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10 Things to Know About Mobile Healthcare

What the services, evidence, payment rules, and federal funding mean for building mobile care into your healthcare ecosystem

By Mollie Williams, DrPH, MPH

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Mobile healthcare has a long track record, a growing evidence base, and a meaningful role in nearly every state's healthcare delivery system. Recent federal investment is expanding what is possible. This primer covers the ten things worth knowing.

1. Mobile health programs deploy fully-equipped medical facilities to communities.

At its simplest, mobile healthcare is the practice of delivering services aboard specially designed mobile clinics. It increases access to care by reducing barriers related to transportation, time, and trust.

Mobile health programs deliver high-quality primary and preventive care, behavioral health services, dental care, vision care, and mammography. Other specialties commonly part of mobile health programs include addiction medicine, dermatology, audiology, obstetrics, and gynecology.

Mobile healthcare is not limited to rural communities or people who are unhoused. Adapting to local needs, mobile health programs can tailor their services for children, seniors, immigrants, veterans, or other rural or urban populations that are underserved.

2. Mobile healthcare is an established and growing part of the healthcare system.

While mobile healthcare is not new, it has grown steadily since the Affordable Care Act's major coverage expansions began in 2014. The COVID-19 pandemic accelerated adoption further as communities deployed mobile clinics for testing, vaccination, and outreach.

Mobile Health Map, a program of Harvard Medical School, estimates that mobile healthcare has grown by at least 80% over the decade covered by its 2025 report. They also report more than 3,600 mobile clinics delivering more than 10 million patient visits annually across all 50 states.[1]

States have taken notice of mobile healthcare's surge in popularity. In 2022, Oregon created a Mobile Health Advisory Committee and commissioned an environmental scan of mobile clinic programs statewide. In South Carolina, the Center for Rural and Primary Healthcare coordinates mobile health activities across the state and provides technical assistance to mobile clinic operators.

Today, federal policy is accelerating growth. The $50 billion Rural Health Transformation Program explicitly funds mobile healthcare infrastructure, and 42 states included mobile health in their 2025 RHTP applications. CMS announced awards to all 50 states on December 29, 2025, and implementation is underway.[2,3]

3. Research demonstrates that mobile healthcare increases access to care and improves health outcomes.

Georgetown Center on Health Insurance Reforms' literature review of more than 160 studies documents mobile healthcare's impact on access, quality, utilization, and cost. The findings are consistent across settings and service lines: mobile clinics improve access, detect conditions that would otherwise go unmanaged, and deliver quality care comparable to, if not better than, fixed-site care.[4]

Examples from the review:

- Among patients of a mobile substance use treatment program, 87% of people who received buprenorphine said they would not have started treatment that day without the clinic.[4]
- A mobile health program used geospatial targeting to progressively increase the share of its patients from the most socially vulnerable communities from 25% to 41%.[4]
- Mobile dental delivery in Ohio significantly increased preventive care and reduced the need for invasive treatments among school-age children.[4]

The evidence is strong. Mobile healthcare works across a range of clinical services and populations.

4. Mobile health programs are responsive to changing and emergent needs.

Being mobile confers many advantages to healthcare organizations, the greatest of which is flexibility. Populations move. Funding streams shift. New health issues arise. Mobile health programs can adapt more quickly to changing environments than fixed delivery models.

Mobile programs can also deploy rapidly. While some organizations opt to own and operate their own programs, others use turnkey contract services where an experienced partner provides the clinic, drivers, operational staff, and logistics. Others use hybrid arrangements or lease clinics.

The COVID-19 pandemic showed this flexibility in action. Many existing mobile clinics were redeployed for COVID testing and vaccination efforts. Some were used as triage sites or outpatient clinics while hospitals limited who could enter their main facilities. Others became command centers for contact tracing efforts. Many organizations launched new mobile programs during the pandemic and have since transitioned to using them for primary care, school-based healthcare, and substance use treatment.

5. Mobile clinics solve access problems that buildings cannot.

The common thread across mobile health programs is a delivery model designed to reach people who face barriers to accessing fixed-site care.

Distance

Whether a patient can reach care depends on the cost of the trip, whether they have a car or a workable bus route, their health, and competing demands from work and family. Bringing care to the community removes most of these barriers at once.

