[LR501]

The Health and Human Services Committee met at 9:30 a.m. on Friday, November 19, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a hearing on LR501. Senators present: Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: Tim Gay, Chairperson; and Dave Pankonin, Vice Chairperson. Senators also present: Heath Mello; and Jeremy Nordquist.

SENATOR CAMPBELL: (Recorder malfunction) ...start. I appreciate everyone coming today. I'm Kathy Campbell, senator from the 25th Legislative District. And before I have my colleagues introduce themselves, I want to thank Lisa, again, for filling in as the clerk for the committee. And we also have Michelle Chaffee who is the legal counsel and Ayisha. I got it right. I know I did. I'm phonetically writing it down. Ayisha is the page today. And a lot of effort has gone into this summer. And I wanted to just open my remarks a little bit by saying that we have brought a group of people together that have brought a group of people together that have been following and working on the issue over the summer and felt that perhaps it was important to continue to explore and find out what has happened to these mothers and their babies. And so today, hopefully, we are going to hear some information from the agencies and direct-line people who are caring for them. So I want to, first of all, say thank you to all of the people who stepped up over the summer and began to care for these families. It's very important that we acknowledge that. As we start today, we'll introduce our colleagues. Norm, would you start? [LR501]

SENATOR WALLMAN: Senator Wallman, District 30, just south of Lincoln here. [LR501]

SENATOR GLOOR: Mike Gloor, I'm senator from District 35, which is Grand Island. [LR501]

SENATOR STUTHMAN: Senator Arnie Stuthman, District 22, and I got 42 days left. (Laughter) [LR501]

SENATOR CAMPBELL: But he's here. I told him I very much appreciate his coming. Senator Howard we know is going to be late. Senator Nordquist was going to try to stop in and spend some time listening to the testimony. I need to indicate that senators also have other hearings, so they will be going and coming as well. I know that people have very tight schedules, and so I'm going to try to get the three Columbus people up first and get them back on their road to work. So we will start with Rebecca Rayman. [LR501]

REBECCA RAYMAN: Dr. Welch and I will come up together. [LR501]

SENATOR CAMPBELL: Oh, absolutely, that's fine. And what we would like you to do is to identify yourself and where you're from. And we're going to go ahead and use a light system just to kind of keep everybody on track because we know people have other appointments this morning, so we'll go with five minutes and after five minutes, Lisa will give you a warning light. But we're flexible today, understanding that we're trying to fit everybody that wants to testify. So, Dr. Rayman, welcome. [LR501]

REBECCA RAYMAN: (Exhibit 1) Thank you. My name is Rebecca Rayman, and I'm executive director of the East Central District Health Department Good Neighbor Community Health Center, and it's R-e-b-e-c-c-a R-a-y-m-a-n. Our health center is located in Columbus. I'd like to thank you, Senator Campbell and the other members of this committee, for allowing us to come here today. The change in Medicaid has really affected us very drastically in Columbus. It has really impacted our prenatal program. The number of women that we are seeing has doubled for prenatal care. As you can see by the graph, we were seeing about 53 women a month in January, and this month, in October, it was 109. We're getting seven to nine calls every single week from new

moms who want to enter into prenatal care in our program. The reason that they're coming into our program, about 43 percent of them are coming from areas outside of our usual service area. And the reason that they're coming is because they can't find prenatal care in their own hometowns, in their own counties, and so they're really being forced to travel. So we have moms who are travelling as far as 156 miles to receive prenatal care. In October alone, we had moms from Buffalo, Butler, Colfax, Dawson, Dodge, Hall, Madison, Merrick, Platte, Pierce, Polk, Wayne, and York Counties. Over the past six to seven months, there have been some additional counties that were included. The change in Medicaid has had a negative effect on when women come in for their first prenatal care visit, and we really know that the best outcomes for babies and for mommas is to get them to enter into prenatal care in that first three-month period of the pregnancy. We were actually very, very proud of our statistics at our health center; we were far above the national average for when women enter into prenatal care. And you can see on the second page there's an actually a graph. And if you look in 2005, we only had about 60 percent of our moms entering into prenatal care in the first trimester. Over the course of years, we were able to bring that up to about 80 percent with a lot of work on our center staff. We're now about six months into this Medicaid change, and we're at 32 percent of our moms are entering prenatal care in the first trimester. And that has a very detrimental affect on our ability to provide them with good prenatal care, and it has a very detrimental affect on our physicians' ability to manage that pregnancy. When they come in late, it's very difficult for the physician to determine the due dates; it's very difficult to manage problems. As you can see by the chart just below that as we have women entering into prenatal care later, we have a higher number of infants who are below normal birthweight. And normal birthweight is considered about 2,500 grams. We have had as high, in some months, as 18.75 percent of the babies born at our clinic being born below normal birthweight. We're averaging about 10 percent now. And you can look at the graph and you can see that we were averaging less than 3 percent of our babies being below normal birthweight. The national average...you know, we were far below the national average of 7.26 percent before. And even in the first six months of 2010, we were at 3.7 percent, so this

is a problem that keeps getting worse, month and month as we go. In addition to the increase in low birthweight, infants or a clinic has also experienced an increase in fetal demise in utero. So we've been providing prenatal care in our clinic since April of 2004. Between April of 2004 and June 30 of 2010, we never had a single baby die in utero past the point of viability. I have now had four babies die in utero this year. We've never had that before; not even one. The other thing that we have now in our clinic that we've never had in the past is, in the entire history of our prenatal clinic we never had pregnant moms come into the prenatal clinic and ask us where they would go to get an abortion, so that's been new for our clinic as well. So this change in Medicaid has had a very drastic affect on the families that we serve. I also want to say just very briefly that it's not just the prenatal care that's been affected with the change in Medicaid. It has affected our ability to provide services overall, because while we're seeing double the number of women we were seeing before, we have a lot less financial resources to do that. Community health centers are the safety net for our community, and we really function on a pretty tight budget. We're not fat agencies. So we've cut behavioral healthcare by 33 percent. I'd just like to say that I see the yellow light, so I'd like to thank you for this opportunity to tell our story in our community health center. And I wish that we could bring our patients and staff to tell you their story. [LR501]

SENATOR CAMPBELL: Thank you, Dr. Rayman. I'm sure we will have some questions. [LR501]

REBECCA RAYMAN: And I would just like to correct, it's not Dr. Rayman, so. [LR501]

SENATOR CAMPBELL: Oh, sorry. (Laugh) Ms. Rayman, thank you very much. [LR501]

REBECCA RAYMAN: I should have finished my doctorate, but I didn't. (Laugh) [LR501]

SENATOR CAMPBELL: We all tend to feel that way, don't we? Dr. Welch, am I saying that correct, sir? [LR501]

PAUL WELCH: Yes, yes. [LR501]

SENATOR CAMPBELL: I think we'll go ahead and take your testimony, and if you'll just stay, Ms. Rayman, then we'll do questions for both of you. [LR501]

PAUL WELCH: Okay. [LR501]

SENATOR CAMPBELL: Welcome, and thanks for coming. [LR501]

PAUL WELCH: (Exhibit 2) My name is Paul Welch. I'm an ob-gyn physician in Columbus, Nebraska. I am the founder and co-owner of Columbus Women's Healthcare in Columbus, Nebraska. I have been practicing in Columbus, Nebraska, for approximately five years now. I have two other partners, Dr. Marvin Scott Haswell and Dr. Stadler, and we also employ a couple of certified nurse practitioners as well in our care for women's healthcare in that region of the state. The changes that we have seen have been significant since this legislation was put into effect. And as Rebecca Rayman has pointed out, there's some very specific things that...particularly in regard to those individuals who have a difficult time applying for Medicaid and who are now kind of on the outside looking in. I'm sure that the proponents of this legislation will have a fairly easy time, at this point, pointing out the large amount of money, perhaps, that's been saved. I would caution that that represents a very short-term evaluation of this current situation, and that when you basically produce a large-scale denial of care for a subsegment of population, you are going to see an immediate financial reward, but in the long-term picture, we'll be starkly different. In our local community, as Rebecca Rayman has pointed out, you know, there's a definite decrease in the percentage of patients that are being seen at an early point during pregnancy. As she alluded to, it does make it very difficult for myself and my colleagues to appropriately manage and deal with these women, not just initially, but as they come to the point of delivery, not to mention that we feel tied down by the fact that the current legislation only allows us to

see any type of reimbursement for cases that are considered emergent only. We do our best not to allow legislation like that to dictate the type of care that we provide but it's very difficult. The other thing that's very important is that really, you know, the most critical time for preventative antenatal care is really during the first trimester. My colleague, Dr. Stadler, had a recent patient who he was very distressed about because of the...you know, some problems with antepartum care brought on by this legislation and, ultimately, ended up falling into the category of one of the intrauterine deaths that we had that really should have been avoided. The other thing that, from a business sense really, the financial implications are very discouraging for us as well. We're kind of a unique set up as far as a small private clinic, but we're dedicated really to the healthcare of that region and to our district. And we have been working with Rebecca Rayman and with the local health department to provide care for folks, and regardless of the fact that we're no longer reimbursed for appropriate preventative prenatal care. We continue to do so because we recognize that it's important and it's critical and, quite frankly, it has a huge impact on outcomes, whether or not folks see it or not in the short term. From a financial standpoint, it's also somewhat difficult because at the current pace, my clinic will probably incur nearly $100,000 deficit from emergency procedures that we have provided that were promised to be supported by the state which have not been paid at this point in time. All of this apparently related to difficulties with getting women to apply to Medicaid, getting their paperwork through Medicaid, Medicaid not being aware of whether or not they've applied, whether or not paperwork has been completed, and going round and round. We're basically essentially anywhere from four to six months behind on people being able to fill out paperwork, and that's having a definite impact on our ability to continue to serve the community. The last thing that is just kind of mind boggling to me is that, you know, as a healthcare provider, being trained in this profession, it is a given that providing appropriate care that improves the lives of those that you serve involves figuring out those things that cause the emotional and the physical hurts that affect us, and not just fixing those when they happen, but figuring out why they occur and taking care of that. That's preventative care. And it just...it's shocking to myself and to my colleagues that that state of Nebraska can

choose to pass a piece of legislation that disregards what is, in our opinions, a huge weight of medical evidence that suggests time and time and time again that preventative care matters, it matters, it matters. And it's not just from a financial perspective but from a people, from a human perspective, and that's probably the most distressing thing to us of all. Thank you. [LR501]

