Findings from the One Care Member Experience Survey (2014)

The One Care Early Indicators Project

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Executive Summary

The *One Care Early Indicators Project* (EIP) was organized with the goal of assessing some of the early perceptions and experiences of MassHealth members who are eligible for One Care, with a focus on collecting actionable information available in the early stages of the implementation of One Care. The EIP Workgroup, a multi-stakeholder committee including representatives from the One Care Implementation Council, MassHealth, and the University of Massachusetts Medical School (UMMS) undertook the work of this project. This report presents findings from a survey of members enrolled in One Care – the ***One Care 2014 Member Experience Survey*** – conducted June 2014 through January 2015, and designed to capture members' perceptions and experiences during the first months they were served in a One Care plan. A total of 1,933 members or 32% of those sampled, responded to the survey.

The One Care 2014 Member Experience Survey (OC-MES) included 38 core questions covering the following eight major domains:

- Enrolling into One Care
- Your Care Team
- Assessment and Care Planning Process
    - Assessing needs for Medical Services and Long-Term Services and Supports
- Your Individual Care Plan
- Your Care – Services You Need and Receive
    - Medical Services and Long-Term Services and Supports
- Moving Into One Care
- Overall Perceptions of One Care
- Member Demographic and Disability Information

Key Findings. Respondents generally found the information they received from MassHealth about One Care easy to understand and enrolling into One Care to be straightforward. Overall, members were quite satisfied with One Care, and with the services they are receiving, and few members reported that they expected to leave the program. Most members had met and were quite satisfied with their Primary Care Providers (PCPs). While fewer respondents had met with their Care Coordinators, those who did showed high satisfaction with the Care Coordinator. Fewer still, less than one-third of members who reported wanting or needing a LTS Coordinator, had met with one when surveyed – though, as with PCPs and Care Coordinators, satisfaction with LTS Coordinators was very high among members who met with this member of the interdisciplinary care team. Although it is expected that not all members enrolled in One Care will want or need a LTS Coordinator, the number of members who reported receiving a referral to a LTS Coordinator, and who reported meeting with a LTS Coordinator appears lower than anticipated, pointing to the need to clarify this role to members and to address a possible lack of availability and capacity of LTS Coordinator services.

Relatively high percentages of 'not sure' responses were collected in response to several questions, including questions about members' wanting and needing LTS Coordinators and specific LTSS services, questions about whether members' LTSS needs were assessed and addressed, and questions about the

member's role in developing and receiving a copy of their Individual Care Plan. These responses seem to indicate a lack of understanding among members about these core aspects of and opportunities in the One Care model.

Members reported good attention to their medical needs in the assessment process, and relatively few unmet medical needs. Among medical services, over 80% of members reported that their needs for prescription medications, mental health services and medical transportation services were assessed. The rate at which members reported that their need for substance abuse services was assessed was markedly lower, at 59%, than for the other medical services. Seventy-five percent reported that their needs for oral/dental care and specialty medical care were assessed. Notably, however, almost 22% of members reported unmet need for oral/dental care.

The rates at which members reported that their medical needs were assessed were somewhat higher than the rates at which LTSS needs were assessed. Moreover, in comparison to medical needs, members were more likely to say that they were 'not sure' if their needs for specific LTSS needs were assessed. Thirty-four percent of respondents reported an unmet need for at least one long-term service. While it was expected that overall the number of One Care members needing LTSS would be lower than the number needing medical services, the higher rates of reported unmet need for LTSS compared to medical services is noteworthy. Among members identifying a need for LTSS, 53% reported meeting with a LTS Coordinator, and notably, members who had met with an LTS Coordinator were significantly less likely to report an unmet LTSS need compared to those who had not.

For the most part, the survey findings pointed to few disparities in members' experiences in One Care related to disability or demographic characteristics. However, there were some statistically significant differences in members' experiences related to disability or demographics. For example:

- Members reporting a learning disability were less likely to say that enrolling in One Care was easy compared to those without a learning disability (93% vs 97%);
- Members who identified as gay, lesbian or bisexual were less likely to have met with a PCP than those identifying as straight (77% vs 85%);
- Members who identified their race as Black/African American were less satisfied with the assessment process than those identifying as White (91% vs 96%);
- Members reporting a psychiatric disability were more likely to identify an unmet need for medical services compared to those without a psychiatric disability (18% vs 13%);
- Members who were homeless in the past year were more likely to have an unmet need for dental services compared to those who were not homeless (46% vs. 23%); and
- Members reporting a physical disability were less likely to say they were satisfied with their care under One Care than those without a physical disability (88% vs 91%).

These and other statistically significant differences in members' experiences are described in the body of the report. Although statistically significant, some of the actual differences related to member characteristics are relatively small, and largely reflect quite positive results across members.

In terms of differences by One Care plan, results indicate that Fallon Total Care and Tufts Health Plan-Network Health put greater emphasis on utilization of the Care Coordinator role, consistent with goals of the program, while Commonwealth Care Alliance, which grew out of a health group structured around PCP-based care management, seems to have maintained enrollees' existing relationships with their PCPs in its approach to implementing One Care. Further discussion of statistically significant differences in survey responses and the results of regression and contrast analyses are described and explained in the body of this report.

While there is room for improvement, overall satisfaction with One Care appears quite high. Over 80% of members reported being extremely or somewhat satisfied with their One Care plan, and almost 82% reported being extremely or somewhat satisfied with the services they are getting under One Care. Over 83% reported that they intend to stay in One Care. The areas showing actionable results are not surprising, will support MassHealth, the One Care plans, and the One Care Implementation Council to address identified areas for improvement, and provide concrete information on which to set out goals for the continued implementation of the One Care demonstration.

Recommendations. Survey findings point to several areas where action is appropriate.

- Focus on certain populations of One Care enrollees is warranted, including but not limited to gay/lesbian/bisexual members, members who are deaf or hard of hearing, members with learning disabilities and members identifying as Black/African American, in order to ensure continued and improved provision of and satisfaction with services under One Care.
- MassHealth and One Care plans should continue to emphasize educating members about the role and benefits of working with an LTS Coordinator, while respecting that not everyone with an LTSS need truly wants to do so (37% said they did not want an LTS Coordinator). In particular, Care Coordinators and PCPs should play a lead role in explaining the LTS Coordinator responsibility to members, and in reinforcing this information in an on-going manner.
- Further, the lower rates at which LTSS needs appear to be assessed, the fact that many members were not sure if their needs for LTSS were assessed, and the level of reported unmet LTSS needs suggest that MassHealth, the One Care plans and One Care providers should focus attention on LTSS assessment and service provision. As well, the plans, advocates and stakeholders must strive to ensure better understanding among members of the potential benefits of both identifying their LTSS needs, and of working with an LTS Coordinator. Better understanding of the program model and benefits to members will support fuller integration of these services.
- The One Care plans, advocates and community based organizations need to ensure sufficient numbers of and training for LTS Coordinators in order to build and maintain appropriate capacity of this important component of One Care and allow for consistent referral to an LTS Coordinator.
- A core goal of One Care is the integration of mental health services with other medical services. While survey results show that plans have achieved broad success in this area, there appears to

be room for improvement in assessing and addressing members' needs for substance abuse services, as well.

- One Care plans should place increased attention to identifying and addressing the dental health needs of members, in particular related to covered dental services that are appropriately indicated for the member. Access to dental services is an important reason why many members enroll.

One Care is clearly a successful program that can move toward better fulfillment of the promise of this integrated model. MassHealth and One Care plans should continue to build on the implementation of this important approach to providing integrated care to members with complex needs, who show high levels of satisfaction with the program overall. As was the goal of the Early Indicators Project and this survey in particular, actionable results were obtained and will help to guide MassHealth and the One Care plans as they continue to implement this program, fulfill its goals and better serve the needs of its members.

Introduction and Background

Massachusetts was the first state in the nation to implement a demonstration project to integrate care and align financing for individuals who are dually eligible for Medicare and Medicaid. Targeted to dually eligible adults ages 21 to 64 and fully operated by the Massachusetts Executive Office of Health and Human Services' (EOHHS) Office of Medicaid (MassHealth), the demonstration is a fundamental component of the Commonwealth's broader effort to transform its health care system by restructuring how care is delivered and how providers are reimbursed. Massachusetts' reform efforts include initiatives to develop patient-centered medical homes, bundled payments, and Accountable Care Organizations, among other efforts. Through these initiatives, Massachusetts seeks to ensure access to appropriate services, integrate comprehensive services at the person level, improve care coordination across the health care, behavioral health and long term support delivery systems, and create payment systems that hold providers accountable for the care they deliver. Massachusetts aims to reward quality care, improve health outcomes, and more effectively spend health care dollars. With the combination of Medicare and Medicaid funding, the integrated care demonstration is designed to offer a broader menu of services to better meet the needs of dually eligible individuals in the most cost effective way.

Enrollment in the demonstration, known as ***One Care,*** began in September 2013, and coverage began on October 1, 2013. Offered by three health care plans[1] in the state, One Care is available to dually eligible MassHealth members living in nine Massachusetts counties[2], and provides integrated care for members' primary, acute, specialty, and behavioral health care needs, as well as prescription medications and long-term services and supports (LTSS), using a person-centered approach. In addition to a Primary Care Provider, One Care plans provide members with a Care Coordinator, and when

[1] One Care is currently offered by Commonwealth Care Alliance, Fallon Total Care and Tufts Health Plan-Network Health

[2] One Care is currently available in Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Suffolk and Worcester counties, as well as in certain towns in Plymouth county

appropriate and desired, an independent living-long term services and supports coordinator (LTS Coordinator). One Care plans are expected to conduct a comprehensive assessment of a member's needs and develop an individualized care plan within 90 days of the member's enrollment.

Eligible members may chose to enroll in One Care at any time. In addition, MassHealth has conducted a series of passive enrollment periods in the four counties in which two or more One Care plans operate. To date, there have been four periods of passive enrollment: January, April, July, and November 2014. Members may opt-out of One Care at any time. As of January 1, 2015, there were 17,839 members enrolled in One Care.

The One Care Implementation Council, a representative group of 21 stakeholders including people with disabilities and community organizations, was convened by EOHHS to assist with monitoring the implementation of One Care, including monitoring members' access to and quality of services under One Care, providing support and input to EOHHS, and promoting accountability and transparency. In August 2013, the Council recommended that MassHealth undertake efforts to assess the experiences of members during the initial roll-out of One Care.

The goal of the ***One Care Early Indicators Project*** (EIP) has been to assess the early perceptions and experiences of MassHealth members who are eligible for One Care, with a focus on collecting actionable information that is available during the very early stages of the implementation in order to inform any needed course corrections. Thus, the EIP effort is distinct from longer-term efforts to evaluate quality of care provided to members under One Care or other programmatic evaluations. The EIP Workgroup is a multi-stakeholder workgroup comprised of representatives from the One Care Implementation Council, MassHealth, and the University of Massachusetts Medical School (UMMS). The EIP Workgroup initially convened in October of 2013, has met regularly since then, and has been responsible for developing EIP data collection methods, tools and related materials; collecting and analyzing data; and developing reports of findings.

The EIP has used a mixed-methods (qualitative and quantitative) approach to understand the perceptions and experiences of One Care eligible members in different enrollment statuses, including members who voluntarily enrolled or were passively enrolled (auto-assigned) into One Care, as well as those opting-out of One Care. Reports of findings from prior EIP activities, including member focus groups, an initial brief survey of One Care eligible members, and monthly One Care enrollment reports, are available at the One Care website at (http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-early-indicators-project-eip-reports.html).

This report presents findings from a second, more comprehensive survey of members enrolled in One Care. The ***One Care 2014 Member Experience Survey*** was conducted with three cohorts of respondents between June 2014 and January 2015 and was designed to capture members' perceptions and experiences during their first months in a One Care plan.

Methods

A. Survey Development and Domains

The One Care Member Experience Survey (OC-MES) was developed by members of the EIP Workgroup during the Spring of 2014. In addition to input from EIP Workgroup members, the survey content was informed by the findings of the earlier focus groups and survey conducted by the Workgroup. Potential domains and survey questions were developed and refined by Workgroup members in an iterative process. Using a near-final version of the questions, UMMS researchers conducted cognitive interviews with six One Care members, including individuals with physical, psychiatric and other disabilities. Cognitive interviews are a method of "pre-testing" survey questions to help ensure that questions and response options are clear and are interpreted by potential survey respondents as intended. The final version of the OC-MES was developed by the Workgroup based on the results of the cognitive testing, and with input from the UMMS Office of Survey Research (OSR). The final version of the OC-MES included 38 core questions covering the following eight major domains:

- Enrolling into One Care
- Your Care Team
- Assessment and Care Planning Process
    - Assessing needs for Medical Services and Long-Term Services and Supports
- Your Individual Care Plan
- Your Care – Services you Need and Receive
    - Medical Services and Long-Term Services and Supports
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- Overall Perceptions of One Care
- Member Demographic and Disability Information

The final version of the survey was translated into Spanish and was customized for three modes of administration – mail, telephone and online (see **Appendix B** for the print/mailed version of the survey).

B. Survey Administration

The OC-MES was administered by the UMMS OSR to three cohorts of randomly-selected members who had been enrolled in One Care for a minimum of 120 days. The minimum enrollment of 120 days was set to ensure that members had sufficient time in One Care to experience the assessment and care planning process and, presumably, to begin to receive health care and other services under One Care.

The survey was administered as follows:

- Members enrolled as of January 1, 2014 were surveyed June to July 2014 (Cohort 1)
- Members enrolled as of April 1, 2014 were surveyed August to September 2014 (Cohort 2)
- Members enrolled as of July 1, 2014 were surveyed November 2014 to January 2015 (Cohort 3)

Using member contact information provided by MassHealth in June, August and November 2014, UMMS researchers randomly selected 2,000 members to include in each of the three cohorts, for a total sample of 6,000 members. The survey sample included both voluntarily and passively enrolled members who appeared to have a valid day or evening telephone number (in the MassHealth data).

The three One Care plans differ in their availability across the state and thus in the number of enrolled members in each plan. Commonwealth Care Alliance is available in all nine counties served by One Care, while Fallon Total Care is available in three counties and Tufts Health Plan-Network Health is

available in two counties. Consequently, the number of members available to be included in the OC-MES sample varied by One Care plan. Table 1 below shows the number of enrolled members and the number randomly selected to be included in the survey sample in each cohort for each plan.

Table 1. Number of One Care Members Selected for the Survey Sample by Cohort and Plan

	Cohort 1			Cohort 2			Cohort 3		
One Care Plan	Enrolled	Valid phone number	Sample	Enrolled	Valid phone number	Sample	Enrolled	Valid phone number	Sample
Commonwealth Care Alliance	5547	3772	800	1350	892	892	2717	1961	741
Fallon Total Care	1983	1291	800	2120	1439	1053	2301	1554	740
Tufts Health Plan-Network Health	684	486	400	78	55	55	695	519	519
Total Sample			**2000**			**2000**			**2000**

The entire final survey sample included 2,433 members enrolled in Commonwealth Care Alliance, 2,593 enrolled in Fallon Total Care, and 974 enrolled in Tufts Health Plan-Network Health.

A print version of the OC-MES was mailed to all randomly selected members by the UMMS OSR. The mailed survey packet included a cover letter and survey fact sheet (both in English and Spanish), the English version of the OC-MES, and a self-addressed, stamped return envelope. The cover letter and fact sheet explained the purpose of the survey, informed members that the survey was voluntary and that the survey could also be completed in English or Spanish via telephone interview (OSR phone number provided) or on-line (with a unique username/password provided). A second mailing was sent three weeks after the first to members who had not responded to the survey by mail. Approximately two weeks after the second mailing, telephone calls were made by OSR trained interviewers to all members who had not responded to the survey by mail or on-line. Multiple attempts were made to contact members by phone. The average time to complete the OC-MES via telephone interview was 15 minutes.

A total of 1,933 members responded to the OC-MES for an overall response rate of 32%.

Response rates across the three cohorts were 35.5%, 31.1% and 30.3%, respectively. Fifty-four percent of members responded to the survey by mail, 42% completed the survey by telephone interview, and 4% completed the survey online. The most common reason for non-completed interviews was an inability to reach the member by phone (no answer; voicemail/answering machine; incorrect or disconnected number). Only 3.7% of the members who were successfully reached by telephone refused to complete the interview.

C. Data Analysis

All survey data were analyzed using SAS Version 9.3. Because the survey sampling rates and survey response rates differed across the One Care plans, the responses were weighted to ensure that the statistics reported represent the experiences of the MassHealth One Care population as a whole. Subsequently, weighted data were used for all analyses. Descriptive statistics (percentages, frequencies) were generated for all survey questions; descriptive statistics are described and presented in Tables 1 to 14 in the main body of this report.

Logistic regression models were generated to examine whether members' experiences in One Care relative to 20 key questions or "outcomes" were associated with differences in member enrollment (e.g. One Care plan), disability (e.g. psychiatric, physical), and demographic (e.g. age, gender) characteristics. The key outcomes examined corresponded to the major domains of the OC-MES and included:

- Enrolling in One Care
  - Ease of enrolling into One Care (voluntarily enrolled)
  - Ease of understanding MassHealth information about One Care (passively enrolled)

- The Interdisciplinary Care Team
  - Met with a Primary Care Provider
    - Satisfaction with Primary Care Provider
  - Met with a Care Coordinator
    - Satisfaction with Care Coordinator
  - Met with a LTS Coordinator
    - Satisfaction with LTS Coordinator

- The Assessment and Care Planning Process
  - Met with a member of Care Team for an assessment
    - Satisfaction with assessment process
  - Has an Individual Care Plan

- Getting Care under One Care – Service Needs and Unmet Needs
  - Has LTSS needs
  - Experienced any unmet medical service need (excluding oral/dental care)
  - Experienced unmet oral/dental care need
  - Experienced any unmet LTSS need

- Transitioning Into and Overall Perception of One Care
  - Ease of transitioning into One Care
    - Experienced disruptions in care during transition
  - Satisfaction with One Care Plan
  - Satisfaction with services under One Care
  - Plans to stay in One Care

Logistic regression allows us to determine the associations between the outcome and each member characteristic while controlling for other member characteristics. For example, it allows us to estimate the association between "Met with a PCP" and "gender" without the estimated association being influenced by age, One Care plan, or other controlled-for member characteristics. The key statistic generated by logistic regression is the Odds Ratio (OR), which provides an estimate of the association between the outcome and the member characteristic. An OR of 1.0 indicates that there is no association between the outcome and the member characteristic. An OR greater than 1.0 indicates the characteristic is associated with increased likelihood of the outcome and an OR of less than 1.0 indicates the characteristic is associated with decreased likelihood of the outcome. We illustrate this with a hypothetical example of the relationship between drinking coffee and gender. An OR of 2.0 for males would indicate that being male doubles the odds of drinking coffee compared to being female. Correspondingly, a hypothetical OR of 0.5 for males would indicate that being male halves the odds of drinking coffee compared to being female.

We cannot determine from the OR alone whether the estimated association occurred by chance or because of a true association. To do this, we use statistical significance. The general standard for

considering an association statistically significant is when there is a 95% probability that the association is true and only a 5% probability that it is by chance. This is the standard we use in this report.[3]

Because there are three One Care plans, along with the logistic regressions we also conducted *contrast analyses* that allowed us to test for any statistically significant differences in the outcomes across the three plans (controlling for other member characteristics). When the results of logistic regression analyses/contrast analyses pointed to statistically significant associations between key outcome and member enrollment, disability or demographic characteristics, those findings are reported in the main body of this report under relevant sections. We also note when the results showed no significant associations between outcomes and member characteristics, as the absence of association can also be instructive. (Additional explanation of logistic regression models and tables showing results of all logistic regression analyses are provided in Appendix A.)

D. Responding Members

Table 2 shows enrollment, disability and demographic characteristics of members responding to the OC-MES (weighted). Just over 40% of responding members had voluntarily enrolled in One Care, while almost 60% had been passively enrolled. The most common disabilities reported by responding members were mental or psychiatric problems, physical/mobility disabilities, and long-term illness; almost 80% of members reported more than one disability. Just over 7% of members reported

[3] Statistical significance is usually reported as a "p value." A p value of .05 (or smaller) indicates that the probability that the association is because of chance is 5% or less. Odds Ratios (ORs) are generated along with "confidence intervals" (a lower and upper value) which provide an estimate of range where the "true" odds lies. A 95% confidence interval is similar to a probability (or p value) of .05 – i.e. there is a 95% probability that the true odds lies within the range of the confidence interval. Whether an association is statistically significant depends not just on the size of the OR, but also the size of the sample and the variability in the outcome and the member characteristics. Confidence intervals that contain 1.0 indicate that we cannot determine with statistical certainty whether there is a true association between the outcome and member characteristic; that is, whether the characteristic is associated with increases or decreases in the outcome. In this report and in tables in Appendix A, we provide either p values or ORs and 95% confidence intervals to indicate statistically significant findings.

experiencing homelessness in the past year.

