



Hosted by the Digital Medicine Society and the American Telemedicine Association, IMPACT is a pre-competitive collaboration of leading digital health companies, investors, payers, and consultants dedicated to supporting virtual first care (V1C) organizations and their commitment to patient-centric care.

Terms used throughout this resource are defined in the [Glossary of Terms](#).

Contract Exhibit: Statement of Work

This exhibit contains all of the project-specific details of the two party's work together on a particular engagement. Because there is so much content in the workplan that is unique to V1C, we've broken this one exhibit down even further into parts, including:

- [Definition of Services](#)
- [Outreach](#)
- [Eligibility Verification](#)
- [Pricing](#)
- [Coding \(if applicable\)](#)
- [Referrals Outside of the V1C Solution](#)
- [Program Participation & Outcomes](#)
- [Program Evaluation](#)

SOW - Definition of Services

This section on the statement of work (SOW) describes the details of the V1C solution being deployed in the project, including the [components that comprise the V1C solution](#).

V1C CONSIDERATION: **Definition of Services**

This section may include:

- Delineation between services offered, where multiple offerings or service lines will be included.
- Details of how the service will work for a participant and what the participant experience will be on the V1C service (by service line, if applicable).

- Any exclusions from the scope of the service offering, such as a V1C service that provides prescribing, but where cost of the drug itself is not included.
- Details on any common medications or procedures that may be prescribed or performed by the V1C solution that are expected to require prior authorization.
- Any customized configurations or implementation planning that will be required.
- Project-specific plans for use of name or brand are contemplated.
- Service Level Agreements (SLAs) where a SLA is a selling point/key feature of the V1C solution. If an SLA is not a key feature of the V1C solution, the same expectations of service level performance applied to brick-and-mortar healthcare should be applied here.
- Commitments around milestones or stage gates and associated timelines.

Transfer of Care Obligations should also be covered in this section. This includes:

- Provisions around V1C services transferring patients to brick-and-mortar facilities for care that cannot be administered virtually.
- Where the V1C service is contracted to provide for an episode of care, how V1C services will transfer participants back to their originating care setting.
- All contracts should include terms around timelines for V1C service transition period for care for a participant who is no longer a covered member by the payer. The number of days of care coverage and any other terms around the transition of care and this time period. Costs related to this transition period should be outlined in the [Contract Exhibit: SOW - Pricing](#) section of the SOW.

..... Phase 1> Phase 2>
Define end of agreement as time or number of members on service	[no timing-specific implications for content are suggested in this phase]
State as much as is known about plans for timing and structure of SOW for Phase 2	

SOW - Outreach

This section of the SOW covers how outreach to payer plan members will be conducted. It should exclude outreach data, as this is defined in the [Contract Exhibit: Data](#) section.

V1C CONSIDERATION: **Outreach**

This section should include:

- What channels (email, mail, phone, text messages, etc.) may be appropriate?
- Who will be initiating the outreach: Will payers contact their members or will V1C service be provided a list to conduct outreach?
 - Determining who will be doing the outreach is important and the decision hinges on a few key factors: what the payer review process is for promotion communications to members, payer requirements around security and verification, and what rules apply to the data being used (Health Insurance Portability and Accountability Act (HIPAA), state privacy law, Federal Trade Commission (FTC), etc.) as well as company preferences of each party. Further, when outreach methods to be used are also regulated by FTC and The Federal Communications Commission (FCC), for example robo-calls or SMS/Texting, the parties should agree on how provisions in those laws around health care apply to the relevant activity and which entity will be responsible for compliance.
- Who will be responsible for crafting outreach messages?
- What is the timeline and cadence for messaging?
- Training plans to support promotion of the V1C service to qualified members at the outset and over time. Training should occur at the payer (i.e. customer service, sales), as well as for third-party partners of the payer’s plan, such as primary care and navigation players on the V1C service offering to ensure “front doors” where the member may first inquire about covered services are educated and equipped to share V1C services with plan members. Training and education plans should also be specified for other V1C services that may refer to the contracting V1C service, as well as brick-and-mortar providers who may refer to the V1C solution.

