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BY ELECTRONIC DELIVERY

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS–1694–P
7500 Security Boulevard
P.O. Box 8011, Baltimore, MD 21244–1850
Mail Stop C4–26–05

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2019 Rates [CMS-1694-P]

Dear Administrator Verma:

Celgene Corporation (Celgene) appreciates this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2019 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Proposed Rule (the "Proposed Rule").[1]

Celgene is a global biopharmaceutical company specializing in the discovery, development, and delivery of therapies designed to treat cancer, and inflammatory and immunological conditions. Celgene strongly believes that medical innovation can lead to better health, longer life, reduced disability, and greater prosperity for our patients and our nation.

To this end, Celgene seeks to deliver truly innovative and life-changing drugs and biologics to our patients. Central to achieving our mission is research to develop new medical technologies that support those who experience serious and life-threatening diseases. Currently, there are more than 160 Celgene-sponsored clinical trials underway, examining

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1 83 Fed. Reg. 20,164 (May 7, 2018).

at least 42 novel medicines for more than 60 indications. Our research and development pipeline drives Celgene's ability to develop cutting-edge and life-saving treatments that are both safe and effective.

As committed as Celgene is to clinical progress, we are equally committed to our guiding principles of patient access and support. Celgene focuses on putting patients first with programs that provide information, support, and access to our innovative therapies. We believe that all who can benefit from our therapies should have the opportunity to do so and have developed industry-leading programs through which hundreds of thousands of patients worldwide have accessed our therapies.

Celgene supports Medicare reimbursement policies that promote beneficiary access to new and effective medical treatments and ensure that Medicare patients benefit from the innovation that defines the U.S. healthcare system.

With respect to the Proposed Rule, Celgene greatly appreciates CMS' willingness to engage with stakeholders to find "the most appropriate mechanism to provide payment to hospitals for new technologies such as [chimeric antigen receptor T-cell (CAR T)] therapy drugs."[2] The comments below on the various reimbursement alternatives represent Celgene's view that CMS should prioritize adequate reimbursement and appropriate access for the use of these novel therapies, irrespective of where patients happen to live and across settings of care.

An effective reimbursement solution will strike a balance between the need to ensure immediate access in the short term for patients with severe, life-threatening diseases, the need to collect data to inform appropriate and stable long-term reimbursement, and the need for flexibility to accommodate differences in costs in treating patient populations for different diseases.

With this in mind, Celgene urges CMS to consider the following approaches to inpatient reimbursement for CAR T-cell therapy:

- Beginning in FY 2019, a separate methodology for reimbursement of CAR T-cell therapies on a three-year, temporary basis that will help ensure adequate reimbursement, enable patient access, and provide for data collection.
- Creation of a long-term, sustainable payment structure through the creation of a new Medicare Severity – Diagnosis Related Group (MS-DRG), after such time as CMS has adequately captured data regarding patient treatment costs and considered the complex issues associated with the creation of a new MS-DRG.

In the event that the approach outlined above cannot be finalized for FY2019, the CMS proposal to assign these therapies to MS-DRG 016 with the addition of a cost to charge ratio (CCR) of 1.0 could serve as an acceptable alternative to address patient access barriers in

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[2] *Id.* at 20,294.

the short term. For reasons described more fully below, we do not recommend this as a long-term approach, but rather as an interim step toward long-term, sustainable payment.

I. CAR T-CELL THERAPIES HAVE TRANSFORMATIVE TREATMENT POTENTIAL

Since its founding, Celgene has been committed to discovering and developing treatments in disease areas of unmet need. Notably, Celgene has played a central role in the significant improvement in patient outcomes for patients with serious and life-threatening hematological malignancies. We believe that genetic modification of T-cells with chimeric antigen receptors (CARs) represents a potential new era for the effective treatment of such malignancies.

