



Executive Summary

The Center for Medicare and Medicaid Innovation (Innovation Center) launched the Accountable Health Communities (AHC) Model in 2017. This model was designed to serve beneficiaries with core needs related to upstream drivers of health. The model tested whether connecting these beneficiaries to community resources could reduce health care expenditures and utilization.¹

Twenty-eight participants, known as bridge organizations, collaborated with clinical partners, community-based organizations, state Medicaid agencies, and other stakeholders. Model participants universally screened all Medicaid and Medicare beneficiaries who received care from clinical partners for five core needs related to their upstream drivers of health, referred to as “core needs.” The five core needs were housing instability, food insecurity, transportation problems, utility difficulties, and interpersonal violence. Those who were identified as

¹ The AHC Model previously used “health-related social needs (HRSNs)” to refer to a set of five core needs related to upstream drivers of health: food, transportation, utility, housing, and safety. In this report, we refer to those five needs as “needs” or “core needs” and use “upstream drivers of health” to refer to a broad set of health-related drivers, including but not limited to the five core needs previously referred to as HRSNs. More information about this change is available in the [CY 2026 Physician Fee Schedule Final Rule](#).

having at least one of these core needs were universally referred to community-based organizations. When the model concluded in 2023, participants had screened more than 1 million Medicaid and Medicare beneficiaries for core needs. Of those screened, 37% screened positive for at least one core need, and 18% also reported at least two emergency department (ED) visits in the past 12 months and were community-dwelling, making them eligible to receive navigation services. Navigation services helped connect beneficiaries with community-based organizations who could address their needs.

There were two AHC Model tracks. In one track, the model provided navigation services to support those who needed help finding community resources. In the other track, the model provided these same navigation services while strengthening the relationships between clinical partners and community-based organizations. The two tracks were known as the Assistance and Alignment Tracks:

- **Assistance Track:** Navigation-eligible beneficiaries in the Assistance Track were randomly assigned to an intervention or control group. Beneficiaries assigned to the intervention group received their usual clinical care, a community referral summary with a list of community resources available for their specific needs, and an offer of navigation services. Beneficiaries in the control group received everything beneficiaries in the intervention group received except for an offer of navigation services.
- **Alignment Track:** Navigation-eligible beneficiaries in the Alignment Track were not randomized, so all beneficiaries received the same intervention as the Assistance Track intervention group. In addition to the beneficiary-level intervention, Alignment Track bridge organizations performed a variety of community-level activities, such as community-level continuous quality improvement.

The AHC Model focused on five core needs:



Housing instability



Food insecurity



Transportation problems



Utility difficulties



Interpersonal violence

One Model, Two Interventions

The AHC Model used two tracks to separately test interventions to help Medicaid and Medicare beneficiaries with core needs resolve those needs:



The Assistance Track tested universal screening and referral to identify Medicaid and Medicare beneficiaries with core needs and refer them to services, adding navigation assistance to connect eligible beneficiaries to the community services they needed.



The Alignment Track tested universal screening, referral, and navigation *combined with* engaging key stakeholders in community-level continuous quality improvement to align community service capacity with the community's service needs.

This final report details the AHC Model's impacts on key outcomes. The [First Evaluation Report](#), released in December 2020, described the key features of the model (eligibility, interventions, model participants) and the evaluation's goals and design. It also presented baseline data on costs and use, preliminary impact estimates for the Medicare fee-for-service (FFS) population, and assessments of program implementation through 2019. The [Second Evaluation Report](#), released in May 2023, described the structural and organizational characteristics of bridge organizations and community-based organizations, communities' capacity and resources to address core needs, progress on AHC Model activities through 2021, and the impact of the COVID-19 pandemic on the model. The [Second Evaluation Report](#) also included estimates of model impacts on costs and health care use for Medicare and Medicaid beneficiaries in both tracks through the fourth year of the model. The [Third Evaluation Report](#) built on these earlier findings with an additional year of data, obtained through 2022. The model ended in April 2023. This final evaluation report includes the final impact results for Medicaid, FFS Medicare, and Medicare Advantage

beneficiaries through December 2023. This report also includes final lessons learned, drawing from both the new analyses and previous reports.