SENATOR CAMPBELL: Thank you, Dr. Welch. If you could stay because I'm sure there are questions. I just want to clarify for you that this change in Nebraska's policy was decided on the executive level and not by a piece of legislation, so this has been a change. The Legislature looked at a bill that would have overridden that and moved the reimbursement under the children's health insurance policy. Unfortunately, we do not feel we have the votes to do that. So I just want to clarify as we're making sure the testimony is clear, and also to welcome Senator Mello and Senator Nordquist who have also joined us in several meetings this summer, particularly when we were in Omaha and I thank them for coming. They've been excellent colleagues to work with over the summer. Questions for Ms. Rayman or Dr. Welch? Senator Gloor. [LR501]

SENATOR GLOOR: Thank you, Senator Campbell. And I'd ask for your allowance of a question to each... [LR501]

SENATOR CAMPBELL: Oh, that's right because you have to leave. [LR501]

SENATOR GLOOR: ...because I have to leave in a couple of minutes. Dr. Welch, thank you for being here and thank you for your commitment to Nebraska and Nebraskans and the unborn. I agree with you about the unintended expense and the long-term expense of not providing appropriate prenatal care or safe deliveries. But do you know of the four in utero deaths that we've had, were any of those...was there a hospitalization that went along with that? Was there a visit to the emergency room that went along with that? Did we have an example in all four of those of expenses that would have been out there? [LR501]

PAUL WELCH: Yeah. I would say that Rebecca Rayman can kind of answer some of those because there...those patients are all related to her health center and our work out there, but. [LR501]

SENATOR GLOOR: Okay. [LR501]

REBECCA RAYMAN: And I would like to ask Theresa Hilton to come forward from the hospital because I think she's going to talk about one of those fetal demises. Is that all right? [LR501]

SENATOR CAMPBELL: Let's go ahead and finish with Senator Gloor's question. [LR501]

REBECCA RAYMAN: Okay, okay. [LR501]

SENATOR CAMPBELL: And then we'll have her come. Do you have other questions that you... [LR501]

SENATOR GLOOR: Yeah. I just...one other question. I want to make sure for purposes of the graphs that are out here, I'm sure someone will point it out at some point in time, but we have a concern, obviously, about the regulatory change that no longer provides that care to women who have no citizenship. [LR501]

REBECCA RAYMAN: Um-hum. [LR501]

SENATOR GLOOR: But we are also in severe economic downturns. [LR501]

REBECCA RAYMAN: Um-hum. [LR501]

SENATOR GLOOR: And so to the extent that you can define the people who are showing up at the clinic... [LR501]

REBECCA RAYMAN: Um-hum. [LR501]

SENATOR GLOOR: ...who maybe are there because they've lost their insurance as a result of employers having to drop insurance versus women who are no longer covered for prenatal care because they lack proof of citizenship, this increase from 3 to 10 percent, help me get comfortable of cause and effect here, if you would. [LR501]

REBECCA RAYMAN: Um-hum. [LR501]

PAUL WELCH: Go ahead. I have something to say about that, but (inaudible). [LR501]

REBECCA WELCH: Okay. I'll let you go first, Doctor, and I'll look at my numbers. [LR501]

PAUL WELCH: Oh, well I don't...Senator, I'm not sure of the exact numbers. Perhaps Rebecca Rayman can kind of find some of those, but I will be very honest that from what I see in our practice, a significant, I would say significant portion of those women that we see that are having difficulty are here illegally. Okay. What...you know, and as a healthcare provider, I completely and am well aware of the large burden that illegal immigration is having, not just on Nebraska but in this country in general. And so I certainly understand the implications there, I believe. What makes antenatal preventative care unusual in this particular case, I think, is that you're not dealing with just one individual; you're dealing with two. And you're not just dealing with someone who has circumvented our laws to live in our country; you're also dealing with someone who has no choice to choose the parents to whom they are born, and yet they are going to be in our current system a legalized United States citizen growing up in this state, in this country, becoming functional members of this society. They're the next generation

of America whether we like it or not. And until the illegal immigration issue is handled in another venue other than healthcare, this will continue to happen. And it seems inappropriate to me that we ultimately, in a sense, end up punishing them for something that they cannot choose. [LR501]

SENATOR GLOOR: Well, and we also have the uncomfortable conflict of regulation in statute that requires anyone who presents at a hospital emergency room to receive care until they're stabilized. [LR501]

PAUL WELCH: Exactly. [LR501]

SENATOR GLOOR: Stabilized being loosely defined by, I suppose, whoever gets drug into court. [LR501]

PAUL WELCH: Well, and no ethically conscious physician would really choose it otherwise. [LR501]

SENATOR GLOOR: Thank you. [LR501]

SENATOR CAMPBELL Ms. Rayman, did you want to... [LR501]

SENATOR GLOOR And I'm going to have to go. [LR501]

SENATOR CAMPBELL I understand that. Did you want to make a comment before...it's Theresa Hilton? [LR501]

REBECCA RAYMAN: Right. I'll just make one short comment for Senator Gloor's question. And that is that you know what...who we serve at our clinic is families and women. We really don't ask them for their immigration status. That isn't part of what we do. But I can tell you that on the fetal demise cases, 75 percent of those were Hispanic,

Latino women, which pretty much mirrors our clinic, and 25 percent were Caucasian. [LR501]

SENATOR CAMPBELL: Okay. Thank you. Questions? Senator Stuthman. [LR501]

SENATOR STUTHMAN: Thank you, Senator Campbell. Becky, of the children that have been born... [LR501]

REBECCA RAYMAN: Um-hum. [LR501]

SENATOR STUTHMAN: ...the ones that have possibly not had the needed prenatal care, have any of these children ended up in intensive care for a length of time? [LR501]

REBECCA RAYMAN: We've had one of the children that were born who has an ongoing cardiac issue. I do not know how long that child was in...you know, whether they were in intensive care or not, but they are in a long-term cardiac process. [LR501]

SENATOR STUTHMAN: At an expense of the state. [LR501]

REBECCA RAYMAN: At an expense of the state. And really we're...community health centers are so cost effective. I mean, we can provide prenatal care to a pregnant woman, really, about $800 a month, which is very, very cost effective when you consider the cost of a single stay in an NICU can be, you know, $5,000 a day just for the stay without any of the treatments and procedures. [LR501]

SENATOR STUTHMAN: Okay. Thank you. [LR501]

SENATOR CAMPBELL: Exactly. Senator Nordquist. [LR501]

SENATOR NORDQUIST: Thank you, Ms. Rayman. So as you've seen this population that you're serving for prenatal care double at your community health center, I guess the first question would be, how have you guys coped with that internally? I know you were about to answer. [LR501]

REBECCA RAYMAN: Yeah. [LR501]

SENATOR NORDQUIST: He said we're cutting behavioral health services and other... [LR501]

REBECCA RAYMAN: We've...you know, there's only so many pennies, and community health centers are really very, very lean operating machines. And so you can't really say, well, you need to just do more with less because we've always done more with less. (Laugh) So, you know, when you take away, you know, at some point you can just do less with less. That's all. You know, that's what it comes down to. And I'll just give you...you know, we've cut back the behavioral health. Now we're out four to five months on behavioral health appointments for that population. That's hurt a lot of people. But besides just that, we had an administrative position. Our chief operating officer was hired by the local community hospital for a nice position, so we lost her to that. We have not filled that position. So I can tell you that I generally work about 50 hours a week. Now, you know, I'm working, you know, 12-and-a-half-hour days, you know, pretty consistently. So we have tried to redistribute those duties rather than hiring, but what that will lead to is so much pressure on the staff that we'll have more staff who leach out, you know. So really we're having to look at where can we cut back, where can we...you know, where can we tighten our belt even further. And I, you know, quite frankly, you know, I would love to have somebody come in and assist me with that process because I think I'm as lean as I can be. [LR501]

SENATOR NORDQUIST: Yeah. Well, you certainly provide a valuable safety net for individuals, and there isn't another community health center, correct, between you and

Scottsbluff? I mean, you're...this... [LR501]

REBECCA RAYMAN: There is one in Norfolk. [LR501]

SENATOR NORDQUIST: Norfolk, yeah, Norfolk. [LR501]

REBECCA RAYMAN: And they have not really gotten fully going on their prenatal program. [LR501]

SENATOR NORDQUIST: They're just getting going. And I think Grand Island is working on an application, but that's a ways off. [LR501]

REBECCA RAYMAN: Yes. [LR501]

SENATOR NORDQUIST: So I guess my next question, then, would be is there a point where you're going to have to...maybe I missed it when I came in a little late, but turn people away? [LR501]

REBECCA RAYMAN: This is actually a discussion that we had as we started to increase so many patients and we started to look at our process and how, you know, we can see, you know, more patients with the time that we had. And we actually got to a point where I went to the staff and, first, I went to HRSA in Washington, which is our grantee for the federal money... [LR501]

SENATOR NORDQUIST: Um-hum. [LR501]

REBECCA RAYMAN: ...and told them I think we're at a point where we just cannot see anymore women, and we really wanted to have a geographic description or to talk to them about a geographic description. And we worked through that process. And then I went to the doctors, to Dr. Haswell and Dr. Welch and Dr. Stadler and we went to our

staff, and they were like, no way, we're not going to leave these women with nothing. [LR501]

SENATOR NORDQUIST: (Laugh) Um-hum. [LR501]

REBECCA RAYMAN: You know, we are going to work this out, and we have worked it out and we have changed processes. But has it placed an enormous amount of stress on our system? You bet. And this bill, you know, came into effect on March 1. I received the resignation from our OB nurse who is in charge of our OB department on March 1 because she said, you know, she was getting so many calls. She was getting like 20 calls a day for OB care. And, you know, she was so stressed out. How are we going to do this with less money? And, you know, at our agency we're very, very, very proud of the quality that we provide. We are Joint Commission accredited. We have outstanding quality. This has put an enormous amount of strain on our system. [LR501]

