CDEC Early Intervention Caseload

Joint Budget Committee Presentation
June 2025

COLORADO
Department of Early Childhood

Community Engagement

- The Department held **18 input sessions** with Early Intervention providers, parents, and partners to discuss cost-containment strategies. This input led to the Department's recommendations on which strategies to implement, which to explore further, and which to not implement.
    - An average of **200 participants** joined each input session.
    - CDEC surveyed providers and families regarding each strategy and received **167 responses**.

Program Enhancements

- Moved approximately $27M from a pooled direct services set aside funding into the EI Broker contracts.
    - **Impact:** Creates better accountability, transparency, and tracking.
- Bi-monthly contract review to better adjust funding.
    - **Impact:** Ensures the Department can more quickly and regularly address underspending or identify trends of higher spending due to additional caseload needs.
- Data-sharing agreement renewed between CDEC and HCPF to ensure access to Medicaid data.
    - **Impact:** Allows close monitoring of enrollment and payment trends; ensures offsets are applied to Broker invoices accurately; and allows for accurate Medicaid enrollment projections.
- The EI program is accelerating activities to have subcontracted providers bill directly through the Provider Portal in the EI Data System.
    - **Impact:** Reduces the lag time between the provision of services and billing/invoicing.
- Strengthened the SOW in EI Broker contracts.
    - **Impact:** Ensures timely invoicing and data entry.

Cost Containment Strategy Recommendations

After analyzing community input, CDEC recommends implementing four cost-containment strategies in FY 2025-26.

Strategy	Implementation Date	FY 2025-26 Cost Avoidance	FY 2026-27 Cost Avoidance
Administrative Reductions	July 1, 2025	$300,000	$0
Discontinue Subcontracted Provider No-Show Payment	January 1, 2026	$261,186	$522,372
Discontinue Mileage and Travel Reimbursement and Subcontracted Providers	January 1, 2026	$359,586	$719,172
Discontinue EI Provider Training Stipend	January 1, 2026	$33,054	$66,108

Implementing the four recommended cost-containment strategies is projected to result in **$953,826 savings in FY 2025-26 (starting January 2026)** and **$1,607,652 in FY 2026-27** and ongoing.

The overarching goal of these strategies is to maintain services for children and their families.

Read the full Cost Containment Strategy Recommendations Report here

FY 2024-25 Actual Services Compared to the Projected Amount of Services: Average Monthly Enrolled

Month/Year	Projected Average Monthly Enrolled (Linear Forecast)	Actual Average Monthly Enrolled	Percent Difference
7/2024	10,723	11,359	5.93%
8/2024	10,779	11,582	7.45%
9/2024	10,926	10,905	-0.19%
10/2024	10,981	11,011	0.27%
11/2024	11,049	10,959	-0.81%
12/2024	11,109	10,974	-1.22%
1/2025	11,151	11,130	-0.19%
2/2025	11,209	10,930	-2.49%
3/2025	11,253	11,062	-1.70%
4/2025	11,298	TBD	TBD
5/2025	11,356	TBD	TBD
6/2025	11,403	TBD	TBD

Month/Year	Projected Average Monthly Enrolled (Linear Forecast)
7/2025	11,175
8/2025	11,225
9/2025	11,349
10/2025	11,383
11/2025	11,433
12/2025	11,469
1/2026	11,502
2/2026	11,555
3/2026	11,563
4/2026	11,577
5/2026	11,604
6/2026	11,655

- Projected and actual enrollment is close. When averaged across the first nine months, the difference is only 80 children.
- Actual numbers for July and August ‘25 are high due to increased enrollment in Extended Part C. Projections are low because they average the whole year. At the end of the year, the projections actuals average out.
- **The total unduplicated count of children served during FY 2024-25 is estimated to be 19,459.**

FY 2024-25 Actual Services Compared to the Projected Amount of Services: Service Utilization (1/2)

Early Intervention services are provided in 15-minute units (4 units is equivalent to one hour of services). **More than 197,000 hours of service have been delivered and billed through the end of the third quarter. A total of 300,225 hours of services are projected to be delivered for FY 24-25.**

Projected Service Utilization FY 24-25		YTD Service Utilization (7/1/24 - 3/31/25)	Percent of Projected Services YTD
Units	1,200,902 units	788,249 units	66%
Hours	300,225 hours	197,062 hours	66%

Projected Service Utilization FY 25-26		Projected Increase
Units	1,397,484 units	16%
Hours	349,371 hours	16%

FY 2024-25 Actual Services Compared to the Projected Amount of Services: Service Utilization (2/2)

CDEC Early Intervention Budget	FY 2024-25 Appropriation	Projected Expenditures (July-March)	Actual Expenditures (July-March)
State Administration Costs (Personnel, Operating, IT)	$2,058,393	$1,543,795	$1,784,530
Early Intervention Evaluation Contracts	$5,050,000	$3,787,500	$4,008,166
Early Intervention Service Broker Contracts	$42,251,678	$31,688,759	$29,835,703
Early Intervention Contracted Direct Services	$29,814,583	$21,913,633	$20,684,550
Totals	**$79,174,654**	**$58,933,687**	**$56,312,949**

