SB25-190 Study

2025 | Special Needs Parole and Correctional Release Options

Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

The following individuals contributed to this report:

Juliann Jenson, Senior Research Analyst

Brendan Fung, Fiscal Analyst

Clayton Mayfield, Fiscal Analyst

Eliyah Chadioun, Research Analyst

Table of Contents

Executive Summary

Aging and ill inmates are the fastest growing population within Colorado prisons. Special needs parole (SNP) is designed to provide early release or parole to incarcerated individuals who have serious, debilitating, or terminal illnesses, or who are advanced age and no longer pose a threat to public safety. Yet, this release mechanism is used infrequently, often due to lack of healthcare services and housing options available upon release to the community.

During the 2025 legislative session, the General Assembly passed Senate Bill 25-190: Offender Release from Custody. The bill directed Legislative Council Staff (LCS) to conduct a study of options for releasing aging and seriously ill offenders from secure custody to appropriate care or placing offenders in alternative programs. LCS spent the 2025 legislative interim reviewing research, consulting with subject matter experts, visiting facilities, and analyzing relevant data from state agencies. Key findings from this work include the following:

- Nearly one-fourth of Colorado's prison population, about 4,000 inmates, is age 50 and older.
- The Colorado Parole Board reviewed 176 SNP cases between 2021 and 2024 and approved 39 of them, representing a 22 percent approval rate.
- State prisons are constitutionally required to provide healthcare to inmates. The Colorado Department of Corrections (CDOC) received $154 million in state General Fund for inmate healthcare in fiscal year 2025-26, representing about 14 percent of its total budget.
- Inmates who require medical support and treatment utilize a disproportionately large share of resources, and these costs are projected to increase over time.
- Releasing 34 eligible SNP inmates to community-based non-state placements could save the CDOC about $2.1 million initially from reduced medical costs and averted county jail reimbursement costs.
- Many SNP eligible inmates are not released because there are no available placements. Assisted living and long-term care facilities exist, but placement is often difficult due to stigma, security concerns, limited resources, and legal barriers that may prevent many approved parolees from placement.
- Inmates are ineligible to receive Medicaid or Medicare funding while incarcerated. Eligibility rules for these programs upon release are complex, and barriers affect placement in long-term care once individuals return to the community.
- Community corrections programs have a limited ability to accept SNP placements. Facilities do not have on-site medical care or professionals, staff do not assist with activities of daily living, and residents are generally responsible for identifying the financial means to support themselves.
- Connecticut, Massachusetts, and Vermont opened long-term care facilities for this population under a public-private partnership, with Medicaid covering 50 to 80 percent of all expenses.
- Retrofitting an existing state facility or building a new facility to accommodate and care for SNP inmates require initial upfront and ongoing maintenance expenses.

Introduction

America's prison population is aging rapidly, with those 55 and older now making up 16 percent of inmates, up from 4 percent in 2002.[1] This shift is straining prison healthcare systems, which are constitutionally required to provide adequate care but often lack the resources and infrastructure to meet older inmates' complex health needs. Furthermore, housing an elderly inmate costs significantly more than a younger inmate, with estimates ranging nationwide from $60,000 to $100,000 annually, depending on location and specific healthcare needs.

Similar to national trends, Colorado's prison population is also aging, with nearly one- quarter of inmates now over 50. From 2000 to 2019, this group grew over eight times faster than the overall prison population.[2] Yet, SNP, a tool that could help address the growing medical and housing demands of older inmates, is rarely used, with fewer than one percent of the inmate population released through the program. As Colorado struggles to meet the healthcare and housing needs of its aging prison population, expanding the use of SNP could reduce state costs and improve the quality of life for older and medically vulnerable inmates.

Senate Bill 25-190 requires LCS to conduct a study that explores options for releasing aging and seriously ill offenders from secure custody into appropriate community-based care or alternative programs to better meet medical and housing needs. The study must specifically include:

- identification of available Colorado community-based facilities to house aging and seriously ill offenders;
- an assessment of community corrections providers' current and future capacity to serve this population, including persons with serious medical issues or disabilities;
- information on healthcare funding, including Medicaid or other funds, that may be available to support community placements;
- identification of statutory or legal barriers that hinder the development or implementation of community-based programs for this population;
- evaluation of the feasibility of opening or retrofitting buildings to be operated by CDOC as an elder-care facility; and
- a review of federal and state compassionate release or special needs parole laws, including placement programs in the community and associated costs.

Section I discusses SNP in Colorado, including legislative changes to the program over the years, data on the use of SNP in Colorado, the costs and cost-saving associated with SNP, state and federal programs that may pay for post-release healthcare for inmates released on SNP, and possible placement options for this population, including community corrections. Section II discusses barriers to the use of SNP in Colorado. Section III evaluates the possibility of constructing or renovating facilities to serve the SNP population in Colorado. Section IV discusses federal compassionate release programs and SNP programs in other states.

1 Trapped in Time: The Silent Crisis of Elderly Incarceration, ACLU, 2025.
2 SB21-146: Improve Prison Release Outcomes Report, Colorado Commission on Aging, 2022.

Section I:
Special Needs Parole in Colorado

Colorado introduced SNP in 2001 to allow early release for terminally ill or severely incapacitated inmates who do not pose a threat to public safety. Since then, eligibility criteria have broadened to include chronic illness, old age, and severe cognitive impairments. Legislation over the past decade streamlined the process and improved the ability of CDOC to identify and refer eligible offenders. Despite these changes, the release mechanism is underutilized, often due to procedural hurdles, lack of placement options upon release, or narrow eligibility requirements.

"It's not just inhumane for the person who is in prison and experiencing it – but even more for the family. That's not right."

Lynn, the sister of dying man in Colorado prison.