SENATOR NORDQUIST: Thank you. [LR501]

SENATOR CAMPBELL: Questions from the senators? Dr. Welch, I have one question for you. You indicated that it was in some cases four to six months before you were being reimbursed, and that must be on an emergency because otherwise you would be denied. [LR501]

PAUL WELCH: There's no...we don't even apply. [LR501]

SENATOR CAMPBELL: I mean, that's something... [LR501]

PAUL WELCH: I mean, it's not even something...and from my billing department what I understand is there's either one or two cases where we have been reimbursed for emergent care of these folks, but we have over 30 or 35 outstanding cases right now, which represents the strain, and at the current pace and that was the number that I had

mentioned. [LR501]

SENATOR CAMPBELL: We'll do some checking in with that. I really appreciate your bringing that information forward. We have been hearing that there is a delay in...for mothers who are applying then for their children because the children would be eligible for Medicaid, but that there has been some delay in that process also. Would you have seen that, Ms. Rayman? [LR501]

REBECCA RAYMAN: I'm sorry, Senator Campbell. [LR501]

SENATOR CAMPBELL: No, that's all right. For the children, mothers coming back and having to go through the Medicaid process for their children, that that's been delayed. [LR501]

REBECCA RAYMAN: I have not seen that delay. My primary concern is just the delay with getting the OB guys paid. And I understand that this is happening all over this state. It's not just in our area. [LR501]

PAUL WELCH: Yes, it's not just us. [LR501]

REBECCA RAYMAN: And, you know, when you look at it, they've been paid for two of these deliveries. That was a lot different than things were laid out for us in February. You also have to write the magic words on the form. You have to get the right caseworker because we don't have...and I'm going to get a little off on a tangent here, but it used to be that your Medicaid caseworker for your area was actually located in your area so that you could find the Medicaid caseworker when you had a problem, and you could talk to them, and you had a relationship with them. Now when you call Medicaid, we might have a woman who lives in Columbus and her caseworker might be in North Platte or maybe she's in Norfolk or maybe she's in Lincoln. It's a very difficult system. As a professional, I can't hardly navigate that system and I get very frustrated.

For our patients, who are low-educational level, low-income, it is an extremely daunting, terrifying hurdle. And we have two more people from Columbus, so I do want to...there are two more. [LR501]

SENATOR CAMPBELL: Oh, okay, of course. I...and that would be Mike Hansen. [LR501]

REBECCA RAYMAN: Actually Theresa Hilton for Mike Hansen and Dr. Ron Klutman. [LR501]

SENATOR CAMPBELL: Okay. Could we have them come forward? Good morning. [LR501]

THERESA HILTON: Good morning. [LR501]

SENATOR CAMPBELL: And you two are also going to testify together? [LR501]

RON KLUTMAN: Well, no, we'll let Theresa go first, then... [LR501]

SENATOR CAMPBELL: Oh, okay. [LR501]

RON KLUTMAN: I'm sort of the cleanup hitter. [LR501]

SENATOR CAMPBELL: All right. Columbus came prepared today. Wow! (Laughter) [LR501]

THERESA HILTON: I lost him. [LR501]

SENATOR CAMPBELL: Yes, he decided to leave you up by yourself for the duration here. [LR501]

THERESA HILTON: (Exhibit 3) Oh, yeah. Okay. Well, good morning. My name is Theresa Hilton. I'm a licensed clinical social worker and a licensed mental health professional. I am currently employed as director of patient and outreach services at the Columbus hospital. I wanted to welcome you, Senator Campbell, all the members of this committee, and really thank you for commissioning this study on the Medicaid prenatal care issue. And wanted to speak to you. I think it's been seven months now since the Medicaid prenatal coverage changes on March 1 of this year, and I'm here to describe to you the detrimental life-long effects that we have seen in our community with our infants, our mothers, all of the families, and certainly our medical community. I will be brief, but just a brief description. Columbus hospital is a 47-bed facility. We're a full service regional hospital, and we're unique in that we're not one of the critical access hospitals in Nebraska that you might think we would be with our size. We are really the smallest urban hospital or the largest of the small guys, if you will. This last fiscal year, we delivered about 570 babies at our hospital. We're certainly on pace and expect that to be higher this year with the changes, the additional women from outside of our region. We typically look at a primary service area of five-counties, and that has grown, as you heard Ms. Rayman describe. We're very pleased we're able to deliver the babies that are being cared for by our physicians at the local health clinic, and so we do expect those number to grow. Following a fairly recent retirement of one of our ob-gyns in the Columbus area, we are so pleased that Dr. Welch has come and begun the Columbus Women's Healthcare Center Specialty Clinic in Columbus. It is now home to three ob-gyns, as Dr. Welch mentioned, and they have all relocated their families and their practices in Columbus, which is tremendous. You've heard from Dr. Welch, the founder of that clinic. Their specialty clinic also includes two mid-level practitioners as well as medical interpreters and other medical support staff. Our hospital, over the past several years, has invested very heavily in these recruitment efforts of these physicians and their families, and now their retention efforts to bring these highly-qualified physician specialists to our area, very much needed. I know as business owners and as legislators, you can appreciate the value of being able to recruit and secure the best

and the brightest of our physician specialist to Nebraska. Additionally, there's a tremendous economic benefit that is derived from a specialty clinic of this size, and it's one of the only ones of its kind in a 50-mile radius. They're serving a complete region. The drastic Medicare cuts to prenatal care on March 1 of this year have certainly threatened this livelihood and continued retention of our ob-gyn specialists in the Columbus area. Our Columbus medical community, specifically our three ob-gyn specialists, their mid-levels, our community health center, and our hospital really have had to bear a burden of a really disproportionate share of these women who were affected and now are newly uninsured. This has been due in part by our geographic location and the population. But as you hear today from Ms. Rayman, our Good Neighbor Community Health Center is one of six community health centers in Nebraska, really one of two, that have carried the burden of serving the larger volume increases in pregnant women as a direct result of these Medicaid changes in March. This has forced our ob-gyn specialists to see twice as many patients, deal with much higher-risk patients, and now are facing a crisis point of being unable to collect Medicaid reimbursement due them for over 30 deliveries. And these are for the babies. These are for the baby's delivery. This has nothing to do with the mother's cost. These Medicaid cuts to prenatal care have driven women and their families to access care outside their normal medical homes and communities. This Medicaid cut that threatens the livelihood and our continued retention of these valuable ob-gyn specialists in our community not only affects these newly uninsured women but all women and families in our larger region that are dependent on this clinic as their medical home. Columbus Community Hospital continues our significant investment in our physician specialists and the quality of healthcare that is made accessible to individuals and families in our region. And we really appeal to the this committee to remedy these changes in the Medicaid process, the Medicaid reimbursement before any other unrepairable damage is done. In addition to our physician specialists, our medical professionals work force concerns, our hospital is very concerned about the viability of our Good Neighbor Community Health Center. Our hospital has made significant contributions to our health center to help them offset some of the losses they have suffered because of the Medicare cuts to prenatal care.

You heard Ms. Rayman describe the tremendous influx of volume increases. Our entire medical community values the significant role they play in healthcare that they provide to our region. We all rely on them to provide a safety net of quality care and drastically increase access to affordable healthcare to families in our region. We cannot jeopardize what has taken over, you know, a decade to build. And so you're hearing today how the mental health services were cut in order to subsidize this. In summary, I just wanted to mention the lifelong impact the statistics regarding from these Medicaid cuts are having, and as, you know, they mention entering prenatal care much later in pregnancy. Our medical community has worked hard together to educate women to seek prenatal care in their first trimester only to watch the statistics slide 50 percent in seven months--50 percent. This is a turn that has caused a dangerous increase in our babies being born with low birthweight, now known to strongly influence lifelong well-being and add to the social and medical costs through adulthood. Ms. Rayman has also brought you information on the sudden trend toward fetal demise in utero amongst our patients. I did personally work with one of the families that actually lost twins in utero over a period of a couple of weeks. They lost one...she was managed and come in and, unfortunately, the second twin succumbed in utero as well. And I can tell you firsthand how devastated they are. This couple has lived and work in our Columbus area for some time. Both parents are working, paying taxes. They have never accessed another state or local program, assistance program up until this time. They had found themselves temporarily uninsured during this pregnancy. And prior to March 1, I believe they would have qualified for Medicaid coverage for their prenatal care and the subsequent deliveries. This is my 30th year as a medical social worker at the Columbus hospital. And it's going to take us, I'm concerned, you know, how long? How many months? How many years, you know, another generation to fix this? I wanted to thank you for your continued support. And our Columbus hospital's mission is to improve the health of those we serve in our region. I think our physician specialists, our medical providers are just one part of the whole story. I would like to extend an invitation for any of you to come out and see us in the region or our families, and I really thank you for your attention to this critical issue, and would stand ready to answer any questions that I could. [LR501]

SENATOR CAMPBELL: Are there any questions for Ms. Hilton from senators? Thank you for your written testimony... [LR501]

THERESA HILTON: Thank you. [LR501]

SENATOR CAMPBELL: ...very much. Good after...I always want to say good afternoon. [LR501]

