FEBRUARY 2026

From Evidence to Implementation: Federal and State Policy Pathways for Scaling Mobile Health

Executive Summary

MAANASA KONA, JULIA BURLESON, AND LEILA SULLIVAN

Mobile health can expand access to in-person clinical, diagnostic and preventive services for patients who face persistent barriers to fixed site care, including provider shortages and transportation constraints. Yet uneven policy infrastructure constrains growth by limiting deployment of mobile services, and hindering their financial sustainability and integration into routine delivery systems.

This report examines how recent federal and state policy has enabled or constrained the expansion, financing and integration of mobile health.

SCOPE

This report defines mobile health as in-person health care delivered through vehicles that function as clinical space or operational hubs. It focuses on eight mobile health models that are prevalent in practice and well-documented in the literature: primary and preventive care, behavioral health care (including medication for opioid use disorder or MOUD), dental care, vision care, mammography screening, stroke care, behavioral health crisis care and community paramedicine/mobile integrated health (CP/MIH).

KEY FINDINGS

Mobile policy is reactive, siloed and often time-limited.

Over the past decade, mobile health has gained policy attention primarily through targeted responses to discrete pressures rather than comprehensive system design. For example, the COVID-19 pandemic accelerated investment in mobile units for testing and vaccination, but much of that support was time-limited and capital-focused, leaving many providers with vehicles but without durable operating revenue or reimbursement pathways once emergency funding expired.

POLICY PATHWAYS

Across states, the report identifies four categories of policy action that determine whether mobile services can launch, scale and persist.

1. BUILDING A REGULATORY FRAMEWORK

States apply a wide spectrum of approval authorities before mobile units launch, including notification/registration to facility-style licensure review. Whether an approval authority is enabling or constraining depends on the implementation burden. For instance, requirements for duplicative approvals across agencies or opaque approval rules can be highly burdensome.

Most states regulate mobile delivery primarily through model-specific frameworks. For example, mobile crisis teams are typically certified or licensed through behavioral health authorities and may have defined staffing, response time, and follow-up expectations. This siloed approach can create high transaction costs for programs that seek to deliver multiple services (a common need in rural or low-volume settings). Few states regulate mobile units comprehensively across service lines. California provides a prominent example, applying uniform licensure standards for most mobile units to allow them to operate under an independent license or as an extension of an existing licensed clinic, while imposing shared operating requirements.

Once authorized, mobile units can be subject to various post-deployment oversight mechanisms: periodic inspections, minimum operating standards, workforce requirements and data reporting. Where states deploy these tools in a coordinated way, they can standardize quality and improve integration. Where they are duplicative or inconsistent, they can deter expansion and make multi-service models difficult to operate.

Local zoning, parking and fire/access rules can materially determine where mobile units can operate, particularly for services (such as those targeting individuals with substance use disorders) that trigger heightened community response. Some cities or localities require special permitting or community-based hearings to approve mobile services, which can serve as barriers to operation. On the other hand, when local law is silent on how mobile units must be permitted or treated, it creates a gray regulatory area that can complicate the launch of mobile services. Some states like California incorporate local approvals into state-level oversight of mobile services and require the parent licensee to obtain the necessary local approvals.

2. PUBLIC INVESTMENT

Mobile programs face significant upfront capital costs (vehicle purchase/retrofit, equipment, connectivity/EHR capability) and recurring operating costs (staffing, maintenance, fuel, supplies, billing/compliance operations). Both federal and state policymakers deploy public dollars through direct appropriations to named programs or assets (earmarks) and grantmaking programs (mobile-specific or broader programs that allow mobile health). States additionally appropriate money to agencies that deliver or finance mobile services through contracts/subgrants/procurement, and, less commonly, offer tax incentives to reduce operating costs.

Crisis response and MOUD-related models appear disproportionately represented in model-wide investment strategies, while earmarks are common for visible assets in primary care, dental care and screening.

