CDEC Early Intervention Caseload

Joint Budget Committee Presentation
December 12, 2025

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Department of Early Childhood

Evaluating Service Delivery Processes with Partners

CDEC has shifted its focus toward evaluating program policies and practices, **with the commitment of ensuring efficient and high quality service delivery.**

Since June, we've prioritized processes that ***increase collaboration and integrate our partners' feedback***.

- Enhanced communication strategies to increase transparency with EI Brokers, providers, and families
- Conducted four community workgroups to evaluate eight potential service delivery practices
    - Solicited applications for workgroup members. CDEC and the Colorado Interagency Coordinating Council (CICC) selected 80 members representing various stakeholder roles, geographic location, and professional disciplines.
    - CICC members facilitated the meetings.
    - Meetings were open to the public. Approximately 60 people attended each workgroup.
    - The evaluated strategies were suggested by the JBC and community partners.
- Conducted a survey for additional public input. **84 partners responded, providing 413 unique comments on the potential strategies.**

Service Delivery Enhancements

- Broker Contract Adjustments in FY 2025-26
  - Incorporated the separate direct services budget into contracts **to improve budget tracking**.
    - Previously, subcontracted direct services were billed out of a separate direct services budget (the General Accounting Encumbrance (GAE)).
  - More flexibility to move funds from underspent budget lines into other lines, **giving Brokers more control over budget planning.**
- Caseload Projection Model Improvements
  - Added variables to enhance predictability of how many children will enter and how long they will remain in the program.
  - Includes improved Medicaid data and enrollment trends of Extended Part C
- Exploring Billing Private Insurance
  - Creating an administrative guide with best practices to be distributed early next year
- Exploring Accessing Medicaid through the EI Services Trust or an EI Code

June Recommendations for FY 2025-26

Previously, CDEC had recommended implementing four strategies in response to the JBC request to target $1 million in cost savings:

1. Discontinue Subcontracted Provider No-Show Payment
2. Discontinue Mileage and Travel Reimbursement for All Subcontracted Providers
3. Discontinue EI Provider Training Stipend
4. CDEC One-time Administrative Reductions **(Implemented)**

Based on input from providers and the Joint Budget Committee, it was clear that the other three strategies would have a negative impact on subcontracted providers. Therefore, CDEC worked to examine alternative methods to ensure program sustainability.

Program Sustainability Recommendation for FY 2026-27

Require Annual Redetermination of Eligibility Starting in FY 2026-27

- Providers will re-evaluate children in all five areas of development at the Annual Individualized Family Service Plan (IFSP) review. The eligibility criteria will remain the same as the initial evaluation.
- Children with an “established condition” (a mental or physical condition that has a high probability of resulting in a developmental delay) will remain eligible without re-evaluation.

This strategy will ensure resources are being distributed to eligible children, based on up-to-date evaluations.

Projected cost savings: $1,078,044 annually starting in FY 2026-27 and ongoing, if implemented beginning July 1, 2026.

Budget Balancing Strategy Recommendation

CDEC conducted an extensive budget analysis to identify a sustainability approach that would limit impact on providers and families. ***CDEC projects it will underspend by $7.3 million in FY 2025-26,*** due to the State's investment from the previous year, historical underspending trends, and the federal carryforward.

Due to the certainty of the $3 million in federal carryforward, there is no longer a need to implement additional cost containment measures this fiscal year.

Therefore, CDEC rescinds its recommendations to implement strategies #1-3 which were included in the original Early Intervention Cost Containment and Financial Sustainability Report (submitted in June 2025):

1. Discontinue Subcontracted Provider No-Show Payment
2. Discontinue Mileage and Travel Reimbursement for All Subcontracted Providers
3. Discontinue EI Provider Training Stipend

Average Monthly Enrollment Actuals vs Projections, FY 2025-26 Q1

Improvements in Caseload Projections: An average 1.9% difference between projections and actuals shows that our projection model is very precise.

Month/Year	Projected Average Monthly Enrolled	Actual Average Monthly Enrolled	Percent Difference
July 2025	11,840	11,903	0.53%
Aug. 2025	12,333	11,870	3.75%
Sep. 2025	11,529	11,249	2.43%
1st Quarter	**11,900**	**11,674**	**1.9%**

CDEC has made improvements to its caseload projection model by adding variables that increase nuance.

Average Monthly Enrollment Projections for FY 2025-26

Month/Year	Projected Average Monthly Enrolled
July 2025	11,840
Aug. 2025	12,333
Sep. 2025	11,529
Oct. 2025	11,713
Nov. 2025	11,729
Dec. 2025	11,751
Jan. 2026	11,848
Feb. 2026	11,898
Mar. 2026	11,986
Apr. 2026	12,288
May 2026	12,385
June 2026	12,622
Average	**11,994**

Caseload projections increase between April to June because children who turn 3 in late spring or summer continue to receive services until the beginning of the school year, when they transition to Part B.

FY 2025-26 Q1 Billed Service Utilization

Caseload shows the number of children enrolled. ***Service Units* shows how much support they receive.**

- Services are provided in 15-minute "units." The average range of services per month is 1-16 units (15 minutes - 4 hours).
    - Ex: One child could receive 30 minutes of support per month from a speech language pathologist. Another child could receive 4 hours of support from an occupational therapist, a behavioral intervention specialist, and a physical therapist.

In the first quarter, 66,288 hours of service were were delivered and billed to more than 8,877 unique children. This number will likely increase as providers continue to submit billings. Billings have a typical delay of 30 to 90 days

Projected Service Utilization FY 25-26		Billed Service Utilization for First Quarter (7/1/25 - 9/30/25)	Percent of Projected Services
Units	1,164,043 units	265,150 units	22.78%
Hours	291,011 hours	66,288 hours	22.78%

FY 2025-26 Appropriations & Projected Expenditures

CDEC Early Intervention Funding Source	Appropriation Amount
Early Intervention Services - General Fund Appropriation	$76,986,834
IDEA Part C Grant- Federal Fund Appropriation*	$10,116,655
*FY 2024-25 Federal Rollforward**	*$3,042,227*
EIST Interest for Administration	$100,000
FY 2025-26 Funding	$90,245,716

*Total Federal Funds $13,158,882

FY 2025-26 Projected Expenditures**	Amount
FY 2025-26 Appropriation	$90,245,716
FY 2025-26 Allocation	*$86,828,096*
Estimated Expenditures	$82,903,489
Final Estimated Balance	$7,342,227

**$86.8 million was allocated prior to the final rollforward amounts, based on spending trends in prior years and the rollfoward

FY 2025-26 Q1 Actual Vs. Projected Expenditures compared to FY 2024-25

CDEC Early Intervention Cost Categories	FY 2025-26 Allocation	Projected Expenditures (July - September)*	Actual Expenditures (July - September)
State Administration Costs (Personnel, Operating, IT)	$2,873,680	$718,420	$509,637
Early Intervention Evaluation Contracts	$6,527,890	$1,631,973	$1,746,937
Early Intervention Service Broker Contracts & Direct Services	$77,426,526	$19,356,632	$14,549,597
Totals	$86,828,096	$21,707,024	$16,806,171

*Based on total allocation costs per month for 3 months

CDEC Early Intervention Cost Categories	FY 2024-25 Allocation	Actual Expenditures (July - September)
State Administration Costs (Personnel, Operating, IT)	$2,058,393	$291,743
Early Intervention Evaluation Contracts	$5,050,000	$1,301,320
Early Intervention Service Broker Contracts & Direct Services	$72,066,261	$10,997,368
Totals	$79,174,654	$12,590,430

Appendix

Joint Budget Committee Presentation
December 2025

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Early Intervention Caseload & R-02 Request

The request includes a $2.1 million increase in funds to address ongoing caseload increases in the Early Intervention Program and ensure adequate fund to serve the growing caseload.

