FEBRUARY 2026

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

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ACKNOWLEDGMENTS

This research was supported by the Leon Lowenstein Foundation. The authors are especially grateful to Dr. Nancy Oriol, Mary Kathryn Fallon, and colleagues from Harvard Medical School's Mobile Health Map team for their thoughtful review and feedback on this report.

Leon Lowenstein Foundation

Introduction

Despite spending nearly $5 trillion annually on health care, millions of Americans struggle with access to health care.

Barriers such as lack of insurance, provider shortages, unreliable transportation, language barriers, and experiences of discrimination persist nationwide. These barriers disproportionately affect rural residents; racial, ethnic, sexual, and gender minorities; immigrants and seasonal agricultural workers; people experiencing homelessness or a substance use disorder; and children in low-income communities. These inequities translate directly into poorer health outcomes and shorter life expectancies for underserved populations.

Improving access to care typically requires bolstering the health care workforce and increasing available points of care, especially in underserved communities. While telehealth has received substantial policy attention in recent years, especially following the COVID-19 pandemic, it cannot fully mitigate gaps in access that require in-person services or affect populations facing digital barriers. Mobile health models can deliver hands-on clinical care directly in communities and reach patients who cannot reliably access fixed site clinics or telehealth services.

A growing body of evidence demonstrates that mobile health can work across a range of clinical contexts and fill critical access gaps. In September 2025, we published a narrative review synthesizing evidence from more than 160 studies on how mobile health models can positively affect access to care, quality, utilization, and costs across a wide range of clinical services and populations. Despite this evidence, policy infrastructure remains a binding constraint, limiting the ways in which mobile health care can be financed and integrated into the broader health care delivery system. As a result, the current mobile health delivery system remains fragmented and ad hoc, with many programs depending on one-time grants or philanthropic support rather than being embedded as durable, reimbursed components of routine care.

In this report, we examine how federal and state policy since 2015 has enabled or constrained the expansion, financing, and integration of mobile health into the broader health care delivery system, and identify concrete policy levers to support sustainable and scalable mobile solutions.

Defining Mobile Health

Mobile health refers to in-person health care delivered through vehicles such as vans, buses, trailers, or retrofitted ambulances. The vehicles function as clinical space, mobile infrastructure, or operational hubs that allow care teams to deliver clinical, diagnostic, and preventive services directly in communities rather than requiring patients to travel to fixed site facilities.

The broader mobile health delivery ***platform*** encompasses multiple delivery ***models***, which cluster programs by the primary type of service delivered. ***Programs*** are local implementations of a given model operated by a specific organization or government entity. Drawing from the evidence base synthesized in our prior report, we have identified eight models of mobile health that are both well-documented in the literature and prevalent in practice and policy discussions:

- ***Primary and preventive care models***
- ***Specialty care models:***
  - Behavioral health care (including Medication for Opioid Use Disorder or MOUD)
  - Dental care
  - Vision care
  - Mammography screening
- ***Models that intersect with crisis and emergency services:***
  - Stroke care
  - Behavioral health crisis care
  - Community paramedicine or mobile integrated health care (referred to in this report as either CP/MIH or community paramedicine)

Although these models vary in clinical scope and operational design, programs operating across them face common policy challenges related to licensure, financing, reimbursement, and integration into the broader health care delivery system. To date, most policy actions target these challenges model by model, rather than treating mobile health as a broader delivery platform with shared infrastructure needs and policy levers.

In this report, we focus on mobile units that deliver in-person health services (clinical, diagnostic, or preventive). We do not include information related to outreach-only or social service mobile programs that do not deliver health services.

Methodology

To identify federal and state policies and funding streams that affect mobile health programs, we reviewed statutory law, legislation, grants, and state Medicaid documents enacted or effective between January 2015 and June 2025.

CURATING SEARCH TERMS. We developed a list of search terms that included multiple phrases used to describe mobile health, the names of each mobile health model identified during our prior literature review, and related terms and synonyms used in the academic and policy literature.

IDENTIFYING POLICIES AND FUNDING STREAMS EXPLICITLY FOCUSED ON MOBILE HEALTH. Using Lexis+, we conducted a scan of federal and state statutes that explicitly referenced one or more mobile health models. We also reviewed Medicaid State Plan Amendments and 1915(b), 1915(c), and 1115 waivers to identify changes affecting the coverage, reimbursement, delivery, or regulation of mobile health services under Medicaid during the review period. In addition, we reviewed federal grant archives and publicly available state grant program materials to identify funding streams that supported mobile program startup or operations or identified mobile health as an allowable use of funds.

TRACKING AND SYNTHESIZING OUR FINDINGS. Each policy or funding item was coded by mobile health model, policy mechanism (such as regulation, direct investment, or payer integration), and mechanism type (such as structural statutory change or time-limited appropriation). We used this coding to identify trends and common policy approaches, highlight illustrative federal and state-level examples, and assess gaps in the policy and funding framework.

LIMITATIONS. While our review was extensive, it was not intended to exhaustively catalogue every federal, state, or local policy affecting mobile health. Rather, it was designed to identify broad policy trends, common approaches, and recurring constraints across jurisdictions, and to highlight illustrative examples that demonstrate how mobile health is currently being regulated, financed, and reimbursed in practice. The presence of a policy does not guarantee consistent implementation, and policies may have evolved after the review period.

A NOTE ON CITATIONS IN THIS REPORT. We use hyperlinks to cite to sources that support the background sections of this report (Sections I to IV). We shift to the use of detailed endnotes when presenting the findings from our research (Sections V to VIII).

Understanding Mobile Health Policy Tradewinds

Over the past decade, mobile health has gained policy attention as states and the federal government have sought new ways to expand access to care and respond to public health crises. That attention, however, has translated into uneven policy development, producing a patchwork of model-specific, time-limited, and often uncoordinated approaches rather than a cohesive framework supporting mobile care delivery as a whole. Mobile health policy has evolved primarily through targeted responses to distinct challenges—such as public health emergencies, behavioral health crises, and strain on emergency care systems—rather than through comprehensive system design. As a result, policy support has tended to cluster around particular models and funding streams, leaving broader questions of sustainability and system integration unresolved.

The ***COVID-19 pandemic*** illustrates this pattern. As public health mitigation measures and social distancing protocols reduced access to in-person care at fixed site facilities, federal and state policymakers acted rapidly to remove barriers to telehealth, and many providers shifted outpatient care to telehealth settings. At the same time, policymakers and providers relied on mobile health as a practical way to deliver essential in-person services that could not be provided virtually, particularly ***COVID-19 testing and vaccination services.*** The ***American Rescue Plan Act of 2021 (ARPA)***, enacted in the wake of the pandemic, supported these efforts by making funding available to health centers to expand access to COVID-19 vaccination, testing, and treatment, and by explicitly allowing those funds to be used to add mobile units.

These investments enabled many providers such as Federally Qualified Health Centers (FQHCs) to purchase mobile units and deploy them quickly for testing, vaccination, and outreach. However, these investments were largely time-limited and capital-focused. As funding expired, many providers were left with newly purchased mobile infrastructure but without reliable operating dollars or reimbursement pathways to sustain mobile services over time.

Pandemic-related stressors, ***rising mental health needs, and the ongoing opioid crisis*** further shifted policymaker focus toward strengthening behavioral crisis response systems. In 2020, Congress enacted the National Suicide Hotline Designation Act, designating 988 as the universal telephone number for the national suicide prevention and mental health crisis hotline system. Building on that foundation, ***ARPA*** created a new Medicaid state option to support ***community-based mobile crisis intervention services*** and authorized a time-limited enhanced federal match to accelerate state investment in mobile crisis response services. As of September 2024, 20 states and the District of Columbia have opted in.

A similar set of system pressures has helped elevate ***community paramedicine and mobile integrated health care (CP/MIH)*** in the policy space in recent years. As states confront rising ***emergency department crowding, workforce shortages, and increased demand on 911 systems***, CP/MIH—through which paramedics provide assessment, treatment, and referral outside of traditional emergency transport—has emerged as a strategy for delivering care in lower acuity settings and reducing unnecessary transports and hospital utilization. The Centers for Medicare & Medicaid Services (CMS) signaled interest in testing core CP/MIH concepts by launching a related demonstration model in 2020. In parallel, national organizations converged around clearer definitions, standards, and evidence establishing the value of CP/MIH. Together, these developments have created a favorable policy environment, and state policymakers are increasingly enacting laws to authorize, standardize, and integrate CP/MIH into the broader health care delivery system.

Taken together, these examples demonstrate both the limitations and the potential of current mobile health policy. While much policy support has been in response to discrete challenges and remained siloed within individual models, recent advances in mobile crisis services and CP/MIH services illustrate how mobile health can move beyond pilots when policy development is comprehensive. In these cases, policymakers have paired recognition/authorization of the model with clearer operating standards, and mechanisms to ensure ongoing payment and system integration.

These experiences suggest that mobile health can achieve sustainable scale when regulatory frameworks, financing mechanisms, and reimbursement pathways are designed to work together as integrated policy architecture.

The findings of our policy scan build on these lessons. Across states, we identify four categories of policy action that are central to supporting the establishment of new mobile clinics, sustaining them over time, and integrating them into the broader health care delivery system:

1. Building regulatory frameworks that recognize and authorize mobile delivery, establish unifying operating standards, and provide appropriate oversight.
2. Infusing capital and operating resources to support acquisition, maintenance, and operation of mobile clinics.
3. Developing reimbursement pathways that ensure adequate payment for mobile services and support long-term financial sustainability.
4. Aligning mobile health with cross-cutting policy domains, such as workforce scope of practice laws or local zoning requirements, that can enable or constrain mobile delivery in practice.

The following sections examine each of these policy domains in turn, drawing on state and federal examples to illustrate how mobile health has been supported as well as where gaps remain.

Building a Regulatory Framework for Mobile Health

A well-designed regulatory framework for mobile health can help standardize care delivery, establish accountability, and integrate mobile health care into the broader health care system. It can make mobile providers visible not only to the state, but also to payers, hospitals, schools, emergency personnel, and local governments. Clear state-level recognition can replace ad hoc, payer-by-payer or locality-by-locality determinations for contracting, reimbursement, and coordination. Such recognition can also help states better understand community needs and resources, and facilitate integration of mobile health into the broader delivery system by setting shared expectations for referrals, handoffs, and data sharing with other providers and public systems.

However, establishing a regulatory framework to oversee mobile health delivery is not inherently enabling. When designed as a clear, proportional pathway, it can reduce transaction costs and facilitate payer and partner integration. When the framework is fragmented across agencies, duplicative across service lines, or unclear as applied to mobile settings, the same framework can operate as a de facto barrier to entry and scale.

The following subsections focus on the regulatory pathways that govern authorization to operate mobile clinics, and the separate set of rules that constrain delivery settings, eligible patients, and provider scope once a mobile service is in operation.

