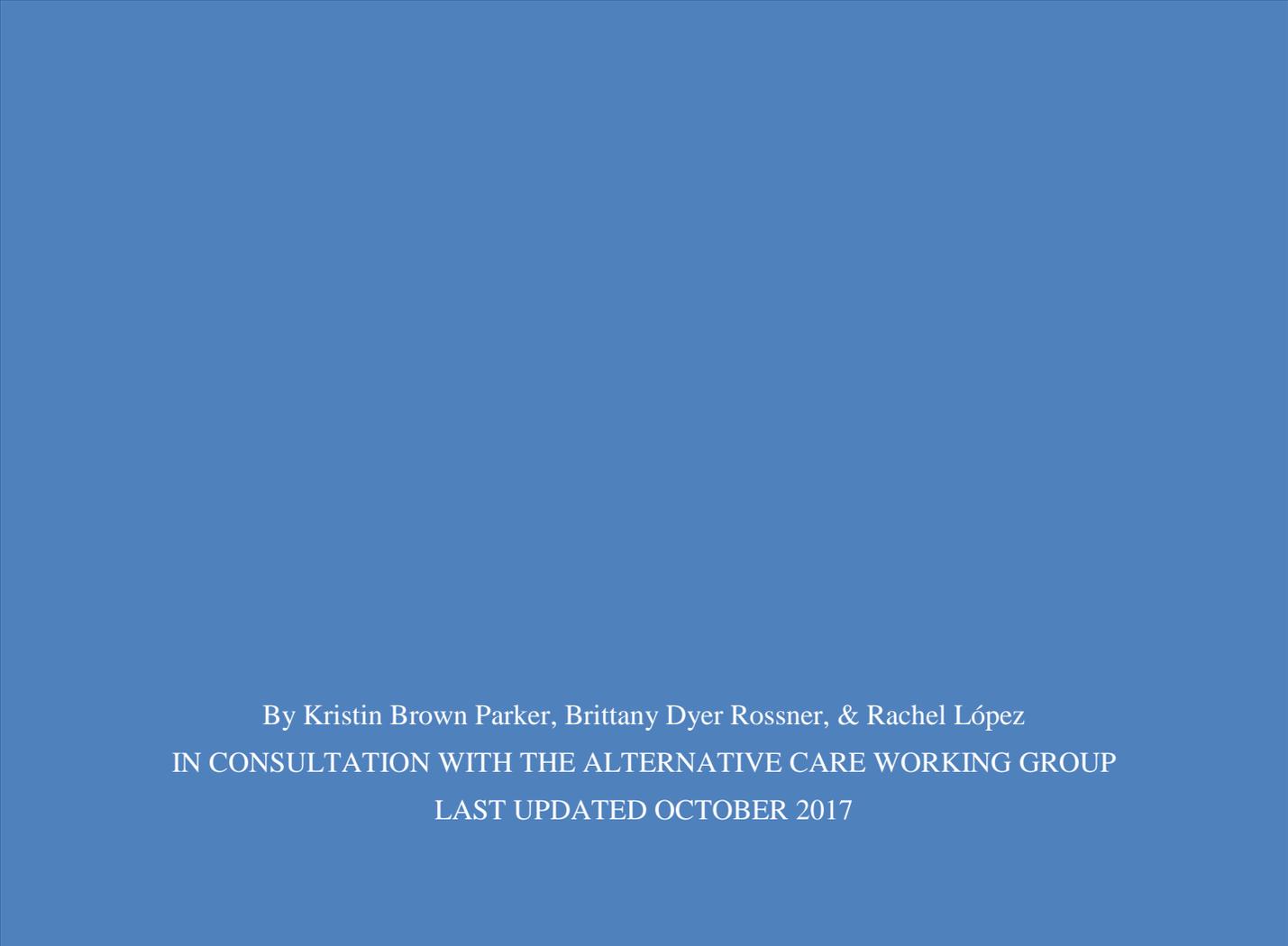




# INCREASING ALTERNATIVE CARE OPTIONS FOR TERMINALLY AND CHRONICALLY ILL PRISONERS



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## I. Introduction

The number of elderly prisoners in Pennsylvania is growing at a rapid rate, nearly doubling in the past ten years. As this population increases, so does the cost of caring for their chronic and physically debilitating illnesses that develop with age. And Pennsylvania's taxpayers are the ones bearing this expense.

Other states across the country that are grappling with this issue have aggressively pursued a variety of avenues to relieve the stress on their corrections departments by adopting or expanding programs that allow for the release or parole of seriously or terminally ill prisoners. However, Pennsylvania has lagged behind. Pennsylvania has a statute that allows for terminally ill<sup>1</sup> prisoners to petition for deferment of their sentences so they can receive care outside of the prison. However, the law is so restrictive that, since its reform in 2008, only thirteen prisoners have had their sentences deferred on this basis.<sup>2</sup>

Concerned about this issue, a working group of academics, attorneys, law students, former medical staff at the Pennsylvania Department of Correction (DOC), criminal justice advocates, and a former prison chaplain, who is also a member of the victim advocate community,<sup>3</sup> came together to devise solutions that take a variety of perspectives into account. This report memorializes the recommendations of that group and outlines how Pennsylvania can ease the burden on its correctional budget by shifting the costs of caring for terminally and chronically ill prisoners to federal programs like Medicaid and Medicare. Specifically, it documents ways to make the current statute more effective as well as a new avenue for chronically ill prisoners to receive care outside of prison walls.

First, the report proposes reforms to the statute that would make the process less onerous and more efficient and clarify existing ambiguities so that the law achieves its intended purpose. Second, it recommends the adoption of a provision for medical parole. Whereas the current statute provides for the *deferment of the sentences* of prisoners who, in effect, must have *terminal illnesses*,

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<sup>1</sup> The existing statute includes a provision for seriously ill prisoners, but in order to be eligible for deferment of their sentences those individuals must also be expected to die in less than a year, so in effect, they must be terminally ill.

<sup>2</sup> Statistics obtained from the Bureau of Health Care Services of the Pennsylvania Department of Corrections on September 29, 2016.

<sup>3</sup> The working group benefited from the insights of Ken Bingham, Susan Brooks, Peter Goldberger, Angus Love, Dr. Donald McEachron, Joan Porter, Phyllis Taylor, Dr. Nicholas Scharff, and Ann Schwartzman. In particular, the working group would like to recognize the contributions of the late Dr. Julia Hall. This report would not have been possible without her expertise and innovation. We would also like to thank the Lifers at Graterford State Correctional Institution, particularly Stan Rosenthal, who were the initial inspiration for this project.

medical parole is different in that allows for *parole* of prisoners who have *debilitating chronic illnesses*. Medical parole will help alleviate the growing costs of caring for individuals who are incapacitated or unable to care for themselves due to a chronic medical condition, but whose life expectancy is more than one year. As an interim measure, we also recommend that the DOC: 1) release an interpretative memorandum to resolve the ambiguities in the existing statute; and 2) establish a procedure through which its staff can identify and notify prisoners of their eligibility for deferment of their sentences.

