

GUIDE TO PAYER – VIRTUAL FIRST CARE (V1C) CONTRACTING

a resource produced by

IMPACT

*Virtual First Medical
Practice Collaboration*

IMPACT, a virtual first care initiative co-hosted by



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About IMPACT

The virtual first Medical Practice Collaboration (“IMPACT”) is the virtual first care (V1C) initiative, co-hosted by the Digital Medicine Society (DiMe) and the American Telemedicine Association (ATA). It is working to expand access to high-quality, evidence-based V1C for patients, healthcare providers (HCPs), and payers to improve clinical and health economic outcomes, enhance access, and provide a better overall patient experience.

IMPACT brings together leading V1C companies, payers, investors, patients, and actuaries in a consortium to support the adoption of V1C. The cross-ecosystem model is a unique enabler for the field, as members jointly identify pain points or opportunities to tackle and work collaboratively to address them by developing action-oriented resources. The results of IMPACT’s work improve processes for administration and adoption of V1C, clinical effectiveness and an enhanced care experience for patients and providers alike.

Scope of the Guide to Payer-V1C Contracting

IMPACT developed this Guide to Payer-V1C Contracting to establish a common baseline for Payer-V1C contracting interactions. This document addresses the current lack of fit-for-purpose approaches to these agreements that incorporate the unique combination of features included in V1C solutions. It details all of the sections traditionally included in a payer-provider contract, and contemplates wraparound services and features that wrap around these providers as components of V1C.

Target Users

IMPACT created this resource for innovators, leaders, and decision makers in V1C companies, and payers who are considering including V1C solutions in their offering.

Within V1C companies, the following audiences will find this resource particularly useful:

- CEOs
- Commercial leads
- Business development functions
- Sales teams
- Legal counsel (internal and external)

At payer organizations, various groups will benefit from this resource:

- Innovation groups charged with piloting and integrating V1C at larger companies
- Chief Medical or Health Officers at smaller regional plans
- Networking
- Procurement officers

- Product teams responsible for contracting and integrating new providers onto the plan
- Legal teams handling contracting with novel V1C solutions

PAYER-V1C CONTRACT FUNDAMENTALS

Foundational to this guide is the definition of V1C solution providers as HCPs. Just because a V1C provider uses software to support care delivery does not make the V1C solution a vendor with a software as services model. V1C solutions are complete solutions that support a person to take all of the necessary steps in their health journey.

Specifically, V1C organizations deliver:

- “Health care” as defined in federal regulations
- Care as a “provider” as defined in federal law, including either:
 - a provider of medical or health services; or
 - any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

V1C solutions are therefore Health Insurance Portability and Accountability Act (HIPAA)-covered entities, with additional implications:

- V1C solution’s own data: as between a payer and any provider, information collected by a V1C solution from individuals who receive care from them as a provider is owned by the V1C and not a payer.
- V1Cs have the same obligations toward their patients as brick-and-mortar providers do.

Throughout this toolkit, you will see references to payers. We define a payer as the person, organization, or entity that sets service rates, collects payment, processes claims, and pays claims associated with healthcare services administered by a provider. Payers include health plans who may represent their own populations or those populations of self-insured employers, as well as government-funded healthcare programs like Medicare and Medicaid.

Depending on the services provided, and the state(s) in which it operates, a V1C organization may follow a number of different organizational models, including separating duties between a professional corporation (PC) that provides health care services to patients, and a Management Services Organization (MSO) that provides support services to the PC. If the V1C entity follows this type of structure, contracts with payers should avoid terms that interfere with the V1C company sharing responsibilities between the entities that make up their offering.

If V1C service has a structure that includes a PC and a MSO, the provider contract is typically between the PC and the payer.

HOW TO USE THE GUIDE TO PAYER-V1C CONTRACTING

This document is organized by the two key parts of a contract:

1. The [Contract Body](#) lists sections routinely included in every contract. Some sections of the body adhere to standard approaches, while others should include language unique to V1C services.
2. The [Contract Exhibits](#) may or may not be applicable to a particular V1C solution, and therefore will be mixed and matched as applicable to a specific relationship. Readers should discern this for themselves.

Note that sections are presented in a logical order, but may be reordered as appropriate for a given agreement. This document should not be considered legal advice. You should seek appropriate counsel for your own situation.

As each section is discussed, contracting practices are denoted as ‘ideal’, ‘acceptable’, and ‘to avoid’ providing end users of these agreements with a spectrum of opportunities and practices to avoid. In specific instances, example text is included as a model for you to consider as you are crafting your own agreements.

Another feature of specific sections that have unique V1C considerations is discussion of Phase 1 and Phase 2 of a collaboration. Recognizing that many new V1C-payer relationships seek to balance risk, the partnership may start small with a goal of generating V1C service data in a given payer population before scaling more broadly.

