Off Wall Street

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New Rec: HMS Holdings Corp. (HMSY: $35.26) August 23, 2012

Position: Sell **Target: $23**

$MM	3Q12e	4Q12e	1Q13e	2Q13e	F2012e	F2013e
Revs	128.0	136.7	126.1	142.1	492.0	573.7
EPS $	0.24	0.25	0.19	0.27	0.88	1.04
Y/Y Gr	27%	21%	17%	18%	24%	19%
PE					40.2	33.8
PSR					6.3	5.4
Consens					0.94	1.18

Shares Out: 88.4M **Market Cap: $3.1B** **FYE: December**

Concept:

1. Growth in HMSY's core business has slowed dramatically due to market saturation and smaller increases in Medicaid spending, but this fact has been masked by the December 2011 acquisition of HDI, a Medicare RAC (recovery audit contractor).

2. Medicare RAC revenue is threatened by high rates of appeals and overturned denials, changing billing behavior by hospitals, and by a potential clarification of Medicare inpatient admission/observation stay definitions. These factors could significantly reduce audit volumes and improper Medicare payments, slowing growth in the contingency fees collected by HMSY.
3. Bulls expect new business from Medicaid payment recovery audits to generate significant revenue for HMSY. Varying and complex state-level rules, along with pressures on states to keep under-funded Medicaid providers afloat, will slow the roll out of this new business and cap potential revenue and profits.

Summary: HMS Holdings (HMSY) verifies Medicaid benefit eligibility and audits health care claims to ensure proper payment for services provided by hospitals and other health care entities. Its primary clients are state Medicaid programs (~70% of 2012e revenue), the Centers for Medicare and Medicaid Services (CMS) (~20% of 2012e revenue), and private insurers (~10% of 2012e revenue). Most contracts pay HMSY a contingency fee based on avoided or recovered improper payments. HMSY earns its fees by identifying paperwork errors or over-ruling health care provider decisions about what is medically necessary, rather than by identifying fraud and abuse.

About 64% of 2012e revenue will come from its core Coordination of Benefits (COB) business, which verifies eligibility for health care benefits before payment, or identifies and collects from third parties (e.g., other state Medicaid programs or private insurers) who are liable for a claim erroneously paid by the client. HMSY is the dominant company in the Medicaid COB market, serving 44 states and 148 Medicaid managed care plans. The remaining 36% of 2012e revenue will come from Program Integrity (PI) services, which audits claims for proper documentation and medical necessity.

HMSY shares are up about 27% since June 28, when the Supreme Court upheld the Affordable Care Act. Bulls see the ruling as a boon for HMSY, since it stands to benefit from increased Medicaid spending, and the resulting increase in erroneous payments. Shares currently trade at 30x 2013 "street" EPS of $1.18. This rich valuation is based on the "street's" view that HMSY has virtually endless growth opportunities in a $165B addressable market of annual improper health care payments, and will generate 25%+ EPS growth for the foreseeable future. We think the addressable market is based on fictional data, and is likely much smaller. The cracks in HMS' endless growth story have begun to show in its core COB business, which was growing at 20% y-y in 2010-2011, and was supposed to continue on that trajectory in 2012, but in 1H12 grew only at 10%. We think this shows there is, indeed, a limit to fees states will pay to correct paperwork errors.

The "street" has been willing to ignore recent slowing core growth because it has been overshadowed by new significant revenue from HMS' December 2011 acquisition of HealthDataInsights (HDI) for $368M (4.3x then-estimated 2012

sales of $85M). HDI is one of four recovery audit contractors (RACs) chosen by CMS in 2008 to audit Medicare claims for improper payments. Medicare RACs identified $1.8B in improper payments, primarily to acute care hospitals, in the first nine months of F2012 alone, and the "street" sees virtually endless future growth, given the company's estimate of $48B in annual improper Medicare payments.

Our research and discussions with industry sources suggest there are many risks ahead for Medicare RAC revenue that could cause growth to slow or even decline. First, hospitals have responded aggressively to RAC audits by appealing an increasing number of denials. Appeals of HMS' audits are the highest of the four RACs (63% vs. 45% nationally, according to data from the American Hospital Association). Moreover, hospitals are winning their appeals, and denials are being overturned. Overturned denials mean hospitals win back revenue that may have already generated contingency fee revenue recognized by the RAC. Since the RAC must return fees from overturned denials, this could lead to revenue recognition issues for HMS, which may not have reserved properly for the unexpected high level of overturned appeals. Second, hospitals have learned what will trigger a RAC denial and are changing their billing behavior. This will reduce future improper payments and RAC contingency fee revenue. Finally, hospitals are taking their complaints about overly aggressive RACs to Congress and to the courts to attempt to change/clarify Medicare regulations so that they no longer make incorrect payments due to vague reimbursement rules.

The final piece of the "street's" revenue growth story for HMS is the rollout of Medicaid RACs, which began in 2012. HMS has won 70% of the state-level RAC contracts awarded to date, and each new award solidifies bullish expectations that this will be a big revenue and profit generator for HMS for years to come. Our research suggests the market is much smaller and less profitable than the "street" believes, which make us think HMS has been successful in large part because its competitors have not bid aggressively for this business. First, states are moving patients into Medicaid managed care plans, which plans do not have to be included in the Medicaid RAC projects. Second, improper payments to fee-for-service (FFS) providers make up only about half of the errors in Medicaid payments as compared to nearly all of the Medicare payment errors. Most of the other payment errors are due to ineligibility, an area already targeted by HMS' COB business. Third, states treat Medicaid providers very carefully, as they may choose to refuse to participate in this already marginally profitable business if they are audited too aggressively. Finally, since Medicaid plans vary widely from state to state, managing multiple programs will be much more complex and expensive than the Medicare RAC program. But, since contingency fees are capped at 12.5% (the highest rate Medicare pays), the Medicaid RAC programs are likely to be much less profitable than the Medicare RAC programs.

