HAWAII STATE VETERANS HOME: A Feasibility Study

CALVIN T. AZAMA
Researcher

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FOREWORD

The Bureau thanks the various public agencies who contributed to this study with their information and assistance: the Department of Health, the Department of Social Services and Housing, the University of Hawaii's School of Public Health, and the Veterans Administration. The Bureau also expresses its gratitude to the following persons: Mrs. Judy Ooka, Mrs. Sylvia Levy, Mr. William Oshiro, Mrs. Edna Sakamoto, and Dr. William J. Vandervort.

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Samuel B. K. Chang
Director

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CHAPTER I
INTRODUCTION

House Resolution 294 of the Regular Session of 1976 requested the Legislative Reference Bureau to conduct a study on the feasibility of establishing a state veterans home.

The part of the study capable of objective examination revolves around two major factors: cost and need.

The examination of cost utilizes a comparative method; the VA's operating and construction aid is compared to the aid available from the U.S. Department of Health, Education and Welfare. The purpose of the comparison was to ascertain which type of federal aid was more advantageous to the State in terms of cost.

Need and projected need were determined from available population and rate of institutionalization data.

Although the study's emphasis is on the two factors, others must be taken into consideration. Factors such as the fiscal priorities of the State, state policy concerning health care institutionalization, state policy concerning the elderly program, and the social obligation to the veterans, must be considered. Appropriate application of these factors requires input from the public and the executive branch of government. In this study, the Bureau can only touch upon these factors because there are too many subjective considerations to anticipate policy positions based on the priorities for governmental commitments or the opinions of the public.

A general outline of the study is as follows:

(1) A general overview of nursing and domiciliary facilities;

(2) The general history and philosophy of state veterans homes;

(3) A discussion of the Veterans Administration's aid to state veterans homes;

(4) A general discussion of the state veterans homes in the country;

(5) Discussion of the VA health services in Hawaii and the demographic characteristics of Hawaii's veterans;

(6) Projection of need for health care institutionalization;

(7) Discussion and comparison of the operating and construction costs; and

(8) The recommendation.

By VA definition a state veterans home may be a nursing home, domiciliary, hospital, or combination. The study, however, focuses only on the nursing home and domiciliary aspect. A hospital is not considered in the scope of the study because:

(1) A state veterans hospital cannot be a distinct entity, it must be a part of a domiciliary or nursing facility;

(2) Hawaii has adequate hospital facilities;

(3) The VA per diem contribution is very low for patients in state veterans hospital facilities; and

(4) The intent of the resolution is towards a state veterans home.

DEFINITIONS

The following terms, which are frequently used in the report, are defined in the context of the report. For example, "Medicaid" is obviously more extensive than defined below, but for our purposes the definition given is sufficient.

Armed forces - United States Army, Navy, Air Force, Marine Corp, Coast Guard, including reserves.

Average or mean daily census - A measurement used by in-patient facilities. Usually taken on an an annual basis. It is computed by dividing the total number of days each patient spent in the facility by 365.

Care home and adult family boarding home - homes for the degrees of domiciliary care in Hawaii as structured by the Department of Social Services and Housing.

Domiciliary - shelter and care to ambulatory patients who are disabled or aged but do not require hospital or nursing care.

Fiscal year - the federal fiscal year is from October 1 to September 30. The state fiscal year is from July 1 to June 30.

Intermediate care - care to semi-ambulant patients who do not require skilled nursing care, or are not healthy enough for domiciliary care.

Medicaid - Title XIX of the Social Security Act; which among other things provides for federal and state participatory aid to patients in skilled nursing or intermediate care facilities who cannot afford such care.

Non-service-connected disability - disability not incurred or aggravated in the line of duty.

Period of war or hostility - any of the following Congressionally recognized periods of war or hostility:

Spanish-American War - April 21, 1898 to July 4, 1902 or April 21, 1898 to July 15, 1903
Mexican Border Period - May 9, 1916 to April 15, 1917
World War I - April 6, 1917 to November 11, 1918 or April 6, 1917 to April 1, 1920
World War II - December 7, 1941 to December 31, 1946
Korean Conflict - June 27, 1950 to January 31, 1955
Vietnam Era - August 5, 1964 to May 7, 1975

Public Law 93-641 - the National Health Planning and Resources Development Act of 1974. Among other things it provides construction aid to medical facilities.

Service-connected disability - disability incurred or aggravated in the line of duty.

Skilled nursing care - 24-hour skilled care under the supervision of a registered nurse to patients who are infirm but do not require hospital care.

State veterans home - facility established by a state primarily for the care of veterans.

Supplemental Security Income - Title XVI of the Social Security Act; which among other things provides the basis for federal aid to persons in domiciliary facilities. The State supplements the SSI payments to meet the cost of total domiciliary care.

VA compensation - monthly payment to a veteran because of service-connected disability.

VA domiciliary renovation aid - codified under Title 38 USCA 644; provides aid for the renovation of state veterans domiciliary homes.

VA nursing home construction aid - codified under part IV, chapter 81, subchapter III of Title 38 USCA; provides construction aid to state veterans nursing homes.

VA pension - monthly payment to a veteran because of service, age, or non-service-connected disability.

VA per diem - codified under Title 38 USCA 641; provides payments for the cost of care of veterans in state veterans homes.

Veteran - a person who served in the active military, naval, or air service, and who was discharged under other than dishonorable conditions.

CHAPTER 2
GENERAL OVERVIEW

NURSING CARE

Prior to the Social Security Act of 1935, institutional care for the indigent elderly was primarily provided by state or county operated almshouses. With the enactment of the Old Age Assistance (OAA) Program of the Social Security Act, federal payments to the institutionalized were authorized. A qualification, however, for the receipt of federal payments was that the patient-beneficiary reside in a nonpublic institution. The local jurisdictions thus transferred the patients of public institutions to private boarding homes to take advantage of the OAA federal assistance.

Private proprietorship of boarding homes increased and competition fostered an offering of intensive, specialized services. Nurses were employed for the medically impaired patients and the terms "nursing home", "convalescent home", and "rest home" evolved.

Through the years federal legislation has allowed payments to patients in public institutions and established standards for nursing facilities.

Medicare and Medicaid, instituted in 1965, provide health care programs for the low-income medically needy. Nursing home care was considered to be a basic health service within the program. By law, all participating states are required to provide nursing care services under Medicare and Medicaid. These programs have had a significant effect upon the nursing home industry.

> *The decade since the Medicare/Medicaid Act was passed in 1965 has witnessed the transformation of the nursing home from a small business operation into a billion dollar industry. The industry's impact on personal lives is now enormous: one in 20 Americans reside in one of the nation's 23,000 nursing homes, while one in five aged can expect to spend at least part of his remaining years in a home. Federal expenditures for long-term care were estimated to have reached nearly $7.5 billion by 1974. Intensive federal efforts to regulate the quality of care offered in these homes have accompanied their rapid growth, culminating in significant amendments to the Act in 1972 and 1973 and the issuance of comprehensive new qualitative standards by the Department of Health, Education, and Welfare (HEW) in 1974.*[1]

Medicare also served the purpose of requiring standards for the operation of nursing homes. When Medicare legislation was being considered, it was generally recognized that the licensing standards of the various states were inadequate. The intent of Medicare was to bar inadequate nursing homes from participation in the program. Later, the standards of Medicare were incorporated into the Medicaid program. Thus, the following discussion of skilled nursing and intermediate care facilities will be in the context of Medicare/ Medicaid standards.

Federal law also stipulates that all nursing homes and nursing home administrators be licensed in the state where operating.[2]

DOMICILIARY

The purpose of domiciliary care is to provide a non-institutional community setting for persons, primarily the aged, who require social, not medical, care. Domiciliary care may be provided in institutions accommodating a large number of patients, or in foster family homes where a few patients live in a home-like atmosphere. Since domiciliary facilities are not considered medical facilities, Medicare and Medicaid do not provide payments. The various states, however, may provide aid through the Supplemental Security Income Program of the Social Security Act, or General Assistance.

SITUATION IN HAWAII

The State of Hawaii provides four related though distinct categories of institutional care. These categories are differentiated by degrees relative to the condition of the patient and the services provided. The categories, ranked descendingly by the more intensive health services provided are: skilled nursing facilities, intermediate care facilities, care homes, and adult family boarding homes. Though skilled nursing care and intermediate care vary in the degree of services provided and the resultant cost, both are considered to provide nursing care. Similarly, care homes and adult family boarding homes also vary in services provided and cost entailed, but both are considered to be in the domiciliary category.

The following is a general discussion of the four categories: their definitions, cost factors, present inventory, and patronage.

Skilled Nursing Facilities in Hawaii. Title XVIII, Medicare, of the Social Security Act provides an extensive definition of a skilled nursing facility. In summary, a skilled nursing facility must:

1. Be primarily engaged in providing in-patients skilled nursing care, or rehabilitative services for injured disabled, or sick transferees from hospitals;

2. Be governed by policies developed by a professional board of review;

3. Have a physician, registered professional nurse, or a medical staff in charge;

4. Require that the health care of all patients be under the supervision of a physician, and that the physician be available in case of emergency;

5. Maintain clinical records on all patients;

6. Provide 24-hour nursing service;

7. Employ at least one full-time registered professional nurse.[3]

Generally, all nursing homes admitting patients receiving federal aid adhere to the enumerated standards.

The State of Hawaii defines a nursing home as:

> *A. "Convalescent Home" or "Nursing Home"--means a facility established for profit or non-profit, which provides nursing care and related medical services on a 24-hour per day to two or more individuals because of illness, disease, or physical or mental infirmity. It provides care for those persons not in need of hospital care but requiring nursing care or related medical services, which medical services shall be prescribed by a physician. These shall be performed under the direction of either a physician or a professional nurse or a physical therapist or an occupational therapist, depending upon the service required. If children are cared for, they shall have a separate unit.*[4]

Nursing homes are certified by the Department of Health pursuant to Public Health Regulation 12A.

Chapter 457B of the *Hawaii Revised Statutes* also provides for the licensing of nursing home administrators. A

board of examiners of nursing home administrators is appointed by the governor and develops and enforces standards of licensure and conduct. The board is also empowered to investigate complaints of noncompliance with its standards.

In fiscal year 1974, there were 1,494 skilled nursing care beds in the State of Hawaii. This total represented 19.4 beds per 1,000 persons aged 60 or over.[5] Estimates by the Department of Health indicate that by 1980 a minimum of 1,513, and a maximum of 1,825 skilled nursing beds will be required to service the population of Hawaii.[6]

In January of 1976, there were 1,270 patients in skilled nursing facilities.[7]

Intermediate Care Facilities. Intermediate care facilities are defined in a very general manner by the federal government as an institution licensed by state law, and providing services for patients requiring less than skilled nursing or hospital care.[8] "Intermediate care facilities under these guidelines have only slightly lower nursing care standards under Hawaii's licensing requirements. Essentially, they must provide 56 hours per week of nursing care, with medical attention prescribed as required."[9]

Chapter 12B of the Public Health Regulations of the Department of Health, as amended, defines intermediate care facilities as:

> *B. Intermediate Care Facilities--are facilities which provide general and personal care and protective services incident to old age or disability to two or more persons unrelated to the operator for which care payment is received. These facilities may admit residents who may be semi-ambulant or medically stable residents not in need of skilled nursing care. All residents admitted to the facility shall be referred by a physician.*[10]

The *Public Welfare Manual* of the Department of Social Services and Housing also defines an intermediate care facility. The definition is as follows:

> *An intermediate care facility (ICF) is a licensed institution, whether public or private, which is designed, equipped and staffed to provide health-related care and services on a regular basis. It may be a free-standing institution, or a distinct part of an institution such as a room, wing, floor, or a building or designated beds which fully meets the State's ICF*

licensure standards and State nursing home standards in the areas of safety and sanitation. Included in this definition are institutions for the mentally retarded.

The administrator of a free-standing general ICF is licensed as a nursing home administrator by the State. In the case of an institution for the mentally retarded, the administrator is a licensed nursing home administrator or a Qualified Mental Retardation Professional.[11]

Federal regulations also stipulate that the services of a physician be available in cases of emergency.[12]

In January of 1976, there were 485 patients in intermediate care facilities.[13] This figure is inconsistent with the projection of the Department of Health. The department projects a need for between 116 and 171 intermediate care beds in 1980.[14,15]

General Discussion. Medicaid, Title XIX of the Social Security Act, is the primary source of payment for long-term, indigent patients of skilled nursing and intermediate care facilities. The Medicaid program in Hawaii is administered by the Department of Social Services and Housing and is a 50-50 cost-sharing proposition with the federal government.[16] Patients requiring skilled nursing or intermediate care must be determined deserving pursuant to the standards of sections 3446 and 3454 of the *Public Welfare Manual*. Patients in these facilities under the Medicaid program may remain in the facilities for the duration determined medically necessary by the Department of Social Services and Housing; there is no arbitrary maximum as to the number of days of institutionalization.[17] Payments provided by Medicaid are "...the lesser of the reasonable cost or the facility's customary charges".[18] Patients are allowed a $25 monthly allowance. The remainder of the patient's income is subtracted from the cost of care and Medicaid assumes the difference. Payments are made directly to the vendor.[19]

Title XVIII, Medicare, of the Social Security Act also provides payments for care in skilled nursing, but not in intermediate care, facilities. These payments are meant to assist the convalescence of patients who are discharged from hospitals, but who require further, less intensive care. There is a 100-day limit for patients in skilled nursing facilities to receive this type of assistance under this program.[20]

The cost of skilled nursing care (SNF) has increased tremendously. In fiscal year 1961-62, the total government expenditure in Hawaii for skilled nursing home care was

$862,706. In fiscal year 1968-69, the expenditure rose to $6,033,000; a 700 per cent increase. Aside from inflation, the tremendous increase was attributable to: a doubling of the average cost per patient day from $8.14 in FY 1961-62 to $16.76 in FY 1968-69; and a three and one-half times increase from 106,039 in FY 1961-62 to 359,918 patient days in FY 1968-69.[21] The cost has continued to rise: in FY 1974-75, the average cost per patient day for skilled nursing facilities was $23.00; and $8,257,000 was spent by the State and federal governments to care for 1,958 skilled nursing care patients.[22] In January of 1976, the average cost per patient day rose to $33.16.[23]

The average cost per patient day in an intermediate care facility (ICF) has also risen, but not at a similar rate as the average cost in a skilled nursing facility. In FY 1974, the average cost per patient day in an ICF was $18.40.[24] In January of 1976, the average cost was $23.73.[25]

The cost differential between skilled nursing and intermediate care facilities has been the center of much discussion. The cost of maintaining a patient in an ICF is considerably less than in an SNF. Coupled with the cost factor is the phenomenon that many patients in SNFs do not require that degree of care. Basically, the discussion revolves around cost-savings by effective placement of patients in the appropriate category of care required.

The Greenleigh report of medical costs in Hawaii found two important facts concerning misutilization of skilled nursing facilities. One was that approximately 80 per cent of the patients in skilled nursing facilities required a lesser level or different form of care. Secondly, the study postulated that effective placement of patients in the proper institutional setting would have resulted in a tremendous savings to the federal and state governments.

Conclusion number two was arrived at by comparison with the State of New York. On May 1, 1969, "...the mean or average daily rate for a skilled nursing home was $16.48, while the corresponding rate for intermediate care facilities was only $10.02" in the State of New York. This represented a savings of 39.1 per cent.[26]

The report then applied the savings rate and the percentage of patients in skilled nursing facilities who could have been served in intermediate care facilities to the amount spent on skilled nursing care.

> *Assuming that the saving-rate of 39.1 per cent would also be similar for Hawaii, and that 80 per cent of the patients could be served by intermediate care facilities, nearly $2 million*

would be saved from the $6 million currently paid to skilled nursing homes for care of the medically indigent.[27]

In 1974, the Comprehensive Master Plan for the Elderly[28] similarly concluded that cost savings could be achieved by effective placement in appropriate categories of care. In FY 1974-75, $8,257,000 was spent on 1,958 patients in skilled nursing facilities. $1,318,000 was spent on 407 patients in intermediate care facilities. The report also determined that the average cost per patient day was $23.00 and $18.40 for skilled nursing care and intermediate care, respectively. The savings rate between both categories was 20 per cent, as opposed to the projected 39.1 per cent of the Greenleigh report.

It was also determined that in May of 1974, approximately 69 per cent of the patients in skilled nursing care facilities did not require such care. Of the 69 per cent, 50 per cent could have been placed in intermediate care facilities and 19 per cent in care homes.[29]

In short, both the Greenleigh report and the Comprehensive Master Plan for the Elderly recommended a more effective and wider utilization of intermediate care facilities as a cost-savings measure.

Skilled nursing facilities and intermediate care facilities are practically identical in design requirements. Should the relative needs for these facilities change, one could easily be used in place of the other.[30]

Domiciliary Facilities in Hawaii. Domiciliary facilities provide care to ambulatory patients who, for reasons of financial, age, mental, or health conditions are dependent on others for their basic needs. Patients in domiciliary facilities may have health impairments, but not to the extent requiring skilled nursing or intermediate care. Domiciliary facilities or, as they are termed by some, "foster-family homes are not used for persons whose physical or mental conditions require care in a medical or psychiatric facility, except for temporary periods pending arrangements for appropriate care".[31]

In Hawaii, domiciliary facilities are termed adult family boarding homes and care homes. "Adult family boarding homes and care homes are non-medical facilities which provide a different type and amount of care to its residents."[32]

The definition of a care home is:

A. "Care Homes"--are those facilities which provide general or rehabilitative care incident to old age or disability to two or more persons unrelated to the operator for which care payment is received. These homes exclude admission of residents less than semi-ambulatory or those needing long-term nursing care.[33]

Care homes are licensed by the Department of Health pursuant to Public Health Regulation 12B.

The definition of an adult family board home is:

1. *An Adult Family Boarding Home: is a family boarding home operating as a business for profit that provides accommodations to no more than three adults, unrelated to the family, who require minimal assistance and supervision in his daily living activities and who desire the opportunity to be a part of a family group.*[34]

Adult family boarding homes are licensed by the Department of Social Services and Housing.

Adult family boarding homes and care homes differ in the level of care they provide. There are three levels of domiciliary care, and rates of payment are commensurate to the level of care provided. Adult family boarding homes provide a less intensive service than care homes. The general definitions of the different levels are:

a. *Level I - An elderly or mentally or physically handicapped recipient who generally requires level of care and services provided in a licensed adult family boarding home. The individual is generally capable of managing most of his physical, mental and social functions with minimum assistance and supervision.*

b. *Level II - An elderly or handicapped semi-dependent recipient requiring level of care usually provided in a licensed care home. He is generally capable of managing certain physical, mental and social functions but requires assistance and supervision in performing a number of functions in his daily living activities.*

c. *Level III - A physically or mentally dependent recipient who requires extensive services in managing his physical, mental and social functions and requires 24-hour supervision.*[35]

Effective July 1, 1976, the payment schedule for the different levels of care are: $257 for Level I, $308 for Level II, and $370 for Level III. The Social Security Administration provides up to $167.80 for all outpatients in domiciliary facilities. The Department of Social Services and Housing assumes the remainder of the cost.[36]

In fiscal year 1974, there were 1,379 care homes and 480 adult family boarding home beds in Hawaii.[37]

CHAPTER 3

HISTORY AND PHILOSOPHY

VETERANS HOMES--BACKGROUND

The federal government first established national veterans care facilities in the early 19th century. Domiciliary care for naval veterans was authorized in 1811. The authorization created the Naval Home in Philadelphia which was occupied in the 1930s. In 1851, the United States Soldiers' Home in Washington, D.C., was established.[1]

Domiciliary and nursing home care for veterans were primarily the burden of the individual states and territories until the advent of the Civil War. A federal Sanitary Commission, organized in 1861 to investigate discharge procedures and facilities for wounded veterans, discovered inadequate conditions and provisions in both areas. To rectify the situation, domiciliary and hospital facilities were constructed along the Union lines. By March 1863, twenty-five facilities were in operation. The average length of stay in these facilities, however, was only three days for each patient. The facilities, thus, were merely transitory stations for the homeward bound, wounded or disabled soldiers. "The Commission's recommendation for a national system of sanitaria was initially rejected by Congress in favor of a hometown-care approach of absorbing such disabled veterans in local facilities."[2] Thus, the burden of the caretaking of disabled and wounded veterans remained with the local jurisdictions.

As the Civil War raged on, the conflict produced a mass of casualties which extended beyond the capabilities of the local programs. In 1861, Congress established the National Home for Disabled Volunteer Soldiers to assist the local programs. At first, only disabled Civil War veterans were eligible for admission. Subsequently, the homes were opened to veterans of previous wars and those with non-service-connected disabilities.[3]

In 1888, the federal government initiated a per capita assistance payment to state veterans homes. Payments amounted to $100 each "...for disabled soldiers and sailors of the United States who served in the war of the rebellion, or in any previous war, who are disabled by age, disease, or otherwise, and by reason of such disability are incapable of earning a living, provided such disability was not incurred in service against the United States...."[4] This financial impetus was a major reason for the creation and continuation of twenty-six state veterans homes prior to 1900.[5]

Federal financial assistance appears to be just one of the reasons for the creation of the homes. Basic humanitarianism also was a reason; if the states did not care for the disabled veteran, no one else would. Another reason can be attributed to the nature of the Civil War. The War was an internal conflict which was tangibly connected with the preservation of the Union. All of the federally recognized state veterans homes established prior to the turn of the century were in the Northern States. Five states of the Confederacy also established homes for their veterans and/or wives or widows.[6] These homes did not receive any federal financial assistance. None are currently in operation today though Louisiana reestablished a state veterans home in 1967.

As time passed, the federal aid to the state veterans homes increased and diversified. Ensuing amendments to the federal per capita assistance raised this amount to $700 a year by 1954.[7] In 1960, Public Law 86-625 changed the method of federal assistance from the per capita to a per diem basis.

Congress in 1964 recognized the requirements for more and better nursing care for the nation's elderly. An approach taken to alleviate the need was to stimulate the nursing care program for veterans. One of the provisions instituted in the veteran care program was a per diem increase from $2.50 to $3.50 for nursing care patients. Previously, the federal per diem was uniform for all degrees of veteran care. Congress in enacting the law ignored the VA's "...position that the per diem of $2.50 represents an adequate measure of federal responsibility for state home care, whether in the nature of hospital, domiciliary, or nursing home care."[8]

Concomitantly, Congress authorized a $5 million annual appropriation for the next five fiscal years "...to assist the State in the construction of new buildings or the expansion, remodeling, modification or alteration of existing structures in order to provide nursing home beds in their state homes."[9]

In 1969, federal legislation was enacted which provided aid for the remodeling, modification, and renovation of existing state veterans domiciliaries and hospitals.[10]

The types of VA aid mentioned will be discussed in further detail later in the report.

GENERAL PHILOSOPHY

The federal/state veterans home relationship is subject to varying interpretations by federal and state officials. The VA's attitude toward the relationship is "...considered to be a cost-sharing undertaking in which the state and federal governments work together to meet a mutual obligation."[11] Implicit in the relationship from the federal government's viewpoint is that the states have obligations and responsibilities to veterans even if the service performed was directly for the federal government. While the states which have state veterans homes generally agree with the sentiment, there is a difference of opinion as to the extent of the obligations and responsibilities.

The following statement made by the Chairman of the Legislative Committee of the National Association of State Veterans home typifies prevailing feelings:

> *These bills which are presently before the committee, ...really call for making the Veteran's Administration and the Federal Government a more equal partner in this relationship between the States and the Federal Government, and it is rather interesting to note in the historical discussion, those of us who have delved into this, back in 1888, in creating this concept, that it was an intent there be a partnership.*
>
> *We assume it was intended there be an equal partnership.*[12]

The "bill" referred to in the above statement would have increased the federal per diem contributions to state veterans facilities to approximately 50 per cent.

Thus there was a difference in opinion between the federal and state governments on the cost of maintaining a state veterans home. In fiscal year 1974, the average per diem cost in state domiciliary care was $12.19; for nursing home care, $23.13; and $37.92 for hospital care.[13] If the VA contributed the maximum amount to the state facilities, they would have contributed: $4.50 for domiciliary care, or 37 per cent of the total per diem cost; $6.00 for nursing home care, or 26 per cent of the total per diem cost; $10.00 for hospital care, or 26 per cent of the total per diem cost.[14] With the enactment of Public Law 94-417 the federal participation increased. Public Law 94-417 amended the rate schedule to $5.50 for domiciliary care, $10.50 for nursing home care, and $11.50 for hospital care. If these rates are applied to the average daily cost of care as determined by

the VA in July of 1975, they would have amounted to 40 per cent for domiciliary care, 45 per cent for nursing home care, and 27 per cent for hospital care.

The relationship between the VA per diem and Hawaii's cost of care is discussed in chapter 4.

The 94th Congress has apparently taken the position that the federal "fair share" is approximately 30 per cent.[15]

> *H.R. 10394, as reported would raise the VA's per diem reimbursement for all three types of care to levels which will keep the Federal proportional share of total operating costs at levels consistent with the average Federal proportional share during the past 5 years--approximately 30 per cent.*

Whether this percentage is satisfactory as the federal "fair share" is subject to question. It surely is not the "fair share" from the position of the National Association of State Veterans Homes.

