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HOUSE BILL NO. 688

Offered January 13, 2016

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A BILL to amend and reenact §§ 23-50.16:22, 32.1-122.05, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-276.5, 54.1-2400.6, and 56-484.19 of the Code of Virginia, to add in Chapter 4 of Title 32.1 an article numbered 9, consisting of sections numbered 32.1-122.23 and 32.1-122.24, and to repeal Article 1.1 (§§ 32.1-102.1 through 32.1-102.11) of Chapter 4 of Title 32.1 of the Code of Virginia, relating to the certificate of public need program.

Patron—Peace

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 23-50.16:22, 32.1-122.05, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-276.5, 54.1-2400.6, and 56-484.19 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 4 of Title 32.1 an article numbered 9, consisting of sections numbered 32.1-122.23 and 32.1-122.24 as follows:

§ 23-50.16:22. Licenses and permits.

~~The transfer of the hospital facilities from the University to the Authority shall not require a certificate of public need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1.~~ All licenses, permits, certificates of public need or other authorizations of the Commonwealth or any agency thereof or of any county, city or town held by the University in connection with the ownership or operation of the hospital facilities shall be deemed to be transferred, without further action, to the Authority as and to the extent the Authority undertakes the activity thereby permitted. All agencies and officers of the Commonwealth and all agencies and officers of counties, cities and towns are directed to confirm such transfer by the issuance of new or amended licenses, permits, certificates of public need or other authorizations upon the request of the University and the Authority.

§ 32.1-122.05. Regional health planning agencies; boards; duties and responsibilities.

A. For the purpose of representing the interests of health planning regions and performing health planning activities at the regional level, there are hereby created such regional health planning agencies as may be designated by the Board of Health.

B. Each regional health planning agency shall be governed by a regional health planning board to be composed of not more than ~~thirty~~ *30* residents of the region. The membership of the regional health planning boards shall include, but not be limited to, consumers, providers, a director of a local health department, a director of a local department of social services or welfare, a director of a community services board, a director of an area agency on aging and representatives of health care insurers, local governments, the business community and the academic community. The majority of the members of each regional health planning board shall be consumers. Consumer members shall be appointed in a manner that ensures the equitable geographic and demographic representation of the region. Provider members shall be solicited from professional organizations, service and educational institutions and associations of service providers and health care insurers in a manner that assures equitable representation of provider interest.

The members of the regional health planning boards shall be appointed for no more than two consecutive terms of four years or, when appointed to fill an unexpired term of less than four years, for three consecutive terms consisting of one term of less than four years and two terms of four years. The boards shall not be self-perpetuating. The Board of Health shall establish procedures requiring staggered terms. The composition and the method of appointment of the regional health planning boards shall be established in the regulations of the Board of Health. In addition, the Board of Health shall require, pursuant to regulations, each regional health planning board to report and maintain a record of its membership, including, but not limited to, the names, addresses, dates of appointment, years served, number of consecutive and nonconsecutive terms, and the group represented by each member. These membership reports and records shall be public information and shall be published in accordance with the regulations of the Board.

C. An agreement shall be executed between the Commissioner, in consultation with the Board of Health, and each regional health planning board to delineate the work plan and products to be developed with state funds. Funding for the regional health planning agencies shall be contingent upon meeting these obligations and complying with the Board's regulations.

D. Each regional health planning agency shall assist the Board of Health by: (i) conducting data

collection, research and analyses as required by the Board; (ii) preparing reports and studies in consultation and cooperation with the Board; (iii) reviewing and commenting on the components of the State Health Plan; (iv) conducting needs assessments as appropriate and serving as a technical resource to the Board; (v) identifying gaps in services, inappropriate use of services or resources and assessing accessibility of critical services~~; (vi) reviewing applications for certificates of public need and making recommendations to the Department thereon as provided in § 32.1-102.6~~; and ~~(vii)~~ *(vi)* conducting such other functions as directed by the regional health planning board. All regional health planning agencies shall demonstrate and document accountability for state funds through annual budget projections and quarterly expenditure and activity reports that shall be submitted to the Commissioner. A regional health planning agency may designate membership and activities at subarea levels as deemed appropriate by its regional health planning board. Each regional health planning board shall adopt bylaws for its operation and for the election of its chairman and shall maintain and publish a record of its membership and any subarea levels as required by this section and the regulations of the Board of Health.

Article 9.

Permits for Medical Care Facility Projects.