The "street" is looking for revenue of $503M and EPS of $0.94 for 2012, and revenue of $603M and EPS of $1.18 in 2013. We expect revenue of $492M in 2012 and EPS of $0.88, and revenue of $574M in 2013 and EPS of $1.04. In 2014, upon the expansion of Medicaid benefits under the Affordable Care Act, the "street" is looking for revenue of $730M and EPS of $1.50, as compared to our estimates of $642M and $1.16. Our price target of $23 is a generous 22x 2013 and 20x 2014 EPS, and represents a 35% decline from current levels.

Borrow information: HMSY

Supply Quantity	Quantity On Loan	Available to Borrow	Date
29.7M	8.1M	22.7M	8.22.2012

Source: Markit/Data Explorers

Background:

HMS Holdings has been a public company since 1992. Its business has grown with the US government's increasing focus on ensuring proper payment for health care services provided to Medicaid beneficiaries. In the early 1980s, the federal government enacted new legislation requiring that states recover Medicaid payments that should have been paid by other insurers (e.g., workers' comp, private insurers). In 1985, the company began offering third party liability services (now called Coordination of Benefits, or COB) to help states meet this requirement. In its COB business, HMS is paid contingency fees calculated as a percentage of amounts recovered, or fixed fees for a specific volume of cost avoidance data.

In 2006, new federal legislation required other entities dealing with Medicaid patients (e.g., self-insured plans, PBMs) to look for third parties that were liable to pay for services provided to Medicaid recipients. This allowed HMS to expand the client base for its COB offering. By 2008, 33 states had enacted legislation to comply with this new requirement, and by 2009, this expanded to 46 states. Over time, the company also expanded its COB offering to clients such as state child support agencies, the VA, and Medicaid managed care plans. Today, HMS is the dominant provider of COB services to the Medicaid market, providing services to 44 states and 148 Medicaid health plans.

Potential new growth opportunities for the COB business opened up with the passage of the Affordable Care Act (ACA) in 2010. Originally, the Act was expected to expand the number of Medicaid beneficiaries from 67M in 2013 to 79M in 2014, an 18% y-y increase. The Supreme Court's June 2012 ruling

upholding the ACA does allow states to opt out of the expansion, reducing the estimated increase in enrollment to 74M in 2014, a 10% y-y increase. The "street" is bullish about potential COB growth in 2014 and beyond, but, as we discuss below, we think this growth will be tempered by states' increasing efforts to control Medicaid spending.

HMS' Program Integrity (PI) business is focused on reducing improper payments to health care providers by auditing claims, primarily to identify billing for unnecessary services and cases with insufficient documentation of services delivered. Until recently, this business has been a smaller part of HMS' revenue (about 23% in 2011). The company did try to expand its presence in the space several years ago by competing to win a region in the 2009 nationwide expansion of the Medicare Recovery Audit Contractor (RAC) program. HMS did not win a region, but in December 2011 acquired HealthDataInsights (HDI), the Medicare RAC contractor for Region D. This acquisition will represent about 20% of HMS revenue in 2012, pushing PI to about 35% of total revenue.

Discussion:

1. "Street" market size estimates based on fictional estimates of improper healthcare payments

Much of the bullish sentiment around HMS shares stems from its supposed low penetration of an enormous addressable market. In a recent investor presentation, the company put the 2011 market at $130B ($39B Medicaid, $48B Medicare, $43B Commercial), and projected market growth to $165B by 2015 ($55B each from Medicaid, Medicare, and Commercial). Assuming HMS or other contingency contractors earn a 10% contingency fee on identifying/collecting these improper payments, the potential annual market would be $1.65B versus "street" estimated 2012 HMSY revenue of $505B, suggesting plenty of room for future growth. We question this market size estimate, however, since on its 3Q11 conference call the company put the current addressable market for Medicare and Medicaid alone at $200B. If we add another $43M in potential commercial revenue, the addressable market according to HMS in 3Q11 would be $243B. But what is $78B between friends, especially when the market is so underpenetrated today?

The federal government estimates improper Medicare payments in 2011 were $29B, well below HMS' $48B number. But even that number may be wildly inflated, in our view. In some political environments, it would behoove CMS to report a low improper payment rate to show it is an effective manager of taxpayer dollars. But in 2009, the federal government was looking for ways to fund a massive expansion of Medicaid benefits to achieve near universal healthcare

coverage. One easy way create potential future savings would be to increase the estimated error rate for Medicare payments, and then implement programs to reduce the error rate in the future. This appears to have occurred in 2009, when CMS' estimated amount of improper payments ballooned to $30.8B from just $10.4B the year before. Not surprisingly (at least to our jaded eye), the error rate fell from 12.4% in 2009 to 8.6% in 2011 as CMS' programs began to work their magic.

Medicare National Improper Payment Rates (Dollars in Billions)

	2007	2008	2009	2010	2011
Total $ Paid	$276.2	$288.2	$285.1	$326.4	$336.4
Improper Payments	$10.8	$10.4	$30.8	$29.7	$28.8
Error Rate	3.9%	3.6%	12.4%	10.8%	8.6%

(www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

According to CMS, the increase in the error rate is "attributed to a significant change in the claim review methodology implemented in 2009." In other words, CMS changed what was deemed an improper payment (e.g., professional medical judgment could no longer be used to find a claim properly paid if a policy requirement was not met), thereby boosting the error rate from 3.6% in 2008 to 12.4% in 2009. Changes to the rules have generated savings so far, as Medicare RACs claw back payments from providers who did not know the new rules and had no time to adapt. But as we discuss below, providers are now changing how they play the game, and are winning back lost payments on appeal. Thus, the supposed change in the payment error rate and generated savings may only be temporary.

