

December 16, 2021

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted to: <https://www.cms.gov/medicare-coverage-database>

RE: Docket No. CAG-00439R, Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

To Whom It May Concern:

On behalf of the American Association for Cancer Research's (AACR) more than 49,000 laboratory researchers, physician-scientists, other health professionals, and patient advocates who constitute our national and international membership, we thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the national coverage determination for lung cancer screening with low dose computed tomography (LDCT).

Tobacco use is the leading preventable cause of premature mortality in the United States, with nearly a half million deaths every year from active and secondhand smoking. Tobacco use has a particularly profound impact on cancer incidence and mortality and has been attributed to 19 percent of all cancers diagnosed in the United States and nearly 30 percent of cancer deaths each year (1). More than 85 percent of lung cancer cases and deaths were attributed to smoking. Continued smoking by patients with cancer and survivors increases risk for overall mortality, cancer-related mortality, second primary cancer, and cancer treatment toxicity. Smoking cessation at the time of cancer diagnosis reduces the risk of dying by 30%-40% (2,3), improves physiological/psychological functioning and QOL (4-6), and has benefits that equal or exceed those of the best cancer treatments available (7). To curb the burden of tobacco-related illness, including lung cancer, the federal government should implement evidence-based policies and programs to treat tobacco use including for patients with cancer and survivors.

The AACR Supports Aligning CMS Determinations with the USPSTF Recommendations for Lung Cancer Screening

Annual LDCT screening for lung cancer among high-risk populations is vital for detecting lung cancer at an early stage. By identifying cancers early, screening greatly improves the ability to treat cancers and thus improve cancer-related morbidity and mortality. For these reasons, the AACR strongly supports the CMS proposed decision to align eligibility criteria for LDCT with the recommendations of the U.S. Preventive Services Task Force (USPSTF). Specifically, lowering the age of eligibility to 50 years and smoking history to 20 pack years is estimated to nearly double the number of Americans eligible for lung cancer screening (8). Importantly, this expansion is especially beneficial for women and historically marginalized racial and ethnic minorities who have an elevated risk of developing lung cancer from tobacco use, but lower average pack years compared to White men.

The AACR Encourages Use of Evidence-Based Smoking Cessation Interventions at Lung Cancer Screening Appointments and Independent Diagnostic Testing Facilities

Screening alone is just one step people who smoke can take to reduce lung cancer mortality. Assisting patients with evidence-based smoking cessation is one of the most impactful tools healthcare providers can utilize to improve the health of patients (9). Patients who are counseled by providers about smoking cessation are 62 percent more likely to attempt quitting (10). Unfortunately, only four out of nine adults who smoked in 2015 received advice from their providers on how to quit (11), and among those who attempted to quit, fewer than one third used evidence-based cessation therapies. The data suggest that more frequent and effective engagement from clinicians or cessation specialists with patients could increase the use of evidence-based therapies and improve quit rates, even if it is simply brief advice (12).

Two recent studies estimate that including cessation counseling with LDCT visits would greatly decrease tobacco-related mortality and increase quality-adjusted life years (QALY) saved (13,14). Meza, et al. estimated lung cancer deaths avoided and QALY gained for adults born in 1960 and are eligible for LDCT under the 2021 USPSTF guidelines with and without a cessation intervention (14). Over the lifetimes of the 1960 birth cohort, screening 30 percent of the eligible individuals would prevent 6,845 lung cancer deaths and save 103,725 QALY. In comparison, adding a 15 percent effective cessation intervention to LDCT screening visits would prevent 9,267 lung cancer deaths (35 percent increase) and save 322,785 QALY (211 percent increase). Additionally, Cadham et al., found the incremental cost ratio of providing cessation services in conjunction with an LDCT visit ranged from \$555 to \$35,531 per QALY, depending on the method of delivery, which is well below the common threshold for cost effectiveness (\$50,000 to \$100,000 per QALY) (13). Furthermore, smoking cessation would likely result in net cost savings for CMS. An analysis of a comprehensive smoking cessation benefit in the Massachusetts Medicaid program found that every dollar spent on cessation reduced spending on tobacco-related illness by \$3.12 (15).

Therefore, we encourage CMS to alter the proposed national coverage determination to require and reimburse providers for smoking cessation counseling in conjunction with regular LDCT screening appointments and Shared Decision-Making appointments. We find the proposal to not cover cessation counseling during every LDCT visit contradictory from the following excerpt in the proposed decision memo:

“It is vitally important to provide information about tobacco cessation or cigarette smoking abstinence to the patient at every touchpoint between provider and patient along the clinical pathway for lung cancer screening”

The AACR supports this statement and strongly suggests that it necessitates reimbursement for cessation counseling “at every touchpoint” patients who smoke have with the healthcare system. The proposed national coverage determination only requires one Shared-Decision Making appointment in a patient’s lifetime; offering cessation counseling only once in relation to LDCT screening is grossly insufficient. On average, fewer than 10 percent of smoking quit attempts are successful (9). Thus, patients attempt to quit multiple times before they are successful and could greatly benefit from regular cessation counseling to support

every quit attempt from this highly addictive substance. We recommend including coverage of cessation counseling in subsequent screenings as described in CAG-00439N “Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)” while adhering to removing the requirement for a written order from a health care provider.

The proposed decision memo has the potential to remove restrictions for practitioners and broaden eligibility criteria for beneficiaries that use tobacco products. However, the proposal places the onus of smoking cessation counseling and intervention on referring providers at Shared Decision-Making visits. For beneficiaries, their needs could be addressed with cessation counseling that entails advice on the benefits of cessation, evidence-based therapies, local cessation resources, collaborative efforts with eligible telehealth providers, and referral to a tobacco cessation specialist and/or behavioral therapy. Ideally, counseling in conjunction with an LDCT screening appointment would entail an in-depth discussion consistent with the Agency for Healthcare Research and Quality’s clinical guidelines on “Treating Tobacco Use and Dependence” (16), and referral to further behavioral therapy. Healthcare providers should also be supported and reimbursed for their efforts to support their patients as they navigate smoking cessation interventions that reduce the health risks associated with tobacco consumption.

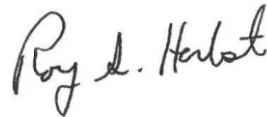
In conclusion, the AACR supports the proposed revisions to CMS eligibility for LDCT coverage which will expand access and save lives. However, by neglecting the value of cessation interventions at LDCT screenings, the AACR believes CMS would miss opportunities to help adults who smoke try to quit. The AACR urges CMS to expand coverage of evidence-based smoking cessation services to meet this vital need. These comments are based on careful discussion and evaluation by the AACR’s Tobacco and Cancer Subcommittee (roster attached) and are approved by the AACR’s CEO, Chair of the Tobacco Products and Cancer Subcommittee, and Chair of the Science Policy and Government Affairs Committee. If the AACR can provide any additional information or assistance to CMS, please do not hesitate to contact Dana Acton, Director of Science Policy and Legislative Affairs, at dana.acton@aacr.org.

Thank you again for the opportunity to comment on this important issue.

Sincerely,



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