OHIO-SPECIFIC POPULATION HEALTH SURVEYS: GROUNDING INFORMATION FOR OHIO'S HEALTH-ASSOCIATED AGENCIES & ENTITIES

OHIO UNIVERSITY, VOINOVICH SCHOOL

DECEMBER 3, 2021

The Voinovich School is a core research entity to the Ohio Medicaid Assessment Survey Series and the Ohio Medicaid Released Enrollees Study Series

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WHY USE SURVEY AS GROUNDING INFORMATION?

- The state-specific surveys provide periodical checks to policy, program, and service needs and assumptions for Ohio's health services-associated agencies, entities, and community service providers at the state, regional, and local levels.

- These data function as tracking information for health area strengths, weaknesses, and areas in extreme fluctuation.

- Currently, the Ohio Colleges of Medicine Government Resource Center heads or participates in 19 surveys for governmental and other sponsors. 5 of these surveys are work as extension, meaning they are work specific to an agency/entity meant for primarily internal needs.

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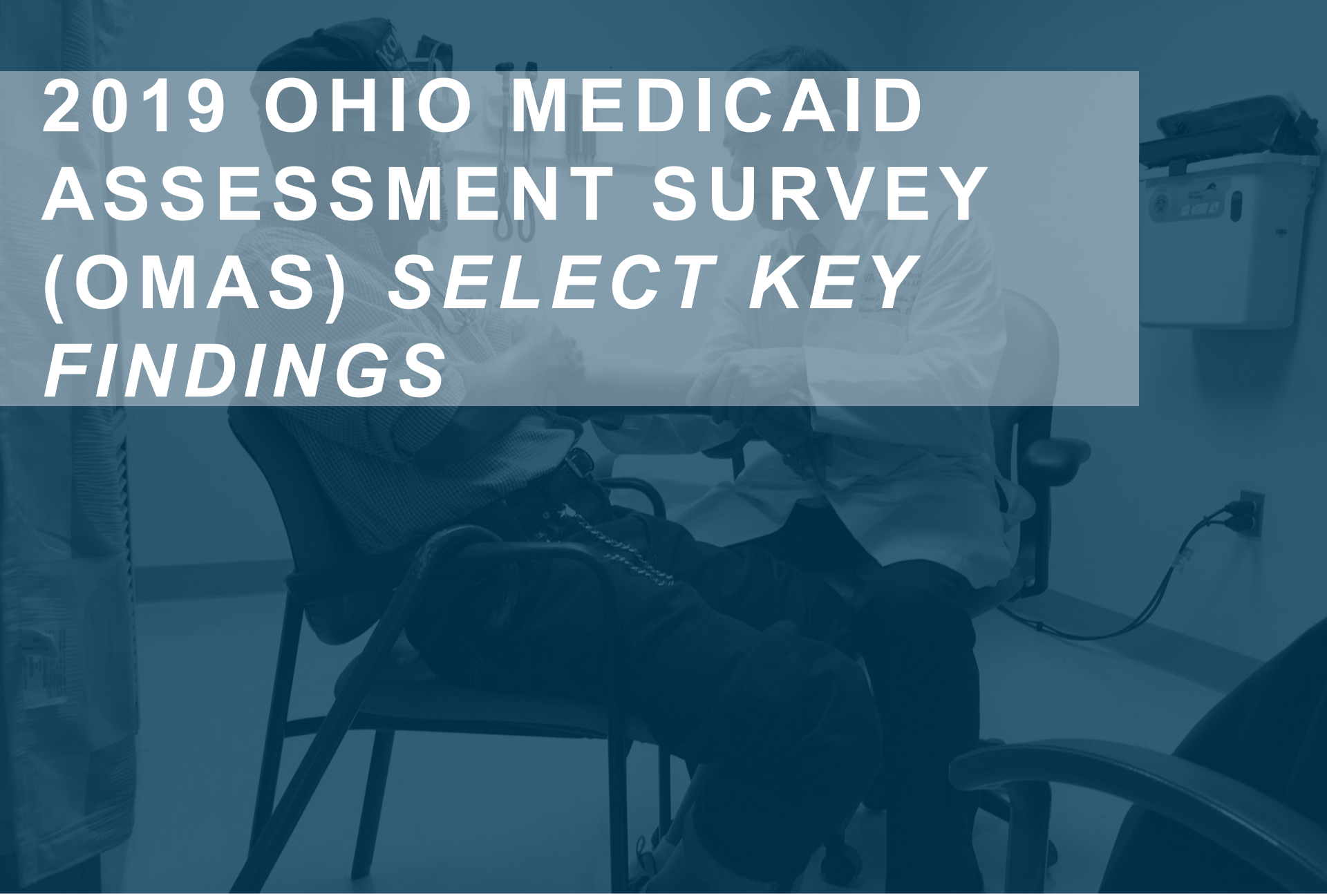
2019 OHIO MEDICAID ASSESSMENT SURVEY (OMAS) *SELECT KEY FINDINGS*



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WHAT IS THE OHIO MEDICAL ASSESSMENT SURVEY (OMAS)?

- The Ohio Medicaid Assessment Survey (OMAS) is a data collection project used to provide estimates of insurance rates, access to health care, health care use, health status, and health demographics for all residential adults and children in Ohio.

- The main emphasis of the survey is the status of Ohio's Medicaid enrolled, Medicaid eligible, and comparative populations.

- This is the 8th iteration of the project (1998, 2004, 2008, 2010, 2012, 2015, 2017, 2019); the 9th iteration (2021 OMAS) is currently in the field – data will be available in late March of 2022.

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2019 OMAS PARTNERSHIP

- 2019 OMAS Executive Committee had members from most health and human services state agencies
  - Ohio Department of Health
  - Ohio Department of Medicaid
  - Ohio Department of Mental Health and Addiction Services
  - Ohio Department of Developmental Disabilities
  - Ohio Department of Aging
  - Ohio Commission on Minority Health
- Many Ohio universities contributed to the design and analyses of the 2019 OMAS
  - The Ohio State University
  - Ohio University
  - Bowling Green State University
  - Mount Union University
  - University of Cincinnati
- As with prior iterations, many health-associated entities are expected to use the 2019 OMAS data; examples include
  - Local Departments of Jobs and Family Services
  - Local public health departments
  - Managed care plans
  - Various health provider associations (i.e., Ohio Hospital Association, Federally Qualified Health Centers Association, Association of Ohio Health Commissioners)
  - Children's Defense Fund
  - Ohio Delta Projects (violence prevention organizations in Ohio)
  - Local Offices on Aging
  - Etc.

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BACKGROUND

- OMAS provides data supporting policy making and strategy development for the efficient and effective operation of Ohio's Medicaid program.

- OMAS is the key research dataset for estimates of insurance rates, access to health care, health status, health risks and poverty of children and adults in Ohio.

- Initial OMAS was the Ohio Family Health Survey and was an initiative of ODH in 1997.

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MAIN TOPICS

- Medicaid status
- Insurance status
- Access to health care
- Health care utilization
- Unmet health needs
- ACA Trends
- Adverse Child Events (ACEs)
- Substance use/misuse
- Employment
- Health risk factors
- Health status
- Mental health distress
- Developmental Disabilities
- Population Health
- Health demographics
- Socioeconomic indicators

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METHODS SUMMARY

- OMAS uses primarily existing, validated questions in a domain setup (anchors to nuance).
- Some agencies'-specific questions can be developed, cognitively tested, and then piloted before being placed in questionnaire.
- Administration methods in 2019 included landline and cell phone telephone surveys as well as an address-based sampling (ABS) pilot that also incorporated paper and web surveys.
- The survey vendor was RTI International.
- The data collection period September through December 2019, if needed call-backs through January 2020.
- Interviews were conducted in English and in Spanish.
- More detailed methods information can be found at grc.osu.edu/OMAS.

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2019 OMAS FIELD ACTIVITY ESTIMATES

- Random Digit Dial (RDD) Interviews:
  - 30,068 Adult Interviews
  - 7,118 Child Interviews*
- Address Based Sampling (ABS) Interviews:
  - 1,561 Adult Interviews
  - 295 Child Interviews*

** Child interview is completed by an adult proxy*

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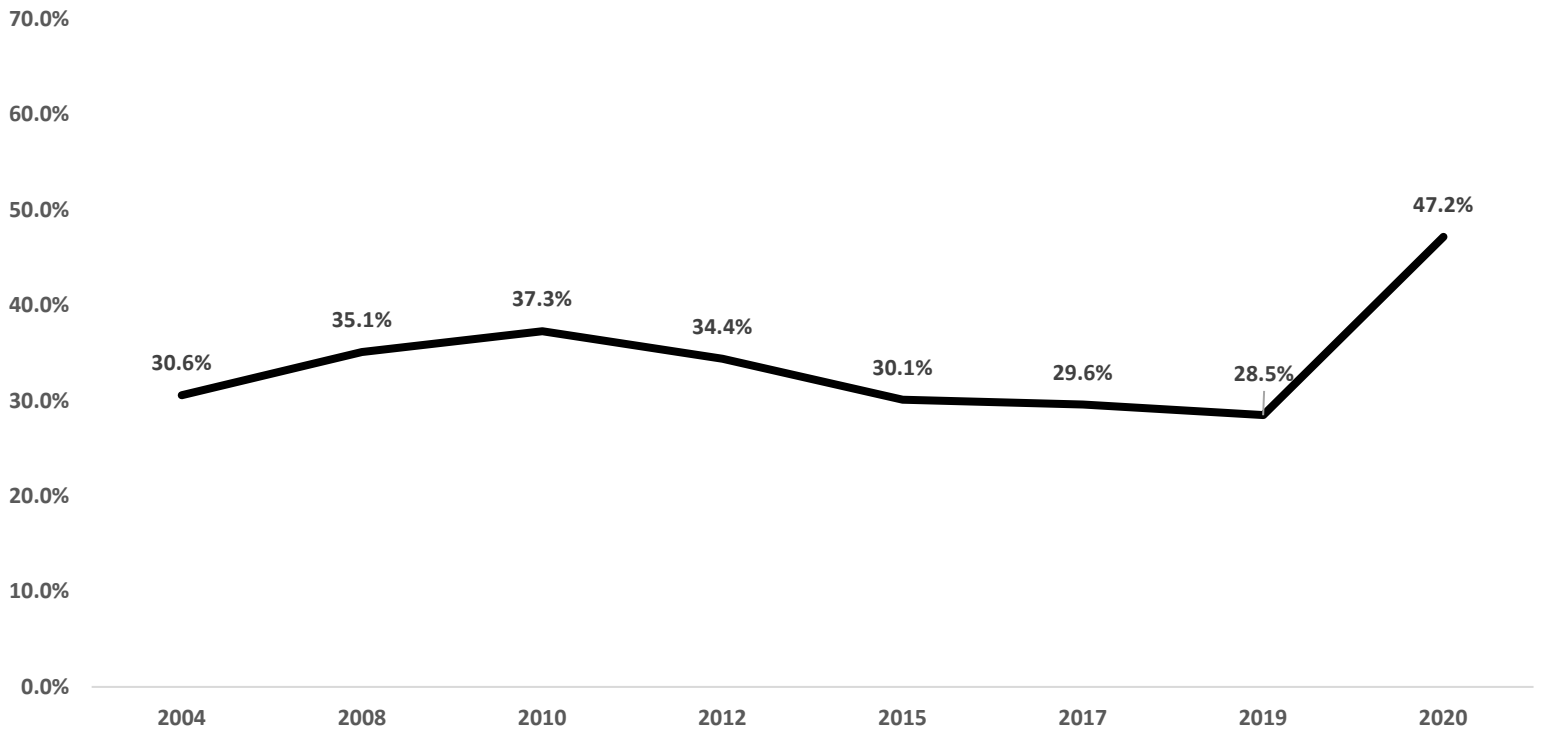
SELECT SOCIOECONOMIC STATUSES

COUNT OF ADULT AGES 19-64 NOT WORKING IN OHIO, 2004-2020



- * The 2020 estimate is generated by adding the count of Ohioans expected to apply for unemployment by the end of May 2020 (1,250,000) to the 2019 Ohio Medicaid Assessment Survey (fall of 2019) count of those self-reporting not working a week (reference week) prior to being interviewed.
- Note that the not working statistic differs from the official federal unemployment calculation, which counts those who are jobless, looking for a job, and available for work (source: US Department of Labor and Current Population Survey).
- Estimate of total population for calculation for 2020 estimate is 6,943,178 adults ages 19-64 years.

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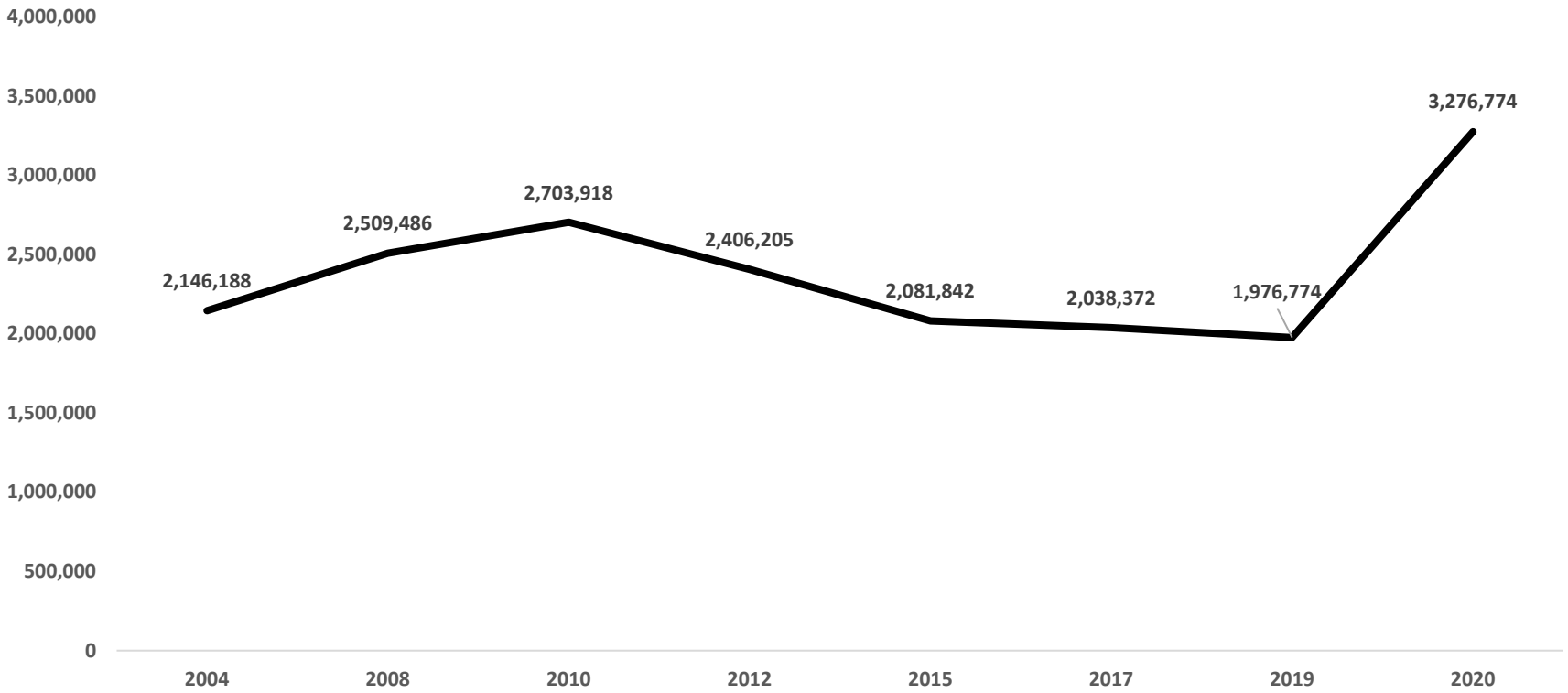
COUNT OF ADULT AGES 19-64 NOT WORKING IN OHIO, 2004-2020



- * The 2020 estimate is generated by adding the count of Ohioans expected to apply for unemployment by the end of May 2020 (1,300,000) to the 2019 Ohio Medicaid Assessment Survey (fall of 2019) count of those self-reporting not working a week (reference week) prior to being interviewed.
- Note that the not working statistic differs from the official federal unemployment calculation, which counts those who are jobless, looking for a job, and available for work (source: US Department of Labor and Current Population Survey).
- Estimate of total working age (19-64 years) population for 2020 estimate is 6,943,178.

