Money Matters: CAR-T

Stephanie Farnia
Director, Health Policy & Strategic Relations
BMT Tandem Meetings
February 23, 2018
The following speakers have nothing to disclose.

- Stephanie Farnia
THANK YOU: ASBMT Cell Therapy Coding & Reimbursement Task Force

Rocky Billups
Colleen Dansereau
Clint Divine
Amy Emmert
Gary Goldstein
Angela Kopetsky
Susan Leppke
Carolyn Mulroney
Peggy Pardoe
Nimitt Consulting
Helene Stephan
Chair: Aaron Chrisman
How does the ASBMT reduce the administrative barriers that may prevent our members from utilizing CAR-T and other effective therapies?
Why is ASBMT leading this work?

- Natural fit in terms of programs and physicians
- Leadership decision to take on these issues
- Partnerships with other key stakeholders – CIBMTR, FACT
- Absence of other organizations proactively engaging
“Mo’ Money, Mo’ Problems”
- Notorious B.I.G.

Coverage

Coding

Reimbursement

Patient Access & Financial Burden
Level-setting: CAR-T Products

- Axicabtagene Ciloleucel (Yescarta; Kite/Gilead)
- Tisagenlecleucel (Kymriah; Novartis)
- Not yet approved

- Manufacturer Auto
- Manufacturer Universal/Allo
- Bedside or 'home-brew' Auto
Level-setting: Product Specifics

**Kymriah**
- Precursor B-cell Acute Lymphoblastic Leukemia (ALL)
  - Refractory or in second or later relapse
  - “Up to 25 years of age” (i.e. up to 25 years, 364 days)
- 34 centers; 25 certified
- $475,000

**Yescarta**
- Relapsed/Refractory Large B-Cell Lymphoma
  - No age restrictions
  - Median age of Dx = 70
  - After failing 2+ systemic lines of therapy
- 31 centers authorized
- $373,000
- [www.Yescarta.com](http://www.Yescarta.com)
Level-setting: Payer Mix

P-ALL patients

Medicaid
Commercial
Medicare/Other

DLBCL

Medicare
Commercial
Medicaid
Other

Sources: KFF.org; Expert estimates
Is CAR-T Covered?

**Commercial**

- **Most** commercially insured patients have coverage for Yescarta and/or Kymriah
- May be limitations for specific plans and/or employer-sponsored groups
  - Experimental/Investigational denial may be attempted
- Contact your Novartis or Kite point person with any issues

**CMS**

- **No indication of non-coverage** nationally or locally
  - Q codes and payment for the OPPS setting
  - Facilities have not reported rejected claims to ASBMT
  - In IPPS, it is a drug used in a part of a covered episode of care – i.e. an inpatient stay for treatment of lymphoma
Advance Beneficiary Notice of Noncoverage

You may get a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) from your doctor, other health care provider, or

CMS: Innovative treatments call for innovative payment models and arrangements

Date
2017-08-30

Title
CMS: Innovative treatments call for innovative payment models and arrangements

Contact
press@cms.hhs.gov

CMS: Innovative treatments call for innovative payment models and arrangements

With today’s U.S. Food and Drug Administration (FDA) approval of Kymriah (tisagenlecleucel) for certain pediatric and young adult patients with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse, the Centers for Medicare & Medicaid Services (CMS) is continuing to explore the development of payment models and arrangements for new and potentially life-saving treatments.

“CMS congratulates all of the scientists and researchers involved in the development of Kymriah (tisagenlecleucel),” said CMS Administrator Seema Verma. “Innovations like this reinforce our belief that current healthcare payment systems need to be modernized in order to ensure access to new high-cost therapies, including therapies that have the potential to cure the sickest patients. Improving payment arrangements is a critical step towards fulfilling President Trump’s promise to lower the cost of drugs.”
What about Medicaid?

- State-by-state decisions
- Medicaid managed care
- Covered in-state vs. out?

New York State Medicaid Will Begin Covering Tisagenlecleucel

New York State (NYS) Medicaid fee-for-service (FFS) and Medicaid Managed Care (MMC) will begin covering tisagenlecleucel (brand name KYMRIAH™) for members who have a diagnosis of acute lymphoblastic leukemia (ALL) when the member meets the criteria outlined in this policy. This coverage policy is effective December 1, 2017 for FFS and February 15, 2018 for MMC.

