

Measures at a Glance

For the Spring 2026 cycle, there are two measures focused on the same concept but with different data sources: CBE #0210 is the registry-version and CBE #5594 is the claims-version.

CBE #0210: Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14/30 Days of Life (lower score – better) (Registry version)

Measure Summary (Where does this measure seek to improve care?)

This measure looks at how often patients with cancer receive systemic cancer-directed therapy (treatment that affects the whole body) in the last 14 or 30 days of life. It focuses on patients who are 18 years and older and who died with cancer. The goal is to track how often treatment continues very close to death. A lower score means fewer patients received this treatment near the end of life, indicating better care.

The measure applies to care given in outpatient settings, such as clinics and clinician offices. It assesses care provided by individual clinicians or clinician groups/practices. This registry-based measure uses data from electronic health records (EHRs), which are digital patient records.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

This measure focuses on care that matters to patients near the end of life. Many patients with advanced cancer want care that supports comfort and quality of life instead of more treatment. This measure looks at how often patients receive cancer treatment very close to death. It may help show whether care is aligned with patient goals, especially when patients prefer less aggressive treatment and more support.

Patients, families, and experts helped develop this measure. Their input helped ensure the measure reflects real patient needs and experiences. Feedback shows that people believe the measure can help show the difference between higher and lower quality care. This measure may show whether patients receive less aggressive treatment near the end of life.

Usability (How will providers use this measure to improve care delivery?)

The measure may help clinicians and groups/practices review how often treatment continues near the end of life and compare their results over time. Patients and families may also find the results useful when discussing care choices. Patients and clinicians may use the measure when talking about care goals and treatment options.

Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

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The measure uses structured data fields (organized data formats) from EHRs. Because clinicians already collect the data during care, they do not need to create new records for reporting. This setup may help ensure that the data are consistent and easy to use across different health care systems.

Programs such as the Merit-based Incentive Payment System (MIPS) have used the measure, which suggests it can work in real health care settings. The measure has a low administrative burden, meaning it may not require a lot of extra time or effort to report. The use of de-identified data, where health care systems remove personal details, may help protect patient privacy while still allowing systems to review care patterns.

Impact (How will using this measure improve patient experiences and outcomes?)

This measure focuses on care (specifically, cancer-directed therapy) near the end of life for patients with cancer. Research links high use of this treatment near death to more hospital stays, including intensive care unit (ICU) stays, and delayed use of hospice care. These patterns may affect a patient's quality of life.

The measure encourages earlier use of palliative care and fewer aggressive treatments near the end of life. Studies show that treatment at this stage does not result in a difference in overall survival.

By showing how often these treatments happen, the measure could help clinicians and care teams review their practices. This may support care that focuses more on comfort, symptom control, and patient preferences.

Performance Gap (Based on current performance, where and how much care can improve?)

Data from January 2023 to December 2024 show differences in how often clinicians and groups/practices provide systemic cancer-directed therapy near the end of life. The percentage shows how many of a clinician's patients who died received cancer treatment in the last 14 or 30 days of life. For example, a score of 10% means 10 out of every 100 patients who died received treatment during that time, and 90 did not.

Individual Clinician Results

Results are based on 158 clinicians with total of 10,268 patients.

For the 14-day measure: scores ranged from 0% to 40%, with an average (mean) of 10% and a median of 10%.

For the 30-day measure: scores ranged from 0% to 60%, with a mean of 25% and a median of 24%.

Clinician Groups (Practices) Results

Results are based on 10 practices with total of 13,812 patients.

For the 14-day measure: scores ranged from 6% to 12%, with a mean of 10% and a median of 10%.

For the 30-day measure: scores ranged from 20% to 32%, with a mean of 25% and a median of 25%.

These results show wide variation across clinicians and groups/practices. Some report 0%, while others report much higher rates. This variation may point to differences in how providers decide when to stop treatment and shift to comfort-focused care. The measure could highlight opportunities to review care practices and support better alignment with patient preferences near the end of life.

CBE #5594: Percentage of Patients who Died with Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 / 30 Days of Life (lower score – better) (Claims version)

Measure Summary (Where does this measure seek to improve care?)

