



**COLORADO**

Department of Health Care  
Policy & Financing

## Meeting Notes Children's Disability Advisory Committee

Colorado Department of Public Health and Environment  
4300 Cherry Creek Drive South, CIA Room Located in Building C  
Denver, CO 80249

March 9th, 2016, 10:00 A.M. to 12:00 P.M.

### 1. Meeting Purpose

Share current issues in children's services.

### 2. Introductions

**In the Room:**

Alex Meredith  
Allison Moffett  
Beth Cole  
Bethany Pray  
Candace Bailey  
Carol Meredith  
Cheryl Jameson  
Chris Russell  
Christy Blakely  
Dawn Caldwell  
Elizabeth Freudenthal  
Erika Walczak  
Gretchen Hammer  
Innessa Porter  
Jennifer Rahrer  
Ken Winn  
Laura Russell  
Loretta Bozeman  
Mallory Cyr  
Marijo Rymer  
Maureen Welch  
Mona Sanchez

Shannon Secret  
Sheila Peil  
Shilo Carson  
Tsilat Petros

**On the Phone:**

Cassidy Dellemonache  
Emily Roche  
Gina Robinson  
Nancy Harris  
Patricia Fulton  
Shannon Huska  
Susan Johnson  
Susan Letkristen  
Susana Herrera



### 3. Agenda Items:

#### A. School Health Services – Shannon Huska

- a. The School Health Services program helps school districts and Boards of Cooperative Educational Services (BOCES) become qualified providers and helps them find federal matched funds for Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) services that are health related.
- b. BOCES are prominent in rural areas and help small districts provide service in schools by sharing PTs, OTs and nurses.
- c. When school districts participate in the program, they will get paid for Medicaid services only.
- d. The fund only pays for the cost (salaries and benefits for providers) of services that are outlined in the IEPs and IFSPs.
- e. Parents must give school districts signed permission to use their child's Medicaid ID to be able to get IEP or IFSP services in school.
- f. Reimbursement goes to the health needs of all children in the school district (it does not follow a specific child).
- g. The Department of Education (CDE) oversees the program and ensures funds are used appropriately according to the district's local services plan.
- h. School districts commonly hire additional nurses or behavioral and mental health professionals with the funds. Targeted case management is also a possibility but is currently not being used.
- i. School Health Centers are different from this program.
- j. Comments, Concerns and Q&A:**
  - i. Question: How are funds being used? Could parents see the explanation of benefits and breakdown of how the funds are being used? Is there transparency (Shannon S.)?
  - ii. Answer: School districts fill out an annual report explaining how they spent their money (according to their local service plan). CDE holds school districts accountable (Shannon H).
  - iii. Question: Are the number of hours available for after school or weekend nursing services reduced from a child once the school



district bills for nursing service (Carol)?

- iv. Answer: No (Shannon H).
- v. Question: There are families that are sending their own PDN to school with their child so the child is able to stay in school safely utilizing their total PDN hours (Erika).
- vi. Answer: Schools should provide those service to children by law if the child needs those services. Families should get those service through the school not privately (Shannon H).
- vii. Comment: I tried to get an explanation of how the funds were being used and I was not able to get an answer. I was also told they meet every five years. Some parents will not give the school districts permission to bill against their child's Medicaid ID for lack of transparency. If more and more parents do that, it will hurt the program (Maureen).
- viii. Answer: Local service plans are developed with the help of stakeholder/public input. Plans are rewritten every five years. There has been recent updates to the procedures of how plans are developed. School districts are used to setting an increasing dollar amount of their revenue to each service area, now districts assign percentages of their revenue to each service area. For additional information, please contact Shannon Huska at HCPF and/or Jill Matthews at CED. They will direct you to the Medicaid Coordinator of your school districts.
- ix. Shannon Huska, School Health Services Program Administrator, [Shannon.Huska@state.co.us](mailto:Shannon.Huska@state.co.us), 303-866-3131 or Jill Mathews, Senior Consultant, School Health Services Program, [mathews\\_J@cde.stare.co.us](mailto:mathews_J@cde.stare.co.us), 303-866-6979.
- x. Question: How do children in private schools receive benefits of this program (Innessa)?
- xi. Answer: This program is only for kids in public school (Shannon H).
- xii. Answer: Private schools children have the right to IEP services. However the program is not as robust as it is in public school. However, even qualified Medicaid providers are not able to bill for school based services under EPSDT (Chris).
- xiii. Comment: School Health Services Program is an administrative