Enrollment Count Trends

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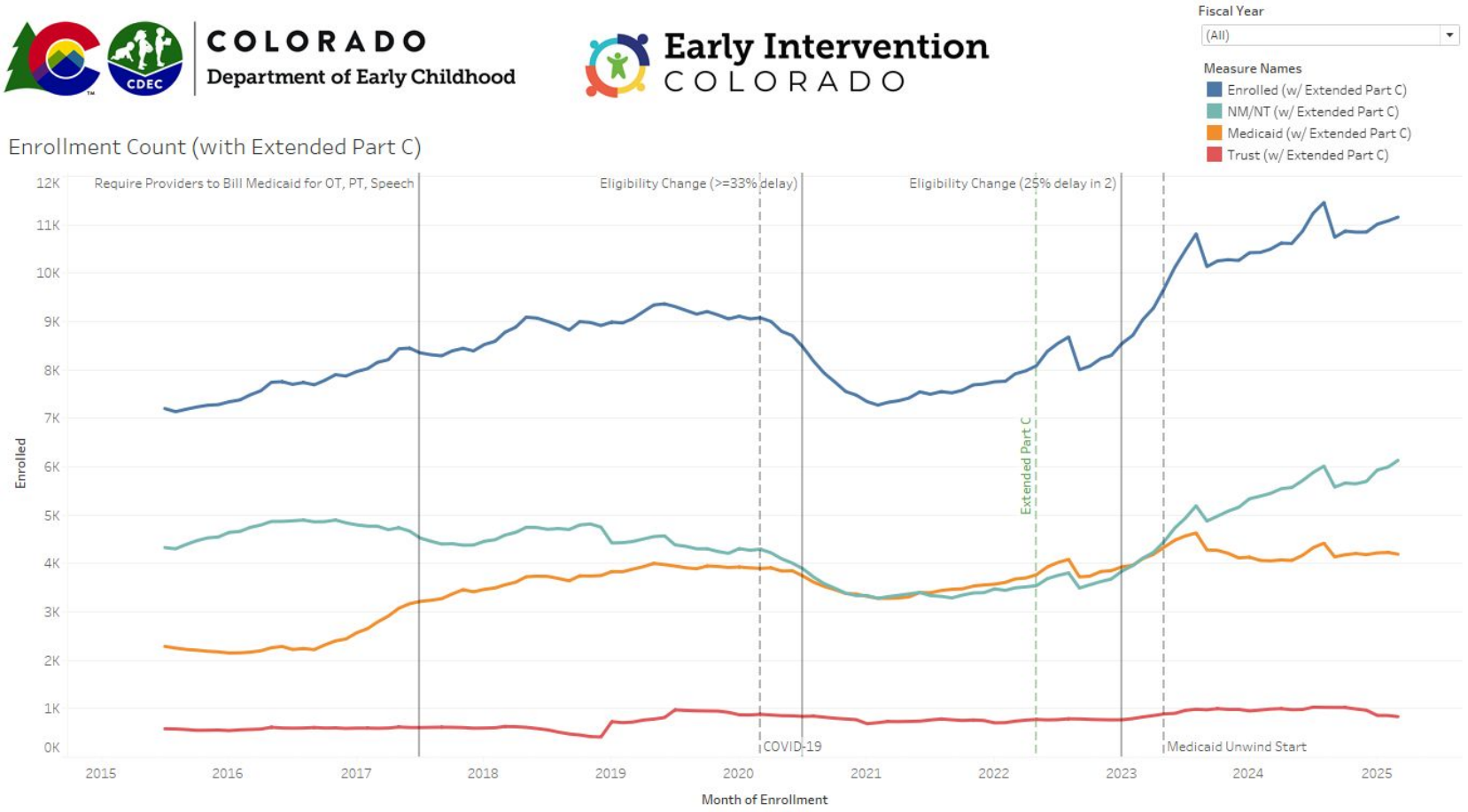

FY 2024-25 Appropriation and Expenditures

CDEC Early Intervention Funding Source	Appropriation Amount
Early Intervention Services - General Fund Appropriation	$62,492,837
IDEA Part C Grant- Federal Fund Appropriation*	$16,681,817
FY 2024-25 Funding	**$79,174,654**

FY 2024-25 Expenditures	Amount
FY 2024-25 Appropriation	$79,174,655
Estimated Range of Expenditures**	$77,073,422 - $78,744,654
Final Estimated Balance	**$400,000 - $2,101,232**

*This is inclusive of the Extended Part C funds with a total new award $10,288,404 and carry forward $6,393,413 for IDEA Part C Grant.
**Estimated range based on current actuals + estimated expenditures through 6/30/2025.

Conclusion and Future Community Engagement

Implementing the four recommended cost-containment strategies is projected to result in a potential $953,826 savings in FY 2025-26 (beginning January 2026) and $1,607,652 in FY 2026-27 and ongoing.

The Department has nine input sessions with families and providers scheduled beginning in July to discuss the impact, feasibility, and cost of additional strategies.

In December, CDEC will submit another RFI response analyzing these potential cost-containment strategies for FY 2026-27.

The CDEC remains committed to working with families, providers and the JBC to effectively and efficiently serve Colorado's children and their families.

Appendix

Joint Budget Committee Presentation
June 2025

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Early Intervention Program

- Supports children from birth through age two who have developmental delays or disabilities
    - Evaluates children referred with a concern about development; enrolls children with a diagnosis which makes them eligible for the program
    - Serves about 11,000 eligible children and their families each month and over 19,000 each year
- Focuses on identifying and addressing delays early to support healthy growth and development.
- Offers services including speech, occupational, physical, and behavioral supports to help with learning, movement, communication, and social-emotional skills.
- Individualized Family Service Plans (IFSP) are developed with the family to prioritize outcomes and identify appropriate services

Early Intervention Services

- Early Intervention services are determined through the Individualized Family Service Plan (IFSP) process with a team of professionals and the family
- The family is supported in determining the priority they have for their child's development as it relates to daily routines, i.e. participating in meal time, playing with siblings
    - EI services are not meant to address medical concerns
    - EI services are meant to impact the child's ability to function successfully in their day-to-day routines and interactions
- Almost half of children who receive early intervention services do not go on to receive Part B Preschool Special Education services, resulting in a potential cost savings to the state

Background on Budget Shortfall

- The Department submitted the FY 24-25 Early Intervention Caseload Growth RFI response on January 1, 2025
  - The RFI was based on first quarter data and no issues were identified at that point
  - The program was set to closely monitor expenditures through the rest of the fiscal year as no funding was available for unexpected expenditures
- In February 2025, contracted direct service billing for quarters one and two projected $4M more expenses than expected for direct services
- The Department amended contracts with EI Service Brokers and Evaluation Entities to secure approximately $2M in underspending to add to the contracted direct services funds
- The Joint Budget Committee approved the transfer of $2M in underutilized Medicaid match funds
- For FY 25-26, the Department would again experience a shortfall if expenditures continue as they currently are because of the following factors:
  - Because of stimulus fall-off, there is $0 in federal carryforward
  - Caseload is projected to continue increasing
  - Workforce investment strategies led to higher costs
- The JBC approved additional funding for FY 25-26 with the understanding that the Department would engage community partners to analyze cost containment strategies that could be implemented to ensure the sustainability of the EI program and services to children and families

Cost Containment Strategy Evaluation Criteria

The Department and its partners evaluated twelve strategies through the following criteria regarding impact, cost, and implementation feasibility:

- Impact on children and families
- Impact on providers
- Cost savings
- Requires change to Early Intervention rules, statutory change, or data system
- Requires Office of Special Education Programs (OSEP) approval
- Requires collaboration with another state department

The Department submitted the Early Intervention Cost Containment Recommendations to the JBC on June 15.

Cost Containment Strategy Recommendations for FY 24-25

Recommended Strategies for Further Consideration and Workplan Development

- Medicaid accessed through EI Services Trust or EI Code
- Require all Providers to be In-Network with Private Insurance
- Analysis of the Bifurcation of the Referral and Intake System

Cost Containment Strategies Not Recommended in FY 2025-26

- Make Billing Child Health Plan Plus (CHP+) Easier
- Discontinue Speech Language Pathologist (SLP) Stipend
- Review Eligibility Tools
- Consider all In-Person Evaluations
- Review the Use of Informed Opinion of Delay (IOD) in Determining Eligibility

Additional Strategies to Review for FY 2026-27

In December 2025, after eight additional input sessions, CDEC will submit a second response to the RFI which will analyze another set of potential cost-containment strategies for FY 2026-27.

