Mapping Medicaid: A Comparative Analysis of State-Level Racial and Ethnic Data Collection to Federal Guidelines

Rayan K. Salih, PharmD[1]; Jon D. Campbell, PhD[1]; Maitreyi Sahu, MSPH[2,3]; Joseph L. Dieleman, PhD[2,3]; Gabri'el D. Shabazz, MPH[1]; Tyler D. Wagner, PharmD, PhD[1]
[1]National Pharmaceutical Council, Washington, DC, USA; [2]Institute for Health Metrics and Evaluation, Seattle, WA, USA; [3]University of Washington, Seattle, WA, USA

State Medicaid applications **display a striking variance in race categories**, showcasing the divergence between OMB and HHS guidelines. Improving race and ethnicity data capture is key to **crafting health policies that truly encompass America's diversity.**

BACKGROUND

- In Medicaid applications, accurate race and ethnicity data collection is paramount, guided by the 1997 Office of Management and Budget's (OMB) minimum standards required by federal law and the 2011 Department of Health and Human Services' (HHS) detailed guidance under the Affordable Care Act (ACA).[1,2]
- The OMB established federal standards for collecting race and ethnicity data by defining the minimum categories (Table 2).
- The expanded HHS recommendations, through the ACA, can be aggregated back to the minimum categories and include various response options like Filipino, Japanese, etc.
- Accurate race and ethnicity data used for policymaking should align with the intended population, which proves to be difficult due to varying methods of data collection among states for Medicaid beneficiaries.

OBJECTIVE

- This study evaluates the consistency of state-level race and ethnicity applicant questions.
- This study also assesses adherence to federal directives to reinforce data integrity in healthcare policymaking.

METHODS

- PubMed was utilized to obtain studies conducted on Medicaid data collection methods.
- Individual state Medicaid websites were reviewed to assess Medicaid applications and the racial and ethnic categories offered to beneficiaries.
- Data was collected and analyzed in Excel and a cross review was conducted by a second researcher.
- A comparative analysis was conducted between various states' racial and ethnic categories as defined by OMB and HHS.

RESULTS

- Fifty states' Medicaid application questions were reviewed.
- All states met the 1997 OMB standards (Figure 2, Table 2).
- States adhered to the HHS guidance to varying degrees (Figure 1, Table 1).
- The median number of race and ethnicity categories offered for patients was 13 (range: 5-56) and 6 (range: 2-37), respectively.

RESULTS (cont.)

Figure 1. Number of Race Categories per 2011 HHS Guidance – Medicaid Applications

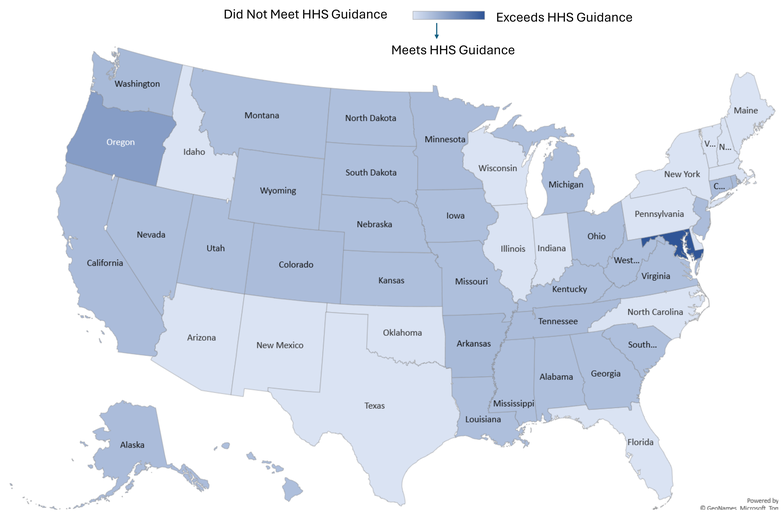

Figure 2. Number of Race Categories per 1997 OMB Requirements – Medicaid Applications