Eligibility

In Colorado, individuals may apply for special needs parole if they are:

- 55 years of age or older and diagnosed by a licensed healthcare provider with a serious functional or cognitive impairment;
- under 55 years of age with no disciplinary violations in the past 12 months, have served a minimum percentage of their sentence depending on parole eligibility, or have a serious functional or cognitive impairment that is irreversible, unlikely to be cured, and likely to cause death;
- any age and diagnosed by a licensed healthcare provider with a terminal illness, or have a life expectancy of 12 months or less; and
- 64 years of age or older, with no specified medical condition, as long as they have served at least 20 calendar years in CDOC custody, were not convicted of a class 1 or 2 felony, unlawful sexual behavior, domestic violence, or stalking.[3]

3 Section 17-1-102 (7.6)(a), C.R.S. Additional information on these crimes is available in the LCS Crime Classification Guide.

Special needs parole specifically excludes inmates convicted of a:

- a class 1 felony, sentenced to life with the possibility of parole and who have served fewer than 20 years;
- a class 1 felony and sentenced to life without parole; or
- a class 2 felony crime of violence and who have served less than 10 calendar years of a sentence.

However, these inmates are eligible for SNP if they are diagnosed as having a terminal illness that is irreversible, unlikely to be cured, and likely to cause death.[4]

Legislative History of SNP in Colorado

The SNP program has undergone various reviews and reforms over the years since its initial passage in 2001, most recently with the following bills and executive orders:

- Senate Bill 18-1109 lowered the eligible age for SNP to 55 and also expanded eligibility for inmates found incompetent to complete their sentence and not expected to pose a public safety risk.
- Executive orders (D 2020 016 and D 2020 043) during the 2020 COVID pandemic temporarily expanded the use and criteria for SNP to facilitate the release of medically vulnerable, low-risk inmates.
- Senate Bill 21-146 expanded eligibility for SNP to include inmates with chronic medical or mental health conditions that severely limit daily functioning. It removed the requirement that CDOC make a recommendation for release and stipulated that parole can only be denied by a majority vote of the Parole Board.
- Senate Bill 25-190 modified the eligibility criteria for SNP and required the referral of an inmate to the Parole Board if they meet the updated criteria, as well as required the study which is the subject of this report.

Parole Process and Data

The CDOC must identify inmates who may qualify for SNP. A licensed healthcare provider then assesses whether the inmate has a serious or severe cognitive impairment. If such a determination is made, the CDOC must submit a referral to the Parole Board and cannot override the medical assessment. Inmates, or their public defender liaisons as necessary, may also request a SNP eligibility determination, and the CDOC must respond within 30 days. [5]

Parole Board members have the sole authority to grant, deny, or table a SNP request. The Parole Board cannot deny special needs parole solely based on the recommended parole plan, but inmates may be placed on conditional discretionary release, also known as "tabled" status, while awaiting an approved parole plan. Factors such as public safety, the inmate's medical and mental health conditions, risk of re-offense, and the proposed parole release plan are all considered.

From 2021 to 2024, 176 SNP cases were referred to the Parole Board. Of these, approximately

4 Section 17-1-102 (7.6)(b), C.R.S.
5 Section 17-22.5-403.5 (3), C.R.S.

22 percent were approved and either released or scheduled for release. Another 30 percent were tabled pending necessary plans or placements, such as adequate housing or medical care. Roughly 10 percent of approved or tabled individuals died before release. The remaining cases were denied, primarily due to public safety concerns. Table 1 below shows the number of SNP applications and outcomes by year.

Table 1
Special Needs Parole Cases Reviewed by Parole Board and Outcomes
2021–2024

Case Type and Outcome	2021	2022	2023	2024	Total
Total Reviews	34	67	57	18	**176**
Granted	16	12	11	0	**39**
Denied	18	32	26	8	**84**
Tabled	0	23	20	10	**53**
Released After Tabled	0	0	0	2	**2**
Deceased After Tabled	0	3	1	2	**6**

Source: Parole Board Annual Reports, 2021–2024

Potential Savings from Releasing SNP Inmates

Legislative Council Staff estimates that the state saves $59,500 per released SNP inmate from reduced medical costs and county jail reimbursement payments. Between 2022 and 2025, 68 inmates were approved for SNP, of which 34 cases were tabled without a release plan. If these 34 unreleased inmates were placed on parole outside of a state-operated facility, the CDOC could save an additional $2.1 million in the first year. Future savings will depend on the lifespan of released SNP inmates, as well as future population and release trends. Notably, any savings may be offset by increased spending on these individuals post-release.

Medical Savings

SNP release from a CDOC setting saves the state an estimated $31,400 per SNP inmate on parole per year from reduced medical costs. This savings takes into consideration higher cost clinical services for inmates with complex health conditions based on the average cost for medical services at the Denver Reception and Diagnostic Center ($119 per day in FY 2022-23) less the total average cost for medical services across all facilities ($33 per day in FY 2022-23) and is adjusted for medical inflation (13.4 percent). The savings rate is then reduced by the daily cost of parole ($30 per day in FY 2025-26), equating to an average saving of $86 per SNP inmate on parole per day. Thus, if the 34 inmates with tabled SNP cases are released, the CDOC will save $1.1 million from medical savings in the first year.

County Jail Reimbursement Savings

Releasing inmates to parole opens up CDOC beds, which saves the state an estimated $28,100 per inmate from reduced county jail reimbursements. Currently, CDOC facilities are at inmate

capacity, which means that individuals sentenced to the CDOC may be housed in a county jail until a facility bed opens up. The state reimburses these jails at a rate of $77 per inmate per day. Upon bed vacancy after SNP release, individuals held in county jails on the inmate backlog will be moved to a CDOC bed, thus incurring reimbursement savings. Therefore, if the 34 inmates with tabled SNP cases are released, the state will save an additional $956,000 from county jail reimbursements in the first year.

Future Savings

Cost savings in future years depend on several factors, including parolee health outcomes, population trends in CDOC, and future decisions by the Parole Board, which have not been estimated. Due to the increasing age of the prison population, it is expected that more inmates will be eligible for SNP over time. If the increased number of eligible inmates are able to be released, cost savings could increase. At the same time, future decisions by the Parole Board on SNP approvals will also affect future savings. For example, if the board releases inmates sooner after they become eligible for SNP, savings will increase due to longer life expectancies. Alternatively, maintaining inmates in custody for longer after they become eligible for SNP will decrease potential savings.

