POLICY BRIEF

Expanding Potential Sources of Capital for Mobile Health Programs

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How to Use This Policy Brief
This brief is intended for state policymakers, health and education financing authorities, and mobile health program leaders. It provides practical guidance on how states can reduce the cost of purchasing and financing mobile health vehicles and high-cost equipment, revise statutes or financing programs accordingly, and coordinate across agencies to scale mobile care sustainability, including initiatives funded through states' Rural Health Transformation Program efforts. For purposes of this brief, *capital costs include both mobile health vehicles and the high-cost medical equipment and technology associated with the operation of mobile health programs*.

Mobile health programs deliver clinical and preventive services directly to communities where access is limited, including rural areas and populations facing transportation or logistical barriers. These programs are effective, in demand, and increasingly relied upon by safety-net providers. However, their ability to scale is constrained by access to affordable capital.

A key barrier to scaling these programs is the high upfront cost of vehicle-based care platforms. In 2025, basic mobile units, such as vans used for screening or limited clinical services, may cost $150,000–$220,000. Larger or more specialized vehicles often start in the $300,000–$600,000[1] range, and can be higher depending on the configuration. In many cases, the cost of clinical equipment, diagnostics, and technology may equal or exceed the cost of the vehicle itself. These capital costs are often difficult for nonprofit and safety-net providers to absorb.

[1] *See* "Mobile Medical Vehicle Pricing and Cost Breakdown Guide" at https://www.craftsmenind.com/blog/mobile-medical-vehicle-cost-guide and "How Much Does a Mobile Clinic or Outreach Van Actually Cost?" at https://www.nextgenvans.com/post/mobile-clinic-and-outreach-van-price. Last accessed February 19, 2026.

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While vehicle costs are well known, access to affordable financing is a less visible challenge. Mobile health programs may have stable demand, but they often lack capital with terms that align with the capacity of the borrowing entity and the useful life of vehicles and associated equipment. Traditional lending is structured for private fleets or real estate-backed borrowers. This structure raises financing costs for nonprofit or low-margin providers whose primary asset is a vehicle.

States already manage tax-advantaged financing, leasing, and credit tools that can address this mismatch. By extending these tools to mobile health vehicles and equipment, states can reduce borrowing costs, align repayment with asset life, and support long-term sustainability. These approaches are currently not common for mobile health programs, so there are relatively few established examples that apply directly to mobile vehicles and equipment. Table 1 summarizes practical public financing tools that states and financing authorities can adapt to lower borrowing costs, better match repayment to asset life, and strengthen the long-term sustainability of mobile health programs.

Financing Approaches

Access to capital, whether public, private, or philanthropic, depends on financial readiness. Financing needs fall into two categories: start-up capital to acquire vehicles and equipment, and ongoing resources to sustain operations over time. Across funding sources, mobile health programs are expected to demonstrate viable business models, achievable revenue pathways, and plans for long-term sustainability.

Private financing is often difficult for mobile health programs to access. Many programs operate on thin margins and cannot meet conventional lender expectations for repayment capacity or the rapid return on investment private lenders demand. Mobile health programs often launch with grant-funded startup models and limited long-term business planning, which increases perceived risk. As a result, upfront vehicle and equipment costs are most often covered through philanthropy or grant funding.

Public financing tools can help close this gap. By lowering borrowing costs, aligning repayment with the useful life of vehicles and equipment, and reducing lender risk, these approaches can help create conditions where private financing becomes more feasible as programs demonstrate stable operations and sustainability.

In addition to standard public and private financing, complementary pathways may be relevant for mobile health programs. These options often sit between public and private capital and are used to

fill gaps where conventional lending is limited. Although uptake is limited today, they represent emerging options for supporting innovation and scale.

- **Mission-driven lenders**, including Community Development Financial Institutions (CDFIs), specialize in serving borrowers that face barriers in traditional credit markets. They may finance nonprofit providers and community-based infrastructure when conventional collateral or underwriting does not align with mobile assets.
- **Private sector manufacturers and leasing companies** that focus on medical equipment and vehicles could offer a community or region-based financing initiative to support nonprofit organizations seeking to scale mobile health programs.
- **Social impact investment** and concessional capital via private foundations, including program-related investments (PRIs) and other impact-oriented financing that prioritizes social outcomes alongside financial return. These tools may offer longer terms or lower-cost financing for projects with a clear public benefit.
- **Public-private partnerships** combine public financing tools, philanthropic capital, and private or nonprofit operators through structured agreements. In the mobile health context, these partnerships can spread risk, align capital investment to operating expectations, and reduce reliance on one-time funding sources.

These pathways complement public financing mechanisms by expanding options for programs or service models that do not fit traditional lending structures.

Table 1 outlines **public financing** approaches that can be used to support mobile health programs through more affordable capital. These approaches connect mobile programs to established financing pathways and, where applicable, may complement grant or philanthropic funding. In practice, this results in lower interest rates, longer repayment terms, and fewer transaction costs for vehicles and associated clinical equipment and technology. Depending on the approach, implementation may occur at the state level, local level, or through a designated financing authority.

