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**Center for Medicare and Medicaid Services (CMS)
Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health
Care Facilities CMS-2014-0058-0001**

CMS-3277-P

**COMMENTS OF:
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BACKGROUND

The International Code Council (ICC) is a membership association dedicated to building safety, fire prevention, and energy efficiency. The International Codes, or I-Codes, published by ICC, provide minimum safeguards for people at home, school, work and play. Uniform building codes benefit public safety and support the industry's need for one set of codes without regional limitations.

Fifty states and the District of Columbia have adopted the I-Codes at the state or jurisdictional level. Federal agencies including the Architect of the Capitol, General Services Administration, National Park Service, Department of State, U.S. Forest Service and the Veterans Administration also use the I-Codes for the facilities that they own or manage. The Department of Defense references the International Building Code for constructing military facilities, including those that house U.S. troops, domestically and abroad. The International Energy Conservation Code (IECC) is designated in Federal law as the U.S. Department of Energy benchmark document for energy efficiency in residential buildings and as a compliance path for commercial building energy efficiency.

ICC was established in 1994 as a non-profit organization dedicated to developing a single set of contemporary comprehensive and coordinated national model construction codes. The founders of the ICC are Building Officials and Code Administrators International, Inc. (BOCA), International Conference of Building Officials (ICBO), and Southern Building Code Congress International, Inc. (SBCCI). Since the early part of the last century, these non-profit organizations developed three separate sets of model codes used throughout the United States. Although regional code development was effective and responsive to our country's needs, the time came for a single set of codes. The nation's three model code groups responded by creating the International Code Council and by developing a single family of model codes; the International Codes. This history is relevant to our discussion of this CMS proposed regulation, as the International Building Code and International Fire Code did not exist at the time of the passage of

the legislation that provides the authority for the adoption of these regulations. Likewise, when these regulations were last adopted, in 2003, it was not yet clear which codes for building and fire safety would be adopted by a majority of states. Today, in 2014, all fifty states have adopted the International Building Code, and over 40 use the fully coordinated International Fire Code.

COMMENTS

The International Code Council (ICC) offers the following comments on *CMS-3277-P- Fire Safety Requirements for Certain Health Care Facilities*

The International Code Council (ICC) appreciates the effort made by CMS to update its fire safety regulations to require compliance to the latest version of the NFPA 101 Life Safety Code, and to eliminate all references to previous versions of that code. As the developer of model building and fire safety codes that are widely adopted by most U.S state and local jurisdictions that adopt building codes to govern minimum standards of construction, ICC is concerned with how buildings, both commercial and residential, perform, and believes strongly in the use of current versions of building and safety codes, to reflect both current technology, and lessons learned in the use and application of codes through real world experience.

ICC supports the updating Sec. 403.744 (a)(1)(i) to reference the 2012 NFPA 101 Life Safety Code. ICC is in agreement with the reasoning provided to support the update of this section: that use of an older version of the code can be problematic, due to advances in safety and technology reflected in the new code, and the reality that new buildings will be built to the latest version of the code adopted by the state or local jurisdiction.

Perhaps the most important lines in the proposed regulation are those found in the section that provides the rationale for updating the Life Safety Code , at page 10 of the announcement: “Requiring compliance with two different editions of the LSC at the same time can create unnecessary conflicts, duplication, and inconsistencies that increase construction and compliance costs without any fire safety or patient care benefits.We believe that adopting the 2012 LSC would simplify and modernize the construction and renovation process for affected health care providers and suppliers, reduce compliance related burdens, and allowing for more resources to be used for patient care.”

Given that this language expresses CMS perspective, we would encourage CMS to take one further step, in addition to updating the 2000 LSC reference to the 2012 LSC.

Since the 2015 IBC and IFC provide a second national model code framework that covers the same issues as the 2012 LSC covering fire safety and annual maintenance requirements, and given the fact that the IBC is adopted in all 50 states, and the IFC is adopted by state and or local jurisdiction in 43 states, it is only logical that CMS recognize that even more unnecessary conflict and duplication and inconsistencies

could be eliminated, and compliance costs could be reduced even more, if CMS created a simple path for recognition of the equivalence of state and local adoptions of the 2015 IBC and IFC.

