

**The Efficacy of Activity Based Accounting Techniques
for Targeted Case Management in Outpatient Settings:**

**A Case Study in Predicting Financial Risk to a Nonprofit Community Health Service
Provider Prompted by Public Policy Change**

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Abstract

This study illustrates how activity based costing (ABC) techniques facilitate the forecast of the financial impact of proposed policy changes. This study was designed to predict the impact of a new reimbursement model on a nonprofit community health service provider in Maryland where a public policy change transitioned nonprofit service reimbursement from capitation to targeted case management. We used ABC accounting techniques to create a workload model using self-report time study data, caseload analysis, and an analysis of the available work hours to project staffing needs. We developed a list of 69 activity codes used by 246 case managers to record 143,326 time entries on work they performed for 11,633 unique clients. Analysis reveals that the proposed reimbursement policy would result in an annual deficit of \$8,468,825, therefore posing an unacceptable financial risk for this agency. Identifying such financial risks can help organizations proactively address the financial viability in an era of innovative payment methodologies.

Key Words: Community Health Services; Financial Management; Activity Based Costing; Nonprofit Organizations; Resource Coordination Staffing; Targeted Case Management; Costing; Workload

Over the past decades, privatization of community health and social services in the United States has been the norm, yet tools for forecasting results are few and of limited scope. The literature on such efforts details its promises, pitfalls, and experiences, including observations on cost savings to government agencies.^{1,2,3,4,5,6} Empirical analyses regarding the decision-making processes that nonprofits use to decide whether or not to accept a contract have received less attention in the literature. As nonprofit community health providers respond to changes in public policy, they can encounter unintended consequences with policy implementation, such as the uncertainty of whether revenues will equal expenditures. Activity-based costing (ABC) techniques, more commonly used in the for-profit sector, offer these providers a method for anticipating heightened financial risks when responding to changes in public policy directed at provision of care for the Medicaid population.

¹ Brown, T. L., & Potoski, M. (2005). Transaction Costs and Contracting: The Practitioner Perspective. *Public Performance & Management Review*, 28(3), 326-351.

² Ferris, J. M., & Graddy, E. (1991). Production Costs, Transaction Costs, and Local Government Contractor Choice. *Economic Inquiry*, 29(3), 541-554.

³ Hefetz, A., & Warner, M. E. (2012). Contracting or Public Delivery? The Importance of Service, Market, and Management Characteristics. *Journal of Public Administration Research and Theory*, 22(2), 289-317.

⁴ Lamothe, S. (2015). How Competitive Is "Competitive" Procurement in the Social Services? *The American Review of Public Administration*, 45(5), 584-606.

⁵ Winston, P., Burwick, A., McConnell, S., & Roper, R. (2002). Privatization of Welfare Services: A Review of the Literature. Retrieved January 15, 2015 from <http://www.mathematica-mpr.com/~media/publications/PDFs/privatization.pdf>

⁶ Witesman, E. M., & Fernandez, S. (2013). Government Contracts with Private Organizations: Are There Differences between Nonprofits and For-Profits? *Nonprofit and Voluntary Sector Quarterly*, 42(4), 689-715.

Activity-based costing (ABC) has been used in manufacturing, government, and, increasingly, health care to improve accuracy when allocating resource costs to products based on resource consumption.^{7,8,9,10,11,12,13,14,15,16,17} ABC assigns resource costs to cost objects—that is, products, services or customers—based on resource consumption.^{18,19} Mullins and Zorn²⁰ labeled the 1938 use of “activity-based income and expense accounts” by the Tennessee Valley Authority as a “public sector innovation” and then considered the pitfalls of ABC in the public sector. Ramsey was an early proponent of utilizing ABC in the hospital environment in response to the financial pressures of managed care contracting.²¹ Others have documented the promise of ABC in health care organizations.^{22,23,24,25} Ross focuses exclusively on applying ABC in the healthcare context and demonstrates the variation in patient costs.¹⁶ Further, he concludes that beyond costing individual patients, ABC’s essential use is to support decision making. Lawson provides the most succinct consideration of the use of ABC in the healthcare environment, including some use in health care settings outside the hospital setting.²⁶ More importantly, Lawson conducts a survey to assess the use of ABC from 1994 through 2004 finding that among the respondents,

⁷ Cardinaels, E., Roodhooft, F., & van Herck, G. (2004). Drivers of Cost System Development in Hospitals: Result of a Survey. *Health Policy*, 69(2), 239-252.

