Literature Review on Integrated Care Models for People Dually Eligible for Medicare and Medicaid

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Authored by

Pamela Nadash
Janelle Fassi
Elizabeth Simpson
Calvin Tran
Edward Alan Miller
Marc A. Cohen

LeadingAge LTSS Center @UMass Boston

LeadingAge LTSS CENTER @UMass Boston

Research bridging policy and practice

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Executive Summary

This review synthesizes the literature on integrated care models serving individuals dually eligible for Medicare and Medicaid, including both older (aged 65 and over) and younger (aged 21–64) adults. Dual eligibles are a medically complex and socially vulnerable population, and are disproportionately costly, they comprise 17% of Medicare enrollees but account for 33% of Medicare spending. Despite longstanding recognition that fragmented delivery systems lead to poor outcomes, fixing this problem has proven difficult.

Integrated care models aim to address these issues by assigning responsibility for beneficiaries to a single entity, thereby fostering efficiency, improving outcomes, and reducing costs. While enrollment in these models has grown significantly – from 2% in 2013 to 9.4% in 2022 – evidence of their overall effectiveness remains mixed. Research shows improved member satisfaction and reduced long-term institutional care, yet findings on other outcomes, such as, hospital admissions and cost savings, are inconclusive. Such results have resulted in the termination of the most fully integrated models, tested by the Financial Alignment Initiative (FAI), and highlight the complexity of evaluating such interventions.

Evaluating integrated care is problematic due to its variability: "integrated care" is more an organizing concept rather than a specific model. Model variations arise from differing state regulations, services covered, organizational structures, provider networks, and the varying capacities of implementing organizations. This variability in context, design, and implementation makes it difficult to identify specific causal mechanisms or generalize findings. Critiques of existing research also point to poor intervention descriptions, lack of conceptual frameworks, and challenges in creating appropriate comparison groups due to selection biases in enrollment.

Thus, it may be more feasible to assess certain key mechanisms that appear to have the potential to improve outcomes for dual eligibles, of which there are many. Two of these have evidence demonstrating effectiveness: care coordination (using dedicated care managers) and interdisciplinary care teams. However, the evidence base for other promising mechanisms is less strong. These include improving support for social determinants of health (SDOH) – for which there is a growing literature -- and integrating behavioral health, which lacks an evidence base but is critical for younger duals with behavioral challenges.

In conclusion, integrated care holds significant promise for improving outcomes among dually eligible individuals through more coordinated, person-centered delivery. However, evidence on its effectiveness is not strong, given the difficulty of producing generalizable findings from multifactorial interventions, and the associated difficulty of assessing the contribution of specific mechanisms that are necessary, but not sufficient for integration. Future studies must clearly define intervention components, identify enabling contextual factors, and adopt consistent evaluation frameworks. Strengthening this evidence base is critical for guiding policymakers and practitioners in scaling integrated models that are not only cost-effective but also tailored to the diverse and complex needs of this vulnerable population.

Introduction

This literature review summarizes what is known about models of integrated care serving people who are dually eligible for Medicare and Medicaid, both the population aged 65 years and older (referred to here as "older dual eligibles") and the population aged 21-64 years (referred to here as "younger dual eligibles"). It has long been recognized that dual eligibles are a highly vulnerable and costly population ill-served by our fragmented healthcare system (Grabowski, 2009; Kirst et al., 2017). Integrated care models have been developed to address this issue, predominately focusing on the older dual eligible population.

This literature review summarizes what is known about models of integrated care serving people who are dually eligible for Medicare and Medicaid, both the population aged 65 years and older (referred to here as "older dual eligibles") and the population aged 21-64 years (referred to here as "younger dual eligibles").

The rationale behind integrated care is that assigning responsibility for individual members to a single entity provides that entity with the opportunity and incentive to manage member care efficiently, resulting in better member outcomes. A significant body of research has sought to determine the truth of this rationale by examining outcomes associated with integrated care models. However, the proliferation of integrated care models, which include a range of components implemented in different ways in varying environments, means that it has been difficult to identify specific mechanisms (or combination thereof) that produce desired outcomes. Moreover, the research typically provides only broad information about model components, focusing instead on assessing outcomes. Indeed, a recent review of the literature on integrated care found that studies rarely included conceptual frameworks or tested specific causal hypotheses, making it difficult to assess the effectiveness of specific plan elements (Barrie Smith et al., 2021).

Despite this lack of clarity, integrated care models continue to be popular – although forthcoming reductions in federal Medicaid spending may slow or reverse the trend toward greater integrated care. Enrollment of dual eligible beneficiaries in integrated care plans grew from 2% in 2013 to 9.4% in 2022 (Velasquez et al., 2023). In 2025, only 12 states did not offer some form of integrated care plan: 34 offered PACE (Program of All-Inclusive Care for the Elderly), while 23 offered other integrated care options, enrolling about 1.5 of the 9.3 million people dually eligible for full Medicare and Medicaid benefits (Integrated Care Resource Center, 2025; Lyons & Andrews, 2025). It is important to note, however, that not all plans serving dual eligibles are fully integrated Medicare and Medicaid programs. Furthermore, PACE programs restrict enrollment to dual eligibles 55 years and older, limiting their ability to serve younger dual eligibles and comparability to other integrated care programs. Recommendations that states be required to develop strategies for integrating Medicaid and Medicare coverage for dually eligible beneficiaries are resisted by those highlighting feasibility challenges – most importantly, a lack of resources at the state level (Hwang & Keohane, 2022; Levy & Allard, 2024).

