HB 515

Department of Legislative Services

Maryland General Assembly
2000 Session

FISCAL NOTE
Revised

House Bill 515 (Delegate Stern, *et al.*)
Environmental Matters

Maternal Mortality Review Program

This bill establishes the Maternal Mortality Review Program in the Department of Health and Mental Hygiene (DHMH), which may contract with the State Medical and Chirurgical (Med-Chi) Faculty for program administration. The Secretary must develop a system, in consultation with the Maternal Child Health Committee of the Med-Chi Faculty, to: (1) identify maternal death cases; (2) review records and data; (3) contact appropriate individuals to collect additional data; (4) consult with experts; (5) make recommendations concerning preventability; (6) develop recommendations for the prevention of maternal deaths; and (7) disseminate findings and recommendations to policy makers, health care providers, health care facilities, and the general public. The bill details reporting requirements and access to death certificates and relevant medical records in cases where maternal death is suspected. A health care provider or facility may not be held liable for civil damages or subject to criminal or disciplinary action for good faith efforts to comply with the bill's requirements. The Secretary is required to submit a report on findings, recommendations, and program actions to the Governor and the General Assembly by December 1 of each year. The bill sunsets September 30, 2003.

Fiscal Summary

State Effect: DHMH could review readily-available records and develop an appropriate system for addressing maternal deaths using existing resources. Increased expenditures to contract with Med-Chi for program administration cannot be reliably estimated at this time.

Local Effect: None.
Small Business Effect: None.

Analysis

Current Law: None applicable.

Background: Maryland has been cited by the Centers for Disease Control (CDC) as one of the ten worst states in the nation for maternal mortality. The CDC data indicates a disparity in maternal death rates between African-American women and white women. "Maternal death" is defined as the death of a woman during pregnancy or within one year after the woman ceases to be pregnant. There is no process in the State to identify, investigate, and develop strategies for the dissemination of information and prevention of maternal death.

State Fiscal Effect: The Vital Statistics Administration (VSA) of DHMH believes general fund expenditures could increase by an estimated $41,500 in fiscal 2001 due to the need for a full-time permanent position (research statistician V) to review birth, death, and fetal death records for the identification of maternal deaths.

The Department of Legislative Services advises, however, that computerized data is currently available within VSA on births and deaths since 1970. This data could be manipulated through an electronic search and cross-referenced to attain a working database on deaths during pregnancy and deaths within one year of pregnancy. This data could be used as the basis for meeting the Maternal Mortality Review Program's goals in accordance with the bill's requirements. Further, the bill allows the Secretary to contract with the Med-Chi faculty, in consultation with the Maternal Child Health Committee, to develop the program. These contracted services could increase future general fund expenditures depending on the services needed. The increase cannot be reliably estimated at this time.

Additional Information

Prior Introductions: None.

Cross File: SB 459 (Hollinger, *et al.*) - Economic and Environmental Affairs.

Information Source(s): Department of Health and Mental Hygiene (Vital Statistics, Community and Public Health), Department of Legislative Services

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