ALTERNATIVES TO INCARCERATION

FOR INDIVIDUALS WHO ARE **ADVANCED IN AGE, DISABLED, OR HAVE SIGNIFICANT MEDICAL NEEDS**

Senate Bill 108, Provision 10 of Item 5222-002-0001, Budget Act of 2024, Chapter 35, Statutes of 2024

March 2026

All images used in this report depict incarcerated individuals in CDCR prisons and are used with their consent.

Background

Senate Bill 108 (SB 108), Chapter 35, Statutes of 2024, directs the California Department of Corrections and Rehabilitation (CDCR) to submit a report to the Joint Legislative Budget Committee by March 1, 2026, outlining "alternatives to incarceration for individuals who are advanced in age, disabled, or have significant medical needs." These incarcerated individuals will be referred to herein as the "focus population."

As of December 2025, there were approximately 90,000 incarcerated individuals housed in CDCR institutions statewide. While the overall prison population is projected to decline over the next five years, the proportion of incarcerated individuals in the focus population is expected to rise, as is the cost of housing and care for this group.

Since 2010, the share of incarcerated individuals aged 55 and older has grown from 7 percent to 21 percent, with a significant portion serving life terms. Aging adults in prison have more complex medical needs than those in the community and typically experience age-related decline in both mental and physical health about a decade earlier. Factors contributing to their increased and premature health care needs include the social determinants of health that also increase the risk of incarceration, including poverty, trauma, high rates of chronic disease, and limited access to care before incarceration. In addition to the increasing population of older individuals in CDCR, health care for this population is more costly than care in the community and poses unique challenges because correctional structures complicate age-appropriate medical care practices. Additionally, CDCR's health care costs, like health care in community settings, increase each year. CDCR's health care costs have increased an average of 4 percent per year over the past 9 years. For Fiscal Year 2026-27, the proposed state budget estimates the average per capita cost of incarceration to be $138,000 per individual.

Health care expenses, including medical, mental health, and dental care; pharmaceuticals; and off-site guarding and transportation account for roughly $57,000 per incarcerated individual, or about 40 percent of the total CDCR per capita cost.

This estimated average cost, however, masks a significant age-related cost disparity among CDCR's population that is driven by medical care costs for the focus population, and in particular older individuals. During 2024, for example, individuals 60 years of age and older in CDCR adult institutions represented 14% of the population yet accounted for an estimated 27% of health system expenses. Figure 1 illustrates that health care-related costs, which are more expensive in the custodial than the community setting, are driven by CDCR's older incarcerated population.

Figure 1: 2024 Estimated Average Annual Health Care Costs
per Person by Age Group

