

June 10, 2019

Dr. Steven D. Pearson
President
Institute for Clinical and Economic Review
Two Liberty Square, Ninth Floor
Boston, MA 02109

Dear Dr. Pearson,

We write representing patients and people with disabilities nationwide living with diverse conditions and diseases, as well as their families, caregivers and providers. We are pleased to provide feedback on ICER's 2020 Value Assessment Framework.

Above all, we urge ICER to put patients and people with disabilities at the center of all of your assessments. While we share your interest in lowering healthcare spending and addressing affordability, we do not believe that generating value assessments in a manner that leads to restricted access and discrimination is a necessary tactic or ethical strategy for achieving these goals. Academics, insurers and policymakers are not capable of determining value to the patient, an unfortunate reality that becomes clear to patients and their providers when coverage decisions based on value frameworks such as those conducted by ICER undermine patient and clinical expertise in decision-making. There are tremendous costs to patients and the health system when we assume all patients are average in a one-size-fits-all healthcare system. Facing restricted access, patients are less adherent to treatments that do not work for them and are more likely to experience adverse events and costly hospitalizations. Ultimately, we support value assessments that decision-makers can use to determine what works for whom and when so that our healthcare system truly drives holistic value in healthcare and minimizes out-of-pocket costs to patients and to the healthcare system.

We encourage ICER to align with innovative leaders in the field. When Congress authorized the Patient-Centered Outcomes Research Institute (PCORI), they created a blueprint for engaging patients and people with disabilities throughout the research process so that it reflected real-world considerations for decision-making. Similarly, the Food and Drug Administration (FDA) has made tremendous progress with patient-focused drug development to identify outcomes that matter to patients and drive innovation to address them. With this in mind, we ask you to consider the following suggestions to update your value framework.

ICER should give patients an equal voice

Last year, Xcenda conducted an analysis to better understand the extent to which ICER meaningfully engages patients and other stakeholders throughout its public comment process. On a positive note, they found that since refining its process for public commenting in 2017, ICER has acknowledged more than 95 percent of comments received from stakeholders. Yet, even when stakeholders proposed solutions that would address their concerns, ICER incorporated only one third (32 percent) of such comments. Comments from patient advocates were least likely to be acknowledged and incorporated (15.9 percent) compared to industry (33.2 percent) and professional/ provider societies (32.6 percent). Patient advocates most frequently commented on adequacy of existing evidence, patient perspective, and

transparency. ICER was more likely to incorporate input on methodology than general feedback on their framework. ICER was least likely to provide a robust response to comments submitted by patient advocates.¹

Patients and caregivers are the only people who can provide essential insight into how living with any one condition impacts their quality of life and what outcomes matter to them in treatment. They are true experts on their condition, yet ICER has chosen to minimize their voices in the review process and generalize patients broadly instead of taking stock of unique considerations for each condition. In fact, ICER does not provide any expert clinicians and patients with the condition being studied with a vote in its final assessments. As ICER develops its updated value framework, stakeholders who have firsthand experience with the specific topic being discussed, either as a patient, caregiver, or clinician, should have an equal voice and vote in all future assessments.

ICER must abandon the use of the QALY and other metrics that treat patients as averages, and, instead, develop novel measures of value to account for patient differences and priorities

The use of quality-adjusted life years (QALYs) and similar summary metrics of cost-effectiveness have long been precluded from use in public health care programs, as they discriminate against patients and people with disabilities by placing a lower value on their lives. For example, Medicare is prohibited by law from using a QALY-based threshold to determine coverage, payment or incentive programs. Health economists from both the United States and other countries have also highlighted that cost-per-QALY should not be the sole method of evaluating new healthcare technologies.^{2, 3}

As you know, utility weights used to derive QALYs rely on survey data. Under population survey models, the non-disabled population may systematically overestimate the burden of life with disability. Illustrating the egregious outcomes that emerge from these types of surveys, research has found a majority of Americans say they would rather have HIV than be blind⁴ and a common QALY measure (EuroQol-5D) rates inflammatory arthritis as “worse than death.”⁵ This issue is particularly visible when ICER’s models include data from studies that use “negative utilities,” such as in the recent study of treatments for secondary progressive multiple sclerosis. It is widely accepted that the logic of having negative utilities for any health state would lead to the contradictory goal of the premature death of a patient resulting in both health gain and being considered a cost-effective intervention. The use of

¹ See

http://www.pipcpatients.org/uploads/1/2/9/0/12902828/pipc_xcenda_icer_stakeholder_mapping_final_report_2018__03_.pdf

² Baltussen R, Niessen L. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost effectiveness and resource allocation*. 2006 Dec;4(1):14.

