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Testimony of Dr. Aaron Carroll, President and CEO, AcademyHealth
Senate Subcommittee on Labor, HHS, Education, and Related Agencies Appropriations
Agency for Healthcare Research and Quality (AHRQ)
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Chairwoman Capito and Ranking Member Baldwin, thank you for this opportunity to offer testimony regarding funding for federal agencies that support health services research and health data, including the Agency for Healthcare Research and Quality (AHRQ). I am Dr. Aaron Carroll, President and CEO of AcademyHealth. We advance evidence to inform health policy and practice and represent more than 3,000 health services researchers, health systems and technology leaders, patients, policy analysts, and practitioners.

In FY26, Congress, on a bipartisan and bicameral basis rejected the President's proposal to eliminate AHRQ. That decision was the right one. The Administration has responded by implementing that elimination administratively—over the objection of Congress, in contradiction of statute, and in ways that the Administration's own budget documents misrepresent. As such, our request is not simply for a funding level, but for accountability to the laws passed by Congress.

For FY27, AcademyHealth strongly recommends that this Subcommittee take three actions:

1. Appropriate at least $500 million in budget authority for AHRQ and keep the Agency intact, independent, and operating effectively to fulfill its statutory responsibilities.
2. Include the strongest enforceable language requiring that AHRQ be fully staffed with clear instructions that positions eliminated in the FY25 reductions in force may be refilled, and that acting assignments may be made where necessary to execute the Agency's mission and statutory functions.
3. Conduct active oversight to ensure that appropriated funds are obligated as Congress directs, and that the Agency is permitted to award and manage grants and contracts, execute interagency agreements, and operate statutorily authorized programs.

This request reflects a broad coalition view. AcademyHealth was proud to join more than 260 health organizations—representing research groups, doctors, nurses, hospitals, health systems, payers, universities, and think tanks—in sending a letter to your offices on March 2, 2026, as part of the Friends of AHRQ calling for this funding level and priority.

What Is at Stake: A Documented Return on Investment
Before describing the current crisis, it is important to establish what AHRQ has delivered for the money this Subcommittee has appropriated over the years. AHRQ-funded research on reducing hospital-acquired conditions prevented an estimated 20,500 deaths and saved $7.7 billion in health care costs between 2014 and 2017. On a base appropriation of roughly $300 million per year, that represents a return of more than $25 saved for every dollar invested. This is the enterprise the Administration is dismantling.

No Other Federal Agency Performs This Function
It is important for this Subcommittee to understand what would be lost if AHRQ is eliminated. NIH studies diseases. AHRQ studies how health care is delivered. These are different missions. NIH can tell us that a treatment works in a clinical trial. AHRQ tells us whether that treatment reaches patients in a rural hospital, whether it is implemented safely, what it costs, and whether a critical access hospital in a rural county can actually use it. No other federal agency performs this function. Eliminating AHRQ does not transfer these capabilities elsewhere. It simply ends them.

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This is not a theoretical concern. AHRQ provides the foundational evidence for clinical practice guidelines used across the health system. It supports the U.S. Preventive Services Task Force (USPSTF). Its Evidence-Based Practice Centers (EPCs) translate research into the protocols that hospitals and clinicians rely on. It develops quality improvement tools such as the Comprehensive Unit-based Safety Program (CUSP) and TeamSTEPPS®, which reduce errors in clinical settings. The Division of Practice Improvement offers targeted assistance to integrate best practices, such as in Medication-Assisted Treatment (MAT) for opioid use disorder, and facilitates the adoption of evidence-based interventions, such as through its EvidenceNOW model. Additionally, the agency houses the Healthcare Cost and Utilization Project (HCUP), the nation's most comprehensive source of hospital data, and the Medical Expenditure Panel Survey (MEPS), which tracks how Americans use and pay for health care. These are not duplicative functions. They are the quiet infrastructure on which much of American health care quality and safety depends.

The Administration Is Implementing Elimination Without Congressional Authorization

The President's FY27 budget, for the second consecutive year, proposes to eliminate AHRQ and absorb its surviving functions into a proposed "Office of Strategy." We urge this Subcommittee to reject that proposal again. But the larger problem is that the Administration has not waited for congressional authorization. It has been implementing the elimination for more than a year.