opportunity for schools to use Medicaid dollars to provide additional health services within their schools. It is not for an individual child service. There is a distinction between the way children access services on School Health Services Program and other school based health programs that provide services directly related to a specific child. This program oversees how school districts interact with Medicaid from administrative perspective and allows for additional resources to schools (Gretchen).

- xiv.** Comment: IEP is not a product of this program. IEP is a product of Individuals with Disabilities Education Act (IDEA). IEPs outline services that should be provided to children regardless of schools participating in this program (Shannon H.).
- xv.** Comment: In a private school setting, local school districts provide Individualized Learning Plan (ILP) not IEP (Maureen).
- xvi.** Comment: Families are losing the flexibility of getting behavioral services in private schools under EPSDT. Children are able to use CES behavioral services in private schools. EPSDT is limiting ways families could get services (Maureen).
- xvii.** Comment: In other states, there is a Medicaid match program for school based ABA service. Individual school districts contract with ABA providers directly and get reimbursed through Medicaid (Ken).

## **B. EPSDT Behavioral Services – Gretchen Hammer**

- a.** Offering behavioral therapy services through EPSDT has been an opportunity for the state to create access for children on state plan Medicaid.
- b.** The EPSDT benefit is available to all children that are Medicaid eligible and meet that medical necessity requirement. It is for all behavioral therapy not just ABA therapy. It is for all children, not just children diagnosed with autism.
- c.** In response to stakeholder feedback, the Department did not limit the Utilization Management (UM) criteria to only autism related services.
- d.** The Department has convened a weekly meeting that includes staff from different divisions including rates, systems, waivers, state plan service, and EPSDT to implement and continue to address issues that come up with providing behavioral therapies services on EPSDT.



- e. The Department has begun enrolling providers, which is a different process from enrolling providers for waiver services. Providers need to comply with additional federal rules and regulations when becoming a provider for state plan. Waivers waive federal requirements to allow for more flexibility for individuals who need more specialized services.
- f. The Department has had a constellation of issues that affected the implementation of this benefit on EPSDT. The federal requirement to revalidate all 40,000 Medicaid providers in the state of Colorado and implementation of a contract with a new UM vendor eQHealth. eQHealth started on September 1, 2015 and revalidation started on September 15, 2015.
- g. There have been some challenges and the Department has been working hard to address issues as they come up. The timing to implement this benefit was not ideal but it's been part of the process and the Department is working through it.
- h. The Department has also set up new billing codes and updated the system to be able to start providing services.
- i. The Department has also been working with eQHealth on the UM or medical necessity criteria. The criteria has to balance state plan and EPSDT requirements. State plan requires that Medicaid provides medically necessary services and EPSDT requires that Medicaid provides access to services to children whether or not the service is offered on state plan.
- j. There have been concerns with the UM criteria. The Department and the Attorney General (AG) office had a productive meeting with Autism Speaks and the Colorado Center on Law and Policy (CCLP) to address their concerns. The Department is responding to those concerns and has outlined proposed changes to the criteria.
- k. Implementing behavioral therapy services on EPSDT has been a manual process which could be a concern on its own. However, that is by design. The Department wants a hands on approach to track and improve the process at every step.
- l. There is a handout attached to these meeting notes with the proposed changes to the UM criteria. The Department is open to feedback and to address additional areas of concerns.
- m. There have not be any denials to behavioral service due to the criteria. There have been denials for lack of information and we are working to address that.



- n. The criteria is a guideline to help get a complete picture of the needs of child and how behavioral services could support the child.
- o. The Department is still working with the nuances of sorting out the school setting piece. The Department main concern is to ensure we are not double paying for services without taking away what the therapy contributes to the child's school experience.

