A calculated risk

Assessing when and how healthcare providers can launch and scale successful health plans – and when they can’t.
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The subject of hospitals launching health plans is not new. Many large hospital systems have evaluated vertical integration into the plan space during earlier periods of industry disruption, most notably in the mid to late 1990s. This time, however, the climate has evolved. Greater levels of consumer and physician acceptance of the need for change, increasing provider consolidation, and significant investments in the physical and technical infrastructures required to manage risk effectively are all providing potential tailwinds for providers seeking to enter the health plan space.

These and other factors are driving a new wave of interest in provider-led plans. Approximately 700 hospitals in the US already have an equity stake in an HMO, and twenty-five percent of the new plans being offered through public marketplaces in 2015 were provider-owned.

While many provider-led plans continue to focus on their own employees, other hospitals have responded to demographic and regulatory changes with external growth plans.

Given this renewed attention, it is perhaps not surprising that the opportunities and risks of launching plans are well understood by many health system executives. Those who are more bullish on the topic typically site three broad benefits from the strategy, which include the ability to:

- Capture a greater proportion of the premium dollar by effectively disintermediating commercial payers
- Retain control over the total cost of care via narrow network products and improved referral patterns
- Develop organizational capabilities transferable to other risk-bearing and/or value-based contracts

While averages can be deceptive, the overall success of these plans has helped provide further support for proponents of the trend. Profit margins for many of them have been broadly similar to traditional payers, which often have much larger membership bases.

Skeptics, on the other hand, can point to some high-profile failures. Some provider-owned plans simply didn’t enroll enough members. Others suffered the far worse fate of enrolling too many but failing to control the cost of care. In both cases, potential losses can run well into the tens of millions.

So does it make sense for providers to launch their own plans or double down on their existing plan investments? The answer is: it depends. Minor differences in market dynamics or system capabilities can mean that what makes sense for one provider may prove disastrous for another. Even where market entry does make sense for a system, this may not be the case in every county its network touches.

This white paper is meant to give readers an insider’s look at what it takes to evaluate the viability of launching a provider-owned health plan, and to provide an overview of how to scale one effectively post-launch.

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1 Herman, B. (2013). Providers becoming payors: Should hospitals start their own health plans? Becker’s Hospital CFO.
This paper outlines five key questions providers must ask themselves in order to navigate some of these complexities:

“Why do we want to play the game?” Achieving stakeholder alignment around this fundamental question is critical to a successful plan launch.

“Do we have what it takes to play?” With the rise of interest in population health management, many providers believe they have already addressed this point. However, further investments will be required and should be carefully quantified and parsed by product segment (Medicare Advantage, individual exchange, etc.).

“What stakes are we playing for?” Answering this question effectively requires detailed financial modelling informed by actuarial assumptions and market insights.

“How will we win?” Provider-owned plans will never be able to beat commercial payers at their own game. Instead, they must change the playing field by focusing on their unique capabilities and hyper-local economies of scale to reduce the total cost of member care.

“What unintended consequences might arise?” Providers must project how commercial payers may react to their market entry in terms of rate pressures, network design, member steerage, and utilization management.

The next section shifts away from market-entry considerations to focus on the question of scaling provider-owned plans following launch. We discuss the different types of operating models that providers are exploring or already employing successfully for their own plans. These include what we call Stand Alone, Loosely Integrated and Tightly Integrated models. As we will discuss, the choice is highly dependent on the market being served, the local competition, and the specific capabilities of the provider system in question.

Whether considering market entry or scaling a plan, a critical trap to avoid is trying to replicate too many health plan capabilities within the context of the provider organization. This kind of me too approach is prone to failure for a range of reasons – differing cultures, lack of expertise, local competition with commercial payers, limited or expensive access to growth capital, etc. Perhaps most important, it is virtually impossible to compete on scale with commercial health plans and the effort can distract provider organizations from their own competitive advantages – namely their ability to manage the total cost of care for a population and find new ways to engage consumers and physicians.

