Healthcare Technology

Food as Medicine: The convergence of nutrition and clinical care in U.S. healthcare

FIRST ANALYSIS QUARTERLY INSIGHT

Integrative insights on emerging opportunities

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First Analysis

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Andrew Walsh is a managing director at First Analysis. He works with entrepreneurs as an investor and as an advisor on growth transactions to help build leading healthcare software businesses, and he also supports First Analysis' investments in Dina and Kno2. Andrew has over 20 years of experience as a healthcare entrepreneur, executive and operator. Prior to joining First Analysis in 2019, Andrew was part of the senior leadership team of Ciox Health, a large private equity-backed healthcare technology company. Andrew brings a wealth of experience to the First Analysis team and has served in senior executive roles at some of the most respected healthcare companies in the United States including UnitedHealth Group, Optum and Davita. Andrew also founded, grew and sold a successful population health company focused on helping vulnerable, high-risk populations. He saw this company through two exits, ultimately selling a combined entity to Guidewell in 2017. Andrew earned an MBA from the University of Notre Dame and a bachelor's degree in economics from the University of Illinois.

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About First Analysis

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HEALTHCARE TECHNOLOGY

Food as Medicine: The convergence of nutrition and clinical care in U.S. healthcare

- Food as Medicine has established a foothold in the U.S. healthcare system. The Food as Medicine concept holds that interventions that align patients' diets with their clinical needs—such as medically tailored meals, customized groceries, and produce subsidies—have the potential to improve health outcomes while reducing total cost of care.
- Under Robert F. Kennedy Jr.'s leadership of U.S. healthcare policy, adoption of Food as Medicine in the U.S. healthcare system could be significantly accelerated—or redefined. In Kennedy's Make America Healthy Again vision, nutrition is not a supplemental benefit, but a foundational element of chronic disease prevention and health restoration.
- The vendor ecosystem supporting Food as Medicine is becoming increasingly sophisticated, but standardized outcomes measurement and integration with payer and provider workflows remain common challenges. As Food as Medicine programs mature, we think vendors with clinical credibility, scalable operations and strong data infrastructure will be best positioned to win share.
- We outline the evolution of Food as Medicine in the U.S. healthcare system, examine key new developments likely to affect its future, and highlight some of the companies building businesses to address this emerging market.

THE RISE OF FOOD AS MEDICINE

Over the past decade, the concept of Food as Medicine has evolved from a public health talking point into a serious clinical and reimbursement framework. This transformation reflects a broader shift in healthcare—away from reactive treatment and toward management of chronic illness, health equity, and social determinants of health. Food as Medicine programs now range from medically tailored meals to produce "prescriptions," and their integration into health insurance benefits—particularly in Medicare Advantage and Medicaid—is accelerating. At the same time, a new generation of vendors is emerging to deliver these services, often with a combination of physical logistics, patient engagement tools and clinical reporting infrastructure.

This report explores the rise of Food as Medicine as a reimbursable healthcare benefit, examining the macro-level cost

and policy drivers, the evolving posture of payers and providers, and the strategies of leading vendors. While state-level initiatives have played a catalytic role, this report concentrates on national-level trends and payer-specific dynamics that are shaping the future of this emerging sector.

THE CLINICAL RATIONALE AND COST IMPERATIVE

The underlying thesis of Food as Medicine is that diet-related disease is both preventable and expensive. In the United States, over 70% of annual healthcare spending is associated with chronic conditions such as heart disease, diabetes, obesity and hypertension. Many of these conditions are caused or exacerbated by poor nutrition. As such, interventions that align patients' diets with their clinical needs—such as medically tailored meals, customized groceries, and produce subsidies—have the potential to improve outcomes while reducing total cost of care.

> *In the United States, over 70% of annual healthcare spending is associated with chronic conditions such as heart disease, diabetes, obesity and hypertension.*

This promise is increasingly attractive to health plans, accountable care organizations, and policymakers facing mounting pressure to curb avoidable hospitalizations, emergency department visits and polypharmacy (the regular use of five or more medications at the same time). In tandem, social determinants of health (SDOH), particularly food insecurity, have gained recognition as key contributors to poor health outcomes. Payers and providers alike are beginning to treat nutritional support as a legitimate medical intervention, particularly for populations with complex, chronic needs.

MEDICARE ADVANTAGE AND THE ROLE OF SUPPLEMENTAL BENEFITS

Nowhere is the shift more apparent than in the Medicare Advantage (MA) program. Since the Centers for Medicare & Medicaid Services (CMS) expanded the definition of "primarily health-related" benefits in 2018, MA plans have gained flexibility to offer meals and groceries to members with chronic illnesses and post-discharge care needs. These benefits typically fall into two categories: meals provided after an inpatient or skilled nursing facility discharge (often 10 to 14 meals over a week or two), and broader nutrition support for chronically ill enrollees, including those with diabetes, heart failure and renal disease.

While this flexibility has led to widespread adoption—an estimated 70% of MA plans now offer some form of food benefit—the design and delivery of these services remain fragmented. Plans vary in how many meals they offer, which populations are eligible, and what vendors they contract with. The lack of uniform standards and long-term outcome data has slowed the expansion of more robust Food as Medicine benefit designs. Nonetheless, the trend is clear: As MA competition increases and Star ratings evolve to emphasize member experience and outcomes, food benefits are becoming a strategic lever for differentiation.

MEDICAID WAIVERS AND THE STATE-LED PUSH

Although MA plans have been early movers, Medicaid may ultimately prove the more fertile ground for structural innovation in Food as Medicine. Because Medicaid allows for significant state-level flexibility, several early-adopting states—California, Massachusetts, Oregon and North Carolina among them—have incorporated nutrition interventions into their Medicaid programs through Section 1115 waivers or managed care contracts.