**p. Comments, Concerns and Q&A:**

- i. Comment/concern: My main concern is the exclusionary criteria that seems to be embedded in the criteria. I would recommend providing ABA therapy early on and setting up regional committees that include providers, client right advocates, and stakeholders to review medical criteria based on established standards to be more objective (Ken).
- ii. Comment: Thank you for the changes that are in progress. I want to emphasize that the behavioral therapies that are offered on EPSDT are not limited to ABA therapies only (Marijo),
- iii. Question: How many providers have enrolled and how many children have received services so far (Marijo)?
- iv. Answer: Six agencies have enrolled and there are a number of individual providers under each agency. (Gretchen).
- v. Answer: A few children have made it through the UM process. However, providers are still getting used to what to provide to eQHealth. The Department has staff that is supporting and working with eQHealth and providers to make sure clients are going through the UM process (Gretchen).
- vi. Question: What is the timeline to send feedback on the document to the Department (Christy)?
- vii. Answer: Please send feedback to the Department within the next two weeks. The Department is open to modifying the criteria until most people are comfortable. We want it to be as clear and comfortable as it can be. The backstop to this is EPSDT (Gretchen).
- viii. Question: What is the meaning of the criteria that states "Be medically stable and without a need for 24-hour monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/IID)?" Does that mean a



client that is on CES wavier would not be eligible? Aren't all kids ICF/IID level of care for this (Erika)?

- ix.** Answer: The reference to ICF/IID or hospital level of care just means that services cannot be provided in those settings. It's ok if clients are at that level of care but services cannot be provided in those facilities (Candace).
- x.** Comment: After dealing with eQHealth for six months as a provider and figuring out what they want in a PAR, and this document leaves even more gray area. What does "less intrusive" or "less intensive behavioral intervention" mean? Providers are going to have different interpretations of each criteria. Also we have been using the last well-child visit report for the medical examination but if it does not show documentation of autism or other distracting behavior, it is not accepted. It would be better to get an order from a doctor (Jennifer).
- xi.** Comment/concern: I went through the onboarding process with Professional Pediatric Home Care and I can speak to the process as a consumer and the experience has been really good so far. It was very similar to CES onboarding process. My biggest concern is with continuity of care from losing providers due to rate cuts and the benefit of having one consistent relationship with a BCBA vs with a technician and a line staff. I am also concerned with the private school setting issues (Maureen).
- xii.** Questions: What are the proposed changes (Cassidy)?
- xiii.** Answer: One area that has raised concern has been requiring 10 or more hours per week of intensive early intervention. The Department's intent was to ensure a level of intensity that will be helpful. There are some that say any hour limit with good intent or with attempt to limit is not allowed under EPSDT from a legal perspective (Gretchen).
- xiv.** Answer: Similarly although there is evidence to suggest that the engagement of a primary care giver in a child's life makes therapy more effective. However, the Department cannot predicate a child's access to service based on third party's engagement (Gretchen).
- xv.** Answer: Also there is language we could change to ensure we are communicating our intent around the ability to prove reasonable expectation of progress after a certain point of time with flexibility to account for other factors in client's life (Gretchen).



- xvi.** Question: What does “less intrusive or less intensive behavioral intervention” mean and could you give example? (Cassidy)?
- xvii.** Answer: This is another area where there was a lot of discussion around and we are leaning towards asking for documentation to get a sense of what other services the child has tried that might have benefited the child (Gretchen).
- xviii.** Question: What is the meaning of the criteria that states “Services that are primarily respite, daycare or educational in nature and are not used to reimburse a parent for participating in the treatment program?” Does that mean that a provider can provide respite for a child while a mom is getting training (Cassidy)?
- xix.** Answer: The last section is ensuring that the Department is not double paying for services. When requesting service for an individual for behavioral therapy services, the focus of those services should not be primarily respite, daycare or educational in nature (Gretchen).
- xx.** Question: How could parents prove they have tried “less intrusive or less intensive” services when Medicaid does not provided the opportunity to try other service and what is the time frame (Shannon)?
- xxi.** Question: What is an example of “less intrusive” treatment (Chris)?
- xxii.** Answer: Families could say they have tried speech therapy or OT and it was not enough (Carol).
- xxiii.** Answer: The Department is moving towards taking out failed first kind of language and leaning towards asking for documentation of other services tried (Gretchen).
- xxiv.** Question: It has been about six months since the mandate to implement this benefit on EPSDT. How is the Department implementing this new benefit? Have they hired appropriate personnel to help with provider enrollments or to process PARs? How many children have received services so far (Shannon)?
- xxv.** Question: Could we get the number of clients and number of providers enrolled (Christy)?
- xxvi.** Answer: The Department is not able to share the number of clients enrolled because of HIPPA regulations. The number of providers



