

Routing Around US Healthcare Systems

Opportunities for better care at lower cost

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TLDR

The opportunity is real, but it is uneven. Selected services can already be delivered more conveniently, with less specialist time or lower operating costs. The most credible strategy combines local human relationships, remote expertise, appropriate diagnostics, AI assistance, and payment that rewards completed care and health improvement.

My strongest reason for optimism is that several necessary pieces now exist together. Narrow medical AI has clinical evidence; community and home care have workable precedents; national consumer platforms can reach people directly; and Medicare is testing payment for technology-supported chronic care outcomes. My strongest reason for pessimism is that the US often rewards the sale of more services, while control of facilities, referrals, data and payment allows established organizations or new platforms to retain efficiency gains.

The emerging breakthrough is a different division of work. A patient can receive more of a complete care pathway near home, supported by a local navigator and qualified clinical team, while AI handles selected information tasks and remote specialists address the cases requiring their expertise. This arrangement becomes financially transformative only when it replaces unnecessary work, improves outcomes, and gives patients or purchasers a share of the savings.

For PSA/IHPF, the best near-term role is to organize and evaluate that complete pathway: identify a local care gap, assign responsibility for each next step, arrange clinical capacity and payment, and test whether AI improves the service. The proposed diagnostic commons is a possible extension after demand and follow-up capacity are established. Neither proposal is yet evidence of a successful operating program.

How to read this report

The executive findings come first, followed by US opportunities, international examples, the most credible breakthroughs, dated developments to watch, reasons for optimism and pessimism, and recommendations for PSA. Numbered references link to primary research, regulators, program documentation and clearly identified company announcements. Forecasts and original proposals are labeled.

This is a strategic evidence review of representative initiatives, not a systematic review of every country or vendor. An operating service, a positive trial, regulatory permission and demonstrated total-cost savings are four different achievements.

Report guide

Start with the ten findings for a quick briefing. Sections 3 and 4 review the evidence and operating models; sections 5 through 13 assess what they mean for US restructuring and PSA.

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Evidence key

Operating means a service or program exists for a defined population. **Clinical evidence** describes measured results and their limits. **Announced** identifies a public plan. **Forecast** and **concept** identify analysis and proposals rather than established results.

1 Ten findings that matter most

- 1. Healthcare can be reorganized one complete pathway at a time.** Diabetic eye screening, medication continuity, selected home hospital episodes and chronic-disease management are more practical starting points than replacing an entire health system. Each has a definable patient group, clinical task and endpoint.
- 2. The strongest route around a bottleneck often preserves a partnership with existing clinicians.** Local acquisition of information, remote interpretation and selective referral can change where expertise is applied. Hospitals remain essential for emergencies and complex treatment.
- 3. Payment reform is becoming as important as model capability.** Medicare's ACCESS model began in July 2026 and creates an outcomes-oriented payment route for technology-supported chronic care. It is a significant institutional experiment whose long-term results remain unproven. [\[3,4\]](#)
- 4. Large consumer platforms can change how people enter healthcare.** Amazon connects an AI interface with clinical and pharmacy services. AT&T distributes access to LifeMD through an existing customer relationship. Their reach could lower customer-acquisition costs, but reach and enrollment are different from improved health. [\[6–8\]](#)
- 5. A free interface is not free healthcare.** Membership waivers and inexpensive consultations can improve access while leaving laboratory, specialist, hospital and medication costs largely intact. The price of the whole episode matters.
- 6. Narrow AI can remove a costly handoff.** Autonomous retinal screening provides a concrete example: moving a specific examination into an existing diabetes visit can avoid a separate screening appointment. Abnormal results still require accountable follow-up. [\[15,16\]](#)
- 7. AI assistance has benefits that do not necessarily reduce spending.** Better notes, faster evidence retrieval and less clinician exhaustion are

worthwhile. They do not by themselves establish fewer admissions, better survival or lower premiums. [\[10,13,38\]](#)

8. **International experience offers operating principles, not plug-in US business models.** Community teams, shared records, remote specialist support and prevention have been implemented under very different financing and workforce arrangements. US adaptation must address those differences.
9. **New entrants can reproduce old incentives.** A platform that controls advice, appointments, prescribing and fulfillment may create a convenient service while acquiring powerful incentives to steer use toward its own businesses. Independent evaluation and patient choice matter.
10. **PSA can add value at the point where advice must become completed care.** A bilingual navigator who verifies that a test, medication or referral actually happened addresses a problem that an excellent chatbot can leave unresolved. PSA's advantage would come from reliable local operations and community accountability.

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2 What routing around should mean

Routing around means creating a better practical route to a health outcome when the established route is slow, expensive, inaccessible or poorly coordinated. It can bypass an unnecessary appointment, a high-cost location, an opaque purchasing arrangement or an avoidable information barrier. It can also change the incentives of an existing organization through a different contract.

The objective is **better care and lower total burden**, including money, time, travel and unpaid family work. It should not become a rationale for

abandoning people with difficult conditions or transferring clinical risk to households.

Six routes with different economics

Route	What changes	Where savings could arise
Place of care	Selected services move to home or local sites	Facility expense and travel
Division of work	Qualified teams and narrow AI perform defined tasks	Scarce specialist time
Purchase and payment	Buyers use subscriptions, bundles or outcome payments	Billing friction and avoidable volume
Access to knowledge	Patients and clinicians obtain usable information directly	Search, preparation and repeat work
Coordination	One team follows a pathway through completion	Missed steps and preventable deterioration
Market power	Purchasers obtain alternative providers and transparent prices	Excess prices and intermediary charges

These mechanisms should be evaluated separately. Moving a consultation online primarily changes access and clinician logistics. Moving a hospital episode home changes physical delivery. A cost-plus pharmacy changes purchasing. None automatically solves the others.