For the 34 unreleased inmates, ongoing savings are not estimated, but are only expected to occur for a limited number of years after release given their health conditions and age.

Current Release Options

Most individuals released on SNP live with family or friends. Since 2022, Colorado has allocated nearly $1 million annually to support up to 10 private nursing-facility beds for CDOC inmates released on SNP, at an average cost of about $257 per person per day.

Other placements, such as community corrections or group homes, may accept SNP parolees, provided they do not have chronic or serious medical conditions. These options are described in more details below.

Medical Assistance Funding for Release Options

Certain individuals released on SNP may be eligible for state and federal funding, while others may utilize private health insurance. Medical assistance programs offered by the state and federal governments, as well as private health insurance options, are described below.

Medicaid

Medicaid is a joint federal and state insurance program that provides healthcare coverage to low-income families and individuals. Currently, federal law[6] and regulations[7] prohibit Medicaid coverage for inmates in public institutions with few exceptions. Upon release from incarceration, those individuals who would otherwise qualify can regain eligibility. Therefore, individuals released on SNP in Colorado are only eligible for Medicaid once released to an outside facility, and not before.

6 42 U.S.C. § 1396d
7 42 C.F.R. § 435.1009

However, in 2025, Colorado received approval for a federal 1115 demonstration waiver that allows Medicaid coverage for certain incarcerated individuals during the 90 days before their expected release date, including individuals approved for SNP. The Centers for Medicare and Medicaid Services (CMS), which regulates Medicaid at the federal level, requires all 1115 waivers to be cost neutral.

Medicaid reimbursement rates to facilities that house and treat individuals released on SNP vary considerably depending on a patient's health needs, whether the facility accepts Medicaid, and what programs are available to supplement Medicaid payments. For additional information on Medicaid, see the LCS Overview of Colorado's Medicaid Program.

Medicare

Medicare is a federal health insurance program primarily for people 65 or older, as well as younger individuals with certain disabilities or conditions. Like Medicaid, Medicare is largely withheld from individuals who are incarcerated; however, upon release, individuals who would otherwise be eligible may apply and begin receiving benefits. Individuals released on SNP may utilize Medicare for acute, hospice, or primary care, but not long-term care such as nursing homes or assisted living residences, among others.

Medicare eligibility is further dependent on the applicant paying Medicare taxes for at least 10 years. Many incarcerated individuals are unlikely to meet this qualification, which makes Medicare a limited option for individuals released on SNP.

Veterans Affairs Benefits

The U.S. Department of Veterans Affairs (VA) may pay certain benefits to veterans who are incarcerated in state penal institutions. Rates from the VA depends largely on the type of benefits and reason for incarceration. Incarcerated veterans remain eligible for VA healthcare, but the VA cannot provide routine hospital or outpatient care while they are confined in a government institution responsible for their medical needs. Once released, including into temporary housing programs, VA care is available.

Private Health Insurance

Incarcerated individuals cannot purchase health insurance through the Marketplace, including Connect for Health Colorado or any other health insurance marketplace. For Marketplace purposes, "incarcerated" means serving time in prison or jail, but does not include those on probation, parole, house arrest, or in a residential facility or halfway house. Once an individual is no longer incarcerated, they become eligible to buy a Marketplace plan.

Identifying Alternative Facilities in Colorado

Aging and seriously ill offenders who are approved for early parole may be placed at a variety of care facilities that meet their specific needs. These may include nursing facilities, assisted living residences, hospice care, community corrections programs, and more. However, placement is often difficult due to stigma, security concerns, limited resources, and legal barriers.

Table 2 provides an overview of alternative facilities that may, or may not, receive aging and seriously ill offenders in Colorado. Additional detail is also provided below.

Table 2
Alternative Facilities for Aging and Seriously Ill Offenders in Colorado

Facility Type	Facilities in State	Setting	Medical Resources	Viability – Seriously Ill	Viability – Aging	Primary Funding
Nursing Facilities	~215	Inpatient	24-hour Skilled Nursing	Moderate – High	High	Medicaid, Medicare, Private
Assisted Living Residences	~661	Residential	Limited/ Non-skilled	Low – Moderate	Moderate – High	Medicaid, Private
Hospice Care	~118	Home-based/ Some Inpatient	Palliative and Medical	High if Terminally Ill	Moderate	Medicaid, Medicare, Private
Community Corrections Programs	25	Residential and Non-residential	Minimal	Low	Low – Moderate	General Fund, Fees
Personal Care and Board Homes	<100	Residential	Limited	Low – Moderate	Moderate	Medicaid, Private
Correctional Facilities	21	Secure Inpatient	Limited	Low	Low	General Fund
Mental Health Hospitals	2	Inpatient	Psychiatric/ Geriatric	Low	Low	Medicaid, General Fund
Community Re-entry Programs	Statewide Network	Non-Residential	Referral-based	Indirect Support Only	Indirect Support Only	Grants, Donations, State Contracts
Guardianship Services	Statewide Network	None	None	Indirect Support Only	Indirect Support Only	Medicaid, State Funds
Regional Centers	3	Residential	Specialized Behavioral and Medical	Low	Low	Medicaid
Veterans Living Community Centers	5	Residential	24-hour Skilled Nursing	Moderate (if veteran eligible)	High (if veteran eligible)	Medicaid, Veterans Affairs, Private

Source: Legislative Council Staff. Detail is provided in the narrative below.

"Viability – Seriously Ill" and "Viability – Aging" are assessments of the likelihood of placing individuals released on SNP based on illness or age in certain facilities. Certain facilities are more viable for parolees who are seriously ill as compared to those who are over 65 years old without a serious illness, and vice versa.