In California, the state's ambitious CalAIM program enables health plans to provide "community supports," including meals and medically tailored groceries, to high-risk enrollees. Massachusetts has similarly leveraged its 1115 waiver to support nutrition services for members with chronic disease and post-hospitalization needs. Oregon's Coordinated Care Organizations (CCOs) have received CMS approval to provide nutrition support under specific pilot frameworks.

Despite this innovation, most Medicaid Food as Medicine efforts remain localized or time-limited. Few states have formalized reimbursement codes or durable funding streams. Demonstration programs are often grant-funded or tied to temporary waiver approvals. Still, the cumulative effect of these programs is meaningful: They establish proof-of-concept, generate early outcomes data, and create a policy roadmap for other states to follow.

> *The 2022 White House Conference on Hunger, Nutrition, and Health articulated an explicit goal of integrating food-based interventions into healthcare by 2030.*

RISK-BEARING PROVIDERS AND ACO ADOPTION

Beyond payers, full-risk provider groups—especially accountable care organizations (ACOs)—are emerging as important adopters of Food as Medicine programs. These providers are directly accountable for total cost of care and often serve populations where diet-related illness is both common and costly. As such, they are well positioned to pilot nutrition interventions and measure their downstream effects.

Some ACOs have launched programs to deliver medically tailored meals to high-risk patients following hospital discharge, aiming to reduce readmissions. Others use produce "prescriptions" or grocery deliveries as part of broader chronic disease management or population health efforts. Advanced primary care organizations and Federally Qualified Health Centers (FQHCs), particularly those operating under capitation or value-based payment models, are also experimenting with Food as Medicine offerings.

For these groups, food delivery is often combined with other wraparound services, such as remote monitoring, care coordination, and community health worker support, to create a more holistic care model. However, the administrative burden, logistical complexity and still-nascent reimbursement standards present meaningful barriers to scale.

FEDERAL POLICY AND EMERGING REGULATORY PATHWAYS

At the federal level, interest in Food as Medicine has expanded significantly in recent years. The CMS Innovation Center (CMMI) has signaled growing openness to integrating nutrition into new care delivery and payment models. The Accountable Health Communities Model and the more recent AHEAD Model both include provisions for addressing

food insecurity. The 2022 White House Conference on Hunger, Nutrition, and Health articulated an explicit goal of integrating food-based interventions into healthcare by 2030.

Legislatively, there is growing bipartisan momentum behind efforts to fund large-scale Food as Medicine pilot programs. One example is the Medically Tailored Home-Delivered Meals Demonstration Act, which has been reintroduced in Congress and would authorize a national Medicare demonstration project for medically tailored meals.

While federal progress remains incremental, the overall policy posture is increasingly favorable, particularly when framed as a strategy to reduce avoidable utilization and advance health equity.

THE VENDOR LANDSCAPE: LOGISTICS MEETS ENGAGEMENT

The vendor ecosystem supporting Food as Medicine delivery is becoming increasingly sophisticated. Early providers, which were often nonprofits like God's Love We Deliver and Community Servings, focused on clinical rigor and meal preparation. Today, a more diverse mix of for-profit and nonprofit players is emerging, offering a range of services, from last-mile delivery to dietitian access to analytics integrated into electronic health records.

SEASON

Among the most prominent is **Season Health**, a venture-backed company that combines medically tailored meal delivery with tele-nutrition and clinical integrations. Its focus on data, outcomes reporting and member engagement has made it a popular partner for both MA plans and provider groups.

FarmboxRx offers produce-centric deliveries tied to MA supplemental benefits and positions itself as a tool for rural and underserved populations.

Tangelo has focused on building the logistical infrastructure required to manage meal procurement and vendor contracting at scale—often acting as a middleware layer for payers and state programs. With its acquisition of Diet ID, Tangelo also offers a rapid, image-based dietary assessment tool that enables clinical measurement of diet quality. This capability supports Tangelo's broader vision of treating diet quality as a vital sign in medical care, enabling providers to integrate nutrition more systematically into risk identification and care planning.

More traditional medically tailored meal vendors like **Mom's Meals** (PurFoods) continue to serve a large share of the market, particularly for Medicare post-discharge meal programs.

Meanwhile, emerging players such as **Savor Health** are carving out niches in specialty care segments like oncology. Notably, some Food as Medicine vendors are now exploring integration with remote patient monitoring, care coordination platforms and digital therapeutics to deliver a more bundled and defensible solution set.

While many of these companies tout early evidence of impact, standardized outcomes measurement and integration with payer and provider workflows remain common challenges. As Food as Medicine programs mature, we think vendors with clinical credibility, scalable operations and strong data infrastructure will be best positioned to win share.

EVIDENCE BASE AND OUTCOMES MEASUREMENT

The broader evidence base supporting Food as Medicine is expanding but still fragmented. A landmark 2022 study in JAMA Internal Medicine found that medically tailored meal programs for Medicaid enrollees led to a 16% reduction in net healthcare spending. Evaluations of state-level pilots—such as those conducted under Massachusetts' Medicaid waiver—have shown improvements in key outcomes, including hemoglobin A1c and reduced emergency department visits.

> *According to a 2022 study in JAMA Internal Medicine, medically tailored meal programs for Medicaid enrollees led to a 16% reduction in net healthcare spending*

However, the field continues to grapple with limitations. There is no universally accepted set of outcome metrics or clinical endpoints for Food as Medicine interventions. Billing codes are inconsistent or absent altogether. Many studies to date rely on quasi-experimental designs, and rigorous randomized trials remain relatively rare. Despite these limitations, the trend lines are favorable. As CMS and states continue to fund pilot programs and request data, vendors and payers are investing in more robust measurement capabilities.