The majority of responding members (75%) were age 45 and over. Responding members were 52% female and 48% male; 0.3% identified as transgender, intersex or other. Over 92% identified as heterosexual, and 6% identified as gay, lesbian or bisexual. Sixty-five percent of responding members identified their race as White, and 13% identified their race as Black/African American. Twenty-one percent identified as Hispanic/Latino. English was the most common primary language spoken (i.e. language mainly spoken at home), identified by 79% of members; 12% of members identified Spanish as their primary language. Over one-third of members reported having some college education or higher and 38% reported having a high school education or completing a GED (General Educational Development tests); 24% of members reported having less than a high school education. Almost 16% of members reported being employed for pay in the past 12 months.

Table 2. Characteristics of Members Responding to the One Care Member Experience Survey

		%
Enrollment		
Survey Cohort	Cohort 1	47.0
	Cohort 2	20.3
	Cohort 3	32.7
Plan	Commonwealth Care Alliance	55.0
	Fallon Total Care	36.7
	Tufts Health Plan-Network Health	8.3
Enrollment method	Voluntarily enrolled (member chose plan)	40.2
	Passively enrolled (MassHealth chose plan)	59.8
Disabilities/Health Conditions		
Reported conditions	Mental/psychiatric	67.1
	Physical/mobility	56.9
	Long-term illness	46.8
	Visual impairment/blindness	28.9
	Learning disability	27.2
	Hearing loss/deafness	14.8
	Developmental disability	11.1
	Alcohol or drug abuse	8.5
	Other	25.8
Number of reported conditions	1 condition	15.9
	2 or 3 conditions	47.4
	4 conditions or more	32.2

	None	4.5
Demographics		
Homelessness	Homeless in past 12 months	7.3
Age	21-34	8.0
	35-44	16.7
	45-54	33.5
	55-64 and over	41.8
Gender	Male	47.9
	Female	51.8
	Transgender/intersex/other	0.3
Sexual Orientation	Heterosexual	92.2
	Gay/Lesbian	4.5
	Bisexual	1.9
	Asexual	1.3
Race	White	64.9
	Black/African American	13.4
	Asian	1.4
	Native Hawaiian/Pacific Islander	0.2
	American Indian/Alaska Native	3.6
	Other	15.5
Ethnicity	Hispanic/Latino	21.0
Primary Language Spoken at Home	English	78.9
	Spanish	12.2
	American Sign Language	0.5
	Vietnamese	0.5
	Other	7.0
Education	Less than high school	24.1
	High school or GED	37.5
	Some college or more	38.5
Employment	Worked for pay in last 12 months	15.5
	Currently working for pay (of above)	84.5

GED=General Educational Development Tests

Enrolling in One Care

Findings: Enrolling in One Care

As noted, 40% of responding members had voluntarily enrolled into a One Care plan and 60% had been passively enrolled by MassHealth. As shown in Table 3, the majority of members who voluntarily enrolled into One Care found it easy to choose a plan (82%) and easy to enroll (87%). Among voluntarily enrolled members, primary reasons for enrolling included: to get better health care (61%); to get additional services (51%); to get better dental care (48%); to have one health plan rather than two (45%); to lower their costs for health care (36%); and to get a Care Coordinator (34%). About a quarter of members reported enrolling to get a LTS Coordinator.

Table 3. Voluntarily Enrolled Members' Experiences with the Enrollment Process

	%
Ease of choosing a One Care plan	
Very easy/somewhat easy	81.8
Somewhat difficult/very difficult	9.2
Don't know/not sure	0.6
Declined to answer	8.5
Ease of enrolling in One Care	
Very/somewhat easy	86.7
Somewhat difficult/very difficult	3.8
Don't know/not sure	0.6
Declined to answer	8.9
Reasons for enrolling in One Care	
To get better health care	61.2
To get additional services	51.1
To get better dental care	48.4
To have one plan rather than two	44.8
To lower the costs I pay for health care	36.1
To get a Care Coordinator	34.2
Someone recommended One Care	26.6
To get an LTS Coordinator	25.6
Other	13.8
Don't know/not sure	0.0
Declined to answer	9.0

The logistic regression model showed few differences in the perception that *enrolling was easy* among those voluntarily enrolling by member characteristic. Members reporting a learning disability were

statistically significantly less likely to perceive enrolling as easy in comparison to those not reporting a learning disability (OR=0.19) (see **Table A-1** in Appendix A). However, no other member characteristics were significantly associated with the perception of enrolling as easy and there were no significant differences in this outcome across the three One Care plans (contrast analysis).

Among members who were passively enrolled into One Care (Table 4), 75% reported that they recalled receiving a letter from MassHealth about the plan chosen for them. Among these members, 78% reported that information they received from MassHealth about the plan was easy to understand.

Table 4. Passively Enrolled Members' Experiences with the Enrollment Process

	%
Recall receiving a letter from MassHealth about plan chosen for you	
Yes	75.1
No	16.8
Don't know/not sure	6.5
Declined to answer	1.5
Ease of understanding information from MassHealth about the plan chosen for you	
Very easy/somewhat easy	78.1
Somewhat difficult/very difficult	16.5
Don't know/not sure	3.1
Declined to answer	2.0

Note: Continued to next question **in this** series Skipped to **next series** of questions

The logistic regression model showed few differences in the perception of MassHealth *information as easy to understand* among those passively enrolled by member characteristics. Members identifying as deaf/hearing loss were statistically significantly less likely to find the information easy to understand than those not identifying as deaf/hearing loss (OR=0.53). Conversely, younger members (age 21-34) were significantly more likely to find the information easy to understand than older members (age 55-64) (OR=3.41) (**Table A-2** in Appendix A). Beyond these differences, no other member characteristics were significantly associated the perception of MassHealth information as easy to understand and there were no significant differences in this outcome across the three One Care plans.

Summary: Enrolling in One Care

Findings from the OC-MES suggest that members voluntarily enrolling in One Care understood and were motivated to enroll by some of the unique features offered by One Care. In addition, for the most part, findings suggest that the process of enrolling in One Care among both voluntarily and passively enrolled members occurred with relative ease. However, results of the logistic regression analyses do suggest that some members – older members; members with learning disabilities; and members identifying as deaf/hearing loss – may have found the enrollment process and/or enrollment information more challenging to understand or navigate than other members.

The Interdisciplinary Care Team

Findings: The Interdisciplinary Care Team

Under One Care, members have access to an Interdisciplinary Care Team ("ICT" or "Care Team"), including, at the member's discretion, three key members – a Primary Care Provider (PCP), a Care Coordinator and a LTS Coordinator.

It is expected that all members will have a PCP and a Care Coordinator as part of their ICT. However, while all members should be offered a LTS Coordinator, it is expected that not all members will want or need a LTS Coordinator. The OC-MES included several questions regarding members' experiences with and perceptions of their team, specifically whether they had met with and their satisfaction with these members of the ICT.

Primary Care Providers (PCP)

As shown in Table 5, the majority of members (66%) reported staying with the same PCP they had prior to enrolling in One Care; 21% changed PCPs after enrolling. A small number of members (<3%) did not have a PCP prior to enrolling, but obtained a PCP when they enrolled in One Care. Thus, almost 90% of members reported having a PCP under One Care. Three percent of members reported that they still do not have a PCP (the remainder were not sure or declined to answer). Among members with a PCP, a majority (84%) reported meeting with their PCP since enrolling in One Care. Overall satisfaction with the PCP was high; over 85% reported being somewhat or extremely satisfied with their PCP.

Table 5. Members' Experiences with Primary Care Provider

Since enrolling in One Care	
Which of the following best applies to you (related to your **PCP**)?	
Stayed with the same PCP	66.1
Changed PCP	21.0
Didn't have PCP before One Care, but have one now	2.4
Still don't have a PCP	3.0
Don't know/not sure	4.1
Declined to answer	3.5
If you have a PCP	
Have you met with your **PCP**?	
Yes	84.2

No	12.4
Don't know/not sure	1.9
Declined to answer	1.6
How satisfied are you with the **PCP** you have under One Care?	
Extremely Satisfied	64.3
Somewhat Satisfied	21.2
Somewhat Dissatisfied	3.5
Extremely Dissatisfied	1.9
Don't know/not sure	6.1
Declined to answer	3.0

Note: ■ Continued to next question **in this** series ■ Skipped to **next series** of questions

Although the overall rate of meeting with the PCP was high, the logistic regression model showed some statistically significant differences in rates of *meeting with the PCP* by member characteristics (**Table A-3** in Appendix A). Members who voluntarily enrolled in One Care were significantly more likely to have met with their PCP than members who were passively enrolled (OR=1.48), as were members reporting a physical disability versus no physical disability (OR=1.64). Conversely, men were significantly less likely to have met with their PCP compared to women (OR=0.66), and members identifying as gay, lesbian or bisexual were also significantly less likely to have met with their PCP than those identifying as heterosexual (OR=0.52). No other member characteristics were significantly associated with meeting with the PCP. However, results of the contrast analysis showed statistically significant differences across the three One Care plans for this outcome. Members enrolled in Commonwealth Care Alliance (CCA) were significantly more likely to report meeting with their PCP, which is consistent with CCA's care model (of using PCPs as Care Coordinators in some instances), than members in Fallon Total Care (87% vs. 80%, p<.003) and in Tufts-Network Health (87% vs. 85%, p<.03). Additionally, members in Tufts-Network Health were more likely to report meeting with their PCP than members in Fallon Total Care (85% vs. 80%, p<.02).

Overall *satisfaction with their PCP* was high among One Care members, and the logistic regression model showed few differences in satisfaction with the PCP by member characteristics (**Table A-4** in Appendix A). However, members identifying as gay, lesbian or bisexual were significantly less

likely to be satisfied with their PCP than members identifying as heterosexual (OR=0.37). There were no significant differences in satisfaction with the PCP across the three One Care plans.

Care Coordinators

As shown in Table 6, 71% of members reported having been contacted by a Care Coordinator from a One Care plan since enrolling (7% were not sure), and of these members, almost 73% had met with a Care Coordinator. From this, we estimate that about 51% of all members met with a Care Coordinator, although this may be an underestimate[4]. Most meetings with a Care Coordinator occurred within three months of enrolling in One Care (77%). As with the PCP, overall satisfaction with the Care Coordinator was high; 91% of members reported being somewhat or very satisfied with the Care Coordinator.

Table 6. Members' Experiences with Care Coordinator

Since enrolling in One Care	
Have you been **contacted** by a **Care Coordinator**?	
Yes	71.3
No	18.6
Don't know/not sure	6.9
Declined to answer	3.2
If contacted, have you **met** with **Care Coordinator**?	
Yes	72.6
No	21.2
Don't know/not sure	3.1
Declined to answer	3.0
If met with **Care Coordinator**, time between enrolling and meeting?	
Less than 1 month	38.8
1 month to less the 2 months	29.2
2 months to less than 3 months	9.6
3 months or more	10.5
Don't know/not sure	9.9
Declined to answer	1.9
If met with **Care Coordinator**, satisfaction with **Care Coordinator?**	
Extremely Satisfied	65.0
Somewhat Satisfied	26.1

[4] Because of skip patterns in the OC-MES, this estimate does not include members who may have met with a Care Coordinator, but answered "no" when asked if they were contacted by a Care Coordinator.

Somewhat Dissatisfied	3.5
Extremely Dissatisfied	2.4
Don't know/not sure	1.2
Declined to answer	1.8

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While there were no statistically significant differences in *meeting with the Care Coordinator* by member disability or demographic characteristics, the logistic regression model showed significant differences in meeting with a Care Coordinator by member enrollment characteristics (**Table A-5** in Appendix A). Specifically, members surveyed in Cohort 1 were significantly more likely to have met with a Care Coordinator than those in Cohort 3 (OR=1.45), and members enrolled in Fallon Total Care were significantly more likely to have met with a Care Coordinator than members in Tufts-Network Health (the comparison group) (OR=1.81). Further, results of the contrast analysis showed significant differences in meeting with a Care Coordinator across all three One Care plans. Members enrolled in Fallon Total Care were significantly more likely to have met with a Care Coordinator than members in both Tufts-Network Health (67% vs. 61%, p<.0001) and Commonwealth Care Alliance (67% vs. 56%, p<.0001). Additionally, members in Tufts-Network Health were significantly more likely to have met with a Care Coordinator than members in Commonwealth Care Alliance (61% vs. 56%, p<.03).

As noted, overall satisfaction with the Care Coordinator was quite high; however, the logistic regression model indicated some differences in satisfaction by member disability and demographic characteristics (**Table A-6** in Appendix A). Members reporting a learning disability were significantly more likely to be satisfied with their Care Coordinator in comparison to members not reporting a learning disability (OR=3.36), and those with a high school education or GED were significantly more likely to be satisfied with the Care Coordinator than those with some college education (OR=3.36). Conversely, Latino/Hispanic members were significantly less likely to be satisfied with the Care Coordinator than members who were non-Latino/Hispanic (OR=0.24). There were no significant differences in satisfaction with the Care Coordinator across the three One Care plans.

Independent Living and Long-Term Services and Supports (LTS) Coordinator

As noted above, while all members should be offered a LTS Coordinator, it is expected that not all members will want or need a LTS Coordinator as part of their Care Team. Table 7 shows that 39% of members reported needing or wanting a LTS Coordinator and almost 42% reported being offered an LTS Coordinator. Nearly 20% of members were not sure if they needed/wanted a LTS Coordinator and almost 30% were not sure if they had been offered a LTS Coordinator. Of note, among the subset of members who reported needing/wanting a LTS Coordinator, 51% reported they had been offered a LTS Coordinator; 23% reported they had not and 25% were not sure.

Among members who reported being offered a LTS Coordinator, 44% had met with a LTS Coordinator (10% were not sure) (Table 7). From this, we estimate that 18% of all members met with a LTS Coordinator, although this may be an underestimate[5]. Among the subset of members needing/wanting a LTS Coordinator, although 51% reported being offered a LTS Coordinator, only 29% reported meeting with a LTS Coordinator. Close to 77% of meetings with a LTS Coordinator took place within three months of enrolling in One Care. Among members who reported having met with a LTS Coordinator, satisfaction with the LTS Coordinator was quite high, with nearly 93% reporting that they were extremely or somewhat satisfied with the LTS Coordinator.

Table 7. Members' Experiences with LTS Coordinator

Need or want a **LTS Coordinator**?	
Yes	39.4
No	36.7
Don't know/not sure	19.8
Declined to answer	4.1
Since enrolling on One Care	
Were you **offered** a **LTS Coordinator** by your One Care plan?	
Yes	41.8
No	23.4
Don't Know/not sure	29.6

[5] Because of skip patterns in the OC-MES, this estimate does not include members who may have met with a LTS Coordinator, but answered "no" when asked if they were offered a LTS Care Coordinator.

Declined to answer	5.1
If offered, have you **met** with your **LTS Coordinator**?	
Yes	44.4
No	42.3
Don't Know/not sure	9.9
Declined to answer	3.3
If met with **LTS Coordinator**, time between enrolling and meeting?	
Less than 1 month	36.3
1 month to less the 2 months	28.6
2 months to less than 3 months	11.6
3 months or more	16.0
Don't know/not sure	6.0
Declined to answer	1.5
If met with **LTS Coordinator**, satisfaction with **LTS Coordinator**?	
Extremely Satisfied	67.4
Somewhat Satisfied	25.4
Somewhat Dissatisfied	3.0
Extremely Dissatisfied	1.1
Don't Know/not sure	1.1
Declined to answer	1.9

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The logistic regression model showed only a few significant differences in *meeting with the LTS Coordinator* by member characteristics (**Table A-7** in Appendix A). Members identifying as deaf/hearing loss were significantly more likely to report meeting with a LTS Coordinator than those not identifying themselves as deaf/hearing loss (OR=1.89), as were members with a high school education or GED compared to those with some college education (OR=1.71). There were no other significant differences in meeting with a LTS Coordinator by member characteristics and there were no significant differences in this outcome across the three One Care plans.

As noted above, overall *satisfaction with the LTS Coordinator* was quite high among members. Because of limited or no variability in satisfaction rates across several member characteristics (**Table A-8** in Appendix A) the logistic regression and contrast analyses were not applicable (and are not shown).

Coordination among the Care Team

While the OC-MES was not designed to provide specific information on coordination or interaction among Care Team members, survey findings showed that members who reported meeting with their PCP were significantly more likely to report meeting with a Care Coordinator and with an LTS Coordinator compared to those not meeting with the PCP. Specifically, among members meeting with their PCP, 65% reported meeting with a Care Coordinator; however the rate fell to 45% among those not meeting with their PCP ($p<.0001$). Similarly, 34% of members meeting with their PCP reported meeting with a LTS Coordinator; this rate fell to 12% among those not meeting with their PCP ($p<.0001$).

Summary: The Interdisciplinary Care Team

As noted above, all members enrolled in One Care are expected to have a Primary Care Provider and a Care Coordinator as part of their Interdisciplinary Care Team. Findings from the OC-MES show that the large majority of One Care members have a PCP, with some members obtaining a PCP with enrollment in One Care. Most members with a PCP had met with the PCP since enrolling in One Care; there were only a few differences in member characteristics between those meeting and not meeting with their PCP. Voluntarily enrolled members were more likely to meet with their PCP than passively enrolled members. It may be that members who actively sought enrollment in One Care were more proactive in seeking to meet with their PCP compared to those passively enrolled. While overall there were few disparities in meeting with the PCP by member demographic characteristics, OC-MES results showed that members who were male (compared to women) and those who identified as gay, lesbian or bisexual (compared to straight) were less likely to meet with their PCP. To some extent, these demographic disparities are consistent with those observed in the general population. Evidence shows that men are less likely than women to make ambulatory care, including preventative care, visits to

physicians[6]. Additionally, there is some evidence that lesbian and bisexual individuals have decreased access to regular medical care compared to heterosexuals[7, 8].

There were significant differences across the three One Care plans in terms of meeting with the PCP; in particular, members enrolled in Commonwealth Care Alliance were more likely to have met with their PCP than members in the other two plans. An additional analysis showed that members enrolled in Commonwealth Care Alliance were significantly more likely to have stayed with their PCP than members enrolled in either Fallon Total Care or Tufts-Network Health (75% compared to 67% and 71% respectively, $p<.0006$), which may explain, in part, why members in Commonwealth Care Alliance were more likely to have met with their PCP than members in the other two plans.

Overall satisfaction with their PCP appears quite high among members enrolled in One Care, and there were few differences in satisfaction by member enrollment, disability or demographic characteristics. However, members identifying as gay, lesbian or bisexual were significantly less likely to be satisfied with their PCP compared to members identifying as straight (87% vs. 95%), suggesting a need for the One Care program overall to make efforts to ensure the cultural competence of PCPs and other providers to best serve gay, lesbian and bisexual members. Again, there were no differences in satisfaction with the PCP across the three One Care plans.

While most members had met with their PCP, fewer members reported meeting with a Care Coordinator. Overall, OC-MES findings suggest that about 51% of all members reported meeting with a Care Coordinator within the first 3-4 months of enrolling in One Care. Notably, meeting with the PCP increased the likelihood of meeting with the Care Coordinator, which is indicative of the value of the

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[6] Hsiao, C.-J., Cherry, D. K., Beatty, P. C., & Rechtsteiner, E. A. (2010). *National Ambulatory Medical Care Survey: 2007 summary.* National Health Statistics Report, No. 27. Hyattsville, MD: National Center for Health Statistics.

[7] Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health, 100*, 1953-1960.

[8] Heck, J. E., Sell, R. L., & Gorin, S. S. (2006). Health care access among individuals involved in same-sex relationships. *American Journal of Public Health, 96*, 1111-1118.