We find one flaw in the rationale that CMS uses in its discussion of the importance of updating to the 2012 LSC, when it states: “Therefore, a healthcare facility that is constructed or renovated in 2013 would likely be required by its state and local authorities to comply with a more recent edition of the LSC, while also being required to comply with the 2000 edition of the LSC to meet the Medicare and applicable Medicaid regulatory requirements.” The fact of the matter is more complicated, and makes for a compelling case for recognition of the IBC and IFC as equivalent to the LSC. In every state, a new hospital built in 2014 or later would be required by its state or local authorities to meet the requirements of the IBC, depending on the state, and in approximately 40 of the states, the hospital would also be required to meet the requirements of the companion IFC—NOT the 2009 or 2012 LSC. The correct way to state the rationale would be as follows: “Therefore, a healthcare facility that is constructed or renovated in 2013 or later would likely be required by its state or local authorities to comply with a recent version of the IBC, and either a more recent edition of the LSC or a recent edition of the IFC, while also being required to comply with the 2000 edition of the LSC to meet the Medicare and applicable Medicaid regulatory requirements.”

To achieve the objective to “simplify and modernize the construction and renovation process for affected health care providers and suppliers, reduce compliance related burdens, and allowing for more resources to be used for patient care,” it is clear that CMS should establish a simple and straightforward path to determine equivalence for state adopted fire and building codes.

We are not asking CMS to do something that it lacks authority to do, and we are not even asking that it do something new. CMS has previously recognized the local and state safety and fire codes, which are almost universally the IBC and IFC, as providing equivalent protection for life safety and fire protection in End Stage Renal Disease Facilities. (See Federal Register, Vol. 77, No. 95, Wednesday, May 16, 2012, Final Rule RIN 0938–AQ96 Medicare and Medicaid Program; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction , revisions to Sec 494.60.) In the final rule issued in that rulemaking, CMS said: “When implemented, these LSC regulations were found to duplicate many provisions of existing State and local fire safety codes covering ESRD facilities. Although the State and local codes protected patients from fire hazards, our rule incorporating the NFPA 101 LSC by reference retroactively imposed some additional structural requirements.”

In that 2012 Final Rule, one commenter had argued that the reason that End Stage Renal Disease Facilities (ESRD) had experienced no fire related injuries was because of the requirement for facilities to comply with the LSC. In response, CMS said: “We agree that application of a fire and building safety code may reduce injuries from fire. However, the ESRD CfCs did not include a Medicare LSC requirement until 2008, and, as stated in the preamble to the proposed rule, there have been no reported patient injuries or deaths due to fire in dialysis facilities in the 35 years of the Medicare ESRD program.

We believe this comment supports the conclusion that existing State and local fire and building safety codes were adequately protecting patients and staff prior to the ESRD CfC requirement finalized in 2008.

In the preamble to the proposed rule, we noted that all ESRD facilities must continue to comply with State and local fire codes and safety standards under § 494.20”

We would also note that in the 2008 rulemaking that first imposed the LSC on ESRD’s, it was argued by the healthcare providers that the cost of compliance would be very great, and would be far in excess of any benefits in patient safety. CMS proceeded to impose the requirement in 2008, in spite of these warnings, but was forced to acknowledge in the 2011 Final Rule that it had badly under-estimated the actual costs of compliance. From the Final Rule: “Through research discussed in the following paragraph, CMS learned that the actual costs for renovation and construction necessary for compliance with the additional requirements of NFPA 101 for dialysis facilities were considerable and profoundly exceed the original government estimate of \$1,960 per facility, as published in the proposed rule for the 2008 ESRD CfC.” The actual cost: “There was a high variability in the cost estimates submitted, ranging from a low of \$23,500 to a high of \$222,000 for an existing facility which needed to renovate, construct and upgrade all four components. The average per-facility cost estimates submitted for the additional structural requirements of NFPA 101 are as follows:

- Smoke compartments—\$32,544
- Occupancy separation—\$28,139
- Hazardous areas separation— \$16,976

The total average cost for a facility to meet all three requirements would be \$77,659.”

This means that the original CMS estimate of the cost of compliance with the LSC requirements, for ESRD’s, was off by nearly 4,000%-- a massive and costly error, which would have directly impacted patient care, had CMS not corrected the error of requiring LSC compliance on top of existing local building safety and fire codes.

This is the identical situation that exists with respect to all the health care facilities regulated under this proposed rulemaking. The incidence of fire related injuries in regulated healthcare facilities is nearly zero, and there has not been a fatality due to code-regulated issues for many years. And we believe the extreme and unnecessary costs of overlapping compliance with the LSC, on top of the already state-adopted IBC and IFC is much higher than is appreciated by CMS.

