Transcript - Expert to Expert Webinar: Annual Updates for PC-02 and PC-07 for 2026 Reporting Year

Broadcast February 26, 2026

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Welcome and thank you for joining us today for this Joint Commission Expert to Expert webinar addressing the 2026 annual updates for the PC-02, Cesarean Birth, and PC-07, Severe Obstetric Complications electronic clinical quality measures. The Expert to Expert webinar series is offered in partnership with the Centers for Medicare and Medicaid Services and eCQM stewards. CE credit is available for this webinar for live broadcast attendance only. I'm Susan Funk, Associate Project Director for Engagement on Quality Improvement Programs at Joint Commission, and today, I'll be serving as this webinar's moderator.

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Before we begin the webinar content, we would like to offer just a few tips about webinar platform functionality. Audio is by voice over internet protocol only – Use your computer speakers/headphones to listen. There are no dial in lines. Participants are connected in listen-only mode. Feedback or dropped audio are common for live streaming events; if you experience such audio or streaming issues, refresh your screen, or leave and rejoin the session. We will not be recognizing the Raise a Hand or Chat features. To ask a question, click on the Question Mark icon in the audience toolbar. A panel will open for you to type your question and submit. The slides are designed to follow Americans with Disabilities Act rules.

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Speaking of the slides, they are available now. There are many links provided throughout this webinar, but they are not clickable on screen. By downloading the slides, you'll be able to access links and also take notes. To access the slides now, within the webinar platform, in the participant navigation pane, select the icon that represents a document. A new pop-up window will open, and you can select the name of the file. A new browser window will open, and from it, you can download or print the PDF of the slides. Slides will also be available within 2 weeks of the webinar on Joint Commission's website at the link included at the bottom of this slide and on the eCQI Resource Center.

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I am sure that many of you attending this webinar today will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout we've included within the webinar resources and has also been communicated on the webinar registration page. The attachment includes the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate. So be sure to download that attachment to learn more. Credit is available for attendance during this live webinar broadcast only. For information on Joint Commission's continuing education policies, visit the link provided on the bottom of this slide.

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The participant learning objectives are:
Locate eCQM resources on the eCQI Resource Center.
Facilitate your organization's implementation of the PC-02 and PC-07 eCQM annual updates for the 2026 reporting year.
Utilize answers to common issues and questions regarding the PC-02 and PC-07 eCQMs to inform 2026 use and implementation.

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This webinar does not cover these topics: Basic eCQM concepts, Topics related to chart abstracted measures, and process improvement efforts related to this measure. While we will not address how to validate eCQM data during this webinar, before submitting eCQM data to CMS or Joint Commission, please ensure your data is validated. Specifically, please ensure that extreme outlier results are verified. For example, extreme outliers may include reporting 0% or 100%.

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All staff and subject matter experts have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

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The agenda for this webinar follows. We will review the PC-02 Cesarean Birth and PC-07 Severe Obstetric Complications eCQM annual updates for the 2026 Reporting Year, provide an overview of the measure flow and algorithm and then we'll address some Frequently Asked Questions (FAQs). Finally, we'll have a live Q&A segment.

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Before we transition to the discussion about the changes for the 2026 reporting year, we wanted to point you to a PDF handout that includes directions to locate and access eCQM specifications, value sets, measure flow diagrams and technical release notes. The link to the eCQI Resource Center landing page is provided on this slide. Be sure to download the PDF Handout that has additional links. You can locate that PDF within the Resource Section of the audience navigation pane within this webinar platform to learn more about navigating to and using these eCQM resources.

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[Susan Funk] I will now turn the webinar over to our first speaker for today, Raquel Belarmino from the Informatics team at Joint Commission. Raquel, please introduce yourself and when you're ready, start your presentation!

[Raquel Belarmino] Thank you, Susan. Hi, I'm Raquel Belarmino, Associate Project Director at the Joint Commission. Before we discuss the measures, let's take a moment to review mapping, data elements, value sets, and terminology that applies to all eCQMs. For this review, we use cesarean birth procedure as our example.

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Let's review one of the data elements for the Cesarean Birth measure, where the logic evaluates the Procedure, Performed: "Cesarean Birth" data element. Cesarean Birth refers to a value set. Within the hospital inpatient eCQM flows posted on the eCQI Resource Center, the words and phrases in all caps with double quotations are value sets.

When you look at the measure specifications – also posted on the eCQI Resource Center, scroll down to the Terminology section of the specifications to see the direct reference codes and value sets contained within the measure. Within this section, we see valueset Cesarean Birth and its OID or Object Identifier code.

On your internet browser, go to the VSAC or Value Set Authority Center located at (vsac.nlm.nih.gov).

Yes, you need to sign in to access the value sets or lists of codified terms needed to be mapped for this measure to report correctly. To sign in, you will need a UMLS account which is free for anyone that requests one.

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Once you have signed in, go to the Search Value Sets tab. In the Query field, type the name of the value set or enter the value set's OID code. You can scroll through the list of terms not depicted here, or Export Value Set Results to a spreadsheet.