A. Pre-Deployment Approval Requirements

Pre-deployment approval requirements determine who may operate a mobile unit, under what authority, and with what accountability to the state. States use different mechanisms to authorize mobile units (see the Key Terms box). These mechanisms sit on a spectrum from low-friction notification or registration to full facility-style licensure. In some states, a mobile site approval may even be routed through a Certificate of Need process.

The goals of these approval requirements vary: (1) tracking the deployment and usage of mobile units; (2) ensuring that all mobile services being delivered in the state meet certain safety and quality standards; (3) creating shared standards to ensure continuity between mobile and fixed site traditional health care services; and (4) in some states, certificate of need reviews assess market need and shape the supply of health care services in response to that need.

In practice, whether a pre-deployment approval mechanism can be considered to be enabling mobile health delivery depends less on the label used for the approval process and more on complexity and burdens associated with that process (such as required documentation, application fees, and minimum operating standards), as well as whether operators must seek approvals from multiple agencies or navigate overlapping or conflicting requirements.

1. Federal Authorization Requirements for Certain Services

Certain service lines trigger federal certification or accreditation requirements that apply regardless of whether care is delivered in a mobile or fixed setting.

- ***Medication for Opioid Use Disorder Services*** – Certain key medications used to treat opioid use disorders—methadone and buprenorphine—are controlled substances under federal law. The United States Drug Enforcement Administration (DEA) closely regulates who can prescribe, administer, or dispense these medications.[2] Of the two drugs, access to methadone is much more closely regulated. The DEA only allows Opioid Treatment Providers (OTPs) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and registered with the DEA to dispense methadone. In 2021, the DEA finalized a rule allowing registered OTPs to operate mobile medication units (MMUs) without seeking a separate DEA registration for the mobile unit.[3]
- ***Mammography*** – The Mammography Quality Standards Act (MQSA) requires that, before a facility can legally perform mammography, it must be certified. To be certified, providers must meet certain standards and obtain accreditation through an accrediting body.[4]
- ***Clinical laboratory testing*** – Under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), clinical laboratories are generally required to hold an appropriate CLIA certificate before they can accept human specimens for testing.[5] Mobile programs that perform only CLIA-waiver point-of-care tests can operate under a CLIA Certificate of Waiver, which generally entails fewer CLIA requirements than moderate- or high-complexity testing, though waived testing still requires a CLIA certificate and adherence to manufacturer instructions.[6]
- ***Nuclear medicine and Positron Emission Tomography (PET) scans*** – Any provider, including a mobile program provider, offering nuclear medicine services or PET scans that uses or possesses byproduct radioactive material for medical use requires a license issued by the United States Nuclear Regulatory Commission (or in certain states, from a state regulator operating under an agreement with the Commission).[7]

2. State Authorization of Mobile Health Care Delivery, as a Whole

Only a few states regulate mobile units as a whole, applying rules across all models and mobile service lines. California serves as an exception and sets uniform licensure requirements for almost all mobile units operating in the state. Units are required to either be independently licensed or approved as part of an existing fixed site facility or clinic license.[8]

Instead of requiring prior approval for all mobile units, a few states require prior approval for only those mobile units that are not already subject to other state or federal regulatory frameworks that oversee providers or licensed clinicians. For example, Minnesota only regulates mobile evaluation and screening providers that are not affiliated with a state-licensed facility or certain state-licensed professionals.[9] Nevada requires a separate license for each mobile unit, but exempts units operated by certain accredited facilities, FQHCs, or emergency medical services organizations.[10] Florida generally requires licenses for mobile health clinics, but broadly exempts many practitioner-owned and safety net entities operating mobile clinics from the licensure requirement.[11]

3. State Certificate of Need Requirements for Mobile Health Care Delivery

Certificate of need (CON) laws require advance state approval for specified types of new health care capacity, service lines, or major capital expenditures. In the mobile context, CON can operate as a conduit for state-level oversight that resembles facility prior approval or licensure requirements, or, in some states, it can operate as a barrier to entry by requiring discretionary approval that can delay or prevent a mobile program from launching, expanding service lines, or deploying certain equipment. Whether a CON process functions primarily as oversight or as a barrier in practice depends on implementation details such as the scope of review, the evidence required, timelines, application fees, opportunities for objections, and the risk of denial. In many states, whether a mobile unit is CON-relevant hinges on whether the unit is treated as (1) a reviewable site of service, (2) a vehicle hosting a CON-regulated service or major medical equipment, or (3) a capital expenditure exceeding a set threshold.

New York treats mobile clinics as extensions of existing health care facilities and requires a CON review to add the mobile extension clinic to the provider's operating certificate (with review framed around safety and appropriateness rather than a formal market need determination).[12] In 2025, the state made mobile vans eligible for a more streamlined "limited review" pathway.[13] Kentucky, on the other hand, specifically exempts "mobile health services" from CON requirements unless the mobile unit is providing a service otherwise subject to CON review, such as imaging services.[14] Iowa's CON definitions treat "any mobile health service" valued over $1.5 million as a "new or changed institutional health service" subject to CON review.[15]

4. State Authorization of Mobile Health Care Delivery, Model-Specific

Several states require prior approval or authorization for individual models of mobile health care delivery, such as community paramedicine or mobile crisis units. Generally speaking, these state laws (1) define a specific mobile model they want to regulate, (2) specify who can operate a mobile unit under this model, and (3) establish some form of prior approval process, an oversight agency, and minimum standards and requirements for operators for continued authorization.

- ***Community Paramedicine or Mobile Integrated Health Care (CP/MIH)*** – The CP/MIH model expands the role of existing emergency medical services (EMS) personnel and vehicles, allowing them to provide certain at-home health care services. At least twelve states recognize CP/MIH programs in law and treat them as an extension of their existing EMS systems instead of establishing a new mobile clinic category. Most of these states require EMS providers to apply for endorsement or approval from a state-level entity, such as the state EMS board, and pair this authorization with minimum program standards and mechanisms for oversight.[16] California combines state approval of a CP/MIH program with local authorization of participating providers by local EMS agencies.[17] New Jersey establishes a statewide MIH program administered by the Department of Health under which entities must obtain departmental authorization and comply with implementing rules.[18] In some states, CP/MIH programs are authorized through the EMS system, and their geographic reach may be limited by the service area of the sponsoring EMS agency and local EMS rules.[19]
- ***Dentistry Services*** – Louisiana, Oklahoma, Virginia, and Wisconsin require mobile dentistry programs to register with a state board of dentistry before delivering services.[20] Virginia exempts certain programs, such as those operated by government agencies or certain safety net providers, from registration requirements.
- ***Behavioral Health Crisis Teams*** – New York defines "mobile crisis teams" as teams licensed, certified, or authorized by the Office of Mental Health and Office of Addiction Services and Supports.[21] Minnesota requires any individual or organization certified to provide mobile crisis services to comply with licensure responsibilities under the state Mental Health Uniform Service Standards Act.[22]

- ***Medication for Opioid Use Disorder*** – After recent federal policy changes that eased restrictions on mobile delivery of methadone (see above), some states have formalized how MMUs fit into state-level oversight of OTPs. Washington and Utah enacted laws recognizing MMUs as extensions of licensed OTPs, with Utah requiring MMUs to adhere to certain additional operational safeguards.[23] North Carolina, on the other hand, requires OTPs to seek approval from the state to add a mobile unit to its license. [24]
- ***Stroke Units*** – Texas allows a hospital to operate a mobile stroke unit under its license as long as the mobile stroke unit is accredited by a CMS-approved accrediting body.[25]

While this kind of model-specific regulation and oversight may be appropriate for tightly regulated services, such as for mobile medication units dispensing controlled substances, siloed frameworks can create confusion and heightened administrative burden in certain settings. In rural communities, low service volume and workforce scarcity might require mobile clinic operators to deliver multiple services or to adapt flexibly to changing community needs, which might result in operators having to navigate several regulatory frameworks at a time.

5. What Pre-Deployment Authorization Processes Look Like in Practice

States that require mobile unit operators to obtain pre-deployment authorization vary widely in terms of establishing the prerequisites that the operator must satisfy to obtain the authorization or prior to launching services. These requirements cluster into a few categories:

- ***Renewal frequency*** – In most states that require pre-deployment authorization, the license or registration is only valid for a certain amount of time, and the program must periodically renew its authorization. Most commonly, authorization lasts for either one[26] or two years.[27]
- ***Registration fees*** – Many states require operators submitting a request for pre-deployment authorization to pay a fee with their application. For example, California requires mobile optometric clinics to pay a nonrefundable fee between $472 and $600 (the authorizing agency has discretion to decide the exact amount).[28] Oklahoma requires mobile dental clinics to pay a fee between $200 and $400, and exempts religiously affiliated nonprofits offering free services from the registration fee requirement.[29] Connecticut requires an annual $200 fee for EMS agencies seeking a state license to operate a CP/MIH program.[30]
- ***Operational plans*** – Some states require mobile clinic operators to submit operational plans during the pre-deployment authorization application process. For example, Minnesota requires mobile screening and evaluation programs to file anticipated locations of practice, schedules, and routes, while California and Utah require CP/MIH programs to submit operational plans ahead of time.[31] Nevada requires mobile clinics to specify in their applications what services they will be providing and their proposed service sites.[32]

A few outlier states, such as California and Nevada, impose more granular approval requirements that mirror licensure requirements for other health care facilities. For example, in California, mobile units must first comply with all applicable requirements of the state's Vehicle Code and receive approval from the state's Housing and Community Development agency certifying compliance with certain safety and construction standards. State regulators are then required to conduct an onsite inspection and review the mobile unit's policies and procedures prior to granting approval.[33] Nevada requires mobile units applying for pre-deployment approval to submit proof of motor vehicle registration and provide information about the manufacturer. Nevada also requires units to meet certain physical specifications and for unit operators to ensure patient privacy and safe waste disposal. Prior to operating, unit operators must have in place written operational policies about clinical care, training and supervision of staff, procedure protocols, medication handling, infection control, and recordkeeping.[34]

B. Constraints on Deployment and Scope

Some federal and state rules limit where and how mobile services can be delivered in practice. They can function as binding constraints on the ability to deploy mobile capacity when needed.

1. Federal Geographic Constraints

Federal requirements for safety net providers, such as Rural Health Clinics (RHCs) and FQHCs, can shape the geography in which affiliated mobile units operate. For example, FQHCs must ensure that their service sites (including mobile service sites) are accessible to the community they serve, taking into consideration travel distance and time for patients.[35] In practice, this means a mobile unit generally operates in the same service area as its parent clinic and deploying a mobile unit outside this area may require approval of a change in scope from the Health Resources and Services Administration (HRSA).[36]

In reviewing requests to add service sites, HRSA considers potential overlap and requires applicants to address how proposed mobile sites will complement, rather than duplicate, existing FQHC services when service areas overlap.[37] On the other hand, RHC certification is tied to a clinic located in a rural shortage area, and Medicare payment depends on encounters meeting the definition of an RHC visit. Providing services away from the certified clinic site can add administrative complexity to the Medicare billing process.[38]

2. State Setting and Patient Population Constraints

In addition to federal program rules, some states impose setting- and population-based constraints that limit mobile services to narrowly defined contexts. These constraints may be framed at the service-line level (restricting where a mobile program may operate and which populations it may serve), or at the workforce level (conditioning where certain clinician types may practice, including on mobile units).