The Department anticipates a 5.6 percent increase in average monthly enrollment from FY 2025-26 to FY 2026-27 as well as a budget surplus due to historical underspending in administration, direct services and evaluations, and additional funds available from the federal carryforward from FY 2024-25.

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

- 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

Enrollment Count Trends

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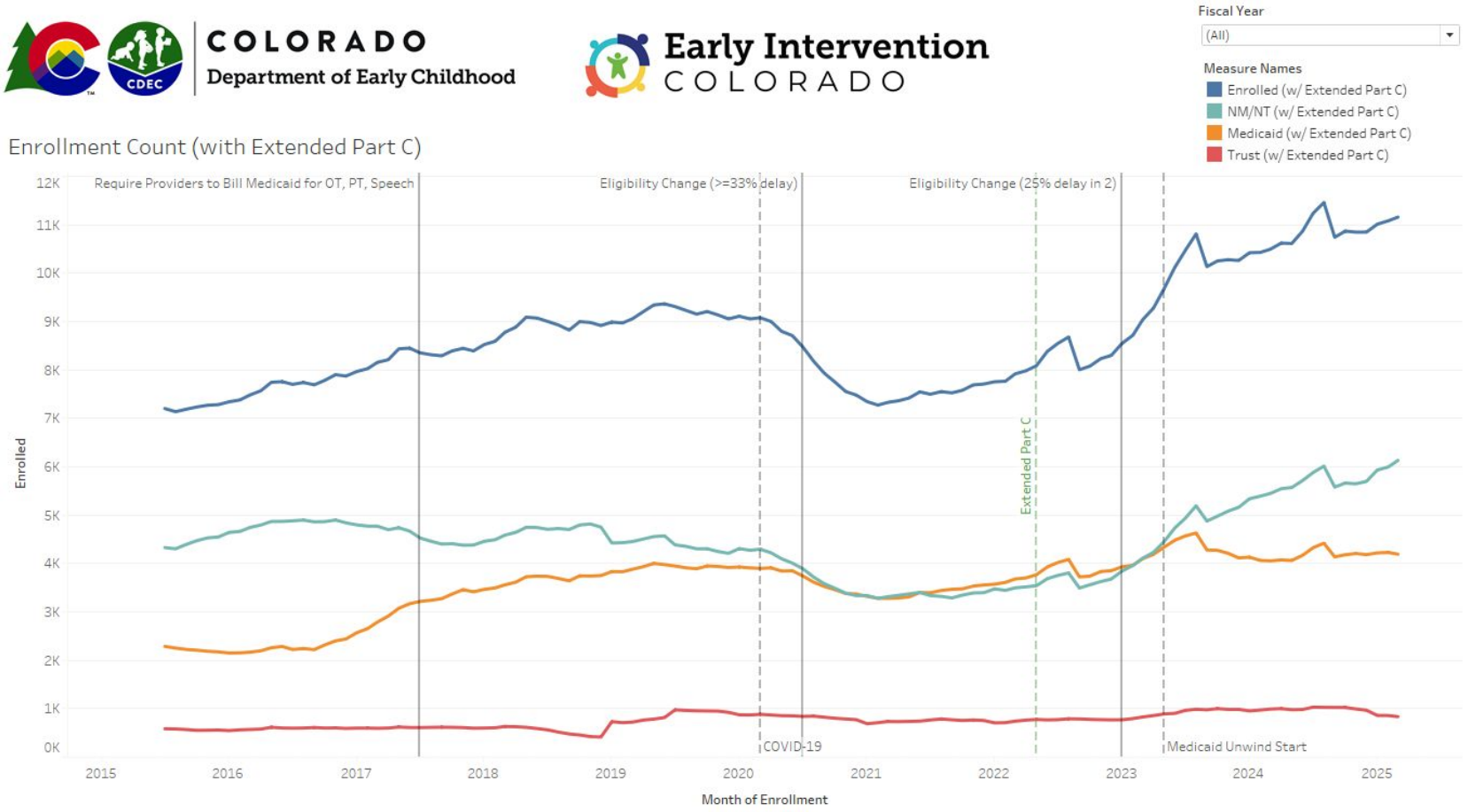

Cost Containment Strategy Evaluation Criteria

The Department and its partners evaluated eight 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 December 10.

EI Funding Hierarchy

Per state law, CDEC uses a coordinated system of payment for EI services and follows a funding hierarchy for accessing 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**

TEAM EI Colorado

- TEAM EI stands for Transdisciplinary, Equitable, Accessible Model. Through this model, a group of early intervention professionals with different skills works closely together to support children's learning and development. These professionals meet regularly with families to share ideas, plan strategies, and help them feel confident in supporting their child's growth in everyday activities and routines.
- Result of the Early Intervention Workforce Investment Committee (WIC), which recommended using a teaming approach for service delivery in June 2023. This was a top priority for a long-term recruitment and retention strategy.
- Currently being implemented as a pilot and is being funded through $1.3 million of stimulus funds.
    - Stimulus funding will sunset in December 2026.
- This is not considered a cost-containment strategy.

Extended Part C

- Extended Part C provides a subset of children with the opportunity to continue Part C services past their third birthday until the first day of the school year following the child's third birthday. The Extended Part C Option is available to children who:
    - Turn three years old between May 1 and the first day of the next school year, as defined by the school district preschool calendar in the district with the family lives, and
    - Are eligible for Preschool Special Education Services under Part B, Section 619 of the IDEA
- **Extended Part C enables qualifying children with delays and disabilities to receive continuous services throughout the transition from Part C to Part B.**
- **CDEC receives $1.8 million in additional federal funding for opting into Extended Part C.**
    - **$1.3 million is set aside for direct services**
    - **$510,000 is used for admin costs, including data system, workforce materials, staff, and assistive technology**

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Department of Early Childhood

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

December 10, 2025

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

Representative Bridges and Members of the Joint Budget Committee:

The Colorado Department of Early Childhood (CDEC) respectfully presents the following report in response to the 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, CDEC's Legislative Liaison, at shannon.schell@state.co.us.

Sincerely,

Lisa K. Roy, Ed.D.

Dr. Lisa Roy
Executive Director
Colorado Department of Early Childhood

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Early Intervention Budget Balancing Recommendations for FY 2026-27

Submitted to

Joint Budget Committee

By

Colorado Department of Early Childhood

December 10, 2025

COLORADO
Department of Early Childhood

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. The EI Program offers several types of services, with the top five utilized being speech therapy, occupational therapy, physical therapy, and behavioural/developmental interventions, such as those targeting social and emotional skills. These services 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 (EI Brokers) contracted by the Department to coordinate and deliver services.