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Here's a screenshot of part of that exported list. There's quite a few different procedure codes for Cesarean Birth. And in this value set, there are ICD-10 and SNOMED codes. There could be other code systems in other value sets. Although this discussion has been about Cesarean Birth, for all eCQMs, ensure all value sets are mapped to codes used by your organization…and when submitting eCQM data, please ensure your data is validated before submission.

Codes that are documented in the medical record may be mapped to the codes used in the value sets to meet the measure. We are unable to provide specific guidance related to the mapping of codes. If mapping is conducted, you should maintain documentation in case of a CMS audit.

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In the previous slides, we reviewed how to access value sets to review terms associated with a measure. In addition, we want to ensure that value sets are mapped to codes used by each hospital organization.

So, what is Mapping Terms? Mapping terms in healthcare IT is the process of establishing associations between codes, concepts, and/or terms in one system and their equivalent concepts or terms in another system to accurately share and understand information.

Within a structured field, one that allows you to choose from a "pick list" or drop-down list and does not allow free-text typing, perhaps the clinician selects C-Section. In the background, hospital IT staff have mapped the local term of "C-Section" to its equivalent, in this case – SNOMED code for the measure to populate the QRDA I file correctly. I now turn it over to Kelley, who will begin the presentation for ePC-02 Cesarean Birth.

[Kelley Franklin]: Thank you, Raquel. I'm Kelley Franklin. I'm an Associate Project Director in the Clinical Quality Measure team, and I am the perinatal lead for the Joint Commission.

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Now we will discuss ePC-02 in detail.

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The Cesarean Birth measure looks at the Nulliparous, Term, Singleton, Vertex (NTSV) cesarean rate which is a primary cesarean in first births (nulliparous) with term singleton pregnancies in a head down position. This is an important population to focus on because Nulliparous patients have 4-6 times the cesarean birth rate than multiparous patients and therefore, the NTSV population is the largest driver of the primary cesarean birth rate. In addition, a reduction in primary cesarean births will reduce the number of birthing persons having repeat cesarean sections as almost 90% of those who have a primary cesarean section will have subsequent cesarean births.

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Although cesarean delivery can be lifesaving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of decreases in maternal or neonatal morbidity or mortality, raises significant concern that cesarean delivery is overused. Studies have also shown an increased risk of severe maternal morbidities, or SMM, for cesarean delivery compared to vaginal delivery. Many studies have also shown that physician factors, rather than patient characteristics or obstetric diagnoses, are the major driver for the

difference in cesarean rates within a hospital. First birth labor inductions and early labor admissions can also cause variation in the rates among hospitals. Main et al. (2012) found that over 60% of the variation in cesarean rates among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. The Cesarean Birth measure can assist organizations in monitoring their quality improvement efforts to reduce the NTSV cesarean rate. Cesarean birth rates have improved; however, there are still hospitals with rates over 30%.

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Measure changes for 2026 include narrative descriptions updated to reference patients as opposed to women to better align the measure narrative with the measure logic which does not specify sex.

Please note throughout this presentation, dark green strikethroughs denote removed content while added content is underlined.

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Other changes for 2026 are the Improvement Notation field updated to read 'Decreased score indicates improvement' based on a tooling update to promote alignment across measures.

You may also notice updates to the Guidance section related to capturing the last estimated gestational age to better align with the logic and articulate measure intent.

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To reiterate, the measure description for PC02 is nulliparous patients with a term, singleton baby in a head down or vertex position who are delivered by cesarean section. The Initial Population is Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period.

The Denominator is Inpatient hospitalizations for nulliparous patients delivering a live term single newborn >= 37 weeks of gestation completed. The measure defines nulliparous as a patient with Gravida = 1 or Parity = 0 or Preterm and term births = 0.

Denominator Exclusions are Inpatient hospitalizations with abnormal presentation or placenta previa, placenta accreta spectrum disorders, vasa previa, or active genital herpes during the encounter.

The Numerator is inpatient hospitalizations delivered by cesarean section. Please note ePC-02 is an inverse measure and therefore, generally speaking, lower scores are better. The Joint Commission does not want to encourage inappropriately low Cesarean rates that may be unsafe to patients. Acceptable PC-02 rates are 30% or lower, however there is not an established threshold for what rate may be too low. PC-06 serves as a balancing measure for PC-02 to guard against any unanticipated or unintended consequences and to identify unforeseen complications that might arise.

There were no changes to any of these populations for this reporting year. I will now turn it over to Raquel who will present the technical aspects of the measure.

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[Raquel Belarmino] Thank you, Kelley. For 2026, we have a few changes to the value sets:
ONC Administrative Sex was renamed to “Federal Administrative Sex” based on updated standards.
Plus, one SNOMED CT code was deleted from the Cesarean Birth value set and one SNOMED CT code was added to Delivery Procedures value set based on terminology updates.

When reading the measure specifications, you may notice that definition titles were changed from title case to initial case, but otherwise, there were no other changes to the logic.

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As part of our ongoing review of feedback from you – our audience, and process improvements for the webinar series, we combined reviewing the measure flow and logic together. If changes are made to the measure specifications or additional clarification on a definition is needed, we will examine the specific definition logic in additional slides.

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The Initial Population main definition for ePC-02 is "Delivery Encounter with Age Range". 3 conditions must be met to qualify for this definition.
1. An inpatient encounter must be present.
2. the patient must be >= 8 and < 65 years of age and
3. There must be a procedure code from the "Delivery Procedure" value set with a start day during the hospitalization encounter.

