| Clerk of the House of Representatives | Secretary of the Senate |
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SECRETARY OF THE SENATE

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# LOBBYING REPORT

Lobbying Disclosure Act of 1995 (Section 5) - **All Filers Are Required To Complete This Page**

1. Registrant Name
BAKER Healthcare Consulting, Inc

2. Address ☐ Check if different than previously reported
One American Square, Suite 2000, Box 82058

3. Principal Place of Business (if different from line 2)
City Indianapolis State/Zip (or Country) IN 46282

4. Contact Name: Dale E. BAKER Telephone: 317-631-3613 E-mail (optional): bakerhealthcare@yahoo.com

5. Senate ID #: 5164

7. Client Name ☐ Self
BRAZOSPORT MEM. HOSPITAL

6. House ID #: 33560

**TYPE OF REPORT** 8. Year 2000 Midyear (January 1-June 30) ☐ **OR** Year End (July 1-December 31) ☑

9. Check if this filing amends a previously filed version of this report ☐

10. Check if this is a Termination Report ☐ ⇨ Termination Date_____ 11. No Lobbying Activity ☐

**INCOME OR EXPENSES** - Complete Either Line 12 **OR** Line 13

**12. Lobbying Firms**

**INCOME** relating to lobbying activities for this reporting period was:

Less than $10,000 ☑

$10,000 or more ☐ ⇨ $_____
Income (nearest $20,000)

Provide a good faith estimate, rounded to the nearest $20,000, of all lobbying related income from the client (including all payments to the registrant by any other entity for lobbying activities on behalf of the client).

**13. Organizations**

**EXPENSES** relating to lobbying activities for this reporting period were:

Less than $10,000 ☐

$10,000 or more ☐ ⇨ $_____
Expenses (nearest $20,000)

**14. REPORTING METHOD.** Check box to indicate expense accounting method. See instructions for description of options.

☐ **Method A.** Reporting amounts using LDA definitions only

☐ **Method B.** Reporting amounts under section 6033(b)(8)of the Internal Revenue Code

☐ **Method C.** Reporting amounts under section 162(e) of the Internal Revenue Code

Signature Dale E Baker 2-11-01.

Printed Name and Title Dale E. Baker, President

LD-2 (REV. 6/98)

PAGE 1 of _____

Registrant Name Baker Healthcare Consulting Client Name Brazos Port Mem Hosp.

**LOBBYING ACTIVITY.** Select as many codes as necessary to reflect the general issue areas in which the registrant engaged in lobbying on behalf of the client during the reporting period. **Using a separate page for each code**, provide information as requested. Attach additional page(s) as needed.

15. General issue area code MMM (one per page)

16. Specific lobbying issues

SEE ATTACHMENT

17. House(s) of Congress and Federal agencies contacted ☐ Check if None

SENATE
House of Representatives

18. Name of each individual who acted as a lobbyist in this issue area

| Name | Covered Official Position (if applicable) | New |
|---|---|---|
| DALE E BAKER | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |
| | | ☐ |

19. Interest of each foreign entity in the specific issues listed on line 16 above ☐ Check if None

Signature Dale E. Baker Date 2-11-01

Printed Name and Title Dale E Baker, President

Form LD-2 (Rev 6/98)

# Executive Summary

In 1983, Congress passed legislation creating the Medicare Prospective Payment System (PPS) for inpatient acute care services. One of the major determinates of payment in the PPS is the wage index which is set for each of 329 Metropolitan Statistical Areas (MSAs) and each statewide rural area. Soon after passage, it became clear that hospitals located just outside one MSA could be paid based on a wage index substantially lower than local market wage levels. This anomaly resulted in hospitals just outside metropolitan areas not being able to compete in the urban labor market for professional staffing.

In 1986, 1987 and 1988, Congress sponsored legislation to try to fix some of the most blatantly unfair issues that had been presented to various members of Congress. In 1989, Congress legislated the Medicare Geographic Classification Review Board (MGCRB) that would annually approve hospitals that meet certain criteria for geographic reclassification and allow them to be paid based on the wage index of a nearby geographic area, or in certain cases, by the standardized amount of a nearby metropolitan area.

