URGENT

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001
6/22/95
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 1763
FILE NO: 1059
Total Page(s): 5

TO: Legislative Liaison Officer - See Distribution below:
FROM: Janet FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference
OMB CONTACT: Robert PELLICCI 395-4871
Legislative Assistant's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Report on Reauthorization of the Agency for Health Care Policy and Research

DEADLINE: 4:00pm Friday, June 23,1995

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President.

Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: HHS proposes to send this letter to the H. Labor and Human Resourses Committee in lieu of a draft bill seeking AHCPR's reauthorization.

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RESPONSE TO
LEGISLATIVE REFERRAL MEMORANDUM

LRM NO: 1763
FILE NO: 1059

If your response to this request for views is simple (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet.

If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:

(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter.

Please include the LRM number shown above, and the subject shown below.

TO: Robert PELLICCI 395-4871
Office of Management and Budget
Fax Number: 395-6148
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Report on Reauthorization of the Agency for Health Care Policy and Research

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No Objection

_____ No Comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of ____ pages, attached to this response sheet

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Honorable Nancy Landon Kassebaum
Chairwoman
Committee on Labor and Human Resources
United State Senate
Washington, D.C. 20510

Dear Nancy:

The Department strongly recommends the reauthorization of the Agency for Health Care Policy and Research (AHCPR). The AHCPR was created six years ago, with broad bipartisan support in both chambers of the Congress. Its principal responsibilities, set forth in Title IX of the Public Health Service Act, are due for reauthorization this year.

The AHCPR is making vital contributions to improving the quality and effectiveness of the Nation's health care services. The momentous changes taking place in the financing and delivery of health care are creating ever greater demands for the kind of practical, evidence-based information being developed and disseminated by the AHCPR.

The work of the Agency supplements, but is quite different from, the mission of the National Institutes of Health. While the NIH promotes basic biomedical research and innovations that will improve the Nation's health, the AHCPR supports research on the proper applications of such innovations and evaluates medical practice in everyday settings. The products of AHCPR sponsored research help clinicians and consumers make more informed decisions about individual health care services. They also help providers, managers of health delivery systems, and policy makers at the state and Federal level make better decisions about the organization and delivery of care.

The mission and responsibilities of the AHCPR are an appropriate, and vital, Federal government function. While the AHCPR has developed strong working relationships with the private sector and will continue to strengthen its collaboration with the private health care sector, the Agency's critical functions will not be carried out in the private sector without AHCPR's financial

support and leadership. This is especially true of the Agency's multidisciplinary research on patient outcomes and medical effectiveness and improvement, its development and analysis of comprehensive data bases, its promotion of health care information systems, and its development of clinical practice guidelines that are universally recognized for their comprehensiveness and objectivity.

AHCPR also serves as a resource and makes important contributions to the policy decisions made in other Federal healthcare programs, including Medicare, Medicaid and CHAMPUS. AHCPR-sponsored clinical practice guidelines and outcomes research have dealt with ten of the 15 most costly diagnoses for hospital care under Medicare and nine of the 15 most costly diagnoses for which Medicaid patients are hospitalized. This work has improved the quality of care for millions of beneficiaries and saved those programs tens of millions of dollars.

I urge you to give prompt and favorable consideration to reauthorizing this vital program. The staff of the Department is prepared to assist you in accomplishing this goal.

We are advised by the Office of Management and Budget that enactment of these recommendations would be in accord with the program of the President.

Sincerely

Donna E. Shalala

NOTE TO REVIEWERS:

ADDITIONAL LETTERS ARE BEING SENT TO —
Bliley
Kennedy
Gibbons
Archer
Packwood
Dingell
Moynihan

cc:
Jennifer
Klein

THE WHITE HOUSE
WASHINGTON

THE PRESIDENT HAS SEEN 5/30

May 26, 1995 95 MAY 26 P5:19

MEMORANDUM TO THE PRESIDENT

FROM: CAROL H. RASCO CHR

SUBJECT: The Agency for Health Care Policy and Research

You had asked for my thoughts on the Agency for Health Care Policy and Research (AHCPR). As the article in The Washington Post stated, the Senate Budget Committee has proposed cutting AHCPR's budget by 75 percent, and the House Budget Committee has suggested that the agency be eliminated completely. Your FY 1996 budget proposed to fund AHCPR at $142 million, a $3.9 million (2.8%) increase over its FY 1995 funding of $139 million. The House Appropriations Committee is expected to begin action on the fate of the agency in late June.

The agency funds three major activities: (1) research on cost, quality and access to health care; (2) the National Medical Expenditure Survey (NMES) (which is the only survey collecting information on both health care expenditures and utilization); and (3) the Medical Treatment Effectiveness Program (MEDTEP) that funds patient outcomes research, grants to study appropriateness and cost-effectiveness of alternative clinical practices, and grants to develop and disseminate clinical practice guidelines.

The agency's funding of cost, quality and access research is not controversial, and the research is generally perceived as reliable and useful. The NMES study is uniformly regarded as a valuable and unique tool for health policy development. MEDTEP, however, has been criticized. The hope in creating AHCPR in 1989 was that studying and disseminating information about appropriateness and effectiveness of health care practices (through MEDTEP) would lead to decreased health care costs. The Office of Technology Assessment (OTA) recently released a report concluding that AHCPR provides important information for the medical community but questioning the Federal role in evaluating treatment effectiveness through programs like MEDTEP. The OTA report noted that the private sector and other Federal agencies, including CDC and NIH, sponsor clinical practice guidelines, and that many of these guidelines overlap and contradict each other.

The agency's supporters argue that AHCPR is best situated to produce clinical guidelines with input from a broad spectrum of health care providers. According to Dr. William Roper -- the HCFA Administrator in the Reagan Administration who is now Senior Vice President and Chief Medical Officer of Group Health Policy for the Prudential Insurance Company -- it would be impossible for even a large company to duplicate AHCPR's work. As part of Reinventing Government II, we have also responded to some of the concerns raised about the duplication of efforts by "privatizing" some AHCPR functions, including the development of practice guidelines and technology assessment. These changes would save $18 million through FY 2000.

In addition, while critics charge that the hoped for cost savings have not yet been realized, practice guidelines and other recommendations about appropriateness and cost-effectiveness may have real impact on health care costs over time. However, there is no mechanism in place to demonstrate cost savings that are directly attributable to the agency's work. The Institute of Medicine did find that AHCPR's technology assessment program saves Medicare $200 million each year. In addition, anecdotal evidence indicates that the agency's work on practice guidelines has produced savings. For example, hospitals in Utah and Minneapolis have reported savings of $240,000 to about $290,000 by using the AHCPR pressure ulcer prevention guideline for six months.

Despite recent criticisms, Senators Kassebaum, Jeffords and Hatch and Congressman Porter strongly support the agency. In addition, Senators Mitchell and Durenburger (who were instrumental in the establishment of the agency) and Bill Gradison remain strong supporters of AHCPR.

As always, in thinking about whether this is "worth fighting for" we need to balance it against our other priorities. The agency does good work and may be more and more useful as time goes on in trying to reduce health care costs.

THE PRESIDENT HAS SEEN
5/16/95

Chris

BC

THE PRESIDENT HAS SE N
5/16/95

House Would Kill New Agency Comparing Medical Treatments

Republican Budget Proposals Put Cutting Initiative at Risk

By David Brown
Washington Post Staff Writer

It doesn't take long to go from being a solution to waste to simply waste.

That, at least, is the congressional budget committees' view of the Agency for Health Care Policy and Research. The $162 million agency is the government home for "medical effectiveness research."

When it was created by Congress in 1989, the AHCPR was viewed as an essential tool in the effort to control medical costs without damaging medical care. Last week, the Senate Budget Committee proposed cutting its budget by 75 percent, and the House Budget Committee said it should be eliminated altogether.

AHCPR was launched with the great hope—much of it enunciated by politicians—that it would help the country cut health care costs painlessly by comparing competing treatment strategies to see which works best, and at the least cost.

Over the last five years, the agency has sponsored 20 Patient Outcomes Research Teams (PORTs), each headquartered at a different hospital or university, which studied such topics as back pain, schizophrenia, prostate enlargement, knee joint replacement, cataracts, breast cancer and heart attack.

The teams reviewed the published medical literature on the topic, delineated the variations in treatment, attempted to uncover links between specific treatments and patient outcome (often using large data banks kept by Medicare or private insurance companies), and occasionally devised new tools. For example, the prostate PORT created a video to educate patients about what to expect with certain treatments—including no treatment—and formally incorporated the tool into medical decision-making [illegible].

Recently, AHCPR has begun funding randomized controlled trials, which are generally the best way to compare one treatment with another. The topics are ones unlikely to appeal to the National Institutes of Health, where new therapies, not old ones (or low-tech ones), are the preferred subjects of clinical research.

AHCPR trials, for instance, are comparing chiropractic treatment to physical therapy in low back pain; testing a mathematical equation that identifies which patients are most likely to benefit from "clot-busting" drugs for heart attacks, and comparing homemade vs. commercial rehydration fluids for children with diarrhea.

The agency also has sponsored 15 "clinical practice guidelines," which, based on the best medical evidence, suggest how to treat such common (and uncommon) problems as cancer pain, urinary incontinence and chronic ear infections.

In a recent example of that program's effects, researchers at Intermountain Health Care System in Utah reported they had cut the incidence of bedsores in high-risk (generally paralyzed) patients from 33 percent to 9 percent at LDS Hospital in Salt Lake City, after implementing a modified version of AHCPR's guideline on pressure ulcers. Incidence of ulcers—which cost an average of $4,200 to treat—also fell among lower-risk patients, and the hospital estimated the annual savings will be at least $750,000.

"To defund a relatively modest effort like that at a time when the questions they need to answer are becoming even more critical doesn't make a lot of sense to me," said Jay Crosson, an executive in charge of quality assurance at Permanente Medical Group, the physician organization of the Kaiser Permanente health maintenance organization (HMO). "There's a lot more work that needs to be done than even AHCPR can fund."

In explaining its recommendation of a 75 percent budget cut, the Senate Budget Committee said AHCPR "was to be the primary administrator of comprehensive health reform."

This, however, is not true. Although data-gathering by AHCPR-funded researchers presumably would have helped assess the equity of a national health care program, the agency had no official role in the defunct Clinton administration plan.

THE WHITE HOUSE

WASHINGTON

May 26, 1995

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Republican Budget Proposals Put Cost-Cutting Initiatives at Risk

House Would Kill New Agency Comparing Medical Treatments

By David Brown
Washington Post Staff Writer

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THE WASHINGTON POST
MONDAY, MAY 15, 1995

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

25-May-1995 02:12pm

TO: Jennifer L. Klein

FROM: Tina M. Kirk-Frank
Office of Mgmt and Budget, HD

CC: Richard J. Turman

SUBJECT: AHCPR & REGO II

Nancy-Ann Min pointed out that I did not mention the REGO II proposals that involve AHCPR. There are two:

1) Privatize Clinical Practice Guidelines for a savings of $14.8 million by FY 2000. No savings are associated with this proposal for FY 1996.

AHCPR would establish, by contract, four private-sector guideline centers. These centers will design clinical practice guidelines for AHCPR and for private sector customers.

2) Privatize Technology Assessments for a savings of $3.3 million by FY 2000. No savings are associated with this proposal for FY 1996.

AHCPR would develop collaborative relationships and cooperative agreements with affected private sector organizations and interests.

Please call or email if you have any questions.

Tina Kirk-Frank
x5-7787

- Cost savings to the Medicare program that are directly attributable to the Agency's work have not been systematically demonstrated. However, mechanisms were never established to directly measure such savings. At least one study by the Institute of Medicine did find that the Agency's technologya assessment program saves Medicare $200 million each year (IOM, 199) In addition, anecdotal evidence is beginning to mount that savings do in fact result from the Agency's work in guidelines:

  The Intermountain Health Care System in Utah reported a saving of $240,000 in one of its hospitals that used the AHCPR pressure ulcer prevention guideline for 6 months.

  Abbott-Northwestern Health Care system in Minneapolis estimated annual savings of $288,000 by also using this guidelines.

TO: JEN KELLY

RE: LISA SIMPSON

TO JEN KLEIN

FR USA

SOME CONTEXT/HISTORY

- The Agency for Health Care Policy and Research (AHCPR) was created in 1989 with strong bipartisan support. **Senators Mitchell and Durenburger** were instrumental in its establishment and continue to strongly support the work of the Agency. (They are currently authoring, with former representative Bill Gradison, an article about the importance of this agency today.)

- Since 1989, the Agency's budget has grown in each year due to each Administration's and Congressional recognition of the importance of the work of the Agency.

- In the **Health Security Act**, the Agency was central to the national quality strategy and was to receive a four-fold budget increase (to $500 million) to work in partnership with the private sector to improve health care quality through report cards, national quality measures, and clinical guidelines.

- The 1996 **President's budget calls** for a $31 million increase for AHCPR. This large increase is largely due to the National Medical Expenditure Survey (NMES), an every 10 year survey that is the only source of detailed information on medical care use, costs, and expenditures. This survey was essential during health reform to estimate the fiscal impact of alternative reform strategies.

WHAT THE AGENCY DOES

- Above all, the Agency conducts research on **what works and what DOESN'T work** in health care and produces information on the **quality and cost of care** being delivered. This work includes outcomes research, clinical practice guidelines, technology assessments, and research on health care organization, delivery, and financing. It places heavy emphasis on **dissemination** of this information.

- Such information plays an increasingly critical role in a private health care marketplace, and in the absence of national reform by

  - Providing hospitals, physicians, and health plans means by which they can improve the quality and cost-effectiveness of care they deliver.

  - Provide purchasers of care --employers, consumers, governments-- the means by which they can compare the quality and cost of care being offered, and thus the means to use the marketplace **to reward those providers offering the greatest value.**

  - Provide states ways to measure the quality and costs of care.

- However, the Agency is most well known among members of Congress for the 16 clinical practice guidelines it has developed and widely disseminated. These guidelines are targeted at conditions that are common and expensive such as **prostate cancer, low back problems, and mammography.**

- The Agency's work is the source of what we know now about **variations in care** and the **amount of unnecessary care** in this country.

- Criticisms of the Agency's work have been:

  - From groups of physicians whose **business might be harmed** by the findings of the Agency's work in the area of outcomes research and guidelines, e.g. high volume cataract surgeons, high volume spine surgeons.

