



From Coverage to Care

How physician payment systems affect a patient's ability to see a physician

Legislative Roundtable on Medicaid
Arkansas Medical Society
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Coverage

Care

Access

What this presentation will do

Four basic concepts

We will keep the story simple:

- 1 Introduce CPT, ICD-10, and RVUs
- 2 Follow Sarah from clinic through the operating room
- 3 Show how payment can differ by payor
- 4 Explain why the ARHOME payment pathway matters for access

The goal is not to make anyone a billing expert.

The goal is to show why payment policy becomes patient access policy.

Meet Sarah

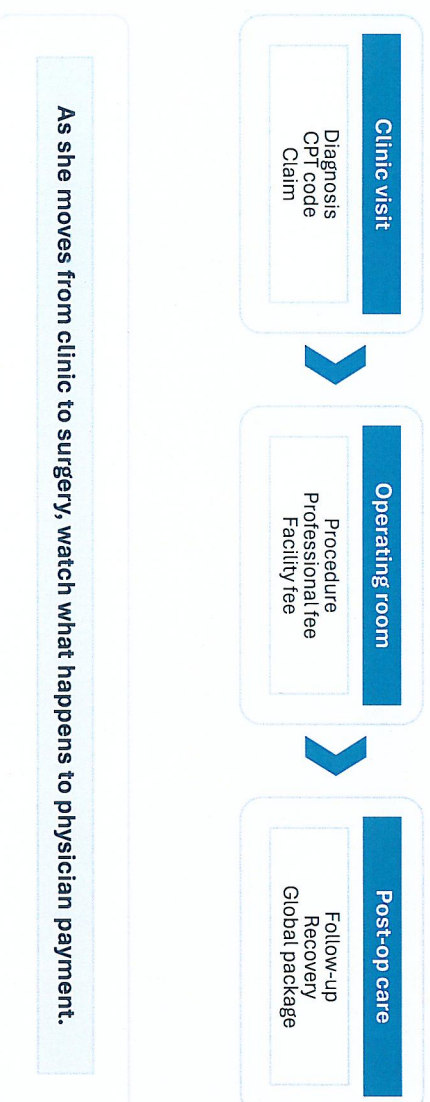
One patient. Three stops.

Sarah, 38

Batesville, Arkansas
Works full time
Symptomatic gallstones

Her insurance card matters, but it does not treat her. The test is whether she can get care.

We will follow Sarah through her care:



Three terms legislators need to know

Diagnosis tells us why. CPT tells us what. RVUs help value the service.

ICD-10
International Classification
of Diseases

CPT
Current Procedural
Terminology

RVU
Relative Value Unit

Why is Sarah being seen?

What service was provided?

How is the service valued?

K80.20
Gallstones

99203
New patient visit

Work + practice expense
+ malpractice

A standard language lets the claim be processed, but it does not create one universal payment amount.

Sarah's first physician visit

A clinic visit becomes a coded claim before it becomes payment.



The medical care can be the same.
The payment result depends on the payor's fee schedule or contract.

Same clinic care. Different payment.

Examples: a high-volume PCP visit and Sarah's surgical consultation.

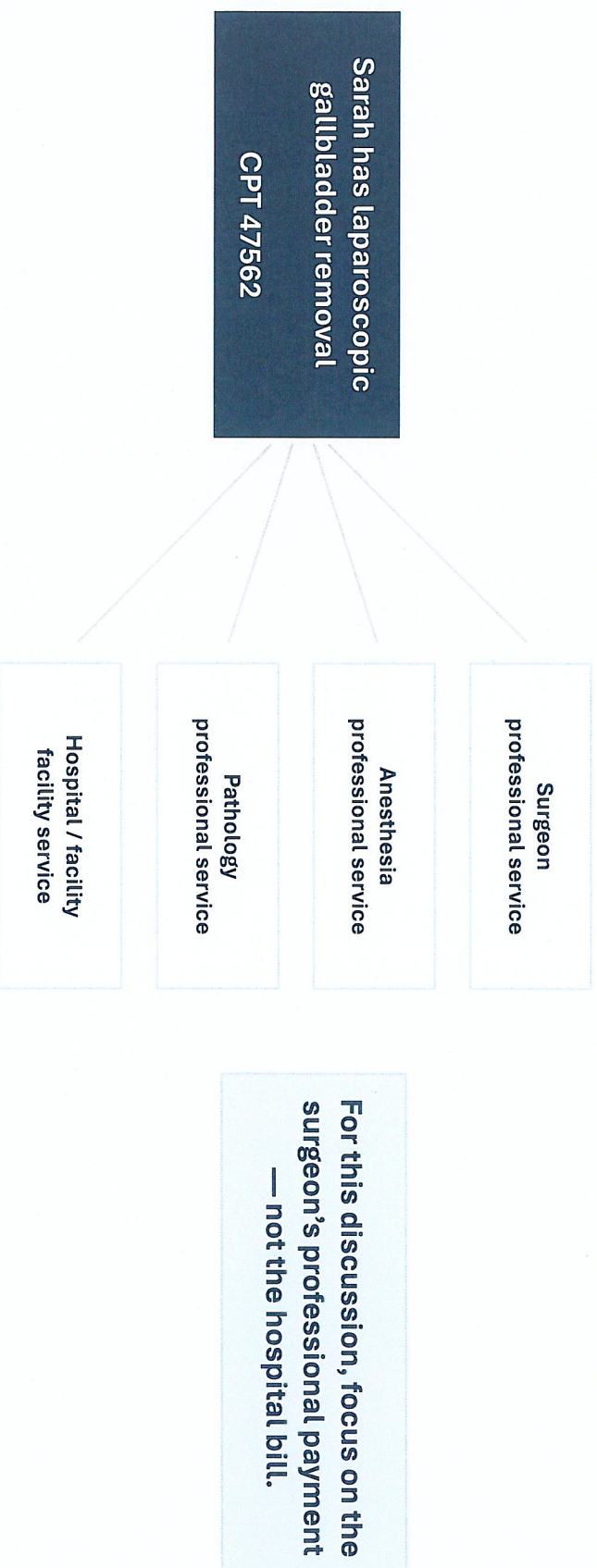
Service	Commercial (ARHOME)	Medicare	Traditional Medicaid
PCP established visit CPT 99213	\$96	\$87	\$39
Sarah surgical consult CPT 99203	\$136.54	\$106.69	\$70.19