Tisagenlecleucel is a chimeric antigen receptor T cell (CAR-T) therapy for the treatment of patients twenty-five years of age or younger with B-cell precursor ALL that is refractory or in second or later relapse. Tisagenlecleucel is a one-time treatment that uses a patient’s own T cells to fight cancer. Tisagenlecleucel is the first therapy based on gene transfer that has been approved by the FDA.

Coverage Policy:
In accordance with FDA indications, Medicaid reimburses for tisagenlecleucel when the following criteria are met:
- The patient must have a diagnosis of B-cell precursor ALL;
- The patient must be less than 25 years of age (up to the end of the 25th year) or younger; and
- The patient must have relapsed or later relapse.

Clinical Policy: Tisagenlecleucel (Kymriah)
Reference Number: CP.HNMC.XX
Effective Date: 09.26.17
Last Review Date: 11.17
Line of Business: Medicaid – Medi-Cal
Coding: Clear as Mud
Example: Diagnosis Coding

Novartis Guidance
- Acute lymphoblastic leukemia not having achieved remission/in relapse
- Encounter for antineoplastic chemotherapy
- **Encounter for antineoplastic immunotherapy (Z5.112)**

Kite Guidance
- **Encounter for antineoplastic immunotherapy (Principal)**
- Lymphoma (Secondary)

CMS Coding Guidance
- Language points to **encounter for immunotherapy**, BUT that language was established for purposes of interferons and interleukins
- Future CAR-T specific instructions?

Coder Perspective
- Coders would typically list **malignancy** as the principal diagnosis
ICD-10-PCS for CAR-T

**New Technology Code Issued in 2017**

<table>
<thead>
<tr>
<th>3 Peripheral Vein</th>
<th>3 Percutaneous</th>
<th>A Bezlotoxumab Monoclonal Antibody</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>B Cytarabine and Daunorubicin Liposome Antineoplastic</td>
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<tr>
<td></td>
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<td>C Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy</td>
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<td></td>
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<td>F Other New Technology Therapeutic Substance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 New Technology Group 3</td>
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</table>

**Libman Education Coding Resource:**

Perhaps in anticipation of FDA approval, *after* October 1st, 2017 the Centers for Medicare and Medicaid Services have created two new PCS codes in the New Technology Section for CAR T-Cell therapy:

- **XW033C3** Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 3
- **XW043C3** Introduction of Engineered Autologous Chimeric Antigen Receptor T-cell Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 3
Q2040: Kymriah

Tisagenlecleucel, up to 250 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion

Effective Date: January 1, 2018
Payment Rate: $503,500

- OPPS Addendum B Update, 10/2017

Potentially problematic

Q2041: Yescarta

Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T cells, including leukapheresis and dose preparation procedures, per infusion

Effective Date: April 1, 2018
Payment rate not yet known; OPPS April Addendum B update (mid-March)
Leukapheresis: In or Out of Q code?

ASBMT letter to CMS on Q code concerns (2/9/2018)

- Manufacturer differences in reimbursement for leukapheresis
- Different sets of services at different points in time
  - Leukapheresis
  - Processing/shipping to/from manufacturing
  - Infusion
- Patients in active treatment at time of leukapheresis
  - To not bill those costs would require manual separation from other services performed for patient on the same day
- If patients are not infused, not able to bill apheresis costs
- Lack of clarity in terms of ‘dose preparation’ procedures
ASBMT New Code Requests

ICD-10

• Request submitted to NCHS/ICD-10 C&M to review the need for ICD-10 DX codes for **Neurotoxicity and CRS** (code as SIRS/Tumor Lysis Syndrome in the meantime?)

HCPCS Level II

• G codes: To track **physician and facility** services during the CAR-T process until CPT codes are established; potential for 2018 issuance
• Manufacturers seeking J codes for individual products

CPT

• ASBMT & partner societies submitted requests for the 2020 cycle
• Interested parties can receive a copy and submit comments through the AMA process; public may register for CPT meetings and comment on the floor if time permits and allowed by the meeting chair
Interim Coding Decisions

Individual Center Best Judgement

www.asbmt.org_Practice Resources - Coding
Reimbursement ‘Quirks’
Credentials Matter

Manufacturer
- Demonstrated expertise
- FACT Immune-effector Accreditation
- Contract to provide care in specified manner
- Clinical and administrative training for involved staff