- Eligibility Determinations Criteria (Established Conditions)
- Redetermine Eligibility at Annual IFSP Review
- TEAM EI Colorado Overview of Primary Service Provider Model
- Consider a Consistent Salary of $65,000-$75,000 Per Year for all Providers and have them as employees of EI Brokers or EI Colorado/CDEC
- Implement a Tiered Service Model
- For Children Diagnosed with Autism who are enrolled in Medicaid, refer to an ABA Provider or a Similar Service
- For Social and Emotional Services, Work with Families (as appropriate) in Groups, such as Circle of Security
- Revise EI Rules to change the definition of Timely Service Initiation from 28 days to 35 or 40 Days
- Reduce the Length of Time for Initial and Annual IFSP Meetings

EI Caseload Request for Information

The Department will submit annually, on or before September 1 and March 1, a report to the Joint Budget Committee concerning caseload growth for early intervention services. The Department shall annually present an update on the Early Intervention program to the Joint Budget Committee in June and December on the status of the program. The requested reports and presentations should at a minimum include the following information:

(a) the total number of early intervention services performed compared to the projected amount of early intervention services;
(b) the amount of funds expended in the fiscal year from July 1 through the time period when the report is created compared to the projected spending for the same time period; and
(c) the amount of any estimated gaps between the appropriation in the long bill and actual expenditures.

Analysis of EI Data

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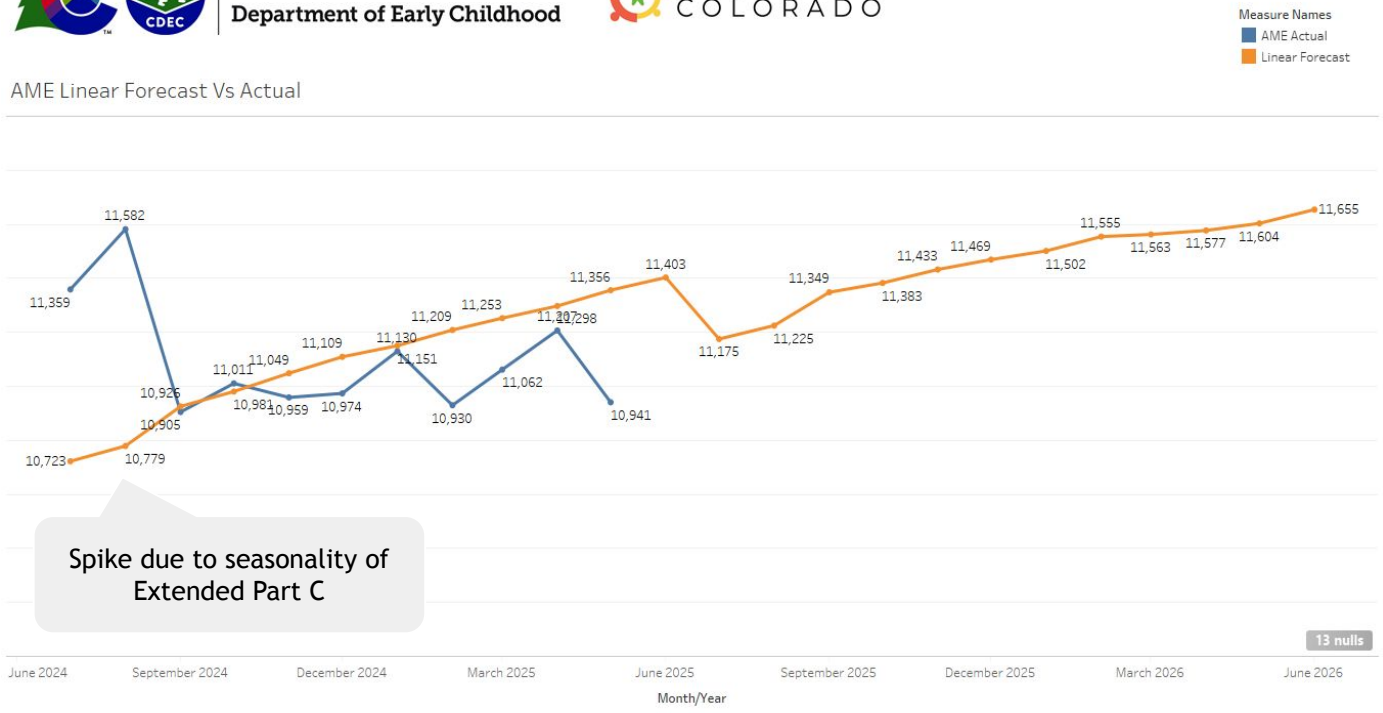

- A linear forecast is traditionally used as a first step in data projections. A quadratic or spline model could be used if the linear model does not work well. The linear model is working well at this time as demonstrated in this example slide
- May and June 2025 appear low for actual enrollment because these two months of data are not fully represented

Caseload by Enrollment Distribution

FY 24-25 Enrollment Distribution by Funding Stream	
Funding Stream	**Year To Date (7/1/24 - 3/31/25)**
Total Enrolled	17,620
Non-Medicaid/Early Intervention Services Trust	50.5%
Medicaid Enrolled	40.4%
Early Intervention Services Trust	9.1%

- Neither Medicaid nor the EI Services Trust (EIST) completely cover the full cost of service coordination or costs to administer the program.
  - Medicaid does not cover the full range of services provided through EI, specifically Development Intervention Services which is one of the most frequently provided services.
- A similar distribution could be assumed for FY 25-26

FY 2024-25 Budget

Early Intervention Budget	Original Budget	Mid-Year Adjustment	Final Budget
State Administration Costs (Personnel, Operating, IT)	$2,666,069	-$607,676	$2,058,393
Early Intervention Evaluation Contracts	$5,050,000	N/A	$5,050,000
Early Intervention Service Broker Contracts	$44,458,585	-$2,206,907	$42,251,678
Early Intervention Contracted Direct Services	$25,000,000	$4,814,583	$29,814,583
FY 2024-25 Budgeted Costs	**$77,174,654**	**$2,000,000**	**$79,174,654**

- The Department considered EI Evaluation Entity contract underspending of approximately $1.25M when calculating figures for the November 1 RFI
- The original budget amount reflects this anticipated reduction in spending and increase to the EI Contracted Direct Services line

FY 2024-25 Contracted Direct Services Spending

Projected Spending* 7/1/24 - 3/31/25	Actual Spending 7/1/24 - 3/31/25	Percent of Original Budget ($25,000,000)
$21,913,633	$20,624,487	82%

Projected Spending 7/1/24 - 3/31/25	Actual Spending 7/1/24 - 3/31/25	Percent of Updated Budget ($29,986,294)
$21,913,633	$20,624,487	69%

*Based on 7/1/24 - 12/31/25 invoicing (extracted 2/5/25) and using a linear projection through the end of the fiscal year

FY 2024-25 EI Broker Contract Spending

Projected Contract Spending* 7/1/24 - 3/31/25	Actual Contract Spending 7/1/24 - 3/31/25	Percent of Original Budget ($45,487,972)
$31,688,759	$30,386,669	67%

Projected Contract Spending 7/1/24 - 3/31/25	Actual Contract Spending 7/1/24 - 3/31/25	Percent of Updated Budget ($42,501,678)
$31,688,759	$30,386,669	71%

*Based on 7/1/24 - 12/31/25 invoicing (extracted 2/5/25) and using a linear projection through the end of the fiscal year

