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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 building code for the United States that was in use all 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 national 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. Our comments are specifically directed at Section A .1. of the notice, the proposal to remove unnecessarily burdensome requirements for End Stage Renal Disease (ESRD) Facilities., Sec 494.60

The first reason stated for the removal of the requirement for all ESRD Facilities to adhere to NFPA 101, is that “these regulations were found to duplicate many provisions of already existing State and local fire safety codes covering ESRD facilities.” This is true, of course, when the State or local jurisdiction is enforcing either the NFPA 101 LSC or the ICC International Fire Code (IFC) and the International Building Code (IBC).

However, while we do agree that there is no reason to require the enforcement of the NFPA 101 under Sec. 494.60 in jurisdictions that enforce, either at the State or local level, both a current building code, such as the IBC, and a current life safety and maintenance code, such as the IFC or NFPA 101, the current requirement should be maintained for facilities that are located in jurisdictions that do not adopt or enforce current building or fire codes. While most states, and most large population local jurisdictions do adopt and enforce the IBC and either the IFC or NFPA 101, there are still some localities, in smaller jurisdictions or unincorporated areas, where no building code or fire/life safety code is enforced. In those locations, ESRD facilities should have to meet the current requirements of Sec. 494.60.

In support of the proposed elimination of the requirement for most ESRD’s to use comply with requirements of the LSC, we would refer CMS to the Federal Register notice of June 8, 2011, wherein the Department of Labor, Occupational Safety and Health Administration also concluded that the ICC International Fire Code provides an equal level of protection for workers as that provided by compliance with the NFPA 101 LSC, that OSHA previously recognized as providing worker protection equivalent to OSHA “Exit Routes and Emergency Planning” requirements. (76 FR 33590). During the lengthy OSHA rulemaking on this subject, numerous local jurisdictions 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.

The notice goes on to explain that “additional structural requirements of NFPA 101 potentially could improve patient safety from fire in specific dialysis facilities” in higher risk locations. This is true ONLY when the facility is located in a jurisdiction that does not enforce the ICC IBC and the IFC, that include structural requirements to assure unsurpassed life safety to all persons in buildings built to the requirements of the IBC, and assure safe egress and fire suppression equipment maintenance,

according to the requirements of the IFC. By requiring adherence to LSC provisions where there is no local Building and fire code enforcement, CMS can avoid attempting to define specific circumstances that might be subject to interpretation and confusion, and simply set up a simple test for when the LSC provisions must be followed. If the dialysis facility is in a jurisdiction that adopts a building and fire code, and is subject to a local annual fire code inspection, there is no need for the duplicative requirements of the LSC to be enforced. There are no requirements in the NFPA 101 that would result in a higher level of protection than the requirements in the IFC and IBC combined, which is why every jurisdiction that adopts a model commercial building code in the United States has adopted the IBC, and 43 states have adopted the IFC.

The costs outlined in the notice express only a part of the costs of the duplication and unnecessary expense caused by the requirement for ESRD Facilities to use the NFPA 101. The notice describes the additional costs of construction, the additional costs of relocating patients during construction, and the additional costs of oversight of LSC surveys, "which often duplicate State LSC surveys." We think it is important to note that not only is there duplication of other LSC surveys, but there are overlapping, duplicate and sometimes conflicting requirements between the Federal LSC surveys examining compliance with the NFPA 101, and state and local fire code and building code enforcement activities including inspections to the IBC and IFC. The overlap and conflict between provisions addressing similar systems can add significant costs to ESRD Facilities.

The IFC and IBC are two of 14 codes developed by the International Code Council, using our highly successful "governmental consensus process" to bring together subject matter experts, safety advocates, 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 use of this process assures CMS 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.

