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HOUSE BILL NO. 2274

Offered January 10, 2007

Prefiled January 9, 2007

A BILL to amend and reenact §§ 2.2-1504, 32.1-102.1, 32.1-102.12, 32.1-276.3, and 32.1-276.5 of the Code of Virginia, to amend the Code of Virginia by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.01 and an article numbered 1.3 in Chapter 5 of Title 32.1, consisting of sections numbered 32.1-137.18 and 32.1-137.19, and to repeal § 32.1-102.1:1 of the Code of Virginia, relating to certificates of public need and deregulation of health care facilities.

Patron—Purkey

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-1504, 32.1-102.1, 32.1-102.12, 32.1-276.3, and 32.1-276.5 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.01 and an article numbered 1.3 in Chapter 5 of Title 32.1, consisting of sections numbered 32.1-137.18 and 32.1-137.19 as follows:

§ 2.2-1504. Estimates by state agencies of amounts needed.

A. Biennially in the odd-numbered years, on a date established by the Governor, each of the several state agencies and other agencies and undertakings receiving or asking financial aid from the Commonwealth shall report to the Governor, through the responsible secretary designated by statute or executive order, in a format prescribed for such purpose, an estimate in itemized form in accordance with the expenditure classification adopted by the Governor, showing the amount needed for each year of the ensuing biennial period beginning with the first day of July. The Governor may prescribe targets that shall not be exceeded in the official estimate of each agency; however, an agency may submit to the Governor a request for an amount exceeding the target as an addendum to its official budget estimate.

B. Each agency or undertaking required to submit a biennial estimate pursuant to subsection A shall simultaneously submit an estimate of the amount that will be needed for the two succeeding biennial periods beginning July 1 of the third year following the year in which the estimate is submitted. The Department shall provide, within thirty days following receipt, copies of all agency estimates provided under this subsection to the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

C. The format used in making these estimates shall (i) be prescribed by the Governor, shall (ii) be uniform for all agencies, and (iii) clearly designate the kind of information to be given. The Governor may prescribe a different format for estimates from institutions of higher education, which format shall be uniform for all such institutions and shall clearly designate the kind of information to be provided.

D. It shall be the policy of the Commonwealth to appropriate 100 percent of the costs of the indigent health care services provided by or through the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center. In addition, it shall be the policy of the Commonwealth to fund at least 50 percent of the costs of indigent health care services provided by or through the faculty, students, and associated hospitals of the Eastern Virginia Medical School.

The Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center shall submit the estimates of the amounts needed for this purpose in the manner required by this section. The Eastern Virginia Medical School shall submit such data and estimates as shall be required by the Director.

§ 32.1-102.01 Three-phased plan for the deregulation of certain medical care facilities' certificate of public need services; components of plan.

Certificate of public need deregulation shall occur in three phases over a period of three years, as follows:

1. Phase I shall include deregulation of computed tomographic (CT) scanning, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, and all nuclear medicine imaging services or equipment introduced at any new or existing medical care facility.

Providers of the Phase I deregulated services shall comply with licensure requirements promulgated and administered by the Board of Health, pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5, which shall apply equally across all health care settings, consistent with appropriate existing, nationally recognized accreditation standards. Entities that are accredited by national accreditation organizations

that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Providers of Phase I deregulated services shall also report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2et seq.), claims data, certain quality outcome information for selected high-risk procedures, where applicable, and annual financial information on indigent care.

Phase I deregulation shall be completed by July 1, 2008.

2. Phase II shall include deregulation of cardiac catheterization, gamma knife surgery, and radiation therapy.

Providers of the Phase II deregulated services shall comply with licensure requirements promulgated and administered by the Board of Health, pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5, which shall apply equally across all health care settings, consistent with appropriate existing, nationally recognized accreditation standards. Entities that are accredited by national accreditation organizations that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Providers of the Phase II deregulated services shall also report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2et seq.), claims data, certain quality outcome information for selected high risk procedures, where applicable, and annual financial information on indigent care.

Phase II deregulation shall be completed by July 1, 2009.

3. Phase III shall include deregulation of (i) ambulatory surgery centers, neonatal special care, obstetric, open-heart surgery, organ and tissue transplantation, medical rehabilitation, psychiatric, and substance abuse treatment services or equipment introduced at any new or existing medical care facility, (ii) nursing home services including any intermediate care service, extended care facility service, or skilled nursing facility service, introduced at any existing medical care facility, regardless of the type of facility in which the services are provided, (iii) any increase in the total number of beds at any existing medical care facility, (iv) establishment of any new medical care facility, and (v) any other service, equipment or facility previously subject to this Article.

