Optimal Care America

A human promise, a national care floor, and a path toward personalized medicine

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Prepared for substantive review by Jimmy
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Status: **editorial policy draft—not a validated financing plan, cost estimate, transition authorization, or publication candidate**

> **How to read this draft.** Each consequential proposition is identified as **Accepted evidence**, **Sponsor direction**, **Proposed design**, **Unresolved question**, or **Criterion-24 blocker**. The labels matter. Sponsor directions are policy choices to explain and test; they are not findings established by the accepted evidence corpus.

Executive proposition

Optimal Care America begins with a promise that should be easy to say and hard to evade: every person will have a meaningful floor of health care, a usable way into that care, and a human being accountable for what happens next.

The promise is not merely an insurance card. It is access to a named care team; preventive, primary, urgent, specialty, hospital, behavioral, oral, pharmacy, rehabilitative, home, long-term, palliative, diagnostic, and emergency capabilities; continuity when care crosses institutions; accommodation and language access; and a right to understand, choose, refuse, appeal, and seek remedy. Care remains a relationship among the patient, the people the patient trusts, and accountable clinicians. Institutions, payment systems, and technology exist to support that relationship.

Accepted evidence. The checked Optimal Care America corpus already defines an outcome-first operating architecture, a rights and outcome constitution, eleven patient-journey families, a symmetric resource-accounting method, and a disciplined evidence frontier. These are specified and checked design artifacts. They are not proof that the proposed system has been implemented, can yet be staffed safely, will improve national outcomes, or will cost less than the current system.[1–7]

Sponsor direction. The preferred financing direction is national single payer for the guaranteed care floor. National minimum standards would define what every person can count on, while delivery would remain local and the patient-clinician relationship would remain central. People could purchase supplemental private care above the universal floor. The longer-term clinical vision is voluntary, AI-enabled personalized medicine: rapid multimodal assessment, diagnosis support, and individualized treatment that benefit the patient and physician rather than an opaque claims intermediary.[8]

Proposed design. This draft connects those directions into one policy architecture. A national public financing layer would fund the common floor. National rules would set rights, benefits, safety, interoperability, evidence, and accountability standards. Local care organizations would determine how to meet that floor in their communities. An optional personalized-data layer would sit above—not replace—the guaranteed standard of care. Supplemental private care would remain separate from the public guarantee and subject to guardrails against weakening the floor.

Criterion-24 blocker. The technical record supports 38 of 39 program criteria. Criterion 24 remains incomplete. There is no accepted comparable bottom-up national and per-resident resource range for the observed baseline, no accepted A1 national or per-resident estimate, no accepted category shares or sensitivity results, and no selected numeric frontier. Therefore this draft claims no A1 total, saving, funding requirement, tax rate, transition budget, or implementation timetable. The technical evidence program remains paused.[6][7]

The immediate purpose is narrower: give the sponsor a coherent policy paper to review without pretending that editorial coherence closes an evidence gap.

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1. The human promise

The system should be judged first at the point where a person needs care. Can the person enter through a route they can actually use? Does someone accept responsibility? Is the next step timely, clinically appropriate, accessible, and understandable? If the first plan fails, is there an escalation path? If the system causes harm or abandons the person between organizations, can the person appeal and obtain remedy?

Accepted evidence. The canonical outcome constitution orders decisions lexicographically. Rights and authority come first; survival and catastrophic safety follow; then health and person-defined outcomes; then access, continuity, experience, equity, and caregiver impact; then resilience and learning. Comparable resource cost comes last. A favorable national average cannot compensate for a serious rights violation or conceal harm to an individual or required subgroup. The constitution contains 39 metrics in 13 domains and keeps missing, incomparable, or underpowered results open rather than treating them as favorable.[2]

This order supplies the moral and operational core of the universal floor:

- bodily autonomy, informed choice, supported decision-making, and refusal;
- nondiscrimination, privacy, dignity, accommodation, and accessible communication;
- timely entry, continuity, safe handoffs, and an accountable receiver;
- prevention of avoidable death, serious harm, abandonment, and unsafe delay;
- attention to health, function, cognition, comfort, patient-defined goals, caregiver impact, and unjust subgroup gaps; and
- transparent review, appeal, correction, remedy, and learning after failure.