Mobile vision program–related constraints. At least three states explicitly limit who may operate a mobile vision program or the sites or populations it may serve. South Carolina limits mobile optometry service sites in statute to specified settings (licensed health care facilities and certain public schools for low-income children).[39] Nevada limits mobile optometry delivery to specified groups and settings (governmental agencies, patients with impaired or restricted mobility, members of low-income and other medically underserved groups, and academic programs).[40] California limits ownership and operation of a mobile optometric office to certain qualifying nonprofit and charitable organizations that provide services regardless of the patient's ability to pay.[41]

Oral health workforce setting constraints. Several states limit the provision of mobile dental services by restricting where certain oral health clinicians may practice and which patient populations they may serve. These laws do not prohibit mobile dental delivery outright, but instead they channel mobile deployment toward safety net contexts by tying mobile practice to specific settings or underserved populations. Two common approaches appear in state statutes. First, states such as Arizona and Virginia restrict certain oral health clinicians to a closed list of approved settings, such as FQHCs, community health centers, nonprofit clinics serving low-income or underserved individuals, school-based programs, long-term care facilities, or other public health settings.[42] Under these frameworks, dental therapists and, in some cases, dental hygienists may provide services on mobile dental units only when the units are operated by, affiliated with, or explicitly included within these permitted settings. Second, states such as Michigan, Minnesota, and Nevada allow dental therapists to practice on mobile dental units only if a defined share of their patient base meets statutorily defined criteria for being medically underserved (enrollment in public health programs, the presence of disabilities or chronic conditions that create barriers to receiving dental care, or lack of coverage combined with a low income).[43]

3. Local-Level Service Constraints

Local land use, parking, and fire/access rules can materially constrain where a mobile unit can operate. In practice, these constraints often show up as (1) requirements to obtain a permit tied to a specific deployment site (temporary use permits, special use permits, event permits, right-of-way or road-closure permits), and (2) operational limits embedded in local zoning codes (limits on operating in residential zones or dispensing MOUD in school zones, restrictions on operating in the public right-of-way, time limits, or requirements for accessible ingress/egress, traffic circulation, and fire access).

California illustrates how local siting requirements can be incorporated into a statewide mobile clinic regulatory framework.[44] The state makes the parent facility or clinic responsible for obtaining any required approvals for the mobile unit site from local planning, zoning, and fire authorities, and the unit must comply with local parking laws. In addition, the licensee must report a new site to the state in advance and notify local authorities before the first visit to obtain any required local approvals.

Some municipalities regulate mobile medical services directly through zoning. For example, Redding, California defines "Mobile Medical" and only allows mobile units to offer oral health preventive services and primary care and preventive health care programs in collaboration with a local hospital or licensed medical clinic.[45] The city requires mobile operators to acquire an approved operational plan and allows for the operational plan process to include a public meeting to solicit feedback from neighboring property owners. Similarly, Springdale, Ohio conditions "mobile use, medical" on obtaining permission from the property owner where the van seeks to park, bans services from being provided in residentially zoned property, and requires an approved road closure to park in a public right-of-way.[46]

The lack of recognition of mobile vans in local ordinances can create problems. In discussing the impact of local zoning ordinances on the operation of mobile methadone units, a 2025 report by the Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy finds that "zoning laws often do not have a section that addresses mobile medication units [and this] might prevent local officials from allowing the units because there is no clear guidance on their approval."[47]

C. Post-Authorization Requirements

Pre-deployment authorization requirements determine who may operate a mobile unit, and deployment constraints determine where and how mobile care can be delivered. Operating standards and oversight mechanisms, by contrast, shape how care must be delivered once a mobile unit is operating. States use a range of tools to set minimum expectations, monitor compliance, and create ongoing accountability over time, including inspection authority, baseline operating standards (sometimes written for mobile units as a platform and sometimes embedded in model-specific frameworks), workforce requirements, data collection and reporting, and (in a smaller set of contexts) liability protections. These levers shape the transaction costs and accountability mechanisms that apply after a mobile unit is authorized.

1. Inspection Authority and Compliance Monitoring

States vary in whether and how they exercise oversight authority once they have granted a mobile program initial permission to operate. For example, Florida requires mobile clinics subject to independent licensure requirements to submit quarterly reports on their projected street location to enable the state to locate and inspect the clinics.[48] California similarly provides that a licensee providing mobile services may be periodically inspected at the regulating agency's discretion.[49]

2. Operating Standards, Clinical Protocols & Patient Protections

Several states have established certain minimum operating standards such as baseline patient protections, standardized clinical oversight, access and responsiveness, and continuity of care. States may impose different operational standards depending on the model of mobile health care delivery:

- ***Baseline Patient Protections*** – Some states set operating standards to ensure that mobile health services provide patients with basic rights and safeguards comparable to those in fixed site settings. These protections often include transparency about services, access to medical records, privacy, and culturally competent care. For example, mobile dentistry laws in Ohio and Wisconsin focus on patient-facing protections, including disclosure of services, access to dental records, and standards of professional conduct.[50] Similarly, behavioral health crisis services in Maryland require culturally competent service delivery, language access, and limits on law enforcement involvement during crisis response.[51]
- ***Standardized Clinical Oversight*** – Some states also require statewide or agency-approved protocols to ensure consistency and quality across mobile health programs. CP/MIH programs can be subject to review and approval by state or local EMS authorities. For example, Connecticut directs its Commissioner of Public Health to establish standards to ensure the health, safety, and welfare of patients served by CP/MIH programs, while California requires its Emergency Medical Services Authority to review local CP/MIH proposals and clinical protocols against statewide minimum standards.[52] In North Carolina, Opioid Treatment Providers (OTPs) must conduct initial intake psychosocial and medical assessments along with a full physical examination within 14 days of admission.[53]

- ***Access and Responsiveness*** – Some states emphasize access and responsiveness as core elements of safe mobile crisis services. Colorado requires mobile crisis units to be available statewide and capable of responding within two hours, whether in person or via telehealth.[54] Maryland defines mobile crisis teams in part by operational capacity, requiring 24/7 availability for assessment, stabilization, follow-up, and referral.[55] Meanwhile, behavioral health crisis services in Kansas rely on the Department for Aging and Disability Services to develop guidelines for deploying mobile crisis teams.[56]
- ***Continuity of Care*** – Some states set standards designed to prevent mobile services from operating in isolation from the broader health care system. For example, Maryland requires mobile crisis teams to prioritize follow-up care, peer support, family support, and referrals to other providers after stabilization.[57]

STATE SPOTLIGHT –

California's Approach to Uniform Licensing and Oversight

California offers one of the clearest examples of a state applying uniform standards across all licensed mobile units, requiring mobile clinics to maintain written policies governing the services they provide, including policies related to patient care, personnel training and orientation, personnel supervision, and evaluation of services provided by the mobile unit.[58] The state also requires mobile units to ensure safe patient access, outlines equipment maintenance requirements, and requires mobile units to have transfer agreements in place with nearby hospitals and clinics in the event of a medical emergency.[59]

3. Workforce Standards for Mobile Delivery

Several states have established a variety of workforce-related standards for different models of mobile health delivery.

- ***Credentialing, Certification, and Permitting*** – Some states set certain minimum qualification requirements for operators and staff of mobile clinics. For example, Louisiana only allows licensed dentists with a state-issued mobile dental permit to operate a mobile dental clinic, and makes the dentist responsible for compliance with state laws and ensuring patient safety.[60] Utah has established certification requirements for mobile crisis teams, while Nevada and California have set certain minimum certification requirements for community paramedics delivering CP/MIH services.[61]
- ***Supervision and Scope of Practice*** – Some states establish supervision requirements for certain types of health care professionals delivering services in a mobile unit. For example, Minnesota requires all mobile health evaluation and screening providers to be directly supervised by a physician and Louisiana similarly requires state mobile cholesterol screening units to be organized and provided under the general supervision of a licensed clinical laboratory or a licensed physician.[62] Indiana requires mobile crisis teams to be supervised by a behavioral health professional, a physician, or an advanced practice registered nurse, but allows the supervision to take place remotely.[63] Maine requires community paramedicine services to be provided under the supervision of a primary care medical director, while Utah requires them to be provided under the direct or indirect supervision of a nurse practitioner or physician assistant.[64] Several states require dental hygienists and dental therapists to be supervised by licensed dentists when providing mobile services.[65]
- ***Staffing of Mobile Crisis Services*** – Several states define the team composition for mobile crisis services. For example, Colorado requires multidisciplinary teams with at least one licensed or bachelor's-level behavioral health worker, while Virginia requires mobile crisis teams to include one or more qualified or licensed mental health professional (including peer support staff), and prohibits law enforcement officers from being team members (they are allowed to provide backup as needed).[66]

- ***Training and Competency Requirements*** – Some states have established certain minimum training and competency requirements for those providing mobile crisis services and CP/MIH services. For example, Connecticut requires mobile crisis personnel to have on hand, in their work vehicles, a communication aid with techniques for serving and interacting with juveniles and adults with autism spectrum disorder, cognitive impairment, and nonverbal learning disorder.[67] Colorado and Iowa require state regulators to establish training standards for mobile crisis service providers.[68] Wyoming requires mobile crisis response personnel to be trained in trauma-informed care, de-escalation, and harm reduction, and requires that the mobile crisis program involve community partners and reflect local demographics.[69]

  Delaware requires that CP/MIH programs use appropriately trained paramedics who have completed a structured education program with didactic and clinical components, while Utah directs the state EMS bureau to establish training requirements.[70]

- ***Immunity from Liability*** – Both Oregon and South Dakota create legal safe harbors for personnel providing mobile crisis services in good faith. Oregon exempts a mobile crisis team member from both criminal and civil liability while South Dakota exempts mobile crisis team members (including crisis intervention team certified law enforcement officers) from civil liability.[71]

- ***Background Checks*** – Wisconsin requires its Department of Safety and Professional Services to investigate whether an applicant for or holder of a mobile dentistry program registration has been charged with or convicted of a crime.[72] Maine requires state regulators to adopt rules requiring authorized community paramedicine services to comply with background check laws.[73]

4. Data Collection and Reporting Requirements

Some states have established data reporting requirements to support quality monitoring, enable program evaluation, and occasionally, to enforce public health reporting requirements related to certain reportable diseases.

- ***General data collection requirements*** – Connecticut and Massachusetts both generally require data collection from the CP/MIH programs.[74] Connecticut's stated goal is to ensure and measure the quality of outcomes for these programs.

