Indians No More: Inconsistent Classification of American Indians and Alaska Natives in Medicare

by Mario D. Garrett, Ph.D.
& Kurt A. Menke, M.A.

To seek out the best through the whole Union we must resort to ... information, which, from the best of men, acting disinterestedly and with the purest motives, is sometimes incorrect.

President Thomas Jefferson, Letter to Elias Shipman , 12 July, 1801.

National information on American Indians and Alaska Natives (AI/ANs) is available from five primary sources; U.S. Census (demographic), Bureau of Indian Affairs (labor force and education), Indian Health Service (health and health care), CDC-National Center for Health Statistics (deaths), and the Health Care Financing Administration (federal health program beneficiaries). This information provides a window into the health and demographics of AI/ANs throughout the country.

National Indian Council on Aging

Introduction

In his February 21, 1998 radio address, then President Clinton announced an initiative committing the nation to the goal of eliminating, by the year 2000, longstanding disparities in health status that affect racial and ethnic minority groups. To help reach this goal, the President described a plan to mobilize the resources and expertise of the federal government, the private sector, and local communities. As part of this plan, the Health Care Financing Administration (HCFA), as an agency under the Department of Health and Human Services (DHHS), is responsible for implementing these policies.

HCFA is the largest purchaser of health care in the world, providing health care coverage to an estimated 71.2 million beneficiaries or nearly one out of four Americans (FY 2000). Of these beneficiaries, approximately 6 million are served by both Medicare and Medicaid. HCFA programs account for more than one of every three dollars spent on health care in the U.S. economy and represent the third largest outlay of the federal government, behind only Social Security and payment of interest on the national debt.

Within this social program, there is evidence of disparities in the quality of care, amount of care provided, and access to health care due to a number of factors including language difficulties, gender, sexual orientation, geographic barriers, and minority status (Osteen et al., 1992; Nattinger et al., 1992; Bame et al., 1993; AAPHR, 1994; AMA, 1991; Kahn et al., 1994; Giles et al., 1995; Rosenbaum et al., 1997; Smollar, 1988).

For those facilities or individuals who accept federal funds, federal civil rights statutes prohibit:

- denial of services;
- provision of a different service or services in a different manner, and
- segregating individuals receiving services

(Office of Civil Rights, 1990).

In 1997 the National Indian Council on Aging (NICOA), with funding from the federal Administration on Aging, initiated an examination of Medicare and Medicaid data using race codes from the Indian Health Service (IHS) database. Unlike U.S. Census or HCFA's Medicare & Medicaid data, which designate race through self-identification, the IHS is obligated to verify the race of its clients according to Bureau of Indian Affairs blood quantum standards. By selecting from HCFA's data only those individuals that IHS identifies as AI/ANs, it was possible for the first time to identify Medicare and Medicaid beneficiaries who are **known** to be Indians, albeit those individuals who have received treatment from the IHS in the last three years. This marks the first time a database has been constructed that crosschecks the accuracy of HCFA's identification of AI/ANs. Interested in expanding its outreach to minorities, HCFA fully supported NICOA's effort to improve data quality.

Current Knowledge

In published reports, HCFA identified 38,000 AI/AN beneficiaries on Medicare[1] (for 1994) and 300,880 AI/AN beneficiaries on Medicaid[2] (for 1993; 1995 Data Compendium: HCFA).

Medicaid

In a HCFA publication (Medicaid Statistics, 1995) AI/ANs are reported to access Medicaid the least among all racial groups. Only 65% of the AI/ANs who are eligible to receive Medicaid access this service, compared with 88% of the total population (White, 87%; Black, 82%; Asians and Pacific Islanders, 83%; and, Hispanic, 91%). Region IX (Arizona, California, Hawaii and Nevada) shows the lowest level of access to Medicaid by AI/ANs, with only 20% of those eligible receiving Medicaid benefits (HCFA, Medicaid Statistics, 1995).

Medicaid data is difficult to analyze by race. Some states do not record race in their Medicaid forms, nor do they report Social Security numbers of beneficiaries. In addition, since Medicaid is a state-operated federally-funded program, some states do not provide data to HCFA for statistical analysis.

