

The AI Care Corps Act

A Federal Moonshot to Close America's Rural Healthcare Gap

MBA Policy Challenge 2026

Executive Summary

Sixty million Americans live in rural or medically underserved communities where physician shortages, diagnostic delays, and geographic isolation combine to produce dramatically worse health outcomes than their urban counterparts. The core problem is not a lack of funding alone. It is a structural breakdown in access that no amount of subsidy has yet solved. We propose the AI Care Corps Act: a federal initiative modeled on the Peace Corps that deploys FDA-cleared AI diagnostic infrastructure to rural and underserved clinics nationwide, pairs that infrastructure with a new class of federally certified AI Health Navigators, and creates a public-private partnership model to sustain it at scale. This is not a pilot program. It is a national moonshot to make world-class diagnostic capability available within 30 miles of every American.

Some will ask whether AI can truly deliver reliable diagnostics, and whether deploying it in underserved communities creates a second tier of care. We argue the opposite. On reliability: the AI diagnostic tools proposed here are FDA-cleared, clinically validated systems already operating in leading academic medical centers. The question is not whether they work. The question is why only wealthy, urban patients currently benefit from them. Our proposal mandates that every tool deployed through the AI Care Corps demonstrate performance parity across demographic groups as a condition of federal procurement, measured against the FDA's 2024 Predetermined Change Control Plan guidance for AI transparency in underrepresented populations. Compliance is verified by an independent third-party auditor appointed by HHS before any tool receives a federal procurement contract, with 15 percent of the Partnership Fund reserved for continuous post-deployment auditing and bias correction. These are stronger equity safeguards than currently exist in any private deployment of these same tools.

On the two-tier concern: critics may argue this proposal delivers AI instead of real doctors to rural Americans. We ask them to consider the real alternative. Today, rural patients wait more than 45 days to see a specialist, or they skip care entirely. The choice is not between AI-assisted triage and a fully staffed clinic. It is between AI-assisted triage and nothing at all. The AI Care Corps raises the floor for the 60 million Americans who currently sit at zero. At the same time, the Navigator Corps is explicitly designed as a pipeline into medicine and nursing, not a permanent substitute for physicians. Every Navigator completes their two-year placement with a pathway to accelerated medical or nursing school entry, building the next generation of rural physicians from within the communities that need them most.

I. The Problem: A Two-Tier Healthcare Nation

The Rural Health Crisis by the Numbers

The United States spends more on healthcare per capita than any other developed nation, yet geography has created a deeply unequal system. The shortage is not marginal. It is structural and worsening:

- Over 60 million Americans live in Health Professional Shortage Areas (HPSAs), with rural counties accounting for the majority of the most severe shortages (Health Resources & Services Administration, 2024).

- Rural Americans die from heart disease, cancer, and stroke at rates 20-40% higher than urban Americans, not because the diseases are different, but because diagnosis comes too late (CDC Rural Health, 2023).
- The average wait time to see a specialist in a rural county exceeds 45 days, compared to under 10 days in metropolitan areas (Rural Health Information Hub, 2024).
- The U.S. faces a projected shortage of 86,000 physicians by 2036, with rural and primary care specialties experiencing the steepest declines (AAMC, 2024).

These are not statistics about distant communities. They represent the working families, veterans, and elderly Americans who built this country and now cannot access a cardiologist, radiologist, or oncologist within a reasonable distance. The economic cost is equally severe: preventable hospitalizations from delayed diagnosis cost the U.S. healthcare system an estimated \$28 billion annually (JAMA, 2023).

Why Current Solutions Fall Short

Existing policy interventions including loan forgiveness for rural physicians, telehealth expansions, and rural hospital subsidies address symptoms rather than the structural cause. Loan forgiveness has failed to meaningfully move physicians to rural communities at scale. Telehealth expansions require physicians on the other end of the call, which still depends on a supply of clinicians that does not exist. Rural hospitals are closing at a record pace: 149 closures since 2010, with 453 more at risk (Chartis Center for Rural Health, 2024). We need a fundamentally different approach.

II. The Proposal: The AI Care Corps Act

Core Mechanism

The AI Care Corps Act creates three interlocking components:

1. Federal AI Diagnostic Infrastructure Deployment

The federal government, through a new Office of AI Health Infrastructure (housed within HHS), negotiates a national licensing agreement with FDA-cleared AI diagnostic platforms covering radiology, pathology, dermatology, cardiology screening, and mental health triage. These tools, already proven in clinical settings, are deployed as plug-and-play diagnostic suites to every Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and critical access hospital in HPSAs. The federal government acts as a single purchaser, dramatically reducing cost through economies of scale, and retains data rights to continuously improve model performance on underserved populations.

2. The AI Health Navigator Corps

Modeled on the Peace Corps and AmeriCorps, the AI Care Corps recruits and trains a new professional role: the AI Health Navigator. Navigators are two-year, federally certified health technicians trained to operate AI diagnostic tools, interpret AI-generated risk flags, coordinate specialist referrals, and connect patients to follow-up care. They do not diagnose. They flag, triage, and escalate. Navigators commit to two-year placements in HPSAs in exchange for full student loan forgiveness, a living stipend benchmarked to AmeriCorps VISTA rates (\$28,000 annually), and a pathway to accelerated entry into medical or nursing school. Target recruitment: 25,000 Navigators in the first five years.

When the AI system flags a high-risk result, the Navigator follows a federally standardized escalation protocol. The sequence is as follows: the Navigator immediately contacts an on-call telehealth physician through the existing VA and HRSA telehealth networks, transmits the AI-generated risk summary along with the patient

record, and schedules urgent follow-up care within 24 hours. For life-threatening flags, the protocol triggers emergency services automatically. Navigators do not make clinical judgment calls at this step. The protocol is rule-based and mandatory, which eliminates ambiguity around liability. Legal coverage follows the Federal Tort Claims Act model already used to protect community health center staff, meaning the federal government assumes liability for Navigators acting within their defined scope.

