

FULLERFIELD INSIGHTS · JULY 2026

The Food Is Medicine Financing Gap

A proven clinical intervention with contracted payer demand still cannot raise the capital to scale. This is the \$1.4 billion gap, and the concessionary debt that closes it.

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The evidence is settled and the payers are paying. What is missing is the capital that lets a mission provider say yes to the contract.

EXECUTIVE SUMMARY

The case for concessionary debt in food is medicine

Food is medicine describes a set of clinical interventions that treat diet-sensitive disease with food: medically tailored meals for people managing serious illness, produce prescriptions for patients with diabetes and hypertension, and medically supportive food and grocery benefits delivered through the health-care system. The category has crossed the threshold that matters to a lender. The clinical evidence is peer-reviewed, the cost savings are documented, and payers are now contracting for the service. Medicaid managed-care plans, state waivers, and Medicare Advantage plans have all begun to reimburse food as a covered benefit.

Fullerfield Capital's research puts the cumulative unmet demand for growth and working capital across U.S. food-is-medicine delivery organizations at **\$1.4 billion** over the 2026 to 2031 window. The gap sits in three places: clinical meal providers that build and staff production kitchens (**\$610M**), the aggregation, produce-prescription, and cold-chain layer that moves food from farm to patient (**\$500M**), and tech-enabled platforms that carry contract receivables while payers pay slowly (**\$290M**). Each is large enough to matter on its own.

The gap is not a story of weak demand. Roughly 90 percent of U.S. health-care spending goes to managing chronic disease, an estimated 43 million Americans are eligible for a food-is-medicine intervention, and medically tailored meals are associated with a 16 percent reduction in total health-care costs (JAMA Internal Medicine, 2019). The problem sits on the capital side. The organizations delivering this care are mostly nonprofits and thin-margin operators that conventional lenders will not underwrite and venture capital will not price.

The three-part gap at a glance

Clinical meal providers (\$610M): Accredited medically tailored meal kitchens face \$12M to \$20M capacity builds and a reimbursement float that grant funding cannot carry. Roughly two-thirds of a flagship provider's budget still comes from donations, not contracts.

Aggregation and produce Rx (\$500M): Regional food hubs and produce-prescription platforms need cold-chain capex and the working capital to pay farmers in 14 days while payers settle in 60 to 128.

Tech-enabled platforms (\$290M): For-profit platforms raise equity for growth but have no efficient way to finance Medicaid receivables through a payment cycle that reaches 128 days at the 90th percentile.

Fullerfield Capital was built to close this gap with **concessionary, mission-priced debt**: the capital form that is missing. Equity does not fit nonprofit and low-margin operators. Grants exist through Fullerfield Foundation and peer funders, but grants cannot scale to a billion-dollar problem. Debt, structured and protected by a catalytic first-loss layer, can. This report sets out the evidence, the bottoms-up model behind the \$1.4B figure, and the capital logic that makes concessionary debt the missing instrument in this market.

Headline Numbers & Report Structure

Ten data points that frame the opportunity

\$1.4B Cumulative U.S. food-is-medicine capital gap, 2026-2031	43M Americans eligible for a food-is-medicine intervention (Rockefeller, 2026)	\$45B State economic activity if FIM scales to eligible population
\$23.7B Annual savings if medically tailored meals reach all eligible patients	16% Lower total health-care cost with MTM (JAMA Internal Medicine, 2019)	128 days 90th-percentile Medicaid managed-care claim payment lag (2022 data)
\$7.92 Medicaid rate per medically tailored home-delivered meal (NC, 2024)	~90% Share of U.S. health-care spending tied to chronic disease	\$412.9B Annual U.S. cost of diabetes alone (ADA, 2022)

What's in this report

I. The field context frames the intervention and the population it serves. **II. Clinical meal providers**, why \$610M of capacity and working capital is required to keep medically tailored meals scaling. **III. Aggregation and produce Rx**, the \$500M distribution and cold-chain layer. **IV. Tech-enabled platforms**, the \$290M receivables gap. **V. Reconciling to \$1.4B**, the bottoms-up build. **VI. Demand-side tailwinds**, evidence and reimbursement. **VII. Capital strategy**, why concessionary debt is the missing instrument. **VIII. Risk framework**. **IX. The Fullerfield approach**. **Appendix**.