- ***Periodic operational reporting requirements*** – Some states require mobile operators to submit periodic operational updates. For example, California requires mobile optometry operators to file a quarterly report with information about services provided, staffing, and complaints, among other metrics.[75] Nevada and Maine require their CP/MIH programs to submit periodic reports. Nevada requires quarterly reports to the local health authority and Maine requires programs to submit data and written reports to the Medical Direction and Practices Board.[76]
- ***Utilization, outcomes, and client experience or demographic data*** – States most often require this data from mobile crisis programs. For example, Minnesota requires mobile crisis providers to submit utilization and outcome data to the state and Virginia requires providers to collect customer service data from individuals served, including demographic information and any information recommended by SAMHSA.[77] Kentucky, on the other hand, requires its CP/MIH programs to collect and provide patient care record data to the state Board of Emergency Medical Services while complying with all federal privacy rules.[78]
- ***Public health reporting*** – Mobile health services can also trigger public health reporting obligations when they involve laboratory examinations or communicable disease findings. Texas requires mobile units conducting certain laboratory examinations to report findings to the health department and the local health authority when findings relate to a reportable disease.[79] Rhode Island requires timely notification to the state department of health for certain mobile unit laboratory examinations related to HIV/AIDS.[80]

Taken together, these operating standards and oversight mechanisms shape the day-to-day functioning of mobile service providers.

A NOTE ON REGULATION AND FINANCING.

Federal and state policymakers can either use their regulatory or licensing authority to mandate minimum standards for mobile service delivery (as discussed in Section V) or they can make meeting certain minimum standards a prerequisite for receiving certain financial incentives, such as direct public investment (discussed in Section VI below) or eligibility for public insurance reimbursement (discussed in Section VII below). When public insurance (Medicare or Medicaid) is a dominant source of revenue for a mobile program operator, such contingent requirements become de facto mandates.

Federal and State Financial Investment in Mobile Health

In terms of financial support, mobile health programs require (1) meaningful upfront capital to purchase or retrofit a vehicle, obtain necessary medical equipment, install storage and infection control infrastructure, and to develop technological infrastructure for electronic records management and internet connectivity; and (2) recurring operating revenue to pay staff, maintain and deploy the unit. Federal and state policymakers have used direct public investment as a way to support mobile health's financial needs.

Across jurisdictions, these investments tend to cluster into three categories: (1) direct appropriations to specific mobile programs or assets; (2) grant programs that mobile operators (or local governments) can apply to; and (3) appropriations to state agencies to support them in delivering services directly or indirectly through contracts and other mechanisms. A handful of states have used tax incentives to support mobile health delivery, and these are treated as related but separate from the three categories of direct investment.

Within our scan, crisis response and MOUD-related models appear disproportionately represented in state financial investment strategies, reflecting both the near-term urgency of behavioral health system pressures and the fact that many states are using public dollars to stand up crisis infrastructure while reimbursement and integration catch up. Appropriations to individual mobile programs are more common in primary care, dental care, and screening contexts, where legislators can fund a discrete mobile asset operated by a known institution.

A. Appropriations to Individual Mobile Health Programs

States sometimes appropriate funds directly to named mobile programs or specific mobile assets. These line-item investments are typically time-limited and place-specific, and they often function as capital acquisition or targeted operating support rather than a durable financing stream. In practice, earmarks are frequently used for safety-net delivery (mobile primary care, mobile dental care, screening) and for visible, discrete infrastructure purchases.

Some illustrative examples:

- Illinois appropriated $1,000,000 to Rosalind Franklin University of Medicine and Science for costs associated with a mobile health program and $375,000 to Advocate Illinois Masonic Medical Center for mobile dental services in 2025.[81]
- Ohio appropriated $500,000 for the Ohio Northern University HealthWise Mobile Health Clinic and $1,000,000 for the Summit County Mobile Medical Project in 2023 and 2025.[82]
- West Virginia appropriated $1,000,000 to support Health Right Free Clinics operating mobile primary care and mobile dental clinics in 2025.[83]
- Minnesota appropriated $993,000 in FY2026 and FY2027 for a mobile dental clinic.[84] Missouri similarly appropriated $400,000 for the Elks Mobile Dental Clinic in 2024.[85]
- Iowa appropriated $5,000,000 to an opioid treatment program to expand access to medication assisted treatment through co-located and mobile recovery units in rural and underserved areas.[86]

Earmarks, such as these, often help operators with capital constraints, such as purchasing a vehicle or major equipment, as well as supporting initial staffing costs, but they often cannot help ensure long-term financial sustainability. Additionally, these kinds of investments rarely build shared infrastructure across programs, such as common protocols, procurement standards, reporting frameworks, all of which are essential for scaling health care delivery models.

At the federal level, directed spending has become an additional pathway for financing mobile health. House Community Project Funding and Senate Congressionally Directed Spending allow Members to request project-specific appropriations for eligible public entities and nonprofits, subject to annual caps, transparency rules, and agency administration.[87] In practice, these awards can help cover equipment-intensive startup needs (including vehicles), but they are one-time and depend heavily on annual eligibility rules and the appropriations cycle, limiting their utility as a durable financing mechanism.

B. Grantmaking Programs

Grant programs are the most flexible and common way that federal and state governments support mobile health. Funding via grantmaking has several potential benefits: (1) funding multiple local implementations of a model, (2) imposing reporting and performance conditions, (3) pairing funding with technical assistance and regulator support, and (4) helping mobile providers integrate into the broader health care delivery system. In the current landscape, it is useful to distinguish between grants where the mobile unit is the primary object of investment (specifically intended to help start up or expand mobile operations) and grants where mobile delivery is one eligible approach within a broader program.

1. Federal Grants

In the past decade, several federal grant authorities have either exclusively targeted mobile clinics or allowed grantees to use funds towards mobile delivery as a permissible use of funds.

- ***Funding for mobile operations of FQHCs*** – In 2022, the MOBILE Health Care Act amended federal law governing FQHC funding to allow FQHCs to establish new mobile unit delivery sites under certain conditions (effective January 1, 2024).[88] In 2021, under the American Rescue Plan Act Funding for Health Centers program, HRSA awarded grants to improve access to COVID-19 vaccination and testing. One of the permissible uses for this funding was to purchase equipment and supplies and hire and train staff to conduct mobile testing or vaccinations.[89]
- ***Mobile crisis response funding*** – For mobile behavioral health crisis response, Congress directed the Department of Health and Human Services (HHS) to establish a pilot program to award grants to states, localities, territories, Indian Tribes, and Tribal organizations. The program is intended to establish or enhance mobile crisis response teams that divert crisis response from law enforcement. Congress authorized appropriations of $10 million per fiscal year for FY 2023 through FY 2027.[90] In 2022, SAMHSA offered additional grants to states and territories to support the development of innovative community crisis response strategies, including through the use of mobile crisis response teams.[91]
- ***Encouraging use of mobile clinics for workforce development*** – To expand the use of mobile units as sites for experiential learning for nurses, in 2021 HRSA provided grants through its Nurse Education, Practice, Quality and Retention-Mobile Health Training Program (NEPQR-MHTP). The grant program was intended to provide enhanced education and training opportunities using community-based, nurse-led mobile units and to train the nursing workforce in providing culturally aligned care in rural and other underserved areas.[92]
- ***Federal innovation funding*** – In 2024, the Advanced Research Projects Agency for Health (ARPA-H) launched the PARADIGM (Platform Accelerating Rural Access to Distributed and InteGrated Medical care) program to develop a scalable vehicle-based care delivery platform intended to bring hospital-level clinical and diagnostic capability to rural communities, including through device integration and interoperability with electronic health record systems. This approach differs from traditional grantmaking in that it focuses on developing and validating a standardized mobile platform rather than financing operations of a specific mobile clinic program.

- ***Disease- and Population-Specific Grants*** – In the past, Congress has also authorized disease- or population-specific grant authorities that explicitly target the expansion of mobile clinical capacity. For example, the HHS Secretary was authorized to create grants under the Children's Asthma Treatment grant program to fully equip mobile health care clinics providing preventive asthma care.[93] Separately, the Secretary was authorized to enter into contracts and grants for construction, purchase, and operation of fixed site and mobile clinical facilities for respiratory and pulmonary impairments among coal miners.[94]

Federal grantmaking also supports mobile delivery indirectly through rural health, workforce, and health system innovation programs administered by a number of different agencies, including HRSA, SAMHSA, and the United States Department of Agriculture.[95] While many of these grants might not be mobile-specific, grantees have sometimes leveraged them to support mobile health delivery. Some illustrative examples:

- ***HRSA's Rural Health Care Services Outreach Grant,*** while not specific to mobile, is being used by Oregon to establish and support the Rural Oregon MIH Program Consortium, coordinate operations across rural EMS agencies and clinics, evaluate community-level impacts, and produce standardized resources (an "MIH toolkit") intended to help Wheeler County (a rural county in Oregon) stand up a local MIH program.[96] This kind of consortium-building approach is notable because it funds shared infrastructure, instead of just funding a single vehicle or program, which the state sees as an important precursor for systematically supporting mobile health delivery.
- ***CDC's National Partners Cooperative Agreement*** funds national partners to provide capacity-building assistance to strengthen public health systems and address equity-based public health priorities. Funded recipients include Mobile Health Map at Harvard Medical School, illustrating a pathway for investing in shared infrastructure supporting mobile clinics.[97]

2. State Grants

States have occasionally used grantmaking to specifically help fund the establishment or expansion of mobile units.

STATE SPOTLIGHT —

Oregon's Approach to Grantmaking Across Mobile Health Models

Oregon provides a clear example of a state treating mobile health as a platform and using grantmaking to expand mobile capacity. In 2022, the Oregon legislature directed the Oregon Health Authority to convene a Mobile Health Advisory Committee and collaborate with them to develop a Mobile Health Unit Pilot Program. The goal of the pilot program is to improve health outcomes and fund culturally and linguistically aligned services through mobile units. The state has appropriated $1.7 million for 2023 to 2025 and $1.6 million for 2025 to 2027.[98] In addition to administering the pilot program, the Oregon Health Authority commissioned an environmental scan to understand the current characteristics and regions of operation for mobile clinics in the state. This is a key step in developing a comprehensive statewide mobile health strategy.

Other states have used pilot and demonstration authorities to seed mobile models, sometimes paired with time-limited public funding or directed agency implementation. For example, California established or extended pilot authorities for multiple mobile programs, including community paramedicine.[99]

New York established a community paramedicine demonstration program,[100] and North Carolina similarly authorized and funded pilot activity that includes both community paramedicine and mobile crisis management components.[101]

The majority of state grant programs, however, are not specific to mobile health delivery and support mobile delivery as one tool inside a broader policy design. Some illustrative examples:

- ***School-linked and school-based models*** – Colorado allows school-based health center grant program dollars to be directed to mobile health units.[102] Oregon created a mobile school-linked health center grant framework and authorized grants for planning, technical assistance, and operations for school districts or education service districts.[103]
- ***Crisis response and deflection*** – Maryland's Behavioral Health Crisis Response Grant Program allows funds distributed to local behavioral health authorities to establish or expand mobile crisis teams, and requires outcome measurement and public feedback reporting.[104] Colorado's early intervention, deflection, and redirection from the criminal justice system grant program can fund mobile crisis services or establish a mobile medication assisted treatment unit.[105] Wisconsin funds crisis program enhancement grants, including mobile crisis team grants, with local match and reporting requirements.[106]
- ***Public health and screening*** – Florida's Dr. and Mrs. Alfonse and Kathleen Cinotti Health Care Screening and Services grant program allows nonprofits to use grant funds to expand screening and services through a mobile health clinic or unit to reach new locations.[107] Minnesota authorizes special grants to establish and subsidize clinic services, including mobile clinics, serving agricultural workers.[108]
- ***Other enabling infrastructure*** – Virginia directed its Department of Housing and Community Development to treat broadband services for mobile health clinics as a priority within broadband programs funded through the federal Broadband Equity, Access, and Deployment Program.[109]

Three common grant design features show up repeatedly in these examples. First, states often use grant eligibility criteria and reporting requirements to shape program design (response standards for crisis teams; required reporting of outcomes and feedback). Second, mobile is frequently treated as a modality inside a broader initiative, rather than as a stand-alone program category. Third, grantmaking is often paired with an explicit policy goal of reaching rural, underserved, or otherwise hard-to-reach populations, which demonstrates that improving access for these populations is one of the key impacts that states are seeking from mobile delivery.