³ Thokala P, Devlin N, Marsh K, Baltussen R, Boysen M, Kalo Z, et al. Multiple Criteria Decision Analysis for Health Care Decision Making--An Introduction: Report 1 of the ISPOR MCDA Emerging Good Practices Task Force. *Value Health*. 2016;19(1):1-13.

⁴ Scott AW, Bressler NM, Ffolkes S, Wittenborn JS, Jorkasky J. Public Attitudes About Eye and Vision Health. *JAMA Ophthalmol*. 2016;134(10):1111–1118. doi:10.1001/jamaophthalmol.2016.2627

⁵ Harrison, M. J., Davies, L. M., Bansback, N. J., McCoy, M. J., Farragher, T. M., Verstappen, S. M., Hassell, A. and Symmons, D. P. Why Do Patients with Inflammatory Arthritis Often Score States “Worse than Death” on the EQ-5D? An Investigation of the EQ-5D Classification System. 2009 Jul; *Value in Health*, 12: 1026-1034. doi:10.1111/j.1524-4733.2009.00565.x

negative utilities can lead to an illogical result whereby a patient's premature death is judged as both a health gain and cost-effective intervention.

A metric based on averages will never adequately reflect patient value, because there is no single perspective on how people see and value "health." With this in mind, it is imperative that ICER looks at the heterogeneity of patient populations, even within the same condition. ICER's focus on developing tools for payers misses the bigger picture – that high-quality individualized health care increases treatment adherence and allows patients to care for their families and meaningfully participate in communities and the workforce, a cost-effective strategy that recognizes the value of all lives as worthy of treatment.

The newly developed evLYG does not fix the problem. While the evLYG partially mitigates the life-extension problem – if insurers use it – it still offers payers a means of refusing access to an effective and beneficial drug by using a summary metric that fails to account for outcomes that matter to patients. The evLYG does not address the challenges described above related to undervaluing quality of life improvements or ignoring clinical knowledge. This kind of QALY-based system remains less effective than condition-specific means of assessment.

In response to stakeholder opposition to the use of the QALY, ICER's response has been that the QALY is the "gold standard."⁶ Discrimination is not the gold standard. We join the chorus of stakeholders that have implored ICER to move beyond QALYs and urge ICER to instead follow the lead of other organizations that are advancing truly innovative value assessment models that are open-source, transparent, and able to generate disease-specific information using methods such as multi-criteria decision analysis.

ICER should have more stringent standards for minimum data requirements to conduct a review and continually revise each review based on new data

Pressure to immediately deliver payers and policymakers with assessments upon FDA approval has led to ICER undertaking its reviews at a stage when adequate data is unavailable. Its subsequent cost-effectiveness models rely on assumptions, oversimplified models, and incomplete data more than would be acceptable under a traditional peer-reviewed process. By prioritizing speed over quality, ICER provides payers and policymakers with flawed information based on limited evidence, which will lead to decisions that are similarly flawed. For example, ICER's methods for assessing treatments for spinal muscular atrophy put patients into three buckets: (1) sitting and walking, (2) need for permanent ventilation, and (3) death. Yet, SMA is a complex illness, and this overly simplistic categorization does not capture the experiences and health gains of all patients nor the value for patients and families from incremental improvements in quality of life.

In order to address this issue, ICER should incorporate in its framework a minimum data requirement for when a review may be conducted and refrain from publishing a value-based price until it is able to determine the "impact on net health benefit" with "high certainty." While doing so will not resolve the implications for discrimination and lack of transparency, it would be positive step to ensuring adequate data is utilized. Additionally, ICER should clarify the limits of its studies at the stage of their

⁶ See <https://icer-review.org/announcements/icer-describes-qaly/>

development and the inability of ICER's model to consider certain patient-centered endpoints that may not yet be reflected in research literature.

