

DEAL-MAKING

AI Resets Healthcare Software by Exposing the Cost of Standardization

Why Health SaaS Repricing Is a Call to Transact, Not a Verdict

By David Feygin and Oded Ben-Joseph, Outcome Capital

Healthcare software has lost roughly \$100 billion of equity value in twelve months, and it has lost it while beating earnings. That is not a judgment on execution. It is the market repricing the terminal value of a delivery model - the one-size-fits-all package, lightly configured, priced by the seat - at the precise moment agentic AI makes institution-specific software economical for the first time. The value released by that shift is larger than the value destroyed. Capturing this value will require transactions and overcoming the cognitive biases of buyers and sellers that routinely derail life sciences M&A - now intensified by the unprecedented transformation, growth and hype of Health AI.

THE ARGUMENT IN BRIEF

Public healthcare software companies are being marked down based on business-model terminal value risk, not operating performance. Profitable, growing, category-leading companies reported good quarters through the first half of 2026 and sold off anyway.

The cause is structural. For thirty years, packaged software asked customers to adopt the vendor's process model in exchange for scale economics. Regulated healthcare paid the incremental costs of standardization in configuration expense, abandoned differentiation, residual manual labor and continued dependence and support. We call it the hidden cost of standardization. Agentic AI grounded in an institution's own operating logic makes this cost uniquely avoidable in healthcare because regulators already require organizations to codify the knowledge needed to make AI beneficial.

So what? AI value delivery models, the required talent & technical capabilities, different customer engagement processes, and customer relationships will be fundamentally different from what healthcare software incumbents do today. For incumbents, this is a classic case of Clay Christensen's Innovator's Dilemma – where the change is too disruptive to incumbent's business model for them to be able to address the coming inevitable disruption.

Therefore, incumbents are unlikely to successfully respond organically and will need to rely on inorganic approaches – acquisitions, mergers and strategic investments. Assembling the required future-proof capabilities inorganically from the plethora of AI companies is the higher-probability path to success – for both strategic buyers and Private Equity. The firms that treat this as a portfolio question rather than a single acquisition will be the ones that successfully navigate disruption.

I. A repricing, not a verdict

Since the iShares Expanded Tech-Software ETF peaked on 19 September 2025, it has fallen roughly 30%, while¹ broad technology indices were approximately flat and semiconductors rose. Between mid-January and mid-February 2026 alone, around one trillion dollars came out of software equities, and the S&P North American Software Index posted its worst monthly decline since 2008. In a single 48-hour window in early February, roughly \$300 billion evaporated. A Jefferies equity trader gave the episode the name that stuck – *SaaS-pocalypse*². By early 2026, software's forward earnings multiple had compressed to roughly 22.7x³ - below the S&P 500 for the first time in the history of the asset class.

Healthcare software fared worse than software generally. PitchBook's healthtech⁴ universe showed provider operations and revenue cycle names down a mean 29.2% in the first quarter, benefit management and care navigation down 33.6%, and electronic health records and clinical information platforms down 24.3%, against an S&P 500 that fell 4.6%. By the second quarter the pattern had hardened: Definitive Healthcare down 71% year to date, Doximity down 53.2%, Waystar down 37.3% - and, in PitchBook's own characterization, *all of them reported solid quarters and sold off anyway*.

Consider the cleanest case in the sector. Veeva Systems⁵ holds roughly 80% share of life sciences vertical software, grew revenue 16% to \$3.20 billion in fiscal 2026, carries gross margins above 75%, and holds net cash equal to roughly a fifth of its market capitalization. It is, by any conventional screen, the highest-quality vertical SaaS asset in healthcare. Its shares closed at \$290.41 on 25 July 2025, valuing the company at \$47.5 billion. Eleven months later, on 23 June 2026, they closed at \$159.71 - a market capitalization of \$25.9 billion, and a 43% decline over 52 weeks. Nothing broke, yet roughly \$21 billion of equity value was erased.

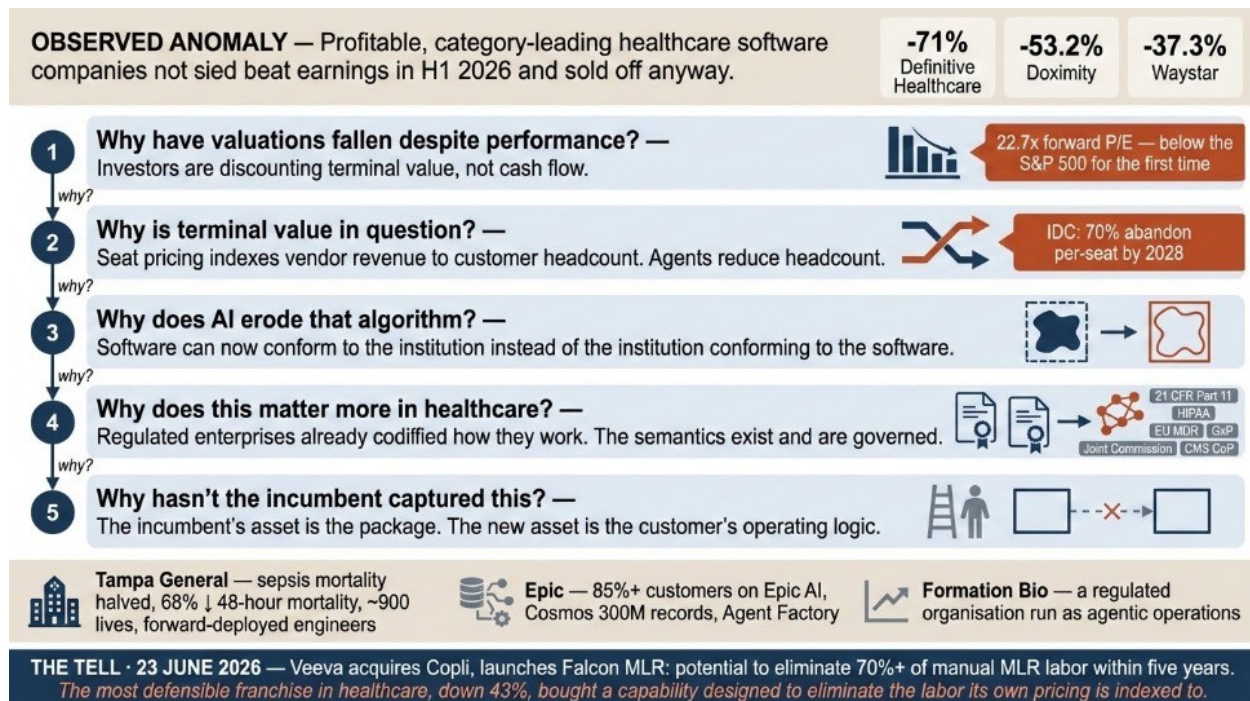
Doximity delivered record 55% adjusted EBITDA⁶ margins on 20% revenue growth and fell 47.4% in a single quarter. Phreesia is down roughly two-thirds over twelve months.

Sizing it. Outcome Capital estimates that the public healthcare software and healthtech universe carried approximately \$255 billion of aggregate market capitalization at the September 2025 peak. Applying observed segment- and company-level declines produces a weighted decline near 29% and roughly **\$75 billion of public equity value erased**. Sponsor-held healthcare vertical software - Athenahealth, Ensemble, Zelis, Cotiviti, WellSky, ModMed, Symplr, HealthEdge, Availity and their peers - represents another \$120 billion or so of enterprise value carried at marks that have not yet met the public tape. A 15% to 35% mark-to-public adjustment adds \$18 billion to \$42 billion of unrealized exposure. Call the total **\$100 billion to \$120 billion**.