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2019 FEDERAL POVERTY GUIDELINES* (GROSS INCOME, BEFORE ANY TAX OR OTHER WITHHOLDINGS

Annual Family Income					
Family Size	**100% FPL**	**138% FPL**	**250% FPL**	**400% FPL**	
1	$12,490 ($1,041 pm)	$17,236 ($1,436 pm)	$31,225 ($2,602 pm)	$49,460 ($4,163 pm)	$17,442 -- annual income for full-time worker (2080 hours) at Ohio's $8.55 minimum wage.
2	$16,910 ($1,409 pm)	$23,336 ($1,946 pm)	$42,275 ($3,523 pm)	$67,640 ($5,637 pm)	
3	$21,330 ($1,778 pm)	$29,435 ($1,945 pm)	$53,325 ($4,444 pm)	$85,320 ($7,110 pm)	
4	$25,750 ($2,146 pm)	$35,535 ($2,961 pm)	$64,375 ($5,365 pm)	$103,000 ($8,583 pm)	

**https://aspe.hhs.gov/2019-poverty-guidelines*

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COST OF EMPLOYER-SPONSORED PREMIUMS: AHRQ ANALYSES, WITH EXTENSION

I. Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance: United States, State: Ohio, years 1996-2013

Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2008	2009	2010	2011	2012	2013
Cost	$4,538	$5,198	$5,483	$5,721	$6,596	$7,203	$8,163	$9,136	$9,590	$10,662	$10,967	$11,425	$11,870	$13,083	$14,327	$15,455	$15,955*

II. Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance: United States: Ohio, years 1996-2018

Year	Average Cost		Year	Average Cost
1996	$1,826		2008	$4,089
1997	$1,990		2009	$4,261
1998	$2,393		2010	$4,669
1999	$2,283		2011	$5,025
2000	$2,574		2012	$5,081
2001	$2,787		2013	$5,679
2002	$3,087		2014	$5,930
2003	$3,416		2015	$5,939
2004	$3,782		2016	$6,291
2005	$3,928		2017	$6,247
2006	$4,054		2018	$6,804

Data sources: Medical Expenditures Panel Survey, Agency for Health Care Quality Research.

* The Medical Expenditures Panel Survey ceased collecting these statistics in 2013.

Citation: Agency for Healthcare Research and Quality. *Average total family premium in dollars per enrolled employee at private-sector establishments that offer health insurance by firm size and State* (Table II.D.1), years 1996-2012: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009), 2009 (July 2010), 2010 (July 2011), 2011 (July 2012), 2012 (July 2013), 2013 (July 2014). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp (January 30, 2020)

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GENERAL ESTIMATE OF ANNUAL HOUSEHOLD EXPENSES IN 2018/2019, OHIO*

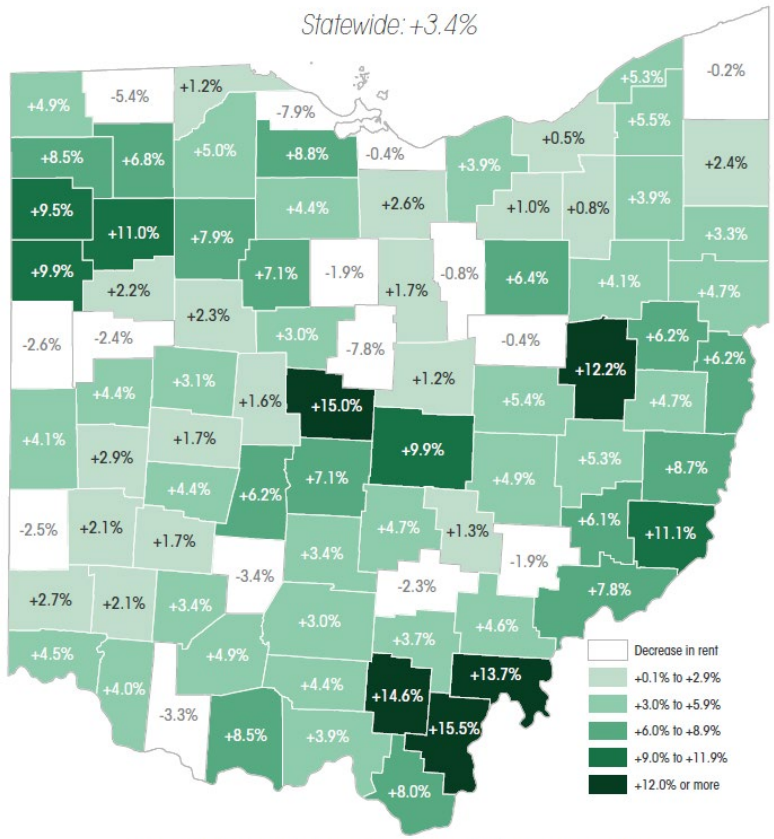
Example of Basic Annual Living Costs in Ohio**		
Category	Annual Average Cost	Source
Employee contribution to ESI for family of 4 (2018)	$5,430	AHRQ/MEPS https://meps.ahrq.gov/data_files/publications/st524/stat524.pdf
Rent/house plus insurance, to 50th percentile income (2018)	$7,220	HUD (https://www.huduser.gov/portal/datasets/cp.html)
Utilities (electric, gas, water/waste water, phone) (2018)	$2,720	Public Utilities Commission of Ohio. (*Ohio Utility Rate Report,* 2018)
Transportation (excluding car payment) (2017)	$2,150	MORP-C, 2018 & Economic Policy Institute. http://www.epi.org/resources/budget/
Average food (USDA thrifty food plan) (months averaged) (2018)	$6,790	USDA Food Plans, 2019 average costs. https://fns-prod.azureedge.net/sites/default/files/media/file/CostofFoodDec2019.pdf
Other basic living expenses (hygiene, clothing, etc.) (2017)	$1,280	CPI statistics, US Bureau of Labor (https://beta.bls.gov/dataQuery/find?fq=survey:[su]&s=popularity:D)
Total estimated annual expenses	$25,590	

* Estimates are median and mean values, reported costs are rounded.

** These cost estimates may understate or overstate the actual living expenses of Ohio's Medicaid enrolled or Medicaid eligible populations. When possible, calculations emphasize basic living expenses (e.g., USDA thrifty food plan).

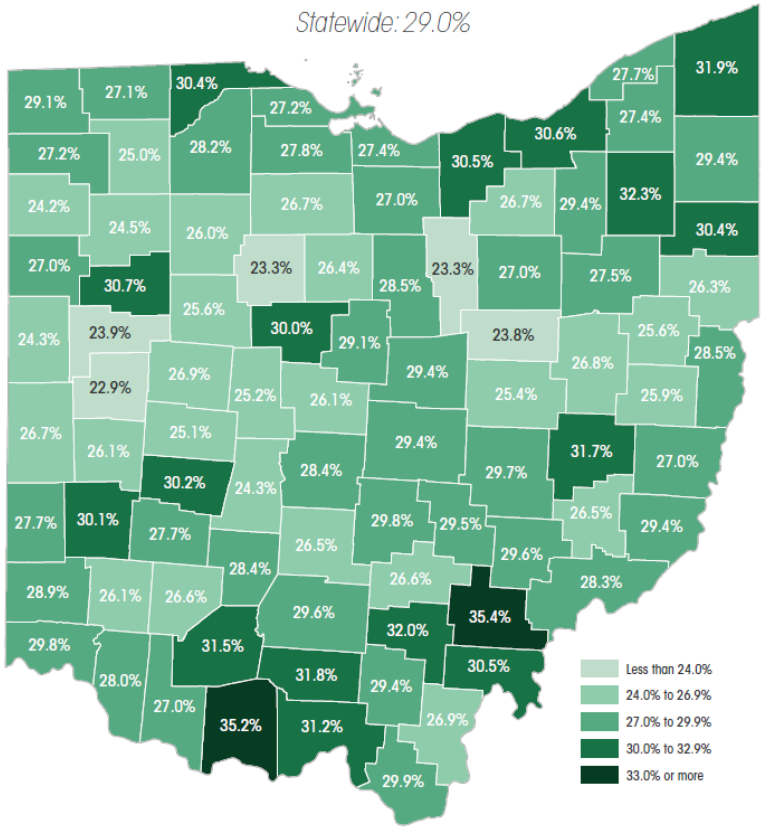
HOUSING EXPENSES: RENT

Exhibit 6-3. Change in Inflation-Adjusted Median Gross Rent by County, 2007-2011 to 2012-2016



Source: 2007-2011 and 2012-2016 American Community Survey Five-Year Estimates, Table B25064

Exhibit 6-5. Median Gross Rent as Share of Household Income by County



Source: 2012-2016 American Community Survey Five-Year Estimates, Table B25071
Note: "Gross rent" includes utility costs, defined as electricity, natural gas, water, and/or sewer bills.

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Source: 2019 Ohio Housing Needs Assessment, p.95 & 97. Ohio Housing Finance Agency.

HEALTH INSURANCE

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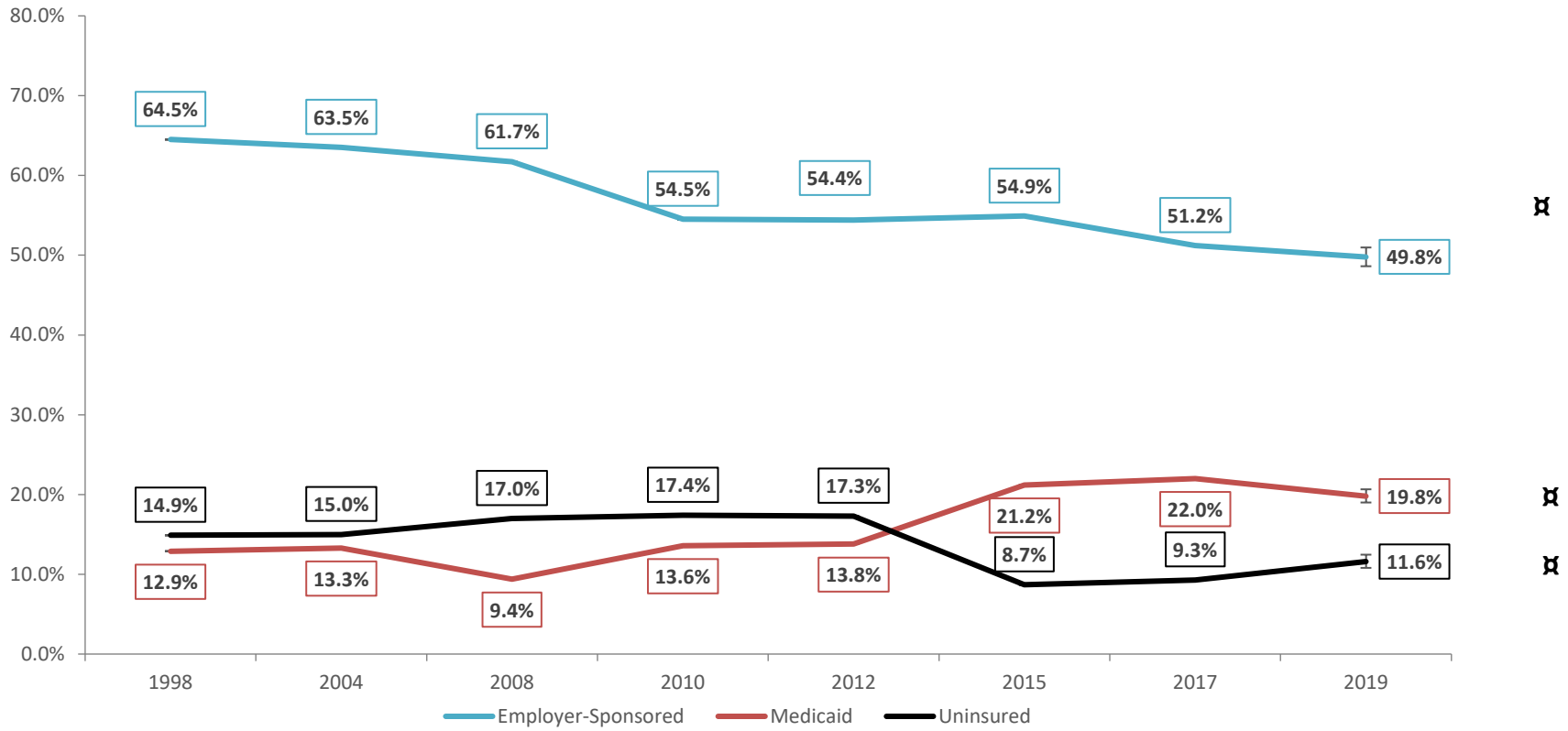
TRENDS IN SELECT INSURANCE COVERAGE, OHIO ADULTS*

AGES 19-64 YEARS (SELF-REPORTED)



Data sources: Ohio Medicaid Assessment Surveys (1998-2019)

¤ Note that 2019 OMAS results are from the 75% completed weighted data set – these estimates will be adjusted once the final weighted 2019 OMAS data set becomes available.

* This slide does not display "Other" insurance types, including Exchange, Privately Purchased, Medicare, Other, and Unknown Type of Insurance.

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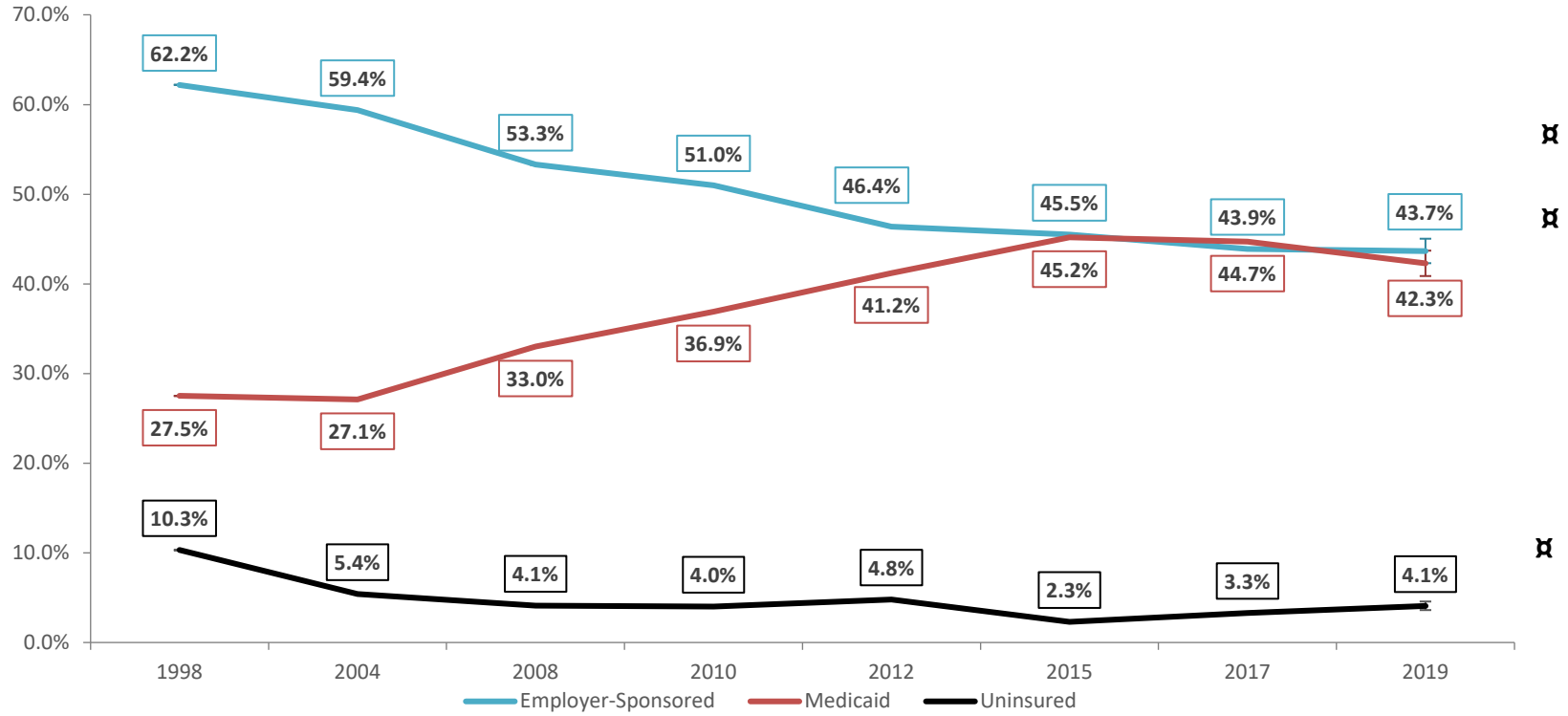
TRENDS IN SELECT INSURANCE COVERAGE, OHIO CHILDREN*

AGES 0-17 YEARS (1998-2010 OMAS), AGES 0-18 (2012-2019 OMAS) (PROXY-REPORTED)



Data sources: Ohio Medicaid Assessment Surveys (1998-2019).