What We Know About Dual Eligibles

People dually eligible for Medicare and Medicaid comprise a vulnerable and expensive population. In 2021, they numbered 12.8 million (Lyons & Andrews, 2025). Although most dual eligibles (64%) are aged 65 years or older, 36% are 18-65 years (MedPAC and MACPAC, 2024). While there are different categories of dual eligibility, this paper focuses on the 73% of dual eligibles (9.3 million) who are eligible for full Medicaid benefits (MedPAC and MACPAC, 2024). The remaining dual eligibles (3.5 million) are eligible for Medicaid payment of Medicare cost-sharing requirements only.

This dually eligible population experiences high rates of chronic illness: 27% of individuals dually eligible for Medicare and Medicaid have six or more chronic conditions, compared to 15% of beneficiaries with Medicare-only coverage (CMS, 2023). Additionally, 11% of dually eligible individuals report that they have "poor" health status, compared to 4% of other Medicare beneficiaries (MedPAC and MACPAC, 2024). Dual-eligibles are also poor: 87% have annual incomes below $20,000 and 45% have annual incomes less than $10,000. They also tend to be more diverse compared to other Medicare beneficiaries: 51% of dual eligibles identify as Black, Hispanic, or belonging to a racial/ethnic group other than White (compared to 19% of those accessing Medicare alone) (Peña et al., 2023).

High needs make the dual eligible population expensive for the healthcare system. Although dual eligible beneficiaries make up only around 14% of the Medicaid population, they account for 32% of Medicaid spending (Peña et al., 2023). Similarly, dual eligibles comprise 17% of Medicare enrollees but account for 33% of Medicare spending. Many of these high costs reflect the expense of institutional long-term services and supports (LTSS), since dual eligible beneficiaries are more likely to use institutional LTSS and represent a greater share of total Medicaid spending on institutional LTSS compared to non-dually eligible individuals (Ballweg, 2024).

Dual-eligibles also have significant health-related social needs (HRSNs)[1], which are associated with higher costs to the healthcare system (Whitman et al., 2022). Key examples include financial strain, food insecurity, unreliable transportation, loneliness or social isolation, and housing insecurity. HRSNs among dual eligibles are high, for example, food insecurity prevalence considerably higher among dual eligible beneficiaries (45%) compared to Medicare only beneficiaries (11%) (ATI & Arnold Ventures, 2022). Similarly, dually eligible beneficiaries report high levels of transportation need for getting to medical appointments; 41% of full benefit dual eligibles reported that they needed to be driven to appointments as compared to 14% of Medicare-only beneficiaries (ATI & Arnold Ventures, 2022). Overall, beneficiaries with more HRSNs have more hospitalizations, physician visits, and emergency department visits (Peikes et al., 2023).

[1] The literature distinguishes between HRSNs, which refer to the social and economic needs individuals experience that affect their health and well-being, and SDOH, which refer to broad social conditions that affect population health. However, these terms are often used interchangeably.

Younger vs Older Dual Eligibles

Research distinguishes between the group of people 65 years and older who qualify for Medicare on the basis of age (90%) and those under 65 years who qualify on the basis of disability (10%) (CMS, 2025). This distinction is made, in part, because dually eligible beneficiaries in these two groups are often enrolled in different public programs and served by different provider groups, including managed care organizations (MCOs) (MedPAC and MACPAC, 2024). Chronic conditions are common but often vary in prevalence between younger and older dual eligibles. For example, older dual eligibles have higher rates of cognitive impairment (20% vs. 4% for younger duals), diabetes (33% vs. 23%), heart failure (19% vs. 8%), hypertension (63% vs. 38%), and ischemic heart disease (28% vs. 12%) (MedPAC and MACPAC, 2024). In contrast, younger dual eligibles have higher rates of severe and persistent mental illness (SPMI) or serious mental illness (SMI)[2] (Kuramoto-Crawford & Zodet, 2014), as well as higher rates of anxiety disorders (34% vs. 22%) and depression (32% vs. 25%) (MedPAC and MACPAC, 2024).

Differences in the prevalence of conditions matter because they imply different priorities for program design for each population. Moreover, such differences have cost implications: patients with SPMI or SMI are expensive: one study found a three-fold increase in spending among Medicare beneficiaries with SMI compared to those without (Figueroa et al., 2020). Similarly, Frank & Epstein (2014) found that younger dual eligibles with SPMI were nearly twice (1.86 times) as expensive as other younger dual eligibles. People with SPMI also tend to have other healthcare issues -- such as functional limitations, multiple chronic conditions, and substance use disorders -- that are associated with high levels of Medicare spending (Frank & Epstein, 2014). Although substance abuse disorder rates are high among all dual eligibles (Legal Action Center, 2024; Parish et al., 2022), they are much higher for younger compared to older duals (48% vs. 14%) (Parish et al., 2023). Another expensive subpopulation are people with intellectual disabilities and related conditions, who comprise 11% of the younger dually eligible population but only 2% of the older dual population (MedPAC and MACPAC, 2023) One study found that persistently high costs were 17 times more likely among dual eligibles with intellectual disabilities and related conditions than other dual eligibles (Zhao et al., 2018).

