Terms and Conditions between Premier Inc. and CMS
of the Hospital Quality Incentive Demonstration
First Amendment

This Amendment is by the Centers for Medicare & Medicaid Services ("CMS"), and Premier Inc., ("Premier") and both CMS and Premier ("Parties") executed the Terms and Conditions between Premier Inc. and CMS on August 25th, 2003 (the "Agreement"). The parties now wish to amend the Agreement as described below and agree by executing this First Amendment; the Parties intend to amend the Original Agreement to extend the demonstration project for an additional three (3) years (hereafter "Year 4, Year 5 and Year 6").

WHEREAS, since the date of the Agreement the parties have made certain changes to their business arrangements and wish to reflect such changes in this written Amendment;

1. Hospitals in the demonstration. Premier will provide a group of hospitals for the Hospital Quality Incentive Demonstration (HQID) extension from among the HQID project participants, within 90 days of this signed agreement. Only hospitals that have completed year 3 of the demonstration are eligible to participate. Participating hospitals must sign an agreement that they agree to all of the terms and conditions of the demonstration amendment, and Premier will forward a copy of these agreements to CMS.

2. Start date and operational period. The start date for the extension is October 1, 2006. The demonstration extension will operate for 3 years. The time periods will be:

   a) Year 4: October 1, 2006 to September 30, 2007 (CMS FY 2007)
   b) Year 5: October 1, 2007 to September 30, 2008 (CMS FY 2008)
   c) Year 6: October 1, 2008 to September 30, 2009 (CMS FY 2009)

   Hospitals can elect not to participate after each year of the extension by providing their intentions in writing to CMS and Premier within 60 days after the start of Year 5 and Year 6.

3. Quality of care data. The Composite Quality Score (CQS) as defined in the Agreement will not change in this Amendment and will be used for both public reporting and payment purposes. The hip and knee replacement clinical area will change for the extension to encompass all inpatient data (in the Agreement, the scoring only included Medicare patients). Appropriate care scores are planned to be calculated for participants in Year 4 and evaluated for use in the payment model for Years 5 and 6.

4. Clinical areas and measures included. Clinical areas included in Year 4 of the extension are acute myocardial infarction (AMI), coronary artery bypass graft

procedures (CABG), heart failure (HF), community acquired pneumonia (PN), and hip and knee replacement procedures (HK). Measures used for calculating the composite quality score in Year 4 of the demonstration are provided in Table 1. In addition, several measures are planned to be used for testing purposes. For example, the AHRQ patient safety indicators may be combined to create a complication index. These test measures are identified as such in Table 1.

Years 5 and 6 offer the opportunity to add additional clinical populations (e.g. Stroke), quality measures (e.g. the test measures of Year 4), and hospital-wide measures (e.g. HCAHPS). As in Years 1 through 3, any new or revised national quality measures reflective of process or outcomes of care may be added and/or modified to the composite quality scores in the year they are required for national reporting (Annual Payment Update) as agreed upon by Premier and CMS. Hospitals will be notified in advance of these changes using the CMS/Joint Commission Specifications Manual for National Hospital Quality Measures release process on the QualityNet website for quality measures included in the manual. Currently, this advance notice provides hospitals with a four (4) month advance notice, but is subject to change. For quality measures and/or clinical populations not listed in the CMS/Joint Commission Specifications Manual for National Hospital Quality Measures and any payment model changes, hospitals will be notified at least four (4) months prior to any changes implemented.

5. Quality Incentive payments. The payment structure for Year 4 provides financial incentives based on threshold attainment, top performance, and significant improvement.

   a. ***Attainment Award*:** Hospitals that attain or exceed median level performance, as measured in Year 2 for each clinical area, will receive, in the aggregate, 40% of the total available quality incentive payment. The incentive amount will be calculated and paid out on a per discharge basis; the incentive amount will be uniform across hospitals and clinical conditions. The attainment median benchmark will be the median composite quality score from two years prior to the performance year and will be updated annually.
   b. ***Top Performer Award:*** Hospitals in the top performer group, defined as the top 20% of hospitals in each clinical area, will receive an additional incentive payment. *Note: This group will receive the performance award for median level attainment as well.*
   c. ***Improvement Award:*** Hospitals that achieve attainment and are among the top 20% of hospitals with the largest quality improvements will receive an additional incentive payment. Improvement will be calculated based on the change in the hospital composite quality score in the performance year compared to two years prior (e.g. from Year 2 to Year 4). *Note: This group will receive the median level attainment performance award as well.*

   Improvement will be determined using the hospital's composite quality score two years prior as a baseline compared to the hospital's composite quality score in the

current year. For example, a hospital with a CQS score of 60% two years prior and a CQS score of 90% in the current project year would be identified as having improved 50% ((90/ 60) – 1) x 100.