Nursing Facilities

Nursing facilities are licensed healthcare facilities that provide continuous inpatient nursing care and support services to individuals who require ongoing medical supervision and assistance. A skilled nursing facility is a designation given by the Centers for Medicare and Medicaid (CMS) to a subset of licensed nursing facilities that offer 24-hour, medically necessary care by licensed nurses under a physician's treatment plan. There are an estimated 215 active nursing and skilled nursing facilities in Colorado.

These facilities may be appropriate for parolees who are seriously ill and require intensive, structured medical care in a regulated environment. Whether a facility accepts a parolee for placement is determined by the individual facility based on its eligibility criteria, care capacity, and security considerations.

Assisted Living Residences

Assisted living residences (ALRs) are licensed residential settings that provide room, board, personal services, and protective oversight to three or more unrelated adults. These facilities are designed for individuals who do not require continuous medical care, but who benefit from regular support with daily living activities. There are an estimated 661 active assisted living residences in Colorado.

ALRs may be appropriate for parolees who meet the age criteria for release, but do not need intensive medical care. Whether a facility accepts a parolee for placement is determined by the individual facility based on its eligibility criteria, care capacity, and security considerations.

Hospice Care

Hospice care programs are licensed providers that deliver palliative and supportive services to individuals with terminal illnesses and a life expectancy of six months or less. Services are designed to manage pain and symptoms while addressing the physical, emotional, and spiritual needs of the individual and their family. The majority of hospice programs provide care in the patient's home. However, some licensed hospice care programs provide these services in their own inpatient settings and are intended only for those with terminal illnesses. There are an estimated 118 active hospice care programs in Colorado.

These programs may be appropriate for parolees who meet the medical criteria for release, depending on their individual condition. Decisions about whether to accept a parolee into hospice care are made by the individual hospice provider and any partnering facility, based on eligibility criteria, available capacity, and the specific care needs of the individual.

Community Corrections Programs

Community corrections (Comcor) programs provide structured supervision, accountability, and rehabilitative services. The programs admit justice-involved individuals on:

- diversion placements, where a person is sentenced directly to Comcor instead of to the CDOC; and

- transition placements as part of release conditions from the CDOC.

Comcor programs are funded through the state's General Fund, daily payments from offenders, and, for certain specialized programs, federal grants that support more intensive treatment and supervision for higher-needs offenders. Programs are generally divided into residential and non-residential, depending on the services provided. There are also three specialized program types, including intensive residential treatment, sex offender supervision and treatment, and residential dual diagnosis treatment.

State law allows, but does not mandate, local governments to establish Comcor programs. Currently, there are 25 programs operating in 16 of Colorado's 23 judicial districts. While some districts have a single program, others host multiple programs tailored to different populations. Local governments also set placement criteria and have the authority to reject placements that do not meet their criteria. The state sets minimum standards to ensure quality services and conducts audits of programs through the Division of Criminal Justice in the Department of Public Safety.

These programs are predominantly not appropriate for any seriously ill or elderly parolee due to a lack of medical resources or transportation to outpatient facilities. However, some parolees who meet the age requirements for release may be eligible. Whether a parolee is placed in a program depends on eligibility criteria, ability to work, available capacity, risk assessments, and ultimately, a decision by the program's board.

Personal Care and Board Homes

Personal care and board homes are small, residential settings that provide personal care assistance, room, board, and meals for individuals who need help with daily activities, but do not require skilled nursing care. Medical services, when needed, are typically accessed through community-based providers. However, some personal care and board homes partner with home health agencies or visiting service providers to improve medical accessibility.

These homes may be appropriate for seriously ill or elderly parolees depending on access to onsite medical resources or transportation to outpatient facilities. Whether a parolee is placed in a personal care and board home depends on the facility's license, contractual agreements with the state, individual's needs, and funding opportunities.

Correctional Facilities

The CDOC operates 19 correctional facilities that house individuals serving prison sentences, and contracts for an additional 2 facilities. Some of these facilities are equipped to manage seriously ill or elderly inmates who cannot safely be placed in standard prison settings. One such example is San Carlos Correctional Facility, a high-security medical and psychiatric facility that provides inpatient mental health treatment and intensive medical supervision for individuals with complex behavioral or physical health conditions. Another is the Denver Reception and Diagnostic Center that has a 12-bed Special Medical Needs Unit, and additional beds for dialysis care.

Correctional facilities are not designed for parolee placement and are therefore not appropriate for seriously ill or elderly parolees.

Mental Health Hospitals

The Colorado Mental Health Hospitals in Pueblo and Fort Logan, which are operated by the Colorado Department of Human Services (CDHS), frequently serve individuals with complex behavioral conditions, including those who are seriously ill and aging. While the Pueblo hospital includes a geriatric unit, this unit is often at full capacity and has a long waitlist for discharge placements for individuals requiring ongoing care. Additionally, the hospitals are structured as inpatient treatment centers rather than post-release residential care options.

These hospitals are not considered viable long-term alternative facilities for seriously ill or aging parolees in need of placement.

Community Re-entry Partners

Community re-entry partners are nonprofit or community-based organizations that support individuals transitioning from incarceration into the community. These partners deliver wraparound re-entry services that may include housing assistance, employment placement, behavioral healthcare, transportation, peer mentorship, identification recovery, and connections to long-term care services. However, these are generally voluntary, and do not include mandated confinement or supervision.

Seriously ill and elderly parolees may use community re-entry partners for individualized re-entry needs, but these organizations do not provide housing.

Guardianship Services

Although not facilities, guardianship services are critical and often overlooked resources when planning discharge from secure settings. For parolees with cognitive impairments, psychiatric conditions, or other challenges that limit their capacity for self-advocacy, guardianship can provide the legal authority to coordinate housing, care, and benefits. The CDHS has identified guardianship as a key enabler of successful community reintegration, especially in cases where parolees lack informal supports or the ability to consent to the own placement and treatment.

While not suitable for housing, guardianship may be a prerequisite for accessing certain types of care facilities or community programs.

