The DMEPOS Rollup: How to Build a $ Platform in 36 Months

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Abstract

This essay outlines a private equity rollup strategy targeting fragmented durable medical equipment suppliers ahead of CMS's 2026 DMEPOS Competitive Biddi Program restructuring. The regulatory shift to nationwide Remote Item Delivery constrained contract awards (4-10 suppliers per category) creates a 24-month wi to consolidate regional operators, achieve scale economies, and position for dom market share capture across multiple product categories.

Key investment thesis elements:

- Acquisition universe: 150-200 regional DME suppliers doing $5-50M revenue v 8-15% EBITDA margins

- Rollup timeline: 18-24 months to acquire 8-12 platforms, integrate operations, prepare competitive bids

- Total equity check: $200-300M across platform acquisitions, bolt-ons, and operational transformation

- Revenue opportunity: $500M-1B annually post-contract award across 3-4 prod categories

- Exit multiple expansion: Entry at 5-7x EBITDA, exit at 12-15x on improved ma and regulatory moats

- Hold period: 4-5 years including 2-year build/bid period and 2-3 year contract optimization

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Why the Rollup Window Is Right Now

Most PE healthcare services deals I see are either too early (market not mature enough, regulatory uncertainty) or too late (strategics already consolidating, mul inflated). This one sits in a perfect window that closes in about 18 months, and I there are maybe two or three firms positioned to actually execute on it.

Here's the regulatory catalyst. CMS just published the final rule for the 2026 DMEPOS Competitive Bidding Program, and buried in the details is a complete restructuring of how Medicare pays for high-volume medical devices and suppli Starting January 2028, seven product categories move to a nationwide Remote It Delivery model where CMS awards only 4-10 national contracts per category. Th current market has probably 200-300 suppliers per category across regional competitive bidding areas. You're going from a fragmented, regionally competit market to a national oligopoly with 95%+ supplier reduction.

The bid window opens late summer 2026, contracts get awarded late summer 20 and the switch flips January 1, 2028. So you've got roughly 24 months from today build a platform that can win multiple national contracts. That timeline is too sl for a startup to build from scratch (they'd need to raise capital, build infrastruct get accreditation, hire teams). It's too short for most strategics to pivot their bus models (legacy DME suppliers are regional, not national, and device manufactur don't have distribution capabilities). But it's perfect for a PE rollup that can acq existing operators, consolidate their EBITDA, integrate operations, and deploy s capital to build the national infrastructure needed to compete.

The categories in scope are massive. Continuous glucose monitors and insulin p represent about $4B in annual Medicare spend. Urological supplies, ostomy sup and hydrophilic catheters are another $3-4B combined. Off-the-shelf braces (bac knee, upper extremity) are maybe $2-3B. Total addressable market across all sev categories is probably $10-12B in annual Medicare revenue, and you need to win contracts to participate at all. There's no opt-in at fee schedule rates, there's no secondary market. If you're not one of the 4-10 contract winners per category, yo cannot bill Medicare for these products.

Now think about the current supplier landscape. The market is super fragmente with a mix of regional DME suppliers (guys doing $10-30M revenue serving spec metro areas), specialty distributors focused on diabetes or ostomy or urology (do $20-80M revenue), and a few larger players like Byram Healthcare or Edgepark t have some national presence but operate regionally. Most of these companies are family-owned or held by small PE funds that bought them 5-7 years ago and are

looking for exits. Their multiples are compressed (5-7x EBITDA) because the ma perceives them as commodity businesses with Medicare reimbursement risk.

But here's what changes with the RID model. If you roll up 8-12 of these regiona operators, you get immediate EBITDA consolidation (they're all doing 8-15% ma you can get to 20-25% with centralized ops). You get national infrastructure that single target has (warehouse network, customer service, compliance capabilities) get scale to negotiate better pricing with device manufacturers (Dexcom, Abbott Medtronic all want large, reliable distribution partners). And most importantly, get the operational credibility and financial capacity to submit winning bids acr multiple categories.

