Beyond the Rounds

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Essential RHC Financial KPIs You Can't Afford to Ignore
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Operating a Rural Health Clinic (RHC) requires navigating complex reimbursement models – from All-Inclusive Rates (AIR) and Medicare cost reports to varying state Medicaid rules, and all the commercial models in between. Because RHC margins are often tight, financial stability hinges on vigilant Revenue Cycle Management (RCM).

Whether your clinic manages billing in-house or partners with an outside billing service, ultimate fiduciary responsibility remains with clinic leadership. Delegating tasks does not mean relinquishing oversight. Monitoring targeted Key Performance Indicators (KPIs) ensures your clinic maintains steady cash flow, minimizing revenue leakage, and keeps vendors and staff accountable.

This week on Beyond the Rounds, we are going to review some of the core, recommended KPIs that clinic leadership should closely monitor – and understand – to maintain operational health, ensure billing compliance and protect the bottom line.

Most Practice Management (PM) systems come equipped with standard, out-of-the-box reporting dashboards to track these metrics automatically. However, if your system lacks built-in KPI reporting—or if you want to verify that your software or billing company is calculating them correctly—the guide below provides the exact formulas, raw data points, and logic you need to calculate each measure independently.

1. Days in Accounts Receivable (A/R)

Days in A/R tracks the average number of days it takes for a claim to be paid after a service is rendered. In rural health, where cashflow dictates payroll and operational sustainability, delayed payments strain reserves. For in-house teams, high Days in A/R usually points to billing backlogs, delayed claim submission, or inadequate follow-up. For outsourced billing teams, a rising Days in A/R is often the first sign that the vendor is prioritizing easy claims while letting complex or disputed RHC claims sit idle.

Most PM Systems pull your current total unpaid balance (patient + insurance) and divide it by your average daily gross charges over a set trailing period (typically 90 or 365 days). Calculating the Days in A/R on your own for your clinic can be just as simple. First find your Total Outstanding A/R balance as of today. Then you will need to calculate your Average Daily Gross Charges, by taking total gross charges from the last 3 months and divide by 90 days. Lastly, divide your Total A/R by the Average Daily Gross Charges to get your Days in A/R.

Days in A/R = Total Accounts Receivable / Average Daily Gross Charges

Once you begin to follow your Days in A/R, start by establishing a clear Days in A/R goal for your clinic. This target can be based on established industry standards or a realistic internal baseline tailored to your specific payer landscape. Both the Medical Group Management Association (MGMA) and the American Academy of Professional Coders (AAPC) report the standard operational benchmark for medical practices is to be between 30 and 40 days in A/R. MGMA notes that Days in A/R greater than 50 days as a sign of operational distress.

Once your target is set, hold yourself, your team, and your billing vendor strictly accountable to it. Think of Days in A/R as your clinic's primary financial smoke detector: when you are consistently missing your target that is your clue to dig deeper into secondary KPIs – such as aging reports, denial rates, or providing coding errors – to determine the root cause of the delay

2. A/R Aging Buckets (Aging Reports)

An Aging report is the distribution of unpaid claims broken down by time intervals: 0-30 days, 61-90 days, 91-120 days, and 120+ days. The probability of collecting on a healthcare claim drops dramatically after 90 days. A healthy aging report reflects rapid initial claim resolution and prompt re-filing. When you are performing your billing in-house you should be reviewing aging reports bi-weekly to identify bottleneck payers or unpaid claims. When outsourcing, you should require your billing company to provide a monthly aged A/R report along with documented action notes on every balance over 90 days. If claims, consistently age past 90 days without resolution notes, your vendor is dropping the ball.

AR aging reports generated by your PM system put outstanding balances into buckets based on either the Date of Service (DOS) or the date of initial billing, but it is best to set your report to age by DOS in

order to accurately measure true revenue delays. To calculate your clinic's aging manually you should run a standard raw A/R detail report. Group open balances by service date, calculate the total dollar amount in each 30-day window, and divide each bucket's dollar total by your overall outstanding A/R balances to get the percentages.

