VIRGINIA RHC PROFILE

Inside a Typical Virginia RHC: Who's Actually on the Team

Independent Virginia RHCs run lean — roughly 3 FTE primary care providers (mostly NPs/PAs) supported by 3–6 clinical and administrative staff. Understanding this team structure is essential context for any solution claiming to reduce burden.

Clinical Support (2–4 Staff)

NURSING & CARE TEAM

- **2–4 RNs, LPNs, or Medical Assistants** across the week
- Responsibilities: rooming patients, vitals, basic procedures, care coordination, and care management
- Often cross-trained to cover multiple roles given lean staffing
- Critical buffer between providers and administrative demands

Admin & RCM (1–3 Staff)

OPERATIONS & BILLING

- **1–3 front-office and billing staff** handling registration, scheduling, referrals, prior authorizations, and claim submission/collections
- Frequently cross-trained across front-desk and billing functions
- This is the team most directly impacted by billing errors, denials, and compliance burden
- Often the first to experience "administrative drag" from improper claims

The pitch-ready description: "A small rural clinic team built around roughly 3 FTE primary-care providers (mostly NP/PA), supported by 3–6 clinical and administrative staff — consistent with national independent RHC benchmarks where about two-thirds of provider FTEs are NPs/PAs rather than physicians."

VIRGINIA RHC PROFILE

A Typical Virginia RHC: Small Team, Big Responsibility

Independent Virginia RHCs typically operate with roughly 2–4 primary care FTE providers — a mix of physicians, NPs, and PAs — serving a panel of ~7,000 patients. Understanding this staffing reality is essential to positioning any solution that claims to reduce burden.

Staffing by the Numbers

~7,000

Patients Per RHC

National average panel size for an independent RHC — the baseline for all productivity and ROI modeling

3 FTEs

Typical Provider Mix

Roughly 3 FTE primary care providers (physicians, NPs, PAs) is the accurate benchmark for a 7,000-patient Virginia RHC

1,300–1,500

Patients Per Provider FTE

Typical primary care panel capacity per FTE — the math that anchors the 3-FTE benchmark for a 7,000-patient clinic

For grant applications and sales conversations: "A small team of roughly 3 FTE primary care providers — a mix of physicians, NPs, and PAs — consistent with national RHC benchmarks for a 7,000-patient panel."

UNIT ECONOMICS

What IT Costs Are Reimbursable — And How to Frame Your Product

Reimbursable IT expenses are those that qualify as allowable RHC costs on the Medicare/Medicaid cost report — directly supporting RHC-billable services (the AIR), reasonable in amount, and properly allocated.

What Qualifies as Allowable RHC IT Cost

Core Clinical & Billing Systems

EHR and practice management software licenses, revenue cycle/billing software for RHC claims and denial management, e-prescribing, e-labs, and clinical decision-support tools integrated into RHC care workflows.

Infrastructure & Hardware

Computers, tablets, networking equipment used for RHC scheduling, documentation, and billing. Server/cloud hosting, data storage, backup services, and internet connectivity reasonably necessary for RHC operations (allocated if shared with non-RHC departments).

IT Staff, Support & Training

Salaries/benefits for in-house IT staff or contracted support allocated to RHC operations. Vendor implementation fees, upgrades, and staff training for systems required to operate the RHC — EHR, PM, billing, compliance tools.

Security, Compliance & Data Protection

Cybersecurity tools (MFA, endpoint protection, firewalls, backup/DR, security monitoring) to protect RHC systems and meet HIPAA obligations. Compliance and audit tools that maintain documentation, coding, and billing accuracy for RHC services.