Regional Centers

The CDHS operates regional centers for adults with intellectual and developmental disabilities (IDD), which offer highly specialized care and services. However, these centers are not considered long-term care facilities, and they do not function as general-purpose placement options for parolees who are seriously ill or aging. Placement in a regional center requires a qualifying IDD diagnosis and enrollment through Colorado's developmental disabilities service system, which includes strict eligibility criteria and funding limitations.

Regional centers do not serve as alternative facilities for the broader parolee population, even when individuals have overlapping behavioral or medical needs.

Veterans Community Living Centers

Colorado's Veterans Community Living Centers (VCLCs), administered by the CDHS, provide high-quality residential care, including skilled nursing and memory care services, for eligible veterans and their families. However, access to these facilities is limited by stringent eligibility criteria, which require individuals to have served on active duty, received an honorable discharge, and meet specific length-of-service thresholds. Eligibility also extends to certain spouses and Gold Star family members.

While the facilities themselves offer the type of care needed by many seriously ill or aging parolees, only a small subset of the parolee population qualify for placement based on these federal and state service requirements.

Section II:
Identifying Special Needs Parole Barriers

Inmates, parolees, CDOC staff, attorneys, and other criminal justice stakeholders collaborated to identify barriers to successful SNP implementation. Members of Legislation Inside, an advisory council of incarcerated individuals, shared their ideas during a weekly meeting. Staff also visited Limon Correctional Facility, the Denver Reception and Diagnostic Center, and a private nursing home to discuss current practices, underutilization of the program, and potential housing options for SNP patients. The challenges identified by these stakeholders and staff are presented below.

"Older people are much less likely to commit crime than the young. They are also much more expensive to lock up."

– German Lopez, New York Times Reporter

Eligibility and Process Barriers

Advocates identified several legal, eligibility and administrative challenges as limiting the availability of SNP in Colorado.

- **Age threshold for geriatric SNP without medical conditions is set too high.** In Colorado, inmates 64 and older who have served at least 20 years for non-violent, non-sexual offenses may apply for SNP. Inmates noted that prison medical care is inconsistent, and incarceration accelerates aging. A younger age threshold would grant inmates the possibility of release before they are too old and infirm to find housing, sign up for benefits, and work. Other states use lower age thresholds. For example, New Mexico, North Carolina, and Alabama set their geriatric parole eligibility at 55, while Washington state uses a broader "advanced age" criterion.
- **SNP eligibility criteria is limited.** SNP eligibility in Colorado is limited by offense type, time served, and medical criteria, excluding many incarcerated individuals. Inmates serving under presumptive sentencing, with longer terms, mandatory minimums, "three strikes," or eliminated parole, are also ineligible. Inmates and other advocates recommended that SNP eligibility consider behavior in custody and participation in treatment or rehabilitation programs, to provide a more comprehensive assessment of the individual.

- **Absence of a legal mechanism to reevaluate a criminal sentence.** Colorado does not have a second look law for adult offenders, which provides a way for the courts to reconsider lengthy sentences based on factors such as time service, rehabilitation, and age at the time of offense. Other states have used this process to release elderly incarcerated people from prison.
- **No special consideration for justice-involved veterans.** Justice-involved veterans have no exceptions under SNP eligibility. Veterans Affairs staff noted that allowing veteran inmates to qualify could enable access to federal veteran's benefits, including disability compensation, pensions, education and training, healthcare, home loans, insurance, vocational rehabilitation and employment, VCLCs, and burial assistance.
- **Over-burdened case managers**. Prison case managers are reportedly overworked due to staffing shortages. They serve as liaisons among inmates, medical staff, the Parole Board, and community providers to create comprehensive release plans, which are essential for showing that an inmate's medical or special needs can be safely met in the community. With staffing shortages, this important work can shift to lower priority for case managers.

Post-Release Barriers

Barriers to reintegration include the lack of community-based services and programs for the SNP population.

- **CDOC lacks mechanisms to intervene when a SNP nursing home placement becomes problematic.** Skilled nursing and assisted living facilities are often reluctant to admit justice-involved individuals, due to challenges managing high-risk patients and limited support from CDOC. Some facilities indicated they may be more willing to accept justice-involved residents if CDOC can intervene or revoke the parole of those patients who pose significant risks. CDOC does not have legal authority to stop this practice or revoke former inmates in cases where a resident has been evicted from a facility, but has not broken the law or violated a condition of parole.[8]
- **Limited available housing with medical care.** State funds currently offset costs for 10 beds in private nursing homes for qualifying SNP participants, and provides other, limited resources for hard-to-place individuals with significant behavioral health needs. However, this limited scope does not meet the identified need for total SNP placements. Other states including Connecticut, Massachusetts, and Vermont use public-private partnerships to fund dedicated facilities for their compassionate release parolees. Similar partnerships in Colorado could offer transitional housing, assisted living, hospice coordination, and family-reunification support, while sharing costs between corrections and community providers to reduce expenses and improve care.
- **Nonprofit organization involvement.** Community groups currently lack specialized housing or services for elderly or infirm people leaving prison. Existing reentry organizations such as the Second Chance Center and WAGEES could expand their transitional housing and support programs to include specialized care, medical services, and social reintegration for this population.
- **One-way communication between CDOC and skilled nursing facilities.** Communication about release planning and facility openings usually is initiated by CDOC staff. The SNP

8 Section 17-2-103, C.R.S.

population could benefit from proactive, two-way communication and collaboration between skilled nursing, assisted living facilities, and CDOC staff to improve care and better coordinate openings.

- **Measurements of success.** Colorado collects basic SNP data, such as applications submitted, decisions made, and pending cases, but lacks a comprehensive evaluation framework to measure humanitarian, health, and fiscal outcomes. Better data collection and outcome measurement would help refine and improve the SNP system to meet the needs of the inmate population more effectively.
- **Medicaid reimbursement.** Traditionally, Medicaid reimbursement rates are much lower than Medicare or private insurance. Therefore, many alternative facilities including nursing homes and assisted living residences are disincentivized to accept placements for individuals who are only covered by Medicaid. Medicare enrollees, on the other hand, receive much higher reimbursement rates. Additionally, Medicaid, which is essential for offsetting costs for community-based care and housing, is undergoing eligibility and funding changes on the Federal level, adding further uncertainty to the feasibility of new SNP housing options.
- **Costs.** Creating suitable housing for SNP placements, whether by retrofitting an existing facility, building a new one, or forming a public-private partnership, would require up-front state funding. Colorado is currently facing a budget shortfall, leading lawmakers to cut existing programs and services. The feasibility of constructing or renovating a facility for the SNP population is explored further in the following section.