> ***"A key element of respectful and fair treatment is protection against discrimination in the delivery of health care services, and in marketing and enrollment, for those eligible for coverage "***
>
> (Consumer Bill of Rights and Responsibilities)

Medicare

Since Medicare data is collected for all states, it is HCFA's only database that allows national analysis of utilization of services by racial classification. The accuracy of this analysis is restricted by the validity of racial classification. Inconsistent classification can occur for a number of reasons:

- Outdated data management where racial codes are not updated;
- Inappropriate classification of race while processing beneficiaries;
- Absence of race classifications on processing forms; and
- Beneficiaries incorrectly report their race.

By selecting Medicare records on the basis of IHS-generated identifiers for AI/ANs, 112,588 AI/ANs were identified. This monograph reports on the level and variation of inconsistent racial classification for AI/ANs in the Medicare database [3]. The majority of AI/ANs (83%) are misclassified as another race. In other studies that have looked at inconsistent classification, such as in death certificates, there is a pattern - states that have high levels of inconsistent classification in death certificates also show greater inconsistencies in classifying Medicare beneficiaries (IHS, 1996). Studies indicate that under-classification ranged from 1.2% in Navajo Area, to 28% and 30.4% in Oklahoma and California Areas, respectively (IHS, 1996). *See table on page 9.*

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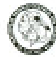
[1] Medicare entitlement is based on whether the beneficiary or spouse worked for at least 10 years in Medicare-covered employment, and is 65 or older (Since 1972 must also be a citizen or permanent resident of the United States). There are exceptions to this age requirement if the person is disabled or has chronic kidney disease or if they have received Social Security or Railroad Retirement Board disability for two years.

[2] Medicaid entitlement is primarily determined by States. To be eligible for Federal funds, States are required to provide coverage to recipients of Aid to Families with Dependent Children (AFDC); persons receiving Supplemental Security Income; infants born to Medicaid-eligible women; children under age six and pregnant women on AFDC or whose income is at or below 133 percent of the Federal poverty level; recipients of adoption assistance and foster care; certain Medicare beneficiaries; and special protected groups.

[3] In accordance with Privacy Act (1974) and Data Users Agreement, detailed maps could not be provided which identify the counties/zips with eleven or less observations. The maps were produced using ArcView, an ESRI product, using ZIP code coverage for 1995. All data is from HCFA for 1995 as extracted by IHS social security numbers of active users. Total population 112,588.

