

Frequently Asked Questions

For Severe Obstetric Complications Electronic Clinical
Quality Measure (eCQM) in the Inpatient Quality
Reporting (IQR) Program

October 2026 Public Reporting

Measure Updates

2

Measure Overview

2

Data Sources

3

- Measure Cohort
- Measure Outcome
- Risk Adjustment

3

- Risk-Standardized
Obstetric
Complication Rate
- Hospital-Specific
Reports

7

- Additional Resources
- Glossary

12

Please note: To return to your original viewing page after clicking on a link, please press the "ALT" and left arrow keys simultaneously.

Measure Updates

1. What updates have been made to Calendar Year (CY) 2025 Severe Obstetric Complications Electronic Clinical Quality Measure (PC-07) for 2026 public reporting?

Centers for Medicare & Medicaid Services (CMS) has made the following updates:

- Updated the year used to calculate the measure (i.e., CY 2025 is now used) ([Question 3](#)).
- Added outcome exclusion ([Question 8](#)):
 - For the PC-07a (Perinatal Care) [outcome](#) capturing any severe obstetric complications: inpatient hospitalizations with blood transfusion or hysterectomy with a diagnosis of placenta percreta or placenta increta and no additional complications are now excluded from the numerator.
 - For the PC-07b outcome capturing severe obstetric complications excluding encounters where blood transfusion is the only numerator event (outcome): inpatient hospitalizations with hysterectomy with placenta percreta or placenta increta without additional complications are excluded from the numerator.
- Performance categories using measure results will be publicly reported starting with October 2026 reporting ([Question 18](#)):
 - Top 25%, middle 50%, and bottom 25% will define the performance categories.
 - Hospitals with fewer than 25 eligible delivery hospitalizations will be their own “number of cases too small” category.
- Electronic specifications updated to V3 on the [Electronic Clinical Quality Improvement \(eCQI\) Resource Center](#), here ([Question 22](#)):
 - Technical release notes are here: https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms1028v3?qt-tabs_measure=release-notes

Measure Overview

2. Why is CMS measuring obstetric complications?

Maternal morbidity and mortality pose serious health threats to pregnant women in the United States. Hemorrhage, hypertensive disorders of pregnancy (HDP), sepsis/infection, cardiovascular conditions, cardiomyopathy, embolism, and mental health conditions have been identified as overall leading causes of peripartum death.¹ Nearly 16% of pregnancy-related

¹ Hoyert DL, Miniño AM. Maternal mortality in the United States: changes in coding, publication, and data release, 2018. *Natl Vital Stat Rep.* 2020;69(2):1–18. <https://pubmed.ncbi.nlm.nih.gov/32510319/>.

deaths can be attributed to cardiovascular conditions,² and more than 75% of pregnancy-related deaths due to cardiovascular conditions are often found to be preventable.³

National health experts and organizations have prioritized quality improvement strategies to mitigate risk of adverse outcomes among maternal populations. The U.S. Department of Health and Human Services (HHS) has called for action to improve maternal health and outcomes and outlines seven actions for healthcare professionals, including participating in quality improvement and safety initiatives.⁴ Most nationally implemented quality measures focused on maternal health are process measures and limited in scope. While existing measures aim to promote coordination of care and standardize healthcare processes, maternal health [outcome measures](#) are needed. Measures that are focused on maternal health outcomes will address the patient safety priority area under the Meaningful Measures 2.0 framework, and electronic clinical quality measures (eCQMs) will use electronic health record (EHR) data to address interoperability, another meaningful measure area for assessing quality health care.⁵

Data Sources

3. What data did CMS use to calculate the Severe Obstetric Complications eCQM?

The Severe Obstetric Complications eCQM (PC-07) uses hospital-submitted EHR data and data from other electronic clinical systems, depending on hospital site workflows, to define all components of the measure. For the 2026 results, hospitals submitted data for delivery hospitalization discharges occurring between January 1, 2025, and December 31, 2025.

Measure Cohort

4. Which patients are part of the measure cohort?

The measure cohort (the denominator) includes all inpatient hospitalizations for patients between eight years to under 65 years who delivered at least one baby (live or stillborn greater

² National Quality Forum. Maternal Morbidity and Mortality Environmental Scan. November 2, 2020. <https://digitalassets.jointcommission.org/api/public/content/ba971f13448a45e9ad00c4ff6ab5c300?v=9dd1485a>.

