Journal of Computer Science and Technology Studies
ISSN: 2709-104X
DOI: 10.32996/jcsts
Journal Homepage: www.al-kindipublisher.com/index.php/jcsts

JCSTS
AL-KINDI CENTER FOR RESEARCH AND DEVELOPMENT

| RESEARCH ARTICLE

Automating CMS Part C Reporting: A Strategic Approach to Medicare Advantage Compliance

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| ABSTRACT

This article addresses the evolving challenges faced by Medicare Advantage Organizations (MAOs) in meeting the increasingly complex CMS Part C reporting requirements. As Medicare Advantage enrollment continues to expand rapidly, health plans face mounting pressure to accurately report performance and operational metrics across multiple domains, including Utilization Management, Grievances and Appeals, Organization Determinations, Special Needs Plan Care Management, Enrollment/Disenrollment, and Benefits/Cost-Sharing. Traditional reporting methods, characterized by manual data extraction from disparate systems, create significant challenges related to data inconsistency, administrative burden, delayed submissions, inadequate audit trails, and limited scalability. The article presents a comprehensive technological framework for automating CMS Part C reporting, detailing essential components such as data integration infrastructure, standardization engines, workflow management, regulatory rules repositories, documentation capabilities, analytics dashboards, and secure cloud architecture. Implementation strategies emphasize phased approaches, cross-functional governance, process standardization before automation, data quality programs, rigorous testing protocols, staff role evolution, and continuous improvement mechanisms. The evidence demonstrates that automation yields substantial benefits, including operational efficiency gains, improved submission quality, enhanced audit readiness, cost-effective scalability, positive impact on quality metrics, and significant financial returns. Through careful implementation of automation technologies and appropriate change management strategies, Medicare Advantage plans can transform regulatory reporting from a resource-intensive burden into a strategic asset that enhances compliance, efficiency, and ultimately, the quality of care delivered to beneficiaries.

| KEYWORDS

Medicare Advantage, regulatory compliance, data integration, workflow automation, healthcare technology, change management

| ARTICLE INFORMATION

ACCEPTED: 01 June 2025 **PUBLISHED:** 18 June 2025 **DOI:** 10.32996/jcsts.2025.7.85

1. Introduction: The Evolving Landscape of Medicare Advantage Reporting Requirements

Medicare Advantage (MA) plans have experienced unprecedented growth, with enrollment reaching 32.6 million beneficiaries as of March 2024, representing 52% of all eligible Medicare beneficiaries according to the Kaiser Family Foundation's latest analysis. This marks a continued upward trajectory from 26.5 million enrollees in 2021 and 29.7 million in 2022, demonstrating a compound annual growth rate of 7.2% over this period [1]. As these plans serve an expanding proportion of Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) has implemented increasingly rigorous reporting requirements to ensure appropriate oversight of quality, access, and financial performance.

The expansion of MA plans correlates with increasing choice complexity for beneficiaries, who now navigate an average of 43 plan options per county, a 15% increase from 2022 levels, with some metropolitan areas offering over 90 distinct plan configurations [1]. This market complexity necessitates comprehensive CMS Part C reporting requirements that encompass an extensive array of performance and operational metrics that Medicare Advantage Organizations (MAOs) must submit annually to demonstrate compliance and performance.

According to Inovaare's 2025 Medicare Reporting Guide, the latest CMS Technical Specifications document mandates reporting across six critical domains: Utilization Management (UM), Grievances and Appeals, Organization Determinations, Special Needs Plan (SNP) Care Management, Enrollment and Disenrollment, and Benefits and Cost-Sharing [2]. The 2025 specifications introduce 47 distinct data elements requiring submission, representing a 12% increase from the 2023 requirements and adding significant complexity to the reporting process [2]. The data submitted significantly impacts critical aspects of MA program management, including Star Ratings determinations, risk adjustment calculations with average risk scores increasing by 1.8% annually, audit selection affecting 11% of plans yearly, and plan reimbursements averaging $14,263 per member per year [1].