- Phase 1 recommendations are intended to serve as critical aspects of an agreement that must be in place as the relationship gets started. Phase 1 is usually bound by a specific time period or number of members, and when that bound is reached, both parties can evaluate financial and clinical performance to inform the next phase.
- Phase 2 contemplates a larger, scaled engagement where additional measures and considerations in the contract may be appropriate and adjustments based on value created in Phase 1 may be appropriate. Where differentiation between what might be needed at the outset differs from an agreement to support a fully scaled solution we have noted that.

On the whole, the suggestions included in each phase are recommended but not required — ultimately, what’s right for the relationship will be decided on a case-by-case basis.

Finally, some sections include sample language that refers to a specific point made in that section to model for readers how that section may be crafted in their agreements. Ultimately, this is meant to be a suggestion for consideration, and is not intended as legal advice, or as appropriate for your specific situation.

Throughout this document, providers of V1C are referred to as V1C services. This includes the management groups of V1C companies that are sometimes performing on behalf of themselves and affiliates that comprise their organization (such as one or several medical practices). As discussed above, other V1Cs may be providing services under protocols that do not require a PC for the applicable healthcare professionals.

Individuals who may be eligible for and receive V1C are referenced two ways in this document. A member or plan member refers to an individual who has healthcare coverage through a payer. A participant or V1C participant refers to an individual who has signed up for a V1C service. Members of a health plan who sign up for V1C services are both members and participants — we've tried to use the appropriate language for the setting the individual finds them in throughout (e.g. when outreach is being conducted to invite someone to a V1C service, the outreach is to a plan member; reporting on individuals enrolled in a V1C service is on participants).

Finally, terms that are italicized throughout the document are fully defined in the [Glossary of Terms](#).

CONTRACT BODY

The sections included in the contract body are general governing principles of the provider/payer relationship and should be applicable across multiple statements of work. They are specifically not intended to state details of a particular phase of engagement between the two parties; they are more focused on the setup of the optimal relationship over the duration of interactions. The order that the body sections appear is not intended to be in a recommended order — that decision is up to the end users and contract developers in a particular deal.

The contract body sections should be tailored to the unique aspects of the V1C approach and include language matched to the novel nature of these solutions. Each of the following sections indicate traditional clauses included in that section, as well as additional features that should be included specifically to contemplate V1C.

Contract Body: Termination Rights

This section focuses on how and when each party may end the agreement/services being provided, setting provisions for the Termination Notification Period, Runout Period, and Maintenance of Records/Duty of Care. This section should not include any terms about how data is handled at termination — this is included in [Contract Exhibit: Data](#). Also, project specific transfer of care obligations will be covered in [Contract Exhibit: SOW Definition of Services](#).

V1C CONSIDERATION: Termination Rights

This section should include:

- Any technical differences between provider-only contracts and V1C solutions. For example, what happens to the data the payer has supplied to the V1C if the V1C provider-payer relationship ends.
- Any rights that a payer may need to retain access to V1C solution software beyond the scope of their contract with a V1C provider, if applicable.
- Runout provisions to avoid disruption of care/continuity of care.

..... Phase 1> Phase 2>
[no timing-specific implications for content are suggested in this phase]	In Phase 2, an evergreen clause should be included, allowing for auto-renewal of the agreement. This can be indefinite or a 1-2 year auto-renewal at the end of the contract term

Contract Body: Assignment of Agreement or Obligations

This section sets forth the circumstances under which each party is allowed to assign its obligations to a third-party. The language in this section should be based on that of a traditional provider contract.

V1C CONSIDERATION: Assignment of Agreement or Obligations

This section should include:

- Where the V1C service is the management group and has affiliates (e.g. one or multiple medical practices), the legal concept of the affiliate.
- V1C management group should be given the right to manage performance of obligations across the entire organization, while accounting for the corporate practice of medicine not being one legal entity.

- Language about what happens if either company is acquired, including continuation of the contract obligation without disruption.
- Generally speaking, nothing in this section should be construed as preventing a V1C service from delegating the performance of any element of this agreement to an affiliate (or member of V1C's "medical group").

Contract Body: Business Associate Agreement

Where V1C services and payers are both HIPAA covered entities (as is typically the case) and their interactions and data exchanges fall within the stated HIPAA uses of Treatment, Payment, or Operations (TPO) definition, many contracts won't need a business associate agreement (BAA). However, there are some unique situations where a BAA is necessary — specifically where data is being exchanged between the two parties for a use not related to TPO. Two key moments in the member/participant experience where one or the other party may prefer to use a BAA are:

1. A payer's disclosure to the V1C of a member list so that the V1C can tell individuals they are eligible for a participation in the V1C service; or,
2. Where a payer is sharing a member eligibility list with a V1C solution to enable authorization for coverage of a qualified V1C participant.

Recruitment for a research project needing approval by an Institutional Review Board (IRB) is another instance where a BAA may be required.