This measure looks at how often patients (aged 18 years and older) who died with cancer received systemic cancer-directed therapy (treatment that affects the whole body) in the last 14 days or 30 days of life. It focuses on care near the end of life. A lower score means better performance and shows fewer patients received these treatments close to death.

The measure does not include patients receiving certain treatments, such as hydroxyurea or Bruton tyrosine kinase (BTK) inhibitors (a type of medicine used to treat some cancers) or chimeric antigen receptor (CAR) T-cell therapy (a type of cancer treatment that uses a person's own immune cells to fight cancer) in the last 60 days, or patients preparing for transplants.

This measure applies to care given in outpatient settings such as clinics and doctor offices.

Meaningfulness (Why does this matter to patients, and how could it improve their care?)

This measure focuses on care that matters to patients near the end of life. Developers used input from patients with advanced cancer and from family members to create the measure. These groups shared what is most important, such as comfort, quality of life, and avoiding unwanted aggressive treatment. Experts also reviewed and ranked these ideas to make sure the measure reflects patient and family values.

A public comment process showed that most respondents agreed this measure reflects meaningful care and can help show differences in care quality. A patient strongly agreed that this measure promotes early palliative care (care focused on comfort and symptom relief) and may help reduce aggressive treatments near the end of life. The feedback shows that the measure reflects patient and family priorities.

Usability (How will providers use this measure to improve care delivery?)

This measure can help show how care, particularly systemic cancer-directed therapy, is provided near the end of life by looking at treatment in the final days.

The results can highlight variation in practice patterns such as higher rates of treatment in the last 14 or 30 days of life and support targeted quality improvement efforts aimed at aligning care with palliative goals.

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Additionally, tracking performance over time can help organizations evaluate the impact of interventions such as earlier palliative care referral, advance care planning, and changes in end-of-life treatment practices.

Feasibility (How can this measure be implemented without adding burden for providers and patients while still improving care?)

This measure uses claims data (billing data from health care services) created during routine care. The data are stored in structured fields, meaning users input the data in set, organized ways. Because the health care teams already collect the data, they do not need to gather new information. This may make applying the measure across different settings easier.

However, claims processing can take time, and some details may be missing if coding is incomplete. Even with these limits, systems check the data for accuracy using billing and care records. Each record links back to the original claim, which supports reliable use of the measure.

Impact (How will using this measure improve patient experiences and outcomes?)

This measure looks at how care near the end of life may affect patients. Systemic cancer-directed therapy close to death is linked to more hospital stays, including intensive care unit (ICU) stays, delays in hospice care, worse quality of life, and higher costs. A palliative approach may offer a better quality of life for patients with serious illness.

The measure encourages earlier palliative care and less aggressive treatment near the end of life. This approach may lead to fewer hospital visits, better symptom control, and improved experiences for patients, families, and caregivers. It may also reduce health care costs by focusing on care that supports comfort rather than intensive treatment.

Performance Gap (Based on current performance, where and how much care can improve?)

Data from January 2023 to December 2024 show a wide range in how often patients receive systemic cancer-directed therapy near the end of life.

14-Day Version

For the 14-day measure, data from 561 practices and 15,027 patients showed a range from 0% to 67%, with a mean (average) of 15.6%. Lower scores mean better performance.

Deciles divide clinician groups into 10 equal parts based on scores. Decile 1 includes clinician groups with the lowest scores, and Decile 10 includes clinician groups with the highest scores. Performance worsens in the higher deciles because higher scores show more treatment near the end of life.

For the 14-day measure, Decile 1 has a score of 0.0%, and Decile 10 has a score of 40.8%.

30-Day Version

For the 30-day measure, data from 561 practices and 15,098 patients showed a range from 0% to 100%, with a mean of 37.9%.

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For the 30-day measure, Decile 1 has a score of 11.1%, and Decile 10 has a score of 69%.

These differences suggest that care patterns vary across clinician groups. Some practices have very low use of treatment near the end of life, while others have much higher use. This variation may show opportunities to review care decisions and better align treatment with patient goals, especially for comfort and quality of life near the end of life.

Disclaimer: Battelle used generative artificial intelligence in the initial drafting of this document. Actual humans with relevant expertise subsequently validated and revised the content.