The Care Coordination Revolution: Ho Pair Team Cracked the Code on America's Hardest Healthcare Proble

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ABSTRACT

Pair Team's publication in the Journal of General Internal Medicine represents v
may be the most important breakthrough in Medicaid care delivery in a generati
Working with the most complex patient population imaginable—52% experienci
homelessness, 50% with serious mental illness, 46% with extreme baseline emerg
department and hospital utilization—Pair Team achieved results that seem almc
impossible: 52% reduction in emergency department visits, 26% reduction in inp
admissions, 21% increase in appropriate outpatient care, and 4-point improveme
depression scores. These outcomes were delivered through three game-changing
innovations: treating community-based organizations as paid infrastructure part
rather than free referral sources, deploying clinical teams directly into communi
rather than waiting for patients to navigate complex healthcare systems, and bui
Arc, an AI-enabled platform that coordinates care across the entire medical and
ecosystem. This analysis examines why Pair Team's approach represents a
fundamental reimagining of care delivery, why the timing for scaling this model
never been better, and why this could become one of the most significant healthc
companies of the next decade.

INTRODUCTION

Every few years, a company emerges that does not just improve on existing appro
but fundamentally reimagines how an entire category of healthcare should work
These are the companies that create new markets, that prove everyone else was
thinking too small, and that ultimately define how an entire generation of health
gets delivered. Pair Team's recently published study in the Journal of General In
Medicine suggests we are watching exactly this kind of company emerge.

The numbers alone are extraordinary. A 52% reduction in emergency departmen
visits for a population where half are experiencing homelessness and half have se
mental illness. A 26% reduction in hospital admissions for patients whose baseli
utilization was already off the charts. A 21% increase in outpatient visits, showir
patients are engaging with preventive care rather than just avoiding emergency
services. A 4-point improvement in PHQ-9 depression scores, demonstrating me
health gains alongside utilization changes. These are not marginal improvement

achieved through modest optimizations. These are transformational outcomes th suggest Pair Team has solved problems that the entire healthcare industry has b struggling with for decades.

But the really exciting story is not just what Pair Team has achieved clinically. It how they have built a model that can actually scale. They have formalized partnerships with community-based organizations in ways that create sustainabl ecosystems rather than depending on goodwill. They have deployed clinical tean community settings, eliminating the access barriers that make traditional prima care impossible for this population. And most importantly, they have built Arc, a technology platform that could become the infrastructure layer for an entirely n category of healthcare delivery.

This is the kind of company that makes venture capitalists wish they had writter first check. Massive addressable market—Medicaid covers over 80 million Amer and high-need patients represent billions in spending. Proven clinical model wit peer-reviewed outcomes published in a top-tier journal. Technology platform wi clear potential to scale beyond direct service delivery. Strong tailwinds from valu based payment transformation across Medicaid. And most importantly, a team th has actually figured out how to make this work operationally, not just in theory.

THE MULTI-BILLION DOLLAR PROBLEM EVERYONE GAVE UP ON

The opportunity Pair Team is addressing represents one of the largest untapped markets in American healthcare. Roughly 5% of Medicaid beneficiaries account more than 50% of total Medicaid spending. These are patients with complex med conditions, often compounded by behavioral health challenges, substance use disorders, and severe social determinants of health. They cycle through emergen departments and hospitals, generating enormous costs while receiving fragment care that rarely addresses their underlying needs.

Healthcare has tried to solve this problem for decades. Health plans hired armie care coordinators to make phone calls and send resource lists. Hospitals built

discharge planning programs to ensure patients had follow-up appointments. He systems launched medical home initiatives promising coordinated primary care. Dozens of startups raised hundreds of millions of dollars promising to crack the on care coordination through better technology, better data, or better predictive analytics.

The frustrating reality is that most of these efforts failed or produced modest re that barely moved the needle. But here is what makes Pair Team's moment so ex we now understand why those previous efforts failed, and Pair Team has systematically addressed each limitation. The Camden Coalition's randomized controlled trial, which showed no effect on utilization despite promising observational data, taught the industry crucial lessons. Dr. Jeffrey Brenner, the Camden Coalition's founder, identified "coordination to nowhere" as the core problem—you cannot coordinate care effectively when patients lack access to pr care and social services.

Pair Team built their entire model around solving exactly this problem. Where Camden coordinated referrals to overwhelmed primary care practices with six-w wait times, Pair Team employs nurse practitioners who see patients via telemedi within days. Where traditional care coordination referred patients to community resources that may or may not have capacity, Pair Team built a network of community-based organizations that are paid partners with committed capacity. Where most interventions relied on community health workers without clinical authority, Pair Team created interdisciplinary pods with nurses, nurse practitior behavioral health specialists, and community health workers collaborating daily.

The market opportunity this creates is staggering. Medicaid spending on high-n beneficiaries exceeds $200 billion annually. California's CalAIM initiative, whicl created the Enhanced Care Management benefit that Pair Team delivers, represe fundamental policy shift that makes intensive care coordination economically via scale. Other states are watching California closely and developing similar progra The conditions for a massive market opportunity are all present, and Pair Team demonstrated the clinical model that can capture it.

