The Next Frontier in Utilization Management

As healthcare continues to evolve rapidly, Utilization Management strategies must adapt to meet new challenges and expectations.

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Overview

The future of Utilization Management (UM) stands to be shaped by an increasingly complex landscape, requiring payors to develop a nuanced understanding of current challenges, emerging market trends, and opportunities for process enhancement to remain competitive and effective.

Regulatory requirements, shifting at both federal and state levels, demand continuous adaptation to be in compliance and reduce risk. Simultaneously, prolonged UM approval times are contributing to delays in care delivery, generating member dissatisfaction and potentially worsening health outcomes.

Administrative complexity and evolving UM criteria have become significant sources of burden for providers, further straining relationships and fueling dissatisfaction. Moreover, the high operational costs associated with extensive reviews, outdated technologies, and challenges with staffing levels are proving unsustainable in the long term.

To address these challenges and the inherently transactional nature of traditional UM processes, the field must undergo a strategic transformation.

This transformation should redefine UM as a more precise, specialized function—one that actively prevents fraud, waste, and abuse while reinforcing clinical decision-making and support. Leveraging automation, artificial intelligence (AI) (including baseline, generative, and agentic models), and workflow enhancement is critical to evolving UM into a future-ready capability that meets both regulatory expectations and market demands.

Today's Challenges

UM remains a vital function for payors, serving as a key mechanism for controlling unnecessary healthcare costs, preventing fraud, waste, and abuse, and aiming towards care that is both proper and evidence-based. However, payors face a persistent paradox: while UM is designed to promote system efficiency, it often contributes to dissatisfaction among members and providers. At the same time, payors must navigate escalating medical and pharmaceutical cost trends, rising operational expenses, and an increasingly complex regulatory landscape. These converging pressures demand a critical reassessment of UM's future—one that strikes a thoughtful balance between cost containment, high-quality member care, provider engagement, and equitable reimbursement strategies.

1. Evolving federal and state regulations

The landscape of UM is heavily shaped by evolving federal and state regulations aimed at addressing challenges in the healthcare industry.

At the federal level, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057)[1] addresses inefficiencies in health information exchange and prior authorization (PA) processes. This rule encourages interoperability among payors, providers, and members to improve care coordination, reduce administrative burdens, and help drive timely access to essential patient information.

State-level legislative efforts such as New Jersey Public Law 296 of 2023,[2] Michigan Senate Bill 247,[3] and Vermont House Bill 766 [4] support federal initiatives by addressing regional issues in PA. These laws aim to streamline and expedite the PA process, reducing administrative burdens while maintaining utilization controls. By balancing cost management with member access, state regulations contribute to a more efficient and member-focused healthcare system.

UM encompasses a range of activities and processes that payors employ to review and approve healthcare services for their members. However, the UM landscape is significantly influenced by federal and state regulations. Recent regulations include:

CMS 0057

The CMS Interoperability and Prior Authorization (PA) Final Rule emphasizes improving health information exchange to provide adequate and necessary access to health records for patients, healthcare providers, and payors. It enhances PA processes through policies and technology, aiming to improve transparency and reduce overall payor, provider, and member burden.

VT H.766

Vermont House Bill 766 addresses health care coverage and PA practices within the state. This legislation establishes guidelines and requirements for insurers regarding PA requests and exemptions. The bill is designed to enhance the electronic exchange of healthcare data and streamline the PA processes in Vermont. By implementing standardized procedures and improving the efficiency of PA, this bill aims to facilitate timely access to necessary medical treatments and services for Vermont residents.

MI SB 247

Michigan Senate Bill 247 is a legislative proposal that focuses on health care coverage and improvement of PA processes within the state. This bill sets forth standards and guidelines for insurers concerning PA requests and exemptions. The aim is to enhance the electronic exchange of health care data and standardize PA procedures, ultimately making it more efficient and streamlined for patients and providers.

NJP.L.2023, c.296

The Ensuring Transparency in Prior Authorization Act (ETPAA) was signed into New Jersey Public Law in 2023 to revise previously established UM and claims payment procedures. The ETPAA updates requirements to streamline PA decisions and implements standards to support continuity of care. By implementing standards to drive efficiency in PA processes, this law seeks to modernize the PA process, enhance transparency, and reduce administrative burden.