§ 32.1-122.23. Definitions.

As used in this article, unless the context requires a different meaning:

"Medical care facility" means (i) any facility licensed as a hospital pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 or (ii) any 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, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam 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.

"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 of beds from one existing medical care facility to another, provided that "project" does not include the relocation of up to 10 beds or 10 percent of the beds, whichever is less, from one existing medical care facility to another existing medical care facility at the same site in any two-year period;

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

5. Conversion in an existing medical care facility of psychiatric inpatient beds approved pursuant to a Request for Applications (RFA) to nonpsychiatric inpatient beds.

6. Introduction into an existing medical care facility of any new cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care, obstetrical, open heart surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging other than nuclear cardiac imaging, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has not provided in the previous 12 months;

7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam 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 $15 million or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or on behalf of a medical care facility other than a general hospital. The amounts specified in this subdivision shall be revised annually to reflect inflation using appropriate measures incorporating construction costs and medical inflation.

§ 32.1-122.24. Permit required; conditions on permits.

A. No person shall commence any project without first obtaining a permit from the Commissioner.

B. At least 90 days prior to initiating a project for which a permit is required, a person shall file with the Department an application for a permit, together with a fee determined by the Board. The Commissioner shall issue the permit within 30 days of receipt of the application.

C. The Commissioner shall condition the issuance of a permit to undertake a project upon the agreement of the applicant to (i) provide a specified level of care at a reduced rate to indigents, (ii) accept patients requiring specialized care, or (iii) facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area.

The holder of a permit that is subject to conditions pursuant to this subsection shall provide such documentation as may be required by the Commissioner to demonstrate compliance with the conditions imposed.

The Commissioner shall monitor compliance with permit conditions pursuant to this subsection and may impose penalties on a permit holder that fails to comply with such permit conditions. If the permit holder is unable or fails to comply with the conditions imposed by the Commissioner, the Commissioner may, upon request of the permit holder, approve a plan of compliance with alternate methods to satisfy the permit conditions. Such alternate methods may include (i) a direct payment by the permit holder to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of the permit; (ii) a direct payment by the permit holder to a private nonprofit foundation that funds basic insurance coverage for indigents authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a permit; or (iii) such other methods for the provision of primary or specialized care to indigent patients or patients requiring specialized care as may be approved by the Commissioner. Any permit holder that fails or refuses to comply with the requirements of a plan of compliance entered into in accordance with this subsection is subject to a civil penalty of up to $100 per violation per day until the date of compliance.

The Commissioner may, pursuant to regulations of the Board, accept requests for and approve amendments to permit conditions pursuant to this subsection upon request of the permit holder.

The Board shall adopt regulations governing the issuance and revocation of permits in accordance with the provisions of this subsection.

D. The Commissioner shall condition the issuance of a permit to undertake a project upon the compliance of the applicant with quality of care standards established by the Board and may revoke a permit issued in accordance with this section in any case in which the permit holder fails to maintain compliance with such standards.

The Board shall adopt regulations governing the issuance and revocation of permits in accordance with the provisions of this subsection, which shall include:

1. Quality of care 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 quality of care standards, compliance with which shall be deemed satisfactory to comply with quality of care standards adopted by the Board;

3. Equipment standards and standards for appropriate utilization of equipment and services;

4. Requirements for monitoring compliance with quality of care standards, including data reporting and periodic inspections; and

5. Procedures for the issuance and revocation of permits pursuant to this subsection.

E. The Commissioner may refuse to issue a permit if he determines that the project for which the permit is sought would be detrimental to the provision of health services in underserved areas of the Commonwealth.

§ 32.1-125.3. Bed capacity and licensure in hospitals designated as critical access hospitals; designation as rural hospital.

~~A. Any medical care facility licensed as a hospital pursuant to this article that (i) has been certified, as provided in § 32.1-122.07, as a critical access hospital by the Commissioner of Health in compliance with the certification regulations promulgated by the Health Care Financing Administration pursuant to Title XVIII of the Social Security Act, as amended, and (ii) has, as a result of the critical access certification, been required to reduce its licensed bed capacity to conform to the critical access certification requirement shall, upon termination of its critical access hospital certification, be licensed to operate at the licensed bed capacity in existence prior to the critical access hospital certification without being required to apply for and obtain a certificate of public need for such bed capacity in accordance with Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title.~~

~~B.~~ Any medical care facility licensed as a hospital shall be considered a rural hospital on and after September 30, 2004, pursuant to 42 U.S.C. § 1395ww (d)(8)(E)(ii)(II), if (i) the hospital is located in an area defined as rural by federal statute or regulation; (ii) the Board of Health defines, in regulation, the area in which the hospital is located as a rural health area or the hospital as a rural hospital; or (iii) the hospital was designated, prior to October 1, 2004, as a Medicare-dependent small rural health hospital, as defined in 42 U.S.C. § 1395ww (d)(5)(G)(iv).