³ Briller J et al. Pregnancy-Related Mortality Due to Cardiovascular Conditions: Maternal Mortality Review Committees in 32 U.S. States, 2017 to 2019. *JACC Adv.* 2024; 3 (12, Part 1). <https://doi.org/10.1016/j.jacadv.2024.101382>.

⁴ U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Improve Maternal Health. 2020. <https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf>.

⁵ Centers for Medicare & Medicaid Services. Meaningful Measures 2.0: Moving to Measure Prioritization and Modernization. Updated July 14, 2026. <https://www.cms.gov/medicare/quality/cms-national-quality-strategy/meaningful-measures-20-moving-measure-reduction-modernization>.

than or equal to 20 weeks gestation). Patients with coronavirus disease 2019 (COVID-19) are only excluded if they had a respiratory complication during the hospitalization.

5. What if a patient has multiple births during the encounter (e.g., twins) or during the performance period?

In the case of multiple births during one encounter (twins, triplets, etc.), map the first delivery date and time (Baby A) as the delivery date/time for the encounter. If there is more than one delivery encounter in the performance period meeting measure specification requirements, both are included in the denominator.

Measure Outcome

6. What is the measure outcome?

The Severe Obstetric Complications eQIM (PC-07) is unique in that it has two outcomes:

PC-07a: Any severe obstetric complication: Severe medical (i.e., sepsis, eclampsia, respiratory, cardiac, etc.) and procedural (i.e., hysterectomy, blood transfusion) complications, including death.

PC-07b: A subset of PC-07a, captures severe obstetric complications excluding blood transfusion-only delivery hospitalizations: Any severe obstetric complication (above) except for delivery hospitalizations where blood transfusion was the only complication.

The measure outcome (the numerator) is based on the Centers for Disease Control and Prevention (CDC) definition of Severe Maternal Morbidity⁶ and uses the International Classification of Diseases 10th Revision (ICD-10) to define diagnoses and procedures that are indicative of a complication. ICD-10 codes are used for billing in hospitals and therefore are generally widely available and offer stability over time. Different from the CDC definition, the measure uses [present on admission](#) (POA) codes to only count complications that occurred after admission for delivery as numerator events. The numerator also includes patients who die during the inpatient delivery encounter.

The measure outcome is defined as the number of inpatient delivery hospitalizations among the denominator who experience any of the following numerator events (note that only diagnoses not present on admission are considered a numerator event), or death:

- Acute myocardial infarction
- Cardiac arrest/ventricular fibrillation
- Aortic aneurysm

⁶ Centers for Disease Control and Prevention (CDC). Severe Maternal Morbidity. Updated May 15, 2024. <https://www.cdc.gov/maternal-infant-health/php/severe-maternal-morbidity/index.html>.

- Heart failure/arrest during procedure or surgery
- Disseminated intravascular coagulation
- Shock
- Acute renal failure
- Adult respiratory distress syndrome
- Pulmonary edema/Acute heart failure⁷
- Sepsis
- Air and thrombotic embolism
- Amniotic fluid embolism
- Eclampsia
- Severe anesthesia complications
- Puerperal cerebrovascular disorder
- Sickle cell disease with crisis
- Blood transfusion
- Conversion of cardiac rhythm
- Hysterectomy
- Temporary tracheostomy
- Ventilation

Read more about the measure outcome within the measure methodology report located on the [eCQI Resource Center](#).

7. Why are there two measure outcomes?

Blood transfusions, generally needed in response to excessive bleeding around delivery, account for the greatest proportion of patients identified as having an obstetric complication, and blood transfusion-only cases may reflect complications of lesser severity. Two outcomes allow the capture of different constructs of maternal quality.

8. What is the outcome exclusion?

For the PC-07a outcome: inpatient hospitalizations with blood transfusion or hysterectomy with a diagnosis of placenta percreta or placenta increta and no additional complications are excluded from the numerator.

For the PC-07b (excluding encounters with blood transfusion-only) outcome: inpatient hospitalizations with hysterectomy with placenta percreta or placenta increta without additional complications are excluded from the numerator.