d. ***Calculation of Top Performer and Improvement Award Amounts***. Hospitals that receive an award in either the top performer or the improvement categories will be paid the same amount on a per discharge basis. The hospitals in these two categories will be determined for each clinical area, and the total number of Medicare fee-for-service patients discharged in that clinical area will be determined. The per patient award amount will be determined by dividing the total number of discharged patients into the available 60% of the incentive award amount. Payments to each hospital will depend on the number of discharged patients in the clinical category. The total incentive category amount for top performers and for improvement hospitals will not be identical since we expect that there will be different numbers of discharged patients in the two categories, but the amount per discharged Medicare beneficiary will be the same. *Note: Any hospital that is in both the top performer and improvement categories will receive only one award for these categories.*

e. ***Threshold Penalty****:* Hospitals that do not score above the 9th decile threshold (Year 2) in any clinical area will receive a 1% reduction of their Medicare payment in that clinical area for Year 4; hospitals that do not score above the 10th decile threshold in any clinical areas (Year 2) will receive a 2% reduction of their Medicare payment in that clinical area for Year 4. The same will occur in Year 5 with the penalty based on Year 3 decile thresholds and for Year 6 with the penalty based on Year 4 decile thresholds.

Incentive payment amounts will be based on the number of cases identified by CMS as being Medicare fee-for-service beneficiaries who received care within the applicable demonstration year in one of the clinical area(s) as determined by the applicable principal diagnosis or principal procedure code.

The payment methodology may be modified in Years 5 and 6 to enable CMS to evaluate alternative incentive models. CMS has budgeted $12 million per year for demonstration incentives. The availability and amount of payment incentives will be based on the approval by CMS. Incentive payments will be made annually in a lump sum. Measures used to calculate the incentive payment will not include any test measures.

6. Public Reporting. All individual quality measures in each clinical population for all hospitals will be publicly reported annually. Composite quality scores will not be publicly reported as in the Agreement.

7. Data audits. Case data submitted for this project to the SDPS Clinical Warehouse will be subject to quarterly chart validation. CMS will use the same percentage validation criteria for the Premier demonstration as for the Annual Payment Update (APU) program, currently 80% of the elements in agreement on a quarterly basis.

Hospitals scoring below 80% quarterly agreement have the option of appealing their validation score using the same appeals criteria as the APU program.

Hospitals where 80% or more of the elements agree for all cases reviewed during the year will be considered to be reporting validated data for payment eligibility. CMS will use the upper limit of 95% confidence interval to determine payment eligibility, using a similar formula to the APU program combining four quarterly validation samples. CMS currently plans to audit seven cases per hospital per quarter, or twenty eight per year, for all clinical areas combined.

8. Rewards Sharing. Participating hospitals may share any quality incentives obtained in this demonstration with their physicians and staff, but must adhere to the following guidelines:

    a. *Accountability*. The rewards sharing arrangement must be transparently based on clear and separate actions taken by the rewarded physician or staff member to provide high quality care. The policies on the calculation and amount of the quality improvement incentives provided to the physicians must be uniform, and similarly the policies on the calculation and amount of the quality improvement incentives provided to categories of staff must be uniform.
    b. *Payment limit*. The total amount of the rewards shared with all physicians and staff may not exceed the amount of incentives provided to the hospital.
    c. *Anti-kickback*. The plan may not be based in any manner on the volume or value of referrals or business otherwise generated between the hospital and physicians and/or staff.
    d. *Not related to reducing services*. The rewards sharing plan may not be based on any reduction in the hospital's costs attributable to reducing or limiting clinical services.
    e. *Documentation*. Any decision to share rewards with physician and staff must be based on clear, written records contemporaneously recording actions taken to improve quality. The hospital must maintain written records related to the decision to share rewards, including the amounts paid, the determination of the physicians or staff to be rewarded, and the reason for the award. These records must be made readily accessible upon request to Federal government representatives, including monitoring and evaluation contractors. The Office of the Inspector General has access to all records, reports, audits, reviews, documents, papers and other materials that relate to programs and operations for which the Inspector General has responsibilities under the Inspector General Act.

IN WITNESS WHEREOF, the parties have executed this Amendment individually or by signature of their duly authorized representatives as of the date written below.

Centers for Medicare and Medicaid Services
Print Name: Timothy P. Love__________
Signature: __________/s/_____________
Title: Director, Office of Research, Development and Information
Date: _February 16, 2007_________

Premier Inc.
Print Name: _Stephanie C. Alexander______
Signature: __ /s/____________________
Title: _Sr. Vice President___________
Date: _February 28, 2007___________

