

Measures at a Glance

For the Spring 2026 cycle, there are two measures focused on the same concept but with different data sources: CBE #0216 is the registry-version and CBE #5595 is the claims-version.

CBE #0216: Percentage of Patients who Died with Cancer Enrolled in Hospice for at Least 3 Days Immediately Before Death (Registry version)

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

This measure looks at how many patients age 18 years and older who died with cancer were enrolled in hospice for at least 3 days before death. Hospice is special end-of-life care that focuses on comfort and quality of life. This timing may matter because short hospice stays can limit the services patients and families receive, such as symptom management and support.

A higher score indicates more patients received hospice care at least 3 days before death.

The measure is for use in outpatient care settings, such as clinics and doctor offices. It can be applied to individual clinicians or clinician groups/practices.

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

This measure focuses on aspects of care that patients with advanced cancer and their families have identified as important at the end of life.

When creating the measure, the measure developer used input from patients with incurable cancer and family members of deceased patients. They identified priorities such as comfort, support, and quality of care.

The measure developers report that many patients nearing the end of life prefer to die at home. Evidence shows that family caregivers rate hospice care in the home higher than hospice care in hospital or inpatient settings.

The measure also incorporates feedback from a public comment period in May 2025. Most respondents agreed the measure captures meaningful aspects of end-of-life care and shows differences in care quality across clinicians and clinician groups/practices.

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

This measure may help clinicians and health care groups/practices understand how often patients receive hospice care before death.

The Merit-based Incentive Payment System (MIPS) uses the measure. MIPS links quality measures to payment and performance tracking.

The results may be used for:

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- Patients and families to compare care across clinicians or practices.
- Physicians to identify opportunities to improve their timing of hospice referrals.
- Facilities to begin quality improvement by showing patterns in care.
- Facilities to track and review results over time (because the measure includes hospice admission dates and death dates.)

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

This measure uses a registry to collect data from multiple sources, including electronic health records (EHRs), paper records, and clinical registries. It uses structured data fields—such as hospice admission dates and death dates—that providers already collect during routine care. Unlike standard measures that rely on one data source, this measure combines data from several systems.

The MIPS uses this measure for reporting. Clinicians and groups can submit data through registry systems, including a Qualified Clinical Data Registry (QCDR). A QCDR is a CMS-approved vendor that helps collect and report quality data for MIPS.

MIPS currently uses this measure, and a national oncology registry also reports it using EHR data. Its broad use shows that it can be easy to report and may not place a high burden on providers. The measure uses nationally standardized data elements, which support consistent reporting across health care systems.

To report this measure, clinicians or groups must have at least five eligible patients. The measure does not require patient surveys, and it removes identifying information before analysis to protect patient privacy.

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

Hospice care is associated with improved symptom management, reduced caregiver stress, and lower health care costs. Hospice care may save about \$8,700 per Medicare patient, and some studies have found patients who receive hospice care survive longer.

However, short hospice stays may limit access to services such as symptom management, social work, and spiritual support. The median length of hospice stay among Medicare patients is about 18 days, and about one-quarter of patients receive hospice care for 5 days or less.

Timely hospice enrollment and palliative care reduce use of high-intensity services, such as hospital stays, emergency department visits, and intensive care at the end of life. Evidence shows that hospice and palliative care are linked to improved quality of life, better symptom control, and differences in end-of-life care patterns.

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

This measure shows differences in how often cancer patients receive hospice care for at least 3 days before death. Data are from January 1, 2023, to December 31, 2024, using EHR data from a national oncology network.

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This measure assesses performance gaps at two levels: individual clinicians and practices. The sections below present results for each level.

Results group clinicians or practices into 10 equal-sized categories (deciles) based on performance, from lowest to highest. The first decile includes the lowest scores, and the tenth includes the highest.

This approach shows how performance varies. As you move to higher deciles, performance improves. Higher percentages mean more patients received hospice care for at least 3 days before death, which reflects better performance.

Individual Clinician Level Performance

Results are based on 158 clinicians, each with at least five patients, and include about 10,250 patients.

The average score was 37%, and the median (middle value) was 38%. In the lowest decile, 8% of clinicians enrolled patients in hospice for at least 3 days before death. In the highest decile, 65% did so.

This gap shows clear differences in performance and highlights opportunities for clinicians to improve the timing of hospice referrals.

Practice Level Performance

Results are based on 10 practices, each with at least five patients, and include about 9,023 patients total.

