POLICY BRIEF

Designating Mobile Health Programs as Essential Community Providers

FEBRUARY 2026

How to Use This Policy Brief
This policy brief[1] is intended for policymakers, state Medicaid agencies, the ACA Health Insurance Marketplace (Marketplace) program staff, Medicaid managed care plans, and mobile health program leaders. Use it to inform policy updates, shape Qualified Health Plan submissions, and strengthen Medicaid contract language so that mobile health programs are clearly visible, contractable, and appropriately credited within networks. For purposes of this brief, mobile clinics and mobile healthcare programs may operate under clinic licensure or other legally authorized healthcare delivery structures, including but not limited to FQHC-based, hospital-based, EMS-based, or multidisciplinary mobile care programs, permitted under state law.

Essential Community Providers (ECPs) are safety-net providers that deliver care to low-income and medically underserved populations. Under the Affordable Care Act (ACA), Marketplace plans must include ECPs in their networks to support adequate access to care. Many state Medicaid managed care programs also impose similar requirements through their contracts. Common examples of ECPs include Federally Qualified Health Centers and Rural Health Clinics. **However, federal ECP policies and state Medicaid managed care contracts typically focus on fixed, site-based providers and overlook mobile health care.** When mobile health services don't "count," compliance measures become less credible, progress toward health equity slows, and significant unmet needs remain – particularly in the communities that mobile care is specifically designed to reach.

As a result, mobile services that improve access can be sustainable in one context and unsustainable in another, depending solely on whether they are recognized and reimbursed within ECP and network frameworks. By contrast, mobile clinics that are not designated as ECPs, or not clearly linked to an ECP entity, are often left out of Marketplace and Medicaid managed care networks, treated as outreach rather than clinical providers, and unable to bill consistently, even when they deliver the same covered services.[2]

How Marketplace ECP and Medicaid Network Rules Overlook Mobile Health Clinics

The ECP framework assumes a fixed, site-based clinic model with similar assumptions appearing in many Medicaid managed care contracts. In practice, mobile health clinics operated by ECP-eligible organizations are hard to recognize, list, and credit. Table 1 shows where this mismatch occurs. (For licensure, permitting, and multi-agency oversight issues that also complicate listing and crediting mobile units, see Healthcare Planning Challenges Facing Mobile Health Programs.

Table1: Mobile Health Marketplace and Medicaid Managed Care Network-Related Challenges

Issue	Marketplace ECP	Medicaid Managed Care
Recognition	The federal ECP list includes provider types but not delivery modes. Because mobile health programs are not a named category, Marketplace issuers and state regulators decide, case by case, whether mobile services "count" and plans can meet ECP thresholds with fixed-location sites alone, even in communities where mobile healthcare programs are the primary access point.	Medicaid programs are not required to use the ACA ECP definition. Also, many state managed care contracts do not list mobile health units as distinct service locations, so plans can meet network requirements without contracting with mobile health providers.
Listing & Data Visibility	The CMS ECP Network Adequacy Templates[3] assume single, permanent addresses. Routes/stops often do not fit filings, and without Place Of Service (POS) 15[4] and unique site/route IDs, encounters are coded to a parent site, hiding mobile reach in directories and reports.	Manuals and directories are site-centric; absent mobile-appropriate POS (POS 12/POS 15) and unique IDs, mobile encounters disappear in access/quality reporting, limiting management insight and auditor recognition.
Metrics & Incentives	ECP compliance emphasizes site counts and geographic spread, not service volume, outreach intensity, or appointment availability. A mobile health program can expand access without improving an issuer's ECP score unless it is recognized as its own site.	Network dashboards, wait time standards, and quality frameworks often exclude mobile availability. If mobile care does not move measured metrics, the business case weakens, limiting plans' and providers' ability to sustain and expand mobile services even when members are seen faster and closer to home.

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Emerging Solutions Across Federal, State, and Plan Levels

There are some solutions emerging at multiple levels. CMS, several states, and Medicaid health plans are taking steps to make mobile clinics easier to recognize, list, and count.

Federal

CMS's Plan Year 2026 Marketplace updates add tighter ECP reviews and a running list of provider changes. This creates a clearer pathway to recognize mobile clinics operated by ECP-eligible providers, show them correctly in applications and directories (rather than only under a parent site), and ensure they are credited appropriately during ECP review.

