Investment Thesis Report:

Navigating the Epic Ecosystem:

Structural Gaps, Competitive White Space, and AI-Driven Opportunity in Acute Care

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Abstract

Epic has become the central operating platform for the American healthcare system. Over the past two decades, the company has expanded from a clinical documentation system into the foundational infrastructure governing how large health systems manage patient encounters, coordinate care, capture revenue, and make operating decisions. Today, Epic holds ~42.3% of the acute care hospital EHR market by facility count and ~54.9% by bed count — numbers that represent not only market dominance but a structural reality from which displacement is nearly impossible.[1] As one health system executive put it, Epic is the *"best of the worst"* — so deeply embedded in financial and operational systems that removal is no longer a practical consideration regardless of performance. Its architecture has become the skeletal structure of American hospital operations.

Yet Epic's dominance does not extend uniformly across the healthcare technology stack. Despite its scale and continued product investment, structural gaps persist across multiple adjacent technology domains. These gaps arise not only from product limitations but from deliberate strategic choices: Epic's neutral posture toward payers, its positioning around FDA-regulated clinical decision support, its reluctance to assume operational or financial risk on behalf of health system clients, and the fundamental mismatch between Epic's workflow-centric architecture and the enterprise, financial, and infrastructure needs of modern health systems. Understanding these structural boundaries — what Epic will not do as much as what it cannot do — is the central analytical challenge for healthcare technology investors and operators.

This analysis evaluates Epic's structural positioning across eleven categories of the acute care technology ecosystem, identifying where Epic maintains durable control and where complementary vendors can build sustainable, differentiated businesses alongside it. The analysis incorporates AI as the defining inflection point of this era: AI is both accelerating Epic's ambitions — evidenced by the launch of Agent Factory, Art, Penny, and Emmie at HIMSS26 in March 2026[2] — and simultaneously creating new categories of structural opportunity in domains where Epic's architecture and business model are poorly suited to compete.

The findings of this report are grounded in primary research: executive discussions with digital transformation leaders at select organizations. Their insights provide the operational realities behind Epic's stated capabilities and surface the specific structural dynamics that define where complementary vendors have the most durable room to build. The report concludes with a prioritized investment framework and vendor qualification criteria drawn directly from health system operator feedback.

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I. Introduction and Scope

Scope

This report evaluates the acute care technology ecosystem with a specific focus on provider-purchased software solutions operating within or adjacent to Epic-installed health systems. The analysis is deliberately bounded: it covers AI-enabled and AI-adjacent solutions across clinical, operational, financial, and infrastructure domains within the acute care setting, where Epic's presence is most concentrated and its structural influence most consequential.

Three boundaries define the scope of this analysis. First, the primary focus is acute care, where Epic's presence is most concentrated and its structural influence most consequential. This is not to suggest that ambulatory, outpatient, and post-acute settings are irrelevant — Epic's architecture increasingly bridges these settings, and ambulatory opportunities in particular, including areas such as dentistry, hospice, and other outpatient-focused specialties where Epic is eyeing but has not yet meaningfully built, represent an adjacent investment universe that warrants dedicated analysis beyond this report's frame. The acute care focus reflects where the structural gaps are best documented by primary research and most immediately actionable for investors, not a judgment that other settings are unimportant. Second, the analysis covers provider-purchased technology exclusively, setting aside payer-focused or employer-focused software markets where the competitive dynamics and buyer motivations differ substantially from the health system technology environment. Third, the evaluation centers on categories where AI-enabled or AI-adjacent capabilities are either already reshaping competitive dynamics or represent the most credible near-term investment opportunity, reflecting FCA's conviction that AI is the primary force multiplier for complementary vendor value creation in the Epic ecosystem over the coming years.

Objective

This report pursues three interconnected objectives. The first is to assess Epic's structural influence across the acute care technology stack with precision — distinguishing between categories where Epic exerts true operational control, categories where it is present but insufficient, and categories where it is structurally absent. This distinction matters because it determines whether vendor opportunity is incremental augmentation, performance-based differentiation, or genuinely open competition.

The second objective is to identify the specific structural dynamics — regulatory exposure, payer posture, risk ownership philosophy, data architecture constraints, and organizational buyer alignment — that determine where Epic competes effectively and where it does not. Epic's boundaries are not arbitrary; they reflect a coherent strategic philosophy. Understanding that philosophy allows investors to distinguish durable structural gaps from temporary product gaps that Epic will close on its next development cycle.

The third objective is to translate the category analysis into an actionable investment framework — identifying the highest-confidence opportunity areas, the vendor qualification criteria that health system operators apply in these categories, and the commercial model characteristics that distinguish vendors positioned to win from those likely to struggle regardless of product quality.

The analysis is informed by primary research conversations with digital transformation leaders at various health systems as well as secondary sources. These organizations represent a meaningful cross-section of health system scale and Epic implementation sophistication — from large academic medical centers managing among the most complex Epic environments in the country to integrated delivery

networks navigating the early stages of AI-enabled operational transformation. Their perspectives provide the operational grounding that market-level analysis cannot supply.

Methodology

The primary research component consisted of structured executive interviews conducted using a consistent question framework across participating health systems. Interview questions were designed to surface how organizations evaluate Epic relative to complementary vendors, where they consistently rely on third-party solutions regardless of Epic's stated capabilities, and how AI investment priorities are evolving within their technology strategy. The interview content was analyzed to identify patterns across organizations and to validate or challenge the structural assumptions underlying each category assessment.

The secondary research component drew on publicly available market data, including KLAS Research's annual EHR market share reports, Epic product announcements from the 2025 User Group Meeting and HIMSS26, and coverage of health system technology deployments across trade publications. Citation sources are documented in the Works Cited section and referenced inline throughout.

II. Epic's Position in Acute Care

A. Historical Context

To understand Epic's current competitive position, it is necessary to trace how the company achieved its dominance — because the mechanisms of Epic's ascent are also the mechanisms of its moat. Epic's rise was not primarily driven by superior technology at the outset; it was driven by a combination of integration philosophy, timing, and strategic patience that created compounding advantages over two decades.

The early electronic health record market of the 1990s and early 2000s was deeply fragmented. Hospital departments operated on separate, siloed systems — different vendors for laboratory information, pharmacy, radiology, billing, and clinical documentation. Data rarely flowed cleanly between these systems, creating administrative burden, documentation errors, and an inability to get a unified view of the patient. Epic's foundational insight was that the value of an integrated platform — one system governing the full patient encounter — would exceed the sum of its parts, even if individual components were not best-in-class.

Federal incentive programs under the Health Information Technology for Economic and Clinical Health Act of 2009 accelerated EHR adoption dramatically, injecting approximately $27 billion into health system technology investment over the following decade. Large academic medical centers and integrated delivery networks — under pressure to attest to meaningful use of certified EHR technology — turned to Epic as the vendor best positioned to deliver the integration and documentation standardization that federal requirements demanded. Epic implemented at a measured pace, maintaining quality control over deployments in ways that smaller vendors could not match, and its early customer base of prestigious academic institutions became a powerful reference network for subsequent procurement decisions.

The compounding effect of this early adoption pattern cannot be overstated. Once an organization the size of Johns Hopkins or the Mayo Clinic implemented Epic, it created an implicit standard for peer organizations evaluating their own EHR decisions. By the mid-2010s, Epic was effectively the default choice for any large health system making a go-forward EHR decision — a dynamic that has only intensified since. The switching cost architecture embedded in Epic’s implementations reinforced this dynamic at the account level: Epic implementations restructure clinical workflows, regulatory reporting pipelines, and financial systems in ways that make replacement not merely costly but operationally transformational. As Dr. Pete Chang of Tampa General Hospital observed, once Epic is part of an organization’s DNA, the realistic question is not whether to keep it but how to optimize around it.

For readers seeking a deeper understanding of Epic’s history, culture, and rise to dominance, the *Acquired* podcast episode on Epic Systems (released April 2025, approximately four hours) is the most comprehensive public account of the company’s founding, growth, and strategic philosophy available. Hosted by Ben Gilbert and David Rosenthal, the episode covers founder Judy Faulkner’s background, the role of the HITECH Act in accelerating Epic’s dominance, the company’s ownership structure, and the cultural principles governing its operations. It is essential listening for anyone seeking to understand not just what Epic does but why it operates the way it does.

B. Current Market Position

As of the end of 2024, Epic holds ~42% of the U.S. acute care hospital EHR market by facility count and ~55% by bed count, according to KLAS Research's annual EHR market share report.[1] The company added a net 176 multispecialty hospitals and 29,399 beds in 2024 alone — its largest single-year net gain on record — and won nearly ~70% of all hospitals impacted by EHR decisions that year. Among large health systems with more than ten hospitals, Epic's market share rises to ~48%.[4]

The competitive gap is widening in ways that suggest Epic's dominance will continue to compound. Oracle Health, which absorbed Cerner following a $28.3 billion acquisition in 2022, lost a net 74 hospitals in 2024 and now holds ~22% of the hospital market and ~22% of the bed market.[1] Meditech holds ~15% of hospitals and ~13% of beds. KLAS analysts noted that Epic was the only EHR vendor to experience net market share growth in recent years and that large health systems making go-forward EHR decisions have chosen Epic exclusively for more than a decade.[4]

Epic's revenue grew from $4.6 billion in 2022 to $4.9 billion in 2023 and $5.7 billion in 2024,[3] a trajectory reflecting not only new implementations but the structural revenue model the company has built. Epic charges health systems through three mechanisms: implementation fees paid upfront, ongoing maintenance contracts, and a per-encounter fee that scales with health system volume. The per-encounter model is particularly significant: it means Epic's revenue grows automatically as health systems grow, creating a deeply aligned and perpetual financial relationship. As Dr. Chang explained, every patient bed-day generates a portion of revenue that flows to Epic — a royalty on health system operations that makes switching increasingly costly over time.

The scale of these financial commitments is significant and frequently underappreciated. For a large health system, an Epic implementation is not a software purchase — it is a capital program. Upfront implementation costs for large health systems typically range from $10 million to $30 million, and for the largest multi-hospital systems the total investment including consulting fees, infrastructure, training, and workflow redesign commonly reaches $100 million to $300 million or more. Recent high-profile implementations illustrate the range: Northwell Health's Epic rollout cost approximately $1.2 billion across its network; AdventHealth's transition ran approximately $660 million; Trinity Health's deployment across 101 hospitals reached approximately $800 million. Annual maintenance fees typically represent ~20% of initial license costs — meaning a system that invested $50 million upfront pays approximately $10 million annually thereafter, before accounting for internal IT staffing, training, and ongoing configuration work. These figures explain both why Epic's revenue grows predictably with the health systems it serves and why the switching cost calculation becomes more prohibitive with every passing year of implementation depth.

UPMC, currently midway through what its technology leadership describes as the largest single Epic instance implementation globally — consolidating ten distinct EHR platforms across its network — illustrates both the scale of Epic's ambitions and the operational reality of its installations. The health system expects to maintain more than 300 ancillary applications integrated into its Epic environment even after full consolidation, underscoring that Epic is a foundational platform rather than a complete solution. This fact — that even the most comprehensive Epic implementations leave more than 300 applications running alongside Epic — defines the investment landscape this report navigates. Investors should apply an important nuance here: health system CIOs are actively rationalizing their application portfolios, not passively maintaining them. Baptist Health has sunset more than 100 applications over the past five years and expects a similar pace over the next five. The pattern is consistent across sophisticated health systems — Epic reaching 80 to 90 percent of the functionality of a bolt-on application is sufficient justification for displacement when the alternative is managing another vendor relationship, integration point, and contract. Vendors occupying categories where Epic is actively building face real displacement risk on a five-to-seven year horizon regardless of current product superiority.

C. Core Products and Sources of Competitive Control

Epic's control over the acute care technology ecosystem derives from a suite of tightly integrated applications governing the end-to-end patient encounter. The core clinical documentation platform — Epic's physician-facing tools for encounter documentation, problem list management, and clinical note generation — is the foundation from which all other Epic applications derive their value. Because clinical documentation is the canonical record of what happened to a patient, every downstream process — billing, quality reporting, population health analytics, care coordination — depends on Epic's documentation environment.

Computerized provider order entry is the second pillar of Epic's control. Orders — for medications, laboratory tests, imaging, referrals, and procedures — flow through Epic's ordering interface and generate the clinical and financial records governing care delivery. Epic's order management infrastructure is deeply integrated with pharmacy, laboratory, and radiology systems, creating a web of dependencies that makes alternative ordering platforms impractical without Epic's active cooperation.