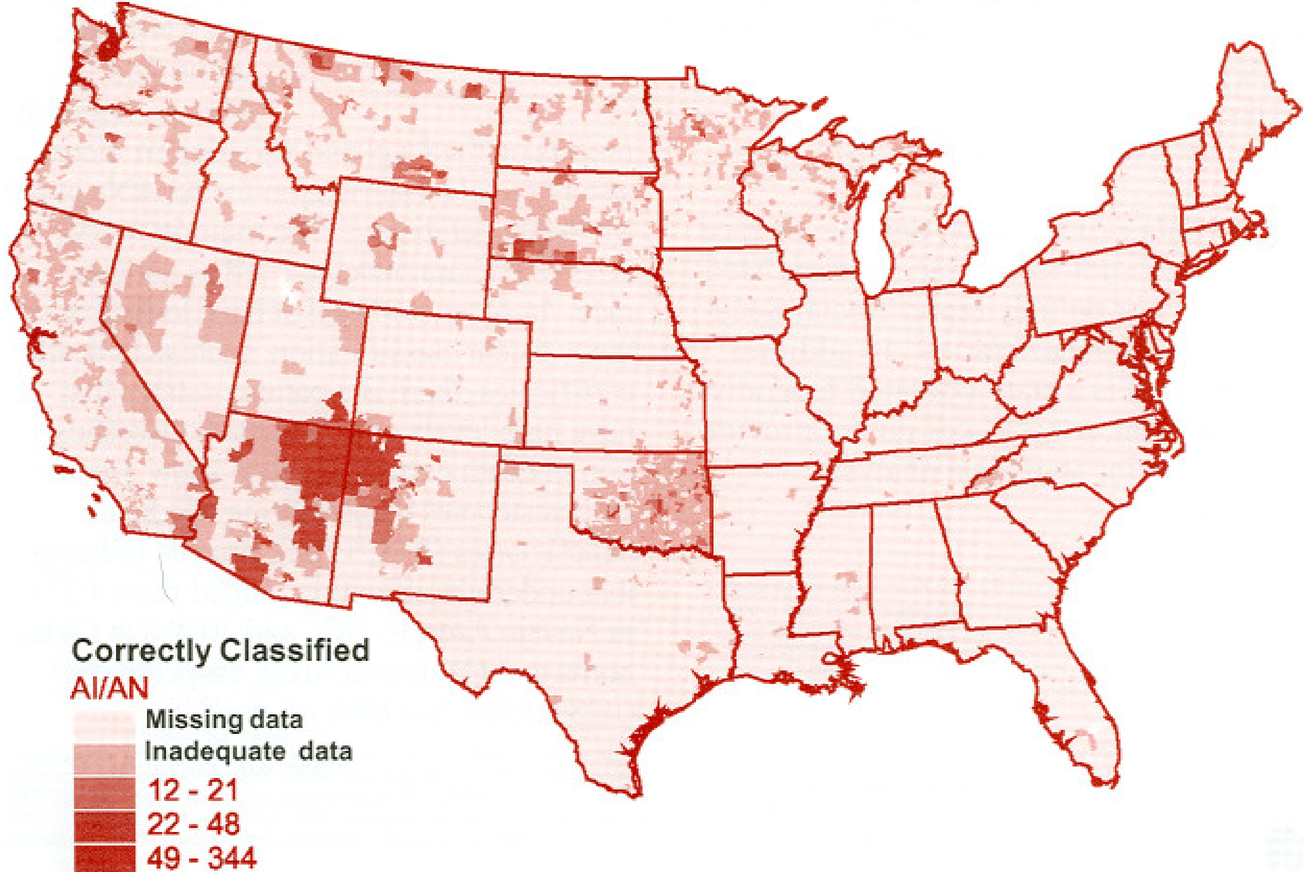


AI/ANs Classified correctly by Medicare

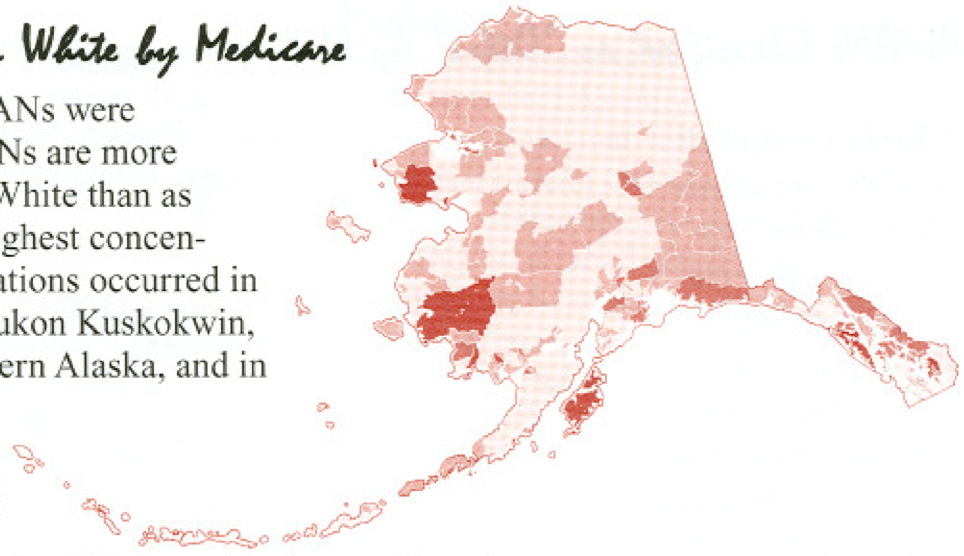
The large majority of AI/ANs (83%) are incorrectly classified as being of another race by Medicare. Only 17% of AI/ANs in the Medicare database were correctly classified.

In Alaska, most of this correct classification was recorded for AI/ANs living in the Yukon Kuskokwim area in eastern Alaska, and in Barrow in northern Alaska.

