HMS Holdings Corp.

HMS Holdings Corp. presentation delivered at the 35th Annual J.P. Morgan Healthcare Conference on 01/09/2017.

Stephanie Davis: Hey, good morning everyone. My name is Stephanie Davis, and I cover the healthcare IT sector here at J.P. Morgan. It is my pleasure to introduce HMS Holdings next. Joining us today to present is the CEO, Bill Lucia.

In the audience, we have the head of marketing and sales, Doug Williams, and next to me, CFO Jeff Sherman. Head of IR, Dennis Oakes, will also be here, and he'll be joining us for the Q&A session after in the Sussex Room down the hall.

As a reminder, please remember to silence your cell phones for the session. With that, Bill, I turn it over to you.

Bill Lucia: Thank you, Stephanie. Welcome, everybody, to our presentation today. I'm glad that you could make it.

Of course, the first slide is our obligatory slide that our counsel makes me put in. You can read this one at your leisure.

We're going to talk a little bit today about our business overview, the market opportunity that is ahead of HMS, the various growth drivers that drive our business, what a strategic lens for 2017 -- how does 2017 impact us going forward in the future, and of course, some of the potential Medicaid changes that may come out of repeal and replace.

If you have a crystal ball around that, we'd be happy to see that crystal ball. Then, we'll conclude a little bit about why we're here as a business and continue to be a strong-growing entity.

Again, we'll start with our products, the key assets that we deploy to help our customers in the market, and then who our principal customers are.

We really are the most integrated point solution for cost containment for healthcare costs for payers of all sorts -- whether you're a commercial payer, a commercial payer that takes Medicaid and Medicare risk, or you're a government program, or you're a "payvider," a government provider at risk.

Our services are all designed to achieve very high return on investment. For most of our customers, they're 10 to 1 or greater. That's a very, very high return on investment. Most of our work being done on a contingency fee. We don't get paid until we find a savings or recovery.

Now our heritage business, where we started, was coordination of benefits for Medicaid. That really assures that the right payer pays the claim. Medicaid's the payer of last resort.

That continues to be where we deliver unparalleled results in the market, both on a perspective side -- from a cost avoidance perspective, so the clients don't pay the claim because of the information we provide them and they put into their system -- or from a recovery side for those claims that categorically can't be cost-avoided or that we recover that have slipped through the cracks.

Still continues to grow, and it's offered to state government, Medicaid managed care plans, and we do some of this work for the VA.

The second line of business that we've grown over the last couple of years specifically is payment integrity. That's really ensuring that the claims that are paid are paid accurately.

The accuracy of the claim submission from the provider -- and that's either finding pricing errors or coding errors -- they may be related to a place of service, they may be related to medical necessity, or could just be that the DRG that was used to code the service was inappropriate for the level of care delivered.

Then many other errors in between. That's the other area that, again, attacks the payment error problem in the nation, which is about $180 billion a year, by the way, paid in error between COB and payment integrity.

Then this year, in 2016, this past year, through acquisition and then some new internal product development and innovation, we introduced a new vertical providing technology and results-driven analytics that will track, manage and impact care decisions and member management.

That's really to make sure that that trillion dollars of waste that's in the healthcare system that's truly healthcare waste, we can start to have an impact on. We'll talk a little bit more about that later.

These are really our core competencies. We bring advanced and proprietary analytics and algorithms and data-match logic that is unmatched in the industry to maximize results for our clients. Again, remember the 10 to 1 ROI or higher -- very sticky model.

Enormous claims ineligibility databases, both current and historical. Some of our clients the data...online data goes back probably five years, but some of our clients we have data back 30 years. Very, very wealth of data for our customers and our trading partners.

Extremely large customer footprint across multiple government and commercial clients, and now, it includes a growing number of provider-sponsored health plans, or what we like to call "payviders," again, these are new entities for us.

They're providers who are taking risk but act like a health plan. Very important for us as we grow our business. Again, our entire goal is to achieve maximum ROI for our customers through our services.

I've got to tell you, this is really why our customers rely on us. It's why they partner with us and why we achieve, year after year, very high net promoter scores as a service technology company. They rely on us for that in-depth knowledge of the Medicaid and Medicare programs, the state and federal regulatory environment.

We're one of the few cost containment companies who are HITRUST certified. That's the highest certification from a security perspective in the health insurance industry. It's a very important certification. In fact, there's large plans who have said to the marketplace that if you're not HITRUST certified within the next 18 months, you're not doing work with us.

