

Are Appropriators Actually Authorizers in Sheep's Clothing? A Case Study of the
Policymaking Role of the House and Senate Appropriations Subcommittees on Labor, Health
and Human Services, Education, and Related Agencies

M. Boyce Ginieczki

A dissertation submitted to the faculty of Virginia Polytechnic Institute and State
University in partial fulfillment of the requirements for the degree of

Doctor of Philosophy
In
Public Administration and Public Affairs

By

M. Boyce Ginieczki

Karen M. Hult (Chair)
Larkin Dudley
Marybeth Farquhar
James F. Wolf

March 31, 2010
Alexandria, Virginia

Keywords: appropriations, policymaking, Agency for Healthcare Research and Quality,
authorization, congressional committees

Are Appropriators Actually Authorizers in Sheep's Clothing? A Case Study of the Policymaking Role of the House and Senate Appropriations Subcommittees on Labor, Health and Human Services, Education, and Related Agencies

M. Boyce Ginieczki

ABSTRACT

In the U.S. Congress, the authorization-appropriation process is the formal model that establishes the separation between legislative and funding bills. Additionally, it determines the jurisdiction of the congressional committees that oversee those bills. However, a number of scholars have concluded that the authorization-appropriations dichotomy is substantially different in practice than the model suggests. Research in this area has shown that broad changes over the years have altered the roles of the authorization and appropriations committees. At different times, members of the appropriations committees have been regarded as guardians of the federal treasury, advocates of federal funds for their congressional district, or partisans in support of a political agenda (Adler, 2000). In addition to these roles, appropriators evidently have become more active in *policymaking* -- a role that traditionally has been the domain of the authorizing committees.

To further explore the policymaking role of appropriators, this dissertation used a case study approach that traced appropriators' interactions with the executive branch, focusing on a federal agency and its links with the appropriations subcommittees that have oversight and funding jurisdiction over the agency's programs. Specifically, the study analyzed the relationship between the House and Senate Subcommittees on Labor, Health and Human Services, Education, and Related Agencies (L/ HHS) and the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) during the period from 1989-2009.

Through an examination of critical incidents and contextual elements, this dissertation examined whether the Subcommittees on L/HHS increasingly have become significant players in shaping AHRQ's policies and direction. In addition, the dissertation examined the impacts on AHRQ and possible reciprocal [Agency] influences on the Subcommittees. This research has the potential to build on existing works related to the dynamics of the authorization-appropriations process. Moreover, this research could provide a conceptual framework for analyzing the roles that the other congressional appropriations subcommittees play in relation to the executive branch agencies under their jurisdictions.

ACKNOWLEDGEMENTS

Conventional wisdom says that the process in achieving a doctorate degree is more like a marathon than a sprint. I actually would take that wisdom a step further and suggest that the process probably resembles something that feels more like an ultramarathon. I say this because there is a lot more to the process than meets the eye -- there is life, and life events often happen unexpectedly and can at times “get in the way” despite the best laid plans. Nevertheless, like anything in life, everything is a learning experience and while events can take things off track, they also can be used as reinforcements and ultimately become motivators in their own rite.

Of course, none of this can occur without the loving support that I have from my wife and best friend, Kelly, and our two wonderful children, Karly and Christian. My family is my *raison d'être* and I could not have completed this journey without their undying patience and support. Also, my mother, father, and siblings (Brandon, T.J., and Ros) provided me with inspiration along each step of the way and their reassurances helped me to persevere.

John Eisenberg, former Director of AHRQ, used to say that, “a turtle does not get on a fence post by itself.” Well, that adage certainly has held true to form throughout each stage of the long and, at times, arduous process of achieving a Ph.D. There are so many individuals who provided me with support, advice, and encouragement along the way that it is nearly impossible to thank everyone individually who helped me make this happen. However, I would especially like to thank those individuals who I was in close contact with throughout this process.

Karen Hult, my advisor and mentor, I want to thank you for all your input and sage advice during the process. The final product would not be where it is today without your insights and enhancements to my research. Thank you for challenging me and sharing your wisdom with me. You provided a very positive learning environment that every doctoral student should be so fortunate to experience. Also, I want to thank my dissertation committee members Jim Wolf, Marybeth Farquhar, and Larkin Dudley who accommodated their busy schedules to lend their guidance, feedback, and advice throughout the research process, which added tremendous value to the dissertation. I particularly want to thank Marybeth who helped me navigate the intricacies of the doctoral process and provided much support along the way.

I want to thank all my friends and colleagues at Virginia Tech, AHRQ, and those who I interact with on a daily basis, who provided me with their encouragement and support. I especially want to thank Jim Jensen and Rita Koch who have been mentors and friends to me and who played important roles in helping me to “grow up” within the confines of the political world of Washington. I also would like to thank Howard Holland, Irene Ritzmann, Karen Migdail, Lucie Levine, Alex Ommaya, Bob Griffin, Emily Holubowich, Christine Williams, Lisa Bernhardt, and Mark Mioduski whose friendship, encouragement, and guidance kept me motivated throughout the process. Additionally, I want to thank Carolyn Clancy and Kathie Kendrick who enabled me to pursue my studies amid my responsibilities at AHRQ. I am truly grateful for your support and accommodating my schedule to help me complete this endeavor.

Finally, I want to thank “Team Platinum,” my Master’s swimming group, who provided encouragement, humor, and challenging (although fun) workouts to help me clear my head each and every morning. I believe that some of my best ideas for this dissertation occurred while I was swimming.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS.....	iv
CHAPTER 1: The Authorization-Appropriations Process.....	1
Figure 1: Timeline of the Congressional Appropriations Process	4
CHAPTER 2: Public Policy Literature:.....	9
CHAPTER 3: Conceptual Framework	25
CHAPTER 4: Methodology	29
Figure 2: Interview Participants.....	34
Table 1: Interviews	36
CHAPTER 5: AHRQ and Critical Incidents	44
Table 2. Critical Incidents (1989-2009).....	46
<i>Critical Incident (1989): Establishing AHCPR</i>	<i>47</i>
Figure 3: AHRQ Appropriations History FY 1990 – FY 2009	51
<i>Critical Incident (1995): AHCPR’s (AHRQ’s) Near-death Experience.....</i>	<i>53</i>
Table 3: Votes by Members of House Appropriations Subcommittee	56
<i>Critical Incident (1995): Attack on AHCPR’s Clinical Practice Guideline Program .</i>	<i>59</i>
<i>Critical Incident (1998): Translate Research into Practice</i>	<i>64</i>
<i>Critical Incident (1999): Reauthorization of AHCPR.....</i>	<i>67</i>
<i>Critical Incident (1999): Medical Errors Report</i>	<i>71</i>

<i>Critical Incident (2003): Health Information Technology</i>	79
<i>Critical Incident (2004): Medicare Modernization Act of 2003</i>	81
<i>Critical Incident (2008): Health Care Associated Infections</i>	83
<i>Critical Incident (2009): American Recovery and Reinvestment Act 2009</i>	88
CHAPTER 6: Potential Explanations	93
Table 4: Members of the House Appropriations Subcommittee on L/ HHS (1995)	101
Figure 4: Letter from John Eisenberg to Chairman John Porter (<i>April 10, 2000</i>)	112
Table 5: Policymaking influence among authorizers and appropriators	131
CHAPTER 7: Interview Findings	127
Table 6: Average Policymaking influence among authorizers and appropriators.....	131
Table 7: Perceived Policymaking Influence of the Subcommittees on L/ HHS.....	145
Table 8: Average Policymaking Influence of the Subcommittees on L/ HHS	146
CHAPTER 8: Conclusions	153
REFERENCES	162
Appendix A: Interview Questions	169
Appendix B: Informed Consent Form	171
Appendix C: Listing of House Committee Reports (FY 1990-FY 2010).....	174
Appendix D: Listing of Senate Committee Reports (FY 1990-FY 2010).....	175
Appendix E: Senate Appropriations Report 106-293 - Medical Errors.....	176
Appendix F: Current Members (2010) House Subcommittee on L/ HHS.....	179
Appendix G: Current Members (2010) Senate Subcommittee on L/ HHS	180
Appendix H: AHRQ Funding History Table	181
Appendix I: AHRQ’s 1999 Reauthorization Act.....	182

To Kelly, Karly and Christian

CHAPTER 1

The Authorization-Appropriations Process:

Erosion of the Model

The House [shall] strip these appropriations bills of everything but were legitimate matters of appropriation, and such were not...be made subject of a separate bill.

John Quincy Adams, member of Congress (1837)

As a result of the active policymaking role of House and Senate Appropriations Subcommittees on Labor, Health and Human Services, Education, and Related Agencies (L/ HHS)¹, the Agency for Healthcare Research and Quality (AHRQ) has changed its direction and priorities throughout the past twenty years. For example, in 1996, AHRQ (then the Agency for Health Care Policy and Research or AHCPR) eliminated its development of a clinical practice guideline program at the urging of the House Appropriations Subcommittee on L/ HHS. Such a change was quite drastic, particularly since one of the driving forces behind the creation of the Agency was to have a federal agency develop practice guidelines. Of course, much of this reaction from the Agency can be attributed to its need for survival in the wake of its “near-death experience” in which the House Appropriations Subcommittee threatened to eliminate its funding entirely, in which I will go into greater detail in Chapter 3.

¹ The House and Senate Appropriations Subcommittees on L/ HHS have appropriations jurisdiction over the Departments of Health and Human Services, Education, Labor, and Related Agencies and their respective agencies.

AHRQ was able to weather the storms during the Republican Revolution and quickly adapt to the unfriendly environment. The Agency did this, in large part, by working more closely with the appropriations subcommittees, which included keeping open lines of communication, responding quickly and thoroughly to requests, and building solid working relationships with the appropriations staff. As time went on, AHRQ slowly became a reliable resource in health care, particularly among many appropriators. As a result, the Agency saw its budget essentially double with the patient safety initiative and then later with an initiative to improve health information technology. While the Agency reaped the rewards of increased resources, it began to see its autonomy diminish as the appropriators played a large role in shaping its policies and direction. Yet, at the same time, AHRQ realized that responding positively to the appropriators' policy recommendations and requests helped ensure continued growth and prominence. As a result of this reciprocal influence, the subcommittees have become protective of the Agency's programs and policies

The pinnacle of the evolution of the appropriations subcommittees' involvement in the policymaking process is evidenced by the passage of the 2009 American Recovery and Reinvestment Act (ARRA) -- an *appropriations* bill. For AHRQ, the Act essentially doubled the Agency's budget, while refocusing its agenda (over a two year period) on comparative effectiveness research.² To underscore the significance of the appropriators' role in the ARRA, an appropriations staffer informed me that, "the AHRQ shall not take its direction from the authorizers, as this [ARRA] is an appropriations bill." ARRA is arguably one of the most

² This is a type of health care research that compares the results of one approach for managing a disease to the results of other approaches. Comparative effectiveness usually compares two or more types of treatment, such as different drugs, for the same disease. AHRQ's definition may be found at: <http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/?pageaction=showterm&termid=118>

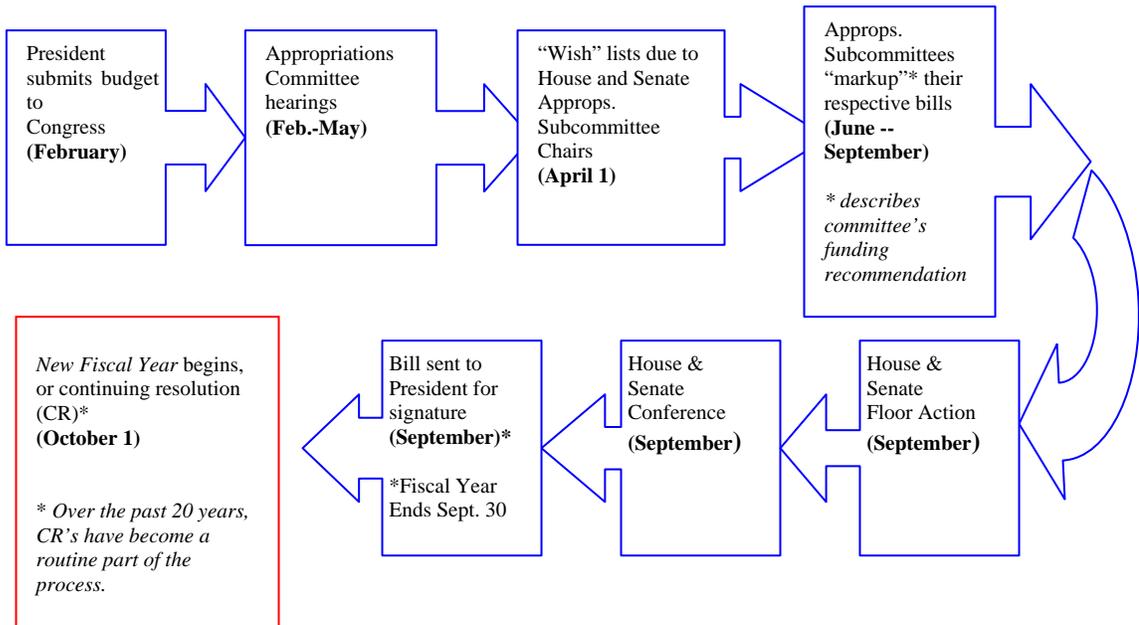
significant policy initiatives (in terms of scope and cost) that this country has witnessed since the New Deal. The fact that it was developed under the province of the appropriations committees underscores the significant policymaking role that the appropriators have assumed, which challenges the formal model of the authorization-appropriations process

The U.S. Constitution grants Congress the legislative power to appropriate funds, also known as the “power of the purse.” Article I, Section 9 of the Constitution prescribes this power by stating that “no money shall be drawn from the Treasury, but in consequence of Appropriations made by law” (Article I, Section 9). The House and Senate Appropriations Committees and their designated subcommittees have jurisdiction over the appropriations process as described by Article I, Sec. 9. In exercising this power, Congress annually considers measures, which provide funding for a range of federal programs and activities including homeland security, health care, education, and national defense. The programs are “considered under certain rules and practices, referred to as the congressional authorization-appropriations process” (Streeter, 2007, .1). This process [see Figure 1] is part of the larger budget cycle, which occurs annually with the president’s submittal of the proposed budget.

There are three types of appropriations measures, which include:

- *Regular Appropriations* – annual funding bills, which must be enacted by the start of the fiscal year (October 1).
- *Continuing Resolutions* – better known as “CR’s,” continue funding until the enactment of the regular appropriations.
- *Supplemental Appropriations* – additional appropriation measures, such as emergency funding, considered throughout the year at Congress’s discretion (Streeter, 2007).

Figure 1: Timeline of the Congressional Appropriations Process



Source: Adapted from Bill Heniff, Jr. (2008). "The Congressional Budget Process Timeline." Congressional Research Report to Congress. p. 1.

An important part of the legislative process is the authorization-appropriations process, which originates from House and Senate rules and is enforced by parliamentary points of order provided by those rules. The formal process involves two steps: (1) enactment of an authorization measure that may create or continue an agency or program as well as authorize the subsequent enactment of appropriations; and (2) enactment of appropriations to provide funds for the authorized agency or program (Heniff, 2008). The House and Senate rules impart four primary prohibitions, which can trigger a point of order. They include the following:

- prohibition of appropriations for unauthorized agencies or programs;
- prohibition of appropriations in excess of the authorized amount;
- prohibition of including legislative language in an appropriations measure; and
- Prohibition (only in the House) of appropriations in authorizing legislation (Heniff, 2008, p. 2).

While the authorization-appropriations process is intended to provide a procedure that promotes order and balance of the legislative process, there is evidence that what is happening in practice is substantially different than the authorization-appropriations model describes.

Over the past 19 years, I have served in a federal policymaking role including working as a legislative director for a member of Congress, government affairs representative for a professional association, and congressional affairs director for an executive branch agency (AHRQ). In my experience, particularly during my experience (14 years) with AHRQ, I have observed appropriators becoming more involved in policymaking activities that typically would be handled by the authorizing committees. I decided to investigate whether and how this phenomenon is actually occurring and then to determine *why* it might be taking place.

Throughout this dissertation, I use the term “policymaking” to refer to any substantive legislative action that customarily would be taken by a congressional authorizing committee. Allen Schick (2000) defines an *authorization act* as, “a law that establishes or continues one or more federal programs or agencies, establishes the terms and conditions under which they operate, sets other policy requirements or restrictions, authorizes the enactment of appropriations, and specifies how apportioned funds are to be used” (Schick, p. 288). For purposes of my use of the term “policymaking,” I focus the House and Senate Appropriations Subcommittees on L/ HHS use of the appropriations process (bills, hearings, and report language) to set the policies related to the programs and direction of AHRQ,

Over the past twenty years, appropriators’ role in policymaking has evolved gradually, as evidenced by the case study. The role has expanded from a more micro-policy oriented role, i.e. focusing on agency oversight and programs specific to AHRQ, to a more macro-policy oriented role which has impacted national policies and programs as witnessed with the appropriator’s significant role in the American Recovery and Reinvestment Act.

Evidence dating back to the 1800s suggests that policymakers have struggled with adhering to the authorization-appropriations model. In reference to authorizing policy in appropriations bills, John Quincy Adams suggested that “the House strip these appropriations bills of everything but were legitimate matters of appropriation, and such were not...be made subject of a separate bill” (House Committee on Rules, 2009). As a result, in 1837, the House adopted a rule that no appropriations bill shall be reported without it being authorized by law. Despite the rule of 1837 and other congressional rules to try to curtail this practice, appropriation bills have been used as effective instruments in dictating public policy issues ranging from Indian treaty making to environmental protection. Often, Congress utilizes the appropriations

process as a way of getting around controversial issues that would otherwise run a higher risk of getting hung up in the deliberations of the lengthier and arguably more open authorizing process. Moreover, the stakes can be higher in appropriations bills due to the association with funding. As a result, members of Congress are often faced with a Hobson's choice and are ultimately compelled to support legislation that they would otherwise oppose.

Over the past several decades, based partly on my observations as a congressional liaison for AHRQ, it seems as though changes in the budget process, political dynamics, committee composition, and critical incidents have led to the transformation of appropriators increasingly delving into policy matters, which were once the "bread and butter" of the authorizing committees. A number of prominent public policy scholars have acknowledged this transformation, and they have pointed to evidence that supports the implication that the appropriations-authorization model has become a guideline, at best. Moreover, the literature has provided ample evidence of how appropriations committees' membership, behavior, and political dynamics can affect their roles. Particular attention has been paid to the impact of critical incidents, such as the Republican Revolution of 1995, and how such incidents have impacted the appropriations committees' involvement in policymaking

The scholarly literature is limited, however, in drilling down to the appropriations subcommittee level and examining their policymaking roles, particularly their involvement in developing and influencing policies carried out by executive branch agencies. The goal of this dissertation is to take a closer look at the subcommittee level by using a case study design that examines how the House and Senate Appropriations Subcommittees on Labor, HHS, and Education have shaped the public health care policies and direction of the Agency for Healthcare Research and Quality (AHRQ). Thus, the dissertation seeks (1) to add to the current evidence

that suggests that there is an increasing public policymaking role among appropriators, and (2) to fill a gap in the scholarly literature by specifically examining the policy sphere of health care to help determine how and why appropriators' involvement in policy matters is occurring.

Given the breadth of this case study, which spans a twenty year period, the research is limited to the examination the relationships between an executive branch agency and the House and Senate appropriations subcommittees that have jurisdiction over its programs. However, one of the objectives of this research is to provide a basis for further exploration into whether this phenomenon (increasing policymaking role of the appropriators) also is occurring among other congressional appropriations subcommittees in their relationships with the executive branch agencies under their jurisdictions. This dissertation also examines the authorization process, particularly how the common practice of long-term authorizations and frequent delays in reauthorizations has encouraged appropriations committees to expand their policy-making.

The remaining chapters attempt to address the question of why appropriators are behaving more like authorizers. Chapter 2 provides an overview of the scholarly literature related to the authorization-appropriations process and how it has evolved over the years. Chapter 3 addresses the study's methodology, and Chapter 4 provides a process analysis of the critical incidents that have occurred over the past twenty years between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ. Chapter 5 provides the conceptual framework of the dissertation. Chapter 6 examines potential explanations for why the House and Senate appropriators have become more involved in the policymaking realm. Chapter 7 presents findings from interviews with key public policymakers. Finally, Chapter 8 offers conclusions from and implications of the case study and suggests avenues for further research.

CHAPTER 2

Public Policy Literature:

The Rise of Appropriators' Involvement in Policy

The authorization-appropriations process no longer works so neatly...with short time, appropriations seemed a fast track way to gain legislative changes, normally the province of authorizing committees.

Aaron Wildavsky (1997)

This chapter examines the public policy literature related to the authorization-appropriations process. It begins with scholarly works that suggest that the authorization-appropriations process is much different in practice than the authorization-appropriations model describes. The next section of this chapter addresses the literature on the characteristics (e.g., guardian, partisans) of the appropriations committees, and how their role has evolved over the years often as a result of the circumstances at that time. The final section of this chapter provides the insights of scholars who have examined the oversight role of the authorization and appropriations committees in relation to the executive branch agencies under their jurisdictions and how executive branch agencies respond to these committees. This section also addresses Thad Hall's suggestion on the use short-term authorizations to enable congressional authorization committees' better control and oversight of executive branch agencies.

Authorization-Appropriations Dichotomy

Budget policy scholar Aaron Wildavsky asserts that Congress's major weapon in obtaining political leverage is the "power of the purse" (Wildavsky, 1997). He suggests that budgetary policy is determined by both authorizing and appropriating committees; authorizing committees are responsible for programs and activities to be approved by Congress, and the appropriators recommend the actual levels of "budget authority" (Fisher, 1979). However, Wildavsky asserts that this dichotomy (authorization-appropriations) "no longer works so neatly," and in fact, "within a short time, appropriations seemed a fast track way to gain legislative changes, normally the province of authorizing committees" (Wildavsky, 1997, p.13).

Wildavsky's appraisal of the authorization-appropriations process supports the basic observation that stimulated this dissertation, i.e., that the appropriators have become de facto authorizers. He says that the boundaries between authorizing and appropriating decisions are hard to maintain in practice (Wildavsky, 1997). For example, the decision to not fund an activity, or to fund it under certain conditions (e.g. abortion funding on U.S. military bases), is essentially a policy decision, which traditionally have fallen under the auspices of the appropriate authorizing committee(s) (Wildavsky, 1997). In essence, the appropriations process "has been and is meaningful" (Wildavsky, 1997, p.13).

Wildavsky's assessment of the deterioration (or at least the blurring of the boundary lines) of the appropriations-authorization dichotomy is echoed by other scholars. Allen Schick, a prominent budget policy scholar, notes that while the appropriations committees are steeped in tradition, the appropriations process has slowly transformed. He observes that "by increments, the [appropriations] process has been made more open and transparent, more partisan and programmatic, and more closely linked to overall budget policies" (Schick, 2000, p.240).

Schick points out that the appropriations subcommittees are able to gain influence in the policymaking process through appropriations reports. He suggests that what gives these reports special force is not their legal status (they are not legally binding), but “the fact that the appropriations cycle is always less than a year away” (Schick, 2000, p. 238). As a result, federal agencies perceive themselves as beholden to the committees’ directives in the report. Often, these reports can alter the Agency’s programmatic focus and direction. A noncompliant agency could face consequences such as reduced funding the following year or more stringent guidance (Schick, 2000). For example, in 1995, the House Subcommittee on Labor, HHS, and Education explicitly stated in the House Appropriations report that the Agency for Health Care Policy and Research (AHCPR) should get out of the business of developing clinical practice guidelines (a program that was authorized by statute in 1989). It should be noted that, at the same time, the committee recommended a 25 percent budget reduction for the Agency. The following year, the Agency believed it had no other choice but to comply with the directive.

At a Harvard Law School seminar on Federal budget policy, Mark Champoux and Dan Sullivan stated: “Congress can and often does circumvent its own rules, resulting in a blurred distinction between authorization and appropriations” (Champoux and Sullivan, 2006, p.8). The two provide evidence that the lines are increasingly blurred between authorizations and appropriations. They suggest that authorizing in appropriations has become a common practice where provisions in appropriation bills can enact entire laws or implement a single policy objective (Champoux and Sullivan, 2006). Such actions are taken through vehicles such as continuing resolutions and omnibus appropriations bills, which force the hand of the president by the threat of a government shutdown. Champoux and Sullivan contend that since legislation can be rolled into appropriations bills, Congress has “less of an incentive to fix problems in the

authorization process...in fact, Congress ends up having an incentive to keep putting legislation in these bills” (Champoux and Sullivan, 2006, p. 27).

In 1979, Louis Fisher, then a specialist at the Congressional Research Service, prepared a report at the request of the Senate Committee on Appropriations. The report concluded that “Congress can and does legislate through the appropriation process” (Fisher, 1979, p.53). Moreover, Fisher pointed out that the real world of the legislative process differs considerably from the “idealized model of the two-step authorization- appropriations procedure” (Fisher, 1979, p.53).

Fisher maintains that the “Appropriations Committees, acting through various kinds of limitations, riders, and non-statutory controls, are able to establish policy and act in a substantive manner” (Fisher, 1979, p.53). For example, officials in the Lyndon B. Johnson administration contended that Congress had authorized the Vietnam War by appropriating for that purpose. In *Berk v. Laird*, several academics challenged this position, claiming that appropriation bills do not encompass major declarations of policy, citing Congressional rules against such action (Fisher, 1979). However, the Court felt differently, and noted that throughout congressional history, policy declarations have been included in appropriation bills despite House and Senate rules.

The Court found:

The Constitution is not concerned with boundaries between the jurisdiction of appropriations subcommittees and the substantive [authorizing] committees...this argument puts too narrow a limit on Congress’s manner of expressing its will (Fisher, 1979, p.83).

Fisher concludes that the authorization-appropriations process is “far from being a two step-procedure, with one stage locking neatly into another” (Fisher, 1979, p.104). The complexity and ambiguity of the rules governing the process provide opportunities for members

of Congress to “depart from formal procedures” (Fisher, 1979). The judiciary remains conflicted on the legality of the practice and essentially has left the door open for interpretation. As a result, Congress has taken advantage of this flexibility by continuing to legislate in appropriation bills (Fisher, 1979, p.104).

Interestingly, in a more recent work, *The House Appropriations Process, 1789-1993*, Fisher observes that the growth of backdoor spending (borrowing authority, contract authority, and mandatory spending) has allowed the authorizing committees to “circumvent the control of the appropriations committees” (Fisher, 2003, p.27). He suggests that backdoor spending schemes have diminished the jurisdiction of the appropriations committees over the past forty years. In effect, the percentage of funding that is under the control of the appropriations committees has declined to be less than 50 percent of total spending (Fisher, 2003, p. 31) -- perhaps a factor that has contributed to the role transformation of the appropriators, in an effort to regain some of the power that they have lost.

Characteristics of the Appropriations Committees

In general, the public policy literature related to the appropriations process is limited in the specific examination of the *policymaking* role of the appropriations committees. It seems that most attention has been focused on the role of partisan politics in relation to appropriators’ decision making process. To this end, there has been a great deal of interest in analyzing the impact of the Republican Revolution in 1995. Such research provides a rich evidence-base for analysis related to potential explanations of why appropriators have become more involved in the policy-making process (in the classical sense of developing and mandating policy).

John Baughman of Bates College specifically examined congressional subcommittees after the Republican takeover of Congress in 1995. He contends that subcommittees play a strong role in the legislative process despite the perceived centralized control of the Republican majority. Even with the “absence of formal procedural protections (as outlined by the previous Democratic Congress’s Subcommittee Bill of Rights), subcommittees have retained much of their role” (Baughman, 2006, p. 243). However, although Baughman looked at Congressional subcommittees as a whole, he did not specifically address appropriations subcommittees or their role vis-à-vis the policymaking process. Nevertheless, Baughman’s analysis provides a basis for examining the impact of a centralized versus a decentralized Congress.

In 2000, John Aldrich and David Rohde focused more specifically on the appropriations committees in their examination of the Republican Revolution. In their analysis, the *Republican Revolution and the House Appropriations Committee*, Aldrich and Rohde (2000) suggest that new institutional changes in the House enhanced the powers of the leadership, which helped advance the party’s policy goals. In reference to the House Appropriations Committee, the authors indicate that the House leadership decided to use the committee as “one of the vehicles of the major policy change” (Aldrich and Rohde, 2000, p.1).

Aldrich and Rohde examined the House of Representatives and the committee system over time. Their analysis focuses on “the interaction between the Republican party and the House Appropriations Committee in the 104th Congress, seen in the context of developments since the 96th Congress” (Aldrich and Rohde, 2000, p.1). Aldrich and Rohde provide a historical perspective on the House Appropriations Committee as outlined by Richard Fenno (1966) and Joseph White (1989). They allude to Fenno’s 1973 book on the appropriations process by noting that the Appropriations Committee was the least partisan of the six committees he studied and

the most autonomous (Aldrich and Rohde, 2000).³ In 1989, White found that both parties “emphasized putting loyalist members on the [appropriations] committee.” In addition, deference to subcommittee decisions was strong (Aldrich and Rohde, 2000, p.6).

Aldrich and Rohde developed a theory known as “conditional party government,” which falls under the rubric of the new institutionalism. The theory assumes the following:

Partisan organizational structures in the House (especially those of the majority party) will (under certain conditions) seek to use powers to shift the policy outcomes produced by the body closer to the median position of the party than would otherwise be the case. The theory additionally implies that the majority party will have some success in shifting the House’s policy away from the median position of the membership on one or more particular policy dimensions and toward the median position of the party (Aldrich and Rohde, 2000, p. 2).

In essence, conditional party theory suggests that there will be a “propensity of party members to grant stronger powers to their leaders and to collective party organizations and to support their exercise of those powers in specific instances” (Aldrich and Rohde, 2000, p. 2). Although I did not focus specifically on the role of political parties and their relationship to committee governance, I do examine party influence, particularly the impact of the Republican Revolution, as a potential influence the policymaking role of the House and Senate Subcommittees on L/ HHS.

In an article entitled “The President, Congress, and Appropriations, 1951-1985,” Christopher Wlezien examined the appropriations process. Wlezien developed a model for congressional and presidential behavior related to the appropriations process. He views the entire process, including regular appropriations, supplemental appropriations, and

³ Fenno’s finding on partisanship is consistent with the sentiments of many of the participants in my study who indicated lesser partisanship among the appropriators as opposed to the omnipresent partisanship among authorizers

impoundments, covering fiscal years 1951-1985. Wlezien's model looks at appropriations as a two-stage process. He suggests that the crux of the model is the "conjecture that the apparent cooperation between the president and the Congress conceals strategic congressional behavior that links regular and supplemental appropriations" (Wlezien, 1996, p. 44).

Wlezien's model, however, examined a period prior to the Balanced Budget and Emergency Deficit Control Act of 1986, where appropriations was a two stage process that now occurs in one stage. Nonetheless, supplemental appropriations are now used for emergency spending, which Wlezien does examine. He suggests that "when seen in the light of the earlier two-stage process, recent congressional behavior may become more understandable" (Wlezien, 1996, p.45). Moreover, Wlezien focused solely on the budgeting behavior of appropriators in relationship to the executive branch's proposed budgets, rather than their policymaking role. He does note that the appropriations committees possess "considerable (not complete) independence" in the markup of appropriations bills and that this control is the "mainstay of congressional influence over budgetary decisions" (Wlezien, 1996, p. 47). My analysis takes this apparent "independence" and "control" a step further by showing how appropriators are more than "guardians" of the budget, but are in essence "policymakers" influencing executive branch policies and activities.

In an article published in the *American Journal of Political Science*, Scott Adler examines the composition of ten House Appropriations subcommittees. Adler specifically studied the "guardian" (guardians of the federal treasury) and "claimant" (claimants of government funds for the pursuit of a partisan agenda) perspectives of Appropriations subcommittee composition (Adler, 2000). The seats on the House and Senate Appropriations committees are considered by a number of public policy observers to be among the most

politically powerful positions in Washington (Adler, 2000). In fact, he alludes to former U.S. representative and Secretary of Housing and Urban Development Jack Kemp, who declared that “the Appropriations Committee is the most powerful committee in the history of the democratic experience” (Adler, 2000; quoted in Munson, 1993, p.7). As such, Adler suggests that members are lured to the Appropriations Committee for various reasons, including opportunities to protect the taxpayer, to influence the direction of the Federal budget, and, to serve the needs of their constituents through the budget authority of the subcommittees (Adler, 2000).

Adler attempts to show that the Appropriations subcommittee assignments are made through the practice of “non advocacy” and that the subcommittees are comprised of members who are there to prevent wasteful spending. He points out, however, that the budgetary reforms in the 1970s changed the assignment practice to assigning members who have vested interests in the subcommittees’ programs with the ultimate goal of benefiting their districts. Adler also recalls Schick’s argument concerning subcommittee assignments: “even in the heyday of fiscal control, Appropriations subcommittees tended to be dominated by program supporters; the forced placement of “indifferent” on subcommittees was an exceptional practice” (Adler, 2000, p. 106).

While Adler did not explicitly address the policymaking role of the Appropriations subcommittees, he implies that the “claimants” have specific advocacy agendas related to their districts’ needs. Adler conducted a test of the ten House subcommittees from the late 1950s to the 1990s, which showed that members “frequently gain assignment to panels of specific interest to their constituencies” (Adler, 2000, p. 113). He concluded that measuring constituency-based characteristics “tells us what legislators *should be doing rather* than what they are *actually*

doing” (Adler, 2000, p.113), thus opening the door for further research into committee outputs and the relationship between ideology (partisanship) and committee dynamics.

In *Appropriations Politics and Expenditure Control*, John Gist looks at the congressional appropriations through a slightly different lens. He challenges the old dictum of the Congress’s (specifically appropriations committees’) “power of the purse” by suggesting that a large portion (over 75 percent⁴) of federal expenditures or outlays are no longer subject to effective appropriations control (Gist, 1978). He brands such expenditures as “uncontrollable.” With the establishment of the House and Senate Budget committees, the increase of mandatory or entitlement programs, and back door spending the appropriations committees’ power over the federal purse strings have diminished significantly over the past several decades. However, it should be noted that while the size of the pot that appropriations committees control has diminished, they remain powerful as they control approximately \$1 trillion in discretionary spending that must approve annually. As Allen Schick points out, “appropriating \$500 billion of discretionary money requires legislative action; spending \$1 trillion of mandatory money can be done with congressional inaction (Schick, 2000, p. 193).” Thus, Gist observes while the uncontrollable expenditures have altered the power of appropriations committees, the power of the purse still remains attractive to the appropriations committees (Gist, 1978, p.165). Gist suggests that there are institutional consequences as a result of uncontrollable expenditures. Specifically, he supports Schick’s argument that “uncontrollable” have been intentionally established by the Congress as a “way of reducing the dominance of their respective

⁴ This figure is measured by total outlays in FY 1976. Contrasted with FY 2008, where total discretionary outlays were 38.1 percent. Austin, A. and Levit, M.(2008). “Trends on Discretionary Spending.” Congressional Research Service Report to Congress. p. 2. Accessed February 15, 2009.

http://www.senate.gov/CRSReports/crs-publish.cfm?pid='0E%2C*QLK9%23P++%0A.

appropriations committees and involving the authorization committee members in federal spending decisions” (Gist, 1978, p. 165). As a result, Gist found evidence that shows that there is a greater desire of appropriations committee members (in this case Senate members) to vie for appropriations subcommittees that hold more prestige. “Prestige” was measured as those subcommittees that hold more control over federal expenditures.