Why the US has both exceptional opportunity and resistance

CMS reports actual US health spending of \$5.3 trillion in 2024, or \$15,474 per person and 18.0% of GDP. These are historical spending figures, not a

measured 2026 total. [1] RAND found that private plans and employers in its 2022 claims sample paid hospitals an average of 254% of Medicare prices for the same services. That comparison is a price benchmark, not proof that every hospital can operate at Medicare rates. [2]

The implications differ. Administrative simplification can reduce the resources needed to provide care. Negotiating a lower price can reduce a purchaser's payment even if the provider uses the same resources. Preventing illness can improve health but may require spending today for benefits years later. A credible report of savings must identify which mechanism operated and who benefited.

The US also has multiple decision makers: employers, public insurers, commercial plans, health systems, professional practices, patients and state regulators. This creates many places to start an alternative, but makes it difficult to coordinate payment, data and clinical responsibility across the complete journey.

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3 Current US opportunities

Medicare payment for technology supported chronic care

Status: operating federal payment experiment; outcome evidence pending.

The Centers for Medicare & Medicaid Services launched ACCESS on July 5, 2026, for a ten-year period. It tests recurring payments to Medicare-enrolled organizations for managing qualifying chronic conditions, with full payment tied to measured outcomes. Its clinical tracks cover early cardio-kidney-metabolic risk, established cardio-kidney-metabolic disease, chronic musculoskeletal pain, and depression or anxiety. [3]

CMS's participant page, updated September 15, lists more than 160 participating organizations. Its technical guidance measures performance across a participant's patients against condition-specific targets. These are

clinician-guided services that complement existing care; enrollment in a federal model is not an endorsement of every product's effectiveness. [\[4,52\]](#)

Why this could restructure care. A provider paid for improvement has more freedom to use remote contacts, home measurements and team care instead of building its operation around billable office visits. AI can help organize monitoring, personalize approved education and identify tasks requiring clinical review. The economic test remains whether the added service improves health enough to justify its full cost and avoids duplicating care already being paid for.

The linked FDA TEMPO pilot offers a limited, risk-based enforcement-discretion pathway for certain finished digital devices used in clinician-supervised ACCESS care. It is not blanket FDA authorization or permission to market the same use everywhere. Manufacturers are expected to collect real-world evidence and ultimately seek appropriate marketing authorization. [\[5\]](#)

Amazon and consumer distribution of care

Status: available services with continuing rollout; independent total-cost evidence limited. Amazon expanded Health AI onto its website and app in March 2026. With permission and available records, the assistant can help explain information and connect the user with One Medical services, appointment booking and prescription workflows. [\[6\]](#) Its current public page advertises direct-message treatment for eligible Prime members for specified common conditions. Exact eligibility and included services should be checked at enrollment because launch promotions and current terms can differ. [\[7\]](#)

The structural importance is the combination of an existing consumer relationship, an information interface, licensed care and medication delivery. It reduces the need for patients to assemble those pieces themselves. It does not establish that the platform has complete records, can supply a scarce local specialist, or reduces total annual medical spending.

AT&T's September 15 LifeMD announcement illustrates a related distribution strategy. It waives the \$19 monthly membership charge for eligible

customers. The initial rollout covers 29 million customers in 11 states, including New Mexico; additional markets are planned for January 2027. Visits, medicines and other services still cost money. The announcement lists message visits from \$29, urgent/primary video visits from \$49 and specialty visits from \$79, subject to terms and availability. These are advertised prices, not an estimate of a patient's complete episode cost. [\[8\]](#)

Assessment. Such partnerships could make routine care easier to obtain at enormous scale. The AT&T announcement is principally evidence of distribution and access; it does not demonstrate that AI caused better outcomes or lower costs. PSA should assess these services as possible components of local care, with explicit arrangements for records, physical examinations and follow-up.

Personal health assistants and clinical copilots

Status: consumer rollout and clinician products; capabilities and access vary.

Health in ChatGPT allows eligible US users to connect supported medical records and Apple Health information for explanations, summaries and preparation. Its rollout should not be assumed to cover every account or organization. [\[9\]](#) Microsoft introduced Copilot Health with a phased rollout and waitlist, combining personal health information with an explanatory interface. [\[11\]](#)

For professionals, ChatGPT for Clinicians is available free to verified US physicians, nurse practitioners, physician assistants and pharmacists. OpenAI describes evidence search, documentation and research support; eligible accounts can obtain additional HIPAA support through a Business Associate Agreement. Product access alone is not an organization's complete clinical-data governance arrangement. [\[10\]](#)

Curai provides another model: AI-assisted virtual primary care delivered with licensed clinicians. Its importance is the attempt to redesign intake and ongoing clinical work around an online service, rather than adding a chatbot to an unchanged appointment system. Public service descriptions establish

what it offers; they do not independently establish population-level savings. [\[12\]](#)

Assessment. These tools can reduce information asymmetry and help smaller practices access capabilities previously concentrated in large systems. A patient still needs someone authorized and able to act on the information. A navigator using AI to prepare an accurate, actionable handoff may therefore be more valuable than an additional stand-alone answer service.

Ambient documentation and administrative work

Status: deployed, with growing but mixed causal evidence. A randomized trial involving 238 outpatient physicians compared two ambient scribes with usual practice. Nabla reduced time spent writing notes by 9.5% relative to control; DAX did not show a statistically significant reduction on that measure. Findings varied by product and outcome. [\[13\]](#)

The potential is practical: clinicians may spend less time documenting, teams may prepare cleaner referrals, and staff may spend fewer hours assembling authorization requests. Translation and patient instructions can also improve when checked against the approved care plan.