Overview of Key Findings

AHC Reduced Expenditures and Improved Quality of Care, as Evidenced by Reductions in Hospital-Based Utilization

Navigation-eligible Medicaid and FFS Medicare beneficiaries in the Assistance Track intervention group had lower total health care expenditures than beneficiaries randomized to the control group (**Exhibit ES-1**). Medicaid beneficiaries in the intervention group also had lower inpatient admissions and unplanned readmissions relative to the control group, indicating that reduced inpatient use—including unplanned readmissions—was a key driver of the lower observed expenditures among Medicaid beneficiaries. FFS Medicare beneficiaries in the intervention group had lower ambulatory care sensitive condition (ACSC) admissions and ED visits, suggesting that use of other emergent services drove lower expenditures among FFS Medicare beneficiaries.

Exhibit ES-1. Impacts on Expenditures and Hospital-Based Utilization

AHC was associated with lower expenditures and hospital-based utilization in both the Medicaid (square) and Medicare (circle) intervention groups.

	 Assistance Track	 Alignment Track
Total Medicaid/Medicare Expenditures 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 3% reduction in total expenditures FFS Medicare beneficiaries had a 4% reduction in total expenditures 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 7% reduction in total expenditures
Inpatient admissions 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 3% reduction in all-cause inpatient admissions and a 7% reduction in unplanned readmissions FFS Medicare beneficiaries had an 8% reduction in ACSC admissions and a 7% reduction in unplanned readmissions 	
ED Visits 	<ul style="list-style-type: none"> FFS Medicare beneficiaries had a 4% reduction in ED visits and a 5% reduction in avoidable ED visits 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 3% reduction in ED visits and a 3% reduction in avoidable ED visits
Ambulatory Care 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 1% reduction in specialist visits FFS Medicare beneficiaries had a 4% reduction in PCP visits and a 3% reduction in specialist visits 	<ul style="list-style-type: none"> Medicaid beneficiaries had a 5% reduction in PCP visits FFS Medicare beneficiaries had a 4% reduction in PCP visits

Definitions: ACSC = ambulatory care sensitive condition; ED = emergency department; FFS = fee-for-service; PCP = primary care provider.

Note: The infographic only highlights impacts that were statistically significant.

Navigation-eligible Medicaid beneficiaries in the Alignment Track also had lower total health care expenditures relative to the comparison group (**Exhibit ES-1**). Lower inpatient admissions and ED visits may have driven the observed reduction in total health care expenditures for Medicaid beneficiaries. We did not find significant impacts for most outcomes among FFS Medicare beneficiaries in the Alignment Track. A set of complementary analyses that aimed to overcome this limitation suggests that the lack of significance was primarily because the sample size was too small to detect impacts, not because the model was ineffective in this population. Moreover, many of the impact estimates among FFS Medicare beneficiaries in the Alignment Track were in the same direction and had a similar magnitude as those observed among FFS Medicare beneficiaries in the Assistance Track.

AHC Generated More than \$200 Million in Net Savings

Across both tracks and payers (i.e., Medicaid and FFS Medicare), the AHC Model generated net savings of more than \$200 million.

Multiple Mechanisms Could Explain AHC's Successes

We expected that beneficiaries who received navigation services would have greater resolution of needs than those who did not receive navigation services. In turn, this would lead to better health outcomes and reduced health care expenditures. As reported in the [Second](#) and [Third Evaluation Reports](#) and in Renaud et al. (2023),² survey results from a subset of beneficiaries showed that approximately 6 months after screening, beneficiaries who were randomized to the Assistance Track intervention group had similar rates of need resolution to those who were randomized to the Assistance Track control group. Despite this finding, data have consistently shown reductions in hospital-based utilization in the Assistance Track. Moreover, in the [Third Evaluation Report](#), there was evidence that the Assistance Track reduced total health care expenditures. This final report continues to support those findings and provides further evidence of reduced total expenditures for Medicaid beneficiaries in the Alignment Track.