For those that take a carefully calculated risk to enter the plan market and scale their operations effectively, focusing on these capabilities has the potential to help create a new paradigm in which the patient is central and care is integrated and coordinated system wide. In such cases, it will be possible to lower the total cost of care, price competitively and capture share from much larger plan rivals. These shifts are helping to spur a new wave of interest in provider-led plans.
With the ebb and flow of interest in provider-owned plans, it is not unusual for the subject of entering the plan space to have been on and off the executive team agenda for two decades or more. In cases where market entry would have proven advisable, such failure to act can have real consequences, e.g., ceding ground to commercial payers and missing a narrow window for establishing viable membership bases and risk pools. In cases where entry would have led to significant losses, system executives may reasonably claim to have dodged a bullet. However, there is still a cost inherent in indecision, as valuable time and focus are squandered.

To avoid these pitfalls and to have a framework for decision making, we suggest that system executives focus on the following five key questions. Although doing so won’t guarantee success, it can help turn gambles into calculated risks. It can also help systems choose the most appropriate operating model or walk away when the cards are stacked against them from the start. The questions are as follows:

1. Why do we want to play the game?

This seemingly simple question is often the hardest to answer. Senior stakeholders can have very different ideas about the potential benefits of owning a health plan. Some may see the move as a catalyst to geographic or demographic expansion—enabling the plan to reach a larger patient base encompassing new counties. Others may point to opportunities to better incent and engage providers to improve referral patterns, decrease leakage and increase inpatient volumes in core markets. Another set may champion using health plan ownership as a kind of pilot program for greater risk-bearing with commercial and government payers. Then there may be those for whom launching a plan amounts to a moral imperative—a chance to live up to their view of obligations to patients and the broader community.

Spending time up front to clearly articulate and align on a vision and set of objectives is critical. The goal is to balance differing views while avoiding being all things to all people. A key consideration is defining how the health plan strategy ties to the broader strategic objectives of the system as a whole, such as meeting the needs of a particular demographic group; enhancing capabilities in managing chronic conditions; or, as in the case of plans with a tightly integrated operating model, capitalizing on the health system’s established brand. The vision may well need to evolve as the organization addresses the other four questions outlined below. Nonetheless, it will provide a kind of North Star to help guide the development of the overall system strategy.
To compete with commercial payers, provider-owned plans must build or outsource a broad range of capabilities across the front, middle and back offices of the payer value chain. A valuable first step is mapping capabilities against those required to perform each value-chain activity. (See Figure 1 below.) By doing so, a provider organization can develop an objective picture of the current-state challenges.

A key output of this process is a preliminary financial model that estimates what the capital expenditures and recurring costs of scaling to a target membership level could be under reasonable base-case assumptions. This, in turn, will feed into which operating model is ultimately chosen. The exercise should include a number of scenarios based on key operating model decisions – for example, whether the organization will outsource front and back office functions that are wholly new to the system (e.g., claims processing) or whether it will repurpose and expand the scope of existing assets and resources to meet new commercial and regulatory requirements (e.g., in middle office areas such as disease management and case management).

The initial modelling phase should also include a preliminary actuarial assessment of the likely risk-based capital requirements for supporting various enrollment levels with the understanding that enrollment numbers may increase exponentially over time, allowing an organization to evolve from a tightly integrated plan to a loosely integrated one, or even to a stand-alone entity. It is important to remember that, even under relatively modest enrollment assumptions, the plan may tie up tens of millions of dollars, a fact that may come as an unpleasant surprise to systems already struggling with capital constraints.

Provider organizations seriously contemplating entry into the plan space often understand these points, but the devil is in the details. Most do not have a full understanding of what it takes to develop, market and support health plan products and position them for success. Similarly, organizations may not appreciate the varying capabilities required to support specific product types in different markets. For example, the people, process and technology requirements associated with selling and marketing large group commercial products bear little resemblance to those required to sell individual exchange products.
What stakes are we playing for?

This question can be divided into two related questions. First, how large is the potential market opportunity within the specific geographic markets and product segments being targeted? Second, what share of this opportunity can be captured based on proposed price points and competitive positioning in the market?

To take the question of market opportunity first, the focus should be on the bottom line, not the top. It is easy to fall into the trap of quantifying the market size in terms of revenues. However, plan profitability can vary widely by product line, geography and year. The real challenge then is to quantify and ideally project available profit pools at a county (or even sub-county) level. Doing so is essential but not simple. This type of analysis requires structured research with data from multiple sources. At a minimum, an effective market model should comprise data from claims systems, government websites, competitors’ state and federal public filings, and community agencies, as well as actuarial assumptions and qualitative interviews with experts familiar with local market dynamics.