¤ Note that 2019 OMAS results are from the 75% completed weighted data set – these estimates will be adjusted once the final weighted 2019 OMAS data set becomes available. Additionally, the 1998-2010 years of OMAS defined children as 0-17 years of age; the 2012-2019 iterations of OMAS redefined children as 0-18 years of age, adjusting to Medicaid eligibility criteria. Due to methodological considerations, these age ranges were not adjusted in this chart.

* This slide does not display "Other" insurance types, including Exchange, Privately Purchased, Medicare, Other, and Unknown Type of Insurance.

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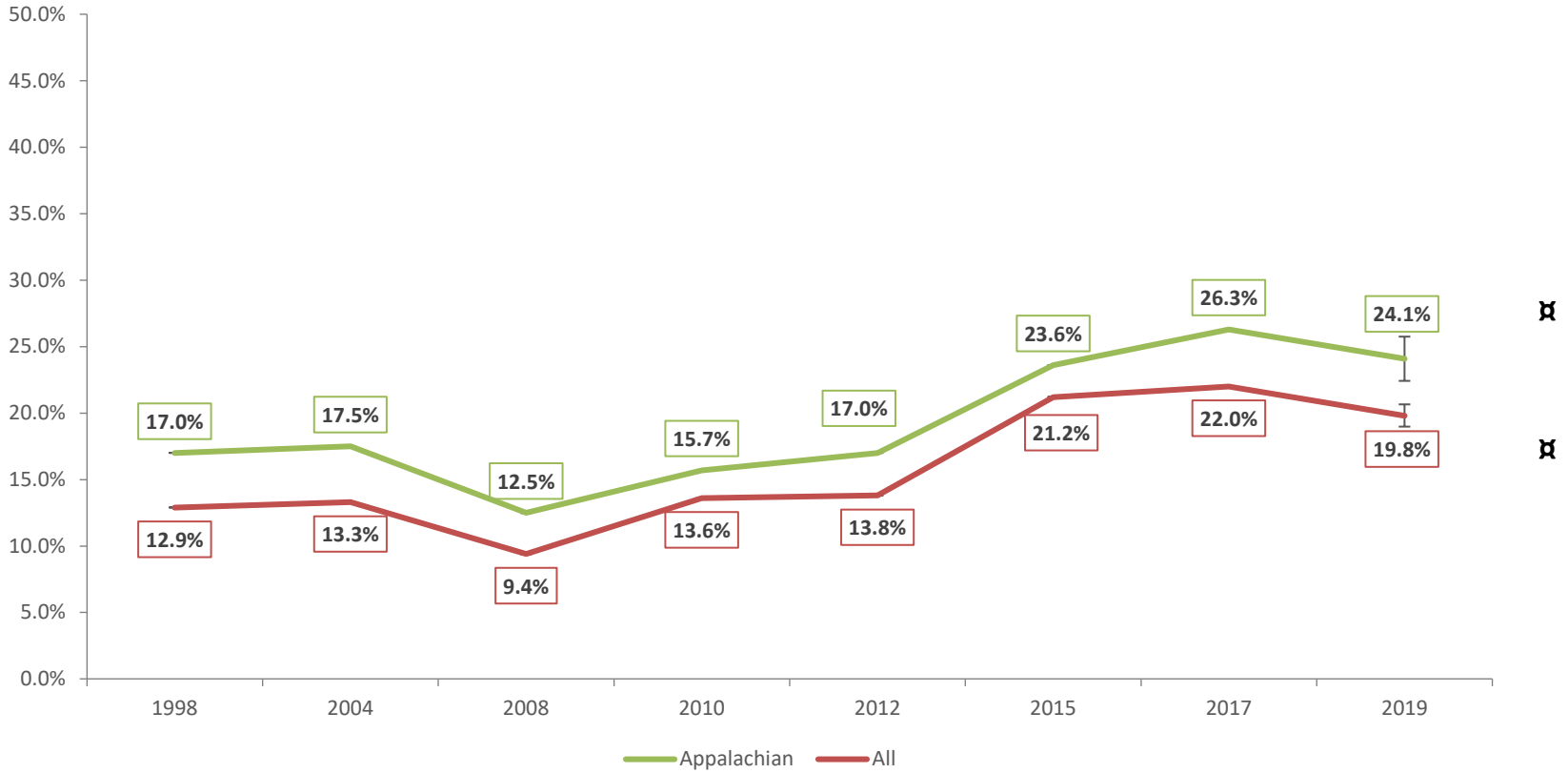
TRENDS IN PERCENT OF ADULTS ENROLLED IN MEDICAID

AGES 19-64 YEARS (SELF-REPORTED)



Data sources: Ohio Medicaid Assessment Surveys (1998-2019).

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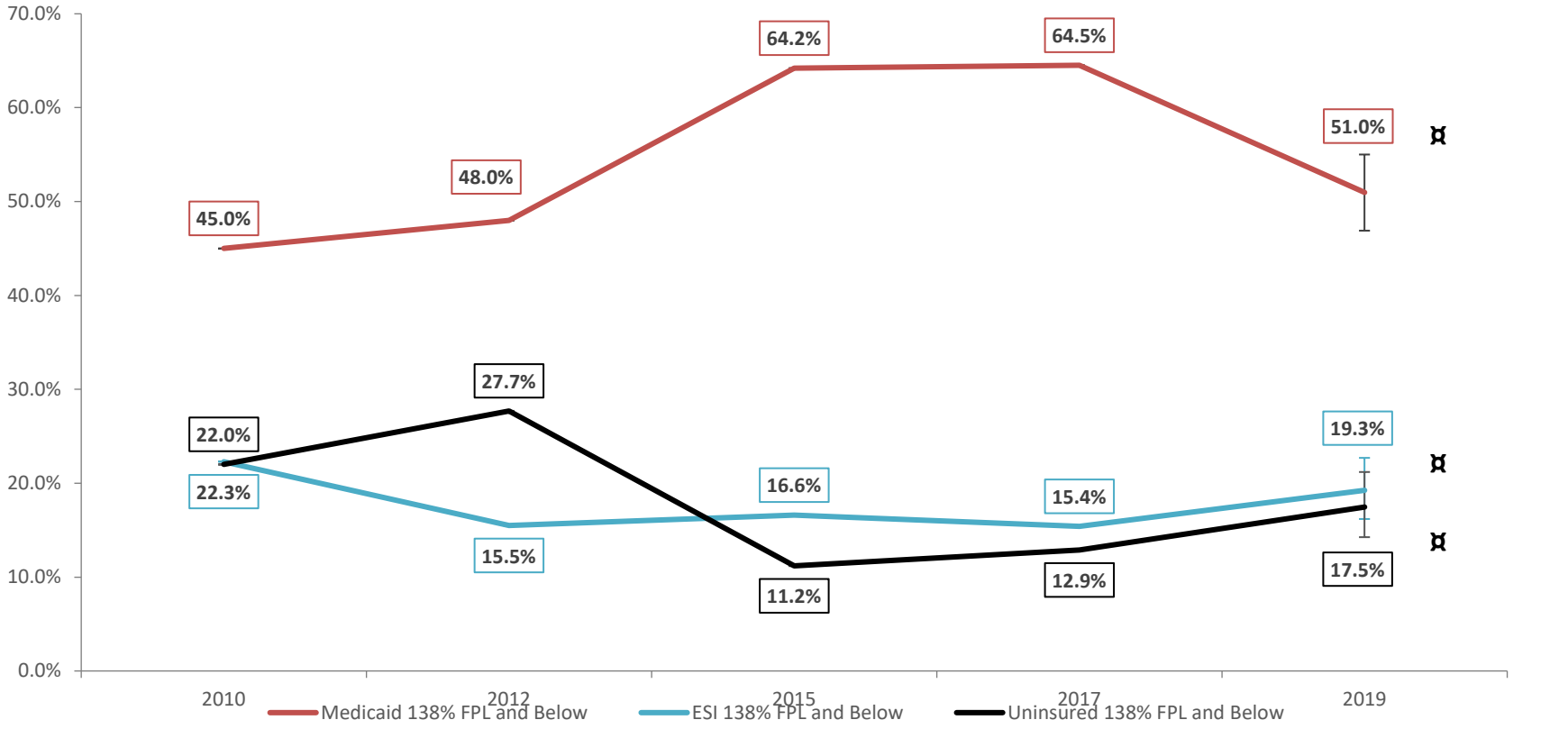
TRENDS IN SELECT INSURANCE COVERAGE: OHIO PARENTS 138% FPL*

AGES 19-64 YEARS (SELF-REPORTED)



Data sources: Ohio Medicaid Assessment Surveys (2010-2019).

¤ Note that 2019 OMAS results are from the 75% completed weighted data set – these estimates will be adjusted once the final weighted 2019 OMAS data set becomes available.

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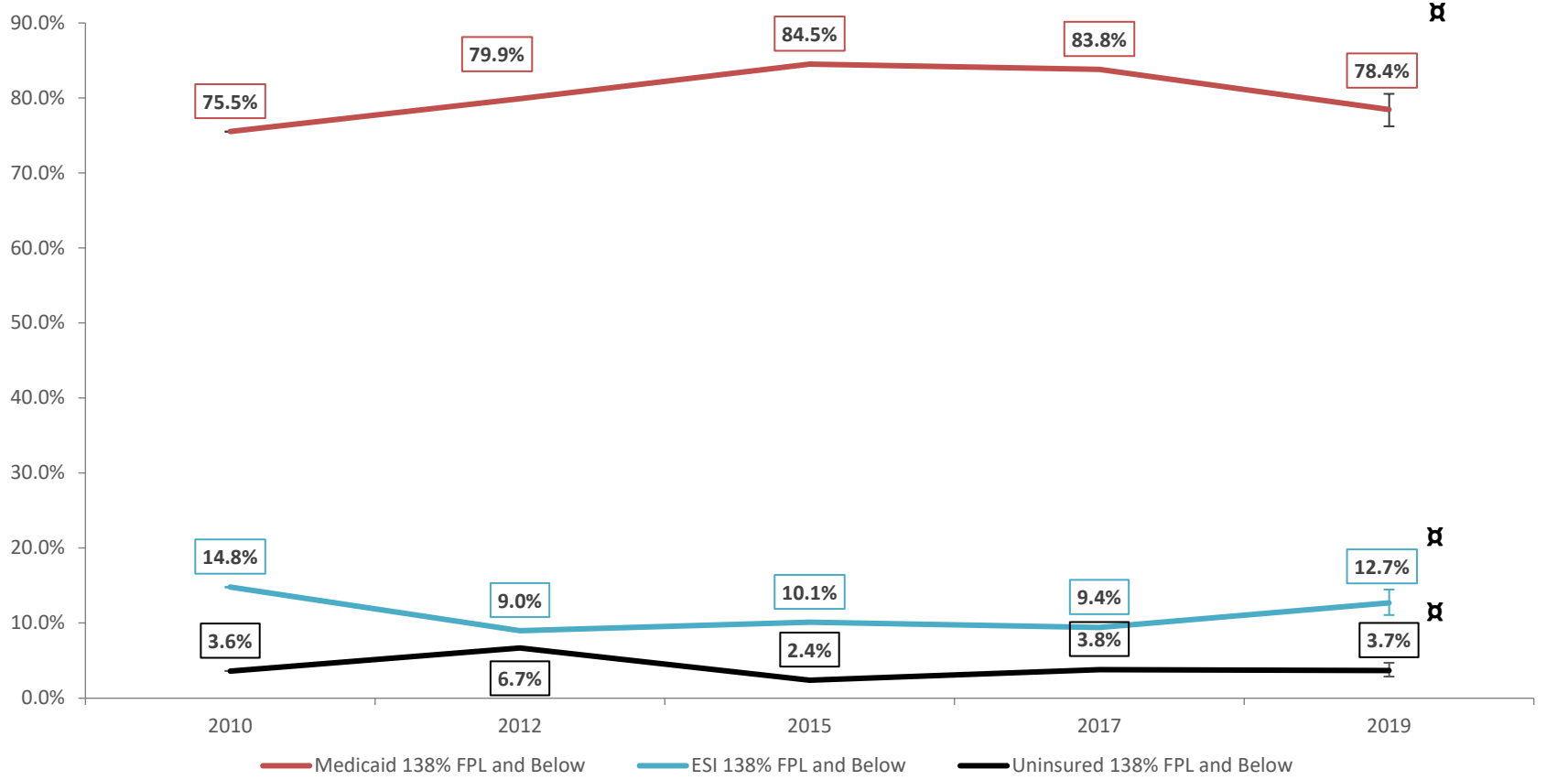
TRENDS IN SELECT INSURANCE COVERAGE: OHIO CHILDREN 138% FPL*

AGES 0-18 YEARS (PROXY-REPORTED)



Data sources: Ohio Medicaid Assessment Surveys (1998-2019).

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RESULTS: 2019 OMAS CHART BOOKS

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BEHAVIORAL HEALTH

- 3.6% of children 5-11 years and 4.9% of adolescents 12-18 years experienced frequent mental distress (FMD) – data was not collected for newborns to 4 years.
- 8.8% of working-aged adults (ages 19-64 years) reported mental health impairment (MHI), defined as not being able to routinely function at least 14 days in the last 30, prior to the interview date.
- MHI was highest for young women (19-24 years), and lowest for late middle-aged men (55-64 years).
- MHI and FDM are associated with comorbidity and adults with MHI experienced barriers and gaps in access to care.
- Medicaid was the most common health care coverage for those with FMD and MH.

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CHILD & ADOLESCENT HEALTH

- The percent of youth covered by employer-sponsored insurance (ESI) has steadily declined since 1998.

- Medicaid Enrollment:
  - Younger youth were more likely than older youth to be enrolled in Medicaid.
  - Black or African American youth were more likely than others to be Medicaid-enrolled.
  - Youth in Rural Appalachian counties were more likely than other youth to be enrolled in Medicaid.

- Medicaid-enrolled youth were:
  - As likely or more likely to utilize health services – including routine check-ups, dental visits, and emergency room visits.
  - Less likely to delay or avoid care in the past year and were more likely to find accessing medical care easier, compared with three years ago.

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CHILD & ADOLESCENT HEALTH (CONT.)

