10-Dec-2014

HMS Holdings Corp. (HMSY)

Oppenheimer Healthcare Conference

CORPORATE PARTICIPANTS

William C. Lucia
President, Chief Executive Officer & Director

OTHER PARTICIPANTS

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

MANAGEMENT DISCUSSION SECTION

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

My name is Bret Jones. I'm the Healthcare, IT, and Personalized Medicine Analyst here at Oppenheimer. On stage with me is Bill Lucia from HMS Holdings, HMSY ticker. Bill is going to give a presentation, and then at the end, we'll have a couple of minutes for Q&A. And I'll turn it over now to Bill. Thank you.

William C. Lucia
President, Chief Executive Officer & Director

Good morning, everyone. And thank you for attending our presentation. I want to thank Bret Jones and his Oppenheimer colleagues for giving us this opportunity to present and for scheduling an entire day of Investor Meeting. So, thanks again, Bret.

Before beginning, I do want to want to draw your attention to our Safe Harbor statements, which of course, you can read at your leisure. And my goal this morning is to give you a sense of our business, our markets and our products, the very favorable macro environment, then the healthcare market in which we operate, some of our key growth drivers, and our competitive strengths. All of which have resulted in a large installed client base in multiple markets. And before closing, I'll also touch on our year-to-date financial performance.

So now, let's start an overview of our business. At the macro level, our business is well, quite simple. We provide solutions to government and commercial healthcare payers to help them contain cost. Now our services fall into two broad product categories. First, there is coordination of benefits or commonly called COB, and that's making sure that the right payer pays the claim. And of course, payment integrity and that's accessing if the claim is billed appropriately and accurately.

We serve three large and growing markets: state Medicaid programs; commercial health plans, and in that market, we define that to include Medicare advantage, Medicaid Managed Care, and group employer and individual plans; and the Federal government. In the state market, our clients include 46 state Medicaid programs and the District of Columbia. In the commercial markets, over 200 health plans, including seven of the 10 largest. And the federal agencies, such as CMS and the Department of Defense.

As these graphs show on the slide, expenditures are expected to grow significantly over the next five years in each of these markets. I'll also touch on some additional environmental factors shortly in the presentation, but I do want to emphasize that the projected organic growth in these markets and our nation's healthcare expenditures overall is a strong underpinning for the growth of our business going forward.

I mentioned there are two broad product categories, and I did say our business was simple. But here is where it gets a little more complex. Each product category has various components. This allows us to offer multiple cost savings initiatives for our clients. Our coordination of benefits or COB product lines will account for about 70% of our revenues this year. Now, COB services again are designed to ensure that the proper payer takes the healthcare claim. Our primary COB services include prospective cost avoidance, that's a service which identifies third-party coverage for a Medicaid member, and then verifies that coverage at a very specific coverage detail level.

The coverage we find is typically employer sponsored insurance. We then electronically load that very detailed information to our clients' processing systems so that they can kind avoid paying claims for that member in the future.

Now retrospective recoveries, these are services applied after our client has paid the claim. And if they're identifying other coverage, we then seek to recover any amount that our client has paid and recover those from our responsible third parties such as an employer-sponsored health plan, or at times from the provider of service.

Our subrogation services are typically a recovery of the claims our client already paid from a member settlement with a casualty carrier. They're often due to a trauma event like a slip and fall, a motor accident, or workers' comp injury. And then finally, there is dependent eligibility audit. This is where we assess whether the individuals listed as dependent on a plan are truly eligible for plan benefits by plan guidelines and this service, of course, is offered to large employers across any of our market.

The other major category is a payment or a program integrity or commonly called PI. And PI products account for balance of our revenues, in this year about 30%. These services are really designated to ensure that healthcare claims are paid accurately. Our primary PI products include automated and complex clinical reviews. This is where we identify overpayments and anomalies using sophisticated data analysis and algorithms and then in the case of complex clinical audit, our nurses or certified coders or physicians actually review medical record. And these reviews are done to see if the service that was billed was actually the service delivered. And that's one of the examples of a clinical review.