Proposed design. These commitments should become enforceable conditions of participation in the national program, not optional aspirations. The national floor should state both what services are covered and what obligations follow the person across those services. A nominal benefit that cannot be reached, delivered safely, or continued through a handoff does not satisfy the promise.

Unresolved question. The precise legal form of these rights—statutory entitlement, private right of action, administrative appeal, independent ombuds authority, injunctive relief, damages, or a combination—requires legal, ethical, disability, patient, clinical, labor, federalism, and Tribal review. This draft proposes the obligation; it does not settle the remedy structure.

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2. The operating system for care

Optimal Care America is best understood as an operating system rather than a single national delivery organization. National financing and standards create the common guarantee. Care itself is organized through four connected layers, with accountability following the person until a named receiver accepts it.

2.1 The person, home, and personal care team

Accepted evidence. The A1 architecture gives every person a named lead clinician, care steward, and team identity supported by a usable longitudinal plan. Attachment is not a name placed in a database. It exists only when the person has a usable route to the team, the team accepts responsibility, and workload remains inside an accepted safety envelope. Direct-entry routes remain available for emergencies and other services where primary-care gatekeeping would be unsafe or inappropriate.[3]

Proposed design. The personal care team would be the default home for prevention, new symptoms, chronic conditions, medication reconciliation, care-plan maintenance, and navigation. The patient could change teams, seek a second opinion, designate supporters, and record preferences and communication needs. If no safe long-term panel is available, a local access team would retain temporary responsibility while the capacity problem remains visible.

2.2 The Community Health Commons

Accepted evidence. The Commons is a local capability platform, not a required building type or ownership form. Its defined capabilities include comprehensive primary and preventive care, round-the-clock access and acute evaluation, behavioral and substance-use care, oral health, pharmacy, common diagnostics, maternity and newborn support, rehabilitation, home and mobile nursing, palliative care, interpretation and accessible communication, transport coordination, and social-care navigation.[3]

Proposed design. A Commons might be a public clinic network, a nonprofit system, a group of contracted independent practices, mobile services, a rural hub-and-spoke arrangement, or a combination. The national standard would define the capabilities and accountability; the

community would determine the physical form that can meet them. A live operations function would track patient clocks, unacknowledged results, open referrals, available staffed capacity, transport, supply constraints, and people at risk of being lost.

2.3 The Regional Care Grid

Accepted evidence. The Grid connects emergency medical services, hospitals, specialty and procedural services, critical care, maternity, rehabilitation, long-term services and supports, laboratories, imaging, pharmacy, blood, and medical transport. The architecture's no-stranded-patient rule requires a named receiving clinician and site before transfer; the sender remains accountable until acceptance.[3]

Proposed design. Regional operating bodies would maintain real-time views of staffed—not merely licensed—capacity and coordinate transfers, scarce resources, disaster response, and cross-organizational recovery. Regions would be drawn around clinical travel time, referral patterns, population need, workforce, and redundancy rather than existing corporate boundaries alone.

2.4 The National Expert Mesh

Accepted evidence. The Mesh is designed to support rare and complex care, reference diagnostics, evidence synthesis, scarce capabilities, and multi-region events without removing responsibility from the local team.[3]

Proposed design. The Mesh would connect centers of expertise to patients and local clinicians through consultation, shared diagnostic work, and specialized treatment planning. It should move expertise more readily than it moves patients. National expertise would augment the relationship closest to the person, not convert ordinary care into a remote command center.

2.5 One journey, one accountable chain

Accepted evidence. Eleven machine-readable journey families cover the major paths through prevention, new symptoms, urgent and emergency care, hospital episodes, maternal and newborn care, behavioral health, rehabilitation, medication management, oral health, long-term care, and serious-illness care. They share a common contract: usable entry, named ownership, acknowledgement, escalation, recovery, patient rights, and subgroup non-regression.[4]

Proposed design. National standards should require this chain of accountability even when ownership, technology, and payment relationships vary. No payer denial, referral closure, discharge, or transfer should erase the clock or reset responsibility without a named receiver.

