National Advisory Committee
On Rural Health and Human Services

Delivery System Reform and Implications for Rural Communities
Policy Brief December 2015

Editorial Note: *At its September, 2015 meeting in Mahnomen, Minnesota, the National Advisory Committee on Rural Health and Human Services examined the changing nature of the health care system in the United States and how rural providers can be included in these changes (known as Delivery System Reform (DSR)) without undermining access to quality health services. During the meeting the Committee met with health care providers in Fergus Falls and Detroit Lakes, Minnesota, along with hearing from representatives of the State government, a Medicaid Accountable Care Organization (ACO) and the CEO of a Quality Improvement Organization (QIO). Despite the differences between urban and rural health care providers, rural providers and patients can benefit from the greater efficiencies, different incentives and improved quality of care that the move to DSR requires.*

RECOMMENDATIONS

1. *The Committee endorses the recommendation of the National Quality Forum (NQF) that the Secretary encourage the Centers for Medicare and Medicaid Services (CMS) to require all rural providers to participate in CMS quality measurement and quality improvement programs, while allowing full participation to phase in across program types and explicitly addressing low case volume. (Pg. 6)*

2. *The Committee endorses the recommendations of the NQF that the Secretary fund the development of rural-relevant quality measures, develop and/or modify measures to address low case volume explicitly, and align measure specifications and data collection requirements across each of the CMS quality programs. (Pg. 8)*

3. *The Committee recommends that the Secretary encourage CMS to incorporate rural-relevant quality measures endorsed by the NQF into each of its quality measurement and quality improvement programs, with emphasis on measures that assess outpatient services and behavioral health impacts. (Pg. 8)*

4. *The Committee recommends that the Secretary encourage CMS to pilot test a broader set of community-level health determinants (e.g., housing needs, housing conditions, transportation access, food access) when stratifying and risk adjusting health outcome data in ongoing and future payment demonstrations that include rural providers, including analyses at finer levels of detail than the state level (e.g., counties, Census tracts), to determine their influence on rural providers' performance. (Pg. 9)*

INTRODUCTION

On January 26, 2015,[1] the Secretary of the Department of Health and Human Services (HHS) announced the delivery system reform (DSR) initiative, including its focus on three key areas:

1. Provider payment incentives that reward value rather than volume;
2. New models of care delivery that coordinate and integrate clinical services for both patients and communities, with a focus on prevention and wellness; and
3. Information sharing that creates transparency on the cost and quality of care to support better decision-making by providers and consumers.

In each of these areas, the announcement included measurable goals and an aggressive timeline to move Medicare and other health care payers toward paying providers based on quality of care rather than quantity:

- Payment incentives aim to allot 30% of Medicare payments to alternative payment models by 2016, and 50% by 2018; and link 85% of remaining Medicare fee-for-serve (FFS) payments to quality or value by 2016, and 90% by 2018.[2]
- Care delivery aims to have 30% of patients in primary care medical homes or physician groups accountable for both cost and quality by 2016, and 50% by 2018; and facilitate 80% of patients participating in shared decision-making regarding their care by 2016, and 85% by 2018.
- Information sharing aims to encourage 85% of providers to adopt certified electronic health records (EHR) by 2016, and 90% by 2018; and bring electronic health information to the point of care for meaningful use, such that 30% of clinical visits have electronic health information available where and when needed by 2016, and 50% by 2018.[3]

Interrelated DSR improvements in payment, care delivery, and information sharing are designed to provide better care at lower cost across the health care system. This is a laudable goal in an era of rising health care costs per capita,[4] but may also present significant challenges for many providers, particularly those serving rural communities.

The 23% of Medicare beneficiaries who reside in rural areas[5] tend to be older, poorer, and sicker,[6] and often more expensive to treat. While this context may present an opportunity for

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[1] United States Department of Health and Human Services. Press release. January 26, 2015. Better, smarter, healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value Accessed on December 14, 2015 at http://www.hhs.gov/news/press/2015pres/01/20150126a.html

[2] Burwell, SM. "Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care." *N Engl J Med* 372 (2015): 897-99. Accessed on December 14, 2015 at 10.1056/NEJMp1500445