RON KLUTMAN: Good morning. Yeah. (Laughter) My name is Dr. Ron Klutman, K-l-u-t-m-a-n. I'm a family physician in Columbus. I help, along with Ms. Rayman, developing the community health center, was its first president, and now is its treasurer. I've also been a past-president of Nebraska Medical Association, and I am representing the physicians of the state at this point in time. I think there's two issues we have to look at. When a patient walks into my private office: I do not ask that patient how they're going to pay; I do not ask them where their country of origin is; I do not ask them what their religion is; and I don't make decisions on their ethnicity. That's my practice as a physician. I'm morally bound, ethically bound by the Hippocratic oath to do those things. So I think this issue as we look is not a matter of law; it's a matter of regulation, as you've already said. We, as citizens of the state of Nebraska, I truly believe have a moral obligation to take care of people within our borders. This thing about being undocumented, being immigrants, not being citizens is an issue that us, as physicians, cannot accept. We have to deliver that healthcare. As we look at the savings by this terrible change of regulation, that savings are insignificant compared to what the total budget of the Medicaid program is. I've studied Medicaid budget for over 30 years. I've served on a Nebraska medical association Medicaid advisory committee. And if you look at that, about 40 percent of the Medicaid budget is presented to about 200,000 citizens of this state. The other 60 percent, as you well know, goes to about 5,000 citizens of this state, and that's basically nursing home care. What we have attempted to do is pick around the easy parts, which is the 200,000 people. Now Dr. Welch I think

has been kinder than I would be if I was in his position. And I will say, point two, his position is not uncommon to what we've seen from the Medicaid department in the last four years. He's had 35 deliveries. He's delivered them. He expected to be paid for them as the standards were. And all of a sudden he probably is not going to be able to get anything on 31 of them. Why? Because all of a sudden the rules of how we sign up patients for emergency delivery have changed. Did the department allow the physicians to know that? No. Did they allow my community health center, how they had changed them? No. So those 31 of them probably will never be able to find and get them to do all the correct paperwork. So finally in the last two weeks, we've now figured out how the department wants us to play this game. The hospital...and I wish Senator Gloor was here so I could stab him a little bit in the back, you know, the hospitals have a lot of money, (laugh) you know. And so that 31, they have to write off, but when you're a multimillion-dollar business, you write it off, and that's what the hospital has done. But this isn't the first example of what the department has done. It dates back two years ago. I have over 50 pending submissions to the department on certain things that they changed a year before Medicare and private insurance did. Did they let us know that they had changed it? No. All of a sudden we kind of started getting denials and we had to try to figure out exactly what they were talking. Nine months later, we finally figured out as Medicare and private insurance said that we would take care of these...or this is the way we're going to go these coding, then we allow the change. As you look at the department of Medicaid, they ask physicians now to submit for MRIs, CAT scans, we have to submit to the department so we can get them approved. Well, the contract was signed one day before this whole process went out for public hearing. So the department continues to go out and do things without allowing the physicians to know. And this just complicates our whole ability. I have been a past-president, as I said, of the state of Nebraska...or the Nebraska Medical Association. And 15 years ago, I went across the state trying to keep my physicians participating in Medicaid. Now you have to understand that greater Nebraska is different than Omaha and Lincoln. In Omaha, 90 percent of the primary care Medicaid charges are delivered by Creighton University Med Center, the University of Nebraska College of Medicine, and--let's see--Clarkson's

Family Practice. In Lincoln, close to 60 percent of Medicaid primary care charges are delivered by the family practice program here. In greater Nebraska, we don't have that safety net. The physicians in greater Nebraska are the safety net. Right now we're paid approximately 35 cents on the dollar as compared to Blue Cross Blue Shield. We have an ethical concern that we will take care of these patients. The one thing we, as physicians in greater Nebraska, have run into is these total changes of rules and regulations without appropriate notice. And that's what's going to drive my other four partners out of Medicaid. And I think many of the physicians in greater Nebraska, we'll accept a little pay, we'll take care of our patients, but there's this constant changing of rules and regulations without proper notification is something that's going to drive us out. I really think the Legislature has to make a decision of asking the Governor to reexamine the Director of Medicaid because she has driven most of the physicians in greater Nebraska out of any attempt we're going to try to work with them. We have worked with them all our lives. I have, for 30 years, worked with the department, and the last 4 years is the worst experience I've had in the last 30 years working with the department. Light is red. I'd be glad to answer any questions. [LR501]

SENATOR CAMPBELL: Dr. Klutman, would you spell your name for the record? [LR501]

RON KLUTMAN: Yes, I'm sorry. K-l-u-t-m-a-n. [LR501]

SENATOR CAMPBELL: Okay. Questions from the senators? Senator Nordquist. [LR501]

SENATOR NORDQUIST: Yeah, thank you for being here. Just for my education here, so you file an application for the emergency Medicaid on the birth. Before they were eligible through the birth, before the birth, and therefore they were enrolled in Medicaid at the birth, so any services after the birth were covered. Now you do the emergency Medicaid, then they can make an application for Medicaid if they need nonemergency

care in between. [LR501]

RON KLUTMAN: It kind of hasn't changed... [LR501]

SENATOR NORDQUIST: Okay. [LR501]

RON KLUTMAN: ...except the rule...except the way the department is handling them. [LR501]

SENATOR NORDQUIST: Uh-huh. [LR501]

RON KLUTMAN: And so if you don't...before, you made an effort and they accepted that effort. [LR501]

SENATOR NORDQUIST: Um-hum. [LR501]

RON KLUTMAN: Now you better have all the sentences dotted, you better have all your quotation marks in. What it is, is set it up a hassle factor. [LR501]

SENATOR NORDQUIST: Um-hum. [LR501]

RON KLUTMAN: Now we...once we've learned how they're game is, then I expect in the future Dr. Welch is not going to have quite the problem. [LR501]

SENATOR NORDQUIST: Sure. [LR501]

RON KLUTMAN: But he just lost 35 deliveries. [LR501]

SENATOR NORDQUIST: Sure. [LR501]

RON KLUTMAN: And I think he's going to have a terrible time collecting unless this Legislature says something. [LR501]

SENATOR NORDQUIST: Yeah. But for care after the birth until their application is approved, is that on the providers as well right now or...I'm sorry. Somebody else can... [LR501]

RON KLUTMAN: If you don't mind I'll lean to the area of expertise. You can sit with me, Becky. I sign her check, so. (Laughter) [LR501]

REBECCA RAYMAN: I would just like to say that quite a lot has changed with the Medicaid change. I mean, the health center, our private providers are not eligible for any reimbursement for any prenatal care, so that's totally gone. That's just off the table. There is not reimbursement whatsoever from Medicaid for that. For the delivery, a lot of things have changed with that. There is a lot of frustration I think with the providers with what they can do now with women. For example, in the past if you had a high-risk woman and you thought things might go wrong, you might induce her instead of waiting until she goes into labor. You might schedule a repeat C-section. So these things are all changed. The care, the amount of time the woman can stay in the hospital has changed. That's like 24 hours. And so, you know, that's going to be covered. So all of that has changed. So what the Medicaid is paying as I understand--and I'm not really on that hospital end, I'm on the prenatal care end--but what I understand that they're paying is just for that delivery. And to get that delivery paid for that baby is one thing, but to get the charges for the mother for the provider takes a whole nother set of paperwork. She has to write on the application that she wants here emergency delivery covered, and it has to be an emergency delivery. And that really concerns me because I think we're placing doctors, like Dr. Welch, Dr. Haswell, and Dr. Stadler, at real risk now. [LR501]

SENATOR CAMPBELL: And I do see some heads nodding, so perhaps in the testimony

to follow we'll get an answer because I know some of the hospitals are here. [LR501]

REBECCA RAYMAN: Thank you. [LR501]

RON KLUTMAN: Senator Gloor, you weren't here. I was just mentioning (laughter) the hospitals are right now all of these because they have all the money in the state. It's a little more heart... [LR501]

SENATOR GLOOR: That's changed since I was in (inaudible). [LR501]

RON KLUTMAN: Yeah, I guess so. But it really has. And like I said, for the last three years this has been a nightmare, not only in this but a whole series of things. I'm not going to have physicians delivering healthcare to the Medicare population not because of what the reimbursement is but because of the hassle factor that's been thrown at us. [LR501]

SENATOR CAMPBELL: And, Dr. Klutman, thank you very much. I've got a whole list of people behind you, so. [LR501]

RON KLUTMAN: No, I understand. [LR501]

SENATOR CAMPBELL: They're eager to go. Okay. I do need to have...where is Ms. LaFave. I need to have her go because she is due back in Creighton for a meeting, and so I apologize. Good morning. [LR501]

ELIZABETH LaFAVE: Hi, there. I'm Elizabeth LaFave with Creighton University, and that's L-a-F-a-v-e. And thank you, Senator Campbell and the committee, for allowing me to speak today. I speak on behalf...I am actually employed by the university, which is the physicians with Creighton medical associates under Creighton University, not with Creighton University Medical Center. There's a difference between the two of us. Our

department is the department of ob-gyn, and I'm here today to speak on what we are seeing with the patients who have lost their prenatal healthcare. I have some specific examples of some less than favorable outcomes. We had one patient wait this spring who quit seeing her physician, quit getting prenatal care when here Medicaid dropped off. She was suffering from hypertension, high blood pressure; came in to our labor and delivery with full blown eclampsia. Her blood pressure was off the charts. This woman went into seizures. They were able to deliver her baby. And, fortunately, she was fairly close to being full term so they did eventually, you know, leave the hospital in a stable manner. But had this patient been able to have access to prenatal healthcare later in her pregnancy, this would have been a completely avoidable situation. We have had another patient who, again, also had high blood pressure, came in with eclampsia, but she came in at 32 weeks and delivered a baby. That baby spent 38 days in the NICU before that baby was allowed to go home. That was 38 days of NICU care that the state then had to pay for that the state would have not had to pay for if this woman had had access to adequate prenatal care. She did attend some of her appointments for prenatal care, but its...as she attended those at One World Community Health Center where we're seeing a lot of our patients that come into labor and delivery do. They have an excellent sliding fee scale there for their patients, but the problem is sometimes even those minimal payments are too much for some of these patients on specific months, and they do skip their appointments. We actually just yesterday had another patient come in to our...we have a high-risk OB physician in our department, and we had a patient from One World come in and see that physician yesterday for an appointment who was immediately walked over to the L and D unit. She is a diabetic who also has high blood pressure. Her blood pressure was off the charts and her diabetes isn't under all that well control because she doesn't have access to the medications and all the equipment that she needs to test her blood sugars on a regular basis to help maintain a healthy pregnancy. So this woman has been admitted to the hospital because she does not have access to all the needed prenatal healthcare. Those are just three examples of the patients. And it's...you know, it's trauma for the patients. It's trauma for the babies. It's trauma for the patient's families, but it's also not that. It's trauma for our physicians.