Payer
- Demonstrated expertise
- In-network facility with specific contract; Center of Excellence networks?
- FACT Accreditation?
- For some payers – use of manufacturer standards as proxy for specialized designation
Best Practices In Obtaining Coverage For CAR-T
Language provided by Kite, a Gilead Company

- Ensure internal financial team understands what is involved in the clinical treatment and monitoring of CAR-T patients within their health system
  - This information is useful for discussions related to single case agreements

- Start clinical discussion early with top payers
  - Peer to Peer discussions prior to patient being identified has been welcomed by some payers
  - Important to let payer know if you are a certified site or will be a certified site soon
  - Discuss the PA criteria that would be required, prior to patient being identified
  - Ask if there is a certain person or department that will be doing the PAs for CAR-Ts
    - Most payers are using their Transplant Case Managers
  - Send as much documentation, as possible, with the PA request
Prior to patient being identified, create a SCA template with your preferred case rate and any carve out requests

Some payers would like to start preliminary SCA conversations after certification and prior to the first patient being identified

At the latest, start the SCA negotiation at PA approval of CAR-T

Ensure the health plan’s contracting team understands the urgency of the patient getting treated

Continuous follow up with the health plan

For more information about patient assistance offerings, contact the manufacturer’s assistance program at 844-454-KITE
Novartis’ Outcomes Based Agreement: Language provided by Novartis

- Novartis has developed a voluntary Outcome-Based Agreement (OBA) for the current approved ped-ALL indication and has begun executing agreements within the network of certified KYMRIAH Treatment Centers.

- Under the agreement, Novartis does not charge participating treatment centers for the cost of KYMRIAH when a patient does not achieve a complete remission (CR) or CR with incomplete blood count recovery (CRi) 28 to 35 days following infusion.

- The OBA applies to patients covered by all forms of insurance, including Commercial, Medicaid, Medicare, and other government health plans.

- The OBA only applies to product orders placed by a participating treatment center on or after signing the agreement to participate.
Inpatient Medicare: MS-DRG Assignment

Reminder: Inpatient cases group to an MS-DRG based on the diagnoses and procedures on the claim

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>MDC</th>
<th>Type</th>
<th>MS-DRG Title</th>
<th>FY 2018 Relative Weights</th>
<th>Geometric mean length of stay</th>
<th>FY 2018 Base Rate (hosp w/ wage index = 1 or less)</th>
<th>FY 2018 National Pmt Rate (10/1/2017 to 9/30/2018)</th>
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Really? $6,000-18,000?

MS-DRG + Outlier + NTAP (FY19?) ≠ Provider Costs
What is the status of NTAP?

New Technology Add-on Payment (NTAP): additional payment w/ DRG
- Up to 3 FY cycles after FDA approval
- Need to be approved by July 1 of the application year

Kite and Novartis presented to CMS on 2/13/18
- Comments from public welcome until February 25
- Public general comments at meeting asked for increased % $

CMS will discuss each application in FY19 IPPS Proposed Rule (April)
- Opportunity for comment by public, societies
- ASBMT anticipates submission of comments

Final determination made after public comment
- Decision and payment parameters issued in FY19 IPPS Final Rule

Implementation date: 10/1/2018
Will there be new MS-DRGs in FY19?

- ASBMT requested CAR-T specific DRGs
  - Potential for split based on presence of certain grades of CRS

- Usually 2-3 years of data needed before CMS will consider new DRGs

- If new DRGs issued, **no guarantee of better reimbursement rates** – just isolation of those cases
What about PPS Exempt Centers?

- Exempt centers experiencing reimbursement issues as well
- Paid differently: NTAP and outlier payments not available
- Will need to seek a novel solution from CMS
  - Potential for legislative activity to find a solution

City of Hope  Sylvester  Moffitt  Dana Farber  Memorial-Sloan Kettering
Roswell Park  Fox Chase  MD Anderson  Seattle Cancer Care Alliance
Patient Access and Financial Burden
On-going Media Attention to Access

Months After Approval, Breakthrough Just Five

By Michelle Cortez, Caroline Chen, December 14, 2017, 4:00 AM CST  Updated

Tuesday, January 16, 2018

Few Patients Get CAR T Cells Because of 'Insurance Snags'

Roxanne Nelson, RN, BSN

January 11, 2018
Patient Financial Burden

Loss of income
- Patient & Caregiver
- Extended duration – CAR-T + several prior lines of therapy

Cost-sharing
- Usual cost-sharing % = large $ amount when CAR-T provided in outpatient setting

Relocation
- Specialized centers mean travel and lodging implications
To address the unique aspects of KYMRIAH therapy, Novartis has developed various patient access programs to support safe and timely access for appropriate pediatric and young adult patients with B-cell ALL.