§ 32.1-126.1. Asbestos inspection for hospitals.

The Commissioner shall not issue a license to or renew the license of any hospital which is located in a building built prior to 1978 until he receives a written statement that either (i) the hospital has been inspected for asbestos in accordance with standards in effect at the time of inspection; or (ii) that asbestos inspection will be conducted within ~~twelve~~ *12* months of issuance or renewal, in accordance with the standards established pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all other buildings; and (iii) that response actions have been or will be undertaken in

accordance with applicable standards. Any asbestos management program or response action undertaken by a hospital shall comply with the standards promulgated pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all others.

The Commissioner may amend the standards for inspections, management programs and response actions for hospitals subject to this section, in accordance with the requirements of the Virginia Administrative Process Act (§ 2.2-4000 et seq.).

~~The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures made by hospitals pursuant to the provisions of this section.~~

§ 32.1-126.3. Fire suppression systems required in hospitals.

After January 1, 1998, the Commissioner shall not issue a license to or renew the license of any hospital, regardless of when such facility was constructed, unless the hospital is equipped with an automatic sprinkler system which complies with the regulations of the Board of Housing and Community Development.

The Commissioner may, at his discretion, extend the time for compliance with this section for any hospital that can demonstrate (i) its inability to comply, if such hospital submits, prior to January 1, 1998, a plan for compliance by a date certain which shall be no later than July 1, 1998, or (ii) that construction is underway for a new facility to house the services currently located in the noncomplying facility and that such construction will be completed and the noncomplying facility relocated by December 31, 1998.

~~The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures required solely for compliance with this section.~~

For the purposes of this section and § 36-99.9:1, "automatic sprinkler system" means a device for suppressing fire in patient rooms and other areas of the hospital customarily used for patient care.

§ 32.1-276.5. 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. 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. Every medical care facility ~~as that term is defined in § 32.1-102.1~~ that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.

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. Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data.

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

§ 54.1-2400.6. Hospitals, other health care institutions, home health and hospice organizations, and assisted living facilities required to report disciplinary actions against and certain disorders of health professionals; immunity from liability; failure to report.

A. The chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth, the director of every licensed home health or hospice organization, the director

of every accredited home health organization exempt from licensure, and the administrator of every licensed assisted living facility in the Commonwealth shall report within 30 days, except as provided in subsection B, to the Director of the Department of Health Professions, or in the case of a director of a home health or hospice organization, to the Office of Licensure and Certification at the Department of Health (the Office), the following information regarding any person (i) licensed, certified, or registered by a health regulatory board or (ii) holding a multistate licensure privilege to practice nursing or an applicant for licensure, certification or registration unless exempted under subsection E:

1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or any other health care institution, for treatment of substance abuse or a psychiatric illness that may render the health professional a danger to himself, the public or his patients.

2. Any information of which he may become aware in his official capacity indicating, after reasonable investigation and consultation as needed with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations. The report required under this subdivision shall be submitted within 30 days of the date that the chief executive officer, chief of staff, director, or administrator determines that a reasonable probability exists.

3. Any disciplinary proceeding begun by the institution, organization, or facility as a result of conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this subdivision shall be submitted within 30 days of the date of written communication to the health professional notifying him of the initiation of a disciplinary proceeding.

4. Any disciplinary action taken during or at the conclusion of disciplinary proceedings or while under investigation, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges that results from conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this subdivision shall be submitted within 30 days of the date of written communication to the health professional notifying him of any disciplinary action.

5. The voluntary resignation from the staff of the health care institution, home health or hospice organization, or assisted living facility, or voluntary restriction or expiration of privileges at the institution, organization, or facility of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution, organization, or facility or a committee thereof for any reason related to possible intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.

