SB 98- Medical and Geriatric Parole-UULM-MD-Suppor

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Position: FAV

Unitarian Universalist Legislative Ministry of Maryland

Testimony in Support of SB 98:
Correctional Services - Geriatric and Medical Parole

TO: Senator Will Smith, Jr. Chair and Members of the Judicial Proceedings Committee
FROM: Karen "Candy" Clark,
Unitarian Universalist Legislative Ministry of Maryland Criminal Justice Lead
DATE: February 2, 2023

The state- wide Unitarian Universalist Legislative Ministry of Maryland asks for a favorable vote for **SB 98- Correctional Services - Geriatric and Medical Parole.** This bill upholds one of our basic faith principles; to honor the inherent dignity and worth of every person.

Our prison systems' purpose is twofold:

1. to ensure a safe environment in which our communities can function and thrive and
2. to remove people who are illegally disrupting this environment and/or are a threat to others

This does not characterize most of our elderly prison population. Most of whom are over 60 years old and have served lengthy prison sentences that have extended their stay well beyond the age range in which they are likely to commit crimes.

In Maryland's famous Unger case , where the average age of the released prisoner was 64, the recidivism rate was only 3% –compared to 40% for younger offenders– after 3 years on the outside. Upon release our elderly are still in the correctional system under the management of parole. Since they are no longer a dangerous threat, our faith calls for a compassionate release process for these geriatric citizens.

Last year JPI, The Justice Policy Institute published a policy brief evaluating our Geriatric and Medical parole process. Many of the noted faults in this brief are addressed in this bill. For example, currently there is no in-person medical evaluation required to determine the state of a persons' health status. It's done by a professional response to medical records which has resulted in some tragic stories. SB 98 requires that if a medical examination is requested it must be done in -person.

This bill calls for changes that align with the concerns in the JPI policy brief. The result is a more efficient, accountable and humane process.

The Unitarian Universalists Legislative Ministry of Maryland asks for your support.

Respectfully submitted,
Karen Clark
UULM-MD Criminal Justice Lead Advocate

UULM-MD c/o UU Church of Annapolis 333 Dubois Road Annapolis, MD 21401 410-266-8044,

www.uulmmd.org info@uulmmd.org www.facebook.com/uulmmd www.Twitter.com/uulmmd

Elise Desiderio Written Testimony Geriatric Parole

Uploaded by: Elise Desiderio

Position: FAV

MARYLAND OFFICE OF THE PUBLIC DEFENDER

Natasha Dartigue
Public Defender

Keith Lotridge
Deputy Public Defender

Melissa Rothstein
Chief of External Affairs

Elizabeth Hilliard
Acting Director of Government Relations

POSITION ON PROPOSED LEGISLATION

BILL: SB 98 - Correctional Services – Geriatric and Medical Parole

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 02/07/2023

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on Senate Bill 98. This written testimony focuses on the geriatric parole provisions within the Bill.

Across the country, elderly populations within prison systems are increasing.[1] Since 2003, the fastest growing age group in the prison system has been persons aged 55 and older.[2] The Maryland Department of Public Safety and Correctional Services reports that as of July 2022, **14,983** people were housed within the Division of Correction.[3] Of those, **2,035 were between the ages of 51 and 60 and 1105 were over 60**. *Id.*

Several considerations specific to incarcerated seniors demonstrate the need for legislation directed at expanding options for their release. **First**, elderly persons have particular health and safety concerns that living in prison exacerbates. **Second**, elderly persons are less likely to reoffend upon reentering the community than younger persons. **Third**, incarcerating elderly persons is more expensive for the State and its taxpayers than incarcerating younger persons.

First, elderly inmates' health needs are more complex than those of younger inmates. Elderly persons in prison are more likely to be living with chronic health conditions than their

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[1] Brie A. Williams, *et al.*, *Addressing the Aging Crisis in U.S. Criminal Justice Healthcare*, 45 J. Am. Geriatric Soc. 1150-56, author manuscript at *3 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/pdf/nihms363409.pdf (citing U.S. Dep't of Justice, Bureau of Justice Statistics, Office of Justice Programs, *Prisoners Series 1990 – 2010*, http://bjs.ojp.usdoj.gov/index.cfm?ty=pbse&sid=40).

[2] U.S. Dep't of Justice, Bureau of Justice Statistics, *Aging of the State Prison Population, 1993-2013* (May 2016), https://www.bjs.gov/content/pub/pdf/aspp9313.pdf.

[3] Maryland Department of Public Safety and Correctional Services, Division of Correction, *Inmate Characteristics Report FY 2022*, https://dpscs.maryland.gov/publicinfo/publications/pdfs/Inmate%20Characteristics%20Report%20FY%202022%20Q4.pdf.

younger counterparts.[4] "On average, older prisoners nationwide have three chronic medical conditions and a substantially higher burden of chronic conditions like hypertension, diabetes and pulmonary disease than both younger prisoners and older non-prisoners."[5]

Research suggests a correlation between prison life and decline in health. In a 2007 study, researchers interviewed 51 incarcerated men in prison in Pennsylvania with an average age of 57.3 years as well as 33 men in the community with an average age of 72.2.[6] The researchers compared the rates of high cholesterol, high blood pressure, poor vision, and arthritis between the two groups, finding that the data suggested that the health of male inmates was comparable to men in the community who were 15 years older. *Id.* A similar study published in 2018 of 238 participants similarly found that "[a]mong older adults in jail with an average age of 59, the prevalence of several geriatric conditions was similar to that found among community[-]dwelling adults age 75 or older."[7]

Additionally, elderly incarcerated persons, particularly those with elevated health concerns, "are at an elevated risk for physical or sexual assault victimization, bullying, and extortion from other prisoners or staff compared to their younger counterparts."[8] Older prisoners also report higher stress and anxiety than their younger counterparts, "including the fear of dying in prison and victimization or being diagnosed with a severe physical or mental illness."[9] Correctional institutions struggle to meet elderly prisoners' health needs. "Prisons typically do not have systems in place to monitor chronic problems or to implement preventative measures."[10]

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[4] Tina Maschi, Deborah Viola, & Fei Sun, *The High Cost of the International Aging Prisoner Crisis: Well-Being as the Common Denominator for Action*, 53 The Gerontologist 543-54 (2012), https://academic.oup.com/gerontologist/article/53/4/543/556355.

[5] Brie A. Williams, *et al.*, *Addressing the Aging Crisis in U.S. Criminal Justice Healthcare*, J. Am. Geriatric Soc. 1150-56, author manuscript at *3 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923/pdf/nihms363409.pdf.

[6] Susan J. Loeb, Darrell Steffensmeier, & Frank Lawrence, *Comparing Incarcerated and Community-Dwelling Older Men's Health*, West J. Nurs. Res. 234-49 (2008), https://pubmed.ncbi.nlm.nih.gov/17630382/.

[7] Meredith Greene, *et al.*, *Older Adults in Jail: High Rates and Early Onset of Geriatric Conditions*, Health & Justice (2018), author's manuscript at *4, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5816733/pdf/40352_2018_Article_62.pdf .

[8] Maschi, *supra*, at 545 (citing Stan Stocovic, *Elderly Prisoners: A Growing and Forgotten Group Within Correctional Systems Vulnerable to Elder Abuse*, 19 J. of Elder Abuse & Neglect 97-117 (2008)). https://www.tandfonline.com/doi/abs/10.1300/J084v19n03_06.

[9] *Id.* (citations omitted); *see also* Stephanie C. Yarnell, Paul D. Kirwin & Howard V. Zonana, *Geriatrics and the Legal System*, 45 J. of the Am. Academy of Psychiatry & the L. Online 208-17 (2017), http://jaapl.org/content/jaapl/45/2/208.full.pdf.

[10] *At America's Expense: Mass Incarceration of the Elderly*, Am. Civil Liberties Union, 28-29 (2012), https://www.aclu.org/report/americas-expense-mass-incarceration-elderly.

The COVID-19 pandemic exacerbates these health concerns. The threat of COVID-19 is not over: as of January 26, 2023, the virus has infected more than **102 million** people in the United States[11] and more than **1.3 million** Marylanders.[12]

People living in prisons are especially vulnerable to COVID-19. The CDC has cautioned that "[c]orrectional and detention facilities are high-density congregate settings that present unique challenges" to effective COVID-19 testing, mitigation, and treatment.[13] Prisons are closed spaces in which detainees sleep, eat, recreate, and share hygiene facilities in close proximity to each other and do not have the freedom to distance themselves from their peers. Under these conditions, communicable diseases like COVID-19 spread more readily through touch inside correctional facilities.[14] From the start of the pandemic to June 25, 2021, the Marshall Project tracked reported cases of COVID-19 among incarcerated people, until the data became impossible to continue collecting.[15] The organization noted **398,627** confirmed COVID-19 cases reported among incarcerated persons across state and federal prisons, which is thought to be a significant undercount. *Id.*

COVID-19 is especially dangerous for incarcerated **seniors**. The CDC cautions that "[m]ore than 81% of COVID-19 deaths occur in people over age 65."[16] Those with underlying medical conditions, which seniors are more likely to have, are also at increased risk of severe illness with COVID-19.[17] The mortality rate for persons with COVID-19 and certain comorbidities are significantly higher than the mortality rate among those without these comorbidities.

I turn now to research demonstrating lower recidivism rates among elderly persons released from prison. The United States Sentencing Commission examined 25,431 federal offenders released in 2005, using a follow-up period of eight years for its definition of

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[11] *COVID-19 Dashboard*, Johns Hopkins University, Center for Systems Science and Engineering, https://www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6 (last visited Jan. 26, 2023).

[12] *Coronavirus Disease 2019 (COVID-19) Outbreak*, Maryland Department of Health, https://coronavirus.maryland.gov/ (last visited Jan. 26, 2023).

[13] *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (last visited Dec. 8, 2020).

[14] Dan Morse & Justin Jouvenal, *Inmates Sharing Sinks, Showers and Cells Say Social Distancing in Impossible in Maryland Prisons*, The Washington Post (Apr. 10, 2020), https://www.washingtonpost.com/local/public-safety/inmates-sharing-sinks-showers-and-cells-say-social-distancing-isnt-possible-in-maryland-prisons/2020/04/10/5b1d5cf8-7913-11ea-9bee-c5bf9d2e3288_story.html.

[15] *A State-By-State Look at 15 Months of Coronavirus in Prisons*, The Marshall Project, https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons (last visited Jan. 26, 2023).

[16] *People with Certain Medical Conditions*, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html (last visited Jan. 26, 2023).

[17] *Id.*

recidivism.[18] For the eight years after their release, the Commision calculated a rearrest rate of 64.8% for the released persons younger than 30, 53.6% for the released persons between the ages of 30 and 39, 43.2% for the released persons between 40 and 49, 26.8% for the released persons between 50 and 59, and 16.4% for the released persons older than 59. *Id.*

The Commission's data shows that the recidivism rate drops off most sharply after the age of 50. Moreover, before age 50, released persons are most likely to be re-arrested for assault. *Id.* After age 50, they are most likely to be re-arrested for a comparatively minor public order offense like public drunkenness. *Id.* The American Civil Liberties Union has also compiled data collected nationally and from various states demonstrating that older incarcerated persons across the country have a "lower propensity to commit crimes and pose threats to public safety."[19]

It is also more expensive to incarcerate elderly persons than their younger counterparts. At the national level, "[b]ased on [the Bureau of Prisons'] cost data, [the Office of the Inspector General] estimate[s] that the [Bureau of Prisons] spent approximately $881 million, or 19 percent of its total budget, to incarcerate aging inmates in [fiscal year] 2013."[20] "According to a National Institute of Corrections (NIC) study from 2004, taxpayers pay more than twice as much per year to incarcerate an aging prisoner than they pay to incarcerate a younger one."[21] These outsized costs are in large part due to the increased healthcare costs associated with elderly persons in prison.[22] Maryland feels this economic strain more acutely than many other states do. From 2010 to 2015, the national median spending per inmate on healthcare was $5,720 per fiscal year, while the state of Maryland spent $7,280 per fiscal year.[23] From 2001 to 2008, per-inmate healthcare spending rose 103% in Maryland from $3,011 per fiscal year to $5,117 per fiscal year.[24]

The public policy interest in retribution has been satisfied by the many years most elderly persons have already spent in prison. Expanding options for parole release for seniors in prison is the right thing to do. Giving weight to their age when evaluating parole suitability is a laudable step.

Senate Bill 98 will create a meaningful geriatric parole standard. Currently, geriatric parole is codified in Criminal Law 14-101, the statute that defines sentences for subsequent

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[18] Kim Steven Hunt & Billy Easley, U.S. Sent'g Comm'n, *The Effects of Aging on Recidivism Among Federal Offenders* (2017), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171207_Recidivism-Age.pdf.

[19] *At America's Expense: Mass Incarceration of the Elderly*, American Civil Liberties Union (2012), https://www.aclu.org/report/americas-expense-mass-incarceration-elderly.

[20] Dep't of Justice, Office of the Inspector Gen., *The Impact of an Aging Inmate Population on the Federal Bureau of Prisons*, i (Feb. 2016), https://oig.justice.gov/reports/2015/e1505.pdf.

[21] *At America's Expense: Mass Incarceration of the Elderly*, Am. Civil Liberties Union, 27 (2012) (citing B. Jaye Anno *et al.*, U.S. Dep't of Justice, Nat'l Inst. of Corr., *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates*, 10 (2004)).

[22] *Id.*; Zachary Psick, *et al.*, *Prison Boomers: Policy Implications of Aging Prison Populations*, Int. J. Prison Health, 57-63 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5812446/pdf/nihms940509.pdf.

[23] Pew Charitable Trusts, *Prison Health Care Costs and Quality* (Oct. 18, 2017), https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.

[24] *Id.*

crimes of violence. Under the current law, only repeat violent offenders are eligible for geriatric parole. Last year, Chairman Blumberg testified before the Judicial Proceedings Committee that the current statute is unworkable. Senate Bill 98 simply moves the geriatric parole provision into the Correctional Services article and at the Commission's suggestion, sets the standard for review for elderly individuals who have served at least 15 years at every two years. Under the amended language, approximately 650 individuals will qualify for geriatric parole.

Maryland has the opportunity to reduce mass incarceration, save the state millions of dollars, contribute to safer communities, and allow Maryland's incarcerated seniors the opportunity they deserve to live their twilight years with dignity, breathing free air.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on SB98.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.

Authored by: Elise Desiderio, Assistant Public Defender II, elise.desiderio@maryland.gov.

MD Catholic Conference_SB 98_FAV.pdf
Uploaded by: Garrett O'Day
Position: FAV

MARYLAND CATHOLIC CONFERENCE

February 8, 2023

HB 98
Correctional Services – Geriatric and Medical Parole

Senate Judicial Proceedings Committee
Position: FAVORABLE

The Maryland Catholic Conference offers this testimony in support of Senate Bill 98. The Catholic Conference is the public policy representative of the three (arch)dioceses serving Maryland, which together encompass over one million Marylanders. Statewide, their parishes, schools, hospitals and numerous charities combine to form our state's second largest social service provider network, behind only our state government.