For each code: same physician service. Different payor. Different allowed amount.

99213 is included because many AMS physicians are primary-care physicians seeing established patients every day.

Sarah goes from clinic to the operating room

One operation can produce several separate payment paths.



Surgery payment can include follow-up work

Many surgical payments are global packages, not one isolated task.



Sarah may come back after surgery, but routine postoperative care may already be included in the surgeon's payment.

Basic point: a single surgical payment may cover more physician work than the day of the operation.

Same operation. Different payment.

Example: CPT 47562, surgeon professional payment.

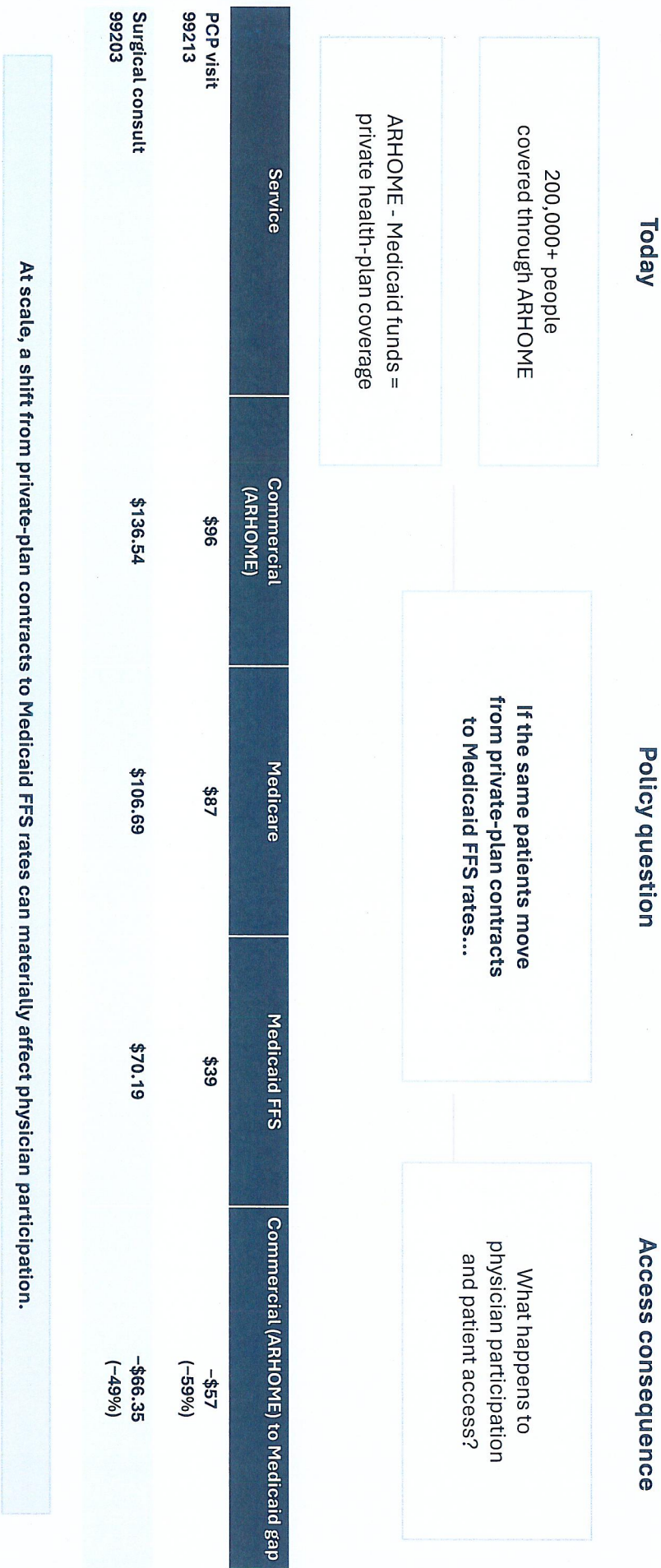
Payer path		Allowed amount
Private-plan contract		\$1082
Medicare		\$631
Arkansas Medicaid FFS		\$708.73

Same operation. Same surgeon. Different payor. Different allowed amount.

Commercial/private-plan amounts vary by contract.

If private-plan payment becomes Medicaid FFS at current rates

A coverage redesign can become an access redesign.



Why this becomes an access question

Physician payment affects whether practices can participate and accept patients.



For Sarah, the practice decision becomes a patient question:

Three questions for the next Medicaid model

These questions test whether coverage turns into care.

1 What will physicians actually be paid by insurance for the same service ?

2 How does that compare with what practices receive for these patients today?

3 Will that payment support enough physician participation to preserve access?

Coverage is only the first step. The policy test is whether coverage turns into care.

Thank you

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