In most cases, because the V1C and payer are each operating as a covered entity, using Protected Health Information (PHI) for their own treatment, payment, and operations purposes, a BAA should not be necessary. If a BAA is needed, the parties should justify it by explicitly defining the scope of the activities it covers and providing sound rationale for why it is needed. The BAA itself is typically appended as an exhibit or it is signed as a separate document entirely by the two parties. This section is then included in the contract to state general principles on how that exhibit or standalone document will be integrated into the relationship.

V1C CONSIDERATION: **BAAs**

- If a payer is sharing a promotion or eligibility file with a V1C service, and the V1C is composed of a PC and a MSO, the master contract with the payer typically exists between the V1C PC and the payer, but sometimes is between the V1C MSO and the payer.

- For promotion activities, the MSO typically conducts that activity, and the contract should appropriately contemplate the necessary arrangement (e.g. a BAA may be needed to cover the MSO if the contract is between the V1C, PC, and the payer).
- If this is the case, this section would reference that arrangement.

IDEAL ★★★	ACCEPTABLE ★★★☆
<p>No BAA is needed because the payer and the V1C solution are each covered entities, using and disclosing PHI to each other for treatment, payment and operations purposes</p> <ul style="list-style-type: none"> • Eligibility data is being retained by the payer (with V1C ping the eligibility database as needed) • V1C is conducting outreach to invite a plan member to join their service with messaging that includes features of the solution for a given disease and explicitly does not mention the payer name and coverage of that service by the payer. A provider can <u>legitimately get a list</u> of people from a payer and then do outreach as the provider's TPO [(c)(4)(i)], as part of healthcare operations <p>Select cases where a BAA may be needed and conventionally is in place, include:</p> <ul style="list-style-type: none"> • V1C is conducting outreach that references payer name and coverage of that service by the payer to invite a plan member to join their service • Exchange of data to support program evaluation for purposes outside of TPO (see <u>Data section</u> for more detail on what may qualify here) 	<p>A BAA is needed to cover any promotion activity being conducted by a V1C service</p> <p>A BAA is needed to cover eligibility data being transferred from the payer to the V1C service because no payer exchange exists</p>

..... <i>Phase 1</i>> <i>Phase 2</i>>
BAA as needed for eligibility and promotion	BAA will likely need to be modified if V1C intends to conduct a Return on Investment (ROI) analysis with data disclosed by a payer. This area can be complex depending what member data may be included and who the intended recipient of that payer data is. Per Contract Exhibit: SOW Program Evaluation and Contract Exhibit: Data sections, the parties should fully define the goals of the ROI analysis and then consult with counsel to structure the agreement appropriately.

Contract Body: Publicity

This section focuses on each party's use of the brand and name of the other party, and consists of standard marketing language around rights and obligations that typically require written permission from each party to use the other's likeness.

V1C CONSIDERATION: **Publicity**

An additional clause related to payer's making a concerted effort to make information available related to V1C services and offerings may be appropriate here. It may include examples such as the promotion of the new service, care, access, or additional benefits being offered to the payer's members, customers, employees, defendants, etc. This gives V1C services some assurance and commitment from payers that the adoption of their offering will be supported by their payer counterparts.

Sample Language: "Either party may publicize its relationship with prior written approval from the other party. Either party may also offer the other party as a reference and/or use case to prospective customers and other partners and use the other party's logos and other branding in customer lists, websites, and other materials advertising the other party's use of the Services."

Contract Body: Payment

This section provides the basic term governing how payment will occur between the two parties. A [Guide to V1C Payment Models](#) has been developed as a resource to support V1C companies and payers in determining the best fit payment model for their relationship.

V1C CONSIDERATION: **Payment**

- A V1C service is a provider and should be compensated at a fair payment rate for the services performed that also takes into consideration the ongoing investment necessary to ensure these virtual first platforms are continuously maintained, seamlessly updated, and services can continue to expand as needed.
 - Claims are the preferred mechanism of billing for whatever payment model will be used, enabling claims data to be used in analysis and tracked explicitly.
 - There are some exceptions to the use of claims where invoicing will be necessary (e.g. if contract starts mid plan year).
- In setting payment timelines, payers should be mindful of V1C provider cash flow needs, and should adhere to industry best practices of terms that are payable net 30 (ideal) or net 45-60 (acceptable).

The following sections in the contract body should not deviate significantly from the approach taken when negotiating an agreement with a brick-and mortar provider and so are not covered here:

- Provider Rights and Obligations
- Payer Rights & Obligations
- Liability Indemnification & Risk
- Effective Date
- Applicable State & Local Laws
- This Agreement Supersedes All Prior Agreements
- Force Majeure
- Disclaimer of Waiver of Performance
- Unenforceable Parts of the Agreement (Severability)
- Confidential Information (related to information exchanged about the two parties and businesses themselves. Information exchanged in the specific project the two parties will do together, including data sharing, is handled separately and in [Contract Exhibit: Data](#))

CONTRACT EXHIBITS

Exhibits are meant to support unique aspects of a given payer-V1C relationship. They are meant to apply broadly to the overall relationship between a V1C service and a payer, with the exception of a statement of work (SOW) exhibit which gets into the specific details of a defined engagement (e.g. Phase 1 or Phase 2 of work). As is the case in the body sections, the order that the exhibit sections appear is not intended to be in a prescriptive order — that decision is up to the end users and contract developers in a particular deal.