Interdisciplinary Care Team model. There were no differences in meeting with a Care Coordinator by member disability or demographic characteristics. However, members surveyed in Cohort 1 were more likely to meet with a Care Coordinator than members in Cohort 3. Members in Cohort 1 included a significantly larger percentage of voluntarily enrolled members compared to Cohorts 2 and 3 (49%, 35%, and 31% respectively, $p<.0001$). Voluntarily enrolled members could have begun receiving services as early as October 2013 (three months before members who were passively enrolled); thus, Cohort 1 may have included members who were enrolled for much longer than the 120 day minimum and may have had more time and opportunity to meet with a Care Coordinator.

The most noteworthy differences in meeting with a Care Coordinator were the differences across plans. In particular, members enrolled in Fallon Total Care were significantly more likely to have met with a Care Coordinator than members enrolled in the other two plans, and members in Tufts-Network Health were more likely to have met with a Care Coordinator than those in Commonwealth Care Alliance. This finding, coupled with findings of differences in rates of meeting with the PCP across plans, suggests possible dissimilarities in the approaches that the plans employed in rolling-out One Care. Commonwealth Care Alliance may have placed greater emphasis on the involvement of the PCP, while Fallon Total Care, and to a lesser extent Tufts-Network Health, in keeping with the One Care program model, appears to have placed greater emphasis on involving and establishing the role of the Care Coordinator.

As with the PCP, overall member satisfaction with Care Coordinators was quite high and there were no differences in satisfaction across plans. Satisfaction was particularly high among members reporting a learning disability and those with a lower level of education (compared to those not reporting these characteristics), which may suggest that members who might be at risk for difficulties in accessing health care and other services or in otherwise navigating the health care system were particularly helped by the efforts of the Care Coordinator. Although quite high across the board,

satisfaction with the Care Coordinator was lower among Latino/Hispanic members compared to non-Latino/Hispanic members, pointing to an ongoing need for plans and providers to make efforts to ensure the ethnic and cultural competence of their services.

While it is expected that not all members enrolled in One Care will want or need a LTS Coordinator, the number of members who reported meeting with a LTS Coordinator appears lower than anticipated. It is notable that almost 20% of members said they were not sure if they wanted a LTS coordinator and almost 30% were not sure if they had been offered a LTS coordinator. This finding suggests that many members do not fully understand the role of the LTS Coordinator. One Care plans and providers, particularly PCPs and Care Coordinators, may need to make further efforts to ensure that members are fully aware of the types of assistance that a LTS Coordinator can offer. As noted, meeting with PCP was associated with an increased likelihood of meeting with a LTS Coordinator.

Additionally, it is of particular concern that less than one-third of members who reported wanting or needing a LTS coordinator had met with one within the first four months of enrolling in One Care, which may point to a lack of availability of LTS Coordinator services and a lack of capacity for LTSS organizations to meet the needs of One Care members. As with PCPs and Care Coordinators, satisfaction with LTS Coordinators was very high among members who met with this member of the ICT, suggesting that members find this to be a valuable service.

Findings in the next two sections below – the *Assessment and Care Planning Process* and *Getting Care under One Care* -- shed additional light on the need for medical and LTSS services among One Care members and the extent to which members' needs for medical and LTSS services are being assessed and met.

The Assessment and Care Planning Process

Findings: The One Care Assessment and Care Planning Process

In most circumstances, One Care plans are expected to conduct a comprehensive, person-centered assessment of a member's medical and other needs within 90 days of enrollment. The next series of OC-MES questions asked members about their experiences during the assessment and care planning process. These questions sought to examine whether members felt their preferences, goals and strengths were considered during the assessment process and whether their needs were identified. The OC-MES also asked members whether their needs for specific medical and LTSS services were assessed, and their satisfaction with the assessment process. Finally, the survey asked members whether they agreed and had been provided with a copy of their Individual Care Plan.

Perceptions of the Assessment Process

Only two-thirds of members (63%) reported that someone from their Care Team met with them to assess their medical and other service needs (33% answered "no" to this question, 1% answered "don't know/not sure", and 4% declined to answer). Among those reporting that the assessment occurred (Table 8), 95% of members felt that the person(s) doing the assessment completely or somewhat asked about their preferences and goals, and over 93% felt the person(s) completely or somewhat asked about their personal strengths. Over 94% felt their needs were completely or somewhat identified and discussed during the assessment process.

Table 8. Members' Perceptions of the Assessment Process

	%
The person(s) doing the assessment ask about my preferences and goals	
Completely	71.6
Somewhat	23.4
Not at all	2.4
Don't know/not sure	1.3
Declined to answer	1.3
The person(s) doing the assessment ask about my personal strengths	
Completely	66.3
Somewhat	27.1
Not at all	3.9

Don't know/not sure	1.4
Declined to answer	1.4
My needs were identified/discussed during the assessment	
Completely	65.6
Somewhat	28.5
Not at all	2.9
Don't know/not sure	0.5
Declined to answer	2.6

The logistic regression model pointed to few differences in characteristics between members who did and did not report that they *had an assessment* (**Table A-9** in Appendix A). Members included in Cohort 1 were significantly more likely to report that the assessment took place than those in Cohort 3 (OR=1.38), as were members who voluntarily enrolled into One Care versus those whose who were passively enrolled (OR=1.36). Additionally, members identifying as deaf/hearing loss were significantly more likely to report that the assessment took place compared to those not reporting this characteristic (OR=1.49). There were no other significant differences in having an assessment by member disability or demographic characteristics.

Results of the contrast analysis showed significant differences in members' reporting that the assessment occurred across the three One Care plans. Specifically, members enrolled in Fallon Total Care were significantly more likely to report that the assessment occurred than members in Commonwealth Care Alliance (71% vs. 61%, p<.0002) and in Tufts-Network Health (71% vs 68%, p<.007). Additionally, members in Tufts-Network Health were more likely to report that the assessment took place than members in Commonwealth Care Alliance (68% vs. 61%, p<.003).

Assessment of Specific Medical and LTSS Needs

If members reported that someone from the Care Team met with them to assess their needs, the OC-MES asked whether their needs for specific medical services and LTSS were assessed. As shown in Table 9, members more often reported that medical service needs were assessed compared to LTSS needs. Among medical services, over 80% of members reported that their needs for prescription medications,

mental health services and medical transportation services were assessed, and 75% reported that their needs for oral/dental care and specialty medical care were assessed. The rate at which members reported that their need for substance abuse services was assessed was notably lower, at 59%, than for the other medical services.

Table 9. Members' Experiences with Assessment of Specific Medical and LTSS Needs

Did the person doing the assessment ask about your needs for:

Medical Services	Yes %	No %	Not Sure %	Declined to Answer %
Prescription Medications	89.3	6.1	3.5	1.2
Mental Health Services	82.9	9.8	5.5	1.9
Transportation to Medical Appointment	81.4	10.9	5.7	2.1
Oral and/or Dental Care	75.2	15.8	7.5	1.5
Specialty Medical Care	74.9	13.9	9.5	1.7
Substance Abuse Services	59.3	25.5	11.1	4.2
Long Term Services and Supports				
Help with transportation and getting to places you want to go	73.3	17.4	6.1	3.3
Help with personal care or with everyday tasks	72.5	18.0	6.3	3.1
Medical Equipment (wheelchair, walker, etc.)	63.2	25.1	8.1	3.6
Help with doing things in the community (work, leisure)	52.8	30.9	12.2	4.1
Day program services	48.4	33.6	13.7	4.3
Assistive Technology (special software, keyboard, etc.)	32.2	46.4	16.6	4.9

Among LTSS needs, over 70% of members reported that their needs for community transportation and for help with personal care or everyday tasks (ADL and IADL) were assessed. Sixty-three percent of members reported that their needs for medical equipment were assessed; approximately 50% reported that their needs for help doing things in the community (e.g. work or leisure activities) or their needs for day program services (e.g. day habilitation or clubhouse programs) were assessed. Just over 30% of members reported that their needs for assistive technology were assessed.

Satisfaction with the Assessment Process

For the most part, members' overall perceptions of the assessment process were quite positive. As

shown in Table 10, over 93% of members agreed completely or somewhat that the person(s) doing the assessment cared about their preferences, goals, strengths and interests, almost 97% agreed completely or somewhat that the person(s) treated them with respect, and 92% were completely or somewhat satisfied with the assessment process.

Table 10. Members' Overall Satisfaction with Assessment Process

	%
The person(s) cared about my preferences, goals, strengths and interests	
Agree completely	70.6
Agree somewhat	22.6
Somewhat disagree	2.9
Disagree completely	1.0
Don't know/not sure	0.9
Declined to answer	2.0
The person(s) treated me with respect	
Agree completely	90.7
Agree somewhat	6.2
Somewhat disagree	0.5
Disagree completely	0.3
Don't know/not sure	0.4
Declined to answer	2.0
Overall, I was satisfied with the assessment process	
Agree completely	77.1
Agree somewhat	15.1
Somewhat disagree	3.3
Disagree completely	1.8
Don't know/not sure	0.5
Declined to answer	2.3

Although *satisfaction with the assessment process* was quite high overall, there were some differences in satisfaction by member characteristics (**Table A-10** in Appendix A). The logistics regression model showed that members identifying their race as Black/African American were significantly less satisfied with the assessment process than those identifying themselves as White (OR=0.28), and members whose primary language was English were less satisfied than those whose primary language was non-

English (OR=0.07). Members who had been employed in the past year were also significantly less satisfied with the assessment process than those not employed (OR=0.30). There were no other significant differences in satisfaction with the assessment process by member characteristics, and there were no significant differences in satisfaction with the assessment process across the three One Care plans.

Members' Experiences with Individual Care Plan (ICP)

As shown in Table 11, close to 38% of members reported that they had an Individual Care Plan (ICP). Notably, over one-third of members (35%) responded that they did not know if they had an ICP. Among members who reported that they had an ICP, 85% said they agreed with the plan and 67% said they received a written copy of the plan. Close to 57% of members said that someone from their Care Team discussed ways to change the plan. Over 89% of members reported that they agreed completely or somewhat that the ICP includes the services that they need.

Table 11. Members' Experiences with Individual Care Plan

Do you have an Individual Care Plan?	%
Yes	37.8
No	23.8
Don't know/not sure	35.0
Declined to answer	3.5
If Yes	
Do you agree with what is in your Individual Care Plan?	
Yes	84.7
No	2.9
Don't know/not sure	8.3
Declined to answer	4.1
Did you receive a written copy of your Individual Care Plan?	
Yes	66.9
No	14.8
Don't know/not sure	13.6
Declined to answer	4.7
Did your Care Team discuss ways to change your Individual Care Plan?	
Yes	56.8

No	23.4
Don't know/not sure	15.2
Declined to answer	4.6
Overall, do you agree that your Individual Care Plan include the services you need?	
Agree completely	66.6
Agree somewhat	22.7
Somewhat disagree	4.0
Disagree Completely	1.0
Don't know/not sure	1.0
Declined to answer	5.0

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Given the large percentage of members who said they did not, or did not know, if they had an ICP, logistic regression analysis was used to determine if there were significant differences between members reporting that they *had an Individual Care Plan* in comparison to those reporting "no" or "don't know" in response to this question (**Table A-11** in Appendix A). Members voluntarily enrolling in One Care were significantly more likely to report having an ICP in comparison to those passively enrolled (OR=1.34). Additionally, members reporting a lower level of education (less than high school or high school/GED) were significantly more likely to report having an ICP than those with some college education or more (ORs=1.49 and OR=1.36, respectively). No other disability or demographic characteristics were significantly associated with members' report of having an ICP.

The results of the contrast analysis also showed significant differences in members' report of having (vs. not having) an ICP across the three One Care plans. Members enrolled in Fallon Total Care were significantly more likely to report having an ICP than members enrolled in Commonwealth Care Alliance (46% vs. 35%, $p<.0001$) and more likely than members enrolled in Tufts-Network Health (46% vs. 40%, $p<.004$). And, members enrolled in Tufts-Network Health were more likely to report having an ICP than members enrolled in Commonwealth Care Alliance (40% vs. 35%, $p<.003$).

Summary: Assessment and Individualized Care Plan

Under One Care, it is expected that most members will have a comprehensive assessment of their medical and other service needs within 90 days of enrollment. Given this, it is notable that only two-thirds of members (63%) reported that someone from their Care Team met with them to assess their medical and other service needs. It may be that One Care plans did conduct an assessment with at least some of the other one-third of members, but we cannot confirm this from OC-MES data.

There were few differences in member disability characteristics and no differences in member demographic characteristics between members who said they had (vs. did not have) an assessment of their needs. However, there were differences in enrollment characteristics between members who did and did not have an assessment. In particular, members who voluntarily enrolled in One Care were more likely to report having an assessment compared to passively enrolled members. It may be that voluntarily enrolling members were more likely to be active participants in their care planning process and to have a greater awareness of the assessment process. In addition, because voluntarily enrolled members could have begun receiving services as early as October 2013, there may have been more time for One Care plans to complete an assessment for voluntarily enrolled members who joined One Care early. As discussed above related to meeting with the Care Coordinator, this may also be the reason that members in Cohort 1 were more likely to report having an assessment than those in Cohort 3.

There were also differences in this outcome across plans. Specifically, members enrolled in Fallon Total Care were significantly more likely to report that they had an assessment than members in either Commonwealth Care Alliance or Tufts-Network Health, and members in Tufts-Network Health were more likely to report having an assessment than members in Commonwealth Care Alliance. Interestingly, this finding mirrors the pattern in meeting with the Care Coordinators seen across the care plans, suggesting that Care Coordinators may be playing a prime role in engaging members in the assessment process.

Overall satisfaction with the assessment process was very high among members, with over 90% reporting satisfaction with the process. However, it is worth noting that members identifying their race as Black/African American were less likely to be satisfied than members identifying as White.

In terms of assessment of specific needs, over 80% of members reported that their needs for medications, behavioral health care and medical transportation were considered during the assessment. Given that a key goal of One Care is to integrate mental health and primary care, it is particularly positive to see that a large majority of members report that their mental health needs were assessed.

Overall, there were notable differences in members' reports of the assessment of their medical needs compared to LTSS needs. The rates at which members reported that their medical needs were assessed were consistently higher than the rates at which LTSS needs were assessed. Moreover, in comparison to medical needs, members were more likely to say that they were "not sure" if their needs for specific LTSS needs were assessed. The lower rates at which LTSS needs appear to be assessed, and the fact that many members were not sure if their needs for LTSS were assessed, suggests a needed area of attention as MassHealth and One Care plans continue to roll out the program.

While over two-thirds of members reported that a member of their Care Team met with them to conduct an assessment, only a little more than one-third reported that they had an Individual Care Plan (ICP). Equally concerning is that just over one-third of members said they were not sure/didn't know if they had an ICP. It is likely that many members have an ICP, but are not aware that they have a care plan – that is, that One Care plans may not be routinely reviewing or sharing ICPs with members in a systematic way or in a manner that is made clear to or acknowledged by the member. Efforts to ensure that members are not only aware of their plan but are also empowered to "drive" their plan are fundamental to the person-centered approach at the core of One Care. The only member demographic characteristics associated with having an ICP was education. Those with lower levels of education were

more likely to report having an ICP, suggesting that plans may be making a particular effort to ensure that certain members understand their ICP.

Certain enrollment characteristics were associated with whether members' reported that they had an ICP. Similar to reporting that they had an assessment of their needs, voluntarily enrolled members were more likely to report having a Care Plan than those passively enrolled. As with these other factors, voluntarily enrolled members were likely more actively engaged in the processes associated with involvement in One Care and may have been more aware of and/or more proactive in requesting their ICP. There were also differences across plans for this outcome, with members enrolled in Fallon Total Care more likely to report having an ICP than members in either Commonwealth Care Alliance or Tufts-Network Health (and members in Tufts-Network Health were more likely to report having an ICP than those in Commonwealth Care Alliance). Again, this finding mirrors the pattern seen across plans related to meeting with the Care Coordinator and in members' report of having an assessment, and points to the likely prime role that the Care Coordinator plays in communicating with members about their care plan.

Getting Care under One Care

Findings: Getting Care under One Care

Service Needs and Unmet Needs

The OC-MES asked members about their use of/needs for both specific medical services and specific LTSS, and sought to determine the extent to which members perceive that their needs for these services are being met under One Care (Table 12). The majority of members (94%) reported a need for at least one of the medical services asked about in the OC-MES.[9] Among the medical services, prescription medications was the service most widely needed by members (91%), followed by oral/dental care (78%), specialty care (e.g. gynecology, neurology, rheumatology) (62%), and mental health services (54%). Close to 40% of members reported a need for medical transportation services; 7% of members reported needing substance abuse services. Only 6% of members reported no need for any of the medical services asked about in the survey.

For the most part, members reported that their needs for medical services were being met ("very well" or "somewhat") under One Care. More than 80% of members' reported that their needs for prescription medications, specialty care, and mental health services were being met. Members who reported that their needs for a service were "not at all" being met were considered to have an unmet need for that service. About 17% of members reported unmet need for substance abuse services and medical transportation services, and notably, almost 22% of members reported unmet need for oral/dental care (members may need more specific information about dental services covered under One Care). Unmet need was lowest for prescription medications, at 2.6%.

While almost all members reported a need for at least one medical service, many fewer members reported using/needing LTSS. Fifty-nine percent of members reported needing at least one LTSS while 41% of members reported no need for any of the LTSS asked about in the OC-MES. The most

[9] Because it was assumed that all One Care members have a need for primary medical care services, the OC-MES did not include a question about need for primary care.

common LTSS that members reported needing included help with transportation to get places in the community (34%), medical equipment and supplies (27%), and help with personal care and everyday tasks (26%). About 8% of members reported needing assistive technology (Table 12).

Members needing LTSS, and those not needing these services, both represent large proportions of the One Care population. Because of this, logistic regression analysis was used to examine the association of member characteristics to the *need for LTSS*; the model showed several member enrollment, disability and demographic characteristics to be significantly associated with a LTSS need (**Table A-12** in Appendix A). Specifically, members who were included in Cohort 1 and Cohort 2 were significantly more likely to report a LTSS need than those in Cohort 3 (OR's=1.36 and 1.61, respectively). Having a physical disability more than doubled the odds of needing LTSS compared to those not identifying a physical disability (OR=2.17). Similarly, members identifying other conditions – including long-term illness, learning disability, and deaf/hearing loss – were all more likely to need LTSS compared to members not reporting these conditions (OR's=1.68, 1.48 and 1.82, respectively). In terms of demographic characteristics, members age 35-44 were more likely to report a need for LTSS than older members (age 55-64) (OR=1.49), as were those identifying their primary language as English compared to non-English (OR=2.18). The contrast analysis showed no significant differences in members' report of need for LTSS across the three One Care plans.

While overall fewer members reported a need for LTSS compared to medical services, members needing LTSS reported notably higher rates of unmet need compared to medical services (Table 12).

Table 12. Members' Need/Use of Medical Services and Long Term Services and Supports

	Do you use/need	If use/need, are needs being met under One Care: Very Well	Somewhat	Not at all
Medical Services	%	%	%	%
Prescription Medications	91.2	87.5	8.7	2.6
Oral and/or Dental Care	77.8	45.2	22.3	21.8
Specialty Care	62.0	66.1	21.2	7.9
Mental Health Services	54.0	69.5	15.2	9.8

Transportation to Medical Appointments	39.6	57.2	16.9	17.4
Substance Abuse	6.8	69.9	7.11	17.7
Long Term Services and Supports				
Help with Transportation and Getting Places	33.5	47.3	19.5	25.1
Medical Equipment and Supplies	27.4	57.3	23.8	15.7
Personal Care and Everyday Tasks	26.4	49.2	18.6	25.4
Help Doing Things in the Community	17.4	30.4	22.5	40.4
Day Program Services	10.8	46.9	19.0	27.1
Assistive Technology	7.8	22.7	13.0	56.6

While the rate of unmet need was relatively low for medical equipment and supplies, with only 16% of members reporting that their needs for this service were unmet, reported rates of unmet need were considerably higher for other types of LTSS, ranging from 25% to almost 57%. Among those needing the services, about 25-27% of members reported that their needs for help with personal care, help with transportation, and for day program services were not being met at all under One Care. More notable, the rates of unmet need for help doing things in the community and for assistive technology were 40% and almost 57%, respectively, for members who reported needing these services.

Logistic regression was used to examine the associations of member characteristics to *unmet needs for medical services, for oral/dental care services, and for LTSS*. Members reporting any unmet need for medical services (excluding oral/dental services) were considered to have an unmet medical service need, and members reporting any unmet need for LTSS were considered to have an unmet LTSS need. Because the rate of unmet need for oral/dental services was higher than the rate for other medical services, unmet need for oral/dental services was examined by itself.