The revenue cycle module — charge capture, claims submission, and billing management — is the third pillar and the one most directly connected to health system financial performance. Because Epic's revenue cycle tools are integrated with its clinical documentation environment, the billing record is built continuously during the clinical encounter rather than retrospectively, reducing charge lag and documentation errors. This integration is genuinely valuable and represents one of Epic's most defensible product advantages.

MyChart, Epic's patient-facing portal, is the fourth pillar and the one with the most significant implications for Epic's competitive positioning going forward. MyChart is the primary interface through which patients interact with health systems in the digital environment — accessing medical records, scheduling appointments, messaging providers, and managing billing. Because MyChart is integrated with Epic's underlying clinical and financial data, it provides a seamless patient experience that standalone patient engagement platforms struggle to replicate without compromising data fidelity. MyChart's ubiquity across health systems also creates patient-level familiarity that functions as a switching cost on the consumer side, not just the institutional side.

Taken together, these four pillars constitute an interlocking system whose value is fundamentally relational rather than modular. Each component is more valuable because the others exist. Epic's moat is not the quality of any individual product but the integration architecture that makes the whole greater than the sum of its parts — and this is precisely what health system operators mean when they describe Epic as ingrained. It is also what defines the contours of where Epic ends and where complementary vendors begin.

D. What Epic Will Not Do — Strategic Gaps versus Capability Gaps

Understanding Epic's structural limits requires distinguishing between two types of gaps that require fundamentally different investment analysis. Capability gaps exist where Epic lacks functionality it could plausibly build and has signaled intention to develop — these gaps close over time as Epic's R&D resources are applied, and investment in categories defined purely by capability gaps carries meaningful obsolescence risk. Strategic gaps exist where Epic has made deliberate choices not to compete, driven by its business model, regulatory posture, payer relationship dynamics, or organizational philosophy — these gaps are durable on investment-relevant timelines and represent the territory where complementary vendor value creation is most defensible.

Epic's relationship with payers is more nuanced than simple neutrality implies. Epic does serve payers directly: its Tapestry application was built specifically for pay-vider organizations — entities that act as both providers and payers — and may expand to more traditional payers over time. Epic has also introduced Aura for device and lab connectivity and recently sold into pharma for the first time with a product called Discovery. What remains structurally constrained is Epic's willingness to build payer-confrontational revenue cycle tools for its health system customers — specifically tools that aggressively pursue claim denials, identify systematic payer underpayments, or generate intelligence health systems could use in payer contract negotiations. Building those tools would put Epic in an adversarial position relative to payer organizations it also serves as platform partners. That constraint is a deliberate business model choice, and it is the constraint most directly relevant to the investment opportunity in revenue cycle AI.

Closely related is Epic's approach to FDA-regulated clinical decision support. The company has historically declined to seek 510(k) clearance for clinical decision support tools, which reflects a rational positioning given how the FDA currently regulates software as a medical device rather than a negative strategic choice on Epic's part. A critical distinction underlies this: clinical decision making should remain with the clinician, and Epic's tools are designed as decision support, not decision making. This constraint is not absolute — Epic's Blood Bank product did require FDA clearance — but it reflects a general organizational preference consistent with how health systems and regulators view the appropriate role of software in clinical care. This posture creates gaps in areas requiring software that crosses into autonomous clinical recommendation territory, where purpose-built vendors with FDA clearance can occupy ground that Epic does not seek to claim, though investors should treat this as a directional tendency rather than a permanent boundary.

Underlying both of these is Epic's broader refusal to assume operational or financial risk on behalf of health system clients. Epic sells software; it does not manage operations, guarantee outcomes, or share in the financial consequences of the capabilities it provides. This posture is entirely consistent with Epic's identity as a software vendor, but it creates structural opportunity for vendors willing to stand behind their products with performance-based contracts, shared savings arrangements, or outcome guarantees that Epic will not offer. As health systems increasingly demand financial accountability from their technology vendors, Epic's risk posture becomes a differentiating factor — just not in Epic's favor.

Investors should note that Epic is crossing into previously ceded categories at an accelerating pace. The most recent example is clinical trial management. Epic announced Forward at HIMSS26 — an integrated clinical trials management system built directly into the Epic platform and connected to its Discovery research database, covering end-to-end study management from study activation to sponsor billing and participant tracking. The first phases are available in 2026, with continued rollout in 2027. Clinical trial management was previously occupied entirely by purpose-built vendors — Veeva Vault, Medidata, and Forte OnCore among the most established — with no meaningful Epic presence. Forward follows the same expansion playbook Epic applied with EpicOps in ERP: announce the product category, establish early adopter programs, and let the integration advantage compound over a multi-year build-out. Investors in any category adjacent to Epic's stated roadmap should evaluate with this pattern explicitly in view.

III. AI as an Inflection Point

A. The Speed and Scale of Epic's AI Build-Out

AI is not a future consideration for Epic — it is already the defining axis of the company's product strategy and the most consequential competitive development in the acute care technology market. By the time of the HIMSS26 conference in March 2026, Epic reported that more than ~85% of its customer base was actively using at least one Epic AI product.[2] This penetration rate, achieved within roughly eighteen months of Epic's first significant AI product releases, reflects the extraordinary distribution advantage that comes with controlling more than half of American hospital beds. When Epic ships an AI feature, it ships it to a customer base that few other health technology startups can approach in scale or speed.

Epic's AI strategy is organized around three named personas corresponding to the three primary user groups within health system operations. Art is the clinician-facing AI, designed to reduce documentation burden and enhance clinical decision support. Penny is the revenue cycle AI, targeting the administrative and financial workflows that consume enormous health system resources. Emmie is the patient-facing AI, embedded within MyChart to handle scheduling, visit preparation, and patient communication. These three personas reflect a coherent theory: that AI value in health systems is best delivered through workflow-native tools integrated directly into Epic's environment, and that Epic's integration advantage gives it a structural head start in delivering that value. Alongside these, Epic also announced Forward at HIMSS26 — an integrated clinical trials management system built into the Epic platform and connected to its Discovery research tools, covering end-to-end study management from study activation to sponsor billing and participant tracking, with first phases available in 2026 and continued rollout in 2027.

The early clinical results from Art's ambient documentation tools are meaningful. Clinicians at multiple health systems are completing discharge summaries 20 to ~30% faster with Art's Draft Hospital Course Notes.[6] At Riverside Health in Virginia, Art's Inpatient Insights reduced documentation and communication time by up to ~32%.[6] Early adopters of Art's AI Charting tool report saving up to 60 minutes of documentation time daily — time previously consumed by the 'pajama time' phenomenon of physicians completing notes at home after clinical hours.[5] Epic's Vice President of Research and Development described the tool's ambition as moving beyond passive transcription toward active clinical assistance: the system surfaces relevant patient data dynamically during the encounter, allowing physicians to remain focused on the patient rather than the keyboard.

UPMC's selection of Abridge for ambient documentation is instructive, though with important context: Abridge originated out of UPMC and the health system likely held an early ownership stake, making this less straightforwardly a best-of-breed-beats-Epic story than it might appear. The more important pattern is that the decision was made before Epic had a competitive ambient product and that UPMC evaluated multiple platforms rigorously — with 800 physicians trialing each solution — before committing. The broader signal — health systems establishing third-party AI commitments before Epic enters a category and maintaining them based on demonstrated performance — is likely to repeat across multiple categories as Epic's AI roadmap expands.

On the revenue cycle side, Penny's early results are similarly compelling. Summit Health reduced prior authorization submission time by ~42% using Penny's automated workflows.[7] Other active health systems report coding-related denials declining by more than ~20%. These figures are consistent with the results that specialized third-party revenue cycle AI vendors have been generating for health systems that

adopted them earlier — and they raise a critical question for investors: whether Penny will displace the third-party revenue cycle AI market over time, or whether Epic's neutral payer posture will permanently constrain Penny's ambitions and leave the back-end of the cycle open for specialized vendors. The evidence from health system operators suggests the latter is far more likely.

B. Agent Factory — The Strategic Challenge to Complementary Vendors

The most consequential Epic announcement at HIMSS26 was not any individual AI product but the architectural platform underlying them: Agent Factory, a no-code, drag-and-drop environment enabling health systems to build, customize, and deploy AI agents that can reason, decide, and execute steps autonomously across clinical and operational workflows.[2] Agent Factory represents Epic's most direct move yet into territory previously occupied by AI middleware vendors, workflow automation startups, and health system digital innovation teams.

Phil Lindemann, Epic's Vice President of Data and Research, described Agent Factory in terms that should command attention from every health technology investor: their customers have ideas for where AI can help, and Agent Factory is how they bring those ideas to life without needing to call a vendor or write a line of code.[9] That framing — the health system as its own AI developer, with Epic as the platform — is a direct challenge to the value proposition of a significant portion of the health technology startup ecosystem. Companies whose core product is 'we understand Epic data and can automate a specific workflow' face a genuine threat from a platform that enables health systems to build those automations themselves, often in days rather than months.

Dr. Pete Chang of Tampa General Hospital identified this dynamic explicitly in our primary research conversations. The vendors he finds most credible today are those that have a clear, specific answer to where Epic's road ends and where they pick up. Vendors that position themselves as alternatives to Epic are misreading the market. Vendors that position themselves as the operational layer sitting above Epic's architecture — handling the complexity, risk, financial accountability, and payer confrontation that Epic will not touch — are aligned with the actual procurement reality that health system leaders navigate. As Dr. Chang put it directly: 'whoever figures out how to come and identify your maintenance on these items, how to make your builds more efficient, will really rule supreme.'

The strategic implications of Agent Factory differ significantly by category, however. Agent Factory is powerful for automating workflows that are already well-defined within Epic’s data environment — scheduling optimizations, alert routing, documentation triggers, and administrative coordination. It is substantially less relevant for categories where the structural gap is defined by Epic’s strategic posture rather than technical capability. Agent Factory cannot make Epic a payer-confrontational revenue cycle vendor. It cannot make Epic an enterprise risk management platform. It cannot address the cybersecurity and infrastructure needs that health system CISOs manage entirely outside Epic’s environment. A critical limitation that health system operators have identified is that Agent Factory operates within Epic’s data model — which raises a fundamental question about whether it can ever effectively act on non-Epic data at scale. The new class of agentic AI platform products emerging in the market operates across data sources regardless of origin; Agent Factory may eventually catch up, but its current architecture creates a meaningful ceiling that purpose-built agentic platforms do not face. For investors, the operative question is whether a category’s structural gap is technical or strategic — because only strategic gaps are durable against Agent Factory’s competitive threat.

C. Curiosity Foundation Models and the Long-Term AI Horizon

Alongside Agent Factory, Epic announced Curiosity at HIMSS26 — a proprietary family of medical foundation models trained on anonymized real-world patient records from Epic's Cosmos database.[7] Curiosity is designed to predict patient journeys across clinical and operational dimensions, representing Epic's ambition to move from workflow automation toward genuine predictive intelligence. The announcement signals that Epic intends to compete not only in task automation but in the analytical and predictive AI layer that health systems have historically built using third-party data platforms and externally developed models.

The strategic significance of Curiosity should not be overstated in the near term — foundation model development is capital-intensive, clinical validation is rigorous and slow, and health systems will not rapidly replace purpose-built predictive models with a newer alternative simply because it comes from Epic. UPMC, which has invested in building 23 predictive models on its own data platform across 180 sources and 8 billion patient records, is unlikely to abandon that infrastructure for a less mature Epic-native alternative in the near term.

Over a longer-term horizon, however, Curiosity represents a meaningful strategic signal. If Epic can build foundation models trained on the largest corpus of real-world clinical data in existence — the de-identified records of more than half of all American acute care patients — the analytical advantage it could deliver would be genuinely difficult for third-party vendors to replicate. Investors should evaluate data platform and predictive analytics opportunities with this horizon in mind: the most defensible positions are those where vendor value derives from proprietary domain expertise, outcome accountability, or specialized data that Epic's architecture cannot match even with superior training data.

D. Where AI Expands Structural Opportunity

Despite Epic's aggressive AI investments, AI simultaneously expands structural opportunity for complementary vendors across dimensions that are likely to define the investment opportunity set for the next five years.

Performance differentiation in categories where Epic's native AI tools are functional but not best-in-class is the most immediate dimension. Revenue cycle AI, ambient documentation for specific clinical specialties, and patient engagement personalization all represent areas where the performance gap between Epic's integrated tools and specialized vendors is likely to persist even as Epic's capabilities improve. Health systems that have committed to third-party AI platforms in these categories and are generating measurable ROI have limited incentive to switch to Epic's equivalent if the performance difference remains meaningful and the commercial model is superior.