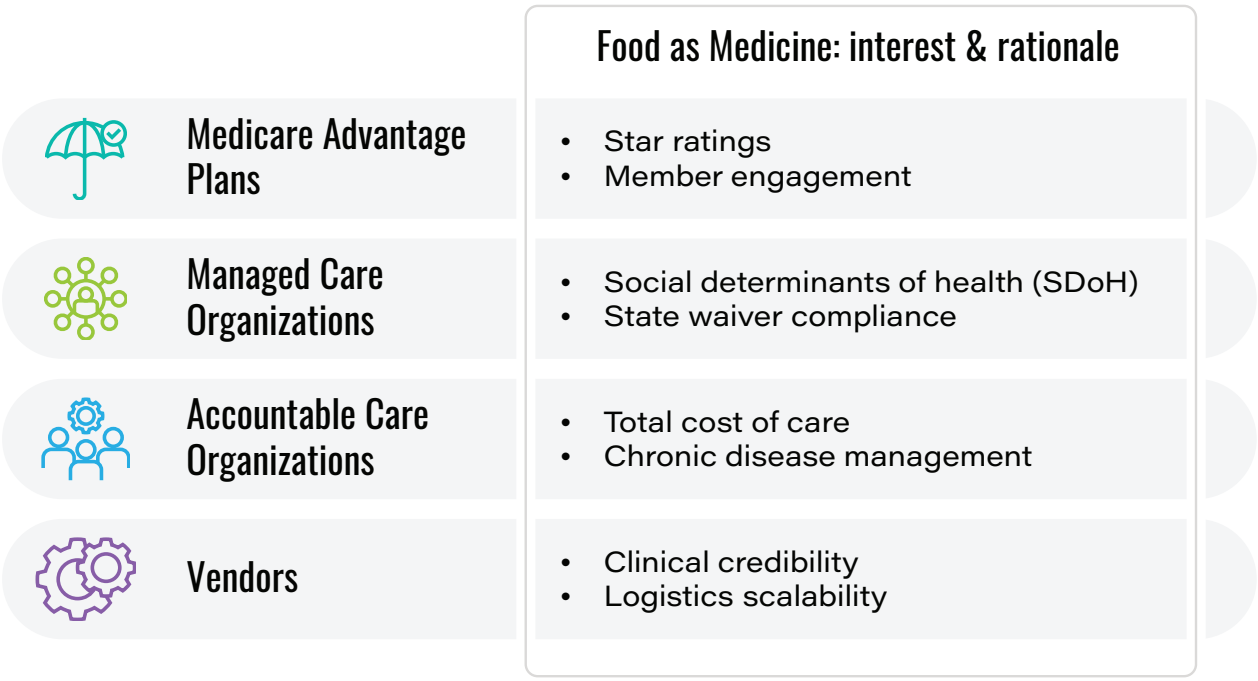
STRATEGIC OUTLOOK: RFK JR. AND THE MAHA PLATFORM

Looking ahead, several forces will shape the trajectory of Food as Medicine in the U.S. healthcare system: the durability of state-led Medicaid innovations, the continued evolution of MA supplemental benefits, and the vendor ecosystem's ability to demonstrate clinical impact at scale. However, a wildcard has emerged in the form of Robert F. Kennedy Jr., whose Make America Healthy Again (MAHA) platform places nutrition, toxin reduction, and lifestyle-based interventions at the center of a proposed transformation in U.S. public health policy.

While MAHA is not yet codified into formal health policy proposals, its core tenets are clear. Kennedy has advocated for a dramatic reorientation of the Department of Health & Human Services (HHS) away from "sick care" and toward prevention, natural immunity and environmental health. Central to this vision is the idea that chronic disease and healthcare costs are driven in large part by nutrition and environmental exposures—not just genetics or access to acute care. Under Kennedy's leadership at HHS and CMS, we think several Food as Medicine-aligned scenarios could unfold:

1. **Food as Medicine as core preventive health infrastructure:** MAHA's emphasis on nutrition could push HHS to establish Food as Medicine interventions (such as medically tailored meals and produce prescriptions) as fundamental to preventive care. These services could be embedded within new CMS Innovation Center models that elevate food alongside primary care and behavioral health.

Rationale behind key stakeholder interest in Food as Medicine initiatives



Source: First Analysis.

2. **CMS-led expansion of nutrition coverage across programs:** MAHA-aligned leadership might direct CMS to standardize or mandate baseline food benefits across MA and Medicaid programs for chronic illness cohorts. Rather than being discretionary, Food as Medicine benefits could become core to benefit design for at-risk populations.

3. **Cross-agency nutrition policy realignment:** Under Kennedy, HHS could collaborate with the Department of Agriculture and the Food and Drug Administration to overhaul nutrition guidelines and integrate anti-inflammatory diet protocols into chronic care pathways, potentially affecting everything from provider education to formulary design.

4. **Public investment in nutrition infrastructure:** Recognizing logistical constraints in Food as Medicine implementation, MAHA could drive new public-private partnerships to scale national food delivery infrastructure, integrate meal prescriptions into electronic health records, and fund technology for outcome measurement.

Though speculative, these scenarios highlight how federal leadership under MAHA could catalyze the mainstreaming of Food as Medicine. The implications for vendors, health systems and investors would be significant, especially for those aligned with clinical rigor, scale readiness, and population health goals.

PROMISING PATH TO REALIZE FOOD AS MEDICINE'S TRANSFORMATIONAL POTENTIAL

Food as Medicine has already established a foothold in the U.S. healthcare system through the flexibility of MA benefits, innovations under state Medicaid waivers, and the enthusiasm of risk-bearing provider organizations. However, its future trajectory could be significantly accelerated—or redefined—by the shift in federal leadership. Under

Kennedy's MAHA vision, nutrition is not a supplemental benefit but a foundational element of chronic disease prevention and health restoration.