These recent regulations highlight the ongoing evolution of UM in response to federal and state guidelines. By embracing the intention of regulations such as these, payors can enhance health information exchange, reduce administrative burden, and streamline PA processes, ultimately improving the overall efficiency and effectiveness of UM.

2. Unwarranted delays in care

Delays in care due to UM procedures can significantly impact member satisfaction and health outcomes.

While UM is essential for supporting appropriate healthcare utilization, prolonged wait times for treatment approvals can frustrate and dissatisfy members, ultimately affecting their engagement, experience, and likelihood of renewing with payors.

The adverse effects on member health are considerable. Delays in accessing essential services, especially in urgent situations, can worsen health outcomes. Research highlights that about 60% of individuals aged 18 to 44 have experienced cancer care delays due to UM requirements, leading to poorer survival rates and prognoses, particularly for aggressive cancers.[5]

Payors must balance effective UM processes with the need for timely access to care to mitigate these negative impacts.

3. Increasing provider abrasion

Provider abrasion, marked by frustration and dissatisfaction with UM processes, undermines the effectiveness of these programs.

Healthcare providers are essential to UM, initiating PAs and coordinating with payors to help promote optimal care. However, complex, repetitive, and confusing UM requirements often strain the provider-payor relationship.

Common issues such as repetitive documentation demand and prolonged approval timelines intensify provider abrasion. These cumbersome procedures consume valuable provider time and hinder efficient care delivery. Addressing provider abrasion is crucial for payors aiming to improve their UM programs.

4. Unsustainable operational costs

UM programs face significant operational and staffing challenges.

Conducting thorough reviews of healthcare services and implementing advanced technologies, including AI, incur substantial costs for payors. These programs require skilled personnel, sophisticated analytics, and a highly advanced technology infrastructure. With more than an estimated 500 million UM reviews conducted annually across the U.S., even a conservative 10% improvement in processing efficiency could translate into tens, if not hundreds, of millions of dollars in administrative savings for payors. These gains stem from reduced manual workload, faster adjudication, and more scalable operations powered by AI, automation, and interoperable platforms.

The operational costs of UM also affect healthcare providers. According to a study in the American Journal of Managed Care, providers spend about 30% of their time each week on PA tasks, illustrating the significant resource allocation needed for UM operations.[6] Extensive documentation, PA requests, and utilization reviews divert staff time from direct member care, increasing costs and potentially compromising care quality.

Embracing Key Value Strategies for the UM of Tomorrow

UM requires an extensive transformation, including a critical review of current strategies and a shift toward innovative models. By adopting a forward-looking approach, payors can better address industry challenges and help maximize value.

We have identified three key value pools essential for future readiness and challenging the status quo:

Value Pool	Today	Tomorrow	Strategic Impact
Technology Modernization: The AI and Automation Revolution	Technology is used primarily for basic functions like claims processing. Manual processes and limited automation contribute to inefficiencies.	Integrated **AI for PA adjudication, predictive analytic**s, and **natural language processing** (e.g., automated review of clinical notes). Tools implemented like real-time **decision engines, virtual clinical reviewers**, and **machine learning-based rules engines**. Moving to **enterprise-wide platforms** that integrate upstream and downstream data (e.g., claims, clinical, eligibility) from siloed UM systems. **Interoperability** within the healthcare ecosystem will likely be a foundational catalyst of next-generation UM.	Cumbersome, lengthy adjudication to real-time, intelligent decisions at point of service
Delivery Model Enhancement and Emerging Global Delivery Models	Payor operating models focused on maintaining the status quo, limiting opportunities for efficiency and innovation in the market.	Scaling global models to handle core UM functions. Embedding **AI and automation** at these centers to reduce manual work and turnaround time. At a market level, decentralizing UM policy enforcement to **market-specific teams** who understand local provider dynamics, where applicable. Market teams focus on **exception-based** and **strategic utilization**, while Global Capability Centers (GCCs) handle **high-volume, rule-based tasks**.	Siloed to scalable operational efficiency
Reimagining UM: Alternative Payment Models (APMs) and Care Management (CM) at the Core	Slow adoption of APMs (e.g., capitation, bundled payments, shared savings, etc.). Continued focus on immediate UM priorities for near-term affordability and trend management. Provider relationships and experience continue to take a backseat.	Providers are incentivized to **manage cost and quality proactively**, reducing the payor's need to control utilization reactively. Providers **manage utilization internally** (e.g., self-owned PA systems), reducing friction and duplication. **Trust is built** and **rewards good performance**, while reducing administrative burden. **Self-regulation of utilization** within clinical workflows is encouraged.	Cost containment to value generation