2. Slowdown in core COB revenue growth due to market saturation, lower growth in Medicaid spending, and shift to Medicaid managed care

Over the past two quarters, growth of HMS' COB business has slowed from about 20% y-y in 2010 and 2011 to about 10% y-y in 1H12. With 44 states and many other entities (e.g., pharmacy benefit managers, Medicaid managed care plans) now using HMSY to satisfy federal regulations to ensure no third party should pay a patient's Medicaid claim, HMSY appears to have saturated its market, and growth is slowing to the rate of growth in Medicaid expenditures.

COB Segment Revenue 2010-2Q12 ($M)

	2010	2011	1Q11	2Q11	3Q11	4Q11	1Q12	2Q12
COB Revenue	$235.5	$285.7	$64.1	$69.8	$74.1	$77.9	$67.7	$78.8
COB Y-Y chng	18.7%	21.3%	22.0%	26.8%	19.0%	18.0%	5.7%	13.0%

Source: HMSY conference calls.

While bulls are excited about growth that may come with expansion of Medicaid benefits in 2014, states are doing their best to hold down spending growth in 2012 and 2013 to prepare for increased enrollment in 2014. According to a survey of states by the National Governors Association (www.nga.org/files/live/sites/NGA/files/pdf/FSS1206.PDF), spending on Medicaid increased 10.6% in FY2011, but will grow by only 1.1% in FY2012. Budget proposals for FY 2013 would increase Medicaid spending by 3.4% due largely to extensive cost containment efforts.

One significant state-level cost containment effort is the shift of patients from Medicaid fee-for-service (FFS) benefits to Medicaid managed care. This shift results in lower COB revenue because the plans spend less per patient than under FFS. In 2010, about 71% of Medicaid beneficiaries were covered by Medicaid managed care, with about 65% having comprehensive managed care benefits (e.g., no carve outs for drugs, psychiatric services). Since the passage of ACA, states have been moving rapidly away from FFS Medicaid to managed care for all health care services. At the same time, Medicaid managed care plans are being acquired by large insurers (e.g., WLP buying AmeriGroup, AET buying Coventry). We think these insurers are more likely to track patient eligibility in their own systems or negotiate lower COB fees with HMS than smaller Medicaid managed care plans and the states were paying, reducing improper Medicaid payments and HMS' COB revenue.

3. Early success of HMS' Medicare RAC program (the HDI acquisition) may be short-lived, as hospitals appeal denials

According to CMS' *Medicare Fee-for-Service 2011 Improper Payments Report*, over 20% of the improper payments identified in 2011 resulted because an inpatient claim was denied, yet would have been payable had the services been billed as outpatient services (e.g., observation). Our research suggests that hospitals are billing for inpatient services that RACs think should be observation stays largely due to confusion about what qualifies for inpatient admission, not because they are purposely trying to get more reimbursement for a patient stay.

We can get a sense of Medicare RAC denial and hospital appeal trends by analyzing the American Hospital Association's quarterly *RAC*Trac survey results (http://www.aha.org/advocacy-issues/rac/ractrac.shtml). The *RAC*Trac survey collects data from over 2,200 hospitals to assess the impact of the Medicare RAC program on hospitals nationwide.

As RACs ramped up their denial activity in 2010, hospitals seem to have been taken by surprise, and appealed only about 20% of cumulative denials. But, during 2011 and continuing into 1Q12, hospitals began to see a high success rate

on appeal, and have now significantly increased their appeal efforts. In the tables below, we show quarter-to-quarter increases in the number of denials and appeals reported by *RAC*Trac hospitals. Hospitals appealed about 15% of incremental quarterly denials in 1Q11, but by 1Q12, they were appealing 45% of incremental denials. Importantly, appeals as a percentage of denials in 1Q12 were highest in HMS' Region D, at 63%.

Quarterly Denials 1Q11-1Q12

	1Q11	2Q11	3Q11	4Q11	1Q12
Region A	3,838	2,947	6,451	3,028	12,891
Region B	1,244	3,660	4,086	700	11,284
Region C	4,164	6,812	7,176	13,715	19,318
Region D (HMS)	6,800	6,454	5,166	6,750	10,846
Total Denials	16,046	19,873	22,879	24,193	54,339

Quarterly Appeals 1Q11-1Q12

	1Q11	2Q11	3Q11	4Q11	1Q12
Region A	1,076	1,423	3,471	1,074	4,453
Region B	n/m	1,292	1,690	2,532	5,301
Region C	1,086	2,268	2,103	2,226	7,811
Region D (HMS)	1,697	2,079	2,806	3,361	6,828
Total Appeals	2,336	7,062	10,070	9,193	24,393

Quarterly Percent of Denials Appealed

	1Q11	2Q11	3Q11	4Q11	1Q12
Region A	28%	48%	54%	35%	35%
Region B	n/m	35%	41%	362%	47%
Region C	26%	33%	29%	16%	40%
Region D (HMS)	25%	32%	54%	50%	63%
% Denials Appealed	15%	36%	44%	38%	45%

Source: American Hospital Association *RAC*Trac

The appeals process can take 6-24 months to complete, so, at first, hospitals did not know how successful they would be on appeal. But now, hospitals have plenty of reason to think an appeal is worthwhile. As shown below, by 1Q12, a stunning 75% of denials that had worked their way through the appeals process were overturned.

