The $145M Federal Subsidy Nobody i Health Tech Is Talking About Yet

FEB 17, 2026 • PAID

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Abstract

- DOL announced a $145M Pay-for-Performance Incentive Payments Program o February 13, 2026, with applications due April 3, 2026

- Program issues up to 5 cooperative agreements over 4 years; individual agreem range from $10M to $40M

- Healthcare is a named priority sector alongside AI/semiconductor, shipbuilding/defense, IT, transportation, and telecom

- U.S. faces projected shortage of 3.2 million healthcare workers by 2026, 141,16 physicians by 2038, and 73,000+ nursing assistants by 2028

- Unlike traditional grants, this is a pay-for-performance model where money flo per enrolled apprentice, not as upfront allocation

- This structure creates at least 4 distinct categories of commercial opportunity health tech entrepreneurs

- Eligible applicants include state agencies, national industry associations, labor management orgs, workforce intermediaries, consulting orgs, and consortia

- Required to include at least one national or multi-regional industry associatior partner

- Deadline is April 3, 2026, which is tight but workable for a well-networked tea

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The Setup: Why the Healthcare Workforce Is a Burning Platform

There is a version of this story that has been told so many times that investors ar operators have sort of tuned it out. Healthcare workforce shortage, aging popula burnout, nursing schools rejecting 92,000 qualified applicants in 2021 alone bec there are not enough faculty and classroom seats, hospitals spending more than of their total operating budget on labor. Right, we know, everyone has a deck ab But it is worth spending a moment actually confronting the magnitude of what i happening before getting to the commercial opportunity, because the numbers h gotten genuinely alarming in a way that shifts what solutions the market will act pay for.

One analysis of EMSI data projects a critical shortage of 3.2 million healthcare workers by 2026, and that is not a point far in the future anymore, that is now. H projects an overall physician shortage of 141,160 FTEs by 2038 and already estin

that the physician workforce in 2026 will only meet 90% of demand nationally, a that gets substantially worse in rural areas where some specialties face shortages approaching 46%. The American College of Physicians is projecting a shortage o 85,000 physicians by 2036. Nursing is its own disaster: more than 100,000 nurses the workforce in recent years, about 35% of the physician workforce is projected retirement age within five years, and per a Harris Poll survey conducted mid-202 55% of healthcare employees say they intend to search for, interview for, or switc jobs in 2026. That last number is almost too large to be believed, but the underly drivers are real: 84% report feeling underappreciated, and only 1 in 5 feel their employer is invested in their long-term career growth.

What this creates at a macro level is a market where health systems are both financially desperate (labor is north of 50% of operating costs and rising) and operationally desperate (there simply are not enough trained bodies to fill open r That combination, expensive and scarce, is exactly the condition that makes a ma receptive to structural innovation rather than marginal improvement. Systems ar looking for a 10% efficiency gain on top of a broken model anymore. They are lo for ways to fundamentally change how they build, retain, and deploy clinical and clinical-adjacent staff. That is the context into which the DOL just dropped $14 million and told the market to figure out how to use it.

What DOL Actually Announced (and Wh the Details Are Weird in a Good Way)

On February 13, 2026, the Department of Labor's Employment and Training Administration announced the Pay-for-Performance Incentive Payments Progra $145 million initiative structured around up to five cooperative agreements with four-year performance period. The stated goal is to help the Trump administrati its executive order target of 1 million active registered apprentices nationwide. Healthcare is one of six named priority sectors. Applications are due April 3, 202

The structure here is worth unpacking because it is genuinely unusual and that unusualness is where the commercial opportunity lives. This is not a traditional The money does not flow upfront to be spent on program activities and reported as outcomes after the fact. Instead, this is a pay-for-performance model where th selected organizations receive payments on a per-apprentice basis for new appre enrolled during the term of the cooperative agreement. The government reimbu for results, not for activities. This is functionally closer to how outcomes-based contracting in healthcare works, or how certain value-based payment models op than to how most federal workforce grants work.

The program is also explicitly structured as a cooperative agreement rather than grant, which means the federal government retains meaningful involvement in consequential decisions. This is not just semantics. It means that whoever wins t agreements will be operating with a federal partner at the table, which creates b constraints and legitimacy. A health tech company or consortium that figures ou to embed itself into one of these agreements gets something valuable beyond the money: federal validation of their workforce model, access to DOL's existing infrastructure, and the credibility that comes from being a named partner in a national apprenticeship expansion program.

The eligible applicants list is broad: state agencies and territories, national indu groups and associations, national labor-management organizations, national eco development entities, registered apprenticeship and workforce intermediary organizations, professional consulting organizations, and consortia. The consort language is key. A health tech company could anchor a consortium that includes national industry association (required), a health system, a community college, a technology platform provider, and submit a competitive application for one of th four industry-specific agreements or the fifth catch-all agreement covering indu not named in the first four.

There is another detail worth flagging from the grants.gov lis the program specifically calls out the need for applicants to describe how they w operate a payment management system to manage the distribution of apprentice payments to sponsors. That is not a minor administrative note. That is a technol

and operations problem dressed up as a compliance requirement, and it is one th
health tech companies are well-positioned to solve.

The Playbook: How Health Tech Entrepreneurs Can Plug In

The strategic options here break into roughly three tiers based on proximity to t
grant mechanism itself and the level of organizational infrastructure required.

The most direct play is to pursue cooperative agreement funding directly, either
lead applicant or as a named partner in a consortium. This requires moving fast
the April 3 deadline, but it is achievable for organizations with existing relation
in workforce development or healthcare association infrastructure. A health tech
company that has existing contracts with health systems, a relationship with a m
national healthcare association like AHA or AHCA, and a technology platform f
tracking and managing workforce data could realistically anchor a consortium. T
key move here is getting the association partner on the phone this week, not nex
month.

The second tier is the infrastructure-as-a-service play, which does not require w
cooperative agreement funding directly but instead involves building the techno
and operational infrastructure that whoever wins will need to run. The payment
management system requirement is a gift for health tech entrepreneurs who hav
anything in the adjacencies of managed care payments, value-based care analytic
workforce management platforms. Running a pay-for-performance payment mod
scale across a national network of apprenticeship sponsors requires data
infrastructure, real-time enrollment tracking, milestone verification, payment
processing, compliance reporting, and audit readiness. None of that exists off th
in a way that is native to registered apprenticeship programs. The winning appli
are going to need to buy or build it, and health tech companies that pitch thems
as the technology backbone of a cooperative agreement can insert themselves int
deal without being the lead entity.

The third tier is what might be called the downstream talent acquisition play. If program succeeds and healthcare apprenticeships scale, the question immediate becomes who is capturing the workforce that gets trained. Health systems that a currently paying $40 to $50 per hour for travel nurses from staffing agencies and substantial placement fees to fill permanent positions are going to be extremely interested in direct pipelines to credentialed workers they helped train. A comp that builds the technology layer connecting apprenticeship programs to health s hiring pipelines, tracks training completion and competency data, and manages ongoing relationship between apprenticeship sponsors and employer partners, is solving a real and expensive problem for a buyer that has demonstrated willingn pay for workforce solutions.

There is also a fourth tier that is less obvious but potentially quite large: the em of record and compliance infrastructure play. Registered apprenticeship prograı require formal registration with the DOL, compliance with wage progression requirements, competency assessment frameworks, and documentation of on-th training hours. For small and mid-sized healthcare employers, which the DOL explicitly calls out as a target population for this program, all of that compliance overhead is a real barrier to participation. A company that wraps apprenticeship compliance services, employer of record capabilities, and training management i SaaS product specifically designed for healthcare employers of under 500 emplo could grow very quickly in a market where the federal government is actively pa sponsors to recruit more apprentices.

The Startup Angles Nobody Is Pitching Yet

There are several more specific startup opportunities that the combination of th DOL announcement and the underlying workforce data seem to be pointing at, a the interesting thing is that almost none of them require winning the cooperativ agreement itself.

The first is a credentialing and skills-mapping platform built specifically around healthcare apprenticeship occupations. Right now the registered apprenticeship framework for healthcare is somewhat underdeveloped compared to the trades. There are about 750 registered apprenticeship occupations nationally, but healthcare occupations are a small fraction of those, and the competency frameworks that exist are not always well-suited to the kinds of hybrid roles that health systems actually need, things like clinical data abstractors, care coordinators, pharmacy technicians with EHR specialization, and patient navigation roles that blend social work with management. A company that works with DOL to develop and register new healthcare occupation frameworks and then licenses the associated competency assessment and training management tools to employers has a durable business model that is hard to compete with once the occupation frameworks are established.

The second angle is rural healthcare workforce, which the DOL explicitly flags as a priority area and which the workforce data shows is dramatically underserved. HRSA projects a 39% shortage of primary care physicians in non-metro areas by 2038 and a 46% shortage of dentists. Rural hospitals are already struggling with closure risk, with 50% of America's rural hospitals were reportedly operating in the red before any of the current labor cost pressures. A company that builds a rural-specific apprenticeship program, potentially using telehealth supervision as a mechanism for extending a more limited number of supervising clinicians to oversee more apprentices across a wider geography, is addressing a market where the pain is acute and the alternatives are limited.

The third angle is the data and outcomes reporting layer. The pay-for-performance model only works if someone can reliably verify that enrolled apprentices are actually completing milestones, which means the DOL and the cooperative agreement holder are going to need real-time data pipelines from apprenticeship sponsors reporting enrollment dates, training hours, competency completions, and wage progression. Health systems and staffing organizations are generally bad at producing this kind of structured workforce data because their systems were not built for it. An analytics and reporting platform that sits between employers and the cooperative agreement holder, aggregating and verifying outcomes data in a format that satisfies federal

compliance requirements, is a product that would essentially be required by the program's own structure.

The fourth angle is the behavioral health workforce specifically, which is called separately in HRSA data and represents arguably the most acute shortage in the system. The problem with behavioral health workforce development historically been that training requirements are long, licensing requirements vary significan state, and supervision requirements for trainees are burdensome for the licensed clinicians who have to provide them. A platform that manages telehealth-based supervision for behavioral health apprentices or trainees, tracks the hours and ty of supervision required for each state's licensure pathway, and connects trainees supervisors nationally could meaningfully reduce the friction of building a beha health workforce pipeline and would plug directly into the registered apprentice framework.

The Fly in the Ointment: Execution Risk in Federal Programs

None of this is free money or easy money and it would be dishonest to frame it t way. Federal cooperative agreements come with substantial compliance overhead reporting requirements, and the operational reality of having a federal agency as partner in decision-making. The DOL's track record on delivering workforce programs at scale is mixed, and the pay-for-performance model, while conceptua elegant, has not been widely tested in the U.S. registered apprenticeship context only domestic precedent of note was a Biden administration report in 2024 that recommended piloting PFP for apprenticeships, which did not actually produce pilot before the administration changed. The international evidence is more encouraging: England's PFP-based apprenticeship system has reportedly genera 300% return on a 2 billion pound investment per analysis by the Chartered Management Institute, and Finland's model has produced strong completion outcomes. But direct translation of those results to the U.S. context requires cau

There is also a timing issue that any entrepreneur thinking about this needs to s with honestly. The April 3 deadline is fast. A well-organized team with existing relationships could put together a competitive consortium application in six wee but it would be a sprint. The organizations most likely to win these agreements a existing workforce intermediaries and large industry associations that have been involved in registered apprenticeship for years, know the DOL stakeholders, and pre-existing program infrastructure. A health tech startup entering cold is probá not winning a cooperative agreement in this cycle. What a health tech startup ca realistically do in this timeframe is identify which organizations are likely to app and get into conversations about being their technology partner before the appli is submitted, because technology partners named in applications carry through i the award.

The political durability question is also worth asking. This program is explicitly aligned with the current administration's America's Talent Strategy. Registered apprenticeship expansion has historically had bipartisan support, which is genui positive sign. But anyone building a business that depends on federal program continuity needs to think about what happens to the program architecture if the policy environment shifts in 2028 or 2029.

The smarter play for most health tech companies is to treat the DOL program as forcing function that validates market demand and creates initial customers, bu build the underlying technology in a way that has standalone commercial value regardless of whether the federal program continues at its current scale. A work data and outcomes reporting platform has value to health systems whether or no there is a federal pay-for-performance overlay. An employer of record and apprenticeship compliance SaaS has customers in states with their own registere apprenticeship programs. The federal program makes the market move faster an risks initial adoption, but the technology should not require the program to surv

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Where This Is All Going

The broader context here is that the U.S. healthcare workforce crisis has finally severe enough to make structural solutions economically viable at scale. Travel n spend has been a persistent and enormous line item for hospitals since 2020 and showed no signs of normalizing to pre-pandemic levels. Health systems have mo past hoping the problem will self-correct and into active investment in alternati including apprenticeship programs, grow-your-own workforce initiatives, and workforce partnership programs with community colleges and regional employe

The DOL program is important not just because of the $145 million, though tha real money, but because federal validation of a model tends to unlock state and p investment that is an order of magnitude larger. When the federal government n healthcare as a priority sector for a pay-for-performance apprenticeship progran provides the financial proof of concept, it gives state workforce boards, health sy CFOs, and private equity-backed staffing companies a framework to point to wh making their own investment cases. The initial $145 million is likely to catalyze several times that amount in complementary investment over the four-year performance period.

For health tech investors, the lens here is less about the grant itself and more ab which founding teams are building durable infrastructure that will be needed whether or not any specific federal program continues. The workforce data and outcomes layer, the employer compliance tools, the rural workforce enablement platforms, and the behavioral health supervision infrastructure are all solving re expensive problems that will not go away if political winds shift. The DOL progr creates a favorable moment to build these companies because it generates imme paying customers, creates a federal data trail validating the model, and compress timeline for market adoption. That combination of near-term revenue validation long-term structural demand is exactly what early-stage healthcare investors sho be looking for right now.

The grant deadline is April 3. That is six weeks from the date of this writing. Wh or not any specific company decides to pursue a cooperative agreement, any oper or investor in healthcare workforce, clinical staffing, health system operations, o adjacent workforce tech owes it to themselves to read the full NOFO, map the

opportunity against their existing portfolio or pipeline, and at minimum get on t
phone with the most relevant workforce intermediary in their network. The win
short and the upside is real.

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