The financial result depends on what happens next. Time saved might support longer visits, fewer after-hours tasks, more appointments or higher revenue. Some of those are benefits without being lower prices. A purchasing contract should specify whether the intended gain is capacity, staff wellbeing, patient experience or reduced spending, and measure that result directly.

Neighborhood diagnostics and narrow medical AI

Status: selected authorized products and clinical evidence; broad neighborhood packages remain a design choice. FDA's medical-device list includes AI for specific diagnostic and imaging functions. Each product has its own intended use, setting and limitations; presence on the list does not validate an entire service model. [\[14\]](#)

The diabetic-eye-screening ACCESS trial provides unusually concrete evidence. Among 164 young people with diabetes, screening completion within six months was 100% with an AI examination at the point of care, versus 22% with referral and education. Among the 25 intervention participants with abnormal results, 16 completed specialist follow-up. The trial demonstrates improved completion, not prevention of blindness or nationwide cost savings. It is unrelated to CMS's newer ACCESS payment model. [\[15\]](#)

The research population must not be confused with a device label. The original IDx-DR authorization covered specified adults aged 22 and older; deployment must follow the current product's actual authorization. [\[16\]](#)

Assessment. A defined screening task that once required another trip can sometimes be completed during an existing visit. That is a meaningful change in delivery. For ultrasound, cardiac testing and micro-labs, the same economic logic is worth testing, but trained acquisition, quality control, consumables, clinical interpretation and an affordable response to abnormal results remain necessary. Specimen collection linked to an established laboratory may be a better first step than operating a new laboratory. Applicable CLIA requirements still govern testing. [\[50\]](#)

Hospital care at home

Status: operating model for selected patients, with an extended federal pathway. In a small US randomized trial of 91 adults, hospital-level care at home had 38% lower direct acute-care costs than hospital care. Participants lived close to the participating hospitals, and the intervention included visits, monitoring, testing and treatment. The result is not a forecast of 38% savings for all admissions or remote rural settings. [\[17\]](#)

CMS's broader evaluation found important differences between people treated at home and in hospitals, limiting simple causal comparisons. [\[18\]](#) Current federal law extends the hospital-at-home waiver authority through

September 30, 2030, improving the planning horizon for qualifying hospitals. [\[19\]](#)

Assessment. This is one of the clearest routes around a costly physical setting. AI may assist monitoring and logistics, but the model predates contemporary generative AI. Rural expansion must account for travel time, emergency transfer, housing conditions and caregiver workload. Hospital operating savings also do not automatically become lower Medicare payments or patient bills; payment contracts determine that distribution.

Direct primary care and direct purchasing

Status: established approaches with a new US tax-policy opening. Direct primary care replaces much routine visit billing with a periodic fee for a defined scope of primary care. Since January 1, 2026, qualifying arrangements no longer by themselves disqualify an otherwise eligible person from contributing to a Health Savings Account. IRS guidance sets conditions, including 2026 monthly fee limits of \$150 for one person or \$300 for arrangements covering more than one person. [\[20\]](#)

Subscriptions can simplify administration and fund more accessible relationships. AI could make a small practice easier to operate. However, primary-care membership is not comprehensive insurance. Patients still need arrangements for expensive specialist, emergency and hospital care, and extra membership charges can exclude those least able to pay. Smaller patient panels can improve individual access while reducing the total population served by the same clinician workforce.

Employers and other purchasers can also contract for specified imaging, procedures or episodes at agreed prices. RAND's price variation supports investigating alternatives, but does not prove that any particular direct contract saves money after travel, complications and follow-up. [\[2\]](#) AI can help compare terms and assemble information; a purchaser still needs actual alternative capacity and bargaining power.

Transparent medication purchasing

Status: operating commercial alternative. Cost Plus Drugs offers direct and employer arrangements built around published cost-plus pricing. Its stated model uses acquisition cost with a fixed 15% markup, alongside applicable charges. [\[21\]](#) This is primarily a purchasing innovation. AI could help reconcile a medication list and identify options for professional review, but it does not make a patented drug generic or remove distribution and dispensing requirements.

The relevant comparison is a patient's actual insured price and total cash price, including delivery, and how each option affects coverage accounting. A pharmacy with a transparent formula will not be cheapest for every prescription. Preserving access to a local pharmacist can be particularly important where the pharmacy supplies other clinical services.

Community health workers and care completion

Status: established human service models; AI augmentation is a separate hypothesis. Penn's IMPaCT community health worker program has randomized-trial evidence, and a published economic analysis estimated \$2.47 returned to Medicaid per dollar invested through reduced hospital use. This is program-specific evidence, not a transferable guarantee for every navigation service. [\[23\]](#)

Medicare has payment mechanisms for Community Health Integration and Principal Illness Navigation under defined clinical, supervision, consent and billing requirements. These are routes to investigate with eligible providers, not unrestricted grants to a community organization. [\[24\]](#)

A revealing US precedent comes from a randomized study in 52 Black-owned barbershops. Bringing prescribing pharmacists into a trusted community setting substantially improved blood-pressure control compared with an active control that encouraged lifestyle change and doctor visits. It did not require AI. [\[25\]](#)

Assessment. Trust, convenient treatment and a person who helps resolve barriers can change outcomes. AI could support preparation, scheduling, documentation and work queues. The incremental question is whether those tools improve completion or reduce staff burden beyond a well-run human service.