When companies that beat estimates are sold, investors are not revising their view of management. They are revising the discount rate and terminal value on a go-forward business model. The market has decided that selling more seats of more standardized modules is no longer a durable growth engine, and pricing accordingly. This repricing is a structural, actionable signal.

II. Five Whys: The root of what the market is pricing

Boards asked to respond to a share-price decline reach reflexively for buybacks, cost discipline, and an AI slide. More useful, is identifying the root cause – which is something you can transact against.



Why have healthcare software valuations fallen despite operating performance? Because investors are discounting terminal value rather than current cash flow. A forward multiple below the market for a sector with 75% gross margins demonstrates doubt about whether, and how long, those earnings compound.

Why is terminal value in question? Because the growth algorithm - more seats, more modules, more configuration - is the part of the model AI erodes first. Seat-based pricing indexes vendor revenue to customer headcount. Agents reduce customer headcount. The vendor's revenue growth and the customer's efficiency gain now point in opposite directions, and CFOs see it.

Why does AI erode that growth algorithm specifically? Because the historical bargain of packaged software has been broken. For three decades the deal was: adopt our standard process model and receive scale economics you could never build yourself. Customization existed, but it was expensive, brittle, and punished at every upgrade. That trade-off was real and accepting it was rational. It is no longer the only option. *Building software that conforms to a specific institution's logic - rather than forcing the institution to conform to the software - has moved from prohibitive to routine.*

Why does this matter more in healthcare than in other verticals? Regulated enterprises have already codified how they work. 21 CFR Part 11, HIPAA, EU MDR, GxP, Joint Commission standards, CMS conditions of participation, credentialing requirements, and validated-system documentation have compelled healthcare organizations to write down their processes, controls, decision rights, and exception paths in auditable form - for decades, under penalty. That corpus is not compliance overhead in an agentic world. It is the grounding layer that drives reliable Agentic AI. *The industry that has been slowest to adopt AI turns out to hold the best-prepared substrate for deploying it, because the reliable semantics already exist and are already governed.*

Why hasn't the incumbent captured this already? Because the incumbent's asset is the standard package, and the new asset is the customer's unique operating logic. Those are different

assets. They are built by different people, sold on different terms, delivered through a different model, and carry a different margin structure. An organization optimized to implement its own software is not, by adjustment, an organization that encodes someone else's.

The destination is real despite execution risk. Skeptics are right that most AI claims in healthcare are unproven, but multiple proof points exist.

Tampa General Hospital rebuilt its care coordination infrastructure on an ontology layer that, in the health system's own description, unifies disparate data into a coherent semantic model connecting care management, nursing, imaging, providers, and rapid response teams. The published results include a halving of overall sepsis mortality, a 68% reduction in 48-hour mortality, roughly 900 lives attributed to the sepsis application as of June 2026, an 83% reduction in patient placement time, a 30% improvement in MRI turnaround, and a 28% decrease in post-anesthesia care unit holds. Two details are critical. First, the work was delivered by forward-deployed engineers embedded with frontline clinicians, co-designing workflows inside the customer's environment. Second, the health system's stated reason for the project was that the incumbent technology vendor could not keep pace with the dynamics of its environment.

Epic is executing the same thesis from inside the incumbency and is a key competitor. More than 85% of Epic customers now use some form of Epic AI. Its Cosmos medical event transformer is trained on approximately 300 million patient records and 16 billion medical events. Most consequentially, Epic previewed Agent Factory - a visual builder that lets health systems create, govern, and deploy custom agents inside the Epic environment, equipped with local policies and knowledge bases. Epic is making a claim on the semantic layer of American healthcare, and they already hold the data.

Formation Bio's move into later stage drug development workflows further validates the model. Biotech and pharma companies have codified SOPs, quality systems, best practices and governance documents that are consistent, pressure tested and written for validation. This knowledge base automatically becomes the grounding for high impact Agentic AI. Formation is betting that there is as-much, if not more, value in later stage drug development AI, than in discovery.

On 23 June 2026, Veeva acquired Copli and launched Veeva Falcon MLR - an agentic medical, legal and regulatory review solution the company says has the potential to eliminate 70% or more of manual MLR labor within five years. *The most defensible vertical software franchise in healthcare, having lost 43% of its market value to AI-disruption fear, responded by buying an agentic capability designed to eliminate the labor its own pricing has historically been indexed to.*

BOX 1 | THE COST OF STANDARDIZATION: SIZING THE EXPANDING PIE

The published baseline. Sahni, Stein, Zimmel and Cutler, writing for NBER, estimated that wider AI adoption could reduce US healthcare spending by 5% to 10% - \$200 billion to \$360 billion annually in 2019 dollars - from use cases attainable within five years with then-current technology, without sacrificing quality or access. Rescaled to a national health expenditure now running near \$5.3 trillion, the same band implies **\$265 billion to \$530 billion annually.**

What that baseline does not isolate. Those estimates were built largely on standardizable processes. They do not separate the value packaged software can reach from the value it structurally

cannot. That separation is the analytically interesting question, because it determines which vendors capture the gain.

Outcome Capital's estimate. US healthcare administrative spend runs approximately \$1.05 trillion, of which roughly 72% - about \$756 billion - is labor, including outsourced and contracted labor. We segment that base by whether packaged software can address it:

Work bucket	Labor base	Penetration by 2031	Labor displaced	Value released
Standardizable, transaction-volume work - claims submission, scheduling, eligibility, posting	\$265B	55%	45%	\$66B / yr
Institution-specific process work - denials strategy, coding judgment, care coordination, VBC contract administration, exception handling	\$340B	40%	40%	\$54B / yr
Regulated evidence and control work - GxP documentation, audit trails, MLR review, quality and safety attestation, credentialing	\$151B	35%	50%	\$26B / yr
US healthcare administrative total	\$756B			\$146B / yr

Of the \$146 billion released annually, \$66 billion is reachable by standardized software. **\$80 billion - 55% of the total - is reachable only by systems built to a specific institution's logic.** That \$80 billion is the standardization tax: the annual cost of forcing organizations to conform to someone else's process model. It has never been priced, because until now there was no alternative to paying it.

Life sciences carries the same tax. Applied to global biopharma R&D (\$300B), clinical development and trial operations (\$130B), commercial and medical affairs including MLR (\$180B), and quality, regulatory and pharmacovigilance (\$75B), at addressable shares of 30–35% and efficiency gains of 35–50%, we estimate a further **\$86 billion per year.** Veeva's own Falcon MLR claim sits inside this pool.