Senate Bill 98 would allow the parole commission to employ a dynamic risk assessment to determine whether certain inmates who are at least 60 years of age should be released on parole. It would also allow for expansion of medical parole, in particular those inmates deemed to be "chronically debilitated or incapacitated".

The Catholic Church roots much of its social justice teaching in the inherent dignity of every human person and the principals of forgiveness, redemption and restoration. Catholic doctrine provides that the criminal justice system should serve three principal purposes: (1) the preservation and protection of the common good of society, (2) the restoration of public order, and (3) the restoration or conversion of the offender. Thus, the Church recognizes the importance of striking a balance between protecting the common good and attentiveness to the rehabilitation of the incarcerated. The Conference submits that this legislation seeks to embody these principals and purposes, relative to intersection between our justice system and our communities, victims and offenders. Older inmates who have served much of their sentence or are medically incapacitated or need treatment outside of the prison system certainly merit the mercy of a consideration for re-entry into society.

Senate Bill 98 would restore hope for elderly offenders or for those in need of certain medical treatment seeking to reincorporate themselves into society, where they can be cared for by the community, as opposed to behind bars. This is particularly warranted where they pose no danger to society. The Maryland Catholic Conference thus urges this committee to return a favorable report on Senate Bill 98.

2023-02-08 SB 98 (Support).pdf
Uploaded by: Hannibal Kemerer
Position: FAV

ANTHONY G. BROWN
Attorney General

CANDACE MCLAREN LANHAM
Chief of Staff

CAROLYN A. QUATTROCKI
Deputy Attorney General

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

FACSIMILE NO.
(410) 576-7036

WRITER'S DIRECT DIAL NO.
(410) 576-6584

February 8, 2023

TO: The Honorable William C. Smith, Jr.
Chair, Judicial Proceedings Committee

FROM: Hannibal G. Williams II Kemerer
Chief Counsel, Legislative Affairs, Office of the Attorney General

RE: SB0098 – Correctional Services – Geriatric and Medical Parole – **Support**

The Office of Attorney General (the "OAG") urges this Committee to favorably report Senate Bill 98. This legislation, sponsored by Senator Hettleman, would require the consideration of an inmate's age, and the extent to which the inmate is likely to recidivate or pose a threat to public safety, in the determination of whether to grant parole. Senate Bill 98 would require an inmate who is at least sixty years-old and has served at least fifteen years of the imposed sentence, and is not registered or eligible for registration as a sex offender, to have a parole hearing every two years. The bill would also provide for medical parole upon a licensed medical professional's determination that an inmate is terminally ill or chronically debilitated or incapacitated, in need of extended medical care better met by community services, and is physically incapable of presenting a danger to society. The bill also contains procedural and reporting requirements for these parole hearings.

Geriatric and medical parole – also known as "compassionate release" – are premised on "a humanitarian desire to allow people to spend their remaining days outside of prison in the company of their family and friends, as well as practical considerations of the high cost and minimal public safety value of incarcerating people who are old or gravely ill."[1] Despite the overall prison population declining across the U.S., the number of incarcerated older adults has increased.[2] These individuals typically pose minimal risk to public safety and lower rates of recidivism due to age and physical condition.[3] Without expanded access to geriatric and medical

[1] Rebecca Silber, Léon Digard, Jesse LaChance, *A Question of Compassion: Medical Parole in New York State*, VERA INSTITUTE OF JUSTICE (April 2018), https://www.vera.org/publications/medical-parole-new-york-state.
[2] *Id.*
[3] JUSTICE POLICY INSTITUTE, *Compassionate Release in Maryland: Recommendations for Improving Medical and Geriatric Parole* (January 2022) at 4–5 (available at https://justicepolicy.org/wp-content/uploads/2022/02/Maryland-Compassionate-Release.pdf) ("In 2012, a Maryland court determined a series of cases involved unconstitutional jury instructions. This resulted in 235 individuals, many of whom had committed serious violent offenses, becoming

parole in Maryland, the elderly population in State prisons will continue to grow, increasing the State's costs in providing necessary health and end-of-life care to inmates, and serving little benefit to public safety.[4]

Additionally, SB 98 provides that any savings as a result of these provisions will revert back to the Department of Public Safety and Correctional Services for use in carrying out these parole hearings, as well as increase pre-release and re-entry resources for inmates released on parole, which will better assist those released from prison in reintegrating into the community.[5]

For the foregoing reasons, the Office of the Attorney General urges a favorable report on Senate Bill 98.

cc: Members of the Judiciary Committee

eligible for release. The average age of those released due to the Unger decision was 64, and they had served an average of 40 years in prison. In the eight years since the ruling, these individuals have posted a recidivism rate of under three percent. This is much lower than the 40 percent rate of recidivism after only three years for all persons released from Maryland prison. The rate for the aging Unger population is so low that the cohort was five times more likely to pass away from old age than to recidivate for a new crime.").

[4] *Id.* at 1.

[5] H.B. 157, 2023 Legis. Sess, 445th Gen. Assemb. (Md. 2023) § 7-310(D).

Senate Bill 098 Written Testimony.pdf
Uploaded by: Joshua Sexton
Position: FAV

To: Senate Judicial Proceedings Committee
From: Joshua "Jay" Sexton, University of Maryland School of Law Clinical Law Program
500 W. Baltimore Street, Baltimore, Maryland 21202
Re: In Support of Senate Bill 098
Date: February 6, 2023

The Gender Violence Clinic at the University of Maryland School of Law represents criminalized survivors of violence—people who have been victims of gender-based violence (intimate partner violence, rape, sexual assault, human trafficking, and violence related to gender identity and/or sexual orientation) and whose incarceration (current or former) is related to in some way to that violence. The clinic's clients include several incarcerated individuals who have sought medical parole or who are aging in prison. The clinic enthusiastically supports the reforms to both medical and geriatric parole that are embodied in Senate Bill 098.
Senate Bill 098 makes necessary changes to the Maryland parole process that will require the Maryland Parole Commission to take into account the ages and medical conditions of those incarcerated individuals who are most in need of help. While medical and geriatric parole do exist conceptually under current law, the statistics will show that neither of the current processes are functioning the way the General Assembly intended.

It should come as no surprise that prisons are not equipped to handle the needs of elderly incarcerated individuals or those with severe illnesses or injuries. Data shows that on average, it can cost the state 2-3 times more per year to care for a incarcerated individual who is sick or elderly than it does to care for a incarcerated individual who is younger and healthier. That cost reflects incarcerated individuals who, in the Clinic's experience, are often receiving the most minimal care and who do not typically have access to the standard of care available in the community. Those incarcerated individuals with life-threatening, debilitating illnesses should be able to seek proper treatment outside of their facilities, rather than be forced to endure whatever remedies exist in their infirmaries at great cost to the State.

The changes that Senate Bill 098 would make to Maryland's medical and geriatric parole scheme are desperately needed to bring relief to people behind prison walls. Among the changes that are most critical in the bill is removing the Governor from medical parole decisions for individuals serving life sentences. Consider the circumstances of one Gender Violence Clinic client:

> In the time this individual has been incarcerated, their health has deteriorated rapidly. They suffer from several chronic conditions which has left them almost entirely blind and wheelchair bound. This person can barely see or walk in a prison that is not handicap accessible, resulting in the individual essentially being confined to their room for fear of injuring themselves outside. They are not capable of fulfilling their own basic needs and require almost full time assistance with eating, bathing, dressing, and going to the restroom. The prison is not equipped with to handle an incarcerated individual with this level of illness and injury, and it falls upon other incarcerated individuals to help them with their daily needs. The individuals poses no future threat to public safety, both because of the rehabilitative work they have done while in prison but also because of their condition and would be more appropriately treated in the community. While the Maryland Parole Commission has recognized the merit of this individual's medical

parole request, the Governor denied release and the individual continues to struggle to navigate the prison environment today.

As for the population of older incarcerated individuals, these numbers continue to rise and do so at a rapid rate. According to the latest statistics from the Bureau of Justice, reported just weeks ago, there were 178,200 persons age 55 or older in state or federal prison at the end 2021, a 7% increase from 166,600 at the end of 2020. As Americans continue to live longer lives, so will those Americans who are incarcerated and serving extended sentences. An ACLU report from 2012 predicted this group of incarcerated individuals could reach as high as 400,000 by the year 2030. As the prison population continues to age, we will see more incarcerated individuals with serious illnesses and other medical conditions, which again will only cost the State more resources to handle and slowly turn the State's correctional facilities into warehousing hospitals for the sick and elderly.

Senate Bill 098 would not open up the flood gate and result in the release of all incarcerated individuals who are over the age of 55 or have an illness, nor would it impair the Commission's ability to take into account the impact on public safety release in any particular case would have. Statistics have shown that the elderly and sick and among the lowest in terms of recidivism rates. Under the language of the bill, the Commission is still required to consider factors like the nature of the crime, victim impact, and the individual's record inside the institution. All this bill does is give the Parole Commission the tools it needs to make a well-informed decision concerning parole for geriatric and sick incarcerated individuals.

Maryland-Compassionate-Release.pdf
Uploaded by: Keith Wallington
Position: FAV

JUSTICE POLICY INSTITUTE

COMPASSIONATE RELEASE IN MARYLAND

Recommendations for improving medical and geriatric parole

JANUARY, 2022

Compassionate Release in Maryland

Policy Brief
January 2022

Most states have established release mechanisms for the aging population and those in prison who are battling a terminal illness, often referred to as compassionate release. Compassionate release policies typically permit individuals in prison to petition for early release after having served a pre-determined number of years for either health (medical parole) or advanced age (geriatric parole). However, the laws frequently have restrictive eligibility requirements and are applied sparingly, often when an individual is expected to survive only a matter of days or weeks.

While Maryland has both medical and geriatric parole options, approval is fleeting. Data are limited but provide a glimpse into their restricted use. Between 2015 and 2020, the Maryland Parole Commission approved 86 medical parole applications and denied 253. Further, the Governor granted nine medical parole requests from individuals serving life sentences and rejected 14 requests. Most notably, the lowest yearly approval rating occurred during the height of the pandemic in 2020 at seven percent. The Justice Reinvestment Act of 2016 expanded geriatric parole eligibility by lowering the age threshold from 65 to 60 years old. However, petitions are rarely approved. Currently, there are about 630 individuals over the age of 60 in Maryland's prison system who have served at least 15 years. These individuals are eligible to be evaluated for release. But, like in most states, Maryland seldom relies on these compassionate release policies to release the elderly and infirm from prison, despite posing a minimal risk to public safety and a significant cost burden on the state budget.

Without substantial reforms to compassionate release in Maryland, the aging population will continue to grow, and the onus will be on the Department of Public Safety and Correctional Services (DPSCS) to provide the adequate care.

The Growing Elderly Population

Over a span of 40 years, the U.S. prison population has experienced staggering growth, from nearly 200,000 in the 1970s to over 1,430,800 in 2019.[1] Research shows that this

[1] E. Ann Carson, *Prisoners in 2019* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2020).

growth has been driven not by more crime, but by policies that send more people to prison and keep them there for longer periods of time. One consequence of this trend is a large and increasing number of older incarcerated individuals.[2] From 1999 to 2016, the prison population over 55 years old increased 280 percent.[3] In 2017, the number of incarcerated individuals over 55 years old eclipsed 200,000, which is more than the entire prison population in 1970.

In Maryland, 6.4 percent of the prison population, or 3,324 individuals, are over 50 years old. Moreover, 2,341 individuals, or about 11 percent of the prison population, are serving life sentences. Unsurprisingly, these individuals are overwhelmingly Black. A 2019 Justice Policy Institute report found that nearly eight in 10 people who are serving the longest prison terms in Maryland are Black. Of the population serving those terms, 41 percent are Black men who were sentenced to prison as emerging adults (under the age of 25). These numbers suggest that the aging of the prison population will not slow down.

National Landscape of Compassionate Release

Medical Parole

Forty-nine states and the District of Columbia have medical parole provisions, but the definitions and parameters vary among the states and are often vague. This leaves releasing authorities and parole boards in charge of who can apply for medical parole. In general, eligibility for consideration of medical parole depends on an individual's inability to perform activities of daily living or, on the other hand, incapacitation resulting in the requirement of 24-hour nursing care.[4] Of the 49 states, only 13 are required by law to track and report statistics, and even fewer release the information publicly. Only nine people were released from prison for medical reasons in Pennsylvania between 2009 and 2015, and only seven in Kansas during the same timeframe. Since 2010, only two individuals have been granted release in New Jersey. Maryland's legislative language is so ambiguous it results in excluding mostly everyone, "*an inmate who is so chronically debilitated or incapacitated by a medical or mental health condition, disease, or syndrome as to be physically incapable of presenting a danger to society.*"

One reason the statutory criteria are so restrictive is that most state legislatures, including Maryland's, do not develop their policies and practices in conjunction with medical professionals to statutorily define conditions such as "chronically debilitated" (see

[2] Chiu, Tina, *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release* (New York, NY: Vera Institute for Justice, 2010).
[3] Julia Vitale, *A look at the United States' aging prison population program* (Richmond, VA: Interrogating Justice, 2021).
[4] George Pro and Miesha Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study," *J Correct Health Care* 23, no. 2 (2017):162–72.

Appendix A).[5] Generally, the application process includes a series of medical reviews, which consume precious time for individuals with worsening health or facing imminent death. Prognostication is often difficult and inaccurate, and requiring exact prognostication is an unreasonable criterion for medical parole.[6]

Maryland's medical parole provision makes all individuals eligible to apply except those sentenced for a sex offense or those with sentences that are not parole eligible. However, Maryland's process is problematic. There is no required medical examination, and an applicant never receives a hearing. Instead, a physician merely reviews medical records, designates a Karnofsky score measuring functional impairment, and sends a recommendation to the Maryland Parole Commission. This is often in the form of an email or a few-sentence memo. The Parole Commission is under no obligation to grant an in-person hearing or to accept that recommendation and, in fact, may come to a different conclusion based on the Code of Maryland Regulations, which are *more* restrictive than the statute and state that the person must be "imminently terminal" to be granted medical parole.

Denying a comprehensive medical review impacts the Parole Commission's ability to grant medical parole. When the standards are applied to hospice care, the healthcare field determines the symptoms of declining health that trigger hospice care when they are expected to have a year or less left to live. Because of the difficulty of accurately predicting time of death, these guidelines are flexible. However, that flexibility is not present in the correctional setting. This has resulted in one tragic case after another.

