Presumptive Eligibility for Medicaid Home- and Community-Based Services: A Cost Estimate for Kentucky

As Kentucky's Medicaid budget strains under the growing pressure of long-term care expenses, state leaders must consider ways to manage costs while improving quality of care for the frail and elderly who require these services. Presumptive eligibility (PE) for patients with long-term care needs is one cost-saving, patient-centered policy option that has been implemented with great success by a number of states.[1] Under the PE model, applicants for Medicaid home- and community-based services (HCBS) are temporarily[2] presumed to be eligible for Medicaid and may begin receiving services immediately, rather than waiting (often up to weeks) for Medicaid eligibility to be finalized. Connecting vulnerable patients with HCBS in a timely fashion is critical, as it prevents costly and inappropriate nursing home admissions, and enables consumers who are at risk for institutionalization to remain in their homes and communities.

Estimating Costs and Savings to Kentucky through Presumptive Eligibility

The major costs associated with PE are service costs during the PE period and administrative costs associated with implementing the program. Savings occur when individual long-term care needs are met outside of institutional settings, which are typically more expensive than community-based care.[3] According to a recent presentation by the Kentucky Department for Aging and Independent Living, the difference in cost between receiving HCBS instead of nursing homes is staggering: the average per capita cost of HCBS is $15,190 per year, while it is $47,187 and $67,525 over that same period for nursing homes funded by Medicaid and private pay, respectively.[4] The same is true in other states. According to a recent article run in the Columbus Dispatch, "nursing-home care costs on average about $64,000 a year [in Ohio] while home-based services run half that amount or less."[5] With those numbers in mind, it is no wonder why Ohio state Medicaid officials are currently devising a plan to move away from the mass-institutionalization of its elderly and sick, and toward the least costly and restrictive alternative: HCBS. Furthermore, back in Kentucky, the Legislative Research Commission recently proposed PE as a means to expand homecare services in the Commonwealth.[6] In early January 2015, the AARP of Kentucky also came out in support of PE as a vital means to provide assistance to family caregivers.[7]

a) Savings to the Kentucky by Expediting Service Delivery

Kentucky will save money by implementing an expedited service delivery process that quickly diverts patients to the most appropriate and least costly setting (usually HCBS), instead of more sending

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[1] Colorado, Georgia, Kansas, Maine, Michigan, New Hampshire, New York, Ohio, Pennsylvania, Vermont, and Washington have all, at one time or another, experimented with presumptive eligibility pilots or programs for patients with long-term care needs.

[2] States typically allow services to be rendered on a presumptive basis for the lesser of 60-90 days or the date of final Medicaid eligibility determination.

[3] See Musumeci, M., & Reaves, E. (2014). *Medicaid Beneficiaries Who Need Home and Community-Based Services: Supporting Independent Living and Community Integration*. Kaiser Family Foundation; Mitchell, G., Salmon, J., Polivka, L., & Soberon-Ferrer, H. (2006). *The relative benefits and cost of Medicaid home- and community-based services in Florida*. The Gerontologist, 46(4), 483–494; Sands, L. P., Xu, H., Weiner, M., Rosenman, M., Craig, B., & Thomas, J. (2008). *Comparison of resource utilization for Medicaid dementia patients using nursing homes versus home and community based waivers for long-term care*. Medical Care, 46(4), 449–453.

[4] Kentucky Department for Aging and Independent Living, April 2014 PowerPoint Presentation.

[5] The Columbus Dispatch, "Ohio Reduces Spending on Nursing Homes." September 11, 2014.

[6] Kentucky Legislative Research Commission, "Supports for Family Caregivers of Elders." Research Memorandum No. 517. December 2014.

[7] Ron Bridges, "Family caregivers need more support." Lexington Herald Leader, Op-Ed. Jan. 4, 2015.

patients to institutional care. These savings may be estimated by calculating the difference between HCBS and nursing facility service costs for certain at-risk consumers.

