ICER's Revised Value Assessment Framework for 2020	
Stakeholder Comment	**ICER Response in Revised Framework**
ICER should abandon its use of the quality-adjusted-life-years (QALY) metric.	ICER continues to use QALY-based analysis as the basis of its value assessments
Equal Value of Life Years Gained (evLYG) analysis does not fix the shortcomings of the QALY.	ICER will use both QALY and evLYG analysis in its assessments, saying that evLYG analysis provides context
QALYs value the lives of individuals with "less than perfect" health less than individuals in perfect health.	"ICER is sensitive to provide a framework for analyses that does not conflict with important ethical goals of US society," the organization writes. However, they continue to use the QALY metric.
QALYs fail to account for patient preferences.	From the framework document: "ICER seeks to involve a representative from a patient organization as an expert reviewer on a pre-publication version of the draft report to ensure the accuracy and comprehensiveness of sections describing the patient experience." In other words, patients will not get further representation in ICER assessments.
ICER's proposed crosswalk between ICER evidence ratings and the German HTA system is unrealistic and irrelevant.	There is no mention of the German HTA system in this version of the framework.
ICER should meaningfully incorporate patient input.	ICER is formalizing some patient input processes. There is a written patient input survey during topic announcement, and patient input is discussed in an annual conference call. However, patient-centered measures are not incorporated into the group's model. ICER says it will work with patient groups to see how patients can empirically contribute, but makes no commitment to actually incorporate patient contributions.
ICER should incorporate RWE into its base models.	ICER is generating a new pilot program for adding RWE two years after the initial report.
ICER should incorporate clinician input into its assessments, particularly for rare diseases.	ICER solicits input from clinicians but does not commit to any particular weight to their guidance.
Disease specialists and impacted populations should serve as voting members for ICER's reviews.	Patient and advocacy representatives are present during voting and pre-voting discussion, however, they do not vote.
Stakeholders support ICER's decision to take new evidence into account a year after its initial assessment, but urges ending premature reviews.	ICER will have a three-month long process to decide if it should add new evidence one year out. Two years out, ICER is piloting a new program that will incorporate new RWE into their assessments.
Comment periods should be extended.	The public comment period is 20 business days for the evidence report and an extra week for large class reviews, i.e. no extension.
ICER should use data that reflects real-world settings and a heterogeneous patient population.	ICER has indicated in cases where "there are knowable effect modifiers or knowable substantial differences in baseline risk," it will highlight these differences in the discussion of evidence. Stakeholders are disappointed heterogeneity of patient populations will not be incorporated in the base case.