20105445D

SENATE BILL NO. 982

Offered January 15, 2020

A BILL to amend and reenact §§ 18.2-270.01, 32.1-127, 32.1-134.1, 38.2-2806, 38.2-4214, and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.21 and by adding a section numbered 54.1-2912.1:1, relating to physicians; requirement of medical specialty board certification.

Patron—Hashmi

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 18.2-270.01, 32.1-127, 32.1-134.1, 38.2-2806, 38.2-4214, and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.21 and by adding a section numbered 54.1-2912.1:1 as follows:

§ 18.2-270.01. Multiple offenders; payment to Trauma Center Fund.

A. The court shall order any person convicted of a violation of §§ 18.2-36.1, 18.2-51.4, 18.2-266, 18.2-266.1 or § 46.2-341.24 who has been convicted previously of one or more violations of any of those sections or any ordinance, any law of another state, or any law of the United States substantially similar to the provisions of those sections within 10 years of the date of the current offense to pay $50 to the Trauma Center Fund for the purpose of defraying the costs of providing emergency medical care to victims of automobile accidents attributable to alcohol or drug use.

B. There is hereby established in the state treasury a special nonreverting fund to be known as the Trauma Center Fund. The Fund shall consist of any moneys paid into it by virtue of operation of subsection A hereof and any moneys appropriated thereto by the General Assembly and designated for the Fund. Any moneys deposited to or remaining in the Fund during or at the end of each fiscal year or biennium, including interest thereon, shall not revert to the general fund but shall remain in the Fund and be available for allocation in ensuing fiscal years. The Department of Health shall award and administer grants from the Trauma Center Fund to appropriate trauma centers based on the cost to provide emergency medical care to victims of automobile accidents. The Department of Health shall develop, on or before October 1, 2004, written criteria for the awarding of such grants that shall be evaluated and, if necessary, revised on an annual basis. *On and after July 1, 2020, the criteria for awarding such grants shall not include a requirement mandating active specialty certification by physicians on the medical staff of, or employed by, a facility receiving such grants.*

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities. For purposes of this paragraph, facilities in which five or more first trimester abortions per month are performed shall be classified as a category of "hospital";

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly

42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer

of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration or reregistration of any sex offender within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is a registered sex offender, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to

make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish protocols to ensure that security personnel of the emergency department, if any, receive training appropriate to the populations served by the emergency department, which may include training based on a trauma-informed approach in identifying and safely addressing situations involving patients or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan; ~~and~~

24. Shall establish an exemption, for a period of no more than 30 days, from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds*; and*

25. Shall provide that a hospital or nursing home that employs a person licensed to practice medicine in the Commonwealth may consider active certification of the physician by a medical specialty board that utilizes profession driven standards and requirements for such certification as a criterion for employment. If certification is required as a prerequisite for employment, such certification by a medical or surgical specialty board that utilizes profession driven standards and requirements as determined by majority vote of the medical staff at each facility, as a criterion for employment shall be acceptable as a prerequisite for employment. Active certification in a given medical specialty may be used as a criterion for physician reimbursement, employment, hospital staff privileges or admitting privileges, licensure, medical malpractice insurance coverage, or residency or fellowship program training faculty or directorship eligibility in the Commonwealth, but such certification by a medical or surgical specialty board that utilizes profession driven standards and requirements as a criterion for employment shall be acceptable as a prerequisite for employment. For the purposes of this subdivision, "active certification" means satisfactory completion of a continuing education program in the practice of medicine or surgery that is approved by a national accrediting organization. Such organizations may include the American Board of Medical Specialties and its affiliated boards, the American Osteopathic Association, the National Board of Physicians and Surgeons, the National Board of Osteopathic Physicians and Surgeons, or an equivalent board recognized by the governing body of a hospital or institution.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

§ 32.1-134.1. When denial, etc., to duly licensed physician of staff membership or professional privileges improper.

~~It shall be an improper practice for the governing body of a hospital which has twenty-five beds or more and which~~ *A. As used in this section:*

"Active certification" means satisfactory completion of a continuing education program in the practice of medicine or surgery that is approved by the American Board of Medical Specialties or an affiliate thereof, the National Board of Physicians and Surgeons, the American Osteopathic Association,

or the National Board of Osteopathic Physicians and Surgeons.