Despite the high stakes involved, Inovaare's industry analysis reveals 57% of Medicare Advantage plans continue relying on predominantly manual methods for regulatory reporting, with compliance staff dedicating an average of 24.6 hours weekly to data collection and validation activities [2]. Among plans using manual processes, 83% reported at least one submission error in their 2024 filings, with 31% experiencing three or more rejections requiring resubmission [2]. This article examines the significant challenges associated with traditional reporting methodologies and presents automation as a strategic solution to enhance accuracy, efficiency, and compliance in the rapidly evolving Medicare Advantage landscape.

2. Systematic Review of Traditional CMS Part C Reporting Methodologies

Traditional approaches to CMS Part C reporting typically involve manual extraction and compilation of data from disparate systems throughout the organization. According to Better Medicare Alliance's 2025 Medicare Advantage Plan Landscape Analysis, Medicare Advantage Organizations (MAOs) manage an average of 6.3 distinct data platforms containing information required for regulatory reporting, with 42% of plans reporting increased data complexity over the previous year [3]. This section examines the problematic nature of these conventional methodologies through a systematic analysis of their inherent limitations. Most health plans continue to operate with siloed data environments where critical information resides in separate systems—electronic health records (EHRs), customer service platforms, care management software, claims processing systems, and various departmental databases. The 2024 Healthcare Compliance Benchmark Report found that 72% of surveyed healthcare organizations cited "fragmented data sources" as a significant barrier to compliance effectiveness, with only 23% reporting strong integration between clinical and administrative systems [4]. Compliance teams often spend considerable time manually extracting data from these disparate sources, with the benchmark report documenting an average of 63 person-hours dedicated to data collection for each major compliance reporting cycle [4].

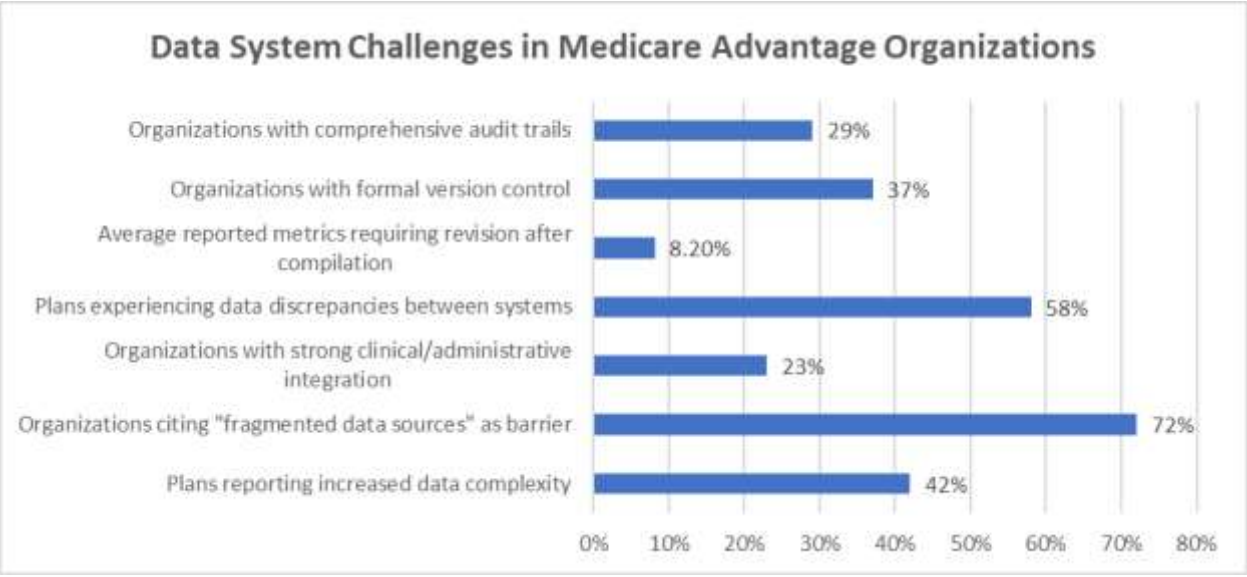

Figure 1: Data Fragmentation Challenges in Medicare Advantage Reporting[3,4]