If this framework guides future HHS policy, Food as Medicine could be elevated from the margins of managed care into the core of federal health strategy. National reimbursement models, logistics infrastructure, and outcomes research might all receive new levels of federal support. For vendors, health plans, and providers positioned at the intersection of food delivery, clinical care, and population health, the MAHA agenda—if realized—could dramatically expand the market and strategic relevance of nutrition-based care.

Yet success in this space will require more than alignment with political trends. Stakeholders must continue to build evidence, simplify workflows, and integrate food into the care continuum in ways that are measurable, scalable and patient-centered. Whether driven by bipartisan health equity priorities or a populist reimagining of federal healthcare, we think Food as Medicine is poised to become a durable feature of U.S. care delivery—transforming not just how we treat illness, but how we define health.

Healthcare index gain masks declines at most constituents

The First Analysis Healthcare Technology Index finished the one-year period ended May 13 up 13.5% overall, with the payer technology group down 38.1% and the provider technology subset up 23.4% entirely due to one large company's substantial appreciation. Over the same period, the S&P 500 gained 12.7%, and the Nasdaq gained 16.0%.

Four of the six payer technology company stocks were down over the one-year period. The worst performer was Evolent Health (EVH), down 61%.

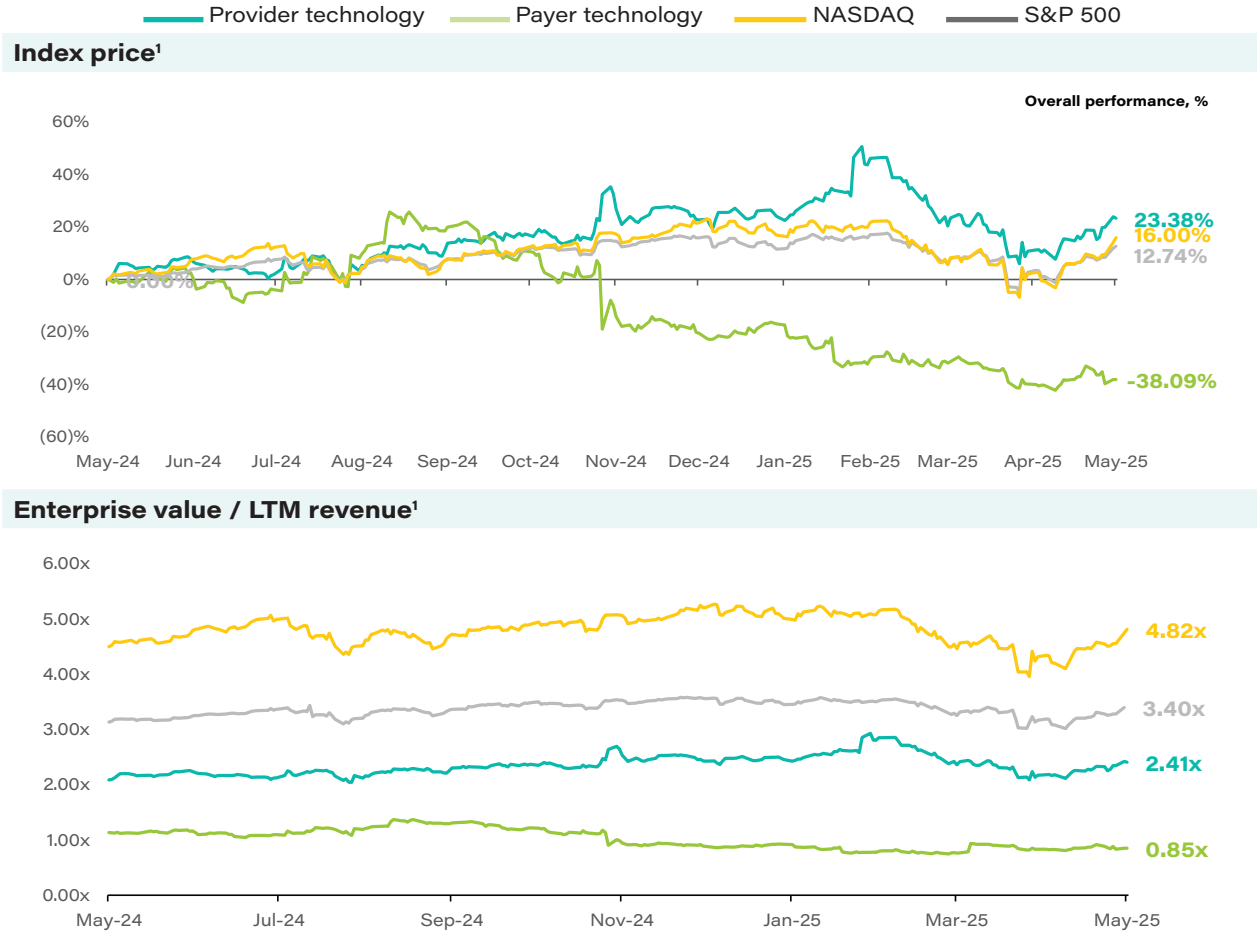
Healthcare technology public comparables*

