



**American Hospital
Association**

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June 16, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

RE: Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities [CMS-3277-P]

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services's (CMS) proposed regulation to update the fire safety standards for hospitals, critical access hospitals (CAHs) and other health care facilities.

Health care facilities must ensure the safety of patients at all times. **The AHA applauds CMS's proposals to adopt the 2012 edition of the National Fire Protection Association's (NFPA) Life Safety Code (LSC) and most chapters of the 2012 edition of the NFPA's Health Care Facilities Code (HCFC).** We also support CMS's intent to retain or modify other fire safety provisions. **Further, we urge CMS to keep fire safety standards current by updating its requirements every three years in conjunction with NFPA code revisions.**

Our detailed comments below are intended to improve selected sections of the proposed rule. In addition, we seek clarity on some of the specific provisions where CMS's proposals differ from the NFPA's 2012 editions of the LSC or the HCFC.



GENERAL COMMENTS ON THE PROPOSED RULE

Adoption of 2012 LSC. As noted above, the AHA supports the adoption of the 2012 edition of the LSC. CMS's current standards are out of sync with those of the NFPA, causing confusion within the hospital field and many challenges for compliance. **We urge that CMS's standards stay aligned with the LSC, as adopted by the NFPA, as much as possible, and depart from LSC requirements only when the agency has clear reason to do so.**

The National Technology Transfer and Advancement Act of 1995 explicitly directs federal agencies to use voluntary consensus standards unless they can justify deviating from those standards. The Office of Management and Budget's (OMB's) Circular No. A-119 provides guidelines for the kind of open, fair, multi-stakeholder process needed for the development of voluntary consensus standards. The intent of the law is to ensure that federal agencies do not waste federal resources and/or those of the regulated industry by imposing their own unique requirements.

The NFPA is accredited by the American National Standards Institute as a standards developer. Thus, NFPA complies with the process requirements for the development of the kinds of consensus standards the law envisioned. When CMS selectively modifies these standards, which have been adopted through an open, consensus-based process with input from national fire safety and engineering experts, among others, the agency creates conflicts with other standards with which health care providers must comply.

Finally, **we urge CMS to keep its fire safety requirements current** to make it easier for hospitals to comply with the most recent standards for keeping patients safe. Current federal regulations state that hospitals, CAHs and other health care facilities must meet the requirements of the 2000 edition of the LSC. NFPA has updated the LSC four times since 2000. As CMS points out in the preamble of the proposed rule, health care facilities constructed today would likely be required by state and local authorities to comply with a more recent edition of the LSC, while also being required to comply with the 2000 edition to meet Medicare and Medicaid requirements. While waivers may be available, we agree with CMS that requiring compliance with two different editions of the LSC at the same time creates conflict and duplication that increase construction and compliance costs without any fire safety or patient care benefits. CMS does not discuss its plans to ensure that these same conflicts will not continue in the future. As the LSC is scheduled to be updated next year, the finalized federal regulations for this rule will soon be inconsistent with the latest standards. We encourage the agency to make needed adjustments to stay aligned with those standards and to provide a defined and timely periodic review when NFPA updates are issued.

Application of 2012 LSC to Health Care Facilities Regardless of Number of Patients Served. CMS proposes to apply the LSC requirements to health care facilities, regardless of the number of patients served. This proposal, which represents a departure from how the NFPA applies the LSC, has caused a great deal of confusion. The LSC generally applies health care and ambulatory care occupancy requirements to facilities serving four or more patients who are incapable of self-preservation on some level. CMS provides very little explanation of how it

would interpret its proposed provision to apply the LSC regardless of the number of patients served.