To understand the comparison between the NFPA codes and the relevant ICC codes, one fire service expert explained the difference as follows: The NFPA 101 LSC primarily deals with Means of Egress. It addresses numerous occupancy types with two Chapters per occupancy type; one chapter for new construction and a chapter for existing buildings. IFC Chapter 10 comparably addresses the Existing Building requirements for Means of Egress with the same level of safety provided by NFPA 101. IBC Chapter 10 provides the same level of acceptable safety for newly constructed buildings. While it is

necessary to compare NFPA 101 to both the IBC and IFC for comparable minimum requirements for Means of Egress; the two documents combined (IBC and IFC) provide a comprehensive building construction and fire safety code for both new construction and existing buildings. The same comprehensive protection requires three NFPA Codes (NFPA 1, 101 and 5000).

OSHA, faced with a similar situation with respect to its Section 1910 Subpart E requirements for “Means of Egress” determined in a Final Rule published in 2011, in Section 1910.35, that compliance with the IFC would be accepted as a means of demonstrating compliance with OSHA requirements, in the same way that OSHA had for many years prior to the new rule accepted compliance with LSC as a means of demonstrating compliance with these OSHA means of egress requirements. (See Docket No. OSHA–2006–0049)

We note that CMS does indicate (on page 7) of this proposed rule that “the Secretary may accept a state’s fire and encountered by states in the past, when a determination of such equivalence was sought. We strongly encourage CMS to establish a much simpler application, with required information and submission criteria, to allow states a rational path to seek such equivalence. It is also important that there be assurance that an application for equivalence will not subject the state to a loss of funding, or other real or perceived penalties, as the current guidelines for requesting equivalence impose. safety code if the Secretary determines that the protections of the state’s fire and safety code are equivalent to the protections offered by the LSC.” While we applaud this statement, the details of such acceptance are critical, and must be spelled out in the final rule, to avoid the kind of problems

That most recent guidance from CMS on the subject of equivalence for state codes, from the then CMS Director of Survey and Certification Group, Thomas Hamilton, was entitled “Compliance With a State Fire and Safety Code in Lieu of the LSC.” (CMS Memorandum to State Survey Agency Directors, Sept. 5, 2008, Ref: S&C 08-34) The memorandum spelled out five specific requirements, including five sub-requirements on how the state must document how the state code provides equivalent protection, and how the state assures initial and ongoing compliance, and any process for waivers from the state code.

In addition to the five numbered requirements, the memorandum also required submission of a detailed crosswalk comparing provisions of the state code to the requirements in the LSC.

The conditions for an approval were described as valid only for so long as CMS approval, which could be revoked at any time, and that any approved codes would have to be re-submitted at any point when any changes are adopted to the state code or if CMS adds any requirements, or changes the version of the LSC that it adopts.

Finally, to discourage states from requesting equivalence, the Memorandum explains that any state code that is approved would result in an immediate loss of CMS funding for conducting LSC surveys in the

state, even if the State Survey Agency is used by the state to survey for compliance with the state code, after CMS has determined that the state code provides equivalent protection as the LSC.

This process, while appearing to allow for the equivalence of a state code, is so burdensome, and results in a loss of Federal funding which most states rely on for surveys of healthcare facilities, that no state has applied for equivalence since the Memorandum was issued, and no state is likely to do so in the future, if all the requirements and conditions remain in place.

ICC would be most happy to work with CMS to create a more reasonable application process for equivalence, which would assure CMS of safe facilities, in the same way it requires demonstration of compliance with the LSC. We urge CMS to recognize the reality that many states are using the IBC and IFC to achieve life safety and building safety in healthcare and other buildings, and that the expense of duplicative and potentially conflicting requirements on healthcare facilities does increase costs dramatically, without increasing patient care, patient safety or patient outcomes. Diverting spending from duplicate code compliance would allow increased spending on patient care, which is the goal of CMS, healthcare providers, and the public generally. We have provided, as an appendix to these comments, a revised and dramatically simplified proposed process for CMS approval of state codes, with no loss of funding to states. This document should be the starting point for a new process of determining equivalence.

We would bring to your attention the fact that significant progress has been made in conforming the requirements in the IBC and IFC with the requirements in the LSC. Many changes are included in the 2015 IBC and IFC, which was published May 30, 2014. The 2015 IFC and IBC reflect a five-year effort by a special task force of code experts, healthcare engineers, and architects to fully conform the provisions of the LSC and the IBC/IFC so that remaining conflicts between the codes approaches are virtually eliminated.

