Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 286 (Delegate Wilkins, *et al.*)
Health and Government Operations Finance

Public Health - Maternal Mortality Review Program - Stakeholders

This bill requires that the stakeholders convened by the Secretary of Health as part of the Maternal Mortality Review Program must include (1) families of women who have experienced a near maternal death, a high-risk pregnancy, other challenges during pregnancy, or a maternal death or (2) women who have experienced a near maternal death, a high-risk pregnancy, or other challenges during pregnancy. The Secretary, when convening the stakeholder workgroup, must contact specified organizations to seek input and recruitment support. To the extent practicable, the stakeholders convened must reflect the racial and ethnic diversity of women most impacted by maternal deaths in the State, and the Secretary must make every effort to ensure that the women's organizations and women impacted by maternal death compromise a majority of the stakeholder workgroup.

Fiscal Summary

State Effect: None. The bill is not anticipated to affect State finances or operations.

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law: At least twice a year, the Secretary must convene a meeting of stakeholders for the Maternal Mortality Review Program, including representatives of (1) the Maryland Office of Minority Health and Health Disparities; (2) the Maryland Patient Safety Center; (3) the Maryland Healthy Start Program; (4) women's health advocacy organizations; (5) community organizations engaged in maternal health and family support issues;

(6) families that have experienced a maternal death; (7) local health departments; and (8) health care providers that provide maternal health services.

The first meeting must be held within 90 days after submission of the Maternal Mortality Review Program's annual report to (1) review the findings and recommendations in the report; (2) examine issues resulting in disparities in maternal deaths; (3) review the status of implementation of previous recommendations; and (4) identify new recommendations with a focus on initiatives to address issues resulting in disparities in maternal deaths. The second meeting must be held within six months of the first meeting to review the status of implementation of previous recommendations and consider any new information that may be relevant for the identification of additional recommendations.

Background:

Maryland Maternal Mortality Review Program

Chapter 74 of 2000 established Maryland's Maternal Mortality Review Program to (1) identify maternal death cases; (2) review medical records and other relevant data; (3) determine preventability of death; (4) develop recommendations for the prevention of maternal deaths; and (5) disseminate findings and recommendations. Maternal mortality reviews are conducted by a committee of clinical experts, the Maternal Mortality Review Committee. The program must submit an annual report on findings, recommendations, and program actions to the Governor and the General Assembly.

Racial Disparity

According to the Maternal Mortality Review program's 2018 annual report, in the U.S. Black women have a maternal mortality rate (MMR) 2.4 times greater than White women, a disparity that has persisted since the 1940s. In Maryland, there is also a large disparity between the rates among Black and White women. The 2012-2016 Black MMR in Maryland is 3.7 times the White MMR.

Additional Information

Prior Introductions: None.

Designated Cross File: None.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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