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3. National financing, national standards, local care

3.1 The financing direction

Sponsor direction. National single payer is the preferred current model for financing the guaranteed care floor.[8]

Proposed design. One national public pool would finance the covered floor for every eligible person under uniform rules. The policy aim is to separate clinical access to the floor from employment, insurer networks, and household claims adjudication. Payment administration would still exist, but it would be an accountable support function rather than the organizer of the clinical relationship.

This is a direction, not a completed financing architecture. The draft does not specify a tax base, collection mechanism, provider-payment schedule, global-budget formula, capital-allocation mechanism, federal-state fiscal relationship, treatment of existing public programs, or transition payment. Those choices require legal design and comparable resource evidence that the current corpus does not contain.

Unresolved question. "Single payer" can describe materially different systems. Sponsor review is needed on whether the public pool would be the sole payer for the covered floor or the sole payer for nearly all clinically appropriate care; how Indian Health Service, Tribal health systems, Veterans Health Administration, military health, workers' compensation, and territorial systems would relate to it; and which functions should be national, regional, state, Tribal, or local. Nothing in this paper can substitute for government-to-government consultation or authorization by a sovereign Tribal Nation.

3.2 The national minimum

Sponsor direction. The nation should establish minimum standards of care while preserving local delivery and the patient-clinician relationship.[8]

Proposed design. The national minimum would contain five linked elements:

1. a covered capability floor, including necessary preventive, diagnostic, treatment, rehabilitative, supportive, long-term, and palliative care;
2. rights and access standards, including accommodation, language access, consent, refusal, appeal, continuity, and remedy;
3. clinical safety and evidence standards, including independent review, protected reporting, and explicit treatment of uncertainty;
4. information standards that let patients and accountable teams use and correct records across settings; and
5. public accountability for availability, waiting, handoff failure, safety, outcomes, subgroup performance, and recovery.

The standard would define the floor without prescribing a single building, employment model, or clinical workflow everywhere. Local variation would be permitted when it meets the floor and preserves the rights of the person.

3.3 Supplemental private care

Sponsor direction. Everyone should retain the guaranteed standard of care, while supplemental private care may be purchased above that floor.[8]

Proposed design. The cleanest initial boundary is to treat supplements as separately financed services, amenities, or options that do not subtract from the public entitlement. A supplement should not buy permission to ignore clinical safety rules, obtain scarce core capacity ahead of a person with greater clinical need, or shift the supplement's cost to the national pool. Providers offering both public-floor and supplemental services would disclose capacity, conflicts, cross-subsidy, and waiting-time effects.

Unresolved question. The boundary between “floor” and “supplement” is one of the most important policy decisions in the paper. If the floor is too thin, supplements recreate unequal access to clinically meaningful care. If the boundary is vague, workforce and facility capacity can migrate away from the floor without a transparent decision. Sponsor review should decide whether supplements are limited to nonclinical amenities and noncovered preferences, or may include additional clinically reasonable services after the floor is fully available. Any choice requires enforceable capacity and equity tests.

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4. Local delivery and the patient-clinician relationship

National scale should be used where national scale helps: universal financing, rights, minimum benefits, portability, evidence standards, rare expertise, interoperability, supply resilience, and public accountability. Local scale should be used where relationship and context matter: team design, physical sites, home and mobile services, referral partnerships, staffing patterns, culturally grounded care, and coordination with community resources.

Proposed design. Clinical decisions would remain with patients and accountable clinicians operating under transparent standards. A national payer could audit eligibility, payment integrity, and program compliance, but it should not become an opaque clinical gatekeeper. When a coverage question turns on medical necessity, the process should expose the rule, the evidence, the responsible reviewer, the appeal route, and the time limit. Urgent care should proceed under safety rules while disputes are resolved.

