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Docket No. CMS-3244-P
Centers for Medicare and Medicaid Services 42 CFR Parts 482 and 485: Medicare and Medicaid Programs: Reform of Hospital and Critical Access Hospital Conditions of Participation

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Comments of the International Code Council
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The International Code Council is a member-focused association dedicated to helping the building safety community and construction industry provide safe and sustainable construction through the development of codes and standards used in the design, build and compliance process. Most U.S. communities and many global markets choose the International Codes (I-Codes). 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 enforce 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 Code Council (ICC) was established in 1994 as a non-profit organization dedicated to developing a single set of 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.

We note that many of the legal requirements governing CMS and its regulations for healthcare facilities were put in place by the Social Security Act of 1964 and subsequent amendments thereto. These legal requirements were generally established during a period when there was no single uniform building code for the United States as there is today, with the International Building Code. Until 2000, there was only one national code, the NFPA 101, that adequately addressed CMS's healthcare facility concerns.

Today, states and local governments have a choice between two code systems, and 43 of the 50 states have chosen to adopt the ICC International Fire Code (IFC) in coordination with the International Building Code (IBC) as their choice for building and occupant safety.

As Secretary Sebelius said in a guest editorial in the Wichita Eagle, published October 23, 2011:

> "One of government's roles is to create rules that protect public health and keep us safe. Thanks to drug-safety regulations, we can take medicine without the fear of being poisoned. Because our nation passed child-labor laws, we no longer see young children working in textile mills. These rules also can help business by building consumer confidence and trust.
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> But we also know that new technology and new approaches can make some regulations obsolete. Others overlap or are overly burdensome.
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> And yet too often, they stay on the books, standing in the way of investment and innovation. They keep employers from putting people back to work or prevent health care providers from delivering their best care."

Our comments address an area of the Conditions of Participation (CoP) that fit squarely into the category of regulations described by the Secretary in her editorial that she has committed to reform.

Our comments are specifically directed at that part of the ANPR that addresses 42 CFR Part 482, and specifically at Section 482.41, Physical Environment.

In that portion of the ANPR, CMS states as follows:

> Currently, hospitals are required to meet the standards of the 2000 edition of the Life Safety Code (LSC), which is not the most recent edition. Many accrediting bodies, as well as state and local jurisdictions, require hospitals to comply with more recent versions, such as the 2003, 2006, or 2009 edition of the LSC. 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.
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> We expect the 2012 edition of the LSC to be released in Fall 2011. Based on the content of the 2012 edition, we will decide whether it or another more recent edition, is appropriate for incorporation into the regulations for hospitals and other affected providers and suppliers. Any regulatory changes would be addressed through separate notice-and-comment rulemaking. We are specifically seeking comment on this issue.

We will suggest in our comments that CMS should go beyond simply updating to a more recent version of the LSC, for incorporation into the regulations. CMS should consider taking the same action that it proposed in CMS-9070, to eliminate the requirements of the Life Safety Codes on End Stage Renal Disease centers, where state and local buidling and fire codes provide the same protections, without the additional cost of the duplicative Federal regulations.

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 where state and local regulations have changed dramatically since the first requirements of Sec. 482.41 were put into place, and those changes suggest that a review of the current regulatory requirements could result in significant savings by eliminating duplicative requirements. Before 2000, there were at least three major regional building and fire codes, as well as dozens of local variations including locally drafted codes. In contrast, at that time, there was only one national code, the NFPA 101, Life Safety Code (LSC) that adequaltely addressed CMS's concerns. In 2000, the International Code Council published the first edition of the IFC, a nationally recognized fire,life safety, fire protection systems and means of egress maintenance code. Along with the IBC, the two codes address the same subjects and risks as the Life Safety Code. Since that time, many states and local jursidictions have examined and considered both the LSC and the IFC. A clear majority of states, 43 at this writing, have chosen to adopt the IFC, along with the IBC, as their state codes to address life safety and fire emergency issues, in all covered buildings in those states. As each code is updated every three years, most states review and update their codes on a regular, systematic schedule, to stay current with best practices and current technology. These changes in the model codes, and the actions of the states and local governments in adopting those codes, have made the duplicative CoP regulations "obsolete," to use Secretary Sebelius's term.