A note on scope and methodology

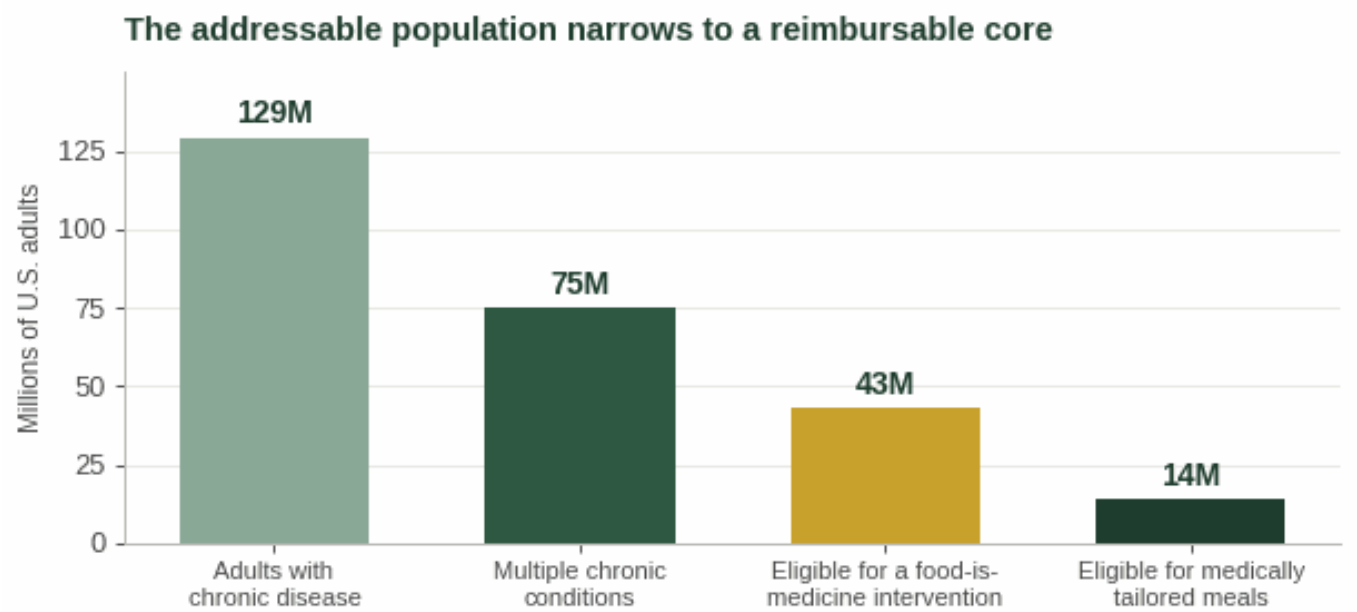
Geographic scope is national. Financial figures are in 2025 USD unless noted. Segment estimates combine USDA and NIFA program data, Tufts Food is Medicine Institute and Health Affairs research, Food is Medicine Coalition and National Produce Prescription Collaborative field data, KFF and CMS policy tracking, and Fullerfield's own pipeline observations. The \$1.4B figure is constructed bottoms-up and reconciled across three segments. All projections are illustrative and do not constitute an offer, solicitation, or return commitment.

I. THE FIELD CONTEXT

What food is medicine is, and who it serves

The United States spends more than \$4.5 trillion a year on health care, and roughly 90 percent of that goes to managing chronic disease (Rockefeller Foundation and Dalberg Advisors, 2026). Tufts researchers attribute a large share of chronic-disease cost to diet: the combined health-care and lost-productivity burden of poor diet runs near \$1.1 trillion annually, and diabetes alone cost \$412.9 billion in 2022 (American Diabetes Association). Food-is-medicine interventions target that spending directly, by treating diet-sensitive conditions with food delivered through the clinical system rather than the charitable one.

The addressable population is large, and it narrows to a reimbursable core. Roughly 129 million Americans live with a chronic disease and 75 million have more than one. Of these, an estimated 43 million are eligible for some food-is-medicine intervention, and more than 14 million, most of them covered by Medicare or Medicaid, meet the clinical and social criteria for medically tailored meals specifically (Tufts and Health Affairs, 2025). This is the wedge that payers can contract for today.



The population narrows from all adults with chronic disease to the medically tailored meal core. Sources: Rockefeller Foundation and Dalberg Advisors (2026); Tufts Food is Medicine Institute and Health Affairs (2025). The reimbursable core is the near-term deployable market.