AHRQ has not awarded a single new grant since April 2025. An estimated $80 million in FY25 appropriated research funding was allowed to expire unused—a pattern consistent with the Government Accountability Office's ongoing impoundment investigation. In FY26, the agency has not funded any of the noncompetitive continuing grants it is statutorily obligated to pay. The FY27 congressional justification now explicitly states a policy of "no new grants," ending AHRQ's four-decade role as the nation's primary funder of health services research—a decision Congress never authorized.

The staffing reality is equally stark. It has been reported that nearly all AHRQ staff have been removed from the Agency. Reporting indicates fewer than 90 employees remain, almost all in programmatic roles, with the agency's entire contracting, grants management, and communications workforce eliminated in the FY25 reduction in force. Remaining staff have been forced to teach themselves administrative functions to keep essential operations running. We are aware of reports that the reduction-in-force rules are being interpreted to prevent the agency from rehiring into eliminated positions at all—meaning that even if this Subcommittee appropriates the funds to restore grants management capacity, the agency may claim to be barred from hiring the people to do the work. Enforceable and clear statutory language will be necessary to override that interpretation.

The Administration's own budget documents cannot reconcile what has happened. The FY27 budget appendix reports 251 full-time employees at AHRQ—a figure that bears no resemblance to the actual workforce. The stated size of the proposed cut varies across documents: $106 million, $116 million, and $129 million all appear in different tables. The congressional justification attributes ongoing AHRQ accomplishments—HCUP data releases, patient safety toolkits, USPSTF recommendations—to an "Office of Strategy" that has no authorizing legislation, no appropriation, and, based on all available information, no organizational existence. This is not a serious reorganization proposal. It is the elimination of a functioning agency dressed in the language of consolidation.

The consequences are visible across the research community. Hundreds of research programs across the country—studying nursing home care, hospital-acquired infection prevention, rural health outcomes, and more—have stopped or laid off staff. Grants that remain technically open have no federal program officers actively managing them. Grantees have been unable to get answers to basic questions because the staff who would answer them no longer work at the agency. This is a dismantling of America's health

services research enterprise, and every month the situation continues, more of that enterprise becomes unrecoverable.

The Window for Action Is Closing
I want to be direct with you about timing. The remaining AHRQ workforce won't stay in a broken Agency forever. Whatever this Subcommittee does, it must do before the last institutional capacity walks out the door. Restoring full funding would not, by itself, restore the agency. Rebuilding grants management, contracting, and communications capacity would take years even under favorable conditions. Some functions, such as the Health Care Extension Service, have lost all the staff who knew how to run them and would need to be rebuilt from the ground up. The longer the current situation continues, the more capability becomes unrecoverable.

This is why the staffing language and oversight components of our request are not secondary to the funding level. They are the mechanism by which a funding decision becomes a real outcome. Appropriation alone will not restore the agency. We have seen over the past year that funds can be left unspent and impounded, that grants can go unawarded, and that statutory programs can be allowed to wither without consequence. FY27 must close those gaps.

Priority Area: Rural Health Care
Rural America has been hit hardest by the opioid crisis, and AHRQ research is helping rural providers respond. While medication-assisted treatment is the evidence-based standard of care for opioid use disorder, many rural doctors and health systems lack access to the training and support needed to offer it. AHRQ has funded and disseminated the practical tools, education programs, and implementation models that bring MAT into rural primary care practices, emergency departments, and community health centers, reaching clinicians no other federal agency is positioned to support. The Agency has pioneered projects and programs dedicated to understanding telehealth and its place in improving rural patients' health, a critical investment for patients who do not live near major medical centers.

By law, AHRQ designates rural patients as a priority population. As rural hospitals close, AHRQ is the only federal agency developing evidence rural providers can actually use. If AHRQ is eliminated, rural hospitals lose their only federal partner whose mission is to study how care is delivered in their settings.

