LETTERS TO THE EDITOR

Average National Payments

To the Editor—A recent article in Value in Health about the direct cost of rheumatoid arthritis used the St. Anthony's DRG Guidebook as a reference for average national payments of hospitalizations classified according to diagnosis-related groups (DRGs) [1,2]. St. Anthony's Guidebook does provide a list of DRGs with a corresponding column called "Average National Payment." This average national payment is calculated using an average hospital Medicare base rate of $4100 in the 1998 edition. However, we have contacted St. Anthony Publishing to learn how the base rate was derived. We were informed that the base rate was not derived from nationally representative data and that it was not intended for research purposes.

An alternative source of cost information is the DRG Guide prepared by the MEDSTAT® Group [3]. It consists of a table with results from their Marketscan® database of health care claims paid by a privately insured population of approximately seven million individuals. The average cost per DRG in their guide represents the total amount paid for both hospital and professional services throughout the admission. The MEDSTAT DRG Guide numbers differ substantially from those of the St. Anthony's Guidebook. For example, the cost per case of DRG 122 (circulatory disorders with acute myocardial infarction, without cardiovascular complications, discharged alive) is $11,262.00 in the MEDSTAT 1998 guide, but only $4692.86 in the St. Anthony's 1998 guide. The MEDSTAT DRG Guide has been cited in the literature before, when it was used in a cost-effectiveness study of statin therapy published in Circulation [4].

The exact appropriateness of the MEDSTAT DRG Guide depends on the specific question being researched. However, for the direct costs of rheumatoid arthritis it may have been more suitable than the St. Anthony's Guidebook, and it may have led to higher reported costs. In future editions, the publishers of the St. Anthony's Guidebook should provide more information on the nature of their average national payment.—Pablo Lapuerta, MD, and Teresa Simon, MPH, Pharmaceutical Research Institute, Bristol-Myers Squibb.

References

1 Ward M, Javitz HS, Yelin EH. The direct cost of rheumatoid arthritis. Value Health 2000;3:243–52.
2 Schmidt K, Culbertson K, Swann KL, eds. St. Anthony's DRG Guidebook (1998 Edition). Reston, Virginia: St. Anthony Publishing, 1997.
3 The MEDSTAT Group. DRG Guide. (1998 Edition). Ann Arbor, Michigan: The MEDSTAT Group, 1998.
4 Pedersen TR, Kjekshus J, Berg K, et al. Cholesterol lowering and the use of healthcare resources: results of the Scandinavian Simvastatin Survival Study. Circulation 1996;93:1796–1802.

In Reply—Dr Lapuerta and Ms. Simon are correct in pointing out that private sector reimbursement rates for hospitalizations are higher than Medicare reimbursements. In fact, there has been considerable lobbying of Congress to increase Medicare reimbursements for hospitalizations, which many hospitals believe have fallen below the cost of service provision.

In our original analyses, we did compute hospitalization costs using 1994 MEDSTAT rates. Using these private sector rates would have increased the incremental hospitalization cost of RA from US$441 million to US$1018 million. Given that some proportion of the population of RA patients requiring hospitalization will be covered by Medicare and some by private insurance, the actual national reimbursement will be somewhere between these two figures.

However, for this paper, we considered it critical to use a consistent set of reimbursement rates across both inpatient and outpatient care (Medicare reimbursement rates) rather than mix private- and public-sector rates. Readers should note that for the paper we analyzed HCFA data to compute the average reimbursement rate for physician, laboratory, and other services (Medicare Part B) for each DRG and added these to the DRG facility reimbursement rate reported by St. Anthony's Guidebook.

We have also been aware for some time of the methodological limitations of using St. Anthony's estimates of Medicare reimbursement rates, which (on the basis of our discussions with them) appear to be derived by substituting estimated average

hospital parameters into the HCFA-supplied software for calculating hospital reimbursement rates. However, the extent to which the derived estimates are nationally representative is unknown. It would be a significant service to the pharmacoeconomic community if HCFA or some other entity with access to recent Medicare data files (containing actual dates of service necessary to accurately link inpatient physician services with hospitalization episodes) for nonpublic use would calculate the total reimbursements for hospitalization episodes by DRG (including costs for physician inpatient services and any patient deductibles and copayments) and publish those findings.—Marcia M. Ward, PhD, Harold S. Javitz, PhD, and Edward H. Yelin, PhD.