Designed to be given as a single treatment, CAR T-cell technology is unique because it harnesses and genetically enhances patients' own immune cells in the fight against cancer. By doing so, CAR T-cells create a truly personalized medical treatment that has enormous potential in effectively treating both blood and solid tumor cancers. As Food and Drug Administration (FDA) Commissioner Gottlieb has explained: CAR T-cell therapies open the door to "a new frontier in medical innovation with the ability to reprogram a patient's own cells to attack a deadly cancer. . . . [Such new] technologies . . . hold out the potential to transform medicine and create an inflection point in our ability to treat and even cure many intractable diseases."[3]

Celgene is at the vanguard of CAR T-cell innovation. We currently are developing two CAR T-cell therapies that we believe have the potential to significantly transform patient outcomes in the treatment of certain blood-based cancers that are under-served by existing treatment modalities:

- **bb2121**. A collaboration between Celgene and bluebird bio, bb2121 is a B-cell maturation antigen (BCMA)-directed CAR T-cell therapy currently in clinical trials for multiple myeloma. Multiple myeloma is a rare plasma cell cancer that affects

[3] FDA, *FDA Approval Brings First Gene Therapy to the United Sates* (Aug. 30, 2017), *available at* https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm574058.htm.

approximately 125,000 Americans, including 30,000 newly diagnosed patients each year. With an average age onset of 69 years, the Medicare population is uniquely and disproportionately impacted by multiple myeloma. Despite advances in five-year survival rates in the past two decades, this blood cancer has remained a persistent challenge to treat using traditional techniques because of its cyclical and progressive nature, as well as its ability to mutate and adapt over time. Multiple myeloma has remained an incurable disease and heavily pretreated patients traditionally have had limited therapeutic options. Based on early clinical trial data, bb2121 has been shown to have the potential to induce durable responses in these heavily pre-treated multiple myeloma patient populations and has been granted breakthrough designation by the FDA.

- **JCAR017**. A CD19-directed CAR T-cell therapy, JCAR017 is in clinical trials for B-cell Non-Hodgkin Lymphoma (NHL). NHL is the most commonly diagnosed blood cancer in the United States and claims the lives of approximately 20,000 Americans each year. Well over half a million Americans currently live with NHL, and approximately 66,000 new cases are diagnosed in any given year. The risk of developing NHL increases over time, and more than half of all NHL patients are ages 65 or older. NHL also has traditionally been characterized by a number of difficult to treat subsets, including diffuse large B cell lymphoma. JCAR017 is an innovative new CAR T-cell therapy that potentially could benefit many of these difficult to treat and unique patient populations. JCAR017 also is an advancement with respect to CAR T-cell technology. Using a differentiated manufacturing approach, JCAR017 provides modified cytotoxic (or "killer") T-cells in a 1:1 ratio with modified helper T-cells. The goal of this approach is to develop a differentiated CAR T therapy for patients with relapsed/refractory DLBCL with a unique safety and efficacy profile. JCAR017 has been granted breakthrough designation by the FDA.

II. Reimbursement Approach Should Recognize the Unique Nature and Transformative Potential of CAR T-Cell Therapy

Celgene recognizes that developing an appropriate Medicare reimbursement policy for novel and innovative breakthrough therapies such as CAR T cells can be complex. We offer the following patient-centric, innovation-supporting guiding principles. These principles inform our perspective on the apropriate CAR T-cell reimbursement mechanisms and our evaluation of the specific alternatives that CMS has presented in its Proposed Rule. We believe these principles will be helpful to CMS' evaluation of possible reimbursement options for CAR T-cell therapies.

First, Medicare's policy should continue to support ongoing innovation that leads to transformative new technologies such as CAR T-cell therapy. The development of transformational medical advances, especially new cutting edge technologies such as CAR T, is resource- and time-intensive. The emergence of CAR T-cell therapies is the realization of decades of research, development, and investment and countless hours of work by physicians, scientists, and researchers.

Celgene believes that the Medicare program has an important role to play in ensuring that America's seniors have access to such innovations. Transformational innovation has long been a distinctive and defining feature of the American healthcare system; appropriate reimbursement is critical to sustaining this progress in developing new medical advances. Medicare reimbursement policy should account for the intensive long-term research and development required to create new technological advancements that empower patients and save lives.