Just like establishing an overall target for your Days in A/R, clinic leadership should establish clear internal goals for how your total A/R is broken down across each aging bucket. Setting specific target percentages for each 30-day window gives your revenue team clear operational boundaries and prevents outstanding balances from quietly migrating into high-risk categories. The Healthcare Financial Management Association (HFMA) guidelines state that top performing healthcare organizations maintain less than 10% (and ideally < 5%) of total accounts receivables in the 90+ days category. Here are some suggest benchmarks:

- 0-30 Days: > 60% of total A/R
- 31-60 Days: 15%-20%
- 61-90 Days: 10%-15%
- 91-120 Days: < 5%
- 120+ Days: < 10% (Target < 5%)

3. Denial Rate & Denial Management

When claims begin migrating into those high-risk aging buckets—or when your Days in A/R starts trending upward—the next critical diagnostic step is investigating why payments are getting held up. The most effective way to uncover the root cause of aging balances is to analyze your initial denial rates and denial reasons. By pinpointing exactly where and why claims are being rejected on initial submission, you can fix systemic billing or documentation breakdowns before they quietly drain your cash flow.

Denials delay cashflow and significantly increase operational costs- per widely sited sources reworking a denied claim costs an estimated $25 to $118 per claim in staff labor. Some of the most common—and costly—denials stem from four core areas: registration and patient eligibility errors, missing prior authorizations, exceeded timely filing limits, and coding or documentation mismatches. What makes these denials particularly frustrating is that they are entirely avoidable. They don't reflect unpaid patient care; they reflect breakdowns in administrative and clinical workflows. By tracking these denial categories routinely, clinic leadership can quickly spot systemic vulnerabilities, implement

targeted staff re-education, and build automated guardrails in your Practice Management system to eliminate repeatable mistakes before claims ever leave the building.

The denial rate is the percentage of claims rejected or denied by payers on initial submission relative to total claims billed. PM systems often track electronic remittance advice (835 ERA) claim adjustment reason codes (CARCs) to identify claims remitted with a non-payment status. If calculating on your own, first count the number unique claims billed in a month, and then count how many of those claims were initially rejected or denied on their first Remittance Advice. Divide denied claims by total billed claims. A healthy denial rate is below 5%, or a clean claim rate of > 95%.

To properly manage your denials, it is best to categorize them by route cause (e.g. registration errors, coding errors, authorization failure). Then hold your staff or outsourced vendors accountable by holding weekly denial reviews. Based on the findings your in-house teams can adjust front-desk or provider templates based on recurring patterns. If working with an outside billing company you should hold them accountable to strict contract SLAs regarding initial submission accuracy and appeal turnaround times (typically between 48-72 hours). Additionally, tracking denials by specific payer is critical for catching unannounced payer policy shifts, contract discrepancies, or clearinghouse processing errors early.

4. Provider Coding Utilization & E/M Bell Curves

It is important to remember that not all revenue issues originate in the billing office or clearinghouse; many stem directly from how clinical encounters are coded at the point of care. Both under-coding (downcoding out of audit fear) and over-coding (upcoding without sufficient documentation) directly impact your clinic's financial stability and compliance profile. Tracking provider coding utilization through Evaluation and Management (E/M) bell curves allows clinic leadership to identify coding trends early, protect against compliance risks, and ensure your providers are capturing the full reimbursement for the care they deliver.

Provider coding utilization tracks the distribution of Evaluation and Management (E/M) levels (e.g. CT 99202-99205 for new patients; 99212-99215 for established patients) broken down by individual rendering clinicians. Even though Medicare and Medicaid reimburse RHCs under qualified encounter rates, coding accuracy remains critical for two reasons: compliance audit risk and commercial contract reimbursement.

Out of fear of audits, rural providers frequently under-code (downcode) complex visits – selecting 99213 when documentation supports a 99214. For commercial and Medicare Advantage plans that pay on a fee schedule, this surrenders revenue. It also understates provider productivity and misrepresents patient complexity on cost reports. On the flip side, heavy skewing toward 99214/99215 codes without bulletproof clinical documentation can trigger payer and Medicare RAC audits, risking costly claw backs.