Contract Exhibit: Data

This exhibit covers what project-related data each party will collect, what data will be shared between parties, file standards for sharing, and security mechanisms in place to protect data. Data sharing is always guided by the question of whether data is being shared for use in TPO of the payer's organization or the V1C service, and therefore whether that data exchange is a part of each party's HIPAA-covered status. Where data is not covered under a party's TPO or where the recipient of participant data is not a HIPAA covered entity (e.g. fully insured employers), additional documentation around appropriate permissions to access, security practices, and other agreements (such as a BAA or patient consent) may be necessary.

Data use is a primary focus of this section. Generally, data use falls into these categories and the contracting parties will need to discuss if and how data will be exchanged in each instance:

Data Type	Data Use	Sample Data Flow
Outreach	To invite members to join a V1C service	Payer copy of member name, email, address, and/or phone will be used by payer for outreach or shared with V1C service to conduct outreach. Data sharing with V1C solution ideally excludes member numbers for security purposes. This data may be collected again by a V1C service in the onboarding process.
Member Eligibility	To support ongoing checks of member eligibility for coverage of care by the payer at the start and for the duration of an individuals participation on a V1C service	Payer houses member name, number, and eligibility status. Data is made available to V1C service either through a platform that can be accessed by V1C service to determine real time eligibility (through a 270 ping) or through a

		monthly eligibility report transmitted to the V1C service. Data on the result of the eligibility check (271 response) is owned by the V1C service, as it is with any provider.
Program Delivery	To support care coordination and payer benefit personalization	Payers may share claims data and other clinical information they store about V1C participant-related medical care provided outside of a V1C solution. V1C services store PHI in their Electronic Health Record (EHR), including clinical, test results or other information about a participant and the care being provided by the V1C service.
Program Participation & Outcomes	To measure enrollment, engagement, and health outcomes	Payers may share claims data and other clinical information about a V1C participant related to medical care provided outside of a V1C solution as part of program outcome analyses. V1C services may share enrollment data, EHR data (de-identified as required by the HIPAA coverage status of the receiving entity), and engagement data. Sharing of this data doesn't change ownership of PHI or proprietary nature of the data.
Program Evaluation	To measure non-clinical outcome variables of V1C performance, such as costs and member satisfaction	Payers may share claims data or member satisfaction data. V1C services may share EHR data, participant engagement, or satisfaction data. Again, ownership resides with the originating party and any publication or Intellectual Property (IP) would be assigned according to data originating from a single party or shared by both parties. Identifiability of data disclosed is defined by HIPAA rules.

Where data will be exchanged, how it will be shared, what the rights are of each party to use another party's data, and data security requirements will all be covered in this section. Finally, this section will include agreements on continuity of TPO data availability following contract termination.

V1C CONSIDERATION: **Data**

Since both parties are covered entities, [requests for data sharing](#) from both parties should be respected where that data (including PHI) is deemed necessary and appropriate for the conduct of each of their TPO, consistent with:

- Guidance from Office for Civil Rights (OCR) on [exchange of PHI for the other party's health care operations](#), and
- The Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) [rules and standards for exchange](#) (for example, the data available in the U. S. Core Data for Interoperability standards for certified EHRs and to payers).
V1C owns payer member data generated on their platform since V1C platform is a medical record and the provider is obligated to own and manage that.

IDEAL ★★★	TO AVOID ☆☆☆
General	
Security requirements should follow traditional provider security expectations — System and Organization Control (SOC) 2 Type II Report or HITRUST should suffice for non-TPO data	Additional security requirements mandated by payer beyond SOC 2 and HITRUST — exposure to member information is low and given V1C is a covered entity they should be trusted
Agreements and projects should proceed if V1C service is still in process of obtaining security certifications, as long as good faith effort and progress are being made	Requests/requirements to provide a SOC 1 (either Type I or Type II) report. A SOC 1 is related to financial controls for publicly traded companies. Unless a V1C service is part of a publicly traded company, this should not be required
Usage of Fast Healthcare Interoperability Resources (FHIR) standards for seamless Application Programming Interface (API) integration	Payer ownership of V1C data — V1Cs are providers and like all doctor's offices, and therefore are the "owner" of all data acquired from patients and stored in EMR upon establishing a care relationship. (Payer retains ownership of marketing data since this is prior to establishment of care relationship.)
	Data blocking — data should be allowed to flow bi-directionally when legitimate TPO justification exists
Program Evaluation	
Where the V1C-payer is undertaking activities that are primarily intended to	Arbitrary assumption that consent is/is not needed. OCR/ONC fact sheet on

