

Optimizing Care Delivery: A Framework for Improving the Health Care Experience



JULY 2025



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“It’s our mission to provide Americans access to excellent care, protect our most vulnerable beneficiaries, and empower healthcare providers. America is facing a generational opportunity to build an efficient and transparent healthcare ecosystem, and CMS is working hard to delete administrative burdens that take doctors away from caring for patients.”

— CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
ADMINISTRATOR DR. MEHMET OZ



Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is the largest provider of health coverage in the United States, responsible for ensuring that more than 160 million individuals supported by CMS programs (i.e., Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplaces) receive high-quality health care. CMS has a critical role in advancing health system efficiency and improving the experience of delivering and receiving health care. Administrative burden is a persistent challenge that can come in many forms and be a factor in limiting a patient’s ability to access quality, timely care. Such frictions can take time away from clinicians and their patients, contribute to inequities in care, and negatively affect the health and well-being of the nation’s health care workforce.

These burdens can be reduced or eliminated through thoughtful interventions at all levels of the health care system. Reducing or simplifying required steps in an administrative process, making systems less onerous, and finding ways to automate tasks can all help. Advancing and enabling collective action in this direction is a top priority for CMS.

For the purposes of this Framework, CMS refers to administrative burdens as the redundant, outdated, or overly complex requirements or processes that may inhibit or delay the ability to deliver or access equitable, quality, safe, and affordable care.

The CMS Office of Healthcare Experience & Interoperability (OHEI), previously known as the Office of Burden Reduction & Health Informatics (OBRHI), leads efforts to enhance an integrated health care delivery system that is informed by and responsive to patients, the health care workforce, and CMS program individuals. OHEI’s mission is to enhance patient care, population health, and the well-being of the health care workforce through policy development, technology, and public engagement. We envision a health care system that functions seamlessly and equitably, delivering safe, high-quality care and improving overall health outcomes.

Optimizing Care Delivery: A Framework for Improving the Health Care Experience is CMS' five-year strategy for improving health care delivery and the care experience by addressing administrative burdens and other frictions in the programs it oversees as well as the health system more broadly. The Framework lays out a shared vision for CMS, in collaboration with the entire health care community, to define our highest priorities for improving the experience of care for patients, clinicians, and other stakeholders, including by reducing administrative burden. This effort will enable CMS, the health care industry, patients and caregivers, and all other relevant parties to better share ideas and challenges and pursue administrative burden reduction activities, aimed at returning time to clinicians, improving their experience of delivering care, enabling the delivery of equitable, safe, quality care, and improving health outcomes for patients.

The Framework establishes a set of seven strategic priorities to guide CMS' work to improve the care experience in health care over the next five years:



The Framework was informed by evidence-based research and public feedback received through CMS outreach. CMS has heard firsthand about challenges and opportunities related to administrative burden through a number of channels, including but not limited to the [2023 CMS Conference on Optimizing Healthcare Delivery](#), with more than 2,500 registrants; the [2022 Make Your Voice Heard Request for Information](#), which received over 4,000 comments; public roundtables with patients and providers; and twelve human-centered design (HCD) customer experience-focused engagements on topics such as Clinician Well-being, Prior Authorization, Mental Health, Chronic Pain, and more. These HCD engagements included interviews with 1,741 participants, 15 site visits, and over 25,000 individual data points generated.

CMS is actualizing these priorities through policies, programs, and initiatives and will continue to define metrics for measuring progress towards achieving our health care experience goals. This includes identifying and mitigating avoidable administrative frictions and avoiding simply transferring burden elsewhere, particularly onto those with the least resources to manage it.

No one person or organization acting alone can solve this problem. Partnering closely with the health sector on tangible solutions is essential to achieving our shared goals. By reducing administrative burden, improving the ability to navigate health care services and the health system writ large, and returning time to clinicians so they can focus on providing care, we can improve the health and well-being of our nation's patients and health care workers and create a more seamless health care experience.