The average score was 38%, and the median (middle value) was 41%.

With 10 practices, each decile represents one practice with at least 5 patients. In the lowest decile, 21% of clinicians enrolled patients in hospice for at least 3 days before death. In the highest decile, 52% did so.

These differences may show variation in performance. Practices below the median have an opportunity to improve the timing of hospice referrals.

CBE #5595: Percentage of Patients who Died with Cancer Enrolled in Hospice For at Least 3 Days Immediately Before Death (Claims version)

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

This measure looks at the percentage of patients age 18 and older who had cancer and were enrolled in hospice for at least 3 days before death. Hospice is a type of palliative care (care focused on comfort and quality of life).

A higher score means a higher percentage of patients received hospice care for this period. This measure does not include patients who had treatments such as bone marrow transplant, chimeric antigen receptor (CAR) T-cell therapy (a type of cancer treatment that uses a person's own immune cells to fight cancer), hydroxyurea, or Bruton tyrosine kinase (BTK) inhibitors (a type of medicine used to treat some cancers).

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

Cancer is the second leading cause of death in the United States and the leading cause of death for people younger than 85 years. In 2026, there have been about 2.1 million new cancer cases and over 500,000 deaths.

Many patients near the end of life prefer to die at home. Care at home with hospice often has higher ratings from family caregivers than care in hospitals or inpatient hospice settings.

The goal of this measure is to encourage earlier hospice enrollment and timely palliative care focused on symptom management instead of aggressive treatment. This approach may help improve patient and family satisfaction and reduce aggressive care near the end of life.

Measure developers used input from patients, families, and experts to create the measure. Most respondents agreed that it reflects meaningful care and helps show differences in care quality.

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

Clinician groups or practices use this measure. It looks at care in ambulatory settings, such as clinics and clinician offices. The measure uses claims data, so providers can review results based on services already recorded during billing.

The results may help clinician groups and practices:

- Understand how often patients receive hospice care near the end of life.
- Identify where changes in care processes, such as earlier hospice referral, could improve timing of care for patients.

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

This measure uses claims data, which are routinely generated and 100% available in electronic systems. The measure uses structured formats, which allow users to enter information in a set, organized way. This structure may make the data easier to collect and review without needing to search through free-text notes.

Because the measure does not require new data collection, administrative burden is low. There is no added cost for implementation, and clinicians do not need to change how they document care or use electronic health records.

Some data issues may still occur. Claims lag, which is a delay between care and claim finalization, may affect timing. Missing or incomplete coding may also affect data accuracy. However, payer systems perform validation and auditing checks. Each record can be tracked using a claim control number (CCN) and a National Provider Identifier (NPI), which supports data accuracy.

To protect patient privacy, the measure uses de-identified data, which removes personal details. In addition, the developer recommends a minimum of five patients for reporting to reduce the risk of identifying individuals in small groups.

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

Hospice and palliative care focus on comfort, symptom management, and quality of life for patients near the end of life. Hospice care is for patients expected to live less than 6 months. From 2022 to 2023, the median hospice stay was about 18 days, and about one-quarter of patients received hospice care for 5 days or less. Short stays may limit access to services such as symptom management and support for patients and families. Studies also show that aggressive end-of-life care is common, with hospice stays of less than 3 days occurring in 14.4% of cases. These findings show that some patients may not receive timely hospice care.

The goal of the measure is to encourage earlier hospice enrollment and timely palliative care. Patients who use hospice may have improved symptoms, less caregiver distress, and reduced costs of about \$8,700 per Medicare beneficiary. Some reports show longer survival for patients who use hospice. Earlier use of these services may reduce aggressive care and may improve patient and family satisfaction.

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

The data show variation in how practices refer patients to hospice and how early these referrals occur. Data from 2023 to 2024 included 555 practices and 15,514 patients. Scores ranged from 0% to 91%. The mean (average) score was 38%, and the median (the middle value when arranging numbers from lowest to highest) was 40%. The mode (most common score) was 0%, meaning many practices had no patients enrolled in hospice for at least 3 days before death.

Performance results are also reported in deciles. Deciles divide clinician group practices into 10 equal parts based on scores. Decile 1 includes practices with the lowest scores, and Decile 10 includes practices with the highest scores; higher deciles reflect better performance. Decile 1 had a score of 0.0%, and Decile 10 had a score of 70.7%.

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