Alan Levine, Chair of the Board and Chief Executive Officer of Ballad Health
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Good morning, Madam Chair and members of the subcommittee. My name is Alan Levine. I have had the privilege of serving as Secretary of Health Care for two states – Florida and Louisiana – through consequential events, from hurricanes to oil spills, budget crises and, yes, even a pandemic.

But never before have I had more of a question about the capacity and capability of our health delivery systems to meet the challenges and needs of our populations as I do now in my current role as Chair of the Board and Chief Executive Officer of Ballad Health. As an integrated community health improvement organization serving 29 counties and more than one million people living in the rural Appalachian Highlands of Northeast Tennessee, Southwest Virginia, Western North Carolina and Southeast Kentucky, we are at the front lines of health care delivery.

Unlike past crises, this one seems to be more structural and, in my view, requires more attention. Because of this, I appreciate the invitation to discuss, along with my colleagues, Ballad Health's approach to mitigating the impact of what appears to be a crisis in healthcare manpower – both in terms of availability and resilience of the current supply.

About the size of New Hampshire, with 20 percent fewer people, the Appalachian Highlands is a largely rural region, rich in natural beauty and history. Hundreds of miles of the Appalachian Trail run over our tallest mountains, and our clean rivers are home to some of the most magnificent sports fishing in the nation. The music played in our mountains for centuries is what gave birth to country music at the Bristol Sessions in Bristol, Tennessee, a community that is also home to the last great colosseum – the Bristol Motor Speedway. Johnson City is home to East Tennessee State University, which produces more nurses than any school in Tennessee, is a national leader in the production of rural family physicians and, even though its Center for Rural Health Research is only 3 years old, it is already home to one of only seven HRSA-designated rural health research centers in the United States – joining great institutions like the

University of North Carolina, University of Kentucky and University of South Carolina. The region is home to world-class manufacturing, engineering and research anchored by Eastman Chemical Company's world headquarters in Kingsport, Nuclear Fuel Services in Erwin and Solar Biotech in Wise, Virginia, which is revolutionizing how synthetic biology products are being brought to market.

But like many rural communities, we face challenges. The region's overall population is expected to increase by only one percent over the next five years while many counties are in significant decline. Our population grows older each year. The shift from coal has eliminated tens of thousands of well-paid middle-class jobs, leading to chronic unemployment and underemployment. This in turn has led to what many refer to as diseases of despair, such as drug abuse, alcoholism, and suicide. Obesity and smoking rates are high, leading to significant prevalence of diabetes and cardiovascular disease. Years of early death per capita in some of our local Tennessee counties, for example, are three to four times that of the wealthiest counties in Tennessee, and the COVID-19 pandemic has only exacerbated premature death and disability.

This puts Ballad Health, as well as many other rural hospitals and health systems, in a unique position critical to the health and overall well-being of the communities we serve. Not only is a robust rural health system critical to serving the *current* disproportionately high chronic health needs of our population and the demands of the COVID-19 pandemic, but as leading providers of preventive services, health education, social care navigation and employment – all proven to contribute far more to health and well-being than healthcare services alone – financially stable and community-led hospitals and health systems are important catalysts for overall community health improvement.

The bills under discussion today, as well as those being considered by this committee and others, are important to sustain robust rural health systems. Few issues are as important as the challenges facing the healthcare workforce, many of which were present prior to the pandemic and are now only exacerbated and accelerated. Most critical is the shortage of bedside nursing and allied health workers,

due to burnout, retirements and lack of capacity in our training environments. The reality is that if the gaps in healthcare employment are not quickly addressed, rural communities and other areas with higher growth in elderly and other vulnerable populations will face a serious inability to meet the needs of those increasingly relying upon the health delivery system.