Among members identifying any need for medical services, 16% reported an unmet need for at least one medical service (excluding oral/dental). The logistic regression model showed that members reporting a psychiatric disability (OR=1.61) or alcohol/drug abuse (OR=2.12) were significantly more likely to report having an unmet medical service need than those not reporting these conditions (**Table A-13** in Appendix A). Across the three younger age groups (21-34; 35-44; and 45-54), younger members were significantly more likely to report an unmet medical need compared to older members ages 55 to

64 years (ORs=2.10, 1.66 and 1.72, respectively). There were no significant differences in unmet need for medical services by other member characteristics, and there were no significant differences in unmet need for medical services across the three One Care plans.

Among members reporting a need for oral/dental services, 22% reported an unmet need for these services. The logistic regression model showed that members identifying as deaf/hearing loss were significantly more likely to report an unmet need for dental services compared to those not identifying as deaf/hearing loss (OR=1.63) (**Table A-14** in Appendix A). Additionally, those who had experienced homelessness in the past year were significantly more likely to report an unmet dental need than those not homeless (OR=4.24). Conversely, younger members (age 21-34) and those identifying as Latino/Hispanic were significantly less likely to report an unmet need for dental services in comparison to older (age 55-64) and non-Latino/Hispanic members (ORs=0.56 and 0.46, respectively). There were no significant differences in unmet need for dental services by other member characteristics, and there were no significant differences in unmet need for dental services across the three One Care plans.

Among members reporting any need for LTSS, 34% reported an unmet need for at least one long-term service. The logistic regression model showed that members reporting a learning disability were significantly more likely to report an unmet need for LTSS compared to those not reporting a learning disability (OR=1.78) (**Table A-15** in Appendix A). Additionally, members who identified their race as Black/African American and those identifying a race other than White (or Black/African American) were significantly more likely to report an unmet LTSS need compared to those identifying as White (ORs=1.77 and 2.17, respectively). There were no significant differences in unmet need for LTSS by other member characteristics, and there were no significant differences in unmet need for LTSS across the three One Care plans.

To further understand members' experiences in One Care in relation to LTSS, we examined whether those who identified both needs and unmet needs for the specific LTSS asked about in the OC-MES also reported wanting and meeting with a LTS Coordinator. Among members identifying the need for at least one LTSS, 51% reported that they need/want a LTS Coordinator (26% said "no" to this question and 20% said they were "not sure"). Further, among those identifying a need for LTSS, 53% reported meeting with a LTS Coordinator (34% said "no" to this question and 11% said they were "not sure"). Members who had met with a LTS Coordinator were significantly less likely to report an unmet LTSS need compared to those not meeting with a LTS Coordinator (22% vs. 49%, $p<.0001$).

Summary: Getting Care under One Care

Overall, findings from the OC-MES suggest that most members are getting their needs for certain medical services met under One Care. Rates of unmet need were low for several services used/needed by large proportions of One Care members – including prescription medications, specialty medical care and mental health services. In particular, a key goal of One Care is the integration of mental health services with other medical services, so it is encouraging that rate of unmet need for mental health services was relatively low. Exceptions to the overall low rates of unmet needs for medical services were the rates of unmet need for medical transportation and substance abuse services (at about 17% each), and particularly for oral/dental services, at 22%. There may be multiple reasons for the higher rates of unmet need for these services, including a lack of provider capacity or other access barriers (although there were no significant differences in the rates of unmet need for medical and dental services across the One Care plans). Of particular concern is the high rate of unmet need for dental services. Dental care is a core component of One Care and getting access to dental services was a major reason for enrolling in One Care for many members. Additional efforts on the part of One Care plans may be needed to address the unmet needs for dental and other services.

Logistic regression results pointed to certain member disability and demographic characteristics being associated with an unmet need for medical and/or dental services. Members reporting a psychiatric disability or alcohol/drug abuse were at a higher risk for unmet medical needs compared to those not reporting these conditions, highlighting the need for integration of mental health and medical services and collaboration across mental health and medical providers[10, 11]. Members identifying as deaf/hearing loss were at a higher risk for unmet dental needs compared to those not identifying as deaf/hearing loss, which may suggest a lack of capacity for adequately serving this population among dentists. Perhaps of even more concern, being homelessness in the past year increased fourfold the odds of having an unmet need for dental care compared to members not experiencing homelessness. This may not be surprising, given the general lack of access to dental care among people experiencing homelessness[12, 13], but should serve to highlight the need for One Care plans to ensure access to dental services for all members.

As expected, while the majority (over 90%) of members reported needs for medical services, many fewer reported needing LTSS. Almost 60% of members identified a LTSS need, and not surprisingly, certain disability/health conditions were strongly associated with the need for LTSS. For example, members reporting a physical disability more significantly more likely to need LTSS compared to members not reporting this condition. Members identifying other types of disability/health conditions, including long-term illness, learning disability, and deaf/hearing loss, were also more likely to report needing LTSS. Behavioral health conditions (i.e. psychiatric disability or substance abuse) and

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[10] American Hospital Association (2012, January). *TrendWatch: Bringing behavioral health into the care continuum: Opportunities to improve quality, costs and outcomes*. Washington DC: Author.

[11] Russell, L. (2010, October). *Mental health care services in primary care: Tackling the issues in the context of health care reform*. Washington DC: Center for American Progress.

[12] King, T. B., & Gibson, G. (2006). Oral health needs and access to dental care of homeless adults in the United States: A review. *Special Care in Dentistry, 23*(4), 143-147.

[13] Okunseri, C., Girgis, D., Self, K., Jackson, S., McGlinley, E. L., & Tarima, S. S. (2010). Factors associated with reported need for dental care among people who are homeless using assistance programs. *Special Care in Dentistry, 30*(4), 146-150.

developmental disability were not associated with an increased likelihood of needing LTSS.

In terms of demographic characteristics, members age 35-44 and those identifying their primary language as English were also more likely to report LTSS needs compared to older members (55-64) and those with a primary language other than English. The somewhat unexpected associations between these demographic characteristics and a reported need for LTSS may be due to a greater awareness of LTSS and the role these services can play in supporting community participation among younger and English-speaking members.

While it was expected that, overall, the number of One Care members needing LTSS would be lower than the number needing medical services, the markedly higher rates of reported unmet need for LTSS compared to medical services is noteworthy. While only a few member characteristics were associated with an unmet need for LTSS, the findings that members with a learning disability and those identifying as non-White (i.e. Black/African American or Other) were at a higher risk for unmet LTSS need suggest that particular efforts might be needed to ensure that the LTSS needs of these members are identified and addressed.

Overall, the fact that there were no differences in the rates of unmet LTSS need across One Care plans suggest a general need for improvement in access to and delivery of these services for the One Care program as a whole. The LTS Coordinator role can be a critical support to addressing the unmet need for LTSS. As discussed above, less than 30% of members who reported wanting/needing a LTS Coordinator had met with one, which may indicate both a need to expand the cadre of LTS Coordinators available to serve One Care members and a need for plans to make additional efforts to connect members to this service. Similarly, as discussed above, there appears to be a need for further education of members on the role of the LTS Coordinator, as many members said they were “not sure” if they wanted or had been offered a LTS Coordinator by their One Care plan. Both PCP and Care Coordinators should provide education to members about the availability of LTSS under One Care and the role of the

LTS Coordinator in assisting members to access these services. The finding that members who met with an LTS Coordinator were significantly less likely to report unmet LTSS needs provides evidence of the importance of this role and reinforces the need to ensure sufficient capacity.

It should be recognized that some members who identify an LTSS need may not want a LTS Coordinator. Findings from previous focus groups conducted under the Early Indicators Project suggest that not all members want an additional person involved with their care[14]. Some might prefer to have all their care managed by the Care Coordinator or other member of the ICT, including family members. Regardless, as the One Care program continues to develop and evolve, it seems clear that efforts are needed to better identify the reasons for, and to reduce, the unmet need for LTSS among One Care members.

[14] Henry, A. D., Long-Bellil, L., & Fishman, J. (2014). *Perceptions of One Care among eligible members: Results from four focus groups*. Shrewsbury, MA: University of Massachusetts Medical School, Center for Health Policy and Research.

Transitioning Into and Overall Perception of One Care

Findings: Transitioning into and Overall Perception of One Care

The last series of OC-MES questions asked members about their experience transitioning into One Care as well as their overall perception of One Care.

Moving into One Care

As shown in Table 13, over 85% of members reported finding the transition into One Care very or somewhat easy. Moving into One Care brought about a change in services or providers for some members; nearly 40% reported receiving a new service and 28% reported a change in a provider(s). Overall, 26% of members reported one or more negative experiences with the transition into One Care; 11% reported experiencing loss of a needed service; almost 14% reported a disruption in services; and nearly 15% reported not being able to access a needed provider(s). Over 54% of members reported that they were told they could dis-enroll from One Care at any time.

Table 13. Members' Experiences Transitioning into One Care

Overall, how easy or difficult was it to move into One Care?	%
Very easy	62.0
Somewhat Easy	23.3
Somewhat Difficult	6.5
Very Difficult	3.0
Don't know/not sure	1.7
Declined to answer	3.5
Which of the following, if any, happened to you when you moved to One Care?	
Got a new service I didn't have before	39.5
A change in providers	28.4
Couldn't access needed provider(s)	14.5
Disruption in a service	13.6
Loss of a needed service	11.1
None of the above	35.0
Don't know/not sure	0.0
Declined to answer	5.6
Did anyone tell you that you can drop out of One Care at any time?	
Yes	54.6
No	39.0
Don't know/not sure	1.8
Declined to answer	4.6

Although overall members found the move into One Care to be relatively easy, the logistic regression model showed some differences in whether the *move was perceived as easy* by member characteristics (**Table A-16** in Appendix A). Members voluntarily enrolling into One Care were significantly more likely to perceive the move into One Care as easy compared to those who were passively enrolled (OR=1.57). Conversely, those less likely to perceive the move as easy included members reporting a learning disability and those reporting homelessness in the past year compared to those not reporting a learning disability and those not reporting homelessness (ORs=0.57 and 0.45, respectively). Additionally, members who were employed in the past year were significantly less likely to perceive moving into One Care as easy compared to those not working (OR=0.38). Results of the contrast analysis showed that members enrolled in Commonwealth Care Alliance were more likely to perceive the move as easy compared to those in Tufts-Network Health (91% vs. 88%, p<.05); there were no other significant differences across plans in this outcome.

As noted above, about 26% of members reported one or more *disruptions to their care* with the move into One Care. The logistic regression model showed that members surveyed in Cohort 2 were significantly more likely to have reported a disruption in care compared to those in Cohort 3 (OR=1.70), as were members who experienced homelessness in the past year compared to those not experiencing homelessness (OR=1.72). Additionally, members who worked in the past year were more likely to report a disruption in care compared to those who did not work (OR=1.78) (**Table A-17** in Appendix A). Similar to above, the contrast analysis showed that members enrolled in Commonwealth Care Alliance were significantly less likely to report a disruption in care than members in Tufts-Network Health (23% vs. 29%, p<.05); additionally, there was a near significant difference between Commonwealth Care Alliance and Fallon Total Care in members' report of a disruption in care (23% vs. 30%, p<.06). There was no difference between Tufts-Network Health and Fallon Total Care in this outcome.

Overall Perception of One Care

As shown in Table 14, overall satisfaction with One Care appears quite high. Over 80% of members reported being extremely or somewhat satisfied with their One Care Plan, and almost 82% reported being extremely or somewhat satisfied with the services they are getting under One Care. Eighty-three percent reported that they intend to stay in One Care. Although less than 2% answered "no" to the question of whether they plan to stay in One Care, almost 12% answered "don't know/not sure".

Table 14. Overall Perception of One Care

Overall satisfaction with One Care Plan	%
Extremely Satisfied	54.8
Somewhat Satisfied	25.5
Neither Satisfied nor Dissatisfied	8.8
Somewhat Dissatisfied	3.7
Extremely Dissatisfied	2.5
Don't know/not sure	1.1
Declined to answer	3.7
Overall satisfaction with medical and other services under One Care	
Extremely Satisfied	59.5
Somewhat Satisfied	22.1
Neither Satisfied nor Dissatisfied	7.9
Somewhat Dissatisfied	2.8
Extremely Dissatisfied	2.6
Don't know/not sure	1.2
Declined to answer	3.8
Plan to stay in One Care	
Yes	83.4
No	1.9
Don't know/not sure	11.7
Declined to answer	3.0

The logistic regression model showed that members reporting a learning disability were significantly less likely to be *satisfied with their One Care plan* compared to those not reporting a learning disability (OR=0.58) (**Table A-18** in Appendix A). No other member characteristics were significantly associated with satisfaction with a One Care plan, and there were no significant differences in satisfaction across the three plans.

Although overall satisfaction with services received under One Care was high, the logistic regression model pointed to several member characteristics being associated with relatively lower satisfaction with services (**Table A-19** in Appendix A). Members reporting a physical/mobility disability and those reporting a learning disability were significantly less likely to report satisfaction with services (ORs=0.60 and 0.59, respectively) than those not reporting these conditions. Members who experienced homelessness within the past year were also less likely to report satisfaction with services compared to those not experiencing homelessness (OR=0.43), as were members identifying as gay, lesbian or bisexual compared to straight (OR= 0.47). Additionally, members who identified their race as Black/African American were less likely to be satisfied with their services under One Care compared to those identifying as White (OR=0.52). Conversely, members with less than a high school education were significantly more likely to report satisfaction with services (OR=1.82) compared to those with some college education. There were no significant differences in satisfaction with care under One Care across the three plans.

Finally, a large majority of members (83%) reported that they plan to stay in One Care and overall there were few differences in the rate of planning to stay in One Care by member characteristic. Members with less than high school education and those with a high school education or GED (i.e. passed General Educational Development tests) were significantly more likely to report planning to stay in One Care than those with some college education (ORs=2.45 and 1.50, respectively) (**Table A-20** in Appendix A). There were no significant differences in the plan to stay in One Care by other member characteristics. Results of the contrast analysis showed that members enrolled in Commonwealth Care Alliance were significantly more likely to report planning to stay in One Care compared to members in Fallon Total Care (89% vs. 83%, $p<.003$) and compared to members in Tufts-Network Health (89% vs. 83%, $p<.04$). There was no difference between Fallon Total Care and Tufts-Network Health in this outcome.

Summary: Transitioning into and Overall Perception of One Care

Overall, findings from the OC-MES suggest that the large majority of members (85%) found the transition into One Care to be easy, and that about 40% of members experienced a positive change with the transitions – namely getting a new service that they did not have before. About one-quarter of members reported experiencing a disruption in care or other negative incident with the transition to One Care. Not surprisingly, members who had voluntarily enrolled in One Care were more likely to find the transition easy compared to passively enrolled members. Because voluntarily enrolling members had actively sought participation in One Care, it is likely that these members had a better understanding of the program and of what to expect with the transition to One Care than passively enrolled members.

There were some parallel findings in the associations of member characteristics to perceiving the move to One Care as easy and experiencing a disruption with the move. Specifically, compared to those who were not homeless, members who reported homelessness in the past year were less likely to perceive the move as easy (91% vs. 81%) and were more likely to report a negative experience related to their care (25% vs. 35%). A subsequent analysis showed a significant difference between members reporting and not reporting homelessness in relation to their experience with their PCP, which may account, in part, for these more negative experiences during the transition to One Care among members with a recent history of homelessness. Compared to those not homeless, members reporting homelessness were less likely to have stayed with the same PCP with the move to One Care (69% vs. 58%), and were more likely to say that they do not have a PCP (3% vs. 6%) or do not know if they have a PCP (4% vs. 11%) ($p<.0007$).

Similarly, compared to those not working, members who were employed in the past year were less likely to perceive the move as easy (92% vs. 81%) and were more likely to report a negative experience related to their care (25% vs. 33%). For working members, managing the sometimes competing demands of work and health care needs can make it more difficult to arrange times to meet

with providers and can result in service disruptions. In addition, it may be that One Care providers were less accommodating of the scheduling and related needs of working members during the transition to the program.

In general, across all three One Care plans, members perceived the move into the program as easy. However, it appears that the transition was somewhat easier for members enrolled in Commonwealth Care Alliance. As previously noted, members in Commonwealth Care Alliance were more likely to have stayed with the same PCP than members in other the other two plans, and this may account for the differences that were observed across plans for this outcome.

Overall, results of the OC-MES show that members' satisfaction with their One Care plan, as well as the care they receiving under One Care, to be quite high, with over 80% of members expressing satisfaction (either extremely or somewhat satisfied) with their plan and their care. Moreover, there were no significant differences in satisfaction across the three One Care plans. However, the survey results did show a number of member disability and demographic characteristics to be associated with relatively lower satisfaction, especially with care under One Care. Specifically, members who reported a physical disability or a learning disability, those who had been homeless in the past year, those identifying as gay, lesbian or bisexual, those identifying as Black/African American, and those with a higher level of education all had lower satisfaction with the medical and other services (compared to those not reporting these characteristics). While these findings should be considered in light of the overall high satisfaction among all One Care members, they do suggest that certain members, particularly if they represent more than one of these characteristics (e.g. a member with a physical disability who is African American) may be at an increased risk for dissatisfaction with the program. Moreover, the findings speak to the ongoing need to monitor the program to ensure that One Care is addressing and meeting the needs of all members.

Finally, although overall rates of planning to stay in One Care were high across all three plans, members in Commonwealth Care Alliance were significantly more likely to say that they planned to stay in One Care compared to members in Fallon Total Care and Tufts-Network Health. As previously discussed, members in Commonwealth Care Alliance were more likely to have stayed with their PCP when they moved to One Care in comparison to members in the other two plans. It may be that members in Commonwealth Care Alliance, who presumably have more stable and long-lasting relationships with their PCPs and other providers compared to the other two plans, experienced the move to One Care as less of an overall change to their care than other members and are thus less inclined to want to leave One Care.

Discussion and Conclusions

Discussion

The goal of the One Care Early Indicators Project has been to examine the experiences of MassHealth members eligible for and enrolled in One Care during the first year of the implementation of the demonstration. Fielded between June 2014 and January 2015, the ***One Care 2014 Member Experience Survey*** gathered information on the experiences and perceptions of members during the first months they were enrolled in a One Care plan, examining members' experience with the enrollment process; their interactions with and perceptions of their Care Team and their experiences of the assessment and care planning process; the extent to which their needs for medical services and LTSS are being met; and their overall satisfaction with and intention to stay in One Care.

On the whole, the **overall findings** from the OC-MES are very encouraging, and point to a high level of satisfaction among members enrolled in One Care. Over 80% of members said they are somewhat or extremely satisfied with both their One Care plan and the services they are receiving under One Care, and over 83% indicated that they plan to stay in One Care. It is noteworthy that satisfaction with and intention to stay in One Care did not differ significantly between voluntarily and passively enrolled members, suggesting that the demonstration is equally effective in serving both types of enrolled members. Moreover, for the most part, members found the process of enrolling in One Care easy, and although about one-quarter of member experienced some sort of disruption in service during the transition, the majority of members described the move into One Care as easy.

The OC-MES was designed to examine members' experiences with some core components of the One Care model, including their experiences with key members of their **Interdisciplinary Care Team (ICT)** – the Primary Care Provider (PCP), the Care Coordinator and the LTS Coordinator, as well as their impressions of the assessment and care planning process. Survey findings brought to light some differences in members' experiences with these team members. More broadly, the findings suggest that the core components of the One Care model may not have been effectively explained to or well

understood by all members. In particular, the findings showed relatively high rates of "not sure" responses regarding whether members want, need or had been offered a LTS Coordinator, as well as whether they have an Individual Care Plan.

Almost 90% of members reported having a PCP (a small percentage gained a PCP with the move to One Care), the majority of these members had met with their PCP since enrolling in the program, and overall satisfaction with PCPs was very high. While meeting with the PCP was quite common, fewer members reported meeting with a Care Coordinator (51%). Given that the Care Coordinator is a core feature of One Care, and there is an expectation that all members will have a Care Coordinator, this rate is lower than anticipated. About 7% of members said they were not sure if they had been contacted by a Care Coordinator, suggesting that there may be a lack of understanding of this role in the ICT among some members. Additionally, some members may have declined to meet with the Care Coordinator.