  - More recently, Republican staff members have been quoted as saying that the Agency should be cut because of its role in health reform, and that it was to be one of the main implementers of the Health Security Act.

WHAT IS THE CURRENT STATUS?

- The House Budget committee recommends elimination of the Agency while the Senate Budget committee recommends a 75% reduction in the budget.

- The next four weeks will be critical in deciding the fate of the Agency. The mark-up by the 12 members of the House appropriations committee (7 Republicans and 5 Democrats), which is slated for late June and early July, is the single most important step in the legislative process ahead. The members must decide whether to sustain the Budget committee action (full elimination) or reinstate funding.

WHAT CAN THE PRESIDENT/WHITE HOUSE DO?

- The President can demonstrate his support for the work of the Agency to both the Democratic and Republican members of this committee.

The Washington Post

Monday, May 15,1995

House Panel Would Kill Agency That Compares Medical Treatments

By David Brown
Washington Post Staff Writer

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This, however, is not true. Although data-gathering by AHCPR-funded researchers presumably would have helped assess the equity of a national health care program, the agency had no official role in the defunct C n istration plan.

Washington Post

EDITORIAL

December 12, 1994

Concerning Your Sore Back

FOR PAIN of the lower back, a malady from which a lot of people occasionally suffer, it now turns out that drugs stronger (and more expensive) than aspirin are generally not desirable. And by the way, it's exercise, not bed rest, that will make things better.

These admonitions are brought to you by a process that is beginning to have an impact on the practice of medicine. As costs of health care soared, doctors began to notice wide differences from one region of the country to another and from one doctor to another in treatments for many conditions including some, like lower back pain, that are very common. Five years ago Congress set up the Agency for Health Care Policy and Research to examine these discrepancies and offer advice.

This guideline on sore backs is the agency's 14th. In each case, it sets up a panel composed largely of recognized specialists, but always including at least one consumer, to conduct a broad sweep of all the available research. It's odd in view of the enormous amounts of money spent on medical research, but much actual practice is based on tradition rather than scientific evidence—and that's one major reason for the disparities in treatments. The agency's job is to look into the questions that come up frequently in practice but on which there is no consensus. The agency has panels working on guidelines for, among other things, the rehabilitation of the victims of heart attacks and strokes, screening for Alzheimer's disease and colorectal cancer and the treatment and management of anxiety and panic disorders. The purpose is to improve the effectiveness of treatment. But in many cases, including back pain, the guidelines also have the effect of discouraging elaborate diagnostic procedures and expensive surgery that is shown to be of little value.

It's useful work, and recently Congress asked its own Office of Technology Assessment to see how the agency was progressing. The OTA concluded that the agency is making valuable contributions but often is limited by an absence of relevant research. It hasn't got the money to fill that need.

Although it runs severely against the budget-cutting fashion to say so, some of the money that the federal government spends does indeed help Americans in ways that the private market, however admirable, cannot. The case of the guidelines on lower back pain is an example to keep in mind.

Report on
Medical Guidelines & Outcomes Research

May 18, 1995
Volume 6 Number 10

In This Issue

AHCPR

AHCPR faces grim alternatives amid GOP 'lobbying' charges

House Republicans are bent on eliminating HHS' Agency for Health Care Policy and Research because, they maintain, it was "lobbying heavily for the Clinton health reform plan while it was supposed to be a research body," according to Chris Ullman, press secretary for the House Budget Committee.

That committee has proposed disbanding the agency altogether; meanwhile, its Senate counterpart voted to cut AHCPR's budget by 75%.

Even without congressional action, HHS on May 11 announced a major reorganization as part of the administration's "reinventing government" initiative that would dramatically alter AHCPR's operations. The development of practice guidelines would be privatized, as would technology assessment activities. HHS projects the changes would reduce AHCPR's costs in those areas by half. The department is also considering creating a new entity to develop a department-wide data collection and survey program.

Ullman's charge that AHCPR was essentially a lobbying arm for the Clinton administration may reflect political resentments that, according to one administration insider, started surfacing last year after the appointment of Clifton R. Gaus, Sc.D., as the agency's new administrator. Prior to taking over AHCPR, Gaus was a key player on the White House's health reform team. His appointment was widely viewed as signalling a higher profile for AHCPR as an analytic and research arm on health reform for its parent U.S. Public Health Service.

Additionally, several advisors Gaus brought on board had been involved in Clinton's ill-fated health reform plan, the administration source maintains, and their presence at the agency generated some hard

(more on next page)

Proposals to axe AHCPR draw fire

Andrew Webber, executive vice president of the American Medical Peer Review Association, Washington, says AHCPR's research is exactly what's needed to help drive competition in the healthcare industry. "I don't see the private sector filling the void," Webber says.

William L. Roper, M.D., who, as head of the Health Care Financing Administration during the Reagan administration, helped create AHCPR's forerunner, AHCPR's current budget and "the entire healthcare sector," notes. Roper now is senior vice president and chief medical officer of group healthcare policy for the Prudential Insurance Co., Roseland, N.J. It would be impossible for even a large company to duplicate the agency's work, he says.

Call Webber at (202)331-5990, and Roper at (201)716-3672.

feelings in some Republican circles.

In an official statement, the House Budget Committee also argues that "guidelines can be developed elsewhere in the Health Resources and Services Administration" and that many of AHCPR's functions "duplicate research in other agencies." The committee's proposal was scheduled for a May 18 floor vote.

A spokesperson for the Senate Budget Committee did not return phone calls.

Dire as the budget committees' proposals are for AHCPR, at this stage they are merely non-binding demonstrations of how the Republicans would cover the tax relief promised under their "Contract with America," Ullman explains. The real test will come when the House and Senate appropriations committees meet within the next few weeks to consider cuts, he says.

For more information, call Ullman at (202)226-7270.

Conference Report

Plan carefully when using outcomes to design disease management programs

Health plans looking to implement new outcomes-based disease management programs need to do more than simply pick the right research partners — they must have a clear vision of what they're doing and why.

That's the lesson Pilgrim Health Care Inc., Norwell, Mass., learned from its foray into disease management. About a year ago, the IPA-model health plan thought its plans for a new asthma management program were right on track. That initiative hinged on Pilgrim's partnership with drug maker Glaxo Inc., Research Triangle Park, N.C., for outcomes research services to help it develop the program.

But things fell apart. The partnership was "like a train stalled in the station for four weeks — with people on it," said Lucille Salvucci, Pilgrim's projects manager. Salvucci discussed the project in detail May 12 at a conference in Philadelphia entitled "Outcomes in Action."

Pilgrim had selected its new partner carefully — making sure the pharmaceutical company would not require inclusion of its products on the plan's formulary and was willing to conduct outcomes research that wouldn't be product-specific, she explained. As an IPA, Pilgrim was looking for a partner that wouldn't try to monopolize its formulary and limit its members' prescription drug choices, Salvucci added.

For its part, Glaxo was pleased that Pilgrim seemed willing to look beyond cost containment and design formularies based on treatment outcomes, she noted.

So what was the problem?

"People were saying 'yes' to a project without really knowing enough about it," said Salvucci. "As more companies get on the disease management bandwagon, most people don't have a clue about what they're selling and don't know who they're selling to." Many of those

(more on page 5)

NOTE

couraging beneficiaries to be cost-conscious, promoting price competition among providers to increase efficiency, reducing intergenerational financing inequities, and reducing beneficiaries' dependence on Medicare by giving incentives for individuals to build medical savings accounts, she said.□

Budget

GORE SAYS MEDICARE SERVICE CUTS INEVITABLE IF PROGRAM SPENDING REDUCED

Vice President Al Gore May 11 harshly criticized congressional Republican budget proposals for Medicare, saying they will lead to fewer benefits, higher costs, and less choice of providers for seniors.

Gore told Department of Health and Human Services employees gathered to hear details of the administration's reinventing government initiative that Republican plans to reduce Medicare spending "run counter to the basic values of the American people" and that the only way to pay for the reductions will be to cut benefits and increase program copayments for beneficiaries.

Republicans have said that they could cut taxes and not reduce federal health spending, but congressional proposals released in the last few days make "the truth about their intentions . . . ever more apparent," the vice president stated, adding that the federal budget cannot be balanced if a tax cut is included without cutting Medicare.

"The numbers don't add up unless they cut deeply into Medicare," he said.

Gore charged Republicans are avoiding detailing what will happen to Medicare if spending is reduced $270 billion over seven years as proposed May 10 by House Budget Committee Chairman John Kasich (R-Ohio). He urged GOP leaders to "lay the facts on the table" and state how Medicare spending reductions would affect the program.

Under Republican Medicare proposals, the Medicare deductible would double, the monthly Part B premium would increase for seven straight years, and there would be a large increase in the copayment for home health services, Gore said.□

Budget

GOP PLAN TO AXE AHCPR FUNDING UNLIKELY TO PASS, AIDES PREDICT

Proposals by the House and Senate Budget committees to slash funding for the Agency for Health Care Policy and Research appear unlikely to pass Congress intact, according to congressional aides.

While AHCPR funding might be curtailed, it probably will not be eliminated altogether as proposed by the House Budget Committee or cut 75 percent as suggested by the Senate Budget Committee, sources agreed.

Instead, key Republicans in the Senate are working with the Clinton administration on a plan to consolidate data collection and research activities within the Department of Health and Human Services, aides said.

In general, there appears to be significant support for AHCPR's stated purpose, especially on the Senate Labor and Human Resources Committee, which handles AHCPR's legislative authorization.

Strong Support For Agency

"There's strong support for the agency's mission on the part of some Republicans," one Democratic staffer told BNA. In addition to Chairwoman Nancy Kassebaum (R-Kan), GOP supporters on the committee are said to include Sens. James Jeffords (R-Vt) and Orrin Hatch (R-Utah). Sen. Bill Frist (R-Tenn), a Nashville heart surgeon, may be another supporter of AHCPR activities, the staffer said.

Actual funding for AHCPR is set by the Senate and House Appropriations committees, which are being lobbied by the Clinton administration to preserve it, sources said.

However, because AHCPR's legislative authorization expires this year, separate reauthorizing legislation must be approved by the Senate Labor and Human Resources and the House Commerce committee, which have jurisdiction over Public Health Service programs.

Compared to the Senate, ACHPR's support appears more tenuous in the House, where the atmosphere is more partisan and Republican leaders need to cut more spending to offset tax cuts, sources said. Some GOP members, however, like House Ways and Means Health Subcommittee Chairman Bill Thomas (D-Calif), have endorsed AHCPR activity in the past, which may mitigate the proposed funding cutback, one House aide noted.

AHCPR was established by Congress in 1989 as an agency of the Public Health Service with bipartisan support, replacing the National Center for Health Services Research and Health Care Technology Assessment. The agency currently has 264 employees.

GOP 'Misinterpreted' Agency Role

GOP proposals to ax the agency also are at odds with Clinton administration proposals to expand it. President Clinton's fiscal 1996 budget request proposed increasing funding to $194 million, an increase of $31 million, or 19 percent, over fiscal 1995 (6 *MCR* 169).

Republicans on the House and Senate Budget committees argue that AHCPR should be cut because it was to be the primary administrator of comprehensive health reform, according to markup documents explaining the proposed cuts. The documents also say many of the agency's functions are duplicated within the federal government or are more appropriately performed by the private sector.

Defending the agency, HHS Assistant Secretary Phil Lee said AHCPR "has a crucial role in outcomes and effectiveness research" and said its expertise in developing a methodology for premium risk adjustment "doesn't exist anywhere else in government." GOP critics "clearly misinterpreted the role of the agency" with respect to health reform, Lee told reporters May 17.

Practice Guideline Funding

According to administration budget documents, about half of the agency's current $163 million budget is devoted to its Medical Treatment Effectiveness Program, which includes funding for development of clinical practice guidel . About 15 guidelines have

been produced so far on topics ranging from bed sores to low back pain at a cost of up to $1 million each.

While critics of the agency say practice guidelines are better developed in the private sector by medical specialty societies, supporters argue AHCPR is better situated to produce objective, scientifically based guidelines with input from a broad spectrum of providers.

"There's no question that doing [guidelines] through AHCPR makes all the difference in the world regarding credibility," said an aide to Sen. Paul Wellstone (D-Minn). For example, AHCPR's guideline on low back pain states that many patients are helped by chiropractors—a finding not popular with orthopedic surgeons but that nevertheless has increased credibility in the medical community, the aide said.

Outcomes Research

Related to its work on practice guidelines, AHCPR devotes significant MEDTEP resources to Patient Outcomes Research Teams (PORTS). These large, three- to five-year clinical studies designed to determine what works best in clinical treatment of common conditions like cataracts, prostate disease, and schizophrenia. Over the past five years, the agency has sponsored about 20 PORTS at various hospitals and universities.

The remainder of AHCPR's budget is devoted to research on a wide range of issues related to the financing and delivery of health care services. About $64 million is earmarked for funding research on health care quality, costs, and access.

According to the president's budget for fiscal 1996, some of this money would be used to fund several extramural grants to study how to adjust health insurance premiums more appropriately. The request also would continue to support five "Rural Health Centers"—operating in Seattle, Minneapolis, Chapel Hill, N.C., Denver, and Buffalo—to study rural health policy issues.

The administration is seeking a big boost in funding for AHCPR's National Medical Expenditure Survey (NMES), from $15 million to $36 million. The data gathered by the survey "will continue to support the restructuring of health care in the private sector and at the federal and state levels," according to HHS budget documents. The NMES survey is projected to cost a total of $92 million and is scheduled for completion in 1998, according to administration documents.

Reinventing Government Initiative

Despite strong support for ACHPR in the budget request, the administration more recently has proposed "privatizing" some AHCPR functions as part of Vice President Al Gore's reinventing government initiative *(see related article in the Regulatory section)*.

According to a May 11 HHS fact sheet, proposals include transferring development of AHCPR guidelines "to public/private partnerships, with AHCPR continuing to fund several centers of excellence and standing panels but moving much of the effort to the private sector."

The administration also is considering privatizing AHCPR's technology assessment activities, which the administration says could save as much as 50 percent over current costs.

The actual amount of savings projected by these changes—$18 million through fiscal 2000 and a reduction in the workforce by 8 employees—is nominal, however, compared to the administration's $194 million fiscal 1996 budget request.□

—By Scott Falk

Fraud and Abuse

PANEL TOLD HHS IG TARGETING HOME HEALTH, NURSING SERVICES, DME

The Department of Health and Human Services Office of Inspector General has begun a major initiative to detect Medicare fraud and abuse in home health care, nursing home services, and durable medical equipment, an OIG official told a House panel May 16.