AS OSHA pointed out in its Advanced Notice of Proposed Rulemaking (ANPR), December 21, 2006, OSHA had previously declined to recognize the building codes in 2002, because at that time there were three different building codes used around the country. As the ANPR stated: "That situation has changed significantly. First, the three former building 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. Now in this proposed rule, OSHA again reviews the IFC and IBC, and again concludes that the IFC alone will provide a level of safety equivalent to the requirements of Subpart E."

We might add that the situation has continued to change since the 2006 OSHA ANPR, in that more states have chosen to adopt the IBC and the IFC.

In steadily increasing numbers, when states have considered both the NFPA LSC and Fire Code, and the ICC IBC and IFC, they have chosen the IBC and IFC. The IBC and IFC meet the needs of the healthcare community, the code enforcement community, and the fire service, all of whom support the integrated approach to building codes that is the hallmark of the International Code Council's suite of building, fire, energy and other codes. Jurisdictions have favored the IFC, over the NFPA 1 and NFPA 101, because of the IFC's correlation and consistency with the IBC.

In addition to the benefits already described, it should also be noted that because the IFC is reviewed and revised on a consistent, fixed three year cycle, new knowledge and new solutions to emerging or previously unrecognized or unknown risks are constantly being considered, and the safety of building users continually upgraded, with every new edition of the model code that is published.

As an example of this innovation, the IFC recognized and allowed for the installation of alcohol-based antiseptic hand rub dispensers in healthcare facilities in the 2006 IFC, recognizing that infection was a far more common cause of death in healthcare facilities than fires, and recognized the need for clear provisions governing these antiseptic dispensers.

ICC has consistently worked with the American Hospital Association, the American Society of Healthcare Engineers, state and local fire marshals and others in the healthcare community to insure that the IBC and IFC reflect the most current science and practices to make healthcare facilities safe and efficient. ICC is proud that our Board of Directors membership currently includes a state Fire Marshal, and a local Fire Marshal, who are vitally concerned with public health and safety issues.

The ICC stands ready to assist CMS in its mission of assuring patient and healthcare worker safety, as that mission is entirely consistent with, and a subset of, the ICC mission of providing a safer built environment for all the people who work, live and do business in buildings here in the United States, and around the world.

To understand the comparison between the NFPA codes and the relevant ICC codes, one fire service expert explained it 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*. The same comprehensive protection requires three NFPA Codes (NFPA 1, 101 and 5000).

Federalism Considerations

With respect to CMS's review of this proposed rule under Executive 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 change proposed in

this rulemaking will clearly not limit State policy options, but will in fact recognize the States that have adopted the IFC, and respect that decision within the context of CMS regulations. The fact that facilitybuilding managers will now be able to demonstrate compliance with a single code document, to satisfy both their responsibility to maintain safe conditions under state building and fire codes, and simultaneously demonstrate compliance with CMS Sec.494.60, will generate saving to states, local governments, CMS, and the regulated community. CMS has very correctly determined that this proposed rule will result in significant savings to ESRD facilities, and that those savings will inure to the benefit of Federal, private insurers, and patients who must pay for the costs of operating and maintaining these facilities. If any error has been made, it is likely that CMS has under-estimated the savings that will accrue as a result of the elimination of the duplicative regulation.

SUMMARY

We agree that the current requirement for compliance with the NFPA 101 Life Safety Code should be eliminated for all ESRD facilities, except when such facilities are located in jurisdictions that do not adopt a current national model building and fire code, such as the IBC and IFC.

We would recommend modifying the proposed Sec 494.60(E), to read as follows:

Except as provide in paragraph (e)(2) of this section, by February 9, 2009, dialysis facilities that are located ~~adjacent to high hazardous occupancies or do not provide one or more exits to the outside at grade level from patient treatment level~~ outside of jurisdictions that have adopted and enforce a current national model building and fire code, must comply with applicable provisions of the Lifes Safety Code of the National Fire Protection Association (which is incorporated by reference at Sec. 403.744(a)(1)(i) of this chapter).

(remainder of proposed Sec. 494.60(E) remains as proposed)