The same principle applies inside delivery organizations. A hospital, regional grid, or AI service may support a decision; none should make responsibility disappear. The patient's named team remains visible. A specialist accepting a defined question owns that question until it is answered or returned with an acknowledged plan. A receiving organization owns a transfer only after acceptance. A discharged patient retains a named follow-up owner.

Unresolved question. National standards can protect a floor, but they can also become rigid or remote if they are written without patient, clinician, worker, disability, rural, territorial, and Tribal authority. The governance process must specify who writes standards, who can challenge them, how local evidence changes them, and how a community can exceed them without fragmenting the national guarantee.

5. The future clinical model: voluntary AI-enabled personalization

5.1 What the vision is

Sponsor direction. The future state is AI-enabled personalized medicine: rapid multimodal assessment, diagnosis, and specialized individualized treatment, with physicians and patients benefiting rather than an opaque claims intermediary.[8]

Proposed design. In that future model, a patient and care team could elect to assemble a governed clinical profile from relevant sources such as history, examination, medications, laboratory results, imaging, pathology, genomics, patient-reported symptoms and goals, and selected device or home observations. AI tools could help organize the record, surface possible explanations, match findings to current evidence, identify uncertainty, and compare reasonable treatment paths. The output would be decision support—not an invisible denial, a final diagnosis without accountable review, or a substitute for consent.

The personalized layer should produce artifacts the patient and physician can use: the data considered, important missing information, plausible alternatives, confidence and uncertainty, relevant evidence, known limitations, the human decision owner, and a monitoring and escalation plan. The system should retain the ability to say “not enough information” and route the case to appropriate expertise.

Accepted evidence. The existing corpus supports requirements for named accountability, consent, correction, audit, safe downtime, independent safety review, second opinions, subgroup non-regression, and an uncertainty-aware decision process. It does not validate this personalized AI layer's national clinical effectiveness, accuracy, staffing impact, privacy performance, or cost.[1–4]

5.2 Voluntary participation and the guaranteed floor

Sponsor direction. Participation in the personalized-data layer is voluntary. People who contribute the data required for personalization gain access to that layer; people who decline retain the guaranteed standard of care.[8]

Proposed design. The policy should make that separation operational:

- declining personalization does not reduce eligibility, timeliness, clinician attention, diagnostic diligence, appeal rights, or the quality of the standard care floor;
- consent is specific enough to distinguish direct care, model improvement, research, public-health uses, and commercial uses;
- the patient can inspect and correct source data, see material uses, and withdraw prospective participation without losing the ordinary record needed for safe continuity;
- a clinician may recommend data that would materially improve an assessment, but the patient can decline and receive the best standard pathway available; and
- models are tested for performance, missingness, error, subgroup harm, security, and workflow burden before and during use.

The phrase “people who contribute the data required for personalization” needs careful definition. Some information is generated during ordinary care and is already necessary for a safe clinical record. Other information—genomic data, continuous device feeds, cross-domain linkage, secondary research use, or model-training reuse—raises distinct consent and governance questions. The program should not use a single all-or-nothing permission to collapse those differences.

Unresolved question. If some people cannot supply high-quality data because of cost, disability, language, geography, historical undermeasurement, or a technology gap, the personalized layer may reproduce those differences. The design needs an affirmative accessibility and data-quality plan, not merely a formal choice to participate.

5.3 The role of the clinician and patient

Proposed design. AI should be accountable through a clinical chain. A named person or team chooses when a tool is appropriate, reviews the output, explains material uncertainty, documents disagreement, monitors consequences, and escalates possible harm. Patients can know when a material AI output shaped care, request human review, seek a second opinion, correct relevant data, and challenge an adverse decision.

This model does not require every clinician to reproduce a model's mathematics. It does require the system to supply usable evidence about intended use, limitations, validation, changes, known failure modes, and the provenance of the output. It also requires safe operation when the tool or network is down.

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6. Data rights, governance, security, and breach accountability

Health data can make care more continuous and personalized; it can also expose people to durable harm. The governance model must therefore begin with purpose, authority, and remedy rather than assuming that security controls alone settle the question.