Stories from the Inside

Barbra Hampton tragically passed away 12 hours after receiving a commutation. Despite her health condition, she was not eligible for medical parole because of her *life without parole sentence.* In the final 24 hours of her life, her sentence was commuted, but she passed away hours after being transferred to a convalescent home. This last minute decision did not allow enough time for Barbra's family to visit her. Barbara's story is a reminder that medical parole in Maryland should be expanded to everyone, including those with non-parolable life sentences.

Amid the COVID-19 global pandemic, family and advocates of Donald Leroy Brown petitioned for a medical parole release due to his waning health conditions. The initial attempt was denied. In the following month, his health worsened and sparked a second attempt of compassionate release. He was granted medical parole and was released from prison but passed away in a nursing home facility just four days later.

[5] Mary Price, *Everywhere and Nowhere* (Washington, D.C. FAMM, 2018).
[6] Nicholas A. Christakis and Elizabeth B Lamont, "Extent and Determinants of Error in Doctors' Prognoses in Terminally Ill Patients: Prospective Cohort Study," *British Medical Journal* 320 (2000): 469–73.

In comparison to the eligibility criteria for federally administered palliative care through Medicare, eligibility for consideration of medical parole has a much higher threshold. Medical parole evaluates the incarcerated person's ability to perform activities of daily living. If federal guidelines for access to hospice care do not require incapacitation to deem patients eligible for palliative care services, it seems that the expectation of complete deterioration before consideration of medical parole is out of line with other reasonably determined standards of care. Involving healthcare professionals in the development of eligibility criteria for medical parole would allow for medically relevant guidelines that are more in line with other widely accepted standards of care and provide a more reasonable threshold for incarcerated individuals to receive necessary health care.

Geriatric Parole

Geriatric parole is offered in only 17 states and Washington, DC. Like medical parole, the parameters of geriatric parole differ in each jurisdiction and often have exclusions for certain offenses. Typically, geriatric parole is an option when an incarcerated individual reaches a specific age and has served a minimum number of years. In Maryland, you must be 60 years of age and have served a minimum of 15 years before applying for geriatric parole. Additionally, eligibility is limited to people who committed a violent offense *and subsequent offenses.* Thus, someone who meets the criteria but has been convicted only one time in their life *cannot* apply for geriatric parole, but someone with two or more convictions is able to apply. In practice, this legal stipulation renders geriatric parole ineffectual. There are more than 600 people older than 60 who have served at least 15 years in prison, yet the current policy excludes most from submitting a geriatric parole petition.[7] In addition, the law remains silent on release decision making guidance. Thus, the Parole Commission typically will resort to relitigating the controlling offense and sentence, rather than focusing on mitigating circumstances, such as age of the individual.

Risks to Public Safety

Older prisoners pose a low public safety risk due to their age, general physical deterioration, and low propensity for recidivism. Medical parole programs should be open to non-terminal patients over age 50 who have health conditions that render them unlikely to pose substantial public safety risks.[8] Research has conclusively shown that by age 50 most people have significantly outlived the years in which they are most likely to commit crimes. For example, arrest rates drop to just over two percent at age 50 and are

[7] Editorial Board, "Maryland should release more elderly inmates," *Baltimore Sun,* (Baltimore, MD), July 19, 2019.
[8] I.M Chettiar, W. Bunting, and G. Schotter, *At America's Expense: The Mass Incarceration of the Elderly* (New York, NY: American Civil Liberties Union, 2012).

almost zero percent at age 65.[9] Nationally, aging people return to prison for new convictions at a rate between 5 and 10 percent, and often far lower.[10]

The story of the people released from prison due to the *Unger* court decision best exemplifies the aging population's low risk to public safety. In 2012, a Maryland court determined a series of cases involved unconstitutional jury instructions. This resulted in 235 individuals, many of whom had committed serious violent offenses, becoming eligible for release. The average age of those released due to the *Unger* decision was 64, and they had served an average of 40 years in prison. In the eight years since the ruling, these individuals have posted a recidivism rate of under three percent. This is much lower than the 40 percent rate of recidivism after only three years for all persons released from Maryland prison. The rate for the *aging Unger* population is so low that the cohort was five times more likely to pass away from old age than to recidivate for a new crime.[11]

Other states have had a similar experience. New York reported a 7 percent reconviction rate for those 50 to 64 years old and only 4 percent for those 65 and older; Virginia experienced a 1 percent reconviction rate for those 60 and older.[12] Overall, the benefit of medical or geriatric parole to incarcerated individuals comes at a very low cost to public safety.

The Toll of Incarceration on Individual Health and Health Disparities

The prison system has a duty to provide adequate health services while incarcerated. The need for adequate access to care is not only a moral duty but is a legal requirement. In 1976, the U.S. Supreme Court ruling *Estelle vs Gamble* found that deliberate indifference to healthcare for the incarcerated population constituted cruel and unusual punishment and was thus prohibited by the U.S. Constitution. Because the ruling mandated health care, doctors became an integral part of the correctional system. Despite this, conditions within corrections are often in direct conflict with optimal patient care.[13]

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[9] Ibid.
[10] Ibid.
[11] Stanley Mitchell, email message to author, November 23, 2021. Note: as of this report, only two individuals have been re-arrested for a new crime, and 10 Ungers have passed away.
[12] Various Authors, *The Ungers, 5 Years and Counting: A case study in safely reducing long prison terms and saving taxpayer dollars* (Washington, D.C., Justice Policy Institute, 2018).
[13] Scott A. Allen, Sarah E. Wakeman, Robert L. Cohen, and Josiah D Rich, "Physicians in US Prisons in the Era of Mass Incarceration," *International Journal of Prisoner Health* 6 no.3 (2010): 100–106.

The World Health Organization defines *quality of care* by identifying components that provide desired outcomes:[14]

- Safe – "Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors."
- Effective – "Providing services based on scientific knowledge and evidence-based guidelines."
- Timely – "Reducing delays in providing and receiving health care."
- Efficient – "Delivering health care in a manner that maximizes resource use and avoids waste."
- Equitable – "Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status."
- People-centered – "Providing care that takes into account the preferences and aspirations of individual service users and the culture of their community."

A large proportion of individuals who are incarcerated experience chronic medical and mental health illnesses. One study from 2009 found the following:[15]

- 38.5 percent of federal prison population suffered from chronic medical condition
- 25.5 percent of federal prison population received psychiatric medication before admission
- 42.8 percent of state prison population suffered from chronic medical condition
- 29.6 percent of state prison population received psychiatric medication before admission
- 38.7 percent of jail population suffered from chronic medical condition
- 38.5 percent of jail population received psychiatric medication before admission

The wellness of the prison population reflects their home community. For example, a neighborhood in Baltimore, Southwest Baltimore, accounts for the fifth-highest population in the justice system, as well as the fifth-highest number of babies born with unsatisfactory weights. This correlation is present in other neighborhoods for a series of health, socio-economic, and justice indicators. Providing adequate care in the justice system means before, during, and after an incarceration stay.

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[14] "Quality of Care," *World Health Organization, Accessed December 21, 2021.* https://www.who.int/health-topics/quality-of-care#tab=tab_1

[15] Andrew P. Wilper, Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein "The Health and Health Care of US Prisoners: Results of a Nationwide Survey," *American Journal of Public Health* 99, no.4 (2009): 666–72.

Because such a large proportion of incarcerated individuals are impacted by chronic illness, it is even more important for them to have access to care. Older individuals who cannot access adequate health care in prison affect community healthcare systems, because more than 95 percent are eventually released, many to urban communities where healthcare disparities are common and acute healthcare resources are overused.[16]

Economic Impact of Aging in the Justice System

The criminal justice system cannot afford to ignore the expense associated with the anticipated growth in the aging prison population.[17] The cost of incarcerating the older population is high. As a person advances in age, the likelihood of developing chronic health issues increases as well.

Medical expenditures for all within the prison industrial complex contribute substantially to the operating cost. Nationally, it costs about $34,000 per year to incarcerate an individual, but that rises to an estimated $68,000 per year for someone over the age of 50. The difference is largely attributed to higher health care costs.[18]

The *Unger* population in Maryland provides a glimpse into the costs of the continued incarceration of the aging population. According to the Department of Correctional Services and Public Safety, the annual cost of incarceration is $46,000 per year, which includes a $7,956 allocation for medical and mental health services. Similar to how health insurance premiums increase with older age, the medical allocation increases 34 percent in the prison system for the geriatric population. This results in an $18,361 allocation for the geriatric population, or a low estimate of $35.5 million a year individuals over 60 years old.

Recent estimates indicate approximately 500,000 individuals in America's prisons have at least one of the following diseases: diabetes, asthma, and hypertension.[19] As a result, it is estimated that older adults are three to five times more expensive to incarcerate than their younger counterparts. Medical care provided inside prison facilities is not covered by federal government health insurance (Medicaid or Medicare), so the correctional system absorbs the cost of providing medical services to the aging population.[20]

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[16] Cyrus Ahalt, Robert L. Trestman, Josiah D. Rich, Robert B. Greifinger, and Brie A. Williams "Paying the Price: The Pressing Need for Quality, Cost, and Prisoners." *Journal of American Geriatric Society* 11, no.61 (2019): 2013–19.
[17] Tina Maschi, Mary Beth Morrisey, and Margaret Leigey "The Case for Human Agency, Well-Being, and Community Reintegration for People Aging in Prison: A Statewide Case Analysis." *J Correct Health Care* 19, no. 3 (2013): 194-210.
[18] Pro and Miesha Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study."
[19] Angela S. Murolo, "Geriatric Inmates: Policy and Practice," J Correct Health Care 26, no.1 (2020): 4–16.
[20] Pro and Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study."

The hardships continue when prisoners are released to the community. The incarcerated population generally are suspended from public health benefit programs (Medicare, Medicaid, Social Security Insurance, Veterans Health Administration) upon incarceration. After release, there is often a substantial lag time until benefits are reinstated. During this time, a formerly incarcerated individual who experiences health problems must rely on costly emergency services for health care.[21] A survey of returning citizens of all ages found that one-third of those with physical or mental health conditions used emergency department care and one-fifth were hospitalized within a year of release. Furthermore, because most state correctional departments provide only a one- to two-week supply of medication, many returning citizens have little or no access to medication while they await their initial healthcare appointment.[22]

Despite these barriers to receiving adequate healthcare in the community, leaving prison can give aging individuals access to community-based health care or end-of-life support at a fraction of the cost incurred behind bars. State criminal justice systems can use those savings toward other initiatives that increase public safety.[23]

Moving Forward

Expand eligibility and develop standards for compassionate release

There are a number of eligibility barriers for an individual applying for geriatric or medical parole release. The primary obstacle is the lack of clarity of how the laws apply and the standard of eligibility.

As part of the recently passed Justice Reinvestment Act, Maryland law declares that all people at least 60 years of age who have served 15 years are eligible for geriatric parole. However, only those persons who meet those criteria and are serving sentences for subsequent violent offenses under 141-101 are eligible. This is problematic. If someone is sentenced to 80 years for a first-time offense when they are 40 years old, with standard parole eligibility at 50 percent, they will not be eligible for release until age 80. Geriatric parole is unavailable to them because it is a first-time offense. This technical issue within the geriatric parole law circumvents the spirit of an age-based release mechanism. Maryland should expand eligibility to all people in prison, not just those individuals' serving non-parolable subsequent sentences for crimes of violence. In addition, the 15-

[21] Cyrus Ahalt, Robert L. Trestman, Josiah D. Rich, Robert B. Greifinger, and Brie A. Williams "Paying the Price: The Pressing Need for Quality, Cost, and Prisoners." (2019).
[22] Ibid.
[23] Price, "Everywhere and Nowhere."

year minimum time served requirement should be removed, so that all individuals of geriatric age are eligible to apply, regardless of how long they have been in prison.

Medical parole has less restrictive eligibility requirements but should still be expanded to the entire prison population, regardless of offense or sentence type. In addition, the decision-making guidance for the Parole Commission must be improved. Those applying for medical parole must be "chronically" debilitated or incapacitated, according to the statute. But the implementing regulation and practice by the Parole Commission is much more restrictive. Code of Maryland Regulations 12.12.08.05 requires that individuals seeking medical parole be considered "imminently terminal," an unworkable standard and one that is more restrictive than the statutory standard. This regulation is what allows the Commission to deny medical parole until the waning days of someone's life and is in contradiction with the General Assembly's intent.

To assess suitability, Maryland relies on the Karnofsky Performance Status Scale, without any in-person examination.[24] A physician issues a short memo to the parole commissioners that includes the score, and if it is below 20, they are typically considered a viable candidate for release. According to the scale, a score of 20 indicates *very sick, hospital admission necessary, active supportive treatment necessary;* 10 is *moribund, fatal processes progressing rapidly*. The applicants are often permanently ill, not chronically ill as outlined in the statute, by the time they reach this score. There is a provision in the law that allows a person to receive an outside medical assessment, but it is rarely used.

Meaningful standards of review, that are developed in conjunction with the medical community, must be adopted in order to introduce fairness, transparency, and predictability to this process. More specifically, Maryland should move away from a blunt, imprecise instrument like the Karnofsky Score as the primary medical determination to assess impairment and adopt a standard that considers illness and impairment more holistically, with an emphasis on future risk to public safety and whether the correctional system can adequately provide necessary medical care and rehabilitation.

Use hospice and nursing care as an alternative to continued incarceration of the ailing population

Medicare is a federally administered health insurance plan that has guidelines that govern access to palliative and hospice care. The Center for Medicare and Medicaid Services defines hospice care as a "*comprehensive, holistic program of care and support for*

[24] "Performance Status: Palliative Care," *Stanford School of Medicine,* Accessed December 21, 2021. https://palliative.stanford.edu/prognostication/performance-status/

terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptoms management instead of care to cure the patient's illness."

To qualify for these services, a medical professional makes the determination based on the decline of health over the last three to six months by a series of medical measures. While the incarcerated population is evaluated in a similar fashion, the parole commission often stands in the way of successful medical parole applications. Maryland could provide alternatives to continued incarceration and rely on the standards set for hospice and palliative care.

Maryland could take lessons learned from Connecticut, which received federal funds and built a 95-bed nursing home to house individuals medically paroled. [25] In the first few years of operation, two individuals transferred back to prison because of minor infractions, but no employees have been injured.[26] This type of innovation can be cost saving, uphold public safety, ensure a smooth transition from prison to the community, and prevent lapses in care and medication that can contribute to negative health outcomes.

Develop reentry programs for geriatric parole-returning citizens

Individuals returning home after long prison terms need individualized reentry support. Maryland must build off the lessons learned from the Ungers and develop a reentry system to deepen the capacity of geriatric parole.

As part of the 2019 Justice Reinvestment Oversight Board meeting, the workgroup recommended a pilot program for reentry. It included designated funding for case managers to connect returning citizens with community-based resources; establish presumptive eligibility and pre-release healthcare availability; expand home detention or residential reentry centers; and provide peer support and senior programs to increase social interactions and connections. The recommendations set by the oversight board, alongside the foundation of the Ungers, can provide an effective reentry system for Maryland's currently incarcerated aging population.