The criteria were determined by the Health Care Financing Administration (HCFA) and published in proposed form in 1989 and in final form in 1990. Subsequent regulatory changes to the criteria have generally had the effect of reducing the numbers of hospitals that were reclassified over the years. On several occasions, Congress has acted to liberalize reclassifications. In the spring of 2000 HCFA did allow for a modest expansion of reclassified rural hospitals by lowering the criteria for reclassification slightly.

In the Balanced Budget Refinement Act of 1999 (BBRA) Congress approved a number of individual hospital and individual county reclassifications for a two-year period. While the popular press labeled many of these fixes as "pork barrel politics" these temporary fixes were in response to serious reclassification deficiencies that had cropped up over the years. Additionally, in BBRA Congress asked the General Accounting Office (GAO) to study the reclassification process and report back to Congress no later than May 20, 2001.

The Coalition to Preserve Reclassification (CPR) is a group of reclassified hospitals (or hospitals that would have been reclassified under previous criteria) that are seeking to preserve the reclassification system and fix criteria that have gone awry over the years or certain other obvious and inequitable situations that simply were not anticipated. The CPR hospitals have three requests of Congress:

1. **If BBA relief is granted in the fall of 2000 would Congress consider the systemic fixes that are outlined herein as a part of that legislation?**

2. **Would individual members of Congress consider approaching GAO, as appropriate to let them know of their general support for the geographic reclassification in its existing form (after fixing the criteria as mentioned above)?**

3. **Consider whether you would be willing to sponsor or support legislation to broadly fix the criteria to preserve the reclassification process and make it work appropriately for perhaps the next ten years. This would likely be for the 2001 Congressional session.**

## COALITION TO PRESERVE RECLASSIFICATION

### SUMMARY OF ISSUES

| Issue | Countywide Reclassification | Urban Floor | 108% Criteria in Small MSAS. | 90% Occupational Mix Alternative Criteria |
|---|---|---|---|---|
| Brief Description of Issue | The criteria for countywide reclassification was designed in 1989-90, before the proliferation of Hospital based Rehab, Psych, SNF and Home Health units and the expanded outpatient unit. Due to changes in the industry, few counties can qualify. For example, in FFY 1995, there were 23 countywide reclassifications affecting 138 hospitals. For FFY 200, there were 2 countywide reclassifications affecting 6 hospitals. | In the original 1989 statute, Congress provided a rural floor for the statewide rural wage index. Thus the wage costs and hours for any rural hospital that was reclassified would not be removed from the computation of the rural wage index.<br><br>A similar treatment is needed for urban reclassifications to prevent non-reclassified hospitals from getting a lower wage index simply because a neighboring hospital was successfully reclassified. | When HCFA implemented the 108% criteria in FFY 1994, it virtually eliminated any reclassifications from small MSAs with three or fewer hospitals to another area. It is statistically almost impossible (for a single hospital MSA - - it is impossible) for a hospital to have an average hourly wage of 108% of the home MSA. Our proposal would deem that highest paying hospital is an MSA with three or few hospitals to be over the 108% criteria. A special provision would consider St. Cloud Hospital (MN) to meet this criteria. | Congress established an alternative criteria for the 84% (82% rural) average hourly wage criteria Congress recognized that lower paid hospitals might necessarily substitute a lower skill mix than nearby urban areas. This criteria looks at input costs and eliminates skill mix bias. No current skill mix data is available. Our proposal would allow the use of older AHA skill mix data for this computation until new data becomes available. |

