

## Exhibit 1

### STATE OF MINNESOTA PROFESSIONAL AND TECHNICAL SERVICES CONTRACT For QUALITY MEASUREMENT, REPORTING AND DEVELOPMENT OF INCENTIVE PAYMENT SYSTEM

Consistent with Minnesota Session Laws 2008, Chapter 358, Article 4, Sec. 5, Subd. 3, "nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota," the State and the Contractor agree that all state funding related to the work in this contract will support the identification, development, data collection and public reporting related to new measures or, in the case of hospitals, costs associated with public reporting of existing measures that can be calculated from existing hospital discharge data already collected in Minnesota.

The goal of this state contract is to build a unified statewide quality reporting system for health care providers. The state intends to significantly increase the number of quality measures for which data are or will be publicly reported by July 1, 2012; to significantly expand the number of physician clinics reporting data on quality measures by July 1, 2012; to allow for a broader array of stakeholders and interested members of the public to understand how measures are identified and to provide meaningful input about the statewide quality reporting system; and to enhance the ease of accessing this information from a consumer perspective. The State has previously entered into an agreement (referred to herein as the "Inventory Contract") with Contractor requiring Contractor to conduct an inventory of existing quality measures of health care providers in Minnesota and elsewhere in the United States (the "Inventory") and to share the Inventory with interested stakeholders at certain public meetings.

Contractor may subcontract certain performance under this Contract, as set forth in Exhibit 3. Contractor must obtain the approval of the Minnesota Department of Health ("MDH") for such subcontracts, which shall set forth the specific duties of the subcontractor. Notwithstanding such subcontracts, Contractor shall be responsible for all performance under this Contract. Contractor shall obtain approval of the State's Authorized Representative before terminating or adding subcontractors.

#### **Task One: Establishment of a Statewide Quality Reporting System in Minnesota**

- A) Recommend criteria for selecting a subset of those measures identified in the Inventory and a subset of quality measures based on those criteria for public reporting purposes in Minnesota. In developing these criteria, the Contractor shall place a higher priority on quality measures of health care outcomes, rather than process measures. Similarly, the Contractor shall place a higher priority on measures for primary care, including preventive services, coronary artery

and heart disease, diabetes, asthma, and depression as well as health care homes. Finally, in recommending quality measures, the Contractor should take issues related to high risk populations and health disparities into account.

B) Contractor shall submit preliminary written recommendations to the MDH by January 9, 2009. This document will contain the criteria described in Task One A as well as those measures recommended to be initially included in the statewide quality reporting system, including 12 specific AHRQ measures and the measures outlined in Section 3 related to depression, health information technology, and patient experience. MDH will distribute the preliminary written recommendations to interested parties Contractor shall hold a public forum ("Final Public Forum") to solicit input, from stakeholders and to finalize the written recommendations must occur no later than January 15, 2009. The Final Public Forum shall be in addition to the public forums identified in the Inventory Contract. The Contractor must incorporate stakeholder input into the final written recommendations to the MDH by January 30, 2009. The dates and meetings outlined above should be considered as the minimum requirements for soliciting stakeholder input. The Contractor must receive written comments from stakeholders and synthesize them in writing as well as summarize meetings in narrative form. MDH will make these written materials available for public distribution and will post them on MDH's Health Reform website ("Website"). Contractor shall repeat the process described in this paragraph during 2010, 2011 and 2012, with the specific schedule to be agreed upon by Contractor and the State.

1) Process: Contractor's Reporting Advisory Committee ("RAC") and its subcommittees will serve as the forum through which Contractor will identify preliminary recommended measures and subsequently share those measures in public meetings. Because the RAC will function as a public workgroup for purposes of this contract, its membership will be expanded to include two consumer representatives. Any other structural changes to the RAC for work related to this contract must be approved by MDH. All meetings of the RAC related to this contract will be open to observation by the public and advertised on the MDH Website. Members of the public who wish to observe RAC meetings will be asked to notify Contractor of their planned attendance, but will not be turned away from observing a meeting unless they have not notified Contractor and there is insufficient room to accommodate them. Contractor will summarize all RAC meetings related to this contract in narrative form and provide those written summaries to MDH for posting on its Website. At Contractor's request, MDH will provide space for meetings of the RAC. After Contractor communicates RAC's preliminary recommendations to provider

organizations and other interested stakeholders at public meetings, it will consider input received about the preliminary recommendations and incorporate that feedback into a draft recommendation to be considered by the MNCM Board of Directors. After the Board's review, MNCM will submit a final recommendation to MDH. That final recommendation will contain the preliminary recommendations as they were submitted to the MNCM Board, highlight any changes the MNCM Board made and provide a rationale for those changes.