FY 2024-25 Direct Services and Broker Contracts

Early Intervention Contracted Direct Services	Projected	Expended
YTD (July - March) Expenditures	$21,913,633	$20,684,550
12-Month Estimates*	$28,525,437	

Early Intervention Service Broker Contracts	Projected	Expended
YTD (July - March) Expenditures	$31,688,759	$29,835,703
12-Month Estimates*	$41,439,592	

*Estimates have been adjusted from prior projections based on actual spending for July-March

FY 2025-26 Appropriation and Estimated Expenditures

Early Intervention Funding	Appropriation
Early Intervention Services - General Fund Appropriation	$74,986,834
IDEA Part C Grant - New Annual Award	$10,288,404
Early Intervention Services Trust (Administration)	$100,000
Appropriation HCPF Medicaid Match	$2,000,000
Total	**$87,375,238**
Estimated Expenditures	
State Administration Costs (Personnel, Operating, IT)	$2,752,281
Early Intervention Evaluation Contracts	$6,527,890
Early Intervention Service Broker Contracts	$74,009,582
Early Intervention Contracted Direct Services	$4,000,000
FY 2025-26 Estimated Costs	**$87,289,753**

Enrollment and Cost Projection Validation

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Analysis and Data Sources

The Department has the tools it needs to project enrollment and cost. **Root Mean Square Error (RMSE), a statistical measure that quantifies the difference between a model's predicted and actual values, testing shows the effectiveness of current projections.**

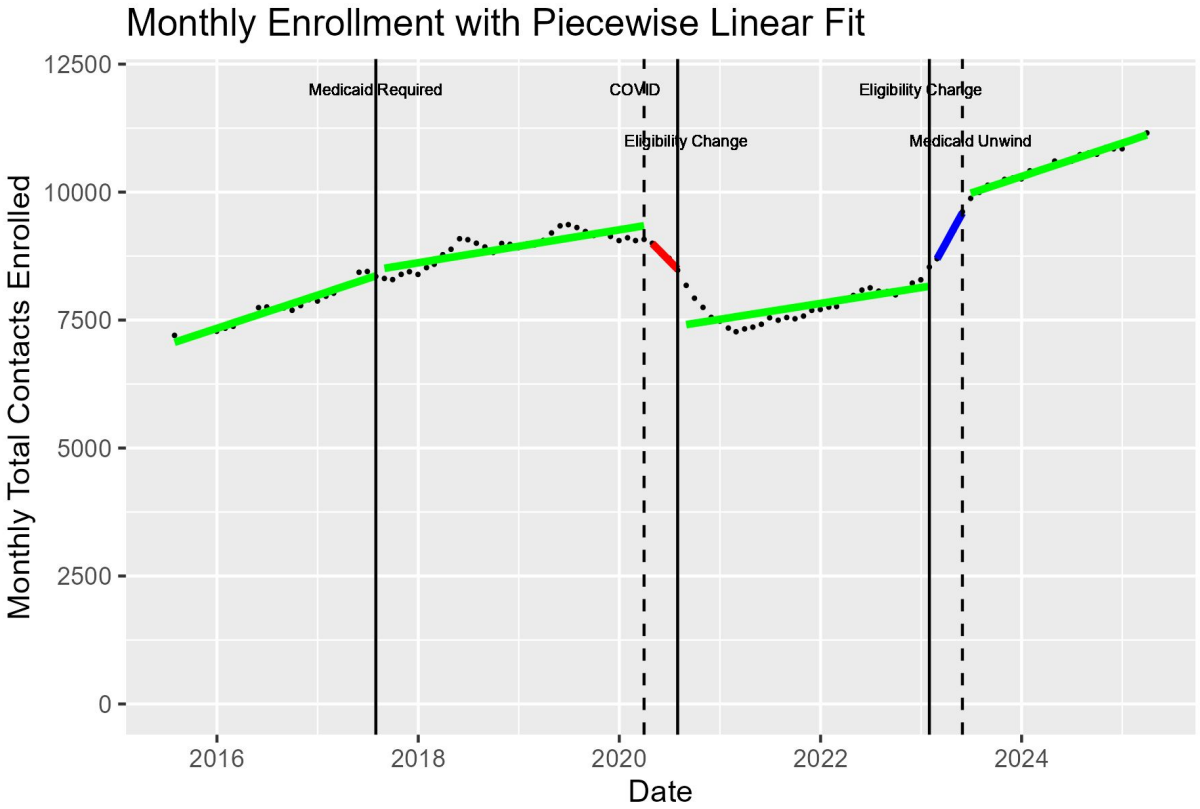
Data Sources:

- EI Salesforce Data System
- CDEC Contracts Data
- HCPF Medicaid InterChange system for enrollment and payment data

Future Expansion of Current Model

- While the Department is confident in the accuracy of the data being currently produced, we will work to continue fine-tune and explore other data elements to lead to a robust projection model

Piecewise Linear Model of Enrollment



- Modeled using the Department's Annual Cost Calculator (using SFY 2024, SFY 2025 Q1)
- Several "shocks" to the data exist which make it difficult to use data prior to 2023
  - Change in Medicaid requirement for providers
  - COVID/eligibility change
  - Second eligibility change
  - Medicaid "unwind"

Methodology for EI Data Projections

Methodology:

- Monthly projections are calculated using next-month fitted values from a simple linear regression (SLR) applied to completed months. SLR is calculated using a rolling twelve-month window of previous enrollment and/or cost.
- Annual totals are calculated using previous (completed) fiscal year totals and monthly year-over-year growth rates.
- Enrollment and cost per child are projected using a linear extension from previous year totals and same growth rates, and CDEC cost percentage is linearly extended using previous year raw changes.
- The annual cost calculator projects enrollment, then applies cost per child to obtain total cost, then applies CDEC cost percent to obtain CDEC costs.
- Monthly EI fund projections are used to split CDEC costs between contracts and invoicing.

Challenges in Analysis of EI Data

- EI Enrollment and services have been altered by a number of “shocks” during the last decade, which is why reliable projections can only be made from 2023 onward
  - 2020
    - COVID resulted in statistically significant decreases in enrollment after March 2020
    - Due to budget balancing needs, EI narrowed eligibility criteria in July 2020 which also caused decreases in eligibility and enrollment
  - 2023
    - The EI Program was instructed to broaden the eligibility in 2023 to serve more children. This resulted in a statistically significant increase in enrollment.
    - The Medicaid “unwind” of continuous eligibility began in May of 2023, resulting in a fewer children being enrolled and reimbursed in Medicaid coverage.
- Lag times in service invoicing
  - Approximately 90% of invoicing occurs within 90 days
  - Approximately 60% of Medicaid billing has a 6 month lag time
- Service plan elements documented on IFSPs in the data system are not effective for projections
  - Many services documented are either funded by something other than EI funds or Medicaid, or, not provided
  - IFSPs are not static and may be updated at any time. Updates must happen every 6 months,

EI Funding Hierarchy

In accordance with state law, CDEC uses a coordinated system of payment for EI services and follows a funding hierarchy in the order in which funding sources are accessed for service payment. Funding sources are considered beginning at the top and then moving downward until an appropriate source is located.