This suggests that the mechanisms underlying the AHC Model's effects may have been more nuanced than originally envisioned. Some other mechanisms that may have led to AHC's successes include the following:

- **Navigators built trust with beneficiaries.** Having a trusted relationship with a navigator may have increased trust in the health care system overall. This could have led to better connection to the health care system and associated providers making care more effective for beneficiaries.
- **Navigators may have had direct impacts on health care utilization.** Interviews with navigators revealed that navigators often went above and beyond in helping their clients. In some cases, navigators would help their clients remember important appointments for ongoing treatment, such as for mental health conditions. Thus, one mechanism that could explain the observed impacts is that navigators leveraged their relationships with clients to help them better navigate the health care system, and better access to care led to improvements in acute health care outcomes. The trust embedded in navigator-beneficiary relationships may have made navigators more effective in this part of their role.
- **Need resolution could have been more likely among certain subpopulations of those navigated.** Results from the [Third Evaluation Report](#) showed that certain subpopulations of beneficiaries, such as those with chronic conditions, were more likely to have their needs resolved than others. Thus, navigation could have had more impact on need resolution for these subpopulations. Many of these same subpopulations also had greater reductions in expenditures, hospital-based utilization, or both. Accordingly, needs resolution in these subpopulations could have driven part of the observed overall impacts.

² Renaud, J., McClellan, S.R., DePriest, K., et al.: Addressing Health-Related Social Needs Via Community Resources: Lessons From Accountable Health Communities. *Health Affairs*. 42(6):832-40, 2023. <https://doi.org/10.1377/hlthaff.2022.01507> 

- **Partially addressing needs through navigation could have directly affected health outcomes.** It is likely that even partially addressing a need could affect health and health care outcomes. For example, providing transportation for medical appointments, even if a beneficiary still has other continuing transportation needs, could lead to better outcomes.

Navigation Services Were More Impactful When Provided Alongside Other Medicare Alternative Payment Models

FFS Medicare beneficiaries who participated in one of four other alternative payment models (APMs)³ at the same time as they participated in the AHC Model had larger reductions in expenditures and hospital-based utilization than beneficiaries who did not. One possible explanation for this finding is that some beneficiaries also in APMs received enhanced care management services alongside the navigation services provided through the AHC Model. In addition, qualitative data collected for this evaluation suggest that navigators performed complementary functions as a care manager or care coordinator for their clients (e.g., providing appointment reminders for medical appointments) in addition to their work connecting beneficiaries to community-based organizations. These care management and care coordination services combined with navigation services may have had synergistic effects on the cost and utilization outcomes.⁴

Navigation Services Were More Impactful for Beneficiaries with Behavioral Health or Chronic Conditions

Evidence from the [Third Evaluation Report](#) showed that Medicaid beneficiaries with behavioral health conditions and FFS Medicare beneficiaries with chronic physical health conditions had larger impacts on their expenditures and utilization outcomes. One possible explanation for this finding is that navigators often helped beneficiaries better navigate the health care system, in addition to connecting them with community-based organizations to address their core needs. Accordingly, beneficiaries with behavioral health and chronic conditions were more likely to benefit from this aspect of the beneficiary-navigator relationship.

In the [Third Evaluation Report](#), we also learned that not all communities had sufficient resources to meet the core needs of beneficiaries. Navigators stressed that this made their job much more challenging. These findings suggest that in resource-constrained communities, it may be beneficial to prioritize navigation services to individuals with more complex needs, such as those with behavioral health or chronic conditions.