Volume

Building more fixed sites does not solve the problem. Clinics in small towns and underinvested urban neighborhoods close when patient volume is too low to cover overhead. A mobile clinic spreads operating costs across multiple sites and is sustainable where a permanent clinic cannot break even.

Trust

Many Americans distrust the healthcare system and only seek care when they are seriously ill. Mobile programs build trust by being present, predictable, and rooted in places people already know. Programs with long track records show more preventive care use and fewer avoidable emergency department visits.

6. Mobile clinics are reliable and durable.

When well-built and regularly maintained, mobile clinics are dependable and long-lasting. Before purchasing a clinic, buyers should gather information about the vendor's warranties, service agreements, service locations, and maintenance schedules.

Operators should receive in-depth training on how to safely drive, park, and operate the clinic. Unlike a personal car, the operator must become comfortable with generators, shore power, wastewater disposal, leveling the clinic, and operating accessories like awnings and wheelchair lifts.

7. Mobile health programs are run by a wide range of organizations and staffed by small multi-disciplinary teams.

Many types of organizations run mobile health programs, including community health centers, hospital systems, health plans, local health departments, universities, and community-based organizations.

Mobile clinics are typically staffed by a combination of clinical and operational personnel. Clinical teams include the same providers who work in fixed-site settings: physicians, nurse practitioners, physician assistants, nurses, dental hygienists, and behavioral health professionals. Operational staff handle driving, clinic setup, patient intake, and logistics. In some programs, these roles are combined. For example, a medical assistant, community health worker, or clinician may drive.

A typical mobile clinic team ranges from two to five people depending on the size of the clinic and services being provided. The team may also include off-site staff who handle scheduling, billing, and care coordination.

8. Site selection, scheduling, and connectivity drive operational success.

Site selection

Most mobile clinics deploy to predetermined locations on a regular schedule, often rotating among several community sites each week. Common sites include schools, community centers, employer worksites, affordable housing communities, and health department facilities.

Scheduling

Mobile clinics run on two schedules at once: the deployment schedule that puts the clinic at a given site on a given day, and the patient schedule that fills the clinic hours. Most programs combine scheduled appointments with walk-in capacity. Walk-ins matter because the clinic's physical presence in a familiar place draws people who would not have called ahead.

Connectivity

Reliable internet is now part of clinical infrastructure. Mobile clinics typically use antennas, routers, and more than one carrier so that service continues if one provider drops. Programs operating in rural areas often add satellite service such as Starlink for higher speeds in places where cellular coverage is limited.

9. Mobile clinics get paid the same way fixed clinics do.

Most mobile programs bill Medicaid, Medicare, and commercial payers for the services they deliver, and some also receive grants or donations. Still others partner with schools, employers, and other groups that have a stake in population health.

Mobile services are reimbursed through existing Medicaid provider and benefit structures, under each state's enrollment and billing rules. Federally Qualified Health Centers and Rural Health Clinics receive prospective payment system rates or an approved alternative payment methodology, while Medicare pays FQHCs under its prospective payment system and Rural Health Clinics under an all-inclusive rate. Hospitals and health systems, meanwhile, typically bill through their existing payer contracts.[5,6,7,8]

Sustainability depends on the operator's revenue sources, patient volume, and payer mix. Mobile delivery incurs certain unique costs, including clinic maintenance, fuel, and travel time between sites. However, mobile programs avoid the costs of purchasing and maintaining a building. Given these variables, organizations considering starting a mobile health program should develop a five-year financial forecast before making a final decision.

10. Mobile healthcare is infrastructure, and it works best when treated as part of the larger delivery system.

Mobile healthcare is infrastructure that works best when integrated into the broader delivery system.

When a mobile clinic is enrolled as a Medicaid provider, included in value-based care arrangements, and connected to referral pathways for follow-up care, it functions as part of the system. It extends the reach of existing providers, fills gaps in the network, and creates access points in communities that would otherwise go underserved.

Organizations considering a mobile program should start with the fundamentals covered here: who the program will serve, where and when it will deploy, how it will be staffed and connected, and how it will be paid for. Programs built on these foundations, and tied into Medicaid enrollment, value-based care arrangements, and referral pathways, are best positioned to endure and grow.

SOURCES

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CONTACT

Mollie Williams, DrPH, MPH

Vice President of Evidence and Insights

mollie.williams@missionmobilemed.com