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U.S. Government Accountability Office

Maternal Health: Information on and Federal Oversight of Mortality Review Committees

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Q&A Report to Congressional Requesters
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Why This Matters

The U.S. faces a maternal mortality crisis, with mortality rates that exceed every other high-income country. More than 600 women die during pregnancy or from causes aggravated by pregnancy each year in the U.S.; over 80 percent of these deaths are preventable, according to the Centers for Disease Control and Prevention (CDC), within the U.S. Department of Health and Human Services (HHS). In addition, there are persistent racial and ethnic disparities in these deaths, with both Black and American Indian/Alaska Native women experiencing deaths at a rate of 2.5 or more times higher than White women, according to our previous work and data from the CDC.

To help prevent these kinds of deaths, CDC provides funding for state and local health agencies to support and maintain Maternal Mortality Review Committees (MMRCs). These committees review deaths that occur during pregnancy or within a year of the end of pregnancy to identify factors contributing to these deaths and to develop recommendations to prevent similar deaths. All states, as well as some territories and localities, have established MMRCs to review these deaths within their respective jurisdictions.

We were asked to provide information on MMRCs and federal oversight of them. This report provides information on whether MMRCs consider laws and policies when reviewing factors that contribute to maternal mortality and in making recommendations to reduce it. It also examines CDC's efforts to evaluate the MMRCs.

Key Takeaways

- MMRCs consider federal and state laws and policies, and a variety of additional information, in their reviews to identify factors that contribute to maternal mortality and to recommend future actions to prevent these deaths.
- They then make recommendations to a range of entities including providers, hospitals, or state policymakers in publicly available reports. Selected MMRCs we examined made recommendations in areas including care coordination, mental health and substance use, and reproductive health. Some recommendations suggested changes to state laws.
- To monitor and assess MMRCs, CDC has incorporated key performance management practices identified in prior GAO work: 1) establishing long-term and near-term goals, 2) establishing performance measures, and 3) using performance information to assess results.

What are Maternal Mortality Review Committees?

MMRCs are multidisciplinary committees that convene at the state or local level to comprehensively review deaths that occur during or within one year of the end of pregnancy. (See app. I for the number of deaths and maternal mortality rate by

state.) They typically operate under the authority of a state department of health, and they are generally partially funded and overseen federally by CDC.

MMRCs include representatives in clinical and non-clinical fields from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, mental and behavioral health, patient advocacy groups, and community-based organizations.

How do MMRCs conduct their reviews?

According to CDC officials and selected MMRC reports, MMRCs typically follow the same general process when reviewing deaths related to pregnancy: they review a variety of sources of information to identify what factors contributed to each death and then discuss this information to recommend future actions to prevent similar deaths. More specifically, for each review:

The state or local health department staff are first responsible for the following activities:

- identifying all deaths of women while pregnant or within one year of pregnancy, regardless of the cause of death;[1] and
- requesting and then examining relevant records, including death certificates, medical records, social service records, and other sources to extract information for the MMRC to review. Other sources of information may include autopsy reports, if available, and informant interviews of family or close contacts of the woman to better understand the circumstances in which she died. This information is entered into CDC's MMRC data system and identifying information is removed when it is shared with the MMRC members.

Then, the MMRC typically meets to discuss this information to determine

- the cause of death,
- whether the death was caused by the pregnancy or aggravated by the conditions of pregnancy,
- whether the death was preventable,
- factors contributing to the death, and
- recommendations to prevent future deaths. Recommendations may be directed to pregnant or postpartum women and their families, providers, hospitals, or state policymakers, among others.

These MMRC determinations are recorded in CDC's MMRC data system, according to CDC documentation.[2] CDC suggests that MMRCs conduct their reviews within 2 years of the death; thus, in 2025, MMRCs aimed to complete reviews of deaths that occurred in 2023.

While MMRCs generally follow this review process, MMRCs may differ by state or locality in the number and types of representatives on the committee, how often the committee meets, the number of deaths they review, and the ability to conduct informant interviews.

States or localities also publish reports of MMRC findings that describe the number of deaths reviewed and demographic characteristics of those deaths, contributing factors to those deaths, and recommendations to prevent future deaths. These reports may be legislatively mandated by the state or locality and addressed to state or local policymakers. These reports differ by state or locality

in the frequency of publication, the years of deaths covered, and any recommendations that were made.

MMRCs themselves do not implement recommendations, but they may collaborate with other organizations such as state health departments, medical professional societies, and community-based organizations to help implement recommendations.