1. **Use of Private Pay (voluntary, at discretion of parent)**
2. **Private Health Insurance (with written consent of parent)**
3. **TRICARE, a Military Health System**
4. **Medicaid (Title XIX), Home and Community Based Services (HCBS) Medicaid Waivers, and Child Health Plan Plus (CHP+)**
5. **Child Welfare and Temporary Assistance to Needy Families (TANF)**
6. **Other local, state, or federal funds as may be available**
7. **State General Funds**
8. **Federal Part C of IDEA funds**

COLORADO
Department of Early Childhood

Joint Budget Committee
Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

June 16, 2025

The Honorable Jeff Bridges
Chair, Colorado General Assembly Joint Budget Committee

Dear Senator Bridges and Members of the Joint Budget Committee:

The Colorado Department of Early Childhood (CDEC) respectfully submits the attached report, responding to Request for Information #6:

> *Department of Early Childhood, Community and Family Support, Early Intervention - The Department, in collaboration with Early Intervention brokers and, to the extent possible, other Early Intervention service providers, is requested to submit, on or before June 15 and December 15, a report to the Joint Budget Committee concerning agreed-upon cost containment measures which may be enacted immediately in FY 2025-26 or in FY 2026-27 to ensure the financial sustainability of the Early Intervention program while maintaining strength of service delivery for children. The cost containment measures should target savings of no less than $1.0 million in FY 2025-26.*

If you have any questions, please contact Shannon Schell, Legislative Liaison for the Colorado Department of Early Childhood, at shannon.schell@state.co.us.

Sincerely,

Lisa R. Roy, Ed.D.

Dr. Lisa Roy
Executive Director
Colorado Department of Early Childhood

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Department of Early Childhood

Early Intervention Cost Containment Recommendations for FY 2025-26

Submitted to
The Joint Budget Committee

By
Colorado Department of Early Childhood

June 16, 2025

Contents

Program Overview

The Early Intervention (EI) Program, authorized under Sections 26.5-3-401 through 409, C.R.S., serves children from birth through age two with developmental delays or disabilities and their families. By effectively identifying developmental delays in infants and toddlers and proactively addressing them, the EI Program mitigates the impact that developmental delays may have on a child's growth and development.

The EI program provides services under Part C of the federal Individuals with Disabilities Education Act (IDEA). The developmental areas that EI services target are adaptive skills, cognitive skills, communication skills, motor skills, and social and emotional skills. Several types of services are offered within EI, with the most commonly used being speech therapy, occupational therapy, physical therapy, and behavioral/developmental interventions, such as those targeting social and emotional skills. These services are provided to support outcomes that are critical to a child's success in school and in life.

EI services are delivered by EI service providers who work directly with children and families, as well as the 20 local EI Service Brokers contracted by the Department to coordinate and deliver services.

Cost Avoidance Strategies and Recommendations Overview

The EI Program is dedicated to supporting Colorado's infants and toddlers with developmental delays and disabilities. Amidst an increased need for services, a constrained state budget, and the sunsetting of federal stimulus funding, the Department is committed to sustaining EI services. Since February, the Department has initiated broad stakeholder engagement, financial analysis, and enrollment modeling to better predict future needs and to help ensure the sustainability of the program.

In Spring 2025, CDEC identified the need to contain costs for the EI program to ensure a balanced budget. On March 19, 2025, the Joint Budget Committee (JBC) recommended funding for the 2025-2026 fiscal year (FY), which allowed services to continue, unchanged, through July 1, 2025, and avoided the immediate need for cost-saving measures.

In order to help sustain the program, the JBC requested CDEC to identify cost containment of no less than $1.0 million in FY 2025-26. From March 12, 2025 through May 5, 2025, the Department held 18 input sessions with early intervention providers, parents, and partners to discuss the measures to reduce EI program costs. Input sessions were well attended and included 200 participants on average. In addition to feedback received during the input sessions, CDEC surveyed providers and families regarding each strategy; 167 people responded to the Cost Containment Surveys, which are available here.

The Department and its partners evaluated each strategy through the following criteria regarding impact, cost, and implementation feasibility:

- Impact on children and families
- Impact on providers
- Cost savings
- Requires change to Early Intervention rules, statutory change, or data system
- Requires Office of Special Education Programs (OSEP) approval
- Requires collaboration with another state department

The Department utilized these criteria to identify strategies that would yield sufficient cost avoidance while minimizing impact on direct services for families. **Based on the analysis, CDEC recommends implementing four cost-containment strategies in FY 2025-26.** The list of evaluated strategies, along with the Department's implementation recommendations, is listed below. Detailed explanations and analyses of each strategy are later in the report.

- **Cost Containment Strategies to Implement in FY 2025-26:**
  - CDEC EI Program Administrative Reductions
  - Discontinue Subcontracted Provider No-Show Payment
  - Discontinue Mileage and Travel Reimbursement for Subcontracted Providers
  - Discontinue EI Provider Training Stipend
- **Recommended Strategies for Further Consideration and Workplan Development**
  - Medicaid Accessed through EI Services Trust or EI Code
  - Require all Providers to be In-Network with Private Insurance
  - Analysis of the Bifurcation of the Referral and Intake System
- **Cost Containment Strategies to <u>Not</u> Implement in FY 2025-26**
  - Discontinue Speech Language Pathologist (SLP) Stipend
  - Make Billing Child Health Plan Plus (CHP+) Easier
  - Review Eligibility Tools
  - Consider all In-Person Evaluations
  - Review the Use of Informed Opinion of Delay (IOD) in Determining Eligibility

The potential cost avoidance of the four recommended strategies depends on when the Department begins implementing each strategy. If all strategies were implemented beginning July 1, 2025, the total potential cost avoidance is $1,607,652. However, it is unlikely the Department could implement all four strategies immediately. The program could implement Administrative Reductions on July 1; meanwhile, the remaining three strategies would be implemented beginning January 1, 2026, ensuring adequate time to communicate changes to community partners and families.

With this implementation timeline, the potential cost avoidance for FY 2025-26 would be $953,826. For FY 2026-27 and ongoing, the Department would continue implementing all strategies, except for the administrative reductions, as this strategy would not be sustainable long-term. The cost avoidance for FY

2026-27 and onward would be $1.3 million. Table 1 outlines the potential cost avoidance associated with each strategy.

Table 1: Cost Containment Strategy Recommendations and Potential Cost Avoidance

Cost Containment Strategy	**Implementation Date**	**FY 2025-26 Cost Avoidance**	**FY 2026-27 and Ongoing Cost Avoidance**
Administrative Reductions	July 1, 2025	$300,000	$0
Discontinue Subcontracted Provider No-Show Payment	January 1, 2026	$261,186	$522,372
Discontinue Mileage and Travel Reimbursement for Subcontracted Providers	January 1, 2026	$359,586	$719,172
Discontinue EI Provider Training Stipend	January 1, 2026	$33,054	$66,108
		Total FY 2025-26 Cost Avoidance: $953,826	**Total FY 2026-27 and Ongoing Cost Avoidance:** $1,307,652

Analysis of Recommended Cost Containment Strategies

The Department's analysis of each recommended cost containment strategy for FY 2025-26 is outlined below.

