Journal of the National Comprehensive Cancer Network

Commentary

Access to and Appropriateness of Cancer Care: Who Decides?

William T. McGivney, PhD

William T. McGivney, PhD, is Chief Executive Officer of the NCCN, responsible for the development of strategies and programs to improve the quality of care available to cancer patients. Such programs include the NCCN Clinical Practice Guidelines in Oncology, NCCN Oncology Outcomes Database, NCCN Oncology Research Program, and NCCN Drugs & Biologics Compendium. Strategically, Dr. McGivney is responsible for the growth of NCCN's influence in the oncology community and for assuring the development of partnerships with managed care companies and employers, the development of NCCN's health information capabilities, and the expansion of centralized research programs.

Before joining NCCN, Dr. McGivney was Director of the Division of Health Care Technology at the American Medical Association and then Vice President for Clinical and Coverage Policy at Aetna Health Plans. While at Aetna, he helped establish the first formal independent outside review process.

Dr. McGivney, a recognized expert in coverage policy and in drug and device regulatory policy, was awarded the FDA Commissioner's Medal of Appreciation in 1989. He has served on numerous national boards and committees including as President of the Board of the Patient Advocate Foundation and National Patient Advocate Foundation and as a member of the UNOS Board of Directors and the Medicare Coverage Advisory Committee.

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

Recent decisions about the optimal frequency and population age for screening mammography and the appropriate uses of bevacizumab and sipuleucel-t have raised questions, if not concerns, about both the decision-making processes and the level of expertise used in these processes, which can result in limiting access to interventions for patients in need. Were no authoritative scientific body and process available, one might acquiesce to such "third-party" decisions. However, the existence of the transparent, credible, and authoritative NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) and NCCN Drugs & Biologics Compendium (NCCN Compendium) begs the question, "why don't all policy decision-makers rely on the evaluative capacity and expert judgment of the 900 or so multidisciplinary experts who serve on the NCCN tumor-specific panels?" UnitedHealthcare, Aetna, and many other organizations, as described below, already rely on and follow the recommendations of the NCCN Guidelines Panels—panels that are composed of multidisciplinary experts who are both leading researchers and treat patients every day.

The Pendulum Swing

Over the past several years, policy development has shown a steady flight from reliance on the judgment of practicing clinicians and on the judgement of experts, in particular. To some extent, the clinical community brought this situation on itself with the variations in care and unnecessary procedure rates that were documented in the late 1980s. Now, unfortunately, the pendulum has swung too far, as those who would intellectualize medical decision-making compound simple concepts into grandiose "schema" that only others in the same circles can pretend to understand and appreciate. Meanwhile, the clinician works with the patient, evaluating the available options with specific reference to that patient's characteristics and preferences and then testing whether or not the agreed-upon treatment can wend its way through the mazes of coverage policy, preauthorization, step therapy, formulary choices, disease management, cost-utility, copay requirements, and more.

The current discussion of the regulatory status of bevacizumab in breast cancer illustrates an interesting decision-making dichotomy. The FDA is recommending removal of the indication for the use of bevacizumab as first-line therapy for patients with breast cancer. The NCCN Guidelines Panel for Breast Cancer reviewed the same studies that the FDA reviewed and reaffirmed its recommendation that bevacizumab and paclitaxel in combination be a treatment option for women with metastatic breast cancer. The vote of the NCCN Guidelines Panel on this issue was 15 to 0. The European Medicines Agency, the counterpart of the FDA for the European Union, has adopted a position consistent with that of the NCCN experts.

Furthermore, as reported by Bloomberg News, the 4 largest insurers in the United States—Aetna, Humana, UnitedHealthcare, and Wellpoint—will continue to cover the use of bevacizumab in breast cancer based on the NCCN recommendation. Dr. Lee Newcomer of United was quoted in *The ASCO Post* in September, before the NCCN decision: "If the NCCN still believes we should cover bevacizumab, we will."

Why Not the Experts

So, is there indeed hope that the pendulum is returning to a position that patients, providers, and payors can all live with together? Can it be that the scientific acumen,

clinical experience, and expert judgment of those who think about and treat hundreds if not thousands of patients with breast cancer be determinative in decision-making across all the important constituencies, with the patient being primary? Can it be that a payor would say, "Please refer to the NCCN Compendium on drugs and biologics issues," and that the same payor would cover the indications if they were recognized in the NCCN Compendium?

After all, this way, payors can eliminate laborious conversations with practice and hospital personnel to arrive at a decision already thoroughly vetted by a group of experts. This way, when the oncologist and patient agree, third parties need not be consulted and the patient can just move on in this critical phase of his or her life.

And if not, why not? It is the right system for patients. It is the right system for oncologists, who have spent 4 years of their lives in medical school and another 5 years in specific training before joining the academy of full-fledged oncologists. It is the right system for payors, who need to achieve appropriateness, efficiency, and equity in their business and in their fulfillment of beneficiary benefit packages. It is even the right system for insurance executives, who often, when faced with the crisis of a newly diagnosed loved one or relative, eschew their companies' tortuous processes and "cut to the chase" as they seek the best place and best treatment. It is the right system and it is a system that actually works now in real, everyday practice and in everyday care.

The current controversy presents an opportunity to extract something truly positive. The positive is bridging the gap between policy decisions and clinical decisions through a continual translation of the results of research and clinical experience into practice and policy by expert clinicians on behalf of patients whom they serve. Simple, clear, direct, and it actually makes sense!