

Characteristics of Medical Groups That Do and Do Not Participate in Medicare ACOs: Implications for Policy



*Robert Mechanic and Andrew Perlman
Institute for Accountable Care (IAC)
June 2025*

The Center for Medicare and Medicaid Services (CMS) has devoted substantial effort introducing payment models with incentives to improve the quality and value of services for Medicare beneficiaries. In 2025, CMS announced that 53 percent of eligible beneficiaries in traditional Medicare fee-for-service were in an accountable care relationship with a provider.[1] The current administration has signaled interest in continuing to promote value-based care models with an emphasis on cost containment and on expanding participation of smaller independent and rural practices.[2]

Medicare's payment models for accountable care organizations (ACOs) covered approximately 12.2 million beneficiaries through the Medicare Shared Savings Program (MSSP) and ACO Realizing Equity and Community Health (REACH) in 2023. After a period of rapid growth through 2018 when Medicare ACO enrollment reached 11.5 million beneficiaries, enrollment growth stagnated. Although the number of ACO-affiliated clinicians grew by about 8 percent annually from 2018 – 2023, beneficiary growth was only 1.2 percent per year. This is in large part due to the shrinking number of eligible FFS beneficiaries as Medicare Advantage grew from 20 million to 31 million over the same time.[3]

Expanding enrollment in Medicare ACOs requires increasing the participation of physician groups. Doing so will be challenging. According to CMS, more than 15,000 physician groups and 4,400 federally qualified health centers (FQHCs) participated in the MSSP in 2023.[4] The initial ACO participants could be characterized as early adopters and they were followed by the early majority.[5] Those who remain outside of ACOs are the late adopters and it will take stronger policy tools and incentives to get them to join.

Strategies to increase participation require understanding the characteristics of medical groups that participate in Medicare ACOs as well as the characteristics of those that do not. This paper profiles all US medical groups that provide attribution-eligible services to Medicare beneficiaries by size, ACO status, provider composition, and geographic location. We then discuss the implications of our findings for future growth in ACO participation.

Methodology

We used 100 percent of Medicare fee-for-service claims combined with beneficiary enrollment data to determine which beneficiaries were eligible to be attributed to a Medicare ACO in 2023. We then used MSSP retrospective attribution to assign beneficiaries to Medicare certified providers based on their tax identification number (TIN) or CMS certification number (CCN) for FQHCs, rural health centers (RHC) and critical access hospitals (CAH).[6]

Medicare beneficiaries are assigned to ACOs if they receive the plurality of their eligible evaluation and management (E&M) services from an ACO physician or advanced practice clinician. In order to be attributed, a beneficiary must have at least one visit with an ACO physician in the past year. The MSSP modified this policy in 2025 to allow attribution for beneficiaries with an ACO physician visit in the prior two years, but we used the method in effect in 2023.

To identify attribution-eligible Medicare beneficiaries, we started with 2023 Medicare beneficiaries with zero months of Medicare Advantage (Part C) enrollment that were continuously enrolled in Medicare Parts A and B. From this pool of 28.5 million beneficiaries, 5.3 million did not have a physician visit in 2023, leaving 23.2 million attribution-eligible beneficiaries (see **Appendix Figure A1**).

We applied MSSP attribution to medical groups and found 21.0 million beneficiaries attributed to nearly 74,000 groups (including solo practitioners). Roughly 2.1 million eligible beneficiaries were not attributed because they did not have a physician visit with the TIN or CCN where they had a plurality of qualifying E&M visits in 2023. Some of those 2.1 million beneficiaries would have been attributed had we run ACO-level attribution since ACOs combine multiple TINs, making a visit with an ACO physician more likely than a visit with any individual TIN physician.

We then categorized the medical groups by whether they participated in an ACO in 2023. We further divided them into size categories based on the number of attributed beneficiaries, with 1 – 99 as the smallest category and 10,000 or more as the largest. Medical groups were also profiled based on the number of providers by National Provider Identifier (NPI) and the proportion of total visits to physicians that practiced primary care, which we defined as having a specialty of general practice, family practice, internal medicine, geriatrics or pediatrics. A visit-day approach was used to count physician services, where services were collapsed to a single visit per beneficiary per day with a unique NPI-TIN combination. NPIs were allowed to be counted under multiple TINs/CCNs.