[25] Adam Wisnieski, "'Model' nursing home for paroled inmates to get federal funds" *Connecticut Health I-Team,* April 25, 2017.
[26] Christine Vestal, *For Aging Inmates, Care outside prison walls* (Philadelphia, PA: Pew Charitable Trust, 2014).

State	Medical professionals in decision-making	Medical professionals develop criteria (for parole)
Alabama	No	No
Alaska	No	No
Arizona	No	No
California	Yes	Yes
Colorado	No	No
Connecticut	N/A	No
Delaware	No	No
Florida	N/A	Yes
Georgia	N/A	Yes
Hawaii	N/A	Yes
Idaho	No	No
Indiana	No	No
Kansas	No	No
Louisiana	N/A	Yes
Maine	No	N/A
Maryland	No	Yes
Massachusetts	No	No
Minnesota	No	Yes
Mississippi	Yes	Yes
Missouri	No	Yes
Montana	No	N/A
Nebraska	No	No
Nevada	No	Yes
New Hampshire	No	No
New Jersey	No	Yes
New York	N/A	Yes
North Carolina	No	Yes
North Dakota	No	Yes
Ohio	No	N/A
Oklahoma	No	No
Oregon	No	Yes

Pennsylvania	No	No
Rhode Island	No	N/A
South Carolina	No	N/A
South Dakota	No	No
Tennessee	No	Yes
Texas	No	N/A
Utah	No	No
Vermont	No	N/A
Virginia	No	N/A
Washington	No	N/A
West Virginia	No	N/A
Wisconsin	No	N/A

Acknowledgements

JPI would like to acknowledge Alva Powell, former intern, and medical resident at Columbia University, for her research and authorship of this policy brief; as well as Lila Meadows, Director at the Justice for Victims of Crime Clinic at the University of Maryland's School of Law, for contributing her subject-matter expertise. JPI would also like to acknowledge the generous support from independent donors that made this project feasible.

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SB98 Medical-Geriatric testimony - LMeadows UMDLaw

Uploaded by: Lila Meadows

Position: FAV

To: Senate Judicial Proceedings Committee
From: Lila Meadows, University of Maryland School of Law Clinical Law Program, 500 W. Baltimore Street, Baltimore, Maryland 21201
Re: In Support of Senate Bill 98
Date: January 31, 2023

Senate Bill 98 makes necessary reforms to Maryland's geriatric and medical parole schemes to move Maryland towards having a true mechanism for compassionate release for elderly and infirm incarcerated men and women. According to recent estimates from the Department of Public Safety & Correctional Services, there are currently 1,233 individuals over the age of 60 in the Department of Corrections (DOC). Approximately 650 of those individuals have already served over 15 years in prison. While there is no data to suggest how many of those individuals present with acute or chronic medical issues, as this population continues to age, DOC will continue to struggle to provide the necessary medical and nursing care at great cost to the state. Data provided by the Maryland Parole Commission (MPC) in response to an MPIA request is instructive. In 2020, the first year of the COVID-19 pandemic when vaccines were not yet available, MPC received medical parole requests from 201 individuals. The Commission granted only 27 of those requests – less than 15%. From 2015 – 2020, only 86 individuals were approved for medical parole. House Bill 157 reforms both the medical and geriatric parole process to ensure these processes are meaningfully available to sick and elderly incarcerated individuals who require care beyond what DOC is set up to provide. Given the extremely low rates of recidivism among elderly individuals released from prison, utilizing geriatric and medical parole is not only the humane thing to do, but it also makes fiscal sense without compromising public safety.

Senate Bill 98 moves Maryland towards a having legally sound standards for medical and geriatric parole. Nothing in House Bill 157 lessens the Commission's obligation to take both public safety or victim impact into account when considering an individual for release under the medical or geriatric parole standards. The Commission is still required to make a determination whether release is compatible with the welfare of public safety and the likelihood that an individual will recidivate if released.

In 2021, the General Assembly took the historic and long overdue step of depoliticizing Maryland's parole process by removing the Governor's authority over parole decisions of individuals serving life sentences. While that step was necessary to move Maryland towards having a functional parole system, it was not sufficient. Medical and geriatric parole affect not only individuals serving life sentences, but the entire correctional population. House Bill 157 moves Maryland closer to having a functional parole system.

Medical parole

Individuals seeking medical parole can ask MPC for consideration by filing a written request under the statute. Current law under MD Code Correctional Services 7-305 requires the Commission to consider an individual's diagnosis and prognosis. In practice, to assess an individual's medical condition and whether it meets the standard in the statute and regulations, the Maryland Parole Commission relies almost entirely on the Karnofsky score provided by

DOC clinician. The Karnofsky score is a measure of functional impairment that can be useful in understanding an individual's limitations but cannot provide a substantive picture of the full medical condition. In my experience, MPC has required a Karnofsky score of 30 or below in order for an individual to merit further consideration for medical parole. The following are examples of clients I have represented who have scored a 40 on the Karnofsky Performance Index and were denied medical parole:

- A client who clearly met the legal standard of being so incapacitated as to pose no threat to public safety. Mismanagement of their diabetes led to the amputation of their leg. While they waited for a prosthetic device that never materialized, they cycled in and out of the prison infirmary because they were unable to care for themself in general population. While in the infirmary, they fell out of the bed, resulting in what clinicians described as a "brain bleed." Not long after their fall, they were taken to a regional hospital for congenital heart failure. They required assistance from nursing staff or other incarcerated individuals to perform all activities of daily living and at times, did not understand that they were in prison. Despite their condition, they were initially denied medical parole.
- A client who had contracted COVID-19 early in the pandemic when DOC staff housed them with another incarcerated individual who was symptomatic. They spent two months at a regional hospital in the ICU on a ventilator before being returned to DOC custody. They now live in the prison infirmary where they are unable to perform most activities of daily living, including showering and walking even short distances, without the aid of supplemental oxygen. DOC clinicians and an independent medical expert agree that the damage to my client's lungs is permanent and there is no prognosis for improvement.

Senate Bill 98 would clarify the process for obtaining an outside medical evaluation, a process already allowed by statute and require MPC to give those evaluation equal weight to that of DOC physicians. This is a critical change given that many of the sickest incarcerated individuals are receiving care from outside providers who have a better sense of that individual's condition and prognosis than DOC physicians. While Commissioners are not medical professionals, comprehensive medical evaluations that move beyond reliance on the Karnofsky score will help Commissioners better understand whether an individual's diagnosis and prognosis meet the legal standard for consideration under the statute.

These changes are necessary to ensure truly vulnerable and infirm individuals are able to seek release and receive care outside of the correctional setting. Continuing their incarceration of these clients and those like them comes at a great human and financial cost. Continuing the confinement of someone with a debilitating medical condition who poses no threat to public safety and who could receive better medical treatment in the community is inhumane. It is unjust. It costs the State of Maryland an exorbitant amount of money that would be better invested elsewhere in our system.

Geriatric parole

Under current law, Maryland has a geriatric parole provision in name only. Eligibility for geriatric parole is currently governed by MD Code Crim Law §14-101(f)(1) – the section of the

code that deals with mandatory sentences for crimes of violence. This alone is a complete anomaly. No other statutory provision governing parole is placed in the criminal law article of the Maryland Code. The construction of the statute leads to a truly peculiar result. As currently written, the law dictates that geriatric parole is only available to an individual who has reached age 60, served at least 15 years, *and is sentenced under the provisions of 14-101* – meaning only those who have been convicted of multiple crimes of violence are eligible. Despite representing many clients over the age of 60 who have served at least 15 years, I have never had a client who satisfies the subsequent crimes of violence section of the statute.

Beyond the problems with the construction of the statute, the law provides no guidance to the Maryland Parole Commission regarding suitability for geriatric parole. Senate Bill 98 would remove the geriatric parole provision from MD Code Criminal Law 14-101 and instead place the provision in the Correctional Services Article, where every other provision regarding parole is codified. It would also give the Maryland Parole Commission direction regarding how to evaluate candidates for geriatric parole, creating consistency with standard parole and medical parole consideration.

This written testimony is submitted on behalf of Lila Meadows at the University of Maryland Carey School of Law and not on behalf of the School of Law or University of Maryland, Baltimore.

Testimony on SB 0098 2023.pdf
Uploaded by: Linda Green
Position: FAV

TESTIMONY IN SUPPORT OF SENATE BILL 0098
Correctional Services – Geriatric and Medical Parole

TO: Hon. William C. Smith, and Members of the Senate Judicial Proceedings Committee

FROM: Linda D. Green MD

DATE: February 7, 2023

Linda D. Green MD, Life After Release

I am writing to support Senate Bill 0098 because I have had and currently have been working with inmates who are suffering or have died in prison due to medical conditions which should certainly have led to their release from jail to receive comfort care with their families at home. I am happy to provide some personal details of these cases but for the purpose of this testimony I will just summarise the situations.

As a physician I have reviewed the medical records of three cases that I want to bring to your attention:

1. Older woman (age 58) with multiple recurrences and treatments for ovarian cancer who was clearly resistant to treatment after at least three cycles of chemotherapy and surgical interventions. She was never given a compassionate release to her family that was willing to take her home. She died after a few weeks in a hospital still under the criminal justice system. She had been at the Women's Correnctional Institution in Jessup.

2. A 61 year old man currently at North Branch receiving palliative chemotherapy for stomach and liver cancer suffering with abdominal pain and difficulty eating.

3. A 41 year old man currently in Hagerstown with severe lung and cardiac conditions from Churg-Strauss syndrome diagnosed at Johns Hopkins. He was recently discharged from a local hospital with a vest that can function as a temporary defibrillator.

The families and the volunteers at Life After Release are concerned about these and other such cases. The organization *APP-HRC is also following these last two cases. We hope that such legislation will open the door to more timely responses so that severely ill inmates will not die in prison and will be able to receive compassionate care which is impossible for the prison system to provide.

Sincerely,

Linda D. Green MD
3113 Varnum Street
Mount Rainier, Maryland 20712
lindadgreen@gmail.com

*Aging People in Prison – Human Rights Campaign

FAV_SB0098_MPRC.pdf
Uploaded by: Maryland Prisoners Rights
Position: FAV

TESTIMONY IN SUPPORT OF BILL SB0098

Correctional Services - Geriatric and Medical Parole

Date: 02/07/2023

From: Maryland Prisoners' Rights Coalition

To: Chairman Smith, Vice-Chair Waldstreicher and Members of the Senate Judicial Proceedings Committee

Re: SUPPORT FOR BILL SB0098

Thank you for bringing this important bill forward and giving us an opportunity to illuminate the issue.

The Maryland Prisoners' Rights Coalition is a directly impacted organization, supported by advocacy partners, that works to improve the conditions of confinement for incarcerated individuals in Maryland correctional facilities.

We have spent many years identifying and analyzing the conditions of confinement in the State of Maryland that pose grave risks to prisoners' health and safety. Consistently, the most egregious condition of confinement is access to, and quality of, healthcare administered within correctional facilities. As you can imagine, COVID-19 only exacerbated this. We receive hundreds of calls annually regarding these conditions, requiring us to intervene with facilities to advocate for everything from prisoners not receiving prescribed medications to care for the chronically and terminally ill.

Maryland correctional healthcare has proven to be not only subpar and inadequate, but also in violation of the 8th amendment of the United States Constitution as cited in the Duvall Case (Duvall v Hogan). . Incarcerated individuals face insurmountable barriers just to file grievances for the medical abuses and neglect they endure, exacerbated by the lack of access to, and quality of, healthcare in the Maryland correctional system.

Many incarcerated individuals are never able to obtain adequate care and languish behind the walls of our correctional facilities. That is both cruel AND unusual. Denial of healthcare is an 8th Amendment violation and needs to be addressed; given that, the issue will lead to compounded health problems leading to unnecessary death for the incarcerated and ultimately legal liabilities for the state and the contracted provider.

When we receive calls from our clients as part of our intake process, we ask them to complete a request for information form (ROI), which we submit to DPSCS for our clients' records. During the course of our research, we found that DPSCS lacked proper medical records and had unclear policies.

We also submitted interrogatories that were returned with vague information. Further, our investigation over these past years have found egregious practices and subpar healthcare standards. The lack of accurate medical records, unclear policies, and starkly inadequate practices, caused directly by neglect, ultimately exacerbate negative health outcomes for our clients. If and when these men and women return to society, they have a multitude of health problems that require specialized care - problems that if they were treated properly would not have catastrophic health implications, like in the case of a gentleman named Donald Brown, Vivian Penda's son.

The Maryland correctional healthcare system cannot and does not serve those who have serious medical issues. Not only is it a waste of millions of dollars in contracts, there is also a serious cost to the wellbeing of our communities and even higher legal liability.

One question we have gotten is, "what about those who provide health care services to inmates?" There lies the problem; we found that:

- Healthcare provided by DPSCS vendors is self-regulated and is not subject to any standards of compliance.

- Because of inconsistent care, DPSCS facilities historically fail their federal correctional accreditation (ACA and NCCH).

DPSCS contracts a medical contractor, currently YesCare (formerly Corizon), that has a long record nationally of litigation for abuses and violations. They were cited for not upholding their contract of care, and have, due to these inadequacies, been terminated in multiple states.

YesCare lacks the capacity to provide long-term medical care for the chronically ill, the terminally ill and the elderly. As an example, the medical cost for an inmate under the age of 60 who is considered healthy in Maryland per year is $7,956. This cost doubles to approximately $16,000 annually for inmates over the age of 60, According to DPSCS there are 1,233 incarcerated citizens over the age of 60 (2020 total of aLL 20,421 prisoners,19,515 men and 906 women). If we multiply this number we find that this group bears an additional $9.81 million per year[1] - these figures don't include people under 60 with serious illnesses, so imagine the expanded cost when they are included. This amounts to almost $49 million over 5 years. YesCare's bid and contract, (made when they were named Corizon), over a five year period is $680 million[2]. With a $680 million contract, BUT overall expenses approaching $812 million over five years, how does YesCare propose to meet the needs of this population? These numbers speak volumes about YesCare's inability to meet the needs for which they are contracted, and presses the need for medical and geriatric parole reform.

Providing those with terminal and debilitating conditions in Maryland correctional facilities the opportunity for parole is a strong first step in correcting a long history of healthcare neglect, and offers a viable opportunity for proper care for those debilitated in Maryland prisons. While it is great that DPSCS claims to want to make improvements, and we agree this would be a huge

undertaking, they continue to make excuses and plans for improvements that are many years away and that are not reasonably obtainable without expert assistance. This bill is a way that these changes can begin in an expedient manner that at least follows a minimum standard of care and protocols. We currently have evidence that the practices and procedures of the healthcare providers DO NOT follow minimum standard protocol. With DPSCS reporting almost half of their population as being designated as chronically ill, Maryland has a serious issue as a large portion of this chronically ill population is geriatric.