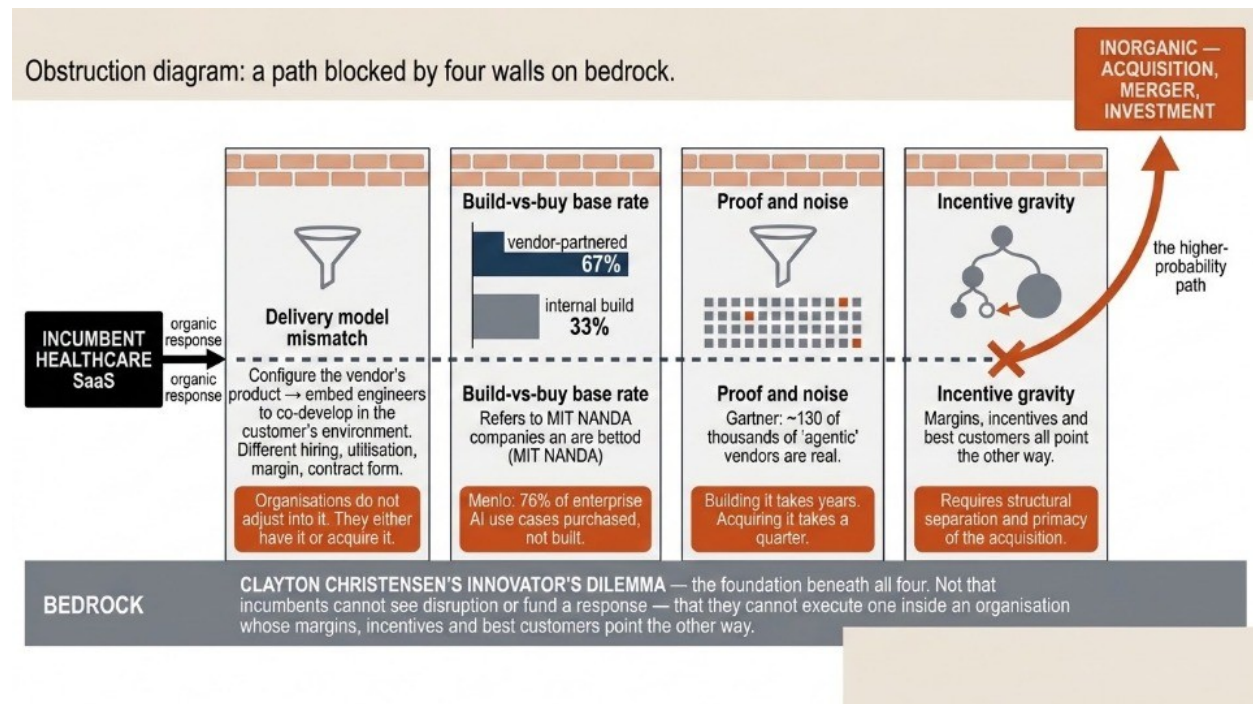
The pool, and the capture. Roughly **\$230 billion per year** of releasable value across US healthcare administration and global life sciences operations. Vertical software has historically captured 2% to 5% of the value it enables, because seat-based pricing is decoupled from outcome. Agentic delivery supports higher capture, because pricing attaches to work performed rather than seats occupied. At a 10% capture rate, that is **\$23 billion of annual vendor revenue** - roughly half again the current healthcare vertical software revenue base - supporting **\$185 billion to \$230 billion of enterprise value** at 8x to 10x revenue.

The asymmetry. Approximately \$100 billion of healthcare software equity value has been erased. Roughly twice that much new enterprise value is available to whoever assembles the capability to capture it. The pie is expanding and a new wave of Health AI is poised to capture it.

Method note: assumptions are stated so that they can be argued with. Sensitivity is roughly linear in penetration and displacement; halving each assumption halves the pool and does not change the direction of the conclusion.

III. Call to Transact: Why organic responses are likely to fail

AI value delivery models, the required talent & technical capabilities, customer engagement processes, and customer relationships are fundamentally different from what healthcare software incumbents do today. For incumbents, this is a classic case of Clayton Christensen's Innovator's Dilemma – where the change to incumbent's business model is too incompatible for them to be able to address the inevitable disruption.



The delivery model is different, and delivery is the job. Incumbent professional services organizations are built to configure the vendor's product against a reference implementation. The emerging model sends engineers into the customer's environment to co-develop workflows specific to that customer, maintaining differentiation and simplifying roll-out, which then improves with use. Rock Health identifies forward-deployed engineering as a defining go-to-market shift, with Commure and Qualified Health making it core to their model. This is a different hiring profile, a different utilization and margin structure, a different contract form, and a different definition of what finished means.

The build-versus-buy base rate is unambiguous, and it applies to vendors too. MIT's NANDA study of enterprise AI deployment found that vendor-partnered implementations reached production roughly 67% of the time, against roughly 33% for internally built tools - a two-to-one gap. Menlo Ventures found that 76% of enterprise AI use cases were purchased rather than built in 2025, up from 53% a year earlier. A SaaS company building an agentic platform internally is making the same bet, with the same odds, as its customers.

Proof points and noise are the key constraints, and both are bought faster than built. Gartner estimates that of the thousands of vendors marketing agentic capability, only about 130 are

real, and describes the remainder as agent washing. In that environment, health system and pharma buyers ration attention toward vendors with published outcomes, reference logos, and standards credibility. Building that from a standing start takes years. Acquiring it takes a quarter.

Clay Christensen's argument is about the limitations of organizational and business structure, not a lack of vision or understanding. The claim is not that incumbents cannot see disruption or cannot fund a response. It is that they cannot execute one inside an organization whose margins, incentives, and best customers all point the other way. This is an argument for acquisition with sufficient structural separation and primacy of the acquisition. Arguably, this is a harder integration mandate, but existentially necessary.

The counter-argument. Inorganic strategic mandates do not guarantee acquisition and post-merger success. Gartner projects that more than 40% of agentic AI projects will be cancelled by the end of 2027 on escalating costs, unclear business value, or inadequate risk controls. MIT found that 95% of generative AI pilots delivered no measurable P&L return. RAND puts overall AI project failure near 80%, roughly double conventional IT.

However, the causes of failure point to non-customized execution, rather than inherent inadequacies. MIT's failing category was not AI generically. It was systems that do not retain feedback, do not adapt to context, and do not improve with use - tools that require the same manual context every time and never learn the institution. The successful programs, by contrast, included process-specific customization and judged vendors on business outcomes rather than software benchmarks.

Which means the diligence question for acquirers is not whether a target has AI capabilities. It is whether the company is structured as a true AI-Native and positioned for advantage; do their solutions incorporate institution-specific knowledge and structuring, learning and feedback systems, and natural ownership of the learned artifact (grounded ontologies, functional workflows, best-practices, etc.) when contracts end.

IV. What buyers are actually purchasing

Theses are cheap, but the transaction record is clear.

Outcome Capital's landscape assessment of AI-healthcare transactions across the United States and Europe for the twelve months ending June 2026 identified 67 disclosed transactions totaling approximately \$26.3 billion, at a median deal size of \$116 million. The market is bifurcated in a way that is itself the forward signal. Venture and growth rounds account for 46 of the 67 transactions but only \$7.5 billion, at a median of \$95 million: capability is still being created. M&A accounts for 12 transactions and \$14.3 billion, at a median of \$668 million: capability is being harvested. Five transactions above \$1 billion absorbed \$17.1 billion, or 65% of all disclosed capital.

Independent counts corroborate the acceleration. A separate tracker of healthcare AI M&A identified 30 relevant transactions over 24 months, with the count rising from 9 in the earlier twelve-month period to 21 in the most recent - roughly 2.3 times more active - and ten transactions in the first half of 2026 alone. Rock Health counted 115 digital health acquisitions in the first half of 2026, against 199 for

all of 2025 and 121 for all of 2024. Roughly 60% of healthcare AI deal values are undisclosed, which means the visible tape understates strategic activity.