Do MMRCs consider laws and policies in their reviews?

According to the MMRC representatives we interviewed, MMRCs do consider whether federal and state laws and policies could be factors that affect maternal mortality, both when examining individual deaths in their internal deliberations, and subsequently, when making recommendations in public reports.

Representatives from all 10 MMRCs in our review said they consider state and federal laws or policies when discussing factors that contribute to a death and in making recommendations to try to prevent similar deaths.[3] This could include recommending changes in existing laws or policies or recommending that new laws or policies be adopted. For example:

- Representatives we interviewed from one MMRC said changing existing state law to expand health care coverage could help save maternal lives by providing access to treatment to reduce chronic disease, such as severe hypertension, that can underlie maternal mortality. This MMRC recommended, and the state later enacted, extended Medicaid coverage for women to 12 months postpartum.[4] Representatives we spoke with from four other MMRCs said their states had extended Medicaid coverage for women to 12 months postpartum due to similar recommendations from MMRCs. According to KFF (formerly Kaiser Family Foundation), 49 states and the District of Columbia have extended Medicaid to include such coverage as of July 2026.[5]
- Representatives from another MMRC said they frequently recommended establishing a home visiting program to provide care at home during pregnancy or the postpartum period to improve maternal health in this period. This state subsequently enacted such a program.

According to representatives from two of the 10 MMRCs in our review, their MMRCs consider the sensitivity of issues, such as restrictions to reproductive health, and as a result may adjust their language when making recommendations or presentations to state legislators. For example, one MMRC representative said the MMRC would likely avoid using the word abortion in recommendation language and instead focus the recommendation wording on contraception.

What do the selected MMRCs commonly recommend?

We found the 10 MMRCs in our review commonly made recommendations in five areas (see fig. 1), according to our review of the most recently published reports from these MMRCs.[6] These reports include data on deaths that occurred from 2014 through 2023.

Figure 1: Common Areas of Selected Maternal Mortality Review Committee Recommendations

Source: GAO analysis of maternal mortality review committee reports; Icons-Studio/stock.adobe.com (icons). | GAO-26-108690

Note: We reviewed publicly available reports from a nongeneralizable sample of 10 Maternal Mortality Review Committees. These reports range in publication dates from 2021 through 2025.

Care coordination. Reports from all (10 of 10) MMRCs we selected had at least one recommendation related to care coordination, the clinical practice of deliberately organizing patient care activities and sharing information among a patient's care team to achieve safer and more effective care. CDC found in its 2026 review of MMRC data that a lack of continuity of care was a common contributing factor to deaths from infections, and highlighted MMRC recommendations to enhance care coordination within and across systems.[7] Our review found:

- Nine MMRCs recommended referring patients to additional medical care, including referral to primary care or other providers when needed. For example, one MMRC recommended that maternal care providers educate themselves and patients about the link between hypertensive disorders of pregnancy and cardiovascular disease and provide appropriate referrals for surveillance of these conditions.

- Nine MMRCs also recommended referrals to other services, including community resources, social work support, and nutrition counseling. For example, one MMRC recommended screening for social determinants of health, including housing and safety, and to make “warm handoff” referrals between health care team members when needed, which can help avoid communication breakdowns that may lead to medical errors.[8]

Mental health and substance use. Reports from most (nine of 10) MMRCs had at least one recommendation related to mental health or substance use disorders. A recent study found that unintentional drug overdose and suicide were among the leading causes of death among pregnant and postpartum women from 2018 to 2023.[9] Our review found:

- Six MMRCs recommended mental health or substance use screenings. For example, one MMRC recommended routine screening for mental health conditions and “warm handoff” referrals when treatment was needed. It also recommended the use of peer navigators to help engage and retain patients in treatment.

- Three MMRCs made recommendations in this area directly to their state legislatures. For example, one MMRC recommended the legislature fund a psychiatry inpatient program for pregnant and postpartum women.

Health equity. Reports from most (nine of 10) MMRCs made at least one recommendation related to health equity, including providing culturally responsive care that considers the diverse needs of various racial and ethnic groups and addressing the effect of racism to help improve health outcomes. Implicit bias, social determinants of health, and systemic racism can lead to

disparities by race in health outcomes, including maternal mortality, according to the American College of Obstetricians and Gynecologists.[10] Our review found:

- Eight of our 10 selected MMRCs recommended that hospitals and health systems provide training on implicit bias or cultural competency. For example, one MMRC recommended that health care systems train staff on implicit bias, integrate interpreters, and provide care that is respectful of cultural differences.