Dual eligibles of all ages have more complex and costly health conditions compared to Medicare-only beneficiaries. However, the needs of dual eligibles are not currently being met by the healthcare system. Integrated care has often been seen as a solution to better serve this population.

[2] Both SMI and SPMI relate to significant mental health conditions but are not interchangeable. SMI is a broader term, encompassing a wider range of disorders that cause substantial functional impairment, including depression and anxiety. SPMI, on the other hand, specifically refers to those SMI conditions that are both severe and chronic, such as schizophrenia, bipolar disorder, or major depressive disorder, which significantly impact a person's ability to function in multiple life areas.

The Diversity of Integrated Care

Integrated care plans are meant to address the fragmented healthcare system and the difficulty people have in navigating it. These issues are particularly pressing for the population that is dually eligible for Medicare and Medicaid, who are, by definition, poor, vulnerable, and likely to have complex medical conditions (MedPAC and MACPAC, 2024; Parish et al., 2023; Peña et al., 2023). Policymakers, concerned about the high costs of the dually eligible population, seek to ensure the most efficient use of resources. Integrated care aims to achieve this, in part, by addressing conflicting incentives created by having two funding sources (Government Accountability Office, 2014; Grabowski, 2007) – that is, the lack of incentives for spending in one program that might decrease costs in the other program. At the provider level, integrated care aims to incentivize providers to engage in behaviors that benefit members and minimize costs.

The primary aim of integrated care is to reduce fragmentation and improve continuity and coordination of care consistent with the goal of better serving dual eligibles at lower costs (Ouwens, 2005). The implementation of integrated care, however, is varied. As one paper described, "Integrated care is best understood as an emergent set of practices intrinsically shaped by contextual factors, and not as a single intervention to achieve predetermined outcomes" (Hughes et al., 2020) – a theme echoed throughout the literature. Reasons for such variation are many: for example, the types, quality, and quantity of providers vary by location. One important factor, however, is government regulation. The federal government has created a range of options for states that enable them to establish differing models of integration. The state's adoption of these options will determine the range of benefits for which an integrated care plan can be responsible for and the extent of financial responsibility it bears, as well as a range of other requirements (Kolber et al., 2022; Lakhmani, 2022; Roberts & Mellor, 2022). Some integration models focus on a specific set of services, such as LTSS. (Burwell & Saucier, 2013 or even nursing home care (Verdier, 2010).

This paper discusses the literature on integration for dual eligibles, focusing on models that cover all Medicare and Medicaid services. These options include Dual Eligible Special Needs Plans (or D-SNPs), PACE – which are limited to those aged 55 and older needing nursing home-level care, and arrangements such as Medicare-Medicaid Plans tested under the Centers for Medicare & Medicaid Services FAI[3] (Bella et al., 2024). In general, these models fall along a continuum of integrated care, with a higher level of integration expected to result in greater coordination of services and less fragmentation across Medicare and Medicaid; the highest level of integration involves a single entity (typically, a managed care plan) that receives a single payment to care for their dually eligible members. In addition to the differing levels of responsibility specific to each model, there are differences in required program elements as well. For example, all D-SNP plans are required to coordinate care and to have enrollee advisory committees focused on underserved populations (Kolber et al., 2022).

[3] The Financial Alignment Initiative (FAI) was a major effort to assess the benefits of integrated care sponsored by the Centers for Medicare & Medicaid Services (CMS), implemented from 2011 to 2025. It tested a variety of models of integrated care across 10 states (Kruse & Soper, 2020).

In addition to the structural differences among integrated care plans, plans vary in the mechanisms they use to execute their responsibilities. For example, plans differ in their information systems, which impact the level of communication amongst providers and plan staff. Provider networks also vary, in some cases incorporating community-based providers while in other cases focusing on large healthcare systems. Organizational capacity (i.e., an organization's ability to use resources effectively and efficiently) in order to achieve plan goals is another point of variation, a topic rarely addressed in the literature (Feldman, 2014; Hong et al., 2014). And yet, variation in plan structure and approach are rarely captured in the research except descriptively, often in case studies. The typical lack of specificity about how integration is operationalized in managed care plans has led to its characterization as a "black box" – the idea that there is little concrete information about what managed care plans actually do to integrate care (Brach et al., 2000; Gresenz et al., 2004). Moreover, there is little evidence about the importance of such variation. Thus, while this review discusses holistic assessments of different integrated care models, it also discusses evidence on specific integrated care components, focusing on mechanisms that have been hypothesized to produce desired outcomes.

Conceptual Models

As noted, "integrated care" is a broad term. One approach is to think about it in terms of its aim to better align health and social care, with the goal of producing better outcomes, experiences, and use of resources. Another approach is to focus on the methods used to efficiently organize, fund, and deliver health and related services (Hughes et al., 2020). A substantial literature aims to identify the key attributes of integrated care models, organizing models and their components in line with theoretical approaches as well as the mechanisms they use to facilitate integration.