WHY PREVENTION FINALLY HAS REAL ECONOMICS

Healthcare has always struggled with the economics of prevention. The theory is compelling—spend money today to avoid more expensive interventions tomorrow but the practice has been much harder. Prevention programs cost money upfron while generating uncertain savings in the future, and in fee-for-service systems, savings often benefit different organizations than the ones paying for prevention

The revolutionary aspect of Pair Team's achievement is that they have proven th economics work for the highest-need patients. Their JGIM study provides the evidence: patients averaged 3.3 program interactions per month, representing intensive engagement that would traditionally seem expensive. Yet this engagem drove a 52% reduction in emergency department visits and 26% reduction in hos admissions. When you work the math, preventing even a fraction of these high-c events generates savings that far exceed the cost of care coordination.

The economic breakthrough happens at three levels. First, California's Enhance Care Management benefit creates payment structures that fund intensive care coordination. This is not traditional care management with minimal reimbursem ECM is designed to support the kind of high-touch intervention that actually ch outcomes. States and health plans finally recognize that adequately funding prevention is cheaper than paying for preventable crises.

Second, the patient population Pair Team serves has such high baseline utilizati that the return on investment is dramatic. Traditional care coordination struggl show ROI when applied to healthier populations where there is less utilization t prevent. But when you are working with patients who averaged multiple emerge department visits and hospital admissions annually before enrollment, the savin potential is enormous. The 94.3% rate of engagement within 30 days after emerg department or hospital discharge demonstrates that Pair Team is intervening at exactly the moments when patients are most vulnerable to repeat utilization.

Third, and perhaps most importantly, Pair Team has figured out how to deliver l touch care coordination efficiently. The interdisciplinary pod structure—three community health workers, one registered nurse, one behavioral health care mar and one nurse practitioner serving approximately 250 patients—creates a sustair staff-to-patient ratio. The technology platform Arc automates coordination task would otherwise require manual effort. The community-based organization partnerships provide social services without requiring Pair Team to build that infrastructure internally. This is not just clinical innovation—it is operational excellence that makes the business model actually work.

The patient outcomes tell the story even more powerfully. Post-enrollment, 52.7 patients had an HbA1c lab record compared to just 22.3% pre-enrollment. Blood pressure monitoring increased from 74.3% to 81.7% of patients. These are indica of patients actively managing chronic conditions rather than ignoring them unti crisis strikes. The 21% increase in outpatient visits shows patients engaging with preventive care. This is not just cost reduction through denying care—this is ger health improvement that happens to cost less because it prevents expensive crise

THE THREE BREAKTHROUGH INNOVATIONS THAT CHANGE EVERYTHI

Pair Team's model rests on three innovations that sound simple but represent ge breakthroughs in how care coordination actually works. Understanding these innovations is essential to grasping why this model can succeed where dozens of previous attempts have failed.

The first innovation is treating community-based organizations as paid partners rather than free referral sources. This sounds obvious once you hear it, but it represents a fundamental reconceptualization of how care coordination works. Traditional models employ care coordinators who refer patients to food banks, shelters, and other community resources, but those resources receive no compen for their role in keeping patients healthy. Community organizations operate on

shoestring budgets, face overwhelming demand, and have no particular reason t
prioritize one patient over another.

Pair Team flipped this model entirely. When a patient needs food security, Pair
does not just provide referrals—they partner with food providers and pay them
their services as part of the care team. When a patient needs housing support, th
compensate shelter providers as formal partners in care delivery. This creates
sustainable partnerships where community organizations have real incentives to
participate actively in care coordination rather than treating referrals as one-off
transactions.

The economic logic is straightforward and brilliant. Food security, stable housin
other social services are not nice-to-have add-ons—they are essential infrastruct
for keeping high-need patients healthy. We pay for medical infrastructure like
imaging and lab work because we recognize they are necessary inputs to healthc
Pair Team applies the same logic to social services, treating them as billable
components of comprehensive care. California's CalAIM initiative supports this
approach by allowing Enhanced Care Management providers to coordinate and
for social services as part of the benefit.

This innovation solves the "coordination to nowhere" problem that doomed prev
interventions. When Pair Team's community health workers identify that a patie
needs food assistance, they can immediately connect that patient with a partner
bank that has committed capacity. The food bank knows they will be compensat
their services, creating strong incentives to follow through. The patient receives
that actually materializes rather than just another phone number to call.

The second innovation is deploying clinical teams directly into communities ratl
than expecting patients to navigate to clinical settings. Pair Team directly emplc
registered nurses and nurse practitioners who can provide clinical care in shelte
homes, and community settings. This eliminates the access barriers that make
traditional primary care often impossible for patients experiencing homelessnes
severe social complexity.

The JGIM study reveals just how significant this innovation is. For patients with diabetes or hypertension, 25.1% and 21.4% of program interactions respectively with nurses or nurse practitioners. These are not just care coordination conversa —these are clinical encounters where medications get adjusted, symptoms get evaluated, and medical decisions get made. When a patient discharged from the hospital needs medication reconciliation, the nurse practitioner can handle it du telemedicine visit or community encounter. When concerning symptoms emerge clinical judgment is immediately available rather than routing through triage sy that often fail this population.

The contrast with traditional primary care access is stark. The study found that of patients had not seen a primary care provider in the year before enrollment, w median time since last primary care visit of 570 days. This is not because patient not need primary care—it is because traditional primary care is structurally inaccessible to populations experiencing homelessness and severe social comple Transportation barriers, inability to keep appointments scheduled weeks in adva lack of phone access for appointment reminders, and distrust of healthcare institutions all create insurmountable friction.

