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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
Emmanuel-St Joseph Hospital

6. House ID #: 33560

TYPE OF REPORT 8. Year 1999 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

Printed Name and Title DALE E BAKER, President

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Registrant Name Baker Healthcare Consult Client Name Immanuel-St Joseph Hospital

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 2-3-2000

Printed Name and Title DALE E. BAKER, President

Form LD-2 (Rev.6/98) Page ____ of ____

THE 90% OCCUPATIONAL MIX GROUP
MEDICARE GEOGRAPHIC RECLASSIFICATION ISSUE

Executive Summary

On August 5, 1997, President Clinton signed the Balanced Budget Act (BBA) of 1997. Included in the health provisions of the BBA Congress and the President legislated an important provision designed to improve Medicare payment to a key group of rural hospitals known as Rural Referral Centers (RRCs). These rural hospitals are large urban like facilities located in rural America that provide primary, secondary, and in some cases tertiary care to surrounding rural residents. The BBA exempted RRCs from an onerous criteria that only approximately fifty percent of the RRCs could meet to allow all RRCs to obtain higher Medicare payment based on the prevailing wage levels in the nearest metropolitan area. This important provision recognizes that these sophisticated hospitals are in direct competition with urban medical centers for health professionals and therefore must be paid by the Medicare program rates that are comparable to city Medicare rates.

Three weeks after the President signed the BBA the Health Care Financing Administration (HCFA) eliminated an alternative criteria that affected approximately thirty rural hospitals nationally (approximately twelve to fifteen percent of the total RRCs). Since 1990, hospitals have had the opportunity to seek the higher urban wage index of the nearest metropolitan area if the rural facility met certain annual statistical criteria. The basic test allow hospitals to be reclassified if the hospital's average hourly wage was equal to 84% or more of the nearest Metropolitan Statistical Area (MSA). If a hospital's hourly wage is less than 84% of the nearby Metro area, Congress mandated that an "occupational mix" adjustment be used to offset any impact on the rural hospital's average hourly wage caused by using a lower skill mix than urban hospitals. This could be caused by either the inability of the hospital to find health professionals in their area or the hospital's financial need to use fewer professionals.

Hospitals with an average hourly wage of less than 84% of the nearby metropolitan area could still be reclassified if using the occupational mix of the metro area multiplied by the wage rates of the rural hospital yields 90% or more of the metro average hourly wage. The American Hospital Association (AHA) was the only organization collecting this occupational mix data and as a result of downsizing, they discontinued the survey data. Because HCFA did not have any other source of data, the 90% criteria was eliminated by regulation on August 29, 1997, three weeks after the President signed the BBA.

The legislation or administrative actions we are requesting would require HCFA to continue to use the AHA data until alternative sources of occupational mix data become available. Statistical comparisons indicate that occupational mix data changes very slowly and thus it would be reasonable to use older data for this purpose.

Adoption of the legislation would improve payment equity to the approximately thirty RRCs throughout the country that do not meet the basic 84% criteria but are able to demonstrate that the occupational mix adjusted average hourly wage is 90% or greater of the nearby metropolitan area. This provision would also impact a relatively small number of other rural hospitals that have not been designated as RRCs. The proposal is budget neutral and would shift an inconsequential amount from the 5,100 US hospitals to affected providers.

Hospitals in at least nine states are contacting legislators on this issue in December of 1997.

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