- One MMRC recommended ensuring the representation of American Indian/Alaska Native people in the planning for, and implementation of, improvements in maternity care. The MMRC cited an increased risk of maternal mortality for American Indian/Alaska Native people compared to other populations as a reason for this focus. (For more information on these health disparities, see text box below.) This MMRC also recommended establishing government relationships with tribal programs that serve American Indian/Alaska Native birthing and postpartum people on reservations.

Tribally Led Maternal Mortality Review Committee
In response to the issues facing the American Indian/Alaska Native population, as of June 2026 the Centers for Disease Control and Prevention (CDC) and numerous tribal partners were exploring the feasibility of establishing a tribally led Maternal Mortality Review Committee to better understand and address the needs of this population. American Indian/Alaska Native women are more likely than White women to have underlying chronic health conditions and experience sexual or interpersonal violence, and also often experience discrimination or racism, according to CDC. They often face systemic barriers to care, including higher rates of poverty and longer distances to quality health care services, which can contribute to maternal mortality.

Source: Information from the CDC. | GAO-26-108690

Reproductive health. Reports from most (eight of 10) MMRCs had at least one recommendation related to reproductive health, including family planning and contraception. According to a systematic review of multiple studies in 2022, unintended pregnancy, compared with intended pregnancy, is associated with adverse maternal outcomes, including being the victim of violence, which can in turn increase the risk of death.[11] Our review found:

- Three MMRCs recommended education on, or access to, contraceptive options.

- Two MMRCs recommended comprehensive reproductive health care, while two other MMRCs recommended comprehensive sex education. For example, one MMRC made a recommendation that community and health care systems implement universal health care coverage that includes comprehensive reproductive health care.

Health care workers. Reports from most (eight of 10) MMRCs had at least one recommendation related to increasing access to, or reimbursement for, health care workers, including doulas, home visitors, and public health nurses. Recruiting and retaining a strong and skilled maternal health workforce is one way to increase access, improve quality of care, and reduce maternal mortality and morbidity, according to the National Conference of State Legislatures.[12] Our review found:

- Eight MMRCs recommended increased access to or reimbursement from Medicaid and private payors for doulas, which are trained professionals that support and advocate for mothers during and after childbirth.

- Six MMRCs recommended increasing access to or reimbursement for home visiting services, including Medicaid reimbursement and access to home visitors for rural communities.

How are MMRCs funded?

Since 2019, CDC has provided funding to support and maintain MMRCs through its Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program.[13] The program supports MMRC efforts to systematically and comprehensively review deaths and to develop recommended strategies to prevent future deaths, according to CDC documentation. CDC also supports MMRCs with the aim of standardizing data collection and making public aggregate data on deaths related to pregnancy. For the first 5-year funding cycle from 2019 through 2024, CDC provided about $65 million to 46 recipients for the ERASE MM program, according to agency officials. Over the second 5-year funding cycle from 2024 to 2029, CDC plans to provide about $134 million to 52 recipients (46 states and six territories).[14]

In addition, states may fund MMRCs from state funding or choose to use funding from the Title V Maternal and Child Health Services Block Grant to support MMRCs, according to officials from the Health Resources and Services Administration within HHS.[15]

How does CDC monitor MMRCs?

CDC monitors MMRCs that receive its ERASE MM funding through various means, including holding regular meetings, reviewing required reports, and conducting site visits. CDC monitoring is intended to ensure MMRC activities meet the intention of the program and to identify successes or challenges to help target support to MMRCs.

According to CDC documentation and MMRC representatives, CDC conducts the following MMRC monitoring activities:

- **Holding regular meetings.** CDC project officers regularly meet virtually with MMRCs to address any questions and monitor MMRC progress, including updating the MMRCs on deadlines or informing them about what MMRCs in other states or localities are doing.

  CDC also hosts regular virtual office hours for MMRC staff with specific roles, including separate meetings for data analysts, staff who summarize information for mortality reviews, and staff that interview families or close contacts of the women whose deaths are being reviewed. Officials from any MMRC, even those that are not recipients of funds from the ERASE MM program, can participate in these office hours, according to CDC officials.
- **Reviewing required reports and information.** As a condition of funding, MMRCs must submit certain reports and information to CDC. CDC officials review these reports, which should include:
  - financial reports that include authorized and disbursed funds,
  - progress reports with annual performance measure data and information used to assess program performance, and
  - work plans, which include the activities the MMRCs plan to conduct, with timelines for accomplishing those activities. CDC monitors these work plans to ensure they are feasible based on budget resources and consistent with the intent of the ERASE MM program.