Results

We found that only 25 percent of eligible medical groups were part of an ACO in 2023 (**Table 1**), but that ACOs captured a majority of large groups while non-participating groups were generally smaller. For example, 77 percent of groups with 10,000 or more attributed beneficiaries were ACO participants, compared with 16 percent of groups with fewer than 100 attributed beneficiaries.

Table 1: Number of ACO and non-ACO Medical Groups by Group Size

Medical Group Size	ACO Medical Groups	Non-ACO Medical Groups	Total Medical Groups	Percent ACO
1-99	7,734	40,963	48,697	16%
100-499	7,601	12,038	19,639	39%
500-999	1,679	1,604	3,283	51%
1,000-4,999	1,326	842	2,168	61%
5,000-9,999	246	112	358	69%
10,000+	224	72	296	76%
Total	18,810	55,631	74,441	25%

SOURCE: Analysis of 2023 claims data from a 100 percent sample of Medicare fee-for-service beneficiaries. Medical groups are defined by Tax Identification Numbers (TINs). Medical groups also include FQHCs, RHCs and CAHs, defined by CCNs. Size is the number of attributed beneficiaries in each TIN.

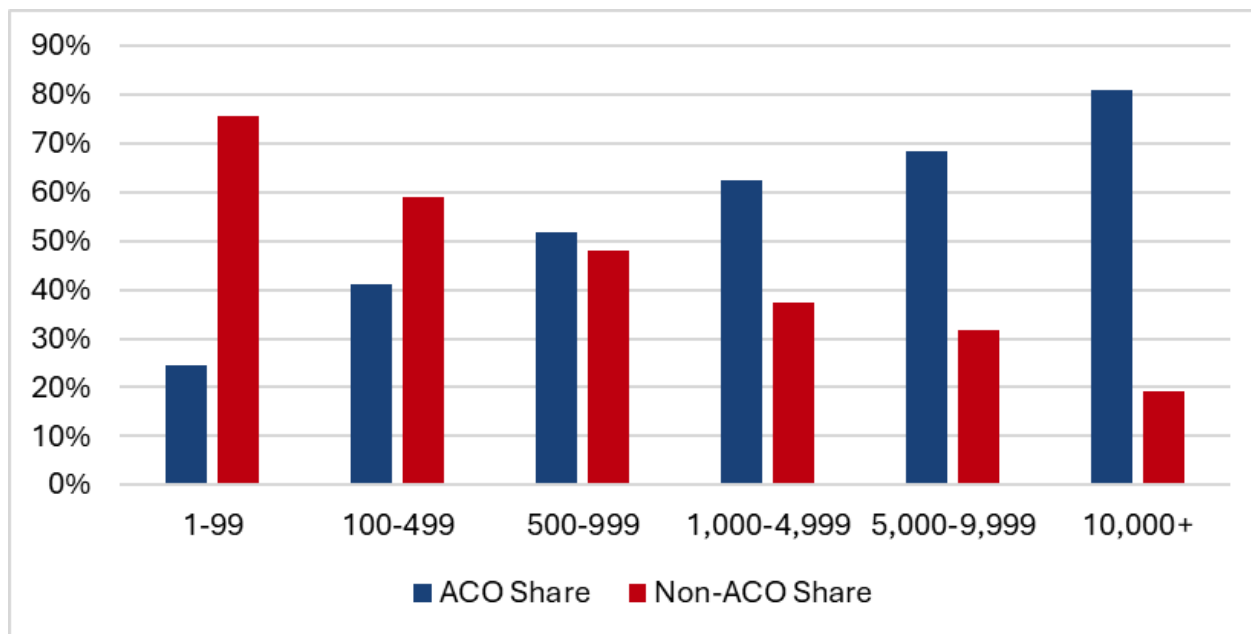
Of the 21.0 million beneficiaries attributed to a medical group in 2023, 5.8 million were attributed to groups with ten thousand or more beneficiaries (**Table 2**). Other categories that drew substantial attribution were those with 1,000 to 4,999 beneficiaries and 100 – 499 beneficiaries, both with more than 4 million beneficiaries. Groups of 100 – 499 beneficiaries had the largest number of beneficiaries that are not in a Medicare ACO (2.6 million). **Figure 1** shows the relative share of ACO vs non-ACO beneficiaries by medical group size.