Beyond performance differentiation, AI is creating entirely new categories of need that did not exist as health technology markets three years ago and are now urgent operational requirements. AI governance and model monitoring infrastructure — the systems required to track model behavior, maintain accountability for AI-driven decisions, audit outputs, and respond to model drift — is a category that no current platform addresses comprehensively, and Epic has no product in this space. The demand signal is urgent and regulatory requirements are strengthening. These dynamics favor early movers significantly.

The data quality and interoperability imperative that AI deployment makes unavoidable is the third major dimension. Every AI tool — including Epic's own — is only as good as the data it is trained and run on. Health systems with complex EHR migration histories, inconsistent documentation practices, and siloed data environments cannot realize the promise of AI without first investing in data normalization, orchestration, and quality remediation. Epic's architecture assumes clean, consistent data inputs and

provides limited tools for addressing environments that do not meet that standard. This creates durable demand for data infrastructure vendors that sit between Epic and the AI applications health systems want to run — a category where the need is structural and the timeline is immediate.

IV. Category Segmentation Framework

The acute care technology landscape can be evaluated through a strategic accessibility framework that reflects the operational reality of how health systems deploy technology. The framework is grounded not in Epic's stated product coverage but in the lived experience of health system technology leaders making actual vendor decisions.

The framework organizes eleven acute care technology categories into three accessibility tiers. The segmentation reflects not only current product capabilities but the structural factors that shape Epic's role within the healthcare technology ecosystem: regulatory exposure, enterprise risk ownership, cross-system integration complexity, payer posture, and the organizational buyer dynamics that determine whether Epic's core IT relationships translate into purchasing influence in adjacent categories.

Epic-Controlled	Categories tightly coupled to core clinical workflows and system-of-record ownership. Epic maintains strong control through embedded workflow integration, high switching costs, and the patient safety and operational risk associated with displacing core systems. Third-party vendors face significant barriers to meaningful differentiation in these domains.
Selective Opportunity	Categories where Epic provides baseline functionality but does not fully meet the operational, financial, or consumer-grade needs of health systems. Organizations frequently deploy complementary vendors to deliver enhanced capabilities, improved performance, or greater flexibility. Vendors willing to assume outcome accountability can compete effectively alongside Epic.
Structural White Space	Categories that fall outside Epic's core operating model and strategic posture. Epic has limited presence or intentionally avoids ownership due to regulatory exposure, payer relationship risk, enterprise-wide accountability requirements, or fundamental architectural mismatch. The dynamics that create this reliance on external vendors are unlikely to change within the investment horizon.

These tiers should be understood as structural assessments, not static predictions. Epic's product roadmap is active and well-funded, and the company will continue expanding into new categories over time. The relevant investment question is not whether Epic will eventually compete in a given category but whether the structural gap — defined by strategic posture rather than product maturity — is durable enough to support vendor development over the next 5-7 years.

The market map below illustrates all eleven categories positioned within this accessibility framework, with scope indicators for each domain.

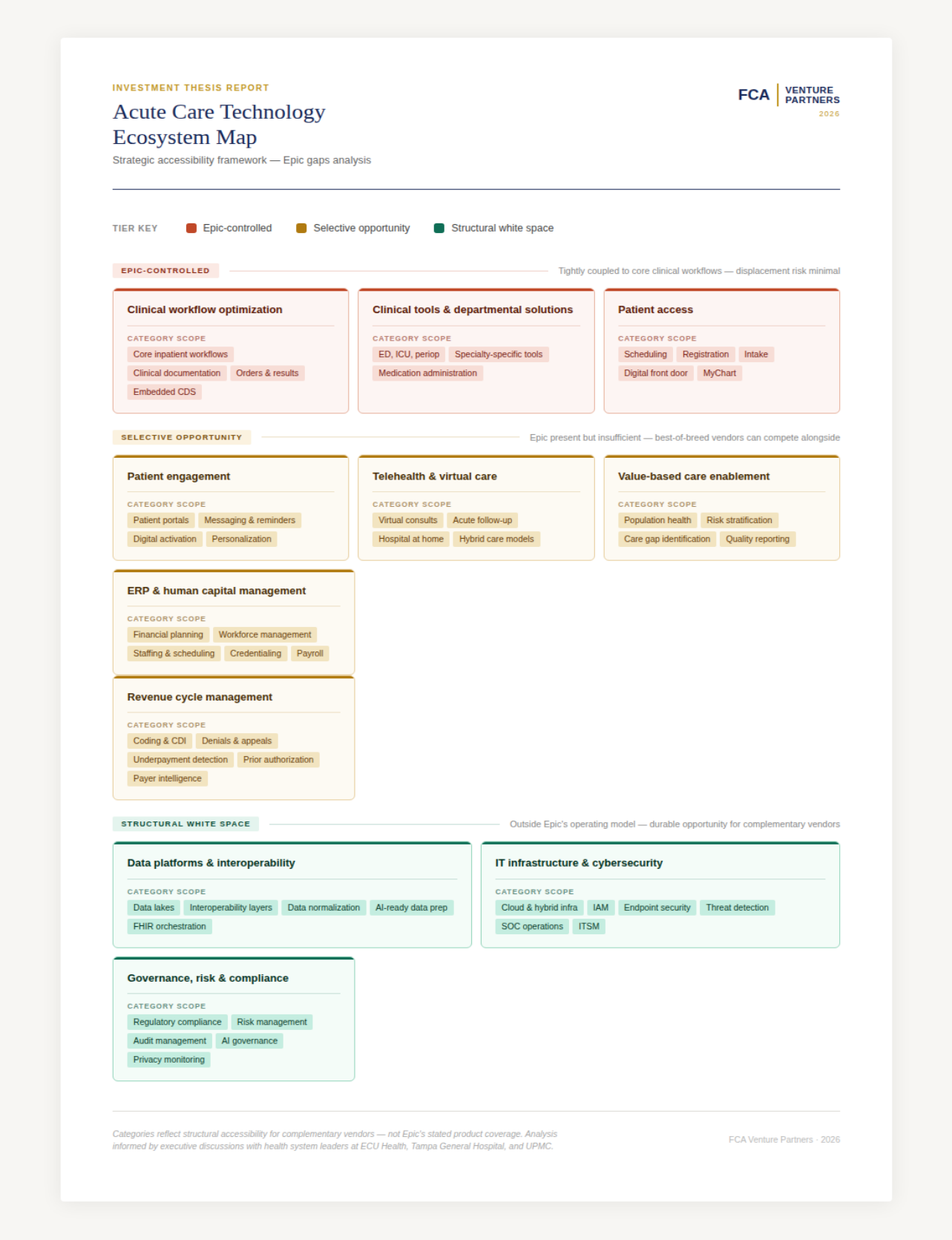

Figure 1. Acute Care Technology Ecosystem Map — Strategic Accessibility Framework

V. Epic-Controlled Categories

A. Clinical Workflow Optimization

Category Overview

Clinical Workflow Optimization represents the operational core of acute inpatient care, encompassing patient documentation, computerized provider order entry, results management, and the embedded clinical guidance systems that shape clinician behavior at the point of care. These workflows occur continuously across every patient encounter and define the fundamental mechanism by which clinical data is generated, captured, and made available for downstream clinical, administrative, and financial use. The category is defined by its zero-tolerance environment for disruption — workflow failures in clinical documentation or order management are patient safety events, not IT incidents — which effectively eliminates competitive alternatives for health systems that have reached operational maturity on Epic.

Epic's Position

Epic maintains near-complete operational control over Clinical Workflow Optimization. Its applications are constitutive of how clinical work is organized and executed at most large health systems — not merely deployed but structurally embedded in every clinical workflow, training program, regulatory reporting pipeline, and operational process that touches patient care. The documentation templates, order sets, alert structures, and clinical decision support logic embedded in Epic's platform have been customized over years of implementation to reflect each health system's clinical protocols, regulatory requirements, and operational preferences. This customization represents enormous institutional value — and an enormous barrier to displacement.

The 'Epic first' evaluation posture — assessing whether Epic can deliver any new capability natively before exploring third-party alternatives — is applied most rigidly in the clinical workflow domain. Health system CIOs and CMIOs who might readily approve a third-party vendor for data analytics or revenue cycle optimization will apply substantially higher scrutiny to any vendor seeking to touch core clinical documentation workflows. Patient safety implications of workflow disruption create an institutional risk aversion that functions as an additional layer of competitive protection for Epic beyond the switching costs that already make displacement practically impossible.

Structural Limitations

While Epic excels at standardizing and managing clinical workflows at scale, its architecture creates friction at two distinct edges that define the spaces where augmentation tools can create value without competing with Epic directly. The first is its positioning around FDA-regulated clinical decision support. Epic has historically declined to build tools that could be classified as medical devices requiring 510(k) clearance — a rational stance consistent with how the FDA regulates software and with the principle that clinical decision making should remain with the clinician. Epic's tools are designed as decision support, not decision making, and the company has reinforced this explicitly by rebranding its Best Practice Advisories to “Our Practice Advisories” — distancing itself from any implication of clinical guidance.[8] As Dr. Chang explained during our primary research conversations, once health systems need heavy clinical decision making, Epic is not the solution — not because of product inadequacy but because of deliberate strategic positioning.

The second structural limitation is population-level data aggregation and self-service analytics. Epic's workflow architecture is optimized for chart-by-chart management of individual patient encounters — extraordinarily effective at organizing and presenting information about a single patient at a specific moment but substantially less capable when analytical questions require aggregating data across large patient populations in real time. A hospitalist who wants to review every history and physical they have written over the past year for quality improvement cannot do so without submitting a formal IT data request. This gap is as much a self-service limitation as a technical one — the data exists within Epic's environment, but users cannot interrogate it in natural language without engineering support. The most compelling vendor opportunity in this space is not building a data extraction layer but enabling a self-service analytics experience where a department head can ask a question in plain language and receive an answer without creating an IT ticket. Vendors who bring that capability to Epic's data environment — without requiring forward-deployed engineers — are addressing the gap that operators actually describe.

The generative AI era is beginning to put pressure on the FDA boundary. Epic's AI Charting tool and the diagnostic support capabilities announced at HIMSS26 push closer to clinical decision support territory the company has historically avoided. The regulatory landscape for AI-enabled clinical tools is actively evolving, and Epic's 2026 product roadmap suggests it is preparing to navigate that landscape more aggressively. Investors should monitor this evolution: categories currently protected by Epic's FDA avoidance may become more contested as Epic's regulatory posture adapts over the next three to five years.

Operational Reality

> *"Epic ends where you need heavy clinical decision making. Because of the 510(k) regulation with the FDA, they don't want to go through that process. They don't want to be deemed as a medical device. They actually changed the name from Best Practice Advisory to Our Practice Advisory — further distancing themselves to say we're not even going to call it best practice because that could be deemed Epic suggested this."*
>
> *"When you're starting to aggregate data across large patient populations — they can do it. But if I wanted to see every history and physical I've written in the last year, why can't I pull that up? I need to create a ticket to IT. For some of these basic tasks of aggregating data across patient records, they're not really good."*
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> **— Dr. Pete Chang, Chief Transformation Officer, Tampa General Hospital — FCA Primary Research, 2026**

Implications

This category remains firmly Epic-controlled. Displacement risk is essentially zero, and meaningful investment opportunity does not exist in direct competition with Epic's core clinical workflow tools. The viable investment thesis is narrow augmentation: tools that deliver analytical, predictive, or AI-enabled capabilities in the specific spaces where Epic's FDA-avoidance strategy and population analytics architecture create persistent gaps, without seeking to displace or compete with Epic's documentation core. Vendors must integrate tightly with Epic and position explicitly as extending Epic's capabilities rather than competing with them.

B. Clinical Tools and Departmental Solutions

Category Overview

Clinical Tools and Departmental Solutions encompass the specialized applications used within specific hospital departments — emergency medicine, intensive care, perioperative services, pharmacy, oncology, behavioral health, and other clinical specialties. These tools support medication administration workflows, specialty-specific documentation, department-specific patient monitoring, and the operational coordination that characterizes high-acuity care environments. Their defining characteristic is the requirement for seamless integration with the broader clinical record alongside domain-specific performance that generalist platforms struggle to match.

Epic's Position

Epic has systematically expanded its departmental footprint through purpose-built modules extending its core platform into specialized clinical environments. The company's module-by-module expansion strategy — covering emergency department workflows, intensive care unit monitoring, perioperative management, oncology documentation, behavioral health, and a growing list of specialty applications — allows health systems to manage an increasingly broad range of departmental workflows within a unified architecture. Epic reinforces this expansion through its institutional scorecard mechanism: health systems receive regular reports identifying modules they have licensed but are underutilizing, creating structural pressure to rationalize third-party vendor relationships in favor of Epic-native functionality.

