1. Responding to COVID-19

On January 21, 2020, the Centers for Disease Control and Prevention (CDC) identified the first case of novel coronavirus in the United States.[21] By late March, the virus had spread to many States and the first wave was growing rapidly, centered in the northeast.[22] This wave brought acute strain on health care and public health systems: hospitals and emergency medical services struggled to manage a major influx of patients; response personnel faced shortages of personal protective equipment; testing for the virus was scarce; and congregate living facilities like nursing homes and prisons saw rapid spread. State, local, and Tribal governments mobilized to support the health care system, issue public health orders to mitigate virus spread, and communicate safety measures to the public. The United States has since faced at least two additional COVID-19 waves that brought many similar challenges: the second in the summer, centered in the south and southwest, and a wave throughout the fall and winter, in which the virus reached a point of uncontrolled spread across the country and over 3,000 people died per day.[23] By early May 2021, the United States has experienced over 32 million confirmed COVID-19 cases and over 575,000 deaths.[24]

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[21] Press Release, Centers for Disease Control and Prevention, First Travel-related Case of 2019 Novel Coronavirus Detected in United States (Jan. 21, 2020), https://www.cdc.gov/media/releases/2020/p0121-novel-coronavirus-travel-case.html.

[22] Anne Schuchat et al., Public Health Response to the Initiation and Spread of Pandemic COVID-19 in the United States, February 24 – April 21, 2021, MMWR Morb Mortal Wkly Rep 2021, 69(18):551-56 (May 8, 2021), https://www.cdc.gov/mmwr/volumes/69/wr/mm6918e2.htm.

[23] Centers for Disease Control and Prevention, COVID Data Tracker: Trends in Number of COVID-19 Cases and Deaths in the US Reported to CDC, by State/Territory, https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases (last visited May 8, 2021).

[24] *Id*.

Mitigating the impact of COVID-19, including taking actions to control its spread and support hospitals and health care workers caring for the sick, continues to require a major public health response from State, local and Tribal governments. New or heightened public health needs include COVID-19 testing, major expansions in contact tracing, support for individuals in isolation or quarantine, enforcement of public health orders, new public communication efforts, public health surveillance (e.g., monitoring case trends and genomic sequencing for variants), enhancement to health care capacity through alternative care facilities, and enhancement of public health data systems to meet new demands or scaling needs. State, local, and Tribal governments have also supported major efforts to prevent COVID-19 spread through safety measures at key settings like nursing homes, schools, congregate living settings, dense worksites, incarceration settings, and in other public facilities. This has included implementing infection prevention measures or making ventilation improvements in congregate settings, health care settings, or other key locations.

Other response and adaptation costs include capital investments in public facilities to meet pandemic operational needs, such as physical plant improvements to public hospitals and health clinics or adaptations to public buildings to implement COVID-19 mitigation tactics. In recent months, State, local, and Tribal governments across the country have mobilized to support the national vaccination campaign, resulting in over 250 million doses administered to date.[25]

The need for public health measures to respond to COVID-19 will continue in the months and potentially years to come. This includes the continuation of the vaccination campaign for the general public and, if vaccinations are approved for children in the future, eventually for

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[25] Centers for Disease Control and Prevention, COVID Data Tracker: COVID-19 Vaccinations in the United States, https://covid.cdc.gov/covid-data-tracker/#vaccinations (last visited May 8, 2021).

youths. This also includes monitoring the spread of COVID-19 variants, understanding the impact of these variants (especially on vaccination efforts), developing approaches to respond to those variants, and monitoring global COVID-19 trends to understand continued risks to the United States. Finally, the long-term health impacts of COVID-19 will continue to require a public health response, including medical services for individuals with "long COVID," and research to understand how COVID-19 impacts future health needs and raises risks for the millions of Americans who have been infected.

Other areas of public health have also been negatively impacted by the COVID-19 pandemic. For example, in one survey in January 2021, over 40 percent of American adults reported symptoms of depression or anxiety, up from 11 percent in the first half of 2019.[26,] The proportion of children's emergency department visits related to mental health has also risen noticeably.[27] Similarly, rates of substance misuse and overdose deaths have spiked: preliminary data from the CDC show a nearly 30 percent increase in drug overdose mortality from September 2019 to September 2020.[28] Stay-at-home orders and other pandemic responses may have also reduced the ability of individuals affected by domestic violence to access services.[29]

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[26] Panchal, *supra* note 4; Mark É. Czeisler et al., Mental Health, Substance Abuse, and Suicidal Ideation During COVID-19 Pandemic– United States, June 24-30 2020, Morb. Mortal. Wkly. Rep. 69(32):1049-57 (Aug. 14, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.