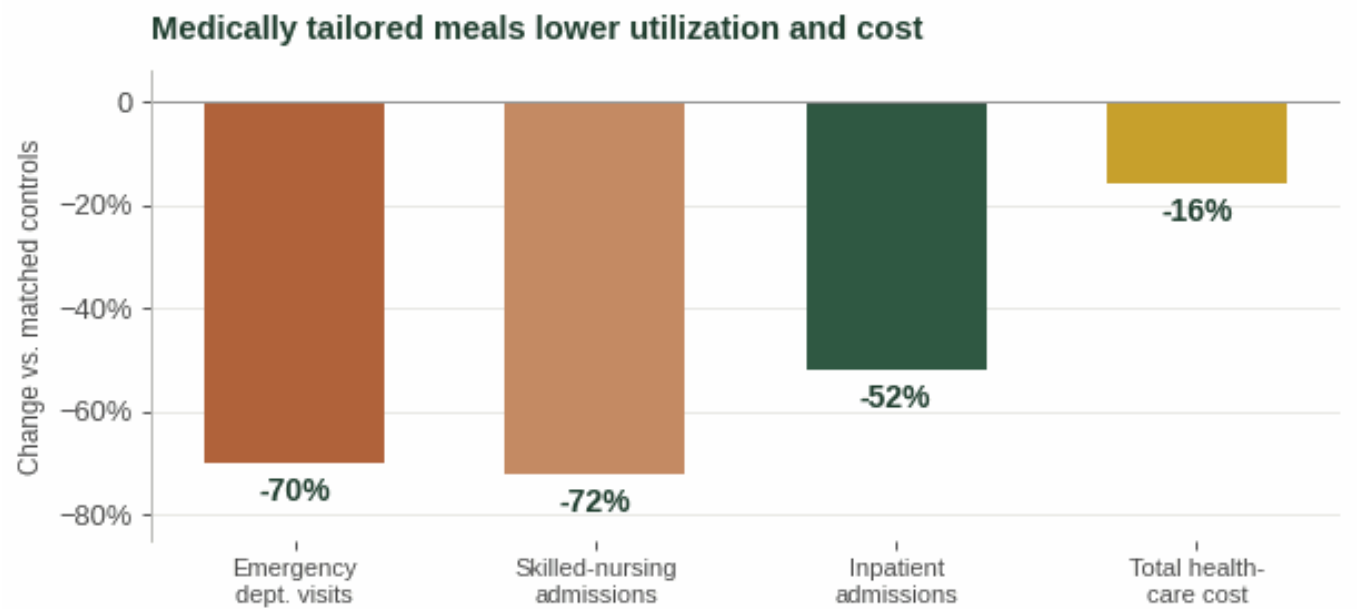
Three delivery models, one clinical discipline

The field runs on three operating models. **Clinical meal providers** cook and deliver medically tailored meals, mostly nonprofits that have run this intervention for four decades. **Distribution organizations** aggregate regional produce and fulfill produce prescriptions, largely food hubs and produce-Rx platforms. **Tech-enabled platforms** connect payers, providers, and patients and manage benefit delivery at scale. Each faces a different capital problem, and none of the three is well served by the capital markets as they exist.

II. CLINICAL MEAL PROVIDERS · \$610M

The strongest evidence sits with the least bankable operators

Medically tailored meals carry the deepest evidence base in the field. In a matched study of dually eligible Medicare and Medicaid beneficiaries, meal recipients had 70 percent fewer emergency department visits and 52 percent fewer inpatient admissions, with net savings of about \$220 per member per month (Berkowitz et al., Health Affairs, 2018). A separate study found a 16 percent reduction in total health-care costs among recipients (JAMA Internal Medicine, 2019). California's CalAIM program, which began covering medically supportive food in 2022, reported inpatient use down 21 percent and emergency use down 22 percent among participants (DHCS, 2025).



Change in health-care utilization and cost among medically tailored meal recipients versus matched controls. Sources: Berkowitz et al., Health Affairs (2018) and JAMA Internal Medicine (2019). Emergency and admission effects are from the dually eligible cohort; the cost effect is program-wide.

Why this becomes a capital problem, not a clinical one

The intervention works and payers are paying for it, yet the operators cannot fund their own growth. The Food is Medicine Coalition counts roughly 20 accredited providers and a pipeline of emerging kitchens; in 2024, 26 surveyed organizations delivered just over four million meal-equivalents. Serving a materially larger share of the 14 million eligible patients requires new production capacity, and a purpose-built kitchen at the scale of a leading provider costs \$12 million to \$20 million. These are nonprofits: they cannot issue equity, and roughly two-thirds of even a flagship provider's budget still comes from donations rather than payer contracts (Nonprofit Finance Fund). The space between a signed Medicaid contract and the capital to deliver against it is where the \$610M sits.

II. CLINICAL MEAL PROVIDERS (CONT.)

How we get to \$610M, the bottoms-up build

Fullerfield's \$610M clinical-meal estimate is the residual capital need after grants and conventional sources are drawn to their realistic ceilings. We start from the reimbursable demand reachable through Medicaid and Medicare Advantage over the five-year window, scope it to the production capacity that demand requires, and net out the philanthropic capital the field can plausibly raise.

Driver	Estimate	Basis
Reimbursable MTM demand, 2031 (annual meal-equivalents)	~260M	14M eligible × ~15% reached × ~124 meals per 6-month course
Incremental production capacity required	~24 kitchens	Over the ~4M meal-equivalents accredited providers deliver today
All-in capex per regional kitchen	\$12-20M	Purpose-built production at ~2-2.5M meals per year
Gross production capex (5-yr)	\$410M	~24 builds and expansions, acreage-weighted to scale
Plus: working capital, reimbursement float	\$180M	Contracted revenue ÷ 365 × 90-128 day payer lag
Plus: readiness, accreditation, bridge capital	\$140M	Contract ramp, RDN staffing, first-contract underwriting
Less: philanthropy and grants applied to build	(\$120M)	Braided grant share of capex at realistic ceiling
Residual financing gap, clinical meal providers	\$610M	Fullerfield estimate, 2026-2031

The model is deliberately conservative. We cap the reimbursable-demand share at 15 percent against a higher-uptake view, and we assume grants carry a fifth of build cost rather than the smaller share providers typically secure. We also exclude national commercial meal vendors that already access conventional capital, because they do not represent Fullerfield's deployable opportunity.