Second, Medicare's reimbursement policy should accurately reflect the value-based benefit generated for patients by new CAR T-cell therapies. CAR T-cell technology is still in an early stage. However, even at this early stage, it is clear that CAR T-cells have the potential to dramatically improve patient outcomes. The first two marketed CAR T-cell products, Yescarta™ and Kymriah™, both have shown promising benefits for specific patient populations and for whom older technologies have proven inadequate.

Medicare's reimbursement policy should reflect and account for the unprecedented clinical value that new CAR T-cell therapies offer to patients. As CAR T-cell science evolves, innovative new CAR T-cells will be developed to treat different types of cancers that will target other new and specific patient populations. Medicare's reimbursement policy should acknowledge the benefit generated for distinct patient populations with each new CAR T-cell breakthrough. Celgene believes that adopting an approach that acknowledges the unique clinical benefits that CAR T delivers is important to ensuring adequate access to innovative CAR T-cell techniques for the full range of Medicare beneficiaries who need such life-saving treatments.

Third, Medicare's policy should appropriately acknowledge clinical and technological differentiation between different CAR T-cell products. Celgene believes that beneficiaries and their trusted health care providers should determine whether CAR T-cell therapy is an appropriate treatment and, if so, which specific therapy is the best choice for the individual beneficiary. Medicare's reimbursement policy, therefore, should be structured in a way that does not function as a barrier to a beneficiary and his or her medical providers' selection of the best CAR T-cell treatment modality given the beneficiary's specific medical needs and disease type.

CAR T-cell therapies are highly specific and differentiated. They are personalized for an individual patient and the CAR T-cell technologies are significantly different from one another. Among other things, the CAR design, vector used for genetic transfer, and manufacturing process can all vary substantially between therapies because each CAR T-cell therapy must be tailored to treat a unique combination of clinical indications, safety profiles, and patient populations in order to provide a therapy that is both effective and personalized for each unique patient.

It is critical that Medicare's reimbursement policy for CAR T cells recognizes the often significant differences between CAR T-cell products, including the specific disease states in which they are used, to ensure adequate beneficiary access and choice. It would not, for example, be appropriate to assume that two CAR T-cell therapies targeting entirely different receptors, cancers, or patient populations (and relying on entirely different manufacturing processes) should be treated identically for reimbursement purposes. If all CAR-T cell

products were reimbursed in exactly the same way, this would distort reimbursement in a way that would significantly slow the adoption of—and beneficiary access to—certain CAR T-cell therapies, even when such CAR Ts are the most appropriate clinically indicated treatments for the beneficiary given his or her individual medical needs and disease state.

Fourth, Medicare's policy should enable access to CAR T cells across all appropriate settings of care. Although these comments are specific to the IPPS Proposed Rule, Celgene believes that patients are likely to receive CAR T-cell therapy in a variety of clinical settings. The medically appropriate selection of administration as an inpatient or outpatient, in a transplant or non-transplant center, will depend on the treating provider's informed judgment as to a particular patient's individualized clinical circumstances and the safety profile of the treatment, which may vary, in part, based upon the FDA-required safety protocols for the relevant CAR T-cell products.

Celgene believes that Medicare's reimbursement framework should not limit a provider's capacity to deliver CAR T-cells in the setting that is safest and most appropriate for each patient. Celgene strongly believes that the informed medical judgment of the provider and the patient's individual medical needs should determine the appropriate site of care and that Medicare reimbursement should support provider decision-making regardless of setting, rather than dictate that decision for the patient and the provider.

III. COMMENTS ON SPECIFIC CAR T-CELL PROPOSALS

Consistent with the guiding principles discussed above, Celgene encourages CMS to adopt a solution to CAR T-cell reimbursement that can enable patient access in both the short- and long-term.