C. Funding State Agencies to Deliver or Finance Mobile Services

A third category of public investment involves appropriations to agencies that then deliver mobile services directly or finance them through contracting, subgrants, procurement of vehicles, or standing trust funds.

This mechanism is especially common in behavioral health crisis policy, where states are building system infrastructure (988, regional crisis networks, standardized crisis team models) rather than just funding one program at a time.

1. Providing or Procuring High-Need Services

Several states authorize or require state agencies to directly provide or procure through contracts and subgrants for the purpose of meeting certain population health needs. Some illustrative examples:

- Arizona authorizes its Department of Health to contract with public and nonprofit private entities to provide primary health care services through mobile medical clinics to indigent or uninsured Arizonans in rural areas or in medically underserved areas.[110]
- Iowa authorizes its Department of Public Health to administer the statewide maternal and child health program and the program for children with disabilities by conducting mobile and regional child health specialty clinics.[111]
- Washington has tasked its Department of Social and Health Services to establish regional or mobile specialty services that are evenly distributed throughout the state, such as dental care, physical therapy, occupational therapy, and specialized nursing care, which can be made available to former residents of residential habilitation centers and, when funds are available, to other individuals with developmental disabilities.[112]
- Washington appropriated funds to the state health care authority to expand the number of mobile methadone units operated by existing opioid treatment providers.[113]
- Texas allows agencies to use opioid abatement account appropriations to support treatment alternatives that include access to mobile health services and telemedicine in areas with geographic access challenges, such as rural areas.[114]

2. State Agency Contracting and Vehicle/Equipment Purchasing

Washington also appropriated funding for the state to enter into contracts to help expand and standardize mobile crisis response and to purchase vehicles for endorsed crisis teams.[115]

3. Dedicated 988 and Crisis Funds

Several states have established 988 financing mechanisms (including funds, trust funds, and accounts) to support their behavioral crisis response efforts, often explicitly including mobile crisis response as a key component.[116] For example, Kansas requires annual transfers from the state general fund into a 988 suicide prevention and mental health crisis hotline fund, and specifies that fund dollars shall pay for mobile crisis response services.[117] Maryland created a 988 trust fund intended to support a statewide continuum of behavioral health crisis services, including mobile crisis team services.[118]

4. Multi-Year Regional Capacity Building

New Mexico appropriated multi-year funding to state agencies to stand up regional mobile crisis and recovery response capacity, implemented through agency-administered regional planning and grants to local and tribal governments (with some funds available for direct state agency use). The goal of this funding is to help mobile crisis services transition toward federally recognized mobile crisis team models eligible for Medicaid reimbursement.[119]

5. Other Agency-Administered Mechanisms

Kentucky created a mobile crisis services fund within the Cabinet for Health and Family Services to provide loans (with capped term and interest rate) to community mental health centers, and frames certain appropriations as one-time startup funds to establish additional mobile crisis units.[120]

D. Tax Incentives

Finally, a smaller set of policies reduce the operating costs of mobile delivery through taxation-related financial incentives. These provisions are not direct capital infusions, but they can materially affect the total cost of ownership and operation for mobile units.

- Minnesota exempts certain mobile medical units providing medical or dental services, when operated by a FQHC, from taxes on gasoline and from certain sales taxes on the vehicle.[121]
- Virginia exempts certain mobile providers from motor vehicle rental and peer-to-peer vehicle sharing tax.[122]
- Oklahoma exempts mobile units that provide screening services without collecting payment from excise tax collected when the state issues a vehicle title.[123]

Fostering Sustainability Through Insurance Reimbursement

Mobile health programs require capital to acquire and launch a unit, but their long-term viability often depends on their ability to generate dependable ongoing revenue. In practice, many mobile programs struggle to cover recurring costs, including staffing, fuel, maintenance, supplies, and back-end operations (billing, compliance, technology, and care coordination).[124] Billing insurance for mobile services can serve as a more predictable payment stream for many operators.

Insurance reimbursement policies can deeply affect the functioning of many mobile programs. Payers determine whether a given service is covered when delivered in a mobile setting and whether any special site-of-service constraints apply. Unfortunately, payer billing systems and enrollment rules are not always built with mobile services in mind, which can create administrative complexities for operators. Public payers can also use reimbursement as a policy tool. They can require mobile providers to meet specified standards as a condition of payment, effectively turning reimbursement into a regulatory mechanism.

The subsections below highlight how Medicare, Medicaid, and private insurance policies impact mobile health delivery. In general, Medicare most often affects mobile delivery indirectly through site-of-service billing rules and service line-specific conditions of payment. Medicaid is more frequently the locus of explicit policy design for mobile models, especially mobile crisis and community paramedicine, and state Medicaid agencies define benefits, provider types, and payment methodologies. Private insurance reimbursement can introduce additional preauthorization, network, and contracting constraints.

A. Medicare

Medicare does not recognize mobile clinics as a distinct provider or supplier category. Instead, mobile delivery is typically handled through place of service coding and service line-specific conditions of payment. As a result, Medicare's influence on mobile programs shows up as a patchwork of billing and compliance rules rather than as a cohesive, mobile-specific reimbursement framework.

1. Mobile as a Site of Service Rather Than a Provider Category

Medicare uses Place of Service (POS) codes to support claims processing, and for many Part B services, to determine the applicable facility versus non-facility payment rate. Mobile units have had a unique POS code (code 15) on professional claims since 2003, and Medicare pays for services billed to POS code 15 at the same rate they pay for office-based services.[125] However, CMS instructs that when a mobile unit is deployed to serve an entity for which another POS code already exists (for example, when a mobile unit is sent to a doctor's office or a skilled nursing facility), providers should use the POS code for that entity rather than POS 15.[126] In practice, this billing policy does not allow for mobile-specific reimbursement rates that take into account the incremental costs of mobile, such as travel time, setup and tear down, or routing inefficiency.

2. Medicare Conditions of Payment for Advanced Diagnostic Imaging Delivered by Mobile Units

For advanced diagnostic imaging (MRI, CT, PET, etc.), federal law conditions Medicare reimbursement on accreditation by a CMS-designated accrediting organization. This requirement applies regardless of whether imaging is delivered in a fixed site or via a mobile imaging unit, and it can operate as a meaningful fixed cost that mobile programs must absorb before they can begin billing Medicare.[127] Separately, many mobile imaging suppliers bill Medicare as Independent Diagnostic Testing Facilities (IDTFs) and must comply with IDTF enrollment and performance standards that explicitly apply to mobile units.[128]

3. Mobile Stroke Units as Telehealth Originating Sites

Medicare law treats mobile stroke units as eligible originating sites for telehealth services for the diagnosis, evaluation, or treatment of symptoms of an acute stroke.[129]

4. Constraints Around Billing for Treat-in-Place Community Paramedicine Services

Medicare regulations have historically tied ground ambulance payment to transport to defined destinations, which limits Medicare reimbursement for "treat in place" care provided through community paramedicine programs. While CMS has a Healthcare Common Procedure Coding System (HCPCS) code for "Ambulance response and treatment, no transport" (A0998), Medicare fee-for-service does not treat it as a payable code.[130] During the COVID-19 public health emergency, CMS allowed Medicare payment for certain ground ambulance services without transport under specified conditions, but these flexibilities terminated with the end of the public health emergency period on May 11, 2023.[131] More recently, Medicare tested treatment-in-place and alternative-destination concepts through the Innovation Center's Emergency Triage, Treat, and Transport (ET3) Model, but the model ended early in December 2023.[132]

Taken together, these examples illustrate that Medicare policy incorporates mobile health only through adaptations of existing payment rules, rather than through a framework designed around the operational realities of mobile care delivery.

B. Medicaid

State Medicaid policy affects mobile delivery in several key ways. States can choose whether and which mobile services to cover under Medicaid, try different methods for paying for mobile services, ensure that mobile is embedded into managed care networks, and use program integrity requirements to set certain minimum standards for mobile delivery.

In practice, states do this through enacting legislation targeting their Medicaid programs, through Medicaid State Plan Amendments (SPAs) filed with the federal government, by filing waivers of certain federal Medicaid requirements (notably through 1115 and 1915 waiver processes), and through Medicaid managed care contracting processes. Our scan found that, in recent years, Medicaid policy activity has been heavily focused on crisis response services, contributing to mobile crisis becoming one of the most standardized mobile models under Medicaid, with comparatively well-defined coverage criteria and tailored payment methodologies.

1. Establishing Medicaid Coverage for Mobile Models

The most direct way states support mobile delivery under Medicaid is by defining a mobile model as a covered service, with explicit standards and provider requirements. This approach is most visible for mobile crisis services, where many states have aligned their coverage language with federal criteria to claim increased federal medical assistance percentage (FMAP) for community-based mobile crisis intervention services.[133] Illustrative examples include the SPAs filed by the District of Columbia (covering youth mobile crisis intervention and establishing service standards) as well as Nevada and New York, both of which cover mobile crisis services aligned with federal criteria for community-based mobile crisis services.[134] By covering these services, states not only enable reimbursement but also set minimum expectations for availability, team composition, and scope of services, since Medicaid coverage inherently carries minimum service standards.

A smaller set of Medicaid actions extend beyond mobile crisis and into community paramedicine models. For example, California treats community paramedicine services as covered under its Medicaid program, and the legislature requires the state Medicaid agency to develop rates specifically for these services.[135] Maryland similarly recognizes these services as covered under its Medicaid program. Our scan of state Medicaid coverage documents found that, diverging from Medicare coverage policies, several state Medicaid programs reimburse for ambulance-based treatment without transports (often using HCPCS code A0998) to support treat-in-place community paramedicine services.

Not all states use Medicaid policy to expand access to mobile services; a few have enacted restrictive policies. For example, Florida allows its Medicaid agency to restrict mandatory and optional services delivered in mobile units,[136] and Connecticut only allows Medicaid reimbursement for mobile dental treatment as long as services are provided within 30 miles of the associated dentist's fixed location (50 miles in certain counties).[137] While states pursue mobile delivery to expand access, these guardrails show that states also worry about oversight, continuity, and program integrity.