Since Kentucky does not collect data regarding the community tenure of consumers diverted from nursing facility placements, one way to create a reliable estimate is to use findings from another state that does—and then compare that data with the information that we do have from Kentucky. One study that is uniquely suited to this purpose is the University of Kansas' 2007 evaluation of the Kansas Client Assessment, Referral and Evaluation (CARE) program.[8]

The CARE program was established in 1994 by the Kansas Legislature as an assessment to provide consumers individualized information on long-term care options, determine appropriate placements in long-term care facilities, and collect data regarding individuals being assessed for possible nursing facility (NF) placement. Starting in 2002, the University of Kansas' School of Social Welfare conducted a five-year longitudinal analysis of 599 individuals who had applied for nursing facility placement, received a CARE assessment, and who were diverted from nursing facility care toward home and community alternatives. The purpose of the study was to ascertain the community tenure status of diverted individuals at three month intervals after they received the CARE assessment, up to 60 months after diversion. The results for the first year after a CARE assessment are displayed below:

Table 1: Summary of Community Tenure Status of Diverted CARE Customers at 3, 6, 9, and 12 Months (N=599)

Time Interval After the CARE Assessment	In the Community	Died While Living in Community	Permanent NF Resident	Died While Permanent NF Resident
3 months	499 (83.3%)	80 (13.4%)	20 (3.3%)	0
6 months	427 (71.3%)	106 (17.7%)	64 (10.7%)	2 (0.3%)
9 months	382 (63.8%)	114 (19.0%)	89 (14.9%)	14 (2.3%)
12 months	347 (57.9%)	120 (20.0%)	107 (17.9%)	25 (4.2%)

Assuming the most conservative attrition rates,[9] average community tenure over the course of the year for individuals diverted from nursing facility care in Kansas was 8.29 months.

Using the methodology from an earlier study of a PE pilot program in Kansas (see Appendix 1),[10] money saved in the first year following nursing home diversion can be estimated by multiplying the per month, per capita difference between Medicaid HCBS and Medicaid nursing facility spending by average community tenure following diversion. For this analysis we use Kentucky's share of monthly per capita Medicaid nursing home bed cost and Medicaid-funded HCBS.[11] The results are displayed below:

[8] Macmillan, K.R. et al. *The Community Tenure Study: Community Tenure Status of CARE Assessment Customers 60 Months after Diversion.* (2007). University of Kansas School of Social Welfare Office of Aging and Long Term Care.
[9] That is, assuming that every individual who died or became a permanent NF resident during a given three month period did so within the first month. (Data are provided in three month ranges).
[10] Chapin et al. "*Expedited Service Delivery Pilot Evaluation Final Report*." (1999). University of Kansas School of Social Welfare Office of Aging and Long Term Care.
[11] Anderson, D. (Commissioner, Department for Aging and Independent Living) (2014, June 9). Adapting to Changing Business Models Aging Service Providers Respond. *48th Annual Conference and Exhibition*. Presentation conducted from National Association of Regional Councils, Louisville, Kentucky.

Table 2: Kentucky's Share of Cost Savings per NF-Diverted Medicaid Consumer, Based on Community Tenure in the First Year after Diversion

(A) **Monthly per capita Medicaid nursing home bed cost**	**(B)** **Monthly per capita Medicaid HCBS services**	**(C)** **Difference between state cost of HCBS and NF** *(A)-(B)*	**(D)** **Average months of community tenure after diversion**	**(E)** **State savings per diverted consumer in year one** *(C)x(D)*
$3,932.25	$1,265.83	$2,666.42	8.29	$22,099.29

To understand these numbers in the context of a PE model, we may look to an earlier University of Kansas evaluation of a PE pilot, called Expedited Service Delivery (ESD). Using the same methodology described above, researchers found that given startup and maintenance costs for the PE pilot, the ESD program would have to have diverted only five individuals (or, 2.5% of the 200 persons screened through the pilot) in order for the program to be cost effective for the state. In their analysis, the authors of the study note that statewide scale-up may result in slightly different costs and potential savings to the state, but add, "[t]his illustration is made to point out **how few people have to be actually diverted to make this effort a success**" (emphasis added).[12]

Significantly, none of the customers who received ESD services in the Kansas pilot had entered a nursing facility as of the 45th day after assessment, compared to 11 of those who did not qualify. "This difference," the authors concluded, "suggests that ESD helped older adults in the pilot avoid nursing facility placement. Outcomes and focus group data reflect that ESD was instrumental in helping older adults remain in their homes."[13]

In 2003, the United States Department of Health and Human Services (HHS) published an evaluation of a similar pilot in Colorado.[14] Using grant funds from the HHS Nursing Home Transition Demonstration Program, the state offered a "Fast Track" Medicaid financial eligibility program to pilot participants who were discharged from the hospital. The purpose of this PE program was to eliminate two of the major identified barriers to community placement, namely: (1) that Medicaid financial eligibility determination took a long time **(usually more than six weeks)** and hospital patients often had to leave the hospital before the process was complete; and (2) the functional eligibility determination for HCBS sometimes was not complete before hospital discharge, often taking three weeks.