An outcome exclusion was added to the measure specifications beginning with CY 2025 based on recommendations of a technical advisory panel. The applicable [value set](#) is "Placenta Increta or Percreta" (2.16.840.1.113762.1.4.1029.388).

⁷ CDC utilizes 21 indicators for defining Severe Maternal Morbidity (SMM), but for the purposes of this measure's outcome, one of the indicators (Pulmonary edema/Acute heart failure) is defined using two distinct value sets.

It is listed here as one indicator, but the value sets identify these as two distinct diagnoses. Likewise, the Measure Authoring Tool (MAT) header that supports this eQIM identifies these two diagnoses separately.

Risk Adjustment

9. How does the measure risk adjust for differences in the measure population?

The goal of [risk adjustment](#) is to account for patient-level factors that are clinically relevant, have strong relationships with the outcome, and are outside of the control of the reporting entity, without obscuring important quality differences. Risk factors can increase (or decrease) the likelihood that a patient experiences a certain outcome. Risk adjustment for case mix differences among hospitals is based on clinical status of the patient and other patient characteristics at the time of admission. Only conditions or comorbidities that convey information about the patient at the time of the admission are included in risk adjustment, determined by POA indicators. Complications that arise during the hospitalization are not used in risk adjustment. The following risk variables are included in each risk model (both outcomes):

- Patient demographics:
 - maternal age (derived from birthdate)
- Laboratory tests and vital signs: Hematocrit, White blood cell (WBC) count, Heart rate, Systolic blood pressure
- Preexisting conditions and pregnancy characteristics defined by ICD-10 codes:
 - Anemia
 - Asthma
 - Autoimmune disease
 - Bariatric surgery
 - Bleeding disorder
 - Body Mass Index (BMI) greater than or equal to 40
 - Cardiac disease
 - Gastrointestinal disease
 - Gestational diabetes
 - Human Immunodeficiency Virus (HIV)
 - Hypertension
 - Mental health disorder
 - Multiple pregnancy
 - Neuromuscular disease
 - Obstetric venous thromboembolism (VTE)
 - Other pre-eclampsia
 - Placental accreta spectrum
 - Placental abruption
 - Placenta previa
 - Preexisting diabetes
 - Preterm birth
 - Previous cesarean
 - Pulmonary hypertension
 - Renal disease
 - Severe pre-eclampsia
 - Substance abuse
 - Thyrotoxicosis
 - Long-term anticoagulant medication use
 - Social Risk Factors:
 - economic/housing instability

Laboratory tests and vital signs (hematocrit, WBC count, heart rate, systolic blood pressure) are intended to be the first captured results upon hospital arrival [first resulted value within 24

hours prior to initial encounter (earliest between inpatient admission, emergency department/obstetric triage, observation stay) and before delivery]. For more detail, see [Question 22](#) and the electronic measure specifications on the [eCQI Resource Center](#).

10. How are present on admission (POA) codes used in the measure and why are they important?

POA codes are used in two ways in the measure calculation:

- 1) **To identify risk factors:** Allows your hospital's rates to be properly adjusted based on how sick a patient is by identifying patient comorbidities that are POA. If POA indicators are missing, it cannot be determined whether a risk factor was present prior to admission. This can make it appear that your patients are healthier than they actually are.
- 2) **To identify numerator events or complications:** Allows for identification of complications that occurred during the delivery hospitalization (and distinguishes them from comorbidities POA). If POA indicators are missing, it cannot be determined if a complication occurred before or during the delivery hospitalization. This can make it appear that patients did not have a complication, when in actuality they did.

11. How and when are my results risk-adjusted?

After your hospital submits Quality Reporting Document Architecture (QRDA) I files with all required data elements to calculate the risk-adjusted outcome rates (including POA codes), CMS will provide you with the observed rates. After receiving data from all hospitals, CMS calculates your risk-standardized obstetric complications rate (RSOCR) and provides your facility with the results during Summer Preview (usually in August). See [Risk-Standardized Obstetric Complications Rate](#) section for details of the RSOCR.

12. Do people with more codes with the same risk factor have that risk factor weighted more?

No, multiple conditions within a condition category are not more heavily weighted in risk adjustment.