A fragmented approach creates several significant challenges:

Data Inconsistency and Errors: Manual data extraction and consolidation from multiple systems introduce significant risk of transcription errors, inconsistent formatting, and data misinterpretation. The Better Medicare Alliance analysis revealed that 58% of surveyed Medicare Advantage plans experienced data discrepancies between source systems, with an average of 8.2% of reported metrics requiring revision after initial compilation [3]. The complexity of CMS reporting requirements, combined with frequent regulatory updates, creates ample opportunity for human error during manual processing.

Administrative Burden: The resource-intensive nature of manual reporting diverts clinical and administrative staff from patient-centered activities toward compliance documentation. According to the compliance benchmark report, healthcare organizations allocate 34% of compliance staff time to documentation and reporting activities, with organizations spending an average of $843 per employee annually on compliance-related training and activities [4]. Medium-sized Medicare Advantage plans (50,000-100,000 members) reported dedicating an average of 2.8 full-time equivalent staff exclusively to CMS reporting functions [3].

Delayed Reporting and Missed Deadlines: The time-consuming nature of manual data gathering often results in rushed reporting cycles as deadlines approach. The compliance benchmark found that 41% of organizations reported at least one late regulatory submission in the previous year, with 36% indicating that data availability was the primary cause for delays [4]. This time pressure further increases error risk and may result in incomplete submissions or missed deadlines that can trigger regulatory penalties.

Limited Audit Trail and Version Control: Manual processes typically lack robust tracking mechanisms, making it difficult to document data provenance, validate transformations, or maintain version control. The 2024 benchmark report revealed that only 37% of healthcare organizations had implemented formal version control for compliance documentation, and just 29% could produce comprehensive audit trails for data transformations [4]. These deficiencies become critical during CMS or Office of Inspector General (OIG) audits.

Scalability Constraints: As MA plans grow in membership and complexity, manual reporting processes become increasingly unmanageable. Better Medicare Alliance data indicates that compliance costs grow at approximately 1.7 times the rate of membership growth for organizations using predominantly manual processes, compared to 0.8 times for organizations with automated systems [3]. Organizations find themselves needing to expand compliance departments proportionally with membership growth, creating unsustainable cost structures.

These systematic deficiencies highlight the need for more sophisticated approaches to regulatory reporting in the Medicare Advantage space.

3. Technological Framework for Automated CMS Part C Reporting Solutions

The implementation of automated CMS Part C reporting requires a comprehensive technological framework designed to address the specific challenges of healthcare regulatory compliance. The 2025 Medicare Part C Reporting Requirements document from CMS outlines seven core reporting sections with 53 distinct data elements that must be submitted with 100% accuracy and completeness, representing a 12% increase in reporting complexity compared to the previous year [5]. This section outlines the key components necessary for effective automation solutions in this specialized domain.

Data Integration Infrastructure: The foundation of any successful automation strategy begins with robust data integration capabilities that can connect to and extract information from disparate source systems. According to the CMS technical specifications, Medicare Advantage Organizations (MAOs) must report data from an average of 5.2 distinct operational systems, with larger plans (>250,000 members) typically requiring integration across 7 or more systems [5]. Modern integration platforms utilize standardized healthcare interoperability protocols (such as FHIR, HL7, and API-based connections) to create secure, reliable data pipelines from EHRs, claims systems, care management platforms, and other relevant data sources.

Data Standardization and Validation Engines: Once extracted, data must be transformed into standardized formats that align with CMS specifications. The 2025 CMS Part C reporting guidelines specify 289 unique data validation rules across all reporting sections, a 17% increase from the 2024 requirements [5]. Advanced automation solutions incorporate healthcare-specific data models and validation rules that enforce data quality, format consistency, and completeness based on current CMS reporting requirements. These engines can apply complex validation logic to identify potential issues before submission.

