November 18, 2025

Chris Klomp, MBA
Deputy Administrator and Director
Center for Medicare
Centers for Medicare & Medicaid Services

Abe Sutton, JD
Deputy Administrator and Director
Center for Medicare & Medicaid Innovation Center
Centers for Medicare & Medicaid Services

RE: Holding ACOs Harmless for Egregious Skin Substitute Spending

Dear Deputy Administrators Klomp and Sutton:

The National Association of ACOs (NAACOS) appreciates your attention to the challenges posed by increased skin substitute spending. We applaud you for finalizing payment policy that will prevent bad actors from providing inappropriate care to beneficiaries and increasing the cost of care. We now ask that **Centers for Medicare and Medicaid Services (CMS) use its existing authority to ensure that accountable care organizations (ACOs) are held harmless from this increased, and often improper, spending.**

NAACOS is a member-led and member-governed nonprofit of nearly 500 accountable care organizations (ACOs) in Medicare, Medicaid, and commercial insurance working on behalf of health care providers across the nation to improve the quality of care for patients and reduce health care costs. Collectively, our members are accountable for the care of more than 9.5 million beneficiaries through Medicare's population health-focused payment and delivery models, including the Medicare Shared Savings Program (MSSP) and Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH).

ACOs identified egregious and suspicious billing for skin substitutes and began actively working to mitigate wasteful and abusive skin substitute use by developing wound care protocols, enhancing care management practices, and coordinating direct outreach to providers with concerning billing and treatment patterns. Despite these efforts, traditional Medicare billing for skin substitutes rose from $1.6 billion in 2022 to $4.5 billion in 2023 and $9.9 billion in 2024. ACOs continue to see increases in spending for 2025, with $7.7 billion in billing in just the first six months of 2025.

While the payment policy will address a large portion of the egregious skin substitute spending in 2026 and beyond, ACOs are left financially responsible for this unchecked, abusive spending outside of their control for 2025. Additionally, **smaller ACOs and those serving patients with complex and high needs are experiencing the most significant adverse impacts.** Failure to address this issue undermines the sustainability of ACOs, ultimately threatening the ability of participating providers to deliver high-quality, coordinated care and jeopardizing beneficiary access to well-managed care. Unfortunately, the existing program policies do not adequately address the increased spending for skin substitutes. **To strengthen and retain competition in health care through sustainable accountable care participation,**

CMS must take immediate action to ensure ACOs and physician practices are held harmless for egregious skin substitute spending outside their control in 2025. CMS should:

Set a truncation factor for skin substitute spending to bring ACOs higher than trend within trend.
The *trend updates for ACOs* account for changes in spending patterns but do not adequately account for ACOs experiencing the most significant increases in spending for skin substitutes. In MSSP, ACOs with higher spending for skin substitutes compared to their regions have a higher percentage of dual-eligible beneficiaries, long-term institutional beneficiaries, and patients with higher risk scores. Similarly, REACH ACOs with the greatest impact to shared savings due to skin substitutes have a higher percentage of dual-eligible and long-term institutional beneficiaries.

Additionally, the *stop-loss* policies do not fully protect ACOs from egregious skin substitute spending. In MSSP, beneficiary-level truncation occurs at the 99th percentile of national Medicare Parts A and B fee-for-service expenditures as determined for the applicable performance year. While this provides protection for beneficiaries with extremely high spending, many ACOs are experiencing a high volume of less extreme cases that fail to trigger stop-loss truncation but, cumulatively, are substantial. In ACO REACH, CMS offers REACH participants the option to obtain stop-loss reinsurance at the start of each performance period. However, like in MSSP, many ACOs are experiencing a high volume of less extreme cases that fail to trigger the stop-loss. Additionally, many REACH ACOs unfortunately did not opt into the CMS stop-loss reinsurance as ACOs could not predict the negative consequences from this ongoing fraud, waste, and abuse that would impact their aligned beneficiaries. Moreover, for those who elected for private market stop-loss programs, many carriers did not provide coverage for exposure to increased skin substitute claims due to known gaming. For ACOs that elected the CMS stop-loss reinsurance, their program will operate as “budget neutral,” for PY 2025, limiting the protection ACOs receive to the amount paid into the program in premiums.