Structural Limitations

Despite broad module coverage, Epic’s departmental solutions consistently prioritize standardization over depth. Highly specialized departments frequently require capabilities, optimization levels, or domain-specific intelligence that exceed what Epic provides natively, and Epic’s development cycles lag behind vendors dedicated to solving specific clinical challenges. Dr. Chang estimated during our research conversations that Epic delivers on approximately ~20% of its stated capabilities as described in sales presentations — a figure that reflects not deliberate misrepresentation but the inherent gap between what a generalist platform can promise and what domain-specific functionality actually requires in complex clinical environments. This estimate warrants important context: other health system leaders find Epic delivers substantially more, and the gap varies significantly by module and implementation maturity. More importantly, Epic is intentionally designed to be configured to organization-specific workflows, policies, and state requirements — meaning any gap often reflects a local configuration challenge as much as a global product limitation. Attempting to build a scalable vendor business around filling every health system’s unique configuration gap is not viable; the variance between organizations is too great. The genuine opportunity is in domains where the limitation is architectural or strategic, not configurable — where Epic’s roadmap has no credible plan to address the gap regardless of how much customization a health system applies.

Surgical scheduling illustrates this gap with particular clarity. Epic can calculate average case durations by procedure type and provider, generating a baseline scheduling recommendation based on historical averages. What it cannot do is incorporate the full range of variables determining whether a specific case will run short or long: the individual patient's anatomical complexity, the configuration of the surgical team on a given day, the real-time availability of specialized equipment, or the case-specific factors that experienced surgical schedulers factor into their judgment intuitively. TGH is integrating camera-based computer vision to capture precise intraoperative timing data — but Epic cannot consume that external data to improve its scheduling recommendations, resulting in persistent unused block time that represents recoverable clinical and financial value.

ECU Health's experience with emergency medicine AI tools provides another illustration. The health system identified AI tools for ED workflow optimization — tools incorporating real-time patient flow modeling, predictive capacity management, and AI-assisted triage support that go substantially beyond Epic's native ED module — as high-priority investments for emergency services leadership. The performance gap between Epic's generalist emergency department module and purpose-built alternatives is measurable in clinical and operational outcomes, and health systems in our research were willing to manage the integration complexity to access that performance advantage.

Operational Reality

> *"Niche products are still delivering strong value propositions. AI tools for emergency services — Kate AI for triage specifically — are a high priority for our leaders of emergency services. Organizations report strong efficiency and quality benefits that Epic's native departmental tools cannot replicate. That said, AI is evolving so rapidly that we now believe we can replicate some of these capabilities using a third-party AI development platform, Bunker Hill, which may allow us to displace or avoid purchases of certain third-party AI solutions and save hundreds of thousands if not millions of dollars. For example, we spend over $400K per year on an NLP-based CDI solution for inpatients — that kind of spend may be avoidable as these platforms mature. Vendors must transition to value-based contracts rather than traditional licensing to compete effectively in these spaces. A solid five-year opportunity exists in highly specialized departmental applications where Epic's generalist architecture cannot match the depth of purpose-built solutions — but vendors need to be aware that the window is defined by how quickly health systems can build equivalent capabilities themselves."*
>
> **— ECU Health Executive Interview — FCA Primary Research, 2026**

Implications

Epic maintains strong control across most departmental workflows where integration with the broader clinical record is the primary decision criterion. Selective opportunities exist in highly specialized clinical environments — surgical services, emergency medicine, intensive care, oncology — where the performance gap between Epic's generalist modules and purpose-built alternatives is measurable and clinically or operationally significant. The most credible vendor positions in this category are anchored by outcome data, value-based contract structures, and a clear articulation of the specific boundary where Epic's departmental capabilities end.

C. Patient Access

Category Overview

Patient Access represents the front door of the health system — scheduling, registration, intake, and patient flow management — alongside the digital front door experience through which patients interact with health systems before, during, and after clinical encounters. Health systems increasingly treat Patient Access as a competitive differentiator: friction in the access experience translates directly into patient volume leakage to competitors offering more convenient digital engagement, and recovery of that volume is far more expensive than retaining it in the first place.

Epic's Position

Epic occupies a central and deeply embedded role in Patient Access through MyChart and its integrated scheduling and registration infrastructure. MyChart's integration with Epic's underlying clinical

and billing data is its primary competitive advantage: scheduling actions update directly in Epic's scheduling system, clinical communications flow through Epic's documentation environment, and patient-generated data enters the clinical record without manual intervention. The 'Epic first' posture is strongly applied here — health systems that have built out MyChart infrastructure have limited appetite for parallel patient access platforms without compelling performance evidence.

Structural Limitations

While Epic provides comprehensive baseline functionality, its Patient Access architecture creates constraints for health systems seeking to differentiate their patient experience. MyChart delivers a standardized experience across all Epic health systems — the same interface, the same interaction patterns, the same functional boundaries — which prevents individual organizations from building the consumer-grade digital experiences that the most competitive healthcare organizations are pursuing. Health systems that look at the digital engagement capabilities of best-in-class consumer health companies and want to match them will consistently find MyChart insufficient.

The digital front door is where the competitive gap is most acute. AI-driven conversational platforms capable of handling complex patient inquiries — navigating multi-specialty scheduling, managing insurance verification in real time, providing personalized care navigation, and handling the nuanced emotional dimensions of patient communication — go well beyond what MyChart's architecture supports. ECU Health's evaluation of conversational AI platforms identified tools incorporating sophisticated behavioral logic, multi-turn reasoning, empathy programming, and adaptive response calibration that Epic's development resources could not match within a five-year horizon even with dedicated effort. Faced with acute patient access challenges and workforce shortages, health systems cannot wait for Epic's product development cycles in this area. Third-party conversational AI vendors may ultimately represent a stopgap as Epic catches up, but they are essential in today's environment given workforce constraints and resource limitations that make digital deflection and automation an operational necessity.

Intelligent scheduling optimization represents a parallel gap. Epic's scheduling system can recommend appointment slots and calculate provider availability, but it cannot incorporate the full range of clinical and operational variables — patient complexity, provider-specific performance patterns, real-time OR capacity — that would make scheduling recommendations genuinely optimal. The consequence is scheduling inefficiency that accumulates across thousands of daily appointments, representing meaningful clinical capacity and financial waste that Epic's architecture is not designed to address.

Operational Reality

> *"Epic is now deploying heavily into patient access — what they're calling their provider finder. If a patient is searching the web for a provider that is skilled at a certain procedure, Epic knows what procedures our providers have completed, but we still have to manually program this information into the provider profile for it to appear on a search. Epic also creates decision trees which help guide patients to the specific type of appointment they need. These decision trees either need to be navigated manually by a patient access specialist or the patient themselves via MyChart — even if the clinic data resides in Epic. There's so much opportunity even within what looks like Epic-controlled territory. I wouldn't say it's dominated. Epic will say they do it, and they do in fact do it, but how well do they do it — and what opportunity is created by the original workflow?"*
>
> **— Dr. Pete Chang, Tampa General Hospital — FCA Primary Research, 2026**

Implications

Patient Access remains substantially Epic-controlled in its administrative core due to deep integration with Epic's clinical and financial systems. The most durable investment opportunity lies in the digital front door: AI-driven conversational platforms handling the patient interaction layer above MyChart, intelligent scheduling optimization incorporating real-world clinical variables that Epic cannot access, and personalization infrastructure enabling health systems to differentiate their patient experience in ways that MyChart's standardized architecture precludes.

VI. Selective Opportunity Categories

A. Patient Engagement

Category Overview

Patient Engagement encompasses the tools and platforms that maintain meaningful communication between health systems and patients outside the boundaries of the clinical encounter. This includes patient portals, asynchronous messaging, condition management applications, appointment reminders, pre-visit preparation tools, post-discharge follow-up platforms, and in-hospital digital engagement. The category sits at the intersection of clinical care and consumer technology — it requires the data fidelity and regulatory compliance of clinical software alongside the user experience quality and behavioral engagement sophistication of consumer applications. This intersection is precisely where Epic's architecture is weakest and where the performance gap between Epic's native tools and best-of-breed alternatives is widest.

Health systems have become increasingly sophisticated about the financial and clinical implications of patient engagement. Engaged patients are more likely to adhere to care plans, keep follow-up appointments, and remain within a health system's network rather than seeking care elsewhere. Disengaged patients generate avoidable readmissions, emergency department visits, and care gaps that degrade both clinical outcomes and financial performance. The ability to engage patients effectively — not merely give them a portal but actually activate behavioral change and sustained health system utilization — has become a genuine competitive differentiator in markets where health systems compete actively for patient volume.

Epic's Position and Structural Limitations

Epic holds a substantial and data-rich presence in this category through MyChart. MyChart’s integration with Epic’s clinical data environment gives it a data access advantage that standalone engagement platforms cannot easily replicate — scheduling actions, clinical communications, and patient-reported data flow through a single infrastructure maintaining fidelity with the clinical record. This is a real advantage, and it explains why health systems default to MyChart rather than deploying parallel consumer engagement platforms. It is important to frame MyChart accurately: it was not designed to be, and should not be evaluated as, a digital front door in the full consumer sense. It is a highly customizable patient portal — though that customization comes at a maintenance cost that health systems increasingly find unsustainable. Epic has begun monitoring and reporting on how much customization health systems apply to MyChart, actively discouraging over-engineering. Patient behavior has validated this direction: adoption of MyChart Central demonstrates that patients do not want multiple apps for each health system — they want a consistent experience. Companies that attempted to build competing consumer health apps to replace or redirect from MyChart, such as b.well, largely missed this insight. The winning strategy is complementary: build around MyChart, help with bill pay, navigation services, and behavioral engagement that MyChart does not own, and position as extending rather than competing with Epic’s patient-facing infrastructure.

However, MyChart's design philosophy — standardization across all Epic health systems — is fundamentally in tension with the personalization demands of effective patient engagement. Research on digital health engagement consistently demonstrates that personalized, contextually relevant communication significantly outperforms generic reminders and portal notifications.[9] MyChart delivers the

latter. The platform presents the same interface, the same notification patterns, and the same functional capabilities to every Epic health system — enabling a functional engagement platform while preventing health systems from building the differentiated experiences that the most consumer-oriented organizations pursue.

Epic's appetite for engagement ROI accountability is similarly limited. The company sells MyChart as a platform feature of its EHR, not as a performance-guaranteed engagement product. Health systems looking for a vendor partner who will take accountability for engagement outcomes — patient activation rates, follow-up appointment adherence, care plan compliance — will not find that partnership with Epic. Emmie, Epic's patient-facing AI chatbot launched at HIMSS26,[2] represents Epic's most direct move into AI-driven engagement and will meaningfully improve MyChart-native engagement capability. But the performance accountability gap is structural, not a product feature that Emmie addresses.

UPMC's response to this limitation is illustrative. The health system built a dedicated platform layer above MyChart specifically to manage patient traffic routing, personalized outreach, and engagement analytics at enterprise scale — reflecting the judgment that MyChart alone is insufficient for UPMC's patient engagement requirements. This pattern — MyChart as foundational infrastructure, supplemented by external platforms delivering the consumer-grade experience Epic's tools cannot provide — is consistent across the most sophisticated health systems in our primary research.

Operational Reality

> *"Epic continues making strides in patient engagement but significant gaps persist. The digital front door is particularly ripe for innovation. Conversational AI platforms we evaluated are not just API integrations with Epic — they incorporate sophisticated logic, rules and parameters for AI agent behavior, and advanced empathy programming for patient interactions. Years of development runway exist in these platforms even with Epic's developer resources. May not be a ten-year play, but it's a solid five-year opportunity."*
>
> **— ECU Health Executive Interview — FCA Primary Research, 2026**

Implications

Patient Engagement represents a well-defined selective opportunity. Epic provides a functional and data-rich baseline through MyChart, but health systems consistently seek complementary vendors to layer personalization, behavioral activation analytics, and consumer-grade experience on top of it. Emmie's launch will raise the competitive bar for patient-facing AI, but the personalization gap and accountability gap are structural rather than purely technical and are unlikely to close within the investment horizon relevant to early-stage vendors. Vendors integrating cleanly with MyChart while delivering measurably better engagement outcomes on performance-based contracts are well-positioned to compete in this category.