<p>contribute to general knowledge, beyond TPO, routine treatment, and internal use of V1C service data for analyses, consent from V1C participants for research uses of data will be needed. Examples include where activities, tests, and assessments in addition to the routine care provided by a V1C solution are being asked of patients to support research goals; engaging external parties (such as researchers, or research institutions) to conduct studies, etc.</p>	<p>exchange of data, and the OCR FAQ on what research is should be considered</p>
<p>..... <i>Phase 1</i>></p> <p>If vision for phase 2 is that the V1C service is performing non-TPO activities, include details for initiating necessary security assessments and processes to setup phase 2</p>	<p>..... <i>Phase 2</i>></p> <p>If V1C service is performing non-TPO activities, SOC 2/HITRUST security assessment in process or completed should be contemplated</p>

Contract Exhibit: Subcontractors

This exhibit focuses on subcontractors and should be included where the contracting entity has subcontractors involved in the delivery of their work. This section then details how those subcontractors will be selected, qualified for their roles, and what their responsibilities will be.

V1C CONSIDERATION: **Subcontractors**

Subcontractors of V1C solutions generally fall into three categories. Depending on which kinds of functions will be served by subcontractors, inclusion of one or several of these sections may be appropriate.

- Consultants or gig workers who may be on a 1099 (independent workers who receive non-employment income). For these individuals, contracts may specify required workforce controls such as background checks or verification of required licensure.

- Vendors and other service providers such as technology companies, cloud service providers, data processors, or other third-parties that support functions of the V1C (especially technology function). These subcontractors are the V1C's business associates, and the V1C should have BAAs in place with them. Contracts may specify requirements around liability insurance.
- If the V1C solution operates as a PC and affiliated MSO that entity should be referenced here. It is the V1C PC's responsibility to ensure that this contract does not interfere with the MSO being able to perform necessary functions.

TO AVOID ☆☆☆

Payer approval for subcontractors — HIPAA-covered entities should be trusted to select and perform their duties without payer approval

Strict BAA pass-thrus. V1C's often have minimal ability to negotiate changes to service provider BAAs (especially BAAs from large cloud service providers)

Contract Exhibit: Credentialing & Verification of Certification and Licenses

This exhibit pertains to V1C solutions that include medical professionals who are formally credentialed, and/or care team members who have professional licenses and certifications that need to be maintained, but may not be in scope for a credentialing organization. Inclusion of one or both of these should be tailored to each specific agreement.

Credentialing of Medical Professionals

For V1C services that rely on select medical professionals who offer clinical expertise in their offering, this section will highlight how those clinicians will be credentialed or verified following the legal or policy stipulations for their professional function. Where clinicians do need credentialing, this section will include who will manage credentialing, how that credentialing process will take place, and how confirmation that they are eligible to practice in a given state will be documented.

V1C CONSIDERATION: **Credentialing**

The goal is to ensure that the V1C service is following guidance on provider credentialing from the:

- National Committee for Quality Assurance (NCQA),
- Utilization Review Accreditation Commission (URAC), or
- Accreditation Association for Ambulatory Health Care (AAAHC) (worksite clinics).

IDEAL ★★★	TO AVOID ☆☆☆
<p>Determine the most efficient way for V1C to credential given their stage and capacity. This may include:</p> <ul style="list-style-type: none"> • V1C as delegate of payer • V1C outsourcing this function to a Credentials Verification Organization (CVO) • V1C using a payer's credentialing process, especially common for earlier stage V1C services, but not as well suited for scale and speed over time <p>Advocate for <u>innovation in credentialing</u> over the long term, considering solutions such as adoption of interstate licensure compacts, interstate licensure through a national credentialing approach, or a centralized repository for the most up-to-date info on credentials that could be widely accessed</p>	<p>Long wait times for credentialing process at payer due to credentialing team confusion about why someone is being authorized in two states — at the outset, payer should be prepared to set context internally for these submissions and advocate for V1C in credentialing process to smooth any concerns or delays around V1C provider location (e.g. why one Doctor of Medicine (MD) is being credentialed in multiple states)</p>
..... Phase 1> Phase 2>
<p>Allow work to start before credentialing process is complete given low risk of virtual providers</p>	<p>[no timing-specific implications for content are suggested in this phase]</p>

Verification of Certification and Licenses

For some care team members included in V1C services, verification of a professional certification or license is appropriate. In these cases, this section should include how that verification will occur and what aspects of verification will be covered. This may include confirmation that license/certificate is active, absence of debarment, criminal background check, review of credentials, etc.