There appear to be some differences across plans with respect to the Care Coordinator role. Fallon Total Care, and to a lesser extent Tufts-Network Health, in keeping with the One Care model, appears to have placed greater emphasis on involving and establishing the role of the Care Coordinator. In contrast, Commonwealth Care Alliance, which grew out of a health group structured around PCP-based care management, seems to have maintained enrollees' existing relationships with their PCP in its approach to implementing One Care. However, across all plans, satisfaction with the Care Coordinator was high among members who met with this member of the ICT. Moreover, most members reported meeting with the Care Coordinator within three months of enrolling in One Care, consistent with expectations of the model.

Notably, fewer members reported meeting with a LTS Coordinator. As discussed previously, not all members in One Care will need an LTS Coordinator, and even members who use LTSS may not want the additional services of a LTS Coordinator. However, only about 30% of members who said they wanted the service reported meeting with an LTS Coordinator. OC-MES findings suggest that there may

be some confusion or misunderstanding of the LTS Coordinator role among members, as many said they were not sure if they had been offered or had met with this member of the ICT. Previous collaborations between MassHealth, the One Care plans, and community stakeholders to educate members and providers about the LTS Coordinator role include the creation of a joint working group that developed a one-page information sheet on the role geared specifically toward members, as well as a dedicated webinar geared toward One Care plan staff and providers. Additional effort is needed to ensure that the One Care program effectively communicates the role and its value to members, and to address what appears to be a lack of availability of LTS Coordinator services to ensure that members have meaningful access to this service, including through consistent referral. These areas are particularly important given the findings that members meeting with a LTS Coordinator reported high satisfaction and were less likely to report unmet LTSS needs.

Although the OC-MES was not designed to capture evidence of communication or coordination among members of the ICT, findings did show that members meeting with their PCP were also significantly more likely to meet with a Care Coordinator and as well as with a LTS Coordinator. As One Care continues to roll out and evolve, further investigation of whether and how plans, providers and ICTs are fully working to implement the person-centered, integrated approach underlying One Care may be valuable.

In addition to examining members' experiences with their Care Team, the OC-MES gathered information on whether members' felt their **needs for medical services and LTSS were assessed and are being met** under One Care. Only two-thirds of members reported that someone from their Care Team met with them to assess their need. However, among these members, perceptions of the assessment process were quite positive and overall satisfaction was high. Members felt their preferences, goals and strengths were considered, that their needs were identified, and that they were treated with respect during the assessment. It is quite possible that One Care plans did, in fact, conduct assessments for

many of the other one-third of members, but not in a way that was made explicit or communicated clearly to the member. As was observed in members' responses to questions about LTS Coordinators and Individual Care Plans, there is significant room for improving the way these core elements of the One Care model are explained and delivered to members.

For the most part, the rates at which members reported that their medical services needs were assessed were quite high (75% and higher for medications, mental health services, transportation, oral/dental care, and specialty medical care); a notable exception was substance abuse services, at 59%. That 83% of members reported that their needs for mental health services were address is particularly positive, as integration of medical and behavioral health care is a key goal of One Care. In addition to medical needs being assessed, findings from the OC-MES suggest that the majority of members feel that their needs for key medical services are being met under One Care.

In general, among members needing the services, reported rates of unmet need for medical services were low, particularly for prescription medications, specialty care and mental health services. Rates of unmet need for substance abuse services and dental services were notably higher than for other services. These findings may be related to a general lack of availability of substance abuse providers and dentists to serve the One Care population, and suggest the need for ongoing efforts to ensure that members' needs in these areas are assessed and addressed.

While the large majority of members (94%) reported a need for at least one medical service, many fewer members (59%) reported a need for LTSS. Although it was expected that not all One Care members will need LTSS, it is notable that overall members stated their needs for LTSS were less frequently assessed than were their needs for medical services. In particular, over 30% of members reported that their needs for assistance with community activities, day program services and assistive technology were not assessed (and many members were not sure if their needs for these services were assessed). Perhaps more compelling are the notably higher rates of unmet need for LTSS compared to

medical services. Unmet need for LTSS ranged from almost 16% for medical equipment and supplies to almost 57% for assistive technology. As previously discussed, OC-MES findings suggest that some members may not fully understand LTSS and the extent to which these services are available under One Care, as well as the role of the LTS Coordinator in helping members to access these services. Again, these findings speak to the need for the One Care program and its stakeholders to continue to build on previous work to educate members and One Care providers about LTSS and to the need to expand capacity among community-based provider organizations that offer LTSS and LTS Coordination services.

In general, **satisfaction was equally high across the three One Care plans.** There were no significant differences across the plans on several outcomes related to satisfaction, including: members' satisfaction with their Care Team (including PCP, Care Coordinator and LTS Coordinator); satisfaction with the assessment process; satisfaction with care received under One Care; and satisfaction with their One Care plan. However, OC-MES findings suggest that there may be some differences in approaches to implementing One Care across the three plans, at least in the early stages, particularly related to the roles of the PCP and the Care Coordinator. As suggested above, Commonwealth Care Alliance may have placed greater emphasis on the involvement of the PCP during members' first few months in One Care, while Fallon Total Care, and to a lesser extent Tufts-Network Health, may have placed greater emphasis on involving and establishing the role of and members' relationships with a Care Coordinator. Some of this observed difference may be attributed to the fact that members in Commonwealth Care Alliance were more likely to have stayed with their PCP when they transitioned into One Care than members in the other plans, with this continuity making it easier for member to meet with their PCP. On the other hand, Fallon Total Care and Tufts-Network Health may have focused on establishing the role of the Care Coordinator, particularly as a strategy for engaging with members for the first time. Finally, member in Commonwealth Care Alliance were more likely to say that they intended to stay in One Care compared to the other two plans, although these rates were high (over 80%) for all three plans. Again, this

difference is likely attributable to the more long-standing relationships that members in Commonwealth Care Alliance have had with their PCPs compared to the other two plans.

Finally, for the most part, the OC-MES findings pointed to **few disparities in members' experiences in One Care** related to disability or demographic characteristics. Notably there were no differences between voluntarily and passively enrolled members in satisfaction with the Care Team members, satisfaction with their One Care plan and services under One Care, or in the intention to stay in One Care. However, some disparities or differences were observed across disability or demographic characteristics. Examples of disparities related to disability characteristics included:

- Members reporting a learning disability were less likely to perceive enrolling in and the transition to One Care as easy, and were more likely to report an unmet need for LTSS (compared to those not reporting learning disability)
- Members reporting a psychiatric disability or substance abuse were more likely to report an unmet medical service need (compared to those not reporting psychiatric disability or substance abuse)
- Members identifying as deaf/hearing loss were less likely to find information about One Care easy to understand and were more likely to report an unmet need for dental services (compared to those not identifying as deaf/hearing loss)

Examples of some of the disparities observed related to demographic characteristics included:

- Men were less likely to have met with a PCP (compared to women)
- Younger members were more likely to report an unmet medical need (compared to older members)
- Members identifying as gay, lesbian or bisexual were less likely to have met with a PCP and were less likely to be satisfied with their PCP (compared to those identifying as straight)
- Latino/Hispanic members were less likely to be satisfied with the Care Coordinator (compared to members who were non-Latino/Hispanic)
- Members identifying their race as Black/African American or as other than White were more likely to report an unmet LTSS need, and those identifying as Black/African American were less satisfied with their services under One Care (compared to those identifying as White)
- Members who were homeless in the past year were less likely to perceive the transition to One Care as easy, were more likely to experience a disruption with the transition to One Care, were more likely to identify an unmet need for dental services, and were less likely to report satisfaction with services under One Care (compared to those who had not experienced homelessness)

Although statistically significant, some of the actual differences related to member characteristics were relatively small, and should be considered in light of the overall survey findings. However, these observed differences do serve to highlight the need for ongoing efforts to ensure the cultural

competencies of plans and providers to fully meet the needs of the diverse group of people served under One Care.

Limitations

Because the findings in this report relied exclusively on survey data, certain limitations need to be acknowledged. As is true of surveys in general, the OC-MES captured members' perceptions of their experiences in One Care; we made no effort to "verify" their reports of their experiences against any other data source (e.g. MassHealth data or data from the One Care plans). In addition, the OC-MES findings provide a "point-in-time" reflection on members' experiences during the first few months they were enrolled in One Care. The findings of the survey do not capture or predict members' longer term experiences or future trends in the program.

Moreover, it is possible that the perspectives of certain One Care members are not fully represented in the findings. For example, the OC-MES was only available in English and Spanish, and thus findings may not be generalizable to One Care members whose primary language is other than English or Spanish. Similarly, because the survey sample included only a very small number of member who identified as transgender or asexual, and only a small number who identified their race as other than White or Black/African American, the findings provide very limited information on the experiences of these members. Additionally, a large number of members could not be reached by telephone despite numerous attempts; there may be something unique about these members that we failed to capture.

Finally, the OC-MES was designed to explore the experiences of members who were enrolled – either voluntarily or passively – in One Care. This report provides no information on the perceptions and experiences of dually-eligible members who have chosen not to enroll in the demonstration.

Conclusion and Recommendations

While there is clearly room for improvement, the findings from the OC-MES point to much that is positive in this first year of the implementation of One Care. The three key conclusions that can be drawn from survey results include:

1. Overall satisfaction with the program is quite high and the large majority of members intend to stay in One Care.
2. There is a need to more meaningfully educate and engage members to fully understand core aspects of the One Care model, specifically the role and benefits of working with the LTS Coordinator, the importance of identifying their LTSS needs, and their own role in driving the care planning process. Continued education on these points is needed, as well, for One Care plans' staff and providers.
3. There is continuing need to focus on strategies to ensure access to the LTS Coordinator by developing sufficient capacity within the system to support consistent referral to an LTS Coordinator.

The OC-MES and the efforts of the One Care Early Indicators Project have **resulted in actionable findings** suggesting areas for improvement and monitoring of the program as it continues. These actionable results are not surprising, will support both MassHealth and the One Care plans to address identified issues, and provide concrete information on which to set goals for the continued implementation of the demonstration.

Recommendations. OC-MES findings point to several areas where action is appropriate.

- Focus on certain populations of One Care members is warranted, including but not limited to gay/lesbian/bisexual members; members who are deaf or hard of hearing; members with learning disabilities; and members identifying as Black/African American, in order to ensure continued and improved provision of and satisfaction with services under One Care to these members.
- MassHealth and One Care plans should continue to emphasize educating members about the role and benefits of working with a LTS Coordinator, while respecting that not everyone with an

LTSS need truly wants to do so (37% said they did not want a LTS Coordinator). In particular, Care Coordinators and PCPs should play a lead role in explaining the LTS Coordinator role to members, and in reinforcing this information in an on-going manner.

- Further, lower rates at which LTSS needs appear to be assessed, the fact that many members were not sure if their needs for LTSS were assessed, and the level of reported unmet LTSS needs suggest that MassHealth, the One Care plans and providers, should focus attention on LTSS assessment and service provision. As well, the plans, advocates and stakeholders must strive to ensure better understanding among members of the potential benefits of both identifying their LTSS needs, and of working with a LTS Coordinator. Better understanding of the program model and benefits to members will support fuller integration of these services.
- The One Care plans, advocates and community based organizations need to ensure sufficient numbers of and training for LTS Coordinators in order to build and maintain appropriate capacity of this important component of One Care and allow for consistent referral to an LTS Coordinator.
- A core goal of One Care is the integration of mental health services with other medical services. While survey results show that plans have achieved broad success in this area, there appears to be room for improvement in assessing and addressing members' needs for substance abuse services, as well.
- One Care plans should place increased attention to identifying and addressing the dental health needs of members, in particular related to covered dental services that are appropriately indicated for the member. Access to dental services is an important reason why many members enroll.
- The One Care Implementation Council should work actively with MassHealth and One Care plans to develop and implement interventions to address gaps identified in the early indicators findings.

One Care is clearly a successful program that can move toward better fulfillment of the promise of this integrated model. MassHealth and One Care plans should continue to build on the implementation of this important approach to providing integrated care to meet the complex needs of members, who show high levels of satisfaction with the program overall. As was the goal of the Early Indicators Project and this survey in particular, actionable results were obtained and will help to guide MassHealth and the One Care plans as they continue to implement this program, fulfill its goals and better serve the complex needs of its members.

Appendix A: Tables A-1 to A-20. Results of Logistic Regression Analyses

A Note on Logistic Regression

As previously discussed, we generated logistic regression models to determine the associations between the outcomes that we examined, such as *met with a PCP* or *satisfied with Care Coordinator* or *has unmet LTSS needs*, and each member characteristic, such as *gender* or *race* or *disability type*, while controlling for other member characteristics. In logistic regression, the outcome (sometimes called the dependent variable) is always categorical and *dichotomous* (i.e. with two categories). Thus, for the outcome *met with a PCP*, the two categories were *yes* (met with PCP) or *no* (did not meet with PCP). For the outcome *satisfied with Care Coordinator,* the categories were *satisfied* or *not satisfied*. The member characteristics we examined included enrollment, disability and demographic characteristics. These characteristics (sometimes called the independent variables) were also categorical, with two or more categories. An example of a member enrollment characteristic that we examined with two categories was *enrollment method*; the categories were *voluntarily enrolled* and *passively enrolled*. An enrollment characteristic with three categories was *plan*; the categories were *Commonwealth Care Alliance*, *Fallon Total Care* and *Tufts-Network Health*. An example of a disability characteristic with two categories was *physical disability*; categories were *yes* (member reported physical disability) or *no* (member did not report physical disability).

Logistic regression models estimate the association between the member characteristic (e.g. enrollment method) and the outcome (e.g. met with PCP); for example, whether persons that voluntarily enrolled were more likely to meet with their PCP compared to those who were passively enrolled. The key statistic generated by logistic regression is the Odds Ratio (OR), which provides an estimate of the association between the outcome and the member characteristic. An OR greater than 1.0 indicates the characteristic is associated with increased likelihood of the outcome and an OR of less than 1.0 indicates the characteristic is associated with decreased likelihood of the outcome. An OR of 1.0 indicates that there is no association between the outcome and the member characteristic.

We cannot determine from the OR alone whether the estimated association occurred by chance or because of a true association. To do this, we use statistical significance. The general standard for considering something statistically significant is when there is a 95% probability that the association is true and only a 5% probability that it is by chance. In logistic regression models, ORs are generated along with "confidence intervals" (a lower and upper value) which provide an estimate of range where the "true" OR lies. A 95% confidence interval indicates that there is a 95% probability that the true odds lies within the range of the confidence interval. Confidence intervals that contain 1.0 indicate that we cannot determine with statistical certainty whether there is a true association between the outcome and member characteristic; that is, whether the characteristic is associated with increased or decreased likelihood of the outcome. **In the tables that follow, ORs and 95% confidence intervals that indicate a statistically significant association are bolded.** Whether an association is statistically significant depends not just on the size of the OR, but also the size of the sample and the variability in the outcome and the member characteristics.

Lastly, it is important to note that logistic regression models require that there are no missing data. Thus, for each of the 20 outcomes we examined, only members who had valid a response or answer to each of the questions included in the model (both the outcome question as well as the questions on member characteristics) could be categorized and be included in the analyses. For example, members who responded "don't know/not sure" or declined to answer the question "*have you met with your PCP*" cannot be categorized as "*yes*" (met with PCP) or "*no*" (did not meet with PCP). Similarly, members who did not answer the question "*what is your age now*," cannot be categorized by age. Members with any missing data were not included in the analysis for the outcome being examined.

Table A-1. Association of member characteristics to ease of enrolling in One Care among voluntarily enrolled members

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Interval**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	95.2 (280)	0.15	0.02-1.34
	2	95.6 (214)	0.16	0.02-1.36
	3	97.4 (148)	Ref	Ref
Plan	Commonwealth Care Alliance	95.7 (368)	1.85	0.50-6.73
	Fallon Total Care	97.6 (168)	3.37	0.46-24.73
	Tufts Health Plan–Network Health	91.5 (105)	Ref	Ref
Disability/Health Condition				
Reported conditions	Physical disability	96.5 (367)	1.71	0.61-4.77
	No physical disability	95.0 (275)	Ref	Ref
	Psychiatric disability	95.6 (464)	0.41	0.11-1.50
	No psychiatric disability	96.4 (178)	Ref	Ref
	Substance Abuse	96.8 (60)	2.36	0.25-22.07
	No substance abuse	95.7 (582)	Ref	Ref
	Long-term illness	95.3 (306)	0.92	0.32-2.65
	No long-term illness	96.3 (336)	Ref	Ref
	Developmental disability	95.5 (73)	2.44	0.53-11.30
	No developmental disability	95.9 (569)	Ref	Ref
	Learning disability	**92.8 (159)**	**0.19**	**0.04-0.84**
	No learning disability	96.9 (483)	Ref	Ref
	Blind/visual impairment	94.1 (182)	0.90	0.27-3.00
	No blind/visual impairment	96.5 (460)	Ref	Ref
	Deaf/ Hearing Loss	95.2 (88)	1.64	0.55-4.94
	No deaf/hearing loss	95.9 (554)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	95.8 (41)	0.51	0.11-2.50
	Not homeless in past year	95.7 (584)	Ref	Ref
Age	21-34	97.7 (45)	3.37	0.32-35.28
	35-44	98.7 (104)	4.71	0.56-39.60
	45-54	94.3 (222)	0.79	0.29-2.16
	55-64	95.4 (255)	Ref	Ref

Gender	Male	95.8 (284)	0.81	0.31-212
	Transgender/intersex	(--)	(--)	(--)
	Female	96.8 (351)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	97.3 (48)	3.90	0.46-33.32
	Asexual	(--)	(--)	(--)
	Straight	96.0 (558)	Ref	Ref
Race	Black/African American	96.8 (79)	0.81	0.15-4.38
	Other	92.2 (95)	0.40	0.11-1.42
	White	96.1 (435)	Ref	Ref
Ethnicity	Latino/Hispanic	93.7 (101)	1.10	0.17-6.91
	Non-Latino/Hispanic	96.2 (511)	Ref	Ref
Primary language	English	96.1 (539)	1.65	0.43-6.32
	Non-English	92.7 (68)	Ref	Ref
Education	Less than high school	93.5 (118)	0.85	0.27-2.66
	High school/GED	96.7 (213)	1.48	0.52-4.25
	Some college or 2-yr degree	96.0 (284)	Ref	Ref
Employment	Worked in past year	95.7 (98)	0.55	0.16-1.88
	Did not work in past year	95.8 (535)	Ref	Ref

*Weighted percentage of members reporting that *enrolling was very/somewhat easy* (OC-MES Question 5). N's are non-weighted, showing the number of members with that characteristic who responded to Question 5.
Ref=reference (comparison) group. Statistically significant ORs and 95% CIs are bolded.
(--) data not reported due to small sample size ($\leq$5).

Table A-2. Association of member characteristics to ease of understanding information from MassHealth among passively enrolled members

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Interval**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	84.8 (267)	1.20	0.67-2.15
	2	78.4 (240)	0.92	0.53-1.62
	3	82.2 (268)	Ref	Ref
Plan	Commonwealth Care Alliance	85.4 (317)	1.06	0.49-2.30
	Fallon Total Care	79.6 (348)	0.69	0.32-1.47
	Tufts Health Plan–Network Health	81.3 (110)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	81.6 (445)	0.75	0.45-1.26
	No physical disability	83.7 (330)	Ref	Ref
	Psychiatric disability	81.4 (514)	0.78	0.45-1.33
	No psychiatric disability	84.9 (261)	Ref	Ref
	Substance Abuse	78.5 (72)	0.67	0.30-1.49
	No substance abuse	83.0 (703)	Ref	Ref
	Long-term illness	82.0 (369)	1.42	0.84-2.42
	No long-term illness	83.0 (406)	Ref	Ref
	Developmental disability	77.9 (83)	0.55	0.25-1.18
	No developmental disability	83.1 (692)	Ref	Ref
	Learning disability	81.2 (211)	1.10	0.62-1.95
	No learning disability	83.0 (564)	Ref	Ref
	Blind/visual impairment	81.7 (226)	0.90	0.53-1.51
	No blind/visual impairment	82.8 (549)	Ref	Ref
	Deaf/hearing loss	**71.8 (112)**	**0.53**	**0.28-0.99**
	No deaf/hearing loss	84.4 (663)	Ref	Ref
Homelessness	Homeless in past year	71.5 (57)	0.63	0.28-1.40
	Not homeless in past year	83.4 (697)	Ref	Ref
Age	21-34	**87.4 (62)**	**3.41**	**1.26-9.24**
	35-44	78.0 (127)	0.93	0.50-1.73
	45-54	83.3 (263)	1.26	0.69-2.30
	55-64	82.5 (308)	Ref	Ref

Gender	Male	82.8 (366)	0.96	0.57-1.62
	Transgender/intersex	(--)	(--)	(--)
	Female	83.2 (394)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	79.0 (44)	0.89	0.37-2.18
	Asexual	83.6 (10)	0.44	0.09-2.19
	Straight	82.9 (668)	Ref	Ref
Race	Black	81.8 (109)	0.73	0.37-1.47
	Other	77.2 (155)	0.69	0.34-1.42
	White	84.3 (439)	Ref	Ref
Ethnicity	Latino/Hispanic	81.5 (190)	0.60	0.25-1.44
	Non-Latino/Hispanic	83.4 (529)	Ref	Ref
Primary language	English	82.5 (591)	0.65	0.28-1.50
	Non-English	84.8 (141)	Ref	Ref
Education	Less than high school	85.7 (188)	1.35	0.66-2.80
	High school/GED	82.4 (275)	1.26	0.74-2.14
	Some college or 2-yr degree	80.4 (280)	Ref	Ref
Employment	Worked in past year	79.0 (115)	0.62	0.33-1.14
	Did not work in past year	83.6 (647)	Ref	Ref

*Weighted percentage of members reporting that *MassHealth information was very/somewhat easy to understand* (OC-MES Question 3b). N's are non-weighted showing the number of members with that characteristic who responded to Question 3b. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size ($\leq$5).

