HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 783 Medicaid Managed Care Plan Performance Metrics
SPONSOR(S): Select Committee on Health Innovation, Berfield and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 794

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Lloyd	Calamas
2) Health Care Appropriations Subcommittee	15 Y, 0 N	Smith	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Medicaid program is a medical assistance program for low-income people and disabled individuals, funded jointly by the state and federal governments. The Agency for Health Care Administration (AHCA) administers the Medicaid program, primarily through a managed care model under contracts with managed care plans. The Statewide Medicaid Managed Care Program (SMMC) operates under a federal waiver to deliver primary and acute care services as the Managed Medical Assistance (MMA) program, and under a second federal waiver to deliver comprehensive long-term care services.

Current law requires AHCA to monitor plan performance, including requiring the managed care plans to report various data related to provider interactions and provider network administration. AHCA imposes detailed reporting requirements for the plans through their contracts, including data not currently published or analyzed by AHCA in a systematic manner.

CS/HB 783 establishes detailed requirements for analysis and publication of data on managed care plan administrative performance related to providers, including data on provider credentialing, prior authorization processing, claims payment and complaints from providers and recipients. AHCA must contract with a third-party vendor to analyze the data submitted by the plans and develop an online dashboard on the agency's website to publish the data.

AHCA must publish the data on the dashboard quarterly beginning October 1, 2024. AHCA must also produce an annual report on the data beginning January 1, 2026, and submit the report to the Medical Care Advisory Committee, the Governor and the Legislature.

The implementation costs of the bill can be absorbed within existing agency resources. *See* Fiscal Analysis.

The bill has an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medicaid

The Medicaid program is a medical assistance program funded jointly between the state and federal governments. The program provides health care coverage for over 4.8 million low-income families and individuals, the elderly, and individuals with disabilities in Florida, including 3.4 million recipients who receive their services through a managed care plan.[1] In Florida, two in every five Florida children receive Medicaid, and 45 percent of all births in the state are covered by the program.[2]

The Agency for Health Care Administration (AHCA) administers the Florida Medicaid program authorized under Title XIX of the federal Social Security Act and Ch. 409, F.S. The AHCA administers the program through the managed care model,[3] under contracts with managed care plans. The program operates under two separate federal Medicaid waivers: Section 1115 waiver for primary and acute care services called the Managed Medical Assistance (MMA) program, and Long Term Care (LTC) services waiver under Sections 1915(b) and (c) of the Social Security Act.[4] Currently, the AHCA is conducting its third procurement process under these waivers with the selection of new contracts anticipated at the end of February, 2024.[5] The existing SMMC contracts have been effective for almost seven years and will expire December 31, 2024.

Managed Care Plan Accreditation

Accreditation is a "seal of approval" given to an organization by an independent evaluator, which has reviewed the practices and performances of the managed care plan. An accreditation rating indicates that a plan meets or exceeds certain quality criteria based on the level or rating that a plan has earned. Accreditation status is one of the statutorily-designated quality selection criteria that the AHCA must consider in the selection of eligible plans during the procurement process. Plans must be accredited by the National Committee for Quality Assurance[6], the Joint Commission[7] or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed.

Each accrediting organization has its own standards and assesses those standards against the health plan's performance and organizational structure to determine if its established standards and performance standards meet the accrediting body's requirements. The plan may be reviewed for its provider credentialing processes, prior authorization procedures, and prompt payments of provider claims. Accreditation can be awarded for different lengths of time and then must be renewed.