Framework Priorities to Improve the Health Care Experience

This Framework defines a set of seven priorities to advance a common vision for improving health care delivery and the care experience, by reducing administrative burden and other frictions throughout the health care ecosystem. Below is a description of each of the priorities, its associated objective, a selection of current CMS efforts underway to address these priorities, and a future state we aim to realize in which the health care delivery system operates optimally, and is informed by and responsive to patients, the healthcare workforce, and customers of CMS programs. The actions included below are intended to highlight featured efforts underway and are not intended to represent an exhaustive list of CMS efforts.



PRIORITY 1: Integrate the voice of the patient and caregiver into opportunities to enhance care access and delivery.



OBJECTIVE: Engage patients and caregivers to understand their needs and challenges in their care experiences.

Ensuring the needs of patients and their caregivers are included in all aspects of their healthcare is foundational to improving the health care experience. Improving the experience of receiving health care for patients and caregivers involves an inclusive and wide-ranging approach that includes ongoing engagement, streamlining enrollment into programs, and easing access to quality, safe, equitable, and coordinated care. CMS is addressing this priority by engaging directly with the patient and provider community to understand the care experience and identify where burdens and challenges exist. This includes meeting people where they live and work to better understand their issues and challenges.

For example, CMS conducted 1,148 rural-related activities, including 125 direct listening sessions with rural partners in 2023, and in-person visits in 42 states and territories. Delivering exceptional service and effective care requires understanding the lived experience of patients and caregivers and ensuring that their voices inform CMS' policy work. Their voices are essential to CMS. We hear the feedback and concerns of those served by our programs through several mechanisms, including HCD engagements, requests for public comment, conferences, small-group engagements and meetings, and other data sources.

As CMS undertakes this effort, we are mindful that reducing administrative burden for clinicians and others in the health care sector should not include the shifting of administrative tasks onto patients, which may negatively impact timely access to care. There is significant evidence indicating that requiring patients to complete administrative tasks can result in delayed or forgone care. A 2021 study found 25% of patients delayed or forwent care due to the burden created by administrative tasks and that this barrier has a comparable effect to a cost-related barrier (e.g., high copay).¹ Another study of caregivers of children and youth with special health care needs found that increased time

spent coordinating care was associated with an increased probability of forgone medical care, and that Hispanic, low-income, and publicly insured or uninsured people are disproportionately affected.ⁱⁱ

CMS is undertaking several actions to integrate the voice of patients and caregivers into opportunities to improve the healthcare experience.

CMS recently finalized a rule streamlining and simplifying how people enroll in and renew Medicaid and CHIP coverage. The rule eliminates waiting periods for CHIP coverage, making it easier for children to be seamlessly transferred from Medicaid to CHIP when their family's income rises. It requires states to provide all applicants with at least 15 days to provide any additional information missing from a first application and 30 days to return needed documentation when applying to renew their coverage. The rule also prohibits states from conducting renewals more frequently than every 12 months with limited exceptions, and from requiring that older adults and those with disabilities attend in-person interviews. The rule also eliminates the requirement to apply for other benefits as a condition of Medicaid eligibility to ensure eligible individuals are not facing unnecessary administrative hurdles.



As part of the Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F), CMS finalized policies to increase the percentage of dually eligible managed care enrollees who receive Medicare and Medicaid services from the same organization. Dually eligible individuals face a complex assortment of enrollment options. The rule will improve experiences and outcomes for dually eligible individuals by increasing the percentage of enrollees who are in dual eligible special needs plans (D-SNPs) and affiliated Medicaid managed care plans, as opposed to D-SNPs that differ from the enrollee's Medicaid plan.

Finally, the Center for Medicare and Medicaid Innovation is currently implementing the *Guiding an Improved Dementia Experience (GUIDE)* Model, which focuses on dementia care management. People with dementia may have multiple chronic conditions and behavioral health needs, which can require hospitalization, residential services, or care from across the health care system, often leading to a fragmented care experience and increased hospital utilization. The challenges of managing care, providing continual support, and managing behavioral and psychological symptoms of dementia can present a significant mental, physical, emotional, and financial burden for caregivers and disproportionately impact Black Americans, Hispanic Americans, and Asian Americans and Pacific Islander populations. The *GUIDE* Model aims to improve quality of life for people living with dementia, reduce strain on their unpaid caregivers, and enable people living with dementia to remain in their homes and communities.