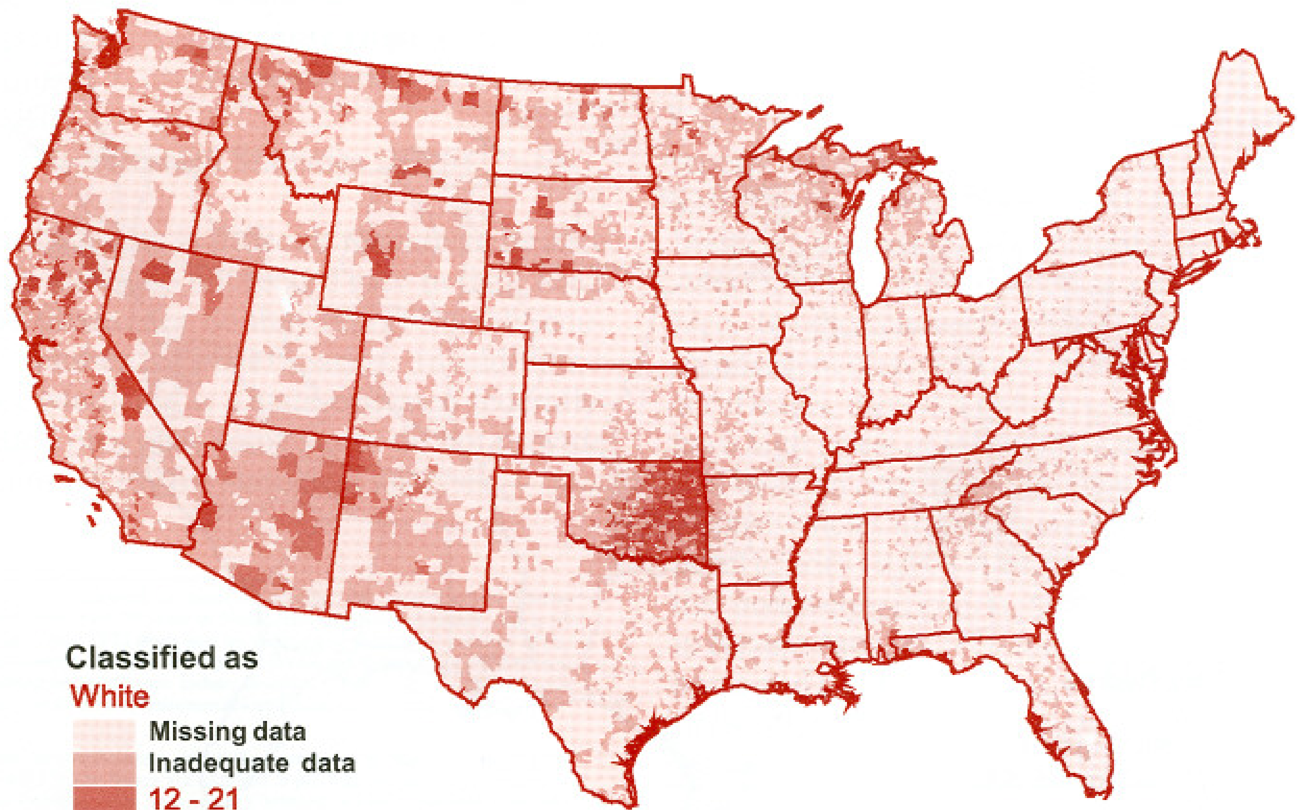
For the lower 48 states, the highest concentration of correctly identified AI/ANs occurs in the Southwest, specifically around the Navajo reservation (four corners region), Hopi (Arizona), Indian Pueblos (Rio Grande basin in New Mexico), and Tohono O'odham (South of Tucson, AZ; formerly known as Papago tribe). With small pockets of correct classification in North and South Dakota, Montana, Oregon, and Oklahoma.