Technology Modernization: The AI and Automation Revolution

The integration of advanced technology is crucial for transforming traditional UM practices. Currently, many payors rely on conventional technology tools and platforms. However, the advancement and adoption of automation and AI technologies present significant opportunities to revolutionize UM processes.

Automating routine tasks, such as claims processing, PAs, and eligibility verification, allows payors to reallocate resources toward complex decision-making. This enhances operational efficiency, adherence to evidence-based guidelines, and drives scalability to handle increased service volumes. Automation also improves member and provider interactions, allowing case managers to focus on personalized care delivery and reducing administrative workloads for providers, thus fostering better coordination within the UM ecosystem.

As AI and automation technologies continue to mature and access to reliable datasets improves, their role in payor UM operations is expected to expand significantly. Additionally, interoperability will likely be a critical catalyst of AI-driven UM transformation, allowing smoother integration of clinical, claims, and eligibility data across systems. By facilitating real-time data exchange between payors and providers, such as sharing PA decisions, clinical documentation, and care coordination updates, interoperability reduces administrative friction, accelerates decision-making, and strengthens collaboration across the UM ecosystem.

Use Cases: Enhancing UM processes

AI-Assisted Medical Policy Development: Payors can leverage generative AI to expedite medical policy development. AI can initiate and draft policies reflecting changes in industry-recommended clinical practices and procedures. These policy drafts are then reviewed by human committees to refine outputs and compliance. By using AI to initiate policy development, payors can significantly reduce the manual research involved in tracking evolving practices, freeing up resources for complex clinical decisions. This leads to improved policy accuracy, faster implementation, and enhanced operational efficiency.

Real-Time, Streamlined Authorizations: When a PA request is submitted, a multi-agent system can gather key data from the member's record, assess the request against payor policies, and generate a recommended decision with an assigned risk score based on predefined criteria. Low-risk cases can be automatically approved by the interoperable, AI-enabled system,[7] expediting adjudication decisions. Potential denials can be escalated to human reviewers, with the system highlighting critical focus areas for proper oversight to reduce risk. This approach enhances efficiency, reduces manual workload, and improves accuracy in authorization decisions,[8] ultimately streamlining care access.

AI has a transformative impact on UM design and execution, particularly in enhancing patient outcomes and productivity. AI-powered UM systems, utilizing generative and agentic AI, accelerate workflows, supporting faster decision-making and more efficient access to medical services. Documented use cases highlight the tangible benefits across critical UM operations:

- **Enhancing UM Processes:** AI accelerates human decision-making, streamlining payor processes to deliver timely care to members. A "human-in-the-loop" approach is recommended, particularly at

Technology Modernization continued

complex decision points, to mitigate risks and help maximize AI potential with human intelligence. Proper use of AI can enhance UM processes, reduce administrative burdens, and improve the efficiency of human reviewers in managing claims, PAs, and eligibility reviews.[9]

- **Empowering Payor-Provider Relations:** Agentic and generative AI can equip staff with timely information for providers, enhancing payor productivity. AI fosters relationships through shared accountability, transparency, and data-driven insights into member needs.

- **Enhancing the Member Experience & Improving Outcomes:** Traditional UM processes can delay care or lead to patients abandoning recommended treatments, negatively impacting outcomes. AI introduces efficiency to UM processes,[10] helping payors focus on valuable operational activities while members access necessary medical services swiftly.[11]