⁸ Carolfi, I. A. (1996). ABM Can Improve Quality and Control Costs. *Cost and Management*, 70(4), 12.

⁹ Eldenburg, L., & Kallapur, S. (1997). Changes in Hospital Service Mix and Cost Allocations in Response to Changes in Medicare Reimbursement Schemes. *Journal of Accounting and Economics*, 23(1), 31-51.

¹⁰ Eldenburg, L., & Krishan, R. (2007). Management Accounting and Control in Health Care: An Economic Perspective. In C. Chapman, A. Hopwood, & M. Shields (Eds.), *Handbook of Management Accounting Research* (Vol. 2.) (pp. 859-883). Oxford: Elsevier.

¹¹ Ittner, C. D., Lanen, W. N., & Larcker, D.F. (2002). The Association between Activity-Based Costing and Manufacturing Performance. *Journal of Accounting Research*, 40(3), 711-726.

¹² Kaplan, R. S., & Porter, M. E. (2011). How to Solve the Cost Crisis in Health Care. *Harvard Business Review*, 89(9), 47-64.

¹³ Kesteloot, K., Lievens, Y., & van der Schueren, E. (2000). Improved Management of Radiotherapy Departments through Accurate Cost Data. *Radiotherapy and Oncology*, 55(3), 251-262.

¹⁴ Naranjo-Gil, D., & Hartmann, F. (2007). How CEOs Use Management Information Systems for Strategy Implementation in Hospitals. *Health Policy*, 81(1), 29-41.

¹⁵ Pirrong, G. (1993). As Easy as ABC: Using Activity-Based Costing in Service Industries. *The National Public Accountant*, 38(2), 22-26.

¹⁶ Ross, T. K. (2004). Analyzing Health Care Operations Using ABC. *Journal of Health Care Finance*, 30(3), 1-20.

¹⁷ Rotch, W. (1990). Activity-Based Costing in Service Industries. *Journal of Cost Management*, 4(2), 4-14.

¹⁸ Blocher, E., Stout, D. E., Cokins, G., & Chen, K. (2006). *Cost Management: A Strategic Emphasis* (4th Ed.). Boston, MA: Mc-Graw Hill/Irwin.

¹⁹ Demeere, N., Stouthuysen, K., & Roodhooft, F. (2009). Time-Driven Activity-Based Costing in an Outpatient Clinic Environment: Development, Relevance and Managerial Impact. *Health Policy*, 92(2-3), 296-304.

²⁰ Mullins, D. R., & Zorn, C. K. (1999). Is Activity-Based Costing up to the Challenge When It Comes to Privatization of Local Government Services? *Public Budgeting & Finance*, 19(2), 37-58.

²¹ Ramsey, R. H. (1994). Activity-based costing for hospitals. *Journal of Healthcare Management*, 39(3), 385.

²² Chan, Y. (1993) Improving hospital cost accounting with activity-based costing, *Health Care Management Review*, 18 (1), 71–77.

²³ Udpa, S. (1996) Activity-based Costing for Hospitals, *Health Care Management Review*, 21 (3), 83–96.

²⁴ Cappelini, R., Chow, C. & McNamee, A. (1998). On the need and opportunities for improving costing and cost management in healthcare organizations, *Managerial Finance*, 24 (1), 46–59.

²⁵ Lievens, Y., Van Den Bogaert, W. , Kesteloot, K. (2003) Activity-Based Costing: a Practical Model for Cost Calculation in Radiotherapy, *International Journal of Radiation Oncology Biology Physics*, 57 (2), 522–535.