We cannot stress enough the importance of this legislation to reform the access to, and quality of healthcare, for incarcerated individuals in Maryland. This is a civil, social, economic, legal and moral issue, which also bears GREAT FINANCIAL COSTS to the Maryland tax payers. This problem cannot wait for changes in the distant future; it needs to be addressed now, starting with offering the viable pathway we've laid out for medical and geriatric parole. As a representative for the entire incarcerated population of the state of Maryland, their families, and loved ones, we strongly urge you to support and give a favorable report for SB0098.

Respectfully,
The Maryland Prisoners' Rights Coalition
MPRC Partners and the Directly Impacted Governance Committee

[1] "Building on the Unger Experience: A cost-benefit analysis of releasing aging prisoners." *Open Society Institute - Baltimore,* 2019. http://goccp.maryland.gov/wp content/uploads/Unger-Cost-Benefit3.pdf.

2 Award of Contract ID #Inmate Medical Care and Utilization Services; DPSCS # Q0017058 to Corizon Health Inc.. Department of Budget and Management, Supplement B, December 19,2018., p. 132.

3 https://dpscs.maryland.gov/community_releases/DPSCS-Annual-Data-Dashboard.shtml

MHowington_SB098MedParole.pdf
Uploaded by: Michael Howington
Position: FAV

Senate Bill 098: Medical/Geriatric Parole
Favorable

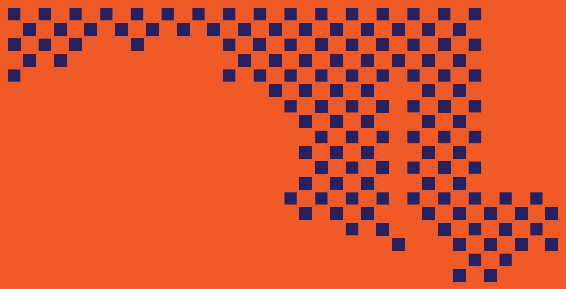
My name is **Michael,** an inmate at the Jessup Correctional Institution, and I am writing to you in support of HB0157, which would deliver enhanced compassionate release opportunities for infirm and/or elderly persons in prisons. The inadequate medical care within correctional institutions and rare opportunities to be approved for medical or geriatric parole have led to a large population of inmates, like me, who remain incarcerated despite posing a minimal risk to public safety and a significant cost to taxpayers.

I began serving my life sentence in 1980, and I am now 71 years old. I am a Vietnam Combat Veteran. The PTSD and drug addiction that developed after my service contributed to the crimes I committed. When I started serving my sentence, I was filled with anger and hate. In 1984, I was shot for trying to escape prison, and I served 4 years in lock up for my actions. In 2000 my life was beginning to change; I gave my life to the Lord and I have less anger towards the world and have been sober for 20 years. In the institution, I work to help other inmates change their lives the way I changed mine. I have been certified as an Observation Aide and have been commended for my outstanding assistance to the staff and inmate population. I have been a pastor since 2006 and helped start a ministry at the JCI regional hospital, where we visit terminally ill patients. *However, I have not been able to visit with these inmates in the last 12 years because of my own personal health issues.*

While incarcerated, I had two strokes and have been confined to a wheelchair for over 9 years. I have changed significantly as a person while serving my sentence. I would like to spend my last years with my children and grandchildren to teach them the things that I have learned in my life. I would like to work with any state agency to work with youth to deter them from a life of crime. I have so much to offer given my experiences in life and in prison.

Due to the low yearly approval rating for compassionate release cases, like mine, I may never be released, despite providing positive reference letters from correctional officers, community religious leaders, certificates of completion for various programs, and a home plan for my release. Something must be done to simplify this process to allow for the release of inmates in my situation. For these reasons I ask you to issue a favorable report on HB 0157. Thank you.

FAMM MD CR Report Card.pdf
Uploaded by: Molly Gill
Position: FAV



Compassionate Release Report Card • October 2022

Maryland

Overall Grade for Maryland	Total Grade	Letter Grade
	16/100	F

Program Grades

	Total Grade	Letter Grade
Medical Parole	**9/100**	**F**
Geriatric Parole	**23/100**	**F**

Medical Parole

Total Grade **9** /100

Letter Grade **F**

Eligibility Criteria

0/30

0/10 UTD* Clearly set out with understandable and measurable standards.

0/10 UTD Generous or not unduly restrictive.

0/10 UTD No categorical exclusions/everyone is eligible for consideration.

- × **Extra credit:** Terminal illness time-left-to-live provisions are reasonable and sufficiently long to permit the completion of the review and decision-making processes. 0

Procedures

0/10

0/5 Documentation and assessment are straightforward, lacking multiple or redundant reviews and authorizations.

0/5 Time frames for completing review and/or decision-making exist and are designed to keep the process moving along.

- × **Extra credit:** Expedited time frames exist for terminal cases. 0

Engaging the Process

2/15

1/5 Clinical and other staff can identify potentially eligible individuals and initiate the process.

1/5 Incarcerated people, their loved ones, and advocates can initiate the process.

0/5 Corrections staff have an affirmative duty to identify incarcerated people eligible for compassionate release and take the steps necessary to begin the process.

Release Planning Support

0/10

0/5 UTD Agencies provide comprehensive release planning.

- × **Extra credit:** Release planning includes helping the incarcerated person apply for benefits prior to release, including housing, Medicaid, Medicare, and/or veterans benefits. 0

0/5 UTD Release planning begins early in the process.

Agency Policy Design

2/15

2/5 Agency rules exist for all stages of identification, initiation, assessment, and decision-making.

0/5 Agency rules are consistent with and/or complement the statute, are up to date, and internally consistent.

0/5 Rules provide clear guidance to reviewers and decision-makers about steps to take and standards to apply.

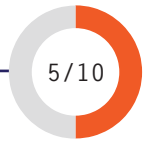
Data Collection and Public Reporting

0/10

0/5 Agencies are obliged to gather, compile, and report release data to legislature.

0/5 Reporting is made available to the public via annual reports or other means.

Right to Counsel and Appeals



5/5 Program allows counsel to represent people before decision-maker (i.e., parole board, commissioner, or court).

- ✖ **Extra credit:** Denials are appealable. 0

0/5 Individuals have the right to reapply should conditions change.

- ✖ **Extra credit:** Revocations are not used to return people to prison because their condition improves or goes into remission or because the individual outlives the prognosis. 0

* UTD stands for "Unable to Determine" and is graded zero. This is when there are no rules, guidelines, regulations, or other authority that FAMM could find addressing the graded category. For example, if there are no published provisions for release planning or telling an agency how it is to evaluate an incarcerated person's eligibility, that results in a zero UTD grade.

The Numbers

While the Parole Commission reports from time to time on how many Medical Parole cases it considers, it does not report on outcomes. The Parole Commission also did not respond to FAMM's request for data for 2019 and 2020.

High and Low Marks

HIGH MARK

- **Right to counsel:** Individuals seeking Medical Parole in Maryland may have counsel represent them before the Parole Commission.

LOW MARKS

- **Overall**, Maryland's Medical Parole program **flunked** because it suffers from internal incoherence, lack of guidance, and conflicting information about everything from eligibility criteria to who initiates the application to standards and procedures. Maryland received one of the worst report cards in the nation because FAMM could not figure out how to reconcile its varied and often contradictory guidance or fill in the many gaps left by incomplete or inconsistent regulations.
- The confusion begins with the **eligibility criteria**. The statute and Division of Correction provide one standard: chronic incapacitation or debilitation so severe a person is physically incapable of posing a danger to society. In contrast, the Parole Commission rules require an individual to be "imminently terminal" or have a condition that indicates continued incarceration will serve no useful purpose (such as when a person is in a permanent coma). FAMM gave a failing grade to generosity of the criteria because we could not determine what the criteria are. Finally, we could not score for categorical exclusions because while the statute states that only parole-eligible individuals may qualify, the Corrections manual apparently allows anyone to be eligible.
- **Engaging the process** is similarly confusing. The statute explains that the incarcerated individual, attorney, family member, medical professional, Corrections employee, or any other person may file a Medical Parole request with the Parole Commission. According to the Medical Parole regulation, the Warden initiates the request.

More on next page ▸

LOW MARKS (CONTINUED)

- Maryland's Medical Parole flunked **policy design** because while some agency rules exist, they at best do not align and, more often, contradict the statute. For example, the statute calls for the Parole Commission to complete an initial review of Medical Parole applications. Medical Parole regulations mention no initial review. The statute and rules also differ on documentation and assessment standards. The regulations do not discuss any steps or standards for the Parole Commission review and decision-making processes.
- Medical Parole also failed **procedures** due to confusion about documentation and rules and an absence of standards and because no deadlines exist for steps in the process.
- **Release planning support** also suffers from conflicting authorities. The statute seems to suggest that the Division of Correction is responsible for discharge information including availability of treatment in the community, family support, and housing. The Medical Parole regulation only directs the Warden to submit information about any special housing requirements and makes no mention of the much more comprehensive discharge plan addressed in the statute.

Geriatric Parole

Total Grade **23** /100

Letter Grade **F**

Eligibility Criteria

21/30

10/10 Clearly set out with understandable and measurable standards.

2/10 Generous or not unduly restrictive.

9/10 No categorical exclusions/everyone is eligible for consideration.

- ✖ **Extra credit:** Terminal illness time-left-to-live provisions are reasonable and sufficiently long to permit the completion of the review and decision-making processes. 0

Procedures

0/10

0/5 Documentation and assessment are straightforward, lacking multiple or redundant reviews and authorizations.

0/5 Time frames for completing review and/or decision-making exist and are designed to keep the process moving along.

- ✖ **Extra credit:** Expedited time frames exist for terminal cases. 0

Engaging the Process

2/15

0/5 Clinical and other staff can identify potentially eligible individuals and initiate the process.

2/5 Incarcerated people, their loved ones, and advocates can initiate the process.

0/5 Corrections staff have an affirmative duty to identify incarcerated people eligible for compassionate release and take the steps necessary to begin the process.

Release Planning Support

0/10

0/5 Agencies provide comprehensive release planning.

- ✖ **Extra credit:** Release planning includes helping the incarcerated person apply for benefits prior to release, including housing, Medicaid, Medicare, and/or veterans benefits. 0

0/5 Release planning begins early in the process.

Agency Policy Design

0/15

0/5 Agency rules exist for all stages of identification, initiation, assessment, and decision-making.

0/5 Agency rules are consistent with and/or complement the statute, are up to date, and internally consistent.

0/5 Rules provide clear guidance to reviewers and decision-makers about steps to take and standards to apply.

Data Collection and Public Reporting

0/10

0/5 Agencies are obliged to gather, compile, and report release data to legislature.

0/5 Reporting is made available to the public via annual reports or other means.

Right to Counsel and Appeals

0/10

0/5 Program allows counsel to represent people before decision-maker (i.e., parole board, commissioner, or court).

- ✖ **Extra credit:** Denials are appealable. 0

0/5 Individuals have the right to reapply should conditions change.

- ✖ **Extra credit:** Revocations are not used to return people to prison because their condition improves or goes into remission or because the individual outlives the prognosis. 0

The Numbers

The Parole Commission did not respond to FAMM's request for information on how many individuals, if any, received Geriatric Parole in 2019 and 2020.

High and Low Marks

HIGH MARK

- By law, Maryland authorizes Geriatric Parole eligibility to individuals serving mandatory minimum sentences for crimes of violence who are at least 60 years old and who have served a minimum of 15 years. Besides being a straightforward description, the **eligibility criteria** explicitly include people convicted of crimes of violence. FAMM commends Maryland for recognizing parole for that population.

LOW MARKS

- Maryland's Geriatric Parole **eligibility criteria** limit parole consideration to people who meet the age and time-served requirements and who are serving mandatory minimum sentences for crimes of violence, except for those registered or eligible to be registered as sex offenders. While FAMM thinks it is commendable that people convicted of crimes of violence and serving mandatory minimum sentences are eligible for consideration, we cannot understand why Maryland provides Geriatric Parole only to such people and not to other incarcerated individuals who meet the age and time-served requirements.
- Despite a statutory directive to do so, Maryland's Parole Commission has not updated regulations to implement Geriatric Parole. Thus, the program fails across the board for **policy design** and **procedures**, because no rules whatsoever exist to carry out this program.
- It also flunks in every other measure because no rules govern **release planning**, **right to counsel or appeals**, and **data collection and reporting**.

FAMM Natl CR Map Grades.pdf
Uploaded by: Molly Gill
Position: FAV

State Compassionate Release

The National Picture

famm.org

FAMM

FAMM statement supporting MD SB 98 SJPC 2.8.23.pdf
Uploaded by: Molly Gill
Position: FAV

Written Testimony of Mary Price
General Counsel, FAMM
In Support of Senate Bill 98
Maryland Senate Judicial Proceedings Committee
February 8, 2023

I thank the Chair, Vice-Chair, and members of the Senate Judicial Proceedings Committee for the opportunity to provide testimony today in support of Senate Bill 98, a bill to improve Maryland's medical and geriatric parole programs. I write on behalf of FAMM, a national sentencing and corrections reform organization. We unite currently and formerly incarcerated people, their families and loved ones, and diverse people working to improve our system of justice.

For more than two decades, FAMM has been a leading voice for measures that allow for the safe release of medically vulnerable, aging, and dying individuals from our nation's prisons. Our system incarcerates people to deter crimes, punish those who commit them, protect the public, and rehabilitate those who will return home one day. FAMM believes that people should have a meaningful opportunity to leave prison when their continued incarceration no longer advances those purposes of punishment. At a minimum, we should consider releasing people who are dying, aging, and those who are too debilitated to offend, too compromised to benefit from rehabilitation, or too impaired to be aware they are being punished.

Since 2018, FAMM has published comprehensive research into state compassionate release programs.[1] We maintain a set of memos on our website that document every program in the 50 states and the District of Columbia.[2] For each, we describe eligibility criteria, application requirements, documentation, and decision-making, as well as post-decision and post-release.

Last year, we produced compassionate release report cards for every state.[3] Nearly two-thirds of the states flunked compassionate release. **Maryland received the third-worst grade in the nation.[4]** Its Medical Parole program received a grade of 9, of a possible 100, failing in every

[1] While we use the term "compassionate release" to describe this authority, we are aware that many jurisdictions, including Maryland, have different names for programs that enable early release for qualifying prisoners. Because of what we have learned of the insurmountable barriers to early release programs encountered by many sick and dying prisoners, we believe every program could benefit from taking a compassion-based look at what it means for the elderly, ill, and dying to go through the process. We call these programs "compassionate release" so that the human experience is foremost in our minds and those of policy makers.
[2] FAMM, Compassionate Release: State Memos (Dec. 2021), https://famm.org/our-work/compassionate-release/everywhere-and-nowhere/#memos.
[3] FAMM, State Compassionate Release Report Cards (Oct. 2022), https://famm.org/our-work/compassionate-release/everywhere-and-nowhere/#memos.
[4] Maryland Compassionate Release Report Card (Oct. 2022), https://famm.org/wp-content/uploads/md-report-card-final.pdf.

grading category, including eligibility criteria, policy design, release planning support, and data collection.