Use Cases: Empowering Payor-Provider Relations	Use Cases: Enhancing the Member Experience & Improving Outcomes
Informed Provider Communication: Generative AI analyzes clinical data to accelerate coverage determinations based on evidence-based guidelines. This insight facilitates transparent communication between payors and providers,[12] offering clear rationale for UM decisions. By promoting shared accountability, payors and providers can support timely care delivery while streamlining decision-making processes.[13]	**Site of Care Coordination:** AI-powered analytics continuously assess clinical data[15] to identify care gaps and recommend optimal patient transitions. Leveraging real-time insights, payors can help members receive suitable care at ideal sites, improving efficiency, reducing unnecessary hospitalizations, and enhancing outcomes.[16] This approach reduces manual intervention and supports proactive care coordination.
AI-Assisted Information Exchange: AI-powered tools streamline data exchange during UM reviews. Embedded within shared interfaces, AI facilitates guided information sharing,[14] reinforcing that relevant clinical and administrative details are assessed before finalizing coverage decisions. This automation enhances data accuracy, reduces administrative burdens, and strengthens provider satisfaction and productivity.	**Proactive Health Management:** AI analyzes utilization patterns to anticipate member needs based on clinical conditions and risk factors. Identifying trends in real time allows for early interventions, facilitating timely access to preventive care and improving long-term health outcomes. This proactive strategy enhances member trust, engagement, and enhances resource allocation,[17] driving better population health management.

Technology Modernization continued

Innovative companies are harnessing AI and automation capabilities, spearheading transformative approaches in UM. These pioneers are demonstrating several impactful use cases that have the potential to shape the future of UM:

Leading Vendors in this Space are Offering the Following Use Cases:

Healthcare technology vendors are leveraging AI and automation to enhance administrative efficiency, streamline processes, and improve patient care. The following use cases illustrate key advancements in the industry:

- **AI-Powered Clinical Support:** Companies are developing AI-driven clinical co-pilots to assist providers with decision-making, reduce administrative burdens, and optimize PA workflows. These solutions help clinicians make faster and more accurate determinations while maintaining compliance with industry standards.

- **Automated Prior Authorization Workflows:** AI and automation are being used to simplify PA processes by streamlining intake procedures, aligning workflows with payor policies, and assisting clinical reviewers with real-time evidence-based insights. These tools have been shown to increase patient access to care and reduce denial rates.

- **Integrated Population Health & Utilization Management Solutions:** Vendors are combining AI-driven UM platforms with CM solutions to create a more balanced approach to healthcare delivery. These integrated platforms enhance provider-payor collaboration, optimize claims adjudication, and improve patient outcomes through automated data processing.

- **AI-Enabled Process Optimization in Utilization Management:** AI-driven platforms are introducing intelligent automation to complex, knowledge-intensive workflows across the UM value chain. By deploying orchestrated AI agents, these solutions facilitate efficiency gains in authorization processing, allowing clinical teams to focus on patient-centered care.

As AI capabilities continue to expand, their role in UM operations will likely catalyze a paradigm shift similar to broader digital enterprise transformations. KPMG LLP (KPMG) research highlights AI's potential as a force multiplier for innovation, consistently delivering measurable value and unlocking new capabilities. Automation and AI are actively reshaping UM practices, empowering payors to embrace streamlined operations,[18] accelerated decision-making, and enhanced member care.

Delivery Model Enhancement and Emerging Global Delivery Models

Payors must check that their operating models remain agile and scalable to help maximize efficiencies from advanced technologies. This requires reengineering both local and global operating models for innovation, modernization, and scalable UM. A shift from rigid, transaction-heavy models to intelligent, value-driven platforms that integrate clinical insight, data, and technology is essential.

Expanding capabilities through global approaches

Global Capability Centers (GCCs), located in regions like India, the Philippines, Eastern Europe, and Latin America, are evolving from back-office hubs to strategic extensions of UM operations. Health plans are investing in these centers for cost savings, operational scalability, 24/7 coverage, and rapid UM workflow innovation. GCCs offer payors access to a diverse talent pool, drive cost efficiencies, and facilitate strategic goal achievement. They contribute to payor adoption and advancement in the following ways:

- **Supporting a wide range of clinical and administrative functions,** including first-level clinical reviews performed by trained nurses and pharmacists who assess PA requests against medical necessity criteria.

- **Efficiently managing routine tasks** like document intake, standardized clinical triage, and flagging exceptions.

- **Implementing process automation** to intelligently ingest and route requests, where robotic process automation (RPA) and AI are deployed, often using technologies[19] like natural language processing and optical character recognition to streamline workflows.

