

Distribution of Direct Care Workforce COVID-19 Funding Between Rural and Urban Counties in Minnesota and Illinois

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Key Findings

- There are state-by-state variations in how COVID-19 relief funding, like the CARES Act, supports direct care workers. (Direct care workers include personal care aides, home health aides, and nursing assistants.)
- Funding allocation was proportionately distributed to rural and urban areas in Minnesota and Illinois; however, the distribution does not necessarily take into account population health needs and challenges faced by the direct care workforce in rural areas.

Purpose

The purpose of this policy brief is to examine trends in the distribution of CARES Act funding designed to support the direct care workforce between rural and urban counties in Minnesota and Illinois.

Background and Policy Context

The direct care workforce in rural communities has faced a number of challenges prior to and throughout the duration of the COVID-19 pandemic, with a more limited supply of direct care workers in rural areas.¹ The direct care workforce encompasses those workers who assist older adults and individuals with disabilities with daily tasks, such as personal care aides, home health aides, and nursing assistants.² Prior to the pandemic, there was already a shortage and high turnover rate of direct care workers due to factors such as limited transportation, lack of opportunities for training and continued education, and low wages.³ Since long-term care facilities have been significantly affected by the pandemic due to the high burden of disease on older adults and individuals with complex medical conditions, the direct care workforce has seen an increase in burnout and high turnover.⁴ This burnout has likely exacerbated the existing shortages of workers in rural areas, although research on the supply of direct care workers in rural areas is limited.⁵

As a result of the COVID-19 pandemic, federal and state governments have allocated several iterations of funding to support of the health care industry. The first main source of funding support at the start of the pandemic was the federal Coronavirus Aid, Relief, and Economic Securities Act of 2020 (CARES Act 2020).⁶ This funding aimed to assist with the public health response and mitigate the economic impact of the virus on organizations and their workforce. In the distribution of CARES Act funds at the state levels, long-term care facilities and the direct care workforce were included as specific line items in the budgets. There has been variation across states regarding how organizations with direct care workforces, such as long-

term care facilities, have utilized this funding to respond to the pandemic and their workforce. This includes using the funding within the federal guidelines set out for the CARES Act funding, as well as creating additional funding to widen the scope of supports for the direct care resources.

In this policy brief, the distribution of CARES Act funding by states aimed at supporting the direct care workforce is examined to see how the funding was distributed between rural and urban counties. We highlight state-by-state differences in two states, Minnesota and Illinois, in CARES Act funding for the direct care workforce and prioritization of funding toward rural counties. These states were selected due to the availability and transparency of data regarding funding awards.

Approach

We identified CARES Act funding resources for the direct care workforce for Minnesota in 2020 and Illinois in 2021, located on the Minnesota Department of Health and Illinois Department of Healthcare and Family Services websites. The federal government provided guidelines for eligible expenditures under the CARES Act funding that states could utilize the funding for in response to the pandemic and its economic impact, such as hazard pay for employees and payroll expenses.⁷ Hazard pay encompasses additional compensation for individuals whose work involves a physical hardship and distress.⁸ For Minnesota, funding for the direct care workforce was allocated through the COVID-19 Health Care Response Grant of 2020.⁹ These grants were a combination of federal CARES Act funds and additional Minnesota state funding. Funds from this grant could be spent by organizations to cover workforce expenses related to staff overtime, hiring additional staff, and staff training and orientation. Since Illinois solely utilized CARES Act funding, they awarded funding to Medicaid providers so that they could provide hazard pay for the direct care workforce.¹⁰ For the funding opportunities in both states, long-term care organizations had to apply for funding. There also did not appear to any earmarks for organizations in rural organizations in either state.

For each funding stream, a researcher pulled the locations of the long-term care facilities, such as skilled nursing facilities and assisted living facilities, and home healthcare organizations, including – but not limited to

– agencies funded by Medicare that were awarded funding. Information about funding award sizes were also compiled. Long-term care and home health and home care organizations were chosen for analysis because they employ direct care workers. The county of each long-term care facility was determined by the address listed on the funding awards. For home health and home care organizations that serve multiple counties, the organization's website was searched to determine the county service area.

The counties were given a rural or urban designation by utilizing the 2013 Urban Rural Classification Scheme for Counties through the National Center for Health Statistics.¹¹ Counties that had a code of 5 or 6 were assigned “rural,” while counties coded 1, 2, 3, or 4 were considered “not rural.” If the service area of an organization included both urban and rural counties, the organization was classified as rural.

In Minnesota, 60 of 87 counties (69%) are considered rural and in Illinois, 62 of 102 counties (60%) are rural. As of 2020, there are roughly 5.7 million residents in Minnesota and 1.2 million of them living in rural areas (21%).¹² Illinois has an estimated population of around 12 million people, with 1.4 million living in rural counties (11%).¹³

Results

Throughout 2020, the state of Minnesota allocated \$150 million to the COVID-19 Health Care Response Grant. About \$10 million of those funds came from the federal CARES Act funding for Minnesota, while the remainder of funds were supplemented by the Minnesota legislature. Funding was awarded through the Minnesota Department of Health in multiple rounds in May, June, July, and October 2020. Funding was awarded to different sectors of the health care industry including Critical Access Hospitals, long-term care facilities, home care and home health organizations, pharmacies, tribal health, federally qualified health centers, and behavioral health treatment centers. For this brief, we limit our analysis to funding awards to home health and home care organizations and long-term care facilities because of their focus on employing direct care workers.

Table 1 shows the distribution of funding from the COVID-19 Health Care Response Grant between rural and urban long-term care and home health and home care providers in 2020. Across each funding round, the

Table 1. Distribution of COVID-19 Health Care Response Grant funding between rural and urban long-term care and home healthcare providers in 2020 in Minnesota

Funding Round	Home Health/Home Care		Long-term Care (Assisted Living or Skilled Nursing Facility)	
	Rural (%)	Urban (%)	Rural (%)	Urban (%)
May 2020	1 (7)	13 (93)	52 (32)	111 (68)
June 2020	10 (20)	41 (80)	25 (30)	61 (70)
July 2020	3 (60)	2 (40)	13 (27)	35 (75)
October 2020*	4 (22)	14 (78)	28 (34)	54 (66)

*Two sets of funding awards were given in October 2020, so numbers are combined.

majority of funding was awarded to facilities located in urban counties. The only round that awarded the majority of funding to rural organizations was in July 2020 to home health and home care organizations, but only five organizations were awarded funding that month. The distribution of funds is comparable to the population distribution across rural counties in Minnesota, with 21% of the population living in rural counties. However, the initial funding awarded in May 2020 to Home Health/Home Care organizations serving rural counties was much lower than the overall rural population distribution.

Illinois distributed CARES Act funding in four rounds in 2021. In the first round of funding distribution, funds were awarded to several categories of long-term care facilities, including nursing facilities, sup-

portive living facilities, and specialized mental health rehabilitation facilities, and intermediate care facilities. Table 2 shows the distribution of Round 1 CARES Act funding to long-term care providers in Illinois in 2021. Across all categories of long-term care, the funding was overwhelmingly distributed to organizations in urban counties of the state. Although only 11% of the population of Illinois lives in rural areas, rural counties make up 60% of Illinois. This may mean that many counties did not receive adequate funds to support their direct care workforce.

In the second and third rounds of funding, the types of facilities awarded funding were consolidated into general long-term care and specialized mental health rehabilitation facilities. Table 3 shows Rounds 2 and 3 funding distribution between organizations in rural and

Table 2. Distribution of Round 1 CARES Act funding in Illinois between rural and urban long-term care providers

Funding Round	Nursing Facility		Supportive Living Facilities		Specialized Mental Health Rehabilitation Facilities		Intermediate Care Facilities	
	Rural (%)	Urban (%)	Rural (%)	Urban (%)	Rural*	Urban (%)	Rural (%)	Urban (%)
Round 1	191 (29)	466 (71)	46 (31)	103 (69)	0 (0)	23 (100)	55 (27)	150 (73)

*There currently are no specialized mental health rehabilitation facilities in Illinois located in rural counties

Table 3. Distribution of Round 2 and 3 CARES Act funding in Illinois between rural and urban long-term care providers

Funding Round	Long-term Care		Specialized Mental Health Rehabilitation Facilities	
	Rural (%)	Urban (%)	Rural (%)*	Urban (%)
Round 2 and 3	83 (22)	301 (78)	0 (0)	19 (100)

*There currently are no specialized mental health rehabilitation facilities in Illinois located in rural counties

Table 4. Distribution of Round 4 CARES Act funding in Illinois between rural and urban long-term care providers

Funding Round	Nursing Facility		Supportive Living Facility		Intermediate Care Facility	
	Rural (%)	Urban (%)	Rural (%)	Urban (%)	Rural (%)	Urban (%)
Round 4	125 (24)	403 (76)	15 (28)	39 (72)	40 (31)	88 (69)

Table 5. Funding allocations distributed to rural and urban providers in Minnesota and Illinois

State	Rural (%)	Urban (%)	Total
Minnesota	\$8,087,249.00 (36%)	\$14,486,048.00 (64%)	\$22,573,297.00
Illinois	\$68,170,098.41 (13%)	\$466,007,910.10 (87%)	\$534,178,008.50

urban counties in Illinois. Similar to Round 1 funding, Rounds 2 and 3 overwhelmingly funded organizations in urban counties, which mirrors the overall distribution of long-term care facilities in rural/urban areas of Illinois.¹⁴

Table 4 demonstrates the final round of funding given between organizations in rural and urban counties in Illinois. Similarly to the other rounds, funds were awarded organizations that were mostly located in urban Illinois counties.

Table 5 demonstrates the amount of funds that were awarded to rural providers versus urban providers in Minnesota and in Illinois. Overall, Minnesota distributed about 36% of the funding directed toward the direct care workforce to organizations in rural communities, which is a bit higher than the 30% rural population in the state. In Illinois, about 13% of funding was directed toward rural providers versus urban providers, which is also slightly higher than the 11% rural population of the state. Looking only at the percentage of older adult (65+; the population most likely to need direct care services) living in rural areas of each state, the distribution of funding was approximately equitable: 32% of older adults in Minnesota live in rural areas (compared with 36% of funds) and 15% of older adults in Illinois live in rural areas (compared with 13% of funding).¹⁵

Discussion and Implications

In both Illinois and Minnesota, COVID-19 relief funding was overwhelmingly distributed to long-term care organizations located in urban areas. Although this allocation of funding does mirror the percentage of rural populations in each state, this still has implications for the direct care workforce in rural areas as organizations with direct care staff may not have received the financial

resources needed to support staff during the pandemic.

In Illinois, CARES Act funds were intended to be used to provide support for Medicaid providers throughout the pandemic and to offset pandemic related costs incurred between March to December 2020, including hazard pay for direct care workers. As COVID-19 posed a significant risk to older adults and those with complex health conditions and spread quickly through long-term care facilities, hazard pay has been needed to compensate direct care workers because caring for populations who are at a higher risk of COVID-19 put them at a higher risk of contracting the virus as well. Individuals living in Illinois's rural counties were infected by the virus at higher rates than urban counties and rural areas also faced provider shortages throughout the pandemic.¹⁶

In Minnesota, the COVID-19 Health Care Response Act funds could be used to cover workforce expenses related to staff overtime, hiring additional staff, and staff training and orientation. Funding aimed at these staffing efforts is important due to the high shortage of direct care workers in the state, particularly in rural counties.¹⁷ This helps reduce burnout among existing staff if there are new staff members who can be trained and help balance out workloads and improve coverage of shifts if staff get sick or need to quarantine. Similar to Illinois and other rural counties across the country, Minnesota's rural counties experienced higher rates of COVID-19.¹⁸⁻¹⁹ However, the majority of organizations with direct care workers that were funded by this grant are located in or serve urban counties in Minnesota. This does not necessarily reflect the needs of organizations with a direct care workforce in rural counties who have been short staffed throughout the

pandemic and could have used additional funding to help them recruit new staff.

One potential barrier for rural organizations attempting to get financial resources to support their direct care workforce is the ease and ability to apply for funds. Many rural organizations do not have the internal capacity to have someone apply for grant funds, especially if their organization is already short staffed and administrative staff are pulled to provide direct care supports.²⁰ So even if federal and state funders want to prioritize rural financial supports for the rural direct care workforce, not having someone with the capacity to apply for funds is a barrier, especially in the midst of a public health crisis.

It is interesting to note the differences in what workforce support efforts are eligible under the CARES Act and the COVID-19 Health Care Response Grant, which was a combination of funds between the CARES Act and additional funding from the State of Minnesota. The distribution of CARES Act funds in Illinois only notes hazard pay as a workforce expense that organizations could have to support their direct care workers. In contrast, since Minnesota combined CARES Act funding with supplemental funds from the Minnesota legislature, this changed the scope of the workforce expenses eligible to be covered. These differences in workforce supports that are eligible expenses through these funding streams is worth noting as it warrants more comprehensive funding opportunities in the future that cover a multitude of retention and recruitment strategies to support direct care workers, especially in rural areas.

Limitations

There are several of limitations to this brief. This brief only examines two states and two specific funding opportunities within those states that impacted the direct care workforce because of the public availability of the funding awards. Both forms of funding that are examined in this brief were also legislated in 2020, so this analysis only speaks to the initial waves of funding to support the direct care workforce at the start of the COVID-19 pandemic. We also were not able to examine the relationship between funding distribution and organization size, total revenue, and population need, all of which are important areas for future study. We were also unable to include information regarding the number of organizations in each state in rural versus urban areas that were eligible to apply for funding. A final limitation is the lack of certain types of providers in rural coun-

ties to apply for funding, which was the case in Illinois where there were not any Specialized Mental Health Rehabilitation Facilities in operation in rural counties during these funding periods. Still, this brief suggested important disparities in funding support for the direct care workforce during a national public health emergency. These results should inform future research on equitable distribution of resources for rural health care provision.

Conclusion

The COVID-19 pandemic has presented numerous challenges to the direct care workforce, particularly in rural counties, where the population is older and has more underlying health conditions. The federal CARES Act provided funding for states to distribute at the local levels in order to assist with the public health response to the pandemic, including workforce issues. Illinois utilized CARES Act funds to award long-term care facilities with funding for hazard pay for their direct care workers. Minnesota created the COVID-19 Healthcare Response Grant, made up of CARES Act funds and additional funding from the state legislature, to be used for retention and recruitment efforts of the direct care workforce. Both states distributed funding between rural and urban areas in relative proportion to the size of the populations living there. However, this distribution does not necessarily take into account population health needs and challenges faced by the direct care workforce in rural areas. Further, urban counties were disproportionately represented among funded agencies. The differences in funding supports for the direct care workforce demonstrate the ongoing need for equitable and comprehensive resources for the direct care workers in rural areas, especially after the impact of the COVID-19 pandemic.

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