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HEALTHCARE ICON 2026

SUSHEEL LADWA

CEO onyx

BETTER HEALTHCARE USING AI

EXECUTIVE FEATURE

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Better Healthcare Using AI

The future of healthcare will be shaped not only by new artificial intelligence capabilities, but by whether the industry can move at the speed those capabilities now allow.

Interoperability has been a stated healthcare priority for well over a decade, but adoption has lagged the standards themselves for most of that time. AI is now changing that equation, not by replacing the need for clean, connected data, but by finally giving organizations a reason to finish the job.

Few executives have lived that shift as directly as Susheel Ladwa, Chief Executive Officer of Onyx Health. A self-described technologist who started out writing Java, Python, and Perl, Ladwa spent nearly three decades in healthcare technology leadership at Wipro, EDS, HP Enterprise Services, and IBM, where he helped scale Wipro's healthcare practice into a business exceeding $250 million in revenue, before leaving a large-company career behind to build Onyx from the ground up.

His perspective extends beyond any single platform or regulation. It is centered on a conviction that small, fast teams, not large organizations, will define the next era of healthcare technology, and that speed itself, not any single new tool, is what separates the companies that adapt from the ones that get disrupted.

FOR HIS LEADERSHIP IN ADVANCING HEALTHCARE INTEROPERABILITY AND BUILDING THE DATA FOUNDATION AI DEPENDS ON.

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RECOGNIZES SUSHEEL LADWA AS A

HEALTHCARE ICON 2026.

Q **You spent years writing code, Java, Python, Perl, before moving into leadership at Wipro, EDS, HP Enterprise Services, and IBM, and eventually founding Onyx. What made you walk away from a big-company career to start over?**

SUSHEEL LADWA

In a large company, you're a cog in the wheel. The processes are set, the opportunities are large, but it's a routine life, you can expect what to expect every day. IBM was pivotal for me because it taught me how technology, industry knowledge, and finance actually come together, why you do what you do and how it produces revenue. But once I left that cushy job and got into the startup world, it was a complete roller coaster. Some days you wake up and you can't make payroll, and by evening you've closed a deal and you're on the moon.

What convinced me it was worth it is that I could already see large organizations struggling to change. A great idea in a big company still needs a lot of people's buy-in before anything happens. In a startup, you have an idea and you execute it by the end of the night. But I won't pretend the ride itself is easy, the highs and lows of a startup are not for everybody. There are days you wake up and can't make payroll, and by evening you've closed a deal and you're on top of the world. I believe the future belongs to small teams working at the speed of light, using AI, and that's going to reshape how industries are structured. I wish I'd made the jump twenty years earlier, knowing what I know now, but I don't regret the timing.

Q **Interoperability has been talked about in healthcare for as long as you've been in the industry. What do you think has actually changed to make real progress possible now?**

SUSHEEL LADWA

My first instinct is to say the industry lacked standards, but that's not quite right, there was never a shortage of standards. What was missing was maturity. HL7 v2 and v3 were never designed for the way the rest of the world already exchanges data. FHIR is the first healthcare standard that actually behaves like the APIs and JSON formats we use everywhere else on the internet.

But maturity of the standard is only half of it. The other half is adoption, and healthcare's adoption has always been narrowly use-case driven rather than broad. What's different now is that CMS is using specific use-case requirements to force broader infrastructure into existence, whether organizations realize that's what's happening or not.

Q **You've said most health plans don't realize what they already built when they complied with CMS's Patient Access API rule. What do you mean by that?**

SUSHEEL LADWA

The requirement is seven years of claims, clinical, formulary, and provider directory data, converted to FHIR and updated nightly, opened up as an API. Most health plans looked at that and said, we spent all this money and nobody's using the apps, what a waste. But that misses what actually happened: for the first time in the history of health plans, there are seven years of clean, FHIR-enabled claims and clinical data sitting there, refreshed every night.