B. Telehealth and Virtual Care

Category Overview

Telehealth and Virtual Care covers the delivery of clinical services through video, asynchronous messaging, and remote monitoring channels. Within the acute care context, this includes virtual inpatient consultations, remote specialist access, acute follow-up care, hospital-at-home programs, and the hybrid

care delivery models blending in-person and digital touchpoints across care episodes. It is analytically important to distinguish between two meaningfully different contexts within this category: telehealth — the delivery of clinical consultations via video or asynchronous messaging — and hospital-at-home, the provision of actual inpatient-level care in a patient's home setting. These are distinct competitive environments. Epic is already meaningfully present in virtual visit telehealth infrastructure; the structural gap identified in this analysis is concentrated in hospital-at-home, where the operational complexity of care delivery at home exceeds what any EHR-centric platform is designed to manage. Investors should calibrate their evaluation accordingly. The pandemic-era normalization of virtual care has matured into a permanent component of acute care delivery strategy. Health systems now evaluate virtual care not as an emergency adaptation but as a structural component of their capacity management, cost structure, and patient access strategy.

The economics of virtual care make this category strategically significant beyond patient convenience. Health system analyses of virtual care programs consistently find that these visits operate at a fraction of the overhead cost of equivalent in-clinic encounters — a differential that, scaled across a large health system's outpatient volume, represents a meaningful opportunity to improve financial performance while maintaining patient access. Health systems that can effectively design and manage hybrid care programs have a structural cost advantage over those that cannot, and the program design and operational execution capability — not the technology infrastructure — is what separates high-performing virtual care programs from poorly utilized technology investments.

Epic's Position and Structural Limitations

Epic offers embedded telehealth functionality allowing clinicians to initiate and document virtual visits without leaving the Epic environment. Documentation, billing, and follow-up workflows remain within Epic's unified system, reducing the friction that earlier standalone telehealth platforms created. Its Care Everywhere module further supports virtual care continuity by enabling patient records to follow individuals across Epic-connected organizations — ensuring that clinical context from prior in-person encounters is available during virtual visits regardless of which Epic-affiliated site initiated the care. For health systems whose primary telehealth requirement is enabling physicians to conduct video visits and document them efficiently, Epic's native functionality is often adequate.

The more significant gap is not in the technology of the virtual visit itself but in the operational infrastructure that makes virtual care programs clinically and financially successful. Epic provides the virtual visit tool but does not provide the program design expertise, clinical protocol development, utilization management, or performance accountability that differentiate a high-performing virtual care program from a poorly utilized technology investment. Health systems that want a vendor partner who will help them build a hospital-at-home program — designing clinical eligibility criteria, managing daily patient monitoring, coordinating home visits, and sharing accountability for outcomes — will find that Epic provides the pipes but not the program.

The hospital-at-home segment deserves particular attention as an investment opportunity. Multiple health systems in our primary research described persistent challenges in adapting Epic's architecture to support hospital-at-home requirements — remote vital sign monitoring, medication delivery coordination, nursing visit scheduling, and care coordination across home-based and facility-based care settings. Epic's architecture was built for the inpatient environment; hospital-at-home requires a fundamentally different operational model that Epic's current tools do not support adequately, creating durable demand for purpose-built solutions.

Operational Reality

> *"Hospital at home is a perfect example. I was talking to a peer hospital-at-home client recently — they already have a program but are having trouble scaling. They asked how we could help them, and they called out the three or four specific pain points that I still struggle with today with Epic and hospital at home. We are conforming to Epic's architecture rather than Epic adapting to ours. Until Epic has more flexibility in how they build and design, there will always be a market for other applications in these spaces."*
>
> **— Dr. Pete Chang, Tampa General Hospital — FCA Primary Research, 2026**

Implications

Telehealth and Virtual Care is a selective opportunity where Epic's presence creates a functional floor but significant ceiling limitations in program design, operational execution, and outcome accountability. The most defensible vendor positions in this category are anchored by execution ownership — vendors who take accountability for virtual care program performance rather than simply providing technology. The hospital-at-home segment and hybrid care model design represent the highest-conviction near-term opportunities, where Epic's architectural inflexibility creates persistent operational friction that purpose-built vendors can address on a performance-guaranteed basis.

C. Value-Based Care Enablement

Category Overview

Value-Based Care Enablement encompasses the analytics platforms, care management tools, and performance intelligence systems that help health systems succeed under risk-bearing contracts and alternative payment models. The category spans longitudinal population health analytics, readmission risk identification, care gap measurement, quality and cost performance tracking, and the cross-setting care coordination intelligence essential for managing patient populations across acute, post-acute, and ambulatory settings.

The category is experiencing a structural tailwind as payer and government programs expand value-based payment arrangements. Under traditional fee-for-service payment, health systems are paid for volume of services delivered; under value-based arrangements, they are paid based on health outcomes and cost efficiency across a defined patient population. This shift fundamentally changes what health systems need from their technology: not just documentation and billing tools, but predictive intelligence, care coordination infrastructure, and financial performance analytics that can identify intervention opportunities before they become costly clinical events. The health system executives who manage VBC strategy operate with a different set of requirements than those managing Epic — and they are looking for vendor partners willing to share in the financial risk of their performance.

Epic's Position and Structural Limitations

Epic has a structural advantage in this category rooted in data origination. Because Epic serves as the primary system of record for acute clinical encounters, it generates the data on which value-based care programs depend. Its Healthy Planet population health module provides baseline functionality for care gap identification, risk stratification, and quality metric tracking. Compass Rose supports care management

workflows within Epic's environment. For organizations operating primarily within a single Epic instance and managing contained patient populations, these tools offer meaningful starting capability.

The structural limitations of Epic's value-based care tooling become apparent under three conditions that characterize the most sophisticated VBC programs. Cross-setting data integration is where Epic is weakest relative to the need: effective population health management requires data from outside Epic's acute care environment — claims data capturing care delivered by out-of-network providers, post-acute records from skilled nursing and home health, social determinants data, and pharmacy data from community pharmacies. Epic's population health modules are least capable precisely where they are most needed: at the boundaries of the care continuum where high-cost, high-risk patients are most likely to fall through the gaps.

Financial and outcome accountability is the second structural limitation. Vendors competing effectively in this space increasingly offer performance guarantees and shared risk arrangements that Epic is structurally unwilling to assume. UPMC, which has built 23 predictive models covering readmission risk, mortality prediction for palliative care decisions, and operational efficiency entirely outside Epic's native environment — on a data platform integrating 180 sources and 8 billion patient records — reflects the explicit judgment that Epic's analytical tools are a starting point, not a solution. The pattern holds consistently across health systems in our primary research: Epic provides the data origination, but the organizations generating real population health intelligence have all built infrastructure that treats Epic as one input among many.

Actionable intelligence generation is where the gap between Epic's tools and what genuine VBC programs need becomes most apparent. The distinction between data visibility and actionable intelligence is critical. Epic's population health module can identify patients with care gaps and flag them for outreach — that is data visibility. What it cannot do is generate the operational intelligence that answers the questions health system leaders actually need answered: Where are referral patterns shifting and why? Which interventions have the highest ROI for a specific at-risk population over the next 90 days? What is the predicted cost trajectory of a risk pool, and what actions would bend that curve? These questions require predictive modeling and analytical intelligence that Epic's workflow-centric architecture is not designed to deliver.

Operational Reality

> *"Epic avoids financial and outcome accountability. We have built 23 predictive models outside Epic — readmission rates, mortality prediction for palliative care decisions, operational efficiency — on a data platform integrating 180 sources and 8 billion patient records going back to 1992. That infrastructure investment reflects a clear judgment about where Epic's analytical tools end and where real population health intelligence begins. Epic is the data source. It is not the data platform in our organization."*
>
> **— UPMC Technology Leadership — FCA Primary Research, 2026**

Implications

Value-Based Care Enablement is one of the most structurally compelling selective opportunities in the acute care ecosystem. Epic controls the data origination layer but is not positioned — and does not seek — to own the predictive analytics, cross-setting intelligence, or financial accountability that effective value-based care programs require. The structural tailwind from payer-driven VBC expansion will continue

to increase the sophistication demanded of VBC enablement tools. Vendors layering advanced cross-setting analytics, AI-driven risk stratification, actionable care management intelligence, and financial risk partnership on top of Epic's data infrastructure are addressing a growing and urgent organizational need.

D. ERP and Human Capital Management

Category Overview

Enterprise Resource Planning and Human Capital Management encompasses the operational and financial backbone of health system administration — financial planning and analysis, general ledger management, workforce scheduling, staffing optimization, credentialing, payroll administration, and organizational performance reporting. For large integrated delivery networks managing tens of thousands of employees across multiple care settings, these are complex enterprise software domains that share more with Fortune 500 corporate infrastructure than with clinical information systems.

Epic's Position and Structural Limitations

Epic maintains meaningful adjacency to ERP and HCM through its role as the system of record for clinical encounter data, which feeds workforce productivity metrics and patient volume projections relevant to operational planning. However, Epic does not meaningfully compete in ERP or HCM. UPMC placed ERP and HCM explicitly in the category where 'Epic is too far behind to be considered,' noting that the organizational buyers — CFOs, CHROs, and Chief Operating Officers — operate with entirely different decision criteria than the clinical IT leaders who manage the Epic relationship. These buyers evaluate workforce management solutions on financial controls, regulatory labor compliance, and operational flexibility — not EHR integration.

Established enterprise vendors — Workday, Oracle, and SAP — maintain strong positions in healthcare ERP and HCM. However, Epic announced EpicOps at HIMSS 2025 — a healthcare-native ERP covering workforce management, supply chain, and financials, with a full rollout timeline extending through mid-2027. While Epic remains far behind established enterprise vendors in functional depth and health systems are not yet treating EpicOps as a near-term displacement threat, its announcement materially changes the investment calculus for ERP-adjacent categories. The opportunity for innovative vendors lies not in competing with legacy ERP platforms on core functionality but in delivering AI-enabled workforce optimization with demonstrated, measurable ROI — specifically predictive staffing models incorporating patient acuity, real-time labor cost optimization, and workforce analytics connecting clinical demand patterns to staffing decisions. Given EpicOps, investors should favor vendors with platform depth and a demonstrated track record that would be difficult for Epic to replicate before its ERP roadmap matures — rather than point solutions that could be displaced as EpicOps builds out. The nursing shortage and escalating labor costs have made workforce optimization a board-level priority, but the risk profile of ERP-adjacent investments has shifted with this announcement.

Implications

ERP and HCM represent a meaningful selective opportunity, particularly for vendors delivering AI-enabled workforce optimization that demonstrably reduces labor costs or improves staffing efficiency within twelve months of deployment. The category is large, the buyers are distinct from Epic's core relationships, and the operational pressure of current labor market conditions makes the investment case for sophisticated workforce analytics increasingly compelling. Vendors should focus on demonstrating measurable labor cost impact rather than competing on feature breadth against established ERP vendors.

E. Revenue Cycle Management

Category Overview

Revenue Cycle Management encompasses the complete financial lifecycle of acute care delivery — charge capture and clinical documentation improvement through claims submission, prior authorization, denial management, underpayment detection, appeals processing, and payer contract intelligence. It is the category most directly connected to health system financial sustainability: in an environment where operating margins at many health systems have compressed to single digits or below, revenue cycle performance is a strategic imperative rather than a back-office function. Even modest improvements in net collection rates translate to tens of millions of dollars annually at large health systems, making RCM technology among the highest-ROI investments in the health system technology stack.

The category has become the primary battleground for AI investment in healthcare, and the logic behind this is straightforward. Revenue cycle process logic is mature and well-defined enough for AI systems to apply reliably — the rules governing coding, billing, and claims adjudication carry far less clinical ambiguity than most other AI applications in health systems. ROI is measurable in concrete dollar terms within months of deployment, making it possible to build the performance-based commercial models that health system procurement increasingly demands. Health systems across our primary research are actively seeking vendors willing to operate on shared-savings or outcome-guaranteed terms in this category, and the vendors delivering those commercial models are winning enterprise contracts.

Epic's Position

Epic provides genuine and meaningful strengths at the front end of the revenue cycle. Its embedded billing workflows, charge capture infrastructure, and claim submission processes are tightly integrated with clinical documentation — creating a continuous billing record built during the encounter rather than constructed retrospectively. This integration reduces charge lag, decreases documentation errors that generate claim denials, and provides revenue cycle staff with a unified view of the clinical and financial encounter record. These are real advantages that explain why health systems default to Epic for core billing infrastructure.

Penny, Epic's revenue cycle AI persona, is generating real results at health systems willing to adopt it actively. Summit Health cut prior authorization submission time by ~42%, and other active deployments report coding-related denial rates declining by more than ~20%.[7] These numbers confirm that Epic is serious about revenue cycle AI and that Penny will become a more meaningful market factor over the next several years. The question is not whether Epic will compete here — it clearly will — but what the structural ceiling on Penny's ambitions is, and whether that ceiling leaves enough room above it for specialized vendors to build durable businesses.

