AGENCY FOR HEALTH CARE POLICY AND RESEARCH

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Program Level	$159	$126	$144	+$18
Budget Authority	141	80	90	+10
Outlays	139	129	97	-32
FTE	267	267	267	0

* Based on levels of the ninth CR, including an incremental policy adjustment.

Summary

The FY 1997 request for the Agency for Health Care Policy and Research (AHCPR) provides a program level of $144 million. Consistent with a Department-wide HHS Survey Integration Plan, AHCPR will fully fund the Medical Expenditure Panel Survey (MEPS)--replacing the National Medical Expenditure Survey (NMES)--at $45 million, as well as continue to fund its highest priority ongoing research commitments.

AHCPR directly contributes to improving the management of this nation's health care enterprise. Results of its health services research and clinical practice guidelines are used every day by health care providers working to improve quality of care while managing the financial bottom line. Its data collection and analysis are important to health policy analysis and help guide the decisions made by those steering the future of this nation's health care industry.

AHCPR works in partnership with the private sector in determining which medical interventions work best and provide the most value for our health care dollar in the day-to-day practice of medicine. In addition, AHCPR research addresses the effectiveness and cost-effectiveness of the organization, financing, and delivery of health services.

Research on Health Care Outcomes and Quality

The FY 1997 request for the Research on Health Care Outcomes and Quality program (HCOQ), formerly the Medical Treatment Effectiveness program (MEDTEP), is $48 million. At this level, AHCPR will continue to fund high priority continuation projects in outcomes research, particularly for conditions prevalent in the Medicare and Medicaid populations. HCOQ research helps consumers and providers make more informed choices about health

care. Part of that effort is to first determine what works in clinical practice through outcomes and effectiveness research and then educate consumers and providers on research results, particularly through the clinical practice guidelines program.

To cite a recent example of outcomes research, a grant to Duke University showed appropriate anticoagulant therapy could prevent strokes and save $600 million annually, cutting the number of strokes each year from 80,000 to 40,000. Implementation of AHCPR findings in just 20 percent of patients for the following conditions could save health care costs as follows (1996-2002): acute low back pain ($1.2 billion); stroke prevention ($832 million); prostate disease ($770 million); and acute pain management ($599 million).

Other HCOQ research includes:

•..... Emergency Department Triage for Suspected Acute Cardiac Ischemia (ACI): Some 3.5 million of the 7 million people with ACI's who present to emergency departments annually are hospitalized, yet 50 percent of those are found not to have ACI and another 7 percent are sent home erroneously. This multi-center prospective controlled clinical trial will evaluate the potential of scanning aids to improve the accuracy of diagnosis of ACI.

•..... Pediatric Asthma Care: This two-stage randomized controlled clinical trial is assessing the cost-effectiveness of comprehensive intervention for pediatric and adolescent asthma patients. The major outcomes to be measured include cost, functional status, results of pulmonary function tests, and changes in medication use.

•..... Pelvic Inflammatory Disease (PID): This project is testing the most effective treatment approach for PID. This condition affects more than one million women a year and can result in infertility, ectopic pregnancies, and chronic pelvic pain. The cost of treating PID and its complications is estimated at $4 billion annually.

•..... Strategies for Care of the Very Low Birthweight Infant: Neonatal intensive care has been the main reason for reduced infant mortality, but with success has come escalating medical treatment costs and increasing burdens of long-term functional impairments and disabilities. This study, which is scheduled for completion in 1997, addresses the outcomes, costs, and utilities of neonatal intensive care.

Improved methodologies have been developed for the second round of Patient Outcomes Research Teams (PORT II). Areas of research in FY 1997 include the care, cost and outcomes of local breast cancer and improving the cost-effectiveness of care for depression.

Pharmaceutical outcomes research projects will be continued in FY 1997, and will study the efficacy and cost-effectiveness of prescription drugs and related pharmaceutical interventions for treating clinical conditions. One recent example of this research is a grant to Vanderbilt School of Medicine that showed requiring prior authorization from the Tennessee Medicaid program in order to prescribe more costly arthritis medication saved $12.8 million over two years, without causing the substitution of other, more toxic drugs or increased use of medical services.

During FY 1997, AHCPR will support seven Research Centers on Minority Populations, focusing on which clinical strategies are best for clinical conditions with the greatest prevalence among African-Americans, Latinos, Asian and Pacific Islanders, American Indians, and/or Alaska Natives. Conditions being studied include high blood pressure, kidney disease, tuberculosis, low birthweight, substance abuse, and certain cancers.

AHCPR's clinical practice guidelines program enhances the quality, appropriateness, and effectiveness of health care. AHCPR has arranged for the development of 22 science-based clinical practice guidelines that address some of the most significant health care problems facing Americans. Seventeen of these guidelines have been released ranging in subject from treatment of acute postoperative pain to cardiac rehabilitation. This month AHCPR released an update of the Urinary Incontinence in Adults guideline, which reaffirms the work of the 1992 panel and shows that urinary incontinence is treatable and those afflicted need not suffer in silence. AHCPR's guidelines not only reduce medical treatment uncertainty, they can directly benefit consumers and medical practitioners by improving patient outcomes and quality of life. The guidelines can also benefit the nation by eliminating or reducing the use of medical tests and therapies that do not work or are unnecessary.

