June 16, 2014

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:
THE INTERNATIONAL CODE COUNCIL (ICC)
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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 V D I H W \ D Q G V X S S R UU^± –ƒ Aë P ƒ AÄÞ>± $)xŸ3 NŸ:ÈFFN– ¥ N‘ 1z¢ ééÕêƒa~_=^õéã >Ÿ>^Â

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

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

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 /6& ZKHQ LW VWDWHV ³7KHUHIRUH D KHDOWKFDUH IDFLOLW 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 0HGLFDLG UHJXODWRU\ UHTXLUHPHQWV ´ 7KH issue of 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 ² NOT the 2009 or 2012 LSC. The correct way WR VWDWH WKH UDWLRQDOH ZRXOG EH DV IROORZV ³7KHUHIRUH a new 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 UHJXODWRU\ UHTXLUHPHQWV ´

7R DFKLHYH WKH REMHFWLYH WR ³VLPSOLI\ DQG PRGHUQL]H WKH health care providers and suppliers, reduce compliance related burdens, and allowing for more resources WR EH XVHG IRU SDWLHQW FDUH ´ LW LV FOHDU WKDW &06 VKRX 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 LVVXHG LQ WKDW UXOHPDNLQJ &06 VDLG ³:KHQ LPSOHPHQWHG 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 UHIHUHQFH UHWURDFWLYHO\ LPSRVHG VRPH DGGLWLRQDO VWUX

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 FRPSO\ ZLWK WKH /6& ,Q UHVSRQVH &06 VDLG ³:H DJUHH WKDW 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 6WDWH DQG ORFDO ILUH FRGHV DQG VDIHW\ VWDQGDUGV XQGHU

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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 S H F W L R Q 6 X E S D U W (U H T X L U H P H
R I (J U H V V ´ G H W H U P L Q H G L Q D) L Q D O 5 X O H S X E O L V K H G L Q L (
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 W K D W ³ W K H 6 H F U H W D U \ P D \ D
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

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 EH ³:K\ DOO RaZender RfuheIBCXIFC, when the codes are nearing complete alignment on issues DIIHFWLQJ KHDOWKFDUH IDFLOLWLHV"´ 7KH DQVZHU LV WKDW WK in over 40 states, for many compelling reasons. All of those states could have adopted the LSC, but chose

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 LQ WKH ¶V IRU 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, LQVWUXFWV DJHQFLHV WR ILQG WKH ³«EHVW PRVW LQQRYDWLYH UHJXODWRU\ HQGV´ 7KHUH LV QR TXH sion 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. 7KDW WKH VWDWH¶V DGRSWLRQ DSSOLHV WR DOO that are regulated by CMS, KHDOWKF as shown in addendum B.
3. 7KDW WKH VWDWH¶V DGRSWLRQ RI WKH ,%& DQG ,)& DUH 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.

8VH RI VWDWH FRGHV ZKHUH FRQVLVWHQW ZLWK WKH ,%& D 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