  CDC officials also regularly review MMRC data and qualitative information submitted through CDC's data system. They do this to help improve MMRC

review processes and data quality and to identify common opportunities for preventing maternal mortality across states. For example, CDC found in its 2026 review of MMRC data that a delay in accessing care was a common contributing factor to deaths from infections. CDC further identified one MMRC's recommendation to address the issue by expanding ways to access medical care, including through telehealth, follow-up phone calls, and mobile clinics.[16]

- **Conducting site visits**. CDC conducts in-person and virtual site visits to MMRCs to observe MMRC meetings and provide feedback on how to improve maternal mortality review processes. For example, representatives from one MMRC told us CDC officials observed an MMRC meeting during an in-person site visit and provided feedback that helped the MMRC identify not only immediate causes of death, but also potentially complex patient, provider, facility, community, and system-level contributing factors.

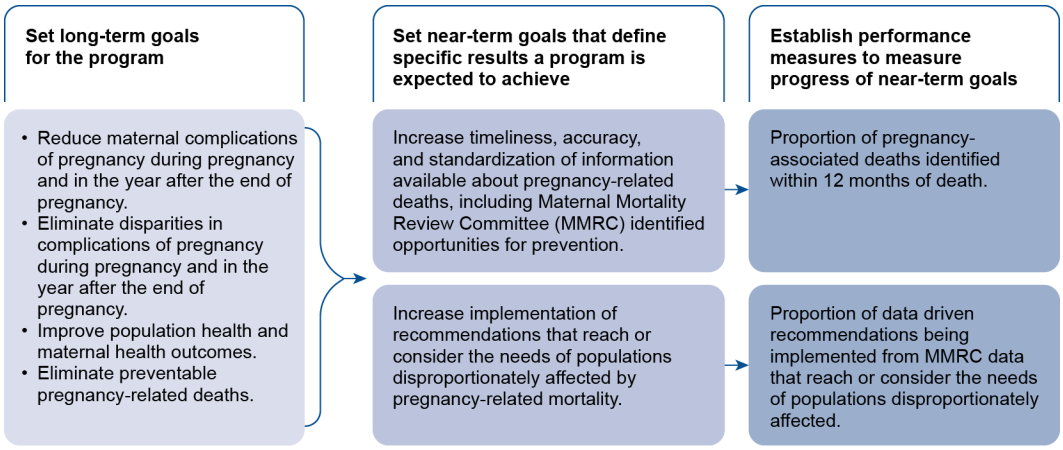
  CDC also hosts an annual "reverse site visit" in which MMRC representatives travel to CDC headquarters. CDC coordinates MMRC-led presentations and discussions among MMRCs intended to share best practices and lessons learned. For example, one MMRC presented on how to balance clinical and non-clinical perspectives among MMRC members to account for both medical issues and the social determinants of health that may have contributed to the death. At the 2025 "reverse site visit," CDC hosted one training session day for newly established MMRCs in the U.S. Pacific Island territories to help them set up processes to review deaths.

How does CDC assess performance of MMRCs?

Based on our review of program documentation and interviews with agency officials, we found that to assess MMRC performance in the ERASE MM program, CDC has incorporated key performance management practices identified in prior GAO work: 1) establishing long-term and near-term goals, 2) establishing performance measures, and 3) using performance information to assess results.[17]

Specifically, CDC has established four long-term goals for the MMRCs, as well as near-term goals identifying the specific results the agency seeks to achieve.[18] CDC has also established performance measures for tracking progress on these goals and collects data on these measures. These efforts align with key federal performance management practices. See figure 2 for an example of how goals and performance measures are linked and appendix II for more detail on the various goals and performance measures.

Figure 2: Examples of Linkages between Selected Goals and Measures in CDC's Performance Assessment of Recipients in its ERASE MM Program



Source: GAO analyis of Centers for Disease Control and Prevention (CDC) information. | GAO-26-108690

Note: CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program provides funding to support and maintain MMRCs.

Establish goals. CDC established four long-term goals that identify desired outcomes for the ERASE MM program and set a general direction for the program's efforts, in keeping with key practices for successful performance management. In addition, CDC established five near-term goals against which performance can be measured, another key performance practice. These goals are being assessed for the performance period for the current funding cycle, September 2024 through September 2029.