Leutz (1999) defines integrated care as a broad systems approach that aims to align the healthcare system (acute, primary, medical, skilled) with other human service systems (e.g. long-term care, educational and vocational services, housing). Nearly all conceptualizations see integration as a continuum, based on the level of organizational change required. Accordingly, Leutz (1999) describes, at the one extreme, *linkage*, which involves healthcare professionals working together on an ad hoc basis, to the middle ground of *coordination*, which involves structures devoted to facilitating communication, information-sharing, and collaboration, to *full integration*, where responsibilities, resources, and financing are consolidated in a single organization or system. Integration of financing was seen as critical, based on the theory that it would incentivize efficiency, resulting in lower costs and better patient outcomes.

The scope of an integration effort matters too. Some research addresses the integration of a limited set of services, health conditions, or providers. For example, managed long-term services and supports (MLTSS) aim to ensure the delivery of appropriate Medicaid LTSS services and to better coordinate them with other health services (National Health Policy Forum, 2012a). On the other hand, discussions of behavioral health integration predominantly

focus integrating behavioral health expertise into primary care practices, rather than systems of care more broadly (Doherty et al., 1996; Ramanuj et al., 2019; Waters et al., 2018).

Integration efforts may also focus on specific patient populations, often those with particularly costly or complex conditions that require ongoing management. This focused attention on high-needs individuals aligns with Leutz's (1999) observation that "You can integrate all of the services for some of the people, some of the services for all of the people, but you can't integrate all of the services for all of the people." At one end of the spectrum, these programs can include relatively limited efforts such as disease management programs, which target individuals with specific conditions (often, diabetes) and provide them with intensive care coordination and access to a range of providers and resources to help them manage their condition (Georgetown University Health Policy Institute, n.d.). More comprehensive, but clinically focused, is the Chronic Care Model, which supports productive interactions between informed, activated patients and a practice team of clinicians and healthcare professionals; the model also incorporates community partnerships (Barr et al., 2003; Wagner et al., 2001). Integrated care efforts with the broadest scope are the focus of this review; these serve the complex dually eligible population, aiming to coordinate the full range of Medicare and Medicaid services by employing a wide range of techniques.

Other conceptualizations focus on different facets of integration. Singer et al. (2020) identifies five: *structural integration*, which concerns physical, operational, financial, or legal ties amongst health system components; *functional integration*, which refers to formal policies that govern coordination and decision-making across an organization; *normative integration*, which refers to a shared organizational culture supportive of integration; *interpersonal integration*, which prioritizes collaboration across the individuals involved in patient care; and *process integration*, which refers to specific processes that support coordination of care, such as shared care plans.

Bronfenbenner's (1979) socio-ecological model is used as the basis of another framework for identifying different levels of integration – macro, meso, and miro (Valentijn et al., 2013). Macro level integration refers to the systems infrastructure necessary to combine processes, structures, and techniques, both horizontally (across domains) and vertically (across levels of specialization and management). Meso level integration refers to integration across organizations, such as health providers and social care organizations (often addressing SDOH, such as housing, food, and transportation). Relationships among organizations can be defined by the rules of the market, dictated by inter-organizational agreements, or exist within a unified organization. The meso level also includes partnerships between professionals similarly executed through market rules (subcontracting arrangements, for example), interprofessional agreements (role clarification), or consolidation into single institutional infrastructure (via inter- or intra-professional teams). Micro level integration takes place at the clinician level, and involves the comprehensive, coordinated delivery of patient-centered care. A review (Peterson et al., 2019) of care coordination theoretical frameworks sees consistency throughout the literature in studies' use of three levels of analysis: the care team level, the organizational level, and the regulatory and market level, consistent with the socio-ecological model. Others have pointed out, too, that each integration effort is embedded in a specific context (sometimes included as another component of socio-ecological models); more recent

literature has highlighted the need to adapt to the specific constraints, environments, and challenges posed by different integration efforts (Hughes et al., 2020; Rohwer et al., 2023).

A major conceptual question is – integration for whom, providers, payers, or patients? Hughes et al. (2020) distinguishes between objective and subjective experiences of integration, and stresses that these are not always in alignment, nor are the goals of integration necessarily shared by different players. Some conceptual models of integrated care prioritize patient perspectives or experiences, such as the World Health Organization's Framework on integrated people-centered health services, which stresses "engaging and empowering people and communities" (World Health Organization, 2016), while others focus on the clinician experience or take a systems approach.

In some cases, theoretical differences among these models may be minimal. However, they may result in real differences in terms of resource allocation: what data are collected and what outcomes are measured? What tools and resources are invested in? For example, emphasizing the patient experience can result in value-based payment systems that require the collection of data that speak to that experience, as well as reward systems that improve those experiences (The Commonwealth Fund, 2023).

Evidence on Integrated Care

A substantial body of literature reaching back many years has used quantitative and qualitative methods to assess the effectiveness of integrated care models providing the full range of Medicare and Medicaid services to dually eligible individuals. Even within this category, the proliferation of differing models – set in differing contexts across the United States (U.S.) – has made it difficult to evaluate effectiveness, identify key causal mechanisms, and generalize findings. Moreover, this research has been critiqued for design flaws and limited by data availability (Barrie Smith et al., 2021; Roberts et al., 2024). Overall, findings are mixed but appear to be consistent regarding the positive impact of integrated care in reducing long-term nursing home stays and on member experience. Disappointingly, there is little evidence of cost savings (Lakhmani, 2024). And while much has been written in the grey literature regarding best practices for integrated plans, the evidence behind the importance of specific model components and organizational factors is thin.