Where Epic's Posture Creates Room for Vendors

Epic’s structural limitations in revenue cycle become acute at the back end of the cycle — the analytically intensive, payer-confrontational work where the largest financial opportunities reside. Epic maintains a deliberately neutral posture toward payers, which has historically constrained its willingness to build tools that aggressively pursue claim denials, identify systematic underpayments, surface payer contract compliance failures, or generate intelligence health systems could use in payer negotiations.[8] Investors should apply a critical caveat: Epic is moving further into RCM intelligence faster than this analysis’s earlier framing assumed. Payer Platform signals that Epic is stepping more actively into payer-provider workflows. Epic leadership has publicly stated ambitions to compete directly with Availity and

Change Healthcare in payer data exchange within two years or less. Penny's capabilities are expanding and the assumption that Epic will stop short of payer confrontation may not hold on the longer end of the investment horizon. The near-term structural gap is real; its long-term durability requires closer monitoring than it did 24 months ago. The cost of Epic's current posture is borne by health systems leaving revenue on the table that more aggressive, payer-confrontational tools would recover — but investors should evaluate RCM opportunities with honest eyes on Epic's stated intent.

This is precisely why RCM belongs in the selective opportunity tier. Epic has genuine and improving product presence — Penny is real — but its strategic posture creates a durable ceiling that specialized vendors can operate above. The opportunity is not to compete with Epic on billing infrastructure; it is to own the payer-confrontational, outcome-accountable work that Epic's relationship model will not allow it to do.

Document management illustrates the operational gap concretely. Tampa General Hospital sends and receives 40 million faxes annually — 40 million individual fax transmissions, not pages — because major commercial payers continue to communicate primarily through fax for prior authorization, clinical documentation requests, and denial correspondence. Epic does offer Gallery, its document management system, which at many health systems is actively replacing Hyland OnBase and provides payer-provider correspondence capabilities alongside Epic's Payer Platform. However, Gallery has meaningful limitations that define the real investment opportunity: it does not have computer vision functionality to automatically read, sort, and assign documents to a patient's chart with appropriate clinical context. Documents still require manual management, and scanned documents do not convert their information into structured data fields within Epic — meaning the data in those documents remains locked in image format rather than becoming actionable clinical or operational intelligence. The structural opportunity lies precisely here: AI-enabled document intelligence that automates classification, applies OCR to identify missing or inaccurate data before it enters the EHR workflow, flags errors for the recipient in real time, and converts document content into structured data. That is where the whitespace in document management actually lives, and where purpose-built AI tools can deliver ROI that neither Gallery nor legacy platforms like OnBase are positioned to match.

AI-enabled coding optimization represents the clearest near-term opportunity within this category. Multiple health systems in our primary research described systematic gaps between the clinical complexity of care delivered and the coding complexity captured in Epic's documentation — gaps that AI coding tools are specifically designed to close. Correcting documentation gaps for comorbidities and complications that are clinically present but undercoded can shift cases between reimbursement tiers with no change in care delivery and no payer confrontation. Vendors like Akasa, SmarterDX, and CodaMetrix are capturing this opportunity on outcome-based commercial models that Epic's risk posture precludes it from replicating. The health systems adopting these tools earliest are building both financial momentum and organizational capability that makes the case for performance-based RCM AI self-reinforcing.

Operational Reality

> *"We are building revenue support tools outside of Epic because the workflows inside of Epic don't meet the need of our team. We have to examine the entire patient journey — we have to go from the time the patient comes in and we submit a notice of admission to a payer all the way to the claim getting dropped and the management of the potential denial workflows and then automation of all these things. Epic does have a payer platform that helps with some of these items, but it actually involves our payer partners licensing Epic and creating a separate team to build their own instance of Epic's payer platform. We can't dictate what systems our payer partners use in many cases. I actually*

> *think the CMS-0057-F rule for payer interoperability will hopefully be a game changer and will ease the patient/provider/payer data exchange landscape, independently of payer platform."*
>
> **— Dr. Pete Chang, Tampa General Hospital — FCA Primary Research, 2026**

Implications

Revenue Cycle Management sits in the selective opportunity tier because Epic is genuinely present and improving — Penny is a real competitor — but its strategic posture toward payers creates a durable ceiling above which specialized vendors can build. The opportunity is the back end of the revenue cycle: payer confrontation, outcome-based guarantees, document management, and deep coding intelligence that Epic's relationship model will not allow it to develop. Representative vendors include Akasa and Waystar for AI-powered denial prevention and prior authorization, SmarterDX for clinical documentation improvement, CodaMetrix for autonomous inpatient coding, and Anomaly for underpayment detection and payer contract intelligence. Vendors operating on performance contracts and willing to take on the payer engagement that Epic structurally avoids are addressing needs that Epic's roadmap will not cover — regardless of how good Penny gets.

VII. Structural White Space Categories

A. Data Platforms and Interoperability

Category Overview

Data Platforms and Interoperability encompasses the infrastructure layer responsible for aggregating, normalizing, and activating health system data across sources and use cases. This includes data lakes and cloud data warehouses, API management and interoperability layers, data normalization and quality remediation, semantic harmonization infrastructure, and the preparation of clinical and operational data for AI model training and inference. The category has moved from a technical consideration to a strategic imperative as health systems have recognized that their ability to benefit from AI is directly constrained by the quality and accessibility of their underlying data — and that Epic's architecture, despite being the primary data origination source, is an inadequate platform for that data activation.

The fundamental challenge is that health systems have accumulated decades of data across multiple EHR systems, departmental applications, billing platforms, and external sources — stored in formats, using vocabularies, and under governance structures that make aggregation and analytical use difficult. Epic is the primary source of this data, but it is not a platform for activating it at enterprise scale. Understanding this distinction is essential for understanding the investment opportunity in this category, and health systems that have made this distinction explicitly — including UPMC, which has invested in a 180-source, 8-billion-record data environment entirely outside Epic — represent the directional marker for where the broader market is moving.

Epic's Position

Epic functions as the dominant system of record within this category — the primary origination point for the clinical, operational, and financial data that health systems need for analytics, AI model training, and interoperability. Epic offers Cogito as its analytics and reporting environment and Cosmos as a federated research database aggregating de-identified data across its customer base. Its Care Everywhere framework enables patient data to follow individuals across Epic-connected organizations, which is a genuine interoperability achievement within the Epic network. These tools provide meaningful value for use cases operating within Epic's data environment and accepting its analytical constraints.

Structural Limitations

Despite controlling primary data capture, Epic's architecture creates significant and documented friction for health systems seeking to build enterprise-grade analytical environments. The most fundamental friction is Epic's protective posture toward its own data models. Epic's proprietary database structure — Chronicle — is designed for clinical workflow management, not analytical flexibility. Health systems seeking to build analytical environments on top of Epic's data must extract it into external platforms, a process Epic controls through data sharing agreements, API licensing requirements, and integration certification requirements.

UPMC's experience illustrates how actively Epic manages this access: building the foundational integration between Epic's Chronicle database and its Snowflake data warehouse required a three-way agreement involving Epic, Snowflake, and UPMC itself.[9] Epic's motivation for this protective posture is understandable — it derives competitive advantage from being the authoritative source of health system

data — but the practical effect is to create barriers to exactly the kind of data activation that health systems need to compete in an AI-driven environment.

The HL7 versus FHIR gap is a second major friction point. FHIR has been widely adopted as the regulatory and industry standard for health data interoperability — CMS interoperability rules require FHIR-based API access, and the broader health technology ecosystem has oriented its integration strategies around FHIR. In operational practice, however, healthcare data remains predominantly HL7-formatted, and UPMC's technology leaders noted explicitly that FHIR adoption is substantially less complete than industry discourse suggests. Epic's FHIR implementation, while present and improving, is more constrained in its write capabilities than in its read capabilities — creating the asymmetry Dr. Chang described: getting data out of Epic is feasible; getting data back in is significantly harder.

The write-back challenge has concrete operational consequences. TGH built a bed planning optimization system on a third-party platform that generates superior bed assignment recommendations by incorporating variables beyond Epic's native tools — real-time capacity data, patient flow predictions, and operational context from external sources. Getting those recommendations written back into Epic's Grand Central bed management module requires navigating the requirements mapping and configuration complexity of Epic's write-back architecture, which TGH has not yet resolved — meaning nurses and care coordinators must manually re-enter recommendations already generated by the system. The friction here is not that Epic categorically prevents write-back; health systems can support this technically. The challenge is the requirements definition and mapping complexity required to make it work reliably in practice — a barrier many health systems have not prioritized the resources to clear. This gap between analytical insight and operational action is a recurring constraint on the value of data platforms operating alongside Epic, and a real opportunity for vendors who can reduce that implementation complexity.

No Epic customer organization in our primary research operates without supplemental analytic tools. ECU Health uses Microsoft Fabric as its underlying analytics platform — combining data from Epic with data from other internal systems and external sources — and uses Microsoft Power BI alongside Cogito for advanced visualization. UPMC has built its data environment integrating 180 sources on Snowflake, Databricks, and Microsoft Fabric — treating Epic as one input among many rather than as the analytical platform. This near-universal pattern of Epic-plus-external-analytics reflects a structural judgment that the health technology market has already reached: Epic is a data source, not a data platform.

Operational Reality

> *"Epic is very protective of its data models — we required a three-way agreement with Snowflake just to get foundational integration in place. Epic-to-Epic integration is still problematic due to configuration differences across instances. Healthcare data remains primarily HL7 in operational practice, not FHIR despite the hype. We have built our data platform across 180 sources and 8 billion patient records going back to 1992 — running on Snowflake, Databricks, and Microsoft Fabric. Epic is a source. It is not the platform."*
>
> **— UPMC Technology Leadership — FCA Primary Research, 2026**

> *"Getting data out of Epic is not a problem — Epic has done a good job at liberating the data out. Data back in is a challenge. We created a bed planning module that recommends a specific bed for each patient based on a host of different factors. Epic doesn't publish APIs to allow the write back of the proposed bed assignment. So our team member goes over to Grand Central and enters the bed*

> *assignment manually. As long as we have a human in the loop process and clear and defined source of truth workflows, we should be safe, but — those fields, you just can't write back to."*
>
> **— Dr. Pete Chang, Tampa General Hospital — FCA Primary Research, 2026**

Implications

Data Platforms and Interoperability represent durable and expanding structural white space. As AI adoption accelerates the demand for clean, accessible, and semantically consistent health data, the gap between what Epic provides and what health systems need will grow rather than shrink. The most compelling vendor positions offer FHIR-native interoperability infrastructure, clinical data normalization and quality remediation, and AI-readiness preparation services sitting between Epic and the analytical and AI applications health systems want to run. Representative companies operating in this space include Rhapsody and Innovaccer for interoperability and data activation, Datavant for patient-level data connectivity and de-identification, and Health Catalyst for enterprise analytics infrastructure. Vendors in this category should expect Epic to continue managing data model access carefully — which creates both a moat around existing vendor positions and a persistent structural opportunity for solutions that help health systems navigate that constraint.

B. IT Infrastructure, Cybersecurity, and IT Services

Category Overview

IT Infrastructure, Cybersecurity, and IT Services encompasses the operational and security foundation on which all health system technology — including Epic itself — runs. This includes cloud, hybrid, and on-premise infrastructure management; network architecture, storage, backup, and disaster recovery; identity and access management; endpoint and network security; threat detection and response capabilities; security operations center services; IT service management frameworks; and managed IT and security services. For health systems operating complex, multi-site environments with zero tolerance for clinical system downtime, this is the category with the highest operational stakes.

The cybersecurity dimension has become increasingly urgent as health systems have emerged as primary targets for ransomware attacks. The consequences of healthcare cybersecurity failures extend beyond financial and reputational damage to patient safety: when clinical systems are taken offline by ransomware, care delivery is disrupted in ways that can directly harm patients. The healthcare sector experienced a significant increase in ransomware incidents in recent years, with several high-profile attacks forcing large health systems to divert patients, cancel procedures, and revert to paper-based workflows for extended periods. This threat environment has elevated cybersecurity from an IT operations concern to a board-level governance priority at virtually every large health system.

Epic's Position and Structural Limitations

Epic maintains application-level security controls and infrastructure compatibility standards that meaningfully shape health system technology decisions. Epic's hosting guidelines, cloud certification requirements, and security configuration specifications give it influence over infrastructure procurement — health systems must ensure their environments meet Epic's technical requirements. Epic Cloud offers organizations the option of delegating infrastructure management to Epic directly. These are genuine contributions to the overall security posture of Epic-installed health systems.

