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To Whom It May Concern:

I am writing to apprise you of an extremely troubling development in health care spending, which could add up to **\$1.7 billion** to the nation's cost of healthcare.

None of this \$1.7 billion would improve patient care or enhance the delivery of medicine in any way. It would, however, enhance the income statements of certain companies by approximately \$345,000 per hospital (or Integrated Delivery Network) they contract with.

Ironically, this cottage industry has sprung up to address the increasing administrative burden of complying with requirements from several federal agencies¹ regarding the credentialing of Health Care Industry Representatives (HCIRs) and their employers.

Hospitals are under increasing pressure to comply with these guidelines and regulations. In an attempt to comply with these demands, many have looked to third-party Credential Verification Organizations (CVOs) to alleviate some of their administrative burden. As a result, these CVOs are populating the healthcare landscape at an alarming rate, with disparate and inconsistent policies for HCIRs and hospital access procedures.

Because the individual HCIR (or his or her employer) pays for the credentialing/access process, the hospitals which contract with a particular CVO have little financial stake in the process initially and without appropriate due diligence often choose to contract with CVO partners who charge up \$250.00 per company, per hospital, *per year*, for information the CVO (often) already has in its database.

CVOs claim that these funds are used to "purchase third party data, perform screening and credentialing..." when in fact most of the information they are compiling comes from free sources (OIG/EPLS), is not required, or is already on file from another hospital.

Assuming the average hospital works with 2,300 vendors², with an average access/credentialing fee of \$150³, across 5,000 acute care hospitals, additional cost engrafted onto the healthcare system could be in excess of \$1.7 billion, *annually*.

For many smaller, independent companies in the health care supply chain, these fees will lead some to ruinous results—possible financial demise. The companies that *do* decide to pay these fees in order to gain access to their hospital customers have little recourse but to pass the cost of these fees on to the hospital via price increases, contributing to the \$1.7 billion increase in spending mentioned above.

The Independent Medical Distributors Association (IMDA) is a non-profit association of privately-owned medical specialty dealers. The annual sales of more than half of our 58 members are less than \$5 million, but this number belies our importance to the health care marketplace.

¹ Department of Health and Human Services Office of the Inspector General and the General Services Administration Excluded Party List. JCAHO has no current standard for credentialing HCIRs, but has indicated that it intends to publish a standard in early 2009.

² www.vendormate.com

³ *ibid*

IMDA's role in the healthcare marketplace is to bring innovative medical technologies to hospitals. Its members represent the medical manufacturer that cannot afford, or chooses not to employ, a direct sales force. Hundreds of the innovations we have introduced for these companies have evolved to "standard of care". Examples include pulse oximetry (Nellcor), closed tracheal suctioning (Ballard), non-invasive ventilation (Respironics), multi-lumen catheters (Arrow International), orthopedic implants (Howmedica), and mechanical heart valves (St. Jude Medical), just to name a few.

The advanced and cost saving technologies of these companies would have had no access in the health care marketplace if it weren't for independent sales organizations like those of our members. Patient safety and outcomes would suffer if it were not for their every day presence in our hospitals.

The HCIRs who are employed by our members serve as valuable resources to clinicians in the environment of care, by virtue of their training, education, knowledge and expertise. They provide a variety of services and functions within the hospital, from sharing product and technical information to providing education and training for staff.

IMDA recognizes the need for and value of HCIR credentialing. However, we urge that vendor credentialing standards be developed on a universal basis, so that all parties involved in what is now a credentialing morass can develop far less costly and more consistent standards.

To that end, we propose the following position statements:

- the first reflects what we deem to be appropriate and reasonable requests for credentials, based on collaboration with industry groups such as AORN, AdvaMed, SMI and ACS;
- the second reflects the attributes that a financially sound, secure and ethical CVO should commit to in order to be considered as a potential partner by a hospital.

HCIRs should be able to access health care providers regardless of their company's size. Inconsistent application and practices regarding vendor access can lead to liability concerns, health and safety issues, and compliance issues among health care facilities, health care employees, supply chain partners and patients.

Our intent with this document is to provide insight to decision makers in the industry so that together we can minimize the expense and bureaucracy of vendor credentialing. We should address the fundamental purpose and intent of vendor credentialing and not be complicit in the creation of niche business models.

Thank you for your time and consideration.

Very truly yours,

Shawn Walker
President, IMDA