## **II. Background**

In 2002, Pennsylvania established the Advisory Committee on Geriatric and Seriously Ill Inmates, whose mandate was to study the geriatric and seriously ill population within the state's correctional facilities and make recommendations to the General Assembly.<sup>4</sup> The committee found that not only was Pennsylvania's geriatric prisoner population increasing, but so was the cost of caring for this population. After considering other options for medical care, like transferring prisoners to an off-site healthcare location within the purview of the DOC, it found that the placement of seriously ill prisoners into the care of family, friends, or outside healthcare facilities was "the only way to accomplish real cost savings" with the cost of care being defrayed by Medicare or Medicaid.<sup>5</sup>

Although the advisory committee drafted two alternative legislative amendments that would provide additional avenues for seriously and terminally ill prisoners to be put into the care of healthcare facilities or the prisoners' families, neither was adopted.<sup>6</sup> Instead, the version adopted by the General Assembly and signed by Governor Rendell in 2008 made it much more difficult for critically ill prisoners to petition for care outside of the state correctional system.

## **III. Arguments for Reform**

### **A. The High Cost of Incarcerating Seriously and Terminally Ill Prisoners**

*"[The elderly prison population is the fastest-growing segment of prison populations..... And part of the problem for these states is that they're not just occupying cells that are in great demand, but*

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<sup>4</sup> GEN. ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA – JOINT STATE GOV. COMM'N, REPORT OF THE ADVISORY COMM. ON GERIATRIC AND SERIOUSLY ILL INMATES, at page 1 (June 22, 2005) [hereinafter ADVISORY COMM. REPORT], available at <http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2005-40-INMATES%20REPORT.pdf>.

<sup>5</sup> *Id.* at 21, 22.

<sup>6</sup> *Id.* at 24-41.

*these older prisoners often cost twice the amount of younger prisoners.*” –Jonathan Turley, Director of the Project on Older Prisons at George Washington University

The need for more robust avenues to care for aging and ill prisoners in Pennsylvania is best understood in the context of the broader problems that mass incarceration and the aging prison population have created for state correctional facilities across the country. The United States has the highest rate of imprisonment in the world, with 2.3 million people under the jurisdiction of federal and state correctional facilities.<sup>7</sup> Between 1995 and 2010, the elderly prison population nearly quadrupled.<sup>8</sup> By 2030, the elderly are expected to account for one third of the prison population in the United States, representing an increase of 4,400% over a fifty-year period.<sup>9</sup>

The problem is particularly acute in Pennsylvania, which a 2012 Human Rights Watch report found to have the second highest rate of prisoners age 55 and older in the country.<sup>10</sup> Moreover, the DOC recently reported to the Senate Appropriations Committee that twenty percent of Pennsylvania’s prison population is over the age of fifty, a rate that has nearly doubled in the past ten years.<sup>11</sup> The DOC considers prisoners within this age group to be geriatric since “inmates age at a rate of five-to-ten years faster than their chronological age.”<sup>12</sup> The especially high rate of incarceration of elderly Pennsylvanians is attributable to this state being one of only few that does not have life with parole as an option available at sentencing.<sup>13</sup> Indeed, about ten percent of the

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<sup>7</sup> UNITED STATES DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES 2014, revised January 21, 2016, at page 5, available at <http://www.bjs.gov/content/pub/pdf/cpus14.pdf>.

<sup>8</sup> OSBORNE ASSOCIATION, THE HIGH COSTS OF LOW RISK: THE CRISIS OF AMERICA’S AGING PRISON POPULATION, at page 2 (July 2014), available at

[http://www.osborneny.org/images/uploads/printMedia/Osborne\\_Aging\\_WhitePaper.pdf](http://www.osborneny.org/images/uploads/printMedia/Osborne_Aging_WhitePaper.pdf).

<sup>9</sup> *Id.*

<sup>10</sup> HUMAN RIGHTS WATCH, OLD BEHIND BARS: THE AGING PRISON POPULATION IN THE UNITED STATES, at page 21 (2012) [hereinafter OLD BEHIND BARS], available at [https://www.hrw.org/sites/default/files/reports/usprisons0112webwcover\\_0.pdf](https://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf).

<sup>11</sup> JOHN E. WETZEL AND MICHAEL L. GREEN, FY 2016/2017 BUDGET REQUEST, PA. DEP’T OF CORR. AND REHAB. SENATE APPROPRIATIONS COMM. HEARING, at page 8, available at <http://www.cor.pa.gov/Documents/2016-2017%20DOC%20Appropriations%20Testimony.pdf>.

<sup>12</sup> *Id.*

<sup>13</sup> “In six states—Illinois, Iowa, Louisiana, Maine, Pennsylvania, and South Dakota—and in the federal system, all life sentences are imposed without the possibility of parole.” Ashley Nellis, *Throwing Away the Key: The Expansion of Life Without Parole Sentences in the United States*, 43 Fed. Sentencing Reporter 27, at pages 27-32, Sept. 22, 2010, available at <http://www.sentencingproject.org/publications/throwing-away-the-key-the-expansion-of-life-without-parole-sentences-in-the-united-states/>. See also Christopher Moraff, *It’s Time to Get Grandpa Out of Jail*, PHILADELPHIA MAGAZINE, Aug. 21, 2013, available at <http://www.phillymag.com/news/2013/08/21/time-grandpa-jail/>.

current prison population in Pennsylvania will die in prison because they were sentenced to a life term without the possibility of parole.<sup>14</sup>

In the United States, prisoners have a constitutional right to healthcare, even inside prison walls.<sup>15</sup> Additionally, the Americans with Disabilities Act of 1990 (ADA) ensures that there is proper accommodation for prisoners with disabilities.<sup>16</sup> Therefore, prisons are responsible for meeting the medical needs of all their prisoners, including those who are chronically and terminally ill or have a disability.<sup>17</sup> This responsibility poses a unique challenge for the DOC, which must ensure that it has adequate medical staff, medicine, and medical equipment, not just for single episode illnesses like bronchitis, but also for chronic diseases such as cancer and kidney disease. Indeed, one nation-wide survey found that 50.5% of all prisoners and 72.6% of prisoners fifty years or older reported having a chronic condition.<sup>18</sup> These prisoners not only need increased medical care, but also require assistance with their daily activities, like bathing and using the bathroom.<sup>19</sup> Chronic illnesses also require surgeries, special treatments, and therapy, which DOC facilities are unable to supply. Therefore, the DOC is required to coordinate with outside hospitals or other medical providers, which further elevates the cost of care. These costs are so high that in an effort to diminish the costs of transporting prisoners to outside medical facilities, the DOC requested additional funds from the Senate Appropriations Committee to establish an on-site dialysis unit and an on-site oncology treatment center at two of its prisons.<sup>20</sup>