Providers of Phase III deregulated services shall comply with licensure requirements administered by the Board of Health, pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5, which shall apply equally across all health care settings, consistent with appropriate existing, nationally recognized accreditation standards. For neonatal special care, open-heart surgery, and organ and tissue transplantation licensure review shall include a review of the applicant's ability to attract sufficient additional volume within the appropriate service area for the applicant to meet nationally recognized quality thresholds for patient volume.

Entities that are accredited by national accreditation organizations that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Providers of Phase III deregulated services shall also report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2et seq.), claims data, certain quality outcome information for selected high-risk procedures, where applicable, and annual financial information on indigent care. The Board of Health shall collect, at appropriate intervals, volume and outcome information from newly deregulated and licensed providers of neonatal special care, open-heart surgery, and organ transplantation.

Phase III deregulation shall be completed by July 1, 2010.

§ 32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

~~2. Sanitariums.~~

~~3~~*2*. Nursing homes.

~~4~~*3*. Intermediate care facilities, except those intermediate care facilities established for the mentally retarded that have no more than 12 beds and are in an area identified as in need of residential services for people with mental retardation in any plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

~~5~~*4*. Extended care facilities.

~~6~~*5*. Mental hospitals.

~~7~~*6*. Mental retardation facilities.

~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

~~9~~*8*. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning,~~ *and* radiation therapy.~~, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation.~~

~~10~~*9*. Rehabilitation hospitals.

~~11~~*10*. Any facility licensed as a hospital.

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; (iii) an intermediate care facility for the mentally retarded that has no more than 12 beds and is in an area identified as in need of residential services for people with mental retardation in any plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; or (v) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation at the same site of 10 beds or 10 percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of 10 percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of any new cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ medical rehabilitation, neonatal special care, obstetrical *service,* open heart surgery, ~~positron emission tomographic (PET) scanning,~~ psychiatric *service,* organ or tissue transplant service, radiation therapy, ~~nuclear medicine imaging, except for the purpose of nuclear cardiac imaging,~~ *or* substance abuse treatment~~, or such other specialty clinical services as may be designated by the Board by regulation, which~~ *that* the facility has never provided or has not provided in the previous 12 months;

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds; *or*

7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ open heart surgery, ~~positron emission tomographic (PET) scanning,~~ *and* radiation therapy.~~, or other specialized service designated by the Board by regulation.~~ Replacement of existing equipment shall not require a certificate of public need.~~; or~~

~~8. Any capital expenditure of $5 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between $1 and $5 million shall be registered with the Commissioner pursuant to regulations developed by the Board.~~

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds

and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 ~~which~~ *that* serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

§ 32.1-102.12. Report required.

The Commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the Commissioner's actions during the previous fiscal year pursuant to this article;

~~2. A five-year schedule for analysis of all project categories which provides for analysis of at least three project categories per year;~~

~~3~~*2.* An analysis, *conducted together with the Joint Commission on Health Care,* of the appropriateness of continuing the certificate of public need program for ~~at least three~~*various* project categories in accordance with the ~~five-year~~*three-year* schedule for analysis of ~~all~~*the* project categories;

~~4~~*3.* An analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department required by § 32.1-102.6 which details the review time required during the past year for various project categories, the number of contested or opposed applications and the project categories of these contested or opposed projects, the number of applications upon which the health systems agencies have failed to act in accordance with the timelines of § 32.1-102.6 ~~B~~, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by § 32.1-102.6 ~~E~~, and any other data determined by the Commissioner to be relevant to the efficient operation of the program; *and*

~~5~~*4.* An ~~analysis of health care market reform in the Commonwealth~~*assessment, conducted together with the Joint Commission on Health Care, of the effects of the deregulation phases, as appropriate, on (i) access to care, particularly access to care by the indigent and uninsured, (ii) quality of care, (iii) the relevance of certificate of public need to the quality of care, and the issues described in § 32.1-102.13* and (iv) the extent, if any, to which such ~~reform obviates~~*effects obviate* the need for the certificate of public need program.~~;~~

~~6. An analysis of the accessibility by the indigent to care provided by the medical care facilities regulated pursuant to this article and the relevance of this article to such access;~~

~~7. An analysis of the relevance of this article to the quality of care provided by medical care facilities regulated pursuant to this article; and~~

~~8. An analysis of equipment registrations required pursuant to § 32.1-102.1:1, including the type of equipment, whether an addition or replacement, and the equipment costs.~~

Article 1.3.