($ in millions)		Revenue growth				Enterprise value /			
						Revenue		EBITDA[1]	
Company	**LTM revenue**	**2024A - 2025E**	**2025E - 2026E**	**LTM gross margin**	**LTM EBITDA margin**	**2025E**	**2026E**	**2025E**	**2026E**
Payer technology									
American Well (AMWL)	$261.7	0.7%	7.3%	44.5%	(47.6%)	NMF	NMF	1.7x	4.3x
eHealth (EHTH)	$552.6	(0.2%)	7.3%	99.7%	9.4%	0.82x	0.77x	8.6x	7.3x
EverQuote (EVER)	$575.8	29.0%	11.5%	96.3%	8.4%	1.21x	1.08x	9.3x	7.9x
Evolent Health (EVH)	$2,398.7	(19.5%)	15.1%	15.2%	3.5%	0.92x	0.80x	12.6x	10.2x
Veradigm (MDRX)	$588.0	0.9%	(1.0%)	52.5%	8.8%	0.82x	0.83x	5.9x	6.5x
TruBridge (TBRG)	$345.7	3.1%	5.3%	51.9%	12.5%	1.48x	1.41x	8.2x	7.4x
Mean	***$787.1***	***2.3%***	***7.6%***	***60.0%***	***(0.8%)***	***1.05x***	***0.98x***	***7.7x***	***7.3x***
Median	***$564.2***	***0.8%***	***7.3%***	***52.2%***	***8.6%***	***0.92x***	***0.83x***	***8.4x***	***7.4x***
Provider technology									
CareCloud (MTBC)	$112.5	0.7%	7.5%	45.7%	13.1%	0.72x	0.67x	3.1x	2.8x
Definitive Healthcare (DH)	$247.9	(6.0%)	1.7%	83.4%	17.7%	2.02x	1.99x	7.6x	7.2x
Doximity (DOCS)	$550.2	12.3%	12.5%	90.2%	41.6%	17.00x	15.11x	31.6x	27.6x
GoHealth (GOCO)	$834.3	7.5%	6.4%	84.2%	12.1%	0.92x	0.87x	5.6x	4.9x
GoodRx (GDRX)	$797.4	3.5%	5.5%	93.8%	14.0%	2.30x	2.18x	6.8x	6.3x
Health Catalyst (HCAT)	$311.3	9.0%	9.7%	45.9%	(6.3%)	1.07x	0.98x	9.0x	7.0x
HealthEquity (HQY)	$1,199.8	8.6%	10.1%	64.8%	30.4%	7.06x	6.41x	17.2x	14.7x
HealthStream (HSTM)	$292.4	3.6%	5.1%	66.2%	12.8%	2.45x	2.33x	10.5x	9.8x
Maximus (MMS)	$5,395.3	0.4%	4.4%	23.6%	11.3%	1.07x	1.02x	9.0x	8.5x
Omnicell (OMCL)	$1,135.8	1.7%	4.1%	43.2%	6.1%	1.16x	1.11x	11.7x	9.9x
Phreesia (PHR)	$419.8	13.3%	11.8%	67.9%	(8.4%)	3.09x	2.76x	18.0x	13.1x
Premier (PINC)	$1,260.4	(22.8%)	(1.4%)	63.3%	26.0%	2.12x	2.15x	8.3x	5.1x
Teladoc Health (TDOC)	$2,552.8	(2.1%)	1.3%	70.5%	1.3%	0.69x	0.68x	6.1x	5.7x
Mean	***$1,162.3***	***2.3%***	***6.1%***	***64.8%***	***13.2%***	***3.21x***	***2.94x***	***11.1x***	***9.4x***
Median	***$797.4***	***3.5%***	***5.5%***	***66.2%***	***12.8%***	***2.02x***	***1.99x***	***9.0x***	***7.2x***

Source: Capital IQ, First Analysis.

Notes: * Public comparable company data shown above is as of May 13, 2025.
(1) EBITDA multiples less than 0 and greater than 50 labeled "not meaningful" (NMF). LTM = last 12 months. EBITDA = earnings before interest, taxes, depreciation and amortization.

First Analysis Healthcare Technology Index 1-year performance



Source: Capital IQ.

Notes: (1) Index performance is based on market cap weighted constituents. For the period from May 13, 2024, through May 13, 2025.

It accounted for 32 points of the 38% decline for the group as a whole. Eight of the 13 provider technology company stocks declined over the period, four by more than 30%. Doximity (DOCS), which appreciated 163%, accounted for all the group's 23.4% gain. Had Doximity been flat, the group would have been down about 2%.

The indexes' enterprise value multiples of trailing 12-month revenue as of May 9 were 0.9 for the payer technology group, down from 1.1 a year prior, and 2.4 for the provider technology group, up from 2.1 a year prior. Looking at forward multiples, the average and median enterprise value multiples of 2025 estimated revenue were 1.1 and 0.9 for the payer technology group and 3.2 and 2.0 for the provider technology group. The average and median enterprise value multiples of 2026 projected revenue were 1.0 and 0.8 for the payer technology group and 2.9 and 2.0 for the provider technology group.

In the payer technology group, TruBridge (TBRG) traded at the highest revenue multiple of 2025 estimated revenue at 1.5, while Doximity led the provider technology group at 17.0. The average 2025 estimated revenue growth rate was 2.3% for both the payer and provider technology groups. Average revenue growth for 2026 is expected to accelerate for both groups, to 7.6% for payer technology and to 6.1% for provider technology.