V1C CONSIDERATION: **Verification of Certification and Licenses**

IDEAL ★★★	ACCEPTABLE ★★★☆
V1C service warranting or representing that V1C will maintain up-to-date certification and licensure, with no ongoing reporting to the payer required	V1C maintaining outside approval of their credentialing process, like URAC, for example

Contract Exhibit: Audits

This exhibit covers the process of payer review of V1C service practices to ensure they are compliant across a diverse set of domains that may include: finances, security, billing, and coding and/or Health Plan Employer Data and Information Set (HEDIS). The contents of this section should include a clear description of the audit process, timeframes and maximum frequency of audits, timeframes for V1C service submission of documents and payer responses to them, a process for appeals, and limitations on extrapolations if issues are found.

V1C CONSIDERATION: **Audits**

- Audit requirements for V1C services should be no more than what's required of brick-and-mortar providers and more broadly what's required by law.
- Payers and V1C services alike should pay consideration to the intricacies of audits of a virtual care model with distributed personnel and structure of care provision. Contract language should be tailored to align to the infrastructure that exists in the V1C service. In developing this section, payers should be attuned to the fact that V1C services are virtual in nature, which means that they don't have a physical site of care for auditing, and gathering necessary personnel across locations and time zones may not be as easy as what is traditionally the case. Business teams at payers may need to be involved in particular in advocating for this with their own legal teams.

Contract Exhibit: Publication Rights

This exhibit details the rights each party holds to publish research or share public reporting related to the relationship. It includes details such as each party's right to publish, what the review process will be among the parties before something is submitted or published, and any rights to block or modify publication (especially related to IP that may be disclosed in the published material). This section naturally follows many of the terms established in the [Data Exhibit](#).

This exhibit should be included in all phases of all contracts, even if there aren't specific publication plans envisioned at the time of contracting, to contemplate the possibility that an unforeseen opportunity may arise and both parties should have the flexibility to respond to it.

V1C CONSIDERATION: **Publication Rights**

Publication rights should follow data rights, whereby research conducted on data wholly owned by a given entity should be freely publishable without needing the other party's permission. Where data is sourced from both entities, agreements about opportunity to review, provide input, and obtain permission to publish may be appropriate.

..... <i>Phase 1</i>> <i>Phase 2</i>>
At least include a boilerplate stating a generic position that will be in place until and unless the parties agree to something else, which would then be documented in a new or revised exhibit	Given the early stage of the field, the best practice is to publish or share a report on the results of the collaboration to engender field-wide learning

Sample Language (Phase 1 Boilerplate): "Each party will have the right, at their discretion, to release information or to publish findings, conclusions, writings, or material resulting from clinical research undertaken with data collected or created from [THE PROGRAM]. The party initiating the clinical research (the "Sponsor") will have the sole responsibility for ensuring that any and all necessary informed consent is collected from participants, or that a waiver has properly been obtained from a competent Institutional Review Board in compliance with HIPAA rules. In the event that any clinical research undertaken pursuant to this section results in the publication of results, the Sponsor will furnish the non-sponsor party with an advanced copy of any proposed publication prior to the proposed publication date and grant the non-sponsor party the opportunity to review and provide comments on the published materials and, upon the non-sponsoring party's request will redact any information that the non-sponsoring party perceives to be confidential to the non-sponsoring party. Sponsor agrees to consult with the non-sponsor party on the use of the non-sponsor party's trademarks, trade dress, or other intellectual property, and will comply with any brand usage guidance provided by the non-sponsor party, however the non-sponsor party agrees that it will not unreasonably withhold permission to name the non-sponsor party or use its trademarks in the published materials."

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](#)

Contract Exhibit: 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.

..... <i>Phase 1</i>> <i>Phase 2</i>>
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	

Contract Exhibit: 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 (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 ☆☆☆
V1C getting promotion data conventionally requires BAA (when it is seen as TPO of the payer, not TPO of the V1C) Clarify responsibilities of each party (generally) — who is responsible for testing, approvals, and frequency of meeting to monitor/revisit	Co-branding of outreach with V1C messaging templates that include space for payer logo	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

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)

Contract Exhibit: 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>

Contract Exhibit: 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: 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><u>Per Participant per Month (PPPM) or Episode of Care</u> 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 2 should be value based and include bonuses/deductions based on set performance/service levels</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 aren't covered by the payer (but V1C service continues to provide continuity until the participant is transitioned)</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 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</p>

<p>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>device or additional exercise program) and may or may not be a covered cost by the payer</p>
..... Phase 1>	 Phase 2>
<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>

Contract Exhibit: 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: 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>
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Contract Exhibit: 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:	
<ul style="list-style-type: none"> • How second opinion requests should be handled. • Preferences for how a specific service not being available in-network should be handled. 	
IDEAL ★★★	ACCEPTABLE ★★☆
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	Provide access to a broader provider directory

Contract Exhibit: 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 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 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>

..... <i>Phase 1</i>> <i>Phase 2</i>>
<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>

GLOSSARY OF TERMS

These terms can be found throughout the Payer-VIC Contracting Toolkit. They are defined here as they are intended to be understood in the context of these resources. Citations of sites follow each definition in parenthesis, where available.