Background

The EI Program supports Colorado's infants and toddlers with developmental delays and disabilities. The Department is committed to sustaining these critical services despite the pressures of increased demand, a constrained state budget, and sunsetting federal stimulus funding.

The Joint Budget Committee (JBC) sustained EI services in FY 2024-25 by approving a $2.0 million General Fund reallocation from HCPF's underspend in Targeted Case Management (TCM) to CDEC for that same fiscal year. The JBC reallocated these funds after CDEC identified a need to reduce their EI spending to maintain a balanced budget for FY 2024-25. This infusion of funds enabled EI services to continue uninterrupted through June 30, 2025, thereby avoiding the immediate need for budget-balancing measures.

The JBC requested the Department to explore cost containment strategies for implementation in FY 2025-26 and FY 2026-27, with a target of reducing costs by $1 million. The JBC requested the

exploration of several specific strategies, and CDEC solicited additional cost containment ideas from the EI community, including providers, Brokers, families, and advocates. This process resulted in a total of 20 strategies for CDEC to explore between May and December of 2025.

Between May and June, CDEC conducted extensive community engagement with Brokers, families, and providers to explore 12 of these strategies.

Based on this partner engagement, in June 2025, the Department submitted a report to the JBC outlining potential budget-balancing strategies to implement in FY 2025-26:

1. Discontinue Subcontracted Provider No-Show Payment
2. Discontinue Mileage and Travel Reimbursement for All Subcontracted Providers
3. Discontinue EI Provider Training Stipend
4. CDEC EI Program One-time Administrative Reductions

Of these recommendations, CDEC has implemented only the departmental administrative reductions. This strategy did not directly impact providers or families but only affected the Department's program administration by freezing staff travel, reducing the budget for data system enhancements, and keeping an open staff position vacant. The strategy resulted in a one-time savings of $300,000.

Based on input from providers and the Joint Budget Committee and the identification of around $3 million in federal carry forward from FY 2024-25, the Department is no longer recommending moving forward with the three strategies impacting subcontractors. CDEC has worked diligently since June to examine additional methods of ensuring program sustainability and efficient service delivery. This report details the Department's findings.

Recommended Budget Balancing Approach for FY 2025-26

The Department conducted an in-depth analysis of the program's budget and historical spending to gain a better understanding of fiscal trends. **CDEC projects that the EI program will underspend around $7.3 million in FY 2025-26.** As outlined in the Department's R-02 Early Intervention request, the Department has identified historical underspending in its administration, evaluation, and direct services lines that can be applied to FY 2025-26. Combined with the federal carryforward of $3.0 million from FY 2024-25, this will result in an estimated $7.3 million in

underspending for FY 2025-26. CDEC will submit a supplemental regarding projected underspending in January 2026.

Given the certainty of the $3 million in federal carryforward, there is no longer a need to implement additional cost containment measures this fiscal year. Therefore, CDEC ***rescinds*** three of its recommendations from the original Early Intervention Cost Containment and Financial Sustainability Report (submitted in June 2025), which include discontinuing subcontracted provider no-show payments, mileage and travel reimbursement for subcontracted providers, and the provider training stipend.

Service Delivery Efficiencies for FY 2025-26 and FY 2026-27

While the EI program does not need to implement cost containment strategies to continue delivering services to children and families, the Department is committed to ensuring EI is coordinated and delivered as efficiently as possible.

CDEC has implemented several program delivery changes in FY 2025-26 to support transparency and efficiency. Additionally, as requested by the JBC, the Department analyzed the remaining strategy ideas from the community — originally suggested as "cost containment measures" — for opportunities to streamline service delivery.

Program Efficiency Recommendation: Redetermining Eligibility Annually

CDEC convened a workgroup of providers, parents, Brokers, and community partners to analyze the additional eight strategies which were originally suggested as part of the cost containment process. With the Department shifting its focus away from containing program costs and toward program efficiencies, the workgroup's analysis made it clear that one strategy would result in streamlined service delivery and further fidelity to the EI service model.

CDEC recommends requiring providers to redetermine children's eligibility annually starting in FY 2026-27. This will ensure that the program and its resources are accessed by children who are eligible, based on up-to-date evaluations. Providers, families, and Brokers overall agreed that this strategy would create efficiencies by ensuring children are served based on consistent criteria.

If implemented beginning July 1, 2026, this measure is projected to save the program $1,078,044 in FY 2026-27 and ongoing.

Program Delivery Enhancements

Contract Adjustments

CDEC has made adjustments to EI Broker contracts to support budget tracking and planning. Prior to FY 2025-26, EI Brokers had contracts for administration, service coordination, and direct services provided by EI Broker staff. Subcontracted direct services were billed out of a separate direct services budget (also known as the General Accounting Encumbrance (GAE)). **CDEC began incorporating the separate direct services budget into contracts for EI Brokers in FY 2025-26 to improve EI Broker budget tracking**. Additionally, there is flexibility within the contracts to move funds from underspent budget lines into areas that may be trending toward overspending (e.g., personnel vacancy savings to direct services), thereby giving EI Brokers more control over their budget planning. The Department will continue to refine the contracts process in FY 2026-27 to further align funding with the caseload.

Projection Model Improvements

The EI Program has been improving its caseload forecast by incorporating additional data to enhance predictability. Previously, projections relied on a straight-line estimation based on the prior year's CDEC EI Broker contractual costs, evaluation costs, caseload figures, and limited Medicaid data. The updated and more robust forecasts now include a range of specific data components, as outlined in Table 1 below, to ensure a more accurate accounting of factors that may impact the potential caseload.

This includes additional Medicaid data, facilitated through an updated Data Sharing Agreement with HCPF, signed March 20, 2025. This improves the forecasting of EI caseload and associated costs. CDEC continues to partner with HCPF to review and revise data reports as needed.

Additionally, the new model more accurately predicts caseload for Extended Part C, which allows a small percentage of children to receive services after their third birthday. Extended Part C is completely federally funded and allows children with birthdays between May 1 and August 31 to continue receiving Early Intervention services throughout the summer until they transition to Part B at the beginning of the next school year. Extended Part C results in an increase in the program's caseload during these months.

Table 1. Updated Early Intervention Caseload Forecast Data

Data	Description
Month of Initial Individualized Family Service Plan (IFSP)	Used to identify seasonal new enrollment trends.
Age of Initial IFSP	Used to identify the average age at enrollment and apply predicted enrollment endpoints.
Birthday (May/June/July/August)	Used to identify enrollment trends in extended Part C.
Medicaid Eligibility	Used to determine enrollment distribution throughout the program.
Established Condition	Used to identify any statistical relationships between established conditions and enrollment duration.
EI Evaluation Score (Domain Delays)	Used to identify any statistical relationships between levels of delay at the time of an evaluation and enrollment duration. Also used to cluster new enrollment monthly projection totals.
Number of Domains Indicating a Delay at Evaluation	Used to identify any statistical relationships between the number of domains with a delay at the time of an evaluation and enrollment duration.
Projected New Enrollment Program End Dates	Used to identify trends in enrollment duration by incorporating the likelihood of participation in Extended Part C as well as the likelihood of underestimating the amount of time in the program, and end dates are adjusted for those likelihoods.