The targets are cheap right now because they don't see the opportunity (most operators are thinking defensively about how to survive competitive bidding, no offensively about how to dominate it). You can probably buy decent regional ope at 5-6x EBITDA, maybe 6-7x for better ones with good customer bases. If you ro $150M in revenue at blended 12% EBITDA margins (so $18M EBITDA) and pay that's $108M in purchase price plus maybe $20-30M in integration costs and wo capital. Call it $130-140M in total capital to build a platform doing $150M reve

Then you spend another 12-18 months and $60-80M building the national infrastructure (technology platform, logistics network, compliance systems, clin support). You submit bids in late 2026, win 3-4 category contracts in 2027, and b 2029 you're doing $500-800M in revenue at 22-25% EBITDA margins (call it $11 200M EBITDA). At a 12-15x exit multiple (justified by the regulatory moats, recu revenue, and market dominance), you're looking at a $1.3-3B exit on $200-300M total invested capital. That's a 4-6x MOIC in 4-5 years, which is exactly what healthcare services PE funds are targeting.

The window closes once the bid process starts because you can't acquire your wa contracts after they're awarded. You need to have the platform built and ready t by summer 2026. So the actionable timeline is: close fund or allocate capital by C 2026, execute first 3-4 acquisitions by Q3 2026, complete remaining acquisitions

integration by Q1 2027, submit bids late summer 2026, receive contract awards f
2027, optimize and scale through 2028-2029, exit 2030-2031.

The Acquisition Targets and How to Fir Them

The ideal target profile is a regional DME supplier doing $15-40M in revenue wi
strong concentrations in the RID categories (diabetes, urology, ostomy, bracing).
want companies that are profitable (10-15% EBITDA), have established physician
relationships, maintain good compliance and accreditation, and are owned by
founders ready to exit or by PE funds at end of hold period.

There are probably 150-200 companies in the US that fit this profile. Most are n
marketed publicly because DME is an unsexy, low-margin business that doesn't
attract broad buyer interest. The deal flow comes from three sources: healthcare
focused M&A intermediaries (firms like VERTESS, Blair, Provident), direct outr
to known operators (you can identify them through Medicare provider databases
industry associations like AAHomecare), and off-market opportunities through
industry relationships.

Let me sketch out what the target list looks like by category:

For diabetes supplies, you're looking at regional distributors that serve endocrin
practices and have relationships with Dexcom, Abbott, Medtronic. Companies li
Med (although they're probably too big at $200M+ revenue and would be expens
Liberty Medical (owned by a large PE fund), or smaller regional players doing $2
50M that focus on specific states or metro areas. The key criteria are high CGM
penetration (not just test strips and basic supplies), good reorder rates (indicatin
customer satisfaction), and strong payer relationships beyond Medicare.

For urology and ostomy, you're targeting specialty distributors like 180 Medical,
Parthenon (although again, probably too large), or regional suppliers that came c

hospital-based home health agencies. These companies typically have clinical sta (nurses, wound care specialists) that provide patient education, which is valuable the RID model where you need to deliver clinical support remotely. The margins these categories are decent (12-18% EBITDA) because the products are recurring the customer switching costs are high.

For bracing, you want companies that serve orthopedic practices and have relationships with brace manufacturers. This category is more transactional (one purchases vs recurring supplies) but the margins are higher (20-25% gross margi The operational requirements are simpler (no monthly refills, less customer serv intensity), so these make good bolt-on acquisitions to add product breadth.

The acquisition strategy is to build a core platform through 2-3 anchor acquisiti then bolt on 5-8 smaller targets for geographic coverage and category expansion. anchor acquisitions should be in the $25-50M revenue range, ideally with some r category presence. You're paying 6-7x EBITDA, so call it $15-35M per anchor de Then your bolt-ons are $10-20M revenue companies at 5-6x EBITDA, so $5-12M deal.

Let's model this out. You do three anchor acquisitions at an average $30M reven and $3.6M EBITDA (12% margin) at 6.5x, so $23M per deal, $70M total. You do bolt-on deals at an average $15M revenue and $2M EBITDA (13% margin) at 5.5x $11M per deal, $77M total. Total acquisition spend is $147M for companies doin $195M in aggregate revenue and $26M in aggregate EBITDA. Add in $25M for integration, working capital, and deal costs, and you're at $172M in total capital the rollup phase.