After conducting the pilot on a total of 115 participants, **the total cost of implementing and managing Fast Track ($106,879) was dwarfed by the savings ($407, 012)**. As in the Kansas pilot, savings were achieved by diverting at-risk patients from costly nursing facility care to a community setting. According to the final evaluation, "State and local staff indicated they believe almost all Fast Track participants would have been admitted to a nursing home without the program."[15]

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[12] Chapin et al. "*Expedited Service Delivery Pilot Evaluation Final Report*." (1999). University of Kansas School of Social Welfare Office of Aging and Long Term Care, 50.

[13] Chapin et al. "*Expedited Service Delivery Pilot Evaluation Final Report*." (1999). University of Kansas School of Social Welfare Office of Aging and Long Term Care, 42-43.

[14] US Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy. (2003). *Fast Track and other Nursing Home Diversion Initiatives: Colorado's Nursing Home Transition Grant*. Prepared by The MEDSTAT Group, Inc.

[15] US Department of Health and Human Services Office of Disability, Aging and Long-Term Care Policy. (2003). *Fast Track and other Nursing Home Diversion Initiatives: Colorado's Nursing Home Transition Grant*. Prepared by The MEDSTAT Group, Inc., 6.

It is worth mentioning that the Kentucky Department for Aging and Independent Living recently reported that, of the 17,050 total slots available for the HCBS waiver, only about 9,475 are currently in use. This leaves approximately 7,575 HCBS waiver slots in Kentucky that are presently not being utilized.

b) Service Costs during the PE period

Following methodology employed by the Kansas ESD pilot evaluation, the following expenses will be incurred during the PE period:

1. **Costs of Conducting the Assessment**

The time and resources needed to complete the PE financial screen depend on the extensiveness of the screening protocols utilized. Generally, states report that the PE screen adds approximately 30 minutes to one hour per client to each assessment,[16] with the exact time depending on a number of factors, including patient cognitive status. Some states, such as Washington, require clients to sign an agreement of understanding indicating that they may owe the state for services rendered during the PE period if they are ultimately found ineligible.

2. **Total cost of in-home services provided to customers receiving expedited services**

In Kentucky, the estimated monthly per consumer cost for providing HCBS is $1,265.83. The total cost to the state for providing HCBS to consumers during the PE period, however, will depend upon how many individuals apply for Medicaid and receive services on a presumptive basis, as well as the proportion of those individuals who would have, if not for expedited access to HCBS, been admitted to the nursing facility. As demonstrated during the Kansas ESD evaluation, however, even if only a small fraction (~2.5%) of these individuals avoided landing in a nursing facility as a result of PE, the policy would be cost-effective.

c) Administrative Costs

Some states have addressed the administrative costs of running a PE program by integrating elements of financial eligibility determination into the functional level-of-care assessments that are required for HCBS waiver applicants.

Of recent note, the Centers for Medicare and Medicaid Services (CMS) Balancing Incentive Program (BIP)[17] requires the following of participating states (including Kentucky):

> *"[D]evelopment of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs."*[18]

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[16] See Chapin et al. "*Expedited Service Delivery Pilot Evaluation Final Report*." (1999). University of Kansas School of Social Welfare Office of Aging and Long Term Care; Stevenson, D., McDonald, J. & Burwell, B. (2002). *Presumptive Eligibility for Individuals with Long-Term Care Needs: Analysis of a Potential Medicaid State Option*. Prepared by the MEDSTAT Group, Inc. for CMS.

[17] The Balancing Incentive Program increases the Federal Matching Assistance Percentage (FMAP) to States that make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports (LTSS). The enhanced matching payments are tied to the percentage of a State's LTSS spending, with lower FMAP increases going to States that need to make fewer reforms.

[18] Mission Analytics Group, *The Balancing Incentive Program: Implementation Manual* (prepared for CMS) (February 2013), 18.