- Adverse childhood experiences (ACEs):
  - Were more prevalent among Medicaid-enrolled youth than among other lower income youth. For instance, among youth ages 13 to 18, 74.5% of Medicaid-enrolled youth had ever experienced any ACE vs 57.2% of non-Medicaid, lower-income youth.
  - Among all Ohio youth, Black or African American youth were more likely to have ever experienced any ACE compared to white and Hispanic youth. Among all Ohio youth, 64.8% of Black or African American youth had ever experienced any ACE, compared to 50.3% of white youth, and 60.3% of Hispanic youth.

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How Do We Improve Health?
Foundational Strategy to Manage Populations

Develop System

- Affordable Care Act & Insurance Coverage
- Culture of Caring
- Dedicated personnel

Get everyone in the system

- Enrollment
- Outreach
- Retention

Identify risk

- Timely identification of priority populations
- Targeted efforts by geography
- Targeted by issue (e.g. preterm birth or Overdose risk)

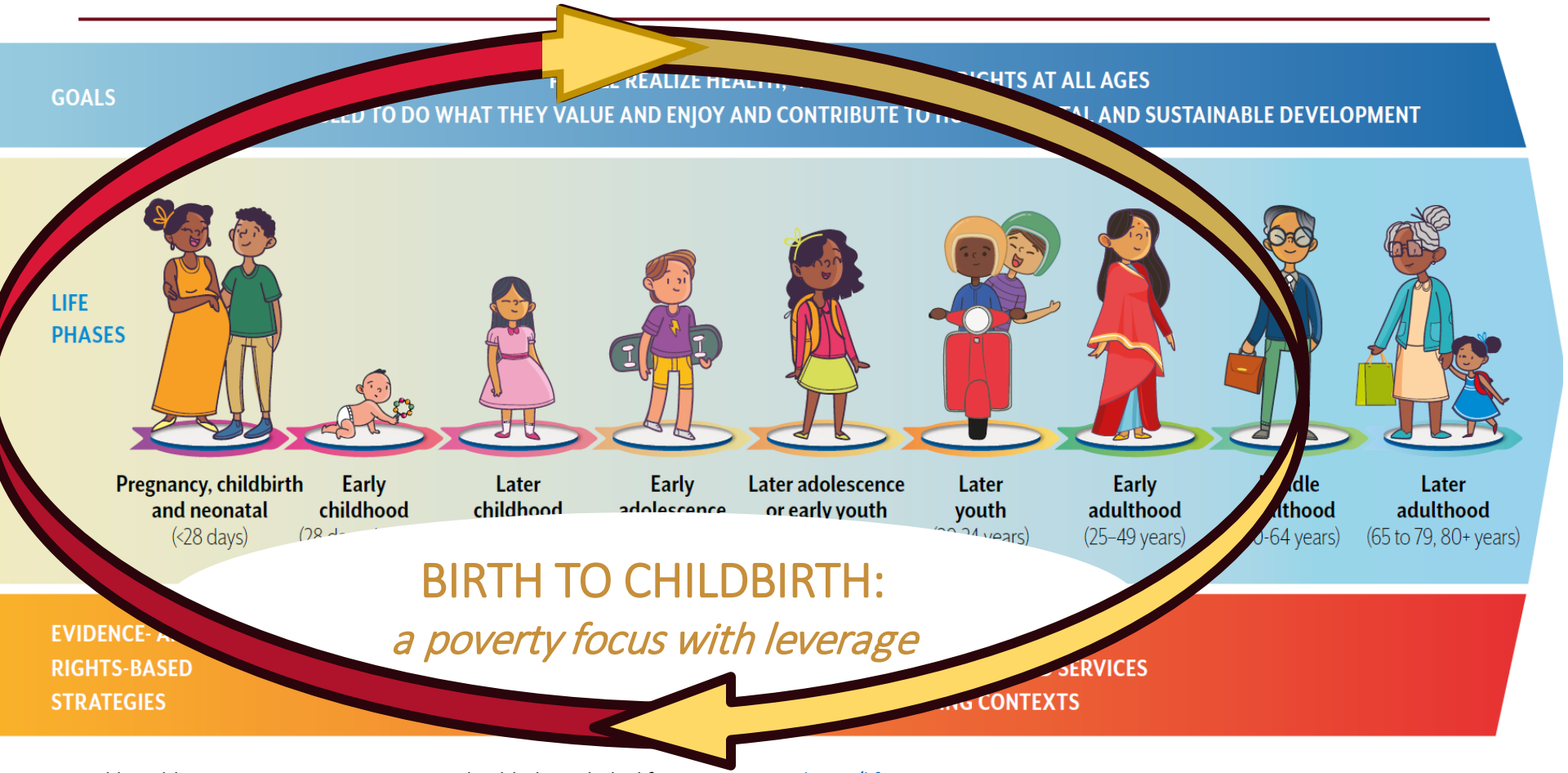
Provide Best-evidenced Services

- Care Management (tiered)
- Comprehensive Primary Care
- Re-Designed systems (Behavioral Health, Schools)

Maintain & Support Life Course

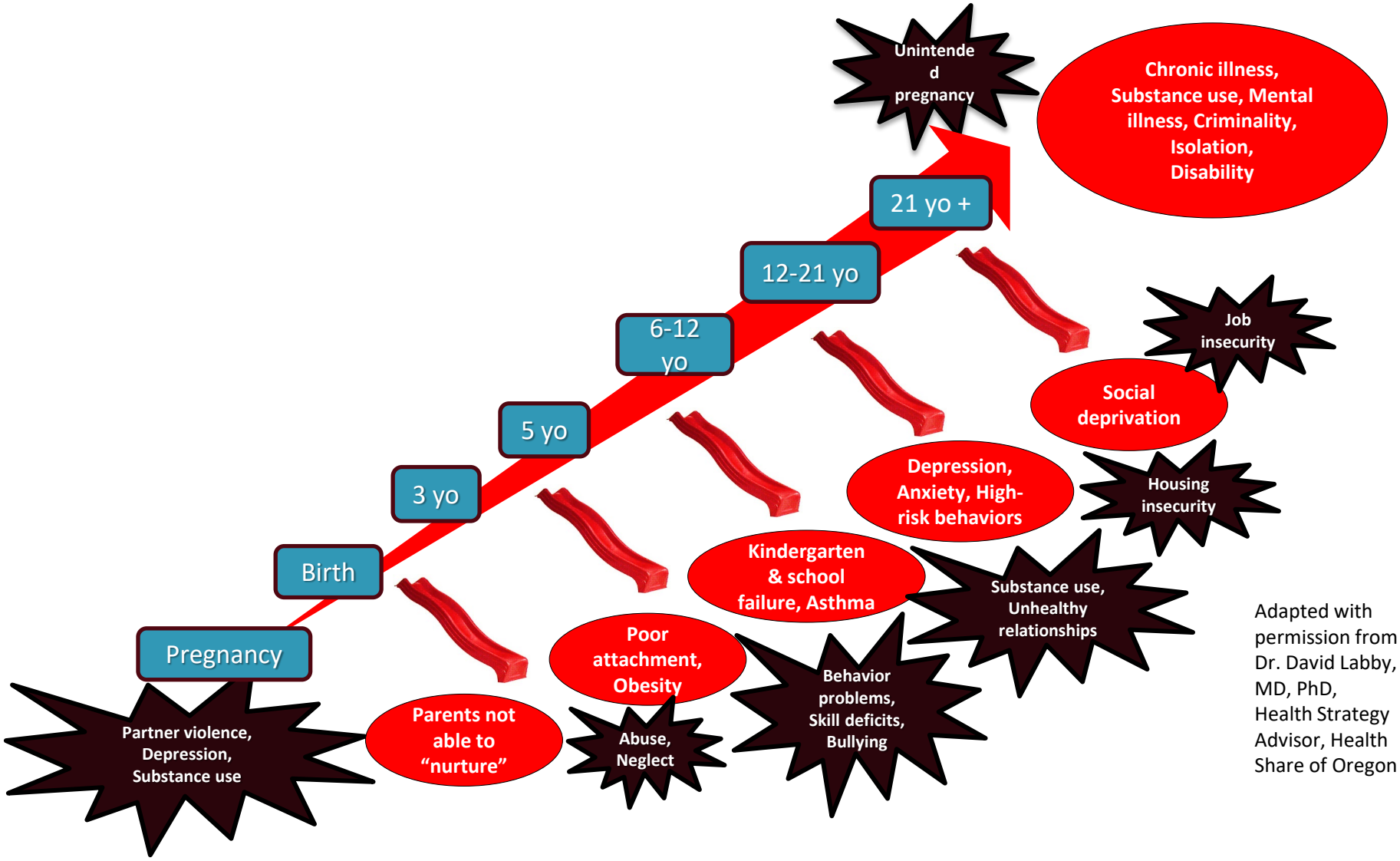
- Enhanced services
- Community & non-traditional Health Workers
- Value-based purchasing
- Quality Improvement & Community efforts
- Cohesive policy package

The Life course of Good Health



World Health Organization, 2019, Promoting health through the life course: www.who.int/life-course

Cascading Impact of Adverse Childhood Events (ACEs)



Adapted with permission from Dr. David Labby, MD, PhD, Health Strategy Advisor, Health Share of Oregon

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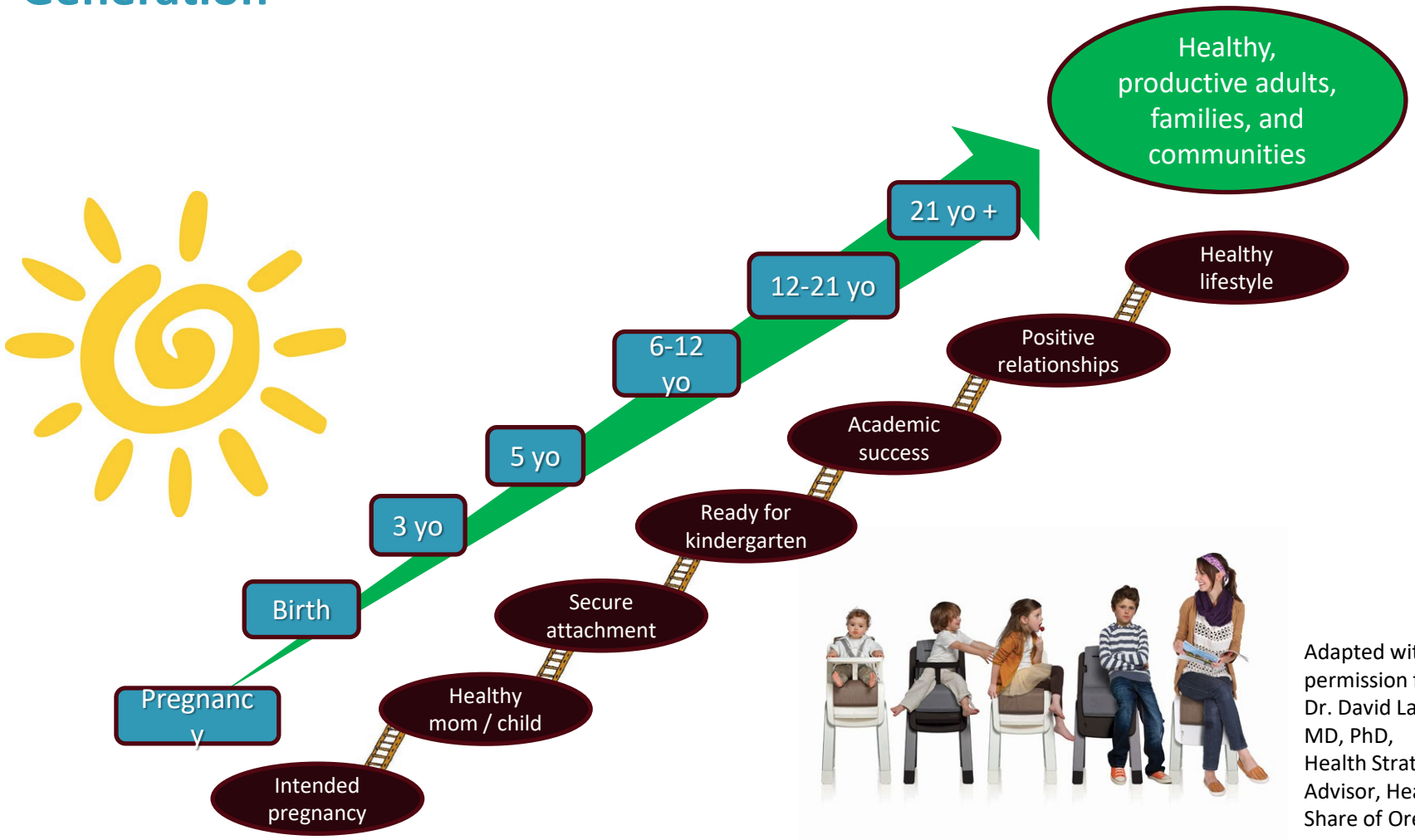
Our Ultimate Goal: A Healthy, Productive Next Generation



Adapted with permission from Dr. David Labby, MD, PhD, Health Strategy Advisor, Health Share of Oregon

Adverse Childhood Events (ACEs)

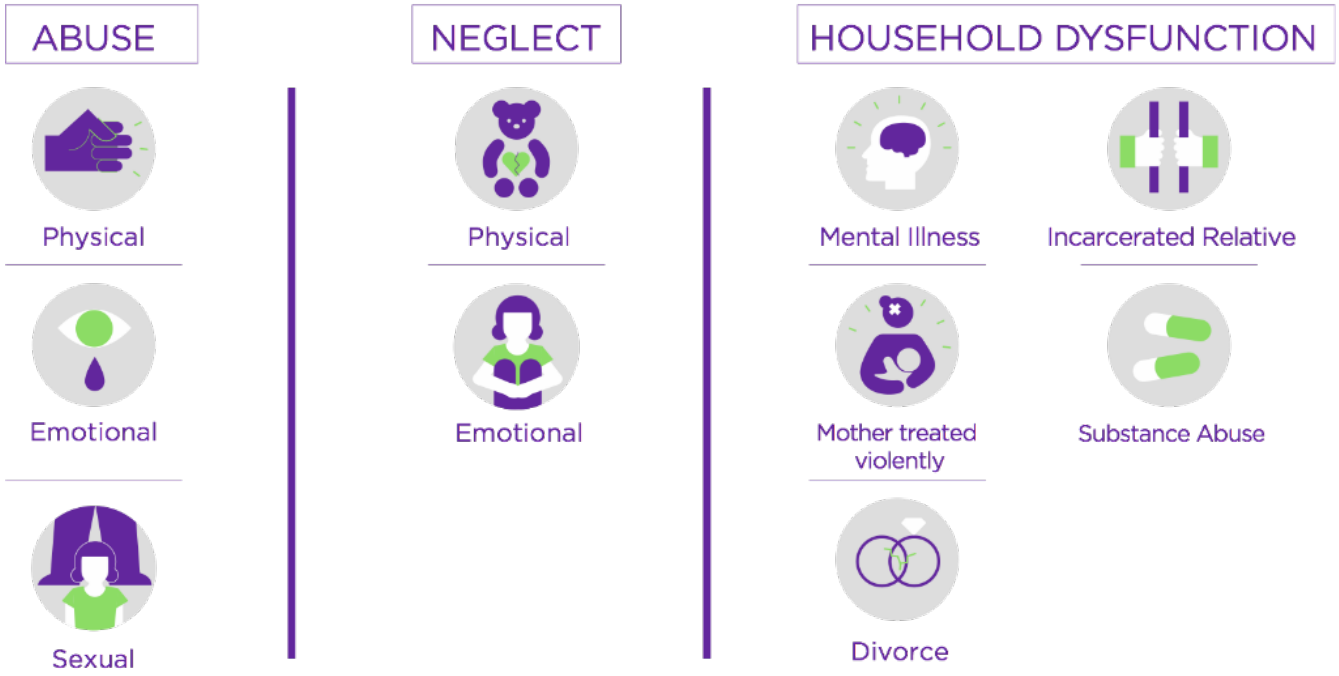


Image courtesy of the Robert Wood Johnson Foundation

ACE's Dramatically Increased Risk for 9 Out of 10, Leading Causes of Death in the US

	Leading Causes of Death in US, 2017	Odds Ratio Associated with ≥ 4 ACEs
1	**Heart Disease**	**2.1**
2	**Cancer**	**2.3**
3	**Accidents**	**2.6**
4	**Chronic Lower Respiratory Disease**	**3.1**
5	**Stroke**	**2.0**
6	**Alzheimer's**	**4.2**
7	**Diabetes**	**1.4**
8	Influenza and Pneumonia	
9	**Kidney Disease**	**1.7**
10	**Suicide**	**37.5**

Source of causes of death: CDC, 2017
Sources for odds ratios: Hughes *et al.,* 2017 for 1, 2, 4, 7, 10; Petrucelli *et al.,* 2019 for 3 (injuries with fracture), 5; Center for Youth Wellness, 2014 for 6 (dementia or Alzheimer's disease); Center for Youth Wellness, 2014 and Merrick *et al.,* 2019 for 9

CHRONIC DISEASE

- Nearly three in ten Ohioans ages 19 years and older had been diagnosed with at least one of the following chronic diseases or conditions: arthritis, asthma, coronary heart disease, congestive heart failure, diabetes, heart attack, hypertension, or stroke. Nearly one-in-five (18.1%) had ever been told they had two or more chronic diseases or conditions.