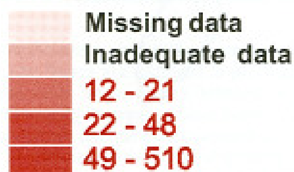


AI/ANs Classified as White by Medicare

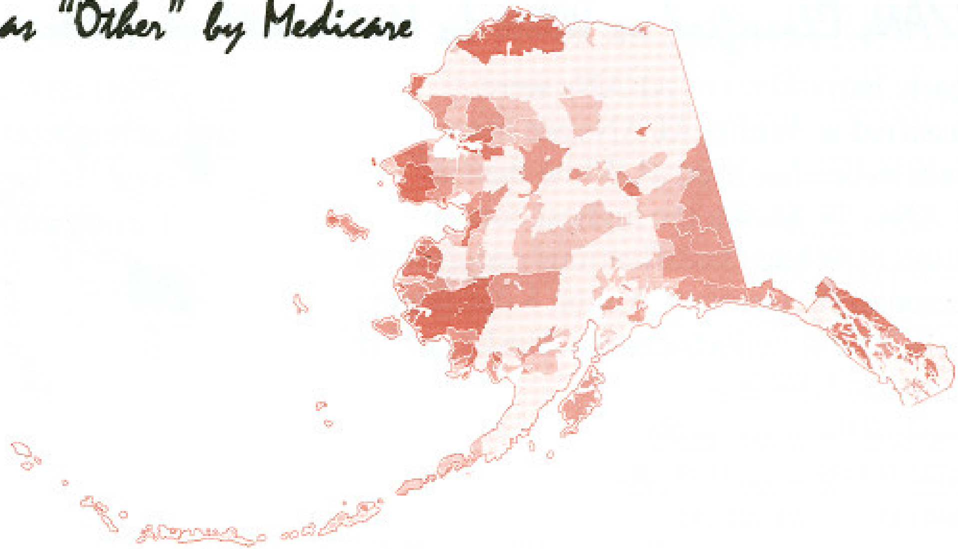


Nearly half (47%) of AI/ANs were classified as White. AI/ANs are more likely to be classified as White than as AI/ANs. In Alaska the highest concentration of White classifications occurred in the southern Aleutians, Yukon Kuskokwin, North Sound in northeastern Alaska, and in Juneau and Annette island in the lower west corner of Alaska. For the mainland, the highest concentration of AI/ANs classified as White by Medicare is predominantly clustered in Oklahoma, more specifically, east Oklahoma, where most American Indians live. Other areas where AI/ANs were misclassified as White are sporadically spread across the country.