Not only does the DOC shoulder the burden of caring for this elderly prison population, but so do tax-payers. Researchers estimate that correctional facilities spend two to three times more in health care costs for geriatric prisoners than the average prisoners.<sup>21</sup> Moreover, Human Rights Watch estimates that the American prison population of individuals age fifty-five and older costs

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<sup>14</sup> Riley Yates, *Should Pennsylvania reconsider life in prison without parole?*, MORNING CALL, Nov. 14, 2015, available at <http://www.mcall.com/news/local/watchdog/mc-pennsylvania-life-in-prison-without-parole-felony-murder-20151114-story.html>.

<sup>15</sup> Prisons that exhibit “deliberate indifference to serious medical needs” may be liable for violations of the 8<sup>th</sup> Amendment prohibition of cruel and unusual punishment. *Estelle v. Gamble*, 429 U.S. 97, 2014 (1976).

<sup>16</sup> *Pennsylvania Dep’t of Corrections v. Yeskey*, 524 U.S. 206 (1998).

<sup>17</sup> KEVIN E. MCCARTHY & CARRIE ROSE, OLR RESEARCH REPORT: STATE INITIATIVES TO ADDRESS AGING PRISONERS (March 4, 2013) [hereinafter OLR RESEARCH REPORT], available at <https://www.cga.ct.gov/2013/rpt/2013-R-0166.htm>.

<sup>18</sup> LAURA M. MARUSCHAK ET AL., MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES, 2011–12, U.S. DEPARTMENT OF JUSTICE, BUREAU OF JUSTICE STATISTICS, at page 5 (Feb. 2015), available at <http://www.bjs.gov/content/pub/pdf/mpsfpi1112.pdf>.

<sup>19</sup> Anthony A. Sterns et al., *Growing Wave of Older Prisoners: A National Survey of Older Prisoner Health, Mental Health and Programming*, 70 Corrections Today 70 (August 2008).

<sup>20</sup> Wetzel & Green, *supra* note 11, at 14.

<sup>21</sup> Lauren Porters et al., *How the US Prison Boom has changed the Age Distribution of the Prison Population*, 54 CRIMINOLOGY 1, 2016.

states and the federal government \$2.1 billion per year.<sup>22</sup> This population growth and the associated increased costs likely contributed to the Pennsylvania Department of Corrections decision to request a 5.4% increase in its budget for medical services in the 2016-17 fiscal year.<sup>23</sup>

The reforms proposed in this report, described in more detail below, would greatly ease the burden on the state's correctional budget by shifting the cost to federal programs, such as Medicare, Medicaid, and Veterans Affairs health benefits. For instance, Medicare, which offers health insurance coverage for individuals who are age sixty-five and older or who are under sixty-five if they have certain debilitating diseases, such as Lou Gehrig's disease or Parkinson's disease, could provide significant financial relief to the state.<sup>24</sup> While Medicare does not provide health insurance coverage to individuals "in custody under a penal statute or rule," it will provide coverage once prisoners are removed from correctional custody.<sup>25</sup> Since Pennsylvania's current statute provides for the temporary removal of an inmate from the custody of the DOC, Medicare could pay for the hospitalization and hospice care of these individuals.<sup>26</sup> However, because of the prohibitive restrictions in the existing statute, the DOC now shoulders costs that could be borne by the federal government.

Medicaid, or Medical Assistance as it is called in Pennsylvania, is another federal program that would lessen the weight of these medical expenses on the state's correctional budget. With the passage of the Affordable Care Act (ACA), in states like Pennsylvania who have "opted in," Medicaid now covers formerly incarcerated individuals with felony convictions, including those who are on parole.<sup>27</sup> Although the state still would incur some supervisory cost for paroled

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<sup>22</sup> OLD BEHIND BARS, *supra* note 10, at 28.

<sup>23</sup> Wetzel & Green, *supra* note 11, at 14.

<sup>24</sup> *You May Get Part A & Part B Automatically If You Have a Disability*, MEDICARE.GOV, <http://www.medicare.gov/people-like-me/disability/get-a-and-b-automatically-disability.html#collapse-3099> (last visited Apr. 22, 2016); *Medicare Program - General Information*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html> (last modified Jul. 15, 2014).

<sup>25</sup> *2013 Claim Denials Due to Beneficiary Incarceration Status*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.cms.gov/Medicare/Medicare-Contracting/FFSPProvCustSvcGen/2013-Claim-Denials-Due-to-Beneficiary-Incarceration-Status.html> (last modified Dec. 2, 2013).

<sup>26</sup> Medicare has three types of coverage: (1) Part A for inpatient care in hospitals, hospice care, and some home health care; (2) Part B for doctor's services and outpatient care; and (3) Part D for drug coverage. *Medicare Program - General Information*, Centers for Medicare and Medicaid Services, <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html> (last modified Jul. 15, 2014). Medicare Part A's hospice benefit is the "predominate source of payment for hospice care." NHPCO Facts and Figures, *supra* note 63, at 10.

<sup>27</sup> Michael Ollove, *Ex-Felons Are About To Get Health Coverage*, HUFFINGTON POST, available at [http://www.huffingtonpost.com/2013/04/05/ex-felons-medicaid\\_n\\_3021207.html](http://www.huffingtonpost.com/2013/04/05/ex-felons-medicaid_n_3021207.html). As of January 1, 2015, Pennsylvania expanded its Medicaid program eligibility under the Affordable Care Act (ACA) and therefore formerly incarcerated and paroled individuals in Pennsylvania are now eligible for Medicaid. *Pennsylvania*, Medicaid.gov,

prisoners, the cost of parole is much less than that of incarceration. The DOC recently estimated that supervising an individual on parole costs the state \$37,500 less than incarcerating the same individual in state prison.<sup>28</sup> Medicaid can pay for long-term care services, including hospice care, as well as hospitalization.<sup>29</sup> It is a resource for terminally ill prisoners whose sentences have been deferred under the current statute, but also could be a source of funding for chronically ill prisoners if the state adopted a medical parole provision.