[3] Health Resources and Services Administration. *Three focus areas of the delivery system reform (DSR) initiative* [PowerPoint slides]. (n.d.). Accessed on December 14, 2015 at http://narhc.org/wp-content/uploads/2015/02/Delivery-System-Reform.pdf

[4] The Henry J. Kaiser Family Foundation. *National health expenditures per capita*. (2015).Accessed on December 14, 2015 at http://kff.org/health-costs/slide/national-health-expenditures-per-capita/

[5] Medicare Payment Advisory Commission. *A data book: Health care spending and the Medicare program*. (June, 2015). See Chart 2-5 (p. 23). Accessed on December 14, 2015 at http://www.medpac.gov/documents/publications/jun14databookentirereport.pdf

improvements that serve DSR goals, previous system changes have proven difficult for providers in rural communities who are often smaller and have lower volume of patients and are subject to distinct statutory requirements. Rural providers have proven that, when included in DSR programs, their performance can match and exceed that of urban providers.[7,8] However, for the majority of rural providers, the Committee is concerned that their participation may be threatened due to (1) a conflict between reform proposals for rural safety net providers and their need to meet short-term fiscal goals, and (2) new models and approaches, which often do not take rural considerations into account. For most rural providers to succeed under DSR principles, these concerns should be addressed.

The Committee maintains that rural providers could participate in DSR if certain concerns such as these are taken into account. This brief describes ways in which DSR initiatives disadvantage and omit rural communities, and recommends ways HHS can amend those initiatives to successfully include rural providers. The implementation of DSR presents several challenges for most rural providers. HHS tools and programs as discussed in this report should be adjusted to recognize rural-specific problems that will be encountered. With such adjustments, rural health can be part of the effort to transform the nation's health care system.

FACILITATE FULL PARTICIPATION

To emphasize value over volume, the DSR framework relies on existing pricing systems under Medicare, such as prospective payment systems (PPS) and fee schedules, and emerging value-based quality adjustments. It also relies on encouraging more participation in alternative value-based payment systems under Medicare, including Accountable Care Organizations (ACOs) and bundled payment programs.

In constructing DSR goals, HHS relies on the value-based tools in payment systems that encompass a large number of health care providers and systems. Unfortunately, several realities of rural care delivery may prevent this approach from garnering meaningful engagement from rural providers:

- Only 15% of rural hospitals receive payment under the standard Medicare PPS.[9] Of these, approximately 80% meet the volume threshold to be part of the Hospital Value-Based Purchasing (HVBP) program.[10]

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[6] Meit, Michael, et al. *The 2014 Update of the Rural-Urban Chartbook.* Grand Forks, ND: Rural Health Reform Policy Research Center, 2014. See Figures 3(a) (p. 12), 5(a) (p. 16), and 21(a) (p. 48) Accessed on May 15, 2015 at https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf

[7] Kahn, C. N., et al. "Assessing Medicare's Hospital Pay-for-Performance Programs and Whether They Are Achieving Their Goals." *Health Aff (Millwood)* 34.8 (2015): 1281-8. Accessed December 14, 2015 from http://content.healthaffairs.org/content/34/8/1281.abstract?=right

[8] Licht, H. *Combined impact of Medicare performance based payment programs on rural hospitals* [PowerPoint slides]. (September, 2015). Accessed on December 14, 2015 at https://nosorh.org/wp-content/uploads/2015/08/Combined-Impact-of-Medicare-Performance-Based-Payment-Programs-Harvey-Licht-September-2015-Revised.pdf

[9] This number includes rural referral centers, but does not include the 17% of rural hospitals that are sole community hospitals, which are paid the higher of standard Medicare PPS or hospital-specific rates, or the 8% that

- Of all rural hospitals, more than 1300 (61%) are critical access hospitals (CAHs),[11] and are thus paid outside of traditional Medicare PPS using retrospective cost-based reimbursement. There are currently no guidelines from CMS on how to estimate historical and expected payments under pay-for-performance arrangements when the providers are subject to cost-based payments.
- Over 3500 rural health clinics (RHCs) are paid per visit rather than under the physician fee schedule. Thus, they do not report quality data under the Physician Quality Reporting System, nor is there a mechanism to allow their reporting under the new Merit-Based Incentive Payment System. As such, RHCs are unable to participate in the DSR physician payment systems.

