Contact Tracing Program

Briefing Date: Jun 2 2020
Funding Source: Coronavirus Aid, Relief, and Economic Security (CARES) Act (532.0000.1020.0000.5003.94573.00000.0000)
Originating Department: Comm Court Administration
Prepared by: Charles Reed, Assistant County Administrator for Governmental Affairs
Recommended by: Charles Reed, Assistant County Administrator for Governmental Affairs

BACKGROUND INFORMATION:
As the State of Texas and Dallas County continue to reopen, local health departments have been charged with a new task of contact tracing to sustain both containment and mitigation activities for COVID-19. New state requirements in Texas for daily active monitoring of all cases and contacts for 14 days. The purpose of this briefing is to outline the staff recommendation for a Contact Tracing Program that is informed by Center for Disease Control guidelines and maintains new state requirements for health departments.

OPERATIONAL IMPACT:
The Contact Tracing Program will be housed in Health and Human Services reporting to the Deputy Health Authority and Medical Director in charge of epidemiology. The attached proposal recommends the hiring of 224 temporary contact tracing personnel and 36 temporary special investigations personnel.

FINANCIAL IMPACT:
The total estimated cost of this proposal is $10,078,560 and will be initially paid for by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (532.0000.1020.0000.5003.94573.00000.0000). However, it is expected that additional grant funding will be available for this program through the Texas Department of State Health Services. Commissioners Court will be notified as additional funding is identified and secured.

This proposal fits the definition of an eligible expense as defined by example 2 of the “Coronavirus Relief Fund Guidance for State, Territorial, Local, and Tribal Governments” issued April 22, 2020 regarding public health expenses.

ADMINISTRATIVE PLAN COMPLIANCE:
This proposal complies with the Dallas County Administrative Plan’s vision to make Dallas County a healthy community by reducing the economic and public health impact of the COVID-19 public health crisis’ impact on Dallas County residents.
RECOMMENDATION:
Approve the attached Contact Tracing Program and direct staff to identify and secure additional available grant funding through the Texas Department of State Health Services.

MOTION:
On a motion made by TBD, and seconded by TBD, the following order will be voted on by the Commissioners Court of Dallas County, State of Texas:

Be it resolved and ordered that the Dallas County Commissioners Court does hereby approve the attached Contact Tracing Program and direct staff to identify and secure additional available grant funding through the Texas Department of State Health Services.

ATTACHMENTS:
DCHHS Contract Tracing Plan updated 5.29 Final with PH edits 138 pm 04222020 Guidance Document
Dallas County HHS Contact Tracing Plan Summary

Approach

With the re-opening of our communities across Texas, health departments across Texas are transitioning to strategies for longer-term approaches to sustain both containment and mitigation activities for COVID-19. The intensity of workload for public health is expected to increase over the coming months due to multiple factors, including:

- The increased availability of testing (including serology testing) for COVID-19, expansion of testing criteria to include asymptomatic or mildly symptomatic priority populations, and community outreach testing efforts may contribute to continued high numbers of laboratory-diagnosed cases.
- The recent introduction of a national, symptom-based “probable” case definition is anticipated to increase the numbers of cases by at least 2-3 fold in certain populations.
- With greater social mobility, many greater numbers of contacts can be expected for each identified case.
- New state requirements in Texas for daily active monitoring of all cases and contacts for 14 days will require significant numbers of contact tracers, in order to reach or respond to these persons daily by phone or text. Although some degree of innovative digital automation can assist this workload, such technological innovations will supplement but are not likely to replace traditional resource-intensive phone interviews and monitoring.
- Greater numbers of congregate-setting cases and outbreaks will occur while there is sustained community transmission of infections and as daycares, schools, colleges and other congregate settings reopen.

Dallas County Health and Human Services’ (DCHHS) epidemiological approach to the COVID-19 response will focus on case investigations accompanied by expanded contact notification, including prioritization of congregate outbreak settings, which are more vulnerable to high attack rates and mortality from COVID-19. Funding support for increased staffing is critical for expansion of contact tracing capabilities to adapt to the evolving understanding of measures needed to optimally curtail COVID-19 transmission in our community. Additional staff for support of contact tracing is needed to allow more potentially exposed individuals to self-quarantine or isolate and slow the spread of the virus.