In order to assist CMS in evaluating the 2012 LSC provisions which were called out in the proposed rule against the equivalent provisions in the IBC (for new construction) and the IFC (for existing buildings) we are prepared to provide a crosswalk that compares the changed 2012 LSC provisions discussed in the CMS proposed rule, to the corresponding sections of the 2015 IBC and the 2015 IFC. ICC is prepared to provide any additional technical support and analysis, to further demonstrate that the provisions of the IBC and IFC provide a level of safety in health care facilities that is unsurpassed by any other code or standard.

Given the increasing convergence of the LSC and the IBC/IFC provisions, a reasonable question might be: "Why allow for equivalence of the IBC/IFC, when the codes are nearing complete alignment on issues affecting healthcare facilities?" The answer is that the IBC/IFC have been chosen as the codes of choice in over 40 states, for many compelling reasons. All of those states could have adopted the LSC, but chose to adopt the IBC and IFC instead. ICC does not claim that its codes provide a higher level of safety- we

believe both the LSC and the IBC/IFC provide equal levels of safety, both to patients, employees and building visitors. Increasingly, however, buildings must be seen as whole systems. Only the I-Codes cover all elements of the building system, including plumbing, HVAC systems, environmental elements, energy efficiency, mitigation of risk against catastrophic natural and man-made events, and the traditional concerns for fire and building safety. States recognize that by adopting the IBC and IFC, they get a code system that is also consistent with the International Energy Conservation Code (IECC) set as the Federal benchmark for energy efficiency in three separate Congressional enactments since 2007. Coordination of codes is very important to the communities we serve, and their code enforcers, as well as to architects and engineers, charged with the responsibility for the performance of buildings across a variety of attributes and criteria, all affecting the physical environment in which care is delivered.

To use a comparison from the technology sector, many remember the two standards that were introduced in the 1980's for consumer video tapes- Beta, from Sony, and VHS from JVC. While both technologies delivered a quality video recording, the two technologies were different, and not compatible. Eventually, as it became clear that consumers preferred the VHS format, even Sony began marketing VHS recorders and players. In the U.S., both NFPA and ICC offered model building codes to the states in the early years of the 21st century, very quickly all states eventually chose the IBC for construction of new commercial buildings, and a clear majority (43) choosing the IFC as their fire code, over the NFPA 5000 building code, and the NFPA 1 fire code. The NFPA LSC contains provisions common to the NFPA 5000 and NFPA 1 codes, which are generally not compatible with the IBC/IFC, due to different nomenclature, formatting and organizational systems of the NFPA and ICC.

This rulemaking follows the issuance of Executive Order 13563, which set as a goal the streamlining of Federal regulations, and the elimination of unnecessary duplication and conflict between Federal regulations and other state and local regulations. The Executive Order, issued on January 18, 2011, instructs agencies to find the "...best, most innovative and least burdensome tools for achieving regulatory ends." There is no question that CMS approval of a simplified equivalence process for state fire and safety codes that achieve the same level of safety for patients and caregivers is a strong step in that direction, which will also achieve dramatic savings in healthcare expenditures, another goal of the Administration and the public at large.

Appendix A to ICC Comments on CMS-2014-0058-0001
Proposed Requirements for Using State Fire and Building Safety Code in Lieu of the LSC

The state must submit an application, signed by the governor, attesting to each of the following items:

1. That the state has adopted both the 2015 International Building Code (IBC), and 2015 International Fire Code (IFC), without amendments affecting the provisions identified in the addendum A to this memorandum that relate to healthcare facilities, that shows the crosswalk between provisions of the IBC and IFC to the 2012 LSC.
2. That the state's adoption applies to all healthcare facilities in the state that are regulated by CMS, as shown in addendum B.
3. That the state's adoption of the 2015 IBC and IFC are minimum requirements, and local jurisdictions may not amend or remove any provisions adopted statewide as related to facilities shown in addendum B.
4. That CMS shall be notified of any changes to the state codes within 30 days of the adoption of such changes.

Use of state codes, where consistent with the 2015 IBC and IFC, shall not affect CMS funding of SA's under Section 1864 agreements between CMS and the State, as the state codes shall be deemed to be Federal requirements in the same way that the LSC is deemed to be a Federal requirement, where the SA is used to survey for compliance with the state code.

Upon submission to CMS, the application will be approved within 90 days, unless CMS determines that one or more of the items in the application is insufficient. In such case, the applying state shall supply any requested information, and the CMS decision shall be communicated within 90 days of submission of the additional information.

It is expected that this memorandum will be revised to reflect later editions of the IBC and IFC, as soon as a crosswalk addendum is provided to CMS, for the purpose of determining equivalence with the new edition of the codes.