POLITICS & REGULATION

'Lifesaving': ACOs laud federal move to address suspect billing

(Adobe Stock)

By **Bridget Early**

April 02, 2026 05:00 AM CDT

Key Takeaways

- The Centers for Medicare and Medicare Services is excluding certain billing codes from how it calculates payments for accountable care organizations.
- CMS will hold ACOs in the Medicare Shared Savings Program and ACO REACH harmless from a set of billing patterns outside their control.
- ACO groups are lauding the decision but say there's more to be done.

Accountable care organizations have long raised concerns about the financial impacts of suspicious billing practices — but an announcement this week from the federal government could provide some relief.

In a Tuesday memo sent to organizations in the Medicare Shared Savings Program and the ACO Realizing Equity, Access and Community Health, or ACO REACH, model, CMS announced it will exclude spending associated with certain codes from ACOs' payment calculations.

Related: CMS launches ASPIRE pediatric Medicaid, CHIP pay model

For the 2025 performance year, CMS will not factor a set of durable medical equipment codes, including for certain orthotics and urinary catheters, into its cost calculations for both ACO REACH and the Shared Savings Program.

CMS will also exclude 90% of billing for skin substitutes in its ACO REACH calculations but will not adjust for these costs in the Shared Savings Program, according to the memo.

Prior regulations sought to mitigate improper spending for some of these services for the 2026 performance year and beyond.

CMS said the billing codes it is limiting are flagged for "significant, anomalous, and highly suspect" activity, meaning the change in volume isn't easily explained by policy changes or increased demand. This type of deviation from historical patterns often signifies fraudulent, wasteful or abusive spending.

The growth of such practices is significant: Medicare spending for skin substitute services rose from $256 million in 2019 to over $10 billion in 2024, CMS said in its 2026 physician pay rule.

ACOs are responsible for their enrollees' care costs, including for services the organization doesn't provide. In other words, if a third party improperly billed for an ACO patient's services and drove up spending for that individual, the ACO would be accountable for the loss.

By excluding these codes from payment calculations, CMS is effectively holding ACOs harmless from the suspect billing practices.

"For a lot of our members, this fix is existential," said Mara McDermott, CEO of the value-based care trade group Accountable for Health. "This guidance is lifesaving for their businesses and makes a huge difference in the quality and comprehensiveness of care for their beneficiaries."

Payments in these models run on a two-year lag, so participants will see the update reflected in their 2027 shared savings.

The change means providers have more savings to invest elsewhere in patient care and could make the difference between receiving shared savings and having to pay losses back to the federal government, said Aisha Pittman, senior vice president of government affairs for the National Association of Accountable Care Organizations.

The memo could also make a substantial difference for ACOs contemplating their future, said Susan Dentzer, president and CEO of America's Physician Groups.

If an organization doesn't think CMS would back them on waste, fraud or abuse issues, "that really would have deterred a lot of organizations from thinking about sticking with accountable care," Dentzer said.

The announcement has room for improvement, ACO groups said.

For instance, CMS' decision not to exempt Shared Savings ACOs from anomalous skin substitute billing will affect about 10% of ACOs in the program, Pittman said. These ACOs tend to care for largely institutionalized populations, populations with high rates of medically complex enrollees or populations with higher percentages of beneficiaries dually eligible for Medicare and Medicaid, she said.

Additionally, when CMS proactively detects anomalous billing trends, it diverts payments to escrow while it investigates the pattern, Pittman said. The agency should modify its approach to exclude escrow payments from ACOs' expenditures, she said.

Some ACOs are also calling for an expedited method for ACOs to identify fraud, report it and have it addressed.

CMS could accelerate the alert process by allowing ACOs to participate more widely in the Healthcare Fraud Prevention Partnership, a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing, McDermott said.

"ACOs have become very vigilant about paying attention, not just to the spending in terms of identifying potential fraud, waste and abuse, but understanding the care

that's happening for their patients," said Jennifer Podulka, senior vice president of federal policy for the trade group America's Physician Groups.

Recommended For You

INSURANCE

Humana shifts stance on Medicare Advantage benefit cuts

Humana expects its Medicare Advantage membership to rise 25% this year.

By: Nona Tepper

INSURANCE

Cigna to quit health insurance exchanges

By: Noah Tong

STAFFING

Visa delays, H-1B fees threaten physician hiring in underserved areas

By: Arielle Zionts

INSURANCE

What happens when Humana is the last Medicare Advantage insurer

By: Nona Tepper, Tim Broderick

Latest News

ACA enrollment losses reshape insurers' 2026 outlook

Inside Advocate Health's plan to scale hospital-at-home

Visa delays, H-1B fees threaten physician hiring in underserved areas

Deals tracker: Cross Country Healthcare to be acquired for $437M

See More in Politics & Regulation

States target insurers over prior authorizations, provider pay

Congress hasn't advanced more healthcare cuts — yet

CMS' rural health fund draws in big companies for possible paydays

Federal borrowing limited for advanced practice provider students