[27] Leeb, *supra* note 4.

[28] Centers for Disease Prevention and Control, National Center for Health Statistics, Provisional Drug Overdose Death Counts, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last visited May 8, 2021).

[29] Megan L. Evans, et al., A Pandemic within a Pandemic – Intimate Partner Violence during Covid-19, N. Engl. J. Med. 383:2302-04 (Dec. 10, 2020), *available at* https://www.nejm.org/doi/full/10.1056/NEJMp2024046.

Finally, some preventative public health measures like childhood vaccinations have been deferred and potentially forgone.[30]

While the pandemic affected communities across the country, it disproportionately impacted some demographic groups and exacerbated health inequities along racial, ethnic, and socioeconomic lines.[31] The CDC has found that racial and ethnic minorities are at increased risk for infection, hospitalization, and death from COVID-19, with Hispanic or Latino and Native American or Alaska Native patients at highest risk.[32]

Similarly, low-income and socially vulnerable communities have seen the most severe health impacts. For example, counties with high poverty rates also have the highest rates of infections and deaths, with 223 deaths per 100,000 compared to the U.S. average of 175 deaths per 100,000, as of May 2021.[33] Counties with high social vulnerability, as measured by factors such as poverty and educational attainment, have also fared more poorly than the national

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[30] Jeanne M. Santoli et al., Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration – United States, Morb. Mortal. Wkly. Rep. 69(19):591-93 (May 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm; Marisa Langdon-Embry et al., Notes from the Field: Rebound in Routine Childhood Vaccine Administration Following Decline During the COVID-19 Pandemic – New York City, March 1-June 27, 2020, Morb. Mortal. Wkly. Rep. 69(30):999-1001 (Jul. 31 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6930a3.htm.

[31] Office of the White House, National Strategy for the COVID-19 Response and Pandemic Preparedness (Jan. 21, 2021), https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf.

[32] In a study of 13 states from October to December 2020, the CDC found that Hispanic or Latino and Native American or Alaska Native individuals were 1.7 times more likely to visit an emergency room for COVID-19 than White individuals, and Black individuals were 1.4 times more likely to do so than White individuals. *See* Romano, *supra* note 10.

[33] Centers for Disease Control and Prevention, COVID Data Tracker: Trends in COVID-19 Cases and Deaths in the United States, by County-level Population Factors, https://covid.cdc.gov/covid-data-tracker/#pop-factors_totaldeaths (last visited May 8, 2021).

average, with 211 deaths per 100,000 as of May 2021.[34] Over the last year, Native Americans have experienced more than one and a half times the rate of COVID-19 infections, more than triple the rate of hospitalizations, and more than double the death rate compared to White Americans.[35] Low-income and minority communities also exhibit higher rates of pre-existing conditions that may contribute to an increased risk of COVID-19 mortality.[36]

In addition, individuals living in low-income communities may have had more limited ability to socially distance or to self-isolate when ill, resulting in faster spread of the virus, and were over-represented among essential workers, who faced greater risk of exposure.[37] Social distancing measures in response to the pandemic may have also exacerbated pre-existing public health challenges. For example, for children living in homes with lead paint, spending substantially more time at home raises the risk of developing elevated blood lead levels, while

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[34] The CDC's Social Vulnerability Index includes fifteen variables measuring social vulnerability, including unemployment, poverty, education levels, single-parent households, disability status, non-English speaking households, crowded housing, and transportation access.

Centers for Disease Control and Prevention, COVID Data Tracker: Trends in COVID-19 Cases and Deaths in the United States, by Social Vulnerability Index, https://covid.cdc.gov/covid-data-tracker/#pop-factors_totaldeaths (last visited May 8, 2021).

[35] Centers for Disease Control and Prevention, Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (last visited Apr. 26, 2021).

[36] *See, e.g.*, Centers for Disease Control and Prevention, Risk of Severe Illness or Death from COVID-19 (Dec. 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-illness.html (last visited Apr. 26, 2021).