The large checks buy data, workflow control, and regulated distribution. Thermo Fisher paid \$8.875 billion for Clario⁷, a business generating approximately \$1.25 billion of revenue whose technology supported roughly 70% of FDA and EMA novel drug approvals over the past decade. Qualtrics paid \$6.75⁸ billion for Press Ganey Forsta. GE HealthCare paid \$2.3 billion⁹ for Intelrad to place imaging AI inside cloud PACS and workflow orchestration. Patient Square took Premier private at \$2.6 billion¹⁰. Waystar paid \$1.25 billion¹¹ for Iodine to place documentation intelligence upstream of billing. Tempus agreed to acquire Personalis for \$1.7 billion¹² in July 2026. Roche acquired PathAI; Medtronic acquired CathWorks. In every case the scarce asset was proprietary clinical or operational data, control of a workflow where money flows or clinical work happens, and distribution into a regulated buying process.

The smaller checks buy the semantic layer and the people who build it. IKS Health¹³ acquired ARAI Solutions for agentic AI, biomedical knowledge graphs, and explainability, having previously acquired ThinkDTM for product talent, and separately acquired TruBridge for \$557 million. Innovaccer has made five acquisitions - Humbi AI for actuarial intelligence across 200 million lives, Story Health for specialty care operations, Caduceus Health for ambulatory revenue cycle covering roughly 4,000 providers and \$5 billion of annual gross patient charges - all layered on its Gravity data platform, into which it is investing \$250 million. Cohere Health acquired ZignaAI for payment integrity. Datavant acquired DigitalOwl. Clarify acquired Loyal. Veeva acquired Copli. In July 2026 Raintree, an EHR and practice management platform, acquired Spike Technologies for agentic voice; in early August, Serelora, building an AI-native agentic EHR, acquired ACTIN's clinical risk-stratification software.

Repeat acquirers are the strongest evidence that this has moved from experiment to strategy. RadNet, GE HealthCare, Innovaccer, and IKS Health are each stacking assets around a defined category thesis rather than buying isolated tools.

Reference points for value, and a warning. RadNet¹⁴ agreed to acquire Gleamer for up to €230 million against expected 2026 ARR of approximately \$30 million - roughly 7.7 times forward ARR - with the combined DeepHealth platform guided to approach or exceed \$140 million ARR by year end. Commure acquired Augmedix at approximately 2.5 to 2.7 times guided revenue. Sword acquired Kaia Health for \$285 million.

This is a small sample from which extreme readings are more likely than representative ones, and it invites anchoring valuation errors based on transactions you happen to know well. Boards on both sides of these processes should treat the visible comps as a starting distribution to be adjusted, not a price to be defended.

A structure worth noting. Large pharma has largely declined to buy AI platforms outright, preferring partnership-plus-equity: GSK with Noetik, Incyte with Genesis, Lilly with Insilico. These structures purchase optionality on an unproven modality at a fraction of control-premium cost, with a defined path to more. Healthcare SaaS acquirers facing genuine uncertainty about which agentic categories endure should study this pattern rather than assuming control is required.

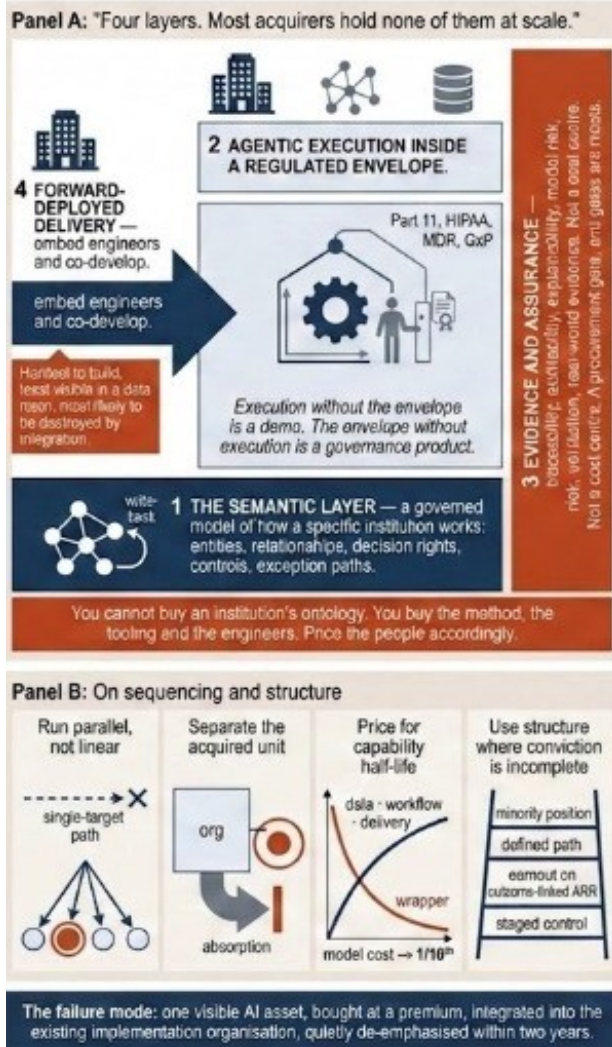
Table 1 · What the tape says buyers are actually purchasing