As part of the quality strategy for the model, patient-reported outcome measures (PROMs) assessing individual quality of life and caregiver strain will be included; these measures are essential to centering the patient in their care experience and reducing burdens. This policy reflects the Innovation Center's efforts to demonstrate quality improvement in models, with a strategic goal for 75% of models to include two or more patient-reported outcome measures (PROMs) by 2030.ⁱⁱⁱ

CMS is committed to building a health care system across all communities where the patient experience is central. Health care providers, health plans, and other health care organizations can achieve better health and higher satisfaction by elevating customer experience (e.g., surveying and responding to patient preferences and improving plan enrollees' ability to find the information they need in online provider directories). Continually listening and responding to the needs of those we serve better informs our policies, programs, and initiatives and better equips us to ensure access to equitable, high-quality health care delivery.



PRIORITY 2: Improve patient safety and reduce administrative burden in care transitions.



OBJECTIVE: Ensure safe, coordinated, and timely care transitions.

Coordinating patient care across providers and care settings is essential for ensuring high-quality outcomes. Transitioning from one provider or setting to another is a particularly vulnerable time. Poorly managed transitions in care can negatively impact health outcomes and increase costs. Evidence indicates that inadequate management of care transitions can lead to unnecessary readmissions, preventable adverse events, and drug-related errors. Potentially preventable readmissions in Medicare are estimated to cost around \$12 billion a year.^{iv} Importantly, inadequately managed care delivery, including care transitions, can lead to a litany of downstream events that can be detrimental to patients and contribute to workforce burdens and, in turn, clinician burnout.

CMS is undertaking several actions to address the challenges that clinicians, caregivers, and patients experience to ensure care delivery is coordinated. For example, in calendar year 2024, CMS began making payments to practitioners to train caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan. This action is intended to not only pay practitioners for their time in supporting caregivers but also to reduce burden on caregivers by better equipping them with information to care for their loved ones.

Additionally, the Innovation Center is testing a new acute care episode payment model, the *Transforming Episode Accountability Model (TEAM)*, which focuses on coordinating care for people with Traditional Medicare who undergo one of the surgical procedures included in the model. Acute care hospitals would assume responsibility for the cost and quality of care from surgery through the first 30 days after the person with Medicare leaves the hospital. The *TEAM* model will continue important improvements in care transitions, including referrals to primary care following hospitalization.^v

CMS also launched the *Care Transitions Human-Centered Design Customer Engagement* in Fall of 2023 with the goal of better understanding how emergency department and inpatient hospital care transitions impact patients and providers, including their mental health and wellness. As part of this engagement, CMS staff spoke with 99 individuals from across the country, including patients, caregivers, providers, advocates, and health system administrators. CMS anticipates releasing more information detailing our findings and next steps in 2025.

Finally, CMS sponsors the [Post-Acute Care Interoperability \(PACIO\) Project](#), which began in 2019 as a consensus-based, collaborative effort, including representatives from the federal government, standards organizations, providers, and industry, to advance interoperable, post-acute care health data exchange across the health care ecosystem with the goal of improving care coordination for patients who interact with various providers across settings. The primary goal of the PACIO Project is to establish a framework for the development of Fast Healthcare Interoperability Resource (FHIR®) implementation guides and reference implementations that facilitate health data exchange across providers through the use of case-driven application programming interfaces (APIs). The PACIO project consists of multiple, community-led use cases, including Transitions of Care, Personal Functioning and Engagement, Standardized Medication Profile, and Advance Directives.

Transitions in care can be negatively impacted by avoidable obstacles and challenges. CMS envisions a health care system where care transitions are safe and seamless and a health care ecosystem in which vital patient information follows the person. Providers, caregivers, and patients alike should be able to easily view care plans and medication lists for patients admitted after receiving services from a different care setting, and caregivers and families should feel confident supporting their loved ones as they undergo treatment. Together, we should ensure that every patient receives coordinated care as they traverse across the trajectory of the care, including by addressing obstacles that impede information sharing and impact the capacity for clinicians in their efforts to provide high-quality care.