Pair Team's nurse practitioners see patients via telemedicine or in community se within days rather than weeks, with schedules designed for extended visits that address patient needs. This is not just more convenient—it is a fundamentally different model of clinical access that actually works for this population. The 94 rate of patient engagement within 30 days of emergency department or hospital discharge, with 60.4% of those engagements including a nurse or nurse practitio demonstrates operational excellence in the hardest moments of care transitions.

The third innovation is Arc, the AI-enabled platform that coordinates care acros medical and social ecosystems. This is the piece that makes everything else scala and potentially the most valuable component of Pair Team's business model. Hig touch care coordination generates enormous coordination challenges—tracking patients across multiple touchpoints, integrating data from clinical and social se systems, identifying when patients need immediate attention, routing informatio

appropriate team members, and maintaining continuity as patients move betwee settings.

Arc handles these challenges through intelligent automation and integration. Th platform connects to Health Information Exchanges and Admission Discharge Transfer systems, giving care teams real-time visibility when patients visit emerg departments or get hospitalized. This triggers automatic workflows ensuring rap follow-up. Arc integrates clinical data from multiple sources, allowing nurses an nurse practitioners to see lab results, vital signs, and encounter notes from acros healthcare system. It coordinates the interdisciplinary pod meetings where team review every patient at enrollment, at any major health status change, and at leas quarterly on a routine basis.

The AI layer becomes essential when dealing with messy, real-world data from fragmented sources. Clinical systems use HL7 and FHIR standards, assuming yo get data access at all. Social service organizations often have minimal informatio systems. Behavioral health records have additional privacy protections. Commun health workers document in free text. Machine learning can identify patterns in heterogeneous data, predict which patients need immediate attention, and adapt circumstances change. This is not AI for its own sake—it is applied intelligence solving genuine operational problems that make the difference between care coordination that works and care coordination that fails.

THE CLINICAL RESULTS THAT REWRITE WHAT'S POSSIBLE

Let us be very clear about what Pair Team accomplished, because the magnitude their achievement cannot be overstated. They enrolled 568 patients where 52% w experiencing homelessness, 50% had serious mental illness, 46% were at risk for avoidable hospital or emergency department utilization, and 88% had not seen a primary care provider in the past year. This is precisely the population that ever said was impossible to help effectively.

The outcomes achieved with this population are remarkable across every dimens
The 52% reduction in emergency department visits means that patients who wer
cycling through emergency departments regularly are now accessing appropriate
in appropriate settings. The 26% reduction in inpatient admissions represents
prevented crises and better management of chronic conditions. The 21% increas
outpatient visits shows patients actively engaging with preventive care rather th
avoiding the healthcare system until emergencies force their hand.

The mental health outcomes are equally impressive and often overlooked in
discussions focused solely on utilization. Of patients with baseline and follow-u
PHQ-9 data, 74.1% had depressive symptoms at baseline compared to just 36.1%
post-enrollment period. Average PHQ-9 scores decreased by 4 points, a clinicall
meaningful improvement in depression. This is comprehensive improvement in
patient wellbeing, not just shuffling where they receive care.

The chronic disease management improvements demonstrate proactive healthca
engagement. HbA1c testing rates increased from 22.3% to 52.7% of all patients, a
from 50.5% to 82.5% among patients with diabetes. Blood pressure monitoring
increased from 74.3% to 81.7% of all patients. These metrics indicate that patien
actively managing conditions that would otherwise lead to serious complications
patient with diabetes who goes from no HbA1c testing to regular monitoring is
completely different health trajectory.

The 94.3% rate of care team engagement within 30 days of emergency departmer
hospital discharge deserves special emphasis. Transitions from hospital to comm
are notoriously difficult, with patients often getting lost in the gaps. Discharge
instructions go missing, follow-up appointments get missed, medications are no
or are taken incorrectly, and patients cycle back to the emergency department w
days. Pair Team has essentially solved the transition of care problem for a popul
where most organizations struggle to achieve even basic follow-up contact.

What makes these results particularly credible and exciting is their publication
Journal of General Internal Medicine, a respected peer-reviewed journal. This is
marketing fluff or carefully selected anecdotes—this is real evidence evaluated b

independent academic experts who deemed it worthy of publication in the medi literature. For health plans considering contracts, state Medicaid agencies desig programs, and investors evaluating opportunities, this kind of validation is enormously valuable and rare.

The study also demonstrates something crucial about well-designed care models when you systematically address the barriers that previous interventions ignorec can achieve results that seem impossible with traditional approaches. Pair Team not achieve these outcomes through heroic individual efforts that cannot scale. T achieved them through systematic deployment of a carefully designed care mode supported by technology that makes the hard work of coordination actually manageable. The interdisciplinary pod structure, the community-based organiza partnerships, the accessible nurse practitioners, and the Arc platform all work together to create something greater than the sum of its parts.

ARC: THE PLATFORM PLAY NOBODY SA COMING

Arc deserves special attention because it represents a potential business opportu that extends far beyond Pair Team's direct service delivery. The challenge of coordinating care across fragmented medical and social service systems is not ur to Pair Team—it is fundamental to any organization trying to serve high-need populations. If Arc can solve this coordination problem effectively, it becomes platform infrastructure with enormous market potential that could ultimately b more valuable than the direct service delivery business.