²⁶ Lawson, R. A. (2005). The Use of Activity Based Costing in the Healthcare Industry: 1994 vs. 2004. *Research in Healthcare Financial Management*, 10(1), 77-94. Retrieved from <http://utsph.idm.oclc.org/login?url=http://search.proquest.com.utsph.idm.oclc.org/docview/200588947?accountid=7134>

while familiarity with ABC has increased actual use has declined. He hypothesizes that the decline might be attributable to the focus of ABC on cost control. More recently, ABC has led to the newer variant time-driven activity based cost accounting.^{27,28,29}

The purpose of this case study was to use ABC techniques as a tool to forecast the impact of a public policy change on a nonprofit community health provider of case management services. This study was prompted by a State of Maryland public policy change effective July 1, 2013. Under the previous law, Medicaid reimbursement for resource coordination services varied by region. In some regions, resource coordination services were reimbursed by waiver services and, in other regions, by targeted case management (TCM) as a state plan Medicaid service. The public policy change would result in a consistent TCM state plan resource coordination service reimbursement for providers of case management services to Medicaid eligible recipients with intellectual and developmental disabilities in Maryland.

Methods

In 2006, the nonprofit provider community health provider (NPCHP) began delivering services to individuals with intellectual and developmental disabilities and billing the State of Maryland utilizing capitation. In order to estimate the impact of the transition from capitation to the TCM reimbursement model, we conducted this study prior to the implementation of the TCM model. Although the NPCHP was still operating under capitation, we developed a time tracking system to identify tasks in client services, associated these tasks with future TCM billable service categories, and projected reimbursement under the TCM model.

The study period was from April 1, 2013, to June 28, 2013. We collected 143,326 time entries completed by 246 service coordinators and senior service coordinators for 11,633 unique clients. The encounters occurred in one of thirteen locations throughout the State of Maryland. Data collection was automated. Each service coordinator was assigned a unique login ID to access the time tracking system used in this study.

Key Assumptions

The revenue projection model assumptions were as follows. First, we assumed the volume and type of work performed by service coordinators under the capitated payment model would remain unchanged in the TCM reimbursement model. Second, we assumed the proportion of direct and indirect time spent in total would remain relatively constant regardless of reimbursement model. Third, we assumed that annual expenses would remain unchanged. Specific assumptions for reimbursement rates, number of comprehensive assessments, and operational days are outlined in Table 1.

²⁷ Kaplan, R. S., & Anderson, S. R. (2004). Time-driven activity-based cost. Boston, MA: Harvard Business Review Press, November, pp. 131-8.

²⁸ Kaplan, R. S., & Anderson, S. R. (2007). The Innovation of Time-Driven Activity-Based Costing. *Journal of Cost Management*, 21(2), 5-15.

²⁹ Kaplan, R. S. (2014). Improving Value with TDABC. *Healthcare Financial Management*, 68(6), 76-83.

Table 1. Revenue Projection Model Assumptions

Hourly Reimbursement Rate	\$58.51
Contractor Annual Expenses	\$19,644,595
Comprehensive Assessments Conducted Per Year	320
Reimbursement Rate – Comprehensive Assessment	\$450
Operational Days Per Year*	249

*(5 days x 52 weeks) – 11 holidays

Data Collection

Three levels of trained staff provided service delivery during client encounters. Table 2 outlines the job title and number of staff involved in the data-gathering phase.

Table 2. Service Delivery Staff

Job Title	Number of Staff	Percent of Staff
Senior Service Coordinator	45	16.6
Service Coordinator	199	73.4
Service Coordinator Supervisor	27	10.0
Total	271	100.0

Identification of TCM Billable Services

All client service processes were identified and then associated with one of sixty-nine TCM task codes (see Appendix A). During the study period, senior service coordinators and service coordinators utilized a pilot time tracking system to record paid time. A simple data entry screen allowed service coordinators to enter client IDs, start and end times, and task codes.

On a weekly basis, we extracted the individual entries. Using the service coordinator code, we calculated time spent by all employees. We then computed the number of direct (billable) and indirect (non-billable) hours. Billable hours were categorized into one of six TCM service categories: (1) comprehensive assessment, (2) waiting list–crisis prevention, (3) waiting list–crisis resolution, (4) waiting list–current request, (5) transition, and (6) community coordination (see Table 3).

Revenue Projection Calculations

Under the new TCM reimbursement model, comprehensive assessments are reimbursed by the Maryland Developmental Disabilities Administration at a flat rate of \$450.00. All remaining billable service categories are reimbursed at the TCM rate of \$58.51 per billable hour.

