HOUSE BILL No. 1349

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-15.8; IC 12-7-2-154.8; IC 12-14-2-1; IC 12-15; IC 12-16; IC 12-29-1-7; P.L.260-1997, SECTION 8.

Synopsis: Disproportionate share providers. Provides that a county office of family and children may not consider $4,500 of equity value in a motor vehicle when determining the eligibility of a child for assistance under Indiana's Title IV-A program (Temporary Assistance to Needy Families). Provides that the office of Medicaid policy and planning may not consider $4,500 of equity value in one motor vehicle belonging to an applicant or a recipient or a member of an applicant's or a recipient's family when the office of Medicaid policy and planning applies a resource standard to determine the eligibility of an applicant or to redetermine the eligibility of a recipient for Medicaid. Allows disproportionate share providers to determine the presumptive

(Continued next page)

Effective: Upon passage; July 1, 1997 (retroactive); April 1, 1998; July 1, 1998.

Crawford, Buell

January 13, 1998, read first time and referred to Committee on Ways and Means.

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eligibility of pregnant women and children for Medicaid. Allows a pregnant woman or the parent or guardian of a child who is presumptively eligible for Medicaid to select a representative of the disproportionate share provider to serve as the child's or pregnant woman's authorized representative in interactions with the county office of family and children to determine Medicaid eligibility. Requires a disproportionate share provider that makes presumptive eligibility determinations to reimburse the office of Medicaid policy and planning for all funds expended in providing care for a presumptively eligible individual if the individual is found not eligible for Medicaid. Provides that applications for Medicaid may be made at a disproportionate share provider or county office of family and children in the county where the applicant resides. Creates a Medicaid shortfall program for governmentally owned hospitals that do not receive reimbursement in an amount that compensates the hospitals for the costs associated with delivering Medicaid services. Finances the state's share of the program through intergovernmental transfers. Creates a new disproportionate share program for municipal hospitals that provides reimbursement for a portion of each hospital's services to indigent patients that is not otherwise reimbursed. Provides that a municipal hospital that has Medicaid volume greater than one percent of the hospital's total volume is eligible to participate in the program. Requires a hospital that wishes to participate in the program to provide an intergovernmental transfer. Creates a similar program for community mental health centers. Provides that certain funds within the health care for the indigent program fund may be deposited into the Medicaid indigent care trust fund to pay the state's share of enhanced disproportionate share payments to qualifying providers. Removes an annual $35,000,000 appropriation from the state hospital care for the indigent fund that was used to help pay for current obligations of the Medicaid program. Repeals provisions that do the following: (1) Provide a formula for computing a hospital's per diem rate that is added to the hospital's base inpatient payment rate. (2) Require certain entities to make certain intergovernmental transfers during state fiscal year 1997. (3) Base a hospital's enhanced disproportionate share payment adjustments on data reported during calendar year 1991. Makes other changes to the basic and enhanced disproportionate share provider programs.

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Introduced

Second Regular Session 110th General Assembly (1998)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1997 General Assembly.

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HOUSE BILL No. 1349

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-15.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 15.8. "Approved claim", for purposes of IC 12-15-15-9, has the meaning set forth in IC 12-15-15-9(a).**

SECTION 2. IC 12-7-2-154.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 154.8. "Qualified entity", for purposes of IC 12-15-2.2, has the meaning set forth in IC 12-15-2.2-2.**

SECTION 3. IC 12-14-2-1, AS AMENDED BY P.L.15-1997, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) After the investigation under IC 12-14-1-6, the county office shall decide the following:

(1) Whether the child is eligible for assistance under this article.

(2) The amount of assistance.

(3) The date assistance begins.

(b) The county office may not consider:

(1) money in an individual development account under IC 4-4-28 that belongs to the child or a member of the child's family; **or**

(2) four thousand five hundred dollars ($4,500) of equity value (as defined in 470 IAC 10.1-3-1) in one (1) motor vehicle that belongs to a member of the child's family;

when determining whether the child is eligible for assistance under this article.

SECTION 4. IC 12-15-2-22 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 22. When the office applies a resource standard to determine an applicant's or a recipient's eligibility for Medicaid under this chapter, the office may not consider four thousand five hundred dollars ($4,500) of equity value (as defined in 470 IAC 10.1-3-1) in one (1) motor vehicle belonging to:**

(1) the applicant or recipient; or

(2) a member of the applicant's or recipient's family.

SECTION 5. IC 12-15-2.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 2.2. Presumptive Eligibility for Pregnant Women and Children

Sec. 1. This chapter applies to an individual who may be eligible for Medicaid under IC 12-15-2-11 through IC 12-15-2-15.5.

Sec. 2. As used in this chapter, "qualified entity" means an entity that is:

(1) a disproportionate share provider under IC 12-15-16-1(a);

(2) an enhanced disproportionate share provider under IC 12-15-16-1(b);

(3) a municipal disproportionate share provider under IC 12-15-16-1(c); or

(4) a community mental health center disproportionate share provider under IC 12-15-16-1(d).

Sec. 3. (a) An entity described in section 2(1), (2)(3), or 2(4) of this chapter may apply to the office, on a form provided by the office, for authorization to be a qualified entity under this chapter.

(b) An entity described in section 2(2) of this chapter is presumed to be a qualified entity.

Sec. 4. The office shall provide each qualified entity with the following:

(1) Application forms for Medicaid.

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(2) Information on how to assist pregnant women, parents, guardians, and other individuals in completing and filing the application forms.

Sec. 5. The office shall provide Medicaid services to a child or pregnant woman during a period that:

(1) begins on the date on which a qualified entity determines, on the basis of preliminary information, including a certified copy of the previous year's tax return or a recent pay stub, that the family income of the child or pregnant woman does not exceed the applicable family income level of eligibility for the child or pregnant woman for Medicaid under IC 12-15-2; and

(2) ends on the earlier of the following:

(A) The date on which a determination is made by a representative of the county office with respect to the eligibility of the child or pregnant woman for Medicaid under IC 12-15-2.

(B) The last day of the month following the month in which the qualified entity makes the determination described in subdivision (1).

Sec. 6. A qualified entity that determines that a child or pregnant woman is presumptively eligible for Medicaid shall do the following:

(1) Notify the office of the determination within five (5) working days after the date on which the presumptive eligibility determination is made.

(2) Inform the parent, guardian, or custodian of the child or the pregnant woman that an application for Medicaid is required to be made at:

(A) a disproportionate share provider;

(B) an enhanced disproportionate provider;

(C) a municipal disproportionate share provider;

(D) a community mental health center disproportionate share provider; or

(E) a county office of family and children;

located in the county where the child or the pregnant woman resides not later than the last day of the month following the month during which the determination is made.

Sec. 7. If a child or pregnant woman is found presumptively eligible for Medicaid under this chapter, the:

(1) child's parent, guardian, or custodian; or

(2) pregnant woman;

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shall complete an application for Medicaid as required by IC 12-15-4 not later than the last day of the month following the month during which the determination is made.

Sec. 8. If a child or pregnant woman:

(1) is found presumptively eligible for Medicaid under this chapter; and

(2) appoints an agent of the qualified entity as the child's or pregnant woman's authorized representative;

the county office may not require a face to face interview with the child's parent, guardian, or custodian or with the pregnant woman to determine the child's or pregnant woman's eligibility for Medicaid.

Sec. 9. If a child or pregnant woman is:

(1) found presumptively eligible for Medicaid under this chapter; and

(2) not eligible for Medicaid after filing an application for Medicaid as required by section 7 of this chapter;

the qualified entity that found the child or pregnant woman presumptively eligible for Medicaid shall reimburse the office for funds expended by the office in paying for care for the child or pregnant woman during the child's or pregnant woman's period of presumptive eligibility.

Sec. 10. The office shall adopt rules under IC 4-22-2 to implement this chapter.

SECTION 6. IC 12-15-4-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. **(a)** An application or a request for Medicaid for an individual must be **made:**

(1) ~~made to the county office of the county in which the applicant resides; and~~

~~(2)~~ in the manner required by the office; **and**

(2) at one (1) of the following locations in the county where the applicant resides:

(A) A disproportionate share provider under IC 12-15-16-1(a).

(B) An enhanced disproportionate share provider under IC 12-15-16-1(b).

(C) A municipal disproportionate share provider under IC 12-15-16-1(c).