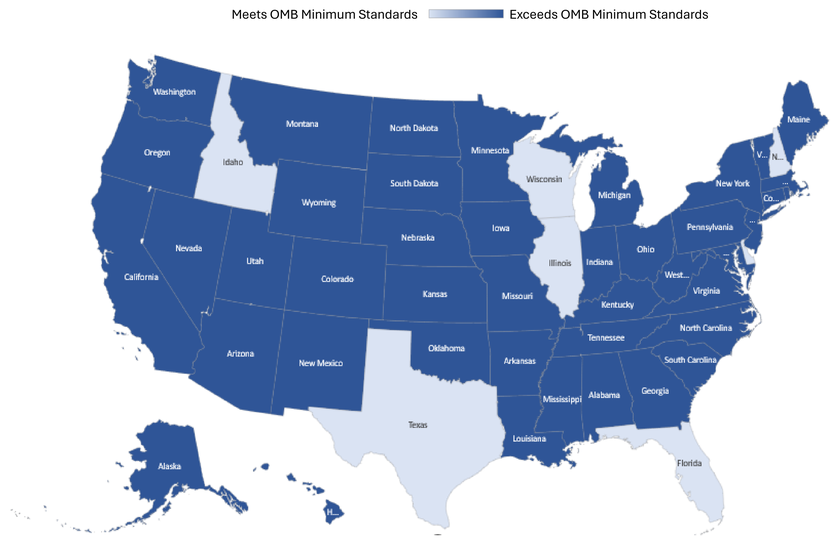

Table 1. State Medicaid Application Findings for **HHS** Guidance

2011 HHS Guidance	
Met or Exceeded HHS Guidance for Race (n = 14 categories)	31 states (62%)
Met HHS Guidance for Ethnicity (n = 5 categories)	34 states (68%)

Table 2. State Medicaid Application Findings for **OMB** Requirements

1997 OMB Guidance	
Highest Number of Race Categories	Maryland (n = 56)
Highest Number of Ethnicity Categories	Oregon (n = 37) Massachusetts (n = 35)
Only met Minimum Race Categories^	7 states (14%)
Only met Minimum Ethnicity Categories* (Hispanic/Latino vs. Non-Hispanic/Latino)	16 states (32%)
^White, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander; *Hispanic/Latino, Non-Hispanic/Latino	

CONCLUSIONS & DISCUSSION

- HHS's broader number of race categories offers patients more precise identity options, reducing potential misclassification.[3,4]
- While all states comply with OMB's standards, further incentives to adopt HHS's detailed classifications could amplify this progress.
  - In March 2024, OMB published a set of revisions to create more useful, accurate, and up-to-date federal data on race and ethnicity, the first updates since 1997.[5]
  - Directive No. 15 on the Federal Register will offer a combined race/ethnicity question, "What is your race and/or ethnicity?" with the ability to "Select all that apply".[5]
- Literature shows misclassification in racial and ethnicity data collected compared to how individuals self-identify.[3,6,7]
  - A study indicates that continued linkage efforts and public access to linked data are essential throughout the United States to understand better the burden of disease in the American Indians/Alaska Natives (AI/AN) population.[5,6,7]
- Comprehensive, standardized data is important for identifying and addressing health disparities and inequities, thereby informing more effective healthcare policies.

REFERENCES

1. Yee K, Hoopes M, Giebultowicz S, Elliott MN, McConnell KJ. Implications of missingness in self-reported data for estimating racial and ethnic disparities in Medicaid quality measures. *Health Serv Res*. 2022;57(6):1370-1378. doi:10.1111/1475-6773.14025
2. Moskowitz D, Guthrie B, Bindman AB. The role of data in health care disparities in Medicaid managed care. *Medicare Medicaid Res Rev*. 2012;2(4):mmrr.002.04.a02. Published 2012 Nov 5. doi:10.5600/mmrr.002.04.a02
3. Jarrin OF, Nyandege AN, Grafova IB, Dong X, Lin H. Validity of Race and Ethnicity Codes in Medicare Administrative Data Compared With Gold-standard Self-reported Race Collected During Routine Home Health Care Visits. Med Care. Jan 2020;58(1):e1-e8. doi:10.1097/MLR.0000000000001216
4. Grafova IB, Jarrin OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity. Med Care Res Rev. Oct 2021;78(5):616-626. doi:10.1177/1077558720935733
5. Orvis K. OMB Publishes Revisions to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. March 28, 2024. Accessed April 25, 2024. https://www.whitehouse.gov/omb/briefing-room/2024/03/28/omb-publishes-revisions-to-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and-presenting-federal-data-on-race-and-ethnicity/
6. Dougherty TM, Janitz AE, Williams MB, et al. Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015. *J Public Health Manag Pract*. 2019;25 Suppl 5, Tribal Epidemiology Centers: Advancing Public Health in Indian Country for Over 20 Years(Suppl 5 TRIBAL EPIDEMIOLOGY CENTERS ADVANCING PUBLIC HEALTH IN INDIAN COUNTRY FOR OVER 20 YEARS):S36-S43. doi:10.1097/PHH.0000000000001019
7. Adia AC, Nazareno J, Operario D, Ponce NA. Health Conditions, Outcomes, and Service Access Among Filipino, Vietnamese, Chinese, Japanese, and Korean Adults in California, 2011-2017. *Am J Public Health*. 2020;110(4):520-526. doi:10.2105/AJPH.2019.305523

SCAN TO DOWNLOAD

ISPOR Annual Meeting, May 5-8, 2024, Atlanta, GA, USA