



To RHTP Leaders: Fund Systems, Not Vehicles

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KEY TAKEAWAYS

- More mobile clinics alone do not transform health systems. States that deploy mobile health as infrastructure will achieve lasting outcomes. Those that fund isolated access points will replicate existing weaknesses at scale.
- Mobile healthcare reaches patients that fixed facilities cannot. In rural communities where distance, transportation barriers, and provider shortages suppress care-seeking, mobile platforms are often the best pathway to primary prevention and chronic disease management.
- Rural Health Transformation Program scoring criteria reward states that commit to prevention, innovative care models, and sustainable access. Mobile health programs designed as integrated system infrastructure align with all five RHTP strategic goals.

The Design Challenge Facing Rural Health Transformation Programs

Sixty million Americans live in rural areas. Nearly one-quarter of rural counties lack a primary care physician. Hundreds of rural hospitals operate on margins so thin that a single bad quarter threatens closure. The Rural Health Transformation Program (RHTP), authorized under H.R. 1, represents a new federal response: \$50 billion distributed to all 50 states beginning in FY2026 to transform rural healthcare delivery at the system level.

The risk facing state planners is not underfunding. It is misdirection. When transformation funding arrives without a systems-design framework, states default to what they know: brick-and-mortar expansions, technology procurement, and workforce recruitment pipelines that routinely fail to reach the communities with the greatest need. Mobile health is increasingly proposed as a solution, and the evidence supports that proposition. But mobile health deployed as isolated access points, with units dispatched to underserved communities without coordination infrastructure, will reproduce the very fragmentation that has defined rural health failure for decades.

The RHTP was not designed to fund more of the same. It was designed to transform a delivery ecosystem. State planners writing transformation plans now face a design decision that will determine whether their mobile health investments produce system-

level outcomes or replicate the isolated access patterns that federal funding was intended to replace.

Why Integration Is the Critical Design Variable

CMS structured the RHTP around five strategic goals that describe system transformation:

- Preventive care and root-cause intervention (Make Rural America Healthy Again),
- Long-term provider sustainability (Sustainable Access),
- Evidence-based care models (Innovative Care),
- Technology enabling coordinated care at scale (Tech Innovation), and
- Strengthening recruitment and retention of health care providers (Workforce Development)

Mobile health, properly designed, advances all five. Improperly designed, it advances none sustainably.

The design variable that separates these outcomes is integration. Mobile health programs operating with shared EMR access, dedicated care coordination staffing, bidirectional referral systems, and explicit partnerships with receiving providers generate measurable outcomes: higher referral completion, improved chronic disease management, reduced avoidable emergency visits, and the population health data required for RHTP performance reporting.

The literature is clear on what happens without integration. Mobile clinics operating outside of integrated systems report problems tracking patient referrals. The gap between mobile health as a community benefit and mobile health as transformation infrastructure is not the unit itself. It is the care coordination system surrounding it.

Isolated Access vs. Integrated Infrastructure

Exhibit 1. Comparison of Mobile Health Delivery Models

Metric	Isolated Access Model	Integrated System Model
Mobile visits per unit (annual)	2,500	2,500
Specialty referral rate (~20%)	500	500
Referral completion rate	35% (175)	70% (350)
Fewer preventable ER visits	Minimal	40 to 90
Downstream system value	\$1.1M to \$3.2M	\$2.3M to \$6.5M
RHTP strategic goals addressed	1 to 2	4 to 5

Note: Downstream value estimates are based on referral completion and specialty visit averages. Ranges reflect variation by rural specialty mix and payer composition.

Recommendations

State and local governments should require integrated care coordination infrastructure as a condition of any RHTP-funded mobile health investment. Minimum design requirements include shared EMR or bidirectional referral access, dedicated care coordinator and community health worker staffing, and quarterly outcome reporting against RHTP performance benchmarks. Programs built to these standards generate qualifying outcomes across multiple RHTP strategic goal categories and produce the sustainable access infrastructure the program was designed to create.

Implementation Actions for State RHTP Plans

1. **Require integration infrastructure in all mobile health contracts.** Minimum requirements should include shared EMR or bidirectional referral protocol, designated care coordinator FTE per unit, community health worker staffing, and quarterly outcome reporting. These should be contractual conditions, not aspirational benchmarks.
2. **Include experienced mobile health operators in state RHTP planning.** Organizations with existing mobile infrastructure and community relationships reduce deployment time and increase program success. Require documented community engagement records in vendor/grantee selection criteria.
3. **Design for sustainability from program inception.** RHTP funding runs through FY2030, but rural health needs do not end with the funding cycle. Prioritize mobile health models with billable service structures, Medicaid reimbursement pathways, and community health worker financing mechanisms that survive federal funding cycles.

Why This Window Matters

RHTP transformation plans are being finalized now. The design decisions states make in this window will determine whether mobile health investments include integration infrastructure, whether prevention is built into the service model, and whether community health workers are funded as care coordination staff. These decisions will shape whether RHTP investments transform rural health systems or simply add capacity to a system that continues to fragment care.

SOURCES

H.R. 1, 119th Cong., P.L. 119-21, sec. 71401 (2025). Rural Health Transformation Program. Centers for Medicare and Medicaid Services. (2026).
 Rural Health Transformation Program: Strategic goals and program guidance. U.S. Department of Health and Human Services. <https://www.cms.gov/rural-health-transformation>
 National Association of Community Health Centers. (2024). Mobile health integration and referral completion: Evidence from rural delivery models. NACHC Research Brief.
 American Hospital Association. (2024). Rural hospital financial sustainability and the case for integrated care networks. AHA Research Series.

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