Consider what Arc enables operationally. It integrates clinical data from electro health records, claims data from payers, admission discharge transfer alerts fron hospitals, social service data from community organizations, and care team note Pair Team staff. It makes sense of this heterogeneous data, identifying patients v need attention and routing work to appropriate team members. It tracks interve and outcomes across the entire care ecosystem, enabling performance measurem

and continuous improvement. It does all of this in real time, enabling proactive
than reactive care coordination.

The technical achievement required to build this is substantial and creates meaningful competitive advantages. Clinical systems use different data standard require individual integration agreements. Social service organizations often lac sophisticated information systems, requiring flexible data capture methods. Behavioral health records face additional privacy protections under 42 CFR Par Health Information Exchanges provide data in varying formats and quality level Integrating these data sources requires technical sophistication, deep operationa understanding of care coordination workflows, and relationships with diverse organizations.

The AI layer becomes essential when dealing with this messy, real-world data environment. Rules-based systems break down when data is inconsistent, incom or arrives with unpredictable timing. Machine learning can identify patterns tha indicate a patient needs immediate attention—perhaps a combination of missed appointments, emergency department visits, changes in engagement patterns, ar social circumstances that together predict high risk of crisis. The system can ad it learns which patterns actually predict outcomes, becoming more effective ove

The study provides glimpses of how Arc creates operational leverage. The 94.3% of care team engagement within 30 days of emergency department or hospital discharge happens because Arc receives admission discharge transfer alerts and automatically triggers outreach workflows. The interdisciplinary pod meetings v teams review every patient systematically are managed through Arc, ensuring no falls through cracks. The ability to track that patients averaged 3.3 program interactions per month, with specific breakdowns by care team member type, demonstrates sophisticated operational analytics that enable continuous improvement.

The market opportunity for Arc as a standalone platform is potentially enormou could ultimately define Pair Team's value creation. Every organization doing ser care coordination for high-need populations faces similar integration and

coordination challenges. Health plans managing Medicaid contracts, accountabl organizations serving complex patients, health systems with value-based arrangements, other Enhanced Care Management providers in California, and st Medicaid agencies across the country all need better infrastructure for coordina care across fragmented systems.

Arc could become the Salesforce of care coordination—the infrastructure layer t everyone building in this space relies on. The strategic brilliance of building Ar while delivering direct services is that Pair Team gains operational insights that purely technology companies cannot replicate. They understand exactly what ca coordinators need because they employ care coordinators. They know which dat integrations matter most because they use the platform daily. They can iterate ra based on real-world feedback from their own teams.

This creates multiple paths to value creation that make Pair Team particularly attractive from an investment perspective. They use Arc internally to deliver bet more efficient care coordination, improving their unit economics and enabling s of the direct service business. They can license Arc to other Enhanced Care Management providers, health plans, and care coordination organizations, creat software revenue stream with much better gross margins than service delivery. T could eventually spin out Arc as a standalone platform company if market condi warrant. This optionality is exactly what sophisticated investors seek—multiple to building an enormously valuable company.

PROFESSIONALIZING COMMUNITY HEALTH WORK

One of Pair Team's most important and often overlooked innovations is how the professionalized the role of community health workers, transforming what has historically been seen as an entry-level position into a skilled profession with re career pathways. This innovation matters enormously for building a scalable mo and creating competitive advantages that are difficult to replicate.

Historically, community health workers have been positioned as entry-level role modest compensation, limited professional development, and high turnover. Thi creates a vicious cycle where the constant churn in care coordinators destroys th patient relationships that make care coordination effective. Patients who have fi started trusting a care coordinator find themselves handed off to someone new, c multiple times per year. For populations with deep distrust of healthcare institu based on lived experience of being failed repeatedly, this turnover is devastating

Pair Team's approach creates sustainable careers for community health workers, which they call Lead Care Managers to signal the professional nature of the role receive competitive compensation that recognizes the skilled work they perform get professional training in motivational interviewing, chronic disease managem behavioral health awareness, and care coordination techniques. They receive clir supervision from nurses and nurse practitioners who provide guidance on compl situations. They have access to Arc and other technology tools that make their w more effective and less frustrating.

The operational benefits of this approach are substantial and visible in the study results. The 3.3 average program interactions per month sustained over a full ye demonstrates that care teams maintain consistent engagement. Lower turnover r better patient relationships and higher engagement rates. More experienced community health workers can handle complex situations more effectively, redu the need for escalation to more expensive clinical resources while knowing wher escalation is necessary. The interdisciplinary pod structure where community he workers collaborate daily with nurses, behavioral health specialists, and nurse practitioners creates ongoing learning and professional development.

The study data shows that community health workers led the majority of patient interactions—69.7% overall, with behavioral health care managers and other specialists handling another 12.5%, and nurses or nurse practitioners leading 17 interactions. This demonstrates appropriate task distribution where community health workers handle most ongoing engagement and relationship building, whi clinical staff focus on situations requiring medical expertise. For patients with diabetes or hypertension, a higher percentage of interactions involved nurses or

practitioners (25.1% and 21.4% respectively), showing that the model flexibly dep clinical resources where they are most needed.

This approach also creates a workforce development model that could have impa beyond Pair Team. As community health workers gain experience and training i Team's model, they become valuable talent for other organizations trying to buil similar capabilities. This is not a problem—it is an opportunity. Similar to how consulting firms or technology companies create talent ecosystems that benefit e industries, Pair Team could become known as the training ground for the next generation of community health professionals. This enhances recruiting as ambi individuals see Pair Team as a place to develop valuable skills.