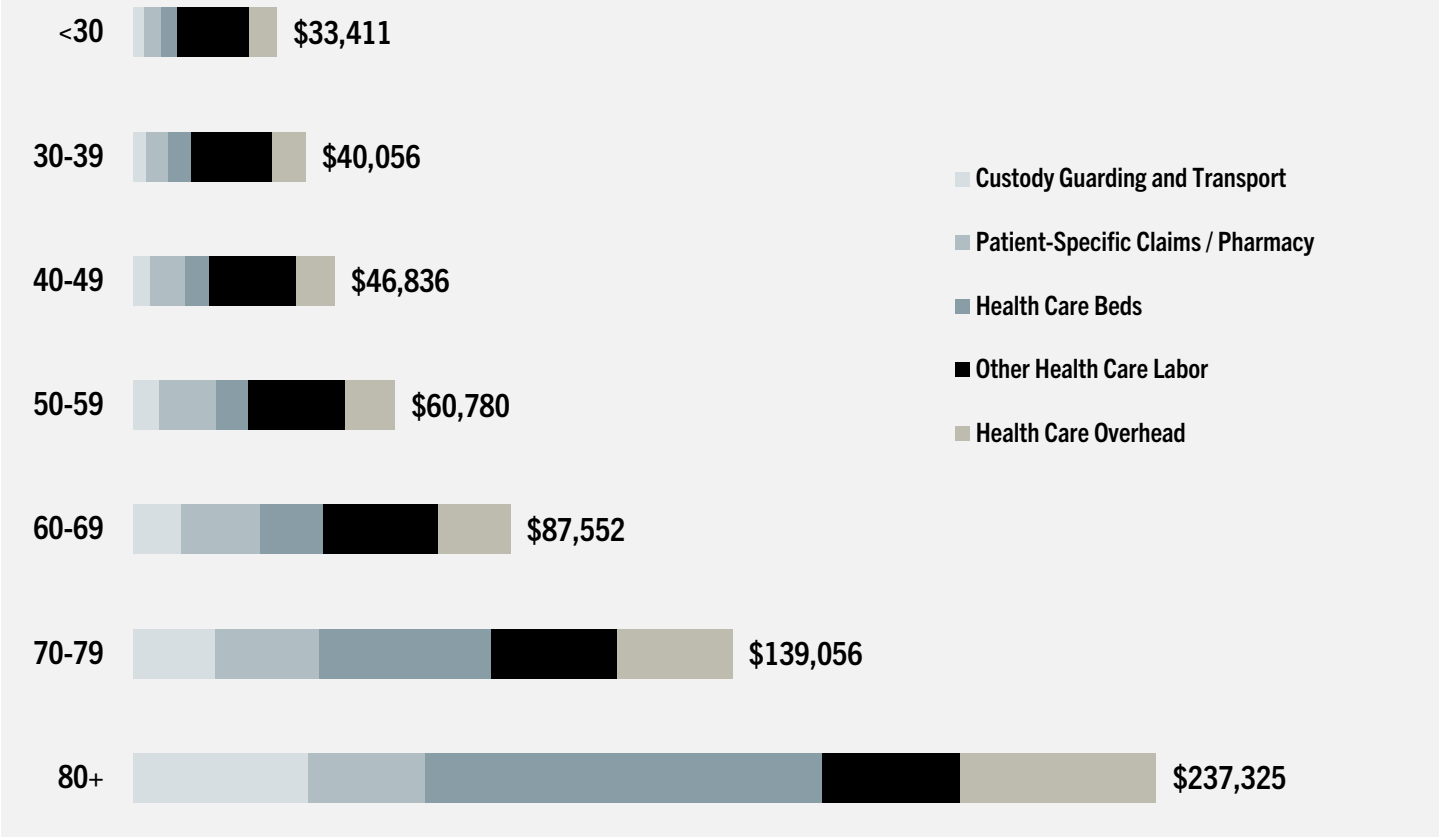
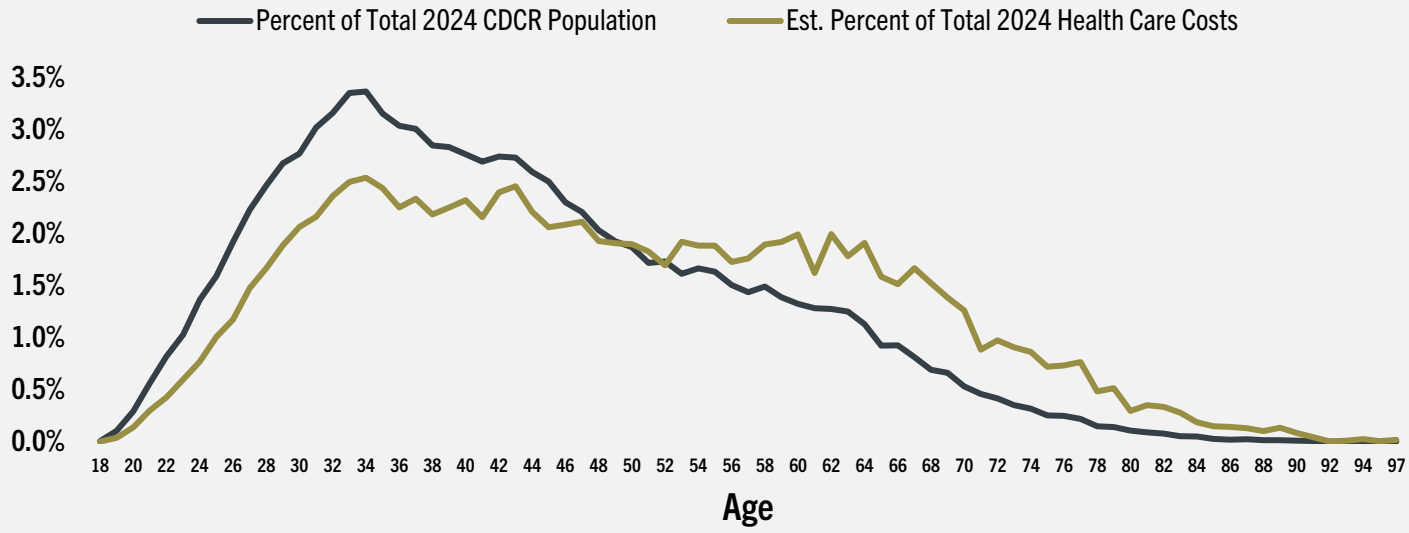