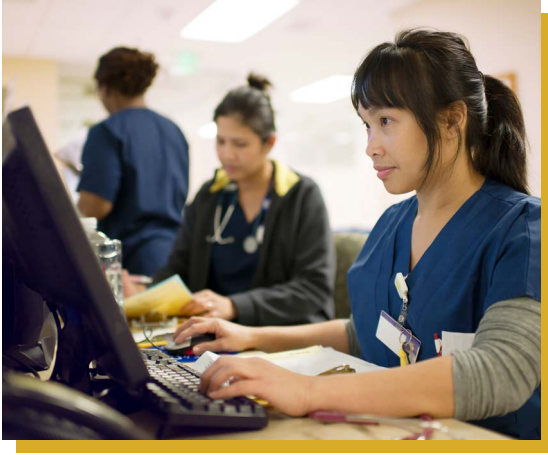
PRIORITY 3: Address well-being and experience for health care workers across the health care enterprise.



OBJECTIVE: Support the overall health and needs of all care team members.

The COVID-19 pandemic exacerbated the stress of, and demands on, the health care workforce, leading to increased reports of fatigue, loss, and grief. In a 2022 Surgeon General Advisory on health worker burnout, it is stated that there is a moral obligation to address the long-standing crisis of burnout, exhaustion, and moral distress across the health community.^{vi}

According to a Centers for Disease Control and Prevention (CDC) study, the health care workforce has increasingly reported higher rates of burnout and harassment. Between 2018 and 2022, nearly half of health care workers said they were looking for a new job.^{vii} Findings from a 2023 study on health care work overload and burnout also found that there is an elevated prevalence of burnout or intent to leave across various roles in the health care system, including among nurses and non-clinical health care staff.^{viii} And according to a 2023 report, 73% of all nonfatal injuries related to workplace violence in 2018 involved health care workers.^{ix} Further, burden falls unequally: A 2023 study from the American Medical Association found that female physicians reported burnout at a higher rate than their male colleagues and reported feeling less valued by their organization. There is also recent evidence linking clinician burnout to increased risk for medical errors and adverse patient outcomes.^x



To better understand the challenges and opportunities for improvements, CMS launched an HCD customer engagement at the beginning of 2024, focusing on how administrative burdens are impacting health care delivery and the clinical workforce. This work is ongoing, and CMS is engaging directly with clinicians of all specialties and licensure to capture their lived experiences in providing and coordinating care.

CMS is undertaking several actions to address the well-being and experience of health care workers.

For example, CMS is awarding 1,200 Graduate Medical Education (GME) slots, as authorized by statute, to enhance the health care workforce and fund additional positions in hospitals serving underserved communities. CMS has prioritized training slots in areas that demonstrate the greatest need for additional providers, as measured by Health Professional Shortage Areas (HPSAs). Having more practitioners available to treat patients could reduce the burden on existing practitioners in these areas.

Additionally, CMS will continue efforts to educate providers on flexibilities designed to ease administrative burden and simplify documentation requirements. This includes changes to allow teaching physicians to review and verify (sign and date) in the medical record any student documentation for the services they bill, rather than re-documenting the work, given the recent changes to Evaluation and Management (E/M) CPT billing codes requirements.^{xi} Research has found, however, that despite the changes and flexibilities introduced through rulemaking, the average note length across all clinical notes has increased 8.1% from May 2020 to April 2023.^{xii}

Finally, as also discussed below under Priorities 4 and 6, CMS released the *CMS Interoperability and Prior Authorization Final Rule* (89 FR 8758) in January 2024. The rule set requirements for Medicare Advantage (MA) organizations, Medicaid and CHIP fee-for-service programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plans (QHPs) on the Federally Facilitated Exchanges (FfEs), (collectively “impacted payers”), to improve the electronic exchange of health information and prior authorization processes for medical items and services. These policies, taken together, will improve prior authorization processes and reduce burden on patients, providers, and payers, resulting in approximately \$15 billion of estimated savings to the health care system over ten years.