The experience of the two first CAR T-cell therapies marketed in the United States is instructive with respect to how reimbursement policy can impact patient access, even for patients who are acutely and severely ill. We understand that, since FDA approval of these therapies, it has taken time for CMS to consider appropriate Medicare coding and reimbursement approaches for these unique therapies. However, during this intervening period, the lack of an appropriate reimbursement policy has contributed to growing waiting lists resulting in only a handful of patients accessing this novel technology, despite the evidence of clinical effectiveness.[4]

Celgene believes that adequate and appropriate Medicare reimbursement for CAR T-cells is essential to improve and protect beneficiary access to these therapies. This will be particularly important as other new CAR T-cell technologies obtain FDA approval. We

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[4] *See, e.g.*, Michelle Cortez et al., *Months After Approval, Breakthrough Cancer Drug Given to Just Five Patients*, Bloomberg News, https://www.bloomberg.com/news/articles/2017-12-14/cancer-patients-with-little-time-left-wait-for-gilead-s-new-drug (Dec. 14, 2017); Michelle Cortez et al., *Novel Cancer Drug Gets Stymied by Medicare Rigid Billing System,* Bloomberg News, https://www.bloomberg.com/news/articles/2017-12-15/medicare-rigid-billing-system-leaves-gilead-cancer-drug-in-limbo (Dec. 15, 2017); Roxanne Nelson*, Few Patients Get CAR T Cells Because of 'Insurance Snags'*, Medscape, https://www.medscape.com/viewarticle/891174 (Jan. 11, 2018).

further believe that CMS should recognize and account for the following considerations as it develops a reimbursement policy for CAR T-cells:

- The personalized and unique potential for single dose/administration of CAR T-cell treatment,
- The small patient populations impacted by these novel therapies,
- The rapid evolution of the science of CAR T-cell therapy,
- The uniqueness of each CAR T-cell treatment and the material distinctions among CAR T-cell products across different diseases, and
- The severity and acuteness of patient health conditions requiring CAR T treatment and the urgency of receiving highly effective treatment.

As it weighs the appropriate reimbursement mechanisms and develops a strategy that accounts for these unique considerations, we also believe that CMS should continue to collect data to inform appropriate payment (and adjustments to payment) over time, ensure that reimbursement for CAR T-cells in the long term does not overly rely on temporary or outlier mechanisms that could limit broader or long-term access to CAR T-cells, and avoid payment mechanisms that rely on or incent providers to significantly mark up their charges for novel therapies. It is important for CMS's CAR T-cell reimbursement to account for the fact that CAR T-cell technology is rapidly evolving. Medicare's reimbursement policy for CAR T-cell therapies should remain flexible in order to account for significant new advances in the CAR T-cell space—including future products and indications.

A . Separate Payment for CAR T-Cell Therapy

Celgene has considered various approaches to CAR T-cell reimbursement and how each might achieve the desired objectives of patient access, alignment with clinical value, and appropriate reimbursement across sites of care.

We encourage CMS to consider reimbursement for CAR T-cell therapy separately from the cost of the services reimbursed under the relevant MS-DRG for a temporary period of three years. This separate reimbursement for CAR T therapy should be set at invoice price. This approach would have several advantages in the short term, including:

- **Creating a clear pathway for payment that would remove existing access barriers for patients**. Medicare beneficiaries should have access to medically necessary CAR T-cell therapies. This is vital because CAR T-cells have shown life-saving effectiveness in certain patient populations for which traditional treatments have failed or been proven ineffective. Particularly in these initial years following the first CAR T-cell approvals, clear, consistent, and adequate Medicare payment for CAR T-cell therapies is critical to ensuring beneficiary access. Otherwise, providers will be discouraged from administering CAR T-cell therapies because this would require that the provider take on significant and often unsustainable financial risk. An invoice-based pass-through payment is the most efficient, transparent, and effective short-term mechanism for eliminating these provider burdens and enabling patient access.

