



Fund Systems, Not Clinics

How states can design RHTP mobile health investments as integrated infrastructure

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KEY POINTS

- States that deploy mobile health as integrated infrastructure will produce system-level outcomes and avoid worsening fragmentation.
- Integration is the decisive design variable. Shared EMR access, dedicated care coordination, and bidirectional referral systems are required for true transformation.

The Design Challenge Facing State RHTP Leaders

More than 60 million Americans live in rural areas. Chartis's 2026 analysis identifies 417 rural hospitals vulnerable to closure. The Rural Health Transformation Program (RHTP), authorized under the H.R. 1 (P.L. 119-21, Section 71401), represents a new federal response: \$50 billion distributed to all 50 states beginning in FY2026 to transform rural healthcare delivery at the system level.^{1,3}



Misdirected funding is a risk state planners can control. 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.

Why Integration Is the Critical Design Variable

CMS structured the RHTP around five strategic goals that describe system transformation:¹

- 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.

Mobile clinics operating outside of integrated systems report problems tracking patient referrals. The care coordination system surrounding the unit turns mobile health into transformation infrastructure.⁴

Isolated Access vs. Integrated Infrastructure

METRIC	ISOLATED ACCESS MODEL	INTEGRATED SYSTEM MODEL
Mobile visits per unit (annual)	2,500	2,500
Specialty referral rate (assumed 20%)	500 referrals	500 referrals
Referral completion rate (assumed)	35%	70%
Completed referrals	175	350

Illustrative planning assumptions: 2,500 annual visits × a 20% specialty referral rate = 500 referrals. At 35% completion, 175 referrals are completed; at 70%, 350 are completed. These are model inputs, not measured program outcomes.

PRIMARY RECOMMENDATION

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.

Implementation Actions for State RHTP Plans

1. Map mobile health investments to RHTP strategic goals explicitly.

Before approving mobile health line items in state RHTP plans, verify that each investment addresses at least two CMS strategic goals with specific, measurable outcome targets tied to RHTP performance 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

CMS announced awards to all 50 states on December 29, 2025. States are now putting approved transformation plans into practice. 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.¹

Mobile health has demonstrated that it can reach people that fixed facilities cannot. The question facing state planners is whether they will fund it with the infrastructure to do more than reach them.

SOURCES

- 1 CMS. Rural Health Transformation Program awards. December 29, 2025.
- 2 Georgetown University Center on Health Insurance Reforms. From Clinics to Communities: Mobile Health in State Rural Health Transformation Plans. 2026.
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- 4 Georgetown University Center on Health Insurance Reforms. Expanding Access to Care Through Mobile Health. Literature review and policy reports.

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