2) Criteria: The RAC will consider the following criteria in recommending which measures should be part of the statewide quality reporting system. It is understood that different measures may relate more to some criteria than others; that each measure does not need to meet each of the criteria and that members of the RAC may also choose to consider additional criteria beyond those articulated below:

- Degree of impact – the magnitude of the individual and societal burden imposed by a clinical condition, including disability, mortality and economic costs.
- Degree of improvability – the extent of the gap between current practices and evidenced-based practices (variation) and the likelihood that the gap can be closed and conditions improved through changes in the clinical processes, as well as the opportunity to achieve improvement in the six quality aims laid out by the Institute of Medicine in their March 2001 report titled *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* (a brief of the report can be found at <http://www.iom.edu/Object.File/Master/27/184/Chasm-8pager.pdf>).
- Degree of inclusiveness – the relevance of a measure to a broad range of individuals with regard to (a) age, gender, socioeconomic status, and race/ethnicity; (b) the generalizability of quality improvement strategies across the spectrum of health care conditions; and (c) the capacity for change across a range of health care settings and providers.
- National consensus – the measure has either been developed or accepted/approved through a national consensus effort (e.g., National Quality Forum or Physician Consortium for Performance Improvement).

- Degree of performance variation – the performance rates show a wide degree of variation (e.g., range from low performer to top performer) from one reported entity to another.

**In recommending new measures, Contractor should take into account the State’s strong preference for data that is submitted directly by providers.**

3) Quality Measures

The Contractor agrees to add at least the number of new measures to the statewide quality reporting system in each year of the Contract outlined in the schedule below:<sup>1</sup>

	First Year (Calendar Yr 2009)	Second Year (Calendar Yr 2010)	Third Year (Calendar Yr 2011)	Fourth Year (To July 1 2012)
Public Reporting on All Data Providers	<ul style="list-style-type: none"> <li>Existing MN<sup>2</sup> and Minnesota Hospital Quality Report data as reported at <a href="http://www.mnhospitalquality.org/">http://www.mnhospitalquality.org/</a></li> <li>12 additional AHRQ<sup>3</sup> inpatient measures</li> </ul>	Previous year plus: <ul style="list-style-type: none"> <li>Depression measure – primary care</li> <li>Depression measure – specialists</li> <li>HIT measure composite</li> <li>Patient experience measures (5 plus composite)</li> <li>2 additional AHRQ inpatient measures</li> </ul>	Previous year plus: <ul style="list-style-type: none"> <li>1 Primary care measure</li> <li>1 specialty care measure</li> <li>Five new hospital measures integrating clinical data with administrative data</li> <li>2 additional AHRQ inpatient measures</li> </ul>	Previous year plus: <ul style="list-style-type: none"> <li>1 additional primary care measure</li> <li>2 additional specialty care measures</li> <li>2 additional AHRQ inpatient measures</li> </ul>
Data Collection on New Measures; Voluntary Data Submission; Voluntary Public Reporting	<ul style="list-style-type: none"> <li>Depression measure – primary care</li> <li>Depression measure – specialists</li> <li>HIT<sup>4</sup> measure composite</li> <li>Patient experience measures (5 plus composite)</li> </ul>	<ul style="list-style-type: none"> <li>1 Primary care measure</li> <li>1 specialty care measure</li> </ul>	<ul style="list-style-type: none"> <li>1 additional primary care measure</li> <li>2 additional specialty care measures</li> </ul>	<ul style="list-style-type: none"> <li>2 additional specialty care measures</li> </ul>