IDEAL ★★★	TO AVOID ☆☆☆
Messaging and deployment should follow outreach and email tracking best practices to ensure effective messaging and embedded tracking	Not planning for any active outreach — people won’t find these solutions on their own without some promotion
Enable traffic from all channels (referrals, physician directory listing in all applicable zip codes, third-party partners, etc.) to V1C solution	Payer outreach team drafting outreach without V1C input/guidance
Define payer and V1C service promotion	

review processes required to approve member outreach, including timelines and SLAs

If V1C service is doing outreach:

IDEAL ★★★	ACCEPTABLE ★★★☆	TO AVOID ☆☆☆
<p>V1C getting promotion data conventionally requires business associate agreement (BAA) (when it is seen as Treatment, Payment, or Operations (TPO) of the payer, not TPO of the V1C)</p> <p>Clarify responsibilities of each party (generally) — who is responsible for testing, approvals, and frequency of meeting to monitor/revisit</p>	<p>Co-branding of outreach with V1C messaging templates that include space for payer logo</p>	<p>Payer request for complete white labeling payer branding and colors — V1C services need to build brand recognition, and relationship and technical customization is expensive and time consuming</p>

If payer is doing outreach:

ACCEPTABLE ★★★☆

Commitment to bare minimum number of promotion opportunities in a given timeline (to prevent payer blocking outreach which results in less adoption of/revenue for V1C)

SOW - Eligibility Verification

This section of the SOW focuses on verifying eligibility on the payers plan for a potential participant on a V1C service and ongoing eligibility verification over the course of a participant's care. This section does not include how eligibility data is accessed which is contained in the [Contract Exhibit: Data](#) section

V1C CONSIDERATION: Eligibility Verification

This section should include:

- Defining criteria for the eligible population (by service line if applicable).

- Specific data that will be used to determine eligibility.
- The process for determining eligibility over the course of participant engagement with a V1C solution.
- Where applicable, the process for prior authorization, if it is necessary to determine whether a member’s plan covers the cost of the V1C service.

IDEAL ★★★	ACCEPTABLE ★★★☆	TO AVOID ☆☆☆
<p>Real-time member eligibility data access to support ongoing verification provided on HIPAA-covered, payer-managed platform (i.e. via 270/271 or Healthcare Effectiveness Data and Information Set (HEDIS))</p> <p>Provide a clear definition of eligibility: May be based on clinical features, demographic characteristics, existing diagnosis (in codes), referral from another provider, etc.</p> <p>Include whole state in location definitions of eligible population to broaden catchment area/eligible population to match V1C licensure</p>	<p>Flat eligibility file transmitted through a Secure File Transfer Protocol (SFTP) solution, shared monthly to align with billing cycle</p>	<p>One time or less than monthly data transfers of verified member information for eligibility checks — V1C is often longitudinal requiring ongoing member verification</p>

SOW - Pricing

This section of the SOW outlines how the V1C solution will be paid for by the payer and is an exhibit that should be included in every agreement. This does not include specifics on coding for payment which will be handled in [Contract Exhibit: SOW-Coding](#).

Contracting parties can reference the [IMPACT Guide to V1C Payment Models](#) to determine the best fit payment model appropriate for a particular SOW.

V1C CONSIDERATION: Pricing

This section should specify:

- What payment model is being used, cost sharing arrangement (across payer, provider, and member/participation, where applicable), and pricing tiers (where applicable).
- What's included in that payment (e.g. [the components of V1C](#)).
- Billing process to be used (invoice or claims).
- Clear definition of engagement, or what counts as one billable participant typically defined as a particular moment of stage in the V1C process a payer's member will reach to count as billable.
- Performance guarantees, service level guarantees, and cutoffs for performance bonuses/credit (including details on how the payment/credit process will work if goals are hit or missed).
 - Should also include a clear definition of which party is capturing this data and with what process is being monitored, as well as how missing data will be handled in accounting for performance and service levels.
 - If/as a V1C is at sub-risk, specify attribution of costs as well.

