TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Aug. 20, 2021

The Honorable Marty Walsh, Secretary
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210
Submitted via www.regulations.gov

Re: Concerns with compliance costs associated with the OSHA Occupational Exposure to COVID-19; Emergency Temporary Standard (Docket No. OSHA-2020-0004)

Dear Secretary Walsh,

On behalf of the Texas Medical Association (TMA) and the undersigned state specialty societies, which together represent more than 55,000 physicians and medical students, we write in response to the Occupational Exposure to COVID-19; Emergency Temporary Standard (ETS) interim final rule with request for comments as published in the June 21, 2021, *Federal Register* on behalf of the Occupational Safety and Health Administration (OSHA).

This regulation, which mostly took effect July 21, 2021, requires covered health care employers to develop and implement a COVID-19 plan during the public health emergency to better protect physicians, health care professionals, and office and other support staff from occupational exposure to COVID-19. According to OSHA's Table VI.B.3 on page 113, this regulation will affect 161,977 physician offices and 10,568 mental health physician-specialty offices. (Our organizations very much appreciate that OSHA published a flow chart showing which workplaces are covered by the COVID-19 health care ETS.)

Many of the provisions of the rule mirror existing best practices implemented by physicians at the outset of the pandemic. Beginning in March 2020, our organizations collaborated to swiftly develop educational resources and tools to help physicians enhance their existing infectious disease mitigation policies to better protect themselves, their staff, and their patients, including screening patients for COVID-19 before arrival, enhancing sanitation procedures, wearing masks, practicing social distancing, and eventually getting immunized.

Infection control is not new to physician practices. After all, practices must regularly contend with contagious diseases, including seasonal flu and other respiratory ailments. Well before COVID-19, many primary care practices had already established "well" and "sick" hours or designated waiting rooms to avoid mingling sick patients with healthy ones. As the pandemic continues, our organizations continue to urge physicians to follow Centers for Disease Control and Prevention (CDC) guidance for safe practice.

Organized medicine supports pragmatic efforts by OSHA to strengthen infection control within the health care delivery system to better protect physicians, patients, and health care workers from possible exposure to the virus. **That being said, while well intended, the ETS will impose new costs on physician practices at a time they can ill afford it. Additionally, the ETS comes late in the public health emergency after physicians have already implemented robust infection control measures. While many of the OSHA measures mirror steps already taken, the ETS provided insufficient time for physicians to comply and also has new staffing, recordkeeping, reporting and compliance standards that will result in new costs to outpatient physician practices.**

The COVID-19 public health emergency has financially strained physician practices. A TMA practice viability survey conducted in May 2020 asked physicians how the pandemic had affected their practice revenue. Sixty-three percent of the respondents reported their revenue had decreased by 51% to 100%.

While many practices have rebounded, the financial margins of physician practices remain lean while they absorb other pandemic-induced costs. **Thus we are concerned with the cost of compliance the ETS imposes on medical practices, especially small, rural, and primary care practices with limited staff and less financial flexibility.**

Covered health care employers must implement requirements to reduce transmission of COVID-19 in workplaces, such as:

- Patient screening and management;
- Standard and transmission-based precautions;
- Personal protective equipment, including facemasks or respirators;
- Controls for aerosol-generating procedures;
- Physical distancing of at least 6 feet, when feasible;
- Physical barriers;
- Cleaning and disinfection;
- Ventilation;
- Health screening and medical management;
- Training;
- Antiretaliation;
- Recordkeeping; and
- Reporting.

Additionally, the ETS requires practices with 10 or more employees to provide paid time off (PTO) for the time needed for employees to get to get vaccinated as well as for any post-vaccine recovery period from the vaccine's possible side effects. We do not object to this provision per se nor do we object to quarantining employees with known or suspected COVID-19 in accordance with CDC guidance. However, the broad definition of COVID-19 symptoms as well as the mandatory PTO could mean employees receiving this benefit unnecessarily at a huge cost. According to the ETS, the costs could be as high as $1,400 per week, though the ETS does cap costs after two weeks and limits costs for small employers. However, even if employees must quarantine only for a few days while awaiting COVID-19 test results, the ETS could be financially onerous to small practices and contribute to even more severe clinical staffing shortages as well as patients being referred to already overcrowded emergency departments.

As noted by CDC, "As the COVID-19 pandemic progresses, staffing shortages will likely occur due to [health care professional (HCP)] exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, *including considerations for permitting HCP to return to work without meeting all return to work criteria" (emphasis added).*[1]

We acknowledge that the ETS contains some exemptions. For example, the rules state that workplaces do not need to comply if all employees have been vaccinated and safety measures prohibit people who are potentially COVID-19-positive from entering the facility. However, this bar is too high for physicians to meet. Despite growing support for vaccine mandates within health care settings, physician practices may be reluctant to impose one for fear of alienating patients or staff, meaning some employees will choose not to get vaccinated against COVID-19. State law also restricts ability to impose vaccine mandates.

Moreover, COVID-19-positive patients will inevitably seek medical care from their physicians even with screening protocols in place. After all, as many as 30% of people who test positive for COVID-19 are asymptomatic.[2] Thus, physicians cannot possibly screen and prevent all COVID-19 positive patients from entering their facilities, especially since COVID-19 symptoms – fatigue, fever, chills, cough – closely resemble many other respiratory infections. Our aim is to encourage patients to seek care from their own physician rather than turn to an emergency department for care, supporting not only the medical home, the bedrock of primary care practices, but also helping to relieve already overcrowded hospitals.

