Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225–3625
Washington, DC 20515–6348
http://waysandmeans.house.gov

October 10, 2018

[redacted]

Dear [redacted]:

According to the Centers for Disease Control and Prevention (CDC), women in the United States (U.S.) gave birth to almost four million babies in 2016.[1] While the majority of women safely deliver their babies, hundreds die each year due to pregnancy-related complications while thousands more experience severe and lasting consequences to their health. Most concerning is that these numbers are on the rise. Compared to 30 years ago, women giving birth in the U.S. are more at risk of dying than their mothers were.[2] As a result, the Committee on Ways and Means is undertaking an inquiry into the causes of rising maternal mortality and morbidity rates and what actions can and should be taken to address this important issue. We therefore write to request information on [redacted]'s efforts to reduce maternal mortality and morbidity in your hospitals.

According to the CDC, approximately 700 women die each year as a result of pregnancy or delivery complications,[3] a number that has risen significantly in recent decades. Among the most common conditions causing maternal deaths are hemorrhages and severe high blood pressure. Moreover, maternal mortality review committees in nine states determined that approximately 63 percent of pregnancy-related deaths were preventable.[4] These deaths are also

[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Births: Final Data for 2016*, National Vital Statistics Reports, Vol. 67, Number 1 (January 2018).
[2] U.S. Department of Health and Human Services, Health Resources & Services Administration, "The World Confronts Maternal Mortality." Accessed on October 5, 2018. https://www.hrsa.gov/maternal-mortality/index.html.
[3] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. "Pregnancy Related Deaths." *Reproductive Health*, Accessed on October 5, 2018, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.
[4] Building U.S. Capacity to Review and Prevent Maternal Deaths, *Report from Nine Maternal Mortality Review Committees* (2018).

characterized by a considerable racial disparity; African American women are three to four times more likely to experience pregnancy-related deaths than Caucasian women.[5]

An astounding 50,000 women are also affected annually by severe maternal morbidity, which can lead to significant and lasting consequences to a woman's health, increased hospital stays, and added medical costs. Severe maternal morbidity, without proper identification and treatment, can also lead to maternal deaths. Similar to maternal mortalities, severe maternal morbidity has also steadily increased in recent years despite a high rate of preventability.[6]

The Committee on Ways and Means is therefore requesting information on how hospitals are addressing rising maternal mortality and severe maternal morbidity in this country. To assist the Committee in this matter, please provide the following information no later than Thursday, November 15, 2018:

For the purposes of answering the questions below, when referring to a hospital system, responses should consider activities of the hospitals within the hospital system on a hospital-by-hospital basis. For example, if answers differ between hospitals within the larger system, please answer on a hospital-by-hospital basis. Additionally, if not explicitly specified, all questions should be read in the context of maternal patients.

1. Please provide a list of the hospitals or other medical facilities within your system that provide labor and delivery services. For each of these facilities, please provide the following for 2017 (or the most recent year available):
    a. Number of babies delivered.
    b. Number, racial demographics, and causes of pregnancy-related deaths.
    c. Number, racial demographics, and causes of women experiencing severe maternal morbidity.

Assessing and Addressing Patient Risk

2. How do you define maternal mortality and severe maternal morbidity?

3. How do your hospitals identify patients at risk for maternal mortality and/or severe maternal morbidity?
    a. What screening indicators do your hospitals use to identify patients at risk for (1) maternal mortality or (2) severe maternal morbidity?

4. Once a woman is identified as being at risk for maternal mortality or severe maternal morbidity, please describe the practices in place to ensure her wellbeing.

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[5] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. "Pregnancy Related Deaths." *Reproductive Health*, Accessed on October 5, 2018, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.

[6] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Severe Maternal Morbidity in the United States." *Reproductive Health,* Accessed on October 5, 2018. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html.

5. What actions have your hospitals taken to address racial and ethnic disparities in pregnancy-related deaths and severe maternal morbidities?
    a. What do you believe to be the causes of these disparities?
    b. Do your hospitals track these disparities? If so, please provide any and all such data for 2015 through 2017.