There's compliance audit. This is where we're making sure that the claims are paid in accordance with the client's benefit plan design or published billing policy, whether it's Medicaid, Medicare, or a group health plan's individual or internal guidelines. And then there's our fraud, waste, and abuse services. In this market, we provide a proprietary software-as-a-service or SaaS technology platform. Our platform is typically integrated with the client's claims processing system to edit claims on a pre-payment basis. We coupled this of course, with an investigative service to augment our clients' own staff and processes and then finally, we also offer financial reviews. And these are often credit balance of hospitals, long-term care facilities or renal dialysis facilities.

Now, we're happy to have recently added a new product to our payment integrity line-up, and it represents what we believe through all of our markets is the future focus for payers. We have – and it's mainly the detection and correction of these improper payments before the providers pay. We already provide, as I mentioned these financial based and compliance prepay edits as part of our fraud, waste, and abuse platform to a number of our clients. But this new product applies our vast clinical expertise and algorithms that we've developed over years for our retrospective recoveries, and applies those before the claim is paid, so it leverages that same technology that

we built for retrospective clinical auditing and applies that upfront. So, paying claims accurately the first time means that our clients capture the savings upfront.

The other benefit is that it does avoid that often unpleasant situation where providers are paid and then later, a portion or all of those funds are called back on a retrospective audit. Now, the simplest measure of our success is really the billions of dollars saved by our clients. We estimate that cash recoveries this year on behalf of our clients will total approximately $3 billion, and our work on the prospective side will allow them to save twice that amount, or $6 billion in future claims.

So, a good example of our cost avoidance or future prospective savings is the identification and verification of third-party insurance which we discussed. This enables our client to coordinate benefits at the point of service and deny claims going forward.

Another example is the correction of a client's claims processing system based on the unique over-payments that we've discovered. Clearly, we generate significant results and recurring financial results for our client. And this equates in our market to very high rates of client retention.

I have to tell you, producing these significant results doesn't come easily. We've built a number of competitive strengths which continue to contribute to our success. First and probably foremost, we have what we believe is the nation's largest eligibly and paid claims database in the nation. Second is the proprietary analytics we built over the last four years in the business. And those analytics continue to evolve constantly and we benefit from the strengths, including our nurses, certified coders, fraud examiners, and physicians who apply their deep experience to our analytics.

We have advanced technology including purpose-built systems with automated workflow and enhanced auditing features. And finally, a large installed client base, many of whom have been with us for decades. In fact, this may very well be the best evidence that our value proposition has persisted over a very long time in a very competitive market.

Let's turn to the growth drivers for our business. Now we'll review key growth drivers for our business on both the macro level and also on an HMS specific level. One of the most significant drivers now for our business is the Affordable Care Act or the ACA. The ACA is driving Medicaid expansion, which is contributing to growth in both our government and commercial markets. In 2014 alone, we've added 8 million Medicaid lives into our database. Those lives are now which the lives on which we can now perform HMS services. Aging baby boomers is another macro phenomenon that's affecting the Medicare market and boosting enrollment. Much of this growth is going into Medicare Advantage Plans, which are our clients'.

Another result of the ACA is the growth of the marketplace, health insurance exchanges, and quite frankly, just more complexity in determining eligibility for Medicaid and/or government premium subsidies. This complexity leads to errors, which HMS may be hired to correct. But it also leads to members potentially shifting from Medicaid to government subsidies, and back. And HMS does benefit from this member churn.

A member churn is when people move on and off, different healthcare programs in our system. Our services often touch those lives as they move back and forth through the various programs.

And finally, commercial payers are wrestling with the complexities of the ACA, including those fees and taxes and the mandated medical loss ratios. They're also seeing a relatively uncertain risk level for the new numbers enrolling through these marketplace exchanges, so our clients need our services now more than ever.

Now, we don't control the macro factors, but we have taken several steps internally to directly enhance our business. We're focusing our efforts particularly on the emerging commercial market opportunities for HMS and we're increasing our operational efficiency as a company. These efforts include expansion of our commercial sales force. We've hired several very talented and experienced individuals this year. Their job is to target or expand large national accounts, Blue Cross/Blue Shield plans, and large regional plans. We expect these new hires will have significant impact on our commercial sales as we enter 2015.