III. AGGREGATION, PRODUCE RX & COLD CHAIN · \$500M

The layer that moves food from farm to prescription

Produce prescriptions have their own growing evidence base. A multi-site study of 3,881 participants across 12 states found meaningful reductions in blood pressure and blood sugar, an increase of about 0.85 cups of fruit and vegetables per day, and a one-third drop in reported food insecurity (Circulation, 2023). Tufts modeling estimates that national produce-prescription coverage for patients with diabetes and food insecurity could prevent roughly 292,000 cardiovascular events (JAHA, 2023). The USDA GusNIP program has directed more than \$330 million to over 250 produce-incentive and prescription projects since 2019.

Delivering that intervention depends on a distribution layer the region under-finances: regional food hubs that aggregate and cold-store farm product, and platforms that fulfill produce prescriptions into clinical settings. There are roughly 400 food hubs nationally; about half report difficulty accessing capital, and 57 percent actively seek help financing it (MSU National Food Hub Survey). The National Produce Prescription Collaborative now spans more than 90 organizations.

Segment	Facilities / need	Gap (\$M)
Regional food-hub aggregation & cold storage	~110 builds and expansions at ~\$3M each	\$300M
Produce-prescription fulfillment platforms	90+ NPPC organizations scaling clinical delivery	\$90M
Farmer-payment working capital	Pay farms in ~14 days against slow payer settlement	\$70M
Last-mile refrigerated distribution	Fleet and satellite cross-docks near patients	\$40M
Total, aggregation and produce Rx		\$500M

The working-capital line is the operational fact that defines this segment. A hub buys from farmers on 14-day terms and waits 60 to 128 days for the payer or clinical partner to settle. The mismatch is not a sign of a weak business: it is a capital-structure problem that conventional lenders decline to underwrite for mission operators without a subordinated layer beneath them.

III. DISTRIBUTION (CONT.)

Why grants and pilots help, and why debt is still required

Public and philanthropic capital has moved into this field. The 2022 White House Conference on Hunger, Nutrition, and Health drew \$8 billion in combined public and private commitments. The Rockefeller Foundation has committed more than \$100 million to food is medicine, and in January 2026 launched a \$10 million Food is Medicine Impact Fund. USDA GusNIP continues to fund produce incentives at roughly \$56 million a year. This capital is necessary. It is not close to sufficient.

Three reasons. First, grants rarely cover more than a third to a half of a capital project, so the operator still has to raise the balance. Second, grant funding arrives on appropriation cycles that do not match construction or contract timelines. Third, and most important for this segment, grants do not finance working capital: a produce hub can have its cold storage paid for by a grant and still fail for lack of the cash to pay farmers while a Medicaid managed-care plan settles a claim over 90 days. The one fund that carries the food-is-medicine name is structured as policy-capacity grants to state officials, not as working-capital debt to operators, which leaves the operating layer without a dedicated lender.

Public and philanthropic capital is a floor, not a ceiling

Programs like GusNIP, the Healthy Food Financing Initiative, and foundation impact funds are essential. They are also cyclical, concentrated on equipment and facilities rather than working capital, and exposed to appropriation politics. In 2025 the federal government rescinded its standardized nutrition-waiver framework and one flagship state pilot was defunded. Private, patient debt is what operationalizes the public investment and carries operators across policy cycles. The \$500M distribution gap is the residual after public capital is fully drawn.

Fullerfield's distribution underwriting is designed to sit alongside public capital, not compete with it. In a typical hub or produce-Rx deal, the stack runs roughly 25 percent grant or owner equity, 35 percent conventional or SBA-backed senior debt, and a 30 to 40 percent Fullerfield concessionary and first-loss tranche. That tranche is what turns a conceptually financeable project into a closeable one.

IV. TECH-ENABLED PLATFORMS · \$290M

Where private capital already flows, and where it stops

The one part of the field that venture capital has funded is the technology layer. Platforms that connect payers, providers, and patients, and manage benefit delivery and outcomes reporting, have raised on the order of \$400 million across a handful of companies. Foodsmart has raised roughly \$115 million and Season Health roughly \$44 million. These businesses can and do issue equity, and they are not the focus of Fullerfield's thesis.