Different Needs Drove Higher Health Care Expenditures for FFS Medicare Beneficiaries Versus Medicaid Beneficiaries

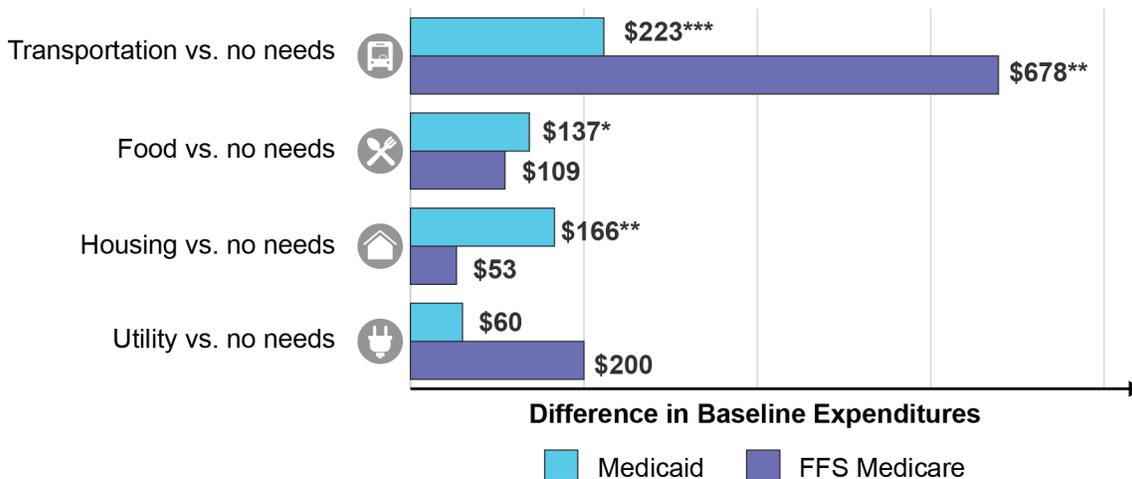
Data from [First Evaluation Report](#) showed that core needs generally predict higher health care expenditures. In this report, we explored which specific need(s) predict higher health care expenditures. We found that among FFS Medicare beneficiaries who self-reported two or more ED visits, transportation needs were uniquely associated with higher expenditures (**Exhibit ES-2**). In contrast, among Medicaid beneficiaries, multiple needs (transportation, food, and housing needs) were associated with higher expenditures. Transportation needs may have been uniquely associated with higher expenditures in FFS Medicare because Medicare does not cover nonemergent medical transportation services, whereas Medicaid does in many states. Thus, FFS Medicare beneficiaries with

³ The four alternative payment models included in this analysis were the Medicare Shared Savings Program, the Next Generation Accountable Care Organization Model, the Comprehensive Primary Care Plus Model, and the Maryland Primary Care Program.

⁴ APMs provide care management and care coordination to beneficiaries. However, these services sometimes are used sparingly (e.g., for patients with the greatest clinical need, for short durations after acute episodes of care such as a hospitalization). We did not have data on which beneficiaries received these services, so we could not assess whether these findings are the result of receiving concurrent care management and navigation services.

transportation needs may have a harder time accessing preventive medical care. Poor access to preventive medical care could lead to a heavier reliance on acute and costly medical services, such as hospital care.

Exhibit ES-2. Differences in PBPM Expenditures in the 12 Months Before Screening by Type of Core Need Among Beneficiaries Who Reported Two or More ED Visits



* p < 0.10; ** p < 0.05; *** p < 0.01.

Medicaid sample sizes: 593,815 Medicaid beneficiaries were screened for core needs and reported two or more ED visits. Of these, 333,026 had no core needs, 93,682 had a transportation need, 170,807 had a food need, 123,551 had a housing need, and 84,935 had a utility need.

FFS Medicare sample sizes: 310,185 FFS Medicare beneficiaries were screened for core needs and reported two or more ED visits. Of these, 225,868 had no core needs, 34,274 had a transportation need, 48,234 had a food need, 37,062 had a housing need, and 21,428 had a utility need.

Source: RTI analysis of Chronic Conditions Warehouse Transformed Medicaid Statistical Information System Analytic Files (T-MSIS) and Medicare Claims.

Timeframe: Data cover May 2018–January 2023.

