MISSION MOBILE MEDICAL
The Mobile Healthcare Company

Completing the Circuit: From coverage to care

March 2026

KEY TAKEAWAYS

- Starting in July 2028, CMS will require all states operating Medicaid MCOs to conduct annual secret shopper surveys measuring actual appointment availability. Scores below 90% will be published by plan and geography, creating regulatory and reputational exposure for noncompliant health plans.
- In designated shortage areas, traditional network strategies (recruitment, rate increases, directory corrections) cannot close these gaps because no workforce exists to recruit. Mobile healthcare infrastructure solves the underlying logistics problem by extending existing provider reach across multiple underserved counties.
- MCOs can act now through internal audit, strategic contracting with mobile healthcare operators, and structured compliance documentation.

Executive Summary

Federal oversight of Medicaid managed care network adequacy is entering a new enforcement phase. Beginning in summer 2028, new CMS rules (42 CFR 438.68) will require independent secret shopper surveys to verify whether enrollees can actually schedule appointments meeting federal time standards. Results will be published by plan and geography, exposing organizations that cannot demonstrate real access.

For MCOs operating in health professional shortage areas, the core problem is structural: there is no provider workforce to recruit, and no rate increase that creates clinicians where none practice. Mobile healthcare infrastructure offers a proven, contractually efficient mechanism for generating verified appointment availability in these areas. This brief outlines the regulatory landscape, the access gap, and a concrete implementation pathway.

The Regulatory Shift

New CMS rules require all states operating Medicaid MCOs to contract with independent entities for annual secret shopper surveys that validate provider directories. The surveys test whether enrollees can schedule appointments meeting specific federal time standards: primary

care and OB-GYN within 15 business days, outpatient behavioral health and substance use treatment within 10 business days. States must publish findings within 30 days of CMS submission, disaggregated by health plan and geography. Scores below 90% will be published by plan and location.

The distinction between claimed access and verified access is already producing problematic results for plans in pilot states. Virginia Department of Medical Assistance Services tested prenatal care directory accuracy and found that fewer than 5% of outreach attempts resulted in appointments meeting state standards. The HHS Office of Inspector General documented similar patterns nationally: 72% of providers appearing in behavioral health network listings should not have been included, and actual availability stood at fewer than five active providers per thousand covered lives.

These numbers represent the scale of the gap that CMS enforcement will document publicly starting in 2028.

Why Traditional Strategies Fall Short in Shortage Areas

MCO network strategies have historically centered on three levers: recruiting providers to join networks, negotiating competitive reimbursement rates, and maintaining directory accuracy. These approaches work where adequate workforce exists but participation or documentation falls short. They cannot solve the problem where no workforce exists to recruit. Rates are irrelevant when there is no one to pay. Directory accuracy cannot create providers.

This is both an operational and an economic challenge. States pay MCOs monthly capitation for services members may need later. When covered individuals in shortage areas hold valid insurance but cannot access providers, capitation payments flow in without converting into healthcare services. Members who eventually seek care, often through emergency departments after conditions have progressed, generate costs that exceed what earlier intervention would have required. July 2028 enforcement will publicly document one critical dimension of this gap: whether networks can deliver the appointments that directories promise.

What Mobile Healthcare Infrastructure Accomplishes

Mobile healthcare operates on fundamentally different spatial economics than facility-based care. Rather than recruiting providers to locations where practice sustainability is questionable, mobile clinic networks extend the geographic reach of providers already practicing in sustainable markets. A physician or advanced practice provider based at a regional hub can deliver services at rotating community sites across multiple underserved counties. This creates verified appointment availability in locations that cannot independently support permanent clinical infrastructure.

A single mobile unit serving eight community sites on a rotating basis can produce compliant appointment availability across multiple counties from one contracted provider relationship.

Mobile units operate under existing enrolled provider credentials and submit claims using Place of Service code 15, integrating into standard MCO claims workflows without requiring new administrative infrastructure.

Implementation Pathways for MCOs

MCOs can address infrastructure gaps through internal operational changes and strategic contracting. None of the steps below require state contract modifications or new regulatory approvals.

Step 1: Conduct Internal Appointment Availability Audits

Contract with an independent entity to test appointment availability before CMS surveys begin. Apply CMS methodology: statistically valid random sampling across all geographic service areas, verification of directory accuracy, and wait time compliance testing. The audit should separate gaps that are solvable through directory corrections from gaps that require infrastructure investment due to workforce scarcity.

Step 2: Contract with Mobile Healthcare Operators

For shortage areas identified in the audit, establish partnerships with mobile healthcare providers. Three contracting models apply:

> **Direct Network Participation.** Mobile healthcare providers join the network roster. Mobile units operate under existing enrolled provider credentials and submit claims using POS code 15.
>
> **Anchor Provider Partnerships.** Regional hospitals or FQHCs deploy mobile services with clinical oversight from the anchor institution and operational management from the mobile healthcare partner.
>
> **Turnkey Service Agreements.** Mobile healthcare operators provide end-to-end solutions including vehicle leasing, maintenance, staffing support, and operational management.

Step 3: Document Mobile Capacity for Regulatory Compliance

Structure mobile healthcare partnerships to support network adequacy demonstrations: published schedules showing community site locations and service hours, encounter data captured with POS code 15, appointment availability reporting by site, and provider directory entries reflecting mobile service availability.

Implementation Timeline

Period	Action
Q1-Q2 2026	Launch internal appointment availability audits. Classify gaps as directory-correctable versus infrastructure-dependent.

Period	Action
Q3-Q4 2026	Initiate mobile healthcare partnership negotiations for shortage areas. Evaluate turnkey and anchor provider models.
2027	Execute contracts and deploy mobile services. Establish published schedules and implement encounter data collection using POS code 15.
Q1-Q2 2028	Conduct follow-up audits. Verify that mobile services generate appointment availability meeting federal time standards.
July 2028	CMS enforcement takes effect. MCOs with established mobile infrastructure demonstrate compliance.

Strategic Positioning

MCOs that address infrastructure gaps before July 2028 position ahead of both regulatory enforcement and public exposure. Organizations that wait will face compressed timelines, limited options for partnership, and the publication of network adequacy failures. Early movers gain a second strategic advantage: reducing financial exposure from members unable to access preventive services in shortage areas. Infrastructure investment that generates verified appointment availability serves compliance requirements and cost containment simultaneously. The window for proactive positioning is open now. Internal audits can launch immediately, partnership negotiations can begin within two quarters, and mobile services can be operational well before CMS enforcement takes effect.

SOURCES

- Centers for Medicare and Medicaid Services. (2024). Medicaid managed care network adequacy requirements under 42 CFR 438.68. U.S. Department of Health and Human Services.
- Virginia Department of Medical Assistance Services. (2023). Prenatal care provider directory accuracy evaluation. Commonwealth of Virginia.
- U.S. Department of Health and Human Services, Office of Inspector General. (2022). Gaps in Medicaid behavioral health network adequacy: Analysis of provider directory accuracy and appointment availability. HHS OIG.

CONTACT

For more information, please contact Mollie Williams, DrPH, MPH, VP of Evidence and Insights at mollie.williams@missionmobilemed.com.