As further evidence that the CoP requirements are no longer appropriate, and impose additional non-value added costs, note that in 2011, the U.S. Occupational Safety and Health Administration (OSHA), a division of the U.S. Department of Labor responsible for assuring worker safety in the workplace, determined that employers who demonstrate compliance with the IFC, 2009 edition, would be deemed to comply with OSHA Subpart E requirements for Exit Routes and Emergency Planning, just as it had previously determined that the LSC should be deemed to comply with those requirements for many years prior to issuing this Final Rule in June 2011 (76 FR 33590).

In its ANPR for this rule, in 2006, OSHA was faced with a similar situation to that now faced by CMS, with respect to the changed conditions in state regulation of buildings since its initial review of state codes, when there was only one national fire and life safety code, the NFPA 101 LSC. In the ANPR published in 2006, OSHA noted that it had previously declined to recognize the International Fire Code. OSHA went on in the ANPR to state: "That situation has changed significantly. First, the three former buiilding codes have evolved into a single code, the IBC. Secondly, OSHA has made a determination that the egress provisions of the IBC and the IFC, when applied together, offer employee protection equal to the

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

> to the new 2008 ESRD/LSC regulations….. The total average cost for a facility to meet all three would be $77,659. We suspect that the variability of the estimates may be due to different State and local requirements already in existence, differences in contractor costs, varying building characteristics (for example, age, size, construction type), and the inconsistent interpretations and applications of NFPA 101 that are prevalent across the nation. The wide range of estimates makes it difficult to determine an average cost related to implementation of NFPA 101. However, using the average costs for the individual structural requirements listed above, if 50 percent or 2,800 facilities required only renovation for hazardous area separation, the savings would be $47.5 million. If 2,800 facilities required renovation for all three structural requirements, the total savings from the burden reduction at the average estimate for all three would be $217 million. These amounts represent a significant financial burden on facilities, with little or no improvement in patient safety from fire for a majority of them."

We would also call attention to the comments filed by DaVita on CMS-9070, on December 13, 2011, which indicated that the cost to DaVita alone would be nearly $120 million over the next ten years, which suggest that the CMS may be underestimating the actual costs of these duplicative regulations.

We believe that the same analysis, applied to hospitals and ambulatory care facilities, would confirm similar financial burdens on a much larger scale. Furthermore, the risk of fire injury in contemporary hospitals and healthcare facilities is extremely low. As with ESRD facilities, money spent on duplicative and non-productive regulation could be re-allocated to address far more prevalent and serious risks to patients within hospitals and other healthcare facilities. We believe, after consultation with hospital facility managers and healthcare engineers, that the total cost of the duplicative regulation of hospitals by requiring compliance with both the LSC and the IFC exceeds 6 billion, no small sum even in the healthcare arena

In this current environment of pursuing every avenue to reduce the overall costs of healthcare, there is no good reason to continue to expend over $6 billion on duplicative inspections and unnecessary and burdensome building modifications, simply because Federal regulations have not kept up with changes in state and local life safety and fire code enforcement.

For those unfamiliar with the International Fire Code, published by ICC, it is one of 14 codes developed by the International Code Council which uses our highly successful "governmental consensus process" to bring together subject matter experts, building owners, engineers, builders and designers, and product and system manufacturers and installers, as well as the code and fire officials who are charged with assuring a safe building environment for all users. Our process is open, transparent, consensus-driven, and meets all due process requirements such as the right of all parties to review, comment and, if necessary, appeal decisions made during the process. The I-Codes are updated every three years to ensure the codes remain current with the latest technology, building materials, best practices; adopt the latest reference standards and address identified fire-safety and health concerns.The use of this process assures OSHA and Code users that the IFC meets all requirements of Federal law, such as the National Technology Transfer and Advancement Act of 1995, and OMB Circular A-119, requiring the use of voluntary consensus standards from the private sector.

In comments filed with OSHA at the time of the publication of its proposed final rule, we noted that "43 states have currently adopted some version of the IFC at either the state or local level," and that "adding the 2009 IFC as an additional "deemed to comply" method of demonstrating compliance will achieve several positive benefits conistent with the mission and purpose of OSHA: increased

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 the Life Safety Code that hospital and healthcare facilities must meet, recognizing the 2009 International Building Code and International Fire Code as an allowable means of meeting the fire and life safety requirements in 42 CFR Part 482.41