Truth in Testimony Disclosure Form

In accordance with Rule XI, clause 2(g)(5)* of the *Rules of the House of Representatives*, witnesses are asked to disclose the following information. Please complete this form electronically by filling in the provided blanks.

Committee: Ways and Means

Subcommittee:

Hearing Date: 03/11/2025

Hearing Title :

After the Hospital: Ensuring Access to Quality Post-Acute Care

Witness Name: DANA L. MADISON, DNP, MBA, BSN, RN

Position/Title: ADMINISTRATOR/PRESIDENT

Witness Type: ○ Governmental ● Non-governmental

Are you representing yourself or an organization? ● Self ○ Organization

If you are representing an organization, please list what entity or entities you are representing:

None

FOR WITNESSES APPEARING IN A NON-GOVERNMENTAL CAPACITY

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

Are you a fiduciary—including, but not limited to, a director, officer, advisor, or resident agent—of any organization or entity that has an interest in the subject matter of the hearing? If so, please list the name of the organization(s) or entities.

SEE ATTACHED

Please list any federal grants or contracts (including subgrants or subcontracts) related to the hearing's subject matter that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the source and amount of each grant or contract.

The funding is awarded under the Request for Applications (RFA) HHS0011339, Home Health Agencies, COVID-19 in Healthcare Relief Grant Program, pursuant to Texas Senate Bill 8 (87th Leg., 3d C.S., 2021), which allocated Coronavirus State and Local Fiscal Recovery Funds (SLFRF) funds received by the state under the American Rescue Plan Act. Camden Bay Ltd. dba BSA Compassion Home Care - awarded $136,620 on November 1, 2022.

Please list any contracts, grants, or payments originating with a foreign government and related to the hearing's subject that you or the organization(s) you represent have received in the past thirty-six months from the date of the hearing. Include the amount and country of origin of each contract or payment.

None

Please complete the following fields. If necessary, attach additional sheet(s) to provide more information.

☑ I have attached a written statement of proposed testimony.

☑ I have attached my curriculum vitae or biography.

*Rule XI, clause 2(g)(5), of the U.S. House of Representatives provides:

(5)(A) Each committee shall, to the greatest extent practicable, require witnesses who appear before it to submit in advance written statements of proposed testimony and to limit their initial presentations to the committee to brief summaries thereof.

(B) In the case of a witness appearing in a non-governmental capacity, a written statement of proposed testimony shall include—(i) a curriculum vitae; (ii) a disclosure of any Federal grants or contracts, or contracts, grants, or payments originating with a foreign government, received during the past 36 months by the witness or by an entity represented by the witness and related to the subject matter of the hearing; and (iii) a disclosure of whether the witness is a fiduciary (including, but not limited to, a director, officer, advisor, or resident agent) of any organization or entity that has an interest in the subject matter of the hearing.

(C) The disclosure referred to in subdivision (B)(ii) shall include—(i) the amount and source of each Federal grant (or subgrant thereof) or contract (or subcontract thereof) related to the subject matter of the hearing; and (ii) the amount and country of origin of any payment or contract related to the subject matter of the hearing originating with a foreign government.

(D) Such statements, with appropriate redactions to protect the privacy or security of the witness, shall be made publicly available in electronic form 24 hours before the witness appears to the extent practicable, but not later than one day after the witness appears.

False Statements Certification

Knowingly providing material false information to this committee/subcommittee, or knowingly concealing material information from this committee/subcommittee, is a crime (18 U.S.C. § 1001). This form will be made part of the hearing record.