- Women more often reported a diagnosis of a chronic disease or condition, with 30.8% reporting one disease or condition and 19.3% reporting two or more (compared to 28.6% and 16.9% respectively among men). Women were more likely to report having arthritis or asthma, while
men were more likely to report a diagnosis of hypertension or heart disease.

- Among those on Medicaid, 31.2% of enrollees reported a diagnosis with one chronic disease/condition, and a quarter (25.2%) reported a diagnosis of two or more.

- Over a third (33.7%) of those with “Other” insurance reported the diagnosis of one chronic disease, and 29.7% reported a diagnosis of two or more.

- While level of education attainment did not appear to have an impact on experiencing one chronic disease or condition, those who had completed less than high school were more likely than those achieving a high school diploma or beyond to have a diagnosis of two or more chronic diseases or conditions (21.9% vs. 12.7% and 12.0% respectively).

EMPLOYMENT

- In 2019, more than two-fifths (43.1%) of adult Ohio Medicaid enrollees were actively employed.
- For all Ohioans not working, leading barriers to work were physical or mental health limitations (51.4%), caring for a family member (30.6%), and not being able to find work (21.5%).
- For all Ohioans not working, looking for work, but unable to find a job, the most common barriers were the need for additional skills through school or training (39.5%), transportation problems (32.4%), and employer background checks (21.1%).
- In terms of Medicaid expansion longevity (duration of enrollment), as of December 2019, approximately half (52.8%) were continuously enrolled since 2018, and less than a quarter (24.4%) were continuously enrolled since 2016.

HOUSING

- More than 40% of all Ohioans experienced some form of housing insecurity in 2019.
- On average, 3.6% of renter households in Ohio experienced an eviction each year in the period between 2002 and 2016.
- Medicaid enrollees were more likely than other Ohioans to experience every form of housing insecurity examined in the present study. The prevalence of housing insecurity also varied by age, race/ethnicity, and county type.
- In 2019, 68.4% of Medicaid enrollees were housing insecure, including 29.8% who were severely cost-burdened and 4.1% who were homeless or living in shelters or other temporary housing.
- Housing insecurity was associated with a greater likelihood of fair/poor self-reported health and mental health impairment, as well as more frequent emergency room visits.

MINORITY HEALTH

- Racial/ethnic disparities, defined as “racial or ethnic differences in quality of care not due to access-related factors, clinical needs, preferences, or appropriateness of care” (IOM, 2009), are persistent and pervasive in Ohio.
- Areas of minority health disparities in Ohio include:
  - Access to health care, Blacks or African Americans and Hispanics have disproportional unmet needs, compared to Whites.
  - Chronic conditions, Blacks or African Americans and Hispanics experienced chronic health conditions more frequently than whites.
  - Substance use, smoking and marijuana use were highest among Blacks or African Americans and binge drinking was highest among Hispanics – opioid deaths were highest among Whites.
  - Economic insecurity, minorities had higher rates of housing burden, food insecurity, debt to income, unmet health needs due to cost. (Note that Ohio has the nation’s 9th largest race wage gap, Whites’ median income was 84% higher than that of Blacks or African Americans.)
  - Incarceration, Blacks or African Americans are 6 times more likely (ratio scale) to be incarcerated.
- Given these stressors, fewer disparities exist among the Medicaid enrolled minorities.
- Concerning COVID-19, Blacks or African Americans are overrepresented among COVID-19 cases, hospitalizations, and deaths, compared to the rest of the state.

RURAL HEALTH

- Rural adults were more likely to report fair/poor health status, and to be obese than Non-Rural adults – regardless of Medicaid status.
- Rural and Non-Rural adults with Medicaid were more likely to report a disability than potentially Medicaid-eligible adults.
- Rural adults were more likely to be current smokers than Non-Rural adults, regardless of Medicaid status. Those with Medicaid were, however, more likely to be current smokers than the potentially Medicaid-eligible.
- Prescription pain pill misuse was the highest within the Rural Medicaid population.
- Rurality did not always matter for health behaviors or outcomes. Rather, Medicaid coverage appeared to make the difference. Further, when rurality did matter, it was not necessarily the case that outcomes were always worse for Rural Ohioans.

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SOCIAL DETERMINANTS OF HEALTH

- There were clear income and education gradients in the prevalence of fair/poor health, mental health impairment and current cigarette use among working age adults—the highest rates of each were among Ohioans with the lowest incomes and with the lowest levels of education.
- Among lower-income working age adults, food insecurity was most prevalent among those enrolled in Medicaid. Roughly 42.3% of Medicaid-enrolled adults reported running out of food in the past year before having money to purchase more.
- Lower-income adults who struggled with food insecurity, particularly those enrolled in Medicaid, were also more likely to report fair/poor health, mental health impairment and current cigarette use, reflecting the multiple stressors associated with living in poverty.
- Loneliness was concentrated among Medicaid-enrolled adults—38.1% of working age adults reported feelings of loneliness compared with 27.5% of the potentially Medicaid-eligible who were covered by other insurance. Adults enrolled in Medicaid who reported that they were lonely had substantially higher rates of fair/poor health, mental health impairment, and current cigarette use than adults who reported that they were not lonely.
- Unmet health care needs were substantially higher among lower-income working age adults with a disabling condition than among those without a disabling condition, across insurance types.

SUBSTANCE USE

- Cigarettes, alcohol, and marijuana (in that order) were the most commonly used substances among Ohio adults.
- Prevalence of substance use varied by gender, age, race/ethnicity, county type, education, poverty, mental health impairment, and Medicaid enrollment status.
- E-cigarettes, alcohol, and marijuana (in that order) were the most commonly used substances among Ohio high school students.
- Over 3,000 individuals in Ohio died in 2018 from an overdose involving opioids.
- Per capita, the distribution of alcohol retailers was seemingly more uniform across the state than the distribution of tobacco retailers (which were more dense in the rural Appalachian region). Marijuana dispensaries were focused in urban areas, although there was also a strong presence in rural Appalachia.

WOMEN'S HEALTH

Healthcare Access and Use

- Unmet needs for healthcare, including mental healthcare, were concentrated among younger women.
- Nearly 45% of women ages 19 to 44 reported delaying or avoiding needed healthcare in the past year.
- Women enrolled in Medicaid were more likely to report a lack of transportation as a reason for avoiding needed healthcare and less likely to report cost as a barrier than women who were potentially Medicaid-eligible but were covered by other insurance or were uninsured.

Health Outcomes and Behaviors

- The prevalence of fair/poor health, mental health impairment (MHI) and disability were highest among women with the lowest income across age groups.
- Women ages 19 to 24 had substantially higher rates of MHI than women at all other ages.
- Among lower-income women, the prevalence of food hardship and loneliness was higher for women who reported having a potentially disabling condition than for women without a potentially disabling condition across age groups.
- Among lower-income women, those ages 45 to 64 reported higher rates of having a potentially disabling condition, asthma, and obesity compared with women at other ages.

Social Determinants of Health

- Over one third (35.2%) of women ages 19 to 44 lived at or below 138% FPL in 2019.
- Black or African American and Hispanic women were more likely to live at lower incomes than white women across all age groups.
- The prevalence of loneliness was highest among women living at lower incomes, for all age groups.

DEMOGRAPHICS

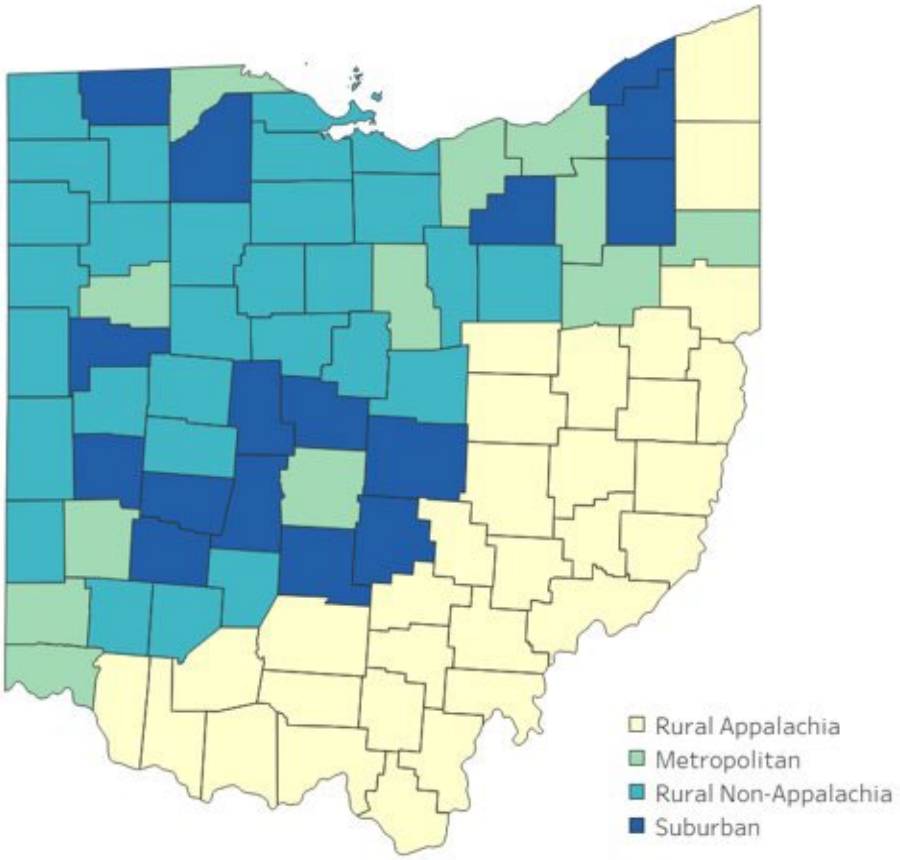
- A plurality of the Medicaid population fell into one or more of the following demographic groups:
    1. non-Hispanic Whites;
    2. females;
    3. 19-44 years old; and
    4. educated at the high school level or below.

  Additionally, more than half (51.7%) lived in a household with children.

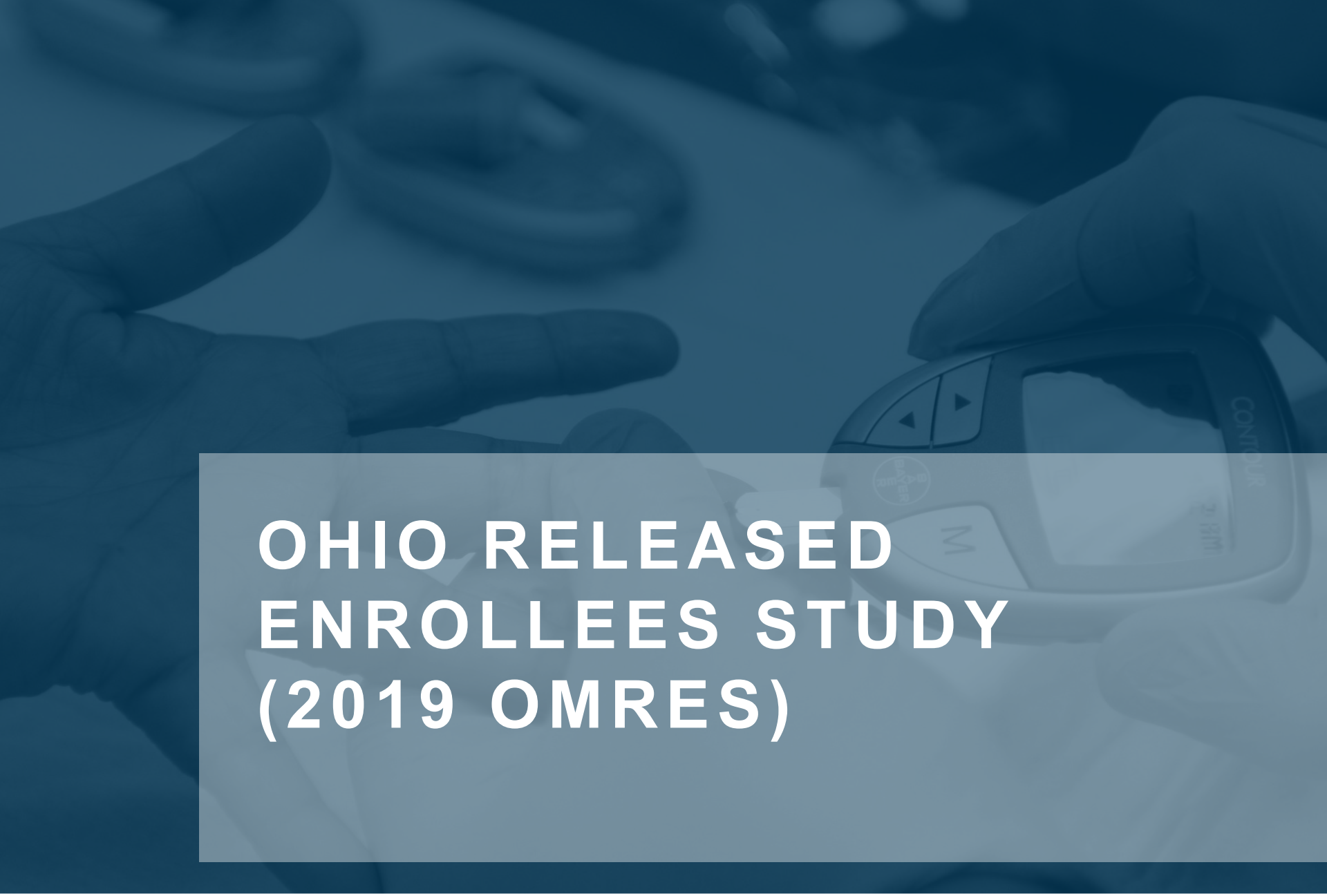
- Health status and mental health-related impairment were both higher among the Medicaid enrolled population than either of the comparison populations.

- Both the Medicaid enrolled population and potentially Medicaid eligible population had higher unmet needs compared to the not eligible population.

COUNTRY TYPE DESIGNATION NOTE



This chart book contains analyses that refer to county types, which are Ohio counties grouped into demographic characteristics. OMAS defines these county types in accordance with federal definitions, as follows: (1) Appalachia is defined using the Appalachian Regional Commission (ARC) standard; (2) Metropolitan is defined using US Census Bureau definitions incorporating urban areas and urban cluster parameters; (3) rural is defined by the Federal Office of Rural Health Policy at the Health Resources and Services Administration (HRSA), excluding Appalachian counties; and (4) suburban is defined by the US Census Bureau and is characterized as a mixed-use or predominantly residential area within commuting distance of a city or metropolitan area. These designations were originally set by the Ohio Department of Health in 1997 for the 1998 Ohio Family Health Survey (OFHS) and were slightly adjusted in 2004 and again adjusted in 2010 to include Ashtabula and Trumbull counties as Appalachian, in accordance with a federal re-designation. Guidance for these categories was provided by National Research Council's Committee on Population and Demography staff – for original designations and revisions.



