..... moves to amend H.F. No. 2412 as follows:

Page 3, line 12, after the period, insert:"The managed care plans and county-based purchasing plans shall provide the encounter data and claims payment data as specified in paragraph (m)."

Page 3, after line 32, insert:

"(m) (1) Beginning July 1, 2013, every day, all managed care plans and county-based purchasing plans and providers shall submit electronic encounter data, as HIPAA Compliant EDI Health Care Claim (837) when available, and claims payment information, as HIPAA Compliant HealthCare Payment Advice (835), to a private entity designated by the commissioner of health for all services provided by managed care and county-based purchasing plans to medical assistance enrollees as they receive or send them to each other. The private entity designated by the commissioner shall maintain and operate an encounter data and payment tracking system to collect, process, store, and report on services provided by managed care and county-based purchasing plans to medical assistance enrollees. The system must be implemented by July 1, 2013, to collect, process, store, and report on covered services provided to all enrollees and payments to providers for services provided to those enrollees.

The commissioner or the designated entity, in developing the system, shall establish methods and protocols for ongoing analysis of the encounter and payment data provided under this paragraph, that adjust for differences in characteristics of plan enrollees to allow comparison of service utilization and costs among plans and against expected levels of use. The commissioner shall use this patient level encounter data and plan and provider payment data to analyze on an ongoing basis the cost, quality, and efficiency of services provided by managed care and county-based purchasing plans to medical assistance enrollees.

The agency and any other authorized state and federal agencies shall utilize this patient level encounter data and plan/provider payment data for any audit or reconciliation related to managed care plans.

The analysis must identify possible cases of systemic underutilization or denials of claims, inappropriate service utilization such as higher-than-expected emergency department encounters, determine administration costs, gain insight into patient treatment outcomes, determine speed of claims payment, and track and evaluate the efficiency and quality of service delivery by managed care and county-based purchasing plans.

(2) The claims information submitted shall be the original source files as submitted by the provider to the managed care or county-based purchasing organization. The remittance information shall be the original source files as submitted by the managed care or county based purchasing organization to the providers. The data must include all of the information that is in the health care claim or equivalent and health care payment information transaction to ensure transparency of information. The commissioner or the commissioner's designee shall use the data submitted under paragraph (1) only for the purpose of carrying out its responsibilities in this paragraph and must maintain the data that it receives according to the provisions of this subdivision.

(3) Data on providers collected under this paragraph are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this paragraph may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(4) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

The commissioner shall provide periodic feedback to the plans and require plans to take corrective action when necessary.

(5) For purposes of this subdivision, the following definitions apply:

(i) "administrative costs" means expenditures on loss-adjustment activities, prior authorizations, utilization reviews, underwriting activities, negotiating networks and contracts with providers, approvals and denials of claims, research activities, reserves, and capital expenses; and

(ii) "medical costs" means the payments to licensed health care professionals and health care entities for delivering to specific patients drugs, devices, supplies, and services, including educational services, or assisting them in accessing medical care. Medical costs may also include expenses that are designed to improve health care quality and increase

the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. These quality expenses should be grounded in evidence-based medicine, widely accepted best clinical practice or criteria issued by recognized professional medical societies, accreditation bodies, government agencies, or other nationally recognized health care quality organizations. They must be primarily designed to achieve the following goals:

(A) improve health outcomes;

(B) prevent hospital readmissions;

(C) improve patient safety and reduce medical errors, lower infection and mortality rates;

(D) increase wellness and promote health activities; or

(E) enhance the use of health care data to improve quality, transparency, and outcomes.

(6) To eliminate the possibility of a conflict of interest, the vendor for this solution or any of its subsidiaries or affiliated firms shall not be a vendor for any state funded health care program."