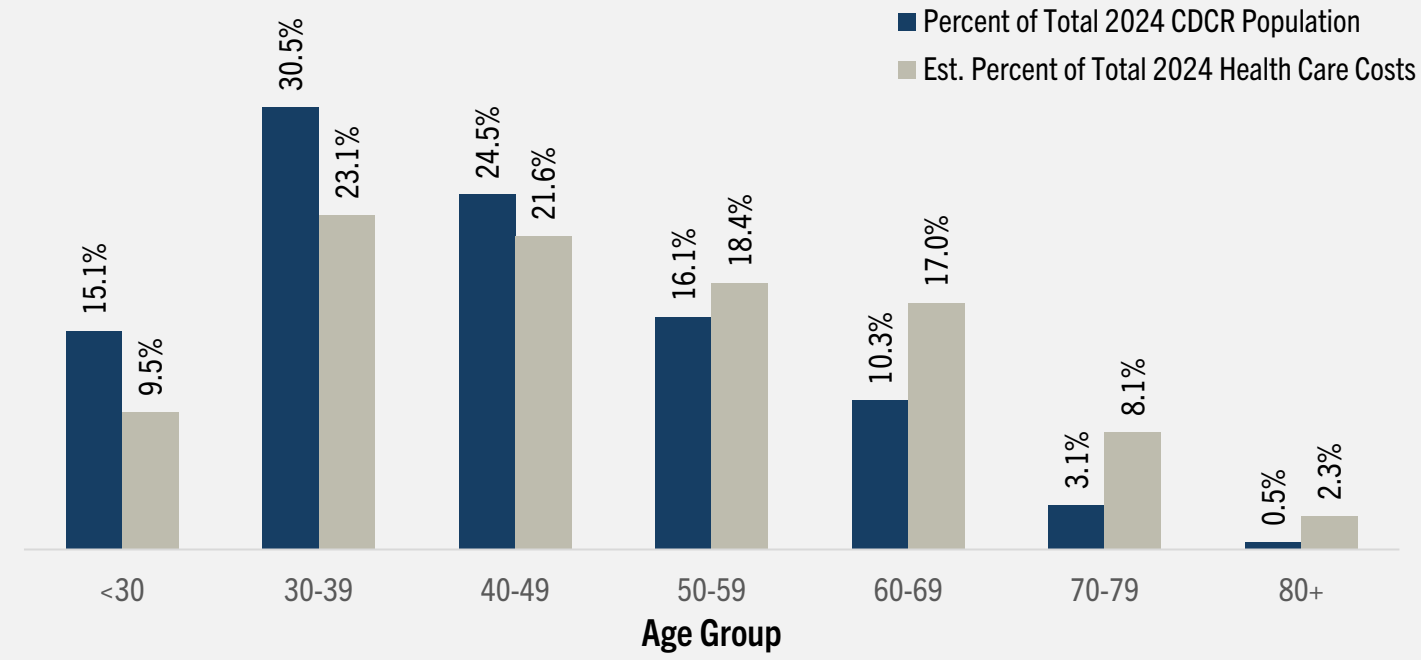
Figure 2 below illustrates that CDCR spends an outsized portion of its health care costs on older adults who represent a smaller percentage of CDCR's overall population. Incarcerated individuals aged 50 and older make up a smaller percentage of CDCR's overall population, yet their proportional health care costs are higher.