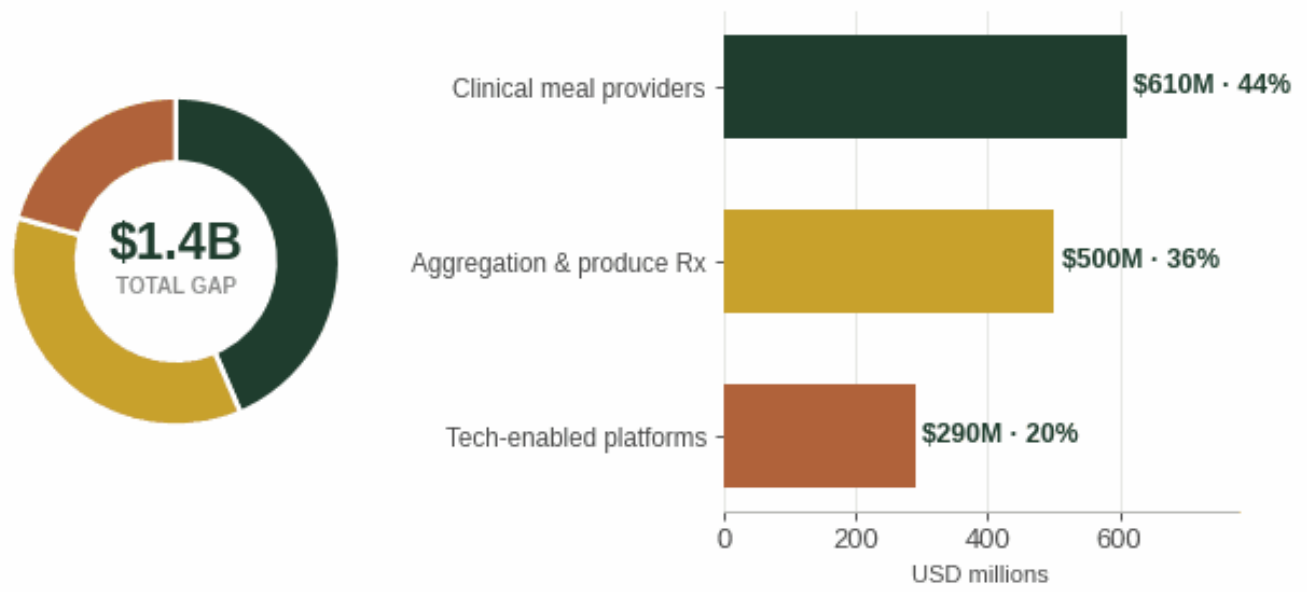
They face one financing problem that equity solves poorly: receivables. A platform contracting with Medicaid managed-care plans and Medicare Advantage plans bills against a payment cycle whose 90th percentile reached 128 days in the most recent national data, with a mean of 53 days (Health Affairs Scholar, 2022 claims data). Financing that float with equity is expensive and dilutive; financing it with a conventional revolver is difficult for a company whose collateral is a contract with a government payer rather than a hard asset. This is a debt problem, and it is where Fullerfield lends into an otherwise equity-funded segment.

Component	Scope	Gap (\$M)
Receivables financing	Medicaid and MCO settlement at 60-128 day cycles	\$170M
Contract-ramp working capital	Onboarding new payer and provider contracts	\$70M
Fulfillment & cold-pack capacity	Regional packing and shipping for benefit delivery	\$50M
Total, tech-enabled platforms		\$290M

This segment is the smallest of the three precisely because equity covers the growth capital. What it does not cover, and what Fullerfield supplies, is a revenue-linked or receivables-secured facility priced to a payer-contract cash cycle rather than to a corporate-credit comp. The instrument is senior, self-liquidating against collections, and short-tenor.

V. RECONCILING TO \$1.4B

The three-segment model, visualized



The \$1.4 billion U.S. food-is-medicine capital gap split across three delivery segments. Fullerfield research, 2026. Segment estimates are built bottoms-up from USDA, FIMC, NPPC, Tufts, and Health Affairs data and Fullerfield pipeline observations.

The \$1.4B figure is the result of a bottoms-up build, not a top-down claim. Each segment is modeled independently from public data and Fullerfield's pipeline, then summed. Where public estimates exist, we cross-walk to them: the clinical-meal figure sits inside Tufts and Health Affairs sizing of the eligible population; the distribution figure is consistent with USDA food-hub survey capital constraints; the platform figure is anchored to documented Medicaid payment-cycle data.