Typical of this literature is a review that found that it is difficult to conclude that integrated care "works" (Barrie Smith et al., 2021), although it found consistent evidence for reductions in hospitalizations, despite mixed findings relating to other outcomes. Its findings align broadly with another review of integrated care initiatives by Roberts et al. (2024), which found limited and inconclusive evidence of impact, though sufficient evidence to support reductions in nursing home stays (Roberts et al., 2024). Another summary, specific to the FAI, found that 5 out of the 7 states for which there were data showed reductions in long-stay nursing facility use; all four of the states with data showed an increase in outpatient utilization, and results were similarly disappointing regarding emergency department visits (Lipson & Chelminsky, 2024). Meanwhile, results were mixed for inpatient admissions and re-admissions. In short, extant research fails to show strong support for effectiveness relating to key utilization

outcomes. The disappointing results of the FAI evaluations appear to disprove (albeit with study-specific exceptions) the causal theory that providing a single entity with financial responsibility for the full range of Medicare and Medicaid services, along with flexibility in providing those services, will provide both incentives and opportunities for health system savings and better care for members.

The evidence for positive impacts on member satisfaction appears stronger, although mixed with respect to specific dimensions of satisfaction. The FAI evaluations found that members report general satisfaction with their plans: in all states, scores for the Medicare-mandated survey of member satisfaction (the Consumer Assessment of Health Plans Survey, or CAHPS) increased over time (Lakhmani, 2024). Consistent with these findings, studies comparing integrated plans with regular Medicare Advantage plans found higher satisfaction among integrated plan members, although some findings were inconsistent (MedPAC and MACPAC, 2023; Meyers et al., 2023). One systematic review found the evidence not strong enough to conclude that integration leads to higher member satisfaction, in part because it was not evaluated consistently across sites (Roberts et al., 2024). Many studies addressing member satisfaction commented on the inability to explore satisfaction among important sub-groups, such as non-English speakers or people with behavioral challenges.

Some findings regarding specific dimensions of satisfaction appear to be consistent across the board. For example, the care coordinator relationship was found to be consistently important to member satisfaction with positive satisfaction being associated with stability and reliability in the coordinator relationship over time. Another factor important to member satisfaction across studies was access to supplemental benefits. Members who had difficulty accessing services – including durable medical equipment or help with HRSNs – were less satisfied (Lakhmani, 2024).

All reviews of research on integrated care identify significant weaknesses. As mentioned previously, the interventions studied vary considerably (as do the contexts in which they are implemented), making it difficult to generalize across models, aggregate findings, or identify effective practices. Moreover, the published research is critiqued for its poor descriptions of the intervention (Rohwer et al., 2023), prompting calls for frameworks that enable structured comparisons (Heath et al., 2013; Lakhmani, 2024). Even where model elements are transparent, there can be issues around implementation and model fidelity. Other critiques include studies' lack of conceptual models or their failure to test specific hypotheses (Barrie Smith et al., 2021). Perhaps the biggest issue, however, is selection. There is evidence that voluntary enrollment has meant that enrollees were more likely to be Black and Hispanic versus White, and were less likely to be rural, younger, or disabled, compared to individuals enrolled in non-integrated plans (Velasquez et al., 2023). Even when enrollment is involuntary (aka "passive", as in the FAI plans), drop-out rates were high for some plans but not for others and varied within plans as well, with the highest disenrollment rates found among Black beneficiaries (Meyers et al., 2025). An associated issue is the difficulty of identifying appropriate comparison groups with which to compare the relative performance of integrated care plans (Roberts et al., 2024). These serious concerns limit the ability to draw strong conclusions from studies to date.

Causal Theory – Key Mechanisms

To advance conversations about integrated care, scholars have developed theories that detail the components of integrated care models that appear to be important for improving member outcomes – that is, they articulate hypotheses about the causal role of specific program elements which, in turn, provides a basis for more rigorously comparing models. As noted, there is limited evidence on the factors that create successful integrated models. Thus, the broad consensus on key features of successful models found in the literature typically reflects expert opinion rather than hard evidence (Feldman, 2014). Much of the literature on model components is descriptive or derives from single-model studies that lack strong control groups (with the exception of care coordination, where the literature is vast). Evidence also derives from interventions that do not fully integrate care, given that the effectiveness of specific components may be more easily identified when studied in isolation, rather than as a part of a broader intervention (which ironically often leads to conclusions that a single component is insufficient for achieving desired outcomes). Overall, rigorous research on the efficacy of model characteristics is generally lacking, particularly in the context of the broader model within which they are situated in practice.

While discussions of integrated care models often articulate different ways of thinking about integration, they also frequently identify specific mechanisms critical to care integration, which may or may not be linked to a conceptual model. For example, many identify information technology, often electronic health records, as critical. This may be described as essential to communication (among care teams, between care teams and providers, or among providers) but not embedded in a larger view. While the list of elements is extensive, here we focus on those components highlighted in reviews of models serving dual eligible or similarly complex populations (Archibald & Kruse, 2015; Feldman, 2014; Hughes et al., 2020; Kirst et al., 2017; Lind & Gore, 2010; Rohwer et al., 2023; World Health Organization, 2016). Such focused interventions respond to the frequently mentioned need to target integration efforts to high-needs (Baxter et al., 2018; Brown et al., 2012; Hong et al., 2014; Lind & Gore, 2010; McCarthy et al., 2015). The components discussed here are care coordination, interdisciplinary care teams, SDOH and HSRNs, and behavioral health.