Most importantly, in regards to the policymaking nature of appropriations committees, Gist found evidence that suggests that members of Congress “behave in a manner that is consistent with a desire to maximize their impact on public policy” (Gist, 1978, p. 178). In examining Senate appropriations subcommittees, he found that when senators get appointed to the appropriations committee, “they serve their apprenticeship on the least attractive subcommittees, but quickly move up to more important subcommittees. There the greater discretion over spending allows them to exercise greater policy influence” (Gist, 1978, p. 178). Thus, Gist concludes that the Senate appropriations members that he examined had a desire to “maximize their impact on federal appropriations, [suggesting] that they are motivated by public policy concerns” (Gist, 1978, p. 178).

Oversight

Work examining the oversight function of Congress and its relationship with the executive branch is extensive (see Aberbach, 1990, 2002). In *Enforcement and Oversight, Using Congressional Oversight to Shape OSHA Bureaucratic Behavior*, Headrick, Serra, and Twombly (2002) examined whether legislative oversight affected the behavior of Occupational Safety and Health Administration’s (OSHA) compliance officers at the congressional district level. In their analysis, the investigators included the appropriations subcommittee that has

jurisdiction over OSHA's programs. They hypothesized that street-level bureaucrats will be more responsive if the congressperson who represents their district serves on the authorization committee or appropriations subcommittee that has jurisdiction over OSHA (Headrick, et al., 2002).

In regards to policy and politics, Headrick, Serra, and Twombly suggest that "when legislators see a connection between their lives and bureaucratic activity they have a compelling reason to oversee the bureaucracy" (2002, p.610). As a result, the investigators submit that "members of Congress try to influence bureaucrats in an effort to promote policy objectives but also so that they can claim credit for promoting the goals valued by their own constituencies" (2002, p. 610).

In specifically studying the role of appropriations subcommittees, Headrick, et al. (2002) suggests that the appropriations subcommittees' work is "*wide* but not *deep*, whereas the work of the oversight committee is *deep* but not *wide*" (p. 619). As such, the appropriations subcommittees are more concerned with OSHA's budgetary issues, as opposed to the authorizing committees, which tend to focus on OSHA's enforcement behavior (Headrick, et al., 2002). Nevertheless, the investigators found that the more pro-labor the committee membership of *both* the authorizing committee and the appropriations subcommittee, the higher the level of enforcement by OSHA's compliance officers (Headrick, et al., 2002).

These scholars did not specifically address the policymaking role of appropriators, but instead focused on the behavior of an executive branch agency based on the authorization committee's and appropriations subcommittee's attitude toward labor. While street-level bureaucrats responded (albeit for potentially different reasons) positively to both the authorizing and appropriations committees, Headrick, et al. (2002) point out that the results underscore the

broader understanding of the influence of congressional oversight over federal bureaucracies. Thus, it is important to recognize in this dissertation the dynamics that are associated with the relationship between the executive branch and congressional oversight committees, as well as the involvement of appropriations subcommittees in oversight.

In *Steering Agencies with Short-Term Authorizations*, Thad Hall (2008) suggests that the use of short-term authorizations by Congress enables congressional authorization committees' better control and oversight of executive branch agencies. Hall (2008) notes that short term authorizations can enable the Congress to "systematically shape the overall goals, structures, and decision rules that govern agency activities" (Hall, p.366).

Hall makes two fundamental points in regards to short term authorizations. First, short-term authorizations provide "agenda control by channeling pressures for legislative activity into systematic, planned timeframes-when the program in question is set to expire" (Hall, 2008, p.368). This provides authorizing committees with a form of "enhanced gatekeeping, constraining interest groups from pressing for policy change whenever it suits that group's interest" (Hall, 2008, p. 368).

Second, the short-term authorizations provide for ongoing policy control by allowing members of Congress to use the legislative process as a mechanism of control (Hall, 2008, p. 368). In other words, Hall (2008) believes that "the process of renewing short-term authorization allows Congress to reconsider the substantive legislation for an agency and examine the previously enacted ex ante controls, adjusting them so the agency function optimally" (Hall, p. 369).

Hall (2008) acknowledges that while short term authorizations can be effective in managing agencies, more research is needed on how likely it is that Congress will make specific

changes and what other factors (e.g., interest group pressure) are part of that equation (Hall, p. 377). Moreover, he recommends further exploration of the difference between “congressional treatment [of] and attitudes” toward programs with short-term authorizations and those with permanent authorizations (Hall, p. 377).

Summary

A number of scholars who have examined the appropriations committees or the appropriations process in general have concluded that the formal authorization-appropriations model is substantially different in practice than what the model suggests. The literature indicates that the appropriations process often is used as a vehicle to get policies through the Congress that would otherwise be held up in the much more deliberative authorization process. Thus, the ambiguity of congressional rules governing the authorization-appropriations process has enabled policymakers to take advantage of the process by loading up appropriations bills and reports with policy initiatives.

Other scholars have examined the behavior of appropriations committees, particularly the House Appropriations Committee. These scholars have found that while the appropriations committees are traditionally less partisan than their authorizing counterparts, partisanship is slowly emerging as one of the more dominant behaviors among appropriators. Partisanship, dating back to the caning of 1856,⁵ has never been a stranger to Congress. However, as a result of growing partisanship both in government and among voters in the early 1990s, the Republican Party took control of the Congress in 1995. As a result, the GOP leadership, led by Newt

⁵ South Carolina Rep. Preston Brooks (D) entered the Senate chamber and beat Massachusetts Senator Charles Sumner (R) unconscious over Sumner’s antislavery stance. (<http://thehill.com/capital-living/23795-partisan-politics-how-bad-can-it-get>).

Gingrich, made a number of structural changes in Congress (especially the House), including using the appropriations process a vehicle for enacting the GOP agenda. This change had a profound effect on the appropriations committees and may be a significant reason for appropriators' increased role in policymaking.

A number of scholars and practitioners alike have observed that control of the federal purse strings is a powerful tool at the appropriators' disposal. As such, appropriators often use this tool as political leverage in order to achieve their objectives, including policy initiatives. Throughout history, appropriators' behavior has been changeable largely due to the political environment at that time. Adler suggests that members of Congress are lured to serve on the appropriations committees for various reasons, whether it be as fiduciary guardians or advocates for funds in order to meet their constituents' needs. In his examination of the Senate appropriations subcommittees, Gist found that the Senators have a desire to serve on appropriations committees because the power of the purse allows them to have maximum impact on public policy.

Scholars have examined the oversight functions of the authorization and the appropriations committees. Although both play critical roles in carrying out the oversight function, Headrick, et al. found that executive branch agencies respond to these committees differently based on their own motivations. Nevertheless, oversight is a powerful tool of both committees, and I will address the dynamics of appropriations oversight as it relates to policymaking later in this dissertation.

Finally, the review concludes with Hall's proposal to make the authorization process more effective. He suggests that the use of short-term authorizations by Congress enables congressional authorization committees' better control and oversight of executive branch

agencies. In my view, Hall's proposal provides a possible explanation of why the appropriations committees have become more involved in policy matters. Thus, his suggestion on increasing short-term authorizations may serve as a complement to my hypothesis. While Hall does not specifically address the appropriators role in authorizing matters, his suggestion that the prevalence of long-term authorizations limits authorizing committees interactions with the executive branch begs the question of whether short-term authorizations would change the current dynamics of the authorization-appropriations process? In other words, the increased use of short-term authorizations could give the authorizing committees more frequent interactions with the executive branch, which the appropriations committees now enjoy on an annual basis. Based on findings, which appear in chapters 6 and 7, the annual nature of the appropriations process may be significant factor for why appropriators increasingly have used the appropriations process as a vehicle for policymaking. Later in this dissertation, I will provide a more in-depth analysis on this factor and other potential explanations associated with the policymaking role of appropriators.

The next chapter provides an overview of the dissertation's conceptual grounding and how the study seeks to build on scholarship related to the congressional appropriations process and dealings between congressional committees and executive branch agencies.

Chapter 3

Conceptual Framework

This dissertation builds on the existing scholarly literature, specifically Scott Adler's (2000) model that suggests that the House Appropriations subcommittees are composed of "guardians" and "claimants." I added "policymakers" as another category in Adler's model, which suggests that the appropriators have become more than just stewards of federal funds, but also de facto policymakers. Thus, I suggest that substantive policymaking, which has been historically the domain of the authorizing committees, increasingly is becoming a routine practice of the appropriators.

Throughout this dissertation, I use the term "policymaking" to refer to any substantive legislative action that customarily would be taken by a congressional authorizing committee. Allen Schick (2000, p. 288) defines an *authorization act* as, "a law that establishes or continues one or more federal programs or agencies, establishes the terms and conditions under which they operate, sets other policy requirements or restrictions, authorizes the enactment of appropriations, and specifies how apportioned funds are to be used." For purposes of my use of the term "policymaking," I focus on the use by the House and Senate Appropriations Subcommittees on L/ HHS of the *tools* that are at their disposal in the appropriations process (bills, hearings, and report language) to set the policies related to the programs and direction of AHRQ. Thus, I examine the institutional notion of policymaking in which the appropriators have supplemented the authorizers' traditional role in substantive policymaking.

Over the past twenty years, appropriators' role in policymaking has evolved gradually, as evidenced by the case study. The role has expanded from a more micro policy oriented role, i.e.

focusing on agency oversight and programs specific to AHRQ, to a more macro policy oriented role that has impacted national policies and programs. A significant contemporary example is the appropriators' significant role in the American Recovery and Reinvestment Act (Public Law 111-5).

I identify the “additional” role of policymaking in a case study that focuses on how the House and Senate Appropriations Subcommittees on Labor, HHS, and Education (L/ HHS) have become more involved in the policymaking activities and direction of the AHRQ. The case study traces how the subcommittees' seemingly expanded policymaking role has evolved from issuing unilateral mandates to engaging in reciprocal policymaking with AHRQ. To an extent, an expanded set of “principal-agent” relations (I provide greater detail on this model in Chapter 6) has emerged and nurtured an environment that has become more consultative than unilateral and controlling. As a result, the Agency has greater opportunities for growth and, more importantly, more involvement in the policymaking process.

Several critical incidents, actors, and influences are included in the conceptual framework that the dissertation employs. The critical incidents for this study were selected based on the following criteria. An event was included if:

- it had a significant impact on AHRQ's budget. In this case several events (the near-death experience, the medical errors initiative, HAIs, and comparative effectiveness research) all had substantial budgetary implications. Indeed, comparative effectiveness and patient safety actually became individual line items in AHRQ's budget.
- it had a significant impact on the Agency's culture and/or direction. For example, the elimination of AHCPR's clinical practice guideline (CPG) program completely changed the Agency's direction and role in the development of CPGs, which was a primary reason for its existence. AHRQ's near-death experience led a number of key personnel to leave for fear of its vulnerability. That fear in turn became an embedded part of the Agency's culture.

- it changed the Agency structure or operations. For example, Chairman Porter’s call to translate research into practice led to the creation of a “TRIPP” team within AHRQ and became a touchstone in the Agency’s planning process. To this day, most grant and contract solicitations include language that encourages potential investigators to find ways to translate their research into practice.

Based on document analyses and my experience with AHRQ, I initially identified several “critical incidents” and included them on a draft list. I then used data from interviews as the determining factor for finalizing the list of critical incidents. If the interviewees’ responses were inconsistent with my initial list of incidents, I narrowed the list, accordingly. For example, I originally listed AHRQ’s role in bioterrorism research as a critical incident, but ultimately eliminated it from the list as its significance was not shared with any of the respondents.

I used a form of process theory (a narrative strategy) as an analytical tool in helping to understand the sorts of factors that might have influenced the possible shifts in the subcommittees and in AHRQ’s responses (e.g., partisanship, committee composition and dynamics, party control of government, and internal Agency dynamics). DiMaggio (1995) refers to a narrative as a story that describes the “process, or sequence of events, that connects cause and effect” (Pentland, 1999, p. 711). The critical incidents (*see Table 2*) provide data that I analyzed for the purpose of helping to explain why the appropriators’ actions evolved toward an increased policymaking role vis-à-vis AHRQ’s policies and direction.

The ever-changing dynamics of our health care system places constant demands on policymakers to make policy changes. As a result, the advantage of using the appropriations process has become an accepted way, if not the best way, to institute policy changes. However, it is important to note that there are often incentives, whether political and/ or current events, on the part of the actors that drive the use of the appropriations process. Vayda et al. (1991)

emphasized that processes are made up of “human actions or of events involving human actions” (p. 324). For example, in the wake of the IOM’s seismic report on medical errors, Senator Specter, known for his independence, decided to use the appropriations process as a swift approach to address the issue. Therefore, it remains unclear whether a different chair would defer to the authorization committees to take the lead on addressing the issue of medical errors.

Recognizing that there is a human element in processes begs the question for this case study of whether the use of the appropriations process is a deliberate attempt among appropriators to enact a policy that may otherwise be stalled in the regular, more deliberative legislative process? An examination of the critical incidents and the actions taken by the House and Senate Appropriations Subcommittees on L/ HHS reveals that the events or “critical incidents,” and the motivations of actor(s) in response to these events, have a significant impact of the use of the appropriations process. In other words, the *process* itself does not necessarily have an *independent* causal effect on the policymaking role of appropriators -- rather, it may be a result of the actor(s) involved.

Therefore, the analysis goes beyond the critical incidents by trying to identify other potential variables (e.g., the economic and political climates) that also might be influencing the subcommittees’ actions. Thus, the “story” is only one part of the case study. In what follows, I seek to (1) establish causal linkages among the critical incidents; (2) to provide possible explanations for *why* appropriators have acted like de facto authorizers; and (3) to describe *how* AHRQ has responded. I try to achieve these objectives, or tell various parts of the “story,” through previous scholarly works, analysis of relevant documents, and interviews with key policymakers.

CHAPTER 4

Methodology

Overview of Methodology

In an effort to more systematically examine the increased policymaking by appropriations committees, I employed a qualitative research methodology to study the congressional appropriations process broadly, and specifically to examine evidence of the emergence and evolution of a policymaking role in the House and Senate Appropriations Subcommittees on L/HHS as it interacted with AHRQ. Such an examination required research that took into account multiple variables, empirical evidence, and opportunity for interpretation. Denzin and Lincoln (1994) suggest that qualitative research involves an “interpretive, naturalistic approach to its subject matter” (Denzin and Lincoln, 1994, p. 2). Additionally, they point out that qualitative research “involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interpretational, observational, historical, and texts” (Denzin and Lincoln, 1994, p. 2). This study drew on a variety of empirical materials and methods, including my personal experience in a congressional liaison capacity with AHRQ. In general, the nature of my research underscores the rationale for using a qualitative research design, as I examine multiple variables from the conceptual framework that I outlined in Chapter 3, documentary evidence, interviews, and direct and participant observation.

Case Study Method of Inquiry

The case study was used as a vehicle for tracing the emerging role of appropriations subcommittees as policymakers and its implications for the focal agency. The study examines a twenty year period (1989-2009) to explore how critical incidents, such as the “near-death experience” of AHCPR (now AHRQ), the Institute of Medicine’s report on medical errors, and the American Recovery and Reinvestment Act served as catalysts to increased involvement of the House and Senate Appropriations Subcommittees on L/ HHS in shaping the public health policies and direction of AHRQ. To this end, the case study traces how the appropriations subcommittees that fund AHRQ, rather than the authorizing committees that have statutory jurisdiction over AHRQ’s programs, took a more policy-oriented response to the critical incidents -- thus, supporting scholars’ claims that the formal authorizing-appropriations model shows signs of erosion.

A case study design permits the examination of “holistic and meaningful characteristics of real-life events” (Yin, 1989, p.14). This study traces the relations between AHRQ and the subcommittees as they unfold over time, incorporating the critical incidents (events) and taking into account elements of the context (e.g., divided v. unified government, subcommittee membership and dynamics, and AHRQ’s internal dynamics).

Additionally, the case study approach is a preferred strategy for answering “how” and “why” questions when the focus is on contemporary events (Yin, 2003). Specifically, the dissertation explores *how* the House and Senate Appropriations Subcommittees on L/ HHS have increasingly shaped the federal health policies of AHRQ.

The study is an instrumental case study in that it aims at achieving analytical generalizability. Stake (1995) suggests that an instrumental case design is used “when the case is

used to understand more than what is obvious to the observer” (Tellis, W., 1997, <http://www.nova.edu/ssss/OR/OR3-3/tellis2.html>). Stake asserts that an instrumental case study provides “insight into an issue or refinement of a theory” (in Denzin and Lincoln, 1994, p. 236). The scholarly literature suggests that the formal authorization-appropriations model is much different than that which occurs in practice. My research assumed a gap between theory and practice existed, and went a step further by exploring whether, how, and why appropriators were becoming *de facto* policymakers.

This research has the potential for generalizations to be drawn, specifically about whether other (among the twenty-four) House and Senate appropriations subcommittees also are playing an increased policymaking role vis-à-vis the executive branch agencies under their jurisdictions. Additionally, it has the potential to provide insight into whether the congressional authorization-appropriations structure is effective in its current bifurcated form, which divides the budgeting and policymaking between the two committees.

The case study examines a twenty year period (1989-2009), which traces critical incidents (*see Table 1*) that have occurred between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ since the Agency’s inception in 1989. During this period, the subcommittees engaged in a number of actions that had a significant impact on AHRQ’s policies and overall direction. Additionally, this period of study includes a change of congressional power with the GOP’s takeover of the House in 1995, which provides insights to how the political environment affected the appropriations committees and AHRQ, in particular.

Data

I analyzed the relationships between AHRQ and the House and Senate Subcommittees on L /HHS as they unfolded from calendar years 1989-2009, by incorporating critical incidents and taking into account contextual elements. The analysis focused on how the relationship between AHRQ and the subcommittees evolved over time and how this relationship impacted AHRQ's policies and direction.

In an analysis of theorizing process data, Ann Langley notes that “process research is concerned with understanding how things evolve over time and how they evolve this way” (Langley, 1999, p. 692). She points out that “process data consist largely of stories about what happened and who did what when – that is, events, activities, and choices ordered over time” (Langley, 1999, p.692). The key is being able to analyze and interpret the data in a way that makes sense to the reader. Thus, Langley (1999) suggests that “the analysis of process data requires a means of conceptualizing events and detecting patterns among them” (p. 692).

Langley submits that for many process researchers, the use of a narrative strategy is “merely a preliminary step aimed at preparing a chronology for subsequent analysis – essentially, a data organization device that can also serve as a validation tool” (Langley, 1999, p. 695). Langley suggests that narratives that go beyond pure descriptions are most interesting. She uses Chandler's (1964) stories of the invention of the M-form organization as an example: “they have embedded ‘plots’ and ‘themes’ that serve as sense-making devices and that ultimately become more explicit theories” (Langley, 1999, p.697).

Similarly, Vayda, et al. (1991) recognizes that process research involves showing how events are connected. They advise that “a causal explanation of processes, and not merely a constitutive one, must be sought, in our view, with respect to the events themselves, the linkages

among the events, and the circumstances under which the linkages do or do not obtain” (p. 329). Thus, as I pointed out earlier, I examine causal linkages among the critical incidents while exploring (or at least acknowledging) what conditions existed at the time of the incident.

To help support this research, I drew upon various data, which include materials from documents, interviews, and direct and participant observation. Yin (1994) suggests the importance of using multiple sources of data in increasing the study’s reliability. Such data triangulation allows for the corroboration of evidence gathered from multiple sources. Stake suggests that triangulation allows the investigator to “get it right,” rather than relying on “mere intuition and good intention” (Stake, 1995, p. 107). Data source triangulation is “an effort to see if what we are observing and reporting carries the same meaning when found under different circumstances” (Stake, 1995, p. 113).

The empirical materials that I drew from include reports of the House and Senate Appropriations Subcommittees on L/ HHS, appropriations legislation, committee hearings, memoranda, news articles and policy statements. I selected these materials based on any critical incident that occurred between 1989-2009. For example, I reviewed the hearing transcript from the hearing on medical errors conducted by the Senate Appropriations Subcommittee on L/ HHS. In reviewing documents, such as hearing transcripts, I looked for any patterns of policy inferences impacting AHRQ in the hearing dialogue. Using the hearing on medical errors as an example, I traced policy inferences during any exchanges between Chairman Arlen Specter (R-PA) and John Eisenberg, former director of AHRQ.

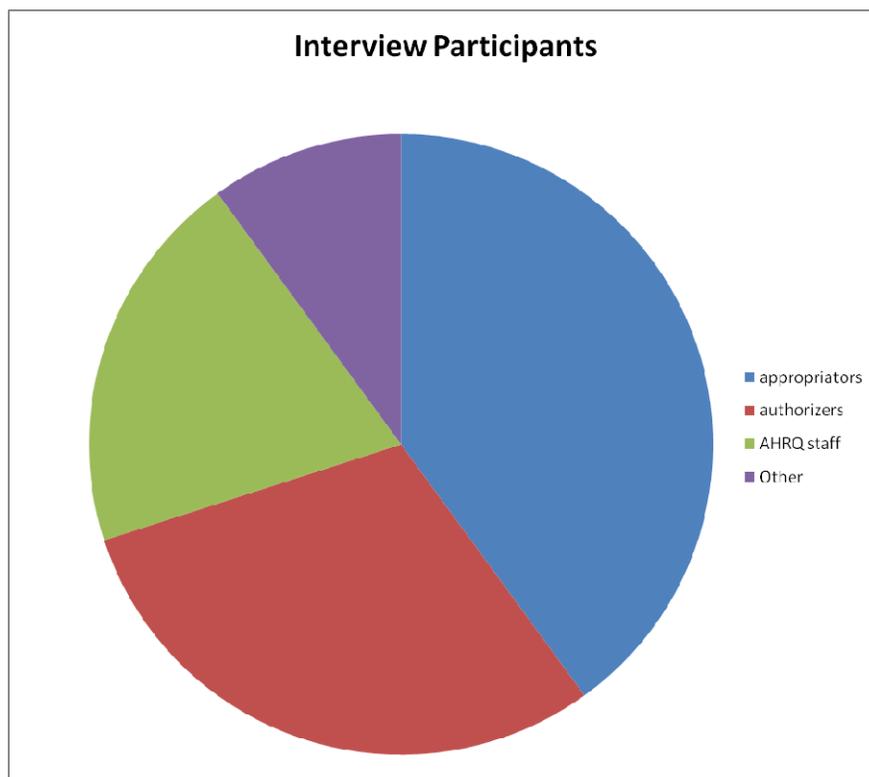
Stake (1995, p. 64) suggests that “much of what we cannot observe for ourselves has been or is being observed by others.” To that end, I conducted interviews with key policymakers who have been closely involved with either the appropriations process, public policy, AHRQ, or

all three. The interviews were intended to serve as (1) additional evidence of whether appropriators are indeed serving in a policymaking capacity; and (2) provide insights of key policymakers at the federal level into *why* appropriators may be behaving in this way.

The interviews that I conducted included members of Congress, congressional staff, AHRQ staff, government relations representatives, and policy analysts. The interviewees were selected based on their role as key policymakers in relationship to the appropriations and authorizations process, and/or to AHRQ. I tried to achieve a balance between gender, legislative role (appropriators and authorizers), AHRQ staff, and external stakeholders.

I classified the interviewees into four categories: appropriators, authorizers, AHRQ staff (current and former), and other (see Figure 2). Although some of the participants are now in different professional positions, I categorized them based on their role during the twenty year period (1989-2009).

Figure 2: Interview Participants



The interview format was a one-on-one interview comprised of unstructured, open-ended questions (*see Appendix C for a list of the interview questions*). Each interview was a one-on-one interview conducted in person or via phone. Interviews typically were approximately 60 minutes in duration. I served as the interviewer and transcribed the responses to the questions from each participant. In an effort to maintain strict confidentiality, participants were given the option to be identified or remain anonymous. Since all the participants requested anonymity, I assigned each participant a code, which is included in *Table 1*. The coding (“R”= respondent) allowed me to convey the participants’ responses anonymously.

The objective in the interviews was to establish patterns in the responses. Once there was a clear evidence of the emergence of patterns, I concluded the interview phase of the study.

Table 1: Interviews

Individuals	Code (R=Respondent)	Role
member of Congress	R1	Served as a member of House Appropriations Subcommittee on Labor, HHS, Education and Related Agencies
member of Congress	R2	Serves as a member of House Appropriations Committee
AHRQ senior leader	R3	Serves in a policymaking role with AHRQ
Former AHRQ senior leader and former budget policy chief, NIH	R4	Served in budget policy for NIH and senior leader with AHRQ
Former staff member of Senate Committee on Finance	R5	Served as a national health care policy expert on the Committee.
Former staff member of House Energy and Commerce	R6	Served as a staff member on the Committee and was responsible for overseeing health care policy and PHS agencies, including AHRQ
Former staff member of Senate Committee on Science and Senior Science Advisor to former Senator Al Gore (D-TN) Current director of congressional affairs for major science policy organization	R7	Served as a staff member on the Committee. Responsibilities included implementing national science policy. Serves as liaison with Congress on a number of issue areas including health care issues and policies developed by the organization. Works closely with AHRQ on a number of collaborations.
Former staff member of the House Appropriations Subcommittee on Labor, HHS, Education and Related Agencies Current vice president of government relations for health care lobbying firm	R8	Served as the staff director on the Subcommittee. Responsibilities included overseeing all of PHS agencies funding, including AHRQ Currently responsible for promoting national health policy initiatives on behalf of clients. Represents some of AHRQ's stakeholders
Staff member of the Senate Appropriations Subcommittee on Labor, HHS, Education and Related Agencies	R9	Serves as a staff member on the Subcommittee. Responsible for overseeing a number of PHS agencies funding, including AHRQ
Vice president for government relations for healthcare interest group	R10	Serves as an advocate for promoting national health care initiatives and health care interests before Congress. Represents some of AHRQ's stakeholders

Finally, in my role as the congressional liaison for AHRQ, I was able to provide in-depth analysis that I obtained through both direct observation and participant observation. This includes observations from interaction with House and Senate appropriations and authorization committee staff; interaction with AHRQ staff and leadership; interaction with officials from external organizations, including other federal agencies; and observations made in congressional hearings, briefings, and meetings. I allowed the observations to help tell the story (Stake, 1995) and provide analysis.

According to Van de Ven and Huber (1990) process research focuses on understanding “how things evolve over time and why they evolve this way, and process data therefore consists largely of stories about what happened and who did what when – that is, events, activities, and choices ordered over time” (Langley 1999, p. 692). The key to process theory is to find patterns in events (Langley, 1999). Thus, as I examine the critical events that occurred between AHRQ and the House and Senate Appropriations Subcommittees on L/ HHS over the past twenty years, I attempted to detect patterns that produce a certain outcome. In this case, I look for evidence of any rise in policymaking activities among the appropriations subcommittees.

Langley (1999) suggests that process theories “provide explanations in terms of events leading to an outcome [e.g., do A and then B to get C]” (Langley 1999, p. 692). Mohr (1982) asserts that temporal ordering and probabilistic interaction between entities is important (Langley, 1999). In this case study, I drill deeper than the interaction between entities, as I examine relationships between individuals, specifically those between members and staff of the House and Senate appropriations subcommittees and the leadership and senior officials at AHRQ. This is particularly important as the behavior of individuals, and their reactions to certain events, help in our understanding to why certain outcomes occurred.

Isabella (1990) and Peterson (1998) note that, “process research may also deal with the evolution of relationships between [sic] people or with the cognitions and emotions of individuals as they interpret and react to events” (Langley 199, p. 693). In this study, the evolution of relationships between the actors involved expands so that it breeds a “principal-agent” type of relationship, which has a significant impact on how AHRQ and the appropriations subcommittees interact with each other. This relationship will be discussed in more depth in later chapters.

The literature on process theory often addresses the various approaches in understanding processes and more importantly, how to detect patterns in the processes. One strategy, which I have employed, is known as the “narrative strategy.” The narrative strategy “involves construction of a detailed story from the raw data.” Lincoln and Guba (1985) suggest that the aim of a narrative strategy is to “achieve understanding of organizational phenomena not through formal propositions but by providing ‘vicarious experience’ of a real setting in all its richness and complexity” (Langley 1999, p. 695).

Throughout the following section, I provide an overview of the critical event, the actors involved, and a sense of the policy environment at that time. Also, I invoke my own perspectives and stories as both an actor and observer. Rimmon-Kenan (1983) advises that “the way a story is told can provide additional insight into the social world, such as the tellers’ point of view and their relationship with their audience, among other things” (Pentland 199, p. 714). In an effort to ward against bias in my data, I triangulate my research with others’ perspectives and/ or actions taken, which I obtained from analysis of documents such as congressional testimony, committee reports, and written correspondence with the House and Senate Appropriations Subcommittees on L/ HHS.

When using a narrative strategy in describing a process, Weick (1995) and others suggest that “stories give meaning to the events, actions, and objects in our lives” (Pentland 1999, p.716). Thus, narrative data provide an understanding of the “cognitive and cultural world of our subjects” (Pentland 1999, p. 717). Pentland (1999) asserts that “narrative is especially relevant to the analysis of organizational processes because people do not simply tell stories – they enact them” (p. 711). In the following chapter, by analyzing the narrative data (critical incidents and relevant documents) I try to detect patterns to provide a possible explanation to *why* the House and Senate Appropriations Subcommittees on L/ HHS have become increasingly involved in shaping the policies and direction of AHRQ.

Stake (1995, p. 62) points out that the “qualitative case study researcher keeps a good record of events to provide a relatively *incontestable description* for further analysis and ultimate reporting.” He also notes that using observation in a qualitative study “usually means finding good moments to reveal the unique complexity of the case” (Stake, 1995, p 63). As a practitioner in this study, I had an extraordinary opportunity to share an insider’s perspective on how contextual elements and critical incidents affected the relationship between the appropriations subcommittees and AHRQ, while being mindful of any possible bias.

Data Analysis

Stake suggests that an instrumental case study is “examined to provide insight or refinement to theory” (in Denzin and Lincoln, 1994, p. 236). This allowed me to provide insight into the erosion of the appropriations-authorization dichotomy and identify more clearly how the House and Senate Appropriations Subcommittees on L/HHS, through their interactions with AHRQ, have played an increased role in the policymaking process.

According to Marshall and Rossman (1990, p.150), “data analysis is the process of bringing order, structure, and interpretation to the mass of collected data.” In order to make sense of the data collected and bring order and structure to it, I conducted an analysis that employed methodological triangulation (that is, multi-method research design to increase confidence of the interpretation) to increase confidence in my interpretations (Stake 1995, p. 114). The data analysis included:

- Reviewing and interpreting responses to questions from the interviews: I identified themes and/ or patterns based on the individuals’ responses to interview questions. The interviews included a diverse group of individuals (refer to Table 1) as a way to improve the reliability of the study. I analyzed the responses by tracking key words and phrases (e.g., “appropriation acts used as policy vehicle,” “appropriators’ changing role and influence”). This allowed me to capture themes and patterns, which helped in the analysis and interpretation of the responses. Using a scale (1-10) enabled me to obtain a degree of each respondent’s perspectives related to the policymaking role of appropriators, generally and, more specifically, the policymaking role of the House and Senate Appropriations Subcommittees on L/ HHS.
- Document analysis: I attempted to determine if there was any corroborating evidence with the interviews and observations. Using triangulation protocols helped to support the credibility and validity of the data. For example, I analyzed transcripts from appropriations hearings to find any exchanges related to policymaking or suggestions thereof. Documents were identified based on their

relevance to the critical incidents that occurred between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ during the period of 1989-2009.

- Observations: I analyzed the participant observations that I experienced to provide further evidence of any patterns discovered throughout the research. I identified any archived (1989-2009) emails, memorandum, and/ or personal notes that directly related to interactions between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ.

Yin (1994) suggested that “every investigation should have a general analytic strategy, so as to guide the decision regarding what will be analyzed and for what reason” (Tellis, 1997, <http://www.nova.edu/ssss/OR/OR3-3/tellis2.html>) Among a number of possible analytic techniques that Yin suggests, I used *pattern-matching*. Using this technique, I was able to find patterns that emerged from documents, interviews, and observations. I identified patterns by reviewing critical incidents that occurred during the period of 1989-2009 and linked them to actions taken by the House and Senate Appropriations Subcommittees on L/ HHS. For example, in 1999 John Eisenberg instituted a research agenda at AHRQ that focused on Translating Research into Practice. As a participant observer, I knew that during the House Appropriations Subcommittee hearing in 1998, Chairman Porter encouraged AHRQ to develop ways to translate research into practice. This was confirmed by the transcript from the 1998 hearing, as well as from a number of the respondents from the interviews.

Stake notes that sometimes patterns are known in advance and sometimes patterns emerge unexpectedly (Stake, 1995). A 1990 GAO report on *Case Study Evaluation* notes that pattern matching “requires using past experience, logic, or theory before the job begins to specify what we expect to find. The analysis then compares actual findings to expectations -- when the findings fit, the pattern is confirmed” (GAO, 1990, p.73). For example, from my own experience, I had certain expectations that there was evidence of policymaking among the House and Senate Appropriations Subcommittees on L/ HHS in dealing with AHRQ. A pattern of policymaking activities emerged from the findings derived from an analysis of the critical incidents, key documents (e.g., hearing transcripts), and findings from the interviews and confirmed my expectations. However, the explanation for the increased policymaking among the appropriators varied, and in some instances went beyond my expectations. These explanations will be discussed in Chapter 5.