Cumulative Percent of Denials Overturned*

	1Q11	2Q11	3Q11	4Q11	1Q12
Region A	61%	74%	71%	66%	70%
Region B	94%	91%	87%	86%	84%
Region C	67%	76%	78%	73%	79%
Region D (HMS)	74%	83%	49%	52%	55%
Total Denials	80%	84%	77%	74%	75%

*Based on denials that have completed the appeals process. Overturned denials as percentage of overturned denials plus appeals withdrawn by providers

The above table does suggest that HDI has had better success on appeal than its peers, since "only" 55% of denials that were appealed have been overturned. This is somewhat deceiving, however, since HDI has the largest percentage of appeals that are still in the adjudication process. As shown below, 80% of cumulative appeals in HDI's region are still awaiting a decision, versus 73% for the nation as a whole. HDI also has the largest percentage of denials in the appeals process (30%) even though it represents only 23% of denials.

Cumulative Percent of Appealed Denials Pending Determination

	1Q11	2Q11	3Q11	4Q11	1Q12
Region A	56%	74%	69%	71%	73%
Region B	51%	51%	55%	58%	61%
Region C	63%	69%	70%	78%	77%
Region D (HMS)	76%	74%	84%	80%	80%
Total Denials	60%	65%	69%	72%	73%

4. CMS may try to reduce the high rate of appeals and denials overturned on appeal, reducing RAC revenue

In its FY2013 Budget Request, CMS states:

> "Ongoing monitoring of appeals activity is a key part of the Recovery Audit Program, as it serves as an important gauge of review accuracy. A decreasing overall appeal overturn rate means an increasing level of accuracy in recoveries obtained due to contractor auditing. CMS believes a preliminary appeal rate baseline, reflective of all claim types and appeal levels, will be available in March of 2012. CMS will target a decrease in each year over the previous for FY 2012 and FY 2013."

We have asked CMS for this baseline rate, but so far have not heard back from CMS. However, we note that, according to a March 2010 GAO report to Congress on the Medicare RAC demonstration program (Source: GAO-10-143, pg. 34), in 2010 CMS was planning to require that the RAC's total percentage of claims overturned on appeal to be less than 10% in Year One, with a subsequent decrease to less than 5% in Year Two.

A 10% overturn rate may have seemed a reasonable goal based on the Medicare RAC demonstration project results, when providers appealed only 12.7% of denials, of which 64.4% were decided in the provider's favor, meaning that only 8.2% of claims were overturned on appeal. But AHA data suggests that providers are appealing 45% of denials and 75% are being overturned, suggesting 34% of claims are being overturned on appeal.

If CMS forces RACs to lower the appeal overturn rate, RACs would be forced to issue fewer denials with a better chance of winning, reducing revenue. If, as the AMA suggests, CMS begins to penalize RACs for incorrect overpayment determinations with a penalty each time a payment is overturned, the profitability of the program would be reduced.

5. HMSY may not be properly reserving for provider appeals

The Medicare appeals process is complex, involving five different levels of appeals. A provider has 120 days to file an appeal to the initial denial, but, to prevent recoupment of funds (where CMS offsets the denied claim payment against current payments due to the hospital), a second appeal must be made within 30 days. If the provider loses its initial appeal, it can file yet another appeal within 60 days to again avoid recoupment. But if the hospital loses in the first two levels of appeals, the overpayment is recouped until the final determination is made, which can take many months.

This creates some interesting revenue recognition issues for HMS. The Medicare RACs are paid their contingency fees once CMS recoups overpayments, but in an unknown number of cases, this fee may be collected before the Medicare appeals process is complete. In the case of complex denials, such as those typically pursued by HMS, industry experts say that 30 days may not be sufficient to gather complete evidence and prepare and appeal. Hospitals may choose to miss the 30-day deadline and be subject to recoupment so they can file a more complete appeal within 120 days. Also, hospitals hit with multiple denials may simply not have enough time to respond within the 30-day window.

HMSY does not carry an estimated liability for overturned denials on its balance sheet. This may present a problem in future periods if providers continue to be successful on appeal, as indicated by the AHA *RAC*Trac data. We note that the only other publicly-traded RAC, Performant Financial (PFMT), whose subsidiary DCS is the Medicare RAC for Region A, created such a reserve, which is an offset to RAC revenues on its income statement. Moreover, PFMT has recently significantly increased its accruals for potential liabilities from successful appeals. As stated in its recent prospectus:

> "Our estimates are based on our historical experience with appeals activity under our CMS contract since January 2010. The overall percentage of commissions received that we estimate will remain subject to potential appeal increased from approximately 7.0% as of December 31, 2011 to approximately 10.4% as of June 30, 2012. This increase was due to recent trends in our historical data related to the likelihood of successful appeals."

With 80% of HMSY denials still in the Medicare appeals process and 55% of denials being overturned, it seems likely that HMSY will have to take charges in future periods to correct overly optimistic recognition of Medicare RAC revenue in prior periods.

6. Hospitals are changing their behavior in response to RAC denials

Hospitals strapped for cash cannot afford to risk RAC denials, which could push them over the edge financially. For example, the *Wilkes Journal Patriot* reported on August 1 that Wilkes Regional Medical Center in Wilkesboro, NC had to repay $312,412 in the first nine months of FY2012 due to Medicare RAC audits. As a result, its net operating income for the period was only $11, 993.

Under the current appeals system, hospitals get paid nothing if the inpatient stay claim is denied and appeals are unsuccessful, because the deadline for filing a claim for appropriate services has already passed. Moreover, even if the hospital is successful, the denial and appeals process can delay payment for many months, hurting cash flow. In response, hospitals are billing for observation stays, which do not trigger RAC denials, but pay less than an inpatient stay.