Care Coordination

Care coordination is at the heart of efforts to integrate care. In all conceptual models of integrated care, it is a core component. By definition, care coordination requires input from and communication among multiple providers from a variety of clinical disciplines and social services (Peterson et al., 2019). It is frequently targeted at high-needs populations that require a range of services to maintain their health. Indeed, studies find care coordination most effective for those with the most intense needs (Dorr et al., 2008; Hudon et al., 2019; Peikes et al., 2009).

Care coordination has many definitions: Albertson et al. (2022) describe it as "the intentional organization of patient care across multiple participants, accompanied by the sharing of relevant information, to improve the safety and effectiveness of services." This definition includes many of the elements incorporated into other definitions: the notion that care

coordination is intentional and systematic; that it involves multiple providers, often from a range of disciplines (and sometimes family and friends); that information-sharing is critical, and depends on a supportive infrastructure as well as trust among providers; and that participants have a shared goal of patient-centered, effective service delivery (Albertson et al., 2022; Doornebosch et al., 2022; Hudon et al., 2019; Schultz & McDonald, 2014). The scope of the services coordinated can vary. In addition to coordinating medical services, many care coordination models facilitate access to social services (Albertson et al., 2022).

Typically, a single point person (variously called a care coordinator, care manager, or case manager) is responsible for care coordination. The care coordinator works with the patient and providers to develop and implement a care plan that aligns with the patient's goals and values. Key components of care coordination include systematic in-person assessments and care planning (Albertson et al., 2022), ideally involving patient input. Such involvement is often referred to as person-centered care or – a related construct – patient engagement; both have been identified as important in integrated care (Berntsen et al., 2019; Feldman, 2014; Kirst et al., 2017; McCarthy et al., 2015; O'Brien et al., 2018; Rohwer et al., 2023). The hypothesis that patient engagement results in increased self-care, more appropriate services, and increased adherence – which in turn results in better health outcomes – has been supported by research (Marzban et al., 2022).

Other factors that increase the effectiveness of care coordination include interpersonal elements. For example, many studies note the importance of relationship quality – the level of trust and/or openness in the relationship between the care coordinator and the patient, or among providers (Hong et al., 2014; Peikes et al., 2009; Rizzo et al., 2016; Van Houdt et al., 2013). Some accounts more specifically note the importance of continuity of care among care coordinators (Albertson et al., 2022; Sheff et al., 2017) or the negative effect of care coordinator turnover (Lakhmani, 2024). A further component of care coordination, noted as important for high-needs individuals, is the use of care coordinators with specialist expertise (McCarthy et al., 2015).

Overall, there is considerable evidence that care coordination improves the effectiveness, safety, and efficiency of healthcare delivery (Berkowitz et al., 2018; Boult et al., 2009; Duru et al., 2020; Peikes et al., 2009; Thorpe, 2011; Tricco et al., 2014; Xing et al., 2015). Broad acceptance of its effectiveness is reflected in its adoption in a wide range of healthcare contexts. Observers note, however, that care coordination may be a necessary but not sufficient condition for achieving positive outcomes for particularly complex, high-needs individuals. Indeed, this has been the conclusion of several rigorous evaluations. As long ago as the 1980s, disappointing results from an early care coordination effort, known as "Channeling", established the need to consider interactions between different systems of care, including long-term care systems and social services (McDonald et al., 2007). More recently, evaluations of the Camden Coalition Care Management Program found a null impact of care coordination on hospitalization rates, resulting in hypotheses that further supports, such as those targeting SDOH, were needed to appropriately support high-needs individuals (Finkelstein et al., 2023; Vrijhoef, 2020). Similarly, a recent investigation of coordination-only D-SNPs in one state concluded that higher levels of integration were needed to reduce or delay nursing home admissions (Coulibaly et al., 2025).

Interdisciplinary Care Teams

A key element of integrated care programs is the interdisciplinary care team, which typically involves a range of disciplines working together to support members, comprising an enrollee, providers (e.g., primary care physician, specialists, behavioral health provider), and other professionals. Care teams may also include roles supporting members' social needs, such as social workers or supportive family members. The primary aim of interdisciplinary care teams is to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a collaborative approach to address clinical, social and behavioral needs (Philip & Soper, 2016). Such teams have become standard practice in supporting individuals with complex needs, endorsed by bodies such as the World Health Organization (2016).

Overall, the literature supports the effectiveness of interdisciplinary care teams, although familiar weaknesses in the research are identified: the interventions studied involve a range of designs implemented in multiple ways in varied contexts (Nazir et al., 2013; Schofield & Amodeo, 1999). Based on reviews of the literature, there is agreement that interdisciplinary care teams improve the quality of care (Resnick, 2013), although the focus of these reviews varies. For example, Nazir et al (2013) reviewed studies investigating the impact of interdisciplinary care teams in nursing homes, concluding that it has a positive impact on a range of resident outcomes. In a different context, Feagin et al. (2024) found that an interdisciplinary care team intervention, which focused on Medicare Advantage plan members identified as at high-risk for hospitalization, resulted in reductions in cost and in inpatient admissions (Feagin et al., 2024). Teamwork in a range of healthcare settings has been found to positively affect performance (Schmutz et al., 2019).

