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To: House Judiciary Committee

From: Maryland Office of the Public Defender

Re: In Support of House Bill 190 - Correctional Services - Geriatric and Medical Parole

Date: February 21, 2025

House Bill 190 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 January 2025 estimates from the Department of Public Safety & Correctional Services, there are currently approximately 439 individuals over the age of 60 in the Department of Corrections (DOC) who have already served over 15 years in prison on a sentence eligible for geriatric parole consideration in Senate BIll 181.[1] In response to a legislative inquiry, the Department recently estimated that approximately 1,1173 incarcerated individuals, or 9.9% of the overall incarcerated population, are living with serious mental illness and require chronic medical care. The numbers are staggering – incarcerated Marylanders are aging and they are ailing. Maryland has always intended to have a release valve for incarcerated individuals who are sick and elderly by adopting a medical and geriatric

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. Senate Bill 181 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.

House Bill 190 moves Maryland towards a legally sound standard for medical and geriatric parole. Nothing in House Bill 190~~157~~ lessens the Commission's obligation to take both public

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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 decide 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 are important release valves for individuals who pose no threat to public safety and require care in the community, not cages.

This testimony addresses each parole provision in turn.

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, Lila Meadows, MOPD's premiere expert on medical and geriatric parole in Maryland has 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 181 would remove the geriatric parole provision from MD Code Criminal Law 14-101 and 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. Both of these provisions are critical as Maryland's prison population ages.

In Maryland, and across the country, elderly populations within prison systems are increasing.[2] Since 2003, the fastest growing age group in the prison system has been persons aged 55 and older.[3] 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.[4] 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 House Bill 190. **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.

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 younger counterparts.[5] "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."[6]

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.[7] 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

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[2] 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).

[3] 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.

[4] 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.

[5] 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.

[6] 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.

[7] 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/.

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."[8]

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."[9] 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."[10] 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."[11] The COVID-19 pandemic exacerbates these health concerns.

R*ecidivism rates among elderly persons released from prison are low.* 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 recidivism.[12] 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

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[8] 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 .

[9] 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.

[10] *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.

[11] *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.

[12] 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.

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."[13]

It is exceedingly expensive to incarcerate elderly persons. 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."[14] "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."[15] These outsized costs are in large part due to the increased healthcare costs associated with elderly persons in prison.[16] 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.[17] From 2001 to 2008, per-inmate healthcare spending rose 103% in Maryland from $3,011 per fiscal year to $5,117 per fiscal year.[18]

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.

House Bill 190 will create a meaningful geriatric parole standard. Not surprisingly, given the aforementioned issues, In 2022, then-Chairman Blumberg testified before the Judicial Proceedings Committee that the current statute is unworkable. MOPD anticipates Chairman Eley will testify to much the same this year. Remedying our broken geriatric parole provision is a critical fix that cannot wait another year. House Bill 190 gives Maryland 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.

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

[14] 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.

[15] *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)).

[16] *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.

[17] 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.

[18] *Id.*

Medical Parole

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 this standard as well as the processes implementing it.

(1) Too few applicants qualify for medical parole under such a stringent standard. In 2024, only 14 people were granted medical parole. Five of those 14 passed away nearly immediately upon their release. According to the FY25 Analysis Maryland's prison population was on average 15,000 people or above for the 2023 year.[19] It is clear that with only 14 individuals being released through medical parole in a year, many of whom were on the cusp of passing away, our current medical parole system is 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.

House Bill 190 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 181 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.

House Bill 190 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, House Bill 190 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

[19] https://mgaleg.maryland.gov/pubs/budgetfiscal/2025fy-budget-docs-operating-Q00-DPSCS-Overview.pdf.

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.

House Bill 190 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. 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.

(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.

House Bill 190 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. House Bill 190 also clarifies the process for obtaining an outside medical evaluation, a process already allowed by statute. It further requires MPC to give those evaluations 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. These improvements 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 181 removes the requirement of gubernatorial approval for medical parole, consistent with the removal of the Governor from the regular parole process through prior legislation.

To elucidate the issues with the current statute, it is important to understand the practical application. First, individuals seeking medical parole 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 the experience of Lila Meadows, APD, the 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 Attorney Meadows has 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 undergoing chemotherapy for an advanced stage of cancer who could not complete many activities of daily living on their own, including bathing, dressing themselves, or cutting their own food. They lived in the prison infirmary where they were often left for long periods of time in their own urine and feces while waiting for correctional nurses to come and assist them.
- 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. For two years after contracting COVID they lived in the prison infirmary where they were 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 agreed that the damage to my client's lungs was permanent and there is no prognosis for improvement. After contracting a secondary lung infection, the client died shackled to a hospital bed.

House Bill 190's 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.

For these reasons, the Maryland Office of the Public Defender urges this Committee to issue a favorable report on House Bill 190.

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