April 8, 2020

Eugene Scalia  
Secretary  
U.S. Department of Labor  
200 Constitution Ave NW  
Washington, DC 20210

Ref: Families First Coronavirus Response Act and Fair Labor Standards Act

Dear Secretary Scalia:

America’s Essential Hospitals appreciates the actions of the Trump administration to mitigate the novel coronavirus (COVID-19) outbreak and to provide critical support to front-line responders as they confront this crisis. These actions will help hospitals meet the immediate needs of their communities as they prepare for and respond to COVID-19 cases. We write to express our concerns about the impact paid leave provisions of the Families First Coronavirus Response Act (FFCRA) and exemption provisions of the Fair Labor Standards Act (FLSA) will have on providers that are indispensable to the response effort.

We are encouraged by the Department of Labor (DOL) guidance and subsequent temporary rule defining the term health care provider for the purposes of the FFCRA. This will help mitigate the disparate impact of the paid leave provisions on essential hospitals responding to COVID-19. However, the regulation fell short in that it still provides for an inequitable application of the FFCRA to public agencies compared with private employers that is inconsistent with the language of the Family and Medical Leave Act of 1993 (FMLA). Existing regulations implementing the FLSA also are unclear about the exempt status of employees who must adapt their duties in the face of a declared public health or national emergency. By allowing employers responding to the COVID-19 crisis to exempt their employees broadly from the FFCRA; by clarifying that public agencies with 500 or more employees are excepted from the FFCRA’s paid leave requirements; and by clarifying the regulatory definition of emergency under the FLSA, DOL can ensure first-line responders can maximize limited staff resources in times of great need.

America’s Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the vulnerable. Our more than 300 members—all nonprofit or public hospitals—fill a vital role in their communities. They provide a disproportionate share of the nation’s uncompensated care, and three-quarters of their patients are uninsured or covered by Medicare or Medicaid. Our members provide state-of-the-art, patient-centered care
while operating on margins one-fifth that of other hospitals—1.6 percent on average compared with 7.8 percent for all hospitals nationwide.¹

Our members serve as cornerstones of care, providing specialized inpatient, outpatient, and emergency services—such as trauma, burn, and inpatient psychiatric care—that often are unavailable elsewhere in their communities. Our members operate 31 percent of all level I trauma centers, 39 percent of all burn-care beds, and 6,200 psychiatric care beds.² These are the types of specialized services that equip hospitals to respond to the COVID-19 crisis. In addition, members of America’s Essential Hospitals play a vital role in providing ambulatory care to their communities—operating a median of nine ambulatory care locations per hospital.³ Through these vast networks, they can reach patients in their communities and reduce unnecessary inpatient admissions and emergency department visits.

Essential hospitals are taking extraordinary steps to respond to COVID-19. Many of these necessary steps come with disruptions to daily operations and a significant price tag. They include constructing temporary spaces for diagnosing and treating COVID-19 patients, ensuring adequate stock of necessary equipment for patient care and personal protective equipment for front-line staff, and canceling planned surgical cases to increase capacity for COVID-19 cases. They also are accommodating staff needs, including providing resources to work remotely when appropriate and accommodating staff child care needs resulting from school closures by establishing onsite child care facilities and subsidizing child care services.

This is an unprecedented and challenging time for our nation, as we are faced with a public health emergency of unknown scope and duration. Essential hospitals, at the center of the nation’s safety net, face this challenge with short supplies of available resources. Costs associated with COVID-19 continue to rise while revenues decrease. To succeed in mitigating the spread of the outbreak, essential hospitals need to divert their limited resources and staff from customary daily operations to diagnosing and treating those affected by the virus. By making the following changes, DOL can ensure essential hospitals have needed resources to respond to this pandemic.

1. DOL should clarify that the emergency exception under the FLSA includes declared public health and national emergencies.

The department should clarify existing FLSA regulations on emergencies to include declared public health and national emergencies, such as the current COVID-19 pandemic. This will allow exempt staff to retain their FLSA exemption even if they perform non-exempt duties to assist in a COVID-19 response.

Under the FLSA, a covered business must offer overtime pay and minimum wage protections to employees unless they fall under one of the exemptions, such as the executive, administrative, professional, outside sales, and computer employee exemptions. To qualify for one of these exemptions, the employee must be paid on a salaried basis, be paid a minimum salary, and perform certain duties that fall into one of the exempt categories. Certain registered nurses, for example, are considered exempt under the learned professional exemption. Hospitals employ

² Ibid.
³ Ibid.
registered nurses in a wide variety of roles, some that are considered exempt and others that are considered non-exempt. In certain administrative and nonclinical roles, registered nurses are exempt from FLSA requirements if their primary duties are considered exempt. Other nurses, including some performing clinical duties, are considered non-exempt from the FLSA if their primary duties are classified as non-exempt. However, in some instances, an employee can perform a combination of exempt and non-exempt duties, which requires a determination by an employer as to whether the employee’s primary duty is of an exempt or non-exempt nature.