Figure 2: Estimated Percentage of Total 2024 CDCR Population and Health Care Costs by Age



This can be seen even more starkly when grouping CDCR's population by 10-year age bands, as shown on Figure 3:

Figure 3: Estimated Percentage of Total 2024 CDCR Population and Health Care Costs by Age Group



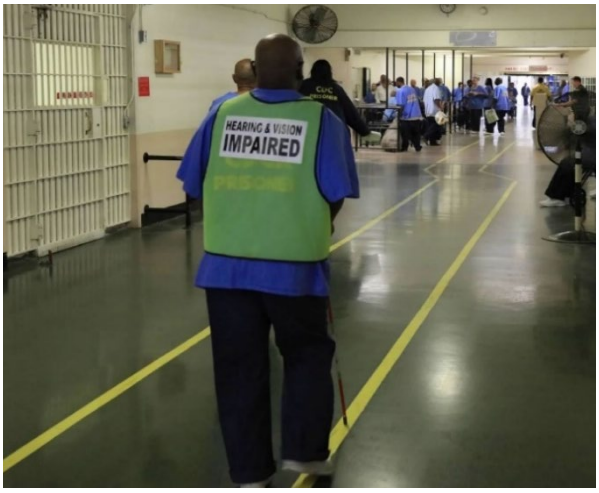
Defining the Focus Population

This report addresses the focus population of 9,283 incarcerated older individuals in CDCR who meet the following criteria:

ADVANCED AGE	*All patients aged 65 or older.*
LIVING WITH A DISABILITY	*Patients with a physical or developmental disability, including those who meet the criteria for the Disability Placement Program or Developmental Disability Program, or who are deemed unable to work as a result of their disability.*
SIGNIFICANT MEDICAL NEEDS	*Patients aged 55 or older with at least two high-risk medical factors. These factors include:* • *Diagnosis with a high-risk condition (e.g., end-stage cancer, cirrhosis, or on dialysis);* • *Diagnosis with multiple medium risk conditions (e.g., hypertension, diabetes, heart disease, or kidney disease);* • *Having a prolonged CDCR specialized medical bed stay (90 of the last 180 days);* • *Prescription for 13 or more medications;* • *Having three or more high-risk specialty appointments (e.g., oncology or neurosurgery); or* • *Having multiple hospital visits over the last year.*

Of the 9,283 incarcerated individuals identified in the focus population for this report:

- **Advanced Age:** 77 percent are aged 65 years or older.
- **Medical Complexity:** 73 percent have 4 or more chronic conditions. 10 percent have 10 or more co-existing medical conditions.
- **Mental Health:** 45 percent have a diagnosed mental illness. About two-thirds of these patients are at CDCR's Correctional Clinical Case Management (CCCMS) level for patients with mild to moderate mental illness that typically can be managed in a primary care setting, while one-third are in CDCR's Enhanced Outpatient Programs (EOP), requiring more specialized behavioral health resources and support. Less than 100 require 24/7 inpatient psychiatric care.



- **Disabilities:** 62 percent have one or more documented physical disabilities; 45 percent have a documented mobility impairment; and 18 percent use wheelchairs.
- **Specialized Health Care:** About 10 percent reside in Specialized Medical Bed (SMB) settings, which provide assistance with activities of daily living (ADLs) or skilled nursing care. The SMBs include skilled nursing facilities, memory care units, assisted living (e.g., Outpatient Housing Units), inpatient mental health care, and hospice. Some of these services can be provided in a home setting or assisted living facility, when individuals are released into the community.

Commitment Offenses, Sentence Types, and Incarceration Trends

Courts impose sentences that determine if an incarcerated individual will become eligible for a parole hearing and when, the type of post-release supervision they will have, and their eligibility for specified release and placement programs, including compassionate release, elderly parole, and community reentry programs.

Of the 9,283 incarcerated individuals identified in this report:

- 86 percent have committed offenses that qualify as a violent offense pursuant to Penal Code Section 667.5.
- 46 percent have sex offense convictions that require registration pursuant to Penal Code Section 290.
- 40 percent have served a prior incarceration period before their current commitment.
- 3 percent are serving a sentence for an offense that does not meet the criteria for any of the following: violent offenses, as defined under Penal Code Section 667.5; serious offenses, as defined in Penal Code Section 1192.7; or sexual offenses that require registration under Penal Code Section 290.

- 28 percent, or 2,612, are serving determinate terms.[1]
- 60 percent, or 5,531, are serving indeterminate sentences, and most of these have served 20 years or more in their sentence.[2]
- 10 percent, or 953, are serving sentences of life without the possibility of parole. Of these, 6 committed their commitment offenses when they were under the age of 18 and are entitled to a parole hearing after they have served 25 years.
- 2 percent, or 197, are sentenced to death and are not eligible for parole.