6. Please provide copies of any policies, procedures, or protocols related to maternal mortality and severe maternal morbidity, including but not limited to assessing patient risk for maternal mortality or morbidity, mitigating those risks, treating patients, required response times, circumstances under which a patient is transferred to another facility, and documentation requirements.

7. Please describe the postpartum care provided to women.
    a. Are medical professionals required to speak to women about postpartum care prior to being discharged from the hospital? If so, what are they required to tell women?
    b. Do your hospitals ensure that women have a medical professional in place for postpartum care after discharge from the hospital?
    c. Are women provided with a list of warning signs and responses for life-threatening postpartum complications prior to being discharged from the hospital?
    d. How are the procedures and requirements in (a) through (c) enforced and documented? Please provide any and all documents pertaining to these procedures and requirements.

Tracking and Reviewing Maternal Mortality and Morbidity

8. Do your hospitals document and track pregnancy-related deaths, severe maternal morbidities, and their causes? If so, please describe.
    a. Do your hospitals code maternal deaths and/or severe maternal morbidities?
    b. Do your hospitals report this information to any external entities? Please provide copies of all information sent to these entities from 2015 through 2017.

9. What maternal mortality- or morbidity-related cases, if any, are reviewed internally? Please describe the process for selecting and reviewing these cases, including whether cases are categorized as potentially avoidable, and any actions taken as a result of these reviews.

10. Do your hospitals employ a mechanism for patients, families, and employees to report concerns and issues with patient care? If so, what is the timeframe for a response to such report?

Participation in Maternal Health Quality Initiatives

11. Do any of your hospitals participate in maternal health quality collaboratives or other initiatives, or employ best practices aimed at reducing maternal mortality and severe maternal morbidity?

a. If any of your hospitals participate in one or employ other best practices, what improvements, if any, have you seen in maternal health?

12. To what extent do your hospitals participate in the Alliance for Innovation on Maternal Health (AIM)?
    a. Please describe which AIM bundles your hospitals have implemented.
    b. If any of your hospitals are participating in AIM, what improvements, if any, have you seen in maternal health?

13. Do your hospitals coordinate with state and local health departments and other external entities in an effort to reduce maternal mortality and severe maternal morbidity? If so, please list the entities and describe the collaboration.

Training

14. Please describe any education or training provided to hospital employees regarding health risks to women before, during, and after giving birth.
    a. Please describe any education or training focused on maternal racial and ethnic disparities and their root causes.
    b. Who is required to complete this education or training?
    c. Please provide copies of all training documents regarding health risks to women before, during, and after giving birth.

15. If your system includes teaching hospitals, what training are you providing to primary care residents regarding delivering babies and preventing maternal mortalities and severe maternal morbidity? Who provides this training?

Community Maternal Health Benefits

Please skip the following section if your hospital system only operates for-profit hospitals.

16. What, if any, community benefits related to maternal health do your hospitals provide? How are these benefits measured?

17. When conducting a community health needs assessment with an accompanying implementation strategy, as required by Section 501(r) of the Internal Revenue Code (IRC), do your hospitals assess maternal health?

18. During the development of your hospitals' most recent community health needs assessments, did members of the community, public health departments, or other entities raise concerns regarding maternal health in your community? If yes, please discuss the nature of those concerns.

19. To what extent do your hospitals educate and notify the community about maternal health risks? Do your hospitals claim this as a community benefit?

20. Has the IRS reviewed your compliance with Section 501(r) of the IRC in the past three years?
    a. Were any hospitals in your system found to be noncompliant with Section 501(r)? If so, which hospitals were noncompliant and for what reasons?
    b. Were any of your hospitals or your system referred to the IRS's field examination function based on the compliance check?
    c. What changes did any of your hospitals and/or system make as a result of the compliance check and/or field examination?

21. What percentage and dollar amount of each of your hospitals' total expenses are considered a community benefit and charity care as defined by the IRC?

Thank you in advance for your prompt response to this request. If you have any questions, please contact Lindsay Steward of the House Ways and Means Committee at (202) 225-9263.

Sincerely,

Kevin Brady
Chairman
Committee on Ways and Means

Lynn Jenkins, CPA
Chairman
Committee on Ways and Means
Subcommittee on Oversight

Peter J. Roskam
Chairman
Committee on Ways and Means
Subcommittee on Health