1. CDEC Administrative Reductions

Currently, administrative costs for the EI program are 2.7% of the total available appropriation. CDEC proposes reducing program administration costs by approximately 13.7%, totaling $300,000 for FY 2025-26 only. This reduction would be achieved through three measures:

(1) Vacancy Savings: CDEC would keep the current Data Specialist position vacant, resulting in FY 2025-26 vacancy savings of $90,000 (including fringe benefits). Additionally, the Department would consider the implications of not replacing any future vacancies that may occur during the fiscal year. Keeping this position vacant may cause delays with provider-facing resources, such as updating the User Guide and resolving data system bugs, due to limited staff capacity. However, there are no other impacts on providers and families.

(2) **Reducing the Data System Enhancement Budget:** The Department proposes reducing this budget by $200,000. A reduction of the budget may result in the Department being unable to prioritize updates to the data system and requests by end users. This could impact the provider and family experience, as the Department may not be able to address system bugs that impact referral and intake data, the ability for Care Navigators to schedule evaluations or provide information to evaluators, or other potential issues that arise during the year.

(3) Freeze Travel for EI Staff: Freezing travel for EI staff would yield a potential cost avoidance of $10,000. This measure would have no direct impact on families, while for providers, there would be no opportunity to interact with EI staff in person. Meanwhile, EI staff would not be able to attend conferences, professional development, or meetings with the Office of Special Education Programs (OSEP). The Department will need permission from OSEP to not attend these meetings.

2. Discontinue Subcontracted Provider No-Show Payment

Currently, providers are compensated when families cancel within 24 hours or do not show up to a scheduled appointment. This policy went into effect less than two years ago, though it is not federally required by IDEA. Prior to the implementation of this statewide policy, no-show payment policies were inconsistent across EI Service Brokers.

CDEC recommends this strategy be implemented beginning January 1, 2026, as discontinuing no-show payments would yield significant cost avoidance, while having the least impact on providers and families out of all the strategies. Partner feedback indicates that the no-show policy could be revised in the future to be more sustainable and to mitigate the negative impact on providers.

Cost Avoidance: Projected cost avoidance of **$261,186** in FY 2025-26 and **$522,372** in FY 2026-27 and ongoing.

- Linear forecasted average projections for no-show payments show that the projected monthly average is $43,531 per month. This results in a total projected cost in FY 2025-26 of $522,372.

Impact on Children and Family:

- Families with medically fragile children may be unfairly impacted if providers refuse services due to frequent no-shows from these families, who often have regular medical appointments and illnesses.
- There may be a disproportionate impact on families who live in rural and mountain communities. If a provider travels a long distance and the family does not show up, the provider may be less likely to continue providing services.
- In both cases, the family has a legal right to the services noted on the Individualized Family Service Plan (IFSP), and CDEC would work with EI Brokers to find a provider to offer services.

Impact on EI Provider:

- Providers would not be paid when a family does not show up for an appointment, so this measure would impact their income.
- This loss of income may result in a decline in morale and may cause a provider to leave the profession.
- Additional provider input on no-show payments

Implementation Considerations:

- Discontinuing no-show payments would reduce the administrative workload for EI Service Brokers and the Department.

- Minor updates to billing categories in the EI Data System would be required to implement this strategy.

3. Discontinue Mileage and Travel Reimbursement for All Subcontracted Providers

Currently, each EI Service Broker establishes an independent mileage and travel policy, resulting in inequities in how subcontracted providers are reimbursed for these expenses across the state. Eliminating mileage and travel reimbursements statewide would yield significant cost avoidance while having minimal impact on providers and families. Currently, only 15% of providers bill for mileage and travel. Other providers choose not to bill these expenses, or they utilize the federal mileage tax deduction annually.

About half of the providers who gave feedback were in favor of eliminating this policy, while the other half supported implementing a uniform statewide mileage and travel reimbursement policy. However, implementing a uniform reimbursement policy is cost-prohibitive at this time. Therefore, the Department recommends discontinuing the policy beginning January 1, 2026, which will yield cost avoidance and create consistency and equity across the state. Feedback indicates that a future policy could be tailored to support rural and mountain communities, which will likely be impacted the most by the discontinuation of this policy.

Cost Avoidance: Projected cost avoidance of **$359,586** in FY 2025-26 and **$719,172** in FY 2026-27 and ongoing.

- Linear forecasted average projections of mileage and travel reimbursements show that the projected monthly average is $59,931 per month. This results in a total projected cost in FY 2025-26 of $719,172.

Impact on Families:

- There may be a potential loss of service providers or a reduction in in-person services, especially in rural and mountain communities, which could impact service options for families. However, the family has a legal right to the services noted on the Individualized Family Service Plan (IFSP), and CDEC would work with EI Brokers to find a provider to offer services.

Impact on Providers:

- Potential impacts would be contained to the 15% of providers who currently bill for mileage and travel. These impacts include a loss of income that could result in a decline in morale and could cause a provider to leave the profession.
- Additional provider input on discontinuing travel and mileage reimbursement

Implementation Considerations:

- In order to implement this strategy, minor updates to billing categories in the EI Data System would be required.

4. Discontinue EI Provider Training Stipend

Currently, new subcontracted providers are paid $250 upon completion of the required 15-hour training and another $250 upon completion of a retention survey sent out six months after the training. Eliminating this stipend would yield cost avoidance while having no direct impact on families and minimal impact on providers.

Cost Avoidance: Projected cost avoidance of **$33,054** in FY 2025-26 and **$66,108** in FY 2026-27 and ongoing.

- Linear forecasted average projections of the training stipend show that the projected monthly average is $5,509 per month. This results in a total projected cost in FY 2025-26 of $66,108.

Impact on Families: No identified direct impact.

Impact on Providers:

- Feedback indicates that the elimination of this stipend would have the least impact on the recruitment and retention of providers, as the financial impact would be minimal for new providers and there would be no impact on existing providers.
- Subcontracted providers indicated that they appreciated reimbursement for training and felt their time was valued. Therefore, eliminating the stipend could lower morale among new providers.
- Additional input from providers on discontinuing the training stipend

Implementation Considerations:

- Minor updates to billing categories in the EI Data System would be required to implement this strategy.
- Discontinuing the retention survey could result in the loss of retention data, which could impact the effectiveness of future recruitment and retention efforts.

Recommended Strategies for Further Consideration and Workplan Development

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The Department recommends continuing to explore the following three strategies to better understand potential cost avoidance and future implementation feasibility. However, the Department does not recommend these strategies for implementation in the upcoming fiscal year.

1. Medicaid Accessed through the EI Services Trust or an EI Code

Currently, Colorado-based private insurance is required to pay into the EI Services Trust (EIST) for all children with qualifying plans for EI direct services. The EIST covers all Individual Family Service Plan (IFSP) services, with the exception of Assistive Technology and Assistive Technology Devices, as well as administrative fees, including the service coordination fee, broker fee, and accounting administration fee.