- Novartis offers patient assistance and support through KYMRIAH CARES. Assistance may include benefit and network investigation, copay assistance, travel assistance and the Kymriah Treatment Access Program.

- The Kymriah travel assistance program is intended to support compliance with the KYMRIAH REMS.

- The Kymriah Treatment Access Program (KTAP) provides financial assistance for those who are uninsured or experiencing a delay in treatment coverage.

- We are committed to assisting eligible patients with access to Kymriah. Patients are welcomed to call 844-4KYMRIAH for additional information.
Valuation of CAR-T

ASBMT “Value of Engineered T Cell Therapies” May 2017

University of York Office of Health Economics (UK) Feb. 2017

ICER began formal process in July 2017

- www.icer-review.org/topic/car-t
- ASBMT named as key stakeholder
- Draft materials & public comment cycle
- Free webcast on March 2 – final vote by CTAF

ASBMT comments:

- Good intentions but premature; clinical and financial data still developing
- Some additional technical feedback and resource suggestions
- Encourage second analysis when more robust data is available
Future State: Resolving Issues
Institute for Clinical and Economic Review Report Finds Costs of Approved CAR-T Therapies Align with Clinical Benefit

– Report will be subject to public deliberation during CTAF meeting on March 2, 2018 –

BOSTON, February 15, 2018 – The Institute for Clinical and Economic Review (ICER) today released an Evidence Report assessing the comparative clinical effectiveness and value of tisagenlecleucel (Kymriah™, Novartis) and axicabtagene ciloleucel (Yescarta™, Kite Pharma/Gilead). The report found that both therapies provided improvements in response rates and survival for patients who have exhausted most other treatment options, and that the drugs are priced in alignment with their clinical value.
Maybe these problems will go away?

- Regardless of ‘solution’, coding and billing will need diligent attention and tracking
- CMS systems adjustments
  - Demo program?
  - New DRGs?
  - NTAP expiration
- Additional products
- Additional codes
Two Pathways to Change

**Regulation**
- Working within current parameters
- ‘Innovative’ alternatives - CMMI

**Legislation**
- Changes to statute
- National or state level
What has the ASBMT done?

- Established Coding & Reimbursement Task Force
  - Coding assessment, guidance and new code requests
- Requests to CMS: MS-DRGs, NTAP, codes, alternate payment
- Dialogue with ASH, ASCO, BIO, NCCN, ADCC
  - Meetings with CMS IPPS and OPPS re: education
- Meetings with CMMI re: potential demonstration project
- On-going dialogue with manufacturer teams
  - Value of T cell therapies meeting
  - Stakeholder coordination
YOUR role in CAR-T Advocacy

Understand local impact

- Decisions about offering CAR-T
- Patient access issues

Communicate with leadership

- Educate hospital executive team
- On-going conversations with financial leadership

Involve your Govt Relations teams

- Call Congressional champions
- Share your concerns/stories with CMS
- Support efforts of ASBMT, other stakeholders
ASBMT work on CAR-T continues in 2018

ASBMT invites you to
REGISTER NOW

CAR-T Coding and Reimbursement Webinar

November 2, 2017 | 10-11AM CT

* FREE for ASBMT Members *
($75 for non-members)

www.asbmt.org
Questions?

Resources:
- Coding grid: www.asbmt.org
- Newsletter issues – open to all
- @HCT_policy
- More to come!

StephanieFarnia@asbmt.org
Appendix
Case Studies & Discussion

- A 67-year-old patient with DLBCL is a good clinical candidate for CAR-T. Will Medicare cover the treatment?

- A 12-year-old patient with ALL is a good clinical candidate for CAR-T, but has Medicaid and lives in a state without an authorized treatment center. Can s/he receive treatment?

- A 58-year-old patient with DLBCL and commercial insurance qualifies for CAR-T according to the insurance plan’s coverage policy. S/he needs to travel 5 hours to the care facility. Will the insurance plan pay for it?
Case Studies & Discussion

- A 67-year-old patient with DLBCL is a good clinical candidate for CAR-T. Will Medicare cover the treatment?
  - **Answer:** We think so. Reimbursement will likely be limited and will depend on the site of care, but coverage should be in place. Discussions with the local Medicare Contractor would be prudent unless/until local or national guidance is issued.