Risk adjustment, payment integrity, HEDIS reporting, care gap analysis, all of that runs on exactly this kind of data, and it's usually a massive project on its own. Here, it's already been handed to them. The organizations that recognize that and build on top of it instead of treating the mandate as finished will have an edge that's very hard for anyone else to close.

Q **Prior authorization is one of the most disliked processes in healthcare. Why do you think it's actually at a tipping point right now?**

SUSHEEL LADWA

When we looked at the prior authorization data our health plan clients had, we found that 40 to 50 percent of prior auths submitted by providers were just-in-case submissions, cases where authorization wasn't actually required, but the provider submitted one anyway rather than risk it. That's an enormous amount of waste on both sides, providers filling out forms they didn't need to, and payers staffing up to review requests that should never have existed.

CMS's 0057-F rule changes the mechanics entirely: a provider can get an instant answer through their own EMR workflow via an API call, and for cases that do need review, the turnaround is 72 hours for urgent requests and seven days for standard ones. I don't think provider adoption will be the hard part, once a provider clicks a button and the authorization question is answered instantly, they will never go back to faxing. The hard part is that every utilization management vendor has its own rule set and isn't all FHIR-enabled yet. I'd expect most of the industry to be there by the end of 2027, but this rule is genuinely going to change the industry once it lands.

Q **Patient Access APIs didn't see the adoption everyone expected when the rule first took effect. Why do you think that happened?**

SUSHEEL LADWA

That's a different problem from the infrastructure question we just talked about. I think the patient isn't actually the center of the US healthcare ecosystem the way patients are in most other countries. In the U.S., someone can see a doctor without knowing what they'll owe for 30, 60, even 90 days. Once a consumer is genuinely paying for something themselves, everything around them becomes accountable to them. That accountability is what drives adoption of patient-facing tools in places like parts of Europe or Canada, where patients often need their own data with them to be seen at all.

It's not that the Patient Access API failed as technology. It's that patient access isn't treated as critical by patients who aren't financially exposed to the outcome. As more of the financial burden shifts toward patients through things like HSAs, I expect that calculus to shift too, slowly, and unevenly, but it will shift.

Q **You've drawn a distinction between AI-native and AI-adaptive companies in healthcare. What's the practical difference, and which one do you think will actually win?**

SUSHEEL LADWA

AI-native companies start with AI as the first way of doing things and grow from there, small teams that can build in a weekend what used to take a large organization a year. Medvi is the example I point to, a healthcare startup built by two brothers, Matthew and Elliot Gallagher, that reportedly did over $400 million in revenue in its first full year with essentially a two-person team. Large, established healthcare organizations are, by nature, laggards in technology adoption, and every contract we sign has clauses restricting how AI vendors can use client data, for good reason, but it does slow things down.

So I don't think most AI that actually gets adopted inside large health plans and provider organizations will be built by those organizations themselves. It'll be AI-native products that show results in two weeks, bought with confidence, not built in-house. Digital HEDIS and risk adjustment are already the clearest examples of where that's happening.

Q **You've talked about your leadership philosophy shifting once you became a CEO. What actually changed, and what's your closing thought for where healthcare technology is headed?**

SUSHEEL LADWA

The core of it is putting your team first and being personally accountable for every person's success, not just your own. When people know you have their back, they take the independent decisions that actually move a company forward. What kind of leadership that requires changes with scale, a five-person startup needs something completely different from a two-hundred-person company, and knowing which one you're in is its own skill. I also learned to ask people a simple question when they're stuck: are you on the problem side or the solution side? Spend too long on the problem side and someone else has already solved it before you.

As for where healthcare is headed, I'd point every executive running a large organization to a line from Jack Welch: change before you have to. The change coming at this industry is many times larger than anything it has absorbed before. Our mantra at Onyx is speed of light, whatever we do, we try to do it at the speed of light, and I think that's the only pace that will actually keep up with what's coming.

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