CONTACT TRACING ACTIVITIES

- Individual Patient Investigations
  - Training & Supervision of Interviewers & Contact Tracers
  - Medical Records Procurement & Storage
  - Data Management & Entry

- Special Investigations (Congregate Setting Outbreaks)
  - High-Risk Workplaces
  - Correctional Facilities
  - Homeless Shelters/Halfway Houses
  - Long-Term Care Facilities
  - Schools/Colleges

Referrals to Testing, Social Work, and Quarantine & Isolation Resources
In the general population, individuals with the “highest level” of exposure (i.e., closest and longest durations of contact with confirmed cases) are prioritized for notification to mitigate disease spread, which is the primary goal of all comprehensive contact tracing systems. Close contacts in congregate settings will also be prioritized for recommendations for quarantine measures.

Given the high risk of spread among more vulnerable populations in settings such as nursing homes, additional advanced-level epidemiology staff are necessary to allow for more targeted and intensive efforts to reduce and prevent transmission in these settings, including but not limited to:

- Risk mitigation assessments for facilities where a cluster is identified
  - ICAR (Infection Control Assessment and Response) assessments for long-term care facilities
  - Essential Facilities Infection Control Assessments
- Testing entire populations (staff and residents) at facilities
- Actions in partnership with facility regulatory agencies

**Tactical Components**

1. **Expanded Epidemiological Workforce**

   DCHHS is requesting funding support to greatly expand its epidemiological workforce, which has only been moderately scaled up from pre-COVID levels, since the majority of the contact tracing workforce has consisted of non-paid volunteers. The goal is to increase the contact tracing capacity to notify as many identified contacts of new cases as feasible, and to additionally perform active monitoring of both cases and contacts. Based on national and international models, DCHHS will develop an initial workforce of 260 contact tracing staff, with the ability to expand as needed.

   Potential sources of additional workforce include:
   - Full Time Employees
   - Temporary hires with verified clinical licensure or public health experience
   - Volunteers with verified clinical licensure or public health experience

2. **Workflow**

   Additional epidemiological workforce members will be on-boarded and trained to a level that reflects their experience and the needs of their position. The epidemiological workflow will be modified as needed to allow for efficient contact tracing and to account for the greater needs for more advanced epidemiological workforce expertise for investigation and control of congregate setting outbreaks. Details of the updated epidemiological workflow are depicted in the subsequent figures.

3. **Innovation and Technology**

   DCHHS’s epidemiology team is currently using a traditional, manual-entry data platform to record and track cases. This platform does not have the capacity to provide daily information on individuals’ location, health status, and alerts when health status has changed or monitoring time period has ended.

   Therefore, DCHHS is assessing and piloting additional technologies to identify innovative methods to increase the speed, quantity, and quality of contact tracing efforts. These efforts could include technological tools such as contact tracing web-based apps, as well as other guidance to the community that could assist in contact tracing and epidemiology. Similar tools are currently being implemented by other jurisdictions, but they are unproven so far and privacy considerations must be weighed. DCHHS will continually monitor best practices in this regard and implement technologies where appropriate.
Justification of Sufficient Contact Tracing

In order for sufficient capacity to conduct case investigation and contact tracing on an average caseload of 192 cases per day, an additional 260 contact tracing staff are necessary. These estimates are based on the following assumptions:

General assumptions for estimates of staffing needs:
- Average caseload of ~192 cases per day in the County
- Each Epidemiology Investigator (for “Individual Patient Investigations” teams) completes an average of 8 case interviews per day.
- Each case identifies on average 12 close contacts
- Each contact tracer completes notification and monitoring of 12 contacts per day on average (40 minutes per contact)
- Each Epidemiology Investigator (for “Special Investigations–congregate settings/outbreaks” teams) completes up to 2 new investigations per day and maintains daily follow-up with up to 5 active facilities/outbreaks per day.
- A work day consists of 8 hours

The numbers assumed above are based on the results from epidemiologic investigations and average estimates thus far in COVID-19 response. As the situation evolves, the numbers are subject to change.

Growing numbers of cases in “congregate settings” are anticipated to be a feature of the COVID-19 pandemic, as standards of practice are evolving to broad screening of such settings, including nursing homes. Congregate settings include places like nursing homes, halfway homes, homeless shelters, jails, monasteries—and will include schools/colleges when they re-open. Some workplace settings, like food processing plants, are also essentially “congregate settings” because of the large numbers of persons in close proximity for >8 hours/day. Cases identified in these situations require intensive investigations by advanced-level public health professionals.