Changes in billing behavior have been significant enough to catch the attention of CMS, which noted in a July 30, 2012 *Federal Register* filing that the number of beneficiaries in observation for more than 48 hours has increased from 3% in 2006 to 7.5% in 2010. CMS further noted that "hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services, often, for longer periods of time, rather than admit them."

This change in hospital behavior will not only reduce potential RAC revenue, but has had other unintended consequences. According to Medicare rules, in order to qualify for skilled nursing care under Medicare after hospital discharge, a patient must spend a minimum of three days in the hospital as an inpatient. An increasing number of elderly patients are now being released after three or more days of observation, only to find that they are responsible for covering skilled nursing charges out-of-pocket. With Medicare recipients now suffering due to RAC audits, advocates for the elderly, the AMA, and the nursing home lobby are now calling for changes that could reduce RAC revenue.

The AMA wants RACs "to be prohibited from reviewing whether hospital services are medically necessary until CMS reviews and revises the three day stay requirements" (www.ama-assn.org/amednews/2012/04/16/gvsb0416.htm). The Center for

Medicare Advocacy has proposed an end to the use of observation status, or set some time (e.g., 24 hours) as the dividing line between outpatient and inpatient. This would clarify the rules for providers, thereby reducing improper payments and RAC revenue.

7. Providers are now using political clout and the courts to try to change regulations

With the rollout of the nationwide Medicare RAC program now into its third year, the AMA, American Hospital Association, and others are pressuring Congress to do something about what they see as the unchecked power of Medicare RACs and other auditors to issue denials and extract funds from hospitals. In June 2012, a bipartisan group of senators and representatives asked the GAO to review the RACs and other contracted Medicare auditors.

Hospitals and physicians are complaining that they are now subject to audits from an alphabet soup of different entities, including Medicaid Integrity Contractors (MICs), Zone Program Integrity Contractors (ZPICs), Medicare Administrative Contractors (MACs), Programs Safeguard Contractors (PSCs), Comprehensive Error Rate Testing contractors (CERT), Medicare RACs, and Medicaid RACs. These entities do not coordinate their efforts, often resulting in duplicate audits and the expenditure of significant hospital resources to respond to and fight audit efforts.

Providers are also going to court to sue CMS for what they deem unfair RAC denials. The outcome of these cases could have significant implications for RAC audits and resulting revenue. For example, in Palomar Medical Center v. Sebelius, currently being reviewed by the US Courts Ninth Circuit (http://www.ca9.uscourts.gov/content/view.php?pk_id=0000000589), Palomar argues that providers should be protected from arbitrary and unreasonable efforts to recover payments for services provided long before initiation of the recovery action. In this case, the RAC looked at a claim that was 20 months old. Palomar argues that after one year following payment, a claim cannot be reopened except for good cause. If the court decides in Palomar's favor, RACs would no longer have a three-year look back on claims, limiting potential revenue. One also has to wonder what impact this would have on the RAC recoupments to date. Will all of the hospitals seek the return of funds that were recouped on claims more than one year old?

In another case, known as the O'Connor Hospital Ruling, the Administrative Law Judge (level four of the Medicare appeals process) ruled that, while an inpatient admission was incorrect, CMS should have allowed the claim to be resubmitted as an observation claim, allowing the hospital to collect for an

observation stay. CMS did not appeal the decision, thereby avoiding the establishment of a precedent that would significantly reduce RAC revenue if applied to the 20% of denials that are inpatient stays that should have been billed as observation. But providers have noticed the ruling, and may even now be using it to appeal inpatient denials that are more than one year old.

8. Medicaid RAC market much less desirable than "street" thinks

The Affordable Care Act requires each state to implement a RAC program modeled on the Medicare RAC by January 2012 to recoup improper payments to providers servicing Medicaid patients. HMS has been competing for and winning contracts to serve as Medicaid RAC on a state-by-state basis, but states delayed final contract awards and rollout of the program while they waited to see if the Supreme Court would uphold the legislation.

With the Supreme Court decision in place, states have been moving forward with RAC implementation. Thirty-seven states have chosen Medicaid RACs, and HMS has won 26 of 37 contracts awarded to date. Bulls are excited about HMS' high win rate, seeing the wins as validation of HMS' superior product. The company says the Medicaid RAC program is a $100M market, and bulls are now giving HMS $70M in revenue once the program is fully implemented.

To our skeptical eye, HMS' high win rate may have more to do with minimal competition than with HMS' prowess. Based on CMS' estimates, the market is much smaller than the "street" thinks. Moreover, industry sources suggest rollout will be slow and complicated, and profitability will be limited. This may have caused other contractors to bid less aggressively than HMS.

CMS estimates that Medicaid RACs will save Medicaid $2.1B over the next five years. Assuming a 12.5% contingency fee (the maximum the federal government will pay on its share of Medicaid recoupments—states can pay more on their share if they choose), this suggests $263M in Medicaid RAC revenue over a five-year period, or about $53M per year, well below the $100M annual opportunity expected by the "street." This is a much smaller opportunity than the Medicare RAC program, which in the first nine months of FY2012 alone generated $1.8B in savings, and about $196M in contingency fee revenue for the four Medicare RACs (average contingency fee = 10.9%).

There are a number of reasons why the Medicaid RAC potential annual contingency fee revenue is only about 20% that of the Medicare RACs:

States moving patients to Medicaid managed care: The Affordable Care Act does not require states to include Medicaid managed care patients in the Medicaid

RAC program, since the managed care plan itself sets the rules for what it will pay for. Moreover, states are expanding their Medicaid managed care plans to include dual eligibles (high cost elderly and disabled patients whose copays/deductibles are covered by Medicaid), further reducing fee-for-service claims that can be reviewed by the Medicaid RACs.