Although the updated caseload forecast incorporates improved data points to better reflect various impacts, all forecasts have limitations, primarily because the EI Program will not have completed a full three-year cycle under the current eligibility criteria until January 2026. As a result, the forecast does not yet utilize data from a complete cohort of enrollments with consistent eligibility, which may lead to variability in predicting the duration of children's enrollment. After January 2026, EI will be in a better position for reliable forecasting.

Despite these limitations, the forecast provides the Department with much-needed additional information to analyze and refine its projections. As more current data become available, the newly added variables will enable deeper analysis to understand what may be influencing the under- or overestimation of the caseload.

Exploring Private Insurance Billing

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 funding source on the list is considered. This continues until an appropriate funding source is identified. Private Health Insurance is second in the hierarchy, preceded only by voluntary private pay.

As part of the cost containment workgroups conducted in May and June, the Department, providers, families, and Brokers explored the feasibility of requiring all providers to become "in-network" with individual insurance companies. This would mean that providers must bill insurance first, thereby making state and federal funding the payor of last resort.

Feedback from workgroup participants made clear that it can be exceptionally difficult for sole independent contractors to become credentialed for in-network status with insurance companies that are currently outside their network. Feedback was overwhelmingly against the implementation of this strategy, with numerous examples of the impacts on program sustainability. Providers mentioned that the administrative burden of credentialing and billing in-network private insurance would likely outweigh any financial benefit of implementing this strategy. The Department is currently working with providers to identify the administrative costs versus the benefits of requiring private insurance billing. Providers have identified the need to hire outside agencies to support billing private insurance, which increases provider administrative costs. Additionally, this strategy would only impact specific services that are billable to private insurance, typically Occupational Therapy, Physical Therapy, and Speech Language Pathology, rather than all EI services available. Finally, EI Brokers and providers have expressed concern that requiring billing of private insurance creates a disconnect between the "medical model" of service delivery and the intent behind EI services, which is an educational and family support model.

In the previous RFI, CDEC committed to conducting further analysis to identify the most utilized insurance companies and determine methods for CDEC to support more providers in becoming in-network. Since then, the Department accomplished the following:

- Added clarifying language to the EI Broker contracts to support private insurance billing requirements.
- Collaborated with the EI Brokers to create a comprehensive Administrative Guide for billing private insurance and started developing statewide strategies to ensure compliance with the funding hierarchy. The guide will include best practices from EI Brokers who successfully bill private insurance that could be implemented statewide. A draft will be available by the end of January 2026, and EI Brokers will be engaged in finalizing the document.
- Requested and subsequently attended the IDEA Part C Infant and Toddler Coordinators Association (ITCA) nationwide meeting to discuss how states bill private insurance.
- Conducted additional research to determine state processes for billing private insurance to understand if different methods exist to bill private insurance.
- Planned collaboration with the Colorado Division of Insurance (CDOI) to compile a list of insurance providers outside of Colorado that frequently issue denials. This information will inform EI providers of which insurance providers are unlikely to approve payment, which will support providers to more efficiently pursue billing private insurance or to otherwise work through the funding hierarchy.

CDEC will conduct further analysis to determine ways to identify the most utilized insurance companies and areas to support more providers in becoming in-network.

Exploring Accessing Medicaid through the EI Services Trust or an EI Code

CDEC, in collaboration with the Department of Health Care Policy and Financing (HCPF), is exploring the option of having Medicaid cover all EI services by paying into the EI Services Trust (EIST) for Medicaid-enrolled children, or, if the EIST is not feasible, by creating an EI billing code. This collaboration is currently underway, with HCPF taking the first steps to explore Medicaid contributions to the EIST.

HCPF originally submitted a request to the Centers for Medicare and Medicaid Services (CMS) to determine whether this strategy would be allowed. CMS responded with follow-up questions in June 2025 and an additional set of questions in late August. HCPF submitted answers to the most

recent questions on October 10, 2025. The discussion regarding an EI billing code will continue until CMS determines the allowability for Medicaid to pay into the EIST. CDEC and HCPF are committed to ongoing collaboration to ensure follow-up to continue to move this strategy forward.

Strategies Overview and Evaluation Criteria

The remainder of this report provides an analysis of the impacts of the recommended strategy of annual eligibility redetermination, as well as an analysis of the seven measures that the Department does not recommend implementing at this time.

Between July and September 2025, CDEC conducted workgroup sessions with 80 Early Intervention providers, parents, EI Brokers, and community partners to discuss eight additional measures aimed at reducing EI costs. Workgroup members applied to be part of the process, and CDEC and members of the Colorado Interagency Coordinating Council (CICC) seated the members. CICC facilitated these sessions. In addition to the workgroup sessions, CDEC publicly posted a budget balancing survey from July 17 to September 30, 2025. This survey provided an additional opportunity for the EI community to provide input on the strategies. 84 partners responded, providing an additional 413 unique comments to inform strategy recommendations.

The budget balancing strategies discussed during the workgroup sessions are listed below:

1. Change Eligibility Determinations Criteria for Established Conditions
2. Implement a tiered service model
3. Redetermine eligibility at the annual IFSP (Individualized Family Service Plan) review
4. Revise EI rules to change the definition of timely service initiation from 28 days to 35 or 40 days
5. Reduce the length of time for initial and annual IFSP meetings
6. For children diagnosed with autism who are enrolled in Medicaid, refer to an Applied Behavioral Analysis provider or a similar service
7. Provide social and emotional services in group settings, as appropriate
8. Consider a consistent salary of $65,000-$75,000 per year for all providers and employ all providers under EI Brokers or CDEC

Initially, a ninth strategy was on the list: the TEAM EI Colorado Primary Service Provider Model, which began in 2023. However, it was determined that this model was not a budget-balancing

strategy, as it was designed to address workforce recruitment and retention and to improve the quality of service delivery, rather than to balance the budget. The Department presented this model to the EI community in a TEAM EI Colorado Overview presentation on August 19, 2025, to further clarify its distinct purpose and share next steps for implementation.

CDEC and workgroup participants evaluated each budget-balancing measure using the following criteria:

- Impact to children and families
- Impact to providers
- Cost savings
- Changes to the Early Intervention rules, a statutory change, or the data collection or payment systems
- Additional implementation requirements, such as whether the strategy requires Office of Special Education Programs (OSEP) approval or collaboration with another state department

Recommended Strategy: Redetermining Eligibility at the Annual Individualized Family Services Plan (IFSP) Review

Currently, eligibility for Early Intervention services is only determined at the initial evaluation, and children are not required to be redetermined as eligible at any future point in their program enrollment.

CDEC recommends that, starting in FY 2026-27, all enrolled children be re-evaluated annually in the five areas of development to determine if the child still meets EI's eligibility requirements. If the child is determined to still meet eligibility requirements, they will continue to receive services. Eligibility criteria must remain consistent for both the initial eligibility determination and the annual redetermination of eligibility. This requirement is that a child must exhibit a 25 percent delay in two or more areas of development or a 33% delay in one or more areas of development. Children with an established condition—defined as a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay—will remain eligible for EI without having to be re-evaluated. The redetermination evaluation must also follow all the same requirements as the initial evaluation.[1]

[1] This includes:

CDEC recommends this strategy, as redetermining eligibility at annual IFSP meetings ensures that each child receiving services is eligible based on current evaluations and allows for the distribution of resources to eligible children, based on up-to-date evaluations. This strategy is federally allowable. Overall, community input regarding this proposed strategy was supportive, with partners emphasizing the need for thoughtful planning, communication, and implementation.