Accountable care and shared savings

Status: mature federal program with measured financial results. In its updated 2024 results, CMS reported \$2.5 billion in Medicare savings relative to benchmarks and \$4.1 billion in payments to Shared Savings Program accountable care organizations. Lower-revenue organizations, often physician-led or involving health centers, generated greater per-person net savings than higher-revenue organizations. These are benchmark-based program results, not a randomized national counterfactual. [\[22\]](#)

An accountable care organization, or ACO, accepts responsibility for the quality and cost of care for a defined population. Such arrangements can make prevention, navigation and fewer unnecessary hospital services financially worthwhile. They may provide a partner that can finance a local intervention and benefit from successful results.

Risk adjustment, patient selection, coding practices, measurement and market consolidation remain central. The term “value-based care” should prompt examination of the contract, rather than an assumption that patients pay less.

Bounded prescribing and digital mental health

Status: limited experiments; important differences from general autonomous care. Utah’s Doctronic agreement permits a staged prescription-renewal pilot. Its public status update says the pilot remains in Phase 1, with all requests requiring licensed-practitioner authorization. It excludes new prescriptions, controlled or addictive substances and treatment-plan changes. The state notes no reported serious safety incidents at the time of that update, but also reports adversarial vulnerabilities and says more time is

needed for firm conclusions. The update is not a real-time September audit. [\[26\]](#)

For mental health, the 2025 Therabot trial randomized 210 adults to a specialized chatbot intervention or a waitlist. Short-term symptom improvements are promising, but a waitlist comparison does not establish equivalence to a qualified therapist, durable benefit, or safety for unrestricted use in high-risk situations. [\[27\]](#)

These are areas to monitor and evaluate under defined clinical arrangements. They do not establish that general consumer chatbots can safely replace broad medical or psychiatric practice.

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4 What the rest of the world is testing

These examples span public systems, commercial platforms, clinical trials and new pilots. Some strengthen existing institutions; others create alternative access routes. They show that reinvention does not require one ownership model. Transfer to the US depends on payment, workforce, geography and public trust.

England brings services closer to communities

Operating services plus a new implementation program. Community diagnostic centres move tests into accessible local settings. The 2026 neighbourhood-health framework seeks to join primary, community, local-government and other services, while improving general practitioners' access to diagnostics. [\[28,29\]](#)

The US lesson is to organize a service around a local population and a complete pathway. A shared diagnostic hub is useful when it reduces delays and makes results actionable. A new building can otherwise become another disconnected institution. NHS procurement and national funding do not

translate directly into US reimbursement, and new local sites still require staff and downstream capacity.

Sweden redesigns mammography reading

Large randomized clinical evidence. MASAI used AI to help triage mammograms for single or double reading and assist detection. Its 2025 analysis reported a 44% reduction in reading workload and increased cancer detection. [\[30\]](#) The 2026 follow-up found a non-inferior interval-cancer rate. The point estimate was 12% lower with AI, but the confidence interval included no reduction; this should not be reported as a statistically proven 12% improvement. [\[31\]](#)

This is a credible change in how specialist effort is allocated. It does not eliminate the mammography examination or prove reduced mortality. US adoption must account for its own reading practices, liability arrangements and reimbursement.

India combines public telemedicine with local access points

Operating at national scale. India's eSanjeevani supports both direct remote consultation and access through local health centres. An official June 2026 report stated more than 480 million cumulative consultations by June 24. These are encounters, not unique people or proof of improved outcomes. [\[32,53\]](#)

The transferable principle is assisted digital access: a resident can reach distant expertise through a nearby human and physical service point. This is more relevant to rural US communities than assuming every patient can manage a smartphone-based journey alone. AI can assist the service, but the headline scale belongs to the wider telemedicine infrastructure and workforce.

Estonia treats shared records as infrastructure

Established national digital infrastructure. Estonia links information from providers into a nationwide record that patients can access. [\[33\]](#) That shared

foundation can reduce repeated collection and make longitudinal interpretation more feasible.

For the US, a practical lesson is to make records portable, attributable to their source and usable across organizations. AI cannot reliably repair every missing, outdated or mismatched record. Estonia's smaller population and national governance simplify coordination compared with the US. The relevant import is the design principle, not a claim that a new AI interface can reproduce the entire system.

Singapore organizes prevention around a regular care relationship

Operating national reform. Healthier SG links residents with a family doctor and personalized preventive health planning, supported by community activities and chronic-disease services. [\[34\]](#)

The US lesson is continuity: digital information becomes more useful when an identified team can act over time. AI coaching could support that team. Prevention should be assessed for health benefit and value, with savings measured rather than presumed. Singapore's financing and governance differ enough that its national model is not a ready-made US contract.

Germany makes selected digital therapies reimbursable

Established regulatory and payment pathway. Germany's DiGA framework assesses eligible digital health applications for reimbursement, including evidence of a positive healthcare effect and a route for provisional listing while evidence is generated. [\[35\]](#)

The lesson is institutional: a digital service needs a payment and evaluation route if it is to become routine care. Listing does not mean every application is equally effective, saves money or uses AI. For the US, ACCESS is worth watching partly because it addresses a related problem through outcomes-oriented care payments rather than simply paying for app downloads.

Brazil builds care around territorial teams

Established primary-care organization. Brazil's Family Health Strategy teams include physicians, nurses, nursing staff and community health agents. The agents visit homes, support prevention and connect residents with clinical teams. [\[36\]](#)

The model treats knowledge of households and neighborhoods as part of healthcare delivery. AI might help these workers manage information or identify missed steps, but trusted local relationships remain central. For PSA, the useful lesson is to give paid community workers a defined place in the operating model, with manageable caseloads and supervision.