Witness signature

3/8/25

Date

DANA L. MADISON - TRUTH IN TESTIMONY DISCLOSURE FORM - 3/8/25
OWNERSHIP/CONTROL OF ORGANIZATIONS WITH AN INTEREST IN SUBJECT MATTER

ORGANIZATION	RELATIONSHIP	PRINCIPAL BUSINESS
CAMDEN BAY LTD DBA BSA COMPASSION HOME CARE	ADMINISTRATOR LIMITED PARTNER PRESIDENT/OWNER OF GENERAL PARTNER	HOME HEALTH CARE AGENCY
PHOENIX BAY LTD DBA COMPASSION HOME HEALTH CARE	ADMINISTRATOR LIMITED PARTNER PRESIDENT/OWNER OF GENERAL PARTNER	HOME HEALTH CARE AGENCY
ADVANCE CARE MANAGEMENT LTD	VICE-PRESIDENT LIMITED PARTNER PRESIDENT/OWNER OF GENERAL PARTNER	CCM/RPM/APCM SERVICE PROVIDER
SITKA BAY LLC (GENERAL PARTNER OF CAMDEN BAY LTD, PHOENIX BAY LTD, & ADVANCE CARE MANAGEMENT)	PRESIDENT OWNER	MANAGEMENT COMPANY
THREE SAINTS BAY LTD DBA CPCS	ALTERNATE ADMINISTRATOR LIMITED PARTNER PRESIDENT/OWNER OF GENERAL PARTNER	PERSONAL ASSISTANCE SERVICES
GOODHOPE BAY LTD (GENERAL PARTNER OF THREE SAINTS BAY LTD)	PRESIDENT OWNER	MANAGEMENT COMPANY

Dr. Dana L. Madison DNP, MBA, BSN, RN
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LUBBOCK, TX 79424
Work phone: (806) 712-1110

Professional Experience:

Nov. 2024 – present	Partner/Administrator of Phoenix Bay, Ltd., d/b/a Compassion Home Health Care, a home health agency in the process of obtaining Medicare certification. Supervise/manage all areas of operations for this agency.
Nov., 2007 - present	Partner/Administrator of Camden Bay, Ltd., d/b/a BSA Compassion Home Care, a Medicare certified home health agency with 100+ employees. Supervise/manage all areas of operations for this agency.
April, 2013 – present	Partner/Alternate Administrator of Three Saints Bay, Ltd. d/b/a CPCS, a Personal Care Agency. Assist with the management of all areas of operation for this agency.
Jan., 2019 – present	Partner/VP Operations of Advance Care Management, a Chronic Care Management Company. ACM currently has 8000 Medicare patients and ten physician group practices. Supervise/manage all aspects of this business.
Jan., 1999 – Nov., 2018	Partner/Administrator of Calvert Home Health Care, Ltd. (formerly Calvert Home Health Care, Inc.), a Medicare certified home health agency with 6 branches & 100+ employees. Supervise/manage all areas of operations for this agency.
Sept., 2008 – Nov, 2018	Partner/Administrator of Cordova Bay, Ltd. d/b/a Calvert Home Health Care, Ltd., a Medicare certified home health agency with 3 provider numbers, 3 parent offices & 3 branches & 50+ employees. Supervise/manage all areas of operations for this agency.
Oct., 1998 – Jan., 1999	CEO/Administrator, First Choice Home Services, a Medicare certified home health agency. Supervise staff and oversee clinical/support functions for this agency with 80+ employees.
July, 1996 – Oct., 1998	Co-owner, CEO/Administrator, Home Health Care, Inc., a Medicare certified & JCAHO accredited HHA Implemented start-up of this agency. Supervised all areas of clinical/support operations.

Jan., 1994 – Sept., 1996	Administrator, OxyCare Home Health, Inc. Started agency for non-clinical owners. Performed initial home health nursing/aide visits. Achieved Medicare certification and JCAHO accreditation. Responsible for all clinical/support operations.
April, 1988 – Jan., 1994	Clinic Manager for HealthPlus Medical Group – 5 MD's with clinic hours seven days per week. Responsible for 15+ employees including nursing/clerical/support. Participant in setting fee structure and marketing.
March, 1987 – Sept., 1988	Part-time staff RN in CCU at Methodist Hospital, Lubbock. Direct patient care of CCU patients.
May, 1985 – April, 1986	Administrative Assistant – Irving Healthcare Systems, Irving Community Hospital, Irving, Texas. Responsible for research, budget, construction, and operation of two outreach projects – Women's Imaging Center and Valley Ranch Medical Center.
June, 1984 – March, 1985	Administrative resident - Irving Healthcare Systems, Irving Community Hospital, Irving, Texas. Helped obtain CON for cardiac catheterization lab and open-heart surgery. Assisted with $12 million hospital expansion project.
June, 1982 – June, 1984	Staff RN, Telemetry unit, St. Paul's Hospital, Dallas, Texas. Direct patient care of pre- and post-op cardiac surgical patients.
May, 1979 – Dec., 1981	Charge Nurse, Telemetry unit, Methodist Hospital, Houston, Texas. Responsible for 32 bed floor for pre- and post-op cardiac patients of Drs. DeBakey, Howell, Crawford and Noon. Responsible for management of staff including RN/LVN/Nurse Aides