Because of the complexity of work involved, these types of investigations cannot be handled by level 3 “contact tracers,” and are instead assigned to “special investigation teams” comprised of advanced level 1 and level 2 investigators. These teams are additionally tasked with investigations of possible outbreaks and follow-up of any difficult cases, and are comprised of epidemiologists with healthcare backgrounds or advanced nurses with infection control experience who are able to conduct this type of complicated work.

These investigations require subject-matter expertise with knowledge of current CDC and infection control recommendations, greater levels of responsibilities and communications experience for discussions with high levels of management (e.g. directors, managers, owners, superintendents) and external agencies (e.g. state and federal public health agencies) in writing and by conference calls, and more involved job duties (e.g. frequent, if not daily, follow-up with facilities) and the professional experience to be able to rapidly assess and respond to complex situations.

DCHHS will closely monitor the performance of its contact tracing team to ensure that staffing is sufficient to meet the objectives of quickly reaching all new cases, and named contacts (with limitations that include declination by the contact and inability to reach the contact). Piloting of new technology will be important to updating processes to increase the speed of reaching contacts.

Hiring/Onboarding/Recruiting Process

To develop a team consisting of nearly 200 contact tracers, DCHHS will develop a management and support structure that will total about 260 staff. DCHHS’s contact tracing teams will utilize an organizational structure similar to a call center that consists of Team Leads and Case Interviewers with a staff ratio of 1:3 for Team Leads to Case Interviewers and 1:8 for Case Interviewers to Contact Tracers/Data Entry. This model will allow for appropriate ratios of advanced staff for numbers and complexity of case loads, such that there can be sufficient QA review of cases and contacts and prompt management of
any identified challenges. This model has been designed to allow for the possibility of adding more Case Interviewers and Contact Tracers if the need arises without changing upper management.

Success will depend not only upon new funding streams, but also integrate use of existing resources immediately available to DCHHS, including: internal DCHHS employees, volunteers, partnerships with local area hospitals and college/university affiliation agreements.

Based on the success of the volunteer-based model used for the past 2 months, investigators and contact tracers will be required to have previous experience in medical healthcare settings or in public health, so that they have immediate capacity to conduct case interviews, background knowledge to respond to clinical questions from patients, and appropriately discern referral needs. DCHHS will accordingly streamline the resume screening, interview, hiring, and onboarding process for new employees, existing DCHHS employees, contractors, and volunteers by utilizing technology and electronic forms. Onboarding and contact tracing training will be conducted on the same day.

Hiring and onboarding will be done in phases to allow for cost control, to ensure that the contact trace load is proportionate to staff, and to give newly on-boarded staff the opportunity to gain sufficient experience before adding additional staff. Quality assurance, maintaining confidentiality and privacy will be of the utmost priority for the individuals recruited.

The total projected cost through December 2020 is $10,078,560. This includes estimated personnel costs of $9,478,560 for 260 contact tracing staff and equipment and office space rental costs of approximately $600,000.

Contact Tracing Staffing Needs

**Projected Personnel Needed for Individual Patient Investigations**

<table>
<thead>
<tr>
<th>Level</th>
<th>Position Title:</th>
<th>Positions Needed*:</th>
<th>Ratio to Contract Tracers:</th>
<th>Personnel Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Senior Epidemiologist/Contact Tracing Lead</td>
<td>8</td>
<td>24:1</td>
<td>Epi II, Public Health Nurse</td>
</tr>
<tr>
<td>2</td>
<td>Epidemiology Investigator/Case Interviewer</td>
<td>24</td>
<td>8:1</td>
<td>Epi I, RN II, Temporary Nurses, Volunteer Physicians</td>
</tr>
<tr>
<td>3</td>
<td>Contact Tracer/Monitoring</td>
<td>192</td>
<td>1:1</td>
<td>LVN II, Medical Students, Nursing Students, MPH Students</td>
</tr>
<tr>
<td></td>
<td><strong>Total Personnel Needed</strong></td>
<td><strong>224</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Projected Personnel Needed for Special Investigations (Congregate Setting Outbreaks)**