How to Frame Your Product on the Cost Report

- The portion of your platform used for **RHC-billable encounters** (billing accuracy, compliance support, documentation, productivity insights) qualifies as an **allowable RHC IT/administrative expense**
- Include this portion on both the **Medicare RHC cost report (CMS-222-17)** and the **Virginia Medicaid RHC cost report (DMAS-222)** — which follows the same cost-allocation rules
- Any modules or usage tied to **telehealth, CCM, or other non-AIR services** must be separated and reported as non-RHC costs

CMS-222-17DMAS-222

Medicare Cost Report: The annual Medicare RHC cost report where allowable IT costs are reported to set your per-visit AIR

Virginia Medicaid Cost Report: Virginia's parallel cost report — follows the same allowable cost principles as Medicare

The bottom line for sales conversations: "The portion of this platform supporting your RHC-billable visits is an allowable cost on both your Medicare and Virginia Medicaid cost reports — meaning CMS and DMAS help pay for it over time, not just your operating budget."

UNIT ECONOMICS

Know What's Not Reimbursable — And Structure Around It

Not all IT costs qualify as allowable RHC expenses. Costs tied to services paid outside the AIR — or to non-patient-care activities — must be carved out of the cost report and will not contribute to a higher per-visit rate.

What Gets Carved Out

IT Tied to Non-RHC Services

Telehealth paid outside the AIR (G2025, G0071), Chronic Care Management (G0511), and any platform fees, software modules, or staff time directly supporting these services — must be classified in Non-RHC cost centers.

IT for Technical Components

Lab, X-ray, and EKG technical components billed separately as Part B services. Any IT or equipment costs used primarily for these must be kept in non-RHC cost centers.

Non-Patient-Care Activities

Marketing/advertising systems, CRM for patient acquisition, fundraising platforms, fines and penalty-related IT, and any IT supporting non-healthcare business lines housed in the same entity.

How to Structure Your Product for Maximum Reimbursability

- The share of your platform used for **RHC-billable visits** (core billing, documentation, compliance) → treat as allowable RHC IT/overhead, include in cost report
- The share used for **telehealth, CCM, virtual care, or other non-AIR services** → carve out as non-RHC; that portion will not be reimbursed through the per-visit rate
- Structure your internal GL so the **bulk of platform cost is allocable to RHC encounters** — and clearly separate any modules tied to non-RHC services

The positioning imperative: Explicitly allocate your product's cost structure so the majority is tied to RHC-billable encounters. The cleaner the allocation, the stronger the cost-report case — and the more compelling the ROI conversation with clinic administrators.

UNIT ECONOMICS

What Average RCM Software Actually Delivers on Denials

Most modern RCM and billing platforms move organizations from a high single-digit or low double-digit denial rate down into the 4–7% range — roughly a 30–50% reduction in denials from typical starting points. Here's what that means for a Virginia RHC.

Translating Denials Into Revenue

8–12%	4–7%	2–4%
Typical Starting Denial Rate	**Realistic Target Band**	**Net Revenue Recaptured**
Where most independent RHCs begin before implementing modern RCM tools — often higher due to lean billing staff	Achievable with modern RCM software — a 2–5 percentage-point drop representing 25–50% fewer denials	Translating the denial reduction into recovered revenue — the core ROI driver for the 3C value proposition

The 3C positioning: Average RCM software delivers a ~30–40% denial reduction (e.g., 10% → 6–7%). A focused 3C tool aims to push Virginia RHCs closer to the **sub-5% band** — and keep them there.

3C IT Is Priced Below the Market — By Design

For a small independent RHC with ~3 FTE providers, mainstream RCM competitors typically land in the $40,000–$60,000/year range once billing services and add-ons are included. At $35,000/year, 3C IT undercuts the market while targeting rural RHC workflows specifically.

athenahealth

~$150K–$250K+/year (effective RCM cost)

- EHR/PM license: ~$140/provider/month (~$5–6K/year for 3 providers)
- RCM priced as **4–7% of collections** — for a $3–4M clinic, that's $120K–$280K/year in effective RCM fees
- Even heavily discounted, the all-in RCM cost is **well above $35K/year**

DrChrono

~$15,000–$30,000+/year (software only)

- $199–$600+/provider/month depending on tier
- For 3 providers: $7,164/year at low end (software only)
- Add billing/RCM tiers, clearinghouse fees, texting/statement overages, and analytics → **$15K–$30K+ before coding/compliance tools**
- Full 3C-equivalent stack pushes into the **$40K–$60K/year** range