Limitations

Throughout the research, I have been mindful to recognize any predispositions or biases that could affect the analysis. Since I have been immersed in congressional activities for over 19 years and I serve in a congressional capacity for AHRQ, I was attentive to any potential bias that may affect my interpretations. To address this issue, I triangulated data sources and methods as a way to provide multiple sources and/ or perspectives. Additionally, I reported throughout the dissertation any potential bias that may have emerged and validate it through triangulation. Flick (1992) asserts that “acknowledging that no observations or interpretations are perfectly reliable, triangulation serves to clarify meanings by identifying different ways the phenomena are being seen” (in Denzin and Lincoln, 1994, p.238).

While the use of a qualitative research design for this study seems most appropriate, particularly as it allowed for studying the interactions of “real” people in “real” settings, generalizability of the findings is a limitation. Because of the subjective nature of qualitative research, it may be difficult to generalize the findings to other cases, such as examining the policymaking role of the other twenty-four congressional appropriations subcommittees. Yin (1994) suggests that this type of study may yield “analytical generalization” rather than “statistical generalization” in its contributions to expanding theories. To this end, I used multiple sources of data to help address this limitation. The interviews alone involved a diverse number of participants, many of whom have experience in serving on, or working with, more than one congressional committee, and thus often provided insights into their experiences with other committees.

Despite these potential limitations, using a qualitative case study design allowed me to examine actors in their natural setting without manipulation or control. This case study requires more than measuring specific parameters; rather it involves the need to take into account behavioral aspects, such as the *relationships* between AHRQ and the subcommittees, which were critical in gaining an understanding of the contextual dynamics. Moreover, the distinctiveness of this study is that it provides the opportunity to examine various dimensions of public policymaking in a real world setting. My 14 years of experience as a congressional liaison with AHRQ provided a distinct advantage in having the access to key policymakers, technical knowledge of the appropriations process, and an “insider’s” understanding of AHRQ’s culture and the relationships between AHRQ and the appropriations subcommittees.

CHAPTER 5

AHRQ and Critical Incidents

The majority leadership has delegated authorizing powers to the appropriations committee, as such the bill includes major authorizing legislation.

Louis Stokes (D-OH), member of Congress (1995)

Critical Incidents

As I mentioned in Chapter 4, a case study served as a vehicle for tracing the emerging role of appropriations subcommittees as policymakers and their impact on AHRQ. The study examines a twenty year period (1989-2009) to explore how critical incidents during this period played a significant part in the House and Senate Appropriations Subcommittees' (L/HHS) role in shaping the public health policies and direction of AHRQ. To this end, I have provided a brief overview (*Table 2*) of each critical incident (beginning in 1989) and an analysis of the outcome.

Table 2 shows evidence of the involvement of the House and Senate Appropriations Subcommittees on L/ HHS in shaping the policies and direction of AHRQ. The critical incident in 2004 is the only instance where the appropriators deferred to an authorizing statute (Medicare Modernization Act of 2003). Other than that one instance, the appropriations subcommittees have taken the initiative to develop policies through mandates and other mechanisms at their discretion.

Over time, the appropriations subcommittees and AHRQ have established close working relationships, which have enabled the Agency to play a more prominent role in the policies

adopted by the subcommittees. For example, AHRQ was able to gain tremendous flexibility in its implementation of provisions in the American Recovery and Reinvestment Act (ARRA). The Agency was given a critical role in spearheading the development of the Federal Coordinating Council for Comparative Effectiveness Research, which is intended to help “coordinate research and guide investments in comparative effectiveness research funded by the Recovery Act” (hhs.gov/ Recovery Act, 2010). Additionally, the Agency has been given permission by the House and Senate appropriations subcommittees to move forward on funding comparative effectiveness research based on its own priority conditions list, as opposed to the authorization committees’ desire to use the Institute of Medicine’s priorities. An appropriations staffer recently noted regarding AHRQ’s role in ARRA: “Please let us [appropriations subcommittee] know if there is any interference from the authorizers in carrying out ARRA. We want you [AHRQ] to have maximum flexibility to get the research done.” The staffer continued, “This is an appropriations bill *not* an authorizing bill.”⁶

In examining the critical incidents, I sought to identify patterns among the actions taken by the appropriations subcommittees with the objective of trying to detect any trends. Vayda et al. submit that there is “a possibility that the connection among a series of actions over a period of time is that they all are deliberate attempts of the actors to carry out a previously formulated program or policy” (p. 324). In what follows, I analyze each incident and attempt to connect it to the overall actions taken by the House and Senate appropriations subcommittees over the study’s twenty year period.

⁶ Author’s personal communications. March 11, 2009

Table 2. Critical Incidents (1989-2009)

Year	Critical Incident	Outcome
1989	Agency for Health Care Research and Policy (AHCPR) is established by Congress.	Establishment of AHCPR
1995	AHCPR's near-death experience.	AHCPR endures near elimination at the hands of the House Appropriations Subcommittee on L/ HHS.
1996	House Appropriations Subcommittee on L/HHS recommends that AHCPR reevaluate the Agency's approach to the development of clinical practice guidelines.	AHCPR eliminates its support for the development of clinical practice guidelines.
1998	Rep. John Porter, Chair, House Appropriations Subcommittee on L/ HHS challenges AHCPR to translate research into practice.	AHCPR creates Translating Research Into Practice program, which becomes a touchstone of the Agency's activities.
1999	IoM report, <i>To Err is Human</i> calls for the need of increased patient safety in U.S. hospitals.	Senate Appropriations Subcommittee on L/HHS provides \$50M to AHRQ and directs the agency to identify and devise ways to prevent medical errors.
1999	AHCPR is reauthorized as the Agency for Healthcare Research and Quality "AHRQ."	The authorizing statute recognizes AHRQ's newly minted role in patient safety, as prescribed by the Senate Appropriations Subcommittee
2003	House and Senate Appropriations Subcommittee on L/ HHS provide \$50M to AHRQ to promote the development, adoption, and diffusion of health information technology.	AHRQ creates an office of health information technology and new research portfolio.
2004	Congress passes the Medicare Modernization Act of 2003, which includes the codification of comparative effectiveness research (CER) at AHRQ.	The Senate Appropriations Subcommittee on L/ HHS provides \$15M to AHRQ and directs the agency to carry out CER as authorized by the Medicare Modernization Act.
2007	House and Senate Appropriations Subcommittees on L/ HHS provide \$30M to AHRQ to increase the agency's work in the area of CER.	AHRQ develops research portfolio for CER and shifts research focus to CER activities.
2008	Senate Appropriations Subcommittee on L /HHS provides \$5M to AHRQ to identify and determine ways to reduce Methicillin-resistant Staphylococcus Aureus (MRSA) in health care settings.	AHRQ incorporates research on MRSA into its patient safety portfolio.
2008	House Appropriations Subcommittee on L/HHS provides \$9M to AHRQ to increase its work in healthcare –associated infections. The Senate Subcommittee provides an additional \$3M to increase AHRQ's research in related to MRSA. The total health-associated infection initiative (including MRSA) amounts to \$17M.	AHRQ refocuses its patient safety research priorities toward research on health-associated infections.
2009	American Recovery and Reinvestment Act (ARRA): House & Senate Appropriations Subcommittees on L/ HHS develop a \$1.1 B initiative to increase comparative effectiveness research. ARRA directs \$300M to AHRQ for comparative effectiveness research.	AHRQ shifts its research priorities to comparative effectiveness research. Initiative almost doubles AHRQ's budget over a two year period.

Critical Incident (1989): Establishing AHCPR

My discussion begins with an overview of AHRQ, the key actors involved in the Agency's creation, and the political hurdles that arose during its formative years. The evolution of AHRQ and its political fortunes and misfortunes is the subject of *AHCPR and the Changing Politics of Health Services Research*, authored by Bradford Gray, et al. Gray et al.'s analysis provides excellent insight into why AHCPR (now AHRQ) had such a turbulent beginning. While certainly a compelling story, and one that could be the subject of further analysis, my goal here is simply to provide a context for the case study not an organizational analysis of AHRQ. The contextual elements that Gray frames are germane to suggesting potential explanations as to why the appropriations subcommittees have played such a significant policy-oriented role in relation to AHRQ

In 1989, the Congress established the Agency for Health Care Policy and Research, better known as AHCPR. AHCPR, which was eventually renamed AHRQ, was created to conduct research on the outcomes and effectiveness of medical care. A primary role for the Agency was the development and dissemination of clinical practice guidelines -- a role that nearly brought about the demise of the Agency several years later.

AHCPR was created as part of the Budget Reconciliation Act of 1989 (OBRA). The Act essentially supplanted the responsibilities (with some modifications) of the National Center for Health Services Research (NCHSR), a small center within the Department of Health and Human Services (DHHS), which often "struggled for funding and respect" (Gray, 1992, p.40). The elevation of NCHSR to a Public Health Service agency within DHHS was prompted by the research of health services researcher John Wennberg, M.D. of Dartmouth University, who found significant geographic variations in medical practice (Gray, 1992). His research, along

with that of Robert Brook of RAND, had the “highest profile on Capitol Hill” (Gray, 1992, p. 41). However, the lack of funding for health services research, and for NCHSR in particular, motivated the health services research community [under the direction of the Association of Health Services Research (AHSR)] to find a new home for this discipline.

By the late 1980s, AHSR's leaders were convinced that NCHSR itself was part of the problem. Its bureaucratic location within the office of the HHS assistant secretary for health lacked prestige and visibility, and its leadership had been ineffective in budgetary battles with the executive branch and on Capitol Hill (Gray, 1992, p. 42)

In 1989, Congress recognized the importance of health services research, particularly outcomes and effectiveness research. The need to try to rein in health costs, coupled with increased concern about closing the gap between scientific evidence and medical practice, created an opportunity for elevating the health services research agenda. The House Energy and Commerce Subcommittee on Health had a number of staffers who supported health services research and the need to promote it from its current standing. A large part of the creation of AHCPR was to market the unit in a way that would convey more than just a run-of-the-mill research agency.

In an analysis of AHCPR and the politics surrounding health services research, Bradford Gray (2003) pointed out that a health services research lobbyist once remarked that “health services research was as difficult to sell as a dead fish wrapped in newspaper” (p 287). Knowing the uphill battle that NCHSR faced, staff on the Energy and Commerce Subcommittee, along with the House Ways and Means Subcommittee on Health and the Senate Finance Committee, decided to include “policy” in the name of this new health services research agency to communicate that its mission was more than just research (Gray, 2003, p. 287).

After much legislative jockeying, the new agency “AHCPR” was included in the OBRA of 1989. A number of intricate maneuvers led to the creation of AHCPR. Some argue, however, that these maneuvers laid the groundwork for the political turmoil that the Agency would ultimately experience.

Funding

The amendments to create the agency were “quietly tucked” into the OBRA of 1989 (Gray, 2003, p. 287). Gray (2003) suggests that “the higher stakes physician payment reform battle provided the [amendment] political cover” (p.287).” Secondly, the funding for AHCPR included a unique funding stream, known as the Public Health Service Evaluation Funds. These funds, better known as the “PHS Evaluation Funds,” allow the Secretary to reallocate up to one percent of the funds appropriated to Department agencies. The Department determines the total amount of one percent evaluation funds available by calculating the “net appropriation” to all the PHS agencies. It is essentially a “tax” on each PHS agency that goes into a designated fund, which the Secretary can allocate. However, the Department can request that the set aside be increased from one percent to a higher percentage but it is up to Congress to approve the increase. Historically, Congress has earmarked the majority of the Department’s one percent evaluation funds for AHRQ and for CDC's National Center for Health Statistics. Because these funds are provided from the appropriations of other agencies (NIH is only one of them, but since it has the largest budget, its contribution is the largest), the receiving agencies consider them to be reimbursable funds but they are appropriated by Congress.

Over the past decade, the House and Senate Appropriations Subcommittees on L/ HHS have funded AHCPR, now AHRQ, exclusively through the Evaluation Fund. The primary

advantage of this technique to the Subcommittees is that it is an “off budget” expense; therefore it does not count against their discretionary funding caps. Referring to the Evaluation Fund, a staffer on the Senate Appropriations Subcommittee on L/ HHS once remarked that “it is a great budgetary mechanism.”⁷

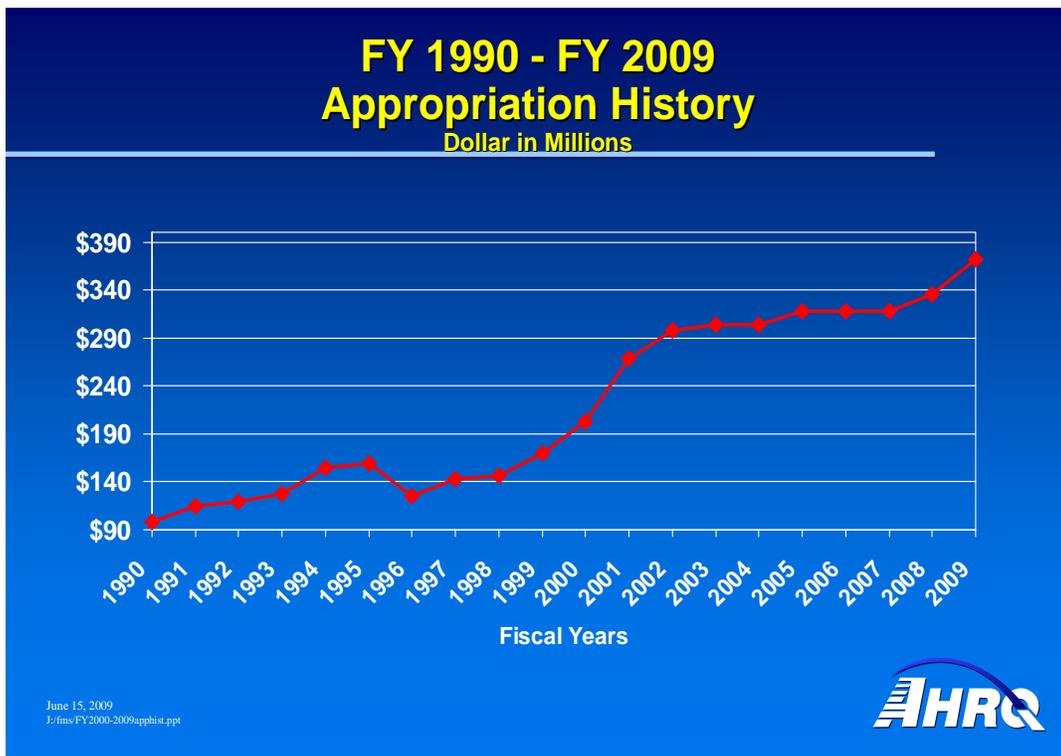
Yet, others see the evaluation fund in a much different light. A contingent of interest groups views it as a loss of critical funding by the other PHS agencies. As a result, numerous stakeholders of those agencies have tried, albeit unsuccessfully, to repeal the evaluation fund. In fact, during deliberations on the FY2007 appropriations bill, Rep. Joe Barton (R-TX) introduced an amendment to repeal NIH’s contribution to the fund. The amendment failed, but it illustrates the grave concern of some policymakers about the detrimental effects that the evaluation fund is having on other PHS agencies. More importantly, this has harnessed AHRQ with a political liability that some argue has hampered the Agency’s ability to grow significantly. An appropriations staffer said to me, “while the evaluation tap [fund] has enabled AHRQ to grow at a steady rate, it does not allow it to make significant gains” (R9, 2009). This is largely due to the conflict over the funding mechanism, as some PHS agencies, such as the NIH, provide a disproportionate share of funding given the sizeable scale of their overall budgets.

A second funding stream came from tapping the Medicare Trust Fund. Supporters justified drawing from the Trust Fund, arguing that AHCPR’s research on outcomes and effectiveness of medical interventions would ultimately find savings in the Medicare program. Yet, opponents saw this as wasteful spending and redirecting already scarce Medicare dollars. In fact, Rep. Sam Johnson (R-TX) offered a floor amendment to the House Appropriations Act of

⁷ Author’s Personal Communication. 1999

FY 1996 that would have “zeroed out” funding for the AHCPR, in part because of its use of Medicare dollars. The amendment failed, but the House Appropriations Subcommittee on L/HHS eventually eliminated the Agency’s tap of the Medicare Trust Fund. Nevertheless, the Trust Fund provided another source of funding to help the Agency get its feet off the ground. AHCPR’s funding started at \$53 million in FY 1989 and grew substantially to by \$162 million in FY 1995 (see Figure 3).

Figure 3: AHRQ Appropriations History FY 1990 – FY 2009



Source: Agency for Healthcare Research and Quality, 2009

Clinical Practice Guidelines

A large part of AHCPR's initial agenda was the development and dissemination of clinical practice guidelines (CPGs). These guidelines were intended to serve as a blueprint for health care providers to help them make informed decisions about the medical care they provide. The CPGs were part of its architects' efforts to increase the use of scientific evidence in everyday practice. Many in the health services research community, led by the Association for Health Services Research (now named "AcademyHealth"),⁸ felt that CPGs were the solution to bridging the gaps in care discovered from the pioneering work⁹ by John Wennberg on practice variations. However, the novelty of the CPGs quickly evaporated as a number of medical specialty groups viewed the CPGs as a federal mandate that interfered with their medical judgment. The controversy over the CPGs ultimately led to AHCPR's near-demise. Arguably, AHCPR's near-death experience is one of the most significant incidents as it presents the appropriators' first foray into shaping the Agency's policies and direction.

Health Reform

During President Bill Clinton's push to reform the nation's health care system, AHCPR served as an "information clearinghouse" for the Administration's proposal. The Administration's Health Care Task Force often called on AHCPR to conduct data runs on the policy implications of certain proposals being considered by the Administration. One of the

⁸ AcademyHealth represents a broad community of people with an interest in and commitment to using health services research to improve health care (AcademyHealth's mission statement on website: <http://www.academyhealth.org/About/?navItemNumber=498>)

⁹ John Wennberg's *1998 Dartmouth Atlas*, showed that the amount of care that Americans receive in their final months of life varies according to the part of the country they live in. For example, Wennberg found that people on the east coast are more than twice as likely to die in the hospital as are people on the west coast. (John Eisenberg, (1997). *Testimony: "Healthcare Quality."* House Subcommittee on Health and the Environment.

more significant roles that AHCPR assumed was serving as the Administration's advisor on cost estimates. This role elevated AHCPR's visibility beyond the health services research community. Gray, et al.(2003) suggests that "AHCPR's work on the Clinton reform proposal provided powerful evidence of the benefits of having constituencies beyond the health services research community" (p. 292). However, as much as AHCPR's role strengthened during the consideration of health reform, the failure of the Administration's health care proposal to materialize was perhaps a foreshadowing for things to come for AHCPR.

In their analysis of the partisan debate surrounding AHCPR, Gray, et al. (2003) suggest a number of potential factors explaining why the Agency lost favor with the Congress and nearly failed to survive. Among the potential influences, the one that stands out is that the AHCPR was identified as a "partisan" given its strong ties in helping to shape the Clinton health reform plan. Many observers, including Gray, et al., suggest that the Clinton reform plan "best symbolized for Republicans all that they opposed "(2003: 296).

As a result, the Agency became a target for the incoming Republican Congress. This political vulnerability highlights the critical nature of AHCPR's relationships with its appropriations subcommittees. It also likely served as an opening for the Subcommittees to take the policymaking reins.

Critical Incident (1995): AHCPR's (AHRQ's) Near-death Experience

In January 1995, the so-called "Republican Revolution" swept into Washington, bringing a new set of policy ideals and objectives. The new leadership that assumed power, particularly in the House of Representatives, tended to be more conservative and representative of the right wing of the Republican Party (Aldrich and Rohde, 2000). The general make up of the House

became more partisan and divided. Among a number of drastic changes that occurred in the House, led by Speaker Newt Gingrich (R-GA), were those in the House committee system. In an effort to ensure the advancement of Republican leadership's policy agenda, Speaker Gingrich sought the right to "name new GOP committee chairs and chose a number of them in violation of seniority rank" (Aldrich and Rohde, 2000,p. 7). Additionally, the greater centralization gave the Speaker more influence over committee assignments (Aldrich and Rohde, 2000). The result was that committees became stacked with partisans who were assigned for the purpose of pushing the Speaker's policy agenda. In fact, Speaker Gingrich required that GOP Appropriations members "sign a 'letter of fidelity' that bound them to follow the leadership's plan of budget cutting" (Adler, 2000, p. 106).

Arguably, one of the most partisan committees was the House Appropriations Subcommittee on L/ HHS. Given the number of social, often controversial programs that fall under this Subcommittee's jurisdiction, the Republican leadership looked to assign partisans on the panel to serve as stalwarts in blocking any programs that contradicted the GOP agenda. A former member of the House appropriations subcommittee told me that "we had to get every Subcommittee mark signed off by the Speaker before bringing our bill to the floor" (R1, July 2009). Aldrich and Rohde (2000) suggest that the Republican leadership were not interested in having subcommittees made up of "legislators acting as constituency advocates" (p. 106) who protected pet projects in their districts and national social programs. Rather, the leadership wanted the subcommittees to push its partisan agenda (Adler, 2000).

As Scott Adler points out, there are competing schools of thought regarding the composition of appropriations subcommittees. He suggests committee composition has varied significantly over time (Adler, 2000). Generally, one camp of scholars believes that the panels

are comprised of those who are uninterested in the programs under their jurisdiction, but serve as “guardians” of the Treasury (Adler, 2000). Conversely, another group of scholars’ views appropriations panels as consisting of re-election minded “claimants” who cater to their constituents’ interests (Alder, 2000). Finally, others assume these committees are composed of “point-people” who serve as advocates for a partisan agenda. The latter probably best describes the composition of the appropriations committees under the GOP leadership beginning in 1995. *Table 3* is an example of a vote on a partisan issue (serving vulnerable populations) by members on the House Appropriations Committee; members of the L/ HHS subcommittee are indicated by asterisks. The subcommittee members in the House majority voted in lockstep and evidently were determined to change the direction of the country. In dissent view, Rep. Obey noted:

As members of the Minority party, we face enormous substantive differences with the Majority over the direction this country should take with respect to many of the critical activities contained in this bill. We disagree on what we should do in terms of educating our kids, protecting our workers, providing the necessary skills to our workforce and seeing to it that the weakest and more vulnerable in this society don't get left out.

This bill is qualitatively different from any bill reported by this Committee in the post war era. It is the meanest, most radical and most extreme attack on women, on children, on workers and on the vulnerable which has been procured by the Majority since their takeover of the House in January. (Obey, 1995, p.309)

Table 3. Votes by Members of House Appropriations Subcommittee

Measure: Labor, HHS, Education Appropriations, FY 1996.

Motion by: Mr. Obey.

Description of motion: To increase funding for programs serving vulnerable populations, mainly energy assistance, and cap the Federal matching rate for Medicaid at 65 percent.

Results: Rejected 17 to 32.

Members Voting Yea

Mr. Chapman
Mr. Coleman
Mr. Dixon
Mr. Durbin
Mr. Foglietta
Mr. Hefner
Mr. Hoyer*
Ms. Kaptur
Mrs. Lowey*
Mr. Obey*
Mr. Sabo
Mr. Skaggs
Mr. Stokes*
Mr. Torres
Mr. Visclosky
Mr. Wilson
Mr. Yates

Members Voting Nay

Mr. Bevill
Mr. Bonilla*
Mr. Bunn
Mr. Callahan
Mr. DeLay
Mr. Dickey*
Mr. Forbes
Mr. Frelinghuysen
Mr. Hobson
Mr. Istook*
Mr. Kingston
Mr. Knollenberg
Mr. Kolbe
Mr. Lewis
Mr. Livingston
Mr. Miller*
Mr. Mollohan
Mr. Myers
Mr. Nethercut
Mr. Neumann
Mr. Packard
Mr. Porter*
Mr. Regula
Mr. Riggs*
Mr. Rogers*
Mr. Skeen
Mr. Taylor
Mr. Thornton
Mrs. Vucanovich
Mr. Walsh
Mr. Wicker*
Mr. Young

Source: House Report 104-209, p. 212, July 20, 1995

In 1995, under Speaker Gingrich's leadership, the House Appropriations Committee and its respective subcommittees were viewed as the most effective vehicle in promoting the GOP agenda. Aldrich and Rohde (2000) suggested that GOP leaders decided to use the committee as a way both to reduce "unnecessary" federal spending and to "enact substantive legislative changes that could, under regular procedures, only be considered by standing legislative (authorizing) committees" (p. 9). They submitted that the appropriations committees were chosen as a way to "bypass established intracommittee relationships" given the number of senior members serving on the standing (authorizing) committees (p.9).¹⁰ "The selection of the Appropriations Committee as a vehicle for policy change involved the delegation of responsibility to the committee for achieving the goals of the [GOP] Conference – a classic principal-agent situation" (Aldrich and Rohde 2000, p.9). In his dissent of consideration of the House's FY 1996 L/ HHS appropriations bill, Democratic member Louis Stokes (D-OH) said, "The majority leadership has delegated authorizing powers to the appropriations committee, as such the bill includes major authorizing legislation"(Stokes, 1995, p.393).

In subsequent chapters, I use the principal-agent model to help frame the dynamics between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ. For purposes of the current discussion, the key point to be made is the transformational use (at the hands of the GOP leadership) of the appropriations committee as a policymaking vehicle. In analyzing the potential impact of the critical incidents on the appropriators' actions related to

¹⁰ Aldrich and Rohde point out that the appropriations committee was not the only device used for getting the GOP's agenda through the Congress. In fact, a number of agenda items from the Contract with America had to go through authorizations committees, such as the House Judiciary and Commerce Committees. However, these committees were in line for new chairs.

AHRQ, there is evidence that the transformation of the appropriators' policymaking role intensified with the Republican takeover of the House in 1995.

AHCPR bore the brunt of the Republican onslaught in 1995. Going into the 1994 congressional elections, House Republicans, led by Newt Gingrich (R-GA), drew up a *Contract with America*, which among other things called for fiscal responsibility and balancing the federal budget. A cornerstone of this element of the Contract was to eliminate unnecessary federal programs, particularly those that were not in line with the Contract's ideals. AHCPR was one of many federal agencies that were singled out as organizations that were used for partisan purposes during the Clinton administration's attempts to pass health care reform. In the eyes of the new GOP leadership, AHCPR represented everything they detested about the Clinton Administration's health agenda. As a result, the AHCPR became an easy target. The House Budget Committee's report for FY 1996 reflected this concern: "The agency [AHCPR] is supposed to support research and information dissemination on health care services and technology, medical effectiveness, and patient outcomes, but performed an advocacy role in the health care debate the past 2 years while its funding increased from \$125 million in 1992 to \$163 million in 1994" (House Report 104-120, 1995, p.86). The Committee further suggested that federal funding to support the Agency be eliminated.

On July 27, 1995, the House Appropriations Committee reported a recommended budget of \$125 million for AHCPR. Once the bill reached the House floor, an amendment was offered by Rep. Johnson (R-TX) to eliminate the funding entirely. A number of members, including Rep. Obey, spoke against the amendment and the amendment eventually went down in defeat. However, the House scaled back the Agency's budget to \$65 million. According to Gray, et al. (2003) the cut was "illusory because before the vote occurred, Representatives [Bill] Thomas [R-

CA], Porter [R-IL], and David Obey (D-WI), the ranking minority member of the Appropriations Committee, had negotiated an agreement with Appropriations Committee Chair Bob Livingston (R-LA) under which the leadership would support the Senate's budget number for the agency in the eventual House-Senate conference committee" (2003: 300). As a result, the final budget in FY 1996 reflected the Senate's recommendation of \$125, an approximately 21% reduction from the previous year (*See Figure 3*). As a result, the Agency had to make a 25 percent across-the-board reduction to its existing research grants and contracts.

Critical Incident (1995): Attack on AHCPR's Clinical Practice Guideline Program

In addition, the House Appropriations Subcommittee began to take a more significant role in shaping the way the Agency conducted its business. One of the Subcommittee's first agenda items related to AHCPR was an effort to eliminate its flagship program on clinical practice guidelines.

The Republican-controlled House responded to a growing sentiment among many health care providers that AHCPR's medical practice guidelines were a stealthy attempt by the federal government to mandate medical standards. The medical community attacked the guidelines as "cook book" medicine, which gave the appropriators ground for taking action. The guidelines were of particular concern to the back surgeons, who believed that the evidence supporting AHCPR's guideline on low back pain was flawed.

In the FY 1995 House Report of the Committee on Appropriations, the House Appropriations Subcommittee on L/HHS urged AHCPR to re-evaluate its role in the "direct development of clinical practice guidelines" (House Report 104-659, 1995, p.104). In an acrimonious hearing, several Subcommittee members criticized the AHCPR's role in guideline

development as duplicating the private sector's work in this area. Additionally, a number of subcommittee members, such as Rep. Henry Bonilla (R-TX) raised concern about mandating how doctors are to practice care.

More specifically, Subcommittee members questioned the legitimacy of a back-pain guideline that suggested that there was no evidence to support spinal fusion surgery. Advocates for this type of surgery, primarily the spinal surgeons, lobbied the prominent members on the House Appropriations Subcommittee on L/HHS to threaten AHCPR's funding, charging that the Agency had "wasted taxpayer dollars" on the back pain study and subsequent guideline (Gray, et al., 2003, p. 298). A prominent back surgeon, Neil Kahanovitz, used his personal contact with an appropriations staffer and patient to try to end AHCPR's funding. Rep. Bonilla spearheaded the charge to eliminate AHCPR, supporting Kahanovitz's argument that "[AHCPR] was supporting unsound research and wasting the taxpayers' money" (Gray, et al., 2003, p. 298).

The following year during the FY 1996 appropriations hearing before the House Appropriations Subcommittee on L/ HHS, AHCPR's Administrator, Clifton Gaus, Sc.D, fielded a number of pointed questions from members about the effectiveness of its guideline program and its very legitimacy as a federal agency. Rep. Bonilla's first comment to Dr. Gaus set the tone for the rest of the hearing, and perhaps foreshadowed what was in store for AHCPR in the years to come:

"Doctor, I would like to start out with a question about your budget request...you are coming before this subcommittee and requesting a 19 percent increase. When this country is running a debt that increases almost \$10,000 every second, I just don't think we are going to be able to meet this request" (House Committee on Appropriations, 1995, p. 169).

Rep. Bonilla then turned to AHCPR's low back pain study, which eventually was developed into a clinical practice guideline: "I have a question now about the low back pain study, I am concerned because I have heard from a lot of very good, reputable orthopedic surgeons that say the study was biased against them. Regardless of whether there was or was not a bias, there is a perception out there, and frankly when it becomes that strong, it may as well be real, whether it is or not" (House Committee on Appropriations, 1996, p. 170).

AHCPR already was placed in a vulnerable position as a result of its ties with the Clinton health care plan and the GOP's agenda to ferret out government waste. The low back pain guideline was simply "low hanging fruit" for the GOP members on the subcommittee in their quest to put AHCPR out of business. Even Rep. John Porter, Chair of the Subcommittee, who generally thought that the low back pain guideline was credible, questioned why the agency "needs to be in the business of producing guidelines?" (House Committee on Appropriations, 1996, p.182). In addition, reports from the General Accounting Office, the Physician Payment Review Commission, and the Office of Technology Assessment raised criticisms about the overall effectiveness of AHCPR's guideline program. The reports gave Republican appropriations staffers further evidence to justify the elimination of AHCPR's guideline program and additional ammunition to use in their ultimate goal of abolishing the Agency. Gray recounts an interview he had with a congressional staffer who said, "the agency [AHCPR] became part of the make-fun-of-government-rhetoric...it was almost the old Bill Proxmire Golden Fleece Award"¹¹ (Gray 2003, p. 296).

¹¹ Senator Bill Proxmire (D-WI) called attention to apparently wasteful federal spending through monthly press releases known as the Proxmire "Golden Fleece Awards."

Feeling intense pressure from the House Appropriations Subcommittee, and in an effort to minimize the risk of further cuts, the AHCPR heeded the Subcommittee's call and abandoned its clinical practice guideline program in 1996. In testimony on the Agency' FY 1997 budget request before the House Appropriations Subcommittee on L/ HHS, Dr. Clifton Gaus said:

Before I present the FY 1997 budget request, I would like to address an important issue that this Committee raised last year in the report accompanying the 1996 request. This Committee encouraged AHCPR to reevaluate our approach to the development of clinical practice guidelines. The Committee questioned the need for AHCPR to allocate resources to this activity when the private sector and professional societies develop their own guidelines and urged us to consider modifying our role to one of certifying the impartiality and thoroughness of guidelines developed by others. We have given the Committee's suggestion the most careful and serious consideration...As the Committee noted in its report last year, it is time for AHCPR to move to a new phase...As a result, AHCPR will no longer be developing clinical practice guidelines in FY 1997 (House Committee on Appropriations, 1996, p. 5).

In the report that accompanied the FY 1997 appropriations bill, the House Appropriations Subcommittee on L/ HHS applauded the AHCPR "for responding to last year's Committee report language urging AHCPR to re-evaluate its role in the direct development of clinical practice guidelines" (House Report 104-659, 1996, p.98). Yet the nation's health services researcher community considered the move to be the most "lamented change" to the Agency (Gray, 2003, p. 302) as it enabled the Agency to move past a major political hurdle.

The apparent politicization of AHCPR, coupled with the philosophical question of whether the public sector should be supporting such an enterprise, set into motion a major campaign to justify the Agency's existence. After an enormous education effort and a reengineering of the Agency's mission, including changing its name to "AHRQ" and changing its leadership with the appointment of John Eisenberg, M.D., the Agency was able to better position itself to regain congressional support and preserve its funding. Eisenberg was very well-connected with key policymakers in Washington, including fellow Tennessean and

Princeton classmate, Senator Bill Frist (R-TN), a cardiologist and former chair of the Senate Committee on Health, Education, Labor, and Pensions.¹² Eisenberg's relationships with prominent policymakers, such as Frist, and his previous role as Chief of Medicine at Georgetown University "brought new stature and a distinctive set of strengths to the job" (Gray, et al, 2003, p. 301).

There is little doubt that Eisenberg's stature and charm played a large part in helping to take the Agency from the brink of demise and put it on a path of growth and change. An analysis of Eisenberg's accomplishments and the organizational changes that he initiated at AHRQ are well beyond the scope of this dissertation. Nevertheless, his tenure at AHRQ is noteworthy, as he was instrumental in helping it get reauthorized and in working closely with the Agency's appropriations subcommittees in shaping AHRQ's policies and direction.

Despite Eisenberg's strengths and the reinvigoration that he brought to AHRQ, the House and Senate Appropriations Subcommittees on L/ HHS continued down the path of playing a part in shaping the policies and direction of AHRQ. In fact, during Eisenberg's first budget hearing before the House Appropriations Subcommittee on L/ HHS, Chairman Porter asked him a tersely worded question, "what effect is it [the agency's research] having on people?" (House Committee on Appropriations, 1998, p. 23). The exchange in the hearing, which I recount in the next section, provides more evidence that the appropriators (even beyond the critical incident in 1996) in this case study continued to exhibit signs of playing the role of policymakers, as opposed to their more traditional role as "guardians" of federal funds.