(D) A community mental health center disproportionate share provider under IC 12-15-16-1(d).

(E) The county office.

(b) At least one (1) employee of a provider described in

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subsection (a)(2)(A) through (a)(2)(D) shall:

(1) accept applications for Medicaid; and

(2) conduct interviews with applicants.

(c) The office shall provide a provider described in subsection (a)(2)(A) through (a)(2)(D) with the materials and training needed by the provider to comply with this section.

(d) A provider described in subsection (a)(2)(A) through (a)(2)(D) shall forward:

(1) an application taken by the location; and

(2) accompanying materials;

to the county office located in the same county as the provider at least one (1) time each week. The county office shall make the final determination of an applicant's eligibility for Medicaid upon receiving an application under this subsection.

SECTION 7. IC 12-15-15-1.1 IS ADDED AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE APRIL 1, 1998]: **Sec. 1.1. (a) This section applies to a hospital that is:**

(1) licensed under IC 16-21; and

(2) owned and operated under IC 16-22 or IC 16-23.

(b) For a state fiscal year ending after June 30, 1997, in addition to reimbursement received under section 1 of this chapter, a hospital is entitled to reimbursement in an amount calculated from the hospital's cost report filed with the office for the hospital's fiscal period ending during the state fiscal year, equal to the difference between:

(1) the amount of payments to the hospital under this article, excluding payments under IC 12-15-16 and IC 12-15-19, for services provided by the hospital during the state fiscal year; and

(2) an amount equal to the lesser of the following:

(A) The hospital's customary charges for the services described in subdivision (1).

(B) A reasonable estimate by the office of the amount that must be paid for the services described in subdivision (1) under Medicare payment principles.

(c) Subject to subsection (e), reimbursement under this section consists of a single payment made as follows:

(1) For the state fiscal year ending June 30, 1998, the payment for a hospital filing the hospital's cost report with the office, before April 1, 1998, for the hospital's fiscal period ending during the state fiscal year, must be made not later than June 1, 1998.

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(2) For the state fiscal year ending June 30, 1998, the payment for a hospital filing the hospital's cost report with the office, after March 31, 1998, and before July 1, 1998, for the hospital's fiscal period ending during the state fiscal year, must be made not more than sixty (60) days after the report is filed with the office.

(3) For state fiscal years ending after June 30, 1998, the payment must be made not more than thirty (30) days after the hospital's cost report, for the hospital's fiscal period ending during the state fiscal year, is filed with the office.

A payment described in this subsection is not due to a hospital unless an intergovernmental transfer is made under subsection (d).

(d) Subject to subsection (e), a hospital may make an intergovernmental transfer, or an intergovernmental transfer may be made on behalf of the hospital, as follows:

(1) For the state fiscal year ending June 30, 1998, for a hospital filing the hospital's cost report with the office, before April 1, 1998, for the hospital's fiscal period ending during the state fiscal year, the intergovernmental transfer may be made not later than June 1, 1998.

(2) For the state fiscal year ending June 30, 1998, for a hospital filing the hospital's cost report with the office, after March 31, 1998, but before July 1, 1998, for the hospital's fiscal period ending during the state fiscal year, the intergovernmental transfer may be made not more than sixty (60) days after the cost report is filed with the office.

(3) For state fiscal years ending after June 30, 1998, the intergovernmental transfer may be made not more than thirty (30) days after the cost report is filed with the office.

An intergovernmental transfer under this subsection shall be made to the Medicaid indigent care trust fund in an amount equal to eighty-five percent (85%) of the amount determined under subsection (b). The intergovernmental transfer must be used to pay the state's share of enhanced disproportionate share payments under IC 12-15-20-2(1).

(e) An entity making an intergovernmental transfer under subsection (d) may appeal under IC 4-21.5 the amount determined by the office to be paid under subsection (b). The periods described in subsections (c) and (d) are tolled pending the administrative appeal and any judicial review initiated by the hospital under IC 4-21.5.

SECTION 8. IC 12-15-15-9 IS ADDED TO THE INDIANA CODE

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AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 9. (a) As used in this section, "approved claim" means a claim for care provided to a patient who satisfies the financial and medical eligibility requirements for the hospital care for the indigent program under IC 12-16. The term includes a determination made under an administrative appeal or a judicial review under the hospital care for the indigent program.**

(b) For each state fiscal year ending after June 30, 1998, a hospital having one (1) or more approved claims during a state fiscal year under the hospital care for the indigent program under IC 12-16 shall receive payment as provided in subsection (c).

(c) A pool in an amount equal to the amount transferred under IC 12-16-14-11 from the state hospital care for the indigent fund during the state fiscal year shall be funded during the state fiscal year. Not more than sixty (60) days after the end of the state fiscal year, the funds in the pool shall be distributed to hospitals having one (1) or more approved claims during the state fiscal year in proportion to the total dollar amount each hospital would have been paid if the hospital's approved claims during the state fiscal year were calculated under IC 12-16-9-1.

SECTION 9. IC 12-15-16-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1. (a) A provider under IC 12-15-17 is a basic disproportionate share provider if the provider's:

(1) Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana; however, the Medicaid inpatient utilization of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient utilization rate; **or**

(2) low income utilization rate exceeds twenty-five percent (25%). ~~or~~

~~(3) Medicaid inpatient days are equal or greater than twenty thousand (20,000) days per year.~~

(b) An acute care hospital licensed under IC 16-21 ~~that, based on utilization and revenue data for the cost reporting period appropriate to determine eligibility for enhanced disproportionate share adjustments as of July 1, 1992, had a minimum of six thousand (6,000) Medicaid inpatient days and a minimum of seven hundred fifty (750) Medicaid discharges~~ is an enhanced disproportionate share provider under either of the following conditions:

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(1) If the provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana. However, the Medicaid inpatient utilization rate of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient utilization rate.

(2) If the provider's low income utilization rate exceeds twenty-five percent (25%).

(c) An acute care hospital licensed under 16-21 is a municipal disproportionate share provider if the hospital:

(1) has a Medicaid utilization rate greater than one percent (1%); and

(2) is owned and operated under IC 16-22 or IC 16-23.

(d) A community mental health center that provides inpatient services to Medicaid patients is a community mental health center disproportionate share provider if the community mental health center's Medicaid utilization rate is greater than one percent (1%).

~~(c)~~ **(e)** A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. However, this obstetric service requirement does not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

(f) The determination of a provider's status as a disproportionate share provider under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office.

SECTION 10. IC 12-15-16-2, AS AMENDED BY P.L.156-1995, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 2. (a) For purposes of basic, ~~and~~ enhanced, **municipal, and community mental health center** disproportionate share, a provider's Medicaid inpatient utilization rate is a fraction (expressed as a percentage) where:

(1) the numerator is the provider's total number of Medicaid and hospital care for the indigent program (IC 12-16-2) inpatient days ~~for a fixed cost reporting period specified in state rules;~~ **in the**

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most recent year for which an audited cost report is on file with the office; and

(2) the denominator is the total number of the provider's inpatient days in the ~~same reporting period determined under section 1(b) of this chapter.~~ **most recent year for which an audited cost report is on file with the office.**

(b) For purposes of this section, "inpatient days" includes days provided by an acute care excluded distinct part subprovider unit of the provider and inpatient days attributable to Medicaid beneficiaries from other states. The term also includes inpatient days attributable to Medicaid managed care recipients.

SECTION 11. IC 12-15-16-5, AS AMENDED BY P.L.156-1995, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 5. (a) The office may not implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, or IC 12-15-20 until the federal Health Care Financing Administration has issued its approval of the amended state plan for medical assistance.

(b) The office may determine not to continue to implement this chapter, IC 12-15-17, IC 12-15-18, IC 12-15-19, and IC 12-15-20 if federal financial participation is not available.

(c) If federal financial participation is approved for less than all of the amounts paid into the Medicaid indigent care trust fund with respect to a fiscal year, the office may reduce payments attributable to that fiscal year under IC 12-15-19-1 ~~and IC 12-15-19-2~~ by a percentage sufficient to compensate for the aggregate reduction in federal financial participation. If additional federal financial participation is subsequently approved with respect to payments into the Medicaid indigent care trust fund for the same fiscal year, the office shall distribute such amounts using the percentage that was used to compensate for the prior reduction in federal financial participation.

SECTION 12. IC 12-15-16-6, AS AMENDED BY P.L.24-1997, SECTION 49, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 6. (a) As used in this section, "low income utilization rate" refers to the low income utilization rate described in section 3 of this chapter.

(b) As used in this section, "Medicaid inpatient utilization rate" refers to the Medicaid inpatient utilization rate described in section 2(a) of this chapter.

(c) Hospitals that qualify for basic disproportionate share under section 1(a) of this chapter shall receive disproportionate share payments as follows:

(1) For each of the state fiscal years ending after June 30, 1996,

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a pool not exceeding eight million dollars ($8,000,000) shall be distributed to all hospitals licensed under IC 16-21 that qualify under section 1(a)(1) of this chapter. The funds in the pool must be distributed to qualifying hospitals in proportion to each hospital's Medicaid day utilization and Medicaid discharge rate, as determined based on data from the most recent audited cost report on file with the office.

(2) For each of the state fiscal years ending June 30, 1994 and 1995, a pool of zero dollars ($0) shall be distributed to all hospitals licensed under IC 16-21 that qualify under section 1(a)(2) of this chapter. The funds in the pool must be distributed to qualifying hospitals in proportion to each hospital's low income utilization rate.

(3) Hospitals licensed under IC 16-21 that qualify under both section 1(a)(1) and 1(a)(2) of this chapter shall receive a disproportionate share payment in accordance with subdivision (1).

(4) For each of the state fiscal years ending after June 30, 1995, a pool not exceeding two million dollars ($2,000,000) shall be distributed to all private psychiatric institutions licensed under IC 12-25 that qualify under either section 1(a)(1) or 1(a)(2) of this chapter. The funds in the pool must be distributed to the qualifying institutions in proportion to each institution's Medicaid day utilization rate, as determined based on data from the most recent audited cost report on file with the office.

(5) A pool not exceeding one hundred ninety-one million dollars ($191,000,000) for the state fiscal year ending June 30, 1995, shall be distributed to all state mental health institutions under IC 12-24-1-3 that qualify under either section 1(a)(1) or 1(a)(2) of this chapter. The funds in a pool must be distributed to each qualifying institution in proportion to each institution's low income utilization rate, as determined based on the most recent data on file with the office.

~~(6) For each of the state fiscal years ending after June 30, 1994, a pool not exceeding eighteen million dollars ($18,000,000) shall be distributed to all hospitals licensed under IC 16-21 that qualify under section 1(a)(3) of this chapter. The funds in the pool must be distributed to qualifying hospitals in proportion to each hospital's Medicaid day utilization rate and total patient days, as determined based on data from the most recent audited cost report on file with the office. Payments under this subdivision are in place of the payments made under subdivisions (1) and (2).~~

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(d) Disproportionate share payments described in this section shall be made on an interim basis throughout the year, as provided by the office.

(e) For years ending after June 30, 1995, the individual pools shall be adjusted by a ratio, the numerator of which is the Medicaid payments for hospital inpatient services for the state's most recent fiscal year, and the denominator of which is the Medicaid payments for hospital inpatient services for the state's fiscal year preceding the state's most recent fiscal year.

(f) For years ending after June 30, 1994, eligibility for basic disproportionate share payments under this section shall be based on data from the most recent year for which audited cost reports are on file with the office for all potentially eligible hospitals on June 30 of the immediately preceding state fiscal year.

SECTION 13. IC 12-15-18-5.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 5.1. (a) Beginning July 1, 1998, the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 are authorized to make intergovernmental transfers to the Medicaid indigent care trust fund in amounts to be determined jointly by the office, the trustees, and each municipal health and hospital corporation.**

(b) The treasurer of state shall annually transfer from appropriations made for the division of mental health sufficient money to provide the state's share of payments under IC 12-15-16-6(c)(5).

(c) The office shall coordinate the transfers from the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 so that the aggregate intergovernmental transfers, when combined with federal matching funds:

(1) produce payments to each hospital licensed under IC 16-21 that qualifies as an enhanced disproportionate share provider under IC 12-15-16-1(b); and

(2) both individually and in the aggregate do not exceed limits prescribed by the United States Health Care Financing Administration.

The trustees and a municipal health and hospital corporation are not required to make intergovernmental transfers under this section.

(d) A municipal disproportionate share provider (as defined in IC 12-15-16-1(c)) shall transfer to the Medicaid indigent care trust fund an amount determined jointly by the office and the municipal

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disproportionate share provider. A municipal disproportionate share provider is not required to make intergovernmental transfers under this section.

(e) A county treasurer making a payment under IC 12-29-1-7(b) to a community mental health center qualifying as a community mental health center disproportionate share provider shall certify that the payment represents expenditures that are eligible for federal financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county treasurer in making this certification.

(f) The trustees and:

(1) a municipal health and hospital corporation under subsection (a); or

(2) a municipal disproportionate share provider under subsection (d);

may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(c).

SECTION 14. IC 12-15-18-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: **Sec. 7. (a) For each state fiscal year ending after June 30, 1998, an amount determined under subsection (b) shall be:**

(1) transferred to the Medicaid indigent care trust fund under IC 12-15-20-2(1); and

(2) used to pay the state's share of the enhanced disproportionate share payments to providers for the state fiscal year.

(b) The amount described in subsection (a) is the product determined under STEP TWO of the following formula:

STEP ONE: Determine the difference between:

(A) the amount transferred from the hospital care for the indigent fund under IC 12-16-14-11 during the fiscal year; and

(B) thirty-five million dollars ($35,000,000).

STEP TWO: Multiply the remainder determined under STEP ONE by the federal medical assistance percentage.

SECTION 15. IC 12-15-19-1, AS AMENDED BY P.L.24-1997, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 1. (a) For the state fiscal year ending June 30, 1997, each hospital licensed under IC 16-21 that

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qualifies as an enhanced disproportionate share provider under IC 12-15-16-1(b) shall receive additional enhanced disproportionate share adjustments, based on utilization data for the hospital's cost reporting period ending during calendar year 1991, subject to the hospital specific limit specified in subsection (d), as follows:

(1) For hospitals with a Medicaid inpatient utilization rate of fifteen percent (15%) or less and less than twenty-five thousand (25,000) total adult and pediatric days of Medicaid care:

(A) one hundred sixty-three dollars ($163) for each Medicaid inpatient day; and

(B) one thousand one hundred eleven dollars ($1,111) for each Medicaid discharge.

(2) For hospitals with a Medicaid inpatient utilization rate of greater than fifteen percent (15%) and less than twenty thousand (20,000) total adult and pediatric Medicaid days:

(A) two hundred fifteen dollars ($215) for each Medicaid inpatient day; and

(B) one thousand one hundred thirty-two dollars ($1,132) for each Medicaid discharge.

(3) For hospitals with a Medicaid inpatient utilization rate of greater than twenty percent (20%) and less than twenty-five thousand (25,000) total adult and pediatric Medicaid days:

(A) two hundred forty-one dollars ($241) for each Medicaid inpatient day; and

(B) one thousand one hundred thirty-three dollars ($1,133) for each Medicaid discharge.

(4) For hospitals with less than four thousand (4,000) Medicaid discharges and at least twenty-five thousand (25,000) total adult and pediatric Medicaid days:

(A) two hundred forty-six dollars ($246) for each Medicaid inpatient day; and

(B) two thousand four hundred sixty-five dollars ($2,465) for each Medicaid discharge.

(5) For hospitals with at least four thousand (4,000) Medicaid discharges and at least twenty-five thousand (25,000) total adult and pediatric Medicaid days:

(A) five hundred twenty-five dollars ($525) for each Medicaid inpatient day; and

(B) three thousand seven hundred sixty-five dollars ($3,765) for each Medicaid discharge.

However, the office may adjust the rates specified in this subsection only to the extent necessary to obtain approval from the federal

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government of the amendments to the Indiana Medicaid plan that are required to implement the rates specified in this subsection and may make additional payments as provided in subsection (c).

(b) For each state fiscal year ending on or after June 30, 1998, the office shall develop an enhanced disproportionate share payment methodology that ensures that each enhanced disproportionate share provider receives total disproportionate share payments that do not exceed its hospital specific limit specified in subsection (d). The methodology developed by the office shall ensure that hospitals operated by the governmental entities described in ~~IC 12-15-18-5(a)~~ **IC 12-15-18-5.1(a)** receive, to the extent practicable, basic and enhanced disproportionate share payments equal to their hospital specific limits.

(c) The office shall include a provision in each amendment to the state plan regarding enhanced disproportionate share payments that the office submits to the federal Health Care Financing Administration that, as provided in 42 CFR 447.297(d)(3), allows the state to make additional enhanced disproportionate share expenditures after the end of each federal fiscal year that relate back to the prior federal fiscal year. Each eligible hospital may receive an additional enhanced disproportionate share adjustment ~~based on utilization data for the hospital's cost reporting period that ended during calendar year 1991,~~ if:

(1) additional intergovernmental transfers are made as authorized under ~~IC 12-15-18-5(c);~~ **IC 12-15-18-5.1;** and

(2) the total disproportionate share payments to:

(A) each individual hospital; and

(B) all qualifying hospitals in the aggregate;

do not exceed the limits provided by federal law and regulation.

(d) Total basic and enhanced disproportionate share payments to a hospital under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account any data provided by each hospital for each hospital's most recent fiscal year (or in cases where a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data ending at the end of the most recent fiscal year) as certified to the office by:

(1) an independent certified public accounting firm if the hospital is a hospital licensed under IC 16-21 that qualifies under ~~IC 12-15-16-1(a)(3);~~ **IC 12-15-16-1(a);** or

(2) the budget agency if the hospital is a state mental health

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institution listed under IC 12-24-1-3 that qualifies under either IC 12-15-16-1(a)(1) or IC 12-15-16-1(a)(2);

in accordance with this subsection and federal laws, regulations, and guidelines.

SECTION 16. IC 12-15-19-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 8. (a) A provider that qualifies as a municipal disproportionate share provider under IC 12-15-16-1(c) shall receive a disproportionate share adjustment, subject to the provider's hospital specific limits described in subsection (b), as follows:**

(1) For each state fiscal year ending on or after June 30, 1998, a pool shall be distributed to each provider qualifying as a municipal disproportionate share provider under IC 12-15-16-1(c). The pool shall not exceed the sum of all hospital specific limits for all qualifying providers.

(2) For each provider qualifying under IC 12-15-16-1(c) to receive basic disproportionate share payments under IC 12-15-16-1(a) or enhanced disproportionate share payments under IC 12-15-16-1(b), the amount in subdivision (1) shall be reduced by the amount of basic disproportionate share payments and enhanced disproportionate share payments received by the provider. The office shall develop a municipal disproportionate share provider payment methodology that ensures that each municipal disproportionate share provider receives municipal disproportionate share payments that do not exceed the provider's hospital specific limit specified in subsection (b). The methodology developed by the office shall ensure that a municipal disproportionate share provider receives, to the extent possible, municipal disproportionate share payments that, when combined with basic disproportionate share payments or enhanced disproportionate share payments owed to the provider, equals the provider's hospital specific limits.

(b) Total basic, enhanced, and municipal disproportionate share payments to a provider under this chapter and IC 12-15-16 shall not exceed the hospital specific limit provided under 42 U.S.C. 1396r-4(g). The hospital specific limit for a state fiscal year shall be determined by the office taking into account data provided by each hospital for the hospital's most recent fiscal year or, if a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data ending at the end

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of the most recent state fiscal year, as certified to the office by an independent certified public accounting firm.

SECTION 17. IC 12-15-19-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 9. (a) For each state fiscal year ending after June 30, 1997, a community mental health center that qualifies as a community health center disproportionate share provider under IC 12-15-16-1(d) shall receive disproportionate share payments in an amount determined under STEP 4 of the following formula:**

STEP 1: Determine the amount paid to the community mental health center during the state fiscal year under IC 12-29-1-7(b).

STEP 2: Multiply the amount determined under STEP 1 by a percentage equal to the state's medical assistance percentage for the state fiscal year.

STEP 3: Add the amount determined under STEP 1 and the product determined under STEP 2.

STEP 4: Subtract the amount transferred to the community mental health center during the state fiscal year under IC 12-29-1-7(b) from the sum determined under STEP 3.

(b) Total basic and community mental health center disproportionate share payments under this chapter and IC 12-15-16 to a community mental health center qualifying under IC 12-15-16-1(d) may not exceed the institution specific limit provided under 42 U.S.C. 1396r-4(g). The institution specific limit for a state fiscal year shall be determined by the office taking into account data provided by the community mental health center for the community mental health center's most recent fiscal year or, if a change in fiscal year causes the most recent fiscal period to be less than twelve (12) months, twelve (12) months of data compiled to the end of the most recent state fiscal year, as certified to the office by an independent certified public accounting firm.

SECTION 18. IC 12-15-19-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: **Sec. 10. If the state exceeds the state disproportionate share allocation (as defined in 42 U.S.C. 1396r-4(f)(2), the state shall pay providers as follows:**

(1) The state shall make basic disproportionate share provider payments under IC 12-15-16-1(a) until the state exceeds the state disproportionate share allocation.

(2) After the state makes all payments under subdivision (1),

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if the state fails to exceed the state disproportionate share allocation, the state shall make enhanced disproportionate share provider payments under IC 12-15-16-1(b).

(3) After the state makes all payments under subdivision (2), if the state fails to exceed the state disproportionate share allocation, the state shall make municipal disproportionate share provider payments under IC 12-15-16-1(c).

(4) After the state makes all payments under subdivision (3), if the state fails to exceed the state disproportionate share allocation, the state shall make community mental health center disproportionate share provider payments under IC 12-15-16-1(d).

SECTION 19. IC 12-15-20-2, AS AMENDED BY P.L.24-1997, SECTION 50, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 2. The Medicaid indigent care trust fund is established to pay the state's share of the following:

(1) Enhanced disproportionate share payments to providers under IC 12-15-19.

(2) Disproportionate share payments and significant disproportionate share payments for certain outpatient services under IC 12-15-17-3.

(3) Medicaid payments for pregnant women described in IC 12-15-2-13 and infants and children described in IC 12-15-2-14, IC 12-15-2-15, and IC 12-15-2-15.5.

(4) Municipal disproportionate share payments to providers under IC 12-15-19-8.

SECTION 20. IC 12-16-3-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. (a) An Indiana resident who meets the income and resource standards established by the division under section 3 of this chapter is eligible for assistance to pay for any part of the cost of care provided in a hospital in Indiana that was necessitated after the onset of a medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following:

(1) Placing the individual's life in jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of a bodily organ or part.

An Indiana resident who is pregnant and is in active labor satisfies the medical condition required under this subsection.

(b) A qualified resident is also eligible for assistance to pay for the part of the cost of care that is a direct consequence of the medical

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condition that necessitated the emergency care.

SECTION 21. IC 12-16-7-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 1. **(a)** The division shall pay the following, subject to the limitations in section 4 of this chapter:

(1) The necessary costs of medical ~~or hospital~~ care for indigent patients.

(2) The cost of transportation to the place of treatment arising out of the medical care.

(b) Payments for hospital care for indigent patients who satisfy the financial and medical eligibility requirements for the hospital care for the indigent program under this article are limited to payments made under IC 12-15-15-9.

SECTION 22. IC 12-16-7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 2. (a) **This section does not apply to payments for a hospital's care of indigent patients.**

(b) Except as provided in section 5 of this chapter, claims for payment shall be segregated by year using the patient's admission date.

~~(b)~~ **(c)** Each year the division shall pay claims as provided in section 4 of this chapter, without regard to the county of admission or that county's transfer to the state fund.

SECTION 23. IC 12-16-7-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 4. (a) **This section does not apply to payments for a hospital's care of indigent patients.**

(b) Each year the division shall pay two-thirds (2/3) of each claim upon submission and approval of the claim.

~~(b)~~ **(c)** If the amount of money in the state hospital care for the indigent fund in a year is insufficient to pay two-thirds (2/3) of each approved claim for patients admitted in that year, the state's and a county's liability to providers under the hospital care for the indigent program for claims approved for patients admitted in that year is limited to ~~the sum of the following:~~

~~(1) The amount transferred to the state hospital care for the indigent fund from county hospital care for the indigent funds in that year under IC 12-16-14.~~

~~(2) Any contribution to the fund in that year.~~

~~(3)~~ any amount that was appropriated to the state hospital care for the indigent fund **specifically in order to fund the insufficiency and allows full payment of the two-thirds (2/3) amount for each approved claim** for that year by the general assembly.

~~(4) Any amount that was carried over to the state hospital care for the indigent fund from a preceding year.~~

~~(c)~~ **(d)** This section does not obligate the general assembly to

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appropriate money to the state hospital care for the indigent fund.

SECTION 24. IC 12-16-7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. **(a) This section does not apply to payments for a hospital's care of indigent patients.**

(b) Before the end of each state fiscal year, the division shall, to the extent there is money in the state hospital care for the indigent fund, pay each provider under the hospital care for the indigent program a pro rata part of the one-third (1/3) balance on each approved claim for patients admitted during the preceding year.

SECTION 25. IC 12-16-12-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: Sec. 5. The division is not responsible for, **and a claim shall not be approved for,** the following:

(1) The payment of nonemergency medical costs, except as provided under the hospital care for the indigent program.

(2) The payment of medical costs accrued at a hospital owned or operated by a health and hospital corporation, except for hospital care provided under this chapter to a person not residing in Marion County.

SECTION 26. IC 12-16-14-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11. (a) For the fiscal year ending June 30, 1998, all money paid into the fund after June 30, 1997, and not:**

(1) paid out before April 1, 1998; or

(2) appropriated under P.L.260-1997, SECTION 8;

shall be transferred from the fund and deposited in the Medicaid indigent care trust fund established by IC 12-15-20-2. The amounts transferred under this subsection shall be used to pay the state's share of the enhanced disproportionate share payments to providers under IC 12-15-19 for the fiscal year. This subsection does not require money in the fund on June 30, 1997, to be transferred from the fund.

(b) This subsection does not apply to amounts appropriated to the fund under IC 12-16-7-4. For each state fiscal year ending after June 30, 1998, before the fifteenth day of each month, all money paid into the fund during the fiscal year shall be transferred from the fund and appropriated for Medicaid current obligations. This subsection does not require money in the fund on June 30, 1997, to be transferred from the fund.

SECTION 27. IC 12-29-1-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: Sec. 7.

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(a) On the first Monday in October, the county auditor shall certify to:

(1) the division of mental health, for a community mental health center;

(2) the division of disability, aging, and rehabilitative services, for a community mental retardation and other developmental disabilities center; and

(3) the president of the board of directors of each center;

the amount of money that will be provided to the center under this chapter.

(b) The county payment to the center shall be paid by the county treasurer to the treasurer of each center's board of directors in the following manner:

(1) One-half (1/2) of the county payment to the center shall be made on the second Monday in July.

(2) One-half (1/2) of the county payment to the center shall be made on the second Monday in December.

A county treasurer making a payment under this subsection to a community mental health center that qualifies as a community mental health center disproportionate share provider under IC 12-15-16-1(d) shall certify that the payment represents expenditures eligible for financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office of Medicaid policy and planning shall assist a county treasurer in making this certification.

(c) Payments by the county fiscal body:

(1) must be in the amounts:

(A) determined by ~~IC 12-29-2-1 through IC 12-29-2-6;~~ **IC 12-29-2-2 through IC 12-29-2-5;** and

(B) authorized by section 1 of this chapter; and

(2) are in place of grants from agencies supported within the county solely by county tax money.

SECTION 28. THE FOLLOWING ARE REPEALED [EFFECTIVE JULY 1, 1997 (RETROACTIVE)]: IC 12-15-15-8; IC 12-15-18-5; IC 12-15-19-2.

SECTION 29. P.L.260-1997, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1998]: FAMILY AND SOCIAL SERVICES, HEALTH, AND VETERANS' AFFAIRS

	Year 1997-98	Year 1998-99
A. FOR THE FAMILY AND SOCIAL SERVICES		

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ADMINISTRATION		
FAMILY AND		
SOCIAL SERVICES		
ADMINISTRATION		
Total Operating		
Expense	12,742,832	12,765,619
HEALTH, FAMILY		
AND SOCIAL		
SERVICES		
COORDINATING		
ACCOUNT		
Total Operating		
Expense	167,409	167,785
COMMISSION FOR THE		
STATUS OF BLACK MALES		
Total Operating		
Expense	100,000	100,000
FOR THE BUDGET		
AGENCY		
FSSA/DEPARTMENT		
OF HEALTH		
INSTITUTIONAL		
CONTINGENCY FUND		
Total Operating		
Expense for		
the Biennium	6,000,000	

The above institutional contingency fund shall be allotted upon the recommendation of the budget agency with approval of the governor. This appropriation shall be used to supplement individual hospital, state developmental center, and special institutions budgets.

FOR THE FAMILY		
AND SOCIAL		
SERVICES		
ADMINISTRATION		
OFFICE		
OF MEDICAID		
POLICY AND		
PLANNING		
OFFICE ADMINISTRATION		
Total Operating		
Expense	3,724,656	3,877,769
MEDICAID DISABILITY		

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ELIGIBILITY EXAMS		
Total Operating Expense	850,000	850,000
MEDICAID - CURRENT OBLIGATIONS		
Total Operating Expense	905,680,000	964,540,000

~~In addition to the foregoing appropriations for Medicaid - Current Obligations, $35,000,000 in each fiscal year is hereby appropriated from the state hospital care for the indigent fund established by IC 12-16-14-6, notwithstanding the provisions of IC 12-16, for Medicaid - Current Obligations.~~ The foregoing appropriations may be augmented from the Indigent Care Trust Fund pursuant to IC 12-15-20-2(3), subject to the approval of the governor and the budget agency.

MEDICAID - ADMINISTRATION		
Total Operating Expense	18,965,993	18,020,613

The foregoing appropriations for Medicaid assistance and for Medicaid administration are for the purpose of enabling the office of Medicaid policy and planning to carry out all services as provided in IC 12-8-6. In addition to the above appropriations, all money received from the federal government and paid into the state treasury as a grant or allowance is appropriated and shall be expended by the office of Medicaid policy and planning for the respective purposes for which such money was allocated and paid to this state. Subject to the provisions of P.L.46-1995, if the sums herein appropriated for Medicaid assistance and for Medicaid administration are insufficient to enable the office of Medicaid policy and planning to meet its obligations, then there is appropriated from the state general fund such further sums as may be necessary for such purpose subject to the approval of the governor and the budget agency.

DIVISION OF MENTAL HEALTH		
Personal Services	2,155,383	2,161,265
Other Operating Expense	240,095	240,522
PSYCHIATRIC RESEARCH		
Other Operating		

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Expense	224,980	224,980
WORK PROGRAM FOR THE CHRONICALLY MENTALLY ILL		
Other Operating Expense	373,448	373,448
RESIDENTIAL SERVICES FOR THE MENTALLY ILL		
Other Operating Expense	22,292,162	22,292,162

The division of mental health must assure that consideration is given to the care and placement of emotionally disturbed children when allocating the above appropriations for residential services for mentally ill persons.

COMMUNITY MENTAL ILLNESS CLINICS		
Other Operating Expense	194,353	194,353
COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES		
Total Operating Expense	56,002,767	56,002,767

The foregoing appropriations for the division of mental health comprehensive community mental health services are from revenues accruing to the state general fund in the following amounts: for fiscal year 1997-98, $51,557,767; for fiscal year 1998-99, $51,557,767; and the balance from revenues accruing to the mental health centers fund as established under IC 6-7-1. With the approval of the governor and the budget agency, these sums may be augmented from revenues accruing to the mental health centers fund. The comprehensive community mental health centers shall submit their proposed annual budgets (including income and operating statements) to the budget agency on or before August 1 of each year. All federal funds shall be applied in augmentation of the foregoing funds rather than in lieu of any portion of the funds.

The above appropriations for comprehensive community mental health services include the intragovernmental transfers necessary to provide the nonfederal share of reimbursement under the Medicaid

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rehabilitation option. With the approval of the governor and the budget agency, $3,300,000 of this appropriation may be transferred to the division of mental health community transition fund each year of the biennium.

ALCOHOL AND DRUG SERVICES COURT REMISSIONS		
Total Operating Expense	2,946,936	2,946,936

The above appropriations are from revenue accruing to the addiction services fund authorized under IC 12-23-2.

GAMBLERS' ASSISTANCE FUND		
Total Operating Expense	1,200,000	1,600,000

The above appropriations to the gamblers' assistance fund may be augmented in accordance with the provisions of IC 4-33-12-6(f).

ADDICTION SERVICES		
Total Operating Expense	1,000,000	1,000,000
MENTAL HEALTH COMMUNITY TRANSITION FUND		
Total Operating Expense	23,717,248	32,333,335
MENTAL HEALTH INSTITUTIONS		
Personal Services	92,947,720	86,482,210
Other Operating Expense	15,146,875	14,473,819
PATIENT PAYROLL		
Total Operating Expense	320,000	320,000

The foregoing appropriations for the mental health institutions are for the operations of Evansville psychiatric children's center, Evansville state hospital, Larue D. Carter memorial hospital, Logansport state hospital, Madison state hospital, and Richmond state hospital.

The foregoing appropriations for the division of mental health institutions are from revenues accruing to the state general fund in the

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following amounts: for fiscal year 1997-98, up to $85,687,590; for fiscal year 1998-99, up to $78,604,635; and the balance from revenues accruing to the mental health fund established by IC 12-24-14.

Sixty-six percent (66%) of the revenues accruing to the state mental health institutions pursuant to IC 12-15 shall be deposited in the mental health fund established by IC 12-24-14, and thirty-four percent (34%) of the revenues accruing to the institutions, under IC 12-15, shall be deposited in the state general fund.

In addition to the above appropriations each institution may qualify for an additional appropriation, or allotment, subject to approval of the governor and the budget agency, from the mental health fund of up to twenty percent (20%), but not to exceed $50,000 in each fiscal year, of the amount in which actual net collections exceed an amount specified in writing by the division of mental health before July 1 of each year beginning July 1, 1997.

DIVISION OF FAMILY AND CHILDREN SERVICES		
Personal Services	4,795,161	4,805,692
Other Operating Expense	1,801,453	1,801,453
PERSONAL SERVICES REIMBURSEMENT TO COUNTIES INCLUDING PERF, HEALTH INSURANCE, AND LIFE INSURANCE		
Total Operating Expense	55,132,803	57,063,486
SPECIAL NEEDS ADOPTION		
Personal Services	263,519	264,017
Other Operating Expense	405,108	405,108
TITLE IV-D OF THE FEDERAL SOCIAL SECURITY ACT (STATE MATCH)		
Total Operating		

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Expense	9,659,139	9,377,518

The foregoing appropriations for the division of family and children Title IV-D of the federal Social Security Act are made pursuant to, and not in addition to, IC 12-17-2-31.

STATE WELFARE FUND - COUNTY ADMINISTRATION		
Total Operating Expense	30,882,198	31,499,841

Without the approval of the governor and the budget agency, the amount of federal administrative allowance transferred to the state welfare fund - county administration shall not exceed $70,172,041 in fiscal year 1997-98 and $71,921,019 in fiscal year 1998-99. The above appropriations for the state welfare fund are from revenue accruing to the fund authorized under IC 12-19-4. These sums may be augmented, with the approval of the governor and the budget agency, from revenues accruing to the fund.

ADOPTION ASSISTANCE		
Total Operating Expense	3,642,358	4,093,526
TITLE IV-B CHILD WELFARE		
Total Operating Expense	2,441,327	2,537,101
NON-RECURRING ADOPTION ASSISTANCE		
Total Operating Expense	175,000	175,000
ADOPTION OPPORTUNITIES		
Total Operating Expense	50,000	50,000

The foregoing appropriations for Title IV-B child welfare, non-recurring adoption assistance, adoption assistance, and adoption opportunities represent the maximum state match for Title IV-B.

IMPACT (JOBS) PROGRAM (AFDC RECIPIENTS)		
Total Operating Expense	11,332,015	11,466,713

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IMPACT PROGRAM (FOOD STAMPS RECIPIENTS)		
Total Operating Expense	5,618,792	5,671,095
BURIAL REIMBURSEMENT - AFDC		
Total Operating Expense	50,000	50,000
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)		
Total Operating Expense	35,057,943	35,057,943
CHILD CARE DEVELOPMENT		
Total Operating Expense	22,115,020	23,170,756

The foregoing appropriations for temporary assistance to needy families (TANF), child care development, burials, the IMPACT (JOBS), and the IMPACT (food stamps recipients) programs are for the purpose of enabling the division of family and children to carry out all services as provided in IC 12-14. In addition to the above appropriations, all money received from the federal government and paid into the state treasury as a grant or allowance is appropriated and shall be expended by the state division of family and children for the respective purposes for which such money was allocated and paid to this state.

DOMESTIC VIOLENCE PREVENTION AND TREATMENT PROGRAM		
Total Operating Expense	1,121,098	1,121,098

The above appropriations for the domestic violence prevention and treatment program shall be paid from receipts to the domestic violence prevention and treatment fund created by IC 12-18-4; provided that if revenues accruing to the fund are greater than the appropriations, the appropriations for grants only may be augmented to the limit of revenues with the approval of the governor and the budget agency.

PROJECT SAFE

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PLACE		
Total Operating Expense	125,000	125,000
STEP AHEAD		
Total Operating Expense	3,687,076	3,699,479
CHEESE COMMODITIES		
Total Operating Expense	146,000	146,000
YOUTH SERVICE BUREAU FUND		
Total Operating Expense	1,000,000	1,000,000

The executive director of the division of family and children shall establish standards for youth service bureaus. Any youth service bureau that is not an agency of a unit of local government or is not registered with the Indiana secretary of state as a nonprofit corporation shall not be funded. The division of family and children shall fund all youth service bureaus that meet the standards as established June 30, 1983. However, a grant may not be made without approval by the budget agency after review by the budget committee.

EARLY CHILDHOOD INTERVENTION SERVICES		
Total Operating Expense for the Biennium	4,347,000	
SCHOOL AGE CHILD CARE PROJECT FUND		
Total Operating Expense	550,000	550,000

The above appropriations for the school age child care project fund include the appropriation made in IC 6-7-1-30.2.

SOCIAL SERVICES BLOCK GRANT - PURCHASE OF SOCIAL SERVICES CONTINGENCY FUND		
Total Operating Expense for		

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the Biennium	34,690,608	

The above appropriated funds are allocated in the following manner during the biennium:

Division of Disability, Aging, and Rehabilitative Services:	6,162,973	6,162,973
Division of Family and Children, Child Welfare Services:	3,200,209	3,200,209
Division of Family and Children, Child Development Services:	4,131,465	4,131,465
Division of Family and Children, Family Protection Services:	1,314,774	1,314,774
Division of Mental Health:	1,373,748	1,373,748
State Department of Health:	166,515	166,515
Department of Correction:	995,620	995,620

FOR THE STATE BUDGET AGENCY

MEDICAL SERVICE PAYMENTS

Total Operating Expense	13,000,000	13,000,000

These appropriations for medical service payments are made to pay for medical services for committed individuals and patients of institutions under the jurisdiction of the department of correction, the state department of health, or the division of mental health if the services are provided outside these institutions. These appropriations

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may not be used for payments for medical services that are covered by IC 12-16 unless these services have been approved under IC 12-16. These appropriations shall not be used for payment for medical services which are payable from an appropriation in this act for the state department of health, the division of mental health, or the department of correction, or that are reimbursable from funds for medical assistance under IC 12-15. If these appropriations to the budget agency are insufficient to make these medical service payments, there is hereby appropriated such further sums as may be necessary.

Direct disbursements from the above contingency fund are not subject to the provisions of IC 4-13.4.

FOR THE FAMILY AND SOCIAL SERVICES ADMINISTRATION DIVISION OF DISABILITY, AGING, AND REHABILITATIVE SERVICES		
AGING SERVICES		
Total Operating Expense	355,412	355,412
C.H.O.I.C.E. IN-HOME SERVICES		
Total Operating Expense	37,482,063	37,482,455

The foregoing appropriations for C.H.O.I.C.E./In-Home Services include intragovernmental transfers to provide the nonfederal share of the Medicaid aged and disabled waiver.

If the above appropriations for C.H.O.I.C.E./In-Home Services are insufficient to provide services to all eligible persons, the division of disability, aging, and rehabilitative services may give priority for services to persons who are unable to perform three (3) or more activities of daily living (as defined in IC 12-10-10-1.5). The division of disability, aging, and rehabilitative services may discontinue conducting assessments for individuals applying for services under the C.H.O.I.C.E./In-Home Services program if a waiting list for such services exists. It is the intent of the General Assembly to serve at least two thousand four hundred (2,400) additional individuals through the C.H.O.I.C.E./In-Home Services program above the level being served on January 1, 1997.

The division of disability, aging, and rehabilitative services shall conduct an annual evaluation of the cost effectiveness of providing

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home care. Before January of each year, the division shall submit a report to the budget committee, the budget agency, and the legislative council that covers all aspects of the division's evaluation and such other information pertaining thereto as may be requested by the budget committee, the budget agency, or the legislative council, including the following: the number and demographic characteristics of the recipients of home care during the preceding fiscal year; the total cost and per recipient cost of providing home care services during the preceding fiscal year; the number of recipients of home care services who would have been placed in long term care facilities had they not received home care services; and the total cost savings during the preceding fiscal year realized by the state due to recipients of home care services (including Medicaid) being diverted from long term care facilities. The division shall obtain from providers of services data on their costs and expenditures regarding implementation of the program and report the findings to the budget committee, the budget agency, and the legislative council.

OLDER HOOSIERS ACT		
Total Operating Expense	1,914,963	1,915,071

The above appropriations for the older Hoosiers act include funds for the community and home options to institutional care for the elderly and disabled program of IC 12-10-10. With the approval of the governor and the budget agency, part of the foregoing appropriations for the older Hoosiers act may be transferred to offset shortfalls in the appropriations for adult protection services or adult guardianship services.

ADULT PROTECTION SERVICES		
Total Operating Expense	758,000	758,000

With the approval of the governor and the budget agency, part of the foregoing appropriations for adult protection services may be transferred to offset shortfalls in the appropriations for the older Hoosiers act or for adult guardianship services.

OBRA PREADMISSION SCREENING		
Total Operating Expense	37,538	37,538
ADULT GUARDIANSHIP SERVICES		

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Personal Services	35,929	36,007
Other Operating Expense	362,338	362,338

With the approval of the governor and the budget agency, part of the foregoing appropriations for adult guardianship services may be transferred to offset shortfalls in the appropriations for the older Hoosiers act or for adult protection services.

OFFICE OF DEAF AND HEARING IMPAIRED		
Personal Services	239,491	240,011
Other Operating Expense	296,180	296,180
COMMUNITY RESIDENTIAL FACILITIES COUNCIL		
Personal Services	7,800	7,800
Other Operating Expense	16,982	16,982
RESIDENTIAL SERVICES - CASE MANAGEMENT		
Personal Services	2,393,276	2,399,944
Other Operating Expense	858,196	859,458
VOCATIONAL REHABILITATION SERVICES		
Personal Services	2,555,780	2,561,313
Other Operating Expense	8,380,347	8,381,222
EMPLOYEE TRAINING		
Total Operating Expense	6,300	6,300
AID TO INDEPENDENT LIVING		

C o p y

Total Operating Expense	22,222	22,222
OFFICE OF SERVICES FOR THE BLIND AND VISUALLY IMPAIRED		
Personal Services	194,097	194,521
Other Operating Expense	139,502	139,502
BLIND VENDING OPERATIONS		
Total Operating Expense	127,670	128,298
EPILEPSY SERVICES		
Other Operating Expense	460,954	460,954
COMMUNITY MENTAL RETARDATION AND DEVELOPMENTAL CENTERS DAY PROGRAMS		
Other Operating Expense	27,661,314	27,661,314

With the approval of the governor and the budget agency, the following amounts may be transferred from the foregoing appropriations for day programs: $1,250,000 for each year of the biennium to early childhood intervention services; and $400,000 for each year of the biennium to residential services-case management. All of the above appropriations to the division of disability, aging, and rehabilitative services community mental retardation and developmental centers for day programs, less the detailed transfers described in this paragraph, shall be authorized and made available for agencies for disbursement only on a units purchase of services basis. Rates for such services shall be determined in accordance with adopted rules based on wage and expense information from agencies providing these services. Agencies shall be paid for actual units provided to eligible recipients up to the limit of the above appropriations and inclusive of social services block grant appropriations. Before any contract is prepared obligating fiscal year 1997-98 appropriations, the division of disability, aging, and rehabilitative services must submit a listing of services to be purchased and the rates for such services for review and approval by the budget agency. After budget agency review

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and approval, the division shall notify each local agency of the services that have been authorized for purchase and shall limit all subsequent contracts to the services as authorized.

The above appropriation for community mental retardation and developmental centers day programs include the intragovernmental transfers necessary to provide the nonfederal share of reimbursement under the Medicaid program for day services provided to residents of group homes and nursing facilities.

DIAGNOSIS AND EVALUATION		
Other Operating Expense	465,394	465,394

The above appropriations to the division of disability, aging, and rehabilitative services community mental retardation and developmental centers for diagnosis and evaluation shall be used primarily for individuals receiving residential services and applicants for residential services who are in need of these services.

SUPPORTED EMPLOYMENT		
Other Operating Expense	3,117,498	3,117,498
FAMILY SUBSIDY PROGRAM		
Other Operating Expense	502,350	502,350
RESIDENTIAL SERVICES FOR DEVELOPMENTALLY DISABLED PERSONS		
Total Operating Expense for the Biennium	26,855,640	

In the development of new community residential settings for persons with developmental disabilities, the division of disability, aging, and rehabilitative services must give priority to the appropriate placement of such persons who are eligible for Medicaid and currently residing in intermediate care or skilled nursing facilities and, to the extent permitted by law, such persons who reside with aged parents or guardians or families in crisis.

BUREAU OF DEVELOPMENTAL DISABILITIES

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SERVICES		
TRANSITION FUND		
Total Operating		
Expense	6,211,000	6,211,000
DIVISION OF DISABILITY,		
AGING, AND		
REHABILITATIVE SERVICES		
ADMINISTRATION		
Personnel		
Services	364,870	365,690
Other Operating		
Expense	1,022,190	1,022,190

The above appropriations for the division of disability, aging, and rehabilitative services administration is for administrative expenses. Any federal fund reimbursements received for such purposes are to be deposited in the state general fund.

ASSISTANCE TO		
PERSONS IN		
COUNTY HOMES		
Total Operating		
Expense	5,482,393	5,482,393
ROOM AND BOARD		
ASSISTANCE		
Total Operating		
Expense	5,983,404	5,983,404
STATE DEVELOPMENTAL		
INSTITUTIONS		
Personal		
Services	97,846,686	101,203,114
Other Operating		
Expense	10,440,249	10,440,249

The foregoing appropriations for the state developmental institutions are for the operations of the Fort Wayne state developmental center; Muscatatuck state developmental center; the New Castle state developmental center; and the northern Indiana state developmental center.

The foregoing appropriations for the state developmental institutions are from revenues accruing to the state general fund in the following amounts: for fiscal year 1997-98, up to $38,609,826; for fiscal year 1998-99, up to $37,479,745; and the balance from revenues accruing to the mental health fund established by IC 12-24-14.

Sixty-six percent (66%) of the revenues accruing to the above

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named state developmental centers pursuant to IC 12-15 shall be deposited in the mental health fund established under IC 12-24-14, and thirty-four percent (34%) of the revenues accruing to the above named institutions under IC 12-15 shall be deposited in the state general fund.

In addition to the above appropriations each institution may qualify for an additional appropriation, or allotment, subject to approval of the governor and the budget agency, from the mental health fund of up to twenty percent (20%) but not to exceed $50,000, of the amount in which actual net collections exceed an amount specified in writing by the division of disability, aging, and rehabilitative services before July 1 of each year beginning July 1, 1997.

B. PUBLIC HEALTH

FOR THE STATE DEPARTMENT OF HEALTH

Personal Services	17,699,092	17,734,825
Other Operating Expense	7,451,594	6,842,019

All receipts to the state department of health from licenses or permit fees shall be deposited into the state general fund.

AID TO COUNTY TUBERCULOSIS HOSPITALS

Other Operating Expense	115,481	115,481

These funds shall be used for eligible expenses according to IC 16-21-7-3 for tuberculosis patients for whom there are no other sources of reimbursement, including patient resources, health insurance, medical assistance payments, and hospital care for the indigent.

PROJECT RESPECT

Total Operating Expense	1,600,000	1,600,000

HOOSIER STATE GAMES

Total Operating Expense	225,000	225,000

CANCER REGISTRY

Personal Services	212,432	212,794
Other Operating Expense	9,632	9,632

C o p y

MEDICARE-MEDICAID CERTIFICATION		
Total Operating Expense	4,186,236	4,198,647
AIDS EDUCATION		
Personal Services	332,271	333,008
Other Operating Expense	487,729	487,729
HIV/AIDS SERVICES		
Total Operating Expense	1,250,000	2,500,000
TEST FOR DRUG AFFLICTED BABIES		
Total Operating Expense	67,200	67,200

The above appropriation for drug afflicted babies shall be used for the following purposes:

(1) An infant shall be tested for the presence of a controlled substance in the infant's meconium if at birth:

(A) the infant's weight is less than two thousand five hundred (2,500) grams;

(B) the infant's head is smaller than the third percentile for the infant's gestational age; and

(C) there is no medical explanation for the conditions described in clauses (A) and (B).

(2) If a meconium test determines the presence of a controlled substance in the infant's meconium, the infant may be declared a child in need of services as provided in IC 31-34-1-10 through IC 31-34-1-13. However, the child's mother may not be prosecuted in connection with the results of the test.

(3) The state department of health shall provide forms on which the results of a meconium test performed on an infant under subdivision (1) must be reported to the state department of health by physicians and hospitals.

(4) The state department of health shall, at least semi-annually:

(A) ascertain the extent of testing under this chapter; and

(B) report its findings under subdivision (1) to:

(A) all hospitals;

(B) physicians who specialize in obstetrics and gynecology or work with infants and young children; and

(C) any other group interested in child welfare that

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requests a copy of the report from the state department of health.

(5) The state department of health shall designate at least one (1) laboratory to perform the meconium test required under subdivisions (1) through (8). The designated laboratories shall perform a meconium test on each infant described in subdivision (1) to detect the presence of a controlled substance.

(6) Subdivisions (1) through (8) do not prevent other facilities from conducting tests on infants to detect the presence of a controlled substance.

(7) Each hospital and physician shall:

(A) take or cause to be taken a meconium sample from every infant born under the hospital's and physician's care who meets the description under subdivision (1); and

(B) transport or cause to be transported each meconium sample described in clause (A) to a laboratory designated under subdivision (5);

to test for the presence of a controlled substance as required under subdivisions (1) through (8).

(8) Not later than January 1, 1999, the state department of health shall begin to evaluate the program established under subdivisions (1) through (8). The state department of health shall report the results of the evaluation to the general assembly not later than June 30, 1999. The general assembly shall use the results of the evaluation to determine whether to continue the testing program established under subdivisions (1) through (8).

(9) A medically appropriate discharge of an infant may not be delayed due to the results of the test described in subdivision (1) or due to the pendency of the results of the test described in subdivision (1).

STATE CHRONIC
DISEASES

Personal Services	88,699	88,898
Other Operating Expense	514,735	514,735

At least $82,560 of the above appropriations shall be for grants to community groups and organizations as provided in IC 16-46-7-8.

CANCER
EDUCATION
AND DIAGNOSIS

BREAST CANCER

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Total Operating Expense	100,000	100,000
PROSTATE CANCER		
Total Operating Expense	100,000	100,000
WOMEN, INFANTS, AND CHILDREN SUPPLEMENT		
Total Operating Expense	150,000	150,000

Notwithstanding IC 6-7-1-30.2 the above appropriations for women, infants, and children supplement are the total appropriations provided for this purpose.

MATERNAL AND CHILD HEALTH SUPPLEMENT		
Total Operating Expense	150,000	150,000

Notwithstanding IC 6-7-1-30.2, the above appropriations for maternal and child health are the total appropriations provided for this purpose. In addition to the provisions under IC 6-7-1-30.2(b), the above appropriations may be used for other services provided under 42 U.S.C. 701 et seq. in underserved areas of Indiana.

ADOPTION HISTORY		
Total Operating Expense	199,013	199,369

The above appropriations for adoption history shall be paid from receipts to the adoption history fund created by IC 31-19-18. With the approval of the governor and the budget agency, said sums may be augmented from revenues accruing to the fund.

RADON GAS TRUST FUND		
Total Operating Expense	15,000	15,000

The above appropriations for the radon gas trust fund shall be paid from receipts to the radon gas trust fund created by IC 16-41-38-8. With the approval of the governor and the budget agency, said sums may be augmented from receipts accruing to the fund.

COMMUNITY HEALTH CENTERS		
Total Operating Expense for the Biennium	10,000,000	

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Subject to approval by the budget agency after review by the budget committee, $1,000,000 of the above appropriation for community health centers may be used for capital projects.

LOCAL HEALTH MAINTENANCE FUND		
Total Operating Expense	2,370,000	2,370,000

The above appropriations for the local health maintenance fund include the appropriation provided for this purpose in IC 6-7-1-30.5.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS		
Total Operating Expense	7,471,003	7,471,096
INDIANA MEDICAL AND NURSING GRANT FUND		
Total Operating Expense for the Biennium	176,000	

The above appropriation for the Indiana medical and nursing grant fund is hereby appropriated from revenue accruing to the Indiana medical and nursing grant fund as created by IC 16-46-5. With the approval of the governor and the budget agency, said funds may be augmented from revenue accruing to the fund.

NEWBORN SCREENING PROGRAM		
Personal Services	258,598	259,166
Other Operating Expense	510,650	510,650

The above appropriations for the newborn screening program of the state department of health are hereby appropriated from revenues accruing to the newborn screening fund as created by IC 16-41-17. With the approval of the governor and the budget agency, said sums may be augmented from revenue accruing to the fund.

BIRTH PROBLEMS REGISTRY		
Personal Services	22,742	22,788
Other Operating		

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Expense	34,700	34,700

The above appropriations for the birth problems registry shall be paid from receipts to the birth problems registry fund created by IC 16-38-4. With the approval of the governor and the budget agency, said sums may be augmented from revenue accruing to the fund.

MOTOR FUEL INSPECTION PROGRAM		
Total Operating Expense	86,500	86,552

The above appropriations for the motor fuel inspection program shall be paid from receipts accruing to the motor fuel inspection fund created by IC 16-44-3-10. With the approval of the governor and the budget agency, said sums may be augmented from receipts accruing to the fund.

MINORITY HEALTH INITIATIVE		
Total Operating Expense	750,000	1,000,000
FOR THE SILVERCREST CHILDREN'S DEVELOPMENT CENTER		
Personal Services	5,465,194	5,476,748
Other Operating Expense	592,250	592,250
FOR THE INDIANA SCHOOL FOR THE BLIND		
Personal Services	9,246,727	9,339,905
Other Operating Expense	854,621	835,986
FOR THE INDIANA SCHOOL FOR THE DEAF		
Personal Services	12,000,425	12,149,563
Other Operating Expense	1,880,863	1,854,547

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FOR THE INDIANA VETERANS' HOME		
Personal Services	15,073,402	15,101,750
Other Operating Expense	3,182,388	3,182,388

The state department of health shall reimburse the state general fund at least $8,471,906 for fiscal year 1997-98; and $8,471,906 for fiscal year 1998-99 from the veterans' home comfort and welfare fund established by IC 10-6-1-9.

FOR THE SOLDIERS' AND SAILORS' CHILDREN'S HOME		
Personal Services	7,321,791	7,336,896
Other Operating Expense	1,520,703	1,520,703
C. VETERANS' AFFAIRS		
FOR THE DEPARTMENT OF VETERANS' AFFAIRS		
Personal Services	360,218	384,096
Other Operating Expense	112,575	189,328

The foregoing appropriations for the department of veteran's affairs include operating funds for the veterans' cemetery. Notwithstanding IC 10-5-1-8 staff employed for the operation and maintenance of the veterans' cemetery shall be selected as are all other state employees.

DISABLED AMERICAN VETERANS OF WORLD WARS		
Total Operating Expense	40,000	40,000
AMERICAN VETERANS OF WORLD WAR II, KOREA, AND VIETNAM		
Total Operating		

C o p y

Expense	30,000	30,000
VETERANS		
OF FOREIGN WARS		
Total Operating		
Expense	30,000	30,000
COMBAT VETERANS		
CONSORTIUM		
Total Operating		
Expense for		
the Biennium	20,000	

SECTION 30. **An emergency is declared for this act.**

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