China integrates AI with a commercial care network

Company-reported deployment at scale. Ping An describes an AI-plus-physician model connecting health advice and care services within its financial and healthcare businesses. Its July 2026 announcement reports a very large user base. Those company counts should not be read as independently verified clinical outcomes. [\[37\]](#)

This is a relevant comparison for Amazon: a large distribution platform can connect information, clinicians, insurance relationships and transactions. It also illustrates a governance question. The same integration that reduces friction can increase dependence on one company and make independent price comparison harder.

Kenya tests whether generative AI improves routine care

Pragmatic randomized evidence with a limited clinical result. A 2026 Nature Medicine study across 16 Penda Health facilities analyzed more than 9,000 encounters in its primary analysis. AI assistance improved documentation, but did not significantly reduce treatment failure within 14 days. Reported model-use cost was about four cents per patient, which excluded the full cost of implementation and care. [\[38\]](#)

The lesson is unusually valuable: inexpensive intelligence and improved process measures do not guarantee better patient outcomes. This finding narrows what was established for that intervention and setting; it does not prove that AI is ineffective in all primary care.

Rwanda and partners begin a larger primary care experiment

Announced pilot and expansion goal. Horizon 1000 brings a \$50 million commitment in funding, technology and technical support from the Gates Foundation and OpenAI, beginning in Rwanda, with a goal of reaching 1,000 primary-care clinics and surrounding communities by 2028. It is a target, not a completed deployment count. [\[39\]](#)

The opportunity is to redesign work around overloaded health teams. Evidence to watch includes local-language performance, clinical escalation, staff workload, fully loaded cost and independent patient outcomes. A successful result would be relevant to underserved US areas, though the financing and available workforce would differ.

Nigeria tests AI at an existing maternal care visit

Randomized clinical evidence for a defined diagnostic task. SPEC-AI Nigeria enrolled 1,232 pregnant or postpartum participants across six sites. AI-guided screening using a digital stethoscope increased detection of pregnancy-related cardiac dysfunction relative to usual obstetric care. [\[40\]](#)

The important operating idea is to add a validated, targeted assessment where a person is already receiving care. A positive screening result still needs confirmatory testing and treatment. This is not evidence for indiscriminate cardiac screening of every community resident, and US deployment must follow the relevant product's authorization.

What transfers most readily

The most adaptable elements are shared information, assisted access, task-specific technology, community workers, remote specialist support and recurring payment for continuity. The least transferable elements are national

price levels, staffing ratios, legal authority and claims that an entire foreign financing system can be imported through a local pilot.

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5 What qualifies as a real breakthrough

I would reserve that description for a change that materially improves a complete clinical pathway, can be repeated outside its original demonstration, and has a credible method of paying for its ongoing operation. Lower resource use, lower payments and better outcomes should be reported separately.

Strongest demonstrated changes

A diagnostic step can move into an existing visit. The retinal-screening trial shows how a validated autonomous task can remove a referral barrier. The structural gain comes from completing appropriate work where the patient already is. Follow-up remains the limiting step for some patients. [\[15\]](#)

Specialist effort can be redistributed without worsening a measured safety endpoint. MASAI supplies evidence for changing the mammography-reading workflow. Its results support carefully specified redesign, with continuing evaluation, rather than a general claim that radiologists are dispensable. [\[30,31\]](#)

Selected acute care can leave the hospital building. Hospital-at-home has a clear mechanism for changing resource use, provided logistics and safe escalation are available. It illustrates a delivery breakthrough that AI could strengthen but did not create. [\[17–19\]](#)

Community delivery can outperform advice alone. The barbershop and community-worker examples show the importance of bringing actual treatment and barrier resolution into people's lives. Adding AI should

enhance those functions and should be evaluated as an additional intervention. [\[23,25\]](#)

Most important institutional opening

Technology-supported care can have an outcomes-based payment route.

ACCESS may help organizations build a different operating model without forcing every useful activity into an office-visit billing structure. The result depends on patient selection, measurement, coordination and full costs. It is an opening for restructuring, with results still to be demonstrated. [\[3–5\]](#)

Promising capabilities that have not crossed that threshold

Microsoft's diagnostic-orchestration research achieved strong results on difficult published cases, including 85.5% accuracy in one configuration. It evaluated a constructed diagnostic benchmark, not a randomized deployment across ordinary patients with real physical examinations, evolving disease and real downstream costs. [\[48\]](#)

Consumer health assistants, autonomous workflow agents, broad AI monitoring and digital twins may become valuable. At present, this review did not establish that they can independently deliver comprehensive care with reliably lower total spending. Vendor benchmark success, clinician ratings, user counts and fundraising should not be substituted for that evidence.

The combination worth building toward

A practical model would let a person enter through a trusted local service or convenient digital channel; share a usable care record; obtain appropriate local measurements; receive clinical decisions from an accountable team; and get help completing treatment. Specialists would handle the cases that require them, while AI supports information work within defined boundaries.

That is an analytical synthesis of existing components, not a claim that one organization has already perfected the entire model. Its success depends on the interfaces: who accepts the referral, who responds to an abnormal result,

who pays for missing capacity, and who remains responsible if the patient cannot complete the plan.

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6 What is coming soon and what is only a forecast

Dated developments with a public basis

Development	Timing and status	What to watch
CMS ACCESS	Began July 2026; ten-year model	Real clinical outcomes and full spending
AT&T and LifeMD	More markets planned January 2027	Actual access, use and continuity
Prior-authorization APIs	Key requirements generally begin January 2027 for affected payers	Working connections and faster decisions
Rural transformation funding	Federal program spans FY 2026–2030	State contracts and sustainable services
Horizon 1000	Goal of 1,000 clinics by 2028	Deployment versus independently measured benefit
Hospital-at-home authority	Extended through September 2030	Equitable access and payment design

Sources and scope: [\[3,8,19,39,41,42\]](#). The first row is already operating. The other rows include scheduled requirements, announced plans, funding windows and statutory authority; these are not all product-release dates.