Recall that the hospitalization function returns the total interval from the start of any immediately prior emergency department visit or OB Triage visit through the observation visit to the discharge of the given encounter. If you would like more information about this concept, please review the 'hospitalization with observation' video short listed on the Resources slide at the end of this presentation.

If the criteria is met, the patient is in the initial population. If not, the patient is not in the initial population and processing ends.

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The denominator flow diagram is a little more complex. The main definition is "Singleton Delivery Encounters at 37 Plus Weeks Gravida 1, Parity 0, No Previous Births". To start, one of 3 definitions must be met to determine that gestational age is >= 37 weeks.

The first is the calculated gestational age >= 37 weeks. The calculated gestational age is based on ACOG's REVITALIZE definition and is the preferred method of determining gestational age.

The second is the estimated gestational age. If the calculated gestational age is null, the estimated gestational is the next preferred method to determine gestational age.

The third and last way to determine gestational age is based on ICD10 or SNOMED codes. This is the lowest in the hierarchy. Both calculated and estimated gestational age must be null, to invoke this logic.

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Let's review those 3 definitions in more detail. The first is the calculated gestational age >= 37 weeks. The calculated gestational age is based on ACOG's REVITALIZE definition which is shown here and is the preferred method of determining gestational age. The initial patient population "Delivery Encounter With Age Range" is our starting point. Then the Calculated Gestational Age function calculates the difference in days between the last time of delivery and the Last Estimated Delivery Date, then subtracts that from 280 and divides by 7.

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The second definition is Delivery Encounter With Estimated Gestational Age >= 37 Weeks. Again, starting with the initial patient population "Delivery Encounter With Age Range" where the calculated gestational age (or CGA) is null, the estimated gestational is the next preferred method to determine gestational age. If CGA is null, the logic calls the LastEstimatedGestationalAge function from the PC Maternal library.

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The third and last way to determine gestational age is based on ICD10 or SNOMED codes. This is the lowest in the hierarchy. Both calculated and estimated gestational age must be null to invoke this logic.

If one of these 3 definitions are met to determine that gestational age is >= 37 weeks, they must intersect with the Encounter with Singleton Delivery definition as the measure only includes single births. If the criteria is not met, processing ends. If the criteria is met, the measure flow continues on the next page.

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If one of the previous 3 definitions are met to determine that gestational age is >= 37 weeks, it must intersect with the Encounter with Singleton Delivery definition and continue to determine if the denominator is met by determining if the gravidity is one OR the parity equals 0 OR both preterm AND term births are = zero.
If just ONE of these 3 conditions are met, the patient will be in the denominator. If not, processing ends.

Note the a1, a2, a3 notations in the small diamonds. We will refer back to these notations when we get to the sample calculation.

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Now that we have our denominator cases, we need to determine if any should be excluded. There are 2 definitions that could be met. The first is an encounter with abnormal presentation, which has 2 options to evaluate abnormal presentation: The logic checks if an ASSESSMENT is performed during the encounter indicating the fetus is in an abnormal presentation.

The LastAbnormalPresentation where an assessment is performed before or on the delivery date that indicates abnormal presentation. And this assessment of abnormal presentation occurs during the full hospitalization encounter or we look for a DIAGNOSIS of Abnormal Presentation.

The second definition could be met if the patient has a diagnosis code(s) within the Genital Herpes or the Placenta Accreta Spectrum Previa or Vasa Previa value sets on the encounter if either definition is met, the patient meets the denominator exclusion if not met, the patient continues on through the algorithm to be considered if the numerator is met.

Again, note the b1, b2 in the small diamonds to be used later in the sample calculation.

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Before moving on to discussing the numerator, let's review a frequently asked question related to denominator exclusions -- more specifically, genital herpes.

Question: Should active genital herpes be excluded from the measure with only ICD-10 codes or physician documentation to include active? A patient had a Cesarean section due to suspected genital herpes lesions, but due to negative test results after delivery, the ICD-10 code for Herpes was not applied to the encounter. Could the SNOMED code through for herpes be captured through provider documentation?

The short answer is yes. Encounters that meet the denominator exclusion related to active genital herpes must include an ICD-10 or SNOMED encounter diagnosis code as identified in the value set "Genital Herpes". If neither an ICD-10 nor a SNOMED code is entered, the patient will not meet the criteria for the denominator exclusion. SNOMED terminology within the value set may be mapped to documentation such as the problem list where physicians update which ones are active.

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Returning our attention to the measure flow, the numerator is fairly straight forward. Did the patient have a Cesarean Birth during the encounter? The logic looks for a procedure of Cesarean birth performed during the delivery encounter hospitalization. No? The patient is not in the numerator. Yes? The patient is in the numerator. And again, note the c notation in the small diamond.

At the bottom of the screen, the sample calculation is available. Now that the numerator, denominator and denominator exclusions are defined, we can plug the quantities in to the calculation formula.
Note the diamond notations referenced from the previous slides. Back to you Kelley.

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[Kelley Fanklin]: Now we will discuss ePC-07 in detail.