As health care facilities, including essential hospitals, respond to COVID-19, they are facing workforce shortages and turning to licensed health care professionals who might normally be in administrative, exempt roles to provide bedside care to COVID-19 patients. The shift from their typical duties to potentially non-exempt duties will require employers to meticulously track their employees’ hours, and if an employee spends more than 50 percent of their time performing non-exempt duties, the employer might have to treat the employee as non-exempt and pay overtime. Tracking these hours and adjusting payroll systems to pay these employees on an hourly basis is extremely burdensome on already resource- and time-constrained hospitals.

The FLSA regulations contain a potential solution to this problem, contained in a provision for emergencies that allows employees to perform non-exempt duties without forgoing their FLSA exemption. Because the provision does not specifically include declared national emergencies or public health emergencies, we urge DOL to clarify that emergencies such as the current national and public health emergency are qualifying emergencies that will not cause exempt employees to lose their exemption by virtue of performing non-exempt duties for the duration of the declared emergency. The COVID-19 pandemic is an unprecedented emergency to which health care providers are responding in innovative ways to manage the surge of patients while balancing constrained resources. By making this clarification, the DOL can allow hospitals to adapt their workforce to focus on providing critical patient care.

2. DOL should interpret the 500-employee threshold of the FFCRA to apply to all employers bound by the new leave requirements, including public agencies, and work with Congress to extend payroll tax credits to public agencies.

The FFCRA requires certain employers to provide two weeks of paid sick leave and 10 additional weeks of paid family and medical leave to employees who meet certain conditions. Employers must provide these 10 weeks of leave to employees affected by COVID-19 school closures or interruptions in child care. The FFCRA also provides a special rule for an employer to exempt employees who are health care providers or emergency responders and vests the Secretary of Labor with authority to issue regulations to exclude such employees from the definition under the FFCRA. We are pleased that DOL issued regulations defining these terms broadly, thus allowing hospitals to best determine their staffing needs and response strategies to the COVID-19 emergency.

Although, the broad definition of health care provider is a positive change, the DOL’s interpretation of “employer” will have a disparate impact on public agencies, including public hospitals that are on the front lines of the COVID-19 response across the nation. In setting out the types of employers to whom the leave requirements apply, the FFCRA creates an employer threshold of fewer than 500 employees. The department should apply the threshold equitably.

4 29 C.F.R. 541.706.
across all employers who are bound by the requirements of the new leave provisions and work with Congress to allow governmental entities to benefit from payroll tax credits.

Specifically, section 101(4)(A)(i) of the FMLA states an employer “means any person engaged in commerce or in any industry or activity affecting commerce [who employs 50 or more employees. ...]” The FFCRA replaces the “50 or more” language with “fewer than 500 employees.” The FMLA language goes on to clarify that this definition of employer “includes any ‘public agency,’ as defined in section 3(x) of the Fair Labor Standards Act of 1938.” It further states that a public agency is “considered to be a person engaged in commerce or an industry or activity affecting commerce.” Because the plain language of the FMLA clearly indicates that the requirements of section 101(4)(A)(i)—that the employer be engaged in or affect commerce—applies to public agencies, it is clear that Congress intended the employee threshold, which also is contained in section 101(4)(A)(i), to apply to public agencies. Therefore, the employee threshold of fewer than 500 employees established by the FFCRA applies to public agencies, as well as private employers. This reading is compelled by the statutory language and would provide an equitable application of the leave provisions across all types of providers, private or public.

Many essential hospitals are owned and operated by state or local governments or by quasi-independent governmental entities, such as hospital authorities or independent taxing districts. There is no conceivable policy rationale for applying the FFCRA exemption for employers of 500 or more employees to private, nonprofit hospitals, for example, but not to public hospitals. Moreover, the FFCRA provides for payroll tax credits to employers to offset the costs of the paid leave but specifically carves out governmental employers from receiving this tax credit. Expecting governmental employers, including public hospitals, to provide paid leave but not receive reimbursement for this paid leave, while other entities can benefit either from an exemption due to their size or from a tax credit, is an inconsistent and inequitable policy. If DOL provides a plain-language reading to the statute, which clearly indicates that the employee limitation applies to public agencies as well, it can avoid this outcome. Simultaneously, the department should work with Congress to ensure that all employers, whether governmental or private, can benefit from the tax credits to help cover the costs of providing paid leave.

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We appreciate the opportunity to share feedback during this extraordinary time, as DOL implements FFCRA provisions. We look forward to continued engagement and partnership to successfully mitigate the COVID-19 outbreak. If you have questions, please contact Senior Director of Policy Erin O’Malley at 202-585-0127 or eomalley@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO

Cc: Cheryl Stanton, Administrator, Wage and Hour Division, U.S. Department of Labor

7 Family and Medical Leave Act of 1993, Section 101(4)(B).