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Findings at a Glance

# Accountable Health Communities Model

## Evaluation of 2018–2023

## MODEL OVERVIEW

The Accountable Health Communities (AHC) Model tested whether connecting beneficiaries to community resources for their health-related social needs (HRSNs) improved quality of care outcomes and reduced costs. The model screened all fee-for-service (FFS) Medicare and Medicaid beneficiaries for core HRSNs in two tracks:

- **Assistance Track:** Eligible beneficiaries were randomly assigned to receive navigation (intervention group) or referral only (control group).
- **Alignment Track:** All eligible beneficiaries were offered navigation and received care from organizations that engaged with model stakeholders in continuous quality improvement to align community resources with beneficiaries' HRSNs.

**The AHC Model focuses on five core HRSNs:**


## PARTICIPANTS

29 organizations located across the United States (referred to as bridge organizations) in collaboration with clinical delivery sites and community service providers screened 1,114,099 unique Medicaid and Medicare beneficiaries between April 2018 and January 2023.

Medicaid and Medicare beneficiaries who reported at least one core HRSN and at least two emergency department (ED) visits in the 12 months before screening were eligible for navigation services.

## FINDINGS

### AHC Model reduced total health care expenditures and improved quality of care

Health care expenditures declined 3% for Medicaid beneficiaries and 4% for Medicare beneficiaries in the Assistance Track. Inpatient stays declined by 6% for Medicaid beneficiaries in the Assistance Track and by 4% for Medicaid beneficiaries in the Alignment Track. ED Visits declined by 5% for Medicare beneficiaries in the Assistance Track and by 4% for Medicaid beneficiaries in the Alignment Track.

| | Assistance Track | Alignment Track |
|---|---|---|
| Total expenditures | FFS Medicare 4% Reduction ↓ | |
| | Medicaid 3% Reduction ↓ | |
| Inpatient stays | Medicaid 6% Reduction ↓ | Medicaid 4% Reduction ↓ |
| ED visits | FFS Medicare 5% Reduction ↓ | Medicaid 4% Reduction ↓ |

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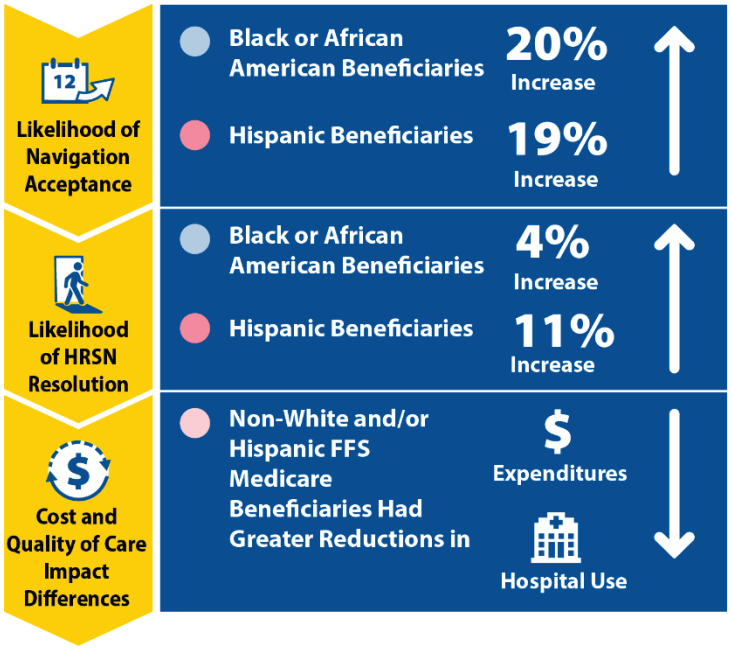
### Beneficiaries from underserved racial and ethnic groups were more likely to accept navigation and have HRSNs resolved.

Black or African American and Hispanic beneficiaries were more likely to be eligible for and accept navigation than white beneficiaries (20% and 19%, respectively). Black or African American beneficiaries were also more likely to have at least one need resolved (4% and 11%, respectively), with Hispanic beneficiaries more likely to have all their needs resolved.




### Expenditures declined and hospital use-based quality of care outcomes improved more for underserved racial and ethnic groups.

Non-white and/or Hispanic FFS Medicare beneficiaries had larger reductions in total Medicare expenditures, ED visits, avoidable ED visits, and inpatient admissions than white beneficiaries.

### Other subpopulations were also more likely to have HRSNs resolved and larger impacts on their health care outcomes.

Beneficiaries with diabetes were more likely to have at least one need resolved. FFS Medicare beneficiaries with diabetes or pulmonary diseases also had larger reductions in expenditures and greater improvements in quality of care. Similarly, beneficiaries who had more than one navigated need were more likely to have at least one need resolved. Medicaid beneficiaries with more than one need had larger reductions in expenditures and greater improvements in quality of care.

## KEY TAKEAWAYS

The AHC Model was associated with significant impacts on total expenditures and quality of care, even though the model resulted in moderate increases in beneficiaries' connection to community services and HRSN resolution overall. Some populations—such as those in underserved racial and ethnic populations—were more likely to have their needs resolved. The model was also associated with more-pronounced health care impacts for these same subpopulations. One possible explanation for these findings is that navigators not only helped beneficiaries with HRSNs but also addressed tangible barriers to health care (e.g., transportation to appointments) and helped them navigate the health care system generally. **Collectively, these findings provide evidence that navigation can transform the delivery of care in ways that address major HRSN barriers to health and promote health equity for underserved populations.**

This document summarizes the evaluation report prepared by an independent contractor. For more information about the AHC Model and to download the Third Evaluation Report, visit https://innovation.cms.gov/innovation-models/ahcm.