- **Simplicity for providers and less payment uncertainty**. As CMS has acknowledged, reimbursement for CAR T-cell therapy can be complicated under the existing MS-DRG payment regime.[5] The MS-DRG system was not designed to accommodate new treatments using novel scientific technologies such as CAR T, and the MS-DRG payment formula introduces uncertainty for providers with regard to adequacy of payment. Particularly, while CAR T-cells are still in a formative stage of adoption and development, a pass through on the invoice would give providers the consistency of payment needed to support appropriate adoption of the therapy and would eliminate geographic (and other) disparities in payment rates that could artificially limit the ability of all Americans to access CAR T-cell treatments. This approach to separate reimbursement ensures that patients' access to CAR T therapy is not determined solely by where they happen to live.
- **Ability to accurately capture data regarding treatment costs for administration and supportive activities for these patient populations separate from actual product costs**. An invoice-based pass through also would give CMS the opportunity to gather the most accurate data possible. Indeed, an invoice-based approach would give CMS unique insights that would allow the agency to disaggregate treatment services costs from costs for CAR T-cells. The additional data collected from an invoice pass-through approach would be invaluable for ensuring stability and accuracy of long-term payment rates for CAR T-cells. After the transitional pass-through expires and CMS adopts a longer-term solution for CAR T-cells, the data collected during the initial transition period will help CMS base its payment rates on the most accurate and complete set of cost information available.

B. Proposal to Assign CAR T-Cells to Transplant MS-DRG 016

Celgene also has considered CMS' proposal to classify the ICD-10 procedure codes associated with CAR T-cells into MS-DRG 016 for FY 2019.[6] We appreciate CMS' recognition that reimbursement changes are necessary to improve payment accuracy for and enable patient access to CAR T-cell therapy.

Celgene views the assignment of CAR T-cell therapies to MS-DRG 016 combined with a CCR of 1.0 as an approach that, while not optimal, could, in the short term, provide better access for patients than exists today through a combination of higher base MS-DRG payments and the calculation of outlier payments that appropriately recognize financial losses without markup. ***If CMS adopts this pathway in the short term, the CCR of 1.0 would be an essential component to ensure adequate payment for CAR T-cells, and would be necessary to allow hospitals to accurately reflect their costs for CAR T-cell treatments. However, we wish to emphasize that the separate reimbursement for CAR T therapy at***

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5 83 Fed. Reg. at 20,189.

6 *Id.*

invoice price from the cost of services reimbursed under the relevant MS-DRG is a more appropriate short-term solution.

Without the additional reimbursement formula change to the 1.0 CCR, CMS' proposed assignment would not correct the significant restrictions on access that are preventing Medicare beneficiaries from obtaining innovative CAR T-cell treatments and would instead perpetuate the barriers that exist today. Our analysis shows that a transfer to MS-DRG 016 would not improve provider reimbursement enough to meaningfully ensure beneficiary access to CAR T-cells. If not accompanied by other changes, Medicare payment for CAR T-cell therapy in this scenario would be woefully inadequate, and providers would continue to face significant financial disincentives against furnishing CAR T-cells to Medicare beneficiaries.

Longer term, in light of the important distinctions between CAR T-cells and bone marrow transplants, assignment to MS-DRG 016 would not be appropriate. CAR T-cell therapies rely on a markedly different mechanism of action relative to bone marrow transplantations. Such transplants most often are used to rescue transplant recipients from high-intensity chemotherapy or total body irradiation (which destroys stem cells in the bone marrow) or to replace bone marrow that already is damaged or diseased. Transplantation of stem cells can repair this damage in certain patients by reconstituting the patient's bone marrow and rebuilding his or her immune function.

CAR T-cell therapies fundamentally differ from these transplant techniques. Unlike bone marrow transplantation, CAR T-cells are not intended to serve as a replacement for damaged or destroyed bone marrow or stem cells or as consolidation therapy. Rather, CAR T-cells are designed to introduce antibody-like recognition in CARs and thereby create durable immune memory and long-term tumor responses. Indeed, CAR T-cells most commonly are used in patient populations for whom bone marrow transplantation and other traditional therapies already have failed.