Ohio, another BIP grantee state, is in the process of developing this Core Standardized Assessment (CSA) as part of its BIP obligations. Per BIP requirements, the CSA will be used "in a uniform manner across the state," including for Ohio's HCBS waivers with PE. Should Kentucky decide to incorporate PE financial assessments into its own CSA, additional costs to the state for this component of a PE program would be minimal.

Conclusion

There is an imminent need for Kentucky to expand Medicaid HCBS to alleviate the state's "continuing capacity constraints and the strain from long-term care expenditures on the Medicaid budget."[19] By adopting a PE policy for Medicaid HCBS, the Commonwealth can ensure timely access to critical services for frail and elderly individuals, enabling consumers to remain in their homes and communities while avoiding unnecessary and expensive nursing facility placements. As demonstrated in multiple studies, offering immediate access to home care services, without waiting for the lengthy Medicaid eligibility determination process to be complete, is extremely cost effective for states. If even a small percentage of people screened for PE avoid entering a nursing facility because of expedited access to services, then PE will pay for itself. Beyond the financial savings the state will achieve, this compassionate, patient-centered policy will give consumers the freedom to reject institutionalization and receive services in their homes and communities.

[19] Deloitte, *The Commonwealth of Kentucky Health Care Facility Capacity Report.* (May 2014).

Appendix 1

[Excerpt from the 1999 University of Kansas Report: Chapin et al. "*Expedited Service Delivery Pilot Evaluation Final Report*." (1999). University of Kansas School of Social Welfare Office of Aging and Long Term Care.]

Cost Analysis

A major consideration in evaluating ESD focuses on the overall cost of ESD. A cost-benefit analysis was conducted as part of the Fiscal Year 1998 Expedited Service Delivery project. It utilized a number of assumptions to examine the costs of an expedited service delivery process incurred by the state (as one of the payers of HCBS-FE services). The analysis was developed using cost data provided in the Client Assessment Referral and Evaluation (CARE) Program Annual Report. The State Fiscal Year (SFY) 1998 ESD cost analysis estimated that if approximately 6% of the HCBS-FE applicants assessed for expedited service delivery, or 9% of the expedited service delivery recipients per year were diverted through expedited service delivery, then the costs of providing ESD would be offset by the savings.

The methodology developed for the SFY1998 ESD project was used to conduct a cost analysis of the ESD process tested in the pilot. It is important to point out that since the pilot did not represent a random sample and the actual number of customers expedited in error was small (2), the results of the following cost analysis should not be generalized to the state as a whole. However, specific elements of the pilot data can be used to refine the assumptions employed in the previous years' cost analysis. The following section provides a cost analysis of the pilot.
The state incurred three types of costs related to expediting service delivery. The first cost is based on the Targeted Case Management (TCM) time required to screen older adults for ESD. This first cost is broken into the following components:

- For those older adults found eligible for HCBS/FE, the TCM cost is the additional amount of time required to process the customer as compared to a regular HCBS/FE screening; and
- For those customers found ineligible for HCBS/FE services, the cost is the total amount of the TCM services provided.

The second cost is based on the additional time customers who are found Medicaid eligible will receive in-home services because of ESD. The third expense is the cost of the in-home services provided to customers who incorrectly received expedited services.

The financial analysis focused primarily on the State General Fund share of Medicaid dollars for Targeted Case Management, HCBS-FE and NF services. In order to conduct the analysis, cost data from the SFY 1998 Client Assessment Referral and Evaluation (CARE) Program Annual Report were used. Appendix P provides the plan of care and nursing facility cost data used for this analysis. The figures used in the cost analysis are as follows:

- **The hourly state Medicaid share of Targeted Case Management is $16.40;**

- **The daily (monthly) per customer, State General Fund *and* federal Medicaid share of HCBS-FE services is $22.09 ($672.00);**

- **The daily (monthly), per customer, State General Fund share of HCBS-FE services is $9.06 ($275.52);**

- **The daily (monthly) per customer, State General Fund *and* federal Medicaid share of nursing facility services is $57.40 ($1746.00); and**

- **The daily (monthly), per customer, State General Fund share of nursing facility services is $23.54 ($715.86).**

Costs to the State by Expediting Service Delivery

ESD-Related TCM Costs

- The total TCM costs related to ESD incurred during the pilot is: **$12,967.60** ($10,032 + $2,214 + $721.60) (Please see explanation and tables below)

TCM Costs of ESD applicants found ineligible for HCBS/FE

The ESD pilot data show that the cost to the state of the TCM time spent on customers that were not found eligible for Medicaid, including the two customers expedited in error, was $10,032. This represents the amount spent during the pilot that could not be recouped from Medicaid.