Proposed design. A national data charter should define:

- the minimum data needed for safe direct care and the separate permissions needed for personalization, research, model improvement, public health, and commercial activity;
- patient access, correction, provenance, segmentation, delegation to trusted supporters, and a usable record of material disclosures and model uses;
- strict role-based access, encryption, logging, independent testing, incident response, recovery, and safe offline clinical workflows;
- retention and deletion rules that account for clinical continuity, legal duties, model training, backups, and the practical limits of deletion;
- model and vendor accountability, including audit access, change control, subcontractor visibility, conflicts, and exit rights; and
- jurisdiction-specific authority, including Tribal sovereignty and sovereign data governance where applicable.

6.1 The sponsor's current liability direction

Sponsor direction. Jimmy currently favors actual-damages recovery for a breach, paired with a safe harbor from class actions when the responsible organization used commercially reasonable security. This is a contested design preference. It is not presented here as settled law, settled ethics, or accepted project evidence.[8]

Proposed design for testing. A defensible version of that direction would need, at minimum, a clear security standard, independent evidence that the standard was met before the incident, no safe harbor for reckless conduct, concealment, repeated uncorrected failures, unlawful use, or violation of consent, and preserved authority for regulators and courts to order correction, notification, monitoring, deletion where possible, and injunctive relief.

Unresolved question. Actual damages can be difficult to identify or prove when the injury is probabilistic, delayed, dignitary, collective, or tied to irreplaceable information such as genomic or biometric data. A class-action safe harbor may reduce opportunistic litigation, but it may also remove a practical remedy for many small or hard-to-quantify harms. “Commercially reasonable” can reward industry custom even when the custom is weak, or become unpredictable after an incident. Sponsor review should ask:

1. Who defines the security standard, and how often does it change?
2. Must compliance be independently certified, continuously monitored, or both?
3. Which claims remain available when conduct was intentional, reckless, deceptive, discriminatory, or outside consent?
4. Are statutory damages, collective remedies, medical monitoring, or a public compensation fund needed where actual loss is hard to prove?
5. Can a safe harbor apply to a data use that was never authorized, even if the system was technically secure?
6. What authority belongs to federal, state, territorial, and Tribal governments, and what cannot be preempted by a national rule?

The final policy should distinguish an unavoidable incident under a strong program from a preventable failure, an unauthorized use, and a business model that created excessive risk in the first place.

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7. A proposed transition sequence—not a validated roadmap

Boundary. The accepted technical program has not opened a transition roadmap. The sequence below is an editorial design for sponsor review. It has no approved dates, appropriations, staffing numbers, tax rates, savings, procurement authority, or implementation authorization. It does not reactivate the paused technical queue.[6][7]

Phase 0: settle the promise before moving money

Confirm the universal floor, rights, sponsor choices, governance principles, and supplement boundary. Identify which matters require statutory authority, clinical standards work, disability and civil-rights review, labor engagement, state and territorial coordination, and government-to-government Tribal consultation. Preserve criterion 24 as open.

Phase 1: write the national charter and benefit floor

Translate the human promise into a reviewable legal and operational charter. Define covered capabilities, access obligations, appeal and remedy, clinical independence, minimum data rights, and the authority and composition of the standards bodies. Establish how the floor is updated and how local systems can exceed it.

Phase 2: design financing and institutional relationships

Only after explicit authorization, specify the national public pool, revenue options, provider-payment methods, capital funding, treatment of existing programs, federal-state-territorial relationships, and sovereign-system interfaces. Test every option against the outcome constitution and the comparable resource boundary. Do not book administrative simplification, price changes, or transfers as real-resource savings.

Phase 3: build accountable local and regional capacity

Map existing capabilities to the Commons, Grid, and Expert Mesh functions. Identify gaps in workforce, training, facilities, diagnostics, transport, home care, long-term services, digital continuity, and reliability reserve. Create readiness gates that measure staffed capability and safe workload, not announcements or licensed capacity alone.