IDEAL ★★★	ACCEPTABLE ★★☆	TO AVOID ☆☆☆
<p>Per Participant per Month (PPPM) or Episode of Care model or an alternative payment model that assigns at least some risk and potential upside to the V1C solution</p> <p>Performance guarantee grounded in clinical outcomes and/or literature where possible is tracked by V1C for their own cohort, and informed by a baseline measure derived by the payer. Admissions, discharges, and transfer data may be useful here</p> <p>If V1C has evidence and track record trusted by the payer — phase 1 and</p>	<p>If V1C is less mature and/or payer requires data in their own population before they can go at risk — then phase 1 can be bundled fee-for-service (FFS) with a transition in phase 2 to more shared risk and bonuses/deductions based on performance/service levels</p> <p>In some plans (e.g. high deductible health plan (HDHP) where co-pay is required) providing V1C without a member fee all the time won't be possible</p> <p>Care transition costs</p>	<p>Ill-defined engagement metrics for what counts as participant/dropout, milestones, or pricing tiers has led to confusion and breakdowns around already complex billing processes</p> <p>Inclusion of penalties for under performance without a bonus for success fails to provide appropriate upside for positive outcomes</p> <p>Shared savings models that don't explicitly spell out how savings will be calculated, which is often difficult to do</p> <p>Restricting V1C service</p>

<p>2 should be value based and include bonuses/deductions based on set performance/service levels No charge to the member for participating in the core service</p> <p>Care transition costs are paid for up to 90 days by the payer (unless V1C service breaches contract)</p>	<p>aren't covered by the payer (but V1C service continues to provide continuity until the participant is transitioned)</p>	<p>from offering guidance on what's clinically indicated for the patient. This may result in add-on selling by V1C to the member (e.g. V1C-developed connected device or additional exercise program) and may or may not be a covered cost by the payer</p>
<p>..... <i>Phase 1</i>></p>		<p>..... <i>Phase 2</i>></p>
<p><u>PPPM or Episode of Care</u> bundled payment for services - OR - Uses a payment model that assigns some risk and potential upside to V1C solution</p> <p>Limited to a set period of time/number of participants to generate necessary evidence to support scaling decision in a payer's population</p>		<p>Review value created and adjust payment model based on this information. This could lead to adjusting the existing model or a transition to a capitated/bundled model</p>

SOW - Coding

This section of the SOW outlines how coding to process payments based on claims will be aligned to the payment model selected in the [Contract Exhibit: SOW - Pricing](#). This exhibit should be included in any contract where medical coding and claims are going to be the basis for reimbursement for a V1C solution.

V1C CONSIDERATION: **Coding**

- Determine what types of codes and specific codes will be used for billing. It's important to recognize that not all payers are using all codes, so V1C services may have to partner with a payer in implementation to navigate to alternate codes or get codes added so they can use them.

- RESOURCE: [IMPACT V1C Coding Library](#) has been developed to support selection of optimal types of codes and specific codes that align to a given V1C service.

IDEAL ★★★	TO AVOID ☆☆☆
<p>Identify a set of codes that clearly reflect all services being provided and that can successfully be approved in the claims submission process</p> <p>Coding claims should be submitted via clearinghouse (in-house or 3rd-party familiar with V1C services) to ensure success in the approval process</p> <p>Future state: collaborate with the field on a set of V1C proposed codes that align to the unique components of V1C-specific offerings</p>	<p>Payers using administrative budget to pay for costs that should be coded as medical spend. This practice is prevalent in the per member per month (PMPM) payment model</p> <p>Not using a clearinghouse to submit claims — leads to an increased rate of rejected claims, which results in added work, delays, and expense in the billing process</p>

SOW - Referrals Outside of the V1C Solution

This section of the SOW describes the payers referral preferences for any referrals the V1C service may need to make. This section should be included in any SOW related to a V1C service that does care coordination with other entities.