Michael F. Mangano, principal deputy inspector general at HHS, cited several examples of fraud and abuse by providers of these services at a joint hearing of the House Commerce Committee's Subcommittee on Health and Environment and Subcommittee on Oversight and Investigations.

Mangano's testimony before the subcommittee follows the May 3 announcement by HHS IG June Gibbs Brown of the IG's multi-prong attack on fraud in nursing homes, home health agencies, and durable medical equipment suppliers in five states under a two-year demonstration project, "Operation Restore Trust" (6 *MCR* 453).

In home health care, Medicare expenditures increased from $3.3 billion in 1990 to a projected $14.4 billion this year, Mangano told the panel. A significant reason for this dramatic increase has been fraud and abuse in the delivery of services and filing of claims, he said.

For example, the IG's review of Medicare claims submitted by St. John's Home Health Agency in Miami, Fla., revealed that 75.5 percent of the claims did not meet Medicare guidelines. In many cases, home visits were not made at all or were made to individuals who were not homebound, he said. A recent random audit of other home health agencies in Florida found that 26 percent of claims did not meet Medicare guidelines, Mangano said.

Nursing Home Billing Questioned

Regarding nursing home services, the IG is particularly concerned about nursing homes billing Medicare Part B for services covered by payments made under Medicare Part A, Mangano said. For instance, the IG has identified roughly $57 million in enteral nutrition charges that were allowed and paid in both 1991 and 1992 under Part B, even though much of these costs should have been included in the Medicare Part A skilled nursing facility payments. In addition, Part B was improperly billed as much as $55 million for rehabilitation therapy and $44 million for medical supplies in 1992, according to Mangano's statement.

The IG also is continuing to focus on the billing of durable medical equipment and supplies to Medicare beneficiaries overall, helping to obtain 131 successful

The New York Times

Sunday, May 21, 1995

Imperiled Agencies Mount Life-Saving Efforts

By ROBERT PEAR

WASHINGTON, May 20 — Republicans often portray Federal agencies as slothful, lethargic, unresponsive. But many agencies have snapped into action in the last two weeks, galvanized by Republican plans to end their existence or cut their budgets.

The agencies on the Republican hit list are mobilizing supporters and deploying their troops on Capitol Hill, pleading with Congress to spare them. Among them are the Departments of Energy, Commerce and Education, the Voice of America, the Agency for International Development and the National Endowment for the Arts.

Energy Secretary Hazel R. O'Leary told Congress this week that her agency was needed to guarantee civilian control of nuclear weapons, and she said that computers built to design such weapons now had myriad civilian uses, at textile factories and in other industries.

Clifton R. Gaus, head of the Agency for Health Care Policy and Research, an arm of the Public Health Service with 270 employees and a budget of $163 million this year, argued that his agency actually saved money for the Government by controlling health costs. Guidelines developed by the agency had shown that cataract surgery, prostate surgery and back surgery are often unnecessary, he said.

His message to Congress was simple: "We are not part of the problem. We are part of the solution to Medicare's budget problems."

The House budget resolution would eliminate the health policy agency. The Senate would cut its budget by 75 percent, on the ground that its work could be "more appropriately performed by the private sector."

The Agency for International Development has infuriated some Republicans with the intensity of its lobbying. Somehow the Republicans obtained a copy of an internal memorandum in which a top Agency for International Development official described the Administration's strategy: "delay, postpone, obfuscate, derail" the Republican plan. It also used the phrase "backdoor isolationist" to describe lawmakers who want to cut foreign aid.

U.S. employees tell why they are important.

The Administration is fiercely resisting Congressional efforts to merge the Agency for International Development, the United States Information Agency and the Arms Control and Disarmament Agency into the State Department, saying that the agencies should retain a large degree of independence.

Officials from these agencies have fanned out across Capitol Hill to spread their message, and Jay Byrne, a spokesman for A.I.D., said his agency had begun "an intensive public outreach and information campaign."

At a recent hearing of the Committee on International Relations, Representative Dana Rohrabacher, Republican of California, asked people in the room who actually worked for the affected agencies to stand up. More than three-fourths of the 200 people in the audience rose, the Congressman recalled.

"Usually, you have outside interest groups swarming around," Mr. Rohrabacher said in an interview. "But today you have as many people from inside the Government as from outside the Government lobbying Congress. It's like a big battlefield. Republican forces are on the offensive, and you have all these Government bureaucrats fortifying the high ground to beat back the attack."

Senator Craig Thomas, Republican of Wyoming, said he was incensed by the attitude of Agency for International Development officials. "Instead of looking for ways to work with members of Congress to streamline its operations, cut waste and bloating, and accept the downsizing that the American people expect of every other agency of the Federal Government," Mr. Thomas said, "A.I.D. has taken on, as its first priority, saving its own skin."

J. Brian Atwood, administrator of the Agency for International Development, said, "I am not intimidated by those who would prefer that I keep my mouth shut." And he insisted that members of Congress trying to cut the foreign affairs budget were "leading us to isolationism through the back door."

To fend off budget-cutters, the agency highlights its efforts to combat the deadly Ebola virus in Zaire; the agency is coordinating the United States response to the health crisis.

And the agency says the budget cuts contemplated by Congress would have "truly horrific" results: fewer children immunized, fewer condoms distributed, more unsafe abortions and more cases of AIDS.

Some agencies on the chopping block are old, like the Interstate Commerce Commission, created in 1887 to regulate railroads. Others are newcomers like the Corporation for National Service, created in 1993 to run the volunteer program known as Americorps.

The House and Senate Budget Committees both recommend abolishing Americorps, with its budget of $575 million. This is a slap at President Clinton, who proposed increasing the number of volunteers to 47,000 from the current 20,000.

Americorps officials said they had little hope of changing the budget resolutions. But they are pleading with friends and supporters on the Appropriations Committees, which could provide money for Americorps if they made deeper cuts at other agencies. Americorps has invited members of Congress to visit its volunteers at work in elementary schools and homeless shelters around the country.

"To eliminate this agency would be tragic, like killing a puppy," said Jay Toscano, a spokesman for Americorps. "The Republicans should use this agency as a model, not a target."

Some agencies threatened with extinction, like the Legal Services Corporation and the Education Department, have overcome similar threats in the past. But some, like the National Institutes of Health, which have enjoyed strong bipartisan support, now face significant budget cuts for the first time.

May 22, 1995

Health Division
Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:
Richard Turman
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Subject: Background Materials on AHCPR

From: Tina Marie Kirk-Frank TKF

Phone: 202/395-7787
Fax: 202/395-3910
Room: #7002

In response to your request last Friday for background materials on AHCPR, we have compiled the attached materials:

TAB A: Description of the Agency for Health Care Policy and Research

TAB B: Excerpts from AHCPR's FY 1996 Congressional Justification

TAB C: Table Detailing AHCPR's funding from FY 1988 - FY 1996

TAB D: FY 1996 Budget, Domenici, and Kasich funding

TAB E: A Wire Service Article discussing likelihood of Domenici or Kasich levels for AHCPR passing.

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TAB A

Divider Title: _____

AGENCY FOR HEALTH CARE POLICY AND RESEARCH
MISSION AND HISTORY

AHCPR's Mission and Activities

AHCPR's statutory mission is to:

> "... to enhance the quality, appropriateness, and effectiveness of health care services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical practice (including the prevention of diseases and other health conditions) and in the organization, financing, and delivery of health care services."

AHCPR funds three major activities: 1) Research on Cost, Quality and Access (CQA); 2) National Medical Expenditure Survey (NMES); and 3) Medical Treatment Effectiveness Program (MEDTEP).

Research on Cost, Quality and Access

- funds numerous grants studying such issues as consumer decision making, improving the health care marketplace, primary care, rural health services, and AIDS/HIV cost and services utilization.
- focuses on health policy issues on a system-wide level.

National Medical Expenditure Survey

- the only data collection tool to collect information on both health care expenditures and utilization.
- has been used extensively to develop and evaluate health care reform proposals.

Medical Treatment Effectiveness Program

- funds grants studying the effectiveness, appropriateness, and cost-effectiveness of alternative clinical practices; patient outcomes research; investigating which clinical strategies are best for conditions affecting minority populations; effects of prescription drugs on patient outcomes; and developing and disseminating clinical practice guidelines and technology assessments.

Recent History

The prevailing hope behind the creation of AHCPR was that the study of appropriateness and effectiveness of health care practices would lead to decreased health care costs. On December 19, 1989 the National Center for Health Services Research and Health Care Technology Assessment (a center within the Office of the Assistant Secretary for Health) was transformed into the Agency for Health Care Policy and Research. NCHSR had long funded health policy studies. AHCPR's broader statutory mission, as quoted above, added focus on patient outcomes research and clinical practice guidelines.

AHCPR Funding

Funding for AHCPR has increased by $92 million (166%) in budget authority (including HCFA

trust fund transfers) from its original funding level of $32 million in FY 1990 to the $148 million in the FY 1996 President's Budget. AHCPR also receives funding from PHS evaluation funds. Counting the three funding sources, AHCPR's total program level has increased by $96 million (99%) from its original level of $97 million in FY 1990 to $193 million in the FY 1996 President's Budget. See attached table (TAB C) for detail of increases by year.

Is AHCPR Fulfilling its Mission?

AHCPR interprets its mission as generating and disseminating information that improves the delivery of health care. AHCPR generates and disseminates information, whether that information improves the delivery of health care has not been demonstrated.

Research on Cost, Quality and Access

Approximately 70% of this funding is awarded as grants or contracts to research health care cost, quality and access. The remaining 30% is devoted to AHCPR's research management. This research may provide information on what affects the cost, quality, and access of health care; but such information does not necessarily lead to improved delivery of health care.

National Medical Expenditure Survey

NMES is a unique data tool within HHS. It provides information that currently cannot be obtained elsewhere. Use of NMES data allows policy-makers to model alternative health care systems with the most reliable information available. The Department is currently re-designing NMES to better integrate department-wide data collection, and to fill in the data-gaps discovered during recent health care reform activities.

Medical Treatment Effectiveness Program

Approximately 84% of MEDTEP funding is awarded as grants and contracts to research medical treatment effectiveness. The remaining 16% is devoted to AHCPR's research management. AHCPR has published several clinical practice guidelines and outcomes research. The Office of Technology Assessment (OTA) has released a report questioning the Federal role in MEDTEP-type activities.[1] The OTA report points out that:

- documenting variations in clinical practice, as AHCPR does, does not itself provide information about which practices are the most effective.
- making recommendations about reducing inappropriate care is not synonymous with reducing the cost of care.
- many federal agencies sponsor clinical practice guidelines (e.g. AHCPR, CDC, and NIH), and many of the resulting guidelines overlap and contradict each other.
- the private sector is flourishing in the areas of health technology assessment (including clinical practice guidelines) and the need for a Federal effort in this area is questionable.

This was the area where advocates place their highest hopes for great things, specifically cost-savings, from AHCPR. These hopes have not yet been realized.

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[1] U.S. Congress, Office of Technology Assessment, *Identifying Health Technologies that Work: Searching for Evidence,* OTA-H-608 (Washington, D.C.: U.S. Government Printing Office, September 1994).

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TAB B

Divider Title: _____

Appropriation History Table

Agency for Health Care Policy and Research

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1990				
Budget Authority..	1/	1/	1/	$ 50,191,000
Trust Fund.....				6,037,000
1% Evaluation.....				41,443,000
Total.....				$ 97,671,000
1991				
Budget Authority..	$ 39,126,000	$ 68,579,000	$ 91,335,000	$ 95,755,000
Trust Fund.....	29,037,000	6,037,000	6,037,000	5,892,000
1% Evaluation.....	40,776,000	13,776,000	40,776,000	13,444,000
Total.....	$108,939,000	$ 88,392,000	$138,148,000	$115,091,000
1992				
Budget Authority..	$ 34,283,000	$ 95,756,000	$ 69,283,000	$100,452,000
Trust Fund.....	37,773,000	5,892,000	7,773,000	5,892,000
1% Evaluation.....	49,944,000	13,444,000	49,944,000	13,444,000
Total.....	$122,000,000	$115,092,000	$127,000,000	$119,788,000
1993				
Budget Authority..	$ 36,083,000	$ 98,671,000	$ 70,572,000	$109,051,000
Trust Fund.....	37,773,000	5,833,000	5,833,000	5,786,000
1% Evaluation.....	51,237,000	13,310,000	53,316,000	13,204,000
Total.....	$125,093,000	$117,814,000	$129,721,000	$128,041,000
1994				
Budget Authority..	$139,045,000	$129,051,000	$139,305,000	$135,409,000
Trust Fund.....	5,786,000	5,786,000	5,786,000	5,786,000
1% Evaluation.....	13,204,000	13,204,000	13,204,000	13,204,000
Total.....	$158,035,000	$148,041,000	$158,295,000	$154,399,000
1995				
Budget Authority..	$104,409,000	$134,624,000	$128,914,000	$138,541,000
Trust Fund.....	5,786,000	5,806,000	5,786,000	5,796,000
1% Evaluation.....	63,204,000	13,202,000	31,504,000	18,300,000
Total.....	$173,399,000	$153,632,000	$166,204,000	$162,637,000
1996				
Budget Authority..	$142,424,000			
Trust Fund.....	5,796,000			
1% Evaluation.....	45,284,000			
Total.....	$193,504,000			

1/ The FY 1990 President's Budget, the FY 1990 House Allowance, and the FY 1990 Senate Allowance did not include funds for the Agency for Health Care Policy and Research (AHCPR). The AHCPR was established on December 19, ~~1990~~ 1989 by P.L. 101-239. Funds for the AHCPR's predecessor, the National Center for Health Services Research and Health Care Technology Assessment, were previously included in the budget estimates submitted by the Office of the Assistant Secretary for Health.

General Statement

The mission of the Agency for Health Care Policy and Research (AHCPR) is to generate and disseminate information that improves the delivery of health care. This mission is unique. AHCPR is the primary Federal agency charged with: (1) developing clinically-based, policy-relevant information for use in improving the health care system; and (2) providing leadership in health services research.

AHCPR's effectiveness and outcomes research brings new insights into the daily needs of patients and medical practitioners. AHCPR's clinical practice guidelines provide valuable analyses and recommendations, not available elsewhere, that promote higher quality, more appropriate, and more cost-effective health care. AHCPR's guideline development process has also established the standard by which guideline development occurs across the United States, in medical and nursing specialty societies. We have made significant advances in the dissemination of this information to consumers and practitioners and voluntary use of these practice guidelines continues to grow across the nation.