enrolled is update regularly on the EPSDT website:  
<https://www.colorado.gov/pacific/hcpf/pediatric-behavioral-therapies>

- xxvii.** Comment: Sometimes the Department is required to comply with federal requirement without additional resources. We do our best to redeploy staff as necessary but the Department has not added new staff to comply with new requirements (Gretchen).
- xxviii.** Question: How is the Department communicating new benefit to the general public? It is my understanding that the Department has only notified CWA wavier clients (Shannon)?
- xxix.** Answer: The Department's public facing website has a dedicated page on behavioral therapies services. Communication has not be limited to a single email distribution list. Our electronic communication has been broader (Gretchen).
- xxx.** Comment: There are people that do not have access to internet. That is an assumption of privilege (Maureen).
- xxxi.** Answer: The reason the Department formally notified the CWA enrolled and waitlist clients is because the benefit was set up as a direct result of CMS denial of the CWA waiver expansion (Candace).
- xxxii.** Answer: Also the Department wanted to ensure that the system was working properly and enough providers were enrolled that could handle the influx of new cases before reaching out to the general public. So far six providers have enrolled with multiple individual providers. Soon the Department will start looking at messaging the new benefit to the public (Candace).
- xxxiii.** Comment: The Arc of Colorado would be happy to partner up with the Department to help inform the community (Marijo).
- xxxiv.** Comment: Providers are not interested in becoming EPSDT providers because it is an 18.6% rate cut and it is more restrictive (Dawn).
- xxxv.** Comment: The rate issue is critical to provider capacity (Maureen).
- xxxvi.** Answer: There is a legislative process that drives the way we look at rates. It was created by the legislature last year. The fee schedule has to go through a public review process and go on a five year cycle. There are also other regulations that we need to



follow when we review and engage with the general assembly regarding rates. We are happy to go through that process (Gretchen).

- xxxvii.** Question: Is it true that services have to be provided in the home and not in the community (Cassidy)?
- xxxviii.** Comment: It could be EPSDT regulation or agency regulation. We need to look into that next time (Christy).
- xxxix.** Comment: My work with personal care and EPSDT leads me to believe that if a service is medically necessary, EPSDT coverage should apply to multiple settings as long as the service is not being paid for by other programs such as the School Health Services Program (Elizabeth).
- xl.** Answer: Early Intervention is the program that mandates service be delivered in the home and not EPSDT. Most EPSDT providers are also Early Intervention providers, which could be part of the confusion. We need to include that in our outreach to the community and providers (Candace).
- xli.** Question: Is it the Department's intent to move this new benefit to state plan or leave it under EPSDT? Will the benefit collaborative process be included (Shannon)?
- xlii.** Answer: The Department did not go through the benefit collaborative process in part due to some stakeholder feedback (Gretchen).
- xliii.** Comment: My stakeholder feedback is to do an expedited benefit collaborative (Carol).
- xliv.** Answer: There is a nuanced distinction between EPSDT and state plan. All children that are eligible for Medicaid through the state plan have access to EPSDT service. It is not a separate benefit. It is a component of the state Medicaid program as an entitlement (Gretchen).
- xlv.** Question: What rules and regulations are the Department following as they set up this benefit if not the benefit collaborative process? Who is vetting the process (Shannon)?
- xlvi.** Answer: The benefit collaborative is an approach Colorado Medicaid takes. It is not done in every state. The reason we are here is to



gather stakeholder feedback. We welcome your guidance and that is the open process we are taking (Gretchen).