Table 2: Number of ACO and Non-ACO Attributed Medicare Beneficiaries by Group Size

Medical Group Size	Total ACO Beneficiaries	Non-ACO Beneficiaries	Total Beneficiaries	Percent ACO
1-99	296,704	947,743	1,244,447	24%
100-499	1,787,137	2,600,198	4,387,335	41%
500-999	1,156,023	1,084,611	2,240,634	52%
1,000-4,999	2,756,623	1,688,850	4,445,473	62%
5,000-9,999	1,733,498	788,329	2,521,827	69%
10,000+	4,947,166	1,251,994	6,199,160	80%
Total	12,677,151	8,361,725	21,038,876	60%

SOURCE: Analysis of 2023 claims data for 100 percent of Medicare fee-for-service beneficiaries. Medical groups are defined by Tax Identification Numbers (TINs). Medical groups also include FQHCs, RHCs and CAHs, defined by CCNs. Size is the number of attributed beneficiaries in each TIN.

Figure 1
Distribution of Medicare ACO and Non-ACO Beneficiaries by Size of Medical Group (TIN)



SOURCE: Analysis of 2023 claims data from a 100 percent sample of Medicare fee-for-service beneficiaries.

Table 3 provides a more detailed breakdown of the groups that do not participate in Medicare ACOs by size and proportion of physicians that practice primary care. In this case the proportion of primary care is determined based on the number of visits provided by PCPs versus specialist physicians in 2023. It illustrates that about 75 percent of groups with more than 5,000 beneficiaries have more specialist visits than PCP visits. As the groups become smaller, the majority of their visits are primary care. In the 100 – 499 category which has the largest number of beneficiaries not participating in an ACO, nearly 60 percent are PCP-only practices while 20 percent are in FQHCs, RHCs, or CAHs.

Finally, to determine whether the composition of medical groups was different in areas with lower ACO penetration, we looked at the number of NPIs per group for non-ACO medical groups with 100 – 499 beneficiaries nationally and by the three metropolitan areas identified above (**Table 4**). Nationally, 43 percent of these groups had a single physician, with another 23 percent in groups with 2 - 4 clinicians. In contrast, the solo practice percentages were 64 percent, 62 percent and 59 percent in Washington DC, Los Angeles, and New York City respectively, which may contribute to their lower ACO participation rates.

Table 4
Distribution of Medical Groups with 100 – 499 Beneficiaries by Number of Clinicians Per Group Not Participating in a Medicare ACO

Number of NPIs Per Group	US Total		Los Angeles MSA		New York MSA		Washington DC MSA	
	Number of Groups	Percentage of Groups	Number of Groups	Percentage of Groups	Number of Groups	Percentage of Groups	Number of Groups	Percentage of Groups
1	5,182	43.0%	533	61.5%	566	58.5%	202	63.7%
2	1,380	11.5%	100	11.5%	129	13.3%	37	11.7%
3-4	1,372	11.4%	64	7.4%	80	8.3%	21	6.6%
5-10	1,775	14.7%	68	7.8%	62	6.4%	29	9.1%
11-20	1,069	8.9%	45	5.2%	53	5.5%	13	4.1%
21-50	763	6.3%	46	5.3%	43	4.4%	7	2.2%
51-100	277	2.3%	8	0.9%	16	1.7%	4	1.3%
Greater than 100	220	1.8%	3	0.3%	18	1.9%	4	1.3%
Total	12,038	100.0%	867	100.0%	967	100.0%	317	100.0%

Discussion

In 2023, we found that a majority of large medical groups already participated in a Medicare ACO, including 76 percent of groups with 10,000 or more attributed beneficiaries and 69 percent of groups with 5,000 – 9,999 beneficiaries. In contrast, only 16 percent of groups with 1 – 99 beneficiaries were in an ACO. The largest number of beneficiaries that are not in an ACO (2.6 million) are served by groups with 100 – 499 beneficiaries. An additional 1.7 million are in non-ACO groups of 1,000 - 4,999 and 1.3 million are in groups of 10,000 or more.

There are important barriers to the future growth in Medicare ACO participation. Many of the Medicare beneficiaries outside of ACOs are served by small practices that lack the ability to participate in value-based care without substantial support. Also, some large groups with the scale and resources to form ACOs appear to be satisfied with the status quo or face difficulty overcoming inertia to change. These groups may also lack comparable value-based contracting options from private health plans. Without pressure to engage in value-based contracts across their whole book of business there is little urgency to voluntarily join a Medicare ACO. Finally, continued growth in Medicare Advantage may further reduce the pool of beneficiaries eligible for ACOs.