CHAPTER 4
FEDERAL AID

The Veterans' Administration (VA) provides three types of financial aid to state veterans homes. First, the VA provides per diem aid in accordance with a rate schedule based upon the category of accommodation. Second, the VA provides aid for the construction of state nursing facilities. Third, the VA provides aid for the "...remodeling, modification, or alteration of existing hospital or domiciliary facilities in state homes providing care and treatment for veterans".[1]

TITLE 38 USCA 641

VA per diem aid to state veterans homes is codified in Title 38 USCA 641. Rates of the per diem payment for eligible veteran-residents are presently $5.50 for domiciliary care, $10.50 for nursing home care, and $11.50 for hospital care. These rates are the maximum allotted. The VA per diem payments cannot exceed one-half of the average per diem cost of each veteran in the state home.[2]

The rationale behind the per diem contribution is based upon two causal factors. One is the mutual obligation of the state and federal governments to care for veterans who served in the defense of the country. The second factor is that the federal government sustains a savings as a result of the cost-sharing arrangement. The following exchange between Dr. Paul Haber, a representative of the VA, and members of the U.S. House Subcommittee on Veteran's Hospitals illustrates this:

> Mr. Satterfield. *I notice in your statement, and agree with it, that this is a good program. I assume we could concede then that the State program is relieving the Veterans' Administration of a rather significant load, which otherwise might have to be absorbed by the Veterans' Administration system?*
>
> Dr. Haber. *Yes, it is. Every one of the veterans paid, to which we must contribute, and must be eligible for care in the Veterans' Administration. The presumption is that the States are not able to provide that care, we would have to.*

Mr. Satterfield. *So that, looking at it that way then, there is a saving to the Veterans' Administration, which would be the difference between what we are now paying under the per diem allowance and the figures you just gave me with respect to the increased costs in the Veterans' Administration system?*

Dr. Haber. *Yes, sir.*

Mr. Satterfield. *Mr. Danielson, do you have any questions?*

Mr. Danielson. *I have maybe one for clarification. I regret that I was not in earlier because I have the usual clarification of having to be in more than one place at one time.*

As I understand it, these two bills are the same bill actually, would not open up a new obligation, that is, so far as the Federal Government is concerned, for the Veterans' Administration but would encourage the use of State-owned, State-operated facilities to help us meet our existing responsibilities under the laws of the United States.

Am I right in that assumption?

Dr. Haber. *Yes, I think that is right. It involves the cost structure.*

Mr. Danielson. *The bills are based on an obligation to veterans who already would be eligible for care in Veterans' Administration facilities but it contemplates a financial participation, the Federal Government reimbursing the State governments for care given to those veterans in States?*

Dr. Haber. *Yes, sir.*

Mr. Danielson. *And it is my understanding from your response to the chairman's last few questions that this might, assuming that the program operates as anticipated, that this might result in a savings to the Federal Government?*

Dr. Haber. *I think that to the extent that the State-owned programs care for individuals who might otherwise have to be cared for by the Veterans' Administration, that is a true statement, Mr. Danielson.*

On the other hand, these programs are ongoing and it should be made clear that the States are already assuming that burden without increased Federal support. How long they can continue to do so is conjectural and I would imagine this burden upon the States is becoming increasingly heavy.

Mr. Danielson. *Well, I appreciate your answer. I think we have to keep everything in context, however. Most States happen to be in a better financial position, net budgetwise, than the Federal Government. Very few are running deficits.*

We have a deficit this year anticipated something like $6 billion or $7 billion, so that is a fact we have to keep in mind.

Thank you very much.[3]

Thus, the federal per diem contribution is perceived as a cost-sharing relationship between the federal and state governments based upon a mutual obligation to the veteran. The portion of the burden entailed by the parties, however, is another matter. The present system, admittedly by the VA, is designed to relieve "...a rather significant load, which otherwise might have to be absorbed by the VA system".

The excerpted statements were in relation to a bill which would have raised the per diem to one-half of the cost of maintenance.

On September 21, 1976, a different bill was enacted as Public Law 94-417. Public Law 94-417 did not provide an escalating/de-escalating provision. Instead, it raised the per diem for domiciliary care from $4.50 to $5.50, for nursing care from $6.00 to $10.50, and for hospital care from $10.00 to $11.50. As noted in the previous chapter, Congress has implied that 30 per cent is the federal "fair share".

Legislative History. In 1888, the federal government authorized a yearly payment of $100 each "...for disabled soldiers and sailors of the United States who served in the war of the rebellion, or in any previous war, who are disabled by age, disease, or otherwise, and by reason of such disability are incapable of earning a living, provided such disability was not incurred in service against the United States...."[4] In 1889, the federal per capita contribution was limited to $100 and could not exceed one-half of each patient's cost of maintenance.[5] In 1920, two provisos were enacted which allowed the federal government to deduct from

the home's total maintenance cost sums "retained" or "collected" by the home from the patients. The Act also broadened the eligibility standards to include veterans "...who served in the Civil War or in any previous or subsequent war...."[6]

Subsequent amendments incrementally increased the federal per capita aid to $700 in 1954.[7] In 1960, the concept of federal aid to state veterans homes evolved from a per capita to a per diem basis.[8]

The increase of federal contributions corresponded to the increase of maintenance costs. In 1948, the average per capita cost to maintain a veteran in a state home was $1,048. Federal per capita contributions at this time was $300, less than one-third of the total cost. Public Law 80-531 temporarily increased the per capita contribution to $500 until a permanent schedule could be derived.[9] Maintenance costs continued to rise, and in 1953 the $500 contribution accounted for only 30 per cent of the average per capita costs of maintaining a patient in a state home.[10] Public Law 83-613 increased the federal per capita contribution to $700.[11] By 1959, the $700 contribution amounted to only 31 per cent of the average per capita costs incurred by the states.[12] In 1960, Public Law 86-625 changed the method of federal contribution from a per capita to a per diem basis. Federal per diem payments were set at $2.50 for each qualified veteran-patient, or approximately $1,250 annually.[13] Amendments in 1968, for the first time, differentiated between the types of care. The per diem for nursing care was increased to $5.00, and for domiciliary and hospital care to $3.50.[14] The lack of greater monetary support was to discourage the use of hospital care as "...inconsistent with the objectives of the federal aid program..."[15] which was primarily directed at providing domiciliary care. This attitude did not prevail for very long. In 1969, Congress increased the per diem for hospital care to $7.50.[16] In 1973, the per diem rate schedule was amended to $4.50 for domiciliary, $6.00 for nursing care, and $10.00 for hospital care.[17] On September 21, 1976, the present rate schedule was enacted.[18]

Before the enactment of P.L. 94-417, an inequity in the proportion of the cost of maintaining a veteran in a state home existed. According to a survey conducted by the VA in July of 1975, the states assumed a higher percentage of the average daily maintenance cost.

Of the nationwide average daily maintenance cost, the combined state and veteran portion amounted to 67.5 per cent for domiciliary care, and 71.9 per cent for nursing home care. The survey is displayed in Table 11.[19]

The intent of P.L. 94-417 was to maintain the VA percentage of the projected total cost in FY 1977 at 32.5 per cent for domiciliary and 37 per cent for nursing care.[20]

Regulations. Title 38 USCA 641 defines standards which veterans must meet to qualify for VA per diem aid. Standards are based upon the VA's requirements for admission into their own facilities. The VA's requirements, however, are somewhat broader than the norm of the various states. Basic standards for a veteran to qualify for per diem aid are listed below:

1. Be eligible for care in a VA facility.

(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which he determines is needed to--

(1) (A) any veteran for a service-connected disability; or

(B) any veteran for a non-service-connected disability if he is unable to defray the expenses of necessary hospital care;

(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

(3) a person who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation; and

(4) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.

(b) The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to--

(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when he is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a

living and has no adequate means of support; and

(2) a veteran of any war or of service after January 31, 1955, who is in need of domiciliary care, if he is unable to defray the expenses of necessary domiciliary care.[21]

Conditional to the receipt of VA per diem aid, the state home must be officially designated as such by the Veterans' Administration. One criteria necessary to receive the designation is that a simple majority of the patients in the home be eligible veterans.[22] There is one exception to this rule which will be discussed below.

VA per diem aid is made for all veterans meeting the individual state and VA eligibility requirement in the state veterans home. There is no limit to the amount of eligible veterans who may reside in the state veterans home and receive VA per diem aid.[23]

Various states throughout the country allow the admission of nonveteran dependents of eligible veterans into the state homes. Nonveteran dependents, however, are not eligible for the VA per diem aid,[24] and must number less than 50 per cent of the total facility population.

At this juncture, cautionary notes must be presented concerning the utilization of nursing home construction aid pursuant to Title 38 USCA 5031 et seq. Title 38 USCA 5031 et seq., it is noted, provides federal grants for the construction of state veterans nursing homes. Regulations limit the VA federal participation to the construction of a maximum two and one-half beds per thousand war veteran residents of the state. The state at its option may construct a facility accommodating more than the maximum number of beds designated by regulation. The VA, however, will not share the construction cost of the extra beds. This restriction relates only to state veterans nursing home construction and has no bearing on, nor in any way limits, VA per diem payments to state veteran home patients.[25]

The second cautionary factor concerning Title 38 USCA 5031 et seq. is the exception to the rule that a simple majority of residents in the home be veterans. Any state utilizing this type of aid must have a patient population of at least 90 per cent veterans.[26]

Definitions and standards of the different categories of accommodations are set by statute and VA regulations. These standards must be met to qualify for federal per diem aid. Basically:

a. "Hospital care" means providing diagnosis and treatment for inpatients with medical, surgical or psychiatric conditions who generally require the services of a physician on a daily basis with attendant diagnostic, therapeutic and rehabilitative services. A hospital facility providing such care will be operated by or under the direct supervision of a physician.

The hospital must be accredited by the Joint State Commission on Accreditation of Hospitals, or, certified as a "hospital" for participation under Medicare programs, or, licensed or approved by state or local laws if required. Nursing services must be supervised by a regisstered nurse and employ qualified personnel to care for the patients. Facilities such as pharmacies, x-ray, and clinical laboratory must be available on the premises or nearby.[27]

a. "Nursing home care" means the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care or domiciliary care but who require skilled nursing care and related medical services.

A licensed physician's service must be at the disposal of the home for the adequate care of each patient, administrative matters, and clinical work. The nursing service must be directly supervised by a registered nurse and provide for skilled 24-hour service. Pharmaceutical, x-ray, and other diagnostic services, if not part of the facility, must be readily available nearby.[28]

a. "Domiciliary care" means providing shelter, sustenance, and [incidental] medical care on an ambulatory self-care basis to assist eligible veterans who are disabled by age or disease, but not in need of hospitalization or nursing care services, to attain physical, mental, and social well-being through special rehabilitative programs.

Adequate safety, sanitary, and dietary requirements must be met. Therapeutic recreational activities should also be provided.[29]

Computation of Per Diem Cost. Per diem rates are computed separately for each category of accommodation. The per diem rates are the sum of the basic per diem rate for indirect care and the per diem rate for direct care.

The basic per diem rate for indirect care is the sum of the necessary operating cost of the home divided by the

total number of days of care for all patients in the home. This rate does not vary with the number of patients or category of accommodation.

> *Examples of such costs would be management and administration, maintenance and repair, allowable equipment replacement or depreciation, kitchen help, those professional costs which do not carry with the patients load, etc....*[30]

The per diem rate for direct care is the total of all costs directly attributable to the category of accommodation divided by the total number of days each patient spent in the respective category of accommodation. Examples "...would include such items as salaries of employees providing direct care..." to each group, "...extra expenses incurred in rations and feeding; drugs, medications and supplies..." particular to each category.[31]

Application. The following are the procedures for obtaining recognition of being a state veterans facility. These conditions must be met before application for federal per diem aid.

> *6165 (Sec. 17.165). RECOGNITION OF A STATE HOME. A State-operated facility which provides hospital, domiciliary or nursing home care to veterans of any war must be formally recognized by the Administrator as a State home before Federal aid payments can be made for the care of such veterans. Any agency of a State (exclusive of a territory or possession) responsible for the maintenance or administration of a State home may apply for recognition by the VA for the purpose of receiving aid for the care of war veterans in such State home. A State home may be recognized if:*
>
> *(A) The State home is a facility which exists primarily for the accommodation of veterans incapable of earning a living and who are in need of domiciliary or nursing home care, and (Dec. 30, 1969)*
>
> *(B) The majority of such veterans who are nursing home care patients or domiciliary members in the home are veterans who may be included in the computation of the amount of aid payable from the VA, and (Dec. 30, 1969)*
>
> *(C) The personnel, building and other facilities and improvements at the home are devoted primarily to the care of veterans of a war, and (Dec. 30, 1969)*

(D) In the case of recognition of State homes having nursing home care facilities the requirements of VA Regulation 6166.1(C) are met. (Dec. 30, 1969)[32]

In the fiscal year 1974, the VA per diem payments to the states totaled $21.2 million. The amount supported an average daily census of 10,894 veterans, 5,861 of whom were in domiciliary care, 4,005 in nursing care, and 1,028 in hospital care.[33]

The projected costs of the program for fiscal year 1976 are estimated at $25,170,000. This amount will support 5,230 veterans in domiciliary care, 5,030 in nursing care, and 900 in hospital care.[34]

TITLE 38 USCA 644

Title 38 USCA 644 appropriates $5 million yearly until fiscal year 1979 for the purpose of "...remodeling, modification, or alteration of existing hospital or domiciliary facilities in state homes providing care and treatment for veterans...." The project must be approved by the Veterans' Administration prior to a grant. The amount granted cannot exceed 65 per cent of the estimated cost of the project. Nor can the amount to an individual state exceed 20 per cent of the annual appropriation for each fiscal year. States utilizing aid under this section must operate the home for the following seven years.[35] Applications for aid are considered on a first come, first served basis.

Legislative History. Title 38 USCA 644 was enacted pursuant to Public Law 91-178. Public Law 93-82 amended the original section by raising the maximum federal participation from 50 to 65 per cent. The statute was meant:

As a companion to the present authorization of appropriations for the construction of state veterans nursing home facilities, section 2 of the bill would authorize a $5 million appropriation on a matching fund basis for 10 years to assist the States in remodeling and modifying or altering existing hospital and domiciliary facilities at state homes.[36]

The language of the statute specifically mentions domiciliary and hospital facilities. Nursing home facilities are excluded from receiving any aid under this section.[37]

The following VA regulations define the cost which would qualify for federal participation:

Sec. 17.180 Definitions.

(a) The phrase "remodeling, modification or alteration of existing hospital or domiciliary facilities in State homes" will be referred to in Secs. 17.180 through 17.184 as "construction". The term includes work performed over and above that required for maintenance and repair. It does not include expansion of existing buildings or construction of new buildings. Equipment included will be that fixed equipment which is initially furnished and installed as part of a construction contract. Fixed equipment includes, generally, building service equipment and fixed operating equipment.

(1) The term "building service equipment" includes equipment and fixtures which are permanently installed in or attached to buildings and structures and become a part of real property for the purpose of rendering the buildings or structure usable or habitable, and includes entire utility systems or segments thereof, i.e., electrical, plumbing and heating systems, elevators, etc.

(2) The term "fixed operating equipment" includes operating machinery and processing equipment which is semipermanently installed in or attached to buildings and structures for operational use such as washing machines, ranges, steam and laboratory tables, etc., removal of which does not render the structure unusable or uninhabitable but may involve consequential defacement and repair. Generally, special provisions are necessary to closely integrate design, construction, and the procurement and installation of equipment.

(b) The term "cost of construction" means the amount found by the Administrator to be necessary for a project of construction of State home hospital and domiciliary facilities including, but not limited to, architectural, engineering, supervision and site inspection services, and printing and advertising costs.[38]

Most importantly, the grant is not applicable for the "...expansion of existing buildings or construction of new

buildings". Maintenance and repair costs also are excluded. Equipment cost, however, is included.

As stated previously, nursing home facilities are not included under this section. If the facility is a combination domiciliary/nursing home, only the domiciliary section would qualify for federal aid.[39]

Unencumbered funds lapse after three years.[40]

The application process and contents for a grant under this section are detailed:

Sec. 17.182 Project applications.

(a) A State or such agency representing the State desiring to receive assistance for construction of existing facilities must submit a formal application to the Administrator. The applicant will submit as part of the application, or as an attachment thereto:

(1) Current as-built site plan, floor plan, and building sections and a description of the present use of the facility to be altered;

(2) Medical program including staffing criteria for operation of proposed facility;

(3) Preliminary drawings to scale and outline specifications;

(4) Narrative description of construction program; and

(5) Preliminary cost estimates.

(b) The applicant must furnish reasonable assurance in writing that:

(1) Upon completion of such project, the facilities will be used to furnish hospital or domiciliary care principally to war veterans for a period of 7 years;

(2) Title to such site is or will be vested solely in the State home, or another agency or instrumentality of the State;

(3) Adequate financial support will be available for the completion of the project and for its maintenance and operation when complete;

(4) The State will make such reports in such form and containing such information as the Administrator may from time to time reasonably require, and give the Administrator, upon demand, access to the records upon which such information is based;

(5) The rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with sections 276a through 276a-5 of title 40, United States Code (known as the Davis-Bacon Act);

(6) Contractors engaged in the construction of the project will be required to comply with the provisions of Executive Order 11246 of September 24, 1965 (30 F.R. 12319), and such rules, regulations or orders as the Secretary of Labor may issue or adopt in implementation thereof; and

(7) The project conforms to the applicable requirements for the implementation, maintenance, and enforcement of ambient air quality standards adopted pursuant to section 103(c) of the Clean Air Act, as amended (42 U.S.C. 1857d); that it conforms to the applicable requirements for water pollution control adopted pursuant to section 10(c) of the Federal Water Pollution Control Act, as amended (33 U.S.C. 466g); and that the project will comply with the standards provided under the National Environmental Policy Act of 1969, Public Law 91-190 (83 Stat. 852), and Executive Order 11514 (35 F.R. 4247), issued pursuant thereto; and

(8) The proposal has been favorably reviewed by the appropriate State or local clearing house pursuant to policies outlined in Part I, Office of Management and Budget Circular A-95 (revised).[41]

Since the enactment of the legislation, the VA has participated in 60 projects. Total estimated cost of the projects amounted to $11,397,545.[42] Of the amount, the VA is obligated for $6,953,571. The VA estimates that between fiscal year 1976 to 1980, 51 projects will be undertaken at a cost of $21.9 million.[43]

TITLE 38 USCA 5031-5037

Part IV, chapter 81, subchapter III of Title 38 of the *United States Code Annotated* encompasses section 38 USCA 5031 to 5037. Entitled "State Nursing Facilities for Furnishing Nursing Home Care", "the purpose of the subchapter is to assist the several states to construct state home facilities for furnishing nursing home care to war veterans...."

The subchapter authorizes a yearly appropriation of $5 million until fiscal year 1979 for the implementation of the program. The number of beds in each project cannot exceed two and one-half beds per thousand war veteran residents in the State. This is the maximum number of nursing care beds the VA will provide construction aid for. The states may construct above the maximum, but the VA will not provide aid for the unauthorized beds.[44] Currently, VA regulations stipulate that Hawaii's war veteran population is 81,000; therefore, 202 nursing beds is the maximum number of nursing beds which would be eligible for aid under this subchapter.[45] Grants also cannot exceed 65 per cent of the total estimated cost of the structure. In addition, 90 per cent of the patients of the nursing home must be eligible veterans. Applications for aid are considered on a first come, first served basis.

Legislative History. Public Law 88-450 first authorized the state veterans nursing home construction aid. The aid was part of an overall program to increase the number of nursing facilities available to veterans.

> *Section 4. Grants to States for veterans' nursing home facilities*
>
> *By this section a program of matching grants would be established to enable the States to construct State home facilities for furnishing nursing home care to war veterans. An aggregate appropriation of $25 million over a period of 5 years, at the rate of $5 million per year beginning with fiscal year 1964, would be authorized. Any State would be subject to the limitation that not more than 10 percent of the appropriation for a fiscal year shall be used for such State and the number of nursing home beds for war veterans could not exceed one-half bed per thousand veteran population in the State. General standards of construction, repairs, modernization, alteration, and equipment would be prescribed by the Administrator. The amount of the Federal grant could not exceed 50 percent of the estimated cost of construction of a project.*

This grant-in-aid program would correlate with the proposed per diem payments under section 3 for maintenance of veteran nursing home patients in State homes. It would undoubtedly assist those States having resources to share the financial requirements in expanding their State home programs to include nursing home forms of care.[46]

Subsequent amendments have deleted the 10 per cent limitation on access to the total annual amount, extended the period of availability from five to ten years, and raised the number of beds from one-half to two and one-half beds per thousand war veterans.[47]

Regulations. The subchapter applies only to state nursing home facilities. Unlike Title 38 USCA 644 which does not provide for the construction of new hospital or domiciliary facilities, this section allows both "...the construction of new buildings, the expansion, remodeling, modification, or alteration of existing buildings, and the providing of initial equipment for any such building". The grant, however, does not include the cost for the acquisition of land or the purchase of a building.

State nursing facilities constructed with funds provided by this subchapter must remain entirely under the supervision and administration of the state.

However,

If, within twenty years after completion of any project for construction of facilities for furnishing nursing home care with respect to which a grant has been made under this subchapter, such facilities cease to be operated by a State, a State home, or an agency or instrumentality of a State principally for furnishing nursing home care to war veterans, the United States shall be entitled to recover from the State which was the recipient of the grant under this subchapter, or from the then owner of such facilities, 65 per centum of the then value of such facilities, as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such facilities are situated.[48]

In addition to the provisions enumerated above, 90 per cent of the patients in the nursing home constructed with a grant under this section must be eligible veterans. Thus, states utilizing this type of federal aid must insure that the population of the home be at least 90 per cent veterans.

States which did not utilize aid under this subchapter may have a simple majority of veterans in the home and still be recognized as a state veterans home.[49]

VA regulations also stipulate that the maximum number of beds allowed to be constructed is two and one-half beds per thousand war veterans. This regulation in no way limits the number of nursing beds, or domiciliary beds, the state may have. Nor does it mandatorily limit the number of beds that can be constructed. States may construct beds over the amount specified, but the VA will not provide aid for the excess.[50]

The following is the project application process:

Sec. 17.173 Applications with respect to projects.

(a) A State desiring to receive assistance for construction of facilities for furnishing nursing home care must submit an application in writing for such assistance to the Administrator. The applicant will submit as part of the application or as an attachment thereto:

(1) The amount of the grant requested with respect to such project which may not exceed 65 per centum of the estimated cost of construction of such project.

(2) A description of the site for such project.

(3) Plans and specifications as required by Appendix "B" to the regulations concerning State home facilities for furnishing nursing home care.

(4) Any comments or recommendations made by appropriate State and areawide clearing houses pursuant to policies outlined in part I, OMB Circular A-95 (revised).

(b) The applicant must furnish reasonable assurance in writing that:

(1) Upon completion of such project the facilities will be used principally to furnish nursing home care to war veterans and that not more than 10 per centum of the bed occupancy at any one time consists of patients who are not receiving nursing home care as war veterans.

(2) Title to such site is or will be vested solely in the applicant, a State home, or another agency or instrumentality of the State.

(3) Adequate financial support will be available for the construction of project, and for its maintenance and operation when complete.

(4) Any comments or recommendations made by appropriate State clearing houses pursuant to policies outlined in Part I, Office of Management and Budget Circular A-95 (revised).

(5) The rates of pay for laborers and mechanics engaged in construction of the project will be not less than the prevailing local wage rates for similar work as determined in accordance with sections 276a through 276a-5 of Title 40 (known as the Davis-Bacon Act), and

(6) Contractors engaged in the construction of the project will be required to comply with the provisions of Executive Order 11246 of September 24, 1965, and rules, regulations, or orders as the Secretary of Labor may issue or adopt.

(7) The project conforms to the applicable requirements for the implementation, maintenance and enforcement of ambient air quality standards adopted pursuant to section 108(c) of the Clean Air Act, as amended (42 U.S.C. 1857d); that it conforms to the applicable requirements for water pollution prevention and control adopted pursuant to section 10(c) of the Federal Water Pollution Control Act, as amended (33 U.S.C. 1251); that the project will comply with the standards provided under the National Environmental Policy Act of 1969, Pub. L. 91-190, and Executive Orders issued pursuant thereto; that it will comply with Pub. L. 90-480, as amended (42 U.S.C. 4151), which provides that certain buildings financed with Federal funds are so designed and constructed as to be accessible to the physically handicapped, and that, when applicable, the requirements of section 102(a) of the Flood Disaster Protection Act of 1973, Pub. L. 93-234 (42 U.S.C. 4012a) have been met.[51]

From 1964 to 1973, the VA has participated in the construction of 31 nursing home projects involving 4,087

beds.[52] Three more projects involving 570 beds were approved in fiscal year 1974. The VA estimates that 18 more projects involving 2,110 beds will be undertaken from fiscal years 1976 to 1980.[53]

CHAPTER 5

STATE HOMES IN THE NATION

Thirty-one states and the District of Columbia operate state veterans homes. Of these, there are a total of 38 domiciliaries, 31 nursing homes, and 8 hospitals. In fiscal year 1974, care was provided for 12,062 veterans in domiciliary care, 7,832 veterans in nursing care, and 6,967 veterans in hospital care.[1] In addition, Colorado has constructed a second state veterans home which began operations in January of 1976.