However, Epic's application-level contributions represent a narrow band of the overall security and infrastructure challenge that health systems face. Epic is not a security vendor and does not position itself as one. It assumes no uptime risk or breach liability beyond the narrow scope of its software licensing terms. It does not provide managed detection and response capabilities, security operations center services, identity and access management infrastructure, endpoint protection, or the threat intelligence and incident response capabilities that constitute a mature security program. The gap between Epic's application-level controls and a comprehensive health system security posture is not a product gap Epic intends to fill — it is a deliberate strategic boundary.

UPMC's deployment of 13,000 iPhones for clinical staff operating Epic's Rover mobile application illustrates this boundary concretely. The mobile device management, authentication, endpoint security, and network access control infrastructure required to make that deployment secure and functional is entirely separate from Epic's environment and represents significant investment in technology that Epic neither provides nor manages. UPMC's technology leadership identified cybersecurity — specifically identity and access management — as an explicit area of structural white space where Epic has no meaningful presence.[9]

The AI governance dimension of this category represents perhaps the fastest-emerging structural gap in the health system technology stack. The proliferation of AI tools across health system environments — Epic's native AI products, independently procured third-party AI tools, and now custom agents built through Agent Factory — is creating a management complexity that no current governance platform adequately addresses. Health systems are deploying multiple AI models across clinical, operational, and administrative workflows simultaneously, each with different training data, different performance characteristics, different update cycles, and different accountability structures. The governance challenge is not merely technical but institutional: when an AI model makes an error contributing to a patient safety event or billing compliance failure, who is accountable? What mechanisms exist for detecting model drift? How does the health system demonstrate to regulators that its AI tools are performing as intended?

Dr. Chang of Tampa General Hospital described this situation directly in our primary research conversations: the organization has a solid governance process for approving AI models before deployment, but there is a significant opportunity for an emerging technology sector to help verify on an ongoing basis that approved models continue to perform as originally designed. As more AI tools are deployed, it becomes increasingly difficult to monitor model behavior, manage feedback loops, and audit AI outputs across the full deployment portfolio. Identifying and responding to model drift is the number one priority. “We need AI to monitor our AI,” he observed — and no current vendor, including Epic, has built that capability at health system scale.

Implications

IT Infrastructure, Cybersecurity, and IT Services represent structurally durable white space across multiple dimensions. Epic's application-level contributions are meaningful but narrow, and the categories where health systems need vendor support — infrastructure risk ownership, breach response, identity management, endpoint security, and AI governance — are areas where Epic has no product and no strategic intention to build one. The growing severity of healthcare cybersecurity threats and the accelerating AI governance imperative both expand the addressable market in this category. Representative vendors operating in this space include Claroty and Medigate for healthcare-specific OT and IoT security, Fortified Health Security for managed security services tailored to health systems, and CyberArk for privileged access management within clinical environments. Vendors offering AI governance

and model monitoring infrastructure with healthcare-specific regulatory alignment are particularly well-positioned, as this is a category where the demand signal is urgent and the vendor landscape remains nascent.

C. Governance, Risk, and Compliance

Category Overview

Governance, Risk, and Compliance encompasses the platforms, programs, and processes that help health systems manage their regulatory obligations, enterprise risk posture, audit functions, privacy and consent monitoring, and quality reporting requirements. Health systems operate in arguably the most complex regulatory environment of any industry in the American economy — navigating overlapping requirements from CMS, the Office for Civil Rights, state health departments, accreditation bodies including The Joint Commission, professional licensing boards, and an expanding set of federal requirements governing AI, data privacy, and clinical quality measurement.

The GRC landscape for health systems is not static — it is actively expanding. Regulatory requirements for AI transparency and accountability are emerging from multiple federal agencies. State-level data privacy legislation is proliferating. CMS quality reporting requirements have grown more complex and consequential as value-based payment programs have expanded. The combination of a growing regulatory footprint, escalating enforcement activity, and the emerging AI governance imperative is creating a GRC function that requires dedicated enterprise-grade platform support rather than the point solutions and manual processes most health systems currently rely on.

Epic's Position and Structural Limitations

Epic contributes to regulatory compliance at the workflow level through documentation standards, privacy access controls, and quality measure reporting tools. For specific requirements tied to clinical documentation — meaningful use attestation, clinical quality measure reporting under MIPS, and HIPAA access logging — Epic's native tools provide compliance-relevant functionality embedded within daily clinical operations. These contributions are genuine: they mean that health systems operating on Epic are not starting from zero on regulatory compliance obligations.

However, Epic's compliance contributions represent a narrow slice of what enterprise GRC programs require. Epic does not position itself as a governance or risk management platform, does not assume enterprise risk ownership, and has explicitly avoided building capabilities that would place it in the role of a compliance partner with legal and financial accountability. The GRC function that health system Chief Compliance Officers, General Counsel, and Chief Risk Officers manage encompasses enterprise risk assessment, regulatory change tracking, audit program management, third-party vendor risk management, privacy and consent lifecycle governance, and the board-level risk reporting that keeps trustees informed of the organization's compliance posture. None of these functions are meaningfully supported by Epic's native tools.

The organizational buyer dynamic reinforces Epic's absence from this category. The CCO, General Counsel, and Chief Risk Officer who make GRC platform decisions operate with different priorities, different reporting lines, and different evaluation criteria than the CIO and CMIO who manage the Epic relationship. GRC platform decisions are driven by regulatory expertise, audit defensibility, legal accountability, and contractual commitment to compliance standards — not by EHR integration or clinical workflow alignment. Epic has no meaningful relationship with these buyers and no product that speaks to their requirements.

Implications

Governance, Risk, and Compliance represents structurally durable white space, though the reason is more precise than Epic simply lacking appetite for the category. Health systems actively do not want GRC data co-mingled with EHR or ERP systems — the separation is intentional and required for audit defensibility, legal accountability, and the independence of compliance review processes. A nurse flagging a potential safety event needs to do so within a system that is separate from the clinical record for the review to be legally credible; compliance training, procedure updates, and risk assessments require platforms that can integrate with operational systems when needed but maintain clear data separation. The structural white space in GRC exists because health systems demand that separation — not because Epic has chosen to avoid the category. What is genuinely missing in the market is a GRC platform purpose-built for health systems that maintains the right data separation from EHR and ERP systems while integrating appropriately when workflows demand it. Representative vendors in this space include Symplr and Healthstream for healthcare-specific compliance and credentialing, and Riskonnect for enterprise risk management.

VIII. Summary Table

The visual below consolidates the category-level analysis across all eleven domains evaluated in this report, summarizing Epic's structural strengths, primary limitations, and the resulting strategic accessibility for complementary vendors and investors. A standalone downloadable version of this table is available as a separate reference document.

INVESTMENT THESIS REPORT · EPIC GAPS ANALYSIS

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Category Summary — Epic Strengths, Limitations & Strategic Accessibility

Across 11 acute care technology categories · Informed by executive interviews at ECU Health, TGH, and UPMC

CATEGORY	EPIC STRENGTHS	STRUCTURAL LIMITATIONS	ACCESSIBILITY	AI OPPORTUNITY
■ EPIC-CONTROLLED — TIGHTLY COUPLED TO CORE CLINICAL WORKFLOWS				
Clinical workflow optimization	Primary system of record; embedded provider workflows; documentation and order management	Avoids FDA-regulated CDS; prescriptive architecture limits flexibility; population-level aggregation is weak; ~20% delivery on stated capability per operators	EPIC-CONTROLLED	INCREMENTAL
Clinical tools & departmental solutions	Broad module coverage; unified documentation across departments; Epic scorecard drives adoption	Standardization over depth; development lags focused vendors; surgical scheduling lacks real-world variable inputs	EPIC-CONTROLLED	SELECTIVE
Patient access	MyChart integration; scheduling and registration workflows; provider finder	Insufficient personalization; digital front door AI is years behind best-of-breed; scheduling lacks clinical complexity inputs	EPIC-CONTROLLED	SIGNIFICANT
■ SELECTIVE OPPORTUNITY — EPIC PRESENT BUT INSUFFICIENT				
Patient engagement	MyChart as default portal; deep integration with clinical and billing data; patient familiarity at scale	Standardized experience constrains differentiation; no engagement ROI ownership; AI-driven activation underdeveloped; no monetization focus	SELECTIVE	SIGNIFICANT
Telehealth & virtual care	Embedded visit documentation; billing workflow integration; unified record for virtual encounters	Avoids operational ownership; no virtual care program management; slower innovation vs. best-of-breed; inflexible for hospital-at-home workflows	SELECTIVE	SELECTIVE
Value-based care enablement	Acute-care data origination; Healthy Planet and Compass Rose modules; care gap identification	Avoids financial and outcome accountability; fragmented cross-setting data; cannot generate actionable population intelligence; no predictive modeling	SELECTIVE	SIGNIFICANT
ERP & human capital management	Peripheral clinical data integration; workflow adjacency; beginning to explore ERP territory	Outside Epic's clinical DNA; different buyers and incentives; no meaningful competition with Workday, Oracle, SAP; no workforce optimization ownership	SELECTIVE	SIGNIFICANT
Revenue cycle management	Embedded billing workflows; charge capture; claim submission; Penny AI for prior auth and denials	Neutral payer posture; avoids outcome-based guarantees; no document management; 40M+ faxes unaddressed; back-end cycle left to third parties	SELECTIVE	SIGNIFICANT
■ STRUCTURAL WHITE SPACE — OUTSIDE EPIC'S OPERATING MODEL				
Data platforms & interoperability	Core system of record; data capture at point of care; Cogito and Cosmos offerings	Protective of data models; requires 3-way agreements for integration; HL7 vs. FHIR gap persists; no AI-ready orchestration; Epic-to-Epic integration still problematic	WHITE SPACE	SIGNIFICANT
IT infrastructure & cybersecurity	Application-level controls; platform compatibility standards; Epic Cloud hosting option	Not a security vendor; avoids uptime and breach risk ownership; no IAM, endpoint, or SOC capabilities; AI governance tooling absent	WHITE SPACE	SIGNIFICANT
Governance, risk & compliance	Workflow-level compliance visibility; audit logging; quality measure reporting tools	Avoids enterprise risk ownership; no AI governance or model monitoring infrastructure; board-level accountability outside Epic's scope; legally sensitive category Epic intentionally avoids	WHITE SPACE	SIGNIFICANT

Analysis informed by executive discussions with health system leaders at ECU Health, Tampa General Hospital, and UPMC. Categories reflect structural accessibility for complementary vendors — not Epic's stated product coverage. AI opportunity rating reflects near-term potential for AI-enabled vendor differentiation in each category.

FCA Venture Partners 2026

Figure 2. Category Summary — Epic Strengths, Limitations & Strategic Accessibility Across 11 Acute Care Technology Domains

IX. Strategic Outlook and Recommendations

A. The Investment Landscape in Context

The healthcare technology investment landscape in 2026 is defined by a tension that FCA has tracked closely through its research and primary market conversations: Epic is simultaneously the most powerful organizing force in acute care technology and the entity whose structural boundaries create the most compelling investment opportunities for complementary vendors. These two facts are not contradictory — they are the same fact viewed from different angles. Epic's dominance concentrates the market in ways that make everything adjacent to it consequential, and Epic's deliberate strategic choices create specific, predictable, and durable gaps that define where complementary vendors can build sustainable businesses.

Epic's HIMSS26 announcements clarify the competitive landscape in two important and related ways.[2] First, they confirm the speed and seriousness of Epic's AI build-out: more than ~85% of Epic's customer base is now actively using at least one Epic AI product,[7] and Agent Factory represents a structural move that compresses the technical moat previously held by workflow automation vendors and AI middleware startups. Any investment thesis that treats Epic's AI roadmap as moving slowly or representing a distant competitive threat is already behind the market reality. The pace of Epic's product development has accelerated sufficiently that categories on its active roadmap will face meaningful competitive pressure within three to five years.

Second, and equally important, the HIMSS26 announcements clarify what Epic is not doing and will not do within the investment horizon relevant to early-stage health technology. Agent Factory operates within Epic's data model and integration architecture — it does not address the payer-confrontational revenue cycle work, the enterprise data orchestration, the cybersecurity and AI governance infrastructure, or the enterprise risk management functions that define the structural white space categories in this analysis. Epic's Agent Factory is a powerful tool for health systems wanting to build AI agents within Epic's environment. It is not a threat to vendors addressing the structural gaps that exist outside that environment.

The primary research conducted for this report reinforces a theme that runs through every health system conversation: the distinction between what Epic can do and what health systems actually need from their technology environment is widening, not narrowing, as AI capabilities mature. UPMC is rebuilding its entire data infrastructure outside Epic's environment. ECU Health is investing in conversational AI for the digital front door that Epic's development resources cannot match. Tampa General Hospital is designing a platform architecture to manage the complexity of multi-vendor agentic AI that Epic's tools do not address. These investments are not made despite Epic's dominance — they are made because of it.