We're also achieving greater product penetration with existing clients. A good example of this is the client that initially hires us to do coordination of benefits and once they've seen successful results, add complex clinical reviews or fraud, waste, and abuse services. We see the greatest opportunity for claim expansions in our commercial market where our current market penetration is not as mature as in our state government market. However, scope expansions do continue in the state market.

We also grow some increasing the yield from our existing product line. In the past several quarters, we've had a concentrated effort in this regard. Essentially, we're leveraging our infrastructure to generate more revenue from the same client data by simply being more efficient and effective at every step in the delivery process.

We do see the commercial market as our greatest growth opportunity at this moment. Our state market does remain a steady source of roughly half of our revenues, but this market for us is much more mature. State market is a little constrained also by what our competitively bid contracts that typically run three years to five years. But as I mentioned earlier, we're well-positioned in that market with relationships with Medicaid programs in 46 states and the District of Columbia. But the up-side is more limited as a result. So the majority of new lives entering both Medicaid and Medicare are entering the commercial market, which again drives our focus.

Our efforts in the commercial market this year have gone very well. We have been successful on closing incremental business with approximately 18.5 million lives through the first three quarters of 2014. About 40% of those came from new clients or brand new engagements and 60% were sales of additional products to our existing clients.

Total commercial lives now under contract exceeds 70 million. Now sizing our market opportunity has always been a challenge for us, but only because, it is so large. With the erroneous claim payments in the combined, commercial, and government sectors of our healthcare system estimated to total more than $120 billion this year, it's clear, there is no shortage of opportunity to sell and apply our services.

Now while we believe this projected $3 billion of cash recoveries this year is probably the highest in the marketplace, it's clear that there is additional market opportunity for additional work because the volume of payment errors is still enormous.

Let's further discuss the HMS business model. HMS is well equipped to take advantage of the market opportunities in front of us. We have a business model built on success, based on six key components. First, we have a receptive audience, finding and correcting erroneous payments is top of mind for government and commercial payers. We have a favorable impact on our clients' bottom line and we help them to stay compliant.

Secondly, our clients get consistent results from HMS. They're measurable and they're a very high return on investment. Next, our contingency fee-based services are viewed as relatively risk-free revenue source for our clients, requiring little or no upfront investment.

Fourth, we've had a very broad and deep experience in healthcare reimbursement and clinical policy. Some of our clinicians have decades of experience in Medicaid and Medicare policy. And fifth, we apply our extensive database, complex algorithms, and robust technology to create the analytics, which produce consistent and accurate results.

And last, but certainly not least, we've assembled a strong senior management team to lead the company. These executives all come with extensive healthcare experience and commercial market experience to assure our ongoing success.

But, let's further dive into our ROI that the clients receive from HMS. This slide shows how our work really adds up for clients. This is an example for our national clients that last year saved about $170 million between direct cash recoveries and costs avoided. Our fees were roughly $11.5 million, producing a 15:1 return on investment. Returns of 10 – 15:1 are very typical of our work. That is our value proposition in a nutshell, and it's repeated day-in and day-out for our clients.

Before taking questions, I do want to touch briefly on our year-to-date financial performance. As we indicated on our third quarter call last month, we expect total 2014 revenue, excluding the Medicare RAC to grow by 10% to 11% over the prior year. This increase comes from a 6% to 8% growth in our state Medicaid market and about a 16% to 18% growth on the commercial market side. And as I mentioned earlier, growing the commercial business is our principal focus and we believe our greatest opportunity at the moment.

In addition to revenue growth, we also have an intense effort underway to reduce operating expenses. By utilizing our lean Six Sigma approach to optimize our cost structure, we've identified and reduced overall cash operating expenses through the first nine months of this year by $13.5 million, or about 4.6% compared to the same period last year. Of course, the decline in the Medicare RAC revenue during this year did present a significant cost challenge to us. But as of the third quarter, we've carefully managed the RAC cost or the RAC-related cash operating expenses down to approximately $3 million per quarter. We expect that will match the RAC revenue for the time being, so that will be a breakeven.