These are significant obstacles to rural participation in DSR payment models. Rural providers paid under traditional Medicare PPS are participating in existing value-based payment programs, but the majority of rural providers are paid under safety net designations (e.g., RHC, CAH) that rely on distinct statutory payment models.

The distinction in payment systems also applies to data collection. Traditional Medicare payment requires providers to submit patient data and quality measures. Rural providers not subject to PPS payment assess patients using instruments different than those required for most other providers. When rural instruments do satisfy program requirements, rural providers often confront volume minimums. Serving fewer patients than their urban counterparts, rural providers often submit fewer cases than required to reliably calculate measures.

Other challenges limit rural participation in alternative payment models:

- While there has been rural participation in ACOs,[12,13] ongoing problems related to patient assignment and cost attribution restrict rural participation.
- For payment bundling, rural providers often have lower volume, inadequate access to data for price setting, and fewer partners to engage in integrated delivery systems. In combination, these limitations make efficient bundling more challenging in rural communities.

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are Medicare-dependent hospitals, which are paid standard Medicare PPS rates plus 75% of the amount by which hospital-specific rates exceed Medicare PPS rates.

[10] Licht, H. *Combined impact of Medicare performance based payment programs on rural hospitals*. (September, 2015).

[11] Medicare Payment Advisory Commission. *Critical access hospitals payment system*. (October, 2015). Accessed on December 14, 2015 at http://www.medpac.gov/documents/payment-basics/critical-access-hospitals-payment-system-15.pdf?sfvrsn=0

[12] National Advisory Committee on Rural Health and Human Services. *Rural implications of the Center for Medicare and Medicaid Innovation*. (June, 2012).Accessed on December 14, 2015 at http://www.hrsa.gov/advisorycommittees/rural/publications/ruralimplicationjune2012.pdf

[13] MacKinney, A. C., et al. "Accountable Care Organizations in Rural America." *Rural Policy Brief*. 2013 7 (2013): 1-4. Accessed on December 14, 2015 at http://cph.uiowa.edu/rupri/publications/policybriefs/2013/Accountable%20Care%20Organizations%20in%20Rural%20America.pdf

Paid and measured under systems other than traditional Medicare PPS, CAHs, RHCs, and other rural safety net providers are precluded from participating in DSR programs.

At the same time, a lack of awareness and other external incentives further impede rural involvement. For some providers, these barriers are likely insurmountable, given their financial vulnerability. For some others, the transition is a welcome validation of their past and current performance. Most rural providers, however, are somewhere in between: searching for a way to participate, but in need of assistance. To facilitate broader rural participation in DSR, HHS should target this middle cohort searching for a way to engage, but in need of help.

Although CMS has announced several initiatives to support providers in the DSR transition, including the Health Care Payment Learning and Action Network (HCPLAN) and Transforming Clinical Practice Initiative (TCPI), it is not clear whether these will offer meaningful engagement for rural providers. For example, responses to the HHS request for proposals for the TCPI Practice Transformation Networks were supposed to include at least 20% participation from clinicians in rural and underserved areas[14] and to provide them with technical assistance in quality improvement and reporting programs. However, many rural clinicians practice in either RHCs or federally qualified health centers (FQHCs), which are not required to participate in the Physician Quality Reporting System. These kinds of initiatives offer the potential for gaining rural participation, but without accounting for the distinct payment and reporting requirements for rural providers, it is not clear how useful their involvement can be.

There are existing mechanisms to encourage quality reporting among providers where it is not required. Through the Rural Hospital Flexibility Grant program, the Federal Office of Rural Health Policy funds the Medicare Beneficiary Quality Improvement Program to support CAH quality reporting. [15] In addition, the Health Resources and Services Administration provides bonus funding to FQHCs that meet high-performance quality benchmarks.[16] HHS may want to consider other mechanisms to emphasize the goals of DSR for those providers statutorily precluded from participating.