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| Issue | Countywide Reclassification | Urban Floor | 108% Criteria in Small MSAS. | 90% Occupational Mix Alternative Criteria |
|---|---|---|---|---|
| Has Congress Addressed This Issue? | Yes. BBRA. Lake County, IN; Butler County, OH; Brazoria County, TX; and Orange County, NY. | Yes. BBRA. Allentown, Bethlehem, Easton, MSA; and Hattiesburg, MS. MSA. | No. | Yes, in the original statute and in BBRA for Lee County, Illinois |
| Approximately How Many Hospitals Will Be Affected? | Approximately 112 hospitals. | Perhaps 100 hospitals. | Approximately 27 hospitals | 36 hospitals. |
| GOAL | Restore criteria to reclassify hospitals at approximately 1995 level. | Do not penalize urban non-reclassified hospitals . . . treat similarly to rural non-reclassified hospitals. | Treat MSAs with three or fewer providers comparably to other areas. | Occupational mix changes slowly. Allow hospitals to use older occupational mix data while HCFA finds a new source for data. |
| Profile of Affected Hospitals | Urban hospitals in a Consolidated Metropolitan statistical Area (large urban) | Urban hospitals in an MSA where one or more hospital(s) are reclassified elsewhere. | Urban hospitals with three of fewer providers in an MSA. Also, St. Cloud Hospital, which is in a similar area unique situation. | Generally larger rural hospitals approximately 50% of which are adjacent to large urban area such as Chicago, Pittsburgh, etc. |
| Estimated Dollar Impact (Budget Neutrality Effect). (Based On Inpatient Operating Costs) | $80,000,000 | We do not believe this should be "scored" as a "cost". It only affects non-reclassified hospitals and is a basic equity issue. $31,000,000 | $18,000,000 | $34,000,000 |

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## COALITION TO PRESERVE RECLASSIFICATION

### SUMMARY OF ISSUES

| Issue | Reverse Competition | Sole Community Hospitals – Exempt from 106% criteria | Standardized Amount Rural to Other Urban & Update Criteria | Include teaching and resident data for 108% (106%) criteria |
|---|---|---|---|---|
| Brief Description of Issue | Geisinger Medical Center , a 598 bed teaching hospital in Danville, PA easily qualified for a Harrisburg, PA wage index. Geisinger gets a wage index over 12% higher (FFY 2000) than two nearby MSAs. Scranton, Wilkes-Barre, Hazelton and Williamsport that must compete for scarce labor. This is unique to northeastern PA. CPR proposal would set the two MSA wage indexes as identical to whatever wage index Geisinger has. | SCHs can be paid the highest of their PPS rates or based on certain base year costs per case treated forward – - whichever is higher.<br><br>CPR proposal would increase the PPS rates to give another payment alternative to then small, isolated rural hospitals. It could also improve outpatient payment under ASC prospective payments. | Emerging Issue. Specify that rural hospitals can be reclassified for standardized amount purposes to " other urban areas." The previous Congressional action in the BBA was for 30 months and has expired. Renew this provision so rural hospitals next to "other urban" areas will be treated consistently with rural hospitals next to large urban areas (for DSH calculation). Also, update standardized amount criteria similar to countywide group. | An industry compromise led by the AHA is phasing out physician teaching costs and interns and residents data out of the wage index over a five-year period.<br><br>This phase out as the unintended side effect of preventing generally larger teaching hospitals just outside major urban areas with teaching hospitals from meeting the 108% or 106% criteria for reclassification. CPR recommends that teaching data be included for the teaching hospitals and the home MSA for the 108% or 106% criteria only ( not for payment purposes). |

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| Issue | Reverse Competition | Sole Community Hospitals – Exempt from 106% criteria | Standardized Amount Rural to Other Urban & Update Criteria | Include teaching and resident data for 108% (106%) criteria |
|---|---|---|---|---|
| Has Congress Addressed This Issue? | No | No | Yes – BBA for the other urban provisions. No, for update of standardized amount criteria. | No. |
| Approximately How Many Hospitals Will Be Affected. | 10 | Not technically feasible to estimate because of alternative payment systems. | First proposal would protect existing hospital reclassification. | A few of presently reclassified teaching hospitals. |
| GOAL | Allow nearby urban hospitals to compete | Treat similarly to RRCs. | Treat rural hospitals next to "larger urban" and other urban area consistently. | Keep geographic for reclassification from these important teaching hospitals. |
| Profile of Affected Hospitals | Two small MSA's in northeastern PA | Small isolated hospitals many in sparsely populated rural western states. | Rural hospitals many with significant DSH levels. | Teaching hospitals in rural or urban area adjacent to areas with medical schools. |
| Estimated Dollar Impact (Budget Neutrality Effect). (Based On Inpatient Operating Costs) | To be determined. | Not determinable - - not considered a major payment issue. | Not presently determined. | None. |

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