Section III:
Facility Feasibility Analysis

The feasibility of establishing a state-operated long-term care facility for aging and seriously ill parolees depends on several key factors: cost and financing, Medicaid reimbursement potential, timing, capacity, control, quality, risk allocation, and operational control. Precise costs cannot be estimated with the available information and resources; therefore, this evaluation draws on prior state capital projects, stakeholder conversations, and comparable facilities operated by the state.

"Expanding and better utilizing compassionate release programs would be an important step in making the prison system more humane and would reduce the financial strain mass incarceration places on states."

– Megan Horner, Broken and Underutilized: Understanding Compassionate Release Programs for Older Adult Prisoners

Feasibility Evaluation Models

While the assessment criteria as outlined in Senate Bill 25-190 assumes that the facility would be operated by the CDOC, findings suggest that the Colorado Department of Human Services may be better positioned to operate such a facility due to its statutory role in health and human services and its existing infrastructure for licensed long-term care.

Table 3 provides a summary of criteria and consideration, followed by additional detail for each model, additional models under CDHS, and comparative notes.

Table 3
Feasibility Evaluation Models and Criteria

Model	Cost and Financing	Medicaid Potential	Timing	Capacity	Control and Oversight	Quality and Compliance	Risk Allocation
Retrofit an Existing State Facility	Moderate upfront cost, high renovation uncertainty	Limited by compliance challenges	3–5 years	Limited by building footprint	Full state control	Variable, dependent on retrofit success	All risks borne by state
Build a New Facility	Highest upfront cost, predictable operations	High likelihood of compliance	3–5 years	Fully customizable	Full state control	Highest quality and compliance	All risks borne by state
Purchase an Existing Facility	Moderate cost, limited availability	High, due to existing licensure	1–2 years	Fixed to existing capacity	Full state control	High quality; already licensed	Operational risk borne by state
Public Funding with Private Operation	Lowest capital cost; state funds through reimbursements	Highest; uses existing CMS-certified operators	1–2 years	Flexible through multiple operator contracts	Limited; contractual oversight only	High, but indirect oversight	Operational and financial risk borne by private partner

Source: Legislative Council Staff

Model 1: Retrofit an Existing State-Owned Asset

Retrofitting an existing state-owned facility—such as a former correctional unit, state hospital building, or administrative complex—would make use of existing public property and infrastructure. This approach could be less costly than new construction and would maintain full state ownership and control. However, most state-owned properties were not designed for medical care and would require significant renovation to meet CMS and Colorado Department of Health and Environment (CDPHE) licensure standards, including accessibility, infection control, and patient safety.

From a financing standpoint, the state would assume both upfront capital and ongoing operation and maintenance costs,

A wheelchair-accessible ramp and a stationary bike at the Minnesota Correctional Facility in Oak Park Heights, MN, are physical accommodations made available for the aging population at the prison.

while facing considerable uncertainty about the extent of the renovations required. Medicaid reimbursement would depend on achieving CMS compliance and ensuring that parolees are considered eligible patients rather than incarcerated individuals. Retrofitting also limits geographic flexibility, as suitable properties may not be located near hospitals and reentry supports necessary for this population. The state would bear all construction and lifecycle risks under this model.

Model 2: Build a New Facility

Constructing a new facility would allow the state to design a purpose-built environment that meets both federal and state regulatory requirements from the outset. This approach offers flexibility in location, enabling proximity to medical facilities and community re-entry services. It would also provide an opportunity to co-locate different levels of care—such as assisted living and skilled nursing—within a single campus. CDHS uses this dual model in its VCLCs, allowing residents to transition between levels of care as their medical needs change.

A new facility would carry the highest capital cost but the lowest long-term compliance risk. Because it would be built to current health and safety codes, it would be more likely to qualify for Medicaid reimbursement. However, new construction is also subject to a lengthy timeline that includes design, land selection, procurement, and commissioning, typically three to five years from concept to occupancy. As with a retrofit, the state would retain operational control and assume all construction and lifecycle risks.

Model 3: Purchase an Existing Facility

Purchasing an existing nursing home, assisted living resident, or hospice facility from a private operator would allow the state to establish capacity more quickly than through new construction. This approach benefits from existing licensure and infrastructure already aligned with healthcare standards, reducing both capital investment and regulatory uncertainty.

Renovation would likely focus on adapting the facility to meet security and staffing requirements for parolees rather than rebuilding major systems. Medicaid reimbursement potential is highest under this model because the facility would likely already meet CMS conditions of participation. However, availability may be limited to smaller facilities in rural or suburban areas, which could affect access to medical services and staff. The state would bear ongoing operational and maintenance costs but could avoid major new construction expenditures.

Model 4: Public Funding with Private Operation

Another alternative approach would be for the state to contract with or subsidize private long-term operators to reserve designated beds for parolees who qualify under the special needs parole program. The state could offer higher per diem rates, supplemental Medicaid payments, or other incentives to encourage participation. This model has been implemented successfully in other states, with Colorado initiating a 10-bed program in FY 2023-24, and offers the fastest route to expanding capacity without major capital investment. Because the facility would be privately owned and operated, it would remain fully eligible for Medicaid reimbursement. The CDOC would retain oversight of placements and eligibility criteria through contract terms,

but would not directly manage the facility or its staff. This approach shifts operational and maintenance risk to the private sector and limits state control over admissions and quality of care.

