BAKER HEALTHCARE CONSULTING, INC.
SUITE 2000, BOX 82058
ONE AMERICAN SQUARE
INDIANAPOLIS, INDIANA
46282

DALE E. BAKER
PRESIDENT

March 5, 2003

Secretary of the Senate
Office of Public Records
232 Hart Building
Washington, DC 20510

Re: Untimely Filing of LD-2 for Year End 2002 Reports

Dear Secretary:

Baker Healthcare Consulting, Inc. is a very small firm with one full-time employee, I Baker, and one full-time leased employee, Karen K. Siders. Ms. Siders' father had surgery l in January 2003 and died on Tuesday, February 25, 2003. Ms. Siders used the Family Medi Leave Act to be with her father and her family throughout this most difficult period.

As a result, normal secretarial activities were delayed and the reports were not filed c to an oversight by Dale E. Baker.

We hope that we have not inconvenienced your office with this oversight. Our inten always been, is, and will continue to be, to fully comply with the Lobbying Disclosure Act c 1995 and its interpretation.

Sincerely,

BAKER HEALTHCARE CONSULTING, INC.

Dale E. Baker

Enclosures

20868_1.DOC

Clerk of the House of Representatives	Secretary of the Senate
Legislative Resource Center	Office of Public Records
B-106 Cannon Building	232 Hart Building
Washington, DC 20515	Washington, DC 20510

SECRETARY OF
03 MAR 13 P

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 Telephone E-mail (optional)
Dale E. BAKER 317-631-3613 BakerHealthcare@yahoo.com

5. Senate ID # 5164

6. House ID # 3356

7. Client Name ☐ Self
T. J. Samson Hospital

TYPE OF REPORT 8. Year 2002 Midyear (January 1-June 30) ☐ **OR** Year End (July 1-Dece

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

10. Check if this is a Termination Report ☑ ⇨ Termination Date 12-31-02 11. No Lobbying

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 repo period were:

Less than $10,000 ☐

$10,000 or more ☐ ⇨ $_____
Expenses (nearest $2

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

☐ **Method A.** Reporting amounts using LDA definiti

☐ **Method B.** Reporting amounts under section 6033 Internal Revenue Code

☐ **Method C.** Reporting amounts under section 162(Internal Revenue Code

Signature Dale E. Baker

Printed Name and Title Dale E. BAKER, President

LD-2 (REV. 6/98) PA

Registrant Name Baker Healthcare Consulting Client Name T. J. Samp... Hos...

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

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

16. Specific lobbying issues

See Attached

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)
Dale E. Baker	

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

N / A

Signature _____ Date March 6, 2

Printed Name and Title Dale E. BAKER

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

Registrant Name BAKER Healthcare Consulting Client Name T. J. Samson Hospital

Information Update Page - Complete ONLY where registration information has changed.

20. Client new address

21. Client new principal place of business (if different from line 20)

City State/Zip (or Country)

22. New general description of client's business or activities

LOBBYIST UPDATE

23. Name of each previously reported individual who is **no longer** expected to act as a lobbyist for the client

ISSUE UPDATE

24. General lobbying issues previously reported that **no longer** pertain

AFFILIATED ORGANIZATIONS

25. Add the following affiliated organization(s)

Name	Address	Principal Place of Bu (city and state or co

26. Name of each previously reported organization that is **no longer** affiliated with the registrant or client

FOREIGN ENTITIES

27. Add the following foreign entities

Name	Address	Principal place of business (city and state or country)	Amount of contribution for lobbying activities

28. Name of each previously reported foreign entity that **no longer** owns, or controls, or is affiliated with the registran affiliated organization

Signature Dale E. Baker Date March 6, 200

Printed Name and Title Dale E. Baker, President

90% OCCUPATIONAL MIX ISSUE SUMMARY

BACKGROUND

In 1989 Congress passed legislation establishing the Medicare Geographic Classificat Review Board (MGCRB) to assist hospitals to obtain Medicare payment levels of nearby generally urban areas that are paid higher Medicare rates. By far the most common reclassifications are to obtain the wage index of the nearby area, which adjusts 71% of total Medicare payment. The Centers for Medicare and Medicaid Services (CMS) defined the crit for reclassification and one of the key criteria for a wage index reclassification is that a hospi must have an average hourly wage of at least 82% of its target Metropolitan Statistical Area (MSA) to demonstrate that the hospital is in the same labor market as the MSA. Additionall rural hospitals must be within thirty-five miles of the boundary of the MSA to which a hospit requests reclassification (although Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) are exempted from this criteria). The last reclassification criteria establish by CMS is the requirement that a reclassifying hospital must also have an average hourly wa of at least 106% of the home rural statewide average.

In 1997, Congress exempted RRCs from the 106% requirement in the Balanced Budg Act. This recognized the special importance of RRCs, large urban like hospitals with special services in rural areas and allowed the vast majority of these hospitals to obtain an urban wag index so the RRCs, can compete for the specialized staff needed to provide the sophisticated services so needed in these referral centers located in rural America. Since then, Congress ha established Critical Access Hospitals (CAHs) and the role of these RRCs has become even m important as some marginal rural hospitals have reduced the scope of services offered to qual for CAH status, thus increasing the need for sophisticated urban like hospitals in rural areas.