V1C CONSIDERATION: Referrals Outside of the V1C Solution

This section should specify:

- How second opinion requests should be handled.
- Preferences for how a specific service not being available in-network should be handled.

IDEAL ★★★	ACCEPTABLE ☆☆☆
<p>Define payer preferences for how they want the contracting V1C service to refer to other V1C services, in-network providers, or the most cost-effective resources</p>	<p>Provide access to a broader provider directory</p>

SOW - Program Participation & Outcomes

This section of the SOW relates to the measurement of enrollment, engagement, and health outcomes of V1C service participants. This exhibit should be included in all phases of all contracts.

V1C CONSIDERATION: **Program Participation & Outcomes**

This section should specify:

- Member outcomes that both parties want to track over time, including what will be captured in data files and reports.
- What reports will be shared, on what schedule, to track progress toward target milestones, outcomes, and goals around the V1C service.

IDEAL ★★★

V1C provides a “participation file” (sensitive that protected health information (PHI) may need to be removed depending on the audience e.g. fully insured employers), accompanied by quarterly review calls, to discuss enrollment data, engagement data, and aggregate (not individual) clinical/economic outcomes. Determine V1C schedule for sharing aggregated clinical data and aggregated financial outcomes reporting on a variety of enrollment, engagement, and outcome data (monthly or quarterly and annually) — in select cases weekly reports may be useful and justified

Set cadence for regular check-ins to discuss any trends or changes

Contract Exhibit: SOW - Program Evaluation

This section of the SOW goes beyond the program outcomes to specify the non-clinical outcomes of the project. This may include variables such as cost and member satisfaction. This section specifies what analyses in particular will be conducted, who will conduct the analysis, at what time/participant volume, and the cutoff point for claims to be included. It also specifies any patient consent expected to be required to collect any non-TPO data, if applicable. Finally, this section will also provide detail on what will be published and who is responsible for the publication in a project-specific SOW.

V1C CONSIDERATION: **Program Evaluation**

- Should contemplate consent for select analyses where research conducted required Institutional Review Board (IRB) review. Generally, this includes

participant engagement with added tests, assessments, and activities outside of what would traditionally be required for them to receive care from the V1C service; where individual level data is being reported on or published; or where participant data is being shared externally with a research partner.

- De-identification practices for audiences that are not covered entities should be followed here when sharing and reporting on data .

IDEAL ★★★	ACCEPTABLE ★★☆☆	TO AVOID ☆☆☆
<p>Upfront commitment from both sides to do program evaluation</p> <p>The two parties collaborate on work with a 3rd-party to conduct the data analyses to ensure the most rigor and unbiased analysis</p> <p>V1C service to collect participant satisfaction data</p>	<p>Either party has the right to conduct independent research with any member/participant in V1C</p> <p>Both parties keep one another informed of independent research design and findings</p>	<p>Denying V1C the right to conduct research in their population — should have the same rights as brick-and-mortar providers</p> <p>Payer conducts program research without discussing methodology or assumptions with V1C solution to ensure that their understanding and assumptions about how V1C solution operates and interpretation of the data is accurate</p>

..... Phase 1> Phase 2>
<p>Consider initial pilot evaluation to inform future evaluation plans</p> <p>Include a timeline for finalizing a long term evaluation plan</p>	<p>The program evaluation plan can be more fully determined here to ensure enough time to design a thoughtful approach to and include early learnings from the first phase</p>

QUICK LINKS: [GUIDE TO PAYER - VIRTUAL FIRST CARE \(V1C\) CONTRACTING](#)

[Overview](#)

[Payer-V1C Contract Fundamentals](#)

[How To Use The Guide to Payer-V1C Contracting](#)

[Glossary of Terms](#)

[Contract Body](#)

- [Termination Rights](#)
- [Assignment of Agreement or Obligations](#)
- [Business Associate Agreement](#)
- [Publicity](#)
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[Contract Exhibits](#)

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