The question of market share is still more challenging. This requires assumptions based on a combination of supply- and demand-side inputs and analyses. On the supply side, provider systems should carefully analyze competitor products to understand how their proposed plan offerings will stack up in terms of network breadth, price, product features, and more. Consideration should also be given to potential new market entrants with the capacity to significantly disrupt the current market structure. On the demand side, systems should seek to understand the characteristics and needs of consumer segments as they relate to their target product lines; which segments they can and will aim to target; and how many members they can expect to convert to their products given their sales and marketing plans and consumer willingness to switch carriers.

To achieve all this, the system will likely need to invest the time to develop initial product concepts (e.g., product design, network design and proposed pricing). These concepts can be used in qualitative and quantitative consumer market research. The output can then be used to inform scenario modelling of both the top line and bottom line. The former should include assumptions related to enrollment levels and premium rates by product and county. The latter should combine estimated operating and capital expenses along with claims cost estimates and resulting medical loss ratios.
The path less trodden

The short answer to the question of how provider-owned plans can win is by not trying to beat health plans at their own game. Or at least by not engaging them in the game as they used to play it. It is important for provider-owned plans to realize that they will likely always be disadvantaged compared to established commercial health plans across many parts of the traditional industry value chain.

When it comes to back office functions, such as enrollment, member services, claims processing, and billing, provider-owned plans’ lack of scale will amount to significant cost disadvantages on a per member per month (PMPM) basis. Similarly, front office functions, such as sales, marketing, product development, and underwriting, can and likely should be outsourced by provider plans to third-party vendors. Even so, the costs of securing and managing those contracts will likely still leave most of them lagging behind their commercial competitors on a PMPM basis. Perhaps the harshest reality for provider systems to face is the fact that commercial plans’ network breadth, depth and even quality may far exceed what they are able to offer for a comparable price point today.

And yet, this is yesterday’s game in many markets and product segments. In today’s world of economic, demographic and regulatory pressure, the focus is increasingly on middle-office functions and how they can help reduce the total cost of care. For example, plans are investing in areas such as enhanced risk stratification; screening and prevention of chronic conditions; targeted medical management for high utilizers; and provider incentives to decrease variability of outcomes for major episodes and complex conditions.

This shifting focus creates both competitive pressures and opportunities for provider-owned plans. Physicians, patients and other stakeholders are growing increasingly used to plans engaging with them differently. And this way of interacting means the infrastructure to change care management and delivery is gradually emerging. In this new world, the answer to the question of how provider-owned plans can win boils down to their ability to manage the total cost of care better than commercial payers.

Going local

We see several ways providers can achieve the goal of providing superior total cost of care management. Each of them is oriented around differentiating the plan by turning an apparent weakness (i.e., their localized and often subscale nature) into a strength:

The first is to focus on assets and resources that are unique to the provider organization in question.

These can be used to develop capabilities in select middle-office functions. For example, traditional health plans have long struggled with gaining access to clinical data and integrating it with claims data to develop more effective models of consumer engagement and care management. Given their access to electronic medical records and other patient data sources, provider-owned plans may elect to put resources behind clinical informatics while maintaining a lean organization at other points in the value chain.

Another potential hospital differentiator is access to affiliated physician groups and other ancillary care workers. The relatively high degree of control over these providers and supporting team members may present systems with opportunities to decrease the total cost of member care. For example, systems with large physician rosters may be well placed to encourage multi-disciplinary teaming or to foster the use of specific protocols to help reduce clinical variation. Such initiatives can improve resource utilization, shift the care of high-cost patients to lower cost settings, help reduce readmissions, and help prevent or forestall the development of chronic conditions among high-risk members.

| KPMG | Five questions (continued) |

4 How will we win?

The second is to reduce the cost of care by creating *hyper-local* economies of scale.