[1] Agency for Health Care Administration, *Comprehensive Medicaid Managed Care Enrollment Reports (December 31, 2023)* available at https://ahca.myflorida.com/medicaid/medicaid-finance-and-analytics/medicaid-data-analytics/medicaid-monthly-enrollment-report (last visited February 8, 2024).
[2] Kaiser Family Foundation, *Medicaid in Florida (June 2023),* available at https://files.kff.org/attachment/fact-sheet-medicaid-state-FL (last visited February 8, 2024).
[3] The vast majority of Medicaid enrollees receive services through the managed care model; those with limited benefits (such as the family planning program) are not, and some populations (such as enrollees in the home and community-based waiver for persons with developmental disabilities) may choose managed care or the fee-for-services model. S. 409.965, F.S.
[4] S. 409.964, F.S.
[5] *See* AHCA ITN 23/24 010 for Statewide Medicaid Managed Care (MMA and LTC) available at MyFloridaMarketPlace Vendor Information Portal (last visited February 8, 2024) and the AHCA ITN for Statewide Medicaid Prepaid Dental Services available at MyFloridaMarketPlace Vendor Information Portal (last visited February 8, 2024).
[6] National Committee on Quality Assurance (NCQA), *About NCQA,* Health Care Accreditation, Health Plan Accreditation Organization - NCQA - NCQA (last visited February 8, 2024).
[7] The Joint Commission, *Who We Are, A Trusted Partner in Patient Care | The Joint Commission* (last visited February 8, 2024).

Provider Network Credentialing

Medicaid Provider Identification Number

To deliver health care services to a Medicaid recipient and be paid for that service, an individual provider must be an enrolled provider through AHCA's provider enrollment system. The credentialing process ensures that health care workers and organizations have the proper education, training, qualifications, and licenses to care for patients. The provider enrollment system also reduces improper payments in Medicaid by minimizing the risk of allowing unscrupulous providers to bill the Medicaid program, according to AHCA. [8]

For providers who only need to enroll for a Medicaid Provider Identification Number for billing under a Medicaid managed care contract and will only be paid through the plan and not through FFS, AHCA established a streamlined credentialing process that includes basic credentialing, licensure verification, review of background screening history, and a check with the federal exclusion database checks.[9] If a provider contracts with more than one SMMC plan, the basic credentialing by AHCA reduces the time it takes for a provider to complete each plan's unique or supplemental credentialing requirements.

The limited provider enrollment option is only for those providers participating with the managed care plans and is not a sufficient process for a provider who is reimbursed as an individual provider in the FFS delivery system.[10] Providers credentialed through the limited process do not have access to the necessary web portal tools, including the ability to submit claims, upload or download files, or view reports.[11] A Limited Enrollment Provider can always submit a new application to become an Enrolled Provider later to have his or her access upgraded to direct billing and other options.[12]

Managed Care Plan Network Credentialing

A plan may conduct its own credentialing process or contract with an accreditation credential verification organization(s) to conduct the process on its behalf. While the managed care plan's credentialing process may be conducted concurrently with the Medicaid provider enrollment process, which could shorten the length of the credentialing period, most of the current plans require a prospective provider to obtain its Medicaid provider ID *prior to* submitting its credentialing application to the managed care plan for credentialing.[13]

The *Medicaid Provider Enrollment Application Guide* presents example timeframes for provider application processing based on stages and if there are no deficiencies with the application. The following stages and timeframes would likely apply for a new application:[14]

- In Process: Application is being reviewed for accuracy and compliance with all provider eligibility requirements (a*pproximately 14 business days*).
- Background Screening: Application processing has been completed. Results of the background screening have not yet been received from the Background Screening Clearinghouse (*approximately 5 business days*)
- Clearinghouse Screening: The application has no deficiencies and is awaiting the results of the background screening (*less than 15 calendar days*). If screening results are not received within 14 days, the provider receives a deficiency letter.
- State Review: Applications pending verification by AHCA will show a status of "State Review." State Review means validating the information on the application, such as certification and expiration dates, search for any prior history with the applicant and Medicaid or any other state agencies, and a review of the applicant's financial history.

[8] *Supra*, note 5.
[9] Agency for Health Care Administration. *An Overview of Streamlined Credentialing (Limited Enrollment), February 2, 2022*, available at https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Managed%20Care/Streamlined%20Credentialing%20(Limited%20Enrollment).pdf (last visited February 8, 2024).
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022)* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited February 8, 2024).

- Enrolled: Enrollment approved. A Welcome letter is mailed within 2 business days after the activation of the new provider (*activated within 5 business days*).

The timeframes for activation of a new provider identification number depend on the sufficiency of the application submitted, and if additional documentation becomes necessary as part of the review process. Ensuring that an applicant's name and identification number are clearly marked on items helps with the matching of supplemental materials and the return of documents after the review.