2. Setting Payment Methodologies That Make Mobile Delivery Viable

Coverage alone is rarely sufficient to ensure sustainability of mobile services.* State statutes rarely set Medicaid rates directly. Instead, they authorize billing, direct agencies to develop rates, or set narrow floors or parity constraints. Several states have explored different payment methodologies specifically for mobile service delivery:

- Increased reimbursement rates explicitly for mobile crisis teams.[138]
- Bundled or per diem payment for mobile crisis response.[139]
- Alternative/bundled payment structures for mobile dental delivery.[140]
- Statutory minimum payment floors for community paramedicine encounters.[141]
- Enhanced payment for crisis response teams that receive an endorsement, a voluntary credential from a state agency.[142]
- Exploring distinct rates for mobile medication units that more accurately reflect the cost of these programs.[143]

States often treat mobile as a service episode with a predictable cost structure and design payment methods accordingly, rather than relying on fee-for-service payments that may not cover the operational costs of delivering mobile services.

A few states have additionally enacted consumer protections that limit patient exposure to cost sharing when using mobile services. For example, Arkansas requires cost sharing parity for services in mobile units compared to other sites of service, and Minnesota prohibits all cost sharing for mobile crisis intervention.[144]

* In the context of mobile crisis services, many states use SPAs to align state coverage with federal standards to claim increased FMAP and view the increased federal match as necessary to ensuring financial sustainability.

3. Making Mobile Billable as a Site of Service or Encounter Modality

Instead of creating a new mobile benefit category, most states make existing benefits work in mobile settings by changing encounter rules, place of service logic, or provider enrollment requirements.

- Arkansas requires coverage of services provided in a mobile unit when billed with the mobile POS code and bars less favorable cost sharing.[145]
- California requires mobile unit visits operated by FQHCs/RHCs to be billed and reimbursed at the same rate as the sponsoring FQHC/RHC.[146] It also provides that an affiliated, appropriately licensed mobile health care unit generally need not enroll as a separate Medicaid provider.[147]
- Mississippi recognizes mobile unit encounters but conditions reimbursement on criteria such as participation in a state survey and CMS approval.[148]
- Missouri has added "mobile unit" as a place of service for services related to Certified Community Behavioral Health Centers.[149]

4. Using Managed Care Contracting and Delivery System Levers to Integrate Mobile Capacity

Even where a service is covered and payable, access often depends on network inclusion and operational integration with other providers. States use managed care contracting requirements or crisis system delegation structures to embed mobile delivery into the broader delivery systems.

- Virginia requires its managed care contracts to include provider agreements for mobile vision services for eligible children in school settings.[150]
- Washington directs managed care and crisis system delegation arrangements that can influence whether mobile crisis services are embedded into the broader behavioral health crisis continuum.[151]

These actions matter because mobile providers often operate at the edge of standard network contracting, and managed care-related levers are one of the few tools states have to ensure that covered services are actually available.

5. Piloting and Scaling Mobile Models Through Section 1115 Demonstrations

States also use section 1115 demonstrations to pilot or scale mobile models as part of broader delivery system reforms related to behavioral health, substance use disorder care, and dental access. These pilots tend to be time-limited and often embed mobile models as one tactic among many rather than establishing a permanent mobile benefit category. States have used this authority to pilot mobile medication assisted treatment units, expand access to dental services through mobile, and integrate mobile crisis services within broader crisis response initiatives.[152]

While states often use 1115 demonstrations to test and build capacity, they use SPAs to lock in benefit and payment rules once the model is ready to be integrated into routine coverage and service delivery systems.

C. Private Insurance

As the primary regulators of insurance, states have a key role to play in shaping how state-regulated commercial plans (which exclude many plans offered by large employers that are regulated by the federal government) cover and pay for mobile health services. However, state policy in this space has been thinner and model-specific compared to state efforts related to Medicaid coverage.

Rather than creating a general reimbursement framework for mobile clinics, states more often intervene through targeted coverage mandates (especially for crisis response, screening, and community paramedicine services) and through consumer-facing protections that govern cost sharing, prior authorization and balance billing.

1. Mandating Coverage of Specific Mobile Models

Some states mandate insurance coverage for services provided by a specific mobile health model, most often mobile crisis services or community paramedicine services.

- ***Mobile crisis services*** – California requires health plans and insurers to treat behavioral health crisis services delivered by crisis providers including mobile crisis teams, as covered behavioral health benefits, including when they are delivered by out-of-network providers. The statute also ties minimum coverage for behavioral health crisis services delivered by 988 centers or mobile crisis teams to items and services eligible for Medicaid coverage.[153] Rhode Island similarly requires private insurers to cover mobile crisis response and stabilization services for youth.[154]
- ***Community paramedicine*** – Several states have used private insurance mandates to expand reimbursement for community paramedicine programs. Indiana requires that policies and contracts covering emergency medical services provide reimbursement for emergency medical services performed as part of a community paramedicine program.[155] Illinois requires certain policies and managed care plans to provide coverage for medically necessary community paramedicine services for eligible enrollees.[156]

2. Creating Reimbursement Processes and Payment Constraints for Mobile Delivery

Some states regulate how private insurers pay for or seek cost sharing for mobile health services. For example, California requires plans and insurers to establish a process to set reimbursement rates for community paramedicine services. California also requires cost sharing parity when an enrollee receives covered services from a community paramedicine provider who is out-of-network and prohibits insurers and plans from paying the out-of-network provider more than the insurer or plan's usual and customary charges for the same services when delivered in-network.[157] Utah prohibits billing for services delivered as part of a community paramedicine program unless the service is provided in partnership with a health care facility and the partnering facility is the entity that bills the individual or health benefit plan.[158]

Ohio requires private insurers and the state employee health plan to cover screening mammography and supplemental breast cancer screening performed in accredited mobile mammography units. The state also allows the total benefit for screening mammography to be capped at 130% of the Medicare reimbursement rate for screening mammography.[159]

3. Consumer Protections That Shape Access and Patient Financial Exposure

Some states have established guardrails around how plans and insurers conduct utilization management for services. California's mobile crisis law includes several consumer-facing protections: it prohibits prior authorization for behavioral crisis stabilization services and care provided by mobile crisis teams, limits payment denials by requiring a reasonable determination that services were never performed, and prohibits balance billing for covered crisis services.[160]

However, Maine takes a different approach. While the state exempts community paramedicine from certain reference-based pricing rules for ambulance services, it explicitly allows carriers to require prior authorization before community paramedicine services are provided.[161]

Additionally, some states explicitly allow network adequacy standards or filings to take into account nontraditional delivery options, such as telehealth and mobile clinics.[162] Illinois requires network adequacy filings to address how telemedicine, telehealth, or mobile care services may partially meet adequacy standards.[163]

STATE SPOTLIGHT —

Arkansas's Approach to Standardizing Insurance Coverage of Mobile Health

In 2025, Arkansas enacted first-of-its-kind legislation that facilitates coverage and reimbursement for all mobile models, across both state-regulated private insurance plans and the state Medicaid program.[164] As seen above, most states expand coverage or reimbursement for mobile services piecemeal, such as by requiring coverage of mammography by private insurers or mandating a state Medicaid agency to develop reimbursement rates for CP/MIH services. Instead, Arkansas requires state-regulated commercial insurers and the state Medicaid program to cover services delivered in a mobile unit when billed by a health care provider using the designated mobile place-of-service code, as long as the service is otherwise covered when delivered in another setting.

Broader State Efforts to Understand and Integrate Mobile Health Delivery

States are starting to treat mobile health as a delivery platform that must be understood, planned for, and integrated into broader care systems. In practice, this has led to (1) state legislatures and executive branches commissioning reports to map the mobile landscape and identify gaps, (2) creating shared learning and quality improvement infrastructure, and (3) formalizing coordination mechanisms that connect mobile services to crisis systems, child welfare systems, and schools.

1. Mapping the Mobile Landscape Through Reports and Assessments

Several states have directed agencies to produce reports that clarify how mobile services fit into the delivery system and where policy or operational barriers remain. In addition to one-time reports, some states have created standing advisory groups or task forces to guide implementation of specific mobile models and to surface recommendations for financing and oversight.

Oregon recently created a Mobile Health Advisory Committee and tasked state regulators with developing a report with recommendations on developing a statewide mobile health unit program.[165] Virginia requires an annual report to the Governor and legislative committees describing the crisis system and mobile crisis response efforts.[166]

California similarly requires the state EMS authority to submit an annual report on the community paramedicine programs in the state, including information on aggregate patient outcomes, assessment of any adverse events, impact on the EMS system, and policy recommendations for improving the administration of these programs and improving patient outcomes.[167] South Carolina's annual appropriation bill requires the Department of Health and Human Services, with support from the Department of Mental Health, to assess existing gaps in coverage for or the supply of behavioral health services, in part, for the purpose of expanding the coverage of claims-based mobile crisis stabilization services that are intended to stabilize individuals at the sites of behavioral health crises.[168]

2. Creating Shared Learning Infrastructure

Some states support structured learning and support for mobile health teams. Connecticut requires the Department of Children and Families to establish and administer a data repository to allow emergency mobile psychiatric services personnel to share best practices and experiences while providing field-based services to children. The repository may also be used, when available and appropriate, to collect outcomes data for internal quality improvement.[169] South Carolina lawmakers provide funding for the South Carolina Center for Rural and Primary Healthcare to provide coordination and requested technical assistance to mobile units in the state. The goal of this effort is to increase access to preventive and diagnostic health care and to reduce inequities for rural, vulnerable, underserved, and displaced populations.[170] Washington has similarly tasked its Health Care Authority to convene stakeholders to assess gaps in the current funding model for crisis services, including mobile crisis services, and to recommend options for addressing these gaps.[171] The state also funds an annual crisis continuum forum to develop collaborative regional solutions for supporting and improving crisis services, including mobile crisis services.[172]

3. Integrating Mobile Crisis Delivery Into Other State Systems

A separate set of policies focuses on interagency coordination and institutional linkages that make mobile services more easily usable. Several states require cross-agency collaboration to guide mobile crisis responses. For example, Virginia directs collaboration between the Department of Behavioral Health and Developmental Services and the Department of Criminal Justice Services when responding to behavioral health crises using mobile crisis services.[173] Oregon similarly uses formal coordination mechanisms at the local level: a city that establishes a mobile crisis program must administer it in accordance with a memorandum of understanding between the city and the county where the city is located.[174] States also embed integration requirements in systems that serve children and adolescents. In Minnesota, coordination mechanisms increase access to mobile crisis for children in foster care by requiring crisis plans for certain children receiving intensive behavioral health services to demonstrate coordination with the local or regional mobile crisis intervention team.[175] Connecticut encourages mobile psychiatric service providers to use memoranda of understanding to collaborate with local and regional boards of education, school-based health centers, and higher education institutions that lack on-campus mental health resources.[176]

Recommendations for Policymakers

Mobile health has demonstrated its ability to expand access to care for underserved populations across a range of clinical contexts. However, as this report documents, mobile health remains constrained by fragmented regulatory treatment, time-limited grant funding, and incomplete integration into public and private insurance systems.