Waystar

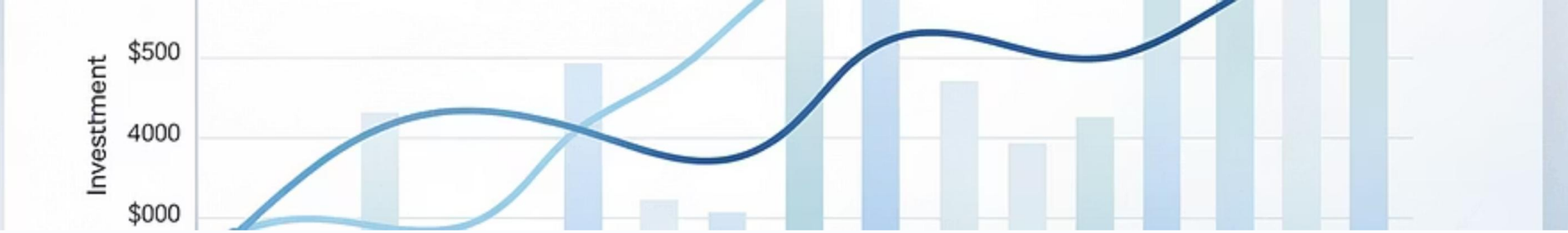
~$40,000–$60,000/year (3C-equivalent)

- Quote-based; marketed as ~33% less than average RCM products
- Per-transaction and per-ID fees for 24,500 claims/year → **five-figure annual range**
- Clinics still need separate coding/compliance tools — pushing total 3C-equivalent spend to **$40K–$60K/year**

Mainstream 3C-equivalent stack for a 3-provider RHC: $40,000–$60,000/year — when fully configured with coding, compliance, and collections tools.

3C IT: $35,000/year flat — purpose-built for rural RHC workflows, undercutting average alternatives with no percentage-of-collections surprises.

> Mainstream RCM and coding/compliance software packages for a 3-provider rural clinic typically cost **$40,000–$60,000 per year** when fully configured. **3C IT is priced at $35,000 per year** — undercutting average alternatives while targeting rural RHC workflows specifically.



UNIT ECONOMICS

Your $35K IT Investment Can Be Cost-Report Recoverable

Within Virginia, a substantial portion of RHC IT costs can be reimbursed or cost-based recovered through CMS and Virginia Medicaid — when treated as allowable RHC costs and properly allocated on the annual cost report.

How Medicare RHC Reimbursement Works

- RHCs are paid a **per-visit All-Inclusive Rate (AIR)** based on allowable costs divided by RHC visits, reported annually on Form CMS-222-17
- Allowable costs include EHR licenses, practice management systems, core clinical/RCM IT, network, hardware, and IT staff — when allocated to RHC services
- These aren't separate "IT line items" — they're **built into your AIR**: higher allowable IT costs increase the cost base used to set your Medicare rate
- ⚠️ Costs tied to non-RHC services (e.g., telehealth G2025, CCM G0511) must be carved out and do not roll into the AIR cost base

Virginia Medicaid Mirrors the Same Logic

- Virginia uses a **prospective payment system (PPS)** for RHCs; the Commonwealth pays the **higher of the PPS rate or the alternative per-visit rate**
- IT costs supporting core RHC encounters (documentation, billing, compliance, scheduling) are generally allowable and can be included in the DMAS-222 cost report
- Over 1–2 cost-report cycles, allowable IT costs contribute to a **higher AIR/PPS rate** — effectively letting CMS and Virginia Medicaid reimburse part of the IT spend through higher per-visit payments

What to say in every sales conversation: "Much of this IT investment can be treated as allowable RHC cost and recovered over time through Medicare and Virginia Medicaid cost-based rate setting — rather than being a pure out-of-pocket expense — provided it supports RHC-billable services and is correctly reported on the cost report."

Why 3C IT Wins in Rural Health — Where Generic RCM Falls Short

3C IT's main competitive advantages are its RHC-specific design, integrated three-pillar focus (coding, compliance, collections), and lower flat pricing relative to generic RCM stacks targeting small practices.