The Committee contends that any approach to quality reporting should consider the following rural realities:

> **First**, readiness for DSR changes among rural providers is variable. New technical assistance under the recently funded TCPI[17] and soon-to-be implemented provisions of

[14] Centers for Medicare & Medicaid Services. *Transforming clinical practices initiative funding opportunity announcement frequently asked questions*. Accessed on December 14, 2015 at http://innovation.cms.gov/Files/x/TCPI-External-FAQs7.pdf

[15] National Rural Health Resource Center. Medicare Beneficiary Quality Improvement Program (MBQIP). Accessed on December 14, 2015 at https://www.ruralcenter.org/tasc/mbqip

[16] For an overview of quality-related performance for community health centers, see Health Resources and Services Administration. (n.d.). Clinical and financial performance measures. Accessed on December 14, 2015 at http://bphc.hrsa.gov/qualityimprovement/performancemeasures/index.html

[17] Of 39 awardees granted $685 million to provide technical assistance to more than 140,000 clinicians, only three target rural communities, together accounting for more than 18,000 clinicians. For more information, see Centers for Medicare and Medicaid Services. (September 29, 2015). Transforming Clinical Practice Initiative awards [Press

the Medicare Access and CHIP Reauthorization Act of 2015[18] should emphasize greater participation from rural providers and target that smaller group of providers who can take full advantage of the help.

Second, rural providers tend to rely more heavily on Medicare and Medicaid, which when combined with regularly low volumes, limits financial capacity. Therefore, a more sustainable path for rural providers could include the opportunity for limited or one-sided risk and, as sought in HCPLAN, broader adoption and alignment of alternative payment models across payers, including Medicare, Medicaid, and private insurers.

CASE STUDY: MINNESOTA'S MEDICAID ACCOUNTABLE CARE ORGANIZATIONS

Minnesota's Integrated Health Partnerships (IHP) program is a Medicaid ACO demonstration that uses a shared savings payment arrangement based on a total cost of care calculation and quality metrics. Individual IHPs are expected to develop coordinated service delivery models and are encouraged to address the social determinants of health at the community level. In September 2014, Minnesota released a request for proposal for a new demonstration called Accountable Communities for Health (ACHs)—local entities that will engage in population health improvement activities and work toward prevention-based health. ACHs must identify a target population (based on geography, resource use, marginalized status, or health condition) and a population-based prevention project to implement. While ACHs can take a variety of forms, they must include partnerships with community residents, provider organizations, local public health departments, and at least one ACO. To evaluate the effectiveness of ACHs, the state will compare ACOs that adopted ACH models with those that did not.

Over the past 25 years, federal policymakers have constructed distinct payment and reporting protections for rural providers to ensure rural beneficiaries' access to care. Today, in combination with low volumes, those same payment protections discourage the care delivery improvements and value-based payment arrangements DSR promotes. As a result, rural providers are relegated to the margins of key national initiatives in a quickly changing health care environment. To reverse that trend, the Committee endorses the NQF recommendation that the Secretary encourage CMS to require all rural providers to participate in CMS quality measurement and alternative payment programs, while also making clear that CMS is expected to make allowances for low case volume and phasing-in full participation across program types, e.g. critical access hospital and rural health clinics.[19]

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release]. Accessed on December 15, 2015 at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-29.html

[18] See §101 of the Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. 114-10, 129 Stat. 87.

[19] In addition to this overarching recommendation, the multi-stakeholder Rural Health Committee provides 13 supporting recommendations under four topic areas in its September 2015 report on *Performance Measurement for Rural Low-volume Providers*. The Committee fully supports and strongly endorses each of these recommendations as factors the Secretary should consider for changes to DSR initiatives related to rural providers and communities. Some of these other recommendations are explicitly referenced in this brief. For the remaining recommendations, the Committee points the Secretary to the NQF website where the report can be found in its entirety.

MEASURE WHAT COUNTS

The transition from volume to value requires that quality measurement occur at the individual provider level. Across the country, providers are investing the time and resources to build the systems necessary to comply. For rural providers, however, small size in relation to their urban counterparts limits the available time, staff, and finances for such investments, especially when noting the increasing number of quality measurement programs to which rural providers are subject. To the degree that these quality measurement programs do not align measures and data collection requirements, these efforts may prove disproportionately burdensome for small, rural providers.[20] In addition to limited administrative capacity, rural providers treat fewer patients than urban providers, thereby restricting their ability to satisfy case minimums or provide statistically valid results. Without meeting these requirements, data are listed as missing or inapplicable for many existing quality measures. This not only excludes rural providers from measures of health care quality, but also rebalances the weights of remaining quality factors in the rural setting. In effect, quality measurement that does not reflect services provided in rural hospitals results in performance scores not entirely comparable to that of their urban counterparts.[21]