- **Managing large-scale data operations,** generating performance reports,[20] analyzing denial trends, and providing insights[21] to enhance UM decision-making.

- **Offering 24/7 provider and member support,** reducing the workload on domestic teams.

Collectively, these shifts transform GCCs into strategic platforms for innovation, scalability, and speed in UM.

Delivery Model Enhancement and Emerging Global Delivery Models continued

Localizing approaches to meet member needs

Payors are also moving from standardized, centralized UM models to locally tailored approaches reflecting regional care delivery systems' complexities. This involves decentralizing certain UM functions, empowering local market teams to adapt utilization policies based on provider performance, population needs, and regional cost trends. This approach enhances collaboration with providers, including initiatives like "gold carding," which exempts high-performing clinicians from PA requirements.

In mature markets, health plans are adopting delegated UM models, allowing trusted provider groups to manage utilization internally while maintaining oversight. These localized strategies, supported by market-specific data and analytics, help identify inefficient utilization patterns and guide real-time interventions.

Market teams often engage with clinical groups to co-develop evidence-based care pathways in high-cost areas such as oncology, orthopedics, and behavioral health. These localized UM approaches foster trust, improve precision, reduce administrative burden, and align with value-based care goals, further enhancing provider engagement and patient outcomes.

To navigate the evolving UM landscape, payors must adopt innovative operating models, invest in advanced technologies, and integrate modern service delivery frameworks like GCCs. Aligning workforce capabilities, governance structures, clinical collaboration, and technological infrastructures with the future of UM can drive significant improvements in population health and amplify the benefits of emerging innovations.

These localized UM approaches foster trust, improve precision, reduce administrative burden, and align with value-based care goals, further enhancing provider engagement and patient outcomes.

Reimagining UM: APMs and CM at the Core

Shifting away from traditional fee-for-service (FFS) models, value-based and alternative payment models (APMs) are emerging as key strategies to reduce unnecessary utilization and improve care quality. These models reward providers for better patient outcomes and cost control, rather than simply increasing service volume. UM is becoming a proactive, cooperative, and data-driven process, with CM playing a central role.

Under FFS systems, UM often involves reactive, case-by-case PAs and medical necessity reviews. APMs shift this approach fundamentally. UM transitions from transactional interactions to strategic collaboration. Providers are incentivized to manage total cost of care and population health. Since providers are incentivized to manage total cost of care and population health, health plans increasingly shift utilization oversight from centralized UM departments to points of care through accountable entities like ACOs, PCMHs, and risk-bearing provider groups.

CM should be a cornerstone of UM models, with payors integrating robust CM programs directly into provider workflows or through dedicated teams. These programs should emphasize preventive care, chronic disease management, high-risk patient stratification, and real-time clinical interventions. By prioritizing early engagement, these initiatives aim to reduce the need for downstream UM interventions, focusing on avoiding inappropriate utilization rather than issuing post-request denials.

Many value-based contracts aim to reduce or eliminate PAs for high-performing providers with strong outcomes. Effective APMs include:

- **Capitated payments** (e.g., global payments or full-risk arrangements).
- **Bundled payments** (e.g., joint replacements, maternity care).
- **Shared savings programs** with downside risk (e.g., Medicare ACO REACH).

These arrangements empower providers to make care decisions more autonomously, with payors maintaining oversight through retrospective audits, quality reporting, and total cost-of-care benchmarks.

To truly operationalize this shift, payors must invest in:

- **Improved risk stratification engines** that identify patients likely to drive avoidable costs.
- **Integrated platforms** that combine UM, CM, and population health tools.
- **Provider dashboards** that track utilization trends, quality metrics, and contract performance.
- **Embedded care navigators or virtual case managers** who coordinate services and reduce duplication or unnecessary escalation.

Strong relationships with providers are essential. APMs foster trust between payors and providers, shifting focus from adversarial UM denials to synergistic care pathway design, evidence-based protocol agreement, and shared accountability. This approach is particularly effective in specialties with high treatment variability, such as cardiology, oncology, and behavioral health, where outcomes depend heavily on coordinated care.

How KPMG Can Help

The dynamic healthcare landscape requires payors to continuously advance their UM programs to align with strategic objectives. Balancing cost control with the need to establish clear UM boundaries presents a complex challenge. KPMG offers extensive knowledge and experience to navigate this intricate terrain.