Put simply, this means finding ways to be a *big fish in a small pond*. For example, a provider system contemplating the launch of a new Medicare Advantage plan may estimate that its likely share of a region’s population will leave it sub-scale relative to other competitors. Nonetheless, the brand, network and supporting services may present opportunities for the system to be a market leader in terms of membership in specific zip codes. Identifying and understanding these pockets of membership concentration can present important opportunities for provider-owned plans to realize returns on investment. For example, the provider might choose to embed behavioral health specialists or case managers into a handful of primary care sites where member traffic is particularly high – helping them to better manage high-risk and high-utilizer individuals. The cost of such investments can then be offset by reductions in the total cost of care for this highly localized population. By contrast, such an approach may make little economic sense for a plan with membership that is more evenly dispersed across a region.

The third way providers can gain an advantage by controlling medical expenditures is to invest in local market understanding.

Provider-owned plans may seek to become experts on the health needs and resources available within a given community. This can be accomplished by developing a centralized data repository that integrates, not only claims and clinical data but, a wide range of other health-status and risk indicators. Such factors as literacy, housing, education, and nutrition status can be aggregated at the zip-code level to help inform disease and care management. Beyond data collection, provider systems may seek to become authorities on the full range of clinical and community resources available to membership in select areas. For example, they may foster relationships with community leaders, substance abuse support groups and local businesses to help develop infrastructures for better wellness, disease and care management for plan members and the wider community. In effect, this approach combines aspects of the first two since it leverages unique assets of the organization (e.g., relationships, data sources) and significant investments at the local level, which commercial plans most likely cannot match. While any of the paths described above is a viable option for provider plans to win in their target markets, it is important to recognize the scale of the challenges involved. Most commercial payers can spread investments in informatics, wellness, disease management, and consumer engagement across membership bases that dwarf even the most successful provider-owned plans. For a commercial health plan, a $10M investment can mean a $10 one-time cost per member for a plan with a million covered lives (or roughly 83 cents PMPM over a single year). By contrast, the same $10M investment would equate to $16 PMPM for a provider-owned plan with only fifty-thousand covered lives. This is more than enough to price such plans out of most markets. Therefore, it is imperative for provider-owned plans to remain laser focused on the unique assets and resources that differentiate them, as well as on targeted investments in areas of relatively high membership density.
Five questions (continued)

5 What unintended consequences might arise?

Provider systems typically focus on one or more of a set of four potential unintended consequences when evaluating market entry into the plan space. Each relates to a different reaction from their existing payer base to the fact that they have effectively become a direct competitor in a local market. They are concerned that:

- Payers may put increasing pressure on rates during contract renewal periods.
- Payers may develop narrow or tiered network products that favor other local provider systems.
- Payers may find ways to steer members to other systems via changes in consumer engagement strategies, benefit designs and other mechanisms.
- Provider-owned plans may come under increased scrutiny for their utilization management (UM) efforts.

These risks can be real and their potential impact should not be underestimated. On the other hand, anecdotal evidence and gut feelings should not be the basis of postponing or canceling a proposed plan launch. Instead, systems should go through a structured process to understand and quantify the potential financial impact of each of these risks at a payer-by-payer and county-by-county level. This requires a combination of detailed analytics and executive judgment.

In terms of analytics, systems should break down their revenues by payer, product line and county at both the facility and physician levels. The resulting data should then be combined with an understanding of each payer’s relative local scale by service line to develop a snapshot of how significant the payer is to the provider and vice versa.

In terms of executive judgment, network development and contracting experts at the health system should weigh in on assumptions about likely payer reactions. In doing so, they can often provide valuable insight into the nature of the system’s relationships with specific payers and the tenor of past negotiations. In some cases, this process will be enough to persuade systems that the risk of entry is simply too great. In other cases, however, each of the four risks outlined above may prove to be less serious than previously anticipated.

For example, rate pressure is a reality in all contract negotiations, with ultimate agreements reflecting the parties’ relative market power rather than particular strategic decisions, such as launching a rival health plan. Similarly, the risk of payers making retaliatory network design decisions can clearly have a dramatic impact on a system’s financial well-being. However, in most cases where plan entry is a viable option, the health system will already enjoy strong local market share, making it challenging for payers to exclude them from products if they aim to remain competitive in the market.