I can tell you that the cost to be certified and maintain that is more than what some very small vendors actually generate in revenue. Very, very important.

We have access to hundreds of clinicians across all specialties. We've got award-winning technology people. We actually sit on the HITRUST board. We're very connected into, and our clients trust us as a data steward.

Of course, all of this foundation supports the operations of our products, our product development and service delivery, as well as the unique collaboration we have with our customers to continue to bring new value to them year over year.

What's interesting is HMS touches millions and millions of lives in our nation, but we're not a household name. We have eligibility information for over 80 percent of the US population. At least 80 percent of you are in our database.

We have a warehouse of 1.2 billion eligibility segments. Every time you've changed insurance, that's tracked in our database. Now that's tracked on behalf of the fact that we get to match that against Medicaid, Medicare or the Veterans Administration, but it's massive amounts of data.

That's how we do what we do. There's an unparalleled volume of current and historical claims data. We have unmatched over 90 percent of the Medicaid historical claims data in our database.

I'll be talking a little later in this presentation about how do you maximize the use of that data, and you can think through if it was really put on steroids and you put some fuel behind it, what can it do for the costs in the Medicaid program.

Then of course, no other company has this treasure trove of data. That's part of why our customers contract with us.

Let's talk about our customer profiles quickly. Our state government is our heritage customer base. We serve 47 states in the healthcare programs, including Medicaid, and in 2017, just from a renewal perspective or reprocurement, 3 out of our top 10 states are up for reprocurement, heavily weighted toward the balance of the second half of the year.

It's less than -- it's about 10 to 12 percent of our state government revenue -- and high expectations that we'll re-win all those contracts. Our state contracts are very long term contracts. Again, extremely high ROIs for our states, often exceeding the 10 to 1.

But one of the things I wanted to mention about this slide is, "Don't let the map fool you." We have states, and I'll give you some examples, like Florida, that has outsourced all of the functions to us around cost containment, and they have three employees who manage our contract.

Then, we have states like California that have outsourced two functions to us, and they have 200 employees that do the work. Embedded in our existing customer base on the state side is growth opportunities to sell them more services.

I'll tell you, with the new administration and the threat of repeal and replace, there's always the opportunity that Medicaid is going to be squeezed and that the states are going to have to look for more cost savings. That's a great selling environment for us.

Our commercial market -- that includes health plans, whether they're commercial, Medicaid, Medicare, employers, and of course, at-risk providers -- that's our fastest growing market. We continue to expect this to grow in the high teens.

We serve now over 100 million lives across 250 health plans. That includes the very large nationals, names that you would know, all the way down to smaller regional plans, and here in California almost all the county Medi-Cal plans.

Then, we serve hundreds of employers each year doing dependent audits. We also see employees as an important future. They've always been a stakeholder in the healthcare system in the US, and they're demanding more cost containment and better services delivered or better outcomes for their employees through the ASO vendors, which are our big commercial accounts.

In the last couple of years, we've built and expanded the sales and service delivery in this market, and now, we're really starting to see the fruits of our labor to continue this high teens growth rate, which we expect to continue in 2017.

Then now, with the recent acquisition of Essette, which we did in September, and I'll talk a little more about that later, we're starting to serve those providers who take risk. They're a new, important part of the equation as the healthcare landscape changes and value-based reimbursement has a stronger foothold.

Serving this new market's important for HMS.

Of course, we partner with the federal government. Somebody who's that integrated into what's happening with healthcare policy has to have a seat at the table with CMS. That's very important for us.

It may not be our largest line of business or market that we serve, but it's very important that we're there and that we're a trusted thought leader to CMS and people in Congress about the Medicaid and Medicare programs.

We did re-win, after the long, protracted Medicare RAC procurement that some of you may know about, it did end with a reward of our existing region to us, but at much more attractive fees.

We do expect a slow startup of that program this year, and that it won't really be a major contributor to top-line revenue in 2017, but things could change and the new administration could find that and fuel that as an opportunity to really bring dollars back into the federal budget.

We were awarded a blanket contract as a UPIC, a Unified Program Integrity Contractor, and that's great recognition for HMS for our experience in investigating, identifying and fighting fraud, waste and abuse in Medicaid and the Medicare programs.

Of course, we're on the team to deliver analytics under the federal public/private healthcare partnership that's health plans and government fighting fraud across the nation.