A recurring pattern is that capital-only investments can expand fleets quickly but do not, by themselves, create durable service capacity. Programs often need parallel support for billing infrastructure, compliance capability and data reporting, and to plan for long-term financial sustainability. Grant and appropriation design that treats vehicles as the primary output can unintentionally leave operators with stranded capital assets once time-limited funds expire.

3. INSURANCE REIMBURSEMENT

Medicare. Medicare does not recognize mobile clinics as a distinct provider/supplier category. Mobile delivery is largely treated as a site of service (with a distinct mobile place-of-service code) governed by service-specific payment rules. This framework generally does not recognize the incremental costs of mobile delivery (travel time, routing inefficiency, setup/teardown). Medicare has also historically tied payment to transport rather than care without transport, constraining treat-in-place models such as CP/MIH.

Medicaid. Medicaid is the locus of more explicit mobile policy design. States can define mobile models as covered benefits (most notably mobile crisis services aligned with federal criteria), set payment methodologies tailored to mobile cost structures (including bundled or per-episode approaches), and use managed care contracting to ensure mobile capacity is actually included in networks and referral pathways. While coverage and rates matter, network inclusion and operational integration often determine whether patients can practically access mobile services.

Private insurance. State-regulated commercial coverage policies are thinner and more model-specific than Medicaid activity, often relying on targeted mandates and consumer protections related to cost sharing, prior authorization and balance billing. A notable cross-model approach is Arkansas's 2025 legislation requiring coverage of services delivered in a mobile unit when billed with a mobile place-of-service code if the service is otherwise covered in other settings, across Medicaid and state-regulated commercial plans.

4. UNDERSTANDING AND INTEGRATING MOBILE DELIVERY

A smaller but meaningful set of states is beginning to treat mobile health as a delivery platform requiring statewide visibility, planning, and integration. These efforts include commissioning landscape assessments, creating advisory committees, building shared learning infrastructure and data repositories, and formalizing coordination mechanisms linking mobile services to other systems.

While still emerging, these approaches reflect an important maturation: mobile units are most effective when routinized into referral networks, data systems and accountability structures, not deployed only as episodic outreach or emergency response.

RECOMMENDATIONS FOR POLICYMAKERS

Expanding and integrating mobile into the broader delivery system depends on whether federal and state policymakers can build a coherent, platform-level policy framework that aligns appropriate oversight with sustainable financing, reimbursement, and routine integration into existing systems.

FEDERAL POLICYMAKER RECOMMENDATIONS

1. Establish a CMMI model to support state mobile health infrastructure development, focused on developing state regulatory frameworks, encouraging Medicaid integration and fostering long-term financial sustainability.
2. Shift the focus of federal grantmaking toward building shared infrastructure and technical assistance instead of just vehicle acquisition.
3. Align Medicare policy with mobile delivery realities by testing payment approaches that recognize the mobile cost structure.
4. Modernize HRSA scope of service policy for FQHC-operated mobile units to streamline mobile site additions.

STATE POLICYMAKER RECOMMENDATIONS

1. Develop regulatory frameworks across mobile that reduce duplicative approval requirements, allow mobile units to operate as extensions of licensed providers where appropriate, and establish baseline mobile operating standards while reserving specific rules for tightly regulated services.
2. Pair grantmaking with technical assistance on regulatory compliance and building financial sustainability.
3. Use Medicaid to normalize mobile delivery by clarifying mobile as an allowable setting of care, adopting payment methods that reflect the realities of mobile operations, and embedding mobile providers into managed care networks and referral pathways.
4. Align state-regulated private insurance with mobile integration goals by normalizing coverage for mobile services and preventing higher cost sharing or unnecessary utilization management.
5. Build durable state capacity to coordinate and integrate mobile health into the broader health care delivery system through standing coordinating bodies and integration requirements with other state systems such as 988 response, emergency departments, schools and child welfare.

Read the full report at chir.georgetown.edu/mobile-health

*This report was produced with a grant from the **Leon Lowenstein Foundation**.*