Further, CAR T-cells are cellular biologics and, unlike bone marrow transplants, are individualized to patients and are solely autologous (i.e., derived from the patient's own cells). A patient's own T-cells (or other blood cells, as opposed to stem cells) are used as the base material in part of a specific manufacturing process that genetically engineers the patient's cells and redirects them to serve as potent anti-tumor "killer" T-cells. In other words, CAR T-cell therapy is different because, among other things, it relies on uniquely individualized genetic modification techniques that are unlike any other traditional treatment. Moreover, unlike most other traditional cancer therapies, CAR T-cells are administered in a single infusion; the modified T-cells infused through CAR T therapy can persist, multiply, and differentiate in a patient's body over the long-term and continue to attack tumors even years after the therapy is administered. In light of these clinical differences, we expect that the data on service-related costs will translate into different severity and cost profiles for CAR T-cell therapy versus transplant recipients.

In addition to the distinctions noted above, Celgene does not believe that an assignment to MS-DRG 016 is a sustainable approach in the longer term even when coupled with a CCR of 1.0 or similar adjustments to the reimbursement formula. Without add-on payments, it is unlikely that the base payment rate for MS DRG 016 would ever compensate providers

appropriately for care delivered to CAR T-cell patients. Under this pathway, adequacy of reimbursement for CAR T-cells is therefore almost entirely dependent on the availability of the outlier and New Technology Add-on Payments (NTAPs). Celgene does not believe that relying on these two add-on payments creates a sustainable reimbursement framework.

First, relying on outlier payments would not contribute to a sustainable long term payment for CAR T-cell therapy. Outlier payments do not contribute to future MS-DRG rate setting and, therefore, if CMS relies on outlier payments to help make providers whole as to the cost of administering CAR T-cells, CMS would be entrenching reliance on outlier payments rather than ensuring the base payment is adequate due to the exclusion of outlier payments in setting reimbursement rates under the inpatient system. This would contribute to provider uncertainty and could impede beneficiary access to CAR T-cell treatments. Further, this approach would permanently redistribute funds available for outlier payments away from other cases – an outcome that conflicts with the fundamental purpose of these payments.

Second, NTAP payments are, by design, temporary add-on payments. NTAPs only last two to three years while data are gathered on the cost of the technology in the applicable MS-DRG.[7] But it is unlikely that CAR T-cells *ever* will be adequately compensated under MS-DRG 016 due to the small number of patients treated with CAR T-cell therapy. When the NTAP period expires, Celgene's modeling indicates that providers would experience a significant drop in Medicare reimbursement for CAR T-cell cases – in addition to already substantial losses.

In sum, while Celgene views the assignment to MS-DRG 016 with a CCR of 1.0 as a potential option to address the acute access barriers patients are facing in the near term, it cannot serve as the long-term approach.

C. Alternative Proposal to Create New CAR-T Cell Specific MS-DRG

As CMS looks beyond short-term solutions to enable immediate patient access, we encourage the agency to propose a longer-term solution that recognizes the innovation and distinction of CAR T-cell therapies (compared to other therapies) and ensures adequate reimbursement of CAR T-cell therapy—including by proposing a CAR T-cell specific MS-DRG and related adjustments that ensure fair and adequate payment for CAR T-cells. We agree with the agency that CAR T-cells "present the unique challenges with respect to the [MS-DRG] assignment."[8] While we strongly support CMS' proposal to establish a new MS-DRG, we believe it would be premature to create this MS-DRG for FY 2019.

Among other things, a new MS-DRG establishes a *durable* reimbursement structure to ensure beneficiary access over the long-term. If designed appropriately, a new MS-DRG ensures that the base payment rate for CAR T-cell therapy is appropriate. This not only

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7 *See generally* 42 C.F.R. § 412.87(b)(2).

8 83 Fed. Reg. at 20,189.

ensures strong alignment between CAR T-cell reimbursement policy and the inpatient reimbursement framework as a whole, but it also reduces provider uncertainty and risk.

Novel transformational therapies such as CAR T-cells require equally inventive reimbursement approaches to ensure that payment is adequate to protect patient access and enable provider adoption. Celgene believes that CMS should consider novel policy options when structuring a CAR T-cell specific MS-DRG, as innovative solutions will play an important role to ensure that that CMS payment policy does not obstruct long-term access to these effective and life-saving new technologies.