We appreciate and support CMS's proposal recognizing that hospitals may have multiple occupancy classifications, which presumably include health care occupancies, ambulatory health care occupancies, business occupancies, and others. However, numerous questions that could have substantial impact upon health care facilities, especially business occupancies, are left unanswered by the proposed rule, including:

- Would CMS prohibit a hospital from taking an inpatient who is incapable of self-preservation to a business or ambulatory health care occupancy for diagnostic services or treatment?
- Under what circumstances would CMS disallow services in business occupancies, such as diagnostic facilities, that serve three or fewer patients simultaneously, or require those occupancies to be upgraded?
- Under what circumstances would CMS disallow services in business occupancies serving four or more patients, or require those occupancies to be upgraded?
- Would CMS diverge from the LSC in its application or definition of the term "incapable of self-preservation?"

It is extremely difficult to ascertain the effect of this proposal without more detailed information from CMS. The effects could be considerable and, in a worst case scenario, could potentially affect access to care for patients. In 1996, the latest year for which we have data, it was estimated that as many as 500,000 health care facilities could be classified as business occupancies. Even if we assumed that only half, or even a tenth, of these business occupancies existed today, it means that CMS's proposals could have far-reaching effects. Given the potential impact of requiring some facilities to make construction upgrades, CMS should provide additional and specific information about how the agency will interpret its application of LSC requirements, regardless of the number of patients served. Stakeholders are entitled to have notice about changes that could affect their ability to provide services.

The safety of patients is paramount. We agree that if CMS can demonstrate that some ambulatory health care or business occupancies need stronger fire protections for patients who may be incapable of self-preservation, the agency should implement higher standards for those facilities. Given the potential access problems that might be caused by disallowing certain care settings, it is imperative that CMS be able to demonstrate the need for care settings to have higher standards and provide some flexibility in how hospitals and other organizations meet those standards. If health care providers cannot make certain building upgrades because costs are prohibitive or because the space is leased from landlords who will not allow construction changes, CMS should consider alternatives that enable facilities to achieve the needed level of safety, such as adding staff. Appropriate alternatives could avoid the potential unintended consequences of causing some smaller yet essential facilities to close or eliminate needed procedures. For example, if a landlord is unwilling to make or allow upgrades, and no other space is available at the desired occupancy level, a provider could have to discontinue a service.

Should CMS finalize its proposal to apply LSC requirements regardless of the number of patients served, we urge the agency to use an open, transparent process for the development of interpretive guidance. Stakeholders must be provided an opportunity to alert CMS about how the agency's application could affect their ability to provide services to patients.

Adoption of 2012 HCFC. **The AHA supports the adoption of the 2012 edition of NFPA 99, as proposed (excluding chapters 7, 8, 12 and 13).** While the LSC provides general fire safety requirements for buildings of many types, NFPA 99 contains specific requirements for health care settings. Given the fact that the NFPA uses a national, consensus-based and open process for standards development, we believe that NFPA 99 requirements are robust, consistent with other fire safety codes, and represent the most up-to-date standards specific to health care settings. In addition, we believe that health care facilities should by and large already comply with NFPA 99 due to state and local requirements, as well as cross-references in the LSC and the International Building Code. In this rule, CMS proposes to exclude chapter 12 of the NFPA, which covers emergency management. Presumably, CMS excludes this chapter because the agency intends to adopt its own emergency preparedness regulations through a separate proposed rule. As we stated in our comment letter on the emergency preparedness proposed rule, we urge CMS to continue to move toward alignment with the framework of NFPA, especially as NFPA updates its codes and standards regularly to reflect new knowledge.