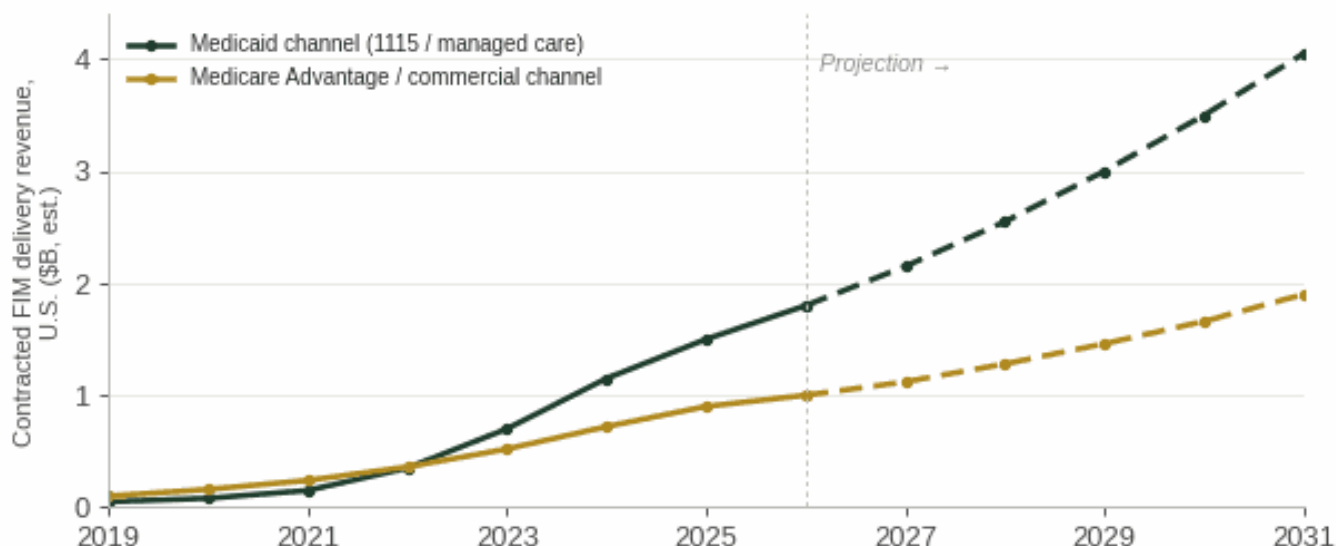
Segment	Gap (2026-2031)	Share	Primary sources
Clinical meal providers	\$610M	44%	FIMC, Tufts, Nonprofit Finance Fund
Aggregation & produce Rx	\$500M	36%	USDA GusNIP, NPPC, MSU food-hub survey
Tech-enabled platforms	\$290M	20%	Health Affairs Scholar, PitchBook
Total	\$1,400M	100%	Fullerfield research, 2026

Two reasonable questions: why not larger, and why not smaller. Larger, because we exclude the national commercial vendors that already raise capital, we exclude pure federal-grant demand, and we exclude the capital required to serve patients beyond the reimbursable core. Smaller, because we do not net out capital that is technically available but practically inaccessible, such as bank lines that exist on paper but are rarely underwritten for nonprofit food operators. These exclusions produce a figure that survives stress-testing.

VI. DEMAND-SIDE TAILWINDS

Why this is a capital problem, not a market problem

Reimbursement is catching up to the evidence



Illustrative contracted food-is-medicine delivery revenue by payer channel, 2019-2031E. Historical values reflect the ramp of Medicaid nutrition coverage and Medicare Advantage food benefits; projections assume continued state-level coverage with decelerating growth. Fullerfield estimates from CMS, KFF, and DHCS data.

Three forces converge on the demand side. First, evidence: the clinical case for medically tailored meals and produce prescriptions is now peer-reviewed and replicated, and modeling puts national savings from medically tailored meals at up to \$23.7 billion a year if scaled to all eligible patients (Rockefeller and Dalberg, 2026). Second, reimbursement: Medicaid Section 1115 waivers and managed-care in-lieu-of-services authority let states pay for food, California's CalAIM served more than 156,000 members medically supportive food in 2024, and nine states now cover medically tailored meals. Third, payer economics: a documented cost offset, up to a \$13 return per \$1 spent in one analysis, gives plans a reason to keep buying.

These tailwinds are real, and they are uneven. In 2025 the federal government rescinded its standardized nutrition-waiver framework and Medicare Advantage food-benefit prevalence declined year over year. The demand signal is therefore best read as contracted but volatile, which is exactly the environment a patient, protected debt structure is built for.