Table A-3. Association of member characteristics to meeting with Primary Care Provider (PCP)

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	88.0 (624)	1.31	0.87-1.96
	2	80.1 (544)	1.02	0.69-1.52
	3	81.5 (515)	Ref	Ref
Plan	Commonwealth Care Alliance	87.4 (766)	1.32	0.79-2.20
	Fallon Total Care	79.7 (657)	0.76	0.46-1.24
	Tufts Health Plan – Network Health	84.6 (260)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	**88.6 (636)**	**1.48**	**1.01-2.18**
	Passively enrolled (MassHealth chose plan)	81.6 (996)	Ref	Ref
Disability/Health Conditions				
Reported Condition	Physical disability	**87.3 (971)**	**1.64**	**1.15-2.32**
	No physical disability	80.1 (712)	Ref	Ref
	Psychiatric disability	84.6 (1154)	1.27	0.86-1.87
	No psychiatric disability	83.6 (529)	Ref	Ref
	Substance Abuse	78.9 (153)	0.65	0.38-1.10
	No substance abuse	84.8 (1530)	Ref	Ref
	Long-term illness	86.7 (811)	1.18	0.83-1.68
	No long-term illness	82.0 (872)	Ref	Ref
	Developmental disability	82.4 (175)	0.62	0.35-1.09
	No developmental disability	84.5 (1508)	Ref	Ref
	Learning disability	84.3 (447)	1.11	0.73-1.68
	No learning disability	84.3 (1236)	Ref	Ref
	Blind/visual impairment	86.4 (512)	1.12	0.75-1.67
	No blind/visual impairment	83.4 (1171)	Ref	Ref
	Deaf/hearing loss	88.9 (251)	1.57	0.91-2.70
	No deaf/hearing loss	83.4 (1432)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	76.8 (113)	0.59	0.32-1.08
	Not homeless in past year	84.9 (1539)	Ref	Ref
Age	21-34	78.5 (131)	0.70	0.37-1.32
	35-44	78.1 (285)	0.64	0.40-1.03
	45-54	84.0 (564)	0.72	0.48-1.10

	55-64	88.4 (677)	Ref	Ref
Gender	Male	**81.4 (799)**	**0.66**	**0.47-0.94**
	Transgender/intersex	(--)	(--)	(--)
	Female	87.2 (863)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	**76.8 (97)**	**0.52**	**0.29-0.94**
	Asexual	74.3 (19)	0.39	0.13-1.20
	Straight	85.0 (1467)	Ref	Ref
Race	Black	80.5 (221)	0.63	0.38-1.05
	Other	83.9 (330)	1.01	0.59-1.74
	White	85.4 (1026)	Ref	Ref
Ethnicity	Latino/Hispanic	82.3 (363)	0.60	0.32-1.15
	Non-Latino/Hispanic	85.0 (1228)	Ref	Ref
Primary language	English	83.8 (1323)	0.76	0.37-1.57
	Non-English	84.8 (282)	Ref	Ref
Education	Less than high school	86.3 (388)	1.53	0.95-2.48
	high school/GED	84.1 (590)	1.26	0.86-1.83
	Some college or 2-yr degree	83.6 (646)	Ref	Ref
Employment	Worked in past year	85.4 (263)	1.28	0.79-2.06
	Did not work in past year	84.2 (1403)	Ref	Ref

*Weighted percentage of members reporting that they *met with PCP since enrolling in One Care* (OC-MES Question 8b). N's are non-weighted. N's are non-weighted showing the number of members with that characteristic who responded to Question 8b. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size ($\leq$5).

Table A-4. Association of member characteristics to satisfaction with Primary Care Provider (PCP)

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	94.1 (584)	0.83	0.44-1.56
	2	93.2 (488)	0.87	0.44-1.71
	3	94.7 (460)	Ref	Ref
Plan	Commonwealth Care Alliance	94.6 (707)	1.22	0.59-2.54
	Fallon Total Care	93.7 (582)	1.06	0.49-2.30
	Tufts Health Plan – Network Health	92.9 (243)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	94.1 (592)	1.09	0.64-1.87
	Passively enrolled (MassHealth chose plan)	93.9 (898)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	93.0 (893)	0.58	0.32-1.04
	No physical disability	95.7 (639)	Ref	Ref
	Psychiatric disability	93.3 (1048)	0.65	0.34-1.23
	No psychiatric disability	96.0 (484)	Ref	Ref
	Substance Abuse	93.0 (123)	1.32	0.42-4.16
	No substance abuse	94.2 (1409)	Ref	Ref
	Long-term illness	93.0 (751)	0.67	0.40-1.14
	No long-term illness	95.3 (781)	Ref	Ref
	Developmental disability	97.2 (159)	2.35	0.56-9.89
	No developmental disability	93.8 (1373)	Ref	Ref
	Learning disability	92.9 (403)	0.67	0.38-1.19
	No learning disability	94.6 (1129)	Ref	Ref
	Blind/visual impairment	93.1 (468)	0.91	0.53-1.56
	No blind/visual impairment	94.6 (1064)	Ref	Ref
	Deaf/hearing loss	93.9 (229)	1.25	0.62-2.50
	No deaf/hearing loss	94.2 (1303)	Ref	Ref
Demographic Characteristics				
Homelessness	Homeless in past year	93.6 (92)	1.20	0.38-3.84
	Not homeless in past year	94.1 (1413)	Ref	Ref
Age	21-34	93.0 (118)	0.89	0.36-2.23
	35-44	92.6 (250)	0.84	0.41-1.75
	45-54	94.1 (515)	1.29	0.67-2.47

	55-64	94.7 (626)	Ref	Ref
Gender	Male	95.0 (717)	1.32	0.73-2.37
	Transgender/intersex	(--)	(--)	(--)
	Female	93.5 (796)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	**86.5 (80)**	**0.37**	**0.16-0.86**
	Asexual	96.8 (14)	2.34	0.23-23.93
	Straight	94.5 (1354)	Ref	Ref
Race	Black	93.8 (204)	0.80	0.35-1.83
	Other	94.1 (289)	1.30	0.55-3.09
	White	94.0 (947)	Ref	Ref
Ethnicity	Latino/Hispanic	93.8 (321)	0.81	0.24-2.71
	Non-Latino/Hispanic	94.2 (1127)	Ref	Ref
Primary language	English	94.0 (1209)	1.65	0.59-4.58
	Non-English	93.8 (253)	Ref	Ref
Education	Less than high school	96.0 (357)	1.96	0.81-4.77
	high school/GED	93.6 (543)	1.02	0.57-1.83
	Some college or 2-yr degree	93.1 (580)	Ref	Ref
Employment	Worked in past year	94.5 (244)	1.03	0.50-2.13
	Did not work in past year	94.0 (1273)	Ref	Ref

*Weighted percentage of members reporting being *extremely/somewhat satisfied with PCP* (OC-MES Question 7c).
N's are non-weighted showing the number of members with that characteristic who responded to Question 7c.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size ($\leq$5).

Table A-5. Association of member characteristics to meeting with a Care Coordinator

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	**64.3 (598)**	**1.45**	**1.07-1.97**
	2	61.2 (529)	1.00	0.73-1.37
	3	54.6 (491)	Ref	Ref
Plan	Commonwealth Care Alliance	56.2 (711)	0.99	0.69-1.43
	Fallon Total Care	**67.0 (663)**	**1.81**	**1.25-2.63**
	Tufts Health Plan – Network Health	57.6 (244)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	62.9 (601)	1.16	0.88-1.53
	Passively enrolled (MassHealth chose plan)	59.5 (962)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	62.2 (923)	1.10	0.84-1.45
	No physical disability	58.4 (695)	Ref	Ref
	Psychiatric disability	62.1 (1104)	1.25	0.94-1.68
	No psychiatric disability	57.3 (514)	Ref	Ref
	Substance Abuse	63.3 (144)	1.21	0.76-1.92
	No substance abuse	60.3 (1474)	Ref	Ref
	Long-term illness	63.4 (771)	1.23	0.94-1.62
	No long-term illness	58.1 (847)	Ref	Ref
	Developmental disability	59.2 (174)	0.86	0.55-1.35
	No developmental disability	60.7 (1444)	Ref	Ref
	Learning disability	59.6 (452)	0.91	0.67-1.25
	No learning disability	60.9 (1166)	Ref	Ref
	Blind/visual impairment	60.8 (484)	0.96	0.94-1.99
	No blind/visual impairment	60.5 (1134)	Ref	Ref
	Deaf/hearing loss	66.2 (250)	1.37	0.94-1.99
	No deaf/hearing loss	59.5 (1368)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	58.4 (117)	1.19	0.70-2.02
	Not homeless in past year	60.8 (1474)	Ref	Ref
Age	21-34	56.7 (125)	1.00	0.59-1.68
	35-44	62.0 (281)	1.28	0.87-1.87
	45-54	59.2 (548)	0.90	0.66-1.23

	55-64	61.9 (640)	Ref	Ref
Gender	Male	60.3 (780)	1.01	0.77-1.31
	Transgender/intersex	(--)	(--)	(--)
	Female	60.8 (816)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	64.6 (94)	1.37	0.81-2.31
	Asexual	66.8 (18)	1.57	0.51-4.78
	Straight	60.4 (1401)	Ref	Ref
Race	Black	60.9 (218)	1.13	0.75-1.69
	Other	60.7 (318)	0.88	0.57-1.35
	White	60.8 (991)	Ref	Ref
Ethnicity	Latino/Hispanic	61.4 (340)	0.90	0.56-1.46
	Non-Latino/Hispanic	60.7 (1191)	Ref	Ref
Primary language	English	60.6 (1289)	0.83	0.49-1.41
	Non-English	58.8 (260)	Ref	Ref
Education	Less than high school	59.5 (363)	0.96	0.66-1.40
	High school/GED	59.7 (575)	1.01	0.75-1.36
	Some college or 2-yr degree	61.5 (620)	Ref	Ref
Employment	Worked in past year	61.4 (249)	1.02	0.72-1.45
	Did not work in past year	60.5 (1350)	Ref	Ref

*Weighted percentage of members reporting that they *met with a Care Coordinator since enrolling* (OC-MES Question 8b). N's are non-weighted showing the number of members with that characteristic who responded to Question 8b. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-6. Association of member characteristics to satisfaction with Care Coordinator

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted % (n)	Odds Ratio	95% CI
Cohort	1	92.6 (388)	0.42	0.15-1.15
	2	93.2 (309)	0.50	0.18-1.41
	3	96.7 (247)	Ref	Ref
Plan	Commonwealth Care Alliance	93.7 (381)	0.70	0.21-2.39
	Fallon Total Care	94.2 (431)	0.80	0.24-2.64
	Tufts Health Plan – Network Health	93.3 (132)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	93.7 (372)	1.14	0.60-2.16
	Passively enrolled (MassHealth chose plan)	93.8 (551)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	93.2 (551)	0.78	0.36-1.68
	No physical disability	94.8 (393)	Ref	Ref
	Psychiatric disability	94.2 (656)	1.58	0.74
	No psychiatric disability	93.1 (288)	Ref	Ref
	Substance Abuse	94.8 (88)	0.65	0.17-2.46
	No substance abuse	93.8 (856)	Ref	Ref
	Long-term illness	93.0 (472)	0.64	0.30-1.35
	No long-term illness	94.8 (472)	Ref	Ref
	Developmental disability	96.8 (105)	0.69	0.22-2.19
	No developmental disability	93.5 (839)	Ref	Ref
	Learning disability	**97.1 (254)**	**3.36**	**1.00-11.29**
	No learning disability	92.7 (690)	Ref	Ref
	Blind/visual impairment	92.1 (280)	0.76	0.36-1.63
	No blind/visual impairment	94.6 (664)	Ref	Ref
	Deaf/hearing loss	94.0 (157)	1.40	0.42-4.61
	No deaf/hearing loss	93.8 (787)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	98.5 (62)	5.84	0.64-52.88
	Not homeless in past year	93.4 (869)	Ref	Ref
Age	21-34	89.0 (70)	0.32	0.10-1.01
	35-44	92.9 (172)	0.77	0.27-2.20
	45-54	94.4 (313)	1.21	0.49-2.96

	55-64	94.6 (375)	Ref	Ref
Gender	Male	95.1 (451)	1.41	0.76-2.54
	Transgender/intersex	(--)	(--)	(--)
	Female	93.2 (480)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	91.6 (56)	0.48	0.15-1.51
	Asexual	81.3 (10)	0.57	0.11-2.93
	Straight	94.1 (823)	Ref	Ref
Race	Black	91.9 (130)	0.48	0.15-1.46
	Other	91.3 (182)	0.54	0.22-1.30
	White	95.6 (579)	Ref	Ref
Ethnicity	Latino/Hispanic	**90.3 (198)**	**0.24**	**0.10-0.62**
	Non-Latino/Hispanic	95.0 (697)	Ref	Ref
Primary language	English	93.8 (756)	0.41	0.13-1.35
	Non-English	94.4 (144)	Ref	Ref
Education	Less than high school	95.7 (206)	2.96	0.94-9.35
	High school/GED	**96.2 (333)**	**3.36**	**1.35-8.35**
	Some college or 2-yr degree	90.8 (366)	Ref	Ref
Employment	Worked in past year	94.0 (144)	1.06	0.43-2.61
	Did not work in past year	93.9 (789)	Ref	Ref

*Weighted percentage of members reporting being *extremely/somewhat satisfied with Care Coordinator* (OC-MES Question 8d). N's are non-weighted showing the number of members with that characteristic who responded to Question 8d. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-7. Association of member characteristics to meeting with a Long Term Services and Supports (LTS) Coordinator

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	43.3 (303)	1.11	0.73-1.69
	2	35.5 (306)	0.75	0.48-1.16
	3	41.6 (271)	Ref	Ref
Plan	Commonwealth Care Alliance	40.1 (412)	0.99	0.60-1.64
	Fallon Total Care	42.3 (327)	1.22	0.72-2.07
	Tufts Health Plan – Network Health	41.2 (141)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	44.0 (340)	1.16	0.79-1.71
	Passively enrolled (MassHealth chose plan)	39.2 (511)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	40.6 (535)	0.87	0.59-1.28
	No physical disability	41.6 (345)	Ref	Ref
	Psychiatric disability	42.3 (615)	1.26	0.82-1.91
	No psychiatric disability	38.1 (265)	Ref	Ref
	Substance Abuse	40.7 (81)	1.06	0.56-1.99
	No substance abuse	41.0 (799)	Ref	Ref
	Long-term illness	43.5 (433)	1.39	0.95-2.02
	No long-term illness	38.6 (447)	Ref	Ref
	Developmental disability	46.0 (96)	1.50	0.79-2.86
	No developmental disability	40.3 (784)	Ref	Ref
	Learning disability	41.3 (234)	0.85	0.53-1.35
	No learning disability	40.9 (646)	Ref	Ref
	Blind/visual impairment	38.5 (293)	0.85	0.57-1.26
	No blind/visual impairment	42.1 (587)	Ref	Ref
	Deaf/hearing loss	**49.7 (145)**	**1.89**	**1.16-3.07**
	No deaf/hearing loss	39.2 (735)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	45.2 (69)	1.75	0.91-3.35
	Not homeless in past year	40.3 (798)	Ref	Ref
Age	21-34	34.3 (54)	0.74	0.30-1.81
	35-44	42.1 (155)	1.03	0.62-1.71
	45-54	41.2 (302)	1.00	0.66-1.51

	55-64	41.3 (358)	Ref	Ref
Gender	Male	40.4 (429)	1.00	0.69-1.46
	Transgender/intersex	(--)	(--)	(--)
	Female	41.5 (439)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	37.1 (45)	0.72	0.31-1.69
	Asexual	(--)	(--)	(--)
	Straight	41.6 (770)	Ref	Ref
Race	Black	40.7 (141)	0.89	0.53-1.49
	Other	38.2 (186)	0.63	0.35-1.15
	White	42.2 (503)	Ref	Ref
Ethnicity	Latino/Hispanic	43.9 (211)	1.80	0.93-3.50
	Non-Latino/Hispanic	40.4 (622)	Ref	Ref
Primary language	English	42.0 (671)	1.60	0.81-3.16
	Non-English	37.6 (162)	Ref	Ref
Education	Less than high school	42.6 (216)	1.47	0.90-2.41
	High school/GED	**44.7 (298)**	**1.71**	**1.12-2.61**
	Some college or 2-yr degree	35.5 (335)	Ref	Ref
Employment	Worked in past year	44.2 (131)	1.31	0.81-2.11
	Did not work in past year	40.4 (742)	Ref	Ref

*Weighted percentage of members reporting that they *met with a LTS Coordinator* (OC-MES Question 9c). N's are non-weighted showing the number of members with that characteristic who responded to Question 9c. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

*Table A-8. Association of member characteristics to satisfaction with Long Term Services and Supports Coordinator***

Member Characteristics		**Percentages***
Enrollment		Weighted % (n)
Cohort	1	95.6 (130)
	2	94.9 (104)
	3	96.4 (109)
Plan	Commonwealth Care Alliance	93.7 (153)
	Fallon Total Care	98.4 (135)
	Tufts Health Plan – Network Health	96.3 (55)
Enrollment method	Voluntarily enrolled (member chose plan)	95.9 (141)
	Passively enrolled (MassHealth chose plan)	95.7 (194)
Disability/Health Conditions		
Reported Conditions	Physical disability	95.1 (208)
	No physical disability	96.8 (135)
	Psychiatric disability	96.2 (245)
	No psychiatric disability	94.6 (98)
	Substance Abuse	100.0 (29)
	No substance abuse	95.3 (314)
	Long-term illness	96.6 (180)
	No long-term illness	94.8 (163)
	Developmental disability	98.7 (44)
	No developmental disability	95.3 (299)
	Learning disability	97.8 (93)
	No learning disability	95.0 (250)
	Blind/visual impairment	94.8 (107)
	No blind/visual impairment	96.1 (236)
	Deaf/hearing loss	99.3 (67)
	No deaf/hearing loss	94.8 (276)
Demographics		
Homelessness	Homeless in past year	100.0 (29)
	Not homeless in past year	95.4 (306)
Age	21-34	79.8 (18)
	35-44	97.3 (62)
	45-54	95.0 (119)

	55-64	97.4 (139)
Gender	Male	96.2 (162)
	Transgender/intersex	(--)
	Female	95.2 (177)
Sexual Orientation	Gay/Lesbian/Bisexual	82.3 (16)
	Asexual	(--)
	Straight	96.3 (304)
Race	Black	92.8 (59)
	Other	96.8 (65)
	White	96.4 (200)
Ethnicity	Latino/Hispanic	96.1 (83)
	Non-Latino/Hispanic	95.5 (244)
Primary language	English	95.4 (269)
	Non-English	97.3 (57)
Education	Less than high school	100.0 (85)
	High school/GED	97.9 (129)
	Some college or 2-yr degree	89.5 (116)
Employment	Worked in past year	92.3 (49)
	Did not work in past year	96.4 (291)

**Because of limited/no variability in satisfaction rates across several member characteristics, logistic regression is not applicable.

