

**CBE 3510: Screening/Surveillance Colonoscopy Episode-Based Cost Measure
Response to American College of Gastroenterology, American Gastroenterological
Association, and American Society for Gastrointestinal Endoscopy Public Comment
Spring 2026 Maintenance of Endorsement**

We appreciate the American College of Gastroenterology (ACG), American Gastroenterological Association (AGA), and American Society for Gastrointestinal Endoscopy (ASGE)'s detailed engagement with the Screening/Surveillance Colonoscopy episode-based cost measure and thank the societies for their comments on cost and quality alignment, assessing cost in the context of quality, and risk adjustment. Our response addresses each area in turn.

Quality and Cost Alignment

We appreciate the societies' recognition that episode-based cost measures aligned with clinical quality measures have the potential to improve quality and reduce cost, and we share the societies' view that cost information is most meaningful when interpreted alongside quality information. This measure is implemented within the Merit-based Incentive Payment System (MIPS), where cost performance is scored and reported alongside quality measures in a composite framework designed to give clinicians and groups a complete view of their performance.

We understand the societies' related concerns that the observed performance gap is small in absolute terms, that these differences may reflect patient preferences and needs such as anesthesia use and bowel-preparation type, and their emphasis that cost measures should provide sufficient information to enable an assessment of whether costs are reasonable and appropriate. The measure is not designed to reward the lowest possible cost per episode, nor is it intended to determine whether a given episode's cost is "reasonable and appropriate" in absolute terms. Rather, for each attributed episode the measure calculates the ratio of the episode's observed cost to the cost expected given the patient's clinical case-mix, then averages that per-episode observed-to-expected ratio across all of the clinician's or group's attributed episodes to produce the measure score, which identifies clinicians and groups whose average risk-adjusted cost is meaningfully higher or lower than expected. Variation in patient risk profile, including the preference- and case-mix-driven factors the societies identify, is accounted for through the risk-adjustment model. Because the measure already adjusts for case-mix and setting, the differences that remain across the entity-level distribution reflect clinician-attributable cost variation that is not explained by patient case-mix, and even modest absolute differences represent meaningful variation in resource use across clinicians and groups performing similar procedures on similar patients.

Assessing Cost in the Context of Quality

We thank the societies for their emphasis on the importance of connecting cost performance to quality of care, and we share their view that examining this relationship is a valuable component of the Usability assessment, consistent with the Battelle guidance the societies reference. We

agree that adenoma detection rate is the clinically most-recognized quality measure for colonoscopy and that a widely reported quality outcome measure such as the GIQuIC26 Screening Colonoscopy Adenoma Detection Rate would in principle provide useful quality context; however, that measure is rarely reported within MIPS, which precluded a meaningful correlation analysis for this evaluation. In place of a direct cost-to-quality-measure correlation, the validity testing analyzes the relationship between measure performance and clinician-modifiable, claims-based events (namely, repeat colonoscopy within the episode window and post-procedure adverse events), which are identified using administrative claims data, not cost data alone, and which are what could be reliably measured across the attributed population.

We appreciate the societies' attention to how the adverse events used in the validity testing are attributed to the colonoscopy and whether those events are risk adjusted. Events during the episode window are counted as clinically related to the colonoscopy only when the underlying service and diagnosis codes meet the clinical-relatedness criteria specified in the codes list; events are not counted solely by virtue of their timing within the window. The validity indicator itself is a raw event share rather than a risk-adjusted rate, while the observed-to-expected ratio it is correlated against is risk-adjusted.

We acknowledge the societies' observation that examining validity correlations stratified by care setting would be informative. That analysis was not part of the testing for this evaluation.

We appreciate the societies' interest in understanding the measure's effect on Medicare spending since its introduction in MIPS. The measure is intended to assess clinician and group performance relative to their peers within a given performance period, rather than to assess changes in cost over time. Section 6.2.4 documents the sustained performance gap the measure continues to produce under current scoring, indicating continued opportunity for cost efficiency across the attributed population. Any evaluation of the measure's broader effect on Medicare spending would need to be interpreted relative to the specific MIPS scoring environment in each performance period, which has changed repeatedly since the measure's implementation, including the reweighting of the MIPS cost performance category to 0% for the 2020 and 2021 performance periods due to the COVID-19 public health emergency, and the change beginning with the 2024 performance period in the cost-measure achievement-point methodology, which replaced decile-based percentile benchmarks with a distribution anchored on the median cost (set at 10% of the performance threshold) with benchmark cut-points defined by standard deviations from the median.

Risk Adjustment

We appreciate the societies' attention to health-related social needs and their potential relationship to episode cost, and their broader methodological point that measures whose measurement window includes care outside the clinician's immediate locus of control may benefit from socio-economic adjustment considered at multiple levels, including patient, clinician, and community. Clinical complexity in the current model is addressed through the

Centers for Medicare & Medicaid Services (CMS) Hierarchical Condition Category (HCC) framework, which is the standard risk-adjustment approach applied across MIPS episode-based cost measures, combined with measure-specific clinical adjustors. As documented in Section 5.4, predictive ratios near 1.0 across risk deciles show that the risk-adjustment model is well-calibrated. Site of service is addressed through the sub-group structure that estimates risk-adjustment coefficients separately for Hospital Outpatient Departments (HOPDs), Ambulatory Surgery Centers (ASCs), and office settings, and equalizes the risk-adjusted mean cost across the three sub-groups. We note that Closing Care Gaps remains optional for maintenance of endorsement, and additional testing of the effect of including social risk factors in the risk-adjustment model is not available at this time.

Conclusion

We thank the societies again for their detailed comments and thoughtful engagement with the Screening/Surveillance Colonoscopy episode-based cost measure. The measure's current specification reflects the guidance of the Gastrointestinal Disease Management Medical and Surgical Clinical Subcommittee that developed it, the 2019 National Quality Forum (NQF) Cost and Efficiency Standing Committee endorsement, sustained CMS use in MIPS since Performance Year 2019 (PY2019), and stakeholder input received through the 2022 Wave 1 Reevaluation public comment period. We appreciate the societies' recommendations regarding additional testing of cost-quality correlation and socio-economic risk factor adjustment, and note these recommendations for future consideration.