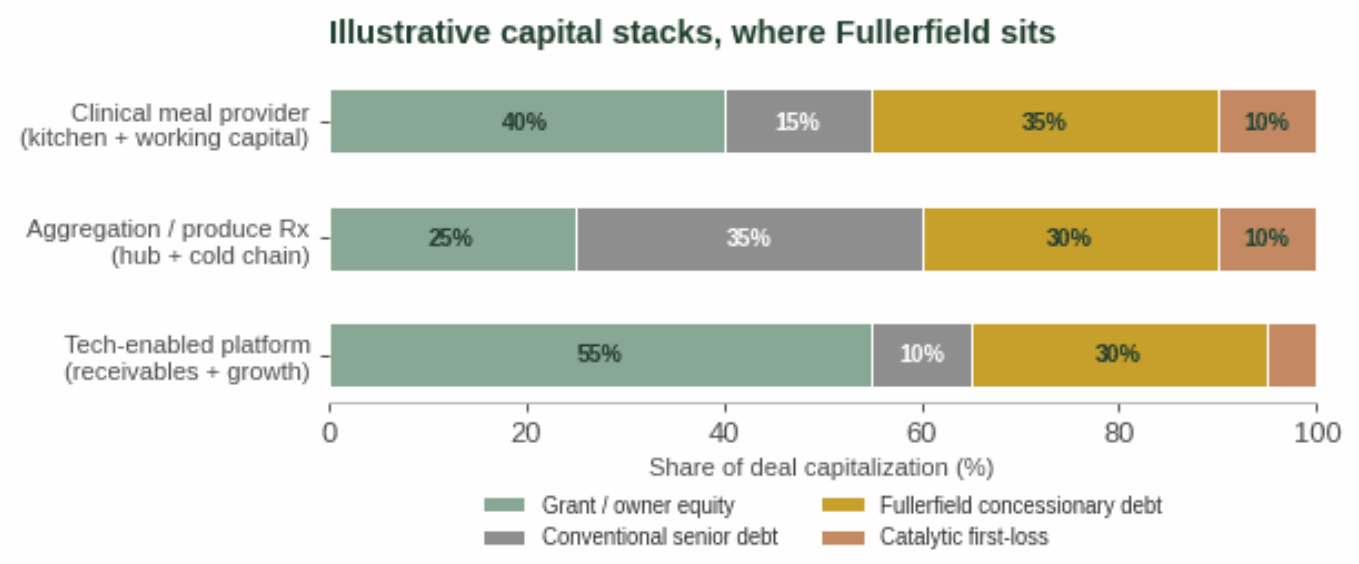
Demand is contracted. Capital is not.

The question for the 2026 to 2031 food-is-medicine system is not whether payers will reimburse food. They already do, across Medicaid and Medicare Advantage, on published fee schedules. The question is whether the providers, hubs, and platforms will have the capital in place to deliver against those contracts through a payment cycle that runs to 128 days and a policy cycle that shifts every session. That is an investable question.

VII. CAPITAL STRATEGY

Why concessionary debt is the missing instrument

Fullerfield's thesis is narrow and testable: across all three segments of the food-is-medicine gap, the binding constraint is the form of capital, not the existence of capital. Equity, grants, and conventional senior debt are each present in the field. Each is also structurally mismatched to the underwriting reality of mission-driven food and health operators. Concessionary debt, senior notes priced below market and protected by a catalytic first-loss layer, is the tranche that makes deals close.



Illustrative capital stacks across the three segments Fullerfield serves. In each case, the Fullerfield concessionary tranche and the catalytic first-loss layer complete a stack that would otherwise stall at conceptual stage.

Why not equity?

Most clinical meal providers and food hubs are nonprofits: they cannot issue equity at all. The for-profit platforms can, but equity is an expensive way to finance a government-payer receivable that turns over in months.

Why not conventional senior debt alone?

Commercial banks and CDFIs are important partners, but they underwrite to collateral and debt-service coverage that do not accommodate contract-year cash flow or a payer settlement cycle that runs past 90 days. Their senior-secured position also needs a subordinated layer beneath it to lend at all.

Why not grants?

Grants and technical assistance, including the work of Fullerfield Foundation, build the investment-readiness that lets debt capital reach these organizations at all. Grants cannot scale to a \$1.4B problem. They can make a \$1.4B problem financeable, by the capital market as a whole rather than any single lender.

VIII. RISK FRAMEWORK

What we worry about, and how we mitigate it

Risk category	Principal exposure	Mitigation
Reimbursement & policy	2025 rescission of the federal HRSN nutrition framework; 1115 budget-neutrality now codified; state waiver renewal risk	Underwrite to a diversified payer base; contract-coverage covenants; Foundation-led state advocacy; avoid single-waiver dependence
Payment timing / liquidity	60 to 128 day Medicaid and MCO payment lag straining borrower cash	Receivables-sized facilities; A/R cover covenants; staged draws
Contract concentration	Borrower dependence on a single MCO or state contract	Payer-diversification covenants; portfolio concentration limits
Provider execution	Thin nonprofit margins; reliance on braided grant funding	Investment-readiness support; full-cost contract underwriting; RDN accreditation covenant
Capex / construction	Kitchen or hub overruns; ramp below design throughput	Fixed-price contracts; interest-only during ramp; third-party operator partnerships
Portfolio / capital source	Over-reliance on a single PRI cohort; first-loss adequacy	First-loss layer raised first; blended LP base of foundation PRI, family office, and CDFI
Political volatility	Federal food-is-medicine agenda tied to shifting administration priorities	Structure to state and commercial channels, not federal pilots alone

The risk framework is deliberately conventional. Nothing about financing food-is-medicine infrastructure requires exotic risk management. What it requires is a lender that understands the operating reality of the underlying borrowers, a payer settlement cycle measured in months, a nonprofit balance sheet with no equity cushion, a contract subject to political renewal, and prices capital to that reality rather than to a generalized discount. Fullerfield's originators and credit team come from mission-lending, community-development finance, and structured-credit backgrounds for this reason.