Licensure of Certain Specialty Services.

§32.1-137.18. Definitions.

As used in this article:

"Accreditation" means approval by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., or the American College of Radiology, or such other national accrediting organization as may be determined by the Board of Health to have acceptable quality of care standards.

"Board" means the Board of Health.

"Specialty Services" means any specialty service regardless of whether located in an outpatient or inpatient setting that (i) required, on July 1, 2006, a certificate of public need for the purchase of the relevant equipment, building of the relevant facility or introduction of the relevant service, and (ii) was subsequently deregulated for the purpose of the certificate of public need program in 2007 or thereafter, or (iii) such other specialty services as may be designated by the Board by regulation.

§ 32.1-137.19. Licensure required; Board regulations.

A. No specialty services, regardless of where located, shall operate in this Commonwealth without a license issued by the Board of Health; however, any specialty service already in operation on or before the effective date of the relevant licensure requirement shall not be required to be so licensed until one year after the effective date of the Board's relevant regulations or January 1 of the year following the promulgation and final adoption of the Board's relevant regulations, whichever comes first.

In the case of specialty services operated as part of a general hospital, no separate specialty service license shall be required; however, regardless of whether such service is operated under the general hospital license or a specialty service license, the Board of Health shall ensure that the quality protection licensure requirements correspond to service intensity or risk and remain consistent across all settings.

B. The Board shall promulgate regulations to grant and renew specialty service licenses in accordance with this article. The Board's regulations shall include:

1. Virginia licensure standards for the specific specialty service that are consistent with nationally recognized standards for such specialty service.

2. A list of those national accrediting organizations having standards acceptable for licensure in Virginia, including, but not limited to, the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology.

3. Procedures for periodic inspection of specialty services that avoid redundant site visits and coordinate or substitute the inspections of the specialty services with any inspections required by another state agency or accreditation organization.

4. Licensure application and renewal forms for specialty services.

5. Licensure fees that are sufficient to cover the costs of the specialty services licensure program.

Licenses issued pursuant to this article shall expire at midnight on December 31 of the year issued, or as otherwise specified by the Board, and shall be required to be renewed annually.

Those providers accredited by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology or such other national accrediting organization as may be acceptable to the Board shall be deemed to be in compliance with the Virginia licensure standards and shall be granted a license. Renewal licenses shall also be granted upon proof of maintenance of such accreditation. The Board's regulations shall condition initial licensure on the satisfactory completion of minimum training and experience requirements for physicians and other health care personnel that are consistent with such national accreditation standards; however, the Board's regulations shall not condition initial licensure of such specialty services on any minimum amount of experience or patient volume at a particular facility.

C. Licensure of specialty services shall be conditioned on the following requirements: (i) all licensed specialty services providers shall accept all patients regardless of ability to pay; (ii) all such providers shall agree to become participating providers in the Virginia Medicaid program and the Commonwealth's State Children's Health Insurance Program (SCHIP) established pursuant to Title XXI of the Social Security Act and Subtitle J of the federal Balanced Budget Act of 1997 (P.O. 105-33); and (iii) all such providers shall participate and contribute to any new or revised mechanism for funding of indigent health care.

D. No license issued hereunder shall be assignable or transferable.

§ 32.1-276.3. (Effective until July 1, 2008) Definitions.

As used in this chapter:

"Board" means the Board of Health.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; ~~or~~ (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1*; or (viii) any person licensed to provide specialty services pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5*. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Article 2 (§ 37.2-403 et

seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for the care and treatment of the mentally ill, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

"Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial surgeon's office, as defined above. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians, and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.5. (Effective until July 1, 2008) Providers to submit data.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section*; however, specialty services providers licensed pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 shall only be required to submit (i) claims data, (ii) quality outcome information for selected high-risk procedures as set forth in regulations promulgated by the Board, and (iii) annual financial information related to the provision of care to indigent patients, as set forth in regulations promulgated by the Board. In addition, the Board shall collect, at intervals designated in regulations promulgated by the Board, volume and outcome data from providers of high-risk or complex services that were formerly but are no longer subject to licensing or regulation pursuant to Article 1.1 (§ 32.1-102.1 et seq.)*. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

C. The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations

and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

D. The Board shall evaluate biennially the impact and effectiveness of such data collection.

2. That § 32.1-102.1:1 of the Code of Virginia is repealed.