December 21, 2011

We note that on the same day that CMS issued this proposed rule, CMS issued CMS-9070, a proposal related to a simliar issue, for End Stage Renal Disease Facilities, in order to "Promote Program Efficiency, Transparency, and Burden Reduction."

We believe that CMS should consider those same objectives when evaluating Section 482.41, and offer the same approach to all health care facilities, for the very same reasons described in the related rulemaking. Certainly, in a time where every effort is being made to reduce the overall costs of the healthcare system, the goals of program efficiency, transparency and burden reduction should be pursued throughout the system, especially when there is no reduction in the quality of care or protection for patients and providers.

This is an area wher.3(m28.1(tha)3.4(t)-11.1(e)-228.1(a)-1.1(nd)l)11.1(i)-4.5-223.1(c)-4.3(a)3.9(e)-227.6(r)13.9(o)2.1(r)2.8

subpart E provisions." OSHA went on in its Proposed Final Rule, issued in 2010, to conclude that the IFC as a stand-alone document, as adopted by the states, provided a level of safety equivalent to the requirements of its own rules at Subpart E.

During the lengthy OSHA rulemaking on this subject that spanned 5 years, across two different Administrations, numerous local jursidictions filed comments in support of recognizing the IFC, and the unanimous view of those commenters was that the acceptance of the IFC as a deemed to comply alternative means of demonstrating compliance with Subpart E would result in significant and ongoing savings to employers. There was no claim or evidence in the docket that would controvert these comments. Even NFPA, the publisher of the LSC that opposed the recognition of the IFC, did not offer any evidence that providing an alternative means of demonstrating compliance would not offer savings to employers and building owners and operators.

We also note that there was no comment or claim that the IFC did not provide equivalent worker protection to the protection afforded by compliance with Subpart E, which was the primary, and most appropriate, criteria to use in deciding whether to go forward with the final adoption of this rule.

We would strongly encourage CMS to also consider reviewing the IFC, and making a similar determination that compliance by helathcare facilities with the 2009 IFC and IBC meets the CMS requirments for physical facilities in the same way, and to the same extent, as compliance with the NFPA Life Safety Code meets those requirements.

As CMS points out in this ANPR:

> "Complying with both the 2000 edition of the LSC, for Federal purposes, and a more recent edition, for accreditation or other purposes, can be challenging for hospitals when there are inconsistencies between the two versions."

How much more challenging then, for those facilities in the 43 state that adopt the International Fire Code, to meet the provisions of BOTH the IFC/IBC and the LSC, for the same facility, addressing the same systems, and building elements. As CMS pointed out in the CMS-9070 ANPR: "When implemented, these Federal LSC regulations were found to duplicate many provisions of already existing State and local fire safety codes covering ESRD facilities. Although the State and local codes protected patients from fire hazards, the NFPA 101 LSC retroactively imposed some additional structural requirements." This is also the case in hospitals and other healthcare facilities, often to a greater extent, and with far greater cost implications.

And the costs of this additional regulation, while resulting in no increase in safety, do impose very high costs. As the CMS-9070 ANPR points out:

> "While the risks of fire are very low in a dialysis facility, the costs of complying with the Federal LSC requirements in dialysis facilities are high. Through research discussed in the following paragraph, CMS has learned that the actual costs for renovation and construction necessary for compliance with the additional requirements of NFPA 101 for dialysis facilities are considerable and profoundly exceed the original government estimate of $1,960 as published in the preamble

compliance by employers, increased flexibility for employers, lower cost for employeers to demonstrate compliance, and finally, a higher level of protection for workers in facilities that demonstrate compliance with the requirements of the IFC."

There is no doubt that adding the IFC and IBC to the currently recognized Life Safety Code, as a recognized means of compliance with CMS Physical Requirements CoP, would achieve similar benefits consistent with the mission of CMS and consistent with the goal of the Administration and Congress to reduce the cost of healthcare delivery, increase the flexibility of regulation, and reduce unnecessary and duplicative regualtions.

To understand why there are two codes required in the ICC framework, one fire service expert explained it as follows: The NFPA 101 LSC primarily deals with protecting building occupants from fire by providing a Means of Egress and features to ensure adequate egress time or protection of occupants exposed to fire. It addresses numerous occupancy types with two Chapters per occupancy type; one chapter for new construction and a chapter for existing buildings. The IFC is a comprehensive safety code that addresses both occupant safety and the safety of firefighters and emergency first responders during emergency operations from all life hazards, not just fire. 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*. The same comprehensive protection requires three NFPA Codes (NFPA 1, 101 and 5000).

If there is concern about adding a requirement for two codes, when one code is currently referenced, two points should be made: First, there is no need for any change for jurisdictions that currently enforce the NFPA 1 and NFPA 101 Life Safety Code as the locally adopted fire and maintenance code. The Life Safety Code, in whatever edition CMS determines is the proper edition to be recognized, will continue to be an acceptable means of demonstrating compliance with Sec.482.41. And likewise, in jursidictions that currently enforce the IBC and IFC, there is no additonal burden on healthcare facilities in following two codes, since they are currently forced to demonstrate complaince with three codes- the IFC and IBC, as well as the sometimes conflicitng LSC.

FEDERALISM CONSIDERATIONS

With respect to OSHA's review of this advanced notice of proposed rulemaking under Exectuive Order 13132, requiring Federal Agencies, to the extent possible, "refrain from limiting State policy options, consult with States prior to taking any actions that would restrict State policy options…", ICC believes that the changes proposed in these comments will recognizeStates that have adopted theIBC and IFC, and respect their decision within the context of CMS regulations. The fact that hospital facility managers would be able to demonstrate compliance using a single family of codes, to satisfy both their responsibility to maintain safe conditions under state building and fire safety codes, and simultaneously

demonstrate compliance with 42 CFR Part 482.41, Physical Environment , will generate significant reductions in costs to states,and the regulated community that willreduce overall healthcare costs.

Because such a large portion of the costs of the regulated community (hospitals) are paid for through Federal reimbursement and payment programs, means that a very large share of the savings generated through recognition of the IBC and IFC would benefit the Federal government, and directly translate into lower costs for both the Medicare and Medicaid programs.

SUMMARY

To save an estimated $6 billion in costs to hospitals and the Federal government, without any reduction in quality of care or patient safety, CMS should consider, at the time it considers updating the version of