Reasons for improper payments much different in Medicaid: According to CMS (http://paymentaccuracy.gov/programs/medicaid#learnmore), the primary causes of improper payments in Medicare (total 8.6% error rate) are medically unnecessary services and insufficient documentation. But for Medicaid, which had an 8.1% error rate in 2011, eligibility was the largest component (5.9%) while the FFS error rate was 4.4% (primarily insufficient documentation) and Medicaid managed care was only 1%. HMS is already collecting contingency fees on eligibility errors through its COB business, and more patients are moving to managed care. This leaves Medicaid RACs to collect on errors in FFS payments, a small and shrinking piece of the error rate picture.

Medicaid providers must be treated carefully: States need providers to continue to accept Medicaid patients, who are a relatively unprofitable population. If states allow RACs to aggressively deny Medicaid claims, providers may simply leave the system.

The Medicaid RAC program is also likely to be much less profitable than the Medicare RAC program. Medicaid RAC contingency fees are capped at 12.5% (the highest rate paid in the Medicare RAC program), but costs are likely to be much higher than in the Medicare RAC program. While Medicare payment policies are standardized across the nation, each state Medicaid program is different, with different policies and rules, meaning HMS will have to set up different audit systems for each state. Some states pay hospitals on a DRG (diagnosis related group) system like Medicare, while some pay per diem or by all-inclusive rates. Medicare pays for every visit, while some states limit the number of days covered. Moreover, each state has its own Medicaid management information system (MMIS), further complicating RAC execution and increasing costs.

With higher program costs and capped contingency fees, industry sources with whom we have spoken speculate that the Medicaid RACs will be risk averse, cherry picking limited types of payments and keeping recoveries, and resulting contingency fees, low.

Finally, we think the poor performance of contractors (including HMS) in CMS' Medicaid Integrity Program may foreshadow the limited potential of the Medicaid RAC program. The Medicaid Integrity Program, established in 2005,

was the first comprehensive effort by CMS to fight fraud, waste, and abuse within Medicaid. CMS contracted with HMS and two other contractors in FY2010, giving them responsibility for reviewing for auditing specific providers and identifying over payments. According to a March 2012 report by the OIG (http://oig.hhs.gov/oei/reports/oei-05-10-00210.pdf), a whopping 81% of the audits done by the contractors between January 1, 2010 and Jun 30, 2010 did not or are unlikely to identify overpayments, and only $6.2M in overpayments was found. The poor performance was blamed on the poor quality of Medicaid data, lack of knowledge of state Medicaid policies, poor administration by both the MIC contractors and CMS. These problems seem likely to face HMS in the Medicaid RAC program as well.

9. Insider selling

HMSY executives have been active sellers of shares over many years, and have sold about 406,000 shares in the first eight months of 2012 as compared to about 551,000 shares in all of 2011.

10. Financial assumptions

The "street" expects topline growth of 38% in 2012 to $504M. We expect growth of 35% y-y and total revenue of $492M, as our lower COB estimates are offset by stronger than expected performance from the HDI acquisition ($101M vs. guidance of $95M). Our HDI estimate could prove to be too high if HMS is forced to take charges or otherwise adjust for higher than expected overturned denials. We think 2012 EPS will $0.88 versus the "street's $0.94.

In 2013, the street is expecting revenue of $603M, up 20% y-y. We expect revenue of $574M, up 17% y-y. We differ from the "street" primarily on continued slow growth for the COB business. We expect EPS of $1.04 versus the "street's" $1.18.

In 2014, the street is expecting revenue of $703M, up 21% y-y. We expect revenue of $642M, up just 12% y-y. We expect PI revenue growth will slow to 12% y-y as the Medicare RAC program reaches its limits. We also expect COB revenue to increase 12% y-y from 8% in 2013 due to expanding Medicaid rolls. We do not have a sense of consensus expectations for the COB and PI growth rates in 2014, but note that one bullish analyst is expecting 23% y-y growth for COB and 35% y-y growth for PI.

"Street" vs. OWS Revenue Estimates

	"Street" Estimates				OWS Estimates		
	2012e	2013e	2014e		2012e	2013e	2014e
COB	$324.0	$365.0	n/a		$313.5	$338.7	$379.4
PI	$180.0	$238.0	n/a		$178.5	$235.0	$263.0
Total Revenue	$504.0	$603.0	$730.0		$492.0	$573.7	$642.4
Adj EPS*	$0.94	$1.18	$1.50		$0.88	$1.04	$1.16

*EPS excludes amortization of acquisition related software/intangibles in all periods

"Street" vs. OWS EPS Estimates

Y-Y change	"Street" Estimates				OWS Estimates		
	2012e	2013e	2014e		2012e	2013e	2014e
COB	13%	13%	n/a		10%	8%	12%
PI	130%	32%	n/a		129%	32%	12%
Total Revenue	38%	20%	21%		35%	17%	12%
Adj EPS	32%	25%	28%		24%	19%	11%

11. Valuation:

Given HMSY's exclusive focus on collection services for health care payers, the company has no useful publicly traded comps. Bulls value HMSY on a P/E basis, awarding shares a multiple of 30x 2013 EPS and 23x 2014 EPS for expected EPS growth of 25% and 28%, respectively.

Our target of $23 is 20x our 2014 estimate of $1.16. This represents a significant premium to the multiple implied by our 11% EPS growth estimates for 2014, suggesting shares could trade much lower if investors decide HMS cannot reaccelerate growth in future periods.

12. Risks:

Risks include greater than expected growth in Medicaid enrollment/spending and higher than expected collections by the Medicare and Medicaid RAC programs.