Our research and analysis informs our support of SB 98. It contains sorely needed reforms. The legislation would revise and standardize eligibility criteria; ensure that a variety of people, including the incarcerated person, could begin the application process; refine standards and consideration steps; direct involved agencies to make conforming changes to rules and regulations; build out Geriatric Parole, and require data reporting. These important reforms align with many that FAMM identified as necessary to overcome barriers to compassionate release and outlined in our comprehensive report, "Everywhere and Nowhere: Compassionate Release in the States."[5]

It is high time to make these changes. Maryland's poorly designed Medical Parole program has led to disappointing outcomes. Between 2015 and 2020, only 86 of 339 requests for medical parole were approved.[6] That is an average of only 17 grants annually, including in the midst of a pandemic – between March 2020 and June 2021 – when 31 people died in Maryland prisons of COVID-19 alone.[7] Maryland's Geriatric Parole is in even worse shape. We were baffled to learn that by law, only a tiny subset of the 650 elderly incarcerated people – only those who have incurred multiple convictions for crimes of violence – are eligible to be considered for geriatric parole.[8] Maryland does not have functioning geriatric parole.

We commend this bill to the committee because we believe it will make possible the more efficient and robust use of medical and geriatric parole in Maryland.

Senate Bill 98 would create and standardize eligibility standards

SB 98 will address one of the most significant problems with the Maryland medical parole program: Parole Commission regulations that contradict the medical parole statute. On the one hand, the current Medical Parole statute makes certain people who are chronically debilitated or incapacitated eligible for consideration. However, Parole Commission regulations limit eligibility to people who are "imminently terminal" or have a condition making their continued incarceration purposeless.[9] More confounding is that the Medical Parole statute does not mention terminal illness at all, much less imminent death.

In our nationwide assessment of barriers to medical release programs, and in our review of Maryland's Medical Parole, we found that poorly defined or inconsistent criteria frustrate program objectives. Missing definitions, lack of clarity, and dissonance between definitions in

[5] Mary Price, Everywhere and Nowhere: Compassionate Release in the States (2018), https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf.
[6] Justice Policy Institute, Recommendations for Improving Medical and Geriatric Parole, 1 (Jan. 2022), https://justicepolicy.org/wp-content/uploads/2022/02/Maryland-Compassionate-Release.pdf.
[7] The Marshall Project, A State-by-State Look at Coronavirus in Prisons (July 1, 2021), https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons.
[8] This is by no means to imply that those with convictions for violent crime do not deserve geriatric parole consideration, only that this important program should be available to all elders in Maryland prisons.
[9] *Compare* Md. Code Ann., Corr. Servs. § 7-309 (b) and Dep't of Public Safety and Correctional Services, Division of Correction Case Management Manual 100.0002, § 22 (D) (2) *with* Md. Code Regs. 12.02.09.04 (A).

statutes and those in program regulations, leave corrections and parole authorities to supply their own definitions of qualifying conditions. Without sufficient guidance, the people who assess incarcerated people for eligibility and those who make the final decision whether to release them cannot be confident they are identifying and/or releasing the right people at the right time. They may fail entirely to act on deserving individuals.

Senate Bill 98 would refine eligibility criteria and oblige the Parole Commission to adopt regulations to implement the statutory criteria and other reforms made by the legislation. Requiring the Commission to conform its regulations with the improvements in the statute will remove some impediments to medical parole.

FAMM is especially happy to see the legislation would ensure that terminally ill people are eligible for medical parole. Presently, Medical Parole does not recognize terminal illness among its eligibility criteria. In our nationwide review, we located only three other states that do not provide release based on terminal illness.[10] We also are pleased to see the definition of terminal illness would track the language used in the federal compassionate release statute.[11] A person would be considered eligible if they have a disease or condition with an "end-of-life trajectory." That language is supported by medical professionals as the gold standard. It is well-known in medical circles that predictions about when a person will die are notoriously inaccurate. Physicians hesitate to predict life spans, or they err on the side of a generous prognosis out of concern for their patient's emotional wellbeing.[12] This definition ensures that people who are dying can be considered for medical parole.

We commend as well the bill's definitions for **chronic debilitation and incapacitation.** Using clear definitions ensures that everyone assessing a person's eligibility are working with the same standard. Debilitation would be assessed by determining whether the individual is unable to perform two or more activities of daily living. This measure is a standard used in a number of states and is understood by medical professionals to evaluate a person's functional impairment. For example, **Alabama** uses daily activities in its definition of "permanently incapacitated." A person is eligible if they, among other things, are (1) unable to perform at least one "necessary daily life function" (eating, breathing, toileting, walking, or bathing) and requiring assistance with one or more of those daily life functions or is completely immobile.[13] **Georgia** similarly uses in its standard, "entirely incapacitated," that the individual (1) requires assistance to perform two or more daily life functions (such as eating, breathing, dressing, grooming, toileting, walking, or bathing) or is completely immobile.[14]

[10] FAMM, Compassionate Release, Delaware, https://famm.org/wp-content/uploads/Delaware_Final.pdf, Compassionate Release, Utah, https://famm.org/wp-content/uploads/Utah_Final.pdf, FAMM, Compassionate Release, Washington, https://famm.org/wp-content/uploads/Washington-Final.pdf.
[11] 18 U.S.C. § 3582 (c) (1) (A) (1).
[12] Brie A. Williams et al., Balancing Punishment and Compassion for Seriously Ill Prisoners, 155 Ann. Intern. Med. (July 19, 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3163454/.
[13] FAMM, Compassionate Release, Alabama at 1, https://famm.org/wp-content/uploads/Alabama_Final.pdf.
[14] FAMM, Compassionate Release, Georgia at 1, https://famm.org/wp-content/uploads/Georgia_Final.pdf.

Senate Bill 98 would standardize application, documentation and assessment steps.

The current medical parole statute and the regulations published by the Parole Commission describe very different procedures for initiating a request and documenting eligibility and other factors, such as public safety. Senate Bill 98 would establish one standard for these procedures and oblige the Commission to adopt conforming regulations.

For example, the Parole Commission operates under a regulation that provides that only the Warden can initiate the Medical Parole consideration. Current law and SB 98 allow the incarcerated individual, their counsel, a prison official, or any other person to file a request directly to the Commission.[15] Similarly, the documentation and assessment stages are inconsistent in current law and Commission rules.[16] Senate Bill 98 would set out a single procedure for gathering and reviewing the essential documents.

Senate Bill 98 also provides for a meeting, if requested, between the applicant, or their representative, and the Commission before the Commission decides whether to formally consider the applicant. We think this is a smart addition and especially commend the provision requiring such a meeting for incarcerated individuals who are or who have frequently been housed in a prison infirmary or hospitalized in the community. This forward-thinking provision would make Maryland a pioneer by ensuring the Commission meet with applicants who are most medically vulnerable. We know of no other state that provides for such a presumptive meeting.

Senate Bill 98 would establish comprehensive geriatric parole in Maryland

Senate Bill 98 will ensure Maryland joins 25 states nationwide that provide early release eligibility to people who are aging in their prisons. Doing so will help the state identify individuals who are among the most expensive to incarcerate and the least likely to pose a public safety concern.

Mandatory prison sentences and truth-in-sentencing laws mean that more people are serving long prison terms that cannot be easily be shortened. Our prisons are graying. While state prison populations overall are generally falling, the same cannot be said for their elderly populations. The total population of individuals detained in state and federal prison systems decreased by 11.4% between 2009 and 2019 while the number of people over age 55 doubled from 75,300 to 180,836.[17] It is estimated that by 2030, prisons will house more than 400,000 people who are 55 years old and older, who will make up nearly one-third of the prison population.[18]

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[15] *Compare* Md. Code. Ann., Corr. Servs. § 7-309 (c) (2) *with* Md. Code Regs. 12.02.08.05 (B) and H.B 600.
[16] FAMM, Compassionate Release, Maryland 2-3 and notes, https://famm.org/wp-content/uploads/Maryland_Final.pdf.
[17] *See* E. Ann Carson, Bureau of Just. Stat., Prisoners in 2019 3, 15 (2020); E. Ann Carson & William J. Sabol, Bureau of Just. Stat., Aging of the State Prison Population, 1993-2013 27 (2016).
[18] George Pro and Miesha Marzell. Medical Parole and Aging Prisoners: A Qualitative Study, 23 J. of Correctional Health Care 162, 162 (2017), https://www.liebertpub.com/doi/abs/10.1177/1078345817699608?journalCode=jchc.1.

Prisons face challenges trying to meet the special needs of a geriatric population, many of whom have multiple chronic age-related medical conditions and disabilities. Elderly individuals need targeted supports such as ramps, lower bunks, and grab bars.[19] They need help getting to pill line, commissary, or the food hall, or in and out of wheel chairs and beds, and those with cognitive impairments need additional support.[20] A recent paper on the topic addressed the lack of, or failure to grant, geriatric parole: "With high denial rates, parole boards almost ensure that older incarcerated people with progressive medical issues will be less fit to care for themselves independently in the community when finally released, or end up de-facto condemning older incarcerated people to die awaiting release."[21]

Meanwhile, the cost of care for aging people in prison is between three and nine times more than for younger people.[22] In Maryland, medical costs double for incarcerated people over the age of 60.[23]

Among the other smart features of the geriatric parole provision is the requirement that the Commission identify and assess people who might be eligible for geriatric parole and provide them hearings bi-annually. Ensuring that potentially eligible people are identified and considered is an innovative reform, adopted by a growing number of states, such as **North Carolina**.[24] This requirement will ensure that no elder in prison is left without a chance to be considered for parole.

Many of the elders in Maryland's prisons have been locked up for years or decades. Geriatric parole will give the Commission the chance to assess whether their continued incarceration is in the public interest, routinely assessing them and taking into account the impact of an individual's age on reducing their risk of recidivism.

Finally, we are pleased to see that the bill would include **annual reporting** on outcomes, using a range of metrics, to the Justice Reinvestment Oversight Board. Transparency is essential if Maryland is to ensure the program works as intended. Lawmakers will be made aware of how many of those eligible for Geriatric Parole were granted and denied and for what reasons, as well as how much time passes between when a person is eligible for parole consideration and when they receive their hearing. Lawmakers should know when their laws are working as intended and when they are not. The data reporting requirement is an excellent addition and one that too few states have. Maryland will be showing the way with such comprehensive reporting.

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[19] Human Rights Watch, Old Behind Bars: The Aging Prison Population in the United States 48-52 (Jan. 2012), https://www.hrw.org/sites/default/files/reports/usprisons0112_brochure_web.pdf.
[20] Steve Berry, et al., The Gold Coats – An Exceptional Standard of Care: A Collaborative Guide to Caring for the Cognitively Impaired Behind Bars 4-5, 31-32 (2016).
[21] Rachael Bedard, et al., Elderly, Detained, and Justice-Involved: The Most Incarcerated Generation 5, The City University of New York L. Rev. 25:1 (Winter 2022), https://academicworks.cuny.edu/clr/vol25/iss1/15/.
[22] Cyrus Ahalt, et al., Paying the Price: The Pressing Need for Quality, Cost, and Outcomes Data to Improve Correctional Health Care for Older Prisoners, 61 J. of the Am. Geriatrics Society 2013, 2014 (2013), https://pubmed.ncbi.nlm.nih.gov/24219203/.
[23] Open Society Institute, Baltimore, Building on the Unger Experience: A Cost-Benefit Analysis of Releasing Aging Prisoners, 8 (Jan. 2019), http://goccp.maryland.gov/wp-content/uploads/Unger-Cost-Benefit3.pdf.
[24] FAMM, Compassionate Release, North Carolina, at 1 (Dec. 2021), https://famm.org/wp-content/uploads/North-Carolina_Final.pdf.

Conclusion

FAMM is happy to support Senate Bill 98.

O.Moyd Testimony on SB 0098 Medical and Geriatric
Uploaded by: Olinda Moyd, Esquire
Position: FAV

MARYLAND ALLIANCE FOR JUSTICE REFORM

Working to end unnecessary incarceration and build strong, safe communities

RE: SB 0098 – Favorable
Medical and Geriatric Parole

Senate Judicial Proceedings
February 8, 2023

Written Testimony - Olinda Moyd on behalf of The Maryland Alliance for Justice Reform

The Maryland Alliance for Justice Reform supports a favorable report on this bill for several reasons.

This bill would add to the existing statute an opportunity for people over 60 to be considered for parole consideration. The bill also affords individuals with chronically debilitating or incapacitating conditions the opportunity for more meaningful medical parole consideration.

The DPSCS continues to report the number of COVID-related deaths among staff and the inmate population. At the time of this writing, the DPSCS dashboard shows 8 staff deaths and 37 deaths among the inmate population. Some of them were elderly individuals who were even more vulnerable due to their medical conditions. Mr. Andrew Parker was in his early 60's and had been in prison for 39 years and Mr. Charles Wright had been in for 30 years and was also in his 60's – both died in prison from COVID. Every week MAJR continues to receive letters from men and women who fit this age group who are afraid of dying from COVID and other diseases in prison.[1]

The bill creates an opportunity for release for elderly prisoners

Due to extreme sentencing, Maryland is experiencing growth in our aging prison population. Along with an aging population come increased costs for healthcare and other conditions associated with growing old. There are thousands of geriatric-aged individuals still in the prison system. I see them on walkers and in wheelchairs as I cross the prison yards.

It is estimated that Maryland imprisons approximately 3,000 people over age 50, and nearly 1,000 individuals who are 60 or older.[2] Based on data showing the geriatric population has

[1] DPSCS reports 3t inmate deaths and 8 staff deaths from COVID-19. The number of persons testing positive for the omicron variant has increased significantly in recent months. See DPSCS Daily Dash reporting,Cumulative COVID – 19 Cases page, viewed, January 27, 2023.

[2] Report by The Justice Policy Institute, *Rethinking Approaches to over Incarceration of Black Young Adults in Maryland,* (November 6, 2019).

higher care costs, a fiscal analysis concluded that continued confinement of this age group for an additional 18 years (based on the expected period of incarceration, the age at release and the projected life expectancy of the Ungers), would amount to nearly $1 million per person, or $53,000 a year. This is compared to the $6,000 a year to provide intensive reentry support that has proven to successfully reintegrate them back into the community.[3]

For those individuals who continue to serve lengthy sentences, most individuals desist from crime as they get older, and they eventually present little threat to public safety. Experts agree that for persons otherwise ineligible, age-based parole is an appropriate consideration.[4]

Maryland lags behind in providing medical and geriatric release opportunities

Medical parole is parole that is granted based on humanitarian and medical reasons. Now is the time for Maryland to act in a more humane way towards individuals who are aging and dying behind our prison walls. This bill broadens who can request a medical parole for an individual and allows for a meeting with the MPC on behalf of an individual who meets the criteria. This bill also outlines the documentation, assessment and decision-making process.