The research supported by AHCPR on cost, quality and access generates important new information on a broad spectrum of issues with respect to the financing and delivery of health care services in a predominantly private health care system. Such information is used by a variety of public and private decision makers to measure and improve quality, enhance consumer decision making, and improve the efficiency of the health care system. In addition, AHCPR's staff expertise and databases help inform public policy debates on the future of the health care system. The National Medical Expenditure Survey (NMES) provides the data to examine the financial implications of various health care reform proposals.

The FY 1996 Request will enable AHCPR to provide the information and expertise required to shape and enhance the health care system and improve the effectiveness and appropriateness of health care. The AHCPR budget is presented in four parts: (1) Research on Health Care Costs, Quality and Access (which includes a health services research program on HIV/AIDS); (2) National Medical Expenditure Survey (NMES 3); (3) Medical Treatment Effectiveness Program; and (4) Program Support. The President's appropriation request of $193,504,000 for this account represents current law requirements. No proposed law amounts are included.

Scorable Budget Authority.....	$142,424,000
Trust Fund Transfer.....	5,796,000
One-percent Evaluation Funds.....	45,284,000
Total Estimate.....	$193,504,000

During the past two years, while the debate over health care reform continued in Washington, private market forces were acting to transform the country's medical system. Major trends include cost cutting, increasing competition within and among all sectors of the delivery system, and continuing consolidation of providers and payers. While these trends have resulted in reductions in the rate of increase of health care expenditures, they have also raised questions about the impact on the quality and appropriateness of health care and the choices available to consumers.

Among the milestones American health care reached during 1993 and 1994 were:

- A majority of Americans with employer-based health benefits were enrolled in managed-care plans. Sixty-five percent of workers at medium and large companies were in such plans by 1994.

- At least three-fourths of all doctors signed contracts, covering at least some of their patients, to cut their fees and accept oversight of their medical decisions. Among doctors who work in group practices, the share of such managed-care contracts was 89 percent by 1993, up from 56 percent the year before.

- Spending on health care continued to grow faster than the economy as a whole due, at least in part, to the adoption of new technologies and the aging of the population.

Issues and concerns raised by these developments can be addressed effectively only when we understand their dimensions, the social and financial implications of change, and the ways to achieve the quality, effectiveness, efficiency and equity we expect from our health care system. These are among the critical issues being addressed by AHCPR.

The goals of AHCPR are pursued through the Research on Health Care Costs, Quality and Access (CQA) program, the National Medical Expenditure Survey (NMES 3), and the Medical Treatment Effectiveness program (MEDTEP). Research performed by and supported through the CQA program focuses on cost, quality and access studies of immediate and long-term importance to policy makers, health care professionals, and the public. These issues are closely related and are studied through investigator-initiated research and intramural research, and are the foundation for all of AHCPR's directed research endeavors.

Research conducted under MEDTEP is designed to improve the effectiveness and appropriateness of health care. MEDTEP findings result in increased cost effectiveness for Medicare, Medicaid, and the entire health care system, by focusing on ways to improve the diagnosis, prevention, treatment, and management of clinical conditions that occur frequently and pose substantial risks to patient health and functional status.

The National Medical Expenditure Survey provides the basic information for estimating the effects of various changes to the American system of health care. No alternative source of information exists for estimating the costs, and for analyzing financing options and the distributional impact of various options. The third survey in the series will begin data collection in January 1996.

Overview

AHCPR is developing a strategic plan that focuses on improving health care delivery and health outcomes for all Americans. We will achieve our mission, to generate and disseminate information that improves the health care system, through the following goals:

- Help consumers make more informed choices;
- Determine what works best in clinical practice;
- Measure and improve quality of care;
- Evaluate and improve the health care marketplace;
- Improve the cost effective use of health care resources;
- Assist health care policymaking;
- Build and sustain the health services research infrastructure.

Research on Health Care Costs, Quality and Access

Authorizing Legislation - Title IX and Section 301 of the Public Health Service Act (PHSA).

FY 1994 Actual		FY 1995 Appropriation		FY 1996 Estimate		Increase or Decrease	
FTE	BA	FTE	BA	FTE	BA	FTE	BA
141	$47,436,000 (60,640,000)	141	$50,559,000 (63,777,000)	139	$53,515,000 (66,717,000)	-2	$ 2,956,000 (2,940,000)

FY 1996 Authorization.....PHSA Title IX expires September 30, 1995
PHSA Section 301 Indefinite

Purpose and Method of Operation

The Research on Health Care Costs, Quality and Access program (CQA) focuses on studies of immediate and long term importance to policy makers, health care professionals, and the public. This includes studies on the interaction of cost, quality and access; health insurance plans; microsimulation modeling to understand the effects of proposed changes to the health care system; analysis of health care costs and financing for acute, ambulatory and long term care for specific diseases (e.g. AIDS); and the effects of medical liability.

In FY 1995, CQA is estimated to support 123 research project grants, including 10 for AIDS; and 39 research contracts, including 8 for AIDS.

In FY 1996, CQA is estimated to support 117 research project grants, including 11 for AIDS; and an estimated 40 research contracts, including 7 for AIDS.

RESEARCH GRANTS AND CONTRACTS supported by AHCPR provided the foundations for major changes in health care financing systems, the measurement of health care quality, and the development of information systems that improve the delivery of health care services. In FY 1995, areas of focus include:

- how consumers make choices on health insurance;
- managed care;
- risk adjustment systems;
- health insurance reform;
- rural hospital closures and rural emergency medical services;
- cost effectiveness of preventing AIDS complications; and
- improved electronic medical records systems.

CONSUMER DECISION MAKING

In FY 1995, AHCPR will initiate the Consumer Assessments of Health Plans Study (CAHPS). Health plans are changing rapidly as providers of health insurance cope with demands to reduce the costs of health insurance coverage while offering plans that provide quality of care from the consumer perspective. Little is known about consumer preferences for information on health plans and how consumers use information in health care decision making. CAHPS will gather valid, reliable information and test its usefulness in assisting consumers with selection of a health care plan. AHCPR plans to make an award for this initiative in FY 1995.

IMPROVING THE HEALTH CARE MARKETPLACE

In FY 1995 AHCPR will refocus interest in the role that market forces play in the provision and financing of health care. The planned solicitation will generate new short term, policy relevant, investigator-initiated research in an environment characterized by rapid financial reconfiguration of the U.S. health care system, continued rising health care costs and rates of uninsurance, cost and access driven state experimentation with a range of regulatory and pro-competitive policies, and continued pressure on Federal and state health care budgets.

The research conducted through this initiative will provide greater understanding of emerging financing and organizational arrangements, such as managed care organizations and hospital/physician/nursing home alliances, and their effects on access, cost, and quality of care. AHCPR plans to make an award for this initiative in FY 1995.

PRIMARY CARE

In the area of primary care research, FY 1995 support includes:

- a study on the cost effectiveness of screening in primary care for hereditary hemochromatosis (HH), a condition in which iron is absorbed at an increased rate leading to organ damage and associated disease:
- a study of the problem of inadequate follow-up of abnormal screening mammograms;
- a study comparing the costs and quality of primary care delivered by different types of physicians - family physicians, general internists and medical specialists - within a health maintenance organization;
- a study to determine the effectiveness of expansions in Medicaid for pregnant women on improvements in birth outcomes;
- several studies testing the effectiveness of interventions in physicians' offices that can improve the delivery of clinical preventive services;
- a study testing the effect of an interactive CD focused on decreasing cervical cancer by improving the quality of screening for patients in community health centers;
- a study comparing patient outcomes following different treatments for acute otitis media; and
- several studies testing the effectiveness of different approaches to implementing AHCPR clinical practice guidelines on the processes and outcomes of care.

RURAL HEALTH SERVICES RESEARCH

During FY 1995, AHCPR will continue to fund five specialized centers for rural health services demonstrations in Oklahoma, Iowa/Nebraska, Maine, West Virginia, and Arizona. Many recent health care innovations such as managed care are available in metropolitan areas but are frequently unavailable to rural populations. The Centers will conduct demonstrations of innovations in the delivery of health care services in rural areas. Rural populations are in poorer health than urban populations and experience limited public

transportation, higher unemployment rates, and a shortage of health care professionals. The new systems would make primary care and preventive services more available to rural residents through managed care arrangements and innovative information and communication. The new rural health care systems will provide valuable data about health care costs and other issues that will help health care administrators improve the quality of rural health care. A detailed table listing the demonstration centers is on page 40.

In addition, AHCPR continues to support five rural centers, established in FY 1993. These Centers address regional issues related to the development of rural health policy for cost and quality of, and access to, health services particularly for disabled and minority populations. A current example is the assistance AHCPR is providing to the State of Oregon in developing a scorecard for consumer's use in selecting health care plans and providers. AHCPR's regional Rural Center at the University of Washington and its subcontractor, Oregon Health Sciences University, Portland, are carrying out this collaborative project.

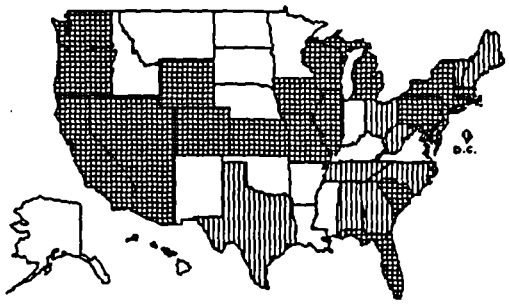
The project will test several scorecard formats based on the needs of participants of the Oregon Health Plan, a State-supported health insurance program that provides universal access to health care by low-income residents.

Beyond helping Oregon achieve its public health policy goals, this project will develop the science base for a State-wide scorecard that can be adapted by other States. A detailed table listing these centers begins on page 41.

INTRAMURAL RESEARCH collects and analyzes data on policy issues of immediate concern to the Administration, Congress and others involved in developing and analyzing national health policy. Using data from the National Medical Expenditure Survey, AHCPR has developed a sophisticated microsimulation model, AHSIM, that is currently being used to assess cost and financing issues related to health care reform. The AHSIM Model is being modified to run on free-standing personal computers, so its analytic capabilities can be shared directly with policymakers throughout the Federal government.

The intramural research program is moving into the third phase of the Healthcare Cost and Utilization Project (HCUP). The project has reached its original goal of obtaining participation from 22 states, two years ahead of schedule. Data has been received from 20 of these organizations.

HCUP-3 Participation



Discussions with other states indicate that many are interested in participating (Alabama, Delaware, Maine, North Carolina, Georgia, New Hampshire, Ohio, Rhode Island, Tennessee, Vermont, West Virginia and the District of Columbia), if funding is available. Patient-level discharge data are collected in 42 states, although all hospitals in the state may not be included. HCUP-3 participants represent 14 state data organizations and 8 private data organizations:

State data organizations:	AZ	CA	FL	IL	MA	MD	NJ	NV
	NY	OR	PA	SC	WA	WI		
Private data organizations:	CT	CO	IA	KS	MI	MO	UT	WY

HCUP-3 is creating two databases by merging hospital discharge data from the different states. Data are processed into a uniform HCUP-3 format to facilitate research. One database will allow analyses of regional and state trends while the other will allow analyses of national health policy issues.

The first, a statewide inpatient database, consists of information on all community hospitals and all discharges from hospitals in 12 states. After processing data into the uniform HCUP-3 format, data will be returned to the respective states. Four states (CA, FL, IL, MA) have received their data in the HCUP-3 format. The states will control release of the statewide data for research outside of AHCPR under their established privacy laws and policies. Representatives of the 12 states, with AHCPR guidance, are exploring the feasibility of developing a uniform procedure among the HCUP-3 states for releasing data for research. The states are attempting to reduce the barriers to accessing data held by different states, while fully protecting privacy.

HCUP-3 Statewide Inpatient Database (SID)
Release 1 - 1995

- 100% of hospitals and discharges in state
- return to states for distribution
- participating states include:

AZ CA CO FL IA IL
MA NJ NY PA WA WI

The second database is a nationwide sample of approximately 1,000 community hospitals and all of their hospital discharges. The sample for Release 1 will be drawn from 11 of the 12 states included in the statewide inpatient database. Future annual releases will include additional states selected to improve national representation.

HCUP-3 Nationwide Inpatient Sample (NIS)
Release 1 - 1995

- 20% of hospitals and 100% of their discharges
- AHCPR release to researchers
- participating states in Release 1 include:

AZ CA CO FL IA IL
MA NJ PA WA WI

The HCUP-3 databases will allow researchers to:

- monitor changes in the structure, conduct, and performance of public and private health care delivery systems;
- track indicators of hospital quality;
- identify variations in medical practice;
- monitor the use of services for vulnerable populations;
- assess the development of uniform, comparable data across geographic areas and sites of care; and
- evaluate changing patterns of illness and treatment for diseases such as AIDS.

HCUP-3 has strong support from the states, which need these data for planning. The project also has the endorsement of the American Hospital Association.

AIDS RESEARCH includes another large database for both intramural and extramural research, the AIDS Cost and Service Utilization Survey (ACSUS) which provides vital information on costs and services resulting from health care delivery to the HIV-infected. The second national utilization survey, the "HIV Cost and Services Utilization Study" (HCSUS) presently is being organized. This study represents a continued commitment by AHCPR to collect data associated with the use and cost of services consumed by persons with HIV infection, and to make this data available to health care policy decision-makers. In addition to cost and utilization data, HCSUS will collect primary data about access and barriers to care in different geographic locations and health care delivery system settings. It will provide current information about relevant demographic and socioeconomic variables (e.g., race, gender, insurance status, income, education, exposure category). The HCSUS will collect data on a broad representation of HIV infected persons over an extended period of time. The study will enable enhanced analyses of the longitudinal effect of various treatment modalities and should have better generalizability than is possible to obtain through studies of a single population group, at a single health care delivery setting in one location. The HCSUS is funded through a cooperative agreement with RAND for four years beginning in FY 1994.

Other AIDS research in FY 1995 includes:

- a grant to evaluate alternative strategies for the prevention of opportunistic infections in persons with AIDS;
- a project aimed at developing a database of individuals receiving care for HIV infection in order to assess utilization, appropriateness, and effectiveness of pharmaceutical therapies used in treating HIV disease;
- a grant to study the effects of the Comprehensive Health and Enhancement Support System (CHESS) on health care costs and quality of care of HIV-infected individuals.