IX. THE FULLERFIELD APPROACH

Two aligned organizations, no guaranteed continuum

Fullerfield is two separate organizations with a shared mission and no committed pipeline between them. Fullerfield Foundation Inc., a 501(c)(3) public charity, provides technical assistance, capacity-building grants, and investment-readiness support to food-is-medicine providers across the country. Organizations that work with the Foundation emerge better prepared to accept institutional debt capital: stronger financial infrastructure, governance, and contract documentation. That readiness is built for the market, not for a single lender. The Foundation does not refer, warrant, or commit its grantees to Fullerfield Capital, and Fullerfield Capital underwrites every borrower on its own merits.

Investment readiness is the constraint the Foundation addresses. A conventional lender encounters a food-is-medicine nonprofit as a set of seemingly unbankable propositions: inadequate statements, informal governance, concentrated payer risk, and contract-driven seasonality. Foundation grants and technical assistance help these organizations build the statements, governance, and documentation that make them underwritable by mainstream capital, whether that capital comes from a CDFI, a community bank, Fullerfield Capital, or another institutional lender. The benefit accrues to the field, not to any one source of capital.

Fullerfield Foundation five-year vision

Prepare 60+ food-is-medicine providers for investment readiness. Support the field toward 25M+ medically tailored and prescribed meal-equivalents annually. Prioritize organizations serving Medicaid and dual-eligible populations, including nonprofit kitchens, regional food hubs, and mission-driven platforms. Help grantees become financeable by the broader capital market, not solely by Fullerfield Capital.

How LPs engage

Fullerfield's platform is structured to accept three cohorts of capital partners. Foundations and health-focused funders aligned with food-is-medicine and nutrition-security mandates typically anchor the catalytic first-loss layer and often add program-related note commitments. Family offices with domain interest in health and food participate in the senior program-related notes. Institutional partners, including CDFI co-lenders and mission-aligned endowments, access diversified exposure across clinical meals, distribution, and platforms in a single commitment.

Fullerfield Capital is led by Charles Wade (Managing Partner), with Savannah Starks (Principal) and Christine Rico (Chief Financial Officer). The team's structured-credit and mission-lending experience includes prior roles at Black Farmer Fund. Contact: charles@fullerfield.com.

APPENDIX

Sources, methodology notes, and disclosures

Principal sources

Tufts Food is Medicine Institute, national modeling of medically tailored meals and produce prescriptions (2022 to 2025). Berkowitz et al., Health Affairs (2018) and JAMA Internal Medicine (2019), medically tailored meal utilization and cost studies. Hager, Mozaffarian et al., JAMA Network Open (2022) and Journal of the American Heart Association (2023). Deng, Hager, Mozaffarian et al., Health Affairs (2024 to 2025), 50-state medically tailored meal modeling. Rockefeller Foundation and Dalberg Advisors, Food is Medicine state economic analysis (2024, 2026). Food is Medicine Coalition, national provider survey (2024) and blueprint (2026). National Produce Prescription Collaborative. USDA National Institute of Food and Agriculture, Gus Schumacher Nutrition Incentive Program (GusNIP). Michigan State University Center for Regional Food Systems, National Food Hub Survey. American Diabetes Association, Economic Costs of Diabetes in the U.S. (2022). KFF, Section 1115 Waiver Watch and Medicare Advantage 2026 Spotlight, and analysis of the 2025 budget-reconciliation law. CMS, Informational Bulletin on nutrition supports (December 2024) and framework rescission (March 2025). California DHCS, CalAIM Community Supports data. North Carolina DHHS, Healthy Opportunities Pilot fee schedule (2024). Health Affairs Scholar, Medicaid managed-care claim payment timing (2022 claims data). Nonprofit Finance Fund. Reinvestment Fund, Healthy Food Financing Initiative. Capital Link, community health center capital need. Federal Reserve CDFI Survey (2025).

Methodology notes

Geographic scope is national. Time horizon is cumulative demand, 2026 to 2031. Currency is 2025 USD unless otherwise noted. Segment estimates are constructed bottoms-up from public sources and reconciled to sum to \$1.4B; individual segment figures are rounded to the nearest \$10M for presentation. Estimates assume continued state-level Medicaid nutrition coverage, decelerating growth in contracted delivery revenue, no federal rollback beyond changes enacted in 2025, and no catastrophic disruption to the underlying payer system. The illustrative demand and capital-stack figures are modeled, not contracted.

Important disclosures

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