<table>
<thead>
<tr>
<th>Special Investigations (Congregate Setting Outbreaks)</th>
<th>Level 1 Personnel Needed:</th>
<th>Level 2 Personnel Needed:</th>
<th>Total Personnel Needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-Risk Workplaces</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Correctional Facilities</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Homeless Shelters/ Halfway Houses</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Long-Term Care Facilities</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Schools/Colleges</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>27</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>
Projected Cost Analysis

**Personnel Cost Estimate:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Position</th>
<th>Positions Needed</th>
<th>Hourly Rate</th>
<th>Hourly Cost to DCHHS</th>
<th>Total Cost Per Week</th>
<th>Total Estimated Cost (28 Weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Senior Epidemiologist/Contact Tracing Lead</td>
<td>17</td>
<td>$36</td>
<td>$45</td>
<td>$30,600</td>
<td>$856,800</td>
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<tr>
<td>2</td>
<td>Epidemiology Investigator/Case Interviewer</td>
<td>51</td>
<td>$29</td>
<td>$38</td>
<td>$77,520</td>
<td>$2,170,560</td>
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<tr>
<td>3</td>
<td>Contact Tracer/Monitoring</td>
<td>192</td>
<td>$22</td>
<td>$30</td>
<td>$230,400</td>
<td>$6,451,200</td>
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<tr>
<td>Total</td>
<td></td>
<td>260</td>
<td></td>
<td></td>
<td>$338,520</td>
<td>$9,478,560</td>
</tr>
</tbody>
</table>

**Equipment & Rental Cost Estimate:**

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<thead>
<tr>
<th>Expense</th>
<th>Number of Staff</th>
<th>Estimated Cost Per Staff Member</th>
<th>Monthly Rate</th>
<th>Total Estimated Cost (7 Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment &amp; Supplies</td>
<td>260</td>
<td>$1,500</td>
<td>-</td>
<td>$390,000</td>
</tr>
<tr>
<td>Office Space Rental</td>
<td>260</td>
<td>-</td>
<td>$30,000</td>
<td>$210,000</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$600,000</td>
</tr>
</tbody>
</table>

**Updated Epidemiology and Contact Tracing Workflow**

In order to expand contact tracing for the anticipated greater numbers of cases (due to the new inclusion of probable cases), and the new state requirement for daily active monitoring, DCHHS would adapt its workflow from the current model, which reserves detailed epidemiological investigations for high-risk cases, to the below series of 3 flowcharts summarizing a planned workflow:
Staff will conduct interviews with case patients to collect demographic information, clinical history including COVID-19, and other relevant information (e.g., occupation, housing). During the interview, staff will elicit information about the case’s household and other close contacts and notify any contacts who are present at the time of interview. Cases and contacts will be educated about isolation and quarantine, and their needs for medical care and wraparound services (e.g., transportation, hoteling [if unable to isolate at home], telemedicine, legal assistance) will be assessed and referred to specific services where appropriate.

Individual, Business, and Public Notification Strategies

DCHHS’s contact tracing efforts will utilize multiple methods of notifying potential contacts of positive cases. The multi-pronged approach is summarized below:

- Contact tracer will attempt three phone calls. Those calls will be on different days at different times of day.
● If those methods are unsuccessful, contact tracers will send a letter and/or email to the contact with instructions for what the contact should do.
● If none of those methods work, the contact is assumed “lost to follow-up.”

Note that although DCHHS will attempt to reach as many contacts as possible, it is not necessary to reach 100% of contacts to reduce the spread of the virus and prevent additional spikes in cases. Additionally, experience has shown that many contacts simply do not want to be contacted or provide information as requested.

DCHHS may also notify businesses and, in certain circumstances, the public when an epidemiological investigation identifies that a COVID+ individual has spent significant time in a public location. This is true for both employees of businesses and individuals who have visited businesses for long enough to be considered a close contact. In summary:

● Infected individuals will be asked to permit disclosure of their name to their employers/businesses that they have visited to allow the business to internally investigate who they may have contacted.
● Businesses will be contacted and informed that an employee/customer that was COVID-19 positive was present, and epidemiologists will work with that business to identify any potential additional contacts.
  ○ If the business chooses to make a public announcement at this point, they are welcome to do so;
  ○ If the employee/customer refuses to consent to disclose their name, this investigation may be more challenging and will need to be addressed on a case-by-case basis.
● If the investigation conducted by DCHHS and the business is unsuccessful, DCHHS may decide to notify the public in order to aid the epidemiological investigation.
● DCHHS may also notify the public in situations where a cluster of cases has occurred.