*Weighted percentage of members reporting being *extremely/somewhat satisfied with LTS Coordinator* (OC-MES Question 9e). N's are non-weighted showing the number of members with that characteristic who responded to Question 9e.

(--) data not reported due to small sample size ($\leq$5).

Table A-9. Association of member characteristics to having an assessment of needs by Care Team

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	**68.3 (658)**	**1.38**	**1.02-1.88**
	2	67.2 (580)	1.12	0.82-1.53
	3	60.7 (557)	Ref	Ref
Plan	Commonwealth Care Alliance	61.4 (828)	0.75	0.52-1.08
	Fallon Total Care	71.3 (697)	1.26	0.87-1.83
	Tufts Health Plan–Network Health	68.1 (270)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	**70.0 (677)**	**1.36**	**1.03-1.80**
	Passively enrolled (MassHealth chose plan)	63.7 (1060)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	68.0 (1026)	1.23	0.94-1.61
	No physical disability	62.5 (769)	Ref	Ref
	Psychiatric disability	68.1 (1222)	1.28	0.96-1.72
	No psychiatric disability	60.4 (573)	Ref	Ref
	Substance Abuse	66.3 (163)	1.17	0.72-1.91
	No substance abuse	65.6 (1632)	Ref	Ref
	Long-term illness	68.8 (850)	1.24	0.95-1.63
	No long-term illness	62.8 (945)	Ref	Ref
	Developmental disability	67.8 (191)	1.11	0.70-1.77
	No developmental disability	65.4 (1604)	Ref	Ref
	Learning disability	64.5 (487)	0.93	0.67-1.27
	No learning disability	66.1 (1308)	Ref	Ref
	Blind/visual impairment	70.0 (541)	1.15	0.86-1.54
	No blind/visual impairment	63.8 (1254)	Ref	Ref
	Deaf/hearing loss	**72.6 (264)**	**1.49**	**1.01-2.21**
	No deaf/hearing loss	64.4 (1531)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	51.0 (129)	0.63	0.38-1.05
	Not homeless in past year	66.7 (1631)	Ref	Ref
Age	21-34	64.1 (141)	1.10	0.65-1.87
	35-44	65.6 (309)	1.20	0.82-1.75
	45-54	63.7 (603)	0.85	0.62-1.16

	55-64	67.2 (715)	Ref	Ref
Gender	Male	63.6 (870)	0.85	0.65-1.11
	Transgender/intersex	(--)	(--)	(--)
	Female	67.2 (901)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	69.7 (102)	1.02	0.61-1.71
	Asexual	53.2 (20)	0.37	0.12-1.14
	Straight	65.4 (1563)	Ref	Ref
Race	Black	62.1 (238)	0.84	0.57-1.24
	Other	63.2 (356)	0.91	0.59-1.39
	White	67.4 (1084)	Ref	Ref
Ethnicity	Latino/Hispanic	63.3 (388)	0.94	0.58-1.51
	Non-Latino/Hispanic	66.8 (1308)	Ref	Ref
Primary language	English	66.8 (1415)	1.10	0.66-1.84
	Non-English	58.9 (293)	Ref	Ref
Education	Less than high school	63.1 (416)	0.79	0.55-1.15
	High school/GED	63.9 (632)	0.81	0.60-1.09
	Some college or 2-yr degree	68.1 (678)	Ref	Ref
Employment	Worked in past year	64.5 (277)	0.90	0.63-1.28
	Did not work in past year	65.7 (1497)	Ref	Ref

*Weighted percentage of members reporting *meeting with Care Team to have needs assessed* (OC-MES Question 10a). N's are non-weighted showing the number of members with that characteristic who responded to Question 10a. Ref=reference (comparison) group. Statistically significant ORs are bolded.

(--) data not reported due to small sample size ($\leq$5).

Table A-10. Association of member characteristics to satisfaction with the assessment process

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	93.2 (455)	0.52	0.20-1.36
	2	96.9 (373)	1.04	0.35-3.13
	3	95.9 (327)	Ref	Ref
Plan	Commonwealth Care Alliance	93.6 (485)	0.67	0.21-2.10
	Fallon Total Care	96.1 (491)	0.89	0.26-3.02
	Tufts Health Plan – Network Health	95.6 (179)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	94.5 (473)	1.56	0.71-3.42
	Passively enrolled (MassHealth chose plan)	95.0 (653)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	94.4 (684)	0.59	0.29-1.22
	No physical disability	95.4 (471)	Ref	Ref
	Psychiatric disability	94.7 (810)	0.91	0.37-2.28
	No psychiatric disability	95.0 (345)	Ref	Ref
	Substance Abuse	97.8 (102)	2.35	0.44-12.63
	No substance abuse	94.5 (1053)	Ref	Ref
	Long-term illness	95.2 (572)	1.34	0.66-2.75
	No long-term illness	94.4 (583)	Ref	Ref
	Developmental disability	96.9 (126)	2.95	0.57-15.35
	No developmental disability	94.5 (1029)	Ref	Ref
	Learning disability	94.8 (306)	0.62	0.27-1.40
	No learning disability	94.8 (849)	Ref	Ref
	Blind/visual impairment	94.7 (364)	0.98	0.42-2.28
	No blind/visual impairment	94.8 (791)	Ref	Ref
	Deaf/hearing loss	93.9 (187)	1.99	0.66-6.03
	No deaf/hearing loss	95.0 (968)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	94.1 (62)	0.55	0.14-2.16
	Not homeless in past year	94.8 (1070)	Ref	Ref
Age	25-34	95.3 (89)	1.84	0.45-7.45
	35-44	96.0 (204)	1.71	0.60-4.91
	45-54	94.0 (378)	1.23	0.56-2.71

	55-64	94.8 (465)	Ref	Ref
Gender	Male	95.6 (542)	0.90	0.43-1.89
	Transgender/intersex	(--)	(--)	(--)
	Female	94.3 (596)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	96.1 (71)	0.86	0.15-5.07
	Asexual	84.5 (9)	0.44	0.09-2.25
	Straight	94.8 (1007)	Ref	Ref
Race	Black	**90.7 (148)**	**0.28**	**0.11-0.72**
	Other	94.7 (218)	0.77	0.23-2.57
	White	95.9 (722)	Ref	Ref
Ethnicity	Latino/Hispanic	96.7 (234)	0.63	0.21-1.89
	Non-Latino/Hispanic	94.4 (866)	Ref	Ref
Primary language	English	**93.9 (933)**	**0.07**	**0.01-0.84**
	Non-English	99.6 (165)	Ref	Ref
Education	Less than high school	95.8 (255)	0.87	0.33-2.31
	High school/GED	96.1 (404)	1.79	0.73-4.40
	Some college or 2-yr degree	93.7 (450)	Ref	Ref
Employment	Worked in past year	**90.0 (176)**	**0.30**	**0.14-0.64**
	Did not work in past year	95.7 (965)	Ref	Ref

*Weighted percentage of members reporting *being completely/somewhat satisfied with assessment process* (OC-MES Question 14c). N's are non-weighted showing the number of members with that characteristic who responded to Question 14c. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-11. Association of member characteristics to having an Individual Care Plan

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	39.4 (665)	1.19	0.89-1.59
	2	39.7 (593)	1.12	0.83-1.52
	3	38.4 (565)	Ref	Ref
Plan	Commonwealth Care Alliance	34.5 (844)	0.76	0.53-1.08
	Fallon Total Care	45.8 (697)	1.28	0.89-1.82
	Tufts Health Plan – Network Health	40.3 (282)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	43.0 (685)	**1.34**	**1.06-1.79**
	Passively enrolled (MassHealth chose plan)	37.0 (1077)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	38.2 (1036)	0.89	0.69-1.56
	No physical disability	40.3 (787)	Ref	Ref
	Psychiatric disability	38.7 (1239)	1.03	0.78-1.36
	No psychiatric disability	40.2 (584)	Ref	Ref
	Substance Abuse	37.7 (160)	1.16	0.75-1.81
	No substance abuse	39.3 (1663)	Ref	Ref
	Long-term illness	39.1 (864)	1.01	0.78-1.31
	No long-term illness	39.2 (959)	Ref	Ref
	Developmental disability	43.1 (192)	1.23	0.81-1.87
	No developmental disability	38.7 (1631)	Ref	Ref
	Learning disability	38.5 (494)	0.92	0.68
	No learning disability	39.4 (1329)	Ref	Ref
	Blind/visual impairment	38.8 (548)	0.93	0.70
	No blind/visual impairment	39.3 (1275)	Ref	Ref
	Deaf/hearing impairment	41.3 (266)	1.22	0.86-1.73
	No deaf/hearing impairment	38.8 (1557)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	33.8 (126)	1.00	0.61-1.64
	Not homeless in past year	39.5 (1652)	Ref	Ref
Age	25-34	38.2 (141)	0.85	0.53-1.37
	35-44	43.3 (313)	1.08	0.76-1.55
	45-54	34.8 (603)	0.76	0.57-1.02

	55-64	40.8 (729)	Ref	Ref
Gender	Male	37.3 (878)	0.84	0.65-1.08
	Transgender/intersex	(--)	(--)	(--)
	Female	40.5 (923)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	33.8 (102)	0.74	0.44-1.23
	Asexual	35.2 (20)	0.84	0.25-2.76
	Straight	39.6 (1588)	Ref	Ref
Race	Black	43.9 (244)	1.24	0.85-1.79
	Other	35.5 (363)	0.96	0.64-1.45
	White	40.1 (1100)	Ref	Ref
Ethnicity	Latino/Hispanic	33.3 (396)	0.87	0.56-1.34
	Non-Latino/Hispanic	41.7 (1325)	Ref	Ref
Primary language	English	40.4 (1436)	1.34	0.84-2.15
	Non-English	30.4 (301)	Ref	Ref
Education	Less than high school	38.0 (425)	**1.49**	**1.04-2.12**
	High school/GED	42.1 (644)	**1.36**	**1.02-1.80**
	Some college or 2-yr degree	36.5 (688)	Ref	Ref
Employment	Worked in past year	42.7 (278)	1.30	0.93-1.81
	Did not work in past year	38.3 (1523)	Ref	Ref

*Weighted percentage of members reporting that they *have an Individual Care Plan* (OC-MES Question 15a).
N's are non-weighted showing the number of members with that characteristic who responded to Question 15a.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-12. Association of member characteristics to need for Long-Term Services and Supports

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Survey Cohort	1	60.4 (706)	**1.36**	**1.01-1.83**
	2	64.4 (621)	**1.61**	**1.19-2.19**
	3	53.2 (606)	Ref	Ref
Plan	Commonwealth Care Alliance	59.3 (895)	1.16	0.81-1.67
	Fallon Total Care	59.3 (738)	1.09	0.76-1.58
	Tufts-Network Health	54.5 (300)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	62.9 (710)	1.14	0.87-1.50
	Passively enrolled (MassHealth chose plan)	59.2 (1107)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	68.6 (1100)	**2.17**	**1.67-2.82**
	No physical disability	46.0 (833)	Ref	Ref
	Psychiatric disability	62.7 (1304)	1.03	0.77-1.37
	No psychiatric disability	51.1 (629)	Ref	Ref
	Substance Abuse	69.6 (172)	1.33	0.82-2.14
	No substance abuse	57.9 (1761)	Ref	Ref
	Long-term illness	67.5 (910)	**1.68**	**1.29-2.19**
	No long-term illness	51.3 (1023)	Ref	Ref
	Developmental disability	68.7 (204)	1.11	0.67-1.83
	No developmental disability	57.7 (1729)	Ref	Ref
	Learning disability	66.0 (520)	**1.48**	**1.08-2.04**
	No learning disability	56.2 (1413)	Ref	Ref
	Blind/visual impairment	67.2 (577)	1.18	0.89-1.58
	No blind/visual impairment	55.5 (1356)	Ref	Ref
	Deaf/hearing impairment	71.7 (278)	**1.82**	**1.26-2.64**
	No deaf/hearing impairment	56.6 (1655)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	66.7 (136)	1.31	0.76-2.26
	Not homeless in past year	59.2 (1747)	Ref	Ref
Age	25-34	51.3 (147)	0.94	0.56-1.57
	35-44	64.1 (327)	**1.49**	**1.05-2.12**

	45-54	63.2 (645)	1.34	0.99-1.82
	55-64	56.5 (773)	Ref	Ref
Gender	Male	56.3 (922)	0.82	0.63-1.06
	Transgender/intersex	(--)	(--)	(--)
	Female	61.4 (983)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	63.2 (108)	1.15	0.69-1.93
	Asexual	56.5 (22)	0.54	0.14-2.15
	Straight	59.4 (1673)	Ref	Ref
Race	Black	61.4 (256)	1.21	0.83-1.78
	Other	60.6 (387)	1.47	0.95-2.28
	White	57.0 (1159)	Ref	Ref
Ethnicity	Latino/Hispanic	61.1 (421)	1.53	0.93-2.51
	Non-Latino/Hispanic	58.2 (1394)	Ref	Ref
Primary language	English	59.7 (1514)	**2.18**	**1.31-3.64**
	Non-English	53.0 (316)	Ref	Ref
Education	Less than high school	55.9 (452)	0.83	0.58-1.20
	High school/GED	56.7 (676)	0.84	0.63-1.12
	Some college or 2-yr degree	63.5 (724)	Ref	Ref
Employment	Worked in past year	57.7 (291)	0.98	0.70-1.37
	Did not work in past year	59.2 (1614)	Ref	Ref

*Weighted percentage of members reporting *a need for any LTSS* (OC-MES Question 22a – 27a). N's are non-weighted showing the number of members with that characteristic who responded to Questions 22a-27a.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-13. Association of member characteristics to unmet need for medical services

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	16.1 (660)	1.15	0.78-1.71
	2	16.5 (584)	0.91	0.61-1.37
	3	15.6 (570)	Ref	Ref
Plan	Commonwealth Care Alliance	17.0 (841)	1.25	0.75-2.08
	Fallon Total Care	14.9 (696)	1.16	0.68-1.96
	Tufts Health Plan – Network Health	14.4 (277)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	14.6 (684)	0.81	0.57-1.15
	Passively enrolled (MassHealth chose plan)	16.8 (1070)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	16.8 (1038)	1.24	0.87-1.78
	No physical disability	14.9 (776)	Ref	Ref
	Psychiatric disability	**17.6 (1251)**	**1.61**	**1.05-2.49**
	No psychiatric disability	12.5 (563)	Ref	Ref
	Substance Abuse	**26.5 (165)**	**2.12**	**1.29-3.48**
	No substance abuse	15.0 (1649)	Ref	Ref
	Long-term illness	16.6 (871)	0.97	0.69-1.37
	No long-term illness	15.5 (943)	Ref	Ref
	Developmental disability	17.0 (193)	0.78	0.45-1.34
	No developmental disability	15.9 (1621)	Ref	Ref
	Learning disability	18.9 (490)	1.28	0.87-1.87
	No learning disability	14.9 (1324)	Ref	Ref
	Blind/visual impairment	16.5 (553)	0.94	0.65-1.35
	No blind/visual impairment	15.8 (1261)	Ref	Ref
	Deaf/hearing loss	17.2 (268)	0.99	0.62-1.59
	No deaf/hearing loss	15.8 (1546)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	25.3 (128)	1.62	0.912-2.87
	Not homeless in past year	15.4 (1644)	Ref	Ref
Age	21-34	**21.8 (139)**	**2.10**	**1.12-3.94**
	35-44	**17.5 (304)**	**1.66**	**1.00-2.74**
	45-54	**18.3 (608)**	**1.72**	**1.12-2.64**

	55-64	12.5 (728)	Ref	Ref
Gender	Male	15.7 (859)	0.96	0.68-1.35
	Transgender/intersex	(--)	(--)	(--)
	Female	15.6 (932)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	20.9 (104)	1.18	0.63-2.20
	Asexual	(--)	(--)	(--)
	Straight	15.5 (1580)	Ref	Ref
Race	Black	19.0 (243)	1.41	0.86-2.31
	Other	15.4 (357)	1.51	0.83-2.74
	White	14.9 (1095)	Ref	Ref
Ethnicity	Latino/Hispanic	13.4 (395)	0.87	0.41-1.84
	Non-Latino/Hispanic	16.6 (1317)	Ref	Ref
Primary language	English	17.1 (1433)	1.54	0.73-3.24
	Non-English	10.9 (292)	Ref	Ref
Education	Less than high school	12.7 (428)	0.87	0.53-1.44
	High school/GED	16.7 (636)	1.28	0.87-1.89
	Some college or 2-yr degree	16.4 (683)	Ref	Ref
Employment	Worked in past year	17.9 (270)	1.11	0.71-1.75
	Did not work in past year	15.4 (1521)	Ref	Ref

*Weighted percentage of members reporting any *unmet need for medical services* (OC-MES Questions 16b-18b,-20b-21b). N's are non-weighted showing the number of members with that characteristic who responded to Question 16b-18b, 20b-21b. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size ($\leq$5).

Table A-14. Association of member characteristics to unmet need for oral/dental services

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	24.6 (501)	1.05	0.70-1.57
	2	25.0 (424)	1.20	0.78-1.85
	3	23.7 (387)	Ref	Ref
Plan	Commonwealth Care Alliance	24.8 (604)	1.23	0.73-2.07
	Fallon Total Care	25.8 (501)	1.22	0.71-2.10
	Tufts Health Plan – Network Health	20.5 (207)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	24.6 (525)	0.92	0.64-1.32
	Passively enrolled (MassHealth chose plan)	24.4 (744)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	26.7 (753)	1.12	0.78-1.58
	No physical disability	21.4 (559)	Ref	Ref
	Psychiatric disability	24.0 (911)	0.85	0.57-1.27
	No psychiatric disability	25.4 (401)	Ref	Ref
	Substance Abuse	28.5 (121)	0.95	0.50-1.79
	No substance abuse	24.0 (1191)	Ref	Ref
	Long-term illness	27.2 (613)	1.25	0.87-1.80
	No long-term illness	21.9 (699)	Ref	Ref
	Developmental disability	26.8 (144)	1.11	0.62-1.99
	No developmental disability	24.1 (1168)	Ref	Ref
	Learning disability	25.3 (345)	0.98	0.63-1.51
	No learning disability	24.1 (967)	Ref	Ref
	Blind/visual impairment	25.9 (403)	1.08	0.74-1.56
	No blind/visual impairment	23.8 (909)	Ref	Ref
	Deaf/hearing loss	**33.8 (196)**	**1.63**	**1.04-2.55**
	No deaf/hearing loss	22.7 (1116)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	**46.3 (97)**	**4.24**	**2.36-7.62**
	Not homeless in past year	22.8 (1184)	Ref	Ref
Age	21-34	12.0 (108)	0.56	**0.27-1.16**
	35-44	25.0 (210)	1.24	0.75-2.04
	45-54	25.3 (458)	1.06	0.71-1.59

	55-64	26.0 (510)	Ref	Ref
Gender	Male	24.9 (610)	1.0	0.70-1.41
	Transgender/intersex	(--)	(--)	(--)
	Female	23.4 (683)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	26.9 (73)	1.41	0.72-2.76
	Asexual	(--)	(--)	(--)
	Straight	23.9 (1156)	Ref	Ref
Race	Black	28.9 (188)	1.32	0.81-2.13
	Other	17.6 (262)	1.17	0.66-2.05
	White	25.2 (771)	Ref	Ref
Ethnicity	Latino/Hispanic	**13.4 (295)**	**0.46**	**0.25-0.86**
	Non-Latino/Hispanic	27.5 (937)	Ref	Ref
Primary language	English	26.3 (1022)	1.65	0.78-3.48
	Non-English	13.3 (222)	Ref	Ref
Education	Less than high school	19.5 (290)	0.72	0.43-1.22
	High school/GED	23.3 (445)	0.88	0.60-1.29
	Some college or 2-yr degree	27.2 (531)	Ref	Ref
Employment	Worked in past year	21.8 (228)	0.78	0.49-1.23
	Did not work in past year	24.7 (1066)	Ref	Ref

*Weighted percentage of members reporting an *unmet need for oral/dental services* (OC-MES Question 19b).
N's are non-weighted showing the number of members with that characteristic who responded to Question 19b.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-15. Association of member characteristics to unmet need for Long-Term Services and Supports

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	34.8 (418)	1.09	0.73-1.64
	2	32.7 (394)	1.11	0.73-1.68
	3	32.5 (322)	Ref	Ref
Plan	Commonwealth Care Alliance	36.4 (529)	1.26	0.77-2.06
	Fallon Total Care	29.9 (442)	1.02	0.61-1.72
	Tufts Health Plan – Network Health	31.9 (163)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	33.7 (446)	0.99	0.70-1.41
	Passively enrolled (MassHealth chose plan)	33.8 (653)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	34.8 (758)	1.30	0.90-1.87
	No physical disability	31.4 (376)	Ref	Ref
	Psychiatric disability	34.3 (815)	1.13	0.77-1.67
	No psychiatric disability	31.9 (319)	Ref	Ref
	Substance Abuse	41.8 (120)	1.16	0.66-2.01
	No substance abuse	32.8 (1014)	Ref	Ref
	Long-term illness	32.8 (609)	0.96	0.68-1.34
	No long-term illness	34.6 (525)	Ref	Ref
	Developmental disability	34.6 (145)	0.83	0.49-1.40
	No developmental disability	33.5 (989)	Ref	Ref
	Learning disability	**38.9 (336)**	**1.79**	**1.21-2.65**
	No learning disability	31.4 (798)	Ref	Ref
	Blind/visual impairment	38.4 (387)	1.16	0.82-1.65
	No blind/visual impairment	31.3 (747)	Ref	Ref
	Deaf/hearing loss	37.4 (195)	0.97	0.63-1.50
	No deaf/hearing loss	32.8 (939)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	43.2 (90)	1.29	0.72-2.31
	Not homeless in past year	33.0 (1033)	Ref	Ref
Age	21-34	47.6 (75)	1.98	0.99-4.00
	35-44	33.8 (208)	0.96	0.60-1.55
	45-54	35.1 (404)	1.25	0.85-1.85

	55-64	29.8 (439)	Ref	Ref
Gender	Male	33.2 (521)	1.11	0.79-1.56
	Transgender/intersex	(--)	(--)	(--)
	Female	33.9 (598)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	37.5 (66)	1.24	0.64-2.41
	Asexual	35.5 (12)	1.92	0.46-8.05
	Straight	34.0 (989)	Ref	Ref
Race	Black	**40.2 (154)**	**1.77**	**1.08-2.88**
	Other	**36.7 (232)**	**2.17**	**1.35-3.49**
	White	30.0 (661)	Ref	Ref
Ethnicity	Latino/Hispanic	29.8 (249)	0.64	0.35-1.16
	Non-Latino/Hispanic	34.4 (813)	Ref	Ref
Primary language	English	33.9 (908)	1.04	0.56-1.93
	Non-English	33.1 (168)	Ref	Ref
Education	Less than high school	28.2 (255)	0.70	0.44-1.12
	High school/GED	30.2 (388)	0.81	0.56-1.19
	Some college or 2-yr degree	39.2 (452)	Ref	Ref
Employment	Worked in past year	36.7 (159)	1.15	0.72-1.85
	Did not work in past year	33.1 (962)	Ref	Ref

*Weighted percentage of members reporting any *unmet need for LTSS* (OC-MES Question 22b – 27b). N's are non-weighted showing the number of members with that characteristic who responded to Question 22b-27b. Ref=reference (comparison) group. Statistically significant ORs are bolded.