CMS's interoperability and prior-authorization requirements are especially relevant to practical automation. Standardized connections could reduce repeated portal entry and fax-based work. They apply to specified payers and services, with differing compliance details; they do not abolish authorization, guarantee approval or instantly connect every US record. [\[41\]](#)

The \$50 billion Rural Health Transformation Program offers a material opportunity for new delivery arrangements. State awards and implementation rules determine access to funds. A technology purchase supported by a grant still needs staffing, maintenance and a post-grant revenue model. [\[42\]](#)

Reasonable expectations over the next one to three years

Forecast, with moderate confidence in direction and low confidence in exact timing. More routine care will begin with digital intake; AI will prepare more clinical work; selected diagnostics will be offered at additional local sites; and some organizations will use agents to coordinate tasks across scheduling and payment systems. The basis is the combination of deployed tools, policy pathways and existing delivery models reviewed above.

The pace will vary by task. Administrative work with clear verification is easier to scale than an uncertain diagnosis. A service with a reliable escalation destination is easier to automate than a service that discovers problems without available treatment. Rural areas may gain disproportionately from remote expertise while facing greater physical-delivery costs.

Possibilities over three to seven years

Scenario, not prediction. Patient-directed care agents could maintain a portable plan across organizations and help compare prices, prepare referrals and track results. Neighborhood services could combine remote clinicians with approved local testing. Outcome contracts could pay for an entire course of care, allowing providers to choose an efficient mix of home, community and facility services.

For these changes to reduce US spending, purchasing and payment must adapt. Otherwise, more capable software may simply create more billable activity or a new subscription layer. A generally autonomous AI physician, a universal diagnostic kiosk and a dependable whole-person digital twin remain poor assumptions for a near-term operating budget.

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7 Reasons for optimism

The components are becoming practical together

There is now evidence for narrow AI tasks, usable remote-care infrastructure, established community-worker models and new payment experiments. This makes a small, complete service more feasible than a plan that depends on a future all-purpose medical AI. The opportunity is to combine validated components around a specific local problem.

Better access does not always require a new hospital

Some bottlenecks can be addressed with an existing room, a qualified visiting professional, a reserved appointment, remote interpretation or a trained navigator. This creates room for lower-capital approaches. The first investment can be service capacity and coordination, with equipment purchased only when demand supports it.

Small organizations can use increasingly capable information tools

A rural practice or nonprofit can obtain drafting, translation assistance, evidence retrieval and workflow support without building its own model. That lowers some barriers to experimentation. It does not remove the need for clinical expertise or reliable operations, but it can make a competent small team more effective.

The financial interest in alternatives is broad

Patients want less travel and expense; employers want affordable benefits; public payers want better outcomes; and clinicians want less administrative work. These interests can support partnerships even when the partners disagree about national reform. A well-defined pathway allows each party to see what it is contributing and receiving.

AI can reveal failures that previously stayed invisible

Used carefully, information tools can identify missing results, contradictory instructions and tasks with no assigned owner. This creates an opportunity to manage completion systematically. The service must provide the human capacity to resolve the resulting queue; detecting more unfinished work is only the first step.

Communities can retain a meaningful role

Large platforms are well placed to provide technology and broad access. Local organizations can contribute knowledge of actual service availability, language, transportation, trust and household circumstances. A community-governed arrangement could purchase national capabilities while retaining control over local priorities and referrals. This is a design opportunity, not an inevitable market outcome.

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8 Reasons for pessimism

Lower production costs can become higher margins

A provider may use AI to reduce documentation cost while charging the same price. An insurer may retain savings. A platform may charge for access to its distribution. Patients benefit financially only when competition, purchasing contracts, benefit design or public payment passes those gains through.

Easier access can increase total use

A cheaper consultation may substitute for a costly visit, or it may be an additional encounter that would not otherwise have happened. More screening can find treatable disease and also produce incidental findings, false positives, repeat tests and anxiety. Appropriate new treatment may improve health while increasing spending. The report's goal requires measuring both value and cost, rather than assuming they move together.

Physical and human scarcity persists

An AI-generated referral does not create a specialist appointment. A home monitor does not provide a nurse at midnight. A clear care plan does not provide safe housing, electricity, transportation or a family caregiver. In rural regions, distance and low service density can dominate costs even when digital work is inexpensive.

Disruptors have failed at the operating economics

Walmart closed its 51 health centres and virtual-care operation in 2024, citing reimbursement challenges and rising operating costs. An enormous customer base and retail footprint did not establish a sustainable care business. [\[46\]](#) This is a caution about the difficulty of combining accessible prices with clinical delivery costs, not proof that all retail or virtual care must fail.

Innovation programs do not reliably save money

GAO's 2026 review reiterates CBO's estimate that the CMS Innovation Center increased net federal spending by \$5.4 billion over 2011–2020, after including the cost of its activities. This historical portfolio result does not determine the outcome of ACCESS, and it is distinct from the Medicare Shared Savings Program results above. It shows why the costs of running experiments belong in the economic analysis. [\[45\]](#)

Commercial integration can create new gatekeepers

The FTC's 2025 interim staff report examined substantial markups and steering incentives in specialty generic-drug markets involving major

pharmacy benefit managers. [47] New AI-led businesses could also control the route from advice to purchase. Referral independence, disclosure of commercial interests, price comparison and the ability to leave a platform should be part of procurement decisions.

Weak evaluation can turn early enthusiasm into permanent spending

Before-and-after comparisons can confuse a new service with changes in case mix, regression to the mean or broader trends. Vendor case studies often omit non-users, attrition, failed referrals and support costs. Improvements in documentation or engagement should not be reported as clinical benefit without evidence connecting them.

