POLICY BRIEF

Payment Approaches for Mobile Health Care Programs

December 2025

How to Use This Policy Brief
Mobile health programs, payers, and Medicaid agencies can use this policy brief as a strategic tool to assess and develop payment options that ensure the sustainability of their services. Differences exist among State Medicaid policies regarding mobile health and what services are reimbursable; readers should be familiar with applicable state policies and payment structures. This brief is designed to support policy development by highlighting the importance of incorporating program-specific expenses that enable sustainability and expansion of services, incentivizing quality and health outcomes, and promoting transparent rate-setting procedures. Please note that this brief does not account for start-up costs, including infrastructure.

Mobile health clinics are transforming health care access in communities all across the United States—bringing high-quality, cost-effective care directly to those who need it most in areas that traditional health care settings do not effectively reach. Mobile health services often address barriers such as transportation, geographic isolation, and housing instability. These services can include mobile primary care clinics, mobile behavioral health and crisis intervention services, preventive health programs and more.

A study found that the Southern California-based Breathmobile Program, a mobile asthma care initiative for underserved children, is highly cost-effective, yielding a return of $6.73 for every dollar invested by reducing emergency visits, including an annual estimate of $2,541,639 in avoided emergency costs

Numerous studies have shown that mobile clinics are more efficient at helping underserved communities access preventive care, manage chronic disease, and pursue healthier living. Yet the funding mechanisms most leveraged to support mobile health clinics - grants, donations and institutional funding - make it difficult for mobile clinics to scale or sustain operations. **This promising sector of the rural health delivery system needs ongoing, reliable payment models in order to flourish.**

Mobile health services are anticipated to grow significantly, particularly in rural health settings, where they can help close access gaps and improve health outcomes. Medicare and Medicaid programs are seeing the proven return on investment as a reason to support paying for mobile health care and can serve as a framework for discussing payment methodologies across payer type.

Overview of Common Payment Models

As mobile health care programs seek sustainable payment strategies, three primary payment models have emerged: fee-for-service (FFS) rates, cost-based rates, and bundled encounter rates. Each approach offers distinct advantages and challenges in supporting mobile health services. These approaches generally do not fully account for start-up costs or other unique dynamics of operating a mobile health vehicle. To date, start-up costs are often still covered through institutional funding, grants, or other temporary funding sources. However, leveraging the FFS, cost-based rates, and bundled payment models to sustain mobile health program services can offer both financial viability and comprehensive care delivery in mobile health settings.

Fee for Service (FFS) Model — Most Applicable for New Programs. Many state Medicaid programs use FFS payments to pay for a broad array of mobile health care services. The mobile health care programs bill the state or the health plan payer, depending on the state's delivery system structure. Medicaid FFS payment rates are typically the lower of submitted charges or a state-determined market-based fee schedule. For example, Hawaii Island Community Health Center uses mobile health vehicles to provide medical, dental, and behavioral health services in rural communities. Hawaii's Medicaid program reimburses these services using Evaluation and Management codes (99202-99205, 99212-99215), billed with Place of Service code 15.[1] Colorado's Medicaid program, Health First Colorado, pays mobile crisis response (MCR) programs through a Regional Accountable Entity (Colorado's managed care organizations), on a FFS basis. Texas Medicaid Managed Care Organizations also pay their in-network mobile health programs on a FFS basis from the capitated payments they receive from the state STAR+PLUS program.

Cost-Based Rates — Most Applicable for FQHCs, RHCs, and Local Programs with Cost-Based Funding. Mobile health programs can receive cost-based payment through several mechanisms. Some state Medicaid programs support cost-based or encounter-based payments for mobile units operated by Federally Qualified Health Centers (FQHCs) or community paramedicine programs that often rely on first responders to deliver care. Medicare allows Rural Health Clinics (RHCs) to include mobile unit costs in their cost reports. However, federal sequestration rules have reduced RHC payments to only 98% (down from 100%) of eligible costs since 2013.[2] La Clínica in Oregon, operates a mobile health clinic as part of its rural health services. The clinic uses cost-based payment principles by including the mobile unit's expenses—such as vehicle modification, staff salaries, and medical supplies—in its financial reporting. These costs are allocated to patient

encounters and reconciled through cost reporting, ensuring that payment reflects actual operational costs rather than a flat fee schedule.

Bundled Encounter Rates — Most Applicable for Mature Mobile Health Programs That Can Demonstrate Value to Payers. Bundled payments in mobile health can support preventive care by providing a fixed rate for a set of services. This approach allows mobile health providers to deliver care that focuses on essential preventive measures, such as blood pressure checks and lab tests, and to reach patients in communities who face barriers in accessing care at physician offices. For example, programs have contracted with health plans to close care gaps by mapping out enrolled members who are missing annual wellness visits or hypertension management and targeting them for mobile outreach and screenings.

The success of bundled payments in mobile health programs depends on a robust team-based care model, including both physician and non-physician providers, who all play a central role in delivering care by following up on medication management and closing care gaps. The Michigan Mobile Health Unit Program uses bundled payments that provide upfront rates for prevention services and per-member-per-month (PMPM) rates for remote management, often managed by pharmacist teams. This flexibility allows providers to cover costs and deliver care without being constrained by traditional fee-for-service-based coding approaches.