Establish performance measures. CDC established 15 performance measures for measuring MMRC performance, 11 of which have specific quantitative targets and time frames. Setting such measures is another key aspect of successful performance assessment, GAO has found.[19] According to CDC officials, four of the newer performance measures do not yet have targets. CDC officials said the agency needed to collect enough data about progress on these newer measures to develop targets that are meaningful and feasible, a process officials say is now beginning. (See app. II for more information on performance measures).

Representatives we spoke with from nine of 10 MMRCs in our review said that in general, they view CDC's performance measures as fair representations of MMRC work, though officials noted that certain measures are hard to track. For example, nine of the 10 MMRCs we interviewed told us they found it difficult to track performance measures related to the implementation of recommendations. One MMRC stated that the number of recommendations being implemented has been difficult for them to determine because it is hard to know from publicly available information if, when, and by whom the implementation of a recommendation occurs.

CDC officials said they are aware of this challenge and provide technical assistance to MMRCs and tools for them to use, regarding sharing recommendations with community stakeholders and tracking the implementation of recommendations. In addition to seeking CDC support, all MMRCs we reviewed shared other actions they have taken to track and implement recommendations. For example, five MMRCs told us that they work with their state's perinatal quality collaborative—state-based, multidisciplinary teams that work to improve outcomes for maternal and infant health—to implement recommendations.

Assess results. CDC collects information, such as progress reports with performance measure data, to evaluate MMRC progress. Officials annually review each performance measure for each MMRC and analyze the measures against associated targets, according to CDC documentation. Then CDC compiles information by MMRCs for internal planning and for technical assistance to all MMRCs, according to officials.

According to agency officials, CDC also reviews performance measures at the end of each funding cycle to determine overall program performance in achieving results and to consider any changes or additions to the measures. Officials told us that in these reviews, CDC considers input such as each MMRC's strategies and actions spelled out in their funding applications and feedback from the MMRCs.

In addition, to determine the effectiveness of the ERASE MM program and guide efforts for improvement, CDC contracted with an external evaluator to develop an evaluation plan. The plan was completed in 2024. According to CDC documentation, the evaluation aims to understand how the ERASE MM program has contributed to changes in awareness of maternal mortality prevention recommendations, public health capacity, and changes in policies, programs, and services that affect maternal health outcomes.

As of July 1, 2026, according to CDC officials, the agency had not allocated funding for the ERASE MM program evaluation plan. CDC officials said that before the evaluation plan could be implemented, the agency needs to make further revisions and refinement to align with administration priorities. In addition, CDC would have to explore funding availability for the evaluation, according to agency officials.

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS did not have any comments on the report.

How GAO Did This Study

To conduct our work, we reviewed the most recent publicly available reports as of December 2025 from a nongeneralizable sample of 10 MMRCs.[20] These reports ranged in publication dates from 2021 through 2025 and reviewed deaths that occurred from 2014 through 2023. We reviewed reports and interviewed state agency officials or members of the MMRCs from these 10 states: Alaska, California, Georgia, Illinois, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, and Pennsylvania. We selected these states to obtain variation in certain characteristics, including geographic location, number of maternal deaths, maternal mortality rate, and racial and ethnic distribution within the state.

To review the reports from selected MMRCs, we conducted a systematic content analysis using NVivo, a qualitative analysis software program, to identify common themes. First, we created an initial codebook of themes. Because content analysis relies on the judgment of coders to determine whether qualitative data reflect particular themes, two analysts tested the draft coding scheme by separately coding four MMRC reports using NVivo. When complete, they compared notes and made edits to develop a final codebook. Using the final codebook to code the reports, one analyst independently coded each report, and a second analyst reviewed the codes to ensure objectivity, accuracy, and consistency.

We interviewed officials representing the selected state MMRCs, including state agency officials and committee members, for information on MMRCs, whether they consider laws and policies in their review process, and interactions with CDC officials who oversee the ERASE MM program.

We also reviewed relevant documents from CDC and interviewed CDC officials who oversee the ERASE MM program. Documentation from CDC included the ERASE MM program notice of funding opportunity (a public document that outlines the requirements for applicants and how applicants will be evaluated), CDC guidance documents, performance measure data dictionary, CDC's evaluation plan, and reports of CDC analyses using MMRC data. We interviewed CDC officials to learn more about CDC monitoring of MMRCs and performance management activities conducted to oversee the ERASE MM program. We assessed CDC's efforts against key performance management practices identified in prior GAO work. Specifically, our past work has defined performance management as a three-step process by which organizations 1) set goals to identify the results they seek to achieve, 2) collect performance information to measure progress, and 3) use that information to assess results and inform decisions to ensure further progress towards achieving those goals.[21]

For background and additional context, we interviewed stakeholder organizations that had worked with or conducted research on MMRCs. These stakeholders are the Association of Maternal and Child Health Programs, Black Mamas Matter Alliance, National Academy for State Health Policy, National Indian Health Board, and the Society for Maternal-Fetal Medicine.