Building and supporting a healthy workforce is foundational to ensuring access to and delivery of safe patient care. We believe this is a shared priority and that the evidence is clear that prioritizing efforts to address the health and well-being of the nation’s health care workforce is necessary. Ensuring all health care workers, including students and trainees, are well-resourced and feel safe and supported in their work environments, will help drive higher-quality care for patients and improve health care worker retention. We must address the root causes of clinician burnout, moral injury, and increasing attrition to guarantee a system where all health care workers can thrive.



PRIORITY 4: Improve care approval processes to increase access to care and reduce care delays.

OBJECTIVE: Ensure delivery of quality care in a timely manner.

There is growing evidence highlighting the need to simplify prior authorization and care approval processes, which can divert time away from patient care. According to a 2023 survey from the American Medical Association (AMA), 94% of participants indicated that prior authorization delays impact access to necessary care.^{xiii}

As part of the recently released Interoperability and Prior Authorization Final Rule (89 FR 8758), starting in 2026, providers will receive decisions from impacted payers for medical items and services faster, significantly reducing wait times for providing care. Impacted payers must provide specific reasons for denying requests. Impacted payers will also publicly report certain prior authorization metrics, which will hold them accountable and improve transparency. CMS also continues to work to reduce the time it takes for providers, suppliers, and people with Medicare to receive decisions on their prior authorization requests in Fee-for-Service Medicare by working to align our FFS prior authorization decision timeframes with those outlined in the CMS Interoperability and Prior Authorization Final Rule.

Finally, through provisions in the 2024 Medicare Advantage and Part D Final Rule, CMS is working to ensure timely access to medically necessary care and streamlined prior authorization to reduce inappropriate denials and delays in care and burden on practitioners.

We believe it is important for health care entities to examine processes and barriers together. Realizing a health care system that is streamlined and optimized, including by promoting the use of modern technologies, such as those that leverage interoperable data exchanges, will allow care delivery to focus on treatment rather than administrative processes. In this future state, patients can receive the care they need as soon as possible, clinicians can obtain an instantaneous response to their prior authorization requests, and health plans can better avoid and pinpoint unnecessary costs and overuse. The efficiency and appropriateness of care approval processes are critical to delivering needed care and retaining a resilient health care workforce.



PRIORITY 5: Reduce redundant or outdated data collection, documentation, and reporting requirements.



OBJECTIVE: Increase provider time with patients by continuing to reduce redundancy and complexity in data reporting requirements from payers, providers, and regulatory agencies.

Quality reporting and other types of data reporting required by payers, providers, regulatory agencies, and other entities can be experienced as overwhelming, redundant, and complex. While CMS operates more than 20 quality programs, we recognize how the large proliferation of quality measures can create an unintended administrative burden, and we are moving towards a more parsimonious set of measures through the [Universal Foundation Initiative](#). Our Meaningful Measures 2.0 Initiative promotes innovation and modernization of all aspects of quality, addressing a wide variety of settings, interested parties, and measurement requirements.^{xiv}

CMS is also promoting the use of electronic clinical quality measures (eCQMs) — clinical quality measures expressed and formatted to use data from electronic medical records (EHRs) and/or health information technology systems — to enhance and expand quality measurement. eCQMs have been found to require fewer resources than claims-based and chart-abstracted metrics.^{xv} However, accessing clinical patient data from EHRs for the purpose of quality reporting remains burdensome. CMS intends to build on advances in interoperability by transitioning to digital quality measures (dQMs). CMS defines dQMs as quality measures that use standardized, digital data from one or more sources of health information that are captured and exchanged via interoperable systems, apply quality measure specifications that are standards-based and use code packages, and are computable in an integrated environment without additional effort. In general, eCQMs are considered a subset of dQMs and are intended to improve the patient experience through higher quality of care, healthier populations, and cost reductions.