Bundled payments are often used to reimburse behavioral health mobile crisis programs for an episode of care, as authorized by American Rescue Plan (ARP) Section 9813. For example, California's Medicaid program, MediCal, uses bundled payments to reimburse mobile crisis program encounters that include the following services[3]:

- An initial face-to-face crisis assessment
- Mobile crisis response
- Crisis planning, as appropriate
- A follow-up check-in, or documentation that the member could not be contacted

California's Department of Health Care Services (DHCS) used a Crisis Resource Need Calculator to develop mobile crisis service encounter rates. The methodology was designed to develop encounter rates that account for the following components of the benefit: travel time, face-to-face time with the member, follow-up time, interpretation services, and standby time. Oregon also uses bundled rates to reimburse for mobile crisis response.

Table 1 provides examples of how different states reimburse mobile health services under Medicaid, detailing the specific service types, payment models, and federal authorities utilized. This summary highlights the variability of payment structures for mobile health care across the country.

Table 1: Examples of State Medicaid Payment Methodologies for Mobile Health

State	Service Type	Payment Model	Federal Authority	Notes
Oregon	Rural Health Clinic Mobile Health	Cost-based	Medicaid State Plan Amendment (SPA)	The clinic uses cost-based payment principles by including the mobile unit's expenses—such as vehicle modification, staff salaries, and medical supplies—in its financial reporting.[4]
California	Mobile Crisis Intervention	Bundled Rate	Medicaid SPA	Rate includes assessment, stabilization, follow-up. It also includes travel time, face-to-face time, follow-up, interpretation, and standby time; Rates are calculated using Crisis Resources Need Calculator.[5]
Oregon	Mobile Crisis and Outreach	Bundled Rate	Medicaid SPA	Covers entire intervention episode, including screening, assessment, stabilization, and care coordination. Planning grants used for design. Services are billed under OAR Chapter 309 and 410.
Colorado	Mobile Behavioral Health	Fee-For-Service (FFS)	Medicaid SPA	Rates based on staff time and travel costs and incorporate telehealth. They are based on cost reports for community mental health centers.
Texas	Mobile Primary Care	MCO capitation includes costs to cover FFS payments to Mobile Primary Care Programs	1915(c) waiver	MCO per member per month payments under STAR+PLUS managed care include the cost of Mobile units that are integrated into managed care networks. Then MCOs typically pay their in-network mobile health programs on a FFS basis.

Summary of Policy Considerations for Mobile Health Care Payment Methodologies

As payers develop effective payment methodologies for mobile health services, they can incorporate the strengths of current approaches and build on these methodologies to account for

the unique operational and service delivery aspects of mobile units. The following policy considerations should be included:

- **Health Impact and Quality Performance:** Ideally, payment methodologies should be periodically updated to incentivize cost-effective mobile health approaches and solutions that contribute to improved health outcomes, such as reductions in hospitalizations and increases in preventive screenings.
- **Mobility Add-Ons:** Rates should incorporate vehicle and trip expenses, recognizing that transport costs are a fundamental component of mobile health delivery and can vary across urban, rural, and frontier areas. This applies to both FFS and bundled rate arrangements, ensuring programs are compensated for travel and vehicle-related expenditures.
- **Enhancements to Cost-Based Payment:** RHCs and their mobile health clinics need alternatives that deliver the advantages of cost-based payment while avoiding the drawbacks currently imposed by Medicare constraints.
- **Uniform Rate Policies:** Standardization and transparency of rate-setting procedures are essential to promote efficiency and sustainability for mobile health programs.
- **Managed Care Integration:** When managed care organizations' capitation rates account for costs of mobile health, they are better equipped to promote sustainable payment arrangements for their network of mobile health programs.

By incorporating these considerations, all payer types can ensure mobile health programs are sustainable and fully leveraged to expand reach, and payment structures reflect the actual cost and impact of mobile health services.

Getting Started
To get started, stakeholders should review their state's Medicaid policies, assess current payment structures, and engage partners to identify opportunities for sustainable mobile health funding. Consider piloting a payment model and leveraging available data to demonstrate value and inform future policy decisions.

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[1] 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#:~:text=Mobile%20Clinic%20Services,BCIS%2DBIM:%2001%2D2021.

[2] Center for Healthcare Quality and Payment Reform, *Saving Rural Hospitals, Cost-Based Payment* website; accessed at https://ruralhospitals.chqpr.org/Cost-Based_Payment.html.

[3] California Department of Health Care Services, *Medi-Cal Mobile Crisis Services Benefit: Frequently Asked Questions*, November 2024; accessed at https://www.dhcs.ca.gov/Documents/Mobile-Crisis-FAQ.pdf (hereinafter, Medi-Cal Mobile Crisis FAQ, 2023.

[4] Higgins, A., Tilghman, M. & Lin, T.K. *Mobile health clinics in a rural setting: a cost analysis and time motion study of La Clínica in Oregon, United States*. BMC Health Serv Res 25, 97 (2025). https://doi.org/10.1186/s12913-024-12203-5

[5] Medi-Cal Mobile Crisis FAQ, November 2023.