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

SPONSOR Lopez **ORIGINAL DATE** 02/21/11 **LAST UPDATED** **HB**

SHORT TITLE Substance Abuse & Family Planning Services **SB** 353

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		*Unknown	*Unknown		Recurring	General Fund and/or Medicaid

(Parenthesis ( ) Indicate Expenditure Decreases)

*See Fiscal Implications

SB353 relates to SB354, Substance Abuse and Pregnant Women Services and HM14, Substance Abuse & Prenatal Care Task Force.

SOURCES OF INFORMATION

LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of Bill

Senate Bill 353 (SB353) proposes a new section to the Family Planning Act which would require any publicly funded health care facility that provides substance abuse treatment to assess whether a patient is in need of family planning services and provide these services or refer the patient for family planning services if they are not available at the health care facility.

FISCAL IMPLICATIONS

The Human Services Department/Behavioral Health Services Division (BHSD) indicates SB353 provides for an additional service, family planning services, that may not be supported by existing public funding streams.

Currently, family planning services are covered through Medicaid if all the following criteria are met:

- The patient is Medicaid-eligible;
- The provider is providing services in accordance with his or her license; and

- The provider must be credentialed as a Medicaid provider of that service through the NM Medicaid fiscal agent or as a network provider of a Medicaid Salud! managed care organization.

SB353 would require DOH operated substance abuse treatment programs to develop systems to assess need, formally identify referral sources and offer referrals for family planning services to those patients that express interest.

SIGNIFICANT ISSUES

The Department of Health (DOH) operates four health care facilities that provide substance abuse treatment services: Fort Bayard Medical Center (Yucca Lodge), Turquoise Lodge Hospital, New Mexico Rehabilitation Center and Sequoyah Adolescent Treatment Center. Currently, the substance abuse treatment programs provide limited referral information to family planning resources when patients express a need. Turquoise Lodge Hospital does have a family process group that meets every Saturday.

The Human Services Department indicates SB353 is derived from the recommendations of the SM19 Task Force (2010). The SM19 Task Force included in its final report (November 2010) the recommendation to incorporate assessment of need for contraceptive services and medical care at intake at substance abuse treatment centers and detention centers, and to link women in need to necessary services. *(SM 19 Task Force Final Report November 2010; Policy Recommendation II. Increase Access to Quality Substance Abuse Treatment, Prenatal Care and Family Planning for Women; Part f. Incorporate assessment of need for contraceptive services and medical care at intake for substance abuse treatment centers and detention centers, link women in need to necessary services).*

ADMINISTRATIVE IMPLICATIONS

The Human Services Department/BHSD indicates under the provisions of SB353, BHSD would need to direct the statewide entity (i.e, Optum Health NM) to add this requirement to its community provider contracts.

SB353 would require Department of Health (DOH) staff time to develop a formal assessment process for family planning need and to develop and implement in the DOH operated substance abuse treatment programs. SB353 would also necessitate the need for additional training of medical staff from the publicly funded health facilities that provide a substance abuse treatment program to properly assess the client's family planning needs.

TECHNICAL ISSUES

HSD/BHSD indicates that SB353 as currently drafted only applies to publicly funded health facilities which are Community Mental Health Centers (CMHCs) and Alcohol and Drug Abuse Treatment Hospitals. The SM19 Task Force report discussed participation in the Family Planning Act by all substance abuse treatment providers funded by BHSD and managed by the statewide entity.

OTHER SUBSTANTIVE ISSUES

The Department of Health indicates maternal use of these substances during early pregnancy (4–6 weeks' gestation) exposes the fetus to a range of adverse outcomes. While most women discontinue drinking after learning that they are pregnant, approximately one-half of all

pregnancies are unplanned, and most women do not know they are pregnant until 4–6 weeks after conception. Thus, even among women inclined and capable of discontinuing drinking after learning they are pregnant, a high percentage of pregnancies are alcohol exposed. Approximately 15 percent of women continue to drink after learning they are pregnant, the actual total number of alcohol-exposed pregnancies is probably significantly higher than this number suggests. One of the strongest predictors of substance use during pregnancy is substance use before pregnancy. (Day et al. 1993; Floyd et al. 1999)

Substance abuse during pregnancy can lead to increased obstetric risks which can affect both maternal and child health. These health risks can be broken down into the medical conditions commonly co-occurring in substance-abusing women and those that primarily relate to the pregnancy. Some of the medical conditions linked to substance abuse include anemia, infections, depression/anxiety, diabetes and sexually transmitted infections. Obstetric complications include placental abruption, uterine infections, fetal growth restriction, fetal hypoxia and brain injury, neonatal abstinence, miscarriage, stillbirth, preterm labor and hypertensive disorders/preeclampsia. (Helmbrecht 2008) Rates of these co-morbid conditions and complications are higher in substance-abusing women compared to the general population, yet these women are less likely to obtain regular prenatal care due to active substance abuse, stigma and logistical barriers to care.

Addiction disorders in pregnancy present a unique challenge and public health dilemma as the rights and health needs of the pregnant, substance-abusing mother must be balanced with optimizing health outcomes for her fetus and family. Though rates of substance abuse typically decline in pregnancy, several studies estimate that as many as 4% of pregnant women continue to use alcohol and/or illicit substances throughout pregnancy (Helmbrecht G.D. and Thiagarajah S. (2008); Management of addiction disorders in pregnancy. J Addict Med, 2 (1); 1-16).

New Mexico may have even higher rates as the PRAMS data from 2004-05 indicated that 6% of all pregnant women surveyed used alcohol in the last 3 months of pregnancy (New Mexico Pregnancy Risk Assessment Monitoring System Surveillance Report: http://www.health.state.nm.us/phd/prams/home.html). Specific data on rates of illicit substance abuse in pregnant women in New Mexico is lacking, but in other states it is approximately 3% (Hawaii and Alaska Pregnancy Risk Assessment Monitoring System Data: http://hawaii.gov/health/family-child-health/mchb/prams-doc/perinatal and http://www.epi.alaska.gov/mchepi/PRAMS/default.stm). Therefore, using PRAMS estimates, of the 30,605 births to New Mexican women in 2007, approximately 1,836 would have been to women using alcohol in the last 3 months of pregnancy and 918 to women using an illicit substance in the last 3 months of pregnancy. This does not account for likely overlap between these two groups nor does it account for early pregnancy exposure to alcohol or drugs.

Because many women's plans change over time, creating a reproductive health plan requires an ongoing conscientious assessment of the desirability of a future pregnancy, determination of steps that need to be taken either to prevent or to plan for and optimize a pregnancy, and evaluation of current health status and other issues relevant to health of a pregnancy (American College of Obstetrics and Gynecologists. The importance of preconception care in the continuum of women's health care: ACOG Committee Opinion No: 313. Obstet Gynecol 2005;106:665-6).

RAE/bym