Twenty-five of the 39 state veterans homes were established prior to 1900. Two homes were established in 1903 and 1910, respectively. Nine homes were also established after 1949. The establishment date could not be ascertained for three homes.

During the summer of 1976, the Bureau undertook a survey of the veterans homes in the nation. Of the 38 homes surveyed, 27 responded, a 71 per cent return. In addition, the Bureau examined the statutes governing the admission criteria of the various state homes to supplement the survey material.

ADMISSION CRITERIA--VETERANS

There are five general criteria for the admission of veterans into a state veterans home. The first is that the veteran had served during a period of war or hostility. Secondly, the veteran must have been discharged under other than dishonorable conditions. Thirdly, the veteran must be destitute and unable to support himself because of age or disability. Fourthly, the veteran must have a service-connected disability or a non-service-connected disability. Fifthly, there is a state residency requirement.

Not coincidentally, these criteria are stricter than those for admission into a VA nursing home or domiciliary. In the previous discussion on VA per diem aid, it was stated that the VA admission criteria constituted the eligibility standards for veterans to participate in VA per diem aid. Veterans within the five general criteria would qualify for VA per diem aid. Thus, it is safe to say that the admission criteria of most state veterans homes are designed to take advantage of the VA per diem aid.

It should be noted that veterans need not be war veterans to qualify for VA per diem aid, though most states retain the requirement for admission.

The state residency requirement is entirely the prerogative of the individual state. This requirement takes three general forms. The first is a cumulative requirement; the veteran must have lived in the state for a specified period during his lifetime. Secondly, the veteran must have a specified period of uninterrupted residency prior to his application for admission into the state veterans home. Thirdly, the veteran is eligible if he was inducted while a resident of the state. Some states have combinations of the forms as the residency requirement.

Other criteria which some states have are that the veteran suffer no chronic illness, have no alcohol or mental problem, and be limited financially.

Two state veterans homes serve special needs of veterans. The District of Columbia's home admits only veterans with alcohol problems. South Carolina's home admits only mentally ill veterans.

ADMISSION--DEPENDENTS

Eighteen state veterans homes allow the admission of dependents of the veteran. All 18 allow both the wife and widow to be admitted. Additionally, four homes allow the admission of dependent fathers of veterans and ten homes allow the admission of dependent mothers. One state home allows the admission of children under 16.

PATIENT POPULATION

The total patient population of all responding homes was 5,766. The following is a breakdown by war of this total:

Table 1

PATIENT POPULATION

War	Number	Per Cent
Spanish-American	46	2%
Mexican	3	below 1%
World War I	2,266	39%
World War II	3,111	54%
Korea	263	5%
Vietnam	77	1%

Source: Legislative Reference Bureau survey, 1976.

The average ages of the World War II veteran population, as indicated by the returns, in the various state homes ranged from 50 to 65.

AVERAGE AGE

The average ages of the veterans in the various state homes ranged from approximately 45 in the District of Columbia's Veterans Home to 80 in the Kansas Soldier's Home. Three states indicated that the average age of veterans in their homes was between 54 and 59. Eight states indicated that the average ages of veterans in their homes were between 62 and 68. Thirteen states indicated that the average ages of veterans in their homes were between 70 and 77. One state did not have this information.

The median of the average ages of the veterans in the respondent's state veterans homes was 70.

NUMBER OF BEDS

Of the responses received, 26 domiciliaries had a capacity of 5,811 beds. The mean and median are 224 and 169 beds, respectively. They range from 24 to 754 beds.

Twenty-one nursing homes had a capacity of 4,215 beds. The mean and median are 201 and 156 beds, respectively. The range is from 41 to 537 beds.

The combined number of domiciliary and nursing beds amounted to 10,026. This total is .10 per cent of the veteran population of the states as determined by the VA.

COST DISTRIBUTION[2]

According to a state home survey conducted by the VA in July of 1975, the average daily cost distribution for all the state veterans homes in the country, except for Vermont, was:

Table 2

COST DISTRIBUTION

Total (average daily cost)	Per Diem	State	Federal	Patient
Domiciliary	$13.73	50.0%	32.5%	17.5% ($2.52)
Nursing Home	$23.42	50.4%	29.1%	20.5% ($4.68)

Source: *U.S., Congress, House, Subcommittee on Hospitals of the Committee of Veterans' Affairs, 94th Congress, 1st Sess., 1975, Doc. 59-876.*

The nonfederal share of the average daily cost amounted to 67.5 per cent for domiciliaries and 70.9 per cent for nursing homes.

The average daily cost for domiciliary care ranged from $7.60 to $22.63. The average per diem cost for nursing homes ranged from $13.51 to $40.50.

Also important is the amount of patient contributions. Only ten states do not charge the patient any cost. Most of the states that do charge determine the assessment upon the patient's ability to pay. As the VA's data show, on the average, patients in domiciliaries contributed $2.52, or 17.5 per cent of the daily cost; and patients in nursing homes contributed $4.68, or 20.5 per cent of their average daily cost.

Table 3

PERCENTAGE OF BEDS TO VETERAN POPULATION

State	Domiciliary	Nursing	Total	Veteran Pop. (1,000)	Per Cent
Colorado	130	-	130	351	.04
Connecticut	754	350	1,104	461	.24
District of Columbia	340	-	340	105	.32
Georgia (Augusta)	-	192	192	618	.13
Georgia (Midgeville)	450	132	582	-	-
Idaho	126	-	126	100	.13
Illinois	401	508	909	1,559	.06
Indiana	162	240	402	721	.06
Iowa	217	80	297	372	.08
Kansas	337	88	425	309	.14
Louisiana	128	-	128	447	.03
Massachusetts (Chelsea)	266	59	325	868	.07
Massachusetts (Holyoke)	104	198	302	-	-
Michigan	255	537	792	1,190	.07
Missouri	142	154	296	693	.04
Nebraska	220	414	634	197	.32
New Hampshire	-	62	62	123	.05
New York	118	68	186	2,519	.01
North Dakota	135	-	135	64	.21
Ohio	566	-	566	1,498	.04
Oklahoma (Ardmore)	176	80	256	392	-
Oklahoma (Clinton)	47	156	203	-	-
Pennsylvania	100	75	175	1,756	.01
Rhode Island	128	175	303	151	.20
South Carolina	-	200	200	322	.06
South Dakota	256	41	297	79	.38
Vermont	24	135	159	63	.25
Wisconsin	182	503	685	577	.12
Wyoming	77	-	77	48	.16

Source: Legislative Reference Bureau survey, 1976.

Table 4

NUMBER OF BEDS

4. What category of accommodations are in operation in your state veterans home? How many beds are designated for each category of accommodation?

Category	No. of Beds
Domiciliary	
Nursing Home	
Hospital	
Other (please specify) _____	

	Domiciliary	Nursing	Hospital
CALIFORNIA	No response		
COLORADO	130	--	--
CONNECTICUT	754	--	350
DISTRICT OF COLUMBIA	340	--	--
GEORGIA (Augusta)	--	192	--
GEORGIA (Milledgeville)	450	132	--
IDAHO	126	a	--
ILLINOIS	401	508	50
INDIANA	162	240	--
IOWA	217	80	198
KANSAS	337	88	b
LOUISIANA	128	--	--
MASSACHUSETTS (Chelsea)	266	59	194[c]
MASSACHUSETTS (Holyoke)	104	198	34
MICHIGAN	225	537	--
MINNESOTA	No response		
MISSOURI	142	154	--
MONTANA	No response		
NEBRASKA	220	414	--
NEW HAMPSHIRE	--	62	--
NEW JERSEY (Menlo Park)	No response		
NEW JERSEY (Vineland)	No response		
NEW YORK	118	68	--
NORTH DAKOTA	135	--	--
OHIO	566	--	250
OKLAHOMA (Ardmore)	176	80	--
OKLAHOMA (Clinton)	47	156	--
OKLAHOMA (Norman)	No response		
OKLAHOMA (Sulphur)	No response		
PENNSYLVANIA	100	75	--
RHODE ISLAND	128	175	--
SOUTH CAROLINA	--	200	--
SOUTH DAKOTA	256	41	28
VERMONT	24	135	--
WASHINGTON (Orting)	No response		
WASHINGTON (Retsil)	No response		
WISCONSIN	182	503	39
WYOMING	77	--	--

Source: Legislative Reference Bureau survey, 1976.

a. Plan to add 80 beds and a 10-bed female dormitory.

b. 80 cottages.

c. Including out-patient facility.

Table 5

VETERAN ELIGIBILITY STANDARDS

10. What are the eligibility requirements of a veteran for admission into your state veterans home? (Check all applicable)

a. Veteran of specific war or hostility ___
b. Honorable discharge ___
c. Other than dishonorable discharge ___
d. No requirement on type of discharge ___
e. Destitution, unable to support himself because of age or disability ___
f. Service-connected disability ___
g. Non-service-connected disability ___
h. State residency requirement (if so, what is the requirement) ___
i. Age requirement (if so, what age) ___
j. No conviction of a crime of moral turpitude or of a felony ___ ___
k. No chronic illness (includes alcoholism, drug addiction) ___ ___
l. Chronic illness of a certain type ___
m. Financial limitations (if so, what is the limitation) ___ ___
n. Others (please specify) _____ ___

	a	b	c	d	e	f	g	h	i	j	k	l	m	n
CALIFORNIA	x	x			x	x	x	x 5 years						
COLORADO	x		x		x			x 5 of 9 years prior		x	x	x		
CONNECTICUT	x	x			x	x	x	x 2 years					x	
DISTRICT OF COLUMBIA														x[a]
GEORGIA (Augusta)	x		x			x	x	x 1 year				x		
GEORGIA (Milledgeville)	x		x			x	x	x 1 year						
IDAHO	x	x						x 2 years						x[b]
ILLINOIS	x	x				x	x	x 5 years						
INDIANA	x	x			x[c]	x[c]	x[c]	x 5 years			d		x[c]	
IOWA		x			x	x	x	x 90 days						
KANSAS	x		x		x			x 2 years prior		x	x			x[e]
LOUISIANA														x[f]
MASSACHUSETTS (Chelsea)	x	x				x		x 5 years prior					x	
MASSACHUSETTS (Holyoke)	x		x				x	x 5 years prior			x			
MICHIGAN	x	x			x			x Proof of residency						
MINNESOTA	x		x					x						
MISSOURI	x	x			x			x 30 days			x			
MONTANA		x			x			x 2 years		x	x			
NEBRASKA	x	x			x	x	x	x 2 years	x				x[g]	x[h]
NEW HAMPSHIRE	x	x						x 3 years prior					x[i]	
NEW JERSEY (Menlo Park)		x			x			x 2 years prior						
NEW JERSEY (Vineland)		x			x			x 2 years prior						
NEW YORK	x	x						x 1 year or at entry[j]						x[k]
NORTH DAKOTA	x	x			x			x 3 years prior					x[l]	x[m]
OHIO	x	x			x	x	x	x 5 years prior						
OKLAHOMA (Ardmore)	x		x		x			x 3 years prior			x			x[n]
OKLAHOMA (Clinton)	x		x					x 3 years prior						
OKLAHOMA (Norman)	x		x		x			x 3 years prior			x			x[o]
OKLAHOMA (Sulphur)	x		x		x			x 3 years prior			x			x[o]
PENNSYLVANIA	x	x			x		x	x 1 year prior		x	x			
RHODE ISLAND	x	x						x 5 years prior/entry			x			
SOUTH CAROLINA	x		x					x 1 year						x[q]
SOUTH DAKOTA	x	x			x			x 1 year prior			x		x[p]	x[q]
VERMONT	x	x				x		x 3 years prior					x	
WASHINGTON (Orting)	x	x			x			x 3 years prior					x[r]	x[s]
WASHINGTON (Retsil)	x	x			x			x 3 years prior						
WISCONSIN	x	x			x	x[t]		x 10 years prior	x[u]	x	x		x[v]	x[w]
WYOMING		x			x			x 5 years		x				

Source: Legislative Reference Bureau survey, 1976 and statutes of non-response states.

a. Veterans with alcohol problems and some connection with District of Columbia.

b. (1) Voted in at least one general election in the State.
(2) Residency and voting requirement waived if the veteran was a state resident at his entry into the service.
(3) Member of the State National Guard who was disabled in the line of duty.

c. Veteran must be "disabled" or "destitute".

d. Only "cured" individuals eligible.

e. Resident at time of entry into service.

f. *Veteran must first be a patient at the East Louisiana State Hospital and entitled to medical care at VA expense.*

g. *Based on assets.*

h. *Dependent on public charity and/or type of care unavailable at other state institutions.*

i. *$1,500 limit in property or savings.*

j. *Veteran who enlisted or was discharged in New York need not be a resident.*

k. *Not in need of hospital care.*

l. *$359 monthly income; $10,000 net worth.*

m. *North Dakota National Guardsmen who are disabled.*

n. *Male, ambulatory.*

o. *Mentally ill.*

p. *$4,000 cash assets.*

q. *$3,700 annual income; couple - $4,900 annual income, $6,500 cash assets limitation.*

r. *Less than $140 monthly income; less than $1,000 in personal property.*

s. *All veterans eligible to enter veterans homes in their resident states.*

t. *Permanent disability.*

u. *50 years or older.*

v. *Same as Medicaid.*

w. *State resident at entry into service.*

Table 6

ELIGIBLE NON-VETERANS

11. Are other persons, related by blood or marriage to the veteran, eligible for admission into your state veterans home? Yes ___ No ___

12. If non-veterans are eligible for admission into your state veterans home, please fill in the following where applicable:

Eligible Non-Veterans (check all applicable)

a. Wife ___
b. Widow ___
c. Father ___
d. Mother ___
e. Others (please specify) _____

	Others Eligible	Wife	Widow	Father	Mother	Others
CALIFORNIA	No					
COLORADO	Yes	x	x		x	
CONNECTICUT	No					
DISTRICT OF COLUMBIA	No					
GEORGIA (Augusta)	No					
GEORGIA (Milledgeville)	No					
IDAHO	No					
ILLINOIS	Yes	x	x			x Husband
INDIANA	Yes	x	x			
IOWA	Yes	x	x			
KANSAS	Yes	x	x	x	x	x Child under 16
LOUISIANA	No					
MASSACHUSETTS (Chelsea)	No					
MASSACHUSETTS (Holyoke)	No					
MICHIGAN	Yes	x	x		x	
MINNESOTA	Yes	x	x	x	x	
MISSOURI	Yes	x	x		x	
MONTANA	Yes	x	x			
NEBRASKA	Yes	x	x	x	x	
NEW HAMPSHIRE	No					
NEW JERSEY (Menlo Park)	Yes	x	x		x	
NEW JERSEY (Vineland)	Yes	x	x		x	
NEW YORK	Yes	x	x		x	
NORTH DAKOTA	Yes	x	x			
OHIO	No					
OKLAHOMA (Ardmore)	No					
OKLAHOMA (Clinton)	No					
OKLAHOMA (Norman)	No					
OKLAHOMA (Sulphur)	No					
PENNSYLVANIA	No					
RHODE ISLAND	No					
SOUTH CAROLINA	No					
SOUTH DAKOTA	Yes	x	x			
VERMONT	No					
WASHINGTON (Orting)	Yes	x	x			
WASHINGTON (Retsil)	No					
WISCONSIN	Yes	x	a	a	a	a
WYOMING	Yes	x	x			b

Source: Legislative Reference Bureau survey, 1976, and statutes of non-response states.

a. Only if membership declines below 92% of available beds.

b. "The State Board of Charities and Reform shall have the power to admit persons who are not veterans or dependents of veterans for care and treatment at the Soldiers' and Sailors' Home any time the Home is not filled to 90% of capacity and no veteran or veteran's dependents applications are pending."

Table 7

NON-VETERANS ELIGIBILITY STANDARDS

12. If non-veterans are eligible for admission into your state veterans home, please fill in the following where applicable:

Eligibility Standards (check all applicable)

a. Husband/son is a patient in the home ___
b. Husband/son is eligible for admission into the home ___
c. Husband/son is a deceased, formerly eligible veteran ___
d. Marriage requirement (if so, for how long must they have been married) ___ _____
e. No remarriage ___
f. Age limitation (if so, what age) ___ _____
g. Financial limitation (if so, what is the limit) ___ _____
h. State residency requirement (if so, what is the requirement) ___ _____
i. Others (please specify) _____

	a	b	c	d	e	f	g	h	i
ILLINOIS	x	x	x	x 5 years				x 1 year	x[a]
INDIANA		x	x	x 5 years	x[b]			x 5 years	
IOWA				x 1 year	x			x 90 days	
KANSAS								x 2 years	x[c]
MICHIGAN						x[d]			
MINNESOTA						x[e]			x[f]
MISSOURI	x	x	x		x			x 30 days	
MONTANA		x	x			x[g]			
NEBRASKA	x	x	x	x 2 years		x[g]	x[h]	x 2 years	x[i]
NEW JERSEY (Menlo Park)	x		x	x 10 years		x[j]		x 2 years prior	
NEW JERSEY (Vineland)	x		x	x 10 years		x[j]		x 2 years prior	
NEW YORK				x 10 years				x 1 year	
NORTH DAKOTA				x 5 years		x[k]	x[l]	x 3 years	
SOUTH DAKOTA				x 1 year prior		x[m]	x[n]	x 1 year prior	
WASHINGTON (Orting)				x 3 years prior	x[o]	x[g]			
WISCONSIN	x	x	x		x	x[p]	x	x 5 years	
WYOMING				x 5 years				x 5 years prior	

Source: *Legislative Reference Bureau survey, 1976.*

a. *Cannot support herself.*

b. *No remarriage except to veteran.*

c. *Incapable of self-support.*

d. *60 years of age.*

e. *55 years of age.*

f. *No adequate means of support; veteran must be disabled.*

g. *50 years of age.*

h. *Based on assets.*

i. *Parents are also eligible if their son or daughter was killed in action.*

j. *For wife - 50 years of age.*

k. *45 years of age or older.*

l. *$350 monthly income; $10,000 net worth.*

m. *None for wife; 60 years of age for widow.*

n. *1 year prior to application.*

o. *No remarriage except to another member of the Colony.*

p. *Widow - 45 years of age; mother - 60 years of age.*

Table 8

NUMBER OF VETERAN-PATIENTS

13. What was the total number of veteran-patients, excluding wives, widows, etc., who were patients in the state veterans home in the fiscal year 1973-74? _____

During the fiscal year 1973-74, what was the average daily census of veteran-patients (total number of days each patient spent in the institution divided by 365 days) for each category of accommodation?

Category	Total Veteran-Patients	Average Daily Census
Domiciliary	_____	_____
Nursing Home	_____	_____
Hospital	_____	_____

	No. of Veterans	Domiciliary No.	Domiciliary Avg.	Nursing Home No.	Nursing Home Avg.	Hospital No.	Hospital Avg.
CALIFORNIA	No response						
COLORADO	109	99	96.9	10	9.2	-	-
CONNECTICUT	1,593[a]	-	576	-	347	-	-
DISTRICT OF COLUMBIA	-	1,429	249	-	-	-	-
GEORGIA (Augusta)	267	-	-	267	168	-	-
GEORGIA (Milledgeville)	2,172	1,973	562	199	67	-	-
IDAHO	-	-	113	-	-	-	-
ILLINOIS	-	149	148	353	354	-	-
INDIANA	-	-	86	-	134	-	-
IOWA	129,659[a]	53,023[a]	145	25,147[a]	69	51,489[a]	141
KANSAS	144	68	63	80	49.4	-	-
LOUISIANA	-	-	118	-	-	-	-
MASSACHUSETTS (Chelsea)	210[b]	-	252	-	54	-	120
MASSACHUSETTS (Holyoke)	686	43	69	101	174	542	20
MICHIGAN	647[c]	222	212	431	422	-	-
MINNESOTA	No response						
MISSOURI	187	77	56	110	55	-	-
MONTANA	-	-	-	-	-	-	-
NEBRASKA	629[d]	126	122	350	327	-	-
NEW HAMPSHIRE	68	-	20	-	45	-	-
NEW JERSEY (Menlo Park)	No response						
NEW JERSEY (Vineland)	No response						
NEW YORK	-	9,840[a]	26.9	5,320[a]	14.5	-	-
NORTH DAKOTA	126	126	98	-	-	-	-
OHIO	763	-	674	-	-	-	-
OKLAHOMA (Ardmore)	-	-	113	-	76	-	-
OKLAHOMA (Clinton)	146[e]	28	28	118	118	-	-
OKLAHOMA (Norman)	No response						
OKLAHOMA (Sulphur)	No response						
PENNSYLVANIA	-	-	98	-	59	-	-
RHODE ISLAND	379	40,252[a]	110	59,424[a]	163	-	-
SOUTH CAROLINA	213	-	-	213	128	-	-
SOUTH DAKOTA	137	102	85	35	28	-	-
VERMONT	-	-	21	-	77	-	-
WASHINGTON (Orting)	No response						
WASHINGTON (Retsil)	No response						
WISCONSIN	583	-	61	-	379	-	5
WYOMING	16,700[a]	16,700[a]	46	-	-	-	-

Source: Legislative Reference Bureau survey, 1976.

a. Patient-days.

b. Dormitory admissions.

c. On June 30, 1974.

d. 85 per cent.

e. Average.

Table 9

NUMBER OF NON-VETERAN-PATIENTS

14. If non-veterans are admitted into your state veterans home, what was the total number of these non-veterans and the average daily census for fiscal year 1973-74?

Category	Non-Veteran Patients	Average Daily Census
Domiciliary		
Nursing Home		
Hospital		

	Domiciliary		Nursing Home		Hospital	
	No.	Avg.	No.	Avg.	No.	Avg.
COLORADO	34	32.6	10	9.7	-	-
DISTRICT OF COLUMBIA	180	31	-	-	-	-
ILLINOIS	83	83	86	86	-	-
IOWA	40	-	8	-	39	-
KANSAS	249	249	-	-	-	-
MICHIGAN	6	4	22	21	-	-
MISSOURI	64	49	68	47	-	-
NEBRASKA	26	26	74	74	-	-
NEW YORK	28,703[a]	78.6	16,596[a]	45.5	-	-
NORTH DAKOTA	2	1.1	-	-	-	-
SOUTH CAROLINA	-	-	10	10	-	-
SOUTH DAKOTA	74	72	14	14	-	-
WYOMING	3,777[a]	10	-	-	-	-

Source: Legislative Reference Bureau survey, 1976.

a. *Patient-days.*

Table 10

NUMBER OF VETERAN-PATIENTS BY WAR

18. What was the distribution of the patient population in the state veterans home by period of war or hostility during fiscal year 1973-74?

Note: The periods of war or hostilities are established by Congress. For veterans who served in two wars, please consider them to be in the category of the first war served in. In this manner, we hope to avoid double counting.

What was the average age of the veterans in each category?