¹² The Senate Committee on Health, Education, Labor, and Pensions is an authorizing committee that had jurisdiction over most public health programs, including AHRQ.

Critical Incident (1998): House Appropriations Committee's Challenges AHRQ to Translate Research into Practice

On March 4, 1998, Dr. Eisenberg, newly appointed as the Administrator of AHCPR, appeared as the Agency's witness for its FY 1999 budget request before the House Appropriations Subcommittee on L/ HHS. In briefings prior to his testimony before the Subcommittee, Eisenberg touted his prior experience in dealing with the Congress, specifically as the one time chair of the Physicians Payment Review Commission (PPRC), which made recommendations to the Congress regarding Medicare and Medicaid benefits.¹³ The PPRC interacted primarily with the House Ways and Means Subcommittee on Health and the Senate Finance Committee, which are the authorizing committees that have jurisdiction over the Medicare and Medicaid programs. However, prior to his tenure with AHRQ, Eisenberg did not have much interaction with the House and Senate appropriations committees as they only managed the discretionary side of the federal ledger. In my observation, it was evident during the hearing preparations that Eisenberg viewed the appropriations committees in their traditional, narrower role of providing funding for executive branch agencies and programs.

Eisenberg quickly discovered that at least the House Appropriations Subcommittee on L/ HH had greater plans in mind than simply writing the check to fund AHCPR. After delivering his testimony before the House Appropriations Subcommittee on L/ HHS, Chairman Porter asked Eisenberg a string of questions that focused on what AHCPR did with the research it conducted and/or supported. As a participant observer at the hearing, it is important to note that

¹³ Author's observations in the role of a participant observer. 1998.

the questions raised by Chairman Porter were terse, and his body language showed irritation with Eisenberg's responses. In the meantime, Dr. Eisenberg who typically exuded confidence and composure began to fidget and perspire. To get a clearer picture of the exchange between Porter and Eisenberg, a Senate appropriations staffer said to Eisenberg in a subsequent meeting following the hearing, "I went to the House hearing and you reminded me of Albert Brooks¹⁴ when he assumed the role of news anchor in the movie *Broadcast News*."¹⁵ Undoubtedly, Eisenberg was caught off-guard by Porter's more policy-focused questions. Nevertheless, Porter pressed on a response about how the AHCPR's research was impacting people's lives: "What we really want to get at is not how many reports have been done, but how many peoples' lives are being bettered by what has been accomplished. In other words, is it being used, is it being followed, is it actually being given to patients?" (Porter, 1998, p. 23).

As a result of the appropriations hearing, Eisenberg gained a new found respect for the power of the appropriations committee. More importantly, he made it a priority to unearth the level of impact the Agency was having with its research and other activities. As such, he made translating research into practice a touchstone at AHCPR and a part of the Agency's planning activities for the year to come. In meetings, Eisenberg often invoked what became known as the "Porter Question," which simply reminded AHCPR staff to use it as a benchmark when developing research agendas. Soon the "Porter Question" became a common phrase around the Agency, and it was incorporated in program announcements and the planning process. In fact, grantees were required (and still are to this day) to submit a plan to the Agency on what they

¹⁴ In the 1987 movie, *Broadcast News*, actor Albert Brooks portrayed a news anchor who was outwardly anxious, including perspiring profusely, when he was on camera.

¹⁵ Participant observation: Meeting with staff member on the Senate Appropriations Subcommittee Education, and Related Agencies. 1998.

planned to do with the results of the research that they conducted. Additionally, Eisenberg created a team within AHCPR's Office of Communications to be responsible for finding the most effective ways to disseminate information and translate it into practice. The current mission statement for what is now the Office of Communication and Knowledge Transfer reads:

The Office of Communications and Knowledge Transfer promotes the communication of information to both internal and external customers. It designs, develops, implements, and manages programs for disseminating and implementing the results of Agency activities with the goal of changing audience behavior (Mission Statement: Office of Communications and Knowledge Transfer. March 2008).

The following year, Eisenberg sat before the House Appropriations Subcommittee on L/HHS and stated:

Mr. Chairman, when I appeared before this committee last year, you asked me how AHCPR's research was helping to improve people's lives. This is an extremely important question, and we have taken it to heart. In fact, your question on how our research helps people has become a touchstone at AHCPR, and we have geared our research agenda toward answering this question. I would like to report to you today on how our past research has improved health care and how the Agency has fashioned its budget priorities to do an even better job of meeting this challenge through the fiscal year 2000 request (House Committee on Appropriations, 1999, p.1051).

In the budget request for that year (FY 2000), Eisenberg crafted a proposal that enveloped the framework of translating research into practice. In presenting the \$206 million budget request Eisenberg (1999) said, "We at AHCPR are making a major new commitment to ensure that the knowledge gained through health care research is translated into measurable improvements in the health care system. The key to the Agency's fiscal year 2000 budget proposal is to translate research into practice by converting new knowledge into action to improve health care" (p.1054). As part of the FY 2000 budget request, the Agency devoted \$13.5 million to develop different strategies to help get new scientific advances in research

translated into practice. After approval of the budget, the Agency developed a program known as TRIPP (Translating Research into Policy and Practice), which focused on finding the most effective strategies to translate research findings into practice and policy. However, translating research into practice went beyond the TRIPP program and was embodied throughout the Agency's intramural and extramural research.

Chairman Porter challenged AHCPH to essentially change the way it conducted, and *continues to*, conduct its research agenda. The significance of this incident is further evidenced in AHRQ's current mission statement:

The U.S. health care system is considered by many to be the finest in the world. Americans are living longer, healthier lives, thanks to significant advances in biomedical and health services research. The *translation of research findings into clinical practice* has raised awareness of the importance of appropriate preventive services—such as timely screenings for cancer, heart disease, and other serious conditions—and the crucial role that maintaining a healthy lifestyle plays in maintaining health and enhancing quality of life (Executive Summary, FY 2010 AHRQ Justification of Estimates for Appropriations Committees, 2009)

The result of the House Appropriations hearing in 1998 produced a clear shift in AHCPH's research focus toward promoting the adoption and use of research findings, which in turn triggered a major paradigm shift in the field of health services research.

Critical Incident (1999): Reauthorization of AHCPH

AHCPH was established in 1989 to address the wide variations in medical care. As mentioned earlier, the goal of the Agency's research was to "close the gap" in these variations through conducting and supporting research on the outcomes and effectiveness of medical treatment. The specter of rising health care costs, particularly in the Medicare program, quickly got the attention of policymakers on Capitol Hill. As a result, legislators became convinced that

“outcomes research, technology assessments, and dissemination of practice guidelines would produce cost savings” (Gray, et al, 2003, p.286). As a result, AHCPR was born, albeit through creative legislative maneuvering, in which congressional leaders incorporated the statutory language creating the Agency in the Omnibus Reconciliation Act of 1989. AHCPR was authorized for five years at a funding level of \$53 million in FY 1989. Over the first five years, funding remained at a steady growth rate (*see Figure 3*) achieving \$162 million in FY 1995. However, the following year AHCPR’s budget plummeted to \$125 million as the Republican-controlled Congress created a more hostile environment for the Agency.

In addition to the budgetary strife, its authorizing statute expired. Thus, AHCPR had to limp along as an unauthorized program with only incremental budget increases through FY 1999 (*see Figure 4*). The lack of renewed authority increased the Agency’s vulnerability as it was still operating under the auspices of a statute that, for all intents and purposes, was slowly being dismantled by the House Appropriations Subcommittee on L/ HHS.

Along with the appointment of John Eisenberg in 1997, the health services research community and some prominent policymakers began to push for the reauthorization of AHCPR. During this time, Eisenberg worked closely with fellow physician and personal friend, Senator Bill Frist (R-TN), to reauthorize the AHCPR. Frist, who was a cardiologist by training, had an acute understanding of the importance of health services research, and he made the reauthorization of AHRQ one of his top priorities in the Senate. In 2001 at the Thirty-seventh Annual Meeting of Thoracic Surgeons, Senator Frist noted that he focused on three primary objectives when he came to the U.S. Senate in 1994, which included: “refocusing federal efforts on quality not just cost; protecting the sanctity and authority of the doctor-patient relationship; and defending the profession against excessive intrusion from HMOs and managed care: (Frist,

2001, p.1410). Frist (2001) pointed out that he helped pass a number of laws including “refocusing the Agency of Health Care Research and Quality (AHRQ) on improving the research behind quality health care delivery” (p.1410)

As the Senate Health, Education, Labor, and Pensions (one of the prominent Senate authorizing committees for health programs) began work to reauthorize the Agency, the appropriations subcommittees (primarily the House subcommittee) grew somewhat impatient, which was likely an indication of their sense of stewardship over the Agency’s programs and direction. Immediately following Eisenberg’s (1999) opening statement on the AHCPR’s FY 2000 budget request, the following exchange took place between Eisenberg and Chairman Porter:

Mr. Porter: Any indication that our authorizing brothers and sisters are going to do anything about reauthorization [of AHCPR]?

Dr. Eisenberg: In the Senate, there was a bill introduced last year to reauthorize the Agency. There were hearings on the bill, but it did not have a vote. We understand that there is continued discussion this year about introducing bills on both sides to reauthorize the Agency, and we are looking forward to working with the Congress to see that happen (p. 1069).

In December 1999, the Congress passed Senator Frist’s Healthcare Research and Quality Act of 1999, which reauthorized AHCPR for six years and formally changed its name to the “Agency for Healthcare Research and Quality” (AHRQ). Among a host of minor changes, the reauthorization made several more significant ones. Key changes included: (1) the removal of “policy” from the Agency’s name to make it clear that the Agency does not determine healthcare policies or regulations; (2) the incorporation of “quality” in the Agency’s name, which established AHRQ as the lead federal agency on quality research; and (3) the elimination of the

requirement that the Agency support the development of clinical practice guidelines (AHRQ Fact Sheet: Reauthorization, 1999).

The codification of eliminating the clinical practice guideline program was largely symbolic since the Agency already had already taken steps to end the program at the urging of the House Appropriations Subcommittee on L/ HHS in 1995. Nevertheless, the symbolism resonated with the research community. In an article on Eisenberg's leadership, the *Washington Healthbeat* exclaimed, "Working with [Senator] Frist, the Agency's role was changed to emphasize its role in funding research by outside institutions and to end its direct identification with the issuance of practice guidelines. It was successfully reauthorized as the Agency for Healthcare Research and Quality (Reichard, 2002, p.1).

It is important to note that the reauthorization bill did not dramatically alter the Agency's direction; it simply codified many of its current activities such as measuring and improving quality of care. In fact, during his testimony in 1998 (well before the Agency's reauthorization passed the Congress) before the House Appropriations Subcommittee on L/ HHS, Eisenberg announced a \$15 million initiative to improve health care quality. In reference to the quality initiative, Chairman Porter asked Eisenberg sardonically, "So, you are just giving the request for an increase a name because you are already doing the quality research in any case?" (House Committee on Appropriations, 1998, p. 20).

Nevertheless, the reauthorization put AHRQ in a better position politically, as it reaffirmed its role as an unbiased, scientific research agency, as opposed to previous allegations by the House GOP leadership that it was a partisan actor during the Clinton's health care reform initiative. In alluding to the ideological divisions that tend to surround health care policy and AHRQ's bumpy ride in particular, Eisenberg said, "I have felt it critical that AHRQ be seen as a

non-partisan agency that helps decision makers with evidence. I felt it critical that AHRQ not get wrapped up in partisan issues and that I personally be seen as one who could work well with both sides of the debate” (Gray, et al., 2003, p. 305).

After Eisenberg’s first hearing before the House Appropriations Subcommittee on L/HHS, I joined him in a series of meetings in which we met with the Subcommittee members and staff from *both* parties in an effort to educate them on the Agency’s programs and activities and to show, in Chairman Porter’s parlance, “how AHCPR was helping people.”¹⁶ For example, we met with Rep. Randall “Duke” Cunningham (R-CA), a subcommittee member who once offered an amendment to drastically scale back funding for AHCPR. After the meeting, Cunningham and his staff offered to arrange for a “town hall” meeting in San Diego, which was a large part of the Representative’s district, to speak to his constituents about how AHCPR’s work was helping them. Getting Subcommittee members such as Rep. Cunningham on board with the Agency’s research agenda was key in establishing positive relations between the Agency and the Subcommittee, which ultimately helped set the Agency on a path of growth and prosperity. The other part of our effort was the reauthorization of AHRQ, which gave it a renewed *raison d’être* and confirmed to policymakers and the research community that AHRQ had an important role in the nation’s health care system.

Critical Incident (1999): Medical Errors Report

On November 29, 1999, the Institute of Medicine (IOM) released a report, *To Err is Human: Building a Safer Health System*. Its findings shook the health care community and

¹⁶ Author’s observations in the role as a participant observer. 1998

quickly grabbed the attention of policymakers on Capitol Hill. The report estimated that between 44,000 and 98,000 Americans died each year as a result of medical errors. It also found that more individuals die each year from adverse events in the delivery of health care than die in automobile accidents (43,458) and from workplace injuries (6,000), and that deaths caused by medical errors exceed the number attributable to breast cancer, the eighth leading cause of death (Kohn, et al., 2000).

Shortly after the release of IOM's report, the Senate Appropriations Subcommittee on L/HHS held hearings on medical errors and patient safety issues. The Subcommittee was one of the first committees in Congress to address the issue of medical errors as outlined in the IOM's report. The Subcommittee, chaired by Senator Arlen Specter (R-PA), called in a panel of experts with particular experience in the area of patient safety to testify. The panel included a number of prominent leaders in the health care field, including John Eisenberg, director of the newly named AHRQ. It is important to note that reauthorization of AHRQ was signed into law by President Clinton on December 6, 1999, only seven days before the Subcommittee's hearing on medical errors. The Subcommittee held the hearing despite the fact that Congress was on recess during that time. Senator Specter opened the hearing with the following statement:

The study of the Institute of Medicine recommended that the Agency for Healthcare Research and Quality receive an appropriation initially of some \$30 million [to conduct research on identifying and preventing medical errors]. That agency is funded by this subcommittee, and it was decided that we should push ahead with a hearing at an early date even though the Congress is in recess at this time so that we may investigate this issue and proceed with the dialogue, hopefully being in a position to introduce legislation on this subject when the Congress reconvenes in late January (Specter, 1999).

What is so intriguing about the hearing is that an appropriations committee took the initiative to address a policy matter of national importance, which typically would be handled by

the authorization committees. Senator Specter's opening statement noted that despite the Congress being on recess, the Subcommittee was prepared to move ahead to "*investigate*" this issue. Additionally, he suggested that the Subcommittee intended to be in a position to ultimately "*introduce*" legislation on this subject.

These very actions are significant, as they provide additional evidence which points toward the transformation of roles between the congressional appropriations committees and authorization committees. This phenomenon will be illustrated in more detail in this section, as I dissect the how the actions that Senator Specter and his Appropriations Subcommittee pursued directly affected the policies and direction of AHRQ as well as the policy agenda nationally. As a respondent commented, "Specter and his Subcommittee had an enormous influence with medical errors that impacted AHRQ more than any other factor" (R4, 2009).

After Eisenberg completed his oral statement on medical errors before the Senate Subcommittee, Senator Specter asked him some specific questions about developing legislation that would focus efforts on reducing medical errors. The significance of the exchange between Specter and Eisenberg is that the Senator's questions went beyond funding issues, over which the Subcommittee has primary jurisdiction. Instead, the questions were much more policy oriented as they focused on the development of potential legislative proposals.

Specter: One suggestion has been made, that as a result of the legislation [AHRQ's reauthorization] which was signed into law just last week by the president, which gave you new authority, your agency, that it might be unnecessary to have additional legislation, that you might be able to handle it within the existing framework of established law. What is your view about that?

Eisenberg: We can certainly do more than we have done in the past. And I think the authorizing language that we have gives us just that authority. It gives us authority to conduct a more aggressive program of research. It asks us to create a national report on health care quality by the year 2003. And we have to respond and we look forward to responding to that authorizing language.

Whether we should do more than the authorizing language already allows us to do is something that our department and the entire administration is looking at very, very seriously. And over the next several weeks we're going to look at it carefully, get back to the president, about what we should do or what we can do even beyond the authorities that we already have.

Specter: Well, when there's a call in the report of the Institute of Medicine to start off with an additional funding sources of \$30 million and then to elevate that to hundred million, I think it likely that to get that kind of additional congressional support there's going to have to be a lot more concern in Congress, which may require some additional legislation and some additional congressional focus.

Eisenberg: Well, we look forward to talking with you about that legislation, what might allow us to do and the kind of resources that it would require (Senate Hearing 106-847, 1999, p.8).

As Senator Specter concluded his questioning of Dr. Eisenberg, he noted that the Congress was likely to consider legislating on ways to reduce medical errors, alluding to Senators Jeffords's (I-VT) and Kennedy's (D-MA) plans to introduce legislation in the Committee on Health, Education, Labor, and Pensions. However, although Specter (1999) raised the prospect of legislating on this issue, he suggested that perhaps his appropriations subcommittee should go beyond its traditional funding role:

Specter: Well, I think the Congress is going to legislate on the issue of mistakes from this [IOM] report. Senator Kennedy has announced his intention to do so and Senator Jeffords is the chairman of the authorizing committee and we're going to be moving it toward here. When you talk about a culture of excellence it's broader, broader range as to whether there's competency here. We [Senate Appropriations Subcommittee on L/ HHS] can appropriate money, as we have for your agency [AHRQ] or we have for the National Institutes of Health or the Center for Disease Control, *but whether we ought to go beyond that*, leaving the implementing decisions to you professionals, whether we have anything more to say is a much tougher question (p.46).

The question that Senator Specter posed, whether the Subcommittee should go beyond its role as "funder," was answered shortly after the hearing. In the FY 2001 (calendar year 2000) Senate Appropriations Committee Report, the Committee provided AHRQ with \$50 million to

lead the national effort to combat medical errors and improve patient safety. The Committee's Report (*see appendix A*) was quite prescriptive about how the Agency was to carry out the Committee's mandate. In fact, as someone who was responsible for helping with AHRQ's implementation efforts, I had to maintain constant (almost daily) contact with the Subcommittee staff to keep them apprised of the Agency's activities in this area, as well as to get guidance from them to ensure that the Agency was adequately carrying out their directives.¹⁷ These were uncharted waters for the appropriations staff, as their role in oversight in policy implementation was going well beyond their conventional funding involvement.

The Committee specifically directed AHRQ to establish a competitive demonstration program for health care facilities and organizations in geographically diverse locations, including rural and urban areas, to determine the causes of medical errors. These projects were to use a variety of techniques and strategies to reduce such errors; develop models that minimize the frequency and severity of errors; develop mechanisms that encourage reporting, prompt review, and corrective action; and develop methods to minimize paperwork. The Committee further urged AHRQ to prepare and submit an interim report to Congress concerning the results of this medical error reduction demonstration program within two years of the commencement of the projects (Senate Report 106-293, 2000, p.195-198).

AHRQ's directive to identify and reduce medical errors provided a financial boost to the Agency's budget. Although the new role provided a new opportunity for the Agency to help improve medical care, some in the health services research community frowned upon it, believing that this initiative was steering AHRQ and its resources away from classical health

¹⁷ Author's observations in the role as a participant observer. 2000.

services research or what is better known as “investigator-initiated research.” Eventually, the health services research community applied pressure to the House and Senate Appropriations Subcommittees on L/ HHS with the goal of limiting the number of targeted or directed programs.

The following year (2001), in its FY 2002 appropriations report, the Senate Appropriations Subcommittee on L/ HHS increased funding in AHRQ’s budget by \$10 million to continue research to reduce medical errors. As in the previous year, the Subcommittee specified how AHRQ was to proceed with its patient safety program. Additionally, the Subcommittee directed the Agency to provide it a report detailing the results of AHRQ’s efforts to reduce errors. The Senate report language noted the following:

Last year the Committee provided \$50,000,000 for initiating research into the causes of medical errors in the hope of dramatically improving the safety of health care services in this country. The Committee commends the Agency for planning and instituting an impressive patient safety initiative, which includes demonstrations to test best practices for reducing errors, development and testing the use of appropriate technologies to reduce medical errors, such as hand-held electronic medication systems, and research in geographically diverse locations to determine the causes of medical errors. Of the total amount provided for HCQO,¹⁸ the Committee directs AHRQ to devote \$60,000,000 to determining ways to reduce medical errors, an increase of \$10,000,000 over the amount provided in fiscal year 2001. The Committee expects that AHRQ will use these funds to share lessons learned and best practices among hospitals and healthcare providers. The Committee directs AHRQ to work with the Center for Medicare and Medicaid Services (CMS) to provide this information to participating hospitals and healthcare facilities so that they can begin implementing successful strategies.

The Committee further directs AHRQ to provide a report detailing the results of its efforts to reduce medical errors. The report should include how hospitals and other healthcare facilities are reducing medical errors; how these strategies are being shared among healthcare professionals; how many hospitals and other healthcare facilities record and track medical errors; how medical error information is used to improve patient safety; what types of incentives and/or disincentives have helped healthcare professionals reduce medical errors and; a list of the most common root causes of medical errors. The

¹⁸ HCQO, “Health Costs, Quality, and Outcomes,” is a line item in AHRQ’s budget that represents all budget items that include comparative effectiveness research, prevention –care management, value-driven health care, health information technology, patient safety, and HAIs.

report should provide data showing the effectiveness of State requirements in reducing medical errors. The report should also describe how AHRQ is responding to some of the findings in the IOM's report *To Err is Human: Building a Safer Health System* (Senate Report 107-084, 2002, p. 11).

The medical errors initiative led to a substantial increase in funding for AHRQ and resulted in a more identifiable, national role for the Agency. Moreover, AHRQ began to shed some of its previous vulnerabilities, as its prominent role in patient safety provided the Agency with some much needed ballast. However, the Agency's elevated stature came with a cost as the leadership's autonomy suffered a setback. In fact, after the Subcommittee approved the appropriations bill and the accompanying report, a senior agency leader noted the following with some concern: “[Does] the Senate [Appropriations Subcommittee on L/ HHS) understand the need to fulfill the expectations and needs of the IOM report beyond a narrow interpretation of the Senate [appropriations report language] language?”¹⁹

In a briefing with Senate Appropriations Subcommittee staff regarding the AHRQ's discretion in carrying out the medical errors agenda as prescribed by the Senate report language, the staff made it clear that AHRQ was to follow the language “as written.” The Subcommittee staff said that Senator Specter wanted the agenda carried out in a certain way, and there was little room to maneuver on the language.²⁰ Nevertheless, AHRQ moved forward with the implementation of the medical errors agenda as directed by the Subcommittee, albeit with some reluctance on the part of the Agency's leadership. However, as the House and Senate Subcommittees on L/HHS intensified their role in shaping the policies AHRQ, the impact on the

¹⁹ Author's personal email archives. 2000

²⁰ Author's personal communication. 2000

Agency's discretion began to become a concern, particularly within the health services research community. The Friends of AHRQ²¹, which is comprised of professional societies and health care organizations that support AHRQ programs, lobbied the appropriations subcommittees to increase AHRQ's discretionary research funds. In a letter to Senator Tom Harkin, Chair, Senate Appropriations Subcommittee on L/ HHS and Rep. Obey of the House Subcommittee, the Friends of AHRQ stated:

As you know, there has been a dramatic decline in the number of, and funding for, grants that support researcher innovation and career development. The Friends of AHRQ support the language and funding proposed in the House and Senate Labor-HHS reports for new and competing grants to rejuvenate the free marketplace of ideas, and greater investment in young researchers to ensure the field's capacity to respond to the growing public and private sector demand for research (Friends of AHRQ, 2008).

In response to the Friends of AHRQ's concern, the following language was included in both the FY 2009 Senate²² Appropriations Committee Report:

The Committee is deeply concerned about declines in the number of, and funding for, training grants for the next generation of researchers. Failure to fund such grants stifles the workforce and knowledge base needed to respond to the Nation's growing health care challenges, including aging baby boomers, unsustainable rising costs, and declining health status (Senate Report, 110-410).

²¹ The Friends of AHRQ is a coalition of health professional, research, consumer, and employer organizations dedicated to ensuring the agency's continued vital role in improving our nation's health. Coalition for Health Services Research: <http://www.chsr.org/FY%202010%20Letter%20to%20House.pdf>

²² The House included similar report language in their FY 2010 Committee Report.

Since that time, AHRQ's leadership has worked with the Friends of AHRQ and the appropriations subcommittees toward achieving a more balanced research portfolio. The FY 2009 appropriations for AHRQ included \$13 million for research development, which is discretionary (non-targeted), investigator-initiated research, the type of research that the health services research community prefers.

Critical Incident (2003): Health Information Technology

AHRQ continued its role as the "patient safety" agency, striving to identify ways to reduce medical errors. The Senate Appropriations Subcommittee on L/ HHS began to recognize the Agency as a key player in the health care system. Through briefings and staff contact, the Subcommittee was able to keep apprised of AHRQ's activities and ensure that the Agency was following through with its directives related to medical errors. It should be noted that during this time, the House Appropriations Subcommittee on L/ HHS supported the medical error initiative and effectively deferred to the Senate on this issue.

Shortly after the Senate Appropriations Subcommittee on L/ HHS entered the health care policy world with its medical errors initiative, the Subcommittee turned its attention to other related policy issues. In 2003, the Subcommittee supported an initiative offered by the Bush administration to increase the use of health information technology [HIT]. In FY 2004, President Bush requested \$50 million for a Patient Safety Hospital Information Technology program to support a variety of activities aimed at improving health care quality and patient safety by promoting and accelerating the development, adoption and diffusion of HIT in a variety of important health care settings.

The Subcommittees accepted the Administration's request as outlined in the following appropriations report:

For fiscal year 2004, the Committee directs AHRQ to devote \$84,000,000 of the total amount provided for HCQO to determining ways to reduce medical errors. This represents an increase of \$29,000,000 over the comparable fiscal year 2003 level. The Committee understands that \$50,000,000 of the recommendation will support an initiative to promote the development, adoption, and diffusion of information technology [IT] in health care. The Committee fully supports the Department's emphasis on information technology as a way to improve patient safety. The U.S. health care system lags behind others in the utilization of the internet and information technology applications. Greater investments in computer technology advances such as computerized physician order entry, automated medication dispensing and computerized patient records have enormous potential to greatly improve health care safety, efficiency and quality. In addition, these types of IT improvements have frequently been shown to have the ancillary benefit of improving cost savings (Senate Report, 108-81, p.187-188)

As a result, AHRQ created an Office of Health Information Technology to spearhead the initiative. Additionally, the Agency established *the AHRQ National Resource Center for Health Information Technology* (the National Resource Center) to help the health care community transition into the information age. Over the next five years, the program expanded to more than \$260 million in grants and contracts in 41 states to support and stimulate investment in health IT (AHRQ, 2009).

While the Bush administration made the initial request for the HIT Initiative, it was the Senate Appropriations Subcommittee on L/ HHS that decided to fund it and advance its objectives. The intriguing point is that the Administration decided to use the appropriations process as the *vehicle* for getting its policy proposal enacted. Certainly, the efficiency of the appropriations process was attractive in getting the Initiative off the ground swiftly, which is often a motivation for taking the appropriations route as opposed to using the more deliberative,

protracted authorization process. Nevertheless, it is yet another example of how the appropriations process has been used as a primary vehicle for policymaking.

Critical Incident (2004): Medicare Modernization Act of 2003

In 2003, the Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). The legislation changed a number of policies related to the Medicare program, including the most significant change, which gave eligible Medicare beneficiaries a prescription drug benefit. Upon signing this landmark legislation, President Bush noted that, “With the Medicare Act of 2003, our government is finally bringing prescription drug coverage to the seniors of America. With this law, we’re giving older Americans better choices and more control over their health care, so they can receive the modern medical care they deserve” (Bush, 2003).

Included in the MMA legislation is a provision (Section 1013) that authorizes AHRQ to conduct and support research with a focus on comparing the outcomes and effectiveness of different treatments and clinical approaches, as well as to communicate its findings widely to a variety of audiences (AHRQ, 2009). Essentially, the legislation laid the foundation for AHRQ’s Effective Health Care program, which conducts and supports research to provide comparative effectiveness research for clinicians, consumers, and policymakers so that they can make informed health care decisions. The MMA authorized \$50 million in FY 2004 for AHRQ to carry out the program and authorized “such sums as may be necessary” for the subsequent years. In FY 2004 the House and Senate Appropriations Subcommittees on L/HHS did not provide any funding for comparative effectiveness research (CER), as prescribed by the MMA of 2003.

However, in FY 2005 the Senate Appropriations Subcommittee directed AHRQ to devote \$15 million to CER. The report that accompanied the FY 2005 appropriations bill stated:

The Committee also directs AHRQ to devote \$15,000,000 of the total amount provided for HCQO to research on outcomes, comparative clinical effectiveness and appropriateness of prescription drugs and other health care items as authorized in Section 1013 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Senate Report 108-345, p. 186).

That year, AHRQ established the Effective Health Care Program and released its first comparative effectiveness report on gastric reflux disease. In fiscal years 2006 and 2007, the Subcommittees continued funding for the Effective Health Care Program at \$15 million. In FY 2008, however, the Senate Appropriations Subcommittee on L/ HHS doubled the funding for CER to \$30 million. In doing so, the Subcommittee made it clear that it would rather put more emphasis on AHRQ's CER program instead of supporting a Bush administration's initiative known as "personalized health care." The Personalized Health Care Initiative was intended to meet "the administration's drive for health care transparency by identifying and consistently measuring effective, high quality of care" (AHRQ, 2007).

The Senate Subcommittee did not see the value of the Personalized Health Care Initiative and was adamant that CER was where AHRQ needed to focus its energy and resources. AHRQ staff did not fully endorse the proposal as there was concern about the Agency's capacity to carry out such a program and the potential for a shift of resources away from the core research of the Agency's CER program.²³ After a number of briefings between AHRQ staff, representatives from the Office of the Secretary, and the House and Senate subcommittees' staffs, the

²³ Author's personal observations. 2007.

subcommittees decided to eliminate the proposal from consideration. The following excerpt from the FY 2008 Senate Appropriations Subcommittee Report illustrates how the Subcommittee played a significant role in steering the policy agenda related to comparative effectiveness research:

The Committee has not provided funding for the administration's personalized health care initiative. Instead, the Committee recommendation includes \$30,000,000 for research regarding the outcomes, comparative effectiveness and appropriateness of health care interventions. The Committee's recommendation doubles the amount provided for this research, which was authorized under section 1013 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

The Committee is aware that despite having the most expensive health care system in the world based on per capita expenditures, the United States ranks well below other countries on key health indicators, such as overall life expectancy and infant survival. Studies have shown that much of this is due to health care that lacks a basis in evidence. Studies have estimated that up to 30 percent of the Nation's health care spending pays for ineffective, inappropriate or redundant care.

In order to help providers and patients achieve the best quality care, the Committee believes we need a sound foundation of evidence about which treatments work best. AHRQ's comparative effectiveness research program helps patients and providers make informed decisions about treatment options by providing them with unbiased, practically useful information on the benefits and risks of treatments for common health problems (Senate Report 110-107, 2007, p.174-177).

Critical Incident (2008): Health Care Associated Infections

In 2008, Methicillin-resistant *Staphylococcus aureus* (MRSA) made headlines across the country as a number of individuals contracted the bacteria. MRSA became increasingly prevalent elementary and secondary schools, particularly among students who participated in athletics where bacteria were being transmitted through their sports equipment and locker rooms. Serious cases of MRSA infections, such as a case of a 17 year old boy in Bath County, Virginia,

who died due to complications of MRSA in 2007, grabbed the attention of public health officials and policymakers nationwide (*Washington Post*, 2008).

As a result of concerns about MRSA, the Senate Appropriations Subcommittee on L/ HHS directed AHRQ in the FY 2008 appropriations conference report to fund \$5 million in activities to identify and reduce the spread of MRSA. The Agency developed an action plan aimed at reducing MRSA. The plan became a subcomponent of the Agency's larger Patient Safety program. The following year, the Senate Appropriations Subcommittee continued the funding for the program, noting that "The Committee is concerned about the prevalence of these [MRSA] preventable infections and has provided a second year of funding for this initiative at AHRQ due to its expertise with patient safety and quality of care issues" (Senate Report 110-410, 2008, p.140).

During this time, staff of the House Appropriations Subcommittee on L/ HHS simply accepted the Senate's \$5 million MRSA initiative in the House and Senate FY 2008 appropriations conference. However, in April 2009, Chairman David Obey (D-WI) of the House Appropriations Subcommittee on L/ HHS became interested in the issue of health care-associated (HAIs) infections and decided to hold a hearing on ways to reduce HAIs, such as MRSA. Expert witnesses, including Carolyn Clancy, AHRQ's Director, testified before the Subcommittee. In his opening statement, Chairman Obey said:

When I look at the simple steps that could be undertaken in order to reduce this [HAIs] calamity, I am reminded of the old movie about Dr. Pasteur, who was simply trying to teach the medical profession to wash their hands. I know it is not that simple, but I do not believe that there has been a sufficient sense of urgency on this issue, either on the part of the Congress or on the part of administrators throughout the government, and certainly on the part of health providers...so let me simply say we are here to try to hear from two panels about we can do to solve a huge medical problem in this Country (Obey, 2009. p1).

Obey's remarks made it clear that his Subcommittee was prepared to help steer national policy in order to reduce HAIs. The title of the hearing, "Pathway to Health Reform: Implementing the National Strategy to Reduce Healthcare-Associated Infection," read more like a hearing that would be held by an authorization committee. In fact, in preparations for the hearing on HAIs, a House Appropriations staffer indicated to me that she was amazed at how involved the Subcommittee was in health care policy. She said that the hearing on HAIs was something that the authorization committees should be doing. She added that this was the "new world order" where appropriation chairs are now hiring subject area experts, such as microbiologists, instead of the conventional budget analysts.²⁴

In her opening statement, Clancy stated, "Mr. Chairman, we greatly appreciate the Committee's understanding of the grave problem of HAIs and your foresight in providing AHRQ with additional funds in FY 2009. We will use the funds to invest in evidence-based research to reduce the incidence of MRSA and other HAIs" (Clancy, 2009, p. 1).

Clancy continued that the number of hospital stays to treat MRSA infections more than tripled after 2000, reaching 368,600 in 2005. She also noted that patients hospitalized for MRSA had longer hospital stays and were more likely to die than patients without MRSA. Additionally, Dr. Clancy said that 1 of every 20 of the roughly 368,600 patients treated in U.S. hospitals in 2005 for MRSA died (Clancy, 2009, p.1).