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Joint Commission developed ePC-07 in collaboration with: Yale New Haven Health Services Corporation-Center for Outcomes Research and Evaluation (CORE) and expert advisor, Dr. Elliott Main, Professor of Obstetrics and Gynecology, Stanford University School of Medicine and Former Medical Director, California Maternal Quality Care Collaborative (CMQCC). This is a Risk-adjusted outcome measure.

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Severe maternal morbidity (SMM) poses serious health threats to pregnant patients in the United States, where rates have been on the rise compared to other developed nations. Severe maternal morbidity is defined as “unexpected outcomes of labor and delivery that result in significant short or long-term consequences to a woman’s health” (ACOG & SMFM). These high rates in the United States present unique opportunities for large-scale quality measurement and improvement activities. Statistics on preventability vary but suggest that a considerable proportion of maternal mortality and morbidity events could be prevented. A report in 2019 from 14 maternal mortality review committees that conducted a thorough review of pregnancy-related deaths determined that 65.8% of them were preventable. Although there are limited measures to assess variability among hospitals, using the CDC definition of severe maternal morbidity or SMM, the US median rate was 1.4% and the highest hospital rate was 12.2% . Studies also show that Non-Hispanic black women are three to four times more likely to die from pregnancy-related causes than non-Hispanic white women. SMM impacts the mother’s health, increasing medical costs and hospital length of stay. One report found that women with SMM delivering vaginally have hospital stays that are 70% longer than women with vaginal deliveries experiencing no SMM, and costs that are almost 80 percent higher.

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SMM is defined as “unexpected outcomes of labor and delivery that result in significant short or long-term consequences to a woman’s health” (ACOG & SMFM). The CDC specifically defines SMM by 21 indicators, defined by International Classification of Diseases, Tenth Revision (ICD-10) diagnosis and procedure codes. Some SMM examples include acute renal failure, acute respiratory distress and blood transfusion. More on this later.

An important distinction compared to the CDC model is that our measure uses present on admission (POA) codes to distinguish SMM that may be POA. The goal of ePC07 is to assess prevalence of SMM and mortality.

Specifications are modeled after a modified version of CDC's SMM indicators with the addition of maternal mortality. At times, we may refer to the CDC indicators of morbidity as SMM, but the outcome of the measure, which includes morbidity and mortality, is referred to as Severe Obstetric Complications or SOC.

Now Valery Danilack from Yale/CORE will explain the risk adjustment model for PC-07.

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[Valery Danilack] The goal of a measure score is to isolate the assessment of quality of care. Risk adjustment enables this goal by accounting for patient characteristics and/or comorbidities that are associated with the measure outcome but are reasonably beyond the control of the hospital, such as those present on admission when the patient arrives at the hospital.

Risk adjustment accounts for case mix differences between hospitals and "levels the playing field", allowing for better comparisons between hospitals on the care patients receive at the hospital.

Risk adjustment is achieved through the development of a risk model or models, which are typically multivariable regression models that include risk factors as covariates.

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We identified candidate risk variables predictive of severe obstetric complications for consideration in the measure risk adjustment model by utilizing literature and research findings and reviewing the list of Hospital Core Clinical Data Elements. We also sought input from clinical expert consultants and members of a Technical Expert Panel (TEP), which included patients.

Only conditions or comorbidities that were present on admission were included in risk adjustment.

The measure only uses risk variables which are submitted with POA=yes or, when applicable, POA=exempt. If a risk variable is submitted with no POA information, it would be treated like POA=no and would have a "no" value in the risk model. That is, it would appear that the patient did not have the condition. In order to accurately reflect your hospitals' case mix, we encourage all hospitals to submit complete POA information for the risk variables which require POA indicators. You can find more details in the electronic specifications found on the eCQI Resource Center.

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Following the identification of risk-adjustment variables, a risk model was developed for the severe obstetric complications and severe obstetric complications excluding blood transfusion-only encounters.

Due to very low prevalence of a few risk variables, Human Immunodeficiency Virus (HIV) was combined with autoimmune disease, and obstetric venous thromboembolism (VTE) was combined with long-term anticoagulant medication use. This was done for the model of severe obstetric complications excluding transfusion-only encounters only in initial measure development and will be implemented as necessary when the measure scores are reported. Otherwise, the same risk variables were included in the risk models for severe obstetric complications and severe obstetric complications excluding blood transfusion-only encounters.

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Social risk factors were considered dependent on the availability of information in the EHR. Economic/housing instability was chosen for inclusion in the model due to support in research literature and availability in the EHR.

The Severe Obstetric Complications Risk Adjustment Methodology Report and the Measure Updates and Results

Report are available on the eCQI Resource Center (https://ecqi.healthit.gov).

Within the annual Measure Updates and Results Report, you can find a summary of measure updates, national-level measure results for the prior year, and information on the frequency and odds ratios for each risk variable in the risk model.

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A frequently asked question:
Question: Why are my hospital's risk-standardized measure results different than my observed complication rates?

Answer: The risk-standardized measure score is anchored by the national outcome rate and not by an individual hospital's observed outcome rate. Risk-standardized measure results should not be compared to observed unadjusted complication rates but can be compared to results from other hospitals and the national rate.