DISSEMINATION ACTIVITIES are designed to promote widespread distribution and assimilation of AHCPR products including results and findings from the AHCPR-funded extramural research studies, and from intramural research activities such as the National Medical Expenditure Survey and Provider Studies Programs. A variety of dissemination methods are employed including: publication in professional journals; press conferences; interviews and story placement with the medical/trade press; and articles in the popular press.

The User Liaison Program (ULP) synthesizes and disseminates research findings to Federal, state, and local policy makers in easily understood and usable formats. The ULP plays a key role in AHCPR's efforts to support capacity-building for public health at the state and local level through policy-

thematic workshops, skill building workshops, and technical assistance. Examples of the types of issues the ULP has addressed include:

- Minority infant mortality
- Long-term care
- Strengthening the public health infrastructure
- Managed care
- Drug utilization review
- Medical liability
- Disease prevention/health promotion
- Rural, urban & child health

In addition, the ULP has worked closely with organizations serving the information needs of state/local officials such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County Health Officers (NACHO), and the National Association of County Officials (NACO) by conducting educational programs for their members.

The ULP is conducting a series of expert meetings with states that are in the forefront of health reform, such as Minnesota, Oregon, and Vermont. These meetings will provide the basis for AHCPR's programs of technical assistance for the states in their implementation of health reform.

Funding for the Research on Health Care Costs, Quality, and Access program during the last five years has been as follows:

Five-Year Funding History

Funding and FTE levels for the Research on Health Care Costs, Quality and Access program over the five year period prior to FY 1996 has been as follows:

	Amount	FTEs
1991	$49,120,000	132
(HIV/AIDS non-add)..	(10,252,000)	(10)
1992	$49,501,000	131
(HIV/AIDS non-add)..	(10,135,000)	(10)
1993	$51,949,000	140
(HIV/AIDS non-add)..	(9,624,000)	(10)
1994	$60,640,000	141
(HIV/AIDS non-add)..	(10,624,000)	(10)
1995	$63,777,000	141
(HIV/AIDS non-add)..	(10,585,000)	(10)

Sources of Research on Health Care Costs, Quality, and Access funding follow:

	Budget Authority	Trust Funds	1 Percent Evaluation	Total
1991	35,676,000	---	13,444,000	49,120,000
1992	36,057,000	---	13,444,000	49,501,000
1993	38,745,000	---	13,204,000	51,949,000
1994	47,436,000	---	13,204,000	60,640,000
1995 Approp.	50,559,000	---	13,218,000	63,777,000
1996 Estimate	53,515,000	---	13,202,000	66,717,000

National Medical Expenditure Survey (NMES 3)

Authorizing Legislation - Title IX and Section 301 of the Public Health Service Act (PHSA).

FY 1994 Actual		1995 Appropriation		FY 1996 Estimate		Increase or Decrease	
FTE	BA	FTE	BA	FTE	BA	FTE	BA
---	$10,000,000	---	$ 9,918,000	---	$9,918,000	---	---
	(10,000,000)		(15,000,000)		(36,000,000)		(21,000,000)

Purpose and Method of Operation

AHCPR's research and databases have provided much of the information used by policy-makers to develop and evaluate health care proposals. Health care issues can be addressed effectively only when we understand their dimensions, the social and financial implications of proposals for change, and the most effective ways to achieve the quality, efficiency, and equity we expect from our health care system.

NMES 3 is the third in a series of projects to collect and compile data on nationwide expenditures and utilization. Funding for the project began in FY 1994. A 5 year project, FY 1996 is a peak year for funding because it covers a period of the most intensive field work.

The following table compares the cost of NMES 2 with NMES 3 adjusted to 1987 dollars. In constant dollars, the cost for NMES 3 reflects a modest increase over NMES 2 despite the use of innovations such as Computer Assisted Personal Interviews (CAPI) which improve the quality of the data and expedite the production of Public Use Data Tapes.

Component	1987 NMES-2	1996 NMES-3	NMES-3 in 1987 Dollars
	(Dollars in Millions)		
Household Survey:			
Household Interviews...	$32.2	$52.4	$34.7
Medical Provider Interviews.....	7.5	10.2	6.8
Health Insurance Plan Survey.....	8.7	15.1	10.0
Subtotal.....	48.4	77.7	51.5
Institutional Survey:			
Institution & Population Interviews.....	11.0	15.2	10.5
TOTAL.....	$59.4	$92.9	$62.0

Funding History

Funding for the National Medical Expenditure Survey (NMES 3) program prior to FY 1996 has been as follows:

	Amount	FTEs
1994.....	$10,000,000	---
1995.....	15,000,000	---

Sources of NMES 3 funding follow:

	Budget Authority	1% Evaluation	Total
1994 Actual	$10,000,000	---	$10,000,000
1995 Approp.	9,918,000	$5,082,000	15,000,000
1996 Estimate	9,918,000	26,082,000	36,000,000

Rationale for the Budget Estimate

The FY 1996 Estimate for the National Medical Expenditure Survey (NMES 3) totals $36,000,000, comprised of $9,918,000 in budget authority and $26,082,000 in one percent evaluation funds. The total reflects an increase of $21,000,000 over the FY 1995 Appropriation of $9,918,000.

National Medical Expenditure Survey 3 (NMES 3) +$ 21,000,000: During FY 1996, many key survey activities will take place. The bulk of costs for interviewer training and data collection (i.e. screening, baseline, and two main rounds of data collection) will be incurred. The innovations planned for NMES 3, such as software development for the CAPI, will allow access to data for policy analysis much more quickly than has been possible in the past.

Support is included for the development of the Provider Inventory and an expanded Nursing Home Survey. The National Center for Health Statistics does not intend to conduct a Nursing Home Survey in 1996. The expansion includes collecting additional information on facility characteristics and the amount of data collected from next of kin.

Interview costs are higher than originally estimated because changes in the composition of U. S. households make information collection more difficult (e.g. an increased number of non-English-speaking immigrants, heightened concerns about privacy, and the increasing numbers of non-traditional household and family arrangements).

The tables that follow provide additional information on the costs of collecting data and then analyzing the data.

TABLE I

DATA COLLECTION CONTRACT COSTS
(Dollars in Millions)

Component	(1977–79) NMES I	(1987–89) NMES 2	(1994–98) NMES 3
Household Survey.....	$16.0	$32.2	$52.4
15,000 Households			
37,000 Persons			
5 Rounds			
Institutional Population Survey...	--	11.0	15.2
810 Nursing Homes			
691 Facilities for Retarded			
11,000 Persons			
Medical Provider Survey.....	3.5	7.5	10.2
22,000 Physicians			
400 Home Health Agencies			
2,687 Hospitals			
Health Insurance Survey.....	3.7	8.7	15.1
13,700 Employers			
400 Unions			
900 Insurance Companies			
Survey of American Indians.....	--	7.0	--
2,100 Indian Households			
7,000 Persons			
3 Rounds			
Medicare Record Component.....	--	0.5	--*
TOTAL.....	$23.2	$66.9	$92.9

* Included in Household Survey

Table II

NMES 3

(Dollars in Millions)

Activity	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	TOTAL
Household Surveys.....	$5.8	$10.3	$20.0	$15.3	$1.0	$52.4
Institutional Population Component Nursing Home Surveys.....	2.1	2.1	5.9	4.1	1.0	15.2
Household Surveys/Medical Provider Surveys.....	1.1	0.7	3.8	4.1	0.5	10.2
Household Surveys/Health Insurance Plan Surveys.....	1.0	1.9	6.3	5.4	0.5	15.1
TOTAL.....	$10.0	$15.0	$36.0	$28.9	$3.0	$92.9

Table III

Estimated Analytic Costs of NMES 3
(Dollars in Millions)

Cost Component	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
Programming.....	$1.5	$2.5	$2.7	$2.7	$2.7
Computer Time.....	0.5	0.8	0.8	0.9	0.9
Personnel.....	1.9	3.2	3.3	3.4	3.5
TOTAL.....	$3.9	$6.5	8	$7.0	$7.1

Medical Treatment Effectiveness Program

Authorizing Legislation - Title III and Title IX of the Public Health Service Act and Section 1142 of the Social Security Act

FY 1994 Actual		FY 1995 Appropriation		FY 1996 Estimate		Increase or Decrease	
FTE	BA	FTE	BA	FTE	BA	FTE	BA
86	$81,328,000 (81,328,000)	89	$81,436,000 (81,436,000)	88	$82,364,000 (88,364,000)	-1	$ 928,000 (6,928,000)

FY 1996 Authorization.....PHSA Title IX expires September 30, 1995
PHSA Section 301 Indefinite
SSA 201(g) Indefinite
SSA Title XI expired September 30, 1994

Purpose and Method of Operation

The purpose of the Medical Treatment Effectiveness Program (MEDTEP) is to increase the cost effectiveness and appropriateness of clinical practice. MEDTEP accomplishes this through four interrelated activities: effectiveness research; development of clinical practice guidelines; development of data bases for research; and the synthesis and dissemination of research findings and clinical practice guidelines. MEDTEP also supports training of health services researchers.

In FY 1995, MEDTEP is estimated to support 95 research project grants and 54 research contracts.

In FY 1996, MEDTEP is estimated to support 92 research project grants and 43 research contracts.

EFFECTIVENESS RESEARCH examines the effectiveness, appropriateness and cost effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of clinical conditions, in terms of patient outcomes. More complete and accurate information regarding what works best in medical care and, especially, the *relative* benefit of alternative treatments and consideration of patients' preferences, together with active dissemination of this information, will help to improve clinical practice and its outcomes. In addition to benefiting individual patients, the results of MEDTEP research are valuable to health care providers concerned about the value, effectiveness, and appropriateness of health care in their institutions and communities and to policymakers concerned about the quality and cost of health care nationwide.

MEDTEP research focuses on conditions that meet the following criteria:

- large numbers of individuals are affected;
- there is uncertainty or controversy regarding effectiveness;
- associated risks and/or costs of treatment are high; and,
- needs of the Medicare and Medicaid programs are addressed.

Recent examples of MEDTEP research include:

- Medical care use and costs for adults with sleep apnea;
- "Let Me Decide" health care advance directives;
- Outcomes following minor head and abdominal trauma;
- Improving efficiency and quality with information systems;
- Videodisc for back surgery decisions;
- Treatment choices and outcomes in prostate cancer; and,
- Practice variation among newborn intensive care units.

PORTs and PORT II

A major component of MEDTEP research is support for Patient Outcomes Research Teams (PORTs), which began in FY 1989. PORTs are 5-year research grants that include the elements of formal literature synthesis (meta-analysis), data acquisition and analysis, development of clinical recommendations, dissemination of findings, and evaluation of the effects of findings on change in clinical practice. The 14 PORT projects are listed on page 55.

The PORT II initiative continues in FY 1995. Like the initial PORTS, PORT II addresses important clinical and policy-relevant questions on the effectiveness and cost effectiveness of different clinical approaches for common clinical conditions, and will advance methods for outcomes research. The new program emphasizes hypothesis testing to provide strong evidence for, or against, the effectiveness of treatments for common conditions. The grant period for PORT II is from three to five years. Six PORT II grants were awarded in FY 1994 for the following areas: prostatic diseases; cataracts; breast cancer; cardiac arrhythmia; end-stage renal disease and oral rehydration. A detailed table listing the PORT II projects is on page 56.

RESEARCH CENTERS ON MINORITY POPULATIONS

Another important MEDTEP research initiative established 11 MEDTEP Research Centers on Minority Populations, four full centers and seven developmental centers. Through this initiative, AHCPR is investigating which clinical strategies are best for clinical conditions whose prevalence or impact is greatest among African Americans, Latinos, Asian and Pacific Islanders, American Indians, and/or Alaska Natives. In addition, the Centers are training minority researchers in effectiveness research, provide technical assistance to practitioners in their communities, and disseminate information to patients and providers. Examples of the conditions being studied are: high blood pressure, kidney disease, tuberculosis, low birthweight, substance abuse, and certain cancers. A detailed table listing the Research Centers on Minority Populations is provided on page 57.

PHARMACEUTICAL OUTCOMES PROJECTS

Another MEDTEP research initiative is studying the effectiveness and cost effectiveness of prescription drugs and related pharmaceutical interventions. Fourteen investigator-initiated grants currently are funded to study the effect of prescription drugs on patient outcomes. Illustrative examples of these research grants include: pharmaceutical care for pediatric asthma (University of Washington); antidepressant drug use in the elderly (University of Minnesota); the role of the patient in arthritis treatment (University of Wisconsin); and prospective drug utilization review (Regenstrief Institute, Indiana University). A table listing the pharmaceutical projects funded under this initiative is provided on page 58.

CLINICAL PRACTICE GUIDELINES are developed by AHCPR's Office of the Forum for Quality and Effectiveness in Health Care. This program promotes the quality, appropriateness, and effectiveness of health care by arranging for the development, review and updating of:

- Clinically relevant guidelines that may be used by health care practitioners and educators, as well as consumers, to assist in determining how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically; and,

- Standards of quality, performance measures, and medical review criteria through which health care providers may assess or review the provision of health care.

By the end of 1995, an estimated twenty guideline sets (i.e. the clinical guideline, quick reference guide for clinicians, and patient's guide) will be available to the public. Two other topics are under development with publication expected in 1996. A detailed table listing the guidelines is provided on page 59.

GUIDELINE EVALUATION

AHCPR has also established a guideline evaluation strategy designed to meet three objectives:

1. Examine the process of developing and disseminating guidelines;

2. Evaluate individual guidelines as they are released; and

3. Support investigator-initiated research to generate new knowledge about the effectiveness of medical care and develop and test new approaches to put that knowledge into use.

Guideline evaluation efforts include:

- Six targeted projects to examine various aspects of the process of developing AHCPR supported guidelines. These projects are designed to summarize our guideline experience to date and will assist in responding to congressional reporting requirements in the 1992 AHCPR Reauthorization Act. They examine methods for selecting guideline topics, methods to conduct peer and pilot review, methods to compare the AHCPR guideline development process to those used by other organizations, methods to assess the perceived quality of guidelines, and methods for analyzing the cost effects of guideline recommendations.