B. No hospital or other entity that has an organized medical staff or a process for credentialing physicians as members of staff or employees or enters into contracts for employment with physicians and that is required by state law to be licensed ~~to refuse or~~ *shall (i)* fail *or refuse* to act ~~within sixty days of a completed~~ *on an* application for staff membership or professional privileges ~~or~~ *submitted by a licensed physician, (ii)* deny or withhold ~~from a duly licensed physician~~ staff membership or professional privileges in such hospital~~, or to~~ *or other entity from a licensed physician, (iii)* exclude or expel a *licensed* physician from staff membership in such hospital *or other entity,* or *(iv)* curtail, terminate, or diminish in any way ~~a physician's~~ *the* professional privileges *of a licensed physician* in such hospital *or other entity,* without stating in writing the reason or reasons therefor, a copy of which shall be provided to the physician. If the reason or reasons stated are unrelated to standards of patient care, patient welfare, violation of the rules and regulations of the institution or staff, the objectives or efficient operations of the institution, ~~or~~ the character or competency of the applicant, or misconduct in ~~any~~ *such* hospital *or other entity,* ~~it~~ *such failure, refusal, denial, withholding, exclusion, expulsion, curtailment, termination, or diminishment* shall be deemed an improper practice.

C. A hospital or other entity described in subsection A may consider active certification of the physician by a medical specialty board of the American Board of Medical Specialties, the National Board of Physicians and Surgeons, the American Osteopathic Association, or the National Board of Osteopathic Physicians and Surgeons as a criterion for the granting or continuing of staff membership or professional privileges to a licensed physician.

D. Any *licensed* physician ~~licensed in this Commonwealth to practice medicine~~ who is aggrieved by any violation of this section shall have the right to seek an injunction from the circuit court of the city or county in which the hospital alleged to have violated this section is located prohibiting any such further violation. The provisions of this section shall not be deemed to impair or affect any other right or remedy; provided that a violation of this section shall not constitute a violation of the provisions of this article for the purposes of § 32.1-135.

§ 38.2-2806. Policy forms; applicants to be issued policies; cancellation of policies; rates; examination of business of association.

A. All policies issued by the association shall be subject to the group retrospective premium adjustment and to the stabilization reserve fund required by § 38.2-2807. No policy form shall be used by the association unless it has been filed with the Commission and either (i) the Commission has approved it or (ii) thirty days have elapsed and the Commission has not disapproved the form or endorsement for one or more of the reasons enumerated in subsection A of § 38.2-317.

B. Policies shall be issued by the association, after receipt of the premium or portion of the premium prescribed by the plan of operation, to applicants that (i) meet the minimum underwriting standards, and (ii) have no unpaid or uncontested premium due as evidenced by the applicant having failed to make written objection to premium charges within thirty days after billing.

C. Any policy issued by the association may be cancelled for any one of the following reasons: (i) nonpayment of premium or portion of the premium; (ii) suspension or revocation of the insured's license; (iii) failure of the insured to meet the minimum underwriting standards; (iv) failure of the insured to meet other minimum standards prescribed by the plan of operation; and (v) nonpayment of any stabilization reserve fund charge.

D. The rates, rating plans, rating rules, rating classifications, premium payment plans and territories applicable to the insurance written by the association, and related statistics shall be subject to the provisions of Chapter 20 (§ 38.2-2000 et seq.) of this title. Due consideration shall be given to the past and prospective loss and expense experience for medical malpractice insurance written and to be written in this Commonwealth, trends in the frequency and severity of losses, the investment income of the association, and other information the Commission requires. All rates shall be on an actuarially sound basis, giving due consideration to the stabilization reserve fund, and shall be calculated to be self-supporting. The Commission shall take all appropriate steps to make available to the association the loss and expense experience of insurers writing or having written medical malpractice insurance in this Commonwealth.

E. All policies issued by the association shall be subject to a nonprofit group retrospective premium adjustment to be approved by the Commission under which the final premium for all policyholders of the association, as a group, will be calculated based upon the experience of all policyholders. The experience of all policyholders shall be calculated following the end of each fiscal period and shall be based upon earned premiums, administrative expenses, loss and loss adjustment expenses, and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders shall be given full credit for all investment income, net of expenses and a reasonable management fee on policyholder supplied funds. Any final premium resulting from a retrospective premium adjustment will be collected from the stabilization fund set forth in § 38.2-2807. The maximum premium for all policyholders as a group shall

be limited as provided in § 38.2-2807.

F. 1. The association shall certify to the Commission the estimated amount of any deficit remaining after the stabilization reserve fund has been exhausted in payment of the maximum final premium for all policyholders of the association. Within sixty days after such certification, the Commission shall authorize the association to recover from the members their respective share of the deficit.

2. Members shall be permitted to recover any assessment made by the association under subdivision 1 by deducting the members' share of the deficit from future premium taxes due the Commonwealth. The amount of premium tax deduction for each member's share of the deficit shall be apportioned by the Commission so that the amount of each member's premium tax deduction in each of the ten calendar years following the payment of the member's assessment is equal to ten percent of the assessment paid by the member.