Risk-Standardized Obstetric Complications Rate

13. What is a Risk-Standardized Obstetric Complications Rate?

A hospital's Risk-Standardized Obstetric Complications Rate (RSOCR) is calculated as the ratio of the number of "predicted" delivery hospitalizations with a complication to the number of

“expected” delivery hospitalizations with a complication at a given hospital, multiplied by the national observed severe obstetric complication rate, as illustrated in **Figure 1**.

Figure 1. Risk-Standardized Obstetric Complications Rate Calculation

$$\frac{\text{Predicted (P) number of delivery hospitalizations with a complication}}{\text{Expected (E) number of delivery hospitalizations with a complication}} = \text{Ratio of P:E} \times \text{National Rate per 10,000} = \text{Hospital RSOCR}$$

For each hospital, the numerator of the ratio is the number of delivery hospitalizations with a complication predicted based on the hospital’s performance with its observed case mix; the denominator is the number of delivery hospitalizations with a complication expected based on the nation’s performance with that hospital’s case mix. This approach is analogous to a ratio of “observed” to “expected” used in other types of statistical analyses. It conceptually allows a particular hospital’s performance, given its case mix, to be compared to an average hospital’s performance with the same case mix. Thus, a lower ratio indicates lower-than-expected complication rates or better quality, while a higher ratio indicates higher-than-expected complication rates or worse quality. The hospital’s ratio of P/E is then standardized by multiplying it by the national observed rate (see an example in [Figure 2](#) for Hospital A’s RSOCR calculation).

Figure 2. Risk-Standardized Obstetric Complications Rate Calculation Example

$$\frac{450}{420} = 1.07 \times 236.70 = 253.61$$

Hospital A

14. How should I interpret my risk-adjusted results?

Each hospital’s RSOCR is calculated based on the ratio of predicted-to-expected number of delivery hospitalizations with a complication and multiplied by the national rate ([Figure 2](#)). The risk-adjusted rate should be compared to the national rate. If your hospital’s risk-adjusted rate

is lower than the national rate, it indicates that the hospital's outcome rate is better than expected given the characteristics of the patient mix for your hospital. In the example above, Hospital A has a RSOCR of 253.6 per 10,000 which is greater than the example national rate of 236.7 per 10,000, indicating that Hospital A's outcome rate is worse than expected when the observed rate is adjusted for its patient case mix. For more details about the risk-adjustment model, please see the [Methodology Report](#) located on the eCQI Resource Center.

15. Why are my risk-adjusted results so much higher than my observed rate, even when my hospital had no complications?

While a hospital's observed rate contributes to the calculation of its measure score, it should not be mathematically compared to the risk-standardized measure score (RSOCR). The measure score represents the hospital's relative performance compared to other hospitals adjusting for case mix, and is anchored by the national rate, and not the hospital's observed rate. A hospital's risk-standardized measure score could be higher than its observed rate if the national rate is higher than the observed rate or if the hospital has more delivery hospitalizations with a complication than would be expected given its patient case mix.

Even if there are zero observed complications, a hospital can still have a non-zero 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.