Purpose-Built for RHC Rules

Most RCM/EHR vendors serve broad ambulatory markets and bolt on RHC functionality as an afterthought. 3C is designed from the ground up for **RHC billing rules, AIR/cost-report implications, and rural staffing constraints** — no configuration consulting required.

$35K Flat — Below Market

Average RCM + coding stacks for small practices land at **$40K–$60K+/year** once per-provider fees, clearinghouse charges, and add-ons are included. At $35K flat per year, 3C undercuts typical all-in alternatives while delivering RHC-specific features — a clear advantage for resource-constrained independent Virginia RHCs.

One Platform, Closed Loop

Competitors separate coding/compliance tools (Optum, AAPC Codify) from denial management and collections (Waystar, athenahealth). 3C **closes the loop** — one system that flags coding issues, tracks denials, and ties them back to root causes in documentation and charge capture. No platform juggling for a lean team.

Built for Lean Rural Teams

Rural clinics often have minimal dedicated billing staff — front-desk and MAs carry pieces of the revenue cycle. 3C surfaces **high-value tasks for non-specialist staff** (fix these 10 claims, correct this code set) instead of requiring a full in-house RCM team. Automation does the heavy lifting.

Cost-Report & AIR Intelligence

Most RCM tools focus on claim throughput. 3C maps improvements in denials, coding, and visit mix directly into **cost-report and AIR implications** — helping clinics defend IT as allowable cost and demonstrate ROI in cost-based reimbursement terms.

3C IT delivers RHC-specific coding, compliance, and collections intelligence in a single low-cost platform designed for tiny rural teams — where generic RCM tools are more expensive, less focused on RHC rules, and often fragmented across multiple vendors.

At Industry-Average Pricing, the ROI Case Gets Even Stronger

Industry-average 3C IT costs for small RHC-scale clinics run $40,000–$60,000/year all-in. At $50,000/year as the benchmark — and our $35K price point below that — the ROI is compelling across every scenario.

Baseline: 7,000 patients × 3.5 visits = 24,500 visits/year | $150 collected/visit | $3.68M baseline revenue | 6% denial rate | 19% no-show rate | 3C IT cost: $50,000/year

Conservative Case

~190% ROI

- Denials: 6% → 4% (+$73,600/year recovered)
- Visit lift: +2% → 490 extra visits (+$73,500/year)

Gross benefit: $147,100

Net gain: $97,100

Payback: **6–7 months**

Typical 6% denial and 19% no-show rates with modest improvement

Moderate Case

~415% ROI

- Denials: 6% → 3% (+$110,400/year recovered)
- Visit lift: +4% → 980 extra visits (+$147,000/year)

Gross benefit: $257,400

Net gain: $207,400

Payback: **Less than 3 months**

Denial rates drop toward 3%, no-shows toward 15% — common for high performers

High-Impact Case

~635% ROI

- Denials: 6% → 2% (+$147,200/year recovered)
- Visit lift: +6% → 1,470 extra visits (+$220,500/year)

Gross benefit: $367,700

Net gain: $317,700

Payback: **~2 months**

Best-in-class coding and collections benchmarks

Our price ($35K) is below industry average ($50K) — meaning the ROI is even stronger than these already-conservative benchmarks.

Even at full industry-average pricing, 3C delivers ~190–635% ROI for a typical 7,000-patient Virginia RHC.

3C IT Plugs In — No EHR Replacement Required

3C IT is positioned as an RCM add-on that sits alongside existing EHRs — pulling just enough clinical and billing data to drive coding, compliance, and collections insights, without replacing the system clinics already depend on.

1

Connect via Standard Interfaces

3C connects to any existing EHR/PM (Epic, athenaOne, eClinicalWorks, NextGen, DrChrono, etc.) via **HL7 v2 messages** (ADT, SIU, DFT/charge), **837/835 claim feeds**, and/or **FHIR APIs** — all standard protocols supported by modern EHR systems.

2

Read Visit, Coding & Payment Data

Data flows **EHR → 3C** for analytics: patient demographics, insurance, encounter metadata, diagnosis/procedure codes, charge data, and claim/remittance status. Limited write-backs (worklists, flags, recommended corrections) where the EHR allows.

