F I S C A L I M P A C T R E P O R T

SPONSOR Rodriguez **ORIGINAL DATE** 2/1/2017 **LAST UPDATED** 2/27/2017 **HB**

SHORT TITLE Maternal Mortality and Morbidity Prevention Act **SB** 137/aSJC

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Minimal	Minimal	Minimal	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

LFC Files

Responses Received From
Department of Health (DOH)
University of New Mexico – Health Sciences Center (UNM-HSC)
No responses received for the amended version of the bill

SUMMARY

Synopsis of SJC Amendment

The Senate Judiciary Committee amendment to Senate Bill 137 would make minor changes adding provisions to ensure information that is protected by law is not disclosed to the public.

Synopsis of Bill

Senate Bill 137 would establish, within DOH, a maternal mortality and severe maternal morbidity review committee responsible for making recommendations to prevent further maternal mortality. The committee would be required to review each maternal mortality and morbidity incident, investigate these cases, outline trends, and compile reports using aggregate data to assist in reducing maternal mortality and morbidity. An abstractor subcommittee would also be created with access to medical and vital records responsible for reporting de-identified information to the full committee. The DOH secretary is required to promulgate rules.

FISCAL IMPLICATIONS

DOH stated that Family Health Bureau staff currently participate in the national Centers for Disease Control standardized maternal mortality review, which has provided two trainings to

DOH staff on evidence-based methodology in 2016 and will provide additional training on case abstraction and analysis in 2017. The Bill would require DOH staff administrative time to form a committee, hold meetings, attend trainings, and create documents for dissemination of findings and recommendations. This is estimated to be a minimum of 20 hours per month to oversee the administrative and epidemiological work required to oversee the chart abstraction and committee work coordination.

Based on average FTE costs LFC estimates the above stated staff costs would be no more than $1.4 thousand annually but these duties would likely be absorbed by one or more of the department's many staff.

SIGNIFICANT ISSUES

Department of Health provided the following:

> SB137 was introduced as a result of recommendations by the NM Chapter of the American College of Obstetricians and Gynecologists to address a critical need for an established and protected entity for reviewing and analyzing maternal mortality data, and interpreting the results to improve clinical guidelines and public health policy in the state. The proposed multidisciplinary committee would consist of up to 25 members to ensure that all necessary entities and medical specialties are represented.
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> From a national perspective, a recent article pointed out that maternal mortality is on the rise in the U.S., and public-private partnerships are being created to improve maternal health. The overall maternal mortality rate for the United States (excludes CA and TX) increased by 26.6%, from 18.8 deaths per 100,000 live births in 2000 to 23.8 in 2014 (https://d279m997dpfwgl.cloudfront.net/wp/2016/08/MacDormanM.USMatMort.OBGYN_.2016.online.pdf). Rates in New Mexico have steadily increased, mirroring the national trend. According to the NM Bureau of Vital Records and Health Statistics, the maternal death rate increased from 15.3 per 100,000 live births (average, years 2007-2010) to 20.7 (average, 2011-2014). https://nmhealth.org/data/view/vital/1910/
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> Maternal Mortality Review is intended to identify issues, through quantitative and qualitative summaries, and to recommend changes for the medical and healthcare delivery systems to decrease maternal mortality. Individual case review would provide the mechanism and a sub-committee would compile reports annually to share important findings with health providers and policy makers.
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> There is an existing state rule, 7.4.5 NMAC (1998), which previously established a requirement for timely provision of identified health and vital statistics records for maternal and child fatality review at the Department of Health.
> http://164.64.110.239/nmac/parts/title07/07.004.0005.htm
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> A summary of NM cases reviewed from the 1980 – 2007 time-frame showed that there were twice as many maternal deaths among Hispanic women as among White women. (Presentation, Maternal Mortality; L. Leeman and S. Phelan; June 4, 2010)

UNM-HSC stated that there must be a vetted process for confirming that the data being used by the committee is actually de-identified per the Health Insurance Portability and Accountability Act (HIPAA).

In regards to the ability for the subcommittee to access patient medical records, there must also be established policies and procedures to effectuate, again, compliance with HIPAA, and other applicable laws (e.g., Mental Health Code of NM, etc.). Terminology contained in SB137, "as not otherwise prohibited by law", does not suffice to cover the many intricacies of HIPAA and applicable laws.

Deaths during pregnancy and the peripartum period that are reported to the Office of the Medical Investigator (OMI) are easy to identify; however, deaths that occur in the late postpartum period will be difficult to identify without having the resources to specifically look into each pre-menopausal women's medical history. Without additional funding to support SB137's requirements, OMI could only report on the information they routinely obtain to identify these cases without investigating further into all potential deaths.

EC/jle