All feedback from the workgroup and survey can be found here.

Cost Savings Projections:

CDEC projects an annual savings of $1,078,044 in FY 2026-27, if this strategy is implemented beginning July 1, 2026. CDEC reviewed data for the most recent fiscal year to identify children who did not exit the program, but potentially could have under an annual redetermination requirement. Among those children, 250 were within age expectations for all five developmental domains; another 774 showed that they were functioning within age expectations on the Global Outcomes Ratings, the state's child outcomes assessment, at their annual assessment; and, finally another 54 did not meet initial eligibility criteria (33% delay in one or more areas, 25% in two) at their annual assessment. Taken together, this would have led to an additional 1,078 children who would have exited using the criteria recommended for redetermination of eligibility.

CDEC projected forward using the same approach for the 2025-2026 fiscal year and estimated that 1,150 children would no longer meet eligibility criteria and would exit the program in FY 2025-26 if this strategy were in effect. CDEC used an impact projection to calculate the actual savings for each child who potentially exited for the duration of the fiscal year. The projected monthly average savings are estimated to be $119,043, with the range of monthly savings fluctuating between $112,126 and $124,680, or $1,428,516 annually.

- The provision of prior written notice and consent to the parent. Two providers conducting the evaluation; one provider with expertise in the area of concern.
- The utilization of an approved evaluation tool.
- Taking the child's history (including interviewing the parent).
- Gathering information from all available sources.
- Evaluating the child in all 5 areas of development.
- Evaluating the child in their native language.

However, since redetermination evaluations must follow the same requirements as the initial evaluation, two providers must conduct the evaluation. In cases where the child does not already have two providers, an additional provider would be needed. The most recently completed year of data, shows 88 percent of children would need an additional provider to evaluate their continuing eligibility. Providers already contracted with the EI Broker serving the child would be utilized for evaluations. This would have an estimated cost of $29,206 per month, or $350,472 annually. Currently, an assessment is a required component of the annual IFSP process; shifting to an evaluation would not significantly increase the time needed to determine eligibility, which, on average, is forty minutes to an hour. Exiting children who no longer qualify for services would allow providers to have more time to serve children with the greatest need.

Therefore, if trends remain the same, the total cost savings from this strategy are conservatively projected to be $1,078,044 in FY 2026-27. This cost savings projection will be updated as CDEC implements this strategy and begins to gather actual data on the number of children who exit the program due to this policy.

Family Feedback: Family feedback was overall positive, as redetermining eligibility annually would ensure all children in the program are served based on the same criteria of significant developmental delay. However, some parents highlighted concerns families might have about losing services. Some parents noted their child's exit from the program could be seen as negative. Parents may feel like they are losing a service that provides security and stability for their child, even when developmental delays are no longer present. In particular, foster parents highlighted EI services help bridge gaps and provide stability during a child’s transitions.

Workgroup participants noted that continuous support is vital for specific needs, such as for children who are deaf or hard of hearing, regardless of progress. Nonetheless, this strategy does not impact children with an established condition.

Provider Feedback:
Provider feedback was overall positive, with providers noting that this strategy could increase their capacity to serve children most in need. While providers would receive

compensation for redetermination evaluations, providers acknowledged that there would be additional work related to redetermination evaluations.

This strategy could also create additional work for Service Coordinators. Due to the requirement that two providers must conduct the evaluation, Service Coordinators may need to identify an additional provider to conduct the evaluation when a child has only one provider on their IFSP. Workgroup participants suggested strategies to support the effective coordination and timing of redetermination evaluations to mitigate these concerns.

Implementation Considerations:

- This change would require the promulgation of rules and the development of policies and procedures to redetermine eligibility annually. Promulgating rules would require approximately six months.
- The Department would need to make data system updates to close out the files of children who are no longer eligible after an Annual IFSP meeting. Currently, the data system can report when a child completes their IFSP and no longer needs EI services. An additional reporting category would be needed for children who exit the program because they are no longer eligible.
- This is a federally allowable change. CDEC has begun conducting research on the implementation of this policy in other states. Texas, New Mexico, and Virginia are a few examples of states that annually redetermine eligibility for children enrolled in EI. CDEC is continuing to identify states that have implemented this policy. Once the rule-making process is completed, CDEC would provide proof of compliance with federally required notice provisions as part of the next federal grant application, and then OSEP would officially approve it.
- CDEC would need to produce and disseminate guidance on redetermination procedures.
- Families would be allowed, consistent with current practice, to dispute the findings of the eligibility redetermination.

If this strategy is implemented, workgroup participants noted that careful preparation and socialization would be necessary. Both families and providers raised concerns about the need for clear messaging around eligibility and transition out of early intervention once services are no

longer needed. Suggestions included service coordinators developing transition plans and ensuring proactive communication with families to avoid surprises regarding service status.

Analysis of Cost Containment Strategies Not Recommended for Implementation

The Department explored seven additional cost containment strategies in the workgroups conducted between July and September 2025. The workgroup feedback received from community partners did not support these strategies. CDEC does not recommend implementing these strategies in FY 2026-27. Some of the strategies are not federally allowable, some were not aligned with the EI service model, and others would have negative impacts on providers and families. Nevertheless, the Department is open to revisiting some strategies that weren't recommended in case any updated analysis proves that would be beneficial.

Elimination of Extended Part C

Children are eligible for Early Intervention services through their third birthday. However, the Extended Part C Option provides a subset of children with the opportunity to continue Part C services past their third birthday until the first day of the school year following the child's third birthday. The Extended Part C Option is available to children who:

- Turn three years old between May 1 and the first day of the next school year, as defined by the school district preschool calendar in the district with the family lives, and
- Are eligible for Preschool Special Education Services under Part B, Section 619 of the IDEA

Extended Part C enables qualifying children with delays and disabilities to receive continuous services throughout the transition from Part C to Part B. Without Extended Part C, children with birthdays in this time frame would experience a gap in services, creating the possibility that children would miss the opportunity to make additional progress or even lose the progress they have already made through EI services. Extended Part C is optional at the federal level. The Department has opted into implementing Extended Part C since May 2022.

As CDEC chooses to implement Extended Part C, the Department receives a $1.8 million increase of its federal grant award. CDEC sets aside $1.3 million for direct services, both for children participating in Extended Part C and those who are receiving standard EI services. $510,000 is utilized for administrative costs, such as data system maintenance, workforce materials and

training, two staff members, and assistive technology devices. In FY 2024-25, 715 children participated in Extended Part C, and the Department expended $491,535 to provide these children with Early Intervention services after their third birthday. This includes services rendered for Extended Part C in July and August of 2024 as well as May and June of 2025. The remaining funding set aside for direct services was used for children who did not participate in Extended Part C.