Table 3. Billable Service Categories and Service Description

Billable Service Category	Service Description*
Comprehensive Assessment	Individuals applying for DDA services and is an assessment of individual needs and supports to determine eligibility as noted in COMAR 10.09.48 and 10.22.12
Waiting List–Crisis Prevention	Individuals who meet DDA eligibility and currently receive no ongoing DDA funding for community services, who are at risk for meeting at least one criteria for crisis resolution within one year, and/or whose caregivers are 65 years of age or older
Waiting List–Crisis Resolution	Individuals who are homeless or at risk of becoming homeless, who are at risk of harming themselves or others, and/or whose caregivers are elderly or unable to provide care
Waiting List–Current Request	Individuals who have applied for DDA services but do not meet DDA eligibility
Transition	Individuals moving from an institutional to community setting
Community Coordination	Individuals approved for DDA funding for individual plan, referral, and monitoring

*<http://dda.dhmh.maryland.gov/SitePages/Developments/Dec%202013/Comprehensive%20Assessment%20%2011-8-2013.pdf> and the Department of Health and Mental Hygiene, Developmental Disabilities Administration

The revenue projection analysis began by calculating the billable hours recorded weekly by services coordinators during the study period. These excluded hours attributable to comprehensive assessments, which were billed at the flat rate. We then annualized the number of billable hours, assuming constant per week billable hours for 52 weeks. The calculated projected average annual billable hours per week came to 3,724.99. We next applied the DDA reimbursement rate of \$58.51 rate and—under the assumptions described above—arrived at \$11,031,770 projected annual revenue for the billing service categories reimbursed under the new TCM hourly rate. Projected annual revenue from comprehensive assessments was calculated as \$144,000—the TCM projected reimbursement of \$450 per comprehensive assessment multiplied by the actual volume of 320 comprehensive assessments (see Table 1 for assumptions).

Findings

Using the assumptions described in the Methods section and employing ABC tools to identify activities and resources used to deliver client services, we projected and annualized revenues that would have been generated during the study period using TCM reimbursement rates. We used actual expenses as noted in Table 1. With these calculations in place, this model projected an anticipated deficit of \$8,468,825 for the first full year of the transition from capitation to the TCM reimbursement model. Results are presented in Table 4.

Table 4. Forecasted Revenue, Actual Expenses and Projected Annual Excess/Deficit

Pro- jected Total Weekly Billable Hours (a)	Projected Annual Revenue from Comprehensive Assessments (b)	Projected Annual Revenue from All Other Service Codes (@ \$58.51) (c)	Projected Total Annual Revenue (b+c) (d)	Actual Annual Expenses (e)	Projected Annual Excess/(Deficit) (d-e)
3,724.99	\$144,000	\$11,031,770	\$11,175,770	\$19,644,595	(\$8,468,825)

Discussion

Nonprofit community health service providers of social services are particularly in need of financial modeling tools to forecast the impact of both revenue and cost changes. Constructing a pro forma statement of financial activities—a projected summary of revenue and expenses under anticipated conditions—can accomplish this task. The pro forma relies on forecasted revenue assuming any price and/or volume changes.

In this case study, the TCM reimbursement model was the basis for the forecasted revenue. ABC costing techniques allowed us to quantify revenue changes more accurately. Given that the NPCHP is contracting with the State of Maryland, price changes would not impact volume, and thus, there was no anticipated variation in demand. Forecasted expenses were assumed equal to actual expenses for the study period, and we assumed no new capacity would be created by the change from capitation to the TCM model.

Under the TCM model, we predict an immediate shift for the NPCHP from self-sustaining to a deficit position. At best, the implementation of TCM in this NPCHP portends urgent organizational change for it to survive the implementation of this particular public policy change. At worst, if the NPCHP is unable to institute immediate structural changes to deliver client services, the organization will not survive and the volume of services provided will default to the state or other existing nonprofits. Either way, the NPCHP is at unacceptable financial risk.

It is not uncommon for privatization of community health and social services to result in financial risk for the nonprofit provider dependent on one source of funding for operating revenue. The literature on the theory of resource dependency clearly articulates that an organization’s autonomy is inversely proportional to the variety of funding sources.^{30,31,32} This

³⁰ Gronbjerg, K. A., & Salamon, L. M. (2002). Devolution, Marketization, and the Changing Shape of Government-Nonprofit Relations. In L. M. Salamon (Ed.), *The State of Nonprofit America* (pp. 447–470). Washington, DC: Brookings Institution Press.