G. In the event that sufficient funds are not available for the sound financial operation of the association, subject to recoupment as provided in this chapter and the plan of operation, all members shall, on a temporary basis, contribute to the financial requirements of the association in the manner provided in this chapter. The contribution shall be reimbursed to the members by the procedure set forth in subdivision F 2.

H. The Commission shall examine the business of the association as often as it deems appropriate to make certain that the group retrospective premium adjustments are being calculated and applied in a manner consistent with this section. If the Commission finds that they are not being calculated and applied in a manner consistent with this section, it shall issue an order to the association, specifying (i) how the calculation and application are not consistent and (ii) stating what corrective action shall be taken.

I. Minimum underwriting criteria for determining eligibility of an applicant for coverage may include active certification of the physician by a medical specialty board or an equivalent board recognized by the governing medical staff of a hospital or institution, but shall not require such certification as a prerequisite of coverage. As used in this subsection, "active certification" means satisfactory completion of a continuing education program in the practice of medicine or surgery that is approved by the American Board of Medical Specialties or an affiliate thereof, the National Board of Physicians and Surgeons, the American Osteopathic Association, or the National Board of Osteopathic Physicians and Surgeons or an equivalent board recognized by the governing medical staff of a hospital or institution. Any licensed insurer that issues a policy of medical malpractice insurance as defined in § 38.2-2800 insuring a physician shall not deny coverage under such policy based solely on the decision by the physician not to participate in any form of maintenance of certification. Maintenance of certification participation or status shall not be considered or used as evidence of a standard of care in any (i) legal action in which a physician is alleged to have engaged in malpractice, (ii) quality improvement assessment, or (iii) peer review assessment. As used in this subsection:

"Maintenance of certification" means any process requiring periodic recertification examinations or other activities to maintain specialty medical board certification, which recertification is provided by one or more of the medical specialty boards of the American Board of Medical Specialties, the National Board of Physicians and Surgeons, the American Osteopathic Association, or any other equivalent board recognized by the governing medical staff of a hospital or institution.

"Specialty medical board certification" means a certification by a board that specializes in one particular area of medicine. Initial certification may be provided by one or more of the medical specialty boards of the American Board of Medical Specialties and its affiliates thereof. A physician licensed by the Commonwealth is considered a board-certified medical specialist in the Commonwealth if the physician receives initial certification by a medical board, without regard to the physician's maintenance of certification participation.

§ 38.2-3407.21. Requirement of medical specialty board certification.

A. As used in this section, "active certification" means satisfactory completion of a continuing education program in the practice of medicine or surgery that is approved by the American Board of Medical Specialties or an affiliate thereof, the National Board of Physicians and Surgeons, the American Osteopathic Association, or the National Board of Osteopathic Physicians and Surgeons or an equivalent board recognized by the governing medical staff of a hospital or institution.

B. An insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporation providing individual or group accident and sickness subscription contracts; or health maintenance reorganization providing a health care plan for health care services may consider active certification of the physician by a medical specialty board of the American Board of Medical Specialties, the National Board of Physicians and Surgeons, the American Osteopathic Association, or the National Board of Osteopathic Physicians and Surgeons or any other equivalent board recognized by the governing medical staff of a hospital or institution as a criterion for participation in a provider network established for a managed care health insurance plan, as defined in Chapter 58 (§ 38.2-5800 et

seq.), or reimbursement for a service covered under such a policy, contract, or plan, but shall not require such certification as a prerequisite for participation or reimbursement.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.20~~*38.2-3407.21*, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, Article 8 (§ 38.2-3461 et seq.) of Chapter 34, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.20~~ *38.2-3407.21*, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, Article 8 (§ 38.2-3461 et seq.) of Chapter 34, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, *38.2-3407.21*, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 54.1-2912.1:1. Requirement of maintenance of certification prohibited.

A. As used in this section, "active certification" means satisfactory completion of a continuing education program in the practice of medicine or surgery that is approved by a medical or surgical specialty board that utilizes profession driven standards and requirements.

B. The Board shall not require active certification as a condition of licensure to practice medicine in the Commonwealth.

C. A physician licensed to practice medicine in the Commonwealth who has received initial certification in an area of medical specialty from the American Board of Medical Specialties or an affiliate thereof, shall be considered board-certified in that medical specialty, regardless of the physician's maintenance of certification participation.

D. Nothing in this section shall exempt a licensed physician from continuing medical education requirements established by the Board of Medicine pursuant to § 54.1-2912.1.