CDEC and the Department of Health Care Policy and Financing (HCPF) are currently collaborating to determine the feasibility of Medicaid paying for EI services via the EIST. This would allow Medicaid to cover more EI services for all Medicaid-enrolled children. While implementing this strategy in FY 2025-26 is not currently feasible, CDEC is committed to ongoing collaboration with HCPF to continue exploring this strategy.

Cost Avoidance: Unknown anticipated costs and savings. There is a potential that this strategy would preserve EI funding if more providers billed Medicaid. However, additional staff would be needed at the state level to implement this funding structure. See data projections for this strategy here.

Impact on Families: This may improve the timeliness of service delivery.

Impact on Providers:

- This strategy would allow Medicaid to cover more EI services than is currently allowed.
- Billing would be made easier for providers, meaning that more providers could potentially accept children enrolled in Medicaid.
- There are many unknowns regarding billing, rates, and funding with this strategy, creating uncertainty for providers.
- Additional provider input on Medicaid paying into the EIST or using an EI code

Implementation Considerations: The departments will need approval from the Centers for Medicare and Medicaid Services (CMS) to implement this strategy.

2. Require All Providers to be In-Network with Private Insurance

EI follows a funding hierarchy that is arranged in the order in which funding sources are accessed for service payment. Beginning from the top of the hierarchy and moving downward, if a funding source is not available, then the next source down on the list is considered until an appropriate funding source is located. Private Health Insurance is second in the hierarchy, preceded only by voluntary private pay. By requiring all providers to become “in-network” with individual insurance companies, providers must bill insurance first, thereby making EI the payor of last resort.

Partner feedback was overwhelmingly against the implementation of this strategy, with many examples of why this would not be of true benefit for program sustainability, as not all EI services would be billable to private insurance. Additionally, feasibility is limited, as it can be extremely difficult for sole independent contractors to become “in-network” with insurance companies. Therefore, CDEC does not recommend implementation at this time. However, the Department will continue to explore how to identify the most utilized insurance companies, as well as how CDEC could support providers to become “in-network.”

Cost Avoidance:

- The administrative burden of credentialing and billing in-network private insurance would likely outweigh any financial benefit of implementing this strategy.
- It is unknown how much money this strategy would bring in for payment for services, especially as many EI services are not medical and would not be billable to private insurance.

Private insurance outside of the EIST may cover occupational therapy, physical therapy, and speech therapy; however, it most likely won't cover services provided in the home. Approximately 66% of EI services could be considered medically allowable. Although these services are considered medical for private insurance, EI has specific definitions that align with key principles that are parent education-based.

Impact on Families:

- Families may be confused regarding co-payments and deductibles
- There would be the potential to "max out" benefit coverage

Impact on Providers:

- This strategy would create a significant administrative burden for providers and EI Brokers.
- The process for independent contractors and organizations can be problematic and prolonged, taking up to a year.
- Additional input from providers on requiring providers to be in-network

Implementation Considerations:

- Implementation would be very challenging due to organizing many plans, companies, and co-payments. Regarding co-payments, these must be covered by EI funds, as federal law clearly states that services must be provided to families at no cost and that "fees will not be charged for the services that a child is otherwise entitled to receive at no cost" (35 CR 303-303).
- Private insurance plans outside of the EIST are not overseen by the Colorado Division of Insurance (DOI). Currently, only one large insurance provider outside of the EIST covers EI services, and this is made possible by an agreement at the federal level.
- Many private insurances impose a limit on the number of services they will cover, and this is not influenced by an IFSP.
- CDEC does not have data on private insurance reimbursement rates outside of the EIST. Neither CDEC nor Medicaid supplement provider rates.

3. Analysis of the Bifurcation of the Referral and Intake System

Currently, the EI program's referral and Intake system is bifurcated. Five EI Brokers complete their own referrals while EI Care Navigators, who are employed by the Department, complete referrals for the additional portions of the state. There are three potential scenarios for how to structure the system in the future:

(1) Maintain the system as it is currently structured
(2) Make EI Brokers fully responsible for referral and intake activities
(3) Make the EI Care Navigation team fully responsible for referral and intake activities, thus creating a fully centralized state system

The Department does not recommend making changes to the system as this creates unnecessary confusion for families, providers, and referral sources amidst a period of high-volume change, particularly since the

system was partially centralized in 2022. CDEC will collect additional data and undertake a process to engage with EI Brokers to further refine current practices and strategies for long-term planning prior to making any significant changes to the system.

Cost Avoidance:

- If the Department were to maintain the current system, costs would remain consistent.
  - EI Colorado: $1.2 million, including 13 staff members to complete 60% of referrals
  - EI Brokers: $1.01 million, including 12.1 staff members to complete 40% of referrals
- Moving responsibility to EI Brokers would be cost-prohibitive, as significant contract and system changes would be required
- Moving referrals to the EI Care Navigators would potentially yield cost savings, as care navigators currently complete more referrals with lower costs. Further analysis is needed to project the full cost implications of this strategy.
- See data and cost analysis of the referral and intake system

Impact on Families:

- Maintaining Current System: Status quo during a time of high-volume change.
- Moving Referral and Intake to EI Brokers: Families would be working with their local program beginning at intake. However, processes, information, and messaging would vary across the state.
- Centralizing Referral and Intake with Care Navigators: Families would receive constant messaging, may experience shorter timelines for intake and evaluation, and have their language needs better met.

Impact on Providers:

- Maintaining Current System: Maintaining the status quo during a time of high-volume change. The Department could make additional process refinements to improve quality and alignment without changing the current structure.
- Moving Referral and Intake to EI Brokers would require changes at EI Brokers, including training, hiring additional staff, and establishing new lines of communication
- Centralizing Referral and Intake with Care Navigators has the potential to create a clear division of referral, intake, and evaluation activities and increase efficiencies. At the same time, there may be a potential to disrupt existing relationships between referral sources, EI Brokers, and programs serving families.
- Additional provider input on the referral and intake system

Implementation Considerations:

- Moderate system updates would be required to change the referral and intake system.

Analysis of Cost Containment Strategies Not Recommended for Implementation in FY 2025-26

The Department does not recommend implementing the following eight strategies in FY 2025-26.

1. Discontinue Speech-Language Pathologist (SLP) Stipend

Currently, SLPs who work with Medicaid-enrolled children and who monitor their IFSP outcomes receive a $30 stipend. The stipend exists because Medicaid rates for occupational and physical therapy include compensation for IFSP monitoring, while the SLP rate does not. The average SLP rate is $72.01/hour. Meanwhile, the average rate for subcontracted providers is $105/hour, and the Medicaid rate for occupational/physical therapy is, on average, $102.92 - $139.88. Neither CDEC nor Medicaid supplement SLP rates, so the stipend exists to create greater compensation parity between providers. Elimination of the SLP stipend has the potential to have a significant impact on families on Medicaid, have a substantial impact on the recruitment of SLPs, and create inequity in services.