Alternative Models under CDHS

The CDHS currently operates several models for various populations that could further inform the state's approach to placement options for seriously ill and aging parolees. Veterans Community Living Centers operate under an enterprise structure and offer two levels of care—long-term care and domiciliary care—allowing residents to move between programs as needs change. This model provides a sustainable framework that balances medical oversight with federal reimbursement mechanisms.

The CDHS also utilizes smaller-scale residential options, such as personal care and board homes, that provide meals, housing, and limited assistance with daily living but rely on community health systems for medical care. These homes are more flexible and community-integrated but lack the clinical infrastructure necessary for individuals with high medical acuity.

Comparative Observations

From a feasibility standpoint, each option presents trade-offs. Retrofitting or building a new facility would maximize state control but require significant upfront investment and long timelines. Purchasing an existing facility may be the most efficient and compliance-ready option, though limited by market supply. Public funding for private operation would create capacity rapidly at a lower cost, but with less direct state oversight.

In all cases, coordination between CDOC, CDHS, and CDPHE would be essential. The CDHS's experience with licensed long-term care operations and existing reimbursement structures make it a natural administrative lead, while CDOC could provide referral, security coordination, and population management support.

Section IV:
Federal and State Compassionate Release Programs

Federal law permits sentence reductions and early releases for certain dying, incapacitated, and elderly prisoners. The vast majority of states also employ some version of it.

"I am holding on, but I would like to die at home."

– Jimmy, a federal inmate with stage 4 lung cancer (Kaiser Health News, February, 2023)

Federal Compassionate Release

Congress first included the concept of compassionate release in the Sentencing Reform Act of 1984.[9] The First Step Act enacted in 2018 expanded opportunities for inmates to participate in the program.[10]

Eligibility

Compassionate release allows early release for inmates with "extraordinary and compelling reasons," such as old age, serious illness, or disability. Inmates aged 65 and older may qualify based on health and sentence criteria, while those 70 and older may be eligible after serving at least 30 years. Younger inmates may also qualify due to medical issues, family needs, or other exceptional circumstances recognized by the Bureau of Prisons (BOP) and courts.[11]

Process

The BOP initiates a compassionate release request or the prisoners themselves may petition the court directly. Once a motion is filed, the court reviews the case considering "extraordinary and compelling reasons" and other factors, such as the medical condition, age, family circumstances, nature of the offense, and need for deterrence. Most successful petitions involve a release plan,

9 Sentencing Reform Act of 1984
10 First Step Act of 2018
11 Amendment 799, United States Sentencing Commission Guidelines.

outlining where the inmate will live and be supported financially, and how medical needs will be addressed.

Related Statistics

Since the passage of the First Step Act and several changes in law, federal inmates receive compassionate release more rapidly than in previous years. However, the practice is still used infrequently, with only about 1 percent of the overall inmate population being granted compassionate release at its highest point in 2020.

The percentage of motions granted varies, depending on factors such as the inmate's age, medical condition, time served, and individual case circumstances; 27 percent of those who applied were granted compassionate release in 2020 and 16 percent in 2024.[12]

Release Options

Inmates seeking compassionate release must show they will receive appropriate care after release, such as support from family, hospice, or a medical facility. While they do not need to detail how they will pay for that care, courts still consider their financial resources and eligibility for programs like Medicare or Medicaid to ensure the release plan is realistic and adequate.

There are no federally run nursing homes or assisted living facilities dedicated for inmates released on compassionate release. The Veteran's Administration runs similar facilities, but are only available to those with veteran's status. Instead, federal inmates are generally released to home confinement, local facilities on an individual basis (i.e. nursing homes, assisted living), or residential reentry centers (RRCs). RRCs are private entities contracted with the BOP to provide community reintegration services to inmates nearing release. RRCs, while not nursing facilities, help with community reintegration.

Independence House in Denver is a Colorado-based RRC. In operation since 2003, it is a 100-bed facility for male and female federal offenders funded primarily by grants from the BOP. The program provides home confinement services, and substance abuse and mental health treatment programs. While RRCs, including Independence House, support access to medical care, they generally are not equipped to handle terminally ill patients.

Compassionate Release in Other States

All states except Iowa have compassionate release or SNP laws, which allow for the early release of elderly or seriously ill inmates who no longer pose a public safety risk. Despite the widespread existence of these programs, they are often underused. Reasons for underutilization include strict eligibility criteria, bureaucratic hurdles, and lack of housing and care in the community. For example, out of more than 2,600 screenings for medical parole in Texas in 2022, 58 people (2 percent) were approved for release.[13]

The SNP laws vary by state, including who qualifies, eligible offenses, the application process, and reporting requirements, among other areas.

12 First Step Annual Report 2024, U.S. Department of Justice, June 2024.
13 Everywhere and Nowhere: Compassionate Release in the States Families Against Mandatory Minimums, June 2018.

- **Eligibility criteria.** States differ in what medical conditions qualify for special needs parole. Some require a specific prognosis, such as having 12 months or less to live, while others automatically include certain terminal or debilitating conditions. Georgia's compassionate release program, for example, is only available to inmates who are deemed entirely incapacitated and expected to die within 12 months. Some states, such as Oregon, consider humanitarian grounds and weigh whether it would be considered cruel or inhumane to keep an infirm individual in prison.
- **Age.** States may have separate geriatric parole laws that allow older inmates meeting age and sentence requirements to be released independently of medical parole criteria. Alabama, New Mexico, and North Carolina have the lowest age for geriatric parole consideration, setting it at 55, while most other states limit the age to somewhere between 60 and 65.
- **Exclusions.** Many states categorically exclude prisoners convicted of certain types of crimes from special needs parole consideration. For example, Alaska prohibits compassionate release to inmates convicted of sexual assault or abuse. Maine only considers prisoners in minimum security.
- **Application process.** State application processes range from relatively straightforward to very complex, with multiple layers of review that often delay or prevent release. Some states use an administrative process to make the ultimate determination, and others allow for judicial review. As an example, Washington requires prisoners to go through multiple reviews and approval stages before the Secretary of Corrections makes the final determination. Minnesota uses a structured assessment process with deadlines. In California, the trial court judge makes the final decision on resentencing or release.
- **Statistics.** Only a minority of states track or collect data about who applies for and is granted special needs parole. Thirteen states have a statutory or regulatory reporting requirement, including New Mexico that directs the Parole Board to provide annual reports. Connecticut also publishes available data.

