August 20, 2021

James Frederick
Acting Assistant Secretary of Labor
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

Electronically submitted via www.regulations.gov

Re: Occupational Exposure to COVID-19; Emergency Temporary Standard

Dear Acting Assistant Secretary Frederick,

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) writes to express our shared commitment to protect healthcare workers from contracting COVID-19. While we appreciate that the U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) is attempting to protect healthcare workers through the COVID-19 healthcare emergency temporary standard (ETS), we believe the ETS was issued much too late and as a result, will disrupt the ongoing efforts of medical groups to balance the needs of patients against the imperative to protect employees.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups in which more than 350,000 physicians practice. These groups range from small private practices in rural areas to large regional and national health systems and cover the full spectrum of physician specialties and organizational forms. Our diverse membership uniquely situates MGMA to offer its expertise on what's already working and what might be improved. The following aspects of the ETS present challenges to medical groups that will disrupt ongoing efforts to deliver patient care safely and effectively.

Key Recommendations

- MGMA recommends that the ETS not be made permanent due to the burdensome, unclear, and repetitive nature of the requirements.
- If, despite these defects, OSHA insists on making the ETS permanent, MGMA recommends that non-hospital ambulatory settings be excluded from the scope. In the alternative, OSHA must provide a much more workable exception for practice settings that proactively balances patient needs with employee protections.

ETS Challenges

Challenges to comply with the non-hospital ambulatory setting exception

MGMA appreciates that OSHA intended to provide an exemption for non-hospital ambulatory care providers but believes that this exemption is so unworkable as to be virtually unavailable to most practices. In the rule, non-hospital ambulatory care settings where all non-employees are screened prior to entry and people with suspected or confirmed COVID-19 are not permitted to enter the setting are excluded from the ETS. However, the ETS defines "COVID-19 symptoms" for someone with "suspected COVID-19" broadly, to include fever or chills; cough; shortness of breath or difficulty breathing; fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

The list of COVID-19 symptoms included in the ETS is so broad that physician practices would essentially have to choose between availing themselves of the exception or treating patients presenting with those symptoms. MGMA members from pediatric practices provided feedback that most pediatric patients present with at least one of the COVID-19 symptoms listed, rendering these practices unable to avail themselves of the exemption. In fact, the American Academy of Pediatrics lists sore throat, bronchitis, bronchiolitis, common cold, and cough as some of the most common childhood illnesses.[1] An unfortunate, unintended consequence of the ETS could be a decrease in access to care for children.

OSHA states that the ETS will be "economically feasible" because healthcare providers in non-hospital ambulatory care settings can avoid the costs of complying with the ETS by simply "performing screening for COVID-19 and preventing people with suspected or confirmed COVID-19 from entering their facility." As discussed above, this list of COVID-19 symptoms would disallow many, if not most group practices, from seeing patients who may routinely present these symptoms. For example, if this ETS were to be made permanent, most patients during seasonal allergy and flu seasons could be turned away from their providers due to these extremely common shared symptoms. MGMA firmly believes that the same is true with respect to virtually all primary care practices, and many specialty practices treating both acute and chronic conditions. To deny care to the vast array of patients presenting with these common symptoms would be totally inconsistent with the patient care obligations of these practices, would be financially burdensome on them, and would likely divert care from the practice setting to the ER or other hospital-based setting, resulting in increased healthcare spending and a disruption in care continuity.

In addition to the list of COVID-19 symptoms that would prevent many medical groups from qualifying for the exemption, the requirement to screen non-employees is burdensome and, in some cases, difficult. Through the COVID-19 public health emergency (PHE), group practices have taken precautions to screen both patients and employees. This is routinely done through questionnaires administered via the phone prior to the appointment. Physician practices have dedicated their own resources to conduct these screenings because they believe it is a critical step in keeping employees and patients safe. However, there are expenses associated with screening, such as hiring additional staff to administer the questionnaires prior to the visit and hiring staff to conduct screens at the entrance points to the office. Practices are required under the ETS to screen any non-employee, such as contractors who enter the setting to perform work. At large facilities, tracking down every non-employee coming in and out of the

[1] American Academy of Pediatrics, November 2019, 10 Common Childhood Illnesses and Their Treatments

building could present challenges and place undue burden on practices already struggling to meet the demands of patient care.