A common question raised by hospitals is related to better understanding differences between the risk-standardized complication rates and a hospital's observed complication rate. Importantly, risk-standardized complication rates shouldn't be directly compared to a hospital's unadjusted or observed complication rates. The risk-standardized complication rates are anchored by the national outcome rates and not by an individual hospital's unadjusted or observed outcome rate. Hospitals can compare their risk-standardized complication rates to other hospital's risk-standardized results and the national rate.

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[Kelley Franklin] Thank you, Valery. Let's review some key points for this measure. ePC-07 uses value sets to group each category of SMM Diagnosis codes. When hospitals review their numerator cases, these categories can be used to identify potential areas for quality improvement as well as opportunities to improve coding documentation. It is also important to understand that the conditions that are used in the risk adjustment model adjust the rate to account for the severity of cases present on admission. They are not excluded from the measure.

As Valery mentioned, if POA information is missing, conditions may not be included as risk variables or correctly qualify for the numerator. We will discuss POA in greater detail in upcoming slides. Also, when looking at ePC07 rates they will be reported per 10,000 delivery hospitalizations.

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To reiterate, the measure description for PC07 is Patients with severe obstetric complications which occur during the inpatient delivery hospitalization. There are two numerators for the measure, which will be explained in the next few slides, but the specifications on this slide are the same for both outcomes.

Let's review more in detail how ePC07 populations are defined. The initial population is defined as Inpatient hospitalizations for patients age >= 8 years and < 65 admitted to the hospital for inpatient acute care who undergo a delivery procedure with a discharge date that ends during the measurement period. The denominator is Inpatient hospitalizations for patients delivering stillborn or live birth with >= 20 weeks gestation completed.

Denominator exclusions for patients with COVID-related respiratory conditions or procedures have been removed based on recommendations from experts.

Please note: Throughout this presentation, new content is indicated with underlined text, while strikethrough text denotes removed content.

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Numerator one is Inpatient hospitalizations for patients with severe obstetric complications. Numerator one includes transfusions. You may recall from earlier in the presentation, we mentioned CDC's SMM indicators. Here are those indicators that are used to define the numerator in addition to a discharge disposition of expired.

1. Severe maternal morbidity diagnoses must be coded as NOT present on admission to get into the numerator.
2. Severe maternal morbidity procedures. 3. Discharge disposition = expired.

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Numerator 2 addresses the second measure calculation: Inpatient hospitalizations for patients with severe obstetric complications excluding cases where blood transfusion was the only SOC. Notice that Numerator 2 is the same as Numerator 1, EXCEPT for when blood transfusion is the only SMM.

1. Severe maternal morbidity diagnoses must be coded as NOT present on admission to get into the numerator.
2. Severe maternal morbidity procedures.
3. Discharge disposition = expired.

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There are numerator exclusions for both numerators. Excluded cases are those in which: The only complication was a transfusion or hysterectomy AND the patient had a diagnosis of placenta percreta or increta.

According to the American College of Obstetricians and Gynecologists (ACOG) the most generally accepted approach to placenta accreta spectrum is cesarean hysterectomy with the placenta left in situ after delivery of the fetus due to the risk of severe hemorrhage with removal or manipulation of the placenta after delivery.

Example: If a patient had a diagnosis of placenta percreta and had a hysterectomy, with no other SMM diagnosis, the patient would be excluded from the numerator. However, if the same patient also has a diagnosis of DIC (Disseminated Intravascular Coagulation) and is admitted to the ICU, they would be included in the numerator due to the presence of an additional SMM diagnosis.

Note: Placenta accreta is not an exclusion for PC-07. Our Technical Advisory Panel (TAP) felt that not all cases of placenta accreta require a hysterectomy, and reproductive justice or preservation should be considered.

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To close out our review of the measure specifications, let's review the risk adjustment conditions for the measure. As mentioned earlier in the presentation, this measure is risk adjusted using the pre-existing conditions listed here. Present on admission codes are used to determine if any of the conditions are pre-existing.
Additional variables used for risk adjustment are: Heart Rate, Systolic Blood Pressure, White Blood Cell Count, Hematocrit.

The first resulted values FROM 24 hours prior to the start of encounter THROUGH before time of delivery are used for the vital signs and laboratory tests.

[Raquel Belarmino] Hi Kelley - before reviewing measure changes for this year, I'd like to review a few Key Points about Present-on-Admission or POA.

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[Raquel Belarmino] As mentioned earlier in this presentation, PC-07 requires POA information.

If you are not familiar with POA, here are a few notes about general reporting requirements:
Reporting POA is required for all claims involving inpatient admissions to acute care hospitals and facilities.
POA is defined as being present at the time of the inpatient admission order, so conditions developed during an OUTPATIENT encounter, including the ED, Obs, or outpatient surgery are considered present on admission.
A POA indicator must be assigned to principal and secondary diagnoses and the external cause of injury codes.

For more information follow the link to the CMS website listed at the bottom of this slide.

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For PC-07, POA is required for both numerators to report accurately.
In the logic for Numerator 1, we see the numerator definition is, “Delivery Encounters with Severe Obstetric Complications.” This is further defined as three separate definitions unioned together.