Prior Authorization

Prior authorization is one method of managing health care utilization and quality. Insurers and managed care plans may require providers to obtain coverage and reimbursement authorization prior to providing certain services or prescribing certain drugs. Prior authorization is often used to help identify under- and over- utilization of services, identify clinical risks such as drug-drug interactions, and prevent fraud and abuse. In Medicaid managed care, both federal regulations and AHCA plan contracts establish maximum timelines for plans to resolve both urgent and non-urgent prior authorization requests.

Prior Authorization Timeline Comparison		
	Federal Regulations 42 CFR 438.210(d)	**AHCA Contract**
Standard Request (Non-Urgent)	14 calendar days	7 days
Standard Request Allowable Extension	14 calendar days	4 days
Standard Request Maximum Allowed	28 calendar days	11 days
Urgent Request	72 hours	2 days
Urgent Request - Allowable Extension	14 calendar days	1 day
Urgent Request - Maximum Extension	17 calendar days	3 days

The AHCA reports that when the current SMMC contracts were renewed, a reduced response time for non-urgent and urgent requests was agreed upon by the parties. The non-urgent prior request maximum time was modified from the federal limit of 28 calendar days to the contractual standard of 11 days.[15] For urgent requests, the current contractual standard is two days with an extension period of one additional day, which reduces the length of the maximum possible review time from 17 review days to three days.[16]

The plans currently report monthly on all service authorization requests completed during the previous reporting month. Service authorization requests are categorized as standard, extended standard, expedited, or extended expedited authorizations.[17] Plans are specifically prohibited from requiring prior authorization for emergency services; however, prior authorization for specific Medicaid services or benefits may be applicable for services with higher utilization or higher costs. In some instances, there are procedural limitations in state statute if a prior authorization process is applied, including a requirement that access to the prior authorization system be accessible 24 hours a day, 7 days a week for approval of hospital inpatient services[18], or that responses to authorization requests be initially made within 24 hours.[19] Other prior authorization directives focus on the entity requesting authorization and the items necessary for a determination such as clinical and medical records, prior use of a treatment or prescription, a recipient's plan of care, and documentation that supports the recipient's diagnosis.[20]

[15] *Supra,* note 5.
[16] *Supra,* note 5.
[17] *Id.*
[18] S. 409.905(5), F.S.
[19] S. 409.912(5)(1)(a), F.S.
[20] *See* ss. 409.905(4) and(5), 409.906(8), (13), (23), and 24 409.912(5)(a), 409.91195(5) and (9), F.S.

Prompt Payment

Federal Medicaid regulations establish standards for the prompt payment of provider claims for Medicaid beneficiaries.[21] The regulation defines a "claim" to mean a bill for services, a line item of service, or all services for one beneficiary within a bill." A "clean claim" is considered to be a claim that can be processed without obtaining additional information from the provider of the service or from a third party.[22]

State law also requires the plan to have a claims payment system which ensures the timely payment of clean claims within state standards under s. 641.3155, F.S.[23] With the receipt of a clean electronic claim, the plan may either dispute or deny the claim or pay the claim within 20 days after the claim has been received. If requested, a provider must submit additional information and documentation within 35 days of receipt of the request for additional information. The claim must be paid or denied with 90 days of receipt. [24]

For nonelectronic or paper claims, a plan must pay the provider also in accordance with federal and state regulations. Paper claims must be denied or paid within 40 days after receipt of the claim; however, the time can be extended if supplemental documentation is required. If the claim is not denied or paid within 120 days of the original receipt date, the Plan is obligated to pay the claim within 140 days.[25]

Contractually, the AHCA and the MMA plan agreed to tighter prompt payment standards in the renewal of their contracts in 2018. With notice periods significantly less than statutory requirements, AHCA reports that the managed care plans must pay or notify a provider that a claim is denied or contested within 10 business days of receipt of a clean claim from either a nursing home or hospice and within 15 days if received from a non-nursing home/hospice facility. If contested or denied, the claim must be paid or denied within 90 days after receipt, but if the claim is neither denied nor paid, the plan has a maximum time period to pay of 120 days.