Epidemiology Strategies for Vulnerable Populations at High Risk of Severe Illness

Although the goal of a comprehensive contact tracing operation is to attempt to perform contact tracing for all new cases, within that group DCHHS will prioritize the highest-risk cases for investigation and follow-up. The addition of more epidemiology and contact tracing staffing will allow DCHHS to expand the list of prioritized case types, as described below:

Current Priorities for Contact Tracing

● Confirmed and probable COVID-19 cases in congregate settings (e.g. nursing homes, correctional facilities, faith-based facilities, daycares, schools)
● High-risk individuals (e.g. immunocompromised/immunosuppressed, 65 years or older, pregnant)
● Cases with high-risk occupations (e.g. healthcare, police, EMS, fire, public health)
● Household contacts
● Clusters of cases in work settings

Additional Priorities for Contact Tracing

● Confirmed and probable COVID-19 cases in congregate settings (e.g. nursing homes, correctional facilities, faith-based facilities, daycares, schools)
● Household contacts
● High-risk individuals (e.g. immunocompromised/immunosuppressed, 65 years or older, pregnant)
● Cases with high-risk occupations (e.g. healthcare, police, EMS, fire, public health)
● Clusters of cases in work settings
● Clusters in circumscribed geographic areas
● Clusters in vulnerable populations
The contact tracing priorities described here coincide with DCHHS’s testing strategy, which also prioritizes settings such as senior and congregate living facilities that could act as sources of “super-spreading” and that house individuals more vulnerable to COVID-19.

**Use of Technology and Innovation**

Innovative and technology-based applications can enable faster, more thorough, and more real-time contact tracing. However, many of these applications are unproven and/or require voluntary use by the public. DCHHS will continue to work to identify best practices and coordinate with local, State, and Federal partners to identify the technology solutions that can improve contact tracing efforts.
The purpose of this document is to provide guidance to recipients of the funding available under section 601(a) of the Social Security Act, as added by section 5001 of the Coronavirus Aid, Relief, and Economic Security Act (“CARES Act”). The CARES Act established the Coronavirus Relief Fund (the “Fund”) and appropriated $150 billion to the Fund. Under the CARES Act, the Fund is to be used to make payments for specified uses to States and certain local governments; the District of Columbia and U.S. Territories (consisting of the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands); and Tribal governments.

The CARES Act provides that payments from the Fund may only be used to cover costs that—

1. are necessary expenditures incurred due to the public health emergency with respect to the Coronavirus Disease 2019 (COVID–19);
2. were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the State or government; and
3. were incurred during the period that begins on March 1, 2020, and ends on December 30, 2020.1

The guidance that follows sets forth the Department of the Treasury’s interpretation of these limitations on the permissible use of Fund payments.

**Necessary expenditures incurred due to the public health emergency**

The requirement that expenditures be incurred “due to” the public health emergency means that expenditures must be used for actions taken to respond to the public health emergency. These may include expenditures incurred to allow the State, territorial, local, or Tribal government to respond directly to the emergency, such as by addressing medical or public health needs, as well as expenditures incurred to respond to second-order effects of the emergency, such as by providing economic support to those suffering from employment or business interruptions due to COVID-19-related business closures.

Funds may not be used to fill shortfalls in government revenue to cover expenditures that would not otherwise qualify under the statute. Although a broad range of uses is allowed, revenue replacement is not a permissible use of Fund payments.

The statute also specifies that expenditures using Fund payments must be “necessary.” The Department of the Treasury understands this term broadly to mean that the expenditure is reasonably necessary for its intended use in the reasonable judgment of the government officials responsible for spending Fund payments.

**Costs not accounted for in the budget most recently approved as of March 27, 2020**

The CARES Act also requires that payments be used only to cover costs that were not accounted for in the budget most recently approved as of March 27, 2020. A cost meets this requirement if either (a) the cost cannot lawfully be funded using a line item, allotment, or allocation within that budget or (b) the cost

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1 See Section 601(d) of the Social Security Act, as added by section 5001 of the CARES Act.
is for a substantially different use from any expected use of funds in such a line item, allotment, or allocation.