ICER should also make a commitment to update its estimated cost-effectiveness results each time new data becomes available on key inputs of cost and effectiveness. In particular, this should include the incorporation of real-world prices, real-world data on outcomes, and quality of life data specific to populations who have been treated with the drug under investigation. These real-world data sources have become ever more important, as the FDA sees real-world data as a key component of evaluating the potential value of new indications in approved therapies.⁷

Other value frameworks have also acknowledged the importance of real-world data that provide robust patient-centered information beyond the limits of randomized clinical trials. For example, the Patient Perspective Value Framework (PPVF), which has been developed by a coalition of stakeholders over the past three years now, has resulted in a framework to assess the benefits and costs of different healthcare options in the context of patients' personal goals and preferences.⁸ The PPVF recently released long-term recommendations provide strong guidance for aggregation and utilization of rigorous real-world data, providing ICER, payers, policymakers, and others with guidance on how to actually achieve real-world data and incorporate it into real-world decision-making.⁹ We are hopeful that ICER and its payer customers will be part of the solution to relieve patients and physicians from restricted access to valuable healthcare innovations that emerge from use of value assessments such as those currently developed by ICER that are built on inadequate and outdated data. With a strong commitment to updating its evaluations as real-world data emerges, such calculations would not need to rely as much on assumptions and RCTs that fail to reflect subpopulations.

ICER's models should be open-source, transparent, and available to all patients and researchers

ICER's assessments are a black box, leaving patients and people with disabilities in the dark on assumptions and important limitations that impact their results. An open-source version of the model where stakeholders can evaluate the different input choices, assumptions, and model structures would assure they are fair and unbiased. It would also allow stakeholders to submit more instructive and informed feedback. We are encouraged that organizations such as the Innovation and Value Initiative (IVI) are advancing open-source models and encourage ICER to follow their lead.¹⁰ Patient groups have consistently called on ICER to be more transparent about the limitations, model design, and evidence used for ICER's assessments. As ICER has heard before, the validity and reliability of ICER reports can be difficult to determine because the inputs used are often opaque.¹¹

In tandem with this, ICER needs to allow more time for stakeholders to submit public comments. ICER takes three months to develop a draft report and another two to produce a final report, yet public

⁷ https://cancerletter.com/articles/20190419_2/

⁸ See http://go.avalere.com/acton/attachment/12909/f-047c/1/-/-/-/20150510_PPVF%20Infographic_Print%20Friendly.pdf

⁹ Insert footnote when available

¹⁰ See <https://www.thevalueinitiative.org>

¹¹ See comments by Alliance for Aging Research at http://icer-review.org/wp-content/uploads/2016/10/ICER_Comments_on_VAF_100316.pdf

comments are generally restricted to three weeks. This short timeline does not allow stakeholders adequate time to properly evaluate the chosen inputs and understand how they interact within model structures.

It is important for ICER to recognize that patient groups, particularly for rare diseases, have limited bandwidth within their small organizations. Meaningful engagement in an ICER report process requires a significant investment by patient groups for whom it is vitally important that ICER's work not undervalue treatments and thereby result in restricted access. Yet, given the lack of transparency and limited description of the model components in the reports, it would take months and significant investment for a stakeholder to build a model based on the report and thoroughly evaluate it. While patient groups do the best they can, this inevitably means that meaningful input and critique of the models is seriously limited, and patient groups and the experience of their members become marginalized as a result. This has been noted to ICER in past comment letters. For example, the MS Coalition urged ICER "to consider ways to make the comment periods friendlier to patients by offering companion draft reports at an appropriate health literacy level for the general MS population" in their comments on the Secondary Progressive Multiple Sclerosis (SPMS) study.¹² If ICER wishes to learn from the public comments, then it is beholden to make that process accessible. ICER's current process for stakeholder feedback demonstrates the limited value they place on receiving thoughtful criticism or commentary on its methods.

ICER must incorporate a range of patient-relevant outcomes and reflect the range of potential levels of effectiveness new treatments have across a heterogeneous patient population

Rather than prioritizing outcomes that matter to patients and people with disabilities in its studies, ICER values a treatment from the health system and insurer perspectives. This misaligns ICER against the best practices within its own field and can lead to situations where it is judged more "valuable" to **not** provide additional care or certain treatments for some patients because doing so would not be "cost-effective."