CDEC again received $1.8 million in FY 2025-26 to implement Extended Part C.

If CDEC eliminated the Extended Part C policy, the State would lose access to approximately $1.8 million in additional federal funding in future years. Additionally, qualifying children would lose access to services between the time they turn three and the start of the next school year. This option is crucial for supporting seamless transitions between Part C and Part B for all children and families, as it ensures that children do not experience a gap in services and retain the progress they have made through Early Intervention services.

Change Eligibility Determinations Criteria for Established Conditions

EI Colorado defines an Established Condition as a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development and is listed in the Established Condition Database. A high probability is considered to be a 50% or greater delay in development over the long term. The Established Condition Database is maintained by EI Colorado and updated as needed based on physician review. The database includes conditions such as chromosomal abnormalities, genetic or congenital disorders, sensory impairments, inborn errors of metabolism, disorders reflecting disturbance of the development of the nervous system, congenital infections, severe attachment disorders, and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome.

The strategy reviewed by the workgroup contains three distinct areas of exploration.

1.1 Reduce the number of established conditions
1.2 Eliminate chronic ear infections as an established condition
1.3 If the child has an established condition yet does not exhibit delays, provide one monthly check-in visit

The workgroup does not recommend implementing any of the three parts of this recommendation because they negatively impact child development and may not be effective at containing costs.

Additionally, 1.3 is not federally allowable. However, some participants suggested possibly raising the threshold for qualifying established conditions. All feedback from the workgroup and the EI community survey can be found here.

1.1 Reduce the number of established conditions

Overall Analysis: Reducing the number of established conditions would negatively impact children in need of services. Additionally, it may not be an effective budget-balancing strategy due to the work it would require. Under federal law, the criteria for determining eligibility due to an established condition must be applied consistently. In order to reduce the number of established conditions, CDEC would have to review all 451 established conditions, which would require additional contract funding for the established conditions physical review panel. CDEC does not recommend implementing this strategy in FY 2026-27 due to the negative impact it would have on providers and families.

Data: In FY 2023-24, 12 percent of children were eligible due to an established condition; the remaining 88 percent of children were eligible due to a significant delay. The annual cost of services for all established conditions totaled $3,288,163. Of the total services funded, services for established conditions comprised 13 percent.

Cost Savings: The cost and administrative burden of reviewing all 451 established conditions would likely outweigh any financial benefit of implementing this strategy.

Family Feedback: Overall, family feedback was negative, with workgroup participants raising concerns that children who need support may not receive services if established conditions (ECs) are reduced.

Provider Feedback: Overall, provider feedback was negative, with workgroup participants expressing concerns about effectively addressing developmental concerns. Additionally, there were concerns about caseload reductions and the reduction of a provider's ability to utilize specialized skills.

1.2 Eliminate chronic ear infections as an established condition

Overall Analysis: Chronic ear conditions currently meet the definition of an established condition, as they can affect language skills, socialization, and self-regulation. Support and

monitoring for children with chronic ear infections are essential due to their correlation with non-speech developmental issues, such as attention and reading difficulties.

Ultimately, CDEC does not recommend this strategy at this time as the application of criteria for established conditions must be uniform and consistent across all diagnoses. Eliminating one condition based on frequency or cost would be in violation of the Individuals with Disabilities Education Act (IDEA) law. The Department cannot reduce or remove individual diagnoses if they meet the criteria for an established condition. For example, chronic ear infections, Down syndrome, or low birth weight cannot be individually removed as an established condition, as these diagnoses meet the criteria. Considering that this strategy would require reviewing all 451 established conditions and the criteria itself, the majority of the workgroup agreed that this would not be an effective budget-balancing strategy.

Data: In FY 2023-24, 3% of the total population of eligible children were eligible due to chronic ear infections. Services for children eligible due to chronic ear infections accounted for $512,551, which is approximately two percent of the total services funded.

Cost Savings: The cost and administrative burden of reviewing all 451 established conditions would likely outweigh any financial benefit of implementing this strategy.

Family Feedback: The workgroup noted that children may not be identified with a delay or receive services until they enter the school system, missing the critical period of brain development during early childhood, which could impact their future developmental potential. The workgroup stated that if children are not served until a developmental delay becomes significant, there could be long-term effects on early language development; other skills related to language/communication, such as reading and writing skills; and cognitive development related to language.

Provider Feedback: The workgroup was divided on this strategy, with some highlighting concerns about the impact on child development if chronic ear infections are no longer recognized as an established condition. Some participants suggested that Speech Language Pathologists (SLPs) may be unable to address developmental concerns as early as possible, which could lead to more children being identified late and increase the need for preschool special education services. Specifically, this could increase the number of children referred due to social and emotional concerns resulting from communication challenges. Others

provided feedback that there should be a more structured approach for determining eligibility based on the type and duration of the infections, particularly whether they are accompanied by confirmed hearing loss. Specifically, there were concerns that unilateral hearing loss is not currently considered an established condition, while chronic ear infections are.

1.3 If the child has an established condition yet does not exhibit delays, provide one monthly check-in visit

Overall Analysis: This strategy is not federally allowable. The federal Office of Special Education Programs (OSEP) confirmed with CDEC that services cannot be limited to one monthly check-in visit. Additionally, community input did not support this strategy, highlighting its inequity. IFSP teams must consider the services the child truly needs, based on the concerns and priorities identified through the family assessment, to individualize services on the IFSP. It may be appropriate to provide services once a month, depending on what is identified as part of the IFSP; however, CDEC cannot create a blanket limitation.

Family and Provider Feedback: In addition to being unallowable due to federal regulations, the workgroup noted this strategy would treat families inequitably, as services for eligible children would not be provided based on individual IFSPs. According to the workgroup, all eligible children should have equal access to therapy services, regardless of developmental delay status. Restrictions based on the absence of delays were viewed as unethical.

Implement a Tiered Service Model

This strategy involves implementing a tiered service model, through which families with less complex needs receive fewer units, thereby allowing for the redistribution of resources to families with more complex needs. **This strategy is not allowable according to federal regulations.** In a discussion with the Department, OSEP representatives cited that services need to be individualized to meet the unique needs of the child, to meet the outcomes identified by the IFSP team, and cannot be restricted.[2]

[2] CFR §303.344(d, as it provides more time for services to commence)

Revise EI Rules to Change the Definition of Timely Service Initiation from 28 days to 35 or 40 Days

Federal regulations say that services are to be provided "in a timely manner." Each state defines what this is for that particular state, and Colorado State Rules define timely service delivery as 28 days from the date of consent. This is a Federal State Performance Plan indicator that is measured and reported to the OSEP.

While some feedback indicated that a 35-day wait could be acceptable, the input from the workgroup provided consensus that the program should prioritize starting services as soon as possible to support families effectively. Overall, the group emphasized the need for timely services and better coordination among providers to minimize stress and delays for families. While some additional time may help providers in resource planning, it could have detrimental effects on families in need of timely support and is not perceived or recommended as a cost-saving strategy.

CDEC does not recommend implementing this strategy in FY 2026-27 due to its negative impact on providers and families.