Priority Area: Telehealth
AHRQ-funded research has produced findings that should directly inform this Subcommittee's decisions on telehealth policy. Studies funded by the agency have shown that primary care telemedicine visits, when properly structured, produce follow-up and treatment outcomes comparable to in-person care. For rural families, pediatric tele-physiatry programs reduced travel burden and family costs while maintaining care quality. At the same time, the research reveals that patients with limited English proficiency are significantly less likely to access video telehealth, a disparity that will widen if coverage policies expand without safeguards.

These are the kinds of actionable evidence that payers, health systems, and Congress need to make sound telehealth policy—and they exist only because AHRQ funded them. Telehealth is now a permanent feature of American health care, and the questions before Congress about what to cover, how to pay for it, and how to ensure quality and safety all depend on the kind of independent, real-world evidence only AHRQ produces. AHRQ is the scientific leader in understanding what training health care professionals and patients need to use telehealth properly (including for mental health), which workforce configurations work best, which types of in-patient visits transfer effectively to virtual care and for which patients, and how changes in payment policy affect the sustainability of telehealth and the health systems that rely on it. Eliminate AHRQ, and Congress makes those decisions without that evidence.

Priority Area: High-Value Care Delivery
AHRQ turns research evidence into measurable improvements in care and measurable savings. Through its EvidenceNOW model, the agency provided quality improvement support to 1,278 small and medium-sized primary care practices serving roughly 4 million patients. This initiative reduced the 10-year atherosclerotic cardiovascular disease risk for high-risk patients—projected to prevent 3,200 heart attacks and strokes and save approximately $150 million in direct medical costs over the next decade.

This is what high-value care looks like: a federal investment that reaches small clinics, changes how they care for patients, and delivers a return measured in both lives and dollars. AHRQ produces this value because it is the only federal agency that does both halves of the work—collecting the data that reveal where the system is failing through HCUP and MEPS, and translating that evidence into the tools and training providers can actually use. Eliminate AHRQ, and this end-to-end capability ends with it.

As additional examples, AHRQ improves access to quality and evidence-based care by for patients by:

- **Collecting and analyzing data to drive evidence-based policymaking.** AHRQ collects data on healthcare disparities, outcomes, and access to care, all of which aid in identifying where inequities exist and whether they decrease over time. Specific data projects managed by AHRQ include the Healthcare Cost and Utilization Project (HCUP), which is the nation's most comprehensive source of hospital data and the Medical Expenditure Panel Survey (MEPS), which is a set of surveys of families, individuals, medical providers, and employers on health status, use of medical care, charges, insurance coverage, and patient satisfaction.
- **Promoting appropriate research and effective dissemination of findings.** AHRQ specializes in disseminating and implementing research, including extramural research grants. The Agency creates online resources, such as interactive data tools, research briefs, and fact sheets, to disseminate its findings and make them more accessible to healthcare providers, policymakers, and patients. Additionally, AHRQ collaborates with a wide variety of partners at all levels of government, including clinicians and health systems, patient organizations, and others, to disseminate its findings and provide technical assistance in implementation.

Conclusion
The accomplishments described above—the lives saved, the billions in costs avoided, the evidence that makes our health system safer—would not be possible without the leadership and support of this Subcommittee. Those accomplishments are now at serious risk. Every month that AHRQ remains unable to fund research, manage its existing grants, and execute its statutory programs, the damage compounds. Every month, more experienced staff leave. Every month, more of the agency's institutional knowledge becomes unrecoverable.

On behalf of AcademyHealth and the broader health services research community, we respectfully ask this Subcommittee to take the three actions outlined at the start of this testimony: appropriate not less than $500 million for AHRQ in FY27; include the strongest enforceable language ensuring the Agency can be fully staffed and that previously eliminated positions can be refilled; and conduct the active oversight necessary to ensure that what Congress appropriates is what the Agency actually receives and is actually permitted to spend.

The patients who depend on this research cannot afford to wait. Neither can the researchers, clinicians, and health systems that depend on AHRQ's work to improve the care they deliver. And neither, respectfully, can this Subcommittee afford to have its prior decision quietly reversed through administrative action.

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