Definitions: ED = emergency department; FFS = fee-for-service; PBPM = per beneficiary per month.

Notes: This chart presents the difference in total health care expenditures over the 12 months before screening among beneficiaries with each of four core needs versus those with none of the core needs. For example, Medicaid beneficiaries with transportation needs had \$223 higher expenditures per beneficiary per month than those with none of the core needs. Beneficiaries who did not report two or more ED visits in the 12 months before screening were excluded from this analysis. The presented differences are regression adjusted for other needs, age, and sex. The sample of beneficiaries with safety needs was too small to provide reliable information. As such, this need has been omitted.

Navigation Services Were Also More Impactful for Beneficiaries with Transportation Needs and for Those with Multiple Needs

AHC had a greater effect on FFS Medicare beneficiaries with transportation needs. These beneficiaries had larger reductions in ED visits and smaller reductions in primary care provider (PCP) visits than beneficiaries without transportation needs. These results suggest that the navigation services these beneficiaries received through this model may have improved their access to preventive medical care. Among Medicaid beneficiaries, beneficiaries with multiple needs experienced larger and more favorable impacts on health care outcomes, including larger reductions in inpatient admissions and ED visits. These results suggest that beneficiaries with multiple needs may have benefited more from navigation services than those with one need only.

Navigation Services Were More Impactful for Beneficiaries Who Were Dually Eligible for Medicare and Medicaid

Impacts on utilization outcomes were greater for those who were dually eligible for Medicare and Medicaid than for those who were only eligible for FFS Medicare. Because dual eligibility indicates a lower income, these results provide another indication that navigation services were particularly impactful for beneficiaries with complex needs. Impacts on expenditures were similar between the two groups.

Conclusion

The AHC Model demonstrated that focusing on patient's needs related to upstream drivers of health can lead to cost savings while maintaining or improving the quality of care beneficiaries receive, as evidenced by reductions in inpatient and ED utilization. Addressing core needs may be particularly impactful for several vulnerable groups, including those with frequent ED visits, chronic or behavioral health conditions, dually eligible for Medicare and Medicaid, transportation needs, and multiple needs. These findings suggest that if resources are scarce, universally screening and referring all beneficiaries and then offering navigation services to those who are most likely to benefit might be a way to use resources efficiently.

More broadly, the AHC Model demonstrated that it is possible to screen for upstream drivers of health on a large scale and that screening can be integrated into the clinical workflow in flexible, patient-centered ways. The model also showed that core needs are prevalent among Medicaid and Medicare beneficiaries, and that most beneficiaries with core needs are receptive to navigation services.

AHC also was more impactful when implemented in the context of other health care reforms. This suggests navigation services can be complementary to the care management and coordination offered as part of value-based care.

The mechanisms that explain AHC's successes may be more nuanced than originally envisioned. Evidence was mixed for whether navigation services did a better job of connecting and resolving needs than referrals alone did. However, partial resolution of beneficiary needs, such as providing transportation to medical appointments, could have improved healthcare utilization. Trust built with navigators could have allowed for improved overall navigation of the healthcare system. Additionally, navigators could have affected health care utilization and expenditures in other ways, such as by reminding beneficiaries of upcoming medical appointments and coordinating with beneficiaries' care managers and providers. Connection and resolution appear more likely for some subpopulations, such as those with chronic conditions, who also have greater reductions in spending and utilization.

Some AHC communities did not have resources to fully meet the demand for services to address core needs.⁵ Navigators also reported challenges tracking which community-based organizations had capacity to take on new beneficiaries, leading to some frustrating experiences in trying to connect beneficiaries. Insufficient community resources will be important to address going forward in order for beneficiaries to maximally benefit from screening and navigation services. Advisory boards were helpful in identifying gaps in resources, and can be helpful resources as screening and navigation efforts that started under the AHC Model continue and expand throughout the health care system and communities across the US.

The final report and additional information about the model are available on the [AHC Model Page](#).

⁵ AHC Model funds could not be used to provide resources and services to address core needs.