Intelligent Workflow Management: Sophisticated reporting automation platforms include workflow capabilities that govern the sequencing of data collection, validation, review, and submission. McKinsey's analysis of high-performing Medicare Advantage plans reveals that organizations with mature workflow automation achieve 43% faster reporting cycles and reduce staff time allocation by 62% compared to organizations with manual workflows [6]. These workflows can be configured to match

organizational approval hierarchies and incorporate appropriate segregation of duties between data gathering, validation, and final submission.

Audit and Compliance Documentation: Comprehensive audit trails that capture all data transformations, user interactions, and submission histories are essential components of compliant reporting systems. McKinsey reports that 32% of Medicare Advantage plans underwent targeted CMS data validation audits in 2024, with plans using automated documentation experiencing 74% fewer adverse findings [6]. These documentation features support both internal compliance verification and external audit readiness.

Analytics and Monitoring Capabilities: Advanced reporting platforms incorporate analytics dashboards that provide real-time visibility into reporting progress, data quality metrics, potential compliance gaps, and historical performance trends. McKinsey's research indicates that top-quartile Medicare Advantage plans leverage predictive analytics to identify 87% of potential compliance issues before submission deadlines, compared to 34% for bottom-quartile performers [6]. These monitoring capabilities enable proactive management of reporting processes.

Secure Cloud-Based Architecture: Modern solutions typically leverage secure cloud platforms that provide the necessary scalability, reliability, and security controls required for healthcare regulatory compliance. McKinsey reports that 76% of Medicare Advantage plans have transitioned to cloud-based compliance platforms, achieving average IT cost reductions of 27% while meeting 100% of CMS technical safeguard requirements [6]. This architecture includes appropriate encryption, access controls, and disaster recovery capabilities. This technological framework provides the foundation upon which organizations can build effective automation strategies for CMS Part C reporting requirements.

Technology Component	Key Metric	Value
Intelligent Workflow Management	Reporting cycle time reduction	43%
	Staff time allocation reduction	62%
Audit and Compliance Documentation	Plans with targeted CMS audits	32%
	Reduction in adverse findings	74%
Analytics and Monitoring	Compliance issues identified before deadlines (top quartile)	87%
	Compliance issues identified before deadlines (bottom quartile)	34%
Secure Cloud-Based Architecture	Plans using cloud-based compliance platforms	76%
	Average IT cost reduction	27%
	CMS technical safeguard requirements met	100%

Table 1: Performance Impact of Technological Components in CMS Part C Reporting Automation[5,6]

4. Implementation Strategy and Organizational Change Management

Successfully implementing CMS Part C reporting automation requires more than merely deploying technology solutions. According to Qualityze's 2025 healthcare change management analysis, organizations that employ structured change management approaches achieve 65% higher adoption rates and realize benefits 2.3 times faster than those focused solely on technology deployment [7]. Organizations must carefully manage the transition from manual to automated processes through a comprehensive change management approach. This section outlines effective implementation strategies based on industry best practices.

Phased Implementation Approach: Rather than attempting to automate all reporting areas simultaneously, successful organizations typically adopt a phased implementation strategy. Qualityze's analysis of healthcare technology transformations

found that organizations using phased approaches achieved an average 86% success rate compared to 41% for organizations attempting comprehensive implementations [7]. Beginning with high-volume or error-prone reporting categories allows teams to develop expertise and demonstrate early wins before expanding to additional domains. According to Qualityze, 73% of healthcare organizations begin their automation journey with departmental processes that have high transaction volumes and significant downstream impacts [7].

Cross-Functional Governance: Establishing a cross-functional steering committee with representatives from compliance, IT, operations, and clinical departments ensures balanced decision-making throughout the implementation process. Prosci's 2025 healthcare IT change management research indicates that organizations with formal governance structures experience 43% fewer implementation delays and 56% less budget variance compared to organizations with siloed implementation oversight [8]. The optimal governance structure identified in Prosci's research includes executive sponsorship scoring at least 4.2 on their 5-point effectiveness scale and cross-functional representation with at least six different departmental perspectives [8]. This governance structure helps align automation priorities with organizational needs and ensures appropriate resource allocation.