- Continuing research into methods for translating clinical practice guidelines into medical review criteria that can be used to measure conformance with guidelines and target areas for clinical quality improvement. These projects include contracts with 1) The American Medical Review Research Center to evaluate the AHCPR-supported guidelines for urinary incontinence, acute postoperative pain, and benign prostatic hyperplasia in care provided to Medicare patients; and 2) The Rand Corporation to evaluate the guidelines for cataract and pressure ulcers. This second project involves collaboration with the Department of Veterans Affairs, which will test guideline-based review criteria for use in VA hospitals throughout the U.S.

- Continuing research into the application of the AHCPR-supported guideline on depression in large group practice settings. In addition, a new research solicitation will sponsor projects to investigate the impact of AHCPR-supported guidelines for urinary incontinence in adults, early HIV infection, sickle cell disease, unstable angina, and depression.

DATA DEVELOPMENT efforts address the quality of patient care by improving the quantity and quality of information available for health services research, with special emphasis on patient outcomes research. In addition, activities related to development of computerized medical records will contribute to the administrative simplification goals of health reform. The two basic components of this activity are:

- Establishing standards for uniform methods of developing, collecting and exchanging data.

- Investigating the feasibility of linking research-related data from a variety of sources.

Continuing in FY 1995, AHCPR and the National Library of Medicine are cooperatively funding grant applications that extend computer-based patient record systems and show their incorporation of guidelines, decision aids, expert systems and reminder systems. Supported research include investigations into the use of automated patient care data for patient care, payment, research, quality assessment, patient outcome analysis, and electronic transmission of such data among institutions and providers.

EVALUATION and synthesis encompasses information on the development and application of clinical quality measures, including:

- guideline-based measures sponsored by AHCPR;
- quality measures developed by other government entities and the private sector;
- methods of comparison for quality measures;
- supporting the capacity to disseminate information;
- and technical assistance on quality measures.

The field of quality measurement has generated vast amounts of this type of information that can be put into practice in the form of medical review criteria and performance measures. The science underlying that process needs to be strengthened. As a first step, AHCPR is funding a study to collect and classify existing clinical performance measurement sets. To date, the project has identified more than 30 measurement sets containing more than 600 clinical performance measures. The aim is to identify areas where better measures are needed, and where further research can have the greatest impact. The information will be placed in a database that can be accessed by managed care plans, hospitals, and other users.

DISSEMINATION of research and clinical practice guidelines is accomplished through the use of professional journal publications, the consumer and trade press, and the mass media, as well as information networks and conferences sponsored by AHCPR. The resources and expertise of the National Library of Medicine (NLM), the Health Resources and Services Administration, and the Centers for Disease Control and Prevention continue to be used to convey final research and guideline findings.

AHCPR has disseminated more than 14.3 million requested guideline documents. Additionally, reprints, excerpts, or summaries of the guidelines have appeared in professional journals with a combined circulation of well over 4.9 million. AHCPR also collaborates with the NLM to make available full text retrieval

versions of guidelines through NLM's MEDLARS database. AHCPR has also arranged for the reprinting of more than 7.7 million additional copies of the guidelines by working cooperatively with industry in public-private partnership.

AHCPR has worked with NLM to create an on-line literature database for health services research that is available to the public, and to significantly increase the scientific literature available on technology assessments. AHCPR also collaborates with the Government Printing Office and the National Technical Information Service to make health services research and guidelines available through computer diskettes, on-line computer systems, and CD ROM disks. Such products include an electronic inventory of AHCPR-supported research available on one database. AHCPR also has made clinical practice guidelines available on the Internet, the most cost effective tool for reaching the largest audience at minimum cost.

TECHNOLOGY ASSESSMENT - This intramural research program provides review of new technologies under consideration for reimbursement by Federal agencies. Examples of current and planned technology assessments are provided in a table on page 60.

Five Year Funding History

Funding and FTE levels for the complete Medical Treatment Effectiveness Program (combined amount for research, guidelines, data, and dissemination) over the five years prior to FY 1996 has been as follows:

	$	FTEs
1991	63,697,000	70
1992	68,041,000	83
1993	73,661,000	93
1994	81,328,000	86
1995	81,436,000	89

Sources of MEDTEP funding follow:

	Budget Authority	Medicare Trust Funds	1-Percent Evaluation	Total
1991	57,805,000	5,892,000	---	63,697,000
1992	62,149,000	5,892,000	---	68,041,000
1993	67,875,000	5,786,000	---	73,661,000
1994	75,542,000	5,786,000	---	81,328,000
1995 Approp.	75,640,000	5,796,000	---	81,436,000
1996 Estimate	76,568,000	5,796,000	6,000,000	88,364,000

Rationale for the Budget Request

The Medical Treatment Effectiveness Program totals $88,364,000, an increase of $6,928,000 or 8.5 percent over the FY 1995 Appropriation of $81,436,000 and includes anticipated savings in FTS costs of $16,000.

The FY 1996 Request level provides support for the following initiatives:

Shared Patient/Practitioner Decision-Making +$944,000: All the major health care reform proposals recognize that reform will bring intensified demands for meaningful information for all parties, particularly consumers. Successful implementation of reform requires information to help consumers participate more actively in decision-making about their personal health care. At this level, AHCPR will support 4 grants to fund innovative activities, such as interactive videodiscs, for providing information on the effectiveness of available treatment options to help patients become better informed health care consumers.

Clinical Effectiveness Trials +$4,000,000: An AHCPR-supported conference was held in May 1994 to establish a future research agenda on the effectiveness of treatments for non-cancerous conditions of the uterus. The consensus of the conference was that there is little or no research evidence to support hysterectomy as an effective treatment for non-cancerous conditions of the uterus. There are about 450,000 hysterectomies performed annually in the United States for non-cancerous conditions. As AHCPR's effectiveness research program matures, it is becoming clear that direct answers to many clinical effectiveness questions will require investment in prospective clinical studies, including trials.

At this level, AHCPR will support 2 clinical effectiveness studies, including an effectiveness trial, on treatments for non-cancerous conditions of the uterus, including hysterectomy.

Technology Centers +$2,000,000: Virtually all proposals for health care reform state that "appropriate" care will be reimbursed. Technology assessments are the most suitable method for judging the appropriateness of health technologies.

At this level, AHCPR will fund 2 cooperative agreements to support Technology Assessment Centers or Consortia to conduct assessments, develop innovative assessment methods, and provide technical assistance to health care providers, payers, policymakers, and managed care organizations.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

TAB C

Divider Title: _____

AHCPR Funding History

FY 1990 to FY 1996 President' Budget

($ in millions)

	Actual Appropriation										President's Budget	
	FY 1988*	FY 1989*	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	% Change	FY 1995	% Change	FY 1996	% Change
BA	22.2	32.5	55.8	101.6	106.3	114.8	141.2	23.0%	144.3	2.2%	148.2	2.7%
Program Level	22.2	49.6	97.2	115.1	119.8	128.0	154.4	20.6%	162.6	5.3%	193.5	19.0%

* Similar activities funded through predecessor agency

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TAB D

Divider Title: _____

FY 1996 Funding Proposals for the Agency for Health Care Policy and Research

- The President's FY 1996 Budget proposed to fund AHCPR at $142 million, a $3.9 million (2.8%) increase over its FY 1995 funding of $139.

- Kasich would eliminate funding for the Agency for Health Care Policy and Research (AHCPR) in FY 1996, saving $142 million BA in FY 1996 and $685 million over 5 years.

- Domenici would cut AHCPR funding by 75% (-$104 million) from the FY 1995 level in FY 1996 and retains a shrunken AHCPR through FY 2002.

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TAB E

Divider Title: _____

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

18-May-1995 09:10am

TO: Mark E. Miller
TO: Barry T. Clendenin
TO: Richard J. Turman

FROM: Farooq A. Khan
Office of Mgmt and Budget, HD

SUBJECT: GOP PLAN TO AXE AHCPR FUNDING UNLIKELY TO PASS, AIDES PREDIC

GOP PLAN TO AXE AHCPR FUNDING UNLIKELY TO PASS, AIDES PREDICT

Proposals by the House and Senate Budget committees to slash funding for the Agency for Health Care Policy and Research appear unlikely to pass Congress intact, according to congressional aides.

While AHCPR funding might be curtailed, it probably will not be eliminated altogether as proposed by the House Budget Committee or cut 75 percent as suggested by the Senate Budget Committee, sources agreed.

Instead, key Republicans in the Senate are working with the Clinton administration on a plan to consolidate data collection and research activities within the Department of Health and Human Services, aides said.

In general, there appears to be significant support for AHCPR's stated purpose, especially on the Senate Labor and Human Resources Committee, which handles AHCPR's legislative authorization.

''There's strong support for the agency's mission on the part of some Republicans,'' one Democratic staffer told BNA. In addition to Chairwoman Nancy Kassebaum (R-Kan), GOP supporters on the committee are said to include Sens. James Jeffords (R-Vt) and Orrin Hatch (R-Utah). Sen. Bill Frist (R-Tenn), a Nashville heart surgeon, may be another supporter of AHCPR activities, the staffer said.

Actual funding for AHCPR is set by the Senate and House Appropriations committees, which are being lobbied by the Clinton administration to preserve it, sources said. However, because AHCPR's legislative authorization expires this year, separate reauthorizing legislation must be approved by the Senate Labor and Human Resources and the House Commerce committee, which have jurisdiction over Public Health Service programs.

Compared to the Senate, ACHPR's support appears more tenuous in the House, where the atmosphere is more partisan and Republican leaders need to cut more spending to offset tax cuts, sources said. However, some GOP members, like House Ways and Means Health Subcommittee Chairman Bill Thomas (D-Calif), have endorsed AHCPR activity in the past, which may mitigate the proposed funding cutback, one House aide noted.

AHCPR was established by Congress in 1989 as an agency of the Public Health Service with bipartisan support, replacing the National Center for

Health Services Research and Health Care Technology Assessment. The agency currently has 264 employees.

GOP 'Misinterpreted' Agency Role

GOP proposals to ax the agency also are at odds with Clinton administration proposals to expand it. President Clinton's fiscal 1996 budget request proposed increasing funding to $194 million, an increase of $31 million, or 19 percent, over fiscal 1995.

Republicans on the House and Senate Budget committees argue that AHCPR should be cut because it was to be the primary administrator of comprehensive health reform, according to markup documents explaining the proposed cuts. The documents also say many of the agency's functions are duplicated within the federal government or are more appropriately performed by the private sector.

Defending the agency, HHS Assistant Secretary Phil Lee said AHCPR ''has a crucial role in outcomes and effectiveness research'' and said its expertise in developing a methodology for premium risk adjustment ''doesn't exist anywhere else in government.'' GOP critics ''clearly misinterpreted the role of the agency'' with respect to health reform, Lee told reporters May 17.

According to administration budget documents, about half of the agency's current $163 million budget is devoted to its Medical Treatment Effectiveness Program, which includes funding for development of clinical practice guidelines. About 15 guidelines have been produced so far on topics ranging from bed sores to low back pain at a cost of up to $1 million each.

While critics of the agency say practice guidelines are better developed in the private sector by medical specialty societies, supporters argue AHCPR is better situated to produce objective, scientifically based guidelines with input from a broad spectrum of providers.

''There's no question that doing [guidelines] through AHCPR makes all the difference in the world regarding credibility,'' said an aide to Sen. Paul Wellstone (D-Minn). For example, AHCPR's guideline on low back pain states that many patients are helped by chiropractors--a finding not popular with orthopedic surgeons but that has nevertheless has increased credibility in the medical community, the aide said.

Outcomes Research

Related to its work on practice guidelines, AHCPR devotes significant MEDTEP resources to Patient Outcomes Research Teams (PORTS). These large, three- to five-year clinical studies designed to determine what works best in clinical treatment of common conditions like cataracts, prostate disease, and schizophrenia. Over the past five years, the agency has sponsored about 20 PORTS at various hospitals and universities.

The remainder of AHCPR's budget is devoted to research on a wide range of issues related to the financing and delivery of health care services. About $64 million is earmarked for funding research on health care quality, costs, and access. According to the president's budget for fiscal 1996, some of this money would be used to fund several extramural grants to study how to adjust health insurance premiums more appropriately. The request also would continue to support five ''Rural Health Centers''--operating in Seattle, Minneapolis, Chapel Hill, N.C., Denver, and Buffalo--to study rural health policy issues.

The administration is seeking a big boost in funding for AHCPR's National Medical Expenditure Survey (NMES), from $15 million to $36 million. The data gathered by the survey ''will continue to support the restructuring of health care in the private sector and at the federal and state levels,'' according to HHS budget documents. According to administration documents, the NMES survey is projected to cost a total of $92 million and is scheduled for completion in 1998.

Reinventing Government Initiative

Despite strong support for ACHPR in the budget request, the administration more recently has proposed ''privatizing'' some AHCPR functions as part of Vice President Al Gore's reinventing government initiative.

According to a May 11 HHS fact sheet, proposals include transferring development of AHCPR guidelines ''to public/private partnerships, with AHCPR continuing to fund several centers of excellence and standing panels but moving much of the effort to the private sector.'' The administration also is considering privatizing AHCPR's technology assessment activities, which the administration says could save as much as 50 percent over current costs.

The actual amount of savings projected by these changes--$18 million through fiscal 2000 and a reduction in the workforce by 8 employees--is nominal, however, compared to the administration's $194 million fiscal 1996 budget request.

--By Scott Falk

- Working w/ private sector to guide quality, save $

- Perceived weakness ⇒ getting back for HCR

- Biggest weakness – for first 5 yrs, focused only on quality rather than cost

AGENCY FOR HEALTH CARE POLICY AND RESEARCH
2101 East Jefferson Street, Suite 600
Rockville, Maryland 20852

TO : JENNIFER KLEIN

PHONE : 456-2599

FAX : 458-2878

FROM : **LISA SIMPSON, MB, BCh, FAAP**
SENIOR ADVISOR

PHONE : **(301) 594-6662**
FAX : **(301) 594-2168**

COMMENTS: Call if questions

NUMBER OF PAGES INCLUDING COVER SHEET ———

AHCPR PROFILE

Agency for Health Care Policy and Research • 2101 East Jefferson Street • Rockville, MD 20852

Mission

To generate and disseminate information that improves the delivery of health care.

Goals

To work with the private sector and other public organizations to:

- Determine what works best in clinical practice.
- Help consumers make better informed choices.
- Measure and improve the quality of care.
- Improve the cost-effective use of health care resources.

Agenda

Patient Outcomes Research — evaluating the effectiveness, in clinical settings, of health care interventions.