	No.	Average Age
Spanish-American War (Apr. 21, 1898-July 15, 1903)		
Mexican Border Period (May 9, 1916-Apr. 5, 1917)		
World War I (Apr. 6, 1917-Apr. 1, 1920)		
World War II (Dec. 7, 1941-Dec. 31, 1946)		
Korean Conflict (June 27, 1950-Jan. 31, 1955)		
Vietnam Era (Aug. 5, 1964-May 7, 1975)		
Others (Please specify) _____		

	Av. Age	Spanish-American No.	Spanish-American Av. Age	Mexican No.	Mexican Av. Age	World War I No.	World War I Av. Age	World War II No.	World War II Av. Age	Korean No.	Korean Av. Age	Vietnam No.	Vietnam Av. Age	Others No.	Others Av. Age
CALIFORNIA	No response														
COLORADO	73.8	-	-	-	-	54	75.2	44[a]	58.9	1	48	-	-	-	-
CONNECTICUT	65	0	96.0	-	-	190	83.5	599	62.4	58	50.9	8	43.2	[b]	[b]
DISTRICT OF COLUMBIA	45[c]	-	-	-	-	-	-	-	-	-	-	-	-	-	-
GEORGIA (Augusta)	71	-	-	-	-	-	-	-	-	-	-	-	-	-	-
GEORGIA (Milledgeville)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
IDAHO	65-67	-	-	-	-	25	80	99	65	2	45	-	-	-	-
ILLINOIS	65	1	98	-	-	212	78	272	60	16	48	1	39	-	-
INDIANA	75	22	96	-	-	235	-	101	-	3	-	-	-	[d]	-
IOWA	72+	1	96	-	-	139	-	211	-	4	-	1	-	-	-
KANSAS	80	1	-	-	-	70	-	74	-	3	-	-	-	-	-
LOUISIANA	59	-	-	-	-	4	82	89	62	18	48	6	30	-	-
MASSACHUSETTS (Chelsea)	71.8	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MASSACHUSETTS (Holyoke)	65	0	-	1	81	161	78	408	54	61	47	55	26	1	78
MICHIGAN	70	1	-	-	-	276	-	334	-	29	-	2	-	2[f]	-
MINNESOTA	No response														
MISSOURI	76	2	95	-	-	137	81	46	64	2	43	-	-	-	-
MONTANA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NEBRASKA	72[g]	12	-	1	-	319	-	371	-	21	-	3	-	-	-
NEW HAMPSHIRE	68	1	80	-	-	40	76	26	53	1	50	-	-	-	-
NEW JERSEY (Menlo Park)	No response														
NEW JERSEY (Vineland)	No response														
NEW YORK	76.5	1	95	-	-	30	80.1	10	64.2	-	-	-	-	-	-
NORTH DAKOTA	-	-	-	-	-	43	81.5	78	62.8	5	45.6	-	-	-	-
OHIO	54.3	1	-	1	-	126	-	560	-	43	-	2	-	-	-
OKLAHOMA (Ardmore)	62	-	-	-	-	-	78	-	55	-	50	-	28	-	-
OKLAHOMA (Clinton)	62	-	-	-	-	-	-	-	-	-	-	-	-	-	-
OKLAHOMA (Norman)	No response														
OKLAHOMA (Sulphur)	No response														
PENNSYLVANIA	72	-	-	-	-	73	82	71	63	4	47	-	-	-	-
RHODE ISLAND	70	2	95	-	-	133	76	141	57	6	42	-	-	-	-
SOUTH CAROLINA	58	-	-	-	-	15	73	189	50	6	40	3	25	-	-
SOUTH DAKOTA	72	-	-	-	-	82	81	54	65	1	43	-	-	-	-
VERMONT	68	-	-	-	-	41	78	38	58	3	42	2	27	-	-
WASHINGTON (Orting)	No response														
WASHINGTON (Retsil)	No response														
WISCONSIN	74.13	1	-	-	-	281	-	188	-	-	-	-	-	470	743
WYOMING	75	1	95	-	-	54[e]	80	44[e]	62	1	41	-	-	-	-

Source: Legislative Reference Bureau survey, 1976.

a. *Present 1976-77 breakdowns: World War I - 51*
World War I/World War II - 1
World War II - 44
World War II/Korea - 5
World War II/Korea/Vietnam - 2
Korea - 2

b. *Campaigns - 6 (average age 79.1)*
Allied Armies Veterans WW I - 20 (average age 83.8)
Allied Armies Veterans WW II - -- (average age 60.5)

c. *Approximate.*

d. *Overall average age - 76*
Average age women - 78
Average age men - 75

e. *Polish Army veteran.*

f. *Cold War veterans.*

g. *For fiscal year 1975-76.*

Table 11

STATE HOME SURVEY

[Based on 3d quarter State home report (VAF 10-5588) and information received by telephone survey of State homes, July 14-23, 1975]

State	Per diem	Percent		Veteran		Census		
		State	VA	Cost	Percent	1975	1980	1985
California—Napa:								
Domiciliary care	$11.40	42.6	39.5	2.04	17.9	540.9	1,037.0	1,025.0
Nursing home care	16.03	35.3	37.4	4.38	27.3	379	475.0	575.0
Hospital care	37.38	61.7	26.6	4.37	11.7	369.4	400.0	400.0
Colorado—Home care:								
Domiciliary care	12.36	47.3	36.4	2.01	16.3	80.2	160.0	160.0
Nursing home care	32.55	44.7	18.4	12	36.9	8.5	60.0	60.0
Connecticut—Rocky Hill:								
Domiciliary care	11.10	59.5	40.5	0	.....	6,079	848.0	1,137.5
Hospital care	31.44	68.2	31.8	0	.....	306.3	426.8	562.4
District of Columbia—Occoquan: Domiciliary care	18.25	55.3	24.7	3.65	20	259	259.0	259.0
Georgia—Augusta: Nursing home care	25.32	76.3	23.7	0	.....	169.5	177.0	177.0
Georgia—Milledgeville:								
Domiciliary care	19.37	76.8	23.2	0	.....	601.2	594.0	594.0
Nursing home care	25.38	76.4	23.6	0	.....	118.9	178.0	178.0
Idaho—Boise: Domiciliary care	7.77	28.4	50.1	1.67	21.5	115.4	116.0	120.0
Illinois—Quincy:								
Domiciliary care	14.94	45.9	30.1	3.59	24	143.3	157.0	172.0
Nursing home care	21.13	41.6	28.4	6.34	30	305.5	500.0	950.0
Hospital care	36.57	42.7	27.3	10.97	30	13.5	15.0	20.0
Indiana—Lafayette:								
Domiciliary care	21.55	79.1	20.9	0	.....	88.3	165.0	200.0
Nursing home care	24.19	75.2	24.8	0	.....	133.8	485.0	600.0
Iowa—Marshalltown:								
Domiciliary care	16.96	43.8	26.5	5.03	29.7	150.6	160.0	160.0
Nursing home care	21.81	31.5	27.5	8.94	41	61.1	440.0	440.0
Hospital care	34.59	40.4	28.9	10.62	30.7	139.8	112.0	112.0
Kansas—Fort Dodge:								
Domiciliary care	7.60	40	50.0	.76	10	68.2	85.0	105.0
Nursing home care	20.91	44.3	28.7	5.65	27	55.8	75.0	80.0
Louisiana—Jackson: Domiciliary care	23.32	67.4	19.3	3.09	13.3	114.8	115.0	117.0
Massachusetts—Chelsea:								
Domiciliary care	10.43	56.9	43.1	0	.....	248.9	400.0	400.0
Nursing home care	24.19	75.1	24.8	0	.....	52.2	330.0	330.0
Hospital care	80.31	88.4	11.6	0	.....	123.12	90.0	90.0
Massachusetts—Holyoke:								
Domiciliary care	16.06	72	28.0	0	.....	72.7	50.0	50.0
Nursing home care	39.71	84.9	15.1	0	.....	180.2	222.0	222.0
Hospital care	95.42	89.5	10.5	0	.....	12.1	30.0	30.0
Michigan—Grand Rapids:								
Domiciliary care	13.71	32.2	32.8	4.80	35	212	202.5	202.5
Nursing care	31.44	47.9	19.1	10.38	33	403	483.0	483.0
Minnesota—Minneapolis:								
Domiciliary care	11.15	37.6	40.4	2.45	22	372.9	900.0	1,250.6
Nursing home care	17.84	51.4	33.6	2.68	15	70.9	500.0	750.0
Missouri—St. James:								
Domiciliary care	7.79	4.3	50.1	3.55	45.6	63.8	82.0	82.0
Nursing home care	13.51	10.2	44.4	5.32	39.4	87.6	80.0	80.0
Montana—Columbia Falls:								
Domiciliary care	10.09	2.23	44.6	5.36	53.17	77.4	178.0	200.0
Nursing home care	20.39	41.7	29.4	5.89	28.9	34.4	95.0	100.0
Nebraska—Grand Island:								
Domiciliary care	20.31	36.8	22.2	8.33	41	104.1	316.0	316.0
Nursing home care	23.27	33.2	25.8	9.54	41	[1]339	[1]614.0	[1]614.0
New Jersey—Menlo Park:								
Domiciliary care	10.66	33.8	42.2	2.56	24	107.8	120.0	120.0
Nursing home care	20.82	50.2	28.8	2.50	12	158.7	280.0	280.0
New Jersey—Vineland:								
Domiciliary care	18.44	66.7	24.4	2.58	14	62.4	100.0	100.0
Nursing home care	24.16	64.2	24.8	2.66	11	188.5	400.0	400.0
New York—Oxford:								
Domiciliary care	18.74	50	24.0	4.87	26	30.2	None	None
Nursing home care	40.50	73.2	14.8	4.66	12	11.9	None	None
North Dakota—Lisbon: Domiciliary care	8.30	50	50.0	0	.....	113.7	114.0	114.0
New Hampshire—Tilton:								
Domiciliary care	19.25	43.6	23.4	6.35	33	14.1	.....	.....
Nursing home care	23.74	41.7	25.3	7.83	33	45.5	95.0	95.0
Ohio—Sandusky (Erie County): Domiciliary care	9.43	52.3	47.7	0	.....	659	[2]800.0	[2]900.0
Oklahoma—Ardmore:								
Domiciliary care	13.37	44.9	33.7	2.66	21.4	108.1	176.0	176.0
Nursing home care	19.10	25.8	31.4	8.17	42.8	76.8	80.0	80.0
Oklahoma—Clinton:								
Domiciliary care	13.95	43.7	32.2	3.37	24.12	42.3	47.0	47.0
Nursing home care	20.80	33.4	28.8	.....	37.8	119.2	158.0	198.0
Oklahoma—Norman:								
Domiciliary care	22.37	65.1	20.1	3.31	14.8	225	160.0	160.0
Nursing home care	26.41	56.3	22.7	5.55	21	49	80.0	80.0
Oklahoma—Sulphur:								
Domiciliary care	16.61	62.4	27.1	1.74	10.5	34	40.0	40.0
Nursing home care	22.83	44.1	26.3	6.75	29.6	130	142.0	142.0
Hospital care	35.70	72	28.0	0	.....	20	[3]33.0	[3]35.0

State	Per diem	Percent		Veteran		Census		
		State	VA	Cost	Percent	1975	1980	1985
Pennsylvania—Erie:								
Domiciliary care	14.20	68.3	31.7	.....		100.7	200.0	200.0
Nursing home care	21.65	63.3	27.7	1.95	9	56.2	75.0	75.0
Rhode Island—Bristol:								
Domiciliary care	14.49	60.2	31.1	1.27	8.76	112.6	148.0	148.0
Nursing home care	23.26	66.6	25.8	1.77	7.6	171	304.0	454.0
South Carolina—Columbia: Nursing home care	25.00	28.3	23.9	12	47.6	100.1	125.0	150.0
South Dakota—Hot Springs:								
Domiciliary care	11.46	38.2	39.3	2.58	22.5	92.5	170.0	180.0
Nursing home care	23.26	61.6	25.8	2.93	12.6	25.7	40.0	40.0
Vermont—Bennington:								
Domiciliary care	13.19	[4] 61.1	34.1	[4] .63	4.8	21.2	25.0	25.0
Nursing home care	20.19	[4] 55.3	29.7	[4] 3.02	15	74.2	139.0	139.0
Washington—Orting:								
Domiciliary care	13.19	65.9	34.1	0	.....	87.7	90.0	90.0
Nursing home care	17.89	66.5	33.5	0	.....	72.1	100.0	125.0
Washington—Retsil:								
Domiciliary care	9.08	50.4	49.6	0	.....	131.8	180.0	180.0
Nursing home care	12.02	50.1	49.9	0	.....	59.9	170.0	190.0
Wisconsin—King:								
Domiciliary care	22.63	71.7	19.9	1.89	8.36	62.6	570.0	[4]
Nursing home care	23.50	55.8	25.5	4.40	18.72	380.1	520.0	[4]
Hospital care	96.57	87.7	10.4	1.85	1.92	6.6	20.0	[4]
Wyoming—Buffalo: Domiciliary care	15.46	15.2	29.1	8.61	55.7	55.6	75.0	77.0
Total (average daily cost):								
Domiciliary (36)	13.73	50	32.5	2.52	17.5	5,982.9	8,839.5	9,197.0
Nursing (31)	23.42	50.4	29.1	4.68	20.5	4,131.3	7,987.0	8,652.0
Hospital (8)	42.20	67	23.7	3.48	9.3	1,096.2	1,126.8	1,254.4

[1] 100 hospital beds planned.
[2] 300 nursing home care beds, 1980 to 1985.
[3] Tahlulna, 165 nursing home care beds, 1980 to 1985.
[4] Not included in total.
[5] Depends on construction.

Note: The total cost program for the 3d quarter, fiscal year 1975—domiciliary care, $7,393,685; nursing home care, $7,653,656; and hospital care, $3,836,371.

CHAPTER 6
VA HEALTH SERVICES

HEALTH SERVICES--SITUATION IN HAWAII

Veterans' Administration Services. The Veterans' Administration provides, among other services, health and social services to qualified and needy veterans. In fiscal year 1974, the VA in Hawaii spent $5,314,224 for "medical services and administrative costs" out of a total expenditure of $48,774,839.[1] In fiscal year 1975, the VA in Hawaii spent $6,324,540 for "medical services and administrative costs" out of a total expenditure of $64,262,214.[2] The following discussion gives a general overview of the VA's health and social services in Hawaii.

By federal statute, a veteran is eligible for "medical treatment" if:

(1) He has a service-connected disability;

(2) He has a non-service-connected disability and attests that he cannot adequately provide care for himself; or

(3) He is receiving a VA compensation or pension.[3]

The eligibility standard for admission into a VA hospital, or in Hawaii's case, to receive nursing care, is similar to those for receiving "medical treatment". The standard is as follows:

> *Sec. 610. Eligibility for hospital and domiciliary care*
>
> *(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which he determines is needed to--*
>
> *(1) (A) any veteran for a service-connected disability; or*
>
> *(B) any veteran for a non-service-connected disability if he is unable to defray the expenses of necessary hospital care;*
>
> *(2) a veteran whose discharge or release from the active military, naval, or air service*

was for a disability incurred or aggravated in line of duty;

(3) a person who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation; and

(4) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.

(b) The Administrator, within the limits of Veterans' Administration facilities, may furnish domiciliary care to--

(1) a veteran who was discharged or released from the active military, naval, or air service for a disability incurred or aggravated in line of duty, or a person who is in receipt of disability compensation, when he is suffering from a permanent disability or tuberculosis or neuropsychiatric ailment and is incapacitated from earning a living and has no adequate means of support; and

(2) a veteran of any war or of service after January 31, 1955, who is in need of domiciliary care, if he is unable to defray the expenses of necessary domiciliary care.

(c) While any veteran is receiving hospital care or nursing home care in any Veterans' Administration facility, the Administrator may, within the limits of Veterans' Administration facilities, furnish medical services to correct or treat any non-service-connected disability of such veteran, in addition to treatment incident to the disability for which he is hospitalized, if the veteran is willing, and the Administrator finds such services to be reasonably necessary to protect the health of such veteran.

(d) In no case may nursing home care be furnished in a hospital not under the direct and exclusive jurisdiction of the Administrator except as provided in section 620 of this title.[4]

It is estimated that the VA health clinic receives 30,000 visits a year. The VA offers three primary services: out-patient, mental hygiene, and a day treatment center.

Services provided in the out-patient area generally involve medical and physical problems. Of the estimated 30,000 annual visits, 20,000 are handled by the health clinic. The health clinic employs seven doctors; two of whom are psychiatrists. In addition, the staff includes three psychologists.

There are no VA-operated hospitals in Hawaii.

Veteran-patients in need of hospitalization are treated at Tripler Hospital. A per diem of $140 is paid by the VA regardless of the illness or problem of the veteran-patient. If the services required cannot be provided at Tripler, and the case is not an emergency, the patient is flown to San Francisco. Queen's Medical Center is also utilized if the required services are available there. Tripler, however, is the main treatment center for VA veteran-patients.

Veteran-patients in emergency situations and requiring immediate care may, with VA approval, receive treatment from an outside hospital. These occur predominantly on the neighbor islands. If the veteran-patient does not require immediate emergency care, he is taken to Tripler.

In June of 1976, the VA had 50 patients in the Kaneohe State Hospital, 50 patients in Tripler, and 10 in other hospitals. Ten veterans were also in nursing homes under VA auspices.

The second type of service is mental hygiene. Services provided in this area are primarily of the psychiatric counseling nature. Patients with a range of emotional and psychiatric problems are served.

The third type of service is the Day Treatment Center. The Center provides daily services for discharged veteran-patients with mental diseases or disorders. The purpose of the Day Treatment Center is to assist the veteran-patient to remain outside of an institutionalized setting and live independently.

The VA pays the entire cost of medical treatment for eligible veterans. VA payments cannot coincide with payments provided by other health insurance plans or public assistance programs. Since there are no VA medical clinics on the outer islands, the VA pays all bills up to a $40 monthly maximum. If the limit is exceeded, the VA will examine, and then, either approve or disapprove additional payments.

Expansion of health services are also planned. An alcoholism program has been recently established. The

Salvation Army has been contracted to serve as a detoxification center. Follow-up services are provided by a VA worker. Dental and rehabilitative programs are planned when the VA is moved into the new federal building. Currently, the lack of space is the major obstacle for the operation of these programs. Additionally, a psychiatric in-service program is in the offing. The program is to be located at Tripler and under the jurisdiction of the VA.

Since the study is concerned with the areas of nursing and domiciliary facilities, an overview of these VA services in Hawaii is necessary. The eligibility standard for admission into a nursing home has been previously described.

Veteran-patients with a service-connected-disability are eligible for indefinite care in a nursing home. Veteran-patients with a non-service-connected disability must have been patients in a VA hospital prior to admission into a nursing home. Additionally, these veterans are limited to a maximum of six months in nursing home care. If after discharge from a nursing home, veteran-patients with non-service-connected disabilities reenter the hospital, they requalify for another six months of nursing home care. Intentional rehospitalization is not allowed to take advantage of the regenerating provision.

There are no VA- or state-operated nursing homes in Hawaii. The VA, however, through the Community Nursing Home Program, is authorized to contract the use of ten nursing home beds. Six of the ten beds are reserved for veteran-patients with service-connected disabilities. The VA pays a per diem of $37 for each nursing home bed. Additional payments are made if the veteran-patient requires special prescriptions unavailable at the VA pharmacy.

The VA Health Clinic Director has the power to approve or disapprove the veteran-patient's admission into a nursing home.

As of June 1976, nine of the ten beds were occupied. There was no waiting list.

Veteran-patients in VA-contracted nursing home beds may utilize the VA's Health Clinic Services. Most veteran-patients in this situation are bed-ridden and cannot, for practical purposes, get to the clinic. The per diem, however, is considered sufficient for the nursing home to provide the services of a physician.[5]

There are, at present, no facilities exclusively providing domiciliary care for veterans. This does not imply that there are no veterans in such facilities. One VA

official estimates that 125 to 150 veterans are currently in domiciliary facilities.[6] The VA social services department is active in assisting veteran placement if deemed necessary. Placement is accomplished primarily through the Department of Social Services and Housing. The VA does not provide any direct monetary aid to the patient or provider exclusively for the utilization of domiciliary services.

The VA's social services section has four social workers. The social worker is "concerned with the total veteran" and is the client's advocate. Thus, the VA social worker is exposed to a wide range of duties and problems. Duties include counseling disabled veterans, vocational rehabilitation, marriage counseling, family counseling, group counseling sessions, employment counseling, academic counseling, duties in the mental hygiene clinic, drug and alcohol counseling, financial assistance, and outreach services.[7]

CHAPTER 7

CHARACTERISTICS OF VETERANS IN HAWAII

The Census of 1970 determined Hawaii's veteran population to be 89,098, or approximately 12 per cent of the State's total population. This amounted to 22 per cent of the total male population, and 40 per cent of the male population over the age of fifteen.[1] As of June 30, 1976, the VA estimated the veteran population to be 94,000, or approximately 11 per cent of the present population of the State.[2]

Table 12 are the figures pertaining to the veteran population from the Bureau of the Census, the Department of Planning and Economic Development, and the VA.

The war veteran population is of importance for two reasons. First, the admission criteria of most state veterans homes generally stipulate that the veteran had served during a recognized period of war or hostility. Secondly, Title 38 USCA 5031 et seq. relating to the construction of nursing homes dictates that the VA will participate to a maximum of two and one-half beds per thousand war veterans.

Veterans of World War II predominate in Hawaii. The Census of 1970 established that there were 31,971 World War II veterans in the State. Of this total, 19,266 World War II veterans ranged between the ages of 45 and 54.[3] In 1975, the VA estimated that the number of World War II veterans rose to 33,000.[4]

Veterans of the Vietnam Era numbered 20,548 in 1970. Of this total, 15,686 were between the ages of 16 and 29.[5] In 1975, the number of Vietnam veterans rose to 31,000.[6] With time, the number of Vietnam veterans are expected to increase and surpass the number of World War II veterans. This is ascribed to the natural attrition of the older World War II veterans, and the conversion to veteran status of military men presently in the armed forces with service prior to May 7, 1975.[7]

Veterans of the Korean Conflict numbered 17,491 in 1970. Of this total, 15,513 were between the ages of 30 and 44. In addition, 2,515 veterans served during both the Korean Conflict and the Vietnam Era.[8] In 1975, the number of Korean Conflict veterans rose to approximately 21,000.[9]

Table 12

NUMBER OF VETERANS IN HAWAII

	1970[a]	1973[b]	1974[b]	1975[b]	1976[c]
Vets in Civil Life	89,098	92,000	93,000	93,000	94,000
War Vets	75,026	79,000	80,000	81,000	
Vietnam	20,548	29,000	31,000	31,000	
Korea	20,006	21,000	20,000	21,000	
World War II	31,971	33,000	32,000	33,000	
World War I	2,501	2,000	2,000	2,000	
Other Services	14,072	13,000	13,000	12,000	

Source: a. *U.S., Bureau of the Census, Census of Population: 1970, Detailed Characteristics, Final Report PC(1)-D13 Hawaii (Washington, D.C.: U.S. Government Printing Office, 1972), Table 151, p. 13-233.*

b. *Hawaii, Department of Planning and Economic Development, The State of Hawaii, Data Book 1975, A Statistical Abstract (Honolulu: 1975), Table 144, p. 140.*

c. *Interview with Edna Sakamoto, Social Services, Veterans Administration, June 28, 1976.*

In 1970, there were 2,501 World War I veterans. None of these veterans were below the age of 65.[10] In 1975, there were an estimated 2,000 World War I veterans.[11]

In 1975, there were approximately 12,000 veterans with service between the end of the Korean Conflict, February 1955, and the beginning of the Vietnam Era, August 1964. Although these veterans are not considered to be war veterans, they are eligible to receive VA aid pursuant to Title 38 USCA 641.[12]

It is hypothesized that the war veteran population will soon peak, stabilize, then decrease. Since the Vietnam Era ended on May 7, 1975, pursuant to Presidential Proclamation, veterans with service prior to the termination of the Era are continuing to be discharged. These veterans, the retirement of career soldiers, and in-migration will add to the war veteran population. Personnel enlisting after the end of the Era are not considered to be of the war veteran population.

AGE

The average age of the veteran population of the nation at the end of fiscal year 1975 was 45.9.[13]

> *Vietnam era veterans with no service in the Korean Conflict are the youngest, with an average age of 28.3 years. The oldest veterans are those who served in the Spanish American War, all of whom are at least 87 years of age, and whose average age is 95.5 years. Between these two extremes are the World War I veterans, averaging 80.3 years; World War II veterans, with an average age of 55.4; veterans of the Korean Conflict (with no service in World War II), with an average age of 43.9 years; and veterans with service between the Korean Conflict and the Vietnam era, averaging 36.7 years of age.*[14]

There are no similar statistical breakdowns pertaining specifically to Hawaii.

Table 13 is an excerpt from the Census of 1970.

In 1970, veterans between the ages of 40 and 59 numbered 42,038 or 47 per cent of the State's total veteran population. Veterans between the ages of 16 and 39 numbered 41,585 which is 47 per cent of the State's veteran population. Veterans over the age of 60 numbered 5,475. These

Table 13

HAWAII VETERANS BY AGE
1970

The State	Total	16 to 24 years	25 to 29 years	30 to 34 years	35 to 39 years	40 to 44 years	45 to 49 years	50 to 54 years	55 to 59 years	60 to 64 years	65 to 69 years	70 to 74 years	75 years and over
PERIOD OF SERVICE													
TOTAL	89,098	8,239	10,658	10,519	12,169	15,516	14,480	8,891	3,151	1,700	986	1,748	1,041
Vietnam conflict	20,548	8,239	7,447	1,772	853	985	666	405	138	43	-	-	-
Korean conflict	17,491	-	13	2,770	9,005	4,728	534	262	115	44	20	-	-
Korean conflict and World War II	2,515	-	-	-	57	587	852	577	209	137	44	31	21
World War II	31,971	-	-	-	237	8,122	11,950	7,316	2,329	1,155	550	163	149
World War I	2,501	-	-	-	-	-	-	-	-	-	221	1,498	782
Other service	14,072	-	3,198	5,977	2,017	1,094	478	331	360	321	151	56	89

Source: *U.S. Bureau of the Census, Census of Population: 1970, Detailed Characteristics.*

Table 14

ESTIMATE OF VETERAN POPULATION BY ISLAND[a]

	WW I	WW II	Korean War[b]	Vietnam Era[c]	Peace-time[d]	Totals	Civilian Population As of 7-1-72	% by Island
CENTRAL OFFICE ESTIMATE OF VETERAN POPULATION IN HAWAII AS OF 12-31-72	2,000	31,000	19,000	27,000	13,000	92,000	756,589	
DISTRIBUTION BY ISLAND								
Oahu	1,608	24,924	15,276	21,708	10,452	73,968	608,474	80.4%
Hawaii	180	2,790	1,710	2,430	1,170	8,280	68,043	9.0%
Maui	112	1,736	1,064	1,512	728	5,152	42,175	5.6%
Kauai	80	1,240	760	1,080	520	3,680	30,598	4.0%
Molokai	14	217	133	189	91	644	4,904	.7%
Lanai	6	93	57	81	39	276	2,155	.3%
Niihau	e	--	--	--	--	--	240	e

Source: Veterans Administration.

a. *Distribution of veteran-population by island was determined on basis of percentage of overall civilian population on each island, including dependents of military personnel but NOT including servicemen.*

b. *Includes 3,000 veterans with service during WW II and the Korean Conflict (these dual-service veterans are not included in the figure for WW II veterans), but excludes 1,000 Korean Conflict veterans who served during the Vietnam Era.*

c. *Service after 8-4-64. Includes 1,000 veterans with service also during Korean Conflict (dual-service veterans not included in figure for Korean War).*

d. *Includes veterans who served only after 1-31-55 and before 8-5-64.*

e. *Percentage too small to use as basis for veteran population distribution.*

veterans accounted for the remaining 6 per cent of the veteran population. The population of the post-65 veterans amounted to 3,775, approximately 4 per cent of the total veteran population.

