Criminal Petitions - Median Days from Filing to Disposition	<u>113</u>	<u>85</u>	<u>51</u>	<u>37</u>	<u>64</u>	66
19	Percentage of Non-Criminal Cases Disposed within 180 Days of Conference/OA	<u>83.5 %</u>	<u>93.1 %</u>	<u>87.7 %</u>	<u>98.9 %</u>	<u>98.7 %</u>	92 %
20	<u>Dispositions on the Merits for Petitions</u>	<u>870</u>	<u>1165</u>	<u>565</u>	<u>733</u>	<u>698</u>	4031
21	<u>Dispositions on the Merits for Notices</u>	<u>2666</u>	<u>2646</u>	<u>1501</u>	<u>1981</u>	<u>2268</u>	11062
22	<u>Anders Dispositions on the Merits</u>	<u>412</u>	<u>288</u>	<u>112</u>	<u>68</u>	<u>380</u>	1260

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

12/11/19

Meeting Date

NA

Bill Number (if applicable)

Topic Appellate Review/County Court Dec

Amendment Barcode (if applicable)

Name Judge Robert Morris

Job Title Second District Court of Appeal

Address 1700 North Tampa St, #300 Phone 813-272-3430

Street

Tampa, FL 33602

City

State

Zip

Email

Speaking: [] For [] Against [] Information

Waive Speaking: [] In Support [] Against (The Chair will read this information into the record.)

Representing State Courts System

Appearing at request of Chair: [x] Yes [] No

Lobbyist registered with Legislature: [] Yes [x] No

Presentation

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

CourtSmart Tag Report

Room: LL 37

Case No.:

Type:

Caption: Senate Appropriations Subcommittee on Criminal and Civil Justice

Judge:

Started: 12/11/2019 1:31:38 PM

Ends: 12/11/2019 3:05:16 PM

Length: 01:33:39

1:31:49 PM Sen. Brandes (Chair)
1:32:17 PM S 346
1:32:23 PM Sen. Bradley
1:38:57 PM Sen. Brandes
1:39:03 PM Sen. Harrell
1:39:48 PM Sen. Bradley
1:41:23 PM Sen. Harrell
1:41:41 PM Sen. Bradley
1:42:00 PM Sen. Rouson
1:42:17 PM Sen. Bradley
1:42:22 PM Sen. Brandes
1:43:07 PM Sen. Bradley
1:44:46 PM Sen. Brandes
1:44:49 PM Sen. Harrell
1:45:28 PM Sen. Bradley
1:47:14 PM Sen. Brandes
1:47:41 PM Sen. Bradley
1:47:49 PM Sen. Brandes
1:47:55 PM Am. 704682
1:48:35 PM Sen. Bradley
1:48:54 PM S 346 (cont.)
1:49:06 PM Ida Eskomani, Public Affairs, New Florida Majority waives in support
1:49:13 PM Dan Hendrickson, President, Tallahassee Veterans Legal Collaborative waives in support
1:49:18 PM Sal Nuzzo, Vice President of Policy, The James Madison Institute waives in support
1:49:23 PM Scott McCoy, Policy Director, Souther Poverty Law Action Fund waives in support
1:49:27 PM Cesar Grajales, Coalitions Director, The Libre Initiative waives in support
1:49:32 PM Nancy Daniels, Legislative Consultant, Florida Public Defender Association waives in support
1:49:38 PM Dr. Adina Thompson, Intake Coordinator, Innocence Project of Florida waives in support
1:49:54 PM Greg Newborn, Florida Director, FAMM waives in support
1:50:00 PM Chelsea Murphy, Florida Director, Right on Crime waives in support
1:50:02 PM Christian Minor, Executive Director, Florida Juvenile Justice Association waives in support
1:50:07 PM Ken Kniepmann, Florida Conference Catholic Bishops waives in support
1:50:13 PM Diego Echeverri, Legislative Liaison, Americans for Prosperity waives in support
1:50:27 PM Pamela Burch Fort, ACLU of Florida waives in support
1:50:32 PM Tracy Johnson, Retired ASAC, Florida Cares waives in support
1:50:36 PM Sen. Rouson
1:52:19 PM Sen. Bradley
1:52:59 PM Sen. Brandes
1:53:31 PM Tab 2 - Presentation on Governor's Fiscal Year 2020-21 Budget Recommendations
1:54:03 PM Katie Cunningham, Public Safety Policy Coordinator, Representing Governor DeSantis
1:57:39 PM Mark Inch, Secretary, Florida Department of Corrections
2:03:50 PM Sen. Rouson
2:04:01 PM M. Inch
2:04:03 PM Sen. Rouson
2:04:09 PM M. Inch
2:04:42 PM Sen. Harrell
2:05:19 PM M. Inch
2:06:11 PM Sen. Harrell
2:06:30 PM M. Inch
2:07:11 PM Sen. Rouson
2:07:38 PM M. Inch
2:07:51 PM Sen. Brandes

2:08:06 PM K. Cunningham
2:08:28 PM Simone Marsteller, Secretary, Department of Juvenile Justice
2:17:17 PM Sen. Rouson
2:17:42 PM S. Marsteller
2:17:50 PM Sen. Harrell
2:18:39 PM S. Marsteller
2:19:43 PM Sen. Harrell
2:19:57 PM K. Cunningham
2:25:30 PM Sen. Brandes
2:25:43 PM Tab 3 - Presentation on a Study of Health Care Services in the Florida Department of Corrections
2:25:49 PM Karl Becker, Senior Vice President, CGL Companies
2:46:52 PM Sen. Taddeo
2:47:04 PM K. Becker
2:47:34 PM Sen. Brandes
2:47:40 PM K. Becker
2:49:18 PM Sen. Brandes
2:49:27 PM K. Becker
2:50:19 PM Ken McGinnis, Senior Vice President, CGL Companies
2:50:58 PM Sen. Harrell
2:51:41 PM K. Becker
2:52:18 PM Sen. Harrell
2:52:50 PM K. Becker
2:52:59 PM Sen. Harrell
2:53:11 PM Sen. Brandes
2:53:24 PM Tab 4 - Presentation on Recommendation of the Appellate Review of County Court Decisions Workgroup
2:54:01 PM Honorable Robert Morris, Judge, State Courts System
2:59:06 PM Sen. Harrell
2:59:24 PM R. Morris
3:00:46 PM Sen. Harrell
3:01:31 PM R. Morris
3:02:35 PM Sen. Harrell
3:02:48 PM R. Morris
3:03:04 PM Sen. Brandes
3:03:25 PM Sen. Rouson
3:03:46 PM R. Morris
3:03:49 PM Sen. Rouson
3:03:53 PM R. Morris
3:03:56 PM Sen. Rouson
3:04:02 PM R. Morris
3:04:04 PM Sen. Brandes