Health Care Factors and Release Factors

Figure 4 details the composition of the focus population, based on two primary categories: health care factors (including medical risk level, specialized care needs, and ability to work, with Row 1 having the highest health risk level) and release factors (including age, sentence, and time served, with Column A having more potential release pathways). This chart represents the expected relative ease or difficulty incarcerated individuals in the focus population will face when attempting to access care in the community, based on existing laws and policies that determine eligibility. For example, the 413 incarcerated individuals in Row 1 and Column A are unable to work, are in a specialized health care bed, have served at least 20 years, are at least 65 years old, and are not sentenced to death or life without the possibility of parole.

[1] They were sentenced to serve a fixed period of time (for example, a term of five years) and after completing that term, are automatically released without a parole hearing. However, the law makes some incarcerated individuals with lengthy determinate sentences eligible for a parole hearing before they have served their full sentence. In those cases, they remain in prison for their full term unless they receive a parole grant. If they are found suitable for parole, they will be released before the end of their determinate sentence.

[2] They were sentenced to life with the possibility of parole (for example, a term of 25 years to life). They are commonly referred to as life-term offenders or "lifers." They will not be released until they serve the minimum term set by law, and the Board of Parole Hearings finds that they do not currently pose an unreasonable risk to public safety and grants them parole.

Figure 4:

9,283 PATIENTS in the focus population	**RELEASE FACTORS**			
	A	B	C	
HEALTHCARE FACTORS	**All of the following:** • At least 20 years served • At least 65 years old • Not LWOP / condemned	**Any of the following:** • Less than 20 years served • Less than 65 years old • Not LWOP / condemned	**Any of the following:** • LWOP • Condemned	**TOTALS**
1 Any of the following: • Unable to work • Currently in specialized health care bed	**413** (4.4%)	**763** (8.2%)	**199** (2.1%)	1,375 (14.8%)
2 Two or more high-risk factors and none of the following: • Unable to work • Currently in specialized health care bed	**1,321** (14.2%)	**2,909** (31.3%)	**582** (6.3%)	4,812 (51.8%)
3 None of the following: • Two or more high-risk factors • Unable to work • Currently in specialized health care bed	**1,115** (12.0%)	**1,628** (17.5%)	**353** (3.8%)	3,096 (33.4%)
TOTALS	2,849 (30.7%)	5,300 (57.1%)	1,134 (12.2%)	**9,283**

Box A1 includes incarcerated individuals who are significantly physically impaired but many of whom are unlikely to meet current criteria for compassionate release or medical parole, which requires permanent incapacitation or terminal illness with an end-of-life trajectory of one year or less. Their release options are limited to the parole board process once they become eligible, resentencing by the court in their county of conviction, or clemency from the Governor.

- 14.8 percent of this population (first row: boxes A1, B1, and C1) have the highest medical health care needs. They are unable to work or are in specialized medical beds.
- 51.8 percent (second row: boxes A2, B2, and C2) have at least two high-risk medical factors, but they are not unable to work, nor do they currently require specialized health care beds.
- 33.4 percent (third row: boxes A3, B3, and C3) have the lowest medical health care needs and at this time require no specialized health care bed.

The more than 1,000 incarcerated individuals (third column: boxes C1, C2, and C3) serving death sentences or life without the possibility of parole, regardless of health status and release options for this subset of the focus population, are currently limited to resentencing by the court in their county of conviction, or clemency from the Governor.

Cost Model Assumptions and Total Annual Cost of Care for Focus Population

CDCR's cost model for estimating patient-specific expenses for the focus population is based on the following:

Patient Specific Costs:

Expenses calculated for the focus population include pharmacy and third-party health care claims for off-site services, such as specialist visits, diagnostics, and hospitalizations.

For reference, these total patient-specific costs for the entire CDCR population in Fiscal Year 2024-25 were approximately $900 million.

Excluded Costs:

Not included for the focus population are health care-related fixed labor, overhead, guarding, and transportation costs.

For context, total health care labor, overhead, guarding, and transportation costs for the entire CDCR population during Fiscal Year 2024-25 were about $5 billion, or $4.1 billion excluding patient-specific costs.

