

## Doctor groups grapple with ‘bonkers’ spending on pricey skin substitutes

In some cases, the rate of spending on the wound treatments is outpacing massive totals for 2024, leaders of accountable care organizations told POLITICO

By: Robert King

The Trump administration promised to bring down the hammer on Medicare waste, fraud and abuse. But perpetrators of skin substitute fraud appear not to have gotten the message, six doctor groups across the country told POLITICO.

The doctor groups – known as accountable care organizations – said they are seeing massive charges this year by hospice, home health and other providers for pricey skin substitutes, which mimic human skin for use in wound care.

The heightened activity comes ahead of a potential crackdown on this type of fraud by the Centers for Medicare and Medicaid Services, which has estimated Medicare spent \$10 billion on the treatments last year. Some of the doctor groups – which agree to cap spending for their Medicare patients in exchange for a cut of the savings – say they are now noticing higher rates of spending on skin substitutes than they did in 2024. The groups, which first alerted CMS to the possible fraud two years ago, are concerned that CMS is not moving fast enough.

“We’ve seen multiple patients with over \$600,000 spent per patient on skin substitutes in 2025, and one case exceeding \$2 million,” said Christiana Beveridge, president and chief medical officer at Upperline Plus, based in Nashville, Tennessee. “These levels of spending raise serious concerns about clinical appropriateness, potential fraud and the lack of tools available to manage this outside of referring cases to the Office of the Inspector General.”

In a statement to POLITICO, CMS said that it has deployed advanced analytics and coordinates with law enforcement to pursue any perpetrators of skin substitute fraud. Officials did not return a request for comment on when it deployed the tool and whether anyone has been arrested as a result.

“The agency takes very seriously reports of potential fraud, waste, or abuse involving skin substitutes, and is actively monitoring this area to detect and prevent improper payments,” it said.

The agency has also proposed new regulations to reduce the fraud that have been met by resistance from the wound care industry.

CMS Administrator Mehmet Oz has taken several high-profile actions to address health care fraud overall. He touted a \$14 billion takedown in July led by the Department of Justice, in which hundreds of defendants were charged in alleged schemes. He also launched a “war room” last spring that relies on artificial intelligence to identify spikes in fraudulent activity before Medicare payments are made.

The latest spending spree shows providers that are overbilling are not deterred by CMS’ actions thus far.

“They are running rampant right now. They are trying to bill as much as possible,” before CMS cracks down, said one provider for an ACO who was granted anonymity to speak freely about the situation.

If the spending per patient goes over the agreed-upon cap with Medicare, ACOs must repay CMS. This means ACOs have a strong interest in finding fraudulent or wasteful spending.

ACOs get Medicare claims data on their patients to identify areas to cut costs. They reported first seeing dramatic spikes in skin substitute spending in late 2022.

CMS said in July that Medicare spending on the skin substitutes rose from \$252 million in 2019 to \$10 billion last year. The agency did not respond to a request for the 2025 total so far.

In a report released last month, HHS’ inspector general attributed the reason for the spike through 2024 partly to providers charging Medicare much higher amounts for the skin substitutes than their discounted purchase prices, and pocketing the difference.

It’s unclear how much of the 2025 spending spike is due to fraud, however. ACOs report fraud cases to CMS and HHS’ inspector general. HHS can then refer fraud cases to the Department of Justice for prosecution, but it can take years for them to act.

The Justice Department announced in June it filed charges in Arizona and Nevada against seven people for \$1.1 billion in fraudulent wound care claims. The department alleged the defendants applied unnecessary skin grafts to patients and did so without coordinating with a patient’s physician, a DOJ release said.

### **Behind the fraud**

Skin substitutes are a legitimate medical treatment used for ulcers or burns and other wounds. A patient can get the treatments from a hospice, home health provider or even a mobile clinic as opposed to going to their regular doctor, often without the knowledge of the ACO.

An ACO may not know a patient got a skin substitute until the claims data comes in. All the ACO can do at that point is educate its patients about the problem of possible and alert CMS or HHS about the spending spike.

ACOs reported in some cases patients got far too much of the treatment. For instance, one ACO said a provider billed 50 square centimeters of a treatment for a wound that required just one square.

ACOs may also suspect fraud if patients receive treatments too frequently, such as once every other day as opposed to once a week.

Some ACOs say they are seeing more skin substitute spending this year compared to 2024.

The ACO United Health Physicians, which has a presence across seven states, has already racked up more than \$4.5 million in skin substitute spending this year, said Jessica Hu, director of quality management. That's more than its total for all of 2024, Hu said.

A representative of an ACO that primarily treats high-needs patients said spending in its physician services category, which includes skin substitutes, outpaced total spending on inpatient hospital services in July.

"That is the first time we have ever seen that," said the person, who was granted anonymity to freely discuss the issue. "It is just bonkers."

The fraud occurs among patients on traditional Medicare as opposed to Medicare Advantage, which enables older Americans to buy a private plan that offers more benefits than traditional Medicare. An MA plan uses tools such as prior authorization, which requires insurer approval before delivering a service, to control spending. It is uncommon for Medicare to apply prior authorization to services.

### **Major change**

By the time a fraud claim reaches the Justice Department, an ACO will already have repaid Medicare for going over its spending targets.

"It is great they fix it next year, but you can't raise capital if you tell your capital partner: 'We are going to get hit with fraud claims we will never recover,'" according to the leader of another ACO granted anonymity to speak freely about the problem.

CMS said that it understands the ACOs' concerns. It is committed to ensuring payment targets "fairly reflect legitimate care delivery and are not skewed by fraudulent or abusive billing practices," the agency's statement said.

CMS proposed as part of a physician payment rule back in July a change to skin substitutes' classification, dramatically lowering reimbursement from as high as \$2,000 per square centimeter to about \$125. This change still needs to be finalized, with a decision likely expected in November. It would take effect Jan. 1, 2026.

The wound care industry is lobbying to nix the change. The MASS Coalition — a group of wound care companies — said in a statement it supports stronger government fraud enforcement, but the payment change won't help to achieve that goal.

The industry is also fighting another regulation to change Medicare coverage of skin substitutes that takes effect in January. The regulation sets a cap on the number of applications for wound care treatment. The regulation, called a local coverage determination, was supposed to take effect in April but got delayed because of a freeze due to changing administrations.

CMS has also launched a voluntary demonstration called WISER that would apply prior authorization to traditional Medicare cases of skin substitutes and several other services. The demonstration will launch in January across six states.

The WISER model has received major pushback from Democrats, who criticize Medicare Advantage plans for excessive use of prior authorization.

“This amounts to importing the most unpopular elements of Medicare Advantage, namely the frequent use of prior authorization, into Traditional Medicare,” said Sen. Ron Wyden (D-Ore.), top Democrat on the Finance Committee, in a statement.

While ACOs have lauded the regulations, some say more can be done at the source before a claim is paid out and they get hurt financially.

The National Association for ACOs has also called for CMS to cap the amount of skin substitute costs certain ACOs are responsible for, according to a statement to POLITICO.

“ACOs must be held harmless for abusive and wasteful spending that is outside of their control,” said Aisha Pittman, senior vice president of government affairs for NAACOS.