For non-electronically submitted claims, the plan must pay the paper claim or notify the provider that the claim is denied or contested within 20 days after receipt of the claim.[26] The chart below shows the existing authorities and standards for Medicaid contracts and prompt payment of claims.

Comparison of Time Standards – Prompt Payment of Claims Maximum Time Measured from First Receipt of Claim				
	Federal CFR 42.447(d)*	**FL Insurance Code** §641.3155, F.S.	**Medicaid Contract** §409.966(3)(c)6, F.S.	
	**Based on a percentage of claims paid within this standard*		Nursing Home Hospice	Non-Nursing Home Hospice
Electronic Clean Claims				
#Days to acknowledge receipt	NA	NA	Next business day	
#Days to pay, notify denial or contest	30 days	20 days	10 business days	15 business days
#Days to provide additional information > denial	NA	35 days	35 days	35 days

[21] 42 CFR 447.45.
[22] *Supra,* note 5.
[23] ss. 409.966(3)(c)(6), F.S. and 641.3155(3), F.S.
[24] *Supra,* note 5.
[25] Agency for Health Care Administration, *Florida Medicaid Provider Enrollment Application Guide (October 2022),* available at Florida Medicaid Provider Enrollment App Guide.pdf (flmmis.com) (last visited February 8, 2024).
[26] *Supra,* note 5.

#Days to pay > additional information	NA	NA	90 days	90 days
Paper Claims				
#Days to acknowledge receipt	NA	40 days	20 days	20 days
#Days to pay, notify denial, or contest	30 days	35 days	20 days	20 days
All Claims Types				
#Days to pay or deny claim	90 days	90 days	20 days	20 days
#Days before Plan must pay if no payment, or a denial or contest	90 days	120 days	90 days	90 days
Maximum time to pay any claim	12 months	140 days	120 days	120 days

Quality Strategies

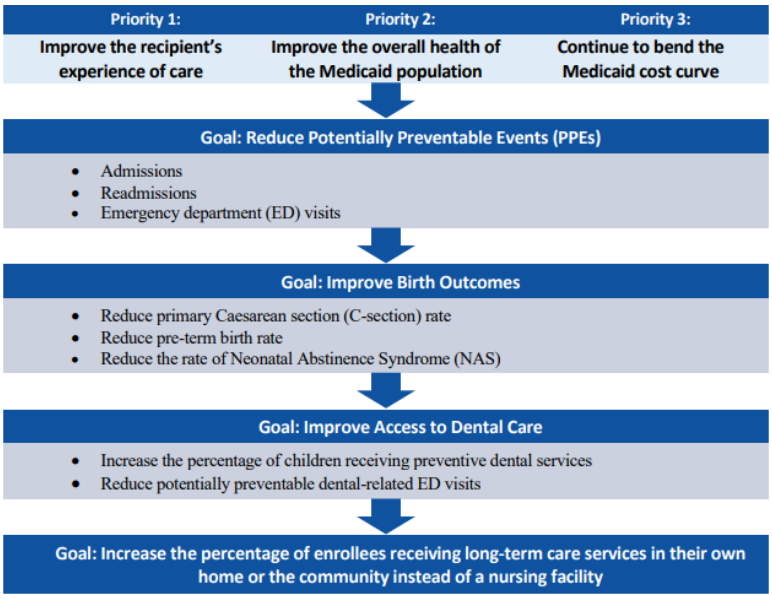
In 2016, the federal Centers for Medicare & Medicaid Services (CMS) re-vamped the Medicaid standards for contracting with managed care plans. States that contract with managed care plans must have a monitoring plan in place which includes:

- Standards for access to care, structure and operations, and quality measurement and improvement;
- Procedures for regularly monitoring and evaluating plan compliance with state standards;
- National performance measures identified and developed by CMS;
- External independent reviews of quality outcomes and access to services;
- Allowance for Intermediate sanctions for plans;
- Operation and review of the state's quality strategy;
- State-defined network adequacy and availability of services standards for managed care;
- Measurable goals and objectives for continuous quality improvement, with consideration of the existing population's health status;
- Performance targets, performance measures, quality measures, and performance outcomes that will be measured and reported;
- Performance improvement projects and other interventions proposed to improve access, quality, or timeliness of care;
- Description of the state's care transition policy;
- Description of the state's plan to address health care disparities; and
- Mechanisms to identify persons who need long-term services and supports or persons with special health care needs.[27]