For Fiscal Year 2024-25, estimated annual patient-specific costs (i.e., third party medical claims and pharmaceuticals) for the 9,238 incarcerated individuals in the focus population were approximately $200 million. Compared to approximately $900 million in annual patient-specific costs for the average population of approximately 90,000 during the period, this suggests that **while the focus population is only 10 percent of CDCR prison census, they represent over 20 percent of total patient-specific costs.**

The average estimated patient-specific cost per individual in the focus population excluding custody costs is more than $20,000 annually; it is $8,000 per individual for the rest of the CDCR population. Notably, estimated costs per individual in the focus group who are unable to work or

who are in a specialized health care bed (boxes A1, B1, and C1 in Figure 4) are more than five times higher than the medical costs for individuals who are able to work and are not in a specialized health care bed (boxes A3, B3, and C3 in Figure 4). This further underscores the concentration of resource utilization among the focus population, a relatively small proportion of this population.

These cost assumptions have several limitations:

- **No Future Predictions:** Findings are based on point-in-time data and do not project future health care needs or health care cost trends. Notably, however, CDCR health care costs per incarcerated individual have never decreased and have nearly doubled over the past decade.
- **State Prison Focus:** The report covers only incarcerated individuals who meet the specified criteria currently housed in CDCR institutions and excludes those in county jails who will transfer to CDCR custody.
- **Cost Assumptions:** Patient-specific costs exclude fixed staffing and overhead expenses, which are not tied to individual patients. However, significant reductions in these other non-patient-specific fixed costs could occur if large numbers of incarcerated individuals from the focus population are released.

Stakeholder Engagement

SB 108 directed CDCR to collaborate with other state agencies, community-based service providers, and other stakeholders to draft this report. To ensure comprehensive stakeholder input, CDCR surveyed external stakeholders, including state and county agencies, community providers, and contracted reentry organizations. The survey aimed to identify available community resources and post-release placement options for the focus population, challenges for serving and reintegrating this population post-release, and recommended solutions.

The majority of survey respondents are nonprofit and for-profit community service providers. Respondents also included state and local government agency staff, advocacy groups, and philanthropic organizations.

Nearly all respondents reported serving formerly incarcerated individuals with significant medical needs. More than half indicated they are more likely to accept formerly incarcerated individuals when they are already enrolled in Medi-Cal, and nearly 70 percent said they can assist with Medi-Cal enrollment. The most common services offered among respondents included long-term care, assisted living, facilities for aged or disabled individuals, case management, care referrals, hospice, substance use disorder treatment, and inpatient medical treatment.

Building on these results, CDCR hosted an in-person stakeholder meeting with providers to further explore opportunities and challenges related to transitioning this population from custody to community care.

Reentry Challenges for Those with Complex Health Care Needs

People released from California prisons face numerous and significant reentry challenges, including securing stable housing, achieving financial stability, overcoming stigma, and rebuilding family and community relationships. For many in the focus population, these challenges are significantly more difficult. Their support needs are greater, but they lack community support networks, which often are lost after decades in prison. Many have cognitive decline, and many lack the technology skills and tools needed to access care, employment, benefits, and housing. Without access to appropriate community resources or coordinated transition processes, they risk serious disruptions in physical and mental health care. There are community constraints on capacity and resources that may affect available support and placement options. Common issues include delays in accessing health providers, interruptions

Patient Stories: Patient A

Patient A, 79, has advanced dementia and is bedridden in a specialized medical bed. The patient no longer recognizes caregivers, is disoriented, and requires full assistance for daily activities, including showering, getting dressed, and transfer from bed to wheelchair. Although the patient meets Penal Code criteria for compassionate release due to permanent medical incapacitation, the judge denied the request because the patient does not have a post-release plan.

Despite extensive placement efforts by the department, no facility has been willing to accept the patient due to the commitment of a violent offense 28 years ago. The family continues to hope for the patient's release and requests lifesaving care, resulting in multiple hospitalizations for the patient for infection treatment.

in medication or treatment due to lost prescriptions or records, and difficulties navigating health systems. Post-release housing options are limited for the focus population due to their criminal history and lack of funding for medically appropriate settings. Specialized transitional housing for the focus population could serve as a bridge to permanent housing. However, these residential community alternatives would require additional funding or contract waivers to support additional staffing and facility upgrades required for the focus population.

The Legislature could consider opportunities to address community-based challenges for placement of incarcerated individuals subject to sex offense registration with long-term health care needs as well as increased transitional housing for the focus population as a bridge to permanent community housing.