The deal structure is pretty standard PE buyout. You're doing management rollo for the anchor deals (keep 10-20% of equity for existing management to stay on a run the integrated business), you're paying mostly cash at close with some earno tied to integration milestones or EBITDA performance. For founder-owned businesses, you might do seller notes to bridge valuation gaps or defer some consideration. For PE-owned businesses, it's cleaner: just negotiate price, do Qo diligence, and close quickly.

The diligence focus is different than typical healthcare services deals. You care l about payer contracts (Medicare rates are standardized) and more about operatic metrics: customer retention rates, reorder frequency, documentation quality (be CMS audits medical necessity), inventory management, and compliance track re You want to see clean accreditation status, no recent Medicare audits or sanctio good relationships with manufacturers, and strong NPS scores from beneficiarie

You also want geographic diversity to demonstrate national capability in your bi all your targets are in the Southeast, you're going to struggle to convince CMS y serve Alaska or Montana. So you're deliberately looking for targets in different regions: a few in the Southeast, a few in the Midwest, one or two in the West, ma one in the Northeast. That gives you the credibility to say you have national infrastructure.

Deal Structure and Integration Playbo

The hardest part of any rollup is integration, and most PE firms screw this up by either going too fast (cut costs aggressively, lose customers and employees) or to (keep redundant systems and teams, never capture synergies). The right approac this deal is a phased integration that prioritizes speed on technology and compli while being patient on customer migration.

Phase one is day one integration of corporate functions. You immediately consol finance, HR, legal, and executive leadership. You pick the best CFO from your a acquisitions (or hire externally), same with Chief Compliance Officer and Gener Counsel. You shut down redundant back-office systems and move everyone to a ERP (probably NetSuite or Sage Intacct for a business this size). This saves you 3 of revenue in G&A costs within 90 days.

Phase two is technology platform migration over 6-9 months. This is the critical for the RID strategy because you need a single, national order management syste that can integrate with EHRs, handle Medicare billing, track inventory across warehouses, and provide customer service tools. None of your acquired compani

will have this (they're all running on legacy DME software like Brightree or Fast which are functional but not designed for national scale).

You have two options here. Option one is build custom on modern cloud infrastructure, which takes 12-18 months and costs $5-8M but gives you exactly you need. Option two is buy a platform from a healthcare IT vendor and customi which is faster (6-9 months) and cheaper ($2-4M) but less tailored. I'd probably g with option two for speed, then plan to rebuild custom post-contract award onc have revenue and can justify the investment.

Phase three is warehouse and logistics consolidation over 12 months. Your acqu companies probably have 10-15 small warehouses scattered across the country, e doing their own inventory management and fulfillment. You need to consolidate 4 regional distribution centers (East, Central, West, maybe Southeast) that can s the entire country. You negotiate with 3PL partners (like Geodis or AmeriCold c healthcare-specific logistics provider) to take over warehousing and fulfillment. reduces inventory carrying costs (you're pooling inventory across locations inste stocking everything everywhere) and improves delivery times (better routing and fewer handoffs).

Phase four is customer service centralization over 6-9 months. You build a singl national call center (probably in a lower-cost location like Texas, Tennessee, or remote/distributed) and migrate all customer service reps to standardized proce and tools. You invest in training so reps can handle all product categories, not ju specific category their legacy company served. You implement Zendesk or Salesf Service Cloud with good telephony integration and knowledge management. Thi improves customer experience (faster answer times, better first-call resolution) a reduces headcount (you need fewer reps when you're pooling volume).

Phase five is clinical support and quality assurance over 6-12 months. You hire a Clinical Officer (probably a nurse or respiratory therapist with DME experience) build standardized clinical protocols, staff a centralized clinical team, and imple quality monitoring. This is important for the RID model where you need to demonstrate clinical outcomes and patient satisfaction to CMS. You're tracking

metrics like device adherence (are patients actually using their CGMs?), complic rates (pressure ulcers from poor fitting braces, UTIs from improper catheter use patient-reported outcomes.

The integration timeline is aggressive but achievable. You're running all five pha parallel, which means you need a strong integration management office (hire a V Integration with consulting or PE portfolio company experience, give them 2-3 p managers) and you need to over-communicate with employees about what's chan and why. The total integration cost is probably $20-25M (technology platform, severance for redundant roles, facility closures, change management), which you already budgeted in the $172M total capital number.