(--) data not reported due to small sample size (≤5).

Table A-16. Association of member characteristics to ease of moving into One Care

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	90.6 (661)	0.76	0.47-1.22
	2	87.6 (582)	0.68	0.41-1.13
	3	90.7 (541)	Ref	Ref
Plan	Commonwealth Care Alliance	91.2 (831)	1.74	0.97-3.12
	Fallon Total Care	88.7 (687)	1.32	0.73-2.40
	Tufts Health Plan – Network Health	87.8 (266)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	**92.3 (682)**	**1.57**	**1.00-2.45**
	Passively enrolled (MassHealth chose plan)	88.8 (1044)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	89.4 (1030)	0.78	0.52-1.18
	No physical disability	90.8 (754)	Ref	Ref
	Psychiatric disability	89.5 (1235)	0.72	0.45-1.17
	No psychiatric disability	91.1 (549)	Ref	Ref
	Substance Abuse	85.4 (164)	0.98	0.50-1.89
	No substance abuse	90.4 (1620)	Ref	Ref
	Long-term illness	89.8 (850)	0.96	0.64-1.42
	No long-term illness	90.2 (934)	Ref	Ref
	Developmental disability	87.6 (192)	0.89	0.47-1.69
	No developmental disability	90.3 (1592)	Ref	Ref
	Learning disability	**86.2 (488)**	**0.57**	**0.36-0.92**
	No learning disability	91.4 (1296)	Ref	Ref
	Blind/visual impairment	89.7 (539)	1.20	0.77-1.87
	No blind/visual impairment	90.1 (1245)	Ref	Ref
	Deaf/hearing loss	87.2 (264)	0.64	0.38-1.07
	No deaf/hearing loss	90.5 (1520)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	**80.9 (126)**	**0.45**	**0.22-0.90**
	Not homeless in past year	90.6 (1640)	Ref	Ref
Age	21-34	89.3 (140)	1.07	0.51-2.25
	35-44	89.4 (308)	1.11	0.63-1.97
	45-54	89.5 (599)	0.93	0.57-1.49

	55-64	90.6 (726)	Ref	Ref
Gender	Male	90.3 (860)	1.15	0.75-1.78
	Transgender/intersex	(--)	(--)	(--)
	Female	90.1 (903)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	91.2 (104)	1.08	0.51-2.30
	Asexual	87.0 (21)	1.75	0.50-6.18
	Straight	89.9 (1559)	Ref	Ref
Race	Black	88.7 (234)	0.82	0.44-1.53
	Other	91.0 (342)	1.08	0.59-1.99
	White	90.0 (1094)	Ref	Ref
Ethnicity	Latino/Hispanic	90.0 (377)	0.59	0.27-1.28
	Non-Latino/Hispanic	89.8 (1306)	Ref	Ref
Primary language	English	89.5 (1414)	0.55	0.26-1.19
	Non-English	91.7 (284)	Ref	Ref
Education	Less than high school	91.4 (412)	1.29	0.74-2.25
	High school/GED	90.8 (624)	1.26	0.81-1.95
	Some college or 2-yr degree	88.4 (685)	Ref	Ref
Employment	Worked in past year	**81.1 (276)**	**0.38**	**0.23-0.59**
	Did not work in past year	91.6 (1490)	Ref	Ref

*Weighted percentage of members reporting that *moving into One Care was very/somewhat easy* (OC-MES Question 28a). N's are non-weighted showing the number of members with that characteristic who responded to Question 28a.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-17. Association of member characteristics to experiencing disruption during move to One Care

Member Characteristics		Percentages*	Logistic Regression	Confidence Intervals
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	23.8 (671)	1.31	0.95-1.82
	2	32.7 (592)	**1.70**	**1.22-2.36**
	3	24.8 (579)	Ref	Ref
Plan	Commonwealth Care Alliance	22.8 (852)	0.75	0.50-1.11
	Fallon Total Care	29.9 (702)	0.97	0.65-1.46
	Tufts Health Plan – Network Health	29.1 (288)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	23.8 (669)	0.84	0.63-1.12
	Passively enrolled (MassHealth chose plan)	28.0 (1065)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	27.5 (1063)	1.25	0.93-1.66
	No physical disability	23.8 (779)	Ref	Ref
	Psychiatric disability	27.3 (1267)	**1.42**	**1.03-1.96**
	No psychiatric disability	23.0 (575)	Ref	Ref
	Substance Abuse	26.0 (166)	0.79	0.50-1.25
	No substance abuse	25.9 (1676)	Ref	Ref
	Long-term illness	29.9 (881)	**1.55**	**1.17-2.05**
	No long-term illness	22.4 (961)	Ref	Ref
	Developmental disability	27.0 (197)	1.17	0.73-1.88
	No developmental disability	25.8 (1645)	Ref	Ref
	Learning disability	26.3 (509)	.81	0.58-1.12
	No learning disability	25.8 (1333)	Ref	Ref
	Blind/visual impairment	30.0 (559)	1.15	0.86-1.54
	No blind/visual impairment	24.3 (1283)	Ref	Ref
	Deaf/hearing loss	30.0 (271)	1.02	0.70-1.49
	No deaf/hearing loss	25.2 (1571)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	35.0 (130)	**1.72**	**1.05-2.82**
	Not homeless in past year	25.4 (1693)	Ref	Ref
Age	25-34	26.4 (146)	1.06	0.62-1.82
	35-44	27.2 (321)	1.13	0.76-1.67
	45-54	27.1 (619)	1.08	0.78-1.50

	55-64	24.5 (744)	Ref	Ref
Gender	Male	26.1 (885)	0.94	0.71-1.24
	Transgender/intersex	(--)	(--)	(--)
	Female	25.7 (938)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	28.6 (103)	1.02	0.58-1.77
	Asexual	(--)	(--)	(--)
	Straight	25.7 (1606)	Ref	Ref
Race	Black	29.5 (243)	1.42	0.94-2.15
	Other	30.6 (376)	**1.57**	**1.04-2.37**
	White	24.2 (1107)	Ref	Ref
Ethnicity	Latino/Hispanic	29.8 (411)	1.55	0.99-2.41
	Non-Latino/Hispanic	25.2 (1327)	Ref	Ref
Primary language	English	26.0 (1443)	1.43	0.90-2.26
	Non-English	28.2 (306)	Ref	Ref
Education	Less than high school	23.9 (431)	0.76	0.52-1.11
	High school/GED	24.9 (639)	0.83	0.61-1.13
	Some college or 2-yr degree	27.6 (708)	Ref	Ref
Employment	Worked in past year	33.0 (282)	**1.78**	**1.24-2.55**
	Did not work in past year	24.7 (1541)	Ref	Ref

*Weighted percentage of members reporting a *disruption during move to One Care* (OC-MES Question 28b)
N's are non-weighted showing the number of members with that characteristic who responded to Question 28b.
Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-18. Association of member characteristics to overall satisfaction with One Care Plan

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	87.9 (659)	0.80	0.52-1.24
	2	88.3 (582)	0.96	0.60-1.54
	3	88.4 (558)	Ref	Ref
Plan	Commonwealth Care Alliance	88.4 (834)	1.28	0.75-2.15
	Fallon Total Care	88.2 (688)	1.07	0.62-1.83
	Tufts Health Plan – Network Health	86.5 (277)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	89.5 (680)	1.20	0.81-1.78
	Passively enrolled (MassHealth chose plan)	87.1 (1060)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	86.8 (1043)	0.67	0.44-1.00
	No physical disability	90.0 (756)	Ref	Ref
	Psychiatric disability	88.1 (1241)	0.96	0.62-1.49
	No psychiatric disability	88.1 (558)	Ref	Ref
	Substance Abuse	83.7 (161)	0.82	0.45-1.49
	No substance abuse	88.6(1638)	Ref	Ref
	Long-term illness	88.1 (866)	0.93	0.63-1.37
	No long-term illness	88.3 (933)	Ref	Ref
	Developmental disability	85.2 (193)	0.86	0.49-1.52
	No developmental disability	88.5 (1606)	Ref	Ref
	Learning disability	**84.1 (488)**	**0.58**	**0.38-0.89**
	No learning disability	89.7 (1311)	Ref	Ref
	Blind/visual impairment	87.7 (549)	1.06	0.69-1.63
	No blind/visual impairment	88.3 (1250)	Ref	Ref
	Deaf/hearing loss	88.7 (265)	1.47	0.84-2.58
	No deaf/hearing loss	88.1 (1534)	Ref	Ref
Demographic Characteristics				
Homelessness	Homeless in past year	79.9 (129)	0.56	0.30-1.05
	Not homeless in past year	88.8 (1651)	Ref	Ref
Age	21-34	87.3 (139)	1.04	0.50-2.17
	35-44	83.6 (309)	0.62	0.37-1.04
	45-54	87.5 (612)	0.74	0.46-1.20

	55-64	90.8 (729)	Ref	Ref
Gender	Male	87.3 (865)	0.75	0.51-1.12
	Transgender/intersex	(--)	(--)	(--)
	Female	89.5 (913)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	82.6 (103)	0.55	0.28-1.08
	Asexual	84.3 (20)	0.69	0.17-2.89
	Straight	89.1 (1576)	Ref	Ref
Race	Black	87.5 (239)	0.73	0.41-1.29
	Other	86.2 (354)	0.59	0.33-1.05
	White	89.3 (1092)	Ref	Ref
Ethnicity	Latino/Hispanic	89.0 (386)	0.99	0.51-1.94
	Non-Latino/Hispanic	88.3 (1310)	Ref	Ref
Primary language	English	87.6 (1422)	0.63	0.29-1.36
	Non-English	92.4 (296)	Ref	Ref
Education	Less than high school	89.4 (416)	1.35	0.77-2.35
	High school/GED	88.7 (630)	0.97	0.62-1.56
	Some college or 2-yr degree	88.0 (686)	Ref	Ref
Employment	Worked in past year	87.8 (275)	0.80	0.47-1.35
	Did not work in past year	88.4 (1504)	Ref	Ref

*Weighted percentage of members reporting being *extremely/somewhat satisfied with One Care Plan* (OC-MES Question 29). N's are non-weighted showing the number of members with that characteristic who responded to Question 29. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-19. Association of member characteristics to overall satisfaction with services under One Care

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	89.3 (656)	0.82	0.51-1.31
	2	88.8 (580)	0.95	0.58-1.57
	3	89.2 (557)	Ref	Ref
Plan	Commonwealth Care Alliance	89.7 (828)	1.47	0.85-2.54
	Fallon Total Care	89.0 (686)	1.12	0.63-1.98
	Tufts Health Plan – Network Health	86.3 (279)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	90.5 (679)	1.12	0.75-1.69
	Passively enrolled (MassHealth chose plan)	88.3 (1055)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	**87.7 (1039)**	**0.60**	**0.39-0.91**
	No physical disability	91.2 (754)	Ref	Ref
	Psychiatric disability	88.6 (1236)	0.86	0.54-1.36
	No psychiatric disability	90.5 (557)	Ref	Ref
	Substance Abuse	82.3 (157)	0.83	0.43-1.60
	No substance abuse	89.8 (1636)	Ref	Ref
	Long-term illness	89.7 (865)	1.30	0.86-1.97
	No long-term illness	88.7 (928)	Ref	Ref
	Developmental disability	87.5 (193)	0.99	0.52-1.88
	No developmental disability	89.4 (1600)	Ref	Ref
	Learning disability	**86.0 (488)**	**0.59**	**0.37-0.93**
	No learning disability	90.4 (1305)	Ref	Ref
	Blind/visual loss	88.0 (549)	0.87	0.57-1.33
	No blind/visual loss	89.7 (1244)	Ref	Ref
	Deaf/hearing impairment	88.5 (265)	1.39	0.79-2.42
	No deaf/hearing impairment	89.3 (1528)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	**76.4 (126)**	**0.43**	**0.23-0.80**
	Not homeless in past year	90.1 (1647)	Ref	Ref
Age	21-34	89.3 (139)	1.24	0.58-2.66
	35-44	85.4 (307)	0.65	0.38-1.12
	45-54	87.7 (606)	0.73	0.45-1.18

	55-64	91.8 (730)	Ref	Ref
Gender	Male	88.8 (861)	0.79	0.53-1.19
	Transgender/intersex	(--)	(--)	(--)
	Female	90.1 (910)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	**83.0 (101)**	**0.47**	**0.24-0.92**
	Asexual	86.4 (20)	1.74	0.46-6.55
	Straight	90.0 (1568)	Ref	Ref
Race	Black	**86.0 (237)**	**0.52**	**0.29-0.94**
	Other	88.2 (350)	0.61	0.33-1.10
	White	90.3 (1090)	Ref	Ref
Ethnicity	Latino/Hispanic	92.1 (390)	1.27	0.66-2.42
	Non-Latino/Hispanic	88.8 (1301)	Ref	Ref
Primary language	English	88.6 (1412)	0.72	0.33-1.56
	Non-English	94.1 (297)	Ref	Ref
Education	Less than high school	**91.9 (415)**	**1.82**	**1.02-3.25**
	High school/GED	89.6 (628)	1.19	0.75-1.89
	Some college or 2-yr degree	87.9 (681)	Ref	Ref
Employment	Worked in past year	89.1 (275)	0.93	0.53-1.62
	Did not work in past year	89.4 (1497)	Ref	Ref

*Weighted percentage of members reporting being e*xtremely/somewhat satisfied with services under One Care* (OC-MES Question 30). N's are non-weighted showing the number of members with that characteristic who responded to Question 30. Ref=reference (comparison) group. Statistically significant ORs are bolded.
(--) data not reported due to small sample size (≤5).

Table A-20. Association of member characteristics to planning to stay in One Care

Member Characteristics		**Percentages***	**Logistic Regression**	**Confidence Intervals**
Enrollment		Weighted% (n)	Odds Ratio	95% CI
Cohort	1	86.8 (667)	0.93	0.63-1.38
	2	86.6 (593)	1.37	0.89-2.11
	3	84.4 (569)	Ref	Ref
Plan	Commonwealth Care Alliance	88.7 (847)	1.25	0.74-2.10
	Fallon Total Care	82.7 (703)	0.69	0.42-1.16
	Tufts Health Plan – Network Health	82.7 (279)	Ref	Ref
Enrollment method	Voluntarily enrolled (member chose plan)	87.9 (686)	1.22	0.83-1.77
	Passively enrolled (MassHealth chose plan)	84.6 (1081)	Ref	Ref
Disability/Health Conditions				
Reported Conditions	Physical disability	86.5 (1055)	1.00	0.69-1.44
	No physical disability	85.2 (774)	Ref	Ref
	Psychiatric disability	86.6 (1263)	1.03	0.69-1.53
	No psychiatric disability	84.5 (566)	Ref	Ref
	Substance Abuse	84.8 (167)	1.04	0.57-1.90
	No substance abuse	86.1 (1662)	Ref	Ref
	Long-term illness	86.5 (878)	1.09	0.77-1.56
	No long-term illness	85.5 (951)	Ref	Ref
	Developmental disability	84.7 (198)	0.74	0.43-1.30
	No developmental disability	86.1 (1631)	Ref	Ref
	Learning disability	85.4 (503)	0.91	0.60-1.39
	No learning disability	86.2 (1326)	Ref	Ref
	Blind/visual impairment	86.6 (556)	1.09	0.75-1.60
	No blind/visual impairment	85.7 (1273)	Ref	Ref
	Deaf/hearing loss	85.9 (271)	1.09	0.67-1.77
	No deaf/hearing loss	86.0 (1558)	Ref	Ref
Demographics				
Homelessness	Homeless in past year	81.1 (130)	0.91	0.48-1.72
	Not homeless in past year	86.4 (1679)	Ref	Ref
Age	21-34	89.8 (141)	1.28	0.65-2.53
	35-44	82.7 (317)	0.73	0.45-1.19
	45-54	85.3 (616)	0.77	0.51-1.17

	55-64	87.4 (744)	Ref	Ref
Gender	Male	85.7 (882)	0.86	0.60-1.22
	Transgender/intersex	(--)	(--)	(--)
	Female	86.3 (926)	Ref	Ref
Sexual Orientation	Gay/Lesbian/Bisexual	87.1 (103)	0.91	0.47-1.77
	Asexual	83.5 (20)	0.82	1.48-4.04
	Straight	86.6 (1594)	Ref	Ref
Race	Black	81.5 (241)	0.64	0.38-1.07
	Other	83.6 (361)	0.66	0.39-1.11
	White	88.0 (1111)	Ref	Ref
Ethnicity	Latino/Hispanic	86.6 (397)	1.36	0.71-2.62
	Non-Latino/Hispanic	85.9 (1331)	Ref	Ref
Primary language	English	86.6 (1444)	1.59	0.84-2.99
	Non-English	84.7 (299)	Ref	Ref
Education	Less than high school	**88.3 (422)**	**2.45**	**1.48-4.04**
	High school/GED	**87.9 (638)**	**1.50**	**1.00-2.23**
	Some college or 2-yr degree	82.3 (700)	Ref	Ref
Employment	Worked in past year	84.2 (282)	0.84	0.53-1.32
	Did not work in past year	86.3 (1527)	Ref	Ref

*Weighted percentage of members reporting *planning to stay in One Care* (OC-MES Question 31b). N's are non-weighted showing the number of members with that characteristic who responded to Question 31b. Ref=reference (comparison) group. Statistically significant ORs are bolded.

(--) data not reported due to small sample size ($\leq$5).

Appendix B – One Care 2014 Member Experience Survey