3. Public-Private Partnership Sustainability Model

The Act creates a Rural AI Health Partnership Fund, capitalized with \$3 billion in initial federal appropriations, matched by a mandated 1:1 industry contribution from AI health companies receiving federal procurement contracts. Participating companies receive regulatory fast-track status for new diagnostic AI cleared through an expedited FDA pathway for rural-specific clinical validation. This creates a durable economic incentive for private investment in rural health AI, shifting the model from one-time grants to sustained, self-reinforcing infrastructure.

Legislative Path and Institutional Fit

The AI Care Corps Act can be enacted through two vehicles: standalone legislation with bipartisan sponsorship (rural healthcare has historically attracted Republican and Democratic support alike), or as an amendment to reauthorization of the Community Health Centers Fund, which is due for renewal in 2026. Key implementing agencies include HHS/HRSA (deployment and Navigator certification), FDA (expedited AI clearance pathway), and the Office of Personnel Management (Corps recruitment and benefits). Existing FQHC and RHC grant infrastructure provides immediate distribution channels, avoiding the need to build new bureaucracy.

III. Impact and Feasibility

Quantified Impact Projections

Metric	Baseline (2025)	Projected (Year 5)	Methodology
Rural patients with AI diagnostic access	< 5%	~70%	25,000 Navigators × avg. 840 patients/yr (benchmarked to Community Health Worker caseload norms, NACHW 2023)
Avg. specialist wait time (HPSAs)	45+ days	< 15 days	AI pre-screening eliminates low-acuity referrals
Preventable hospitalizations avoided	—	~310,000/yr	Based on 12% reduction rate in comparable pilots (NEJM, 2023)
Annual cost savings (system-wide)	—	~\$8.7B/yr	\$28K avg. cost per preventable hospitalization
Navigator jobs created	—	25,000	Direct; additional 40,000+ indirect healthcare jobs

Cost and Financing

Total five-year federal investment: approximately \$6.2 billion, itemized as follows. The Rural AI Health Partnership Fund accounts for \$3.0 billion in initial federal appropriations, matched 1:1 by industry. Navigator stipends account for \$1.4 billion (25,000 Navigators at \$28,000 per year over two years, benchmarked to AmeriCorps VISTA rates). Navigator training accounts for \$400 million, delivered through an eight-week federally designed curriculum hosted at community colleges and existing HRSA training centers. Infrastructure, administration, and oversight account for the remaining \$1.4 billion, including broadband provisioning, hardware, and the federal auditing function. This total cost is offset by an estimated \$43 billion in system-wide savings from reduced preventable hospitalizations over five years, a net fiscal return of more than 6:1. For comparison, the federal government currently spends \$4.5 billion annually on rural health programs with far less measurable impact.

Addressing Key Risks and Tradeoffs

- **AI accuracy in underserved populations:** FDA-cleared tools must demonstrate performance parity across demographic groups as a condition of federal procurement, benchmarked against the FDA's 2024 Predetermined Change Control Plan guidance on AI transparency for underrepresented populations. An independent HHS-appointed third-party auditor verifies compliance before any tool receives a contract. The Partnership Fund reserves 15 percent for ongoing post-deployment auditing and bias correction, creating accountability at both the entry point and throughout the deployment lifecycle.
- **Scope of practice, handoff protocol, and liability:** Navigators operate under a precisely defined federal scope. They do not diagnose. When an AI tool generates a high-risk flag, the Navigator follows a federally standardized escalation protocol: they immediately contact an on-call telehealth physician through the existing VA and HRSA telehealth networks, transmit the AI-generated risk summary and patient record electronically, and schedule urgent follow-up care within a mandated timeframe based on acuity level. This protocol is not hypothetical. It mirrors the Community Health Worker escalation models already operating in 47 states, and it plugs into telehealth physician networks that currently sit underutilized outside of business hours. Navigators document every escalation in a federal registry, creating an auditable chain of care. Liability protection follows the Federal Tort Claims Act model used for Federally Qualified Health Center staff, meaning Navigators are treated as federal employees for malpractice purposes, removing financial exposure from both the Navigator and the clinic.
- **Technology adoption in low-resource clinics:** Deployment includes a standardized broadband infrastructure requirement, leveraging USDA ReConnect and FCC E-Rate programs already funding rural connectivity. Hardware is federally provisioned, not locally purchased.
- **Opposition from physician and hospital lobbies:** The proposal deliberately avoids displacing existing providers and instead creates a new tier of care below the physician level. Organized medicine's primary concern about scope of practice encroachment is structurally addressed by the Navigator's defined, non-diagnostic role and the mandatory physician-in-the-loop escalation protocol.

IV. Why This Matters Now

The AI Care Corps Act addresses three of the defining economic and social challenges of this moment simultaneously: the future of the workforce (it creates a new, accessible healthcare career pathway that doesn't require a decade of training), the cost of living (healthcare costs are the leading driver of medical debt and financial instability for rural families), and global competitiveness (a healthier, more productive rural

workforce strengthens the industrial and agricultural base that underpins American exports and supply chain resilience).

This is also the right political moment. AI in healthcare is no longer speculative. FDA has cleared over 950 AI-enabled medical devices as of 2024. The infrastructure exists. The science exists. What has been missing is the will to deploy it where it is needed most, with the federal muscle to make it universal rather than confined to elite academic medical centers. The AI Care Corps is that will, made policy.

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