OHIO RELEASED ENROLLEES STUDY (2019 OMRES)

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OMRES: KEY RESEARCH THEMES

- For MPRE enrollees:
  - Specific benefits of Medicaid
  - Health status, including chronic conditions and behavioral health conditions
  - Access and barriers to care
  - Health services utilization
  - Employment, including barriers and role of Medicaid in workforce readiness

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OMRES RESEARCH DATASETS

- **Medicaid Administrative Data**
  - All individuals ever enrolled in Medicaid through MPRE as of March 2018 (N=22,066)
- **Telephone Survey**
  - **OMRES Telephone Survey**: Sample of individuals enrolled through the Medicaid Pre-Release Enrollment (MPRE) process with certain exclusions (non-institutionalized, no TPL, 4+ months since re-entering the community) (N=661)
- **Qualitative**
  - **OMRES Focus Groups**: Subsample of OMRES telephone survey respondents (N=91)

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SURVEY VS. ADMINISTRATIVE DATA: STRENGTHS AND WEAKNESSES

- Medicaid administrative data:
  - detailed information about enrollment, place of residence, detailed clinical information and utilization while on Medicaid (some diagnoses may be underreported).
  - Data are a census – in principle, everyone is included.

- Survey data:
  - employment (informal economy), life events such as marriage, self-rated health, diagnosis self-report, experiences (e.g. open-ended questions about barriers to employment and reasons why Medicaid reduces risk of recidivism).
  - Data are a sample – limitations with statistical power, risk of bias.

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MPRE PARTICIPATION & POPULATION CHARACTERISTICS

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MAP 1: EVER ENROLLED THROUGH MPRE

Source: Medicaid Administrative Data
n = 22,066
*5,513 cases excluded due to missing county information

OMRES & GROUP VIII: DEMOGRAPHIC CHARACTERISTICS

	OMRES	Group VIII 2018
	Weighted %	*Weighted %*
Male	79.5%	46.7%
Age		
19-44 years	78.8%	62.2%
45-64 years	21.2%	37.8%
Race		
White	66.1%	84.1%
Black	30.3%	11.5%
Other	3.5%	4.4%
Hispanic	4.1%	2.8%
Educational Attainment		
High School or Less	78.6%	60.5%
Some College	19.3%	29.1%
4-Year Degree or More	2.1%	10.1%
Marital Status		
Married	8.9%	20.5%
Divorced	25.4%	27.4%
Widowed	1.4%	3.1%
Never Married	56.6%	41.9%
Domestic Partner	7.8%	6.8%
Parent of child in household	21.0%	29.5%

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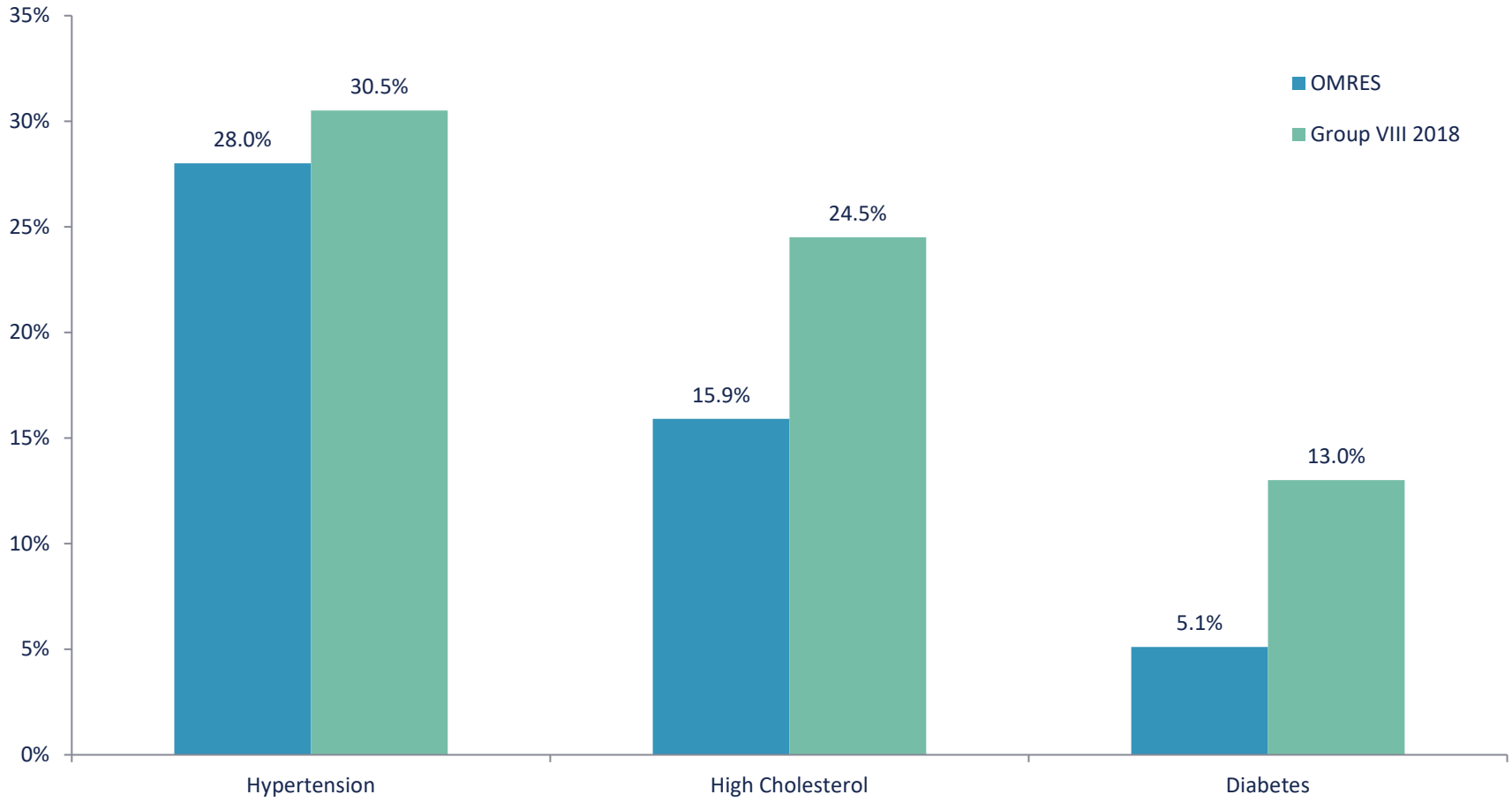
Sources: 2018 Group VIII and 2018 OMRES Telephone Surveys. 2018 Group VIII estimates are for continuously enrolled

OMRES & GROUP VIII: PERCENT REPORTING CHRONIC CONDITIONS



Sources: 2018 Group VIII and 2018 OMRES Telephone Surveys
2018 Group VIII estimates are for continuously enrolled

ACCESS TO CARE & HEALTH SERVICES UTILIZATION

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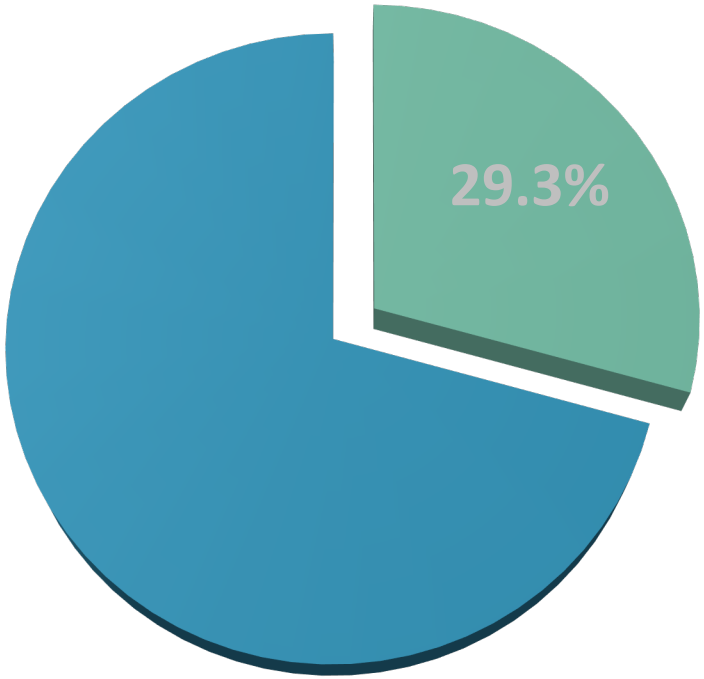
OMRES: SUBSTANCE USE TREATMENT

Nearly one third (29.3%) of all OMRES survey respondents reported receiving some kind of substance use treatment since their release.



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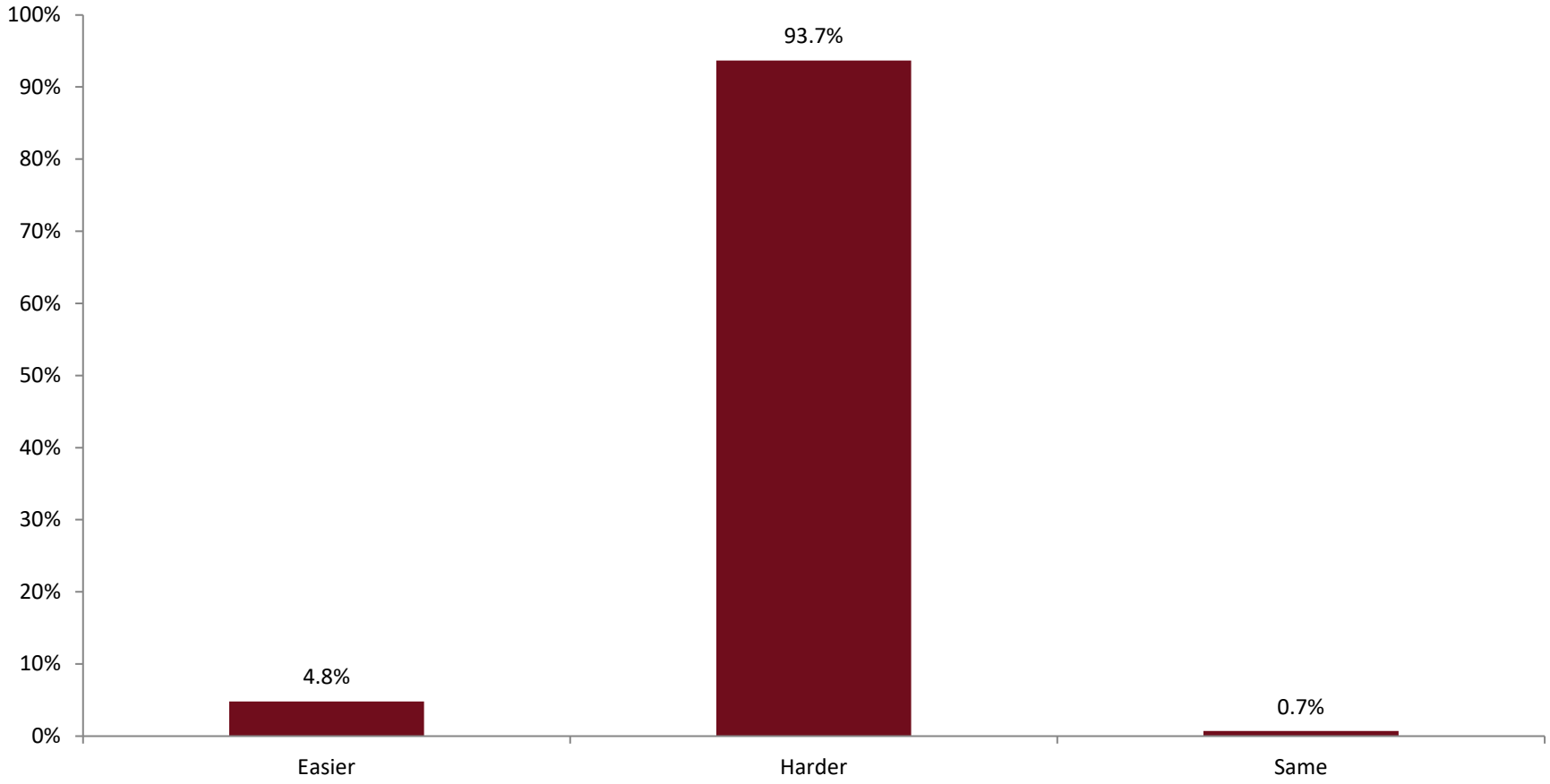
Sources: 2018 OMRES Telephone Survey

OMRES: WOULD LOSING MEDICAID MAKE IT EASIER OR HARDER TO GET NEEDED HEALTHCARE?



Source: 2018 OMRES Telephone Survey

PHYSICAL, MENTAL, & BEHAVIORAL HEALTH

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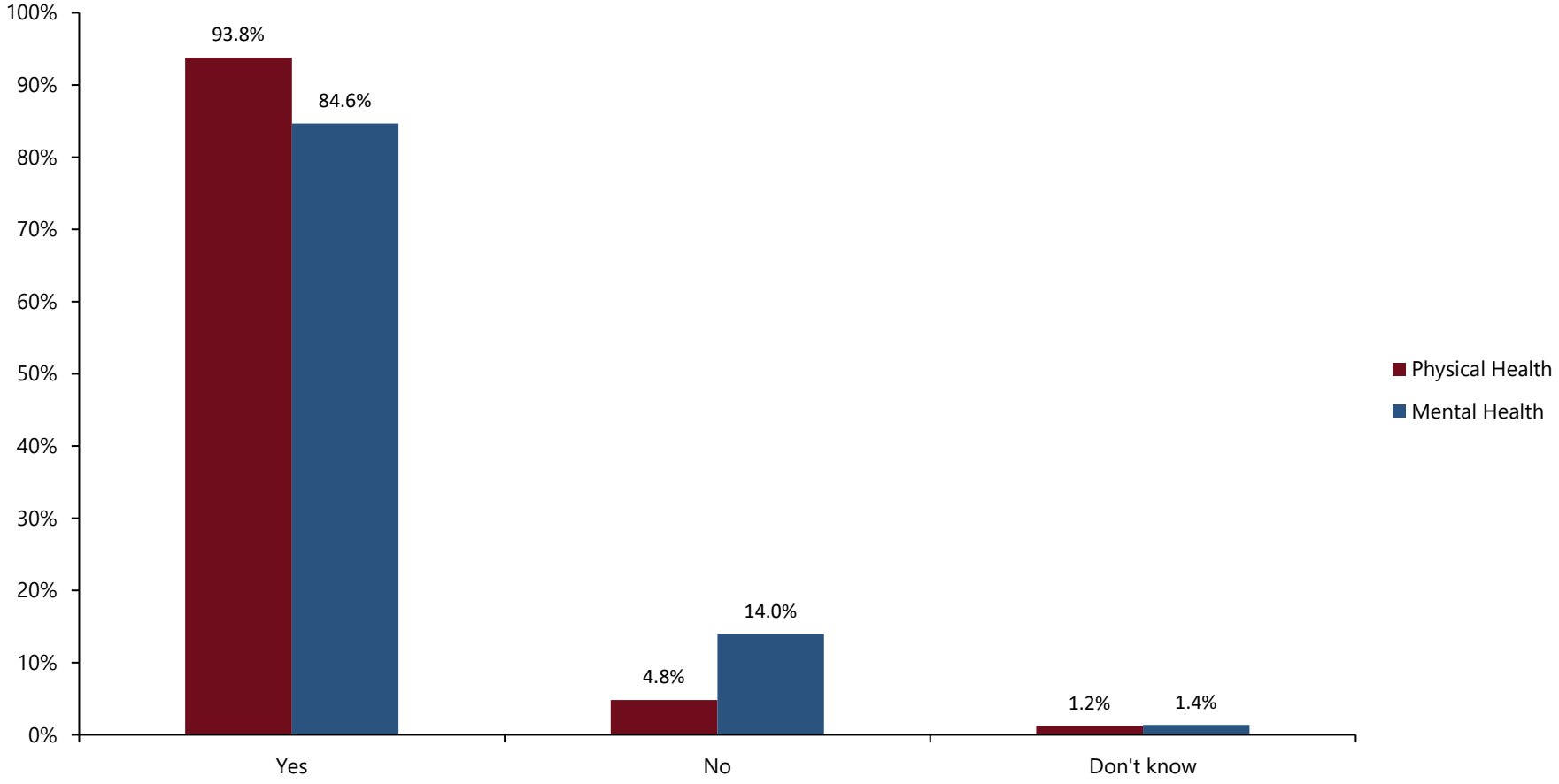
OMRES: DOES HAVING MEDICAID BENEFIT YOUR PHYSICAL AND/OR MENTAL HEALTH?



