SPOTLIGHT Q/A

Shaping the Future of Dermatology Practice: Leadership Insight From Susan C. Taylor, MD

Shifting practice demands and evolving policies are reshaping the landscape of dermatology. As President of the American Academy of Dermatology (AAD), *Cutis* board member Susan C. Taylor, MD, shares her perspective on the challenges ahead and the AAD's role in leading the specialty forward.

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What are the American Academy of Dermatology's (AAD's) top advocacy priorities related to Medicare physician reimbursement?

DR. TAYLOR: Medicare physician payment has failed to keep up with inflation, threatening the viability of medical practices. The AAD urges Congress to stabilize the Medicare payment system to ensure continued patient access to essential health care by cosponsoring the Medicare Patient Access and Practice Stabilization Act of 2025, which reverses the 2.83% cut and provides a positive inflationary adjustment for physician practices for 2025. In July 2025, Congress passed the One Big Beautiful Bill Act, which provides for a 1-year 2.5% increase to Medicare physician payment in 2026 to account for sustained cuts as Congress continues to work toward long-term payment reform. This short-term remedy is only applicable to 2026—a fix for 2025 as well as long-term reform still are needed. The AAD recently formed an ad-hoc task force on sustaining physician practices for senior citizen care that will continue to press for solutions to the Medicare payment crisis.

What is the AAD's stance on transitioning from traditional fee-for-service to value-based care models in dermatology under Medicare?

DR. TAYLOR: Current value-based programs are extremely burdensome, have not demonstrated improved patient care, and are not clinically relevant to physicians or patients. The AAD has serious concerns about the viability and effectiveness of the Quality Payment Program (QPP), especially the Merit-Based Incentive Payment System (MIPS). Numerous studies have highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. For instance, researchers examined whether MIPS disproportionately penalized surgeons who care for these patients and found a connection between caring for these patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments.

Additionally, the US Government Accountability Office was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. Findings indicated that physician practices with 15 or fewer providers, whether located in rural or nonrural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices. To maximize participation and facilitate the best possible outcomes for dermatologists within the MIPS program, the AAD maintains that we must continue to develop and advocate that the Centers for Medicare and Medicaid Services approve dermatology-specific measures for MIPS reporting.

Does the AAD have plans to develop or expand dermatology-specific quality measures that are more clinically relevant and less administratively taxing?

DR. TAYLOR: The AAD is committed to ensuring that dermatologists can be successful in the QPP and its MIPS Value Pathways and Advanced Alternative Payment Model programs. These payment pathways for QPP-eligible participants allow physicians to increase their future Medicare reimbursements but also penalize those who do not meet performance objectives. The AAD is constantly reviewing and proposing new dermatology-specific quality measures to the Centers for Medicare and Medicaid Services based on member feedback to reduce administrative burdens of

MIPS reporting. All of our quality measures are developed by dermatologists for dermatologists.

How is the AAD supporting practices dealing with insurer-mandated switch policies that disrupt continuity of care and increase documentation burden?

DR. TAYLOR: The AAD works with private payers to alleviate administrative burdens for dermatologists, maintain appropriate reimbursement for services provided, and ensure patients can access covered quality care by building and maintaining relationships with public and private payers. This critical collaboration addresses immediate needs affecting our members' ability to deliver care, such as when policy changes affect claims and formulary coverage or payment. Our coordinated strategy ensures payer policies align with everyday practice for dermatologists so they can focus on treating patients. The AAD has resources and tools to guide dermatology practices in appropriate documentation and coding.

What initiatives is the AAD pursuing to specifically support independent or small dermatology practices in coping with administrative overload?

DR. TAYLOR: The AAD is continuously advocating for our small and independent dermatology practices. In every comment letter we submit on proposed medical practice reporting regulation, we demand small practice exemptions. Moreover, the AAD has resources and practical tools for all types of practices to cope with administrative burdens, including MIPS reporting requirements. These resources and tools were created by dermatologists for dermatologists to take the guesswork out of administrative compliance. DataDerm is the AAD's clinical data registry used for MIPS reporting. Since its launch in 2016, DataDerm has become dermatology's largest clinical data registry, capturing information on more than 16 million unique patients and 69 million encounters. It supports the advancement of skin disease diagnosis and treatment, informs clinical practice, streamlines MIPS reporting, and drives clinically relevant research using real-world data.

What are the biggest contributors to physician burnout right now? What resources does AAD offer to support dermatologists in managing burnout?

DR. TAYLOR: The biggest contributors to burnout that dermatologists are facing are demanding workloads, administrative burdens, and loss of autonomy. Dermatologists welcome medical challenges, but they face growing administrative and regulatory burdens that take time away from patient care and contribute to burnout. Taking a wellness-centered approach can help, which is why the AAD includes both practical tools to reduce burdens and strategies to sustain your practice in its online resources. The burnout and wellness section of the AAD website can help with administrative burdens, building a supportive work culture, recognizing drivers of burnout, reconnecting with your purpose, and more.

How is the AAD working to ensure that the expanding scope of practice does not compromise patient safety, particularly when it comes to diagnosis and treatment of complex skin cancers or prescribing systemic medications?

DR. TAYLOR: The AAD advocates to ensure that each member of the care team is practicing at a level consistent with their training and education and opposes scope-of-practice expansions for physician assistants, nurse practitioners, and other nonphysician clinicians that threaten patient safety by allowing them to practice independently and advertise as skin experts. Each state has its own scope-of-practice laws governing what nonphysicians can do, whether supervision is required, and how they can represent their training, both in advertising and in a medical practice. The AAD supports appropriate safeguards to ensure patient safety and a focus on the highest-quality appropriate care as the nonphysician workforce expands. The AAD encourages patients to report adverse outcomes to the appropriate state licensing boards.

Is the AAD developing or recommending best practices for dermatologists who supervise NPs or PAs, especially in large practices or retail clinics where oversight can be inconsistent?

DR. TAYLOR: The AAD firmly believes that the optimal quality of medical care is delivered when a qualified and licensed physician provides direct on-site supervision to all qualified nonphysician personnel. A medical director of a medical spa facility should be a physician licensed in the state where the facility is located and also should be clearly identified by state licensure and any state-recognized board certification as well as by medical specialty, training, and education. The individual also should be identified as the medical director in all marketing materials and on websites and social media accounts related to the medical spa facility. The AAD would like to see policies that would provide increased transparency in state licensure and specialty board certification including requiring disclosure that a physician is certified or eligible for certification by a private or public board, parent association, or multidisciplinary board or association; requiring disclosure of the certifying board or association with one's field of study or specialty; requiring display of visible identification—including one's state licensure, professional degree, field of study, and the use of clarifying titles—in facilities, in marketing materials, and on websites and social media; and requiring all personnel in private medical practices, hospitals, clinics, or other settings employing physicians and/or other personnel that offer medical, surgical, or aesthetic procedures to wear a photo identification name tag during all patient encounters.