The House subcommittee pushed forward to tackle the issue of HAI's by launching a comprehensive, national initiative to reduce the incidence of these infections. In the FY 2009

²⁴ Author's personal communications. 2009.

House Appropriations bill, the Subcommittee provided AHRQ with \$9 million to address the issue of HAIs. This funding was part of the Subcommittee's broader initiative to combat HAIs. In announcing key investments in the FY 2009 bill, Chairman Obey noted that the bill included "a new initiative to reduce hospital and clinic infections that cause nearly 100,000 deaths each year, and requires national and state plans to combat infections with \$22 million"(House Appropriations Committee, 2008). In addition, the Subcommittee included language in the FY 2009 Appropriations Report that prescribed how the Secretary of HHS was to carry out the HAI initiative, including the development of an action plan for reducing HAIs nationwide:

The Committee believes that combating HAIs is an urgent public health issue that demands greater attention. The Committee includes \$1,000,000 within the Office of the Secretary to ensure that HHS engages in a stronger, coordinated effort, involving CDC, the Centers for Medicare and Medicaid Services (CMS), and the Agency for Health Research and Quality (AHRQ), to reduce HAIs. The Committee expects the Secretary to use these funds to collaborate with outside experts, as well as experts within at CMS, CDC, and AHRQ, to conduct a thorough review of HA1 activities across the Department and to develop an action plan for reducing HAIs in the U.S. This action plan shall identify data deficiencies, additional activities needed for a strengthened, coordinated public health response, timelines and benchmarks for improved outcomes, new enforcement mechanisms that may be needed, and short- and long-term budget estimates for carrying out the action plan. This information will be critical for the Committee to make an informed, appropriate response to this urgent problem (House Report 110-X, 2009)²⁵

In 2009, the House Appropriations Subcommittee on L/ HHS took a significant step by including \$202 million in its 2010 appropriations bill to funds the initiative to reduce HAIs. Of the \$202 million, AHRQ received \$18 million to develop strategies to reduce HAIs. In their report that accompanied the FY 2010 appropriations bill, the Committee stated the following:

²⁵ The House did not have a committee report to accompany the FY 2009 Appropriation Bill; instead the information was provided by the Department of Health and Human Services in the "significant items" that it identified for AHRQ to respond to, which became part of AHRQ's *FY 2010 Justification for Estimates for Appropriations Committees*, which can be found on pages 89-91

The Committee continues to be concerned about healthcare-associated infections (HAIs). According to CDC, HAIs are one of the top ten leading causes of death in the U.S., accounting for nearly 100,000 associated deaths and \$28,000,000,000 to \$33,000,000,000 in excess health care costs annually. The Committee provides \$25,000,000 within the total for Patient Safety Threats and Medical Errors for AHRQ's HAI activities, which is \$15,696,000 more than the fiscal year 2009 funding level and the budget request. With increased resources, the Committee directs AHRQ to place major emphasis will on expanding the checklist model for reducing central-line associated blood stream infections in intensive care units (House Report 111-220, 2009, p. 150).

As a result of the House Subcommittee's HAI initiative, AHRQ developed an "action plan" in collaboration with other Public Health Service agencies, such as the Centers for Disease Control and Prevention. The Plan outlined how AHRQ was to address the issue of HAIs as outlined by the House Appropriations Subcommittee's directives. In October 2009, AHRQ announced the expansion of an effort called the Comprehensive Unit-based Safety Program (CUSP), which successfully reduced central line-associated blood stream infections in intensive care units in Michigan. The announcement expanded CUSP to all 50 States and additional hospitals in States already participating in the CUSP, as directed in the FY 2010 House Appropriations Committee Report (AHRQ, 2009). The announcement was a direct response to the language in the House Appropriations Report:

The Committee directs AHRQ to place major emphasis on expanding the checklist model for reducing central-line associated blood stream infections in intensive care units, which was originally developed through AHRQ-funded research at Johns Hopkins University. In fiscal year 2009 this program was expanded from 10 to 32 States, the District of Columbia, and Puerto Rico. Additional funding in fiscal year 2010 will bring this successful model to all 50 States and to enhance the initiative to focus on other HAIs, including surgical site infections and catheter-associated urinary tract infections and to broaden the reach of the checklist to all units of hospitals (House Report 111-220, 2009, p. 151).

AHRQ has since made HAIs a focus of its overall Patient Safety Program and continues to its work in HAIs pursuant to the House Appropriations Subcommittee's direction. In its FY

2011 budget request to the Office of Management and Budget, the Agency noted that “due to increased Congressional interest in the prevention of health care –associated infection, the Agency has been awarding increasing amounts of funding to reduce HAIs...AHRQ is poised to continue this work in close collaboration with our DHHS partners” (AHRQ, 2009, p.53-54).

Critical Incident (2009): American Recovery and Reinvestment Act 2009

Toward the end of President Bush’s second term in office, the United States faced what was arguably the country’s worst economic crisis since the Great Depression of the 1930s. Federal Reserve chair Ben Bernanke called the financial crisis, “the worst the country has faced since the end of World War II” (CNN, 2008).

The first action taken by the Bush administration was to stabilize the financial market. The only way the Administration believed this could be accomplished was through a \$700 billion government bailout. On October 3, 2008, the President signed legislations, the Troubled Asset Relief Program (TARP), which was a comprehensive, government sponsored approach to curbing the economic fallout that was looming from the financial crisis.

Shortly after the passage of TARP, the country elected Barack Obama in the 2008 election. A large part of Obama’s campaign was to end the country’s financial crisis and stimulate the economy, primarily by getting people back to work. In his victory speech, President-elect Obama said, “And above all, I will ask you join in the work of remaking this nation the only way it’s been done in America for two-hundred and twenty-one years - block by block, brick by brick, calloused hand by calloused hand...Let us remember that if this financial crisis taught us anything, it’s that we cannot have a thriving Wall Street while Main Street suffers - in this country, we rise or fall as one nation; as one people” (*Huffington Post*, 2008).

In January 2009, the Democratic Congress quickly got to work and developed a economic recovery plan as an answer President Obama's call to end the economic crisis. On January 26, 2009, Chairman David Obey of the House Appropriations Committee introduced the American Recovery and Reinvestment Act (ARRA) of 2009. In introducing the bill, Obey said, "Mr. Chairman, this country is facing what most economists, I believe, consider to be the most serious and the most dangerous economic situation in our lifetimes, certainly going back to the early thirties... this package today that we are considering is an \$825 billion package that does a variety of things to try to reflate the economy" (Obey, 2009). A similar bill was introduced in the Senate, sponsored by Majority Leader Harry Reid (D-NV).

Several things related to this research should be noted about ARRA. First, the mere size (\$825 billion) of the package covered an unprecedented number of areas, including health care, as a way to help stimulate the economy. Second, the legislation, which made a number of bold national policy changes, was spearheaded by the House and Senate Appropriations Committees. Finally, the passage of ARRA is examined as a "critical incident." The Act almost doubled AHRQ's budget, compelling the Agency to dramatically shift its research priorities.

On February 17, 2009, President Obama signed ARRA into law: "The American Recovery and Reinvestment Act that I will sign today -- a plan that meets the principles I laid out in January -- is the most sweeping economic recovery package in our history" (Obama, 2009). Additionally, the President (2009) noted that the stimulus package included a mix of tax cuts and investments. Among those investments was a \$1.1 billion initiative for AHRQ, the National Institutes for Health, and the HHS Office of the Secretary to evaluate the relative effectiveness of different health care services and treatment. AHRQ received \$300 million of the \$1.1 billion to increase its work in this area. To put this into perspective, as *Figure 3* shows, the Agency's total

budget in FY 2009 was \$372 million. More importantly, comparative effectiveness research is a cornerstone in President Obama's health care reform plan currently being considered by Congress. Thus, the fact that the appropriations committees delved into such a critical, and sometimes controversial, policy underscores their ongoing policymaking role.

The ARRA comparative effectiveness provision directed AHRQ to conduct comparative effectiveness research as prescribed in Section 1013 of the Medicare Modernization Act. The legislation established a Federal Coordinating Council, which, along with the Institute of Medicine, would set research priorities. The Act also required that each agency develop an operating plan to be submitted to the House and Senate appropriations committees. Additionally, the agencies must submit annual reports to the House and Senate appropriation committees and the appropriate House and Senate authorization committees on their activities in CER.

Although the House and Senate authorization committees that have jurisdiction over health care issues were involved in helping to craft ARRA, the House and Senate appropriations committees had primary jurisdiction over the bill, and they made the final decisions. Not only was ARRA a historic undertaking in its magnitude, but it also highlighted how congressional appropriators had assumed such an active policymaking role. This was underscored in ARRA's overall policy objectives, as well as an examination of the specific role that the House and Senate Appropriations Subcommittees on L/ HHS played in crafting the provisions related to comparative effectiveness research. In fact, in my role as AHRQ's congressional liaison, I

worked closely with the appropriations staff on a number of technical issues, including devising a working definition for comparative effectiveness research.²⁶

During congressional staff negotiations on the ARRA provisions, I witnessed tremendous tension over turf between the staffs of the appropriations and authorizing committees. In light of these negotiations, an appropriations committee staffer remarked, “The authorizers are trying to modify the CER language because of some policy concerns. We are hearing them out, but they need to get used to the fact that this is our [appropriators’] bill.”²⁷ It was apparent that the appropriators were “steering the ship” with ARRA, as the authorizers served in a more consultative role.

Once ARRA passed, AHRQ established an operations plan as required by the Act. The Plan was vetted through the Department and OMB before being sent to the appropriations committees for final approval. Upon the approval by the appropriations committees, AHRQ announced its research agenda in concert with the intent of the CER provision in ARRA. The research agenda related to ARRA funding encompasses about a third of the overall AHRQ budget, making CER the Agency’s highest funded program in its history. As required by ARRA, the Agency must submit operations plans every six months to the House and Senate Appropriations Subcommittees on L/ HHS, as a way of keeping them apprised of AHRQ’s activities.

ARRA is the last critical incident that I address over the case study’s twenty year span. Ironically, this incident probably was the most appropriate one to conclude with, as the evidence

²⁶ Author’s participant notes and observations. January 2009.

²⁷ Author’s personal communications. Meetings with House and Senate appropriations staff regarding comparative effectiveness provision in the ARRA. January 26, 2009.

of the policymaking role of the House and Senate Appropriations Subcommittees on L/ HHS was substantial. Moreover, that ARRA was treated as an appropriations measure is particularly noteworthy, since the bill impacted a number of national policies, particularly health care policy. As an appropriations staffer said to me, “ARRA is essentially a down payment for health care reform.”²⁸

In the next chapter, I more closely examine the policymaking roles of the House and Senate Appropriations Subcommittee on L/ HHS relative to AHRQ and suggest *why* this phenomenon might be occurring.

²⁸ Author’s personal communication. 2009.

CHAPTER 6

Potential Explanations

Throughout various periods of history appropriations members have been considered “guardians” of the federal Treasury, “claimants” of funds for their congressional districts, and “point-people” in support of a partisan agenda.

Scott Adler (2000)

The critical incidents that I discussed in Chapter 4 are key features of a framework for exploring how the House and Senate Appropriations Subcommittees on L/ HHS developed significant policymaking influence over AHRQ’s programs between 1989 and 2009. It is important to point out that this increased subcommittee policymaking role has not been a rapid transformation, but rather a gradual evolution over the past two decades.

This chapter examines potential factors that might have influenced the increased involvement in policymaking by the House and Senate Appropriations Subcommittees on L/ HHS. These factors suggest possible explanations for why the Subcommittees have gravitated to a more policy-oriented role in their dealings with AHRQ. These factors include:

- A weakening of the appropriations committees’ power and autonomy as a result of organizational changes in Congress over the years.
- The 1995 Republican Revolution and its generation of increased partisanship among members on the appropriations committees.

- The vulnerability of AHRQ following its “near-death” experience, which created a window of opportunity for appropriators to influence the Agency’s policies and direction.
- The annual nature of the appropriations process, which provides for a more timely process, particularly as it relates to the ever-changing dynamics of the U.S. health care system.
- The evolution of the principal-agent relationship between the House and Senate Subcommittees on L/ HHS and AHRQ.

This chapter examines each of these factors by linking them to critical incidents and/or other findings obtained from document analyses, interviews, and observations. The chapter provides evidence through narrative data to validate the five potential explanations. As I alluded to in Chapter 4, Langley contends that for many process researchers, the use of a narrative strategy can “serve as a validation tool” (Langley, 1999, p. 695).

Organizational Changes

Some scholars have suggested that the organizational changes in Congress, brought about by budget reforms, such as the Congressional Budget and Impoundment Control Act of 1974, have prompted appropriators to carve out a new niche for themselves, given their diminished role in the budget process. The legislation moved the Congress toward a more centralized budget process. A major move in that direction was the establishment of the budget committees and the reconciliation process, where the “Congress as a whole is empowered to give instructions concerning changes in law to congressional committees” (Joyce, Philip, 1996. p. 319), took away a large part of the appropriators’ control of federal funds.

Once, the appropriations committees controlled virtually all federal spending; now they have effective jurisdiction over only one-third. Once they had no rival in Congress for determining how much was spent on the programs in their jurisdictions; now they must reckon with budget resolutions and (in some years) preset spending caps. Since the beginning of Congress, the notion was branded into the political mind-set of the appropriators that their job was to restrain the spending ambitions of executive agencies, not to legislate. Appropriators were to decide how much the agencies, established through previous congressional decisions, should spend. The weakening of tradition has made the appropriations process more similar to other congressional activities and much less insulated from the partisan tides affecting Congress. The appropriations process is more permeable than it once was, although it still stands apart from other legislative activities (Schick 2000, p. 189).

Schick contends that the reduced role of the appropriations committee in determining spending has “ruined the incentives for members of that committee to police the spending of their colleagues: members of the House Committee, it is argued, no longer seek to cut executive spending requests, but instead seek to secure their own slice of the federal largess” (Schick in McCubbins, 1990, p. 134). He (2000) also suggests that the weakening of the appropriations committees under the Budget Act has contributed to increased legislation in spending bills, among a number of other behavioral changes (p. 192).

Schick and Wildavsky (1992) asserted that the budget process has “removed a level of guardianship (i.e. the Appropriations Committee) and replaced it with weaker spending control mechanism or pro-spending bias” (Forgette, 1996, p. 25). Wildavsky (1997) observed that the boundaries between authorizing and appropriations committees had become blurred, as appropriations funded less than half of the budget. As a result, a power struggle exists between

the authorizing and appropriations committees. Moreover, Wildavsky contends that appropriations acts are so complicated, which exacerbates this power struggle. For example, “a decision to fund an activity, or to fund it under certain conditions (e.g. abortions allowed only in the case of rape or serious threat to the mother), looks much like a policy decision” (Wildavsky, 1997, p.13). Wildavsky acknowledges that the establishment of the budget committees was intended to help safeguard the Treasury. However, an unintended consequence of this change served as a catalyst in transforming appropriators from their previous role as guardians of the Treasury to “self-expression” by committee members (Wildavsky, 1997, p. 13). As a result, Wildavsky (1997) suggests that program advocacy became “the main purpose for appropriators” (p. 13). A former staff member of the House Appropriations Subcommittee on L/ HHS said: “appropriators used to be tight ‘fisted,’ now appropriators want to spend money” (R8, 2009). He added: “There is a lot of tension between the authorizing committees and appropriations committees, particularly when the Budget Committee tries to flex its muscle through the budget resolution by requiring the appropriators to cut certain programs. The budget resolution is a gimmick and the appropriators ignore it for the most part.”

Despite the various role changes that the appropriators have gone through, Wildavsky (1997) points out that they remain an important arm of the Congress and continue to yield tremendous power. “Although the whole passing through the appropriations process has declined, the absolute amount is still far larger than the total budget in all of the last two decades.” (p. 14).

In his research on the composition of appropriations committees, Scott Adler finds that at various periods throughout history appropriations members have been considered “guardians” of the federal Treasury, “claimants” of funds for their congressional districts, and “point-people” in

support of a partisan agenda (Adler, 2000, p.104). Although he does not specifically address the policymaking aspect of appropriators, Adler does acknowledge that members of these panels can gain policy benefits provided by a particular subcommittee that ultimately meet the needs of their constituents. While he rejects a pure “guardian” (committee members serving as “nonadvocates”) model, he recognizes that other factors can influence committee behavior. The findings reported here are consistent with Adler’s notion that the appropriations committees’ dynamics are not necessarily stagnant and change at different periods of time. The period under study (1989-2009) shows evidence of perhaps another shift in the committee composition, in which there is a strong inclination toward policymaking.

In Appropriations Politics and Expenditure Control, John Gist (1978) argues that the diminished control of funds by the appropriations committees has changed the institutional dynamics of how appropriations committees perform and operate. “Uncontrollability is intriguing because it seems to controvert the established dictum that control over purse strings is fundamental to congressional power (Gist, 1978, p.164).” Instead, Gist (1978) found that appropriation committee members are “motivated by public policy concerns” (p. 178). Thus, the niche of policymaking, evidenced throughout the critical incidents in the case study, may be a response to appropriators’ diminished control of the budget. Gist (1978) found evidence that appropriators “often behave in a manner that is consistent with a desire to maximize their impact on public policy” (p. 178).

Rise of Partisanship

The Republican Revolution²⁹ not only changed the political landscape, but also altered committee roles, particularly the role of the House Appropriations Committee. The literature is abundant on how the Republican leadership changed the governing dynamics of the House Appropriations Committee and its subcommittees. Aldrich and Rohde (2000) observed that in 1994, the GOP leadership decided to “use Appropriations as one of the vehicles of major policy change” (p.1). In their analysis of the impact of the Republican revolution on the House Appropriations Committee, they noted that Speaker Gingrich had substantial influence over the selection of committee chairs, committee assignments, and the committee’s agenda. Gingrich required that the GOP appropriations members sign a “letter of fidelity” that bound them to follow the leadership’s agenda (Adler, 2000, p. 106). A former member of the House Appropriations Committee said that every mark coming out of the Committee had to be approved by Speaker Gingrich – the Chair did not have the final say. Gingrich focused primarily on any controversial policy issues associated with the bill. If it went against the GOP’s agenda, then he would demand that the bill be modified (R2, 2009). While the autonomy of the appropriations chair has returned since Gingrich’s rein, the increased partisanship of the committee (an in the Congress) has continued. In fact, the majority members and their staffs do not consult with the minority members and their staffs prior to committee mark ups. A staff member on the Senate Appropriations Subcommittee on L/ HHS, said to me that “at least we consult with the minority staff on our bill.”³⁰

²⁹ The “Republican Revolution” was a term that the Republican Party used to describe its gain of congressional seats (54 House and 8 Senate) after the 1994 election, which effectively gave the Republican Party control of both the House and Senate with the convening the 104th Congress in 1995.

In addition, Aldrich and Rohde (2000) point out that the Appropriations Committees were used to “enact substantive legislative changes that could, under *regular procedures*, only be conducted by standing legislative [authorizing] committees” (p. 9). An examination of the critical incidents shows that the beginning of the Republican majority in 1995 was marked with a number of significant changes to executive branch agencies stemming from the House Appropriations Committee, including its Subcommittee on L/ HHS demanding that AHCPR eliminate its support for the development of clinical practice guidelines. In response to the Subcommittee’s policy directive, AHCPR eliminated its guideline program and revamped the way it conducted evidence-based practice. As a result, AHCPR completely altered a substantial part of its mission - designed by its *authorization statute* - as a result of the appropriators’ directive.

Gingrich did not want appropriations panels to be made up of members acting as advocates, but preferred the subcommittees to be composed of “disinterested” (Adler, 2000, p.106). However, Aldrich and Rohde (2000) suggest that under the GOP leadership, “appropriators might not have the degree of attachment to programs that authorizers did, but many GOP members of the committee funded these programs for years” and used the appropriations as a vehicle for policy change and sometimes for their own benefit (p. 9). Thus, a number of members of the committee were not necessarily committed to the programs under the appropriations committee’s jurisdiction, but they eventually gained more of an interest in the programs over time, particularly if a program had provided benefits to them. For example, Rep. Ernest Istook (R-OK) was elected to the Congress in 1994 as part of the new freshman class that

³⁰ Author’s Personal Communication, 2009.

sought to make major policy changes as outlined by the Contract with America. Speaker Gingrich appointed Istook (appointed in 1996) and other partisan stalwarts to the House Appropriations Subcommittee on L/ HHS with the hopes of getting their help in ushering through the GOP agenda and thwarting the growth of more controversial programs, such as AHCPR, under the Subcommittee's jurisdiction. Table 4 lists the 1995 House subcommittee members.

Table 4. Members of the House Appropriations Subcommittee on L/ HHS (1995)

Majority

John Porter (IL), Chair
C.W. Bill Young (FL)
Henry Bonilla (TX)
Dan Miller (FL)*
Jay Dickey (AK) *
Frank Riggs (CA)*
Roger Wicker (MS)*

Minority

David Obey (WI)
Louis Stokes (OH)
Steny Hoyer (MD)
Nancy Pelosi (CA)
Nita Lowey (NY)

*newly appointed member

In the FY 2000 hearing before the House Appropriations Subcommittee on L/ HHS, Rep. Istook asked Dr. Eisenberg: “In a competitive marketplace such as ours, what role is there for a Federal agency such as yours?” (House Committee on Appropriations, 1999, p. 1098). However, in discussion of the fiscal year 2003 appropriations bill, Istook came out in favor of increasing funds for AHRQ to address the issue of high costs in health care. In the FY 2003 subcommittee hearing the Representative said that the Bush administration’s proposed funding cuts to AHRQ were one of the “gravest areas of concern in the FY 2003 health care budget” (Helms, 2002). An exchange during that hearing between Istook; Kerry Weems, Budget Director of HHS; and Carolyn Clancy, Acting Director of AHRQ further illustrates Rep. Istook’s evolution from a “disinterested” partisan to an “interested” advocate:

Mr. Istook. That's the TRIP, the translating research into----

Dr. Clancy. That's part of it. We also have a very specific initiative focused on research on cost effectiveness. One area where we've been able to make some inroads in there is looking at the use of pharmaceuticals.

Mr. Istook. But Dr. Clancy, my question is, and I understand you're Acting Director, and you're presenting the budget that's been provided for you. My question is, if you are not providing, if AHRQ is not providing the resources to translate research into affordable patient care, is there any place else in the Administration budget that we have resources allocated for that mission?

Mr. Weems³¹. Mr. Istook, AHRQ would be the main place where that would occur.

Mr. Istook. So in other words, if we take it out of AHRQ, it ain't going to happen, despite the need expressed by the Director of NIH and by Secretary Thompson, certainly with which I agree?

³¹ Kerry Weems worked in the DHHS Office of Budget at the time of the FY 2003 appropriations hearing. As with any PHS agency’s budget presentation before the appropriations subcommittee, a DHHS budget representative serves as a witness on the panel. Incidentally, after being in the Office of Budget, Weems served as the Acting Administrator of the Centers of Medicare and Medicaid in the Bush administration.

Mr. Weems. AHRQ is the place where that mission directly happens. There are other places in HHS where one might see work on that occurring. But AHRQ is the main place where that happens, sir.

Mr. Istook. And that is what is de-funded under the Administration's proposed budget, that particular portion, the major portion of AHRQ's mission, that's what's being de-funded?

Dr. Clancy. Yes.

Mr. Istook. Okay. I appreciate that. I think the point is made. Thank you and I'll work to see that doesn't happen. Thank you, Mr. Chairman (House Committee on Appropriations, 2002, p. 1380).

Adler (2000) addresses the shift in the behavior of some members on the appropriations subcommittees, specifically during the Republican takeover of the House in November 1994:

The objectives set forth by the Republican leadership through management of Appropriations' members correspond with the principles of partisan control over legislative structure stated in the works of scholars such as Aldrich and Rohde (1996) and Cox and McCubbins (1993). But the Republican leaders' explicit implication about the composition of the guardian model -- narrowly focused Appropriations subcommittees should not be acting as constituency advocates. Gingrich and the GOP leadership saw constituency-oriented Appropriations subcommittees as an impediment to pursuing their partisan agenda.

We are faced, therefore, with two opposing assumptions as to the composition of Appropriations subcommittees. On the one hand, scholars argue that these panels are composed on legislators who are disinterested, at least from a constituency perspective, in the programs they control...On the other hand, a distributive perspective predicts that these subcommittees, like other panels in Congress, are made up of reelection-oriented representatives seeking to provide for constituency needs through budgetary control (p. 106).

The illustration involving Rep. Istook shows how a member initially was assigned to the Subcommittee as a disinterested partisan but eventually became an interested advocate. Adler (2000) explains that by rejecting part of the guardian model, "I have cast doubt on the argument that committees, particularly Appropriations, are exclusively delegates of higher institutional

authorities [the chamber or party caucus]" (p. 113). The political environment and constituent needs can often override "higher callings."

In examining the case here, it would appear that the guardian model among members of the House and Senate Appropriations Subcommittees on L/ HHS has eroded and been supplanted by a more policy-oriented role since the Republican takeover in 1994. However, the appropriators have evolved from being "partisans" to appearing more as "policymakers" with interests in, and advocacy for, specific programs or constituent interests. Therefore, I would take Adler's conclusions on appropriations committee composition a step further and suggest that a policymaking role has emerged as a by-product of the initial partisan role that characterized many of the appropriations committee members under GOP leadership in 1995. An analysis of the critical incidents suggests that the policymaking trend among appropriators continued under the leadership of Rep. Dennis Hastert (R-IL) and Rep. Nancy Pelosi (D-CA).

In 2006, Keith Edwards and Charles Stewart presented on the "Value of Committee Assignments in Congress since 1994," at the annual meeting of the Southern Political Science Association. Referring to the House Appropriations Committee, Edwards and Stewart (2006) suggested that "the changes set in motion by the Contract with America in 1995 have for the most part remained in place to the present day" (p.13). They continued that the since 1995, the "Speaker and leadership are still very much in control of the policy process, especially when we compare the Republican era with the committee dominated periods during Democratic control of Congress" (2006, p.14)

Wildavsky (1997) noted that the appropriations committees were "critical to the success of a large part of the Republican agenda" (p. 311). However, Wildavsky is quick to point out that the appropriations committees are unique and steeped in tradition. Fenno (1966) once

described the House appropriations subcommittees as 13 “vigorously autonomous subcommittees” (Forgette, 1996, p. 26). Wildavsky (1997) characterized the appropriations committees as “bipartisan, pragmatic, and quiet,” which contrasted with Speaker Gingrich’s way of doing business. (p. 311). Thus, the cultural divide between the traditions of appropriations committees and the GOP leaders’ more heavy handed agenda often created a rift between the two camps. As a result, appropriators in some instances continued to operate as they did prior to the Republican takeover.

In 1995, complex trading among different agendas often occurred due to partisan pressures (Wildavsky, 1997). Wildavsky (1997) illustrates how conflicting politics often ran into the face of ideological pursuits. He notes that consideration of the FY 1995 agriculture appropriations bill created a dilemma between the Republican leadership’s goal of cutting the budget by the way of nutrition programs and farm subsidies. It pitted members from agricultural states against liberal Democrats from urban areas members. As a result, the nutrition programs received only minor cuts. Subsidies were reduced, but a favorable market helped soften the blow, instead of having to cut expenditures (Wildavsky, 1997).

AHCPR experienced a similar outcome at the hands of appropriators. In FY 1996, the Agency was cut approximately 25 percent below its FY 1995 level. However, in FY 1997, the Agency received a 15 percent increase in funding despite the GOP leadership’s initial plans to eliminate the Agency. Such a change was attributed, in part, to the changing political winds that began to favor AHCPR as a resource for helping to find costs savings in an vastly bloated health care system. A former authorization staffer said to me that when the appropriators needed to find a way to reduce the extreme costs associated with health care, they turned to AHRQ, which gave the Agency a reason to live (R6, 2009).

Eliminating the clinical practice guideline program and getting endorsements from well-established interest groups such as the American Medical Association and American Hospital Association certainly helped AHCPR get back on track. While an analysis of AHCPR's survival is beyond the scope of this research, the key point here is that the GOP leadership in 1995 instituted a number of changes in the appropriations process as a way of promoting its larger partisan agenda. However, often these changes were met with resistance due to political forces beyond their control.

This not to say that using the appropriations process as a policy vehicle was a failed experiment. In fact, as Wildavsky (1997) points out, "the appropriations process [during the Republican takeover in 1995] provided multiple opportunities to assert political positions that really had little to do with money issues" (p. 315). Kiewiet and McCubbins (1991) contend that appropriators are "responsive agents to their respective party caucuses, and formal procedures [such as the budget process] designed to constrain these appropriators will be ineffective" (Forgette, 1996, p. 26). Under the Republican leadership in 1995, the appropriations process became a fast track to make legislative changes, which were typically handled by the authorizing committees. Allen Schick observed that "the paradox of 1995 is that in some ways, the Appropriations committees are weaker in money matters and stronger in legislative matters, which is exactly the opposite of what it's supposed to be" (Wildavsky, 1997, p. 316).

There is strong consensus among scholars that significant changes took place in the way appropriations committees operated under the Republican leadership in 1995. The findings here are consistent. Indeed, I argue that the Republican Revolution served as a catalyst in the evolutionary transformation of the roles of the House Appropriations Subcommittees on L/ HHS from guardians and partisans to policymakers.

It is important to note that while the Senate also was under Republican control, it was arguably less partisan during this time. For example, AHCPR had the bi-partisan support of a number of senators including Edward Kennedy (D-MA), Jay Rockefeller (D-WV), and Orrin Hatch (R-UT) (Gray et al., 2003, p. 300). In fact, Senators James Jeffords (R-VT) and Rockefeller sent a letter (signed by eight Senate Democrats and two Senate Republicans) to Senator Specter supporting funding for AHCPR at the FY 1995 level. Gray et al. (2003) noted that the letter stated that “it is essential to have a federal agency that works with the private sector to provide consumers with information to make informed choices, measure and improve the quality of care and improve the cost and effectiveness of our health care system” (p.300)

AHRQ’s Near-death Experience

In his examination of the composition of appropriations committees, Scott Adler rejects part of the guardian model that purports that appropriators are essentially “green-eye” shade, non- advocates (Adler, 2000). In doing so, he offers some alternative reasons to be considered in understanding the structure and behavior of the House Appropriations Committee, some of which I have addressed earlier. To this end, I have explored other potential factors that may have influenced the behavior of the House and Senate Appropriations Subcommittees on L/ HHS and their relationship with AHRQ over the past twenty years. Among these potential factors is how the Agency’s near-death experience placed it in a vulnerable position, which resulted in a shift in the appropriations committees’ behavior toward the Agency. Consequently, the Agency changed its behavior toward the committees.

As I discussed in the previous section, there is strong evidence that the Republican Revolution changed the dynamics of the appropriations committees and their relationship with

executive branch agencies. However, AHRQ, then AHCPR, was particularly affected by the change in congressional leadership, as the House Appropriations Subcommittee on L/ HHS questioned the very existence of the Agency. This fell on the heels of the House Budget Committee's recommendation to eliminate the agency altogether. While the Agency was able to survive from being completely eliminated, it suffered a significant blow to its resources (a 25 percent decrease in funding) and arguably its clout in the health care policy arena. This tumultuous experience in 1995 may provide some insight into why the House and Senate appropriators have increasingly focused their energies on shaping the policies and direction of AHRQ.

An analysis of the critical incidents suggest that AHCPR's near-death experience in 1995 presented an "*opportunity*" to the appropriations committees to become more involved in the Agency's policies and direction. In other words, the Agency's increased vulnerability opened what John Kingdon (2003) would refer to as a policy window – "an opportunity for advocates of proposals to push their pet solutions, or push attention to their special problems" (p.165). Kingdon asserts that "policy windows open infrequently, and do not stay open long. Despite their rarity, the major changes in public policy result from the appearance of these opportunities" (2003, p.166).

Underscoring AHCPR's vulnerability, Gray et al. (2003) suggest that "AHCPR was weaker in 1995 than it had been in 1989 [when it was created] in three ways: It no longer had supporters in key positions; it now had active enemies; and it faced challenges to its rationale, legitimacy, and performance" (p. 298). Thus, it seems the Agency's political vulnerability created an opportunity for the appropriations committees to seize the moment by taking a more active policymaking role in their dealings with AHCPR. While the policymaking role of the

House Appropriations Subcommittee on L/ HHS blossomed during the political turmoil that surrounded AHCPR in 1995, it bore fruit for years to come as the appropriations committees' active policymaking continues to evolve in relation to the Agency's programs and activities.

Kingdon (1984) suggests that there are problem streams (policymakers focus on a particular problem or issue), policy streams (solutions to problems), and political streams (changes in political climate, e.g., ideological changes in Congress); when they converge and a policy window opens (p. 203), changes in public policy can occur. In their analysis of AHCPR's narrow escape from extinction in 1995, Gray et al. (2003) note that "the change from Democratic control of Congress in 1995 set the stage for the agency's near demise" (p.295). The new Congress came in with an agenda to respond to the perceived problem of federal spending spiraling out of control. One step toward solving this problem was to drastically scale back domestic spending, particularly funding for unpopular government agencies. AHCPR quickly became a target of the House GOP leadership and emerged as one of the "solutions" (if only symbolically) for resolving the nation's budget woes. Thus, the convergence of these "streams" (budget cutting agenda coupled with a change in political leadership) created an opportunity, which enabled the GOP leadership to use the appropriations committees as vehicles to implement their agenda and ultimately change policy. In essence, AHCPR got caught up in the confluence of the streams and essentially became a test bed for policy solutions. As Kingdon (2003) points out, the separate streams come together when "a problem is recognized, a solution is developed and available to the policy community, a political change makes it the right time for policy change, and potential constraints are not severe" (p. 165).

In pursuit of their agenda in 1995, the GOP leaders' attempts to eliminate AHCPR placed the Agency in a vulnerable position politically. As a result, the appropriations committees'

interactions with the Agency (at least initially) were dogmatic. The leadership at AHCPR knew that the stakes were high and that in order to survive, it had to change its way of doing business. As a result, the Agency eliminated its clinical practice guideline program at the request of the House Appropriations Subcommittee on L/ HHS. Arguably, such a move signaled to the committee that the Agency would take whatever steps were necessary for its own survival --- perhaps the cost of exposing its own vulnerabilities. After Dr. Gaus, former Administrator of AHCPR, made his opening statement before the House appropriations subcommittee, committee member Rep. Henry Bonilla (R-TX) said, “Dr. Gaus, I would like to commend AHCPR for listening not only to this subcommittee, but also the Congress in reevaluating your approach to developing clinical practice guidelines” (House Committee on Appropriations, 1996, p. 12).”