Table 1. Public Financing Approaches

Approach	What Public Authorities Can Do	How it Lowers the Financing Cost
Tax-Exempt Financing for Mobile Health Vehicles (State or Local Financing Authorities)	• Authorize tax-exempt revenue bonds for nonprofit mobile health providers. • Define mobile health vehicles and integrated medical technology as essential public purpose capital assets eligible for tax-advantaged financing. • Enable and coordinate mobile health purchasing pool bonds to aggregate vehicle and equipment demand and share transaction costs • Align repayment terms with vehicle and equipment life (often 7 – 10 years). • Prioritize providers serving rural, underserved, and health care desert communities.	Reduces interest rates and spreads repayment over longer time periods, lowering annual debt service and upfront barriers to purchasing and outfitting mobile units.
Statewide Tax-Exempt Equipment or Vehicle Leasing Programs* (State Agencies or Central Procurement Authorities)	Classify eligible public and nonprofit private mobile health units and specialized equipment as essential public health infrastructure for purposes of state or municipal lease-purchase agreements. Include mobile health vehicles and equipment in master lease programs. • Structure lease payments over the useful life of vehicles and equipment. • Incorporate public-sector budget features, such as annual appropriation considerations.	Provides faster access to vehicles, limits large upfront cash needs, and delivers favorable public-sector pricing while preserving operating funds.
Pooled Financing for Small and Rural Providers (State or Regional Authorities)	• Establish pooled purchasing or financing through an appropriate state or regional authority. • Bundle multiple small or rural providers into a single transaction. • Allow the administering authority to act as aggregator or limited credit backstop where appropriate.	Spreads fixed transaction costs across providers, improves pricing through scale, and makes financing feasible for organizations that

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Approach	What Public Authorities Can Do	How it Lowers the Financing Cost
	• Offer optional standardized vehicle and equipment specifications.	cannot support standalone deals.
Revolving Loan Funds for Community Health (State Agencies or Designated Intermediaries)	• Explicitly include mobile health vehicles and integrated medical technology as eligible capital uses. • Offer below-market interest rates and repayment terms aligned with vehicle and equipment life. • Recycle loan repayments to replenish the fund and finance future mobile health investments. • Coordinate with federal programs and other funding sources to grow the fund.	Creates a durable, predictable source of affordable capital that supports expansion without repeated fundraising or one-time appropriations.
Credit Support to Lower Private Borrowing Costs (State or Regional Authorities)	• Establish a state-level credit enhancement fund for mobile health. • Provide partial loan guarantees to reduce lender risk. • Use loan-loss or first-loss reserve accounts to improve pricing and terms. • Address collateral gaps for vehicles and high-cost medical equipment and technology.	Lowers perceived lender risk, enables longer repayment terms, reduces collateral requirements, and moves private loans closer to public-sector pricing.
Partner With State Education Agencies (State-level Coordination)	• Clarify allowable use of Title I and Title IV funds for mobile health services delivered in schools. • Authorize Title I support for services tied to attendance and academic outcomes. • Leverage Title IV Part A for student wellness, safety, and behavioral health services where allowable. • Align educational operating funds with state capital financing for vehicles and equipment.	Aligns school-based service delivery with capital financing, allowing consistent mobile health access without forcing tradeoffs between vehicles and operations.

Centralized ownership and pooled purchasing remain the most visible pathways for full-service mobile clinics. For example, the Kentucky Primary Care Association (KPCA) received more than $5 million in state funding to acquire mobile health clinics for deployment through member organizations.[2] Mobile Care Chicago operates multiple mobile units and has built shared operational infrastructure through its "Community Dispatch" model, illustrating an asset-sharing approach that can improve utilization even when vehicles are owned rather than leased.[3]

Examples of Existing State and Local Financing Models

Existing state and local financing approaches can lower borrowing costs for vehicles and equipment, but they are rarely used for mobile health programs today. Florida provides the clearest example, while the other examples show approaches that could be adapted to explicitly include mobile health vehicles and equipment.

Some Florida county health financing authorities, such as the Escambia County Health Facilities Authority (ECHFA), explicitly allow tax-exempt lease financing for vehicles and other eligible property used in health care delivery.[4] ECHFA also authorizes bond proceeds to be used for equipping health care facilities. This structure provides a clear pathway for financing mobile health vehicles and related equipment when those assets are treated as eligible leased property or eligible capital uses under an authority's financing program.

The Dormitory Authority of the State of New York, a public benefit corporation, operates the Tax-Exempt Equipment Leasing Program (TELP).[5] This program provides low-cost financing for medical equipment, information technology, and related assets for nonprofit hospitals and clinics, and higher education institutions by allowing lenders to receive tax-exempt interest on leases. This same model can be applied to not-for-profit mobile health vehicles.

Texas uses a statewide master leasing program that allows public agencies to finance vehicles and equipment at lower interest rates through a centralized state program. Texas's master equipment leasing program (MELP) can be used by state agencies to finance mobile health vehicles to address rural health shortages.[6]

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[2] KPCA New Mobile Clinics

[3] Mobile Care Chicago

[4] ECHFA Tax-Exempt Financing

[5] DASNY TELP.

[6] Master Lease Purchase Program Overview. Texas Public Finance Authority.

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The California Health Facilities Financing Authority (CHFFA) operates a pooled bond financing program[7] whereby CHFFA issues bonds and subsequently loans the proceeds to multiple borrowers. Eligible borrowers must be a health facility that is a non-profit 501(c)(3) corporation or public health facility (e.g., district hospital) as defined by California law. Funds must only be used for allowed purposes, which include working capital for start-up, remodeling, renovation, and other improvements, and equipment or furnishings. The model could be expanded to allow mobile health programs as borrowers and include their capital costs as eligible expenses.

Getting Started
To get started, review current financing programs in your locality to see whether mobile health vehicles and equipment are clearly eligible and appropriately financed (see the National Association of Health and Educational Facilities Finance Authorities www.naheffa.com to find your local authority). Policymakers, health and education finance authorities, and mobile health program leaders can partner to update statutes, procurement rules, and financing approaches so mobile health programs can access established, lower-cost capital and scale services in underserved communities.

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[7] CHFFA Bond Financing Program.