AI-healthcare transactions, United States and Europe, twelve months to June 2026

67 transactions, US + Europe 12 months to June 2026	\$26.3B disclosed capital, median deal \$116M	12 / \$14.3B M&A deals, median \$668M capability harvested	46 / \$7.5B venture + growth, med. \$95M capability created	65% of capital in five deals above \$1B (\$17.1B)
Transaction	Value	The scarce asset acquired	What it implies	
TIER 1 — THE LARGE CHECKS: data, workflow control, regulated distribution				
Thermo Fisher / Clario	\$8.875B	Trial-endpoint data infrastructure on ~\$1.25B revenue; technology supported ~70% of FDA and EMA novel drug approvals over the past decade	Position inside the approval pathway is not buildable at any price or timeline	
Qualtrics / Press Ganey Forsta	\$6.75B	Patient-experience data at national scale	Longitudinal proprietary data, not the analytics layer on top of it	
Patient Square / Premier	\$2.6B	Provider network and supply-chain operating data, taken private	Sponsors are buying the operating spine — and out of public view	
GE HealthCare / Intelrad	\$2.3B	Cloud PACS and workflow orchestration	Imaging AI placed inside the workflow rather than sold alongside it	
Tempus / Personalis · Jul 2026	\$1.7B	Sequencing and clinical-genomic data	Vertical consolidation of the data asset itself	
Waystar / Iodine	\$1.25B	Documentation intelligence positioned upstream of billing	Control of the point where money actually moves	
Roche / PathAI · Medtronic / CathWorks	undisc. · \$585M	Clinical decision data inside a regulated diagnostic or device pathway	Regulated distribution is the moat, not the algorithm	
In every case the scarce asset was proprietary clinical or operational data, control of a workflow where money or clinical work actually moves, and distribution into a regulated buying process. In no case was it a model.				
TIER 2 — THE SMALL CHECKS: the semantic layer and the people who build it				
IKS Health / ARAI Solutions	undisc.	Agentic AI, biomedical knowledge graphs, explainability	The semantic layer bought directly, as a named capability	
IKS Health / ThinkDTM	acqui-hire	Product talent	The engineers are the asset — priced accordingly	
IKS Health / TruBridge	\$557M	Provider revenue-cycle scale	Capability acquired first, distribution acquired second	
Innovaccer / Humbi AI	undisc.	Actuarial intelligence across 200 million lives	Data breadth as the input to institution-specific reasoning	
Innovaccer / Story Health	undisc.	Specialty care operations	Workflow depth in a defined clinical domain	
Innovaccer / CaduceusHealth	undisc.	Ambulatory revenue cycle — ~4,000 providers, ~\$5B annual gross patient charges	Volume of real operational exception-handling	
Innovaccer / Gravity platform	\$250M inv.	The layer all five acquisitions are stacked onto	A portfolio assembled onto a single semantic substrate	
Cohere Health / ZignaAI	undisc.	Payment integrity	Money-movement workflows, again	
Datavant / DigitalOwl · Clarify / Loyal	undisc.	Records intelligence; patient engagement data	Category-adjacent capability, bought not built	
Veeva / Copli · Jun 2026	undisc.	Agentic MLR review — Falcon MLR, targeting elimination of 70%+ of manual MLR labor within five years	The most defensible franchise in healthcare responding inorganically	
Raintree / Spike Technologies · Jul 2026	undisc.	Agentic voice inside an EHR and practice management platform	Incumbent platforms buying the interaction layer	
Serelora / ACTIN · Aug 2026	undisc.	Clinical risk-stratification software	AI-natives consolidating too — the window is not indefinite	
The large checks buy position. The small checks buy the method, the tooling and the engineers — the only part of an institution's operating logic that is actually for sale.				
TIER 3 — REPEAT ACQUIRERS: from experiment to strategy				
RadNet	—	Gleamer, plus prior assets stacked into DeepHealth	Category thesis, executed serially	
GE HealthCare	—	Intelrad and adjacent workflow assets	Buying the workflow around the algorithm	
Innovaccer	—	Five acquisitions onto one platform	Portfolio assembly, not a defensive purchase	
IKS Health	—	ARAI, ThinkDTM, TruBridge	Capability, talent and distribution as three distinct problems	
Repeat acquirers are the strongest evidence that this has moved from experiment to strategy. Each is stacking assets around a defined category thesis rather than buying isolated tools.				
TIER 4 — VALUATION REFERENCE POINTS, and a warning about them				
RadNet / Gleamer	up to €230M	~7.7x forward ARR (~\$30M expected 2026 ARR)	DeepHealth guided to approach or exceed \$140M ARR by year end	
Commure / Augmedix	\$139M	~2.5–2.7x guided revenue	Ambient documentation, post-saturation pricing	
Sword / Kaia Health	\$285M	Multiple not disclosed	Digital MSK consolidation	
Three comparables is not a comparable set. It is a small sample from which extreme readings are more likely than representative ones, and it invites exactly the error the outside view is designed to prevent: anchoring a valuation expectation on the one transaction you happen to know well. Boards on both sides should treat the visible comps as a starting distribution to be adjusted, not a price to be defended.				
TIER 5 — PARTNERSHIP-PLUS-EQUITY: buying optionality instead of control				
GSK / Noetik	\$50M	Equity plus collaboration	Optionality on an unproven modality	
Incyte / Genesis	\$120M	Equity plus collaboration	A defined path to more, at a fraction of control-premium cost	
Lilly / Insilico	\$115M upfront	Equity plus collaboration	Exposure without integration risk	

V. For acquirers: assemble a portfolio, approach it strategically

Assembling and Transacting the Strategic AI Portfolio



The failure mode we expect to see most often over the next eighteen months is the single defensive acquisition: one visible AI asset, bought at a premium, announced with confidence, integrated into the existing implementation organization, and quietly de-emphasized within two years. It is the predictable output of an availability bias - buying an asset you have read about rather than assembling the solution your customers will pay for.

The solution required is not a product, but four capability layers that most acquirers don't have at scale.

1. The semantic layer. A governed model of how work is accomplished across specific institutions: its entities, relationships, decision rights, controls, and exception paths, against which agents can reason and act. This is the asset that compounds, because every decision and outcome written back into it makes the next one better, and switching costs accrue to the party that holds it. While you cannot buy an institution's ontology, because it belongs to the institution, having a baseline ontological framework is a direct accelerator of value. And, you can buy the method, the tooling, and the engineers who can construct and customize ontologies in weeks

rather than years. Price the people accordingly.

2. Agentic execution inside a regulated envelope. Agents that act, with human-in-the-loop checkpoints, role-based authority, and control points that map to Part 11, HIPAA, MDR, and GxP requirements. Execution without a compliance and regulatory envelope is just a demo. The envelope without execution is a governance/oversight product that doesn't drive business value.

3. Impact, transparency and assurance. Traceability, auditability, explainability, frontier model competitive risk management, validation documentation, real-world evidence of rapid ROI and delighted customers are now a baseline for value delivery through Healthcare AI. The FDA and CMS position is clear – show me your work with “Glass-Box” AI and real world impact, and we'll even create new reimbursement mechanisms - SaMS (Software as a Medical Service) introduced by CMS in the 2027 proposed payment rules. Health system and pharma procurement is converging on similar logic - explainability, assurance, ownership and proof of impact is a procurement gate, and gates can become

competitive moats. Qualified Health's \$125 million round demonstrates the criticality of AI Governance and even establishes it as a fundable category – even though it generates no direct business value.

4. Forward-deployed delivery. The organizational capability to embed engineers in a customer's environment and co-develop. This is the hardest to build, the least visible in a data room, and the most likely to be destroyed by integration.

On sequencing and structure, we would press these points in any board discussion.

Run parallel, not linear. Base rates for any single transaction closing are low, and the standard error on a one-target process is enormous. Sequential discussions consume the one asset you cannot replenish - momentum - and remove the competitive tension that disciplines both price and behavior.

Separate the acquired unit from the standard-software implementation P&L. Every incentive in a configure-the-package organization will pull an acquired agent team toward becoming a feature. Structural separation, with its own targets and its own path to market, is the difference between a capability and a line item.

Price for capability half-life. Ask what happens to the target's economics when the underlying model becomes ten times cheaper. If the answer is that margins improve, you are buying data, workflow understanding, and value delivery. If the answer is that the product commoditizes, you are buying a thin wrapper.

Use structure where conviction is limited. Minority positions with a defined path, earnouts tied to outcome-linked ARR rather than bookings, and staged control are appropriate instruments in a market where nobody can underwrite terminal value with confidence.