To advance the use of standardized data, models, implementation guides, and value sets in quality measurement, CMS will focus on leveraging interoperability data requirements for APIs in certified health information technology (USCDI) and the additional nationwide standardization efforts (USCDI+) as vehicles to support modernization of CMS quality measure reporting.

Finally, Innovation Center models, including the Enhancing Oncology Model (EOM), are aligning key data elements to national standards in their clinical domain (e.g., EOM as a use case for USCDI+ Cancer Initiative and alignment with Health Level 7 (HL7) FHIR® minimal Common Oncology Data Elements (mCODE)).

Ensuring high-quality health care relies on the capacity to monitor and evaluate outcomes. It also relies on ensuring that patient health information is accessible to patients and the care delivery team. However, there is an urgent need to tackle the challenges that have emerged as a result of duplicative and unnecessary documentation requirements. We believe that by working together, we are best able to identify where we can align and streamline requirements, including by harmonizing data reporting requirements across payers, providers, and regulatory agencies.

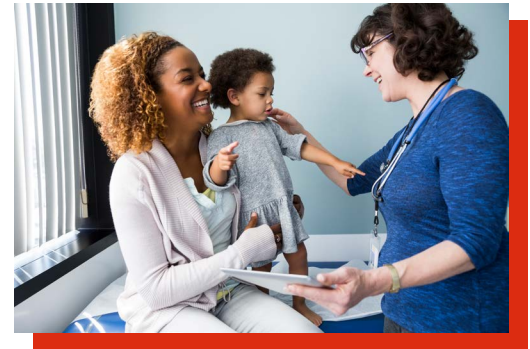


PRIORITY 6: Leverage technology to accelerate innovation and the adoption of best practices.

► **OBJECTIVE:** Optimize the care experience through innovative technology and best practices.

CMS is committed to making health care data flow more freely and securely among payers, providers, and patients by laying the foundation to foster a more connected health care system. CMS is working toward this goal by increasing and advancing health care data exchange functionality to better inform decision-making for patients and their providers, support and improve patient care, and reduce the administrative burden on providers and payers. Additionally, a 2019 study found that health data are largely contained in silos and incompatible systems, making data difficult to exchange, process, and interpret.^{xvi}

CMS is committed to advancing interoperability and reducing administrative burden across CMS programs, policies, and operations. For example, the CMS Interoperability and Prior Authorization Final Rule (89 FR 8758) requires its impacted payers to implement and maintain certain HL7® FHIR® APIs to improve the electronic exchange of health care data, as well as to streamline prior authorization processes. APIs — used widely in other industries — allow two different systems to talk with one another. The existing Patient Access API^{xvii} will thus be expanded to include prior authorization information for items and services, empowering patients with access to more of their data. A new Provider Access API will allow providers, with patient permission, to more easily access their patients' health data directly from payers, facilitating better care coordination and decision-making. Also with patient permission, payers will be able to securely exchange health data with another payer via a Payer-to-Payer API, allowing data to follow the patient if they change payers. Finally, a new Prior Authorization API will automate the process, saving time and effort for providers and payers.



Through the Beneficiary Claims Data API (BCDA), which uses the FHIR® standard, CMS enables a simple, flexible, and effective way to receive Medicare Part A, B, and D claims. Organizations using the BCDA receive expanded insights into assigned people with Medicare populations with Medicare claims data, to support high-quality, coordinated care.

As part of the Medicare Fee-for-Service Requirements Modernization (MFRM) initiative, CMS is exploring a tool that could support identifying, organizing, and digitizing Medicare FFS Coverage requirements to enhance access and usability for providers, payers, patients, vendors, and others who use them. Currently, these requirements are found in statutes, regulations, national and local coverage determinations, and guidance documents. Digitizing, modernizing, and co-locating Medicare FFS coverage documentation and administrative requirements could enable providers to access FFS requirements within normal clinical workflows to support decision-making at the point of care. In addition,

providing centralized access to coverage requirements allows other payers and individuals to utilize information needed for care delivery. Creating efficiencies in how information is communicated to end users may aid in reducing burden and increase opportunities for interoperability and automation, leading to reduced costs.