Any report required by this section shall be in writing directed to the Director of the Department of Health Professions or to the Director of the Office of Licensure and Certification at the Department of Health, shall give the name and address of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported. The report shall include the names and contact information of individuals with knowledge about the facts required to be reported and the names and contact information of individuals from whom the hospital or health care institution, organization, or facility sought information to substantiate the facts required to be reported. All relevant medical records shall be attached to the report if patient care or the health professional's health status is at issue. The reporting hospital, health care institution, home health or hospice organization, or assisted living facility shall also provide notice to the Department or the Office that it has submitted a report to the National Practitioner Data Bank under the Health Care Quality Improvement Act (42 U.S.C. § 11101 et seq.). The reporting hospital, health care institution, home health or hospice organization, or assisted living facility shall give the health professional who is the subject of the report an opportunity to review the report. The health professional may submit a separate report if he disagrees with the substance of the report.

This section shall not be construed to require the hospital, health care institution, home health or hospice organization, or assisted living facility to submit any proceedings, minutes, records, or reports that are privileged under § 8.01-581.17, except that the provisions of § 8.01-581.17 shall not bar (i) any report required by this section or (ii) any requested medical records that are necessary to investigate unprofessional conduct reported pursuant to this subtitle or unprofessional conduct that should have been reported pursuant to this subtitle. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17. No person or entity shall be obligated to report any matter to the Department or the Office if the person or entity has actual notice

that the same matter has already been reported to the Department or the Office.

B. Any report required by this section concerning the commitment or admission of such health professional as a patient shall be made within five days of when the chief executive officer, chief of staff, director, or administrator learns of such commitment or admission.

C. The State Health Commissioner or the Commissioner of the Department of Social Services shall report to the Department any information of which their agencies may become aware in the course of their duties that a health professional may be guilty of fraudulent, unethical, or unprofessional conduct as defined by the pertinent licensing statutes and regulations. However, the State Health Commissioner shall not be required to report information reported to the Director of the Office of Licensure and Certification pursuant to this section to the Department of Health Professions.

D. Any person making a report by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

E. Medical records or information learned or maintained in connection with an alcohol or drug prevention function that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 42 U.S.C. § 290dd-2 or regulations adopted thereunder.

F. Any person who fails to make a report to the Department as required by this section shall be subject to a civil penalty not to exceed $25,000 assessed by the Director. The Director shall report the assessment of such civil penalty to the Commissioner of Health or the Commissioner of Social Services, as appropriate. Any person assessed a civil penalty pursuant to this section shall not receive a license or certification or renewal of such unless such penalty has been paid pursuant to § 32.1-125.01. The Medical College of Virginia Hospitals and the University of Virginia Hospitals shall not receive certification pursuant to § 32.1-137 ~~or Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1~~ unless such penalty has been paid.

§ 56-484.19. Definitions.

As used in this article:

"Alternative method of providing call location information" means a method of maintaining and operating a multiline telephone system that ensures that:

1. Emergency calls from a telephone station provide the PSAP with sufficient location identification information to ensure that emergency responders are dispatched to a location at the facility from which the emergency call was placed, from which location emergency responders will be able to ascertain the telephone station where the emergency call was placed (i) by being able to view all of the telephone stations in the area contiguous to the telephone station from which the emergency call was placed or (ii) by the activation of an alerting system at the facility, which activation is triggered by the placing of the emergency call, and which readily allows arriving emergency responders to determine the physical location of the telephone station from which the emergency call was placed. A light or alarm located near the telephone station is an example of such an alerting system;

2. Emergency calls from a telephone station, in addition to reaching a PSAP, connect to or otherwise notify a switchboard operator, attendant, or other designated on-site individual who is capable of giving the PSAP the location of the telephone station from which the emergency call was placed; or

3. Calls to the digits "9-1-1" from a telephone station connect to a private emergency answering point.

An alternative method of providing call location information shall also be deemed to be provided, as a result of the imputed ability of emergency responders to readily locate all telephone stations from which the emergency call could have been placed, when emergency calls provide calling party information corresponding to a contiguous area containing the telephone from which the emergency call was placed, of fewer than 7,000 square feet, located on one or more floors.

"Automatic location identification" or "ALI" means the automatic display at a PSAP of information defining the emergency call location, which information shall identify the floor name or number, room name or number, building name or number, cubicle name or number, and office name or number, as applicable, or imparts other information that is sufficiently specific to provide the emergency responders with the ability to locate the telephone station from which the emergency call was placed.

"Automatic number identification" or "ANI" means the automatic display at a PSAP of a telephone number that a PSAP may use to call the telephone station from which the emergency call was placed.