Medical and geriatric parole typically go hand-in-hand. Nearly every state has a policy allowing for people with certain serious medical conditions to be eligible for parole, known colloquially as medical parole. In 45 states, the authority for the release of these individuals has been established in statute or state regulation. Additionally, at least 17 states have geriatric parole laws in statute. In the federal system persons may apply for geriatric parole pursuant to the US Parole Commission Rules and Procedures, Title 28, CFR, Section 2.78.

These laws allow for the consideration for release when a person reaches a specified age. At least 16 states have established both medical and geriatric parole legislatively. It is time for Maryland to pass this legislation.

For these reasons, we urge a favorable report.

Olinda Moyd, Esq.
moydlaw@yahoo.com
(301) 704-7784

[3] Report by The Justice Policy Institute, *The Ungers, 5 Years and Counting: A Case Study in Safely Reducing Long Prison Terms and Saving Taxpayer Dollars*, November 2018.
[4] E. Rhine, Kelly Lyn Mitchell, and Kevin R. Reitz, Robina Inst. of Crim. Law & Crim. Just., *Levers of Change in Parole Release and Revocation* (2018).

SB98_CorrectionalServices_GeriatricandMedicalParol
Uploaded by: Olivia Spaccasi
Position: FAV

Testimony for the Senate Judicial Proceedings Committee

February 8, 2023

SB 98 - Correctional Services - Geriatric and Medical Parole

FAVORABLE

OLIVIA SPACCASI
PUBLIC POLICY PROGRAM
ASSOCIATE

AMERICAN CIVIL
LIBERTIES UNION
OF MARYLAND

3600 CLIPPER MILL ROAD
SUITE 350
BALTIMORE, MD 21211
T/410-889-8555
or 240-274-5295
F/410-366-7838

WWW.ACLU-MD.ORG

The ACLU of Maryland urges a favorable report on SB 98 which would greatly improve Maryland's medical and geriatric parole processes. The bill would establish a more appropriate set of criteria for the Parole Commission to consider when deliberating parole. Specifically, it includes the age of the individual among the factors that should be considered by the Commission. The bill also clarifies what constitutes being "chronically debilitated or incapacitated" means for the purposes of medical parole. In order for an inmate to be considered for medical parole, they must be considered chronically debilitated or incapacitated. However, current measurements for incapacitation are outdated. And more accurate indicators for incapacitation, like the inability to walk, breath, and bathe on one's own are not codified into law. Under SB 98, individuals who have a diagnosable medical condition or a permanent medical or cognitive disability and cannot complete one or more basic activities of daily living would be classified as such. The bill would also allow medical parole applicants and their lawyers to request a meeting with the Commission. These requests must be granted if the person is currently in an infirmary or hospital or has been to one of these facilities frequently in the last six months. The bill would also remove the Governor from the medical parole process, creating parity between all parole processes in the state.

Under the current parole system, too few people are considered eligible for geriatric and medical parole. Petitions for geriatric parole are rarely approved. Currently, there are about 630 individuals over the age of 60 in Maryland's prison system who have served at least 15 years. Risk of reoffending drops significantly past age 60. [1] Recidivism

[1] Hunt, K. S., & Easley, B. (2017, December). The effects of aging on recidivism among federal offenders. United States Sentencing Commission. Retrieved February 7, 2023, from https://www.ussc.gov/research/research-reports/effects-aging-recidivism-among-federal-offenders

drops to just 2% in people ages 55-65 and to almost zero for those older at 65.[2] Despite this, in Maryland, older, aging prisoners have the lowest rates of release.

Low rates of release are seen among medical parole considerations as well. In 2015 and 2020, of the 339 people considered for medical parole, only 86 applications were granted. From 2021 to 2023, the Commission only granted medical parole for only 14 people serving life sentences. Five people died waiting for the Governor's approval. The rest were denied. In 2021, the legislature removed the Governor from the parole process for those serving life sentences. But, because of a bill drafting error, the Governor was not removed from the medical parole process for lifers. This bill would remedy that error, while also updating the criteria for release and establishing a more appropriate method for considering these requests.

Current standards for medical parole mean that many individuals remain incarcerated while unable to complete daily tasks like toileting, grooming, and walking. Inmates are forced to rely on the goodwill of other people inside to survive because they are simply "not sick enough" to be released. Many of these applicants would pose no threat to their communities if released. Rather, they would go to a facility in which they would receive appropriate, comprehensive care at the end of their life.

For the foregoing reasons, the ACLU of Maryland urges a favorable report on SB 98.

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[2] Silber, R., Shames, A., & Reid, K. (2017, December). Aging Out: Using Compassionate Release to Address the Growth of Aging and Infirm Prison Populations. Vera Institute of Justice. Retrieved February 7, 2023, from https://www.vera.org/publications/compassionate-release-aging-infirm-prison-populations

Council's Letter of Support for SB 98 signed (2).p
Uploaded by: Paul Ballard
Position: FAV

WES MOORE
GOVERNOR

ARUNA MILLER
LT. GOVERNOR

CHRISTOPHER D. KEARNEY, M.D.
CHAIRPERSON

STATE OF MARYLAND
ADVISORY COUNCIL ON QUALITY CARE AT THE END OF LIFE

February 6, 2023

William C. Smith, Jr.
Chair
Senate Judicial Proceedings Committee
2 East
Miller Senate Office Building,
Annapolis, MD 21401

RE: Senate Bill 98 – Correctional Services – Geriatric and Medical Parole – Support

Dear Chair Smith,

The State Advisory Council on Quality Care at the End of Life supports Senate Bill 98.

The main statutory mission of the Council is to advise on issues of care for seriously ill Marylanders at the end of life. The Council is currently partnering with the Maryland Health Care Commission as part of a legislatively mandated workgroup to study the existing state of palliative care services provided to seriously ill patients throughout the health care system in Maryland. In addition to the Council's participation in this workgroup's work to review hospital, nursing home, and community-based care, the Council has been reviewing the care of seriously ill incarcerated Marylanders.

In our public meetings, recent examples of care provided to seriously ill inmates have been presented, raising significant concerns about the quality of care provided to these elderly and terminally ill citizens. We have learned about a dying patient who was transferred back and forth to an acute hospital bed, shackled, and no contact with his family. We have heard other examples of wheelchair and oxygen dependent individuals, as well as demented inmates in prison infirmaries, who likely could receive appropriate care in a community setting, and who pose no meaningful threat to society. We know there is no true hospice care in our prisons.

In the Council's public meeting held on January 31, 2023, it was the consensus of the Council members to support Geriatric and Medical parole reforms as proposed in SB 98. We strongly feel all Marylanders, regardless of their residency, deserve equal access to standard care for their serious medical illnesses, and compassionate end of life care.

Sincerely,

Christopher Kearney\kt

Christopher D. Kearney, M.D.

ALL CORRESPONDENCE AND INQUIRIES TO:
Paul J. Ballard, Counsel, Health Decisions Policy
300 West Preston Street ♦ Baltimore, Maryland 21201
Telephone: 410-767-6918 ♦ TTY For Disabled (Maryland Relay Service) 800-735-2258 ♦ 877-4MD-DHMH

SUPPORT SB 98 – Geriatric and Medical Parole.pdf
Uploaded by: Philip Caroom
Position: FAV

SUPPORT SB 98 – Geriatric and Medical Parole

TO: Chair Will Smith and Senate Judicial Proceedings Committee
FROM: Phil Caroom, MAJR Executive Committee
DATE: February 8, 2023

Maryland Alliance for Justice Reform (MAJR-www.ma4jr.org) strongly supports SB 98 that would permit parole of Marylanders who, due to age and medical conditions, pose no risk to public safety and, also, would permit transfer of their costly medical care to Medicaid.

The Parole Commission will have extensive documentation from medical and correctional personnel in every such case. They will have input from victims and prosecutors. Life sentences are the most serious category of case that Parole Commissioners, themselves selected by the Governor, will face in their careers. Legislators can have confidence that the Parole Commissioners will make sound decisions in these important cases.

Savings from parole of these older and medically-disable inmates to the State Budget and, especially, the DPSCS medical budget, via transfer of these costs to Medicaid, will be great. The Pew Institute has reported: "***The older inmate population has a substantial impact on prison budgets. ...The National Institute of Corrections pegged the annual cost of incarcerating prisoners age 55 and older with chronic and terminal illnesses at, on average, two to three times that of the expense for all other inmates, particularly younger ones. More recently, other researchers have found that the cost differential may be wider***." See 7/14 Pew State Prison Health Care Spending Report.

Public safety concerns are greatly reduced with older and disabled inmates, as national studies show. See, e.g., "*Graying Prisons- States Face the Challenge of an Aging Inmate Population* (2014)," Council of State Governments. A study of more than 130 older Maryland inmates released as a result of the Maryland Court of Appeals Unger decision indicated virtually no recidivism. Maryland's DPSCS, in 2006, also reported a zero recidivism rate for inmates paroled over age 60. *Aging Inmate Population, supra*. Funds saved from medical parole may be redirected towards for younger, higher-risk inmates who may pose much greater threats to public safety without appropriate services.

For all these reasons, Maryland Alliance for Justice Reform strongly supports passage of SB 98.

PLEASE NOTE: Phil Caroom offers this testimony for Md. Alliance for Justice Reform and not for the Md. Judiciary.

SB 98 Compassionate Release OPD Fav.docx (2).pdf
Uploaded by: Rachel Kamins
Position: FAV

MARYLAND OFFICE OF THE PUBLIC DEFENDER

Natasha Dartigue
Public Defender
Keith Lotridge
Deputy Public Defender
Melissa Rothstein
Chief of External Affairs
Elizabeth Hilliard
Acting Director of Government Relations

POSITION ON PROPOSED LEGISLATION

BILL: SB 98 - Correctional Services - Geriatric and Medical Parole

FROM: Maryland Office of the Public Defender

POSITION: Favorable

DATE: 2/7/23

The Maryland Office of the Public Defender respectfully requests that the Committee issue a favorable report on Senate Bill 98. This written testimony focuses on the medical parole provisions within the Bill.

The medical parole system in Maryland is dysfunctional and inhumane. The eligibility criteria for medical parole are unduly restrictive and, as a result, the release of chronically debilitated and terminally ill incarcerated persons is seldom granted. Present law also denies the Parole Commission critical information in determining whether to grant medical parole.

Under current law, those eligible to apply for medical parole must be "so chronically debilitated or incapacitated by a medical or mental health condition, disease, or syndrome as to be physically incapable of presenting a danger to society." There are many problems with both this standard and the processes implementing it.

(1) Too few applicants qualify for medical parole under such a stringent standard. Between 2015 and 2021, the Parole Commission ***granted 111 and denied 362*** medical parole applications it received, relegating far too many terminally ill and physically incapacitated incarcerated persons—who are far too sick to pose any risk to public safety—to die behind prison walls, separated from their loved ones and receiving subpar medical and palliative care as compared to what is available outside of prison.

Senate Bill 98 expands the scope of eligibility to include incarcerated persons (1) deemed by a licensed medical professional to be "chronically debilitated or incapacitated" ***or*** (2)

suffering from a terminal illness that requires extended medical management that would be better met by community services than the health care provided in prison ***or*** (3) physically incapable of posing a danger to society as a result of their physical or mental health condition. Patently, releasing incarcerated persons whose health care needs exceeds the capacity of the prison health care system is the humane thing to do. It also ameliorates the exorbitant cost to Maryland taxpayers, making Senate Bill 98 a clear "win-win."

(2) Under the current medical parole statute, the applicant is not afforded a meeting with the Maryland Parole Commission in connection with the request for medical parole.

Senate Bill 98 allows the incarcerated person or their representative to request a meeting with the Commission and requires the Commission to grant the request for a meeting, provided the inmate (1) is then housed in a prison infirmary or a hospital in the community or (2) has been frequently housed in such a facility without the preceding six months. Importantly, Senate Bill 98 gives the Commission the ***discretion*** to provide a meeting to an inmate who does not meet the aforementioned housing criteria. Requiring a meeting between the Commission and the inmate allows for the presentation of a more comprehensive picture of the inmate, his medical condition(s) and, if applicable, his family situation, and enables the Commission to render a more informed and reasoned decision about whether to grant medical parole in any given case.

(3) Under present law, medical parole candidates are evaluated using the Karnofsky Performance Status Scale, an outdated and inadequate assessment instrument for determining functional impairment.

Senate Bill 98 provides for an updated, dynamic medical assessment that more effectively and holistically demonstrates a medical parole candidate's degree of debilitation, specific medical needs, and prognosis.

(4) The current medical parole statute does not require a medical examination of the individual seeking parole. Instead, a doctor merely reviews existing medical information, assigns the aforementioned "Karnofsky" score, and then makes a recommendation to the Parole Commission. The Commission is not required to adopt that recommendation.

Senate Bill 98 allows the incarcerated person to obtain, at no cost, an independent medical evaluation, which consists of an in-person examination of the incarcerated person. The

findings of the independent medical evaluation and any medical conditions detailed in the evaluation are to be given equal consideration by the Commission. This addition to the law appropriately acknowledges the informative nature of a medical evaluation and assigns it equal weight among the numerous other factors to be considered by the Commission in determining whether to grant medical parole.

(5) Finally, under the current medical parole statute, the Commission's decision to grant parole to an inmate serving a life sentence must be approved by the Governor.

Senate Bill 98 removes the requirement of gubernatorial approval for medical parole, consistent with the removal of the Governor from the regular parole process through prior legislation.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on Senate Bill 98.

Submitted by: Maryland Office of the Public Defender, Government Relations Division.
Authored by: Rachel Marblestone Kamins, Assistant Public Defender, Appellate Division, rachel.kamins@maryland.gov.

Kheirbek, MD Oral Testimony .pdf
Uploaded by: Raya Kheirbek
Position: FAV

HB 157/SB 98- Correctional Services – Geriatric and Medical Parole

Oral Testimony

Raya Elfadel Kheirbek, MD, MPH, FGSA

Thank you for this opportunity. My name is Raya Elfadel Kheirbek. I am speaking in favor of Geriatric and Medical Parole on behalf of the incarcerated patients under my care.

As Chief of Geriatrics and Palliative Medicine at the University of Maryland School of Medicine in Baltimore, as well as a Professor of Medicine, I have a duty to relieve suffering, uphold human dignity, and protect and care for patients based on an evidence-based clinical assessment.

I have cared for dying prisoners. Our teams across the Medical Center scramble though administrative hurdles to fast-track compassionate release, but often we fail to ensure human dignity and unite inmates with their loved ones. No one deserves to die with their feet shackled to a bed, accompanied only by two fully armed guards.