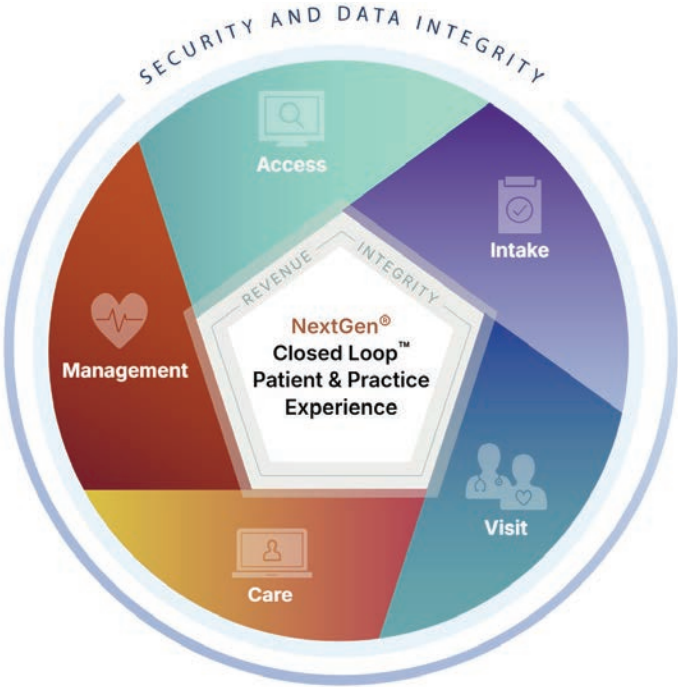
Healthcare tech M&A: Notable transactions include NextGen Healthcare, UpLift

We highlight two noteworthy healthcare technology merger and acquisition transactions since the beginning of the year.

On May 2, Madison Dearborn Partners announced it would acquire a significant ownership stake in NextGen Healthcare for an undisclosed amount alongside Thoma Bravo, which had taken the company private in November 2023 in a $1.8 billion transaction. NextGen Healthcare provides electronic health record and practice management software and services. The partnership aims to accelerate NextGen's growth by investing in its SaaS platform for ambulatory care, revenue cycle management, and population health.

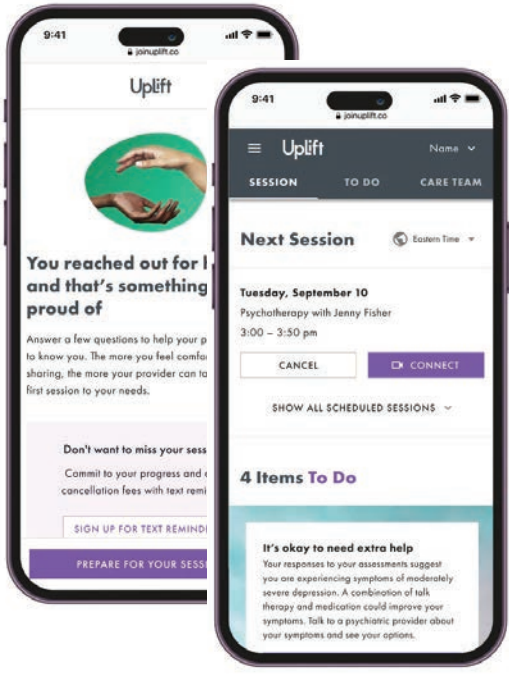
On April 30, Teladoc Health (TDOC) announced it acquired UpLift, a provider of virtual mental health therapy, psychiatry and medication management services, in an all-cash transaction for $30 million, with up to $15 million in additional contingent earnout consideration. UpLift's 2024 revenue was approximately $15 million. The acquisition expands Teladoc's suite of mental health offerings and deepens its reach in covered populations by integrating UpLift's therapist network and tech platform with Teladoc's existing virtual care infrastructure. The move reflects Teladoc's continued strategy to consolidate consumer access points under a unified, benefits-integrated model.

NextGen closed loop patient and practice experience



Source: NextGen.

UpLift mobile app interface



Source: UpLift.

Select recent M&A transactions *(sorted by date of announcement)*

($ in millions)

Date	Target	Target business description	Buyer	Enterprise value	Enterprise value/rev
5/2/2025	NextGen Health-care	Electronic health record and practice management software and services	Madison Dearborn Partners	Undisclosed	Undisclosed
4/30/2025	UpLift	Virtual mental health therapy, psychiatry and medication management services	Teladoc Health (TDOC)	$45.0	3.0x
4/24/2025	MedAllies	Health Information Service Provider and Qualified Health Information Network focused on health data connectivity and clinical data exchange	Centauri Health Solu-tions	Undisclosed	Undisclosed
4/22/2025	Novillus	Solves complex payer and provider group workflow and collaboration challenges with digital solutions and omni-channel engagement expertise	Reveleer	Undisclosed	Undisclosed
4/8/2025	HealthEdge	Integrated financial, administrative and clinical software platform for healthcare payers	Bain Capital	$2,600.0	Undisclosed
4/2/2025	RevNu Medical Management	Audiology-focused revenue cycle man-agement services	CareCloud (CCLD)	Undisclosed	Undisclosed

Source: Capital IQ, First Analysis.

Healthcare tech private placements: Notable transactions include Blooming Health, Nourish

We highlight two recent healthcare technology private placements that reflect growing investor focus on AI-powered care enablement and nutrition-driven chronic disease management.

On April 29, Blooming Health announced a $26 million Series A round led by Insight Partners, with participation from existing investors Afore Capital, Crossbeam Venture Partners, and Metro-