States have implemented a broad spectrum of programs and services to address aging inmates, including those with terminal illnesses and dementia. Additionally, some states have invested in programs to better protect and serve older people who remain incarcerated.

Community-Based Programs Post-Release

Special needs parole reentry initiatives are limited, and older parolees often face significant challenges in the community. Nursing homes are frequently hesitant to accept formerly incarcerated elderly people, and halfway houses typically lack needed healthcare services. New programs are emerging, however, to address the needs of this aging and vulnerable population.

Long-Term Care Facilities

Connecticut, Massachusetts, and Vermont partner with specialized private health networks to provide skilled nursing care for certain formerly incarcerated individuals who have complex health needs. State prison officials make referrals to these private facilities, which are certified to receive federal Medicare and Medicaid payments. These certified facilities follow standard regulations and often include staff who are social workers or formerly incarcerated. The states also use additional reentry supports like halfway houses, RRCs, and supportive housing.

Permanent Supportive Housing

The Returning Home Ohio (RHO) program provides supportive housing for incarcerated individuals with medical needs who are homeless or at risk of homelessness upon release. Launched in 2006, it is funded by a partnership between the Ohio Department of Rehabilitation and Correction and the Corporation for Supportive Housing. While RHO does not provide medical care directly, it helps participants access needed services.

Reentry Programs

The Elder Reentry Initiative (ERI) in New York specifically serves older adults returning to the community after incarceration. It is the only program in the state dedicated to this population, and services begin inside prison and jails with comprehensive geriatric assessments and discharge plans. Once in the community, staff helps the formerly incarcerated seniors find stability and safety by providing resources for housing (including skilled nursing facilities), healthcare benefits, employment training, and social support such as career counseling and peer mentors. The initiative was established in 2015 and is partly funded by a Second Chance Act reentry grant from the federal Bureau of Justice Assistance.

Senior Ex-Offender Program

A first-of-its-kind initiative, the San Francisco-based Senior Ex-Offender Program supports formerly incarcerated seniors with comprehensive wraparound services. These include counseling, healthcare guidance, transitional support, and basic needs like clothing and hygiene. The program also runs two transitional homes with built-in supports and staffing. Funding comes from government grants (local and federal), contracts, and private and nonprofit partnerships.

Inside Correctional Facilities

Correctional facilities across the country have developed healthcare, assisted living, rehabilitation, and hospice programs to better address the health and safety needs of elderly and infirm inmates.

Inmate Companion Programs

Several states have launched programs where inmates support fellow inmates. These peer-support roles involve helping with daily tasks, offering companionship, and providing basic supervised medical care. The initiatives aim to improve prison conditions and address the unique needs of aging inmates.

California's Gold Coats program trains inmates with good conduct records to provide care and support to fellow inmates with dementia and other cognitive impairments. The Gold Coats, named for the gold smocks they wear, assist with daily living tasks, escort patients around the facility, and act as companions. The program does not replace trained medical or correctional staff. Gold Coats program participants earn higher wages, receive longer meal times, and have improved chances for parole.

Structured Living for Elderly Inmates

Nevada's Senior Structured Living Program, also known as True Grit, began in 2003 as a way for older inmates in state prisons to engage with their peers while receiving improved physical and mental care. Located in a medium-security prison, the program serves 170 inmates and includes daily physical activity, therapy, and spirituality. It also helps connect inmates with the community and provides re-entry and housing support for parole eligible inmates. The program reports a decrease in doctor visits and medication intake, in addition to combatting loneliness.

Retrofitted Prison Units within Facilities

Some states have opted to retrofit existing units. At a state prison in Minnesota, the Transitional Care Unit (TCU) has expanded twice in the past two decades. Two specialized units are now equipped to care for 150 elderly male prisoners, including a clinic where prisoners receive dialysis and other medical treatments. Nursing care is available 24 hours a day, in-room sinks and doorways allow for wheelchair space, and beds resemble those found in hospitals. Rooms also include a nurse call button, and each cell has a glass door so staff can provide better oversight.

Dedicated Facilities

California constructed the California Health Care Facility in Stockton to centralize care for inmates with high medical and mental health needs. The facility cost $839 million to construct in 2014. It houses 1,700 inmates, employs approximately 4,000 custody, medical and support staff, and also contracts for skilled nursing providers.

Kansas recently constructed a 240-bed Geriatric and Cognitive Care Unit to provide geriatric care and substance abuse treatment. The facility also hosts a training program for inmates to become a certified nurse aide to help with the care of fellow elderly patients. The renovation cost close to $10 million in 2023, with operational and staffing costs estimated at $8.3 million a year.

Palliative Care

A variety of states have palliative care units for older or terminally ill inmates. Louisiana State Penitentiary, for example, has a well-established hospice program supported by a nonprofit organization that has been in operation since the 1990s. The program provides end-of-life care for terminally ill inmates through a multidisciplinary team of physicians, nurses, social workers, chaplains, and trained inmate volunteers. Inmates have private rooms with hospice amenities, and are permitted family visits. A hospice nurse runs the program and inmates provide the day-to-day care.

Conclusion

This report is intended to help policymakers approach the task of developing early release community-based housing and medical care options for the SNP eligible population. Whether in the context of healthcare, housing, or economic assistance, state lawmakers and stakeholders have opportunities to support older and infirm adults leaving prison. Community-based housing and medical services are key to the success of most SNP laws and policies. Expanding and better utilizing SNP would be a step in reducing the financial strain of overcrowded prisons and high medical costs for this population while allowing for individuals, many in the last stages of their lives, to live their final days outside bars.

"You can't go back and change the beginning, but you can start where you are and change the ending."

- C.S. Lewis

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