> **Cost Savings Projections:** No cost savings could be identified. Changing this timeline would incur costs, as it would require updating all required training and making adjustments to the EI data system.
>
> **Family Feedback:** This strategy could require families to wait longer for services to begin, and the workgroup communicated that this could lead to frustration and hinder children's development. Rural areas could be impacted significantly as the wait time for services to begin is already longer due to a lack of immediate provider availability. The workgroup expressed that the Department would need to carefully evaluate the impact on children, especially those nearing preschool transition, and consider if there would be a disproportionate effect of delays on non-English-speaking families due to the capacity and availability of bilingual providers and interpreters.
>
> **Provider Feedback:** Feedback was mixed on the impact this strategy would have on providers. On the one hand, the workgroup noted the strategy could positively impact time management, reduce pressure and urgency associated with meeting requirements, and enhance work-life balance for providers. At the same time, providers stated they may need

to reserve spots for children who might not start services for over a month, which could impact their ability to serve other families.

Implementation Considerations:

- This would require CDEC to promulgate rules, develop a policy, and update procedures.
- This is a federally allowable process. However, the OSEP would need to review policy/procedures to ensure federal compliance and provide approval to submit with the Federal Grant Application. This strategy could have a positive impact on federal compliance with the timeline requirement, as it provides more time for services to start.

Reduce the Length of Time for Initial and Annual Individualized Family Service Plan (IFSP) Meetings

Generally, IFSP meetings last between one and two hours. Various factors can impact the length of a meeting, including a family's understanding and readiness for the process, as well as the facilitator. While workgroup feedback suggested that shorter meetings may have benefits for families and providers, the federal requirements of Part C of the IDEA stipulate that the initial and annual IFSP meeting processes must be individualized for each child and family. This means that CDEC cannot dictate a set amount of time for meetings.

Overall, community feedback indicated the need for a leaner, more efficient IFSP process while maintaining the quality of family involvement and communication. Currently, one of CDEC's goals for the mandatory State Systemic Improvement Plan (SSIP) related to OSEP goals is to streamline the IFSP development process and documentation to address inefficiencies within the process. As part of this work, meetings may potentially become shorter. All feedback from the workgroup and the EI community survey can be found here.

Cost Savings Projections: Although CDEC cannot mandate a specific amount of time for IFSP meetings, meetings may become streamlined due to the SSIP activities currently underway. Extensive data analysis would be needed to determine if this streamlined process has cost savings. This would involve determining the actual cost of IFSP meetings by examining

individual IFSP meeting billing data. Once the streamlined process is implemented as part of the SSIP, CDEC will need to compare the new billing data to identify any discrepancies.

The SSIP process will also incur some costs for data system changes and enhancements, as well as training updates. The amount will depend on which changes are made as a result of the required process.

Family Feedback: Families were generally supportive of this strategy, as shorter meetings could alleviate stress for families, especially those participating virtually with young children, or improve management of family dynamics. Families stated a thoughtful reduction in meeting length is possible without sacrificing the quality of information gathered about needs. Some feedback noted that shorter meetings might risk leaving families unprepared to engage meaningfully without adequate support and information upfront.

Provider Feedback: Overall, providers agreed that a more streamlined process is needed, as it could free up time to potentially serve more children. Providers voiced that meetings often take longer than necessary, especially for simpler reviews, and there is a need for greater consistency in meeting durations and processes.

Implementation Considerations:

- Streamlining the IFSP process in accordance with the SSIP will require adjustments to the EI data system, program processes, and potentially rules, depending on the changes adopted.
- This does not require OSEP approval; however, OSEP may need to review any new procedures to ensure compliance with IDEA.
- The workgroup suggested efficiency improvements, such as potentially combining the Family Assessment and Global Outcomes processes—both of which are required components of the IFSP process and, respectively, determine child and family needs and the child's developmental stage. These components tend to be lengthy and disconnected. Participants expressed a desire for a more consistent statewide approach to these processes.

For Children Diagnosed with Autism who are Enrolled in Medicaid, Refer to an Applied Behavior Analysis (ABA) Provider or a Similar Service

Autism is considered an established condition for EI eligibility. However, few children enter the program with a diagnosis of autism; more often, children qualify for Early Intervention services based on having a significant developmental delay. Children often receive a diagnosis of autism from a qualified diagnostician later on. EI Colorado does not conduct diagnostic evaluations, including for autism.

This strategy involves referring children with an autism diagnosis to Applied Behavior Analysis (ABA) therapy, a type of therapy that examines why a behavior occurs and works to shape it by providing direct reinforcement of the desired behavior. ABA therapy is not one of the allowable service types for EI, per IDEA, and a child must be referred to an ABA agency to receive this specific service.

All children enrolled in EI have a legal right to receive the services listed on their IFSP, and OSEP and federal law will not allow children to be referred to ABA in lieu of receiving EI services. Referring children with autism who are enrolled in Medicaid to an ABA agency will not necessarily result in cost savings for the Department, as these children would remain eligible for EI services. Children can receive support from EI and ABA agencies simultaneously.

Feedback from the workgroup was generally not supportive of this strategy. Workgroup member responses advocated for maintaining family-centered, individualized service planning within the EI model, with ABA therapy as one option among many, rather than a replacement for EI or other therapies. Providers emphasized that families should be informed and empowered to choose the most suitable supports for their child.

CDEC does not recommend implementing this strategy in FY 2026-27 due to its negative impact on providers and families.

> **Data:** In FY 2023-24, thirty-six children were eligible for EI based on an established condition of autism. In the same time frame, 467 children had a diagnosis of autism entered into the EI data system, and 254 of these children (54%) were enrolled in Medicaid.
>
> **Cost Savings Projections:** Since federal law will not allow children to be referred to ABA in lieu of receiving EI services, the Department is unable to quantify whether this strategy

would yield potential cost savings. While some families accessing ABA outside of EI may choose to utilize fewer EI services and resources, others may opt to maintain their level of EI services.

Additionally, families opting for ABA services in lieu of EI services may reduce EI costs, but it would increase Medicaid burden, as Medicaid covers ABA through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Family Feedback: Overall, families were not supportive of this strategy, as they expressed concern over the loss of choice if they were pushed toward ABA rather than being given informed options. Additionally, families were concerned that children could lose access to current therapies (e.g., Speech Therapy, Occupational Therapy) before ABA therapy starts, creating service gaps. This strategy created an equity concern amongst the workgroup, as children without formal autism diagnoses would be treated differently from those with a diagnosis.

Workgroup participants also noted that ABA centers are not equally accessible across the state, and waitlists are long and access can be inconsistent, especially for families without formal diagnoses. Finally, the workgroup noted that some families may not want or be able to participate in ABA due to its time-intensive nature.

Provider Feedback: Overall, providers expressed concerns with this strategy. Participants voiced that providers could feel replaced by a system that does not prioritize family choice or is not equally accessible. Others noted there could be a risk of providers discouraging Autism Spectrum Diagnosis (ASD) if it results in children losing access to EI services.

For Social and Emotional Services, Work with Families in Groups (As Appropriate)

Currently, social and emotional services delivered by EI Colorado may be provided in either an individualized or group setting. EI is federally mandated to provide services in natural environments and through parent coaching. In some cases, group models may meet these standards, but in others, they may not. Federal regulations specifically state that group social-emotional services are allowable. For example, this could be a provider working with a group of children and their families on emotional regulation strategies.