Absent deliberate policy design, mobile health risks remaining a collection of pilots instead of becoming a recognized and durable component of the health care delivery system. The following recommendations focus on aligning regulation, financing, and reimbursement to support scalable, sustainable mobile health delivery.

Federal Policymaker Recommendations

1. Establish a CMMI Model to Support State-Level Mobile Health Infrastructure Development

Federal policymakers should direct the Center for Medicare and Medicaid Innovation (CMMI) to design and test a multi-state technical assistance and demonstration model focused on developing a state mobile health infrastructure that encompasses the various models of mobile health care. Rather than funding mobile services directly, the model would support a cohort of participating states to undertake the foundational work required to integrate mobile health into their delivery systems, including:

- Developing coherent regulatory frameworks that recognize mobile health as a delivery platform, reduce duplicative or conflicting approval requirements, and establish proportionate oversight across mobile models.
- Designing Medicaid coverage, payment, and managed care contracting pathways that make mobile services billable, adequately paid, and network-integrated.
- Coordinating state grantmaking, procurement, and reimbursement strategies so that capital investments in mobile units are paired with realistic long-term financial sustainability.

CMMI could support this work through planning grants, structured learning collaboratives, embedded federal technical assistance, and limited demonstration authority to test alternative payment and contracting approaches.

Through this model, CMMI would help states do the foundational work of system design while surfacing transferable state policy templates, rate-setting approaches, and regulatory best practices across jurisdictions.

2. Use Federal Grant Programs to Fund Shared Infrastructure and Technical Assistance, Not Just Mobile Assets

Federal agencies administering mobile-relevant grants should prioritize funding shared infrastructure and technical assistance over one-time vehicle purchases. As the report shows, capital-only investments often leave providers with mobile assets but no sustainable operating model once grant periods expire. Grant design should explicitly encourage or require:

- Participation in state-led or regional mobile health coordination efforts.
- Adoption of standardized data collection, reporting, and quality frameworks.
- Engagement with regulatory and payer integration efforts as a condition of funding.
- Planning for transition to insurance reimbursement or other durable revenue streams.

Where feasible, federal grants should also include dedicated funding for compliance support, billing infrastructure, and sustainability planning, recognizing that regulatory navigation and payer integration are binding constraints for many mobile operators.

3. Align Medicare Policy with Mobile Delivery Realities

While comprehensive Medicare reform is beyond the scope of this report, federal policymakers should recognize that Medicare's treatment of mobile health as merely a site of service limits sustainability for many mobile programs. Priority areas for federal action include:

- Testing payment approaches that recognize the additional costs associated with mobile delivery, such as travel time and routing inefficiency.
- Expanding Medicare coverage of treat-in-place models of mobile delivery, such as community paramedicine and mobile integrated health care.
- Clarifying and simplifying Medicare billing and enrollment requirements for mobile units operating as extensions of existing providers.

Absent these changes, Medicare policy will continue to lag behind Medicaid and state-regulated insurance in supporting mobile delivery.

Many of these priorities are also well-suited to testing through CMMI demonstrations, which can evaluate alternative payment and billing approaches for mobile delivery before broader Medicare adoption.

4. Modernize HRSA Service Site and Scope Policies for FQHC-Operated Mobile Units

HRSA should update guidance and operational processes to better reflect the realities of mobile care delivery, while preserving safeguards against duplicative clustering of safety net services. Priority actions could include:

- Establishing a streamlined pathway for adding mobile van/unit service sites to scope, particularly when mobile units are operated as extensions of existing FQHCs and are deployed to serve populations with documented access barriers.
- Using objective access and need indicators, such as travel time, shortage designations, or documented service gaps, as a basis for presumptive approval for adding a mobile van site to scope, instead of requiring extensive, site-addition documentation and overlap narratives in low risk cases when adding a new mobile van/unit to scope.
- Requiring periodic aggregate reporting on patient origin, visit locations, and deployment patterns, to monitor the mobile unit's impact on access and assess overlap in service area.

By shifting toward clearer standards tailored for mobile and data-driven oversight, HRSA can reduce administrative burden for FQHCs seeking to establish or expand mobile services while maintaining accountability and ensuring that mobile units expand access.

State Policymaker Recommendations

1. Develop Coherent, Platform-Level Regulatory Frameworks for Mobile Health

States should move away from fragmented, model-by-model regulation toward regulatory frameworks that treat mobile health as a delivery platform with shared infrastructure needs. Where states require pre-deployment approval, authorization pathways should be clear, proportional, and coordinated across agencies to reduce administrative friction. Key design principles include:

- Allowing mobile units to operate as extensions of existing licensed providers where appropriate, rather than requiring duplicative licensure.
- Avoiding unnecessary certificate of need or facility-style requirements that delay deployment without improving quality or safety.
- Establishing baseline operating standards applicable across mobile models, while reserving model-specific requirements for services that need to be tightly regulated.

Clear state-level recognition of mobile health can reduce uncertainty for payers, local governments, and partner organizations and lower transaction costs for providers seeking to scale services.

2. Pair State Grantmaking with Regulatory, Reimbursement, and Sustainability Technical Assistance

States that use grant programs to support mobile health should explicitly pair funding with technical assistance on regulatory compliance and long-term financial sustainability. Grantmaking that focuses solely on startup or expansion risks perpetuating dependence on short-term funding. Effective grant programs should:

- Provide structured technical assistance on licensure, scope of practice, data reporting, and compliance requirements.
- Support grantees in developing Medicaid and commercial payer billing capacity.
- Require sustainability plans that address post-grant reimbursement, contracting, or public financing pathways.
- Facilitate peer learning among grantees to reduce duplication of effort and surface common challenges.

States may also consider funding centralized support entities or consortia to provide this assistance across multiple mobile programs, particularly in rural or resource-constrained regions.

3. Use Medicaid Policy to Normalize and Sustain Mobile Health Delivery

State Medicaid programs are the most powerful lever for making mobile health financially viable at scale. States should prioritize:

- Explicitly recognizing mobile services as covered when delivered in mobile settings, either by defining mobile models as covered services or by clarifying place-of-service and encounter rules.
- Developing payment methodologies that reflect the cost structure of mobile delivery, including bundled, per diem, or prospective payments where appropriate.
- Ensuring that mobile providers are meaningfully integrated into managed care networks, crisis response systems, and referral pathways.
- Avoiding arbitrary geographic or setting-based restrictions that undermine access goals.

Where states pilot mobile models through waivers or demonstrations, they should plan early for transition into permanent state plan coverage once models are operationally validated.

4. Align Insurance Regulation with Mobile Health Integration Goals

For state-regulated private insurance markets, policymakers should consider approaches that normalize coverage of services delivered in mobile units when those services are otherwise covered in fixed site settings. States may also use consumer protection levers to ensure that mobile delivery does not result in higher cost sharing, trigger unnecessary prior authorization or permit balance billing. In doing so, states should treat mobile health as a means of improving network adequacy and access, rather than as a specialty or out-of-network modality.

5. Build State Capacity to Coordinate, Standardize, and Integrate Mobile Health Delivery

States should invest in durable coordination and planning infrastructure to ensure that mobile health delivery is systematically integrated into broader care systems, rather than deployed as a collection of disconnected programs. Specifically, states should:

- Maintain baseline visibility into mobile health delivery. Designate a lead agency or cross-agency entity to maintain an inventory of mobile units, service lines, and geographic coverage, and to periodically assess gaps to inform regulatory, Medicaid, and grantmaking decisions.
- Create standing coordination and policy feedback mechanisms. Establish a permanent advisory or coordinating body charged with translating landscape assessments into concrete recommendations related to regulation, Medicaid coverage and payment, grant priorities, and cross-system integration.
- Require formal integration with adjacent systems. Condition certification, contracting, or grant eligibility on executed coordination agreements with fixed site providers and relevant systems such as 988, emergency departments, schools, and child welfare agencies, focused on operational handoffs and referral pathways.

This approach allows states to move beyond one-off pilots by pairing mobile health financing with the coordination infrastructure necessary for sustainable scale.

Conclusion

Across the past decade, mobile health has typically been treated as a flexible delivery modality in service of broader priorities (crisis response, opioid use disorder treatment, school-based care, rural access, and public health preparedness), rather than as a platform requiring its own durable policy architecture.

Where mobile delivery aligns with those priorities, policymakers have been more likely to establish the authorization, financing, and payer pathways needed to support deployment.

This priority-driven approach has produced uneven maturity across models. Mobile crisis services have moved more quickly toward standardized coverage and payment, while other models, including mobile primary care, remain dependent on time-limited funding and fragmented reimbursement. The central policy question is therefore no longer whether mobile health can improve access, but whether federal and state policymakers will build coherent, platform-level frameworks that align proportionate oversight with sustainable operating revenue and routine integration into payer networks, referral pathways, and health data systems.

Endnotes

[1] The Oregon Health Authority hired researchers to assess the mobile health landscape in the state, and a 2025 report by the researchers found that because Oregon does not have registration or licensing requirements for mobile health units, the team needed to undertake extensive fieldwork to identify all mobile health units and even then, they found that their list is likely to be incomplete. Oregon Health Authority. Mobile Health Unit Pilot Program Feasibility Study – Interim Report (2025).

[2] United States Government Accountability Office. Report to the Majority Leader, U.S. Senate. Opioid Addiction: Laws, Regulations, and Other Factors Can Affect Medication-Assisted Treatment Access (2016).

[3] 86 Federal Register 33861 (2021). See Assistant Secretary for Planning and Evaluation, Office of Behavioral Health, Disability, and Aging Policy, Implementation of Mobile Medication Units: Findings from a Qualitative Study (2025) for more information about MMU operators' experiences with and concerns about obtaining DEA registration: "DEA regulations require MMU units to outfit a suitable vehicle with a secure safe to store the methadone, appropriate security measures, a system for record keeping, adequate workspace for clinicians, and Wi-Fi access for computers. The MMUs must also have a detailed system to track dispensing and properly dispose of unused medication (Breve et al. 2022). In addition, MMUs must return to their affiliated brick-and-mortar OTP at the end of each business day for storage (Bureau of Justice Assistance 2021). These regulations can limit the geographic range and operating hours of the MMU and contribute to wear-and-tear on vehicles (DEA 2021). Respondents also described wide variation in the interpretation of requirements across local DEA offices; this meant some implementers reported limited challenges obtaining DEA approval and others noted substantial challenges. Four respondents reported that it can take a long time to secure DEA or state regulatory approvals. For example, it took an OTP in Massachusetts two years to obtain the needed regulatory approvals and to outfit a recreational vehicle to comply with DEA requirements (Serres 2023). DEA rules also require MMUs to return to home base at the end of each day, which limits the ability to add more stops or travel longer distances from home base. DEA's overnight exemption, which allows units to park in a gated area instead of returning home, are only granted in emergency situations rather than on a routine basis."

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[5] 42 U.S.C. § 263a.