The synergies are real and meaningful. You're taking companies doing aggregate 14% EBITDA margins and getting them to 18-20% post-integration through:

Reduced COGS from better manufacturer pricing (you're now buying $150M+ in products vs $15-30M per legacy company). This probably saves you 3-5% on COG which at 60% COGS as a percent of revenue is worth 2-3% EBITDA margin improvement.

Lower fulfillment costs from consolidated logistics (fewer warehouses, better rou volume discounts with shippers). This saves maybe 1-2% of revenue.

Reduced G&A from centralized corporate functions (you need one finance team, HR team, one legal team, not eight). This saves 2-3% of revenue.

Improved revenue retention from better customer experience (national platform better technology, faster response times). This doesn't show up as margin improvement but does show up as revenue growth (you're retaining 95%+ of cust vs 85-90% for legacy operators).

All in, you're getting from 13-14% EBITDA margins to 18-20% within 18-24 mon post-acquisition. On $195M in baseline revenue, that's going from $26M EBITD $36-39M EBITDA, so $10-13M in annual synergies. At a 12x exit multiple, that synergy capture alone is worth $120-156M in enterprise value creation.

Building the National Platform While Y Roll

The parallel workstream to the rollup is building the greenfield capabilities you to compete nationally. Even with 8-12 acquisitions, you're not going to have everything required for the RID model. You need to invest $60-80M in new capabilities across technology, logistics, compliance, and clinical support.

On technology, you're building or buying an order management platform that ca handle the entire patient journey. Physician e-prescribes a CGM through Epic, t script flows into your system via HL7 or FHIR integration, your system automati checks patient eligibility with Medicare, retrieves prior medical records to verif medical necessity, generates the required documentation, submits to Medicare f approval, and notifies the patient of approval status. Then the patient chooses de method (ship to home, pick up at pharmacy partner, pick up at retail location), t order routes to the appropriate warehouse, the product ships with tracking, and patient receives automated onboarding (video tutorials, text-based support, connection to live clinical support if needed). Post-delivery, the system tracks de usage (via manufacturer APIs for CGMs and insulin pumps), monitors for issues automatically triggers reorder workflows every 90 days.

This is not trivial to build, but it's also not rocket science. You're talking about engineers over 12-18 months, mostly backend and integration work, with some frontend for patient and internal user interfaces. Total cost is $3-5M for the bui plus $500K-1M annually for maintenance and enhancements. You can accelerate buying a base platform from a DME software vendor (like Brightree or Kareo or newer player) and customizing it, which might cut the timeline to 6-9 months an cost to $2-3M.

On logistics, you're building a national distribution network that can deliver to states within 1-2 business days. Your 3-4 regional distribution centers give you geographic coverage, but you also need last-mile delivery partnerships (FedEx, U regional couriers) and pickup location agreements (with pharmacy chains like Walgreens or CVS, or with urgent care networks, or with retail partners who ha

local presence). The pickup location piece is interesting because it differentiates from pure mail-order competitors and appeals to beneficiaries who want in-pers handoff for expensive devices.

The capital requirement for logistics is mostly working capital (inventory) plus s facility setup. You need $10-15M in inventory across your product categories (C insulin pumps, catheters, ostomy supplies, braces). You need maybe $2-3M for warehouse equipment and setup (racking, RF scanning, inventory management systems). And you need $1-2M for delivery partnerships and pickup location agreements (mostly onboarding costs and integration, the actual delivery costs a variable and get billed to individual orders).

On compliance, you're building a best-in-class program that exceeds CMS requirements and positions you well for bids. You hire a Chief Compliance Offi (probably someone from a large DME supplier or a consulting firm like PwC or Deloitte that does healthcare regulatory work), a few compliance analysts, and y invest in technology for documentation management, audit trails, and quality monitoring. You implement automated processes for verifying medical necessity (using AI/NLP to extract relevant info from physician notes), tracking product q (monitoring manufacturer recalls, patient complaints, device failures), and mana audits (CMS does regular audits of contract suppliers, you need to be able to res quickly with complete documentation).