- A 12-year-old patient with ALL is a candidate for CAR-T, but has Medicaid and lives in a state without an authorized treatment center. Can s/he receive treatment out-of-state?
  - **Answer:** It will depend on the state and the agreement that can be reached between the Medicaid program and the treatment hospital. Enlisting the assistance of the hospital’s government affairs team and the manufacturers’ market access teams will be helpful.

- A 58-year-old patient with DLBCL and commercial insurance qualifies for CAR-T according to the insurance plan’s coverage policy. S/he needs to travel 5 hours to the care facility. Will the insurance plan pay for it?
  - **Answer:** It depends on the insurance plan. Some plans are developing travel and lodging benefits to help patients travel for care. Call the manufacturer to understand patient assistance program options.
FY 2018 IPPS Hospital Outlier Formula

- Uses a hospital’s total inpatient covered charges billed on the claim
- Multiplies the total inpatient account charges by the hospital’s operating cost-to-charge ratio (CCR) from the most recently filed cost report
- Compares the calculated amount to the sum of the MS-DRG payment for the case and the outlier threshold.
  - For FY2018, the IPPS fixed dollar outlier threshold is $26,713
  - IPPS MS-DRG base payment for MS-DRG 840 is $18,557
- If there is “excess cost” CMS will make an outlier payment
  - Recap: (Total charges billed on claim) \(\times\) (hospital’s CCR) = \(X\)
  - If \(X > (MS-DRG\ payment + fixed\ outlier\ threshold)\), outlier payment is warranted
  - Outlier payment = 80% \(\times\) (\(X - (DRG + IME + DSH + threshold)\))

Note: Outlier payments not available to PPS-exempt hospitals
FY 2018 IPPS Hospital NTAP Formula

- Uses a hospital’s total inpatient covered charges billed on the claim
- Multiplies the total inpatient account charges by the hospital's operating cost-to-charge ratio (CCR) from the most recently filed cost report
- Compares the calculated amount to the MS-DRG payment for the case
- NTAP payment, by design, allows up to no more than 50% of the cost of the new technology
- IPPS MS-DRG base payment for MS-DRG 840 is $18,557
- If there is “excess cost” CMS will make an NTAP payment
- Recap: (Total charges billed on claim) * (hospital’s CCR) = X
- X minus (MS-DRG payment + DSH + IME) = NTAP payment is warranted up to cap
- Hospitals can qualify for outlier payment after NTAP; the NTAP payment is added to the MS-DRG payment and the cost outlier threshold before determining if the calculated cost exceeds these thresholds and qualifies for the additional 80% outlier payment

Note: NTAP payments not available to PPS-exempt hospitals
Two Hospital Example of the Medicare IPPS Outlier Calculation for CAR-T Claims With Different Mark-Ups

**Hospital A Example - Assume 10% Mark-up and CCR of 0.25**

<table>
<thead>
<tr>
<th>Example CAR T Inpatient Hospital Claim with Invoice Detail</th>
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<tbody>
<tr>
<td>Hospital Uses 10% Mark-up &amp; CCR = 25%</td>
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<tr>
<td>FL12 = Admit Date 10-1-17</td>
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<td><strong>Value Code = xx</strong></td>
</tr>
<tr>
<td>FL 42 Revenue Code</td>
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<tr>
<td>0121</td>
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<td>0636</td>
</tr>
<tr>
<td>0940</td>
</tr>
<tr>
<td>0001</td>
</tr>
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</table>

**Hospital A Example CAR-T Inpatient Operating Outlier Calculation**

| Example MS-DRG 840 Base Payment | $18,557 |
| FY2018 Outlier Threshold | $26,713 |
| Example Hospital Operating CCR | 0.25 |
| Total Charges from Inpatient Claim | $26,713 |
| Calculated Hospital Cost (Charges x CCR) | $131,075 |
| Outlier Threshold (MS-DRG Pmt + Threshold) | $45,270 |
| Outlier Payment (Cost minus threshold *80%) | $68,644 |
| Total case payment (MS-DRG Payment Plus Outlier) | $87,201 |