- xlvi.** Comment: This is a statewide benefit that is open to all children that are eligible for Medicaid. Input from a limited stakeholder group is not enough for a statewide benefit (Shannon).
- xlviii.** Answer: The benefit collaborative process is still an option if that is what the stakeholder community wants. The Department took an approach that we thought would give us a starting point to implement the new benefit. We copied UM criteria other states developed, updated our system, enrolled providers and opened access to the benefit. We are here to modify the UM Criteria based on feedback (Gretchen).
- xlix.** Comment: The whole process did not start organically from the ground up. We could probably find faults but let's move forward and figure it out. If at the next meeting, there is an agreement to go through the formalized benefit collaborative process we need to make sure it is expedited (Marijo).
  - i.** Comment: How could people find out about future meetings? We need to bring broader representation to the table. I would recommend creating a communication plan to be more inclusive (Maureen).
  - ii.** Answer: This meeting has been meeting for twenty years and is an open group (Christy).

### **C. CES Denials – Sheila Peil**

- a.** CES is for children 0-18 years of age who have a developmental disability or delay and have a behavioral or medical condition that requires intense level of human intervention; more intense than a verbal reminder and redirection.
- b.** Intervention has to be due to a developmental disability or delay of a child and not the age of the child.
- c.** Frequency of intervention has to be at least every two hours during the day and every three hours during the night on a weekly average.
- d.** The behavioral condition has to have an established pattern. It has to be a pattern that is on-going and has to be documented over six months across all environments.



- e. Constant vocalization is also an eligibility criteria.
- f. In addition to the targeting criteria, the application includes developmental disability determination, ULTC level of care determination and Medicaid financial determination.
- g. Those are the eligibility components reviewers look at.
- h. CES denial can occur at any stage and it is not only focused on the CES targeting criteria.
- i. Question: There were indicators that show denials due to fiscal cap or fiscal reduction (Christy)?
- j. Answer: That is not true. Eligibility criteria and CES targeting criteria is what is looked at. The larger fiscal issue is not part of the eligibility criteria.
- k. Denial letters site reasons such as: developmental delay or disability was not determined prior to submitting HCBS application; frequency or level of intervention does not meet criteria; behavioral or medical condition did not have an establish pattern; and behavior was age appropriate.
- l. The last three months (December, January, and February) denial trends:
  - i. Total applicants: 512
  - ii. Annual Continued Stay Review (CSR): 318
  - iii. CSR Denials: 11 (Maybe the child improved or there was an error on initial review)
  - iv. Initial reviews: 194
  - v. Initial denials: 104
- m. CES is seeing a high volume of initial reviews since CCBs cleared the backlog of initial reviews. The elimination of the CES waitlist three years ago caused a backlog. CES opened enrollment at once instead of phasing it out when the waitlist was eliminated and it created a large backlog. More and more families that do not meet the criteria are applying since the backlog was cleared.
- n. Question: What kind of tools are you using to determine age appropriateness? For consistency sake, I would recommend using the ages and stages guideline that are used in other parts of Medicaid and around the nation (Carol)?
- o. Answer: We are using the reviewer's point of view and expertise. We



could look into adding the ages and stages (Shelia).