It's very traumatic for our physicians to be called in for an emergency labor and delivery issue or it's a patient they've never seen that has not received adequate healthcare, that it turns quickly into an emergency situation. It's incredibly stressful on our physicians and it's something they should not have to go through. I'm quite frankly afraid that we're going to start losing physicians because it's not right to put our physicians through this either. I mean, there is great concern for the patients and the babies, but our physicians who...they are the ones who, they're in the hospital, they have to deal with the situation right then and there. And when it goes...none of these physicians want the situation to go ugly but it's happening and it's taking a toll on our physicians. Actually with the people from Columbus who spoke, Dr. Stadler was actually one of our residents and I know he was devastated with that patient that had the intrauterine demise of the baby. And so it's a concern of not only for the patients but of the physicians in this state too. So and then my last closing comment would be, the university choose to opt out of the Big 12 early and forego $9.2 million in revenue by opting out of the Big 12 early without proper notice so they could switch over to the Big 10 so that our sports...don't get me wrong, I love Nebraska football, baseball, volleyball. I love all of the Nebraska sports dearly. But they choose. They could have given proper notice and not had to forego that $9.2 million in revenue that we're supposed to get from the Big 12, and they chose to do that for sports. This is a state that will not spend, you know, $800,000, $900,000 to provide prenatal care that will eventually affect the future citizens that will be born to our state, and then we're going to on the back end pay for it in the long run with NICU expenses, with special ed expenses, with therapy expenses. I, myself, have a child with autism, fortunately have good, private insurance, but I've spent plenty of money out of my pocket and through my insurance just to have my child be a functional member of this community. By the state not paying for this prenatal care, they're going to get a huge bill on the back end through those 18, 19 years of the life of that child. So I thank you and if you have any questions. [LR501]

SENATOR CAMPBELL: Senator Stuthman. [LR501]

SENATOR STUTHMAN: Thank you, Senator Campbell. Thank you, Elizabeth, for your testimony. It really touches my heart because I've been in with the youth and the kids and stuff like that, and they're very dear to me. These three examples that you gave, would you have any type of a knowledge of a figure as to how many prenatal care individuals you could have served with the cost of these three examples that the state is going to incur? [LR501]

ELIZABETH LaFAVE: No, unfortunately I don't today. I don't. I think, you know, they say the average daily cost for a child in NICU is about $3,000. So if you have 38 days, you know, that's a lot of money. [LR501]

SENATOR STUTHMAN: Yeah, there's several hundred thousand dollars. [LR501]

ELIZABETH LaFAVE Yeah. And I think the states, they were talking, I think one of the articles I read when this originally was being argued back in February, the state estimated they spent about $850 to $950 (sic) for the prenatal care portion, and they estimated 1,000 women were going to drop off Medicaid rolls when they, you know, disallowed the undocumented immigrants to be covered. So we're looking at the state paying $850,000, $950,000 a year for prenatal coverage is what the states decided to drop off. [LR501]

SENATOR STUTHMAN: That's the thing that really, really bothered me when the state decided to, you know, not allow the prenatal care anymore, and I think it's going to haunt us in years to come because of those children that don't receive the proper prenatal care. It's not just these 38 days in intensive care or anything like that; it's 20 years. [LR501]

ELIZABETH LaFAVE: Exactly. These children, low birthweight babies tend to have issues that go on their entire lifetime, learning issues, physical issues. And the state, you know, until you're 19, you're a child of the state and that child can be on Medicaid

those 19 years. And the expense to the school systems to provide special ed services. [LR501]

SENATOR STUTHMAN: It's never ending... [LR501]

ELIZABETH LaFAVE: It's never ending... [LR501]

SENATOR STUTHMAN: ...with the expense that can happen because of lack of prevention. [LR501]

ELIZABETH LaFAVE: Yes. [LR501]

SENATOR STUTHMAN: So thank you for your testimony. [LR501]

SENATOR CAMPBELL: Any other questions? Thank you very much. [LR501]

ELIZABETH LaFAVE: Thank you very much. [LR501]

SENATOR CAMPBELL: I want to welcome Senator Howard who has joined us for the morning. Sir, do you wish to testify? And thank you very much for your patience. [LR501]

BRIAN FAHEY: (Exhibit 4) No, she's definitely more important, there's no doubt about it. Good morning, Senator Campbell and members of the Health and Human Service Committee. I am Brian Fahey, F-a-h-e-y, March of Dimes, Nebraska Chapter board chair, and father of premature twins. The mission of March of Dimes is to improve the health of pregnant women, infants, and children brought by preventing birth defects, premature birth, and infant mortality. Maternity care can help improve the health of both mothers and babies. Women who receive prenatal care are more likely to have access to screening and diagnostic tests that can help identify problems early, services to

manage existing problems, and education, counseling, and referral to reduce risky behaviors like substance abuse and poor nutrition. Premature birth is a very serious problem for babies in the United States. More than half a million babies are born too soon each year and thousands don't live to celebrate their first birthday. This serious health problem costs the United States more than $26 billion annually, according to the Institute of Medicine. Prematurity is the leading cause of newborn death, and babies who survive often face lifetime health challenges, including learning disabilities, cerebral palsy, and intellectual disabilities. Even infants born just a few weeks early have higher rates of hospitalization and illness than full-term infants. I can testify this with my own kids. I've had two twins that were premature at one pound, five ounces at 28 weeks. They were a conservative number, $1.5 million within the first four or five months. I have a third child who was 36 weeks gestation, and then she was probably less than $5,000. On Wednesday this week, the March of Dimes released its preterm birth report card for the United States and Nebraska. While Nebraska's rate dropped from 11.9 percent to 11.8 percent, Nebraska still received a D. Nebraska also showed an increase in the number of uninsured women from 15 percent to 15.3 percent in this report. The Institute of Medicine, among others, has found that uninsured women forgo or postpone needed care. The reverse is also true. Having health insurance improves access to timely medical care, a critical factor for women who are at risk of preterm birth. Early care and treatment of medical conditions--diabetes, hypertension, sexually transmitted disease are examples--may reduce the risk of preterm birth. Lack of prenatal care can have serious health and cost ramifications for both the mother and the baby. During the first year of life, for a premature baby, the average healthcare costs, including both inpatient and outpatient care, were about ten times greater--$32,325 compared to $3,325 for a full-term baby. Early and regular prenatal care can also prevent other serious prenatal issues, such as stillbirth, fetal alcohol syndrome, and postpartum depression. Uninsured women are more likely to have poor pregnancy outcome than are insured women, including pregnancy-related to hypertension, placental abruption, and extended hospital stays. Their newborns are also more likely to have adverse outcomes, including low birthweight and even death. The United States Preventative Services Task Force has

issued a number of recommended medical intervention related to pregnancy--including folic acid supplementations, screening for preeclampsia, and counseling on breast-feeding--that can be provided if a woman has health coverage. The emotional well-being of Nebraska citizens, as well as financial costs, should be considered for this body. March of Dimes strongly supports providing coverage for prenatal care for all pregnant women in Nebraska. I'll be happy to answer any questions. [LR501]

SENATOR CAMPBELL: Mr. Fahey, I have neglected to ask, would you spell your name for the record? [LR501]

BRIAN FAHEY: Yeah. Brian, B-r-i-a-n, Fahey, F-a-h-e-y. [LR501]

SENATOR CAMPBELL: The clerk keeps trying to get my attention on that. Senator Gloor. [LR501]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for being here, Mr. Fahey. What was Nebraska's score last year? [LR501]

BRIAN FAHEY: We were a D. [LR501]

SENATOR GLOOR: So we continue to be a D. I mean,... [LR501]

BRIAN FAHEY: The scores...to get all the information, the scores reflect the year of 2008 and partial of 2009. [LR501]

SENATOR GLOOR: Okay. [LR501]

BRIAN FAHEY: We are...you know, with the help of March of Dimes, we are actually trying to reduce that number, but for nationally we scored a D. I'll also note that the average score in the United States was...I don't think anybody scored higher than a C.

[LR501]

SENATOR GLOOR: Thanks for that clarification. And, I mean, don't misunderstand my line of questioning here. It's not to, you know, cast any doubt on what a D means necessarily but to point out that we already have problems of access and appropriate provision of care. [LR501]

BRIAN FAHEY: True. [LR501]

SENATOR GLOOR: And this just adds to that level of challenge that we have to deal with. [LR501]

BRIAN FAHEY: It will certainly add to the challenge. [LR501]

SENATOR GLOOR: Thank you. [LR501]

SENATOR CAMPBELL: Other questions? Senator Howard. [LR501]

SENATOR HOWARD: Thank you. Brian, I'm glad to see that the March of Dimes is making mention of fetal alcohol syndrome because I worked with them for quite a few years to get that in the forefront of their minds. But I have to point out to you that prenatal visit in itself won't prevent fetal alcohol syndrome. [LR501]

BRIAN FAHEY: I think what they were trying to express is that, you know, the March of Dimes...there's a number of issues that can hinder a premature birth or can add to a premature birth. Fetal alcohol syndrome is just one. [LR501]

SENATOR HOWARD: Well, that's certainly a contributor. [LR501]

BRIAN FAHEY: But I think what the goal... [LR501]

SENATOR HOWARD: Fetal alcohol babies tend to be very low birthweight. I think one of the ways that the prenatal visit can help is discussing the issue of drinking with a pregnant mom, and pointing out that the serious consequences of that. And that's certainly easy enough to do and not everybody wants to hear that, (laugh) but I think it's an important part of the doctor talking to the woman. [LR501]

BRIAN FAHEY: Specifically with the fetal alcohol syndrome, it's imperative, I think, that they get...they're sitting down with the prenatal care and it is explained to them the cause and effect of that issue. [LR501]

SENATOR HOWARD: I would certainly endorse that. Thank you. [LR501]

BRIAN FAHEY: Um-hum. [LR501]

SENATOR CAMPBELL: Thank you very much. I don't see any other questions. Thank you, Mr. Fahey. [LR501]

BRIAN FAHEY: Thank you. [LR501]

SENATOR CAMPBELL: Before you leave, though, how are the twins doing? [LR501]

BRIAN FAHEY: Besides me being their father, I think they're going to be okay. (Laughter) [LR501]

SENATOR CAMPBELL: Thank you very much. Andrea. [LR501]

ANDREA SKOLKIN: Kind of short for the chair. [LR501]

SENATOR CAMPBELL: Good morning. [LR501]