Compassionate release is often the most humane and ethical course of action for elders and terminally ill inmates. These individuals usually carry a low public safety risk and low rate for recidivism due to accelerated biological aging, advanced illness, and poor physical health. They could be released to the care of their loved ones or local community programs, including inpatient hospices. Incidentally, it would be at substantially less cost for Maryland taxpayers.

Our seeming indifference to the healthcare needs of incarcerated persons is a violation of the 8th amendment of the United States Constitution and is cited in *Duvall vs Hogan*. Within the Maryland Correctional Health System, access to geriatric care for inmates is limited at best; the same is true for palliative medicine and hospice care. Appropriate access to care for inmates is both a moral obligation and a legal requirement.

Thank you for allowing me the time to speak. I have also submitted written testimony for your consideration.

Kheirbek, MD Written Testimony.pdf
Uploaded by: Raya Kheirbek
Position: FAV

Testimony of Raya Elfadel Kheirbek, MD, MPH, FGSA
Maryland Senate Judicial Proceedings – February 8th at 1:00pm
HB 157/SB 98- Correctional Services – Geriatric and Medical Parole

I recommend a favorable report for **HB 157/SB 98** on behalf of the incarcerated patients I have cared for. My name is Raya Elfadel Kheirbek, and I am both a Professor of Medicine and Chief of Geriatrics and Palliative Medicine at the University of Maryland School of Medicine in Baltimore. *Geriatrics* is the medical discipline focused on delivering cost-effective, quality medical care to older adults. *Palliative Medicine, including Hospice,* is specialized, patient-centered medical care for patients with serious illness, or at the end of life, that has been shown to result in better health outcomes and lower costs. My experience in the last two decades caring for my patients leads me to write this testimony today.

Older prisoners pose a low public safety risk due to their accelerated biological age, general physical deterioration, and low propensity for recidivism. "Compassionate Release," adopted by Congress as part of the Sentencing Reform Act of 1984, was enacted in part to lower the cost of incarcerating the seriously ill by allowing those who pose no safety risk to die outside of prison. Across the nation, nearly all jurisdictions have adopted some form of health-related early release policy, but relatively few dying, or aged and seriously ill prisoners are released under such mechanisms.

Providing access to health care services is both a moral duty and a legal requirement for all people, incarcerated or not. In 1976, the U.S. Supreme Court ruling Estelle vs Gamble found that deliberate indifference to healthcare for the incarcerated population constituted cruel and unusual punishment and was thus prohibited by the U.S. Constitution. In the state of Maryland Correctional Facilities, access to geriatrics remains limited and access to palliative and hospice services simply does not exist.

While Maryland has both medical and geriatric parole options, approval rate is low. Between 2015 and 2020, the Maryland Parole Commission denied 253 medical parole applications and approved only 86—a 75 percent denial rate. Currently, there are about 630 individuals over the age of 60 in Maryland's prison system who have served at least 15 years. In the state of Maryland, 6.4 percent of the prison population, or 3,324 individuals, are over 50 years old which in several states are considered geriatric due to accelerated biological aging while incaracerated. Moreover, 2,341 individuals, or about eleven percent of the prison population, are serving life sentences. They are overwhelmingly Black. A 2019 Justice Policy Institute report found that nearly eight in ten people who are serving the longest prison terms in Maryland are Black. Of the population serving those terms, 41 percent are Black men who were sentenced to prison as emerging adults (under the age of 25). It's important to recognize the racial inequities being perpetuated by the current system.

Cost should also be considered. Incarcerated inmates are not eligible for public health benefit programs (Medicare, Medicaid, Social Security Insurance, Veterans Health Administration) upon entering the prison. The cost of care falls upon the state to cover. Nationally, the annual cost to incarcerate an individual is $34,000. Older prisoners have a disproportionately high burden of chronic medical conditions, cognitive impairment and disability compared to younger prisoners and compared to their age-matched counterparts outside of prison. On average, older prisoners generate between 4 and 9-fold higher annual costs than younger prisoners with an estimated cost of $35.5 million a year in the state of Maryland for incarcerated individuals over 60 years. The underutilization of compassionate release suggests an opportunity to achieve a more cost-effective system by incarcerating fewer older and seriously ill prisoners.

The Geriatric and Medical Parole bill is a good step in the right direction because historically, the misalignment of compassionate release eligibility with medical realities results in a very few compassionate releases—despite a quickly rising number of deaths in inmates. Studies have demonstrated that even when physicians are relatively certain of a prognosis, they are frequently uncomfortable to prognosticate and— when they do— they are apt to significantly overestimate prognosis. For example, they assess their patient has twelve months to live when in fact they have only two. This amount of time is obviously way too little to get through an entire burdensome compassionate release evaluation process. Therefore, it would be appropriate to include the provision of a fast-track option for prisoners deemed to face "imminent death" who are either actively pursuing or wish to pursue compassionate release. The 6-month prognosis approach is best for a medical illness that has a predictable course, such as many metastatic cancers. However, many conditions that are ultimately terminal are not predictably so. These include conditions such as advanced heart failure, liver cirrhosis, lung disease and dementia. All these maladies are increasingly common causes of complication and death among inmates yet prognosticating the exact date or month of death for these conditions is likely to be very difficult. These terminal illnesses tend to result in sudden death or a sudden, less predictable, precipitous decline in health. In both of these instances, the scientific reality of prognostication and the dying process do not match the intent of the bill, and as a result, many patients will be dying in prison instead of more humanely in the community. The fields of geriatrics, palliative and hospice medicine have adopted the end-of-life trajectory framework. It has been incorporated into the Federal First Step Act with success

It's important to clarify that compassionate release in no way means the patient automatically gets out of prison; it simply allows for doctors to use their expert clinical judgment

based on scientific evidence to conclude that their patient has entered an “end of life trajectory” of a serious, life-limiting disease, where death in the next several months would not be a surprise. The treating physician could initiate the corrections and court-based assessment process for their patient to be assessed for their suitability for compassionate release. This would require each prison facility housing older prisoners to receive comprehensive education in geriatrics principles and training in how to identify and care for inmates of older age (geriatrics training) and to those with serious and terminal illnesses (palliative care and hospice training).

The state of Maryland remains behind the rest of the country with compassionate release , which makes the passing of this bill imperative. We cannot wait any longer, it’s the right thing to do.

Resources:

- National Institute of Justice, "Compassionate Release of Terminal Inmates," 2019.
- American Medical Association, "Hospice and Palliative Medicine Principles," 2017.
- National Hospice and Palliative Care Organization, "Improving Prognostication in Terminal Illness," 2020
- Justice Policy Institute,
- “Compassionate Release in Maryland: Recommendations for Improving Medical and Geriatric Parole.”
- Families Against Mandatory Minimums (FAMM): States Compassionate Release: The National Picture, October 2022

SB98_FAV_Hettleman.pdf
Uploaded by: Shelly Hettleman
Position: FAV

SHELLY HETTLEMAN
Legislative District 11
Baltimore County

Judicial Proceedings Committee

Joint Committee on Children, Youth, and Families

Joint Committee on the Chesapeake and Atlantic Coastal Bays Critical Area

James Senate Office Building
11 Bladen Street, Room 203
Annapolis, Maryland 21401
410-841-3131 · 301-858-3131
800-492-7122 *Ext.* 3131
Shelly.Hettleman@senate.state.md.us

The Senate of Maryland
ANNAPOLIS, MARYLAND 21401

TESTIMONY OF SENATOR SHELLY HETTLEMAN
SB 98 CORRECTIONAL SERVICES – GERIATRIC AND MEDICAL PAROLE

Maryland law currently provides for both medical and geriatric parole release opportunities. The problem is that requests for either are rarely granted. The Maryland Parole Commission approved just 149 medical parole requests and denied 464 between 2013 and 2022, meaning more than three times the number of people approved for release were denied. While the Justice Reinvestment Act lowered from 65 to 60 the age eligibility for geriatric parole, it is rarely approved.

This bill is a consensus bill and represents a piece of work that the Department of Corrections, advocates and the Parole Commission worked on

As this committee is well aware, over the past decades our prison population has ballooned, attributable more to longer sentencing than increased crime. As this population ages, just like it does outside the walls, the care of older adults will cost more. As it currently stands, the annual cost of an inmate is over $46,000 per year and estimates are that health care costs double for those age 60 and over.

Current law enables anyone to apply for medical parole except those sentenced for a sex offense and those ineligible for parole. No medical examination is required and there is no hearing. A physician reviews the medical record, assigns a Karnofsky score that measures impairment, and sends a recommendation to the Parole Commission. Regulations are actually **stricter** than statute and stipulate that a person must be "imminently terminal" in order to be eligible for medical parole, which is also dramatically **more restrictive than federal standards of care**.

The bill permits the inmate, a family member or other representative to request a meeting with the Parole Commission to request medical parole. They may also request a medical evaluation that the Parole Commission must consider along with other factors in assessing whether to grant parole. The bill strikes an important balance between the health care needs of the inmate with public safety concerns by taking into consideration whether an ill inmate is likely to recidivate.

With regard to geriatric parole, Maryland's experience with the Unger population is telling. These older inmates (whose average age was 64 and who had served an average of 40 years), and were released by court ruling, demonstrate that as individuals age, the risk to public safety is minimal (under 3%). In other words, most people age out of criminal behavior.

SB 98 fixes a quirk in current law that allows geriatric parole only to offenders who have committed multiple violent offenses and are not otherwise parole eligible. This should be fixed. It should also be moved from the Criminal Code section to the Correctional Law section where other parole matters are.

As evidenced in recent article from The Baltimore Banner titled, *Maryland among the 'worst' states for releasing again or sick prisoners. Is reform coming?*, Maryland has a lot of work to do.[1] According to the article, written by Dylan Segelbaum, Families Against Mandatory Minimums (FAMM), a national nonprofit organization in Washington, D.C., that advocates for fair and effective criminal justice policies, released report cards in 2022 grading compassionate release in each state. Maryland received an F with a score of 16/100, with FAMM noting that the state's program is internally inconsistent and incoherent. This is worse than Virginia (scored at 45/100), Pennsylvania (41/100), West Virginia (32/100), and Delaware (19/100).[2] This is unacceptable.

SB 98 addresses the very real problems with our medical and geriatric parole systems. It standardizes them, provides an opportunity for medical oversight at the same time that it protects public safety and saves resources. Thank you for your consideration of SB 98.

[1] https://www.thebaltimorebanner.com/community/criminal-justice/compassionate-release-maryland-GWHUHTCF45AWPOENEITOPUAOEQ/
[2] Id.

SB0098_JPI. ComRelease.pdf
Uploaded by: T. Shekhinah Braveheart
Position: FAV

JUSTICE POLICY INSTITUTE

Testimony to the House Judiciary Proceeding Committee
House Bill 0157/Senate Bill 0098 — Compassionate Release: Medical/Geriatric Parole Reform

Justicepolicy.org

Founded in 1997, the Justice Policy Institute (JPI) is a nonprofit organization developing workable solutions to problems plaguing juvenile and criminal justice systems. For over 25 years, JPI's work has been part of reform solutions nationally, as well as an intentional focus here in Maryland. Our research and analyses identify effective programs and policies, in order to disseminate our findings to the media, policymakers, and advocates, and to provide training and technical assistance to people working for justice reform.

JPI supports Senate Bill 0098, which would provide a fix to the language errors contained within Maryland's current medical parole statute, as well deliver enhanced compassionate release opportunities for infirm and/or elderly persons in prison.

Medical parole

Two years ago, this legislative body took the important and necessary step of removing the governor from the parole decision-making process for people serving a life sentence; thereby removing politics from parole in Maryland. That was a historic step that means Maryland governors can no longer undermine the Maryland Parole Commission (MPC). The long-term impact of that policy change will be less tax dollars spent for excessively long stays of incarceration with no demonstrable public safety benefit, less funds diverted away from important services like education and healthcare and will help to mitigate the huge racial disparities in the Maryland justice system.

Between 2015 and 2021, the MPC approved 112 medical parole petitions and denied 350, a 32 percent approval rate. Furthermore, during the COVID-19 pandemic, only 17 percent of parole petitions were approved for medical parole. Currently, the MPC receives a medical recommendation from the treating doctor, which includes the general prognosis, an individual's capacity, a Karnofsky Performance Score,1 and institutional information such as program participation. Unfortunately, this process is woefully inadequate to assess an individual's prognosis, and the reliance on an imprecise and inappropriate quantitative score has resulted in the denial of many deserving petitions.

During debate on the bill to remove the governor from the parole process we heard how the MPC is much better situated to evaluate someone for release due to their history of involvement with the incarcerated population. The governor was making decisions based off no interaction with the population whose fate he was deciding. The idea of making uninformed decision on medical parole recommendations is unfathomable. We have seen what happens when the governor makes uninformed decisions in the case of Donald Brown whose initial attempt for

[1]Maryland relies on the Karnofsky Performance Status Scale, without any in-person examination. A physician issues a short memo to the MPC that includes the score, and if it is below 20, they are typically considered a viable candidate for release. According to the scale, a score of 20 indicates that an individual is very sick, hospital admission is necessary, and active supportive treatment is required.

medical parole was denied by the previous governor. In the following month, Mr. Brown's health got worse and sparked a second attempt of medical parole. He was granted medical parole and was released from prison but passed away in a nursing home four days later. That was not medical parole. That was the state avoiding funeral cost.

Unfortunately, due to a technical error, the bill to remove the governor from parole did not remove the governor from the medical parole decision making process. The same logic and considerations that went into passage of that bill should be applied to removing the governor from medical parole. There is no legitimate policy goal, least of all protecting public safety, which supports keeping the governor in the medical parole process.

Geriatric parole

While Maryland law has a geriatric parole provision that was intended to benefit incarcerated individuals over the age of 60 who have served at least 15 years, in reality very few individuals are eligible because the law requires only those persons who meet those criteria and are serving sentences for subsequent violent offenses are eligible. This is problematic. If someone is sentenced to 80 years for a first-time offense when they are 40 years old, with standard parole eligibility at 50 percent, they will not be eligible for release until age 80. Geriatric parole is unavailable to them because it is a first-time offense. This technical issue within the geriatric parole law circumvents the spirit of an age-based release mechanism.

According to a forthcoming comprehensive report on the Maryland parole system, Six percent of the Maryland prison population, or 3,324 individuals, are over 50 years old. Additionally, Maryland currently has 2,341 people serving a life sentence, suggesting that the aging population will continue to grow. The older the individual, the more complications with health. A study in Pennsylvania concluded that an incarcerated population with an average age of 57 has similar health ailments to men in the general public with an average age of 72. A prison is not a hospitable setting for aging and is downright hostile for those individuals suffering from a chronic or terminal illness.

The Justice Policy Institute urges this committee to issue a favorable report on SB 0098.