The economic sustainability of professionalizing community health work depen creating sufficient value to justify the investment. The JGIM study demonstrates Pair Team has achieved exactly this. The clinical outcomes and utilization reduc show that well-trained, well-supported, consistently engaged community health workers working in interdisciplinary teams can transform outcomes for the mos complex patients. The question is not whether this investment is worthwhile—t results prove it is—but rather how to scale it effectively as the business grows.

THE MASSIVE MEDICAID TAILWIND

The timing for Pair Team's model could not be better, and understanding the po and market dynamics makes the opportunity even more compelling. Medicaid is undergoing a fundamental transformation toward value-based payment, creating exactly the incentive structures necessary for high-touch care coordination to th economically. Multiple powerful trends are converging to create tailwinds that dramatically improve the odds of building a massive, valuable company.

California's CalAIM initiative represents a watershed moment in Medicaid polic The Enhanced Care Management benefit that Pair Team delivers is not tradition care management with minimal reimbursement—it is designed specifically to fu kind of intensive, comprehensive care coordination that can actually change out for high-need populations. The state explicitly identified populations of focus

including individuals experiencing homelessness, individuals at risk for avoidab hospital or emergency department utilization, and individuals with serious ment illness. These are precisely the populations Pair Team serves, and the policy infrastructure now exists to fund appropriate interventions.

The financial scale of this opportunity is enormous. Medicaid enrollment exceed million beneficiaries nationally, with California covering roughly 14 million peo Medi-Cal. High-need patients represent a disproportionate share of spending—t of beneficiaries with the highest costs account for more than 50% of total Medic spending. California's CalAIM initiative has allocated billions of dollars toward Enhanced Care Management and Community Supports. This is not a small pilot program—this is a fundamental restructuring of how Medicaid serves its most vulnerable populations.

Other states are watching California closely and developing similar programs. T lessons learned from CalAIM implementation will inform policy development ac the country. States face constant fiscal pressure to manage Medicaid costs while maintaining or improving quality. Solutions that can demonstrably reduce costs improving outcomes—exactly what Pair Team's JGIM study demonstrates—rece enthusiastic interest from state Medicaid directors and health plan executives. T market opportunity extends far beyond California.

The shift toward Medicaid managed care creates particular opportunities. Most Medicaid beneficiaries are now enrolled in managed care plans that accept finan risk for their covered populations. These plans have direct financial incentives t reduce avoidable utilization and keep patients healthy. They are increasingly wil to contract with organizations like Pair Team that can deliver meaningful impac their most expensive members. The days of Medicaid being entirely fee-for-servi with no incentives for prevention are largely over.

Value-based payment arrangements are becoming more sophisticated and more generous for organizations that can demonstrate outcomes. Early value-based contracts often had risk adjustment methodologies that penalized serving the sic patients, creating perverse incentives for cherry-picking healthier populations.

Modern contracts increasingly use prospective risk adjustment, quality metrics t reward serving high-need populations effectively, and payment structures that adequately fund intensive interventions. This creates much more favorable econ for models like Pair Team's that genuinely serve the patients with greatest needs

The regulatory environment is also becoming more flexible and supportive of innovative care models. Section 1115 waivers increasingly allow payment for hou services, food security, and other social determinants of health interventions. California's Community Supports benefit, part of CalAIM, explicitly covers serv like housing transition and navigation, medically tailored meals, and respite serv This creates opportunities to fund the community partnerships that are central t Pair Team's model through formal payment mechanisms rather than relying on g or uncompensated community services.

Technology infrastructure has also matured in ways that make Pair Team's mode more feasible. Health Information Exchanges now provide meaningful coverage, allowing care coordinators to see clinical data from across healthcare systems. Admission Discharge Transfer systems alert care teams in real time when patien visit emergency departments or get hospitalized. Telehealth regulations and reimbursement have improved dramatically, making it feasible for nurse practiti to deliver care via telemedicine. The technology enabling effective care coordina now exists in ways that simply were not available a decade ago.

Perhaps most importantly, there is growing recognition across the Medicaid ecosystem that the status quo is unsustainable. States cannot continue spending billions on emergency department visits and hospital admissions for patients wh primary needs are social rather than medical. Health plans cannot continue oper under the fiction that traditional primary care can meet the needs of patients experiencing homelessness and serious mental illness. Health systems cannot co cycling the same high-utilizing patients through emergency departments withou addressing underlying needs. Everyone in the system is looking for solutions tha actually work.

Pair Team's JGIM publication arrives at exactly the right moment. It provides rigorous, peer-reviewed evidence that a comprehensive care model can deliver transformational outcomes for the populations that states and health plans are explicitly trying to serve through CalAIM and similar initiatives. The clinical pr points align perfectly with policy priorities and payment structures. The operati model has been refined through real-world implementation. The technology plat exists to enable scaling. All of the pieces are in place for rapid growth.

WHY PAIR TEAM WILL DEFINE THE NEX DECADE OF HEALTHCARE

Pair Team is positioned to become one of the defining healthcare companies of t next decade for several reasons that extend beyond their impressive published cl outcomes. They have demonstrated operational excellence in one of healthcare's hardest challenges. They have built technology infrastructure that could become industry standard. They have created a model that aligns incentives across multi stakeholders. They have a sophisticated, experienced team with deep expertise a medicine, operations, technology, and health policy. And they have done all of th market segment that is massive, growing rapidly, and desperately in need of innovation.