Table 1: Clinical Conditions and Measures for Reporting and Incentives – Year 4

Measure	APU (501b)	JCAHO	HQID Current	HQID Extension
Acute Myocardial Infarction (AMI)				
Aspirin at Arrival	✓	✓	✓	✓
Aspirin Prescribed at Discharge	✓	✓	✓	✓
ACEI/ARB for LVSD	✓	✓	✓	✓
Beta Blocker at Arrival	✓	✓	✓	✓
Beta Blocker Prescribed at Discharge	✓	✓	✓	✓
Primary PCI Received within 90 minutes of Hospital Arrival	✓	✓	✓	✓
Smoking Cessation Advice/Counseling	✓	✓	✓	✓
Fibrinolytic received within 30 minutes of Hospital Arrival	✓	✓	✓	✓
Inpatient Mortality Rate (JCAHO Risk Adjustment)		✓	✓	✓
30 Day Mortality Rate[T,1]				T
Readmission within 30 Days Rate[T]				T
AHRQ Patient Safety Indicators (combined to a complication index)[T,2]				T
Isolated Coronary Artery Bypass Graft				
Aspirin Prescribed at Discharge			✓	✓
CABG Using Internal Mammary Artery			✓	✓
Prophylactic Antibiotic Received within 1 hour Prior to Surgical Incision	✓	✓	✓	✓
Prophylactic Antibiotic Selection for Surgical Patients	✓	✓	✓	✓
Prophylactic Antibiotic Discontinued within 48 hours of Surgery End Time	✓	✓	✓	✓
Inpatient Mortality Rate (3M APR-DRG™ Risk Adjustment)			✓	✓
Post operative Hemorrhage or Hematoma			✓	✓
Post operative Physiologic and Metabolic Derangement			✓	✓
30 Day Mortality Rate[T]				T
Readmission within 30 Days Rate[T]				T
AHRQ Patient Safety Indicators (combined to a complication index)[T,2]				T
Heart Failure				
Evaluation of LVS Function	✓	✓	✓	✓
ACEI/ARB for LVSD	✓	✓	✓	✓
Detailed Discharge Instructions	✓	✓	✓	✓
Smoking Cessation Advice/Counseling	✓	✓	✓	✓
30 Day Mortality Rate[T]				T
Readmission within 30 Days Rate[T]				T
AHRQ Patient Safety Indicators (combined to a complication index)[T,2]				T
Inpatient Mortality Rate[T] (AHRQ IQI)				T
Hip and Knee Replacement[3]				
Prophylactic Antibiotic Received within 1 hour Prior to Surgical Incision	✓	✓	✓	✓
Prophylactic Antibiotic Selection for Surgical Patients	✓	✓	✓	✓
Prophylactic Antibiotic Discontinued within 24 hours of Surgery End Time	✓	✓	✓	✓
Recommended Venous Thromboembolism Prophylaxis Ordered (Required for APU and JCAHO effective Jan 2007 discharges)	✓ (Jan 07)	✓ (Jan 07)		✓ (Jan 07)
Appropriate Venous Thromboembolism Prophylaxis within 24 hours	✓ (Jan 07)	✓ (Jan 07)		✓ (Jan 07)

Measure	APU (501b)	JCAHO	HQID Current	HQID Extension
Pre and Post Operative Period (Required for APU and JCAHO effective Jan 2007 discharges)				
Post operative Hemorrhage or Hematoma			✓	✓
Post operative Physiologic and Metabolic Derangement			✓	✓
Readmission within 30 days to Acute Care Inpatient Rate[4]			✓	✓
AHRQ Patient Safety Indicators (combined to a complication index)[T,1]				T
Pneumonia				
Appropriate Initial Antibiotic Selection	✓	✓	✓	✓
Blood Culture Performed in ED Prior to First Antibiotic Received in Hospital	✓	✓	✓	✓
Influenza Vaccination	✓	✓	✓	✓
Oxygenation Assessment	✓	✓	✓	✓
Pneumococcal Vaccination	✓	✓	✓	✓
Smoking Cessation Advice/Counseling	✓	✓	✓	✓
30 Day Mortality Rate[T]				T
Readmission within 30 Days Rate[T]				T
AHRQ Patient Safety Indicators (combined to a complication index)[T,1]				T
Inpatient Mortality Rate[T] (AHRQ IQI)				T

[T]Measure is important to evaluate for future use and will be used for test purposes only. Measure will not be used in the Composite Quality Score calculation for incentive payment.
[1]30 day Mortality rate – uses CMS hierarchical model based on administrative data
[2]All applicable AHRQ Patient Safety Indicators will be applied to each appropriate clinical area (AMI, Isolated CABG, HF, PN, and H/K). See PSI list.
[3]Hip and Knee population is expanded to all payers effective with October 1, 2006 discharges.
[4]30 day Readmission rate – uses Premier data risk-adjusted with 3M APR-DRG™ methodology

Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs)

PSIs applicable to the HQID populations:

1. Complications of Anesthesia
2. Death in Low Mortality DRGs
3. Decubitus Ulcer
4. Failure to Rescue
5. Foreign Body Left during Procedure
6. Iatrogenic Pneumothorax
7. Selected Infections due to Medical Care
8. Postoperative (postop) Hemorrhage of Hematoma
9. Postop Hip Fracture
10. Postop Physiologic and Metabolic Derangement
11. Postop Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT)
12. Postop Respiratory Failure
13. Postop Sepsis
14. Technical Difficulty with Procedure
15. Transfusion Reaction
16. Postop Wound Dehiscence

The PSIs will be used to create a complication index which will be a risk-adjusted composite of all of the applicable PSIs for each specific clinical area at the hospital level.