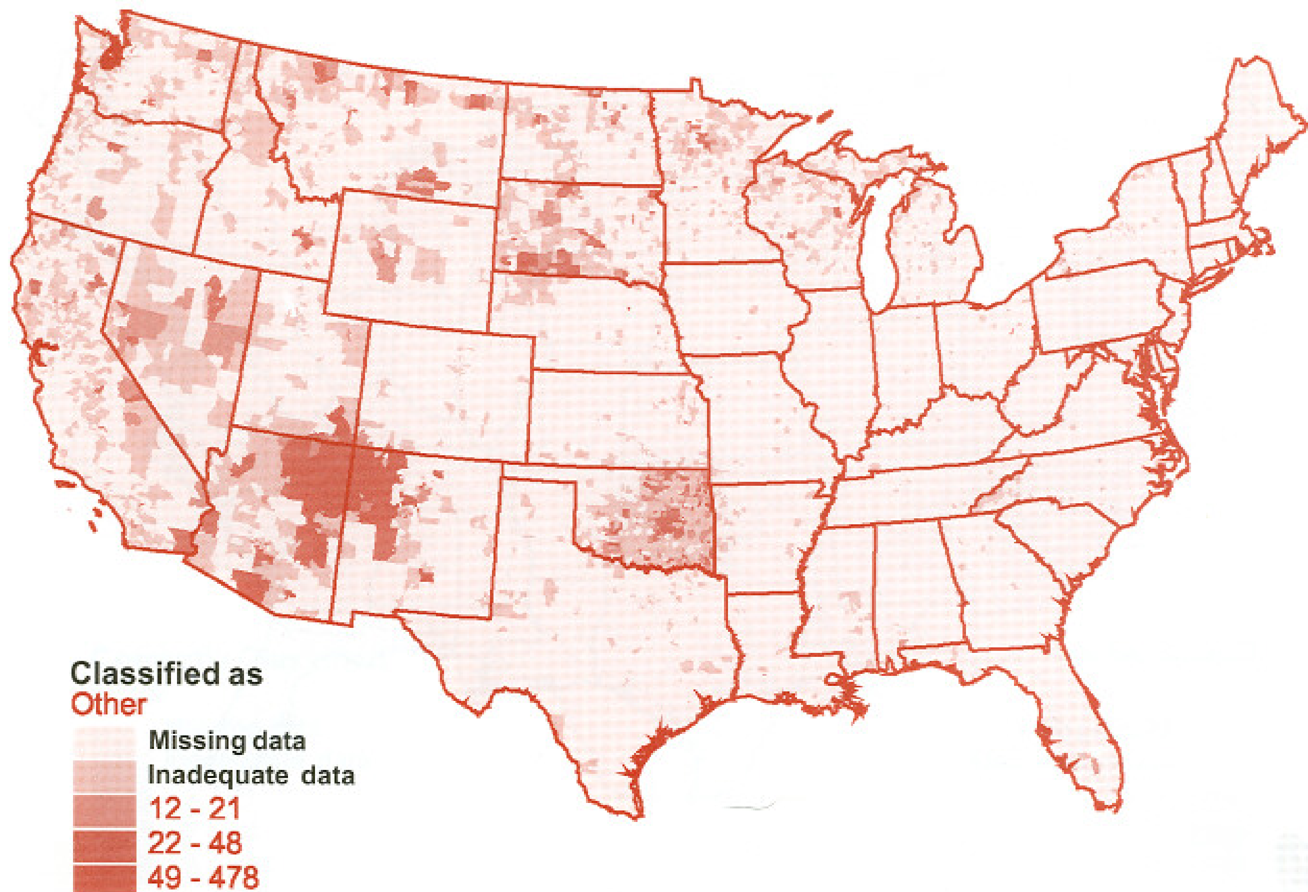




AI/ANs Classified as "Other" by Medicare

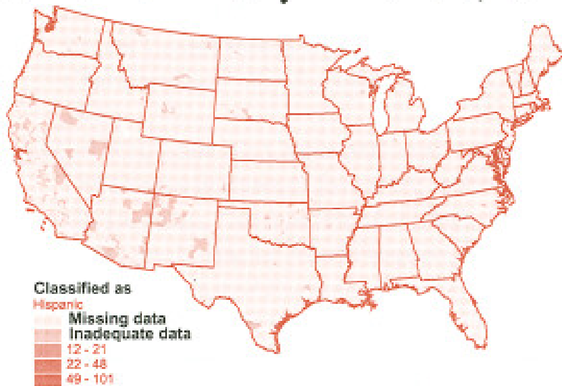


A third (33%) of all AI/ANs were classified as "Other" by Medicare. This catch-all category is the least specific of all racial classification. In Alaska, as well as in the lower 48 states, there are dispersed clusters of "other" misclassifications. In the Southwestern U.S., the area with the highest correct classification of AI/ANs, similarly shows the highest concentration of "other" classification.



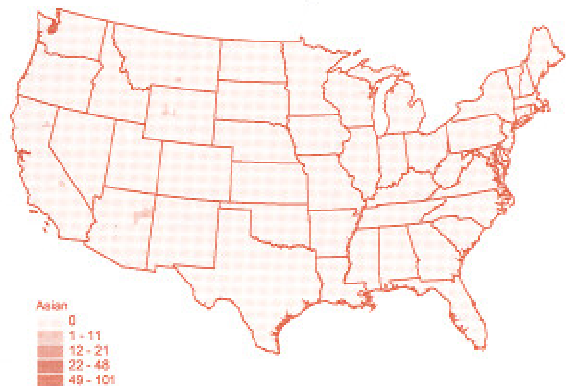
Classification of AI/ANs as Hispanics occurred for 0.6%, Asians for 0.2%, and Blacks for 1.1% of all AI/ANs in the Medicare database [4].