ANDREA SKOLKIN: (Exhibit 5) Senator Campbell, members of the committee, I'm here today. Thank you so much for the opportunity for me. I'm Andrea Skolkin. I'll spell that. A-n-d-r-e-a S-k-o-l-k-i-n, and I really appreciate the opportunity to share with you, on behalf of OneWorld Community Health Centers, some of the impacts with data on our patient population at OneWorld. As you know, we're one of six federally qualified health centers in Nebraska, and we are located in Omaha. Interestingly enough, this month is about nine months since the change in the law. So the results that you're hearing I think are just a little preliminary and full pregnancy, the outcomes are yet to be seen, I think. So since March 1, OneWorld has provided prenatal care for about 835 women, an average between 300 and 350 a month. We stepped up and continue to provide prenatal care and actually tried to open our doors wider to allow women who would otherwise not get prenatal care to come to the clinic. We anticipate a 12 percent increase this year in women getting prenatal care in our clinic, approximately 1,100 women. During this time period, on average women have visited for prenatal care a little bit shy of five visits each. Now if you have a daughter or a grandchild that is attending prenatal care, you know that five visits is not adequate prenatal care. Data for this time period indicates that 54 percent of uninsured women that visited the health center came within their first trimester as compared with 84 percent of women that were insured or had Medicaid in this very important first trimester. Overall, it was 64 percent of women that entered care in this trimester as compared with 82 percent in 2009. The percentage of pregnant uninsured mothers coming from outside the service area increased by 5 percent, not as much as you heard from the Columbus health center but nonetheless an increase. We've had pregnant women from Grand Island, Nebraska City, Fremont, Nickerson, Lexington, just to name a few. We've seen nine premature births from uninsured women and five from insured women. We also had two babies born at the health center, which is highly unusual circumstance in the history of the health center of 40 years, we've had three births in the health center. So the two were within this year. One, fortunately, was a very healthy birth but nonetheless then transported to the hospital, and one was a baby that did not survive and wasn't born live. This was from a

woman who received no prenatal care. This was her first visit to the health center. Both of these mothers came to the health center fearful because of the costs of presenting at the hospital, not knowing whether they were really in labor or not. We've heard over and over again from women, especially during the beginning of the change, calls. They don't know if they're in labor. They don't want the cost of going to the hospital. What should they do? So either through the call or just by showing up, they're afraid to go to the hospital because of the costs. Only 44 percent of uninsured mothers received adequate prenatal care according to what we use, which is the Kotelchuck Index, which is a national index that's used to measure the adequacy of prenatal care. It uses two crucial elements that comes from birth certificate data. That's the date the prenatal care began, and the number of visits from the beginning of prenatal care until the delivery. This number, 44 percent for uninsured moms as compared to 79 percent of moms with Medicaid or insurance. We've had another interesting phenomena that we really, just looking at the data to prepare to come here, need to take another look at. But among for Cesarean births, we have had double the Cesarean births for uninsured moms than those that are insured or on Medicaid. And we're really not sure what the reason for that is. But we're doing our best to provide access to high-quality, prenatal care to uninsured moms. As you might have guessed, our payer mix has changed dramatically for OB patients, moving from 85 percent covered by Medicaid to now about...a lot less than that, 66 percent uninsured. Though we've had to switch resources, we have made some shifts in order to make sure that a prenatal mom have access to healthcare. We ask donors to step up and, in fact, we have received some resources but, obviously, not enough to cover the topic. We were fortunate to be a grantee of a limited time grant from the Centers for Medicaid and Medicare which allowed us to hire, actually, a large team of now seven people to help enroll children into Medicaid, but the CMS allowed us to two of these workers to help enroll mothers for emergency Medicaid. So we have been aggressively, more than we would have done in the past, enrolling children into Medicaid to help balance our budget, quite honestly, so that the kids that come to the health center would have a source of reimbursement. And then that helped mitigate the currents that we found ourselves in. We are very concerned about any further

reductions for community health centers in the state and we hope that you will do your best to not have that happen. But I heard a lot of discussion about emergency Medicaid and I did want to touch on that though I see the light is red. [LR501]

SENATOR CAMPBELL: I think we need to hear it, your information, Andrea. [LR501]

ANDREA SKOLKIN: This has been...the loss of prenatal care is huge in terms of coverage, but the process for emergency Medicaid is both burdensome and, I feel, discriminatory in the actions that are taking place. It is taking on average four months, which means a couple of them come early but we do have reimbursement waiting as long as six months. Took us a lot to get them in the queue and get them moving. And, again, we have devoted two staff members from this special grant in order to follow all the paperwork and work with the state to make sure these moms get their coverage. We do not attend all of our deliveries but out of almost 300 deliveries, 122 of them have been delivered by our providers. We have Creighton OB residents that also deliver babies. But we did the enrollment for 122 applications, and 66 of those have been approved, 49 have been paid, 43 are not yet processed, 10 are still pending, and 3 have been denied. But the process is very burdensome, I think, both for the state workers as well as our clinic and other providers. And not only is it the paperwork but the attitude and the request for multiple documents that seem to be lost, duplicative information, and seemingly more invasive questions in order to qualify. It has been disheartening. Fortunately for newborn babies the situation is a little bit better. But it's about an average two-month wait for which we can retroactively bill and eventually get paid, but it is still a more burdensome process. And we do have some children actually waiting still yet from July. So the best case, of course I'm going to ask for this, is that (laugh) coverage be restored for prenatal care. But short of that the one thing I would ask you all to consider, and I know it's tight budget times, is to resume the practice or even just begin the practice for emergency Medicaid of presumptive eligibility. Since you can see, we are making great progress in getting paid anyway. It seems an additional labor cost that is not necessary as long as women do meet the income criteria in this state that

they should be assumed presumptively eligible. So, again, I'd like to thank you for allowing me to share our story, go into overtime. And your continuing efforts, Senator Campbell and all of the members that are here today, in continuing to shine the light on the need for prenatal care. [LR501]

SENATOR CAMPBELL: Thank you, Andrea. Questions? Senator Nordquist. [LR501]

SENATOR NORDQUIST: Thank you for being here, Andrea. Just on the statistic you had on the front page here, the five times during pregnancy, did you guys...a little less than five visits during their pregnancy, did you track that prior or can...is it possible to look back? [LR501]

ANDREA SKOLKIN: It is. I don't have that data with me, but our on average was over...I think it was five and a half. I did look at that data. So there is a drop. I wouldn't say it's down to zero, but yeah. [LR501]

SENATOR NORDQUIST: Yeah. Okay. Thank you. [LR501]

SENATOR CAMPBELL: Senator Stuthman. [LR501]

SENATOR STUTHMAN: Thank you, Senator Campbell. Andrea, as we had heard from the Columbus Health Center,... [LR501]

ANDREA SKOLKIN: Um-hum. [LR501]

SENATOR STUTHMAN: ...do you find are there more questions being asked about where can they receive an abortion? Do you see anything of a possibility of abortion clinics being opened up or anything like that? [LR501]

ANDREA SKOLKIN: I wasn't going to discuss the emotionally charged issue, however,

just recently we've had more contemplation of abortion. Just recently a case of someone that was pregnant and was contemplating the morning-after pill. We don't know the outcomes of that. Of course we try to refer right into our prenatal intake by...it is the law that, you know, a woman has a choice. So there is a new clinic, a new Planned Parenthood clinic being established in Omaha that will provide that service. I don't know if there's an uptick or not. I couldn't speak to that. [LR501]

SENATOR STUTHMAN: I mean, this is very much of a concern of mine, you know, of the effects of what we're doing, you know, right now and how it effects people and, you know, what decisions they are making to try to cope with it. [LR501]

ANDREA SKOLKIN: I do know that our providers have shared with me on numerous times, there are discussions of the fear of the cost, finding out they're pregnant, and the costs of raising a child. And I'm sure incorporated in that decision are whether to proceed or not to proceed. [LR501]

SENATOR STUTHMAN: Okay. Thank you. I'm sorry I put you on the spot. It's very emotion to me too. [LR501]

ANDREA SKOLKIN: Um-hum. [LR501]

SENATOR STUTHMAN: But, you know, these are things that are going to happen. [LR501]

ANDREA SKOLKIN: Yeah. [LR501]

SENATOR STUTHMAN: I think. [LR501]

ANDREA SKOLKIN: As was said previously, I think for me as a citizen of the state of Nebraska, just thinking forward into the future of Nebraska where the growth is coming

from, where the economy is being jump started is through the same population that we are not taking care of prenatally. [LR501]

SENATOR STUTHMAN: Thank you. [LR501]

SENATOR CAMPBELL: Senator Howard. [LR501]

SENATOR HOWARD: Thank you. I have to thank you so much for all of the good work you do. And I told you this before, it's not only that you have such good ideas, but you see them through and get things done. That was a wonderful article in last night's Omaha World-Herald about the expansion and the programs. [LR501]

ANDREA SKOLKIN: Um-hum. [LR501]

SENATOR HOWARD: And I see you're anticipating 1,100, possibly 1,100 moms. I'm going to have to get my neighbors cutting and sewing faster on those baby bibs (laughter) for you. They're slacking off at this rate. [LR501]

ANDREA SKOLKIN: Right. In spite of the change in the prenatal care in our new facilities, which people saw in the paper, we do plan a women's health center and we're very grateful for Senator Howard beginning our, what I'm calling, "Gwen's Boutique". [LR501]

SENATOR HOWARD: Oh, thank you. Thank you. I think it's important that we respect life, not only talk about it but actually be there to provide the services to see that these babies are born healthy. So thank you. [LR501]

SENATOR CAMPBELL: Thank you, Andrea, very much for coming. [LR501]

ANDREA SKOLKIN: Thank you. [LR501]

SENATOR CAMPBELL: Any other questions? Okay. On my list, I do have additional people. Then I'm just going to go with what I've been given. Jennifer Carter, are you testifying today? Is there anybody, while Ms. Carter is making her way to the front, who has to leave for a particular appointment that I may not have gotten that message? Okay. How many other people wish to testify today? Okay. And I think I have you all on the list. Good morning. [LR501]