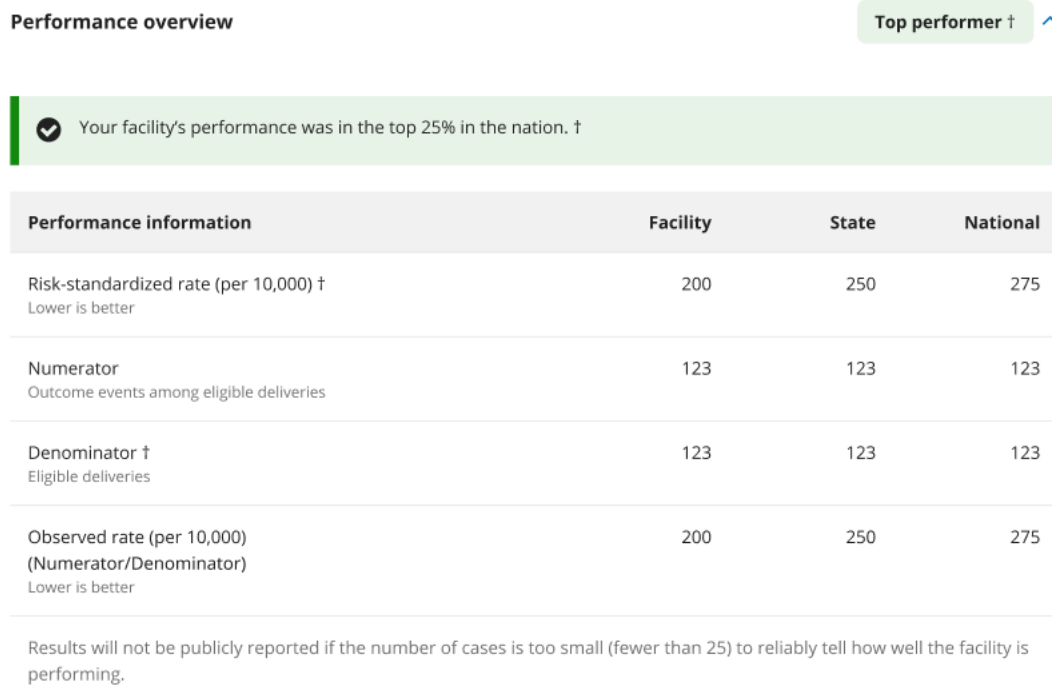
For more details about the risk-adjustment model and how the measure score is calculated, please see the [Methodology Report](#) located on the eCQI Resource Center.

Hospital-Specific Reports

16. What is in my report?

CMS is providing your facility with a summary of the results called a [Hospital-Specific Report](#) (HSR) (see [Figure 3](#) below) as well as a detailed downloadable comma-separated values (CSV) file with patient-level data and an accompanying user guide. The HSR includes the observed rate for your hospital, the RSOCR, the performance category, the numerator (number of outcomes among eligible deliveries), and the denominator (number of eligible deliveries). It also includes results of frequencies of individual complications that make up the outcome. For instructions on accessing these reports, see the following video on [YouTube](#). You will find the following results on the [Hospital Quality Reporting](#) platform. If your hospital did not receive an HSR, see [Question 21](#).

Figure 3. Example Summary of Facility Results



17. How should I use my measure results?

Generally, knowing your hospital's performance compared to other hospitals could suggest an opportunity for improvement in the provision of care. The results are intended to guide hospital efforts to improve maternal health outcomes by reducing severe obstetric complications. This can be achieved through implementing evidence-based practices, assessing the QAPI program oversight, strengthening care systems, and delivering timely, effective treatment—ultimately enhancing the quality of maternal care.

18. Are my results publicly reported?

Your hospital's RSOCR, number of delivery hospitalizations, and performance category for both outcomes will be publicly reported on the [Compare Tool](#) and in the [Provider Data Catalog](#) on [Data.CMS.gov](#) if your hospital has 25 or more eligible delivery hospitalizations.

19. How does CMS categorize hospital results?

CMS assigns performance categories to hospitals to describe how each hospital compares to other hospitals in the nation. These performance categories indicate whether a hospital performed at a top, middle, or bottom level relative to other hospitals in the nation. For the PC-07a and PC-07b measure outcomes, performance categories are determined using a percentile-based methodology. Specifically, hospitals are grouped based on their relative performance

distribution, with thresholds defined by the top and bottom 25% (of hospitals with at least 25 eligible cases). Due to lower measure scores being better, hospitals with lower RSOCRs are considered top performers.

Performance categories will be included alongside the risk-standardized measure results for hospitals with at least 25 eligible delivery hospitalizations:

- Top performers: hospitals with RSOCRs within the top 25% of hospitals in the nation
- Middle performers: hospitals with RSOCRs within the middle 50% of hospitals in the nation
- Bottom performers: hospitals with RSOCRs within the bottom 25% of hospitals in the nation

Figure 4. Performance Categories for RSOCRs per 10,000 delivery hospitalizations (any Severe Obstetric Complication (SOC)) using top 25% and bottom 25% thresholds

Performance Category:	Top Performer (RSOCR is in the top 25%)	Middle Performer (RSOCR is the middle 50%)	Bottom Performer (RSOCR is in the bottom 25%)
RSOCR (any SOC)	RSOCR 207 or fewer per 10,000 delivery hospitalizations	RSOCR between 208-419 per 10,000 delivery hospitalizations	RSOCR 420 or more per 10,000 delivery hospitalizations

CMS assigns hospitals with fewer than 25 eligible delivery hospitalizations during the reporting period a performance category of “number of cases too small.” If a hospital has fewer than 25 eligible delivery hospitalizations, measure performance cannot be reliably estimated. In these cases, CMS will not publicly report the applicable measure rates for that measure; however, CMS includes these data in hospitals’ confidential HSR.