Prisoners removed from the custody of the DOC for medical reasons may also be eligible for veterans' benefits provided by the federal government. In Pennsylvania, veterans who have been approved for parole are eligible for different medical services depending on the VA Medical Center where they are assigned.<sup>30</sup> All individuals released on parole in Pennsylvania are eligible for inpatient medical care.<sup>31</sup> In addition, individuals who have been assigned to the VA Medical Centers in Erie, Lebanon, Philadelphia, and Pittsburgh are also eligible for hospice care.<sup>32</sup> Since the DOC currently houses 3,234 veterans, the VA could become an important financial resource for the state if it were to adopt a medical parole statute.<sup>33</sup> Rather than drawing from the DOC's already strained coffers to fund the care for terminally or chronically ill prisoners, the state should benefit from these federally funded programs.

## **B. Diminished Rationale for Incarcerating the Terminally or Chronically Ill**

*"My prison is becoming an old folks' home."* –Burl Kain, former warden at the Angola State Penitentiary in Louisiana, the nation's largest maximum-security prison

Deterrence, rehabilitation, and retribution, the primary goals of incarceration, have less relevance when a prisoner is terminally or chronically ill. First, the deterrent value of imprisonment is diminished when prisoners are terminally or chronically ill, especially if they are elderly, because they pose very little risk to public safety. As the Advisory Committee on Geriatric and Seriously Ill

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<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/pennsylvania.html> (last visited Apr. 22, 2016).

<sup>28</sup> Wetzel & Green, *supra* note 11, at 4.

<sup>29</sup> *Medical Assistance and Long Term Care Services*, PENNSYLVANIA DEP'T OF HUMAN SERVS., <http://www.dhs.pa.gov/citizens/longtermcareservices/medicalassistanceandpaymentoflongtermcareservices/> (last visited Apr. 22, 2016).

<sup>30</sup> LEO L. DUNN, PA BOARD OF PROBATION AND PAROLE, REBUILDING YOUR LIFE AS A VETERAN WHILE ON PAROLE 2, available at

<http://www.pbpp.pa.gov/Information/Documents/Publications/Rebuilding%20your%20life%20as%20a%20Veteran%20while%20on%20parole%2010%202015.pdf>.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 4.

<sup>33</sup> Wetzel & Green, *supra* note 11, at 11.

Inmates highlighted in its 2005 report, parolees released at age fifty or older had a recidivism rate of 1.4% and commuted lifers on parole had a recidivism rate of 1.01%.<sup>34</sup> The Pennsylvania Commission on Sentencing also examined age when developing its risk assessment tool and found it to be one of the most predictive factors of recidivism.<sup>35</sup> On the risk scale it developed for crimes at all gravity levels, the tool assigns individuals fifty years and older a score of a zero, representing the least amount of risk.<sup>36</sup> As the former warden at the Angola State Penitentiary in Louisiana, the nation's largest maximum-security prison, explained, older inmates are filling beds needed for younger criminals who represent more of a threat.<sup>37</sup>

Second, rehabilitation activities and programs in prison are aimed at providing prisoners with the skills and treatment needed for them to become law-abiding citizens upon release. However, once prisoners become terminally or chronically ill, it becomes very difficult for them to participate in such programs. Furthermore, terminally or chronically ill prisoners are unlikely to be able to work upon release or otherwise participate in society at large. Also, due to their medical condition, the likelihood that they will commit another crime is significantly decreased, so they have less of a need for programs aimed at decreasing recidivism.

Retribution is based on the principle that a person who commits a crime should pay some price, either through incarceration or another sanction, generally in proportion to their offense, in order to atone for he or her crime. As the United States Supreme Court recognized in *Atkins v. Virginia*, 536 U.S. 304, 321 (2002), when an individual's capacity is so diminished that they fail to understand why they are being punished, the goal of retribution is not served and punishment amounts to "cruel and unusual punishment" prohibited by the Eighth Amendment of the U.S. Constitution. Prisoners who are incapacitated or so sick that they do not even remember their crimes fall within this class of individuals. As acknowledged explicitly in Oregon's law, incarcerating individuals in this condition is "cruel or inhuman."<sup>38</sup>

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<sup>34</sup> ADVISORY COMM. REPORT, *supra* note 6, at 81.

<sup>35</sup> RISK ASSESSMENT PROJECT II, INTERIM REPORT 2: VALIDATION OF A RISK ASSESSMENT INSTRUMENT BY OFFENSE GRAVITY SCORE FOR ALL OFFENDERS, PENNSYLVANIA COMMISSION ON SENTENCING at page 18, available at <http://pcs.la.psu.edu/publications-and-research/research-and-evaluation-reports/risk-assessment/phase-ii-reports/interim-report-2-validation-of-risk-assessment-instrument-by-ogs-for-all-offenses-february-2016/view>.

<sup>36</sup> *Id.* at 19.

<sup>37</sup> Rick, Bragg, *Where Alabama Inmates Fade into Old Age*, NY TIMES, Nov. 10, 1995, available at <http://www.nytimes.com/1995/11/01/us/where-alabama-inmates-fade-into-old-age.html?pagewanted=all>

<sup>38</sup> Compassionate and Geriatric Release Laws, *supra* note 37, at 19.

Incarceration of a terminally ill prisoner is especially cruel when it forces an individual with a minimal sentence for a non-violent crime to spend the last days of their lives away from their loved ones. This situation was the case with Douglas Murphy.<sup>39</sup> Mr. Murphy was sentenced to one to two years for retail theft. On his first day in prison, Mr. Murphy was rushed by ambulance to a nearby hospital because the prison was unable to provide the intensive care he required. At that time, he was diagnosed with stage four pancreatic cancer. For the next two months, he was transported between the prison and the hospital for treatment, putting a significant strain on his fragile body and placing a major burden on already scarce prison resources.

Mr. Murphy had not been convicted of a violent crime (nor had he ever been).<sup>40</sup> He had a close, dedicated family, who wanted to be there with him during the final months of his life. His mother visited her son in prison once a week, travelling an hour each way. Although his family had started the process of petitioning for deferment of his sentence due to his illness, he died before they could pull together the necessary paperwork. Indeed, the family only obtained an answer to their request for his medical records after he died.

#### **IV. The Challenges under the Current Statute in Pennsylvania**

In Pennsylvania, prisoners have one rigorous and restrictive avenue through which they can petition for deferment of their sentences on medical grounds: a statute entitled “Transfer of inmates in need of medical treatment.”<sup>41</sup> Before the reform of this statute in 2008, a prisoner only needed to show that: (1) he or she was seriously ill and (2) it was necessary for him or her to be removed to another facility better equipped to attend to his or her special needs.<sup>42</sup> However, now, under the current statute, a prisoner is only eligible for temporary removal from DOC’s custody if he is able

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<sup>39</sup> Throughout this report, prisoners and their family members are referred to using pseudonyms to preserve anonymity.