The operational excellence is particularly important and difficult to replicate. Healthcare is littered with companies that had great ideas but could not execute consistently at scale. Pair Team has proven they can deliver complex care coordi with 94.3% reach rates within 30 days of hospital discharge, maintain patient engagement averaging 3.3 contacts per month over a full year, and achieve transformational clinical outcomes across diverse patient populations. This operational capability is much harder to replicate than technology or strategy al

The team itself deserves recognition. The authors of the JGIM study include Lul Mueller (data science and analytics), Neil Batlivala (operations and implementati Jonathan Palisoc (health policy), Connie Kim (clinical operations), Andrey Ostro MD (former CMS Chief Medical Officer with deep health policy expertise), Mich

Ong MD PhD (academic physician and researcher from UCLA), and Nathan Fav MD MS (physician executive with dual training in medicine and public health fr UC Berkeley). The acknowledgments thank Cassie Choi RN, Co-Founder who developed the intervention, and note contributions from health economists Jessi Juusola PhD and Shefali Kumar MPH.

This is not a team of engineers who decided to tackle healthcare as a technical problem. This is not a team of clinicians without operational or technology expe This is a uniquely balanced team with deep capabilities across all the dimension necessary to build a transformational healthcare company: clinical care delivery, operational excellence, technology development, health policy, health economics data analytics. This combination is extraordinarily rare and creates competitive advantages that persist as the company scales.

The technology platform creates multiple paths to value creation and defensibili Arc is not just a tool for Pair Team's internal operations—it is potentially infrastructure for an entire industry. Companies that build platform infrastructu tend to compound their advantages over time as more organizations build on the platform, creating network effects and switching costs. If Arc becomes the stand platform for coordinating care across medical and social systems, Pair Team's competitive position becomes increasingly strong with every new customer and integration partner.

The stakeholder alignment is unusual and valuable. Patients benefit from better health outcomes, improved quality of life, and more dignified care that treats th whole people rather than collections of diagnoses. Health plans benefit from red costs, better quality metrics that affect Star ratings and regulatory compliance, a solutions to their most challenging populations. Healthcare providers benefit fr patients who are healthier, better able to engage with primary care, and less like use emergency departments inappropriately. Community organizations benefit f sustainable funding that allows them to professionalize their operations and ser more people effectively. States benefit from better Medicaid outcomes, improved sustainability, and progress toward health equity goals.

When a business model creates genuine value for every stakeholder rather than extracting value from some to benefit others, it tends to have remarkable staying power. There is no natural opposition to Pair Team's model because everyone wi This creates a virtuous cycle where success breeds more success as satisfied stakeholders become advocates who refer more patients, create more partnershi opportunities, and support favorable policy development.

The market timing is exceptional and possibly the most important factor. Medic value-based transformation is accelerating across the country. State budgets are pressure to control costs while improving outcomes. Health plans are seeking solutions that demonstrably work rather than just more pilots. Technology infrastructure has matured to enable sophisticated data integration. Clinical workforce models are evolving to include community health workers as professi Payment policies are becoming more flexible about covering social services. Regulatory frameworks like CalAIM are explicitly designed to enable models lik Team's.

All of these trends favor exactly the model that Pair Team has built and proven effective. They are not fighting uphill against misaligned incentives or hoping p will change to make their business work. The policy infrastructure already exist payment mechanisms are in place, the clinical evidence is published, and the ma is ready. This is the rare situation where timing, product-market fit, team capabi and external conditions all align simultaneously.

The path to building an enormously valuable company is clear. Scale the direct s delivery business across California by contracting with additional Medicaid mar care plans and serving more populations of focus under CalAIM. Expand to othe California counties where Enhanced Care Management is being implemented. Demonstrate continued clinical outcomes and economic performance that make Team the obviously superior choice for health plans and states. License Arc to o Enhanced Care Management providers, creating a software revenue stream with margins. Expand to other states as they implement CalAIM-like programs. Build definitive platform for care coordination across medical and social systems that becomes industry infrastructure.

Each of these steps is achievable based on what Pair Team has already demonstr
They are not dependent on unproven assumptions or hoping something fundam
changes about healthcare. The model works clinically, the economics are favorab
the policy environment is supportive, and the team has shown they can execute.
is the recipe for building a truly transformational healthcare company.

THE VENTURE OPPORTUNITY OF THE DECADE

For investors, Pair Team represents several characteristics that define exceptiona
venture opportunities. Large addressable market with clear pain points and will
customers. Proven business model with peer-reviewed clinical evidence. Techno
platform with potential to scale beyond direct service delivery. Strong market
tailwinds from regulatory and payment transformation. Team with demonstrated
ability to execute in a complex, challenging environment. Multiple paths to build
an enormously valuable company. These elements together create the profile of a
investment that could generate exceptional venture-scale returns.

The addressable market is enormous and growing. Medicaid spending on high-n
beneficiaries exceeds $200 billion annually. California's Medi-Cal program alone
covers 14 million people with tens of billions in spending. The Enhanced Care
Management benefit under CalAIM creates a direct payment mechanism for exa
the services Pair Team provides. Even capturing a small percentage of this mark
would create a business with billions in revenue. The total addressable market
extends beyond California Medicaid to include other states developing similar
programs, Medicare Advantage plans serving dual-eligible beneficiaries, safety-n
health systems, and potentially commercial plans serving complex populations.