While group social and emotional services are federally allowable, mandating that these services be offered to families in groups is unlikely to be a cost-effective strategy, given the relatively low number of children receiving social-emotional support and the associated low cost of services. Additionally, mandating group services for this service type could increase costs due to the need for startup costs, additional training, dedicated space, materials, and additional administrative activities.

More importantly, feedback for this strategy was largely negative, with families and providers raising significant concerns around service equity and access. Families may have significant issues with group models, which could lead them to opt out of services. Additionally, there are no proven models for group-based social-emotional services, while studies do support the value of one-on-one services. All feedback from the workgroup and the EI community survey can be found here.

Based upon the feedback received, the department is not recommending this strategy

Data: In FY 2023-24, 9,634 children were referred, evaluated, and found eligible for EI services. Of these children, only 7.8 percent (761 children) had social and emotional services added to their IFSPs. This resulted in expenditures of $746,921 for all billable services, of which $719,691 was direct service billing. Fifteen children had only social and emotional services on their IFSPs, and the cost for all billable activities was $15,142.

Cost Savings Projections: Any cost savings resulting from this strategy are likely to be modest and may simply reflect reduced service utilization (as discussed below), rather than actual savings.

Family Feedback: Overall, families were not supportive of this strategy.

- Participants emphasized that mandating group services could jeopardize families' trust and privacy. According to the workgroup, families, especially immigrant or foster families, often fear sharing in groups. Families expressed concerns over being reported or judged by others in the group. Additionally, feedback noted confidentiality as a concern, as public locations like parks and libraries are not suitable for private conversations, and challenges to Health Insurance Portability and Accountability Act (HIPAA) compliance exist in group settings.
- Importantly, the workgroup noted that this strategy could result in decreased participants, as post-COVID trends show that families are avoiding group settings.

Many people prefer one-on-one services due to the added safety and comfort they offer. Therefore, the workgroup believed the strategy would pose a high risk of service loss, as families may choose to opt out of services rather than participate in group services.

- This strategy raised equity and access concerns for the workgroup, as families may lack access to transportation, child care, or flexible schedules, particularly in rural areas.

Provider Feedback: Providers also gave largely negative feedback, as this strategy could impact providers' reimbursement rates since Medicaid and private insurers pay very little for group services. Providers also express concern as group services require individualized documentation for multiple families. Additionally, providers reported that group services introduce complexity in billing with Medicaid, private insurance, Tricare, and other providers, as group services may not be reimbursable.

Implementation Considerations: The workgroup emphasized that group models might be of benefit at some point and should be considered outside of the budget balancing process in the future, with the following considerations:

- Should be offered in addition to (not instead of) 1:1 services.
- Participation should be truly optional and driven by the IFSP.
- Should be used for peer support, education, or lower-intensity needs.
- Proper training, reimbursement, and fidelity monitoring should be in place.
- Could work in urban areas or via telehealth in rural regions.
- It could be useful in community-building or reducing isolation.
- Group programs, such as Circle of Security or Nurturing Parenting, rather than therapy, could support parent education.

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

This strategy proposes establishing a standardized salary of $65,000 to $75,000, which would additionally include fringe benefits, a retirement plan, and compensation for activities that are not

currently reimbursed. This strategy and salary range was proposed by a member of the EI community when the Department solicited ideas for budget-balancing strategies.

Currently, sixteen percent of service providers are employed by an EI Broker and are paid via the EI Broker Contract. Salaries are determined by each EI Broker and submitted to the Department for approval each year. While salaries are determined by EI Brokers, pay increases are dependent upon provider rate increases approved by the Legislature. The remaining 84 percent of service providers are subcontractors of the EI Broker and may be employed by an agency or a home health agency, or be self-employed. Rates and requirements for subcontracted providers are determined by each EI Broker. The average rate is $105 per hour and varies according to the EI Broker service area, provider credentials, and longevity. Medicaid rates are established by the Department of Health Care Policy and Financing (HCPF) within guidelines set by the Centers for Medicare and Medicaid Services (CMS).

Creating a consistent salary of $65,000 to $75,000 is not practical due to implementation logistics and the low salary range. First, this strategy would require subcontracted providers, which make up 84% of the field, to become employees of either EI Brokers or CDEC. The average salaries for employees of EI Brokers range from approximately $82,000 to $120,000, which is significantly higher than the strategy's recommended range of $65,000 to $75,000. To be employed by CDEC and the state of Colorado, providers must fit within established job classifications determined by the Department of Personnel Administration (DPA), resulting in an average salary of $96,126. Input from the workgroup and survey responses strongly oppose the proposal for a standardized salary of $65,000–$75,000, as it is perceived as too low and could lead to a loss of high-quality providers.

Neither CDEC nor EI Brokers currently have the necessary infrastructure to support the approximately 800 current subcontracts who, under this strategy, would be required to become full-time employees. Logistically, there would be an extensive administrative burden, including numerous contract justifications, negotiations, monitoring, and amendments to hire staff. If providers were employed under CDEC, the Department would likely hire most positions at 1.0 FTE, which would eliminate scheduling flexibility that contracted positions may have. Additionally, EI Brokers would have increased costs as they would need to include employee fringe benefits. All feedback from the workgroup and the EI community survey can be found here.

CDEC does not recommend implementing this strategy in FY 2026-27 due to its negative impact on providers and families.

Data: Per contract with Brokers, the average annual salary and fringe benefits for provider types are:

- Speech Language Pathologist: $104,068.24
- Occupational Therapy: $96,656.67
- Clinical Therapist: $104,273.10
- Social/Emotional: $120,863.63
- Developmental Interventionist: $90,010.17
- Physical Therapist: $103,772.21
- Special Educator: $86,443
- Registered Dietitian: $82,917.50

Cost Savings: This strategy cannot provide cost savings as it is not feasible to implement.

Family Feedback: Families expressed concern that this strategy could exacerbate service delivery delays due to a decrease in provider availability. A loss of providers could disproportionately impact rural areas.

Provider Feedback:

- Feedback from providers emphasized that the proposed salary range of $65,000-$75,000 is insufficient, and some providers may not find it beneficial to be employed, stating that this change could deter high-quality providers from entering or remaining in the EI system. Many participants believe that this salary does not accurately reflect their qualifications and is not a livable wage in Colorado, given its high cost of living. On the other hand, some input indicated that providers could find a consistent salary with benefits appealing, which could increase provider availability.
- Many providers prefer the flexibility of working part-time as a subcontracted provider and are not seeking full-time employment.
- Some feedback indicated that one benefit of this strategy is that collaboration and coordination could increase as a result of all providers being employees of EI Brokers. Some input indicated this strategy has the potential for more equitable reimbursement across disciplines.

Conclusion and Next Steps

As part of the Department's ongoing commitment to evaluate budget balancing for the EI Program, implementing the recommendation to redetermine eligibility at annual reviews supports the goal of promoting EI service sustainability. It is projected to result in a cost avoidance of $1,078,044 in FY 2026-27 and ongoing. The Department will present these recommendations at the Joint Budget Committee's upcoming Briefing on December 12th.

Accessibility Statement

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