<sup>40</sup> In Pennsylvania, only 33% of prisoners in state prison (and only 15% in jails) are serving time for committing a violent crime. Justice Reinvestment in Pennsylvania: Third Presentation to the Pennsylvania Reinvestment Working Group, July 26, 2016, slide 9, *available at* <http://www.pccd.pa.gov/Documents/Justice%20Reinvestment/PA%20Presentation%203%20Final.pdf>.

<sup>41</sup> 42 Pa.C.S. § 9777.

<sup>42</sup> Prior to its reform in 2008, the statute was entitled “Illness of prisoner; removal for treatment” and provided that “Whenever any convict or person is confined in any jail, workhouse, reformatory, or reform or industrial school, penitentiary, prison, house of correction or any other penal institution, under conviction or sentence of a court, or is so confined while awaiting trial or confined for any other reason or purpose and it is shown to a court of record by due proof that such convict or person is seriously ill, and that it is necessary that he or she be removed from such penal institution, the court shall have power to modify its sentence, impose a suitable sentence, or modify the order of confinement for trial, as the case may be, and provide for the confinement or care of such convict or person in some other suitable institution where proper treatment may be administered. Upon the recovery of such person, the court shall recommit him or her to the institution from which he or she was removed.” 61 P.S. § 81. *See also Com. v. Folk*, 40 A.3d 169, 171-172 n.3 (Pa.Super. 2012).

to satisfy the rigorous requirements laid out in one of two multipart tests, which differ depending upon whether the prisoner is requesting placement at a hospital or long-term care nursing facility, on one hand, or a hospice care location, on the other.<sup>43</sup>

If the prisoner requests placement at a hospital or long-term care nursing facility, they must show by “clear and convincing proof” that: 1) their medical needs will be more appropriately addressed in the hospital or long-term care facility; 2) the hospital or long-term care facility has agreed to provide them with the necessary medical care; 3) they are seriously ill and not expected by a treating physician to live for longer than one year; and 4) there are no writs filed or detainers lodged against them nor are they subject to any court orders.<sup>44</sup> On the other hand, if the prisoner is requesting placement at a hospice care location, the petitioner must establish that: 1) they are terminally ill, not ambulatory, and likely to die in the near future; 2) a licensed hospice care provider can provide more appropriate care; and 3) appropriate medical and palliative care and supportive services will be provided by a licensed hospice care provider at the proposed hospice care location.<sup>45</sup> In addition, regardless of the location of treatment, the court must also be satisfied that: 1) the prisoner does not pose a public safety risk; 2) the health care provider has agreed to notify the department and the sentencing court of any “material changes” in the prisoner’s health condition; and 3) each agency representing the Commonwealth, the state or local correctional facility housing the prisoner, and any registered victim have been notified of the petition and provided with an opportunity to be heard.<sup>46</sup>

The current statute is flawed because the process is unnecessarily onerous and lengthy, the terminology is ambiguous, and the statute’s requirements are unduly restrictive. As a result, eligible prisoners often die before they are able to obtain deferment of their sentences, courts face difficulties interpreting the terms in the statute, and prisoners with severe illnesses are unable to secure placement at facilities that may be better suited to address their medical needs.

### **A. The Process Can Be Lengthy and Onerous**

#### *i. The Lack of Expedited Processing*

One reason the process for petitioning for deferment of a sentence on medical grounds can be lengthy is because the petition must be processed through the court system. Since the statute does

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<sup>43</sup> 42 Pa.C.S.A. § 9777(a)(1)-(2).

<sup>44</sup> 42 Pa.C.S.A. §9777(a)(1).

<sup>45</sup> 42 Pa.C.S.A. §9777(a)(2).

<sup>46</sup> 42 Pa.C.S.A. §9777(a)(1)-(2).

not provide for expedited processing of these petitions, the speed with which they are processed depends on whether the court that rendered the original sentence has a backlog and/or gives priority to the case. Additionally, in contrast to other jurisdictions, such as Arkansas and Washington D.C., where the correctional department must identify and notify either the board of parole or the sentencing court of potentially eligible prisoners, the Pennsylvania DOC bears no such responsibility.<sup>47</sup>

ii. *Difficulty Obtaining Required Documents*

Delays in obtaining the necessary documentation for a petition, including medical records and prison behavior records, also pose a significant barrier to the timely preparation of petitions. In order to obtain medical records from the prison, the prisoner must complete and sign a medical release authorizing the prison to provide the records to the attorney or other individual named on the form. Although this may seem like a simple task, it is quite difficult for attorneys to gain access to ill prisoners who are housed in the prison infirmary, especially if the attorney does not already have an attorney-client relationship with them.

Even when the attorney secures the necessary paperwork, prisons are sometimes slow to produce the prisoner's records. The Community Lawyering Clinic ("CLC") at Drexel's Dornsife Center for Neighborhood Partnerships experienced this issue when it tried to obtain the medical records of a prospective client. At the end of October in 2015, a relative of the prisoner contacted the CLC to request assistance in preparing a petition for deferment of the prisoner's sentence since her relative had been diagnosed with stage four cancer. Working with an official visitor of the Pennsylvania Prison Society who has increased access to prisoners at the facility, the CLC was able to obtain a signed medical release from its client and submitted the request for medical records to the prison on October 30, 2015. Unfortunately, although the CLC requested that the prison expedite its request due to the prisoner's terminal condition, the prison did not respond until November 13, 2015, five days after he passed away, on November 8, 2015, at the age of 48.

**B. The Terminology Is Ambiguous**

The terminology in the current statute makes it difficult for prisoners to know what criteria they must satisfy in order to be eligible for deferment of their sentence, especially 1) "ambulatory"; 2) "more appropriate care"; and 3) "licensed hospice care location."

i. *"Ambulatory"*

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<sup>47</sup> See AR ST § 12-29-404(b) (2013).