The compliance investment is probably $2-3M in upfront costs (hiring, technolo process design) and $1-2M annually for ongoing operations. This sounds expens but it's essential for two reasons. One, you need clean compliance to win bids (C reviews your compliance track record as part of bid evaluation). Two, you need r compliance to avoid penalties post-award (contract suppliers can be terminated compliance failures, which would be catastrophic).

On clinical support, you're building a team of diabetes educators, respiratory therapists, wound care nurses, and other specialists who can provide patient education and clinical guidance. The RID model requires you to deliver product remotely, which means you can't rely on in-person education and fitting like

traditional DME suppliers do. You need to train patients via video, phone, or tex how to use their devices correctly, how to troubleshoot issues, when to call for h and how to manage their underlying conditions.

The clinical team size depends on your projected patient volume, but for 50-80K patients across all categories you probably need 15-20 clinical staff. These are m contractors or part-time employees (you hire per-diem nurses and educators who flexible hours to handle patient onboarding and support calls). The cost is $2-3M annually, but it drives huge value in terms of patient outcomes (better device adherence, fewer complications) and customer satisfaction (NPS in the 70-80 ran 30-40 for competitors).

All in, the greenfield investment is $60-80M over 18-24 months. Add that to the $172M for acquisitions and integration, and you're at $232-252M in total capital That's a meaningful check, but it's totally achievable for a mid-size healthcare P fund ($1-2B in AUM) as a large platform investment, or for a larger fund ($3-5B- AUM) as a normal platform deal.

The Bid Strategy and Why Scale Wins

The actual bid submission is where all the work comes together. CMS evaluates on two dimensions: price (your proposed payment amount) and capability (your operational plan and track record). The price dimension is straightforward - low bids are better, subject to the bona fide bid review process where CMS rejects unrealistically low bids. The capability dimension is more subjective - CMS look your accreditation status, compliance history, financial stability, operational infrastructure, and beneficiary satisfaction.

Your bid strategy is to price aggressively but not recklessly, and to differentiate heavily on capability. On price, you want to bid in the 25th-35th percentile of th expected bid distribution. You have better cost structure than most competitors (economies of scale from the rollup, better manufacturer pricing, efficient logist you can afford to bid lower while maintaining 45-50% gross margins. You're not

to be the absolute lowest bidder (that triggers bona fide review scrutiny), you're to be low enough to win while high enough to be credible.

CMS calculates the Single Payment Amount at the 75th percentile of winning bi if you bid at the 30th percentile and the 75th percentile comes in 25-30% higher, you're getting paid 25-30% above your cost structure. That's huge margin expans compared to your baseline business.

On capability, you're showcasing the national infrastructure you built through t rollup. You demonstrate that you have warehouses in multiple regions, delivery partnerships covering all 50 states, clinical staff to support patient education, technology platforms for seamless ordering and tracking, and a track record of h beneficiary satisfaction. You highlight your compliance program, your accredita status, your financial stability (backed by a PE fund with hundreds of millions in AUM), and your management team's experience.

The capability narrative is essentially: "We're the only bidder with true national modern technology, and the financial backing to deliver exceptional service to Medicare beneficiaries everywhere." Most of your competitors are regional opera bidding up to national (they lack the infrastructure and credibility), or device manufacturers bidding down to distribution (they lack the logistics and custome service capabilities), or legacy DME suppliers with outdated technology and fragmented operations. You're positioned as the modern, scaled, well-capitalized alternative.

You submit bids across 4-5 categories. The obvious ones are CGM/insulin pump (biggest market, highest value), urological supplies (good margins, recurring rev and ostomy supplies (similar to urology). Then you decide whether to bid on the categories (back, knee, upper extremity). The braces are lower revenue per patie also lower operational complexity, so they're good margin enhancers if you win.

The bid amounts vary by category based on your cost structure and market dyna For CGMs, the bid limit is around $273/month (using 2025 fee schedules adjuste 2026 inflation), and you probably bid $210-230 depending on your COGS and

competitive positioning. For urological and ostomy supplies, you bid at 20-30% b current fee schedules. For braces, you bid at 15-25% below fee schedules. In ever case, you're pricing to win while maintaining strong margins.

The contracts get awarded late summer/fall 2027, and realistically you should wi categories with this strategy. Winning all 4-5 would be great but probably optim (CMS wants supplier diversity, so they might not award multiple categories to th same bidder). Winning 2 would be disappointing but still valuable. The base cas categories, which gets you into CGM/insulin pumps plus two of the supply/brac categories.

Post-Award Value Creation Levers

January 1, 2028 is when the real work begins. You've spent 24 months rolling up companies and building infrastructure, now you need to execute on patient acquisition, operational excellence, and margin expansion.

The patient acquisition strategy is all about the transition period. For the first si months of 2028, existing Medicare beneficiaries using non-contract suppliers ne switch to contract suppliers. CMS requires contract suppliers to do beneficiary education, and physicians are notified about the transition. Your job is to make switching as easy as possible and to capture as many patients as you can.

You run a multi-channel outreach campaign. One, you work directly with physic and endocrinology practices to communicate the transition and encourage them prescribe to your platform. You hire 10-15 sales reps who call on high-volume prescribers and make the case for why you're the best contract supplier (better technology, faster delivery, superior clinical support). Two, you do direct-to-beneficiary outreach via mail, phone, and potentially digital channels (email, tex beneficiaries where you have contact info from your legacy acquired companies. Three, you optimize for organic discovery through Medicare's supplier directory 1-800-MEDICARE, where beneficiaries can search for contract suppliers by loca and product.

The target is to capture 15-20% market share across your contract categories by 2028. Total market is probably 300-400K beneficiaries across CGM/insulin pum urology, and ostomy (assuming those are your three categories). At 15-20% share, you're serving 45-80K beneficiaries. Average revenue per beneficiary varies by category but blends to maybe $2,200-2,500 annually (CGMs are $3,000+, supplie $1,500-2,000). So you're doing $100-200M in annualized revenue by end of year

The operational excellence focus is on customer experience and clinical outcome You track NPS religiously and target 70+ (vs industry average of 30-40). You mea device adherence for CGMs (are patients wearing sensors consistently?) and aim 85%+ (vs industry average of 60-70%). You monitor complications and adverse ev and drive them below industry benchmarks. You track reorder rates and retenti (95%+ of patients should stay with you once they're onboarded).

The margin expansion comes from scaling fixed costs across growing revenue. Y technology platform, corporate G&A, and compliance functions are largely fixed you grow from $150M to $300M to $500M revenue, those costs as a percent of re decline from 8-10% to 5-6%. Your logistics costs are semi-variable (some fixed co for warehouses and systems, variable costs for shipping and handling), so you ge some margin benefit from density. Your clinical support is variable but you get efficiency gains from better tooling and standardized protocols.

The overall margin trajectory is from 18-20% EBITDA at baseline (post-rollup integration) to 22-25% EBITDA at scale (year 2-3 of contract). On $500M revenu that's $110-125M in EBITDA. You're also growing revenue because the Medicar beneficiary population grows (10K new Medicare enrollees per day, plus increasi CGM adoption rates as technology improves and coverage expands). So by year t you might be doing $600-700M revenue at 23-25% EBITDA, which is $138-175M EBITDA.

The other value creation lever is category expansion and contract renewal. Wher next competitive bidding round comes around (bids in 2029 for 2031 contracts), the incumbent with proven operational excellence and strong beneficiary satisfa You should be able to retain your existing categories and potentially add 1-2 mo

You also have the option to expand into non-RID categories (other DME produc non-Medicare populations, ancillary services like diabetes education or telehealt using the infrastructure you built.

Exit Scenarios and Expected Returns

The exit timing is probably 2030-2031, which is 4-5 years from initial investmen want to get through the first contract period (2028-2030) to demonstrate the bus model works, show margin expansion from scale, and build a track record for co renewal. By 2030-2031, you're a $600-800M revenue business doing $140-200M EBITDA with regulatory moats, recurring revenue, and a clear path to continue growth.

There are three potential exit paths:

Path one is sale to a strategic acquirer. The obvious buyers are device manufactu (Dexcom, Abbott, Medtronic, Insulet, Tandem) who want vertical integration an direct relationships with patients. Dexcom in particular has been acquiring distribution assets (they bought Sequel Med Tech for this reason), and owning a national DME platform would give them control over the patient experience and flows. The other strategic buyers are pharmacy benefit managers (CVS, Cigna, O who want to expand into DME as part of broader healthcare services, or retail he platforms (Walgreens, Amazon) who see DME as an adjacency to pharmacy and primary care.

Strategic buyers typically pay 12-15x EBITDA for assets with regulatory moats a recurring revenue. On $150M EBITDA (conservative case), that's a $1.8-2.25B ex $180M EBITDA (base case), that's $2.16-2.7B. These buyers care about strategic (does this asset help them achieve their broader goals?), defensibility (can compe replicate this?), and growth trajectory (is the business still growing or is it matu You have strong answers on all three dimensions.

Path two is sale to another PE fund as a platform for further consolidation. A la healthcare PE fund or a generalist PE fund looking for healthcare exposure migl

you as a platform to continue rolling up DME suppliers and expanding into adja categories. They'd be buying a proven operating model, strong management tean attractive growth profile. The multiple here is probably 11-13x EBITDA (slightly lower than strategic because there's less synergy potential and more execution ri On $150-180M EBITDA, that's a $1.65-2.34B exit.

Path three is continuation fund or dividend recap, where you refinance the busi return capital to LPs, and hold for another 3-5 years. This makes sense if the cor renewal is looking good and you see a path to $1B+ revenue and $250M+ EBITD the next contract period. You could refi at 5-6x leverage on $150-180M EBITDA which gives you $750M-1B in debt proceeds to return to investors while keeping equity upside. This is less common in healthcare services (more common in infrastructure or software) but could work if the business is truly annuity-like.

The return math on a strategic exit is pretty compelling. You invest $250M total capital ($172M rollup, $78M greenfield build). You exit for $2-2.5B at 12-15x on 180M EBITDA. The gross MOIC is 8-10x, but you have management equity (10-2 rollover from acquisitions), deal fees, and ongoing monitoring fees that reduce n MOIC to 6-8x. On a 4-5 year hold period, that's a 40-50% IRR, which is exactly w top-quartile healthcare PE funds are returning.

The downside scenario is you don't win enough contracts (maybe only 1-2 categ instead of 3-4), or you win contracts but struggle with execution (poor customer experience, compliance issues, margin pressure). In that case, you're still buildin valuable business (you have the rollup EBITDA and some contract revenue), but exit multiple compresses to 8-10x and the valuation is maybe $1.2-1.5B. That's st 5-6x MOIC and a 30-35% IRR, which is acceptable but not exceptional.

The risk mitigation is all about execution discipline. You need to be rigorous on acquisition due diligence (don't overpay, don't buy broken companies, ensure cu fit). You need to be aggressive on integration (move fast on cost synergies, don't acquired companies drift). You need to be thoughtful on the technology and infrastructure build (don't over-engineer, focus on what's needed to win bids an

serve customers). And you need to be excellent on the bid strategy (price to win l maintain margins, differentiate on capability).

The other risk is regulatory. CMS could change the program structure, alter pay methodologies, or terminate contracts if they perceive access issues. But the fina is pretty clear and stable, and CMS has strong incentives to make the RID model (it saves money, improves quality, and reduces beneficiary out-of-pocket costs). T regulatory risk is lower than most Medicare businesses because you're working v an established program with clear rules.

For a healthcare PE fund with $1-3B in AUM, this is probably the best risk-adju opportunity in the market right now. You're getting immediate EBITDA from th rollup, regulatory tailwinds from the CMS restructuring, margin expansion from scale, and multiple expansion from moat creation. The execution is hard but tota within the capability of a good PE operating team. And the timing is perfect - yo have 18 months to build before you need to bid, which is enough time to do it ri but not so much time that competitors catch on and multiples inflate.

I'd be making calls to healthcare M&A intermediaries today to start sourcing tar lining up debt financing with healthcare lenders (firms like Ares, Owl Rock, Blu Torch who understand the model), and recruiting operating partners who know DME space. The fund that moves fast on this is going to build a generational ass The funds that wait or miss it are going to be looking at the 2031 contract round wishing they'd started in 2025.

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