³¹ Meezan, W., & McBeath, B. (2011). Moving toward Performance-Based, Managed Care Contracting in Child Welfare: Perspectives on Staffing, Financial Management, and Information Technology. *Administration in Social Work*, 35(2), 180-206.

³² Smith, S. R. (2002). Social Services. In L. M. Salamon (Ed.), *The State of Nonprofit America* (pp. 151-188). Washington, DC: Brookings Institution Press.

NPCHP's reliance on a single funding source creates exquisite sensitivity to any change in the revenue stream.

Devine, Ealey and O'Closk propose a framework utilizing ABC and ABC cost management to enhance not only cost management but operating decisions and strategic management in the health care environment.³³ This case study demonstrates the efficacy of ABC techniques in TCM reimbursement scenarios. As expected, using ABC techniques to identify processes and assign TCM billable service categories defined product costs. Product costs could then be combined with projected revenues to support strategic decision making on the part of the NPCHP. Gathering this data positions the NPCHP to identify potential service delivery efficiency improvements. Variations in time spent on the TCM tasks shown in Appendix A were captured in the data collection process. Minimizing these variations could create additional capacity for service delivery and, thus, increased revenue under the TCM reimbursement model.

Conclusions

ABC costing tools offer a methodology to identify processes, assign TCM billable service categories, estimate revenues and costs in a transition from capitation to a TCM reimbursement model. Further, in this case study, ABC costing tools facilitated the prediction of the financial risk involved for a NPCHP transitioning from a capitated to TCM reimbursement model. This is especially important for those NPCHPs reliant on public contracting and subject to financial risk. Baker and Boyd have previously reported the primary use of ABC in a hospital setting to support strategic planning and managed care contract negotiations as well as managed care contract management.³⁴ This case study demonstrates that ABC techniques can be equally useful in an outpatient setting.

Limitations

Bias can influence projections used in this case study.^{19,35,36} Service coordinators self-reported their time spent in client encounters. This reporting is subject to recall bias, can affect the accuracy of billable service categories, and, therefore, can affect revenue projections. Additionally, self-reporting can skew billable and non-billable time.

This NPCHP's relatively simple service delivery model of six specific service categories facilitates the use of ABC techniques to identify the actual cost of providing specific services. Nonprofits providing a larger number of service categories and/or comprised of more than sixty-nine tasks could find the data gathering required by this model to be daunting.

³³ Devine, K., Ealey, T. & O'Clock, P. (2008). A Framework for Cost Management and Decision Support Across Health Care Organizations of Varying Size and Scope, *Journal of health care finance*, 35(2).

³⁴ Baker, J. J., & Boyd, G.F. (1997). Activity-Based Costing in the Operating Room at Valley View Hospital, *Journal of Health Care Finance*, 24(1), 1-9.

³⁵ Kaplan, R. S., & Anderson, S. R. (2007). *Time-driven activity-based costing: A simpler and more powerful path to higher profits*. Boston, MA: Harvard Business Review Press.

³⁶ Everaert, P., Bruggeman, W., Sarens, G., Anderson, S. R., & Levant, Y. (2008). Cost Modeling in Logistics Using Time-Driven ABC. Experiences from a Wholesaler. *International Journal of Physical Distribution & Logistics Management*, 38(3), 172-191.

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Appendix A: TCM Task Codes and Service Category