A two-tier system is a plausible failure scenario

Affluent patients could receive human care enhanced by AI, while poorer patients receive mostly automation with difficult escalation. People without broadband, English fluency, accessible devices or stable coverage could fall further behind. Fair design requires measuring who completes care and who disappears from the process.

Existing services may lose revenue before their costs fall

Moving profitable routine services elsewhere can weaken a hospital that still must maintain emergency and other essential capacity. The response should be to finance necessary standby services explicitly and coordinate changes with regional providers. Assuming all incumbent revenue is waste can damage access in precisely the communities a reform is meant to serve.

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9 How to know whether better care really costs less

Use four separate accounts

Account	Include	Misleading shortcut to avoid
Patient and household	Copays, cash fees, travel, time and caregiver work	Counting only the advertised visit price
Clinical operator	Staff, review, equipment, software, support and overhead	Counting only AI usage charges
Payer or purchaser	All relevant claims and program payments	Treating benchmark savings as universal causation
Community and system	Access, essential capacity, equity and long-term effects	Treating shifted cost as eliminated cost

Report outcomes separately: clinical improvement, appropriate test completion, treatment initiation, avoidable escalation, patient experience and time to care. A project may provide excellent value without saving money in its first year. It should describe that result honestly.

Identify the expensive step that actually disappears

A useful business case names the avoided resource or payment: a second screening trip, an unnecessary facility visit, repetitive manual data entry or a preventable admission. Then it subtracts the cost of the replacement service and any additional downstream care. Savings should not be counted simply because a person who received the service did not have an emergency visit. If an intervention adds a navigator, remote clinician, monitoring subscription and testing without removing or preventing enough other cost, it may improve care but raise spending. That may still be justified for an underserved

population. It is a different claim from delivering the same or better outcome for less money.

A simple illustrative threshold

Assume a proposed program costs \$200,000 annually after all staffing, technology and overhead are included. Assume it avoids \$400 in genuine net payer spending per substituted episode, after paying for the replacement and downstream care. It would need 500 such substitutions to break even for that payer.

These are invented planning inputs, not PSA estimates, market prices or a savings forecast. They show why verified substitution and sufficient volume matter. If the benefit instead comes from health improvement without avoided spending, the program needs a purchaser willing to pay for that improvement.

Build a credible comparison

Measure the existing pathway before changing it. Where practical, use randomized allocation or a phased rollout with comparable sites and a prespecified analysis. At minimum, account for differences in patient risk, prior utilization and access. Include everyone offered the service, not only enthusiastic users or successful completions.

Assess the service with and without AI where feasible. A navigator-plus-AI program compared only with usual care cannot tell whether its gains came from navigation, technology or both. That distinction affects future staffing and purchasing decisions.

For a small pilot, focus on observable completion, delays, safety and workload. A sample of a few hundred people will rarely support confident claims about uncommon harms or long-term total-cost savings. Plan a larger and longer evaluation before using those claims to justify scale.

Put the intended savings into the contract

Specify the population, covered tasks, escalation responsibilities, data access, prices and evaluation method. If a payer expects savings, define how they will be measured and shared. If patients should pay less, write that into benefits or price terms. If the priority is capacity or reduced staff exhaustion, measure those outcomes directly.

Avoid incentives that reward unnecessary testing, suppression of needed referrals or exclusion of difficult patients. Require a continuity plan if a vendor closes, changes prices or withdraws a product.

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10 Conditions that alternatives still must satisfy

Healthcare alternatives can change the organization of work while preserving professional and public responsibilities. US telehealth authority varies across state lines; the patient's location and the provider's licensing route matter.

[\[49\]](#) Diagnostic testing remains subject to applicable laboratory and device rules. [\[14,50\]](#)

Health-data protections also depend on context. HHS explains that many personal apps are outside HIPAA unless supplied by a covered entity or business associate. This does not mean that no other privacy law applies; it means "health app" is not itself a guarantee of HIPAA protection. [\[51\]](#) A community service needs clear consent, limited access, appropriate agreements, retention rules and usable records if a vendor relationship ends.

These requirements shape the operating model. A licensed clinical organization should own clinical decisions and escalation. Community representatives should have a meaningful voice in priorities, access and accountability. AI outputs should have traceable sources and a defined review process for consequential actions. The service needs a workable response

when information is wrong, a patient cannot be reached or capacity is unavailable.

No model reviewed here eliminates the need for risk pooling for expensive illness. A low-cost primary-care subscription or AI service can complement insurance and public financing; it cannot provide comprehensive financial protection on its own.

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11 Implications for PSA and southern New Mexico

Build on the current planning record

The August Healthcare Vision 2.0 proposed an initial 90-day preparation stage followed by a limited, bilingual Next Step Closure service in Doña Ana County. It placed paid community workers, named human responsibility and measurement of burden ahead of broad autonomous diagnosis. The September diagnostic-commons report proposed a provider-operated, community-governed service, with capacity purchasing or leasing before major asset commitments. These are planning proposals; this review does not establish that the board authorized them or that partners have committed.

[\[54–56\]](#)

That sequence remains sensible. PSA should first show it can help people complete an important care pathway, then add diagnostic capacity where the observed bottleneck justifies it. Buying equipment before confirming demand and treatment capacity would reverse that logic.

First priority is a complete navigation pathway

Select one partner-defined problem, such as completion of an appropriate referral or test after a primary-care visit. Use a named bilingual navigator to confirm the plan, resolve scheduling and transportation barriers, track the

result and verify the clinically indicated next step. Clinical questions go to an identified professional with agreed response capacity.