AI/ANs Classified as Hispanic



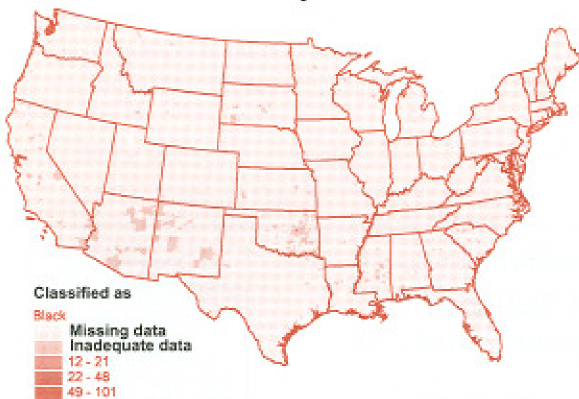
For the lower 48 states the greatest concentration of misclassification of AI/ANs as Hispanic is in the southwest.

AI/ANs Classified as Asian



AI/ANs misclassified as Asians and Pacific Islanders, though few, were concentrated in counties in Arizona, around the Hopi reservation, and small clusters in California, and in Montana and Wyoming.

AI/ANs Classified as Black



Misclassfication of AI/ANs as Black is concentrated in parts of California, Arizona, New Mexico, Oklahoma, Alabama and South Dakota.

Conclusion

Eliminating disparities in health status that affect AI/ANs is not possible without correctly identifying who and where your clients reside. There is remarkable disparity between population estimates used by different federal agencies. For example the U.S. Census estimated 1,932,000 AI/ANs in 1995. On the other hand, for the same year, both the Indian Health Service (with 1,256,532) and the Bureau of Indian Affairs (with 1,428,270) have different estimates of their user populations. The IHS bases its figures on those who have accessed the IHS health care system within the last three years and

[4] Numbers in Alaska are too few, and for Privacy Act of 1974 compliance, authors are unable to show their distribution.

live on or near a reservation, while the BIA records those who are members of a federally-recognized tribe, have more than one fourth degree of Indian blood and live on or near a reservation.

To date, there does not exist one single accurate source of information on AI/ANs. Yet the accuracy of these data play a crucial role in allocation of federal resources to serve AI/ANs. In addition, because of the emerging importance of information on health and health care costs, it has become more important that this information is accurate enough to allow tribes and advocacy organizations to plan for services, deliver needed services, and process reimbursement for services.

In 1995, HCFA reported that only 65% (291,354) of AI/ANs that were eligible for Medicaid accessed these benefits as compared with 87% for Whites, 82% for Blacks, 83% for Asians, and 91% for Hispanics (HCFA, 1996). Similar statistics emerge for Medicare, which reported that while the general population accesses Medicare at high levels, only two thirds of AI/AN elders participate in this program (Cunningham & Shur, 1991). The lack of accuracy in racial classification is likely to result in erroneous conclusions.

Such statistics ostensibly indicate that HCFA is not meeting the needs of AI/ANs. However, this monograph has shown an alternative interpretation: **HCFA is not capturing services to these beneficiaries because it is classifying them incorrectly.**

Recommendations

There is a need to address and promote solutions to resolve inconsistent classification within the Medicare denominator file. HCFA needs to develop a set of guidelines that address these inconsistent classification issues for AI/ANs, along with a road map showing how to mitigate these inaccuracies.

Undercounting of AI/ANs is widespread and threatens the perceived significance of, funding for, and research focus on the AI/AN population. Because inconsistent classification is uneven across geographic regions, this suggests that some states are more prone to inaccuracies in recording. To initiate the amelioration of some of these existing conditions it is recommended that HCFA;

- establish an inter-agency technical group;
- review the scope of inconsistent racial classification;
- examine data source(s) of the problem; and
- identify technical and logistical solutions.

Inconsistent classification is only part of the problem, but a significant one, because only with accurate information can services for AI/ANs be measured and improved.

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This publication benefitted from technical comments provided by Dorothy Dupree from HCFA, Roger Gollub, M.D, from IHS, and Anthony D'Angelo. However the authors are solely responsible for the views expressed and for any inaccuracies.

Mario D. Garrett, Ph.D. *is Director of Data Analysis Service. das@unm.edu*
Kurt A. Menke, M.A. *is a GIS Specialist, EDAC, UNM. kmenke@spock.unm.edu*

Table Showing % of Inconsistent Classification in Death Certificates (Ranked) and the % of Inconsistent Classification (Ranked) in the Medicare Denominator File for 1995.