In addition to these ongoing requirements, the plans must continually demonstrate ongoing compliance with state contractual requirements for being nationally accredited, having experience with the population to be served, offering sufficient primary care and specialty care physicians, and processing of uncontested claims in a timely manner.[28] The plans were required before the federal regulation to maintain accurate and complete databases of their provider network and display data and patient feedback on the provider in such a manner that it allowed patients to easily make provider comparisons.[29]

The federal regulations[30], also require states to develop and implement a written quality strategy and to re-assess that strategy every three years. The AHCA last updated these goals during the 2019-2020 state fiscal year and identified three priorities tied to four specific program goals.[31]

[27] 42 CFR 438.340.
[28] S. 409.966(3), F.S.
[29] ss. 409.967(2)(c)(1) and 409.967(2)(e), F.S.
[30] 42 CFR section 438.340
[31] Agency for Health Care Administration, Health Services Advisory Group, *SFY 2021-2022 External Quality Review Technical Report (April 2023),* available at SFY 2021–2022 External Quality Review Technical Report (myflorida.com) (last visited February 8, 2024).



The state may implement performance improvement projects (PIP) as another quality improvement strategy. A PIP includes four elements:

- Performance measurement;
- Implementation of interventions;
- Evaluation of the interventions' impact using the performance measures; and
- Activities to increase/sustain improvement.[32]

A PIP may be focused on a specific improvement need of a plan or region, or it could be a PIP that is shared among all plans as a systematic goal of the Medicaid program. In a few cases, CMS has mandated a national PIP to see improvements in specific areas of health care, such as a focus on children's oral health. At this time, the MMA plans have three shared PIP topics incorporated into their contracts relating to maternal health, potentially preventable events, administration issues of the transportation benefit. In addition, the contracts require plans to add a PIP of their choosing in behavioral health or integrating behavioral health and primary care.[33]

An External Quality Review Organization (EQRO) is also required for each state's Medicaid program.[34] An EQRO acts to validate the data behind the performance measurements and other mandatory state and federal reporting requirements the state is held accountable for, review of the performance and measurement of the PIPs of the managed care plans, and to assist in the development of the state's quality rating system.

Complaints and Grievances

The AHCA uses a centralized approach to resolve Medicaid complaints and to determine if Medicaid managed care plans are meeting their contractual obligations. All complaints are recorded whether the complaint is later substantiated or not.[35]

Complaint and grievance are defined in state statute in several places and while sometimes used interchangeably, the two words are statutorily and procedurally different. Federal laws and rules which govern the Medicaid program do not define "complaint", but do define "grievances".[36] By contract, the SMMC contract defines both "complaint" and "grievance." The SMMC contract defines "complaint" as "any oral or written expression of dissatisfaction by an enrollee submitted to the Managed Care Plan or

[32] 42 CFR 438.330(d)
[33] Agency for Health Care Administration, *Medicaid Managed Care, 2018-2024 Model Contracts, Managed Medical Assistance, Attachment II, Exhibit II-A, Section IX (Quality),* available at https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care/2018-2024-smmc-plans (last visited February 8, 2021).
[34] Section 1932(c)(1) of the Social Security Act.
[35] *Id.*
[36] 42 CFR 438.400(b) defines grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination.

to a State Agency and resolved by close of business the following business day." A complaint is considered to be a subcomponent by a grievance by the AHCA as any unresolved complaint at the end of the following business day becomes a grievance.

A "grievance" is then defined by the federal regulation definition. As a grievance, the managed care plan must provide the beneficiary with a written notice of the resolution within 90 days from the date of the receipt of the grievance. Unresolved grievances can then lead to a plan appeal, the Medicaid fair hearing process, the District Court of Appeal, and ultimately the Florida Supreme Court. The maximum time frames for these processes are established in the Code of Federal Regulations.[37]

Quarterly, the managed care plans submit a report to AHCA on the total number, description, and outcome of the grievances filed by beneficiaries. This internal review process is part of each plan's quality review process.