Cost Avoidance:

- If the strategy was implemented July 1, 2025, there is a projected cost avoidance of $345,168 in FY 25-26.
- If the strategy was implemented January 1, 2026, there is a projected cost avoidance of $143,820 in FY 26-27.
- Linear forecasted average projections of the SLP stipend show that the projected monthly average is $28,764 per month. This results in a total projected cost in FY 2025-26 of $345,168.

Impact on Families:

- This strategy may lead to fewer SLPs willing to provide services for children enrolled in Medicaid.
- This strategy may cause delays in service initiation, disparities in services, and less provider availability. This could be particularly problematic, as there is a high demand for SLPs since children with language and communication delays are the largest group served by EI.

Impact on Providers:

- Elimination of the stipend could result in a loss of earning potential for SLPs
- There may be a potential impact on recruitment/retention, impact, and provider availability
- Additional provider input on eliminating the $30 SLP stipend

Implementation Considerations:

- This strategy would require minor updates to the billing categories in the EI data system.

2. Make Billing CHP+ Easier

Currently, three of the four CHP+ Managed Care Organizations (MCOs) pay into the EIST, so the billing is centralized. Moving the fourth MCO to the EI Services Trust would add a revenue stream for EI services.

While stakeholders overwhelmingly requested that CDEC work towards creating an easier billing process, there would be a minimal impact on cost savings from moving CHP+ Colorado Access, the only MCO currently not in the EIST. Additionally, concerns were raised related to the lower reimbursement rates, as not all EI Services are covered by CHP+.

Cost Avoidance: Minimal impact on EI costs.

Impact on Families:

- Only 3.5% of all children enrolled in EI, or approximately 300 children, had CHP+ coverage, meaning that a small percentage of EI cases would have easier billing
- Only medical services are covered by CHP+, which would exclude several EI services

Implementation Considerations:

- CHP+ is administered through HCPF, so CDEC's influence on billing would be minimal

3. Review Eligibility Tools

In 2021, a 30-person workgroup chose two eligibility assessment tools: the Infant-Toddler Developmental Assessment (IDA-2) and the Developmental Assessment of Young Children (DAYC-2). Although DAYC-2 and IDA-2 have flaws, they are simple tools and were chosen as the best options to meet a variety of evaluation methods.

Some stakeholder feedback suggested that DAYC-2 over-qualifies children in the areas of fine motor and adaptive development, **but data analysis does not back this up.** Eligibility rates remain consistent across the DAYC-2 and IDA-2, with an eligibility rate of 82-83%. This is in alignment with eligibility rates over the past six years, with the exception of variables due to the pandemic.

The current evaluation tools allow for consistency in eligibility determination statewide and flexibility for conducting evaluations in person or virtually. The Department can provide additional technical assistance and training to ensure that children are not overqualified in certain areas of development.

Cost Avoidance:

- Reviewing and changing tools would involve costs, though exact amounts are unknown. However, purchasing additional tool protocols would likely be cost-prohibitive at this time.
    - The costs associated with the DAYC-2 and the IDA-2 can be seen here.

Impact on Families:

- If multiple tools were allowed to be used, there could be inconsistency in eligibility assessments across the state.

Impact on Providers:

- Reviewing evaluation tools would require a time commitment from the field, and changing tools would pose a learning curve and require training.
- At the same time, changing tools would enable additional choices for evaluators.

- Additional provider input on reviewing eligibility tools

Implementation Considerations:

- Changing eligibility tools would require significant changes to the EI data system, as well as updates to evaluation procedures and statewide training

4. Consider All In-Person Evaluations

Currently, providers have the option of conducting evaluations in person at a central location or the child's home, virtually with the child and family at home, or hybrid with one evaluator in person and the other virtually. In FY 2023-24, 51% of evaluations were conducted virtually with the child and family in their home. The remaining 49% were conducted in person. In reviewing the completion of virtual evaluations, data demonstrate that similar rates of eligibility determination occur regardless of evaluations occurring virtually or in-person. See data on eligibility evaluations here.

Requiring all evaluations to be conducted in person would increase travel costs and potentially increase the wait time for children to have an evaluation. This strategy could impact the program's ability to meet the federally required 45-day timeline to complete the IFSP.

Cost Avoidance: This strategy would not yield any cost avoidance, as evaluations are billed at a flat rate of $525.30, regardless of where they are conducted.

Impact on Families:

- Requiring all in-person evaluations may increase wait times for evaluations
- This policy may have a larger impact on rural communities, as some counties only have virtual access at this time.
- Virtual evaluations are conducted in the child's home environment, while some in-person evaluations can be conducted at a central location. This requires travel for families and results in the evaluation being conducted outside of the child's natural environment.

Impact on Providers:

- Costs for time and travel would increase, either to the EI program or evaluation entities and contracted providers.
- This strategy would decrease the number of visits providers are able to complete in a day or week.
- Additional input from providers on requiring in-person evaluations

Implementation Considerations:

- This strategy would require amendments to Request for Proposals (RFPs), Statement of Work (SOW), and contracts for evaluation agencies. This may impact the ability of current contractors to reapply.

5. Review the Use of Informed Opinion of Delay (IOD) in Determining Eligibility

The Informed Opinion of Delay (IOD) is required under federal IDEA requirements and must be part of the evaluation. Therefore, it cannot be eliminated. Currently, IFSP meetings include discussions on the use of the IOD. While there have been suggestions that the IOD may lead to overidentification of children determined eligible for EI, data did not support that the IOD is being overused. In FY 2023-24, approximately 45 children a month were determined eligible based on the IOD. The Department has developed and provided technical assistance to evaluation entities to ensure proper use and understanding of when the IOD can be used. See data on the use of the IOD here.

Cost Avoidance: No cost avoidance, as using the IOD does not impact the costs of conducting an evaluation.

Provider Input:

- Provider input on IOD usage

Conclusion and Future Strategy Evaluations

Implementing the four cost-containment strategies recommended above is projected to result in a cost avoidance of $953,826 in FY 2025-26 and $1,607,652 in FY 2026-27 and ongoing.

In December, CDEC will submit a second response to the RFI analyzing another set of potential cost-containment strategies for FY 2026-27, listed below. The Department has nine input sessions with families and providers scheduled beginning in July to discuss the impact, feasibility, and cost of these strategies.

- Eligibility Determinations Criteria (Established Conditions)
- Redetermine Eligibility at Annual IFSP Review
- TEAM EI Colorado Overview of Primary Service Provider Model
- Consider a Consistent Salary of $65,000-$75,000 Per Year for all Providers and have them as employees of EI Brokers or EI Colorado/CDEC
- Implement a Tiered Service Model
- For Children Diagnosed with Autism who are enrolled in Medicaid, refer to an ABA Provider or a Similar Service
- For Social and Emotional Services, Work with Families (as appropriate) in Groups, such as Circle of Security
- Revise EI Rules to change the definition of Timely Service Initiation from 28 days to 35 or 40 Days
- Reduce the Length of Time for Initial and Annual IFSP Meetings