In 1983, with the Federal Government’s adoption of diagnostic related groups as a basic reimbursement methodology the hospital industry and clinical laboratories of the United States were highly impacted. This change has created some traumatic impacts upon management philosophy within the hospital and has caused the laboratory to be viewed as a different type of operating entity. The hospital clinical laboratory has reacted by adapting and substantially altering its production and management philosophy and approach.

Key among these changes has been a much higher level of competition by the commercial laboratories for physician office referral testing. The independent laboratories of the nation have faced a number of dynamic changes. Among them was realignment of the major commercial interest owning the laboratories, a highly competitive entrance into the marketplace of hospital laboratories seeking out patient work, and finally the challenge of aggressive marketing of new technologies which created high levels of cost benefit for the physician office laboratories.

These factors have caused substantial realignment in the independent clinical laboratory field and create an entirely different world for the professionals operating these organizations.

Technological advancement, both in hard scientific techniques and information technology, an increasing appetite for economy in insurance coverages and appropriateness of medical treatment have all caused a reduction in overall demand for laboratory work, despite a technological trend in which new testing provides broad areas of more precise medical information than has ever been available before. I shall attempt then, in this presentation, to highlight the major forces causing the organizational changes and provide a snapshot of the clinical laboratory both as it exists in hospital and independent environment today and present several thoughts with regard to future trends which will dictate the strategies necessary for maintenance, expansion and general improvement of the clinical laboratory.

Diagnostic related group reimbursement was originally adopted by the Congress of the United States in 1983 as a method to drastically curtail the payment levels of the Medicare program which covers the aged of the
United States. The technique was adopted because of the achievements of similar programs in four state environments over the previous five years. It should be noted that reimbursement by diagnosis was hardly a new theory. Its foundations can be found in European systems that date back to the 1930's. In the course of medical economics, various government and private experiments have attempted to link payment with diagnosis every four of five years, somewhere in the world. Certainly, the imposition of the methodology for the reimbursement of the large number of Medicare recipients in the U.S. was the largest, direct application of the theory and it has had profound impact.

Prior to this methodology hospitals were basically reimbursed by reviewing their actual cost. This type of reimbursement was started in the 30's by the Blue Cross plans of the U.S. Though commercial coverage and private payment created a reason for the hospitals to continue to have a system of charges for each service, the expansion of the Blue Cross program, the addition of Medicare in 1966, and the growth of a number of new type HMO and PRO organizations in the U.S. all prompted more concentration on cost reporting, cost analysis and cost reimbursement. Though the American hospital system is generally dominated by a not-for-profit institution, all of the cost systems generally allowed some level of "cost plus" reimbursement.

At the time of adoption, the projected funding for the Medicare program was inadequate to actuarily support its long run existence. The cost of health care was virtually increasing at twice the rate of other costs in the national economy and Congress, as well as the private sector, was frantically seeking a solution that would halt this escalation.

As a practical matter, hospitals started to work under the yoke of three reimbursement methodologies. There still was enough commercial reimbursement and private payers to require the maintenance of the system of charges. Though the federal government moved swiftly into the DRG payment methodologies, the Blue plans and many developing HMOs essentially stayed with the older cost reimbursement methodologies. The DRG system was implemented using historic costs as they could be apportioned across hospital departments and generally related to the mix of DRG patients the institution had historically treated. It's important to understand that a good deal of the inaccuracy that developed was because DRG coding system was not standardized as a medical diagnostic system. In many cases it had overlaps and in other areas it had insufficient codes. Hence, reclassifying cases into the DRG matrix for evaluation of their previous cost to the hospital was at best a nebulous process.

Also key to interpreting what has happened in a managerial sense, to clinical laboratories, is understanding that the DRG system also had the effect of providing an incentive to administrations. It said, in essence, that any amount of money that can be saved by altering the method of delivery of laboratory services to the hospital could be kept, since the DRG payment would continue to be adjusted by a mix of national, regional and local cost factors. In short, the previous year's cost did not become the standard by which the next year's reimbursement was determined at least by the major governmental program. This provided some profound shifts in the administration's economic philosophy in a majority of the hospitals.

In retrospect, the nation's hospitals have had greater prosperity under the DRG reimbursement system than ever before recorded. The completion of their fiscal years in both 1985 and 1986 demonstrated much higher numbers of institutions with greater operating reserves and improved financial results. One must finally realize that the threat of the DRG reimbursement caused a substantial management re-thinking by the