

# The Impact of Rising Skin Substitute Costs on ACOs

Traditional Medicare has recently seen extreme growth in the cost and utilization of skin substitutes, increasing from \$1.6 billion in 2022 to \$9.9 billion in 2024. **This rapid expenditure growth is problematic for Medicare's accountable care organizations if their spending per beneficiary for skin substitutes grows more rapidly than the trend factor used to update their benchmarks.** In the final Physician Fee Schedule rule, CMS noted the impact skin substitute billing had on ACOs but failed to designate it as Significant, Anomalous, and Highly Suspect (SAHS) billing. This left ACOs responsible spending spikes beyond their control. The agency explained that skin substitute expenditures represent roughly 1 percent of total Parts A and B expenditures for ACOs on average for PY 2023. The National Association of ACOs and its data partners conducted an analysis of 2024 Medicare claims illustrating the damaging and varying effect on ACOs. This is especially problematic for ACOs serving high-needs or institutionalized seniors who are much more likely to require wound care services. With continued billing for skin substitutes expected to reach \$15.4 billion in 2025, a similar impact is expected.

In **figure 1**, the distribution of the difference between MSSP ACOs' skin substitute spending growth in 2023 and 2024 is compared with their region. Some ACOs have seen increases much larger than their regions. For example, ACOs in the bottom ten percent had skin substitute spending that increased by \$89 more on average than their region's spending with some exceeding the regional trend by more than \$400.

ACOs in the bottom 10 percent generally serve a more complex patient population that are more likely to need skin substitutes. As shown in **table 1**, more than 10 percent of beneficiaries in these ACOs are long-term institutionalized (LTI) while 17 percent are dually eligible for Medicaid. They also have higher risk scores. Both the top and bottom deciles are made up of smaller ACOs.

MSSP trend adjustments based on regional average spending growth would mitigate the negative financial impact of rapid growth in skin substitute expenditures for a majority of ACOs and would provide a positive financial impact for many. However, small ACOs that serve more complex populations have a much higher exposure to these expenditures and are more likely to experience reductions in shared savings due to growth in skin substitute expenditures that are not captured by regional trends.

Figure 1: Medicare Shared Savings Program

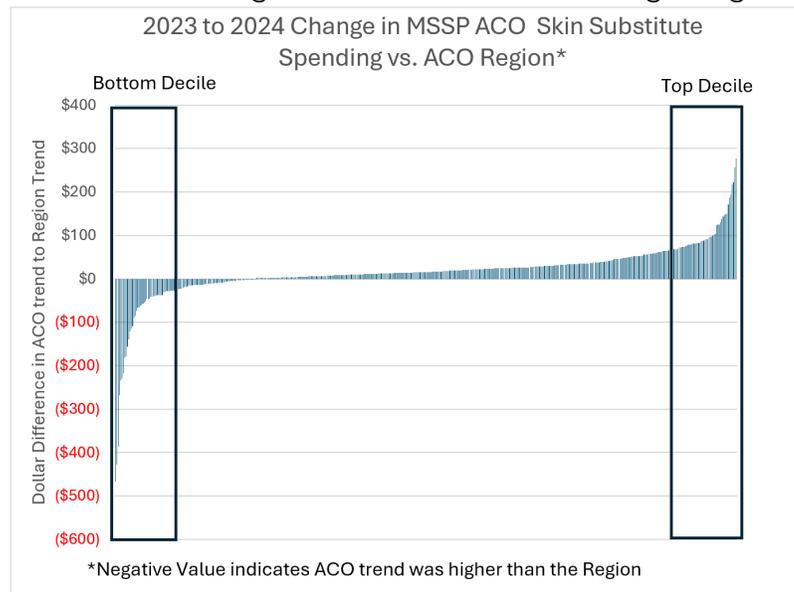


Table 1

	Attribute d Benes.	% Duals	% LTI	2024 Aged-dual HCC	2024 Aged-nondual HCC
Top 10%	12,564	12.8%	0.5%	0.93	0.98
Middle 80%	22,991	8.3%	1.1%	0.97	0.99
Bottom 10%	11,850	17.0%	10.4%	1.0	1.13

While this analysis did not include the national or ACPT trends that are blended with the regional trend, the ACPT will likely not have accounted for this rapid rise in skin substitutes. This analysis looks at a single year trend from 2023 to 2024. Actual benchmark updates for ACOs depend on when the ACO’s current contract began as the update is from BY3 to the PY. However, this single year trend illustrates the challenges in relying on MSSP benchmark trend factors to account for rapid changes in skin substitute expenditures experienced by some ACOs.

Table 2

As shown in **table 2**, REACH ACOs with the largest impact have the highest proportions of dually-eligible and long-term institutionalized (LTI) populations. Additionally, over 40% of ACOs have an impact greater than the retrospective trend adjustment (RTA) cap of 1%. The top 10 ACOs skin substitute impact ranges from 4% to 13%.

Impact to Shared Saving	# of ACOS	% Duals	% LTI
0-1%	72	20%	1%
1-3%	31	23%	8%
3%+	18	34%	16%

**METHODS:** The National Association of ACOs and its data partners conducted an analysis of Medicare allowed amounts (e.g., Medicare payment plus beneficiary coinsurance amount) to measure the per-capita change in skin substitute spending for each Medicare Shared Savings Program ACO between 2023 and 2024 and then compared the change to their region’s skin substitute spending. Regional trend was used as a simplifying assumption rather than the three-way blended trend that includes regional, national, and the Accountable Care Prospective trends. This spending analysis included only spending on products billed as Part B drugs (e.g., HCPCS codes Q4100-Q4367). Skin substitute spending was truncated at the 99th percentile of total Part A and B expenditures by entitlement group based on the MSSP truncation thresholds.

For ACO REACH, the impact of skin substitute was estimated by recalculating shared savings percentage by removing the skin graft expenditures for Q4100 to Q4353 from performance year expenditures and comparing it to shared savings including all expenditures. For example, an impact of 1% reflects an 1% increase to shared savings if skin substitutes were excluded from expenditures.

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