Professional Affiliations:

1999 – present	Texas Association of Home Care & Hospice
2019 – present	Board Member – Owner's Auspice
2017-2019	Board Treasurer
2010-2012	Board President
1999 - present	Lubbock Chamber of Commerce
2019 – 2024	Executive Board of Directors
2017 – 2024	Board of Directors

2019 – present	Covenant Health Foundation Board
2021 – 2023	Children's Council Chair
2025 – present	Chair of Covenant Health Foundation Board
2004 – 2010	Lubbock Meals on Wheels Board Member
1986 – 2020	Lakeridge United Methodist Church
2011 - 2015	Co-Chair - Change for Children Ministry
2016 – 2020	Change for Children Ministry Committee
Social Organizations:	First United Methodist Church Junior League of Lubbock
Education:	B.S.N., Texas Women's University, 1979 M.B.A., Health Care – University of Dallas, 1983 DNP, Texas Tech University Health Science Center, 2024 **Registered Nurse, State of Texas, License No. 247996** **Expiration Date: 07/31/2026**

Good afternoon. My name is Dana Madison. It is an honor and privilege for me to be here today representing the home health industry. I serve as the Administrator of our family-owned agencies that serve both urban and rural patients in the Texas Panhandle and the West Texas region.

I have practiced as a registered nurse for 46 years. I received my bachelor's in nursing from Texas Women's University in Houston, my MBA in Healthcare from the University of Dallas, and my Doctorate in Nursing Leadership from Texas Tech University Health Science Center. I served as the President of the Texas Association of Home Care and Hospice (TAHCH) from 2010 to 2012, have served on the Board of Directors of TAHCH, and have served as Chairwoman of the TAHCH Medicare committee.

I started my first home health agency in Lubbock, Texas 31 years ago for two pharmacists, and two years later I started my own agency with my husband. Both agencies were officed in a converted bedroom in my home, and I performed all the nursing visits, wrote the policies and procedures based on the State of Texas and Medicare regulations, and was the case manager for all patients. I managed both the clinical and administrative operations until we had enough patients for my husband to join me in running the agency. When I initially started in home health, most patients had Medicare coverage and reimbursement was cost-based. The Balanced Budget Act (BBA) of 1997 dramatically changed the reimbursement model for home health care. It created the first of several payment systems that we would encounter over the next 30 years.

The BBA of 1997 created the Interim Payment System (IPS)that went into effect in 1998. The cost-based reimbursement methodology that existed prior to 1998 was further complicated by an annual capitated amount of reimbursement per each unduplicated patient that was generally based on when the home health agency had started in business. Most home health agencies were like mine, relatively small agencies that were owned by a nurse, and this new payment system was devastating to the industry. Over the next year, in Texas alone, 70% of the home health agencies closed and nationwide approximately 30% closed.

In January 2000 the Medicare Home Health Prospective Payment System (PPS) went into effect with a goal of aligning reimbursement with patient needs based on diagnosis, functional capability, and volume of therapy services, if any, required to rehabilitate the patient. In conjunction with PPS, CMS implemented a new assessment tool, Outcome and Assessment Information Set (OASIS), that established reimbursement rates for each 60-day period of care and established a baseline for

each patient from which outcomes could be measured. Agencies that were successful under this payment system had to have a sufficient volume of patients to balance the wide variance in reimbursement rates under the PPS system. As part of PPS, and in recognition of challenges faced by rural home health providers, there was a small "rural add-on" payment for rural patients which was helpful, but in most cases did not cover the costs of "windshield time" of the staff. My agencies have always attempted to provide services to rural areas, so it is not uncommon for some of our staff to drive 400+ miles a week. This rural add-on was phased out and home health agencies continue to struggle with providing services in rural settings.