BOX 2 | QUESTIONS FOR GOVERNED HEALTHCARE AI

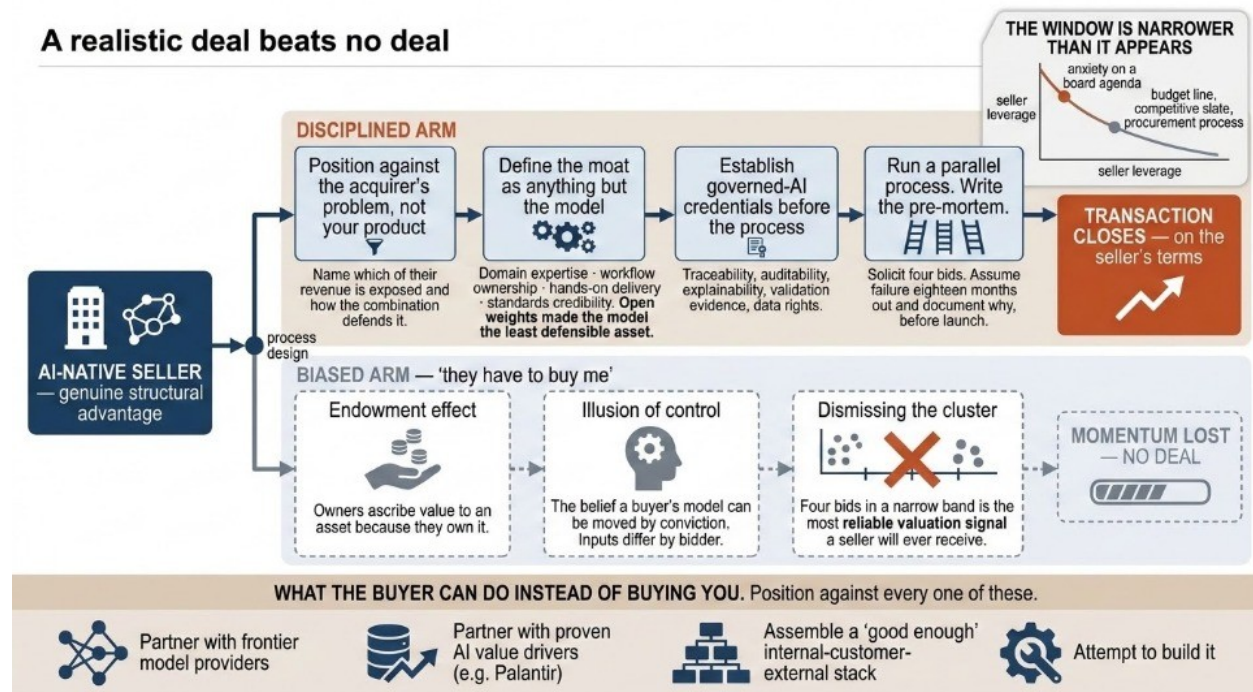
While a checklist is a crude instrument, it's better than unaided judgment. Here are ten questions we believe are critical:

1. Does the system retain feedback and improve with use in production, and can you show the improvement curve on a named account?
 2. Who owns the learned artifact when the contract ends: the vendor, the customer, or is it ambiguous?
 3. Is the semantic model portable and explicit, or is it captive to the vendor's runtime and a 'black-box'?
 4. Can the system produce an audit trail a regulator would accept without remediation?
 5. What proportion of ARR is outcome-linked versus seat-linked, and what is the trend?
 6. What is revenue per forward-deployed engineer, and how has it moved as the account has grown?
 7. How long from contract signature to first production workflow, measured across every account rather than the reference ones?
 8. What share of gross margin is absorbed by model inference, and what happens at one-tenth the cost?
 9. Which customer processes does the system touch where money flows or clinical work happens, and
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which are advisory or diagnostic only?

- 10.** If the foundation model layer were free tomorrow, what remains that a competitor cannot replicate within twelve months?
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VI. For AI-Native seller: do not mistake their urgency for your leverage



Competent sellers hold a structural advantage but risk misreading its size.

Optimize by positioning against the acquirer's problem, not your product. The buyer is not shopping for capability in the abstract. The seller who can articulate, in the buyer's own segment and with the buyer's own customers, which revenue is exposed and how the combination defends it will be valued differently from the seller who presents a product roadmap. This is a strategic-fit and future differentiation argument and what separates a large revenue multiple from a control premium.

Define the moat beyond the model and against the frontier. Rock Health's framing is the correct one: buyers and investors have stopped asking who has AI and started asking who has something AI alone cannot provide. Five capabilities survive model commoditization and frontier 'good-enough' solutions - domain expertise embedded in the product, ownership of more of the workflow, hands-on delivery into legacy and chaotic organizations, solution governability, and partnerships or standards credibility a buyer cannot replicate.

Establish governed-AI credentials before the process. Traceability, auditability, explainability, validation evidence, model risk documentation, and a defensible position on data rights are diligence accelerants in regulated healthcare. Sellers who assemble this proof too late risk converting a competitive process into a discount negotiation, because only the most motivated buyer will fund remediation.

Discipline. A seller who concludes that the acquirer must buy has committed two of the most expensive errors in this bank's experience. The endowment effect causes owners to ascribe value to an asset for the simple reason that they own it. The illusion of control causes them to believe they can

move a buyer's valuation model by force of conviction. In private transactions there is no right price and no fair market value. What a buyer pays reflects the likely financial future of the asset in that buyer's hands - its synergies, its integration plan, its alternatives, its risks. Inputs differ by bidder, and all of them differ from the seller's view.

The practical expression of this discipline is simple. Run a parallel process, because the information content of four bids clustering within a narrow band is enormous, and it is only available if you solicit four. When they cluster, treat the cluster as a signal rather than an insult; sellers who dismiss a tight distribution as a market failure are dismissing a reliable market signal. And write the pre-mortem before launch: assume the process has failed eighteen months from now, and document why. That exercise legitimizes doubt inside a management team that has been selling optimism to investors for years, and it surfaces the vulnerabilities in the plan while they are still fixable.

Finally, deeply consider the acquirer's alternatives to purchasing your asset. While it may be differentiating, the Health AI space is robust with both behemoths and small companies driving value; remember that acquirers can move toward partnerships with frontier model providers or proven AI value drivers like Palantir; they can piece together internal-customer-external solutions that may be "good-enough" (at least in the short term), and they may, despite our advice, attempt to build their own. Positioning yourself against all of these alternatives during the process is key to an optimal capital outcome.

The Health AI acquisition playbook has not been standardized – and the space is evolving monthly, so every transaction is inherently unique in time, structure, positioning and value. Seek expert advice broadly and value true market signals.

On timing. The window is narrower than it appears. The best moment to sell into a strategic's imperative is while the imperative is an anxiety on a board agenda, not after it has become a budget line with a defined competitive slate and a procurement process.

VII. For the sponsor: the most asymmetric entry point in a decade

Private equity's software franchise has repriced faster than its portfolio marks.

Global software-focused buyouts reached roughly \$50 billion in the first five months of 2026,¹⁵ down from approximately \$88 billion in the same period of 2025 and the weakest start since 2020, against roughly \$290 billion of software acquisitions completed across 2025. US platform deal value in software ran \$16.24¹⁶ billion through five months, a pace that would deliver about a quarter of 2025's record \$156 billion. Global technology buyout value across April and May 2026 combined totaled \$9.3 billion¹⁷, a level one senior technology banker described simply as frozen. Meanwhile Bain's midyear work put software¹⁸ valuations in private equity portfolios down roughly 8% through March, far less than the public correction.

The gap between those two facts is the whole opportunity, and the whole risk. Approximately \$1 trillion of dry powder is waiting. Roughly \$800 billion of private credit¹⁹ is deployed against software borrowers, with Morgan Stanley noting that nearly half of the \$235²⁰ billion software loan market is

rated B– or lower. Deal teams report an inability to gain investment committee approval because nobody can defend a terminal value assumption. TPG's Nehal Raj has been explicit that the risk concentrates in assets underwritten in 2018 through 2020, before generative AI - vintages now approaching the end of their hold periods.

Two symmetric plays follow, and both are transactable now.

Sponsors holding legacy healthcare software face a narrowing exit window on their oldest assets. The buyer universe for a healthcare application with no agentic capability and no forward-deployed delivery motion is contracting. Bolt-on acquisition of agentic capability is not a value-creation nicety in this context; it is a prerequisite for exit. The transactions are small relative to platform size, the assets are available, and the alternative is holding into a market that is repricing the category faster than the portfolio is being marked.