Accreditation Association for Ambulatory Health Care (AAAHC). Ambulatory health care accreditation organization that accredits ambulatory surgery centers, office-based surgery facilities, endoscopy centers, student health centers, medical and dental group practices, community health centers, employer-based health clinics, retail clinics, and Indian/Tribal health centers, among others. ([AAAHC website](#))

American Telemedicine Association (ATA). Established in 1993, ATA is a non-profit organization of 400 members committed to transforming health and care through enhanced, efficient delivery. ([ATA website](#))

Affiliates. A corporation, partnership, joint venture, limited liability company, or similar organization, other than a hospital, that is devoted primarily to the provision, management, or support of health care services and that directly or indirectly controls, is controlled by, or is under common control of the hospital. For the purposes of this definition, "control" means having at least an equal or a majority ownership or membership interest. ([Law Insider website](#))

Application Programming Interface (API). A technology solution intended to simplify software development and innovation by enabling applications to exchange data and functionality easily and securely. ([IBM website](#))

Assignment of Agreement or Obligations. An assignment of rights and obligations under a contract occurs when a party assigns their contractual rights to a third party. The benefit that the issuing party would have received from the contract is now assigned to the third party. ([Upcounsel website](#))

Audit. A systematic assessment of performance within a healthcare organization. Audits typically look at components of finances, security, billing, and coding to evaluate compliance with guidelines, agreements, and federal and state regulations.

Business Associate Agreement (BAA). A contract between a HIPAA covered entity and an organization that is not a covered entity (the business associate) to ensure that the business associate will appropriately safeguard PHI by clarifying and limiting the permissible uses and disclosures of PHI by the business associate. ([HHS.gov](#))

Covered Entity. See HIPAA Covered Entity.

Digital Medicine Society (DiMe). Founded in 2019 the Digital Medicine Society (DiMe) is the professional society for the digital medicine community to advance the safe, effective, equitable, and ethical use of digital medicine to optimize human health. ([DiMe website](#))

Eligibility. Conditions that must be met in order for an individual or group to be considered eligible for insurance coverage. ([eHealth Insurance website](#))

The Federal Communications Commission (FCC). A federal agency responsible for implementing and enforcing America's communications law and regulations. The FCC is an independent U.S. government agency overseen by Congress that regulates interstate and international communications by radio, television, wire, satellite, and cable in all 50 states, the District of Columbia and U.S. territories. ([FCC Website](#))

Fast Healthcare Interoperability Resources (FHIR) standards. A standard for describing data formats and elements, as well as an application programming interface (API) for exchanging electronic health records. The standard was created by the Health Level Seven International health-care standards organization to provide resources that can easily be assembled into working data systems that solve real world clinical and administrative problems in healthcare. ([HL7.org](#))

Federal Trade Commission (FTC). An independent agency of the United States government whose mission is the enforcement of civil U.S. antitrust law and the promotion of consumer protection. The FTC shares jurisdiction over federal civil antitrust enforcement with the Department of Justice Antitrust Division. ([FTC.gov](#))

Healthcare. Care, services, or supplies related to the health of an individual, including (i) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. ([HHS.gov](#))

Healthcare Effectiveness Data and Information Set (HEDIS). A set of performance measures for health plans developed by the National Committee for Quality Assurance (NCQA) that provides purchasers with information on effectiveness of care, plan finances and costs, and other measures of plan performance and quality. ([NCQA website](#))

Health Insurance Portability and Accountability Act (HIPAA) Covered Entity. Health plans, health care clearinghouses, or health care providers that transmit health care information electronically as a part of a "covered transaction" defined in HIPAA, and therefore must comply with rules and requirements set forth by HHS to protect the privacy and security of health information, and must provide individuals with certain rights with respect to their health information. ([HHS.gov](#))

HITRUST. A security measure in healthcare to assure risk and compliance management frameworks, related assessment and assurance methodologies in health technology. HITRUST Common Security Framework (CSF) is the leading information security framework for the healthcare industry. ([HITRUST website](#))

IMPACT (The virtual first Medical PrActive CollaboraTion). Hosted by DiMe and ATA, IMPACT is a pre-competitive collaboration of leading digital health companies, investors, payers, and consultants dedicated to supporting virtual-first care organizations and their commitment to patient-centric care. ([IMPACT website](#))

Maintenance of Records/Duty of Care. Physicians have an ethical obligation to manage medical records appropriately, which includes the responsibility to safeguard the confidentiality of patients' personal information. This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies. ([AMA website](#))

Management Services Organization (MSO). A healthcare-specific administrative and management entity that provides select core functions for a healthcare offering.

Management Group. See Management Services Organization (MSO).

Medical Group. See Professional Corporation (PC).

Member. See Plan Member.

National Committee for Quality Assurance (NCQA). A non-profit organization that works to improve healthcare quality through the administration of evidence-based standards, measures, programs, and accreditation of health plans. ([NCQA website](#))

Participant (or V1C participant). An individual who initiates participation in a healthcare offering. V1C participants are, therefore, individuals who initiate participation in a V1C solution.