Develop new measure	<ul style="list-style-type: none"> <li>• 1 Primary care measure<sup>5</sup></li> <li>• 1 specialty care measure<sup>5</sup></li> <li>• Clinical-data enhanced database to support five new hospital measures integrating clinical data with administrative data</li> </ul>	<ul style="list-style-type: none"> <li>• 1 additional primary care measure</li> <li>• 2 additional specialty care measures</li> <li>• Clinical-data enhanced database to support five new hospital measures integrating clinical data with administrative data</li> </ul>	<ul style="list-style-type: none"> <li>• 2 additional specialty care measures</li> </ul>	
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<sup>1</sup> Contractor may consider “frontloading” measures that may take more time to develop. For example, in the first year of the contract, the Contractor may decide to add two new primary care measures. In doing so, the Contractor would meet its responsibility for both year one and year two of the contract related to primary care measures.

<sup>2</sup> “Existing MNMCM” means those quality measures being reported by Minnesota Community Measurement in December 2008.

<sup>3</sup> AHRQ is the Agency for Healthcare Research and Quality.

<sup>4</sup> HIT means health information technology.

<sup>5</sup> MNMCM will provide recommendations about these new measures by July 1, 2009.

In any year, previously existing measures may change because of new science or updated measurement methodologies. Changes or deletions of measures are acceptable provided any deleted measures are replaced by another of the same type in addition to the number of measures already included as part of this contract and approved by MDH.

Understanding the “pipeline” for measure development: The State and the Contractor agree that “adding a measure,” as referred to herein, means that MNMCM has recommended a new measure to be added to the statewide quality reporting system. While the timeframe for each new measure to move through the development, data collection and public reporting timeline may vary, the Contractor agrees the general timeframe shall be as follows:

- Year 1: development of the measure;
- Year 2: data collection and voluntary public reporting;
- Year 3 and subsequent years of the Contract: mandatory public reporting.

For example, when a new measure is incorporated into the statewide quality reporting system in January 2010, MNCM generally agrees that data submission and voluntary public reporting for the measure will begin in January 2011 and mandatory public reporting of that data would occur by January 2012.

- The exception to the “pipeline” described above is related to existing Agency for Healthcare Research and Quality (“AHRQ”) hospital measures calculated from hospital discharge data. Those measures will be incorporated into the statewide public reporting system as set forth in the chart at section 1(B)(3).

Any change to the reporting requirements set forth herein must be approved in writing by the State’s Authorized Representative.

- C) MNCM will advise the State as it develops regulations establishing the quality measures to be publicly reported. To provide advice, the Contractor will review draft rules, as requested by MDH, and propose corrections for technical accuracy and policy consistency.

### **Task Two: Development of a Quality Incentive Payment System**

- A) Through a subcontract with the University of Minnesota, Contractor shall develop a comprehensive inventory of existing (either in theory or in practice) quality incentive payment systems, pay for performance systems, and other payment systems across the country currently based on quality measures. This inventory must be completed and submitted to MDH by February 1, 2009.
- B) Through its subcontract with the University of Minnesota, Contractor shall recommend a subset of the quality measures identified under Task One as the basis for a quality incentive payment system and identify the rationale for choosing those measures. The Contractor should prioritize outcome-related measures that improve care and lower costs for high volumes of people; focus on chronic conditions; and minimize both providers’ administrative burden and duplication of related activities. This preliminary written recommendation must be submitted to the MDH by February 15, 2009.
  - 1) The Hospital Quality Reporting Steering Committee will assist MNCM in recommending the measures to be used for hospitals in a statewide quality incentive payment system. MNCM will form a work group to assist it in recommending the measures to be used for ambulatory settings in a statewide quality incentive payment system (“Incentive Payment

Work Group”). The Contractor will submit membership of the Incentive Payment Work Group and any changes in the membership of either the Incentive Payment Work Group or the Hospital Quality Reporting Steering Committee to MDH for approval. The tasks of the steering committee and work group will include review of preliminary recommendations from the University of Minnesota regarding quality measures and methodology for the incentive payment system. All meetings of the Incentive Payment Work Group and the Hospital Quality Reporting Steering Committee will be open to the public.