In order to be eligible for placement at a licensed hospice care location, a petitioner must establish that he or she is not ambulatory. Yet, the statute does not define “ambulatory.” According to Harvard’s medical dictionary, ambulatory means “able to walk; not confined to a bed.”<sup>48</sup> Despite this definition, in a recent case, the DOC took the position that a prisoner who was wheelchair bound but could walk short distances on his own, for example to the bathroom, was ambulatory, even while acknowledging that he “experience[d] shortness of breath” while doing it.<sup>49</sup> This prisoner had been diagnosed with terminal liver cancer, but was just shy of his mandatory minimum sentence so could not petition for parole. The judge ultimately granted his petition, concluding that he was not ambulatory. However, since there is no clear statutory or regulatory definition of ambulatory, judges could, within their discretion, reject a petitioner’s request on this basis. Furthermore, disputes between the parties about whether a prisoner is ambulatory could result in undue delay.

ii. “More Appropriate Care”

In order for a prisoner to be eligible for placement at a licensed hospice care location, the prisoner must demonstrate that the prospective provider can provide “more appropriate care” than the prison.<sup>50</sup> Similarly, petitioners requesting placement at a hospital or long-term care nursing facility must show by clear and convincing evidence that “[t]he medical needs of the inmate can be more appropriately addressed in the hospital or long-term care nursing facility.”<sup>51</sup>

It is unclear how a prisoner can satisfy this requirement. For example, does the prisoner need to establish that the proposed health care provider specializes in the type of treatment required or demonstrate that the prison lacks the services he needs? In the case of placement at a licensed hospice care location, since the statute already requires the petitioner to establish that “[a]ppropriate medical care and palliative and supportive services will be provided by the licensed hospice care provider at the proposed hospice care location,” this extra step is unnecessarily duplicative.<sup>52</sup>

This requirement also pits the prisoner against the DOC by forcing the prisoner to expose the deficiencies in a prison’s medical services. Instead of fostering an adversarial posture, the law

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<sup>48</sup> *Ambulatory Definition*, Harvard Medical School – Medical Dictionary of Health Terms, <http://www.health.harvard.edu/a-through-c> (last visited Apr. 22, 2016).

<sup>49</sup> Department of Corrections Response to Defendant’s Petition for Transfer for Medical Treatment and Deferment of Service of Sentence, Pursuant to 42 P.A. C.S. § 977, October 20, 2014. On file with Author.

<sup>50</sup> 42 Pa.C.S.A. §9777(a)(2)(ii).

<sup>51</sup> 42 Pa.C.S.A. §9777(a)(1)(i).

<sup>52</sup> 42 Pa.C.S.A. §9777(a)(2)(iii).

should encourage the DOC to work with terminally and seriously ill prisoners to identify outside facilities.

iii. “Licensed Hospice Care Location”

Another aspect of the statute that has raised questions is its reference to a “licensed hospice care location.” According to advocates who have assisted individuals petitioning for deferment of their sentences, courts have questioned whether the term “licensed hospice care location” refers to a medical facility only, thereby excluding in-home hospice care.<sup>53</sup> Yet the “definitions” section of the statute makes clear that hospice care can be provided in the home of a family member or friend.<sup>54</sup> This definition is also in line with general practice. According to the National Hospice and Palliative Care Organization, hospice is usually provided in a patient’s home.<sup>55</sup>

While many judges addressing motions for deferment of sentence have ultimately granted applications for placement in a prisoner’s family’s home, there is no assurance that other judges would interpret the statute similarly. The availability of home hospice care as an option for terminally ill prisoners is essential if the existing statute is to be effective, since many health care facilities are reticent to accept custody of prisoners because of the stigma associated with this population and concerns about liability. Consequently, the statute should be revised to clarify this ambiguity.

**C. The Requirements Are Unduly Restrictive**

i. Notice to Registered Victims

The current statute requires the petitioner establish by clear and convincing evidence that “any registered crime victim has been given notice and an opportunity to be heard on the petition.”<sup>56</sup> In addition, under the section entitled “Service,” which specifies who the petitioner must notify of their petition, the statute also states that the “court shall ensure that any crime victim entitled to notification under section 201(7) or (8) of the act of November 24, 1998 (P.L. 882, No.

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<sup>53</sup> Interview with Phyllis Taylor, a nurse and former prison chaplain in Pennsylvania, and Joan Porter, Official Visitor with the Pennsylvania Prison Society.

<sup>54</sup> 42 Pa.C.S.A. §9777(g).

<sup>55</sup> National Hospice and Palliative Care Organization, *The Medicare Hospice Benefit* 6 (Jan. 2015).

<sup>56</sup> 42 Pa.C.S.A. §9777(a)(1)(vii) & (a)(2)(vi).

111),<sup>1</sup> known as the Crime Victims Act, has been given notice and the opportunity to be heard on the petition.”<sup>57</sup>

However, it is unclear how the petitioner would satisfy this requirement. It would be highly inappropriate, and in some cases illegal, for the petitioner, or even the legal representative of the petitioner, to directly contact any victims of their crimes. Indeed, in an effort to protect the privacy of victims and ensure their safety, the Victims’ Basic Bill of Right provides that the contact information of victims should not be “disclosed to any person other than a law enforcement agency, corrections agency or prosecutor’s office without the prior written consent of the victim.”<sup>58</sup> The existing statute should be revised to clarify that the prosecutor’s office or the Office of the Victim Advocates is responsible for notifying the victim of the petition, and to remove any suggestion that this notification is the movant’s responsibility.

ii. The Failure to Distinguish between Seriously and Terminally Illnesses

Under the current statute, a terminally ill prisoner must be likely to die in the near future to be eligible for hospice care outside of the prison, whereas a seriously ill prisoner must be expected to die within one year to be eligible for placement at a hospital or long-term care nursing facility.<sup>59</sup> Although the statute outlines different requirements for seriously and terminally ill prisoners, this delineation is superfluous since prisoners who are expected to die within one year or in the near future are both terminal. The definition of “serious illness” devised by the Advisory Committee was much broader and included any “disease process including chronic illness that requires care and treatment over a long period of time, is usually not cured, whether due to a physical or cognitive impairment, and has progressed to the degree that the inmate meets Department of Aging [and] Area Agency on Aging criteria for nursing facility clinical eligibility.”<sup>60</sup>

The time restriction on an individual’s prognosis in the statute disqualifies chronically ill individuals from petitioning for deferment of sentence, even if that prisoner is incapacitated and unable to care for himself. A chronically ill prisoner may have the same quality of life as a prisoner who is expected to die in the near future or within one year, but would be ineligible for deferment of his sentence because his disease does not come with a prognosis of death within a particular period of time. Indeed, a prisoner may live for many years in an incapacitated state.

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<sup>57</sup> 42 Pa.C.S.A. §9777(c).

<sup>58</sup> 18 P.S. §11.211.

<sup>59</sup> See generally 42 Pa.C.S.A. §9777.

<sup>60</sup> ADVISORY COMM. REPORT, *supra* note 4, at 17.