TCM Costs of ESD applicants found eligible for HCBS/FE

As mentioned previously, the TCM costs of ESD for applicants found eligible for HCBS/FE, is based on the additional amount of time required to process the customer as compared to a regular HCBS/FE screening. For the older adults who did not qualify for ESD, it is the time spent completing the ESD Intake Form, ESDFSW, ESD Outcomes Form and any additional time related to ESD such as explaining the ESD process. In other words, it is the TCM time that would not have been spent if there were not a pilot. The pilot-related TCM costs for the older adults who qualified for ESD are the same as those described above with the addition of the time spent getting the ESD POC approval and setting up the ESD services.

The amount of ESD-related TCM time spent on older adults who did not qualify for ESD but were found eligible for HCBS/FE is estimated to be one hour. This figure is based on the following: 1) On average, it took case managers 29 minutes to complete the ESDFSW and 2) Based on discussions with ESD pilot staff, completion of the additional ESD forms for these older adults would not take more than a half hour. (See Table 29)

The amount of ESD-related TCM time spent on older adults who qualified for ESD and were found eligible for HCBS/FE is estimated to be two hours. This estimate is based on the reasons listed above, and the additional time needed to set up the ESD services and complete the ESD process steps. (See Table 30) The ESD cost calculations do not include SRS staff time. When the ESD pilot was planned, it was not anticipated that SRS would incur costs since it was expected that HCBS/FE applications would be processed as usual. SRS staff from one pilot area reported that additional time was expended on their part in processing the ESD customers, regardless of whether they qualified for ESD. Future ESD work will need to track the amount of and need for extra SRS staff time expenditures.

Tables 29 and 30. Targeted Case Management Costs Related to ESD for Persons Found Eligible for HCBS/FE Services.

Number of persons who did not qualify for ESD and were found eligible for HCBS/FE Services	**135**
Hours of ESD-related TCM required, per customer	x 1
Total hours of TCM required	**135**
The hourly state share of TCM costs	x $16.40
Total state share of the ESD-related TCM costs for persons who did not qualify for ESD and were found eligible for HCBS/FE Services	**$2,214**

Number of persons who qualified for ESD and were found eligible for HCBS/FE Services	**22**
Hours of ESD-related TCM required, per customer	x 2
Total hours of TCM required to expedite services	**44**
The hourly state share of TCM costs	x $16.40
Total state share of the ESD-related TCM costs for persons who qualified for ESD and were found eligible for HCBS/FE Services	**$721.60**

ESD-Related In-Home Service Costs

- The total cost to the state of in-home services related to ESD incurred during the pilot is **$2,576.52**. ($384 + $2,192.52) (Please see discussion and table below)

ESD service costs for ESD applicants found HCBS/FE ineligible

As reported earlier on page 21, the total in-home ESD service costs incurred by the state for the customers expedited in error was $384.

ESD service costs for ESD applicants found HCBS/FE eligible

Customers who were expedited received in-home services sooner than they would have if they had to wait for the Medicaid determination to start services. The state share of this additional service time is one of the costs of an ESD program. Data from the pilot showed that on average ESD customers received services for 11 days before the Medicaid HCBS/FE determination was made. Therefore, 11 days is used as the estimate for the additional amount of time Medicaid eligible customers will receive services under ESD as compared to without it. (See Table 31)

Table 31. State Share of the Cost of Providing an Additional 11 Days of Service to Customers Found Eligible for Medicaid HCBS-FE Services

Number of persons correctly receiving expedited service delivery	**22**
The daily state share of HCBS-FE service costs, per customer	x $9.06
State cost per day of persons receiving expedited service delivery	**$199.32**
Multiply by number of additional days services are received through ESD	x 11
Total service-related cost of persons receiving expedited service delivery	**$2,192.52**

- Therefore, the total cost to the state of providing expedited service delivery through the pilot is **$15,544.12** ($12,967.60 + $2,576.52).