We conducted this performance audit from August 2025 to September 2026 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

List of Addressees

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Jon Ossoff
United States Senate

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at https://www.gao.gov.

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Appendix I

This appendix provides additional information on maternal mortality rates, based on our analysis of the Centers for Disease Control and Prevention's (CDC) National Vital Statistics System data. See table 1 for maternal mortality rates by state. Table 1 includes the number of deaths of women while pregnant or within 42 days of termination of pregnancy, which aligns with CDC's definition of "maternal death." However, Maternal Mortality Review Committees (MMRCs) review pregnancy-related deaths that occur during pregnancy or within a year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the effects of pregnancy. Thus, these data do not include all of the deaths that MMRCs review.

We used the vital statistics mortality data and diagnostic code numbers A34, O00-O95, and O98-O99 of the *International Classification of Diseases, 10th Revision* to identify maternal deaths, which are based on the underlying cause of death listed on the death certificate.

We obtained the mortality and live births data from the online data access portal, CDC WONDER. We used these data to calculate the mortality rate—the number of deaths per 100,000 live births. We aggregated mortality and live birth data starting in 2018, because of changes in data collection and coding for maternal deaths revised as of 2018, and through 2024, the most recent full year of data. We analyzed these data by state to calculate the number and rate of deaths.

To the extent possible, we present this information by state-level jurisdiction. In some cases, certain jurisdictions have counts of less than 10 and are suppressed by CDC WONDER. (Data suppression is defined as when a record or certain parts of a record are not included in the data query to ensure that data cannot be re-identified.) Such suppressed information is noted as not available in table 1.

Table 1: Maternal Mortality Number and Rate by State, 2018–2024

State	Number of maternal deaths	Maternal mortality rate (per 100,000)	95 percent confidence interval
Alabama	130	32.0	26.5, 37.5
Alaska	17	25.7[a]	15.0, 41.2
Arizona	149	27.1	22.7, 31.4
Arkansas	87	34.7	27.8, 42.8
California	326	11.0	9.8, 12.2
Colorado	67	15.3	11.8, 19.4
Connecticut	37	15.3	10.7, 21.0
Delaware	—	—	—
District of Columbia	16	26.9[a]	15.4, 43.7
Florida	343	22.3	19.9, 24.7
Georgia	256	29.2	25.6, 32.8
Hawaii	18	16.3[a]	9.7, 25.8
Idaho	27	17.4	11.4, 25.3

Illinois	164	17.6	14.9, 20.3
Indiana	161	28.8	24.3, 33.2
Iowa	48	18.6	13.8, 24.7
Kansas	49	20.1	14.9, 26.6
Kentucky	115	31.2	25.5, 37.0
Louisiana	145	36.4	30.5, 42.4
Maine	10	12.1[a]	5.8, 22.2
Maryland	94	19.7	15.9, 24.1
Massachusetts	73	15.3	12.0, 19.2
Michigan	130	17.9	14.8, 20.9
Minnesota	57	12.7	9.6, 16.4
Mississippi	88	35.6	28.6, 43.9
Missouri	119	24.4	20.0, 28.8
Montana	21	26.9	16.6, 41.1
Nebraska	40	23.2	16.6, 31.6
Nevada	46	19.5	14.3, 26.1
New Hampshire	13	15.5[a]	8.2, 26.5
New Jersey	170	24.1	20.5, 27.7
New Mexico	36	23.5	16.5, 32.5
New York	321	21.6	19.3, 24.0
North Carolina	211	25.1	21.7, 28.5
North Dakota	15	21.4[a]	12.0, 35.3
Ohio	208	22.8	19.7, 25.9
Oklahoma	95	28.0	22.7, 34.2
Oregon	48	17.0	12.6, 22.6
Pennsylvania	147	16.0	13.4, 18.6
Rhode Island	15	21.0[a]	11.8, 34.7
South Carolina	118	29.4	24.1, 34.7
South Dakota	16	20.1[a]	11.5, 32.7
Tennessee	213	37.3	32.3, 42.3
Texas	710	26.6	24.7, 28.6
Utah	41	12.7	9.1, 17.2
Vermont	—	—	—
Virginia	190	28.4	24.3, 32.4
Washington	100	17.1	13.7, 20.4
West Virginia	29	23.9	16.0, 34.3
Wisconsin	61	14.2	10.9, 18.3
Wyoming	13	29.8[a]	15.9, 51.0
United States	5613	21.8	21.3, 22.4

"—" indicates that data were not available.