20. Am I required to submit data for PC-07?

If your hospital participates in either CMS’s [Hospital Inpatient Quality Reporting \(IQR\) Program](#) or [Medicare Promoting Interoperability Program](#), your facility is required to submit data for the measure. For CY 2025, the program required eligible participating hospitals to report on and submit a full year’s worth of data on six total electronic clinical quality measures (eQMs): three eQMs selected by CMS, and three eQMs self-selected by the hospital from a list of 12 remaining eQMs. The eQMs selected by CMS are: Safe Use of Opioids-Concurrent Prescribing; Cesarean Birth (Perinatal Care [PC-02]); and **Severe Obstetric Complications (PC-07)**. More information can be found under Measures for Calendar Year (CY) 2025 Reporting Period on [QualityNet](#) at <https://qualitynet.cms.gov/inpatient/measures/ecqm/measures#tab2>.

For the exact data elements to submit, see the [Specifications and Data Elements tab](#) on the eCQI Resource Center here https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms1028v3?qt-tabs_measure=specifications-and-data-elements along with additional resources for hospitals.

21. Why didn't my hospital receive an HSR with measure results?

Your hospital will not receive an HSR if it was not defined as open during the measurement period/reporting period deadline.

If you believe that your hospital should have received an HSR but did not, please contact the QualityNet Service Center at qnetsupport@cms.hhs.gov. Please ***do not include Personally Identifiable Information (PII) or Protected Health Information (PHI) in questions submitted.***

Additional Resources

22. Where can I find more information on this measure?

The Measure Methodology Report and Measure Updates Report are located on the [eCQI Resource Center](#) at <https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms1028v3> and the specifics on measure specifications, data elements, and value sets are [here](#) https://ecqi.healthit.gov/ecqm/hosp-inpt/2025/cms1028v3?qt-tabs_measure=specifications-and-data-elements.

Additional information can be found on [QualityNet](#) at <https://qualitynet.cms.gov/inpatient/measures/ecqm/measures#tab2>.

23. Where do I go to ask questions?

If your question is about technical measure specifications, you can submit your question at <https://oncprojecttracking.healthit.gov/olp> -> and [create an issue ticket](#). A login is required.

Please submit other questions about the measure or general program requirements following these steps:

1. Access the [QualityNet Q&A Tool](#) - Opens in new browser tab.
2. Select "IQR - Inpatient Quality Reporting" from the drop-down menu in the Program field.
3. Click into the Topic field and select "eCQMs".
4. Complete all other mandatory fields, the CAPTCHA, and click "Submit Question".

For proper handling of inquiries, please refer to the specific measure (PC-07 or severe obstetric complications for this measure) to which your questions relate.

Glossary

Hospital-Specific Reports (HSRs): Reports issued by CMS in the Hospital IQR Program and other quality programs that give hospitals detailed measure results, discharge-level data, and state and national results.

Outcome: The result of performance (or nonperformance) of a function or process.

Outcome measure: A measure that assesses what happens or does not happen to a patient following a process; agreed upon desired patient characteristics to be achieved; or undesired patient conditions to be avoided.

Present on admission (POA): This refers to whether a diagnosis or condition existed at the time a patient was admitted to a hospital for inpatient care, to distinguish between conditions that were (POA) and those that developed during the patient's stay.

Risk adjustment: Risk adjustment means identifying patient characteristics like severity of illness or age that increase or decrease the chance of a patient having a particular outcome, such as a complication, and adjusting for them in a measure calculation. In some cases, CMS adjusts for risk when reporting performance measures to fairly compare hospital performance.

Value Set: A set list of codes and corresponding terms from standard clinical vocabularies such as Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), RxNorm, or Logical Observation Identifiers Names and Codes (LOINC), that define specific clinical concepts. These value sets specify the acceptable codes for data elements in clinical quality measures, ensuring data consistency and interoperability.