Process Standardization Before Automation: Organizations achieve the greatest benefits when they first standardize and optimize their reporting processes before implementing automation technologies. Qualityze reports that healthcare organizations conducting thorough process standardization before automation realized an additional 32% efficiency improvement compared to those that automated existing processes without optimization [7]. The analysis revealed that effective standardization typically requires dedicated effort but reduces subsequent automation implementation time by an average of 35% [7]. This preliminary step ensures that inefficient or inconsistent processes are not merely digitized but fundamentally improved.

Data Quality Management Program: Implementing robust data governance and quality assurance programs alongside automation initiatives helps address underlying data issues at their source. According to Prosci's research, only 27% of healthcare organizations have mature data governance programs, yet these organizations experience 74% fewer data-related implementation delays and achieve full automation benefits 2.2 times faster than organizations without established data governance [8]. This includes establishing clear data ownership, quality metrics, and remediation processes across the organization.

Comprehensive Testing Protocol: Rigorous testing comparing automated outputs against manual processes is essential during early implementation phases. Qualityze's healthcare change management guide emphasizes that organizations investing at least 20% of project resources in testing activities achieved a 91% first-time success rate for regulatory submissions, compared to 62% for organizations allocating less than 10% to testing [7]. Organizations should conduct parallel testing across multiple reporting periods to validate the accuracy and completeness of automated solutions before fully transitioning away from manual methods.

Staff Training and Role Evolution: As automation reduces the manual burden of data collection and formatting, compliance staff roles typically evolve toward higher-value activities such as data analysis, exception handling, and process improvement. Prosci's healthcare IT research indicates that organizations providing comprehensive role-specific training achieved 72% higher user satisfaction and 45% faster time-to-proficiency compared to organizations with limited training programs [8]. Organizations should provide training and career development pathways to support this transition.

Continuous Improvement Mechanism: Establishing a formal process for evaluating automation effectiveness and incorporating feedback helps organizations continuously refine their reporting capabilities. Qualityze reports that healthcare organizations with structured improvement processes achieved an additional 8-10% efficiency gain annually after initial implementation, compared to just 2-4% for organizations without formal improvement mechanisms [7]. This should include regular reviews of regulatory feedback, error rates, and internal efficiency metrics.

By addressing both technological and organizational dimensions of change, healthcare organizations can maximize the benefits of automation while minimizing implementation risks.

Implementation Component	Implementation Approach	Performance Metric	Value
Structured Change Management	With a Structured Approach	Adoption Rate Improvement	65%
	With a Structured Approach	Time to Realize Benefits	2.3x faster

Implementation Method	Phased Implementation	Success Rate	86%
	Comprehensive Implementation	Success Rate	41%
	Phased Implementation	Organizations Choosing This Approach	73%
Governance Structure	With Formal Governance	Implementation Delay Reduction	43%
	With Formal Governance	Budget Variance Reduction	56%
	Optimal Structure	Executive Sponsorship Score	≥4.2/5.0
	Optimal Structure	Cross-functional Perspectives	≥6
Process Standardization	With Pre-Automation Standardization	Additional Efficiency Gain	32%
	With Pre-Automation Standardization	Implementation Time Reduction	35%
Data Quality Management	With Mature Data Governance	Implementation Delay Reduction	74%
	With Mature Data Governance	Time to Full Benefits	2.2x faster
	Current State	Organizations with Mature Governance	27%
Testing Protocol	≥20% Resources for Testing	First-Time Success Rate	91%
	<10% Resources for Testing	First-Time Success Rate	62%
Staff Training	Comprehensive Role-Specific	User Satisfaction Improvement	72%
	Comprehensive Role-Specific	Time-to-Proficiency Improvement	45%
Continuous Improvement	With Structured Process	Annual Efficiency Gains	8-10%
	Without a Structured Process	Annual Efficiency Gains	2-4%