Sponsors with dry powder are looking at AI-native healthcare assets at the cheapest well-underwritten entry point in ten years, with a defined strategic exit path to the very incumbents whose multiples are compressing. The Thoreau Group's \$12 billion agreement for Ensemble Health and Clearlake's ModMed position at a \$5.3 billion valuation indicate that sponsors are already backing the platform layer. The mid-market - companies with \$10 million to \$50 million of ARR, real regulated deployments, and forward-deployed delivery - is where the strategic buyer list is longest and the competitive tension highest.

The caveat is that terminal value genuinely cannot be underwritten with confidence today. That argues for structure - minority with path, staged control, earnouts against outcome-linked revenue - rather than for abstention. Abstention in a repricing is a decision based on the sunk-cost fallacy, not discipline.

VIII. Avoid the cognitive biases that derail strategic success

In a prior article in these pages, one of us argued that life sciences transactions fail less often for want of strategic logic than for want of an outside view: decision-makers substitute a coherent internal narrative for the statistics of similar cases, and the emotional tail wags the rational dog. The extreme transformation associated with Health AI, unprecedented growth, and marketing hype are driving cognitive bias – for both targets and acquirers – to a new level.

- **Narrative fallacies** that dismiss capable incumbents like Epic with both data access and AI, or the reality of frontier model encroachment.
- **Base-rate neglect** that disregards the > 95% AI Pilot failure rates and scaling challenges of novel AI solutions inside legacy healthcare institutions.
- **Availability bias** that assumes viable, value-driving and proven AI solutions abound because LinkedIn and X are full of compelling stories.
- **Endowment effect** overvaluing your company's AI capabilities and dismissing competitors or buyer's ability to quickly recreate solutions.

- **Not-invented Here or Reactive Devaluation** of buyers who dismiss truly differentiating assets because they can't imagine the power of novel AI or ontological approaches.

Avoiding these, or at least mitigating them, on both sides of transactions will lead to lucrative outcomes. Ignoring these biases risks disruption and failure.

IX. What we would do now

Adopt the outside view before your internal one hardens. Establish the base rates for your segment: how many comparable capabilities have been built organically and reached production, at what cost, over what timeline. Compare them against the acquisition path honestly. Most boards have never done this arithmetic and are surprised by it.

Map the landscape before you mandate. The relevant universe is not healthcare AI companies. *It is the specific set of assets that, in combination, close the four capability gaps for your customer given your regulatory posture.* That map is a piece of analytical work with perhaps two hundred names in it, and it should be developed with the help of a banker, not after transactions are in motion.

Run parallel processes and generate alternatives. Set out specific alternative paths - organic, acquisitive, partnership-plus-equity, joint venture - and make the probabilities sum to one hundred percent. Having a good set of alternatives is at least as important as choosing wisely among them.

Conduct a pre-mortem. Before committing, assume the transaction has failed and write the explanation. Do it by collecting individual written judgments before any group discussion, which extracts more information and suppresses groupthink than the meeting alone ever will.

Separate what you acquire. Communicate that the acquired capability will be separate from the organization, which would otherwise metabolize it. This is a change management requirement that will help your organization plan and integrate successfully.

Price assuming commoditization. Underwrite what the asset is worth once models are commoditized and open weights are the default. What survives that test is data, domain, delivery, and distribution. Everything else is a wrapper on someone else's model.

The repricing of healthcare software is not a verdict on the sector's value. It is the market's early and imprecise attempt to price a foundational change in how software is built and value is delivered in the most regulated and most process-codified industry in the economy. The value released by that change will be roughly twice the value destroyed so far. It will accrue to the organizations that assemble the semantic layer, the governed execution, the assurance, and the delivery capability - and, on current evidence, almost none of them will assemble all four organically.

That makes the next thirty-six months a transaction market. The participants who do the analytical work now, who set expectations against base rates rather than against the one deal they happen to know, and who build genuine alternatives before they need them, will transact on their own terms.

Everyone else will be explaining why the market got it wrong.

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References

1. SaaStr. "The SaaS Rout of 2026 Is Even Worse Than You Think. For the First Time Ever, Software Now Trades at a Discount to the S&P 500." <https://www.saastr.com/the-saas-rout-of-2026-is-even-worse-than-you-think-for-the-first-time-ever-software-now-trades-at-a-discount-to-the-sp-500/>
2. Forbes. "The SaaS Apocalypse or the SaaS Evolution?" <https://www.forbes.com/sites/jonmarkman/2026/02/17/the-saas-apocalypse-or-the-saas-evolution/>
3. SaaStr. "The SaaS Rout of 2026 Is Even Worse Than You Think. For the First Time Ever, Software Now Trades at a Discount to the S&P 500." <https://www.saastr.com/the-saas-rout-of-2026-is-even-worse-than-you-think-for-the-first-time-ever-software-now-trades-at-a-discount-to-the-sp-500/>
4. PitchBook. "Q1 2026 Healthtech Public Comp Sheet and Valuation Guide." <https://pitchbook.com/news/reports/q1-2026-healthtech-public-comp-sheet-and-valuation-guide>
5. Seeking Alpha. "Veeva La Vida: Here Comes the Rebound for Veeva Systems." <https://seekingalpha.com/article/4867690-veeva-la-vida-here-comes-the-rebound-for-veeva-systems>
6. TIKR. "Doximity Stock Beats Q4 Revenue but Margins Compress as AI Costs Mount." <https://www.tikr.com/blog/doximity-stock-beats-q4-revenue-but-margins-compress-as-ai-costs-mount>
7. Applied Clinical Trials. "Thermo Fisher Completes \$8.875 Billion Acquisition of Clario, Expanding Clinical Trial Data Capabilities." <https://www.appliedclinicaltrials.com/view/thermo-fisher-acquisition-clario-clinical-trial-data>
8. Qualtrics. "Qualtrics to Invest \$6.75 Billion in Press Ganey Forsta Acquisition to Advance AI-Powered Experience Management." <https://www.qualtrics.com/news/qualtrics-to-invest-6-75-billion-in-press-ganey-forsta-acquisition-to-advance-ai-powered-experience-management/>
9. GE HealthCare. "GE HealthCare to Acquire Intelrad, Advancing Cloud-Enabled Enterprise Imaging Across Care Settings." <https://investor.gehealthcare.com/news-releases/news-release-details/ge-healthcare-acquire-intelerad-advancing-cloud-enabled>
10. Bloomberg. "Patient Square to Take Premier Private in \$2.6 Billion Deal." <https://www.bloomberg.com/news/articles/2025-09-22/patient-square-to-take-premier-private-in-2-6-billion-deal>
11. Bloomberg. "Patient Square to Take Premier Private in \$2.6 Billion Deal." <https://www.bloomberg.com/news/articles/2025-09-22/patient-square-to-take-premier-private-in-2-6-billion-deal>

