Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
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Submitted via *http://www.regulations.gov*.

June 16, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3277–P
P.O. Box 8010
Baltimore, MD 21244–8010

RE: Comments on Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities

I write on behalf of the Tribal Technical Advisory Group (TTAG) of the Centers for Medicare & Medicaid Services (CMS) to comment on the Notice of Proposed Rulemaking issued by the Centers for Medicare and Medicaid Services (CMS) on CMS-3277-P, Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities (the Proposed Rule).[1] The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or in part) by CMS. In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations.

Thank you for the opportunity to respond to the Notice. The TTAG generally supports CMS's proposed changes, particularly CMS's adoption of the majority of the National Fire Protection Association's (NFPA's) Life Safety Code (LSC) 2012 edition. However, the Proposed Rule includes several proposals that we believe either require clarification or are unnecessarily burdensome on providers. We set out our concerns below.

I. Discussion.

1. The Proposed Occupancy Reclassification is Unclear.

Both the 2000 and 2012 editions of the LSC classify a health care occupancy (to which the fire safety rules would apply) as a facility used for "[care] of 4 or more [patients] mostly incapable of self-preservation." However, the Proposed Rule states instead that "the requirements, conditions of participation, and conditions for coverage for all Medicare and Medicaid participating health care providers and suppliers subject to these rules would apply

[1] 79 Fed. Reg. 21,552 (Apr. 16, 2014).

on a facility basis, regardless of the size of the facility or the facility's patient census."[2] CMS accordingly proposes to apply the Proposed Rule to covered facilities "regardless of the number of patients the facility serves."[3]

It will be difficult to determine the practical implications of this proposal absent additional guidance from CMS. For example, on the one hand, as it is unlikely that any hospital would have only three or fewer patients, this proposal might not have much of a practical impact on the manner in which hospitals currently operate. However, if CMS intends to apply this new health care occupancy standard to virtually any facility billing Medicare or Medicaid under a hospital's provider number (such as nuclear medicine and diagnostic imaging facilities, freestanding emergency departments, or dental practices that use nitrous oxide and render patients "mostly incapable of self-preservation"), the American Society for Healthcare Engineering estimates that up to 400,000 facilities "would have to change services, upgrade their buildings to a higher occupancy type, or close their doors completely."[4] Such an interpretation would also disproportionately affect smaller and more rural facilities that are associated with a larger, off-site hospital but communicate through telehealth or similar long-distance methods.

We therefore recommend that CMS clarify the scope of its proposed occupancy standards, and recommend that in the case of hospitals, the requirements be limited to the hospital facility itself, and not off-site facilities billing under the hospital's provider number. If CMS does intend to apply the Proposed Rule to all facilities billing under a hospital provider number, we also urge CMS to extend the comment period in order to allow hospitals and other facilities more time to properly respond to the proposal.

2. CMS Should Extend the Required Timeframe for Implementing Fire Watch/Evacuation Procedures.

As CMS notes, the 2012 edition of the LSC requires the evacuation of a building or the institution of an approved fire watch when a facility's sprinkler system is out of service for more than ten hours in a 24-hour period, with the evacuation/fire watch maintained until the system is returned to service.[5] However, citing "the increased reliance upon a facility sprinkler protection system in the 2012 edition of the LSC, and to ensure a facility is adequately monitored when a sprinkler system is out of service," CMS propose to "retain the

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[2] *Id.* at 21,554.

[3] *See generally id.* at 21,564 *et seq.*

[4] Chad Bieber, American Society for Healthcare Engineering, "Breaking Down the Proposed CMS Changes to Life Safety Requirements," *available at* http://www.ashe.org/resources/ashenews/2014/proposed_cms_changes_to_lsc_requirements_140603.html#.U5oFZXamU40 (last visited June 12, 2014) [hereinafter ASHE Report].

[5] Proposed Rule at 21,555.

requirement for evacuation or a fire watch when a sprinkler system is out of service for more than 4 hours."[6]

The TTAG supports the LSC's extension of the fire watch/evacuation period from four hours to ten hours and recommends that CMS increase the applicable timeframe accordingly. Mechanical, electrical, or other problems with a facility sprinkler system routinely take over four hours to repair, particularly in larger facilities with more complex systems or in remote facilities that might have to wait hours for a repair service (and in Alaska, potentially even longer due to inclement weather and other factors). Requiring evacuations or fire watches in the event of simple maintenance is costly and disruptive: for example, certain jurisdictions impose onerous fire watch requirements such as contracting for off-duty firefighters or assigning dedicated staff to monitor fire hazards in each area with an outage. Not only does this drain scarce resources and divert staff attention, it is generally unnecessary during working hours at a fully-staffed facility.