B. Priority Investment Areas

Based on the category analysis and primary research conducted for this report, FCA identifies four priority investment areas organized by confidence level and investment horizon:

1. Revenue Cycle AI — Highest Confidence, Near-Term

Revenue cycle AI is the clearest and most actionable investment opportunity in the acute care technology stack. The category is large — hospital revenue cycle operations represent hundreds of billions

of dollars in annual transaction volume — the ROI is measurable in concrete dollar terms within months of deployment, the structural gap from Epic is explicit and unlikely to close given Epic's payer relationship posture, and health system operators are actively seeking vendors willing to operate on performance-based contracts.

Health systems that have moved earliest on revenue cycle AI are already generating returns that make the ROI case self-reinforcing. Vendors like Akasa, SmarterDX, and CodaMetrix have demonstrated that AI-enabled coding and denial management can recover material revenue within months of deployment — returns measurable enough to meet even the most rigorous health system impact card methodology. The market is moving faster than most investors have priced, and health systems still running traditional coding operations are already operationally behind the early adopters.

The most compelling near-term opportunities within revenue cycle AI are coding and CDI optimization, denial management and appeals automation, and underpayment detection — precisely the back-end revenue cycle functions where Epic's neutral payer posture creates the largest gaps. Investors should apply caution specifically around prior authorization as a standalone investment thesis: CMS-0057 and CMS-0062 require EHRs to connect directly to payers for prior authorization data exchange, which will compress the independent prior auth market as EHRs build this connectivity natively. The longer-term opportunity within RCM lies in contract management, general ledger reconciliation, and the tying of payer contract performance back into operational workflows — areas where Epic's structural posture creates lasting room. The vendor characteristics that distinguish the strongest investment candidates are performance-based commercial models, a demonstrated track record of measurable ROI at comparable health systems, technical architecture integrating with Epic's billing infrastructure without requiring Epic's cooperation, and willingness to pursue payer confrontation that Epic's relationship model precludes.

2. Data Platforms and AI Infrastructure — High Confidence, Longer Duration

The data infrastructure layer — normalization, orchestration, FHIR-native interoperability, AI-readiness preparation, and the activation services sitting between Epic's data environment and the AI applications health systems want to run — represents a foundational investment opportunity whose strategic importance will grow as AI adoption accelerates. UPMC's data infrastructure investment — 180 sources, 8 billion patient records, rebuilt on Snowflake, Databricks, and Microsoft Fabric — illustrates the scale of commitment that sophisticated health systems are making to infrastructure that sits entirely outside Epic's environment and that Epic has neither the architecture nor the appetite to replace.

The investment thesis is not disrupting Epic as a system of record — that battle is over and would require capital and timelines inaccessible to early-stage vendors. The thesis is building the activation layer between Epic and the analytical and AI applications that health systems want to run: normalization tools resolving Epic's inconsistent data outputs across instances and over time; orchestration platforms connecting Epic data to AI model training and inference pipelines; FHIR-native integration solutions addressing the real-world gap between Epic's interoperability claims and operational reality; and governance infrastructure ensuring AI applications running on Epic data perform as intended. These are infrastructure categories with high switching costs once deployed, recurring revenue potential, and a structural tailwind that will persist as long as AI adoption continues to accelerate.

3. AI Governance and Compliance Infrastructure — Emerging, High Conviction

AI governance is emerging as a mandatory category — a compliance requirement rather than a discretionary capability — on a timeline that most health systems are unprepared for. The regulatory signals are increasingly clear: CMS has begun requiring documentation of AI tool use in certain clinical

contexts; the Office for Civil Rights has indicated that AI-driven health decisions must be auditable under civil rights frameworks; and state-level AI accountability legislation is proliferating. Health systems deploying AI at scale — which now includes virtually every large Epic customer — will need formal governance infrastructure to demonstrate compliance with these requirements.

The opportunity is compounded by Epic's own AI expansion. Agent Factory, Art, Penny, Emmie, and the custom agents health systems build going forward create a complex AI deployment environment requiring orchestrated monitoring, version control, performance tracking, and audit capability. Epic provides none of this governance infrastructure. The vendor that builds a platform capable of monitoring AI performance, managing model versions, tracking audit trails, and generating compliance documentation across both Epic-native and third-party AI tools will address a need that is currently unmet and will become urgent for every large health system within two to three years.

The investment characteristics of this category require careful navigation: the market is nascent, buying authority is fragmented across IT, compliance, legal, and clinical leadership, and the regulatory requirements driving adoption are still developing. But the structural tailwind is powerful, the competitive landscape is uncrowded, and the first vendors to establish credible enterprise deployments will benefit from high switching costs and expanding regulatory mandate. Investing ahead of mandate in this category — before the market has fully matured — is likely to be a significant source of return.

4. Specialty Clinical AI — Selective, Criteria-Dependent

Clinical AI tools operating where Epic explicitly avoids regulatory risk — differential diagnosis support, early detection algorithms, specialty-specific decision support — represent a selective investment opportunity where evaluation criteria are more demanding and competitive dynamics more complex. Epic's movement toward AI-assisted differential diagnosis, announced at HIMSS26 as a forthcoming Art capability,[7] signals intent to push further into this territory, and the pace of Epic's development has accelerated sufficiently that any clinical AI category on its active roadmap faces meaningful competitive pressure within three to five years.

The most defensible positions in clinical AI share a clear profile. They operate in clinical domains where the development timeline for Epic to reach comparable performance is genuinely long — specialty applications with limited training data, rare disease contexts, or highly specialized clinical environments where Epic's generalist architecture is structurally disadvantaged. The clinical outcome evidence is strong enough to justify independent procurement decisions even when Epic has a nominal competing product. And the vendor can offer a performance guarantee or outcome-based contract that Epic's risk posture precludes it from offering. ECU Health's experience with departmental AI tools delivering efficiency and quality benefits that Epic's native tools cannot match illustrates the model: niche depth plus measurable clinical ROI plus outcome accountability.

C. What the Evidence Demands of Vendors

The primary research conducted for this report surfaces consistent themes in what health system leaders actually look for when evaluating vendors in the Epic-adjacent technology landscape. Across every organization size and Epic implementation maturity level that FCA studied, the same four criteria emerged as decisive — and the vendors winning enterprise contracts are the ones who have internalized all four, not just the ones that happen to align with their product strengths:

Performance accountability over integration claims. Health system executives are sophisticated enough to know that integration with Epic is table stakes, not a differentiator, and that many vendors claim

integration capabilities they cannot deliver in practice. What health system operators are actually evaluating is measurable outcome: dollars recovered, time saved, readmissions reduced, coding accuracy improved, staff efficiency gained. The most analytically rigorous health systems now require ROI formulas pre-agreed with the CFO and internal audit — backed by biostatistician analysis isolating technology-attributable effects from other operational changes — before committing to vendor relationships. Vendors that cannot meet this standard at comparable organizations should not expect to penetrate the buyers who matter most for scale.

Platform orientation over point solutions. Dr. Chang's framing was direct and should inform portfolio construction: 'Widget X that does something really good is going to have to quickly diversify and go into other verticals to become a little bit more platform-ish. They can't be one-trick ponies anymore — because I have the technology to create that overnight in-house now.' Health systems are actively reducing the number of vendor relationships they manage, moving toward fewer, deeper partnerships with vendors who can grow with them. Agent Factory lowers the threshold for building narrow-function AI tools internally, which means point-solution vendors face increasing procurement resistance. Vendors demonstrating a coherent platform trajectory — even from a focused starting position — are better positioned to achieve and sustain enterprise relationships.

Risk-sharing commercial models. The expectation that vendors share in the financial risk of their solutions has moved from differentiation to baseline requirement in revenue cycle, value-based care, and patient engagement categories. ECU Health's vendor selection framework identified contract flexibility — specifically the ability to structure short-term or risk-sharing arrangements — as one of its most critical evaluation factors, reflecting a broader pattern across our primary research organizations. Vendors resisting performance-based models face growing disadvantage as health systems' expectations have shifted and as competing vendors are willing to accept outcome accountability that their predecessors were not.

Time to value over roadmap vision. ECU Health placed ‘time to deliver’ first in its vendor evaluation criteria — ahead of relationship quality and contract structure — though product vision and roadmap are viewed as equally important evaluation factors. Health systems operating under financial pressure find multi-year implementation timelines unacceptable for non-core-infrastructure purchases, and the pace of AI development has created a market where health systems are signing abbreviated deals specifically because they are uncertain what the technology landscape will look like in three years. Vendors demonstrating rapid deployment pathways — pilot to production in 90 days, measurable ROI within twelve months — are better positioned than those requiring extended implementation cycles. ECU Health’s overall approach to technology investment also favors platforms over point solutions, reflecting the same consolidation dynamic described throughout this analysis: vendors who can grow with the organization across multiple use cases are more defensible than narrow single-function tools, regardless of how well those tools perform in their specific domain.

D. Strategic Implications for Portfolio Construction

FCA's investment approach in the Epic-adjacent acute care technology market is organized around three strategic principles following from the category analysis and primary research in this report.

Prioritize structural gaps over technical gaps. Structural gaps — defined by Epic's payer posture, regulatory strategy, risk philosophy, and organizational DNA — are durable on the five-to-seven year investment horizon that early-stage healthcare technology requires. Technical gaps close as Epic's product development cycles run their course, and investors who confuse technical gaps with structural gaps will find

their portfolio companies facing increasingly capable Epic competition within the investment period. Revenue cycle AI, data infrastructure, AI governance, and GRC all have structural gaps. Clinical workflow optimization does not. That distinction is the most important analytical judgment in healthcare technology investing today.

Favor vendors with demonstrated ROI at comparable health systems over those with compelling technology but limited deployment evidence. The health system procurement environment rewards proven performance and penalizes unproven innovation, particularly in the post-pandemic era of margin pressure and capital constraint. Portfolio companies that can walk into a procurement conversation with audited impact data from peer organizations have a structural advantage that product sophistication alone cannot provide. Building the evidence base early — even when it requires forgoing revenue in exchange for reference deployment terms — is the right strategic choice for vendors in Epic-adjacent categories. The health systems that agree to early reference deployments are not doing vendors a favor; they are the mechanism through which the vendor's commercial flywheel starts to spin.

Invest ahead of mandate in categories where regulatory requirements are developing rather than waiting for the market to fully mature. AI governance is the clearest current example: the regulatory signals are present and strengthening, the health system need is urgent, the vendor landscape is nascent, and the first movers establishing credible enterprise deployments will benefit from switching costs and expanding mandate. Waiting until regulatory requirements are fully codified means entering a market where the competitive dynamics have already settled and first-mover advantage has already compounded. FCA's investment horizon is long enough to benefit from getting to these markets early — the primary research conducted for this report suggests the window for AI governance infrastructure is open now and will not stay open indefinitely.

E. Conclusion

Epic's acceleration — from a documentation platform to an AI-native operating system for health systems — is real, sustained by extraordinary R&D investment, and reinforced by distribution advantages that no health technology startup can approach. The HIMSS26 announcements confirm that Epic intends to compete actively across clinical AI, revenue cycle AI, patient engagement AI, and now custom AI agent development. Categories on Epic's active product roadmap will face increasing competitive pressure as Epic's execution matures, and investors should evaluate those categories with appropriate caution about the sustainability of competitive differentiation on a three-to-five year horizon.

At the same time, the structural boundaries defining Epic's strategic gaps will not move significantly within the investment horizon relevant to early-stage healthcare technology. Epic's payer neutrality is not a temporary product limitation — it is the business model choice of a company that derives competitive advantage from its relationships with payers and has no incentive to jeopardize those relationships for revenue cycle market share. Epic's avoidance of financial risk ownership is not a feature gap — it is the philosophy of a software company that has never sought to own operational outcomes and has no organizational capability to do so at scale. Epic's limitations as a data platform are not engineering failures — they are the structural consequences of an architecture designed for clinical workflow management, not analytical flexibility.

The health systems defining the next decade of acute care delivery have already made their own judgment about where Epic ends and where they need to build or buy: UPMC rebuilding its entire data infrastructure outside Epic's environment on a platform integrating 180 sources and 8 billion patient records; Tampa General Hospital constructing its entire revenue cycle operation outside of Epic and

designing a platform architecture to manage the complexity of multi-vendor agentic AI; ECU Health investing in conversational AI capabilities for the digital front door that Epic's development resources cannot match within five years. None of these investments are made despite Epic's dominance — they are made because of it. The gap between what Epic controls and what health systems actually need is the investment thesis. Understanding that gap with precision — in each of the eleven categories evaluated in this report — is the analytical foundation for building a portfolio positioned to benefit from it.

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