12. Bloomberg. “Tempus AI to Buy Cancer Tech Firm Personalis for \$1.7 Billion.” <https://www.bloomberg.com/news/articles/2026-07-20/tempus-ai-to-buy-cancer-tech-firm-personalis-for-1-7-billion>
13. Fierce Healthcare. “IKS Health to Acquire TruBridge for \$557M.” <https://www.fiercehealthcare.com/health-tech/iks-health-acquire-trubridge-557m-deal>
14. RadNet. “RadNet Acquires Gleamer, Making RadNet’s DeepHealth the Largest Provider of Radiology Clinical AI Solutions Worldwide.” <https://www.radnet.com/about-radnet/news/radnet-acquires-gleamer-making-radnet-s-deephealth-the-largest-provider-of-radiology-clinical-ai-solutions-worldwide>
15. Private Equity Wire. “Software Buyout Market Slumps to Post-Pandemic Low as AI Disruption Weighs on Valuations.” <https://www.privateequitywire.co.uk/software-buyout-market-slumps-to-post-pandemic-low-as-ai-disruption-weighs-on-valuations/>
16. PitchBook. “PE Pivots as Platform Buyouts in Software Fall to Decade Low.” <https://pitchbook.com/news/articles/pe-pivots-as-platform-buyouts-in-software-fall-to-decade-low>
17. Axios. “Tech Private Equity Is ‘Frozen.’” <https://www.axios.com/2026/05/20/tech-private-equity-frozen>
18. Bain & Company. “Winning Firms Will Focus on What They Can Control, Weather the Rest, as Triple-Shock Brakes Private Equity’s Latest Revival — Bain & Company 2026 Midyear PE Report.” <https://www.bain.com/about/media-center/press-releases/2026/winning-firms-will-focus-on-what-they-can-control-weather-the-rest-as-triple-shock-brakes-private-equitys-latest-revival-bain--company-2026-midyear-pe-report/>
19. L40°. “Private Credit, PE Buyers & SaaS Exits in 2026.” <https://www.l40.com/insights/private-credit-saas-2026>
20. Investing.com (Reuters). “AI-Led Software Selloff May Pose Risk for \$1.5 Trillion U.S. Credit Market, Says Morgan Stanley.” <https://www.investing.com/news/stock-market-news/ailed-software-selloff-may-pose-risk-for-15-trillion-us-credit-market-says-morgan-stanley-4497161>

¹ SaaStr. “The SaaS Rout of 2026 Is Even Worse Than You Think. For the First Time Ever, Software Now Trades at a Discount to the S&P 500.” <https://www.saastr.com/the-saas-rout-of-2026-is-even-worse-than-you-think-for-the-first-time-ever-software-now-trades-at-a-discount-to-the-sp-500/>

² Forbes. “The SaaS Apocalypse or the SaaS Evolution?” <https://www.forbes.com/sites/jonmarkman/2026/02/17/the-saas-apocalypse-or-the-saas-evolution/>

³ SaaStr. “The SaaS Rout of 2026 Is Even Worse Than You Think. For the First Time Ever, Software Now Trades at a Discount to the S&P 500.” <https://www.saastr.com/the-saas-rout-of-2026-is-even-worse-than-you-think-for-the-first-time-ever-software-now-trades-at-a-discount-to-the-sp-500/>

⁴ PitchBook. “Q1 2026 Healthtech Public Comp Sheet and Valuation Guide.” <https://pitchbook.com/news/reports/q1-2026-healthtech-public-comp-sheet-and-valuation-guide>

⁵ Seeking Alpha. “Veeva La Vida: Here Comes the Rebound for Veeva Systems.” <https://seekingalpha.com/article/4867690-veeva-la-vida-here-comes-the-rebound-for-veeva-systems>

⁶ TIKR. “Doximity Stock Beats Q4 Revenue but Margins Compress as AI Costs Mount.” <https://www.tikr.com/blog/doximity-stock-beats-q4-revenue-but-margins-compress-as-ai-costs-mount>

⁷ Applied Clinical Trials. “Thermo Fisher Completes \$8.875 Billion Acquisition of Clario, Expanding Clinical Trial Data Capabilities.” <https://www.appliedclinicaltrials.com/view/thermo-fisher-acquisition-clario-clinical-trial-data>

⁸ Qualtrics. “Qualtrics to Invest \$6.75 Billion in Press Ganey Forsta Acquisition to Advance AI-Powered Experience Management.” <https://www.qualtrics.com/news/qualtrics-to-invest-6-75-billion-in-press-ganey-forsta-acquisition-to-advance-ai-powered-experience-management/>

⁹ GE HealthCare. “GE HealthCare to Acquire Intelera, Advancing Cloud-Enabled Enterprise Imaging Across Care Settings.” <https://investor.gehealthcare.com/news-releases/news-release-details/ge->

[healthcare-acquire-intelerad-advancing-cloud-enabled](#)

¹⁰ Bloomberg. “Patient Square to Take Premier Private in \$2.6 Billion Deal.”

<https://www.bloomberg.com/news/articles/2025-09-22/patient-square-to-take-premier-private-in-2-6-billion-deal>

¹¹ Bloomberg. “Patient Square to Take Premier Private in \$2.6 Billion Deal.”

<https://www.bloomberg.com/news/articles/2025-09-22/patient-square-to-take-premier-private-in-2-6-billion-deal>

¹² Bloomberg. “Tempus AI to Buy Cancer Tech Firm Personalis for \$1.7 Billion.”

<https://www.bloomberg.com/news/articles/2026-07-20/tempus-ai-to-buy-cancer-tech-firm-personalis-for-1-7-billion>

¹³ Fierce Healthcare. “IKS Health to Acquire TruBridge for \$557M.”

<https://www.fiercehealthcare.com/health-tech/iks-health-acquire-trubridge-557m-deal>

¹⁴ RadNet. “RadNet Acquires Gleamer, Making RadNet’s DeepHealth the Largest Provider of Radiology Clinical AI Solutions Worldwide.” <https://www.radnet.com/about-radnet/news/radnet-acquires-gleamer-making-radnet-s-deephealth-the-largest-provider-of-radiology-clinical-ai-solutions-worldwide>

¹⁵ Private Equity Wire. “Software Buyout Market Slumps to Post-Pandemic Low as AI Disruption Weighs on Valuations.” <https://www.privateequitywire.co.uk/software-buyout-market-slumps-to-post-pandemic-low-as-ai-disruption-weighs-on-valuations/>

¹⁶ PitchBook. “PE Pivots as Platform Buyouts in Software Fall to Decade Low.”

<https://pitchbook.com/news/articles/pe-pivots-as-platform-buyouts-in-software-fall-to-decade-low>

¹⁷ Axios. “Tech Private Equity Is ‘Frozen.’” <https://www.axios.com/2026/05/20/tech-private-equity-frozen>

¹⁸ Bain & Company. “Winning Firms Will Focus on What They Can Control, Weather the Rest, as Triple-Shock Brakes Private Equity’s Latest Revival — Bain & Company 2026 Midyear PE Report.”

<https://www.bain.com/about/media-center/press-releases/2026/winning-firms-will-focus-on-what-they-can-control-weather-the-rest-as-triple-shock-brakes-private-equitys-latest-revival-bain--company-2026-midyear-pe-report/>

¹⁹ L40°. “Private Credit, PE Buyers & SaaS Exits in 2026.” <https://www.l40.com/insights/private-credit-saas-2026>

²⁰ Investing.com (Reuters). “AI-Led Software Selloff May Pose Risk for \$1.5 Trillion U.S. Credit Market, Says Morgan Stanley.” <https://www.investing.com/news/stock-market-news/ailed-software-selloff-may-pose-risk-for-15-trillion-us-credit-market-says-morgan-stanley-4497161>