The median age in 1970 was approximately 40.[15]

SEX

There are no figures providing the number of women veterans in the State of Hawaii. Prevailing opinion is that the population is very small.

GEOGRAPHICAL DISTRIBUTION

The VA has provided the following figures on the veteran population distribution throughout the State (see Table 14).

As stated in footnote (a) of the table, the figures were derived by applying the percentage of the population distribution minus military personnel to the state veteran population. Ideally, a more representative method of forecasting distribution is to apply the percentage of male population minus military personnel and dependents. There are data available, which can be manipulated to apply the formula. First, Table 4 of the *Statistical Abstract of 1975* provides county distribution of the State's civilian population. The table, however, includes military dependents in the civilian distribution. Inclusion of military dependents in the civilian population distribution is undesirable because an inordinately large number of them reside on Oahu. Data from Table 2 of *Statistical Report 114* was utilized to adjust for this factor. This table provides data on the distribution of military dependents in the different counties. These data were subtracted from the civilian population to eliminate the military dependent factor.

Table 15

POPULATION DISTRIBUTION BY ISLAND

1974	State	Honolulu C&C	Hawaii County	Kauai County	Maui County
Civilian Residents	792,300	636,900	72,100	31,500	51,800
Military Dependents	68,324	67,867	210	212	35
Civilian Non-military Dependents	723,976	569,033	71,890	31,288	51,765
	(100)	(79)	(10)	(4)	(7)

Source: Department of Planning and Economic Development, Statistical Report 114.

The next step would have been to obtain the percentage of civilian males in the various counties. Prevailing data assume that there is a 52 per cent across the board percentage of civilian males throughout the counties. This step, thus, can be eliminated.

The final step was to distribute the veteran population correspondingly to the distribution of the nonmilitary dependent civilian population. What results is the following:

Table 16

VETERAN DISTRIBUTION BY ISLAND

	State	City & County of Honolulu	Hawaii County	Kauai County	Maui County
Veterans	93,000 (100)	73,470 (79)	9,300 (10)	3,720 (4)	6,510 (7)

Source: Legislative Reference Bureau estimate.

INCOME

Since income is a direct variable to admission into a state veterans home, an examination of this aspect should be undertaken. On the average, veterans have a substantially larger income than the males of Hawaii in general. The following is a combination of Tables 141 and 198 of the 1970 Census which compares the average income of veterans to the male population.

Table 17

MEDIAN INCOME

	State (Male)	Veterans
Total	$6,528	$ 9,147
14-19	929	3,985[a]
20-24	2,920	--
25-29	7,101	7,741
30-34	8,601	9,612
35-39	9,211	10,316
40-44	9,674	10,134
45-49	9,964	10,824
50-54	9,681	10,565
55-59	8,120	9,721
60-64	6,465	8,062
65-69	3,317	5,644
70-74	2,262	2,962
75-over	1,753	2,695

Source: *U.S., Bureau of the Census, Census of Population: 1970, Detailed Characteristics.*

a. 16-24 years.

Table 18 is an excerpt from the 1970 Census relating to the income of veterans in 1969.

Data of the 1970 Census reveal that veterans of advanced ages are likely to be poorer. The data show that 62 per cent of the veterans over the age of 75 have incomes of less than $3,000; 53 per cent of the veterans between the ages of 70 and 74 have incomes of less than $3,000; and 30 per cent of the veterans between the ages of 65 and 69 have incomes of less than $3,000. In addition, 16 per cent of the veterans between the ages of 60 and 64 are not in the labor force.

The 1970 Census also revealed that 95 per cent of the veterans over 75 are not in the labor force; 83 per cent of the veterans between the ages of 70 and 74 are not in the labor force; 64 per cent of the veterans between the ages of 65 and 69 are not in the labor force; and 29 per cent of the veterans between the ages of 60 and 64 are not in the labor force.

The data support the hypotheses that:

Table 18

INCOME BY AGE

INCOME IN 1969 OF PERSONS	Total	16 to 24 years	25 to 29 years	30 to 34 years	35 to 39 years	40 to 44 years	45 to 49 years	50 to 54 years	55 to 59 years	60 to 64 years	65 to 69 years	70 to 74 years	75 years and over
Total	89,098	8,239	10,658	10,519	12,169	15,516	14,480	8,891	3,151	1,700	986	1,748	1,041
Without income	2,011	618	233	92	238	231	197	141	54	65	20	71	51
With income	87,087	7,621	10,425	10,427	11,931	15,285	14,283	8,750	3,097	1,635	966	1,677	990
$1 to $999 or loss	1,649	621	104	100	147	112	100	107	42	65	69	148	34
$1,000 to $1,999	3,165	831	277	133	224	264	151	252	133	90	96	476	236
$2,000 to $2,999	3,028	1,086	366	136	166	171	184	93	110	57	115	223	321
$3,000 to $3,999	3,993	1,292	762	211	211	346	265	311	92	133	83	198	89
$4,000 to $4,999	4,252	908	793	376	449	497	450	272	106	110	64	153	74
$5,000 to $5,999	5,341	679	1,073	600	584	744	685	453	174	136	87	91	35
$6,000 to $6,999	6,070	731	1,028	659	681	1,052	905	559	155	121	69	76	34
$7,000 to $9,999	22,424	1,094	3,279	3,444	3,244	4,328	3,613	2,043	812	298	77	133	59
$10,000 to $14,999	23,854	292	2,337	3,605	4,101	4,793	4,785	2,523	827	269	155	108	59
$15,000 or more	13,311	87	406	1,163	2,124	2,978	3,145	2,137	646	356	151	71	47
Median income	$9,147	$3,985	$7,741	$9,612	$10,316	$10,134	$10,824	$10,565	$9,721	$8,062	$5,644	$2,962	$2,695

Source: *U.S. Bureau of the Census, Census of Population, 1970, Detailed Characteristics.*

(1) As veterans become progressively older, they are excluded, or cannot participate in the labor force; and

(2) Older veterans tend to have lesser incomes.

Both generalizations appear related. While various reasons can be given as to why this is so, for the present study, however, the fact that older veterans have lesser incomes suffices. This information is important because, generally, destitution must be combined with age or disability for admission into state veterans homes. The connection of age and destitution reemphasizes the fact that patients of state veterans homes are primarily the aged.

CHAPTER 8
VETERANS IN INSTITUTIONAL CARE

VETERANS IN INSTITUTIONAL CARE IN HAWAII

The *Characteristics of Hawaii* from the U.S. Census for 1960 and 1970 contains data on the number of veterans residing in "nursing homes and homes for the aged".

In 1960, 89 veterans resided in "nursing homes or homes for the aged". This represented .16 per cent of the total population of 55,938 veterans. The distribution by age was:

Table 19

VETERANS IN INSTITUTIONS
1960

Age	No. in Institutions	Percentage in Institutions	Total No. of Vets	Percentage
40-44	4	4.5	7,145	.01
45-49	8	9.0	3,048	.26
50-54	13	14.6	1,739	.75
55-59	4	4.5	1,375	.29
60-64	14	15.7	1,713	.82
65-69	15	16.8	1,493	1.00
70-74	22	24.7	655	3.36
75 and above	9	10.1	301	2.99

Source: *U.S., Bureau of the Census, Census of Population: 1960, Detailed Characteristics.*

It should be noted that 60 out of 4,162 veterans age 60 or over were residents in "nursing homes or homes for the aged". The total was 1.44 per cent of the post-60 population.[1]

In 1970, 121 veterans resided in "nursing homes or homes for the aged". This number represented .14 per cent of the total population of 89,098 veterans. The distribution by age was:

Table 20

VETERANS IN INSTITUTIONS
1970

Age	No. in Institutions	Percentage in Institutions	Total No. of Vets.	Percentage
40-44	15	12.4	14,480	.10
50-54	7	5.8	8,891	.08
55-59	8	6.6	3,151	.25
60-64	25	20.7	1,700	1.47
64-69	0	0	986	0
70-74	22	18.2	1,748	1.26
75 and over	44	36.4	1,041	4.23

Source: *U.S. Bureau of the Census, Census of Population: 1970, Detailed Characteristics.*

It should be noted that 91 out of 5,475 of the post-60 veteran population were in "nursing homes or homes for the aged". This represented 1.66 per cent.[2]

SURVEY

A survey of the skilled nursing facilities, intermediate care facilities, and domiciliaries in the State was taken in July of 1976. The purpose of the survey was to gather corresponding data to that of the census. Questionnaires were sent to the skilled nursing and intermediate care facilities listed in *The Hawaii State Plan for Health Facilities and Services*. Questionnaires were also sent to the care homes licensed by the Department of Health and the adult family boarding homes licensed by the Department of Social Services and Housing.

The content of the questionnaire was relatively simple in order to elicit a high response. In addition to the number of veterans in each facility, their respective ages were sought. Also included in the questionnaire were inquiries into certain characteristics of the veterans involved. The characteristics were sex, years of service, whether they were receiving a VA compensation or pension, and information on their income level. A copy of the questionnaire is included in Appendix D.

A total of 446 questionnaires were mailed. There were 273 responses, a return percentage of 61 per cent. These responses resulted from mail returns and phone calls. The

following is a breakdown of the number of questionnaires sent out and returns by type of care.

Table 21

SURVEY RESPONSE

	No. of Questionnaires Sent Out	No. of Response	% of Response
ECF	10	8	80%
SNF	12	12	100
ICF	5	3	60
Care	236	183	78
AFB	183	67	36
Total	446	273	61

Source: Legislative Reference Bureau survey, 1976.

The survey indicates that 139 veterans resided in nursing homes or domiciliaries. Additionally, 17 veterans were reported to be in an alcoholism treatment facility. Since most state veterans homes do not allow the admission of alcoholics, these 17 were disregarded.

The findings should not be regarded as conclusive. Rather, it is an estimate of the number of veterans in health care facilities. It also gives a picture of the current distribution of veterans by type of care and age.

The following is a table of the number of veterans, by age, in each type of care:

Table 22

VETERANS IN INSTITUTIONS
July-August 1976

Age	SNF	ICF	Care	AFB	Total
39-under	-	1	1	-	2
40-44	-	-	1	4	5
45-49	-	1	2	7	10
50-54	1	-	10	3	14
55-59	5	3	2	2	12
60-64	-	2	3	2	7
65-69	2	2	4	3	11
70-74	2	-	3	7	12
75-79	3	5	4	4	16
80-84	10	5	6	5	26
85-89	4	4	8	4	20
90-over	2	1	-	1	4
Total	29	24	44	42	139

Source: Legislative Reference Bureau survey, 1976.

The data collected support the premise that residents of nursing care facilities and domiciliaries are primarily the elderly. Further, there is a noticeable difference in the age distribution of the nursing care and domiciliary population.

The veteran population in skilled nursing facilities are primarily the aged. Only six veterans, or 21 per cent, in skilled nursing facilities are below the age of 60. Fourteen veterans, just under half of the veteran population in skilled nursing facilities, are between the ages of 80 and 89. The mean and median ages of the veterans in skilled nursing facilities are 76 and 81, respectively.

The veteran population in intermediate care facilities are also primarily the aged. Nine of the 13 veterans in ICF, or approximately 79 per cent, are 60 years or over. The mean and median ages of the veterans in ICFs are 73 and 78, resepctively.

On the other hand, veterans in domiciliary-type settings are more evenly distributed. Twenty-five, or 64 per cent, of the veterans in care homes are aged 60 or over. The age

distribution of veterans in adult family boarding homes is similar to those in care homes; twenty-five, or 60 per cent, are aged 60 or over. The mean and median ages of the veterans in care homes are 67 and 68, respectively. The mean and median ages of the veterans in adult family boarding homes are 64 and 69, respectively.

OTHER DATA COLLECTED

A secondary, though important, purpose of the survey was to determine the type of care necessary. As noted earlier, the federal aid available is very different for domiciliaries and skilled nursing facilities. The cost per patient differentiation between them is also significant. The census does not break the data down into the type of care. Thus, the survey serves the purpose of determining what type of care is required.

The results of the survey indicate that, currently, more veterans are in domiciliary facilities than in nursing care facilities. Fifty-three veterans are in skilled nursing or intermediate care facilities. This number is 38 per cent of the 139 veterans. Eighty-three, or 62 per cent, of the 139 are residents of care or adult family boarding homes.

Income. Most of the patients of nursing care facilities have low incomes. Twenty of the 29 veterans in skilled nursing facilities have incomes of $5,500 or less. Of this twenty, 15 had an income of between $3,000 and $5,500. Twenty-three of the 24 veterans in intermediate care also have incomes of $5,500 or less.

Table 23

INCOME OF VETERANS IN INSTITUTIONS
JULY-AUGUST 1976

	$3,000 & below	$3,000-$5,500	$5,500 & up	NA	Total
SNF	5 (17%)	15 (52%)	3 (10%)	6 (21%)	29 (100%)
ICF	16 (67%)	7 (29%)	0	1 (4%)	24 (100%)
Care	10 (23%)	10 (23%)	4 (9%)	20 (45%)	44 (100%)
AFB	13 (31%)	7 (17%)	11 (26%)	11 (26%)	42 (100%)

Source: Legislative Reference Bureau survey, 1976.

Females. Nine females are residents of nursing facilities or domiciliaries. Five of them are residents of adult boarding homes. Their mean age is 68. One female veteran was 90 years old and a patient in a skilled nursing facility. The three remaining female veterans were patients in intermediate care facilities. Their average age was 85.

Comparison. Comparison of the data for the different years is made in the following table. Columns one and two represent official data of the 1960 and 1970 Census. The average percentage of veterans in nursing homes or homes for the aged is .15 per cent. Column three represents the data the Bureau gathered. The total number of veterans is taken from the official estimates of the U.S. Department of Commerce. The number of veterans in nursing homes and homes for the aged are derived from the results of the Bureau's survey. Since our results are not derived from a hundred per cent response, that actual number appears to be higher.

Table 24

PER CENT OF VETERANS IN INSTITUTIONS

	1960	1970	July 1976
No. of Veterans	55,938	89,098	94,000
No. in Institutions	89	121	139
Per Cent of Total	.16	.14	.15

Source: *U.S., Bureau of the Census, Census of Population: 1960 Detailed Characteristics, Census of Population: 1970 Detailed Characteristics, and Legislative Reference Bureau survey, 1976.*

CHAPTER 9
PROJECTIONS

Projections of the future veteran population are necessary to ascertain the estimated number of beds a state veterans facility would require. With the projections, the number of veterans needing institutionalized health or domiciliary care is estimated by applying morbidity formulas. Then, the optimum number of beds required to accommodate the indigent population is decided.

For various reasons, concentration is upon the native, older veteran population of Hawaii. Reasons for the narrow focus are:

1. The absence of data concerning the increase of the veteran population (regeneration);

2. Utilization of the facility would be primarily by the elderly;

3. State veterans homes are meant to service the residents of the State.

The lack of data concerning the regeneration of the veteran population is also a factor in considering the older, established population. Ideally, the projections would include the decrease of veteran population by mortality and out-migration; and increase by discharges, retirement and in-migration. Lack of data, however, renders such an ideal formula impossible. There is no information pertaining to the veteran status of in- and out-migrants. Nor is a projection of native, discharged military persons returning to Hawaii feasible because of the relatively recent replacement of mandatory service with the volunteer concept. Attempts to consider the variables by manipulation and application of known data and statistics are unreliable and unsafe.

Data do support the premise that health and domiciliary institutions are utilized primarily by the elderly. Veterans are no exception to this fact. Data from the "Characteristics of Hawaii" provided by the Census of 1970 indicate that a large portion of the veteran population will attain senior citizenship within the next twenty years.

Inherent in the concept of the state veterans home is that it serves state residents. A substantial amount of state revenues will be involved, if the home is established. The

general philosophy of the various state veterans home supports the concept.

Projections are made to the turn of the century. This time period is chosen for three reasons. One, veterans attaining senior citizenship during this period represent the bulk of the veteran population. Two, since the base used to project the population is the Census of 1970, the rationale is that the post-30 veteran population in 1970 is unlikely to be significantly affected by new dischargees. The figures of the pre-30 veteran population are unstable because of the subsequent influx of veterans discharged. Use of past trends to project the number and characteristics of dischargees are hampered by the repeal of conscription. Three, Title 38 USCA 5031, relating to aid for the construction of state veterans nursing homes, contains a recapture provision. The patient occupancy must be 90 per cent veterans for the following twenty years. Noncompliance with the provision obligates the state to reimburse the federal aid.

The base utilized is the Census of 1970. Table A-12, relating to projected survival rates of the DPED Statistical Report 114, entitled "The Population of Hawaii 1958-2025 Recent Trends and Projections", is applied to the base population. The projections are displayed in Table 25.

PROJECTION OF NEED

It is projected that the over-65 veteran population will increase greatly for the remainder of the century. This increase will be the result of the aging of the bulk of the current veteran population. The projection is one of the tools used to estimate future bed requirements. Other tools utilized are the generally recognized rate of institutionalization in health facilities, the data of the 1960 and 1970 census, and the Bureau's survey. These tools are utilized in an attempt to determine the number of beds and type of care required.

It is generally recognized that five per cent of the persons over the age of 65 require institutionalization in health facilities. This figure is based on the past trends of Hawaii and the nation. The percentage includes persons over 65 in all types of health care institutions: in mental health facilities, facilities for the chronically ill, as well as in nursing homes and domiciliaries. The following table represents the application of the five per cent formula to the population projections:

Table 25

VETERAN POPULATION PROJECTION

	16-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-over
1970	8,239	10,658	10,519	12,169	15,516	14,480	8,891	3,151	1,700	986	1,748	1,041
1970-75		8,177	10,578	10,430	12,018	15,239	14,079	8,502	2,951	1,546	850	1,874
1975-80			8,122	10,485	10,295	11,789	14,785	13,421	7,923	2,662	1,319	1,797
1980-85				8,054	10,344	10,087	11,413	14,050	12,443	7,087	2,246	2,017
1985-90					7,960	10,124	9,744	10,812	12,960	11,039	5,915	2,709
1990-95						7,813	9,759	9,201	9,922	11,403	9,113	5,379
1995-2000							7,572	9,187	8,401	8,658	9,312	8,872

Source: *Department of Planning and Economic Development, Statistical Abstract 114, and U.S., Bureau of the Census, Census of Population: 1970 Detailed Characteristics.*

Table 26

VETERAN INSTITUTIONALIZATION PROJECTIONS (5%)

	65-69	70-74	75-over	Total
1980-85	7,087	2,246	2,017	11,350
				x .05
				568
1985-90	11,039	5,915	2,709	19,663
				x .05
				983
1990-95	11,403	9,113	5,379	25,895
				x .05
				1,295
1995-2000	8,658	9,312	8,872	26,842
				x .05
				1,342

Source: Department of Planning and Economic Development, Statistical Abstract 114, and Legislative Reference Bureau survey, 1976.

Thus, according to the projections, there will be a need for a large number of health institutional beds to care for the veteran population by the turn of the century. Unfortunately, the type of health care most needed cannot be determined under this approach.

For veterans, the five per cent figure may be a little high. According to the Bureau of the Census, in 1960 and 1970, 3.0 per cent and 2.8 per cent, respectively, of the veteran population over 65 were in health care institutions. These figures also include veterans in non-nursing, non-domiciliary health care institutions.

The census has figures extrapolated for veterans in "nursing homes and homes for the aged". In 1960 and 1970, 1.9 per cent and 1.8 per cent, respectively, of the post-65 veteran population were in these types of institutions. Thus, to determine the number of veterans who would require

care in "nursing homes and homes for the aged", a linear projection utilizing a liberalized percentage of two per cent is applied to the projected population of veterans. The following are projections of need utilizing the two per cent formula:

Table 27

VETERAN INSTITUTIONALIZATION PROJECTIONS (2%)

	65-69	70-74	75-over	Total
1980-85	7,087	2,246	2,017	11,350
	x .02	x .02	x .02	x .02
	141	45	40	227
1985-90	11,039	5,915	2,709	19,663
	x .02	x .02	x .02	x .02
	221	118	54	393
1990-95	11,403	9,113	5,379	25,895
	x .02	x .02	x .02	x .02
	228	182	107	518
1995-2000	8,658	9,312	8,872	26,842
	x .02	x .02	x .02	x .02
	173	186	177	537

Source: *Department of Planning and Economic Development, Statistical Abstract 114.*

The next tool utilized is the Bureau's survey. The survey indicates that in July of 1976, there were 139 veterans in nursing care and domiciliary facilities. Of this total, 53 veterans, or 38 per cent, were in skilled nursing and intermediate care facilities; and 86 veterans, or 62 per cent, were in domiciliary facilities. This distribution, however, is questionable as being the most reliable representation of the future veteran needs. Rather, the mean ages of the veterans in the different types of facilities appears more relevant in connection with the type of care required.

The survey determined that the population in nursing facilities were older than those in domiciliary facilities. Specifically, the mean ages of the veterans were: 76 in skilled nursing facilities, 73 in intermediate care facilities, 67 in care homes, and 64 in adult family boarding homes. Advanced age, thus, appears to require more intensive care. In addition, a substantial percentage of the institutionalized below-65 veterans were in domiciliary care facilities.

Future need can be estimated using these data if an assumption is made that the age distribution will reflect the type of care required. That is, the needs of the over 70 veteran population will be primarily for nursing, and the needs of the 65-69 veteran population will be for domiciliary.

Under this assumption, a shifting need is apparent. To illustrate, in the 1980-85 interval, the projected bed need for the 65-69 population is more than the projected need for the over-70 population. Thus, during that period there will be a greater need for domiciliaries. But as the population advances in age, the projected bed need for the over-70 population will be greater than the 65-69 group. At that time, there will be a greater need for nursing beds.

It should be recalled that the survey discovered a substantial number of veterans in domiciliaries who were not senior citizens. This factor has not been taken into account.

Though a precise projection of need cannot be made, it can be said that veterans as a group will have a need for health care beds. It is projected that approximately 535 beds will be needed for the veteran population by the year 2000. A determination of the type of care is dependent on other factors. The factors and the different alternatives will be discussed later.

It is important that the factors of the need of the total elderly population, the need of the elderly veteran population, and the VA aid be integrated into a workable plan for the future.

CHAPTER 10
OPERATING COST

The purpose of this section is to compare the VA's per diem aid as codified in Title 38 USCA 641 with the federal aid utilized today. It is not the purpose of this section to determine the total projected operating cost. Instead, the cost of maintaining a veteran under three models is calculated. The first model follows contemporary practice; for veterans in nursing care the cost distribution under the Medicaid formula is determined. Similarly, the cost distribution for domiciliary patients under the SSI formula is determined. In the second model, the cost distribution will be determined as if the previous VA per diem rates were utilized. The third model will portray the cost distribution as if the amended VA per diem rates were utilized.

NURSING HOMES

Between November of 1975 and April 1976, the average cost per patient day in a skilled nursing facility in Hawaii was $33.37. During the same period, the average cost per patient day in an intermediate care facility was $23.41.[1] The average daily cost translates into an annual average cost of $12,180.05 for skilled nursing care, and $8,544.65 for intermediate care.

The following discussion will compare present federal programs against the VA's per diem rates. A prerequisite to the discussion is an understanding of the Medicaid program. Medicare is not considered for this purpose because it limits the period of service in a nursing care institution to one hundred days.

Medicaid provides a 50-50 participation of cost between the state and federal governments. Patients must contribute their incomes except for the first $25 a month to the cost of care. The monthly $25 deducted is for the personal use of the patient. The difference between the cost of care and the patient's contribution is split evenly between the state and federal governments. In addition, the patient is allowed $1,500 worth of resources.[2]

A theoretical model is shown below comparing Medicaid and the old and new VA per diem rate schedules.

Each model assumes that the patient contributes nothing towards his maintenance. Title 38 USCA 641 makes only one stipulation concerning the patient's contribution. It states that the aggregate contributions from all sources cannot exceed the cost of care. Conceivably, the patient may be assessed any amount of the cost of care minus the VA per diem.

The veteran-patient, however, is not expected to account for a great amount of the cost. Reasons for this are:

1. The philosophy of the state veterans home is to care for those who cannot care for themselves because of financial limitations. This would preclude individuals with significant incomes or resources. Most of the state veterans homes throughout the country have a financial limitation requirement.

2. Private health insurance, like Medicare, have limitations on the period of nursing care benefits. For example, the HMSA Service Benefit Plan allows for care in a nursing home for up to 60 days.[3] This avenue cannot be relied upon as a long-term reimbursement factor.

3. The VA's 1975 survey shows that the veteran, on the nationwide average, accounts for only 20.5 per cent of the daily cost.[4]

Thus, the following assumes no patient contribution:

SKILLED NURSING FACILITY

	Avg. Cost Per Day	Avg. Annual Cost Per Vet.	Per Cent of Cost
Old VA Formula:			
Total	$33.37	$12,180.05	100.0
Federal (VA)	6.00	2,190.00	18.0
State	27.37	9,990.05	82.0
New VA Formula:			
Total	$33.37	$12,180.05	100.0
Federal (VA)	10.50	3,832.50	31.5
State	22.87	8,347.50	68.5
Medicaid:			
Total	$33.37	$12,180.05	100.0
Federal (SSA)	16.685	6,090.25	50.0
State	16.685	6,090.25	50.0

INTERMEDIATE CARE FACILITY

	Avg. Cost Per Day	Avg. Annual Cost Per Vet.	Per Cent of Cost
Medicaid:			
Total	$23.41	$ 8,544.65	100.0
Federal (SSA)	11.705	4,272.325	50.0
State	11.705	4,272.325	50.0
New VA Formula:			
Total	$23.41	$ 8,544.65	100.0
Federal (VA)	10.50	3,832.50	44.9
State	12.91	4,712.15	55.1
Old VA Formula:			
Total	$23.41	$ 8,544.65	100.0
Federal (VA)	6.00	2,190.00	25.6
State	17.41	6,354.65	74.4

As shown in the models, the nonfederal share under the Medicaid program is much less than under the VA program. It is also evident that the recent amendment to the VA per diem schedule has a great impact on the distribution of cost. Under the old VA program, the per diem would have accounted for 18.8 per cent of the maintenance cost. With the recent amendment, the VA assumes 31 per cent.

A factor to remember is that the VA may not recognize intermediate care. VA regulations provide that "nursing home care", and not "skilled nursing care", meet the following standard, among others:

> *c. The nursing service, patient care and related medical services shall be under the direct supervision of a registered professional nurse currently licensed to practice in the State. There shall be such other Personnel (registered nurses, licensed practical nurses and attendants) as are reasonably necessary to provide adequate skilled nursing home care of patients 24 hours a day. Staffing criteria for VA Nursing Home Care Units should be used as a guide.*[5]

Some ambiguity exists in the use of the phrase "...adequate skilled nursing home care...". Section 1861(j)(6) of the Social Security Act states that a "skilled nursing facility" provides 24-hour nursing service which is sufficient in accordance to the policy of the facility.

VA regulation also states that:

1.02

* * *

Specifically, the services to be provided nursing home care patients will be:

(1) Skilled Nursing Care. In addition to room and board, those nursing services and procedures employed in caring for the sick, which requires training judgment, technical knowledge, and skills beyond those which the untrained person possess should be provided. It involves administering medicates and carrying out procedures in accordance with the orders, instructions, and prescriptions of the attending physician.[6]

There are, however, indications that "intermediate care" is recognized, albeit unofficially. This conclusion is reached by an examination of Table 11. The range of the per day cost for nursing care is $13.51 to $40.50, This range may result from the difference in the regional cost indexes, or varying wages for public employees. No definite conclusion can safely be made for the range. Since cost is directly related to amount of services, it is possible that intermediate care may be unofficially recognized.

PATIENT CONTRIBUTION

Although the previous model presumes that the patient makes no contribution, if the patient contribution is included, the State's share may be lessened. The VA's survey of July 1975 indicates that in some of the other state veterans homes, the patient's contribution is substantial. For example, the average daily contribution of nursing care patients in the Colorado State Veterans Home is $12.00. Still, this amounts to only 36.9 per cent of the total cost. The State of Colorado assumes 44.7 per cent and the VA assumes the remainder.

There are no data as to the amount of contributions of nursing care patients under Medicaid. Thus, a comparison between Medicaid and the VA per diem including the factor of the patient's contribution cannot be made. The following model assumes the federal contribution under Medicaid to equal the VA per diem. Since the federal and state contributions are even, the state's share would also equal the VA per diem with the patient paying the remainder.

SKILLED NURSING FACILITY

	Avg. Cost Per Day	Avg. Annual Cost Per Vet.	Per Cent of Cost
Old VA Formula:			
Total	$33.37	$12,180.05	100.0
Federal (VA)	6.00	2,190.00	18.0
State	6.00	2,190.00	18.0
Patient	21.37	7,800.05	64.0
New VA Formula:			
Total	$33.37	$12,180.05	100.0
Federal (VA)	10.50	3,832.50	31.5
State	10.50	3,832.50	31.5
Patient	12.37	4,515.05	37.0

In the model constructed for the new VA schedule, the patient would have to contribute $12.37 per day toward his cost of care. This means that the patient would need to have an annual income of approximately $3,515.05, excluding the $25 monthly deduction. If the deduction is taken into account, the patient requires an additional $300 of income.

The results from the Bureau's survey indicated that 18 of the 29 veterans in skilled nursing facilities had incomes of $3,000 or more and 7 of 24 veterans in intermediate care facilities had incomes of $3,000 or more.[7] Also relevant are the statistics of the 1970 Census. The median income in 1969 of veterans between 60 and 64 was $8,062; 65 and 69 was $5,644; 70 and 74 was $2,962; 75 and over, $2,695.[8] There are no current updates in these categories.

From these data, it is conceivable that patients in a state veterans nursing home may be able to contribute enough to offset the difference in the state's share between the Medicaid and VA programs.

CONCLUSION

In the context of operating cost, the patient's contribution is a very important factor. In the case of skilled nursing care, the Medicaid program is more desirable than the VA program. Under the Medicaid program, the non-patient costs are split evenly between the state and federal governments. The VA per diem is a fixed rate and currently would amount to approximately 30 per cent of Hawaii's cost of skilled nursing care. A hypothetical situation has been created which would display the point of equilibrium between the two programs. The break-even point is the point where

the state and federal share the cost 50-50 under both programs. Under the Medicaid program, the federal and state shares are equal. Thus, if the federal government assumes 30 per cent of the total cost, as they would under the VA program, the state would also assume 30 per cent. The patient would have to assume the remaining 40 per cent. Thus, the breakeven point of the two federal programs would be where the patient can contribute, at this writing, approximately 40 per cent of his cost of care. With the course of inflation, maintenance of the break-even point would necessitate a higher and higher patient contribution or a greater state contribution, absent new federal legislation.

Currently, at the break-even point, the patient would have to contribute approximately $4,500 a year. This amount, as indicated in the Bureau's survey, may be within the reach of some patients. However, maintaining the break-even point in the future would mean higher contributions on the part of the patient.

Another factor to consider is that the Medicaid program contains escalating/de-escalating provisions for rising costs. The VA program does not. The cost of medical care is still on the rise and the VA per diem may account for a still smaller percentage in the future.

Though Congress has acted and raised the amount of VA assistance to the states, in Hawaii's case it does not appear to be enough.

Intermediate care adds a new dimension to the cost factor. The average per day cost of intermediate care was $23.41. The VA per diem of $10.50 would assume 45 per cent of the cost. The break-even model follows:

INTERMEDIATE CARE

	Avg. Cost Per Day	Avg. Annual Cost Per Vet.	Per Cent of Cost
New VA Formula:			
Total	$23.41	$ 8,544.65	100.0
Federal (VA)	10.50	3,832.50	44.9
State	10.50	3,832.50	44.9
Patient	2.41	879.65	10.2

The model indicates that the patient will have to contribute $2.41 per day, or $879.65 annually, at the break-even point between the VA program and Medicaid. An increase in the contribution of the patient would lower the state's share.

The attractiveness of a VA program in intermediate care is readily apparent. The VA, however, may not recognize intermediate care. Nonrecognizance of intermediate care does not mean patients of the condition requiring such care will not be admitted. The cost of care of these patients, however, would probably be dependent on skilled nursing criteria.

If Medicaid and the VA per diem can be simultaneously used towards the cost of care, the state would benefit tremendously. At this writing, it is not known whether a combination is allowed. An examination of available data appears to preclude the combination. Two factors point to the non-allowability. One, is the response from the out-of-state survey of state veterans homes, and the other, is an examination and interpretation of the statutes of the Social Security Act.

The advantages of combining Medicaid and the VA per diem aid are obvious. If it were allowable, it is inconceivable that the state veterans homes throughout the country would not utilize this arrangement. Only New York has indicated that veterans utilized Medicaid. Examination of the per diem percentages in Table 11 does not indicate a combination of the two programs. Though the out-of-state survey did not specifically inquire about the arrangement, there was no other feedback in this vital area.

The second reason for deducing that the combined use is not allowed is by the examination of the eligibility statutes of the Social Security Act. The problem here is the interpretation of "unearned income". "Unearned income" is defined as "...all other income, including--(A) support and maintenance furnished in cash or kind;..." in section 1612(2) of the Social Security Act. Section 416.120(c)(2) of Volume 20 of the *Code of Federal Regulations* defines "income" as "...the receipt by an individual of any property or service which he can apply, either directly or by sale or conversion, to meeting his basic needs". In the context of these definitions, the VA per diem though technically paid to the institution and not the veteran, appears to be "income". If the VA per diem is "income", the veteran would be ineligible to receive Medicaid because of an excess of income. Thus, Medicaid and the VA per diem aid cannot be simultaneously used.

The data presented in this chapter also raise a related question; whether or not Medicaid can be used as a source of funding instead of the VA per diem aid. This question was posed to the VA and the following reply was received:

If the State establishes a State veterans home and if both Medicaid and VA per diem cannot be applied simultaneously, can the State choose the aid of the Medicaid program rather than the VA per diem?

Answer: State may establish a veterans home and use Medicaid instead of VA per diem, providing Medicaid criteria are met. Should the State apply for VA recognition, the State would have to meet VA criteria as outlined in the attached VA Regulation 6165 to 6166. I might add that the requirement for war time service has been removed by the 94th Congress. (Public Laws 94-417 and PL 94-581). VA recognition would be necessary for the purpose of requesting VA per diem aid for the care of residents under the provisions of Section 641, U.S.C. 38. Additionally, VA recognition is necessary in case a State wishes to apply for construction grants for remodeling of existing hospital and domiciliary facilities under the provisions of Section 644, U.S.C. 38.

The answer indicates that the State may establish a state veterans home of the nursing variety and utilize Medicaid instead of the VA per diem.

DOMICILIARY

In Hawaii there are three levels of domiciliary care. The difference between the levels is the degree of care provided; level III provides the most intensive care followed by level II and level I. Domiciliary care for the indigent is shared by the Social Security Administration under the Supplemental Security Income program and the Department of Social Services and Housing. The current monthly cost of care is: level III $370; level II $308; level I $257.[9] Of these amounts, the SSI program (federal) contributes a monthly maximum of $167.80, or $5.52 a day. The State assumes the remainder. Persons in "public institutions", as defined by federal regulations, cannot receive SSI payments. Thus, patients in a veterans home could not receive SSI payments. Models are created, similar to that of the previous discussion. These models assume no contribution by the patient.

DOMICILIARY

	Monthly	Annual	Per Day	Per Cent
LEVEL I:				
Total	$257.00	$3,084.00	$8.45	100.0
Federal (SSI)	167.80	2,013.60	5.52	65.3
State	89.20	1,070.40	2.93	34.7
LEVEL II:				
Total	$308.00	$3,696.00	$10.13	100.0
Federal (SSI)	167.80	3,013.60	5.52	54.5
State	140.20	1,682.40	4.61	45.5
LEVEL III:				
Total	$370.00	$4,440.00	$12.16	100.0
Federal (SSI)	167.80	2,013.60	5.52	45.4
State	202.20	2,426.40	6.64	54.6

The models show that the SSI per day contribution of $5.52 is only two cents higher than the maximum VA per diem of $5.50. The VA per diem of $5.50, however, is the maximum allowable. It must also be remembered that the VA contribution cannot exceed one-half of the cost of care. Thus, if the patient makes no contribution, the SSI program appears more desirable under levels I and II, and at least equal to level III.

The patient's contribution is an important factor. The average cost of domiciliary care is substantially lower than that for nursing care. Contributions by the patient may then account for a higher percentage of the total cost.

Another factor is the structure of the SSI program. Unlike the Medicaid program, the patient's contribution is deducted from the federal, and not the state's, share. The patient's contribution would lessen the federal share while not lowering that of the state's.

The following table is formulated from data of the DSSH. The table reflects the contributions of the state, federal, and patient for the month of July, 1976. During the month, there were 207 patients in level I care, 473 in level II care, and 692 in level III care.

DOMICILIARY

	Amount	Monthly	Annual	Per Day	%
LEVEL I:					
Total	$ 53,199	$257.00	$3,084.00	$ 8.45	100.0
Federal (SSI)	21,027	101.58	1,218.96	3.34	39.5
State	17,927	86.60	1,039.25	2.85	33.7
Patient	14,245	68.82	825.79	2.26	26.8
LEVEL II:					
Total	$145,684	$308.00	$3,696.00	$10.13	100.0
Federal (SSI)	43,926	92.87	1,114.40	3.05	30.2
State	63,191	133.60	1,603.15	4.39	43.4
Patient	38,567	81.54	978.44	2.68	26.5
LEVEL III:					
Total	$256,040	$370.00	$4,440.00	$12.16	100.0
Federal (SSI)	61,940	89.51	1,074.11	2.94	24.2
State	131,822	190.49	2,285.93	6.26	51.5
Patient	62,278	90.00	1,079.96	2.96	24.3

The table indicates that the SSI contribution is less than the maximum of $5.52 per day. It appears, in consideration of the patient's contribution, that the VA rates are more desirable. As the table shows, the patient's annual contribution based on the data is $825.84 for level I, $978.36 for level II, and $1,080.00 for level III. These figures are not high, and appear to be within the reach of the patient.

The following models display the cost distribution if the VA contributes the maximum and the patient's contribution remains the same. Preceding them are models of the same circumstances under the old VA per diem schedule.

DOMICILIARY A

	Per Day	Annual	Monthly	Per Cent
LEVEL I:				
Total	$ 8.45	$3,084.00	$257.00	100.0
Federal (VA)	4.22	1,540.30	128.33	50.0
State	1.97	719.05	59.92	23.3
Patient	2.26	825.79	68.82	26.8
LEVEL II:				
Total	$10.13	$3,696.00	$308.00	100.0
Federal (VA)	4.50	1,642.50	136.87	44.4
State	2.95	1,076.75	89.73	29.1
Patient	2.68	978.44	81.54	26.5

	Per Day	Annual	Monthly	Per Cent
LEVEL III:				
Total	$12.16	$4,440.00	$370.00	100.0
Federal (VA)	4.50	1,642.50	136.87	37.0
State	4.70	1,715.50	142.96	38.6
Patient	2.96	1,079.96	90.00	24.3

DOMICILIARY B

	Per Day	Annual	Monthly	Per Cent
LEVEL I:				
Total	$ 8.45	$3,084.00	$257.00	100.0
Federal (VA)	4.22	1,540.30	128.33	50.0
State	1.97	719.05	59.92	23.3
Patient	2.26	825.79	68.82	26.8
LEVEL II:				
Total	$10.13	$3,696.00	$308.00	100.0
Federal (VA)	5.06	1,846.90	153.91	50.0
State	2.39	872.35	72.70	23.6
Patient	2.68	978.44	81.54	26.4
LEVEL III:				
Total	$12.16	$4,440.00	$370.00	100.0
Federal (VA)	5.50	2,007.50	167.80	45.2
State	3.70	1,350.50	112.54	30.4
Patient	2.96	1,079.96	90.00	24.3

CONCLUSION

Cost-wise, the VA program appears to be better than the SSI program. This determination is dependent on the patient's contribution. No break-even analysis was necessary because data are available for the amount of patient contributions.

If the patient makes no contributions, SSI is more desirable for the first two levels of care and the equal to level III. Patient's contributions under the SSI program, unlike Medicaid, are deducted from only the federal share. Thus, the data display that the VA per diem is better under all three levels of domiciliary care if the amount of patient contributions remains the same as when the data were gathered.

It should also be noted that SSI has a cost of living provision that escalates the federal contribution, whereas the VA program does not.

CHAPTER 11
CONSTRUCTION COST

In order to get an idea of construction costs, the construction cost of a hypothetical veterans home was estimated, using a cost per bed approach. It should be noted that the estimate is subject to modification depending on the actual site and floor plan and required adjustments to costs due to inflation.

Two factors worth noting must be taken into consideration in estimating cost. One is that the construction specifications of the VA are more rigid than the minimum specifications of the State Department of Health. VA specifications also require such appurtenances as chapels, separate employees' dining rooms, etc. which would increase cost. Second, in Hawaii the basic structural requirements of domiciliary, intermediate, and skilled nursing rooms are essentially the same. This factor makes only one projection necessary for the estimation of a veterans facility.

In developing a cost estimate, a model was available with which to compare cost. Kuakini Medical Center is in the process of constructing an 8-story facility to house 100 intermediate care beds and 150 care home beds. The project involves the new construction of all 100 intermediate care beds, 101 care home beds, and the renovation of 49 care home beds. Further, an examination of the floor plan indicates that the structure would substantially comply with the VA specifications. Total estimated cost of the project in October of 1975 was $9,050,000; which translates into an average cost per bed of $45,025. This figure excludes the cost of land and ancillary facilities, such as a parking lot.[1]

CONSTRUCTION COST INDEX

Another factor which must be considered is the inflationary aspect of construction cost. Historically, construction cost has risen steadily though disproportionately. The following is the annual average construction cost index for high-rise buildings:[2]

Year	Index	Point Change from Previous	Point Change from Previous
1967	100	--	--
1968	105.2	5.2	5.2%
1969	110.8	5.6	5.3%
1970	117.9	7.1	6.4%
1971	125.1	7.2	6.1%
1972	133.6	8.5	6.8%
1973	144.9	11.3	8.5%
1974	163.7	18.8	13.0%
1975	178.8	15.1	9.2%

In the case of the model used, the construction cost index stood at 183.0 in October of 1975[3] when the cost of the Kuakini Medical Center was estimated. In August of 1976 the construction cost index rose to 201.8,[4] an increase of 10.3 per cent since October of 1975. As indicated by the preceding table, cost does not increase proportionately and thus cannot be safely predicted. If, however, the percentage of increase between October 1974 and August 1976 is applied to the average cost per bed of the Kuakini Medical Center as follows:

$45,025	$45,025
x .103	+ 4,638
$ 4,638	$49,663,

the cost in August 1976 would be approximately $49,663 per bed.

It has been stated that the average cost per bed is, at this writing, approximately $55,000 and that construction cost is expected to rise at two per cent a month. Another factor stated is that construction cost is 10 to 30 per cent higher in the rural areas.[5] These figures could not be verified, but it was stated by an authority and cannot be dismissed without mention.

RENOVATION

A projection of renovation cost would vary with the facility being renovated. Each facility differs in condition, age, and conformity to building and fire codes.

A study of the renovation of the old Kona Hospital into a domiciliary facility was conducted in 1971 by the Department of Health and the Department of Social Services and Housing. The study estimated that a renovated facility accommodating 46 persons would have cost $734,000. This would have amounted to $30.46 per square foot, or $16,200 per person. The study also estimated that the replacement of the facility to accommodate 40 persons would have cost $680,000. This would have amounted to $57.78 per square foot, or $17,600 per person. The study further stated that the replacement model was economically more feasible than the renovated model. This determination was based on the projected maintenance cost; the replacement model would have cost fifty per cent less than the renovated model in that respect.

NON-VA FEDERAL AID

Title XVI of P.L. 93-641 provides allotments, loans, loan guarantees, and interest subsidies for projects involving:

(1) Modernization of medical facilities;

(2) Construction of new outpatient medical facilities;

(3) Construction of new inpatient medical facilities which have experienced (as determined under regulations of the Secretary) recent rapid population growth; and

(4) Conversion of existing medical facilities for the provisions of new health services.

Part C of Title XVI of P.L. 93-641 makes loans and loan guarantees available to only nonprofit private entities. This, in the context of our discussion, is not applicable because the state veterans home must be state administered.

Part B of Title XVI of P.L. 93-641 provides allotments to the various states. The allotments are distributed "among the States on the basis of population, financial need, and

need for medical facilities projects". At present, the allotment figure is not available. Indications are that it will probably be approximately $1 million.

Section 1611(d)(1) of P.L. 93-641 also has a provision that:

> *(d) In any fiscal year--*
>
> *(1) not more than 20 per centum of the amount of a State's allotment available for obligation in that fiscal year may be obligated for projects in the State for construction of new facilities for the provision of inpatient health care to persons residing in areas of the State which have experienced recent rapid population growth; and*[6]
>
> * * *

It is apparent that the construction aid offered by the VA is more attractive to the federal aid offered under Title XVI of P.L. 93-641. Title 38 USCA 644 allows a maximum of 65 per cent federal participation in the renovation of an existing domiciliary facility. Title 38 USCA 5031 allows a 65 per cent federal participation in the new construction or renovation of a skilled nursing facility. Both types do not afford aid toward the purchase of land or of an existing building.

Unfortunately, aid provided under P.L. 93-641 cannot be combined with the VA construction aid.

CHAPTER 12

SUMMARY AND RECOMMENDATIONS

SUMMARY

The question of the feasibility of establishing a state veterans home does not revolve around cost factors alone. Cost is only one of the many factors which must integrate into the determination of feasibility. The relevant factors may be grouped into three categories: the kinds and conditions of VA aid, immediate and long-range need, and state policy and fiscal condition and social obligation.

KINDS AND CONDITIONS OF VA AID

Construction Aid. The problem in this category is the different stipulations attached to the VA construction aid. A state veterans domiciliary facility can only be renovated with the assistance of the VA. The domiciliary facility for which VA aid is utilized must be used as a state veterans home for seven years after the renovation. Veteran-patients need only comprise a simple majority of the total patient population of the home to retain designation as a state veterans home. In addition, a state is limited to 20 per cent of the funds available in a year.

VA construction aid for a nursing facility may be used for both the renovation or construction of a facility. The State must operate the facility for the next twenty years, or upon failure to comply, return the VA portion of the cost. In addition, ninety per cent of the patient population must be veterans.

There is no question of the desirability of either type of aid in terms of federal moneys forthcoming. The VA would participate to a maximum of 65 per cent of the cost, excluding acquisition of land and purchase of building. The amount of money potentially available is much more than under Title 16 of Public Law 93-641.

Aside from the amount, each type of VA construction aid has its particular advantages. In terms of utilization flexibility, the VA construction aid for a nursing facility is more desirable because it allows for both renovation and new construction. In terms of the time stipulation, the VA aid for a domiciliary facility is more desirable because it needs to be operated as a veterans home for only seven years, as opposed to the twenty years attached to the VA nursing facility aid.

In terms of type of patient population, a domiciliary facility is more desirable in that it requires only a simple majority to be veterans. The patient population in a nursing facility constructed with the assistance of the VA must be 90 per cent veterans. SSI, however, does not allow payments to patients in "public institutions". Thus, non-veterans in a state veterans domiciliary facility would receive no federal assistance under either the SSI or VA per diem program. Non-veteran patients in a state veterans nursing facility, however, would qualify for Medicaid.

One important factor worth noting is that both types of VA construction aid expire in fiscal year 1979. The VA has indicated that it does not have any idea whether the aid will be renewed.

VA Per Diem. The VA provides a per diem of $5.50 for domiciliary patients and $10.50 for skilled nursing patients. The per diem was recently raised from $4.50 and $6.00 for domiciliary and nursing care, respectively.

In comparing the VA per diem against the other types of aid available for the maintenance cost of patients in nursing and domiciliary facilities, it appears that, for nursing patients, Medicaid is a much more attractive option than the VA per diem aid. The per diem of $10.50 would account for one-third of the total cost. Chapter 10 shows that, under current cost, the patient would have to account for approximately 40 per cent of the total cost, or $12.40 a day for the VA program to equal Medicaid. A contribution of $12.40 a day would require an annual net income of $4,500. According to the Bureau's survey, this amount, although substantial, may be within the reach of some veteran-patients presently in nursing care.

In the case of domiciliary patients, the VA per diem appears to be better than, or at least equal to, the SSI program. The VA per diem is $5.50 compared with the SSI maximum of $5.52. Patient contributions, however, are deducted from the federal, and not the state, share. Data show that the SSI contribution is less than the maximum because of the patient contribution. The VA per diem is better than the SSI program if the patient's ability to contribute is considered.

Another important factor is that Medicaid and SSI have escalating clauses for inflation and rising costs. The VA per diem rates are statutorily fixed. Although Congress has, in the past, amended the VA per diem rates because of the State's bearing of a disproportionate burden of the cost, continued favorable action by Congress cannot be guaranteed.