Savings to the state by expediting service delivery

The state will save money through an expedited service delivery process by enabling HCBS-FE customers who, *if not for* expedited service delivery, would have entered a nursing facility. The savings are based on the difference between HCBS-FE and nursing facility service costs for these customers. In order to calculate costs, an estimate of the length of time a customer, who *if not for* expedited service delivery would have entered a nursing facility, remains in the community receiving HCBS-FE services is needed. Since Kansas does not collect data regarding the community tenure of customers diverted from nursing facility placement, statistics from Missouri were utilized. After discussion with Missouri Care Options staff about diversion rates and services available in Missouri (see note 1 below) it was determined we should use 213 days as the average amount of time a customer remains in the community receiving services in Missouri1. Therefore, for the following analysis an estimate of seven months is used.

Table 32: State Share of Cost Savings Per Customer, Based on Community Tenure

(A) The monthly state share of NF services, per customer	(B) The monthly state share of HCBS-FE services, per customer	(C) Difference between state cost of HCBS-FE and NF (Subtract Column B from A)	(D) Months of community tenure	(E) State savings (Multiply Columns C by D)
$715.86	$275.52	$440.34	7 months	$3082.38

- If the length of community tenure is seven (7) months, then the state cost savings per customer is **$3082.38**.

Therefore, if 5 of the ESD customers would have entered a nursing facility if not for ESD, then the costs of the pilot would be offset. This represents 21% of those who qualified for ESD or 2.5% of all the applicants screened for ESD.

Calculations:

During the pilot 200 persons were screened for ESD and **24** customers qualified for ESD services. **2** of these customers received services in error, and **22** customers received services "correctly." Of these 22 customers, assume just **5** are diversions and **17** would not have entered a nursing facility.

The calculations below use these diversion figures to estimate the costs and savings/cost avoidance of the pilot expedited service delivery process. The costs are presented first and are followed by the savings/cost avoidance.

Expedited service delivery costs:

- **Total Cost (12,967.60 + 384 + 1,694.22) = $15,045.82**
(Please see calculations below)

- **TCM Costs:** TCM costs of screening all 200 customers = **$ 12,967.60**

HCBS service costs:

- The ESD in-home service costs incurred for the 2 persons expedited in error were **$384.**

- Costs of expediting services to the 17 "non-diversions" = **$1,694.22**

(17 persons $9.06 (HCBS daily state share) 11 days)

Minimum number of diversions necessary to begin to realize cost savings:

- Cost avoidance of expediting services to 5 diversions: 5 $3082.38 = **$15,411.90** (See Table 32. This is the difference between the cost of NF and HCBS-FE services for these 5 customers)

Therefore, if just 5 of the ESD recipients in the pilot would have actually entered a nursing facility and stayed for 7 months, if not for ESD, then the costs of assessing all 200 applicants for expedited service delivery and expediting services for all 24 would be offset.

As of the 45th day after the ESD assessment, none of the customers who received ESD services had entered a nursing facility compared to 11 of those who did not qualify for ESD.

This difference suggests that ESD helped older adults in the pilot avoid nursing facility placement. Outcomes and focus group data reflect that ESD was instrumental in helping older adults remain in their own home. For example, one case manager noted on the ESD Outcomes Form "[the customer] was able to remain at home thanks to Expedited Service Delivery." Another case manager reported that "ESD provided service for an elderly man who was virtually bedbound. He had skilled nursing from home health, but that was ending soon. ESD started before he lost that service. Client was able to stay in his home, which he strongly preferred."

Cost Implications of Expediting Service Delivery

In summary, this cost analysis demonstrates the potential cost avoidance/savings of the pilot ESD process. The pilot data shows that if only 2.5% of the older adults screened for ESD, or 21% of the ESD recipients in the pilot were diverted for seven months through ESD, then the pilot costs were offset by the savings. These figures can be considered the "break-even" point for the expedited service delivery pilot. It is the point at which the state's costs equal the savings of conducting an expedited service delivery process. If ESD were implemented statewide, any changes in the filtering or screening criteria would result in different costs and potential savings to the state. This illustration is made to point out how few people have to be actually diverted to make this effort a success. In addition, expedited service delivery has many benefits for the customer and the state that are not cost related.