### iii. Burdens on Outside Health Care Facilities

The requirements of the statute increase health care providers' liability and duties associated with caring for prisoners with terminal illnesses and, consequently, discourage them from doing so. For instance, the statute mandates that health care providers "notify the department and the sentencing court of any material changes in the health status of the inmate, the nature of the care provided or other information required by the department," but "material change" is not defined in the statute.<sup>61</sup> The term "material" might reasonably be construed in this context to mean "not insignificant," "affecting the prisoner's eligibility under the statute," or perhaps something else altogether. Also, since the statute does not specify that an update to the DOC is only required when there is a significant *improvement* in the prisoner's health, health care providers are required to be in contact with the DOC as the health of the prisoner deteriorates in order to comply with the statute.

The statute further requires health care providers "to ensure that each person receiving care at, and each employee or contractor working in, the hospital, long-term care nursing facility or hospice care location is notified that the placement was ordered if it is foreseeable that the person, employee or contractor will come into contact with the inmate during the placement."<sup>62</sup> Compliance with this provision is extremely difficult, if not impossible. In a hospital facility, it is difficult to predict who might come in contact with a patient. This requirement may also conflict with health care providers' ethical duties of confidentiality (or federal legal duty of medical privacy under HIPAA). Consequently, hospitals are reticent to accept seriously ill prisoners because it could expose them to additional liability for failing to notify an employee or another patient. Additionally, this rigorous level of notification may not be necessary when a prisoner has not been convicted of a violent crime or is permanently incapacitated.

### iv. Electronic Monitoring

The statute includes language requiring seriously ill prisoners placed at a hospital or long-term nursing facility to be "under electronic monitoring by the department."<sup>63</sup> On the other hand, the statute provides that a terminally ill prisoner placed at a hospice care location be "*subject to* electronic monitoring by the department."<sup>64</sup>

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<sup>61</sup> 42 Pa.C.S.A. §9777(a)(1)(vi) & 42 Pa.C.S.A. §9777(a)(2)(vi).

<sup>62</sup> 42 Pa.C.S.A. §9777(d)(1).

<sup>63</sup> 42 Pa.C.S.A. §9777(a)(1).

<sup>64</sup> 42 Pa.C.S.A. §9777(a)(2).

The meaning of this language was at issue in a case involving a terminally ill Vietnam veteran with cancer, who also suffered from alcoholism (related to his service-connected PTSD), and had received a mandatory prison sentence on account of several DUIs. When he petitioned for sentence deferment, he was so sick that he could not walk beyond a couple of steps (and only with a lot of effort). Since he satisfied all elements of the statute, the court granted his petition for deferment of his sentence. However, the court delayed his placement in hospice care for several days until electronic monitoring could be secured, because the court agreed with the DOC's argument that the statute required such monitoring. This decision was contrary to the common meaning of "subject to" and rules of statutory construction, which imply that the court had discretion regarding whether to require electronic monitoring.<sup>65</sup>

In addition, as a practical matter, in cases like this one, where the prisoner does not pose a risk to public safety or any risk of escape due to their diminished physical condition, electronic monitoring is an unnecessary extra step and expense for the state. In addition, the potential delay under these circumstances could have fatal consequences. Instead of a blanket rule, courts should have discretion to tailor the conditions of release or parole to the circumstances of the case. When there are grounds to be concerned about the threat to public safety, such as a criminal history involving a violent crime, the court can take additional security measures on a case by case basis that take into account these individualized concerns.

## V. Best Practices from Other States

Like Pennsylvania, other states across the country are also struggling to address the rising cost of caring for geriatric and seriously ill prisoners and many have adopted a range of programs that could serve as models for Pennsylvania.<sup>66</sup> In total, forty-six states, Washington D.C., and the

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<sup>65</sup> Merriam-Webster Dictionary defines "subject to" as is "affected by or *possibly* affected by." See <http://www.merriam-webster.com/dictionary/subject%20to>. (emphasis added). 1 Pa. Stat. and Cons. Stat. Ann. § 1921. In addition, the rules of statutory construction mandate that courts assume that when the legislature uses different words in two places in a statute addressing related subjects, that it intends different meanings for each differently-worded provision. *See, e.g., Com. v. McCoy*, 962 A.2d 1160, 599 Pa. 599, Sup.2009 (providing that all sections of a statute must be read in conjunction with each other, construing them with reference to the entire statute).

<sup>66</sup> *See generally* TINA MASCHI, ET AL., ANALYSIS OF UNITED STATES COMPASSIONATE AND GERIATRIC RELEASE LAWS: TOWARDS A RIGHTS-BASED RESPONSE FOR DIVERSE ELDERLY AND THEIR FAMILIES AND COMMUNITIES (May 9, 2015) [hereinafter COMPASSIONATE AND GERIATRIC RELEASE LAWS], available at <http://www.realcostofprisons.org/materials/analysis-of-us-compassionate-release-laws.pdf>.

federal government have adopted some form of release or parole for terminally and chronically ill prisoners.<sup>67</sup>

Many jurisdictions have the option to release terminally ill prisoners.<sup>68</sup> Seventeen states provide that a terminally ill prisoner must have a certain life expectancy, usually between six months and one year, to be eligible for release; nineteen states do not.<sup>69</sup> Fifteen states and Washington D.C. have also created geriatric release provisions, aimed at the release of elderly prisoners ranging from forty-five to sixty-five years old.<sup>70</sup> Most states require that these prisoners be unable to care for themselves and not pose a risk to public safety.<sup>71</sup>

Eighteen states instituted medical parole, either in lieu of or in addition to medical or geriatric release.<sup>72</sup> In contrast to medical or geriatric release, which are options typically only available to terminally ill prisoners, medical parole is also available to prisoners who are medically incapacitated and/or have a medical condition that renders them unable to perform activities of basic daily living.<sup>73</sup> Because the board of parole, instead of the sentencing court, oversees the process, there is increased supervision of the prisoner and it is easier to recommit the prisoner if his or her medical condition improves. When a prisoner is chronically ill, as opposed to terminally ill, more oversight is necessary because the likelihood that his or her medical condition will improve is much greater.

California, which has both medical parole and medical release, could be a model for Pennsylvania. In California, medical parole is limited to prisoners who are “permanently medically incapacitated with a medical condition that renders him or her permanently unable to perform

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<sup>67</sup> *Id.* at 8.

<sup>68</sup> *Id.* at 10.

<sup>69</sup> *Id.* at 10-11.

<sup>70</sup> TINA CHIU, VERA INSTITUTE OF JUSTICE, IT’S ABOUT TIME, AGING PRISONERS, INCREASING COSTS, AND GERIATRIC RELEASE, at page 7, available at <http://www.vera.org/sites/default/files/resources/downloads/Its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf>.