We do remain hopeful that CMS will make the new RAC awards next year, and we look forward to our continued participation in this very important effort of returning erroneous payment to Medicare trust funds. In the meantime, we continue to expand our engineering efforts across our entire enterprise and continue to see cost leverage as we grow.

So to sum up, we feel extremely good about the position – our position in this large and growing healthcare cost containment market. We have a very strong track record of result, a huge warehouse of claims and eligibility data across our nation's healthcare system, a highly focused clinical expertise, purpose-built technology platforms, proprietary data mining and matching algorithms, and finally, a client base second to none.

We look forward to the future with confidence and great enthusiasm, particularly with the variety of macro tailwinds that appeared destined to grow our market opportunity and the changes that will continue to add complexity to the healthcare system, all of which is expected to drive more business in our direction.

Thank you for your attention. I believe, Bret, we have some time for questions.

QUESTION AND ANSWER SECTION

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

I will start this off, if anybody has a question, please raise your hand. I just wanted to touch on the clinical prepay audit a little bit, I just wanted to better understand how that product works from a post-payment perspective, I can see how you would – you would look at claims and find out why isn't a – dig into EHRs after that, how do you that on a pre-payment basis?

William C. Lucia
President, Chief Executive Officer & Director

A

So, what we've actually done is apply the same technology and algorithm. We already have a technology platform that does this for a financial audit or for duplicate payments or some other policy-related audit that's not clinical. We now apply those algorithms to that technology, so as the claims comes in and this will be a client giving us claims naively, before they've actually cut the check, the claim comes in, our analytics and algorithms review it, we select those that has historically had the highest propensity to be a true overpayment from a clinical perspective, we send the transaction back to our client that same evening that says, this claim should be pended or denied, it's up to the clients to either deny us their medical record or pended for medical record, and then the medical record comes in.

Of course, if it's before the claim is paid, the provider is very incented to give that medical record. Of course, we import medical records in any way – electronically, mail, or whatever, but provider will get it into us, and then we have a very quick turnaround for that record, so that we can review it, and then the client can release that pend or deny if it's an appropriate service, or they can deny the service, billed at that level.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

All right. Great. And then, if we could take a step back then just at a higher level, let's go back to the COB business, if we look at – obviously, ACA and Medicaid expansions had a nice benefit to the state COB business, but the base business is doing well, that took a little bit of time to stabilize, that stabilized and is now growing again, how much of this is simply, we've put the transition over the managed Medicaid behind us or are there other factors we should be thinking about?

William C. Lucia
President, Chief Executive Officer & Director

A

I think it's a combination of, we've put that transition behind us, but not only have we put it behind us, but those clients that are in managed Medicaid are now buying more services. So a while ago, we had an average of 1.5 services per Medicaid Managed Care account. Now we have over 2 services. So those are growing. In our state market, we have an average of 6 services per client. So this market is maturing. It's also the increase from the ACA. The ACA, as we said, added 8 million lives this year. We expect that to add additional lives next year. And of course, there are states considering expansion. And then third, is the growth from our yield improvement. So we have a couple of point growth from that perspective.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

I wanted to also touch on the commercial side. You've talked about the things you are doing internally in terms of the focus, obviously, you've got some new products you've rolled out, you're expanding the sales force. But from the market side of it, if you're looking from the commercial payers, are there any reasons as to why they might be more receptive? I think the [ph] MOR (22:49) caps as a reason as to why they might want to outsource more. Are you seeing any of that? Are the customers telling you that, or is that just not the case yet?