Clinical Practice Guidelines — assisting practitioners and consumers in making better health care decisions.

Consumer Choice — providing useful information on quality and value of health care.

Quality, Costs, and Access — improving the financing and delivery of health care.

Health Care Delivery — understanding and evaluating the health care marketplace.

Technology Assessments — providing information on the risks, benefits, and clinical effectiveness of new technologies.

Data Standards and Health Information Systems Development — contributing to the simplification of health care administrative systems.

In the current market-driven health care system, there is a critical need to understand the structure and organization of health care and the multiple factors influencing health care costs, quality, and the delivery of services. Additionally:

- Consumers need information to improve decisionmaking about benefits, practitioners, and treatments.
- Practitioners need information to improve the quality of care they provide.
- Policymakers need information to understand how the system is evolving and to make sound decisions about the future direction of health care.

To meet these needs, AHCPR builds and sustains the knowledge base through the following major areas of research:

Patient Outcomes Research

These studies evaluate the effectiveness of treatment strategies to show how they affect results important to patients—including quality of life and functional status. Patient outcomes research looks at treatments applied to typical patients by typical practitioners in typical community settings. Research findings can help to reduce unnecessary procedures. Projects include:

- **Patient Outcomes Research Teams (PORTs)** are large-scale, 3- to 5-year clinical studies designed to determine "what works best" in clinical treatment for common diseases and conditions. PORTs examine clinical problems as diverse as cataract, prostate disease, and schizophrenia. They have succeeded in documenting the current state of knowledge for common clinical practices, identifying areas for further research, and demonstrating the **relative benefits** of different interventions.

  For example, AHCPR's PORT on prostate problems found no clear evidence that radical surgery to remove the prostate is an effective treatment for localized prostate cancer, and found that the procedure results in high rates of serious complications. The PORT

- **Publishing free consumer information,** such as guides developed in connection with clinical practice guidelines. **These guides are used, and they work.** Knox Community Hospital in Mount Vernon, Ohio, reported that, thanks to the consumer guide on acute pain management, patients are less anxious, recover faster, and are better able to manage their conditions following discharge from the hospital. AHCPR also publishes other consumer information, including *Checkup on Health Insurance Choices*, to help consumers select insurance plans, and *Questions To Ask Your Doctor Before You Have Surgery*, to help consumers decide about surgery and get the best results.

Quality, Costs, and Access

AHCPR-supported research generates important new information on a wide range of issues related to the financing and delivery of health care services in the Nation's market-driven health care system. The goal of this research is to understand trends occurring in the health care marketplace (cost-cutting measures, consolidations and mergers, and increasing competition among providers) and their implications on quality and consumer choice. Examples of key activities include:

- **National Medical Expenditure Survey,** which analyzes how Americans use and pay for health care. No other national source of information exists for estimating the costs and analyzing financing options of proposed changes to the health care system. A new survey begins this year.
- **HIV Cost and Services Utilization Study** is developing information on the services used by persons with HIV infection and their costs. Unlike other AIDS-related biomedical research and service delivery programs, HCSUS will collect data on access and barriers to care that can be used to make policy decisions regarding the cost and quality of care for patients with HIV/AIDS.
- **Quality measures** developed by AHCPR will enable practitioners and policymakers to assess and continually improve the quality of care delivered in everyday patient care settings.

Health Care Delivery

- **Primary care** is the most frequent site of health care delivery, and the source of most referrals to secondary and tertiary care. AHCPR's research in this area focuses on the processes of referrals and consultations by primary care clinicians and on variations in referral patterns. Research also evaluates strategies that lead to changes in provider behavior.
- **Managed care** is one focus of research supported by AHCPR that provides a greater understanding of the rapid financial and organizational changes occurring in the U.S. health care system. Understanding these changes and informing policymakers of their effects on the access, costs, and quality of health care is an important goal of AHCPR.

  For example, data from an AHCPR study show that doctors in managed care plans spend more time with patients than do fee-for-service doctors, and their patients receive more preventive care, ask more questions, and are more involved in treatment planning. AHCPR-backed researchers also have found that these plans deliver care at lower costs.
- **Rural health care** demonstrations supported by AHCPR develop innovative ways to deliver health care services in these areas. Many health care innovations such as managed care are available in metropolitan areas, but are frequently unavailable to rural populations. Five specialized rural health centers will lay the groundwork for planning future Statewide or regional managed care systems, which would make primary care more available to rural residents.

Technology Assessments

These studies evaluate the risks, benefits, and clinical effectiveness of new medical technologies, and often form the basis for coverage decisions by federally funded medical programs. Technology assessments also yield information that helps managed care plans and other purchasers make more rational decisions about which new, highly technical equipment to purchase and which newly introduced or commonly performed tests and procedures to cover.

Examples of technology assessment topics include liver transplantation, cardiac rehabilitation programs, diagnosis and treatment of impotence, and carotid endarterectomy.

Data Standards and Health Information Systems Development

AHCPR is leading efforts to help overcome one of the largest barriers to evaluating the health care system: the lack of standards for uniform methods of developing, collecting, and exchanging data. AHCPR also supports activities to develop computerized medical records. These efforts will contribute to the administrative simplification goals that many experts believe are critical to improving the efficiency of the health care system.

also documented the high and rapidly increasing use of this surgery, particularly in men older than 70, for whom the benefits are most questionable.

- **Research Centers on Minority Populations** investigate which clinical strategies work best for conditions prevalent among African Americans, Latinos, Asian and Pacific Islanders, Native Americans, and Alaskan Natives. Examples of the conditions under study are high blood pressure, kidney disease, tuberculosis, low birthweight, substance abuse, and certain cancers.
- **Pharmaceutical Outcomes Projects** study the effects of prescription drugs on patient outcomes. Among the 14 research grants supported to date are studies examining pharmaceutical care for pediatric asthma, antidepressant drug use in the elderly, and the role of the patient in arthritis treatment.

Clinical Practice Guidelines

AHCPR facilitates the development of guidelines by convening multidisciplinary panels of private-sector experts. The guidelines—which are based on comprehensive reviews of the scientific literature, including PORT findings—help health care practitioners and consumers determine the best ways to prevent and treat diseases and other health conditions.

AHCPR has disseminated more than 15 million guideline documents to hospitals, managed care plans, consumers, and others. Through partnerships with private-sector firms, AHCPR has arranged for the reprinting of almost 10 million additional copies—**a value of $9.7 million in printing and distribution costs footed by the private sector.** In collaboration with the National Library of Medicine, AHCPR offers full-text retrieval of guidelines through the MEDLARS database.

With widespread use, it is anticipated that clinical practice guidelines will improve the overall quality of health care and lead to lower health care costs. For example:

- Findings from an AHCPR-supported panel showed that 90 percent of **acute low back problems**—a condition estimated to cost $50 billion a year overall—disappear on their own within one month, obviating the need for costly interventions in most cases.
- AHCPR's guideline on **preventing pressure ulcers** saved Salt Lake City-based Intermountain Health Care nearly a quarter of a million dollars in just six months in one of its hospitals. The chain is implementing the guideline in its 23 other hospitals.

Consumer Choice

Consumers today demand greater quality and value from their health care than ever before. AHCPR provides solid, reliable, easily understandable information to help consumers select health care plans, practitioners, and facilities based on quality and value, and to help them make better informed choices about their personal health care needs. AHCPR is:

- **Developing "report cards"** that will provide comparative information on health plans' abilities to provide high-quality, accessible services that satisfy consumers' needs.
- **Designing and testing consumer surveys** that measure consumer perceptions of health care plans and services. The surveys ultimately will be used by the health care industry, managed care, and others to assist consumers as they select health plans.

Examples of other released guideline topics include:

- **Unstable Angina**
- **Heart Failure**
- **Urinary Incontinence**
- **HIV Infection**
- **Acute Pain**
- **Cancer Pain**
- **Depression**
- **Cataract**

Guidelines under development include:

- **Post-Stroke Rehabilitation**
- **Cardiac Rehabilitation**
- **Screening for Alzheimer's Disease**
- **Smoking Cessation**
- **Chronic Pain: Headache**

What Others Say About AHCPR

"...Some of the money that the federal government spends does indeed help Americans in ways that the private market, however admirable, cannot. The case of the guidelines on lower back pain is an example to keep in mind."

Washington Post editorial
December 12, 1994

"The AHCPR is responsible for producing and relaying scientific and policy-relevant information about the quality, medical effectiveness, and cost of health care.... This is a very valuable resource for public policy makers, Members of Congress, the Executive Branch...."

John Liu
The Heritage Foundation

And about our guidelines:

"By moving from traditional pain management, we're seeing a shift from [typically] 8 to 10 day stays in the hospital to 3 day stays...."

Dr. Anthony Nyerges
UCLA Medical Center
(Implemented AHCPR guideline on acute pain management)

"We've seen less than half the number of hospital-acquired pressure ulcers than we had previously."

Pamela Schopp, R.N.
South Suburban Hospital, Hazel Crest, Illinois
(Implemented AHCPR guideline on preventing pressure ulcers)

And about our consumer information:

"...The best material on the subject — most comprehensive and least technical...."

Ann Landers—on the depression guideline consumer guide
(Column generated over 100,000 requests)

Facts About AHCPR

Established

December 1989; replaced the National Center for Health Services Research and Health Care Technology Assessment.

Employees

AHCPR has 264 employees, including experts in health policy, medicine, nursing, economics, epidemiology, sociology, and statistics.

Budget

$162,637,000 for FY 1995.

For more information, contact:

Robert Griffin, Peter Garrett, or Kevin Murray
Agency for Health Care Policy and Research
2101 East Jefferson Street
Rockville, MD 20852
Telephone: (301) 594-1364
Fax: (301) 594-2283

Lisa Simpson
600

AHCPR MAKING A DIFFERENCE: COST SAVINGS

The Nation now spends over $1 trillion annually on health care, including $400 billion by Medicare and other Federal health programs. Government, business, other large payers, as well as the average consumer, are looking for ways to rein in health care costs.

The Agency for Health Care Policy and Research (AHCPR) is part of the solution to reducing health care costs. AHCPR contributes to reducing health care expenditures by identifying ineffective, suboptimal, unproven, and unnecessary medical treatments and technologies, and by demonstrating more efficient and cost-effective means of delivering health care. AHCPR research, technology assessments and clinical practice guidelines convey accurate, scientifically based information which, if widely applied, can help reduce health care costs and, at the same time, improve the quality of health care.

AHCPR clinical practice guidelines and patient outcomes research teams address 10 of the 15 most costly diagnoses for which Medicare patients are hospitalized as well as other costly health problems for the non-elderly population, such as low back pain.

What are some of the things we have learned from AHCPR's investments in outcomes research, guidelines and technology assessments?

- There are wide variations in clinical practice.
- Many clinical interventions are unproven.
- Overuse, underuse, and misuse of some services and treatments is common.
- Better quality health care often costs less.

AHCPR Clinical Practice Guidelines

AHCPR-supported clinical practice guidelines emphasize eliminating the use of unproven, ineffective or unnecessary medical tests and therapies and encourage the use of those that have been shown to be effective and appropriate. Wide adoption of AHCPR's guidelines, as a whole, will help reduce costs and improve quality of care.

Following AHCPR guideline recommendations leads to lower costs through:

- Early detection of disease.
- Shortened hospital stays.
- Fewer hospital re-admissions.

- Increased use of outpatient care vs. hospitalization.
- Faster return to work (increased productivity).
- Prevention of medical complications.

National Projections

Cost impact projections have been conducted to date for three of the 16 guidelines released by AHCPR--acute low back problems in adults, otitis media with effusion in young children, and treatment of pressure ulcers. Systematic adoption of these three AHCPR guidelines alone could save more than $6.9 billion a year. Even 10 percent adoption results in annual cost savings exceeding the Agency's budget.

- Low back pain: AHCPR's guideline could save $5 billion annually and reduce direct medical costs for acute low back pain by 25 percent--from the current estimated $20 billion a year to $15 billion annually. Avoidance of unproven and/or unnecessary diagnostic tests and therapies would produce the savings.

OR

- Use of AHCPR's acute low back problem guideline can reduce health care costs for a typical 3-month episode of back pain by 35 percent, compared with current medical practice. Currently, acute low back pain costs an estimated $20 billion annually in medical care.

- Acute otitis media with effusion (a common ear problem in young children): The AHCPR guideline on this problem could save an estimated $850 million a year by reducing the use of antibiotics and the use of unnecessary ear surgery.

- Pressure ulcer (bed sores) treatment: Savings from the use of this AHCPR guideline could total $40 million by improving the effectiveness of care and reducing the need for surgery.

Local Use

Evidence is growing of how AHCPR guidelines are helping hospitals, nursing homes, home health agencies, and other local users to reduce their costs.

For example:

- Intermountain Health Care, a Salt Lake City-based health care system, saved $240,000 in 6 months by using AHCPR's pressure ulcer prevention guideline in one of its hospitals. Intermountain is now implementing the guideline in its 23 other hospitals.

- Abbott-Northwestern Healthcare System in Minneapolis estimated it would save $288,000 annually by using AHCPR's pressure ulcer prevention guideline; it is now using the guideline throughout its system of medical facilities.

- Singing River Hospital in Pascagoula, Mississippi, has reduced the average length of stay for surgical patients by 1 day since 1993. The hospital says AHCPR's acute pain management guideline contributed to the decrease.

- The Ralston-Penn Center in Philadelphia has reduced initial patient testing for urinary incontinence and cut costs since adopting recommendations from AHCPR's guideline on this condition.

- Applying techniques from AHCPR's pressure ulcer prevention guideline has helped Arizona's Tucson Medical Center reduce surgical patients' length of stay and costs.

AHCPR Health Technology Assessments

AHCPR evaluates the safety, effectiveness, cost-effectiveness, and appropriate uses of medical devices, procedures and other technologies being considered for coverage by Medicare. AHCPR's recommendations influence Medicare coverage decisions, and are used by many private health insurers as well. Recommendations against the use of a particular technology, or for limiting its use, help payers avoid needless expenditures.

Although AHCPR has not conducted a formal analysis of the cost-saving potential of its overall health technology assessment program, the National Academy of Sciences' Institute of Medicine estimated the program saves Medicare at least $200 million a year--200 times the budget for the Office of Health Technology Assessment, and $27 million more than AHCPR's entire budget in FY 1995.

Examples of Cost-Saving AHCPR Technology Assessments:

- By finding that cardiac rehabilitation is appropriate only for specific conditions, AHCPR saved Medicare as much as $12.4 million annually.