In developing a CAR T-cell specific MS-DRG, we urge CMS to bear in mind the following specific considerations that will likely prove critical to ensuring that payment rates under a CAR T-cell MS-DRG do not induce disparities in access, but, instead, accurately reflect the significant value that CAR T-cells represent to patients who have a critical medical need for such treatments.

First, to promote broad access to patients throughout the country, it is important that reimbursement for CAR T-cells be reasonably consistent for all providers regardless of their geographic location. To this end, we encourage CMS to consider mechanisms to correct the disparities that otherwise would be caused by the wage index under a CAR T-cell specific MS-DRG.

Celgene's analyses suggest that, absent an adjustment or other correction for the wage index, low wage index hospitals could be significantly under-reimbursed when furnishing CAR T-cells, while high wage index hospitals may see significant over-reimbursement. For example, some projections have estimated that low wage index hospitals could be reimbursed at tens of thousands of dollars (or more) less than their costs under a CAR T-cell specific MS-DRG, while certain high wage index hospitals could be reimbursed more than their costs. These disparate outcomes are fundamentally inequitable. And, while some over/under disparity may not be unique to a CAR T-cell MS-DRG where both drug costs and services costs are reimbursed in a bundled payment, given the large portion of the total payment that would be comprised of a fixed, non-labor adjusted cost, the wage index differences amongst institutions could be significant.

Stark geographic differences in CAR T-cell payment rates could easily discourage adequate patient access to CAR T-cells. Celgene strongly urges that any CAR T-cell specific MS-DRG incorporate some mechanism for leveling the effect of the wage index—such as a wage index floor and ceiling adjustment for CAR T-cell payments adopted pursuant to CMS's adjustment authority[9]—to ensure that patients in all geographic locations have adequate access to medically necessary CAR T-cell therapies.

Second, we believe it is prudent to allow for some time to capture accurate data regarding the cost to treat CAR T patients. Due to the health condition of these patients, the

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[9] Social Security Act § 1886(d)(3)(e).

personalized nature of CAR T-cell therapy, and the unique profile of each CAR T, it will be important to collect this data in order to establish accurate base payments.

Third, and relatedly, we encourage CMS to ensure that no improper incentives are created whereby Medicare reimbursement policy improperly steers providers to favor a particular site of service that might not otherwise be the best location for the patient. Celgene believes that Medicare reimbursement for CAR T-cells should be appropriate to the treatment, regardless of the care setting chosen. The informed judgment of the patient and his or her treating physician (as opposed to reimbursement incentives) should determine the most appropriate setting of care, taking into account important patient circumstances such as ability to travel in the context of serious illness. While Celgene acknowledges the significant differences in how payment rates are calculated under the IPPS and the Hospital Outpatient Prospective Payment System, we believe that CMS should structure a CAR T-cell specific MS-DRG with the ultimate objective of promoting adequate Medicare payment in *all* settings where CAR T-cell therapies can safely and appropriately be administered.

Fourth, CMS should account for the fact that, as CAR T-cell technology develops and new CAR T-cell products are approved by the FDA, a CAR T-cell specific MS-DRG approach will account for therapies targeting different disease states and patient populations. As diversity of CAR T-cell therapy increases with time, there are likely to be differences in the costs of providing different classes of CAR T-cells. We encourage CMS to be proactive in evaluating how these probable distinctions in disease state and patient population will affect adequacy of reimbursement for different CAR T-cells and to structure any CAR T-cell specific MS-DRG (or related adjustments) in a manner that recognizes and accounts for material distinctions in the costs of different CAR T-cells based on the disease state and patient population they target. Doing so will be vital to ensuring that a CAR T-cell specific MS-DRG is effective in achieving the objective of providing a long term solution and promoting patient access to what is likely to be an increasingly wide range of novel and effective new CAR T-cell therapies.

Celgene acknowledges that accounting for these challenges will require significant evaluation by CMS, and we are committed to working with the agency to develop a sound long-term approach to a CAR T-cell specific MS-DRG methodology that will encourage adequate patient access to these transformative new treatments and promote ongoing innovation for this exciting and still-evolving new class of therapies.