William C. Lucia
President, Chief Executive Officer & Director

A

I have to say we've had more engagements with commercial payers across the landscape, whether it's through government risk or through commercial risk. And part of it is this complexity of the ACA. So in the past, an individual was under it. They got to understand the risk and write them accordingly. They don't that opportunity today and millions of members have come through the exchanges. So they're dealing with this somewhat uncertain risk population and at times have to hedge their bets. And of course as they go through Medicaid re-procurements where they're actually bidding for stay, Medicaid is always sharpening their pencil too. So they have to be – and Medicaid is not a very high profit margin for the commercial carriers. So they're always looking for ways to continue to save cost, and commercial carriers are not – I mean, they are all built with very large systems and engines to process claims. But to make sure that they're doing appropriate audits and appropriate clinical audits takes a lot of time and internal development and really, it's better to augment that with a service vendor.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

All right. Great. I feel obligated to ask the Medicare RAC question. Just in terms of an update on where things stand currently?

William C. Lucia
President, Chief Executive Officer & Director

A

So on the Medicare RAC procurement, one of the bidder CGI has protested and it's gone through two levels of Federal court. It's now in that second level of Federal court and they're expecting a hearing in early 2015, I don't know, I don't think it's yet on the docket. That's holding up the awards of three Medicare RAC regions that were protested. There were two regions, Region 3 and Region 5, which is the national DME award which we did not bid on. CMS says that they plan to award those two regions by the end of the year and publicly CMS has said that after they – as the legal process takes place and there is decisions about that, they expect to award the RAC contract in the summer, the balance of the RAC contracts that were protested. And there has been active discussions with CMS on a regular basis about allowing us to extend the contract and continue to do work and broaden the limited scope of work we're doing now.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

Just one quick follow up on that. I just want to make sure, I wasn't clear whether CMS was saying that the awards would happen in late summer or they thought the contract would restart in the summer, I didn't – because there is obviously going to be additional appeals once the contracts are awarded, so I didn't know if there was any nuance to that timeline?

William C. Lucia
President, Chief Executive Officer & Director

A

Yeah. I think it's sort of fine line because once awards are made and if the court case is decided in February and in favor of CMS, they can go to awards quickly or go through best and final or some other process. If it's in favor of

CGI, they may have to put the procurement and start over. So I think they're being careful to just say, we expect this to start up again in the summer of next year.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

Okay. Can you remind us in terms of where you are in terms of the commercial rollout? You have expanded the sales force, but how far along are you, is there something you think will be complete in the next six months or from a sales force standpoint and also product development?

William C. Lucia
President, Chief Executive Officer & Director

A

From a sales force standpoint, I think we hired the staff that we will hire for now. We are still building out the [ph] account (26:28) engagement teams for the commercial market below those teams, but we're already seeing traction and attracting independent Blues plan where typically had a low penetration rate and expanding our footprint with the large national payers that were already clients. So we are well on our way with commercial sales and very confident about that.

On the product side, we developed the product engineering team this year. In the past, we've never really had a formal product management function. As a services company, sometime those don't exist. So we hired a senior product management executive, years of doing this in healthcare industry, and a team of product managers and we are going through both engineering existing products and adding features and benefits on a more rapid and formal basis into the market for existing products and we are looking for new products either through internal development or through acquisitions.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Q

If you can just touch on kind of the areas, one of the things that clinical prepay obviously is something you've just recently rolled out, what are the other areas within – on the commercial side, do you think are attractive?

William C. Lucia
President, Chief Executive Officer & Director

A

Well, there is a lot of focus on the commercial side about understanding the member, understanding the risk profile of the member, and using data analytics to do that. We really are one of the few companies that have standardized the data across multiple payers in one database. So that means we can look at activity across payers in a specific market and look for fraud, waste, and abuse. That's pretty unique. So in a given state, we have the state Medicaid claims, all of the Medicaid Managed Care plans, and a couple of the commercial carriers of the large Blues plan in that state, you can find providers who fall under the radar screen if you're looking at just a client claim, one payer's claim. But when you're looking across all the claims, you can see that they're defrauding the healthcare system. So, applying those analytics on a pool basis is one of the products we're talking to our clients about now.

Bret D. Jones
Oppenheimer & Co., Inc. (Broker)

Okay. Great. And I think we're just about out of time. So, I want to thank you again, Bill for coming and we'll have – you have one-on-ones for the rest of the day, but I will catch up with you. Thank you.

William C. Lucia

President, Chief Executive Officer & Director

Thank you. Thank you, everyone.