IMPACT

Virtual First Medical Practice Collaboration

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.

Language matters. Terms used throughout this resource are defined here in the Glossary of Terms.

GLOSSARY OF TERMS

These terms can be found throughout the Payer-V1C 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 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 PrActice 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)

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)

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 Foundation)

System and Organization Control (SOC) Report. A 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)

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
- Payment

Contract Exhibits

- Data
- Subcontractors
- Credentialing/Certification & Licenses
- Audits
- Publication Rights
- Statement of Work