3

Surface Actionable Insights

3C analyzes the incoming data to flag coding gaps, compliance risks, and denial patterns — delivering prioritized worklists to lean RHC staff without requiring workflow changes or new data entry.

Weeks

Not Months

Configuration and testing of HL7/FHIR interfaces typically completes in weeks when starting with a narrow scope — visit and claim feeds first, then enrich.

Any EHR

HL7 v2 or FHIR

If the clinic's EHR supports standard HL7 v2 or FHIR APIs, 3C can integrate — covering virtually all modern EHR/PM systems used by Virginia RHCs.

HIPAA-BA

Compliant by Design

3C operates as a HIPAA-compliant Business Associate — encrypted connections, least-privilege access, and full audi logging as standard.

3C IT plugs into the clinic's existing EHR and billing system using standard HL7 and FHIR interfaces. It reads visit, coding, and payment data to surface coding, compliance, and collections opportunities — without requiring an EHR replacement or major workflow change.

3C IT vs. The Alternatives — Head to Head

For a 3-provider independent Virginia RHC with ~7,000 patients/year, here's how 3C IT stacks up against leading RCM and coding platforms across cost, capabilities, and rural fit.

Vendor	Annual Cost (3-Provider RHC)	Pricing Model	Coding & Compliance	Denial Management	Rural/RHC Focus
3C IT ⭐	**$35,000 flat/year** (all-in)	Flat annual subscription — no % of collections	Built-in CPT/ICD/HCPCS rules, RHC-specific encounter types, compliance prompts, and audit support	Integrated denial tracking, root-cause tags, A/R dashboards tuned to RHC payer mix	Purpose-built for small independent RHCs; templates and analytics aligned to AIR, cost-report logic, and rural staffing constraints
athenahealth	~$5–6K/year (EHR/PM) **+ 4–7% of collections** = $150K–$250K/year effective RCM cost	% of collections + per-provider subscription	Strong general coding support; not RHC-specific; often supplemented with external tools	Robust enterprise-grade denial queues and worklists; optimized for multi-specialty groups	Broad ambulatory focus; no explicit RHC specialization; configuration effort required
DrChrono	~$7K–$22K/year (software); full RCM + add-ons push to **$15K–$30K+/year** before coding tools	Per-provider monthly subscription + RCM service fees	Basic coding assistance; complex compliance workflows require third-party software	Standard small-practice RCM features; limited denial analytics vs. dedicated AI tools	Designed for small practices generally; not tuned to RHC regulations or cost reports
Waystar	Quote-based; ~mid-five-figures/year for 24,500 claims + add-ons + separate coding tools	Volume-based / per-transaction or per-ID pricing layered on existing EHR	Claim-level edits and eligibility; relies on EHR or third-party for deep coding guidance	Strong clearinghouse, denial analytics, underpayment detection; optimized for larger groups	Generic across specialties; not RHC-specific out of the box
Coding Tools (e.g., Optum, AAPC Codify, RapidClaims)	~$6K–$25K/year (per-seat/per-user)	Per-user or per-seat SaaS	Deep coding search, bundling edits, LCD/NCD checks, AI error detection — very strong	Limited; relies on separate RCM platform for denial workflows and A/R strategy	Not RHC-specific; require local configuration for RHC AIR and cost-based quirks

The 3C IT advantage: Flat $35K/year combines coding + compliance + collections intelligence in one RHC-specific platform — at a lower effective cost than mainstream RCM suites that charge % of collections and aren't built for rural cost-based reimbursement.

Live in Weeks. Moving the Needle in 60–90 Days.

3C IT is credibly faster to stand up and show financial impact than large enterprise IT/RCM systems. Because it layers on top of the clinic's existing EHR instead of replacing it, the path from contract to results is measured in weeks — not months or years.