Service Coordinator Codes		Service Category
1110	Initial Visit Work	Comprehensive Assessment
1115	CNR Work	Comprehensive Assessment
1116	Gathering Eligibility Information	Comprehensive Assessment
1130	Service Location/Referral and Related Activities	Comprehensive Assessment
1180	Document Efforts/Progress Notes	Comprehensive Assessment
1190	Travel	Comprehensive Assessment
1199	DDA Eligibility - Other	Comprehensive Assessment
1210	Visit Work	Wait List - Monitor and Follow Up
1220	Individual Plan Work	Wait List - Individual Plan
1230	Service Location/Referral and Related Activities	Wait List - Referral and Related
1240	Monitor and Follow-Up Activities	Wait List - Monitor and Follow Up
1250	Waiver Work	Wait List – Maintain Waiver Eligibility
1260	Service Funding Plan (SFP) Work	Wait List - Individual Plan
1271	CNR Work - Update	Wait List - Monitor and Follow Up
1280	Document Efforts/Progress Notes	Wait List - Monitor and Follow Up
1299	Wait List Services – Other	Wait List - Monitor and Follow Up
1310	Visit Work	Transition - Monitor and Follow Up
1320	Individual Plan Work	Transition - Individual Plan
1330	Service Location/Referral and Related Activities	Transition - Referral and Related
1340	Monitor and Follow-Up Activities	Transition - Monitor and Follow Up
1350	Waiver Work	Transition - Maintain Waiver Eligibility
1360	Service Funding Plan (SFP) Work	Transition - Individual Plan
1370	Request for Service Change (RFSC) Work	Transition - Monitor and Follow Up
1371	Complete Written Plan of Habilitation (WPH)	Transition - Individual Plan
1380	Document Efforts/Progress Notes	Transition - Monitor and Follow Up
1390	Travel	Transition - Non-Billable Travel
1399	Active Transition – Other	Transition - Monitor and Follow Up
1410	Visit Work	Community Coordination – Monitor and Follow Up
1420	Individual Plan Work	Community Coordination – Individual Plan
1430	Service Location/Referral and Related Activities	Community Coordination – Referral and Related
1440	Monitor and Follow-Up Activities	Community Coordination – Monitor and Follow Up
1441	Matrix Work	Community Coordination – Referral and Related

Service Coordinator Codes		Service Category
1450	Waiver Work	Community Coordination – Maintain Waiver Eligibility
1460	Service Funding Plan (SFP) Work	Community Coordination – Individual Plan
1470	Request for Service Change (RFSC) Work	Community Coordination – Monitor and Follow Up
1471	Obtain Documentation from Others	Community Coordination – Monitor and Follow Up
1480	Document Efforts/Progress Notes	Community Coordination – Monitor and Follow Up
1490	Travel	Community Coordination – Non-Billable Travel
1499	Community Coordination – Other	Community Coordination – Monitor and Follow Up
1901	Reporting - Export/Prepare Reports	Administrative – Not Related to a Specific Client
1902	Reporting - Reviewer Work	Administrative – Not Related to a Specific Client
1903	Reporting - Other Reporting	Administrative – Not Related to a Specific Client
1910	Staff Development - Staff Meeting	Administrative – Not Related to a Specific Client
1911	Staff Development – Attend Training	Administrative – Not Related to a Specific Client
1912	Staff Development – Conduct Training	Administrative – Not Related to a Specific Client
1913	Staff Development – Supervision	Administrative – Not Related to a Specific Client
1914	Staff Development – Monitor/Observe New Staff	Administrative – Not Related to a Specific Client
1915	Staff Development - Small Group Meetings	Administrative – Not Related to a Specific Client
1916	Staff Development – File Reviews	Administrative – Not Related to a Specific Client
1917	Staff Development – Other	Administrative – Not Related to a Specific Client
1920	Material/Resource Development – Network With Community/External Groups	Administrative – Not Related to a Specific Client
1921	Material/Resource Development – Other	Administrative – Not Related to a Specific Client
1930	Communications – Conferences/Fairs/Presentations	Administrative – Not Related to a Specific Client
1931	Communications – Document Preparation	Administrative – Not Related to a Specific Client

Service Coordinator Codes		Service Category
1932	Communications – Other	Administrative – Not Related to a Specific Client
1933	Communications – Computer Projects	Administrative – Not Related to a Specific Client
1950	Other Duties – Respond to Public Inquiries	Administrative – Not Related to a Specific Client
1951	Other Duties – Covering for Staff	Administrative – Not Related to a Specific Client
1952	Other Duties – Serve on External Committees	Administrative – Not Related to a Specific Client
1953	Other Duties – Serve on Internal Committees	Administrative – Not Related to a Specific Client
1954	Other Duties – Serve as Interpreter	Billable - Interpreter
1955	Other Duties – Timesheet/Reimbursement Tasks	Administrative – Not Related to a Specific Client
1956	Other Duties – Workload Study	Administrative – Not Related to a Specific Client
1957	Other Duties – Other	Administrative – Not Related to a Specific Client
1990	Break	Non-Billable - Break
1991	Leave/Holiday (Paid and Unpaid)	Non-Billable - Leave
1992	Employee Interaction(Not Case Related)	Administrative
1993	Lunch	Non-Billable - Lunch