American Lung Association.

June 5, 2023

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicare Program; FY 2024 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update (CMS-1783-P)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Lung Association appreciates the opportunity to submit comments on the FY 2024 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update.

The American Lung Association is the oldest, voluntary public health organization in the United States. One of our four strategic imperatives is to create a tobacco-free future, and tobacco cessation is vital to that effort. Tobacco use is the leading cause of preventable death and disease in the United States, responsible for the deaths of 480,000 Americans annually.[1] An additional 16 million Americans live with a disease cause by tobacco.[2]

In 2020, then Surgeon General Jerome Adams released *Smoking Cessation: A Report of the Surgeon General*.[3] One of the major conclusions of this report was that "quitting smoking is beneficial at any age," repeating a conclusion reached 30 years previously in the 1990 Surgeon General's report. Data show that across demographics, including age, insurance status and education level, most smokers want to quit.[4] This recommendation, if put into practice by providers across the country, could have a substantial impact on helping smokers quit and improving health.

Unfortunately, the Surgeon General's Report on smoking cessation also found that four out of nine adult cigarette smokers who saw a healthcare professional in the past year did not receive advice to quit smoking. It determined that "the prevalence of smoking is increasingly concentrated in the United States in populations that may face barriers to quitting. These include persons with behavioral health conditions, including mental health conditions or substance use disorders."[5] This disparity is also evident in annual surveillance data. Individuals with serious psychological distress smoke at a higher rate (21.8%) than those without serious psychological distress (10.9%).[6]

The Lung Association believes these data underscore the importance of tobacco cessation interventions focused on individuals with behavioral health conditions. Providers advising their patients to quit and providing evidence-based treatment can help reduce the rate of tobacco use in the United States, specifically for priority populations including patients with behavioral health

conditions. Unfortunately, the proposed *FY 2024 Inpatient Psychiatric Facilities Prospective Payment System and Quality Reporting Updates* would not promote this goal of reducing the rate of tobacco use.

The Centers for Medicare and Medicaid Services (CMS) proposes removing measure TOB-2/2a (Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention) from reporting requirements. The argument for its removal is that brief tobacco use interventions are being provided or offered nearly ubiquitously. As a result, CMS asserts that this measure is not needed to change provider behavior and creates unnecessary paperwork, a point with which the Lung Association fundamentally disagrees. Indeed, the data show providers are not providing or offering tobacco cessation interventions for the behavioral health population; only 51.7% of mental health treatment facilities and 64.9% of substance abuse treatment facilities offered tobacco cessation counseling to their patients and approximately a third of these facilities provided cessation medications.[7]

These data clearly highlight the importance of maintaining TOB-2/2a. More providers and facilities can and should be asking about tobacco use and treating it. By keeping TOB 2/2a and TOB 3/3a, CMS will encourage providers to ask about tobacco use, counsel patients to quit and provide the necessary, evidence-based treatment.

People with behavioral health conditions that smoke die, on average, 15 years earlier than their counterparts with behavioral health conditions that do not smoke.[8] More can and should be done to help these individuals quit. Providers advising patients to quit is an important intervention that can help save lives. Now is not the time to drop TOB-2/2a. To the contrary, more providers should be utilizing this intervention and helping their patients who smoke, end their addiction.

We appreciate that CMS has proposed to keep TOB 3/3a (Tobacco Use Treatment Provided or Offered at Discharge and Tobacco Use Treatment at Discharge) and we support its inclusion in the final rule. However, CMS should not finalize the proposal to remove TOB 2/2a. The data does not support its removal.

Additionally, the Lung Association encourages CMS to include TOB 1 (Tobacco Use Screening) into the FY2024 final rule. This measure was removed in FY2019, when the most recent data showed that only 48.9% of mental health treatment facilities and 64% of substance abuse facilities screen for tobacco use.[9] Screening for tobacco use is not universal for patients with behavioral health diagnosis. The American Lung Association believes CMS was premature in its action and we urge CMS to restore this measure.

Tobacco use is the leading cause of death and disease in the United States and can exacerbate comorbid conditions. Helping all tobacco users quit improves health outcomes and reduces overall healthcare costs.

Thank you for the opportunity to submit comments.

Sincerely,

Harold P. Wimmer
National President and CEO

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