2020 will forever be remembered by our nation for the COVID-19 pandemic and resulting public health emergency, but it will also be remembered by home health providers in Texas for other reasons. In January of 2020 we started with a new Medicare payment system, the Patient Driven Groupings Model (PDGM). This new payment system was still based on a 60-day period of care but changed the reimbursement to two 30-day increments with minimum service requirements to earn full reimbursement. As a result, our claims volume doubled, and we had to add administrative staff. January 2020 marked the beginning of the public health emergency (PHE) due to COVID-19. When other employers were sending their employees home to work our employees were taking care of up to 80 Covid patients a day in the patient's home. Supplies such as N95 masks, gloves, gowns, soap, disinfectants were extremely difficult to obtain. My husband and I were each spending twenty hours a week obtaining the required personal protective gear to protect both our employees and patients. My greatest nightmare was that one of our employees would unknowingly infect a patient or our employees would contract the virus from a patient. Our costs skyrocketed for both labor and supplies, but we were determined to do our part to free beds in the hospitals for sicker COVID patients. In my opinion, home health met and exceeded expectations in helping this country through the PHE. And finally, in March 2020 the Review Choice Demonstration (RCD) began in Texas and required a prior authorization from Medicare for all traditional Medicare patients. To meet the demands of RCD, we added administrative staff to review and submit the information to Medicare.

In 2023 CMS introduced Home Health Value Based Purchasing (VBP). Under this model we are graded on improvement in functional scores, rehospitalization, and customer satisfaction. We can receive up to a 5% bonus or up to a 5% decrease in all Medicare payments under HHVBP. This program has the potential to eliminate the home health agencies that are not producing good patient outcomes, and I am very excited about how this program can improve our industry.

Medicare Advantage (MA) plans currently cover approximately 50% of the Medicare-eligible patients that we serve. Most MA plans reimburse us at a rate below our costs and many are limiting, or denying, the volume of patient care required for quality outcomes. MA plans do offer services not covered by traditional Medicare and there is one plan that provides up to 20 hours of custodial / homemaker services per week. This service is extremely beneficial to our patients and helps them stay in their home.

As a health care professional that has spent most of my career in home health, I am very passionate about what we do and the positive impact we have on the overall health care system. The average Medicare home health patient that we serve is a 79-year-old female that lives on a limited income. My husband and I, along with my peers from TAHCH, come to Washington several times each year, and have done so over the past 20 years, to represent our patients. In all our years of meeting with our elected officials we have never asked for an increase in reimbursement, but rather to stop the reductions in reimbursement and regulations. CMS has forgotten the contributions that home health made during the PHE, and for the past two years have implemented permanent payment cuts in reimbursement because they contend that home health was overpaid in 2020 and 2021. MedPac annually reports to the Congress that home health margins are 20% for traditional Medicare. To arrive at these margins, they exclude hospital-based home health agencies and costs for MA plans. I ask Congress to instruct both CMS and MedPac to include all costs for all Medicare-eligible patients to show the true picture of home health margins which are closer, on average, to 5% nationally.

I want to leave you with these takeaways: 1) on average, one 60-day period of care of home health costs less than one treatment in an emergency room; 2) most senior citizens in America want to receive care in their own home; 3)in many rural counties in West Texas and the Texas Panhandle patients have to travel 60 miles or more for health care; 4)home health care is less than 2% of the overall Medicare budget; 5)our country continues to have a critical nursing shortage that was exacerbated by the Covid pandemic; 7)the utilization of telehealth in home health care must become reimbursable and most importantly, 8) on average, there are 10,000 baby boomers each day that turn 65, and this trend continues until 2030, and become eligible for the Medicare benefit; and finally, 9)I believe that home health care is cost-effective and can be at the forefront to help our country meet the challenges of our aging population, now and in the future.