The business model has been proven to work clinically and shows strong econon
The JGIM study demonstrates that the clinical model achieves transformational
outcomes. The unit economics are favorable when serving high-cost patients wh
intensive intervention generates substantial savings. The Enhanced Care Manag
payment structure in California provides adequate reimbursement to fund the h

touch care coordination that drives results. This is not a business model that dep on hoping payment rates improve or regulatory barriers disappear—the economi fundamentals work today.

The business model also has multiple revenue streams and paths to profitability. Direct service delivery through Enhanced Care Management contracts with Med managed care plans provides revenue that scales with patient volume. Platform licensing of Arc to other Enhanced Care Management providers, health plans, ar care coordination organizations creates software revenue with significantly bette gross margins than service delivery. Potential expansion into Community Suppo services under CalAIM creates additional revenue opportunities. Performance-b payments tied to quality metrics and utilization reductions create upside as the demonstrates continued effectiveness. This diversification reduces risk and crea multiple paths to building a large, valuable company.

The competitive dynamics are highly favorable. Most care coordination compani have struggled to serve the highest-need populations effectively, creating opport for a company that has actually figured out how to make it work. The barriers to are substantial—building clinical operations, establishing community partnersh developing sophisticated technology platforms, and navigating complex payer contracting all require significant capabilities that take years to develop. Once P Team establishes relationships with Medicaid managed care plans in specific ma replicating their model would require competitors to build equivalent capabiliti convince plans to switch, which is difficult when Pair Team is delivering strong outcomes.

The technology platform creates particularly strong competitive moats. Arc requ substantial investment to build and represents accumulated operational knowle about what actually works in care coordination. The data integrations with Heal Information Exchanges, Admission Discharge Transfer systems, and community organizations take time and relationship building to establish. As more organiza use Arc, the platform becomes more valuable through network effects—more us generate more data that improves the AI algorithms, more integrations make the

platform more useful, and more case studies demonstrate value. These dynamics create compounding competitive advantages that strengthen over time.

The exit opportunities are multiple and attractive. Strategic acquirers could incl national health plans like Centene, Molina, or UnitedHealthcare that manage Medicaid contracts and would benefit from owning this capability rather than contracting for it. Health systems serving safety-net populations like CommonSp Health or Intermountain Healthcare could acquire Pair Team to strengthen thei ability to manage value-based contracts. Technology companies like Epic or Cer wanting to move into care delivery could see Pair Team as an entry point. Large physician practice groups or urgent care chains could acquire Pair Team to expa into complex care management.

The financial profile could support an eventual IPO if the company reaches suffi scale and profitability. The combination of service revenue and platform licensir creates a hybrid financial model that public market investors find attractive—recurring revenue, clear path to profitability, large addressable market, and stro growth potential. Companies like Oak Street Health and Agilon Health have demonstrated that public markets reward well-executed models serving complex populations when there is clear evidence of clinical outcomes and economic sustainability.

Private equity firms focused on healthcare services would likely be very interest business with recurring revenue, demonstrated unit economics, and opportuniti scale through acquiring smaller competitors or entering new markets. The grow equity market is particularly active in healthcare and would find Pair Team attra as the company reaches later stages. This creates multiple potential exit paths depending on how the company evolves and what opportunities emerge.

The impact dimension compounds the investment thesis in important ways. Inve can feel genuinely good about building a company that dramatically improves he outcomes for some of America's most vulnerable populations while also generati attractive financial returns. This impact orientation helps with recruiting top cli talent who want their work to matter beyond just shareholder returns. It creates

goodwill with policymakers and potential customers in ways that benefit the bus
It maintains team motivation through the inevitable challenges of building a
healthcare company.

The impact also creates strategic advantages in policy and regulatory processes.
Medicaid agencies and health plans are not just looking for vendors—they are lo
for partners who genuinely care about improving outcomes for vulnerable
populations. Pair Team's track record of serving patients experiencing homeless
serious mental illness, and profound social complexity demonstrates authentic
commitment that creates trust with policymakers. This trust translates into mor
favorable contract terms, earlier access to new opportunities as programs expand
willingness from states to structure payment mechanisms that support the mode

The team's background and expertise make them particularly well-positioned to
capitalize on these opportunities. Having Andrey Ostrovsky, former CMS Chief
Medical Officer, involved provides deep understanding of Medicaid policy and
relationships with key decision-makers across states. The combination of practi
physicians, public health expertise, health policy knowledge, operational excelle
and technology development is extraordinarily rare. This team can speak credibl
clinicians, policymakers, health plan executives, and investors because they have
expertise across all these domains.

From a venture capital perspective, the key insight is that Pair Team sits at the
intersection of massive market need, proven clinical model, favorable policy
environment, and scarce execution capability. Markets reward companies that so
hard problems that matter, and Pair Team has demonstrably solved one of health
hardest problems. The JGIM publication transforms this from a promising idea
proven fact, dramatically reducing execution risk for investors.

The valuation opportunity is substantial because the market is not yet fully pric
the platform potential of Arc. If investors view Pair Team purely as a services
business, the valuation would be reasonable but not extraordinary. However, wh
recognize that Arc could become infrastructure for an entire industry of care
coordination providers, the valuation implications change dramatically. Platform

businesses command much higher valuations than service businesses because of margins, faster scaling, and stronger competitive positions.