COMMENTS ON SPECIFIC PROVISIONS IN THE PROPOSED RULE

2012 LSC Changes. We agree with CMS that the NFPA has made changes to the LSC that will benefit patients and improve the ability of health care facilities to improve care, including enlarging the permissible size of sleeping suites, allowing for fixed furniture in corridors, and other provisions. In response to CMS's specific request for comments, **the AHA supports a 2012 LSC provision for existing health care occupancies over 75 feet high to have automatic sprinkler systems throughout the building, and we support the phase-in period of 12 years.**

Extinguishment Provisions. The AHA suggests a revision to CMS's proposal for most facilities included in the rule to require the evacuation/partial evacuation, or the instituting of an approved fire watch, when a sprinkler system is out of service for more than four hours in a 24-hour period. The current LSC requires the same actions when a sprinkler system is out of service for more than 10 hours in a 24-hour period. We suggest that CMS align with the NFPA requirement of 10 hours and further require facilities to institute additional activities to increase safety until a fire watch is triggered under the NFPA standard. This would include, at a minimum, ensuring that fire and smoke detection systems are working properly before the sprinklers are disabled, alerting staff that sprinklers are not functioning, providing additional extinguishers, and monitoring areas of the building likely to be unattended.

Exhaust Systems. We agree with CMS's proposal to require hospitals, CAHs and ambulatory surgery centers to have supply and exhaust systems in windowless anesthetizing locations that automatically vent smoke and products of combustion, prevent recirculation of smoke originating within the surgical suite, and prevent the circulation of smoke entering the system

intake. However, CMS does not clarify whether the agency expects dedicated exhaust systems to be installed. We do not think CMS should require a dedicated exhaust system if a hospital's current air handling system will adequately achieve these same outcomes described above. Use of a dedicated system could require the shut-down of air handling units providing ventilation to multiple operating rooms, which might result in a greater risk of surgical site infections to patients in other operating rooms not affected by the fire. Therefore, CMS should provide flexibility in the types of exhaust systems allowed, so long as they properly vent smoke and products of combustion.

Outside Windows and Doors. The AHA disagrees with CMS's proposed requirement related to outside windows or doors in every health care occupancy patient sleeping room. Specifically, CMS proposes to include the following regulatory language for hospitals and CAHs:

Except for newborn nurseries and rooms intended for occupancy for less than 24 hours, every sleeping room must have an outside window or outside door, and the sill height must not exceed 36 inches above the floor. Special nursing care areas shall not exceed 60 inches. Windows in atrium walls are considered outside windows for the purposes of this requirement.

CMS would include similar language for long-term care facilities, inpatient hospices and religious non-medical health care institutions. CMS states that "outside windows and doors may be used for smoke control, building entry, patient and resident evacuation and other emergency forces operations during an emergency situation."

While we support the need for windows or doors in patient sleeping rooms from the standpoint of providing a healing, supportive environment, requiring windows and doors as a fire safety standard is not advised. Construction standards for some time have required non-operable windows. Windows in hospitals may not open or be easily breakable for a variety of reasons, particularly due to safety concerns. Hospitals must safeguard against accidents, especially for patients in multiple-story buildings, and also must protect patients who may be at risk of suicide. In addition, hospitals often care for patients who, for dementia or other reasons, may wander. Moreover, the NFPA has stated that opening windows during a fire can draw smoke and combustion into the building. Therefore, hospitals may not have operable outside windows or doors in every patient sleeping room.

Finally, if CMS does finalize this provision, we urge CMS to clarify that the proposed regulatory language would apply to new construction only, as retrofitting existing facilities would be extremely costly. Because there is no evidence the benefits would exceed the increased risks for patients, and because such changes would add to health care costs, CMS should reconsider this proposal.

Alcohol-based Hand Rubs (ABHRs). **The AHA supports CMS's proposal to shorten its regulations related to ABHRs and defer to the 2012 NFPA 101 requirements, which have been expanded.** In addition, CMS would clarify in regulations for every provider or supplier type covered by this rule that ABHR dispensers may be installed only "in a manner that

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June 16, 2014

Page 6 of 6

adequately protects against inappropriate access.” **The AHA asks for clarification as to what constitutes “inappropriate access.”**

Thank you again for the opportunity to comment. If you have any questions, please contact me, Nancy Foster, vice president for quality and patient safety policy, at nfoster@aha.org, or Evelyn Knolle, senior associate director of policy, at eknolle@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President