Individual rural providers also confront systemic problems that impede quality measurement. The metrics selected for different health care settings are designed to measure quality, but often assess services offered by a declining number of rural providers.[22] The distribution of hospital revenues has shifted from inpatient services to outpatient services,[23] particularly among rural hospitals.[24] While most of the measures for rural hospitals are relevant for the majority of providers,[25] recent research has found that each of three hospital pay-for-performance programs includes measures of services not provided by many rural hospitals, such as requiring tracking of readmissions following hip and knee arthroplasty in hospitals without orthopedic surgery.[26] Until the measures of quality in DSR programs apply to rural providers and the services they deliver, HHS may perpetuate the misperception that low volume and rural location implies substandard performance.

A quality measurement that would include rural providers should take into account the following three issues:

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[20] National Quality Forum. *Performance measurement for rural low-volume providers*. (September 14, 2015). Accessed on December 14, 2015 at http://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx

[21] Licht, H. *Combined impact of Medicare performance based payment programs on rural hospitals*. (September, 2015).

[22] National Quality Forum. *Performance measurement for rural low-volume providers*. (September 14, 2015).

[23] American Hospital Association. *TrendWatch Chartbook 2015: Trends affecting hospitals and health systems*. (2015). Accessed on December 14, 2015 at http://www.aha.org/research/reports/tw/chartbook/2015/15chartbook.pdf

[24] *Ibid.*

[25] Casey, M., et al. *Texas Hospital Compare CAH quality measure results, Q2 2013 – Q1 2014*. (March, 2015). Accessed on December 14, 2015 at http://www.flexmonitoring.org/wp-content/uploads/2015/04/Texas.pdf

[26] Licht, H. *Combined impact of Medicare performance based payment programs on rural hospitals*. (September, 2015).

First, the relative lack of resources at individual rural providers mirrors the lack of resources in rural communities at large. Particularly in remote and frontier communities, rural providers' ability to invest in and implement quality measurement efforts will remain stunted until there is better access to health IT tools, personnel[27] and broadband telecommunications necessary for their operation.[28]

Second, although rural providers now deliver more outpatient services, the safety net of rural inpatient providers should remain protected. Payment and quality systems that incorporate both inpatient and outpatient settings may better serve rural interests, though rural providers would likely require additional supports to implement models such as bundled payments for episodes of care or global payments per beneficiary per month. As recommended by the NQF, these supports to accommodate low volume providers could include limited or one-sided risk in early phases of implementation, voluntary groupings of rural providers to aggregate case volume and payment incentives and scoring by achievement or improvement.[29]

Third, the lack of behavioral health services may limit the effectiveness of other treatments. The Committee has heard from stakeholders that rural providers are beginning to prioritize behavioral health services. As rural providers integrate behavioral health, the development of new quality measures that evaluate its immediate value (e.g., treatment adherence) and downstream effects (e.g., reduced avoidable hospitalizations, increased patient engagement across the continuum of care) may better represent the value of care delivery in rural communities.

In summary, as quality measurement under DSR exists today, the combination of low volume and inappropriate measures impedes meaningful rural participation and improvement. To address these issues, the systems built to measure quality should respond to the unique challenges and trends affecting rural communities. To aid in that the process, the Committee endorses the NQF recommendations that the Secretary (1) fund the development of rural-relevant quality measures, (2) develop and modify measures to address low case volume explicitly, and (3) align measure specifications and data collection requirements across each of the CMS quality programs.[30] Regarding existing NQF-endorsed measures, the Committee recommends that the Secretary encourage CMS to incorporate rural-relevant measures into each of its quality measurement and quality improvement programs, particularly those that assess outpatient services and behavioral health impacts.

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[27] Agency for Healthcare Research and Quality. Health IT in small and rural communities. (February, 2015). Accessed on December 14, 2015 at https://healthit.ahrq.gov/key-topics/health-it-small-and-rural-communities

[28] Federal Communications Commission. *The broadband availability gap* [OBI Technical Paper No. 1]. (April, 2010). Accessed on December 14, 2015 at https://transition.fcc.gov/national-broadband-plan/broadband-availability-gap-paper.pdf

[29] The NQF Rural Health Committee describes and provides evidence to substantiate these other supports in detail under its Pay-for-Performance Considerations.