We think the feds are going to be squeezing dollars. We think that's the mantra that's coming out of the new administration, and when there's a squeeze on programs, it's a great opportunity for HMS, because we contain costs.

But let's talk about what the big market opportunity is ahead of us. We're really focused now on broadening this definition of cost containment. For years, we've been calling ourselves a cost-containment company and very focused on how do we get the claims paid by the right party or paid accurately.

We've been attacking that $100 billion a year of claims that are paid in error, but let me give you a new way of thinking about us going forward. In reality, there's a trillion dollars of waste in our program. That's a big, big number - a trillion dollars of waste.

Now this waste is really, it's improving care. It's identifying where there's preventative care that wasn't delivered that could have brought costs down. It's looking for inefficient care, ineffective care, over-utilization, all the things that impact the cost of our system.

It's interesting to note that five percent of our population costs our system 50 percent. It's 50 percent of the cost is just five percent of the people. If you can wrap your arms around those five percent of the people and really manage that, you're going to be able to really move the needle and do something about this trillion dollars.

We're now attacking that trillion dollars of waste by adding member risk analytics and care management workflow, particularly through our new acquisition, and then the aggregation of data across the landscape.

Aggregating data really gives you the opportunity to look into the care delivered to a patient from multiple entities and determine how that can be improved.

Let's talk about how do we see growth for the Medicaid enterprise. We'll continue to maintain and defend that thought leadership position and that very high stickiness sin our coordination of benefits and payment integrity product lines, and we'll continue to accelerate the ROIs.

We always focus on yield improvement from each step we take in those products. Our clients are going to continue to face budgetary pressures, whether they're states, the federal government or the health plans that serve the government.

The changes to the regulatory environment are going to force more cost containment needs. Of course, we're intently focused on bringing new product to market, whether it's through acquisition, or through internal innovation and product development.

Lastly, we've got this team of Six Sigma experts that are running around the company all focused on making us much more effective in every step of the way. That's all an intent focused on margin expansion.

But the macro trends continue to be in our favor as an organization. With Medicare growth boosted by Baby Boomers that are retiring and enrolling at the rate of 10,000 a day into the Medicare program, most of them moving into Medicare Advantage plans, which is a sweet spot in our commercial marketplace, and also, they're living longer with more chronic conditions.

Whoops, I think I...there you go.

Employers, as I said, are demanding more from the ASO providers. The costs are going up for employers. They need them to do more than pay claims and bring network discount. The kinds of services we're bringing today to the market in care management and member analytics is critical.

This complex, very complex regulatory environment, it's just going to get more complex with the repeal and replace once there is a replace. Lastly, it all brings a long list of inefficiencies across the entire system.

The lack of care coordination, failures in care delivery, you couple that with fraud and significant payment errors and there's no silver bullet to fix all this, but it's a great opportunity for HMS.

Sorry about that. Let's talk about the commercial market and why we believe we can continue to hit high teens growth.

Really, the biggest factor of growth each year is the full-year run rate or the impact of implementations we did in 2016 that are going to have a full-year run rate sometime in 2017. That's always the biggest impact.

The next is sales that we did in 2016 that get implemented in 2017. Those are always the two factors, and then of course, we continue to sell to our customers. Our selling season's the first half of the year. Everything we sell in the first half of the year we usually get implemented through the second half of the year.

Some projects are more complex and take longer, and then an intense focus on yield improvements. That means every claim we touch we find more dollars. All of those are part of -- and you can add medical cost inflation -- and the growth of the program we serve and our clients all add up to continued growth.

That's how we're expecting to continue to achieve these high teen growth rates in that market.

Our payment integrity growth, that's really helping fuel the commercial market growth, but really this year, we focused on fine-tuning our PI capabilities -- both our technology, our data longboarding process. We're doing more yield improvement and cost efficiencies.

I've got to tell you, payment integrity's like a space race. We launch edits and algorithms out into the market. Our clients, we find money, we take it back, our clients improve their systems and then we launch again. That's really what this business is about.

We've adopted new technology, restructured internally to really focus more on more rapid deployment of edits and algorithms, and now, we're also focusing this on our state market.

We've got a state market with about half of the states that are seeing budget shortfalls this year, and we would expect that's going to continue. They're now going to be, we think, more of a buyer and more interested in recovering claims that have been paid inappropriately.

Of course, the new administration has really publicly said they're planning to fight fraud, waste and abuse in healthcare.