"Calling party information" means information that is delivered by the MLTS provider to the PSAP that is used to provide the ANI and ALI function.

"Central office system" means a business telephone service offered by a provider of communications services that provides features similar to a private branch exchange by transmitting data over telecommunications equipment or cable lines.

"Emergency call" means a telephone call that enables the user to reach a PSAP by dialing the digits

"9-1-1" and, if applicable, any additional digit or digits that must be dialed in order to permit the user to access the public switched telephone network.

"Emergency call location" means the location of the telephone station on an MLTS from which an emergency call is placed and to which a PSAP may dispatch emergency responders based upon ALI provided via the emergency call.

"Emergency responders" means fire services, law enforcement, emergency medical services, and other public services or agencies that may be dispatched by a PSAP in response to an emergency call.

"Enhanced 9-1-1 service" means a service consisting of telephone network features and PSAPs that (i) enables users of telephone systems to reach a PSAP by making an emergency call; (ii) automatically directs emergency calls to the appropriate PSAPs by selective routing based on the geographical location from which the emergency call originated; and (iii) provides the capability for ANI and ALI features.

"Facility" means real estate and improvements used principally for or as a (i) hotel as defined in § 35.1-1, (ii) college or university dormitory, (iii) medical care facility ~~as defined in § 32.1-102.1~~, (iv) group home or other residential facility licensed by the Department of Behavioral Health and Developmental Services or Department of Social Services, (v) assisted living facility as defined in § 63.2-100, (vi) apartment complex or condominium where shared tenant telephone service is provided, (vii) commercial or government office building, (viii) manufacturing, processing, assembly, warehouse, or distribution establishment, or (ix) retail establishment.

"MLTS provider" means a person who operates a facility at which telephone service is provided, with or without compensation, through a multiline telephone system.

"MLTS service provider" means a person offering or operating third party services that combine communications services, private branch exchange or central office systems, and multiline telephone systems where such services are provided to an MLTS provider on a fee-for-service basis.

"Multiline telephone system" or "MLTS" means a telephone system, including network-based or premises-based systems, whether owned or leased by a public or private entity, operated in the Commonwealth, that serves a facility, has more than one telephone station, and is comprised of common control units, telephones, and control hardware and software that share a common interface to the public switched telephone network, whether by a private branch exchange or central office system, without regard to whether the system utilizes VoIP technology.

"Person" includes any individual, corporation, partnership, association, cooperative, limited liability company, trust, joint venture, government, political subdivision, or any other legal or commercial entity and any successor, representative, agent, agency, or instrumentality thereof.

"Portable VoIP services" includes any MLTS utilizing a VoIP service and providing an end user with the capability to use the service at a location independent of the original physical location of telephone stations on the MLTS.

"Private emergency answering point" means an answering point that is equipped and staffed during all hours that the facility is occupied to provide adequate means of responding to calls to the digits "9-1-1" from telephones on a multiline telephone system by reporting incidents to a PSAP in a manner that identifies the emergency response location from which the call to the answering point was placed.

"Public safety answering point" or "PSAP" means a communications operation operated by or on behalf of a governmental entity that is equipped and staffed on a 24-hour basis to receive and process telephone calls for emergency assistance from an individual by dialing, in addition to any digits required to obtain an outside line, the digits "9-1-1."

"Public switched telephone network" means the worldwide, interconnected networks of equipment, lines, and controls assembled to establish circuit-switched voice communication paths between calling and called parties.

"Retail establishment" means any establishment selling goods or services to the ultimate user or consumer of those goods or services, not for the purpose of resale, but for that user's or consumer's personal rather than business use.

"Telephone call" means the use of a telephone to initiate an ordinary voice transmission placed through the public switched telephone network.

"Telephone station" means a telephone on a multiline telephone system, from which a call may be placed to a PSAP by dialing, in addition to any digits required to access the public switched telephone network, the digits "9-1-1." However, in any medical care facility or licensed assisted living facility, "telephone station" includes any telephone on a multiline telephone system located in an administrative office, nursing station, lobby, waiting area, or other area accessible to the general public but does not include a telephone located in the room of a patient or resident.

"VoIP service" has the same meaning ascribed to it in § 56-484.12.

2. That Article 1.1 (§§ 32.1-102.1 through 32.1-102.11) of Chapter 4 of Title 32.1 of the Code of Virginia is repealed.