- Finding that intermittent positive pressure breathing was not useful saved Medicare $1.5 million in annual expenditures.

- AHCPR found no evidence that diagnosis or treatment of insomnia is improved by polysomnography. Denial of

coverage for this technology for qualified members of the uniformed services and their dependents saved the federal government as much as $1.6 billion the first year. Continuing savings, as a result of this technology assessment, may total up to $100 million annually in avoided costs.

- AHCPR found that the most expensive lymphedema pumps are not superior to the least expensive devices. This finding could save Medicare between $12 million and $14 million annually.

AHCPR Research

Medical effectiveness and other health services research sponsored by AHCPR provides valuable insights into how to improve the efficiency of health care delivery and reduce health care costs.

For example:

- Use of transurethral resection of the prostate--an operation for benign prostatic hyperplasia (BPH)--has fallen nearly 33 percent in recent years, influenced in part by AHCPR research on prostatic diseases and AHCPR's guideline on BPH. This drop in volume saves Medicare an estimated $104 million annually.

- AHCPR research on low back pain has produced findings that have the potential of reducing health care expenditures. These include findings that:

  - Back surgeries could fall by 250,000 a year--or 80 percent--and produce a savings of $1 billion to $2 billion annually, at a minimum, as a result of changes that are implied by AHCPR's findings. For example: many decisions to operate are influenced by the physician's practice style, not objective criteria; and long-term outcomes for many back surgery patients appear to be the same whether or not they have back surgery.

  - Elimination of thermography for diagnosis of herniated discs would save at least $10 million annually. AHCPR research found insufficient scientific evidence to justify using the test for this condition.

  - Elimination of unnecessary applications of lumbar imaging could reduce its use by 25 percent and save nearly $1 billion annually. This could be achieved by application of a cost-effective diagnostic strategy for primary care physicians developed by AHCPR researchers.

- AHCPR research found screening methods employers currently use to predict which employees will have low back problems to be of questionable value. They indicated that if the costs of these tests were redirected to more effective preventive activities on the job, the savings could exceed $10 million annually.

o Cataract surgery has declined 7 percent over the last 3 years, due in part to findings from AHCPR research on cataract management and AHCPR's cataract guideline. This represents an annual savings of $210 million for Medicare and $40 million for other payers, or $250 million overall per year.

o AHCPR research estimates that Medicare could save at least $472 million a year if all non-insulin-dependent diabetics were screened and treated for eye diseases. Even if only 60 percent were screened and treated, Medicare would realize a net annual savings of nearly $250 million.

o AHCPR research shows that 60 percent of patients who develop pneumonia outside the hospital can be safely managed in ambulatory care settings and, thereby, save the expense of hospitalization.

o An Indiana Hospital participating in an AHCPR-funded study saved $887 per admission by having its physicians order drugs, diagnostic tests, and nursing care, through personal computers conveniently located throughout the hospital. Although this was an experiment, adoption of the system could have saved the hospital $3 million per year.

o A large primary care practice, also the site of an AHCPR-funded study, could have saved $250,000 annually by having physicians order tests through use of an experimental computer system that instantly provides cost and other information. Study results showed that physicians ordered 14 percent fewer tests per patient during the experiment.

Other significant AHCPR research findings:

o Cervical cancer screening at 4-year intervals is cost effective.
o Patients enrolled in HMOs use 10-40% fewer hospital days than fee for service patients.
o Prenatal care for pregnant women with diabetes saves $2,425 per patient.
o Prenatal smoking cessation programs saved $3 in averted medical costs for every $1 spent.

- Providing appropriate home care to patients with poor cognitive function reduces costs by 20%.
- Medicaid drug caps can backfire by increasing emergency room and inpatient costs.
- Poor and uninsured patients are hospitalized more often than insured patients for some costly conditions

Building Partnerships in the Public and Private Sectors

AHCPR's close working relationships with the medical and nursing communities, the business community, the managed care community, consumer organizations, and State and Federal agencies have translated into real savings to taxpayers. As an example, the Agency has leveraged private sector support to reprint over 9 million copies of its clinical practice guideline products, with a market value of $10 million in printing and distribution costs. This supplements the 18 million copies of guidelines published by AHCPR, for a total of 27 million printed documents.

These efforts have brought AHCPR's work respect and credibility. The American Medical Association is one of the strongest proponents of AHCPR's guidelines program and has been an active participant in the press conferences announcing guidelines. State and local governments have praised the Agency for bringing research findings and policy-relevant information to officials who have to manage health programs at the State and community levels. Consumer organizations have commended AHCPR for producing understandable information to help consumers make better choices in the health care they receive.

###

SUMMARY OF COST SAVINGS ATTRIBUTABLE TO AHCPR ACTIVITIES (ESTIMATE)

Condition	Annual Savings
Low back guideline	$5 billion
Reduction in use of unproven diagnostic modalities for low back pain	$1 billion
Reduction in back surgeries	$1-2 billion
Elimination unnecessary lumbar imaging	$1 billion
Eliminate unnecessary screening for back problems	$10 million
Reductions in cardiac procedures	$941 million for Medicare
Otitis media guideline	$850 million
Screening & treatment of eye diseases in diabetics	$472 million for Medicare
Reductions in cataract surgeries	$200 million for Medicare
Technology assessments	$200 million for Medicare
Pressure ulcer prevention	$544 million
Reductions in prostate surgeries	$104 million for Medicare
Thermography for herniated discs	$10 million
Reductions in x-rays for injured limbs	$79-139 million
Urinary incontinence guideline	$42 million
Pressure ulcer treatment	$40 million
Use of inexpensive lymphedema pump	$14 million for Medicare

Role and Contributions of the Agency for Health Care Policy and Research

Background

AHCPR was created on a bipartisan basis by Congress in 1989 with a specific mandate to improve health care quality and reduce health care costs by conducting research, developing clinical practice guidelines, and disseminating information widely. In the last 5 years, AHCPR has more than met this mandate.

AHCPR's Important Role

- **Developing Tools for Ensuring Quality of Care in Public and Private Sector Health Care Programs.**

  In a competitive marketplace, buyers always consider cost. But in health care the stakes are often too high to consider costs alone. The challenge is to assure that purchasers and consumers receive quality care at a reasonable price. ***AHCPR is the principal Federal agency for developing the tools desperately needed by the public and private sectors to measure and compare quality.*** Without AHCPR's leadership and support, private organizations would not have the economic incentives to develop these tools and make them widely available to those involved in delivering quality health care.

- **Providing the Public and Private Sectors with Critical Information to Achieve Health Care Savings.**

  AHCPR is the principal Federal agency devoted to determining what is effective, and cost-effective, in health care. Americans spend nearly $1 trillion annually on health care; the Federal Government's share amounts to over $350 billion. With the rapid change in the health care system through mergers, consolidations, and new delivery systems, there is a critical need to understand what works best in the organization, financing, and delivery of health care services—answers that AHCPR-supported research can provide.

  While the Agency's outcomes research and clinical practice guidelines have focused on improving quality of care, these activities are also saving taxpayers' dollars. There are numerous, real-world examples from health care providers of how AHCPR's products are reducing costs. For example, the Agency's research on cataract surgery and lens replacement has contributed to an 8-percent decline in the rate of cataract surgery paid for by Medicare while improving the quality and appropriateness of cataract care in elderly patients.

- **Serving as a Source of Unbiased Information in Today's Market-Driven Health Care System.**

  Policymakers, practitioners, purchasers, insurers, consumers, and patients face daunting and often controversial choices: Which treatment, procedure, or technology is most effective? Which physician or health plan is best? Which services should be reimbursed and at what price? Given the complexity of health care, it is extremely difficult to sort through the vast amounts of scientific data in order to judge the validity of competing claims.

  In this environment, ***AHCPR plays a unique role as a source of unbiased information.*** As a public agency with no regulatory authority and no responsibility for the day-to-day operation of specific Federal health care programs, the Agency serves as an "honest broker" among competing public and private sector interests. Because its mission is improving the health of all Americans, it conducts and supports studies on questions of national significance, far beyond the capacity or scope of an individual health plan or a consortium of plans.

- **Building Partnerships in the Public and Private Sectors.**

  Whether it is developing or disseminating clinical practice guidelines, quality measures, consumer surveys for enrollees in managed care systems, or profiling "best practices" in the purchasing or delivery of health care services, ***AHCPR relies upon public-private sector partnerships in every aspect of its work.*** AHCPR's close working relationships with the medical and nursing communities, the business community, the managed care community, consumer organizations, and State and Federal agencies have translated into real savings to taxpayers. As an example, the Agency has leveraged private sector support to reprint over 8 million copies of its clinical practice guideline products, with a market value of $10 million in printing and distribution costs.

  These efforts have brought AHCPR's work respect and credibility. The American Medical Association is one of the strongest proponents of AHCPR's guidelines program and has been an active participant in the press conferences announcing guidelines. State and local governments have praised the Agency for bringing research findings and policy-relevant information to officials who have to manage health programs at the State and community levels. Also, consumer organizations have commended AHCPR for producing understandable information to help consumers make better choices in the health care they receive.

AHCPR's Contributions

- **Improving the Efficiency of the Health Care Delivery System.**

  AHCPR has been a leader in research directed at understanding the growth and competitive effects of health maintenance organizations (HMOs) and other managed care systems. AHCPR-supported research found that potentially large savings could be achieved through the use of HMOs and contributed to bipartisan policies to promote their use.

- **Improving the Clinical Practice of Medicine.**

  AHCPR has made important contributions assisting clinicians in providing better quality medical care. Its work to uncover the most effective strategies for treating and preventing commonly occurring and expensive health conditions, such as low back pain, cataracts, prostate disease, otitis media, and pressure ulcers, has resulted in recommendations that not only improve the quality of clinical practice but also lead to significant savings in health care expenditures.

- **Reducing Health Care Costs.**

  According to the Institute of Medicine, at least $200 million a year in Medicare expenditures is saved through AHCPR's technology assessment program. Savings result from assessments that recommend against paying for certain procedures that demonstrate little clinical utility.

- **Development of Measurement Systems.**

  AHCPR established the basis for the Prospective Payment System, using Diagnosis-Related Groups as an approximation of case mix. Through continued research, AHCPR developed internationally used systems for measuring severity of illness in intensive care units, such as the Acute Physiology and Chronic Health Evaluation (APACHE) instrument. The Agency also supported the development of Activities of Daily Living (ADLs) as a measure of functional disability used in eligibility determinations and in nursing home evaluation and reimbursement decisions.

- **Supporting Research on the Clinical Uses of Computers.**

  AHCPR established the value of computers in clinical decision-making and initiated the development of software that has become the basis for the National Cancer Institute's Physician Data Query (PDQ) system. AHCPR also supported the development of the *M*assachusetts General Hospital *U*tility, *M*ulti-*P*rogramming *S*ystem (MUMPS), a medical computer language that has become a standard for the field.

Samples of AHCPR's Significant Contributions to Improved Health Care

- **Prostate Disease** - Benign enlargement of the prostate gland and the urinary dysfunction it causes affects over half of all men older than age 60, and 8 of every 10 men by age 80.

  AHCPR supported research on prostate disease—and AHCPR's clinical practice guideline—have contributed to a reduction in transurethral resection of the prostate (TURP) of over one-third. Annual Medicare payments for this procedure have dropped by $90 million in just three years.

- **Cataract Surgery** - is the most common operation among Medicare beneficiaries, with more than 1.35 million procedures performed annually at a cost of $3.4 billion.

  AHCPR's Patient Outcomes Research Team (PORT) on cataracts, along with a clinical practice guideline on cataract management, have helped reduce the rate of surgery and preoperative testing. The volume of surgery has dropped by 8 percent. Over a three year period, annual Medicare payments for cataract surgery have dropped by $300 million.

- **Managed Care** - AHCPR and its predecessor, the National Center for Health Services Research, has been a leader in research directed at understanding the growth and the competitive effects of health maintenance organizations and other managed care systems. Throughout the 1980s, AHCPR provided financial support to researchers to investigate these issues. The finding that potentially large savings could be achieved through the use of health maintenance organizations and other managed care organizations has led to bipartisan policies promoting their use. The studies also identified problems and offered solutions in translating these potential savings into lower overall premiums to the population.

- **Low Back Pain** - In 1990, the United States spent more than $20 billion for direct medical costs associated with all low back problems. Widespread adoption of AHCPR's recent guideline on the treatment of acute low back pain may not only improve the quality of care and hasten recovery of patients, but could also reduce direct medical costs by one quarter—a savings of over $5 billion per year. The low back pain PORT also has produced studies that improve quality and reduce cost.

- **Pressure Ulcers** - Implementation of AHCPR's pressure ulcer prevention guideline in hospitals and nursing homes nationwide could save payers several hundred million dollars per year, based on the experience of an Intermountain Health Care hospital in Salt Lake City, Utah. Intermountain saw its pressure ulcer rate drop by more than 50% with an estimated savings of $4,200 per pressure sore averted. An estimated 150,000 patients per year get pressure ulcers in hospitals and 109,000 get them in nursing homes nationwide.

- **Otitis Media** - Implementation of AHCPR's guideline on the treatment of otitis media with effusion in young children would cut the total cost of care in half. Annual savings among 2-year-old children would exceed $700 million.

- **Pneumonia** - AHCPR's research on community-acquired pneumonia focused on the most expensive component of pneumonia care, i.e., hospitalization, and developed a measure to identify patients who are at low risk of death or serious complications if they are not hospitalized. Approximately 60 percent of pneumonia patients can be safely managed in ambulatory settings and, thereby, save the expense of hospitalization.

- **Technology Assessment** - According to the Institute of Medicine, at least $200 million a year in Medicare is saved through technology assessments by AHCPR's Office of Health Technology Assessment. For example, savings result from assessments that recommended against paying for thermography and polysomnography for evaluation of insomnia.

  OHTA's assessments also improve the quality of care for the Medicare population. Procedures for which clinical utility has been shown for the Medicare program include liver transplantation, cardiac rehabilitation, and laparoscopic cholecystectomy.

- **Cardiac Disease** - Coronary artery disease remains the primary cause of death and major illness in the United States. AHCPR supports a wide range of research on cardiac problems and treatment of coronary artery disease. Research products include software to help physicians quickly identify heart attack patients, evidence that less expensive care is as effective as high-tech care, and evidence on the effectiveness and costs of coronary angioplasty and coronary artery bypass surgery.