THE PROBLEM

A few RRCs (and at least one other rural hospital) have "slipped through the cracks" this type of reclassification. These hospitals have met all relevant MGCRB criteria except th hospital average hourly wage is less than 82% of the target MSA. These hospitals are thus denied a wage index reclassification.

Congress foresaw this issue in 1989 when legislating the MGCRB and specified alter occupational mix adjustment criteria for hospitals that did not meet the CMS determined 82% criteria. Congress recognized that some rural hospitals paid based on a rural wage index nee compete with a nearby urban area by offering comparable wage levels. But since these facilit are paid less by Medicare these hospitals must substitute lower paid workers for higher paid workers to maintain fiscal solvency. This labor substitution factor can cause a hospital's ave hourly wage to drop below the 82% threshold. CMS responded by establishing an alternative criteria for hospitals unable to meet the average hourly wage criteria. The 90% occupational criteria was designed to determine if a hospital's pay rates are at least 90% of the target MSA pay rates for similar positions. This eliminated the bias introduced by the labor substitution

factor on the average hourly wage and effectively gave facilities a criteria based on "input c of various groups of employees.

Originally there were two occupational mix sources of data available for hospitals, t Bureau of Labor Statistics and the American Hospital Association (AHA). The Bureau of L Statistics stopped collecting this data in the early nineties and the AHA discontinued the kee of the data, as a result of downsizing in 1993. Congress gave the Secretary of HHS the discretion to eliminate the 90% occupational mix criteria and HHS exercised this authority a eliminated this criteria in the August 29, 1997 Federal Register (see pages 45988 and 45989 Interestingly, on the same page, HHS implements the BBA provision exempting RRCs from 106% (at that time – 108%) criteria thus allowing virtually all RRCs to be reclassified. The rationale is summarized on page 45989 of the aforementioned Federal Register as follows:

"We have no updated occupational mix data to correspond with the FY 1994 wage d that will be used for FY 1999 reclassifications. Therefore, this option will no longer be avail to hospitals."

WHAT HAVE WE DONE?

A group of hospitals has doggedly sought a regulatory or statutory solution to this iss In 1996, when HHS first suggested the possibility of eliminating this criteria these hospitals hired a consultant who demonstrated that occupational mix changes occur very slowly, so us one years occupational mix data with another years wage index would be a reasonable methodology. HHS rejected this and other proposals supported by the AHA and other propo discussed in the August 29, 1997 Federal Register.

These hospitals continued to file applications with the MGCRB as the hospital execut sought administrative or statutory relief. Four hospitals timely filed for a wage index reclassification for FFY 2002 and received completeness notices from the MGCRB. All were subsequently denied their reclassifications.

WHAT IS NEW?

In the Benefit Improvement and Protection Act of 2000 (BIPA), Congress modified th MGCRB process by using three years data to demonstrate compliance to the 82% and 106% criteria and they extended such wage index reclassifications to be effective for three years, rat than using one years data for an annual reclassification as was done previously.

Also, BIPA instructed HHS to obtain occupational mix data and use this data to compu a wage index to be applied for FFY 2005 and thereafter. ***Congress specifically required CMS only obtain the occupational mix data once every three years*** recognizing that occupational m data changes slowly, and can be matched with more recent wage data without producing excessively outdated estimates of occupational mix. Congress adopted a proposal consistent with our consultant's argument developed in 1996 and rejected by CMS.

On May 4, 2001, HHS issued a proposed rule, which was worded in such a way, that i appeared that CMS would accept the AHA data for the occupational mix criteria. The hospit responded during the comment period in favor of this treatment but CMS/HHS rejected reinstitution of the occupational mix adjustment in the final rule.

Representative Ron Lewis's office contacted Tom Scully, Administrator of CMS in August asking him to reinstate the 90% occupational mix criteria. Mr. Scully responded but declined to reinstate the occupational mix criteria.

ARGUMENT

Congress passed the BBA in August 1997. This effectively allows the vast majority RRCs to be reclassified by exempting these key rural hospitals from the 106% criteria. Only handful of these hospitals fail to meet the 82% criteria presumably because of labor substitut

All four of the hospitals requesting a legislative solution are adjacent to large urban metropolitan areas where there is a large "cliff" between the urban area wage index and the statewide rural wage index. Due to the magnitude of the differences between the urban and wage indexes, these four hospitals have likely done more labor substitution than other RRCs Also, all four hospitals have aggressively pursed administrative and legislative solutions to t issue since 1996.

PROPOSED SOLUTION

We ask that Congress reclassify any hospitals that filed with the MGCRB a timely request for FFY 2002 reclassification based on the 90% occupational mix criteria, received completeness notice from the MGCRB, but the MGCRB denied the application. This woul allow only four hospitals to obtain this reclassification, the hospitals that have pursued this remedy for years. In light of Congress BIPA and BBA provisions this would result in equit Medicare payment for these hospitals.

BUDGET NEUTRALITY

For FFY 2002, this would increase payment to the four hospitals by an estimated $7,132,000. The budget neutrality impact on the other approximately 4,790 hospitals with inpatient payments of $79 billion ($7,141 x 11,079,177 – average payment x number of cas August 1, 2001 Federal Register) would be to decrease payment by approximately .01% (.0

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