The strategic timing for investment is excellent. Early enough that there is enor upside as the company scales across California and expands to other states. Late enough that the model has been proven and de-risked through peer-reviewed publication and operational track record. The Enhanced Care Management bene under CalAIM is still in relatively early stages of implementation, meaning Pair can capture significant market share before competition intensifies. This is the s spot where risk-adjusted returns are most attractive.

CONCLUSION

Pair Team's publication in the Journal of General Internal Medicine will be remembered as a pivotal moment in healthcare delivery transformation. The clir outcomes—52% reduction in emergency department visits, 26% reduction in hos admissions, 21% increase in outpatient visits, meaningful improvements in ment health—demonstrate conclusively that high-touch care coordination can work fo most complex patients when designed and executed properly. But the real story i just what Pair Team has achieved clinically. It is what they have built operationa and technologically to make these outcomes sustainable, scalable, and economic viable.

The three core innovations—treating community organizations as paid partners, deploying clinical teams into communities, and building Arc as platform infrastructure—represent genuine breakthroughs in how care coordination worl These are not marginal improvements on existing models. They are fundamental reconceptualizations of how to deliver comprehensive care to patients whose nee exceed what traditional healthcare can provide. Each innovation alone would be valuable. Together, they create a care model that is clinically effective, operation sustainable, and economically viable at scale.

The market opportunity is extraordinary and the timing is perfect. California's CalAIM initiative creates exactly the right payment structures and policy framev

States across the country are watching and developing similar programs. Medica managed care plans are desperate for solutions that demonstrably work. The addressable market measures in the tens of billions of dollars. Technology infrastructure has matured to make sophisticated care coordination possible. Regulatory flexibility is increasing. Workforce models are evolving. Every trend i the model that Pair Team has proven effective.

The peer-reviewed publication provides credibility that marketing can never rep and transforms the conversation from "does this work?" to "how do we impleme this?" For health plans considering contracts, the JGIM study provides evidence Pair Team can deliver on their promises. For state Medicaid agencies designing programs, it demonstrates what is possible when you adequately fund comprehe care coordination. For other care coordination providers, it shows the bar for wh effective intervention looks like. For investors, it substantially reduces executior by proving the clinical model works.

What makes this moment particularly exciting is watching all the pieces come together simultaneously. The clinical model has been proven. The operational capabilities have been demonstrated. The technology platform has been built. Th policy environment is supportive. The payment mechanisms exist. The market is ready. The team has the expertise to execute. These conditions rarely align so perfectly, and when they do, extraordinary value creation becomes possible.

For healthcare entrepreneurs, Pair Team demonstrates several crucial lessons ab building transformational healthcare companies. Clinical credibility through pe reviewed research creates opportunities that no amount of marketing can replica Technology platform development alongside service delivery creates multiple pa value creation and stronger competitive positions. Building genuine operational excellence in complex care delivery creates moats that are difficult to replicate because they require accumulated knowledge and relationship building. Alignin incentives across multiple stakeholders creates business models with staying pov because everyone wins.

The venture opportunity is clear and compelling. Large market with clear pain p and willing customers. Proven model with peer-reviewed evidence. Strong team diverse expertise. Favorable policy environment and payment structures. Techno platform with potential to become industry infrastructure. Multiple paths to bu an enormously valuable company. This is exactly the profile that generates excep returns while creating meaningful social impact.

The patients who have been underserved by fragmented, episodic healthcare fina have a model designed around their actual needs rather than asking them to nav systems never built for their circumstances. The health plans and states managi Medicaid programs finally have a solution that delivers meaningful outcomes an favorable economics rather than more pilots that show modest results. The inves seeking opportunities to build consequential companies while generating attrac returns have found a compelling thesis with multiple paths to success. And the healthcare industry has proof that we can do dramatically better for our most vulnerable populations when we commit to building the right infrastructure and supporting it with the right technology.

Pair Team is not just solving a healthcare problem—they are creating the templa how care delivery will work for complex populations for the next decade and bey The JGIM publication provides the clinical evidence. The operational track reco proves the execution capability. The technology platform creates scalability and defensibility. The policy environment is supportive. The market opportunity is massive and growing. The team has demonstrated they can execute on a complex multifaceted vision.

This is what a transformational healthcare company looks like in its early stages a company with a clever idea hoping something about healthcare changes to mak their business work. Not a company with impressive technology searching for product-market fit. Not a company with clinical credentials but no operational capability. Pair Team has proven clinical outcomes, demonstrated operational excellence, built platform technology, secured favorable policy environment, and assembled a team with expertise across all necessary dimensions.

The next few years will determine whether Pair Team fulfills this enormous pote but the foundation they have built suggests they are exceptionally well-positione do exactly that. The clinical model works. The economics are favorable. The poli support exists. The technology platform creates leverage. The team can execute. market is ready. All of the pieces are in place for Pair Team to become one of the defining healthcare companies of the next decade, transforming how America ca for its most vulnerable populations while building extraordinary value for all stakeholders.

This is the kind of company that reminds us why healthcare entrepreneurship matters. Not just because there are profits to be made, though the financial opportunity is substantial. But because solving hard problems that improve lives scale represents entrepreneurship at its best. Pair Team has shown us what is po when clinical excellence, operational capability, technology innovation, and poli alignment come together. The 568 patients in their study are just the beginning. Millions of Americans with complex needs deserve this level of care, and Pair Te has proven it can be delivered effectively. That is a vision worth building, investi and supporting as it scales to reach everyone who needs it.

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