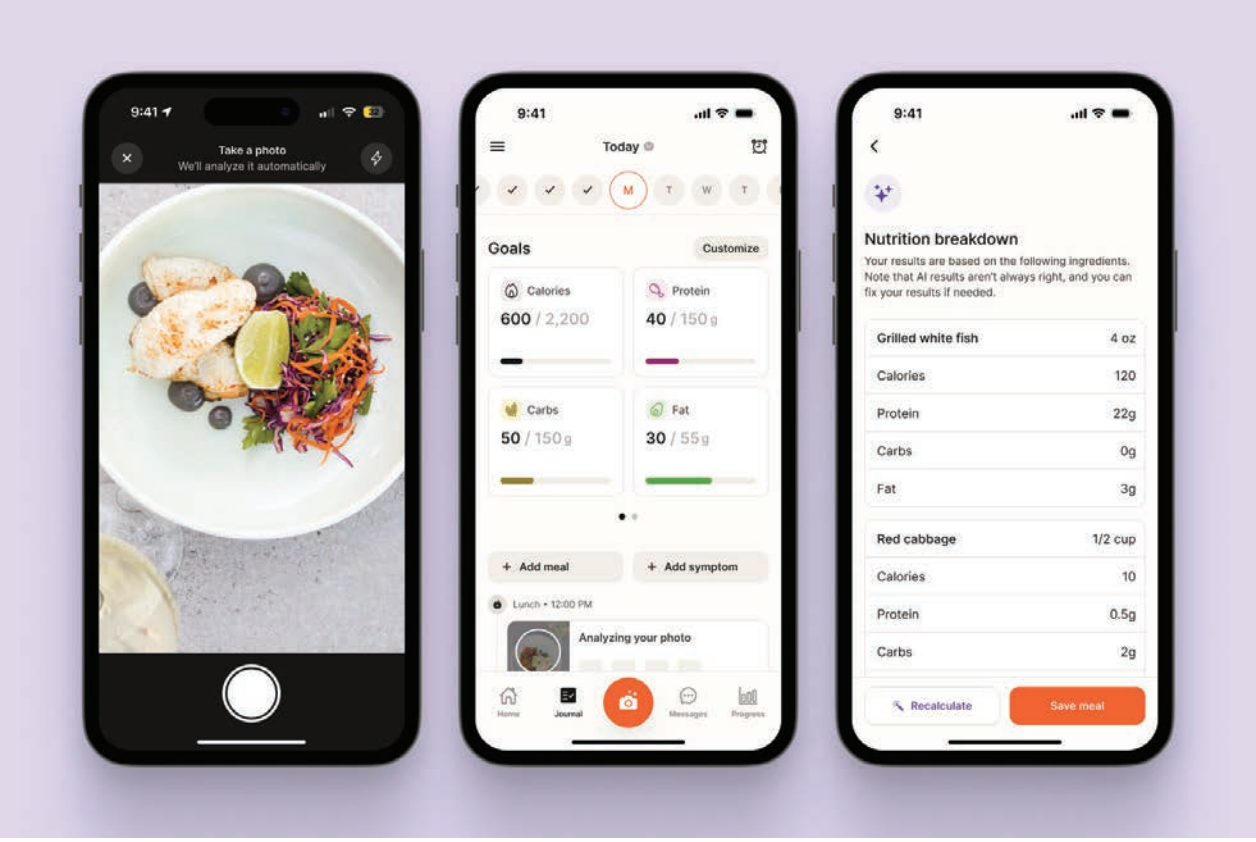
Blooming Health platform capabilties

Source: Blooming Health.

dora Ventures. This investment brings Blooming Health's total funding to $32.5 million. Blooming Health provides an artificial intelligence-powered platform for aging and social care agencies to engage older adults across more than 25 languages and communication channels. The platform supports outreach efforts to address social determinants of health, reduce isolation, and improve outcomes among Medicaid and dual-eligible populations. The investment is intended to help scale operations nationally and deepen integrations with healthcare payers and providers.

On April 23, Nourish, a registered dietitian-led virtual care platform, announced a $70 million Series B round led by J.P. Morgan Private Capital's Growth Equity Partners, with participation from Thrive Capital, Index Ventures, Y Combinator, Maverick Ventures, BoxGroup, Atomico, G Squared, and Pinegrove. Nourish connects people with chronic conditions—such as diabetes, obesity and hypertension—to personalized nutrition care, fully covered by insurance. The company uses artificial intelligence to optimize patient-provider matching and streamline care delivery. The funding will support expansion of Nourish's insurance-covered offerings and continued investment in its clinical intelligence platform.

Nourish's AI-powered personalized nutrition platform



Source: Nourish.

Select recent private placements *(sorted by date of announcement)*

($ in millions)

Date	Company	Business description	Investors	Raise type	Amount raised	Total amount raised
5/8/2025	Kouper	Software to support patients after discharge from the hospital	General Catalyst Group Management; 25Madison; CVS Health Ventures	Venture	$10.0	$10.0
5/8/2025	Clarium	Data and analytics platform for health system supply chain optimization	General Catalyst Group Management; Northzone Ventures; Kaiser Permanente Ventures; 1984 Ventures; AlleyCorp; The Texas Medical Center Venture Fund	Series A	$27.0	$37.5
4/30/2025	Plenful	Workflow automation platform that streamlines pharmacy and healthcare operations and is used for 340B audit and missed savings, intelligent document processing, inventory planning and contracted rates optimization, and pharmacy revenue cycle management	Bessemer Venture Partners; Susa Ventures; Arena Holdings; TQ Ventures; Notable Capital; Kivu Ventures	Series B	$50.0	$76.0
4/29/2025	Persivia	AI-driven platform for managing multiple concurrent value-based care programs and data for healthcare providers	Aldrich Capital Partners	Growth	$107.0	$138.0
4/29/2025	HealthPlan Data Solutions	Pharmacy analytics platform	MK Capital; Rev1 Ventures, Investment Arm; Tamarind Hill Fund	Growth	$15.0	$15.3
4/29/2025	Blooming Health	Software to address social determinants of health, reduce isolation, and improve outcomes among Medicaid and dual-eligible populations	Afore Capital; Insight Partners; Metrodora Ventures; Crossbeam Venture Partners	Series A	$26.0	$32.5
4/23/2025	Nourish	Software to connect people with chronic conditions to personalized nutrition care, fully covered by insurance	Index Ventures SA; Atomico Investment; Y Combinator; Thrive Capital; BoxGroup Services; G Squared; Maverick Ventures; J.P. Morgan Growth Equity; Pinegrove Opportunity	Series B	$70.0	$123.0
4/16/2025	Assort Health	Contact center platform that simplifies healthcare operations by managing patient intake and inbound phone calls	First Round Capital Management; Quiet Capital Management; Chemistry Ventures	Venture	$3.5	$26.0
4/15/2025	Solaborate	Telehealth and virtual healthcare delivery platform	Bon Secours Mercy Health; LRVHealth; University of Colorado Health; HealthQuest Capital; OSF Ventures	Growth	$47.0	$47.0
4/2/2025	Rapidclaims	Revenue cycle management and billing platform for the healthcare sector	Accel Partners; Together Fund	Series A	$8.0	$11.1

Source: Capital IQ, First Analysis.