JENNIFER CARTER: (Exhibit 6) Good morning. My name is Jennifer Carter, C-a-r-t-e-r. I'm the director of public policy in the healthcare access program at Nebraska Appleseed. And I also wanted to thank Senator Campbell and the members of the this committee for all their hard work on this issue and the continued dedication to the health of women and babies in this state. You know, I don't think we could speak more eloquently to the human toll. We've certainly talked to mothers as well who have a history. One client has a history of gestational diabetes, was no longer eligible for prenatal care, although she does have legal status but it wasn't an eligible legal status, and was going to the drugstore to try to test her...just try to test her blood sugars as she went along. The baby was born but they are concerned about continuing health issues though generally I think is not super critical, so that's good. But I think one thing that we could speak to a little bit is that...and I think we've already heard this, that there is a real fiscal toll to this policy, aside from a human toll. And it's not just long term. I think we've heard when we were seeing babies in the NICU for 38 days and we're paying for that on Kids Connection, we're seeing the costs already. And that was one thing that I wanted to reenforce that if this was a mother who might have been eligible for prenatal care coverage, their income is already below the income that you need...threshold that you need for Kids Connection. So these kids, the day they are born, are automatically eligible, and we are going to be paying for those immediate or chronic health issues going forward as a state. To the emergency Medicaid issue, we've been working on that closely and talking to some providers about that, and I think a lot of the concerns have been well raised. The way, as we understood the Medicaid rules that used to work,

prenatal care used to provide prenatal care, labor and delivery, 60 days postpartum. So you could plan for C-sections, you could plan for inducements, and avoid more complicated and costly emergency care that way, and not only...and obviously, provide for the health of the baby and the mother. Now the only coverage that you can get is emergency Medicaid for labor and delivery. And our understanding is, and I think we've heard this from providers, there's been a huge increase in the number of emergency Medicaid applications, which is one thing that I believe was predicted when we talked about this during the session. I don't think we would see that if we asked HHS for budget numbers precisely because these are not getting processed or they're not getting approved. So I don't know that we would actually see what I think are the true budget implications of this just yet, and I think what's more concerning is, and I think it was well described, that HHS is requiring these magic words. And there's nothing on the application that requires the magic words. There's actually no place to write on the application the magic words. And my understanding was this was not initially known to providers, this technicality. It's still not known to a lot of the patients, and occasionally if the hospital hasn't been able to work with that patient to...on the application, that patient needs to put in the application later, and they don't know that either. And what...there's a side issue, by the way, also in that if these applications are being that extensively delayed, there are federal rules and laws under Medicaid that require timely processing of Medicaid applications. So there could be an issue of liability separately to the state if they're not providing this. But I think more importantly this is a huge cost shift (laugh) based on this policy, not only to providers but to all Nebraskans. Because when you have a hospital who can't get reimbursed for a service that they are eligible for and the patient is eligible for, eventually that's going to end up as uncompensated care, and we are all going to see that in our premiums. And the hospitals can't sustain it and I don't think we can sustain it. And so we had a few thoughts about how to solve emergency Medicaid problems. Some of them are simple. Tell people, tell them what magic words you need (laugh) now. What are the technicalities? Change the form. Have a check box or a line that says, I'm applying for emergency Medicaid for labor and delivery. Things like that that I think could really help push those applications along and could be really

simple solutions. I actually really like the idea of presumptive eligibility for emergency Medicaid or you could look back...you just could look back, as I believe some places do, 90 days when somebody applies and said, have you had an emergency in the last 90 days, and will look to see what that is and if she should have coverage for that. I am...you know, we've been following this issue but I have to say I've been...the potential access issues are gravely concerning to me, hearing the stress that this is placing on clinics and on doctors in the sense that there may be increased attrition, I think, is really concerning when they've done such a wonderful job of trying to fill in the gap here. What happens if that starts to fall through? We're already seeing some devastating consequences. What happens if that continues? So I mean the other...we're going to make the plug I think nobody would be surprised about, but we feel their...you know, the really clear, simple, straightforward solution is to restore prenatal care. And HHS has full authority to do this under our statute as they exist. It is a simple state plan amendment, literally checking a box that we send to the federal government to provide prenatal care for the unborn child. So actually the benefits look a little bit different because it's just prenatal care for that child. There's no postpartum care. Under SCHIP, CMS suggested this almost a year ago. It's almost the anniversary of their November 30, 2009, letter where they suggested the state do this. And so even though that's all in place, the Legislature could still obviously make that an explicit requirement and we would encourage you to do so. And I know it's a difficult budget time but our current policy is not a fiscally sound policy. It's actually more...and I think we're hearing that more and more, is more fiscally responsible for us to provide this preventative care and avoid these longer term costs. So if we can be helpful, continue to be helpful in any way with that, we would really like to see and encourage the Legislature when you're going to have to make so many tough decisions (laugh) about a lot of priorities that I don't know that there could be a higher priority here. So thank you very much for your time. I'm happy to take any questions. [LR501]

SENATOR CAMPBELL: Any questions? Okay. [LR501]

JENNIFER CARTER: Okay, thank you. [LR501]

SENATOR CAMPBELL: Thank you. Next. I think we have three gentlemen left. Is that correct? Good morning. [LR501]

HOWARD DOTSON: Good morning, Senator Campbell... [LR501]

SENATOR CAMPBELL: Welcome. [LR501]

HOWARD DOTSON: ...and fellow senators. I come before you as a Presbyterian pastor and a closet Jesuit. (Laughter) And I want to speak to your question about the abortion. Shirley Mora James is local counsel for MALDEF. And she had to leave and go across the street for another meeting. But my church is in south Omaha, midtown. And there is concern of women in south Omaha considering abortion in light of this situation. We've spoken about the fiscally conservative dimension of this. And as a pastor, I want to speak to the moral dimension. Each life is sacred. And those four babies that we talked about in Columbus and the one baby here in Omaha should break our hearts. These babies are innocent and we're punishing them for the documentation status of their mother. And last March, we were having a meeting at Grace Lutheran Church the day that your bill was pulled. And we need to stand up to the anti-immigrant sentiment in this state, the racism that many Nebraskans have not confronted that's driving this. And it's not only this issue it's other issues. And it's not Republican or Democrat. What's playing out right now in our nation is really disconcerting. And those five babies are casualties of what's playing out right now. So SCHIP would cover 70 percent and all we're asking is 30 percent. And what's playing out is the anchor baby argument, people worried about by 2050 the whites are going to be a minority. And some of those other aspects that are playing out in this anti-immigrant sentiment for Republican senators who are pro-life and for more of the faith community who's pro-life to stand up and support the senators that have courage to restore prenatal. We face a moral crisis in this nation as the anti-immigrant sentiment continues to drive very poor legislation and immoral

decisions. Thank you. [LR501]

SENATOR CAMPBELL: I'm sorry, could you spell your name for the... [LR501]

HOWARD DOTSON: D-o-t-s-o-n. [LR501]

SENATOR CAMPBELL: Did you get that, Lisa? Okay. Thank you very much for your testimony. Good morning. [LR501]

JOHN CAVANAUGH: (Exhibit 7) Good morning, Senator Campbell, members of the committee. My name is John Cavanaugh. I'm the executive director of Building Bright Futures. We're located at 1004 Farnam Street in Omaha, Nebraska. And I'm here this morning first of all to commend you, Senator Campbell, for keeping your focus on this extremely important issue and to add our voice in terms of restoring prenatal care as a very high priority for this state. In the last, since March of this year the state of Nebraska moved from a leading position in which every child had an opportunity for prenatal care to denying a significant, over 1,000, population access to that what we know is vital for not only their individual health but for the health of our community. So we think that this is a primary issue for the Legislature and for the state of Nebraska. Building Bright Futures is focused on academic success and eliminating disparities in academic performance. We know that health and with the help of this committee and this...the last Legislature we did institute for the first time in the state of Nebraska as a matter of (inaudible) school-based health centers which is all about expanding access to healthcare for low-income students with a view to meeting that need that...which is the single biggest gap impediment to academic performance. When we now look at the denial of prenatal care that's a huge setback for that commitment to improving opportunity and access to academic and eventually economic success. Building Bright Futures largest commitment in terms of dollars and programming is to that very large void in our society--the first three years of a child's life. And we are committing over $6 million in the current year to addressing the needs of those infants and children. And

this is a major blow to the success that we can recognize in that effort. The more children who come to life with health impediments it is a domino of destruction that will follow them and us throughout their entire life. And I think that this committee should be commended for recognizing that. I think the challenge is for us to raise that recognition throughout the state. As I've sat and listened to this testimony today, it's graphic in that not...there's not one word of testimony of a positive impact of this change in policy for the state of Nebraska. So it's obviously clear that this change of removing and denying prenatal care for a large segment of our population is not in the state's interest, certainly not in the interest of these individual children but very destructive in terms of its consequences for all of us and for the state of Nebraska. So I encourage your work. I want to leave a bit of research that we collaborated with, with Voices or Children. This is birth indicators. What we did was asked Voices to examine all the birth records from the Department of Vital Statistics, going back to 2005, in terms of births within Douglas and Sarpy County. And this gives you a baseline picture up to 2009. So that when you begin to look at what occurred since we instituted this policy you'll be able to see that against what the historical record was in terms of access to prenatal care by trimester and actually by hospital and by category of insurance. So we've broken it out by Medicaid patients access to prenatal care, private pay and uninsured. And we'll be able to see graphically what the impact is going forward at least in the Omaha metropolitan area. So thank you again. And keep up the good work. [LR501]

SENATOR CAMPBELL: Okay. Questions? Senator Wallman. [LR501]

SENATOR WALLMAN: Yeah. Thank you, Senator Campbell. Thank you for being here, John. [LR501]

JOHN CAVANAUGH: Thank you. [LR501]

SENATOR WALLMAN: Appreciate you being here and also Voices for Children. I'm definitely for children. And this is going to affect our children as you and I probably

know. [LR501]

JOHN CAVANAUGH: True. [LR501]

SENATOR WALLMAN: And I'm convinced it will. So of these children born, how many do you think will be wards of the state, you know, if something is not quite right or something these young mothers or older? Do you have any stats on that? [LR501]

JOHN CAVANAUGH: Well, I think first of all the most important thing for us to recall is that they'll be citizens of the United States... [LR501]

SENATOR WALLMAN: Yeah. [LR501]