While we understand the public health need for medical removal protection, these requirements will be onerous for many practices, particularly small and rural ones, even with capping paid time off costs.

Additionally, OSHA proposes that employers who own or control buildings or structures with existing heating, ventilation, and air conditioning (HVAC) systems must ensure that:

- The HVAC systems are used in accordance with the HVAC manufacturer's instructions and the design specifications of the HVAC systems.
- The amount of outside air circulated through its HVAC systems and the number of air changes per hour are maximized to the extent appropriate.
- All air filters are rated Minimum Efficiency Reporting Value (MERV) 13 or higher, if compatible with the HVAC systems. If MERV-13 or higher filters are not compatible with the HVAC systems, employers must use filters with the highest compatible filtering efficiency for the HVAC systems.
- All air filters are maintained and replaced as necessary to ensure the proper function and performance of the HVAC systems.
- All intake ports that provide outside air to the HVAC systems are cleaned, maintained, and cleared of any debris that may affect the function and performance of the HVAC system.

Many physicians lease their office space, potentially making this provision inapplicable to their setting. But for those who do own or control the building, these requirements will impose additional, unfunded costs. As noted in Table VI.B.24 (pgs. 132-133), OSHA estimates it will cost "Other Patient Care" settings, which include small practices, only $30 for filter costs and replacement times. However, the rule does not assign any additional costs related to maintenance, which will result in additional expenses. HVAC maintenance contractors will certainly impose them on medical practices.

Texas physicians continue to incur significant costs implementing increased infection control measures required to provide safe care during the COVID-19 pandemic. The public health emergency continues to threaten practices' financial viability due to months of lost revenue from practice closures and operating at reduced capacity. Moreover, rising numbers of uninsured patients have increased rates of uncompensated care, further threatening the financial stability of many practices and potentially jeopardizing access to care.

Regarding proposed wage rates, OSHA estimates that physicians and advanced practice registered (APRNs) nurses are paid the same (based on data from the Bureau of Labor and Statistics) – $154.71. However, we believe the rule should differentiate between the two professions because the practice costs associated with physician salaries and APRN salaries are not the same. Practices composed exclusively of physicians will have higher costs than those that employ a mix of physicians and APRNs. Moreover, by establishing a single wage rate for the two professions, it implies APRNs and physicians are interchangeable. While APRNs are an integral part of physician-led health care teams, nurse practitioners cannot substitute for physicians especially when it comes to diagnosing complex medical conditions, developing comprehensive treatment plans, ensuring that procedures are properly performed, and managing highly involved and complicated patient cases. TMA therefore respectfully requests that OSHA update the ETS to reflect separate wage rates for physicians and APRNs.

Other estimated costs within the rules also appear to underestimate the compliance costs for physicians and certainly do not account for the unfunded mandate. For nonhospital patient care settings, OSHA estimates compliance costs to be $1,686 on average, roughly six hours for such settings to develop a compliance plan, and 21.5 hours to monitor the plan's effectiveness.

We acknowledge that other components of the cost-impact statement seem better informed, including the estimated costs for nonhospital settings to comply. **While we appreciate that the ETS accurately reflects that compliance costs for small practices will be significantly higher than for facilities, the unfunded nature of the rules raises significant concerns despite being issued during a public health emergency.**

Moreover, it appears OSHA enacted rules without any prior discussion with the medical community about whether the rules' requirements are necessary or feasible, writing them with a one-size-fits all approach and seemingly geared towards large hospitals and health care systems. As written, and with a mere month to comply with the requirements, the rule has generated **considerable confusion and disruption in light of already existing infection control initiatives, thus diverting physician resources from direct patient care.**

We understand that OSHA is statutorily obligated to address workplace safety – a goal we share. However, we have serious concerns about the rules as published. This is not to say we object to common-sense strategies to mitigate communicable disease transmission within physician practices. We plainly support such efforts. **Yet, we believe these rules, as written, could harm the financial viability of many physician practices, potentially backfiring on efforts by the administration to improve access to care.**

As such, our organizations implore OSHA to take the following actions:

- Establish a practicing physician advisory committee in conjunction with the Centers for Disease Control and Prevention to devise infection control rules better suited for outpatient physician practices and that minimize duplication among federal agencies.
- Revise the rules to reflect the workgroup's recommendations.

We appreciate the opportunity to comment. If you have any questions, please do not hesitate to contact Helen Kent Davis, TMA associate vice president for governmental affairs, at helen.davis@texmed.org.

Sincerely,

E. Linda Villarreal, MD, President
Texas Medical Association

***Joined by the**:*
American College of Obstetricians and Gynecologists-District XI (Texas)
Texas Academy of Family Physicians
Texas Ambulatory Surgery Center Society
Texas Association of Obstetricians and Gynecologists
Texas Chapter, American College of Physician Services
Texas Dermatological Society
Texas Pain Society
Texas Pediatric Society
Texas Neurological Society
Texas Association of Otolaryngology

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[1] www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
[2] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707/