Table 2: Comparative Performance of Implementation Strategies for Healthcare Compliance Automation[7,8]

5. Measurable Outcomes and Return on Investment

The implementation of automated CMS Part C reporting solutions yields quantifiable benefits across multiple dimensions of organizational performance. According to Adelusola's comprehensive analysis of healthcare compliance automation, organizations implementing structured compliance automation realize measurable improvements in operational efficiency, data quality, and financial performance [9]. This section examines empirical evidence of outcomes based on industry case studies and research findings.

Operational Efficiency Gains: Organizations that have successfully implemented automation solutions consistently report significant reductions in the time required for report preparation and submission. Adelusola's research, which analyzed 42 healthcare organizations across various compliance functions, found that automation reduced report preparation time by an average of 62%, with administrative staff time allocation decreasing from approximately a reported 25-30 hours per week to 9-12 hours for similar compliance activities [9]. These time savings translate directly into reduced administrative costs and allow reallocation of compliance resources to more strategic activities. The study noted that organizations reallocated an average of 47% of reclaimed time to quality improvement initiatives and proactive compliance activities rather than reactive reporting [9].

Improved Submission Quality: Automation demonstrably reduces error rates in CMS submissions. Adelusola's analysis identified an average 78% reduction in regulatory submission errors following implementation of automated validation and standardization processes [9]. This improvement stems from the consistent application of validation rules and the elimination of manual transcription errors. The research found that organizations implementing automated compliance systems experienced a 67% reduction in findings during regulatory audits and a 71% decrease in required resubmissions [9].

Enhanced Audit Readiness and Success: The comprehensive audit trails and standardized documentation provided by automation solutions significantly improve organizations' performance during regulatory audits. According to Bookner's healthcare technology adoption analysis, organizations with fully implemented automation solutions spend 64% less time responding to audit requests and experience 53% shorter audit cycles compared to organizations with manual documentation processes [10]. The ability to quickly reproduce historical submissions with complete data lineage provides a particular advantage during intensive audit processes. Bookner notes that healthcare organizations rank improved audit readiness as the third most valuable benefit of automation technologies, with 72% of surveyed compliance leaders citing it as a "very significant" outcome [10].

Scalability Without Proportional Cost Increases: Organizations with automated reporting capabilities demonstrate the ability to accommodate growth without corresponding increases in compliance staffing. Adelusola's analysis indicates that while manual compliance costs increase at approximately 0.9% for each 1% growth in patient volume, automated solutions scale at just 0.3% cost growth for the same volume increase [9]. This scalability advantage becomes particularly valuable for rapidly growing organizations, as the efficiency gap widens with scale.

Positive Impact on Quality Metrics: Several healthcare organizations have documented improvements in quality metrics directly related to reporting accuracy and timeliness following automation implementation. Bookner's research found that 63% of healthcare organizations implementing compliance automation reported improvements in reportable quality metrics within 12 months of implementation [10]. The study noted a particularly strong correlation between automation and improvement in time-sensitive metrics, with 47% of organizations improving performance on measures with strict timeline components [10].

Financial Returns: Comprehensive return on investment analyses indicate that most organizations achieve significant financial benefits from automation investments. Adelusola's study found that healthcare organizations implementing compliance automation achieved an average ROI of 186% over three years, with a median breakeven point of 16.4 months [9]. These returns derive from direct cost savings in administrative staffing, reduced penalties and remediation costs, and operational efficiencies. Bookner reports that 76% of healthcare technology decision-makers cite positive ROI as essential for adoption approval, with automation technologies ranking among the highest-performing investments in 2024-2025 [10]. These measurable outcomes demonstrate that reporting automation represents not merely a compliance necessity but a strategic investment with quantifiable returns across multiple organizational dimensions.