In both MSSP and REACH, CMS should implement a stop-loss policy for a defined area of care. That is, CMS should set a code specific truncation factor for skin substitute spending that would bring ACOs above trend within trend. Additionally, in REACH, CMS should allow ACOs to retrospectively opt-in to the CMS stop-loss reinsurance program and reverse the budget neutral policy change.

Adjust Trend Factors to Account for Skin Substitutes.
Across ACOs, trend factor updates adjust benchmarks to current day spending; however, prospectively set trend factors do not account for unpredictable spending associated with fraudulent, wasteful, and abusive practices. In MSSP, the Accountable Care Prospective Trend (ACPT) has failed to accurately predict spending trends since implementation. In 2025 alone, overall spending is 90% higher than the ACPT. The addition of this ACPT to the national and regional trend update arbitrarily lowers benchmarks. NAACOS continues to recommend that CMS eliminate the ACPT and focus on other approaches to address the benchmark ratchet. At a minimum, the ACPT should be updated to account for the trend in skin substitutes and prevent clinicians from losing crucial revenue as they provide high-value, preventive care.

In ACO REACH, the Retrospective Trend Adjustment (RTA) is applied if there is a meaningful difference (>1%) between the observed expenditure trend for the ACO REACH National Reference Population and the prospective adjusted United States Per Capita Cost (USPCC) trend in a performance year. Nearly 40% of REACH ACOs, including standard and high needs ACOs, are affected by skin graft expenditures over and beyond the RTA 1% cap. Additionally, CMS implements symmetric RTA risk corridors that limit the positive and negative impact of the RTA. NAACOS continues to recommend that CMS eliminate the RTA corridors as it does not accurately reflect spending trends and has the potential to arbitrarily lower benchmarks. At a minimum, the corridors should increase to account for the trend in skin substitute spending.

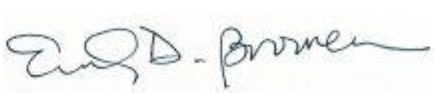
Adjust the Significant, Anomalous, and Highly Suspect Billing Policies.
CMS established a policy for 2024 and beyond that would remove fraudulent spending from benchmarks, trends, and expenditures that have national or regional impact or significance, with all adjustments being made nationwide. NAACOS has recommended that CMS revise the *significant, anomalous, and highly suspect (SAHS) billing policies* to account for local instances of improper claims and ongoing investigations of fraud that may impact only one or a few ACOs. CMS has stated that billing for skin substitutes does not meet the criteria for SAHS. While we understand that only a portion of the increased spending can be attributed to improper claims as spending is largely driven by inappropriate care and payment policy that places no limits on the cost for skin substitutes, the result is that ACOs are held accountable for waste and abuse. CMS should establish approaches to address instances of waste and abuse. For example, CMS could make a permanent policy to set code or clinical truncation factors for known areas of waste and abuse.

Align timelines across total cost of care models for reopening settlements if criminal proceedings are initiated against potentially fraudulent providers who rendered services to ACO-aligned beneficiaries.
The timeline for which ACOs may request an analysis of the impact of improper payments on financial calculations and a potential reopening of payment determinations differs between MSSP and ACO REACH. In MSSP, ACOs can submit a reopening request at any time in the case of fraud, or no later than four years after the notification of the initial determination of savings or losses for the relevant performance year for good cause. In ACO REACH, the guidance is clear for how CMS may reopen and revise a settlement report in the event of fraud or similar fault. However, the participant agreement does not expressly establish a procedure by which the ACO may request a reopening on grounds of fraud or improper claims. CMS should align REACH and any future total cost of care model policies for reopening settlements in the case of fraud with MSSP.

CONCLUSION

Thank you for your consideration in ensuring that ACOs remain viable amid fraudulent and wasteful spending by bad actors. NAACOS and its members are committed to providing the highest quality care for patients while advancing population health goals for the communities they serve. We look forward to our continued engagement in sustaining accountable care. If you have any questions, please contact Aisha Pittman, senior vice president, government affairs at aisha_pittman@naacos.com.

Sincerely,



Emily D. Brower
President and CEO
NAACOS