As for the risk of increased steerage or scrutiny of utilization management, these are real threats but, in many cases, they are levers that plans will already have pulled and will likely have only a minimal impact on future provider payments as a result. Faced with these reactions from payers, providers may choose to model a downside scenario in which they suffer modest revenue reductions from select plan populations that are offset by the projected benefits of entering the plan space.

Finally, as the picture of the opportunity is built up, it is also important to bear in mind that hospitals with potential membership bases that cross county or state lines are subject to multiple sets of state regulations, some of which might contradict each other, as well as varying profit pools, reimbursement rates, patient access regulations, and more. Failure to put appropriate risk and compliance structures in place to navigate these complexities can lead to costly unintended consequences in the form of fines, settlements, or damages to the organization’s reputation.
## Summary of market-entry considerations

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<tr>
<th>Market-Entry Question</th>
<th>Common Challenge</th>
<th>Leading Practices</th>
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<tr>
<td>Why do we want to play the game?</td>
<td>Aligning stakeholders on targeted future state</td>
<td>• Spend time clarifying corporate vision and objectives</td>
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<td>• Clearly articulate how launching a plan ties to system-wide goals</td>
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<td>• Use vision to guide strategy, but maintain flexibility in light of new evidence</td>
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<td>Do we have what it takes to play?</td>
<td>Understanding variations across product sectors and markets</td>
<td>• Map capabilities to value-chain activity</td>
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<td></td>
<td>• Develop preliminary financial model, including capital expenditures and recurring cost estimates at varying membership levels</td>
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<td>• Conduct an actuarial assessment to inform an initial risk-based capital assessment</td>
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<td>What stakes are we playing for?</td>
<td>Quantifying and projecting profit pools at a county or sub-county level</td>
<td>• Conduct structured research with data from multiple sources to understand needs by consumer segment and product line</td>
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<td>• Analyze competitive positioning versus incumbent plans and potential new entrants</td>
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<td>• Develop scenario models based on top- and bottom-line assumptions</td>
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<td>How will we win?</td>
<td>Finding true differentiation from commercial health plans</td>
<td>• Focus on middle-office functions’ ability to reduce total cost of care for targeted populations</td>
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<td></td>
<td></td>
<td>• Integrate clinical and claims data to enhance consumer engagement and care management programs</td>
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<td></td>
<td></td>
<td>• Target local populations with care offerings and support leveraging local market data and understanding</td>
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<tr>
<td>What unintended consequences might arise?</td>
<td>Assessing the impact of potential payer reactions</td>
<td>• Quantify financial impact of risk on a payer-by-payer and county-by-county level</td>
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<td>• Balance potential downside scenarios with the benefits of entering the plan space</td>
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<td>• Put risk and compliance structures in place to manage conflicting county-based regulations</td>
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Once provider organizations answer these five questions to assess the risk of moving into the health plan space, they need to turn their attention to how closely integrated they intend the hospital and health plan to be. Making this choice is less dependent on what they are than on what they want to be. Hospitals must analyze how they want to approach matters of branding, operations, reporting lines, governance, outsourcing, utilization management, demographics, targeted number of members, and more.

In our view, there are three broad models of provider-owned plans—Tightly Integrated, Loosely Integrated and Stand Alone. While some hospitals may start as narrowly as only insuring their own employees, many do aspire to become stand-alone plans. This will not be for everybody. However, when it is a viable option, it is important to recognize that a hospital can enter the health plan space under the aegis of any of these models without progressing through the different phases.

Developing and implementing a scalable operating model

Tightly integrated model

For hospitals that have already embraced the HMO model and have a large group of affiliated primary care physicians (PCPs) and specialists, it may be feasible and attractive to integrate the hospital and the health plan in terms of branding, technology, operations, and leadership. It is helpful if there is already a roster of patients that is accepting of managed care, as well as high deductibles and premiums. These plans can really excel in the areas of medical and utilization management, by mandating close adherence to health plan protocols and the use of evidence-based clinical decision support tools. There are a good number of health plans that fall under this model that have been in the market for some time. As we look forward, those that are seeking to market their products on the exchanges will be in a one-up position if they already have a good number of these capabilities in place.
Loosely integrated model

Mid-sized hospitals with sufficient resources may be best served by creating a health plan that is only loosely integrated with the hospital. Such organizations should look for affinities and co-branding between the plan and the system and build the health plan gradually by adding membership and appropriate product lines over time. Many organizations in this category have aspirations to do more and - once they surpass 100,000 members – will need to take steps to develop or access more mature claims systems, tightly integrate care delivery to better manage high-risk populations, and invest in front-office capabilities to better market themselves on the exchanges.