Here are some pre-pandemic data points related to nursing, for example:

- Some studies have found the number of nurses leaving the workforce each year has grown from 40,000 in 2010 to nearly 80,000 by 2020. The Bureau of Labor Statistics projects 175,900 openings for registered nurses each year through 2029. A 2018 survey by the Health Resources and Services Administration found the average age for a registered nurse is 50 years old, which portends a wave of retirements in the coming decade. Again, this data is pre-pandemic. There is no question these numbers are now outdated, and far worse.
- Before the pandemic, nursing school enrollment was not growing fast enough to meet the then-projected demand for registered nursing services. The American Association of Colleges of Nursing (AACN) reported a 5.1 percent enrollment increase in entry-level baccalaureate programs in nursing in 2019, but this increase is insufficient to meet projected demand.
- According to the AACN's 2019-2020 report on Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing, *U.S. nursing schools turned away more than 80,000 qualified applicants from baccalaureate and graduate nursing programs in 2019* due to insufficient numbers of faculty, clinical sites, classroom space and clinical preceptors.

Several publications predating the pandemic and citing multiple surveys of nurses suggest more than 75 percent of nurses report the nursing shortage presents a major problem for the quality of their work life, the quality of patient care, and the amount of time nurses can spend with patients. These shortages and their effects have only been made worse by the COVID-19 pandemic.

Linda Shepherd, chief nursing officer at our Johnston Memorial Hospital in Abingdon, Virginia, and president of the Virginia Nurses Association, summed it up on a recent VNA call with state-wide media. "Our nurses are mentally depleted, exhausted and traumatized, experiencing pandemic-related PTSD with little or no time to seek mental health services. Suicide among nurses and other members of the medical community is also on the rise. We have had nurses over the past six months who have lost tremendous amounts of weight being unable to focus or get themselves in a place where they're emotionally settled, so they just stop eating. All of these things are impacting all of our nurses here in Virginia, as well as across the nation."

Contrary to popular perception, hospitals are not generally full of death and despair. In more normal times, hospitalization leads to recovery from illness and injury. When death does come in the hospital, families provide emotional support to their dying loved ones and each other. COVID-19 has changed that. Nurses and physicians – working in isolation, because of visitation restrictions resulting from COVID-19, with patients dying of COVID-19 and other conditions – bear much of the burden, first with the patient and then with the family.

Our Chief Clinical Officer, Dr. Amit Vashist, told Senator Tim Kaine during the senator's efforts to pass the Dr. Lorna Breen Health Care Provider Protection Act in the Senate, "I'm used to death. But I'm not used to so many deaths happening all in the space of several days. It's not easy to pronounce three people [dead] on a 12-hour shift." Dr. Vashist went on further to say that caregivers have no one to talk to other than each other, they are isolated from their families and that he personally has felt despair.

We have countless more local stories, many shared through social media, local television and national media, about the daily strain placed on nurses, physicians and other caregivers. And while Ballad Health has significantly increased the availability of our Employee Assistance Program, which provides confidential counseling and support to any employee, our internal statistics bear out the toll of caregiver burnout: Ballad Health's annual nursing turnover prior to the pandemic was 15 percent, below the

national average cited in the 2021 NSI National Health Care Retention and RN Staffing Report. During the pandemic, we saw turnover spike to as high as 27 percent as nurses and their support teams burned out or nurses left to become travelers – in some cases increasing their hourly wages by four-fold beyond what the hospital could afford to pay on its fixed revenue reimbursement.

Beyond the emotional toll, nursing burnout has very real cost implications for Ballad Health and the nation. Since last year, Ballad Health has increased spending on nursing and allied health salaries and benefits by approximately $100 million annually to retain our current staff, attract new staff and pay contract workers to fill the gaps. Those costs are now a part of our recurring base. Prior to the pandemic, Ballad Health operated on a margin of only approximately 2.0 percent – even then below what is necessary for long term sustainability. Without the generous federal support we've received, which has sustained us through this year – and were temporary measures – these new labor costs, going forward, risk wiping out our operating margins on a recurring basis, which I will discuss more momentarily. Some health systems operate in regions with a sizeable commercially-insured population, providing them with options for seeking revenue enhancement to pass on these costs. In rural regions like ours, however, where only 21 percent of our inpatient volume is commercially insured – with 70 percent being Medicare, Medicaid or uninsured – these new costs, which I do not believe have peaked, truly leave us with no recourse.