Paid leave requirements and medical removal protection benefits

The ETS requires that employers provide medical protection benefits (for employers with 11 or more employees) when an employee is removed for being COVID-19 positive, has been told by a licensed healthcare provider that they are suspected to have COVID-19, is experiencing recent loss of taste and/or smell with no other explanations, or is experiencing both a fever and new unexplained cough associated with shortness of breath. Employers are further required to provide medical protection benefits for employees who were in close contact with employees who tested positive for COVID-19 in certain situations.

The ETS states that employers can offset this pay with employer benefits, such as paid leave. However, the tax credits available from the American Rescue Plan sunset after September 30, 2021. Without further congressional action, medical groups are slated to experience significant cuts to Medicare reimbursement, stemming from statutory PAYGO, the return of the 2% Medicare sequester, and cuts to the Medicare conversion factor. As much as healthcare employers try to support their employees, providing paid time off while coping with a healthcare workforce shortage is simply financially unsustainable. While it is true that it is financially difficult to provide medical paid leave, it is also difficult to retain enough staff to meet patient demands. A March 2021 MGMA poll found that 28% of healthcare leaders reported at least one physician unexpectedly retiring from their organization in the last year.[2] New data from the Association of American Medical Colleges (AAMC) estimates that the United States could see a shortage of between 37,800 and 124,000 physicians by 2034.[3] The difficulty of recruiting and retaining nursing staff is an acute problem, widely reported in the press throughout the country and confirmed by our members. MGMA has also heard from members that it is similarly difficult to retain and incentivize non-clinical staff to return to work, leading practices to face massive staffing shortages.

The Families First Coronavirus Response Act (FFCRA) acknowledged the importance of healthcare employers having the ability to maintain staff and therefore provided for a "healthcare provider" exemption from the paid leave rule. The ETS essentially undermines this and requires healthcare employers to foot the bill for employees who take risks outside the workplace. MGMA supports medical groups that choose to implement policies requiring COVID-19 vaccinations for their employees, but a recent MGMA poll found that as of August 2021, only 18% of group practices require workers to be vaccinated.[4] If an employee contracts COVID-19 outside of the workplace, the medical group is still required under the ETS to provide medical removal protection benefits for employees. This requirement would be more reasonable if other industries were held to similar standards set forth under the ETS.

Ventilation requirements

MGMA agrees that improving existing ventilation and ensuring optimal performance of ventilation can be an effective way to reduce viral transmission. However, the requirements outlined in the ETS are unclear and potentially place unnecessary burden on group practices. The ETS places ventilation requirements on employers who "own or control buildings or structures with an existing heating,

[2] MGMA Stat, March 4, 2021, Measuring the toll COVID-19 took on the physician workforce
[3] AAMC, June 2021, The Complexities of Physician Supply and Demand: Projections from 2019 to 2034
[4] MGMA Stat, August 4, 2021, Vaccine requirements for healthcare workers gain traction to defeat COVID-19's delta surge

ventilation, and air conditioning (HVAC) system." It is unclear from the ETS what constitutes as having "control" over a building or structure. If a group practice owns part of a building (e.g.— an office suite) with a shared HVAC system, are they deemed to have control under the ETS? This is a critical distinction because a practice might own part of a building but not have control over the HVAC system, placing them in the unfortunate position of being responsible for something they do not actually have control over. The same issue could arise under certain lease arrangements where the tenant practice has partial responsibility for maintenance and repairs.

The actual ventilation requirements are incredibly confusing and outside the scope of most healthcare employers' purview and expertise. To comply with these requirements would likely require hiring and retaining an HVAC company to explain as well as fulfil the requirements.

Conclusion

MGMA believes the protocols medical groups have had in place for over a year already fulfil the spirit of what the ETS is trying to achieve. Furthermore, infection control is something physician practices have always addressed and prepared for. **We urge you not to make the ETS permanent and if the ETS were to become permanent, to exclude non-hospital ambulatory settings from the scope.** Many of the requirements under the ETS are confusing, burdensome, and duplicative of other state mandates and recommendations. To require compliance within weeks of publishing a 916-page rule is unreasonable. Medical practices are battling challenges associated with COVID-19 and at the same time are facing significant cuts to Medicare reimbursement in CY 2022. The costs and burdens associated with compliance will further exacerbate an already precarious financial situation.

As the voice for the country's medical group practices, MGMA remains committed to promoting policies that enhance the ability of our members to provide high-quality, cost-effective care to the millions of patients they serve routinely, and to the emergency cases they are called upon to serve during this pandemic. Thank you for the opportunity to provide feedback on the ETS. Should you have any questions, please contact Claire Ernst at cernst@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs