

**Northwest Portland Area Indian Health Board
Policy Recommendations to Senate Finance Committee
Health Care Reform
May 28, 2009 DRAFT**

Tribal Specific Recommendations:

1. **Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations.** Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.
2. **Consult with Tribes across the county to be sure health reform policies and regulations are developed in a way that will create positive changes in the diverse Indian communities.** Across the United States Indian cultures, tribal resources and tribal health system structures differ greatly. Health reform must work in all of these situations. Only by directly consulting with Tribes as policies and regulations are being developed can HHS develop policies and regulations that will work in all Indian communities.
3. **Confer with representatives of urban Indian organizations to determine the impact of reform proposals on the Indian people served by those programs.**
4. **Indian tribes perform several roles in a health care context: They are governments, employers, health care providers (through Indian Self-Determination agreements), patient advocates, and beneficiaries of the U.S. trust responsibility for health. All of these roles must be respected, together with the recognition that Indian tribes are political entities, not merely a racial group.**
5. **Indian tribes must retain the authority to decide whether to serve non-Indians at their health facilities.** Tribes recognize that the demand for health services will greatly increase in a reformed health care environment and that they are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. The I/T/Us must be able to either open their doors or continue to serve only IHS beneficiaries. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who wish to serve non-Indians, the legislation must –

- a. Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers currently.)
- b. Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

- 6. Health care reform should require collaboration across all HHS agencies (e.g. HRSA, SAMSA, Administration on Aging, CMS) and programs with Tribes to coordinate health care resources in order to ensure health related funding is more effectively available to tribes.**
- 7. The Indian Health Service budget must be protected from offsets and must be enhanced to assure that Indian programs can attract and retain health care personnel needed to fulfill the Federal government's trust obligation to "permit the health status of Indians to be raised to the highest possible level".**
 - a. Chairman Baucus has noted that "[i]n fiscal year 2008, total funding for IHS was \$4.3 billion, about 48 percent of estimated need."
- 8. Enact incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.**
- 9. A demonstration project should be funded through Medicaid and IHS to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care.**
- 10. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.**
- 11. While health care reform holds great promise for ensuring coverage for all Americans, in Indian Country it will create a short term financial burden on the already seriously under funded Indian health system.** Tribes need to be involved in policy analysis and rule making, but there are no new resources. At the tribal level staff will need training and the resources to build the local systems that are needed to effectively educate, enroll and coordinate patient participation in a reformed system. I hope that if new funding is available for implementing health reform in Indian Country that provisions will be made to ensure that it is available to all Tribes equally. Our recent experience with the new ARRA funding is that

over 70 percent (\$358 million) of economic stimulus funds for Indian Country will be provided to only two states or be retained at IHS headquarters. This type of inequity must be prevented from happening when making changes or providing new resources for the Indian health system. Tribes must be provided the same opportunity to deliver consistent levels of health care services on an equal basis in order to improve the health status of all Indian people. (Jamestown S'Klallam Tribal comments 5/22/09)

- 12. Are Indian organizations like NPAIHB adequately addressed in the recommendations? (NPAIHB)**
- 13. Establish blue ribbon commission to gather evidence and make recommendations to systematically improve the IHS system and improve quality of care. Commission should be determined by Tribes being served and not left at Secretarial or Congressional discretion. (NPAIHB)** Is this still desirable? Alternative wording: **Include funding to establish a Blue Ribbon Commission, to conduct comprehensive research and a decision making process to redesign the Indian health system within the context of health reform goals.** The Indian health system has evolved over time and by and large has been successful at recognizing and responding to the challenges of serving diverse and very poor populations with health status that is unacceptable by any measure. Significant inroads have been hampered primarily by a serious lack of funding. Indian health has adopted a community based, public health model to provide services. Health reform activities are using a competitive, insurance based model, which will not work in many Tribal communities. To research the options and develop the most promising changes for the Indian health system will take time and money. It is important to preserve the strengths while ushering in new system changes that are specifically designed to improve the health of AI/AN in a culturally relevant way. **Any group established for this purpose must have a majority membership of tribal representatives.**
- 14. Extend the new Indian-specific provisions of ARRA and CHIPRA to all health programs in which the federal government participates financially.**
- 15. If the Indian Health Service (IHS) is provided additional resources to fund health services consistent with what would be provided in a publicly-funded health plan, the IHS shall distribute funds equitably to tribal health programs under the terms and conditions of Indian Self-Determination and Education Assistance Act (ISDEAA) on the same allocation basis IHS makes funds available to directly operated service units. (Jim Roberts)**

		Existing Recommendations
Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans May 14, 2009		
I: Insurance Market Reforms	Page 2	
	Non-Group and Micro-Group Market Reforms	
	Small Group Market Reforms	
	Health Insurance Exchange	<p>In order to enhance AI/AN access to a public insurance plan, the legislation should expressly allow outreach and enrollment activities to take place at I/T/U sites.</p> <p>In recognition of the Federal government's trust responsibility to provide health care to Indian people, a special (open) enrollment period should apply for AI/ANs served by the Indian health system.</p> <p>Any new publicly-sponsored health insurance plan established to provide coverage for low/moderate income individuals must assure that AI/ANs who meet the income requirements are eligible to enroll, and that eligibility for services from the Indian health system is not a barrier to participation.</p> <ul style="list-style-type: none"> ○ AI/ANs eligible for care through the Indian health system have been encouraged to also enroll in Medicaid if they meet the eligibility criteria. The same opportunity must be made available for any Federally supported or subsidized health insurance coverage. <p>Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.</p> <ul style="list-style-type: none"> ○ To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).

	Transition		
	Role of State Insurance Commissioners		
II: Making Coverage Affordable	Page 8		
	Benefit Options	<p>In recognition of the Federal government's trust responsibility to provide health care to Indian people, to the extent that any cost-sharing (premium, co-pay, etc.) would apply to a publicly-subsidized plan, an AI/AN served by the Indian health system should be expressly exempt from all such cost-sharing.</p> <ul style="list-style-type: none"> ○ Such a policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act which prohibit the assessment of any cost-sharing against an AI/AN enrolled in Medicaid who is served by the IHS, or by a health program operated by a tribe, tribal organization or urban Indian organization. <p>Enact provisions that permit and encourage integration of behavioral health services (mental health and substance use disorder) with other health services.</p>	
	Low-Income Tax Credits		
	Small Business Tax Credits		
III: Public Health Insurance Option	Page 13		
<p>Approach 1: Medicare-Like Plan</p> <p>Approach 2: Third Party Administrator</p> <p>Approach 3: State-Run Public Option</p>		<p>AI/ANs must not be subject to any restriction on selection of a provider. AI/ANs must be permitted to elect to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider.</p>	

		<p>If the legislation requires either the Secretary or outside entities to establish provider networks to serve individuals covered by a public insurance plan, it should contain assurances of participation by Indian health system (I/T/U) providers including –</p> <ul style="list-style-type: none"> ○ assurance that the network includes sufficient Indian health care providers to assure access for Indians; ○ a requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider; and ○ a requirement for prompt payment to an I/T/U provider. <p>Such express language is needed to assure that these providers are not arbitrarily excluded from participation as has occurred with some Medicaid managed care entities. When an I/T/U provider serves an individual enrolled in a public plan, the provider must be able to claim reimbursements and be assured of receiving payments.</p> <ul style="list-style-type: none"> ○ Congress recently enacted protections for Indian health providers vis a vis Medicaid managed care entities which can be used as a model for similar protections for public plan network creation. <p>The legislation should also include a requirement that the Secretary establish special terms for participation by I/T/Us that takes into account the unique circumstances of those providers in order to facilitate their participation.</p> <ul style="list-style-type: none"> ○ This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require special additions to pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies. <p>Explicitly permit Indian plans to qualify as options available through the Connector (NPAIHB)</p>
<p>IV: Role of Public Programs</p>	<p><i>Page 14</i></p>	
<ul style="list-style-type: none"> • Eligibility Standards and Methodologies 	<p>Medicaid Coverage</p>	<p>If Medicaid and CHIP are expanded to raise the maximum income ceiling or establish new eligibility categories, the legislation must require</p>

<ul style="list-style-type: none"> • Medicaid Program Payments • Options for Medicaid Coverage <ul style="list-style-type: none"> Approach 1: Increased Coverage through the Current Medicaid Structure Approach 2: Increased Coverage through the Exchange Approach 3: Increased Coverage through Both the Current Medicaid Structure and the Health Insurance Exchange 		<p>States to perform outreach and enrollment activities on/near Indian reservations and in Indian communities. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility. In order for this segment of the U.S. population to have full opportunity to participate in these programs, a significant outreach effort is required.</p>	
	Children's Health Insurance Program (CHIP)		
	Quality of Care in Medicaid and CHIP	Membership in the MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC) should include at least one representative of the CMS Tribal Technical Advisory Group. (Locke)	
<ul style="list-style-type: none"> • Enrollment and Retention Simplification • Family Planning Services and Supplies • Treatment of Selected Optional Benefits • Interstate Coordination Requirements for Child Medicaid Beneficiaries • Mandatory Coverage for Prescription Drugs • Change the Status of Some Excludable Drugs • Changes to Medicaid Payment for Prescription 	Other Improvements to Medicaid	<p>Indian health providers must be permitted to enroll eligible AI/AN beneficiaries on site and to participate as Express Lane or other Medicaid enrollment simplification network entities.</p> <p>Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.</p> <ul style="list-style-type: none"> ○ This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such an patient who travels out of state in order to receive culturally competent care at an Indian health facility, including 	

<ul style="list-style-type: none"> Drugs • Transparency in Medicaid and CHIP Section 1115 Waivers • Changes to the FMAP Formula • Automatic Countercyclical Stabilizer 		<p>care related to behavioral health needs, including substance abuse treatment.</p> <p>All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).</p>	
	Medicaid Disproportionate Share (DSH) Hospital Payments		
<ul style="list-style-type: none"> • Waiver Authority for Dual Eligible Demonstrations • Cost-Effectiveness Test • Office of Coordination for Dually Eligible Beneficiaries 	Dual Eligibles		
<ul style="list-style-type: none"> • Reduce or Phase-Out the Medicare Disability Waiting Period • Temporary Medicare Buy-In 	Medicare Coverage	<p>Pursuant to the Federal trust responsibility for Indian health, the Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. But in recognition of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would annually infuse over \$40 million more into the Indian health system, funds that would be used to reduce health status disparities.</p> <p>Permit CHS or other Tribal payments to count toward Part D TROOP.</p>	
V: Shared Responsibility	Page 39		
	Personal Responsibility Coverage Requirement	Indian tribes, as sovereign governments, should have the express authority to pay the costs of providing health insurance coverage to their members and the value of such coverage should not be considered to be taxable income to the tribal member.	

		<p>Because of the Federal trust responsibility to provide health care to Indian people, AI/ANs must be exempted from any penalty for failing to obtain or purchase health insurance if an individual mandate is included in the legislation. (creditable coverage)</p> <ul style="list-style-type: none"> ○ Whether an individual mandate applies may depend on whether an individual is considered to have creditable coverage or is considered uninsured. A recent Congressional Budget Office report concludes that AI/ANs served by the IHS system are uninsured. <p>Despite this, the fact that an AI/AN is eligible for health care from the Indian health system (whether or not such eligibility is considered creditable coverage) should not be a barrier to an AI/AN's eligibility for any publicly-funded health program such as Medicaid, or any publicly-subsidized health insurance option.</p> <p>To the extent premiums and cost-sharing apply to AI/ANs, I/T/Us should be expressly permitted to make such payments on behalf of their Indian beneficiaries, and administrative barriers to doing so must be removed.</p> <p>In recognition of the Federal trust responsibility to Indian people, individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for participation in a publicly-subsidized plan.</p>
	Employer Requirement	<p>To the extent reform legislation includes an employer mandate, Indian tribes should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes as employers must be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.</p> <ul style="list-style-type: none"> ○ The exemption of Indian tribes from any penalty or tax must also apply with regard to any tribal employees who opts out of a tribally-sponsored group health plan and buy insurance on their own outside of the workplace.

		<p>Indian Tribes should be given the option to purchase health insurance for their governmental employees through the Federal Employees Health Benefit Plan. As employers, some Indian tribes have been unable to find affordable health insurance. Indian tribes should have the option to purchase coverage for their governmental employees through the FEHBP, an option that would benefit both tribes – by making an affordable option available – and the FEHBP – by increasing the volume of insured and thereby promoting greater competition among participating insurers.</p> <ul style="list-style-type: none"> ○ This option should also be extended to tribes and tribal organizations for their employees who perform agreements issued under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as to the employees of health programs operated by urban Indian organizations. 	
VI: Prevention and Wellness	Page 43	<p>Assure that prevention services are eligible for payment by all publicly-supported health programs (Medicare, Medicaid, CHIP and any new public health insurance option), and that I/T/U providers are eligible to collect such payments.</p> <ul style="list-style-type: none"> ○ To the extent an Indian health program integrates traditional health care practices into its prevention programs, it should be permitted to do so with no adverse impact on its ability to collect reimbursements for covered prevention services. 	
<ul style="list-style-type: none"> ● Personalized Prevention Plan and Routine Wellness Visit ● Incentives to Utilize Preventive Services and Engage in Healthy Behaviors ● Coverage of Evidence-Based Preventive Services 	Promotion of Prevention and Wellness in Medicare	NPAIHB research comment	
<ul style="list-style-type: none"> ● Access to Preventive Services for Eligible Adults ● Incentives to Utilize Preventive Services and Encourage Healthy 	Promotion of Prevention and Wellness in Medicaid	NPAIHB research comment	

Behaviors			
<ul style="list-style-type: none"> • “RightChoices” Grants • Prevention and Wellness Innovation Grants 	Options to Prevent Chronic Disease and Encourage Healthy Lifestyles		
	Employer Wellness Credits		
SECTION VII: Long Term Care Services and Supports	Page 49		
	Medicaid Home and Community Based Services (HCBS) Waivers and the Medicaid HCBS State Plan Option		
	Eligibility for HCBS Services		
	Increase Access to Medicaid HCBS	Include provisions which require States, all agencies of the Department of Health and Human Services, and the Department of Veterans Affairs to demonstrate how they will assure that AI/ANs have meaningful access to Federally-supported long-term care programs and services.	
	Increase Federal Match for Medicaid HCBS		
	Medicaid Spousal Impoverishment Rules		
	Medicaid Resources / Asset Test		
	Long Term Care Grants Program	Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project; Real Choice Systems Change Grant Initiative; Aging and Disability Resource Centers (ADRC); Informal Caregivers; prevention and Health Promotion; and Green House Model.	

	Functional Assessment Tool for Post-Acute LTC		
	Money Follows the Person Rebalancing Demonstration		
SECTION VIII: Options to Address Health Disparities	Page 56		
	Required Collection of Data	Health reform legislation must include funding to develop, and support implementation by all providers within the I/T/U of, a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources support the level of need throughout the system and improve the quality and effectiveness of care..	
		<ul style="list-style-type: none"> ○ Funding should also be provided for developing and implementing throughout the I/T/U patient identification smart card technology. 	
	Data Collection Methods		
	Standardized Categories for Data		
	Public Reporting, Transparency, and Education		
	Language Access		
	Elimination of Five-year Waiting Period for Non-Pregnant Adults		
	Reduction in Infant Mortality and Improved Maternal Well-Being		
		NPAIHB Comments on what would address disparities for AI/AN?	
Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs			

April 29, 2009		
Section I: Payment Reform - Options to Improve the Quality and Integrity of Medicare Payment Systems	<i>Page 2</i>	
<ul style="list-style-type: none"> Physician Quality Reporting Initiative (PQRI) Improvements and Requirement Quality Reporting 	Linking Payment to Quality Outcomes	
<ul style="list-style-type: none"> Primary Care and General Surgery Bonus Payment for Transitional Care Activities 	Primary Care	
Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration	<i>Page 11</i>	
	Chronic Care Management	
<ul style="list-style-type: none"> Sustainable Growth Rate (SGR) Medicare Shared Savings Program (i.e. Accountable Care Organizations) Extension and Expansion of the Medicare Health Care Quality Demonstration Program 	Moving From Fee-for-Service to Payment for Accountable Care	
Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform	<i>Page 19</i>	

<ul style="list-style-type: none"> • Encouraging Health Information Technology Use and Adoption in Support of Delivery System Reform Goals • Improving Quality Measurement 	Health IT	<p>Health information technology improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive a fair share of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.</p>	
	Comparative Effectiveness Research	NPAIHB Comment regarding research?	
<ul style="list-style-type: none"> • Physician Payment Sunshine • Physician-Owned Hospitals • Nursing Home Transparency 	Transparency		
<ul style="list-style-type: none"> • Redistribution of Unused GME Slots to Increase Access to Primary Care and Generalist Physicians • Promoting Greater Flexibility for Residency Training Programs • TANF Health Professions Competitive Grants • Proposal on Development of a National Workforce Strategy 	Workforce	<p>The proposed coordinated national strategy to address health care workforce shortages must include as a key focus area the Indian health delivery system.</p> <p>Unlimited access to the National Health Service Corp should be made available to the I/T/U.</p> <ul style="list-style-type: none"> ○ Resources for training, recruiting and retaining health providers should be made available to the I/T/U directly. ○ Funding for training and supporting alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists should be expanded. ○ Indian health programs must be provided with the resources needed to enable them to compete for health care professionals, to recruit personnel to fill existing vacancies, and to retain existing staff. ○ Funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs must be enhanced. ○ Mechanisms for assignment of National Health Service Corps personnel should be revised to enable Indian health programs to access these personnel on the basis of their Indian service population. <p>NPAIHB workforce comments?</p>	
<p>Section IV: Medicare Advantage – Options to Promote Quality, Efficiency</p>	Page 37		

and Care Management			
Section V: Public Program Integrity - Options to Combat Fraud, Waste and Abuse	<i>Page 42</i>		
	Provider Screening		
	Data Base Creation and Data Matching		
	Provider Compliance and Penalties		
	Program Integrity Funding and Reporting Requirements		
Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options			
May 20, 2009			
SECTION I: Health System Savings	<i>Page 4</i>		
<ul style="list-style-type: none"> ○ Improving Payment Accuracy through Adjusting Annual Market Basket Updates ○ Updating Payment Rates for Home Health Services ○ Updating Payment Rates for Inpatient Services ○ Adjusting Reimbursement for High-Growth, Over-Valued Physician Services ○ More Appropriate Payment for Durable Medical Equipment ○ Increase the Medicaid Brand-Name and Generic Drug 	Ensuring Appropriate Payment		

<ul style="list-style-type: none"> ○ Rebate Amounts ○ Extend to and Collect Rebates on Behalf of Managed Care Organizations ○ Application of Rebates to New Formulations of Existing Drugs 			
	Capturing Productivity Gains		
	Reducing Geographic Variation in Spending		
<ul style="list-style-type: none"> ○ Making Beneficiary Contributions More Predictable ○ Means Testing Part D Premiums 	Modifying Beneficiary Contributions		
SECTION II: Options to Modify the Exclusion for Employer-Provided Health Coverage	Page 16	AI/AN are entitled to receive health care as a federal trust responsibility. As such, AI/AN must be exempt from any personal income tax on health benefits, services, premiums or cost sharing paid or provided on their behalf. (Locke)	
SECTION III: Other Health Care Related Revenue Raisers	Page 18		
	Modify or Repeal the Itemized Deduction for Medical Expenses		
	Repeal of Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield or Other Qualifying Organizations		
	Modify Health Savings Accounts		
	Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements and Health Reimbursement Arrangements		
	Limit the Qualified Medical Expense Definition		
	Modify FICA Tax Exemption		

	Extend Medicare Payroll Tax to all State and Local Government Employees		
	Modify the Requirements for Tax-Exempt Hospitals		
SECTION IV: Lifestyle Related Revenue Raisers	Page 33		
	Impose a Uniform Alcohol Excise Tax		
	Enact a Sugar-Sweetened Beverage Excise Tax		
SECTION V: Administration's Revenue Raising Proposals	Page 35		