Additionally, CMS' Electronic Clinical Templates API (ECTA) project facilitates the exchange of electronic clinical data elements from EHRs into a standardized format. This process utilizes FHIR® APIs to support electronic prior authorization for provider claims.

This is a time of remarkable technological advancements that can serve to enable efficiencies in health care delivery and offer relief to the clinical workforce while improving patient care delivery. The use of technology relies upon the use of consensus standards, sound principles, and best practices. Advancements in the technological space require both innovation and collective action to ensure that such technologies are safe and secure, can be implemented with minimal friction, and enable access to high-quality, equitable health care. For example, CMS' participation in the FHIR® standards community enables collaboration on best practices, lessons learned, and opportunities to improve the care experience through standards and technology. Through this collaboration and partnership, we can ensure the application of efficient and equitable solutions that alleviate administrative burden, address disparities, and increase quality of care.



PRIORITY 7: Convene and support public-private partnerships to advance health care experience and burden reduction efforts.



OBJECTIVE: Work across the healthcare ecosystem to catalyze progress in reducing administrative burden at scale.

As part of the agency's work to obtain ongoing customer insight and feedback to inform CMS' policies and programs, CMS hosted the inaugural [CMS Conference on Optimizing Healthcare Delivery](#) in November 2023. The conference focused on opportunities across the health care enterprise to reduce administrative burden, strengthen access to quality care, and make it easier for clinicians to provide that care. To continue this work, we have been holding a series of roundtable discussions with patients, clinicians, and other partners to hear directly about lived experiences, challenges to receiving and delivering care, and best practices and solutions being implemented locally.

Additionally, CMS, on behalf of HHS, uses recommendations from the health care industry to develop and enforce regulations that adopt standards, operating rules, unique identifiers, and code sets that all covered entities must follow when conducting administrative health care transactions. A transaction consists of an electronic exchange of information between two parties to carry out financial or administrative activities related to health care. Standardizing how these transactions are transmitted reduces inconsistency and, therefore, burden in the process.

CMS also partners with HL7® to host a free annual Connectathon, an interactive collaborative event in which technical and business entities from across the health care industry convene to test HL7 FHIR® Implementation Guides and Reference Implementations to demonstrate their usability for solving health care data exchange challenges. The 2024 CMS-HL7 Connectathon included nearly 900 unique participants.^{xviii}



As outlined with each Priority, addressing the obstacles and challenges that stand in the way of patient care delivery and impact the health and well-being of our nation's health care workforce requires a call to action by all. CMS is committed to bringing together our public and private partners, fostering communication, and collaborating to achieve our goals. Partnering across health systems, academia, accreditors, regulators, vendors, and patient advocacy organizations is necessary to inform opportunities to improve health worker retention and reduce administrative burdens impacting patient care and the health of our workforce. Together, we can realize a health care system centered around patient experience and improve the health and well-being of patients and our health care workforce.



Conclusion

This Framework establishes a CMS-wide vision for reducing administrative burden and further moving towards a health care system that operates seamlessly and equitably to achieve health. With it, we aim to support the national conversation on opportunities for reducing administrative burden, as well as create new avenues for the voices of patients, caregivers, and health care workers to be centered in CMS policies, programs, and operations. Safely and effectively reducing administrative burden can return time to providers, time they can spend focusing on what truly matters, the health and well-being of the people who rely on them for care.

Additionally, CMS remains intent on finding opportunities to relieve administrative burden through collaboration with the broader health care ecosystem. Understanding the root causes and real-world impacts of administrative burden, including understanding its effects on patients and the health care workforce, will better enable us to work together as regulators (including at the federal, state, and local levels) along with health care systems, academia, the vendor community, and advocacy groups, to find solutions. Working together in public and private partnerships will create the systemic change needed to impact patient care and provider frictions.

We invite everyone to work with us and to share your successes and challenges in reducing administrative burden. Please send us your feedback, ideas, and suggestions by visiting <https://cms.gov/OptimizingCareDeliveryFramework>.

We look forward to your continued engagement and partnership with us in this work.

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