<sup>71</sup> *Id.*

<sup>72</sup> See AR ST § 12-29-404 (2013); CA PENAL § 3550 (2014); CT ST § 54-131b et seq. (2012); DC CODE § 24-464 (2014); KY ST § 439.3405 (2011); LA R.S. 15:574.20 (2011); MD CORR SERV § 7-309 (2010); MT ST 46-23-210 (2014); Neb.Rev.St. 83-1,110.02 (2006); NH ST § 651-A:10-a (2004); NJ ST 30:4-123.51c (2013); NM ST § 31-21-25.1(1978); NY EXEC § 259-r (2006); N.C.G.S.A. 15A-1369.2 et seq. (2008); OK ST T. 57 § 332.18; RI ST § 13-8.1-2 (2011); TX GOVT § 508.146 (2015); VT ST T. 28 § 502a; WY ST § 7-13-424 (2012).

<sup>73</sup> See, e.g., CA PENAL § 3550 (2014). See also MD CORR SERV § 7-309 (2010) (“An inmate who is so debilitated or incapacitated by a medical or mental health condition, disease, or syndrome as to be physically incapable of presenting a danger to society.”); AR ST § 12-29-404 (2013) (“permanently incapacitated means . . . [h]as a medical condition that is not necessarily terminal but renders him or her permanently or irreversibly incapacitated; and requires immediate and long-term care”); LA R.S. 15:574.20 (2011) (“permanently disabled inmate means any person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical impairment which can be expected to result in death or which can be expected to be permanently irreversible”).

activities of basic daily living and results in the inmate requiring twenty-four-hour care,” while medical release is available to prisoners with a terminal illness who have six months or less to live.<sup>74</sup> In 2014, a federal court required California to expand its medical parole program in an effort to address prison overcrowding and reduce costs.<sup>75</sup> As part of this expansion, prison medical staff are now required to identify prisoners who may be eligible for medical parole and, if appropriate, refer them to California’s parole board, sending a post-release plan for the prisoner’s residency and medical care along with the referral.<sup>76</sup> As part of the parole board’s review, it must determine whether the proposed measures are enough to ensure that the prisoner’s placement at the medical facility will not pose an unreasonable risk to public safety.<sup>77</sup> When the board approves parole, California’s DOC is responsible for identifying a skilled nursing facility that meets the specified terms of parole within 120 days.<sup>78</sup> California’s DOC considers the medical parole program to be a great success.<sup>79</sup> Within the first six months of the program, California released twelve prisoners, nearly the same amount that Pennsylvania transferred from DOC custody for medical reasons in the last seven years.<sup>80</sup>

In addition to medical parole, California also has a medical release law, which permits the original sentencing court to reduce the sentence of an individual who is terminally ill and whose release does not pose a threat to public safety.<sup>81</sup> In stark contrast to Pennsylvania’s law, California’s law includes strict expedited processing rules. Once an eligible candidate is identified, the prison is required to submit the requisite paperwork recommending release to the sentencing court within 30 days.<sup>82</sup> Then, the sentencing court must hold a hearing within ten days of receiving this recommendation, and if the request is granted, the prisoner must be released within forty-eight hours.<sup>83</sup>

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<sup>74</sup> For California’s medical parole law, *see* Ca. Penal Code § 3550 (a) & 15 CCR § 3359.1(a)(1). For its compassionate release law, *see* Penal Code § 1170(e)(1) and (2); 15 CCR § 3076(b).

<sup>75</sup> Prison Law Office, *Medical Parole and Compassionate Release* (May 2015), at page 2, available at <http://prisonlaw.com/wp-content/uploads/2015/09/MedParoleCompReleaseMay2015.pdf>.

<sup>76</sup> Cal. Penal Code § 3550(c) & (e)

<sup>77</sup> Ca.. Penal Code § 3550(g).

<sup>78</sup> BOARD OF PAROLE HEARINGS, STATE OF CALIFORNIA, MEMORANDUM ON EXPANDED MEDICAL PAROLE (June 16, 2014), available at [http://www.cdcr.ca.gov/BOPH/docs/Policy/Expanded\\_Medical\\_Parole\\_Overview.pdf](http://www.cdcr.ca.gov/BOPH/docs/Policy/Expanded_Medical_Parole_Overview.pdf).

<sup>79</sup> REPORT OF 2014 ANNUAL ACCOMPLISHMENTS, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, available at <http://www.cdcr.ca.gov/Reports/docs/2014-AnnualAccomplishments-FINAL-webversion.pdf>.

<sup>80</sup> *Id.*

<sup>81</sup> Cal. Penal Code § 1170(e) (as amended by Section 1 of Chapter 378 of the Statutes of 2015).

<sup>82</sup> Cal. Penal Code § 1170(e)(6)

<sup>83</sup> Cal. Penal Code § 1170(e)(3) & (9) (as amended by Section 1 of Chapter 378 of the Statutes of 2015).

## **VI. Recommendations for Reform**

### *To the General Assembly:*

- Pennsylvania should reform the existing statute to:
  1. require that the courts provide expedited processing of petitions for medical deferment of sentence;
  2. remove or define ambiguous terms from the statute, including “ambulatory,” “more appropriate care,” and “licensed hospice care location;”
  3. remove blanket security measures, such as electronic monitoring, and mandate individualized release plans that take into account the specific risk to public safety, if any, posed by a prisoner’s release;
  4. remove overly burdensome requirements from the statute, such as the unnecessarily broad reporting and notification requirements on receiving health care facilities and providers, as well as the inappropriate requirement that the prisoner notify the victim of their petition; and
  5. consolidate the statute to allow for release of prisoners with terminal illness to hospice or hospital nursing care facilities, as opposed to having separate requirements for seriously and terminally ill prisoners.
- Pennsylvania should introduce a medical parole bill that provides a parole option to prisoners who suffer from chronic, debilitating diseases and do not pose a risk to public safety.

### *To the Department of Corrections:*

- The DOC should issue an interpretive memorandum with the goal of:
  1. providing expedited release of medical and behavioral records to terminally ill prisoners applying for deferment of their sentences;
  2. clarifying the various ambiguous terms in the statute, including “ambulatory,” “licensed hospice care location,” and “more appropriate care”
  3. specifying that courts have discretion over whether to require electronic monitoring for non-ambulatory prisoners that do not pose a risk to public safety; and
  4. educating its staff about the steps that a prisoner must take in order to submit a petition for deferment of their sentence on medical grounds.
- The DOC should take steps to identify terminally ill prisoners who may be eligible for medical transfer from its custody when they first become ill and educate them about how to file their petition, so that the prisoner may begin the process early on.