Most of the small practices that don't participate in Medicare ACOs simply lack the capacity to participate successfully in value-based care models.[7,8] More than half of the groups with 100 – 499 beneficiaries are either solo or two-physician practices. The most practical way for them to participate is to join an existing ACO, but the cost to recruit and onboard small practices is relatively high. One pathway for these groups is through third-party ACO enablement firms.[9] Enablers provide services like data analytics, care management, and practice improvement support. They typically absorb some or all of the financial risk of VBP contracts and share contract savings with participating groups. Enablement firms are much more likely to recruit smaller practices than independently managed ACOs. One limiting factor, however, is that many independent primary care physicians are nearing retirement age[10] and may be less likely to engage in new payment and practice models.

The large medical groups that have not chosen to participate in ACOs over the past dozen years are typically owned by hospitals or academic medical centers (AMCs). Many of these practices have high total spending per beneficiary compared with their region which previously would have made them subject to a negative benchmark adjustment of up to five percent. This negative adjustment was eliminated in 2024 which may make ACO participation more attractive. But hospitals may still be reluctant to let their physicians participate if they are concerned that the ACOs will reduce their admission and procedure rates.[11] Many of these groups also are more risk adverse following the financial challenges they experienced during the COVID-19 pandemic.[12]

Many of the large non-participating groups may not have a strong enterprise-wide business case to participate in value-based care because they lack comparable private health plan options in their local markets. According to the HCP-LAN, nearly two-thirds of commercial health plan payments were fee-for-service in 2023.[13] A recent survey sponsored by the National Association of ACOs found only 30 percent of respondents said that more than a quarter of their revenue was tied to value-based contracts.[14] The government could play a meaningful role by creating stronger incentives for Medicare Advantage plans to implement value-based contracts and working with coalitions of private plans and providers to simplify participation through use of standard agreements and payment methodologies.[15]

Expanding participation in voluntary accountable care models will likely require making the program more attractive financially for new entrants. One way to do this would be for Congress to extend the 5 percent advanced alternative payment model (AAPM) bonus enacted under MACRA that expired in 2024. The bonus is currently applied to all Part B payments for ACO physicians, but its cost could be reduced by two-thirds by limiting it to services received by ACO beneficiaries.[16]

Conclusion

The majority of beneficiaries participating in Medicare ACOs are served by large medical groups. Continued growth in the number of traditional Medicare beneficiaries in accountable care relationships will be challenging. Organizations that have embraced value-based care – the innovators, early adopters, and early majority – are already in, while the non-participating groups – a large number of which are small practices – will be harder to recruit. Medicare has surpassed other payers in accountable care adoption,[17,18] and the reluctance of some commercial health plans to offer comparable contracts reduces the incentive to participate in value-based care. Continued growth in Medicare ACOs will likely require a combination of new policy incentives to encourage provider participation combined with new efforts to encourage private health plans to simplify, standardize and broadly offer value-based contracting opportunities.

Acknowledgements: This work was generously supported with funding from Arnold Ventures (Grant ID 22-06921).

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Appendix

Medical Group Size	ACO Medical Groups				Non-ACO Medical Groups	Total Medical Groups	Percent ACO
	Convener	Hospital-Led	Physician-Led	Total			
1-99	3,056	2,930	1,748	7,734	40,963	48,697	16%
100-499	3,435	2,747	1,417	7,601	12,038	19,639	39%
500-999	838	618	225	1,679	1,604	3,283	51%
1,000-4,999	619	552	155	1,326	842	2,168	61%
5,000-9,999	83	137	26	246	112	358	69%
10,000+	39	153	35	224	72	296	76%
Total	8,070	7,137	3,606	18,810	55,631	74,441	25%

Medical Group Size	ACO Beneficiaries				Non-ACO Beneficiaries	Total Beneficiaries	Percent ACO
	Convener	Hospital	Physician	Total			
1-99	125,935	102,978	67,791	296,704	947,743	1,244,447	24%
100-499	820,913	6,456,777	319,863	1,787,137	2,600,198	4,387,335	41%
500-999	577,746	425,922	153,585	1,156,023	1,084,611	2,240,634	52%
1,000-4,999	1,255,674	1,196,569	304,380	2,756,623	1,688,850	4,445,473	62%
5,000-9,999	575,742	970,075	187,681	1,733,498	788,329	2,521,827	69%
10,000+	759,842	3,490,360	851,156	4,947,166	1,251,994	6,199,160	80%
Total	4,115,852	12,642,681	1,884,456	12,677,151	8,361,725	21,038,876	60%