All of those I interviewed agreed that the Agency’s “near-death” experience at the hands of the appropriators was the most significant event that occurred to AHRQ over the past twenty years. It not only had an enormous impact on the Agency at the time, but it has affected the dynamics between the AHRQ and the appropriations committees over the past two decades. A member of the House Appropriations Subcommittee on L/ HHS lamented that “the Bonilla amendment [to effectively eliminate the Agency] affected policy in such a significant way that it has put a damper on AHRQ since that time” (R1, 2009).

Shortly after the fallout from the budget attacks in 1995, AHCPR transitioned to new leadership with John Eisenberg taking the reins. While Eisenberg was politically savvy, he did not have the relationships yet with the appropriations committees; nor did he realize that the committee members were playing a more active role in shaping AHCPR’s research agenda. In fact, prior to the hearing, Eisenberg appeared largely indifferent to the appropriations

committees, emphasizing his contacts with the authorizing committees and intimating that those were the committees we should focus on.³²

During Eisenberg's first budget hearing in 1998, he quickly realized that Chairman Porter of the House Appropriations Subcommittee in L/ HHS was interested in more than just approving funds for the Agency, but also wanted to know how the Agency carried out its agenda and policies. Referring to the need to translate research into practice, Porter noted: "We really want to provide some focus because on the past, and not necessarily applying to this agency, the measurement [use of research findings] might be how many PORTS [Patient Outcome Research Teams] did you do how many reports were generated? Well, it really does not matter how many reports are out there if nobody ever reads them, or does anything with them. Right?" (House Committee on Appropriations 1998, p. 22).

Realizing the Agency's vulnerability and the House Appropriations Subcommittee's active involvement in the AHCPR's policies and direction, Eisenberg reorganized the legislative affairs function. In the summer of 1998, he directed that the function be transferred from the Office of Policy Analysis to the Office of Budget. This move aligned the Agency's legislative affairs and policy function with budget and appropriations, indicating the Director's understanding that the appropriations committees were interested in more than just funding matters.

During the next several years of Eisenberg's tenure, he reached out to both the House and Senate appropriators to educate them about AHRQ's activities and programs. He undoubtedly realized the enormous impact that the appropriations committees had on AHRQ's policies and

³² Author's personal communication. AHCPR appropriations briefing. March 3, 1998.

direction. The impact is further evidenced in a letter (*see Figure 4*) from Eisenberg to Chairman Porter.

Figure 4: Letter from John Eisenberg to Chairman John Porter (April 10, 2000)

Chairman Porter:

I would like to thank you for meeting with me to discuss some of the activities and programs of the Agency for Healthcare Research and Quality (AHRQ).

As I mentioned during our meeting, your guidance over the years has played a major role in shaping the way AHRQ carries out its mission. Your emphasis on targeting research on the nation's health care challenges and on translating the research into practice has become a watchword at AHRQ. While you will be retiring from your service in the Congress, your commitment to improving health care through research will continue to be felt for many years to come.

As we discussed, a large component of AHRQ's patient safety initiative will be to translate what we learn from our research on medical errors into practice. If errors were a disease, we would call it an epidemic and would respond by targeting resources for research and getting that research into practice. This will require that we work together with clinicians, health care system leaders, and policymakers. We have already begun to meet with a number of both public and private organizations to start to lay the ground work for achieving a reduction in medical errors. I look forward to working with you as the Agency strives to meet this objective (Ginieczki, 2000).

As someone who played a large part in AHRQ's campaign to educate the appropriations committees on AHRQ's programs and activities, I view the first year of briefings as being distinguished by efforts to justify the Agency's *raison d'être*. However, the Agency's vulnerability was a double-edged sword: (1) the appropriators increased their involvement in AHRQ's policies and direction without much resistance; and (2) the Agency's leadership learned that by working closely with the appropriators (both Congress members and staff) and following

their guidance, they gained invaluable support, which set the Agency onto a path of sustained growth.

Annual Nature of the Appropriations Process and Health Care

The health care system in the U.S. is in a constant state of flux given technological breakthroughs and discoveries, spiraling costs, concerns about quality and efficiency of care, and organizational changes in hospitals and other health care settings. Reports issued by the Institute of Medicine and others raise issues about the nation's diminishing quality of care, increased occurrences of medical errors, and the underutilization / overutilization of services (AHRQ, 2009) Recognizing that the system and the policies surrounding it are in constant flux, I submit that the annual nature of the appropriations process, which arguably provides for more efficient and timely policymaking, has become an effective and widely used approach to address health care policies that would otherwise be delayed through the more deliberative legislative (authorization) process.

AHRQ is one of 12 agencies in the U.S. Department of Health and Human Services that have a distinct role related to the nation's health care. AHRQ is in a distinctive position, in that its primary mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans (AHRQ, 2009). This broad mission as outlined in the Agency's FY 2010 budget submission (2009) is translated into a research portfolio that touches on nearly every aspect of health care, including:

Outcomes of care and effectiveness.

Evidence-based medicine.

Primary care and care for priority populations.

Health care quality.

Patient safety/medical errors.

Organization and delivery of care and use of health care resources.

Health care costs and financing.

Health care system and public health preparedness (p.1).

Over the past two decades, policymakers at both at the state and federal levels increasingly have tried to rein in health care costs and to find ways to improve access to, and provide for, better quality of care. President Bill Clinton made health reform a priority during his time in office. Although his efforts ultimately failed, he helped raise the issue of health care at the national level. Given AHRQ's broad mission, it played an important role in the Clinton administration's efforts to reform health care. The Administration often tapped the Agency to provide analytic and data support, as well as support based on its research findings.

Even beyond the Clinton presidency, the ever-changing dynamics of health care has been a constant. While President Clinton successfully brought the issue of health care reform to the forefront, policymakers have been making attempts for years to try to address the multiple policy facets involved in changing the U.S. health care system. Given AHRQ's distinct and broad mission, its potential to have an impact on the nation's health care system is significant. Thus, the efficiency and annual nature of the appropriations process, coupled with AHRQ's impact on the nation's health care system, could be an explanation into why the House and Senate Appropriations Subcommittees on L/ HHS have become more involved in the policy aspects related to AHRQ.

A review of the critical incidents associated with the case study show that a number of policy matters that the House and Senate Appropriations Subcommittees on L/ HHS addressed in their dealings with AHRQ had significant policy implications. For example, the medical errors initiative proposed by the Senate Appropriations Subcommittee on L/ HHS had an immediate impact nation-wide. The seriousness of the issue and its wide reaching implications is best described in the following testimony before the House Appropriations Subcommittee on L/ HHS delivered by John Eisenberg, in which he referred to medical errors as an epidemic:

We're going to treat this [medical errors] like we would treat an epidemic. We are going to spend \$20 million on understanding the causes of errors in American hospitals and outpatient care, to use that information and to use those tools so that patient safety in the United States can be assured and improved (Eisenberg, 2000).

Thus, it was apparent that the problem of medical errors needed to be addressed rapidly. There is little doubt that initiatives, such as medical errors, were developed and passed through the appropriations process given the urgency, as expressed by the IOM Report, to address the problem. During the hearing on medical errors before the Senate Appropriations Subcommittee on L/ HHS, Senator Specter (1999) said, "Well, I think the Congress is going to legislate on the issue of mistakes from this report. Senator Kennedy has announced his intention to do so and Senator Jeffords is the chairman of the authorizing committee and we're going to be moving it forward here...this is a very provocative and a very, very important subject. It's obviously life and death. And we wanted to have this hearing as soon as we could...stay tuned" (p.46). In subsequent briefing with Senate Appropriations staff, the staff member mentioned to me that while authorizing legislation related to medical errors had been introduced in the Senate, "it is expected that the appropriations bill will be the ultimate legislative vehicle, given the truncated (at that time) legislative calendar." Within five months after the hearing, the Senate

Appropriations Subcommittee on L/ HHS included the \$50 million initiative for AHRQ to reduce medical errors nationwide. A similar sense of urgency emerged when the Senate Appropriations Subcommittee included an initiative in an appropriations bill to address the rising cases of MRSA throughout the country.

Jason Paltis (2003) describes lawmaking as a two-step process. “The first step, which is the one that the general public associates with Congress, is the formulation of substantive policy the creation of a new law, a new program, or other initiative. The second step is the funding of those substantive policies, through the budget and appropriations process.” (p. 4). Paltis alludes to Wildavsky’s characterization of the *second* step, in which he suggests this step, “used to be the preserve of insiders and technicians [with] few realizing that the budgeting and appropriations process was the life-blood of government, the medium which flowed the essential life-support systems of public policy” (p. 4). Thus, the annual cycle of the appropriations process increases its use in practice as a vehicle in getting policies through. A former staffer on the House Appropriations Subcommittee on L/ HHS said that “appropriations bills tend to be the only vehicle moving through Congress because of the slow and deliberative process of authorizing measures. Besides, appropriators interact more with agencies under their jurisdiction, given their oversight function which occurs annually” (R8, 2009).

Louis Fisher (1979) points out that members of Congress appreciate the flexibility that permits some overlapping between the authorization and appropriations stages, particularly the opportunity to legislate on appropriation pills that pass through each chamber every year” (p. 105). The annual cycle of the appropriations process gives the appropriations committees’ opportunity to review executive branch agencies activities on a yearly basis, unlike the authorizing committees which typically only examine agencies on a more periodic basis given

the often long-term nature of authorizations. Schick (2000) suggests that agencies are more compelled to follow through with certain policy provisions in appropriation bills given that the next appropriations cycle is only a year away.

In addition to the advantage of the annual cycle of the appropriations process, the looming threat of a government shutdown provides appropriations committees' substantial leverage to force the hand of members to vote for policy provisions that they might otherwise oppose. This is particularly the case with appropriations for Labor, HHS, and Education programs, which tends to harbor controversial policies that would be much more difficult to pass under the regular legislative process. For example, policies impacting the many issues surrounding abortion often are addressed through the appropriations process.

In passing the FY 2010 Consolidated Appropriations Conference Report, Chairman David Obey outlined the highlights of the bill. "As we are working to pass a health reform bill that will expand the reach of the health care safety net to millions of more Americans, it would be irresponsible not to build the capacity of our health care system to deal with the additional demand created" (Obey, 1999) In doing so, the House Appropriations Committee addressed a vast number of policy initiatives in its appropriations bill, which ranged from the expansion of health coverage and services to reducing health-associated infections (which directly impacted AHRQ). The Senate followed suit and passed its version of the FY 2010 appropriations bill just a few days before the continuing resolution (CR)³³ was set to expire, which compelled members to vote on the bill or face a possible government shutdown. Prior to the vote, a Senate Appropriations Committee staffer remarked: "The plan is to bring the Senate [FY 2010]

³³ A continuing resolution is a joint resolution that provides budget authority for programs or agencies whose regular appropriation was not enacted by the start of the fiscal year. A continuing resolution is usually a temporary measure that expires at a specified date or is superseded by enactment of the regular appropriations act. (Schick, 2000)

Appropriations bill to the Senate floor right before the CR is set to expire as a way of forcing members' hand in voting in favor of it.”³⁴

In their paper, “Authorizations and Appropriations: A Distinction Without Difference,” Champoux and Sullivan (2006) acknowledge that allowing legislative matters in appropriations bills allows these bills to be used as vehicles “for enacting legislation that would not become laws under other circumstances” (p. 27). They conclude that since legislation can be rolled into appropriations bills, “Congress has less of an incentive to fix the problems in the authorization process. In fact, Congress ends up having an incentive to keep putting legislation in these bills” (p. 27). The dynamic nature of health care may be a factor in the increased use of the appropriations process in enacting policy. To this end, one could conclude that there the House and Senate Appropriations Subcommittees on L/ HHS have increased their role in policymaking because of AHRQ’s considerable role in health care policy.

Principal-Agent Relationship

As I discussed in earlier in this chapter, Isabella (1990) and Peterson (1998) suggest that process research may deal with the evolution of relationships between people. It is evident in this case that relationships among the actors, specifically members and staff of the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ, have evolved over the past twenty years. I submit that the relationship between the AHRQ and its appropriations subcommittees has evolved from a more traditional, principal-agent framework, or “top-down” approach, to a more collaborative and proactive model.

³⁴ Author’s personal communication. December 9, 2009.

According to Waterman, et al. (1998), the principal-agent model is generally viewed in the literature as principals influencing the behavior of their bureaucratic agents. Thus, this classical principal-agent model assumes a dyadic relationship, whereas one principal influences one agent (Waterman, et al., 1998). Perrow (1986) noted that the principal-agent model assumed that “social life is a series of contracts” (Waterman, et al. 1998, p. 15) and described the model as follows:

The buyer, or purchaser, of goods or services was designated as the principal, while the seller, or provider, was called the agent. Because the seller or agent has more information than the buyer or principal, and since the principal does not want to pay more for goods or services than they are worth, the principal-agent relationship is governed by a contract specifying what the agent should do and what the principal must do in return (Waterman, et al. 1998, p. 15).

This economics-based model has been applied to public organizations by a number of scholars including Terry Moe. In this application, the model suggested that there is a strong relationship between principals and their bureaucratic agents (Waterman, 1998). This type of a framework is appropriate for describing the initial relationship between AHRQ and the House and Senate Appropriations Subcommittees on L/ HHS. From the start of the Republican Revolution in 1995 through 1999, AHRQ was beholden to the whims of the appropriations subcommittees, particularly the House subcommittee which focused on adopting its broad partisan agenda.

Critical incidents such as the AHCPR’s near-death experience, coupled with the House appropriators’ directive for AHCPR to eliminate its clinical practice guideline program, illustrate how the relationship between AHCPR (AHRQ) and the appropriators initially was hierarchically-based as the appropriators (principal) unilaterally controlled AHRQ’s (agent) agenda. In the classical principal-agent model, the agents are more passive and “either

responding or not responding to principal cues” (Waterman, et al. 1998, p. 17). Waterman et al. (1998) point out that empirical studies show that principals do influence the behavior of their bureaucratic agents. However, because agents have information advantages over their principals, there can be an influence shift. Waterman et al. (1998) suggest that the principal-agent framework has limitations, particularly the focus on a dyadic relationship (one principal and one agent being considered at a time). Instead, they suggest that multiple principals are involved their influence over an agent. They argue that “once we move from a dyadic model to a multiple principal model, the agents’ motives and behavior can become more dynamic and strategic” (Waterman, et al. 1998, p. 18). As a result, “agents can side with principals that most closely represent their policy perspectives or they can play one principal against another” (Waterman et al., 1998, p. 18). Waterman, et al. (1998) advocate the venue of influence theory, where *multiple* principals influence an agent. The key to this theory is that agents respond to these various principals in different ways, whether politically, legally or symbolically (Waterman, et al., 1998).

I do not plan to go into great detail about the venues of influence theory or defend its merits, particularly since the case that I examined was not selected to analyze the organizational dynamics of AHRQ. Rather, my focus is on *why* the House and Senate Appropriations Subcommittees on L /HHS have become more policy-oriented in their dealings with AHRQ. Therefore, the element of the theory on which I want to focus is that agents tend to respond to their principals based on their perceptions of different types of influence. Throughout the twenty years of the case study, AHRQ has been influenced by a number of different principals, which include the appropriations committees, authorizations committees, the Office of Management and Budget, and interest groups. However, AHRQ has responded to each of these

principals in decidedly different ways -- based on the Agency's *perceived* influence of the principals.

Although AHRQ has not neglected its other principals, its relationship with the appropriations subcommittees has become more strategic given the appropriators' increased influence on the Agency's policies and directions. For example, John Eisenberg made a strategic decision to reorganize AHRQ's congressional affairs function so that it would be more aligned with the Agency's budget and appropriations activities. The move signaled that he perceived that the House and Senate Appropriations Subcommittees on L/ HHS had considerable influence over AHRQ's programs and activities. Thus, AHRQ's ("agent") motives and behavior changed to adapt to the perceived role of its appropriations subcommittees.

As I pointed out earlier, the relationship between the appropriations subcommittees and AHRQ was initially a one-sided, hierarchical relationship. However, the relationship evolved over time and became much more collaborative, particularly as the Agency reaped the benefits of steady funding increases. Thus, maintaining close working relationships with the House and Senate Appropriations Subcommittees on L/ HHS have become a large part of the AHRQ's culture and its practices. In reference to the health care reform bill being considered by the Congress in 2009, a senior staff member at AHRQ said, "They [Senate authorizing committee] have some wonderful ideas on what they would like the Agency to do, but it really doesn't matter unless the appropriators' agree."³⁵ This is not to say that AHRQ does not have a relationship with the authorizing committees, but simply that the interactions with these

³⁵ Author's Personal Communication. November 2009.

committees are different due, in part, to the Agency's *perceived* influence. As Moe (1987) noted in regards to limitations of the simple principal-agent model:

The agency finds itself surrounded by notable principals: various authorizing and appropriations committees in both Houses of Congress, the Office of Management and Budget, the president and members of his White House staff, and departmental units in the executive branch. These principals compete for influence over the agency – which, as a result, finds itself under cross pressures, forced to make compromises and trade-offs favoring some principals over others, and in its own self-interest, attracted to strategies that play its principals off against one another (Waterman et al., 1998, p. 16).

While the authorizing committees that have jurisdiction over AHRQ's programs have played a major role (and should be considered as one of AHRQ's "principals") in the reauthorization of the Agency's program and name change in 1999, the groundwork arguably already been laid by the appropriations subcommittees beginning with the Republican Revolution in 1995. While others might argue differently, I would suggest that the appropriators' more active and more frequent interactions with AHRQ have played a large part in the Agency's perception of the appropriations subcommittees as its primary principal.

Other principals, such as OMB, the HHS Office of the Secretary, and authorization committees certainly have had an impact on the Agency, but not necessarily to the degree of the appropriators -- at least in the eyes of many observers, including senior leaders at AHRQ. In fact, one of those leaders at AHRQ once remarked to me that, "We need OMB for the initial mark [president's budget request] coming out of the White House, but the appropriation subcommittees is where we really need to focus our attention, as they have the final say on our bottom-line."³⁶ Waterman, et al. (1998) note that, "faced with competing signals, the bureaucracy can often choose which principal to respond to, and the choice is usually the one

³⁶ Author's personal communication: AHRQ Senior Leader, November 2009.

closest to bureaucratic preferences” (p. 17). In one of the interviews that I conducted, the respondent alluded to their experience in serving in one of the Public Health Service agencies and the Administrator’s decision to not brief³⁷ OMB on its budget request since OMB cut the agency’s budget the previous year, yet the appropriations committee restored the cut. The Administrator remarked that “since it was the appropriators that restored OMB’s proposed cuts last year, we don’t need them this year, so I am not going down there [OMB] to brief them” (R4, 2009).

I use Waterman’s adaptation of the principal-agent model (1) as a way of helping to tell the story of how the relationship between AHRQ and the House and Senate Subcommittees on L/ HHS has evolved over the twenty year period of study; and (2) to show how the *perceptions* of the increased influence of the Subcommittees’ impact on AHRQ’s programs and policies have had direct effects on how AHRQ responds to, and interacts with, the Subcommittees. It is critical to point out that during my tenure as the congressional liaison for AHRQ, a majority of my time has been spent consulting with the appropriations staff, as opposed to authorization staff.

In a separate analysis, Waterman and Meier (1998) introduce a “broader theoretical framework for conceptualizing bureaucratic politics” (p.173), which may help provide a fuller explanation for the evolving relationship between AHRQ and the House and Senate Appropriations Subcommittees on L/ HHS. Waterman and Meier (1998) note that Congress “rarely speaks with a single voice. Individual committees often press for distinctly different goals

³⁷ Agencies in the Public Health Service traditionally brief OMB on the Secretary’s budget request for their respective agency as part of the annual budget cycle. The briefing is usually between the director of the agency, along with the agency’s senior staff, and OMB analysts in the health division. This briefing gives OMB staff an opportunity to learn about an agency’s budget request.

within a policy area” (p. 181). Here, the House and Senate Appropriations Subcommittees on L/ HHS had decidedly different goals than other congressional committees, as evidenced by the critical incidents.

Waterman’s and Meier’s expanded principal agency framework treats the two assumptions in the classical principal-agent model (information asymmetry³⁸ and goal conflict/ consensus³⁹) as *variables* rather than constants. Thus, Waterman and Meier suggest that the dynamics of the principal-agent relationship varies based on the actors’ information levels and whether goal conflict/ consensus is present. In their 1998 article, the scholars present a more dynamic framework that produces eight different patterns of relationships between principals and agents. The eight patterns combine information levels and goal conflict/ consensus (relating to the policy preferences of principals and agents) as variables to better understand how relationships between principals and agents can vary based on circumstance.

In comparing those patterns with the study here, two instances (Cases 4 and 7) seem to most accurately represent the relationship that has evolved over the past twenty years between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ.

In “Case 4,” principals have “much” information and agents have “little,” and there is goal conflict. “In this situation politicians will dominate any relationship with bureaucrats since politicians have both legitimacy and knowledge” (Waterman and Meier, 1998, p. 190). In the earlier interactions between AHRQ (AHCPR) and the appropriations subcommittees (particularly in the House), their relationship was much more hierarchical, with the

³⁸ Information asymmetry in the traditional principal-agent model assumes that agents possess more information than their principals (Waterman and Meier (1998).

³⁹ Waterman and Meier (1998) treat goal conflict/consensus as differences or similarities in goal “preferences between principals and agents” (p.185)

subcommittees dictating the Agency's policies and direction. The House Subcommittee's recommendation to eliminate the AHCPR's clinical practice guideline program illustrates this more one-sided situation. In this instance, goal conflict existed in which the Subcommittee, having control of AHCPR's resources, compelled the Agency to change its role (policy) in its development of clinical practice guidelines despite the Agency's preference for the established policy. Waterman and Meier (1998) hypothesize that in such situations of "goal conflict . . . [where] principals have an information advantage, bureaucrats act as personal staff to politicians" (p. 190).

Over the years, however, AHRQ and the appropriations subcommittees arrived at more of what Waterman and Meier refer to as "goal consensus," and AHRQ gained more information (both about how to work constructively with the subcommittees and about its own programs). In this scenario, the principals and agent share substantial information in what amounts to a classic policy subsystem (Waterman and Meier, 1998, p. 192). The scholars note that this case is most likely to develop between Congress and the bureaucracy, and the relationship requires "a repeat games situation with principals and agents interacting over long period of time" (Waterman and Meier, p.192). They describe such a relationship as symbiotic in which "influence should be regarded more as reciprocal than [as] congressional dominance." (p. 192). In the case study examining the relationship between AHRQ and the appropriations subcommittees, a symbiotic relationship has developed; the Agency is now able to share information with the subcommittees, which has led to a more consultative process in steering the Agency's policies and direction.

Although Waterman and Meier present the eight cases as being static, treating the framework as being dynamic can help in understanding that relationships change over time.

Relationships between principals and their agents often go beyond the scope of the traditional principal-agent model, as seems to be the case between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ.

CHAPTER 7

Interview Findings: Further Evidence of Appropriators’ Changing Role toward Policymaking

I do not apologize for using the legitimate appropriations power in shaping policy...we
[appropriators] are not just mindless funders of agencies.

Member of the House Appropriations Committee (2009)

As I pointed out earlier in the dissertation, Adler (2000) has astutely observed that throughout different periods of time, members of the appropriations committees have been regarded as guardians of the federal treasury, advocates of federal funds for their congressional district, or partisans in support of a political agenda. Through my experience and the perceptions of other scholars and practitioners, appropriators seemingly have taken on an active role in *policymaking* -- a role that has traditionally been the province of the authorizing committees. This chapter brings some of those practitioners to the fore, providing a summary and analysis of the findings from the interviews.

Summary of Findings

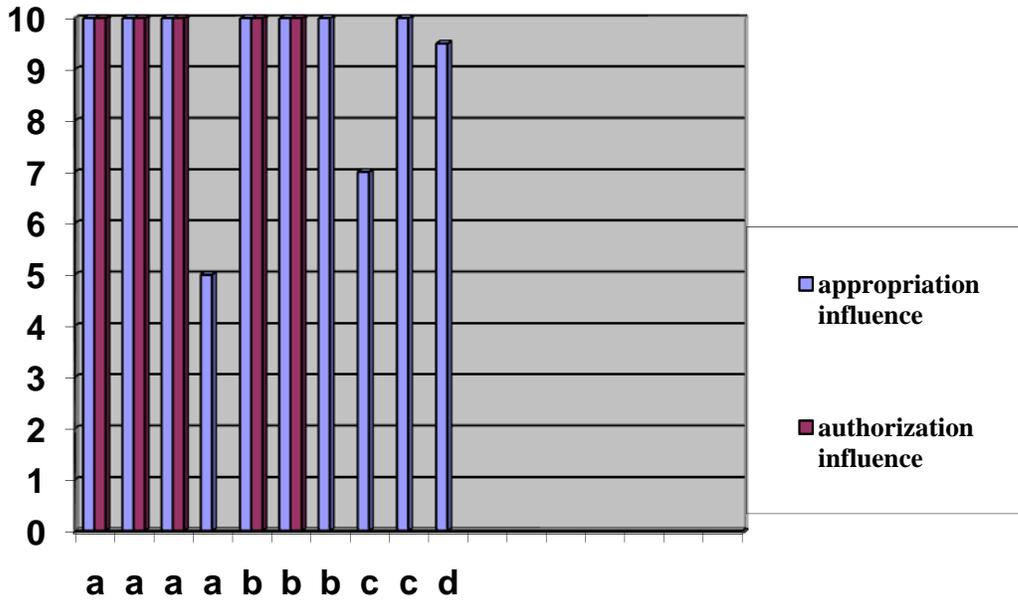
The following four (4) major findings emerged from the interviews about why appropriators may be acting more like authorizers.

- The increased partisanship in Congress, particularly as a result of the Republican Revolution, is playing major role in how appropriations and authorization committees operate.
- Appropriations committees' involvement in oversight of executive branch agencies creates strong relationships with agencies and more participation in agencies' operations and directions.
- The annual nature of the appropriations process provides for a more efficient vehicle for policymaking.
- Authorizers tend to focus on macro-level policy, while appropriators tend to focus on micro-level policy.

The interview respondents were unanimous that appropriators have become more involved in policymaking, particularly between the House and Senate Subcommittees on L/ HHS and AHRQ. I state this with a caveat, however, as some participants view “policymaking” as a legitimate power of the appropriations committee, separate from that of the policymaking powers of the authorizing committees. Nevertheless, all of the respondents believed that the appropriators have had an influence in policymaking, although the degree of perceived influence varied (*see Table 5*). For example, one respondent said, “here’s a juxtaposition for examining appropriators’ policy influence, look at the buildings on the NIH campus, almost all of them are named after influential appropriations chairs”(R4, 2009) Yet, while another respondent agreed that appropriators have become more influential in policymaking, she noted that mandatory funding mechanisms, such as the Medicare Trust Fund are powerful tools that allow the authorizing committees that have jurisdiction over mandatory programs to wield tremendous power and have a significant impact in policymaking. *Table 6* reports the mean degree of

perceived policymaking influence among authorizers and appropriators based on the total interview responses.

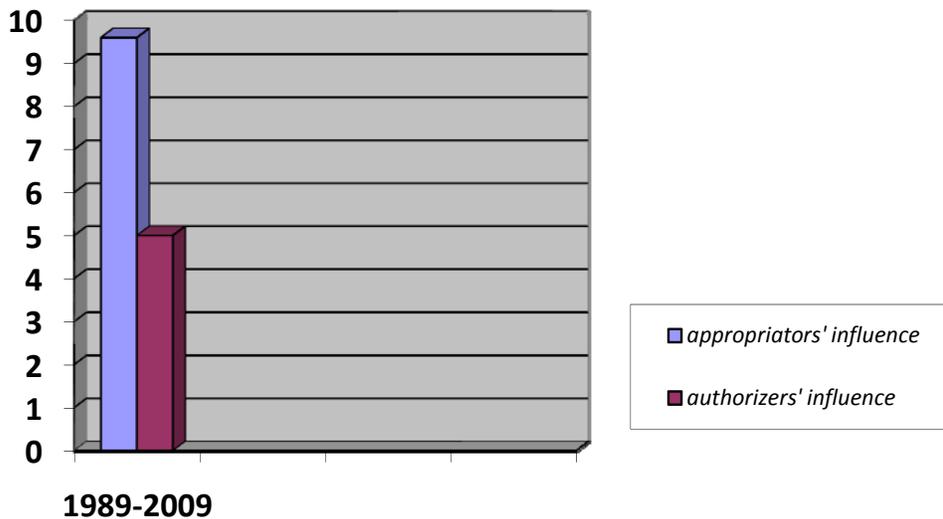
Table 5: *Over the past 20 years, who (appropriators / authorizers) do you think has had more influence in the policymaking process (scale -1-10 -- “10” being ‘most influential’)*⁴⁰



⁴⁰ a=appropriations respondent
 b=authorization respondent
 c=AHRQ respondent
 d=Other (e.g., lobbyist)

Note: In some cases, respondents voluntarily provided a scale of influence for both authorizers and appropriators. In other cases, the respondents provided a response for only one camp, in which case I assumed a degree of “0.”

Table 6: Average degree of policymaking influence among authorizers and appropriators



Finding 1: Increased partisanship is playing major role in how appropriations and authorization committees operate.

Increased partisanship seemed to be a major factor accounting for why the appropriations committees may be behaving more like authorizers. All of the participants suggested that because of the great divisiveness that has been apparent among members of Congress, especially since the Republican Revolution, the appropriations process has become a more efficient, less partisan vehicle for getting policies enacted. A current member on the House Appropriations Committee noted that the level of partisanship has increased to such an extent that it is fueling the increased use of appropriations a vehicle for policy, since appropriations are still one of the “less partisan aspects of Congress” (R2, 2009). However, this is not to say that the appropriations committees are insulated from partisanship. In fact, the interviews revealed that partisanship has risen among the ranks of appropriators since the Republican takeover in 1995.

A former Republican member of the House Appropriations Subcommittee on L/ HHS remarked that the appropriations process became much more partisan and centralized with the Republican Revolution. The number of hearings diminished under Republican control and markups of the appropriations became “a perfunctory, orchestrated exercise, in which the minority party did not have any input” (R1, 2009). As a result, any policies that were included in appropriations bills were dictated by the majority party. The same respondent noted that if you didn’t support the Speaker’s policies that were incorporated in the appropriations bill, then you were in danger of being kicked off the committee. Speaker Gingrich significantly increased the use of the appropriations process as a vehicle for getting policies enacted, or in some cases, eliminated. Under Speaker Gingrich, all appropriations bills had to be “signed off by Gingrich before it went to the House floor for approval” (R1, 2009).

A former staff director of the House Appropriations Subcommittee on L/ HHS observed that partisanship increased significantly with the Republican Revolution and as a result the appropriations process overall became more policy-oriented. The staffer observed that appropriations committees’ reports started to read more like authorization bills. Additionally, he noted that “the Contract with America was played out through the appropriations process” (R9, 2009). He also pointed out that policy proposals often get tied up in the authorization process because those committees tend to be more partisan than the appropriations committees, which have a richer tradition of bi-partisanship. As a result, the phenomenon of the omnibus appropriations bill has become the normal practice, in which a number of bills have far reaching policy measures that are wrapped up into one freestanding appropriations bill.

Given the breadth of an omnibus bill and the threat of a government shutdown if the bill doesn’t pass, the Congress has more political leverage at its disposal by moving the bill through

the appropriations process. One of the respondents referred to an underground process known as “ash and trash” that emerges during the last few days before the end of a congressional session, where the authorizing committees make numerous requests to incorporate unfinished legislative proposals into the omnibus appropriations bill. The respondent recalled that in the “old days you could pull provisions out of appropriations bills and vote on them separately, but now the only option is an ‘up’ or ‘down’ vote” (R9, 2009).

As a current member on the House Appropriations Committee noted, the omnibus appropriation bills and continuing resolutions have contributed to “how we organize appropriations bills” – the key is to avoid end of the session “train wrecks.” He added: “you will probably find that the attempts to authorize on appropriations bills go up when you have a divided [partisan] government” (R2, 2009).

Another outcome of the increased partisanship is the change in the power structure of the committees, which has affected the way they operate. An interview with a former staff member on the Senate Committee on Science and a senior advisor to then-Senator Al Gore (D-TN) revealed that the power of committee chairs has changed over the past twenty years as a result of the Republican Revolution. Prior to the Republican Revolution, he observed that appropriation committee chairs yielded tremendous power. In his words, the chairs were “gods who governed capriciously and unilaterally” (R7-2009). With the change of power in 1995, appropriators, particularly the chairs, became much more partisan as they carried the policy mantle of GOP leadership. As a result, they actually became unpopular among a number of the rank and file members of Congress, and ultimately the public, as they bestowed drastic cuts upon many popular programs. The respondent said in a sarcastic tone that, “In 1995, appropriations chairs were no longer regarded as Santa Claus” (R7, 2009). Under Democratic control, the

appropriations chairs arguably have regained their popularity given the increased investments in domestic discretionary programs, particularly the passage of the \$787 billion economic stimulus package (ARRA), which provided significant investments to discretionary programs including education, health, and housing programs. From 1998-2008, non-defense discretionary programs have grown at an average rate of 6.4 percent per year from 1998 to 2008. In 2009, the growth rate for non-defense discretionary programs increased to 11.5 percent,⁴¹ with ARRA accounting for a large percentage of the increase.

The loss of power that the appropriators endured as a result of the Republican Revolution was quickly restored as the GOP leadership discovered that the best way to get its policies through was through the appropriations process, as the authorizing process was too protracted. Thus, a respondent from an n authorization committee acknowledged that the appropriators ultimately became stronger. He remarked that in the end, “Wherever the revenue is, is where the power is” (R7, 2009).

Finding 2: Appropriations committees’ role in oversight of executive branch agencies creates a stronger relationship with the agency and more involvement in agencies’ operations and directions.

An interesting distinction in defining “policymaking” emerged from the interviews. Both members of Congress (appropriation subcommittee members) that I interviewed made it clear that appropriators have not overextended their reach into policymaking, which they maintain is the province of the authorization committees. Rather, they suggested that the

⁴¹ Source: Congressional Budget Office Estimates: <http://www.cbo.gov/ftpdocs/108xx/doc10871/Chapter3.shtml>

appropriations committees' role in oversight of the executive branch agencies funds gives them a legitimate role in shaping the agencies' policies and direction. In regards to appropriators' oversight role, the former member of the House Appropriations Subcommittee on L/ HHS said, "I think that review and oversight to ensure that federal dollars are being spent wisely, gives us [appropriators] a right to make decisions about agencies programs" (R1, 2009). He continued, "appropriators certainly will step in and do the authorizers' job, if they aren't doing it. Other than that, we never paid much attention to the authorizers" (R1, 2009).