State	% Inconsistent in State Death Certificates *	Rank Order State	% Inconsistent Medicare Denominator	Rank Order Medicare
Alabama	-	38	94.00	35
Alaska	**4.30**	**9**	**81.20**	**12**
Arizona	**2.30**	**2**	**64.40**	**1**
Arkansas	**43.60**	**27**	**94.70**	**39**
California	**11.10**	**18**	**91.30**	**25**
Colorado	**4.20**	**8**	**78.50**	**7**
Conneticut	-	32	93.10	29
D.of Columbia	-	50	-	50
Delaware	-	49	-	49
Florida	**28.10**	**23**	**91.70**	**27**
Georgia	-	45	96.40	45
Hawaii	-	33	93.10	30
Idaho	**5.90**	**12**	**87.70**	**19**
Illinois	-	29	87.20	18
Indiana	-	40	94.70	40
Iowa	**3.30**	**4**	**81.40**	**13**
Kansas	**28.60**	**24**	**88.00**	**20**
Kentucky	-	48	98.80	48
Louisiana	-	39	94.10	38
Maine	-	30	88.10	21
Maryland	-	44	95.90	44
Massachusetts	-	34	93.50	31
Michigan	**31.70**	**25**	**94.00**	**36**
Minnesota	**9.80**	**16**	**80.10**	**9**
Mississippi	**4.10**	**7**	**80.80**	**11**
Missouri	**38.70**	**26**	**94.00**	**37**
Montana	**4.80**	**10**	**80.20**	**10**
Nebraska	**7.20**	**14**	**76.70**	**5**
Nevada	**5.40**	**11**	**84.20**	**16**
New Hampshire	-	41	95.00	41
New Jersey	-	46	97.10	46
New Mexico	**2.50**	**3**	**70.60**	**3**
New York	**14.90**	**20**	**84.00**	**15**
North Carolina	**8.60**	**15**	**91.30**	**26**
North Dakota	**3.60**	**6**	**79.80**	**8**
Ohio	-	42	95.10	42
Oklahoma	**26.30**	**22**	**90.40**	**23**
Oregon	**17.30**	**21**	**88.30**	**22**
Pennsylvania	-	43	95.30	43
Rhode Island	-	31	90.80	24
South Carolina	-	47	97.10	47
South Dakota	**1.90**	**1**	**73.90**	**4**
Tennessee	-	37	93.90	34
Texas	**47.10**	**28**	**91.80**	**28**
Utah	**7.20**	**13**	**68.10**	**2**
Vermont	-	35	93.70	32
Virginia	-	36	93.70	33
Washington	**9.90**	**17**	**83.50**	**14**
West Virginia	-	51	-	51
Wisconsin	**14.10**	**19**	**86.40**	**17**
Wyoming	**3.40**	**5**	**77.40**	**6**

* Data from Adjusting for Miscoding of Indian Race on State Death Certificates, IHS, 1996 :Table A3-2

Sponsors:
This monograph series is drawn from the project "An Interactive Atlas of American Indian Elders Health," made possible by funding from the Indian Health Service, U.S. Department of Health and Human Services, Rockville MD 20875, Reference ISH002063-01 ISH73, Elder Health Care Initiative.

Principal Investigator:
Dave Baldridge
Executive Director
National Indian Council on Aging

Project Team:

National Indian Council on Aging
10501 Mongtomery Blvd. NE
Suite 210
Albuquerque, NM 87111
(505) 292-2001/Fax 292-1922
mail-dave@nicoa.org

Earth Data Analysis Center
University of New Mexico
Bandalier West
Albuquerque, NM 87131
(505) 277-3622/Fax 277-3614
Email: mindis@spock.unm.edu

Data Analysis Service
1009 Bradbury Dr. SE, Suite 33
Albuquerque, NM 87106
(505) 272-7597/Fax 842-8018
E-mail: das@unm.edu

CAPE Associates
6405 Cranbrook NE
Albuquerque, NM 87111
(505) 821-8476/Fax 797-7172
E-mail: lesen@unm.edu

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National Indian Council on Aging, Inc.
10501 Montgomery Blvd., NE
Suite 210
Albuquerque, NM 87111

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