

June 26, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1690-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Docket No. CMS-1690-P, RIN 0938-AT32, Medicare Program; FY 2019 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates for Fiscal Year Beginning October 1, 2019

To Whom It May Concern:

The American Association for Cancer Research (AACR), with over 40,000 members, is the oldest and largest scientific organization in the world dedicated to the prevention and cure of cancer through research, education, communication, and collaboration. We appreciate the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services (CMS) proposed rule to update the prospective payment rates for Medicare inpatient hospital services provided by inpatient psychiatric facilities (IPFs). More specifically, we would like to respectfully offer comments on the proposed removal of measures for Tobacco Use Screening (TOB-1) and Tobacco Use Treatment Provided or Offered at Discharge (TOB-3 and TOB-3a).

Tobacco use is the leading preventable cause of premature mortality in the United States and globally. In 2016, tobacco use caused over 7.1 million deaths worldwide due to active and secondhand smoking. In the United States, about a half million deaths from active and secondhand smoking occur every year, accounting for about 1 in 10 deaths from multiple causes. Tobacco use has a particularly profound impact on cancer incidence and mortality. Tobacco accounts for 30 percent of all cancer deaths and is causally associated with 18 different human cancers, including: lung, head and neck, stomach, pancreas, colon, and cervical cancers. Continued smoking by cancer patients and survivors increases risk for overall mortality, cancer-related mortality, second primary cancer, and cancer treatment toxicity. Tobacco use in any form is one of the strongest threats to public health. To curb the burden of tobacco-related disease, we

need to implement evidence-based policies and programs to stem tobacco use and continue investing in monitoring and evaluation to ensure programs are achieving their intended outcomes.

About 25% of adults in the U.S. have some form of mental illness or chronic substance abuse disorder and this population consumes 40% of all cigarettes smoked by adults¹. Those with a history of mental illness or substance abuse die approximately 5 years earlier than the general population and the most common causes of death (e.g. cancer, heart disease, and lung disease) are associated with tobacco use¹. This population reports that they would like to quit smoking at similar rates as the general population and it has been documented that, with a tailored intervention approach, cessation rates are similar to those without a mental illness². Given the data on high levels of interest in quitting, the fact that tobacco use interferes with the metabolism of some psychiatric medications, evidence that smoking cessation interventions provided during psychiatric treatment increase the likelihood of long-term abstinence from alcohol and illicit drugs, and evidence that smoking cessation improves behavioral outcomes for people with mental illness^{2,3}, we strongly urge CMS to retain measures of TOB-1 and TOB-3/TOB-3a at IPFs.

CMS states that the rationale for the removal of measures for TOB-3 and TOB-3a at IPFs is that the cost outweighs the benefit. We are concerned that the estimates and reasoning provided for these conclusions are inconsistent with evidence in the peer-reviewed literature and with CMS' own Meaningful Measures Framework. The proposed rule estimates that removal of TOB-3 and TOB-3a from IPFs will lead to a decreased provider burden of 456.75 hours per IPF and would save \$16,707.92 per IPF (\$28.9 million across all IPFs). We are concerned that these estimates do not reflect the accurate time or cost associated with providing these vital services and ignore large benefits, particularly given the strong potential to eliminate tobacco use disparities in patients with mental health disorders and the incredibly high impact of tobacco control on public health. Based on evidence from a rigorous large-scale randomized clinical trial that was conducted within an inpatient psychiatric setting, delivery of a comprehensive inpatient tobacco cessation program (inclusive of 6 months post-discharge follow up support) was highly

¹ "Tobacco Use Among Adults with Mental Illness and Substance Abuse Disorders." *CDC.gov*, Centers for Disease Control and Prevention, 10 Mar. 2017, www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm.