Research on Health Care Systems Costs and Access

The FY 1997 request includes $49 million for the Health Care Systems Cost and Access program (HCSCA), formerly the Research on Health Care Costs, Quality and Access program. HCSCA research develops the analyses and tools needed to improve the functioning of the health care system. At this level, AHCPR will fund high priority continuation projects in a variety of areas, including consumer decision making; the health care marketplace; primary care; managed care; rural health services; and AIDS health services.

AHCPR will continue to support a major initiative to assist consumers in selecting high quality health plans and services, the Consumer Assessments of Health Plans Study (CAHPS). Surveys by objective, non-government polling firms have shown that most Americans would like to have more information to help them choose hospitals, doctors, and health care plans. CAHPS brings together the nation's top experts in patient satisfaction and survey research to develop and test the best methods for measuring consumers' satisfaction with their health plans and methods for getting the results to consumers.

Also, research on market forces in a changing health care system will be sustained. These projects are examining how changes in the structure of defined markets have affected the way health care providers produce and deliver care and the price, distribution, and quality of services available.

The request will maintain support for research on primary care, the most frequent site of health care delivery, and the source of most referrals to secondary and tertiary care. Examples of primary care research include a study testing the effect of an interactive CD designed to decrease cervical cancer by improving the frequency and quality of screening for patients in community health centers.

Managed care research supported by AHCPR provides a greater understanding of the rapid financial and organizational changes occurring in the U.S. health care system. An example of managed care research underway is a study showing that managed care patients spent two fewer days in an intensive care unit than patients with fee-for-service health insurance, with the average stay for managed care patients costing $8,000 less, with no difference in mortality or ICU readmission between the two groups.

AHCPR will continue to fund five specialized centers for rural health services demonstrations in Iowa/Nebraska, Maine, West Virginia, Arizona, and Oklahoma. AHCPR also will continue to support the HIV Cost and Services Utilization Study (HCSUS), a large-scale study that provides vital information on costs and services resulting from health care delivery to the HIV-infected persons.

Health Insurance and Expenditure Survey

The FY 1997 request includes $45 million, an increase of $30 million over FY 1996, to support the second year of the Medical Expenditure Panel Surveys (MEPS). This investment will fund costs associated with the move from the development phase and early data collection phase of the surveys to the full data collection phase. The field work for the household and nursing home surveys started in FY 1996. In FY 1997, these surveys both continue with the household survey intensifying, plus the health insurance plans survey, the medical provider plan survey, and the national health insurance survey will all start data collection. During the full data collection phase, all five surveys will be in the field where extensive interviews are conducted by employing such innovations as computer assisted personal surveys that will greatly improve the timeliness of MEPS results. Early access to data for analysis will allow health care policy makers to base decisions on more current information than has been available in the past.

No surveys other than MEPS provide the Federal Government or the private sector with detailed information regarding the health care services used by American families and individuals; the cost, scope, and breadth of private health insurance coverage held by and available to the U.S. population; and the specific services that are purchased through out-of-pocket and/or third-party payments. This information is essential for developing national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy, and estimates of who benefits and who bears the cost of a change in policy.

Under the Department's Survey Integration Plan, important linkages with other HHS surveys have been established that will help keep survey costs lower than originally projected--and improve data collection and analysis of health care expenditures and health insurance in the U.S. MEPS builds upon the strengths of the 1977 and 1987 National Medical Expenditure Survey (NMES) and streamlines the Department's data collection efforts. Unlike NMES, which developed its own large sampling frame of families to interview, MEPS relies upon an existing nationally representative sampling frame developed by the National Center for Health Statistics (NCHS) and eliminates duplication that existed with the Health Care Financing Administration (HCFA) in surveying the over-65 population. MEPS also incorporates and links the National Health Interview Survey (NHIS) with the survey components of MEPS.

MEPS, which began in FY 1994, will now include a national employer health insurance survey component. The purpose of the employer health insurance survey is to obtain national and state-specific estimates of the availability of health insurance at the workplace, type of coverage provided by employers, and the associated costs of coverage.

Analytical work on the data collected will begin in FY 1997 and is expected to be complete by FY 2001. As part of the Department's Survey Integration Plan, MEPS will no longer be a periodic annual survey. Instead it will be converted to an ongoing continuous survey--resulting in a continuous resource for those dependent on these data to manage this nation's health care industry. Over time, MEPS will provide more comprehensive data for public and private sector decision makers.

AHCPR OVERVIEW

(Dollars in millions)

	1995 Actual	1996 Policy*	1997 Request	Request +/-Policy
Research on Health Care Outcomes and Quality	$80	$55	$48	-$7
Research on Health Care Systems Cost and Access...	62	54	49	-5
Health Insurance & Expenditure Survey	15	15	45	+30
Program Support.....	2	2	2	0
Subtotal, Program Level	$159	$126	$144	+$18
Less Transfers: PHS Intra-agency....	-18	-46	-54	-8
Total, BA	$141	$80	$90	+$10
Medicare Trust Funds [Non add]....	[6]	[3]	[6]	[+3]
FTE	267	267	267	0

* Based on levels of the ninth CR, including an incremental policy adjustment.