Payer. The person, organization, or entity that sets service rates, collects payment, processes claims, and pays claims associated with healthcare services administered by a provider. This term most often refers to private insurance companies that provide their customers with health plans that offer cost coverage and reimbursements for medical treatment and care services.

Protected Health Information (PHI). Health and demographic information that is received by a Covered Entity that relates to the past, present, or future physical or mental health or condition of the identified individual, the provision of health care to that individual, or the payment for that health care. Protected Health Information is individually identifiable health information that is regulated by HIPAA. ([HHS Website](#))

Plan Member. An individual who receives coverage of their healthcare expenses by a third-party payer.

Prior Authorization. Approval from a health plan that may be required before a person gets a service or fills a prescription in order for the service or prescription to be paid for or covered by a health plan. ([HealthCare.gov](https://www.healthcare.gov))

Professional Certification (or Professional License). Proof of training or capability in a specific area of expertise required for the performance of care duties. For example, a person who is a [Qualified Healthcare Professional](#) under the Social Security Act would have to have the requisite licenses or certifications, but there may be professional licenses or certifications of other professionals that are appropriate.

Professional Corporation (PC) or Professional Association (PA). A type of corporate entity for which the shareholders must hold a professional license in the business in which they plan to operate. In many states, PCs are the only type of corporate entity that are allowed to engage in business to provide those professional services. Certain states also limit ownership of a PC to licensed members of that profession. For example, a husband who does not hold a medical license cannot own shares in his spouse's medical practice.

Provider (or health care provider (HCP)). Under HIPAA, a provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business. ([HHS.gov](https://www.hhs.gov))

Qualified or Eligible (plan member or V1C participant). An individual who, based on key criteria, such as demographics, clinical information, or other factors, has the characteristics appropriate for receipt of a healthcare service. A qualified/eligible plan member is a person whose plan data suggests that they are well suited for a given intervention (such as a V1C solution). A qualified/eligible V1C participant is a person who meets the medical and demographic criteria to be appropriate for a specific V1C solution.

Runout Period. The contractually agreed upon time frame during which a V1C solution may be obligated to continue to provide services after contract termination to ensure continuity of care.

Service Level Agreement (SLA). An agreement between an IT service provider and a customer. A service level agreement describes the IT service, documents service level targets, and specifies the responsibilities of the IT service provider and the customer. A single agreement may cover multiple IT services or multiple customers. ([ITIL](#))

SOC Report. A System and Organization Control report that attests that a particular service is being provided securely. There are several kinds of SOC reports (e.g. SOC 1, SOC 2, etc). SOC 2 reports are most applicable to V1C solutions, and address an organization's controls that are relevant to their operations and compliance. SOC 2 includes criteria related to availability, confidentiality, processing integrity, and privacy, and allows the flexibility to incorporate additional suitable criteria, for example, around adherence to public, industry-specific frameworks such as the HITRUST. SOC

2 Type reports align to progressing stages of compliance. A SOC 2 Type 1 report pertains to a service organization's system and the suitability of the design of controls, validating design sufficiency of all administrative, technical and logical controls. A SOC 2 Type 2 report expands on the Type 1 report to describe and evaluate at least 6 months of evidence of control effectiveness, attest to systems and controls in place, and describe whether they are functioning as described by the management of the service organization. ([AICPA website](#))

Treatment, Payment, or Operations (TPO). Defined in HIPAA Privacy Rule at 45 CFR 164.501, the circumstances under which covered entities are allowed to disclose patient information without the need to obtain authorization from patients. ([HHS.gov](#))

Utilization Review Accreditation Commission (URAC). Leading nationwide quality accrediting organization for pharmacy, health plan, digital/telehealth, mental health, patient care management, administrative management entities. ([URAC website](#))

Virtual First Care (V1C). Medical care for individuals or a community accessed through digital interactions where possible, guided by a clinician, and integrated into a person's everyday life. ([IMPACT website](#))

virtual first Medical PrActice CollaboraTion ("IMPACT"). See IMPACT.

V1C service. V1C provider. V1C organization. See V1C solution.

V1C solution. A V1C approach that combines technology and human capital to enable: the ability to initiate care for anywhere at any time through telecommunication and digital technologies; intentional selection of the care setting matched to a person's clinical needs and preferences, with some aspects safely and effectively delivered virtually, and others necessitating in-person care; complete solutions that support a person to take all of the necessary steps in their health journey; and, adherence to all applicable laws that apply to HCPs, including best practices on standards of care, individual safety, security, privacy, and data rights. ([IMPACT website](#))

ABOUT IMPACT MEMBERS

IMPACT members are committed to enabling expanded access to high-quality, evidence-based V1C to improve clinical and health economic outcomes, enhance access, and provide a better patient experience.



IMPACT

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Practice Collaboration*

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