Let’s review the first of the 3 unioned definitions:
”Delivery Encounters with Severe Obstetric Complications Diagnosis Or Procedure Excluding Blood Transfusion.”
It starts with the denominator definition, or its alias, TwentyWeeksPlusEncounter…where “POAIsNoOrUTD” is indicated when there is an encounter diagnosis from the “Severe Maternal Morbidity Diagnoses” value set or exists, SMMProcedures during the encounter in question.

POAIsNoOrUTD. This is a function that determines if Present On Admission is NO or Unable to Determine is indicated for an encounter diagnosis identified from the “Severe Maternal Morbidity Diagnoses” value set. When any of the 17 SMM diagnoses are identified, they must have a POA indicator to confirm that the diagnosis was or was not present on admission. If the diagnosis WAS present on admission, it could be a risk adjustment variable.
Now, you may be thinking, “Well, what if the POA indicator does not exist?” We refer to that missing indicator as POA is null; which indicates that reporting is likely inaccurate. Either the condition was there on inpatient admission or is exempt from POA reporting -- or it was not present, clinically undetermined, or documentation was insufficient. These value sets need to be mapped to report accurately.

As noted in the Numerator section of the header in the human readable, it may be helpful to know that present on admission codes may be extracted from billing/claims data that were entered by coding staff.

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POA values are also required for Risk Adjustment Variables. Let’s review the logic for risk variables anemia, asthma, and autoimmune disease.

The POAIsYesOrExempt function is in each of the risk variable definitions. This function checks for the present on admission indicator for encounter diagnoses identified from the list of 29 risk adjustment conditions. If your organization uses different codes, be sure to map them to this value set’s codes to accurately report risk-adjusted rates.

Thank you for your attention. Now, Kelley will summarize major measure changes for 2026. Thanks for letting me interject, Kelley!

Slide 50 00:46:10

[Kelley Franklin] No problem, Raquel! Additional updates to the Guidance section are related to capturing the last estimated gestational age to better align with the logic and articulate measure intent.

Slide 51 00:46:28

Other changes for 2026 reporting consist of multiple sections of the human readable header being updated to better clarify the Numerator Exclusions for Population Criteria 2 and better align with the logic.

In addition, as mentioned earlier, denominator exclusions for patients with COVID-related respiratory conditions or procedures have been removed based on recommendations from experts.

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Also for reporting year 2026, the Improvement Notation field was updated to read 'Decreased score indicates improvement' based on a tooling update to promote alignment across measures. The Supplemental Data Elements (SDEs) section was updated to clarify which SDEs reporting entities are required to submit and which ones are calculated after data receipt. I will now turn it over to Raquel to cover some of the technical changes.

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[Raquel Belarmino] Thanks, Kelley. In addition to the removal of Denomination Exclusions, technical changes for reporting year 2026 include the removal of 'Day of' logic from the definitions used in the measure's Numerator to include only severe maternal morbidity procedures that start during the delivery encounter in the Numerator, aligning with measure intent.

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Other measure changes for 2026 include multiple CQL definitions, functions, and/or aliases were updated to align with the CQL Style Guide. Mainly, the definitions were changed from title case to initial case with prepositions and articles capitalized. Logic was added to the Supplemental Data Elements (SDE) section for 'SDE Delivery Encounters With Severe Obstetric Complication Procedures' and 'SDE Delivery Encounters with Severe Obstetric Complication Diagnosis' so all SDEs are shown in the appropriate section. Plus, multiple value sets had code additions/deletions due to terminology updates. For more details, download a copy of the Technical Release Notes in the eCQI Resource Center at the link provided here.

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Next, we will review the measure flow diagram with logic. Measure flow diagrams provide a high-level overview of the steps to calculate the measures and are found on the eCQI Resource Center. The measure specifications are the source of truth, but the measure flow diagrams are like algorithms that can clarify the main concepts.

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Remember that there are two measure calculations for this measure. The Initial Population is the same for both measure calculations and is identical to ePC-02's initial population which was described earlier in this presentation.

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Like PC-02's denominator, the denominators for both PC-07's measure calculations have 3 different approaches to evaluate the gestational age, but PC-07 looks for gestational age greater than or equal to 20 weeks. The preferred method is the Calculated gestational age based on ACOG's REVITALIZE definition; then the Estimated gestational age if the calculated age is not present; and the third and last approach is based on ICD10 or SNOMED codes. Calculated and estimated gestational age must be null, to invoke this third set of logic.

If the criteria is not met, processing ends and the case is not in the measure. If the criteria is met, the case is in the denominator.

And just as you saw in the PC02 measure flow diagram, the a1, a2, a3 notations in the small diamonds will be used in the calculation.

There were no changes this year to denominator population, and as mentioned earlier in this presentation, the denominator exclusions were removed.

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Cases qualify for the numerator if one of 3 definitions are met:
1. Delivery Encounters with a severe obstetric complication or severe obstetric procedure excluding blood transfusion. 2. Expirations. 3. Blood Transfusion was performed during the encounter.

If the criteria is NOT met, processing ends, and the case is not the numerator. If one of the three definitions is met, the case is then evaluated for numerator exclusions.

Again, note that the c1, c2, c3 notations in the small diamonds will be used in the calculation.
There were no changes this year to this population.