Homing in on specifics, the literature identifies components of interdisciplinary care teams that appear to promote effectiveness. Commonly identified themes are reflected in studies of interprofessional collaboration, an associated construct more specific to the medical field (Doornebosch et al., 2022; Fewster-Thuente & Velsor-Friedrich, 2008). Elements appearing repeatedly include interpersonal trust and open communication, information technology tools that facilitate communication; collaborative development of care plans; ongoing assessment; regular communication among team members; shared norms and goals; and many others (Nazir et al., 2013; Philip & Soper, 2016; Xyrichis & Lowton, 2008). These elements overlap with many of the other mechanisms used to integrate care, particularly with respect to information technology, which plays many roles in supporting integration (Archibald & Kruse, 2015; Feldman, 2014; Hong et al., 2014; Kirst et al., 2017; Lind & Gore, 2010; McCarthy et al., 2015; Tian et al., 2022; Tricco et al., 2014).

Social Determinants of Health and Health-Related Social Needs

While clinical care is at the heart of healthcare, it is recognized that many factors affect individual health. Indeed, it is estimated that clinical care affects only 20% of county-level variation in health outcomes, while SDOH affect as much as 50% (Hood et al., 2016). Defined as the non-medical conditions in which people are born, grow, work, live, and age, SDOH include factors such as housing, food/nutrition, and transportation (World Health Organization, n.d.). A related concept, HRSNs, reflects an individual's needs for SDOH

(Whitman et al., 2022). Recognizing the importance of SDOH, some integrated care programs incorporate SDOH elements to address them (Chepaitis et al., 2020).

Dual eligible individuals have high levels of HRSNs, because access to SDOH is associated with many of the same factors that predict dual eligibility, such as race/ethnicity, income, rurality, and disability level (ASPE, 2016). These factors greatly impact social inequities and health outcomes, which in turn impact healthcare utilization and overall spending (Whitman et al., 2022). Individuals with high HRSNs are likely to have high healthcare utilization; addressing social needs can lead to favorable outcomes (Peikes et al., 2023). A wide body of evidence shows that connections to social support services, including supportive housing, transportation, nutrition, and caregiver respite, are associated with reduced healthcare utilization (e.g., emergency department visits, hospitalizations), reduced Medicare spending, and better health outcomes for high-needs individuals (Berkowitz et al., 2018; Shier et al., 2013; Whitman et al., 2022). Providing such supports may be especially important for dually eligible individuals because, compared to Medicare-only beneficiaries, they experience higher rates of food insecurity and issues with access to transportation (ATI Advisory, 2024). However, while much has been written about the rationale for addressing SDOH and HRSNs for high-needs individuals, there have been mixed findings regarding their effectiveness in healthcare settings (Kirst et al., 2017; Noor et al., 2023; Silva-Tinoco et al., 2020; Whitman et al., 2022), although one review found that most (82%) of the studies reviewed reported some positive impacts on either health outcomes, healthcare costs, or both (Taylor et al., 2016). A recent government report found that, overall, the evidence was strong regarding interventions in healthcare but less so in other domains (ASPE, 2021), calling for additional research to identify interventions that have long-term impacts on population health.

A central approach to mitigating the SDOH is the use of social workers and community health workers (CHWs) to help members access relevant resources, due to their expertise in SDOH and the complexities of patient populations (Berkowitz et al., 2018; Petruzzi et al., 2024). Social workers and CHWs can be included in interdisciplinary care teams or made available through referrals, with the former potentially indicating higher levels of integration. The literature distinguishes between contracted and in-house CHWs in managed care organizations where, for example, in-house CHWs were found to focus more on high-risk members, while contracted CHWs tended to be from community-based organizations, thus providing stronger community connections (Wennerstrom et al., 2022). CHWs typically come from the communities being served, which helps ensure trust and mutual respect between healthcare workers and their patients (in part, due to their ability to provide culturally competent support), thus bettering patient health outcomes (Gronowski et al., 2022).
The role of CHWs is increasingly being incorporated into models addressing the SDOH and serving as the subject of investigation (Duminy et al., 2022; Gronowski et al., 2022; Petruzzi et al., 2024). A review of their use in Medicaid managed care programs found them to play roles as diverse as conducting outreach, case management, individual and community advocacy, providing direct services, and conducting community assessments, among others (Wennerstrom et al., 2022). Several systematic reviews have found use of CHWs (deployed for a range of purposes) to be associated with some positive health outcomes as well as cost savings (Duminy et al., 2022; Gibbons & Tyus, 2007; Jack et al., 2017; Kim et al., 2016), although all stress that more research is needed, given variations in findings and models.

Gibbons & Tyus (2007) stress that CHWs alone do not make a chronic care management intervention successful, underlining the need for multifactorial approaches. However, we were unable to find research speaking specifically to the effectiveness of CHWs in integrated care for dual eligibles, although their broad adoption in Medicaid managed care contexts indicates confidence in this mechanism for addressing SDOH (Lipson, 2017).