Effect of Bill

CS/HB 783 creates a new section of statute relating to Medicaid managed care contracts and data analysis related to provider credentialing, prior authorization, and the prompt claims payment. Under the bill, AHCA must contract with a third-party vendor to analyze data reported to AHCA by the plans pursuant to statutory and contract requirements. The data analyses must produce and document performance metrics specified in the bill, as listed below:

- Provider Credentialing volume, including:
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 60 days;
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 90 days
  - Percentage and total number of provider applications processed and loaded for provider billing within the last 120 days.
- Prior authorization requests, including:
  - Percentage and total number of standard prior authorization requests approved by service type;
  - Percentage and total number of standard prior authorization requests denied;
  - Percentage and total number of expedited prior authorization requests approved by service type;
  - Percentage and total number of expedited prior authorization requests denied;
  - For each of the approvals, the standard length of time for an approval;
  - For each of the appeals, the percentage of appeals granted and the length of time from appeal to granting of request;
  - Average and median time between submission of requests and decisions, for standard and expedited authorizations.
- Prompt payment of claims:
  - Percentage and total number of claims that are rejected before review;
  - Percentage and total number of claims that are rejected before paid;
  - Percentage and total number of claims that are rejected before partially paid;
  - Percentage and total number of claims that are rejected before denied;
  - Percentage and total number of claims that are rejected before suspended;
  - Average length of time to pay clean claims;
  - The percentage of clean claims paid within seven, 10 and 20 days, and in excess of 120 days;
  - Top 10 reasons for claim denial, with the percentage and the total number of claims for each reason cited.
- Managed care plan complaints:
  - Number of managed care recipients enrolled in the statewide Medicaid Managed Medical Assistance program;

[37] *Supra,* note 5.

- Number of complaints per 1,000 beneficiaries;
- By each managed care plan, per 1,000 recipients;
  - Number of complaints by provider category (physicians, hospitals, outpatient services; skilled nursing facilities, assisted living facilities, therapy services, transportation; services, laboratories, home care services, and community based services);
  - Number of complaints received by region;
  - Number of complaints resolved by region;
  - Number of complaints pending for resolution by region;
  - Average length of time to resolve provider complaint by region; and
  - Average length of time to resolve Medicaid recipient complaint by region.

Most of the data required by the bill relating to claims payment, prior authorization, and complaints are already being collected by AHCA; some data would require additional reporting by the managed care plans. Not all of the data *calculations* required by the bill are included in current reporting; however, the agency would be able to perform those calculations.

AHCA must publish the data quarterly on the dashboard developed by the third-party vendor, beginning October 1, 2024. In addition, the bill requires AHCA to create and make publicly available an annual report on the listed metrics beginning January 1, 2026. AHCA must also submit the report to the Medical Care Advisory Committee, the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The effective date of the bill is July 1, 2024.

SECTION DIRECTORY:

Section 1: Creates s. 409.9673, relating to managed care plan performance metrics.
Section 2: Provides and effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA indicates the bill would have an operational and fiscal impact on the Medicaid program. AHCA would be required to contract with a third-party vendor to create a dashboard to display the required reports of plan data. AHCA estimates the bill implementation cost would total $584,241, with $500,000 in nonrecurring costs for the third-party vendor contract, and one FTE position totaling $84,241, of which $78,685 is recurring. [38] Based on prior year reversions and long term vacant positions, the agency can absorb the implementation costs within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[38] Agency for Health Care Administration, *2024 Agency Legislative Bill Analysis: HB 783* (published December 28, 2023), on file with the House Health Care Appropriations Subcommittee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The AHCA has sufficient rule-making authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Limited the AHCA data analysis to information already reported by managed care plans pursuant to law or contract.
- Required complaint data published to be based on plan enrollment per 1,000 enrollees.
- Require certain prior authorization data to be analyzed by service type.
- Required quarterly publication on an agency dashboard developed by a third-party vendor, beginning October 1, 2024.
- Required an annual report beginning January 1, 2026.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.