A win by the GOP in November would represent further downside for HMSY, in our view, as it may lead to a repeal of all or parts of the Affordable Care Act that will benefit HMSY in future periods (e.g., expansion of Medicaid benefits). Our model assumes the ACA stands, and expansion in benefits through 2014 happens as expected by the Congressional Budget Office.

13. Financial Projections:

Quarterly projections:

Income Statement ($M)	1Q12	2Q12	3Q12e	4Q12e	1Q13e	2Q13e	3Q13e	4Q13e
Coordin of Benefits	67.7	78.8	81.5	85.7	73.1	85.1	88.0	92.5
Core Program Integrity	16.2	16.7	16.5	18.0	17.0	18.0	18.0	20.0
HDI	23.5	23.8	26.0	28.0	29.0	30.0	30.0	33.0
Medicaid RAC	0.0	0.8	4.0	5.0	7.0	9.0	10.0	14.0
Total Program Integrity	39.7	41.3	46.5	51.0	53.0	57.0	58.0	67.0
Total Revenue	107.3	120.1	128.0	136.7	126.1	142.1	146.0	159.5
Compensation	39.3	40.0	42.0	45.0	46.0	48.0	49.0	53.0
Data Processing	6.9	8.0	9.0	9.5	9.5	10.0	10.5	10.5
Occupancy	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.8
Direct project costs	12.8	13.2	15.0	17.0	16.0	17.0	17.0	18.0
Other operating costs	5.1	6.0	6.5	6.5	7.0	7.0	7.5	7.5
Amort (excl from COGS)	8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
COGS	68.3	71.5	76.8	82.4	83.0	86.6	88.7	93.8
SG&A	14.9	14.9	15.0	16.0	16.0	16.5	17.0	17.5
Stock Option Exp	3.7	3.4	3.4	3.8	4.0	4.0	4.0	4.0
Adj Op Profit (ex stock op)	27.9	37.2	39.6	42.1	31.1	43.0	44.3	52.2
Interest expense	(4.2)	(4.2)	(4.2)	(4.2)	(3.5)	(3.5)	(3.5)	(3.5)
Interest income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other income/(expense)	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2
Pretax Income	23.8	33.2	35.6	38.1	27.8	39.7	41.0	48.9
Taxes	9.8	13.3	14.2	15.2	11.1	15.9	16.4	19.6
Net Income	14.0	19.9	21.4	22.9	16.7	23.8	24.6	29.4
EPS	0.16	0.23	0.24	0.25	0.19	0.27	0.27	0.32
S/O	88.6	88.4	88.4	90.8	90.1	89.9	89.9	92.3

Y-Y change	1Q12	2Q12	3Q12e	4Q12e	1Q13e	2Q13e	3Q13e	4Q13e
Coordin of Benefits	6%	13%	10%	10%	8%	8%	8%	8%
Core Program Integrity	-12%	-15%	-10%	-8%	5%	8%	9%	11%
HDI	n/m	n/m	n/m	n/m	23%	26%	15%	18%
Medicaid RAC	n/m	n/m	n/m	n/m	n/m	n/m	150%	180%
Total Program Integrity	116%	111%	154%	134%	34%	38%	25%	31%
Total Revenue	30%	34%	39%	37%	18%	18%	14%	17%
Compensation	25%	27%	32%	41%	17%	20%	17%	18%
Data Processing	38%	42%	51%	46%	38%	25%	17%	11%
Occupancy	8%	12%	13%	18%	9%	10%	9%	9%
Direct project costs	34%	19%	52%	42%	25%	29%	13%	6%
Other operating costs	22%	30%	40%	41%	36%	17%	15%	15%
Amort (excl from COGS)	368%	394%	391%	140%	0%	0%	0%	0%
COGS	27%	26%	37%	40%	22%	21%	15%	14%
SG&A	39%	39%	42%	33%	8%	11%	13%	9%
Stock Option Exp	81%	77%	78%	52%	8%	17%	18%	5%
Adj Op Profit (ex stock op)	40%	55%	43%	34%	12%	16%	12%	24%
Interest expense	n/m	n/m	n/m	n/m	n/m	n/m	n/m	n/m
Interest income	n/m	n/m	n/m	n/m	n/m	n/m	n/m	n/m
Other income/(expense)	n/m	n/m	24%	-400%	91%	0%	0%	0%
Pretax Income	18%	37%	28%	24%	17%	20%	15%	28%
Taxes	21%	36%	26%	25%	14%	20%	15%	28%
Net Income	16%	37%	29%	23%	19%	20%	15%	28%
EPS	14%	34%	27%	21%	17%	18%	13%	26%
S/O	2%	2%	2%	2%	2%	2%	2%	2%

% Total Revenue	1Q12	2Q12	3Q12e	4Q12e	1Q13e	2Q13e	3Q13e	4Q13e
Coordin of Benefits	63%	66%	64%	63%	58%	60%	60%	58%
Core Program Integrity	15%	14%	13%	13%	13%	13%	12%	13%
HDI	22%	20%	20%	20%	23%	21%	21%	21%
Medicaid RAC	0%	1%	3%	4%	6%	6%	7%	9%
Total Program Integrity	37%	34%	36%	37%	42%	40%	40%	42%
Total Revenue	100%	100%	100%	100%	100%	100%	100%	100%
Compensation	37%	33%	33%	33%	36%	34%	34%	33%
Data Processing	6%	7%	7%	7%	8%	7%	7%	7%
Occupancy	4%	3%	3%	3%	4%	3%	3%	3%
Direct project costs	12%	11%	12%	12%	13%	12%	12%	11%
Other operating costs	5%	5%	5%	5%	6%	5%	5%	5%
Amort (excl from COGS)	8%	7%	6%	6%	6%	6%	6%	5%
COGS	64%	60%	60%	60%	66%	61%	61%	59%
SG&A	14%	12%	12%	12%	13%	12%	12%	11%
Stock Option Exp	3%	3%	3%	3%	3%	3%	3%	3%
Adj Op Profit (ex stock op)	26%	31%	31%	31%	25%	30%	30%	33%
Interest expense	-4%	-3%	-3%	-3%	-3%	-2%	-2%	-2%
Interest income	0%	0%	0%	0%	0%	0%	0%	0%
Other income/(expense)	0%	0%	0%	0%	0%	0%	0%	0%
Pretax Income	22%	28%	28%	28%	22%	28%	28%	31%
Taxes	9%	11%	11%	11%	9%	11%	11%	12%
Net Income	13%	17%	17%	17%	13%	17%	17%	18%