[37] Milena Almagro et al., Racial Disparities in Frontline Workers and Housing Crowding During COVID-19: Evidence from Geolocation Data (Sept. 22, 2020), NYU Stern School of Business (forthcoming), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3695249; Grace McCormack et al., Economic Vulnerability of Households with Essential Workers, JAMA 324(4):388-90 (2020), *available at* https://jamanetwork.com/journals/jama/fullarticle/2767630.

screenings for elevated blood lead levels declined during the pandemic.[38] The combination of these underlying social and health vulnerabilities may have contributed to more severe public health outcomes of the pandemic within these communities, resulting in an exacerbation of pre-existing disparities in health outcomes.[39]

Eligible Public Health Uses. The Fiscal Recovery Funds provide resources to meet and address these emergent public health needs, including through measures to counter the spread of COVID-19, through the provision of care for those impacted by the virus, and through programs or services that address disparities in public health that have been exacerbated by the pandemic. To facilitate implementation and use of payments from the Fiscal Recovery Funds, the Interim Final Rule identifies a non-exclusive list of eligible uses of funding to respond to the COVID-19 public health emergency. Eligible uses listed under this section build and expand upon permissible expenditures under the CRF, while recognizing the differences between the ARPA and CARES Act, and recognizing that the response to the COVID-19 public health emergency has changed and will continue to change over time. To assess whether additional uses would be eligible under this category, recipients should identify an effect of COVID-19 on public health, including either or both of immediate effects or effects that may manifest over months or years, and assess how the use would respond to or address the identified need.

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[38] *See, e.g.*, Joseph G. Courtney et al., Decreases in Young Children Who Received Blood Lead Level Testing During COVID-19 – 34 Jurisdictions, January-May 2020, Morb. Mort. Wkly. Rep. 70(5):155-61 (Feb. 5, 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a2.htm; Emily A. Benfer & Lindsay F. Wiley, Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic, Health Affairs Blog (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/.

[39] *See, e.g.*, Centers for Disease Control and Prevention, *supra* note 34; Benfer & Wiley, *supra* note 38; Nathaniel M. Lewis et al., Disparities in COVID-19 Incidence, Hospitalizations, and Testing, by Area-Level Deprivation – Utah, March 3-July 9, 2020, Morb. Mortal. Wkly. Rep. 69(38):1369-73 (Sept. 25, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6938a4.htm.

The Interim Final Rule identifies a non-exclusive list of uses that address the effects of the COVID-19 public health emergency, including:

- *COVID-19 Mitigation and Prevention.* A broad range of services and programming are needed to contain COVID-19. Mitigation and prevention efforts for COVID-19 include vaccination programs; medical care; testing; contact tracing; support for isolation or quarantine; supports for vulnerable populations to access medical or public health services; public health surveillance (e.g., monitoring case trends, genomic sequencing for variants); enforcement of public health orders; public communication efforts; enhancement to health care capacity, including through alternative care facilities; purchases of personal protective equipment; support for prevention, mitigation, or other services in congregate living facilities (e.g., nursing homes, incarceration settings, homeless shelters, group living facilities) and other key settings like schools;[40] ventilation improvements in congregate settings, health care settings, or other key locations; enhancement of public health data systems; and other public health responses.[41] They also include capital investments in public facilities to meet pandemic operational needs, such as physical plant improvements to public hospitals and health clinics or adaptations

[40] This includes implementing mitigation strategies consistent with the Centers for Disease Control and Prevention's (CDC) Operational Strategy for K-12 Schools through Phased Prevention, *available at* https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/operation-strategy.html.

[41] Many of these expenses were also eligible in the CRF. Generally, funding uses eligible under CRF as a response to the direct public health impacts of COVID-19 will continue to be eligible under the ARPA, including those not explicitly listed here (e.g., telemedicine costs, costs to facilitate compliance with public health orders, disinfection of public areas, facilitating distance learning, increased solid waste disposal needs related to PPE, paid sick and paid family and medical leave to public employees to enable compliance with COVID–19 public health precautions), with the following two exceptions: 1) the standard for eligibility of public health and safety payrolls has been updated (see details on page 20) and 2) expenses related to the issuance of tax-anticipation notes are no longer an eligible funding use (see discussion of debt service on page 44).