The current member of the House Appropriations Committee made a clear distinction in defining policymaking, in which he suggested "policy by oversight" is a power vested in the appropriations committees, as opposed to "legislative policy," which is well within the bounds of the authorizing committees. "I do not apologize for using the legitimate appropriations power in shaping policy...we [appropriators] are not just mindless funders of agencies" (R2, 2009). He added that "Appropriators have tools to shape policy and should when given the opportunity" (R2, 2009). For example, he said appropriators often play a role in shaping the policies of the Department of Homeland and shaping its direction. When I asked him on a scale from 1-10 ["10 being most influential" who (appropriators and/ or authorizers)] has the most influence on policy, he responded: '10' for appropriators on year-to year policy influence; '10' for authorizers in making major statutory changes" (R2, 2009). This phenomenon that he raised, i.e., macro-level policymaking versus micro-level policymaking, is a noteworthy distinction that I return to later in this section.

The appropriations oversight function seems to create more of an "ownership" role in the relationship between the appropriations subcommittees and the executive branch agencies under their jurisdiction. In fact, during negotiations over the current health care reform proposal, a

staffer on the Senate Appropriations Subcommittee on L. / HHS remarked to me that she was consulting with the Senate authorizing committees to ensure that certain policy proposals did not negatively impact AHRQ, stating that, “I feel ownership with the Agency [AHRQ] and I want to protect its interests” (R8, 2009).

One result of appropriators’ oversight function is their increased interaction with agencies, which occurs on an annual basis. Thus, agency staff and appropriations staff can become very close and often work collaboratively on policies and agency direction. This can be an advantage to both parties as the appropriators’ have a more in-depth understanding of an agency’s programs, and the agency is able to keep the committee staff and members constantly updated on their activities, some of which may be a benefit to committee members. The former chief of budget policy at the National Institutes of Health (NIH) and former senior leader at AHRQ said, “Politicos come and go, but the relationships between the ‘cave dwellers’ (agency civil servants) and appropriations staff do a lot of good – it then becomes hard to put an agency out of business” (R4,2009). For example, she suggested that, “If it weren’t for the strong relationships between AHRQ’s staff and the staff on the House and Senate Appropriations Subcommittees on L/ HHS, AHRQ wouldn’t have had grown as much as it has over the past twenty years” (R4, 2009).

Of course, too much interaction and oversight can be detrimental to an agency, as the appropriations subcommittee can get overly involved in the Agency’s programs and becomes a micro-manager. For example, in 1995 the dynamics, between AHRQ and the appropriators were much different than they are today. AHRQ almost experienced its demise at the hands of the House Appropriations Subcommittee on L/ HHS. At that time, the Subcommittee’s actions were completely unilateral. A senior leader at AHRQ put that time period into perspective, “The

Republican Revolution changed the tone between the appropriations staff and AHCPR staff -- simply there was no positive interaction” (R3, 2009). Thus, the appropriators’ role in oversight can be a liability to an agency’s policies and growth, as much as it can be a benefit.

Nevertheless, it was clear to every respondent that the appropriations subcommittees’ frequent interaction with the executive branch agencies that they oversee enhances their opportunity for input into those agencies’ policies. According to a former staff member on the House Energy and Commerce Committee, “Appropriators simply have a much better handle on executive branch agencies” (R6, 2009).

In sum, the respondents overwhelmingly saw the appropriators’ oversight function as a legitimate policymaking power, distinct from the act of legislating in appropriations as a result of policy riders. However, some respondents made a fine distinction between appropriators’ policymaking role by oversight and by legislative (authorizers’) policymaking. An examination of the critical incidents and the appropriators’ role in ARRA suggests that the distinction is indeed blurred. As an authorizing staffer said, “Over the past five years authorizers haven’t been able to do anything” (R6, 2009). She clarified that since most of the policies over the past five years have been more incremental or “low-level,” the appropriators have been playing a more of a role in policymaking.

Finding 3: The annual nature of the appropriations process provides for a more efficient and less partisan policymaking vehicle.

A former staff member on the Senate Finance Committee said that “in an ideal world appropriators should fund what authorizers authorize, but too often that’s not happening and appropriators are stepping in” (R5, 2009). There was a general sentiment, echoed by all the respondents, that the appropriations process has become a more effective and efficient process in

getting policies through the Congress. The reasons for the use of appropriation bills as the primary policymaking vehicle varied. However, the respondents agreed that the authorization process is often too deliberative as it tends to focus on specific issues, which creates a more fertile environment for partisanship. A former staff member of the House Appropriations Subcommittee on L/ HHS said that, “authorization bills are more partisan because they focus on a specific issue, which tends to stall the bill in committee” (R8, 2009). Moreover, because authorizations tend to be periodic and are not tied to an annual time table, their political leverage is minimized, as opposed to the looming threat of a government shutdown associated with the failure to pass an appropriations bill.

The use of appropriations bills as a policymaking vehicle has been reflected through the incorporation of policy riders into appropriations bills and the use of committee report language that accompanies the appropriations bills. The use of report language as a policy medium is a rising trend among appropriators. Appropriations committee reports are now laden with numerous committee requests and directives for agencies to carry out. Many of these directives, such as AHRQ’s directive to reduce medical errors, read like legislative language. A former appropriations staff member of the House Appropriations Subcommittee on L/ HHS once said: “Appropriators cure cancer [with appropriations for NIH] through report language.”⁴²

While the report language is not legally binding, it is *politically*⁴³ binding, and executive branch agencies take the language seriously, knowing that they could suffer budget cuts for

⁴² Author’s personal communications. 2009.

noncompliance for the next budget cycle. On the contrary, authorizing committees often have their only real interactions with executive branch agencies around the time that their authorizations expire. Most agencies are authorized by long-term (5 year) authorizations. A number of agencies, including AHRQ (whose authorization expired in 2005), continue to operate for years on expired authorizations. In this case, the appropriations committees' approval of an agency's budget request and any policy changes that the committee makes becomes the agency's de facto authorization. In reference to expired authorizations, a respondent declared, "NIH made money hand over fist without being authorized. You can authorize things until you are blue in the face, it doesn't matter unless you get the dollars from the appropriators...I'm not going to pretend to act like there is any use for authorizers" (R4, 2009).

The frequency of appropriations bills provides a greater opportunity for committee members to play a role in policymaking. A Senate appropriations staffer said, "There's always an appropriations bill going through Congress, whether it's an annual appropriations bill or supplemental appropriations bill" (R9, 2009). She continued: "With so much appropriating going on everything ends up getting attached to the appropriations bills. For example, in one of the omnibus appropriations bills, we included the authority to fund buses for the Head Start program, something that the authorization committees should have done" (R9, 2009).

A former Senate authorizing committee staffer said, "if authorizers don't do their job, their power is atrophied, which is why some agencies basically ignore their authorizing

⁴³ Executive branch agencies often are given directives in appropriations reports that require them to carry out certain policy initiatives or eliminate certain program activities. For example, AHCPR followed through with the House Appropriations Committee Report that directed the Agency to eliminate the development of clinical practice guidelines. Knowing the political ramifications that can ensue if an agency does not follow through with such a directive, agencies almost always oblige. Thus, report language has become a very powerful policymaking tool for the appropriators.

committees” (R7, 2009). As a result, appropriators yield more power and end up becoming the only game in town. A health care lobbyist told me that, “with authorizing bills, there is never a crisis or an impetus for getting things done as opposed to appropriations bills” (R10, 2009). She added that, “more advocacy groups understand that if we want to get policies through quickly, we go to the appropriations committees. We can’t wait seven years for a policy to go through the authorization process. The appropriations process has a much more predictable time frame” (R10, 2009).

In addition to the efficiency of the appropriations process with its more “predictable”⁴⁴ time frame, respondents noted that controversial policies often are attached to the appropriations bills as a way of circumventing an often more partisan and cumbersome authorization process. For example, provisions on stem cell research and abortion have been some of the more high profile policies that have appeared in appropriations bills. A staff member of the House Appropriations Subcommittee on L/ HHS said that there was a lot of controversy in establishing a separate institute for HIV/ AIDS research at the NIH. The authorization committees wanted to establish a separate institute, but their bill became mired in controversy. Instead, the appropriators decided to make a policy decision in an appropriations bill that essentially spread HIV/ AIDS research funding and related activities across the other institutes, which was contrary to what the authorizers wanted.

Conversely, even though appropriations bills are on a more fixed time table, a member of the House Appropriations Committee said that the increased policy provisions included in

⁴⁴ I use “predictable” loosely here, as continuing resolutions have become a normal practice in the appropriations process and have extended the length of the process beyond the end of a given fiscal year. Nevertheless, most of the continuing resolutions last for a few months beyond the fiscal year as opposed to the more protracted process of authorization bills.

appropriations bills can actually make the process much more inefficient. He said, for example, that the continuing resolution for FY 2009 appropriations was almost derailed until Rep. David Obey (D-WI) pulled a policy provision from the bill that would have banned offshore oil drilling. The respondent noted that often times that the range of the appropriations policy involvement has a lot to do with whether the appropriations chair is a policy activist. The chair dictates the committee's agenda and decides what should, or should not be included in an appropriations bill. However, as noted by a former member of the House Appropriations Subcommittee on L/ HHS, under the GOP leadership in 1995, control of the appropriations committee's agenda was much more centralized as the appropriations chairs had to get prior approval of what was to be included in their bill from Speaker Gingrich. Nevertheless, the chair still had the power to make the initial decision of the bill's content -- it just involved an extra step in negotiating with Speaker Gingrich on what the final bill was to look like before going forward.

Finding 4: Authorizers focus on macro-level policy while appropriators focus on micro-level policy.

Although it is evident from the interviews that the respondents agreed that policymaking has increased in the appropriations process over the past twenty years, a number of the respondents (6 out of 10) differentiated between two types of policymaking: *macro-level policymaking* (done by authorizers) and *micro-level policymaking* (done by appropriators). These respondents observed that appropriators deal with the "day-to-day" operations of an agency, and therefore develop more micro-level, incremental policy. Thus, the authorizers tend to address "big-picture," or more macro-level policies that arguably have a more significant impact on the national policy landscape. For example, a former staff member of the House

Energy and Commerce Committee suggested that appropriators make policies at the agency level, such as directing changes in AHRQ's clinical practice guideline programs, whereas the authorizers tend to deal with "big policies such as Medicare coverage, health care reform, and HIV/ AIDS policy" (R6, 2009). However, she pointed out that over the last five years, "authorizers haven't been able to do anything" (R6, 2009). She continued that ARRA illustrated a "major change in appropriators' involvement in policymaking at the macro-level" (R6, 2009).

Similarly, a staff member of the Senate Appropriations Subcommittee on L/ HHS believed that the frequent interaction between the appropriations committee staff and the agency staff provides "us with a much better understanding of the agency's programs and policies, and as a result, we try to work within the bounds of that agency's programs" (R9, 2009). However, she said that ARRA was an anomaly as appropriators' involvement reached a macro-level in policymaking, which "essentially served as a down payment on health care reform" (R9, 2009). She suggested that since authorizers tend to act in more partisan ways, getting macro-level policies passed has become more difficult as party polarization has increased. To illustrate, she said that during negotiations on ARRA, the Democratic authorizing staff did not want the Republican authorizing staff in the same room. As a result, "appropriators being less partisan end up picking up the slack" (R9, 2009). The same respondent noted that one of the major reasons for the failure of the reauthorization of the Substance Abuse and Mental Health Services Administration (SAMSHA) in 2008 was that the Democratic authorizers wanted to strike provisions relating to faith-based initiatives, while the Republican authorizers resisted, and the bill ended in stalemate. Nevertheless, the appropriators moved forward with funding SAMSHA based on its "old" statute, which expired in FY 2003.

A senior leader at AHRQ said that with ARRA, “appropriators just took the ball and ran with it” (R3, 2009). The policy initiatives incorporated into ARRA, such as comparative effectiveness research, had all the traces of an authorization bill. Thus, while some of respondents acknowledged that a dichotomy existed between the levels of policymaking (micro v. macro), it seems that in practice this dichotomy is gradually changing, with appropriators becoming more involved in the macro-level aspects of policymaking as well. A former staff member of the House Appropriations Committee gave authorizers high scores on influence on policymaking (7 out of 10), particularly at the macro-level, and a low score (3 out of 10) to appropriators. Yet, he acknowledged that their relative policy influences have been changing over the past twenty years due in large part to increased partisanship, which has become an obstacle in getting policies through authorization channels. “The appropriators’ ‘power of the purse’ is a very effective tool in overriding the partisanship” (R8, 2009).

A former staff member of the Senate Finance Committee suggested that authorizing committees, such as the Senate Committee on Senate Health, Education, Labor and Pensions (“HELP”), are in a weaker position politically because they do not have a funding mechanism to use as leverage. She suggested that in the past, the power of the Senate HELP Committee was derived, in large part, from its chair, the late Senator Edward Kennedy (D-MA). What has hurt the prospects of health reform in her view is the absence of Senator Kennedy’s influence, thus suggesting that the roots of power can come from more than just the purse.

Findings: AHRQ and the policymaking influence of the House and Senate Appropriations Subcommittees on Labor, HHS, Education, and Related Agencies.

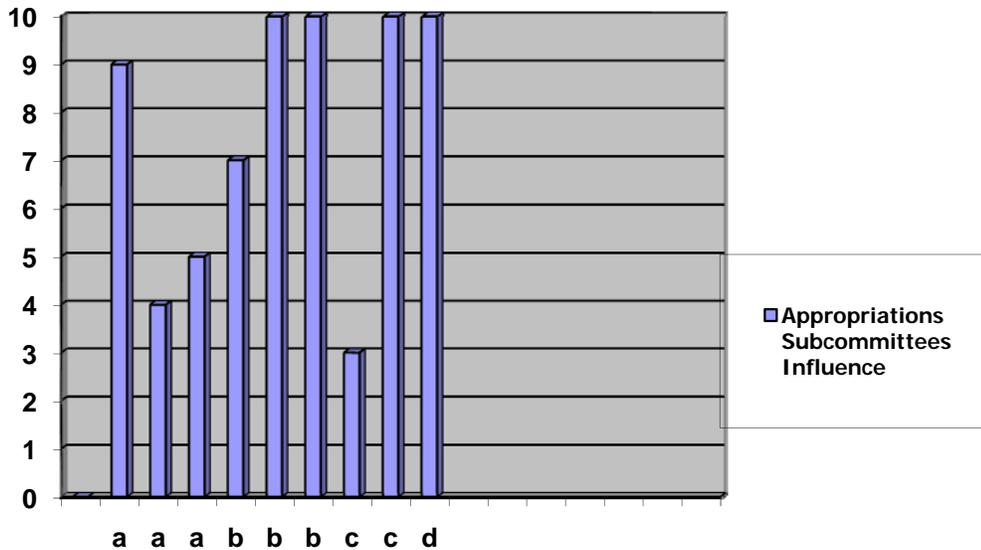
The respondents⁴⁵ who answered my question about the influence of the House and Senate Appropriations Subcommittees on L/ HHS in shaping the policies of AHRQ reported that the Subcommittees have had a significant influence on the Agency, but again with varying degrees of perceived influence (*see Table 6*). For example, one respondent said that Senator Specter and his appropriations subcommittee had an “enormous impact on AHRQ, more than anyone else” (R4, 2009). Another stated that the Senate Appropriations Subcommittee on L/ HHS “put AHRQ on the map” with medical errors. However, he noted that, “Senator Frist also had a “tremendous influence in changing the Agency’s name and direction through his committee’s reauthorization bill” (R7, 2009). *Table 8* reports the average degree of perceived policymaking influence of the House Appropriations Subcommittee on L/ HHS related to AHRQ. This average is based on the total interview responses.

⁴⁵ Because some of the respondents did not have an association with AHRQ/ AHCPR, they were not asked about the influences that the House and/ or Senate Appropriations Subcommittees on L/ HHS played in the Agency’s policies.

Table7: *On a scale of 0-10, with zero being “no influence” and ten being the “most influential,” how influential have the House and Senate Appropriations Subcommittees on L/HHS been in shaping the policies of AHRQ?⁴⁶*

Perceived Policymaking Influence of House and Senate Appropriations

Subcommittees on L/ HHS on AHRQ



⁴⁶

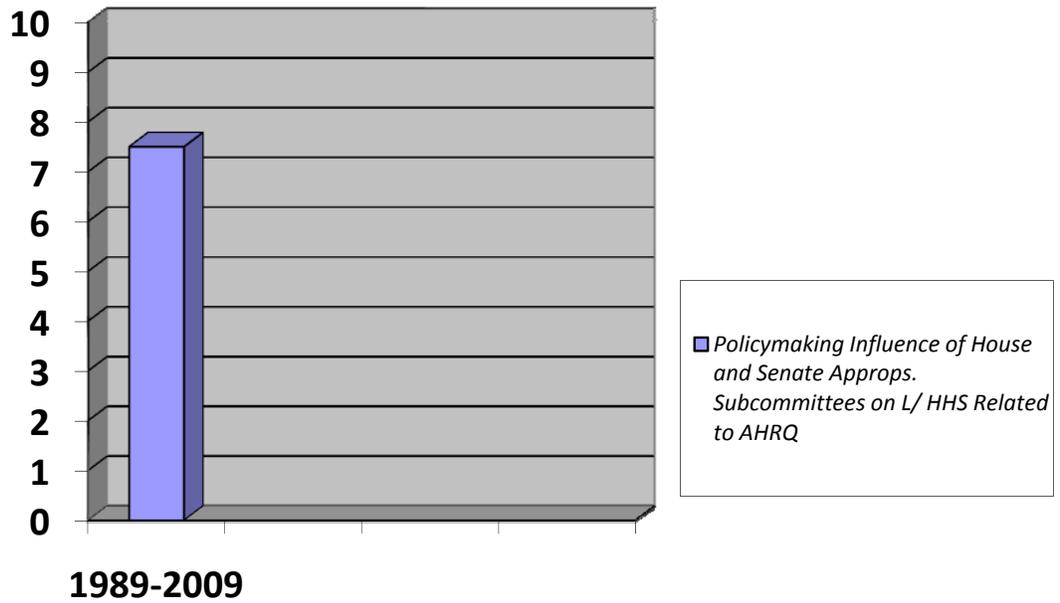
a=appropriations respondent

b=authorization respondent

c=AHRQ respondent

d=Other (e.g., lobbyist)

Table 8: Average Degree of Perceived Policymaking Influence of the House and Senate Appropriations Subcommittees on Labor, HHS, Education and Related Agencies Related to AHRQ



The genesis of my hypothesis that the House and Senate Appropriations Subcommittees on L/ HHS increasingly have influenced the policies and direction of AHRQ stemmed largely from my 14 years as the congressional/appropriations liaison for the Agency. Through experience and observations, I concluded that the appropriations subcommittees with jurisdiction over AHRQ's budget have played a significant role in shaping the Agency's policies and direction. This conclusion was based on several factors, including: (1) the Agency's increased interaction with and reliance on its appropriations subcommittees; (2) the structure of the AHRQ's budget, which directly corresponds to the priorities and directives that have originated from the subcommittees; and (3) the Agency's growth and direction largely being due to the actions of the subcommittees.

A review of the critical incidents provides evidence of the Subcommittees' influence over the policies and direction of AHRQ. Additionally, key documentary evidence including hearing transcripts, memorandum, and report language further suggests that the Subcommittees have had substantial policymaking impact on AHRQ. However, other influences on AHRQ need to be taken into account. Therefore, I decided that interviews with key policymakers who, in most cases, have been either involved with the appropriations process, the House and Senate Appropriations Subcommittees on L/ HHS and/ or AHRQ, also would help shed some light into whether – and why - the appropriations subcommittees have taken on an active policymaking role as it relates to AHRQ's programs and activities. The following section provides key points that were raised during the interviews.

Of the participants in the interviews (with only one exception who was not directly involved with AHRQ), *all* agreed that the House and Senate Subcommittees on L/ HHS have influenced AHRQ's policies and direction. As I pointed out earlier in this chapter, the degrees of

influence varied (*refer to Table 6*). Overwhelmingly, the respondents noted that the Subcommittees' policymaking influence with AHRQ increased exponentially with the House Appropriations Subcommittee's directive to halt the development of clinical practice guidelines, coupled with the threat of eliminating the Agency. A former senior leader at AHRQ said, "Rep. Bonilla really shook things up when he almost put the Agency out of business" (R4, 2009). She noted that the House Appropriations directive to eliminate AHCPR's role in clinical practice guidelines "opened the door to the Subcommittee's ability to shape the Agency's policies and direction" (R4, 2009). She said that the first real evidence of policymaking occurred after the 1995 critical incident when Chairman Porter of the House Appropriations Subcommittee on L/ HHS called on AHRQ to translate research into practice. She went on to suggest that next to the Senate Appropriations Subcommittee's initiative to reduce medical errors, Porter's challenge to AHRQ "completely changed the way AHRQ carried out its research agenda" (R4, 2009).

A former member of the House Appropriations Subcommittee on L/ HHS who sat on the Subcommittee during the Republican Revolution remarked that in his view Representative Bonilla and his efforts to eliminate AHCPR had a "profound impact on AHCPR and impacted the Agency for years to come" (R1, 2009). A former staff member of the House Appropriations Subcommittee on L/ HHS who served during the time of the Republican Revolution argued that AHCPR's "near-death" experience at the hands of the appropriators actually helped the Agency in the long-run. "People began to realize the capacity of the Agency to address a large part of the economy where lives and fortunes are at stake" (R8, 2009). He continued that the appropriations subcommittees played a "huge role in shaping the Agency's policies and direction" (R8, 2009). He suggested that the Subcommittees' policymaking role is well documented by simply reviewing House and Senate Appropriations Reports since 1995 (*See Appendix D*), which reveals

prescriptive language impacting AHRQ's programs and policies. However, when I asked him whether appropriators' policymaking role was unique to AHRQ given its brush with "death," he replied, "the CDC is actually much more managed by the appropriators given the number of programs that have a direct impact states and localities" (R8, 2009). He said that on the contrary, NIH is least managed by the appropriators because of its sheer size.

A number of the respondents noted that the directive by the Senate Appropriations Subcommittee on L/ HHS for AHRQ to find ways to reduce medical errors was one of the most significant incidents over the twenty years. Many saw this event as a major turning point for AHRQ's growth trajectory and exemplified the appropriations subcommittees' role in shaping AHRQ's policies and direction. A former staff member with the Energy and Commerce said, "The Senate saved AHRQ with the medical errors initiative by creating a new agenda for the Agency that gave it new life" (R6, 2009). The significance of this incident was that the appropriators "figured out how to operationalize policies for AHRQ" (R6, 2009). A staff member of the Senate Appropriations Subcommittee on L/ HHS confirmed this by saying that the patient safety agenda really "opened the door for the Subcommittee to guide AHRQ's research agenda" (R6, 2009). For example, she observed that when "MRSA became a real concern we knew that we could go to AHRQ and get something done quickly" (R9, 2009). As a result, a large percentage of the Agency's research agenda (prompted by both the House and Senate Appropriations Subcommittee on L/ HHS) is dedicated to develop strategies to reduce MRSA and other health care-associated infections.

When asked if the House and Senate Subcommittees on L/ HHS have had an influence on AHRQ's policies and directions, the Senate appropriations staffer said, "absolutely, I would rate it a '9' on a scale from 1-10" (R9, 2009). However, the same respondent noted that while the

appropriators' involvement in AHRQ's policies and direction has been substantial and helped the Agency grow and prosper, there has been a downside: the Agency's discretion has been compromised. A health care lobbyist noted that the "near-death" experience of the Agency changed its direction mostly because of an unpopular research study related to back surgery. She suggested that there is always going to be some controversy with research findings and that history shows that "unfortunately everything will be micromanaged with controversy" (R10, 2009); given the appropriators influence over AHRQ, they will likely dictate AHRQ's research, regardless of what the science says. In referring to the Agency's research finding related to back surgery, a former member on the House Appropriations Subcommittee on L/ HHS said that, "politicians should not dictate results; instead we need to defend the integrity of the science" (R1, 2009).

The interview findings confirm that the House and Senate Appropriations Subcommittees on L/ HHS have had a significant role in the policies and direction of AHRQ. This begs the question of whether the authorizing committees have had a similar impact on AHRQ. A number of the respondents provided some insight into this question.

"Authorizers don't matter. It would be more effective to put the two [authorization and appropriations committees] together and have one funder" (R4, 2009), suggested a former budget policy chief at NIH and senior leader at AHRQ. The same respondent said that NIH never really paid attention to the authorizers, noting that it went for years without being reauthorized. When asked about the impact that authorizers had on AHRQ's policies, she said "very minimal." She suggested that the reauthorization of the Agency in 1999 simply "changed the name and gave the staff more work" (R4, 2009).

A former staff member of the Senate Finance Committee, who helped draft AHCPR's original statute, had a much different perspective on the authorizers' policymaking role related to AHRQ. She said that the Senate HELP committee played a major policymaking role with the reauthorization of AHRQ, but the Committee has been disengaged since that time. Similarly, a former staff member on the Senate Committee on Science said that Senator Frist and the Senate HELP Committee had "tremendous" impact on AHRQ's direction, but he also acknowledged that the Committee has not been as involved with AHRQ due largely to the infrequent interaction that it generally has with executive branch agencies.

One respondent pointed out that the "institutional knowledge" of the Agency and health services research, in general was lost in the Congress with the retirements of key Members, including Senators George Mitchell, David Durenberger, John Danforth and Representative Bill Graddison. The loss of "champions" for the Agency, including influential staffers, clearly hurt the Agency's prospects with the authorizing committees. As a result of the loss of key authorizing members and staff, the appropriators, with the exception of Senator Frist and the Senate HELP Committee, have "filled in the void over the past twenty years" (R5, 2009). She noted that the prospect of health reform is starting to change this dynamic as the authorizers are getting more involved in executive branch policies, particularly policies related to AHRQ's programs.

The former staff member on the Senate Committee on Science suggested that while power often "resides in the committee that writes the checks, often times it is the 'power of personalities' that get things done" (R7, 2009). For example, he noted that the role of the Senate HELP Committee as the lead congressional committee in policymaking has diminished greatly with the absence of Senator Kennedy. Similarly, he said that Senator Frist's' interest and

background in health care contributed a great deal to the HELP Committee's significant role in reauthorizing AHRQ. However, the Committee has not been nearly as active in relationship to AHRQ since his retirement from the Senate.

The interviews provided further evidence appropriators are acting more like authorizers, particularly when examining the relationship between the House and Senate Appropriations Subcommittees on L/ HHS and AHRQ from 1989-2009. While there was consensus among the respondents that policymaking has increased among appropriators, the explanations for why this phenomenon may be occurring vary. In the following chapter I draw conclusions based on the evidence revealed from the case study, scholarly findings, document analysis, and my own professional experience in public policy. In addition, I identify some areas for further research and analysis.

CHAPTER 8

CONCLUSIONS

The most effective way to get things done anymore is to use the appropriations process...

I'm not sure the authorization process is even relevant.

Health Care Lobbyist (2009)

Through an examination of critical incidents, interview responses, and document analysis, it is evident that over the past twenty years: (1) appropriators increasingly are acting more like authorizers, as they are more involved in policymaking activities that were once the domain of authorizing committees; and (2) the House and Senate Appropriations Subcommittees on Labor, HHS, Education, and Related Agencies have had a significant impact on the policies and direction of the Agency for Healthcare Research and Quality.

This dissertation used a case study design both to explore whether and how appropriators are behaving more like authorizers, and more importantly, to examine *why* they are behaving in this manner. Based on a number of scholars' findings and various theoretical frameworks, coupled with my own experience in a congressional liaison role and interviews with key federal policymakers, the following potential reasons emerged as to why appropriators may be acting more like authorizers. They include:

- A weakening of the appropriations committees' power and autonomy as a result of organizational changes in Congress.
- The impact of increased partisanship in the Congress is playing a major role in how appropriations and authorization committees operate.

- The window of opportunity opened by AHRQ's vulnerability as a result of its "near-death" experience.
- The annual nature of the appropriations process, providing a more efficient and less partisan process, particularly as it relates to the every-changing dynamics of the U.S. health care system.
- The appropriations committees' role in oversight of executive branch agencies creates a strong relationship with the agency and more involvement in agencies operations and directions. As a result, an emergence of closer principal-agent relationship between the House and Senate Subcommittees on L/ HHS and AHRQ has occurred.
- The authorizers tend to focus on macro-level policy issues, as opposed to the appropriators who focus on more micro-level policy issues.

Although these findings support my initial hypothesis, it is important to point out that the human element that makes up the critical incidents should not be taken for granted. Vayda et al. assert that "social scientists sometimes use process to explain reality as if processes had lives of their own, as if they existed independent of human agency and were regulated by some larger dynamic in history" (1991, p. 320). In reference to the increased use of the appropriations process as a vehicle for enacting policy, a member on the House Appropriations Committee remarked that, "*partisanship* is playing a large role in that" (R1 , 2009). Therefore, one could surmise that the while the appropriations process in and of itself is an effective policymaking mechanism, other behavior by the actors involved in the process can affect its intended use or its

outcomes. Often, as this dissertation has pointed out, the behaviors can be a result of a number of environmental factors such the prevailing political or economic climates.

To further illustrate, Vayada et al. (1991) discuss how the “natural cycle” of the U.S. president is not always inevitable and different circumstances can change the predicted course. For example, the unpredictable terrorist attacks that occurred on September 11, 2001 arguably altered the expected cycle of President Bush’s presidency. Vayda et al. (1991) conclude that the social science literature needs to more explicitly acknowledge that processes are made up of “human actions or events involving human actions” (p. 324). Thus, to fully comprehend why the appropriators have been acting like “authorizers in sheep’s clothing,” it is critical to take into account the human factor and the circumstances of the time.

Further Research

The interview participants were unanimous in their agreement with my hypothesis that the House and Senate Appropriations Subcommittees on L/ HHS increasingly have become more involved in the policies and direction of AHRQ. While participants differed in describing the degree of the Subcommittees’ influence, the evidence is clear that the Subcommittees have had a significant policymaking role related to AHRQ over the twenty year period of study. These findings demonstrate that appropriators have become involved with the policymaking process, particularly as it relates to AHRQ’s programs and activities. Furthermore, the findings lend further support to previous research that suggests what is happening in practice is much different than what the appropriations-authorization dichotomy portends.

However, this case study was limited in its scope by focusing on just two appropriations subcommittees and one executive branch agency, indeed one that was in a distinctive position

given its political history. Thus, additional studies are needed to examine whether the increased policymaking role is a trend among the other House and Senate appropriations subcommittees and the executive branch agencies under their jurisdiction. My expectations are that this is a growing trend among the other appropriations subcommittees. I found evidence of this trend in an interview I conducted with a current member on the House Appropriations Subcommittee on Homeland Security who noted that the subcommittee uses its appropriations power as a legitimate policymaking tool in its dealings with the Department of Homeland Security. However, it is important to point out that since the Department of Homeland Security is a relatively new department, appropriators' engagement of salient policy issues could be an anomaly compared with other established executive branch agencies.

With the exception of one participant in this study, all of the interview respondents are currently involved, or have been involved, with health care policymaking at the federal level. The one participant who is not involved with health care currently serves a member of the House Appropriations Committee. His perspectives provided a broader view of the appropriations process and the activities of the appropriations committee. His responses suggest that the policymaking role of appropriators I identified may not be an isolated case or unique to the House and Senate Appropriations Subcommittees on L/ HHS. Therefore, there is opportunity for broader studies to examine the other House and Senate appropriations subcommittees to determine whether those subcommittees are involved in policymaking activities and to what degree.

During the interviews, one respondent said that “most effective way to get things done anymore is to use the appropriations process... I'm not sure the authorization process is even relevant.” While this dissertation focused on the appropriations process and the role of

appropriators in policymaking, it left some questions about whether the authorization process is broken, or whether perhaps a restructuring of the legislative process is needed. As I pointed out earlier, it is critical to account for the human factor in any examination of processes. IOM's report *To Err is Human* noted that "building safety into processes of care is a more effective way to reduce errors than blaming individuals (some experts, such as Deming, believe improving processes is the only way to improve quality)" (Kohn, et al., 1999, p.4). Thus, while there is a human factor to all processes, changes to the process itself or the system surrounding the process can sometimes improve the outcomes.

In Chapter 2, I raised the suggestion by Thad Hall that the increased use of short-term authorizations by Congress could enable congressional authorization committee to better control and oversee executive branch agencies. He believes that short term authorizations can enable the Congress to "systematically shape the overall goals, structures, and decision rules that govern agency activities," arguing that, "by revisiting the status of a given program at set intervals, Congress can steer policy in much the same way that a captain steers ship" (p. 366).

An issue that respondents continually raised was that the periodic nature of authorizations limits authorizers' interactions with executive branch agencies. Conversely, appropriations committees interact with executive branch agencies much more given the annual nature of the appropriations process. As a former staff member on the House Appropriations Subcommittee on L/ HHS said, "appropriators have much more oversight and say in agencies' operations as opposed to authorizers who only review and reauthorize programs periodically." Thus, further research is needed into what structural or process changes, such as short-term authorizations, might make the authorization process a more effective policy tool.

Another area of research that needs to be further explored is the idea of consolidating the authorization and appropriations committees into one standing committee. An interesting observation that arose during the interviews was that the authorization committees that have jurisdiction over mandatory funding or entitlements enjoy the “power of the purse,” yet they also have legislating authority. These committees, such as Senate Finance Committee and House Ways and Means Committee, are what I refer to as “hybrid” committees given their mix of legislative and funding authority.

Using the hybrid committees as a model might be a basis for additional research into determining what congressional committee structures are most suitable for effective and efficient policymaking. Research in this area might include an analysis of the policymaking activities of the hybrid committees, which include the House Ways and Means Committee and the Senate Committee on Finance. A former staff member of the Senate Finance Committee remarked that one of the reasons (in addition to the loss of Senator Kennedy) the Senate HELP Committee is not playing such a dominant role in health reform is that they do not have the resource of the Medicare Trust Fund at their disposal. Thus, this begs the question for additional research into whether the current congressional committee structure is effective as it currently organized.