States

Some states already show how to make mobile health programs visible and countable. **California** allows licensed clinics to register mobile or intermittent sites, giving plans clear identifiers usable in networks, directories, and claims.[5] **Minnesota** requires health plans to contract with state-designated ECPs, enabling safety-net clinics to bill mobile services as in-network care rather than grant-funded outreach.[6] In **Massachusetts,** community health centers may operate licensed mobile units and deliver care through MassHealth ACOs; although mobile health programs are not explicitly named in provider manuals, existing flexibility allows mobile services to function as a recognized mode of access, pointing to the value of clearer guidance.[7]

Medicaid Health Plans

On the **Medicaid plan** side, some health plans are making mobile care easier to see and measure. For example, **UnitedHealthcare Community Plan** has a billing policy that requires use of the right Place of Service code (POS 15 for mobile units) so mobile visits show up correctly in claims and reports.[8] **HMSA (Hawai'i)**[9] also has a clear POS15 policy that spells out the difference between fully equipped mobile clinics and drive-through events and tells providers exactly how to code them, reducing billing errors. **Blue Cross and Blue Shield of Minnesota (Blue Plus**) helps members find care by listing contracted mobile clinics with services, service areas, and languages on its site.[10]

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Recommendations and Call to Action

For CMS/CCIIO (Marketplace ECP Policy):	• **Clarify how to count mobile healthcare programs** operated by ECP-eligible organizations in QHP applications and ECP reviews (e.g., route/schedule fields; recognition when mobile is the primary access point). • Update issuer guidance, FAQs, and application templates to ensure mobile units are not attributed only to parent sites and can be credited where appropriate. Encourage issuers to capture POS 15 and unique route/location identifiers in network submissions and provider directories.
For State Agencies (SBMs and Medicaid Programs):	• **Provider enrollment:** Allow mobile healthcare programs to register mobile or intermittent sites with clear identifiers; align Medicaid provider enrollment to recognize mobile as a service location. • **Medicaid managed care contracts:** Define mobile healthcare programs as allowable service locations; require directory listing of mobile health clinics (hours, routes, languages); allow mobile-appropriate POS usage (e.g., POS 12, POS15) and unique route/location IDs in encounter data; allow mobile healthcare programs to count toward network adequacy and access standards when they are the practical access point. • **Quality and equity strategies:** Support targeted mobile deployment in documented access-gap areas; incorporate mobile services capacity into quality and access validation frameworks.
For Medicaid Managed Care Plans:	• **List mobile health clinics as service locations** in provider directories (include hours, locations, and languages). • **Enforce accurate billing** so mobile visits use appropriate POS and required modifiers; audit for compliance to ensure visibility in reports. • **Monitor and report outcomes** showing how mobile health services reduce wait times, travel distances, and appointment barriers; use results to support ongoing contracting and network inclusion (e.g., in access remediation plans).

Mobile health programs already bring care to people who face the biggest barriers, but current policy and contracting rules often make them difficult to recognize and harder to count. CMS, states, and health plans should collaborate to make mobile health programs visible, contractable, and countable across ECP and Medicaid managed care systems. Doing so will help plans meet access requirements, support safety-net providers, and integrate mobile health programs as a stable, accountable, and sustained part of provider networks.

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Getting Started
To get started, stakeholders should review how ECP requirements are currently defined and implemented within their Marketplace and Medicaid managed care plans and identify where mobile health programs are not clearly recognized or credited. State agencies, plans, and providers can then engage key partners to identify practical opportunities to improve visibility of mobile health clinics within provider enrollment, health plan network listings, and access monitoring processes.

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[1] This brief is the fourth in our series, which can be accessed at: https://www.drivinghealthforward.org/policy-advocacy. For more information on the Driving Health *Forward* campaign, please visit https://www.drivinghealthforward.org

[2] The Commonwealth Fund. *Strengthening Marketplace Network Rules for Essential Community Providers Is a Matter of Health Equity.* Accessed at: https://www.commonwealthfund.org/blog/2023/strengthening-marketplace-network-rules-community-providers-health-equity

[3] Standardized CMS templates used in Qualified Health Plan certification and Marketplace regulatory filings. Accessed at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter18ECP_NATemplateInstructions_Version2-32416.pdf

[4] POS 15: Place of Service code for Mobile Units.

[5] California Department of Health Care Services (DHCS) website, *Requirements and Procedures for Reporting of Intermittent Clinics and Mobile Health Units*, accessed at: https://mcweb.apps.prd.cammis.medi-cal.ca.gov/page/requirements-and-procedures-for-reporting-of-intermittent-clinics-and-mobile-health-units

[6] Minnesota Department of Health (MDH) website, *Essential Community Providers,* accessed at: https://www.health.mn.gov/facilities/insurance/managedcare/ecp

7 MassHealth, *Community Center Manual for MassHealth Providers*, accessed at: https://www.mass.gov/lists/community-health-center-manual-for-masshealth-providers

[8]United Healthcare Community Plan, Reimbursement Policy CMS-1500 Number 2026R7108C, *Procedure to Place of Service Policy, Professional,* accessed at: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan-reimbursement/UHCCP-Procedure-to-Place-of-Service-Policy.pdf

[9] HMSA, *Mobile Clinic (POS 15) Payment Policy for E&M Codes*, accessed at: https://prc.hmsa.com/s/article/Mobile-Clinic-POS15-Payment-Policy-for-E-M-Codes

[10]Blue Cross and Blue Shield of Minnesota website, *Mobile clinics: Bringing healthcare to your community and home*, accessed at: https://www.bluecrossmn.com/our-plans/medical-assistance-medicaid/medical-assistance-resources/mobile-clinics