- 2) Any changes the Incentive Payment Work Group makes to the University of Minnesota’s preliminary recommendations for either quality measures to be included in the quality incentive payment system or the methodology for the incentive payment system must be documented in writing with a rationale provided for the changes. MNCM will prepare these summaries and share them with the MDH for posting on the MDH’s health reform website.
- C) Contractor shall propose a specific methodology for building a quality incentive payment system. This methodology must reward providers for achieving specific performance targets as well as improving the quality of their care over time. Contractor shall work in cooperation with MDH to develop recommendations on an approach to risk adjustment of quality measures for both reporting and quality incentive payment systems. Contractor’s recommendations on risk adjustment shall identify strengths and opportunities of potential methodologies as well as identify data sources and discuss their strengths and weaknesses. This written proposed methodology for a quality incentive payment system, including an approach to risk adjustment must be submitted to the MDH by February 15, 2009. If the approach to the risk adjustment system is accepted, the Contractor must work with stakeholders to incorporate the method into each measure in future measurement cycles.
  - D) Contractor shall submit a written draft outline and format for Tasks Two B and C to MDH for approval by February 1, 2009.
  - E) The Contractor shall hold at least two public meetings to solicit stakeholder input on the proposed incentive payment methodology and examples of how the methodology would be implemented in specific situations. One of these meetings must occur outside the Twin Cities metro area. These meetings must occur by February 25, 2009. Contractor shall consider stakeholder input, incorporate stakeholders’ input and public comments on the measures and methodology for a quality incentive payment system, and submit final written recommendations to MDH by March 25, 2009.

- F) The Contractor shall advise MDH as MDH develops regulations establishing the incentive payment system. To provide advice, the Contractor will both review draft rules, as requested by MDH, and propose corrections for technical accuracy and policy consistency.
- G) Contractor must provide regular updates to MDH via a scheduled weekly conference call or meeting.

**Task Three: Implementation of Quality Reporting and Payment System**

The Contractor shall be responsible for collecting quality data from reporters.

- A) Contractor shall expand the capacity of MNCM's existing portal system to accommodate a substantially larger amount of data and to receive data on new measures on a statewide basis. MNCM must verify programming and other necessary preparatory work is complete at least two months prior to when data collection for each new measure is slated to begin.
- B) Contractor shall propose a strategy for educating physician clinics and hospitals about quality reporting requirements and the incentive payment system established in rule. This education strategy must include communication about the rule's substantive goals and requirements as well as training about technical issues related to compliance. Training should be focused on written materials and large scale training opportunities and include detailed written materials, an on-line seminar, and meetings with providers. Contractor may propose additional methods of providing technical assistance. Written recommendations for educating physician clinics and hospitals about quality reporting requirements and the incentive payment system must be submitted to MDH by July 1, 2009.
- C) Upon receipt of written approval from MDH, Contractor shall implement the approved plan to educate physician clinics and hospitals about how the incentive payment system will work and how to comply with reporting requirements. These efforts must begin in July 2009.

In the event that MDH rejects Contractor's proposed education strategy or requests elements for which the cost of implementation will exceed \$100,000, the Contractor and MDH will renegotiate the budget and the scope of work and, if they are unable to reach agreement, either party may choose to be released from the terms of the Contract providing for implementation of the approved education plan.

1) Recognizing that the law requires all providers to submit data but that neither the state nor MNCM have reliable information about how many physician-staffed health care delivery sites there are in Minnesota, and thus how many providers should be expected to report quality measurement data, the State requires MNCM to:

- Produce an estimate of the number of physician-staffed health care delivery sites in Minnesota. To produce the estimate, MNMCM may draw on data sources including reporters of financial data to the MDH, as well as data reported to the MDH Office of Rural Health and Primary Care and the Minnesota Board of Medical Practice. The estimate must be submitted to the MDH by Oct. 1, 2009.
- Based on the estimated number of physician-staffed health care delivery sites as determined above, the State expects MNMCM to substantially increase the number of clinics reporting in each year of the contract following the completion of the estimate. For purposes of this section, the base number of clinics reporting in the first year shall be no less than 370. In each subsequent year following the completion of the estimate, the Contractor shall decrease the gap between the estimated number of physician-staffed clinics in Minnesota and the number of physician clinics reporting data in the previous year by at least 20%.