Source: GAO analysis of data from the Centers for Disease Control and Prevention, National Center for Health Statistics. | GAO-26-108690

Notes: The data table shows maternal deaths, which according to the Centers for Disease Control and Prevention, is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Maternal deaths are assigned to code numbers A34, O00–O95, and O98–O99 of *the International Classification of Diseases, 10th Revision*. However, Maternal Mortality Review Committees (MMRCs) review pregnancy-related deaths that occur during pregnancy or within a year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the effects of pregnancy. Thus, these data do not include all of the deaths that MMRCs review.

The 95 percent confidence intervals are noted in the last column and provide information on random variation, which are possible results that could have arisen under the same circumstances.

[a]The maternal mortality rate is based on fewer than 20 deaths and should be interpreted with caution.

Appendix II

The Centers for Disease Control and Prevention set long-term and near-term goals and established performance measures for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Program in the 2024 Notice of Funding Opportunity. See table 2 for the long-term goals and near-term goals and their related performance measures.

Table 2: Goals and Performance Measures for CDC's Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Program

Long-Term Goals	Near-Term Goals[a]	Performance Measures
Reduced maternal complications of pregnancy during pregnancy and in the year after the end of pregnancy. Eliminated disparities in complications of pregnancy during pregnancy and in the year after the end of pregnancy. Improved population health and maternal health outcomes. Eliminated preventable pregnancy-related deaths.	Increased timeliness, accuracy, and standardization of information available about pregnancy-related deaths, including maternal mortality review committees (MMRC) identified opportunities for prevention.	Proportion of pregnancy-associated deaths identified within 12 months of death. Proportion of deaths identified for committee review, fully abstracted, and ready for review within 18 months of death. Proportion of deaths identified for committee review, reviewed within 24 months of death. Proportion of death records with a pregnancy checkbox error that are corrected.[b] Proportion of cases reviewed by the committee that include information from an informant interview.[b] Proportion of recommendations from pregnancy-related deaths that include What/Who/When statements.[c]
	Increased implementation of recommendations that reach or consider the needs of populations disproportionately affected by pregnancy-related mortality.	Proportion of data-driven recommendations being implemented from MMRC data that reach or consider the needs of populations disproportionately affected.[b]
	Increased engagement and cooperation between MMRCs, partners, and communities to communicate information from data on pregnancy-related deaths.	Proportion of MMRC committee members with clinical expertise to those with non-clinical expertise. Number of MMRC committee members that represent populations most affected by pregnancy-related mortality.[b] Number of engagements with communities most affected by pregnancy-related mortality.
	Increased adoption of clinical and nonclinical policies and programs that reflect the highest standards of care.	Number of data driven clinical recommendations being implemented from MMRC data. Number of data driven non-clinical recommendations being implemented from MMRC data.
	Increased availability of MMRC recommendations among communities, clinicians, public health practitioners, and decision makers	MMRC data analysis on leading causes of pregnancy-related death stratified by populations most affected by pregnancy-related mortality. Number of MMRC data products. Number of dissemination of MMRC data products.

Source: Information from the Centers for Disease Control and Prevention (CDC). | GAO-26-108690

[a]CDC established short-term and intermediate goals. For the purposes of our report, we group those together as "near-term goals."

[b]Performance measure does not yet have a target.

[c]Each MMRC recommendation should be actionable and structured in the form (Who?) should (do what?) (when?), according to CDC guidance.

Endnotes

[1]Throughout this report, we use the term "women" based on definitions in the data sources.

[2]All MMRCs can use CDC's MMRC data system, regardless of whether they receive CDC funding.

[3]We reviewed publicly available reports from a nongeneralizable sample of 10 MMRCs. We reviewed reports and interviewed state agency officials or members of the MMRCs from Alaska, California, Georgia, Illinois, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, and Pennsylvania. We selected these states to ensure variety in characteristics including geographic location, number of deaths to review, maternal mortality rate, and racial and ethnic distribution of the state.

