NCCN: Your Best Resource in the Fight Against Cancer

William T. McGivney, PhD

An oncologist came up to me not that many years ago and said, “We thank NCCN; NCCN is our last, best hope.” Those words still ring true. The policies and processes in the cancer care delivery system increasingly attempt to limit the autonomy and authority of oncologists and other clinicians to decide—in concert with patients and caregivers—what is best for patients. The strength of NCCN has been and shall be the ongoing commitment to integrating scientific evaluation of the results of clinical research with the vast experience, expertise, and clinical judgment of NCCN panel members and others to establish evidence-based/expert-based recommendations regarding appropriate therapeutic options.

The NCCN Guidelines stand as testament to the dedication and commitment of those who, through the years, have painstakingly established the thousands of pages of recommendations. The NCCN Guidelines quickly became the standard of oncology care in the United States in the early 2000s. Soon thereafter, payers began using guideline recommendations as the basis for coverage policy. NCCN was fastidious and driven about timely updating and communicating recommendations about new technologies and important issues. NCCN also was exceedingly adept at applying formats to attract and facilitate the work of decision-makers (eg, physicians, practice managers, payers). As an example of this, the NCCN Drugs & Biologics Compendium (NCCN Compendium), a derivative of the NCCN Guidelines, became the basis for and the driver of coverage policy for drugs and biologics.

Indeed, on January 16, 2008, UnitedHealthcare became the first commercial payer to announce that if an indication for a drug was a Category 1, 2A, or 2B NCCN recommendation, it would be covered. The Medicare program followed suit on June 5, 2008, at 4:16 pm (but who was watching that closely). Other payers and managed care companies fell in line as well. The significance of this was that in less than 10 years, NCCN had flipped the system back to where expert NCCN doctors were driving clinical and coverage policies.

Indeed, who should decide what appropriate care is? It has always been intriguing to interact with executives of insurance companies when the unfortunate diagnosis of cancer befalls them or a loved one. For them, then, the narrow networks and population-based coverage policies become personal impediments that are cast aside by their direction that “I want the best place, in-network or not, and the best treatment, and do not talk to me about coverage policies.”

NCCN has set a remarkable example in terms of developing and disseminating authoritative information and recommendations across the globe. The NCCN Web site annually provides information to more than 1 million unique visitors. The experiences have been memorable, and also entertaining. For example, for a few years the largest NCCN conference was held in Beijing, where approximately 2000 oncologists would gather. NCCN thought leaders would sit down with thought leaders from China and develop Chinese adaptations of the NCCN Guidelines. And, if you need a fun fact for your next cocktail party: in 2007, the full printed set of NCCN Guidelines weighed 32 pounds. How do I know? The Centers for Medicare & Medicaid Services (CMS) requested a paper copy of all NCCN Guidelines even though they were available electronically. Given that the CMS request was a prelude to granting recognition for the NCCN Compendium, NCCN willingly complied.

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William T. McGivney, PhD, is Principal at McGivney Global Advisors LLC, a consulting company established in 2012 to advise pharmaceutical, biotech, and device companies and investment houses on the positioning of drugs, biologics, and devices in the market. He received his PhD in Pharmacology from the University of North Carolina, and completed a Postdoctoral Fellowship at Harvard Medical School.

Dr. McGivney has vast experience and expertise that he focuses on real world issues and strategies. He was CEO of NCCN from 1997–2011, during which the organization experienced a period of major growth in scope and influence, developed the NCCN Drugs & Biologics Compendium, and established global collaborations in Asia, the Middle East, and Latin America. Previously, Dr. McGivney was Vice President, Clinical and Coverage Policy, at Aetna Health Plans (1991–1997). He was also a member of the Medicare Coverage Advisory Committee (2003–2007) and an FDA liaison for the AMA (1988–1991), and developed and directed AMA's Technology Assessment Program, DATTA (1985–1991).

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of NCCN.

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NCCN has been propelled by a staff that is “all in.” The ultimate objective, unflagging integrity, standard of excellence, and recognition of the exigency of patient need drove the achievement of a scientific, timely, clinically expert, user-friendly, patient-oriented set of guidelines such as the world had never seen.

At NCCN, the mission humbled us. Our accomplishments drove us on and on. Our clinical colleagues in oncology applied our work optimally. The demonstrated needs across the spectrum of tumor types propelled us forward. The patients whom we served inspired us.

NCCN is critical to the introduction and integration of innovative health care technologies (ie, drugs, biologics, devices, and techniques). NCCN is exemplary in its timely scientific evaluation of the results and data available. NCCN is critically needed by those oncologists, clinicians, caregivers, and patients who sit down every day and decide how best to fight the diagnosis that has been thrust into their lives. The NCCN Member Institutions, the expert clinicians and administrators, and the superb staff of NCCN work every day to serve the best interests of patients in need. Such dedication, commitment, and work are needed today more than ever!