Contractor shall obtain, validate and process data from hospitals and clinics, as identified herein, related to the standardized quality measures identified in administrative rules for public reporting purposes starting January 1, 2010.

- 1) Contractor may collect data for various measures at staggered intervals provided that it collects data for each measure on at least an annual basis and such collection begins by January 1, 2010.
  - 2) Contractor shall validate data submitted for both hospital and clinic measures with rigorous techniques jointly agreed to by the State and Contractor.
  - 3) Contractor's processing of data may include calculation of composite measures, validating data, risk adjustment and other necessary steps.
- D) Contractor shall develop and implement a process for sharing summary data with providers related to their own performance compared with statewide averages and/or other applicable benchmarks prior to publication of a public report for both physician clinics and hospitals. Contractor must accept and track comments from providers for purposes of revising quality public reporting system over time. Providers must be allowed to submit technical corrections prior to publication and be given a reasonable length of time to do so, although they will be required to do so by a date certain.
- E) Contractor shall recommend processes for to accomplish robust public reporting, including a required annual report from the Commissioner of MDH.

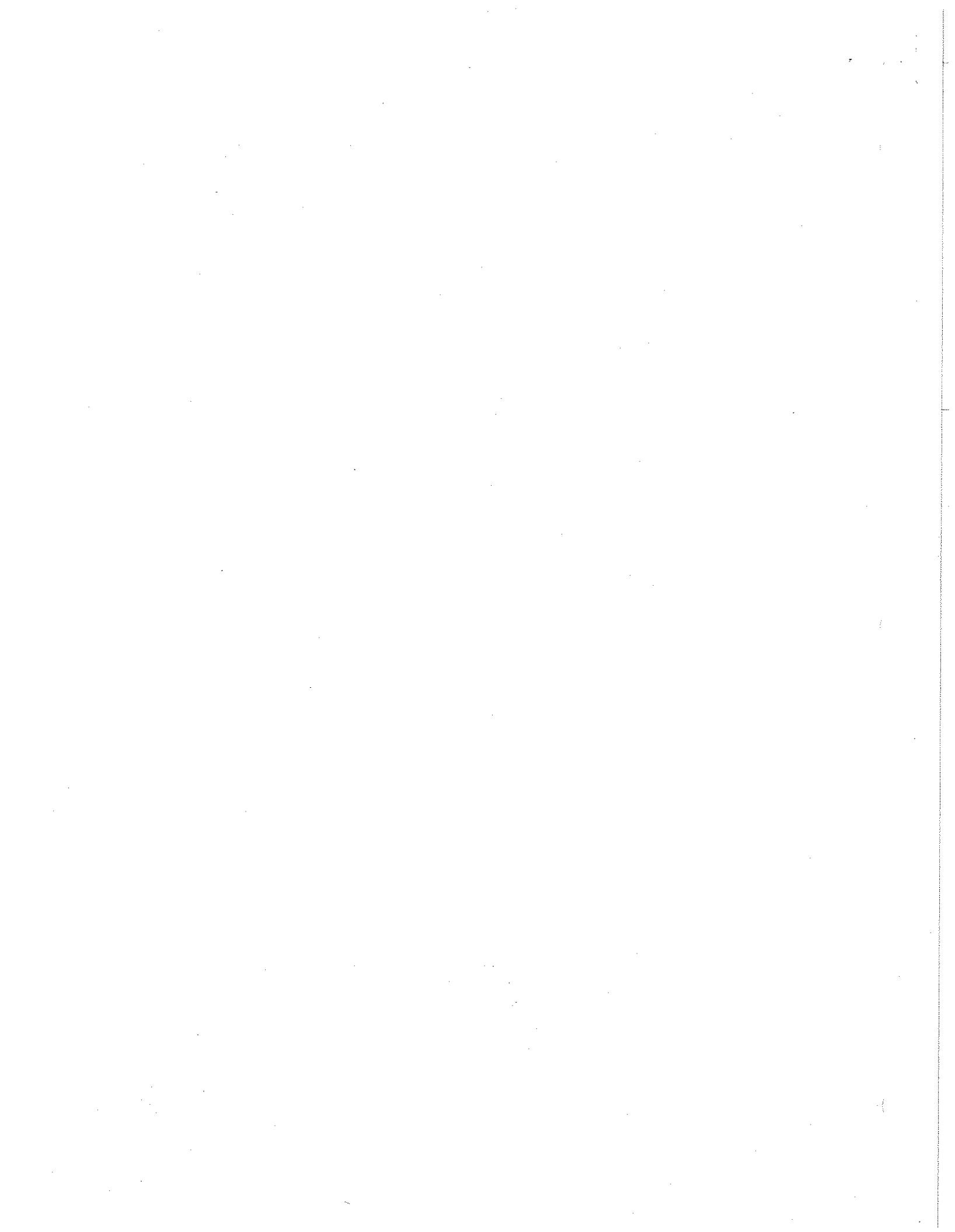
- 1) The Contractor must propose the format and content of the public report on quality. The proposed format must provide for publication on a website and the content must include the following: methodology, including risk adjustment available, addressing small numbers, types of comparisons possible, search functions, organizations, and level of analysis. Contractor must submit written recommendations for the public report by February 1, 2010.
- F) Contractor shall develop a Minnesota Community Measurement “one-stop shopping” website for all quality reporting from both clinics and hospitals. This website will have the same functionality, including search functions, as MNCM’s current website. Contractor shall produce the following public reporting on quality measures:
- 1) An annual public report by July 1 of 2010, 2011, and 2012. The first report must be complete and available both in print and on-line on MNCM’s website by July 1, 2010.
  - 2) The “one-stop shopping” website to go live by July 1, 2010 with the same functionality as MNCM’s current website for all measures.
- G) Contractor shall conduct annual review and maintenance of both the measures for which data is collected and technical implementation issues. For example, scientific advances or changing technologies may affect the quality measures being reported. Contractor shall provide written recommendations about how MDH can identify and resolve implementation issues in the short and long term. These recommendations must be submitted to MDH by October 1, 2009, October 1, 2010 and October 1, 2011.
- H) The Contractor shall meet in person with MDH staff on a quarterly basis, beginning no later than July 1, 2009. Contractor shall also participate in a more formal annual review in the fourth quarter of each year of the Contract beginning in 2009, relating to reporting issues, potential changes and lessons learned from the implementation experience.