Finally, this dissertation demonstrated that models, such as Waterman and Meier’s (1998) expanded principal agent model, were useful in analyzing the relationship between AHRQ and the House and Senate Appropriations Subcommittees on L/ HHS. It is important to note that other theoretical frameworks such as Actor Network Theory have been employed with great success by scholars of public administration and policy to help explain the role of bureaucratic agents in a democracy. Thus, this dissertation presents an opportunity for follow-up studies that

examine the institutional dynamics between congressional appropriations committees and executive branch agencies.

Final Thoughts

This dissertation focused on the increased policymaking activities of congressional appropriations subcommittees. The evidence supported the hypothesis that the appropriations committees have become more involved in the policymaking realm, which traditionally has been the province of the authorizing committees given the subject matter expertise of the members and staff of those committees. The case study examined a twenty year period (1989-2009), which revealed a gradual evolution of an increased policymaking role of the House and Senate Appropriations Subcommittees on L/ HHS in their relationship with AHRQ. This policymaking role seemed to peak with the appropriators' control of the American Recovery and Reinvestment Act (ARRA) of 2009, which was laden with significant policy initiatives, including initiatives such as comparative effectiveness research that have become cornerstones of Congress's efforts to reform the nation's health care system.

ARRA in all its glory and controversy became the quintessential, if not unprecedented, illustration of appropriators' involvement in the policymaking process. Thus, it seemed like a reasonable ending point for this study. However, I would be remiss not to address the Patient Protection and Affordable Care Act, which is intended to make substantial changes to our nation's health care system. As I am writing this chapter, the House and Senate *authorizers* are attempting to iron out the differences between the House and Senate passed versions of the bill. I am not here going to go into the idiosyncrasies of the bill, or health care reform for that matter. Rather, I mention this as a way of showing that while the appropriations committees have

seemingly had their share of legislative triumphs over the past twenty years, the authorizing committees are undoubtedly back in the “game” and they are on the cusp of making history.

I do not mean to imply that the appropriators have been sitting on the sidelines relative to health care reform. In fact, ARRA was in essence a down payment for many of the policy initiatives incorporated in the draft bills and pilot studies, such as medical malpractice demonstrations, which were included in AHRQ’s FY 2010 appropriations. Also, in providing technical assistance for the health reform bill, I have witnessed appropriations staff serving as consultants to authorizing staff in drafting certain sections of the bill that have a direct impact on agencies under the appropriators’ jurisdiction.

While it remains uncertain whether any health reform bill will pass in Congress, there is a subplot going on: the appropriations-authorization dichotomy is playing out true to form. During this time, two main points from the interviews have stuck with me -- one from a current appropriations staff member and another from a former authorization committee member, respectively:

I hope this bill [health reform] passes so that comparative effectiveness is codified into law and we don’t have to deal with it anymore.

Over the years authorizers have not paid much attention to AHRQ, but with health reform they are now paying a lot of attention to the Agency and will continue to do so if the bill [health reform] passes.

It seems that health care reform might be the impetus that once again alters the dynamics between the appropriators and authorizers. There certainly appear to be signs of a shift back to the “traditional” roles of the authorizers and appropriators, at least in some of the most recent congressional actions taken in relationship to AHRQ. However, in wrapping up this dissertation, it looks like the health reform bill has stalled due to political fallout of the special election in Massachusetts where Republican Scott Brown has filled the Senate seat once held by the Senator Edward Kennedy for the past 40 years. While the fate of the health care reform legislation remains unclear, there already are signals coming from key policymakers that health care reform might be accomplished incrementally through none other than the appropriations process.

REFERENCES

- Adler, E. Scott. (2000). "Constituency Characteristics and the 'Guardian' Model of Appropriations Subcommittees, 1959-1998," *American Journal of Political Science*. 44 (1): 104-14.
- Aldrich, John H. & David W. Rohde. (2000). "The Republican Revolution and the House Appropriations Committee," *Journal of Politics*. 62:1-33.
- Agency for Healthcare Research and Quality. (2009). "History of the Effective Healthcare Program." AHRQ Website. Retrieved November 3, 2009.
<http://effectivehealthcare.ahrq.gov/index.cfm/what-is-the-effective-health-care-program1/history-of-the-effective-health-care-program/>
- Agency for Healthcare Research and Quality. (2008). "Mission Statement: Office of Communications and Knowledge Transfer." Retrieved on January 10, 2010.
<http://www.ahrq.gov/about/ockt/ocktmiss.htm>
- Agency for Healthcare Research and Quality. (2007). "Budget Estimates for Appropriations Committees, Fiscal Year 2007." Performance Budget Submission for Congressional Justification. Retrieved November 3, 2009. <http://www.ahrq.gov/about/cj2008/cjweb08.htm>. Accessed November 3, 2009.
- Agency for Healthcare Research and Quality. (1999). *Reauthorization Fact Sheet*. (1999) AHRQ Publication No. 00-P002, Rockville, MD. Retrieved January 12, 2010.
<http://www.ahrq.gov/about/ahrqfact.htm>
- Agency for Healthcare Research and Quality. (2009). "Ending Health Care-Associated Infections." Rockville, MD. <http://www.ahrq.gov/qual/haicusp.htm>. Accessed November 9, 2009
- Agency for Healthcare Research and Quality. (2009). "FY 2010 Justification for Estimates for Appropriations Committees." Executive Summary.
- Agency for Healthcare Research and Quality. (2009). "Justification of Estimates for Office of Management and Budget FY 2011." 53-54
- Agency for Healthcare Research and Quality. (2009). "Health Information Technology." AHRQ Website. Retrieved November 3, 2009.
http://healthit.ahrq.gov/portal/server.pt?open=512&objID=562&parentname=CommunityPage&parentid=1&mode=2&in_hi_userid=3882&cached=true.
- Baughman, John. (2006). "The Role of Subcommittees after the Republican Revolution," *American Politics Research* Vol. 34, (2): 243-268.

- Bush, George W. (2003). White House Press Release. Retrieved November 3, 2009. <http://www.cms.hhs.gov/MMAUpdate/>.
- Champoux, Mark and Sullivan, Dan. (2006). "Authorizations and Appropriations: A Distinction without Difference?" Harvard Law School Federal Budget Policy Seminar, Briefing Paper No. 15. 1-33.
- Clancy, Carolyn. (2009). "Reducing Health Care-Associated Infections." Statement before the House Appropriations Subcommittee on Labor, HHS, Education, and Related Agencies. 1-7
- CNN Money.com. (2008). "Bush Plans Prime Time Speech." Retrieved November 3, 2009 http://money.cnn.com/2008/09/24/news/economy/bush_speech/?postversion=2008092410
- Darlington, Yvonne and Scott, Dorothy. (2002). *Qualitative Research in Practice: Stories from the Field*.
- Devins, Neal E. (1987). "Regulation of Government Agencies through Limitation Riders." *Duke Law Journal*. 456.
- Denzin, Norman K., and Lincoln, Yvonna S. (1994). *Handbook of Qualitative Research*.
- Edwards, Keith M. and Stewart, Charles III. (2006). "The Value of Committee Assignments in Congress since 1994." Presentation: 2006 Annual Meeting of the Southern Political Science Association. Atlanta, Georgia. 1-42.
- Farquhar, Marybeth (2008). "Actor Networks in Health care: Translating Value into Measurement of Hospital Performance." Dissertation.
- Fenno, Richard (1966). *The Power of the Purse: Appropriations Politics in Congress*
- Fisher, Louis. (1979). "The Authorization-Appropriation Process in Congress: Formal Rules and Informal Practices." *Catholic University Law Review*, Vol. 29, 53-105
- Fisher, Louis. (2003). *The House Appropriations Process, 1789-1993*.
- Flick, U. (1992). "Triangulation revisited: Strategy of validation or alternative?" *Journal for the Theory of Social Behavior*. 22: 175-198
- Forgette, Richard. (1996). "Constraint or Accommodation: The Congressional Budget Procedure's Effect on Appropriations Decisions," *American Politics Quarterly*. 23: 24-42.
- Frist, Bill. (2001). "Public Policy and the Practicing Physician." *Annals of Thoracic Surgery*. 1410-1414. Retrieved February 15. <http://ats.ctsnetjournals.org/cgi/content/full/71/5/1410>
- GAO Report (1990). *Case Study Evaluation*. Retrieved January 31, 2009. <http://ojp.usdoj.gov/BTA/evaluation/guide.documentary/documentree.html>.
- Golden, Marissa. (1998). "Interest Groups in the Rule-Making Process: Who Participates? Whose Voices Get Heard?" *Journal of Public Administration and Theory*. 235-270.

Ginieczki, B. (2000). "Thank you letter to Chairman John Porter." Personal Archive.

Gray, Bradford, Guzman, Michael, and Collins, Sara. (2003). "AHCPR and the Changing Politics of Health Services Research." *Health Affairs*. 283-305.

Gray, Bradford. (1992). "The Legislative Battle Over Health Services Research," *Health Affairs*. Winter: 39-65.

Using Congressional Oversight to Shape OSHA Bureaucratic Behavior," *American Politics Research*. 608-629.

Headrick, Barbara, Serra, George, and Twombly, Jim. (2002). "Enforcement and Oversight to Shape OSHA Bureaucratic Behavior." *American Politics Research*. Vol 30. 608-629

Heniff, Bill. (2003). "Overview of the Authorization-Appropriations Process," *Congressional Research Service Report*.

House Committee on Appropriations. (2002). "Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2003." Hearing Transcript: House Committee on Appropriations. 1379-1421

House Committee on Appropriations. (1995). "Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 1996." Hearing Transcript: House Committee on Appropriations. 157-259

House Committee on Appropriations. (1996). "Departments of Labor, Health and Human Services, Education and related Agencies, Appropriations for 1997." Hearing Transcript: House Appropriations Committee. 1-111

House Committee on Appropriations. (1999). "Departments of Labor, Health and Human Services, Education, and Related Agencies, Appropriations for 2000."Hearing Transcript: House Committee on Appropriations. 1051-1323

House Committee on Appropriations. (1998). "Departments of Labor, Health and Human Services, Education, and Related Agencies." Transcript: House Appropriations Committee. 1-159

House Committee on Appropriations. (2009) Summary: "Labor, Health and Human Service, Education, and Related Agencies Appropriations, Consolidated Appropriations bill."

House Committee on Rules. (2009). "Legislating and Appropriating in the House." House Committee on Rules Website. Retrieved November 3, 2009. para. 1.

http://www.rules.house.gov/Archives/legapp_house.htm

House Report. 104-120 (1995). "Concurrent Resolution on Budget, FY 1996" Report of the Committee on Budget. 1-237

House Report 104-209. (1995). "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 1997." Report of the House Committee on Appropriations. 103-104

House Report 104-659. (1996). "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 1997." Report of the House Committee on Appropriations. 97-98

House Report 110-X. (2009). "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 2009." Report of the House Committee on Appropriations in *AHRQ FY 2010 Justification of Budget Estimates*. 89-91

House Report 111-220. (2009). "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 2010." Report of the House Committee on Appropriations. 150-156

Helms, David. (2002). "Proving Our Mettle: We Can't Do it Without You." *Academy for Health Services Research Report*. 6.

Huffington Post. (2008). "Obama Victory Speech." Retrieved November 9, 2009
http://www.huffingtonpost.com/2008/11/04/obama-victory-speech_n_141194.html Accessed November 9, 2009

Joyce, Philip.(1996). "Congressional Budget Reform: The Unanticipated Implications for Federal Policymaking. *Public Administration Review*. 56: 317-325.

Kettl, D.(1992). *Deficit Politics: Public Budgeting in Its Institutional and Historical Context*. Macmillian Publishing Company.

Kingdon, John W. (2003). *Agendas, Alternatives, and Public Policies*. Addison-Wesley Educational Publishers Inc.

Kohn LT, Corrigan JM, Donaldson MS. (1999). *To Err Is Human: Building a Safer Health System*. Washington: National Academy Press.

Langley, Ann. (1999). "Strategies for Theorizing from Process Data," *Academy of Management Review* 24: 691-710

Lewis, Verne. 1952. "Toward a Theory of Budgeting," *Public Administration Review*, 12, No. 1. (Winter). 43-54.

Marshall, C. and Rossman, G.B. (1999). *Designing Qualitative Research*. Thousand Oaks, CA: Sage Publications.

Munson, Richard. (1993). *The Cardinals of Capitol Hill: The Men and Women Who Control Government Spending*. New York: Grove Press

Obama, Barack. (2009). "Remarks by the President and Vice President at the Signing of the American Recovery and Reinvestment Act." White House Website. Retrieved November 9, 2009. http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-and-Vice-President-at-Signing-of-the-American-Recovery-act .

Obey, David. (1995). Departments of Labor, Health and Human Services, Education and Related Agencies Appropriation Bill, 1996. House Report 104-219. 1-393

Obey, David. (2009). "Statement: FY 2010 Consolidated Appropriations Bill." Press Statement.

Paltis, Jason M. (2003). "The Endangered Species Act: Thirty Years of Politics, Money, and Science: Riders on the Storm, or Navigating the Crosswinds of Appropriations and Administration of Endangered Species Act." *Tulane Environmental Law Journal*.

Reichard, John (2002). "John Eisenberg Mourned." *Washington Healthbeat*.

Respondent 1. Interview with former member of Congress. Person to Person. July 22, 2009.

Respondent 2. Interview with member of Congress. Person to Person. July 21, 2009.

Respondent 3. Interview with Senior leader at AHRQ. Person to Person. September 9, 2009.

Respondent 4. Interview with former AHRQ Senior Leader and former Budget Policy Chief, National Institutes of Health. Person to Person. July 14, 2009

Respondent 5. Interview with former staff member of the Senate Committee on Finance. Person to Person. July 21, 2009.

Respondent 6. Interview with former member of the House Committee on Energy and Commerce. Phone Interview. September 10, 2009.

Respondent 7. Interview with former staff member of the Senate Committee on Science and Senior Advisor to former Senator Al Gore. Phone Interview. September 4, 2009.

Respondent 8. Interview with former staff member of the House Appropriations Subcommittee on Labor, HHS, Education and Related Agencies. Phone Interview. September 14, 2009.

Respondent 9. Interview with staff member on the Senate Appropriations Subcommittee on Labor, HHS, Education and Related Agencies. Person to Person. August 11, 2009.

Respondent 10. Interview with vice president for government relations (health care advocate). Person to Person. August 12, 2009.

Robbins, Domino. (2005). "Administrative Discretion: Its Use in Budgetary Analysis." *Public Administration Quarterly*. Vol. 29.

Schick, Allen, with Felix Ostrich. (2000). *The Federal Budget: Politics, Policy, and Process* Brookings.

Schick, Allen. (1983). "Incremental Budgeting in a Detrimental Age." *Policy Sciences*, 1-25.

Senate Hearing 106-847. (1999). "Medical Mistakes." Hearing Transcript: U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 1-218

Senate Report 106-293. (2000). "Department of Labor, Health and Human Services, Education and Related Agencies, 2001." Report of the Senate Committee on Appropriations. 195-198

Senate Report 107-084. (2001). "Department of Labor, Health and Human Services, Education and Related Agencies, 2002" Report of the Senate Committee on Appropriations. 201-205

Senate Report 108-81. (2003). "Department of Labor, Health and Human Services, Education and Related Agencies, 2004." Report of the Senate Committee on Appropriations. 187-188.

Senate Report 108-34. (2004). "The Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriation Bill, 2005." Report of the Senate Committee on Appropriations. 185-187.

Senate Report 110-410. (2007). "Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriation Bill, 2009." Report on the Senate Committee on Appropriations. 139-142

Shapiro, Stuart. (2008). "Does the Amount of Participants Matter? Public Comment, Agency Responses and the Time to Finalize a Regulation." *Policy Sciences*. Amsterdam. 33 -50.

Stake, Robert. (1992). "Case Studies." in *Handbook of Qualitative Research* (Denzin & Lincoln). 236-247

Stake, R.E. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage Publications.

Stockman, David A. (1987). *The Triumph of Politics: The Inside Story of the Reagan Revolution*.

Stokes, Louis. (1995). *Departments of Labor, Health and Human Services, Education and Related Agencies Appropriation Bill, 1996*. House Report 104-219. 1-393

- Strauss man. (1986). "Courts and Public Purse Strings: Have Portraits of Budgeting Missed Something?" *Public Administration Review*. 345-351.
- Specter, Arlen. (1999) "Hearing on Medical Mistakes." Transcript: U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies. 1-218
- Tellis, W. (1997). "Application of a Case Study Methodology," *The Qualitative Report*. Retrieved January 31, 2009. <http://www.nova.edu/ssss/OR/OR3-3/tellis2.html>
- True, James. (2000). "Avalanches and Instrumentalism: Making Policy and Budgets in the United States," *American Review of Public Administration*. Vol. 30, (1): 3-18.
- Vayda, McKay, & Engender. (1991). "Concepts of Process in Social Science Explanations," *Philosophy of the Social Sciences* 21, (3): 318-331
- Washington Post. (2008). "Drug Resistant Stash Cases Have Killed 35." B8
- Waterman, Richard and Meier, Kenneth.(1998). "Principal Agent Models: An Expansion?" *Journal of Public Administration Research and Theory*. 8:2:173-202
- Water, Richard, Rouse, Amelia, Wright, Robert.(1998). "Venues of Influence Theory," *Journal of Public Administration Research and Theory*. Vol 8. No 1: 13-38
- Wildavsky, Aaron and Camden, Naomi. (1997). *The New Politics of the Budgetary Process*, 3rd ed.
- Wildavsky, Aaron. (1984). *The Classic: The Politics of the Budgetary Process*, 4th edition, Little, Brown and Company.
- Wlezien, Christopher. (1996). "The President, Congress, and Appropriations, 1951-1985," *American Politics Quarterly*, Vol. 24, (1):43-67.
- Yin, R.K. (1989). *Case Study Research: Design and Methods*. Thousand Oaks, CA: Sage Publications.
- Yin, R.K. (1994). *Case Study Research: Design and Methods*. Thousand Oaks, CA: Sage Publications.
- Yin (2003). *Case Study Research: Design and Methods*. 3rd ed., Thousand Oaks: Sage Publications
- Zellmer, Sandra Beth. (1997). "Sacrificing Legislative Integrity at the Altar of Appropriations." *Harvard Law Review Rev.* (457):1-69.

Appendix A: Interview Questions

Appropriations-Authorization Dichotomy:

- Over the past 20 years, has the congressional appropriations process changed in significant ways? How?
- Has the distinction between authorizations and appropriations changed at all during this time?
- Over the past 20 years, who (appropriators / authorizers) do you think has had more influence in the policymaking process (scale -1-10 -- “10” being ‘most influential’)

Role of Appropriators:

- Do you think that the role of appropriators has changed over the past 20 years? If so, in what way(s) have appropriators’ role changed?
- Do you think that appropriators have become more or less involved in policymaking, i.e., legislating/ authorizing?
- What role do you think is most appropriate for appropriators to play?
- What role/ relationship do you think that appropriations subcommittees should have with executive branch agencies under their jurisdiction?

AHRQ:

- Over the past 20 years, AHRQ's mission/ direction has changed significantly.
What influences or factors do you think might have contributed to AHRQ's change of direction over the past 20 years?
- Do you think that the House and/ or Senate Appropriations Subcommittees played a role in this change of direction?
- On a scale of 0-10, with zero being 'no influence' and ten being the 'most influential,' how influential have the House and Senate Appropriations Subcommittees on L/ HHS been in shaping the policies of AHRQ?
- What role do you think is the House and Senate Appropriations Subcommittees on L/HHS should play in relationship to AHRQ?

Appendix B: Informed Consent Form

Identification of Project:

Appropriators Acting as Authorizers: A Case Study of the Policymaking Role of the Congressional Appropriations Subcommittees

Introduction:

The Center for Public Administration and Policy at the Virginia Polytechnic Institute and State University (Virginia Tech) supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time.

Purpose of the Research:

The purpose of this research is to trace appropriators' interactions with the executive branch, focusing on an agency and its links with appropriations subcommittees. Specifically, the study will analyze the relationship between the House and Senate Subcommittees on Labor, HHS, Education, and Related Agencies (L/ HHS) and the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health and Human Services during the period of 1989-2009.

Procedure:

Participation of this study will take approximately 60 minutes of your time and consists of a one-on-one interview comprised of unstructured, open-ended questions. The interviewer (investigator) will transcribe the questions.

Risks and/ or Discomforts:

There is no more than a minimal risk or discomfort associated with this research.

Benefits:

This research has the potential to build on existing works related to the dynamics of the authorization-appropriations process. Moreover, this research could provide a conceptual framework for analyzing the roles the other congressional appropriations subcommittees play in relation to the executive branch agencies under their jurisdiction. Such information has the

potential to provide policymakers with a better understanding of the congressional policymaking process and how best to navigate the process.

Confidentiality:

Any information obtained during this study which could identify you will be kept strictly confidential. The data will be stored in a locked cabinet in the investigator's home office and only will be seen by the principal investigator and co-investigator during the course of the research. The information obtained in the study may be published in peer-reviewed journals or presented in academic meetings, but the data will be reported in generic terms, unless a participant agrees to be identified.

If you agree to be identified in publication, please check the box

Opportunity to Ask Questions:

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study. Or you may call the investigator at any time, cell phone (240)-863-8121, or after hours, (703) 478-6815. If you have questions concerning your rights as a research subject that have not been answered by the investigator or to report any concerns about the study, you may contact Virginia Tech Institutional Review Board at (540) 231-4991.

Freedom to Withdraw:

You are free to decide to not participate in this study or to withdraw at any time without adversely affecting your relationship with the investigators or Virginia Tech.

Consent, Right to Receive a Copy:

You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. At your request, you will be given a copy of this consent form to maintain for your records.

Signature of Participant:

Signature of Research Participant

Date

Name and Phone Number of Investigators:

Karen Hult, PhD, Principal Investigator

Office: (540) 231-5351

Boyce Ginieczki, Co-Investigator

Office: (301) 427-1214

David Moore, PhD, IRB Chair

Office: (540) 231-4991

Appendix C: Listing of House Committee Reports that Accompanied the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Bills (FY 1990-FY 2010)

Fiscal Year	Committee Report Number
1990	101-172
1991	101-591
1992	102-121
1993	102-708
1994	103-156
1995	103-553
1996	104-209
1997	104-659
1998	105-205
1999	105-635
2000	106-370
2001	106-645
2002	107-229
2003	No Report
2004	108-188
2005	108-636
2006	109-143
2007	109-515
2008	110-231
2009	No Report
2010	111-220

Appendix D: Listing of Senate Committee Reports that Accompanied the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Bills (FY 1990-FY 2010)

Fiscal Year	Committee Report Number
1990	101-127
1991	101-516
1992	102-104
1993	102-397
1994	103-143
1995	103-318
1996	104-145
1997	104-368
1998	105-58
1999	105-300
2000	106-166
2001	106-293
2002	107-84
2003	107-216
2004	108-81
2005	108-345
2006	109-103
2007	109-257
2008	110-107
2009	110-410
2010	111-66

Appendix E: Senate Appropriations Report 106-293 (Departments of Labor, Health and Humans Services, Education, and Related Agencies, 2001) Related to Directive for AHRQ Medical Errors

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Appropriations, 2000	\$198,799,000
Budget estimate, 2001	249,943,000
Committee recommendation	269,943,000

The Committee recommends \$269,943,000 for the Agency for Healthcare Research and Quality [AHRQ]. The Committee provides these funds through transfers available under section 241 of the Public Health Service Act.

The Agency for Healthcare Research and Quality was established in 1990 to promote improvements in clinical practice and patient outcomes, promote improvements in the financing, organization, and delivery of health care services, and increase access to quality care. AHRQ is the Federal agency charged to produce and disseminate scientific and policy-relevant information about the cost, quality, access, and medical effectiveness of health care. AHRQ provides policymakers, health care professionals, and the public with the information necessary to improve cost effectiveness and appropriateness of health care and to reduce the costs of health care.

HEALTH COSTS, QUALITY, AND OUTCOMES

The Committee provides \$226,593,000 for research on health costs, quality and outcomes [HCQO]. HCQO research activity is focused upon improving clinical practice, improving the health care system's capacity to deliver quality care, and tracking progress toward health goals through monitoring and evaluation.

MEDICAL ERRORS REDUCTION

The Committee has held hearings to explore the factors leading to medical errors which, according to the Institute of Medicine, are responsible for as many as 98,000 deaths each year. This ranks medical errors as the fifth leading cause of death. Aside from the enormous personal cost, medical errors have a substantial economic cost, with estimates ranging as high as \$29,000,000,000 annually. The Committee is troubled by these statistics and directs AHRQ to devote \$50,000,000 to determining ways to reduce medical errors. Funds should be used to develop guideline on the collection of uniform

data related to patient safety, to establish a competitive demonstration program for health care facilities and organizations to test best practices for reducing errors, and to determine ways to improve provider training in order to reduce errors.

State reporting

The Committee instructs AHRQ to support the development of guidance on the collection of uniform data related to patient safety. The guidance should address issues surrounding how providers may report, and how States may collect data. The guidance should also address issues surrounding how States may collect, analyze, and disseminate such data, including guidance to States on appropriate confidentiality rules. In developing this guidance, the Committee urges AHRQ to consult with interested non-government parties, including patients, consumers and health care provider groups. The Committee requests AHRQ to report to Congress on this guidance no later than December 31, 2000.

Health system demos

The Committee encourages the Director to establish a competitive demonstration program for health care facilities and organizations in geographically diverse locations, including rural and urban areas, to determine the causes of medical errors. These projects should use technology, staff training, and other methods to reduce such errors; develop replicable models that minimize the frequency and severity of medical errors; develop mechanisms that encourage reporting, prompt review, and corrective action with respect to medical errors; and develop methods to minimize any additional paperwork burden on health care professionals. Health systems and providers participating in this demonstration program should utilize all available and appropriate technologies to reduce the probability of future medical errors.

To evaluate the best and most effective methods of error reporting and use of the collected data, the Committee urges the Director to ensure that each of the awarded projects examines any one of three types of error reporting parameters: voluntary reporting to the Director by participating health care providers of any adverse or sentinel events, health care-related errors, or medication-related errors; required reporting to the Director by participating health care providers of any adverse or sentinel events, health care-related errors, or medication-related errors; and required reporting to the Director and to the affected patient or family member by participating

health care providers of any adverse or sentinel events, health care-related errors, or medication-related errors.

The Committee believes that the Director must ensure that information reported within this demonstration program remains confidential, and is used only for the purpose of evaluating the ability to reduce errors in the delivery of care.

The Committee further suggests that the Director encourage, as part of the demonstration program, the use of appropriate technologies to reduce medical errors, such as hand-held electronic medication and specimen management systems and prescription pads, training simulators for medical education, bar-coding of prescription drugs, patient bracelets, and automated dispensing of medication in a hospital setting.

The Committee urges the Director to prepare and submit to Congress an interim report concerning the results of this medical error reduction demonstration program within 2 years of the commencement of the projects

Appendix F: Current Members (2010) on the House Appropriations Subcommittees on Labor, Health and Human Services, Education, and Related Agencies

House MAJORITY

David R. Obey (WI), Chair

Nita M. Lowey (NY)

Rosa L. DeLauro (CT)

Jesse L. Jackson, Jr. (IL)

Patrick J. Kennedy (RI)

Lucille Roybal-Allard (CA)

Barbara Lee (CA)

Michael Honda (CA)

Betty McCollum (MN)

Tim Ryan (OH)

James P. Moran (VA)

House MINORITY

Todd Tiahrt (KS), *Ranking Member*

Dennis R. Rehberg (MT)

Rodney Alexander (LA)

Jo Bonner (AL)

Tom Cole (OK)

Jerry Lewis (CA), Ex Officio

Appendix G: Current Members (2010) on the Senate Appropriations Subcommittees on Labor, Health and Human Services, Education, and Related Agencies

Senate MAJORITY

Senator Tom Harkin (IA), *Chair*

Senator Daniel Inouye (HI)

Senator Herb Kohl (WI)

Senator Patty Murray (WA)

Senator Mary Landrieu (LA)

Senator Richard Durbin (IL)

Senator Jack Reed (RI)

Senator Mark Pryor (AR)

Senator Arlen Specter (PA)

Senate MINORITY

Senator Thad Cochran (MS)

Senator Judd Gregg (NH)

Senator Kay Bailey Hutchison (TX)

Senator Richard Shelby (AL)

Senator Lamar Alexander (TN)

Appendix H: AHRQ Funding History Table

Fiscal Year	Total Appropriation
1990	\$98,000,000
1991	\$115,901,000
1992	\$119,788,000
1993	\$128,041,000
1994	\$154,399,000
1995	\$159,386,000
1996	\$125,169,000
1997	\$143,479,000
1998	\$146,510,000
1999	\$170,955,000
2000	\$203,766,686
2001	\$269,796,000 *
2002	\$298,730,000
2003	\$303,695,000
2004	\$303,695,000
2005	\$318,695,000
2006	\$318,695,000
2007	\$318,695,000
2008	\$335,564,00
2009	\$372,053,000

*FY 2001 includes the start of the \$50 million initiative to reduce medical errors

Appendix I: AHRQ's 1999 Reauthorization Act

Below is the general establishment and general duties provisions related to AHRQ's reauthorization bill, known as the *Health Care Research and Quality Act of 1999*.

AHRQ Reauthorization Statute – Part A - Establishment and General Duties

One Hundred Sixth Congress of the United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Wednesday, the sixth day of January, one thousand nine hundred and ninety-nine

An Act to amend title IX of the Public Health Service Act to revise and extend the Agency for Healthcare Policy and Research.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the 'Healthcare Research and Quality Act of 1999'.

SEC. 2. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) IN GENERAL- Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.) is amended to read as follows:

TITLE IX—AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

PART A—ESTABLISHMENT AND GENERAL DUTIES

SEC. 901. MISSION AND DUTIES.

(a) IN GENERAL- There is established within the Public Health Service an agency to be known as the Agency for Healthcare Research and Quality, which shall be headed by a director appointed by the Secretary. The Secretary shall carry out this title acting through the Director.

(b) MISSION- The purpose of the Agency is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health system practices, including the prevention of diseases and other health conditions. The Agency shall promote health care quality improvement by conducting and supporting—

(1) research that develops and presents scientific evidence regarding all aspects of health care, including—

(A) the development and assessment of methods for enhancing patient participation in their own care and for facilitating shared patient-physician decision-making;

(B) the outcomes, effectiveness, and cost-effectiveness of health care practices, including preventive measures and long-term care;

(C) existing and innovative technologies;

(D) the costs and utilization of, and access to health care;

(E) the ways in which health care services are organized, delivered, and financed and the interaction and impact of these factors on the quality of patient care;

(F) methods for measuring quality and strategies for improving quality; and

(G) ways in which patients, consumers, purchasers, and practitioners acquire new information about best practices and health benefits, the determinants and impact of their use of this information;

(2) the synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and

(3) initiatives to advance private and public efforts to improve health care quality.

(c) REQUIREMENTS WITH RESPECT TO RURAL AND INNER-CITY AREAS
AND PRIORITY POPULATIONS-

(1) RESEARCH, EVALUATIONS AND DEMONSTRATION PROJECTS- In carrying out this title, the Director shall conduct and support research and evaluations, and support demonstration projects, with respect to—

(A) the delivery of health care in inner-city areas, and in rural areas (including frontier areas); and

(B) health care for priority populations, which shall include—

(i) low-income groups;

(ii) minority groups;

(iii) women;

(iv) children;

(v) the elderly; and

(vi) individuals with special health care needs, including individuals with disabilities and individuals who need chronic care or end-of-life health care.

(2) **PROCESS TO ENSURE APPROPRIATE RESEARCH-** The Director shall establish a process to ensure that the requirements of paragraph (1) are reflected in the overall portfolio of research conducted and supported by the Agency.

(3) **OFFICE OF PRIORITY POPULATIONS-** The Director shall establish an Office of Priority Populations to assist in carrying out the requirements of paragraph (1).

SEC. 902. GENERAL AUTHORITIES.

(a) **IN GENERAL-** In carrying out section 901(b), the Director shall conduct and support research, evaluations, and training, support demonstration projects, research networks, and multidisciplinary centers, provide technical assistance, and disseminate information on health care and on systems for the delivery of such care, including activities with respect to—

(1) the quality, effectiveness, efficiency, appropriateness and value of health care services;

- (2) quality measurement and improvement;
- (3) the outcomes, cost, cost-effectiveness, and use of health care services and access to such services;
- (4) clinical practice, including primary care and practice-oriented research;
- (5) health care technologies, facilities, and equipment;
- (6) health care costs, productivity, organization, and market forces;
- (7) health promotion and disease prevention, including clinical preventive services;
- (8) health statistics, surveys, database development, and epidemiology; and
- (9) medical liability.

(b) HEALTH SERVICES TRAINING GRANTS-

(1) IN GENERAL- The Director may provide training grants in the field of health services research related to activities authorized under subsection (a), to include pre- and post-doctoral fellowships and training programs, young investigator awards, and other programs and activities as appropriate. In carrying out this subsection, the Director shall make use of funds made available under section 487(d)(3) as well as other appropriated funds.

(2) REQUIREMENTS- In developing priorities for the allocation of training funds under this subsection, the Director shall take into consideration shortages in the number of trained researchers who are addressing health care issues for the priority populations identified in section 901(c)(1)(B) and in addition, shall take into consideration indications of long-term commitment, amongst applicants for training funds, to addressing health care needs of the priority populations.

(c) MULTIDISCIPLINARY CENTERS- The Director may provide financial assistance to assist in meeting the costs of planning and establishing new centers, and operating existing

and new centers, for multidisciplinary health services research, demonstration projects, evaluations, training, and policy analysis with respect to the matters referred to in subsection (a).

(d) RELATION TO CERTAIN AUTHORITIES REGARDING SOCIAL SECURITY- Activities authorized in this section shall be appropriately coordinated with experiments, demonstration projects, and other related activities authorized by the Social Security Act and the Social Security Amendments of 1967. Activities under subsection (a)(2) of this section that affect the programs under titles XVIII, XIX and XXI of the Social Security Act shall be carried out consistent with section 1142 of such Act.

(e) DISCLAIMER- The Agency shall not mandate national standards of clinical practice or quality health care standards. Recommendations resulting from projects funded and published by the Agency shall include a corresponding disclaimer.

(f) RULE OF CONSTRUCTION- Nothing in this section shall be construed to imply that the Agency's role is to mandate a national standard or specific approach to quality measurement and reporting. In research and quality improvement activities, the Agency shall consider a wide range of choices, providers, health care delivery systems, and individual preferences.

(g) ANNUAL REPORT- Beginning with fiscal year 2003, the Director shall annually submit to the Congress a report regarding prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations.

Source: *Healthcare Research and Quality Act of 1999*. Signed into law, December 6, 1999.

<http://www.ahrq.gov/hrqa99a.htm>