[6] Centers for Medicare and Medicaid Services, *How to Obtain a CLIA Certificate of Waiver* (March 2019); Centers for Disease Control and Prevention, *Test Complexities* (2024).

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[9] Minn. Stat. § 144.077.

[10] Nev. Rev. Stat. §§ 449.0151,.01515,.0302; Nev. Admin. Code § 449.970 et seq.

[11] Fla. Stat. §§ 400.9905, .991.

[12] N.Y. Dep't of Health, RFA No. CCH-2023-05, *CDC COVID-19 Health Disparities Grant – Mobile Health Vehicle: Questions and Answers* (2023).

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[15] Iowa Code § 135.61; Iowa Admin. Code r. 481-2202.

[16] Colo. Rev. Stat. § 25-3.5-203.5; Conn. Gen. Stat. §§ 19a-175, -180; Del. Code Ann. tit. 16, §§ 9801–9817; Ind. Code §§ 16-31-12-1 et seq.; Ky. Rev. Stat. Ann. §§ 311A.010–.200; Me. Rev. Stat. tit. 32, § 84-A; Mass. Gen. Laws ch. 111O, § 1 et seq.; Nev. Rev. Stat. §§ 450B.100, .199–.1996, .200, .240, .250.

[17] Cal. Health & Safety Code §§ 1797.259, 1835, 1851.

[18] N.J Stat. Ann. §§ 26:2K-7, -9.1, -10.

[19] Cal. Health & Safety Code § 1855; Conn. Gen. Stat. § 19a-180; Haw. Rev. Stat. § 321-224.4.

[20] La. Rev. Stat. Ann. § 37:796.1; Okla. Stat. tit. 59, §§ 328.3, .40a, .51a; Va. Code Ann. § 54.1-2708.3; Wis. Stat. §§ 440.02–.08, 447.058.

[21] N.Y .Mental Hyg. Law § 36.03.

[22] Minn. Stat. § 245I.011.

[23] Wash. Rev. Code §§ 71.24.590; Utah Code Ann. § 58-17b-309.7.

[24] N.C. Gen. Stat. § 122C-35; N.C. Dep't of Health & Hum. Serv., Div. of Health Serv. Regulation, *Medication/Mobile Unit Licensure Application Packet* (2025).

[25] Tex. Health & Safety Code § 241.023.

[26] Ind. Code §§ 16-41-42.1-1 to -10; N.C. Gen. Stat. § 122C-35; Conn. Gen. Stat. § 19a-180; Nev. Rev. Stat. Ann. §§ 450B.100, .200, .240, .250; Minn. Stat. § 144.077.

[27] Nev. Rev. Stat. Ann. § 636.2899. Wis. Stat. §§ 440.02-.08, 447.058.

[28] Cal. Bus. & Prof. Code § 3070.2.

[29] Okla. Stat. tit. 59, §§ 328.51a,.3.

[30] Conn. Gen. Stat. § 19a-180.

[31] Minn. Stat. § 144.077; Cal. Health & Safety Code §§ 1797.259, 1835, 1851; Utah Code Ann. § 53-2d-211.

[32] Nev. Admin. Code § 449.97024.

[33] Cal. Health & Safety Code §§ 1765.101-.175.

[34] Nev. Admin. Code §§ 449.970–.97036.

[35] Health Res. & Servs. Admin., *Chapter 6: Accessible Locations and Hours of Operation; Scope of Project overview*.

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[36] Id.

[37] Health Res. & Servs Admin., *Guidance on Adding a New Service Site; Policy Information Notice 2007-09 – Service Area Overlap: Policy and Process*.

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[40] Nev Rev. Stat. Ann. § 636.2899.

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[42] Ariz. Rev. Stat. § 32-1276.04; Va. Code Ann. § 54.1-2722.

[43] Mich. Comp. Laws § 333.16654; Minn. Stat. § 150A.105; Nev. Rev. Stat. Ann. § 631.3122.

[44] Cal. Health & Safety Code § 1765.155.

[45] Redding, Cal., Zoning Ordinance, ch. 18.17, *Temporary Use Permits* (2022).

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[48] Fla. Stat. §§ 400.990-.995.

[49] Cal. Health & Safety Code § 1765.145. See also Ark. Code Ann. § 17-84-310.

[50] Ohio Rev. Code Ann. §§ 4715.70-.73.; Wis. Stat. §§ 440.02-.08, 447.058.

[51] Md. Code Ann., Health–Gen. §§ 10-1401–1403.

[52] Conn. Gen. Stat. § 19a-177; Cal. Health & Safety Code §§ 1832, 1835, 1851. See also, Del. Code Ann. tit. 16, §§ 9801–9817.

[53] N.C. Gen. Stat. § 122C-3.

[54] Colo. Rev. Stat. § 27-60-104.

[55] Md. Code Ann., Health–Gen. §§ 10-1401–1405.

[56] Kan. Stat. Ann. §§ 75-5965 to -5966.

[57] Md. Code Ann., Health–Gen. §§ 10-1401–1405.

[58] Cal. Health & Safety Code § 1765.160.

[59] Cal. Health & Safety Code § 1765.155, .160, .170.

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[61] Utah Code Ann. § 26B-5-609; Nev. Rev. Stat. Ann. §§ 450B.100, .200, .240, .250; Cal. Health & Safety Code § 1814.

[62] Minn. Stat. § 144.077; La. Rev. Stat. Ann §§ 40:1213.1-:1213.5.

[63] Ind. Code ch. 12-21-8.

[64] Me. Rev. Stat. tit. 32, § 84; Utah Code Ann. § 53-2d-210.

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[66] Colo. Rev. Stat. § 27-65-102; Va. Code Ann. § 37.2-311.1; see also Del. Code Ann. tit. 16, §§ 10201A–10214A; Kan. Stat. Ann. §§ 75-5965 to -5966; Nev. Rev. Stat. Ann. § 433.704; Or. Rev. Stat. § 430.626; Ind. Code ch. 12-21-8; Minn. Stat. § 256B.0624.

[67] Conn. Gen. Stat. § 19a-910.

[68] Colo. Rev. Stat. § 27-60-104; Iowa Code § 225C.19.

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[71] Or. Rev. Stat. § 430.401; S.D. Codified Laws § 27A-10-23.

[72] Wis. Stat. §§ 440.02-.08, 447.058.

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[76] Nev. Rev. Stat. Ann. § 450B.199-.1996; Me. Rev. Stat. tit. 32, § 84.

[77] Minn. Stat. § 256B.0624; Va. Code Ann. § 37.2-311.3; see also N.Y. Mental Hyg. Law § 36.03; Wyo. Stat. Ann. §§ 35-25-501-503.

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[79] Tex. Health & Safety Code § 84.004.

[80] R.I. Gen. Laws § 23-6.3-14.

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[83] W. Va. H.B. 2026, 87th Leg., Reg. Sess. (2025).

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[86] Iowa H.F. 1038, 90th Gen. Assemb. (2025).

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[93] 42 U.S.C. § 280g.

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[103] Or. Rev. Stat. § 413.223.

[104] Md. Code Ann., Health-Gen. § 7.5-208.

[105] Colo. Rev. Stat. § 27-60-402.

[106] Wis. Stat. §§ 46.536, 20.435.

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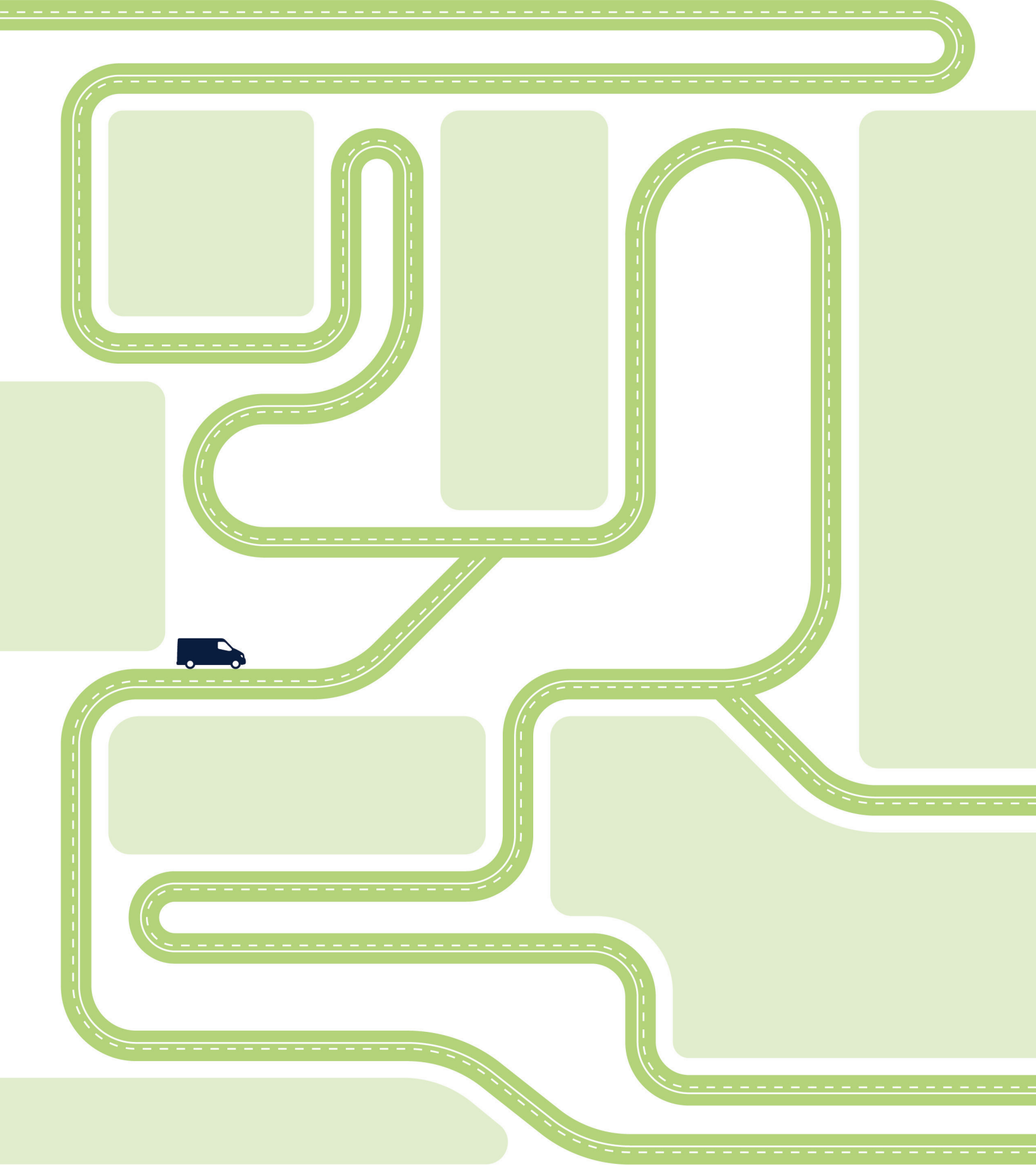

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