**Hospital B Example – Assume x 4 Mark-up and CCR of 0.25**

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<tr>
<th>Example CAR T Inpatient Hospital Claim with Invoice Detail</th>
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<td>Hospital Uses 400% Mark-up &amp; CCR = 25%</td>
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<td>0001</td>
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</tbody>
</table>

**Hospital B Example CAR-T Inpatient Operating Outlier Calculation**

| Example MS-DRG 840 Base Payment | $18,557 |
| FY2018 Outlier Threshold | $26,713 |
| Example Hospital Operating CCR | 0.25 |
| Total Charges from Inpatient Claim | $1,606,000 |
| Calculated Hospital Cost (Charges x CCR) | $401,500 |
| Outlier Threshold (MS-DRG Pmt + Threshold) | $45,270 |
| Outlier Payment (Cost minus threshold *80%) | $284,984 |
| Total case payment (MS-DRG Payment Plus Outlier) | $303,541 |
Example of IPPS Outlier Calculation and NTAP Based on Different Mark-Ups Utilized

<table>
<thead>
<tr>
<th>Hospital A Example CAR-T Inpatient Operating Outlier Calculation</th>
<th>Hospital B Example CAR-T Inpatient Operating Outlier Calculation</th>
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<td>Example MS-DRG 840 Base Payment</td>
<td>Example MS-DRG 840 Base Payment</td>
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<tr>
<td>FY2018 Outlier Threshold</td>
<td>FY2018 Outlier Threshold</td>
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<td>Example Hospital Operating CCR</td>
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<td>Calculated Hospital Cost (Charges * CCR)</td>
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<td>Hospital loss for just the invoice cost of CAR T</td>
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<thead>
<tr>
<th>Hospital A Example CAR T Inpatient NTAP + Outlier Calculation</th>
<th>Hospital B Example CAR T Inpatient NTAP + Outlier Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example MS-DRG 840 Base Payment</td>
<td>Example MS-DRG 840 Base Payment</td>
</tr>
<tr>
<td>FY2018 Outlier Threshold</td>
<td>FY2018 Outlier Threshold</td>
</tr>
<tr>
<td>Example Hospital Operating CCR</td>
<td>Example Hospital Operating CCR</td>
</tr>
<tr>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Total Charges from Inpatient Claim</td>
<td>Total Charges from Inpatient Claim</td>
</tr>
<tr>
<td>$524,300</td>
<td>$1,606,000</td>
</tr>
<tr>
<td>Calculated Hospital Cost (Charges * CCR)</td>
<td>Calculated Hospital Cost (Charges * CCR)</td>
</tr>
<tr>
<td>$131,075</td>
<td>$401,500</td>
</tr>
<tr>
<td>Less MS-DRG Payment ($131,075 minus $18,557)</td>
<td>Less MS-DRG Payment ($401,500 minus $18,557)</td>
</tr>
<tr>
<td>$112,518</td>
<td>$382,943</td>
</tr>
<tr>
<td>Estimated CAR T NTAP Cap (Half of $373,000)</td>
<td>Estimated CAR T NTAP Cap (Half of $373,000)</td>
</tr>
<tr>
<td>$186,500</td>
<td>$186,500</td>
</tr>
<tr>
<td>Estimated NTAP Payment</td>
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</tr>
<tr>
<td><strong>$112,518</strong></td>
<td><strong>$186,500</strong></td>
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<td>$401,500</td>
</tr>
<tr>
<td>Outlier Threshold (MS-DRG Pmt + NTAP + Threshold)</td>
<td>Outlier Threshold (MS-DRG Pmt + NTAP + Threshold)</td>
</tr>
<tr>
<td>$157,788</td>
<td>$231,770</td>
</tr>
<tr>
<td>Outlier Payment (Cost minus threshold *80%)</td>
<td>Outlier Payment (Cost minus threshold *80%)</td>
</tr>
<tr>
<td>none</td>
<td>$135,784</td>
</tr>
<tr>
<td>Total case payment (MS-DRG Payment + NTAP + Outlier)</td>
<td>Total case payment (MS-DRG Payment + NTAP + Outlier)</td>
</tr>
<tr>
<td>$131,075</td>
<td>$340,941</td>
</tr>
<tr>
<td>Hospital loss for just the invoice cost of CAR T</td>
<td>Hospital loss for just the invoice cost of CAR T</td>
</tr>
<tr>
<td><strong>($241,925)</strong></td>
<td><strong>($32,159)</strong></td>
</tr>
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