When Chick Fil-A can pay up to $20 per hour – almost what a starting nurse receives – they can increase the price of their chicken sandwiches, and many of us, who can afford to do so, will pay. But in a rural hospital with prices established by the federal government, the reimbursement for these rural health providers simply does not keep up with the market. The damage being done is very real, and I urge Congress to consider that as a relevant component to any solution.

I say this because we are not alone. It has been widely reported that other systems nationally have experienced similar increases in expenses. A report by Premier, Inc., published earlier this month

found that “hospitals and health systems across the country are paying $24B more per year for qualified clinical labor than they did pre-pandemic.” The Premier study also found that “overtime hours are up 52 percent as of September of 2021 when compared to a pre-pandemic baseline. At the same time, use of agency and temporary labor is up 132 percent for full-time and 131 percent for part-time workers.”

Some would accurately argue this is the labor market at work, and we know labor shortages are driving up wages in other industries also. As I pointed out in my previous statement, however, healthcare is not a free market where prices for goods and services are self-regulated by buyers and sellers negotiating in an open market. On the revenue side, the price is largely fixed by the government (given our more than 70 percent mix of government sponsored patients), but on the labor supply side, we are left with free-market forces that have driven the price of a nurse to as much as $140 per hour for a nurse made available through a contract agency. Our system is not able to simply pass on the cost of labor and other increases, given the nature of our government payor mix, and what was once a slim operating margin of approximately 2.0 percent in FY2019 has deteriorated to negative 2.4 percent (not counting federal and state relief funds) in FY2021. Payments from the American Rescue Act were certainly important to Ballad Health in maintaining fiscal stability the past 18 months; however, the shift in the labor market is expected to be an ongoing expense.

While larger health systems may weather the storm for some period, many rural hospitals might not be as resilient. The University of North Carolina’s Sheps Center for Health Service Research has recorded 181 rural hospital closures since 2005 – 138 of which occurred within the past decade. According to the Chartis Center for Rural Health, 453 additional rural hospitals are vulnerable and could close due to mounting financial pressures, and 46% of rural hospitals had negative operating margins. This data was assembled prior to the pandemic, raising an even greater question about the resiliency of this important safety net.

Even before the COVID-19 pandemic, rural and non-urban hospitals found themselves in negative feedback loops leading to the mounting wave of hospital closures. For many rural hospitals, these negative feedback loops are initiated by declining revenues caused by declining inpatient utilization rates, declining populations in their service areas and downward pressure on reimbursement rates, resulting from the archaic and harmful implementation of the Medicare Area Wage Index. Often combined with increasing debt-servicing costs, these declining revenues lead to a decline in available resources for employee recruitment and compensation, acquisition of new equipment and technology and facility improvements. As a result, rural hospitals are often left with a less-favorable case mix and a less-favorable payor mix, which in turn lead to further declines in revenue, making the negative feedback loop increasingly difficult to escape.

Increasing wages for nursing and allied health workers is a short-term fix. Working together, healthcare systems, universities and the states and federal government can begin to address the mid- to long-term reasons we are currently facing this critical shortage at the time it is most needed. Many of the bills under discussion today will directly or indirectly support health systems, such as the Enhancing the Community Health Workforce Act, which supports community health workers in underserved communities. And Ballad Health was proud to support the introduction of the Dr. Lorna Breen Health Care Provider Protection Act, which should help improve healthcare providers' mental health and reduce burnout.

My team at Ballad Health has also been working with Congress, including many of you on this Committee, to gain passage of the Save Rural Hospitals Act to establish a permanent national minimum Area Wage Index. This would permanently prevent all hospitals from falling into the Medicare payment death spiral created by a flaw within the Medicare Area Wage System, where annually declining Medicare payments negatively impact the wages a hospital is able to pay its employees, which in turn results in further declines in future Medicare payments for the hospital and more downward pressure on wages.