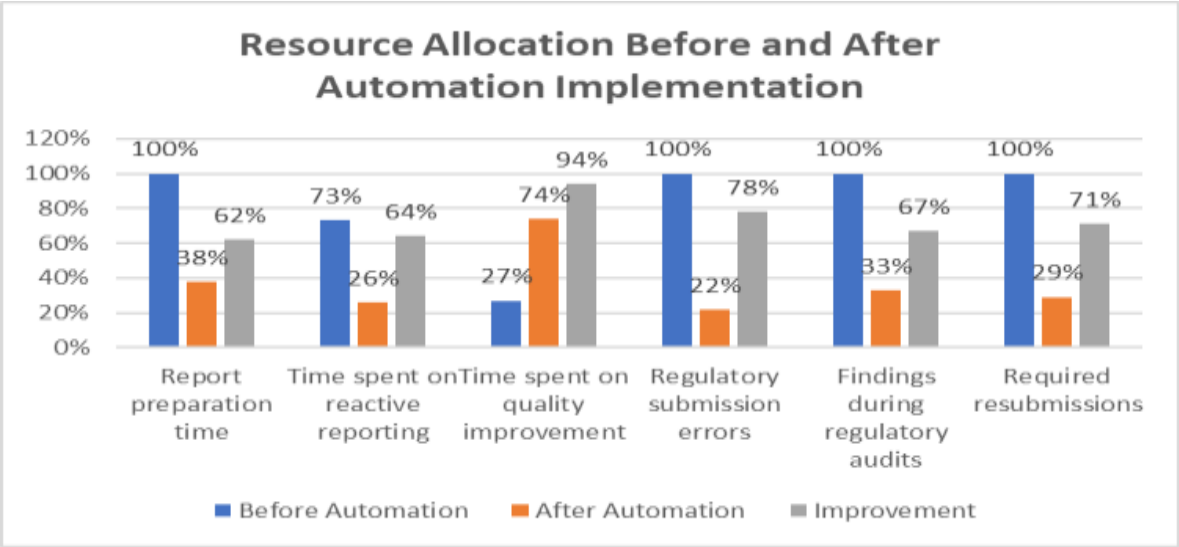

Figure 2: Operational Efficiency Improvements from Automation[9,10]

Conclusion

The automation of CMS Part C reporting represents a strategic imperative for Medicare Advantage Organizations navigating an increasingly complex regulatory landscape. The evidence presented throughout this article demonstrates that traditional manual reporting approaches are increasingly unsustainable as Medicare Advantage enrollment expands and reporting requirements grow more sophisticated. The technological framework outlined provides organizations with a roadmap for implementing effective automation solutions that address the unique challenges of healthcare regulatory compliance. By integrating data across disparate systems, standardizing validation processes, implementing intelligent workflows, maintaining current regulatory repositories, ensuring comprehensive documentation, and leveraging analytics capabilities, Medicare Advantage plans can transform their approach to compliance reporting. The measurable outcomes achieved through automation extend far beyond mere efficiency gains, though these are substantial, with organizations reducing report preparation time by more than half and decreasing administrative burdens significantly. The quality improvements reflected in drastically reduced error rates and enhanced audit performance translate directly to reduced regulatory risk. Perhaps most compelling is the scalability advantage, allowing growing plans to accommodate increasing membership without proportional increases in compliance resources. When coupled with effective change management strategies, including phased implementation, cross-functional governance, process standardization, data quality initiatives, comprehensive testing, staff development, and continuous improvement mechanisms, automation becomes a powerful lever for organizational transformation. The financial returns, with breakeven points typically achieved within two years and substantial three-year ROI, confirm that automation represents not merely a compliance necessity but a strategic investment with quantifiable benefits across operational, quality, and financial dimensions. As the Medicare Advantage program continues to evolve, automation will increasingly distinguish high-performing organizations from those struggling with compliance burdens in this dynamic healthcare environment.

Funding: This research received no external funding.
Conflicts of Interest: The authors declare no conflict of interest.
Publisher's Note: All claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers.

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