D. New Technology Add-On Payment Applications for Kymriah™ and Yescarta™

Celgene is concerned that, in evaluating the NTAP applications for Kymriah™ and Yescarta,™ CMS may be overlooking the significant ways that these two technologies represent a substantial medical advance compared to existing therapies, most of which patients have already failed, before they go on to receive their CAR T-cell treatment. CMS, instead, appears to be unduly focusing on the perceived similarities between the two newly approved CAR T-cell therapies versus the advance they represent over existing therapies. We encourage CMS to recognize the ways in which Kymriah™ and Yescarta™ significantly differ from existing technologies and further to apply the "newness" requirement for NTAP

eligibility in a manner that does not unnecessarily discourage the availability of NTAPs for these newly approved CAR T-cell therapies that represent significant clinical advantages over existing treatments.

To qualify for an NTAP, CMS requires a technology to meet a cost criterion and to demonstrate substantial clinical improvements in efficacy. In addition, CMS requires the technology to be "new," which CMS has interpreted to mean that the technology is not "substantially similar" to an existing technology.[10]

We believe that CMS should not interpret the NTAP's "newness" criterion in a way that unnecessarily restricts the availability of NTAPs for recently approved CAR T-cell products that both satisfy the cost criterion and are substantial clinical improvements relative to existing technologies. In particular, Celgene is concerned that CMS' proposed approach in jointly evaluating Kymriah™ and Yescarta™ does not appear adequately focused on evaluating the significant medical advance that these two CAR T-cell therapies represent relative to existing technologies and is instead narrowly focused on the ways that CMS believes that the two newly approved CAR T-cell products are similar to one another.

Celgene notes that the Social Security Act does not appear to clearly authorize CMS to jointly evaluate Kymriah™ and Yescarta,™ which were submitted by separate manufacturers as separate NTAP applications for two different products approved by FDA under two separate Biologics License Applications with distinct clinical and cost data submissions. Without conceding that this joint evaluation in permissible, CMS' assessment appears concentrated on a handful of perceived similarities in the mechanism of action and patient and disease categories between the two newly approved CAR T-cell products. In the first instance, this approach appears to give little weight to the distinctions in the manufacturing process and co-stimulatory domains between the two CAR T-cell therapies, which obscures the important distinctions in how the different CAR T-cell technologies have been refined and optimized. The evaluation also does not fully account for the difference in clinical profiles of these two agents.

Failure to recognize the legitimate distinctions and technological innovations reflected by CAR T-cell therapy—and inherent across different CAR T-cell treatments, such as Kymriah™ and Yescarta™, could artificially restrict access to NTAPs for these new and promising technologies. To encourage medical innovation, CMS should apply the NTAP "newness" criterion in a way that recognizes the unique, novel, and distinct nature of CAR T-cell technology. Doing so is consistent with Congress' objective when it created the NTAP adjustment and will be vital both to ensuring that there are adequate incentives to provide patient access to new CAR T-cell products and to encouraging the rapid development of CAR T-cell technologies, which is a necessary step to ensuring that CAR T-cell therapy reaches its full transformative potential to significantly impact serious, life-threatening diseases.

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[10] CMS has operationalized this definition by looking to whether the technology uses the same "mechanism of action" as an existing technology, is assigned to the same MS-DRG, and treats "the same or similar" types of diseases and patient populations.

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Celgene appreciates the opportunity to comment on the FY 2019 Proposed Rule and thanks CMS for its consideration of our comments. We respectfully urge CMS to adopt a Medicare reimbursement policy for CAR T-cell therapies that recognizes the significant value for beneficiaries generated by this transformative new treatment option and that creates appropriate incentives to promote beneficiary access to CAR T-cell therapies over both the short and long-term. If you have any questions with regard to our comment letter, please do not hesitate to contact Lisa Nelson, US Public Policy at linelson@celgene.com or by telephone at (202) 280-6744.

Sincerely,

Richard H. Bagger

Executive Vice President,
Corporate Affairs and Market Access