- p.** Question: Out of the 104 denied for initial reviews, how many were denied because they were missing information on their application or because their application was not filled out correctly? Is there a way CCBs or other organization such as the ARC could assist the parents in understanding what to expect? And how could we help CCBs understand the criteria since they are the first line of contact to determine a child's eligibility (Marijo)?
- q.** Answer: I train reviewers to look for justification to prove a child is eligible rather than looking for justification to prove they are not eligible. Also, if we get an application that is not complete or has missing information, we contact the case manager and ask for additional information. We do not deny based on incomplete information (Shelia).
- r.** Answer: In addition, the Department holds quarterly case management meeting with CES case managers. On the last quarterly meeting, we trained case managers how to interview families and how to fill out the CES application correctly. Also I hold regular training and Technical Assistance calls for individual CCBs or CMs or if I see a repeating problem. I also meet with eQHealth on a weekly basis since they started reviewing CES application (Shelia).
- s.** Question: How can we make changes to the night time intervention requirement? Do we have to wait till the waiver is renewed in 2019 or could we amend the waiver now (Maureen)?
- t.** Comment: There is a need to certify all case managers statewide in Colorado. We need to set a ground level of knowledge/understanding of every waiver and other programs. We should also open the market for independent case management agencies (Maureen).
- u.** Question: What was the reason behind the night time sleep requirement? Parents engage in pharmacological intervention so kids could sleep through the night and it suppresses the true nature of the needs (Ken).
- v.** Answer: The waiver was created in the early nineties. I do not have the rationale behind the sleep requirement or night time behavior requirement. But I believe the waiver was created to service children with the most intense needs. It starting serving 75 kids. It gradually grew to 350 and exploded to 1200 (Sheila).
- w.** Answer: Eliminations of the night time criteria will expand the CES waiver. The Department has to look at the budget impact of expanding the



- waiver. We also have to look at the overall impact that will have on the multiply initiatives the Department is working on. There is an amendment process to make changes on the waiver and it includes the general assembly (Shelia).
- x.** Comment: That implies there are kids not being served if there is a fear that eliminating the night time criteria will increase the waiver (Ken).
  - y.** Question: Is there an appeal process and what options do families have if they don't qualify for CES and EPSDT for behavioral services (Ken)?
  - z.** Answer: Families could be eligible for Medicaid Buy in Program or another waiver (Christy).
  - aa.** Answer: There is an appeal process when you are denied eligibility. The entity that reviews the application notifies the CCB. The CCB notifies the family and include information about the appeal process, timeline, and contact information (Sheila).
  - bb.** Question: Out of the 104 that were denied, how many appealed (Carol)?
  - cc.** Answer: I do not have that information with me (Sheila).
  - dd.** Question: On the CES website, the criteria is broad. Do you have a more detailed list of criteria that includes the information you mentioned above? We could share that with families so they don't have to go through the application process that requires so much effort on their part if they could to be denied (Erika)?
  - ee.** Comment: Families might misunderstand such a document and does not apply to the waiver (Dawn).
  - ff.** Question: Could parents that use drugs so their child could sleep through the night qualify for CES (Dana)?
  - gg.** Answer: There is a misconception that the criteria is based on a child sleeping through the night. It is based on the intervention that is required during the night. There are some interventions that parents provide while the child is asleep. Those typically are medical interventions that are more than a brief observation of status. Reviewers look at what intervention is being provided, check to see if the intervention is due to a behavior that could cause harm to self or others, and check if the intervention meets level of intensity (Sheila).
  - hh.** Answer: If a child made progress due to behavioral therapy which resulted



in a child sleeping through the night, there is a section on the CSR application that needs to be filled out to show CES is doing what it is designed to do. We use to not have that and it was a revolving door (Sheila).

**D. Legislative Update**

- a. Tracking primary care provider rate cuts (Carol).
- b. Tracking bills related to schools that are unfairly tagging kids with IDD, Medicaid provider rates, and hospital provider fees as enterprise funds (Marijo).
- c. Tracking CCB transparency bill and explanation of benefit for Medicaid bill (Maureen).

**E. Waiver Updates (Amendments, renewals, public comment, numbers)**

- a. Waiver Numbers

Waiver	Enrolled	Waitlist
CWA	75	371
CLLI	153	-
CHCBS	1223	-

**4. Outstanding Issues**

- A. Case study of School Health Program and PDN (Erika and Christy)
- B. Underutilization of CHRP waiver and CHRP enrollment numbers.
- C. School Health Programs and private schools.
- D. Follow up meeting for behavioral therapies services on EPSDT (Candace and Gretchen).
  - a. Agenda items for meeting: Rates, UM Criteria, community outreach and messaging, setting (location of service), provider outreach regarding setting, and continuity of care with private insurance.

**5. Agenda items for next meeting**

- A. Private Duty Nursing (tabled from February Meeting)

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B. Medicaid Re-branding

C. Speech therapy being denied on Home Health and codes.

## 6. Adjourn