Begin with a reliable manual process. Let AI assist with drafts, approved-language explanations, document organization and queue management. Compare the added benefit and review burden before expanding its authority. This is an implementation recommendation, not evidence that the PSA service already improves outcomes.

Second priority is shared diagnostic capacity

Choose one pathway from actual unmet need. Compare reserved appointments and transport with a visiting service at existing clinics. Consider a portable modality only after confirming qualified operation, appropriate indications, interpretation, maintenance and affordable follow-up.

Community governance can address which populations are served, hours, language access, procurement and reinvestment. The clinical operator should retain professional control over individual care. Participating Tribal nations would determine their own governance and data arrangements; regional collaboration does not confer authority over Tribal services.

Third priority is an outcome aligned funding partner

Explore partnerships with an FQHC, rural clinic, hospital, ACO, Medicaid plan or other purchaser that has both a care gap and an incentive to improve it. CMS ACCESS is a potential model or partner route for eligible Medicare services, not an assumed direct funding mechanism for PSA or for a Medicaid pilot. Medicare navigation codes also require an eligible clinical and billing arrangement. [\[3,24\]](#)

New Mexico's federal Rural Health Transformation award for FY 2026 is \$211,484,741 in the HHS award record. [\[43\]](#) Its published application abstract includes access, workforce, technology and other transformation priorities, but expressly cautions that proposed budgets do not establish approved uses or final awards. [\[44\]](#) PSA should investigate current state procurement and

partnership routes with a clinical operator; this report does not claim that a specific funding opportunity is open or that PSA qualifies.

A proposed first 90 days

1. **Define one population and unfinished step.** Ask residents, caregivers and a clinical partner where completion fails. Document recent volumes, travel, delay and reasons for noncompletion.
2. **Secure real service capacity.** Identify the ordering clinician, navigator supervisor, test or referral destination, urgent escalation contact and backup arrangements. Obtain concrete prices and staffing assumptions.
3. **Agree on payment and evaluation.** Establish who pays for navigation, clinical review, uninsured gaps and ongoing operations. Specify a comparison and outcome measures before enrolling participants.
4. **Run the workflow with de-identified or approved test cases.** Measure handling time and failure points. Test whether AI reduces work after checking and corrections are counted.
5. **Bring a specific pilot decision to the board.** Include partner commitments, a budget ceiling, clinical responsibilities, enrollment criteria and numerical performance thresholds chosen with the clinical and evaluation partners.

These are recommended next steps, not actions already authorized or undertaken.

What to measure and what would justify stopping

Measure completed next steps, time to completion, unresolved clinical concerns, staff minutes, patient and caregiver burden, and results by language, geography and relevant risk groups. Record the full cost per completed pathway and identify which entity pays it.

Pause enrollment or the affected AI function if unresolved clinical tasks exceed the team's response capacity, consequential errors recur, follow-up cannot be obtained, or the service adds unacceptable burden. Expansion

should require demonstrated improvement and a sustainable operating arrangement. “Stopping” means correcting, narrowing or discontinuing a particular intervention when its evidence warrants that decision; it does not mean abandoning PSA’s goal.

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12 Imaginative possibilities worth keeping in view

The following are strategic concepts, not verified products, announced launches or recommendations for immediate implementation.

A community health utility

A locally governed organization could purchase shared navigation, selected diagnostics, remote clinical support and reserved referral capacity for several communities. Its public purpose would be dependable access and completion. AI could help coordinate demand and staff work. Durable financing and enforceable service obligations would matter more than ownership of any particular device.

A patient directed care agent with delegated authority

A future agent could maintain a portable plan, prepare forms, compare qualified options and help book services across organizations. People would choose which actions it may take. A trusted human could assist residents who prefer telephone or in-person access. Clinical decisions, corrections, records provenance and accountability would need explicit rules.

A regional market for unused clinical capacity

Providers could make reserved appointment slots, imaging sessions and remote-consult capacity available to a coordinated regional service. AI could help match appropriate demand with available capacity and transportation. This would require reliable schedules, clinical suitability rules and prices that

make participation worthwhile; it should not become a system that rewards unnecessary testing.

A cooperative purchaser of complete care pathways

Counties, employers, community organizations and willing payers could jointly purchase a defined service such as hypertension management or referral completion. The contract could reward better outcomes and lower household burden, while requiring patient choice and transparent reporting. This is a governance and purchasing proposal that would need separate legal and feasibility work.

Continuous support without continuous medicalization

Future tools could provide occasional, consented checks on whether a care plan is working, reserving clinical attention for meaningful changes. The design challenge is to reduce disruption and avoid treating every wearable fluctuation as illness. Whole-person digital twins may eventually help, but their reliability and added clinical value should be demonstrated before they direct care.

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13 The strategic choice

My assessment is optimistic about targeted restructuring over the next several years and cautious about rapid, nationwide reductions in total spending. Useful alternatives already exist. Their gains are greatest when they remove a barrier to appropriate care, shift work to a capable and less costly setting, and operate under a contract that supports the resulting behavior.

For PSA, I would prioritize a clinically partnered care-completion service, followed by one justified diagnostic pathway. I would monitor ACCESS, home-care payment, consumer-platform expansion and bounded clinical AI, while requiring evidence before adopting their stronger claims. I would defer an

autonomous primary-care service, a broad screening package or a digital-twin program as the foundation of the first pilot.

Sources and evidence notes

Public sources were checked for this briefing on September 27, 2026. Publication dates and study periods are retained where relevant. Company and government announcements establish offerings or program design; they do not independently prove clinical benefit.

Original analysis, recommendations and scenarios are distinguished in the text. Prior PSA reports supply planning context and are not counted as independent clinical evidence.

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