Source: 2018 OMRES Telephone Survey

IN THE WORDS OF OMRES RESPONDENTS

"I have a lot of mental health issues, [and] without Medicaid I wouldn't be able to afford my medicine that keeps me stable."

"[Without it] My quality of life wouldn't be as good… I go to counseling for my trauma history. I was in hospice grief counseling and they covered that. And my IOP [intensive outpatient addiction treatment], and my detox before that. I take anti-depressants, and I wouldn't be sober if I weren't doing all that. They covered a lot of stuff for me. I wouldn't be sober [without it]."

"[Medicaid has] kept me sober going on 3.5 years now. Seeing that therapist really helped me get over that shame and I was depressed. Seeing a psychiatrist…I never thought about going to the doctor and worrying about my heath; I was too busy doing drugs."

"[With Medicaid] Life is beautiful. Keep it simple. Work. Build a home…I'm blessed to keep those [other] bills paid…I'm living today."

"Medicaid helps me stay out of trouble and stay in treatment, and pays for counseling and groups. If I didn't have it I wouldn't be clean right now."

"Medicaid allows me to be able to go to the doctors and get the appropriate prescriptions instead of going to the 'street pharmacist' and doing illegal activities."

"I used to go to a dentist, and he would pull a tooth, and he would give me 30 perks (percoset). Just take it out. 'Cause I wanted those pain pills. And I didn't realize [the consequences]. I used to have really nice teeth….without Medicaid, I wouldn't have these teeth. And with recovery [also]. Just makes you feel better, having all your teeth in your mouth. Without Medicaid I don't know where I'd be."

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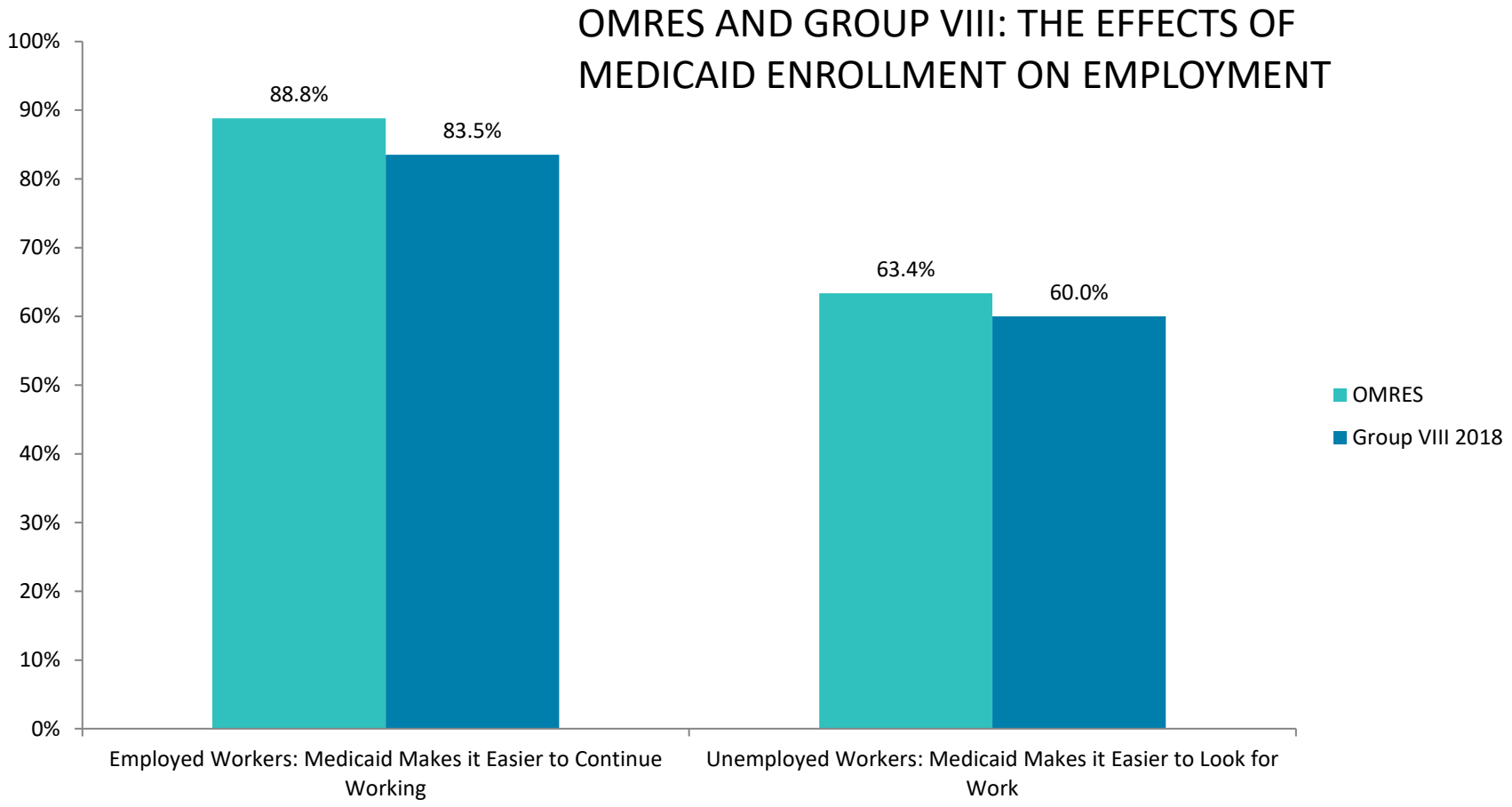
Source: 2018 OMRES Telephone Survey

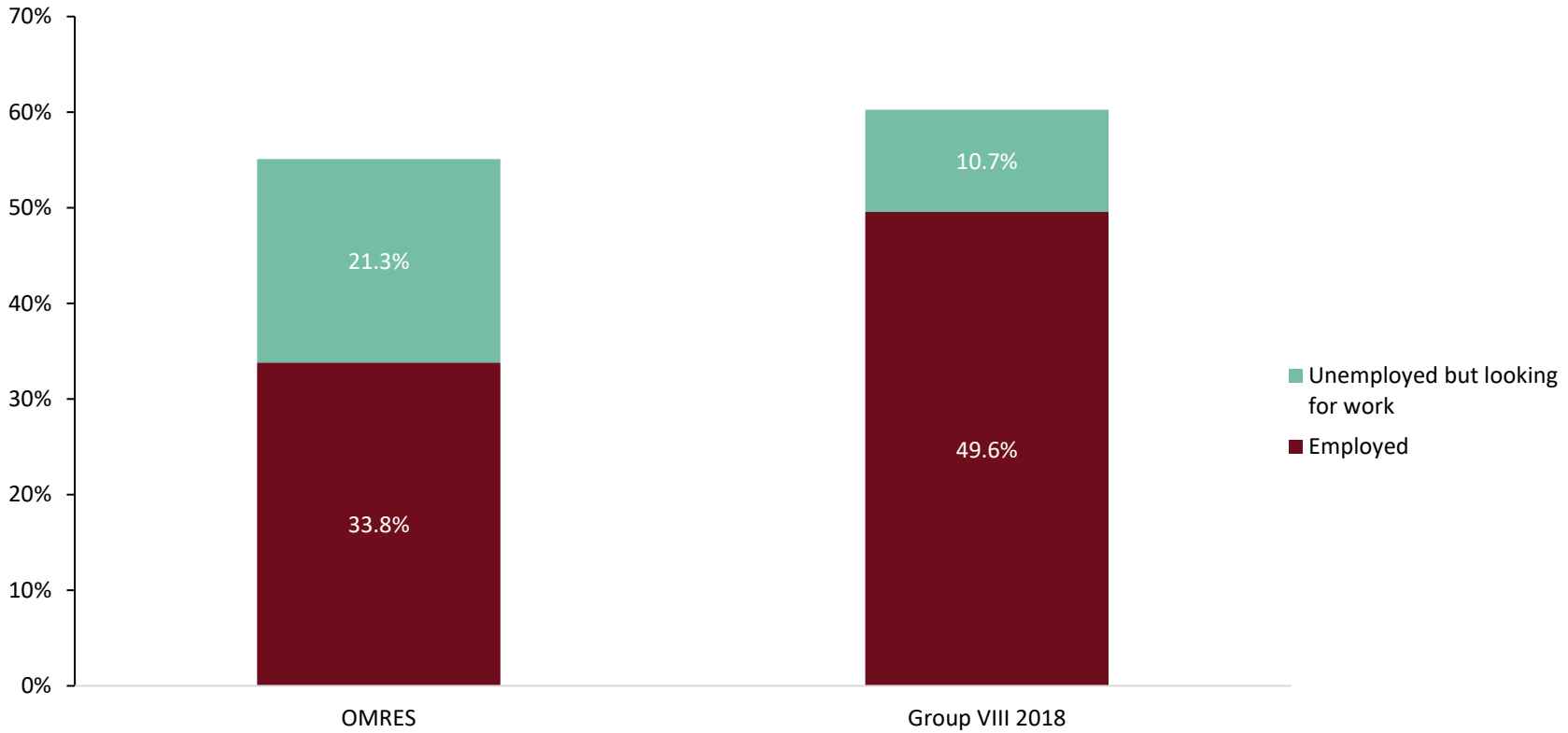
EMPLOYMENT & ECONOMIC STABILITY

OMRES AND GROUP VIII: THE EFFECTS OF MEDICAID ENROLLMENT ON EMPLOYMENT



Sources: 2018 Group VIII and 2018 OMRES Telephone Surveys
2018 Group VIII estimates are for continuously enrolled

OMRES AND GROUP VIII: PERCENT IN THE WORKFORCE



Sources: 2018 Group VIII and 2018 OMRES Telephone Surveys
2018 Group VIII estimates are for continuously enrolled
Most (82.6%) OMRES survey respondents not working or actively looking for work reported having a disability which prevented them from working.

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OMRES: PREVALENCE OF FINANCIAL STRESS INDICATORS

Indicator	Weighted %
Overall homeless	11.1%
Employed and homeless	5.8%
Receiving SNAP benefits in past 4 months	62.6%
Household does not have:	
Home heating such as a furnace	5.7%
Refrigerator	3.0%
Television	6.7%
Computer	58.4%
Seasonal clothing such as a coat for winter	8.0%
Car or truck	39.6%
Stove for cooking food	5.3%
Running water in the home	2.0%

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Source: 2018 OMRES Telephone Survey

REENTRY INTO THE COMMUNITY & RISK OF RE-OFFENCE

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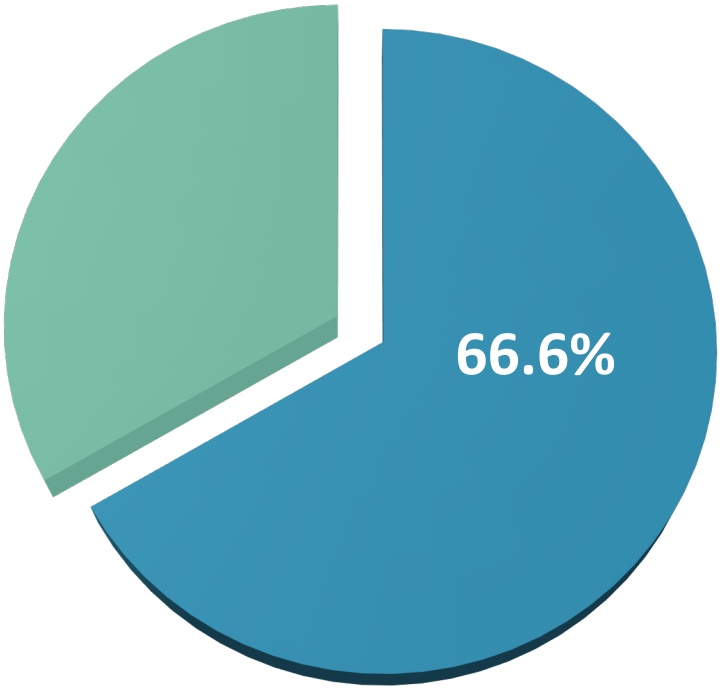
OMRES: MEDICAID AS A FACILITATOR OF SUCCESSFUL COMMUNITY REENTRY

Two-thirds (66.6%) of OMRES survey respondents reported that Medicaid reduced their chances of going back to jail or prison.



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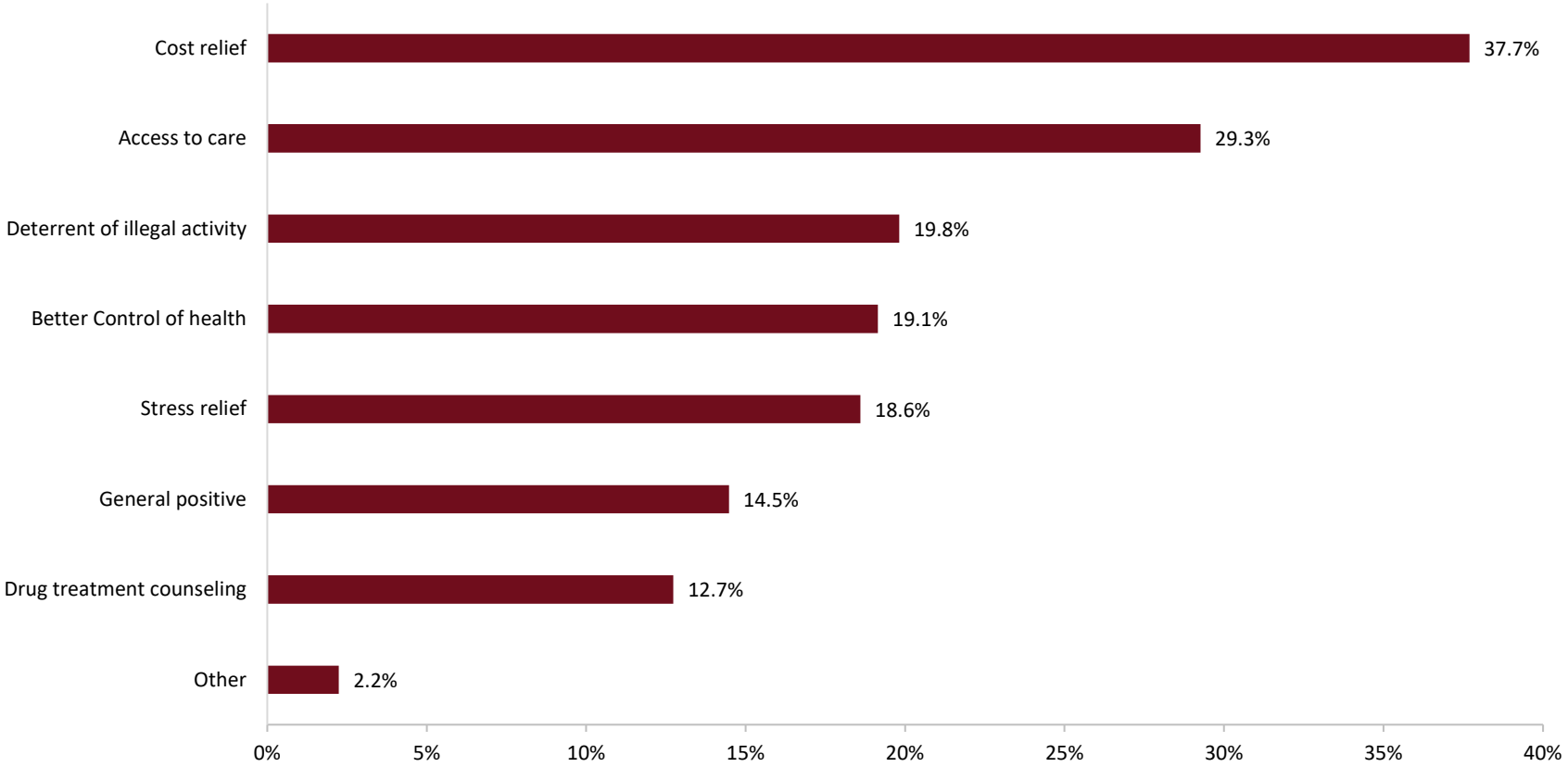
Source: 2018 OMRES Telephone Survey

OMRES: HOW DOES HAVING MEDICAID REDUCE YOUR CHANCES OF GOING BACK TO JAIL OR PRISON?