#### Role of the MDH

The MDH agrees to provide public space for each public forum related to this Contract; to provide public notice of all Reporting Advisory Committee, public forums and other related meetings on the MDH’s Website and through its list-serv as appropriate; and distribute post meeting summaries and synthesized comments.

## Amount of Contract and Terms of Performance Bonus

The MDH agrees to pay a base of \$2,674,640 for the work outlined in this Contract. The Contractor must provide invoices and payment will be structured around completion and acceptance of milestone tasks, as set forth in Exhibit 2. The State does not pay for the passage of time, but instead will only pay for completed and accepted deliverables. The Contractor may earn an additional \$100,000 for successfully implementing voluntary collection of data on race and ethnicity for 2009 dates of service on at least one existing MNMCM measure, as set forth in footnote 2. The Contractor may earn another \$100,000 for augmenting collection of data on race and ethnicity on a second measure related to Minnesota Statutes 145.928 (the initiative to eliminate health disparities). The State and the Contractor shall establish a more detailed mutually acceptable written agreement about what specific level of performance will warrant payment of the performance bonuses described in this section.



**EXHIBIT TWO  
DELIVERABLES AND PAYMENT SCHEDULE**

The Contractor shall be paid on a quarterly basis after the deliverables outlined below have been received and approved by the Minnesota Department of Health. The Contractor shall not be paid any portion of the quarterly amount unless all deliverables have been produced and approved according to the agreed upon schedule.

In addition to this payment schedule, the Contractor may be eligible for up to two performance bonuses. Full payment of the first performance bonus of \$100,000 related to reporting of racial/ethnic data will be made in February 2010 provided the Contractor meets the criteria outlined in the main contract. Full payment of the second performance bonus of \$100,000 related to reporting of racial/ethnic data will be made in July 2012 provided the Contractor meets the criteria outlined in the main contract.