Existing Release Programs for the Focus Population

Over the years, the Legislature has enacted some laws that address some of the challenges CDCR faces in caring for an aging prison population.

Elderly Parole

On February 10, 2014, a Three-Judge Panel in the *Plata v. Newsom* and *Coleman v. Newsom* class action lawsuits ordered CDCR to "finalize and implement a new parole process whereby inmates who are 60 years of age or older and have served a minimum of twenty-five years of their sentence will be referred to the Board of Parole Hearings (BPH) to determine suitability for parole." In response, the State implemented the Elderly Parole Program. In 2018, the California Legislature enacted Assembly Bill 1448 (Weber), Chapter 676, Statutes of 2017, which codified into law the Elderly Parole Program by adding Penal Code Section 3055.

On January 1, 2021, AB 3234 (Ting), Chapter 334, Statutes of 2020, modified Penal Code Section 3055 to

lower the age of qualification for the statutory Elderly Parole Program to individuals 50 years or older and who have served 20 years or more of continuous incarceration. (Pen. Code, 3055, subd. (a).) There are exclusions to these criteria, and incarcerated individuals disqualified under the statutory Elderly Parole Program are entitled to elderly parole consideration under the Elderly Parole Program established by the Three-Judge Panel (60 years old and 25 years of continuous incarceration). BPH (or the Board) implemented regulations for conducting elderly parole hearings. These regulations can be found in California Code of Regulations, Title 15, Sections 2449.40 through 2449.43.

Once someone becomes eligible for an elderly parole hearing, the Board conducts a standard parole suitability hearing for the subject at which they give special consideration[3] to whether specified elderly parole factors have reduced the incarcerated individual's risk of future violence. Incarcerated individuals released through elderly parole have a re-conviction rate of 1.8 percent, which is consistent with the longstanding trend of low recidivism rates among older age groups and incarcerated individuals released after a parole hearing.[4] State regulations[5] require the Board to consider the following elderly parole factors when assessing current risk:

1. Cognitive decline and its impact on an elderly incarcerated individual's ability to process information, convert thought to action, learn, plan, recall, organize, reorganize information, control impulses, execute a task, incorporate feedback, change a strategy, sustain complex attention, or emotionally regulate.
2. Physiological changes that decrease the person's motivation to commit crimes or be violent.
3. Time served in custody and evidence of reduced criminal propensity, change of attitudes and beliefs over time, evidence of prosocial routines, social conformity, and detachment from crime-producing environments and peers.
4. Diminished physical condition, disability, and/or chronic or terminal illness impacting the person's physical ability to commit crimes.

[3] Pen. Code, § 3055, subd. (c); Cal. Code Regs., tit. 15, § 2449.42, subd. (c)

[4] Recidivism Rates for Individuals Released Through Board of Parole Hearings Processes in Fiscal Year 2019-20 at page 6.

[5] 194 Cal. Code Regs., Tit. 15, § 2446, subd. (c). 195 Pen. Code, § 3055, subd. (c); Cal. Code Regs., tit. 15, § 2449.42, subd. (c). 196 Pen. Code, § 3055, subd. (c); Cal. Code Regs., tit. 15, § 2449.43. 197 Cal. Code Regs., tit. 15, § 2449.43, subd. (a).

Patient Stories: Patient B

Patient B, 82, has diabetes with visual impairment, a left below-knee amputation, and end-stage renal disease requiring thrice-weekly dialysis. Mostly independent in daily activities, the patient is often weak, however, due to kidney failure and dialysis, with frequent low blood pressure episodes that increase fall risk. The patient requires assistance in using a wheelchair while outside their housing unit. The patient requires an assisted living environment and does have a spouse and nurse daughter willing to provide support, but the patient does not meet current compassionate release criteria, which require an advanced illness with an end of life trajectory (he is stable on dialysis) or permanent incapacitation (he is able to complete activities of daily living independently).