Source: 2018 OMRES Telephone Survey
Question limited to individuals who reported that Medicaid lowered the risk of going back to jail or prison.
Manual coding of open-ended responses
Answers are not mutually exclusive

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MEDICAID AS A FACILITATOR OF SUCCESSFUL COMMUNITY REENTRY

"[Because of Medicaid] I don't have to sell drugs, I don't have to risk my life or put anyone else's life in danger. I can go to the hospital and get help."

"[Life was] a rollercoaster ride but now [because of Medicaid] I have balance and stability. My therapist sees it, my case manager sees it, my pastor sees it, and everyone I associate sees it. And I'm still getting better, this is the first time I've been out over a year and a half in ten years, I've hit my mile marker and I have no intent on going back."

"If I had to pay into something that's taking away from my living, I'd be forced into doing criminal activity again to make ends meet. If I'm paying this money and I'm already suffering from trying to get housing…I think it would take away and force me into that dark life of crime."

"[Medicaid] makes me not be in the streets, it makes me not sell drugs, not commit any crimes anymore. [Medicaid] makes me think positive instead of negative and allows me to work a steady job."

"I don't think [people] realize that giving people access to services saves you ten fold as compared to the people that you locked up."

"I am proud to say that I have been out of the system for close to three years now. I've accomplished a lot [during that time]. I haven't had a drink for over 18 years. Of everything else, it's pretty much going into line."

OMAS Ohio Medicaid Assessment Survey

Source: 2018 OMRES Telephone Survey

THE 2018 & 2019 OHIO MEDICAID RELEASED ENROLLEES STUDIES (OMRES)

- The OMRES is an evaluation of Ohio Medicaid's Medicaid Pre-Release Enrollment program (MPRE) that enrolls incarcerated individuals just prior to release.
- The goal of OMRES is to assess the role of Medicaid during reentry into the community across several domains, including health, access to care, employment, housing, personal finance, and community involvement.

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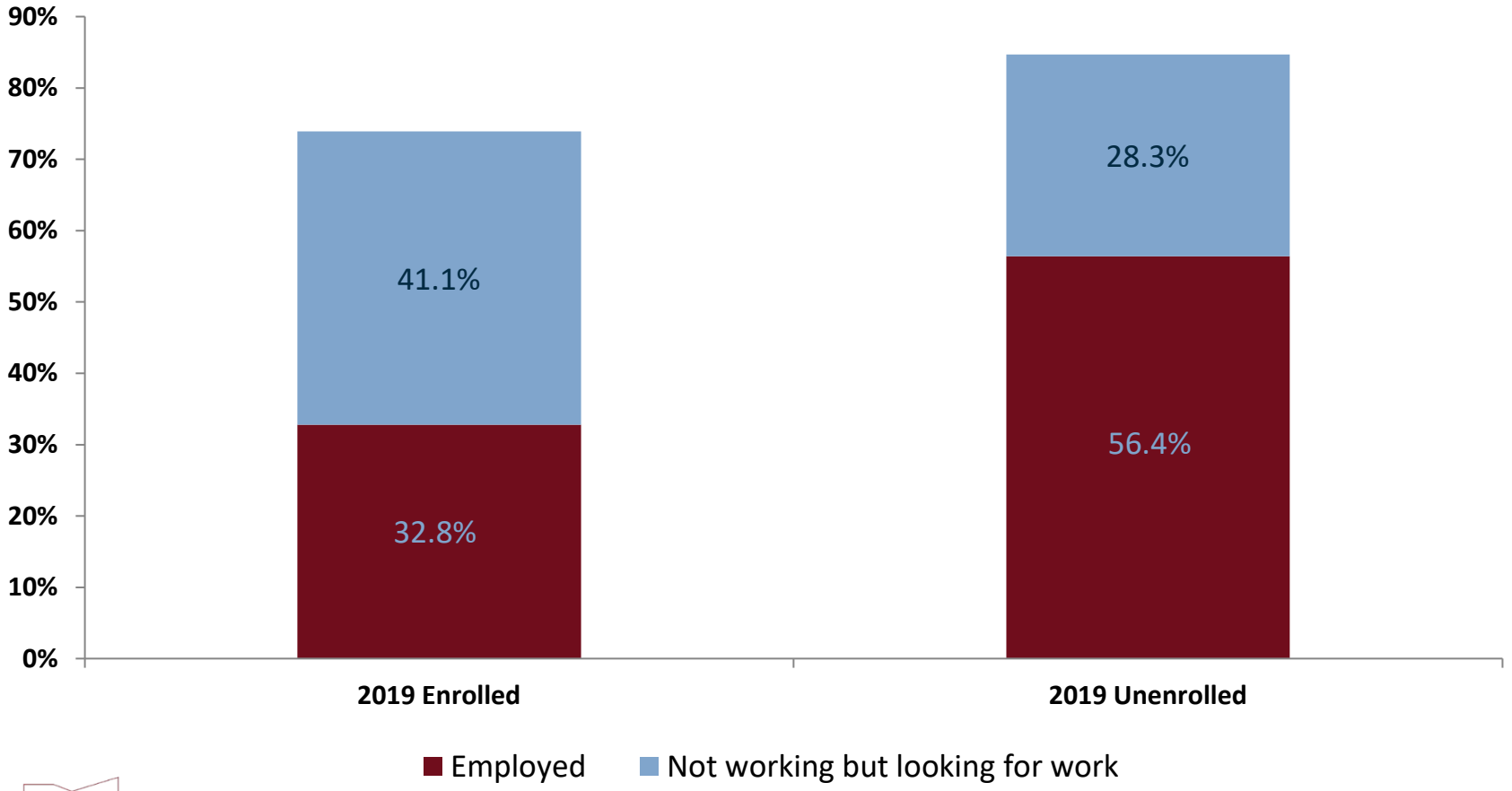
LABOR FORCE STATUS, CURRENT & FORMER MPRE ENROLLEES



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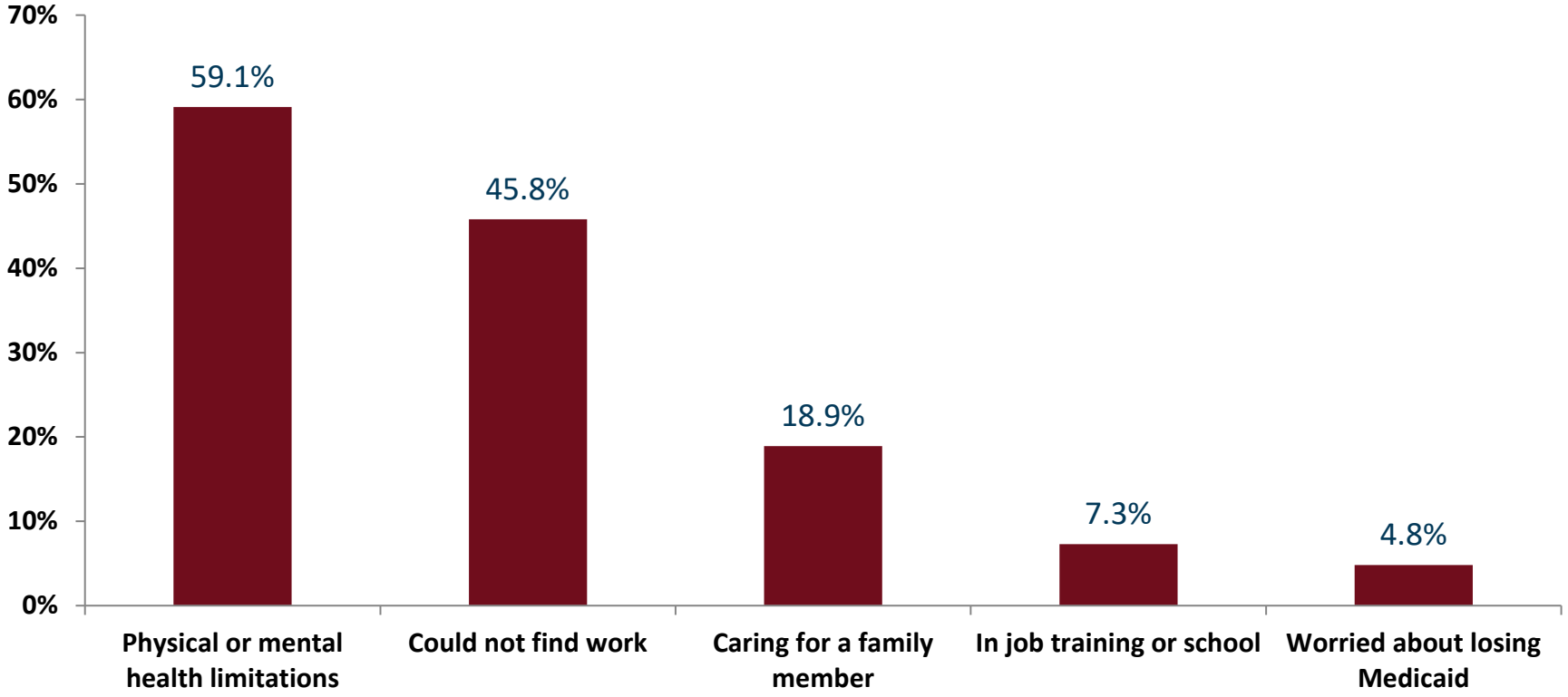
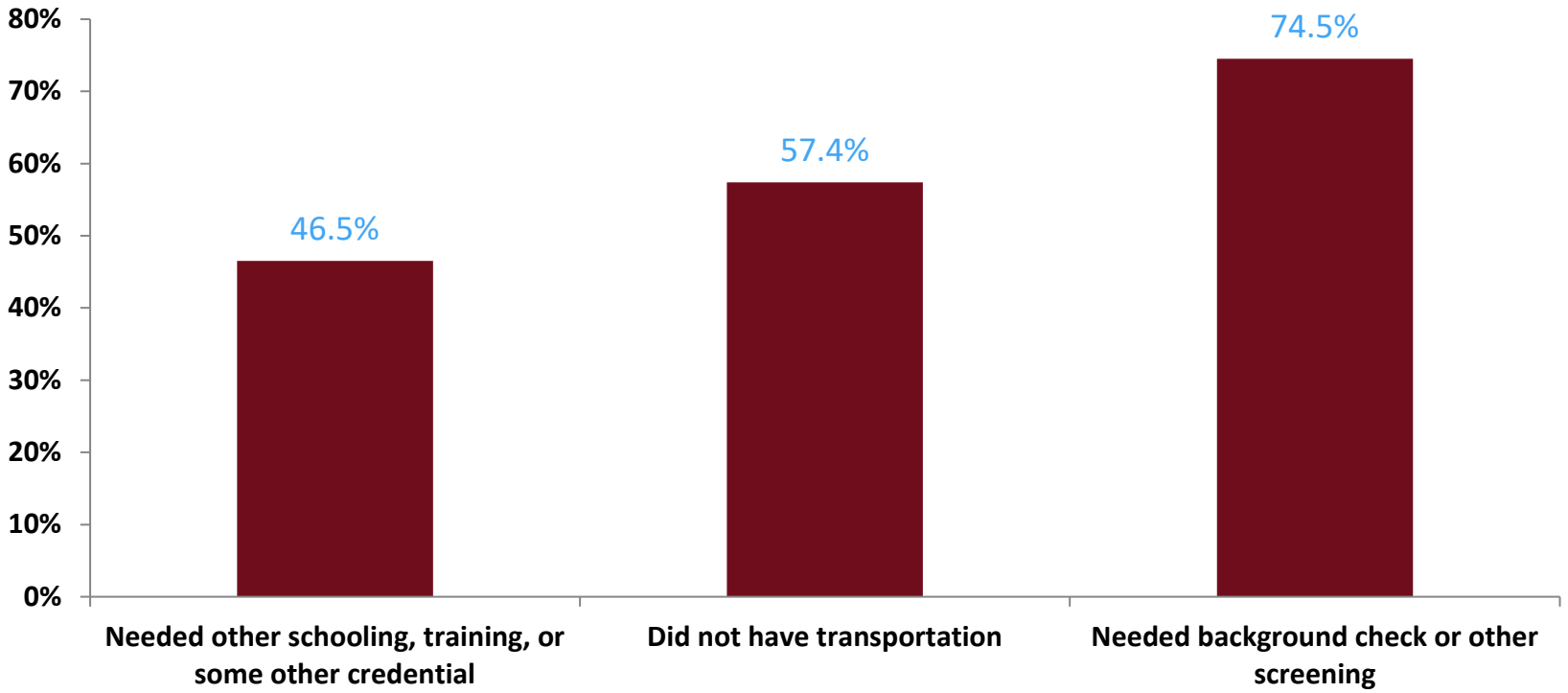
MPRE ENROLLEES, REASONS FOR NOT WORKING



Source: 2019 OMRES Survey
Answers are not mutually exclusive; respondents may select more than one.

MPRE ENROLLEES WHO COULD NOT FIND WORK: REASONS FOR NOT BEING ABLE TO FIND WORK



Source: 2019 OMRES Survey
Answers are not mutually exclusive; respondents may select more than one.
This question was asked of the respondents who reported not being able to find work

COMPARISON OF 2018 VS 2019: RESPONSE RATES

2018 OMRES: Distribution of Disposition Codes by AAPOR Response Category, for All Sampled Persons

AAPOR Group	Disposition	Overall	
		Total	Percent
1.1	Completes (full interviews only)	661	5.1%
2.1	Refusals and Break-offs	2,953	22.8%
4.7	No Eligible Respondent	243	1.9%
3.0	Unknown Eligibility, Non-interview	9,119	70.3%
	Total	12,976	100.0%

2019 OMRES: Distribution of Disposition Codes by AAPOR Response Category, for All Sampled Persons

AAPOR Group	Disposition	Overall		Continuous		Unenrolled	
		Total	Percent	Total	Percent	Total	Percent
1.1	Completes (full interviews only)	1,653	7.9%	1,271	11.1%	382	4.0%
2.1	Refusals and Break-offs	7,749	37.0%	4,437	38.6%	3,312	35.1%
4.7	No Eligible Respondent	390	1.9%	165	1.4%	225	2.4%
3.0	Unknown Eligibility, Non-interview	11,136	53.2%	5,620	48.9%	5,516	58.5%
	Total	20,928	100.0%	11,493	100.0%	9,435	100.0%

OMAS
Ohio Medicaid Assessment Survey

For academic or academic applied research data from these and other projects, please contact either Dr. Ruhil or Dr. Lewis at the Voinovich School with an inquiry.

Thank You and Questions?