Annual projections:

Income Statement ($M)	2010	2011	2012e	2013e	2014e
Coordin of Benefits	235.5	285.7	313.6	338.7	379.4
Core Program Integrity	67.4	75.9	67.4	73.0	75.0
HDI	0.0	2.2	101.3	122.0	128.0
Medicaid RAC	0.0	0.0	9.8	40.0	60.0
Total Program Integrity	67.4	78.1	178.5	235.0	263.0
Total Revenue	302.9	363.8	492.0	573.7	642.4
Compensation	106.4	126.6	166.3	196.0	225.0
Data Processing	18.0	23.1	33.4	40.5	43.0
Occupancy	13.3	15.1	17.0	18.6	19.0
Direct project costs	35.5	42.5	58.0	68.0	75.0
Other operating costs	16.5	18.1	24.1	29.0	34.0
Amort (excl from COGS)	7.0	8.5	32.6	32.6	32.6
COGS	189.7	225.4	298.9	352.1	396.0
SG&A	40.2	43.9	60.7	67.0	74.0
Stock Option Exp	7.5	8.4	14.3	16.0	17.0
Adj Op Profit (ex stock op)	80.5	102.9	146.7	170.6	189.4
Interest expense	(0.1)	(0.6)	(16.7)	(14.0)	(12.0)
Interest income	0.1	0.1	0.0	0.0	0.0
Other income/(expense)	(0.1)	0.6	0.7	0.8	1.0
Pretax Income	80.4	103.1	130.7	157.5	178.4
Taxes	32.1	41.3	52.6	63.0	71.4
Net Income	48.4	61.7	78.1	94.5	107.0
EPS	0.57	0.71	0.88	1.04	1.16
S/O	85.4	87.4	89.0	90.5	92.5

Y-Y change	2010	2011	2012e	2013e	2014e
Coordin of Benefits	19%	21%	10%	8%	12%
Core Program Integrity	118%	13%	-11%	8%	3%
HDI	n/m	n/m	4505%	20%	5%
Medicaid RAC	n/m	n/m	n/m	308%	50%
Total Program Integrity	118%	16%	129%	32%	12%
Total Revenue	32%	20%	35%	17%	12%
Compensation	38%	19%	31%	18%	15%
Data Processing	31%	28%	45%	21%	6%
Occupancy	22%	13%	13%	9%	2%
Direct project costs	25%	20%	37%	17%	10%
Other operating costs	18%	9%	34%	20%	17%
Amort (excl from COGS)	0%	21%	286%	0%	0%
COGS	32%	19%	33%	18%	12%
SG&A	43%	9%	38%	10%	10%
Stock Option Exp	18%	11%	71%	12%	6%
Adj Op Profit (ex stock op)	27%	28%	42%	16%	11%
Interest expense	n/m	n/m	n/m	n/m	n/m
Interest income	n/m	n/m	n/m	n/m	n/m
Other income/(expense)	n/m	n/m	n/m	n/m	19%
Pretax Income	29%	28%	27%	20%	13%
Taxes	25%	29%	27%	20%	13%
Net Income	32%	28%	27%	21%	13%
EPS	27%	25%	24%	19%	11%
S/O	3%	2%	2%	2%	2%

% Total Sales	2010	2011	2012e	2013e	2014e
Coordin of Benefits	78%	79%	64%	59%	59%
Core Program Integrity	22%	21%	14%	13%	12%
HDI	0%	1%	21%	21%	20%
Medicaid RAC	0%	0%	2%	7%	9%
Total Program Integrity	22%	21%	36%	41%	41%
Total Revenue	100%	100%	100%	100%	100%
Compensation	35%	35%	34%	34%	35%
Data Processing	6%	6%	7%	7%	7%
Occupancy	4%	4%	3%	3%	3%
Direct project costs	12%	12%	12%	12%	12%
Other operating costs	5%	5%	5%	5%	5%
Amort (excl from COGS)	2%	2%	7%	6%	5%
COGS	63%	62%	61%	61%	62%
SG&A	13%	12%	12%	12%	12%
Stock Option Exp	2%	2%	3%	3%	3%
Adj Op Profit (ex stock op)	27%	28%	30%	30%	29%
Interest expense	0%	0%	-3%	-2%	-2%
Interest income	0%	0%	0%	0%	0%
Other income/(expense)	0%	0%	0%	0%	0%
Pretax Income	27%	28%	27%	27%	28%
Taxes	11%	11%	11%	11%	11%
Net Income	16%	17%	16%	16%	17%

14. Financial Metrics

Debt	$341M
Equity	$421M
Tangible book	($63M)
Market value	$3.1B
Cash	$105M
EV	$3.3B

	FY11	FY12e	FY13e	FY14e
EBITDA	108.6	154.8	180.2	201.2
Capex	18.5	35.0	36.0	35.0
Free cash flow	55.7	69.8	87.5	102.3
EV/EBITDA	30.4	21.3	18.3	16.4