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.