April 21, 2022

Mr. Douglas L. Parker
Assistant Secretary of Labor for
Occupational Safety and Health
U.S. Department of Labor
Occupational Safety and Health Administration
200 Constitution Avenue, NW
Washington, DC 20210

Electronically submitted via www.regulations.gov

Re: Occupational Exposure to COVID-19 in Healthcare Settings; OSHA-2020-0004

Dear Assistant Secretary Parker,

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 a final standard, we believe that developing a final standard similar to the original healthcare emergency temporary standard (ETS), could cause unintended consequences to medical practices and the millions of patients they treat.

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.

Key Recommendations

- MGMA originally recommended that the ETS not be made permanent due to the burdensome, unclear, and repetitive nature of the requirements**.** MGMA still believes that the requirements in the original ETS would disrupt the ongoing efforts of medical groups to balance the needs of patients against the imperative to protect employees. **Therefore, MGMA urges the agency not to promulgate a final standard.** Instead, the agency should allow medical practices to continue implementing best practices to protect workers, such as those aligned with current CDC guidelines.
- MGMA does not believe that the final scope of the final standard should cover all employers regardless of screening procedures for non-employees and/or vaccination status of employees. **MGMA maintains that non-hospital ambulatory settings be excluded from the scope of the rule.**

- MGMA urges OSHA to provide flexibility in aligning CDC guidelines with a final standard as to avoid a situation where the rule reflects outdated CDC guidelines in the future.

Request for Comment

MGMA general comment

MGMA shares OSHA's commitment to protect workers from occupational exposure to COVID-19 in healthcare settings. However, as stated previously in our ETS comments to the agency, we are concerned that a final standard could disrupt the ongoing efforts of medical groups to balance the needs of patients against the imperative to protect employees. MGMA urges the agency not to promulgate a final standard. Instead, the agency should allow medical practices to continue implementing best practices to protect workers, such as those aligned with current CDC guidelines.

To place rigid, inflexible requirements on practices two years into an ever-evolving global pandemic could lead to unintended consequences for patients. As of Feb. 1, nearly 3 in 4 medical practices (74%) were reporting staff turnover rates that were as bad, or worse than the previous quarter.[1] On top of that, at a time when inflation is at its highest in four decades, and medical groups are slated to experience Medicare reimbursement cuts in the double digits moving into 2023, the costs and burdens associated with compliance will further exacerbate an already precarious situation. If OSHA insists on promulgating a final standard, MGMA offers the following feedback regarding OSHA's specific requests for comment.

Potential changes from the ETS

A.1—Alignment with CDC: OSHA seeks comment on whether it is appropriate to align its final rule with some or all of the CDC recommendations that have changed between the close of the original comment period for this rule and the close of this comment period.

MGMA comment: MGMA agrees with OSHA that "evolving CDC recommendations have resulted in inconsistencies between those recommendations and some of the Healthcare ETS provisions." Since it seems plausible that guidelines will continue to evolve past the close of this comment period, **we urge OSHA to provide flexibility in aligning CDC guidelines with a final standard as to avoid a situation where the rule reflects outdated CDC guidelines in the future.**

A.3—Removal of Scope Exemptions (e.g., ambulatory care facilities where COVID–19 patients are screened out; home healthcare): OSHA solicits comment on whether the scope of the final standard should cover employers regardless of screening procedures for non-employees and/or vaccination status of employees to ensure that all workers are protected to the extent there is a significant risk.

MGMA comment: MGMA does not believe that the final scope of the final standard should cover all employers regardless of screening procedures for non-employees and/or vaccination status of employees. **MGMA maintains that non-hospital ambulatory settings be excluded from the scope of the rule or, at the very least, OSHA must provide a much more workable exception for practice settings that proactively balances patient needs with employee protections.**

[1] MGMA *Stat*, Feb. 3, 2022

In terms of the previous policy set forth in the original ETS, MGMA reiterates that that while we appreciated that OSHA intended to provide an exemption for non-hospital ambulatory care providers, we believed the exemption was 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 were not permitted to enter the setting were excluded from the ETS. However, the ETS defined "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; and 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.[2] An unfortunate, unintended consequence of the ETS could be a decrease in access to care for children.

OSHA stated 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, most patients during seasonal allergy and flu seasons could be turned away from their providers due to these extremely common shared symptoms. MGMA 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 were 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 building could present challenges and place undue burden on practices already struggling to meet the demands of patient care, especially during a staffing shortage crisis.

Conclusion

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

MGMA believes the protocols medical groups have had in place for over two years already fulfil the spirit of what the ETS and now final rule is trying to achieve. Furthermore, infection control is something physician practices have always addressed and prepared for. **We urge the agency not to promulgate a final standard, but if OSHA moves forward with one, 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. Medical practices are battling challenges associated with COVID-19 and at the same time are facing significant cuts to Medicare reimbursement in CY 2023. The costs and burdens associated with compliance will further exacerbate an already precarious financial situation, all while practices are trying to prioritize caring for patients.

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 final standard. 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