While patient-reported outcomes are an essential step in the right direction for patient-centered research, even patient-reported outcome (PRO) tools are often insensitive to changes in actual patients' real health-related quality of life (HRQoL).¹³ Some studies have shown that patients often highlight very different areas of concern than those that dominate weights in HRQoL studies.^{14 15} This information alone should make ICER question using the QALY while ignoring outcomes that matter to patients. The National Alliance on Mental Illness (NAMI) highlights this in its November comment letter to ICER on its study on Treatment Resistant Depression (TRD), noting that patients with TRD place high priority on

¹² See https://icer-review.org/wp-content/uploads/2018/10/ICER_MS_Draft_Scope_Comments_112918.pdf

¹³ Schafer K, De Santi S, Schneider L. Errors in ADAS-cog administration and scoring may undermine clinical trials results. *Current Alzheimer Research*. 2011 Jun 1;8(4):373-6.

¹⁴ Jones PW, Rennard S, Tabberer M, Riley JH, Vahdati-Bolouri M, Barnes NC. Interpreting patient-reported outcomes from clinical trials in COPD: a discussion. *International journal of chronic obstructive pulmonary disease*. 2016;11:3069.

¹⁵ Urquhart-Secord R, Craig JC, Hemmelgarn B, Tam-Tham H, Manns B, Howell M, Polkinghorne KR, Kerr PG, Harris DC, Thompson S, Schick-Makaroff K. Patient and caregiver priorities for outcomes in hemodialysis: an international nominal group technique study. *American Journal of Kidney Diseases*. 2016 Sep 1;68(3):444-54.

treatments that offer fast, effective relief, and the ICER model fails to capture this by using a model that does not account for esketamine's immediate impact.¹⁶ The Asthma and Allergy Foundation similarly questioned whether the assumptions ICER made in its economic analyses meaningfully reflect the actual experience of asthma patients using biologics or any subpopulations of this group.¹⁷

In addition, ICER's practice of reporting outcomes as population-wide estimates runs counter to the direction in which medicine and the health care system is moving. The emergence of personalized medicine presents a paradigm shift to a world where innovations in medicine no longer treat a disease, they treat that disease in a specific person or population. As clinical decision making evolves in that direction, the methodology for interpreting and reporting evidence on value of innovations should evolve with it. It is imperative that ICER catch up to contemporary medical innovation and reflect evidence on heterogeneity, as it is well established that generating and reporting differential value assessment across subgroups will lead to substantial health gains.^{18, 19} Simply reporting estimates for overall populations – despite clinical evidence showing differential effectiveness across sub-populations – leads to a disconnect between how evidence is interpreted by payers versus clinicians and patients. This disconnect can ultimately lead to inefficient decision-making and loss of health gain.

Conclusion

Thank you for your consideration of our suggestions on ways in which ICER can make its value assessments fairer and more equitable to patients. Please feel free to reach out to Sara van Geertruyden (sara@pipcpatients.org) in response to our recommendations above.

Sincerely,

Aimed Alliance
Alliance for Aging Research
American Academy of Physical Medicine &
Rehabilitation
American Association of People with Disabilities
American Association on Health and Disability
American Urological Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autistic Self Advocacy Network
Bridge the Gap - SYNGAP Education and Research
Foundation
Cancer Support Community
CancerCare

¹⁶ See https://icer-review.org/wp-content/uploads/2018/10/ICER_TRD_Draft_Scope_Comments_112918.pdf

¹⁷ See <https://www.jmcp.org/doi/full/10.18553/jmcp.2019.25.5.514>

¹⁸ Basu A. Economics of individualization in comparative effectiveness research and a basis for a patient-centered healthcare. *Journal of Health Economics* 2011; 30(3): 549-559.

¹⁹ Espinoza MA, Manca A, Claxton K, Sculpher MJ. The value of heterogeneity for cost-effectiveness subgroup analysis: conceptual framework and application. *Medical Decision Making*. 2014 Nov;34(8):951-64.

Coelho Center for Disability Law, Policy and Innovation
Diabetes Patient Advocacy Coalition
Epilepsy Association of North Carolina
Epilepsy Foundation
Global Liver Institute
GO2 Foundation for Lung Cancer
Haystack Project
Headache and Migraine Policy Forum
Heart Valve Voice
Lakeshore Foundation
Lupus and Allied Diseases Association, Inc.
LUNGeivity Foundation
National Alliance on Mental Illness
National Council on Independent Living
National Diabetes Volunteer Leadership Council
National Infusion Center Association
National Minority Quality Forum
Not Dead Yet
NTM Info & Research
Partnership to Improve Patient Care
Philip Posner
Rosie Bartel
Southern Maine Chronic Pain Support Group
The Arc of the United States
The Association of University Centers on Disabilities
Whistleblowers of America