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Now, let's continue with the measure flow. Numerator Exclusions 1 looks for delivery encounters with severe obstetric complications with a blood transfusion or hysterectomy with a diagnosis of Placenta Increta or Placenta Percreta and no other severe obstetric complications, or in other words, EXCEPT if there is an additional Severe Obstetric Complication present.

The last portion of the logic after "except" keeps the encounter in the numerator if there is any additional severe obstetric complications present. With that said, if a patient with a diagnosis of placenta percreta has a hysterectomy during the delivery encounter, the numerator exclusion is met. However, numerator exclusions 1 is NOT met if the patient also has an acute MI or heart attack during the same encounter.

The e1 notation in the small diamond is used in the sample calculation provided at the bottom of the screen. The difference this year is the absence of denominator exclusions.

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To identify the second measure calculation's numerator: Numerator 2, Overlap "Delivery Encounters with Severe Obstetric Complications" With Delivery Encounters with SOC Diagnosis or Procedure Excluding Blood Transfusions" and Expirations.

If the criteria is NOT met, processing ends, and the case is not the numerator. If criteria is met, the case is then evaluated for numerator exclusions. There were no changes to this population.

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Numerator Exclusions 2 evaluates for delivery encounters with severe obstetric complications (SOC) except where blood transfusions were the only SOC with a blood transfusion or hysterectomy AND a diagnosis of Placenta Increta or Placenta Percreta except if the delivery encounter has other severe maternal morbidity diagnoses whose present-on-admission indicator is no or unable to determine or the delivery encounter also has procedures of cardiac conversion, tracheostomy, or ventilation, or the patient expired.

While the numerator EXCLUSIONS address the same procedures with a diagnosis of placenta increta or percreta in both measure calculations, the difference is that encounters where blood transfusion is the only SOC won't be in numerator 2 before the exclusions are applied.

A sample calculation to determine the measure's rate is provided. The difference this year is the absence of denominator exclusions.

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Let's take a moment to review a Frequently Asked Question.
The numerator exclusions are for inpatient hospitalizations with a diagnosis of placenta percreta or placenta increta and no additional severe obstetrical complications and a blood transfusion or hysterectomy. Is placenta accreta included in this exclusion?

Answer:
Placenta accreta is not included in the numerator exclusions. The Technical Advisory Panel (TAP) felt that not all cases of placenta accreta require a hysterectomy, and reproductive justice or preservation should be considered.

On that note, our eCQM presentation has reached its end. Back to you, Susan!

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[Susan Funk] Thanks Raquel, Kelley, and Valery for presenting today. We've included an additional resource slide and provided links to direct the audience to: the eCQI Resource Center – CMS Eligible Hospital Measures page and the Get Started with eCQMs links. The Teach Me Clinical Quality Language (CQL) Video Series including video shorts on Hospitalization with Observation and What is a Value Set.

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Continuing with Resource Links, we've included a link to direct you to the Specifications on the eCQI Resource Center. The Value Set Authority Center or VSAC Support. The Expert to Expert Webinar series on Joint Commission's website, and finally, the ASTP/ONC Issue Tracking System – where clinical and technical questions about these eCQMs should be submitted.

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We will now move into our live Q&A segment. Please submit questions via the question pane. Click the Question mark icon in the audience toolbar. A panel will open for you to type and submit your question. All questions not answered during the live event will be addressed in a written follow-up Q&A document. The follow-up document will be posted to Joint Commission's website several weeks after the live event – after CMS review and approval.

Our subject matter experts have been busy during the presentation responding to many questions as they've been submitted. We'll now share some of the questions and answers. Melissa Breth from Joint Commission's Informatics team will be facilitating this Q&A segment. Melissa, please introduce yourself and then, when you're ready, start with the first question.

[Melissa] Certainly. This is Melissa Breth, Associate Project Director for Joint Commission, and a Measure Lead for maternal health for eCQMs. The first question we have, "For PC-07 and PC-02 delivery procedures, where is the appropriate place to pull data for these measures?"

Each EHR system is different, so we cannot provide a specific source for mapping. Notice that the Delivery Procedures definition uses the data element, Procedure Performed. When pulling data for this definition, as well as for similar definitions, we recommend using a source of documentation that the procedure was completed and not merely referring to the order for the procedure.

Next question. "For PC-07, the measure specification states, 'Please note that Present on Admission codes may be those entered by coding staff, extracted from billing and claims data for both Numerator and risk adjustment.' Can you please confirm the data source for reporting is based solely on the submitted QRDA I file, or are Present on Admission codes also pulled from the billing claims data?"

The answer, yes, only QRDA I file is submitted to report on this measure, as opposed to any additional file or document. Present on Admission, POA, codes are required to report this measure accurately and may be mapped from billing and claims data to be pulled into the QRDA I file. We recommend working with your IT department and EHR vendor to determine what is best for your organization.

Next question. "Why isn't W, or clinically undetermined, part of the present on admission value set, like it is in other measures?" Answer. Thank you for your question. When developing the eCQM, it was determined that the values, U, insufficient documentation, and W, clinically undetermined, essentially have the same outcome of Unable to Determine, and were grouped together within the POA value set. Therefore, an encounter with a POA value containing a W would be considered for the eCQM as a complication.

