PMICs, or Psychiatric Medical Institutions for Children, were created in 1987 by a legislative effort led by then-Senator Charles Bruner and myself.

It was spurred by the goal of creating adequate reimbursement for residential treatment centers serving more difficult children by utilizing Medicaid funding.

In many ways, Iowa was on the leading edge when PMICs were created. However, this edge quickly accelerated beyond us.

While other states developed PMIC care later, they then used it as a platform to create multiple levels of care and to develop step-down services. Iowa simply failed to take advantage of the promise of the PMIC level of care.

The Iowa Policy Research Organization at the University of Iowa conducted a comparative study of PMICs in 2008. Their conclusion best sums up the problem (*The federal designation of PRTF obviously allows a great deal of state flexibility as evidenced by the variety of services in the states of this survey. While Iowa has had PMIC since 1987, it lags*

***far behind the other states in level of reimbursement, development of multiple levels, and creation of step-down services.*)**.

Since its inception, the number of PMIC beds in Iowa has been capped by legislative mandate. Until approximately two years ago, the daily rate of reimbursement for PMICs was also capped by the legislature. Because of this, the expenditure for PMICs in Iowa has been very tightly controlled from the beginning.

Today there are several issues confronting PMICs and the populations we serve. For the purposes of brevity, I would like to highlight what I consider some of the most important problems:

1. **<u>Lack of a rate-setting mechanism.</u>**

   The initial cap for PMICs was set in the 1987 legislation and no reimbursement mechanism was created specifically for PMICs. This has led to an artificially suppressed rate of reimbursement for PMICs. This is why multiple levels of care have been impossible to develop.

2. **Rising acuity of children.**

With the onset of public managed care in Iowa, acute care beds began to close down. With their closure, the acuity of children in other levels of care began to rise. We have seen this trend continue for a number of years.

3. **Licensing.**

PMIC licensing was based on comprehensive residential treatment standards. These standards were developed in the late 1970s and early 1980s. Licensing standards have never been revised nor designed specifically for PMIC level of care. This has led to problems such as outdated standards. For example, LISWs (Licensed Independent Social Workers) working in a PMIC require weekly documented supervision. PMIC licensing does not recognize nurse practitioners.

4. **Client participation.**

Client participation is a growing burden on both providers and clients. When clients are admitted to a PMIC via Medicaid, the state determines the amount of financial participation which a client is responsible for. Our already low rate of reimbursement is

automatically reduced and the expectation is that we will collect that money from the client.

The reality is that many clients cannot and will not pay for this. For example, if you are a single mother dependent upon your child support and you have a child admitted to a PMIC, you are expected to forfeit your child support to pay for the PMIC care. Clearly, this is unlikely to happen.

The result is that our already low rate of reimbursement is further reduced by uncollectable amounts. Other states have developed better methods to deal with client participation that should be adopted by Iowa.

5. **<u>Lack of step-down services.</u>**

   The availability of outpatient services for children with serious emotional disturbance is by everyone's account severely lacking. This makes it very difficult to provide after-care services and to prevent admissions. It is the major impediment to reducing length of stay.

PMIC is the only level of care in Iowa specifically designed for children needing psychiatric treatment.

The issues I have described here today have been pushed down the road since the inception of PMICs in 1987. As a result:

- **We consistently have 40-50 children placed in out-of-state PMICs at an average daily cost of just under $400. Compare that to our in-state rate of $179.89. Many of these children could be treated in facilities in Iowa close to home, with that revenue benefiting Iowa's economy.**

- **The service available for children with psychiatric disabilities pales in comparison to services available for children with intellectual disabilities.**

These are issues that need to be addressed by the joint efforts of the Department of Human Services, PMIC providers and the legislature. Ultimately, solutions must be found by you on behalf of the citizens of Iowa.