[4]States are required to cover all pregnancy-related and postpartum medical assistance for eligible women for a 60-day period following the end of a pregnancy. See 42 U.S.C. § 1396a(e)(5). The American Rescue Plan Act of 2021 allowed states the option to extend full Medicaid benefits to eligible women for 12 months postpartum; the law stated this option would be available for five years, beginning in April 2022. Pub. L. No. 117-2, § 9812, 135 Stat. 4, 212. The Consolidated Appropriations Act, 2023, made this option permanent. Pub. L. No. 117-328, § 5113, 136 Stat. 4459, 5940 (2022). See also 42 U.S.C. § 1396a(e)(16). Medicaid is a joint federal-state program that finances health care coverage for certain low income and medically needy individuals.

[5]KFF. Medicaid Postpartum Coverage Extension Tracker. Jul. 15, 2026.

[6]We reviewed publicly available reports from a nongeneralizable sample of 10 MMRCs. These reports range in publication dates from 2021 through 2025.

[7]Naima T. Joseph et al. “Pregnancy-Related Mortality Due to Infection,” *Obstetrics and Gynecology*, 2026:1–9. doi:10.1097/AOG.0000000000006172.

[8]A “warm handoff” is a transition of care, conducted in person, between two members of the health care team, in front of the patient (and family if present), according to the Agency for Healthcare Research and Quality, Department of Health and Human Services.

[9]Hooman A. Azad et al. “Overdose, Homicide, and Suicide as Causes of Maternal Death in the United States." *New England Journal of Medicine*, vol. 394, no. 7 (2026): 722-723. doi: 10.1056/NEJMc2512078. In addition, a CDC analysis of MMRC data found mental health conditions, including substance use disorders, were the most frequent underlying cause of pregnancy-related deaths. See CDC, *Pregnancy-Related Deaths: Data From Maternal Mortality Review Committees in 38 U.S. States, 2020,* May 28, 2024.

[10]American College of Obstetricians and Gynecologists Committee “Statement No. 10: Racial and Ethnic Inequities in Obstetrics and Gynecology,” *Obstetrics & Gynecology*, vol.144, no. 3 (2024):e62-e74. doi: 10.1097/AOG.0000000000005678.

[11]Heidi D. Nelson et al. “Associations of Unintended Pregnancy With Maternal and Infant Health Outcomes: A Systematic Review and Meta-analysis.” *JAMA*, vol. 328, no. 17 (2022):1714-1729. doi: 10.1001/jama.2022.19097 and Hooman A. Azad et al. “Overdose, Homicide, and Suicide as Causes of Maternal Death in the United States." 722-723.

[12]National Conference of State Legislatures. *Workforce Supports: Improving Maternal Health Outcomes*. Washington, D.C.: 2024.

[13]The Preventing Maternal Deaths Act of 2018 authorized CDC to create a program to support states, Tribes, and tribal organizations in establishing or operating MMRCs, among other activities; the program was authorized for fiscal years 2019 to 2023. Pub. L. No.115-344, § 2, 132 Stat. 5047; see also 42 U.S.C. § 247b-12. The Consolidated Appropriations Act, 2026, authorized the program through fiscal year 2030. Pub. L. No. 119-75, § 6501, 140 Stat. 173, 689.

[14]CDC funds MMRCs in all states except Idaho, Florida, North Dakota, and Texas. The District of Columbia also has an MMRC although it is not funded by CDC.

[15]The Title V Maternal and Child Health Services Block Grant, administered by the Health Resources and Services Administration, provides funding to all 50 states and nine other jurisdictions to fund public health systems and a variety of activities that support grantees’ maternal and child health priorities.

[16]Joseph et al., “Pregnancy-Related Mortality Due to Infection.”

[17]GAO, *Evidence-Based Policymaking: Practices to Help Manage and Assess the Results of Federal Efforts*, GAO-23-105460 (Washington, D.C.: Jul. 12, 2023). Performance management is a three-step process by which organizations 1) set goals to identify the results they seek to achieve, 2) collect performance information (a type of evidence) to measure progress, and 3) use that

information to assess results and inform decisions to ensure further progress towards achieving those goals.

[18]CDC established short-term and intermediate goals. For the purposes of our report, we group those together as “near-term goals.”

[19]Performance measures are concrete, objective, observable conditions that allow the agency to assess the progress made toward achieving each near-term goal. Agencies collect evidence, which includes performance information, such as performance measures, to measure actual performance toward results.

[20]California did not have a statewide MMRC report available at the time of our review. For our analysis of California’s recommendations, we reviewed a slide deck with analysis of MMRC recommendations from 2019-2021 shared with us by state officials that was presented in May 2025. Mississippi released two reports in 2025, one in April and another in December. We included both 2025 reports as part of our analysis.

[21]See GAO-23-105460.