Next question. "It looks like our EHR is referencing the last EDD identified in the latest ultrasound in the record to calculate the gestational age. Is that right?"
Answer. The logic should look for the most up-to-date EDD that is clinically used to estimate gestational age. This date should not change with every ultrasound unless clinically determined. We recommend working with your EHR vendor to ensure the correct estimated date of delivery or EDD is pulled.

Next question. "What," rather, "Why is previous myomectomy not included as an exclusion?"
Answer, a history of uterine surgery or myomectomy is not an exclusion for CMS 334 PC-02 as current myomectomy codes are too broad and may include cases not warranting cesarean birth. We continue to monitor coding updates and consult with the Perinatal Technical Advisory Panels for potential revisions.

Next question. "Why does the logic not stop at gravida 1?" I mean, sorry, let me start that again. "Why does the logic not stop at gravida 2? We have patients in our Denominator only that are gravida 2 or more."
Answer, Denominator would include all deliveries. However, these are not included in the Numerator.

Next question. "Why isn't myomectomy accepted as a Denominator Exclusion?" Answer, myomectomy is not an Exclusion for PC-02 as current myomectomy codes are too broad and may include cases not warranting cesarean delivery. We continue to monitor coding updates and consult with the Perinatal TAP for potential revisions.

Next question. "The measure is specific for gravida 1, para 0, so previous miscarriages are exclusionary, for example, gravida 5, para 0, but have four miscarriages prior to 20 weeks."
Answer, previous miscarriages are not exclusionary. The measure includes nulliparous patients, so logic looks for gravidity equals one or parity equals zero, or preterm and term births both equal zero.

Okay, next question. "Is the national rate risk adjusted?"
Answer, no. The national rate is simply the number divided by the Denominator for all encounters submitted in the country without considering hospital.

Next question. "How does a hospital that has no cases, 0%, with severe complications, excluding blood transfusions, only have a risk adjusted rate greater than 0%?"
Answer: Even if there are zero observed complications, a hospital can still have a non-zero risk standardized obstetric complications rate, or RSOCR, since the RSOCR represents the hospital's relative performance compared to other hospitals with the same case mix, and not a raw complication rate. The measure score is a risk-standardized rate anchored by the national rate, and not a risk adjusted rate.

Next question. "Placenta increta and percreta are Numerator Exclusions for blood transfusions and hysterectomies. Why did the Technical Advisory Panel not include placenta accreta as an Exclusion as well?"
Answer, you are correct that the placenta accreta is not included in the Exclusions for PC-07. The TAP felt that not all cases of placenta accreta require a hysterectomy, and reproductive justice or preservation should be considered.

Next question. "If a patient is admitted with a diagnosis of anemia, and this is listed as POA Yes, why does the case still fail the PC-07 measure?"
Answer, anemia is a risk factor, and its value, including POA status, does not affect the measure Numerator.

Okay, next question. "Is patient in Denominator for PC-07 if fetal demise at week 17, or does it need to be greater than or equal to 20 weeks?"
Answer, the measure looks for gestational age greater than or equal to 20 weeks.

Susan, I think that we're nearing the end here. There's some additional questions that will take a few more moments to complete, but I think those are all the ones we have for today.

[Susan] Great. Thank you so much for moderating, I'm sorry, facilitating the Q&A segment. Okay, as Melissa explained, we will include anything that wasn't answered live within the written Q&A document, and all of those, the Q&A document will be posted to the Joint Commission website within several weeks. As we noted, the responses need to be reviewed and approved by CMS.

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Previous Expert to Expert recording links, slides, and transcripts can be accessed on the Joint Commission's webpage via the link displayed on this slide. You'll just scroll down and use the checkbox to sort for Expert to Expert webinars, and within a couple weeks, the recording and materials will be posted on that site, and also on the eCQI Resource Center. After this webinar, if you still have questions about webinar operations or obtaining Continuing Education credit, you can submit them via email to tjcwebinarnotifications@jointcommission.org.

And for those that wish to attend any of our future webinars in this series, we've included a handout that has the registration links for all of the scheduled webinars that are going through April of this year. There will be additional ones scheduled, so just keep an eye on the Joint Commission website for any additional webinars, and please share that document with your colleagues so that they can register for the upcoming webinars.

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Before this webinar concludes, a few words about the survey. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. A QR code will appear on the next slide. You can use your mobile device to scan and access the survey. If you prefer to take the survey later, an automated email also delivers the link to the survey.

After you complete and submit your survey responses, you will be redirected to a page from which you can print or download a blank certificate that you complete by adding your own name and credentials. In case you miss that opportunity to download, an automated email will also be sent to you that includes the link to the certificate.

One additional thing to keep in mind, the survey is only open for two weeks, so you'll want to promptly complete that survey.

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We will leave this slide up for a few moments so that the participants can scan the survey QR code. I want to extend my sincere thanks to Raquel, Kelley, and Valery for presenting today regarding the changes to the perinatal care eCQMs, and thanks to Melissa for facilitating the Q&A segment. Big thanks, too, to the entire team that was responding to questions in the queue, as well as the operation staff that supported the webinar. Finally, thanks to all of you in our audience that joined today, and this concludes our presentation.