Implementation Timeline Comparison

Solution	Time to Go-Live	Notes
3C IT (add-on to existing EHR)	**4–8 weeks**	Limited scope RCM overlay, standard HL7/FHIR feeds, small independent clinic footprint
Large EHR Replacement (Epic, Cerner, etc.)	6–18 months	Includes build, data conversion, training, and deep workflow redesign
Enterprise RCM Platform Overhaul	3–9+ months	Complex payer setup, charge master work, change management across many sites and specialties

60–90 Days

3C IT: First Results

Changes in denial rates and A/R metrics are visible within 60–90 days of go-live — similar to focused RCM optimization projects on leading EHR platforms

6–12 Months

Enterprise Systems: Stabilization

Full revenue-cycle benefit from a big EHR/RCM overhaul often isn't stable until 6–12 months post-go-live, due to parallel fixes, staff learning curves, and build iterations

3C IT is live in weeks, not months or years — because it layers on top of the clinic's existing EHR instead of replacing it. Where major overhauls take 6–12 months to stabilize, 3C starts moving the needle on denials and cash in **2–3 months**.

3C IT — 5-Year P&L (Illustrative)

A simple, defensible 5-year financial model at $35,000 ARR per org, using conservative healthcare SaaS benchmarks. Years 1–3 are an intentional investment phase; profitability arrives in Year 4.

Line Item	Year 1	Year 2	Year 3	Year 4	Year 5
Customer Orgs (end of year)	10	30	70	140	230
ARR at Year-End ($35K/org)	$350K	$1,050K	$2,450K	$4,900K	$8,050K
Recognized Revenue	$300K	$900K	$2,000K	$4,000K	$7,000K
COGS (hosting, support, onboarding)	**$120K**	**$315K**	**$600K**	**$1,000K**	**$1,750K**
Gross Profit	**$180K**	**$585K**	**$1,400K**	**$3,000K**	**$5,250K**
Gross Margin	60%	65%	70%	75%	75%
R&D (product/engineering)	$600K	$700K	$800K	$900K	$1,000K
Sales & Marketing	$400K	$600K	$900K	$1,200K	$1,600K
G&A	$250K	$300K	$350K	$400K	$450K
Total OpEx	$1,250K	$1,600K	$2,050K	$2,500K	$3,050K
Operating Income	**-$1,070K**	**-$1,015K**	**-$650K**	**$500K**	**$2,200K**
Operating Margin	**-356%**	**-113%**	**-33%**	**12%**	**31%**

Years 1–3: Investment Phase

Intentional operating losses while building product, integrations, early customer success, and Virginia reference sites. Common for healthcare SaaS given longer sales cycles and compliance costs.

Year 4: Breakeven

ARR crosses $4M, gross margin improves to 75%, and operating income turns positive at $500K — the inflection point where the Virginia model begins paying for itself.

Year 5: Strong SaaS Profile

~$7M revenue, ~75% gross margin, ~31% operating margin — squarely in "strong vertical SaaS" territory for a purpose-built healthcare platform.

Key assumptions: $35,000 ARR/org | 10 → 30 → 70 → 140 → 230 org growth | 65–75% gross margin improving with scale | CONUS-led, topping out near U.S. SOM upper end.

3C Five Year PnL

Line item	Year 1 (after Launch Grant Pilot)	Year 2	Year 3	Year 4	Year 5
Clinics (end of year)	10	30	70	140	230
ARR at year-end ($35k/org)	$350k	$1,050k	$2,450k	$4,900k	$8,050k
Recognized revenue	$300k	$900k	$2,000k	$4,000k	$7,000k
COGS (hosting, support, 3rd-party, onboarding)	$120k	$315k	$600k	$1,000k	$1,750k
Gross profit	$180k	$585k	$1,400k	$3,000k	$5,250k
Gross margin	60%	65%	70%	75%	75%
R&D (product/engineering)	$600k	$700k	$800k	$900k	$1,000k
Sales & Marketing	$400k	$600k	$900k	$1,200k	$1,600k
G&A	$250k	$300k	$350k	$400k	$450k
Total OpEx	$1,250k	$1,600k	$2,050k	$2,500k	$3,050k
Operating income	-$1,070k	-$1,015k	-$650k	$500k	$2,200k
Operating margin	-356%	-113%	-33%	12%	31%