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Prepare Now for Secret Shoppers: Mobile Healthcare Creates Network Adequacy

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KEY TAKEAWAYS

- July 2028 enforcement creates a compliance obligation that most current Medicaid programs cannot meet. CMS secret shopper surveys will measure actual appointment availability, not directory listings. Results will be public.
- Provider recruitment cannot close rural access gaps where providers do not exist. 31 of 35 physician specialties face shortages; 432 rural hospitals are vulnerable to closure.
- Mobile health programs solve the provider distribution problem. One provider serves rotating community sites, closing access gaps across multiple counties.

The Compliance Problem

Beginning July 1, 2028, CMS will enforce Medicaid managed care network adequacy through independent secret shopper surveys (42 CFR 438.68, as amended by CMS-2439-F). The rule requires states to verify actual appointment availability: 15 business days for primary care; 10 business days for behavioral health. Results will be posted publicly by MCO and geography.

Virginia conducted secret shopper testing for prenatal care in 2023. MCOs reported full directory compliance. Actual results: 13 of 1,844 calls (0.7%) resulted in appointments within state standards. 46.3% of listed providers did not offer the services they were listed for. This gap between reported compliance and actual access exists in managed care networks nationwide.

The structural problem compounds the directory accuracy issue. The Chartis Center for Rural Health reports 46% of rural hospitals operate at negative margins. 432 are vulnerable to closure. 116 labor and delivery units have closed since 2020. In many rural service areas, the provider workforce required for network adequacy simply does not exist.

Alternative Access Standards will not provide relief under the new enforcement framework. Under the 2024 rule, AAS requests become documented failures. When MCOs request waivers for rural

areas and states grant them, that documentation becomes public evidence that managed care networks cannot meet federal access standards.

Why Traditional Network Strategies Will Not Solve This

State managed care contracts have relied on three primary approaches to address network gaps: provider recruitment, telehealth expansion, and rate increases. Each has structural limitations that prevent compliance in areas with workforce shortages.

Provider Recruitment. Recruitment assumes providers can be attracted to underserved areas. In markets with structural workforce shortages, there is no provider pool from which to recruit. HRSA designates 65 million Americans as living in primary care Health Professional Shortage Areas. The shortage is not temporary; it reflects permanent features of rural healthcare economics.

Telehealth Expansion. Telehealth extends access for consultations but cannot perform physical examinations, administer vaccines, draw blood, conduct screenings, or provide urgent care. For services requiring in-person contact, telehealth documents access failure rather than solving it.

Rate Increases. Higher rates incentivize existing providers to see more Medicaid patients, but do not create providers where none practice. Rate increases in a county with two primary care physicians cannot produce a third physician.

What Mobile Healthcare Infrastructure Solves

Mobile health programs operate on a different logic than facility-based care. Rather than recruiting providers to underserved areas, a network of mobile clinics extends the geographic reach of providers who already exist elsewhere.

A physician or advanced practice provider based at a regional FQHC or hospital can serve rotating community sites across multiple counties via a mobile unit. This produces appointment availability in locations that cannot independently sustain fixed infrastructure. The same provider who is unavailable for recruitment becomes available for extension.

For network adequacy purposes, the relevant question is whether a Medicaid enrollee in a rural county can obtain an appointment within federal time standards. Mobile clinic networks produce appointment availability without requiring a permanent provider presence in every service area.

The Solution: MCO Contract Requirements

The most direct implementation pathway is through managed care contract amendments. States can require MCOs to include mobile healthcare capacity as part of network adequacy demonstrations for designated service areas without requiring a State Plan Amendment. Consider adding the following language:

> **Network Adequacy:** *For service areas designated as Health Professional Shortage Areas or Rural Health Priority Areas, the Contractor may demonstrate compliance with appointment*

availability standards through one or more of the following mechanisms: (a) contracted fixed-site providers meeting time and distance standards; (b) contracted mobile clinic networks with published schedules providing service within the designated area at intervals sufficient to meet appointment wait time standards; (c) telehealth arrangements for services appropriate to virtual delivery.

Mobile Healthcare Provider Standards: *Mobile health programs qualifying as a network adequacy mechanism must: (i) operate under the license of an enrolled Medicaid provider; (ii) maintain published service schedules with community site locations and hours; (iii) provide services consistent with the scope of the sponsoring provider; (iv) submit encounter data using Place of Service code 15 (mobile unit); (v) meet all applicable state licensure and vehicle safety requirements.*

Documentation Requirements: *Contractor shall report the mobile healthcare network capacity annually, including: service area coverage maps; published schedules by location; utilization data by site; and appointment availability testing results for mobile sites using the same methodology applied to fixed sites.*

Regulatory Pathway

Exhibit 1. Regulatory Pathway for Mobile Healthcare Network Adequacy

Action	Description	Approval
State Plan Amendment	Required only if creating a distinct mobile provider type with a different reimbursement methodology or if establishing mobile-specific rate enhancements.	CMS approval required
Directed Payment Preprint	Required if mandating MCOs pay enhanced rates to mobile providers specifically. Must demonstrate value-based connection.	CMS approval required
MCO Contract Amendment	Requires CMS review if a material change to network adequacy standards. Recognizing mobile clinics as a qualifying mechanism is generally within state discretion under 42 CFR 438.68.	CMS review
Operational Guidance	Clarifying that mobile units operating under existing enrolled providers count toward network adequacy.	No CMS approval required
MCO Contract Conditions	Requiring MCOs to include mobile healthcare in network development plans as a condition of contract compliance.	No CMS approval required
RHTP Infrastructure Funds	Allocating RHTP infrastructure funds for mobile clinic capacity building.	No CMS approval required

Implementation Timeline

Exhibit 2. Implementation Timeline

Period	Action
Q1–Q2 2026	Issue guidance to MCOs clarifying mobile clinic networks as a qualifying network adequacy mechanism. Identify priority service areas based on current access gaps and AAS request history.
Q3–Q4 2026	Draft MCO contract amendments for the 2027 renewal cycle. Coordinate with RHTP implementation planning for infrastructure funding.
2027	Execute MCO contract amendments effective with renewal. Mobile healthcare infrastructure deployment begins. Establish documentation and reporting requirements.
Q1–Q2 2028	Verify mobile network capacity in advance of July enforcement. Conduct internal secret shopper testing. Address gaps before CMS surveys begin.
July 2028	CMS enforcement begins. States with established mobile healthcare infrastructure demonstrate compliance.

SOURCES

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