² Prochaska, J. J. (2011). Smoking and Mental Illness — Breaking the Link. *The New England Journal of Medicine*, 365(3), 196–198. <http://doi.org/10.1056/NEJMp1105248>

³ Prochaska, J. J., Delucchi, K., & Hall, S. M. (2004). A Meta-Analysis of Smoking Cessation Interventions With Individuals in Substance Abuse Treatment or Recovery. *Journal of Consulting and Clinical Psychology*, 72(6), 1144-1156. <http://dx.doi.org/10.1037/0022-006X.72.6.1144>

cost-effective and consistent with findings from other tobacco cessation interventions. Upon study completion, 19% of patients in the tobacco cessation intervention arm of the study were abstinent from smoking, compared to 7% in the control arm of the study. The study reported an incremental cost effectiveness ratio of \$428 per quality-adjusted life year (QALY), which is well below the commonly used threshold for judging cost-effectiveness (the range of \$50,000-\$100,000/QALY in the U.S.)⁴. Additionally, results from a recent study that evaluated the effect of a comprehensive inpatient tobacco cessation service on hospital readmission and cost, delivery of a tobacco cessation service that mirrors the Joint Commission's (formerly the Joint Commission for the Accreditation of Healthcare Organizations) standards for tobacco cessation was associated with a 23% reduction in the odds of hospital readmission and a \$7,299 reduction in overall one year post-discharge healthcare costs per patient. Given the magnitude of cost savings associated with the intervention, the cost of delivering tobacco cessation services (\$34 per smoker in this study), was modest^{5,6}

CMS also proposes removal of measures for TOB-1 with the stated rationale that meaningful improvements in the performance of TOB-1 can no longer be made. Although CMS states that tobacco screening will likely continue after removal because the practice is embedded in the clinical workflow, they provide no evidence that this will be the case. In the extremely busy IPF workflows, there is constant pressure to trim assessments and interventions. We are therefore concerned that a lack of provider incentives (i.e. reimbursement) for measurement of TOB-1 will lead to termination of these important interventions to help identify and support psychiatric patients' cessation of tobacco use.

In conclusion, although smoking rates have declined over the last 50 years, tobacco use is still prevalent among disparate populations, including those with mental illness. It is imperative to continue providing tobacco screening and cessation services to this vulnerable population and to continue monitoring programs to ensure intended outcomes are achieved. Thank you very much for considering our input on this important issue. These comments are based on careful

⁴ Barnett, P. G., Wong, W., Jeffers, A., Hall, S. M., & Prochaska, J. J. (2015). Cost-effectiveness of smoking cessation treatment initiated during psychiatric hospitalization: analysis from a randomized, controlled trial. *The Journal of Clinical Psychiatry*, 76(10), e1285–e1291. <http://doi.org/10.4088/JCP.14m09016>

⁵Cartmell, K. B., Dooley, M., Mueller, M., Nahhas, G. J., Dismuke, C. E., Warren, G. W., . . . Cummings, K. M. (2018). Effect of an Evidence-based Inpatient Tobacco Dependence Treatment Service on 30-, 90-, and 180-Day Hospital Readmission Rates. *Medical Care*, 56(4), 358-363. doi:10.1097/mlr.0000000000000884

⁶ Cartmell, K., Dismuke, C., Dooley, M., Mueller, M., Nahhas, G., Warren, G., . . . Cummings, K. (2018). Effect of an Evidence-based Inpatient Tobacco Dependence Treatment Service on 1-Year Post-Discharge Healthcare Costs. *Medical Care*. (accepted pending journal review of final revisions).

discussion and evaluation of the extant literature on tobacco treatment by the AACR's Tobacco and Cancer Subcommittee (roster attached), and are approved by the AACR's CEO and Chairs of the Tobacco and Cancer Subcommittee and Science Policy and Government Affairs Committee. If the AACR can provide any additional information or assistance to CMS, please do not hesitate to contact Nicole Boschi, PhD, Senior Science Policy Analyst, at 215-446-7275 or nicole.boschi@aacr.org.

Sincerely,



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