For the 117th Congress, the Save Rural Hospitals Act of 2021 is H.R. 4066. It is a bipartisan bill sponsored by Representative Terri Sewell of Alabama and Representative Drew Ferguson of Georgia. I want to thank Representatives Sewell and Ferguson for their continued leadership on this issue, and I also want to thank Representative Morgan Griffith of Virginia, who represents many of our hospitals in the Commonwealth of Virginia, in addition to serving as one of the lead cosponsors of the Save Rural Hospitals Act. I also want to thank Representatives Buddy Carter of Georgia, Gary Palmer of Alabama and Gus Bilirakis of Florida, as well as Ranking Member Guthrie, who have all co-sponsored this legislation in previous years. I invite you all to consider co-sponsoring this important bipartisan legislation again this year.

I am also pleased to report that yesterday, Ballad Health announced it has committed $10 million to create the Center for Nursing Excellence at East Tennessee State University. In collaboration with other local colleges and universities, the Center will focus on data collection, research and advocacy to promote the nursing profession.

Not only will the newly created Center work with current nurses and nursing students, but it will also seek to attract more students to the nursing profession. The Center will partner with other institutions to develop a common pipeline for high school students to identify those with aptitudes for the sciences and help match them with employment and pathways to certification as a nursing support professional or for a nursing degree. These programs could match students with jobs within Ballad Health while they're in high school, providing a path to certification by their high school graduations, and linking them with the possibility of scholarships for nursing degrees, as well as employment opportunities within Ballad Health.

Further support by Congress to support nursing and allied health training is critical – in particular the support of nursing faculty. As previously noted, U.S. nursing schools turned away more than 80,000 qualified applicants from baccalaureate and graduate nursing programs in 2019, due to insufficient

numbers of faculty, clinical sites, classroom space and clinical preceptors. We have the interested applicants, but we simply cannot attract enough faculty to teach them. Intervening here would be one of the quickest ways to increase the nursing workforce.

Finally, one important way to reduce the demands of the nursing shortage, especially of bedside nurses within hospitals, is to admit fewer patients into hospitals. Working with employed and community based physicians, Ballad Health has reduced its hospital admissions from more than 96,000 annually to less than 82,000 annually through a deliberate effort to improve value through improved care management and prevention efforts in our physician practices, reductions in hospital readmissions, a focus on health-related social needs of patients and connecting high-utilizing uninsured individuals to no-cost primary care, diagnostics and specialty care. If Ballad Health had not reduced its inpatient admission by this amount over the past several years, it is unlikely we could have managed our repeated COVID-19 surges successfully. Simply put, I cannot imagine attempting to serve these admissions while also dealing with the peak volumes we have seen during the pandemic.

Much of what Ballad Health is doing to improve health relies on community health workers, navigators, peer recovery specialists and other non-traditional healthcare providers. Several of the bills under consideration at this hearing – such as the Alzheimer's Caregiver Support Act, the Helping Enable Access to Lifesaving Services Act and the previously-mentioned Enhancing the Community Health Workforce Act are important tools to help create a more well-rounded workforce focused on the prevention of hospitalization. Beyond education and training dollars, Congress should encourage CMS to reimburse for the services provided by many of these positions, continue to push for well-designed Value Based Payment programs in fee for service, expand telemedicine and hospital-in-the-home programs and promote Medicare Advantage and Medicaid Managed Care total cost of care arrangements with providers that are proven to reduce hospital and emergency department utilization.

Again, I would like to thank Chairman Pallone, Chairwoman Eshoo, Ranking Member McMorris Rodgers and Ranking Member Guthrie for the invitation to participate in today's hearing, and especially thank Congressman Griffith for his unwavering advocacy for our region. I would be happy to discuss Ballad Health's internal initiatives and any other legislative or administrative proposals impacting rural hospitals during the upcoming question-and-answer portion of this hearing. I am looking forward to the discussion.