NEED AND PROJECTED NEED

A large number of the veteran population will attain senior citizenship within the next 10 to 15 years. In this respect, veterans as a group will require more health institutionalization than the present veteran population. Whether this need can be integrated into the total need of, and provision for, the elderly population as a whole is unknown because of the nonexistence of a long-range plan. It is, however, apparent that a veterans home is a vehicle for providing institutionalized health care beds for the elderly or a segment of the elderly.

There appears to be an adequate number of nursing beds for the total elderly population, including elderly veterans, for the next five years. Domiciliary care is another matter. There are no hard reported data to indicate whether current demands are being met in this area; nor are any long-range plans or directions available.

It is also important to note that studies have shown that alternative types of care other than skilled nursing care could be better utilized. The studies have shown that a large number of patients in skilled nursing care could be better served in a lesser type of care, such as intermediate care or care homes. Utilization of the appropriate type of care would result in cost savings.

STATE FISCAL CONDITION AND POLICY AND SOCIAL OBLIGATION

The summation of the factors in this section uses a "pro" and "con" approach. These factors are important with respect to the policy decision as to whether a state veterans home should be established. Some factors are intangible, hence incapable of being proved right or wrong. Others are, to a large extent, dependent on state priorities, thus necessitating policy positions of the executive branch.

1. State Fiscal Condition

Pro: Although the State's fiscal condition is not very bright, the federal aid available for construction of a state veterans home is extremely attractive. This aid expires in fiscal year 1979. Construction costs also are rising; thus the sooner the facility is built the less expensive it will be.

Con: The State may have other priorities more urgent than a state veterans home. Services provided by a state veterans home may be better assumed by the private sector for the purposes of stimulating the economy.

2. *Possible Renovation of Existing Facilities*

Pro: Some facilities in Hawaii may possibly be renovated using the VA construction aid. An existing surplus of hospital beds may also be renovated to accommodate nursing or domiciliary care.

While the Bureau did not investigate this aspect, it is a very important one in the context of the VA construction aid.

Con: Renovation might possibly be more expensive in the long run than new construction. The VA domiciliary construction aid is limited to renovation, and does not cover expansion of an existing facility.

3. *Effect of State Entrance into the Private Sector*

Pro: In the case of domiciliary patients, the VA per diem is more than the SSI contribution thus entailing a lesser burden on the State and patient. To the extent that private sector beds are in short supply, each veteran who goes into the veteran's facility will free one bed for general use.

Con: Investments of the private sector in anticipation of projected need will be lost if the State establishes a facility and lessens the available patient population. To the extent that state involvement results in an oversupply of beds, all providers will experience revenue losses.

4. *Institutionalization vs. Non-institutionalization*

Pro: Institutionalization of persons with a common interest and experience, in this case veterans, may prove beneficial to them and offset any alleged detrimental effects institutionalization has.

Con: Institutionalization may provide a negative atmosphere. Interaction with the community and society, and participation in a family setting for persons whose conditions permit, is more desirable to the person's well-being.

5. *Should Veterans be Treated as a Special Group?*

Pro: Veterans deserve a facility because of their service to the country. VA aid is available so maximum advantage should be made of it. Largely through military action, the United States has twice since 1917 assisted in the repulsion of aggressors of the free world.

Con: The care of veterans should not be separated, but treated in the context of an overall aging program. The public consensus may be that veterans, as a special group, should not be singled out for separate treatment.

RECENT DEVELOPMENTS

Public Law 94-581. In the waning days of the 94th Congress, the Veterans Omnibus Health Care Act of 1976 was passed. It has since been enacted and designated as Public Law 94-581. In the context of a Hawaii state veterans home, the expectations of the Act have not been realized. Some aspects of the Act relating to the subject of the report are as follows.

Construction Aid. The bill included provisions for Alaska and Hawaii to utilize the construction aid for new construction of a domiciliary facility. This provision, however, was deleted by the House in the final version of the bill.

The Act also did not extend the construction aid.

Intermediate Care. Throughout the report the Bureau has pointed out that intermediate care is not officially recognized. The Act takes a step toward official recognizance of intermediate care. The VA may now authorize placement and commensurate payment of persons requiring intermediate care in the community nursing home care program. Though this recognition does not extend to state homes, a precedent has been established.

Standards of Care. The VA is also required to prescribe standards of care for state homes. Failure to comply with the standards would mean a loss of VA reimbursement assistance.

Nursing Beds. The VA is required to operate a minimum of 10,000 nursing beds by fiscal year 1980. This raises the minimum capacity from 8,000 beds. Whether the VA plans to include Hawaii in the mandate is not known.

RECOMMENDATION

Some questions concerning the direction of state policy must be answered before any veterans facility is established. These questions are:

(1) Does a state veterans home fit into the State's long-range institutionalization plan?

(2) Does the State consider the institutionalization of persons versus placement in the community as necessary or desirable?

(3) How would a state veterans home fit into the overall program for the elderly?

(4) Should veterans as a distinct group be treated separately from the total elderly population?

(5) In view of the present fiscal condition of the State, should expenditures for a state veterans home be given priority?

(6) Is the amount of the VA share, historically in the range of 30 per cent, acceptable to the State?

(7) Are land or existing facilities available which will make the establishment of a state veterans home available within the State?

The answers to some of these questions necessitate input from the executive branch and the public. All of the answers will reflect public policy decisions. If the answers to these questions are not adverse to the establishment of a state veterans home, the Bureau, in light of the data gathered by the study, recommends consideration of the following alternatives. Favorable consideration should be given to the establishment of a domiciliary. The establishment of a nursing home also has its advantages, but its detriments outweigh those advantages.

1. *Domiciliary*

Renovation of an existing facility for the purpose of establishing a state veterans domiciliary facility is recommended as the first alternative because:

(1) The VA will participate for up to 65 per cent of the renovation cost, excluding the cost of land or purchase of building, expansion of an existing building, or construction of a new building;

(2) Indications are that existing vacant hospital beds or decrepit domiciliary facilities may be renovated; if facilities are available for

renovation, it may correspond nicely with the VA construction aid for domiciliaries;

(3) The newly revised VA per diem may be better than, or at least equal to, the SSI contributions for domiciliary care depending on the patient's contribution;

(4) A large number of the veteran population will attain senior citizenship within the next 10 to 15 years;

(5) Studies have recommended the utilization of appropriate lesser degrees of care rather than skilled nursing care;

(6) After the use of the VA construction aid, the State need only operate the facility as a state veterans home for the next seven years. The facility may then be converted to other needs if required.

Another possible advantage is that the patient population in a domiciliary facility need only be a simple majority; and that the facility could be shared with non-veterans. The seeming advantage, however, could be tempered by the fact that non-veteran patients in a state veterans home cannot qualify for either VA or SSI aid. Thus, the cost of maintenance for non-veterans would be assumed by the State and patient without federal participation.

The most decisive factor in making the recommendation is the VA per diem aid. The VA per diem aid would, if applied to current cost, amount to approximately 37 per cent of the total cost for level III care; and 50 per cent for levels I and II. While the percentages of participation may not seem very high, it is greater than under the SSI program and greater than the VA would assume under a nursing facility arrangement.

In light of the fact that the facility, if established, will not be operational immediately, the following model projects the cost five years from now. The model assumes a 10 per cent increase in cost and that the VA per diem will remain the same.

Type of Care	Current Cost	Per Cent	Future Cost	Per Cent
Level I				
Total	$257.00	100.0	$385.50	100.0
Federal	128.33	50.0	167.80	43.5
Level II				
Total	$308.00	100.0	$462.00	100.0
Federal	153.91	50.0	167.80	36.3
Level III				
Total	$370.00	100.0	$555.00	100.0
Federal	167.80	45.2	167.80	30.2

As indicated in the model, the percentages of the federal participation under the assumptions are 30 per cent or more.

While the operating cost aspect makes the establishment feasible, the availability of existing facilities which may be renovated is also important. It must be recalled that the VA construction aid for a domiciliary facility can only be used for renovation of an existing facility.

2. *Domiciliary, then Conversion into Nursing Home*

An examination of the projected need offers another possible alternative that might be considered. Based on the hypothesis that more veterans under the age of seventy will require domiciliary care, while more veterans over the age of seventy will require nursing care, the table in chapter 9 indicates that until the year 1985, more veterans will be between the ages of 65 and 69 than over 70. After 1985, the post-70 veteran population outnumbers the population between 65 and 69. The alternative plan would be the establishment of a state veterans domiciliary facility, then a conversion into a nursing facility after 1985. This alternative can be accomplished if the facility's structural requirements are designed to meet specifications of both types of care. In Hawaii this presents no major problem because the structural requirements are similar.

The metamorphosis in the future would naturally depend on the desirability for nursing care. In the following section the disadvantages of establishing a state veterans nursing home are discussed. The main point, however, is that the State would be obligated only for seven years, after which, other more urgent priorities may be pursued.

3. Nursing Home

The establishment of a state veterans nursing facility could be considered as a third alternative. However, the Bureau feels that the negative factors outweigh the positive factors. The positive factors are as follows:

(1) The VA construction aid for nursing facilities covers both renovation and new construction;

(2) Nursing care is more expensive than domiciliary care and would appear to be the area which public assistance is needed because of the prohibitive costs;

(3) Use of federal funds in the establishment of a more expensive facility will tap a larger amount of federal resources;

(4) The state veterans nursing facility could be an integral part in the future nursing care need if a long-range policy is developed.

On the other hand, there are two factors unfavorable to the establishment of a state veterans nursing facility. One is the VA per diem rate. And the other is the possible non-recognition of intermediate care. The VA per diem rate for nursing care has been compared with Medicaid. It has been shown that the patients will have to contribute a substantial amount to his maintenance cost if the VA per diem is to match Medicaid, percentage-wise. As discussed in the summary, the VA may recognize intermediate care unofficially. The average cost per day of intermediate care between January of 1976 and July of 1976 was $23.41. The VA per diem rate of $10.50, if applied to the cost, amounts to 45 per cent. Percentage-wise, this does not match the Medicaid maximum of 50 per cent. The patient contribution, however, must be considered and a facility of the intermediate care variety would be attractive.

In other states, patients whose conditions require intermediate care probably are in state veterans nursing homes. But the cost of care for these patients probably would be higher because the VA staffing criteria is designed for skilled nursing care. Thus, while the conditions of patients may differ, their "direct cost" will be dependent on skilled nursing criteria.

Regarding nursing care, institutionalization versus non-institutionalization is not a relevant question. Nursing care is a service which is generally better obtained in an institutional setting, rather than in a community setting. The important factor here is that the State must integrate

the planning of a nursing care facility with the conditions of the private sector. State involvement in this area may intrude upon the private sector by diverting patients. However, if the private sector cannot meet the need, then the establishment of a nursing facility may, even with the disadvantages, be desirable or necessary.

4. *Combination*

A fourth possibility, a combination facility, is unattractive because the VA construction aid would entail separate projects on the same facility. The construction aid cannot be bonded together into a comprehensive project. Otherwise, the advantages and disadvantages attached to a domiciliary and nursing facility previously enumerated would apply.

OTHER RECOMMENDATIONS

The Bureau also recommends that the legislature urge the Congress of the United States to take the following action if it decides to establish a state veterans home:

(1) To enact legislation which will conform and possibly extend the VA construction aid;

(2) To amend the VA per diem rate schedule from one that is statutorily fixed, to one based on a percentage of cost;

(3) Raise the VA share of the cost.

FOOTNOTES

Chapter 2

1. John J. Regan, "Quality Assurance Systems in Nursing Homes," Journal of Urban Law, Fall 1975, p. 154.

2. Social Security Act, as amended, sec. 1908, 42 USCA sec. 1396g.

3. Social Security Act, as amended, sec. 1861(j), 42 USCA sec. 1395x(j).

4. Hawaii, Department of Health, Public Health Regulations, ch. 12A, sec. 2(A).

5. Gordon Associates, Inc., Comprehensive Master Plan for the Elderly (Hawaii: 1974), p. 90.

6. Health Facility Research Associates, The Hawaii State Plan for Health Facilities and Services (Hawaii: 1975), v.p.

7. Hawaii, Department of Social Services and Housing, "Statistical Summary on Medical Assistance Program," April 1976. This figure represents persons who utilize the state medical assistance program. Persons not utilizing the program are not accounted for.

8. Social Security Act, as amended, sec. 1905(c), 42 USCA sec. 1396(d).

9. Gordon Associates, p. 93.

10. Hawaii, Department of Health, Public Health Regulations, ch. 12B, sec. 2(B).

11. Hawaii, Department of Social Services and Housing, Public Welfare Manual, sec. 3446.1(1)(a).

12. 20 C.F.R. sec. 405.1123(c).

13. DSSH, "Statistical Summary". This figure represents persons who utilize the state medical assistance program. Persons not utilizing the program are not accounted for.

14. Health Facility Research Associates, v.p.

15. The discrepancy may be due to the method of projection; the projections are based on past occupancy. Intermediate care was not recognized as distinct from skilled nursing care until recently. The discrepancy also may be due to intermediate care patients utilizing skilled nursing beds.

16. Interview with Judy Ooka, Adult Program Administrator, Department of Social Services and Housing, July 16, 1976.

17. Ibid.

18. DSSH, Public Welfare Manual, sec. 3463(e).

19. Interview, Ooka.

20. Social Security Act, as amended, sec. 1812(b)(2), 42 USCA sec. 1395d(b)(2).

21. Greenleigh Associates, Inc., Audit of the Medical Assistance Program of the State of Hawaii (Hawaii: 1970), p. 311.

22. Gordon Associates, p. 88.

23. DSSH, "Statistical Summary".

24. Gordon Associates, p. 88.

25. DSSH, "Statistical Summary".

26. Greenleigh Associates, p. 311.

27. Ibid.

28. Gordon Associates, pp. 86-95.

29. Ibid., p. 92.

30. Health Facility Research Associates, p. 32.

31. U.S., Department of Health, Education and Welfare, Foster Family Care for the Aged (Washington, D.C.: U.S. Government Printing Office, 1965), p. 1.

32. DSSH, Public Welfare Manual, sec. 4251.

33. Ibid., sec. 4202(1).

34. Ibid., sec. 4152(1).

35. Ibid., sec. 4251(3).

36. Interview, Ooka.

37. Gordon Associates, p. 90.

Chapter 3

1. 38 USCA, p. 27.

2. California, Senate Factfinding Committee on Labor and Welfare, State Veterans' Home in Southern California, 1965, p. 11.

3. Ibid.

4. Act of August 27, 1888, ch. 914, 25 Stat. 450.

5. 1864 - Connecticut; 1866 - New Jersey (Menlo Park); 1877 - Massachusetts (Chelsea); 1880 - Ohio; 1882 -California; 1884 - Vermont; 1885 - Illinois, Michigan, Pennsylvania; 1886 - Iowa; 1887 - Minnesota, Nebraska, Wisconsin; 1889 - Colorado, Kansas, South Dakota; 1890 - New Hampshire, Rhode Island; 1891 - North Dakota, Washington (Orting), Washington (Retsil); 1895 - Idaho, New York; 1896 - Indiana, Missouri; 1898 - New Jersey (Vineland).

6. Alabama, Arkansas, Louisiana, North Carolina, and Texas.

7. Pub. L. 93-613, 68 Stat. 757.

8. Pub. L. 88-450, 78 Stat. 500.

9. Ibid.

10. Pub. L. 91-178, 83 Stat. 836.

11. U.S., Congress, House, Subcommittee on Hospitals of the Committee of Veterans' Affairs, Per Diem Allowances for State Homes; CHAMPVA Benefits for Certain Veterans' Survivors; VA Reimbursements for Health Care in Certain Cases; and VA Quality Care Study, 94th Cong., 1st Sess., 1975, Doc. 59-876, p. 767.

12. Ibid., p. 777.

13. Ibid., p. 768.

14. The per diem has been since raised.

15. U.S., Congressional Record, 94th Cong., 2nd Sess., 1976, Vol. 122, No. 129.

Chapter 4

1. 38 USCA sec. 644.

2. 38 C.F.R. sec. 17.166.

3. U.S., Congress, House, Subcommittee on Hospitals of the Committee of Veterans' Affairs, Per Diem Allowances for State Homes; CHAMPVA Benefits for Certain Veterans' Survivors; VA Reimbursements for Health Care in Certain Cases; and VA Quality Care Study, 94th Cong., 1st Sess., 1975, Doc. 59-876, pp. 772, 773.

4. Act of August 28, 1888, ch. 914, 25 Stat. 450.

5. Act of March 2, 1889, ch. 411, 25 Stat. 975.

6. Act of January 27, 1920, ch. 56, 41 Stat. 399.

7. Pub. L. 83-613, 68 Stat. 757.

8. Pub. L. 86-625, 74 Stat. 424.

9. Pub. L. 80-531, 62 Stat. 237.

10. U.S., Code Congressional and Administrative News, 83rd Cong., 2nd Sess., 1954, p. 3095.

11. Pub. L. 83-613, 68 Stat. 757.

12. U.S., Code Congressional and Administrative News, 86th Cong., 2nd Sess., 1960, p. 2986.

13. Pub. L. 86-625, 74 Stat. 424.

14. Pub. L. 90-432, 82 Stat. 448.

15. U.S., Code Congressional and Administrative News, 90th Cong., 2nd Sess., 1968, p. 2763 et seq.

16. Pub. L. 91-178, 83 Stat. 836.

17. Pub. L. 93-82, 87 Stat. 196.

18. Pub. L. No. 417, 94th Cong., 2nd Sess. (September 21, 1976).

19. Subcommittee on Hospitals of the Committee of Veterans' Affairs, pp. 773, 774.

20. U.S., Congressional Record, 94th Cong., 2nd Sess., 1976, Vol. 122, No. 129.

21. 38 USCA 610.

22. U.S., Veterans Administration, VA Regulations Medical-Trans. Sheet 105, 6165(B).

23. Correspondence from Dr. Bedford H. Berrey to the Legislative Reference Bureau (see Appendix B).

24. Ibid.

25. Ibid.

26. 38 USCA sec. 5035(a)(4).

27. U.S., Veterans' Administration, Department of Medicine and Surgery, Operations, Manual M-1, Part I, ch. 3, sec. II (3.09).

28. Ibid., sec. 3.10.

29. Ibid., sec. 3.11.

30. Ibid., sec. 3.28(c).

31. Ibid., sec. 3.28(d).

32. 38 C.F.R. sec. 17.165.

33. Subcommittee on Hospitals for the Committee on Veterans' Affairs, p. 768.

34. Ibid.

35. 38 C.F.R. sec. 17.182(b)(1).

36. Pub. L. 93-82, 87 Stat. 196.

37. Letter from Dr. Berry.

38. 38 C.F.R. sec. 17.180.

39. Letter from Dr. Berry.

40. Ibid.

41. 38 C.F.R. sec. 17.182.

42. U.S., Veterans' Administration, Status Report - Grants for Construction of State Extended Care Facilities, Grants for Remodeling, Modification or Alterations of Existing State Home Hospital or Domiciliary Facilities, COB 6/30/76.

43. Subcommittee on Hospitals for the Committee on Veterans' Affairs, p. 775.

44. Letter from Dr. Berry.

45. VA regulation 6171, as revised, November 10, 1975.

46. Pub. L. 88-450, 78 Stat. 500.

47. Pub. L. 91-178, 83 Stat. 836.

48. 38 USCA 5036.

49. Letter from Dr. Berry.

50. Ibid.

51. 20 C.F.R. sec. 17.173.

52. U.S., Veterans' Administration, Status Report - Grants for Construction of State Extended Care Facilities, Grants for State Nursing Home Construction, COB 6/30/76.

53. Subcommittee on Hospitals for the Committee on Veterans' Affairs, p. 775.

Chapter 6

1. U.S., Veterans' Administration, Administrator of Veterans Affairs, Annual Report, 1974 (Washington: 1974), pp. 206, 207.

2. U.S, Veterans' Administration, Administrator of Veterans Affairs, Annual Report, 1975 (Washington: 1975), pp. 200, 201.

3. Interview with Dr. William J. Vandervort, Health Clinic Director, Veterans Administration, June 28, 1976.

4. 38 USCA sec. 610.

5. Interview, Vandervort.

6. Interview with Edna Sakamoto, Social Services, Veterans' Administration, June 28, 1976.

7. Ibid.

Chapter 7

1. U.S., Bureau of the Census, Census of Population: 1970, Detailed Characteristics, Final Report PC(1)-D13 Hawaii (Washington, D.C.: U.S. Government Printing Office, 1972), Table 151, pp. 13-233.

2. Interview with Edna Sakamoto, Social Services, Veterans' Administration, June 28, 1976.

3. Bureau of the Census, 1970.

4. Hawaii, Department of Planning and Economic Development, The State of Hawaii, Data Book 1975, A Statistical Abstract (Honolulu: 1975), Table 149, p. 146.

5. Bureau of the Census, 1970.

6. Data Book 1975.

7. Presidential Proclamation No. 4373, issued May 7, 1975, declared May 7, 1975 to be the last day of the "Vietnam Era".

8. Bureau of the Census, 1970.

9. Data Book 1975.

10. Bureau of the Census, 1970.

11. Data Book 1975.

12. Ibid.

13. U.S., Veterans' Administration, Administrator of Veterans' Affairs, Annual Report, 1975 (Washington: 1975), p. 2.

14. Ibid.

15. Bureau of the Census, 1970.

Chapter 10

1. Hawaii, Department of Social Services and Housing, "Statistical Summary on Medical Assistance Program," April 1976.

2. Section 1902(a)(10)(A) of the Social Security Act, as amended, states that one of the eligibility requirements for receiving medicaid assistance is that the person be eligible to receive SSI payment. The resource limit is codified in Social Security Act, as amended, sec. 1611(a)(1)(B), 42 USCA sec. 1382(a)(1)(B), and Department of Social Services and Housing, Public Welfare Manual, sec. 3415(3).

3. Hawaii Public Employees Health Fund, Health Fund Benefits for State and County Employees and Retirees (Honolulu: 1976), p. 25.

4. U.S., Congress, House, Subcommittee on Hospitals of the Committee of Veterans' Affairs, Per Diem Allowances for State Homes; CHAMPVA Benefits for Certain Veterans' Survivors; VA Reimbursements for Health Care in Certain Cases; and VA Quality Care Study, 94th Cong., 1st Sess., 1975, Doc. 59-876, pp. 773, 774.

5. U.S., Veterans' Administration, Department of Medicine and Surgery, Operations, Manual M-1, Part I, ch. 3, sec. II (3.10)(c).

6. U.S., Veterans' Administration, Department of Medicine and Surgery, Program Guide, Professional Services, Nursing Home Care Units, G-1, M-2, part 1 (Washington: 1966), sec. 1.02.

7. See Table 23.

8. U.S., Bureau of the Census, Census of the Population: 1970, Detailed Characteristics, Final Report PC(1)-D13 Hawaii (Washington, D.C.: U.S. Government Printing Office, 1972), Table 151, pp. 13-233.

9. Hawaii, Department of Social Services and Housing, Public Welfare Manual, sec. 3308.

Chapter 11

1. Kuakini Medical Center, Application for a 3-Year Certificate of Need (Honolulu: 1975).

2. First Hawaiian Bank, Economic Indicators, various issues.

3. Ibid., November-December 1975.

4. Ibid., September 1976.

5. Interview with Sylvia L. Levy, Comprehensive Health Planning Officer, Department of Health, October 20, 1976.

6. Pub. L. 93-641, 88 Stat. 2225.

APPENDICES

(To be made one and ten copies) APPENDIX A

HOUSE OF REPRESENTATIVES
EIGHTH LEGISLATURE, 1976
STATE OF HAWAII

H.R. NO. 294

C
O
P
Y

HOUSE RESOLUTION

REQUESTING A STUDY ON THE FEASIBILITY OF ESTABLISHING A HAWAII STATE VETERANS HOME.

WHEREAS, veterans represent a special segment of the population who have contributed much to our country through military service; and

WHEREAS, at the present time there are approximately 93,000 veterans residing in Hawaii and the presence of a large number of veterans in the State would warrant the establishment of a Hawaii State veterans home; and

WHEREAS, there may be a future need for a Hawaii State veterans home as years move on for the aged and youthful veterans and therefore, it is important that its feasibility be determined as soon as possible; and

WHEREAS, because any implementation of a feasibility study requires many steps such as planning, land acquisition, funding and construction of the facility as well as management, operational funding, staffing and administrative costs, the timeliness of a feasibility study is important; and

WHEREAS, the federal government has already recognized the growing need for state veterans homes in the country and has made funds available for the cost of new construction or remodeling of existing facilities for such homes and domiciliary care payments for the residents of these homes; now, therefore,

BE IT RESOLVED by the House of Representatives of the Eighth Legislature of the State of Hawaii, Regular Session of 1976, that the Office of the Legislative Reference Bureau is requested to conduct a study on the feasibility of establishing a Hawaii State veterans home; and

BE IT FURTHER RESOLVED that the director of the Legislative Reference Bureau submit a report of his findings and recommendations to the Legislature twenty days prior to the convening of the Regular Session of 1977; and

BE IT FURTHER RESOLVED that a certified copy of this Resolution be transmitted to the director of the Legislative Reference Bureau.