Phase 4: stage the care-floor transition with continuity protection

Move populations and payments in bounded stages only when receiving systems can maintain access and continuity. Protect ongoing treatment, medicines, maternal care, behavioral care, complex specialty care, long-term services, and active appeals. Run old and new administrative functions in parallel only where necessary for safety, with an explicit exit and reconciliation plan.

Phase 5: operate and improve the universal floor

Certify availability, outcomes, rights, subgroup performance, handoffs, workforce safety, and resilience. Publish intelligible measures without turning a dashboard into a substitute for individual remedy. Correct failures before declaring expansion or savings.

Phase 6: introduce the voluntary personalized layer

Begin with narrow, clinically supervised uses whose data authority, intended use, validation, workflow, consent, security, and remedy are explicit. Expand only after direct inspection and independent evidence show that a use is safe, useful, accessible, and governable. Maintain a complete standard-care route for people who decline.

Unresolved question. Whether financing and the personalized layer should move on separate legal and operational schedules is not settled. The safer design presumption is that universal coverage should not depend on the readiness of the optional AI layer.

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8. The exact evidence frontier

The paper must be candid about what the project knows and what it does not.

8.1 What is accepted

Accepted evidence. The local corpus contains a checked canonical policy architecture; an outcome constitution; an observed baseline with source-level provenance; patient journeys; resource-accounting rules; attack and non-regression ledgers; a local paper and site; and builder and independent verification. The evidence baseline retains 73 substantive source records across 66 source families. The technical release map derives 38 supported criteria and one incomplete criterion.[1–7]

The observed baseline has one prominent national accounting anchor: final 2024 National Health Expenditures of $5,278.6 billion and the official CMS value of $15,474 per resident. Those are expenditure-account values. They combine real resources with wages, prices, rents, transfers, markups, and accounting rules; they are not a bottom-up real-resource total comparable with A1.[1][5][6]

8.2 What is not accepted

Criterion-24 blocker. Criterion 24 requires comparable national and per-resident central estimates, credible ranges, category shares, and sensitivity results for B0, every retained challenger, and the selected frontier design on one symmetric resource boundary. The current corpus does not provide them.[6][7]

Specifically:

- B0 lacks a complete comparable bottom-up real-resource total and range;
- A1 has no accepted national or per-resident low, central, or high total;
- A1 category shares, sensitivity results, capacity quantities, unit resource costs, and coherent covariance remain unaccepted or unknown;
- no pairwise B0–A1 resource delta or saving can be calculated;
- B1 was not constructed, A2 was not reached, and no design entered a numeric frontier; and
- financing and transition cannot inherit a cost, saving, budget, or timetable from an empty frontier.

Unknown means unknown—not zero, equal, adequate, affordable, favorable, or passed. The 2024 expenditure anchor cannot be subtracted from an invented A1 number, and a policy preference for single payer cannot supply the missing resource evidence.

8.3 What this draft adds

Sponsor direction and proposed design. This draft adds a coherent policy direction: national single-payer financing for a universal floor; national minimum standards with local delivery; supplemental private care above the floor; voluntary AI-enabled personalized medicine; and a contested breach- liability preference for further review. It organizes those choices around the accepted operating architecture.

It adds no external validation. It does not close criterion 24, alter the canonical v1.0 paper, change any accepted hash, reopen the deterministic queue, or authorize financing, transition, procurement, deployment, publication, or external review.

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9. Decisions requested from the sponsor

This draft is ready for substantive direction on the choices that now shape the policy story:

1. **The floor.** Is the intended guarantee comprehensive medically necessary care across the full life course, including oral health, behavioral health, drugs, rehabilitation, home care, long-term services, and palliative care?
2. **The payer boundary.** Is the national pool the sole payer for the defined floor, or should any covered services retain parallel payers?
3. **Supplemental care.** Should supplements be limited to amenities and noncovered preferences, or may they include additional clinically reasonable services after the floor is demonstrably available?
4. **Local freedom.** Which elements must be uniform nationwide, and which may vary by state, territory, Tribal Nation, region, community, delivery organization, or care team?
5. **Clinical governance.** Who writes and updates national standards, and what formal authority should patients, clinicians, workers, disability experts, local communities, and sovereign governments hold?
6. **Personalization consent.** Which data uses belong to ordinary direct care, and which require separate opt-in permission?
7. **AI accountability.** What decisions must always have named human review, notice to the patient, and an appeal or second-opinion route?
8. **Breach remedies.** Should the actual-damages and reasonable-security safe harbor direction be retained, revised to preserve collective or statutory remedies, or replaced?
9. **Sequencing.** Should the universal financing program proceed independently of the optional personalized-data layer?
10. **Evidence gate.** Should the paused technical program remain frozen until qualified external numeric review can supply the comparable B0/A1 evidence required by criterion 24? This draft assumes yes.

Conclusion

Optimal Care America proposes a national guarantee delivered through local relationships. Its core promise is universal: a meaningful care floor, a usable route into it, and accountability that follows the person. Its financing direction is national single payer. Its delivery model is plural and local within national rights and capability standards. Its clinical future is personalized and AI-enabled, but voluntary, human-accountable, and subordinate to the guaranteed standard of care. Its data policy must make consent, security, authority, and remedy real rather than rhetorical.

That is a serious policy direction. It is not yet a priced system. The accepted corpus has done the important work of defining the operating proposition and the proof boundary. It has also identified the point where honesty requires a stop: criterion 24. Until qualified external numeric evidence supplies a comparable B0/A1 resource frontier, the project cannot truthfully claim an A1 cost, saving, funding requirement, or implementation schedule.

The choice before the sponsor is therefore not whether to pretend the gap is closed. It is whether this human promise, financing direction, local operating model, personalized clinical vision, and accountability framework express the system worth taking into the next authorized design and evidence stage.

Controlling records

1. **Canonical paper:** `paper/optimal-care-america-v1.0.md`—checked outcome, baseline, architecture, resource method, attacks, limitations, and exact evidence frontier.
2. **Outcome constitution:** `analysis/outcome-constitution-v1.0.md` and `analysis/outcome-metric-dictionary-v1.0.csv`—decision order, 39 metrics, 13 domains, denominators, uncertainty, subgroup, and certification rules.
3. **A1 operating architecture:** `analysis/a1-architecture-v1.0.md`—personal team, Community Health Commons, Regional Care Grid, National Expert Mesh, cross-layer controls, and capacity truth boundary.
4. **Patient journeys:** `analysis/a1-patient-journeys-v1.0.json`—eleven journey families and the global handoff contract.
5. **Observed baseline and provenance:** `analysis/b0-evidence-baseline-v1.0.json`, `research/b0-claim-evidence-matrix-v1.0.csv`, and `research/b0-source-ledger-v1.0.json`—including the final 2024 CMS NHEA accounting anchor and its scope.
6. **Resource and frontier controls:** `costing/b0-comparable-resource-model-v1.0.json`, `costing/a1-resource-model-v1.0.json`, and `costing/outcome-cost-frontier-v1.0.json`—symmetric boundary, null semantics, no selected design, and no saving claim.
7. **Release and closeout status:** `review/local-candidate-criterion-evidence-map-v1.0.json`, `review/local-candidate-release-gate-v1.0-acceptance.md`, and `review/program-closeout-independent-check.md`—38 supported criteria, criterion 24 incomplete, financing closed, transition unopened.

8. **Sponsor directions and editorial contract:** `program/optimal-care-draft-task-2026-08-23.md` —the six sponsor directions, deliverables, boundaries, and preserved truth for this dated draft.

Boundary statement. This sponsor draft preserves the canonical v1.0 technical evidence state and the status `FRONTIER_CONTRACT_PASS_NUMERIC_SELECTION_BLOCKED`. The technical evidence program remains paused. Criterion 24 remains incomplete. No A1 total, saving, category share, sensitivity result, selected frontier, financing architecture, transition authorization, publication, hosting, or external delivery is claimed.