



Position Statement

on

Opposing Financial-Based Credentialing Including Narrowing of Provider Networks of Physicians (Approved by the Board of Directors: December 9, 1993; Amended by the Board of Directors: August 5, 2007; Amended by the Board of Directors: August 9, 2014)

The American Academy of Dermatology Association (AADA) is opposed to economic credentialing, which we define as the use of economic criteria unrelated to quality of care or professional competency in determining an individual physician's qualifications for initial or continuing hospital medical staff membership or privileges and/or for participating in a health insurer's provider panel. Moreover, the AADA believes that any willing, qualified physician should be allowed to participate in managed care networks.

The AADA supports the American Medical Association's efforts to actively oppose economic credentialing and to promote the ability of any willing, qualified physician to participate in care delivery.

Further, the AADA is opposed to the practice in which health insurers reduce the size of their provider networks (i.e., engage in "network narrowing") through a process of economic credentialing. The Academy believes provider networks exist to serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise. Therefore, provider networks and consequent patient access to physicians should not be restricted based primarily on metrics related to cost. The Academy believes that insurance companies must instead focus on the quality of care provided to beneficiaries, with a crucial element of quality care being the availability of sufficient providers and provider subspecialties within the network. Specifically, the Academy believes:

- Plans should be required to objectively demonstrate that their provider network is adequate. Relevant metrics that should be benchmarked include numerical measures of provider availability by geographic location, provider subspecialty and patient demographics;
- Since the medical specialty and subspecialty categories that health insurers currently use are routinely obsolete or incomplete, health insurers should be required to develop complete, updated lists of current medical specialties, subspecialties and practice focuses, and to ensure that providers in each of these areas are available to their covered patients;
- Health insurers should be required to maintain up-to-date directories listing their individual current providers by specialty, subspecialty, and practice focus, and these lists should be easily accessible by telephone and internet;
- Physicians should be provided a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement; and
- Beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated from a network mid-year.

Furthermore, the Academy advocates that managed care organizations, public and private health insurers, government entities, employers, and other healthcare groups adhere to the following principles in regards to physician profiling metrics and benchmarks.

- Seek active involvement from practicing dermatologists and their medical specialty associations, when profiling metrics and benchmarks are being designed;

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- Once profiling methods and benchmarks are developed, make available the data collection methods and analysis methodology, as well as the underlying rationale associated with each, to the physicians in the network and to their medical specialty associations;
- Ensure that any dermatologist profiling be based on valid data collection and profiling methodologies, including establishing statistically significant sample size;
- Evaluate on a regular and routine basis, but no less than annually, the quality and accuracy of physician profiles, and the data sources and methodologies used to construct them;
- Acknowledge and disclose all known and likely limitations in data sources and analysis methodology that are present in dermatologist profiling;
- Guarantee to the greatest extent possible that dermatologist profiling shall be based on standards-based norms derived from widely accepted, dermatologist-developed practice parameters;
- Share dermatologist profiles and any other information that have been compiled related to a given physician's performance with the dermatologist under review;
- Adjust comparisons among dermatologist profiles for patient case-mix, risks, and physician specialty/subspecialty/practice focus;
- When assessing a physician's care patterns with regard to procedures and interventions, appropriately distinguish between the ordering or referring physician, and the physician providing the service or procedure; and
- Develop and institute effective safeguards to protect against unauthorized use or disclosure of physician profiles.

This Position Statement is provided for educational and informational purposes only. It is intended to offer physicians guiding principles and policies regarding the practice of dermatology. This Position Statement is not intended to establish a legal or medical standard of care. Physicians should use their personal and professional judgment in interpreting these guidelines and applying them to the particular circumstances of their individual practice arrangements.