JOHN CAVANAUGH: ...and of this state and that we are adding to an already a disadvantage that they come into the world with. You know, I can't think of a more vulnerable person than an infant of an undocumented parent and yet under our system they're entitled to equal protection of the law. So they come in with a serious disadvantage but they come in with the same rights that every other Nebraskan has. And I think that once we share that importance with the rest of our citizens, I think the perspective should change in terms of making sure that we go back to where we were just in March of this year with a recognition that everybody should start with the best chance that they have. I think that what...how many will become wards of the state, you know, all of the work that we did clearly demonstrated that if you start with an economic disadvantage that's the biggest impediment, still the biggest impediment to success. And those are the populations who fail academically, they fail economically, they fail socially, and they certainly occupy the largest portion of our prison population, as you well know. That's a population more than 40 percent without a high school education. And so as I say, it's the first domino in a whole series of human destruction and it's one that we can avoid. You know, that...the difference that we'll make in the number of lives to have solid prenatal care we will...we are going to find that out. That's why we

produced this is to say here's what we started with, but why not avoid those consequences because we already know what the outcomes will be and they won't be good for any of us. [LR501]

SENATOR WALLMAN: Okay. Thank you. [LR501]

JOHN CAVANAUGH: Yeah. Thank you. [LR501]

SENATOR CAMPBELL: Any other questions? Thank you very much for the research. [LR501]

SENATOR HOWARD: I have to...I have to tell him something. [LR501]

SENATOR CAMPBELL: Oh, I'm sorry, Senator Howard. [LR501]

SENATOR HOWARD: No, that's fine. I just have to tell you thank you. Thank you for using Congress as a stepping stone to doing good things. (Laughter) [LR501]

JOHN CAVANAUGH: Doesn't seem to be. [LR501]

SENATOR HOWARD: You work hard at it and I appreciate it. Thank you. [LR501]

JOHN CAVANAUGH: Well, thank you. Thanks for all your help. [LR501]

SENATOR CAMPBELL: Thank you very much. Mr. Cunningham, do you wish to testify? Good morning. [LR501]

JIM CUNNINGHAM: Good late morning, senators. My name, for the record, is Jim Cunningham and I'm executive director of the Nebraska Catholic Bishops Conference. I'm here to share some thoughts with you. I actually had not intended to testify today

because I really don't have any facts and figures and data to share with you that I know is really a key purpose at this particular time to assess the consequences of this policy change. But I do have some thoughts to share with you. Our concern has been consistent and ongoing since the day we first learned of the policy change. And our concern is that eliminating this important means of access to prenatal care services would result in harsh and harmful consequences for a highly vulnerable population--impoverished pregnant women and their unborn children. I would ask you not to lose recall of one comment that Dr. Welch made when he described the consequences as inappropriate punishment of the unborn child, the risk that the unborn child faces, the unborn child who is not illegal or is not an illegal to use the bad grammar that seems to coming more and more a part of the immigration debate. Our failure to persuade the administration and the Legislature to continue this longstanding pro-life policy was not merely disappointing it was disheartening, especially in view of the fact that there was such a clear and reasonable path for accomplishing retention and continuation of the policy. But like others, we continue to plan to work for restoration of prenatal care for this vulnerable population. I would like on behalf of our conference to express gratitude to Senator Campbell and to others who are intent on monitoring the consequences of the policy change because that at this point is going to be a very important aspect of restoring prenatal care. I'm pleased that this is not a court of law or a trial because I would like to...and the only thing I can do is share with you some hearsay evidence and I would like to do that. First, I would like to read to you a paragraph that comes from the summer newsletter of "AAA Center for Pregnancy Counseling," which is located in Omaha. And I don't want to in any way suggest that this in any way represents a position that that entity is taking on the question of changing public policy or restoring public policy because I don't know that. But this has more to do with those who would deal and provide services to low-income pregnant women. And I quote this, Since the beginning of March we have seen a definite increase in the number of women coming to us past their tenth week of pregnancy. They have not seen a doctor yet. Most of them have not even taken a pregnancy test. They tell us that they are either afraid or in denial because they do not have the money for prenatal care.

They had either been rejected by Medicaid or were afraid that they would be so they were just taking their chances without prenatal care. Unfortunately, those chances could have deadly consequences for both mother and child. I have had two conversations in recent weeks with Catholic pastors, one in the Hastings area and one in the Lexington area, who were dealing with situations of a pregnant undocumented woman. And it struck me that their reaction to the situation was so much in line with what this statement says--the women were afraid. And that's one thing that we've heard a great deal about in our work on the immigration issue is that there is a great deal of fear in the immigrant community. And I salute Howard Dotson for so forthrightly and eloquently addressing that issue of immigration in the state and the nation. And also that they were taking their chances without prenatal care, that's what they were told, that they were intent on just taking their chances, not getting prenatal care and waiting until delivery time and then hoping for the best. In one of these cases the woman had a previous pregnancy and delivery, had a great deal of difficulty with the pregnancy, this was prior to the change of policy in March, had a great deal of difficulty. Fortunately, the outcome was a good one. But you can understand the fear that this woman would have, having gone through a difficult pregnancy, of what the outcome might be without getting prenatal care. And I would have to say that the response that we've been recommending to those who contact us, especially if they're outside of Lincoln and Omaha, is to look into the services that they're providing at the health center in Columbus because from what we've been able to understand that is the best resolution or suggestion that we can give to them. So thank you very much. [LR501]

SENATOR CAMPBELL: Thank you, Mr. Cunningham. Questions? Senator Stuthman. [LR501]

SENATOR STUTHMAN: Thank you, Senator Campbell. Mr. Cunningham, you know, I really appreciate your comments. And this is more of a statement from me as I'm leaving the Legislature. I fear that in five to ten years from now the state is going to have an ongoing expense that we cannot stop because of the decision that was made. We're

going to have children that are going to be needing help, you know, for 20 years and it's going to be an expense of the state just because of the...what we have done. And I just fear that coming. And I'm one to always believe that we should try to get these babies to be born healthy so that they can become an asset of the state of Nebraska instead of a liability... [LR501]

JIM CUNNINGHAM: Appreciate that. [LR501]

SENATOR STUTHMAN: ...with just a little bit of prevention and care and very little expense. [LR501]

JIM CUNNINGHAM: That's why we both, Senator, can so much appreciate the testimony delivered by...today by those who deal with these cases on a very human and direct basis, because that's what they're telling you and others... [LR501]

SENATOR STUTHMAN: Um-hum. [LR501]

JIM CUNNINGHAM: ...that the long-term consequences are going to be devastating. [LR501]

SENATOR STUTHMAN: And that could last up to 20-25 years. [LR501]

JIM CUNNINGHAM: Right. [LR501]

SENATOR CAMPBELL: Thank you, Mr. Cunningham. [LR501]

JIM CUNNINGHAM: Thank you. [LR501]

SENATOR CAMPBELL: Is there anyone else in the hearing room that would like to testify? Lazaro, did you want to make a comment? [LR501]

LAZARO SPINDOLA: Good morning, senators. [LR501]

SENATOR CAMPBELL: Good morning. [LR501]

LAZARO SPINDOLA: (Exhibit 8) Thank you for receiving me today. My name is Lazaro Spindola, S-p-i-n-d-o-l-a. I am the executive director of the Latino American Commission here in the Legislature. You have heard a lot of arguments and you'll probably hear some of them, both pro and con, regarding the cost of denying prenatal care to women. Some will point to savings to the Medicaid system. Some will allege that it will be more expensive for Nebraska to deny this type of care because we will end up paying for a care provider to children born with complications that were perfectly preventable. Both sides are right. Potential savings to the Nebraska Medicaid system, according to the commission's calculations which are rather conservative, are about $1.2 million. Potential costs are such that it would only take 11 low-birthweight children to erase those savings. If you look at page 3 of the March of Dimes fact sheet that I enclosed in my testimony you will notice that Nebraska, between 1997 and 2007, has had a stable rate of children born with low-birthweight. In 2007 it was about 1,800 to 1,900 of them. By now we know that this number will increase according to the testimony that was given by people better prepared than me. So the cause that I wish to reference today is not the economic, the moral or the ethical cost because people better prepared than myself have already done it. The cause that I wish to reference is the cost to the credibility of this Legislature, this state government, me because (inaudible). The only thing that should be unbreakable in a piece of legislation is the principle behind it. Nebraska's Legislature, Nebraska's government, the Nebraska people have traditionally opposed the destruction of a beating human life inside a mother's womb whether it be through mechanical, physical or chemical means. In fact, not very...quite recently, not too far ago we approved a law in which such destruction could not be carried out after 20 weeks of pregnancy because of the suffering that we'd be imposing on that beating human life. And yet we are simultaneously conducting (inaudible)

through which that life is being destroyed through lack of appropriate prenatal care. We already heard testimony regarding the fact that five of those lives have already been destroyed by starving them to death through inadequate prenatal care. And we have also basically approving causing pain to those children, the pain that comes from developmental disabilities, from neurological developmental (inaudible). And my question right now is, what is the principle behind this? What do we stand for? Because that is a question out on the street. That is a question that I hear in Omaha. That is a question that I hear in Lincoln, in Wakefield, in Wayne, in Schuyler, in Columbus, in Lexington, and Grand Island, and Hastings, and Scottsbluff, what do we stand for? What are we? Thank you. [LR501]

SENATOR CAMPBELL: Thank you, Dr. Spindola. Any questions? Okay. Anyone else in the hearing room who wishes to provide testimony today? I would like to say that when we gathered the group of people this summer to begin looking at this issue I think we were all somewhat naive that we could find all of the figures and what was happening to these mothers. And what we soon found is that what one gathered as figures was apples and another was grapes and another was tomatoes. It was just really all over the board. And I think, I know I was very naive in thinking that we would have all the figures and we would be able to tell you. We are very fortunate in the last month that a woman has stepped forward who is working on her doctorate and is going to help us begin gathering that data and putting it in a form in which it is all the same and which we truly can understand what is happening. So I'm very grateful for her stepping forward to help us with that. And I also want to thank all of the federal health clinics. You truly are the gateway for these women and their babies and we thank you very much for being the frontline in this issue. With that, I'll close the public hearing and we'll continue to keep you all apprised through our e-mail list. Thanks for coming. [LR501]