	<b>Deliverable</b>	<b>Due Date</b>	
<b>CY 2009<sup>1</sup></b>			
<b>1<sup>st</sup> Q:</b>	<b>1C:</b> Preliminary recommendations for quality measures	1/9/09	
	Final public forum to solicit input on measures	1/15/09	
	Final recommendations to Commissioner	1/30/09	
	Comments and meeting summaries	1/30/09	
	<b>2:</b> Inventory of measures for quality incentive programs	2/1/09	
	Draft outline/format for subset of measures and proposed methodology for quality incentive payment	2/1/09	
	Preliminary recommendations to Commissioner on measures for quality incentive payment	2/15/09	
	Preliminary recommendations to Commissioner on methodology for quality incentive payment	2/15/09	
	Recommendations to Commissioner on approach to risk adjustment	2/15/09	
	Three public meetings on payment incentive methodology	2/15/09	
	Final recommendations to Commissioner on measures and methodology for quality incentive payment	3/25/09	
	<b>Payment for all first quarter deliverables: \$163,370</b>		
	<b>2<sup>nd</sup> Q</b>	Progress report: measure development to reporting	
		<b>Payment for all second quarter deliverables: \$163,370</b>	
<b>3<sup>rd</sup> Q</b>	<b>3C:</b> Recommendations to Commissioner on	7/1/09	

<sup>1</sup> "CY" means calendar year.

	<b>Deliverable</b>	<b>Due Date</b>
	provider education plan.	
	<b>Payment for all third quarter deliverables: \$171,703</b>	
4 <sup>th</sup> Q	<b>3B:</b> Recommendations to Commissioner on how MDH will identify and resolve implementation issues in the short and long term.	10/1/09
	<b>Payment for all fourth quarter deliverables: \$171,703</b>	
<b>CY 2010</b>		
1 <sup>st</sup> Q	<b>1C:</b> Preliminary recommendations from RAC of YR 2 measures	
	Public forum to solicit input	
	Final recommendations to Commissioner	
	Comments and meeting summaries	
	<b>3G:</b> Proposed format and content of public report on quality	2/1/09
	<b>Payment for all first quarter deliverables: \$171,703</b>	
2 <sup>nd</sup> Q	Progress report: measure development to reporting	
	<b>Payment for all second quarter deliverables: \$171,703</b>	
3 <sup>rd</sup> Q	<b>3H:</b> Publication of public report	7/1/10
	<b>Payment for all third quarter deliverables: \$171,703</b>	
4 <sup>th</sup> Q	Status report to Commissioner: Lessons Learned	
	<b>Payment for all fourth quarter deliverables: \$171,703</b>	
<b>CY 2011</b>		
1 <sup>st</sup> Q	<b>1C:</b> Preliminary recommendations from RAC of YR 3 measures	
	Public forum to solicit input	
	Final recommendations to Commissioner	
	Comments and meeting summaries	
	<b>Payment for all first quarter deliverables: \$171,703</b>	
2 <sup>nd</sup> Q	Progress report: measure development to reporting	
	<b>Payment for all second quarter deliverables: \$171,703</b>	
3 <sup>rd</sup> Q	<b>3H:</b> Publication of public report.	7/1/11
	<b>Payment for all third quarter deliverables: \$171,703</b>	
4 <sup>th</sup> Q	Status report to Commissioner: Lessons Learned	
	<b>Payment for all fourth quarter deliverables: \$171,703</b>	

	<b>Deliverable</b>	<b>Due Date</b>
<b>CY 2012</b>		
<b>1<sup>st</sup> Q</b>	<b>1C: Preliminary recommendations from RAC of YR 4 measures</b>	
	Public forum to solicit input	
	Final recommendations to Commissioner	
	Comments and meeting summaries	
	<b>Payment for all first quarter deliverables: \$171,703</b>	
<b>2<sup>nd</sup> Q</b>	<b>3H: Publication of public report</b>	7/1/12
	<b>Payment for all second quarter deliverables: \$161,105</b>	
	<b>10 percent withhold for completion of project: \$287,464</b>	