[30] National Quality Forum. *Performance measurement for rural low-volume providers*. (September 14, 2015).

RECOGNIZE STRENGTHS BY CONTROLLING FOR WEAKNESSES

Rural providers face several challenges when delivering care, many of which emanate from characteristics of rural communities. First, rural communities are geographically isolated. This can limit the recruitment and retention of providers, particularly specialists and post-acute practitioners, but also contributes to access issues related to transportation, broadband telecommunications, education and social services. Second, rural communities are heterogeneous. They vary according to social and economic factors that influence health and wellbeing. As in urban communities confronting similar issues, the distribution of vulnerable patients and populations may influence rural providers' performance. In fact, the Committee heard from stakeholders during the recent site visit that poverty is the "anchor dragging down programs to diminished returns." This may be especially impactful when patient poverty is compounded by geographic properties of rurality,[31] such as proximity to urban or suburban areas and seasonal hazards. In effect, the unique challenges and risk factors in rural communities may also be disproportionately "dragging down" health providers' performance when compared to urban counterparts. Thus, in the rural context, capturing more information about community social determinants for analysis may allow HHS to better assess providers' performance in relation to the risk factors of their populations.

Current CMS quality measurement and alternative payment programs adjust health outcome data to control for beneficiary-level risk factors such as age and health condition. However, recent research suggests that the characteristics included in prevailing risk-adjustment models do not explain the full variation in hospital performance.[32] Other characteristics likely play a substantial role. HHS has already begun researching whether beneficiary-level socioeconomic risk factors such as education, income, or rural location affect quality measures. Although this research includes rural as a risk factor, it does not consider the distribution of socioeconomic risk factors within rural communities, including community-level determinants such as educational achievement, poverty, housing needs and condition, transportation access, or food access.[33] In support of the NQF recommendation to consider rural-relevant socio-demographic factors in risk adjustment,[34] the Committee recommends that the Secretary encourage CMS to pilot test a set of community-level, not simply state, health determinants in ongoing and future payment demonstrations that include rural providers.

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[31] Singh and Siahpush. "Widening Rural-Urban Disparities in Life Expectancy, U.S., 1969-2009. *American Journal of Preventative Medicine*, 46, no. 2 (2014): e19-e29.

[32] Barnett, M. L., J. Hsu, and J. M. McWilliams. "Patient Characteristics and Differences in Hospital Readmission Rates." *JAMA Intern Med* 175.11 (2015): 1803-12. Accessed on December 14, 2015 at http://scholar.harvard.edu/files/mbarnett/files/barnett_jama_im_2015.pdf

[33] Alfero, C., Coburn, A. F., Lundblad, J. P., MacKinney, A. C., McBride, T. D., Mueller, K. J., & Weigel, P. *Care coordination in rural communities: Supporting the high performance rural health system*. Columbia, MO: RUPRI Rural Health Panel, June, 2015. Accessed on December 14, 2015 at http://www.rupri.org/wp-content/uploads/2014/09/Care-Coordination-in-Rural-Communities-Supporting-the-High-Performance-Rural-Health-System.-RUPRl-Health-Panel.-June-2015.pdf

[34] Licht, H. *Combined impact of Medicare performance based payment programs on rural hospitals*. (September, 2015).

CONCLUSION

Rural health care providers face significant challenges in a quickly transitioning health care environment. A network of special statutory designations has protected rural safety net providers for nearly 30 years, but now proves to be a significant obstacle blocking the rural transition from volume to value. Innovative quality measurement programs encourage improvement for most providers, but exert little incentive for rural communities where low volume and varied service delivery limit their applicability. Sophisticated risk-adjustment methodologies allow accurate comparisons between providers regardless of patient populations, but exclude the community-level risk factors that make providing care in rural communities especially difficult. Resolution of each challenge will require innovation and contextual integration. Despite limitations, rural providers are willing to work toward DSR goals, if only they are provided the necessary flexibility and support to participate. The Committee has provided several recommendations to enable that process. When HHS makes full use of its capacities to incorporate rural providers and rural considerations where it can, DSR will have successfully included all of the health care delivery system in the effort to transform health care.