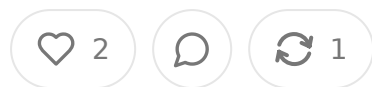


# What Actually Needs Building: Ten Healthcare Companies for 2026

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## Abstract

The healthcare investment landscape entering 2026 reveals clear consensus around several fundamental shifts despite surface-level disagreement on timing and magnitude. Major themes emerging from year-end reviews include the maturation of AI from experimental to operational deployment, the breakdown of traditional payment models creating monetization opportunities, the collision of consumer expectations with legacy infrastructure, and the persistent reality that software cannot fix broken workflows. This synthesis identifies ten specific company archetypes that thread through multiple investor theses: revenue cycle automation that captures real cash for providers, clinical decision support that reduces liability exposure for physicians, logistics platforms for specialty pharmacy, API infrastructure for prior authorization, ambient documentation that actually works in specialty settings, patient acquisition engines for elective procedures, care navigation for Medicare Advantage plans facing margin compression, AI coding compliance tools, longitudinal care coordination for behavioral health, and workforce optimization software for non-physician providers. Each opportunity represents a clear buyer, an acute pain point and measurable ROI, validated by current market behavior rather than hypothetical future states.

## Key Themes from 2025 Year-End Reviews

- AI deployment moving from pilots to production with clearer ROI metrics
- Payment model disruption creating monetization windows (GLP-1s, Medicare Advantage margins, specialty pharmacy)

- Infrastructure plays around data movement and API standardization gaining traction
- Clinical workflow automation showing actual time savings in specific use cases
- Consumer expectations forcing transparency and convenience upgrades
- Regulatory environment creating compliance technology opportunities
- Behavioral health and specialty care coordination emerging as priority areas
- Workforce shortage driving non-physician provider enablement tools

### Market Signals Validating These Opportunities

- Provider systems cutting vendor contracts while increasing spend on automation
- Payer margins compressing forcing efficiency plays and care management investments
- Specialty pharmacy volume growing 15-20 percent annually with logistics bottlenecks
- Prior authorization volumes up 30 percent creating API infrastructure demand
- Elective procedure volumes recovering but patient acquisition costs rising
- Medicare Advantage plans scrambling for care coordination tools as Star ratings matter more
- Medical coding compliance becoming existential risk as audits intensify
- Psychiatry and specialty practice no-show rates hitting 25-30 percent

## **The Ten Companies That Need Building**

Revenue cycle automation capturing actual cash

Clinical decision support reducing malpractice exposure

Specialty pharmacy logistics and patient support

Prior authorization API infrastructure and workflow tools

Ambient documentation for specialty practices

Patient acquisition and conversion for elective procedures

Care navigation platforms for MA plans

AI-powered medical coding compliance

Longitudinal behavioral health care coordination

Workforce optimization for nurse practitioners and physician assistants

## **The Consensus Nobody Wants to Admit**

Reading through a dozen year-end healthcare predictions from investors ranging from early stage specialists to growth equity firms to strategic consultancies reveals something genuinely interesting. Everyone agrees on the same fundamental shift while carefully hedging their language to sound differentiated. The consensus position has become that AI will matter enormously but probably not as fast as everyone hoped six months ago, that payment models are breaking in ways that create actual business opportunities rather than thought experiments, and that the companies winning right now are solving very specific workflow problems rather than reimagining healthcare from first principles.

Townhall Ventures puts it plainly when they note that 2026 will be the year healthcare AI moves from science projects to actual deployments with measurable outcomes. They are not alone. Bessemer predicts AI scribes will be table stakes by end of year. Seven Wire expects ambient documentation to hit critical mass. The pattern holds across every major thesis. Everyone spent 2024 funding experimental AI companies and watching pilots that showed promise but limited scale. The shift for 2026 in

backing companies that can demonstrate concrete savings or revenue increases within 90 days of implementation.

What makes this consensus interesting rather than boring involves the specific mechanisms people expect to drive results. Sequoia argues in their rethinking performance piece that the real opportunity lies not in replacing humans but in making expensive humans more productive. A16z counters that the breakthroughs will come from AI agents that can actually complete entire workflows without human intervention. Both camps agree that healthcare workflows are wildly inefficient and ripe for automation. They just disagree on whether the path forward runs through augmentation or replacement.

The payment model discussion reveals similar underlying agreement wrapped in different framing. Multiple sources highlight GLP-1 medications as a forcing function that will reshape obesity care delivery, diabetes management, and downstream chronic disease prevention. EY and Deloitte both point to Medicare Advantage margin compression as an existential crisis forcing plans to find new ways to manage costs. PitchBook notes that fee-for-service is dying faster than anyone expected, with bundled payments and value-based arrangements growing 40 percent year over year. The common thread suggests that companies solving acute payment problems for specific stakeholders will find eager buyers in 2026, while companies still pitching the promise of value-based care will struggle.

The infrastructure conversation follows a predictable pattern where everyone agrees that data interoperability remains terrible and that APIs will matter more, but nobody can quite articulate which specific data movement problems are worth billions versus millions. Bessemer talks about the need for better prior authorization infrastructure. A16z highlights the continued importance of healthcare data platforms. Seven Ventures predicts that synthetic data generation will become critical for AI training. These are all correct observations about real problems. The challenge involves figuring out which infrastructure plays have actual business models attached rather than just solving annoying technical problems that nobody will pay to fix.

Consumer expectations creating forcing functions represents another consensus position that manifests in different ways depending on who is writing the prediction. MedCity News quotes VCs predicting that patients will demand Amazon-like convenience in healthcare. Chief Healthcare Executive highlights how AI-powered chatbots will become standard for patient communication. Hospitalogy notes that transparency requirements will force price visibility across the system. The unified insight suggests that healthcare has run out of rope on the consumer experience dimension and that companies making it meaningfully easier for patients to access and navigate care will capture disproportionate value.

What nobody wants to say directly but everyone implies involves the recognition that most healthcare innovation over the past decade solved problems that did not matter very much or created new problems worse than the ones being fixed. Digital health had its moment. Telehealth proved useful for some things and actively harmful for others. Remote patient monitoring generated lots of data that nobody knew what to do with. Care navigation created another layer of bureaucracy between patients and care. The companies that will win in 2026 are the ones that learned from these expensive mistakes and are building tools that slot into existing workflows rather than requiring everyone to change how they work.

The timing question lurks underneath every prediction. Vinod Khosla says we are getting closer to AI-powered healthcare and gives it another five to ten years before general purpose medical AI assistants can replace most routine physician work. Others argue the transformation is already happening and will accelerate dramatically in 2026. The reality probably splits the difference. Narrow AI tools that do one thing extremely well in a specific clinical context are already showing value. General purpose AI that can reason across complex medical problems and make high-stakes decisions remains further out. The companies that need building in 2026 should focus on the narrow applications with clear ROI rather than swinging for transformational breakthroughs.

## **Revenue Cycle Automation That Captures Actual Cash**

Every healthcare CFO in America will tell you that revenue cycle remains a disaster. Claims get denied at rates approaching 20 percent for some payer-provider combinations. Underpayments happen constantly because contract rates are nearly impossible to verify against actual reimbursements. Patient collections fail spectacularly because nobody wants to be the bad guy chasing grandma for a copay. The existing revenue cycle vendors are slow, expensive, and generally terrible at their core function of making sure providers get paid correctly for services rendered.

The opportunity for 2026 involves building revenue cycle automation that demonstrably captures cash that would otherwise be lost. Not software that promises to improve denial rates eventually through better insights. Not analytics platforms that show providers where they are losing money without fixing it. Actual robotic process automation combined with AI that can identify underpayments, file corrected claims, follow up on denials, and get money that providers are owed into their bank accounts.

Several investor theses point toward this opportunity without naming it directly. Bessemer talks about the need for better revenue integrity tools. PitchBook highlights that provider margins are under pressure and that efficiency plays will be highly valued. Seven Wire predicts that AI will automate back-office functions at scale. These observations all point toward the same underlying reality, which is that healthcare systems are bleeding cash through terrible revenue cycle operations and will pay significant money to companies that can plug the leaks.

The business model writes itself. Take a percentage of captured revenue that would have been lost. No upfront fees. No long implementation cycles. Show up, plug into existing systems, start finding money within 30 days, and take a cut of whatever is collected that would not have been collected otherwise. This aligns incentives perfectly and removes all the friction around healthcare sales cycles where procurement committees argue about ROI calculations for 18 months.

The technical challenge involves building AI that can understand complex payer contracts, identify discrepancies between expected and actual reimbursements, and navigate the baroque appeals process for getting claims corrected. This is hard but

solvable. The contract interpretation piece requires strong natural language processing and the ability to track across thousands of contract variations. The underpayment detection piece needs good anomaly detection and pattern match across historical payment data. The appeals automation piece involves understanding the specific documentation and procedural requirements for each payer and being able to generate and submit appeals that meet those requirements.

Existing players like Change Healthcare and Optum provide some of these capabilities but they are expensive, slow to implement, and not particularly good at the core function. They also get paid on a subscription basis rather than on performance, which means they have limited incentive to actually maximize cash capture. A new entrant that can demonstrate superior results and operates on a pure performance basis will take significant market share quickly.

The go-to-market strategy focuses on mid-size health systems and large physician groups that are sophisticated enough to measure results but small enough to move quickly. Show them a 90-day pilot where the software finds and captures specific dollars they would have lost. Make the contract simple and the implementation easy. Build case studies and references. Scale to larger systems once the product is proven.

## **Clinical Decision Support Reducing Malpractice Exposure**

Physicians are getting sued at increasing rates as litigation funding becomes more sophisticated and as AI tools make it easier to identify potential medical errors in historical records. Malpractice insurance costs are rising, particularly in specialties like obstetrics, emergency medicine, and surgery. At the same time, the volume of medical literature continues to explode, making it impossible for individual physicians to stay current on best practices across their entire scope of practice.

Clinical decision support systems have existed for decades and have generally failed to deliver meaningful value. They are too noisy, generating alerts that physicians ignore because they interrupt workflow and are mostly false positives. They are not context-aware enough, providing generic recommendations that do not account for specific

patient situations. They are not liability-focused, meaning they warn about lots of things that do not actually matter for malpractice risk.

The opportunity for 2026 involves building clinical decision support that specifically targets high-risk decisions where physician judgment errors create litigation exposure. Not general-purpose CDS that tries to improve all clinical decisions. Not another alert system that physicians will ignore. Focused tools that identify the specific clinical scenarios where malpractice risk is highest and provide physicians with clear, evidence-based guidance on how to reduce that risk.

Multiple investor predictions touch on aspects of this opportunity. AI16z discusses agents that can synthesize medical literature and provide decision support. Bess highlights the need for better clinical workflow tools. Chief Healthcare Executive notes that AI will help physicians make better diagnostic decisions. These pieces recognize that physicians need better decision support but they do not quite articulate the specific angle around malpractice exposure reduction.

The business model involves selling to malpractice insurance carriers rather than directly to physicians or health systems. Insurance carriers have direct financial incentive to reduce claims and they have relationships with all their covered physicians. A CDS tool that demonstrably reduces malpractice claims by helping physicians avoid high-risk errors becomes valuable enough that carriers will either require it or heavily incentivize its adoption. The pricing could be based on premium reductions for physicians who use the tool, creating a clear ROI calculation.

The technical requirements involve several components. First, the system needs to identify high-risk clinical scenarios based on historical malpractice data. What are the specific situations where physicians most commonly get sued and where better information at point of care would have prevented the error? Second, it needs to integrate into clinical workflow in a way that does not create alert fatigue. This probably means limiting alerts to truly high-risk situations and making recommendations extremely clear and actionable. Third, it needs access to current medical literature and clinical guidelines so that recommendations stay up to date as evidence changes.

The initial focus should be on a single specialty with high malpractice exposure and clear evidence about common error patterns. Emergency medicine represents a strong candidate because the litigation rates are high, the decisions are often made under time pressure with incomplete information, and there is good data about what goes wrong. Build a tool that specifically helps emergency physicians avoid the most common diagnostic misses that lead to lawsuits. Prove that it works by showing reduced claims rates among users. Then expand to other specialties.

## **Specialty Pharmacy Logistics and Patient Support**

Specialty pharmacy volumes are growing 15 to 20 percent annually as more biologics reach market and as conditions like multiple sclerosis, rheumatoid arthritis, and various cancers increasingly get treated with expensive specialty medication. These drugs often require cold chain storage, careful handling, patient education about administration, and monitoring for side effects. The logistics around getting specialty medications from manufacturer to patient while ensuring proper storage, timely delivery, and patient adherence are genuinely complex.

Existing specialty pharmacy operations are mostly manual, involving lots of phone calls between pharmacies, physician offices, payers, and patients to coordinate referrals, handle prior authorizations, schedule deliveries, and troubleshoot problems. Patients frequently report terrible experiences with delayed shipments, confusing billing, and lack of support for learning how to administer medications. Physicians complain about the administrative burden of managing specialty pharmacy coordination on top of actual patient care.

The opportunity for 2026 involves building the logistics and patient support infrastructure that makes specialty pharmacy work smoothly. This means software that coordinates all the stakeholders, automates the routine administrative tasks, ensures medications get delivered on time with proper handling, and provides patients with the education and support they need to successfully manage their therapies.

Several predictions point toward this space without directly naming it. Deloitte discusses the growth of specialty pharmacy and the need for better patient support. EY highlights logistics challenges in healthcare supply chain. MedCity News talks about the importance of patient experience improvements. These observations all recognize that specialty pharmacy is broken and getting worse as volumes grow, but nobody quite connects the dots to the specific company that needs to exist.

The business model involves taking a fee per prescription or per patient per month from specialty pharmacies, manufacturers, or payers who all have economic interests in better coordination and adherence. Specialty pharmacies want to reduce costs and improve throughput. Manufacturers want to ensure patients stay on therapy and have good experiences. Payers want to avoid complications from poor adherence. A platform that demonstrably improves these outcomes can charge a meaningful fee to multiple stakeholders.

The technical components include inventory management and cold chain tracking to ensure medications are stored and shipped correctly, communication orchestration to coordinate between all the parties involved in a patient's specialty medication journey, patient engagement tools to provide education and support, and analytics to identify adherence risks and intervention opportunities. The key involves stitching these pieces together into a coherent workflow that reduces the coordination burden on everyone involved.

Initial go-to-market should focus on a specific therapeutic area with high compliance and poor current patient experience. Oncology support drugs represent a strong candidate because the medications are expensive, the patient population is highly motivated to succeed with treatment, and the current coordination is notoriously broken. Build a platform that specialty pharmacies can white-label for their oncology patients. Demonstrate improvements in adherence rates, patient satisfaction, and operational efficiency. Expand to other therapeutic areas once the model is proven.

## **Prior Authorization API Infrastructure and Workflow Tools**

Prior authorization volumes have increased roughly 30 percent over the past three years as payers have expanded requirements to cover more services and medications. The process remains almost entirely manual, with physician offices submitting requests via fax or web portal, payers reviewing them using outdated criteria and taking days or weeks to respond, and everyone losing track of what is pending or approved. Physicians report spending hours per day on prior auth, and patients experience dangerous delays in needed treatments while waiting for approvals.

The regulatory environment is finally catching up to this disaster, with CMS requiring payers to implement FHIR-based prior authorization APIs by early 2027. This creates a window where infrastructure companies that can help payers build compliant APIs and help physician offices integrate with those APIs will capture significant value. The window closes once the infrastructure becomes commoditized, but 2026 represents the peak opportunity for building and selling these tools.

Multiple investor theses highlight this opportunity more or less directly. Bessen specifically calls out prior authorization infrastructure as a key need. A16z discusses healthcare data interoperability challenges. PitchBook notes that regulatory requirements are creating technology opportunities. These predictions all recognize that prior auth is broken and that regulatory mandates will force change, creating monetization opportunities for companies that can deliver the required infrastructure.

The business model involves selling to both sides of the transaction. On the payer side, build the API infrastructure and workflow tools that allow them to comply with regulatory requirements while maintaining some level of medical necessity review. On the provider side, build integration tools that connect EHRs to payer APIs and automate as much of the prior auth workflow as possible. Both sides have an acute term need and clear budget to solve the problem.

The technical requirements include building FHIR-compliant APIs that meet regulatory specifications, creating workflow engines that can route prior auth requests through payer review processes, and building integration tools that connect to major EHRs and can submit requests programmatically rather than manually.

hard part involves not just the technical infrastructure but also encoding the necessary criteria that different payers use for different services so that the system provide instant decisions for straightforward cases and route complex cases to human reviewers.

Go-to-market should focus on regional payers and physician groups that are sophisticated enough to see the regulatory deadline approaching but small enough that they cannot build this infrastructure in-house. National payers and large health systems will try to build their own solutions or will buy from established vendors. Regional players need outside help and will move faster. Build case studies showing faster prior authorization turnaround times and reduced administrative burden. Scale to more customers once the product is proven in smaller markets.

## **Ambient Documentation for Specialty Practices**

Ambient documentation using AI to transcribe and structure clinical notes from natural conversation has proven valuable in primary care settings. Multiple companies have demonstrated that the technology works and that physicians like using it because it reduces documentation time and improves note quality. The next frontier involves adapting this technology for specialty practices where the documentation requirements are more complex and domain-specific.

Specialists face different documentation challenges than primary care physicians: an orthopedic surgeon needs detailed musculoskeletal exam documentation with specific measurements and descriptions. A cardiologist needs to capture complex rhythm findings and echo results. A psychiatrist needs to document mental status exams and treatment planning. The generic ambient documentation tools built for primary care do not handle these specialty-specific requirements well.

The opportunity for 2026 involves building ambient documentation tools specifically designed for high-volume specialties with complex documentation needs. Not trying to be all things to all specialties, but rather going deep in specific domains where

documentation burden is highest and where physicians will pay meaningful money for tools that understand their specific workflow.

Several predictions touch on this opportunity. Bessemer says ambient documentation will become table stakes, which implies that differentiation will come from specific features. Seven Wire predicts that AI tools will penetrate deeper into clinical workflow. A16z discusses AI agents that can handle domain-specific tasks. These theses recognize that ambient documentation is proven but that there is room for specialized solutions that go beyond what the current general-purpose tools provide.

The business model involves direct sales to specialty practices and ambulatory surgery centers. These organizations have clear pain around documentation burden, they have a budget to solve it, and they can move quickly without the lengthy procurement processes that plague health system sales. Pricing should be per provider per month with clear ROI based on time savings and improved documentation quality leading to better coding capture.

The technical requirements involve not just transcription and note generation but also domain-specific medical language understanding. An orthopedic tool needs to recognize and correctly capture range of motion measurements, strength testing results, and physical exam findings using the correct terminology and format. This requires training models on specialty-specific clinical notes and building templates and structured data capture that matches how specialists actually practice.

Initial go-to-market should focus on a single high-volume specialty. Orthopedics represents a strong candidate because the documentation burden is high, the procedures are often elective so providers have more flexibility to try new tools, there are clear industry groups and conferences where the product can be marketed. Build a tool that orthopedic surgeons love and that demonstrably saves them 30 minutes per clinic session. Get strong references and case studies. Expand to other specialties once product-market fit is proven.

## **Patient Acquisition and Conversion for Elective Procedures**

Elective procedure volumes have recovered from pandemic lows but patient acquisition costs have increased substantially as more providers compete for the patient pool and as traditional marketing channels become more expensive. Orthopedic surgery, bariatric surgery, cosmetic procedures, fertility treatment, and other elective services all face similar challenges around finding patients who are candidates and converting them from initial inquiry to scheduled procedure.

The patient journey for elective procedures is complex. Potential patients typically research online, may contact multiple providers, have questions about costs and insurance coverage, want to see before-and-after results or success rates, and often take months to make decisions. Providers struggle to manage this long sales cycle with limited marketing sophistication and without good tools for lead nurturing and conversion optimization.

The opportunity for 2026 involves building patient acquisition and conversion platforms specifically designed for high-value elective procedures. This means tools that help providers generate qualified leads, nurture those leads through education and engagement, handle pricing transparency and insurance verification, and convert inquiries into scheduled procedures at higher rates than current manual processes can achieve.

Several investor predictions point toward this opportunity indirectly. Hospitalogix discusses how healthcare will need to adopt consumer marketing approaches. MedCity News talks about the importance of patient experience and convenience. The Hill highlights how transparency requirements will force better price communication. These observations all suggest that providers need better patient acquisition and conversion tools, but nobody quite spells out the specific company that should emerge.

The business model involves performance-based pricing where providers pay per booked procedure or per patient converted. This aligns incentives perfectly and removes the risk from provider investment. The platform generates leads through paid marketing, organic search, or partnerships with referring physicians. It nurtures leads through automated communication and education. It handles insurance verification and price quotes. It optimizes conversion using data about what

messaging and touchpoints work best. It takes a fee only when a patient actually schedules.

The technical requirements include lead generation and management tools, marketing automation for email and text campaigns, insurance verification APIs, price transparency calculators, conversion optimization using machine learning to identify high-intent leads and best outreach strategies, and integration with practice management systems for scheduling. The key involves building a full-funnel solution rather than just solving one piece of the patient acquisition puzzle.

Initial go-to-market should focus on a single procedure category with high margin and clear patient acquisition challenges. Bariatric surgery represents a strong candidate because the procedures are expensive, patients are highly motivated but take time to decide, and current conversion rates are low. Build a platform that demonstrably increases booked procedures for bariatric surgery practices. Get clinical studies showing 30 to 50 percent improvement in conversion rates. Expand to other elective procedure categories once the model is proven.

## **Care Navigation for Medicare Advantage Plans**

Medicare Advantage plans are facing margin compression as medical costs rise faster than premium growth and as Star ratings become increasingly important for enrollment. Plans need to keep members healthy and out of the hospital while also ensuring they access preventive care and complete health risk assessments.

Traditional care management approaches using nurse call centers are expensive and not particularly effective at engaging members.

The opportunity for 2026 involves building care navigation platforms that help Medicare Advantage plans proactively engage members, close care gaps, coordinate specialists and services, and prevent unnecessary utilization. This needs to be lower cost than traditional nurse-staffed models while achieving better engagement and outcomes.

Multiple predictions highlight aspects of this opportunity. Deloitte discusses the need for better population health management tools. PitchBook notes that MA plans are under pressure to improve efficiency. Seven Wire predicts that AI will enable more scalable care coordination. These theses recognize that MA plans need better care management tools but do not quite articulate the specific product that should exist.

The business model involves selling directly to MA plans on a per-member-per-month basis with performance guarantees around quality measures and utilization reduction. Plans have clear budget for care management and they have acute near-term need to improve Star ratings and reduce medical loss ratios. A platform that demonstrably moves quality metrics while costing less than traditional care management will get adopted quickly.

The technical components include risk stratification to identify members who need outreach, omnichannel engagement using text, email, and phone to reach members where they are, care gap identification and closure tracking, specialist and service coordination, and analytics showing impact on quality measures and utilization. The platform needs to combine AI-driven automation for routine tasks with human care coordinators for complex situations.

Go-to-market should focus on regional MA plans that are too small to build sophisticated care management programs in-house but large enough to have a meaningful budget. These plans are fighting to maintain enrollment against national competitors and they need every advantage on Star ratings and member satisfaction. Build case studies showing improvements in specific HEDIS measures and reduction in avoidable ER visits. Expand to larger plans once the product is proven.

## **AI-Powered Medical Coding Compliance**

Medical coding audits are intensifying as payers and CMS crack down on upcoding and documentation deficiencies. Health systems face significant financial risk from coding errors, both from having to pay back overpayments and from penalties for patterns of non-compliance. At the same time, coding guidelines continue to evolve with new diagnosis and procedure codes being added regularly.

Human coders struggle to keep up with the volume of charts that need coding as with the complexity of current guidelines. They make errors, sometimes coding aggressively and sometimes leaving money on the table by coding too conservatively. Quality assurance processes catch some errors but not all of them, and the QA is expensive and slow.

The opportunity for 2026 involves building AI-powered coding tools that both suggest appropriate codes based on clinical documentation and validate codes assigned by human coders to identify compliance risks before claims are submitted. This is not fully automated coding replacing humans, but rather augmentation and QA that improves accuracy and reduces risk.

Several investor theses touch on this space. A16z discusses AI tools for administrative automation in healthcare. Bessemer highlights the need for better revenue cycle. PitchBook notes that regulatory compliance is creating technology opportunities. These predictions recognize that coding remains a bottleneck and risk area but do not specifically call out the AI coding compliance opportunity.

The business model involves selling to health systems and large physician groups a revenue cycle tool that reduces coding errors and compliance risk. Pricing could be based on number of charts processed or could be tied to value delivered through avoided denials and prevented audit penalties. The ROI calculation is straightforward when the alternative is expensive human QA and the risk of six-figure audit recaptures.

The technical requirements include natural language processing to extract relevant clinical information from documentation, coding logic that applies ICD-10, CPT, and HCPCS guidelines to suggest appropriate codes, validation algorithms that identify potential coding errors or compliance risks, and integration with EHRs and coding software so the tool fits into existing workflow. The hard part involves building models that understand nuanced clinical documentation and can apply complex coding rules with high accuracy.

Initial go-to-market should focus on specific specialties or service lines with high coding complexity and frequent audit issues. Inpatient hospital coding represents a strong candidate because the charts are complex, the financial stakes are high, and audit risk is substantial. Build a tool that demonstrably reduces coding errors and compliance flags for inpatient cases. Get strong references from early customers. Expand to other service lines and settings once product-market fit is proven.

## **Longitudinal Behavioral Health Care Coordination**

Behavioral health care is notoriously fragmented, with patients cycling through services, therapists, psychiatrists, and primary care without good coordination between providers. No-show rates for psychiatry appointments run 25 to 30 percent. Medication adherence is poor. Care plans made in inpatient psychiatric settings are not followed in outpatient settings. The result is high costs from preventable crises and poor outcomes for patients who do not get consistent ongoing care.

The opportunity for 2026 involves building longitudinal care coordination platforms specifically for behavioral health. This means tools that track patients across settings and providers, ensure care plans get communicated and followed, monitor for early warning signs of decompensation, and facilitate intervention before crises happen.

Multiple predictions point toward behavioral health as a priority area. Deloitte discusses mental health access challenges. MedCity News highlights the need for better behavioral health tools. Chief Healthcare Executive notes that AI will help with care coordination. These theses recognize that behavioral health is broken but do not quite articulate the specific care coordination solution that should exist.

The business model involves selling to behavioral health organizations, health plans with behavioral health risk, and accountable care entities trying to manage total cost of care. All of these stakeholders have financial incentive to reduce crisis utilization and improve outcomes. Pricing should be per patient per month with performance metrics around reduced inpatient days and improved engagement.

The technical components include longitudinal patient tracking across multiple providers and settings, care plan sharing and monitoring, patient engagement tools for medication reminders and symptom tracking, risk algorithms that identify patients at high risk of crisis, and intervention workflows that trigger outreach when warning signs appear. The platform needs to be simple enough that it does not create an administrative burden for already-overwhelmed behavioral health providers.

Go-to-market should focus on behavioral health organizations that are taking risk contracts or that are part of larger integrated systems where they face pressure to reduce costs. Build a platform that demonstrably reduces psychiatric hospitalizations and ER visits for enrolled patients. Get case studies showing ROI through avoided crisis costs. Scale to payers and ACOs once the product is proven in provider settings.

## **Workforce Optimization for Nurse Practitioners and Physician Assistants**

Healthcare workforce shortages continue to worsen, particularly for physicians in primary care and many specialties. Nurse practitioners and physician assistants are being deployed to fill gaps, often practicing at top of license or even beyond their training in under-resourced settings. These clinicians need support tools that help them handle clinical complexity safely and that optimize their workflow so they can see more patients without burning out.

The opportunity for 2026 involves building workforce optimization platforms specifically designed for NPs and PAs. This includes clinical decision support tailored to their scope of practice, workflow tools that reduce administrative burden, and supervision and collaboration features that connect them with supervising physicians when needed for complex cases.

Several predictions touch on workforce challenges. Sequoia discusses the need to make expensive workers more productive. Deloitte highlights workforce shortage as a persistent problem. A16z talks about AI augmentation for healthcare workers. These theses recognize that workforce constraints are limiting healthcare delivery but do not specifically articulate the NP and PA optimization opportunity.

The business model involves selling to health systems and large physician groups that are increasingly relying on NPs and PAs to deliver care. These organizations have clear pain around workforce productivity and quality. A platform that helps NPs and PAs see more patients safely while reducing physician supervision time becomes valuable quickly. Pricing should be per clinician per month with ROI based on increased patient throughput.

The technical requirements include clinical decision support that understands NP and PA scope of practice variations across states, workflow tools that automate routine documentation and ordering tasks, supervision features that facilitate synchronous and asynchronous collaboration with physicians, and analytics showing productivity and quality metrics. The platform needs to be simple and fast so it does not slow clinicians down.

Initial go-to-market should focus on primary care settings in health systems that are expanding NP and PA roles due to physician shortages. Build a platform that demonstrably increases patient visits per day for NPs and PAs while maintaining quality measures. Get references from early customers. Expand to specialty settings once the model is proven in primary care.

## **Why These Ten and Not Others**

Reasonable people could construct different lists of high-priority healthcare opportunities for 2026. Virtual care platforms, health equity tools, social determinants screening and intervention, genomics integration, supply chain optimization, credentialing and licensing automation, and many other areas all represent legitimate unmet needs. The ten opportunities outlined above got selected based on several criteria that distinguish them from other possibilities.

First, each opportunity has a clear buyer with acute near-term pain and budget to solve the problem. This eliminates many conceptually interesting opportunities that lack obvious business models or that depend on hypothetical future payment model changes. Revenue cycle automation sells to CFOs dealing with cash flow problems right now. Prior authorization infrastructure sells to payers facing regulatory

deadlines. Patient acquisition tools sell to elective procedure providers watching marketing costs rise. Each company has an obvious customer who will pay mean money quickly.

Second, each opportunity is validated by current market behavior rather than requiring the world to change. Specialty pharmacy volumes are growing rapidly. Malpractice costs are rising today. MA plans are facing margin pressure today. Physicians are spending hours on documentation today. The companies being proposed would succeed in the current environment rather than betting on future transformation.

Third, each opportunity is specific enough to be built and sold as a focused product rather than requiring a platform that does everything for everyone. This matters enormously for startups that need to find product-market fit quickly and scale efficiently. Building ambient documentation for orthopedists is a concrete product with clear scope. Building general-purpose clinical decision support for all of medicine is an impossible task. The opportunities outlined above are all narrow enough to be tractable while being large enough to support venture-scale business.

Fourth, each opportunity leverages AI or automation in ways that are proven today rather than depending on breakthroughs that may or may not happen. Natural language processing for extracting information from clinical notes works now. Computer vision for analyzing medical images works now. Workflow automation using APIs works now. The companies being proposed would use current technology rather than betting on AGI or other hypothetical capabilities.

Fifth, each opportunity exists in a space where incumbent solutions are genuine and where there is room for new entrants to take share. Revenue cycle vendors are slow and expensive. Coding QA is mostly manual. Care coordination for behavioral health barely exists. Prior authorization is a disaster. Patients hate the experience navigating elective procedures. These are not markets where companies need to convince people that a problem exists. The problem is obvious and acute. The challenge involves building a solution that actually works.

Sixth, each opportunity has reasonable answers to the typical objections that kill healthcare startups. Provider time and attention is limited, which kills tools that require behavior change or heavy workflow disruption. Most of these opportunities either save clinician time or happen in back-office functions that do not require provider engagement. Data access is hard, but APIs and interoperability requirements are improving and most of these opportunities can work with data that is already accessible. Sales cycles are long, but most of these opportunities have clear ROI and can demonstrate value quickly. Regulations are complicated, but most of these opportunities work within current regulatory constraints rather than requiring regulatory change.

The common thread running through all ten opportunities involves solving acute operational problems for healthcare organizations under financial pressure. Healthcare systems need to capture more revenue, reduce costs, see more patients, and avoid compliance risks. Payers need to manage costs while improving quality. Specialty pharmacies need to scale operations. Physicians need to spend less time on administration and reduce liability exposure. These are not nice-to-have improvements, they are existential challenges that organizations must address to survive.

## **What Does Not Need Building**

Just as important as identifying what should be built involves recognizing what should not be built. Several categories of healthcare companies continue to attract investment despite having fundamental problems that make success unlikely. Avoiding these traps matters as much as picking the right opportunities.

General-purpose virtual care platforms do not need more entrants. The market for winners in telemedicine and the business model has proven challenging as reimbursement normalizes post-pandemic. Companies still trying to build undifferentiated telehealth solutions will struggle to find traction. The opportunity for virtual care involves specialty-specific or condition-specific applications where virtual delivery offers clear advantages, not general-purpose consults.

Health equity screening and intervention tools remain conceptually important but have struggled to demonstrate ROI that justifies the investment required. Healthcare systems care about equity but face acute financial pressure that forces prioritization of tools with clearer financial return. Unless equity tools can demonstrate reduced costs through better population health management, they will remain difficult to scale at meaningful scale.

Consumer-directed healthcare apps that depend on behavior change generally fail because behavior change is hard and most people will not sustain engagement with health apps beyond initial novelty. The exceptions involve apps that solve acute problems like medication reminders or that connect to high-stakes situations like diabetes management. Generic wellness apps and health tracking tools without clinical integration have proven to have limited staying power.

Platform plays that try to connect all stakeholders in healthcare face chicken-and-egg problems where value only emerges after achieving critical mass on multiple sides of the market. Two-sided and three-sided marketplaces are extremely difficult to build in healthcare where stakeholders have limited incentive to share data and where network effects are weak. Most healthcare platform companies end up picking one side to focus on and becoming point solutions.

Clinical trial matching and recruitment companies continue to struggle with the fundamental problem that clinical trials are not designed for easy patient matching and that most patients do not want to participate in trials even when matched. The market opportunity is real but the operational challenges of actually enrolling patients are severe enough that most companies in this space either pivot or fail.

Digital therapeutics without clear reimbursement pathways face existential challenges as payers and employers prove unwilling to pay for these tools at scale. The clinical evidence may be strong but the business model does not work without someone willing to pay ongoing subscription fees. Companies in this category either need to find pharmaceutical partners who will bundle DTx with drugs or they need to pivot to tools that clinicians will adopt independent of reimbursement.

Remote patient monitoring for general populations has proven to generate lots of data that nobody knows what to do with. The costs of providing devices and monitoring alerts typically exceeds the savings from prevented hospitalizations except in very specific high-risk populations. RPM works for certain conditions like heart failure in recently hospitalized patients, but general-purpose RPM for broad populations is a poor economics.

Healthcare social networks and community platforms struggle with engagement and monetization. Patients do not want Facebook for their diabetes and physicians do not want LinkedIn for medical professionals. The attempts to build these types of platforms have mostly failed because the value proposition is weak compared to existing general-purpose social networks and because healthcare is not inherently social in ways that support network effects.

Administrative burden reduction tools that require physicians to change workflow generally get rejected no matter how good the underlying technology is. Physicians are busy, resistant to change, and skeptical of new tools that promise to save time but actually create new work during adoption. The successful administrative burden reduction tools are the ones that work in the background without requiring behavior change, like ambient documentation. Tools that require physicians to interact with new interfaces or complete new steps will struggle.

## **What Actually Matters for Success**

Identifying the right opportunity represents only the first step. Execution matters enormously and most healthcare startups fail because of execution problems rather than picking the wrong market. Several factors distinguish companies that successfully build and scale from those that struggle.

Getting to fast time to value separates winners from losers. Healthcare buyers are skeptical and they need to see concrete results quickly. A 90-day pilot that demonstrates clear ROI will close deals. An 18-month implementation that requires extensive integration and workflow changes will die in procurement. The compa

that win are the ones that can show up, plug in, and deliver value within weeks rather than months.

Building for the buyer not the user matters when those are different people. Physicians are often users but they do not control budget. Administrators and executives make purchase decisions based on financial impact even if that means forcing tools on reluctant physicians. Understanding this dynamic and building products that deliver executive-level ROI while being tolerable for physician use is critical. The best products deliver value to both but when forced to choose, optimizing for the buyer wins.

Obsessive focus on narrow use cases beats trying to do everything. Healthcare is complex for startups to succeed with broad platforms. Pick one specific problem, make the solution excellent, get references and case studies, then expand. Companies that try to build horizontally from day one end up with mediocre products that can't solve any problem well enough to win deals.

Understanding the actual sales process and budget cycles prevents many startups from running out of money before they can scale revenue. Healthcare sales take longer than founders expect. Budget approval processes are opaque and political. Getting contracts signed does not mean getting implementations started or getting paid. Companies that plan for 18 to 24 month sales cycles and that maintain sufficient runway to survive multiple budget cycles have much better odds of success.

Building change management and implementation services into the business model rather than treating them as someone else's problem makes the difference between tools that get adopted and tools that get shelved. Healthcare organizations are not good at implementing new technology. They need help with workflow design, training, change management, and ongoing optimization. Companies that build these services into their offerings and price accordingly succeed at higher rates than companies that just ship software and expect customers to figure out implementation.

Regulation and compliance cannot be afterthoughts. Healthcare is heavily regulated and buyers will not take risks on companies that seem uncertain about compliance.

Understanding HIPAA, state licensing requirements, FDA oversight where relevant, payer contracting rules, and other regulatory constraints from the beginning prevents expensive pivots later. Building compliance expertise into the team and making it a part of the product development process matters.

## **The Path Forward**

Healthcare in 2026 offers genuine opportunities for new companies despite the challenges and failures of many previous attempts at innovation. The difference between success and failure comes down to picking specific operational problems where organizations have acute near-term pain, building solutions that deliver measurable value quickly, and executing through the difficult sales and implementation processes that characterize healthcare.

The ten opportunities outlined above represent areas where smart teams with good execution can build valuable companies. None of them are easy. All of them require deep healthcare expertise, sophisticated technical capabilities, and strong commercial execution. But they are all solvable with current technology and they all have clear paths to revenue and scale.

The broader lesson involves recognizing that healthcare innovation succeeds when it solves acute operational problems rather than pursuing transformational visions. The companies that will define healthcare in ten years are probably being started in 2024 by teams focused on narrow workflow problems and demonstrable ROI rather than by teams pitching grand platform visions. Betting on the former makes a lot more sense than betting on the latter.



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