Compassionate Release

Compassionate Release law requires CDCR to refer incarcerated individuals who meet specified medical criteria to courts for a hearing where a judge determines if the person poses an unreasonable risk to public safety. Specifically, medical staff must refer incarcerated individuals who are either suffering a serious and advanced illness with an end-of-life trajectory or are permanently medically incapacitated with a medical condition or functional impairment that leaves them permanently unable to perform activities of daily living (Pen. Code Section 1172.2). Incarcerated individuals sentenced to life without parole or death or who are serving sentences for specified crimes are ineligible for Compassionate Release. Common barriers to compassionate release include finding viable housing as part of the patient's release plan and the requirement for some incarcerated individuals to wear a GPS monitor. The Legislature could explore opportunities to increase reimbursement or create incentives for long-term care facilities to accept justice-involved patients.

Medical Parole

Medical parole was established in 2011 by Penal Code Section 3550 and was later expanded in 2014 under an order from a Three-Judge Panel in the *Plata* and *Coleman* class action cases. The medical parole hearing process is commonly referred to as Expanded Medical Parole, although it is entirely distinct from the Board's parole suitability hearing process.

A medical parole hearing determines if an incarcerated individual who is permanently medically incapacitated should be placed in a licensed health care facility in the community, and eligibility criteria are broader than the Compassionate Release program. Individuals suffering a serious and advanced illness with an end-of-life trajectory may be eligible for both Compassionate Release and Medical Parole programs. CDCR and California Correctional Health Care Services determine

who is referred to BPH for an Expanded Medical Parole hearing.

Medical parole shall be granted if the BPH determines the conditions under which the incarcerated individual would be placed would not reasonably pose a threat to public safety.

There have been challenges with medical parole. The individual who is granted medical parole is not a parolee and is still considered an incarcerated individual; therefore, when placed in the community, no federal funds can be recovered for their care and the State and its general fund are required to pay the costs. There are conditions placed on the individual that are usually in direct contradiction to the licensed facility's patient's bill of rights, including inability to freely leave the facility or use the internet/computer systems. Such conflicts have made it impossible for licensed care facilities to accept these individuals as it puts the facility license at risk. The expanded medical parole program was suspended as CDCR/CCHCS had available beds and the ability to care for the patients and did not have to pay an outside provider for their care.

The Legislature could consider revising the medical parole statute to address barriers to placement and acceptance at facilities, if placement in a licensed facility is necessary, or if there are other viable placement options. Additionally, if referrals for medical parole increase, BPH would need additional resources for parole hearings.

Currently, when an incarcerated individual becomes ineligible for medical parole, they are returned to state prison. In order to draw down federal funds for the individual, they must be considered a parolee. If the statute is amended so that the individual is deemed to be a parolee, then revocation of parole would not automatically result in a return to state prison. In most cases, a revocation results in confinement in a county jail pursuant to realignment, unless new criminal charges are filed or other statutory circumstances require a return to

Patient Stories: Patient C

Patient C, 67, has mild cognitive impairment, diabetes, renal failure, congestive heart failure, and Parkinson's disease. After a hip fracture from a fall, the patient became unable to walk. Although eligible for parole, the lack of a supportive post-release plan and community placement options keeps the patient in CDCR custody and in a specialized medical bed. A second fall one month after the patient's parole hearing resulted in another fracture, leading to multiple surgeries, prolonged hospitalizations, long-term antibiotics, and rehabilitation for the patient.

state custody. If revocation is warranted, questions arise regarding the appropriate placement authority and custody setting. Also, if the individual is treated as a parolee rather than an incarcerated individual, they may be entitled to the due process protections and liberty interests afforded to parolees under established case law. If the Legislature desires these individuals to ultimately be parolees, they may want to consider where revocation placement would occur (state prison or county jail), under what circumstances each placement would be appropriate, and the legal and operational complexities associated with each option. The CDCR Division of Adult Parole Operations would also need additional resources for supervision of these parolees.

Conclusion

CDCR is committed to its mandate to provide medical, dental, and mental health services to California's incarcerated population at all 31 CDCR institutions statewide and to facilitate the safe and successful reintegration of incarcerated individuals back into their communities.

Demographic shifts and local sentencing policies have resulted in an older population of incarcerated individuals who require higher levels of care and earlier and greater community support on release. Rising health care costs and numerous other factors complicate CDCR's mandate. CDCR welcomes the opportunity to collaborate with the Legislature and all stakeholders to find innovative ways to address the increasingly complex and costly challenges of incarcerating, reintegrating, and supervising the focus population.

The options outlined in this report do not necessarily reflect current CDCR policies, and no suggestions or options should be interpreted as CDCR having a position on the true viability of any such considerations.