Utilization reports created by your PM system typically tally procedure code frequencies by rending provider ID over a selected range and display the percentage breakdown of each E/M code level. If calculating manually, you can export a CPT code frequency report filtered by rendering provider for a 30- or 90-day window. Then you can total the number of established office visit (99212-99215) and/or new patient visits (99202-99205) and divide the count of each specific code by the total established or new patient visits to determine the provider's percentage distribution.

When evaluating your provider coding utilization, you should mirror clinician coding profiles against a "bell curve" aligned with specialty peers (e.g. CMS/AAPC national specialty averages). A suggested online resource is the AAPC "E/M Utilization Benchmarking Tool" https://www.aapc.com/tools/em_utilization.aspx?msockid=0fcb94413c5a68d43db3832c3d73690e. This tool allows you to select your provider's specialty and enter your provider's E/M 12-month totals for each code. The tool will benchmark your provider against other like providers based on national Medicare averages. If you find your providers are not in line with their peers, you should perform quarterly random chart audits (5-10 charts per provider) to validate documentation against billed codes. Then use the data from your reviews to help educate providers on proper coding along with the necessary supporting documentation.

5. Payer Mix Analysis

Understanding the breakdown of your patient population across Medicare, Medicaid, commercial insurance, and self-pay is essential for long-term strategic planning and accurate cash flow forecasting. Because RHCs rely heavily on cost-based or capped All-Inclusive Rates (AIR) for traditional Medicare and Medicaid encounters, even subtle shifts in your payer mix can directly alter your clinic's financial health and year-end cost report reconciliations. Most notably, the growing migration of patients from traditional Medicare into Medicare Advantage plans poses a significant financial risk: many Medicare Advantage plans reimburse RHCs on standard commercial fee-for-service schedules or

negotiated rates that fall far below your full RHC encounter rate, drastically eroding expected revenue if left unmonitored.

A Payer Mix Analysis is the percentage distribution of your patient population and revenue across different payer's types: Medicare, Medicaid, Commercial, Managed Care, and Self-Pay/Uninsured. PM systems aggregate encounter counts or gross billed charges by insurance financial class and calculate each category's share of the total. If calculating manually, you should sum the total of gross charges (or total encounters) for a given month by payer category. Then take total for each payer category and divide by your total gross charges to get the percentage distribution of your revenue.

Industry benchmarks can vary by region, but typical RHC distributions feature high proportions of Medicare (30%-45%) and Medicaid (25%-40%). If your monthly reporting reveals a steady migration of patients away from traditional Medicare into specific Medicare Advantage plans, clinic leadership must take proactive steps to protect the practice's bottom line. Seeing a significant shift into one or two dominant plans is your signal to pull those specific payer contracts for immediate financial evaluation. Armed with your actual cost-per-visit data and RHC encounter benchmarks, you can approach these payers to renegotiate commercial rates, push for favorable RHC-specific carve-outs, or secure fee schedule adjustments that align more closely with traditional Medicare reimbursement.

Final Thoughts: Holding Your Billing Structure Accountable

While this guide focuses on five foundational metrics, Revenue Cycle Management extends well beyond these core areas. Countless secondary KPIs exist—from patient collection rates at the front desk to clearinghouse rejection logs—that can provide deeper operational context. However, consistently tracking and mastering these primary financial health metrics provides clinic leadership with a crystal-clear, accurate diagnostic of your clinic's A/R and overall fiscal stability.

Ultimately, these numbers are more than just line items on a monthly report; they are the strategic compass that protects your clinic's mission. By setting clear benchmarks, using your Practice Management data to uncover hidden revenue bottlenecks, and holding both in-house teams and third-party billing vendors strictly accountable, you create actionable goals that safeguard your practice's bottom line. Taking control of your billing operations ensures that your Rural Health Clinic remains financially resilient, operationally sound, and equipped to deliver high-quality healthcare to your community for generations to come.