to public buildings to implement COVID-19 mitigation tactics. These COVID-19 prevention and mitigation programs and services, among others, were eligible expenditures under the CRF and are eligible uses under this category of eligible uses for the Fiscal Recovery Funds.[42]

- *Medical Expenses*. The COVID-19 public health emergency continues to have devastating effects on public health; the United States continues to average hundreds of deaths per day and the spread of new COVID-19 variants has raised new risks and genomic surveillance needs.[43] Moreover, our understanding of the potentially serious and long-term effects of the virus is growing, including the potential for symptoms like shortness of breath to continue for weeks or months, for multi-organ impacts from COVID-19, or for post-intensive care syndrome.[44] State and local governments may need to continue to provide care and services to address these near- and longer-term needs.[45]
- *Behavioral Health Care.* In addition, new or enhanced State, local, and Tribal government services may be needed to meet behavioral health needs exacerbated by the pandemic and respond to other public health impacts. These services include mental health treatment, substance misuse treatment, other behavioral health services, hotlines or

[42] Coronavirus Relief Fund for States, Tribal Governments, and Certain Eligible Local Governments, 86 Fed. Reg. 4182 (Jan. 15, 2021), *available at* https://home.treasury.gov/system/files/136/CRF-Guidance-Federal-Register_2021-00827.pdf.

[43] Centers for Disease Control and Prevention, *supra* note 24.

[44] Centers for Disease Control and Prevention, Long-Term Effects (Apr. 8, 2021), https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html (last visited Apr. 26, 2021).

[45] Pursuant to 42 CFR 433.51 and 45 CFR 75.306, Fiscal Recovery Funds may not serve as a State or locality's contribution of certain Federal funds.

warmlines, crisis intervention, overdose prevention, infectious disease prevention, and services or outreach to promote access to physical or behavioral health primary care and preventative medicine.

- *Public Health and Safety Staff.* Treasury recognizes that responding to the public health and negative economic impacts of the pandemic, including administering the services described above, requires a substantial commitment of State, local, and Tribal government human resources. As a result, the Fiscal Recovery Funds may be used for payroll and covered benefits expenses for public safety, public health, health care, human services, and similar employees, to the extent that their services are devoted to mitigating or responding to the COVID–19 public health emergency.[46] Accordingly, the Fiscal Recovery Funds may be used to support the payroll and covered benefits for the portion of the employee's time that is dedicated to responding to the COVID-19 public health emergency. For administrative convenience, the recipient may consider public health and safety employees to be entirely devoted to mitigating or responding to the COVID-19 public health emergency, and therefore fully covered, if the employee, or his or her operating unit or division, is primarily dedicated to responding to the COVID-19 public health emergency. Recipients may consider other presumptions for assessing the extent to which an employee, division, or operating unit is engaged in activities that respond to

[46] In general, if an employee's wages and salaries are an eligible use of Fiscal Recovery Funds, recipients may treat the employee's covered benefits as an eligible use of Fiscal Recovery Funds. For purposes of the Fiscal Recovery Funds, covered benefits include costs of all types of leave (vacation, family-related, sick, military, bereavement, sabbatical, jury duty), employee insurance (health, life, dental, vision), retirement (pensions, 401(k)), unemployment benefit plans (federal and state), workers compensation insurance, and Federal Insurance Contributions Act (FICA) taxes (which includes Social Security and Medicare taxes).

the COVID-19 public health emergency, provided that the recipient reassesses periodically and maintains records to support its assessment, such as payroll records, attestations from supervisors or staff, or regular work product or correspondence demonstrating work on the COVID-19 response. Recipients need not routinely track staff hours.

- *Expenses to Improve the Design and Execution of Health and Public Health Programs.* State, local, and Tribal governments may use payments from the Fiscal Recovery Funds to engage in planning and analysis in order to improve programs addressing the COVID-19 pandemic, including through use of targeted consumer outreach, improvements to data or technology infrastructure, impact evaluations, and data analysis.

Eligible Uses to Address Disparities in Public Health Outcomes. In addition, in recognition of the disproportionate impacts of the COVID-19 pandemic on health outcomes in low-income and Native American communities and the importance of mitigating these effects, the Interim Final Rule identifies a broader range of services and programs that will be presumed to be responding to the public health emergency when provided in these communities. Specifically, Treasury will presume that certain types of services, outlined below, are eligible uses when provided in a Qualified Census Tract (QCT),[47] to families living in QCTs, or when these services are provided

[47] Qualified Census Tracts are a common, readily-accessible, and geographically granular method of identifying communities with a large proportion of low-income residents. Using an existing measure may speed implementation and decrease administrative burden, while identifying areas of need at a highly-localized level.

While QCTs are an effective tool generally, many tribal communities have households with a wide range of income levels due in part to non-tribal member, high income residents living in the community. Mixed income communities, with a significant share of tribal members at the lowest levels of income, are often not included as eligible QCTs yet tribal residents are experiencing disproportionate impacts due to the pandemic. Therefore, including all services provided by Tribal governments is a more effective means of ensuring that disproportionately impacted Tribal members can receive services.

by Tribal governments.[48] Recipients may also provide these services to other populations, households, or geographic areas that are disproportionately impacted by the pandemic. In identifying these disproportionately-impacted communities, recipients should be able to support their determination that the pandemic resulted in disproportionate public health or economic outcomes to the specific populations, households, or geographic areas to be served.

Given the exacerbation of health disparities during the pandemic and the role of pre-existing social vulnerabilities in driving these disparate outcomes, services to address health disparities are presumed to be responsive to the public health impacts of the pandemic. Specifically, recipients may use payments from the Fiscal Recovery Funds to facilitate access to resources that improve health outcomes, including services that connect residents with health care resources and public assistance programs and build healthier environments, such as:

- Funding community health workers to help community members access health services and services to address the social determinants of health;[49,]
- Funding public benefits navigators to assist community members with navigating and applying for available Federal, State, and local public benefits or services;

[48] U.S. Department of Housing and Urban Development (HUD), Qualified Census Tracts and Difficult Development Areas, https://www.huduser.gov/portal/datasets/qct.html (last visited Apr. 26, 2021); U.S. Department of the Interior, Bureau of Indian Affairs, Indian Lands of Federally Recognized Tribes of the United States (June 2016), https://www.bia.gov/sites/bia.gov/files/assets/bia/ots/webteam/pdf/idc1-028635.pdf (last visited Apr. 26, 2021).

[49] The social determinants of health are the social and environmental conditions that affect health outcomes, specifically economic stability, health care access, social context, neighborhoods and built environment, and education access. *See, e.g.*, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030: Social Determinants of Health, https://health.gov/healthypeople/objectives-and-data/social-determinants-health (last visited Apr. 26, 2021).

- Housing services to support healthy living environments and neighborhoods conducive to mental and physical wellness;
- Remediation of lead paint or other lead hazards to reduce risk of elevated blood lead levels among children; and
- Evidence-based community violence intervention programs to prevent violence and mitigate the increase in violence during the pandemic.[50]

2. Responding to Negative Economic Impacts

Impacts on Households and Individuals. The public health emergency, including the necessary measures taken to protect public health, resulted in significant economic and financial hardship for many Americans. As businesses closed, consumers stayed home, schools shifted to remote education, and travel declined precipitously, over 20 million jobs were lost in March and April 2020.[51] Although many have returned to work, as of April 2021, the economy remains 8.2 million jobs below its pre-pandemic peak,[52] and more than 3 million workers have dropped out of the labor market altogether relative to February 2020.[53]

Rates of unemployment are particularly severe among workers of color and workers with lower levels of educational attainment; for example, the overall unemployment rate in the United

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[50] National Commission on COVID-19 and Criminal Justice, Impact Report: COVID-19 and Crime (Jan. 31, 2021), https://covid19.counciloncj.org/2021/01/31/impact-report-covid-19-and-crime-3/ (showing a spike in homicide and assaults); Brad Boesrup et al., Alarming Trends in US domestic violence during the COVID-19 pandemic, Am. J. of Emerg. Med. 38(12): 2753-55 (Dec. 1, 2020), *available at* https://www.ajemjournal.com/article/S0735-6757(20)30307-7/fulltext (showing a spike in domestic violence).

[51] U.S. Bureau of Labor Statistics, All Employees, Total Nonfarm (PAYEMS), retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/PAYEMS (last visited May 8, 2021).

[52] *Id*.

[53] U.S. Bureau of Labor Statistics, Civilian Labor Force Level [CLF16OV], retrieved from FRED, Federal Reserve Bank of St. Louis, https://fred.stlouisfed.org/series/CLF16OV (last visited May 8, 2021).