Behavioral Health Integration

The integration of behavioral health has been gaining increasing attention. Such integration is particularly important for younger dually eligible individuals, who have high rates of mental illness and substance abuse disorders. Traditionally, behavioral and physical health services have been delivered separately, with minimal coordination. Often, behavioral health is delivered through a separate managed care plan, referred to as a "carve-out." This bifurcation leads to uncoordinated care, service gaps, duplicative or misaligned treatments, and even safety risks such as medication interactions when medical care and information are not aligned (Chelminsky et al., 2024; Frank, 2021).

Growing recognition of the importance of behavioral health integration has led the American Medical Association (AMA) to issue statements emphasizing the critical role of behavioral health in person-centered care (AMA, 2024). In response, policymakers are creating mechanisms that support such integration, particularly through regulatory changes to the Medicaid program. One such mechanism is the patient-centered medical home —a clinic-based model led by primary care providers—which promote team-based care and greater coordination between medical and behavioral health services (Hamblin et al., 2011; Jackson et al., 2013; Murphy et al., 2018). Patient-centered medical homes and similar enhanced primary care models have been associated with improved access to care, reduced emergency room services, increased preventive screening, and improved cardiometabolic outcomes (Archer et al., 2012; Gertner et al., 2023; Grove et al., 2021; Jackson et al., 2013; Murphy et al., 2018). However, the clinic-centric design and limited behavioral health infrastructure of medical homes often fall short in addressing the complex physical, behavioral, and social needs of high-needs populations, such as dually eligible individuals with behavioral challenges (Alakeson et al., 2010; Bao et al., 2013; Murphy et al., 2018).

To address these limitations, states have adopted complementary models like behavioral health homes, which embed primary care within specialty behavioral health settings (Murphy et al., 2018). Behavioral health homes are typically community based and aim to coordinate physical, behavioral, and social services (CMS, 2024). Evidence suggests these models can improve a variety of outcomes, including care transitions, preventive and primary care utilization, and patient and provider experience (Kennedy-Hendricks et al., 2021; Murphy et al., 2018; Progovac et al., 2021). However, the overall findings are mixed. Notably, behavioral health homes have not consistently reduced hospital readmissions, and improvements in health indicators such as LDL cholesterol have been limited (Johnson et al., 2022; Kennedy-Hendricks et al., 2021). Moreover, implementation challenges—such as low patient engagement in wellness initiatives, limited uptake of population health strategies, and insufficient capacity and infrastructure to support their execution—have raised concerns about the feasibility and sustainability of the behavioral health home model (McGinty et al., 2018; Murphy et al., 2018; Progovac et al., 2021).

Despite the development of the models discussed above (and others), the integrated care literature tends to skirt discussions of behavioral health, although there is a considerable body of work that focuses on integrating behavioral health into primary care practices (as in the patient-centered medical homes discussed previously). While the goal of behavioral integration is sometimes mentioned as desirable (National Health Policy Forum, 2012b), there appear to be few focused efforts to do this within models supporting the dual eligible population. To some extent, this is likely due to practical issues, such the currently limited supply of behavioral health providers (Cheung et al., 2019; Office of the Inspector General, 2024).

Conclusion

It is apparent that there is widespread support for integrating care for dually eligible beneficiaries, although what "integration" means varies considerably, both in theory and in practice. Accordingly, there have been multiple attempts to characterize core elements of integration. Similarly, researchers have attempted to identify the evidence behind various elements of integrated models. These include those discussed above as well as a host of others, such as transitions management, organizational culture and norms, provider engagement, quality management techniques, data utilization, and more (Hewner et al., 2021; Kirst et al., 2017; Leijten et al., 2018; Valentijn et al., 2015). The FAI evaluation results, however, seem to have put to bed the notion that integrated financing will necessarily incentivize positive outcomes, at least within the context of Medicare and Medicaid.

Immersion in the integrated care literature makes it clear that while research tends to find that various mechanisms "are necessary but insufficient" (Vrijhoef, 2020), the success of more multidimensional efforts is difficult to evaluate, given variations in context, model, and implementation. Thus, proponents of integrated care can argue that a lack of positive results likely stems from the difficulty of designing studies capable of producing conclusive findings. They can also point to a broad consensus on the need for care coordination (for which evidence is strong), interdisciplinary care teams, and several other mechanisms that are broadly replicated across integrated care models. Although there is also broad consensus about the need to address the SDOH, there is a need for stronger evidence that bettering access to these supports will result in system savings and positive health outcomes for high-risk individuals – specifically, dual-eligibles. Similarly, although there is growing recognition of the need to reduce barriers between physical and behavioral health, it is not clear that evidence about the value of integrating the two will be forthcoming, given how rarely it has been implemented within a fully integrated context and the poor prospects for experimentation and research in the current political climate.

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WASHINGTON, DC OFFICE
2519 Connecticut Avenue NW
Washington, DC 20008
202-508-1208
LTSScenter@leadingage.org

BOSTON OFFICE
Wheatley Hall, 3rd Floor, Room 124A
University of Massachusetts Boston
100 Morrissey Blvd.
Boston, MA 02125
617-287-7306
LTSScenter@umb.edu

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