Stand-alone health plan model

For a hospital system with a dominant or very strong local market position, it may be a viable option to create a stand-alone health plan. Such plans function similarly to commercial plans and, therefore, compete more directly against them and in some cases partner with them, as well. Provider systems taking this route will need to be confident that their plans are large, strong and independent enough to attract external partnerships, including co-branded products and shared networks. Eventually, the health plan may have enough brand equity to establish itself as a separate entity not just from a legal perspective but in the sense of being a self-sufficient and-sustaining business.

Weighing market potential

**KPMG client case study**

**Problem:** A New York-area multi-hospital system was struggling to assess whether they were ready to launch a health plan product. However, it was difficult to quantify the potential opportunity and anticipate the risks as the system spanned several counties.

**Solution:** KPMG helped the health system conduct detailed market analyses comprising the following:

- Supply and demand trends, including consumer price sensitivity and competitive positioning
- Competitive review of network strategies, including price points, reimbursement rates and premiums
- Scenario modeling to reflect varying conditions, including potential enrollment, costs, and unintended consequences, such as rate pressure, network design decisions, steerage, and increased scrutiny of UM.
- Readiness assessment, including gap analysis between current and target states related to capabilities, operating model and culture

**Client impact:** Based on market analyses and scenario modeling, KPMG identified several market entry options. Each one included Net Present Value (NPV) and Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) models to assess the impact in various markets on the health system and health plan. Ultimately, the client’s senior leadership team made an informed market-entry decision based on detailed market demand and supply assessments, scenario models, and capability readiness/network assessments that reflected consumer needs and preferences and the endeavors of other payer networks.
Launching a health plan isn’t the answer for every provider. These initiatives come with considerable requirements and risks. From escalating administrative and medical costs to potential payer steerage to difficulty appealing to consumers, the issues a hospital needs to examine are countless.

On the other hand, the payoffs can be significant as well. Whether through care coordination, population health management, cost reduction, or achieving economies of scale, hospitals that successfully enter the health plan arena may be able to take a quantum leap forward in their transition to new value-based care models.

Our hope is that the questions laid out in this paper spur further thought about your organization launching its own health plan and how to identify the operating model that will meet your objectives.

Whether a hospital should launch its own health plan requires considerable analysis of system capabilities, local market demand and the proposed plan’s likely competitive position in the market. KPMG’s Healthcare practice includes a wide range of senior talent with deep experience of strategy and implementation work across both the payer and provider value chains who can help conduct such analysis and inform decision making. We also have extensive experience working with a range of provider organizations at different stages of the journey towards launching commercial, Medicare Advantage and Medicaid managed care products.

In conducting our analyses in this and other areas, our advanced data and analytics capabilities serve as the foundation. We assist provider organizations in mining and analyzing clinical, operational and financial data to better understand issues of population health, care management, improved outcomes, and brand effectiveness both nationally and on a state-by-state level – all critical variables in the strategic decision of whether or not to launch a health plan.

We appreciate that major decisions such as whether to launch a health plan need to be viewed through the lens of strategic, operational and reputational risks, as well as compliance with regulatory requirements. To this end, we bring a wide range of risk and compliance expertise to bear to help ensure clients understand and mitigate these risks and are fully prepared to comply with state and federal regulations. Finally, should organizations need support in implementing their plans, we have the operational bench strength to guide the transition from strategy to execution by deploying experts in such areas as technology enablement, transformation, performance improvement, change management, and workforce planning.
Contact us:

Ashraf W. Shehata  
US Healthcare Payer Lead  
for Advisory and Global Center of Excellence  
513-763-2428  
ashehata@kpmg.com

Alex White  
Managing Director, Advisory  
212-954-2815  
alexanderwhite@kpmg.com

Alex Marsden  
Director, Healthcare, Strategy Practice  
404-402-9514  
alexandermarsden@kpmg.com

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