ASPE RESEARCH NOTES
INFORMATION FOR DECISION MAKERS

FOCUS ON: *Long-Term Care* *Issued April 1992*

ESTIMATING ELIGIBILITY FOR PUBLICLY-FINANCED HOME CARE: NOT A SIMPLE TASK…

Public funding of home care services for the disabled elderly is divided among Medicare, Medicaid, the Social Services Block Grant, the Older Americans Act programs and other State and community programs. In recent years, many proposals have been advanced to create a more uniform home care benefit for the disabled elderly. For example, the Congressional Pepper Commission recommended a new social insurance program for home and community services. Other proposals have included: expanding home care benefits under Medicare, mandating home care coverage under Medicaid, and modifying the optional new Medicaid program for the "frail elderly" (Section 4711 of the Omnibus Budget Reconciliation Act of 1990). All of these proposals face similar questions: which elderly persons with disabilities should be eligible? how many such persons are there?

Recent home care proposals base eligibility on a standardized assessment of physical and cognitive functioning. Physical disability is typically indicated by the need for substantial assistance in performing the Activities of Daily Living (ADLs), e.g., eating, bathing, dressing. Most proposals also include persons needing supervision and cuing with ADLs due to cognitive impairments arising from Alzheimer's Disease and related disorders.

Measures of Functioning

Estimating the number of persons eligible for a home care benefit on the basis of physical disability is a function of several factors: (1) identifying the particular ADLs where loss of function indicates a qualifying disability; (2) determining the minimum number of ADL deficits that warrant a home care benefit; and (3) specifying how the disabilities are to be measured.

Determining eligibility for services based on cognitive impairment is more difficult. The state of the art in measuring and screening for the cognitively impaired elderly is at a much earlier stage of development than it is for the physically disabled.

Estimates Vary by Survey

Estimates of the functionally disabled elderly come from nationally representative surveys like the National Health Interview Survey/Supplement on Aging (SOA), National Medical Expenditure Survey (NMES), National Long-Term Care Survey (NLTCS), and Survey of Income and Program Participation (SIPP)--see Table 1. Findings from national survey data are affected by: sampling frame used to select respondents, sampling procedure and sample size, data collection methods, particular ADLs covered, wording of ADL questions, and selection of variables for analysis.

TABLE 1: Comparison of Survey Estimates of Disabled Elderly in the Community* (in thousands)

	1984 NLTCS	1984 SOA	1984 SIPP	1987 NMES
1+ ADL Disabilities	2,067 (7.8%)	1,318 (5.0%)	1,538 (5.8%)	2,250 (8.1%)
N**	19,720	11,425	5,900	5,751

SOURCE: Weiner, et al., 1990.

* Noninstitutionalized elderly receiving help from another person
** Unweighted number of elderly in sample.

Across five national surveys where the questions on ADL impairments were standardized for analytic purposes, the percent of non-institutionalized elderly estimated as impaired in at least one of five ADLs ranged from 5.0% to 8.1% (Wiener, et al., 1990). This difference is not large relative to the total community-based elderly population. It establishes "boundaries" within which the true disabled elderly population is likely to fall under the selected ADLs and definition of disability. At the same time, the difference of 60% between the lowest and highest estimates appears large. It shows that estimates of the number of eligible beneficiaries of a new federal home care program may vary considerably depending on the survey data used. Caveat emptor...

In addition, approximately 1.4 million persons aged 65 or over reside in nursing homes (Hing, 1987). Over time the interaction between community-based and institutionalized frail elderly could affect the size of the eligible home care population. Based on current research, such interaction effects are likely to be small (Kemper, 1988).

Alternative Definitions of Disability

Jackson and Burwell (1990) produced estimates of the long-term care population under different definitions of disability, using the 1984 NLTCS, adjusted to 1990 (see Table 2).

The most stringent definition required an individual to need active, hands on assistance with at least two of

three heavy care ADLs (eating, toileting, transferring). This definition yields 472,000 persons. The most liberal definition of eligibility encompassed those who use either human help or an assistive device to cope with one or more of five ADLs (eating, transferring, toileting, dressing, bathing). This definition yields an estimate of about 3.8 million persons.

TABLE 2: Elderly in Community Under Different Definitions of Disability (000)

Type of Help	ADL Disability					
	1+ of 3 Heavy Care ADL	2+ of 3 Heavy Care ADL	2+ of 3 Heavy Care ADL or CI	1+ or 5 ADL	1+ 5 ADL or CI	2+ of 5 ADL or CI
Active Help	901	472	1,041	1,837	2,114	1,458
Active or Standby Help	1,628	1,071	1,515	2,417	2,619	1,942
Active or Standby or Uses Assistive Device	2,961	1,673	2,050	3,770	3,915	2,717

SOURCE: Jackson and Burwell, 1990.

Many persons found eligible on the basis of physical impairment may also be cognitively impaired. However, when the eligibility criteria specify physical *or* cognitive impairment (so that cognitively-impaired-only persons are also included), the estimates range from 1.0 million persons under the very stringent definition of ADL disability, to 3.9 million under the most liberal definition.

Conclusion

Definitions of disability using measures of ADL impairment have become popular mechanisms for allocating resources under home care proposals. Survey data can best be used to establish ranges for the probable size of the eligible elderly disabled population rather than precise point estimates. Finally, it should be noted that eligibility for publicly financed home care services (and consequently estimates of the eligible population) may be affected by factors beyond level of disability, such as financial need and informal supports.

Related Resources

Hing, E., "Use of Nursing Homes by the Elderly: Preliminary Data from the 1985 National Nursing Home Survey." ADVANCE DATA, Washington, DC: National Center for Health Statistics, May 14, 1987.

*Jackson, M.E. and B.O. Burwell, "Publicly-Financed Home Care for the Disabled Elderly: Who Would Be Eligible?," Contract No.HHS-100-88-0041. December 1990. [http://aspe.hhs.gov/daltcp/reports/pubfines.htm]

Jackson, M.E., B.O. Burwell, R.F. Clark, and M.F. Harahan, "Eligibility for Publicly-Financed Home Care." American Journal of Public Health, (forthcoming 1992). [http://aspe.hhs.gov/daltcp/reports/pubfhces.htm]

Kemper, P., "The Evaluation of the National Long-Term Care Demonstration: Overview of the Findings." Health Services Research, 1988; 23(1): 161-174. [http://aspe.hhs.gov/daltcp/reports/hsres.htm]

Manton, K., "A Longitudinal Study of Functional Change and Mortality in the United States." Journal of Gerontology, 1988; 43:S153-161.

Spector, W., "Cognitive Impairment and Disruptive Behaviors Among Community Based Elderly Persons: Implications for Targeting Long Term Care." The Gerontologist, 1991; 31:51-59.

Stone, R. and C. Murtaugh, "The Elderly Population with Chronic Functional Disability: Implications for Home Care Eligibility." The Gerontologist, 1990; 30:491-496.

*Wiener, J., R.J. Hanley, R. Clark, and J.F. Van Nostrand, "Measuring the Activities of Daily Living: Comparison Across National Surveys." Journal of Gerontology, 1990; 45:S229-237. [http://aspe.hhs.gov/daltcp/reports/meacmpes.htm]

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ASPE Research Notes is circulated periodically to the Department of Health and Human Services by the Office of the Assistant Secretary for Planning and Evaluation. For further information on long-term care issues, call Patrick Fagan, Deputy Assistant Secretary for Family, Community, and Long-Term Care Policy at 202-245-6443. To obtain asterisked reports referenced, contact Brenda Veazey, DHHS/OS/ASPE/OFCLCP, Room 424E, HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.