With an established track record of assisting payors in enhancing their UM operations, KPMG provides a suite of services, including operational assessments, target operating model design, code value analysis, technology implementation, and transformation management.

By working with KPMG, payors can effectively address market pressures and regulatory challenges while balancing utilization, controlling costs, and delivering exceptional care to their members.

Recent Examples of Our Work

UM Solution Implementation for a Regional Payor

With an established track record of assisting payors in enhancing their UM operating models, a regional payor engaged KPMG to select and implement a new UM solution as part of a broader platform replacement initiative. KPMG's advisory services included:

- **Detailed Current-State Assessment:** Analyzed the existing UM environment, vendor landscape, and internal infrastructure to identify capability gaps and improvement opportunities.

- **Future-State Definition:** Developed a strategic roadmap outlining the target-state UM capabilities and transformation objectives.

- **Business Value Quantification:** Designed a measurement framework to assess the new solution's impact on operational performance and clinical outcomes.

- **Implementation Enablement:** Provided architectural recommendations and a detailed implementation plan, promoting alignment with overarching enterprise goals.

UM Transformation for a Major Payor

KPMG partnered with one of the nation's top five payors to transform its UM operations as part of a system-wide clinical excellence initiative. Key components of our engagement included:

- **Thorough Assessment:** Identified inefficiencies, defined improvement opportunities, and developed a roadmap for integrating UM capabilities aligned with clinical policies.

- **Strategic Value Framework Creation:** Built a detailed framework to prioritize initiatives and track performance against defined clinical and operational goals.

- **Platform Consolidation and Behavioral Health Integration:** Led the migration to a unified UM platform and developed a targeted value model for behavioral health capabilities.

- **Agile Delivery Model Assessment:** Analyzed the payor's agile delivery practices and provided actionable recommendations to enhance product development efficiency and responsiveness.

References

1 Centers for Medicare & Medicaid Services. (2024, January 17). *CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).*

2 State of New Jersey Department of Banking and Insurance. (2024). *Bulletin No. 24-17: Ensuring Transparency in Prior Authorization Act (P.L. 2023, c. 296).*

3 State of Michigan. (2022, April 7). *Enrolled Senate Bill No. 247.*

4 Vermont General Assembly. (2024). Act No. 111 (H.766): *An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts.*

5 Bailey, V. (2022, July 20). *Medicaid Beneficiaries Face Barriers to Cancer Care Access.* TechTarget.

6 Salzbrenner, S. G., Lydiatt, M., Helding, B., Scheier, L. M., et al. (2023, July). *Influence of Prior Authorization Requirements on Provider Clinical Decision-Making.* The American Journal of Managed Care, 29(7), 331–337.

7 NORC at the University of Chicago. (2024, November). *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management.*

8 Blue Shield of California. (n.d.). *Prior Authorization.*

9 Panthaloor, A. (2025, January 16). *Where AI can deliver benefits in the payer value chain.* Health Data Management.

10 NORC at the University of Chicago. (2024, November). *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management.*

11 Blue Shield of California. (n.d.). *Prior Authorization.*

12 Optum. (n.d.). *AI Solutions for Utilization Review.*

13 HFMA. (2023, July 27). *How leveraging artificial intelligence in utilization management can enhance your revenue cycle.*

14 Availity. (2024, June 4). *Creating a Direct Connection between Payers and Providers Through AI.*

15 Productive Edge. (n.d.). *Transforming Utilization and Care Management with Agentic AI* [Case study].

16 Health Catalyst. (2021). *UnityPoint Health: AI-Enabled Care Management Reduces Healthcare Spending by $32.2M.*

17 Huggins, J. (n.d.). *How Implementing a Utilization Management Strategy Impacts Member Care.* Inovalon.

18 KPMG. (2025). *AI and Transformations: The enterprise power couple.*

19 Roy, D. (2025, April 7). *How GCCs are Supporting Digital Health Initiatives.* InOrg.

20 nasscom. (2024, May 13). *Global Capability Centers (GCC) Quarterly Landscape Report.*

21 Mocskonyi, N.D. (2024, December 10). *The Future of Global Capability Centers: Trends, Forecasts, and Expert Insights for 2025.* InOrg.

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