Healthcare technology public comparables appendix*

($ in millions)

Company	Market cap	Enterprise value	LTM revenue	Revenue growth 2024A-2025E	Revenue growth 2025E - 2026E	LTM gross margin	LTM EBITDA margin	Enterprise value / Revenue 2025E	Enterprise value / Revenue 2026E	Enterprise value / EBITDA[1] 2025E	Enterprise value / EBITDA[1] 2026E
Payer technology											
American Well (AMWL)	$118.6	$(84.7)	$261.7	0.7%	7.3%	44.5%	(47.6%)	NMF	NMF	1.7x	4.3x
eHealth (EHTH)	$150.4	$438.2	$552.6	(0.2%)	7.3%	99.7%	9.4%	0.82x	0.77x	8.6x	7.3x
EverQuote (EVER)	$900.3	$778.7	$575.8	29.0%	11.5%	96.3%	8.4%	1.21x	1.08x	9.3x	7.9x
Evolent Health (EVH)	$1,074.0	$1,890.8	$2,398.7	(19.5%)	15.1%	15.2%	3.5%	0.92x	0.80x	12.6x	10.2x
Veradigm (MDRX)	$712.6	$485.5	$588.0	0.9%	(1.0%)	52.5%	8.8%	0.82x	0.83x	5.9x	6.5x
TruBridge (TBRG)	$362.3	$523.0	$345.7	3.1%	5.3%	51.9%	12.5%	1.48x	1.41x	8.2x	7.4x
Average	***$553.1***	***$671.9***	***$787.1***	***2.3%***	***7.6%***	***60.0%***	***(0.8%)***	***1.05x***	***0.98x***	***7.7x***	***7.3x***
Median	***$537.5***	***$504.3***	***$564.2***	***0.8%***	***7.3%***	***52.2%***	***8.6%***	***0.92x***	***0.83x***	***8.4x***	***7.4x***
Provider technology											
CareCloud (MTBC)	$83.8	$80.3	$112.5	0.7%	7.5%	45.7%	13.1%	0.72x	0.67x	3.1x	2.8x
Definitive Healthcare (DH)	$386.4	$479.5	$247.9	(6.0%)	1.7%	83.4%	17.7%	2.02x	1.99x	7.6x	7.2x
Doximity (DOCS)	$11,338.9	$10,506.9	$550.2	12.3%	12.5%	90.2%	41.6%	17.00x	15.11x	31.6x	27.6x
GoHealth (GOCO)	$89.9	$793.5	$834.3	7.5%	6.4%	84.2%	12.1%	0.92x	0.87x	5.6x	4.9x
GoodRx (GDRX)	$1,649.5	$1,889.7	$797.4	3.5%	5.5%	93.8%	14.0%	2.30x	2.18x	6.8x	6.3x
Health Catalyst (HCAT)	$298.6	$359.0	$311.3	9.0%	9.7%	45.9%	(6.3%)	1.07x	0.98x	9.0x	7.0x
HealthEquity (HQY)	$8,389.3	$9,201.9	$1,199.8	8.6%	10.1%	64.8%	30.4%	7.06x	6.41x	17.2x	14.7x
HealthStream (HSTM)	$836.7	$740.0	$292.4	3.6%	5.1%	66.2%	12.8%	2.45x	2.33x	10.5x	9.8x
Maximus (MMS)	$4,246.5	$5,759.6	$5,395.3	0.4%	4.4%	23.6%	11.3%	1.07x	1.02x	9.0x	8.5x
Omnicell (OMCL)	$1,311.6	$1,310.6	$1,135.8	1.7%	4.1%	43.2%	6.1%	1.16x	1.11x	11.7x	9.9x
Phreesia (PHR)	$1,534.0	$1,467.5	$419.8	13.3%	11.8%	67.9%	(8.4%)	3.09x	2.76x	18.0x	13.1x
Premier (PINC)	$1,882.3	$2,105.7	$1,260.4	(22.8%)	(1.4%)	63.3%	26.0%	2.12x	2.15x	8.3x	5.1x
Teladoc Health (TDOC)	$1,336.8	$1,730.3	$2,552.8	(2.1%)	1.3%	70.5%	1.3%	0.69x	0.68x	6.1x	5.7x
Average	***$2,568.0***	***$2,801.9***	***$1,162.3***	***2.3%***	***6.1%***	***64.8%***	***13.2%***	***3.21x***	***2.94x***	***11.1x***	***9.4x***
Median	***$1,336.8***	***$1,467.5***	***$797.4***	***3.5%***	***5.5%***	***66.2%***	***12.8%***	***2.02x***	***1.99x***	***9.0x***	***7.2x***

Source: Capital IQ, First Analysis.

Notes: * Public comparable company data shown above is as of May 13, 2025.
(1) EBITDA multiples less than 0 and greater than 50 labeled "not meaningful" (NMF). LTM = last 12 months. EBITDA = earnings before interest, taxes, depreciation and amortization.

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