While the TTAG certainly agrees with CMS that it is critical to maintain fire safety in the event of a sprinkler outage, we believe that a ten hour, "normal work day" standard, as recommended by the LSC, will both ensure that facilities are properly monitored and that providers need not implement expensive and burdensome fire watch procedures without good cause. We therefore request that CMS extend the fire watch time period accordingly.

3. Requiring Smoke Exhaust Systems in Operating Rooms is Unnecessary.

The NFPA no longer requires that facility operating rooms (ORs) contain smoke exhaust systems. But citing the risk of surgical fires, CMS proposes to mandate the presence of such systems in ORs.[7] We believe that this requirement is unnecessary at best and counterproductive at worst.

The ASHE Report includes a number of concerns with the smoke exhaust proposal shared by the TTAG:

- The NFPA ultimately removed the smoke exhaust requirement after determining that hospitals no longer use flammable anesthetics and have limited the presence of any combustibles in ORs.

- Surgical fires occur during .00092 percent of the surgeries performed each year in the United States, or roughly only 250 per year, and witnesses report that they cause little smoke and are easily contained by trained staff.

[6] *Id.*

[7] *Id.*

- Operating a smoke control system requires shutting down air-handling units or controls, thus altering operating room environments and potentially leading to surgical delays or wound site infections.

- Installing a smoke control system can cost up to $20,000 per operating room.[8]

Again, the TTAG does not seek to minimize the importance of OR fire safety. But the materials traditionally responsible for most OR fires have been largely phased out, surgical fires are very rare and can be extinguished using on-hand materials, smoke control hardware is expensive, and the control systems can alter the carefully-maintained (and medically-necessary) OR atmosphere. We therefore suggest that CMS withdraw this requirement.

4. Window Requirements are Unlikely to Improve Safety and of Unclear Applicability.

The 2012 edition of the LSC eliminated a previously-applicable provision that every health care occupancy patient sleeping room have an outside window or outside door with a sill height not to exceed thirty-six inches above the floor. CMS nevertheless includes this requirement in the Proposed Rule, citing concerns over outside windows and doors being used for "smoke control, building entry, patient and resident evacuation, and other emergency forces operations during an emergency situation."[9]

The TTAG believes this proposal to be unnecessary as it pertains to windows. Sleeping room windows are not currently required to be large enough for people to climb through or even be able to open. In the event of an emergency, even if the window could fit a person out of it, staff or the patient might be required to shatter the glass in order to get through, which is not safe and can counterproductively draw smoke or other combustibles into the room at the same time. Given the many other applicable fire safety provisions in medical facilities, such as sprinkler systems, trained staff, and fire protocols, it is similarly unlikely that a patient would ever be placed in a situation where a window would (or even could) serve as a safe exit strategy in the event of a fire.

It is unlikely that this requirement will affect newer facilities, which are generally constructed with windows that satisfy the proposed guidelines. However, the Proposed Rule does not specify whether these window height standards only apply prospectively. Requiring existing facilities to retrofit their occupancy rooms is a potentially tremendous expense for comparatively little reward in terms of increased safety. We therefore request that CMS either (preferably) remove this requirement from the Proposed Rule or at least clarify that it only applies to new construction and not existing facilities.

[8] *See generally* ASHE Report.

[9] Proposed Rule at 21,556.

II. Conclusion.

The TTAG largely agrees with CMS's approach in the Proposed Rule and believes that its provisions will greatly improve fire safety in facilities nationwide. In order to further aid providers in implementing these requirements and minimize unnecessary expenses or ineffective safety measures, the TTAG additionally suggests that CMS clarify the occupancy standards requirement, extend the fire watch timeframe, and withdraw the smoke exhaust and window height requirements.

The TTAG appreciates the opportunity to comment on the Proposed Rule and looks forward to a continued open dialogue with CMS on the issues discussed above.

Sincerely,

Valerie Davidson
Chair, TTAG