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

JUL 2 2 1976

JUL 16 1976

IN REPLY
REFER TO: 181

Mr. Calvin Azama
Researcher
Legislative Reference Bureau
State Capitol Room 004
Honolulu, Hawaii 96813

Dear Mr. Azama:

I am pleased to respond to your letter of June 10 addressed to Ms. Marjorie R. Quandt. The responsibility for the State Home program was transferred in September 1975 to this office.

In addition to the requested materials, we have responded to the questions enclosed in your letter.

Please do not hesitate to contact Mr. Herman Hahn, State Home Program Coordinator (181), in my office, for any additional assistance you may require.

We are glad to learn that Hawaii continues to be interested in the State Home Program.

Sincerely yours,

Richard M Fuller
for BEDFORD H. BERREY, M.D.
Deputy Assistant Chief
Medical Director for
Extended Care

Enclosures

Show veteran's full name, VA file number, and social security number on all correspondence.

JUL 16 1976

181

Mr. Calvin Azama
Researcher
Legislative Reference Bureau
State Capitol Room 004
Honolulu, Hawaii 96813

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Please do not hesitate to contact Mr. Herman Hahn, State Home Program Coordinator (181), in my office, for any additional assistance you may require.

We are glad to learn that Hawaii continues to be interested in the State Home Program.

Sincerely yours,

BEDFORD H. BERREY, M.D.
Deputy Assistant Chief
Medical Director for
Extended Care

Enclosures

1. What are the reasons, if any, for the lack of VA nursing and domiciliary facilities in Hawaii?

It has been the VA policy to establish nursing homes and domiciliaries adjacent to a VA medical facility which can provide a broad spectrum of medical care when needed. As you know, the VA contracts for hospital and nursing home care services in your State.

2. Does the VA have minimum staffing requirements for state nursing homes? For state domiciliary homes?

The VA encourages the States to meet the staffing criteria for VA Nursing Home Care Units especially as it pertains to nurse staffing (see enclosed Program Guide and standards for nursing home care on Page 3-3 of State Home Manual). We have no staffing requirements for domiciliaries, however, the standards on page 3-3 of the State home manual necessitate staffing to meet the standards and provide the services required to meet VA recognition for the purposes of VA per diem aid. Too, it must be kept in mind that domiciliary members must have physical disabilities which prevent them from earning a living to be eligible for VA per diem. VA maintains 24-hour staff coverage in its domiciliaries in case of unexpected illnesses.

3. Can a veteran in a state home, if one is established, continue to utilize the VA hospital and medical services if necessary?

Veterans in a State home cre eligible for VA hospital and medical services, however, the VA per diem payment is discontinued on admission to a VA hospital. States are expected to provide services according to level of care furnished as mentioned below.

Or would the state assume complete responsibility if the veteran was in a state home?

The States responsibility pertaining to provision of medical care is described in the standards for care on Page 3-3 of the enclosed State home manual.

The following questions refer to the federal per diem aid as provided in Title 38 USCA 641:

4. Some states allow the admission of wives, widows, fathers, and mothers of eligible veterans into state veterans homes. Does the VA contribute per diem aid for these non-veteran dependents?

   VA does not contribute per diem aid for non-veteran dependents.

5. If Hawaii were to allow peacetime veterans into the state veterans home, would federal per diem aid apply to peacetime veterans?

   At present, Federal per diem aid payments are authorized for veterans of any war or of service after January 31, 1955.

6. Are there any indications of an increase in the federal per diem rate schedule?

   A number of bills were introduced by the 94th Congress to raise the per diem paid to States. Several of the bills are still under consideration.

The following questions refer to remodeling of domiciliaries and hospitals as provided in Title 38 USCA 644:

7. Is information available on the past projects and amounts spent on the domiciliary/hospital remodeling program? May we have whatever data are available?

   See Enclosures

8. Is there any information available on any future projects which would utilize hospital/domiciliary remodeling aid? If available, please furnish.

   States have submitted estimates of $4.3M for FY 1977. VA funds are committed in the order in which applications are received subject to availability of funds.

9. Does the aid provided for in Title 38 USCA 641 include the remodeling of a combination domiciliary/hospital facility?

   Yes.

10. According to Appendix A of section 17.171 of the *Code of Federal Regulations*, the maximum number of nursing home beds for Hawaii is calculated at 200 beds. Does this also apply as the maximum number of beds for a strictly domiciliary facility?

No. This is the number of State nursing home care beds which may be constructed with VA participation in a State.

11. Aid provided for by Title 38 USCA 644 applies to "...remodeling, modification or alteration..." of existing state hospitals and domiciliaries, and appears not to include expansion or construction of new buildings. Is this interpretation correct?

VA can only participate in the remodeling, etc., of existing facilities, i.e., those which have been recognized by the VA for purposes of VA per diem aid. The VA cannot participate in construction of new buildings and expansion of existing ones.

12. Are there any indications of an increase or extension of hospital/domiciliary aid?

Legislation has been introduced by the 94th Congress to permit VA to participate in new State home domiciliary construction in Alaska and Hawaii (S. 2908, S. 3090).

The following refers to nursing home construction aid as provided in Title 38 USCA 5031:

13. Is information available on the past projects and the amounts spent on the nursing home construction program? May we have whatever data are available?

See Enclosure.

14. Is there any information available on any future projects which would utilize nursing home construction aid? If available, please furnish.

During FY 1977 we expect to receive applications for VA grants in excess of the appropriation of $5M.

15. Does the aid provided for in Title 38 USCA 5031 include the construction of a combination domiciliary/nursing facility?

No. VA participation in new construction under 5031 U.S.C. 38 is limited to State nursing home care facilities. (See #11).

16. Does the maximum number of nursing home beds as established by VA regulation also apply to a combination domiciliary/nursing facility?

No. (See #10)

If, in a combination domiciliary/nursing facility, the amount of nursing beds is below the maximum, can the total number of both domiciliary and nursing beds exceed this maximum and still qualify for federal aid?

There is no limit on domiciliary beds for which per diem is claimed. The limit of nursing home beds in Appendix A to 17.71 CFR pertains to VA grants for new construction only.

17. Does the cost of construction of a nursing facility include the cost of purchasing a building?

No. VA does not participate in the purchase of land or buildings.

18. VA regulation (CFR 17.170(c)) appears to allow the remodeling and expansion as well as the construction of a nursing home facility. Is this interpretation correct?

Yes. VA also participates in the cost of equipment incident to construction for nursing home care.

19. Since the war veteran population of the state may vary from year to year, does the VA revise the maximum number of nursing beds a state qualifies for?

Yes

If so, when are the revised numbers applicable?

The regulation is changed yearly, usually after June 30. I have enclosed a prior revision which reflects 202 nursing home beds for Hawaii.

20. If Hawaii allows the admission of wives, widows, fathers, and mothers of eligible veterans, in regards to CFR 17.173(b)(1), are these occupants considered to be of the war veteran population?

No. State Nursing homes constructed with VA grants must have 90% veteran population. VA recognition requirements for State homes are in enclosed VA Regulation 6165. In order to be eligible a State established home must exist primarily for accomodations of war veterans, i.e. 51% of residents must be eligible for VA aid. As noted above use of a VA construction grant unde 5031 U.S.C. 38 increases the percentages of war veterans.

21. In computing the number of veteran-patients in the state home pursuant to CFR 17.173(b)(1), are peacetime veteran-patients considered to be of the war veteran population?

No.

22. If Hawaii were to plan construction for more than the maximum number of beds allowed, will the VA contribute aid for only the maximum, or will the application be totally disqualified?

VA can only participate in the construction of up to 2½ beds per 1000 war veterans.

23. Are there any indications of an increase or extension of nursing home construction aid?

No legislation has been introduced to extend or increase grants under 5031 U.S.C. 38.

24. Can a state obtain aid in two separate fiscal years for the same project?

Construction grants are committed for the duration of a project. VA reimburses States in the amount of VA participation. Five percent is witheld pending final fiscal audit.

25. Is there a period in which funds allotted through Title 38 USCA 5031 lapse if not used?

Yes, after three fiscal years.

26. If Hawaii receives VA aid for the construction or remodeling of a state veterans facility, can we receive other federal aid as well?

No. At least not for the scope of the project in which VA participates.

APPENDIX C

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

IN REPLY REFER TO: 181

NOV 8 1976

Mr. Calvin Azama
Researcher
Legislative Reference Bureau
State of Hawaii
State Capitol Room 004
Honolulu, Hawaii 96813

Dear Mr. Azama:

I am responding to the questions in your recent letter to Mr. Herman Hahn, State Home Program Coordinator, concerning VA per diem aid under the provisions of Title 38 U.S.C. 641.

(1) Can the VA per diem aid and Medicaid be used simultaneously toward the maintenance cost of a veteran in a State veterans home?

If the State establishes a State veterans home and if both Medicaid and VA per diem cannot be applied simultaneously, can the State choose the aid of the Medicaid program rather than the VA per diem?

Answer: VA per diem aid cannot exceed one-half of the cost of care to the State. In addition, total VA aid payments to a State for a fiscal year may not exceed the difference between the total amount collected by the State for maintenance from all veterans for whom aid is claimed and from all other sources on their behalf and the total costs in the aggregate for their maintenance for the year. The above does not bar use of Medicaid as far as the VA is concerned, however, we would advise you to get a response from DHEW on this question.

Answer: State may establish a veterans home and use Medicaid instead of VA per diem, providing Medicaid criteria are met. Should the State apply for VA recognition, the State would have to meet VA criteria as outlined in the attached VA Regulation 6165 to 6166. I might add that the requirement for war time service has been removed by the 94th Congress. (Public Laws 94-417 and PL 94-581). VA recognition would be necessary for the purpose of requesting VA per diem aid for the care of residents under the provisions of Section 641, U.S.C. 38. Additionally, VA recognition is necessary in case a State wishes to apply for construction grants for remodeling of existing hospital and domiciliary facilities under the provisions of Section 644, U.S.C. 38.

(2) Can veterans in a State veterans domiciliary home receive simultaneously VA per diem aid and benefits of the Supplemental Security Income Program, Title XVI of the Social Security Act?

Mr. Calvin Azama

Answer: VA per diem aid is not paid to the veteran, it is paid to the State or the designated State agency for the care of an eligible veteran. We suggest that you take up this question with DHEW after you modify the question as suggested by our answer.

Please let us know if we can be of further assistance to you.

Sincerely yours,

Richard N Filer

RICHARD N. FILER, Ph.D.
Acting Assistant Chief Medical
Director for Extended Care

Enclosure

APPENDIX D

LEGISLATIVE REFERENCE BUREAU
State of Hawaii
State Capitol Room 004
Honolulu, Hawaii 96813
Phone 548-6237

June 29, 1976

0246-A

Dear Sir:

The Legislative Reference Bureau is doing a study on whether we should build a state veterans home in Hawaii. Enclosed is House Resolution 294 of the legislative session of 1976 asking for the study. Under federal law, a state veterans home can include hospital, nursing, or boarding and care homes. It is important in the study to find out the number of veterans currently in these institutions. Since there is no up-to-date information on this matter, we are surveying the adult boarding homes, care homes, intermediate care facilities, and skilled nursing facilities. We need to know how many veterans are in your institution and the following things about each individual veteran in your institution. A veteran is any person who served in any branch of the United States armed forces.

a. The veteran's sex.

b. The veteran's age.

c. The years in which the veteran served in the armed forces.

d. The type of facility the veteran currently resides in: adult family boarding home, care home, intermediate care facility, or skilled nusring facility.

e. Whether the veteran is receiving a Veterans Administration pension or compensation payment.

f. The veteran's income level.

Enclosed is a questionnaire to fill in the information. We do not need the veteran's name.

The headings of the questionnaire and explanation of what they mean are as follows:

1 No.	2 Sex	3 Age	4 Years Served in Armed Forces	5 Type of Care: Adult Family Boarding	Care Home	Intermediate	Skilled Nursing	6 VA Benefits: Compensation	Pension	7 Income Level: $3,000-below	$3,001-$5,5000	$5,501-above

The numbers in Column 1 are used to replace the veteran's name since the veteran's name is not needed.

In Column 2, please fill in the veteran's sex; M for male and F for female.

In Column 3, please fill in the veteran's present age.

In Column 4, please fill in the years in which the veteran served in the armed forces.

In Column 5, please check the type of institution the veteran is currently in: adult family boarding home, care home, Intermediate care facility, skilled nursing facility.

In Column 6, if the veteran is receiving a Veterans Administration compensation or pension, please check the appropriate space. If the veteran is receiving neither, please leave the space blank.

In Column 7, please check the space which applies to the veteran's total annual income.

The following is an example of how to fill in the questionnaire. Assume a veteran is a male, 60 years old, and served in the army from 1940 to 1945. He also is in a skilled nursing facility, is receiving a VA pension, and has an annual income of $2,500.

No.	Sex	Age	Years Served in Armed Forces	Type of Care: Adult Family Boarding	Type of Care: Care Home	Type of Care: Intermediate	Type of Care: Skilled Nursing	VA Benefits: Compensation	VA Benefits: Pension	Income Level: $3,000-below	Income Level: $3,001-$5,5000	Income Level: $5,501-above
1.	M	60	1940 - 1945					✓		✓	✓	

We would greatly appreciate a response to the questionnaire as soon as possible, preferably before August 1, 1976. We have also enclosed a return addressed envelope for your convenience. The information we have asked for is very important to our study. If you have any questions, please call me at 548-6237.

Thank you for your time and help.

Very truly yours,

Calvin Azama

Calvin Azama
Researcher

CA:as

Enclosures

APPENDIX E

LEGISLATIVE REFERENCE BUREAU
State Capitol
Honolulu, Hawaii 96813

STATE VETERANS HOME QUESTIONNAIRE

1. What is the name and location of your state veterans home?

Name	Location

2. What is the governing authority of your state veterans home?

PHYSICAL ASPECTS

3. How large is your veterans home?

Structure Area	No. of Floors	Land Area (Exclusive of structure area)	Total Area

4. What category of accommodations are in operation in your state veterans home? How many beds are designated for each category of accommodation?

Category	No. of Beds
Domiciliary	_____
Nursing Home	_____
Hospital	_____
Other (please specify) _____	_____

5. What type of physical facilities does your state veterans home have? (Check all applicable)

a. Kitchen ___
b. Dining Room ___
c. Recreational Room ___
d. Rehabilitative/ Therapeutic Room ___
e. Doctor's Office ___
f. X-Ray Facilities ___
g. Caretaker's Home ___
h. Commandant's Home ___
i. Outdoor Leisure Area ___
j. Classrooms ___
k. Library ___
l. Others (please specify)
_____
_____
_____

6. Are the present facilities adequate for present and foreseeable future (next 3 years) use? Yes ___ No ___

Comments:

7. If your state veterans home is presently not operating at capacity, would the facilities be adequate if filled to the maximum? Yes ___ No ___

Comments:

8. If your state veterans home is presently operating at capacity, and a great demand for admission is apparent or a projected increase in application is foreseen, are there any plans to remodel, renovate, enlarge, or modify the present facility? Yes ___ No ___

Comments:

9. What facilities presently not available, could your state veterans home use?

Necessary	Not Necessary But Desirable
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT POPULATION

10. What are the eligibility requirements of a veteran for admission into your state veterans home? (Check all applicable)

a. Veteran of specific war or hostility ___
b. Honorable discharge ___
c. Other than dishonorable discharge ___
d. No requirement on type of discharge ___
e. Destitution, unable to support himself because of age or disability ___
f. Service-connected disability ___
g. Non-service-connected disability ___
h. State residency requirement (if so, what is the requirement) ___ _____
i. Age requirement (if so, what age) ___ _____
j. No conviction of a crime of moral turpitude or of a felony ___
k. No chronic illness (includes alcoholism, drug addiction) ___
l. Chronic illness of a certain type ___
m. Financial limitations (if so, what is the limitation) ___ _____
n. Others (please specify) _____ ___

11. Are other persons, related by blood or marriage to the veteran, eligible for admission into your state veterans home? Yes ___ No ___

12. If non-veterans are eligible for admission into your state veterans home, please fill in the following where applicable:

Eligible Non-Veterans (check all applicable)

a. Wife ___
b. Widow ___
c. Father ___
d. Mother ___
e. Others (please specify) _____

Eligibility Standards (check all applicable)

a. Husband/son is a patient in the home ___
b. Husband/son is eligible for admission into the home ___
c. Husband/son is a deceased, formerly eligible veteran ___
d. Marriage requirement (if so, for how long must they have been married) ___ _____
e. No remarriage ___
f. Age limitation (if so, what age) ___ _____
g. Financial limitation (if so, what is the limit) ___ _____
h. State residency requirement (if so, what is the requirement) ___ _____
i. Others (please specify) _____

13. What was the total number of veteran-patients, excluding wives, widows, etc., who were patients in the state veterans home in the fiscal year 1973-74? _____

During the fiscal year 1973-74, what was the average daily census of veteran-patients (total number of days each patient spent in the institution divided by 365 days) for each category of accommodation?

Category	Total Veteran-Patients	Average Daily Census
Domiciliary	_____	_____
Nursing Home	_____	_____
Hospital	_____	_____

14. If non-veterans are admitted into your state veterans home, what was the total number of these non-veterans and the average daily census for fiscal year 1973-74? _____

Category	Non-Veteran Patients	Average Daily Census
Domiciliary	_____	_____
Nursing Home	_____	_____
Hospital	_____	_____

15. If your state veterans home admits non-veterans, what is the policy on priority?

When a husband and wife, or a son and parent apply for admission, are they entered as a group? Yes ___ No ___

Is the veteran ever admitted before his spouse or parents can enter, e.g., because of lack of space? Yes ___ No ___

Comments:

16. Is there a waiting list of eligible veterans desiring to enter your state veterans home? Yes ___ No ___

If so, what is the total number on the waiting list?

Category	Number on Waiting List
Domiciliary	_____
Nursing Home	_____
Hospital	_____

17. What was the average age of the veterans in your state veterans home during fiscal year 1973-74? _____

18. What was the distribution of the patient population in the state veterans home by period of war or hostility during fiscal year 1973-74?

Note: The periods of war or hostilities are established by Congress. For veterans who served in two wars, please consider them to be in the category of the first war served in. In this manner, we hope to avoid double counting.

What was the average age of the veterans in each category?

	No.	Average Age
Spanish-American War (Apr. 21, 1898-July 15, 1903)	_____	_____
Mexican Border Period (May 9, 1916-Apr. 5, 1917)	_____	_____
World War I (Apr. 6, 1917-Apr. 1, 1920)	_____	_____
World War II (Dec. 7, 1941-Dec. 31, 1946)	_____	_____
Korean Conflict (June 27, 1950-Jan. 31, 1955)	_____	_____
Vietnam Era (Aug. 5, 1964-May 7, 1975)	_____	_____
Others (please specify)		
_____	_____	_____

19. Are patients in your state veterans home charged a fee? Yes ___ No ___

20. If patients are charged a fee, what is the fee and the fee requirements? (Fill in all applicable)

Fee Requirements	Fee
a. Fixed rate	_____
b. Dependent on per capita cost	_____
c. Rate at cost to home (no profit margin)	_____
d. Sliding scale in relation to income	_____
e. Others (please specify)	
_____	_____

21. When a patient in the state veterans home is financially destitute, and cannot pay the fee, are they allowed to remain? Yes ___ No ___

Is the fee requirement waived? Yes ___ No ___

22. Do non-veteran patients also qualify for federal per diem aid? Yes ___ No ___

If not, how is their cost distributed?

State Contribution	_____%
Federal Contribution	_____%
Patient	_____%

STAFF

23. What was the number of staff, classified by position, in your state veterans home? What was the salary range within these classifications?

Classification	No.	Salary Range
Professional	_____	_____
Para-Professional	_____	_____
Non-Professional	_____	_____

24. Is the composition and amount of staff at your state veterans home based on:

Capacity Population _____ *or* Actual Population ____

EXPENDITURES

25. What was the total operating cost in your state veterans home for the fiscal year 1973-74? Of the total cost, what was the staff payroll, equipment acquisition and maintenance cost, daily operating cost?

Staff Cost	Equipment Cost	Daily Operating	Total Cost

REVENUES

26. What was the proportion of the total revenues contributed by the federal government, state government, and the patient?

State Contribution	Federal Contribution	Patient Contribution	Municipal	Others (gifts, contributions)	Total

27. Listed below is the proportion of the per diem payments of a patient which is paid by the state government, federal government, and the patient. Are there any corrections? (The table is taken from the Annual Report, 1975, of the Veterans' Administration)

Category	Per Diem Cost	State %	Federal %	Patient %
Domiciliary	_____	_____	_____	_____
Nursing Home	_____	_____	_____	_____
Hospital	_____	_____	_____	_____

APPLICATION FOR FEDERAL AID

Title 38 USCA 5031 (Construction Aid to State Nursing Facilities)

28. Did your state utilize this type of federal aid? Yes ___ No ___

29. If so, how much did your state receive towards the construction of the state nursing facility? Total received _____

30. The language of this particular statute specifies "state nursing facilities". Did your state utilize this aid towards the construction of a hospital, domiciliary, or a combination domiciliary/nursing home? (Check all applicable)

Hospital ___ Domiciliary ___ Combination ___

31. Were there any problems in the application process? Yes ___ No ___

Title 38 USCA 644 ("...*remodeling, modification or alteration of existing hospital or domiciliary facilities in State homes...*")

32. Did your state utilize this type of federal aid? Yes ___ No ___

33. If so, how much did your state receive towards the remodeling of your existing state home? Total received _____

34. Were there any problems in the application process? Yes ___ No ___

GENERAL PHILOSOPHY

35. Why did your state establish a state veterans home?

36. What is your state's philosophy of the continuance of operating your state veterans home?

37. Does your state consider operations of the state veterans home to be a cost-sharing venture with the impetus on the federal government?

Or are the operations of your state veterans home primarily the responsibility of the state?

June 8, 1976

APPENDIX F

STATISTICAL SUMMARY ON MEDICAL ASSISTANCE PROGRAM
APRIL 1976, STATE OF HAWAII

During April 1976, HMSA processed and tabulated medical claims amounting to $5,875,219 (to be paid by DSSH).

The totals for the past six months are shown below:

1975-6	Total patients (1/)	Amount of claims (DSSH)	Average per patient	Percent of DSSH amount to total amount
November.....	43,063	$4,499,728	$104.49	92.4
December.....	44,644	$4,599,882	$103.03	90.0
January.....	46,725	$4,806,367	$102.86	91.6
February.....	42,411	$4,101,318	$ 96.70	92.9
March.....	47,369	$4,566,790	$ 96.41	92.4
April.....	49,321	$5,875,219	$119.15	91.7

Institutional claims. Of the total $5,875,219 claims processed in April 1976, $3,268,202 or 55.6 percent represented institutional claims covering inpatients in hospitals, skilled nursing facilities and intermediate care facilities. During the past six months, the percent of institutional and non-institutional claims to the total amount of monthly claims ran as follows:

1975-6	Total	Institutional	Non-institutional
November.....	100.0	54.6	45.4
December.....	100.0	52.5	47.5
January.....	100.0	52.8	47.2
February.....	100.0	53.4	46.6
March.....	100.0	48.6*	51.4* (Note change in percent her
April.....	100.0	55.6	44.4

The number of patients, the average cost per patient day, by type of institution are shown below by month:

	Number of patients				Average cost per patient day			
1975-6	Total	Hospital	Nursing	ICF	Total	Hospital	Nursing	ICF
November.....	3,394	1,834	1,209	351	$45.84	$136.45	$31.63	$22.81
December.....	3,220	1,549	1,267	404	$42.48	$130.55	$32.41	$23.76
January.....	3,560	1,805	1,270	485	$41.70	$134.34	$33.16	$23.73
February.....	3,095	1,559	1,196	340	$45.92	$148.55	$32.86	$23.25
March.....	3,012	1,314	1,230	468	$40.35	$127.42	$34.37	$23.56
April.....	4,194	2,426	1,321	447	$54.57	$146.08	$35.58	$23.37

(1/) The patient count is unduplicated

APPENDIX G

RELEVANT EXCERPTS FROM THE PRINTOUT OF SSI PAYMENTS
DATED AUGUST 5, 1976
PROVIDED BY THE DEPARTMENT OF SOCIAL SERVICES AND HOUSING

	Oahu	Hawaii	Maui	Kauai	Total	
Level I	183	5	2	17	207	No. of individuals
	102	5	2	8	117	No. of males
	81	--	--	9	90	No. of females
	18,733	364	91	1,839	21,027	Fed. share ($)
	15,866	365	140	1,556	17,927	State share ($)
Level II	385	23	22	43	473	No. of individuals
	193	19	16	31	259	No. of males
	192	4	6	12	214	No. of females
	37,199	1,569	1,838	3,320	43,926	Fed. share ($)
	51,531	3,149	2,855	5,656	63,191	State share ($)
Level III	554	60	21	57	692	No. of individuals
	250	34	9	36	329	No. of males
	304	26	12	21	363	No. of females
	51,018	4,401	1,594	4,927	61,940	Fed. share ($)
	105,524	11,206	4,131	10,961	131,822	State share ($)