The “most recently approved” budget refers to the enacted budget for the relevant fiscal period for the particular government, without taking into account subsequent supplemental appropriations enacted or other budgetary adjustments made by that government in response to the COVID-19 public health emergency. A cost is not considered to have been accounted for in a budget merely because it could be met using a budgetary stabilization fund, rainy day fund, or similar reserve account.

Costs incurred during the period that begins on March 1, 2020, and ends on December 30, 2020

A cost is “incurred” when the responsible unit of government has expended funds to cover the cost.

Nonexclusive examples of eligible expenditures

Eligible expenditures include, but are not limited to, payment for:

1. Medical expenses such as:
   - COVID-19-related expenses of public hospitals, clinics, and similar facilities.
   - Expenses of establishing temporary public medical facilities and other measures to increase COVID-19 treatment capacity, including related construction costs.
   - Costs of providing COVID-19 testing, including serological testing.
   - Emergency medical response expenses, including emergency medical transportation, related to COVID-19.

2. Public health expenses such as:
   - Expenses for communication and enforcement by State, territorial, local, and Tribal governments of public health orders related to COVID-19.
   - Expenses for acquisition and distribution of medical and protective supplies, including sanitizing products and personal protective equipment, for medical personnel, police officers, social workers, child protection services, and child welfare officers, direct service providers for older adults and individuals with disabilities in community settings, and other public health or safety workers in connection with the COVID-19 public health emergency.
   - Expenses for disinfection of public areas and other facilities, e.g., nursing homes, in response to the COVID-19 public health emergency.
   - Expenses for technical assistance to local authorities or other entities on mitigation of COVID-19-related threats to public health and safety.
   - Expenses for quarantining individuals.

3. Payroll expenses for public safety, public health, health care, human services, and similar employees whose services are substantially dedicated to mitigating or responding to the COVID-19 public health emergency.
4. Expenses of actions to facilitate compliance with COVID-19-related public health measures, such as:
   • Expenses for food delivery to residents, including, for example, senior citizens and other vulnerable populations, to enable compliance with COVID-19 public health precautions.
   • Expenses to facilitate distance learning, including technological improvements, in connection with school closings to enable compliance with COVID-19 precautions.
   • Expenses to improve telework capabilities for public employees to enable compliance with COVID-19 public health precautions.
   • Expenses of providing paid sick and paid family and medical leave to public employees to enable compliance with COVID-19 public health precautions.
   • COVID-19-related expenses of maintaining state prisons and county jails, including as relates to sanitation and improvement of social distancing measures, to enable compliance with COVID-19 public health precautions.
   • Expenses for care for homeless populations provided to mitigate COVID-19 effects and enable compliance with COVID-19 public health precautions.

5. Expenses associated with the provision of economic support in connection with the COVID-19 public health emergency, such as:
   • Expenditures related to the provision of grants to small businesses to reimburse the costs of business interruption caused by required closures.
   • Expenditures related to a State, territorial, local, or Tribal government payroll support program.
   • Unemployment insurance costs related to the COVID-19 public health emergency if such costs will not be reimbursed by the federal government pursuant to the CARES Act or otherwise.

6. Any other COVID-19-related expenses reasonably necessary to the function of government that satisfy the Fund’s eligibility criteria.

Nonexclusive examples of ineligible expenditures

The following is a list of examples of costs that would not be eligible expenditures of payments from the Fund.

1. Expenses for the State share of Medicaid.
2. Damages covered by insurance.
3. Payroll or benefits expenses for employees whose work duties are not substantially dedicated to mitigating or responding to the COVID-19 public health emergency.

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2 In addition, pursuant to section 5001(b) of the CARES Act, payments from the Fund may not be expended for an elective abortion or on research in which a human embryo is destroyed, discarded, or knowingly subjected to risk of injury or death. The prohibition on payment for abortions does not apply to an abortion if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Furthermore, no government which receives payments from the Fund may discriminate against a health care entity on the basis that the entity does not provide, pay for, provide coverage of, or refer for abortions.

3 See 42 C.F.R. § 433.51 and 45 C.F.R. § 75.306.
4. Expenses that have been or will be reimbursed under any federal program, such as the reimbursement by the federal government pursuant to the CARES Act of contributions by States to State unemployment funds.
5. Reimbursement to donors for donated items or services.
6. Workforce bonuses other than hazard pay or overtime.
7. Severance pay.
8. Legal settlements.