We are, as I said, intently focused on margin expansion. I do have to tell you the first way is every new dollar of revenue comes in at a higher average margin than our existing revenue. That's the first key, but the rest is that we have the scalable business model and that we can continue to invest in this on-going effort with the lean Six Sigma engineers that run around the company looking for ways to automate specific tasks.

Of course, this year, we're bringing a new technology. We're completing the implementation of our Hadoop data lake layer that's going to help us rapidly get to building edits and algorithms faster, and then tied to that will be our robotic process automation that's going to let us eliminate work steps through the process.

Margin expansion's the key goal for HMS's growth.

But let's look at 2017 through a more strategic lens. We're heavily, heavily focused on the data infrastructure, as I said., that's going to enable us to return higher margins, speed the market and innovate products faster.

Our team is further engaging with, now, this very large customer base and 18 of the top 25 payers in the nation, 47 states and the federal government to add new products to meet demands much earlier, really identifying and anticipating the problems that are happening and expanding these true partnerships.

Of course, building on that strategy of new products for these customers -- always keeping the customer's need sat the center of our strategy as we look at buying or building new products.

The Essette acquisition's a perfect example of this. We acquired them in Q3 of 2016. Was founded in 2007. There's about 40 employees, about 40 customers. Mostly health plans, but again, it brought a set of "payviders" to the table for us, a new market for us to sell our more traditional services in.

It's a web-based care management platform that really helps manage all the tests you have to take to manage that very chronic member through the program, and now, we're selling this through the HMS distribution channel, and I'm really proud to say that in just three months we've sold an Essette contract to an existing HMS customer. That's pretty quick after an acquisition.

Of course, we're building analytics. We're building and buying additional, very results driven analytics, not broad analytics programs, and one of the ones we've built is this net member health profile that's being piloted in a state this month.

Our plans have told us it takes them a good four to six months when they see a member to be able to understand what kind of risk that member is -- what's the risk profile -- and then they take action. In a Medicaid plan, they may have that member for six to nine months.

By aggregating that data at the state level, we can tell them at enrollment time, "This is the risk of the member. These are the 50 people, when you get these members in your plan, that you really have to focus on."

Think about if they move that member to the Essette program and they track all of the activity so we make sure that member is getting the preventative services and that nothing's falling through the cracks. Outcomes will improve, and costs will go down.

That's what we're building as we go into the future to hit that trillion dollar of waste in the system.

Now, we also have this very large pipeline of transactions that we'll continue to focus on from an M&A perspective. For us, it's speed to market. It's speed to market, prudent deployment of capital, making sure we don't overpay, but really looking at entities that can help us hit that trillion dollar of waste and have an impact on the market going forward.

I'll talk a little bit about Medicaid changes, but I wanted to put a crystal ball on this slide and our general counsel wouldn't let me. In reality, I got to tell you it's too soon to tell. You've probably heard, recently, top Republicans saying, "Well, you know, we really don't want 20 million people to lose coverage."

You've got a potential Medicaid block grants that will cap at federal fiscal year 2016, but if you're a Republican state that didn't expand, you're hosed. You're happy if you're John Kasich and you expanded in Ohio, but you're not happy if you're Texas or Florida.

There's probably going to be some horse trading. We know that it's all about the deal, anyway. There's probably going to be some horse trading in this case, and there will be states that will probably end up with a different type of expansion in the Medicaid program.

I wouldn't take repeal and replace as definitely a negative for the Medicaid program, because it's one of the railroad tracks that's in place to get more people covered, just at a more cost-effective rate.

What does this all mean? We deliver on a true partnership with our customers to solve their problems in an ever-changing healthcare system. Again, end-to-end solutions and the one point of contact for them for cost containment.

We've got an infrastructure and data assets, as I told you, with actionable analytics, and lastly, a strong cash flow to support innovation and acquisitions.

It's all bolstered about a culture that's centered around collaborating with the customer and doing everything we can to build new products and services to support them, and it's supported by an award system on a way of doing business to attack that with a sense of urgency and addressing customer loyalty and continuing to improve our net promoter scores.

In closing, because the red light's blinking, that's why we're here. If you just look at this slide and the growth rate of healthcare expenditures in the nation, something has to be done about it.

We're not a silver bullet, but we're one of the proven solutions that can impact the rising cost of healthcare in the US, I thank you for being in our presentation. The rest of the HMC executive team that's here will join you in the Q&A session.